

**Department of Veterans Affairs (VA) / Department of Defense (DoD)
Joint Incentive Fund Project
Final Report
Date: September 30, 2015**

**Improving Patient-Centered Care via Integration of
Chaplains with Mental Health Care**

Collaborating Departments:

VA: Mental Health and Chaplaincy (Durham, NC)

DoD: Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
(DCoE; Washington, DC)

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PREFACE

This Joint Incentive Fund (JIF) project sought to implement recommendations from the final report on VA / DoD Integrated Mental Health Strategy (IMHS) Strategic Action #23 (Chaplains' Roles), which was a collaboration between VA Mental Health and Chaplaincy (Keith Meador, Director) and the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) Deployment Health Clinical Center (Mark Bates, Associate Director for Psychological Health Promotion). Comments about the present JIF report can be directed to the leads on this project. In VA, these are Dr. Jason Nieuwsma (jason.nieuwsma@va.gov), Chaplain William Cantrell (william.cantrell@va.gov), and Dr. Keith Meador (keith.meador@va.gov). In DoD, this is Dr. Mark Bates (mark.j.bates.civ@mail.mil).

ACKNOWLEDGEMENTS

Implementation of this JIF project was made possible through extensive collaboration and participation with individuals internal and external to VA and DoD. We are deeply grateful and indebted to all of these persons for their participation, insights, contributions, suggestions, and willingness to partner with us to enhance the care of Veterans and Service members. We list below the key partners as part of this JIF project, and we also wish to express our sincere gratitude to those unlisted who nonetheless contributed to this work. Thank you all.

Mental Health Integration for Chaplain Services (MHICS) Participants:

VA participants in the MHICS training program included: Constance Arthur, Nancy Cornell, Alejandro J. De Jesus, George "Ed" Diller, Octavio J. Di Iulio, Tammie L. Elfadili, Jennifer Hanksmeier, Kerry Haynes, Derrel Hughes, Gretchen M. Hulse, Beverly Hume, Melvin L. Jones, Jr., Lyn Juckniess, Brian L. Manigold, Rob McLaren, Joe McMahan, Elizabeth Putnam, Louise C. Shaw, Ronald D. Skaggs, and Ronald C. Vicars. DoD MHICS participants included: Jesse Adkinson, Chad Bellamy, Carlos Brito, Sean Burson, Matthew Cassady, Bruce Crouterfield, Daniel Dunn, Christopher Earley, Stephanie Handy, Kevin Humphrey, Alfred Matthews, Baron Miller, Robert Miller, David Ravenscraft, Ben Sandford, Chuck Seligman, Matthew Stevens, John Tarr, Adam Tietje, and Mike Tomlinson.

Learning Collaborative Teams:

In VA, the mental health provider and chaplain team leads for the learning collaborative were: Kathy Aldrich, Clyde Angel, Donald Blomberg, Robert Myers-Bradley, Rodney Haug, Kerry Haynes, Gretchen Hulse, Lannie Lake, Woodburne Levy, Grant Metcalf, Kyle Olesek, Anushka Pai, Sara Perez, Reed Robinson, Barby Wilson, and Victor Wong. In DoD, they were: Rochelle Binion, Wayne Boyd, Allison Clark, Melinda Fierros, Timothy Hall, Jonathan Kerr, Stephanie Latimer, Jason Nobles, Robert Olson, Karen Robinson, Paul Rumery, Tracy Skipton, Jerrell Smith, and Steven Smith. The systems redesign team coaches were: Daniel Bucsko, Craig A. Fagan, Cynthia P. Gorum, Jesse Johnson, Linda D. Johnson, James Luoma, Heather Miller, and Gary Rolph. Additionally, participating sites had numerous additional team members, supervisors, and colleagues who participated in various aspects of the collaborative.

Faculty and Presenters:

Faculty and presenters include those who contributed presentations as part of MHICS (both at face-to-face meetings and in the videos), learning collaborative sessions, various training videos, and webinars. These individuals included: Will Barnes, Mark Bates, James Bender, Balmatee Bidassie, Edwin Brown, Denise Bulling, William Cantrell, Jeni Cook, Christine Corum, Michael Davies, Clint Davis, Mark DeKraai, Kent Drescher, Don Doherty, Keith Ethridge, John Fairbank, George Fitchett, John Forbes, Melissa Ming Foynes, Nathan Galbreath, George Handzo, Steven Hayes, Charles Hoge, Ro Hurley, Ellen Idler, George Jackson, Chad Kessler, Heather King, Warren Kinghorn, Marek Kopacz, Lowell Kronick, Sharon Kwasny, Jeff Levin, Keith Meador, Joe Melvin, Patricia Murphy, William Nash, Arthur Nezu, Christine Nezu, Jason Nieuwsma, Mary Ellison Baars-O'Malley, Shelia O'Mara, Onna Van Orden, Kenneth Pargament, Michael Pollitt, John Ralph, Shelly Rambo, Rajeev Ramchand, Patricia Resick, Jeffrey Rhodes, Jonathan Shay, Sarah Shirley, Beth Stallinga, Elizabeth Stanley, Roy Stein, Karen Steinhauer, Richard Stoltz, Steven Sullivan, Richard Tedeschi, Loren Townsend, Shelley MacDermid-Wadsworth, Robin Walser, John Williams, Kristen Woodward, Laura Wright, and John Yeaw.

Film and Videography:

Hundreds of hours of film were recorded, edited, and compiled into over 50 hours of final production videos. Those most responsible for this effort include: Haley Hargett, Keith Johnson, Vanessa Roddenberry, Tyler Schwartz, and John Stewart. Of noteworthy importance was the work of TJ Volgare.

Implementation and Evaluation Support:

Numerous persons were involved in the systematic implementation and evaluation of objectives in this JIF. From Durham VA Health Services Research and Development (HSR&D), these included: Santanu Datta, George Jackson, Heather King, Nina Sperber, and Brandolyn White. From DCoE, these included: Justin Curry and Shannon Gatewood. From the VA Engineering Resource Center (VERC) / VA Center for Applied Systems Engineering (VA-CASE), these included: Balmatee Bidassie, Ryan Dendinger, Chris Corum, Angela Howard, Theadora James, Ryan Mika, Kristen Tingley, and Laura Wright. Additional guidance was provided by Ro Hurley and Sharon Kwasny.

VA and DoD National Leadership:

Many VA and DoD leaders in mental health, chaplaincy, and other fields supported and coordinated activities for this JIF project. In VA, these included: Dr. Sonja Batten, Chaplain Jeni Cook, Dr. Chris Crowe, Chaplain Keith Ethridge, Chaplain Will Kinnaird, Chaplain Lowell Kronick, Chaplain Michael Pollitt, and Dr. Wendy Tenhula. In DoD, these included: CH (COL) Daniel Ames, USA; CAPT Anthony Arita, USN; CAPT Roosevelt Brown, CHC, USN; CH (COL) Brent Causey, USA; Dr. Allison Cernich; CAPT Michael Colston, USN; Dr. John Davison; Ch, Maj, Darren Duncan, USAF; Col, John Forbes, USAF; CDR Nichole Frazer, USN; CH (COL) LaMar Griffin, USA; CAPT Paul Hammer, USN; LTC Christopher Ivany, USA; RADM Margaret Kibben, CHC, USN; CH (COL) Joseph Melvin, USA; Ch, LtCol, Mike Newton, USAF; CAPT John Ralph, USN; Dr. Sushma Roberts; CH (MG) Donald Rutherford, USA; CAPT Joseph V. Sheldon III, CHC, USN; CDR Beth Stallinga, CHC, USN; Ch, Maj Gen,

Howard Stendahl, USAF; CAPT Richard Stoltz, USN; RADM Mark Tidd, CHC, USN; CDR Brian Weigelt, CHC, USN; and Ch, Col, George Youstra, USAF.

Additional Support:

Critical support for the JIF project was provided by many others functioning in a wide range of capacities. In VA, these included: Ethan Allen, Elizabeth Bowling, Patricia Hubbard, Robert (Julian) Irvine, Lokia McKnight, Amy Pabon, Rob Patterson, and Nancy Pierce. In DoD, these included: Shannon Boone, Dan Bullis, Luemma Davis, April Ford, Janet Hawkins, Chris Hoerauf, Dana Lee, Denise McCollum, Miguel Roberts, Thu Stubbs, Mary Thornquist, Bernard Williams, Teressa Wooten, and Jacques Zoo.

RECOMMENDED CITATION

Nieuwsma, J.A., King, H.A., Cantrell, W.C., Jackson, G.L., Bates, M.J., Rhodes, J.E., Wright, L., Bidassie, B., White, B., Davis, R.C., Ethridge, K., Roddenberry, V., O’Mara, S., Gatewood, S., Irvine, R.J., & Meador, K.G. (2015). Improving patient-centered care via integration of chaplains with mental health care: Department of Veterans Affairs (VA) / Department of Defense (DoD) Joint Incentive Fund project final report. Durham, NC: Department of Veterans Affairs Mental Health and Chaplaincy.

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EXECUTIVE SUMMARY

Health sciences research robustly suggests dynamic interrelationships between the biological, psychological, social, and spiritual aspects of persons. Health systems need to be correspondingly dynamic with respect to structuring the interrelationships between their care professionals and equipping these professionals to care for the full person. In the Departments of Veterans Affairs (VA) and Defense (DoD), one important area wherein to focus such efforts is on the integration of mental health and chaplain services. Findings from the VA / DoD Integrated Mental Health Strategy (IMHS) indicate that chaplains frequently see Veterans and Service members with mental health problems. However, IMHS findings also indicate that chaplains often are not optimally prepared to care for these persons and that chaplain and mental health services in VA and DoD often are not well integrated. The present Joint Incentive Fund (JIF) project sought to address these gaps by developing and implementing different trainings and systems redesign efforts across the two departments.

The current project involved the implementation of three different objectives. Objective #1 was to implement the Mental Health Integration for Chaplain Services (MHICS) training, which provided 40 VA and DoD chaplains with an intensive sub-specialty education in mental health topics and evidence-based approaches to care. Objective #2 was to conduct a Mental Health and Chaplaincy Learning Collaborative, which consisted of bringing together teams of chaplains and mental health professionals from 14 VA and DoD facilities to develop and implement quality improvement efforts aimed at integrating their care services. Objective #3 was to develop and offer a variety of different broad-based educational offerings across VA and DoD, which included a range of products and trainings offered across an array of different platforms.

All three objectives were successfully implemented. For objective #1, retention of chaplains in the intensive year-long MHICS training was high (35/40), and chaplains rated the various educational offerings very favorably. Chaplains who completed the MHICS training reported being better equipped to care for Veterans and Service members suffering from anxiety, depression, posttraumatic stress, and psychosis. They also reported being better able to apply evidence-based principles within chaplaincy and to function more effectively as part of an integrated care team. For objective #2, teams in the learning collaborative were able to implement new processes for screening and referring patients to one another. Further, chaplains and mental health professionals at the participating facilities reported improvements in the areas of identifying patients who could benefit from seeing the other discipline, making appropriate referrals, understanding how to collaborate, and having opportunities to train together. For objective #3, numerous enduring written and training products were created, including a series of training videos and an ongoing webinar series.

The improvements and products from this JIF project are being sustained in different ways. Another cohort of 40 VA and DoD chaplains is scheduled to begin a new cycle of the year-long MHICS training in January 2016. Lessons from the learning collaborative have been and will continue to be disseminated to various audiences, elements from the collaborative are being integrated into the MHICS training, and a video series featuring important elements of the collaborative is being created to disseminate important principles to other facilities. Many of the broad-based training products and processes have been established as enduring resources, with continuing plans for disseminating important lessons learned from the present JIF project. Finally, on a broader level, the current JIF project has fostered the continuance and substantial growth of a meaningful community of educators, practitioners, care providers, researchers, policy makers, and leaders across VA and DoD who are invested in the shared purpose of improving the lives of Veterans and Service members.

FULL REPORT

I. PROJECT OVERVIEW

Veterans and Service members with emotional, social, psychological, behavioral, spiritual, and other problems frequently turn to chaplains (Nieuwsma, Rhodes, et al., 2013; Nieuwsma, Fortune-Greeley, et al., 2014). As clergy, chaplains are a trusted point of contact for numerous reasons, including being familiar and accessible (Weaver, Revilla, & Koenig, 2002), presenting a care resource that is less stigmatized than mental health (Milstein, Manierre, & Yali, 2010), serving as first responders in crisis (Oppenheimer, Flannelly, & Weaver, 2004), ensuring a more stringent form of confidentiality (Bulling et al., 2013), and often sharing a common worldview with the persons seeking care (Curlin et al., 2007). Chaplains have been recognized for some time in the Departments of Veterans Affairs (VA) and Defense (DoD) as playing critical roles in attending to the psychosocial needs of Veterans and Service members (e.g., Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, 2010; Department of the Army, 2012). In 2010, this understanding was reaffirmed by including a focus on roles for chaplains in mental health care as part of the VA / DoD Integrated Mental Health Strategy (IMHS; DoD and VA, 2010).

The IMHS study on chaplains' roles used a mixed methods quantitative / qualitative approach to examine whether there was a gap between existing practices and optimal practices (Nieuwsma, Jackson, et al., 2014; Nieuwsma, Rhodes, et al., 2013). Findings from this gap analysis underscored the importance of chaplains in attending to the needs of those with mental health problems and also found that there was room for improvement with respect to training and systematic integration of chaplains with mental health care. Some of the more important findings from this study included: the most common problems seen by chaplains in VA and DoD were psychosocial (e.g., anxiety, depression, stress) rather than overtly spiritual in nature; the majority of chaplains perceived that Veterans and Service members with mental health problems commonly seek support from chaplains *instead of* mental health providers; many chaplains and mental health professionals reported rarely exchanging referrals with one another; and there was widespread openness and interest from chaplains and mental health professionals across both departments with respect to the potential for better integration and further training where indicated.

Findings from the IMHS study on chaplains' roles were used to develop a set of recommendations for training and healthcare system redesign. These recommendations focused on providing broad-based training across VA and DoD to mental health professionals and chaplains, providing in-depth mental health training to a subset of chaplains, and undertaking quality improvement efforts to design more intentionally integrated care practices between mental health and chaplaincy. Ultimately, these recommendations were further refined with input from VA and DoD leadership to then serve as the basis for the current Joint Incentive Fund (JIF) project. Of note, the objectives for the current JIF project directly support the VA / DoD Joint Executive Council Joint Strategic Plan (JSP) by advancing a patient-centered, evidence-based, standardized training model (JSP Goal #2; JSP Objective 2.1; JSP Objective 2.1.H) aimed at reducing the stigma associated with seeking mental health care (JSP Objective 2.2.B) by placing

within mental health care systems appropriately trained chaplains – who many Veterans and Service members initially feel more comfortable trusting with sensitive emotional, relational, spiritual, and mental health problems. The goals and overarching summaries for the three objectives as part of the present JIF project are described below.

Objective #1: Mental Health Integration for Chaplain Services (MHICS)

Goal: To implement the MHICS training program, which aimed to provide high quality sub-specialty education in mental health topics and evidence-based approaches to care to select chaplains in VA and DoD.

