VA Mental Health Education Expansion, Phase II for 2014-15

I. PURPOSE AND OVERVIEW

Request for Proposals (RFP): The Office of Academic Affiliations (OAA, 10A2D), in collaboration with Veterans Health Administration (VHA) Mental Health Services and Office of Mental Health Operations, solicits proposals to expand opportunities in Department of Veterans Affairs (VA) behavioral and mental health clinical training programs. Such expansion is intended to increase expertise in critical areas of need, expand the recruitment pipeline of well-trained, highly qualified healthcare providers in behavioral and mental health disciplines, and promote the utilization of interprofessional team-based care. Successful proposals will result in the allocation of additional funded trainee positions to the facility. Paid training positions in the primary mental health disciplines of psychiatry, psychology, and social work may be requested through this initiative. Positions for pharmacy residents may also be requested provided the focus of the residency will be mental health and that pharmacy preceptors who are board certified in psychiatric pharmacy or who have a defined mental health scope of practice are available. Training positions in clinical pastoral education may be requested if mental and behavioral health services are emphasized in the curriculum. Trainees from additional disciplines may be considered with justification if a primary educational focus is on delivering behavioral or mental health care to Veterans. Proposals submitted in response to this RFP may not request any training positions outside of the behavioral and mental health programs described in this RFP. Funding will not be provided for other purposes, such as infrastructure, faculty development, or travel. VA sites are encouraged to think creatively and innovatively about provision of mental health services and may submit non-traditional proposals with the stipulation that all trainees must receive clinical experiences in at least one of the core mental health programs described below (Section III, A1-5). NOTE: There is a separate RFP for Nurse Practitioner Mental Health Residency programs. As a result, nursing positions may not be requested through this RFP.

This RFP lists three different categories of Mental Health programs that may be included in proposals (See Section III). All submissions must be based in at least one core mental health clinical training program from those listed in category A or in specific advanced training opportunities listed in category B. Proposals that also provide clinical experiences in programs targeting underserved populations, such as those listed in category C, will be given special consideration. Thus, unique and innovative rotations embedded in a core mental health program or advanced specialty program are encouraged. A facility may not submit more than two proposals.

II. BACKGROUND AND RATIONALE FOR INITIATIVE

OAA, with the concurrence of the Under Secretary for Health, has made a commitment to a 5-year expansion of approximately 1200 clinical training positions in mental health. This initiative reflects the convergence of several trends and commitments within VHA.
Specifically, this initiative is a response to the current efforts to enhance access to mental and behavioral health services for Veterans and to promote ongoing efforts to transform VA’s primary and mental health care delivery systems. It is also specifically intended to support VHA’s commitment to expansion of its mental health workforce.

Since 2004, VA has re-emphasized its commitment to meeting all mental and behavioral, as well as physical, health needs of Veterans. The agency formally adopted the VHA Comprehensive Mental Health Strategic Plan in 2004, followed in 2008 by VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics. The Uniform Services Handbook provides guidance to all VA facilities as to what mental and behavioral health services must be available for all Veterans.

In parallel with VA’s national transformation of its primary and specialty care delivery systems, preparing the future health professions workforce for practice in this new environment is a priority. An essential component of patient-centered primary or specialty care practice is interprofessional teamwork. High-functioning teams addressing behavioral and mental health needs require collaboration among diverse professions, including (but not restricted to) chaplains, nurses, pharmacists, physicians, psychologists, and social workers. Therefore, it is essential that all disciplines collaborate in the application process for this RFP. This OAA initiative is designed to enhance the development of true interprofessional care delivery teams in any of the targeted settings or programs described below in Section III.

The success of new educational partnerships will be critically dependent on the organization and culture of the clinical learning environment. Patient-centered clinical practices with strongly motivated leadership and high-functioning interprofessional teams will be essential for appropriate professional identity formation. The acculturation of learners to practice in patient-centered, team-based models of care is a central feature of this initiative. For a discussion of development of interprofessional competencies, please see Core Competencies for Interprofessional Collaborative Practice, developed by the Interprofessional Education Collaborative, found at https://www.aamc.org/download/186750/data/core_competencies.pdf.

In addition, this initiative is intended to expand training opportunities for (1) behavioral and mental health professions in rural and other underserved VA settings, including through telehealth care delivery and (2) VA’s large geriatric population, which has special behavioral health needs. Sites that meet these needs or that incorporate clinical rotations from among those specialized or innovative program areas listed in Section III.C will be given special consideration (See Section V.b.1-7 for review criteria).

Phase I of the Mental Health Education Expansion Initiative occurred in the fall of 2012, with new positions allocated for 2013-14. Phase I resulted in the addition of 86 trainee positions dedicated to outpatient mental health and 116 positions to Patient Aligned Care Teams (PACTs) with mental health integration.
III. PHASE II OF THE MENTAL HEALTH EDUCATION EXPANSION INITIATIVE

This Request for Proposals invites facilities to submit proposals that match their areas of strength or areas in which they have the potential to enhance innovative interprofessional clinical education programs in behavioral and mental health. Each facility may submit up to two proposals, each of which will be reviewed and rated separately. If submitting two proposals, a facility may submit two proposals from Category A, two from Category B, or one from Category A and one from Category B. For purposes of this RFP, health care systems with two or more divisions, such as Puget Sound (Seattle and American Lake) will be considered one facility rather than multiple.

Up to 300 recurring training positions may be approved under this RFP. OAA is particularly interested in soliciting proposals from facilities that can offer innovative and interprofessional educational opportunities and from facilities that traditionally have had smaller clinical education programs.

OAA, in collaboration with Mental Health Services, Office of Mental Health Operations, and Care Management and Social Work Service, encourages both the expansion of VHA’s core mental health training opportunities and incorporation of specialized or innovative program content areas into the core programs. Accordingly, OAA has developed a list of potential program content areas in three primary categories, Core Mental Health Programs, Advanced Clinical Education Programs, and Innovative Expansion Programs Targeting Underserved Populations. All program areas are important for the future of behavioral and mental health care in VA. Any individual proposal must include a minimum of one of the core programs listed below in category A or represent an advanced clinical training opportunity from those listed in category B. All proposed clinical education programs may include rotations in inpatient, outpatient, and residential settings. Special emphasis programs targeting underserved populations from category C may be included as innovative rotations in one of the core category A or advanced category B programs.

