

**AVAPL Mid-Winter Meeting
February 25 – March 1, 2013**

**Mid-Winter Executive Meeting
Sunday, February 24, 2013
3:30 pm – 6:00 pm**

In attendance:

Mary Levenson, Ph.D. President
Pam Fischer, Ph.D. Past President
John Klocek, Ph.D. President-elect
Ann Landis, Ph.D. Treasurer
Stephen Cavicchia, Psy.D. Secretary

Dr. Levenson presented the schedule for the upcoming week of meetings. Responses from the recent survey sent to the membership were discussed. Dr. Ann Landis presented the treasurer's report:

Treasurer's Report

Conference Account: \$28,016.01
Membership Account: \$38,512.94
Membership: 319

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

1. The membership is asking for clarity in terms of the benefit of Hybrid 38 versus Title 38.
2. Ongoing concerns regarding promotions to GS 14s and 15s in light of the recent survey to Psychology leadership in the field.
3. The impact of travel restrictions in the field.

February 25-26, 2013: Meetings with VA Central Office Leadership

David Carroll, Ph.D., Acting Chief Consultant, Mental Health Services, and Sonja Batten, Ph.D., Deputy Chief Consultant for Specialty Mental Health, Mental Health Services

Dr. Carroll identified four key areas that are current priorities. Primary responsibility is to develop VA policy and services. This includes promoting research, education and staff training. His office also spends much time responding to requests for information from Congress, the media, VSOs, etc. Time is spent educating stakeholders, the media, VSO's and other departments within VHA about MH issues. They work to partner with the rest of VHA including MHO, PC and Specialty Care. Equally important is taking care of the providers who are caring for Veterans. Broader issues include supporting culture change, the integration of peers, developing measurement-based outcomes and team-based care.

Concern about progress in promotion to GS-14 and GS-15 was discussed. The issue is that the decision is made at the facility and/or VISN Director level and admittedly is uneven across the country. If the

Director says “no” to a promotion recommendation, the psychologist may choose to appeal. It was acknowledged that this is a difficult time given the pressure on the Directors and the mood around the country about government workers. Psychologists who are declined a promotion can take this forward through the complaint process. Those that have done so have had some success. It was noted that VACO positions are not immune from the perspective that the National PSB is not fair and balanced. The concern is that there is grade inflation at a time when budgets are a challenge. There may be a benefit to working with Social Work and Nursing to determine if there is consistency with the boarding of those disciplines or if the concerns are shared.

A large number of or MH staff (1600) and peer specialists (800) are being hired. Concerned was raised about how training can occur with this large group of new staff with the travel restrictions that are currently in place. Alternative approaches to training in place are being considered. The Executive Committee reported on the great variation that occurs in the field regarding the interpretation of the restrictions.

Dr. Carroll also reported that developing outcomes will be a focus. Also discussed was a recommendation to place C&P exams in a part of the medical record that is not accessible to Veterans through the "blue button." This report is viewed as a forensic exam and not treatment. Reports from the field have identified concerns about Veterans confronting their examiner about the results before a final determination has been made by VBA.

Staff in the field was encouraged to volunteer for various details to VACO.

Sean C. Clark, J.D., National Coordinator, VJO, VHA Homeless Programs (10NC1)

VJO is in its 4th year of operation, starting in spring of 2009 with 10N memo mandating at least one VJO in each medical center providing services to local vets, outreach to law enforcement, treatment linkage to mandated programs and outreach programs to prisons. Healthcare for Reentry Veterans is a sister program; they are VISN employees and there are two/VISN.

Over 40 VJO positions were funded in the fall of 2009, 80 more were funded in FY 2011 and 46 in 2012. The public face of these efforts is the work done in the Veterans Treatment Courts. Not every VA medical center has a full time VJO. Of the 178 current positions, 85% are SW and 9 are Psychologists across both programs. These are funded as a GS-12 and requires staff to be an LIP.

There are 95 formal Veterans Treatment Courts around the country. These are part of 168 treatment courts that are networked with VA and link Veterans to services. VHA is present in 98% of the hearings (and covers the remaining 2% by phone or telehealth), VBA in 12% and Vet Centers in 17-18%.

The process of identifying Veterans is a huge issue. The fidelity of how justice system agencies are asking the question of who is a Veteran is improving. Federal Bureau of Prisons is the leader in asking the question; state corrections facilities are improving. Self-report yields a 2-5% positive response rate, while DoJ estimates that 9-10% of inmates have a history of military service. A secure on line portal for jails and prisons as a secure web site outside the VA fire wall has been developed to improve the accuracy of identifying Veterans. Users log in and upload bits of information on each inmate. VA

reaches out and imports it and runs it against the VADIR (DOD) data base and finds out if there is any record of military service. The history of military service is public information. A more detailed elaborate version of the information is sent to the outreach specialist.

The nature of the charges does not impact on the involvement of the VJO, or on eligibility for any other component of VA health care. Sexual offenders or those having to register under Megan's law are managed no differently though these Veterans present with much greater challenges for housing. Level 3 lifetime offenders are not eligible for a HUD/VASH voucher.

Employment is the best answer for many Veterans who have been incarcerated. Local probation officers are typically the ones who know the track record of employers who willingly hire Veterans with criminal records. Approximately 44% of those released from prison do not know where they will be living. There are 10,000/year that reenter society that are being served by HCRV. There are more that are not being reached. Data is captured in HOMES. The 44 HCRV specialists are covering 80% of all prisons in the US. There may be an additional 75 VJO positions added.

