Welcome from the APAHC President

I couldn’t be happier to be writing this brief column. Thanks to the initiative of our new editor, Lauren Penwell-Waines, one of my favorite professional newsletters is back in production! It’s a remarkable capstone on what’s been a busy and fruitful year for the association.

Some of the work we’ve undertaken has been somewhat behind the scenes but still important. The entire APAHC Board helped shepherd a revamping of our Bylaws (the document that outlines our structure and function) and Officers’ Manual (the document that gets into the nitty-gritty of how we do our work). As those projects were completing, two teams led by Brian Isakson and Laura Daniels worked with a web developing firm to completely redo our public and members-only websites (visit: ahcpsychologists.org).

Earlier this year, RoseAnne Illes and Michael Meija organized a very well attended, CE-offering webinar on social determinants of mental health for Latino/a immigrants. As of this writing, Wendy Ward is poised to deliver the APAHC talk at APA Convention on interprofessional education. We are also grateful that Ron Brown has assumed leadership of our flagship journal, Journal of Clinical Psychology in Medical Settings. Amy Williams and John Yozwiak are planning a superb APAHC conference in New Orleans next February – you won’t want to miss it! You can keep on top of all APAHC news on Facebook and Twitter, thanks to Joanna (“Joey”) Yost.

In addition to this work, we continue to strengthen our connections to larger organizations. We reviewed and endorsed the APA PTSD Clinical Practice Guidelines earlier this year, and through our liaisons Laura Shaffer and Bill Robiner, continue to advocate for psychology on the AAMC Council of Faculty and Academic Societies (CFAS).

But do you know what has me most excited so far this year? In an effort to help get word out about APAHC, we offered a free membership to interested early career professionals and trainees. In the span of a few weeks, we went from just over 200 members to nearly 700! What gets me even more excited is that nearly half of those members are trainees – the future of this organization. Teresa Pan and Leila Islam have been doing a wonderful job communicating with our new members and helping them get engaged.

So, all that said, I hope you’ll take a few minutes to read through this issue of the Grand Rounds. It’s a wonderful way to hear what our association and its members are doing. Maybe it will inspire you to make a suggestion or get involved in some way. If so, I hope you’ll let us know what you’re thinking.

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Reading Distress in Chronic Pain: Teasing Apart Biopsychosocial Factors and Substance Abuse

Alison M. Vargovich, PhD

"I don't know what to do anymore. This pain is ruining my life!" These words, or some version, often are heard in medical settings. While many providers struggle with "how" to treat chronic pain, perhaps the actual issue is "what" to treat, which is a perfect question for a psychologist to help answer. Pain is defined as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage." Pain then is inherently a biopsychosocial experience. Therefore, when patients present with chronic pain, it is the provider's duty to determine the components contributing to the patient's experience. Understanding that pain is biopsychosocial in nature provides guidance when interpreting a patient's distress in clinic. Below are four key areas to consider when deciding what to treat for a patient presenting with chronic pain.

Physiological/Biological factors. An important aspect of the "bio" in biopsychosocial is outlining the difference between acute and chronic pain. The key feature tends to be related to sensitization of the nervous system. With acute pain (i.e., pain lasting less than 3-6 months), the pain is a warning of injury or potential damage. The treatment will focus only on where the tissue damage has occurred, and the pain dissipates as the injury heals. With chronic pain, the pain persists beyond the expected healing time or greater than 3-6 months. The problem is not with the initially injured area. Rather, for patients with chronic pain, the persistent pain messaging, now a false warning, occurs throughout the nervous system. Chronic pain is characterized by sensitization, meaning that the nervous system is more sensitive to stimuli manifesting as allodynia and hyperalgesia. Therefore, the treatment for chronic pain should focus on calming the nervous system as a whole rather than treating the initial site of the injury. Psychologists' role in this domain can be to provide psychoeducation on the difference between acute and chronic pain, and engage patients in relaxation techniques to help increase control over the sympathetic response.