Category A: Core Mental Health Programs. Options described in this section represent core mental health clinical education opportunities into which trainees from any of the mental health disciplines might fall. Typically, a trainee is not assigned full time or for a full year to any of these sites or programs, but rather would rotate through them as part of a broad and comprehensive clinical education program. Instead, OAA would expect that for each trainee approved for these programs, the facility would commit to rotating the equivalent of 100% of an FTEE through the new position. Typically, this time commitment would be from a combination of several trainees.

A facility may choose to combine two or more of the Category A options into one comprehensive proposal.

1. Outpatient Mental Health Teams. All trainees in Outpatient Mental Health would spend the majority of clinical time providing care in the interprofessional general mental health outpatient clinic setting, working under the supervision of staff who are full time members of the outpatient mental health team. Training for interprofessional care must be a core component of education, along with skill development in discipline-specific care. In
addition, training in adaptations of care for the older adult population must be a core component. This geriatric focus would include clinical education on adaptations of assessment and diagnosis; close interrelationships of medical, behavioral, and mental health problems in this population; identification of suicide risk; pharmacology utilization; and adaptations of brief psychosocial interventions for older adults.

2. **Patient Aligned Care Team (PACT) - Mental Health Integration.** All trainees for the integrated behavioral and mental health component of PACT care must spend significant time providing care in the PACT setting, working under the supervision of staff who are members of the integrated mental health component of PACT. Training for interprofessional care also must be a core element of education, along with skill development in discipline-specific care. In addition, training in adaptations of care for the older adult population would be a core component. This geriatric focus would include clinical education on adaptations of assessment and diagnosis; close interrelationships of medical, behavioral, and mental health problems in this population; identification of suicide risk; pharmacology utilization; and adaptations of brief psychosocial interventions for older adults.

3. **Psychology Internship.** OAA will accept proposals for new Psychology Internship programs in states where no VA internships exist or at a facility located in a federally designated mental health professional shortage area (see [http://bhpr.hrsa.gov/shortage/updateddesignations/2012June29/mentalhealthhpsas06292012.pdf](http://bhpr.hrsa.gov/shortage/updateddesignations/2012June29/mentalhealthhpsas06292012.pdf)). Such new internship programs must incorporate a curriculum in interprofessional education and collaborative practice, as well as more traditional psychological practice. Each may request a maximum of four interns for the new program, depending on facility infrastructure and ability to absorb trainees. If approved, a new program must become a member of the Association of Psychology Postdoctoral and Internship Centers (APPIC) and must receive accreditation from the American Psychological Association within three years of program initiation.

4. **Expansion of pipeline psychiatry residency programs, PGY-1 to 4,** with an emphasis on interprofessional training. OAA recognizes that general psychiatry residency programs must provide a broad array of experiences and that most programs follow a pattern where the first year is primarily inpatient, the second year largely outpatient, and the third to fourth years allow extensive elective experiences depending upon the interests of the individual residents. If this option is chosen, sites must explain how exposure to interprofessional models of mental health care would be structured into VA clinical training experiences at each level of the program.

5. **Expansion of accredited subspecialty psychiatry fellowship programs,** PGY-5, with an emphasis on interprofessional training. OAA recognizes that accredited subspecialty psychiatry fellowship programs provide valuable training and improve patient access to care in addiction psychiatry, geriatric psychiatry, and psychosomatic medicine. If this
option is chosen, sites must explain how exposure to interprofessional models of mental health care would be structured into VA clinical training experiences. Note: all programs must be accredited and only programs in the 3 specialties of addiction, geriatrics, and psychosomatic medicine will be considered for funding. These three specialties may also be integrated into any of the other content areas listed in this RFP, such as PACT.

**Category B: Advanced Training Opportunities.** OAA has traditionally supported a handful of specialized, advanced training programs in order to develop health care professionals who have the expertise, knowledge, and skills to lead VA’s development in those specialized content areas. To that end, this RFP also includes opportunities for modest expansion of these programs.

1. **Rural Health.** Proposals with Rural Health rotations must include training in rural behavioral and mental health, including development of expertise in telemental healthcare delivery. Trainees may be funded at sites delivering telemental health care to rural areas or to Veterans who need telemental health care for other reasons. Training must include delivery of care to rural areas and the specific training for using telemental health services. At least two mental health disciplines must be engaged in the educational and care delivery processes. Psychiatry positions must be in accredited programs and accredited years.

As one example of expansion of training in rural health a Psychology Postdoctoral Fellowship in Rural Health Care might be considered. These fellowships must commit to greater than 60% time allocation to work in mental health. Up to three sites, each with one or two fellows in one discipline or up to four fellows (if two disciplines are proposed) may be approved as a three-year pilot program. Despite the discipline-specific nature of these fellowships, proposals must incorporate interprofessional education and collaborative practice in order to be approved. See Appendix D.

2. **Interprofessional Fellowship Programs in Psychosocial Rehabilitation and Recovery (PSR).** The purpose of the program is to develop future mental health leaders with vision, knowledge, and commitment to transforming mental health care systems in the 21st century by emphasizing functional capability, rehabilitation, and recovery. This program provides clinical training on the theory and practices of psychiatric rehabilitation to help support the recovery of Veterans living with serious mental illness.

There are currently Interprofessional PSR programs at six VA sites. Each of these programs is funded annually for one full time, full year fellow in each of four disciplines, nursing, psychiatry, psychology, and social work. Funded fellows also come from other disciplines with a strong commitment to rehabilitation and recovery, such as occupational therapy.
OAA will consider proposals to expand existing programs by up to two positions each, for a total of 6 trainees. New positions may target the same four disciplines as currently are funded or may, with justification, add new disciplines to the interprofessional mental health team.

