

**AVAPL Mid-Winter Meeting
February 3 – 7, 2014**

**Mid-Winter Executive Meeting
Sunday, February 2, 2014
3:30 pm – 6:00 pm**

In attendance:

Jody Rubenstein, Ph.D. Presidents
Mary Levenson, Ph.D. Past President
John McQuid, Ph.D. President-elect (excused)
Mary Beth Shea, Ph.D. Treasurer
Stephen Cavicchia, Psy.D. Secretary

Dr. Rubenstein presented the schedule for the upcoming week of meetings. Dr. Shea updated the treasurer's report:

Treasurer's Report

Conference Account: \$31,576.13
Membership Account: \$51,013.19
Membership: 259, 32 trainees and 35 new members

The Executive Board discussed the message we would present at VACO:

1. Hybrid 38 versus Title 38 continues to be a concern as related to hiring practices and promotions to GS 14s and 15s.
2. The impact of travel restrictions in the field.
3. Challenges facing MH and how AVAPL can assist.

February 3-4, 2014: Meetings with VA Central Office Leadership

Jeffrey Burk, Ph.D., National Mental Health Director for Psychosocial Rehabilitation and Recovery Services, VACO Mental Health Services

Peer Support remains a priority for the Psychosocial Rehabilitation and Recovery Services Section (PSR&RS) and for Mental Health Services (MHS). The White House Executive Order mandated the hiring of 800 peer support staff by 12/31/13, and the requirement was met prior to the deadline. There are now 936 peers, and almost all are certified. Meeting this goal was a team effort, and HR, Workforce Management and Consulting, and Mental Health Operations were very helpful. Those above 800 were funded by VISNs or local facilities. Those who are not yet certified should be certified in the coming weeks. The next step is to make certain the Peers are assigned as planned. The minimum standard is three peers per medical center and two peers per very large CBOC. With the hiring goal met, attention is turning to other peer support-related issues. For example, a fidelity measure is being developed by Dr. Matt Chinman. A question was raised about how to handle a Peer Specialist or Peer Apprentice if they should experience an exacerbation of mental health symptoms. The position of the PSR&RS Section is that peers should be treated just as any other employee. EAP can be utilized if needed. For longer-term treatment, supervisors may provide peers with information about options for treatment, and the peers

can determine how they wish to proceed. Termination issues during the probationary period are managed no differently than with other employees. Issues are addressed on a case-by-case basis. Another area of attention regarding peer support involves the capture of workload. Beginning in April, a 4-character suffix is to be appended to clinic workload to allow tracking of workload. This is a stop-gap measure until the beginning of FY 2015, when a new DSS stop code will go into effect. User class is also a problem, and a proposal has been submitted to classify a new user class for Peer Specialists.

Dan Bradford, MD, National Director of MHICM, is working the Intensive Community Mental Health Recovery (ICMHR) Handbook through its final stages of review/approval. MHICM, RANGE and E-RANGE will be under one umbrella, and the Handbook will place a stronger emphasis on Recovery in these programs.

There are over 100 Psychosocial Rehabilitation and Recovery Centers (PRRCs) currently in existence, with a few more in development. The PRRCs are overseen by Dr. Timothy Smith. Dr. Smith is also working on incorporating recovery on the inpatient mental health units, and a toolkit addressing that issue is now developed. A key component to the toolkits is a checklist to determine the recovery-oriented status of the inpatient units.

Regarding an area outside PSR&RS that Dr. Burk is working on, the revised qualification standards for psychologists are in the final stages of review. It is hoped these revisions will be released to the field in the coming few months. If approved in their current state, being board-certified by the American Board of Professional Psychology (ABPP) will substitute for an APA-approved internship. Applicants will still have to have completed an internship in professional psychology; however, if that internship was not accredited by APA, then board certification by ABPP may substitute for the lack of accreditation for their internship. In addition, doctoral programs accredited by the Psychological Clinical Science Accreditation System (PCSAS) will also be recognized. Also, there will be a new job assignment at the GS-13 grade level for those psychologists primarily engaged in research. A question was asked about how many promotion recommendations are implemented at the local facility. Dr. Burk stated that this information is unknown, as there is no feedback from the local station to the National Board as to whether recommended grade increases are implemented.

Marsden McGuire, MD, Acting Chief Consultant, Mental Health Services, David Carroll, Ph.D., National Director, Recovery Services and Program Integration (phone) and Sonja Batten, Ph.D., Deputy Chief Consultant for Specialty Mental Health, Mental Health Services

Dr. Carroll works with Recovery Coordinators and also works with Program Integration. Dr. Batten reported that travel is something for which there is limited control. The travel legislation also included tracking of external conferences which is now being implemented through ACES. EES is responsible for tracking conferences over \$100,000 and for those where over 50 VA employees attend. EES must approve any conference for those with over 50 employees. Above 100, the COS for VA must approve. Employees may attend on their own with AA and travel. Links are going live today (2/3/14). Dr. Batten is facilitating the AVAPL Conference as it goes through this process. She was thanked for her efforts. She will notify the AVAPL EC when the link is "live" for upcoming conferences at which point dissemination of this information to the field can occur. A recent report to Congress indicated the significant decline in travel expenses across the different agencies. A number of organizations and efforts have been made to educate on the negative impact some of the travel restrictions have

occurred. Two examples were shared by the AVAPL EC to highlight the negative impact the travel restrictions are having on training.

