AVAPL Mid-Winter Meeting Minutes

March 2017

Stacey Pommer, LCSW and Ken Jones, Ph.D.

Office of Academic Affairs

1) Initial items
    a. Dr. Gironda initiated the meeting by expressing thanks for
        i. General support of VA training
        ii. The extensive support to exempt trainees from the hiring freeze
    b. Ms. Pommer expressed appreciation for support from APA in efforts to exempt psychology trainees from the hiring freeze.
    c. Dr. Jones also stated his thanks for the efforts of many to resolve the issue. He noted that his office thinks APA efforts made a major difference and mentioned in particular the efforts of Drs. Heather O'Bierne Kelly, Karen Studwell and Cynthia Belar.

2) Issues discussed
    a. Dr. Jones shared that OAA has worked on dealing with PIV cards issues for trainees.
    b. They shared they had successfully launched a contract for OAA to paying dues for training program certification
    c. Regarding VA staff serving as APA site visitors, Dr. Jones shared that VA employees need to know that OAA has to pay for their travel. These processes are now being worked out.
        i. Because of the nature of the funding arrangement, Dr. Jones wants us to alert individuals that VA site visitors must be on travel duty status when serving as a site visitor (TDY).
        ii. We all discussed ways for disseminating this information. Dr. Jones noted his recent email provides guidance on travel, and they both mentioned that there is a weekly call addressing site visitor issues. Ms. Pommer is also drafting additional information for site visitors. Dr. Wan noted that there will be a site visitor training at the VA Psychologist Leader conference. Dr. Jones intends to go and discuss the travel issues. He also would like to start a site visitor mailgroup and asked the executive committee to request a list of VA staff who are site visitors. Dr. McQuaid suggested distributing the travel and reimbursement information to the administrative officers and business managers at relevant services. Dr. Jones will contact Dr. Carroll to get the relevant email list.
    d. Dr. Wan asked if you can't have 2 VA members on a team, and Ken said that is permissible. He noted that having both VA and non-VA is good for a broader perspective, but this concept is not codified in APA policy.

e. Ms. Pommer and Dr. Jones shared that OAA will continue the Mental Health Expansion initiative. The focus is on new internship sites, and they are aware of approximately 20 rural sites that do not have programs.
    i. Primary areas of training include
        1. Neuropsychology
        2. Physician Assistant training programs
            a. Dr. Jones noted this is unique in that PAs often do not have residency type training
            b. 1 year training
        3. They are continuing to expand LPMHC and MFT training programs (500 hour internship). He noted that the MFT programs have expanded very slowly due in part to limited number MFT staff in VA to participate in programs. If sites want to develop an MFT training program they should contact David Latini.
        4. New doctoral psychology internships.
f. Dr. Jones reported that Dr. William Marks has left OAA for a position Google Health (Verily). Kathleen Klink, MD is now in in the position of Chief, Health Professions Education.
g. Dr. Jones is now on the National Leadership Council Workforce Committee.
    i. He reported that the GAO has been encouraging OPM to address federal departments with longstanding shortages. The VA identified psychologists as well as psychiatrists and primary care physicians as top priorities.
    ii. Dr. Jones has proposed to add a section in VA focused on hiring trainees. He stated his goal is for the VA to get more benefit from its investment in training, noting that it trains enough individuals annually to fill its vacancies. He noted several problems in hiring trainees, including HR staff not always knowing rules related to trainee recruitment (e.g., posting a position as requiring a license when that is not actually the case). He noted that there is a workforce recruiting section, but he is not sure if it meets the needs of trainee recruitment. He also shared that there is a policy stating there should be a facility recruitment liaison to help with hiring, including trainees, but this has not been broadly implemented.
    iii. Dr. Kirchberg noted they have lost several trainees due to delays in HR. Dr. Shea noted the critical need for good HR support.

3) Wrap-up: Dr. Gironda asked for other items with which AVAPL could help.
    a. Dr. Jones asked that we ask APA for the contact information for all VA staff who are site visitors, so they can be contacted as needed.
    b. Dr. Jones also noted that feedback on problems from the field is welcome.
        i. Dr. Shea noted one problem has been the uniform match process for postdoctoral fellows. She shared that her site lost two top candidates to other sites that did not follow the rules. However, she also noted that it worked better than expected, and that she was looking forward to computer matching.

ii. Dr. Jones shared that they had investigated problems, and had found that VA sites had generally complied with the match rules. He also noted that computerized matching was close to implementation.
iii. Dr. Wan shared that it was important for sites to find out where trainees went when they go to other sites, and others agreed.

c. Dr. Gironda closed the meeting by thanking Dr. Jones and Ms. Pommer for the clear guidance they consistently provide to the field regarding hiring issues.

David Carroll, Ph.D.,

1) Initial items
    a. Dr. Kirchberg expressed thanks for Dr. Carroll's helpful communication during his presidency.
    b. Dr. Carroll in turn expressed thanks for AVAPL's support to VA, veterans, and advocacy for veterans.
2) General discussion
    a. Dr. Carroll started by noting that OMHO, MHS and the Office of Suicide Prevention all work closely together.
    b. Dr. McQuaid asked Dr. Carroll for his perception of Dr. Shulkin's perspective and direction, and Dr. Carroll indicated this was a primary goal for him in this meeting as well. Dr. Carroll perceives the transition as a time of opportunity.
    c. He noted that Dr. Shulkin is dogged in pursuit of his priorities, and he will bring that focus to the whole department. He has a special appreciation for the VA, and Dr. Carroll noted that the President has included veterans and mental health in his top 10 priorities.
    d. In terms of changes, he reports there is a greater sense of urgency. The message is "tomorrow is not an option." There is expectation of wholesale change rather than incremental progress. In this context, Dr. Carroll thinks this is a time to advocate for changes related to key priorities such as suicide prevention and access.
    e. He stated that Suicide Prevention is #1 priority, and there is an expectation of a "breakthrough on suicide prevention."
        i. This emphasis supports other initiatives including access and same day services. There is an expectation of open access to care across all sites.
        ii. There is also a need for increase in PCMHI. He noted that the PCMH5 measure (access same day in primary care) is up from 30% to 45% nationally, and needs to go higher.
        iii. There will also be an increased emphasis on depression treatment in relation to suicide prevention.
    f. Dr. Kirchberg asked about staffing to support these initiatives. Dr. Carroll indicated that sites should be able to backfill clinical positions. In addition, the Secretary is trying to address administrative and clinical positions. When asked about additional funding, he did not know if there was any support coming, although he noted that if there were additional funds they would likely be associated with suicide prevention (for example, accessing veterans not currently in the VA system).