Trainees in new positions will be expected to develop and implement Educational Dissemination Projects to increase professional education and quality of care beyond the training site.

Expanded programs will also be encouraged to build capacity to extend training in psychosocial rehabilitation and recovery to inform the care of Veteran populations not widely served by PSR, such as Veterans with PTSD and those with other co-occurring psychiatric, substance use-related, and medical concerns.

3. **Palliative Care Interprofessional Fellowship Program.** Proposals may be submitted to expand existing interprofessional palliative care programs by up to two positions each, for a total of 6 trainees per site. Proposals submitted for Palliative Care programs must focus on the behavioral and mental health aspects of palliative care services. They may be used only for training positions in the mental health disciplines, and they must focus on behavioral and mental health curricula and care delivery.

**Category C: Innovative Expansion Rotations Targeting Underserved Populations.** Options described in Category C are intended to supplement or round out the core mental health programs listed in Category A and advanced programs in Category B. A facility may choose to include any of these specialized emphasis areas subject to its infrastructure and programmatic offerings. Selections from Category C are not intended to be stand alone proposals but may be incorporated into a broader proposal that recognizes the critical importance of training at this level being broad and general in nature.

1. **Family Support Programs.** This option targets expansion of interprofessional mental health training in couple and family services by encouraging Interprofessional clinical rotations through Family Support programs. The goals of these programs would be to develop health care providers across the mental health disciplines who have the skills and knowledge necessary to provide assessment and treatment of marital, family, and caregiver support systems with a goal of enhancing the strength of the family unit. Ultimately, it is expected that enhanced functioning of the family unit will support the recovery and improved functioning of the Veteran. See Appendix B for a more detailed description of what these programs might look like.

Family Support programs must provide services to Veterans of all eras. In addition, such programs must include trainees from at least three disciplines, with an interprofessional curriculum and plans for interprofessional, collaborative practice. Only sites where supervising practitioners have received VHA training in family and caregiver psychoeducation in addition to family and couples therapies, or with demonstrable expertise, are eligible to include trainee rotations in family support.
2. **Innovations in Substance Use Disorder (SUD) Care.** A proposal incorporating this content area must demonstrate the types of evidence-based treatment modalities to be provided and a curriculum for teaching these services in an interprofessional service delivery system. Rotations in this area may include residents or fellows in addiction medicine or addiction psychiatry in addition to other associated health trainees. Facilities submitting proposals are encouraged to consider linkages between pain and SUDs and between PTSD and SUDs. Proposals incorporating training in substance use disorder care must be interprofessional in nature and include at least three disciplines in the training programs.

3. **Rotations in Interprofessional Health Care for Lesbian, Gay, Bisexual, and Transgender (LGBT) Veterans.** These interprofessional rotations should provide training in delivery of health care, including both physical and mental health care, for LGBT Veterans. These clinical experiences should provide interprofessional training and assure collaborative practice with a particular focus on PACT care and sensitive comprehensive care for the Veterans they serve. Trainees from at least two mental health disciplines must be engaged in these rotations. Please refer to Appendix C for a fuller description of this option.

4. **Physical Rehabilitation.** Mental and behavioral health services are integrally involved in existing rehabilitation care programs including polytrauma, spinal cord injury, and blind or low vision rehabilitation. Proposals may be aimed at development of behavioral and mental health professionals with expertise in evaluation and treatment in rehabilitation areas at any existing VA rehabilitation center.

5. **Other Innovative Rotations** that the facility is able to propose. These should fit previously unmet behavioral and mental health needs of Veterans or develop innovative ways of training and delivery of mental and behavioral health care. This option provides the facility a chance to tell OAA what clinical exposure is needed or how it can creatively meet the needs of VA’s future health care professionals and Veterans. We invite sites to think creatively and let us know what the real needs are and how to assemble an interprofessional staff to train multiple relevant trainee disciplines.

All approved new programs will be required to participate in an annual OAA-determined evaluation process for at least the first three years of funding (through the 2016-17 year). Details of the evaluation will be specified as the programs are implemented and will include such factors as accreditation, completion rate, trainee satisfaction, and competency assessment.

**IV. APPLICATION INSTRUCTIONS**

**A. DEADLINES.** There are two key deadlines for this initiative.

**August 5, 2013.** A Letter of Intent (LOI), separate for each proposal, is due to OAA no later than 11:59 pm Eastern Daylight Time on August 5, 2013. These letters are to allow OAA to project the demand for expansion positions and to allow us to plan for the review panels that will be needed to review these proposals.
September 5, 2013. The full proposal is due to OAA no later than 11:59 pm Eastern Daylight Time on September 5, 2013.

B. LETTER OF INTENT INSTRUCTIONS

Letters of Intent, not to exceed two pages, must be submitted by the medical center or health care system’s Designated Education Officer (DEO) rather than by individual service lines within the medical center. Each facility or health care system may submit up to two separate LOIs.

Letters of Intent are due no later than 11:59 pm Eastern Daylight Time on August 5, 2013, and must be sent via email to VHACOAA@va.gov. Letters should be addressed to the Chief Academic Affiliations Officer (10A2D).

Letters of Intent should be from the Designated Education Officer and should contain the following information (OAA recognizes that some of this information might evolve or change with the development of a full proposal):

1. Name, credentials, and contact information for the person responsible for the proposed education program.
2. Content areas of submission anticipated, selected from those listed in Section III, ensuring that at least one option from Category A or B is highlighted.
3. For each discipline for which training positions will be requested, the number and educational level of trainees (e.g., “2 Pharmacy Residents, PGY2” or “3 Psychology Postdoctoral Fellows”).