Psychologists are more often engaged in providing direct clinical services. The majority of the SW staff do not. Psychologists tend to see smaller caseloads, stay longer in the role and are more engaged in the national discussion. Approximately 70% of Specialists' time should result in clinical encounters, although administrative and planning activity, often with justice system partners, is also an essential part of the role. A psychologist from Palo Alto, Dr. Joel Rosenthal, is the National Director of Training for both Veterans Justice Programs. The goal includes promoting awareness among law enforcement. This starts at the local station by providing VA Police training on MH issues. VA Police are required to have 14 hours of training. Police officers generally indicate the desire for additional training on mental health-related topics. Over the next two years, a train the trainer program will be implemented that includes local VAMC-based teams consisting of a VJO specialist, a mental health clinician (a psychologist would be ideal) and 2 Police Officers. All VA Police officers will receive this training at their local VAMCs by early FY 2015.

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

The DRAFT Inpatient MH Handbook will soon be sent out for concurrence. Inpatient mental health units are required to have a Recovery focus. Inpatient MH units meet the high safety standards but are perceived to be too sterile. The environment of care will need to be transformed to reflect a warm, therapeutic, recovery-oriented ambience while maintaining safety standards. Peter Mills is the contact for environmental safety. The requirement for peer support services in the draft handbook.

A share point and inpatient MH e-mail group have been developed along with monthly conference calls, open to all inpatient MH staff and others interested in inpatient MH care. In addition, there is a national 6-session Webinar series, each providing 1.5 CEU hrs.

There is no national repository of seclusion and restraint data. Work is underway with Operations and the OQP to develop a national reporting mechanism. Training is planned to reduce usage of coercive interventions, including seclusion and restraint.

Staffing guidelines are not included in the handbook. Nursing staffing guidelines apply to mental health. It is important for units to be staffed adequately for safety and to provide needed clinical treatment and programming. A tool kit for inpatient MH Health providers is being considered for next year.

Another focus of inpatient mental health is the reduction of long in-patient lengths of stay, particularly, considering patient who have been in the hospital for a year or more, including a focus on options for discharge to non-institutional care. There are still long-term mental health units in existence and these will also be the focus of the effort.

Operations is developing staffing guidelines for OPT MH along with an outpatient model. A focus on team-based care is planned. There are several Pilots already running in the field.

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

MST screens (no co-pays) have been occurring at every station in the country since 2002. One in five women and one in one hundred men endorse that they experienced some form of MST. The figures are slightly lower for the newest Veterans: 73% of women who screened positive for MST went on for treatment and 59% of the men went on for treatment which is up from 33%.

Notably, 96% of all providers were trained in MST. MH providers are required to take a 2 hour training and PC providers had 20 minutes of training. The vast majority of medical centers have the capacity to provide this care.

The Answer the Call Campaign to speak to the MST coordinator at each medical center recently completed its third round. Medical Centers are graded green if they were able to reach the MST coordinator, yellow if 1/2 success and red if both call attempts failed.

Sexual Assault Awareness Month campaign is scheduled for April. There is now a blog which identified many issues and questions about claims.

Medical Centers were surveyed regarding compliance with gender based training and identified needs for training in other areas such as eating disorders. A monthly teleconference just began regarding women Veterans with SMI, PTSD, homelessness, IPV and suicide. The call is scheduled on the first Monday of the month at 12:00 Noon

An assessment of training needs about Women's Reproductive Health will soon be sent to the field. Intimate Partner (Domestic) Violence is in development. An IPV consultant was recently hired.

Family Services training has been impacted by the travel restrictions. One training this year will be related to PTSD issues and the family. Other areas of priority include Family Resiliency, Problem Solving Therapy, and working with same sex couples. Behavioral Family Therapy has not been approved for this year. There will be a greater focus on growing trainers/consultants in the field so training can be more local.

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

Kendra Weaver talked about the Crisis Line and the Homeless Crisis Line, Therapeutic and Supported Employment (CWT & HVSEP) and the National Clozapine Coordination Program. These areas have different missions but all linked by clinical operations. Dallas (Dr. Robbie Green) is responsible for the Clozapine program. Supported Employment must stay current on the needs of Veterans with TBI. The change in title from Suicide to Veterans Crisis Line has resulted in an increase in calls.

VISNS 1, 4, 17 & 22 are piloting a MH team-based staffing model similar to PACT. It is expected that by the end of the FY all medical centers will be required to have at least one such MH team in operation. In Mental Health, there will be 1000 Veterans assigned for each team. It is expected that a significant training effort will be required. Dr. Kearney discussed the implementation of the MH Uniformed Services Plan (Handbook). Site visits will now occur once every three years. The ultimate goal is to roll out a national MH model of care. Staffing metrics will be developed on the expected staff size per the staffing model.

Discussion also occurred regarding Hybrid Title 38 and Title 38. A few medical centers have increased the pay for psychiatrists. Market data is collected every two years. Psychiatrists assisted by pulling together data on salaries, years in practice, assigned duties, etc. to assist MHO in advocating for appropriate salary pay scales.

Dr. Levenson identified the variation in interpretation that is occurring with travel restrictions in the field. Dr. Schohn indicated she will follow-up. Dr. Levenson also discussed concerns with Veterans having instant access (Blue Button) to their medical record especially with C&P exams. It was emphasized that C&Ps are forensic exams belonging to VBA. They are not directly tied to treatment.

The National Defense Authorization Act (NDAA) requires transparency in government and requires a staffing model and a set of outcome metrics posted externally. OMHO is working on establishing outcome metrics that will be available later this year. An education plan for the training for mental health managers in metrics will be required. MH outcomes will be more standardized. Included will be a staffing cube which will include productivity numbers by provider.

