AVAPL Mid-Winter Meeting
February 9-13, 2015

Mid-Winter Executive Meeting
Sunday, February 8, 2015
8:00 pm – 10:00 pm

In attendance:
John McQuaid, Ph.D. President
Steven Lovett, Ph.D. Past President
Thomas Kirchberg, Ph.D. President-elect
Mary Beth Shea, Ph.D. Treasurer
Monica Cortez-Garland, Ph.D. Secretary

Dr. McQuaid presented the schedule for the upcoming week of meetings. Dr. Shea reviewed the treasurer's report that was previously provided.

Treasurer's Report:

1. Conference Account: $27,755.89
2. Membership Account: $63,420.68
3. Membership: 378

The Executive Committee discussed the specific issues we would like to present to VACO:

1. Title 38 versus Hybrid 38 in regards to concerns related to hiring practices and promotions to GS 14 and 15.
2. Physical and psychological safety for psychologists including specific issues such as C&P exams and the tragic loss of Dr. Fjordbak
3. Professional issues including the position of Lead Psychologist within VACO

February 9, 2015: Meetings with VA Central Office Leadership

Kenneth Jones, Ph.D., Director, Associated Health Education OAA and Stacy Pommer, LMSW, Health Systems Specialist Associated Health Education OAA

AVAPL gave thanks to OAA for support for training, which positively impacts the profession in general. It provides the opportunity to educate within the VA and OAA has been a huge partner in that process.

Dr. Jones and Ms. Pommer noted that psychology is the largest discipline within the Associated Health portfolio. Group discussed current Mental Health expansion, Round 3. There is money set aside for next fiscal year but the budget is tight this year. Questions remain regarding whether OAA is able to pull off the Mental Health expansion as set out. The expansion may be delayed a year but not likely. Decisions were made within OAA to spend money that they have now rather than withhold funds for next year. Spending is important since in the past funds related to physicians were not spent (last 2yrs), and approximately 85 million was withdrawn from OAA's total FY15 budget.

Recent increases in OAA staffing have allowed the portfolio of training programs for 43 disciplines to be evenly split between Stacy Pommer, Debbie Hettler and David Latini. Ms. Pommer is responsible for supporting psychology training.

There has been Congressional interest in OAA activities, but in general there is little inquiry from the public or Congress regarding psychology training. Inquiries instead tend to be around opportunities for disciplines that currently do not have training opportunities in the VA.

Psychology should make sure we're represented well with strategic planning and expansions. In regards to the Mental Health strategic plan, psychology received 139 out of the possible 228 positions. This has been increasing over the past 4-5yrs. There were 18 psychology training programs added this year alone in Phase III of VA's Mental Health Education Expansion (9 internships, 9 fellowships).

There is a challenge of a number of funding streams as well as better determining what track trainees are in, especially fellows. OAA had a facility allocation report listing positions by funding streams, but it was difficult to total up psychology trainees. A second report listed trainees by discipline which was broken down by funding stream and education level. Funding stream is important as it can be related to a sense of permanence for those positions. For example, the Associated Health regular funding stream is relatively more permanent. Other streams such as the rural health and GRECC are special streams which have a higher likelihood of being cut if the need arose.

The Health Services Education committee meets quarterly and advises OAA. Bill Marks is Ken Jones' direct supervisor. This may be a good committee to ask about membership or participation in order to have more information regarding education and future directions. Committee is co-chaired by Dr. Marks. Members include Executive leadership, VISN leadership, discipline leads and academic affiliation. Committee membership is all internal VA staff.

National Academic Affiliations Council is another committee but is more heavily medical. This one includes external members. Norman Anderson (from APA) was part of that committee but has not been attending recently.

OAA works closely with the Council on Accreditation. There have been big problems recently with paying for APA accreditation site visits to VA facilities ($3400). This amount goes over what can be made with a credit card at a site, making the process more complicated for facilities. This leads to delays in submission of payment to APA. There have been problems with sites being told by their fiscal service that they did not complete the process correctly, and that APA won't be provided funding for the site visit. OAA suggested that it would be beneficial to hire a person just to help manage these accounts and issues. It was also mentioned that VERA dollars that go to facilities and VISNs have within them monies to pay for the accreditation process (APA site visits).

Continuing with the VERA funding, this funding is based on an older model where training monies are closely correlated with physician training. Dollar amounts given to the field by VERA are based upon the number of physician trainees that are at the facility. Example: the only state that does not have psychology training is New Hampshire. They do not have medical trainees so they don't get VERA funds for training. Psychology, as the largest associated health program, may be interested in advocating for VERA to include non-medical trainee levels for determining how VERA monies are allocated. Another important question would be at a local level in regards to where VERA dollars are being allocated within the facility and are they available to psychology. Monies get put into a general post fund and are not used for stipends but rather for space, offices, lights, accreditation fees, and such. Funds are

approximately $85k/physician trainee (full time equivalent). A difficulty related to funds is that they arrive on a dedicated line but after that the usage is not being tracked.

Three consortia agreements have had an OGC (Office of General Council) review. It took those sites 6-12 months to get through the process and achieve approval. Issues identified were related to the VA not having their name noted in the program title and costs not being shared equally. There are currently approximately 15 consortia in VA. VA Psychology Training Council came to aid in sorting these issues. OAA is looking at consortia and determining what is in their memoranda of understanding agreements. It is being determined that many of them may have to edit their agreement to pass the OGC approval process. The sites have agreements that meet APA accreditation standards, but are not going to meet OGC requirements. At this time no new consortia are being added, as there is a need to improve the current agreements before new ones come on board. OGC will not allow a template for consortia agreements. Sites are unique but there are currently 3 example agreements that have been through the approval process that are used to begin the process. [3 sites that went through the process Connecticut/ Newington, Walla Walla/Spokane, and Birmingham.]

Issues related to 2 year funded fellowships such as neuropsychology and rehabilitation psychology were discussed. Sites that would like to have 2 year funded fellowships need to complete the accreditation process so that the fellowship is fully accredited in the appropriate specialty area.

A question was asked regarding issues that have occurred with HR not having a good understanding of what a psychology intern is and how to work the hiring process before the internship year is complete. OAA has worked with MHS to discuss with HR. The concern was related to employment postings and the question to be addressed whether an accredited internship has been completed. If the intern responds "no" they do not meet minimum criteria. The desire was to get a check box into the posting that asked if an accredited internship has been completed OR have you met the exception for the qualification standards. This has been approved but local HR needs to put this new information into their template. Loretta Braxton sent out an email with this change to training directors to be given to HR if needed to facilitate this change. Ms. Pommer stated that she can send that email to AVAPL who can help to distribute to constituents. It was also suggested that the information be sent out to Chiefs of Psychology who are involved in HR postings. Support was given for this assistance. It was also mentioned that OAA's Deputy Chief Officer, Dr. Karen Sanders went to labor management to advocate for the direct hire of trainees which has been helpful.

Ms. Pommer discussed the current database of what national psychology internship affiliation agreements exist. She discussed difficulties with some programs that have both clinical and counseling Ph.D. programs or Ph.D. and Psy.D. Agreements have to be accurate for each program and not just one agreement when there are a number of accredited programs. OAA will attempt to get a list of interns that match with the VA in order to make sure that accurate agreements exist. They have the support of OAA's data team and a statistician assigned to work with associated health to help them clean up the database. At this time the estimate is that over 50% of the agreements are not completely accurate. There are some differences in what APA has listed versus VA. Many of the changes involve getting titles and appropriate signatures. When there is an intern from a new site OAA will take the lead to get the new affiliation agreement as in their experience it can be a struggle. It is critical to get them done timely as training cannot start unless you have the agreements in place. The goal would be to make a report that was easy for local sites that has information regarding affiliations, specific degrees (Ph.D., Psy.D.), and city.

OAA expressed their gratitude to AVAPL for helping them obtain a broad perspective on some training issues. They expressed their desire to see New Hampshire come on line with an internship program and suggested that AVAPL might reach out and provide any support available to the lead psychologists.

A final note was mentioned in regards to OIG and their separate arm for investigation that looks at policy and whether the VA in moving in the right direction. It was determined that Psychologists were among the top 5 positions where we are going to have shortages. There is a clear long term need for Psychologists that will continue past the 5yr MH expansion.

OMHO: David Carroll, Ph.D., Acting Executive Director OMHO; Dean Krahn, M.D., M.S., Deputy Director OMHO (Phone); Ira Katz, M.D., Ph.D., Senior Consultant, Mental Health Program Analysis (Phone); Lisa Kearney, Ph.D. ABPP, Senior Consultant, National Mental Health Technical Assistance (Phone) and Kendra Weaver, Psy.D., Senior Consultant, Mental Health Clinical Operations(Phone)

A major theme in the meeting was potential VACO reorganizations. OMHO has been asked to work very closely with MHS. While there has been some suggestion that OMHO and MHS may merge, Dr. Carroll emphasized that whether they do or not, OMHO and MHS are already working together closely. The current focus of OMHO is on items emphasized by the Secretary: improving trust, service delivery, sustainable system for the future. The Blueprint for Excellence talks more about moving from an illness to a wellness focus. AVAPL can help with the hiring and retention of psychologists in the field. For the ongoing growth of MH services we need to have the staff. The demand for services is increasing but staffing increases are variable by site. We need to continue to make sure psychologists understand that VA is a great place to work and there are wonderful careers available. Retention has been challenging due to the climate right now (e.g., support staff, loss of Dr. Fjordbak, safe and secure place to work).

The 2nd item where AVAPL can be of service is in regards to the where we need to go as a system- Veterans Choice Act and the focus on access and scheduling. VA needs to get better at clinic management and appointment scheduling. There may have not been training previously in appointment management and clinic management but we can ask for support. Behavioral health interdisciplinary teams are an example of a new way to manage clinics and work together as a team. There needs to be ongoing support as that develops. There is a new clinic manager for every facility. AVAPL is urged to support this.

A 3rd area involves working with leadership to better align the way management, leadership and providers work across the system. There is a need for a MH system that is based on Veteran-reported outcomes. We need IT resources to help us have an outcomes-based health system. We can begin to better define the role we all have. VACO sets standards and looks at data while also empowering people at local level to do something with that information. Central Office can then help fix problems that are found. Dr. Krahn discussed looking to better understand care delivery. He asked AVAPL if there is an access problem to deliver timely care. The response highlighted the range across the country from low access to remarkable access. How do we deal with that variety? Sites with great staffing and connection to universities have easier hiring. Other places are not as connected and they are below staffing levels with increasing Veteran access challenges. Assistance also comes in the way of Telehealth delivered mental health care, which is proving just as good as in-person care.

Dr. Katz asked about our sense of how the recruitment of Licensed Professional Counselors (LPC) and Marriage and Family Therapists was affecting psychology in the VA. AVAPL response discussed the difference by site regarding how they are being hired and rolled out. There was concern raised related

to the variability in LPC training. It is hard to determine what you can expect with the level of training and different states even have different definitions of LPC.

It was also highlighted that a survey from AVAPL members questioned why psychology does not have a designated lead other than general Mental Health leadership. Social work has a strong discipline specific lead that has been able to protect social work positions and advocate for those positions. AVAPL staff noted that psychologists in leadership need to be focusing across disciplines and psychology may benefit from a vocal person to be clear about what we do, how we are unique and the value we add to the system (e.g., assessment, teaching, understanding of data, research participation).

In addition, the non-mental health areas where psychology participates, such as health and behavior, fall through the cracks. How to we define and acknowledge those roles? At times, there is not time devoted to the other skills we have and so we are not able to illustrate those strengths within teams. One example of psychology working outside of mental health is the National Center for Organizational Development. Even within mental health, psychologists view patients differently. Dr. McQuaid provided an example of a Veteran being treated for hoarding where a psychologist was treating with an EBT in combination with peer support. It was a successful case that is going to be written up for publication. Our ability to evaluate and quantify success is not in labor mapping for that psychologist. Many times there is not a lot of time to do work like that that highlights our skills. We need to be able to innovative, and work with partners, but also disseminate that work.

