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Welcome Letter

Tracy Gaudet, MD, Executive Director,
Office of Patient Centered Care and Cultural Transformation
Veterans Health Administration

Thank you for your commitment to Whole Health! VA’s transformation to a Whole Health System will require champions across VHA —especially from those of you who are directly involved in caring for and supporting our Veterans. We are glad you are a part of this movement, because it will take a movement to change our system. No large system changes happen from the top down. It must come from people like you - people who feel this in their depths, people who believe there can be a better way.

All of us are aware that health care in the US is expensive and underperforming. Despite our large expenditures, our citizens suffer from more chronic conditions and poorer health than most. Health care consumes 18% of our GDP, and costs continue to rise. An enormous portion of our health care expenditures, about 75%, go toward treating chronic conditions, conditions which are largely affected by people’s choices and behaviors. The current healthcare model doesn’t work because we do not have a core competency in engaging the person to optimize their health, self-care, and well-being. The VA is uniquely positioned to change this by promoting a Whole Health approach to health and well-being.

The redesign that supports Whole Health is a partnership across time, consisting of three elements, each with a corresponding program component. The first of these is the self-empowerment element, which we are addressing through the Pathway, a process that helps each person reflect on their life and their health, by exploring their mission, aspiration, and purpose. The second element is self-care. Through Well-being Programs, people will learn new self-care strategies, and find ongoing support — sometimes informally from others in the centers they visit, sometimes in groups from trained peers, and sometimes from health coaches. The third element of this redesign is whole health clinical care. In the Whole Health approach, primary care and specialty clinicians are aligned with Complementary and Integrative Health, as they work in partnership with the Well-being Programs to bring the best of Whole Health Clinical Care to their patients.

With self-empowerment realized through the Pathway, and greater levels of self-care achieved through a new set of Well-being programs, our Clinical Care programs will be better positioned to treat the whole person. Our Veterans will be able to experience seamless medical care as they benefit from significant improvements to their health and well-being.

Over the coming year, each of our Veterans Integrated Service Networks (VISNs) will start the process of implementing, expanding and enhancing their Whole Health programs. In conjunction with the Comprehensive Addiction and Recovery Act (CARA) legislation, the VA will be standing up 18 Whole Health Flagship Facilities in FY18. In developing this Whole Health System Implementation Guide, our intent is to provide useful information and tools that help each VISN succeed in this important work. This comprehensive Whole Health System Implementation Guide, along with education and training, resources, tools and onsite support is part of a coordinated
effort to ensure success in the 18 Flagship Facilities as well as with the next waves of implementation in the coming years.

This transformation we are involved in will bring opportunities, and challenges, to your approaches and to the people involved. Each VISN will face some common obstacles and challenges. Each of you will also face some of your own unique challenges and needs. We hope this Implementation Guide is useful to your efforts, and that each VISN can apply elements of this Guide toward achieving a successful Whole Health System implementation.

Thank you for joining me in this important undertaking. I look forward to partnering with you on this exciting journey!

Tracy Gaudet, MD
Section 1: Introduction

What is Whole Health?

Whole Health (WH) is an approach to health care that empowers and equips each individual to take charge of their health and well-being, and to live their life to the fullest. VA facilities have been exploring what it takes to shift from a system designed around points of medical care — primarily focused on disease management — to one that is based in a partnership across time — focused on whole health.1

We have learned that clinical interactions are only one part of this equation. We need a health system focused not only on treatment but also on self-empowerment, self-healing, and self-care. Thus, the Whole Health System includes three components, each of which has a corresponding program component described later in this section.

- **Empower: The Pathway** - In a partnership with peers, Veterans and their family, explore their mission, aspiration, and purpose, and begin their overarching personal health plan.

- **Equip: Well-being Programs** – With a focus on self-care, skill building and support, these programs are not diagnosis or disease based but support the personal health plan of each individual. Services include proactive, complementary and integrative health (CIH) approaches such as stress reduction, yoga, tai chi, mindfulness, nutrition, acupuncture, health coaching. Well-being programs build on the existing health education and health promotion programs developed by the National Center for Health Promotion and Disease Prevention (NCP), Recreation Therapy, Voluntary Services, and other programs.

- **Treat: Whole Health Clinical Care** - In the VA, community, or both, clinicians are trained in Whole Health and incorporate CIH approaches as well as self-management support and shared decision-making, based on that Veteran’s personal health plan, grounded in the healing relationship.

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1 Various terms are in use for describing the concept of whole health. Terms such as ‘Integrative Health’, ‘Complementary Health’, ‘Alternative Medicine’ and ‘Integrative Medicine’ are used in literature, health and medical settings. While the terms ‘Integrative Health’ and ‘Whole Health’ are largely synonymous, ‘Whole Health’ is the term endorsed by VHA leadership and used widely within VHA to describe this larger transformation of healthcare delivery.
In its full form, Whole Health is a reorientation of the Veteran’s relationship with VA. It combines state-of-the-art conventional healthcare with personalized health planning, complementary and integrative health approaches, and innovative self-care. This approach not only partners with Veterans to improve their whole health, but is also critically important for Veterans with complex conditions, such as chronic pain and the invisible wounds of war. Additionally, the whole health approach can improve access and reduce the burden on primary care.
Components of the VA’s Whole Health System

The Whole Health System represents a comprehensive and systematic approach to provide whole health care at any stage of the relationship between VA and the Veteran. It emphasizes self-care in the larger context of well-being, incorporating a full range of conventional and complementary and integrative health approaches.

The Whole Health System also represents the VA’s vision for fully integrating CIH into its VISNs. Fully realized, the Whole Health System will move VA from a focus on episodic care to a more continuous engagement with the Veteran throughout his/her life.

The VA Whole Health System is based on three central components: The Pathway; Well-being Programs; and Whole Health Clinical Care. The Personal Health Plan—a living document which grounds the approach to care in what matters most to the Veteran—forms the basis of decision-making and treatment planning as the Veteran moves through the various parts of the system.

- **The Pathway:** For many Veterans, their initial introduction to the Whole Health experience will begin here. Through the Pathway, VA will partner with Veterans either during their initial enrollment or at any point during their care at the VA. This partnership will continue throughout their relationship with VA. It will support Veterans in discovering their sense of mission, aspiration, and purpose, as each creates a personal health plan that integrates care both in the VA and the community. The Pathway may include:
  - Whole Health Orientation – Veterans will be invited to participate in an orientation program as part of their entry into VA health care. This orientation will share important information about Whole Health program and offerings, including Pathway options.
  - Core Program – Here, the emphasis will be on exploring what matters most to the Veteran, identifying avenues for self-care using tools such as the Components of Proactive Health and Well-Being, and beginning a personal health plan. This may include participating in Whole Health Group-Taking Charge of My Life and Health programs (virtual or in person), or working through online options.
  - Ongoing Support – Options that will be offered may include peer support & Whole Health Partners (individual or groups), and/or Health Coaches (individual or group).

- **Well-being Programs:** The core offerings of CIH approaches will be available through the Well-being Programs. In some sites, the Well-being Programs will be housed entirely within the facility; in others, the programs will combine some services offered within the VA facility, with others offered in the surrounding community.
Consistent with the WH vision, these programs will not be disease-focused. Rather, the focus will be on complementary and integrative health approaches to optimize health and well-being.

Well-being programs build on the existing health education and health promotion programs developed by the NCP, including the MOVE! Weight Management Program and the Veterans Health Library.

Programs and offerings will be coordinated by a WH clinical lead, supported by teams which may include: an integrative nutritionist, movement therapists and teachers (yoga, tai chi, qi gong), licensed acupuncturists, mind-body therapists (stress reduction, guided imagery, clinical hypnosis, etc.), chiropractors, health coaches, and more.

While most services will be aimed at developing self-care skills and providing ongoing classes and support, Veterans will also have the option to be seen individually in support of their personal health plan.

All Well-being Programs will have strong relationships to the clinical care team and the WH Clinical Care Component. Communication mechanisms and referral capabilities should be established between all WH Program Components to ensure open and full exchange of information.

**Whole Health Clinical Care:** Clinicians trained in the Whole Health approach will provide clinical care in multiple service lines oriented around shared goals and what matters most to the Veteran

As the VA’s Whole Health vision becomes fully realized, clinics offering conventional care in both outpatient and inpatient settings will begin to integrate healing environments and healing relationships and holistic approaches into their treatment plans.

Self-management support and shared decision-making are emphasized as key elements of the Whole Health Clinical Care model.

While the VA’s vision for the future state of health care is for the WH Clinical Care components to work seamlessly with the Well-being Programs (whether offered through the VA or throughout the community), realizing a fully integrated WH model will develop over time.

**Healing Environments** and **Healing Relationships** are foundational elements of the Whole Health System and key to fostering healing and promoting overall well-being for patients, caregivers, and staff.
- **Healing Environments:** A place or setting that supports and empowers patients and families through stress imposed by illness, hospitalization, clinical visits, recovery, and sometimes bereavement that fosters health, healing, and well-being. It’s inclusive of architecture, interior design, and ambience designed to support well-being by reducing stressors and impediments to healing resulting in improved health outcomes, as well as increased patient and staff satisfaction.

- **Healing Relationships:** Healing relationships between Veterans, staff, and caregivers are essential for delivery of Whole Health care. The Veteran Health Administration’s core ideals of I-CARE (Integrity, Compassion, Advocacy, Respect, & Excellence) are the building blocks that help to build and maintain these healing relationships. It is an integral part of our culture and should be ongoing and continuous in all our interactions.
  - Systems should be in place that support needs specific to the individual Veteran, taking into consideration things such as ethnic and cultural backgrounds, socioeconomic status, and educational experience/needs.
  - All relationships (staff to Veteran, staff to staff, staff to caregiver, etc.) must be built on interactions and communication that is approached with an open and non-judgmental mind. Being mindful of every interaction and directing full attention to being present while listening and understanding each Veteran’s story is crucial to developing these types of relationships.

Additional information on Healing Environments and Healing Relationships can be found on the OPCC&CT intranet site: [https://vaww.va.gov/PATIENTCENTEREDCARE/The_Experience.asp](https://vaww.va.gov/PATIENTCENTEREDCARE/The_Experience.asp).

Cultural transformation in the VA requires a fundamental change in every employee, not only in how they interact with Veterans and perform their duties, but also in their personal experiences and how they live their own lives. To that end, OPCC&CT and Occupational Health Services established a collaboration to begin to develop this crucial part of the Whole Health approach and deploy **Employee Whole Health** as an integral component of the Whole Health System. A new Employee Whole Health section of this guide is under construction and will be published in subsequent versions.

**VETERAN EXPERIENCE WITH WHOLE HEALTH: RELATIONSHIPS OF THE COMPONENTS OF WHOLE HEALTH**

Although the Whole Health System involves three elements—the self-empowerment element (through the Pathway component), the self-care element (through the Well-being component), and the clinical element (through the WH Clinical Care component) — the entry point through
which a Veteran becomes involved with Whole Health is not fixed. New Veterans may first engage in Whole Health through Pathway services and offerings, through Well-being programs, or through the WH Clinical Care component. Existing Veterans may already be engaged in WH Clinical Care and choose to participate in Pathway or Well-being options. More important than any order or sequence of services, is the need to provide care consistent with Veteran preference and for full alignment across all elements and components in which a Veteran chooses to participate.

Ultimately, what ties these pieces together is the Veteran’s personal health plan (PHP). It is this PHP that should bring together, and effectively integrate, all the parts. In the personal health planning process, a Veteran engages in self-exploration utilizing the Personal Health Inventory (PHI) and Components of Proactive Health and Well-being to identify their mission/aspirations/purpose (MAP), set SMART and shared goals based on their MAP, and connects these to education/skill building/support in support of those goals. Aspects of this process happen across each Whole Health System component and informs the development of a Veteran’s PHP.

Because the manner and entry point by which Veterans become engaged in Whole Health will vary, any of the three Whole Health components/elements may refer a Veteran to one of the other components and care will flow seamlessly amongst them.

Figure 2. Components of Proactive Health & Well-being
TIMING FOR IMPLEMENTING WHOLE HEALTH

Consistent with our mission and strategic priorities\(^2\), and in conjunction with the Comprehensive Addiction and Recovery Act (CARA) legislation\(^3\) and the new CIH Directive\(^4\), the VA is now ready to launch the full Whole Health System in 18 Flagship Facilities in FY18. VHA staff has been working with Veterans around the country to bring this approach to life. In addition to multiple Whole Health design sites, many facilities across VHA are already involved in implementing, expanding and enhancing their approach to Whole Health and will implement the full WH System in subsequent years.

Purpose and Audience for this Guide

This initial version of the Whole Health System Implementation Guide has been developed to provide VISNs and facilities with information and tools to support effective implementation of their Whole Health programs and offerings. In combination with WH education and training, resources, tools and onsite support, this Guide is intended to help each of the VISNs successfully implement their part of the VA’s “18 in 18” plan and beyond.

This Guide was developed by the Office of Patient-Centered Care and Cultural Transformation (OPCC&CT) with input from the field, from Veterans, and from other VHA program offices including Primary Care, Office of Nursing Services, and the National Center for Health Promotion and Disease Prevention. It includes strategies for addressing common challenges that many sites will face, and incorporates best practices gathered from similar WH implementation efforts in VHA and the private sector.

The Guide also includes factors VISNs and facilities should be aware of to help ensure each site is positioned to launch a successful Whole Health transformation. Comments and suggestions on this Guide are welcome and may be sent to: [VHAOPCCCT@va.gov](mailto:VHAOPCCCT@va.gov)

Additional information and resources can be found on the internal OPCC&CT Whole Health System site: [https://vaww.va.gov/PATIENTCENTEREDCARE/Whole_Health_Partnership.asp](https://vaww.va.gov/PATIENTCENTEREDCARE/Whole_Health_Partnership.asp)

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\(^2\) VHA’s mission is to ‘Honor America’s Veterans by providing exceptional health care that improves their health and well-being’. Its first strategic priority is to provide Veterans personalized, proactive, patient-driven health care. Several guiding documents, including the Blueprint for Excellence and the MyVA plan, have embraced Whole Health as a central component to the transformation of VA health care.