C. PROPOSAL INSTRUCTIONS

Proposals must be submitted by the medical center or health care system rather than by individual service lines within the medical center. Each facility or health care system may submit up to two separate proposals, each of which may be no more than 12 pages of narrative, single spaced, with 12 point Arial or Calibri font. Margins must be at least one inch all around (excluding headers and footers). Proposals will be uploaded through the OAA Portal in three sections, Core Narrative, Support Letters, and Supplemental Materials (optional). These materials may not exceed 40 pages total. Any pages in excess of 40 will not be read or reviewed.

Core Narrative, not to exceed 12 pages, must include these elements:

1. Designation of the core initiative under which the facility requesting trainees, corresponding with categories A1-5 or B1-3 as well as any innovative rotations from categories C1-5 listed in Section III above. Please include both the number and the title of the core or advanced initiative in addition to all innovative clinical rotations corresponding with programs targeting underserved populations. Facilities requesting trainees for more than one of the core or advanced options should submit a separate proposal for each unless the options are combined to generate one training program.
Thus, a facility may combine more than one of the initiatives listed above into a single proposal as long as the requirements for each are fully met (i.e. a trainee may be primarily integrated into PACT while receiving exposure to a rehabilitation center or family support rotation).

2. Name, position, and contact information for the person responsible for the interprofessional clinical education programs.

3. Name and title of each individual to be notified of decisions regarding approval of the proposal. These must include the facility Director and the Designated Education Officer as well as any others the facility desires. Please include any non-VA email addresses to be used.

4. Table of trainees requested. Copy the table in Appendix E and include
   a. Professions requested
   b. Level of training in discipline (e.g., psychology intern vs. postdoctoral fellow, or, for physician residents, PGY level)
   c. Number of trainee positions and hours per position requested for each discipline

5. Details of how trainees will be assigned to the VA training sites (e.g., whether the trainee experience will be full time, year-long in the identified settings or rotational in nature and, if rotational, the duration of each clinical experience).

6. Accreditation status of each involved discipline’s training program.

7. Identified faculty and supervisors, with credentials and qualifications briefly described.

8. VA training sites (e.g., specific clinics, CBOCs, or other venues to which trainees will be assigned), with brief descriptions of each site. Describe how training sites will be committed to patient-centered, team-based delivery models for providing clinical services to Veterans. Identify the relevant mental and behavioral health care practices in these training sites. Describe how the training venues will have appropriate, on-site supervision and role models for trainees of all involved professions. **NOTE:** Veterans Centers may not be used as training sites unless there is a signed MOU between the Center and the VHA facility that specifies how the Center complies with national VHA trainee policies.

9. Narrative description of the proposed training programs, including a description of the Interprofessional Curriculum. The proposal should emphasize the “core” educational objectives and “critical” outcome measures that will be used to establish the effectiveness of the new curriculum. The curriculum must emphasize experiential learning in addition to didactic pedagogy. These elements should be included in the curriculum:
   a) **Shared Decision Making:** At a minimum, the proposals should address the assessment and alignment of health interventions with patients’ preferences, shared goal setting, patient education, promotion of healthy behaviors, and self-management.
   b) **Sustained Relationships:** Proposals should describe how trainees will be integrated into patient-centered practices at the VA, as well as how continuity will be maintained when trainees are not physically present. Ideally, there would be continuity with a panel of patients as well as with supervising practitioners.
c) **Interprofessional Collaboration**: Applicants should describe how they will design curricula to foster interprofessional learning, with an emphasis on experiential learning in addition to didactic experiences. Curricula need not be entirely “in common” between professions. Rather, they should reflect prior learning experiences and expected roles in high-functioning, interprofessional care teams in clinical settings.

d) **Performance Improvement**: Ongoing and substantial involvement in panel management and performance improvement activities must be integral components of the curriculum. Describe how trainees will establish, track, and use quality measures to enhance patient outcomes.

**Letters of Support** must provide assurance of local facility and VISN support. Medical Center and VISN leadership must have a demonstrated commitment to health professions education, behavioral and mental health care, and patient-centered practice models. There must be a letter of support from each of the individuals listed below:

1) Facility Director. The director’s letter must address the facility’s commitment to the educational process, including sufficient release time for the program directors, mentors, and supervisors to be fully engaged in the educational mission and process, as well as administrative support. For any proposals that will ultimately result in accreditation expectations (such as psychology internship or postdoctoral fellowship programs), the director must indicate willingness to pay accreditation fees and membership fees for any required professional or match organizations.

2) Facility Designated Education Officer (DEO) or Associate Chief of Staff for Education

3) VA Training Director for each discipline requesting trainees

4) VISN Director (through the Chief Medical Officer)

5) Designated Institutional Official at the affiliate if psychiatry residents are requested

**Supplemental materials.** Supplemental materials, such as brief biographical sketches for the program directors, may be added as desired, so long as the total number of pages in the proposal does not exceed 40.

**D. SUBMISSION OF PROPOSALS**

1. **Preparation of Applications.** The VA Designated Education Officer (DEO), ACOS/Education, or equivalent should be the focal point for coordination and submission of the Letter of Intent and Full Proposals.

   a) **File formats.** Word, Excel, PDF, or TIF files formats may be used. Letters must include a signature (i.e., they must be a scanned copy of an original, signed document).

   b) **Font and margin sizes.** Font size must be 12-point Arial or Calibri for narrative portions. Margins must be at least one inch all around (excluding headers and footers).
2. **Online submission instructions:**

Applicants will submit the Core Narrative, Letters of Support, and supplemental materials using an OAA Support Center password protected web portal. A special application entry point has been established for submission of applications in response to this Program Announcement. Proposals are to be submitted through this site: http://vaww.oaa.med.va.gov/rfp_general/default.aspx?PID=13. The individual submitting the proposal will need to register on the first use of this portal.

   a) The application will be uploaded as two or three files, depending on whether supplemental materials are submitted.

   b) The Mental Health Expansion application site will be opened and ready to accept applications after the Letter of Intent deadline. Applications may be changed or modified up to the closing date for applications. Only authorized individuals may upload files or other information into the application database.

   c) **Faxed, mailed, or e-mailed applications will NOT be accepted.**

V. REVIEW PROCESS

a. **Review Committee:** An ad hoc, interprofessional peer review committee designated by the Chief Academic Affiliations Officer (CAAO) will assess the merits of applications. Reviewers will have demonstrated expertise and leadership in education and patient care. The CAAO may, at his discretion, create subsets of applications for special review according to considerations such as rurality, site complexity, and other needs consistent with VA goals and missions.

b. **Review Criteria:** Applications will be scored according to these criteria:

   Required: Demonstrated commitment from the local VA facility and VISN, including executive and program management levels, to patient-centered care and the particular requirements of this Program Announcement, by guaranteeing protected time for program directors and supervisory staff. If applicable, demonstrated commitment from academic affiliates to support the training program expansions and to recruit for any new positions.