Summary: A total of 40 chaplains evenly split between VA and DoD participated in the year-long training program. The MHICS training relied upon a mixture of distance education and in-person pedagogical approaches. The training utilized learning tools such as video didactics, readings, group webinars, surveys, threaded discussions, exams, papers, and in-person trainings and exercises. Chaplains learned about important mental health topics (e.g., mood disorders, PTSD, suicide), linkages between mental health care and spiritual care, and possibilities for adapting evidence-based modalities for use in chaplaincy work.

Objective #2: Mental Health and Chaplaincy Learning Collaborative

Goal: To bring together motivated teams of chaplain and mental health representatives from VA and DoD healthcare facilities to use systems redesign principles in developing and implementing quality improvement efforts aimed at improving the integration of care services.

Summary: The learning collaborative included seven VA facilities and seven DoD facilities and engaged systems redesign experts and “coaches” from the VA Engineering Resource Center (VERC) to help teams implement their aims and problem-solve around implementation barriers. Learning collaborative teams developed aims in the areas of screening, referrals, assessment, documentation and communication, role clarification, and cross-disciplinary training.

Objective #3: Broad-based Education

Goal: To share VA and DoD training resources and platforms to enhance broad-based educational opportunities for chaplains and mental health professionals.

Summary: Educational offerings were aimed at a variety of audiences using various approaches and platforms. In addition to multiple presentations in different venues, two notable educational packages were supported, developed, and established as sustainable recurring offerings: the DCoE Chaplain Working Group Calls; and the Bridging Chaplaincy and Mental Health Care three-part video series.

II. PROJECT IMPLEMENTATION

The JIF award was jointly granted to VA Mental Health and Chaplaincy and to the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE). VA Mental Health and Chaplaincy and DCoE partnered in the IMHS project and continued to partner as part

of the JIF project in developing and implementing the three objectives. VA Mental Health and Chaplaincy assumed the larger share of funding allocation and corresponding accountabilities, being that the primary focus of this VA office is on integration of mental health and chaplain services. While there was some overlap and cross-pollination between the three objectives as part of the current JIF initiative, the objectives represent three distinct projects. Therefore, the activities for each project are described separately below.

ACTIVITIES

Notification of JIF award status was received in early calendar year 2013, with the two-year JIF project then spanning the two federal fiscal years of 2014 and 2015 (i.e., October 2013 – September 2015). The steps taken to accomplish project goals for the three separate objectives of this JIF are described below.

MHICS Activities (JIF Obj. #1)

The MHICS training program was developed based on findings from the VA / DoD IMHS study on chaplains' roles. The IMHS study provided evidence that chaplains are frequently seeing Veterans and Service members who suffer from a range of psychosocial stresses and mental health problems (Nieuwsma, Rhodes, et al., 2013), including severe problems like suicidality (Kopacz et al., 2015). The study further indicated that chaplains desired training on various mental health issues as well as training in the use of evidence-based approaches to care (Fitchett, Nieuwsma, Bates, Rhodes, & Meador, 2014). In addition to using IMHS findings such as these to guide curriculum development, the JIF leads also shaped the training so as to address mental health issues prioritized by national leadership in VA and DoD (e.g., suicidality) and to make use of appropriate evidence-based modalities.

The three modalities used in the MHICS training were Acceptance and Commitment Training (ACT; Hayes & Lillis, 2012), Problem Solving Training (PST; Nezu, Nezu, & Zurilla, 2012), and Motivational Interviewing (MI; Miller & Rollnick, 2013) – references are to the primary books that were provided to MHICS participants as course readings and resources. These modalities were selected based on fit with chaplaincy practices, capacity to address the problems that chaplains encounter, established evidence bases, ability to flexibly apply principles to address a range of problems, precedent for dissemination of these modalities to broadly construed groups of care providers (i.e., beyond just specialty mental health), and ability to use principles from these modalities in integrative and synergistic ways with mental health professionals. The evidence-based modalities were taught in a manner that encouraged chaplains to incorporate useful principles into their spiritual care provision, rather than practicing these modalities as stand-alone psychotherapies per se (note the use of the word “training” instead of “therapy” for ACT and PST, which reflects a larger pedagogical approach). Relatedly, an important part of the MHICS training throughout was working with chaplains in their different contexts to understand how to best work with, when to refer to, and how to jointly collaborate with licensed mental health professionals as available in different settings, with the clear understanding that the MHICS training intended for chaplains to retain their core professional identities as chaplains and to value the distinctive, necessary, and complementary roles and capacities of licensed mental health professionals.

The MHICS training was designed to equip VA and DoD chaplains who function across a diversity of settings, including: inpatient and outpatient healthcare contexts; mental health specialty settings and general medical settings; and a wide array of non-medical operational contexts within the military. This diversity - which embodies differences in the types of persons chaplains serve, the problems chaplains encounter, the motivations for seeking chaplain care, the availability of specialty mental health care, and the willingness of different populations to use mental health services - was understood as likely to influence the ways in which chaplains would apply the knowledge and skills learned in the MHICS training. Recognizing this, the MHICS training aimed to equip chaplains with skills that could be flexibly applied. In particular, the MHICS training aimed to equip chaplains to do the following:

- Identify the signs and symptoms of mental health problems (especially those prevalent among Veterans and Service members).
- Judiciously use evidence-based psychological practices and principles within the scope of chaplaincy practice.
- Effectively collaborate with mental health professionals (including bidirectional exchange of referrals and mutual understanding of services offered).
- Foster resilience, human flourishing, and prevention of mental health problems.

Table 1: MHICS Training Program Overview

Course 1 (May 12 - August 1, 2014)		
MODULE	UNIT	INSTRUCTOR(S)
1. Spirituality and linkages to mental health	1. Examining the relationship between spirituality and health	Ellen Idler, Ph.D; George Fitchett, D.Min., Ph.D
	2. Research growth and trends in spirituality and health	Jeff Levin, Ph.D.
	3. Spiritual care in the time of therapeutic technique	Keith Meador, M.D., Th.M., M.PH.; Ellen Idler, Ph.D.; Jeff Levin, Ph.D.; Lowell Kronick, BCC
2. Pastoral care and approaches to psychotherapy	1. History of psychotherapy and pastoral care	Jason Nieuwsma, Ph.D.; Kent Drescher, Ph.D., M.Div.; Lowell Kronick, BCC KentDrescher, Ph.D., M.Div.; Jason Nieuwsma, Ph.D.
	2. Defining evidence-based in psychotherapy	Jason Nieuwsma, Ph.D.; William Cantrell, M.Div., BCC
	3. Overview of contemporary psychotherapies	Jason Nieuwsma, Ph.D.; Kent Drescher, Ph.D., M.Div.; William Cantrell, M.Div., BCC Elizabeth Stanley, Ph.D Steven Hayes, Ph.D.
3. Spiritual care and innovations	1. Spiritual practices and contemporary psychotherapy	Robin Walser, Ph.D.
	2. Mindfulness	Robin Walser, Ph.D., Steven Hayes, Ph.D. Steven Hayes, Ph.D.
	3. Possibilities for spiritual care in ACT	Warren Kinghom, M.D., Th.D.; Col. John Forbes, M.D., USAF; Captain John Ralph, Ph.D., USN; Lt. Col. John Yeaw, Psy.D., ABPP, Army Warren Kinghom, M.D., Th.D Warren Kinghom, M.D., Th.D.; Col. John Forbes, M.D.
4. Acceptance and Commitment Training (ACT)	1. Introduction to ACT: The perils of language	Warren Kinghom, M.D., Th.D.; Col. John Forbes, M.D., USAF; Captain John Ralph, Ph.D., USN; Lt. Col. John Yeaw, Psy.D., ABPP, Army Warren Kinghom, M.D., Th.D Warren Kinghom, M.D., Th.D.; Col. John Forbes, M.D.
	2. The practice of ACT: Facilitating the process of change	
	3. Applications of ACT with chaplaincy	
5. Mental health essentials	1. Mental health providers and settings	
	2. Mental health diagnoses	
	3. Pharmacotherapy	

Course 1 Training Workshop

May 21-23,2014

VA National Chaplain Center, Hampton, VA

- Critically interpret, use, and potentially participate in scientific research.
- Understand important psychological processes and psychosocial issues.
- Provide care for care providers and practice good self-care.
- Address the unique religious, spiritual, cultural, and relational needs of persons with mental health problems.

The resulting MHICS training curriculum consisted of three 12-week courses (see Table 1). Each course was comprised of five distance modules and one face-to-face training. The online distance modules featured a total of approximately 45 hours of video didactics from 43 different presenters. Most presenters were nationally renowned in their topic area and came from the disciplines of psychiatry, psychology, medicine, epidemiology, sociology, chaplaincy, theology, and others. Each distance module typically included three one-hour video didactics (including video engagement questions), readings, a threaded discussion, and a one-hour group webinar. Distance modules were housed online via Blackboard and could be flexibly completed at any

Table 1: MHICS Training Program Overview (continued)

Course 2 (September 15 - December 5, 2014)		
MODULE	UNIT	INSTRUCTOR(S)
1. Chaplaincy standards of practice	1. Toward a research informed chaplaincy	George Fitchett, D.Min, Ph.D.; George Handzo, BCC, CSSBB
	2. Spiritual assessment	Kenneth Pargament, Ph.D.; George Fitchett, D. Min, Ph.D
	3. Documentation of chaplaincy care	George Handzo, BCC, CSSBB; Shelia O’Mara, MDiv
2. Care for the care provider	1. Stress response and self-care	Elizabeth Stanley, Ph.D.; Jeffrey Rhodes, D.Min
	2. Care for care providers and command	Keith Ethridge, M.Div; Jeffrey Rhodes, D.Min Jason Nieuwsma, Ph.D.
	3. ACT for the care provider	
3. Motivational Interviewing (MI)	1. Motivational Interviewing (MI) training: An introduction	Roy Stein, M.D.; Patricia Murphy, Ph.D., L.P.C. Roy
	2. Motivational Interviewing (MI) training: Fundamental skills	Stein, M.D.; Patricia Murphy, Ph.D., L.P.C Roy
	3. Motivational Interviewing (MI) training: Considerations and techniques	Stein, M.D.; Patricia Murphy, Ph.D., L.P.C
4. Problem Solving Training (PST)	1. Problem Solving Therapy (PST) training: An introduction	Arthur Nezu, Ph.D.; Christine Nezu, Ph.D. Arthur
	2. Problem Solving Therapy (PST) training: Treatment components and tools	Nezu, Ph.D.; Christine Nezu, Ph.D.
	3. Problem Solving Therapy (PST) training: Applications for chaplaincy	Arthur Nezu, Ph.D.; Christine Nezu, Ph.D.
5. Current pastoral concerns	1. Post-deployment adjustment and spirituality among recent Veterans	CDR Beth Stallinga, CHC; Kent Drescher, Ph.D., M.Div; Steven Sullivan, Th.M., M.Div.; Jeffrey Rhodes, D.Min Shelley MacDermid Wadsworth, Ph.D.
	2. Marriage and family issues for Veterans and Service members	
	3. Advanced topics in selected populations	CDR Beth Stallinga, CHC; Steven Sullivan, Th.M, M.Div; Jeni Cook, D.Min., M.Div., BCC; Capt. Mary Ellison Baars O’Malley, M.Div, M.A.
Course 2 Training Workshop		
December 3-5,2014		
Bay Pines VAMC, Bay Pines, FL		

point during a two week span. The modules took an estimated 8-12 hours each to complete. The courses also included exams at the end, and the final course required a capstone paper from participants that integrated content from the full training and their clinical application of the training. The three 2.5-day face-to-face trainings, one for each course, served as critical complements to the distance education training - allowing needed time for clinical skill training and application along with other activities. In all, participants are estimated to have devoted approximately 10-15% of their professional effort over the course of a year to this program (i.e., 200-300 hours).

In VA, chaplains were invited to apply for the MHICS training via an e-mail from the VA National Chaplain Center, which included a description of the training and an application to apply. A total of 74 VA chaplains applied, and 20 were able to be selected. In DoD, representatives from the Chiefs of Chaplains Offices for Army, Navy, and Air Force were engaged to select chaplains to send to the training that the Service branches deemed to be an

Table 1: MHICS Training Program Overview (continued)

Course 3 (January 5 - March 27, 2015)			
MODULE	UNIT	INSTRUCTOR(S)	
1. Mood disorders, substance abuse, and mental illness	1. Depression and mood disorders	John Williams, M.D.; Jason Nieuwsma, Ph.D.; Keith Meador, M.D., Th.M., M.P.H.	
	2. Substance use disorders	Roy Stein, M.D.; Michael Pollitt, D.Min., BCC	
	3. Serious Mental Illness (SMI)	Warren Kinghom, M.D., Th.D.	
	2. Suicide	1. Suicide in military and Veteran populations	Rajeev Ramchand, Ph.D.; Jason Nieuwsma, Ph.D.
		2. Suicide prevention	Marek Kopacz, M.D., Ph.D.
		3. Religion, spirituality, and suicide	Loren Townsend, Ph.D.
	3. Posttraumatic Stress Disorder (PTSD)	1. Overview and evolution of PTSD	John Fairbank, Ph.D.; Kent Drescher, Ph.D., M.Div.
		2. Evidence-based psychotherapy for PTSD	Patricia Resick, Ph.D.; ABPP
		3. Military Sexual Trauma (MST)	Onna van Orden, Ph.D.; Nathan Galbreath, Ph.D., M.F.S.; Melissa Ming Foynes, Ph.D.; Capt. Mary Ellison Baars O'Malley, M.Div., BCC; Kent Drescher, Ph.D., M.Div.
	4. Moral injury	1. Moral injury: Part I	Kent Drescher, Ph.D., M.Div.; Jonathan Shay, M.D., Ph.D.
		2. Moral injury: Part II	CAPT William Nash, M.D., MC, USN (Ret.) Warren Kinghom, M.D., Th.D.
		3. Providing Care for moral injury	Shelly Rambo, Ph.D., S.T.M., M.Div. Richard Tedeschi, Ph.D.
	5. Spirituality, suffering, and resilience	1. Theological rethinking of suffering	Keith Meador, M.D., Th.M, M.PH.; Richard Tedeschi, Ph.D.
		2. Resilience	
		3. Human flourishing	

Course 3 Training Workshop

March 17-19,2015

Joint Chaplain Training Schools,
Ft. Jackson, Columbia, SC

***Requirements for successful completion of course content: watching and completing engagement questions for every unit's training video (each course contains 15 videos of ≈ 1 hour each); completing assigned readings for all units; contributing to online threaded discussions for all modules; participating in Adobe Connect LIVE Calls for all modules; passing the final exam for each course; completing the final capstone paper (Course 3 only); and attending a 2.5-day face-to-face training for each course.**

appropriate fit. The 20 DoD chaplains who were selected included 8 Army chaplains, 7 Navy chaplains, and 5 Air Force chaplains.

