The Battle Creek VA Medical Center (BCVAMC) is currently recruiting applicants for our Clinical Neuropsychology Postdoctoral Residency Program for the training year starting Fall 2019. **Our Aim is to prepare early career Neuropsychologists for entry level positions in Neuropsychology at the VA equivalent of GS-13 within the context of interprofessional practice, who ultimately will be prepared to apply for ABPP board certification in Clinical Neuropsychology.**

We offer ONE full time, two year residency position starting on or around September 1. The stipend rate for full-time psychology Residents is $46,553. Comprehensive benefits are available to VA trainees including medical insurance, paid sick and vacation leave, as well as 5 days of guaranteed authorized leave for professional activities during the training year. We WILL participate in APPCN Match, interviewing at INS. Applicants should have completed an APA-accredited internship or a VA sponsored internship, with approximately 50% time devoted to neuropsychology work under a Clinical Neuropsychologist. Neuropsychology/Neuroanatomy coursework preferred.
ACCREDITATION STATUS
The Clinical Neuropsychology Postdoctoral Residency Program at the Battle Creek VA Medical Center is currently Accredited on Contingency by the Commission on Accreditation of the American Psychological Association. As a new program, we are expected to provide data regarding outcomes of our graduates by September 1, 2022 to be evaluated for full accreditation.

*Questions related to the program’s accredited status should be directed to the Commission on Accreditation:

Office of Program Consultation and Accreditation American Psychological Association
750 1st Street, NE, Washington, DC 20002
Phone: (202) 336-5979
E-mail: apaaccred@apa.org
www.apa.org/ed/accreditation

APPLICATION & SELECTION PROCEDURES

Eligibility
There are several important eligibility requirements for participating in Psychology Training in the VA. Applicants are strongly encouraged to review this site prior to applying:

https://www.psychologytraining.va.gov/eligibility.asp

Additional details are found within this PDF:

https://www.psychologytraining.va.gov/docs/Trainee-Eligibility.pdf

All residents are required to have completed their doctorate prior to starting the residency, including dissertation defense. We will require either updated transcripts with degree conferral noted or a letter from your graduate program training director indicating that all requirements for graduation are complete at least three weeks prior to the designated start date. Please reach out to the training director as soon as possible should you predict a delay that would not allow you to have completed all requirements by then.

Please note marijuana use is not allowed by staff or trainees at this facility regardless of whether or not use is legal for medical or recreational reasons in other settings. While health professions trainees are not drug-tested prior to appointment, they are subject to random drug testing throughout the entire VA appointment period.

Residents selected for this program are strongly encouraged to complete American Heart Association Basic Life Support (BLS) provider certification prior to working at this facility. All residents are required to have proof of BLS by the second week of their appointment and may elect to complete it at this facility upon starting.

Sensitivity to Diversity
The Battle Creek VA Medical Center in which our training program resides is an Equal Opportunity Employer; we are committed to ensuring a range of diversity among our training classes. Our Residency program welcomes and strongly encourages applications from all qualified candidates, regardless of gender, gender identity, age, religion, race, ethnicity, culture, nationality, socioeconomic status, sexual orientation, disability, or other minority status. Students from diverse cultural backgrounds or historically underrepresented groups are strongly encouraged to apply.
**Travel**
Residents matching to this site will be expected to engage in some travel between the WHCC and the Battle Creek VA Medical Center. Additional travel between sites to participate in peer support, completion of research activities and engaging in site-specific training opportunities may be required and will occur during business hours. Didactic experiences are primarily on Battle Creek VAMC campus; however, additional opportunities for unique experiences at other sites likely will become available. Individual supervision will always be face-to-face, on site.

**Licensure:**
All psychology Residents are required to apply for a Michigan Doctoral Education Limited License for Post-Doctoral Degree Experience as soon as possible after acceptance of the position (i.e. March). Final conferral of the Limited License requires proof of completion of internship and all requirements for graduation and is quicker if initial steps are already completed. Residents are referred to the Michigan Board of Psychology for additional details.

https://www.michigan.gov/lara/0,4601,7-154-72600_72603_27529_27552---,00.html

This program meets requirements for postdoctoral experiences to qualify for licensure within the State of Michigan provided the Resident obtains the Doctoral Education Limited License prior to or within two weeks of starting the position. Residents should examine licensure requirements for any state in which they might ever desire to be licensed. The Battle Creek VAMC Psychology Residency training program will attempt to meet those requirements if possible, should we be informed of them.

**Application Process**
The Battle Creek VAMC will utilize the APPIC Psychology Postdoctoral Application Centralized Application Service (APPA CAS). Additional details are found here:

http://www.appic.org/About-APPIC/Postdoctoral/APPA-Postdoc-Application-Information

Prospective Residents are asked to submit a cover letter detailing their career aspirations and how this training program is suited to help in achieving them. Also, applicants should submit 3 letters of recommendation, two de-identified neuropsychological reports, a current CV, graduate school transcripts and a statement of dissertation status from your dissertation chair, including anticipated completion date. If your chair is one of your letter writers, dissertation status may be addressed in that letter without the need for an additional statement. These materials should be submitted electronically via the APPA CAS. Application materials should be submitted by December 31.

**Interviews**
We will participate in the APPCN Neuropsychology Match. Details may be found here:

https://www.natmatch.com/appcnmat/

Notification of interview selection will occur ASAP or by January 9 at the latest. Interviews will occur during the INS conference in mid-February. In person interview at INS is preferred and interviews onsite are not offered. Applicants will meet with primary neuropsychology supervisor, the training director(s), and current resident.
Selection Criteria
Selection will be based on the goodness of fit between the applicant’s training goals and prior experiences with the training offered within the Residency program.

Notification of Selection
Upon notification of a match, we will reach out via phone and follow-up with a formal letter acknowledging the match. The Resident will be asked to sign and return a formal letter of acceptance, which is the basis of starting the Human Resources onboarding process.

Contact Information
Further information regarding the Battle Creek, MI VAMC Clinical Neuropsychology Residency Program can be obtained by visiting our website or contacting training leadership:

http://www.battlecreek.va.gov/careers/Battle_Creek_Psychology_Training_Programs.asp

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TRAINING SETTING

Overview of the Medical Center
The Battle Creek Veterans Affairs Medical Center (BCVAMC) operates with five locations. The main Battle Creek facility lies 20 miles to the west of Kalamazoo, and the Medical Center is about two hours from Detroit and three hours from Chicago. There are 91 inpatient psychiatric and intermediate medical beds, 92 residential rehabilitation beds, 11 acute medical beds, and 100 beds in the Community Living Center. The Medical Center has a fine Medical Library, and excellent library facilities are available at the nearby campus of Western Michigan University.

Approximately 50 miles north of the main Battle Creek Campus is the Wyoming Health Care Center (WHCC), which is a 100,000 sq. ft. facility that encompasses outpatient primary and specialty medical care as well as comprehensive outpatient mental health services. Just 5 miles south of Downtown Grand Rapids, Michigan, this facility opened for patient care on December 1, 2014.

In addition to these, the BCVAMC has community based outpatient clinics in Benton Harbor, Muskegon, and
Lansing Michigan. Home Based Primary Care provides in-home services throughout the entire Battle Creek VAMC catchment area. A Vietnam Veterans Outreach Center is also located in Grand Rapids.

Mission
The MISSION of the Battle Creek VA Medical Center is to provide primary medical care, comprehensive psychiatric care, specialty care, extended care and related social support services to Veterans in 22 counties of the southwest lower Peninsula of Michigan. As a hub for Mental Health services, Veterans are also referred from throughout Michigan and neighboring states for services. Further, the mission of the Medical Center is to honor America’s Veterans by providing exceptional health care that improves their health and well-being. The VISION of the Battle Creek VA Medical Center will continue to be the benchmark of excellence and value in health care and benefits by providing exemplary services that are both patient centered and evidence based. This care will be delivered by engaged, collaborative teams in an integrated environment that supports learning discovery and continuous improvement. It will emphasize prevention and population health and contribute to the nation’s well-being through education, research and service in National emergencies. The Core VALUES of the Medical Center are: Integrity, Commitment, Advocacy, Respect, and Excellence—I CARE!. The Strategic Priorities of the Medical Center are Access, Performance, Mental Health, Recruitment and Retention, Resource Management, and Communication and Outreach.

In the context of the basic mission of the Battle Creek VAMC to provide quality health care services, the mission of Psychology Service is to: (a) promote the physical and psychological well-being of VA patients, their families, and VA staff through comprehensive quality psychological health care services, (b) provide training in psychology to students and VA staff, and (c) advance the knowledge and applications of psychology through clinical practice, education, and research. The Residency program is viewed as an integral part of the Medical Center's and Psychology Service's missions. The Battle Creek VAMC Psychology Service is committed to providing high-quality Residency level training in psychology, which includes in-depth training in applied skills and exposure to a variety of clinical professional issues.