Dr. McGuire reported that the OIG workgroup is looking at the impact on psychiatry staffing. Tele-MH is one way of addressing staffing challenges. National level credentialing for Tele-MH is being worked on by Dr. Godlesky and Dr. Darkins through the Office of Tele-MH. Another initiative is looking at making the credentialing system consistent with DoD and would have a positive impact on psychologists within VA transferring more easily from one facility to another.

The position of Chief Consultant, Mental Health Services (vice Zeiss) has been posted twice. There continues to be an opportunity for a psychologist to be considered. Encouraging psychologists to consider and apply for this and other positions remains open. Other leadership positions that will soon become vacant include Brad Karlin (EBP) and Jan Kemp (Suicide Prevention). Dr. Petzel will be retiring soon as well.

AVAPL discussed the importance of moving psychologists to Title 38. A number of barriers to hiring the best qualified candidates were discussed. One example is research positions where certificates under Hybrid Title 38 do not produce the strongest candidates. This would also change the boarding process to pay panels that are local. There are leave benefits which would also attract stronger candidates. PC/MH integration and BHIP were discussed. Concern is over promoting team-based care in outpatient without destroying the specialty care.

The following link was shared and AVAPL was asked to disseminate to its membership:
<https://vawww.portal.va.gov/sites/OMHS/mhperformancemeasures/default.aspx>

Laurent (Larry) S. Lehman, MD National Program Director, MH Disaster Response/Post Deployment Activities/PTSD MH Services (10P4M)

Dr. Lehman reported that there has been significant improvement in working with DoD on the issues facing returning troops. There is a greater focus on resiliency and understanding PTSD. There is more responsiveness to the MH needs of veterans within VHA. OMHO is responsive to implementing MH initiatives in the field. Psychiatry is attempting to develop a similar organization as AVAPL. Appreciation was offered for the manner in which AVAPL operates and how psychologists and psychiatrists work well together. Recruitment of psychiatrist is a challenge. Enriching their duties to include research, training and EBPs may serve to make VA more attractive.

Tele-MH is an effective way to address some staffing issues at CBOCs. It may not work for all veterans, but it can be useful as one way to supply the needed services to remote sites. Poly-trauma offers a multidisciplinary approach to treatment of veterans with head trauma that includes neuropsychologists. There is complexity with returning troops who often come to VA on significant pain meds and experiencing undiagnosed PTSD. Neuropsychologists are helpful in sorting out pain versus trauma versus PTSD. Integration of pharmacotherapy and psychotherapy is an important area for research to determine the most efficacious ways in which these treatment approaches may, be combined if needed to improve symptomatic and functional outcome for a given patient.

One area of concern as related to PTSD and SUD is the impact of BHIP on the specialty services. Some sites are not maintaining the integrity of these specialty programs. Emergency preparedness includes a MH component.

Dan Kivlahan, Ph.D., National Program Director, Addictive Disorders

There are ongoing efforts to revise the MH Services Handbook, including clarifying required services for Addictive Disorders. Gambling Disorder is now recognized in DSM 5 and will be addressed in the revised Handbook. As with other required elements of care, some treatment services may need to be arranged by fee-basis, contract or other agreements with community partners if it cannot be provided by qualified staff at the facility.

There are ongoing training and other implementation efforts to improve initial access and ongoing retention involving evidenced-based psychosocial interventions and pharmacotherapy for SUD. Pharmacotherapy for alcohol and opioid use disorders is not consistently utilized in the field. Recently published research (Oslin et al., JGIM 2014) has shown that integrating alcohol care management including pharmacotherapy in Primary Care can be more effective for selected Veterans than referral to specialty SUD care. Since the majority of Veterans with alcohol use disorders are not seen in SUD specialty care (and could not be accommodated there even if they were all willing to attend), we need to continue efforts to make individualized services available in other settings. Other technology-based efforts to expand access include web-based applications and use of telemental health.

There are Interagency efforts with DoD to develop common process and outcome metrics for mental health. Measurement-based care is a challenge for VA implementation given current informatics limitations, however DoD has a web-based application called the Behavioral Health Data Platform that allows service members to use tablets or other mobile devices to complete self-report measures in advance of visits and have the results available for review with the provider during the clinical encounter.

Senior VACO leadership remains committed to MH as a priority. Dr. Petzel charged a Mental Health Innovations work group to revolutionize patient-centered services across settings of care for Veterans with five high prevalence conditions that are associated with disease burden and risk of suicide (SUD, PTSD, Depression, Insomnia and Pain). Shared decision making and measurement-based care are two themes being emphasized in the developing action plans.

Expansion of BHIP has the goal of making mental health services more readily available and better coordinated over time through team based care. Specialty services such as SUD and PTSD clinics will remain essential complements to BHIP given needs for greater intensity of specialized services for some Veterans. Implementation challenges to address include effective handoffs between those levels of care.

Dr. Kivlahan made suggestions regarding CPT code changes and wRVU workload credit to discuss when AVAPL meets with APA.

Mary Schohn, Ph.D., Director, Mental Health Operations, VA Central Office and Lisa Kearney, Ph.D., Senior Consultant for National Mental Health Technical Assistance, (by phone)

Dr. Rubenstein spoke about MH staffing and if the resources in the field are adequate, Hybrid 38,

Travel, EBP rollouts with Brad leaving, and space. Dr. Schohn reported that the National Defense Authorization Act of 2013 requires the development of metrics for timeliness of care, patient satisfaction, EBP and capacity plus staffing guidelines for general and specialty MH staff. Semiannual reports are sent to Congress and external reports will start to be posted hopefully by the end of March. The staffing plan calls for a minimum of 7.72 FTEE per 1000 veterans in outpatient. This does not include clerical staff and is not limited to LIPs. There are some metrics for space but this is in the beginning stages. Priority is being given to MH for available space as it becomes available locally. Extended hours are also being considered. Compressed tours may have a positive impact on available space.