The MHICS training ran from May 2014 to March 2015. Upon completion of the training, all chaplains received a certificate and transcript. In addition, the MHICS training prompted the creation of other opportunities for credit. In DoD, completion of the MHICS training allowed chaplains in some of the branches to receive a sub-specialty code. Of substantial significance, the MHICS training inspired the creation of the Mental Health Chaplaincy Specialty Certification that is now being offered by the National Association of VA Chaplains (NAVAC; for details, see http://www.navac.net/html/mental_health.html). While NAVAC is heavily composed of VA chaplains, it is officially an independent body from VA. As such, military chaplains and others who meet eligibility requirements can apply for this certification. Furthermore, there is precedent for specialty certifications offered by NAVAC to have reciprocity with the Association for Professional Chaplains (APC). APC currently only offers a specialty certification in palliative care, but the creation of the mental health specialty currently housed with NAVAC is a promising development for the broader field of healthcare chaplains across the U.S.

Learning Collaborative Activities (JIF Obj. #2)

The Mental Health and Chaplaincy Learning Collaborative was developed in response to gaps identified as part of the VA / DoD IMHS study on chaplains' roles, in particular from site visits during which intensive interviews were conducted with 396 mental health professionals and chaplains at 33 different VA and DoD facilities. These site visits helped to identify a number of themes across VA and DoD facilities, including that suboptimal integration between mental health services and chaplain services was often the result of the disciplines lacking familiarity and understanding of one another. Furthermore, where collaboration between the disciplines did exist, it was frequently informal. Building on these and other findings, the JIF leads developed the following overarching goals for the learning collaborative:

- I. Establish chaplains as collaborators within models of integrated mental health care.
- II. Improve reliability, efficiency, and usefulness of care processes by sharing information about strong practices across sites.
- III. Increase timely, reliable, bidirectional access to chaplain and mental health services for Veterans and Service members with PTSD and mental health problems.
- IV. Establish participating facilities as resources for other sites seeking to better integrate mental health and chaplain services.
- V. Contribute to the optimization of health system performance as delineated by VA Triple Aims and DOD Quadruple Aims.

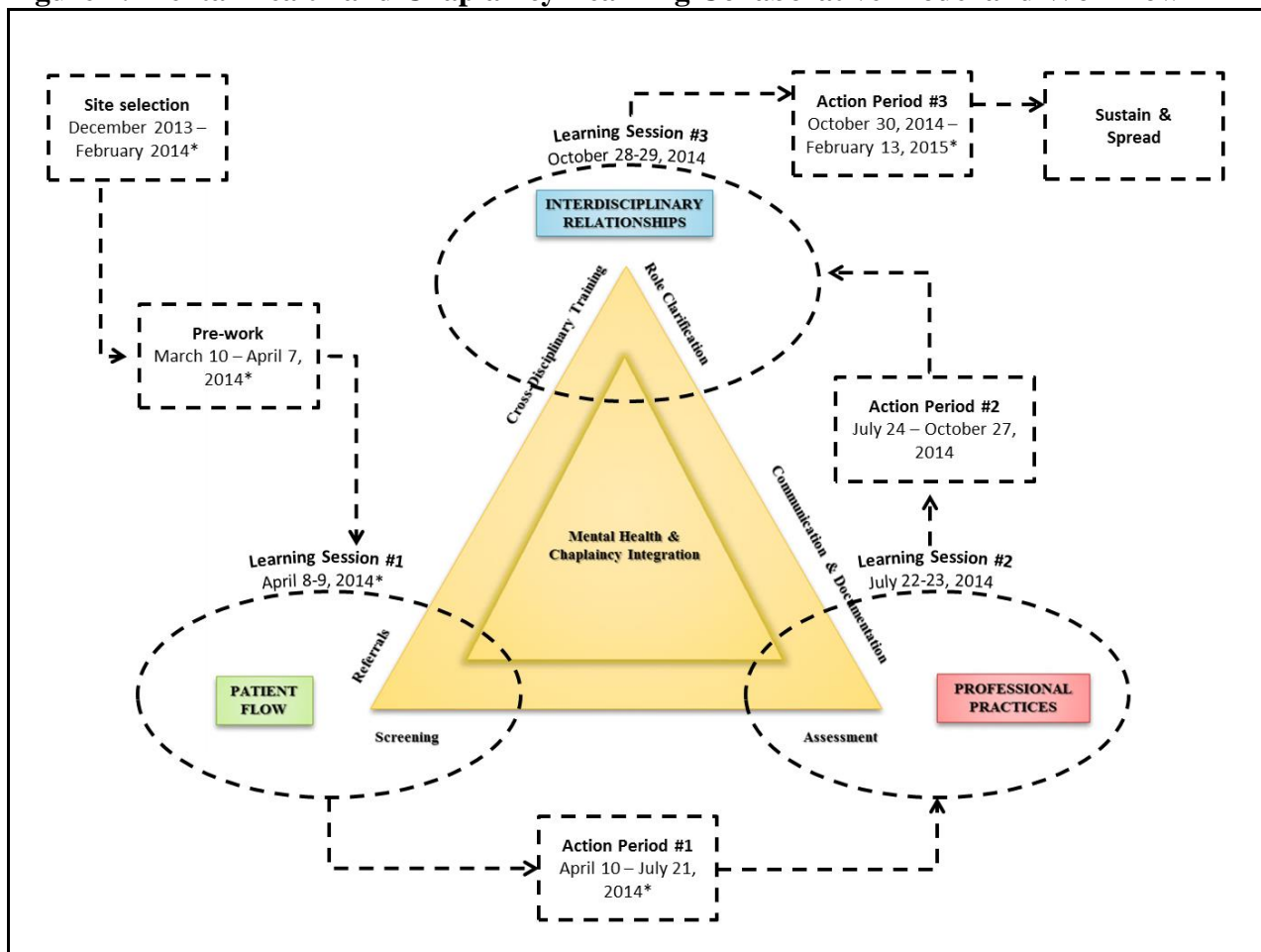
These goals were implemented using the “learning collaborative” approach to systems redesign. The learning collaborative methodology has been used by healthcare organizations to improve care processes across a range of conditions and practices. The approach is adapted from the Breakthrough Series Collaborative (BSC) model, which was developed by the Institute for Healthcare Improvement (IHI). A learning collaborative typically includes the following components: three in-person training sessions; follow-up consultation activities, feedback loops, and resources to support sustained learning; and opportunities to practice new skills and share

progress through the collaborative. For the present collaborative, the VA Engineering Resource Center (VERC) / VA Center for Applied Systems Engineering (VA-CASE) provided expertise and support with respect to systems redesign and quality improvement.

To accomplish the overarching goals of the Mental Health and Chaplaincy Learning Collaborative, participating teams engaged with six specific aims. Each of the three learning sessions focused on two of these aims (see Figure 1). The specific aims of the Mental Health and Chaplaincy Learning Collaborative were to strengthen and improve:

- I. **Screening** - Evaluate current practices for screening patients for spiritual and mental health issues, with the intention of strengthening existing practices and / or implementing new research-informed screening practices where none exist.
- II. **Referrals** - Strengthen and / or develop clearly articulated processes for referring patients between disciplines, including processes to contact the other discipline, communicate the core issue, articulate a basic care plan, and conduct follow up.

Figure 1: Mental Health and Chaplaincy Learning Collaborative Model and Workflow



* The figure displays workflow dates as originally intended and as experienced by VA teams in the learning collaborative. DoD teams were delayed in joining the collaborative and therefore were selected later, participated in initial parts of the collaborative later (learning session #1 was conducted virtually for DoD teams on June 3-4, 2014), and had an extended period during which they could complete work for the collaborative.

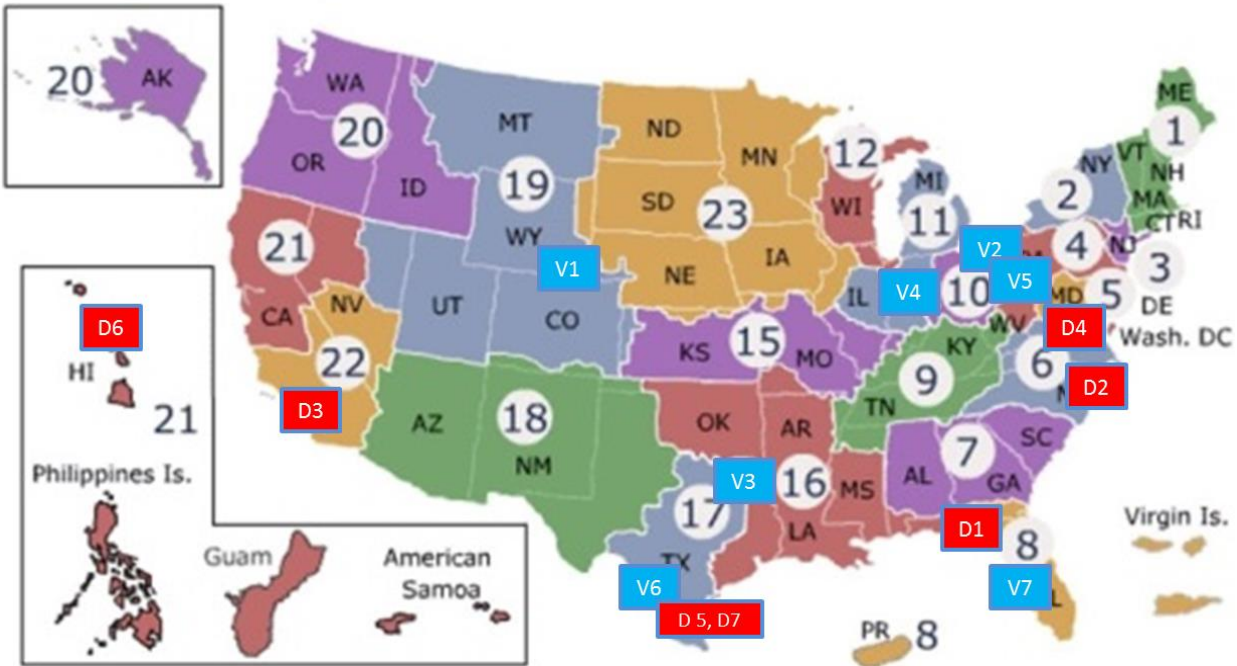
- III. **Assessment** - Develop, improve, and / or ensure standardized use of multidimensional spiritual and mental health assessments that can contribute to making effective referrals and to providing relevant healthcare information to the other discipline.
- IV. **Communication and Documentation** - Establish regular communication practices, ideally as part of recurring integrated care team meetings, and document care and consults in a useful manner to the other discipline (at facilities where chaplain documentation of care is expected).
- V. **Cross-Disciplinary Training** - Champion cross-disciplinary training opportunities, at a minimum to inform colleagues about the aims of and rationale for this learning collaborative.
- VI. **Role Clarification** - Develop a better understanding of chaplain and mental health provider roles, culminating in the development of formal documentation of how mental health and chaplain services collaborate (e.g., care coordination agreement).

Seven VA and seven DoD teams were selected for participation in the collaborative. VA teams were invited to participate in the collaborative based on preexisting knowledge of facilities and personnel from the IMHS site visits, recommendations from VA National Chaplain Center leadership, and geographic diversity. DoD teams were selected in close coordination with appropriate leadership in the domains of mental health and chaplaincy in the three branches of the military. Figure 2 displays the names and locations of participating VA and DoD facilities. Teams consisted of:

- Core team from facility (required to participate in all activities):
 - Mental health provider champion (traveled to learning sessions)
 - Chaplain champion (traveled to learning sessions)
 - Non-clinical team member (did not travel)
- Support staff members identified and provided by learning collaborative leadership:
 - Team level coach (a process improvement expert)
 - Integration of mental health and chaplaincy coach captain

As depicted in Figure 1, the learning collaborative included three learning sessions and three action periods. The learning sessions were two-day face-to-face events that included presentations by JIF leads and other subject matter experts on issues pertaining to the aims of the collaborative. In addition, education in the learning collaborative and quality improvement processes was provided by VERC / VA-CASE staff. Learning collaborative teams learned to use Plan Do Study Act (PDSA) cycles, which they then used to implement changes during action periods. During action periods, teams tracked their progress implementing their individualized goals. Teams were encouraged to develop customized goals that addressed areas most in need of improvement at their facilities and that could be feasibly accomplished. Teams were not necessarily expected to develop goals pertaining to all six of the aims domains identified for the collaborative.

Figure 2: Mental Health and Chaplaincy Learning Collaborative Participating Sites



Participating VA Facilities:

- V1 = Cheyenne VA Medical Center, Cheyenne Vet Center, Cheyenne, WY & Ft. Collins Vet Center, Ft. Collins, CO
- V2 = Louis Stokes Cleveland VA Medical Center, Cleveland, OH
- V3 = VA North Texas Health Care System, Dallas, TX
- V4 = Richard L. Roudebush VA Medical Center, Indianapolis, IN
- V5 = VA Pittsburgh Health Care System, Pittsburgh, PA
- V6 = South Texas Veterans' Health Care System San Antonio, TX
- V7 = James A. Haley Veterans' Hospital, Tampa, FL

Participating DoD Facilities:

- D1 = Naval Hospital, Pensacola, FL
- D2 = Naval Hospital, Camp Lejeune, NC
- D3 = Naval Medical Center, San Diego, CA
- D4 = Army Ft. Belvoir Community Hospital, Ft. Belvoir, VA
- D5 = Army Southern Regional Medical Command, San Antonio, TX
- D6 = Army Pacific Region Medical Center, Tripler, Honolulu, HI
- D7 = Air Force Joint Base, San Antonio, TX

Broad-based Education Activities (JIF Obj. #3)

Whereas the MHICS training (JIF Obj. #1) and the learning collaborative (JIF Obj. #2) targeted select groups of chaplains and mental health professionals to undertake intensive activities over the course of approximately one year each, the aim of the broad-based educational activities in JIF Objective #3 was to reach a much larger audience with less time-intensive offerings. This was accomplished through face-to-face and virtual presentations, and in venues sponsored by the JIF committee (e.g., conferences, webinars, web videos) as well as in broader settings (e.g., invited talks, professional conferences, journal publications).

Table 2 provides an overview of the major broad-based educational activities related to the JIF. Of particular note are two ongoing educational offerings that are now being independently sustained: the DCoE Chaplain Working Group calls; and the *Bridging Mental Health and Chaplaincy* video series. The DCoE Chaplain Working Group calls target chaplains in VA and DoD, and other professionals often attend these calls as well. The calls feature a 90-minute webinar format during which a nationally renowned expert presents on issues of relevance to DoD and VA audiences and fields questions from the virtual audience. The *Bridging Mental Health and Chaplaincy* video series includes three separate videos, approximately one hour each,

that feature mental health and chaplain experts speaking to the rationale for integrating care services, evidence in the area of spirituality and mental health, and ideas on how to improve integration at local facilities. In addition to these two major sustained educational offerings, the JIF team further disseminated training and education via a variety of other means (see Table 2).