Dr. Weaver discussed BHIP as a priority. She would like there to be continued growth in BHIP over the year and acknowledged that support from us is meaningful. She asked AVAPL what the struggles may be at sites. The response highlighted the variability. The mandate is for one team, so people are literally making a single team. The ratio of staffing has been a problem as well as role clarity and knowing what disciplines can do what role the best so that everyone can work at the top of their license. There has been a struggle weaving BHIP into the overall structure of mental health services.

Dr. Kearney discussed mental health leaders building skills in business-related issues. Psychologist leaders are beginning to own those roles with clinic productivity and management. Important questions were raised: how do clinic staff with interest and expertise get into these issues, how do we get them more training to be able to talk with those doing the business side of stuff in the language they are working with? It is good to have clinicians on those teams and committees, on the business side of the house. The conference calls have been helpful as well as support coming from OMHO to help staff get familiar with this information. It was suggested that there should be encouragement at the facility level to advocate for protected time around these issues.

The issue of recruitment for remote areas was discussed, especially related to HR struggles and getting support for incentive options. There have been problems with loan repayment and other incentives. Remote sites are understaffed and then attempting to manage business management which can be overwhelming. Main sites attempt to help but there are important differences in what CBOCs go through.

AVAPL asked this group about the opinion regarding requesting a move for psychology to Title 38 versus Hybrid 38. Research has not been done at VACO. Some unanswered questions were brought up regarding how it might facilitate hiring and how leave is managed. The group stated that they would be interested in looking at a white paper on this issue. Some advantages highlighted were the increased flexibility in salary structure for where there is a move to additional roles. AVAPL highlighted current hiring difficulties related to the requirement to rule on certifications from any Veterans before moving

forward which does not allow you to see the whole group that has applied. The current hiring inflexibility appears to be related to current hiring practices being under Title 5 due to a legal challenge. Veteran's preference may negatively impact hiring for a specialty within psychology since the Veteran may meet the basic qualifications but not have the specialty training needed.

AVAPL expressed that many have felt supported by OMHO. It was mentioned that site visits have been very constructive and help you improve your service. They have been functionally constructive and provided in a professional way. The effort in developing and facilitating that process was appreciated. AVAPL also highlighted that serving as a site visitor you can gain information as well.

OMHO was thanked for the support after the El Paso tragic situation. The group highlighted that AVAPL reached out with supportive emails and listserve discussions. It was mentioned that there are discussions of a new internship site in Dr. Fjordback's name. OMHO was asked how AVAPL can be involved in any support for the El Paso site and colleagues there. In addition the question was posed about how others are proceeding and attempting to acknowledge his service. OMHO stated that they have been working thru the VISN and the facility. It was suggested that AVAPL could offer mentorship to the program as it heals and grows. Both groups also do not want to burden them with more information and contact.

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

Dr. McCutcheon stated that her busiest section has been MST. The Veterans Access, Choice, and Accountability Act (VACAA) of 2014 Sec. 401 expanded VA MST-related healthcare services to those Veterans who have experienced MST during inactive duty for training – such as weekend drill. This area has been a gap in MST–related healthcare services as they were previously ineligible for services.

Section 402 of the VACAA authorizes, but not requires, VA, in consultation with DoD to provide MST-related healthcare services the Active Duty Service Members (ADSMs) without a referral from DoD. VA believes that Congress intended this to be confidential MST-related healthcare services for ADSMs. There has also been a formal internal and external (AMA) ethics consultation. DOD has a focus on military readiness. The VA/ DoD Workgroup is currently developing criteria regarding instances where records should not be confidential and shared with DOD. The current law states that services should start in August 2015. VA/ DoD have decided to use a phased approach to implementation. One question posed by AVAPL was how VERA capture/reimbursement would work. How are active duty registered and captured in VERA? There is concern that there will be pushback if they are not reimbursed for services provided. The Office of General Council's Formal Opinion has stated that DoD will pay for the ADSMs MST-related healthcare services even if they do not have access to the records. Dr. McCutcheon is doing geo mapping. It is known which facilities would be most impacted, with the influx of active duty service members.

There is a VA partnership with Ruth Moore. Ruth met with the Secretary in November where he made a commitment for VA to partner with her. As she receives complaints/concerns from Veterans, she is asked to relay those so that the VA can assist her with solving problems identified from her non-profit website. Ruth has been working with the MST Support Team and the MST Coordinators and there have been some successful outcomes and it has worked extremely well. There has been help to promote sensitivity and access to VA system. The MST Support Team went to Maine where Ruth lives and made a sensitivity video at her home and at the Bangor CBOC. The video will be used for Sexual Assault

Awareness Month. The video is for all staff not just mental health as various staff members (e.g., clerks, LPNs) interact with Veterans who have experienced MST. The Secretary provided the intro for the video.

In regards to family services, there is encouragement to decentralize like other EBTs. Questions remain on how to do this. The family services training was never as large as other EBT trainings. NAMI has launched a new family education program – NAMI Home Front which is a modified Family to Family Education Program that is focused on military family members and Veteran families. They hope to have it online eventually.

On the topic of Women's MH, there has been approval to do a mini residency. There will be 200 slots and a planning committee. There are two volunteers helping part time, 1 psychiatrist and 1 psychologist. The monthly calls are going well.

Training in Emotion Focused Therapy is ongoing, but is not funded by the VA. This is not officially being rolled out by family services but Dr. McCutcheon supports these training efforts. Again the focus is on decentralization. There are senior therapists willing to mentor those struggling to get EFT programs up and running.

Dr. McCutcheon was asked how AVAPL can provide support. It was suggested the issues of women's MH and family services could use support. Clinically complex women and the struggles to provide them services are ongoing. Dr. McCutcheon asked for input from the field regarding where the challenges are in serving women Veterans and providing family services. One area identified has been inpatient programs.

Dr. McCutcheon also highlighted the need for expertise coming from the field on various clinical issues. There are a lot of people interested in research topics related to MST and PTSD but they are looking for other areas such as eating disorders and depression. It is hard to find anyone interested in women with SMI. Dr. McCutcheon asked that we let the membership know that there is an interest in expertise.

Dr. McCutcheon was asked about caregiver access. She explained that it is under care management within social work services. She stated that the VA draws a gray line between family and caregiver services. Currently there is an unfunded mandate to provide services to caregivers. Question remains, how to balance needs and deliver services?

Harold Kudler, M.D., Chief Consultant for Mental Health Services; Marsden McGuire, M.D.,M.B.A., Deputy Chief Consultant, Mental Health Services and Wendy Tenhula, Ph.D., National Mental Health Director, VA/DOD Integrated Mental Health and Acting Deputy Chief Consultant for Specialty Mental Health

Dr. Kudler discussed changes related to the structure of MH services. He stated that it is vague regarding what is happening. There is some indication that VHA leadership may undo the split between MHS and OMHO. He highlighted that he is already working with Dave Carroll and Dean Krahn and how they partner together. Everyone agrees that that is the goal. There was discussion regarding the hiring freeze in VACO and the loss of key people. He highlighted that there are good people remaining who worked with the previous leaders. There was a description of VACO going through a "forced diet" in order to shrink. It is difficult at times when there are fewer people to do more work, especially during crisis conditions such as with the El Paso tragedy. They look forward to a manpower refresh. Despite the hiring freeze continuing, there have been successes such as hiring Dr. Kudler, which was an exception. It

was acknowledged that interim leadership is in some delicate positions and in some cases does the job for months or a year

AVAPL extended a thank you for the support provided to the field despite the struggles within Central Office.

How the VA regions will be aligned is uncertain. The goal of the proposed realignment is that a veteran should be able to go to any facility within a region and get guidance on how to access all three services: VHA, VBA, NCA. The possibility of aligning by state lines might be helpful but perhaps not. There likely will not be 3 different VISNs within one state. The VISN office may get smaller leaving more responsibility at local level. They will monitor if areas are following the specifications put forth by VA (e.g., MH handbook). There may be more focus on not giving specifics on how to accomplish a goal but making sure the mark is hit. Facilities will know they need to do and whether it is getting done. The good news is that Mental Health is looked on in central office as example of how this should be done.

The expansion of non-VA care through the Veterans Access, Choice and Accountability Act (VACAA) was discussed. A RAND survey found that less than 20% of non-VA providers have military/veteran expertise. Before VACAA there was PC 3 contracting. There was also a pilot conducted at 24 sites to partner with community providers. Sites were identified by HHS and attempted telehealth services and/or sending Veterans to private providers. It highlighted the difficulty and importance of coordination of care between MH and other services, and between providers. No matter how they arranged the pilot, all sites found that coordination was critical. VA has developed with DoD a military cultural competence training course that is available to all providers including community providers. Providers are able to obtain free CEUs for this course. The job now is to get the word out, especially to community providers and get them to take the course. How are we going to know if it helps them be prepared or if it affects their practice/behavior? Who is taking the course? They are looking to find a way to evaluate these questions and the effectiveness of the course. VA plans to have training on the internet that is available for community providers and this military course will be the first VA training put there. There is work being done with Give an Hour and the American Psychological Association in order to help disseminate information.

Currently VA recognizes that lots of Veterans get care outside of VA. For the first time, there will be a CPT code for obtaining military history from patients. One question is: Have you or someone close to you served in the military? We need to get our colleagues to take a military history. There needs to be an appreciation that every client needs to be asked about military history. Providers could be missing all kinds of exposures that the patient was exposed to, and all kinds of services that they may qualify for. One out of every 5 Americans has been affected by the military. Many tend to misjudge how many Veterans there are.

Space was discussed as a huge issue. This affects the hiring of new positions. There were a protected number of slots under VACAA for MH but it is difficult. There is a limited amount and the same money must also be used to build new buildings or pay others in community. We will have to wait to see how it will really be distributed. One of the best ways to address space is with telehealth. The laws unfortunately have not caught up with it. Can I see patients across state lines where I am not licensed? Can I help with those at other VAs even though I am not credentialed? People are working to help solve this problem. There also need to be ancillary staff to make sure that the equipment works properly so you don't lose the Veteran. Sometimes it may not help with space if you are doing telehealth from site to site. You need 2 offices, one on each end, and staff at both ends to provide services and technical support. There are also thoughts about increasing off-tour or weekend hours to help with space. This

practice is more easily done with new hires versus old staff. Do Veterans want that? There have been sites that attempted extended hours and in at least some locations it was not well-utilized.

In regards to access, we must have staff to get Veterans in for services. Unfortunately, this could result in VA staff doing intakes only and then therapy is then contracted out. VA staff who want to do the therapy will be disappointed and not doing what they enjoy. Is there a solution to this? AVAPL described that this could affect the morale of staff. The pressures of the system are on access. When we contract out, we have to increase awareness of military culture. A related concern in the focus on access has been to the detriment of quality at times. When performance measures focus exclusively on access and not on quality, it almost gives the message that once the Veteran is in we don't care about the services. It also affects being able to see the Veteran at a frequency you want or complete EBT due to your schedule being full of intakes. Psychology has led the way in building and training in EBTs. There is still a need to focus on building the relationship, a clinical relationship. People want to be listened to and engaged on a personal level.

MHS leadership was also notified of the hiring and HR challenges. Specific issues: the constraints of Hybrid 38, limitations on HR specialists, variability on how HR performs at various sites, and staffing issues in HR. Many sites are dealing with access issues and are attempting to take advantage of funding but HR struggles make it difficult. One idea to improve this situation is to request for psychology to move out of Hybrid 38 and go straight to Title 38. The hiring concerns reported will be moved up the chain of command. Other hiring issues: needing to hire for positions quickly before they are lost, problems hiring trainees at times, and Directors having a hard ceiling on FTEE.