Travel is not the purview of OMHO. The process is changing but is problematic. IT is also a challenge in terms of software and support issues. The need is to develop more measurement-based care. The Army is utilizing a package and it is not clear if something similar can be imported into VHA. A pilot may be considered so that recommendations may be developed.

OMHO is advocating for more VISN-based EBP training programs. The other option discussed was certifying existing staff who received comparable training. Tool for implementation of evidence-based psychopharmacology are being developed. wRVUs are being utilized to measure productivity. There is no difference in wRVU coding for an EBP versus general MH therapies. For 2013, there was 8-weeks of data lost when switching to the new MH CPT codes which impacted the wRVU data and VERA. Improvement in coding accuracy is encouraged and several coding guides for MH have been created and are available for utilization to help providers.

BHIP training includes a continuum that includes Specialty MH care. This care would be episodic. Current practice appears to have veterans in specialty care that are really general care. Any changes would occur over time to avoid disruption.

Mental health staff were encouraged to go through their respective leadership chain. Look for opportunities to develop leadership in other parts of the system.

The MH legacy is established and should not change with a change in leadership. The impact on VA from national healthcare reform is expected to be minimal. Some of this is an unknown. OMHO is continuing to work on outcome measures. The data is not easy to understand. Psychologists can serve a critical role in assisting in understanding and integrating the data.

Jan Kemp, RN, Ph.D., National MH Program Director, Suicide Prevention and Caitlin Thompson, Ph.D., Deputy Director, Suicide Prevention

Jan Kemp reported that this will be her last week in VACO. Dr. Caitlin Thompson will assume her duties beginning next week until a full-time replacement is appointed.

In the area of the suicide prevention program, a supplement to the suicide data report has been released and it appears there has been a positive impact on suicide rates. Local facilities have added staff over and above what VACO funded. Some facilities utilize other staff to do some of the case management. Tracking of SPC workload is being developed. Burnout is a concern. 18-24 year old veterans are a concern and pose a higher potential suicide risk. VHA and VBA are working on a model to coordinate efforts related to benefits and mental health services through a single veteran contact on college campus.

There are some areas where suicide prevention is a challenge. One area is firearms (“means”). There is a pilot related to means restrictions in San Francisco. Research is also being explored. The second area is risk assessment based on high risk groups. Training in risk management and other preventive measure may assist in decreasing the risk.

The second area is related to community engagement. There are over 20 pilot sites to determine if veteran MH care can be improved through these community-based pilots. The Mental Health Summits that were held produced some additional partnerships. The response from attendees was very positive. 4-hour summits seemed to be too short. 6-hour summits appeared to be sufficient though some sites did full day summits. At this time, it is expected that the next summit will be left to the discretion of the local facility. OMHO will track the two action items that were developed at each Summit.

The Caregiver Law allows VHA to give services to the family of returning veterans within the first three years of their discharge. Vet Centers are very interested in offering this service. Vets Prevail provides online CBT counseling along with online peer support. Effectiveness has been demonstrated. It is an incentive-based program and appears to capture those who do not come to VA for care. They do refer to the Crisis Line and to the local SPC. Dr. Dave Carroll and Dr. Tracy Smith will assume responsibility for this program when Jan leaves.

The EAP and Community Provider toolkits were recently released. The Veterans Employment and Student Campus toolkits are previous releases.

The Clinical Practice Guidelines (VA/DoD) are now published and available on the website. Toolkits are being developed.

Wendy Tenhula, Ph.D. National Director, VA/DoD Integrated Mental Health

Dr. Tenhula’s primary role is to facilitate VA and DoD working together. Integrated MH Strategy (IMHS) resulted from with the October 2009 VA/ DoD Mental Health Summit. IMHS includes 28 strategic actions. There is a VA and DoD lead assigned to each Action. The October 2013 IMHS Status Update was shared. There are also currently three VA staff assigned to the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE), two of whom are MHS employees (the third is under Rehab and Prosthetics Services).

The National Problem Solving training initiative is another shared initiative. Almost 200 clinicians have been trained to date. The Problem Solving pilot is being launched utilizing a 4-session group format. This training is targeting OEF/OIF troops. There is also an online self-help version (www.startmorvingforward.org) that was developed jointly with DoD as part of IMHS. Training is now being expanded to train MH providers assigned to Primary Care. A web-based self-help parenting course has also been developed with DoD (www.veteranparenting.org). A number of new APPs, including companion apps for the PST and Parenting self-help courses will soon be released.

Make the Connection Campaign is a website with 200-300 Veterans telling their own story of Recovery in their own words. The strength and resilience they demonstrate are extremely positive. The Facebook page has over 2 million "likes" as of December. Within the first several months after it launched, it was the fastest growing government page on Facebook. The website is monitored 24/7 and referrals made to the Crisis Line or other VA resources if indicated.

A 4-module course on military culture training is available through the internet for VA, DoD and community providers. A total of up to 8 CE credit will be offered for providers who take all four modules.

<http://www.deploymentpsych.org/online-courses/military-culture> and <http://www.tms.va.gov/learning>. For the time being non-VA participants must print out and email the end of course evaluation to the VA to receive CE credits, instructions and the email address are on the website.

Visit - Deploymentpsych.org/military-culture for more resources related to military culture
The integration of Chaplain services into MH is being promoted through the IMHS and follow up work funded by the Joint Incentive Fund (JIF). A survey of VA and DoD chaplains had a 76% response rate. 32-site visits occurred in DoD and VA. A collaborative training program is being developed between MH and Chaplaincy. A collaborative model in the field was discussed along with ways to best integrate chaplain services at the local medical center level.

