

A Psychology Postdoctoral Fellowship Program in Integrated HIV and Hepatitis C Clinical Care: Rationale, Progress, and Future Directions

Maggie Chartier

Clinical Public Health/Office of Public Health,
Washington, DC

Tara Steinberg

Michael E. DeBakey Veterans Affairs Medical Center,
Houston, Texas

Erin Dehon

G. V. (Sonny) Montgomery VA Medical Center,
Jackson, Mississippi

Rebecca K. Blais

VA Puget Sound Health Care System,
Seattle, Washington

Stephanie Catella

San Francisco VA Medical Center,
San Francisco, California

David Ross

Clinical Public Health/Office of Public Health,
Washington, DC

Robert A. Zeiss

Office of Academic Affiliations, Washington, DC

Individuals with HIV/AIDS and hepatitis C virus (HCV) often present with complex mental health (MH) and substance use disorder (SUD) treatment needs. Evidence shows that providing MH and SUD services in integrated care settings results in improved medical treatment outcomes and disease management for these populations. Given the importance of addressing the MH and SUD needs of veterans seeking care at Veterans Health Administration (VHA) facilities for HIV and HCV, the Office of Public Health is collaborating with VHA's Office of Academic Affiliations to support a clinical psychology postdoctoral training program with this emphasis. Through a discussion of fellowship competencies, structure, and implementation, this article highlights the unique contribution that a psychology postdoctoral training program with a focus on these populations provides.

Keywords: postdoctoral fellowship, training, HIV, hepatitis C, integrated care

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MAGGIE CHARTIER received her MPH from the University of Washington, and her PsyD from the Pacific Graduate School of Psychology–Stanford Consortium. She is currently the national public health clinical psychologist in the HIV, Hepatitis, and Public Health Pathogens Program in the U.S. Department of Veterans Affairs Office of Public Health, Washington DC and is a staff psychologist at the San Francisco VA Medical Center, San Francisco, California. Her areas of professional interest include HIV, hepatitis C, acceptance and commitment therapy, and mindfulness.

REBECCA K. BLAIS received her MS and PhD in clinical psychology from the University of Utah. She is currently a research postdoctoral fellow at the Traumatic Stress Center, Rush University. Her areas of professional interest includes identifying factors related to mental healthcare utilization in veterans, cognitive-behavioral therapy for anxiety disorders and depression and couple-level therapies including, integrative-behavioral couple's therapy.

TARA STEINBERG received her MA from Southern Methodist University and her PhD from the University of North Texas Denton/University of North Texas Health Sciences Center. She is currently a staff psychologist at the Michael E. DeBakey VA Medical Center in Houston, Texas. Her areas of professional interest include brief therapies for health-related behaviors in veterans living with chronic illnesses, particularly HIV and liver diseases, presurgical evaluations for transplant and other medical procedures; and bedside psychotherapy for medically ill and hospitalized veterans.

STEPHANIE CATELLA received her PsyD at La Salle University. She is currently a psychology postdoctoral fellow at the University of San Francisco, California. Her areas of professional interest include HIV and hepatitis C,

coping with chronic illness, stress management, stigma and barriers to accessing care, substance use, and mindfulness-based interventions.

ERIN DEHON received her PhD from Jackson State University. She is currently an assistant professor and director of behavioral science education in the Department of Emergency Medicine at the University of Mississippi Medical Center. Her areas of professional interest include medical education, adjustment to chronic illness, and primary and secondary prevention of chronic illnesses.

DAVID ROSS received his MD and PhD from the New York University School of Medicine. He serves as the national director of the HIV, Hepatitis, and Public Health Pathogens Programs at the U.S. Department of Veterans Affairs, Washington DC.

ROBERT A. ZEISS received his PhD from the University of Oregon. He has recently retired from the position of director of associated health education for the Office of Academic Affiliations in the VA Central Office, Washington DC.