Section 2: Preparing

Preparing to Implement Whole Health at your VISN or Facility

For most facilities, particularly non-Flagship sites, implementing Whole Health will occur in phases. During the initial start-up period, a limited set of service offerings and program elements, perhaps offered only on specific days or for certain hours, may be offered. As the Whole Health System expands, additional services will be introduced, resulting in a more robust and integrated service environment. Building on existing VHA programs that are well-aligned with the Whole Health model will be critical to success. Programs such as Home-Based Primary Care and Shared Medical Appointments in Primary Care; the Recovery Model and Peer Support programming in Mental Health; the Advanced Care Planning/Shared Decision-Making program in Geriatrics; Case Management in Social Work and Nursing Programs; and the HealtheLiving Assessment and Gateway to Healthy Living programs provided by NCP all provide opportunities to align with and build on existing initiatives.

Just as the actual services a Veteran receives will deepen and expand over time, so too must the capabilities needed for the Whole Health System to be fully realized. Each of these enabling capabilities must be planned for, and grown, to match the needs of the Whole Health System as it expands. A description of the phases of Whole Health expansion, and resources needed for each phase can be found in the WHS Implementation Toolkit.

The enabling capabilities summarized below are not specific to any one Whole Health System component. They will apply to any site engaged in implementing Whole Health services. The manner and order in which a VISN or facility implements the three components of the Whole Health System may vary. But regardless of the implementation approach taken, these capabilities must be in place. Each will play an important role in ensuring a smooth transition, and in determining the overall success and adoption of Whole Health at your site.

Leadership and Steering Committees

Leadership support and advocacy is crucial to the success of your Whole Health program. Engaged and committed leadership is needed to advance the concepts and vision of the Whole Health System. It is also needed to negotiate support and forge agreements across different stakeholder groups. An effective leader in this regard is not simply a senior person assigned to oversee Whole Health implementation. It must be a recognized leader in the facility, one who is committed, passionate and vocal on the benefits and realization of Whole Health.

A Steering Committee is also a critical component of Whole Health implementation. This can be a new committee, or sites may choose to incorporate WH System implementation into an existing committee structure. Each site rolling out Whole Health will be assigned an OPCC&CT Field Implementation Team (FIT) Consultant. Working closely with your site’s Whole Health Clinical Director or Program Manager, your FIT Consultant will assist your site in bringing together this
Steering Committee either de novo or by adding appropriate members to an existing committee. A sample Steering Committee Charter can be found in the WHS Implementation Toolkit.

It may be helpful to have a workgroup or subcommittee of the Steering Committee dedicated to support visioning for the Well-being Programs. Additionally, since many well-being/CIH clinicians will need to be validated (See 'Credentialing' section below), this subcommittee could also be responsible for validation of these clinicians. You may also want to consider a second subgroup overseeing WH Clinical Care, as described below in Section 5.

**Communications, Outreach and Advertising**

For many Veterans and their families, the concepts of Whole Health will be different and new. This will also be the case for many patient-care clinicians and staff. As with anything new, some will readily embrace the ideas, while others will resist. Regularly communicating and reaching out to the various stakeholders and audiences affected by the move toward Whole Health is an essential ingredient for building awareness, support and trust. Effective strategies and programs for communication and outreach will be needed at many levels.

Communicating effectively the vision of the VA’s commitment to Whole Health, as well as the particulars that apply to your specific site, will involve many different strategies. These should come together to communicate a consistent message, and support a common set of goals. This will involve a range of communication vehicles and forms — from formal welcome letters and introductory kick-off sessions, to monthly newsletters, awareness campaigns, social media, web blogs and more. Your FIT Consultant can share information, tools, and materials for organization-wide awareness campaign as well as strategies employed by VHA facilities that have engaged in cultural transformation activities related to WH over the past five years. Communication mechanisms have included blogs, fairs, email blasts, town hall meetings, staff meetings, use of VA PULSE, New Veteran Orientation, New Employee Orientation, and participation in community activities.

OPCC&CT will be working with you over the coming months to define and develop strategies and communication pieces that can be adopted or tailored to meet your specific needs. Additional information on communications, outreach and advertising is provided in the WHS Implementation Toolkit.

**Whole Health Clinical Director and Clinical Champions**

Identifying and bringing your Whole Health Director and Clinical Champions on board early in the process is strongly encouraged. These individuals can play multiple critical roles in shaping the Whole Health program at your site, championing the vision and the benefits of Whole Health, and influencing and educating stakeholders, partners and staff.

The Whole Health (WH) Clinical Director is someone who will be knowledgeable in Integrative Medicine/Whole Health, as well as Clinical Care, and will be charged with integrating the Whole
Health approach into the established practices and processes of the site or facility. This could be a physician, nurse, psychologist or other clinical leader. The WH Clinical Director works collaboratively with all health care system and community resources to create a robust menu of services that are highly integrated.

Table 1 summarizes the key roles of the WH Clinical Director.

**Table 1. Whole Health Clinical Director Role**

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<td>Recommendations for the WH Clinical Director role include the following:</td>
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<td>▪ Clinician with experience in Integrative Medicine/Whole Health approaches (i.e. meditation, yoga, guided imagery, acupuncture, etc).</td>
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<td>▪ Models the provision of WH clinical care in their practice.</td>
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<tr>
<td>▪ Provides innovative support across all areas of clinical care.</td>
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<tr>
<td>▪ Builds and maintains programming for the implementation of Whole Health care across all areas of clinical care (MH, PACT, Surgery, Specialty care, etc.)</td>
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<td>▪ Trains other health professionals and providers in Whole Health principles and practices.</td>
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<tr>
<td>▪ Works with steering committee to build and further disseminate current Whole Health practices and communication of all aspects of the WH System</td>
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<tr>
<td>▪ Engages the staff within the medical center at an emotional level to motivate and gain investment in the Whole Health approach</td>
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Local Clinical Champions within specific programs or service lines should also be identified early in the process. These Clinical Champions can be instrumental in guiding and leading change, motivating colleagues, and coordinating individuals and groups. A WH Clinical Champion should be an expert in Whole Health within the organization (or on their way to becoming one) and should have a high level of motivation to implement, spread, and encourage others to adopt the practice of Whole Health within the medical center. It is strongly recommended that WH Clinical Champions have attended the Whole Health in Your Practice course and implemented the change in approach to their own clinical practice. Because the champions will be working with and educating other healthcare team members, it is highly encouraged that these champions have protected administrative time to support their Whole Health work.

**Volunteers**

Volunteers can play a very important role in transitioning a site to the Whole Health System, and in operating parts of the Whole Health System as well. For example, volunteers may help lead a Pathway course, or may provide yoga instruction in the Well-being Program. Volunteers may be
from the local community (including the business community), may be friends and family members of the Veteran, or may be other Veterans who have participated in Whole Health and other patient-centered programs, such as MOVE! or interdisciplinary pain programs. Effectively planning for and managing volunteers will be a necessary and ongoing part of any site’s success with Whole Health. Many sites already have volunteers who may be providing some of these services. To find your local VA Voluntary Services coordinator, visit the Local Voluntary Service Offices Directory: https://www.volunteer.va.gov/directory/index.asp

Space Planning, Equipment and IT

Space must be available for the range of activities involved in delivering Whole Health. Shared group activities, waiting areas, clinic rooms and work stations will be needed. During the initial periods of operation, shared space may be an option if dedicated space cannot be arranged. As your Whole Health service offerings expand, dedicated space may be needed. Seeking community partnerships is an excellent option to expand available space. All WH activities do not necessarily have to be provided within the VA facility.

This is also true for equipment and IT capabilities and support. Telehealth technology should be evaluated as a means for broadening reach. Overall, sites should start considering their needs for space, for A/V equipment, and for other types of technology and IT support early in the implementation process. See the Resource Matrix on the WHS Implementation Toolkit webpage.

Embedding Whole Health into Hiring Process and Competencies

Embedding Whole Health into both hiring processes and employee competencies helps to ensure that the right people are hired to support transformation and that all employees understand the expectations that Whole Health be the approach through which they interact with Veterans. Doing so will take collaboration between our labor partners, Human Resources and leadership teams. This is an ambitious goal but an important step in creating a long lasting Whole Health organizational culture.

Select a Start Date for the Whole Health Program

When to initiate Whole Health services is a question that is heavily influenced by stakeholder engagement and available current resources at each site. Developing an educational plan and a set of core competencies is a foundational step. Some facilities may find it advantageous to have a fully developed organizational chart and wide-scale education completed before the first Veteran is scheduled. Other sites may choose to focus on initiating services with specific providers or pilot teams, with an interest in Whole Health, to gain experience with specific modalities while working to put in place the organizational structure needed to support long term growth of the full Whole Health System. However, it is important to remember to engage and obtain the support of facility leadership before initiating services or pilot work. Refer to the Timeline in the WHS Implementation Toolkit; it may be helpful in choosing your start date(s) for different processes.
Veteran engagement can be enhanced by attending a Whole Health Orientation. All Veterans, whether newly enrolled or existing, will be offered and encouraged to attend a Whole Health orientation session. These sessions are conducted by a Whole Health Partner. The Whole Health Partner is a new, non-clinical position designed to engage Veterans early in their relationship with the VHA. Veterans’ family members are welcome to participate in the orientation sessions.

Facilities will be responsible for developing and delivering the Whole Health Orientation Sessions. As you plan for your initial sessions, OPCC&CT is available to assist you with materials and guidance to help ensure your sessions are successful. Table 2 summarizes recommended topics that should be addressed in each of your sessions. The staff responsible for developing and planning the Whole Health Orientation Session at each facility should also work collaboratively with the facility's Veterans Health Education Coordinator, who is responsible for developing and supporting the facility's new patient orientation. Look for local opportunities to align or integrate the Whole Health Orientation session with existing or required new patient orientation sessions and materials.

### Table 2. Recommended Topics for WH Orientation Session

<table>
<thead>
<tr>
<th>WH Orientation: Topics Addressed</th>
<th>New Veteran*</th>
<th>Existing Veteran*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Facility Orientation</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Benefits (e.g. eligibility, travel, etc.)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Access (e.g., appointments, call centers, My Healthe-vet, after hours)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Whole Health overview: new approach to care to empower and equip Veterans to take charge of their health and well-being. Options available:</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>▪ Pathway: WH Partner reviews all program options</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Well-being Programs: WH Coach reviews</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ WH Clinical Care: WH Clinician reviews</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Description of in-house and community resources</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>PHI/PHP pocket card</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>WH Partner biographies and contact information</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

**Facility-dependent options:**

Here are some things to consider as you prepare to offer your WH Orientation sessions:
**Frequency:** Initially, plan on offering weekly or bi-weekly WH Orientation Sessions for new Veterans. For existing Veterans, consider weekly, bi-weekly or monthly WH Orientation Sessions depending on demand and capacity to accommodate consults. Consider aligning or integrating these sessions with local existing or required new patient orientations.

**Whole Health Partner Attendance:** WH Partners will conduct WH orientation sessions for Veterans. Ideally a clinician and a coach should also participate in the orientation sessions to provide information or perspective on the WH System. WH Partners, participating clinicians and/or coaches should provide brief insight into how whole health is different and what to expect. Consider developing talking points or a script for clinician delivery/training.

**Virtual Attendance:** Make preparations to allow attendance via telehealth, including scheduling of off-site space and availability of materials and resources for Veterans participating remotely.

**POST ORIENTATION FOLLOW-UP:**

Once a Veteran has attended a WH Orientation session, WH Partners are expected to contact each Veteran to discuss follow-on participation in the Whole Health approach. Based on the degree of interest, Veterans may be categorized into one of the following groups:

- **GO:** Veteran decides to participate in the Pathway through group-based activities offered in the Taking Charge of My Life and Health Programs (see below) by the WH Partner. The Veteran also agrees to engage in Well-being programs and WH Clinical Care options. These Veterans should be immediately offered a referral to a WH Coach.

- **SLOW:** Veteran decides to choose services or resources offered through the Pathway, Well-being Programs and WH Clinical Care, but only as needed. The Veteran prefers to participate in on-line activities associated with the Pathway (e.g., through the Virtual health system, videos, podcasts, etc.). These Veterans will also be offered a referral to a WH Coach.

- **NO - Not interested now:** Veteran decides he/she is not interested now in the Whole Health approach. The WH Partner offers some on-line resources and material and agrees to check back annually. Veteran is encouraged to contact WH Partner sooner if he/she becomes interested.

**Whole Health System Collaborative Series**

The WHS Collaborative Series is a process launched in May 2017 which combines strategic and tactical planning, education, and implementation undertakings for the 18 VISN teams over an initial 18-month period and up to the full three years of the CARA pilot requirement. The WHS Collaborative Series includes a preparatory phase, ongoing virtual meetings and communities of practice, and alternating face-to-face Collaborative Seminars and action phases.
WH and CIH educational offerings, objectives, target audience, and competencies will be introduced during the preparation phase and implemented throughout the WH Collaborative Series. Across the three pilot years, the facilities will complete the WH programs they identify and develop local Facility Education Champions to disseminate education broadly. Additional information about the series is further addressed in the Section 6.
Section 3: Overall Approach to Personal Health Planning

Description

What is Personal Health Planning?

Personal health planning is a process that facilitates the development of a Veteran’s overarching Personal Health Plan (PHP). As part of this process, a Veteran engages in self-exploration to identify their mission/aspiration/purpose (MAP), sets Shared and SMART goals (Specific, Measurable, Action-oriented, Realistic and Time-based) with their team members based on their MAP, develops an action plan, and is connected with education, skill building, resources and support in support of their PHP. Aspects of this process can take place in each Whole Health System (WHS) component.

Principles of Personal Health Planning

Figure 3. Key principles of personal health planning across all components of Whole Health System
Veteran Ownership

- The Veteran can work independently or in partnership with professionals and peers (both within and outside VHA) to engage in personal health planning, and is the ultimate owner of their PHP.
- Education, skill building and offering resources and support to assist with development of the PHP ideally occur in all aspects of the WHS (e.g., including both group and individual activities), as well as within the larger community.

Self-Reflection/Exploration – MAP

- Self-Reflection/Exploration involves the Veteran's consideration of what is important to them and the area(s) in their lives which they prioritize for behavior change.
- This process leads to identification of their Mission/Aspiration/Purpose (MAP), to which all goals in the PHP will
- Starting with identification of MAP, rather simply setting health-related goals, provides a motivating context for difficult life-changing behaviors and maximizes the opportunities for success. In addition, living one’s life according to MAP, or what matters most, can be health/life-enhancing, in and of itself. Identification of strong values (i.e. family, honor, country, career) is important, but exploration of MAP may provide an even deeper foundation for these values.