DoD providers, like in VA, continue to need training in services/issue related to LGBT. There are no specific joint initiatives at this time.

Lisa Kearney, Ph.D., Senior Consultant for National Mental Health Technical Assistance and Andrew Pomerantz, M.D., National Mental Health Director, Integrated Care

Dr. Pomerantz reported that PACT continues to develop and is now accepted both in the field and VACO. The Secretary has embraced workload expectations which are now established. Recent reports see a significant increase in integrated care encounters. A research base tends to lag behind. Dr. Kearney indicated that feedback from the site visits reveals more sites are in line with the model. Some sites do not have care management. OIG started site visits this past fall looking at PCMHI at the local level. Facilitation, an intensive evidence-based form of consultation, is available for sites facing challenges with PCMHI implementation and matches facilities with experts in PCMHI to assist.

The BHIP model was reviewed and compared to the PCMHI/PACT model. BHIP is a general MH team for those patients whose needs are too complex for PCMHI. BHIP uses a team based model for MH services, with clear role definitions and panel sizes, much like PACT does for primary care. SMI PACTS are also being developed in some sites to provide primary preventive healthcare to Veterans with Serious Mental Illness. . The PACT handbook discourages use of these special population PACTs as a long term plan for primary care for this population but supports its use as a transition when Veterans are unwilling or unable to receive care in regular PACTs. Dr. Kearney supplied the following link: <https://vaww.portal.va.gov/sites/OMHS/BHIP/default.aspx?PageView=Shared>.

The PACT Handbook has been in development for two years and is expected to be released soon. PCMHI is included along with other services in the expanded PACT, which includes pharmacy, clinical dietetics and SW case management in providing support for the core primary care team. National PCMHI leadership supports staffing at the level of 1.0 MH FTEE for 2000 PC veterans. Challenges come from not understanding the model as related to shifting staff from MH to PC. wRVU for delivering a short-term intervention in PC generates less workload CPT codes used for MH services in the same amount of time. PC tends to appreciate the MH support available within their clinic. Space is another barrier. Care management can still occur even with limited space.

There is a mail group (Mental and Behavioral Health in PACT) that addresses PCMHI. Administrative and clinical issues are discussed. There is a list serve which has good discussion and feedback from the field. Discussion occurred related to use of wRVUs and panel sizes which are used in PACT. Open access can be in conflict with WRVUs in that allowing for open availability in one's schedule means less scheduled patients generating wRVU. This is viewed as a work in progress.

Susan McCutcheon, R.N., Ed.D., Director, Family Services, Women's Mental Health and Military Sexual Trauma, VACO Office of Mental Health Services

Family Services – VA and NAMI just completed a Memorandum of Understanding to offer family to family services that started in 6/2008. This will not be renewed though VA and NAMI organizations that have a relationship are encouraged to continue. NAMI received new funding for a program called NAMI Homefront. This contains a 6-session curriculum for veterans which will be piloted in 6 states. There will be no additional models of care in marital and family therapy disseminated. Existing training has been on hold. Three pending releases are related to Basic Parenting, Intimate Partner (Domestic) Violence and Same Sex Relationships.

Section 304 of the Public Law relates to family members of returning troops being able to receive care within the first 3 years. More information is needed especially as related to care the VA would need to contract out.

Gaps in research and services related to MST have been identified. A wide range of initiatives related to women's health, MST, couples and other issues were presented. One such initiative was "Answer the Call" which placed a call randomly to medical centers asking to be connected to the MST Coordinator. Those that failed were required to create an Action Plan.

Rates of those reporting MST have stayed relatively stable over the years. The numbers have increased slightly to where 1 in 4 (versus 1 in 5) are now reporting MST. It is not clear if vets are responding more or if there are actual increases in the rate of MST.

Training delays for M&F Counselors are causing a problem due to the limited number of trainers. They must be scheduled 6 months apart. External trainers are brought in until internal consultants/trainers can be developed.

February 4, 2014 – Tuesday – VACO

Gloria Holland, Ph.D., Acting Director, Associated Health Education, Special Assistant for Policy and Planning, Debbie L. Hettler, OD, MPH, FAAO, Clinical Director, Associated Health Education, and Stacy Pommer, LMSW, Health Systems Specialist

Dr. Zeiss has agreed to remain available as an unpaid consultant. Dr. Holland is currently covering his position duties. There remains one state (New Hampshire) without training slots. There is still interest in funding this state. No additional resources for new training are available at this time. Future budgets will be tight.

AVAPL thanked OAA for the additional post-docs that were funded this past year. Discussion focused on whether facilities had capacity to train additional interns/post-docs. Assistance was requested in crafting the next RFP for areas that are up and coming. A salary survey will be forthcoming and assistance from AVAPL for educating APIC on the survey was requested.

Dr. Hettler has been successful in developing a Consortium Agreement that has overcome the past legal barriers. VA will pay for liability coverage "everywhere" and the university will also cover when on their campus. This model contract may be utilized with other affiliated agreements where psychology has strong affiliated partnerships. APA is aware of this revision.

For rural initiatives, housing support cannot be supplied from OAA. At some sites, the local medical center leases housing. OAA asked AVAPL to assist in creating new ways to support additional trainees. In 3 months, an RFP will be requested with a very quick turnaround. Dr. Rubenstein indicated that AVAPL agrees to work with Directors of Training to follow-up and survey the field regarding needs and capacity. Responses would need to be received by the middle of March.

