

Mid-Winter Meeting March 2018

Sunday, March 4th

AVAPL Executive Committee met to review the week and establish priority talking points.

Monday, March 5th

Ken Jones and Stacy Pommer, Office of Academic Affiliation (OAA)

Psychology Training Programs

-New priorities for psychology internships due to a balance shift – there are now more positions than interns. For the past 2 years, there has been a trend of having unfilled internship slots – especially at new internship programs but some at long-standing programs. As a result, OAA is not moving forward with a previously planned Phase 7 of VA's Mental Health Education Expansion Initiative, which would have added new internship positions.

-Past 3 years, the focus has been only for expansion with neuropsychology postdoctoral residency programs.

-OAA was able to increase stipend rate 8% for psychology interns and residents beginning academic year 2018-19.

-OAA is also trying to re-allocate slots where possible, to be good stewards of the funding. Therefore, the recommendation is that sites don't just fill to fill – if that becomes the case, remediation can become a problem.

Hiring Initiative

- There is a new hiring initiative in VA to hire a net (not just backfill) of 1,000 additional mental health FTEs by the end of the year. OAA is working closely with the VA national healthcare recruitment service and Office of Mental Health Services and Suicide Prevention (OMHSP).

-OAA is working to improve the awareness of non-competitive hiring so it can be clear to all VAMC's how to hire trainees efficiently.

-Local bargaining unit agreements rarely require the posting of positions at USAJOBS and many times trainees are disqualified because HR does not modify the assessment questionnaire to allow for current trainees to be considered.

-Also, OAA wants to work on a good matching system to pair trainees with positions. Right now, the best applicant tracking system they have is through trainee.recruitment@va.gov, where trainees are matched with VISN recruiters based on their interests. However currently there is no automated system for doing this, which makes it a time intensive process and requires that service chiefs provide updates on vacant positions.

The group discussed improved ways of doing this, including:

- They have asked chiefs to give them a list of vacancies and have sent this list to trainees. They have had some success but this is also time intensive and no funding is allocated for such an endeavor.
- The group discussed having a work-study or volunteer help provide support with this.

- Also discussed reaching out to the AVAPL Early Career Psychologist (ECP) workgroup to see if they have any ideas or could provide support in matching trainees with vacancies.
- It was noted that with the new restructuring of central office, OAA is likely going to be reporting to the clinical line, as opposed to the non-clinical line where they are currently. This restructuring has included a proposal for new position(s) that would focus on trainee recruitment. The positions would include workforce recruiters and education experts who would know more about the rules/limitations of the system.

-When there is a new program, like HR smart, in development, conditions needed for trainees are not considered so codes are not developed for tracking. Job codes were updated August 2017 so they can be more easily tracked so it can be seen how many trainees convert to staff positions.

Shift in Accreditation

-There is an APPIC psychology match issue regarding accreditation due to a shift in the Psychological Clinical Science Accreditation System (PCSAS) recognition. In the past, all PCSAS programs were also dually American Psychological Association (APA)-accredited programs but these programs have expressed that they are considering discontinuing their APA accreditation in favor of a single PCSAS accreditation.

-One impact of this is that there have been discussions about having to do a separate internship match system in VA to align all the programs with VA psychology qualification standards and allowing students from PCSAS-accredited doctoral programs to participate. OAA has been working with APPIC over a year to resolve this issue, and subsequently Congress has requested progress reports.

-The group discussed how PCSAS programs tend to be academically-oriented, scientist-practitioner programs that focus on leadership, systems thinking, critical thinking, research, and other areas that make psychology unique from other mental health disciplines. -The goal moving forward will be continue to be on assisting all trainees, the field of psychology, and VA; OAA is still working to resolve this issue so an independent VA match is not needed.

National Academic Advisory Council

OAA used to have APA's executive director serving as member but since that APA director retired, there has been no psychology representation there. OAA suggested that psychologists at least attend the public portions of it – they meet twice a year face to face.

Chris Crowe, Senior Consultant, VA/DoD Integrated Mental Health (OMHSP)

National Academy of Medicine Report - "Evaluation of VA Mental Health"

This congressionally mandated report was recently released by the NAM (formerly IOM). Major findings include VA offers mental health care as good as community care but not consistently. The overarching recommendation is development of a 3-5 year strategic plan to ensure reliably high quality mental health care across all facilities. The report also addresses issues such as Title 38 for psychologists, which it suggests needs to be seriously considered and VA's inability to engage in meaningful quality improvement since it has yet to routinely collected patient reported clinical, functional, and quality of life outcomes VA must respond to recommendations in a response to Congress with an action plan. A technical work group has

been formed to draft VA's response and plan. Dr. Tenhula is chairing the technical work group. There will be a requirement to update Congress on the progress of the 3-5 year strategic plan.

One of the main findings is that VA's care is as good as any – the comparison group which is the community, where quality mental health care lags behind every other specialty. There have been some findings where mental health in community was ahead but it was very inconsistent, especially with EBPs – some places were doing it, some were not.

Measurement Based Care

VA does not collect patient reported outcome data – which is the foundational basis of ensuring quality care, so this remains to be a huge gap. In order to facilitate collaboration with OIT, workgroup has been formed to look at reach of EBP and the fidelity with which it's delivered. Routinely collected patient report outcomes is central to doing anything significant. The reach and fidelity report is in initial phases.

Evidence Based Treatment

Factors affecting acceptance of EBPs on field were discussed. These included the inability to do weekly treatment due to access issue, focus on availability of walk in slots and the fact that only 35% of facilities are meeting staffing requirements for mental health. OMHSP is beginning to have a conversation with pharmacy's academic detailing office and considering working with them and/or using their model to increase evidence-based practices/ psychotherapy. To be effective VACO will need to offer leadership (facility/clinic) not only the data but usable solutions. The intent is to offer and there is recognition of the need to restore the tension between "all access" to "sustained access."

Other strategies were disused including truly moving forward with case management. There are many veterans being seen at linger intervals and this is an opportunity for more case management. Related to this is the need to develop a mental health continuum care plan looks at strategic planning, redundancies, and working on flow between levels so all levels have a back door. A plan is being considered in VACO and the field may want to weigh in. Reports from the field are that front line staff are afraid if they discharge someone, they will "get in trouble" and a complicating factor is veterans don't tend to want to lose that relationship. There was discussion about a need for a major cultural shift to include VBA messaging.

There was discussion about collaboration with HSR&D to promote implementation strategies for different kinds of systems that address current problems in the field.

Clinical Practice Guideline Concordant Care

Opportunities and challenges to instating system-wide CPG concordant care was discussed at length. The focus is now to broaden out from the current VA EBPs to enable clinicians to practice consistent with CPGs regarding of setting or presenting condition. An example was the CPG for suicide – a suicidal patient is supposed to be 1) receiving evidence-based care for the underlying mental health condition (top diagnoses include depression, bipolar, substance use, and BPD). There is no process in place to track that. The other thing is that it calls for is 2)

specific treatment related to suicidality. Some examples of that are cognitive therapy for suicidality, problem solving therapy, and the Safety Planning/ Crisis Planning interventions. The current model of SP has a heavy emphasis on administrative processes and less of clinical work.

Whole Health Movement

Ideas for integrating with Whole Health were discussed. These included coaches leading drop in groups for aftercare, developing models of care that incorporate whole health in the continuum of care, and psychologist's consultation on evidence based practice.

EBP Templates

Challenges with EBP template adoption were discussed. Some estimates say 3% of the VA clinicians use the PTSD templates. Work is being done to move toward more streamlined templates. Templates could be a reminder to clinicians about what is the standard treatment approach and also offer a way of tracking.

Emotional Support Animals

Assistant Dogs International is the main accrediting body for service dogs. Up until January, there were no standards for PTSD dogs so most major organizations have not invested in this. ADI just came up with standards which included developing pro-social behaviors among support animals.

Kristine Day and Kristin Lester-Williams, Evidence-Based Psychotherapy Coordinators (OMHSP)

Chris Crowe, Senior Consultant, VA/DoD Integrated Mental Health (OMHSP)

EBP Training

A report of EBP training progress was provided. 12,800 clinicians have been trained in EBPs. Out of 12 EBP training programs, 7 programs are implementing regional models (in person training – local/VISN level) – the remaining 5 use a blended learning model (live, webinar, and self-paced training). Both models are experiencing successes and continue to learn from earlier challenges.

EBP programs are developing a live webinar course (with CEUs offered), which will include a history of EBPs within VA, a review of the EBP Trainings currently offered/available within VA, and information regarding appropriate referrals to EBPs. Development of the webinar course will be completed by end of fiscal year. They are also near completion of the shared decision-making web course for all MH providers, which is interactive and gives providers an opportunity to participate in case scenarios on how to implement shared decision making –it is anticipated to be completed in May of this year.