Psychology Service
Embedded within the Mental Health Service of the BCVAMC, Psychology Service is the main chain of command for the Psychology Training Program. Across the five locations, psychologists provide patient care services to all treatment units of the Medical Center, including medicine, psychiatry, the Residential Rehabilitation Treatment Programs, the PTSD Clinical Team (PCT), the Community Living Center, Home Based Primary Care, and the Mental Health Clinic in Battle Creek. Primary Care-Mental Health Integration and Health Psychology work closely with Primary Care and medical specialty services to provide assessment and behavioral health interventions. Psychological services are provided within a multidisciplinary treatment program and cover the full range of treatment modalities including: individual and group counseling/therapy; consultation; personality, intellectual, and neuropsychological assessment; behavioral assessment; behavior therapy; relaxation training; couples and family counseling and therapy. There are more than 30 doctoral level psychologists assigned to services and programs at the medical center who serve as supervisors for the Psychology Training Program at all levels. Members of the staff come from a variety of universities and internships representing a wide range of approaches and orientations. Considered as a whole, the staff has expertise in most areas of current clinical and counseling psychology practice. All supervising psychologists are fully, independently licensed in psychology within the jurisdiction in which they practice. Usually, this means they hold a Michigan Psychology license; however, some may hold licenses from other states. Supervisors in Neuropsychology have completed a two year postdoctoral specialty training residency and/or are board certified in Clinical Neuropsychology by ABPP. Psychology service, as part of the broader medical center, has access to a quality in-house and electronic medical library. A variety of assessment and intervention tools and materials are available for Residents to use. Ongoing professional development activities are offered for all staff, in which Residents are invited to participate as space allows.
TRAINING MODEL AND PROGRAM PHILOSOPHY

Within the Battle Creek VA Medical Center Clinical Neuropsychology Postdoctoral Residency Program, we offer and implement a specialty practice program in Clinical Neuropsychology within an interprofessional context. We identify with and conceptualize from a scientist-practitioner model. Residents generate new research projects and/or join current research projects already underway at this facility.

TRAINING AIM & COMPETENCIES

**AIM:** To prepare early career Neuropsychologists for entry level positions in Neuropsychology at the VA equivalent of GS-13 within the context of interprofessional practice, who ultimately will be prepared to apply for ABPP board certification in Clinical Neuropsychology.

Expected competencies, as well as the training methods that will used to develop those competencies are as follows:

1. Residents demonstrate competence in the **Integration of Science and Practice** including
   a. Applying the scholarly literature to all professional activities in their setting
   b. Conducting quality improvement/outcome assessment evaluation or research appropriate for this complex medical center.

   **TRAINING METHODS:** Experiential. Residents demonstrate and develop this ability within their professional work, monitored and guided by their supervisors. Residents complete a research/quality improvement project that includes substantial literature review, which will be presented to an audience of peers and professionals (e.g. Mental Health Grand Rounds; International Neuropsychological Society conference). Residents demonstrate integration of diversity research into clinical practice during the diversity case presentation to other trainees.

2. Residents demonstrate competence in **Ethical and Legal Standards** by conducting themselves ethically at all times, recognizing ethical dilemmas as they arise, applying ethical decision-making processes to resolve them and demonstrating knowledge of and acting in accordance with:
   a. The current version of the APA Ethical Principles and Code of Conduct,
   b. Relevant laws, regulations, rules, and policies governing health service psychology in at the Battle Creek VA Medical Center as well at the state and federal level.
   c. Relevant professional standards and guidelines both within the Veterans Health Administration and beyond.

   **TRAINING METHODS:** Experiential. Residents demonstrate and develop this ability within their professional work, monitored and guided by their supervisors. Residents attend monthly Interprofessional Ethics didactic, which includes each Resident presenting an ethical issue.
3. Residents demonstrate competency in **Individual Differences and Cultural Diversity** including:
   a. An understanding of how their personal/cultural history impacts how they understand and interact with others;
   b. Knowledge of current scholarly literature related to addressing diversity across all professional activities;
   c. An ability to independently integrate that awareness and knowledge into all professional activities within our setting.

**TRAINING METHODS**: Experiential. Residents demonstrate and develop this ability within their professional work, monitored and guided by their supervisors. Residents attend monthly Diversity Series didactics where they are expected to take on an advanced role in guiding conversation as attendees. They will also formally lead one of the seminars, presenting a case to the group.

4. Residents demonstrate competence in **Interprofessional Practice** relevant to their setting including:
   a. Describing the role of their own discipline in the context of working with other disciplines, including the common and unique knowledge base and skills of each.
   b. Recognizes the interdependence of all disciplines and team participants in any decision-making process and apply that awareness in professional practice.
   c. Defining broader concept of interdisciplinary teams including describing the roles of family members, community providers, and self-advocates, in addition to discipline representatives.

**TRAINING METHODS**: Experiential. Residents demonstrate and develop this ability within their professional work, monitored and guided by their supervisors. Residents are involved in some form of mixed discipline team. They will consult with other disciplines. Residents attend Interprofessional Ethics and Interprofessional Mental Health Grand rounds.

5. Residents applies **Patient Centered Practices** to all professional work including:
   a. Fostering self-management, shared-decision making, and self-advocacy/direction
   b. Soliciting the preferences, needs, and goals of the patient during clinical encounters and integrates that information into care plans and treatments
   c. Recognizing the role of caregivers/family in improving outcomes for Veterans and involves them in care-planning as desired by the Veteran.

**TRAINING METHODS**: Experiential. Residents will demonstrate and develop this ability within their professional work, monitored and guided by their supervisors. Recovery Model and Patient-Centered practices are common topics within group and individual supervision. Didactics may be available that enhance their professional work.

6. Resident competently conducts **Assessments**, including:
   a. Independently interpreting interview data and records, integrating relevant measures as indicated to develop appropriate diagnostic impressions and recommendations
   b. Completing assessments in a timely, well-written and organized way
   c. Providing meaningful feedback to patients, consulting providers, and/or team members
   d. Attending to individual differences and cultural diversity

**TRAINING METHODS**: Experiential. Residents demonstrate and develop this ability within their professional work, monitored and guided by their supervisors. These are highly specific to the setting of practice (e.g. inpatient, outpatient, primary care setting).

7. **(OPTIONAL)** Residents provides **Intervention** appropriate to their setting demonstrating ability to:
   a. Establish and maintain effective relationships with recipients of psychological services
   b. Develop treatment plan informed by the current scientific literature, assessment findings, diversity characteristics and contextual variables
c. Implement interventions, evaluating intervention effectiveness and adapting according to ongoing evaluation
d. Apply relevant research literature to clinical decision making
e. Modify and adapt evidence-based approaches effectively when a clear evidence-base is lacking

TRAINING METHODS: Experiential. This is an optional experience for the Neuropsychology Resident. Should they elect an intervention based experience during their training time, these competencies are demonstrated and developed within that professional work, monitored and guided by their supervisors. Residents attend didactics, Grand Rounds, continuing education seminars about intervention as well as potential involvement in more comprehensive trainings.

8. Resident will demonstrate a high degree of **Professionalism** including:
   a. Behave in ways that reflect the values and attitude of psychology such as integrity, deportment, professional identity, accountability, lifelong learning and concern for the welfare of others
   b. Engaging in self-reflection regarding personal and professional functioning and independently engaging in activities to maintain and improve performance.
   c. Actively seek and demonstrate openness and responsiveness to feedback and supervision
   d. Respond professionally in increasingly complex situations
   e. Serve as a role model of professional behavior to other less developed trainees (e.g. practicum students, medical students, interns)

TRAINING METHODS: It is expected that this competency will have developed during graduate training and solidified during their internship year. Residents will have ample opportunity to demonstrate competency in this area during their routine professional work as well as demonstrate professional savvy as it relates to their clinical setting. Supervisors will monitor this competency within the Resident’s professional work and provide areas to stretch their professionalism as an emerging early career Neuropsychologist.

9. Resident demonstrates professional **Communication and Interpersonal skills** including
   a. Developing and maintaining effective relationships with a wide range of individuals, including colleagues, community partners, supervisors, supervisees and those receiving professional services as well as their support persons
   b. Producing and comprehending oral, nonverbal and written communications that are informative and well-integrated, demonstrating a thorough grasp of professional language and concepts
   c. Demonstrating effective interpersonal skills and ability to manage difficult communication well

TRAINING METHODS: It is expected that this competency will have developed during graduate training and solidified during their internship year. Residents will have ample opportunity to demonstrate competency in this area during their routine professional work and develop additional skills relevant to their particular clinical settings. Supervisors will monitor this competency within the Resident’s professional work to identify undeveloped aspects and build communication and interpersonal skills appropriate to early career Neuropsychology.

10. Resident demonstrates competency in the foundations of **Brain Behavior Relationships** including
    a. Demonstrating working knowledge of CNS, functions attributed to a particular part of the brain or spinal cord and functional pathways and networks. Integrates this knowledge into delivery of Neuropsychological Practice. *(Functional Neuroanatomy)*
    b. Demonstrating working knowledge of **neurologically based insult and diseases** such as base rates, onset, course, symptoms, progression, associated features, diagnostic criteria, cognitive and behavioral patterns and neurophysiology, integrating this knowledge into delivery of Neuropsychological Practice.
c. Demonstrating working knowledge of **non-neurologic conditions impacting CNS** functioning (i.e. cognitive, psychiatric and behavioral), integrating this knowledge into delivery of Neuropsychological Practice.

d. Demonstrating working knowledge of **neuroimaging and neurodiagnostic techniques** and diagnostic reports/findings, integrates this knowledge into delivery of Neuropsychological Practice.

e. Demonstrating working knowledge of **neurochemistry** and the impact on cognition, mood and behavior, integrating this knowledge into delivery of Neuropsychological Practice.

f. Demonstrating working knowledge of **neuropsychology of behavior** (i.e. understanding of interplay between neuroscience, cognitive and abnormal psychology, cognitive science and related evidence base of brain-behavior relationship), integrating this knowledge into delivery of Neuropsychological Practice.

**TRAINING METHODS: Experiential.** Residents are exposed to patients with a variety of conditions that require working knowledge of the above, integrating that knowledge into case conceptualization, interpretation of data, differential diagnosis, treatment recommendations, interventions, and consultation under the direction of clinical supervisors. Resident attends weekly Neuropsychology Didactics that provide didactic information which will be integrated into clinical work, which is the venue in which competency will be evaluated.