Table 2: Overview of Broad-based Training Offerings and Products

QUARTER	ACTIVITIES
Pre-work (Jan-Sep 2013) & FY14, Quarter 1 (Oct-Dec, 2013)	<ul style="list-style-type: none"> ◆ Major Educational Events¹ <ul style="list-style-type: none"> ▪ Selected presentations and publications (small font)² ◆ September 2013: Bridging Chaplaincy and Mental Health Care Conference <ul style="list-style-type: none"> - Two-day conference for Clinical Pastoral Education (CPE) Supervisors - Nashville, TN ◆ September – November 2013: DCoE Chaplain Working Group <ul style="list-style-type: none"> - <i>The war within: Preventing suicide in the U.S. military</i> (Rajeev Ramchand; 9/4/2013) - <i>Promoting recovery from military sexual trauma: Opportunities for chaplains</i> (Melissa Ming Foyne; 11/6/13) ▪ January 2013: Chaplaincy and mental health in the Department of Veterans Affairs and Department of Defense. <i>Journal of Health Care Chaplaincy</i>, 19, 3-21. ▪ February 2013: <i>Integrated Mental Health Strategy (IMHS), strategic action #23: Chaplain roles in mental health teams</i>. Invited talk presented to Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) Chaplains Working Group. ▪ May 2013: <i>Expanding the frame on integrated care: Inviting chaplains into mental health care systems</i>. Invited talk presented at Duke University Psychiatry and Behavioral Sciences Grand Rounds, Durham, NC. ▪ June 2013: <i>Navigating a course for chaplaincy in mental health waters: Findings and suggestions from a joint initiative between VA and DoD</i>. Workshop presented at the Association of Professional Chaplains Annual Conference, Orlando, FL. ▪ August 2013: <i>Chaplains' engagement with suicidality in service members: Findings from the DOD/VA Integrated Mental Health Strategy</i>. In Chaplain panel on suicide awareness: What the chaplain offers to the integrated mental health team. Symposium conducted at the fifth annual Warrior Resilience Conference, Washington, DC. ▪ September 2013: <i>Implementing integrated chaplain and mental health care service models in VA and the military</i>. Poster presented at the Inaugural Summit on Transformative Innovation in Health Care, Duke Institute for Health Innovation, Durham, NC. ▪ November 2013: <i>Chaplains' engagement in enhancing resiliency for service members and veterans</i>. In Trauma and resilience: The role of professionals I. Symposium conducted at the International Society for Traumatic Stress Studies Annual Conference, Philadelphia, PA.
FY 14 Quarter 2 (Jan-Mar, 2014)	<ul style="list-style-type: none"> ◆ January – March 2014: DCoE Chaplain Working Group <ul style="list-style-type: none"> - <i>Understanding posttraumatic stress disorder from an occupational perspective</i> (Charles Hoge; 1/8/2014) - <i>Trauma of war: PTSD and moral injury</i> (Jonathan Shay; 3/7/2014) ▪ January 2014: Confidentiality and mental health/chaplain collaboration. <i>Military Psychology</i>, 25, 557-567. ▪ February 2014: <i>Integrating mental health and chaplaincy: From evaluation to implementation in VA and military contexts</i>. Invited talk presented at the Durham VA Health Services Research and Development Monthly Seminar, Durham, NC. ▪ February 2014: The role of military and Veterans Affairs chaplains in the treatment of alcohol problems. <i>Pastoral Psychology</i>, 63, 1-11.

Table 2: Overview of Broad-based Training Offerings and Products (cont.)

<p>FY14 Quarter 3 (Apr-Jun, 2014)</p>	<ul style="list-style-type: none"> ◆ May 2014: Launched <i>Bridging Mental Health and Chaplaincy</i> Video Series (http://www.mirecc.va.gov/mentalhealthandchaplaincy/Bridging_Videos.asp) <ul style="list-style-type: none"> - <i>Video 1: Why do it?</i> (52 min) - <i>Video 2: Knowing our stories</i> (58 min) - <i>Video 3: Opening a dialogue</i> (58 min) ◆ May 2014: DCoE Chaplain Working Group <ul style="list-style-type: none"> - <i>PTSD 101</i> (James Bender; 5/7/2014) ▪ May 2014: <i>Expanding the role of chaplains</i>. Invited talk presented at the VA Mental Health Showcase, Washington, DC. ▪ June 2014: <i>Evidence-based chaplaincy care: Attitudes and practices in diverse healthcare chaplain samples</i>. Poster presented at the Association of Professional Chaplains Annual Conference, Anaheim, CA. ▪ June 2014: <i>Acceptance and commitment therapy (ACT): Building evidence-based skills to enhance professional chaplaincy</i>. Half-day workshop presented at the Association of Professional Chaplains Annual Conference, Anaheim, CA. ▪ June 2014: <i>Integrating chaplaincy and behavioral health care: From clinical inceptions to current implementations</i>. Invited talks presented on the VA Clinical Pastoral Education Training Didactic Call. [Talk also presented in 2013 & 2015.]
<p>FY14 Quarter 4 (Jul-Sep, 2014)</p>	<ul style="list-style-type: none"> ◆ July – September 2014: DCoE Chaplain Working Group <ul style="list-style-type: none"> - <i>The uniqueness of the National Guard and their families</i> (Will Barnes; 7/9/2014) ▪ August 2014: Pastoral care use among post-9/11 veterans who screen positive for mental health problems. <i>Psychological Services</i>, 11, 300-308. ▪ September 2014: <i>The role of chaplains in service member care</i>. Symposium conducted in-person and virtually at the Psychological Health and Resilience Summit, Washington, DC.
<p>FY15 Quarter 1 (Oct-Dec, 2014)</p>	<ul style="list-style-type: none"> ◆ November 2014: DCoE Chaplain Working Group <ul style="list-style-type: none"> - <i>Developing better listening skills with patients between inter-disciplinary professionals</i> (Chad Kessler; 11/5/2014) ▪ October 2014: Evidence-based chaplaincy care: Attitudes and practices in diverse healthcare chaplain samples. <i>Journal of Health Care Chaplaincy</i>, 20, 144-160. ▪ October 2014: <i>Utilizing an Interprofessional Clergy-Mental Health Partnership Approach to Moral Injury</i>. Paper presented at the American Society for Bioethics and Humanities Annual Meeting, San Diego, CA. ▪ October 2014: <i>Acceptance and commitment therapy (ACT): Building evidence-based skills to enhance professional chaplaincy</i>. Invited full-day workshop presented at the South Carolina Society of Chaplains Annual Meeting, Columbia, SC. ▪ September 2014: <i>Using acceptance and commitment therapy (ACT) to improve integrated psychological and spiritual care</i>. Invited full-day workshop presented at Portsmouth Naval Medical Center, Portsmouth, VA. ▪ December 2014: Collaborating across the Departments of Veterans Affairs and Defense to integrate mental health and chaplaincy services. <i>Journal of General Internal Medicine</i>, 29, S885-S894.
<p>FY15 Quarter 2 (Jan-Mar, 2015)</p>	<ul style="list-style-type: none"> ◆ January – March 2015: DCoE Chaplain Working Group <ul style="list-style-type: none"> - <i>United States Air National Guard Strong Bonds program overview</i> (Edwin Brown; 1/7/2015) - <i>Common goals for preventing and repairing moral injury</i> (William Nash; 3/4/2015) ▪ January 2015: <i>Joint Incentive Fund 1: Improving patient-centered care via integration of chaplains with mental health care</i>. Invited talk presented to the National Conference on Ministry to the Armed Forces, Washington, DC.

Table 2: Overview of Broad-based Training Offerings and Products (cont.)

<p>FY15 Quarter 3 (Apr-Jun, 2015)</p>	<ul style="list-style-type: none"> ◆ May 2015: DCoE Chaplain Working Group <ul style="list-style-type: none"> - <i>Make your chatter matter: Structured communication for chaplains</i> (Karen Steinhauser; 5/6/2015) ▪ April 2015: <i>Implementation of a mental health certification program for chaplains</i>. Workshop presented at the Caring for the Human Spirit Conference: Integrating Spiritual Care in Healthcare, Orlando, FL. ▪ April 2015: <i>Make your chatter matter: Structured communication for healthcare chaplains</i>. Workshop presented at the Caring for the Human Spirit Conference: Integrating Spiritual Care in Healthcare, Orlando, FL. ▪ June 2015: <i>Advancing chaplaincy-mental health integration with research and technology</i>. Workshop presented at the Association of Professional Chaplains Annual Conference, Louisville, KY.
<p>FY15 Quarter 4 (Jul-Sep, 2015)</p>	<ul style="list-style-type: none"> ◆ July – September 2015: DCoE Chaplain Working Group <ul style="list-style-type: none"> - <i>RAND report chaplains as gatekeepers</i> (Rajeev Ramchand; 7/1/2015) - <i>Families Over Coming Under Stress (FOCUS) and Preservation of the Forces and Family (POTFF)</i> (Kristen Woodward & Sarah Shirley; 9/2/2015) ▪ August 2015: Possibilities within acceptance and commitment therapy for approaching moral injury. <i>Current Psychiatry Reviews</i>, 11, 193-206. ▪ August 2015: Chaplains’ engagement with suicidality among their service users: Findings from the VA/DoD Integrated Mental Health Strategy. <i>Suicide and Life-Threatening Behavior</i>, 10 AUG 2015 online pub.

1) Major educational events include training events and educational products developed, promoted, and disseminated by the JIF team. 2) Presentations may have occurred by invitation or at a professional conference. Selected presentations and publications include those authored by members of the JIF team and related to the topic of the JIF.

RESOURCES

JIF monies were used to fund personnel, contractors, evaluation staff, and travel in support of the three different project objectives. Significant obstacles and delays were encountered in the contracting processes, both in VA and DoD. Various approaches were employed to manage these delays and proceed in a timely fashion with work on the three objectives, including utilizing existing contracts, using bridge contracts to allow for work to continue, sharing personnel between VA and DoD to support joint aims, and utilizing and optimizing other interagency resources. Tables 3 and 4 below present an overview of VA and DoD obligation plans through FY15 as compiled for interim project reviews.* Permission to extend remaining JIF resources in support of future MHICS training was received on June 19, 2015. Plans for sustainability into future fiscal years are covered later in the report within the conclusions section.

* *Table information removed due to ongoing use of financial resources during extension period.*

Table 3: VA Obligation Plan

<p><i>Use of financial resources is ongoing due to JIF extension. Planned and actual financial obligations are provided to JIF oversight committee.</i></p>

Table 4: DoD Obligation Plan

<p><i>Use of financial resources is ongoing due to JIF extension. Planned and actual financial obligations are provided to JIF oversight committee.</i></p>

III. METRICS

The methods for collecting data and the findings associated with each of the three objectives are presented below. All below described evaluation activities were certified as non-research quality improvement activities following both VA and DoD regulations. As the goal of this project was to improve the quality of services for Veterans and Service members and the project was not funded by research dollars, it was not considered a research activity as described in VHA Handbook 1058.05. Further, the evaluation was certified as a non-research operations activity by the VA Director of Mental Health Operations, Chief Consultant for VA Mental Health Services, and Director of the VA National Chaplain Center. In DoD, the headquarters, US Army Medical Research and Materiel Command's Office of Research Protections (ORP) Institutional Review Board Office (IRBO) determined that this effort did not constitute research as defined under the human subjects protection regulations (32 CFR 219.102(d); also see DoD Instruction 3216.02). Finally, we wish to thank the VA Employee Education System (EES) for contributing to collecting, cleaning, managing, and sharing pieces of the data used in our evaluation.

MHICS Metrics (JIF Obj. #1)

The data collection methods and findings for JIF Objective #1 (MHICS) are presented below. Data sources include extensive pre / post evaluations of participants as well as participant ratings of course content.

Methods

MHICS participants completed paper surveys at the beginning (pre-survey at first face-to-face meeting) and end (post-survey at the last face-to-face meeting) of the training program. The paper questionnaires included metrics assessing both primary aims and secondary outcomes. The *primary aims* of the MHICS training included equipping chaplains to: provide better care to Veterans and Service members; make use of evidence-based approaches; and integrate with mental health care services. *Secondary outcomes* were aspects of the chaplain's care that we were not necessarily expecting to influence as part of the MHICS training, though we were still interested in measuring whether the training had any impact in these areas.

Of the 40 chaplains who began the MHICS training, a total of 35 chaplains (18 VA, 17 DoD) completed the full year-long program. For an intensive year-long training program, this is considered a high retention rate, especially considering the highly mobile nature of the training cohort: at the beginning of the training, 46% of participants reported being in their present facility / assignment for less than a year, and an additional 37% reported being in their present location for one to five years. For the five chaplains who did not complete the full training, reasons included separating from a facility / assignment, deploying, and significant illness or family emergencies. All 35 chaplains who finished the full MHICS training completed both the pre- and post-surveys. Except for participant ratings of the quality of course content (which include participants who were currently active in MHICS), all other below analyses are based on the 35 chaplains who completed MHICS. Additionally, because of the moderate sample size for running comparative statistical analyses, a lenient level for reporting *p* values is used, with exact values reported.

Findings

Baseline (pre-survey) demographics of MHICS completers can be found in Table 5. As can be seen in the table, the large majority of chaplains had clinical pastoral education (CPE) training, approximately three quarters had been a chaplain for at least five years, and around half identified as Evangelical Protestant. In addition, on a scale of “rarely,” “sometimes,” or “frequently,” most chaplains reported “frequently” seeing Veterans / Service members with the following problems: anger (n=30/35, 86%); relationship or family stress (n=28/35, 80%); spiritual struggle understanding loss/trauma (n=28/35, 80%); anxiety (n=27/34, 79%); difficulty forgiving self (n=27/35, 77%); depression (n=27/35, 77%); and guilt (n=27/35, 77%).

Table 5. Demographic Characteristics for MHICS Completers at Baseline

	n (%)
<u>Education / certification (n=35)</u>	
Doctoral degree	10 (29%)
At least 3 units of clinical pastoral education (CPE)	32 (91%)
Board certified chaplain	15 (43%)
<u>Religious Affiliation (n=33)</u>	
Evangelical Protestant	16 (48%)
Mainline Protestant	10 (30%)
Catholic	2 (6%)
Other Christian Traditions	1 (3%)
Other faith	3 (9%)
Multiple	1 (3%)
<u>Time as a chaplain (n=35)</u>	
1 year or less	0 (0%)
More than 1 year but less than 5 years	8 (23%)
5 years or more but less than 10 years	12 (34%)
10 years or more but less than 20 years	9 (26%)
20 years or more	6 (17%)
<u>Time at VA / DoD (n=34)</u>	
1 year or less	1 (3%)
More than 1 year but less than 5 years	10 (29%)
5 years or more but less than 10 years	10 (29%)
10 years or more but less than 20 years	7 (21%)
20 years or more	6 (18%)
<u>Time in present facility / assignment (n=35)</u>	
1 year or less	16 (46%)
More than 1 year but less than 5 years	13 (37%)
5 years or more but less than 10 years	6 (17%)
<u>Military experience (n=18)</u>	
Veteran (VA only)	10 (56%)
<u>Military experience of Service members and Veterans (n=27)</u>	
Rank ≥ O4	12 (44%)
Iraq deployment	9 (33%)
Afghanistan deployment	13 (48%)
<u>Stationed in healthcare facility (DoD only) (n=17)</u>	
	10 (59%)

Percentages are based out of the total number of those that responded to each question. Participants who selected more than one religious category are included in the Multiple category.