    g. Suicide prevention goal

i. Dr. Shea asked about programs that had successfully reduced suicide, and Dr. Carroll indicated that the VA was looking at suicide initiatives adopted by Henry Ford hospital and other settings. These programs use a system-based approach to prevent suicide in all patients. The theory of adopting a goal to eliminate suicide is that it forces the consideration of all options, including partnerships with others.
ii. He also indicated that a national MH conference was being considered again with an emphasis on suicide prevention.
iii. Dr. Gironda shared that he had read the suicide proposal, and had concerns that framing these efforts in terms of a zero goal would have
    1. Dr. Kirchberg stated that to eliminate suicide, there needs to be a new way to assess veteran values, which is not currently part of standard assessments. He noted this would be much more time intensive.
    2. Dr. Shea pointed out the work of Nestor Gallarzo that long term recovery is a key approach to suicide prevention.
iv. Dr. Carroll noted that part of the challenge is the size of the organization. How do we create a standard and make sure it happens everywhere.
    1. Dr. Shea noted that REACH vet is interesting approach.
    2. Sam Wan reflected on the challenge in San Francisco where the Golden Gate Bridge is the site of many suicides. He noted that efforts for suicide prevention need to include a broad coalition (e.g., partnering with city and bridge authorities).
    3. Dr. Shea reemphasized the integrated nature of care "Everything is related everything else" in successfully preventing suicide. Notes that we have tools that work, and we don't have time to administer effectively.

h. Dr. Carroll provided an overview of other OMHO priorities.
i. They plan to continue the quarterly call around MH management and SAIL. Site visits will be conducted for hospitals in the lower two quartiles on the MH SAIL metrics, as well as visits for cause.
ii. OMHO continues to work with VERC partners around access
    1. They are trying to ty access to continuity, so that the emphasis is not solely getting veterans into care, but also having the necessary follow-up services. He noted that OMHO has a good relationship with Dr. Lieberman in access office.
    2. Dr. Gironda asked how AVAPL could help, and Dr. Carroll noted that he appreciated us supporting the message that access and quality need to go together. Dr. McQuaid stated that he had found OMHO guidance helpful for advocating for access and continuity resources at his local site.
iii. There is a continued expansion of Telemental Health
    1. VISNs are developing expanded capacity

2. Vacancies are being filled at a national level
3. Ten regional hubs are being established.

iv. Peer services are expanding.

v. There is an emphasis on improving collaboration with community partners
    1. He noted that OMHO recognizes a need for better communication with them
    2. He hopes that new CHOICE legislation will potentially help with improving quality control.
    3. Dr. Shea and Dr. Gironda noted frustration with no quality control and no constraints on inappropriate care. Dr. Carroll noted Atlanta had success using VA care managers. He thinks that would help. He noted that there has also been success with Triwest and Healthnet providers using TMH to provide services, noting this was successful in San Diego. He indicated that the vast majority of patients who were given this option and accepted it engaged in treatment. He also noted that it was rolled out very carefully with lots of communication.
    4. Dr. Kirchberg asked about what is available in the community, and expressed doubts that they have capacity. He noted this is very worrisome to him. Dr. Carroll noted that we in the VA have the responsibility to provide that care, and we need to oversee it either way. We need to figure out how to do it.

vi. Dr. Carroll is very concerned about morale in the work force. Everyone is working hard and he expressed that he didn't know if we are doing enough to support each other.
    1. Dr. Kirchberg noted that at his site he was aware of the importance of staff being treated with respect.
    2. Dr. Gironda noted that the media environment contributes to demoralization
    3. Dr. Shea advocated for the adoption of a "psychologist day."
    4. Dr. Kirchberg stated he has not heard much support from outside for morale.

The meeting ended with thanks for the opportunity to connect, and a commitment to continue to work together for veterans care.

Sandra Resnick, Ph.D. and Rani Hoff, Ph.D., MPH- NEPEC Evidence-based care

Measurement based care

Dr. Gironda initiated the meeting by asking how AVAPL could support their efforts. Dr. Resnick provided an overview of the current status of the measurement based care initiative.

1) They are implementing a phased rollout
    a. Phase 1 (current)
        i. Developing Partnerships and infrastructure
        ii. Determining parameters, e.g., best measures, frequency of assessment, how to best implement
        iii. The first phase is adopting a learning mindset. The goal is to provide infrastructure, let sites be creative, and learn together.
    b. Future phases will be based on lessons learned and recommendation from current sites.
2) Dr. Hoff
    a. She noted that they have both quantitative and qualitative data to guide efforts
    b. At baseline, they did a needs assessment. Themes included concerns about clinician time and impact of measurement based care on clinician interactions. They are trying to develop materials that make measurement based care a seamless part of the clinical process rather than an extra task. She acknowledged this is a challenge. She also wants to make clear to participants that this is a clinical initiative to improve outcomes for veterans, not just a data collection exercise.
3) Dr. Gironda asked what has been learned and how the program will bring people along for whom this is a major change.
    a. Dr. Resnick indicated she is hoping the champion sites will give insight. Early adopters and frontline providers will be tapped to help craft the message. They can represent the field. She noted that people who are already doing this are providing great feedback. They are also discussing motivational approaches to sensitively change behaviors.
4) Dr. Shea asked about later phases
    a. Dr. Resnick noted that until we get formal feedback from Champion sites, it is not clear what will come next.
    b. Dr. Hoff agreed that creativity at sites will be key to implementation. This is a principles based topic, and different sites will likely have different needs. She noted they are looking to get more sites and providers on board.
5) Dr. McQuaid expressed appreciation for the effort, particularly around the provision of IT support. Dr. Hoff agreed that this was an important issue and noted the IT support had been nearly intractable, but some success had been achieved. She noted that the current mechanism is not a long-term solution, and that they are working with local regional and national partners about the need for a long term IT support for this effort. While many sites are doing paper and pencil, this is not an efficient strategy, and not good for the future measurement-based care.
6) Dr. Gironda asked for main sticking points on the IT issues
    a. Multiple issues identified that are problematic

i. What is the best software for data collection? 2 options:
    1. MHA: This already deployed, but has inconsistent use across sites.
    2. Behavioral Health Lab
        a. There is an update with a large, robust, strong support infrastructure
        b. It can be deployed for secure desktop computer, but this is not always practical in clinic flow situation
ii. Use of mobile device is the challenge
    1. Nothing for BHL is on Apple IOS, but the only approved hardware are Apple.
    2. Dell tablets have been provided, but they no longer manufactured and therefore are not supported for maintenance by Dell.
    3. When devices are distributed they need to be imaged at sites, which delays distribution to providers.

b. Despite the challenges, they have worked through national barriers. Regional and local folks have to address their specific challenges. They have distributed 540 tablets, but the current approach is not a maintainable option.

7) Dr. Shea cited worries about what happens with data that are collected and emphasized the need to be mindful of this. Dr. Resnick noted stated this is an issue for all data that are generated, and that it important to address the appropriate use of data in all sites. She did note that the current variables being tracked are the increase in use of measurement, not the outcomes themselves.