Whole Health (WH) Assessment

- A WH Assessment includes an examination of an individual's overall whole health.
- The Personal Health Inventory (PHI) can be used to help facilitate this process but other methods (e.g., asking the “big questions”; use of the My Health Choices tool) can suffice as well. Note that the PHI is available in different forms and sites/programs will choose which best suits their needs (My Story PHI, Short Form PHI).
  - The “big questions” are 1) What matters most to you? (Why do you want your health? Why do you need to be healthy?) 2) On a scale of 1-5, where are you in terms of your physical health? On a scale of 1-5, where are you in terms of your emotional health? On a scale of 1-5, how is it to live your day-to-day life? and 3) What is your vision of your best possible health?
- Others may elect use the “Circle of Health” (aka Components of Proactive Health and Well-Being) for this assessment.
- This assessment can take place one on one, or via groups. Whole Health group visits (e.g., Taking Charge of My Life and Health program), Gateway to Healthy Living sessions and Shared Medical appointments are good examples of group settings to help Veterans explore what matters to them and explore the areas of self-care outlined in the “Circle of Health”.

- In the WH Clinical Care setting, the WH Assessment would also include clinically relevant assessments such as a comprehensive History and Physical (H&P) (including social history and discussion of health habits and behaviors), health risks, diagnostics, genomics, and could include self-care around the “Circle of Health.”

- Veterans registered through MyHealthVet can complete a Healthy Living Assessment to review individual risk factors as well.

- Different disciplines may add their own dimensions to the assessment.

**Goal Setting (Shared and SMART)**

- Shared Goals are the goals developed/shared collaboratively by the Veteran and the health team member in service of the Veteran’s MAP.

- Health care team members that participate in the development of Shared Goals are those who bring their expertise and recommendations to the interaction (e.g., clinicians, CIH providers) as opposed to team members whose roles are primarily intended to help facilitate the Veteran’s self-exploration and discovery (e.g., WH Partners).

- Shared Goals facilitate common ground, and align the health team and Veteran so all are “on the same team”.

- Shared Goals may be clinically focused on health outcomes (such as lowering a blood pressure), but could also be focused on a particular aspect of self-care or other activities (such as being able to go hiking with one’s family members again).

- They are used as a foundation and source of motivation for setting and achieving SMART goals.

- Shared Goals do not have to be complex. Simple and basic goals can have meaning and serve an important purpose in the “here and now” of a person’s life and well-being pursuits.

- Shared Goals have typically been used in the context of the WH Clinical Care settings, but may also be appropriate in working with CIH-providers and WH Coaches in whichever setting they are working (i.e., Well-being Program and/or WH Clinical Care).

- Setting Shared Goals is a concept that is similar to the approach taken in Shared Decision Making and in establishing the Goals of Care, wherein the Veteran and the clinician work together to come to a common agreement
about how best to move forward. With Shared Goals, this process is based on the Veteran’s MAP.

- Building from Shared Goals, VHA uses the SMART goals framework to set the stage for successful achievement of goals. Veterans identify concrete, specific things he/she can do to improve their health, focused on behavior, not outcome, starting small and building over time, with a short, defined time frame.
- Note that not all Veterans will know, or wish to identify, their MAP or engage in the personal health planning process as related to Whole Health care. The Veteran’s preferences should be considered, and interactions/services can be tailored accordingly.

**Education, Skill Building, Resources and Support**

- Education alone rarely results in sustained behavior change.
- This approach emphasizes helping the Veteran build new self-care skills and partner with them as they create new behaviors in their life.
- Skill-building through concrete experiential learning and access to resources and tools empowers Veterans with the skills, knowledge and confidence they need to succeed in achieving their SMART goals.
- This can include exploring the Veteran’s strengths and past successes in meeting goals. TEACH and MI skills can be helpful here.
- Support from the healthcare team, groups, caregivers, family members, friends, and the community is critical to success.
- WH Partners, Coaches, CIH and clinical staff need to know the resources available within the team, the facility, the Whole Health System and in the community, that can assist Veterans with their self-care. This may include technology such as apps, and virtual and telehealth options.
- VHA has Healthy Living Programs that include education, resources and services related to health promotion, disease prevention, health behavior change and goal setting. These also include trainings in Motivational Interviewing and TEACH. Associated with Healthy Living Programs are environmental scans that list internal and external resources for Veterans. The local Health Promotion and Disease Prevention Program Manager is often the local subject matter expert in these resources.
- Education and skill-building opportunities should be offered to Veterans in support of their SMART goals and PHP.
- Connecting Veterans with other parts of the Whole Health System can be an important part of the process.
- Veteran engagement in the WH System should be revisited at periodic intervals as agreed upon by the Veteran. For Veterans that are not actively
engaged in a WH System element, an annual WH Partner check-in might be one strategy allowing a WH Partner to maintain a connection with the Veteran.

**Personal Health Plan**

- The PHP is the overarching, documented (e.g., hardcopy or electronic) compilation of the above information (ideally both in CPRS and with the patient via app/wallet card).
- The Plan may be brief, or extensive, depending on the Veteran’s preferences and the degree to which they are involved in the WH System.
- The PHP is a living plan; regular updates will help ensure that it stays current and relevant for all users. It should ideally be updated annually but may require more frequent updates.
- Progress and next steps could be documented within the routine progress notes or clinic/well-being visits.
- The PHP is the guiding document that keeps all members of the Veteran’s team on the same page, and should be referenced in every interaction.

**Tips for Implementing Personal Health Planning**

**Overall Whole Health System Considerations**

The following are considerations for implementing personal health planning across the WH System. For specifics about how the personal health process functions in each of the WH System components, please refer to those sections of the Guide.

- Education about Whole Health and personal health planning should be widely provided to prepare both Veterans and staff for WH transformation and personal health planning. This will help to avoid issues such as having a Veteran present to WH Clinical Care with the start of their PHP and the clinical team being unaware of what it is or the purpose it serves.
- Pursue alignment with key facility and/or health care team performance metrics (e.g., HEDIS, SHEP, SAIL).
- Deliver training that is tailored to the audience (e.g., if presenting to clinical care providers, elicit and acknowledge similarities and alignments with current practice, as well as areas to consider transforming in support of a more effective, efficient system to better support the whole person).
- Communicate alignment with existing programming (e.g., NCP Gateway to Healthy Living, MOVE!™) Veterans Health Education programs, and tools/resources (e.g., Health e Living Assessment (HLA), Veterans Health Library (VHL), SMART Goal forms such as the My Health Choices worksheet), that can also be a part of the WH approach.
• Illustrate how the personal health planning process aligns with processes that may already exist, and to invite staff to identify these when possible.
• Offer staff the opportunity to select whichever tools best suit their practice style, in support of the WH approach.
• Often, it is best to start implementation with a small number of individuals or teams. Then, have those individuals involved in the training of the next cohort.
• Training should ideally include not only didactic education, but emphasize experience including real-time coaching, feedback, role-plays, and other skill building exercises.
• Fidelity checks may be helpful for identifying training and coaching opportunities, as well as assessing implementation.
• Key leaders representing each of the main WH System components should support seamless personal health planning across the components, and assure that communication of the PHP across disciplines is happening as well.
• Critical to successful cultural transformation and implementation is the employee’s own experience of Whole Health. Emphasizing strategies that create these opportunities, through such things as personal experiences integrated in trainings, and broader Whole Health Employee programs are key.

**Documentation and Communication**

The PHP is owned by the Veteran, but those partnering with the Veteran will need to be informed. This will be accomplished via a combination of methods. At this time, there is no one way to document the PHP and sites may explore various options to develop a documentation and communication plan that is as seamless, simple, and effective as possible. Options to consider:

• The Veteran may complete a hard copy of the basic template.
• WH Partner, WH Coach, CIH-provider or WH Clinical Care team should enter relevant part of the PHP into CPRS. The method and format by which this is done should be decided with input from representatives of each component of the WHS to ensure it is a well-coordinated documentation plan.
• Use a shared template format for the PHI so that anyone can pull it into their existing note, and it can still be searched for those health factors.
• Consider using radio buttons for each aspect of the PHP, including COHWB. Once selected, this will open text boxes that can be used to document Shared and SMART goals.
• If possible, the PHP may be best be housed under the “Postings” tab. This allows it to be easily searchable and updated.
• If care is being received in the community, Veteran will share the PHP with their health team members as appropriate.
• Within WH Clinical Care, teams will determine most appropriate process for documentation depending on clinical flow/roles/duties. Ideally, the basics of the PHP will
be documented in a note that can be queried or easily located so that providers across clinics can access the information (as opposed to embedded in clinical notes for example).

- Develop patient data objects for the “big questions”, the MAP, Components of Proactive Health and Well-Being, and Shared Goals, in addition to a PHP template. A large PHP template is a separate stand-alone document which can be referenced when needed, but for clinical teams within a session, writing notes, the ability to drop in these data objects (which would always be current) would allow flexibility and ease of use. These data objects could be easily incorporated into provider and clinical care templates.

- A copy of the PHP with MAP, Shared and SMART goals, and self-care actions should be provided to the Veteran.
**Personal Health Plan (PHP)**

**Name:**

**Date:**

**Mission, Aspiration, Purpose (MAP):**

*My mission, aspiration or purpose in life is...*

**My Goals:**

**Strengths (what’s going right already)/Challenges:**

**My Plan for Skill Building and Support**

**Mindful Awareness:**

**Areas of Self-Care:**

- Working Your Body
- Surroundings
- Personal Development
- Food and Drink
- Recharge
- Family, Friends, and Co-Workers
- Spirit and Soul
- Power of the Mind

**Professional Care: Conventional and Complementary**

- Health concerns
• Prevention/Screening

• Treatment (e.g., conventional and complementary approaches, medications, and supplements)

• Referrals

Community

• Resources

• Support Team

Next Steps

Please Note: This plan is for my personal use and does not comprise my complete medical or pharmacological data, nor does it replace my medical record.
The Pathway
Section 4: The Pathway

Description

The Pathway component of the Whole Health System includes processes that allow Veterans and family members to connect with staff, and resources that support the Veteran’s sustained health and well-being. A Whole Health Welcome and Orientation session and the Pathway’s “Taking Charge of My Life and Health Programs” are the foundation of this connection.

Key staff associated with the Pathway component are referred to as Whole Health (WH) Partners. The WH Partner is a new non-clinical position designed to engage Veterans early in their relationship with VHA and beyond.

Whole Health System

The Pathway Taking Charge of My Life and Health, or TCMLH, is a term for a range of VHA program options that are available to Veterans and their family members. As with the rest of the Whole Health System, the Pathway builds on existing VA programs that focus on the Veteran’s plans for
well-being, including NCP’s Gateway to Healthy Living Program, the Stanford Chronic Disease Self-
Management Program offered at many VHAs, the Wellness Recovery Action Plan (WRAP) groups
offered in many Mental Health Psychosocial Rehabilitation and Recovery Centers and the Goals of
Care Conversations for Veterans with serious life-threatening conditions developed by the VHA
National Center for Ethics in Health Care. The T CMLH program is aimed at empowering and
helping Veterans explore their mission, aspiration and purpose (MAP) for health and well-being. In
the Pathway, Veterans and family members receive education on Whole Health and the personal
health planning concepts. Through group, individual sessions or on-line resources, Veterans and
family members with their WH Partner: engage in an exploration of their MAP and personal health
planning; explore the “Circle of Health” and take actions or place referrals that address needs
drawn from that exploration; identify actions to pursue their MAP and act on referrals or additional
resources needed to support Shared and SMART goals (e.g., referral to clinical care, CIH, health
care coach etc.); develop a basic PHP to summarize the process of MAP exploration and development of
goals and action steps.

TCMLH programs are facilitated by WH Partners. The core element of the TCMLH includes
individual and group forums for Veterans and family members to do self-exploration of their MAP,
set goals and actions, and engage in the personalized health planning process. Tools associated
with this core element include the Personal Health Inventory (PHI) pocket card and the Personal
Health Plan (PHP). Options include: (1) Individual sessions with a WH Partner to complete core
elements, (2) group options conducted by a WH Partner to complete core elements and further
explore self-care areas of interest to the Veteran, or 3) referral to a WH Coach.

Step 1: Identify the Whole Health Partners

The number of WH Partners will vary at each site depending on the size of the facility, but should
include a lead WH Partner. The Whole Health Partners will be full-time equivalents (FTEs),
preferably non-clinical and Veterans with peer experience. Volunteers can be used to expand the
availability of the Pathway offerings. Depending on the recruitment process selected, consider the
following:
Full Time Employees (FTEs):

- Hire a full time Whole Health Partner Lead to supervise and manage the Pathway programs.
- Hire full time Whole Health Partners, preferably non-clinicians, Ideal candidates will be Veterans with peer experience to conduct group programs, work individually with Veterans and their families to begin the process of personalized health planning and connect the Veteran with internal and external well-being resources.
- Plan for, and ensure local approvals. Work closely with HR to
  - determine background and skills required,
  - develop the Position Description based on the nationally standardized PDs for the WH Partner and lead WH Partner which are available on the OPCC&CT SharePoint,
  - draft the vacancy announcement.
- For spread and growth, utilize existing FTE staff. Determine if you can partner with a department for them to “loan” a non-clinical FTE to facilitate a TCMLH group.

Volunteers:

- Partner with a local VSO or Veteran group
- Meet with the local Voluntary Services representative to determine if they can help with recruitment of facilitators or be a facilitator.
- Look for volunteers who can speak in a group but are not focused exclusively on their own experiences. Remember, the intent here is not to simply educate or instruct. Instead, it is to facilitate a group discussion. Facilitators watch the time and guide the group. Make sure volunteers selected have enough flexibility and availability to provide a return on the training investment (Two facilitated courses per year are suggested.)
- Volunteers may not have access to CPRS so consider the clinical supervision of this person and how encounters will be documented or communicated.

Step 2: Whole Health Partner Training

Once identified, the WH Partner will complete two courses offered through the Office of Patient Centered Care & Cultural Transformation: (1) WH Taking Charge of My Life and Health Facilitator course, a three-day face-to-face training that focuses on facilitation skills, mindful awareness, and exploration of mission, aspirations, and purpose using the PHI and PHP, and (2) WH Partner Skills Training which focuses on developing a core skill set to implement the concepts and components of the Whole Health Pathway. WH Partners gain knowledge specific to the services available within the Whole Health System, offerings within the Pathway, and resources available in Well-being Programs and Whole Health Clinical Care. WH Partners will be well-versed in engaging Veterans in groups, one-on-one, and telephonically to introduce them to Whole Health, the Whole Health System, the Pathway program options including the Four-Stage Whole Health Process for navigating change and the Personal Health Inventory/Personal Health Planning tools.
Determine what level of clinical consultation your Whole Health Partners will need. At a minimum, the WH Partner Lead should consult regularly with the WH System Clinical Director or Program Manager to discuss programming and other issues. In addition, consider the following as appropriate:

- Availability of an on-call credentialed clinician in the event of an emergency, to assess risk, and to determine if a higher level of care is needed.
- Scheduled consultation time/forums for lead WH Partner or WH Partners with a clinician (e.g., Whole Health Partners meet with licensed, credentialed provider weekly to discuss the TCMLH groups.).