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CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Maggie Chartier, San Francisco VA Medical Center (116B), 4150 Clement St., San Francisco, CA 94121. E-mail: maggie.chartier@va.gov

The Department of Veterans Affairs (VA) is the single largest provider of HIV and hepatitis C virus (HCV) care in the United States, with 173,416 veterans with HCV and 26,033 HIV-positive veterans receiving care in 2012 (M. Chartier, personal communication, September 16, 2013). Veterans with these blood-borne pathogens have high rates of mental health (MH) and substance use disorders (SUD) (see Table 1), which not only impact overall well-being and functioning, but also contribute to challenges in access to treatment, disease management, and health outcomes. Many VA facilities do not routinely have specialized MH resources readily available to address these issues (Healthcare Analysis and Information Group [HAIG], 2010, 2008).

This article describes the background, rationale, creation, and progress of the VA's Office of Public Health (OPH)–Office of Academic Affiliations (OAA) joint initiative to address this issue on a national level. The Clinical Psychology Postdoctoral Fellowship, with an emphasis in HIV and HCV, aims: (a) to increase postdoctoral training opportunities in specialized health psychology and SUD treatment of HIV- and HCV-infected veterans; (b) to increase access to specialty MH services among veterans with HIV or HCV; and (c) to raise awareness by HIV/HCV medical and MH providers across the system about the often unmet MH and SUD needs of veterans with HIV and HCV.

HIV/HCV Postdoctoral Fellowship in Clinical Psychology

In response to the recent Institute of Medicine (2010) report on hepatitis and liver cancer, the U.S. Department of Health and Human Services (DHHS; 2011) released an action plan for the prevention, care, and treatment of viral hepatitis. This DHHS report highlights the importance of providing HCV treatment to

patients with comorbid MH and SUD in the context of appropriate behavioral health support. Access to integrated care with MH and SUD treatment for HCV patients is echoed in VA's most recent treatment recommendations for HCV (Yee et al., 2012). Following the release of these calls to action, VA's Principal Deputy Under Secretary for Health charged the Clinical Public Health (CPH) Program to address the looming epidemic of untreated HCV in the VA, one critical component of which is addressing MH and SUD comorbidities that represent significant barriers to care.

In a 2007 survey of VA HCV clinics, only 61% routinely screened for MH and SUD prior to HCV treatment; 20.3% of clinics had a dedicated psychologist, psychiatrist, or substance abuse counselor (HAIG, 2008). A similar survey for HIV was conducted in 2009; 57% of HIV clinics routinely screened for MH and SUD and only 27% of clinics had dedicated MH staff (psychiatrist, psychologist, or substance abuse counselor).

VA's CPH section, within OPH, is charged with designing programs that prevent illness, promote healthy behaviors, and support vulnerable populations. To support the growing need in the VA to treat veterans with HIV and HCV, as well as to expand integrated MH and SUD expertise for these patients across the VA system, CPH launched a pilot Postdoctoral Fellowship Program. In 2011, the VA's HIV, Hepatitis, and Public Health Pathogens Programs, part of CPH, in collaboration with OAA announced the availability of four positions for postdoctoral fellowships in clinical psychology with an emphasis on the MH and substance use treatment of veterans with HIV/HCV.

The MH and SUD care of patients with HIV and HCV is complex and requires in-depth training that psychologists are uniquely suited for due to their extensive training in assessment, diagnosis, intervention, research, and administration. There are

Table 1
Mental Health and Substance Use Comorbidities in HIV- and HCV-Infected Veterans^a

Comorbid condition group	Comorbid condition	HCV ^b		HIV ^c	
		Number ever diagnosed with condition	Percent ever diagnosed with condition	Number ever diagnosed with condition	Percent ever diagnosed with condition
Blood-borne viral diseases	HCV			6,670 ^d	26
	HIV	5,802 ^d	3		
Mental illness	Bipolar disorder	21,353	12	2,482	10
	Depression	102,523	59	14,416	55
	neuroses and anxiety states	62,436	36	8,019	31
	PTSD	47,999	28	4,291	16
	Schizophrenia	16,590	10	1,720	7
	Any mental illness	119,258	69	16,193	62
Substance use	Alcohol Use	95,234	55	8,810	34
	Cannabis	43,009	25	4,058	16
	Opioids	37,370	22	3,021	12
	Other and unspecified drug use	66,308	38	6,544	25
	Sedatives and anxiolytics	8,164	5	475	2
	Stimulants	60,240	35	7,223	28
	Tobacco use	113,927	66	12,381	48

Note. HCV = hepatitis C virus; PTSD = posttraumatic stress disorder.