There is a completed preliminary analysis on the impact of EBPs for depression on suicidal ideation in Veterans which will be presenting this data at the American Academy of Suicidology Conference next month.

Suicide Prevention

Discussions with the suicide prevention team have begun to explore areas for collaboration and enhancing provider training on suicide prevention. This started with a lit review to have a better understanding on what research which shows that CBT and DBT show the strongest evidence for decreasing suicidality.

Implementation of EBPs

The office described efforts around implementation, fidelity and templates for EBPs. Training numbers are strong but implementation continues to be a challenge. The primary mechanism for tracking implementation has been the templates, but they are under-utilized so it is difficult to accurately track actual EBP delivery. Focus is on streamlining them and developing templates for CPG-concordant treatments that are not currently part of the VA EBP initiative.

Consideration is being given to using one template for treatment of a particular disorder. The template would include all CPG-concordant treatments and the provider would indicate in the template which treatment was provided.

Al Ozanian, Mental Health Communications and Strategic Planning

Topic: Executive Order (EO) from January 9

1. Discussion regarding offering VA healthcare to all transitioning service members. The estimated number of transitioning Veterans who would otherwise not obviously and routinely have access to MH care during the first year of transition is an estimated 37,000.
2. Discussion of how much VA care should be “made” versus “bought”. Made meaning regular VA care. Bought means VA purchases by non-VA providers. The Secretary [Shulkin] is very clear that he is impressed with mental health in the VA – we are a public company so we are held to standards that other healthcare services aren’t held to. VA spends a lot of resources in facilitating patients into care (not something civilian practice does) – this requires work – time, resources. As we increase access to a growing number of beneficiary categories, you have to be able to make it or buy it. One part of that is the hiring initiative (hiring 1000 new people, net gain). Another consideration this brings up has to do with Guard and Reserves. Technically you could be “activated” depending on the amount of time spent on active duty. For reserve component personnel they are typically issued a DD214 after 90 days of continuous active duty time, if they have a disability that resulted from some time on active duty, or if they are activated to serve in contingency operations.
3. The main take-aways from this are:
 - a. There is an increased focus on transition
 - b. This allows for better access
 - c. Inclusion of DHS
 - d. This is where suicide prevention is going.
4. Overall – we are trying to broaden our suicide prevention efforts. One focus of a broader level is Whole Health – we are hoping to work with them and call centers, communicating with individuals on what they might be eligible for. We are also engaging VSO’s and non-stakeholders, talking to them about whole health and transitional care. There is no budget for the communication plan.

Andy Pomerantz, Director of Integrated Services (OMHSP)

1. Broader Focus in PCMHI

a. There is increasing concern regarding resistance to changing the PCMHI model that was formed over 10 years ago. The original model should be thought as a starting point with the ability to adapt. There is excitement over the possibility of merging PCMHI and BHIP – a single care system – not be separate silos, but an integrated system. One way to do that is as we move forward with national implementation of FLOW (a project that aims to improve the transition of stabilized/recovered mental health patients to Primary Care(PC) is to have PCMHI providers become comfortable with more complicated clients. There are other clinics who are working on this (Monterrey clinic is working on developing a space and clinical flow that blends specialty, BHIP, and PCMHI together). There have been some great results but it is just a starting point.

2. Brief Evidence Based Treatments for PCMHI

- a. Brief treatments developed for primary care have helped with this change – like problem solving training.
- b. One-year pilot of brief CBT-CP in PCMHI for those who have trained in the full version.
 - i. Results are very positive, in terms of clinician acceptance and workability and patient outcomes and patient satisfactions.
 - ii. The next step is to put that manual in the hands of those already familiar with CBT, but not trained in CBT-CP, and see how that works in the hopes of just distributing the manual with webinars so people could implement it in PC-MHI. Hopefully over the next year we will have that in everyone's hands.
- c. We are just beginning a small roll out with a brief intervention of PTSD using clinicians trained in a longer treatment protocol.
- d. A number of brief interventions for insomnia are also out there – hopefully we will have something to try out in PCMHI soon.
- e. We are also looking into online versions of CBT-I treatments.
- f. 5-6 years ago, we had no evidence-based treatments for PCMHI and now we have some, with more to come. Some growth comes down to the resources and having the FTE who are willing to and can be in primary care. PCMHI folks can't do everything, so when it comes to managing complex patients we will still need to have more resources to help with that.

3. Peer Support

- a. We are in the process of completing the peers impact project, a 2-year unfunded program. Most of them had training in whole health coaching. Many faced stiff entry into primary care, though in general there has been some support after the fact.
- b. Some questions arose with this, such as what is a peer? In mental health, that means a certified peer specialist. Whole health and patient centered care have a different definition. Office of Patient Centered Care recognizes various

definitions of peers. In the community there are different definitions for peers as well. There is also a lack of understanding that a peer is not a therapist/service provider.

4. Discussion regarding how to handle Veterans who believe they must remain in specialty mental health to keep their benefits.
 - a. With the new strategic plan, we need to do something about the system of incentives for getting worse. There is a lot of mythology around what causes people to lose benefits. Recovery is the bigger issue compared to getting their treatment through primary care. Maybe we need some sort of fact sheet regarding VBA. We need this fact sheet to go out to the VSO's, because many are still being told by their VSOs they need to be in therapy.
5. Discussion regarding general mental health providers who are resistance to transitioning patients back to PC because PC is dealing with some high caseloads, though this may be about a fear rather than a reality (many of those in PC are already seeing these patients – just renewing medications). AVAPL has been advocating for how essential integrative care is in VA's model of care. There is strong data that supports strong integrative systems.

Teresa Boyd, Operations

Serving now as Acting Assistant Deputy Under Secretary for Health for clinical operations since February 2018 (was detailed to work with the former ADUSH/CO prior to that – since August 2017)

1. MH is front and center in the fabric of everything VA does on the clinical side of operations. Unfortunately, VA has siloed program offices and this has contributed to being in vacuums. Might VA be better if we aligned ourselves with the initiatives – not have 9-20 offices and duplicate efforts but rally around the 5 things we need to do for patients and figure out our role in those. Help staff in all program offices aware of their value in these initiatives. It doesn't make sense to divide Veterans into pieces based on their disparate health problems (e.g., geriatric, mental health, primary care). A prime example of success in this is PCMHI – it was difficult at first but now I am the biggest cheerleader.
2. In order to maintain leaders, we need to continue to “grow our own.” The ten top VA sites have residencies – how many of those trainees stay? No one is going to hand us these leaders/professionals.
3. AVAPL Concern - What happens when VA non-foundational services are fractured off due to CHOICE/Purchased Care? For example, underperforming VA's often lose staff, underperform more, and so on. In a related area, SAIL is being misused from how it was originally designed. The public and media fail to understand that 50% of VA's have to be “failing” at any given time (given that all VAMCs are ranked with each other). If it often mis portrayed appropriately to the public – it looks like we have these huge VA's who are “failing” so people seek private care.
 - a. When the whole idea of core competencies came out, VA needed to look and act like a high performing organization and figure out what are our foundational elements. That really means if you provide services, you better do everything

you can do be robust and successful in those chosen areas – if you do it, be the best (or stop dabbling). Originally if patients sought services that we didn't offer, we "made the service". In some sites, what happened was we did it half-deep, so we lacked the volume to ensure provider competencies and so forth. This could be due to some areas where they struggle with recruitment. If that's the case, then we look at the market – there could be better options for those services in the market (high quality, safe care, good access) – if so, then we make the decision to partner. Before a final decision (Make versus Buy), we make sure that such decision does not impact our teaching, research, emergency preparedness missions. Or maybe we are in an area where some things are needed on site – in that case, VA needs to develop that care. Right now, many facilities are sending things out to fee-basis without a strategic or organized reason. Instead of purchasing a bit of care in multiple services, we need to figure out what needs to be bought versus grown and then only send those things needing bought out to fee.