Psychological/Emotional factors. Although psychology is often utilized as a therapeutic "last resort" for chronic pain, psychological factors often are one of the primary factors in the patient's pain experience. After all, pain is defined as a sensory AND emotional experience. Patients with chronic pain are more likely to experience symptoms of depression and anxiety, and these symptoms affect both the perception of pain and the ability to function. Pain catastrophizing is a prime example of how psychological factors can impact coping with pain. Pain catastrophizing is a cognitive-affective response to anticipated or actual pain comprised of helplessness, magnification, and rumination. It is associated with worse outcomes, heightened pain sensitivity, and impaired functioning. Beth Darnall, a pain psychologist at Stanford University, uses the following analogy to explain pain catastrophizing in the context of chronic pain—through sensitization, the body's nervous system is on fire, and pain catastrophizing is the gasoline. Psychologists can assess patients for psychological correlates of pain, but also successfully treat catastrophizing and other psychological factors through cognitive-behavioral interventions, while also teaching our physician colleagues how to identify these potential concerns.

Social/Environmental factors. One area that often is overlooked in the physician's office is the impact of social and environmental factors on chronic pain. When evaluating potential exacerbating factors, secondary gain is necessary to consider, as these sometimes invisible incentives can change a patient's response to pain. For example, patients who enjoy their job and find it fulfilling are significantly more likely to return to work after an injury than a patient who is unsatisfied. Patients who are receiving workers' compensation have greater frequency and duration of claims, as well as worse surgical outcomes than those not receiving compensation. Additionally, patients' friends and family can have an impact on coping with pain. A person whose spouse started helping them with household chores and giving them more attention since becoming injured may not want these positive changes in their relationship to disappear. In general, patients are not aware of the influence their environment has on their pain, but often can recognize that their friends' and family's response to their pain impacts how they feel, both physically and emotionally. Psychologists can assess for such environmental factors and educate both patients and family members on how to better respond to chronic pain, thereby increasing support, while decreasing enabling behaviors.

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Substance abuse. Lastly, the importance of assessing for risk and substance abuse is incredibly important in our current climate. With substance use disorders (SUDs) and overdose death rates continually increasing across the country, we have a responsibility to treat our patient’s distress while keeping them safe. Up to 48% of patients with chronic pain have a current SUD, with a lifetime prevalence of 16-74%, which is higher than the general population’s lifetime prevalence of 16.7%. Additionally, patients with chronic pain and a history of a SUD are significantly more likely to be prescribed an opioid. This situation is an example in which the distress the patient is bringing to the room may have been misread or not fully addressed. It is our responsibility as providers to conduct a thorough history, record review, and substance use assessment to avoid putting our patients at risk for more problems. Psychologists are well-suited to assist with risk assessment for potential substance abuse and current substance abuse issues, as well as engage patients in treatment for these concerns.

More than likely, what to treat involves multiple disciplines and providers. Some patients may need more treatment in one domain than another, but ultimately if the distress is incorrectly interpreted we risk mismanaging our patients, putting them at risk for more problems, and inadequately addressing their chronic pain. Psychologists are well-suited to determine what to treat and provide interventions to address the distress.

References

Facts in Brief

Over 30% of Americans experience chronic or acute pain, more than diabetes, heart disease, and cancer combined. (Institute of Medicine, 2011)

Adults with low back pain experience higher rates of psychological distress than adults without pain. (National Centers for Health Statistics, 2006)

Almost 2 million Americans abused or were dependent on opioid pain medication in 2013. (SAMHSA, 2014)
Interprofessional Education and Collaborative Team-Based Care: Twin Forces Shaping the Culture and Focus of Academic Health Centers

