

**AVAPL Mid-Winter Meeting Minutes**  
2/21/16 – 2/26/2016

**SUNDAY 2/21/2016**

**Attendance:** Dr. Tom Kirchberg, Dr. John McQuaid, Dr. Ron Girona, Dr. Mary Beth Shea and Dr. Stephen Cavicchia

The Executive Committee met to finalize the Agenda for the Mid-Winter meetings.

**MONDAY 2/22/2016**

**Kenneth R. Jones, Ph.D., Director, Associated Health Education and Stacy Pommer, Health Systems Specialist**

Thanks was offered for attendance at the leadership meeting and all the support offered. Discussion focused on the payment of APA fees. Psychology is the largest group in Associated Health. A project is underway to address issues with fee payment which has the potential to save time and manpower. Contracts are needed for costs over \$3000. Work is underway to establish a portal to receive data from Psychology Training Directors. The existing portal has been useful to automate communication with Internship Directors. It is a policy violation to have internships without holding accreditation. A national contract with APA is being developed that will bypass the local medical center. Work continues with the National Contracting Office, local sites and APA to improve the VISN-level billing/payment process.

LPMHC and MFT – There are more issues with MFT as the process for credentialing as a supervisor is much more difficult. Two or more must be available in case one leaves. Only one site so far has qualified. Reports from some LPMHCs at some sites reveals discomfort in their interactions with psychologists and social workers, who have been perceived as less than supportive or frankly hostile of these new professions.

OAA is preparing to release a Request for Proposals for a Mental Health Physician Assistant Residency program (post-PA degree) to the field.

With CHOICE, there appears to be positive feedback about preserving current VHA mental health programs of care and the academic mental health programs built over the years.

The fifth and final round of the Mental Health Education Expansion was discussed. The RFP will be announced around May. New Hampshire is the remaining state without an internship training program. A mentor is working with the local VA Medical Center to improve their proposal. OAA hopes to fund similar remaining programs that would like to establish psychology internships.

Memorandum Policy No2 established academic affiliations in January 30, 1946. This year marks 70 years of VA training for psychologists and physicians. OAA would welcome AVAPL in celebrating the contributions of VA psychology training to mental health care for Veterans and our nation, generally.

**David Carroll, Ph.D., Executive Director, Mental Health Operations**

Dr. Carroll expressed his thanks for AVAPL's support, and then the Executive Committee asked for his views on several key issues – access to care, hiring, and employee morale. The highest priority is to ensure rapid evaluation for urgent MH care and suicide risk. There is also a need for veterans already in care to access MH care immediately, 24/7. This may involve partnership with the community if VA does not have the capacity, and it must be collaborative.

VHA leadership is concerned about employee morale and is committed to provide support and opportunities for engagement, and leadership always welcomes employee input. VHA is working hard to get the word out about all the great work and accomplishments of its employees.

There are known challenges in filling MH positions in the field. All MH fenced monies for staffing went into VERA this year. There are always competing priorities at the local level. Efforts are underway to think outside the box, such as expanded inter-facility tele-MH, and to look for additional resources. The Executive Committee suggested that VACO tracking of VERA dollars generated by MH may assist the field in prioritizing the filling of MH vacancies. AVAPL also discussed the difficulty in coordinating care with the private sector.

MH Management System Dashboard and SAIL data are discussed with each network on a quarterly basis. The focus is on supporting leaders and managers in their efforts to enhance access to care.

Title 38 was discussed and AVAPL conveyed that Dr. Shulkin and Secretary McDonald were not aware that psychologists were not under Title 38. AVAPL emphasized the benefit of Title 38 for recruitment and retention.

**Susan McCutcheon, RN, Ed.D., National MH Director, Family Services, Women's Mental Health & MST**

NAMI Home Front – VA and NAMI leadership signed their 3<sup>rd</sup> MOU, the first one in in 2008. It includes all medical centers though there is an exceptions if the local NAMI affiliate does not have the resources to conduct the Family-to-Family Education Program and/ or the new NAMI Homefront Program. Each VAMC must host both with 20% participation of family members of veterans to be in compliance with the MOU. This MOU requires a modified Revocable License which eliminates the requirement for indemnification and insurance which none of the smaller affiliates would have the resources to meet the insurance requirements. The NAMI affiliates usually works with the LRC but there may be a different POC for the purpose of the MOU. Some VA employees want to be NAMI instructors. There are some barriers with the requirements to becoming a NAMI – peer instructor.

The only EBPs that is still permitted to continue face-to-face national trainings are the Marriage and Family Counseling trainings. Efforts are underway to place the pre-training materials on the web. At this time there will still be funds to do this training next year. There is an increasing interest in parenting classes for children with emotional challenges

A 3-day Women's Mental Health Mini-Residency is planned for 200 clinicians. MH issues will be addressed and includes the impact of addictive disorders on health. The Memo has not been released

as of yet. There is a need for clinicians with special interest in Women Health that will champion Women's MH issues. Want a mix of providers to participate since both psychotherapy and psychopharmacology are involved in the training (1 per medical center). This will occur April 5-7 at Salt Lake City. A "Save the Date" has gone out.