MHTC role is to coordinate care which is not the same as case management. It is to make certain that staff who are contributing to care are talking with each other.

Chris Crowe, Ph.D. from VA for the Defense Centers of Excellence (DCoE) for Psychological Health and TBI, Wendy Tentula, Ph.D. National Director, VA/DoD Integrated Mental Health, & Sonya Batten, Ph.D., Deputy Chief Consultant for Specialty Mental Health.

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 1.5 million "likes" and is the highest trafficked government site on Facebook.

DOD/VA collaboration has 28 strategic actions. There is a VA and DOD lead assigned to each Action. One example is related to the sharing of mental health staff. DOD experiences surges of returning soldiers and VA has sent personnel to help to provide support to DOD. Progress has been made in resolving the credentialing and privileging barrier. Each strategic action has a VA and a DoD lead to facilitate collaborative efforts. Notably, 17 of the strategic actions' DoD leads work under the oversight of DCoE. The initiative is in its 3rd year and many are closing out. Seven of these initiatives are applying for JIF (Joint Incentive Funding) to further their work.

DCoE is a cooperative venture between VA and DOD mandated by Congress. DOD primarily focuses on resilience or preparedness of troops. Dr. Crowe is working on a committee looking at stigma that limits people from accessing care. DCoE is now embracing program evaluation. There are 167 programs that have been identified. VA is assisting and 8 psychologists have volunteered to assess the programs and see which ones show promise.

DOD providers, like in VA, need training in LGBT. DCOE is now under the Army. A stronger collaborative relationship with the National Guard is planned.

A Problem Solving pilot is being launched utilizing a 4-session group format. This training is targeting OEF/OIF troops. 150 providers were trained. There is also an online version (www.startmovingforward.org). Results, thus far, have been very promising.

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

Peer Support is a priority for Mental Health Services (MHS), especially in light of the White House Executive Order mandating the hiring of 800 Peer Specialists by 12/31/13. Peer support is a new profession that has presented many challenges. A contract to provide peer certification training was awarded to the Depression and Bipolar Support Alliance. The original contract required training for 40 peers. Efforts are underway to modify the contract or to solicit bids for a new contract to accommodate the additional 800 planned hires. Lag funds are available to pay for the travel to the training. Training can also be done by state organizations but must meet the established standards which not all do. The biggest challenges last year were related to position descriptions and classification. Despite MHS' objections, HR has determined that Peers are technicians. They will be classified under Title 5 and will use the 102 job series, with grades GS 6-9. Originally, peers had to be Veterans who served during wartime; however, General Counsel ruled that a broader definition of "Veteran" could be used. If not certified at the time of hiring, Peers are classified as GS-5 Peer Apprentices. A directive about documentation requirements for transitional patient advocates and peer specialists requires their entries in the medical record to be co-signed. Their work is currently considered "non-count."

Other topics of discussion: MHS is working with SMITREct to implement the SMI Re-engagement Program. This program seeks to bring back into care Veterans with SMI who have been lost to follow-up. The integration of recovery on inpatient mental health units is a new initiative. There will need to be a focus on the balance between recovery and safety.

There is a new Handbook for MHICM programs which consolidates MHICM, RANGE and E-RANGE under one umbrella. They will be recovery focused and referred to as ICMHR (Intensive Community Mental Health Recovery) programs. The Handbook will replace the expired MHICM Directive. In addition to the focus on recovery, the Handbook will focus on breaking down barriers to admission. These programs will be required to be CARF accredited.

The annual recruitment for new members for the National Psychology Professional Standards Board will be underway in the spring. The Psychologist qualification standards are being revised to include accepting accreditation from the Canadian Psychological Association, recognizing the Psychological Clinical Science Accreditation System (PCSAS; recognized as an accrediting body by CHEA), adding a new job assignment to GS-13 for psychologists who are predominantly researchers, and substituting board certification by ABPP for an accredited internship.

Implementation of Hybrid 38 as related to promotions for psychologists to the GS-14 and 15 levels has been overall very positive but has had pockets of problems. There is an appeal process but staff are sometimes hesitant to utilize it.

February 26, 2013 – Tuesday – VACO

Robert Zeiss, Ph.D., Director Associated Health Education and Debbie L. Hettler, OD, MPH, FAAO, Clinical Director, Associated Health Education.

Dr. Zeiss was thanked for the additional training positions released to the field this year. Thanks were also given to Mark Hintertour for assistance in allowing interns to travel on AA. Travel is an issue across VHA for staff due to inconsistencies in interpreting the new restrictions. For OAA, travel is a significant concern. The OGC initially reported that AA is inappropriate if doing presentations even if on VA issues. This was a major change. Staff are not covered if on travel status. It is inappropriate for VA staff to participate in site visits at non-VA or VA sites using AA. The issue had been accepting "gifts" from APA. This is now resolved. OAA's position is that since VA pays for our accreditation costs, that money indirectly funds our site visitors. It is not viewed as a gift and we can follow APA protocol. There remain concerns about conflicts of interest or what appear to be COI when a VA Psychologist visits another VA site for accreditation purposes. The resolution may be avoiding doing a site visit within their own VISN. OAA is not aware of any 50 mile rule regarding granting AA for training even if paid by the intern or staff.

Regarding staff travel, Dr. Zeiss indicated he may be required to use AL and pay his own way for AVAPL but may receive funding and AA to attend APA. Federal law requires \$1000/year for physicians for outside training. The travel restrictions have been imposed by VA after Congress asked for closer oversight.