Routinely, the strong programs get stronger. The Secretary's initiative includes regions where programs are not strong but have a need for these services. Consortiums may be able to assist in meeting this need. Funding initiatives have targeted sites with modified criteria but those sites still need to apply. OAA continues to work closely with local sites and APA to strengthen training programs

LPMHC have a very active lobby. Dave Bergman is the Executive Director of the LPC organization and their lobbyist.

Legislation is being considered to develop training programs for LPMHC and M&FT. RFPs will be forthcoming. Discussion occurred regarding the feasibility of establishing training programs locally. There are many barriers including CACREP accreditation and the requirement that clinical supervision must be from another LPMHC.

The AVAPL conferences will include a session by Dr. Toni Zeiss will be on interprofessional cooperation and training, an area with was not well understood as indicated in the prior RFP's. OAA was thanked for their continued strong support for psychology training.

Stacey Pollack, Ph.D., National Director, Program Policy Implementation

Performance Measures are a shared venture with Operations and Policy. 60% is overlapping. There is a weekly meeting for all stakeholders that oversee all the metrics so there is a coordinated approach. Dr. Pollack now is the Chairperson of the Office of M&FT and LPMHC (vice Karlin). There will be efforts to expand their roles. There are @ 75-100 of M&FT and LPMHC within VHA. Others are in RCS. The lobby groups are very active and wanted a minimum hired at each facility. The National Board will remain since the numbers are so small across VHA. Workgroups will begin meeting that contain both groups are established to increase knowledge of the professions and what they can do is planned. The CACREP requirement was built in as it was the only national accreditation body. Congress is very active in asking about CACREP given the impact on limiting those that can qualify for these positions. This is less of an issue for M&FT.

MH and C&P exams, vocational rehabilitation and employment (VR&E) – the goal is to make it more recovery focused. A workgroup was established to update the rating criteria for MH. General Counsel is reviewing and once approval is given, a pilot for the new criteria will be established. The changes will include moving to a functional-based versus symptom-based rating system. Veterans that are currently rated will not be downgraded with any of these changes. Data is routinely received from VBA of veterans that are newly rated for a SC condition. The goal is to reach out and engage them in VHA services if they are not already involved.

There are no plans to move C&Ps into VBA and out of VHA. A policy will be coming that mandates a walk-in DBQ clinic for medical C&Ps. MH is not part of the policy. There are various models of completing C&Ps including collateral duties, fulltime C&P, and contracted out. Contracts are done through fee basis, National DEM contract and QTC contract (VBA). There is some negative feedback about contracted providers who are paid by the completed C&P. OMHO and the VISN MH lead address

these concerns. Blue Button access is being reviewed to determine if access can be removed for MH C&Ps. There is differing opinions as to whether this is the best option.

List serve etiquette has improved. Negative comments about veterans are never appropriate. There continues to be a need to improve communication with the field on these issues. Workgroups are being created in specialized areas such as MSTs. A SharePoint site is still a need where relevant questions can be answered. This would need to be a shared effort. A field-based PTSD C&P call will occur in April with Dr. Matt Friedman.

One area that would be helpful is to interface with the state licensing boards to address and understand about C&Ps.

Brad Karlin, Ph.D., National Mental Health Director, Psychotherapy and Psychogeriatrics

This is Dr. Karlin's last week at VBA. He was the SME and POC for LPMHCs and chaired the Professional Standards Board. The major issue that has come up is the CACREP requirement. It is the only national accrediting body and was selected to be consistent with other professionals to maintain a standard of care. VHA has maintained that this standard is relevant. It was recently established which has limited the number of qualified candidates. The Professional Standards Board is reviewing other options including specific certifications. There is no mandate for clinical supervisor except for those that are below the GS-11 (GS-9) must be supervised by another LPMHC. There is no mandate as to how LPMHCs are aligned and supervised in the field beyond those at the GS-9 level. Also addressed were the planned VHA training programs for M&FT and LPMHCs which is currently limited due to the number of available supervisors in the field.

Program evaluation data for EBPs has found a correlation between the therapeutic relationship and outcomes. CBT for SUD will be the next EBP training program and will soon be launched this FY. Changes needed to be made to the audio recording procedures due to IT changes. A significant change that has occurred since the inception of EBPs is the increase in the number of psychotherapy sessions at 60 and 90 minutes.

The training needs remain especially for new staff currently being hired. Processes are being developed to decentralize training to each VISN. It will be implemented through a phased approach over the next few years. A key challenge is to make certain this is supported by the VISNs. Work will occur with the VISN MH leads to make certain the expectations are clear and the support remains strong. There is a current process for permitting similarly trained providers to be certified. Those that have received previously may also be certified. The criteria and applications will soon be released to the field. An appeal mechanism may be part of this certification process. The dollars that support National EBP trainings cannot be utilized for trainees. Decentralized training will permit the training of trainees. Given the high percentage of newly hired psychologists that completed a VA training program, having them certified when hired is an advantage.

STAR-VA is a psychosocial approach to managing challenging behaviors associated with dementia. This was piloted in 17 CLCs with good anecdotal outcomes. This was expanded to another 20 sites with the training modeled after the EBP training program. A nurse champion role was created to engage nursing and other CLC staff in working with the psychologist. Outcome data is being reviewed and the primary results will be forthcoming in the next few weeks. It is expected that an interdisciplinary approach to

addressing challenging behaviors in GEC will be promoted as a result. More training opportunities are needed in working with aging veterans.