Take into consideration transportation to the training site:

- FTEs and volunteers all require different levels of approval to travel to off-site trainings.
- Work with your local travel office to determine the requirements and process as that will vary by location. View the [WHS Implementation Toolkit](#) for more information and resources.

**Step 3: Plan the TCMLH groups**

Determine how many groups and what type of groups will be offered:

- Start slowly and gradually increase
- Consider beginning with one Taking Charge of My Life and Health group a month
- Consider offering TCMLH groups at CBOCs, YMCAs, Vet Centers, Community Colleges, or through Telehealth venues
- Consider setting a goal of offering four groups/month

Identify what items will be needed for the groups:
- **Supplies needed**: Consult the TCMLH curriculum from the Office of Patient Centered Care & Cultural Transformation for supplies needed.

- **Pocket card**: Consider providing pocket card for Veterans to identify goals that they can take with them to appointments with their providers. (For a pocket card example, see Sec. 7 in the WHS Implementation Toolkit).

- **Space**: Determine the location for the TCMLH groups. This should be a healing environment conducive to group appointments and conversation.

- Determine what will be needed for the administrative set-up and what documentation will be necessary. Work with your Health Administration Service (HAS) and DSS and CAC personnel to set up the appropriate clinic stops and note templates to document Veteran participation in groups or individual sessions. Note template examples can be found in Section 8 in the WHS Implementation Toolkit. Whole Health Partners will be non-licensed, non-credentialed providers, but will need access to CPRS template notes.

- **Set up the Clinic and CPRS Documentation/Coding**: *Use the clinic set up outlined below in Section 4 for non-licensed, non-credentialed providers and refer to the Pathway TCMLH Group Clinic Set Up Guidance resource document [please click here].* The table below provides specific guidance on clinic set up, note titles and coding for WH group sessions:

<table>
<thead>
<tr>
<th><strong>Veteran Pathway Group – Guidance for Clinic Set-Up and CPRS Documentation / Coding</strong></th>
</tr>
</thead>
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<tr>
<td><strong>FAQ</strong></td>
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<tr>
<td>FACILITATORS</td>
</tr>
<tr>
<td>NOTE TITLE</td>
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<tr>
<td>CLINIC TITLE</td>
</tr>
<tr>
<td>STOP CODES</td>
</tr>
<tr>
<td>CHAR4 CODE</td>
</tr>
<tr>
<td>PROCEDURE CODE</td>
</tr>
<tr>
<td>**Facilitators may use any topically appropriate CPT code specific to their scope of practice. <strong>Recommendation:</strong> 59446: patient education, not otherwise classified, rendered by a non-physician provider in a group setting, per session.</td>
</tr>
</tbody>
</table>
Step 4: Plan the Veteran Recruitment Strategy for the Pathway TCMLH Programs

NEW VETERAN ORIENTATION (NVO)

Determine what recruitment source can be used to identify and enroll Veterans. Some examples of recruitment sources include:

- Provide an orientation to Whole Health and information on the upcoming groups and contact information for the Whole Health Partners or POC for enrolling in the Pathway TCMLH Groups.
- Determine if there is a letter that invites Veterans to NVO and request to add information about the Whole Health Pathway groups and approach to care.

ELIGIBILITY OFFICER

- Partner with your local eligibility officer for recruitment to the Pathway TCMLH Groups. Bring brochures to them, speak at a staff meeting, encourage recruitment for the group programs.
- Determine if there is a welcome letter that is offered after a Veteran enrolls, and request for the Pathway TCMLH Group information to be added.

PRIMARY AND SPECIALTY CARE

- Contact the leadership team for Primary Care and introduce the Pathway TCMLH Groups. This information could be presented at a staff meeting, to a smaller group representing Primary Care, or in email form.
- Provide brochures and materials that could be offered to patients. See the WHS Implementation Toolkit, for examples.
- Give PCPs an EASY and FAST way to refer!
- Determine what this referral method will be. For example: Veterans call to schedule the group if they are interested, the PCP adds a provider as an additional signer in a note, the PCP places a consult, etc.
- Follow these same steps for outreach to Specialty Care clinics.
Recruiting for your WH Pathway TCMLH programs will involve time and effort, which should be factored in to your start-up plans. Sites should assess how many individuals will be needed to start the group, and how large the group can grow to reach the target size. For example, if you are aiming for 10 group members to begin a group, consider what efforts will be needed, in terms of outreach and communications, to achieve that number. Make sure to factor in attrition. Attrition rates for groups that meet for nine weeks can go as high as 50%. For that reason, plan to sign up about twice the number of Veterans and family members to ensure an optimal session size (e.g., 30-35 Veterans for a group of 15).

- Leverage public spaces such as the atrium:
  - Consider setting up a table in the atrium or lobby of your facility if Veterans congregate in that area
  - Locate a place in your facility where Veterans naturally gather and set up a table with brochures, a sign, and information for WH Orientation

- Allow Veterans to choose an orientation they would like to attend immediately

- Consider Vet Centers, college Vet offices and VSO groups and work with such liaisons to provide information on the WH System and TCMLH programs.

- Consider having Veterans who have participated in TCMLH programs or other WHS components spread the word in their communities and at town halls, etc.

- The Toolkit includes information on outreach, communication and awareness. Be sure to coordinate with the Office of Patient Centered Care & Cultural Transformation for updates on national recruitment templates.

**Step 5: Plan the referral and enrollment process**

- Determine how WH Partners will manage referrals, who will be the POC for questions, and TCMLH group program enrollment. Consider the easiest and most efficient way to manage referrals to a WH Partner and the TCMLH groups. Some options may include:
  - Veterans may enroll by returning a brochure to a WH Partner indicating interest in the groups,
  - Veterans may call the WH Partner to inquire about the groups,
  - Be sure to consider the Veteran’s readiness to participate in deciding about referral or employment. Although we want everyone to join, being too aggressive in referral can lead to a high no-show rate.
Step 6: Establish Guidelines for Collaboration Both Within and Outside the VA

**COLLABORATION WITH FACILITY BASED RESOURCES**

The WH Partners collaborate with the facility’s Health Promotion and Disease Prevention Coordinators (HPDP), Voluntary Services, Recreation Therapy, and or Social Work Service to incorporate the facility’s updated environmental scan/resource list for internal and external well-being (based on National Center for Disease Promotion guidelines) and other resource lists into a Directory of resources that includes:

- Resource options for Veterans that correspond to the eight areas of self-care on the Circle of Health
- Facility based resources (e.g., MOVE!, well-being programs etc.)
- Community resources to broaden referral options for Veterans enrolled in the Whole Health pathway groups (e.g., Community Supported Agriculture program, local YMCAs)

**COLLABORATION WITH EXTERNAL COMMUNITY RESOURCES**

The WH Partners may also collaborate with local VSOs (VFW, American Legion, etc.) as well as Vet Centers, YMCAs, community centers, community college outreach and Veteran services etc., to identify opportunities for space, outreach and programming collaborations.
Wellbeing Programs
Section 5: Well-being Programs

Description

The Well-being Programs focus on equipping Veterans with skills to support self-care and well-being. Well-being programs build on and incorporate the existing health education and health promotion programs developed by the National Center for Health Promotion and Disease Prevention (NCP), including the MOVE! Weight Management Program and the Veterans Health Library. Consistent with the Whole Health vision and philosophy, the services provided through the Well-being Programs are not disease-focused. Rather, the focus is on well-being — offering and equipping the Veteran with skills to optimize their health and well-being.

The core offerings of a Well-being Program should include:

- Complementary and Integrative Health (CIH) approaches (e.g., yoga, tai chi, acupuncture, meditation, etc.).
- Well-being Classes (e.g., classes focused on nutrition, mind-body skills, spirituality, etc.).
Health Coaching.

The MOVE! Weight Management Program, Tobacco Cessation programs, and other health education, health behavior change counseling, and health promotion and disease prevention services may be offered within the Well-being Program, or may be available by referral elsewhere in the facility. Regardless of whether these services are co-located, close coordination and collaboration across the spectrum of wellness and self-management support programs is critical.

Well-being and CIH approaches aim to help the Veteran optimize health and well-being. Because Well-being Programs are not disease-focused, it is important to emphasize that all Veterans with interest should be made to feel welcome within the program. Enrollment should not be based on specific disease or diagnosis.

Teams may include a range of providers such as an integrative nutritionist, movement therapists and teachers (e.g., yoga, tai chi, qi gong), licensed acupuncturists, chiropractors, mind-body therapists (e.g., stress reduction, guided imagery, clinical hypnosis), and health coaches. Veterans will be able to be seen individually in support of their personal health plan, but most services will be focused on self-care skills and ongoing classes and support.

The Well-being Program will have strong relationships with both the Whole Health Clinical Care and Pathway program components. Outreach and communication mechanisms may be shared across the different WH system components. Referrals — to and from primary care providers, from other service lines, and from WH Partners — may also be shared across the different VHA WH system components.

**Helpful Hint:** Integration with other health promotion entities at your facility (e.g., MOVE! Health Promotion & Disease Prevention, Food & Nutrition Services, Tobacco Cessation) is strongly encouraged. Remember, the goal is to create alignment so **whole health is a system approach, not just another program.**

### Overall Well-being Program Structure

The Well-being Program has five main elements:

1. Referral
2. Orientation
3. Complementary and Integrative Health and Well-being Approaches
4. Class Tracks
5. Tracking Mechanisms for Well-being Program Services (these methods are further described under Section 8: Evaluation Strategy)
Figure 5 depicts the overall structure of the Well-being Program.

Setting Up Your Well-being Program
This section provides a detailed review of the necessary steps for the administrative set-up of the well-being programs.

Step 1: Establish the Referral Process
The best option based on experience to date is to create a CPRS consult as the referral system to the Well-being Program

- A referral through a CPRS consult provides:
  - A tool to track utilization of services: the number of Veterans entering the program can be retrieved by pulling consult referrals.
  - A deeper understanding of why a Veteran is interested in the Well-being Program.
A way to obtain medical clearance when needed: the Veteran’s medical provider can be alerted to the consult and can review and sign off, without the Veteran needing to be seen or contacted. Clearance may be necessary depending on local policy.

Helpful Hints

- VHA policy governs aspects of consults, such as appropriate timeframe for initial contact to be made and completion to occur. Completion or “closing” the consult can be done by writing a consult note for attendance at a Well-being Program orientation. The number of orientation sessions needed weekly will be determined by the volume of referrals to the Program. (Orientation Session is discussed more below).

- A Well-being Program consult can be placed by any provider. If you are using the consult for medical clearance, you can alert their PCP or another medical provider for appropriate clearance.

- Although a Veteran may be referred for a specific service it is essential that he/she has the opportunity to develop and design his/her own plan for engaging with the Well-being Program. An orientation session can support this process of Veteran centered and driven care within the Well-being Program.

SETTING UP A REFERRAL VIA CPRS CONSULT TO THE WELL-BEING PROGRAM

Start by generating content for the CPRS consult for your program. Work with Medical Informatics at your facility and/or your ADPAC to create a consult. Note that the title must start with the word “Consult.” It will help if the template you send has the exact wording and response fields you want. You can base your CPRS consult on the sample consults in the WHS Implementation Toolkit.

Additionally, you will need to create a Well-being Program “Consult Note” to use when closing your consult. Work with your CAC and/or ADPAC to create a “Consult Note” so that the consult can be completed after orientation. This can also be set up as a group note, which can make completion easier. After the consult is done, attending the Well-being Program Orientation is the Veteran’s next step.

Step 2: Planning the Well-being Program Orientation Session

An orientation session helps explain the philosophy of the Well-being Program and provide an overview of how to get the most out of the services. This session also empowers the Veteran to develop his/her own plan for using the Well-being Program that is aligned with his/her goals.
You will want to try to ensure that the orientation session is offered on the same day as other Well-being Program services so that Veterans who are new to the program do not have to travel back to the facility to start their self-care journey.

Veterans can also be referred to the Pathway programming directly from the Orientation to work with a Whole Health Partner to start their PHP. Additionally, Veterans could be paired with a health coach in the Well-being Program to assist them in creating a PHP.

Consider other important information that you would like to know before the Veteran arrives for orientation.
- Is the Veteran accompanied by a service dog?
- Does the Veteran require a caregiver?
- Does the Veteran need transportation to and from the Medical Center?
- Does the Veteran have other special needs (e.g., need a translator, Hearing impaired, blind)?
Suggested Orientation Session Outline

**Overview of Program**
- Discuss the philosophy of the Well-being Program

**Overview of Well-being Program Services**
- Describe the CIH approaches, the 5 class tracks, and the health coaching opportunities offered within the Well-being Program
- Answer questions

**Review schedule for Well-being Program Services**
- Provide a printed schedule of Well-being Program services
- Explain when and where Well-being Program services are held and how to get involved with each service
- See the WHS Implementation Toolkit for sample schedules

**Review provider bios**
- A printed list of providers with their picture and bios is a nice touch when orienting Veterans to the services

**Offer resources**
- Review online and community resources so that Veterans can participate in well-being services outside the walls of the facility
- Share the OPCC&CT online well-being resources with veterans.
  - OPCC&CT Internet Site: https://www.va.gov/patientcenteredcare/
  - OPCC&CT Intranet Site: https://vaww.va.gov/patientcenteredcare/

**Discuss Personal Health Plan**
- Help Veterans choose services that align with their goals

**Review administrative items**
- Local travel information
- Process for how Veterans will know if a service is canceled (particularly important for drop-in groups)
- Contact information for the program front desk/administrative staff

**Evaluation**
- Consider setting aside 20-30 min for Veterans to fill out patient reported outcome measures to help with follow-up evaluation

**Helpful Hint:** Create orientation session folders for Veterans that include: Well-being Program schedule, provider bios, contact information for the program, online and community resources, evaluation measures.
Step 3: Planning Your Complementary and Integrative Health and Well-being Offerings

PLAN FOR STAFFING FOR THE REQUIRED CIH APPROACHES

In response to Section 933, Subtitle C (Complementary and Integrative Health) of the Comprehensive Addiction and Recovery Act of 2016, and to the recent CIH Policy Directive the VHA has prioritized five evidence-based CIH approaches to offer during the FY18 roll-out of Whole Health System implementation:

- Acupuncture
- Chiropractic/Osteopathic
- Tai Chi/Qigong
- Yoga
- Meditation

Provision of these CIH services will be required for all 18 Whole Health System Flagship sites. In some sites, chiropractic and acupuncture services may be offered primarily within clinical care due to the treatment nature of these services; in others, they may be largely based in the Well-being Program. Similarly, although Tai Chi, yoga, and meditation will be offered primarily within a Well-being Program in most sites, they may also be offered in other departments (e.g., mental health, pain clinic, CLC, etc.). For the Whole Health Flagship Sites, osteopathic manipulation would satisfy the chiropractic requirement, and qigong would satisfy the tai chi requirement. Clinical Guidelines for Acupuncture and Chiropractic care can be found on the IHCC SharePoint under Clinical Guidelines.