With respect to primary outcomes, results from the analyses of our pre / post questionnaires demonstrate that upon completing the MHICS training chaplains felt significantly better prepared to care for Veterans and Service members suffering from a range of common mental health problems, including:

- Anxiety ($p = .023$)
- Depression ($p = .026$)
- Posttraumatic stress ($p = .054$)
- Psychosis ($p = .004$).

Further, at the end of our training, we asked chaplains to indicate how their participation in MHICS had influenced their practice. For these questions as related to our primary aims, responses from our chaplains indicate that:

- 94% are able to provide better care to Veterans / Service members.
- 88% understand how to apply evidence-based psychological practices within chaplaincy.
- 88% function more effectively as part of an integrated care team.

With respect to secondary outcomes, results from an analysis of our pre / post questionnaires are suggestive of a trend in the direction of chaplains being more likely upon completion of the MHICS training to use a routine process to identify patients who could benefit from mental health services ($p = .133$). Though this was a secondary outcome, it is noteworthy that the direction of the change for participants in MHICS was for them to become somewhat more likely to systematically identify patients for referral to mental health (i.e., gaining more knowledge and skill related to the care of persons with mental health problems somewhat promoted referral).

With respect to questions asked at the end of our training regarding how participation in MHICS influenced practice, responses from chaplain participants indicate that:

- 44% are able to see a greater quantity of Veterans / Service members.
- 41% are able to see Veterans / Service members more quickly.
- 62% are more likely to receive referrals from mental health providers as appropriate.
- 65% are able to better facilitate Veteran / Service member entry into mental health care when needed.
- 91% report making appropriate referrals to mental health providers.

Importantly, 97% of chaplains who completed the MHICS training said that they would recommend participating in the program to a colleague. Indeed, chaplains rated all components of the courses very highly (see Figure 3). On a scale of 1 = poor, 2 = fair, 3 = good, and 4 = excellent, the average rating across all courses tended toward “good” for threaded discussions ($M = 3.07$) and LIVE calls ($M = 3.28$) and “excellent” for readings ($M = 3.54$), videos ($M = 3.69$), and face-to-face meetings ($M = 3.84$).

Figure 3: Participants' Ratings of Course Content



F2F = Face-to-face meeting (2.5 days); LIVE = Live Adobe Connect webinars; TD = Threaded Discussion.

Numerical labels for videos and readings correspond to the 45 different units (15 per course) as previously presented in Table 1 (e.g., 1.3.3 = video and reading corresponding to Course 1, Module 3 [Acceptance and Commitment Training], Unit 3 [Applications of ACT within chaplaincy]).

Learning Collaborative Metrics (JIF Obj. #2)

The data collection methods and findings for JIF Objective #2 (learning collaborative) are presented below. Data sources include metrics generated by teams, data assembled by VERC systems redesign support staff, and pre / post electronic surveys and qualitative interviews.

Methods

Team / VERC Metric Tracking. The purpose of a learning collaborative is to have participating teams, facilities, and related entities develop and test changes to the delivery of services (Jackson et al., 2010; Kilo, 1999; Schouten, Hulscher, van Everdingen, Huijsman, & Grol, 2008). In the present learning collaborative, the ultimate goal was to make these changes in service to enhancing effective collaboration between chaplains and mental health providers. Because the implementation of change is based within the concept of lean management, the expectation is that learning collaborative teams map their current processes for providing care (i.e., current state) followed by their desired system for providing care (i.e., future state). Teams in the present collaborative were encouraged to move from their current states to desired future states via the use of PDSA cycles, which stands for: Plan (develop changes); Do (implement a test of the change); Study (measure and evaluate the impact of the change); and Act (decide if the change is ready to be implemented, needs to be altered, or needs to be abandoned). PDSA cycles are intended to be repeated by teams, such that teams can test implementation changes, learn lessons, regroup, develop new approaches, and test new changes. It is important to consider that PDSA cycles are a tool used in the lean management concept. As a result, it is expected that some changes will be successful and others will need to be modified.

Electronic Surveys. Electronic surveys included surveys of: 1) learning collaborative team members; and 2) all mental health professionals (i.e., at least all psychiatrists and psychologists; social workers and others could be included depending on the mental health service line makeup at a facility) and chaplains at participating facilities. In VA, all electronic surveys were programmed and hosted by the VA Employee Education System (EES). In DoD, all electronic surveys were done using max.gov. Pre-surveys were disseminated and completed during the early stages of the collaborative, and post-surveys were completed a number of months following completion of the collaborative (due to differences in team start times, team finish times, and survey platform capacities, exact open and close dates for the surveys varied between VA and DoD). On the pre-survey across VA and DoD, responses were submitted from 80 chaplains and 381 mental health providers. On the post survey, responses were submitted from 51 chaplains and 215 mental health providers.

Qualitative Interviews. The first round of semi-structured individual qualitative interviews was primarily conducted in-person at the second learning session (which was the first face-to-face session for DoD participants). These initial qualitative interviews were focused on early participation in the collaborative. Questions were asked in the areas of inputs (e.g., team composition and functioning, organizational readiness, and resource availability), activities (e.g., helpfulness of learning sessions and coaching), and outputs (e.g., identification of practices that can change or have changed as well as action plans). In total, 29 individual, initial interviews were conducted with the chaplain (N=15 [VA: N=8 / DoD: N=7]) and mental health provider (N=14 [VA: N=7 / DoD: N=7]) traveling team members. Interviews ranged from approximately

15 to 40 minutes in duration. The second round of follow-up, individual qualitative interviews was conducted remotely via phone following completion of the collaborative. Similar to the initial interviews, the follow-up interviews focused on activities, outputs, and outcomes (e.g., what has changed in the key focus areas for the collaborative). A total of 25 interviews were conducted with the chaplain (N=13 [VA: N=8 / DoD: N=5]) and mental health provider (N=12 [VA: N=7 / DoD: N=5]) traveling team members. Follow-up interviews ranged from approximately 21 to 45 minutes in duration.

Findings

Team / VERC Metrics. Teams in the learning collaborative were very active throughout. All teams participated in making quality improvement changes. The majority completed current and future state maps, and all teams sought to implement quality improvement changes with the help of improvement coaches. The below bullets provide an overview of key accomplishments from the collaborative.

- A total of 74 PDSA cycles / organizational changes were tried over the course of the collaborative across all sites (5.28 per site). This includes 38 for VA teams (5.43 per team over ~10 active months) and 36 for DoD team (5.14 per team over ~7 active months). Teams generally identified the largest gaps in the areas of screening, referrals, and role clarification. Accordingly, these areas had the most PDSA cycles. See Figure 4.
- Overall, PDSA cycles were highly successful. PDSA cycles / changes in the collaborative were linked to specific, measurable aims. These aims could vary by site based on local context and current state of services. By the end of the collaborative, only 4 of the 74 PDSA cycles had to be “abandoned” (i.e., process was determined to be unsuccessful). See Figure 5.
- Overall, 35 specific, measurable metrics were developed (20 among the 7 VA teams, and 15 among the 7 DoD teams). Of note, these figures should be interpreted in the context of DoD teams having less time as active participants in the collaborative than VA teams (7 months vs. 10 months).
- Overall, 2/3 of objectives were achieved by the end of the collaborative (23 of 35), which compares favorably to many collaboratives (e.g., Jackson et al., 2010). One would not expect all of the goals to be achieved because teams were asked to develop new systems of providing care that needed to be tested and refined. Table 6 provides detail on the degree to which measurable aims in each domain of the learning collaborative were achieved.

Figure 4: Domains of PDSA Cycles / Care Changes Tried by Collaborative Teams

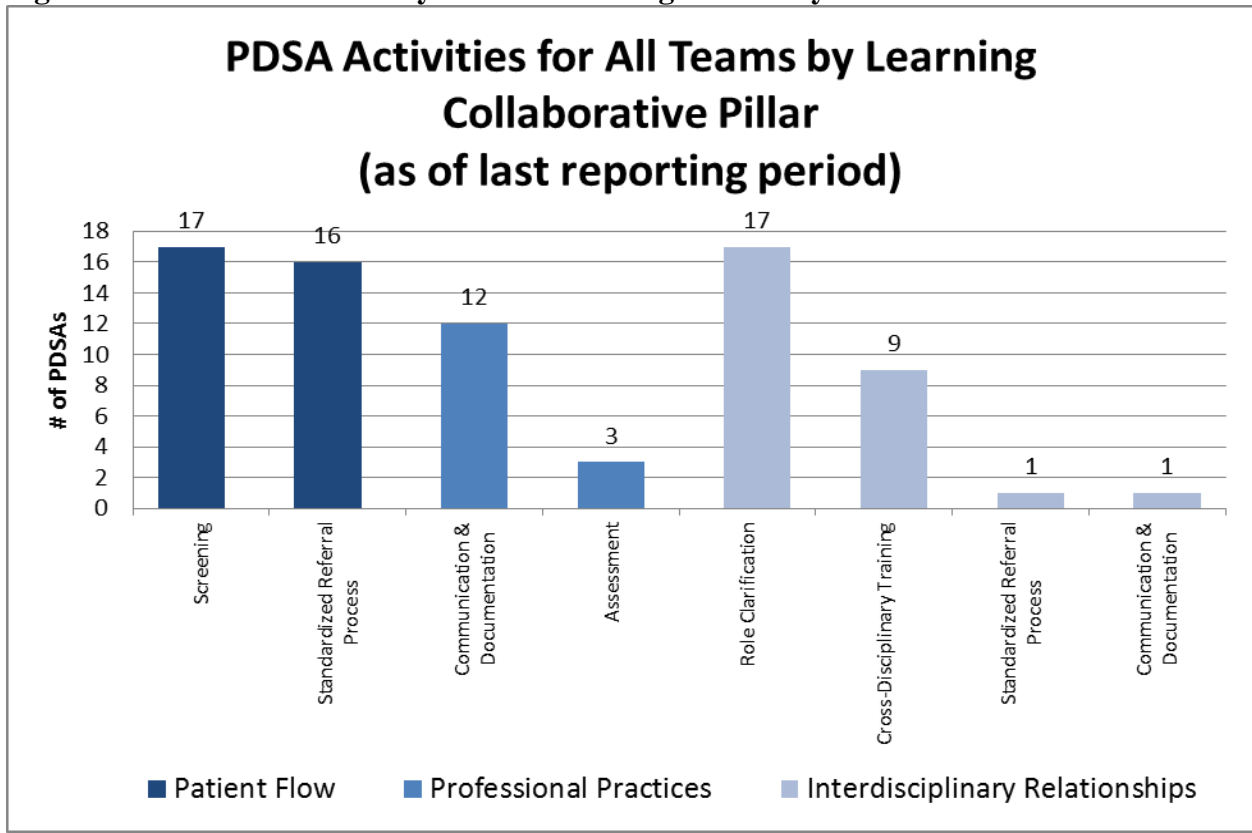
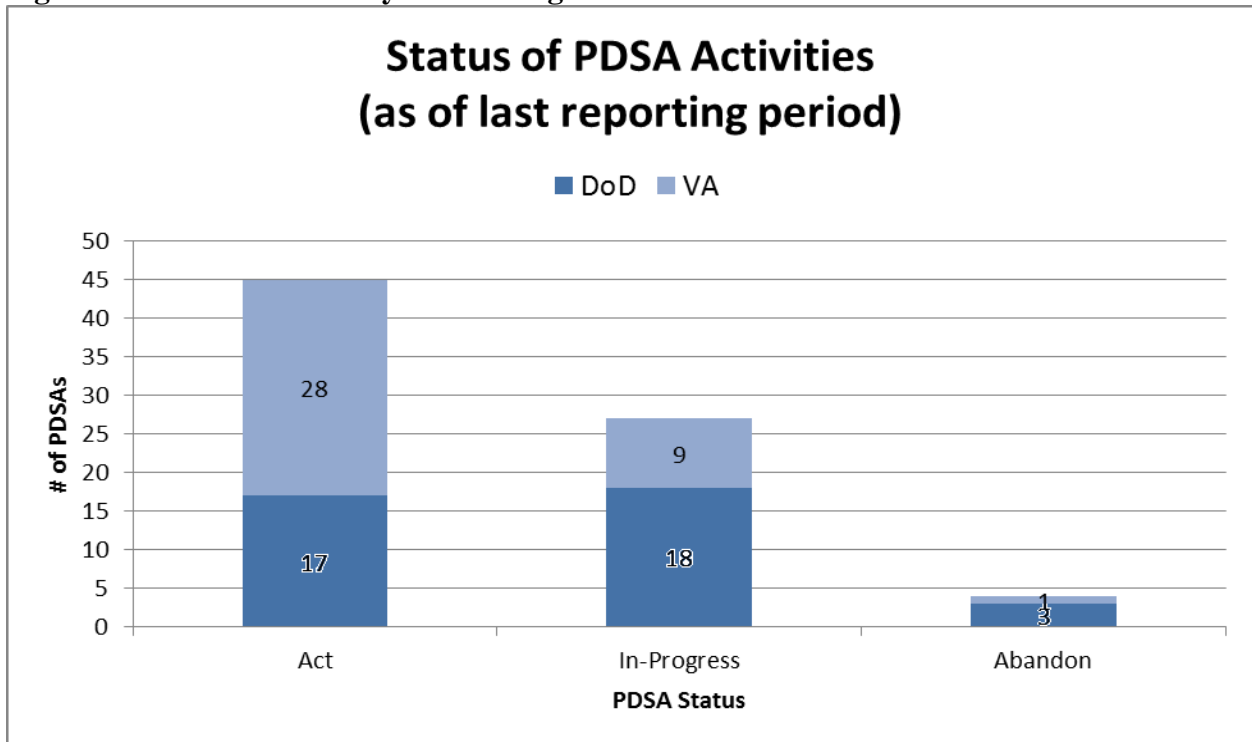


Figure 5: Status of PDSA Cycles / Changes at the End of the Collaborative



Act = Fully implemented change.

Table 6. Success in Meeting Established Metrics by Learning Collaborative Teams

	Total # Metrics	% Achieved	% Achieved by Category			
			Consults / Referrals	Education	Screening	Other
VA	20	60%	25%	25%	33%	17%
DoD	15	73%	36%	36%	28%	N/A

Teams undertook a number of different change efforts in keeping with the overarching aims of the collaborative. These efforts were tracked individually by the different teams in the collaborative. Such individually driven tracking is an important part of the learning collaborative method as it allows for metrics to be optimally designed to fit different settings and for tracking processes to be meaningfully adopted at the local level. Figures 6-9 provide examples of mapping and metric tracking processes at the team level.