Lisa Pape, LISW, National Director, VHA Homeless Programs and Sharon L. Lien, Staff Assistant

The goal to end homeless by 2015 is still the goal for VHA. There are gaps, such as employment, which continue to be challenges. Mayors will be challenged to pick a sister city and have the goal of ending veteran homelessness. Starbucks will be hiring 500K employees over the next 5 years and discussions are occurring to consider a % of those new hires to be homeless veterans. Discussion occurred related to how to improve access to VBA benefits for the most vulnerable veterans, some of whom are homeless with no identifiable address. Since 2009 there has been a 24% decrease (through early 2013).

SOARS is a new program which will help veterans connect to their benefits. Initial data reveals good outcomes. Housing First is still a model which is being implemented differently at different sites. The key is to make certain there are follow-along and MH services. HUD-VASH and HCHV are funded through 2015 after which funding may be limited. Grant and Per Diems could improve services by moving to a Recovery focus and utilize repair councils. This may require a legislative fix since the contracts are recurring and based on the original proposal submitted by the community provider. Gap analysis is being utilized to identify areas that have greater need. One of the areas is in transitional housing. Moving through homeless programs more quickly with good disposition plans and housing can greatly assist in improving outcomes.

Special needs grants may be ended in the next year. The outcomes do not appear to be different when compared with those programs that do not have those funds. The dollars could be shifted to other programs which would enhance outcomes.

Veterans account for @ 8% of the prison population. The VJO program remains very effective.

Loren Wilkenfeld, Ph.D., National Mental Health Director of Outpatient and Inpatient Care Services

The Inpatient MH Handbook was published in September 2013. Phasing out long term care beds is one of the goals. Conversion to CLC or residential programs are options. A med-psych model is being discouraged as an alternative. Staffing guidelines would be useful in making certain the relevant MH staff are available to make recovery the focus in inpatient mental health units and CLCs that are caring for veterans with an SMI.

A MH toolkit will be launched very soon. Efforts are underway to collect data on restraint usage in consideration of restraint free inpatient environments. There is currently not a handbook for outpatient MH services.

Timothy O'Leary, Ph.D., Acting Chief, Research and Development Officer and Terri Gleason, Ph.D., Senior Program Manager

Research for MH remains a high priority including PTSD, depression and mood disorders. A post deployment includes comorbidities of SUD. \$585 million is the budget for VA research. Indirect costs are paid through VERA. The various research programs were identified along with their focus. Last year, in addition to VA budgeted and other dollars, \$485 million came through NIH grants and \$170 million from partnerships with smaller non-profits and pharmacy (\$1.7 billion total for VA research).

The MIRECCs are varied in terms of their focus. Research may not always be their priority. R&D is cooperative in their support of the MIRECCS but is not directly involved. The larger research grants would still need to be competitively acquired.

Enthusiastic and savvy researchers are the most successful. The ability to engage potential subjects and encourage their participation in research is an important skill set.

VA research has been very successful in producing a wide range of clinically relevant outcomes. These outcomes are related to both medical and mental health issues. VA research is a “better investment” when looking at the research outcomes that have been produced. Legislative earmarking of specific research issues can be problematic as the scope and ultimate costs are not known.

Rollin “Mac” Gallagher, MD, Anesthesiologist, Pain Program

Integrated pain management is a major focus. Behavioral change is a key component of pain management. More psychologists are involved in behavioral medicine. More than 50% of patients experience some form of pain. A team approach to pain management is the best care. It makes all disciplines better as their respective expertise is shared. The PACT psychologist is key in primary care.

Access within primary care to a psychologist with relevant training in pain management is needed. The availability of collocated space is one of the challenges. Peers may be in a unique position to assist in educating veterans about alternative treatments for pain that are effective.

Key needs include promote the biopsychosocial model and having the necessary resources to bring the psychologist into the primary care session.

Katy Lysell, Ph.D., National Mental Health Director, Informatics

Informatics supports IT development for MH software and supported the T-21 initiatives. There are a few in their final year of development. The availability of funds limits the roll out of some of the projects. There is \$700 million of work beyond the current IT budget. Measurement-based care is being impacted. Tools that facilitate the availability of standard data that can be collected and made available at the treatment level are needed.

DoD has a tablet-based assessment tool that includes a number of brief assessment tools that are completed prior to the treatment session. The results are not directly linked to the medical record though the results are sent to the psychologist electronically. It is not known if the data is automatically entered as part of the medical record or if it has to be manually entered or copied into a progress note. PHQ-9, PCL and other brief assessment tools are utilized.

MyHealthyVet was originally intended to be a standalone system for vets to have access to their medical records. It was not designed to allow direct communication with the provider. Outside of MH, the provider would review before the data was entered into CPRS. Storing a MH standardized self-report assessment (My Goals, Clozapine enhancement) will not be available with the newer version. It will be moved into a separate program but will not be stored in MyHealthyVet.

\$1 million is needed to fix MHA and \$10 million to address the other T-21 MH initiatives. Clinicians need to be aware that coding is in ICD-10 which will soon be implemented. More education is needed as coders are looking for ICD language and not DSM language.

February 5, 2014 – Wednesday – APA

Heather O'Beirne Kelly, Ph.D. – Sr. Legislative & Federal Affairs Officer, Government Relations Office

Science – Dr. Steve Breckler, Executive Director, Dr. Howard S. Kurtzman, Deputy Executive Director

An overview of the Science Directorate was presented. Chief advocacy efforts are focused on Federal agencies for research. APA Center for Workforce Studies is now part of Science. They focus on determining how many psychologists are there in the US, what do they look like, where are they working, settings, populations served, are they being replaced. What is the future need? The total number of psychologists remains a challenge. Information on VA Psychology is also needed. VA may assist in predicting future needs in areas such as non-psychopharmacological pain interventions and PC/MH integration.