   1) Strength of the proposed faculty and curriculum, including potential to achieve the primary objective of integrating trainees from multiple disciplines into high-functioning care teams focused on mental and behavioral health and all facets of health care that interface and the inclusion of thoughtful strategies to surmount difficulties of interprofessional endeavors.

      **25 points**
2) Strength of the interprofessional team functioning in the sites for which trainees are requested, including evidence of high-functioning care teams and evidence of thoughtful strategies to integrate trainees in these interprofessional endeavors.

   25 points

3) Incorporation of innovative emphasis areas into core and advanced training programs as described in Section III.C.

   10 points

4) Special consideration for documentation of service to predominantly Rural and Highly Rural Veteran populations or Veterans residing in underserved locales.

   10 points

5) Special consideration for curricula that incorporate significant educational experiences in behavioral telehealth.

   10 points

6) Special consideration for curricula that incorporate significant educational experiences in psychogeriatrics.

   10 Points

7) Special consideration for facilities with small clinical training programs.

   10 points

VI. SCHEDULE

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<tr>
<th>Date</th>
<th>Event</th>
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<tr>
<td>July 16, 2013</td>
<td>OAA sends Program Announcement to eligible facilities, VISNs, and appropriate Central Office officials. Program Announcement published on OAA website.</td>
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<tr>
<td>August 5, 2013</td>
<td>Nonbinding letter of intent due to OAA.</td>
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<tr>
<td>September 5, 2013</td>
<td>Full Proposals from eligible facilities due in OAA via an ONLINE submission process</td>
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<tr>
<td>September 30, 2013</td>
<td>OAA notifies facilities about the approval/disapproval of proposals</td>
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<tr>
<td>December 31, 2013</td>
<td>Selected Programs submit curricula for OAA review</td>
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<td>July – September, 2014</td>
<td>Trainees begin according to respective academic cycles</td>
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VII. OAA CONTACT PERSONS

a. **General information:** Please contact Debbie Hettler at (202) 461-9499, (Debbie.Hettler@va.gov), Stacy Pommer at (202) 461-9877, (Stacy.Pommer@va.gov), or Robert Zeiss at (202) 461-9493, (Robert.Zeiss@va.gov). Questions about inclusion of psychiatry residents should be referred to Judy Brannen at (804) 675-5481, (Judy.Brannen@va.gov).

b. **Technical information:** For information regarding the online submission process, e-mail the OAA Help Desk (oaahelp@va.gov) or contact David Bernett at (803) 647-5806, (David.Bernett@va.gov).
APPENDIX A. TRAINEE POLICIES.

a. **Physician Trainees:**

1) **Governance.** OAA maintains overall responsibility for the administration of VA’s Mental Health Primary and Specialty Care education. Academic institutions providing physician trainees to these programs shall comply with the Program Requirements for Residency Education (as published in the current Graduate Medical Education Directory), the requirements of the Liaison Commission on Medical Education (LCME), and VA provisions for the training of medical students and residents. Applicable requirements of the Accreditation Council for Graduate Medical Education (ACGME) and the program-specific Residency Review Committee (RRC) must be addressed in the proposal.

2) **Graduate Medical Education (GME) Program Sponsorship.** GME positions currently allocated to the facility may be included in activities undertaken as a part of this Program Announcement. _No new residency programs sponsored in the name of a VA facility may be initiated._ Existing, accredited psychiatry programs may seek additional positions under this RFP.

3) **OAA Support for Trainees.** OAA will provide funds to VA facilities for residents’ stipends and fringe benefits. Funding of physician residents’ stipends and benefits through a disbursement agreement is recommended. Disbursement agreements cannot be used to fund administrative costs of residency training programs.

4) **Appointment and Compensation of Physician Residents.**

   a) **Appointment authority.** Appointments will be made under 38 U.S.C. 7406.

   b) **Stipend determination.** The stipends of individual positions or fractions of positions will be based on PGY levels and VA stipend rates based on the local indexed hospital. Physician resident positions can be paid directly or reimbursed under a disbursement agreement only for the time spent in educational or clinical activities at the VA facility, with excused absences as defined by VA policy (e.g., didactic sessions).

5) **Liability.** Physician residents and students will be protected from personal liability while providing professional services as a trainee at a VA facility under the Federal Employees Liability Reform and Tort Compensation Act, 28 U.S.C. 2679(b)-(d).

6) **Trainee expenses.** Except as specified above, expenses connected to trainee recruitment, educational activities, or research are not funded under this program. Transportation to the VA facility and housing arrangements are the sole responsibility of the trainee.

b. **Trainees in Associated Health Disciplines:**

1) **Governance.** OAA maintains overall responsibility for the administration of VA’s health professions education. All “associated health” trainees (defined here as trainees not in dentistry, medicine, or nursing) included in these teams shall comply with the
Program Requirements of the respective discipline’s educational accreditation bodies and with VA provisions for training in those disciplines.

2) Program Sponsorship. Currently allocated facility associated health trainee positions may be included in activities undertaken as a part of this Program Announcement. All trainees must be in programs sponsored in the name of an affiliate or in internships and residencies sponsored by the VA, such as psychology internships and postdoctoral training programs or pharmacy residencies.

3) OAA Support for Trainees. OAA will provide funds to VA facilities for trainee stipends and fringe benefits when involved in activities of these programs.