Jeffrey Burk, Ph.D., National Mental Health Director, Psychosocial Rehabilitation & Recovery Services (PSR&RS)

Dr. Burk highlighted peer support efforts and the fact that 973 peer specialists have been hired. This was initiated by the White House Executive Order to hire 800 peers. These peers are on the ground and doing good work. The PSR&RS office is looking at areas that need to be concentrated on such as supervisors for these peers and the uncertainty of how to best use their skills. Most of the supervisors have been psychologists. There have been concerns expressed regarding peer specialists practicing under their supervisor's license. There have been fears that their license will be at risk.

Specific concerns are that peers are not professionals and are not licensed. There are questions regarding the extent of their training in clinical services and their performing clinical-like services. Concerns about the peers may be an extension of the stigma toward MH patients. Some clinicians are worried peers will do things that are problematic which will then reflect badly on their supervisor's license. Dr. Burk shared that experience thus far shows that there are no greater problems than with other professionals. There have been several years of experience with peers, and the number of problematic incidents is very small. These issues have been addressed straight-forwardly, and there have been conferences to address these issues. There will be a second peer supervisors conference later this month in Phoenix.

The question was asked, how do you help a psychologist with a peer that is having problems? The solution is no different than working with an intern or postdoc or any other staff. Your license is equally at risk. If you are managing a clinical program, there are staff (SWs, nurses) working under your license. With peer staff, you have the same disciplinary action process that you are allowed to use with any other employee under VA policy. So far, there has not been a time when a psychologist's license has

come under review. Dr. McQuaid highlighted a good experience at his site where a peer proved to be very helpful and provided a very human experience.

Dr. McQuaid asked about the issue of dual relationships related to providing the Veteran peer with MH treatment when needed. Discussion took place regarding policies related to if you are or are not employed thru mental health. Another question related to peers is the need to provide reasonable accommodations if the peer is continuing in treatment. Peers should be far enough along in their own mental health recovery at the time they are hired that they would be less likely to need ad hoc or emergency services. If they do need treatment, options should be discussed with the peer about where to get services. You should discuss concerns related to medical records and getting treatment where they are working.

The field might benefit from consultation to get guidance on difficult issues. Dr. Burk highlighted that there are supervisor and peer points of contact for each VISN. The peer support site has this contact information.

There is a push to expand peer services into other areas like primary care that was supported in an Executive Action following the President's speech to the American Legion. A work group will soon start soliciting proposals for 25 pilot sites for this initiative. The biggest challenge is to find a way to implement this initiative without funding.

Another major area being worked on is implementing recovery on inpatient units. The Inpatient Handbook is very recovery oriented and requires inpatient units to provide recovery-oriented treatment programming. PSR&RS is working with Loren Wilkenfeld, who oversees inpatient and outpatient policy, to implement a national conference call or other type of training to promote recovery issues on inpatient units.

MHICM is also working on a new handbook. It is still not out but getting closer to a release. Two MHICM conferences were approved, with one in early May [now rescheduled for August] and another conference for early June. The primary goal of these conferences is to discuss the forthcoming changes in the new Handbook and to reorient programs to a recovery model. A question posed to Dr. Burk: what portion of MHICM staff are psychologists? It is predominantly nursing and social work, psychology third and psychiatry minimally. It would be great to see more psychologists involved. It may be related to most jobs being posted for nursing or SW but not posted to psychologists. This would need to be addressed at a national level. Psychology assistance in a consultation role might be helpful if there is no FTEE. HBPC specifically had psychologist FTEE as part of the team.

Local Recovery Coordinators (LRC) are working as hard as ever. There is work on the SMI Re-Engage Program. This program resulted from a performance improvement study from the Office of the Medical Inspector that identified Veterans with SMI who had dropped out of care and invited them to come back into care. The study found that re-engaging Veterans with SMI into care decreased mortality three-fold. Hundreds of Veterans have been brought back into care in the SMI Re-Engage Program. In addition, LRCs have been heavily involved in the MH summits. A question regarding these summits in regards to whether they are going to continue or work to provide long term relationships with community providers was posed. Dr. Burk highlighted that it will depend on the Secretary's office and reorganization plans. For now, the summits will continue but the structure may change.

Dr. Burk also discussed psychology qualifications standard. This has been in the concurrence process for over two years. The document is in its final stages for concurrence. One of the anticipated changes in

the standards is the use of board certification through ABPP for those psychologists whose internships were not APA-accredited. AVAPL thanked Dr. Burk for his continued hard work on this issue.

Timothy O'Leary, M.D., Chief, Office of Research & Development (ORD); Theresa Gleason, Ph.D., Senior Program Manager and Samantha Smith, Ph.D., Program Manager

Dr. O'Leary shared the fact that mental health remains the largest single discipline area within ORD's portfolio from a funding perspective. He also indicated that ORD's overall research budget has been fairly static.

Dr. O'Leary updated the group on several ongoing research studies funded by ORD. There are several new projects using data from the Million Veteran program (MVP). One project highlights those that suffer from schizophrenia or bipolar disorder, focusing on negative symptoms and functional disability. The second MVP protocol has to do with the susceptibility of PTSD, focusing on polymorphisms.

A very large clinical trial involves Prolonged Exposure versus CPT. This project is in the process of getting patients enrolled. This study will hopefully will answer gaps in this area.

Another large project involves augmentation vs switching for refractory depression. Enrollment has been a severe challenge. Within the next 3 months they may stop enrollment.

Another study underway uses Repeated Transcranial Magnetic Stimulation (RTMS) for depression. This project may not be completed due to enrollment and dropout issues.

Cooperative Studies Program study #590, focusing on suicide prevention, will begin enrolling in March. The relationship between the use of lithium and decreased suicide rate will be investigated. It would be nice to have a tolerable pharmacological intervention to decrease suicide.

The study on supported employment with PTSD is doing well with enrollment. The project is close to finishing.

Dr. O'Leary shared information about some small clinical trials. Studies looking at mindfulness and mantra repetition for PTSD have recently been completed, using the PTSD CAPS as the outcome. Publications are expected in the next few months.

There is a group of related funded projects using service dogs for those with PTSD. There are a couple hundred participants; the outcome is general well-being. These studies have had many challenges, including problems with dogs biting people. The studies will likely go forth because of high political visibility.

Dr. O'Leary also discussed some important VA issues surrounding PIs who are also clinicians. Pressure from the clinical side can negatively impact continued research time. We are a cutting edge research institution as well as clinical institution. There is a need to educate leadership regarding the future negative impact on VA's provision of care if we do not complete Veteran-focused research.

In a recent informal analysis (based on observational data), ORD's conclusion was that VA research field stations need to have 30 investigators with research interest in order to effectively compete for federal research funds. If you want to start a research program, you need to attract people who can do it.

Unfortunately, there are not funds to help those trying to start those programs. Programs will need to be entrepreneurial to get funds from different entities, associations (e.g., heart association) and academic affiliations. You likely need a minimum of 4 or 5 people, plus a supportive environment.

AVAPL members posed the question of what AVAPL can do to facilitate research. Dr. O'Leary suggested that a mentorship program would help to give some realistic goals and inform others of VERA dollars to buy back time from facilities for research. Having strong mentorships within the same discipline is important. He cautioned that some young investigators prematurely go for research money. ORD has career development awards and merit awards available to researchers. Career Development Awards cost a lot more and are very competitive. Contrary to what some mentors and mentees may assume, young researchers should be aware that, early on in their careers, they actually may be more competitive for a merit award than a career development award. You don't need a K award to be successful.

AVAPL could potentially be involved with advocating to Directors regarding the value of protected time for clinical researchers, reminders about reimbursement, VERA funds, and the resources that are brought in to medical centers. In addition, AVAPL members can mentor and spread the word by giving others realistic expectations regarding what it takes to conduct research at the VA.

The group initiated a discussion about starting a mail group of VA psychologists interested in research, focused on improving communication across facilities related to research opportunities. ORD does not have the manpower to start such a group, but would applaud this being done. VA Pulse was mentioned, which is an interactive medium that might accomplish this goal.

Dr. O'Leary mentioned other important research resources, such as multi-day University-offered sessions on how to write a successful application. Researchers likely need to refresh those skills every 10 yrs. These courses offer facts regarding what works and does not work in a grant application. Dr. O'Leary urges people to do this no matter how successful they have been in the past. Many such courses offer a critique on the style of application and not a technical critique. Sometimes it may not be the technical side but the style/excitement aspect of a proposal that makes the difference.

Dr. O'Leary discussed some related factors that can affect research success. He highlighted the need for support for information technology that could be earmarked for research. Data sharing and IT support cost money as well. Trying to disseminate research also costs money.

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

Within PCMHI, space limitations are also a barrier which is a challenge to overcome with a lack of space for co-located collaborative care providers. Overall primary care providers are pleased with the presence of PCMHI providers, however another barrier present is the challenge of believing that this model of care matches only particular personality traits due to the high pressure, protocol driven nature, and 30 minute appointment structures. Another barrier may be sustainability over time of the model as we must ensure appropriate staffing support. There are also challenges in teaching new competencies of providing integrated care to providers trained in other models. Further, care management implementation has yet to be fully realized . TIDES/BHL implementation has been lagging for quite some time. Finally, it is important to address how PCMHI/PACT coordinates with the care provided in general mental health/BHIP.

There is a focus on making sure staffing levels are able to sustain the PCMHI model. Nationally we have fewer than half of the needed staff. Staff are needed to allow for the most access and also to have follow up care. There is a need to develop briefer and briefer interventions. There may be an increased use of web-based information guided by clinicians and option to call if necessary. In the stepped care model the 1st step is self-care, self-management. We also need to have contingency staff for times in which the demand increases for same day service in the clinic.

Kudos were provided to what has been built. The private sector is trying to model what VA is doing. They got a later start but are moving quickly. Where is responsibility of the Primary Care Provider (PCP)? PCPs should be empowered to be a part of the treatment of mental health conditions in primary care. PCPs are asked to do so much; thus PCMHI providers can work to improve their support in treatment of MH conditions while also empowering them to be part of the continuum of care. The Veteran sees everyone working as a team. As a training model, it is great for physicians to be engaged in it and see another role and another way for psychologists to perform. Interdisciplinary care is evolving from multidisciplinary care. The more everyone works together the more they become truly interdisciplinary/interprofessional. There is frustration from the field with policy versus guidelines to get staff versus waiting for funding. We have staffing models that recommend appropriate staffing for PCMHI, but these are not requirements. In the near future it will be interesting to see the shift in My VA and the shift to more local decision making. We might see more of a focus on overall goals and meeting them. If this happens, it will be critical to empower staff to measure outcomes in PCMHI and to examine how the model works across different facilities. Metrics are good, but tracking data real time to make good changes is difficult with the current software platform. At times it can be hard for providers and administrators to get data for those that need it for program evaluation and improvement. Obtaining real time data continues to be a challenges.

Dr. Kearney discussed the importance of psychological and physical safety. What is it like for providers to work in VA during this challenging time? How do we support ourselves? How can we tangibly support El Paso? All the emails and group responses to the tragedy were great. How can you continue to capture that in the next few months as the hard work continues in El Paso? We can consider sending a care package or well wishes in a month or so. In regards to the C&P services in El Paso, it might be nice for them to have some mentorship as they continue to build. AVAPL might consider sponsorship to get to the AVAPL conference and think of potential ways to honor Dr. Fjordbak at the conference. It is important to encourage front line providers during a time when the news may be more negative.

The group also discussed issues of physical security/safety. Issues related to the C&P exams were discussed: 4-6 C&P exams per day, the exams going immediately into CPRS, threats to providers related to results of the exams. We want to provide patient-centered care while also being safe. No one wants a prison-like environment in VA. We as behavioral health experts have expertise in communication to decrease frustration in general. The work by Dr. Van Male in workplace violence may also be helpful. Veterans need to feel that they are getting effective care and feel heard. Many Veterans say they love the care they get at VA.