^a Data from National HIV Registry Reports: 2012 and National HCV Registry Reports: 2012 personal communication from Office of Public Health/Population Health. ^b Number of veterans in care in year used as denominator = 173,416 veterans with HCV in care during 2012. ^c Number of veterans in care in year used as denominator = 26,033 veterans with HIV in care during 2012. ^d Entry into registry requires human review and clinical confirmation. Presence of comorbidities is determined by ICD-9 codes, whose accuracy may vary by condition, resulting in differing counts of HCV+ Veterans with comorbid HIV and HIV+ veterans with comorbid HCV.

several key competency areas that HIV/HCV psychology fellows are trained to address. The following are adapted from “best practices” in health psychology training outlined by Masters, France, and Thorn (2009): (a) *Assessment*: Assessing psychiatric and substance use issues as well as behavior risk factors specific to these patients; (b) *Intervention*: Providing evidence-based practice for psychiatric and substance use problems and effective disease management, as well as monitoring emerging best practices in the literature; (c) *Consultation*: Participating in interdisciplinary collaborative teams and developing the ability to interact with and facilitate collaborative relationships among various health providers across disciplines; (d) *Research*: Participating in or initiating research or quality improvement projects with a focus on integrated HIV and HCV care with the expectation of publication or presentation of results; (e) *Education, Supervision, and Training*: Participating in supervision and training both as a trainee and as a supervisee, and gaining experiences as a trainer and supervisor in integrated HIV and HCV clinical settings; (f) *Administration*: Demonstrating leadership skills, developing quality improvement or program development projects, and successfully navigating administrative and systems issues; and (g) *Professionalism*: Displaying professional interpersonal behavior, time efficiency, appropriate documentation and use of supervision, and an understanding of ethics and the integration of cultural competency and diversity issues into clinical settings as well as advocating for the professional identity and role of psychologists in HIV and HCV clinical care.

Providing a full year of clinical training for VA psychology postdoctoral fellows in HIV and HCV is consistent with VA initiatives to increase access to MH care, disease management and prevention, and patient-centered care for vulnerable populations (Dundon, Dollar, Schohn, & Lantinga, 2011). Psychologists are uniquely suited to be integrated into these clinical settings because many people with HIV and HCV suffer from long-term and debilitating psychiatric and substance use disorders that occur in the context of complex medical comorbidities and other environmental challenges. Psychologists are specifically trained in assessment, diagnosis, and often evidence-based intervention, all of which are necessary to address the needs of these patients. As with any specialty care service, although a psychologist with general training in health psychology may competently deliver a specific intervention for a behavioral health problem, a psychologist with training and experience working with this often stigmatized and complex patient population will be able to deliver such interventions in a culturally competent manner to treat the patient more holistically. This fellowship also emphasizes integration and interdisciplinary collaboration, as research has shown that MH and substances use, for differing reasons that are outlined in the consultation section below, greatly impact the clinical outcomes and treatment options for patients with HIV and HCV. This fellowship program focuses on the following competencies and targets of training, which are described below in the context of HIV and HCV clinical populations.

Assessment

The prevalence of psychiatric and substance use disorders are higher in people living with HIV and AIDS than in the general population (Hinkin, Castellon, Atkinson, & Goodkin, 2001;

Klinkenberg, Sacks, & HIV/AIDS Treatment Adherence Health Outcomes and Cost Study Group, 2004), and higher still in veterans with HIV and AIDS (Gaynes, Pence, Eron, & Miller, 2008; Department of Veterans Affairs [DVA], 2012). For example, as of 2012, 59% of all HIV patients in the VA system had ever had a diagnosis of depression and 55% had, had a diagnosis of alcohol use disorder (see Table 1). The interaction of aging and living with HIV and AIDS increases vulnerability to HIV associated neuro-cognitive disorders and other cognitive challenges (Becker, Lopez, Dew, & Aizenstein, 2004; Valcour, Shikuma, Watters, & Sacktor, 2004). A study at an academic medical center estimated that half of people living with HIV/AIDS have mild to severe cognitive impairment (Heaton et al., 2010; Simoni, Amico, Smith, & Nelson, 2010). These risks are higher for those with comorbid psychiatric illnesses and alcohol dependence (Hinkin et al., 2001). Of the 26,000 HIV-positive veterans receiving care, 40% are between the ages of 50 and 59 years, and 30% are over the age of 60 (DVA, 2012).