Notably, VHA Directive 1137 Provision of Complementary and Integrative Health (CIH) was approved by the Acting Under Secretary for Health on May 19, 2017 establishing policy regarding the provision of CIH approaches. These approaches can be particularly impactful for Veterans dealing with pain and mental health issues, including suicide prevention. As described in the directive, the IHCC in collaboration with the IHCC Advisory Workgroup (IHCCAW) has identified CIH approaches for inclusion in the Veteran Affairs’ (VA) medical benefits package, referred to as “List I”. These approaches have been vetted by IHCCAW and found to have published evidence of promising or potential benefit. VA must provide a mechanism to offer these approaches either within the VA facility or in the community if they are recommended by the Veteran’s health care team. As of October 26, 2017, the list of CIH approaches approved by the USH includes:

1. Acupuncture

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2. Biofeedback
3. Guided Imagery
4. Hypnosis
5. Massage Therapy
6. Meditation
7. Tai Chi
8. Yoga

The list is updated and maintained by IHCC, and can be found on the OPCC&CT SharePoint.

**PLAN THE STRATEGY FOR DELIVERY OF CORE WELL-BEING SERVICES**

CIH and well-being services can be offered in individual sessions or group format as appropriate. Decisions on how to balance individual vs. group services in your well-being program will need to consider space available, staff, and expected patient volume.

- **Individual Sessions:**
  - Some CIH services (e.g., Acupuncture, chiropractic) may lend themselves better to individual formats; however auricular acupuncture techniques like Battlefield Acupuncture can work well in a group setting

- **Group Sessions:**
  - These can be either drop-in groups offered on a first come/first served basis or closed groups offered through appointment
  - Increase access to CIH approaches
  - Increase potentially therapeutic relationships among Veterans participating in these services

In some cases, there may be a demand for women-only classes or services (e.g., Yoga for Women, Yoga for Military Sexual Trauma). If this is the case, facilities should consider offering women-only CIH groups and/or well-being classes.

**Be prepared to be flexible in balancing group vs. individual care as you learn more about the level of demand for each of the CIH approaches in your Veteran population.**
Close collaboration between the Well-being Program and WH clinical care and clear and consistent documentation of well-being services provided are both essential to ensure a coordinated approach for the Veteran.

**COMMUNITY CARE**

- Some facilities may choose to refer out to CIH/Well-being services from the community rather than hire these professionals at the facility. This strategy obviously has pros and cons, as does all community care. Coordination and quality control are easier to manage when services are offered in-house. However, access can be improved in some cases by referring out to the community.

**WHOLE HEALTH COACHING**

Whole Health Coaching is a core service of the Well-being Program. The Whole Health Coach is a new position within VA and is an integral part of the Whole Health System. A nationally classified Position Description (PD) for health coaches has been developed which should be available soon. Health coaches can provide individual and group coaching services not only within the Well-being Program but also within Whole Health Clinical Care.

A whole health coach needs to have a clinical supervisor that also has whole health coaching skills. Checklists will be available soon that reviews how to evaluate the skills of a whole health coach as well as how to set up a health coaching program at the facility.

Helpful Hint: *In some cases, services offered within the Well-being Program can also be offered to staff in specific staff classes, which can increase awareness and understanding of these services and reduce employee burn out. Keep in mind though that because of VERA and financing issues, in some facilities this may be better provided in conjunction with the employee health service.*

**FORMULATE AN INITIAL PLAN FOR OFFERING ADDITIONAL CIH APPROACHES**

- Consider surveying existing expertise among staff at your facility and capitalizing on this training. For example, you may already have a Registered Dietitian specialized in integrative/functional nutrition, a psychologist with extensive mindfulness training, or a social worker with yoga and tai chi background. Work with these staff and their supervisors to see if they could provide some services in their area of expertise within the Well-being Program. Obtaining an informal MOU with the supervisor is suggested so the staff member has protected time for providing well-being/CIH services.
• If your facility does not have many Well-being providers available, explore and expand community partnerships that do have these types of services (e.g., Vet Centers, YMCA, VSOs, etc.)
• If there are current VA providers interested in specific CIH approaches, cross training these individuals in these approaches could expand the CIH offerings within your Well-being Program. It is important that both the provider and his/her supervisor clearly understand the time commitment for both the training and the use of the skills in the Well-being Program following the training.

CREDENTIALING WELL-BEING PROVIDERS: WELL-BEING VS. TREATMENT

Providers of well-being approaches who come from the community (volunteers or fee-basis) will not be credentialed and privileged within the VA facility. The National VA Credentialing Office has given guidance on this and recommends that facilities develop their own local procedures and policies for vetting non-licensed, non-credentialed providers of health and well-being approaches. OPCC&CT has developed PDs (located on the OPCC&CT SharePoint) for minimum proficiencies for health coach, yoga, tai chi, qigong practitioners which can assist in this process.

Please note, this procedure does not apply to CIH treatment approaches such as acupuncture, massage, and chiropractic, where it IS necessary to have licensed, credentialed, and privileged providers of these approaches. Additional information on setting up local validation procedures, including examples from the Washington DC VA and St. Louis VA, can be found in the CIH Resource Guide.

Step 4: Plan your Well-being Class Tracks

Well-being Program structure may vary from site to site but ideally the program will have 9 class tracks available to Veterans after they attend orientation. During orientation, Veterans will learn about the class tracks and choose the track(s) that are most aligned with their personal health plan. Materials for the classes as well as the online starter class will be provided by OPCC&CT. Class tracks are aligned with the eight areas of self-care (i.e., components of health and well-being) outlined in the personal health plan.
THE 9 CLASS TRACKS ARE ALIGNED WITH THE CIRCLE OF HEALTH:

- **8 Class Tracks Aligned with the Circle of Health:**
  - Power of the Mind
  - Working Your Body
  - Food & Drink
  - Surroundings
  - Family, Friends, Co-workers
  - Recharge
  - Personal Development
  - Spirit & Soul

- **Maintenance Class Track:** Classes focused on the Circle of Health and reviewing or refreshing the Veteran’s PHI and/or PHP. These classes will likely be led by a Whole Health Coach or Whole Health Partner.

BUILDING YOUR TRACKS:

- A starter class, offered in person or online, can be utilized by the Veteran to explore self-care in that domain. Materials for the in-person starter class as well as the online version will be provided by OPCC&CT.
- Longer course offerings, such as 6 to 8 week track classes, can also be offered if there is Veteran interest and provider availability. In FY18, these classes will need to be developed by the facility based on veteran interest and provider expertise. In future years, OPCC&CT will develop curriculum guidance and eventually have these classes available on-line.
- Tracks can also incorporate and build on Physical Activity/Movement and Food & Nutrition programming and resources currently supported through HPDP Program Managers and MOVE! programming.
- The 9 Healthy Living messages developed by NCP in collaboration with other VHA program offices can also be a resource for Veterans participating in the Well-being Program tracks: [https://www.prevention.va.gov/Healthy_Living/index.asp](https://www.prevention.va.gov/Healthy_Living/index.asp) and [http://vaww.prevention.va.gov/HPDP_Patient_and_Staff_Educational_Materials.asp](http://vaww.prevention.va.gov/HPDP_Patient_and_Staff_Educational_Materials.asp)

CLASS PROVIDERS

Classes within each track can be led by a variety of providers. Whole Health Coaches or other VA providers cross-trained in whole health coaching skills are ideal candidates for leading these classes. Additionally, utilizing providers from different disciplines, such as nutrition, social work,
psychology, chaplain services to help teach courses can help incorporate whole health into clinical care.

**Step 5: Develop Tracking Mechanisms for Well-being Program Services**

Establishing tracking mechanisms is key to evaluating well-being programming. Following the below clinic set up guide is essential for adequate tracking of Well-being Program services and will be required for the 18 Whole Health Flagship sites. As part of effective tracking of utilization, we recommend creating a spreadsheet of all clinics, as there will be many to coordinate over time.

There are three National Tracking Mechanisms for the Whole Health System:
- Stop Codes
- Four Character (CHAR4 Codes)
- Note Titles

**Important:** For tracking to be effective – ALL CIH and Well-being Services (groups and individual) MUST have clinics set up in VISTA and enter all notes/encounters into CPRS.

If the CIH or Well-being provider does not have CPRS access, another VA provider should write an historical note in a non-count clinic.

The [CIH Resource Guide](#) provides in depth information regarding tracking and coding for Well-being Services. Please refer to this guide for more information.

*Current Procedural Terminology (CPT) codes exist for Chiropractic Manipulative Treatment (98940-98943) and Osteopathic Manipulative Treatment (98925-98929).*

**Overview of National Tracking Mechanisms**

**Stop Codes:**

- Primary and Secondary Stop Codes are determined when setting up a clinic in VISTA.
- **Stop Code 159 – Complementary and Integrative Health Treatment:** Used for treatment services, such as integrative medicine consult, acupuncture, massage.
- **Stop Code 139– Health and Well-being Services:** Used for well-being services, such as yoga, tai chi, meditation, health coaching.\(^7\)
- Stop Code 139 and 159 are available to support clinic infrastructure for the field; however, we understand that they will not be used consistently for CIH across the enterprise due to competing stop code demands.

\(^7\) Regulation change is in process to make Stop-code 139 co-pay exempt, but this will not be in place for at least 1-2 years.
Stop Codes are tracked by the National Managerial Cost Accounting Office.

**CHAR4 codes:**

- Four-character codes that follow the Stop Code pair.
- Designated at the time of clinic setup (same time as stop code designation).
- Work with your local Managerial and Cost Accounting (MCA) office and ADPAC (Automated Data Processing Application Coordinator) to setup Well-being Program clinics.

**Note Titles:**

- Your local CIH and Well-being Notes should be mapped to the national note title, entitled Integrative Health Note to facilitate tracking at the national level.
- In your local CIH or Well-being Note Title include the type of approach being provided. For example, if yoga was being provided in that session, make sure your local note title includes the word ‘yoga’
- Note titles for the visit are determined at the time the Veteran is seen for a Well-being or CIH service.
- Work with your CAC to develop local notes for Well-being/CIH services and to help map them to the national note title.

Make sure that all CIH/Well-being Services (including those offered in the Pathway, Well-being Program, and Whole Health Clinical Care) use the appropriate Stop Codes if possible and have a CHAR 4 designation as these are most important for both local and national tracking of utilization. We understand that it is not always possible to know that a Wellbeing/CIH approach will be offered in that clinic when setting up the clinic profile – for those situations, using note titles only is sufficient.

**Helpful hint:** Set up a different clinic for each well-being service as much as possible. This makes reporting numbers easier. For example, a clinic for “yoga” and a separate clinic for “meditation” will allow you to easily pull clinic utilization data and monitor encounters by each service.

**WELL-BEING PROGRAM NOTES**

For data to be transferred and tracked to national data bases, all well-being program services must have notes in CPRS and all notes associated with these services must have an encounter. It will be helpful to use a templated note to ensure consistency and ease of documentation. Consider important items to include in the note template and work with your local medical informatics office to create note templates.
The CIH Resource Guide provides in depth information on all these tracking mechanisms as well as note templates.

### Step 6: Finalizing your Administrative Set-up

**CPRS Access for Providers**

Well-being/CIH providers need access to CPRS to write notes. If the CIH or Well-being provider does not have CPRS access, another VA provider should administratively enter a note in a non-count clinic. In cases where you do want to secure CPRS access for a new provider, here are some important steps you will need to tackle. Your Administrative Officer (AO) or ADPAC can help with these steps:

- TMS trainings (HIPAA, security, etc.),
- Background check,
- An AO or ADPAC should enter the employee into the VA system,
- Establishing the new users “person class” and “user class” (HR will guide you on this). Note that some user classes require a co-signer. Medical Informatics can help you choose the right class. You can find relevant Person Class Taxonomies in the WHS Implementation Toolkit.

**Travel**

Travel is a common topic that Veterans will want addressed and can easily cause misunderstandings. Each facility may have different requirements and regulations regarding transportation to and from the medical center (e.g., for those individuals who will need a van that accommodates a wheelchair). Typically, for Veterans who qualify for travel reimbursement, they attain 2-way travel pay for scheduled appointments and 1-way travel pay for drop in appointments. Partner with your local travel department to better understand the travel requirements and to attain more information. Official guidance from VACO Beneficiary Travel is that CIH and well-being services offered in non-count clinics can still get travel pay since travel pay is based on Veterans’ eligibility and the medical benefits package. Due to the CIH Directive, well-being services in non-count clinics are part of the medical benefits package and, therefore, eligible for travel pay.

**Personal Health Plan: The Whole Health System (WHS) Integrator**

The Veteran’s personal health plan is owned by the Veteran and integrates the three components of the Whole Health System. Thus, the personal health plan is an essential aspect of the Veteran’s journey through the Well-being Program.
If a Veteran attends the Well-Being Programs with a written PHP already started, the Veteran should bring the Plan to the program and use it to help identify well-being services that are aligned with their MAP/goals.

During the Veterans’ experiences in the Well-Being Program, other Shared Goals (and related SMART goals) may be established with Well-Being providers, thereby expanding the PHP.

If a Veteran attends the Well-Being Program without a PHP and is interested in creating one, the Veteran will be provided with an overview of the PHP, and be offered well-being class options or a referral to a Whole Health Coach or Partner to begin the personal health planning process.