Wendy Ward, PhD, ABPP

There are two interrelated movements shaping academic health centers (AHCs) across the nation: collaborative team-based care and interprofessional education (IPE). These movements were both catalyzed when the Triple Aim concept was coined by the Institute for Healthcare Improvement and the healthcare system was charged with three goals: to improve population health, to improve the experience of care for patients and families, and to reduce per capita cost. This emphasis not just on treating the ill who present in clinics but also on promoting health in the population, all in a cost effective manner, was an important refocusing of our health system. Soon after, the World Health Organization defined collaborative care as occurring “when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings” (p.13). As such, collaborative care was then seen as an avenue for meeting the Triple Aim. The Patient Protection and Affordable Care Act reinforced the trend toward integrated, team-based care by supporting healthcare homes and led to the consideration of interprofessional team-based, collaborative care as a way to provide comprehensive care to patients and their families. Four core competency domains (with 9 to 15 specific skills in each) were determined to be the foundation of effective team functioning in clinical environments, educational efforts, and research teams. Thus, these core competencies apply to the missions of AHCs and involve the understanding of professional roles (including overlap and distinctions), shared values of mutual respect and collaborative decision-making, clear and positive communication among all team members and the patient/family, and effective team dynamics (including clinical process and flow as well as positive approaches to differences of opinion).

To prepare for the transition to collaborative care, AHCs have been working to develop evidence-based programs dedicated to student skill development in the four core competency domains of high quality interprofessional team-based care that keeps patients and their needs first. Accreditation policies for many of the national health care professional associations have now incorporated IPE as a required curriculum element including both Medicine and Psychology.

Delivery of quality care to provide comprehensive health care services for patients and their families is challenging and complex. Fostering collaborative, integrated care and evidence-based IPE experiences that implicate specific skill acquisition in addition to didactic learning is key. Specifically, research supports the idea that IPE experiences (where learners from two or more professions learn about, from, and with each other) enhance the quality of clinical collaborations and team-based care in both faculty and students, reduce safety events, and positively impact patient- and family- engagement and satisfaction in the care environment.

Psychologists working in AHCs could play a role in IPE that would potentially impact the landscape of collaborative care in the future. First, psychologists could encourage psychology trainees at different levels to become involved in IPE events at their institution. This would foster the inclusion of psychologists into the cognitive framework that professional students are developing in IPE of what a collaborative care team looks like. This framework would drive expectations when students reach the “real life” clinical environment and create a demand for increased psychology involvement. Second, psychologists could become facilitators of IPE events. They have expertise in the four core competency domain skill sets; namely, developing a culture of mutual respect and shared values, communication skills among team members and the patient/family, understanding and negotiating role overlap and role distinctions among professions, and team dynamics and process. Creating active learning experiences that enhance these skills are already familiar to psychologists (such as role play, small group discussion, observation with feedback, etc). It is important to point out that a role as creator or facilitator of IPE events (or even an IPE Curriculum Director role) adds value to psychologists and the field of psychology in AHCs. Further, development of evaluation tools to assess the quality and utility of the programming as well as pre/post knowledge and skill acquisition for students is needed.

Research in this field is in its infancy with less known about the impact on service quality, patient satisfaction, and cost effectiveness when students join the existing workforce post-graduation. Psychologists’ research skills are invaluable in this regard and critical for identifying key components of IPE events that most impact learning and skill development, documenting the translation of these skills from the learning environment to the practice environment, and

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tracking the impact of IPE over the long term on key Triple Aim objects like patient satisfaction, population health, and cost-effectiveness of care. Finally, psychologists could promote IPE events for physicians and other health care professions faculty, designed to enhance the four core competency domain skill sets in the current work force as they move toward collaborative, team-based care.

Sociopolitical forces have influenced the movement toward collaborative team-based care in academic health centers which provides a need for trained professionals who can work effectively together to treat patients and improve population health, all in a cost-effective manner. Interprofessional education learning experiences are designed to promote skills in student and faculty learners that prepare them for effective team-based care. These interrelated movements provide an opportunity for psychologists to become more involved and shape the future of our health system to one that includes psychology as a discipline.