**11. Resident demonstrates competency in practice of Clinical Neuropsychology foundations including**

a. Demonstrating knowledge and application of solid scientific foundations/clinical decision making in formulating new cases, including selection of appropriate test battery and normative data, professional, consistent and accurate test administration and scoring, integrating this knowledge into delivery of Neuropsychological Practice (**specialized neuropsychological assessment techniques**).

b. Demonstrating working knowledge of current theories in **Neuropsychological and Rehabilitation interventions**, integrates this knowledge into delivery of Neuropsychological Practice.

c. Demonstrating working knowledge of **research design and analysis in Neuropsychology** through participation in direct research activities (i.e. Database and new and ongoing IRB projects), integrates this knowledge into delivery of Neuropsychological Practice.*

d. Demonstrating and applying working knowledge of **professional standards, law and ethics** in the practice of Clinical Neuropsychology. Integrates this knowledge into all forms of service delivery, teaching and research activities.**

e. Demonstrating and applying working knowledge of and sensitivity to **individual and multicultural diversity issues** in the practice of Clinical Neuropsychology. Integrates this knowledge into all forms of service delivery, teaching and research activities.***

f. Demonstrates working knowledge of the **practical implications of neurologic and non-neurologic conditions** on cognition, mood and behavior, integrating this knowledge into delivery of Neuropsychological Practice.

**TRAINING METHODS: Experiential.** Residents are exposed to patients with a variety of conditions that require working knowledge of the above, integrating that knowledge into case conceptualization, interpretation of data, differential diagnosis, treatment recommendations, interventions, and consultation under the direction of clinical supervisors. Resident attends weekly Neuropsychology Didactics that provide didactic information which will be integrated into clinical work, which is the venue in which competency will be evaluated.

*Neuropsychology residents are required to demonstrate the ability to integrate scholarly literature into all areas of practice (assessments, peer supervision), and engage in the process of a research/quality investigation project common to any psychologist at the advanced practice level (1.a-b) as well as demonstrate understanding.
of neuropsychology specific research design and analysis appropriate to the specialty practice level (11.c)

**Neuropsychology residents are required to demonstrate ethical and legal competencies common to any psychologist at the advanced practice level (2a-c) and also competencies in ethical issues appropriate to specialty practice in Neuropsychology (11.d).

***Neuropsychology residents are required to demonstrate competency in individual differences and cultural diversity appropriate for any psychologist at the advanced practice level (3.a-c) as well as competence in individual difference and multicultural factors specific to Neuropsychology (11.e).

Our program uses our SoA Competency Form for Neuropsychology Residents, which is found in Appendix 1.

**STRUCTURE OF THE PROGRAM**

Our program offers advanced postdoctoral training within the specialty practice areas of Clinical Neuropsychology, with a primary site of training at the Battle Creek VA Medical Center (BCVAMC) campus in Battle Creek, Michigan with additional training at other sites such as the Wyoming Health Care Center (WHCC) in Wyoming (Grand Rapids) Michigan (Dementia Screening Clinic, up to 4 times monthly) or the Mary Free Bed Rehabilitation Hospital in Grand Rapids Michigan (up to 4 months, part time during the second year). Over the two year training period, the resident will devote at least 50% of their time to clinical care including face to face direct services, report writing, scoring and other activities to support patient care. Up to 25% is designated for research activities and at least 10% of their time is devoted to educational/didactic activities. Residents received at least 2 hours of face to face individual supervision per week. Supervision will include live observation.

The resident will meet with the Neuropsychology training team to discuss training needs and select rotations. A formal training plan is developed to include clinical experiences as well as other activities. All clinics and supervisors are engaged in interprofessional practice and recovery focused service as central to their activities. Substantial modeling of these practices occurs. Residents have a minimum of two supervisors in Neuropsychology over the course of the year, with additional non-Neuropsychologist supervisors.

**Clinical Experiences:**

Residents complete core neuropsychology rotations at the Battle Creek VAMC campus and WHCC campus. The resident also selects elective experiences according to their needs and goals including:

- Mary Free Bed Rehabilitation Hospital (up to 4 months during second year) under Neuropsychologist
- Dementia Long-Term care within the Community Living Center under Geropsychologist
- Home Based Primary Care Neuropsychology
- Outpatient Therapy at Battle Creek under Psychologist
- Rounding with Neurology, Radiology, Speech and Language Pathology and Medicine clinics under various professionals. These are usually brief, lasting an hour to a day.

**Core Rotation Descriptions:**

Neuropsychology, Battle Creek, MI: The resident will spent at least 50% of their time within the BCVAMC Neuropsychology clinic addressing needs of outpatients, inpatients, and residential Veterans. Patient population includes all adults 18 and above. Residents will also provide peer supervision/consultation to internship level Neuropsychology trainees (second year) and undergraduate interns (summer of the first year). Typically at least 10 direct patient care hours are expected, with two hours of individual supervision. Primary supervisor is Jeremy Bottoms, PsyD, ABPP-CN with additional supervision by Jessica Kinkela, PhD, ABPP-CN.

Battle Creek VA Medical Center Psychology Residency
• Outpatient consults include neurocognitive disorders (dementia), medical conditions impacting cognition (stroke, cardiovascular disease), post-acute traumatic brain injury, and cognitive implications of psychiatric diagnoses. The resident is also exposed to movement disorders, atypical dementias, and metabolic disorders. Compensation seeking and invalidity are frequent issues in younger outpatient referrals. Occasionally, evaluations are completed at the request of Compensation and Pension examiners.

• Inpatient Consults come from the 10 bed acute medical unit (AMU) or the 40+ bed acute inpatient mental health (IMH) unit. The AMU provides care for decompensation, congestive heart failure, sepsis, pneumonia, COPD exacerbation/respiratory failure/hypoxemia, and complications from diabetes. The resident may serve as consultant or round more frequently with the team depending on level of involvement desired. The IMH addresses the acute psychiatric needs of patients with suicidal ideation/attempts, decompensation of chronic psychotic/bipolar conditions, or geriatric dementia/chronic SMI patients. In both settings evaluations are bedside in nature; however, for more stable patients they may be transported to the outpatient clinics. Referrals for both inpatient settings tend to be for capacity to live independently for discharge planning, level of cognitive impairment, need for guardianship, and dementia differentials.

• Residential Veterans are also seen on an as needed basis from the Psychosocial Rehabilitation, PTSD, and Substance Use programs. These individuals are seen in the outpatient clinics and involve substantial collaboration with psychologists on the unit. Typical referrals are related to behavioral challenges impacting the Veteran’s ability to be successful in the program. Examples include differential of personality pathology versus neurological condition, cognitive challenges from substance use, implications of concussion on presentation, validity of presentation cognitively, and level of intellectual/cognitive functioning to help with career/job planning or a return to school. Residents have offered a Cognitive Remediation group intervention (CogSmart) as part of Residential programming.

Neuropsychology WHCC: The resident participates in the dementia screening clinic at WHCC approximately 16 hours monthly. This clinic occurs four times monthly, although the resident will only participate in a portion of them. Patients are older (65+) and are seen for a brief, four hour appointment. Referral questions include functional capacity, dementia differentials, medical decision-making and level of independent functioning. This is a fast-paced clinic where typically the resident sees the first patient with the supervisor in the morning followed by scoring and report writing in the afternoon. During the second year, the resident will supervise the morning case with the intern. Direct patient contact is typically 4 hours per day when working in the clinic. Supervisors are Jeremy Bottoms, Psy.D., ABPP and Jessica Kinkela, Ph.D., ABPP.

**Additional Rotation Descriptions:**

Community Living Center: Under Geropsychologist Ann Smolen-Hetzel, Ph.D., the resident will provide intervention and assessment focusing on older adults and dementia care. They are involved in management of behavioral challenges on the locked dementia unit (STAR VA program). They are part of the treatment team, consulting and evaluating medical decision-making and functional capacity as well as completing brief cognitive screening evaluations. On this unit they will have the opportunity to work with associated health professionals including occupational therapy, physical therapy, and recreational therapy. Palliative and hospice care experiences are also available. Typically, this rotation is one day weekly for 6-12 months.

Home-Based Primary Care (HBPC) Assessment: Where the HBPC Psychologist does not have the skill set to perform cognitive evaluations and when diagnostic differential requires specialist Neuropsychology involvement, in home evaluation is possible. With Drs. Bottoms and Kinkela providing supervision, coordinating
with the patient’s HBPC Psychologist, the resident has exposure to providing in-home cognitive evaluations to Veterans in rural community settings with limited access to service. The resident would complete an orientation period with HBPC Psychologists with future evaluation referrals occurring via Consult, concurrent with their outpatient Neuropsychology clinic work. It is expected that the resident choosing to focus on this mode of cognitive evaluation delivery would complete 3-6 evaluations over the course of the year.

Outpatient Therapy: Psychotherapeutic interventions, while not typically emphasized in many Neuropsychology postdoctoral programs, remain a core clinical skill. As Neuropsychologists may be asked to serve in interprofessional settings in which they may be required to provide brief interventions, the resident may elect to complete a brief therapy rotation 1 day weekly for 6 months) in Primary Care-Mental Health Integration or outpatient mental health. This would be concurrent to their Neuropsychology work. Supervisors will be licensed Psychologists serving within the selected clinics.

Mary Free Bed Rehabilitation Hospital: Under the supervision of Jacobus Donders, Ph.D., ABPP, the resident will rotate within this rehabilitation setting. Clinical activities will be negotiated with Dr. Donders and the resident according to needs and experience availability. Typically, this will mean two days/week for 3-4 months. This rotation occurs at the end of the first training year. The majority of clinical work will be outpatient, with some subacute and inpatient consultation. The resident will be responsible for traveling to Mary Free Bed Hospital located in Grand Rapids, MI and a government car may be available.

Rounding: To increase resident exposure to other health areas relevant to neuropsychological practice, the resident will observe and potentially contribute to clinical care while rounding with Neurology, Radiology, Speech and Language Pathology and/or Medicine clinics. This will be established based on resident interest and prior experience with other medical and associated health specialties. This typically is a one to two day experience with each service section.