Additional aspects of personal health planning in a Well-Being Program include:

- Provide education about personal health planning in the Well-Being Program Orientation
- Provide forums to discuss what matters most to them in life (MAP exploration)
- Provide education and information regarding CIH and its role in health and well-being
- Conduct any CIH-approach specific assessment
- Provide education re. VA and non-VA CIH resources
- Offer referral to WH Coach, WH Partner, TCMLH or WH Clinical Care programs
- Offer Veteran the opportunity to connect with other whole health hospital programming in support of MAP (e.g., Healthy Living, Food and Nutrition, MOVE!, etc.)
- Engage in the PHP/PHI Class Track (i.e., Starter Class and/or Maintenance Class) to develop or revise PHP
Section 6: Whole Health Clinical Care

Description

As mentioned throughout this guide, to deliver effectively on the Whole Health vision, the Veteran’s experience needs to be based on full alignment across all three components of the Whole Health System. This section summarizes key activities and steps suggested for implementing the third component of Whole Health.

What is WH Clinical Care?

Whole Health Clinical Care (WHCC) is a clinical practice which:

- Acknowledges and values what a Veteran wants their health for, and then links their health care to that mission, aspiration and purpose,
- Develops and links shared goals for health and well-being (and associated interventions) directly to what matters most to the Veteran in their life,
- Attends to and addresses the full range of physical, emotional, mental, social, spiritual and environmental influences that affect a person's health and understands the connections between all those influences,
- Collaboratively helps Veterans develop or refine their personal health plan and uses this plan to guide their care, and delivering personalized care,
- Integrates use of complementary and integrative health (CIH) approaches not only to treat illness but to also support health and well-being,
- Assesses well-being or vitality signs as a hallmark of Whole Health Clinical Care,
- Utilizes Whole Health coaching to aid the Veteran in achieving his/her goals,
- Is conducted via a therapeutic relationship between staff and Veteran, within a healing environment,
- Recognizes the importance of self-care focused on health and well-being (not solely disease-based self-management),
- Addresses ways to strengthen a Veteran’s innate capacity to heal (proactive),
- Incorporates use of health education and group services to support Veteran’s ability to attain their health and wellness goals as appropriate and desired by the Veteran,
- Makes use of multiple tools and approaches to support use of the Whole Health clinical process (as opposed to one tool or a singular checklist approach), and
- Connects seamlessly with Pathway and Well-being Programs.

This reflects a change from a system that asks, ‘What’s the matter with you?’ to one that asks, ‘What matters to you and how can we help you live your best life?’

**SETTING REALISTIC GOALS AND PARTNERING WITH THE VETERAN TO ACHIEVE THOSE GOALS**

In the context of Whole Health, one of the most important roles of the clinician / care provider is to work with the patient to understand their current situation, to set realistic goals for achieving greater well-being, and to support and collaborate toward achievement of those goals. In this way, the Veteran and the clinician have entered into an agreement — a partnership built on establishing goals, and supporting the Veteran in progress toward those goals. This is what is meant by the “shared commitment to goal achievement.”
By forging this shared commitment, the Veteran and their care provider make connections between what brings meaning to the Veteran’s life and the Veteran’s health and well-being. The provider partners with the Veteran to set goals that match and support what is most important to the him or her, and that are also informed by the clinical expertise of the provider/team. This engagement approach is an important aspect. By setting their own goals, the patient is more likely to commit to changes in health behavior where they may be needed. Goals based on other factors, such as another person’s desires or priorities, that are not grounded in the Veteran’s own life values are far less likely to be sustained over time.

Many existing VA initiatives share a focus on empowering the Veteran for self-management and shared decision-making. The Planned Care Model, Self-Management Support, and Veteran-Centered Health Education programs all work to support collaborative goal setting between clinicians and Veterans. These approaches have been promoted over the past several years through Primary Care/NCP sponsored educational programs, and provide an important foundation for the spread of WH Clinical Care. For example, the TEACH for Success and Motivational Interviewing courses have been completed by over 35,000 PACT clinicians since 2010.

The Personal Health Plan is a critical component of the WH model of care. Veterans can be referred into WH Clinical Care from the Pathway component, or the Well-being component; but regardless of which component they enter from, Clinical Care will work closely with the Veteran to establish or update their Whole Health goals. These goals will be reflected in an updated Personal Health Plan for each Veteran. They will represent a shared commitment by the clinical team and the Veteran to support achievement of these goals.

The ideal state is for all clinical programs (both outpatient and inpatient) to work in partnership toward delivering Whole Health Clinical Care. This will not occur immediately, but rather in stages. Transformation from the existing approach to clinical practice takes time and therefore should be approached in an incremental manner, initially capitalizing on the passion of early adopters, piloting changes that can provide important learning opportunities for future efforts, and benefitting from the wisdom of other sites that have already begun this journey.
Implementing WH Clinical Care in Your Facility

This section provides a detailed review of the necessary steps for implementing WH Clinical Care.

Step 1: Aligning to the VISN and Facility Strategic Plan and Building Leadership Support

As with the other two Whole Health program components, planning for the implementation of the Clinical Care component should align to the strategic plan of your specific VISN and facility. OPCC&CT Field Implementation Team Consultants can aid VISN and facility leadership in exploring this alignment and developing a tailored plan that reflects how implementing WH CC will support your overall priorities and strategies. Information on consultation services is available here.

Executive leadership support is an essential element of WH implementation. Ensuring an Executive level sponsor or champion is on board is an important first step, and will streamline the work to follow.

Step 2: Building Your Organizational Structure for Overseeing Progress

Given the breadth of work to be accomplished, creation of a subcommittee or workgroup, which reports to your Facility PCC/WH Steering committee and is specifically tasked to implementation of WH CC, is highly recommended. Once the support and sponsor are on board, bring all involved parties together before the initial phase of implementation. These parties may include, but are not limited to:

- Associate Chief of Staff for the clinical area of implementation
- Associate Chief Nurse or equivalent in Nursing Service
- Business Manager of the clinic/team
- MSA chief
- PI/Risk Manager of the clinic/team
- Nurse Manager
- Health Behavior Coordinator
- Veteran Health Education Coordinator
- MOVE! Coordinator
- PACT leadership or representative
- Clinical Applications Coordinator
- Health Promotion Disease Prevention Program Manager
- Local Recovery Coordinator
- Employee Health and Well-being
- Others whose staff will touch the process, including ancillary services. Consider EMS, Voluntary Services, Quality Management, etc.
- Include a Veteran patient presence as the “voice of the Veteran” in this subcommittee

### Step 3: Identify Potential Partnerships in Both Clinical and Non-clinical Settings

Forming partnerships with other programs throughout your facility is essential, especially with those who have expertise in areas that relate to Whole Health. Partnerships will be essential to your Whole Health program’s success, not just during the implementation and transition period, but to achieve full acceptance and adoption of the Whole Health vision and philosophy. Many service lines or programs offer natural partnership opportunities, given their existing work. The list below is not exhaustive, but offers likely areas where fellow champions and allies may be found. Additional discussion on engaging these different groups can be found in the Toolkit.

- Health Promotion and Disease Prevention Coordinator (HPDP)
- MOVE! Health Behavioral coordinator (HBC)
- Health Coaches and Transformational Coaches
- Veteran Health Education Coordinator
- Primary Care/PACT
- Primary Care Mental Health Integration (PCMHI)
- Substance Abuse Residential Rehabilitation Treatment Program (SAARTP)
- Pain Management Teams
- Patient Advocates/Veteran Experience officer
- Physical Medicine and Rehabilitation (PMR)
- Medicine
- Surgery/Anesthesia
- Employee Health and Well-Being
- Quality Management
- Social Work Services
- Nutrition
- Pharmacy
- Mental Health
- Peer Support Specialists (PSS)
- Nursing Service
- Well-being Program

Do an assessment of available resources and programming at your facility that align with and support Whole Health. Motivational Interviewing (MI) and TEACH for Success techniques and champions are assets in developing WH CC. Members of the facility Healthy Living Team (i.e., Health Behavior Coordinators, Health Promotion Disease Prevention Program Managers, Veterans Health Education Coordinators, MOVE! Coordinators, Flu Coordinators) are local champions for
Whole Health and personalized, proactive, patient-driven care and can offer key WH-consistent educational programs (e.g., TEACH for Success, Motivational Interviewing), as well as a wide range of training programs, clinical programs, and clinical tools and resources that support the Whole Health System.

Other assets include employees who have attended Whole Health Education programs, Integrative Health-trained practitioners, Functional Medicine trained practitioners, holistic nurse certified staff, health coaches, staff certified other complementary and integrative health approaches such as battlefield acupuncture, and those with a passion for the work. Also, if your facility has already developed a Well-Being Program, it would be a great resource to draw upon – potentially well-being/CIH providers from the Well-being Program could support CIH and health coaching within whole health clinical care, if time allows.

**Step 4: Develop Your Initial Strategy for Implementing WH Clinical Care**

Because WH CC involves the transformation of the approach to care, it can be difficult to decide where to begin. The starting place will vary depending on sites. Your site’s OPCC&CT Field Implementation consultant can help you in determining what makes the most sense for your site. A phased approach to implementation beginning with educating leadership and key stakeholders in WH CC prior to formal implementation, is usually the best approach.

**START WITH CHANGING THE CONVERSATION**

Some sites may opt to “start big by starting small”. A reasonable place for almost any site or program to begin transforming the delivery of their clinical care is to begin by having clinicians and staff “change the conversation”. This means starting the conversation with the Veteran as opposed to their disease or problem. Veterans are given an opportunity to reflect on the “big questions” and share their mission, aspiration & purpose (MAP). Some sites have discovered that a particular order to these questions works best for them and there is certainly flexibility in how these are integrated into clinical practice. For example, not all the following questions are covered with each Veteran at each encounter. Many clinicians worry asking these questions will require substantially more time or have other concerns. Strategies for changing the conversation, addressing perceived barriers and answering FAQ’s can be found in the Passport to Whole Health. Also, such content is covered in the Whole Health in Your Practice course.

Some examples of questions that are used for this purpose are:

- What REALLY matters to you in your life?
- What do you want your health for?
- What brings you a sense of joy and happiness?
- What is your vision of your best possible health?
Clinicians and providers should also begin assessing the Veteran’s well-being or vitality signs. The health care team can do everything right and yet still miss valuable information about well-being. Including an assessment of well-being or vitality signs can give the team a fuller picture of how their patient is doing in their life and provides another avenue to identify and explore the MAP. A simple and straightforward way of doing this is through use of a brief, validated measure called Cantril’s Ladder.

Cantril’s Ladder: Please imagine a ladder with steps numbered from zero at the bottom to ten at the top. The top of the ladder represents the best possible life for you and the bottom of the ladder represents the worst possible life for you. Indicate where on the ladder you feel you personally stand right now.

Alternately, the team could assess well-being by asking the Veteran to rate him- or herself in three areas:

Rate where you feel you are on a scale from 1 – 5, with 1 being miserable and 5 being great.
- Physical well-being
- Mental/Emotional well-being
- Life – How is it to live your day-to-day life?

Assessing well-being or vitality signs is a hallmark of Whole Health Clinical Care.

**Implementing Personal Health Planning**

Personal Health Planning plays a central role in WH Clinical Care. Implementing Personal Health Planning (PHP) into Clinical Care teams begins with identifying teams that are ready to engage in this work. Once these teams are identified, the first step involves educating the team on the overall Whole Health concepts (changing the conversation) and the four Organizing Principles of Personal Health Planning: Whole Health Assessment; Shared Goals; Personal Health Plan; and Skill Building & Support. Teams will also need reinforcement and support for needed skills such as Motivational Interviewing. PHP consultation services are available from OPCC&CT to aid in this process.
Overview of Personal Health Planning

Personal Health Planning consists of four organizing principles. These offer a process by which the flow of Whole Health information can best be assimilated into the traditional clinical visit. The PACT model can be utilized to transform the traditional clinic visit into a Whole Health clinical visit.

The process of Personal Health Planning can be broken down into Pre-provider, Provider, and Post-provider responsibilities.

In the ideal state, the first organizing principle **Whole Health Assessment** is obtained pre-provider. This can occur during a clinic visit via the HT/LPN or RN, through the Veteran Whole Health partners, or through a Personal Health inventory that is obtained during a CIH experience. It is

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**Steps for Implementing PHP**

- Solicit leadership support
- Develop a plan for organizational support
- Identify education needs of staff
- Determine current state. Clinical care teams are likely in many different stages of transformation. Some may be ready for change and others are resistant. Your Steering Committee can be useful in identifying service lines who exhibit key characteristics for success (see select teams to pilot), and those that may take longer to transform.
- Plan to address gaps. Achieving the ideal state is a process. Your healthcare teams may need to start with simple steps towards the ideal future state. That may include clarifying their team member roles, working on their team dynamics, or perhaps that is just **changing the conversation with the patient** by asking them what really matters to them. It is important to approach this process with patience, and meet the team where they are. Acknowledge your team’s administrative and clinical burdens, and utilize your WH champions at all levels to inspire transformation.
- Tool selection/creation
- Select outcome measures: CollaboRATE, CARE, PROMIS, etc.
  Start pilot begin to partner with patients to create personalized health plans based on shared goals, utilizing the 4 organizing principles. Teams will continue to provide health coaching around those shared goals and continually update the PHP to reflect changes in shared goals. Ideally, 100% of the teams’ panels will participate in personalized planning. Regardless of the entry point into the Whole Health system, teams can build upon existing personal health plans to promote personalized, pro-active, patient-driven care for their Veterans
- Measure; and Refine
- Consider utilizing the [Passport to Whole Health](#)
important to note that the WH Assessment includes the Veteran’s mission, aspiration and purpose (MAP) as well as other information about the Veteran.

The second organizing principle, **Shared Goals**, occurs when the provider/clinician utilizes the new Whole Health information obtained during the Whole Health Assessment (or via another aspect of the WH System) to find common area(s) where provider and Veteran goals overlap. The strength in the principle of Shared Goal setting is threefold: 1) it provides an area of motivation for health behavior change, 2) it allows for SMART goal setting and 3) it provides a means to start or expand the Personal Health Plan.