Rates of MH and SUD are also much higher among people with HCV than the general population (Schaefer et al., 2012). Veterans with HCV have higher rates of psychiatric disorder than those in the general public, particularly considering the “tri-morbidity” of substance use, psychiatric illness, and HCV (Fireman, Indest, Blackwell, Whitehead, & Hauser, 2005; Loftis, Matthews, & Hauser, 2006). Of the 173,416 veterans seen for HCV care in 2012, 3% were coinfecting with HIV and 26% of HIV-positive veterans were coinfecting with HCV (DHHS, 2011; DVA, 2012). There is evidence that coinfecting individuals are at risk for higher psychiatric distress than people with HIV alone (Baillargeon et al., 2008; Fuller, Loftis, Rodriguez, McQuesten, & Hauser, 2009; Rosenberg, Drake, Brunette, Wolford, & Marsh, 2005).

Bini et al. (2005) evaluated the HCV treatment candidacy of 4,084 veterans with HCV using both standardized criteria and treating clinician opinion. Based on standardized criteria, only 32.2% were determined to be eligible to begin antiviral treatment; this number was higher (40.7%) when clinical judgment was used as the criterion. Ongoing substance use (20.2%), having an active psychiatric disorder (18.3%), or having a comorbid medical illness (17.9%) were the predominant reasons for treatment ineligibility.

By virtue of graduate school and internship training experiences in health psychology, postdoctoral fellows are trained to diagnose, assess and treat psychiatric illness in the context of chronic medical diseases and to understand the impact of engagement in care and treatment on both psychiatric and medical outcomes. In this fellowship program, fellows apply health psychology and behavioral medicine training to HIV and HCV clinical populations, which, as outlined above, have unique and specific needs that are both psychiatric, medical, and environmental in nature. Fellows are also expected to gain experience in neuropsychiatric screening, assessment for medication and treatment adherence, and behavioral health assessment. In the case of HCV, this assessment can also be critical in determining a patient’s readiness for antiviral treatment. The results of these assessments are then communicated to interdisciplinary teams and patients.

Intervention

The presence of mood, anxiety, and SUD have been linked with HIV disease progression and increased risk behavior (Leserman, 2003; Pence, Miller, Whetten, Eron, & Gaynes, 2006). Specific conditions (e.g., depression, substance use, posttraumatic stress disorder, severe mental illness) have also been linked to more rapid HIV disease progression and increases in AIDS-defining illnesses and death (Carrico, 2010; Carrico et al., 2011; Gore-Felton & Koopman, 2008; Nurutdinova, Abdallah, Bradford, O'Leary, & Cottler, 2011).

In a recent review article, Bonner, Barritt, Fried, and Evon (2012) laid out a rationale for expanding hepatitis C treatment to patients with MH and SUD. This review highlights many studies in which patients with MH and SUD have been safely and effectively treated for HCV as long as they are provided with appropriate multidisciplinary care that includes MH and SUD services. There are also several studies that have found that HCV patients with MH and SUD can achieve HCV cure rates (e.g., Sustained Virologic Response [SVR]) similar to patients without these comorbidities (Bonner et al., 2012).

Referrals for evaluation and treatment for HCV are critical in increasing the number of HCV-infected patients who are treated. Once on treatment, a high level of medication adherence is needed to increase the likelihood of viral clearance (Backus et al., 2011; Lo Re et al., 2011).

As this literature has shown, the role of MH providers, and specifically psychologists, can be critical to engaging HIV and HCV patients in care. For HIV patients, addressing psychiatric and SUD can impact disease progression and increase adherence. For HCV patients, having a patient engaged in psychotherapy to address psychiatric and substance use disorders can help to facilitate patients being referred for antiviral therapy and successfully staying on antiviral treatment. Assessment of suicidality and suicide prevention, which is standard practice in the VA, is often a particular focus for fellows, and their integration into HIV and HCV clinics facilitates this engagement. For both HIV and HCV patients, who may face issues of stigma, receiving MH and SUD care within the context of their medical care can increase engagement and help to facilitate patients' overall treatment.