RESEARCH EXPERIENCES
Up to 25% of their training time is devoted to completing an Institutional Review Board/Research Development approved research project. During their first three months they will identify a project and complete an application or join a current project. Their research must result in a scholarly product, defined at minimum as a paper or poster presentation at a regional or national Neuropsychology conference. The resident will identify a primary mentor to assist them with this project and additional consultation with the research coordinator is available. See Appendix 2.

EDUCATIONAL EXPERIENCES
Residents complete 4 hours of educational activities weekly, two of which are face-to-face individual supervision. The remaining 2 hours of educational activities weekly are made up of a combination of activities relevant to the individual Resident. This could include additional supervision, formal didactics, consultation, journal clubs, grand rounds and other activities as they become available. Traditionally, residents average significantly more than 4 hours weekly educational experiences. During the second year, the Resident may opt out of seminars that are repeated (e.g. a second presentation of a diversity topic by the same presenter; interprofessional ethics). They are required to still sustain 4 hours of educational activities weekly, including individual supervision. Residents document educational and clinical activities in a log that is completed monthly and is provided to the Training Director via a shared electronic folder.

A list of all required and additional optional educational opportunities are found in the shared folder:

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Residents should check this folder frequently to be aware of changes in required trainings. While updates are often sent out via email, Residents are responsible for attending as scheduled and contacting the training director or listed presenter for clarification as needed.

**Required Educational Experiences**

**Individual Supervision** (2 hours/weekly, as scheduled)
**Training Director Meeting** (First/Third Friday 11a-12pm)
**Diversity Series** (First Friday, 2:30-4pm)
**Interprofessional Ethics** (Third Friday, 2:30-4pm)
**Mental Health Grand Rounds** (Second Friday, 3-4pm)
**Peer Support** (As scheduled, approximately 2 times monthly)
**Neuropsychology Seminars** (local 2-3pm; multisite 3-4pm, weekly on Wednesdays)
**Additional Activities** (as scheduled to bring total to 4 hrs/wk including 2 hours of individual supervision)

**Individual Supervision**: Residents receive a minimum of 2 hours of face-to-face supervision weekly by rotation supervisor. No telesupervision will be used to obtain these two hours of supervision. Primary purpose of individual supervision is to facilitate clinical competencies and provide oversight of clinical care provided by the resident.

**Training Director Meeting**: 2 hours monthly, 11-12, Fridays. Residents will meet as a group with the training director for an hour. Initially this will occur weekly; however, it will decease to bimonthly as the trainees progress. This does not take the place of individual supervision and is not meant for primary clinical supervision. It will be either via video conference or in person. Addressing administrative and professional issues, this is a resident led experience, guided by training directors. In addition, each Resident engages in mentorship with the training directors.

**Diversity Series**: This seminar is open to any trainee, including non-psychology disciplines; however, it is presented at the level of internship or higher and involved integration of the scholarly literature. Format involves a formal presentation, Q&A with specific program leader (e.g. Military Outreach Coordinator), or case study with integration of the literature. Postdoctoral residents are expected to model integration of diversity into practice via teaching one session and also by serving as a leader during discussion. Repeated presentations are optional year two.

**Interprofessional Ethics Series**: This is devoted to exploration of Ethics in an interprofessional context. Psychology, Pharmacy Residents and Optometry Residents collaborate to provide trainees with a forum for discussion of ethics in clinical settings. The format of this series is evolving, but remains applied in focus. Optional year two.

**Mental Health Grand Rounds**: All mental health service line professions attend, including social work, nursing, psychiatry, medicine, psychology, mental health pharmacy. Residents attend and frequently are given the opportunity to present their internal outcomes/research projects during one of the spring/summer sessions, as well as develop a poster for the May session. This is available via video conferencing to all CBOCs. While mainly occurring within Battle Creek VAMC, presenters may broadcast from the WHCC. Thus, Residents may view this in person or via video conference along with their Mental Health Service Line peers within their setting. The level of presentation is targeted to staff development, thus is will be very much at the advanced level Residency trainees would require.

**Peer Support**: 2 hours monthly, minimum. This is a flexible time window in which Residents meet for mutual support, discussion of professional/personal issues, and general collaboration and bonding. This time window is
also available for Residents to work on a joint research project if they prefer. They may elect to meet via videoconference, phone, or either the Battle Creek or WHCC locations. Additionally, they may meet off-site with leadership/training program approval. Prior residents have had monthly video calls, lunch/brunch off campus, or gathering in a conference room.

**Neuropsychology Seminars:** Wednesdays 2-3pm. Designed to address the needs of staff and advanced trainees alike, topics may include neuroanatomy, pathology, ethics, preparing for board certification in neuropsychology, case presentations, and other topics. Residents are offered the opportunity to present as their interest allows. This is shared with neuropsychology staff and trainees at other VA settings and local attendees connect with other sites via videoconferencing. Wednesdays 3-4pm. Multiple site Neuropsychology Residency specific didactics completed with MIRECC and other neuropsychology residency programs via telehealth. Involves specific functional neuroanatomy readings/presentations at the postdoctoral level.

**Other Educational Experiences**

Residents attend a variety of individualized educational activities to add up to 4 hours of weekly educational activities, including individual supervision. Some examples regularly occurring seminars include:

**Preceptor Development:** Six times annually. This is an interprofessional staff preceptor meeting designed to provide peer support and education at an advanced level, around provision of training. Residents, who are akin to our unlicensed early-career staff psychologists, are invited to attend. Residents are required to attend if they will supervise a trainee.

**Psychology CE:** Various times, approximately 2-4 times annually. Covering a variety of topics, internal or external presenters provide APA-accredited CE programs to staff and trainees. This often includes updating staff on new treatment methods or assessment techniques. Recent topics of note include Recovery Oriented Care, Suicide Prevention research, WAIS-IV, Seeking Safety, Cognitive Processing Therapy, ADHD in Health Care Settings, MMPI-2-RF. Depending on the topic, only psychologists may attend, while in other cases providers of many disciplines attend.

**Medical Grand Rounds:** First Friday at 1pm-2pm. Covering a variety of topics, internal or external presenters provide continuing education to Medical staff and trainees. Topics of interest to psychologists, or which carry Psychology CE are announced and may or may not be made mandatory for residents.

**Integrated Care Journal Club:** Fourth Friday at 12pm. This interprofessional journal club targets continuing professional development with topics selected by a rotating list of staff and trainees. Two or three journal articles are selected and discussed, with emphasis on application to clinical work within this setting.

**General Assessment Seminar:** Fridays 10-11am. This seminar is case focused and based on the needs of those attending regarding assessment processes. It is mixed between interns, residents and practicum students. Residents may attend according to the topic of interest. Because of the significant case presentation element, even familiar topics include substantial new material due to the differing presentation of the case.

**Mentorship:** In addition to mentorship with the training director and on clinical rotations, a resident also has the option to identify a specific mentor (non-evaluative or otherwise) to work with throughout the course of the year. This could be with one of several collaborating VA neuropsychologists or a psychologist on campus. Selection of a mentor will be based on Resident preferences and ideally will include someone who shares their professional interests and career goals, who can provide informal guidance and support throughout the year.
ADMINISTRATIVE STRUCTURE

Ultimate responsibility for the Psychology training program rests with the Chief, Psychology Service. This responsibility is delegated to the Psychology Training Council consisting of the Psychology Training Director, Associate Training Directors, psychologists supervising trainees, a representative of the current intern and resident class, and the Chief of Learning Resource Service. Day-to-day administrative decisions for the program are made by the Psychology Training Director. The Psychology Training Director's duties include: serving as Chair of the Psychology Training Council, arranging training seminars, serving as preceptor for trainees, communicating with the university training directors as indicated, coordinating trainee and staff evaluations, overseeing the trainee selection process, and coordinating the program's self-assessment and quality enhancement procedures as decided upon by the Training Council.

Psychology Training Council
The Psychology Training Council is responsible for overseeing all Psychology training at all levels on campus. The Council consists of, at minimum, the following individuals:

Director of Psychology Training, Chairperson
Chief, Psychology Service
Associate Director of Training, Undergraduate
Associate Director of Training, Practicum
Associate Director of Training, Internship
Associate Director of Training, Residency
All psychologists who are currently supervising an intern
Representatives of the current intern class
Representatives of the current resident class
Chief, Learning Resources Service, Ex-officio

Any staff psychologist with a valid Psychology license is potentially able to serve as a clinical supervisor and as such, all staff psychologists may elect to be active in the Training Council’s activities at any given time regardless of whether they are currently supervising a trainee. The Psychology Training Council is responsible for establishing policies pertaining to training; participating in the selection of new trainees; evaluating and approving trainee training plans; addressing training issues as they affect university-VA training relationships; considering any trainee grievances; and conducting the psychology training program’s self-assessment and quality improvement efforts. The Psychology Training Council meetings are held at minimum, quarterly, or at the call of the Psychology Training Director. The Training Council meets quarterly to specifically review and discuss trainee progress and to facilitate the trainee’s overall success in the Program.

