DEPARTMENT OF LABOR AND INDUSTRY

Meeting minutes: MSRB PTSD Workgroup

Date: Sept. 26, 2018
Minutes prepared by: Anita Hess
Location: DLI Minnesota Room

Attendance

Workgroup members	Interested parties
Beth Baker	Kim Olson – MSRB RN alternate, Corvel Corporation
Dan Wolfe	
Elisha Harris	**DLI staff members**
Buck McAlpin (phone)	Ernest Lampe
	Chris Leifeld
Guests	Ethan Landy
Mimi Lynn – MCIT	Laura Zajac
Karen Ebert – MCIT	Anita Hess
Gary Thaden – MMCA and NECA	Pam Carlson
Dennis Conroy – psychologist	Ann Tart
Matthew Kaler (phone) – psychologist, Minneapolis Veterans Affairs Health Care System	Lisa Wichterman

Call to order

Chairwoman Dr. Beth Baker welcomed all to the fourth PTSD Workgroup meeting. Introductions were made around the room.

Comments offered about post-traumatic stress disorder (PTSD)

a) Matthew Kaler, Ph.D., L.P.; Minneapolis Veterans Affairs Health Care System (VAHCS)

Baker introduced Dr. Matthew Kaler, program manager and staff psychologist at the Minneapolis VA. Kaler said he was, overall, quite impressed by the rules draft and only had very specific comments to offer. Kaler clarified he is not speaking for the VA per se, but instead is offering his personal professional opinion.

Kaler stated the rules as drafted tap into evidence-based methods for undertaking initial evaluation and treatment. He suggested in subpart 3, section A, it might be useful to require the use of a structured clinical interview like the CAPS or PSSI. That is the ideal method for diagnosis rather than a self-report measure. He thinks there is a degree of caution that needs to be exercised in initial diagnosis. Using a checklist like the PCL-5 is good for measuring general distress, but doesn't do a good job of diagnosing PTSD. There is a 70 percent false-positive rate when using self-report measures.

Kaler's second point is to prioritize those psychotherapy treatment modalities that have a higher quality or quantity of evidence. Baker stated the treatments included were rated as strong or recommended by the 2017 American Psychological Association (APA) guideline. Kaler agreed it is a good list, but there are still varying levels of both the amount and quality of research conducted. Kaler said the treatments are all empirically supported, but there is more or stronger evidence for prolonged exposure therapy (PE) and, secondarily, cognitive processing therapy (CPT).

Kaler pointed to the rule language that states if a co-morbidity is identified that prevents the successful treatment of PTSD, the co-morbidity should be addressed or treated before resuming treatment for PTSD. Kaler explained there is some evidence that certain co-morbidities can be addressed concurrently with PTSD. He questioned whether the language should be changed to reflect this. Dan Wolfe asked for examples. Kaler mentioned substance use disorders.

Baker asked Kaler whether the reference in the rules to borderline personality disorder is appropriate and whether additional personality disorders should be added to that provision. Kaler said borderline personality disorder is the disorder that has received the most attention and there is empirical support for including it in the rule.

Baker asked Kaler whether the rule language stating only one psychotherapy modality should be used at a time in treating PTSD is appropriate. Kaler replied yes, only one of these treatment modalities should be used at a time for the treatment of PTSD.

Dr. Ernest Lampe asked Kaler who should establish if the PTSD diagnosis is still present when patients drop out. Kaler replied it could be the therapist if that is easiest, but a follow-up assessment using the CAPS would be the gold standard for determining if the patient no longer meets PTSD criteria.

Kim Olson asked if requiring an evaluation at least every two weeks is too soon or too often. Kaler stated this requirement accords what most of these protocols would recommend. In prolonged exposure therapy, there is supposed to be a symptom measure every two weeks. In CPT, typically they would do this every week. The measurement tools track progress and also identify what patients are responding to so clinicians can modify the protocol to fit the patient as needed.

b) Dennis Conroy, Ph.D., L.P.; consultant

Baker introduced Dr. Dennis Conroy. Conroy agreed with Kaler that the workgroup has done a lot of good work. Conroy stated he was a St. Paul police officer and police psychologist for 30 years. His perspective is from law enforcement, which he described as a healthier-than-normal segment of the population with decided control issues. He explained police officers have adversarial relationships with a very vocal portion of the community, which is isolating to the officers. They have high exposure to traumatic events.