4) Appointment and Compensation of Trainees.
   a) Appointment authority. Appointments will be made under 38 U.S.C. 7405.
   b) Stipend determination. The stipends for individual positions or fractions of positions will be based on the discipline, educational level, and geographically adjusted VA stipend rates.

5) Liability. Trainees will be protected from personal liability while providing professional services as a trainee at a VA facility under the Federal Employees Liability Reform and Tort Compensation Act, 28 U.S.C. 2679(b)-(d).

6) Trainee expenses. Except as specified above, expenses connected to trainee recruitment, educational activities, or research are not funded under this program. Transportation to the VA facility and housing arrangements are the sole responsibility of the trainee.
Appendix B. Family Support Programs: Proposal to expand Health Professionals training in couple and family services for Veterans

Background

The scientific literature in the areas of psychological resilience and natural recovery suggest that the majority of people exposed to stress benefit primarily from their natural support systems, the most important of which is their nuclear family and their intimate partnership.

1. Absence or deterioration in such natural support systems partially predicts help-seeking from professional resources. Health care costs can be reduced when a patient’s natural support system is strengthened (or when a distressed couple or family is restored to functioning status so that its natural ameliorative processes can resume).

2. Health care costs can be reduced and access improved when patients are treated in a stepped care model, such that the smallest dose of appropriate treatment is delivered by providers at the point-of-entry to the health care system, as an element of holistic care, in the form of secondary-prevention (i.e., less-intrusive intervention that promotes wellness and aims to forestall the development of maladaptive mechanisms), with specialty services available on referral for the most distressed or complex cases. This approach is entirely consistent with the Patient Aligned Care Team (PACT) model.

3. Evaluation and intervention with stressed and distressed couples or families typically requires contact with providers of multiple disciplines (e.g., psychology, social work, family medicine), which makes it logical that such services should be offered within a PACT framework and in an interprofessional environment.

4. Families of returning service members typically include children. These children are at risk for developing emotional, behavioral, and health problems associated with deployment absences, post-deployment readjustment, frequent life changes, parental unemployment, and parental health conditions. Therefore, problems experienced by children necessarily impair the wellness of the entire family and particularly the Veteran. These child behavior problems can be addressed through parent education and empirically-supported models of Parent Training. An improvement in parenting skills leads to improvements in overall family functioning and satisfaction, which holds promise for improving Veterans health status.

Therefore,

1. In order to maximize the natural recovery processes inherent in a Veteran’s primary social support system (and thereby improve the Veteran’s overall health condition while simultaneously reducing health care costs and improving access to care), it is necessary to increase the availability of evidence-based couple and family services.

2. Given the barriers for insurance reimbursement of couple and family treatment, the dissemination and implementation of evidence-based approaches in this area has significantly lagged behind individual treatment approaches, despite its strong empirical base. That is, reimbursement is frequently allowed for individual but not multi-client encounters. As a consequence, there is a relative paucity of education and training...
opportunities in health care programs, as well as a relative shortage in the professional workforce capable of delivering such care.

3. Veteran health care would be improved by the inclusion of advanced training of mental health, behavioral health, and physical health providers in the delivery of couple and family services, within a stepped care, interprofessional model.

Proposed training program

1. Each program would comprise a training infrastructure, which as part of its educational mission would provide services to a Veteran as a member of a couple or family. The program would fulfill this service mission while providing advanced training to an interprofessional cohort of trainees with terminal degrees (i.e., a fellowship program).

2. The infrastructure at each site would include a core faculty composed of providers from multiple disciplines, each with expertise in an area that promotes couple and family wellness. At a minimum, this would include psychology, psychiatry, and social work. Ideally, it would include family or primary care medicine. It could include additional disciplines as appropriate to local circumstances, such as nursing, pharmacy, and chaplaincy. Each site would sponsor a cohort of advanced trainees from those disciplines represented by the core faculty.

3. Training would be delivered within an interprofessional model. Didactics would include trainees from all disciplines, to be taught by core faculty from different disciplines, with an emphasis on shared functions and roles, while still allowing for some discipline-specific activities. VA’s Interdisciplinary Fellowship in Substance Abuse and the Centers of Excellence for Substance Abuse Treatment and Education (CESATE) are successful models to emulate.

4. The Center itself might logically be ‘housed’ within a Mental Health service, but training and services should cut across clinic silos, with a focus on delivering stepped care. For example, trainees might be located in (or deliver services to) Primary Care, PTSD Clinical Teams, Women’s Clinics, or Polytrauma programs. Trainees of all disciplines would receive supervised experience in

- screening of relationship and family problems
- brief interventions aimed to restore normal system functioning
- consultation to primary care providers (including training and coaching of providers in brief couple and family interventions)
- identification and referral to community resources, including housing, childcare, and emergency finances
- referral of non-Veteran family members to community health care or other necessary resources in order to reduce family stress and burden.
The goal of these trainee activities would be to assist primary VA providers in supporting family integrity or to provide brief services themselves as an integrated member of a primary care setting.

5. Trainees would also learn advanced skills in treating distressed couples and families, for those cases that are not appropriate for management in Primary Care due to severity or complexity (e.g., self-harm, violence, acute psychiatric condition, or substance use). These skills would include empirically supported treatments aimed at strengthening the relationship itself as a means of secondary prevention or treatments that appear to ‘supercharge’ gains achieved by other treatments that specifically target PTSD. Additionally, trainees would receive education and supervised practice in teaching parenting skills to be offered to Veterans and families as a preventive measure or as a stand-alone intervention. Many of these services could be offered conjointly by trainees, thereby enhancing the interprofessional nature of training.

6. Training should include delivery of these services via Telehealth, especially to CBOCs in underserved or rural areas where availability of evidence-based couple or family care is negligible or non-existent.

7. Given the rollout of Integrative Behavioral Couple Therapy (IBCT), the expansion of Integrated Primary Care, and numerous Social Work programs aimed to assist returning Veterans, it is likely that many VA facilities could organize existing faculty resources and training infrastructure to create such a Center for Family Support. Further, these Centers could be linked nationally sharing curricula and didactics.