Stacy Palmer, LCSW is assisting with tracking information on the incoming class of Psychology interns. With 50% responding, 78% are females. 20 positions were not filled in phase 1. OAA would also like to look at post-docs and how many came from VA internships. AVAPL offered to assist in gathering data related to interns/post-docs being hired into VA careers. The offer was appreciated but may not be required.

With the MH expansion, 200 MH positions were awarded across the disciplines. Of these, 60 went to Psychology in phase 1. In phase 2, 5 disciplines will be involved in the 200 positions. An RFP is slated to be released in April or May. Psychology will not be earmarked. Interprofessional education/training must be included and tied to PACTS or MH Teams. There will be four more years of the MH expansion plan.

There may be up to 1000 unpaid practicum students in the system. The exact numbers are not known but the numbers appear to be increasing.

APA has drafted a model licensing law for licensure after internship. Ten states have adopted it so far. There is some pressure to bestow the doctoral degree before internship which is similar to physician practice.

NH, Montana and DE have no training programs for psychologists. Consideration may be given to Rural Health options in those states. Training related to telehealth may be a consideration.

Integrated care is the new focus. Ideas were shared on how such training would look and which training sites might be viable.

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

Performance Measures: Mental Health is tasked with developing outcome measure metrics. A number of stakeholders are working to establish outcome oriented population-based metrics. An NQF framework will be utilized and the measures will start with existing available data. Congress is interested in knowing how VA knows that what we are doing is working. Process measures have been used in the past. Outcome data is needed to justify the resources being spent on MH staffing. Target date for implementation is FY14. MH is still working on developing additional access metrics from the OIG report on access from last year. Access is the critical issue. Mental Health Operations is charged with development of staffing standards (in conjunction with Mental Health Services). MH capacity and access needs to be defined by the end of this FY (short term plans). It is expected that 75% of the new outcome oriented metrics will be draft coded by the 3rd qtr. with all of the metrics implemented by FY14.

Disability Examinations: A committee was formed to look at VASRD MH rating criteria. This is the second committee that was formed, as the first attempt at revision was not accepted. The VASRD workgroup is chaired by a VBA Representative and Dr. Pollack is serving as co-chair. Work on this committee is to start in March and it is anticipated it will take 1 year to complete. Membership includes individuals from VBA, DoD, Office of Disability and Medical Assessment, and VSO Representatives. Other issues that relate to MH C&P examinations (beyond updating the rating criteria) involve how VA will transition from DSM-IV to DSM-5. VBA and the Board of Veterans Appeals will determine what trainings are needed for their staff (MH will assist with developing trainings). VA will monitor if there is an increase in claims filed as there is some question if Veterans will want their claims re-adjudicating (if the claim had been previously denied under DSM4). Guidance has gone out from

(DMA) regarding looking for information online about Veterans as part of the C&P process. Mental Health is working to create similar guidance form the MH Offices.

Blue button issues were discussed. Some examiners have expressed concerns with Veteran's having access before claims have been fully adjudicated. MH examiners have expressed more concern about this than examiners from other disciplines. C&P examinations have been in the medical record for over 5 years. There are a variety of stakeholders who believe there are benefits to having the examinations in CPRS.

MH is considering creating a method to communicate with the field regarding C&P examinations, as currently the program office does not have any regular communication other than through the DMA office. Options that have been discussed include a quarterly call on the topic of C&Ps.

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

EBP trainings continue to be expanded. Training programs addressing EBPs for SUD (e.g., Motivational Enhancement Therapy, Behavioral Couples Therapy) and behavioral health conditions (e.g., CBT for insomnia, CBT for chronic pain) have been established and are actively underway. A training program in CBT for SUD is in development. More than 6400 VA staff have received training in one or more EBPs, and many staff have received training in more than one EBP. A VHA Handbook (VHA Handbook 1160.05) has been developed and issued to the field that provides information on fully implementing EBPs at the local level. The VA EBP training programs, like all trainings in VHA this year, have been awaiting final approval by VHA leadership, which has caused some delay to the planned training schedule. However, significant EBP training is still planned for this year and will begin as soon as final approval is received. MHS and MHO have been further discussing expanding decentralized EBP training opportunities, which will consist of EBP trainers/consultants in each VISN. This will be planned in coordination with the VISN MH Leads. Program evaluation results have shown that the training in and implementation of EBPs in VHA have resulted in very significant therapist training outcomes and patient clinical outcomes. In fact, for many of the EBPs being disseminated in VHA, Veteran outcomes are comparable to results of randomized clinical trials in the EBP. Efforts are underway to educate staff and leadership in VHA about these results and to more broadly communicate important information related to the impact of EBPs with Veterans and VHA's experience through presentations, journal articles, and other forums outside of VHA. A national workgroup has completed the development of EBP equivalency training criteria to recognize VA staff who have received competency-based training in various EBPs outside of VHA. The criteria have been piloted in 3 VISNs. Once finalized, there will be an application process by which staff in the field can apply for equivalency training status.

There is significant need and opportunity to promote nonpharmacological management of Veterans with challenging dementia-related behaviors. MHS, with the support of staff in the field, has developed the STAR-VA intervention. STAR-VA intervention – a multi-component, psychosocial approach to managing challenging behaviors associated with dementia. STAR-VA is based on STAR (Teri, Huda, Gibbons, Young, & van Leynseele, 2005), a training program originally developed for nursing staff in assisted living residences. STAR was adapted into an interdisciplinary clinical intervention, led by Dr. Karlin, that is guided by the behavioral expertise of a MH Provider (typically a psychologist) who serves

a behavioral coordinator, working closely with a variety of other CLC staff members (referred to as “Staff Partners” in the intervention) in the development and implementation of a behavioral intervention plan to decrease challenging dementia-related behaviors and enhance Veteran care. STAR-VA was implemented in 17 VA CLCs as part of a pilot implementation initiative. Program evaluation results demonstrated that STAR-VA led to clinically significant reductions in the frequency and severity of dementia-related behaviors, as well as in reductions in depression and anxiety. Based on these positive results, VA is in the process of implementing an expanded STAR-VA training and implementation initiative designed to double the number of psychologists and sites trained in and actively implementing the intervention. This intervention provides an opportunity to expand traditional roles and areas of focus for psychologists and significantly enhance the lives of individuals with dementia.