Consultation: Integrating MH and SUD Services Into HIV/Infectious Disease (ID) and HCV/Liver Clinical Settings

Given the significant MH and SUD burden in veterans with HCV or HIV, increasing the availability of MH services is of critical importance (see Table 1; DHHS, 2011; DVA, 2012; Bonner et al., 2012). Although there are no consensus guidelines that recommend integrated care in HIV and HCV, clinical trials examining the efficacy of colocated psychological services for patients with HCV have shown that integrated MH care increases treatment eligibility and completion, decreases problematic drinking, and increases rates of viral suppression (Evon et al., 2011; Bonner et al., 2012; Ho et al., 2008; Knott et al., 2006). Integrated care has also been shown to increase access to MH and SUD services in HIV populations (Chartier, Carmody, & Lamipris, 2010; Hoang et al., 2009; Soto, Bell, & Pillen, 2004; Zaller, Gillani, & Rich, 2007). For example, in a retrospective matched case-control study

of HIV/AIDS clinics in the VA, Hoang et al. (2009) found that patients with co-occurring MH and SUD receiving integrated care were 3.1 times more likely to achieve viral suppression compared with patients who had MH and SUD but were not receiving care in integrated VA clinics (Hoang et al., 2009).

Integrating psychologists into HIV and HCV clinical settings can also help individuals deal with illness-specific social stressors, including stigma. Stigma experienced by the individual with HCV has been linked with negative outcomes, including depressive or anxiety symptoms, difficulty coping, loss of control, occupational problems, and heightened pessimism in individuals with HCV (Golden, Ronan, O'Dwyer, Golden, & Hardouin, 2006; Zickmund, Ho, Masuda, Ippolito, & LeBrecque, 2003). HIV-related stigma may also interfere with treatment engagement or adherence (Chesney & Smith, 1999) and can lead to depressive symptoms (Steward et al., 2008) resulting in increased HIV disease progression. Individuals living with HIV/AIDS may also experience stigma from care providers. Indeed, stigma perceived from medical providers has been negatively linked with patient satisfaction in individuals living with HIV/AIDS (Li, Comulada, Wu, Ding, & Zhu, 2013) and medical access and follow-up (Kinsler, Wong, Sayles, Davis, & Cunningham, 2007). Further, in a sample of 147 patients with HCV, 60% of patients related that they experienced some type of stigma from medical providers (Zickmund et al., 2003). Psychological interventions incorporating education, adaptive coping skill development, and empowerment can decrease the negative effects of stigma (Lucksted et al., 2011), which may lead to improved outcomes in individuals with HIV/AIDS or HCV.

Given the unique training that health psychology provides, fellows are able to gain experience and expertise in the treatment of HIV and HCV by working collaboratively within integrated medical teams. Developing relationships with health providers across disciplines and over time and being seen as a member of the core treatment team by attending team or staff meetings and being colocated facilitates this interdisciplinary collaboration.

Research

In this fellowship, there is an optional 20% protected time that fellows could use to focus on research. Given the nature of health psychology and the role that evaluation and quality improvement can often play in providing evidence of efficacy and validation of resource allocation, this was strongly encouraged. Not all fellows or all sites decided to have research as a rotation, but for those that did, the expectation was that research would focus on HIV and HCV care. A publication or presentation was also expected for fellows who chose this research rotation.

Education, training, and supervision. Fellows gained experience in supervision and training in integrated HIV and HCV clinical settings through supervision of psychology interns or practicum students. Fellows also play an educational role by presenting to HIV/Infectious Disease (ID) and HCV/liver clinic teams on the impact of MH and SUD in their patients, and the role of integrated clinical psychologists in their clinics. At all sites, they teach psychoeducation classes to patients with HIV and HCV and present on these topics to various providers to enhance awareness of the role of psychology in their clinics. Fellows also participate in informal psychoeducation and con-

sultation with interdisciplinary providers throughout their training year.