4. AVAPL discussion with Dr. Boyd - VA has used fee basis for a long time so the "make versus buy" thing is not new to VA. When CHOICE was developed, the money for it was "fenced" – separated from VA services. The spending on CHOICE dollars has increased 500% since 2014. Our concern is that when CHOICE dollars are no longer fenced, we may come to a tipping point where VA doesn't have enough to support foundational services. VA needs to be able to monitor the quality of CHOICE care, and we have a hard enough time doing that within VA. The idea that we "buy what we can't make" is a lofty idea but the deals we are making (such as the recent MOA with Cohen) does not reflect that. The original MOA was that they wouldn't charge but what they are describing now is that they want to be CHOICE providers and that 50% of their income will be from federal sources.
 - a. Dr. Clancy is talking with the Veteran Service Organizations (VSO's) about the Memorandum of Agreement (MOA) with the Cohen network. The Office of General Counsel (OGC) will look at the MOA to make sure everything is on par.
5. AVAPL discussion with Dr. Boyd - As training directors, we also see limiting factors of "buying" versus "making" have to do with culture and environment and how our professionals want to work. For people who are very eager to make their mark, they can go across the street and have healthier clients. Our concern is that CHOICE providers will want the more lucrative parts of VA health care (e.g., transplants, medical procedures, and more), what's will be left are the "sicker" folks which can lead to provider burn out thus creating retention issues.
 - a. I agree – we shouldn't just "buy" if we don't "make" it well. We should look at why we didn't make it well, for instance, maybe we needed to have some support staff. It's up to us to teach our trainees to work on a team. How do we make the best services we can with what we have?
6. AVAPL discussion with Dr. Boyd - Another problem is that only 35% of VAs have the recommended 7.72 FTEE/per 1000 Veterans needed to provide the foundational MH services.

- a. Boyd - We have a multidisciplinary team working on this hiring initiative. We have discovered after this past year that you really need to hire 3 people to gain 1. Therefore, in order to gain net new 1000 people, you have to hire 3000. While the recent net new is slim, it's not because of lack trying. The workgroup is going to look at why – why are they leaving, who are we hiring? All facilities had to do 5% allocations to look at the foundational services and see where the gaps are. We are trying to be creative and remind medical center directors and HR to see what else can we do.
- 7. AVAPL discussion with Dr. Boyd - One potential driving point for recruitment could be moving psychologists to Title 38 – psychologists are one of the only doctoral level professions who are not title 38. We were under the impression that it required a congressional fix but recently the Secretary said he didn't need that.
 - a. Boyd: Not sure of that. Please explain the benefits of such a change.
- 8. AVAPL Discussion with Dr. Boyd: We are not competing well with the private sector (the pay differential is growing between private and public) on the recruitment end. On the retention side, after being at the VA for 28 years, we top out at a 13-10, and during a time when we weren't getting annual increases, you are basically making less each year. Within 15-16 years, you are topped out. If there are program managers, researchers, and leadership positions at a higher pay scale, why would I sit at a low pay rate? This takes our strong clinicians out of clinical work and into administration. This is also not on par with similar professions, which decreases morale. With the full title 38, there are multiple ways of compensating people (as opposed to just pay scale). You can reward them for going above and beyond, you can offer recruitment incentives, funds for continuing educations, leave is different (e.g., psychologists never get similar hours of leave per pay period - even after 30 years). Some psychologists have noticed grade creep in other jobs. Now Administrative Officers (AOs) are GS-13, so they are equivalent to what early-career psychologists are and more than trainee/entry level psychologists. Peers are 11s. Psychologists used to be 2 steps above masters' level professions, but others have increased in grades, and we have stayed the same. We were told for a while that it had to be in legislation, but it is unclear now.
- 9. Dr. Boyd regarding the proposed move of special purpose funding to general funds – This endeavor was meant to fix something like - “Don't tell local leadership how to reach goals – tell them the desired outcome and let them figure out how to get there.” This as an attempt to work around an initiative and think outside the box.

Megan McCarthy, Deputy Director of Suicide Prevention (OMHSP)

- 1. Acting executive director (as of 4 months) is Dr. Keita Franklin. She is a wonderful addition, with a really clear vision regarding how effective suicide prevention requires a comprehensive public health approach (including all public health domains), not just crisis work or even mental health care. This includes universal messaging (for all individuals, not just Veterans). We are looking within and outside VA, as well as socializing this approach with leadership. Goal is to disseminate this idea of a public health model to facilities and support facilities in how to implement it, given all the constraints at these facilities.

2. Two primary goals for 2018:
 - a. “Beef up the data, surveillance reporting infrastructure. We don’t know enough about Veterans and suicide (especially those not in VA care). We want to be able to describe the problem to ourselves and others much better.
 - b. Better develop a national system of community-based partnerships. If we are going to be preventing suicide, we need a community effort to do it. Each community has its own suicide prevention needs, depending on the community’s unique problems and resources. What is the problem, what is the potential solution, and what is getting in the way of reaching that solution?
3. AVAPL Discussion with Dr. McCarthy - In addition to partnering with the community, we need to deal with upstream interventions. What’s being done at the more foundational level, prior to them even getting them to the point of thinking about suicide? What are the primary diagnoses for these Veterans, what are the treatments we are providing to them, how are we getting those treatments to them, how’s the lethal means reduction going, and how are we working on these things - when they currently don’t seem to be the priority of suicide prevention? Are we talking about universal interventions such as going into gun shops and talking about safe storage, instead of targeting those at risk?
 - a. We are hoping that most of this work will not fall upon psychologists because most of this is not psychologist work. Though most suicide prevention is housed in MH service line.
4. AVAPL Discussion with Dr. McCarthy: As psychologists we understand behavior chaining and how it is always good to start an intervention at the beginning of the chain as opposed to just the end of the chain.
 - a. We are hoping to move some of this to primary care not just within mental health.
5. AVAPL Discussion with Dr. McCarthy: How good of a fit is psychology in the suicide prevention field?
 - a. We can talk to Greg Hughes on the team who might know more – there is no data that I know of. The roles for suicide prevention coordinators that psychologists are uniquely suited to include leadership and data gathering.
 - b. Turnover has been known to be high, with trouble recruiting and retaining. Mental health hiring initiative says to hire 286 more, but it is difficult to fill the ones already out there.
6. REACH vet and SMI re-engage
 - a. I don’t know much about SMI re-engage - these are patients who would certainly be more at risk but don’t do any direct work with them.
 - b. REACH vet began in November 2016 and is overseen by Aaron Egan in the suicide prevention office. Evaluation of the program is complete and in the clearance process. Informally, REACH vet appears to be doing a couple of really good things – increasing outpatient engagement in care and decreasing all-cause mortality. We don’t know if there is a decrease in suicide risk. From initial review, results look good, and we are looking forward to what comes next. Now we are looking at what’s the best course of action – expand REACH vet? It takes a lot of resources. We are starting to have VCL responders know if someone was

identified by REACH vet (if they are at higher risk). How has this been going on the provider end?

- c. AVAPL response - It's been a burden that created another set of tasks for everyone. If it's paying off, so that's good. To be frank, the work was not welcomed. But if you can show they are doing something that's creating a positive outcome, it is easy to keep them sustained in that effort. It's a great way of showing what we can do with big data and how VA can provide a service that's unique in US. Same with SMI-re-engage (reduction in all-cause mortality) – it doesn't matter what the specific treatment or care, if they are engaged, they stay alive.
7. AVAPL Discussion with Dr. McCarthy - We are worried about the impact of privatization causing problems in providing wrap-around treatment for Veterans.
 - a. I am aware of the Federal Practitioner paper by Dr. Lemle and the MOA signed with Cohen Network in Oct (but press released this year). I am, and our office is, aware that especially for suicide prevention, the services VA provides are better than the services provided in the community. Essentially an evidence-based suicide prevention model focuses on top quality evidence-based care and looks systemically on how to prevent Veterans from falling through the "cracks" (e.g., lost to follow-up). In that sense, we believe Veterans would be harmed by having their care transitioned to the community, because they wouldn't have the level of treatment that they would have in the VA. In terms of the MOA with Cohens, it is about publicly available/general information sharing, no money is being exchanged.
 - b. AVAPL Question: Why would we need a MOA for public information sharing?
 - c. McCarthy: MOA's are common. There isn't and there is not anything in the MOA itself concerning to me. There is a stipulation that says local VA suicide prevention coordinators will attempt to build relationships with the Cohen Veteran Network (CVN) in their area. Dr. Carroll is aware of the situation. What VA and VACO believe is that all Veterans should have care. "There's no wrong door to care" is one theme in this. Some Veterans cannot and do not want VA care and so this partnership is a way to get them to care. However, a concern is that CVN says they will not share info with VA and that they will be receiving VA funding. What would you like us to know?
 8. AVAPL: Any chipping at VA integrative care is a potential serious erosion of VA integrative care and is at risk of becoming a self-fulfilling prophesy. If CHOICE dollars were fenced off, then VA has an operating budget and CHOICE has an operating budget. If funds are co-mingled and the profitable parts of VA get sent out then money can be siphoning off from VA to CHOICE. In such a case VA risks reaching a tipping point where there is no longer sufficient funding for "foundational services". AVAPL wants VA to continue to try to "make" care well instead of just buying it. Suicide prevention will always be VA's role. Even if CVN takes on Veterans, it will never be their role. Everyone will still continue to point to VA's failures (as the purchaser of care), even if all of the money is going to CHOICE. We must ensure we are using our existing systems of high-quality care.