The third organizing principle **Personal Health Plan Development** in the clinical care realm begins with the provider. While it encompasses the MAP elements which are often obtained pre-provider, it also includes additional elements:

- MAP
- Shared Goals
- Self-care
- Professional Care
- Skill building and education
- Consults and referrals
- Timeline and follow up

The fourth organizing principle **Skill Building and Support** usually occurs post-provider with a Health Coach, a member of the multidisciplinary PACT Team (e.g. PCMHI, dietician, pharmacy, MOVE, etc) or with a CIH instructor.

**Organizing Principles of Personal Health Planning**
The Whole Health Assessment consists of three elements and associated activities. It is very important to note that the Whole Health Assessment includes the Mission, Aspiration and Purpose (MAP). At the very least, the MAP is new information that the clinical care teams utilize to incorporate into the Veteran’s plan of care.

1. **Self-Reflection:** The first step is the Veteran’s self-assessment of what is important to them and the area(s) in their lives that they are most motivated to make behavioral change. The Personal Health Inventory (short or long form) can be used for this purpose. Often it is mailed out to the patient before the visit or given to them at the visit to take home and complete. The Recovery Plan used in Mental Health also serves this purpose. Some teams prefer verbally asking 3 questions during a clinic visit about what matters to the person, what they want their health for, and what activities they would like to be able to do. Other teams use a picture of the “Circle of Health” for this assessment. Whole Health group visits are another good setting to help Veterans explore what matters to them.

2. **Health Risk Assessment (HRA)** - The provider or provider team usually conducts HRA’s to assess the patient’s current health status and gauge current risks. It includes factors such as family history, genetic markers, lifestyle habits, environmental risks, and available biometric data to determine a baseline susceptibility to disease. There is an HRA on MyHealthVet that patients can complete themselves and share with the team. Some teams use clinical reminders
as a form of HRA. There is an example of WH clinical reminder language in Appendix E in the WHS Implementation Toolkit.

3. **Clinical Assessment** —The clinician’s physical, mental and psychosocial exam including diagnostic and genomic data.

**Principle 2: Shared Goals**

As previously stated, shared goals bring together the Whole Health assessment and what matters to the Veteran, as well as their health risks, diagnostics, the clinical exam and the provider’s expertise. In creating shared goals, the Veteran and their provider link what brings meaning to the Veteran’s life with their health. Goal setting is most effective and meaningful when the Veteran guides the process instead of the provider prescribing solutions. Goals do not have to be complex and grand. Simple and basic goals can have meaning and serve an important purpose in the “here and now” of a person’s life. Remember, this is a shared activity; the Veteran is the expert on themselves and what matters most to them, and the provider is the clinical expert. Both these parties bring their knowledge and recommendations to the table, and work together to identify meaningful goals that will help the Veteran live his/her life more fully.

The process of patient-centered goal setting is featured in TEACH for Success training and a number of other tools have been developed and disseminated to address collaborative goal setting. These additional tools are available in the PACT Roadmap to PPPDC and from facility-based Healthy Living Teams as well as at [http://vaww.prevention.va.gov/HPDP_Patient_and_Staff_Educational_Materials.asp](http://vaww.prevention.va.gov/HPDP_Patient_and_Staff_Educational_Materials.asp)

VHA uses the SMART goals framework (specific, measurable, action-oriented, realistic and time-based). Veterans identify concrete, specific things he/she can do to improve their health, focused on behavior, not outcome, starting small and building over time, with a short, defined time frame. SMART goal tools are widely used in VHA and in Primary Care PACTs.

**Principle 3: Personal Health Plan Development**

Guided by the Veteran’s personal mission, and the shared goals the clinician and Veteran have established, a plan is developed to help the Veteran achieve his/her goals. The components of the Personal Health Plan (PHP) are listed in the earlier PHP section of this document.

The clinician seeks to understand the patient’s strengths and challenges and connects/refers the Veteran to others who can help. The personal health plan is documented in the record and shared with the patient. The elements may be captured in different areas of CPRS, a locally developed template, or a hand-written or typed document. All members of the healthcare team are aware of and contribute to these elements and the Veteran is the primary “owner”.
**Principle 4: Skill Building and Support**

Skill-building through education and training empowers Veterans with the skills and knowledge they need to succeed in achieving their goals. Explore the Veteran’s strengths and past successes in meeting goals. Support from the healthcare team, groups, caregivers, family members, friends, and the community is also critical to success. Clinical staff needs to know the resources available within the team, facility, and in the community, that are available to assist Veterans with their life and health goals. VHA has health promotion, disease prevention, and self-care programs (e.g., MOVE!, meditation), social programs, provider-based care, and resources for complementary and integrative health programs and services. Each VHA facility has an Environmental Scan that lists internal and external resources for Veterans. HPDP Program Managers at facilities are charged with conducting environmental scans to identify both internal and community based programs and resources that Veterans may access. Collaborating with the HPDP Program Manager and other members of the facility Healthy Living team is strongly recommended. Staff may be innovative and personalize the skill-building and support employed for each individual.

**TOOLS TO SUPPORT PERSONAL HEALTH PLANNING PROCESS IN WH CC**

Specific tools to aid in the implementation and delivery of Whole Health Clinical Care can be varied and include a combination of existing and new tools. Remember, delivery of WH CC is not defined by what tool is used but rather how the tool is used and for what purpose. The level of Whole Health Assessment in which a clinic will engage a Veteran will help to determine which tools the clinic will employ. For example, a clinic or Veteran group with staffing and enough available time may choose to utilize the My Story PHI as a Personal Health Inventory (PHI) tool. A clinic that has a busier flow or less opportunity to review a PHI with the Veteran, may choose to utilize a modified version of this PHI, for example a Whole Health Review of Systems tool.

Available Tools:

- [My Story PHI](#)
- [Brief PHI](#)
- Whole Health Review of Systems from Boston ([WHS Implementation Toolkit](#))
- Reviewing the [Circle of Health/Components of Health & Well-Being](#)
**ADAPT OR CREATE NEEDED MATERIALS**

Many materials have been developed by pilot sites, and are available to share or modify. Examples of many of these are available in the WHS Implementation Toolkit.

- **Letters and/or brochures for Veterans with WH language can be created and often provide an opportunity for the team to use the new WH language and craft a message to Veterans to set the tone for the new WH clinical visit. This change is new to the Veteran, as well as the team.**

- **WH Assessment tools include a mechanism to allow Veteran self-reflection on their Mission, Aspiration & Purpose, and around the Components of Health & Well-Being. The Personal Health Inventory (PHI) is available for this purpose in the My Story PHI, PHI One Pager, or PHI pocket care format. Some sites have modified the tools to include a clinical focus as well.**

- **Personal Health Plan in CPRS templates are under development, but may take some time for completion. In the interim, many VA facilities have created CPRS templates for personalized health inventories and personalized health planning or goals. You can share templates between facilities through the Clinic Application Coordinator’s (CAC) VISTA email group. They can then update the template and get your facility medical records approval for use. Additionally, you can work with them to find ways to have the PHI and/or PHP uploaded to the cover sheet through clinical reminders or postings. This will allow multiple teams to easily access the document. It is highly recommended that you start this process as soon as possible so that teams have a mechanism for documentation.**

- **Take Home note technology or After-visit reports can be developed to allow Veterans to have a copy of their PHP. This allows Veterans to have portions of the CPRS note printed in the clinical encounter and for the team and Veteran to have the same goals and plan, and supports follow-up.**

- **Brochures that outline the WH approach for Veterans are available free of charge from OPCC&CT here.**

- Developing and maintaining a current list of CIH resources, both internal and community based, that are easily accessible for clinical teams to draw upon, make incorporation of CIH modalities a simpler process.

**Brief Tips for Implementing Personal Health Planning in WH Clinical Care**

- If a Veteran presents to clinical care with a PHP already started, the clinical care team should review and discuss the plan with the Veteran. Then, the team should work with the Veteran to set Shared Goals (and related SMART goals) thereby expanding the PHP.

- If a Veteran presents to the clinical care team without a PHP and is interested in creating one, the team should provide an overview of personal health planning, and offer to begin the Veteran’s process of identifying their MAP, and setting Shared Goals and related SMART goals if desired.
• Responsibility for the above actions should be shared across team members whenever possible, and that this process is likely to occur across multiple encounters
• Basic actions for conducting personal health planning in a WH Clinical Care setting include traditional care planning and management guided by the establishment of Shared Goals, as well as the following (some of which may already be occurring):
  o Review chart for PHP note or reference to PHP in other clinical notes.
  o Inquire regularly (frequency dependent on Veteran, provider assessment, etc.) regarding MAP and update Shared and SMART goals as needed.
  o Take a team-based approach to initiating and developing a PHP.
  o Develop basic, or expand existing, PHP (e.g., high-level MAP with clinical care-related Shared and SMART goals or simply desire/motivation to improve self-care/self-management in some way).
  o Begin or continue Veteran’s education about personal health planning via pre-visit phone calls, mailings, in-clinic handouts or discussions.
  o Utilize MI/TEACH skills in helping Veterans develop their PHP.
  o Explore or review what matters most to them in life (MAP) and re-visit barriers to achieving goals.
  o Align Shared Goals, SMART goals and treatment plan with MAP.
  o Discuss actions Veteran will take to address bio-psychosocial needs in pursuit of MAP, anticipated barriers, and potential solutions to them.
  o Conduct WH Clinical Care assessment (H&P and self-care around “Circle of Health”).
  o Offer link to WH Coach, WH Partner TCMLH or Healthy Living programs and staff when appropriate and available to further expand PHP.
  o Identify and deliver medical and other interventions needed in pursuit of MAP & disease treatment, self-management/prevention and ultimately the Veteran’s highest achievable state of wellness.
  o Address relevant prevention, treatment, self-management, advanced care planning etc.
  o Offer education regarding prevention and connection with Healthy Living programs (e.g., MOVE!, Tobacco Cessation, Gateway) and Veterans Health Education programming, including self-management support programs.
  o Document the above in CPRS using a PHP template that will be viewable to others in VHA system.

**Step 5: Selecting Teams to Pilot the Initial Implementation of WH Clinical Care**

Hallmarks of successful implementation efforts for WH Clinical Care include:

- Support from all levels of leadership.
- Well-functioning, trans-disciplinary teams with established roles of members, such as a high-functioning clinical care team. Healthy interpersonal team dynamics are critical to success.
- While not necessary, it is an asset to have at least one team member with a working knowledge of Whole Health. Courses & workshops are available from OPCC&CT, such as WH In Your Practice, WH Health Coaching, PHP Workshop, all of which offer useful introductions to this work.
- Teams that have had Motivational Interviewing/TEACH, and are utilizing these skills in daily practice.
- For PACT settings, full implementation of the PACT model is also a useful foundation.
- It may be wise to start by selecting fully oriented and established team members; selecting team members who are “new to the VA” may have some disadvantages. Providers often struggle with additional responsibilities during the first year while learning the VA system. They can, however, observe more seasoned Whole Health clinical care teams.

**ASSESSING CURRENT FLOW OF VETERAN CARE**

Before implementing a Personal Health Planning Process, or before beginning any Whole Heath Clinical Care, it is necessary to assess the patient flow within the clinic. This specifically refers to how a Veteran is checked into the clinic, and the nature of the interactions they experience during each encounter. Whole Health dialogue can potentially occur at each point of contact during that experience; teams should work to assess the optimal opportunities for that conversation in their clinic flow. The level of Whole Health conversation will be determined partly by the role and training of the employee at each specific point of interaction. Mapping the flow of Veteran care through a clinic is an important part of the preparation process. Some sites have found it helpful to utilize resources at the facility, such as the Systems Redesign Coordinator or flow mapping tools and resources to assist in the effort. Accessing the VA Transformational Coaching program is another avenue to help with creating change towards implementation of the WH model ([https://www.vapulse.net/groups/national-transformational-coach-captains](https://www.vapulse.net/groups/national-transformational-coach-captains)).

**ASSESSING CURRENT TEAM DYNAMICS**

Healthy team dynamics are an essential foundation for high-performing teams. Efficient work can be difficult when there are so many different individual and team roles and responsibilities. Take some time to assess your current team dynamics. Do you need to assist with team building to improve trust, civility, or team cohesion? Does your team focus on self-care practices? A healthy team will be able to interact with patients in an open and compassion manner.

**DEFINING Team ROLES**
Success of a team requires that each team member know what and how they and their coworkers contribute. The following provides suggestions for defining various roles in support of team success. Teams may look different depending on where the clinical setting is (outpatient, inpatient, CLC, etc.) and the following presents an example using PACT to illustrate how different members of a team can all contribute to the delivery of WH CC. Teams can be defined in a number of ways, and expanded teams can also work well. The core PACT teamlet is often defined as the Administrative Associate (usually called the Medical Support Assistant or MSA), the Clinical Associate (usually a Licensed Practical or Vocational Nurse [LPN/LVN], the Care Manager (Registered Nurse [RN]), and the Provider (Physician, Nurse Practitioner, or Physician’s Assistant).

**MEDICAL SUPPORT ASSISTANT (MSA)**

- MSA’s focus on script/language to use when presenting Whole Health to Veterans. This can be developed by the MSA group during a learning opportunity about Whole Health and their role. Resources for use with the MSA group can be found in Appendix I. MSAs are often the face of the team: consistent language is important, and begins with them.
- MSA’s have a working knowledge of the [Components of Health & Well-Being](#) (i.e., what it encompasses).
- MSA’s are the face of the team, and often set the tone for the WH visit. They can also contribute tremendously to the healing environment of the waiting room, which ideally should support self-reflection. Some suggestions are:
  - Quiet space
  - Soothing music rather than a TV blaring
  - Light
  - Odor free, or use of aromatherapy
  - Availability of space to complete the PHI including a pen, clipboard, etc.
  - Soothing colors
  - Comfortable seating that allows privacy
  - Use of videos playing on a monitor to introduce the WH concept and/or mindfulness practices support the Veteran’s self-reflection

For example, one WH site has the MSAs:

- Distribute the WH brochure, and Intake forms; samples of both are in the [WHS Implementation Toolkit](#).
- Provide an explanation of Whole Health approach

Please note that the PHI can be completed by the Veteran in a group process, or as part of a Shared Medical Appointment (SMA), as well as in the waiting area prior to an appointment.

**LICENSED PRACTICAL/VOCATIONAL NURSES AND HEALTH TECHNICIANS (LPN/LVN/HT)**
Some teams will choose to integrate one or more CIH approaches into clinical care, in addition to being able to refer to these services through the Well-being Program. The team should meet with the appropriate WH champions or subject matter experts to discuss education, training, and resources.