AVAPL can help with the message of needing continued funding for resources in PCMHI. We can continue to highlight utility of integrated care, reduction in stigma, and improvements to access. There is still a long way to go. Some stories were shared regarding the success of PCMHI related to patient-centered care, decreasing of the pressure on specialty mental health, and on training the model.

February 10, 2015: Meetings with VA Central Office Leadership

Stacey Pollack, Ph.D., National Director, Program Policy Implementation and Gerald Cross, M.D., Chief Officer, Office of Disability and Medical Assessment

Dr. Pollack stated that she is now over both MFT and LPMHC professions. VACO gets many inquiries related to the qualification standards. Professionals need to have graduated from accredited programs but many programs today are not accredited. Some express that VA is discriminating against these groups but it is the same standard for every profession. Dr. Pollack has received letters from Congress and other parties. There are also concerns as to why VACO doesn't consider regional accrediting bodies to be the same as accrediting bodies that accredit programs.

When Dr. Batten left, Dr. Pollack became the liaison to OAA and deals with anything related to psychology, MFT, and LPMHC training. She is also covering some of the work left following Larry Lehman's retirement. She now manages anything related to former POWs and is the liaison for the special committee for PTSD and the National Center for PTSD. The hiring freeze means that no positions are being backfilled at the moment.

There have been positive improvements in MST claims issues. It has been a collaborative effort between VBA, DOD, and VA to work to address claims processing for MST. A course was created and is now mandated for all examiners related to MST. They are working to encourage people to disclose MST during the separation health exam before they leave service. There is also an important need to protect confidentiality in this process. If they file during active duty, a restricted report may be filed which provides them with protections of confidentiality. There are discussions with DOD to manage policies so that there is a balance between disclosure and confidentiality. During the separation health assessment, information is given with chain of command currently having access to records. Would a victim be comfortable discussing MST in that environment? If they say no, that they did not experience any sexual assault/harassment that "no" can resonate for the rest of their lives and may prohibit them from getting disability later on. The option VHA chose instead of asking directly about MST is to ask instead: have you received the brochure about MST so that you know what to do to report MST?. More needs to be done to provide information on benefits and treatment of conditions related to MST. Active duty service members are encouraged to report to the safe help line. The active duty service members need to be provided information on restricted versus unrestricted reports so that they can make an informed decision.

The shooting in El Paso was discussed. The compassion for the site and family of Dr. Fjordbak was highlighted. There has also been the reaction of anxiety, fear and worry as there was speculation about what led to this event. There were concerns that it was related to unhappiness with the C&P exam process. The site may name an internship after Dr. Fjordbak and will likely need help with pragmatic issues as they try to get it off the ground. How do we balance safety with attending to the recovery of Veterans? There have been discussions with VA police, the Assistant Secretary and others related to safety and how to respond (e.g., panic buttons, windows, locks). Dr. Cross reported that he had 23 pages of concerns from examiners regarding safety. Dr. Kirchberg shared concerns from the field regarding safety and C&P exams including intimidation of examiners, Veterans taking photos of examiners, and making threats. Concern related to completing 4-6 exams/day, time pressures, deadlines, and a lack of time to establish a sense of empathy was also shared. It is concerning that these issues will lead to further discontent with the process. It is also unethical to do exams with such little time to prepare and complete. There is a professional conflict related to wanting to perform competently but being put under time and quantity pressures.

It was highlighted that the exams are important to VACO but they are most important to the Veterans. It supports them emotionally, financially, and is a means to potentially get their family supported. It can lead to medical care. Dr. Cross highlighted that the VA is resourced for these exams. He highlighted VERA funds to support time for C&P exams and are a separate fund. He emphasized that there is a mission, funding and extra staff to complete this task. If C&P exams were dropped from VHA, the funding and resources would be taken away. Dr. Cross expressed his desire for them to remain in VA and be supported by AVAPL. He stressed that VA is better at this task. Contactors to assist will continue, but they will be supplemental. A problem with contractors is that the mission may not be there like within VA.

Another problem is the dual role of some providers who are providing clinical and C&P duties. There is a desire for more support for additional delineation. They may include C&Ps occurring at different facilities or by separate staff. There are some providers that like both duties. There is so much variety between sites and how C&Ps are handled. How can some local Directors request examiners to perform 4-6 exams/day? There are pressures from the VISN level and DMA. Dr. Cross highlighted that he felt that sites have the internal staff, contracting staff and fee basis options to complete the task. C&P exams should be performed with high quality and on time. The standard is 30 days.

Some people feel they are told to do something outside of the VA mission but there are 2 missions: clinical care and C&P exams. If this message was presented it might decrease frustrations. Dr. Cross stated that facilities will likely not be told exactly how many exams should be done per day. The CAPS was going to be mandated previously in exams, but that was held up with the transition to DSM 5. AVAPL can help by helping others see a systems perspective and how the whole system affects that Veteran.

AVAPL was asked to help decrease the negativity on the AVAPL listserve. The inclusion of more positive stories on the list serve might also be helpful. We don't like how the media portrays us but how do we portray ourselves in the list serves?

Chris Crowe, Ph.D., Senior MH Consultant & Liaison DCOE for Psychological Health & TBI and Alfred (Al) Ozanian, Ph.D., Assistant Deputy Director for National Mental Health Communications

Dr. Ozanian described being with the VA 13 months but having experience in management and delivery of healthcare. He has observed that much of the care is VA-centric. When the question is "should we make it our buy it," VA always says "make." He discussed a culture shift within VA/DO and learning to manage transitions in care. We need a better understand of how to coordinate care across different systems of care, which is fairly complicated. He discussed centralized, managed care, regional contracts and the management of contracted care. Should facilities engage in contracting care for issues that we don't offer? We want bulk cost to work with third party contractors to leverage. VACAA is leveraging the PC3 contract. VACAA dollars are separate dollars.

Providers are confused about how and when to refer to a service and then who is responsible for the Veteran and their care. The Veteran gets a choice. If they want non-VA care they are put on a VACAA wait list which goes to NVCC (non-VA coordinated care center) and sent to a 3rd-party contractor. At this point, the clock starts to get the person seen. The 3rd-party contractor takes control and makes an appointment. When the episode of care is done, information goes to NVCC and then the VA takes care back.

AVAPL described Veterans who may ask to be placed on the wait list for both VA and VACAA. They want to go with whoever can see them first. In California the outside provider, TriWest, has been saturated and there is a problem finding people to do the work. Dr. Ozanian stated that one needs to leverage a community service that isn't available. The third party is obligated to build a network. It is ok to call up the area manager or program offices assigned to sub regions, and talk with them about issues. They have other options that they can leverage. We pay them to manage care and cost. It is not just VA that has to get creative, but also the 3rd-party contractor. VISN and facilities need to get involved with the 3rd-party contractors. How do we give feedback on how that info can be pushed to 3rd-party contractors? The provider can make recommendation: do we need a neuropsychologist or can there be another recommendation? One difficulty is related to getting this back-and-forth done.

How active will the Mental Health Treatment Coordinator within VA need to be in this process? Are they related to this issue of contracting or just a point of contact? Do we still need to keep up contact if the person is getting outside care? At the clinician level, it is continued worry and nothing is taken off their plate. Overall standards of care become an issue as well. That is a different expectation of standard of practice than the private sector. We have 9000 practitioners trained in EBPs, lots of site visits and accreditation processes. Someone out in public has a hard time meeting these same standards. This brings up questions regarding cost effectiveness related to what we do versus contracted care.

Dr. Crowe discussed the mandate for VA to collaborate with the military. The Deputy Director of Deployment Health Clinical Center liaisons with VA. Prior to the transition program, service members had to opt into care and there was a warm handoff from DoD to VA. By Presidential Executive Order, Veterans now have to opt out versus opt in. The new military culture curriculum is required for VA and is now up and running. There is a community provider tool kit and a military culture course as well. There is a pledge to train 3000 community providers by the end of the year. Service members often do not know how to be patients. They would benefit from VA culture training and learning how to work with this system versus DOD. We also need ways to demedicalize the entry point into VA. Dr. Crowe is on the VA/DOD clinical practice guidelines workgroup. One goal is to help standardize care across the 2 systems. They may be able to create guidelines, but struggle to implement them.

There is a lot of interest in the community for information related to Veterans and their care. Dr. Crowe would like feedback from the community on the toolkit. The community wants clinical practice guidelines for various disorders. People would likely use guidelines but many times don't know about them. AVAPL members can provide information and stories on how things are being used.

Dr. Crowe also stated that he is currently managing $40 million of RAND money which he will be distributing information about. He also reported that the PTSD consultation team can now provide consultation to the private sector. VA and DoD are working out details for the implementation of VACAA Sect 402 which enables Active Duty Service members who have experienced military sexual trauma to receive care at VA without needing a referral or permission from his or her command. Admiral Hunter heads MH for the National Guard. Many times, the Guard gets left out of DoD and we can coordinate with local National Guard to increase our interactions.

Caitlin Thompson, Ph.D., Deputy Director, Suicide Prevention (Phone)

The Suicide Prevention national office previously had a National Director, Deputy and secretary. Now it is made up of Dr. Thompson and a secretary. To increase assistance, they instituted a program to help

make sure the field is represented. Every 3 months, 2 suicide coordinators come through the national office. Each person works half-time in the national office. They get the opportunity to see what is happening at the national level while also informing what they do. MST and women's health have also been doing rotations. You need to apply to be considered. Announcements get sent out at the end of the year.

Dr. Thompson discussed the Clay Hunt Bill that is to be signed by the President this Thursday. MH has been providing feedback on the bill. There is a focus on peer support in the bill. It also mandates that every year, VA MH and suicide prevention will have an outside evaluation. There are internal evaluations but an outside look will also likely be helpful. The bill includes providing loan repayment for psychiatrists, specifically. VA MH will coordinate with non-profit organizations through Suicide Prevention Coordinators nationally. There is a good relationship with the National Council and other institutions like NAMI. There are already good relationships but how do you operationalize? Many of them look to VA because we are looked at as knowledgeable. A lot of the bill is related to overarching mental health, not just suicide prevention. The bill has been the brainchild of Iraq and Afghanistan Veterans of America (IAVA). It is complicated because VA supports the bill but it is stated that it is related to VA failures.

In regard to the bill and community partnerships, there are a lot of great things going on like community summits and outreach. Who is being considered for the outside evaluation of MH and suicide programs? Dr. Thompson's thoughts were RAND but she want other ideas. IOM might be another agency which is well respected and perceived as competent and objective. Unsure if Congress will want input from VA.

Dr. Thompson does not have VITAL as part of her programs.

At a Senate Congressional hearing back in August, one of the questions brought up was on female Veterans and suicide. The Senate discussed that female Veterans are dying at higher rates that non-Veterans and they are using firearms more than non-Veteran women. The Secretary was prepped for questions and asked to discuss gun safety. We have a gun lock safety program. We never want Veterans to fear they will have their weapons taken away but they need to remain safe with their weapons. At times it may be a good idea to remove weapons in collaboration with family and other services. A gun safety toolkit with brochures, gun locks, and information on the importance of guy safety is being developed. There is a good gun safety video from last year (National Shooting Force Foundation). There have also been discussions with VSOs to help get the message out about gun safety. VSOs can help with guidance on how to proceed with this sensitive topic.

There is going to be a directive written regarding how to distribute the gun locks. The House Veterans Affairs Committee was concerned following a *Washington Times* article that stated that the VA was distributing gun locks and likely keeping a gun registry. One facility sent out 140,000 letters to Veterans asking if they wanted gun locks. If they wanted one they were instructed to send their name and address with how many gun locks they wanted. There was some concern that they were keeping that list but 120,000 gun locks were distributed despite this. This program was very successful despite the negative press. Facilities need to make sure they are not taking names or adding to lists but perhaps telling Veterans where they can pick up a gun lock. If it is clinically relevant, there is a place to ask about weapons and include that information as part of the clinical note.