Gene Migliaccio, Dr. P.H - Office Community Care

1) Dr. Gironda provided Dr. Migliaccio with VA white paper regarding VA care and response to commission on care. Dr. Migliaccio provided a slide deck on community care which we reviewed.
2) Dr. Migliaccio provided his background. He as been in the VA 1.5 years VA, coming from HHS. He has always been in hospital administration, first with the Air Force and then with the Public Health Service. In the Air Force, he oversaw the move of an Air Force hospital into a VA facility in the late 1980's. He stated it was a good experience and he appreciated the strengths of the VA. He noted that during the access issue he saw parallels to problems he had seen in the DoD. He noted that he has worked in occupational health settings where purchased care was one of his responsibilities. He came to the VA because he is motivated to help,
3) Dr. Migliacco's current responsibilities include:
    a. CHOICE
    b. Paying claims with archaic system
    c. CHAMP VA
    d. Networking and contracts
    e. New acquisition
    f. Developing a plan for Congress on CHOICE implementation
        i. He noted that much of the challenge with CHOICE arose from the timeline of implementation. Whereas Tricare which took 9 years to launch, CHOICE had 90 days.
    g. Reviewed slide deck (see attached). The major themes covered included:
        i. Dr. Migliaccio's office is working on improved care coordination
        ii. They want to facilitate veterans moving back into VA.
        iii. He discussed poor reimbursement process as a severe problem. The strategy going forward is doing more care through contracts.
        iv. He is attempting to incorporate other reports in improvements in CHOICE/community care
        v. He supports goals to
            1. Simplify
            2. Build networks
            3. Provide better payment
            4. Facilitate timely access
            5. Improve information exchange
        vi. They are planning an RFP for more expansive purchase of a network with more reliance back on the VA. They have received feedback from veterans that we have outsourced too much.
        vii. Dr. Shea noted the concern that there is disconnect in what is provided in the community and what is in-house. He agreed VA has stringent quality standards. Community is at times not able to meet requirements, and they have seen

safety and quality issues. He is hoping to develop processes for accrediting networks, and acknowledged challenges.

h. Dr. Migliaccio wants to work with providers to increase ease of veterans access.
i. Dr. Kirchberg asked what percent of CHOICE were MH. Dr. M said he will provide that information.

He noted that the VA is asking for CHOICE to continue into next year, and that the next couple of years will be tough if CHOICE goes away.

Marsden McGuire, M.D.

1) Dr. McGuire let us know that Dr. Kudler had been briefly detailed and Dr. Tenhula was out sick. We expressed our thanks for him making time for us.
2) Noted there are a huge number of personnel changes in 10P, and this makes some activities challenging. He cited the main issues as the hiring freeze, and that some reorganization could be difficult. He noted that currently each VACO office was going through the process of defending their budgets to the Chief Financial Officer, Frank Costa.
    a. He indicated that MHS has a very defensible budget of approximately $100 million. There are a number of congressionally mandate programs, and the programs in general are in alignment with the major priorities of Dr. Lee, the Acting Deputy Undersecretary for Patient Care Services.
        i. Suicide prevention
        ii. Women's health
        iii. Geriatrics
    b. He described the internally derived priorities for MHS
        i. Measurement –based care
        ii. Targeting under resourced settings
    c. Dr. McGuire provided a grid defining key programs and how they address key priorities
3) He reviewed Important vacancies on org chart
    a. Deputy Director of Substance Use Disorders (vice Drexler)
    b. VA-DoD integrated care position (Vice Tenhula)
    c. National Program Director for Geriatric MH (this is a new position funded by the conversion of prior GS-15)
    d. EBP director (vice Karlin)
    e. EBP for implementation and fidelity (vice Tracey Smith)
    f. Aspirational- vice Lehman; disaster psychiatry, postdeployment, PTSD-
4) Dr. Kirchberg asked if Dr. McGuire was aware of efforts to engage veterans not in our care. He said he is anticipating some items reflecting this as a focus. However, he doesn't have details.
5) Dr. McQuaid asked about other major changes with the new administration. Dr. McGuire couldn't think of anything in particular
    a. One thing under some threat is conference/training exercise. Travel budgets for each office were fixed in 2010. While they have been going above those caps, the caps are going to be enforced by 2010 standards this year.
        i. He did report a potential exception. They were planning a MH conference in the 4th quarter. He received word it dovetails with a suicide prevention conference that will be approved. They are retailoring to a new agenda on suicide prevention, and hope to move the conference ahead to May or June.
        ii. He noted that other conferences might be able to proceed if they are connected to this one.

6) Re: Suicide conference, Dr. McGuire noted the potential for a conference in spring/summer. We will get more information as soon as possible.
7) Dr. Shea asks if there were particular issues to which AVAPL should be attending.
    a. Dr. McGuire emphasized two points
        i. Bold changes+
        ii. Implementing lean management
    b. He says Secretary Shulkin is developing new mechanisms to emphasize and facilitate bold changes
8) Other issues coming up
    a. Dr. McGuire noted that the relationship between MHS, OMHO, and Suicide Prevention is very good.
    b. There will be transitions in the next couple years (Dr. Kudler will be completing his 4 year commitment in a year and ½). These may lead to changes.
    c. Dr. Shea noted concern about suicide prevention coordinators at her site doing tracking and case management, but not more interventional programs. Marsden suggested discussing with Caitlin Thompson. He also suggested discussing with Dr. Carroll about suicide prevention being across disciplines/roles. She asked that MH be an active player in this discussion, and Dr. McGuire acknowledged her request.
    d. Dr. McGuire also wants to facilitate the system responding as a learning culture in response to suicide, rather than current model. We also discussed REACH, and the zero suicide goal

Harold Kudler

Dr. Kudler was able to arrange an opportunity to meet.

1) He noted that the Secretary's 10 objectives not final
    a. 2 are relevant to community care
        i. CHOICE 2.0
            1. Dr. Shulkin wants to let veterans choose and to offer a broader CHOICE. The goal would be for the VA to have it's own network of partners/affiliates. The aspiration is that the VA would require training on VA and veteran culture from affiliates. In addition, there would be improved interoperability for records. Dr. Kudler indicated that the VA may be able to leverage payment to get support for additional training, better records. He noted that some of this has already been implemented, with Triwest requesting training from Psycharmor.
            2. Dr. Gironda said this sounds like privatization. Dr. Kudler noted that what has been proposed is not vouchers, and not without oversight. Like Tricare, the VA would get records and know what happened. Dr. Kudler stated that veterans will vote with their feet. He sees an opportunity to raise knowledge of the VA in community, and better integrate internal and external care. Secretary Shulkin knows the VA is necessary because we are the only resource for much of what veterans need. Dr. Kudler believes VA will be in a stronger rather than weaker position.
            3. Dr. Kirchberg asked what's the risk of this draining VA. Dr. Kudler acknowledged it is a real risk. However, not changing is not an option
            4. Dr. Shea pointed out that there is no access in community. Dr. Kudler noted we can prove same-day access, but need to also have quality care. He stated that Secretary Shulkin wants to look at veteran's perspective and let patients decide. He also stated we are not engaging veterans enough. He sees an opportunity to get more veterans' input.
            5. Dr. Wan noted that one concern is that the better product doesn't always win. He noted that if funds are directed to other programs, it will hurt the VA, and Dr. Kudler agrees with this. He noted these are risky times.
            6. Dr. Shea expressed concerns that the VA is being held to standards that the community is not, and that funds will necessarily be diverted from the VA and lead to damage to the VA. Dr. Kudler acknowledged the potential risk of this.
            7. Dr. Kirchberg noted that if all individuals had access to quality of care, community-based care would be fine. However, he doubts that would

be achieved, and Dr. Kudler agreed. Dr. Kudler noted we are going to provide data with community comparators. He noted that the goal is for the VA to compete from a business perspective. He noted that some factors (difficulty of getting insurance) may benefit the VA. As a group we discussed some possible opportunities to increase enrollment.