Eating Disorders – a work group is being developed with the goal of producing educational materials. Collaboration will occur with Dietitians, Medical and MH providers. There appears to be hesitancy by some providers to address this issue due to lack of understanding and treatment knowledge.

STAIR Training is a skills strengthening model for dealing with PTSD. This is a web-based training and there is great interest with more applying than can be accommodated.

**Marsden H. McGuire, M.D., MBA, Deputy Chief Consultant for MH Standards of Care & Wendy Tenhula, Ph.D., National MH Director, VA/DoD Integrated MH Care**

AVAPL reported that it recently presented on the Commission on Care. Concerns were shared regarding how best to present VA. Discussed CHOICE and the issue with care coordination. An example given of CHOICE medical care was shared where opioids and benzos were prescribed. For a PTSD diagnosis, veteran on benzos raise concerns. Issues of coordination of care and the quality for CHOICE providers was discussed. A mechanism for holding these providers to VA standards of care was encouraged. Suggestions received regarding how best to present concerns from the field. AVAPL's presentation on the Commission on Care emphasized the importance of coordination of care and the challenges faced with CHOICE providers. Discussed the need to work with things "as they are." Fee basis has and does work now since Vets stay tied to VA with VA oversight. The key is to measure outcomes. This is difficult within VA and much more challenging outside VA. IT infrastructure is a challenge. There are also issues with Vets being fearful of losing their service connection if they get better.

A Measurement-based Forum us meeting regularly – Dr. Ira Katz is involved along with OMHO and MHS.

Title 38 – AVAPL shared the benefits of recruitment and retention given Psychology is now one of the top five disciplines identified with recruitment retention challenges. There is a risk of losing the best clinicians due to a lack of upward opportunities and other benefits (EDRP). Hiring delays would also be addressed.

Safety issues for MH providers, especially C&P providers was discussed. C&P exams remain in CPRS and are available to veterans through Release of Information. Contracted C&Ps do not appear in CPRS.

AVAPL encouraged a more public response from VA to offer a corrective narrative about the suicide call line going to voice mail. The Secretary and Under Secretary are being more proactive with publicizing VA's good work. There is a need more efforts at the local VAMC to publicize VA accomplishments.

AVAPL reported that staffing issues impacts quality of care and access to care. Morale is being impacted.

**Jeffrey P. Burk, Ph.D., National Mental Health Director, PRRS**

Travel restrictions remain an issue for VACO which is a challenge for decentralized VACO staff.

The Psychosocial Rehabilitation and Recovery Services section in Mental Health Services leads the transformation of VA to the Recovery model. It also makes certain services to Veterans with serious mental illnesses (SMI) are maintained. There are concerns raised in the field due about the maintenance of previous MH funding initiatives. There are 1100 peer support positions now (800 were created by Executive Order). It appears some vacancies are not being filled and others are being eliminated. . It is not certain if this is due to budgetary challenges or something else. Some may want to shift the position to other duties. There is a minimum number of peers (2) per medical center and per very large CBOC. RRTPs have staffing guidelines that includes Peer Specialists. In addition, there is some push back from local facilities about PRRCs. Though it is not a large number, there has been an increase in the number of facilities not wanting to maintain their PRRC. . . If there is less interest from local facilities in supporting MH, the most vulnerable Veterans are being impacted as these programs and MH staffing are eroded.

The Qualification Standards are now in their 3rd year of the concurrence process. It is an HR document that is now waiting for final signatures. This is the last stage of the process but difficult to know when this will happen. Changes include adding the Canadian Psychological Association as an accrediting body for doctoral programs and internships, PCSAS as an accrediting body for doctoral programs, direction to HRs on how to deal with respecialization, and exceptions for ABPP if there is no APA-accredited internship. There will be a new GS-13 job assignment for research. Special advancement for achievements (SAAs) have been limited due to concerns over the cost and the perception that too many have been given.

Privatization has not brought up often on the calls in MH services. Message from Secretary and Under Secretary is that VA will never be privatized. "Chipping away" over time may have a cumulative impact. There is a focus on what VA does best and uniquely, so Primary Care may be more vulnerable than MH. There continues to be a strong focus on access, the #1 priority for the Under Secretary. It is less likely now that VA will be contracted out but this could change with a change in administration and VA Leadership. .

Support given for Title 38 and promoting the positive that VA does.

**Wendy Tenhula, Ph.D., Deputy Chief Consultant for Specialty Mental Health**

Dr. Tenhula presented on suicide prevention efforts on behalf of Dr. Caitlin Thompson. Suicide prevention outreach efforts are taking broader perspective focused not solely on encouraging Veterans to contact the Veterans Crisis Line, but on a range of suicide prevention tactics. There are efforts underway to consolidate other call centers. Rates of suicide for vets coming to VA are lower than for those that are not in VA care. Naltrexone kits being used successfully for opioid overdose reversal. The total number of kits distributed and known reversals is available from Pharmacy services. It was recommend that community safety check data be incorporated because many safety checks are initiated locally and do not always go through the Crisis Line.