The National Licensed Professional Mental Health Counselor (LPMHC) Professional Standards Board is active and new hires are being boarded. Alignment varies in the field, sometimes in MH, Psychology or Social Work. This depends on the local organization. DoD has also begun hiring LPMHCs.

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

Promoting effective treatment and recovery for Veterans with addictive disorders (especially SUD) is my primary focus within VHA. Gambling disorders will be given future consideration for inclusion in the Uniform MH Services Handbook due to changes in DSM-V. VA/DoD Clinical Practice Guidelines for SUD have not been fully implemented. Some UMHS Handbook requirements involving evidence-based practices are not feasibly monitored with administrative data and site visit findings suggest there has been a lag in implementation. Key areas that can be monitored with the MH Information System metrics include ambulatory or inpatient detox, continuing care after detox, reliance on intensive services and pharmacotherapy for SUD (alcohol and opioid). As VHA moves towards general MH teams we need to assure that they will have capacity to integrate some basic services for SUD and make only appropriate referrals to SUD specialty care for more intensive and specialized services. There will be more team-based integrated care regardless of setting. Sexual “addiction” is not a diagnostic category in DSM-V – it is considered a condition requiring more research. Expertise for treatment of sex-related conditions is limited in VHA and typically require referral to community resources.

Although VHA has done more than any other healthcare system to implement routine population-based screening for alcohol misuse, routinely referring those who screen positive to specialty care is not the best practice. There is increasing evidence that even for some Veterans who meet criteria for alcohol use disorders; a better option is to offer alcohol care management within PC first. Currently, only 5% of all PCMH encounters identify alcohol use disorders as a recognized diagnosis and the extent to which it is an active focus of treatment is unclear.

Quality improvement initiatives include the development of metrics, including a plan requested and approved by the Under Secretary for Health to develop this FY population-based, outcome-oriented measures related to MH. Recently enacted National Defense Authorization Act legislation includes a section on VHA reporting requirements that are being coordinated by OMHO and MHS related to a MH staffing model and measures of access, capacity and implementation of evidence-based treatments. The context for the request is to confirm that the investment in MH staffing in recent years has resulted in

positive outcomes and is adequate to meet the increasing clinical need. There is a much broader spectrum of symptom monitoring and outcome evaluation measures being considered.

The process for updating needed changes to the MHA software is “broken” resulting in extensive delays for needed upgrades. Efficient adoption of patient reported outcome monitoring will also require implementation of existing information technology like PC tablets or kiosks to permit direct patient entry of data on symptoms, function and experience of care.

Tobacco cessation and treatment of depression are increasingly recognized as essential clinical agenda for PC and MH. There is a need to achieve the same level of PC and general MH involvement with alcohol use disorders and more selectively with other SUD. Two-thirds of PC patients with documented diagnoses of SUD don't have any visits to SUD specialty care during a given year and of those who do, the majority is seen only once or twice. Most of the clinical care provided to Veterans with SUD occurs outside SUD specialty care so there cannot be sole reliance on referral to that setting. PC with integrated behavioral health and evolving general MH teams need to be able to work together to cover more of the needs related to SUD as it relates to other presenting conditions. Harm reduction approaches as alternatives in addition to abstinence oriented care must be incorporated to reduce barriers to recovery and promote engagement consistent with patient-centered care.

AVAPL can continue to support and address some of the resistance to monitoring treatment outcomes. Clinical trials help provide an evidence base for what works best “on average” but that is a different reality from the need for individualized measurement-based care that needs to occur in clinical practice. Selected items from the Brief Addiction Monitor (BAM) may be useful over time in PC settings to standardize documentation on Veteran reports of alcohol and other drug use. The complete BAM presumes some orientation toward recovery and works well in SUD Specialty Clinics (~5000/month now, but there are over 10,000 new episodes of SUD specialty care per month). BAM monitoring at intake and reassessment in early recovery for those who remain engaged in care (e.g., 30-60 days after intake) are not mandated as of yet. Routine initial and early reassessment with BAM has been implemented at some sites as a way to individualize treatment planning and monitor treatment response so that treatment plans can be adjusted if needed.

Among guideline recommended EBPs for SUD that are part of ongoing national competency-based training initiatives are Behavioral Couples Therapy alcohol dependence, Contingency Management primarily as adjunctive treatment for stimulant disorders, and Motivational Enhancement Therapy (MET) . MET can be helpful for other SUD in addition to alcohol use disorders. MET is a systematic adaptation of principles of Motivational Interviewing (MI) that involves assessment, personalized feedback and development of a change plan that is an appropriate option in specialty care intervention for SUD. MI addresses ambivalence about committing to change and may help patients seek specialty care or pursue other efforts to change their behavior, but by itself MI is not sufficient as a specialty treatment for SUD. A forthcoming training initiative is Cognitive Behavioral Therapy for SUD.