8. Dr. Kudler also wanted to congratulate the APA on the PTSD guidelines, and noted that in the public commentary he had shared some concerns expressed about the focus of the APA guidelines. Dr. McQuaid provided information of the APA guideline process. Dr. Kudler noted how helpful Lynn Bufka of APA was.
9. Dr. Kudler shared that he has completed 2.5 years of a 4 year commitment. He stated he will advocate for the VA after he leaves.

Kendra Weaver, Psy.D.

1) Dr. Gironda asked about upcoming initiatives around BHIP and Telehealth
    a. Dr. Weaver shared that the major focus for BHIP will be integrating collaborative care models, and psychologists will be critical to this effort to help shape teams. She noted that they are looking at measurement based care for BHIP teams, and incorporating it as part of collaborative care model principles. The primary goals are access, improving employee experience, and suicide prevention.
    b. Telehealth: She shared that telehealth hubs are being created to provide EBPs in access-challenged sites. She noted that psychologists and psychiatrists are being prioritized for hub teams, although in response to a question by Dr. Kirchberg she noted it has been hard to get psychiatrists. She shared there are 10 hubs now, and some have psychologists as hub directors
2) Dr. Shea asked if AVAPL could help with TMH to home
    a. Dr. Weaver noted that there are some barriers, including the Ryan Height Act that requires face to face prescribing for controlled substances, and limitation on equipment. She indicated that there is a technical analysis to address issues. Dr. Shea asked if we could see it, and Dr. Weaver said she would check. She indicated basic advocacy would be helpful, as well as advocating for telework.
    b. Dr. Gironda asked about TMH to home across state lines. She indicated that there are different opinions on that. There should be federal supremacy, but she tells people to check with regional counsel (Dr. Weaver later emailed additional guidance- see attached).
3) Dr. Weaver shared she is working on a Mission Critical Occupation Action Plan (with Dr. Pollack). It addresses barriers to hiring mission critical, including psychologists. She indicated it is relatively exhaustive but she cannot yet disclose details. She did share that it is a large interdisciplinary workgroup.
4) She is also on a space workgroup. They are updating design guides, and MHS is a primary focus. They are getting focused on how to better integrate MH (for example, in PCMHI). Dr. Shea asked about "podding" MH in future designs. Dr. Weaver said she has not seen that anywhere. She stated that part of design guide's goal is to look 15-20 years ahead. She wants to also be realistic. They are trying to make current space more aligned with purpose and goals as well as plan for new renovations.

Andy Pomerantz, M.D.

1) Dr. Pomerantz reviewed document on PCMHI. The program has been in place for 10 years and is integrated In the PACT model (although initial efforts predate PACT). However, implementation still uneven across country. He noted that we have "come a long way" on health-related behaviors (pain, insomnia, stress management) which are high priorities for primary care providers. He noted these activities 0verlap with HPDP and Health Behavior coordinators. In many medical centers there is an increase in collaboration/joining together, while in some there is a need to do more.
2) He shared that there are new efforts on brief treatment
    a. PST in primary care has been very well received.
    b. They are in the early stages of the CBT for pain roll-out.
    c. Brief prolonged exposure for PTSD- Sheila Rausch is the lead.
    d. Insomnia.
    e. Increased use of self-care apps (e.g., start moving forward).
    f. The agenda for these implementations includes increasing fidelity with the model. He noted that many providers have difficulty giving up the 50 minute hour and adjusting to a brief treatment model. To help, Dr. Lisa Kearney is spearheading a competency-based training, using a train-the-trainer model.
    g. Dr. Pomerantz also noted that there is need for folks in PACT in some sites to realize that PCMHI is part of PACT. Fortunately, new leadership in VACO primary care is very supportive and understands PCMHI well.
3) Challenges
    a. One key challenge Is how to help manage more complicated mental illness in primary care. Dr. Pomerantz stated that community providers focus more on this, providing treatment in community-based settings. He stated it is not clear if adding MH to PACT or PC to an SMI clinic is better for serving more complex patients.
    b. Dr. Pomerantz noted that the design guide has emphasized "on stage off stage" model, with patients placed in interview rooms and providers coming to them. This is not popular in MH.
    c. Base on IOM aspiration, there is a goal of complete integration, with teams changing shape based on patient need. This is an evolving program in its infancy.
4) There is a proposal for large MH conference, that is being redesigned to address suicide prevention. The secretary wants to move it to May, and Dr. Pomerantz is guessing it will happen in early June. It was discussed that VA psychologist meeting is in May, and we would appreciate consideration and coordination. Dr. Pomerantz thought that made sense.
5) Dr. Gironda returned to same day access vs. continuity of care challenges and asked about thoughts on balancing those competing interests. Dr. Pomerantz supports local facility discussions around these issues. He noted that if any program is not adequately staffed, it can't

work. He also noted that if a PCMHI program becomes only an access clinic, it is no longer a PCMHI clinic and won't stand up to Joint Commission scrutiny.

Katy Lysell, Ph.D., and Manny Garcia, Ph.D.

Dr. Lysell and Dr. Garcia provided a slide deck with updates on IT issues, and provided permission to post it to the AVAPL website (see attached). Dr. Shea asked to get update on budget for Mental Health IT, and Dr. Lysell noted information was available in the slides. Dr. Lysell also shared that vacancies such as the web lead are caught in the hiring freeze. She also indicated the budget is very tough and that they do not know what FY 18 holds. They therefore cannot do comprehensive planning given budget uncertainty.

3/7/17

Jeff Burk, Ph.D.

1) Dr. Burk reported on the issue of recovery-oriented treatment planning, which was a topic on a recent VISN MH Leads conference call. The discussion focused on the MH Suite, which the leads want to eliminate. Drs. Lysell and Garcia discussed MH Suite on the call. There will be a new set of policies coming out that will mandate MH Suite, including additional training. The complaints of the VISN are that it is cumbersome and not easy to use, and they requested it either be removed or else made optional. However, that can't be done because of a recently signed contract. He noted that they had been open to alternatives, but no one had been able to offer an alternative. However, one point he made is that MH Suite is only required for treatment plans, which can significantly simplify its use. The plan therefore is to:
    a. continue to mandate use of MH Suite
    b. Provide enhancements to improve functionality
    c. Provide additional training to support implementation
2) He mentioned that peers can help facilitate treatment plans. For example, a peer could help by pulling treatment plans together for others to review and sign.
3) Dr. Burk noted that there continues to be support for peers. The Acting Under Secretary for Health has asked about peers being more involved in suicide support. Dr. Burk noted that there is a need for more peers in a number of areas.
4) Dr. Burk shared that the position of Director of Consumer and Liaison Services is vacant. The previous occupant used to be involved with MH councils and stakeholder engagement. The position has been redefined as 50% consumer/liaison and 50% for peer support. A selection has been made, but the position is frozen. Until the position is filled, there will be no new work in peer support.
5) Key issues
    a. Supervision of peers: Many supervisors are psychologists. He is getting feedback from the field that supervision of peers has some challenges.
        i. Issues include
            1. Not enough time
            2. Supervisors don't know about or understand peer support (e.g., having a hard time providing guidance on appropriate disclosure)
            3. Assigned inappropriate work (transport, gophers)
        ii. He is trying to get a peer conference this year. They are also working on supervisor training
        iii. Dr. Burk's office is developing new GS9-11 for peer leads/supervisors. Peers are requesting this, and HR has been helpful and cooperative. Peers would still need to have an LIP supervisor.
    b. Dr. Burk wants to do evaluation of peer support, but there is no funding budgeted. However, VISN 16 is helping provide some targeted evaluation.