Figure 6 displays a baseline flow-map developed by a DoD team to identify gaps in current processes, which at this facility illustrates the need for developing more formal referral processes between chaplaincy and mental health. Teams used flow maps to identify the areas in which they wanted to implement changes and track metrics. For many teams, an early step was implementing standard screening processes. One metric that teams tracked related to this was the percentage of patients screened in the particular clinic or area where the change process was being implemented (see Figure 7 for a DoD team example of tracking this process).

Many teams also then focused on the number of referrals that passed from mental health to chaplaincy and vice versa. Figure 8 shows the number of consults placed by mental health professionals for chaplain services at one of the participating VA facilities, with a noticeable increase occurring after a month in which an in-service was provided to mental health professionals explaining chaplain services. Other sites looked at the patients who screened positive for a possible referral to track the percentage that actually accepted the referral (see Figure 9 for a VA team example). Such data helped teams refine screening efforts. Of note, many facilities reported that patients who did not accept a referral at the time it was offered sometimes expressed interest in the referral at a later time point.

Figure 6: Sample Flow Map from DoD Team

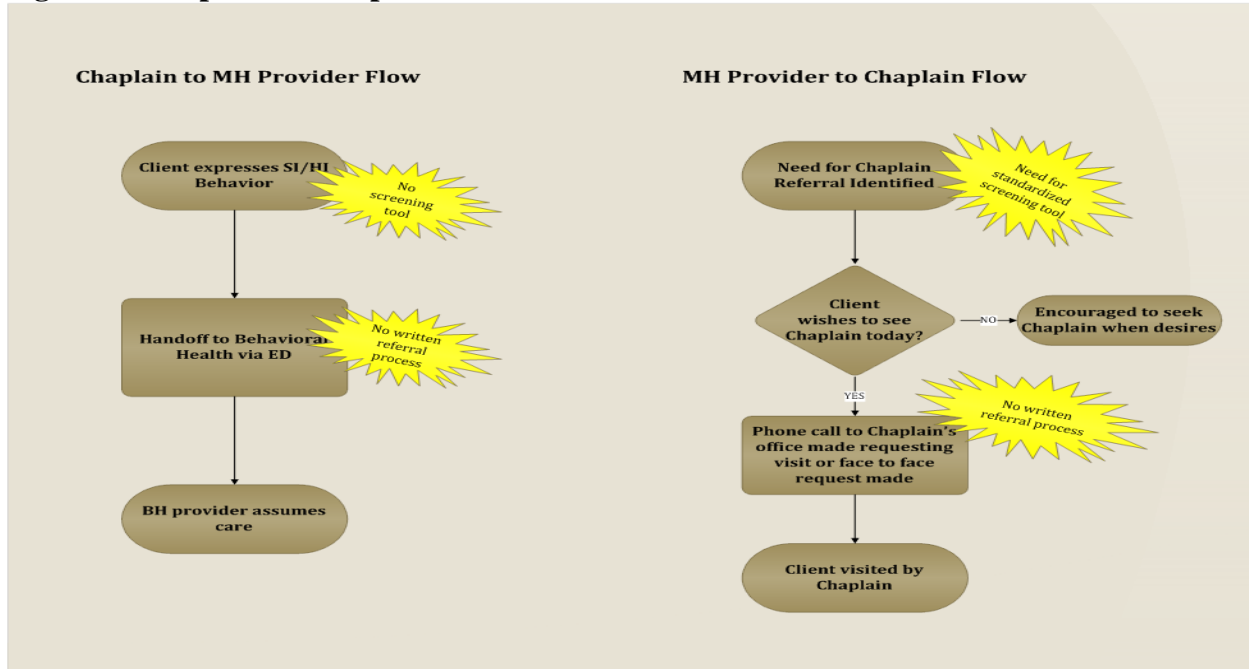
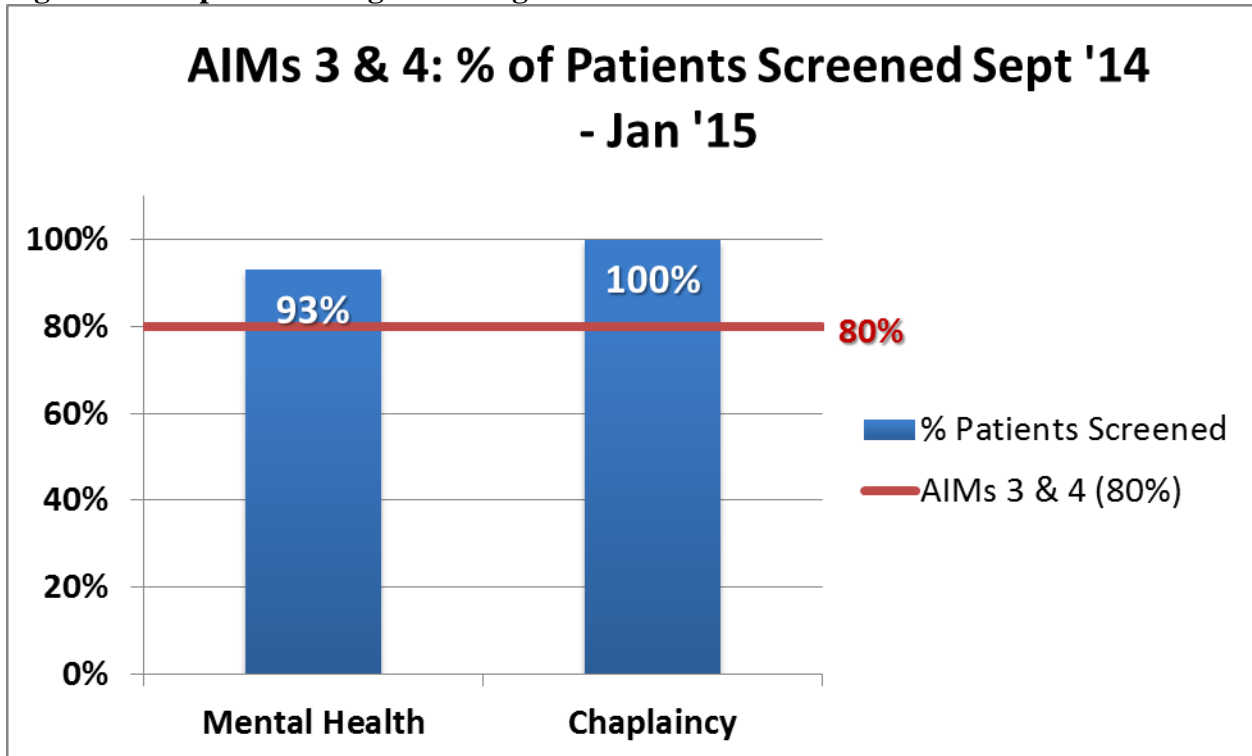
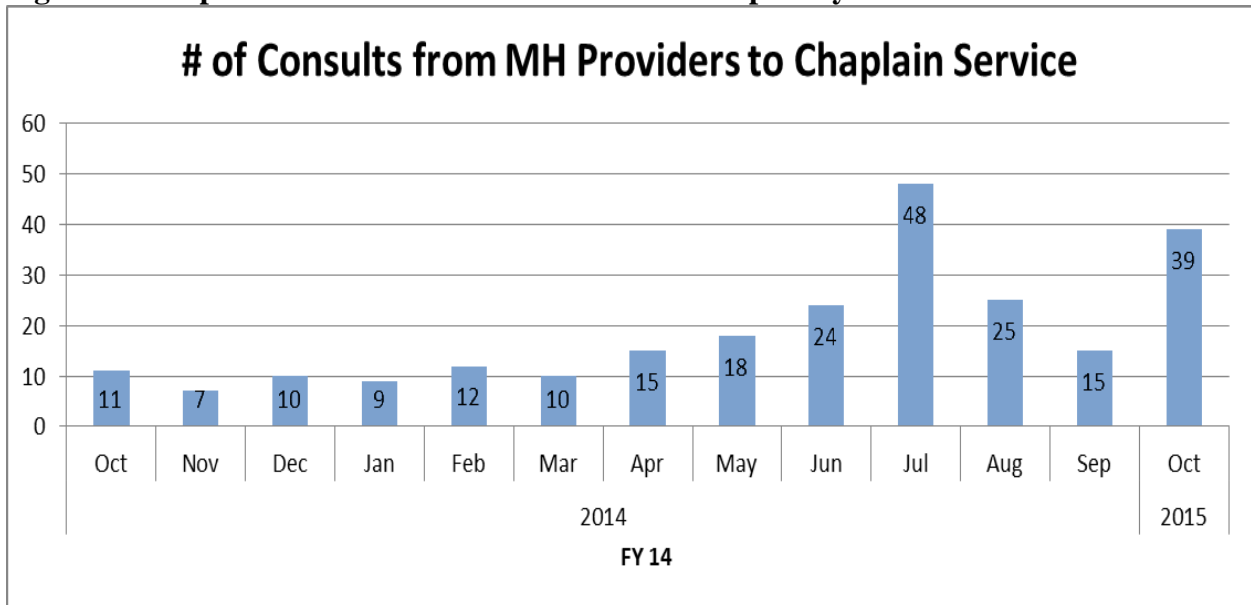


Figure 7: Sample Screening Percentage from DoD Team



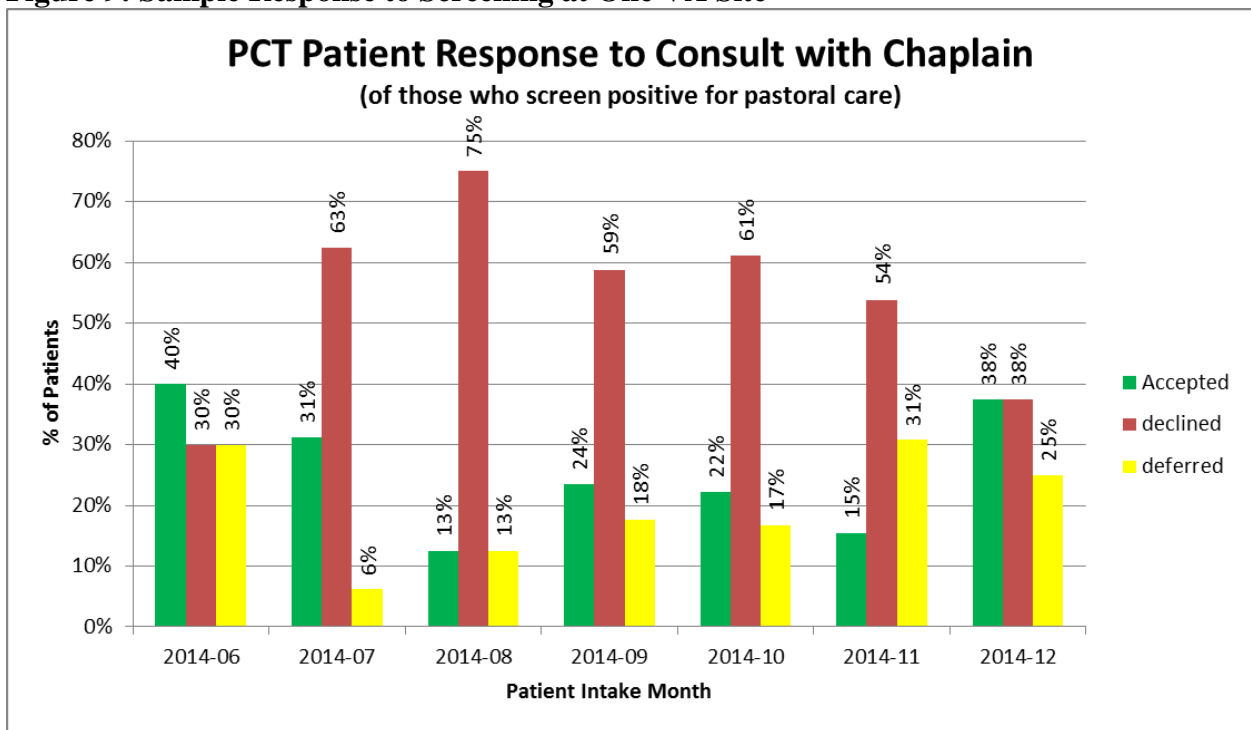
The relevant aims for this team were: Aim # 3 – Establish a formal screening process for active duty from mental health to chaplaincy that screens at least 80% of patients who present. Aim #4 – Establish a formal screening process from chaplaincy to mental health that screens at least 80% of patients who present.

Figure 8: Sample Consults from Mental Health to Chaplaincy at One VA Site



Chaplain provided in-service to mental health providers in June, after which consults significantly increased.

Figure 9: Sample Response to Screening at One VA Site



Across the entire learning collaborative, teams tended to focus heavily on making accomplishments in certain areas. The areas of focus and corresponding accomplishments are suggestive of system-wide domains that merit focus and are amenable to improvement. Below is a summary of major change efforts undertaken and status at the end of the collaborative.

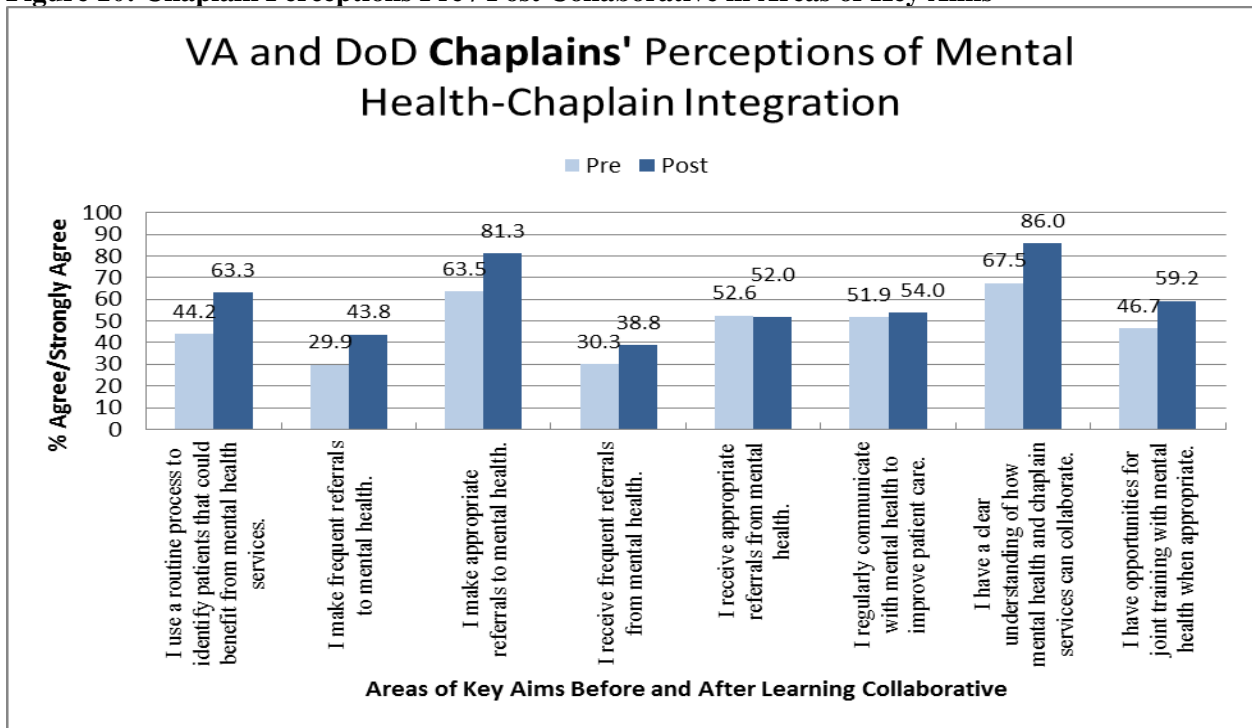
Major Change Effort

Status

- | | |
|--|---|
| <ul style="list-style-type: none"> • Development of care coordination agreements (standard operating procedures for collaboration and patient referral) between chaplaincy and mental health • Mental health provider education concerning chaplaincy and / or spirituality • Chaplain education concerning mental health services and / or mental health topic • Implementation of specific screening question to be used in mental health clinics to assess the potential need to refer mental health patients to a chaplain • Chaplain screening for possible referral to mental health • Implementation of specific mental health to chaplain referral processes • Development of new processes for chaplains to refer to mental health | <ul style="list-style-type: none"> ▪ Zero agreements were in place before the collaborative; by the end, agreements were completed or in progress for 6 of 7 VA teams and 7 of 7 DoD teams. ▪ Completed or in progress for all 14 teams across VA and DoD ▪ Completed or in progress for all 14 teams across VA and DoD ▪ Completed or in progress for 6 of 6 VA hospital teams (1 Vet Center team used a different process that allowed for collaborative service delivery) and 7 of 7 DoD teams ▪ Four of 7 DoD teams implemented systems for chaplains to screen Service members for possibly needing to be seen by a mental health provider. VA teams did not implement changes in this domain, likely due to VA chaplains often functioning in a different capacity than in DoD. ▪ Completed or in progress for 6 of 6 VA hospital teams (1 Vet Center team used a different process that allowed for collaborative service delivery) and 6 of 7 DoD teams ▪ Three of the 7 DoD teams implemented specific processes for such referrals, while only 1 of 6 VA hospital teams had done so (1 Vet Center team used a different process that allowed for collaborative service delivery) – reflective again of differences in chaplain functioning between VA and DoD. |
|--|---|