Greg Hughes, Field Ops Director, Suicide Prevention

1. The Veterans Crisis Line (VCL) has been extended significantly over the past 1-1.5 years. After the OIG reports: staff were added; caller protocols updated; infrastructure improved; and managing the call volume. Around that time, there were concerns in the field that Veterans were trying to access what they thought was the VCL but they would call their local VA and get caught in the phone tree there. A decision was made to add VCL to local VA phone tree/options (Called Press 7). This added significant volume to the line so a second VCL site was created to address that volume. Adding this site also created needed redundancy for issues like weather or other problems. A certain percentage of calls were having to go to back up call centers previously. Those back up centers wouldn't have Joint Legacy Viewer (JLV) or CPRS (Computer Patient Record System), so staff there would not be as prepared to address some issues. Now only <1% of calls go to back up centers, and those <1% are intentionally diverted there to keep those lines running. We also just opened up a 3rd VCL location in Topeka – part of the reason is because now the phone tree option will be added to every Community Based Outpatient Clinic (CBOC). Chat/text is not available at all sites yet.
2. The VCL is going through CARF accreditation this year.
3. Developing specific interventions and ways of intervening with high frequency callers – some have significant MH needs and some not. One example - setting up outgoing call interventions - one example is for those who have just separated from the service (Concierge to Care). VCL markets itself as an anonymous resource. Of course, the operators will ask for that information and if they could connect them with the VA but it is an option, not mandatory. We are trying to come up with better ways of moving Veterans to care if they are in some sort of distress. VCL also gets a lot of calls that have nothing to do with suicide prevention since it can be a way to get a live person as opposed to a phone tree. Both VCL and suicide prevention coordinators spend a lot of time on things not having to do with crisis (could be transportation, benefits, appointments). You never know when those issues could spill over into a crisis.
4. Press 7 is rolled out now to half of the CBOCs and all of the hospitals. Voicemails will still say hang up and call the crisis line but calling the main number will give the VCL option. Also, if you call the main line and press 7, the VCL can track that person/call. If the Veteran calls a specific extension and it is redirected from there, the VCL would not be able to track it.
5. There are approx. 2200 calls a day in VCL/MCL – averaging about 80 emergency dispatchers (intervening), 400 consults a day.
6. AVAPL: Is there anything we can do for you?
 - a. Psychologists are typically pretty great. We had to get the lead psychologist for VCL's position upgraded to get her to stay, and they were able to do that. The position is now slotted at that level. VCL is 800+ FTE right now. Many responders don't have to have a clinical degree, so having two psychologists at the top helps.

Sandra Resnick and Rani Hoff, Northeast Program Evaluation Center

Measurement Based Care (MBC)

- The center has passed phase 1 (volunteer champions) of Measurement-Based Care (MBC) to national implementation. Stronger recommendations are being made for phase 2.
- MH RRTP and substance use programs are doing MBC as a mandate. Also, joint commission standards have included a requirement for MBC for programs accredited under behavioral health standards (which includes MH RRTP and SUD programs), and this program is providing support for those services.
- We have developed an extensive SharePoint with materials which includes a joint commission section.
- The idea of measurement-based care is a “socialization” process. It helps to be a part of the language, and the culture of clinical services is gradually moving toward that.
- New technology: there is a new version of BHL that is being tested to see if it can be deployed on an iPad; if it passes, facilities that have iPad could deploy BHL on them, and the devices could be handed to the veteran for direct entry.
- With positive progress, there are still a lot of challenges with facilities purchasing iPad, and deploying them correctly, and there are places that would rather use mental health assistant.
- The Office of Connected Care is encouraging iPad use and is hoping to utilize a blanket purchase agreement, along with other medical equipment purchases.
- The Center is working to help develop a comfort level with the iPad to improve the utilization of BHL.
- WIFI in hospitals: The newest version of it can be used as an application or it can act as a web deployment. Data would reside on the tablet until you send it to MHA.
- Using my HealtheVet or other apps to collect patient data: Not currently, because it cannot be passed through to the medical record. There is something that is in long-term development that might work on getting data from a Veteran’s smart devices into the medical record.
- There are lots of ways people are trying to solve the problem of collecting data and passing it into the medical record. We are working with OI&T to put together a plan for them to look at processes and gaps that need filling to form an all-encompassing process that could work. OI&T is determining a budget and funding, perhaps projecting until 2020. The priority for this year is to develop tools that make sense for providers to use on the front line, Inc. templates, dashboards, reporting systems, etc.
- Measuring the successful implementation with MBC: increasing use of measures. The “collect, share, act” model is a good measure of how we are doing. We attempt to count whether the administrations of these measures are increasing. However, there is not a lot of literature on how to implement MBC in some programs, including measure selection. These programs are likely using a broad range of measures, finding which measures work best, and working to add measures to MHA and BHL. As we do this, we are working on the challenge of accurately counting the number of measurement administrations across programs.

Tuesday, March 6

Clifford Smith, Deputy Director (OMHSP)

- The office continues to evolve as we figure out our functional work relationships subsequent to the realignment, with continued refinement.
- The Secretary is committed to the 1000 net hire. Last year facilities declared what their hiring needs were and what they were trying to do, and that exceeded 1000. Hiring has been a challenge to implement on the ground and we are working to hire wisely.
- There was a paper submitted on staffing levels and mental health quality – looking at optimal staffing levels at SAIL performance. Medical directors tend to prefer mapping productivity by wait time. This model can sometimes lead to an overestimation of staffing levels and delay hiring.
- The staffing ratio and SAIL metrics appear to have some correlation. 7.72 may have been the median at the time, and it has shown it has validity. Central office leadership is increasingly hiring additional staff with education, processes, and support.
- EDRP into psychologists hiring: EDRP funds are sent to the VISN, then distributed and assigned. Facilities can take this funding and add to it, but perhaps rarely do. We are working to increase that by having each medical center list their challenge positions and continue to work from there. We are also looking at the student loan repayment program, and working with workforce management and a consulting program, developing more funding for that as well.
- Title 38 legislation? There are advantages of being a pure Title 38 – payment, flexibility with hiring. The hiring initiative workgroup will tackle that one. We will pursue the options of what it would take to move from hybrid to Title 38.
- Open access initiative negatively impacting EBT time? We would like both open access and sustained access. If you are a 4.68 FTE per 1000 it's hard to have balance, but if you are at 10 per 1000, it will be an easier endeavor. The open access process is continual – we are still learning. It will improve when we eventually get the new computer scheduling system which will not be slot-based, allowing for more flexibility.
- Time frame for the new scheduling system? TBD. Development is making progress, and several sites are now using the character 4 code. Salt Lake City is leading the nation in that. Scheduling EBP is hard itself but also continuing to move our system away from continual support care is also an ongoing challenge.
- Some veterans prefer continual support care and do not want to forego that. We are seeking leadership support to focus on more recovery-oriented care.
- The American Psychologist is writing about the changing face of mental health. Our provision of mental health care is looking very different than how some of us were previously trained. Same day services usually referred to crisis intervention.
- The model the VA wants may mean more drop-in clinics, inc. group drop-in clinics.
- Any evidence that shows this works? The VA is veteran centric so the evidence we are using is their desire for this.
- The focus right now on MBC is on tailoring the care with the discussion with the veteran, that provider feedback. That will be the interesting extension – how do we use our data to inform ourselves about our care.
- Measurement-based care may also be used in performance evaluations.

- Quintiles in SAIL measures are set up to compare VA facilities to other VAs; no facility is the same. The goal is to have zero 1 star facilities.
- Comparison to local/area community hospitals may change the “star rating” system to communicate comparison to community, not only comparison between VA facilities. Important to look at performance compared to the private sector.
- Comparable metrics to compare us to the community: there are a number of comparisons for inpatient but VA measures mental health uniquely
- We are aligning our follow up measure with the private sector and it is not difficult to comply with their standards of measuring.
- National Academy report indicates that VA care is as good as or better than the private sector, contrary to some news headlines suggesting poor VA care.
- Managing consults: some clarifications coming. We will end at a good place with PCMH.
- The online scheduling system is coming. We hope it will assist with meeting access needs along with continuing care.