Loren Wilkenfeld, Ph.D., National Mental Health Director, Inpatient & Outpatient Policy, Mental Health Services (Phone)

Facilities are making progress implementing the Inpatient Mental Health Handbook. There are some struggles with phasing out of long term mental health units. There is a workgroup developing guidance for the care of patients with complex needs. There is a focus on Veterans with SMI and medical needs as well as Veterans with behavioral disturbance related to dementia. Dr. Wilkenfeld has been a consultant to the task force working on this. Dr. Michelle Karel, psychologist co-chair, would be a good contact for this workgroup. Dr. Wilkenfeld is also discussing developing an outpatient handbook but they are still working out how to approach that. No progress has been made on that handbook.

Program restructuring requests are being made from the field as they are looking to develop either new buildings, new CBOCs or combining CBOCs, or renovating space. The issue of space allocation is a huge issue, along with staffing. She has been involved in discussions related to the new PACT space design to see if the model can be adapted for use in MH clinics. There are concerns related to work space being separate from office space. How will extended therapy sessions be accommodated? There are activities that require confidentiality such as phone calls, supervision, and administrative activities. How much private and patient space do you need at one time in addition to community space? The staff perception issue and protecting personal space has been challenging. Having mandates can help prioritize space during the leasing process and with leadership. There was discussion regarding the utility of discussing this on the listserve or the conference at some point.

There are concerns that the way we operate now is unsustainable. How do we conceptualize MH care? Even the way we provide care may be unsustainable. Issues include space and staffing. There are a finite number of various staff available to complete activities. In the rural areas, people are hard to find. The greatest challenge is in psychiatry hiring. We may consider a wellness model with centers to provide prevention, wellness, and coaching services. We have new generation of Veterans with concerns related to parenting and work/life balance issues. Dr. McQuaid discussed a partnership with YMCA to build a wellness center with recreation therapy. Some Veterans may not want PTSD treatment but might participate in other services like exercise.

Are we getting any closer to measurement based care? There may be a conference on measurement-based care. It will be for only a limited number of people and it is uncertain who the target audience will be. If you never discharge people, where do you put new people? How do you measure success when there is a piece of compensation related to treatment? This may be a good discussion for Dr. Pollack. Another question is whether providers are measuring success or asking Veterans about what they are getting out of care. We may be providing social support groups that may not need a provider but could be peer-led. We need to find ways to ensure that there is engagement in the right care for the right amount of time. We need to have the message of wellness and growth.

Dr. Wilkenfeld is also part of a workgroup developing a directive for psychological evaluation of police officers. The current guidance dates back to 2005. The group is updating information and putting it into a directive.

Dr. Wilkenfeld was asked about her thoughts regarding Title 38 vs Hybrid 38. She expressed her strong support of the move to Title 38. She expressed interest in what reservations existed and if perhaps they were based on myths. The group discussed some of the issues. There is a myth about not being able to have private practice work outside the VA. There is also some reservation about being on call. Physician colleagues have felt that it was not an issue.

Dr. Wilkenfeld also encouraged people to get Board certified. She is a part of the American Board of Clinical Psychology. Previously there was no monetary benefit, but now there is an opportunity to get an SAA, although it is not guaranteed.

Tracey Smith, Ph.D., Psychotherapy Coordinator, Mental Health Services

There is a big push to decentralize EBP trainings and how to do that well. There are two models depending on the EBP. The regional trainer model is like that of CPT. There is also the blended learning model. Our new mission is to: maintain the quality of training and train more staff. We need to continue with the consultation process in order to show practice changes. Staff are unlikely to get supervisor support for volunteering to review tapes since it is time consuming. We need to train more trainers and consultants to support these alternative training methods. We can't expect that clinicians in the field will have time without financial support. What parts do we keep centralized versus decentralized? In the past, 43% of the EBP budget was used on travel and conferences. When you get away from in-person training, you can use money to pay for more consultants and/or trainers to train more people. There is support, but there are changes in the VA and we don't know what the budget for next year will be.

This year, PE and CBT-D are piloting the blended learning model. It will help compare how the decentralized model works versus in-person workshop. There can be tech problems and some people will find them less fulfilling, but will it affect Veteran outcomes? We are learning from the first 2 pilots. The CPT program talked with other programs to help them do regional trainings well and get EES support. If there is no centralized component, we are concerned there will not be sufficient people to do consulting. This can lead to a lot of variability in quality. A central component can also help with updating content, creating educational and promotional material and training consultants/trainers.

How do we protect time for people to do the decentralization? They want to have at least 2-3 consultants per site. That way if you have three 33%-people, you have the ability to backfill if needed and it will not affect the delivery of clinical care. EBP team have done surveys to find out from EBP coordinators, chiefs, and training directors what has been liked and disliked. What, if any, role would training directors like to have in EBP training? Many felt it might be more work.

What about those that have a good experience in EBP but have not done the VA training? There is an equivalency process application but likely still a challenge. Now those people have an opportunity to be on the provider list. There is an appeals process and currently the appeals board is Dr. Tracey Smith, Dr. Claire Collie, and a field based member as well. The EBP Equivalency Appeals board reviews appeals once every 4 weeks or 10 applications. There are no longer certificates for completion, there are only records of completion. It is tricky to say staff are certified in an EBP. Another issue is how do we get training for low base rate problems such as hoarding and eating disorders?

As part of decentralization process, our section is putting together what the requirements are for all the programs. The complexity of the protocols currently does not necessarily match the requirements of the programs. There was an RCT and it became the rule of the land without anyone asking if it made long term sense for implementing EBPs in VA. CBT-D has shifted the consultation requirement and does flex consultation where if someone does enough tapes that demonstrate competency they are considered completed. Research is needed to determine what components are necessary so that flexibility can be encouraged, but essential components are known.

Where are we on being able to use data from EBP templates? The Program Evaluation and Resources Center is looking at health factor data and creating a national dashboard. Over time, we hope to be able to also use the dashboard as a clinical tool for local EBP coordinators. The health factor data are inherently messy. There needs to be education about what can be extracted from the data. Right now they are looking nationally at who is using the templates. There is a push to help people use templates in an efficient way. Knowing what sections you need to fill out and what is most helpful. The EBP training programs are training staff in template use in their training materials. There is also work on trying to figure out a good solution for groups and templates. Our section is looking for some minimum number of health factors to attach to a group note so that people don't have to create a separate note for each group member.

AVAPL expressed congratulations that the templates have been rolled out. Unfortunately the contract ended before testing was complete for all the templates. They have received feedback but it has been difficult to make changes very easily. To add even one character, it has to go back nationally to be tested.

How do we measure and know what we are getting from treatments? In addition, what about Veterans who might report that they are not getting better because they believe it will help with service connection? The interesting thing about medical utilization is that it does not require them to say they are all better from PTSD and can provide good data. It can be documented that it is helping and they are doing better, which is cost effective.

AVAPL expressed praise for the way things are moving and support for Dr. Smith in the role.

Dan Kivlahan, Ph.D., National Program Director, Addictive Disorders, Measurement-Based Care (Phone)

MH leadership will soon initiate the Veterans Outcome Assessment which involves baseline and follow-up telephone interviews with a national sample of Veterans beginning new episodes of mental health care. A preliminary consensus interview tool was developed ~ 2.5 yrs. ago. It included a cohort from each of six pilot facilities, who were assessed with the PCL, PHQ 9, and some functional status tools. They were able to get a modest initial response rate. Of those who completed the baseline assessment, there was ~90 day follow-up with 2/3, providing some indication of feasibility for this method. However, the need to ask about multiple co-morbid conditions made the phone interview too lengthy to be practical. In moving to an approach that was not disorder specific, leadership wanted to look at Veteran experience of care, recovery, functional status, general distress, recent alcohol and drug use, and selected items from the WHO Disability Assessment Schedule. The Veterans Outcome Assessment resulted in around 40 items which were piloted and found to be feasible in a 20-25 minute phone call. It was submitted to Office of Management and Budget (that reviews all federal surveys as part of the Paperwork Reduction Act) in the summer of 2013 and was finally approved in November 2014. The sampling plan involves Veterans beginning new episodes of MH care with numbers suitable for estimates of change quarterly on a national level (approx. 400 follow-ups per quarter), and annually with less precision at a VISN level (<100 per VISN). Once follow-up data are available for analysis in Q4FY15, there will be validation with other available metrics (e.g., from administrative data). Due to budget constraints that limit the number of callers, it is premature to know whether assessment targets can be achieved as originally planned and how long it might take to accumulate sufficient data for even national estimates. So, despite aspirational discussions in leadership for several years, we do not yet have results of systematic outcome evaluation for outpatient mental health services.

A separate initiative involves implementation of measurement-based care to improve outcomes for those who remain engaged in treatment. We need modern health informatics tools to gather information and display it timely to patients and providers. There are projects underway to develop such tools, including a mobile application for prompting and collecting patient reported measures of symptoms, but that is not expected to be available until late 2015 and implementation will likely take well into the following FY.

Dave Oslin of VISN 4 MIRECC has worked on incorporating measurement-based care into the Behavioral Health Lab (BHL) that is being used at several dozen facilities, Further development will take other IT support and hardware such as tablet PCs that have been used by clinicians in Philadelphia to facilitate the interview process and data entry in MHA. A more optimal approach will require direct patient entry of responses outside the clinical encounter (such as in the waiting room or from mobile devices) to avoid inefficient of limited clinical time to complete the relevant assessments during the encounter. Longer term questions include how to get measurement-based care up to scale overcoming IT barriers at each site? For some, it raises the question of how we can have a modern healthcare system when the person in charge of VHA does not have control over healthcare informatics?

In addition to being able to collect the data efficiently, VHA needs to develop an analytic infrastructure to use the data appropriately. There is a tendency for leadership to expect good news out of data like changes in the PHQ-9 without considering potential biases like differences in severity between programs and who remained engaged in care vs. early drop-outs. Without critical analyses, aggregate data could be used inappropriately. Despite the promise of "Big Data" (lots of numbers), we need to be cautious about whether and how aggregated results can inform the future of mental health policy and practice.

The group discussed EBP implementation and non-LIP providers' participation in roll out of EBPs. As we move toward decentralization of the EBP roll-out efforts, it may be important to concentrate on training those that can get facility support for schedule flexibility to deliver psychotherapy and be local champions, consultants and clinical supervisors. In the context of team-based delivery models, how do we raise the quality of care and keep people working at the top of their professional credentials? To promote improved access to EBP, the importance of patient education about EBP and the impact of patient preference, values, and strengths was emphasized. EBP practices are those that work better "on average," but EBP care does not necessarily mean effective care for an individual Veteran. The importance of measurement-based care is to recognize that providing an EBP and does not mean it will work and we need to monitor treatment response to see if it does work or alternatives need to be considered.

Up until FY15, there were 9 domains on the Strategic Analytics for Improvement and Learning (SAIL) report. There was no explicit emphasis on MH, although some data on MH access and screening was incorporated in general domains. Leadership appropriately questioned "Can a facility be doing well without tracking MH services?" This led to a brief window to select some initial MH quality metrics for FY15 based largely on expert consensus. There was limited opportunity to validate those measures as being closely linked to clinical outcomes. There was understandable confusion from the field: What is this new metric? What are the specifications? Why are my numbers so funky? All SAIL data are graded on a curve so that there is a distribution that will always show a bottom tier (e.g., lowest 10^{th} percentile). However there are also some mechanisms that allow facilities to show improvement over time. One component of the MH domain includes some info from the mailed Veteran MH Satisfaction Survey to a convenience sample of new and continuing patients approximately once per year. The satisfaction data are still not telling us much about symptom or functional outcomes. The satisfaction

component also incorporates data from the anonymous MH provider's survey which is administered 1x/year.