In February, VHA received regulatory approval to query state prescription drug monitoring program (PDMP) databases without the Veteran's signed consent that had previously been required. Access to the state PDMPs can identify non-VA prescriptions for controlled substance that may have implications

for patient safety or potential for diversion. The Opioid Safety Initiative is another effort to provide more data at the facility level regarding provider prescribing practices. The goal is to identify prescribing patterns that warrant protected peer review to assure effective pain management and avoid adverse events, including risks specific to prescribing addictive medications to Veterans with SUD diagnoses or at risk for developing addiction.

Ira Katz, M.D., Senior Consultant for MH Program Analysis

Dr. Katz reported that he coordinates the three program evaluation centers. VHA is moving towards accountable action plans. OMHO completed site visits at all facilities and will review 1/3 again this year. Efforts are underway to improve accountability by having Action Plans include action steps, deliverables, targets and timelines. Dr. Petzel has directed that outcome oriented measures be developed.

The Suicide Hotline was changed to the Veterans Crisis Line. It is a change in title, not in mission. The work of the Suicide Prevention Coordinators will also be evaluated.

Site visit accountability is also a goal. There is more involved in setting up a mechanism to determine if there are issues that are occurring.

A primary task is to develop outcome oriented measures. This may include process measures. In the short term a series of measures will be developed that are based on clinical and administrative measures. Intermediate and extended screening measures will be developed that include population-based evaluations such as alcohol screening. Problem drinking will be determined and programs will be tracked to determine effectiveness in its reduction. This approach will also extend to PTSD. The PHQ9 and PCL may be utilized. The frequency in terms of how often such measures are taken is to be determined. The two major goals are 1) outcome determination for planning and 2) clinical determination. Whatever system is used for outcomes it should lead to a treatment analysis versus an "as treated" analysis. There may be a greater focus on self-report measures. Screening measures could include a Reminder. These efforts are in the early stages.

Jody Grafton in PERC is working on measures for the staffing model. Frank Lowe and SMITREC are characterizing suicide rates. NEPEC is also involved. OMHO will have primary responsibility for the staffing model.

Lisa Pape, LISW, National Director, VHA Homeless Programs

Ms. Pape has led a continuum of homeless programs since 2010. The goal is to prevent and eliminate Veteran homelessness by the end of (2015). This past year there was a 7% decrease (17.2% since 2009). There is a \$1 billion budget and 85% of planned staffing has been hired. All proposed programs were funded except for 2 Doms due to issues outside VA's control.

The role of the local medical center is to build coalitions with community providers to fill the gaps in services. There is much discussion on how to better network and partner with the private sector and community non-profits to address the needs of homeless Veterans.

Ms. Pape presented handouts with outcome data over the past 3 years. Housing First teams are to be funded and the SSVF Program (Supportive Services for Veteran Families), provides grants and technical assistance to community-based, nonprofit organizations to help Veterans and their families stay in their homes. The financial cap is set at \$300 million which was congressionally imposed.

The Homeless Veteran Supported Employment Program (HVSEP) provides vocational assistance, job development and placement, and ongoing supports to improve employment outcomes among homeless Veterans and Veterans at-risk of homelessness. Formerly homeless Veterans who have been trained as Vocational Rehabilitation Specialists (VRSs) provide these services.

Safe Havens include a low demand harm reduction approach. Veterans may be using substances and may not be taking their prescribed medication, and are still able to utilize Safe Havens. The goal is to assist Veterans in getting off of the streets and keeping them safe. Additional funding opportunities may be available.

The Grant and Per Diem Program provides grants and per diem payments (as funding is available) to help public and nonprofit organizations establish and operate supportive housing and service centers for homeless. This program has been operational for over twenty years. The National Homeless Program Office is in the process of exploring ways to assist some of our community partners in converting some of their transitional beds to permanent housing.

Robert Kerns, Ph.D., National Director, Pain Program

Dr. Kerns is full time VA and full time at Yale. He spends 5/8 time as the Director of A VA Health Services R&D Service Center – Pain Research, Informatics, Medical comorbidities, and Education (Prime) since 2008. The balance of his time is spent as the National Program Manager for Pain Management. He reports to Michael Doukas, MD, Chief Consultant for Specialty Care Services, through Leonard Pogach, MD, National Director for Medicine, and then to Dr. Jain, Assistant Deputy Undersecretary for Health for Patient Care Services.

Dr. Kerns is responsible for implementation of the VHA National Pain Management Strategy. The Strategy is intended to provide for system-wide improvements in pain management for Veterans with acute and chronic pain and pain associated with end-of-life. Data document that as many as 50% of male Veterans and as many as 75% of female Veterans report persistent pain. VA is required by law to provide an annual appraisal of the Strategy to Congress.

Among several high priority initiatives, one of particular importance is the Opioid Safety Initiative. The aims of this initiative are to promote clinical actions to protect Veterans from harms associated with opioid therapy, to promote provide competencies in opioid therapy, and to promote system improvements in team based, integrated pain care including opioid therapy. National and local medical centers will be tracking opioid prescribing practices by providers. This is being piloted in VISNs 1,19, 20, and 21. Education will be offered and managed through Dr. Kerns' office. A rapid rollout will occur by end of FY 2013.

Two recently funded Joint Incentive Fund projects focus on improvements in pain care across DoD and VA. One focuses on education and training related to pain management targeting the PACT. The other focuses on enhancing the capacity to provide evidence-based acupuncture. Both focus on transitions from military service.