References

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Suicide Prevention in Primary Care Settings

Lori Holleran, PhD, MPH, and Alison Athey, MA

Suicide is a leading cause of death in the United States among both adolescent and adult populations.\(^1\) Concerningly, even in the face of increased awareness and prevention efforts, suicide attempts are increasing. Most individuals who die by suicide have contact with medical providers in the month prior to death,\(^2\) illustrating an opportunity for life-saving interventions to occur. This is particularly relevant for providers within primary care (PC), as Americans receive most of their health and behavioral health care in PC settings. Indeed, PC providers are more likely than other providers to interact with suicide decedents in the months leading up to death.\(^3\) Risk assessment and management of suicidal patients are key components of care in specialist mental health services, but these issues are relatively unexplored in PC services. Accessibility and familiarity make PC an ideal setting for suicide prevention; however, these environments must be prepared to respond to the presentation of risk. This requires the presence of trained clinicians with the capability to identify and treat individuals experiencing varying levels of risk for suicide.

**Risk Detection**

The first steps in a comprehensive suicide prevention program in PC settings involve well-developed suicide screening and assessment practices. PC providers can implement targeted screening programs focused on at-risk populations (e.g., patients with positive depression or substance misuse screens) or universal suicide screening protocols, with universal screening protocols identifying significantly more suicidal patients.\(^4\) Regardless of the screening strategy employed, empirically supported screening tools should be implemented in PC settings to improve identification of at-risk patients while ensuring adequate predictive value.\(^5\) Several brief suicide screening measures have been developed for PC and other medical settings including the Ask Suicide-Screening Questions (ASQ) Toolkit,\(^6\) the Risk of Suicide Questionnaire,\(^7\) the suicidal ideation item of the PHQ-9,\(^7\) along with other tools that directly assess suicidal ideation and warning signs. Ultimately, identifying patients at risk for suicide is necessary but not sufficient for prevention efforts. Once a patient has been identified as at-risk, appropriate treatment provisions must be offered.

**Risk Management**

Interventions focused directly on suicide, such as stabilization during acute crises,\(^8\) may be more effective in reducing suicidal behaviors than interventions focused on depression, hopelessness, substance use or other factors related to suicide risk.\(^9\) Additionally, suicide safety plans, in which the patient and provider collaboratively develop an individualized plan to utilize during a suicidal crisis, can also assist with managing suicidality.\(^10\) These plans proactively identify suicidal triggers, intra- and interpersonal coping resources, supportive resources (e.g., suicide crisis hotlines or chatlines), reasons for living, and safe storage of lethal means. PC providers can also attend to suicidal patients by assisting them with accessing specialized mental health treatment and coordinating transitions between providers, given that most patients do not follow-up on referrals for suicide related treatment.\(^11\) Further, providing written messages expressing care and interest in their patients’ well-being can significantly reduce suicidal behaviors among vulnerable populations,\(^12\) and could perhaps increase service utilization. However, suicide specific interventions delivered by PC physicians may vary in effectiveness,\(^13\) highlighting the necessity of psychologists in this setting as well as improved training efforts.

**Clinical Training**

A critical barrier impeding effective suicide prevention services within PC settings is the lack of adequate training. Many physicians receive no specific training related to the assessment and treatment of suicidal individuals during their education,\(^14\) with only a few states requiring this type of training.\(^15\) This is alarming when considering that among PC physicians, training improves self-perceived competence in addressing suicidality, which has been found to directly influence willingness to assess for and treat suicidal individuals.\(^16\) Thus, psychologists may find themselves tasked with evaluating the willingness of PC team members to respond to suicide risk and providing training as needed. Additionally, there are formal suicide prevention training resources intended for broad clinical audiences including Question, Persuade, Refer, Train: Suicide Triage, Safety Planning Intervention for Suicide Prevention, and Recognizing and Responding to Suicide Risk in Primary Care among others. Moreover, trainings on lethal means assessment such as Counseling on Access to Lethal Means are available. These may be particularly useful investments of time as reduction of access to lethal means, in the absence of any psychological intervention, is found to effectively decrease suicides.\(^17\)