There is progress in having the Veteran experience of MH care being reflected in a prominent metric but facility-level information is not informative about programs and annual administration is not sufficient for tracking change. Other data elements in the MH domain of SAIL include a continuity measure to show transition from inpatient to outpatient care and some diagnostic cohort specific measures of initial outpatient engagement (i.e., do new psychotherapy patients with PTSD remain for 3 encounters within the first 6 weeks)? Implementation of the MH SAIL domain is intended to promote a culture change to look at system issues (including staffing, space, productivity, MH population growth) which is a departure from prior emphasis to focus efforts on improving performance on a specific metric in isolation. We need to look at the systemic response to the overall pattern of measures to inform planning and quality improvement vs. the reactive model to "improve the score". SAIL makes up 40% of Network Director's performance plan so it gets close attention from leadership.

Dr. Kivlahan discussed working on clinical practice guideline development with VA and APA models. There are VA/DOD guideline efforts underway to revise the Depression and SUD guidelines and PTSD will be revised in FY16. Concerns were expressed related to the lack of implementation of guidelines and the challenge to accurately monitor implementation was discussed. There is little evidence that publishing guidelines (passive dissemination) motivates practice change. Many times providers need answers to targeted questions quickly and don't have time to read 80-100 pg. guideline. Also needed are decision support tools for providers and patient decision aids that could be used to inform ongoing clinical work.

The VA guideline development contract is now accelerated with a timeline of approximately one year for completion. There is a charter from the VA/DoD Health Executive Committee as well as an expectation of completion of 4 guidelines (or revisions) each year. Some years none got through and in FY14, they completed 7. Guidelines become outdated in just a few years due to changes in the evidence base, but some have not been updated for 5-7 years. Guidelines along with systematic reviews are very expensive to complete by a single organization. As foundational documents, they may not receive close study by the target group of providers, but they may help a program leader more leverage to advocate for a particular clinical/research action if it is recommended in the clinical guidelines.

There have been recent funding sweeps within VHA, including MHS. This also directly affected colleagues involved with the MH and SUD Quality Enhancement Research Initiative (QUERI). The fund sweep has affected SUD QUERI projects that were approved already such as a trial of implementation strategies for alcohol care management in primary care. Overall, millions in funding were cut for already funded QUERI projects. This is a chilling message for junior investigators that peer-reviewed funding approvals may not mean funding and some commitments may not be sustained.

Katy Lysell, Psy.D., National Mental Health Director for Informatics (Phone)

Dr. Lysell spoke about IT and IT challenges. As background, there aren't enough IT resources to meet the demands of the agency. There are a lot of regulations within VA, and Congressional oversight of how IT dollars can be spent, more so than other parts of the budget. On a positive note, VA got as increase in its FY16 IT budget (proposed, not yet finalized), whereas other agencies have all had IT cuts to their budgets for FY16.

Current Projects/Activities:

- At the time of the mid-winter visit, Mental Health had been informed that a new major IT project was prioritized in the FY16 budget and had survived a recent round of cuts. This project is the MH Quality and Clinical Outcomes Reporting System. At the time of publication, this project has received approval to start planning in the fourth quarter of FY15 and is projected as a large, multi-year IT initiative for MH. The Quality and Clinical Outcomes Reporting System is intended to provide reporting tools that will facilitate tracking the flow of Veterans throughout the entire system of mental health care, and integrate outcome measures in support of reporting for measurement based care. This is a high priority for both VHA and VA with regard to mental health services.
- In FY15, a new project was started for Clozapine Coordination. This is a multi-year effort to improve the management of the process for prescribing Clozapine and meeting the Food and Drug Administration requirements for Clozapine registry and monitoring. As an example of challenges, this project was originally submitted for funding in FY10, and it took five years to obtain funding.
- Mental Health Assistant (MHA) enhancements: most psychologists are familiar with the MHA software, which administers and scores a library of standardized assessment instruments. An active IT project, which focused primarily on adding new content to the package was put into a paused status in February 2014, after potential patient safety issues were identified with a tool that had been implemented to handle "complex scoring" instruments. This tool, the MHA_AUX_dll, was not recognized by CPRS, leading to potential for erroneous MHA test results in clinical reminders and health summary. MHS has been actively lobbying to get the project restarted, and as of the time of publication of these notes, has just received word of approval on a multi-year project. This will include releasing fixes to instruments that have reported errors and releasing the PCL-5 and other content that had been developed but paused last year (see attached list of errors to be fixed and new instruments to be included in first release of new project).
- Support for migration from PCMM to PCMM-Web: The Primary Care Management Module (PCMM) is the software tool for identifying MH teams and MH Treatment Coordinator (MHTC) role. A new, web-based version is being developed and deployed. MH Informatics staff (Julie Wildman and Manny Garcia) are providing MH input into the overall development effort and will be providing training to the MH PCMM Coordinators as the software gets deployed (has been delayed but targeted for initiation in fourth quarter FY15).
- MH Suite—treatment planning software. MH Informatics staff (Jennee Evans and Manny Garcia) provide ongoing education support around enhancements and successful implementation of the MH Suite software for MH treatment planning purposes.
- Web-based self-help program (Ken Weingardt, Carolyn Greene)—the team has worked on development and implementation of several web-based self-help resources (available at www.veterantraining.org), including courses on problem-solving (Moving Forward), parenting, and recently launched anger management course. Current plans are for development of course on management of insomnia symptoms.
- Mobile app (Julia Hoffman)—efforts are currently underway for development of mobile app in conjunction with the Connected Health program office to support MH measurement based care. The app, labeled MH PRO, will allow providers to assign specific patient self-report outcome measures to be completed remotely and sent to the provider. Results will be stored in the VistA MH files, integrated with other test administrations from MHA. This should be available for initial implementation early in calendar year 2016.

Unfunded Requirements

- As part of the Clay Hunt Bill, Congress included a requirement that VA provide information regarding all MH and SW programs available system wide via the internet. Our current efforts are focused on updating the program locator service. However, no additional funds were made available as part of the legislation. New unfunded mandates, such as this project, draw away from other activities. This current effort is still in an analysis phase, and remains unfunded at this time.

Discussion/Q&A:

Q: Can MHA tests be administered in VistA?
A: The VistA psychological assessment option (roll and scroll) was available until 4-5 yrs. ago and is now gone forever. In the past, you could go into VistA, sign in and complete psychological testing in VistA. This was the original format for the psychological testing package, and was replaced by MHA. It did not include required security features to prevent patients who were completing tests from accessing other computer programs. It has been inactivated as a VistA option.

The other component to direct patient administration of testing is the Secure Desktop software component of MHA. This is intended to lock down the computer to allow patients to complete MHA instruments online. When Windows 7 was implemented, it was identified that Secure Desktop could be overridden. This is a known issue that has been caught up in the pausing of the MHA project. It is scheduled to be addressed in the recently approved MHA project

Q: Are there other options for patient administered assessments, such as using tablets or mobile apps?
A: There are efforts underway (MH PRO mobile app) looking at briefer symptom monitor screening assessments. This will be designed in HTML 5, which is essentially a mobile web page, so can be accessed on mobile phone, tablet, or PC. The assignment of an assessment can be sent to a patient through secure messaging mechanism. There are some individual facility projects looking at use of tablets, but at this time, the Connected Health Office has primarily focused on tablets for providers, rather than for patient use.

Q: Is it ok to purchase software to do some psychological testing?
A: Yes it is. Every facility's ISO and IT resources are different. Some have been successful and others have been totally unable to do it. They have not tried to look at proprietary psychological testing software purchases at a national level, but they can be purchased locally. Using test publishers' online testing and scoring services gets more complicated, primarily around the issue of test data ownership. VA needs this to be VA owned, within our firewall, whereas for most of the test publisher systems, they own the test data and maintain their own database. We recognize this is a service that would be of benefit to many psychologists, but there are numerous challenges to navigate.

Q: Is there a way to get data from apps like PE coach?
A: No. It is an independent standalone that was intentionally designed as a self-help tool. It is recognized that sharing information with providers, using the tool as a therapy adjunct, is desirable. Unfortunately, that adds significant complexity and cost to the development process. The Connected Health program office is currently working on development of mobile apps that are "connected", passing information to the Patient Generated Database, but we do not have any published apps that have this capability at this time.

Q:How is the collaboration with the DOD system going?

A: In terms of interoperability of electronic health records between VA and DoD, there have been a number of transformations over the years. The initial charge was to integrate, but that was ultimately viewed as counterindicated. Currently, the plan is that VA will stay with VistA. They will move VistA forward to be more web-based. Efforts are focused on VistA Evolution and the eHealth Management Platform (eHMP) to update the current VistA, CPRS system. DOD has made the determination that they will purchase a new system. There have been positive efforts toward interoperability. Five facilities deployed the capability of viewing CPRS and DOD records together. Medications and labs were both displayed in integrated fashion. They are looking toward wide-spread deployment, but are still working through details of information sharing before moving toward broader implementation at a national level.

Additional Information/Comments provided by Dr. Lysell after the February meeting during editing:

MH Informatics has taken the lead on a workgroup regarding psychological assessment policy. Psychological assessment has not had ownership in a "clinical" section in MHS, but has typically fallen under the purview of the Informatics Section since MHA is managed by informatics, and we handle all of the psychological testing contracts. Currently, there is no national policy related to psychological assessment records. Dr. Manny Garcia has taken the lead. The group is developing guidance regarding records retention and release of information. They are looking at what is required from an ethics, privacy, and HIPAA perspective. There will be comprehensive guidance around this issue. The draft may be shared for review and input, expected late in the fiscal year.

Planned Upcoming Additions to MHA:

ASSIST-NIDA	NIDA Version of Alcohol Smoking and Substance Involvement Screening Test
BRS	Brief Resiliency Scale
BSL-23	Borderline Symptom List
CAM	Confusion Assessment Method
CCSA-DSM5	Cross-Cutting Symptom Assessment
CEMI	Client Evaluation of Motivational Interviewing
CSI	Couple Satisfaction Index
DBAS-16	Dysfunctional Beliefs About Sleep
DERS	Difficulty in Emotion Regulation Scale
FAD	Family Assessment Device
FOCI	Florida Obsessive Compulsive Inventory
IMRA	Illness Management and Recovery Assessment
ISI	Insomnia Severity Index
KTZADL	Katz Index of Activities of Daily Living--Modified Scoring
MDQ	Mood Disorders Questionnaire
PCL 5	PTSD Symptom Checklist for DSM 5
PSOCQ	Pain Stages of Change Questionnaire
PSS	Perceived Stress Scale
QOLIE-10	Quality of Life in Epilepsy-10
QOLIE-31	Quality of Life in Epilepsy-31
RLS	Restless Legs Syndrome Rating Scale
SOCRATES-8A	Stages of Change Readiness and Treatment Eagerness Scale-Alcohol

SOCRATES-8D	Stages of Change Readiness and Treatment Eagerness Scale-Drugs
SST-VOF	Social Skills Training-Veteran Outcome Final Visit
SST-VOI	Social Skills Training-Veteran Outcome Initial Visit
STOP	Snoring, Tired, Observed, Blood Pressure
WHOQOL-BREF	WHO Quality of Life
YBOCS-II	Yale-Brown Obsessive Compulsive Scale--II
YBOCS-II Symptom	Yale-Brown Obsessive Compulsive Scale--II Symptom List

Current errors in MHA that are to be addressed in next patch:

AAQ-2

Problem: There is a typo in the Scoring Key file for "Seldon true". Since there isn't an exact match with the Choices file "Seldom true", 4 of the questions (2, 3, 4, and 7) do not score correctly.