    c. There is an executive order to establish peer support in PCMHI in 25 sites. Despite there being no funding for it, the 25th site was established in February. Sites are at different stages of implementation Dr. Pomerantz has been very involved.

6) Dr. Kirchberg noted that problems in vetting have led to peers being hired who have not been effective. Dr. Burk noted that for selection, a clinician should be following the job interview template provided by the Peer Support office in order to assess the concept of lived experience properly. He also shared that sites need to figure out how peer leads and supervisors should be involved in interview process.
7) PRRCs
    a. Dr. Burk reported that the number of PRRCs has plateaued at about 102 or 103. He also shared there are fewer sites required to have a PRRC that don't, and that many places that were resistant have successfully implemented programs. He reminded us that sites are required to have a PRRC if they have 1500 veterans with SMI, or if they have day treatment program, which then needs to be converted to a PRRC. He noted that PRRCs are generally aligned under MH.
8) Inpatient and Outpatient recovery-Tim Smith's section.
    a. Dr. Burk shared that they had an inpatient recovery conference a couple years ago. VACO had Intended to implement monthly recovery calls, but that was stopped until the definition of a recovery oriented unit could be established. There is now a definition and checklist, and a conference call has begun, which grew out of general inpatient MH call. There are 150-250 participants every call. Tim Smith and Peggy Henderson co-lead the call.
9) LRC- Peggy Henderson oversees the LRC program.
    a. Dr. Burk noted that Dr. Shea has been a key leader in the success of the LRC program. He indicated that Dr. Henderson is continuing to push for protected time for LRCs.
    b. Dr. Henderson is also overseeing the SMI reengagement program. Wave 14 coming out. Wave 13 had highest completion rate of all waves. Reconnection rate is 25-30% range. He would like to see it increase, but it is still an improvement.
10) MHICM
    a. The Intensive Community MH Recovery (ICMHR) handbook is now out They retooled the old MHICM handbook to be more recovery oriented
11) Dr. Burk summarized by saying it remains to be seen what the future of the section will be.

Stacey Pollack, Ph.D.

1) MFT & LPMHC qualification standards being updated to include doctoral level LPMHC. This was excluded from the original standards by mistake. They should be going to concurrence. There will be a senior level equivalent to a senior social worker. LPMHC standards are written more rigorously than the social work standards, so it is unclear how the process will proceed.
2) The VA continuing to hire LPMHC quicker than MFTs.
    a. Recent legislation removed the requirement that MFTs COAMFTE requirement removed in recent legislation. A workgroup made up of MFTs was very unhappy about the requirement. The suspected that sites would be very hesitant to hire MFTs since other professions do not have this requirement. This will impact training programs. If supervisors are not AMFT accredited, training programs will not want them. In contrast, Dr. Pollack anticipates LPMHC numbers will continue to grow.
    b. The fact that qualification standards were modified for a discipline by legislation is a very big deal. It implies that could happen in psychology.
3) VBA has awarded a contract for comp & pen exams.
    a. The requirement is that requests for exams to be sent to facilities with capacity, and to contractors if there is no capacity. Dr. Pollack noted that many sites to not conduct C & P exams now. She also notes that some staff are unhappy with the arrangement.
    b. One concern is that the VBA contract does not require APA accredited internship. VHA opposed this contract for this reason. Contract providers and DoD providers who do not have an APA approved internship argue they should be eligible for VA. However, VHA and AVAPL are opposed to reducing qualification standards.
    c. Another problem is that a pilot to implement the CAPS in PTSD exams will not happen because it cannot be forced on contractors.
4) Revision of Mental Health Rating Criteria has moved forward
    a. A work group of BVA, VBA, and VSOs is recommending a move from symptom based rating criteria to functional impairment rating criteria. Representatives from MH include Marc Rosen, Brian Marks, Stacey Pollock among others. Eating disorders is getting included with MH, and antiquated definitions are being replaced.
5) Dr. Pollack's office updated the PTSD policy handbook which had expired. They will have to do so again when the continuum of care workgroup makes recommendations.
6) They also updated former prisoner of war policy. Changes include dropping the current requirement is to have a care and benefits team trained face-to face every 5 years. This is replaced by a 1-time online training. There is also a better definition on roles.
7) Dr. Pollack reiterated that service connection being reduced after recovery from treatment is very rare, but acknowledged that it does happen and then word of mouth can lead to concerns among veterans. Dr. Shea mentioned that the data Dr. Pollack provided previously regarding this issue was very helpful.

8) There is new course on working with Voc Rehab and Employment (VR & E), focused on how to improve collaboration.
9) We thanked Dr. Pollack for her contribution to getting trainees exempted from the hiring freeze. Dr. Wan asked why the postdoc level being left out of the initial exemption. Dr. Pollack indicated that was due to internship being in the midst of decision-making, and she anticipated we will be able to address the post-doc issues.
10) She also noted they are looking for better ways to convert our trainees into hires.

Caitlin Thompson, Ph.D. & Megan McCarthy, Ph.D., Office of Suicide Prevention

1) Since last year, the OSP added Dr. McCarthy as deputy and moved out of MH Services to under Dr. Lee (10P, Policy and Planning). The office was move in September. There is a defined org chart with a number of staff who are detailed to roles. Dr. Gironda noted that we had heard excellent feedback from the suicide prevention meeting.
2) The Office's charge is to prevent suicide in all 22 million veterans. The goal is to have an umbrella under which initiatives fall. Dr. Thompson indicated that there was recognition of the need to get into community settings and have a more comprehensive approach. Few weeks prior to this meeting, the zero suicide initiative was announced.
    i. Don't like the term
    ii. Much of it we are doing
    iii. What we aren't doing is evaluating how we're doing on relevant initiatives
        1. Training
        2. Leadership buy-in that suicide is preventable
    iv. Trying to educate leadership about term, models, etc.
    v. Concerned about impact of label and impression

b. Implications for psychology
    i. Will be contracting with Education Development Center (affiliated with SPRC-Suicide Prevention Resource Center). Jerry Reed is lead who is very experienced in this field. They will evaluate zero suicide in medical centers around country. Will help us figure out the communication to providers.
    ii. Will want to think through this site leaders about how to be supportive.
    iii. Dr. Gironda asked how it will be different- Answer- lots of new initiatives
        1. Reach Vet- large piece in Huffington Post. Will need to address likelihood that there will be deaths among hi risk group.
        2. VA-DoD Suicide prevention conference 1st week of August.
        3. Secretary will have a summit focused on rolling out zero suicide.
        4. Dr. Clancy is the co-lead for the National Action Alliance for Suicide Prevention. Private co-Lead is Robert Turner (CEO for railroad).