**Conclusion**

Psychologists often serve as critical suicide prevention resources within PC settings, by providing team members with the knowledge needed to identify signs of suicidality and the confidence required to enable responsive, and effective, action. They may also encourage the utilization of resources to support the development of suicide screening programs, assessment selection, and provider trainings offered by national organizations such as the Suicide Prevention Resource Center, the American Foundation for Suicide Prevention, and the National Institute of Mental Health. Ultimately, psychologists are vital to enhancing suicide prevention practices within PC settings through their roles as consultants, interdisciplinary team members, and leaders of program implementation and enhancement efforts.

(References on p. 11)
CFAS Corner
Bill Robiner, PhD, and
Laura Shaffer, PhD,
APAHC CFAS Reps

Have you ever wondered what that newsletter is that Dr. Shaffer forwards you from the AAMC every week? Per the CFAS website, “CFAS News reports on the comings and goings of major figures at medical schools and teaching hospitals, the trends and trendsetters influencing the field, and news and happenings in biomedical research, medical education, and patient care.” A quick perusal each week is a helpful way to better understand academic healthcare and the multiple missions of the institutions where AHC psychologists work. It offers a synopsis of critical issues in the news that are on the minds of deans, department heads, and faculty at medical schools around the country as well as that concern leaders of diverse health professional disciplines and organizations.

In addition to its brief summaries, CFAS News presents links to more in-depth information about many of the stories. It also acquaints readers with structural changes in medical schools and throughout healthcare. This information helps readers to become better informed about current events in academic healthcare, the healthcare system, and a range of factors that affect education, research, and healthcare. The more psychologists understand these matters, the greater their ability to speak the same language and understand the concerns and thinking of their medical colleagues. Reading it can provide psychologists both a broader national perspective and, at times, an insider view of their workplaces and the opportunities available to them.

As a bonus, the AAMC staff member who writes CFAS News has a wry sense of humor, so it is usually worth a scroll to the end to see what entertaining article he has found!
Membership Survey (continued from p.7)

Overall satisfaction with specific Member Benefits was rated positively: extremely satisfied (12%), very satisfied (44%), or somewhat satisfied (25%). Most members indicated they intended to renew membership (55% Definitely; 29% Very Likely). Among the 21 benefits sampled, the most highly rated benefits of APAHC membership included reinforcing members’ identities as AHC psychologists, the organization’s advocacy on behalf of AHC psychologists, the organization’s help in keeping abreast of developments in AHCs, APAHC’s journal JCPMS, the APAHC listserv, and networking and training opportunities. These and the other advantages that membership confers contribute to APAHC’s vital role in the professional lives of its members.

The APAHC Board reviewed in detail the responses to questions related to member benefits. General comments suggested growing membership and enhancing the diversity of the association. Further, exploring additional ways to network and promote professional development between conferences (e.g., webinars) was suggested. Enhancing opportunities in research, networking, and mentorship was encouraged. Survey results spurred the Board to spearhead several initiatives to address member concerns.

A complete redesign of the existing website was undertaken. A more user-friendly design emerged, resulting in a more dynamic website that more effectively conveys the missions of APAHC and facilitates membership application and renewal (ahcpsychologists.org). Revisions to the editorial process for the Journal of Clinical Psychology in Medical Settings have also been completed. Ronald Brown, PhD, was elected as Editor-In-Chief for a five-year term. Dr. Brown has restructured the work of four Associate Editors (Andrea Bradford, PhD, Liz Cash, PhD, James Paulson, PhD, and John Wryobbeck, PhD) serving one-year terms. To facilitate journal efficiency, Associate Editors’ process manuscripts within three days of receipt, and reviewers are allotted 28 days to complete their assignments. Initiatives to expand the content of the journal are also under development. Several special issues are currently in the planning phases; announcements highlighting those topics will be made in the coming months.