There are clinical practice and professional practice guidelines. Professional practice guidelines have been available for a number of years. In 2010, more emphasis was placed on clinical practice guidelines with Science and Practice taking the lead. The three areas that are currently being developed include depression, PTSD and obesity. Dr. Kivlahan is a member of the advisory steering committee. Dr. McQuid is chair of depression; Drs. Friedman, Fairbank and Cook are also involved. It was recommended that DoD be invited to participate in this effort. VA/DoD has developed practice guidelines so their inclusion would be beneficial.

Executive Office – L. Michael Honaker, Ph.D. – Deputy Chief Executive Officer, Executive Director for Staff Initiatives

APA is \$125 million operation. Dues only accounts for a small amount (10%) of that budget. Building leasing and publications account for a much higher percentage of the income budget. Budgets remain positive. Membership continues to drop. There has been a 4% decrease over the past 4 years. New members come in but do not stay. Some are moving into specialty societies and attend those conferences. Special Assessment payers are stable.

Dr. Honaker expressed APA's continued strong support for VA Psychology. VA is a forerunner of where psychology is headed. As new staff come into APA, more support will be given to VA. AVAPL identified concerns with the changes in VACO and the perception that psychologists are not being considered in MH leadership positions. APA indicated they would be following up through appropriate channels.

APA's strategic plan was shared. There are three primary goals including maximizing organizational effectiveness, expanding psychology's role in advancing health and increasing recognition of psychology as a science.

Practice Directorate – Katherine Nordal, Ph.D. – Executive Director, Dr. Lynn Bufka, Assistant Executive Director, Research and Policy

There are four groups working on practice guidelines. Efforts are being made to involve other professional organizations including the American Psychiatric Association. AVAPL recommended that

DoD representation be included given the well-established VA/DoD Clinical Practice Guidelines. The panels are multidisciplinary.

AVAPL identified an effort to establish a standardized credentialing and privileging effort across VHA. APA expressed interest in learning more and assisting. APA continues to work to have psychologists included under the physician definition in Medicare. WRVUs were discussed and the challenge with intensive psychotherapies being weighted no more than supportive therapies. Dr. Randy Phelps was identified as a good point of contact for this issue.

There is currently not a single staff person dedicated to VA in Practice. Drs. Zeiss and Patterson are involved. Membership of VA psychologists in APA was discussed and strategies shared on how to increase active participation. Early career psychologists are only at 52% with many not renewing after 3-5 years.

AMA continues to make efforts to restrict the use of “**Doctor**” to physicians. APA continues to address this in various states where medicine has attempted to regulate the practice of other professions. Nursing and other health professions are moving to the doctoral level and there is push back by physicians. Psychiatry is very active in working to keep psychologists out of the Medicare definition of “physician.”

The APA website has many resources that are available. Many are related to health psychology and non-psychopharmacological approaches to treatment. Appreciation was offered by AVAPL for the Practice Directorate’s efforts on behalf of psychology and VA psychology.

Title 38 was discussed and identified as a priority for AVAPL and VA psychology. Practice would be willing to support this initiative with a consensus in VA psychology. A VA Psychology Position Paper would permit APA to move forward with support and legislative action.

Education Directorate – Cynthia D. Belar, Ph.D., Executive Director and Karen Studwell, JD, Associate Executive Director, Government Relations Office, Education Directorate

The MedEdPortal was discussed. This offers teaching resources utilized by medical and other professions. Psychological science now has a portal. This is a one-year trial. Educational materials may be submitted. EBPs were discussed and how introductions/overviews may be utilized. Co-sponsored Webinars may be one way of disseminating this information.

Dr. Studwell replaced Dr. Nina Levitt who retired. University counseling centers and VA are the primary sites for psychology interns. The Center for Deployment Psychology helps civilian and military psychologists serve returning troops. Additional Graduate Psychology Education funds were included in the recent approved budget for services to support graduate psychology education which is designed to supply services to underserved populations, including military services.

Efforts and funding are being dedicated to increase the number of APA-approved internships. Consortiums may be utilized and would allow for an increase in internship sites.

Public Interest – Clinton W. Anderson, Ph.D., Associate Executive Director and Director, Lesbian, Gay, Bisexual and Transgendered Concerns Office and Deborah DiGilio, MPH, Director, APA Office on Aging

A number of fact sheets on issues related to aging have been developed. The Committee on Aging has VA representation. Guardianship evaluation fact sheets have been created to educate judicial and other professions. Some states have modified their definitions to reflect APA's recommendations. Other guidelines have also been developed around geriatrics and aging issues.

AVAPL shared updates on the state of LGBT services and training opportunities within VA. Assessment for MST and issues around orientation are being assessed.

An ABPP in geropsychology is being established. Discussion occurred on how to better coordinate efforts and improve communication between APA and VA Psychology.

2:00 PM – Dr. Heather Kelly APA Lead, Military and Veterans' Policy

The following issues were identified and prioritized for discussion with Congressional representatives:

Thanking congress for their efforts in the services of veterans, including

1. Research Funding
2. Additional training dollars
3. Responding to the VA regarding travel restrictions

Discussing recommendations for FY 2014, including:

1. Title 38 for psychologists
2. Space concerns
3. The continuing impact of travel restrictions
 - a. Training needed for newly-hired staff
 - i. VA has higher standard including 6 month mentoring following training.
 - ii. Travel restrictions impact the training new and existing staff in new models of care needed to improve access

Discussing other Issues

1. Centralized credentialing and privileging
2. IT funding of MH initiatives, \$1 Million for MHA, \$10 million for the balance of T-21 MH initiatives.