Michele Karel, Director, Geriatric Mental Health (OMHSP)

- Focus on issues that overlap with providing services to older vets and having a workforce prepared to do that.
- Some challenges with STAR VA – getting the staff to use it. The main ingredient for success is nursing leadership being on board. STAR-VA needs to be viewed for the way usual care should be delivered for CLC (Community Living Center) residents with dementia. Many sites have had success when they are able to demonstrate to staff that it can help.
- It is empowering for direct care staff when we show that the nursing staff’s observations are critical to improving care for the Veteran. Some sites integrate STAR VA into new nursing staff orientation. Our office can connect STAR-VA nursing and psychology leaders with others to help with implementation if needed.
- The potential fragmentation of care that is considered other than foundational, which can affect the care that is considered foundation. There is a focus on the great strength of VA that is an integrated system and communicating and working with each other. Care that could be fragmented would alter this. The norm in the private sector can be having multiple providers and not much of a bridge.
- One proposed solution is more telehealth with older vets. We work against assumptions that older people are not technologically connected, which is not necessarily the case. Research out of Charleston SC with older vets with depression has found that they were quite receptive to clinical-video psychotherapy. Some HBPC (Home-Based Primary Care) clinics have had positive responses so far to telehealth.
- The main issue with telehealth can be connectivity in rural areas and with providers. There is an enormous potential there. In VISN 23, there is a geriatric psychiatrist providing tele-MH to CLCs and community nursing homes that is reportedly working well.
- Improvements in working with family members of older veterans, particularly with record keeping. Guidance is basically if you are working with the family member in support of the veteran’s care, we can document in the veteran’s chart. If you are

working separately with a family member (not as THEIR provider) then we can provide a lot of caregiver support when the veteran is not in the room and create a collateral chart.

- Building more CLCs or long-term facilities: VA is likely not building more CLCs or long-term care facilities any time soon. We need to continue to expand home and other choices. The “Choose Home” initiative focuses on how we can provide care to Veterans in their chosen homes. The push is home and community-based care whenever possible.

Kendra Weaver, Senior Consultant, MH Clinical Operations (OMHSP)

Mission Critical Occupation (MCO) Action Plan

- We have been working with Workforce Management & Consulting (HR) to develop and implement a comprehensive action plan related to hiring and retention of ‘mission critical occupations,’ including psychology.
- We plan to send the field a data request, which collects facility-level information about psychologists’ grade levels. This request supports an Office of Personnel and Management (OPM) initiative that has 1) identified psychology as a top-10 MCO in VA, and 2) has been developing strategies to mitigate difficulties with hiring and retaining VA Psychologists.
- VA has informed OPM that we are going to (1) review inconsistencies between National Psychology Professional Standards Board (NPPSB) recommendation for Psychologists’ grading and grading in qualification standards vs funded implementation at VAMCs and (2) review inconsistencies of Psychologists performing duties above the full performance level and submission of boarding packets to the NPPSB. The data collection has 20-25 questions and is confidential and anonymous. We’re trying to determine the circumstances around the different situations.
- Viability of moving to Title 38 from Hybrid 38. The Office of Workforce Management Consulting is leading that effort. Increased stipends for interns and increases in EDRP are always goals. For EDRP, psychologists are listed nationally as ‘hard to recruit’ but local sites must also make the determination, based on data/local recruitment information, that psychologists are ‘hard to recruit’ locally.
- Psychologists and case management versus direct clinical psychotherapy. The VA Case Management Model and national directives mainly refer to care and case management tasks being performed by nursing and social work. There are efforts to ensure the field is also thinking of the least intensive levels of care first (including self-management and self-directed care) so that psychologists and other MH providers can work closer to the top of their license and offer increased access for Veterans who truly need their services.
- In the Summer we will be re-educating the field about the MH Continuum of Care model on national calls.
- Space: Outpatient MH space design guide is in a final draft format, being reviewed by various VACO program offices. Later in the summer we anticipate seeing final documents. They are meant to give people a general framework for and guidance about space, based on the recovery model and Veteran-centric care, without being too prescriptive.

- Telehealth: “Anywhere to anywhere” – There are draft national VA regulations on providing care from anywhere the provider is located to anywhere the Veteran is located (US and its territories). We expect the regulation to be finalized and published in the Federal Register. There is also a simultaneous parallel track of legislation moving forward regarding the same anywhere-to-anywhere concept. Neither the VA regulations nor the legislation address controlled substances via telehealth – those regulations will remain in effect. With Anywhere to Anywhere, Psychologists will be able to do their work seamlessly no matter where they are located.
- We currently have 11 telemental health (TMH) hubs. We are moving toward a VISN gap coverage model in which VISNs may choose to use hubs and other resources to ‘cover’ vacancies and other staffing gaps. In addition, primary care has hubs, and we are trying to increase collaboration between the hubs. Hub work is mostly focused on providing EBPs – psychotherapy and pharmacotherapy.
- Another big initiative we are working on is telemental health emergency department coverage—to update policy to allow sites to provide MH ED coverage via TMH.

Karen Drexler, Director of Substance Abuse Disorders

The Future of Substance Use Treatment in VA

1. The opioid crisis has led to increases in Veterans seeking care for abuse.
 - a. Increased demand is putting a strain on VHA substance use disorder (SUD) clinics. We may have reached our capacity and we are exploring new and different ways to provide timely access and treatment.
 - b. One idea is a stepped care model for SUD which will impact PCMHI/BHIP teams. There are good clinical trials on how EBTs can be used in primary care. Some research has been done but VA is unique since VHA has a co-located, team-based approach.
 - c. More Veterans can be treated for co-occurring SUD in BHIP. The first step would be to train interdisciplinary teams to use this model in PCMHI and among pain management teams, then BHIP.
 - d. The Care Law mandated integrated interdisciplinary teams for opioid use disorders. VA has been working to include an addictions specialist (for substance use disorders) and a behavioral health specialist (for CBT for Chronic Pain – CBT-CP). Additional VHA funding was not tied to the legislation so more funds are needed to staff the pain teams appropriately.
 - e. The SUD section in OMHSP created a one-page white paper on SUD treatment facts at the end of the last fiscal year which included the number of Veterans with opioid use disorders and efforts to increase access to treatments.
 - f. The opioid use education program has made great strides in educating veterans and their families about opioid abuse and making naloxone available.
2. In terms of numbers of Veterans affected by SUD – the legal drugs like alcohol and tobacco are the highest. VHA does great job screening and providing on the spot referrals in primary care (PC)
 - a. An area of growth is the need for short-term treatments.

- b. Behind alcohol and tobacco, cannabis use disorder is growing faster than opioid use disorder (based on diagnoses coded on encounters).
 - c. We have some evidence-based psychotherapies (EBPs) that are helpful – Cognitive Behavioral Therapy (CBT) for SUD, Motivational Enhancement (ME), and contingency management (three-pronged approach to cannabis).
3. Marijuana is a schedule 1 controlled substance, has an active potential. There are some cannabinoid medications in the field that are being studied. The THC is the addicting component and can cause intoxication and can lead to the psychotic symptoms. Some are bred to be stronger in THC, which can lead to more substance use disorders. Research shows insufficient evidence or recommended against treatment for PTSD, but this is not impacting legislation. The academic detailing service is partnering on the opioid safety initiative and have put together educational materials for veterans; they also recently put together a document for marijuana.
4. Alcohol – VHA screens and refers well for these problems. The next step is providing more than the one-time intervention. Next frontier is in PCMHI and BHIP.
5. Benzodiazepines are not helpful for PTSD. Just like opioids, once people get started on them, it's hard to get them off. The psychotropic drug safety initiative (PDSI) is in phase 3 -- the next phase is reducing benzodiazepine use. VHA mental health providers can help by providing CBT for Chronic Pain (CBT-CP) and Prolonged Exposure (PE), Cognitive Processing Therapy (CPT) and Eye-Movement and Desensitization Reprocessing (EMDR) for PTSD. These treatments actually work and can help with tapering off of medications.
6. Cocaine use continues to decline while methamphetamine (METH) has been steadily increasing.
7. A bright spot for treating SUD in VHA is contingency management. This program uses incentives such as canteen coupons for clean urine screens. We need to spread the word on how effective it is.
8. A huge paradigm shift is needed in VHA. Providers need to realize that SUD is a chronic illness. A lot of providers expect it to be an acute issue – you treat it and it should be good. However, the best treatments are biopsychosocial and require ongoing management. The hope is a stepped care approach will free-up capacity in SUD clinics and enable SUD specialists to act as consultants to other providers and also take on more intensive patients.

Kim Hamlett – Berry, Director of Tobacco and Health

1. Tobacco use disorder is the leading cause of preventable disease in the United States and needs a chronic treatment approach. Smokers are at increased risk for suicide. There are a lot of psychologists at the forefront of tobacco research and in implementation of best practices. If children can make it past 18, they typically won't become chronic smokers. However, those who enter the military are more likely to begin smoking (30% of people in the military use tobacco).
2. We are working with all providers to integrate tobacco cessation into their care – even dental providers to integrate this into their discussions of oral health care – there is no wrong door.