On 2/2/16 Dr. Shulkin pulled together a Call to Action on Suicide Prevention. Caitlin Thompson, Ph.D. Deputy Director, Suicide Prevention was designated as the lead for the effort. She reported what VA was doing and then asked for input from others as to what more could VA be doing. Congressional offices were represented. VSOs also present included IAV and Vn Vets of America. Themes included access and 12 breakthrough priorities related to suicide prevention were added. Partnerships with community, family involvement in care and data is to drive the decision as to how to proceed. 24/7 access for acute care needs is the goal. There has been more positive feedback from Congress of late. Congress wants to know if community providers are competent in EBPs.

Discussed psychologist leadership position similar to SW and RN. Wendy indicated she would be an advocate for the profession of psychology. She did not see significant benefit to separating out Psychology like Nursing and SW.

**Kyong-Mi Chang, M.D., Acting Chief R&D, Theresa Gleason, Ph.D., Acting Director**

Dr. Chang and Dr. Gleason encouraged more education about research and protected time as well as the VERA implications for those doing research. Career Development grants are a good pathway to developing a stronger research emphasis and improve the opportunities for future funded research. Mentoring in research is not consistent across VHA. Research budget has stayed constant for MH (@ 20%). Some recent studies on medication for depression will soon be completed along with transcranial stimulation. Supported Employment study will soon close. Suicide study and use of Lithium is coming online as well as a comparative study on the effectiveness of PE versus CTP psychotherapy. The next research questions that need to be answered include PTSD, TBI and Gulf War syndrome—including those using large-scale genetic data gathered through VA's innovative Million Veteran Program. The Million Veteran Program has enrolled over 450,000 Veterans already for genetic analysis (targeting to a million Veterans in the next 5 years) and is VA's Precision Medicine effort to examine the interface between genetics, clinical outcome and treatment. Precision medicine mental health study with a focus on depression and genetic testing is also in the initial phase of development. There are also joint projects with DOD and NIMH. These efforts highlight the strength of VHA in clinical training and research on efficacy of comparative psychotherapies in very short periods of time. VA research answers questions that would not be answered by anyone else. Private sector research focus tends to be profit driven and not focused on veterans, not so with VHA Research.

**Lisa K. Kearney Ph.D., ABPP, Senior Consultant, National MH Technical Assistance and Andrew Pomerantz, M.D., National MH Director, Integrated Care**

Currently we are beginning to review with the field the implementation of same day access within PCMH, including same day warm handoff. This is now happening a little more than 1/3 of the time when looking at PCMH15. Integrated primary care has been shown to have significant positive impacts on outcomes including reducing no show rates, decreasing stigma, and improving patient engagement in care. Co-location of PC and MH is one critical factor for implementation. Many sites still struggle with PCMH implementation and several factors are noted for these challenges, including include staff inadequately trained to the model and lack of care management. Further, standards for wRVU productivity are often applied without consideration for fidelity to the PCMH model. Staffing

recommendations are: 1 MH provider per 2000 PACT . While penetration rate of the PCMHI program is important, same day MH access is another critical factor which will be important for sites to attend to in improving access.

Local research is encouraged to identify the benefits of same day warm handoffs between PC and MH. Research at other sites reveals a decrease in referrals to MHC, especially PCT referrals, when PCMHI is implemented and also a better engagement in specialty in MH when first seen in PCMHI. The greatest benefit is reduction in wait times and a decrease in no-show rates. There is still a need to educate stakeholders and others that VA is ahead of the private sector in integrated care. Treatment needs to be focused on brief assessments, a Problem Solving focus and EBPs for brief interventions. Outcome measurement is also part of the PCMHI program.

## **TUESDAY 2/23/2016**

### **Jamie Ploppert, National Director, MH RRTP and Jennifer Burden, Deputy Director MH RRTP**

An overview of MH RRTPs was presented . There are 244 programs with 8148 beds in operation (SUD, PTSD, Homeless, General and CWT/TR), @28000uniques are served. Most programs are east of the Mississippi. There has been a slow decrease in demand. Decrease in demand for DCHV has gone from 98% occupancy to a little over 80%. OEF/OIF vets now represent 25% of the residents. Overall, 60% seek SUD treatment, more than 40% seek treatment for PTSD and greater than 10% are diagnosed with SMI and are dually diagnosed. The ALOS 49.5 days which the overall LOS showing a decrease over time: 32.7 days SUD MHR RTP, 42.1 days PTSD, 52.2 days Gen, 80.3 days DCHV and 108.2 days CWT/TR. EBP use within RRTPS is tracked through the Annual Report. Psychologists are part of the core clinical staff (154) but are also program managers and part of the specialty staff. Staffing levels are monitored twice/year to address gaps. Sometimes it is a recruitment issue or prioritization to hire issue. AVAPL recommended reporting on wRVUs for staff within the RRTPs given the focus on this metric. Part of the lack of data is because not all programs are using encounters. CHOICE ACT could be an opportunity since non-VA residential care can be funded. Several VISNs are utilizing this option. There are challenges with their implementation. Some of the community programs have limitations such as being able to work with dually diagnosed Veterans. Access is the number one challenge since 1500-1800 are waiting for admission. More than half of those are waiting more than 30 days.