c. Dr. Wan asked about addressing concerns about suicide prevention with our veterans in community care
    i. We have none of the suicide prevention resources/policies for veterans in community care.

d. Dr. Wan asked about fiscal support for suicide prevention
    i. Dr. Thompson- budget about $30 million (up from $2 million). Seems adequate

e. Kacie Kelly on board to help facilitate public-private partnerships.

f. Colorado National Collaborative initiative- veterans -Megan
    i. Identify demographics- currently don't know much about those outside of VA care.

ii. Co-Chairs- Dr. Eric Caine- renowned suicidologist and Jerry Reed.
iii. Hi suicide rates and hi government commitment to eliminate suicide.
iv. Working on model to develop strategies to reach veterans
v. Identify areas with high veteran suicide burden
vi. Once knowing who they are and how to find them, develop strategies to reach them, invite into VA.
vii. Has extensive interactive database with pertinent health information on all who had died by suicide in Colorado.

g. Note- SUD huge risk, and creates risk in PTSD.
h. Megan- one thing focusing on is on re-engaging veterans who have fallen out of care. Thinking more about doing that.
    i. Dr. Shea suggests communicating with Jeff Burk and Peggy Henderson

3) Dr. Kirchberg asked if there is a particular theory/model guiding their work
    a. Megan-Lot of evidence that difference between dying and not is access to a gun, so there is a very strong focus on reducing risks from guns.
4) For HVAC & SVAC- strength of lethal means safety is strong. NRA is a partner. NSSF. AFSP. Want to focus on lethal means safety initiative.

Chris Crowe, Ph.D.

1) Dr. Crowe reported that in addition to his role as Liaison to DoD for psychological health and TB, he has been pulled back to help cover duties for the National Mental Health Director for VA-DoD collaborations. At the time of this meeting, he is still covering that frozen position.
2) He reported that there likely going to be a realignment of the Defense Center of Excellence with which he works, but it is unclear how those 508 employees over 3 centers will be realigned.
3) Current projects
    a. There is an effort to develop an MOU for the VA to provide services to a small number active duty service members with gambling problems.
    b. He is working with clinical practice guideline program to expand evidence-based practice in the DoD. He is partnering to do components on clinician guidance e.g. a "clinician's corner" to get EBP principles to clinicians. This is being done in collaboration with the PTSD COE.
4) Dr. Gironda asked how many DoD providers were contract, and how many had a DoD internship? Dr. Crowe noted that while they've tried to expand training in the DoD, it has been difficult to implement. He noted that the Army has very significant influence over DoD processes, and the Army currently does not have much will to implement evidence-based practice.
5) Dr. Crowe noted he hoped that the vice Karlin position (which oversaw CPG development) would have broader responsibilities. He feels that it could focus on how to use guidelines to shape policy.
6) HSRD has reached out to be applicable. They want to make sure MH helping to shape priorities and receiving results. He shared that Bob O'Brien leads is the lead of the relevant HSR&D portfolio, and Amy Kilborne is the acting lead of HSR&D.
7) Dr. Crowe shared that the EBP section has developed a strategic plan for the section. He noted this is the first time ever.
    a. There are 14 training programs with similar problems:
        i. Managing their relationship with the field
        ii. Pivoting to begin to include implementation planning (which will be part of performance plans).
        iii. There may be fewer trainings, with more emphasis on implementation.
    b. He noted they have a very talented group involved. The goal is to develop a 5 year plan. Dr. Crowe will share it when it is available.
8) Dr. Crowe provided information on a 2016 report of a special committee. There was concern regarding fidelity to EBPs in field. The committee recommended addressing fidelity issues. There is a concern about many are trained but not using therapy, which leads to implementation issues. This may lead to a recommendation for a minimum requirement. The VA agreed with the concerns, but in response to the committee noted the greatest importance is clinic adoption and increasing reach to veterans. They are chartering a workgroup, involving as many implementation scientists as possible. National Center for PTSD will fund it. Shannon Wiltsey-Stirman , an implementation scientist from the NCPTSD will lead the workgroup, Dr. Crowe and

Claire Collie will co-chair. He is hoping this can be make an impact. Dr. Shea expressed support for the implementation of EBP treatments. Dr. Crowe noted the need to target intervention plans for different types of stakeholders. He wants to pilot if possible, and assess outcomes. He noted they may have funding for a fellow to support this effort.

9) He shared they are creating data portals for all evidence-based psychotherapy programs. Trainees data will go directly to the portal. Each section will own the data. Dr. Crowe hopes to use the CPT & PE programs to do every session outcome measurement. He noted that folks at MIRECC are supportive. They would also make portals as a provider resource, and link to other more sophisticated resource. He would like to follow and support providers for a year after training. Dr. Wan mentioned we spoke with the measurement-based care group and noted the challenges of technology.
10) As a group we discussed challenges to EBP implementation. Dr. Shea asked what we can do to support these efforts. Dr. Crowe suggested:
    a. Get info from the field on where implementation is,
    b. Provide input on what is the field ready for in terms of advancing EBP implementation.
    c. We also discussed the need to support more time for clinicians and to facilitate discharge from care. Dr. Wan noted that substance use complicates treatment and makes discharge more difficult.
11) Dr. Crowe ended on pointing out that in Great Britain the highest trained staff provide intensive therapy for patients with the most complex needs, and, and boost the use of licensed professional counselor and recreation therapists.

Al Ozanian, Ph.D. and Amber Haf, M.S.- VA/DoD Health Affairs

Ms. Haf introduced herself as Clinical program analyst in the office of VA/DoD Health Affairs and a former Army Nurse.