8. The programs would be in alignment with important VA emphases on Wellness and Recovery (i.e., support and strengthen natural systems of recovery), on improving access and reducing costs (i.e., stepped care, especially within Integrated Primary Care settings), and on interprofessional training (made especially feasible given the frequent use of co-providers in couple and family interventions).

9. Training would best occur at an advanced level (i.e., post-terminal degree or Fellowship level) given the complexity of couples and families, and given the focused nature of such professional training.

Brief summary of research support (authored by Meghan McGinn, M.A., Psychology Intern, VA Puget Sound, Seattle)

In recent years, the study of Veteran families within the VA system has become more in line with the VA mission, as priorities have shifted towards serving the whole family rather than just the Veteran. This is evidenced by initiatives such as the Caregiver Support Program and the recent roll-outs for couple and family-based interventions. Further, as social support has been cited as a buffer for PTSD, with individuals who perceive greater social support less likely to develop symptoms (Ozer, Best, Lipsey, & Weiss, 2003), there has been increasing interest in the ways in which couple or family relationships may facilitate or hinder PTSD recovery. Indeed, Evans et al (2010) found that family functioning for Veterans enrolled in a skills group for PTSD was not only related to the severity of their pre-treatment symptoms, but also predicted their 3 months post-treatment symptoms, suggesting that family functioning may play
an important role in the extent to which individuals may benefit from PTSD treatment. From a systems perspective this is not surprising, as both the Veteran and the family have often made behavioral adaptations to cope with the Veteran's PTSD symptoms, and some of these accommodations may in fact hinder behavioral change.

One's partner is often a primary source of social support and a key player in an individual's family environment; thus, couple-based interventions may be particularly helpful in addressing the ways in which the family system maintains PTSD symptoms. There is preliminary support for couple-based interventions specifically designed to treat PTSD, such as Monson and colleagues' CBCT for PTSD, which has been shown to be effective in improving PTSD symptoms and relationship satisfaction from pre to post treatment (Monson, Fredman, & Riggs, in press).

We might also expect some benefit from couple therapies that are not specifically trauma-focused in nature. Common principles of couple therapies include eliciting emotion-based, avoided, private events and altering patterns of communication, such as mutual avoidance (Benson, McGinn, & Christensen, in press). Therefore, engaging in couple therapy may counteract the generalized avoidance and emotional numbing symptoms of PTSD. It has been suggested, for instance, that IBCT, which is currently being disseminated in VA nationally, may be particularly well-suited towards reducing experiential avoidance and numbing in combat veterans (Erbes, Polusny, MacDermid, & Compton, 2008); however this is yet to be demonstrated empirically. Whether IBCT or other couple-based interventions offered within VA do indeed have this impact is an important question, as one or both partners may be unwilling to engage in treatment that is explicitly trauma-focused, but could still see significant improvement in quality of relationships and quality of life with improvements in this symptom cluster. Alternatively, partners may subsequently be more willing to engage in trauma-focused treatment as experiential avoidance decreases and social support improves within the context of their primary relationships.

Thanks to Stephen McCutcheon for preparing the first draft of this program conceptualization. As a subject matter expert, Dr. McCutcheon may be contacted with any questions.
Appendix C. Interprofessional Health Care for Lesbian, Gay, Bisexual, and Transgender (LGBT) Veterans

Purpose

The purpose of the interprofessional\(^1\) Lesbian, Gay, Bisexual, and Transgender (LGBT) Clinical programs is to expand VA’s clinical capacity for working with sexual and gender minorities by developing clinical leaders in LGBT health care and education. This pilot may establish up to five LGBT training programs over a three-year trial period. The goal of the interprofessional LGBT Fellowship programs is to produce a pipeline of nurses, physicians, psychologists, and social workers with expertise in collaborative LGBT health care practice in VA settings.

Background

At present, VA has few clinicians with expertise in cultural and clinical health care issues affecting LGBT Veterans. Training in LGBT health care is not routine in VA and only recently has system-wide training on transgender health care been available in VA. Four recent events have reinforced the need for trained and culturally competent LGBT health care providers in VA:

2. The repeal of Don’t Ask, Don’t Tell increases the likelihood that openly gay, lesbian, and bisexual Veterans will access VA services.
3. VHA Directive 2011-024 on transgender health care (www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2416) describes the services available to transgender Veterans. This policy will likely increase the number of transgender Veterans who receive care at the VA.
4. In a report to the Principal Deputy Under Secretary for Health, the Office of Health Equity (April 16, 2012) stated: “VHA needs to take a forward-leaning stance toward LGBT Veterans as a means to concretely demonstrate that we have an environment and culture that is informed, welcoming, positive, and empowering to all the Veterans and families whom we serve (p. 5).” The report recommends training for clinical staff on LGBT health care.

“LGBT” refers to diverse groups with different needs, although all experience common health care disparities due to social stigma, victimization, and discrimination due to minority status. Generally, lesbian, gay, and bisexual groups are related by issues of sexual orientation. The transgender group primarily involves issues of gender identity. A subset of transgender

\(^1\) Interdisciplinary refers to collaborative, team-based care or decision-making that involves several specialties within the same profession: e.g., a mental health clinic involving psychiatry and psychology. Interprofessional refers to collaborative, team-based care involving members from more than one profession: e.g., primary care clinic involving primary care, social work, nursing, and psychology.
Veterans meet criteria for Gender Identity Disorder (GID) and may be engaged in behavioral and body modifications to appear as their preferred gender.