The next APAHC biennial conference is scheduled to take place February 7-9, 2019, at Le Méridien New Orleans in Louisiana. Conference planning has focused heavily on responses from the Member Survey as well as on feedback from the last conference. Based on respondent comments, expanded conference offerings are being planned to include programming on pediatrics, women in academic healthcare, late career transitions, hospital and staff privileging of psychologists, breakout sessions to facilitate networking, as well as increasing conference planning involvement among junior APAHC members. APA Self-Study and Site Visitor training, as well as the APA Division 38 Spring Board Meeting also will be held in conjunction with the conference.

As results of the membership survey were discussed by the APAHC Board, initiatives to reach out to potential new members and retain existing members also were considered. Our goal was to retain existing members through the implementation of ongoing quality improvement efforts for existing member benefits and to consider new benefits as well. A recent new membership recruitment program was initiated and designed to provide early career psychologists and trainees a year of free membership to APAHC in the hopes that new members will find value in ways many of our current members cited in the survey responses. As a result of this initiative membership grew by more than 200% (from 207 active members on Feb 15 to 671 active members on April 2). Another goal was that new members might identify ways they can become more involved in APAHC and add their perspectives and contribute in ways that further enhances the membership experience (e.g. participation on APAHC committees, webinars, journal reviewers, conference attendance). Efforts related to this latter aspiration are in development, and the membership committee anticipates providing more information and updates in this regard to membership in the future.

The APAHC Membership Survey provides insights into characteristics of its membership and crystallized some of the most valuable elements of being a member. This brief report focused on responses related to membership benefits only. Three workgroups are currently analyzing and writing up remaining results (psychologists’ roles in education in AHCs, professional wellness and sources of stress for psychologists in AHCs, and the diverse leadership roles that psychologists’ serve in AHCs). The feedback from members via survey responses is much appreciated by the Board and is driving ongoing efforts to improve member benefits and to better understand the issues and needs central to the experience of psychologists working in academic health centers and other medical settings.
Immigration mental health: Policy as a social determinant
Kiara Alvarez, PhD, & Giuliana McQuirt, PsyD

There were 56.5 million Latinos in the U.S. in 2015, comprising 17.6% of the population, and 34% of this group was foreign-born. In February, we presented a webinar on behalf of the APAHC Committee on Diversity and Disparities entitled Social Determinants of Mental Health for Latino/a Immigrants: Implications for Clinical Practice. In the webinar, we explored social determinants of mental health specific to Latino/a/x immigrant populations, using the CAMINO framework1 as a guide to these social determinants. We also identified relevant clinical factors and potential resources for mental health providers. In this article, we briefly discuss key points from the webinar and reflect on the webinar’s focus in light of recent events.

Social determinants of mental health include differences in social, economic, and environmental circumstances and policies which impact the conditions in which people live and the services they can access. We posit that a focus on social determinants is important to clinical work with the U.S. immigrant population for two reasons. First, immigrants (particularly those of low socio-economic status) may be disproportionately exposed to adverse social, economic, and environmental circumstances both in the country they have left and in the country to which they migrated. Second, there are social determinants of health specific to the process and experience of migration and of living as an immigrant in the U.S.

The CAMINO framework provides a useful mnemonic for clinical assessment with Latino immigrant populations1. CAMINO is the Spanish word for path, and the letters of CAMINO stand for Community & Family Support, Acculturative Stress, Migration History, Idioms of Distress and Resilience, Native Language and Preferences, and Origin. A focus on these domains provides an entry point into a number of social determinants impacting the health of immigrant Latinos in the US; for example, understanding the migration history of a Latino/a client can provide a window into the social context that may have impacted an individual and their family before, during, and after migration. The experience of planned migration from a politically stable country is very different from the experience of fleeing an unstable and dangerous environment. By the same token, arrival in the US as a member of a group that is welcomed may facilitate adjustment and well-being, while arriving as a member of a group that is disparaged and marginalized may have adverse effects on mental health via the impact of acculturative stress, discrimination, and barriers to opportunity. The CAMINO framework also brings balance to the provider’s view of their Latino immigrant patients by delving into specific sources of strength and resilience such as community and family support, and by highlighting the use of idioms of resilience (such as Si, se puede/”Yes, we can” and No hay mal que por bien no venga, which is like the English phrase “Every cloud has a silver lining”).