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

VHA is working with VBA on issues related to Veterans who receive an "other than honorable" discharge from military service. The determination regarding whether these individuals are eligible for VHA services is made by VBA after a review. In many cases, after the review, partial access to benefits is granted. There are concerns that there are higher rates of suicide amongst this group since they do not access to VA care. Discussions are underway to see if VHA can provide these individuals healthcare while they await their decision on eligibility for services. This is a joint effort between VBA and VHA. MH is very involved in discussion about this issue. Swords to Plow Shares is a strong advocate group for these veterans. There have been legislative proposals that also aim to change temporary eligibility status while SC is being considered.

CAPS Pilot – Connecticut is a current pilot site for using the CAPS-5 during initial PTSD C&P evaluations. They have fulltime C&P examiners and are allocated 3 hours/exam. There may be an option for other sites in VISN1 to join the pilot in the future. A formal proposal will be made to relieve those sites from the 30-day requirement given the added time that it may take for some of those sites to utilize the CAPS (during the pilot). Since the online training course on the CAPS-5 is not yet fully developed, there may be delays in further implementation of the pilot. It is anticipated that the CAPS-5 training be released by Q1FY17.

MHS and MHO are looking at data about Veterans who are service connected for MH but not enrolled in VA care. Pilots are being planned to outreach to those individuals. Pilots are also being planned to outreach to Veterans who are SC for SMI (bipolar and schizophrenia) and 100% SC (no treatment within a 3 month period). SMI reengagement efforts already in place would be utilized as a starting point for pilot development.

Safety Issues are also being addressed. The Blue Button still raises questions. It is MH's position that access in CPRS should be limited. Others are not as supportive. Issues are complex given position that access to medical tests utilized in C&P exams should be made available for treatment purposes.

There will be one national contract for C&P exams that would be administered through VBA (who would be responsible for their quality). Sufficiency for rating purposes is different than the quality of the exam. DBQs can be completed by community providers for some conditions. Non-MH providers are required to complete DBQs on their patients, not the same for MH (MH providers not required to complete DBQs on their own patients). Mental Health continues to strongly advocate for this position.

PTSD – one of the recommendations of the special committee for PTSD is to charter a work group for development of a continuum of care across MH. MHS plans to have this workgroup be broader than just PTSD and will include other diagnoses.

PCL5 is to be made available in the MHA by the end of the fiscal year.

Workload credit for PTSD may be missed at many sites because of the use of the SeRV-MH stop codes. There is a proposal to remove those stop codes next fiscal year.

MFT and LPMHC lobbying groups are very strong. Some oppose the COAMFTE and CACRECP accreditation requirements. There are issues that have come up recently regarding the COAMFTE requirement in California. The number of LPMHCs hired in the VA are increasing while the numbers of MFTs hired in the VA remains static.

**Chris M. Crowe, Ph.D., VA/DoD Integration, Senior Mental Health Consultant and Alfred Ozanian, Ph.D., Assistant Deputy Director for National MH Communications**

It was reported that CHOICE as a way to leverage community is often misunderstood. It gives VA the opportunity to send someone for an episode of care, but does not mean a VA facility will not or cannot provide other types of care and services. When CHOICE is used, the VA retains the right of first refusal, allowing facilities to recapture care as they are able. There are some standard differences between

contracted MH services and VA mental health services. For example, VA has very specific follow up requirements for no-show mental health appointments that are not required by non-VA care providers through CHOICE. A suggestion was given to learn from Fee Basis providers where the relationship between a VA facility and community provider is well established. VA needs trusted partners in the community. The importance of military culture training for community providers was endorsed.

Four Congressionally mandated DoD Centers of Excellence include vision, hearing, psychological health and TBI, and extreme trauma and amputation. A realignment within DoD may impact on its relationship with VA. Collaboration accomplishments include a cross agency Integrated MH Strategy, TBI outcome measures, information sharing, sharing of suicide data, and coordinated research portfolios. There are a number of recommendations that include further improvement of those areas where progress has already taken place. LGBT enhanced policies and procedure for inclusion are also under consideration.

Problem Solving training is now under Dr. Crowe. There are movement towards blended and regional trainings. It was suggested that streamlining the guidelines for decentralized training would help the field. Providers need protected time for the training and the mentoring. There are challenges with verifying compatible training.