Two of the 8 performance measures of VHA leadership relate to pain management education and the Opioid Safety Initiative. Several other initiatives can also be highlighted. VHA can now participate in State Prescription Drug Monitoring Programs (SPDMPs) that permit providers to query State data bases to identify patients receiving opioid prescriptions from multiple providers. No patient consent is required. Another initiative that is still in concurrence is the requirement for signature consent for long term opioid therapy. CBT for chronic pain is part of the Evidence Based Psychotherapy rollout. By 9/20/14, every VISN is to have a CARF approved Pain Management Program. Psychologists are instrumental in the role of pain assessment and non-pharmacological treatment. For example, psychologists comprise the second largest discipline within the membership of the American Pain Society. There is a need for psychologists to be in pain leadership roles at the local level, at the seat at the local pain management committee/group.

February 27, 2013 – Wednesday – APA

Diane Elmore, Ph.D., MHP – Associate Executive Director, Government Relations Office
Heather O'Beirne Kelly, Ph.D. – Sr. Legislative & Federal Affairs Officer, Government Relations Office

Executive Office – Donald N. Bersoff, Ph.D. - President, APA
Norman Anderson, Ph.D. - CEO
L. Michael Honaker, Ph.D. – Deputy CEO
Ellen Garrison, Ph.D. – Senior Policy Advisor

AVAPL was welcomed by APA. Dr. Bersoff talked about his military experience and that of his father, a WWII Veteran. He shared the presentations planned at the upcoming APA Annual Convention by VA psychologists. The film, "Invisible War" will be shown. A special trip to the USS Arizona will be arranged. Dr. Zeiss will receive a special Presidential Citation. He shared his upcoming April column which focuses on the military community and psychology. Dr. Levenson shared information about AVAPL. She thanked Dr. Bersoff and APA for their support. Dr. Elmore reported that VA Psychology and integrated care is significantly ahead of the private sector in the services offered to Veterans. Sequestration was discussed. While there will be no impact on VA there may be an impact on internships at DOD. Concern is that there will be furloughs. VA research may be impacted as they are on a different funding cycle. DOD Research will be impacted.

Drs. Anderson and Honaker presented an overview on VA National Academic Affiliations. This advisory group to the Secretary is now permanent. Dr. Anderson is a member. The membership is multidisciplinary in the health field. The goal is to meet and make recommendations to the Secretary. Recommendations of the Advisory Committee were presented. Dr. Anderson asked for issues which APA can assist in his capacity on the Advisory Board. Discussion focused on research and affiliates. Resources are limited and need to stay under VA versus the affiliates. MH providers who are on staff at

each medical center is an issue for Congress. The numbers presented to Congress were not accurate and may have been impacted, in part, by those staff spending part time at the affiliates. Dr. Anderson asked that AVAPL serve as his advisory committee to the VA National Academic Affiliations Council which was readily agreed.

APA Center for Psychology and Health Scope of Work is a roadmap for psychologists' role in the healthcare system. APA will be recruiting for the Director of Integrated Healthcare as a permanent position. This decision was made in the past week. Dr. Garrison spoke to how strong VA is in integrated care and how APA can learn from VA Psychology. APA needs to make a long-term commitment to this area. This perspective also needs to be incorporated into training programs.

Dr. Honaker discussed APA's Strategic Plan, its goals and objectives. Publications are a major revenue generator. He spoke to several of the strategic initiatives. APA plans on reinvesting in expanding its publications and database technology. Forging strategic alliances with health care organizations to include psychologists in integrated health care services is also a strategic initiative.

Education Directorate - Cynthia Belar, Ph.D. – Executive Director, Catherine Grus, Ph.D. – Deputy Executive Director, Nina Levitt, Ed.D. – Associate Executive Director, Government Relations Office

APA is in collaboration with the White House on the Joining Forces initiative. "The Pledge" is a commitment to prepare the workforce and communities for receiving our returning vets. AVAPL can post on its webpage the link to "The Pledge." AVAPL informed them of VA's initiative to recognize (certify) comparable training outside of VA EBP training. Dr. Belar requested information on the criteria that will be utilized. Dr. Levitt spoke to Graduate Psychology Education. No VA Psychology programs applied for grants for internships. Implementation and the reporting structures make participation difficult. Also, VA OAA has been involved in a dramatic increase in the training slots which has occupied the time of many training directors. AVAPL shared information on practicum students within VA. Discussion occurred regarding the challenges that occur at the local site in managing practicum students. Few practicum students are exposed to health systems. Dr. Grus reported that few sites, even in the private sector, have paid practicums. She also discussed "A Blueprint for Health Services Psychology Education and Training" and spoke to the imbalance between internships and programs. Competencies were created for Health Service Psychology (HSC). It was noted that there is an overlap in HSC between clinical, counseling and school psychology. Recommendations were made for further discussion and action. Information will be published in the American Psychologist. APA encouraged utilization within VA training as related to core competencies.

There are two areas of partnership with advocacy. There is a CE interactive classroom which offers a "101" course for advocacy for psychology. The other area is around the development of competencies for trauma psychology. VA Psychology is involved. It is interdisciplinary.

ASPB – changes in licensing laws are being considered so psychologists are licensed after internship. Twelve states are moving on this issue.

Practice Directorate – Katherine Nordal, Ph.D. – Executive Director, Ron Palomares, Ph.D. –

Dr. Nordal talked about the long relationship with AVAPL. She noted that Dr. Randy Phelps is now working in the Office of Health Care Financing. Dr. Nordal introduced Dr. Palomares as the primary liaison from Practice for VA Psychology. He is a Veteran. A publication was shared which includes a crosswalk with the old and new CPT codes. A 90-minute CPT code is not in the new codes but there are modifiers. There are crisis codes and other modifiers that can be utilized. The effective date is 1/1/2014 for insurance purposes. Efforts continue to make certain psychotherapy codes accurately reflect the work done by the psychologist. Dr. Phelps will be consulted regarding CPT codes as that is his major focus at this time. Clinical practice guidelines are being developed. The clinical depression across the lifespan guideline is chaired by a VA Psychologist. VA Psychologist (Dan Kivlahan) is also on the Advisory Steering Group for Clinical Practice Guidelines. There is a PTSD group which includes two VA staff. Obesity is the third group. There is no DOD representative but their work will be reflected.