BAI

Problem: Interpretive statement included in report is erroneous
Solution: Revise report to use interpretive statements found in BAI manual

Barthel

Problem: Two items have incorrect scoring values: Walks with help of one person (verbal or physical) This has a score value of 5. It should be a score value of 10; Independent (but may use any aid, e.g., cane) This has a score value of 5. It should be a score value of 15.

CIWA-AR

Problem: Some text was missing from the instrument presentation. Also, some text was presented in incorrect order.

MCMI-3

Problem: The scoring of the MCMI-3 automatically passes outpatient status, leading to incorrect scoring for inpatients.
Solution: The scoring criteria are updated-previously had automatically inserted outpatient status and did not allow for calculation of scores based on inpatient status.

MMPI-2-RF

Issues Addressed:
a) Made minor formatting changes in the Instrument Results Review option output such as "Higher Order" to "Higher-Order".
b) In the Instrument Administrator option, fixed a problem with the progress bar color to correctly indicate when all questions are answered.
c) When this instrument was released two questions, 305 and 306, were displayed in reverse order which also caused a scoring error. These two questions are corrected..

MoCA, MoCA Alt1, and MoCA Alt2

Problem: There is an error in the way the, MoCA and its' alternate forms, MOCA ALT1 and MOCA ALT 2 are scored. This resulted from a spelling error in the scoring algorithm.
Solution: The scoring error is fixed for all three instruments. An additional statement was added to the report text for each of these three instruments to explain the scoring.

Quality of Life Inventory QOLI

Problem: The order of the questions was incorrect, leading to incorrect display order
Solution: Items are re-ordered to display in the correct order.

February 11, 2015: Meetings with Dr. Jill Draime, Dr. Heather Kelly, and VSO's

Jill Draime, Psy.D., Acting VHA Chief of Staff

Dr. Draime came into VA as psychology intern and worked at the Cincinnati VA. She worked in the National Center for Organization Development. She has been Acting Chief of Staff working in D.C. for 4 months. It has been a difficult time in VA with the loss of the Under Secretary and then the Secretary. There has been a flux in leadership, congressional pressure, and media pressure. At this time at least, the acute crisis phase is over but there is a steep hill in front of us. Dr. Draime expressed optimism in regard to where VA is heading and the opportunity to reinvent ourselves. The Blueprint for Excellence is overarching umbrella as we move forward. Two areas of focus are access to care and an exceptional Veteran experience. We have a clear destination and need everyone to work toward these organizational priorities. AVAPL emphasized the focus of access in their year's conference.

Dr. Draime highlighted that employees at all levels are impressive and doing extraordinary things. What does it mean to lead in an access crisis? What can we do as individuals and leaders moving forward? The Secretary is very clear in regard to the importance of MH and knowing that it is an incredible priority for the organization. It continues to need support from a leadership standpoint.

Is there any sense of a timeline for the VISN and CO firing freeze? During the National Leadership Council meetings, the leadership team came together to discuss how to get to where they are going. There is a need to take a serious look at function and structure and where the right place is for an activity to take place. VISNs were created to be mini living laboratories. They were meant to have 10 or fewer people but some have grown to up to 150 people. There were requests for oversight that required VISN-level management which impacted this. CO has grown as well. Mike Mayo-Smith, VISN 1, and Patricia Vandenberg, ADUSH are leading the group taking a look at this question. They hope to come back to senior leadership with what the function at CO and function at the VISN level might look like. The form will then follow function. Until that work is done, in regards to the hiring freeze, we won't know what is going to exist and in what form.

There was discussion regarding the growth in the training programs and how they develop the next generation of employees who are invested in the VA system. Psychology trainees get the best experience in regard to breadth and depth. Staff are dedicated to training future psychologists. Many trainees coming out of internship want to go into employment with VA. We need to take the best people into internship and work to keep them. At times, there are hiring difficulties that impact the ability to hire interns completing VA internship and the cert says "completed internship process." Psychologist leaders in particular are important as growth is wonderful but also stressful. Dr. Draime asked if there had been difficulty getting interns after the recent crisis. It does not seem to be affecting who we draw for internship. Previous Chief of Staff, Lisa Thomas is a psychologist and is now ADUSH for Workforce Services. She is an ally in terms of HR policies and how to get the information out to field HR officers in terms intern hiring. She may be a good contact that likely would be happy to help.

In regard to the difficult loss of Dr. Fjordbak, these has been a lot of discussion regarding supporting each other. Trainees are insulated from a number of issues, with postdocs being less insulated.

Space continues to be a challenge. In regards to CHOICE, Section 301 is related to providing a staffing report. There are difficulties with HR and then there is nowhere to put new hires. There may be creative but legal ways to help with space issues. Some sections are moving off-campus such as administrative and clinical function services.

There is a VA crisis with problems related to access and staff but we still love the VA and Veterans love it. A vast majority of Veterans want to stay in VA rather than go out in the community. We offer something special. We are Veteran care with a holistic approach. We share their mission and approach well-being in a special way.

Dr. Draime highlighted that the VA has the greatest mission with greatest employees. One issue is that Veterans who are already in care can be seen easily, but those new to the system are more of a struggle. We struggle to get them connected to the system with providers and clinicians. Once they can connect with the people in organization, they are happy. PCMHI is striving to be that first face within VA. We need to excel in our relationships and provider contact.

Dr. Heather O'Beirne Kelly, Ph.D., Lead, Military & Veterans Policy, APA

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

- **Improving Mental Health Care Access for Veterans**
    - Continued, increasing support for primary care-mental health integration and recovery models
    - Suicide prevention expansion
    - Support for VA research, which builds the knowledge base for and facilitates implementation of best practices in treatment
    - Expanding treatment services once Veterans have access
    - With increased non-VA care services being supported, assuring that non-VA providers are competent in Veteran-specific needs and Veteran culture
    - Continued support for expansion of telemental health services
    - Building on the success of evidence-based psychotherapy (EBP) roll-outs
    - Expanding evidence-based assessment standards

- **Addressing Hiring and Retention Challenges for Psychologists**
    - New VA-OIG Report notes that psychologists are 1 of top 5 disciplines in need of recruitment.
    - For remote areas or areas with high competition, improved incentives (particularly loan repayment) can be a critical factor in attracting strong candidates.
    - For psychologists, Hybrid 38 has improved some hiring processes.

- **Addressing Concerns with Compensation and Pension (C&P) Evaluations**
    - Concerns related to the dual role involved with completing forensic evaluations and therapeutic services for the same Veterans
    - Access of Veterans to C&P exams (as well as mental health records) in CPRS, without any ability to provide guidance or interpretation, is leading to Veteran anger and frustration, and in some unfortunate situations, threats towards examiners.
    - Efforts to separate C&P responsibilities (which is a VBA role) from VHA (which is otherwise an institution focused on Veteran care) could reduce these conflicts.

- **Space/Contracting for Leased Space**
    - Space limitations significantly constrain the ability to expand access to patient care.

- In competitive real estate markets (e.g., San Francisco, Los Angeles, Boston) the inability of the VA to implement a lease in a timely fashion undermines the ability to expand services in needed areas.
- As an example, San Francisco's Veterans Memorial Building wants to lease to the VA. However, we have to go through the VA lease process, which is taking years. Meanwhile, we have a current MH space deficit of 11,400 square feet.

- **Travel for Training (ACES)**
  - Need to expand opportunities for staff training in state-of-the art interventions, and remove or reduce barriers to conference attendance

- **Safety Concerns Within VA Facilities**
  - Recent tragic events highlight the rare but concerning possibility of violence towards providers.
  - We applaud efforts to expand workplace violence prevention programs. However, implementation has been inconsistent across VA settings.

Meeting with the Veterans Service Organizations

Joy J. Ilem, Deputy National Legislative Director, Disabled American Veterans
John M. Bradley, Senior Advisor, Disabled American Veterans
Shurhonda Love, Associate National Legislative Director, Disabled American Veterans
April Commander, National Field Service Representative, The American Legion
Warren Goldstein, Assistant Director for TBI and PTSD Program, National Veteran Affairs and Rehabilitation Commission, The American Legion
Glenn E. Minney, Director of Government Relations, Blinded Veterans Association
Michael O'Rourke, Assistant Director of Government Relations, Blinded Veterans Association
Janet Handy, Senior Associate of Individual Giving, Iraq and Afghanistan Veterans of America
Sarah S. Dean, Associate Legislative Director of Government Relations, Paralyzed Veterans of America
Carlos Fuentes, Senior Legislative Associate, Veterans of Foreign Wars
Thomas J. Berger, Executive Director, Veterans Health Council & Senior Advisor on Veterans Health, Vietnam Veterans of America

AVAPL discussed the possibility of emailing VSOs a few weeks prior to this meeting in order to request important topics so that all members can be better prepared to discuss important issues.

The issue of gun safety and responsible gun ownership was discussed in great detail. The importance of clinicians being able to ask about access to legal means especially during a suicide risk assessment were highlighted. The relationship between the Veteran and the clinician is the key to having an open conversation about safety. AVAPL and VSOs agreed that the issue was not about taking Veterans' guns away. VSOs were asked for input on maintaining a respectful and productive discussion with Veterans regarding gun safety. A question regarding guns and gun safety was recently included in a Veteran survey and so they will have more data on how Veterans feel about discussing this issue. Both groups discussed contacts and ways to continue to communicate and advocate about this important issue.

A question was posed regarding the connection between MH treatment and the law prohibiting some people who have been in mental health treatment from buying firearms. The possibility of having a fact sheet regarding this connection was discussed. There are questions asked at the time of gun sale related

to a history of MH treatment or psychiatric hospitalization. The potential sale is stopped if there is a positive response. Some patients might avoid MH treatment for this reason. VSOs highlighted state differences such as California having a law against giving your weapon to someone else who has not had a background check. AVAPL agreed that this was important information to be related to Dr. Caitlin Thompson. The DOJ might be an important party to involve in discussions about any new laws in this area. VSOs asked if clinicians are comfortable talking about gun safety. There likely are some clinicians that are not knowledgeable and so are not comfortable.

There is a section of Veterans that do not trust the VA and choose not to get their care within the VA. The important of training community providers on working with Veterans was highlighted. The recent news regarding CPT codes for obtaining a military history, PTSD consultation being open to the community and the dissemination of the toolkit was shared with VSOs.

The concern from National Guard and Reserve that VA medical records would be shared with DOD and negatively affect their career was discussed. The importance of serving this community was emphasized. AVAPL reported that VA facilities serve this population differently as there is nothing standard. Some are very involved with local Guard and Reserve and participate in activities such as yellow ribbon events.

VSOs highlighted the struggle of Veterans in remote areas obtaining care. Telehealth and the expansion of telehealth to the home was highlighted. Younger Veterans are likely more comfortable with telehealth services due to their experience with skype and other technology, including during deployments. VSOs asked if providers are provided enough time to provide telehealth and secure messaging services. AVAPL shared that many times this is done in-between sessions or during no shows. There is no standard protocol and guidance for specific time is done at a local level.

It was expressed that clinical reminders done during patient encounters take up a lot of time during care. It was acknowledged that it can make it difficult to build a relationship.

There was discussion regarding recent funding changes in regards to the Query programs. The group acknowledged the need and value of research in VA. The group discussed how we can advocate for the continued importance of research.

VSOs asked about the use of CAM within VA. They highlighted that CAM is being renamed to include “integrated care” rather than “alternative.” AVAPL discussed that at times it is unclear which activities should be included in care as they differ in their research basis. One needs to look at the references and clinical studies done on various techniques. It was also highlighted that some techniques such as relaxation are done regularly throughout the VA. The issue of therapy dogs was briefly discussed. Various opinions were provided including the struggle between therapy and support animals. The importance of certified and well trained animals was stressed.

VSOs suggested the potential of CAM being used in the process of opioid decrease rather than a Veteran going “cold turkey.” The struggle with opioid prescription and use was discussed. The potential for the process of decreasing/terminating opioid use increasing violence in clinics was mentioned. Integrated care and the collaboration between pain management teams, primary care providers, and likely MH was highlighted.