Conroy explained there is anecdotal evidence that one-third of officers suffer from PTSD; research states 15 percent of male officers and 18 percent of female officers suffer from PTSD. Reaching out for treatment can put their careers in jeopardy. Accepting light-duty work can impact their pensions. It is hard to treat police officers without understanding this culture. Also, Conroy noted police officers must be resilient to future traumas that will inevitably occur upon their return to work. Officers can easily have 12 to 15 traumatic experiences in a year. Conroy shared that police officers who are diagnosed with PTSD must complete a fit-for-duty evaluation, which is an assessment by an outside agency.

Conroy discussed that he sometimes uses eye movement desensitization and reprocessing (EMDR) and then cognitive behavioral therapy (CBT) to process what came from the EMDR. He said he wondered if restricting therapy to one treatment modality at a time is too limiting.

Laura Zajac, Department of Labor and Industry (DLI) attorney, said DLI had followed up with Dr. Sutherland about this issue after the most recent workgroup meeting. Zajac said Sutherland was of the opinion his specialties, CPT and PE, should not be done concurrently with any other treatment modality and that none of the other therapies should be done concurrently.

Zajac noted EMDR does have a component of CBT within it. Conroy stated one of the parts of EMDR is the cognitive interweave, which is very close to CBT. Conroy suggested listing EMDR to include the cognitive interweave. Wolfe asked Kaler if that was consistent with his experience. Kaler said there are procedures in many of these therapies that include a cognitive processing component, but that does not mean the therapist is running two treatment modalities concurrently.

Olson discussed her preference that psychotherapy treatment be limited to a single therapist. Conroy agreed.

Workgroup discussion

Baker led the workgroup in reviewing the revised draft treatment parameters page by page for any changes or suggestions.

Olson stated she would like to add a reference to Minnesota Rules, part 5221.6050, subpart 1(C), which requires that the least-intensive appropriate setting be used for treatment and requires that patients' reliance on providers be decreased if possible. Also subpart 4 of that rule part should be included, which relates to chemical dependence.

Baker and Olson suggested edits to the definitions and requirements for health care providers treating PTSD. There should be a definition for "mental health care provider" and also the term "licensed" should be added as needed.

Baker recommended initial evaluations cover a patient's "history of mental health conditions and treatment" rather than the language as drafted.

There was discussion about clarifying where assessment tools should be required.

Olson expressed concern that there isn't enough guidance in the draft rules for patients who are not meeting goals and are not compliant. Lampe argued subpart 6 was very specific about these issues. Baker agreed with Olson and suggested documentation requirements be made clearer, so compliance with the treatment plan is documented, not just attendance. Baker noted homework is an important component of the treatment.

There was discussion about restructuring the rule draft to put all therapy requirements in one place. Zajac stated she would move subpart 9 into subpart 5.

Baker raised concerns about requiring a psychological assessment for patients who do not complete a course of treatment, because the patients may drop out because they are better. Zajac said this issue was addressed by adding the requirement that the therapist confirm DSM-V criteria for PTSD continue to be met before any additional periods of treatment begin. Lampe asked Kaler how patients who fail to continue therapy are handled in the VA system. Kaler said the VA also struggles to address therapy drop-outs. The VA tries to increase commitment to the treatment by involving the veterans' families; Kaler performs outreach to his PTSD patients when needed.

Olson raised the issue of the rule language's interplay with Minnesota Rules, part 5221.4030. The patients need to be able to have a primary care provider for their physical injuries at the same time as they treat for PTSD. The rules should be clear that the current law regarding a patient's change of primary care provider is not affected by a change of their PTSD therapist.

Baker raised the issue of whether the PCL-5 should be included because it is a pretty subjective measure. Zajac said the tools that were included were those both recommended by Sutherland and APA. Olson cautioned against being too limiting in terms of what measures should be allowed. The

workgroup discussed leaving the list of examples as is. Kaler stated the tools listed are all publicly available and free.

Adjournment

The next Medical Services Review Board (MSRB) meeting is Oct. 4, with a special meeting of the MSRB scheduled Nov. 8. DLI Deputy Commissioner Chris Leifeld said the public will be welcome to speak about the draft PTSD rules at these meetings. Baker thanked everyone.