1) Dr. Ozanian noted progress has been made in several areas. He noted much of the interagency activities comes out of an executive order that had 8 recommendations of areas on which to focus. Those include:
    a. Suicide Prevention
        i. He noted REACH vet has exceptional promise.
    b. Development of a research plan
    c. Identifying agreed outcomes
        i. He noted he is trying to get VA to take briefing on DoD behavioral health data portal, which may inform VA efforts to implement measurement-based care.
    d. Expanding community partnership
        i. Dr. Ozanian shared he Cohen group wants to build MH clinics in partnership with the VA. The VA is supporting the Cohen Group's efforts to support locations where high demand for mental health care for Veterans exists.
        ii. VA is also working with SAMHSA who certify community centers for MH. SAMHSA provides supportive grants for some programs.
        iii. VA is leveraging the CHOICE program to meet the demand for mental health care when necessary.
    e. LGBT services
    f. Sexual assault services
    g. SUD services
    h. Workforce development
        i. A clear need is military culture training. It is tough to get people to take the training, and encouraging community providers to take the training is important, but we don't want to create a barrier to provider participation as a non-VA care provider.
2) Dr. Ozanian noted Dr. Carroll is his supervisor and sets the strategic agenda.
    a. He stated that staff are adjusting to the structuring of the VA suicide prevention office being organizationally elevated out of traditional mental health program offices. He reiterated the excitement around the REACH-Vet approach.
3) Ms. Haf referenced the Cross Agency Priority Goal (CAPG). This is separate from the previously referenced executive order, but administration asked they be merged.
    a. Goals
        i. Reducing barriers- seamless transition from DoD to VA
            1. e.g., evaluate crisis line
            2. Medication management (addressing differences in formulary between agencies)
        ii. Enhance access

iii. PTSD & TBI treatment
iv. Improve patient safety

b. She indicated 19 additional goals have been identified, and they are looking forward to guidance from Administration regarding priorities. She stated that they were unsure if CAPG will continue as currently structured

Dr. Ozanian and Ms. Haf gave an update on the Clay Hunt Act. They indicated that OMHO briefs Congress regularly on implementation. The VA has contracted with independent evaluator of programs associated with the Act. The contractor will be submitting interim report and then a final report in 2018. They noted though it is difficult to do program evaluation on an integrated program, the study promises to be informative. They also highlighted efforts to implement measurement based care. They shared that one outcome is the publication of an internet website that points in the direction of resources. They also discussed the repayment of loans for psychiatrists. Costs will be coming from VACO Loan Repayment Office, although there are no additional appropriations.

Susan McCutcheon, RN, Ed.D.

1) Dr. McCutcheon provided an overview of services for women
    a. She shared that her office is focused on training for clinicians. They have a monthly training 200 lines per call. They are also working on Improvements on their SharePoint site
    b. They conducted a Women's MH mini-residency. Nearly every VA was represented, plus vet centers. Attendees became designated women's MH champions for their sites, and developed action plans which were implemented. They are planning now to have a virtual reunion.
    c. She reported on a multidisciplinary training in eating disorders. They selected 3 sites out of 30 applications, and plan to offer this again (fully web-based). Sites need to have an MD, therapist, and dietician
    d. Dr. McCutcheon shared there is a great deal of interest in STAIR initiative (Advanced Skill training in Affective and Interpersonal Regulation). People really looking for this, and they will be adding parenting STAIR. They are piloting the model now, with a roll-out in 2018.
    e. The have also added a prescriber-focused health training series on women's related topics
2) MST
    a. Answer the call continues. In round 7; 80% of VAs and 63% of CBOCs could be reached
    b. The consultation program continues. Requests are addressed within 24 hours and they provide services to non-VA as well as VA callers.
3) Family services
    a. She noted this is the only group that does evidence-based training that is face-to-face. Programs include
        i. IBCT- Andy Christiansen
        ii. CBT-C for PTSD- Candace Munson
    b. They have an MOU with NAMI- Jan 2016-Jan 2019 to offer Family to Family and NAMI homefront.
4) Dr. Shea asked if she was aware of AVAPL women's SIG. She was not. Dr. Shea suggested we might collaborate a bit more about this.
5) We asked about Dr. Lee's priority on Women's health.
    a. Dr. McCutcheon stated that there was a close relationship with Patty Hayes, lead of women's health, and that the eating disorder program is a collaboration with the women's health office). She stated that we are fortunate to have well-received initiatives, and that programming has grown from nothing to extensive opportunities in 10 years. She stated that in the future there is interest in women peers, and how to identify and address settings that aren't welcoming to women.

Karen Drexler, M.D.- SUD services

1) Dr. Drexler noted that a critical priority is addressing the opioid crisis. They are working on improving access to replacement. In addition, a small team of dedicated clinical pharmacists who are also programmers are working to reduce unsafe opioid prescribing using, informatics and dashboards, MI for coaching to the prescribers, and problem-solving therapy. They are working to expand Nalaxone availability. They are also implementing the psychotropic drug safety initiative, which focuses on medication-assisted treatment for alcohol use disorders and opioid disorders
2) She noted that they were partnering with PC and PCMHI to implement stepped care for opioid use disorders. She identified the following issues:
    a. Staff in PC have difficulty tapering veterans down from opioids, which is a sign of use disorder.
    b. When PC and pain specialists attempt to refer to SUD, patients are resistant
    c. The goal is to bring SUD in PC, and for pain programs to provide EBPs. This program is not packaged yet, but will be coming.
    d. She noted that the Comprehensive addiction and recovery act requires each VA have a pain management team, although there is nothing specific about improving medication assisted treatment (although Congress may know we're doing it).
    e. She noted that opioid use disorders are associated with 50% mortality by age of 45
        i. However, when she tried to find data on this in community it was hard to find.
        ii. For patients admitted to SUD specialty, 25% are offered specialty care in the community. The VA is ahead of that, but low compared to other disorders, despite this disorder being so life threatening.
    f. She is anticipating needing to double capacity for opioid use treatment.
3) She noted that since Dr. Kivlahan's retirement, 1 of 2 key positions are vacant.
4) She would love to improve basic educational guidelines.
5) They are updating the specialty care handbook (directive 1160.04)
6) They are continuing SUD EBP trainings
    a. Dr. McQuaid offered to send some research comparing CBT and 12-step facilitation for dual diagnosis depression and substance use.
7) Dr. Drexler wrapped up by stating she would appreciate support for doubling capacity for opioid treatment.

APA

Lynn Bufka, Ph.D.- Practice Directorate

1) Dr. Bufka shared that APA adopted its first ever clinical practice guideline. It was not clear if it was going to be approved by Council. There were many concerns regarding which interventions were recommended (recommendations are based on evidence derived from a systematic review). The document is online now, and additional support materials are in development. She noted that they are relying in part on the VA materials from the National Center for PTSD, and she will plan to reach out to Dr. Norman to see what can be used from the VA, particularly around access to consultation. The Council of Representatives voted for it 79%.
2) Not clear what will happen after this year. Advisory Steering Committee is planning to meet to discuss future. The ASC will likely focus on using existing systematic reviews for future guideline development.
3) Dr. Bufka anticipates the future for APA clinical practice guideline development will be collaborating with other organizations in efforts (e.g., Child and Adolescent Psychiatry, VA-DoD). There is some evidence elected leaders of the American Psychiatric Association have interest in collaboration although staff have had nothing more than cordial conversations and informal agreements to review one another's draft documents.