A focus on the social context of immigrant mental health has taken on greater urgency at the time of this writing, given the separation of over two thousand children, including babies and toddlers, from their families due to a “zero tolerance” policy applied to undocumented immigrants crossing outside of official U.S. checkpoints. The American Psychological Association, along with many other professional associations, has issued official statements emphasizing the devastating long-term effects that may be caused to children needlessly traumatized by separation from their parents2. Yet, despite widespread condemnation, reunification of these children with their families has not happened quickly, and news reports have highlighted parents being deported without their young children, lack of records linking children to the identity of their parents, and an onerous verification process for parents and children to be reunified.3 Attention to this crisis has also brought awareness to the myriad other ways that mental and physical health can be impacted via the current immigration system – from the impact of deportation of parents on child mental health to the safety risks that ensue when immigrants fear calling police to report crimes.4

As psychologists in academic health centers, we serve diverse populations across the country and are part of a healthcare workforce in which nearly 17% of professionals are immigrants.5 We must be active in understanding the impact of our country’s immigration system and policies on mental health. We must recognize how a climate of fear erodes the well-being of immigrant populations, including by making it less likely that immigrants will seek care in health centers or call for crisis services when needed.6,7 And beyond bringing this awareness into our care of individual patients, we should consider what collective actions can be taken to improve the social conditions impacting immigrant populations in the US. For example, via our professional associations, medical institutions, and individual efforts, we can ensure that empirical evidence and clinical insights continue to inform advocacy; and we can identify actions at the local level that can make our communities and medical systems safe and welcoming to immigrants. This crisis brings into sharp relief the reality that it is not enough to be aware of social determinants and integrate them into our clinical practice with individual patients; if we are to practice population health as medical center psychologists, then we must also commit to bringing systemic solutions to bear upon systemic problems.

(References on p.11)
References for Suicide Prevention in Primary Care Settings


References for Immigration mental health: Policy as a social determinant

Letter from the Editor

It is with great excitement that I write this article to re-launch *Grand Rounds*. As I reviewed article proposals for this issue, I was struck by the diverse, amazing things our members do. Psychologists in academic health centers are involved in patient care, education, and research related to topics that are in the news regularly, from the opioid crisis and increasing rates of suicide to immigration mental health to new models of healthcare delivery. AHC psychologists are finding innovative ways to address these issues and improve the well-being of individuals, systems, and society. It is fitting, then, that the theme for the next APAHC conference is *Psychology on the Cutting Edge: Celebrating Psychologists’ Roles, Contributions, and Diversity in Academic Health Centers*. I hope that you will join us for the conference and connect with leaders in our profession. As our fearless leader, Zeeshan Butt, encouraged in his article, I also hope that you all will want to get more involved in the organization. In particular, I welcome members who would like to join the editorial staff of *Grand Rounds* and contribute to its growth and development. Consistent with feedback we received in the membership survey, *Grand Rounds* will include a greater diversity of topics and contributors, with releases planned for the spring and fall each year. I look forward to receiving article proposals from our membership and sharing all the amazing things psychologists in academic health centers are doing.

Call for proposals and editorial staff!

Have exciting clinical research that you want to share? Using innovative teaching methods? Involved with policy?

Let APAHC members know what you’re doing!

We are seeking submissions of approximately 500—1,000 words for upcoming installments of *Grand Rounds*. We also are looking for editorial staff to help publish future issues.

E-mail your proposals to the Editor at apahcassociation@gmail.com by Dec. 1, 2018