3. Anyone who has skills in talking to patients about their behavior can do this. We also know of some strong comorbidities – there tends to be a higher rate of tobacco use in those with mental health issues, and it also can impact ongoing struggles. As a result, we have been working on integrating tobacco cessation with PTSD treatment, and we have shown good results with that.
4. We are also working to engage psychologists more in integrating this into their healthcare. Medications and therapy work together. We are working on eliminating barriers to tobacco cessation. From 2002 to 2010, it was a one-person endeavor although we used special purpose funding to help support this initiative –that funding pays for 100% of a PharmD and 50% of a clinical psychologist who serve as clinical experts/consultant.
5. VHA has developed handbooks for special audiences: Veterans with PTSD or SMI who smoke; women Veterans; pharmacy toolkit; and how to conduct a drop in tobacco cessation clinic.
6. Our section targets low performing sites who need help with tobacco cessation (smoking and smokeless) for their Veterans. We do onsite training for them that is flexible and adapted to site needs. We have also translated many of our materials into Spanish. We train a team at each site versus solo providers. We also model our education to address each particular population – younger folks may not care that it can affect their heart later, but they may care about other issues (like day to day functioning right now).
7. Other education efforts: regular webinars with CEUs; a regular newsletter; the QUIT line (since 2013). QUIT line folks are well trained and know how to do a warm transfer to the crisis line. Now we have a text line quitting tips service. Mobile texting program includes 6 weeks of targeted messages based on the Veteran's quit date. This includes messages about medication.

Katy Lysell, Director of MH Informatics (OMHSP)

Quick highlights

1. In Q1 FY17 the MH Informatics section lost all IT funding with some restored in FY17 Q3. Previously approved requests were thus eventually funded (about \$10 million dollars).

Main projects:

1. Continued work on enhancements for management of and distribution of clozapine; meeting VHA needs and following FDA recommendations.
2. Enhancements to mental health assistant (MHA) to support suicide risk assessment and to support requirements for measurement-based care (MBC). Working on finding a way use the secure desktop feature with MHA (for patients to enter data directly) but this must align with Microsoft's own advancements. Hoping to move MHA to a web-based version for compatibility with mobile devices. The long-range version of doing this would be a kiosk mode – via an iPad or laptop. But it's going to be another year or two down the road.
3. We don't yet know what elements will be included in Cerner Genesis (the new commercial electronic health record VHA will be using). It's possible that Veterans could respond to measures as part of the check-in process similar to what DOD has been

doing. Implementation and initial testing will begin 12-18 months after the contract is signed. We will follow the DoD pattern, starting with VISN 20 (3 sites) and gradually move across VHA from there: a 10-year process from the first site to the last site. The project will be funded year to year depending on the budget.

4. Suicide high risk patient enhancements – fixes to patient documentation and waving co-payments for people with a high-risk flag. VHA does not want financial aspects to be a barrier to care (e.g., VHA might want to see high risk Veterans more often, which could lead to an increase in co-payments) and to support the impact of Veterans with Other Than Honorable discharge (OTH).
5. The MH Informatics section has also been active in EHR modernization working on: behavioral health requirements and initial testing; web-based self-help tools although that has significantly decreased in terms of priorities. With the move toward commercial EHR, funding for VISTA/CPRS is being stripped left and right, and MH has close to 25% of that funding. Because suicide prevention is one of the secretary's top priorities, all sections in VHA want to help mental health.
6. *Modernizing for Measurement Based Care (MBC)*. This is definitely a need and there are many challenges. For example, patient entered data is not considered part of the medical record. To include in the medical record the provider must be involved in ordering, or requesting, etc. We have made the case that we have patient data that has been passed to CPRS, but the process of patients submitting data directly has complicated things. Working on developing an app with Office of Connected Care where the provider can order measures on a regular basis, and the patient can input his/her responses. It's proven to be a really difficult thing to accomplish – taking things outside the VA firewall and allowing it to get through all the VA security standards. Additionally, while working on these issues, the contract expired and now is in the process of renewal. The app was called MH Pro, now it's call MH Checkup. Another complicating factor is working with another mobile device – iPad is general considered medical devices, not IT, so the process by which they are purchased becomes complicated. There have been some recent changes in December, an update in IT policy regarding what is and is not considered IT equipment. We had tried to order tablets for MBC, but they were not approved by OI&T to be connected to the VHA network due to security concerns. Currently there is no clear path forward.
7. *EBP Templates* – Psychotherapy section staff have drafted new templates with a focus on Clinical Practice Guideline (CPG) concordant care. There is now a greatly streamlined process for getting these into CPRS. So now we are moving away from fidelity-oriented EBP templates to one more focused on the workflow aspect – what the type of psychotherapy is that is being performed during the session and to facilitate the usual documentation for the therapy session. Refining the template and getting it beyond a test site will be a challenge.

Dave Carroll, Chief Consultant - OMHSP

1. *Choice Legislation* – VHA leadership is convinced that we need partners. Thus, the move is when VHA cannot provide something, Veterans need to be able to access it in the

community. We are moving forward with developing our infrastructure, not with the intent for privatization.

2. In response to AVAPL's concern about the comingling of CHOICE dollars with VHA's general budget, there is no clear resolution on this as of yet.
 - a. Veteran service organizations (VSOs) are extraordinarily concerned about this and are very vocal. For example, the Cohen Network announcement came on Thursday, and 30 people were on a call this morning to VSOs. That's appropriate, and they are really looking out for veterans.
 - b. However, the CHOICE legislation is drafted and it emphasizes that the Veteran is the critical point and maybe the best way of deciding this. If the legislation is written so the veteran is able to continue to have input on what is clinically appropriate, that will help.
3. AVAPL raised the issue of the star ratings as part of SAIL metrics. Given the current system puts all VA Medical Centers (VAMCs) into quintiles, 20% of VAMCs will always be "one-star" which the public/media perceives as failing. VACO is aware that SAIL is being used in a manner beyond how it was originally envisioned and is working on a new system.
4. *Funding specific purpose to general purpose:* A workgroup has been charged with coming up with recommendations regarding how all the MH Centers of Excellence (including MIRECCs) are funded. There is an expectation of a reduction in some of the special purpose funding but not all of it or that the funds will become part of OMHSP's core office funding instead of special purpose funding. Some aspects could be aligned more locally in our centers of excellence but there are some things we need to hold on to.
5. *Measurement Based Care* - There may not be an elegant IT situation, but they are working on solutions. Veterans outcome assessment (telephone) to support Clay Hunt is supporting the idea of measurement in mental health care, and we just need to work on logistics. Right now, patient-generated data is not supported in medical chart but the VACO digital services team and The Office of Veteran Experience is in discussion about web services.
6. *Telehealth* – OMHSP is working closely with the Office of Connected Care on all aspects of telemental health including: scheduling; VA Video Connect; and improvements through cloud-based solutions.
7. *Title 38* – This is really an HR issue and suggest discussing this with Lisa Kearney and Cliff Smith. Sec. Shulkin said he could move directors and psychologists to Title 38 without Congress but needed to verify. (Later verified that move to Title 38 requires legislation).
8. *MOA/Cohen Veterans Network* - This MOA was developed to: share training resources (like SAVE training); Cohen can refer to VA care like the crisis line. This MOA is similar to the one VHA has with Give An Hour and other community organizations. The MOA was signed last October but the release was delayed. These MOAs are meant to spur those positive relationships and remove barriers to coordination. What has complicated things is that Cohen seems to have changed their business model, and they now want to be a CHOICE provider. The Office of General Council is reviewing the MOA again and determine if any changes are needed.