EVALUATION

Formal Competency Ratings will be completed quarterly using the SoA Competency Assessment Form, which is provided to Residents at the onset of training. See Appendix 1. Each Resident will have at least two supervising Neuropsychologists evaluating their daily work and professional factors over the course of the year. Additionally, the Training Director and Associate Training Director will provide feedback at the quarterly marks. Informal evaluation and feedback by the supervisor of the Resident will occur on an ongoing basis. Resident progress will also be discussed at Training Committee meetings. The Resident is encouraged to engage in self-assessment and ongoing performance improvement. The Resident is encouraged to provide feedback to supervisors and program leadership to improve their overall residency experience.
Residents will be evaluated based on the level of supervision required:

Level 6: Advanced Practice, life-long learner and Consultant
- Competency in this area is at the level expected of fully licensed, independent psychologists at the GS-13 level in the VA System
- **Residency:** Residents may achieve this rating on a few advanced practice tasks that represent particular strengths. This rating is for rare occasions when a Resident can serve as a consultant to other licensed psychologists in a particular area.
- **Internship:** Inappropriate for internship level trainees
- **Practicum:** Inappropriate for internship level trainees

Level 5: Ready for Autonomous Practice.
- Competency in this area is at the level expected of psychologists ready to apply for licensure, such as those at the GS-12 level in the VA system.
- **Residency:** Supervision is required for compliance with professional standards, but with proper licensure, Resident could perform independently. Consultation is self-guided and directed toward life-long learning and ongoing advanced practice development. **Residents must achieve this level rating on all target competency measures for successful program completion.**
- **Internship:** This level of rating should be extremely rare for interns and be limited to a few areas of particular and exceptional strength.
- **Practicum:** Inappropriate for practicum level trainees

Level 4: Requires consultation-based supervision
- Competency in this area is at the level expected of unlicensed, entry level psychologists, such as those who have been working at the GS-11 level in the VA system for six months.
- **Residency:** The resident acts as a unlicensed “junior” colleague, requiring supervision according to compliance standards. Resident requires only consultation-based/resident directed supervision for core health service psychology tasks with ongoing consultation and supervision as required for advanced practice areas. **This is expected at the mid-point of residency for all target competency measures.**
- **Internship:** Interns may achieve this rating on a few core tasks that represent particular strengths; however, it will be rare.
- **Practicum:** Inappropriate for practicum level trainees

Level 3: Requires occasional supervision.
- This is the rating expected of incoming doctoral staff members just starting at the GS-11 level within the VA system who have just received their doctorate and are beginning to undergo postdoctoral supervision towards licensure.
- **Residency:** This is the rating expected of incoming postdoctoral residents and would be a common rating for first quarter evaluations. The resident requires occasional supervision for core health service psychology tasks, but regular supervision for advanced practice tasks.
- **Internship:** This is the rating expect at the end of the training year for interns. Intern does not require additional supervisory sessions to complete this task. The supervisor can rely primarily on some of the reports of the trainee with occasional direct observation for compliance.
- **Practicum:** Students may achieve this rating on a few core tasks that represent particular strengths for the practicum student; however, it will be rare and limited to trainees in advanced practicum placements.
Level 2: Requires close supervision
- **Residency**: Resident requires close supervision for core health service psychology tasks. Ratings at this level represent an area of underdeveloped competency, which requires specific attention when noted. A formal remediation plan may or may not be implemented.
- **Internship**: Interns may receive this rating at internship start or first quarter, but it must be achieved at least by the midpoint of the internship training year. The intern requires less frequent direct observation and extra supervision is needed only occasionally for more challenging tasks or new areas of development.
- **Practicum**: Practicum students in their final practicum before internship, will be at this level. Practicum trainees doing their first external placement may achieve this rating on several core tasks, but are unlikely to be at this level for all items.

Level 1: Requires Substantial Supervision
- **Residency**: Any evaluation at this level requires a remediation plan.
- **Interns**: Interns are expected to start at this level or level 2. Interns require frequent direct observation and additional supervision sessions outside the minimal requirements to meet core competencies.
- **Practicum**: Students will generally be working at this level although advance practicum students may be working at level 2.

**REQUIREMENTS FOR COMPLETION**

Requirements for successful completion include:

**Hours**: The residency requires two years of full-time training (2080 hours annually) to be completed in no less than 24 months. This includes paid federal holidays and accumulated paid annual and sick leave that can be taken during the year. The Resident is encouraged to examine individual licensure requirements for any state they wish to be licensed in to ensure that use of annual or sick leave does not need to be subtracted from total licensure hours. This is particularly important in the case of transferred leave or prior federal service placing the resident in a higher leave bracket.

**Patient Contact**: Successful completion of the resident requires a minimum of 25% direct patient care. Direct patient care includes face-to-face, telehealth, or phone consultation in which the intern and the patient(s) are interacting for the purpose of patient care including for intervention, assessment or other treatment/care purposes. Consulting with other staff about a patient when a patient is not present/participating in the consultation is not considered direct patient care. Typically residents spend between 12-18 hours weekly in direct patient care. Please note, while we meet criteria for the state of Michigan with regard to patient contact, the Resident should investigate minimum patient contact requirements for any jurisdiction in which they would like to be licensed.

**Quality/Research Project**: The Residents are required to complete a quality or research requirement that would include literature review, oral presentation, and written presentation. See Appendix 2.

**Diversity Seminar**: The Residents are required to lead a diversity series seminar, observed by a staff member who will offer feedback on teaching methods and presentation.

**Competency**: Residents need to be evaluated as Level 4 or higher at the mid-point and Level 5 or higher at the end of the training on all target competencies. Completion of licensure paperwork is dependent on achieving successful end of the year competency ratings. See Appendix 1.
Supervision: Neuropsychology residents engage in supervision in several capacities, although it is not necessarily a full requirement: It could be supervising full reports, supervising undergraduate research interns, supervising general interns in WAIS-IV administration, or supervising neuropsychology interns with interview/administration of neuropsychological cases. Supervision is contingent on the resident demonstrating satisfactory project in their own development to be able to redirect focus to the development of a junior colleague.

TRAINING FACULTY

Psychology Staff Supervisors involved in the Neuropsychology Residency training program, their theoretical orientations, and their special areas of interest are listed below. Most supervising psychologists are licensed within the state of Michigan. Should a supervisor not be licensed in the state of Michigan, the Resident will be informed and discussion regarding implications will occur. All Residents receive 2 hours of individual, face-to-face supervision weekly, and will have a minimum of 2 supervisors over the course of the year.

Neuropsychologists:

Jeremy M. Bottoms, Psy.D. ABPP  
Board Certified in Clinical Neuropsychology  
Dr. Bottoms is Associate Training Director for the Clinical Neuropsychology residency program and primary supervisor for internship and postdoctoral level neuropsychology trainees. He served as internship Psychology Training Director at Chillicothe VAMC before starting at the Battle Creek VAMC in 2014. He completed his graduate training at Wright State University School of Professional Psychology, his internship at the Cincinnati VAMC, and his postdoctoral residency at the Geisinger Health System. His theoretical orientation is Cognitive-Behavioral and his interests are on Quality of Life, Ecological Validity, Dementia, and Training. He completed pre-employment and annual Police evaluations and serves on the Dementia Workgroup and Mental Health Improvement Committee.

Jacobus Donders, Ph.D. ABPP  
Board Certified in Clinical Neuropsychology  
Dr. Donders is Chief Psychologist at Mary Free Bed Rehabilitation Hospital and is Training Director for their Neuropsychology residency program. He serves as external rotation supervisor and provides consultation. He is a leader in the field of Neuropsychology, with active research projects and service in various professional organizations.

Jessica H. Kinkela, Ph.D., ABPP  
Board Certified in Clinical Neuropsychology  
Dr. Kinkela serves as Training Director for the Psychology Training program as is a supervisor in both the internship and residency programs. Specifically, she supervises outpatient, inpatient and residential neuropsychology consults as well as general assessment cases for non-neuropsychology trainees. She completed her graduate work at Ohio University with internship at the Detroit VAMC. She completed her residency at Hines VA Hospital. Her orientation is behavioral/cognitive-behavioral, with heavy emphasis on Motivational Interviewing techniques. Her interests are in cognitive screening, validity, recovery focused assessment, and strengths based feedback. She serves on the Dementia Workgroup and consults with the medical training programs on campus.

For the most up-to-date faculty roster on non-neuropsychology faculty, contact the training director.
ADMINISTRATIVE POLICIES AND PROCEDURES

Stipends
The trainee stipend is divided into 26 equal bi-weekly payments, minus taxes, insurance and other deductions. This is automatically deposited into the account of their choice. Trainees are encouraged to switch to “electronic only” documentation. This can be established at this site: https://mypay.dfas.mil/, which also is where electronic copies of paystubs and tax forms may be downloaded.

Work Hours
The scheduled work hours typically are 8:00 a.m. - 4:30 p.m. Monday through Friday except for federal holidays. Lunch breaks are 30 minutes, usually taken from 12:00 noon to 12:30 p.m. Trainees may not stay on the medical center grounds after hours unless they have a designated supervisor present and available. This should be rare to promote positive work-life balance. The exception is use of the fitness center before or after working hours, although a workout partner or another person should be with them for safety.

Personal Leave
Trainees accumulate 4 hours sick leave and 4 hours annual leave per two-week pay period. In addition, trainees receive 10 federal holidays. Should extensive periods of illness or other circumstances cause an trainee to have to exceed his/her allotted leave during their one-year appointment, the trainee will have to work beyond the 12-month appointment without stipend to accumulate the extra hours that were lost. Additional leave may be granted for off-site educational workshops, seminars, lectures, conferences, professional meetings and other approved training activities. Up to five days of authorized leave per year may also be approved for use for professional psychology activities. This might include job interviews, attendance at conferences or trainings, or to attend formal graduation.

Timekeeping and Leave Requests
Requests for annual or sick leave, or authorized absence should be discussed with the supervisor for that day. If approved, the Resident submits leave request via the VATAS system. https://vatas.va.gov/webta/Login

Leave requests are approved by the Chief of Psychology Service. Except in the case of emergencies, all leave (except holidays) must be approved in advance. To avoid disrupting patient care, the trainee may be required to schedule planned leave 60 days in advance. Trainees should inform the Training Director and ALL supervisors of planned absences, typically by sending an outlook invite to the training director and following the procedures outlined by rotation supervisors. This facilitates coordination of unexpected clinical or administrative issues that cross beyond rotation days. Supervision missed due to planned or unexpected leave will need to be made up to ensure minimum requirements for weekly supervision are met. Rescheduling supervision is the trainee’s responsibility.