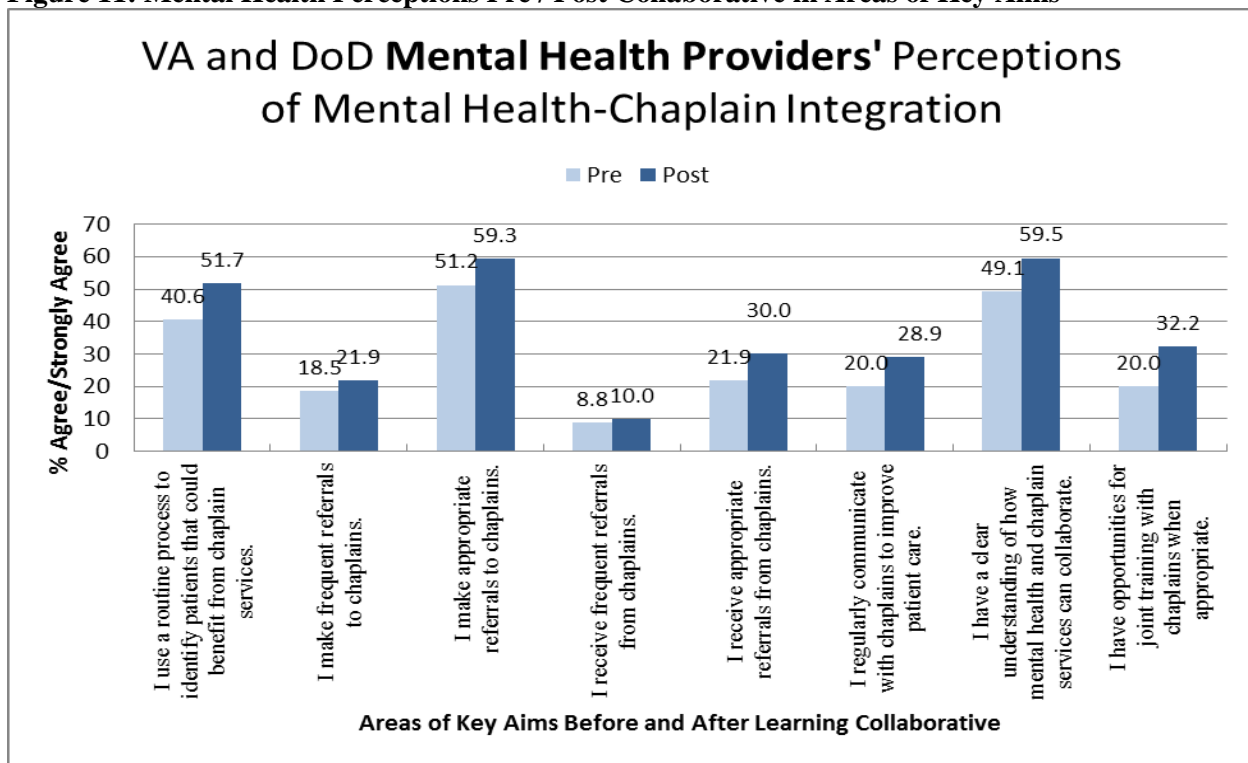
Electronic Surveys. Pre / post surveys of mental health providers and chaplains at participating facilities demonstrate that changes implemented by teams had a spread effect to the larger facility. Of note, teams participating in the learning collaborative were generally focusing on making changes in a particular area within the medical center (e.g., implementing new screening processes in the PTSD Clinic) rather than the entire facility. Figures 10 and 11 demonstrate that there were discernable improvements in many of the key focus areas for the collaborative. In general, both chaplains and mental health professionals appeared to make gains, with the gains being more pronounced among chaplains – likely because they are a significantly smaller service and were more likely to be directly influenced by the collaborative. Both mental health providers and chaplains evidenced facility-level improvements in the areas of using routine processes to identify patients who could benefit from seeing the other discipline, making appropriate referrals to the other discipline, understanding how to collaborate with the other discipline, and having opportunities for joint training with the other discipline.

Figure 10: Chaplain Perceptions Pre / Post Collaborative in Areas of Key Aims



Percentages based on number of valid observations for each variable. Missing values range from 1 to 7 respondents across variables / questions.

Figure 11: Mental Health Perceptions Pre / Post Collaborative in Areas of Key Aims



Percentages based on number of valid observations for each variable. Missing values range from 1 to 7 respondents across variables / questions.

Qualitative Interviews. Feedback from the first round of qualitative interviews was used to identify issues potentially in need of addressing and to develop actionable and constructive improvements to the learning collaborative process. For example, traveling team members expressed a desire for more time dedicated for team sharing, which was reflected accordingly in the agenda for the third learning session. For the follow-up interviews, individual interview data and notes based on recording transcripts were organized in matrices to address aspects of collaborative operations and processes, such as degree of team flexibility. Individual qualitative data were aggregated to identify patterns across facilities by collaborative operations / processes and organization (VA, DoD). The following themes emerged.

- VA and DoD teams reported aspects of the collaborative-coaching strategy that worked well, including:
 - Enhancing local focus on mental health-chaplaincy integration
 - Utilization of in-person learning sessions to share experiences
 - Utilization of team-specific improvement coaches / facilitators to guide the process
- DoD teams desired or identified:
 - Earlier help understanding specific collaborative objectives
 - Greater initial clarity concerning the roles of improvement coaches (also reported by VA)
 - Need to translate improvement and VA language into DoD nomenclature
 - Difficulty with an initial “virtual” learning session

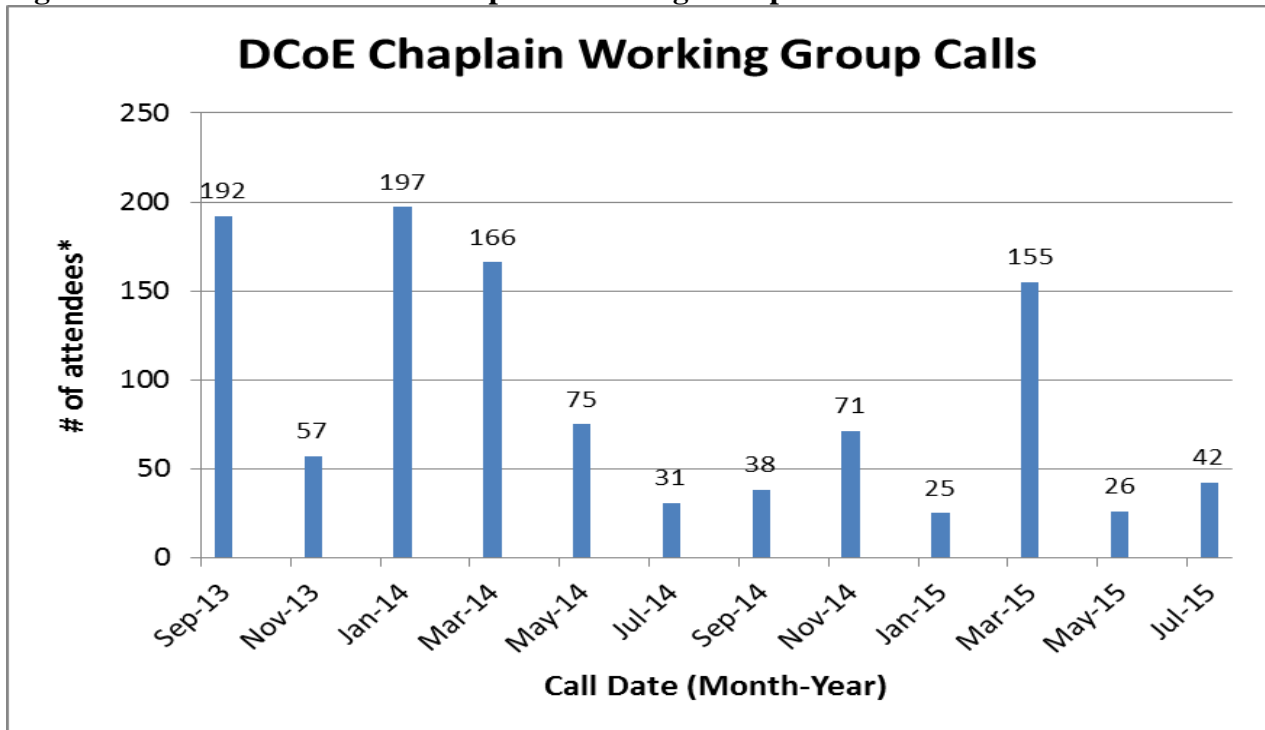
- DoD teams reported that coaches and collaborative leadership effectively facilitated this process over time.
- In contrast to DoD teams’ desire for more structure, VA teams reported a desire for a less structured collaborative model.

DoD and VA teams reported that the implementation strategy (learning collaborative with coaching / facilitation) worked well for enhancing collaboration across healthcare professions. However, DoD arguably has a greater level of command and control and a wider variety of missions than the VA healthcare system. When working across organizations with different levels of centralized control to conduct collaboratives, there appears to be a need to balance flexibility with standardization. Organizational context, culture, and structure may be important to consider when selecting and designing appropriate implementation strategies.

Broad-based Education Metrics (JIF Obj. #3)

Broad-based educational efforts as part of the JIF spanned multiple areas of activity, including putting on conferences, presenting at conferences, presenting in other venues, disseminating written products in various venues, and producing educational videos for broad consumption. Table 2 in the above “Activities” section of the report provides an overview of many of the activities in addition to those entailed in the MHICS training and the learning collaborative. In total, the table lists a two-day conference, 8 publications in professional peer-reviewed journals, and 19 formal presentations. Additionally, it includes 12 DCoE Chaplain Working Group calls and the production of 3 professionally produced one-hour videos.

Figure 12: Attendees on DCoE Chaplain Working Group Calls*

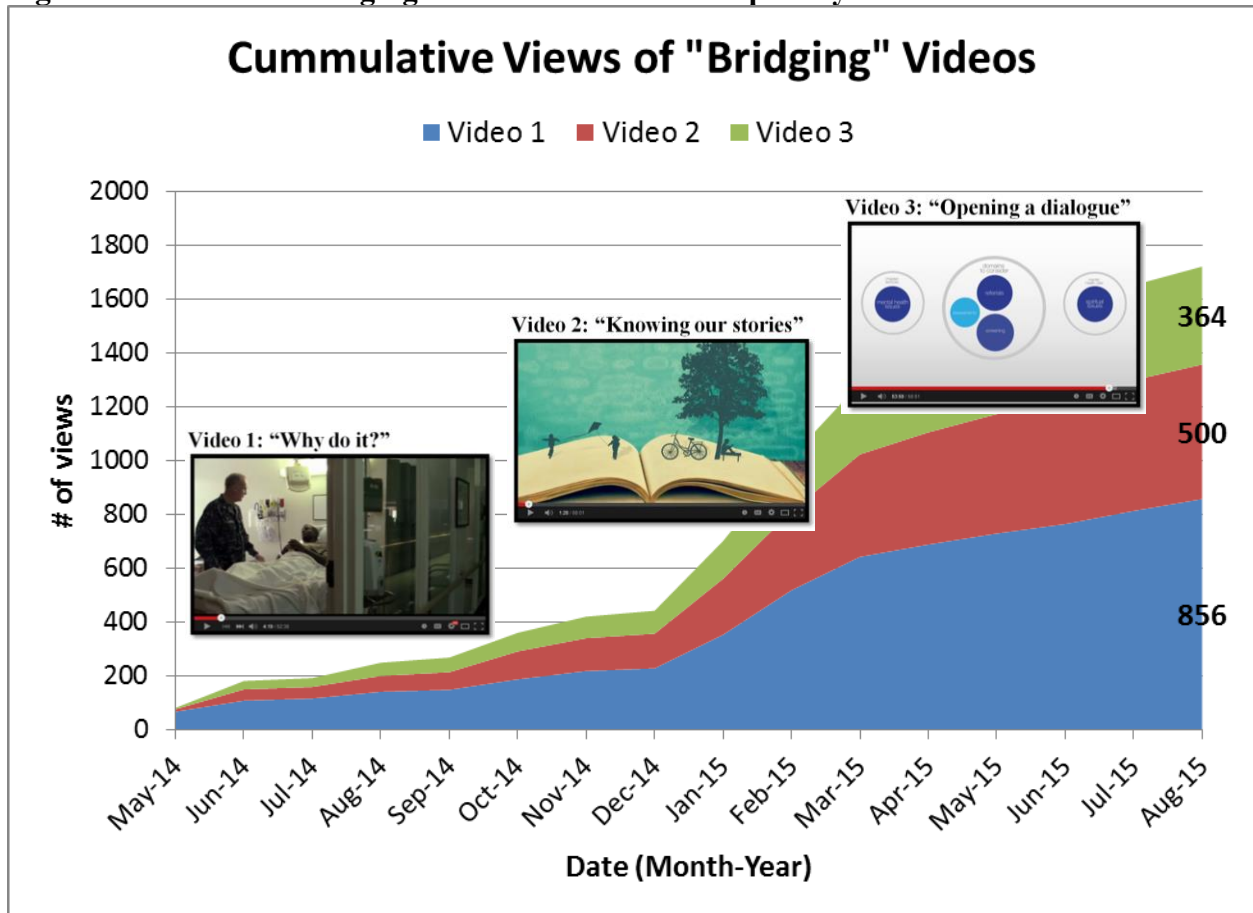


*The number of attendees is a conservative estimate, as it only counts numbers of connected phone and / or internet lines. Per report from participants, multiple individuals will often use a single line to attend the call.