One issue put on the agenda for the next meeting is the role of MH in judicial Veterans Courts.

AVAPL expressed thanks for the meeting and praise for the collaborative and informative nature of the discussions.

February 13, 2015: Meetings with the American Psychological Association
Heather O'Beirne Kelly, Ph.D., Lead, Military and Veterans Policy, Science Government Relations Science Directorate

Howard Kurtzman, Ph.D., Acting Executive Director and Raquel Halfond, Ph.D., Project Officer, Clinical Practice Guideline Development

The initiative for the Clinical Practice Guidelines began in 2010. It is focused on disorders or conditions and the treatments directed towards them. It is meant for guidance to clinicians, patients, and payers. The Guidelines include clinical experiences, patient experiences, and research. They use the Institute of Medicine standard for guidelines. Current projects in the developmental panel: PTSD, Depression, and Obesity.

The PTSD guidelines are the furthest along. A systematic review of efficacy and comparative effectiveness is being completed. They also look at harms and burdens. There are community representatives on the panel as well as community members such as the Executive Vice President of Wounded Warriors. The group is working to develop basic recommendations, looking for gaps, and determining how best to word these recommendations. After a draft is prepared, it is sent out for comment which may be in the mid- to latter-half of this year. After the public comments, changes will be made if appropriate. AVAPL can assist with distributing this draft to AVAPL members through the listserve.

The Depression guidelines workgroup is being chaired by Dr. John McQuaid. The panel has spent a lot of time determining the scope and focus of the guidelines. It is not feasible to cover all aspects of treatment for all aspects of depression. What treatment outcomes should be the focus? What are the biggest questions for clinicians? Where is the most evidence? They focus will be on Major Depressive Disorder, Dysthymia, and some comorbidity in the population group of adolescents thru older adults. They will look at psychological, pharmacological, and CAM treatments. Guidelines will also include recommendations on where research needs to go. The difficulty with the role of non-specific factors, common factors, and how you capture these will be discussed in the document but the guidelines will focus on treatments.

The Obesity guidelines are focusing on children and adolescents. The focus will also be on behavioral treatments which received less attention in previous guidelines.

Questions that were posed: How do you facilitate between APA and VA/DoD clinical guidelines going on at the same time? How can we improve communication between the groups? What do clinicians do if the guidelines come out different? The group discussed the different audiences that the two guidelines target, but also other issues such as insurance and payment issues that are addressed in APA guidelines.

APA is attempting to develop a strategic plan to disseminate and increase utilization of guidelines. One consideration was whether both sets of guidelines could be put within MHS under references for VA providers to access. AVAPL can follow up with Dr. Katy Lysell.

Recent changes in the VA QUERY research program were discussed. A brief explanation of this program was provided and a discussion pursued about the recent termination of funding for approved projects in order to shift funding to VACAA research. The importance of these critical studies to implement science into practice was highlighted. Support for continued research within VA was discussed.
The Center for Workforce Studies is housed in the science directorate but overseen by all 4 major directorates. It has a targeted focus on psychology workforce, income, debt, need for psychologists, subfields, and geographic regions. They gather information from their surveys and include information from other sources. One project is the Health Service Provider Survey which will be out to field in about a month and will target practicing psychologists in mental and physical healthcare. Questions will be about their work settings, income, education, training and such. They hope to learn more about what the work life of today's practitioner looks like.

AVAPL stated that they may be able to provide reports on VA staffing to add to the information they collect.

Public Interest Directorate
Gwendolyn Puryear Keita, Ph.D., Executive Director; Andrew Austin-Dailey, M.Div., M.S., Director of the Minority Fellowship Program and Deborah DiGilio, MPH, Director, Office on Aging

There are Transgendered guidelines that are being worked on at this time.

There is work being done with the Justice Department with parents who are in prison, and services to help parenting skills.

There is a Health Disparities Program looking at smoking and stress in boys and men. There will be a Work Stress and Health conference in May in Atlanta. There is an HRQ on smoking that APA is working on with a group out of California. They are also working on an app for clinicians to provide information on the harmful effects of smoking and how to best treat tobacco-use disorders.

Andrew Austin-Dailey is the director of the Minority Fellowship Program. They have helped train 100 individuals since 1974. The focus is on those interested in working with ethnic minority populations. Many go into VA practica, internships and employment. They just started a program for terminal masters-level practitioners. It is a fellowship for those interested in Services for Transition-Age Youth (STAY) in ethnic minorities.

The Recovery to Practice initiative received SAMHSA contracting funds to complete. It is a curriculum for psychologists in training on MH recovery for those with SMI. It is based on the Larry Davidson recovery model. The curriculum is 15 modules and is free to download at www.apa.org/pi/rtp.

Deborah DiGilio in the Office of Aging has been really involved with VA for the past 14 yrs. There are VA representatives on the Committee on Aging. They have a new fact sheet, "Integrated Health Care for an Aging Population." There is a free handbook, "Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists" that can be downloaded at
http://www.apa.org/pi/aging/programs/assessment/capacity-psychologist-handbook.pdf

There is also a new CE program where you can get CEs for reading material online
http://www.apa.org/education/ce/

Also available is the Family Caregiver Briefcase which includes facts, interventions, assessment tools and resources. There are sections in there for patients and caregivers.
http://www.apa.org/pi/about/publications/caregivers/index.aspx

Practice Directorate
Lynn Bufka, Ph.D. Associate Executive Director, Practice Research and Policy

Dr. Bufka highlighted her pervious training in VA. The Practice Directorate focuses on research and policy work on behalf of practicing psychologists. The areas she oversees include: EBT, accountability, and outcome assessment. Within the government relations team, there is work being done related to the Medicare definition of physician and who is included. The legal and regulatory team works on issues related to insurance companies, parity, scope of practice, and telepsychology, and they take calls from members regarding issues such as subpoenas. The advocacy department works with state associations. The State Leadership Conference works to educate leaders in psychology on how to take issues to state legislation, advocacy on the hill, and overall leadership develop. The communications team works on the practice update e-newsletters for members and the public education campaign.

Dr. Bufka highlighted that the APA Practice Organization is a separate 501 (c)(6) organization from APA. This organization is able to advocate on behalf of licensed psychologists with the separate dues assessment. APA cannot advocate in the same way.

They are currently working on promoting and elevating what psychologists are doing. They are working to help members understand the growth within primary care and the movement to have care in that setting. How do we help people shift and get trained?

AVAPL provided information regarding the ability of community providers to utilize the VA PTSD telephone consultation. In addition, the web-based military culture training (with CEU) and toolkit were highlighted. APA stated that they could assist in distributing this information.

Dr. Bufka stated that VA does not reach out to her regarding practice issues. AVAPL highlighted the variability of credentialing and privileging for VA staff across VA. There are still sites where psychologists do not have privileging. In the legal and regulatory section, there are 5 attorneys that focus on psychology practice and members. APA can be a partner in advocating if needed.

Ethics Office
Stephen Behnke, JD, Ph.D., Director

Dr. Behnke highlighted that his office is available as a resource if needed as well as for activities such as workshops or in consultation.

The Ethics office has 4 main activities: adjudication, education, consultation, and special projects (e.g., responding to humanitarian involvement, interrogation). Groups may reach out to the ethics committee regarding different issues such as telepsychology. They may write an article from their perspective on how to do telepsychology in an ethical way and produce clinically sound work. There was on article in *Psychological Services* regarding a discussion on how telepsychology is working. Dr. Behnke has been working with 3 VA staff whom he stated he would provide to AVAPL to follow up with them on this issue.

Dr. Behnke was asked regarding his opinion on some of the possible ethical concerns that have been brought up by the field regarding C&P exams. Specifically:

1. Is there a systemic dual role if VA staff are providing clinical services and then do the C&P exams?
2. Is it ethical for there to be a demand to do a large number of exams/day with a perceived lack of appropriate time to do complete a sufficient interview and record review?
3. Is there an ethical concern if the report is immediately accessible in the medical record and the patient can view with no clinical input into the results and conclusions? There can then be assumptions made by the patient about the outcome of the VBA decision.

Dr. Behnke stated that he would like some time to review these questions rather than giving a response at this time. He did state that ethics should follow best practice and asked AVAPL if there were guidelines/policies for the C&P exams that could help him better understand the process. AVAPL stated that they would follow up and provide more information to further this discussion.

Dr. Behnke was thanked for this time in discussing these difficult issues.

Education Directorate
Karen Studwell, JD, Associate Executive Director, Government Relations Office; Jacqueline Remondet Wall, Ph.D., Director-designee, Program Consultation and Accreditation and Catherine Grus, Ph.D., Deputy Executive Director for Education

Dr. Grus provided the committee with a copy of *The Educator* newsletter which includes updates from the Education Directorate. There was a highlight on the 2014 Education Leadership Conference. There has been a focus on professional psychology training. One project is related to primary care psychology competencies, which was taken up at the Council of Representatives and may be approved. If approved, this may help those that want to start training in this area.

The guidelines on supervision have been approved as policy. The Education Directorate is hoping to distribute more material so that programs can learn how to use them. AVAPL discussed that the VA has guidelines for interns and postdocs. Perhaps VA and APA could share information back and forth to see if they line up with each other?

They are working to develop more web-based resources for education and training. They are currently looking at what to cover and what resources there are to help them. There are currently 4 webinars on "Psychology's role in health care settings." These are available free of charge for education and training programs.

Dr. Remondet Wall discussed her work with OAA regarding accreditation issues. They are working to streamline some processes to improve some of the issues VA is having. Sixty percent of all postdocs are in VA settings. There are 85 internship and 63 postdoctoral programs with a few of them being multi-specialty. There will be site visitor training before the AVAPL conference. This pairing was praised. The commission will review 220-250 programs this year, including new applications as well as those coming up for accreditation. There are two new categories to submit: eligibility or accreditation-on-contingency. The eligibility category does not count to accreditation. The program can choose to put forth an illustration of the organizational structure, program, philosophy ,goals, outcomes, and competencies. The committee reviews the material and determines if they are on the right track. The accredited-on-contingency category includes a self-study with exclusion of outcome data. You can be awarded this status but need to submit outcome data by the time two classes have been completed. If outcome data

are submitted then, you are granted accreditation and the program has three years before a program review needs to happen again. Currently, four programs have been awarded this category: 2 internships and 2 postdoctoral programs.

The guidelines and supporting documents for how programs are evaluated for accreditation are being revised. There are new standards of accreditation over the past 3 yrs. which are more concise. They are also more assistive to help programs get through the process. They will likely be open for public comment in March. If the standards are approved, those with a site visit for 2017 or after will be subject to the new standards. There will be a roll-out as not everyone will move to the new standards right away.

Ms. Studwell is with the Government Relations Office. She helps work to train psychologists to go to Capitol Hill. There are advocacy efforts towards campus-based suicide prevention programs and discretionary funds. There was a $1 million increase for the Graduate Psychology Education (GPE) program to focus on Veterans and families of returning Vets. The 2015 Garrett Lee Smith Memorial Act was introduced to reduce youth suicide. Congressman Jolly from Florida is the Republican sponsor. APA is supporting that Act and working to support members of Congress who support VA. There is also a push to keep the focus on Geropsychology going.

Executive Office
L. Michael Honaker, Ph.D., Deputy ECO and Executive Director of Staff Initiatives

Dr. Honaker highlighted the new conference center built at the top of the APA building. It will be utilized mostly by APA but will also be rented out. He described that the building and renovations were completed without any money from APA dues. The funds came from revenue obtained from renters in APA buildings. They are also working to redesign APA space which is now 20 yrs. old.

Dr. Honaker was thanked by AVAPL for being a host to these meetings and the tour of the new conference center. The work by Dr. Kelly was highlighted and AVAPL expressed appreciation for all that she does to assist AVAPL.