Unexpected Leave
Trainees will discuss with their supervisors what to do in the event of unexpected leave. At the minimum, trainee will contact the time keeper, Training Director, all their clinical supervisors and Chief of Psychology. They are encouraged to keep these emails available to them off site (e.g. in a non-VA email) to facilitate ease of communications. Other actions as indicated based on rotation will also be required, again as discussed with the rotation supervisor. It is the trainee’s responsibility to take appropriate action for rescheduling patient care responsibilities and appointments (e.g. informing your supervisor or requesting other staff cancel the appointments). Supervision missed due to planned or unexpected leave will need to be made up to ensure minimum requirements for weekly supervision are met. Rescheduling supervision is the trainee’s responsibility.

Logs
Each week a record should be completed indicating the trainee’s activities. This data should be uploaded into the Psychology Training folder for review by the Training Director and the trainee’s current rotation supervisors. Current forms are found in the psychology training folder.

Battle Creek VA Medical Center Psychology Residency
Identification Badges
All trainees and staff are required to wear PIV identification badges at all times during duty hours. Identification badges will be issued at the start of training and are required to access the computer network. In the event that an identification badge is lost, the Trainee should first do a search of likely places (i.e. in the badge slot). If a preliminary search does not result in finding it, the Trainee should contact the Training Director and Chief, Psychology Service. If a badge is not lost, but is unavailable (e.g. left at home) a temporary access code can be obtained for the day by contacting the National Service Desk x35480. Please inform the Training Director you are requesting PIV exemption.

Test Materials, Equipment and Keys
Obtaining of keys will be facilitated by Psychology Service. Trainees are financially responsible for all items checked out during the trainee year. The hospital requires a fee for lost keys. Keys to the test materials cabinet are distributed by the training director. If keys are lost, the Trainee should contact the Training Director and Chief, Psychology Service immediately.

Business Cards
Trainees will be provided with business cards during their first few weeks on station. This is submitted through the Battle Creek VA Intranet “communication request” link. The formal title for Residents is “Psychology Resident”. Trainees will work with the Training Director to enter appropriate contact information and the suicide help line.

Telephone Changes
Trainees should give the Service secretary their current home address and phone number during the week of orientation. It is also the trainee’s responsibility to notify the Service secretary of any changes in address or phone number during the year.

Policies
All medical center policies are found within a medical center SharePoint, with relevant internship policies placed in a shared folder for review. These include the dress code, procedures for mandatory reporting, and recording of patient care sessions in addition to others.

Accommodations
To the best of our ability, it is the practice of this training program to accommodate individual needs when requested. Within the training program, this could be informally or via following formal disability accommodation procedures described in medical center policy. Examples of accommodations previously provided include offering dictation software and adapting workstations. Trainee offices are handicap accessible.

Emergency Consultation:
For an immediate problem, the trainee is expected to contact the supervisor(s) first. If the immediate supervisor is not available, the trainee should contact their designated back-up supervisor, the Director of Training or the Chief, Psychology Service (in that order) for emergency consultation. In the event that a psychologist is not immediately available, the trainee may consult with any licensed independent provider, following up as soon as possible with their supervisor or other supervising psychologist. If, in the course of conducting patient assessment or treatment, the trainee has any concern about a patient’s dangerousness to self or others, the trainee is required to bring this to the supervisor’s attention as soon as possible or necessary to prevent untoward outcome. For outpatients, this consultation should occur prior to the patients leaving the clinic and definitely before leaving the Medical Center. For inpatients, this consultation should occur no later than the end of the same day as the concern occurs, as protection for both the patient and trainee. The supervisor will then determine whether any steps need to be taken to protect the patients or others, and will assure that documentation appropriately reflects actions taken.
**Conduct**

It is important that Residents conduct themselves in an appropriate, professional manner in all interactions with patients and other staff of the Medical Center. Under no circumstances should Residents accept gifts from, or engage in any monetary transactions with VA patients or family members. Residents are expected to abide by all ethical guidelines as stated in the APA’s Ethical Principles for Psychologists. Residents will receive a copy of these guidelines as part of orientation. Notify your supervisor, Director of Training, or the Chief, Psychology Service immediately if you are asked to engage in unethical behavior or if you have any questions regarding ethics. Serious conduct violations may result in termination of the Residency appointment. Substantiated allegations of patient abuse are also grounds for termination.

**Grievance Procedures**

Residents have a responsibility to address any serious grievance they have concerning the Residency Program, the Psychology Service, or the other Medical Services. A Resident has a grievance if he or she believes that a serious wrong has been committed and that a complaint is in order. A grievance can be addressed either formally or informally. Usually, an effort should be made to attempt to resolve the grievance informally. Embedded within Mental Health Service line, Psychology Service is responsible for initially addressing grievances of Psychology Trainees that cannot be addressed informally between the Resident and involved party. The Resident can attempt to direct resolution of the grievance with the involved party, or the Resident can informally address the grievance with a supervisor, the Training Director, or Chief, Psychology Service. Additional involvement of leadership in other Service Lines may occur depending on the relevant chain of command for involved staff members.

If an informal procedure does not satisfactorily resolve the grievance, or a formal procedure is indicated, the Resident should prepare a written statement describing the grievance and any actions taken to try to resolve the grievance, and submit the written statement to the Residency Training Director with a copy to the Chief, Psychology Service. Within 10 working days, the Residency Director or Chief, Psychology Service will provide a written response describing any decisions made and any corrective actions taken. The Resident also will be informed if further consideration of the grievance is required.

The Training Director or Chief, Psychology Service will notify the Training Committee if a grievance has the potential of affecting the Residency’s evaluation of the Resident, or if it might substantially affect the future conduct or policies of the Residency. The Training Director or Chief, Psychology Service will notify the Training Committee if the Resident has requested an appearance before the Committee.

Throughout the grievance process, everyone involved is expected to be sensitive to the privacy, confidentiality, and welfare of others. Although the Training Committee will be sensitive to the privacy and confidentiality of the individuals involved in a grievance, the Committee reserves the right to discuss among its members any grievance that is brought to its attention from any source. If the committee desires a discussion with anyone associated with the grievance, it will make this request to the Chief, Psychology Service.

It is not the charge of the Training Committee to judge the actions of those involved in a grievance or to have direct responsibility for the resolution of the grievance. The responsibility of the Training Committee is to ensure that a Resident is evaluated fairly, to ensure that a Resident’s training experience meets APA guidelines and policies of the Residency, and to advise the Residency Director and Chief, Psychology Service.

The Chief, Psychology Service has the ultimate responsibility for the sensitive, proper, and appropriate evaluation of all Resident grievances against Psychology Service personnel and will make the final decision concerning a grievance. Additional leadership may be involved should grievances involve non- Psychology Service personnel. The Chief, Psychology Service also is responsible for maintaining equitable and unbiased procedures regarding trainee grievances. The Chief will eliminate any conflict of interest in the evaluation of a grievance.
The Resident can also discuss a grievance with the Chief, Human Resources Management Service to determine other procedures for addressing a grievance within the policies and procedures for the Department of Veterans Affairs.

**Equal Employment Opportunity (EEO)**

If a trainee has an EEO complaint of discrimination or sexual harassment, the trainee should follow procedures outlined in Medical Center Memorandum MCM-00-1010. The trainee should contact the EEO Manager at extension 35235 and obtain a list of current EEO counselors who are available for EEO counseling.

**Employee Assistance Program**

Any paid trainee or staff member may access the employee assistance program, which offers free, confidential services for a variety of concerns such as time management, substance use, stress, relationship problems, burnout and other issues that may or may not impact performance. This is found on the Battle Creek VA intranet homepage “Resources”


**Remedial Action and Termination Procedures:**

When any concern about a Resident’s progress or behavior is brought to the attention of the Training Committee, the importance of this concern and the need for immediate action will be considered. If action by the Resident is considered necessary to correct the concern, the Training Director or his/her designee will discuss the concern and reach agreement about action to be taken.

If the concern is sufficient to raise the possibility of discontinuing the Residency, the Resident will be asked to meet with the Training Committee, and the concerns and a proposed plan of action will be communicated to the Resident in writing.

A recommendation to terminate the Resident's training must receive a majority vote of the Training Committee. The Resident will be provided an opportunity to present arguments against termination at that meeting.

Concerns of significant magnitude to warrant termination include but are not limited to: (a) failure to demonstrate competency or adequate progress towards competency in performing psychological assessment and treatment services, (b) violation of the APA Ethical Standards of Psychologists, (c) failure to meet minimum standards for patient contact, didactic training, testing or treatment competence, (d) behaviors or conduct which are judged as unsuitable and which hamper the Resident’s professional performance.