There are quarterly meetings that occur with each VISN. The MH Management System allows for the contextual influences that are affecting facilities. Overall, mental health staffing needed to improve access, but it is not the only issue, there are space challenges and contracting delays. Not all MH care is being captured, especially that which is occurring in PCMH.

#### **Michele Karel, Ph.D., ABPP, Psychogeriatrics Coordinator, Mental Health Services**

- A. Aging Veterans - Largest cohort utilizing VHA is Vietnam era cohort. Numbers of VHA enrollees over age 65 continues to increase.
- B. Mental health integration in Geriatrics and Extended Care programs:
  - 1) MH Handbook requires integration of psychologists and/or psychiatrists in Home Based Primary Care, Community Living Centers, and Hospice and Palliative Care teams
  - 2) Growing number of psychologists serving on GeriPACT teams
  - 3) Workload/productivity expectations for psychologists integrated in geriatric care programs
    - a. Workload data shared indicate that HBPC psychologists have wRVUs of approximately 50% of the outpatient specialty targets, and CLC psychologists with wRVUs approximately 50-65% of outpatient specialty targets. Due to nature of their roles and much workload not captured via CPT codes (e.g., team meetings, staff training/consultation, driving).
    - b. See OMHO Business Operations presentation (file entitled BPC and CLC productivity Bus Ops call 12.11.15), here:  
[https://vaww.cmopnational.va.gov/CR/MentalHealth/MH\\_Business%20Rules/Forms/AllItems.aspx?RootFolder=/CR/MentalHealth/MH\\_Business%20Rules/Presentations&FolderCTID=0x01200001E5C7B36DA1E845A330A369BB95A1C8&View=%7BAF9A7AEA-6621-497D-B567-BFE95B0FB762%7D](https://vaww.cmopnational.va.gov/CR/MentalHealth/MH_Business%20Rules/Forms/AllItems.aspx?RootFolder=/CR/MentalHealth/MH_Business%20Rules/Presentations&FolderCTID=0x01200001E5C7B36DA1E845A330A369BB95A1C8&View=%7BAF9A7AEA-6621-497D-B567-BFE95B0FB762%7D)



C. STAR-VA

- 1) Training program to address care of CLC residents with dementia and related challenging behaviors; trained 68 CLC teams between 2010 pilot and 2015
- 2) Positive clinical and staff outcomes to date
- 3) Nursing –Psychology collaboration is critical to program success
- 4) 2016 training upcoming
- 5) Currently, no similar training to address care of CLC residents with SMI

D. Task Force on Inpatient Care for Veterans with Complex Cognitive, Mental Health and Medical Care Needs

- 1) Joint MH/GEC initiative to address care of the aging “complex” patient in inpatient Med/Surg, Mental Health, and CLC settings
- 2) Report with 57 recommendations across 8 domains
  - Veteran and family-centered behavioral health care across settings
  - Integrated medical/behavioral health care settings
  - Prevention and early intervention
  - Competency-based staff training
  - Data gathering and reporting infrastructure
  - Policy implementation and updates
  - Technical consultation and assistance
  - Care transition and prevention of avoidable hospitalizations
- 3) Implementation plan pending
- 4) Discussion re: role of CLCs and gaps in continuum of care. CLCs to focus increasingly on shorter-stay, rehabilitation care, work to increase capacity for behavioral care over time. Disposition challenge for behaviorally complex patients – many community nursing homes reluctant to admit. Many Veterans with complex care needs do not need skilled nursing care, but do need supervised/assisted living, which is not a funded VA benefit. GEC focus on home and community based long-term services and supports including HBPC, Medical Foster Home, Community Residential Care, Veteran-Directed Care, etc.

E. Geriatric Mental Health Community of Practice

- 1) Inquiry sent to field re: interest to build an interprofessional community focused on behavioral/mental health care for older Veterans
- 2) Overwhelming response/interest indicated
- 3) Working to build community at VA Pulse. Stay tuned.

F. Discussion: Professional concerns for psychologists

- 1) Issues of productivity expectations
- 2) Geropsychology competency development
- 3) Opportunities for QI/research collaboration – an interest of many psychologists in psychogeriatric programs.

The greatest challenge for inpatient MH is developing appropriate resources for geriatric veterans and veterans with complex care needs. Appropriate resources need to be developed for veterans that remain on long-term and intermediate units as those programs are targeted for closure by the end of 2016 per the Inpatient MH Handbook, 1160.06. AVAPL indicated that the fear is that there will not be the necessary community supports in place as occurred in the private sector when deinstitutionalization occurred. VA has considerable community supports in place including its focus on recovery, RRTPs and Peer Support programs. VA needs to maintain its commitment to caring for veterans throughout the process of transition to other settings and this is clearly stated in the Handbook. The inpatient guidelines do not include specific staffing expectations as its focus is on the functions and services which must be present.

The requirements for outpatient mental health services are described in the Uniform Mental Health Services Handbook 1160.01. There is no policy requirement or mandate for BHIP other than the 10N memo and it is not a replacement for or a requirement for general mental health programs.