The prevalence of LGBT Veterans is unknown. These groups currently are not identifiable in DoD or VA databases. Population estimates of transsexuals seeking sex change (a subset of transgender individuals) are about 1:11,000 natal males and 1:30,000 natal females (Bakker, van Kesteren, Gooren, & Bezemer, 1993). That figure could mean about 2,000 transsexual Veterans, if the prevalence among Veterans is similar (e.g., Brown, 1988), but could be as high as 6,000 extrapolating from a convenience survey of the rate of Veteran status in the transgender community (Shipherd et al., 2011). In addition, some evidence suggests that transgender rates of VA utilization are high among transgender Veterans (Shipherd et al., 2011). Based on 2000 US Census data and more recent studies, the prevalence of LGB active duty military personnel is about 3% (Gates, 2010). If the rate among Veterans is similar, there could be more than 600,000 LGB Veterans. These figures are probably an underestimate of the actual number of LGBT Veterans. It is unknown what proportion of LGB Veterans utilize VA health care services.

Program Description

At this time, OAA is able to fund mental health training positions that provide an emphasis on LGBT clinical needs. These positions must be part of core mental health clinical education programs, with rotations to specialized emphasis areas experiences.

Program curriculum may vary based on the strengths of the site. However, at minimum, content should include didactics on the following topics:

- human sexuality
- sexual orientation
- gender identity and expression
- LGBT health disparities and risks
- ethnic and cultural aspects of sexuality and health
- taking a sexual history
- sexual health and functioning
- sexual health counseling
- treatment of sexual dysfunctions
- couples counseling
- sexuality and aging
- conducting evaluations for cross sex hormones

Although training will vary somewhat by discipline (e.g., more training for physicians in pharmacotherapy), Fellows will meet together for shared didactic education and review of collaborative practice. In addition, a common curriculum will be shared across the sites during monthly video or audio conferences to allow the LGBT Fellows to interact across sites and share knowledge.
Faculty: Faculty should include at least one physician, psychologist, nurse, and social worker who will develop the local curriculum and provide clinical supervision and mentorship. Faculty should demonstrate training experience as well as knowledge in sexual health and working with LGBT populations.

Trainee stipends: For Physician fellows, stipends are based on PGY levels and VA stipend rates for the local index hospital. For Nursing, Psychology, and Social Work fellows, stipends are based on the discipline, educational level, and geographically adjusted VA stipend rates.

References


Thanks to Michael Kauth, PhD, Jillian Shipherd, PhD, and John Blosnich, PhD, Mental Health Services, for preparing the first draft of this program conceptualization. As subject matter experts, Drs. Kauth and Shipherd may be contacted with any questions.
Appendix D. Mental Health Fellowships in Rural Health Care Delivery

Background

Training in rural health, including the development of expertise in telemental healthcare delivery, is critical to fulfilling VA’s mission to serve rural and highly-rural Veteran populations. By expanding health professions clinical education at non-traditional training sites that serve predominantly rural Veterans, access to quality healthcare care will continue to increase.

According to the 2005 Institute of Medicine report, *The Future of Rural Health*, “the smaller, poorer, and more isolated a rural community is, the more difficult it is to ensure the availability of high-quality health services.” With 44% of current military recruits coming from and returning to rural areas, it is imperative that VA meet the pressing health care needs of our rural Veterans.

Many community based outpatient clinics (CBOCs) serve a high volume of Veterans residing in rural communities. With increasing demands for mental health services, expansion of interprofessional training programs will enhance Veterans’ care in addition to trainees’ clinical education. Evidence-based psychotherapies and case management are key components to providing comprehensive mental health services, and training in the delivery of rural mental health care is not typically covered in clinical graduate and post graduate program curricula nationally.

Proposed Training Program

As an example of expansion of training in rural health, a Psychology Postdoctoral Fellowship in Rural Health Care might be considered. The goal of a fellowship program would be to create a cadre of experienced clinicians with experience in delivery of health care in rural settings, who have interest in developing professional careers in those rurally based sites, and who can develop into national leaders in the field of rural health care. As recruitment of these professionals grows upon completion of their fellowships, we can expect to see improved access, quality, and capacity of mental health services to rural Veterans for these targeted outcomes:

- Increased outreach and Veteran enrollment
- Increased total number of Veterans served
- Increased availability of evidence-based treatment and case management
- Increased access to specialty services targeting substance use, chronic mental illness, sequelae of military sexual trauma, and posttraumatic stress disorder
- Decreased wait times for mental health services

Location/Sites

Up to three sites, each with one or two fellows in one discipline or up to four fellows if two disciplines are proposed may be approved as a three-year pilot program. Despite the discipline-specific nature of these fellowships, proposals must incorporate interprofessional education and collaborative practice in order to be approved.
Eligible Fellows

Mental health fellows must have a degree that would make them eligible for employment in VA in their profession. The degree must be from an accredited graduate program and the fellow must meet VA Qualification Standards for employment in the discipline prior to entering the fellowship program. Fellows must be US citizens.

Curriculum

Each fellowship will be one year full time (2080 hours) and must commit greater than 60% time allocation to work in mental health. Curricula may vary based on the strengths of each site but must include providing evidence-based psychotherapy and mental health case management services to rural Veterans in an interprofessional clinical environment. The delivery of telemental health care to rural areas also should be a key component to fellowship training. In addition, didactic training should include fellows from all disciplines represented at each site.

Faculty

Supervision and mentorship should be provided by licensed clinicians from the same discipline as the fellow. Faculty should demonstrate training experience as well as knowledge in working with rural Veteran populations. Each discipline’s supervision requirements must meet professional licensure criteria.

Trainee Stipends

Fellowship stipends are based on the discipline, educational level, and geographically adjusted VA stipend rates.

Thanks to Keith Armstrong and Thais Williams for preparing the first draft of this program conceptualization.
Appendix E: Trainees Requested

Use the table to list all new trainee positions requested under this initiative. You may add as many rows to the table as necessary.

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Program</th>
<th>Training Positions Requested</th>
<th>Hours per Position</th>
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<td>Post-Masters Resident or Fellow</td>
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<tr>
<td>Pharmacy</td>
<td>Residents (PGY 1)</td>
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<td>Residents (PGY 2)</td>
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<td>Psychiatry</td>
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<td>Social Work</td>
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<td>Other</td>
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