**Appeal:**

Should the Training Committee recommend termination, the Resident may invoke his/her right of appeal. The Chief, Psychology Service will then appoint a panel composed of at least three members who may be drawn from the Psychology Service staff and Residency Training staff not on the Training Committee or other members of the Medical Facility at large. The panel will include at least one member of the staff from another APA approved training program. The Director of Training will present the position of the Training Committee; the Resident, together with any counsel he or she may choose, will present the appeal. The Chief, Psychology Service will abide by the majority judgment of the Appeal Panel. If termination is recommended, the Chief will direct the Human Resources Service to suspend the Resident’s appointment. The training staff will abide by the Panel's majority judgment if the Appeal Panel recommends continuation, and the Director of Residency Training, the Resident's rotation supervisors, and the Resident are responsible for the negotiating an acceptable training plan for the balance of the training year.
Local Information

The VAMC, Battle Creek, MI is located about 7 miles west of downtown Battle Creek, Michigan and about 17 miles east of downtown Kalamazoo, Michigan and is centrally located to many recreational, cultural, and entertainment opportunities. There are many special events, attractions, and festivals in the area throughout the year. The area also features lakes, ski lodges, libraries, museums, parks, unique local shopping, farmer’s markets, and many live theatres. The cost of living is very affordable—average rent for a one bedroom apartment is less than $700. Interns have found various housing styles available including houses, apartments, townhomes, and settings that welcome pets. For additional information about the area:

http://www.battlecreekvisitors.org/

http://www.discoverkalamazoo.com/
APPENDIX 1 Neuropsychology Resident SoA Competency Assessment Form

<table>
<thead>
<tr>
<th>Trainee:</th>
<th>Supervisors:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Period:</td>
<td>6 months; 12 months; 18 months; 24 months.</td>
</tr>
<tr>
<td>Date of Evaluation:</td>
<td></td>
</tr>
</tbody>
</table>

This rating is based on the following: (Check all that apply)

<table>
<thead>
<tr>
<th>LIVE OBSERVATION (insert supervisor initials)</th>
<th>ADDITIONAL OPTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-Therapy</td>
<td>Review of work samples</td>
</tr>
<tr>
<td>Live from same room</td>
<td>Feedback from staff</td>
</tr>
<tr>
<td>Live via streaming video</td>
<td>Feedback from trainees</td>
</tr>
<tr>
<td>Review of Video</td>
<td>Feedback from patients</td>
</tr>
<tr>
<td>Review of audio recordings</td>
<td></td>
</tr>
</tbody>
</table>

*APA Requires that ratings are based, in part on live observation.*

<table>
<thead>
<tr>
<th>Item #</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Integration of Science and Practice.</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Resident integrates the scholarly literature to all professional activities in relevant setting</td>
</tr>
<tr>
<td>2</td>
<td>Resident conducts quality improvement/outcome assessment evaluation or research appropriate for this complex medical center</td>
</tr>
<tr>
<td><strong>Ethical and Legal Standards</strong></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Resident demonstrates knowledge of and acts in accordance with current version of the APA Ethical Principles and Code of Conduct</td>
</tr>
<tr>
<td>4</td>
<td>Resident demonstrates knowledge of and acts in accordance with relevant laws, regulations, rules, and policies governing health service psychology in at the Battle Creek VA Medical Center as well at the state and federal level</td>
</tr>
<tr>
<td>5</td>
<td>Resident demonstrates knowledge of and acts in accordance with relevant professional standards and guidelines both within the Veterans Health Administration and beyond</td>
</tr>
<tr>
<td>6</td>
<td>Resident recognizes ethical dilemmas as they arise and applies ethical decision-making processes to resolve them</td>
</tr>
<tr>
<td>7</td>
<td>Resident conducts self in an ethical manner in all professional activities</td>
</tr>
<tr>
<td><strong>Individual Differences and Cultural Diversity</strong></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Resident understands how their personal/cultural history, attitudes, and biases may affect how they understand and interact with people different from themselves (Self-reflection)</td>
</tr>
<tr>
<td>9</td>
<td>Resident has knowledge of current theoretical and empirical knowledge base as it relates to addressing diversity in all professional activities including research, training, supervision/consultation, and service (scholarly awareness)</td>
</tr>
<tr>
<td>10</td>
<td>Resident integrates awareness and knowledge of individual and cultural differences in the conduct of professional roles (e.g., research, services, and other professional activities) including the ability to apply a framework for working effectively with areas of individual and cultural diversity not previously encountered over the course of their</td>
</tr>
</tbody>
</table>
Also included is the ability to work effectively with individuals whose group membership, demographic characteristics, or worldviews create conflict with theirs (Application to Clinical Work)

| 11 | Resident applies their knowledge and demonstrates effectiveness in working with the range of diverse individuals and groups encountered during particular residency experiences (Application to Residency Setting) |

### Interprofessional Practice

| 12 | Resident describes the role of Psychology in the context of working with other disciplines within their specific settings, including the common and unique knowledge base and skills of each |
| 13 | Resident recognizes the interdependence of all disciplines and team participants in any decision-making process and applies that awareness in professional practice |
| 14 | Resident recognizes broader concept of interdisciplinary teams including describing the roles of family members, community providers, and self-advocates, in addition to discipline representatives |

### Patient Centered Practices

| 15 | Resident fosters self-management, shared-decision making, and self-advocacy/direction in their patients |
| 16 | Resident solicits the preferences, needs, and goals of the patient during professional work and integrates that information into care plans and interventions, advocating for their patients as needed |
| 17 | Resident recognizes the role of caregivers/family in improving outcomes for Veterans and involves them in care-planning as desired by the Veteran |

### Assessment

| 18 | Resident selects and applies assessment methods for their setting, drawing from the best available empirical literature and which reflects the science of measurement and psychometrics (E.g. What is the best way to answer the question-patient interview, collateral interview, objective testing, direct patient observation) |
| 19 | Resident collects relevant data using multiple sources and methods appropriate to identified goals and questions of the assessment as well as relevant diversity characteristics of the service recipient |
| 20 | Resident interprets assessment results, following current research and professional standards and guidelines to inform case conceptualization, classification/diagnosis, and recommendations including avoiding decision-making biases and distinguishing between subjective and objective aspects of the assessment |
| 21 | Resident communicates findings, both orally and in written documentation, in an accurate and effective manner sensitive to the target audience |

### Intervention (Optional—If they do a supplemental rotation)

<p>| 22 | Resident establishes and maintains effective relationships with the recipients of psychological services |
| 23 | Resident develops evidence-based intervention plans specific to the service delivery goals |
| 24 | Resident implements interventions informed by the current scientific literature, assessment findings, diversity characteristics, and contextual variables |</p>
<table>
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<tr>
<th></th>
<th>Description</th>
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<tbody>
<tr>
<td>25</td>
<td>Resident demonstrates the ability to apply the relevant research literature to clinical decision making</td>
</tr>
<tr>
<td>26</td>
<td>Resident modifies and adapts evidence-based approaches effectively when a clear evidence-base is lacking</td>
</tr>
<tr>
<td>27</td>
<td>Resident evaluates intervention effectiveness, and adapts intervention goals and methods consistent with ongoing evaluation</td>
</tr>
<tr>
<td></td>
<td><strong>Professionalism</strong></td>
</tr>
<tr>
<td>28</td>
<td>Resident behaves in ways that reflect the values and attitude of psychology such as integrity, deportment, professional identity, accountability, lifelong learning and concern for the welfare of others</td>
</tr>
<tr>
<td>29</td>
<td>Resident engages in self-reflection regarding personal and professional functioning and engaging in activities to maintain and improve performance</td>
</tr>
<tr>
<td>30</td>
<td>Resident actively seeks and demonstrates openness and responsiveness to feedback and supervision</td>
</tr>
<tr>
<td>31</td>
<td>Resident responds professionally in increasingly complex situations</td>
</tr>
<tr>
<td>32</td>
<td>Resident serves as a role model of professional behavior to other less developed trainees (e.g. practicum students, medical students, interns)</td>
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<tr>
<td></td>
<td><strong>Communication and Interpersonal skills</strong></td>
</tr>
<tr>
<td>33</td>
<td>Resident develops and maintains effective relationships with a wide range of individuals, including colleagues, community partners, supervisors, supervisees and those receiving professional services as well as their support persons</td>
</tr>
<tr>
<td>34</td>
<td>Resident produces and comprehends oral, nonverbal and written communications that are informative and well-integrated, demonstrating a thorough grasp of professional language and concepts relevant to their setting</td>
</tr>
<tr>
<td>35</td>
<td>Resident demonstrate effective interpersonal skills and ability to manage difficult communication well</td>
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<tr>
<td></td>
<td><strong>Neuropsychology Specialty Competencies (Level 3)</strong></td>
</tr>
<tr>
<td>36</td>
<td>Functional Neuroanatomy: Demonstrates working knowledge of the CNS, functions attributed to a particular part of the brain or spinal cord and functional pathways and networks. Integrates this knowledge into delivery of Neuropsychological Practice (i.e. case conceptualization, interpretation of data, differential dx, treatment recommendations and intervention).</td>
</tr>
<tr>
<td>37</td>
<td>Neurological and related Disorders: Demonstrates working knowledge of neurologically based insult and disease (i.e. base rates, onset, course, sx, progression, associated features, dx criteria, cognitive and behavioral patterns and neurophysiology). Integrates this knowledge into delivery of Neuropsychological Practice (i.e. case conceptualization, interpretation of data, differential dx, treatment recommendations and intervention).</td>
</tr>
<tr>
<td>38</td>
<td>Non-Neurologic conditions affecting CNS functioning: Demonstrates working knowledge of non- neurologic conditions impacting CNS functioning (i.e. cognitive, psychiatric and behavioral). Integrates this knowledge into delivery of Neuropsychological Practice (i.e. case conceptualization, interpretation of data, differential dx, treatment recommendations and intervention).</td>
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<td></td>
<td>Description</td>
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<tr>
<td>39</td>
<td>Neuroimaging and other Neurodiagnostic Techniques: Demonstrates working knowledge of neuroimaging and neurodiagnostic techniques and dx reports/finding. Integrates this knowledge into delivery of Neuropsychological Practice (i.e. case conceptualization, interpretation of data, differential dx, treatment recommendations and intervention).</td>
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<tr>
<td>40</td>
<td>Neurochemistry of Behavior: Demonstrates working knowledge of neurochemistry and the impact on cognition, mood and behavior. Integrates this knowledge into delivery of Neuropsychological Practice (i.e. case conceptualization, interpretation of data, differential dx, treatment recommendations and intervention).</td>
</tr>
<tr>
<td>41</td>
<td>Neuropsychology of Behavior: Demonstrates working knowledge of neuropsychology of behavior (i.e. understanding of interplay between neuroscience, cognitive and abnormal psychology, cognitive science and related evidence base of brain-behavior relationship). Integrates this knowledge into delivery of Neuropsychological Practice (i.e. case conceptualization, interpretation of data, differential dx, treatment recommendations and intervention).</td>
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<tr>
<td></td>
<td><strong>Foundations for the Practice of Clinical Neuropsychology</strong></td>
</tr>
<tr>
<td>42</td>
<td>Specialized Neuropsychological assessment techniques: Resident demonstrates knowledge and application of solid scientific foundations/clinical decision making in formulating new cases, including selection of appropriate test battery and normative data, professional, consistent and accurate test administration and scoring. Integrates this knowledge into delivery of Neuropsychological Practice (i.e. case conceptualization, interpretation of data, differential dx, treatment recommendations and intervention).</td>
</tr>
<tr>
<td>43</td>
<td>Specialized Neuropsychological Intervention Techniques: Resident demonstrates working knowledge of current theories in Neuropsychological and Rehabilitation Intervention. Integrates this knowledge into delivery of Neuropsychological Practice (i.e. provision of feedback, Cog rehabilitation Group and Individual therapeutic treatment recommendations and intervention).</td>
</tr>
<tr>
<td>44</td>
<td>Research Design and analysis in Neuropsychology: Resident demonstrates working knowledge of research design and analysis through participation in direct research activities (i.e. Database and new and ongoing IRB projects). Integrates this knowledge into delivery of Neuropsychological Practice (i.e. case conceptualization, interpretation of data, consumption and critical review of national research findings) and production of research product (posters, peer referenced journal articles).</td>
</tr>
<tr>
<td>45</td>
<td>Professional issues and ethics in Neuropsychology: Resident demonstrates and applies working knowledge of professional standards, laws and ethics in the practice of Clinical Neuropsychology. Integrates this knowledge into all forms of service delivery, teaching and research activities.</td>
</tr>
<tr>
<td>46</td>
<td>Individual Differences and Multicultural Diversity in Neuropsychology: Resident demonstrates and applies working knowledge of and sensitivity to individual and multicultural diversity issues in the practice of Clinical Neuropsychology. Integrates this knowledge into all forms of service delivery, teaching and research activities.</td>
</tr>
<tr>
<td>47</td>
<td>Practical Implications of Neuropsychological Conditions: Resident demonstrates working knowledge of the practical implications of neurologic and non-neurologic conditions on cognition, mood and behavior. Integrates this knowledge into delivery of Neuropsychological Practice (i.e. practical treatment recommendations and intervention), teaching and development of research projects.</td>
</tr>
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</table>
## Strengths:

<table>
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<th>Areas for Development (including “stretch” areas a highly competent resident):</th>
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<tr>
<th>Supervisor Tasks to Promote Continued Growth:</th>
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</table>

Target Outcomes:

- **Year 1:** All items are rated Level 4 (Consultation Based Supervision) or higher.
- **Year 2:** All items are rated Level 5 (Autonomous Practice) or higher.

This trainee **HAS / HAS NOT** met target for this rotation rating.

**Training Director** ____________________________________________ Date _____________

I have received a full explanation of this evaluation. I understand that my signature does not necessarily indicate my agreement.

**Trainee** ____________________________________________ Date _____________

### LEVELS OF COMPETENCY

**Level 6:** Advanced Practice, life-long learner and Consultant

- Competency in this area is at the level expected of fully licensed, independent psychologists at the GS-13 level in the VA System
- **Residency:** Residents may achieve this rating on a few core tasks that represent particular strengths. This rating is for rare occasions when a Resident can serve as a consultant to other licensed psychologists in a particular area.
- **Internship:** Inappropriate for internship level trainees
- **Practicum:** Inappropriate for internship level trainees
Level 5: Ready for autonomous Practice.

- Competency in this area is at the level expected of psychologists ready to apply for licensure, such as those at the GS-12 level in the VA system.
- **Residency**: Supervision is required for compliance with professional standards, but with proper licensure, Resident could perform independently. Consultation is self-guided and directed toward lifelong learning and ongoing advanced practice development. Residents must achieve this level rating on all competency measures for successful program completion.
- **Internship**: This level of rating should be extremely rare for interns and be limited to a few areas of particular and exceptional strength.
- **Practicum**: Inappropriate for practicum level trainees

Level 4: Requires consultation-based supervision

- Competency in this area is at the level expected of unlicensed, entry level psychologists, such as those who have been working at the GS-11 level in the VA system for six months.
- **Residency**: The resident acts as a unlicensed “junior” colleague, requiring supervision according to compliance standards. Resident requires only consultation-based supervision for core health service psychology tasks with ongoing consultation and supervision as required for advanced practice areas. This is expected at the mid-point of residency.
- **Internship**: Interns may achieve this rating on a few core tasks that represent particular strengths; however, it will be rare.
- **Practicum**: Inappropriate for practicum level trainees

Level 3: Requires occasional supervision.

- This is the rating expected of incoming doctoral staff members just starting at the GS-11 level within the VA system who have just received their doctorate and are beginning to undergo post-doctoral supervision towards licensure.
- **Residency**: **This is the rating expected of incoming postdoctoral residents and would be a common rating for first quarter evaluations.** The resident requires occasional supervision for core health psychology service tasks, but regular supervision for advanced practice tasks.
- **Internship**: This is the rating expect at the end of the training year for interns. Intern does not require additional supervisory sessions to complete this task. The supervisor can rely primarily on some of the reports of the trainee with occasional direct observation for compliance.
- **Practicum**: Students may achieve this rating on a few core tasks that represent particular strengths for the practicum student; however, it will be rare and limited to trainees in advanced practicum placements.

Level 2: Requires close supervision

- **Residency**: Ratings at this level represent an area of underdeveloped competency, which requires specific attention when noted. A formal remediation plan may or may not be implemented.
- **Internship**: Interns may receive this rating at internship start or first quarter, but it must be achieved at least by the midpoint of the internship training year. The intern requires less frequent direct observation and extra supervision is needed only occasionally for more challenging tasks or new areas of development.
- **Practicum**: Practicum students in their final practicum before internship, will be at this level. Practicum trainees doing their first external placement may achieve this rating on several core tasks, but are unlikely to be at this level for all items.

Level 1: Requires Substantial Supervision

- **Residency**: Any evaluation at this level requires a remediation plan.
- **Interns**: Interns are expected to start at this level or level 2. Interns require frequent direct observation and additional supervision sessions outside the minimal requirements to meet core competencies.
- **Practicum**: Students will generally be working at this level although advance practicum students may be working at level 2.
APPENDIX 2: Research/Quality Project

Resident Quality/Research Project:

Monitoring the quality and effectiveness of your work is important for psychologists regardless of practice setting. As such, this residency program requires that you complete either a formal IRB/RD approved research project or a formal quality evaluation project. Neuropsychology Residents typically are encouraged to complete IRB/RD approved work; however, in special cases a quality project will be acceptable. The quality project could include previously collected outcomes data, new evaluation of a current clinical activity such as a specific intervention or assessment process, or implementing and evaluating a new clinical activity. The quality project, if selected, should be well formed and demonstrate your ability to a) develop a plan for evaluating a question in a clinical setting, b) review the relevant literature and apply it to your question and c) engage in statistical evaluation and clinical problem-solving related to your question. A formal research project also would demonstrate the above, but should not include collection of new data due to the limited timeline. Think about this as a pragmatic translation of the skills you learned during your dissertation to a clinical professional setting.

Expectations:

- Participate in formulation of a project idea
- Develop methods for completing the project, including following appropriate policy/medical center procedures
- Determine appropriate deadlines to successfully complete the project
- Meet deadlines as determined above
- Gain approvals as needed to implement the project
- Implement and complete the project using the developed methods
- Present the findings of the project
- Prepare a manuscript/poster or other written document of the project
- Report to assigned mentors on a routine basis

Within three months of start date: Complete an initial project proposal. It should be approved by project mentors/supervisors and include the following elements:

- Topic Title
- Project Participants (e.g. other staff/trainees involved)
- Names of Project Mentor &/Or Clinical Supervisor for the project. Identify how often you will meet and the specific dates if known. Should these be two different people, describe their roles and how they will work together.
- Narrative description of project, with preliminary literature review. (10 references minimum, five from peer reviewed journals within the last 5 years. APA-format please). If this is a formal IRB/RD project, include your IRB/RD amendment/proposal narrative documentation.
- If this is a formal IRB/RD project, please describe the intended publication plan (be specific regarding possible journals or conferences). The goal is to have a poster submission to the International Neuropsychological Society’s Annual Meeting in February of the second training year. The deadline for abstract submission is August.
- List of steps and the timeline for completing these steps. Include who is responsible.
- Description of Research & Quality Team involvement (e.g. a date when you met)
- After this step is completed, you may move forward with IRB/RD submissions/Quality Application
April 1: **Submit ABSTRACT** for May MHGR Research & Quality Symposium to Drs. Kinkela & Pope at: jessica.kinkela@va.gov; Elizabeth.Pope2@va.gov *

April 15: **Submit Poster for MHGR*** to Drs. Kinkela & Pope.

May: Present your poster at the Mental Health Grand Rounds Research and Quality Symposium. (For year 1 this likely will be a project proposal; for year 2 this will be updated with final data such as presenting a poster already presented at INS)

Spring/Summer of second year: Present during MHGR if doing so. At least 45 days before, **provide full PowerPoint and any handouts** to MHGR workgroup along with any required disclosures or other items needed by CE workgroup. *This should be reviewed and approved by your mentor/clinical supervisor listed in your proposal before submitting.*