**Kristine Day, Ph.D., National Evidenced Based Psychotherapy Program Manager and Dr. Kristin Lester Williams**

There are plans underway to have EBP regional trainings rolled out. More support from the field is needed to support clinician dedicated time. Some training will be web-based, some will be virtual. Consultation with an expert and fidelity monitoring are key aspects which need to be maintained. Clinicians need to be able to practice the new skills they are learning in the training. Half of programs will receive their training through a web-based course. There is also a VA Virtual Medical Center which may be able to assist. Current support is coming through EES. AVAPL suggested development of guidelines/cookbook for the field in terms of how to do local training. One issue from the field is resistance to implementing EBPs due to access issues. Some local leadership will not support attendance even when the training is paid through VACO. A presentation on EBP treatment efficacy, positive measurement-based outcomes and patient and provider satisfaction is being developed to help educate providers and local leaders. Recommendations and suggestions were offered for increasing outpatient access through discharging veterans to lower levels of care. Equivalency application outcomes vary in terms of the specific EBP and those that are approved. AVAPL encouraged more flexibility with those cases where equivalency is objectively obvious. Sometimes the issue is related to clinicians who cannot complete the mentoring within 6 months due to various issues, including veterans dropping out of treatment. A digital solution versus use of cassettes tapes is planned for 2017.

**Karen Drexler, MD, Deputy National Mental Health Program Director, Addictive Disorders**

The VA-DoD Practice Guidelines for Management of Substance Use Disorders were updated and published in January 2016. This was a large team effort led by Dr. Kivlahan (VA) and Dr. Chris Perry (DoD) that included a systematic review of the evidence for 12 key questions. This update of the original 2009 guidelines focused on promoting evidence-based practices. Over 160 recommendations were reduced to 36. Psychosocial interventions were broken out in four areas: Cannabis, alcohol, opioids and stimulants. The 2015 Guidelines are more precise. There was not sufficient evidence to support a

psychosocial intervention alone for opioid treatment without being combined with medication treatment. Opioid plus contingency management was also found to be effective. 31% of opioid users receive EBP medication assisted treatment. SAMHSA data indicates that only 12% of those with OUD in the community are getting any form of SUD treatment.

Methadone and buprenorphine combined with naloxone are also effective. Methadone has slightly better treatment retention. Extended release long-term Naltrexone is recommended if Methadone and Buprenorphine are not viewed as a viable option or viewed as another “addictive drug.” The training time for Buprenorphine providers can be a barrier for some. VHA providers average 11 patients/provider when the full caseload is 30 and with a waiver can go up to 100. The lack of a marketing strategy along with concerns about abstinence versus long-term use and diversion are challenges. Studies showed only 6% maintained abstinence after detox. Those on medication after detox had higher levels of abstinence after two years of treatment. A psychosocial intervention (contingency management) is effective for cannabis and stimulus use disorder. Tobacco and opioid also benefit.

There have been several challenges for implementation science related to SUD treatment. Several projects that were reviewed and funded in FY 2015, had funding rescinded due to budget constraints. The SUD QUERI center was not renewed for FY2016, so these projects were encouraged to apply instead for Merit Review funding. It is unknown whether they will receive support when competing with more traditional research. One such promising study from Dave Oslin’s group in Philadelphia proposes to disseminate a model for Alcohol Care Management in Primary Care, using the Behavioral Health Lab to guide care management by PC-MHI providers.

There is a changing model with Evidence-based Psychotherapy EBP trainings. There are three specific for SUD; Behavioral Couples therapy, CBT-SUD and MET. Behavioral Couples Therapy may be discontinued. It was challenging finding veterans with intact families and spouses willing to come into treatment. CBT-SUD will be continued through disseminated trainings.

CHOICE – The Purchased Care Hierarchy indicates that fee basis and other purchased care options may be continued if CHOICE not available. Currently, the network of Buprenorphine providers is very thin. There are only 32 Federally regulated Opioid Treatment programs (OTPs) within VA facilities. Most facilities make use of private sector OTP (methadone) clinics. There are no Medicare-funded methadone clinics in existence. Fee-basis is currently the only option for this service, though recent updates to the Choice Act to include Medicaid providers will open the network to most community OTPs. Even if fee-basis is utilized, integrated care between community providers and VA psychosocial interventions is limited.

#### **Kathleen M. Lysell, Ph.D., National Mental Health Director for Informatics**

Informatics section in Mental Health Services has primary responsibility for serving as liaison between IT and the program office around MH IT projects that support MH initiatives. Additionally, the informatics staff provide web services support for MH; mobile apps development and management; and clinical analytics services.

The Mental Health Assistant (MHA) is the main IT project in the MH portfolio for MH that would be of interest to AVAPL members. The current project for MHA will release the PCL-5 this year, fix scoring errors in several instruments, and resolve structural issues with the software package. This work was put on pause in 2014 and only restarted this fiscal year, so there has been a long gap in coverage for addressing issues in MHA.