February 6, 2014 – Thursday – Visit to Capitol Hill

The AVAPL Executive Committee met with the majority and minority congressional staffers from the House and Senate Veterans Affairs Committees.

February 7, 2014 – Friday – Meetings with VSOs

Joy J. Ilem, Deputy National Legislative Director – Disabled American Veterans

John M. Bradley III, Senior Advisor – Disabled American Veterans

Alethea Predeoux, Associate Director of Health Policy, Paralyzed Veterans of America

Warren J. Goldstein, National Field Service Representative, The American Legion

Ralph Ibson, National Policy Director, Wounded Warrior Project

Hannah Fairman, Health Policy Analyst, Wounded Warrior Project

Glenn E. Minney, Director of Government Relations, Blinded Veterans Association

Michael O'Rourke, Assistant Director of Government Relations, Blinded Veterans Association

Aleksandr Morosky, Senior Legislative Associate, National Legislative Service, VFW

Copies of the Friends of VA (FOVA) proposed budget for 2015 was shared by DAV. The section on Mental Health Services was also shared in its entirety.

AVAPL updated the group on the vacancies within VHA Central Office. The White House had mandated the hiring of 800 Peer Counselors – over 1000 were hired prior to the deadline. While these are newly funded positions, a number of HVSE positions will be abolished at the end of this FY. Concerns were raised that these very successful positions will be lost if the local medical center does not shift these positions to permanent.

Questions arose regarding how EBPS were being disseminated in the field and if exposure therapies were too difficult for some of the veterans. Alternative treatments to exposure-based therapies were identified including those utilizing a CBT approach. Also discussed was the role of Peer Counselors in facilitating returning veterans accessing VA services. Vet Centers and their linkage to VA Medical Centers was discussed. VHA is not sending staff on a consultative basis to Vet Centers to coordinate services. Formal and informal links are not uncommon throughout the system. Training in some EBPs are offered to Vet Center staff.

Space issues were also discussed. While TeleHealth is available, space remains a main issue for the newly hired, Peers, mental health staff and trainees. There was agreement that the manner in which VHA contracted for space has contributed to the problem. VSOs recommended looking for space that may be available through local hospitals, VSO offices, Country Veteran offices, etc.

Travel funding was identified as a challenge especially as related to training restriction and its impact on the training of new staff. VSOs concurred and viewed VHA as having overreacted.

Complementary and alternative medicine (CAM) therapies do not appear to be offered consistently across VHA. VSOs expressed support for a variety of alternative therapies that can be offered to returning veterans who may not be ready for intensive exposure-based treatments. What is the evidence base, what do the providers know about the evidence base, and what the veterans need and want need to be incorporated into the decision making process. Research dollars are not readily available for evaluating the efficacy of alternative approaches to treatment. Research budgets are not earmarked for specific research areas; it is left to the clinical scientist to determine. A number of medical centers are incorporating a number of CAM therapies including aquiline, meditation, kayaking, meditation, exercise, fly fishing, pet therapy and others. Some of these are offered through voluntary and recreation services. A CAM survey was completed but the outcomes are not known.

VSOs reported that the Summits that were held last year were very beneficial but there is concern that it will not be repeated. Some sites have alternative meetings while others have continued though there is currently no mandate to do so. Without a mandate, not all medical centers are repeating the Summits. It is AVAPL's understanding that consideration is being given to mandate that these Summits be repeated.

Treatment of chronic pain and concern over the sudden withdrawal of pain medication was identified. Returning veterans often come to VA with narcotics prescribed as the primary treatment for the management of pain. Pain teams have been developed at VA Medical Centers but their efficacy and effectiveness is inconsistent.

VSOs asked whether the funding of Peers and 1600 MH staff addressed the need across all facilities. AVAPL reported that the meeting of staffing needs was inconsistent across the system. Some staff were counted as MH that should not have been counted giving the impression of more available resources than actually existed. Challenges to hiring in specific areas were identified. Title 38 for psychologists may be one way to enhance the hiring of psychologists in hard to staff locations. More specialized staffing for mental health remains a need. Concern was raised regarding the variation in workload credit and sufficient consideration being given to offering the more intensive forms of therapy which keep panel sizes low.

DAV asked for AVAPL to stay in touch throughout the year regarding developing issues.

The Wounded Warrior Project asked AVAPL what priorities should be presented to the Hill and VACO. The following were identified as important areas for continued and ongoing support: MH staffing, interdisciplinary pain treatment, PC/MHI, recovery focus, IT issues and training for EBPs. Questions also came regarding whether WIFI was available locally as well as other IT issues. F9/F11 emergency calls are not functional at every site. Integration of VA and DoD did not work after many years and dollars spent on attempting to integrate the systems. \$1 million is needed to address remaining MHA issues and \$10 million to address all the remaining T-21 initiatives. No funding has been allocated to date. A new "VISTA" is forthcoming.

VSOs asked about MST and services to male veterans. Data was shared which reported that the number of male veterans acknowledging MST is now higher than female veterans. Female veterans are much more likely to seek and accept treatment. VSOs reported the data they are seeing indicates a significant rise in MST for both males and females. They anticipate the demand for services will significantly increase. The Clinical Reminder for MST is only asked one time. It would be beneficial for this Reminder to be asked more frequently. There was agreement that this question should be asked more than one time.

/ES/

Stephen Cavicchia, Psy.D.
Secretary