4) APA is working to develop a qualified clinical data registry. This began initially in response to CMS requirements but APA anticipates other payers will also want outcome data and may give providers a bonus for reporting.
    a. She noted that the existing PQRS requirements are not a good match for professional psychology
        i. Mostly process measures
        ii. Only 9 relevant to MH
        iii. Most providers not using it because the penalty is small
    b. Merit Based Incentive Payment (new Medicare requirements, replacing PQRS)
    c. Want QCDR to be useful across behavioral health
    d. Have consulted with Joe Ruzek on this
    e. The goal is to create a registry that is relevant and useful across spectrum of psychological practice
    f. Dr. Kelly mentioned that Joe Ruzek hopes VA psychologists will use resource for the ability to compare with non-VA.
    g. APA is hoping some VA psychologists will be part of this.
    h. Dr. Shea noted that Drs. Resnick and Hoff are overseeing VA measurement-based outcomes efforts.
5) Dr. Bufka reported they just finished Practice Leadership Conference
    a. This included advocacy training
    b. During Congressional visits- major points were:
        i. Include psychologists in physician definition of Medicare
        ii. Concerns about efforts to repeal and replace the ACA:
            1. There is a need to ensure 10 mandated coverage areas remain covered
            2. Advocating so patients don't lose access
            3. 3 bills that support mental health care endorsed by APA
            4. Dr. Kelly will send press release

    c. Participants in the conference are providing feedback, but this is not yet completed.
6) Dr. Shea asked about prescription privileges. Dr. Bufka indicated this was not a major focus of the practice directorate although staff provide support to states pursuing prescription privileges.
    a. Dr. Kelly noted that several states are active in pursuing prescription privileges.
    b. APA sees VA push for prescription privileges as the next battle to win. They hope that it will facilitate progress in other areas.
    c. Dr. Shea noted that VA leadership has not wanted it. Dr. Kelly indicated that VA leadership is more open to it recently.
    d. Dr. Bufka noted it would be helpful to have more data on prescribing psychologists.
7) Dr. Bufka discussed the Annual Stress in America report
    a. She noted there was a great deal of good press
    b. Political stress information led to about 30 interviews in January and 60 during the fall.
    c. Recent report on stress and technology.
        i. Folks who are “plugged in” are more stressed.

Catherine Grus- Education Directorate

1) Dr. Kelly noted Dr. Grus was point-person for getting universities to pay attention to military veterans issues.
2) Dr. Grus shared that their focus was on professional psychology and health service psychology
    a. Improve graduate and postgraduate training
    b. Work with APAGS
    c. Competency development and assessment
    d. Psychologist role in healthcare setting (Dr. Grus was a pediatric psychologist in hospital setting)
3) They are supporting Dr. Susan McDaniel's project on interprofessional education and practice
    a. Curriculum- modules
        i. For interprofessional learners (not psychology in isolation)
            1. Healthcare policy
            2. Healthcare financing
        ii. Includes links to resources
        iii. Expected learning outcomes
        iv. Modules designed to be used either in isolation or as a full course
        v. Section on how to create interprofessional learning environment- help reduce barriers
    b. Designed for learners early in their training.
        i. May not be a bad thing to expose to other disciplines early in training.
    c. Trying to promote, push word out, post to large portals.
    d. Chaired by Ron Rozinsky and Jeff Goody (at USIS).
4) Office of accreditation
    a. Good progress on interaction around site visits
    b. Continue to need site visitors from the VA.
    c. Dr. Gironda noted that Dr. Jones would like to have access to the list of site visitors who are employees of the VA. Dr. Grus will take that request back to Jackie Wall
    d. Dr. Kirchberg mentioned concerns about training and qualifications of CHOICE providers
    e. Dr. Grus noted APA passed a resolution that all trainees should be trained in accredited program or approved by US Secretary of Education.
    f. Dr. Wan noted that APA has to reimburse OAA for travel, and that means a change in how VA staff travel (i.e., they need to be on TDY). This needs to be communicated to site visitors, and hence the need for the list.
    g. Dr. Shea expressed concern at the quality of some of the programs from which she was getting applications.
        i. E.g.- no live supervision, never done MMPI, never done a WAIS.
        ii. Then have difficulty on internship.
        iii. Dr. Kirchberg noted similar problems in Memphis.
        iv. Dr. Grus noted-
            1. Conversation with DCT would be appropriate.
            2. Create culture where the DCT and internship director mapped out training goals.
        v. Discussion noted that there is a range in what psychologists define as core training
        vi. Dr. Grus noted that Society of Personality Assessment has been posting webinars on assessment. She will send us the link.
5) Dr. Wan noted that VA leading on Postdoc match

    a. Noted that early offers, particularly for non-VA sites, is still an issue.
    b. Dr. Grus noted that she was part of summit last year.
    c. She noted that this is a moving target, going in right direction.
    d. She appreciated that APPIC taking the lead and including non-APPIC members.
6) Dr. Wan and Dr. Shea stated that having postdoc match overlapping with internship is challenging.
7) Dr. Wan noted that APPACS & UPPD (appic portal) are both very helpful.
8) Some debate around advertising (APPIC wants use of UPPD), being asked not to advertise.
    a. Dr. Gironda noted he used to advertise on several listservs but has been asked not to do so.
    b. Dr. Wan noted he is concerned trainees will not know about unfilled positions.
    c. Dr. Grus suggested communicating this to VA representative to the council of chairs of training programs (which will be in DC). The will be meeting soon and this would be a good topic. Dr. Wan will inform Bernadette Pasquale.
9) PCSAS (Psychology Clinical Science Accreditation System) and APA
    a. APPIC has been approached about including PCSAS in match.
    b. Education had discussion with APPIC board- discussed different accrediting systems and differences between APA accreditation and PCSAS
        i. Differences in robust clinical training (more specificity in APA; PCSAS focused more on clinical researchers).
        ii. Try to provide accurate, up to date description of the two systems.
    c. Dr. Kelly was concerned about implications

Ben Vonachen, MA- Public Interest Directorate

1) Deals with social justice issues
2) Had previously had portion of veteran's issues
3) Worked in House and handled VA issues. Aurora CO VA hospital was under his purview.
4) Populations
    a. Aging
    b. Minorities
    c. LGBT
    d. Poverty SES
    e. Trauma, violence, abuse
    f. Women
    g. Taking on more social justice themes
5) He works with disability
6) Team Home-based health model for medicare
    a. Initial home-based team in legislation does not include psychology in team (to prevent cost increase- CBO score).
    b. Knows that the VA is doing this.
7) Working across directorates re: APA repeal and replace
    a. Particularly concerned about people with disabilities
8) Planned briefing on police and community relations
9) Dr. Kelly noted that APA will be broadcasting hill briefings
10) Unique mission compared to other scientific organizations
11) Identified other representatives
    a. Violence and trauma-
12) Discussed bill HR 1181 to require a judicial review prior to losing gun rights following being identified as requiring a fiduciary.
13) Dr. Wan shared VA undersecretary's 3 items of geriatrics, women, and suicide.
14) Dr. Shea asked about federal advocacy training
    a. Federal Action Network is an email system to alert constituents about relevant issues. Helps get members opportunities to engaged/involved.
15) Dr. Gironda mentioned about tools, and Dr. Kelly stated she provides this.
    a. Ex. Stand for science campaign.
    b. Dr. Kelly noted that advocacy training is also available at the convention.
    c. Dr. Kelly and Dr. Vonachen provided info on other training opportunities.
16) Dr. Kirchberg asked about anticipated changes in federal funding- possible loss of funding for
    a. Violence against women act
    b. NEA
    c. NEH
    d. Legal aid