Attendance on the Chaplain Working Group calls is shown in Figure 12. Of note, four of these calls had participation from over 150 phone lines – actual attendance was likely significantly higher since numerous sites reported having multiple people attend on a single phone line / web connection. Attendees on these calls are invited but not required to complete evaluation forms. Feedback on these evaluation forms was consistently positive for the speakers who were chosen to present on the calls. Dissemination and sustainment efforts include developing a central website in DoD where chaplains can download materials archived from the Chaplain Working Group calls as well as other psychological health resources to support chaplain services.

Number of views as calculated by YouTube for the “Bridging Mental Health and Chaplaincy” videos is shown in Figure 13. As of the end of August 2015, the three videos had an accumulated total of 1,720 views: 856 for Video 1 (“Why do it?”), 500 for Video 2 (“Knowing our stories”), and 364 for Video 3 (“Opening a dialogue”). These videos have been advertised as part of multiple conference presentations and have served as a resource for efforts within MHICS and the learning collaborative. For instance, a number of chaplains participating in MHICS used the videos to help explain to mental health colleagues the potential value of collaboration, and participants in the learning collaborative similarly used the videos to help provide a framework for their systems redesign work.

Figure 13: Views of “Bridging Mental Health and Chaplaincy” Videos



Numerical figures for “views” are provided by YouTube and cover the period from when the videos launched in early May of 2014 through the end of August 2015.

IV. LESSONS LEARNED

This project provided the opportunity for learning multiple lessons about how to integrate mental health and chaplain services, how to provide training, and how to collaborate across the distinctive organizations of VA and DoD. Below are some of the major lessons learned over the course of this project, articulated so as to include relevant information about some of the challenges encountered and potential approaches for overcoming these challenges.

Mental Health and Chaplaincy Integration Lessons Learned

- *Because in many locations there is a substantial gap between mental health and chaplain services, improvement efforts in many places may need to focus first on establishing basic building blocks before moving on to making improvements in other domains.* Surveys of mental health professionals at participating learning collaborative sites indicated that a large proportion of mental health professionals knew very little about the services that chaplains could offer. Hence, a critical foundational piece is to provide mental health professionals with such information about chaplaincy – both in general and in contextually-specific ways (i.e., what do chaplains do in general and what can chaplains provide in the context of specific facilities and clinics). This educational process then inherently informs other domains where improvements need to be made. For instance, mental health professionals who implemented screening procedures to identify spiritual problems were most effective in conducting screenings and making meaningful referrals to services when they understood precisely the function of chaplain services to which they were referring a patient.
- *Global recommendations for integrating mental health and chaplain services must be able to accommodate variations in the local characteristics and capacities of different facilities and providers.* There are marked variations between different VA and military facilities. Patient populations, provider capacities, and sufficiency of staffing are among some of the more important characteristics that drive if and how different quality improvement efforts can be successful. For instance, facilities with a limited number of chaplains might be able to offer spirituality groups but may not be able to offer as much in the way of individual spiritual counseling time to patients. Processes for screening and referring patients to chaplains must be structured according to this reality. Of additional note, a handful of participating learning collaborative sites also had chaplains who were participating in MHICS, either as members of the learning collaborative team or as staff chaplains at the facility. These sites generally appeared to be more successful in integrating care services, which per participant report was in large part due to the enhanced capacities of those chaplains going through the year-long intensive MHICS training.
- *Service members and Veterans commonly endorse having mental and spiritual problems when asked, and continued efforts are merited with respect to further developing and refining approaches to screening, referrals, and treatment.* In general, when mental health professionals began systematically asking about religious and spiritual issues and tracking patients' responses, teams discovered that a substantial

proportion of patients indicated having such problems. At the same time, there was also fairly wide variation between sites in the proportion of patients who endorsed suffering from spiritual problems as well as the proportion of patients who subsequently indicated interest in seeing a chaplain. It is likely that patient characteristics, provider characteristics, and characteristics of the screening question influenced this variation. The intention of conducting quality improvement efforts in a learning collaborative is to meaningfully and iteratively enhance “on the ground” care processes, not to conduct a controlled research study. Conducting such real world improvements across an array of sites provides rich information for potential follow-up in more controlled research settings. Lessons learned from the collaborative can and are being used to inform future controlled research studies on topics ranging from tool development to treatment protocols.

Training Lessons Learned

- *Technology can be effectively used to accomplish significant educational objectives, yet some in-person training remains necessary to achieve optimal outcomes in key areas.* The MHICS pedagogical process relied heavily on distance education technology, with only three 2.5-day face-to-face meetings over the course of the training. Per participant report, these in-person trainings were crucial for the success of the overall training, providing value not only during the events themselves but also extending that value during the distance education portions of the course. The threaded discussions, group calls, and other opportunities for distance interaction were greatly enhanced because participants came together for the three meetings. In addition, these in-person meetings helped provide necessary motivation to stay on track throughout the year. A training experience in the learning collaborative further underscores this point. The VA teams experienced the first learning session face-to-face, while the DoD teams participated in the first learning session activities via webinar. The DoD teams’ engagement was noticeably lower, as was their retention of the material, which was evident at the second learning session when all teams came together in-person. However, after the second learning session, DoD teams then rapidly began to engage with the collaborative. Much training can and has been accomplished through the use of technology; in this JIF project, technology appeared to be optimized when combined with at least some in-person training.
- *Opportunities for “credit” are important to provide.* The chaplains and mental health professionals engaged in the various parts of this JIF project generally seemed to genuinely believe in participating in the work for its own sake – meaning for the benefit of Service members and Veterans. Nonetheless, providing different forms of credit was valued by participants and is also likely to help with sustainability of the developed trainings. For mental health professionals in the learning collaborative, continuing education credits were provided. For chaplains, the desired types of credit were more varied depending on the context in which that chaplain worked and stage in his or her career. The external motivators to complete MHICS that appeared to appeal most to VA chaplains were: it enhanced their credibility with mental health professionals and opened doors for functioning collaboratively on mental health teams (and possibly for applying for such jobs in VA); it came with a certificate of

completion signed by national VA offices; and it paved the way for a mental health sub-specialty through NAVAC. For DoD chaplains, the most appealing external motivators to complete the training appeared to include: it provided a sub-specialty code (in some branches); it gave them a potential advantage in applying for a VA job post military service; and it may assist with promotion. Some chaplains indicated that they would be interested in academic credit for completing MHICS, a possibility that has been investigated and is still being further explored.

- *It is important to provide opportunities for learning application and accountability.* In the MHICS training, participants had multiple outlets through which to demonstrate and be held accountable for their learning. These included threaded discussions, end of course exams, and a final capstone paper. At the final face-to-face meeting, numerous participants were invited to present on the integrative work that they had accomplished in working with mental health and integrating evidence-based practices with their spiritual care. These presentations were typically very moving illustrations of how chaplains had functioned to restore meaning, purpose, and hope to the lives of patients who often began in the midst of significant despair. For future MHICS cohorts, it is our intention to further enhance opportunities for application of learning content. Various methods for accomplishing this are being considered, including different forms of mentorship, completion of paper elements at earlier portions in the course, and the interactive use of psychosocial-spiritual care modeling videos.

VA / DoD Collaboration Lessons Learned

- *Cultural differences between VA and DoD (as well as between the branches of the military) have an important influence on implementation processes.* This was evident in various parts of the JIF project but particularly so in the learning collaborative. A telling insight is that VA teams in the learning collaborative came up with a greater number of individualized aims to implement than DoD teams. However, DoD teams had a higher rate of completion for the aims that they advanced. This is consistent with the different cultures in VA and DoD, with VA's culture being more permissive of variance, individual initiative, and creative experimentation with quality improvement strategies and DoD's culture being more focused on successful completion of leadership mandates.
- *The time, resources, and approaches necessary to achieve project socialization, buy-in and sustainment are considerably different in VA and DoD.* In VA, many of the relevant national leaders (e.g., VA National Chaplain Center leadership, VA Central Office Mental Health Services leadership) were already familiar with and supportive of our team's work. Compared to DoD, there were fewer persons in national leadership that needed to be consulted and it was considerably less time-intensive to garner needed tangible support from these personages (e.g., letters of support to provide to medical center personnel at various VA facilities). Further, the JIF team had substantial latitude on the VA side to take on independent responsibility for coordinating various aspects of the project, such as recruiting facilities to participate in the learning collaborative and identifying chaplains to participate in MHICS. In

DoD, there were many times more individuals in leadership positions across the three branches that needed to be appraised of the project. Their buy-in was also more critical in certain respects, as these leaders were relied upon to permit aspects of the project to proceed, to identify and select sites / individuals for participation, and to create orders and / or allowances that permitted specific individuals to participate in facets of the JIF project. Further, the turnover rate is much higher in DoD than in VA. While there remained some key leaders who were familiar with our team's work by virtue of having been included in the IMHS project, many of the DoD leaders were new and many more changed over the course of the JIF project. Thus, socializing projects and garnering buy-in from relevant DoD leadership requires more time and needs to be done on a more intensive ongoing basis due to the higher number of relevant leaders and higher turnover rate. In addition, the relative increased transiency of DoD chaplains and providers increases the challenge of completing training courses and learning collaborative activities as well as retaining these experienced staff in the military Services.

- *While the differences between VA and DoD can present multiple challenges, their different strengths can also mutually complement each other.* The core missions of VA and DoD are plainly different. VA – VHA in particular – is primarily concerned with health care and maintains a fairly stable workforce. DoD is primarily concerned with national defense. As such, it generally values and rewards diverse experiences among its personnel (advancement in the military typically requires this), must be ready and responsive to the needs of the moment, and can experience substantial changes to its makeup over time. Over the past five years of collaboration on IMHS and JIF projects, VA has been in a more stable position to anchor efforts and provide continuity over time. DoD, by comparison, has been in a better position to identify the most pressing needs facing Service members depending on the nation's current defense activities and priorities (which have a downstream effect on VA). In general, processes in the current JIF project seemed to be most effective when one agency was able to take on primary responsibility. Some of the surveys in the current project were administered by just VA, whereas others were administered by VA and DoD. Separate administration caused complications. One system would be preferable when possible.

V. CONCLUSIONS

Overall, this JIF project implemented the intended activities for all three stated objectives. A total of 20 VA and 20 DoD chaplains were recruited to participate in MHICS, and 35 completed this intensive year-long training program (a high retention rate). Course content was very well received by chaplains participating in the training, and evaluation findings suggest that chaplains who completed the program were significantly better equipped to provide high quality care. A total of 7 VA teams and 7 DoD teams were recruited to participate in the learning collaborative, and all teams completed the full collaborative. Teams were able to successfully implement their quality improvement efforts in keeping with the proposed learning collaborative model, and findings suggest that benefits were experienced not just within the particular domains of

implementation but also spread to a degree within the larger facility. Finally, the array of broad based educational efforts reached diverse and sizeable target audiences. Below we present plans for sustaining various elements of the JIF project.

SUSTAINABILITY AND EXPORTABILITY

The JIF monies provided indispensable seed funds to develop products and processes that would not otherwise have been possible to produce. The report authors are sincerely appreciative of the opportunities allowed by these funds and have worked to maximize utilization of funds as well as to promote sustainability and exportability of the deliverables associated with the three objectives in this JIF project. The present status for each of the three objectives is provided below.

For the MHICS training (Obj. #1), another cohort is scheduled to commence in January 2016 and will run through the remainder of that calendar year. The products developed for the first MHICS training (e.g., videos, Blackboard course structure, assignments, etc.) will be used to support this second cohort. Hence, this cohort will cost significantly less to support than the first. Still, expenses for this 2016 cohort include travel, creation of some new video trainings, and funding for training support staff. Since not all initially awarded JIF funds were expended, these costs are being covered through a “no-cost” extension of remaining JIF monies. Relevant leadership in VA and DoD have been appraised of the cost implications of supporting MHICS beyond depletion of JIF funds, and various avenues are being explored to secure sufficient funding support in the future.

With respect to the learning collaborative (Obj. #2), sustainability is being pursued through multiple avenues. First, JIF leadership and learning collaborative teams have presented on multiple occasions to various external audiences about lessons learned from the collaborative and suggestions for sites interested in integrating services. Second, systems redesign principles from the collaborative have been incorporated into elements of the MHICS training such that future participants in that training will be better equipped to undertake quality improvement efforts. Third, a package of three separate one-hour videos is being created to disseminate principles from the learning collaborative. These videos share important instructions from the collaborative and feature successful VA and DoD teams sharing about their experiences and lessons learned. There are multiple avenues by which these videos can be used and disseminated. Concrete plans are in place to utilize the videos in connection with the MHICS trainings, and numerous other processes for dissemination are being actively developed.

For the broad-based trainings (Obj. #3), established processes and products are in place to ensure sustainability. DCoE has incorporated into its regular educational offerings the Chaplain Working Group calls, which are scheduled to continue on a bi-monthly basis. The “Bridging Mental Health and Chaplaincy” videos exist as a permanent online resource for anytime access by interested individuals, and they continue to be used and referenced in coordination with various presentations and related training efforts. Finally, there are plans in place to continue disseminating information about the JIF project through professional outlets, such as conferences and peer-reviewed journals.

VI. SHARING AGREEMENT

With respect to the three objectives of this JIF project, there are understandings and agreements in place that appropriately correspond to different elements of the ongoing collaboration. For the MHICS training, VA is agreed to anchoring the 2016 cohort in a similar way to the initial cohort, providing management of distance education and conference planning. DoD and VA JIF leadership are presently collaborating to identify 20 DoD and 20 VA participants for this next cohort. For the learning collaborative, the various sustainability efforts described above have been conducted jointly (e.g., presenting on findings from the collaborative), and the learning collaborative videos being produced will be used in both VA and DoD. For the broad training, DCoE has and will continue to advertise the Chaplain Working Group calls jointly to DoD and VA personnel, and the “Bridging” videos are freely available for anyone to view.

On a broader level, the team on this JIF project has now successfully partnered for five years, first as part of the IMHS project and now through the present JIF project. Extensive, organic, continually evolving sharing has taken place over the course of these projects. Meaningful ties have been developed not only between leadership on these projects but also between the literally hundreds of collaborators that have graciously partnered with us. The result is a community of educators, practitioners, care providers, researchers, policy makers, and leaders that extends jointly across VA and DoD. While their positions and daily work vary substantially, this community has come to be united by the shared purpose of investing in chaplains and mental health professionals to achieve our shared objective of improving the lives of those who have served.

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