Reimbursement issue under health care reform is a primary focus. APA is working to have psychologists included under the physician definition in Medicare. Practice is also supporting the move of psychologists to more hospital-based care.

APA has addressed recent proposed legislation in Florida that would limit the use of "Doctor" to physicians. APA has addressed this in other states and it is seen as an effort by medicine to regulate the practice of other professions.

AVAPL addressed the issue of Title 38 versus Hybrid Title 38. There is uncertainty as to which one has the greater benefit. The second issue is related to the inconsistency with implementation of Hybrid 38. Some sites and VISNs are resistant to promoting psychologists. Travel restrictions are also problematic across VHA. This is impacting travel for training.

Ethics Office – Lindsay Childress-Beatty, Ph.D., JD – Deputy Director

Dr. Childress-Beatty reported that the Ethics Office is now offering more training and workshops. Consultation services are also available including to non-members. VA staff has not taken advantage of this service. Staff may call 202-336-5930 to access this consultative service. Stephen Behnke, JD, PhD, Director of APA's Ethics Office, also travels and conducts workshops on ethics (including at VAs). There is an Ethics Education Award which is now open for nominations. There is a change in this award in that the contribution may be state-wide or local. The deadline for submission is June 2013. A letter of recommendation is all that is needed. VA staff may be nominated. AVAPL discussed the growing use of Tele-MH and other technologies and the need to establish appropriate ethical guidelines. There is an APA task force that includes a VA psychologist (Sara Smucker-Barnwell – Puget Sound) and a military psychologist (Col. Bruce Crow – San Antonio). APA reported on its Member Initiative Task Force on Interrogation. It recognizes the role of psychology in National Security. Its goal is to pull together relevant policies to establish consistent guidelines. Several Divisions are involved (9 and 48) and include Dr. Linda Wolfe and Dr. Bill Strickland. Discussion ended with an offer of consultation on issues related to C&P exams and other issues facing VA psychologists.

1:45 PM – *Practice Directorate – Dr. Heather Kelly and Dr. Diane Elmore*

Discussion focused on the FOVA (Friends of VA Medical Care and Health Research) and Recommendations for FY 2014:

1. Funding for the Department of Defense (DOD) and Department of Veterans Affairs (VA)
2. Mental and Behavioral Health Services for Military Personnel, Veterans, and their Families
3. Training Opportunities for Military and Civilian Psychologists

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

1. Recognize the support given to meet the MH needs of returning troops and the funding of additional MH positions – identify the expanded role of psychologists.
2. Implementing MH Staffing – talk to local issues
3. Credentialing - (centralize primary source verification of graduate school training and internship) – there are time delays when a VA Psychologist moves from 1 station to another
4. Training needed for newly-hired staff – VA has higher standard including 6 month mentoring following training
5. Travel restrictions for training new and existing staff in new models of care (to improve access)
6. Address research funding
7. Address access

Other areas that may be addressed include highlighting the importance of Integrated Health Care and the role of psychology, non-psychopharmacological psychological interventions (pain, sleep, depression, and anxiety), educate on MH PACT teams with the goal of increasing access and address reducing the risk of suicide – it is treatable.

February 28, 2013 – 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.

March 1, 2013 – 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

Thomas J. Berger, Ph.D., Executive Director, Veterans Health Council & Senior Advisor on Veterans Health, Vietnam Veterans of America

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

Nick McCormick, Iraq & Afghanistan Veterans of America

Hannah Fairman, Health policy Analyst, Wounded Warrior Project

Concerns shared by the VSOs included the gaps in services even with the recently funded resources and staffing. There were three important retirements in VHA, Dr. Batres, Dr. Friedman and Dr. Zeiss. Currently, VSOs are not involved in the Search Committee. VVA has expressed concern over any delays in filling these positions. For Readjustment Counseling Service, prior service is particularly important and mandatory. There is concern that the focus of RCS not be changed and moved to a more medical model of care with a focus on medication rather than therapy. There are currently many interim and acting positions within VHA. There is concern over continuity in these programs especially as related to MH.

There are currently 15 pilot projects underway by Executive Order. Private providers are being enlisted to address timeliness of services to Veterans. Community resources are being utilized to improve access. The pilots cover 5 regions. The RFP is due 3/15/13. \$6 billion per year is currently contracted out through DOD Tricare and includes United Health Care, Humana and Triwest. There is a move to incorporate a similar model in VA. Another approach is unmanaged care through a fee basis ID card. The concerns are that there will be a negative impact on the continuity of care. The change in the model of care could be significant and Veterans may not be able to come back to VA if issued the card.

There is no problem in filling MH positions in certain areas. Other locations pose significant challenges. VA stopped requesting special incentive funding for these hard to fill positions.

Funding for HVSE positions are sun setting at the end of FY 2014. VA will not approve any new leases given the current CBO decision based on a new interpretation. OMB, VA and the VSO's all disagree with CBO's interpretation.

Discussion occurred on how to best reach out to returning Veterans so that they can receive needed MH services. One suggestion was to integrate MH professional with the guard and reserve units prior to deployment. Other concerns related to inadequate pain management.

/ES/

Stephen Cavicchia, Psy.D.
Secretary