A major challenge facing MH, and many other programs in VHA is a significant cut in IT development funding in FY17. The entire MH IT portfolio was defunded for FY17. Prioritization for FY18 planning is in process. Impacted projects include MHA, MH Quality and Clinical Outcomes Reporting System (MHQCORS) and National Clozapine Coordination Center. These projects are funded in FY16, and effort is underway to rescope to accomplish as much work in current year to mitigate the impact of loss of funding. New starts that were planned for FY17 included support for Methadone dispensing system interface with CPRS and a project to support audio recording for EBP consultation. Those projects will not be able to start as planned. The Clozapine project is designed to meet new FDA regulations and requirements associated with dispensing and monitoring use of Clozapine; the project runs a risk of potentially not being able to meet the new requirements, which could impact VA's ability to prescribe this drug. This is still being evaluated, and VA is in discussions with FDA to finalize the VA requirements for reporting.

Web-based training for staff is being developed through EES so it is not impacted by IT development funding.

Vacancies have produced resource limitations. The informatics section has 4 vacancies in permanent positions, and lost two positions at the end of FY15 that were term positions. Progress on MH-specific projects has been slowed due to available staff resources. The office has received permission to fill behind a key current vacancy, the National Director for MH Web Services, and that position is under review for recruitment currently.

### **WEDNESDAY 2/24/2016**

#### **APA – Heather O'Beirne Kelly, Ph.D.**

Reviewed first two days and discussed the upcoming meetings with VSOs and the Hill visit. VSO's will request AVAPL's priorities. For the Hill there is interest in gaining input about CHOICE. HVAC Health Subcommittee works well together. 2016 Priority Issues for VA Psychologists are as follows:

1. Improve Mental Health Care Access for Veterans While Building on VA Strengths
2. Address Recruitment and Retention Challenges for Psychologists
3. Address Concerns with Compensation and Pension (C&P) Evaluations
4. Space/Contracting for Leased Space
5. Safety Concerns Within VA Facilities

#### **VSO Meeting – DAV Headquarters**

VSO's in Attendance:

The American Legion – Roscoe G. Butler, Deputy Director for Healthcare, Rebecca L. Devilla, Assistant Director for TBI & PTSD Programs

DAV – Joy Ilem, Deputy National Legislative Director at Disabled American Veterans, John M. Bradley III, Senior Advisor, Adrian M. Atizado, Deputy National Legislative Director, Shurhonda Y. Love, Assistant National Legislative Headquarters

Paralyzed Veterans of America – Sarah S. Dean, Associate Legislative Director Government Relations

Positive feedback from VSOs was received regarding what VA is doing well relative to the private sector. Congressional Briefing and Policy Goals for 2016 were shared by DAV. They emphasized the importance for VA to talk about the accomplishments that have changed the standards of care across America. Interest was expressed in VA-sponsored research and professional presentations that highlight health-related issues in veterans. DAV is promoting legislation to address Opioid addiction. Coordination of care is recognized as an issue with contracted providers. CHOICE is not viewed as a replacement for VA. VA care should be the first choice of care, not the second. Very positive feedback given to AVAPL on the joint effort to present to the Commission on Care. VA is viewed as reacting late to negative press. VSO perspective is that VA issues tend to be overblown by the press. VSOs are concerned about VA's silence when negative stories appear in the press. More recently, push back by VA has improved. There is frustration with a lack of detail on VA's plan for CHOICE. There is support for provider agreements to supplement the CHOICE program. They are concerned that changes to CHOICE will not have the necessary input and changes will not correct the issues that currently exist. VSO's have changed over the past 5 years and are more supportive of an integrated healthcare system where VA maintains the primary role. \$12.2 billion set aside for community care in the President's budget. AVAPL discussed IT budget cuts even though the overall IT budget has increased. Dollars are being shifted to support community care. Concern expressed for GEC and inability to manage veterans with SMI and who also are in need of a nursing home level of care. VA looking to implement a teared system of care through development of a high performance network. Terminology is confusing for congress and some VSOs.

#### **THURSDAY 2/25/2016**

##### **The Hill**

AVAPL Executive Committee met with the Majority and Minority members of the House and Senate Veterans Affairs Committees. Primary issues presented related to CHOICE and the need to improve access for Veterans without doing harm to existing VA programs, Recruitment and Retention issues and the need for Title 38 for Psychologists and, concerns related to C&P exams. Also presented were space and contracting issues with leases and safety concerns within VA facilities.