9. This is a wonderful time for VHA mental health because so many people are eager to support our mission. We are now a single program office (OMHO and MHS combined) to include: suicide prevention; Veterans Crisis Line; workplace violence prevention team; and all of the mental health team. OMHSP is currently on the second version of its org chart since new resources are being added to suicide prevention. The push in the organization is to put resources where the care is delivered. Overall, the size of the national infrastructure will continue to shrink but VHA will still need some national leadership for critical roles. The combined office is working well together and we have some things to continue to figure out like better communication. This is a good opportunity because we can continue to support what we need to do and support leadership.
10. Access to mental health care has greatly improved. The office is now focused on strengthening same day access. Veterans may not be able to see their usual provider same day but someone will be able to provide this care. The office is also focused on sustained access as part of the tripartite access model and continued work is needed in the field to improve that model.
11. *Executive Order (EO)* – This will be game changing for VA, VHA and Veterans. The order requires seamless transition from the time a Veteran leaves the service to connecting with VHA. The year after leaving the service carries an increased risk for suicide. Obviously, it is the right thing to do. VHA wants to be proactive versus waiting for Veterans to call us. The VHA Health Eligibility Office Call Center will call Veterans 30 days after leaving the service, whether or not they are enrolled, to enroll or potentially set up an appointment. The peer support program will also help with some calls. The Whole Health team will have open access Whole Health orientation groups which emphasize why health post-discharge health is important. The EO has been misrepresented in some media accounts. Not every transitioning service member needs MH services but for those who do need it, easy access is the goal. There are some Veterans who are barred for seeking treatment in the VA so the EO requires us to connect them with resources outside of VA. That's why partners and vet centers are important in this. In the discharge/transition process, exiting service members will have their demographic data populated in the VHA enrollment system. VHA cannot auto enroll, because not everyone is eligible and auto enrollment could impact financial and family care benefits servicemembers receive. However, Veterans' form 1010EZ can be prepopulated and the health eligibility office can review that and make those phone calls within 30 days of discharge. VHA will be able to have information from DoD about Veterans who have discharged in various geographic areas and that can be provided to the local medical centers. Service members provide an address of record when separating from the service, where they receive their last paycheck, VHA will use that address.
12. The VHA report on EO implementation is completed and awaiting signature. The call center and Whole Health orientation groups, are ways to proactively connect with new Veterans. VSO's are on board with this. We are trying to expand suicide prevention to get as upstream as much as possible. Currently about 40-50% of discharged Veterans enroll in VHA. Over and above what we are already getting it could be 32,000 but we don't know for sure. We know there are over 500,000 veterans with OTH discharges.

13. *Hiring Initiative* - Last year the Secretary wanted to hire 1000 new net hiring. We didn't make that goal. OMHSP has created a team with workforce management, Mr. Young, HR staff, data managers, and the network managers. The team attends network director and facility calls. A dashboard is being created for regular reports to the field. Workforce management is working on national announcements and tracking what's really new and what's backfilling – out of 1000 we are at net new of 250 right now.

Jeffrey Burk, Director of Psychosocial Rehabilitation and Peggy Henderson, Deputy Director PSR&R (OMHSP)

Psychosocial Rehabilitation

Updates: PSR&R was able to repurpose the Director of Recovery Services to a Deputy Director position and hired Dr. Henderson into that position. As of last year, peer support remains strong, and it is still high profile. VACO continuously getting draft legislation for things peer support can help out with. The pilots are on board for peers in PCMHI.

Clay Hunt Act: OMHSP is developing partnerships with community as part of the Clay Hunt Act. Peer support has gotten to a point where it is becoming a profession in VHA. We have developed the PDs for peers, apprentice level at GS-5 and GS-6 through 9 specialist level. We have now developed new positions descriptions for peer supervisors (GS-11) and peer specialist leads (GS-10). They will still need to be supervised by an LIP for charting purposes and for oversight. The LIP will supervise the lead/supervisor and not the specialists.

SMI Re-Engage: A list of veterans with SMI who are lost to VA care for over a year is generated, and LRCs make contact with those veterans and facilitate reconnecting them to care. SMITREC has been a good partner with this, and they are looking at a variety of outcome issues. Not only do they reconnect to care, but even if they don't connect then, they find that several months down the line they are reconnecting more often. The LRCs are spending about an hour per veteran, with 30% coming back in. The success stories are significant. Unfortunately, this outreach does not count in terms of billable hours/counting toward productivity. However, their labor mapping should be changed as a result.

LRCs: These are high energy, highly motivated, capable people. The challenges we have is that 75% administrative time is difficult for leadership to accept. Because of their capability, they are tapped to do a lot of other things and frequently they wear multiple "hats". The time allowed for LRCs to focus on recovery transformation has become less and less. The SMI-re-engage program has been very helpful with encouraging facilities to backfill the LRC vacancies. It provides some motivation to get LRC positions filled. We usually have around 11-12 vacancies. LRCs are frequently not provided the time they need to focus on recovery transformation.

Concerns for our section and our mission: PSR&R is about implementing recovery in the system, making sure veterans with SMI—some of the most vulnerable veterans we treat—don't fall through the cracks and are able to receive the services they need. PSR&R is starting to see that fade. PRRC and peer support – these all factor in to suicide prevention. As the shift from central office to the field becomes stronger, we find it increasingly difficult to ensure fidelity to our

policies. These are the most vulnerable veterans and may be uniquely challenging to facilities, programs and providers.

Psychology Qualification Standards

After 2 years in concurrence, the newest revisions to the qual standards were published. The revisions are not major. The changes accommodate those who are respecialized and those senior psychologists who got training before 1979. There are also changes to the grandfathering clause. There's going to be a training coming on the changes to the qual standards.

There is an initiative to dissolve the Professional Standards Boards based on the belief that the board hold up onboarding of new staff. The policy to accomplish this is going through the concurrence process. This would mean the local, national, and VISN boards will be gone. This places complete responsibility for ensuring that the qual standards are met to the individuals in charge of the professional practice of the profession, who must work closely with HR. There is a concern that this will lead to an inconsistent application of the qual standards and to an increase in errors.

Stacey Pollack, Director, Program Policy Implementation

Benefits Administration

Related to the EO, OMHSP has updated all the TAP material (Transitional Assistance Program). VA only has 6 hours as a part of their TAP – and instead of having a separate section on mental health, we have woven it into the whole process. The contractors did a really good job of taking feedback and having mental health information being woven throughout. As part of the suicide prevention initiative, we re-worked the stressor form completely. The hope is that it will be out soon. Veterans will no longer need to fill out as much of the information that is often triggering; we have gotten the documentation requirements down to just what VBA actually needs. As a part of the suicide prevention initiative – OMHSP are talking with VBA about looking at all forms/letters/information that is given out. The hope is that when Veterans receive “bad news” (foreclosure, due bills, SC denied), the language can be soften and more information added about MH services and the crisis hotline. Margarita Devlin from Benefits Assistance Service is taking the lead on this from VBA. All of the VBA business lines, Compensation Service, Home Guarantee, etc, are working on the initiative. and are invested in being a part of the suicide prevention initiative.

OMHSP is going to update the TBI course for C&P evaluators after an OIG report and the Montana case (a psychologist did the RBANS, and because he wasn't a neuropsychologist, he was not deemed qualified by his state Licensing Board). VA disagreed with the Opinion of the State Licensing Board, but the psychologist was still reprimanded by the licensure board. The National Academy of Sciences is in the process of creating a committee to examine VA's processes and procedures related to TBI examinations whether we do adequate training, etc.

Dual relationship issues in VA

There was discussion about whether or not staff psychologists should be participating in police evals and EAP. Right now, these are controlled locally. There is not a lot of SME experts on police psychology within VHA. OMHSP is looking at whether it would be preferable to have all policy psychology evaluations done by contractors due to the issue of dual relationship. OMHSP is also looking at whether or not we should be providing EAP services internally. This takes away from patient access and also creates dual relationships.

Qual Standards

Updated MFT qual standards should be published at the end of this month – there was legislation that required the removal of the requirement for COAMFTE accreditation. There are now have 5 of the core mental health disciplines with program education accreditation requirements and one discipline without program accreditation requirements. OMHSP had concerns that Congress intervened and directed what must be in the qualification standards. There is a concern that once one of the core mental health professions does not have program educational accreditation that congress could dictate the same for other disciplines, including psychology.

For LPMHCs and MFTs, approximately ¼ of the packets that get sent to the Professional Standards Board are not qualified based on either education or grade level. There are concerns that when the Professional Standards Boards are eliminated individuals will get hired and may eventually be let go if/when it is discovered that they don't meet the qualification standards.

Recruitment/Retention

As part of the mission critical occupation workgroup, OMHSP is trying to put EDRP (recruitment and retention) on the list automatically for psychologists, even if they aren't listed as difficult to recruit locally. Currently each facility develops their own list of the top hard to recruit positions. That list may or may not be consistent with the national list. If psychology is not on the local list (even if it is on the national list) a psychologist may not be eligible for EDRP.

Wendy Tenhula, Director, Innovation & Collaboration (OMHSP)

Described the shift within VACO and the definition of roles. Centers of Excellence/MIRECCs, NC for PTSD, and VA/DoD all are part of the "Innovation and Collaboration" group in the Office of Mental Health and Suicide Prevention (OMHSP).

Long-term effects of VA funding going to Choice

The report that came about from RAND that suggests community providers are not well equipped to provide services to veterans as well as VA. Data is showing that a relatively low percentage of choice is mental health care – Veterans are "voting with their feet."