Administration

Fellows are evaluated on their demonstration of leadership skills and focus on their thinking about and successfully navigating administrative and system issues that arise during their training year. Many of the fellows were the first MH providers to be colocated and integrated into HIV and HCV clinics at their facilities, and they face challenges inherent to that process. This is largely a function of a lack of previous MH presence in these clinical settings outside of a health psychology or behavioral medicine consult service, which is not uncommon across the VA system (HAIG, 2010). In these cases, supervisors are often located in integrated primary care or other specialty care clinics, or were health psychologists working in consultation with various medical clinics at their facilities. Given the relative newness of these clinical experiences, fellows were encouraged to consider quality improvement or program development projects to address pertinent issues that they identified in these settings. Fellows meet monthly with the national coordinator of the program, who is also a clinical psychologist in integrated HIV and HCV clinical settings and who is able to provide additional guidance and consultation on these issues.

To supplement local didactic training, fellows are required to participate in the National HIV/HCV Psychology Seminar Series, which is a weekly, hour-long seminar that provides training on medical and MH/SUD issues in HIV, HCV, and liver disease (see Table 2). Speakers are experts in their topic areas. This seminar

Table 2
National HIV and HCV Psychology Seminar Series Topics

Topics
Clinical aspects of HIV infection/AIDS
Clinical aspects of HCV
Mental health and substance use assessment, monitoring, and treatment in patients with HCV
Substance use and HIV: intertwined epidemics
HIV psychiatry
HCV psychiatry
HIV and HCV medication adherence
HCV support groups
Smoking cessation in HIV
Advanced liver disease and HCC
Cognitive impairment in HIV
Using data to improve health outcomes
Outbreaks and exposure: investigations fundamentals
Providing care to transgender veterans: managing HIV, HCV, and other related concerns
Evidence-based treatment of alcohol use disorders
HIV testing in VA
Complementary and integrative medicine
Mental health pre/post liver issues: focus on impact of medical factors
Cannabis use in HIV and HCV
Cognitive impairment in HCV
Self- and other-generated stigma: implications for interventions for veterans with HCV/HIV
Intersections of HIV and intimate partner violence

Note. HCV = hepatitis C virus; HCC = hepatocellular carcinoma; VA = Veterans Health Administration.

series is opened to all VA psychology training programs and, currently, psychology trainees from 15–20 VAs typically attend the calls. This seminar series, originally designed for the HIV and HCV fellows, has proved to be an excellent opportunity to disseminate HIV and HCV knowledge more broadly throughout the VA's psychology community.

Professionalism

As mentioned earlier, patients seeking care for HIV and HCV often have many complex medical and psychiatric issues that can be complicated by issues of stigma and other environmental concerns. As fellows interact with interdisciplinary teams, they are evaluated on their interpersonal behavior and understanding of cultural and diversity factors specific to HIV and HCV. Fellows are also encouraged to develop their professional identity as integrated providers to better understand and articulate the role of psychology in these clinical settings. Additional domains of competency in this area are also considered and included: documentation, efficiency, use of supervision, and ethics.

Fellowship Structure

VA facilities with existing American Psychological Association–accredited postdoctoral training programs in clinical psychology that also had the capacity to provide appropriate supervision in this content area were eligible to apply for pilot funding. Those with higher prevalence of HIV and HCV in their facility's catchment area were strongly encouraged to apply. The fellowship structure had to include integrated HIV and HCV clinical rotations as well as a minor rotation in substance use treatment. Availability of knowledgeable supervision was also a requirement. Given the lack of expertise in the system among MH providers in this area, relevant supervision included supervisors with a specialty focus in health psychology, integrated medical care, and some experience working with HIV and HCV clinical populations. In 2012, the following sites were selected for this fellowship: (a) VA Puget Sound Health Care System in Seattle, Washington; (b) Michael E. DeBakey VA Medical Center in Houston, Texas; (c) G. V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi; and (d) San Francisco VA Medical Center in San Francisco, California.