#### **FRIDAY 2/26/2016**

##### **American Psychological Association**

##### **Integrated Care**

**W. Douglas Tynan, Ph.D., ABPP – Director of Integrated Health Care**

Dr. Tynan heads the Office of Integrated Health Care across the age span. All professional societies are now looking at integrated care. There is a focus on data related to outcomes. There is a need for caregiver groups to be reimbursed. Home visits with teenage mothers has proven to have positive outcomes for the child. One study looked at those with headaches waiting two weeks before follow-up medically and seeing a psychologist instead. The outcome was that this protocol significantly decreased the need for further testing. Psychology must promote what it does well. VA is at the forefront of integrated care. Large numbers of veterans do not need specialty care in MH. Define services based on the needs of the patients, not the staff. Psychiatry is looking at a collaborative care model. VA Office of Integrated Care contacts shared. APA Center for Psychology and Health has videos on integrated care. APA will release the videos for VA use upon request through Dr. Tynan's office. Concern raised with CHOICE was shared related to the impact on integrated care if PC is contracted out while MH stays within VA.

### **Public Interest Directorate**

**Gwendolyn Puryear Keita, Ph.D. Executive Director and,  
Deborah A. DiGilio, MPH, Director, APA Office on Aging**

Focus on intimate partner violence. Presented at a meeting of Chiefs of Police. Women with disabilities have a 40% greater chance of intimate partner violence than women without disabilities. Also focus on psychology's role in homelessness. A handbook for "Assessments of Older Adults with Diminished Capacity: A Handbook for Psychologists" has been published and is free online or by mail (postage cost only). Also reported on Supporting the Geriatric Workforce and Older Veterans: Department of Veterans Affairs. APA Strategic Initiative on Health Disparities was shared. Aging LGBT Veterans may not know they are eligible for VA services. Some Veterans may also know that if they received a less than honorable discharge due to their sexual orientation are able to request that their discharge status be upgraded. Transgender issues being addressed but are challenging.

### **Practice Directorate**

**Dr. Lynn Bufka, Ph.D.**

Practice sponsors the State Leadership Conference every year – starts tomorrow (2/27/16). There are three days of training and education on advocacy followed by Hill visits. Asking that psychologists be included in the Medicare provider definition is a priority. Working on development of clinical practice guideline, PTSD will be out soon. Depression panel meeting next month. Discussions are occurring with the American Psychiatric Association. Multiple organizations now looking at similar efforts. The hope is that there will be more collaboration. The Agency for Healthcare Research and Quality is looking to take on Schizophrenia. Want bipartisan input but apa is resisting. It is important to not make it all about medications. VA names offered for inclusion which includes psychiatrists and psychologists.

Extensive public education campaign on mind-body health is occurring from a psychology perspective. Stress in America survey will soon be initiated again. There has been very good media coverage on these types of educational initiatives. Training on military culture education and what non-VA psychologists need to know is available. This could assist in addressing Congressional interest for non-VA providers. Cross state practice and implication on licensing laws specifically related to tele-MH was

discussed. There is some Congressional opposition due to resistance to implications that this may lead to National Licensing.

The Committee for the Advancement of Professional Practice (CAPP) – consider nominating VA Psychologists who can represent the interests of VA Psychologists. Addresses Psychologist reimbursement through Medicare and other relevant issues impacting psychologists. Dr. Judy Patterson is a VA contact person as is Dr. Toni Zeiss.

#### **EDUCATION DIRECTORATE**

**Karen Studwell, JD, Senior Legislative and Federal Affairs Office, Science Government Relations**

**Catherine L. Grus, Ph.D., Deputy Executive Director**

**Jacqueline Remondet Wall, Ph.D., Director, Program Consultation and Accreditation & AED, Education Directorate (Past President of Div. 18)**

Dr. Grus reported has membership in the Institute of Medicine's forum on innovations in healthcare education. Embrace exposure to interprofessional training. Work to support psychology as part of a team-based care which is not always evident to other disciplines.

Dr. Wall identified the New Standards of Accreditation which are to be implemented 1/1/2017. Much of what was previously included remains but was "repackaged." Professional Psychology has changed to Health Service Psychology. The definition is broader than Health Psychology. The time frame for reaccreditation will be from 3 to 10 years. The annual reporting requirements remain. This allows programs to diversify its focus. Training on the new process will be started this year. The May meetings of APPIC and ABPP will offer training along with web-based training. "Town Hall" type meetings will also be established for question and answers. Communication with SMITREC will occur over the changes and implications. In May as there will be more information to share. They are working closely with Dr. Ken Jones and Stacey Pommer. There are 379 APA Accredited doctoral programs and just over 500 Accredited Internships. 4,000 entered the match process, 3700 matched with close to 3800 slots available. Very close to 100% are now being matched to a site though not all are accredited. Under 2000 APA Accredited sites are available. Internships may apply for accreditation on contingency after which data may be submitted after the first two classes are completed.

Dr. Studwell indicated that graduate psychology training focus is to now include psychology in integrated training especially of underserved populations. They included VA training numbers in the Geriatric Workforce white paper.

Education on military culture to the private sector and potential contracted providers is an issue for Congress. APA may be able to assist through their Education Directorate and through Joining Forces. Building that education into training programs is also an option. Give an Hour has @ 8,000 participants and does include a military educational component. Training is available in university counseling centers some of which contain VA liaison staff.

/ES/

Stephen Cavicchia, Psy.D.  
Secretary, AVAPL