Special Purpose Funding

There has been a pause on the realignment of specific purpose funds to general purpose. The biggest impact would be on the Centers of Excellence but there were other programs that would also be affected. The health services committee has put together a taskforce on the Centers of Excellence, which Dr. Tenhula. Mental health is represented with three seats and

there are representatives from other specialized centers of excellence and various field based leadership roles. That group is in the process of meeting and gathering information on all Centers of Excellence and making recommendations about funding (will specifically be looking at those funded by special purpose funding when it comes to making recommendations). Parkinson's Centers, Centers of Epilepsy, MIRECCs, are the CoEs under discussion. Other programs have transitioned away from Special Purpose Funding to local, research, or other funding. GRECCs were changed over to general purpose funds. They now have metrics, a % of clinical care, and an extensive oversight process. There are mixed views on how this transition went and whether it has reduced their impact. The value of special purpose funding to the VA mission was discussed.

Leadership positions not being advertised to disciplines other than MDs

This continues to occur at some sites. Strategies for addressing it were discussed.

Prescription privileges

OMSHIP would benefit from knowing how many people in VA have been trained and what their opinions are. It would be good to have a sense of the pulse of the VA psychologists and the penetration. The idea is being discussed as a potential quick-win short-term solution for access to mental health care.

Wednesday, March 7th

Dr. Heather Kelly, Lead Psychologist for Veterans Military Policy

Met with Dr. Kelly to review the prior days and establish talking points for meetings with Congress and VSO's.

Ellen Garrison (Senior Policy Advisor to the CEO)

In a brief meeting, Dr. Garrison discussed "three main initiatives at the forefront of our innovative, cross-cutting work throughout the association":

1. New proposed joint membership dues agreement. This would involve APA members becoming members of a new 501c6 organization that would increase member benefits and expand and provide additional tools for our advocacy work across the full discipline and profession.
2. Master's level training. Currently under consideration – does APA want to accredit master's training for health service psychologists? What would the title be? What would their practice parameters be?
3. Clinical practice guidelines. A decision was made to develop a professional practice guideline. They are discussing the scope of this – leave it broad or exclusive to the first clinical practice guideline on PTSD?

Meetings with National Veterans Service Organizations

In attendance: representatives from AM-Vets, DAV, and American Legion

Friday March 9th

Deborah A. DiGilio (Director, APA Office on Aging, Public Interest Directorate), Maggie K. J. Butler (Director, Office of Disability Issues in Psychology, Public Interest Directorate)

Butler: We are expanding the narratives of disability, using grants, webinars, etc, to include all sectors, including veterans.

DiGilio: There is a new working group on end of life care, which is updating and creating educational materials for providers and policy makers. 3 out of 8 psychologists are in the VA. We work with the Elder Care Workforce Alliance to promote geriatric training. Integrated care models that include psychologists on the team, like home-based care in VA are important and not necessarily provided in private sector. We promote the models in our work.

Butler: What are some of the areas in terms of disability that you see struggles with?

AVAPL: When it comes to disability, it ties to service connection, there is a group of younger people who are working through that system; they are also struggling to find work and also work toward recovery. There is some transitional work there- voc rehab is only available to people with a certain level of service connection. We have tried to work with city vocational services.

Butler: A lot of my work experience was with veterans using shelters in Iowa. You see a lot of people who are not eligible, and the services at the shelter were not sufficient.

DiGilio: A lot of people do not know about how VA connects with local community groups and we educate them. One example is the National Coalition on Aging. We were able to facilitate presenters from the VA Central Office to its recent meeting to encourage community connections.

Butler: How can we best serve your psychologists who are interfacing with these individuals?

AVAPL: As younger people, they have little exposure to the disability process – assessing for it and/or what systems exist for disability. We have two systems to navigate. They have to figure out which system to work with first. Maybe for trainees – if there is something can be done to understand the disability systems; these systems are difficult to understand – comparisons and contracts.

Butler: How can we incorporate that into the learning space -in schools, sharing information from dept on education and psychology/counseling, webinar?

AVAPL: We use those videos on students with disability in supervision of supervision in some programs, discussing the parallel processes. If nothing else, it would be good to highlighting the resources you already have, letting others know they exist.

Sangy Panicker (Director of Research Ethics, Science Directorate)

Dr. Panicker oversees the Research Ethics Office in the APA Science Directorate. The office is works on ethical, legal, and scientific issues pertaining to the conduct of behavioral and psychological research, including issues related to research ethics and research integrity, protection of human participants in research, humane care and treatment of laboratory animals, research misconduct, data sharing and publication practices. She serves as the staff

liaison to the APA Committee on Animal Research and Ethics (CARE) and the APA Committee on Human Research (CHR).

Dr. Panicker discussed APA's assessment of the newly revised federal policy for the protection of research participants (Common Rule), which was issued on Jan 19, 2017, but is currently on hold. She noted that although the revised rules had the potential to meet the intended dual goals of enhancing research participant protections and reducing regulatory burden on investigators and institutional review boards (IRBs), the rule was so poorly drafted (including inconsistent terminology, lack of definitions, lack of specific details, etc.) as to render interpretation cumbersome at the local institutional level.

Dr. Panicker also raised the issue of the changing nature of tactics by so called "animal rights" groups – entities that are ideologically opposed to all research with nonhuman animals. She noted that while high profile groups such as PETA are still engaged in sustained, well-funded campaigns targeting individual researchers and research areas, newer organizations such as White Coat Waste have adopted a newer strategy of portraying nonhuman animal research as a futile endeavor and as such is a waste of taxpayer dollars. Regardless if the veracity of the statement, this particular group has publicly claimed victory for the VA shutting down research with dogs.

In its continuing effort to support and promoting ethically sound and scientifically valid nonhuman animal research, over the last few years, APA has sponsored Congressional briefings to accurately portray the nature of nonhuman animal research and its relevance to furthering scientific understanding of brain and behavior of people and other animals.

Jodi Ashcraft (Director, Advertising and Exhibit Sales)

Hiring Initiative

We are working with Lisa Kearney on how we can partner on the hiring initiative in VA. We have also been in touch with the in-house ad agency (J. Walter Thompson). Historically, different VA's have posted internally – what we hope to discuss with Lisa is to see if there is any way we could make it so we can highlight the mental health hiring initiative and also capturing those jobs. Taking those psychologist jobs and putting them on PsycCareers – putting them online and in the Monitor. We used to publish 88-92 pages of classified pages of jobs. Now it's 2-3 pages with most of them online now. The other things we've noticed over time is people tend to go to LinkedIn and other job boards.

As you have hired at individual VA's – how do you do that and where do you place that?

AVAPL: We blast listservs with announcements, target as many different listservs as we can (chief's, training directors, AVAPLs, divisions) – blanket as many of those as possible, and we do that to get around USAJOBS. There are requirements that make using that software more restrictive. We are encouraged to not use it; we can direct hire our own trainees much easier if we divert from USAJOBS. Since we have a lot of trainees, if we can time it right – near the end of training programs – we can find success in hiring trainees. But you have to be in this window of time – first of Jan through March. We have talked about using the Monitor – but the timing

has been an issue, but PsycCareers is another option for quick turnaround options. The number of people in the private sector who are competitive who want to come into the VA is not high. Also, it is a significant transition for folks who have been working in the private sector 30 years who come into the VA. The transition is often better for those coming from training programs. We also work with OAA – we also feel some loyalty to that office and their focus on training. Return on investment is a part of that, it also supports our training programs and other funding issues.

Ashcraft: What is the issue with USAJOBS?

AVAPL: there are some restrictions, some issues with working with HR, in general not using it eliminates unnecessary steps.

Sarah Martin is planning a special section of the Monitor on working at the VA. We want to do it in a good time window for hiring but we also want to time it right with what's going on in VA/Congress/society. We will be updating our PsycCareers site soon to make it a much better resource. We are also updating our careers tab on apa.org as well.

Since this meeting we have had a discussion with Lisa Kearney and her team. They recommended we publish the special VA editorial and classified section in the October issue of Monitor on Psychology to better align with the Mental Health Hiring Initiative. Work is underway now to make that happen.

Recruitment/Advertising

Recruitment advertising is huge. It is the way we connect with the market but we also collect a significant amount of revenue from it. The landscape has really changed over time.

AVAPL: At our conference, we usually have 2 tables – Pearson and ABPP. Do you have suggestions if we decided to open it up to other tables or exhibitors?

Ashcraft: Other testing companies to provide other options. MHS is an option (more willing to do different and new things). We have criteria for what we allow with different exhibitors. It is a living document. Our number 1 criterion is that they have to be related to the field psychology or improve the field in some way. We can decline anyone for any reason – very delicately and very vaguely, such as “it is too atypical for what we think will work and we just don't see it being a good fit for that reason.” I would be happy to send all of our policies. Please feel free to call me at any time with questions like that.