After successful implementation of fellowships at these sites (which included provision of quality supervision, successful integration of the fellow into HIV and HCV integrated care and SUD rotations, and increased interest from VA psychology training programs and HIV and HCV medical providers in the field), the fellowship was expanded in 2013, with a follow-up competitive request for proposals that resulted in the approval of five additional sites: (a) Miami VA Health Care System in Miami, Florida; (b) Providence VA Medical Center in Providence, Rhode Island; (c) VA Connecticut Health Care System in West Haven, Connecticut; (d) VA Long Beach Health Care System in Long Beach, California; and (e) Washington DC VA Medical Center. Two additional sites—(a) VA Maryland Health Care System in Baltimore, Maryland, and (b) John D. Dingell VA Medical Center in Detroit, Michigan—will be joining the program in fall 2014.

An evaluation of this fellowship program is currently underway to assess the quality of training in terms of the competencies outlined above and patient outcomes. In addition to site-specific

evaluation forms, the Learners' Perceptions Survey is administered to fellows twice during their training year. Clinical and performance outcomes, such as numbers of patients seen and referred to MH and SUD services, missed appointments, adherence, and other markers of disease management, will be assessed using the VA's Corporate Data Warehouse and compared with matched nonfellowship sites. This portion of the evaluation will begin at the end of the 2014 academic year.

Summary and Future Directions

There is a high burden of MH disorders and substance use in veterans with HIV and HCV, and a lack of adequate resources in the VA system to address these concerns. This pilot postdoctoral fellowship program is a first step in training a cohort of psychologists to work with the special needs of these underserved populations. Thus far, the program is accomplishing its stated aims. Current postdoctoral fellows are receiving specialized training and clinical experience working in integrated HIV/ID and HCV/liver clinics, thereby increasing access to MH and SUD services in those settings. As this cohort of fellows graduates, they increase the capacity of psychologists in the field who are trained to meet the unique needs of these patients and to provide supervision to the trainees they will supervise in their clinical settings moving forward. The presence of this fellowship has also raised awareness both locally and nationally, as evidenced by requests from psychology training programs and HIV and HCV medical providers in the field for expansion of the program to include their facilities. Further, there are 20 VA psychology training programs that have their trainees regularly participate in the National HIV/HCV Psychology Seminar Series, even in the absence of specific HIV and HCV rotations at their facilities.

As HIV testing increases in the VA, the numbers of veterans with known HIV will increase in the years to come (Czarnogorski et al., 2013). Although the formulary of medicines to treat HIV/AIDS continues to grow and become more effective and less toxic, management of this chronic illness will undoubtedly continue to require an interprofessional approach that considers the psychological well-being and impact of psychiatric disease on patient outcomes and longevity. As the face of HCV treatment transforms in the decade to come, the role of integrated psychologists and fellows in HCV/liver clinics can also expand to address the needs of patients with hepatocellular carcinoma, advanced liver disease, and MH/SUD and health behaviors that affect liver disease progression and impact on antiviral treatment and transplant candidacy (e.g., depression, alcohol use and misuse). As veterans with HIV and HCV age, there will also be increasing complications due to cognitive impairment and other issues related to aging and disease management that psychologists are uniquely qualified to address in integrated care settings.

Looking toward the future of this fellowship program, expansion of training and provision of MH and SUD care to these high-risk populations of veterans are important considerations. Retention of VA-trained psychologists is an important factor to increase the VA's capacity to provide care for veterans with HIV and HCV and to provide high-quality training in these areas. Although the VA has many high priority patient populations and is extensively expanding MH services to address the existing gaps in care and staffing for those patients, specialty integrated care set-

tings like HIV/ID and HCV/liver clinics should be represented. Because there are many competing demands and unmet policy mandates, it may be difficult to implement this type of initiative broadly without additional resource allocation. Evaluation of the impact of the fellowship and systematic health services research can help to support this important initiative.

There is a compelling need to address access to MH and SUD services in HIV- and HCV- infected veterans. This fellowship program demonstrates that it is feasible to train postdoctoral fellows in integrated HIV and HCV clinical settings, and that there are tremendous benefits in terms of increasing access to MH/SUD services, disease management, and overall functioning. Providing specialty postdoctoral training is only one of many vital steps in addressing these issues on a system level. Training in these specialty areas should also be considered at the graduate and intern level wherever possible.

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