**Step 6: Integrating Complementary and Integrative Health Approaches**

CIH providers may be embedded within a clinical care team, may work within the Well-Being Program, and may be seen on a consultative basis. Within the Whole Health System, CIH approaches should be offered both within the Well-Being Program and within WH Clinical Care. CIH within the Well-Being Program are offered to veterans not based on diagnosis or disease, but to support and optimize health and well-being; programming is open to any interested Veteran. CIH within clinical care is offered within a specific clinic to support treatment of a specific disorder and the CIH modality is only offered to the Veterans referred to that clinic (e.g., yoga within pain clinic; MBSR class within Trauma Services; battlefield acupuncture within PACT). Appropriate integration of CIH within clinical care is a key aspect of WH clinical care.

WH champions can help the team integrate CIH by offering WH education, including the WH library, the WH 101 course, or the ability to go through 3 day ‘Whole Health in Your Practice’ clinical course to have a good understanding of how to integrate the approaches into the clinical setting and the Personal Health Planning process. The new TMS module on CIH can be helpful as well.

The WH champion should provide the team with POC’s for the health and well-being program or individual CIH programs and with short descriptions of CIH approaches (glossary of terms) and links to existing ESP’s located at: [https://www.va.gov/PATIENTCENTEREDCARE/clinicians/research/evidence-based-research.asp](https://www.va.gov/PATIENTCENTEREDCARE/clinicians/research/evidence-based-research.asp).

The WH champion can do case reviews with the team to build their confidence in integrating CIH; this may require specifically protected administrative time for this work.

Often Health Behavior or Health Promotion Disease Prevention (HPDP) coordinators have an environmental scan that has been completed. This scan shows the community and internal resources for CIH modalities available for Veterans, from which clinicians can refer.

**Step 7: Integrating Health Coaching**

Health Coaches may be embedded within a clinical care team, may work with the health and well-being programs, or may be seen on a consultative basis. This is a new and growing area, and the ideal state includes utilization of certified health coaches in many different settings. In the interim, there may be many staff already trained in health coaching skills that can be a part of the newly developed process, including, for example, Motivational Interviewing and TEACH for Success graduates. The clinician coaching developed by NCP can play an important role in promoting this
approach in the clinical setting. Through this program, TEACH and MI facilitators are available at many facilities to help PACT and other clinicians apply TEACH and MI skills in actual practice. NCP provides extensive training and support to TEACH and MI facilitators to prepare them to serve as clinician coaches. Clinician coaches provide coaching in both individual and group settings and are available for individual case consultation to assist clinicians to overcome barriers to use of Veteran-centered communication and health coaching approaches. The Whole Health System implementation provides a great opportunity to support and expand clinician coaching in the use of effective Veteran-centered communication strategies.

Integrating health coaching on a wider scale begins with identifying clinical staff or other team members who are interested in committing to the Whole Health Coaching course. Once Health Coaches have been trained, the clinical care team needs to create the process whereby the team can refer the Veteran to health coaching for further support of that Veteran’s health goal. For example, a Clinical team RN, LPN, or Peer Support Specialist who has had Health Coaching Training can then easily follow the health goal that was created by the Veteran with the provider, thus allowing for continuity of care within the clinical team setting.

Additionally, existing resources within the VA (e.g., MOVE!, smoking cessation programs, HBC consults) also serve to reinforce the Veteran’s health goal and are consistent with the practice of health coaching.

and the roles of each team member has been clearly defined, the team is ready to begin their pilot process:

- Reflect on why the team was chosen as an initial pilot site. Encourage them to focus on their strengths and clarify roles once more before beginning.
- Based on the determination of “where to start”, decide which team member will carry out which role, whether it is just the first 3 questions of the PHI or the full PHI.
- Encourage use of non-traditional encounters to meet demand.
  - Shared Medical Appointments
  - Tele-health
  - Telephone encounters
  - Secure messaging through My Health e-Vet
  - Group PHI exploration

**Step 8: Initiate Pilot Implementation of WH Clinical Care**

- The WH champion and/or team coach should meet regularly with the team to check on progress, obstacles, ensure fidelity to the WH model, and need for further resources (see SHADOWING)
- Encourage teams to start small and expand from there. Perhaps they can start with 1-3 patients a day and grow from there. Often new Veteran appointments are a way to start: there are no pre-conceived expectations to overcome on the part of the Veteran.
Regardless of where the pilot teams are starting, they should progress across a continuum until they reach the desired future state of Whole Health clinical care.

**Shadow the Developed/New Processes**

Once the newly developed process(es) have been under way for a trial period (30-90 days typically), a team (e.g., the FIT team or a facility-based team) may “shadow” the process and interactions, and use systems redesign to make improvements. The scope of shadowing occurs between the point of check in and check out of the clinical encounter. The team should be aware of the shadowing plan well in advance, and the Veterans asked if their experience can be shadowed in advance of their appointment, and again at check in. It is advisable to reassure Veterans that at any time they can ask the shadowing to end, if they were to become uncomfortable in any way. It is important to note that the goal of shadowing is to improve the WH encounter for both Veterans and staff and the process should not be punitive.

During the shadowing, an observer sits in on the WH encounter. The observer should:

- Be a neutral witness to the Veteran and staff experiences through the encounter
- Observe the steps in the process in real time, and have familiarity with the established process, often best viewed in flow map format.
- Take note of what works well and opportunities for improvement.
- Explain the shadowing process to the participating Veteran patients. Briefly clarify the role of the shadower to observe, record, and evaluate the Veteran care experiences in the hopes of improving the delivery of care for all Veterans and their family caregivers.
- Ask permission before entering the treatment area with the Veteran and let them know that any observations noted and all personal health information discussed during their episode of care will be kept confidential. Reinforce the Veteran’s prerogative to stop the shadowing or to ask the observer to step out of the room at any time during the shadowing event.

Post shadowing, the observer reviews and consolidates observations and revises the flow map for the process. The goal is to ensure consistency between the newly developed “ideal” process, and the observed process. The team and the observer then come together to hear the shadowing observations, and develop next steps to improve the process.

The shadowing tool used to ensure fidelity to the WH model can also be included in continuous quality improvement efforts.

**Refine**

Employing process improvement tools to manage and understand the depth and impact of change, such as flowcharts, shadowing (see above) and facilitated listening session with Veterans and staff.
promotes fidelity to the WH model as well as the provision of high quality, efficient and coordinated care. Engaging local Quality Improvement professionals will provide expertise in the development of measurement and improvement plans to facilitate integration and sustainment of system-wide change.

**Sustain**

Once implementation of the WH CC is complete, it is necessary to continually evaluate the Whole Health Program. This on-going evaluation will help staff to modify, improve, and strengthen the practice within the clinic. Additionally, clinical staff will need continued support from their leaders to ensure dedicated time permits completion of training, planning and implementation of process changes, and ongoing skills development. Contingency plans should include proactive plans for staff absences and vacancies.

**Spread**

A dissemination plan is necessary to expand the WH CC program from the pilot team(s) to full facility implementation. This will involve engaging Clinical Champions of the Whole Health System to spread the Program to new teams and sites through education and support. A formal dissemination plan with timelines offers the most successful approach for full implementation.
Section 7: The Whole Health Learning Collaborative: The Road to Deployment

Initial deployment of the Whole Health System (WHS) at the flagship sites is proposed over approximately one year, acknowledging that any given site may require more or less time according to multiple variables that may or may not exist. These variables include but are not limited to readiness for change and subsequently the acceptance of the components of the WHS by the existing culture; the extent of staff and Veteran knowledge of Whole Health (WH); demand for Complementary and Integrative Health (CIH) services; and availability of resources (funding, staff time, space, etc.). The framework for deployment of health care transformation to the WHS aligns with VHA’s adopted model for change management (Prosci) and requires the 18 Flagship sites to work both independently and collaboratively to allow for innovation and shared learning. The initial 18 months will be deployed through a learning system that incorporates elements of the Institute for Healthcare Improvement (IHI) Breakthrough Series Collaborative and Collaborative Innovation Network designs. This deployment plan outlines the specifics for the initial 18 months, commencing April 1, 2017, and provides a prospective but general forecast for the activities in Fiscal Year (FY) 2019 and FY 2020.

Whole Health System Collaborative Series

Description
The WHS Collaborative Series brings together the 18 VISN/Flagship teams over an initial 18-month period of time to participate in multiple face-to-face learning & innovation forums separated by action periods at each team’s respective site.

All facilities selected as the flagship site in each of the 18 VISNs will receive introductory materials that will include the WHS Implementation Guide and related tools to facilitate implementation of the WHS. These materials will outline the specifics of WHS implementation and expectations of the flagship sites.

Ongoing support for the collaborative model includes access to OPCC&CT Field Implementation Team (FIT) consultants, community of practice calls, networking, and distance learning. Teams are brought together periodically for additional, focused learning, knowledge and skill acquisition, and education planning for implementation and sustainment. In partnership with educators, the core team members and others at the flagship site will conduct local education and training to broadly disseminate concepts to key target audiences – Veterans and families, general staff, leaders, clinical staff, trainees. Tools to facilitate a particular stage of implementation or component of the WHS will be introduced at appropriate times of the implementation process on community of practice (CoP) calls, face to face learning and innovation forums, and by FIT consultants working with the 18 flagship sites. See Figure 6, illustrating the life of the WHS Collaborative Series below.
Whole Health System—Implementation Guide and Toolkit

Whole Health System Collaborative Series Objectives

- Expedite deployment of the Whole Health System at the 18 flagship sites
- Create a high-performing WHS in each VISN that:
  - Partners with the person and his/her family, exploring their mission, purpose, and/or aspirations, and begins to create an overarching personal health plan.
  - Provides skill building and supports proactive, integrative health approaches such as stress reduction, yoga, tai chi, mindfulness, nutrition, acupuncture, and health coaching that is not driven by a diagnosis or disease based.
  - Provide clinical care by providers trained in WH; including healing environments and relationships, complementary and integrative health approaches, personal health planning.
- Sustain and spread those WH practices with measurable success across the flagship site and to other sites within the VISN and VHA.
WHS Collaborative Series Preparation (April 1, 2017 – August 31, 2017)

Each VISN flagship site has a designated an OPCC&CT FIT Primary Consultant (PC) who will initiate the field engagement process beginning with an Executive Leadership Consultation (ELC). The ELC includes conversations with executive leadership, staff, Veterans and others, and incorporates an assessment component to further define leadership, staff and Veteran awareness, understanding and buy-in to a WH approach to care, as well as the current and desired state regarding implementation of the WHS. WH and CIH educational offerings will be introduced including course objectives, target audience and competencies.

The extent of ELC activities is determined by the facility’s experience with WH, CIH practices and prior engagement with the OPCC&CT. Outcomes of the ELC include the identification of the facility’s WH Deployment Core Team, as well as priorities, goals and actions for transformation documented in a Tailored Organizational Plan (TOP). The ELC is expected to be completed on or before August 31, 2017.

During this preparation phase, the WH Core Team will oversee development of an initial concept design for the WHS within their respective facility. OPCC&CT FIT can recommend available resources and tools, as well as facilitate conversations through an exploration process leading to an initial draft of this concept if requested. This design will be further refined at the first Collaborative Learning and Innovation Forum.

Collaborative Innovative Community of Practice (CoP) calls will be initiated in quarter 3 of FY 17 to support implementation of the WHS and connect flagship sites in the preparation phase and throughout the activities of the WHS Collaborative Series.

Three members of the WH Core Team from each site will be invited to participate in a face-to-face Collaborative Learning and Innovation Forum, scheduled for September 13-14, 2017.

The WH Deployment Core Team consists of three or more members who will ensure the integrity of the deployment plan. Membership includes:

- An executive leader who can expedite decision making and ensure accountability for action;
- A provider champion and potentially a nurse champion to lead the campaign to transform to a WH approach care; and
- A project manager with analytical skills to facilitate action and communication within the organization, act as point of contact for the collaborative, and ensure adherence to the WH Collaborative Series structure.

Optionally include on a routine or ad hoc basis:

- Health Behavior/Disease Promotion and Health Behavior Change Coordinators.
- Key people within the organization that leverage success, such as educators, improvement specialists, clinical and administrative champions, data analysts, etc.
- A Veteran champion, preferably a recipient of the organization’s clinical services, who can offer perspective and insight to shape action and guide decision-making.
Face-to-face Learning and Innovation Forums (FY 2018)
There are three face-to-face forums planned at this time:

1. The initial Collaborative Learning and Innovation Forum will bring together participants from the flagship Whole Health Core Teams, and will focus on planning and strategic deployment. This forum is scheduled for September 2017.

2. A second Collaborative Learning and Innovation Forum, held in the 2nd quarter of FY18, will include the core team and additional key implementation personnel. This meeting will include best practice presentations, plenary forums, skill building, and topic and discipline specific tracks.

3. The third Collaborative Learning and Innovation Forum, held in the 4th quarter of FY 18, will bring together participants from the flagship Whole Health Core teams, to provide an opportunity to evaluate progress, share lessons, resolve evaluation issues, and set the stage for enhancement and spread of innovation for months to follow.

A virtual Learning and Innovation Platform is planned for the 3rd quarter of FY 18 to support teams between Actions Periods two and three. This virtual session will focus on mid-year evaluation to identify best practices to date and troubleshoot any challenges faced by the flagship sites. Site visit teams may be scheduled at the discretion of the flagship core team.

Action Periods
The time between the face-to-face forums is critical, and management and accountability for action will ultimately determine the success of the implementation process and sustainment of change. Broad expectations are contained within the implementation guide; however, it is the facility’s responsibility to own its unique design and innovation around implementation of the WHS. Specific aims with defined milestones, assigned responsibility for action, dedicated resources, and a plan for measuring success are imperative and should be documented in the TOP and updated as the collaborative progresses.

Steps to undertake when implementing the multiple elements of the WHS, including evaluation, are provided under each element’s chapter of the WH Implementation Guide. Depending on the path taken, a flagship site may decide to charter multiple facility-level teams working simultaneously on unique but integrated aspects of the WHS. It is the responsibility of the WH Core Team to facilitate communication and engagement not only amongst these teams, but across the organization to include staff, Veterans, families, volunteers, and community partners so that the organization moves together toward adoption of the WHS.

Flagship sites may avail themselves of multiple resources including OPCC&CT’s FIT consultative services, networking, CoP calls, WH education courses, educational tools and program supplies available via the Supply Depot, and on-line resources to support local implementation of the WHS.
Leadership

It is essential that executive leadership and other facility leaders at flagship sites participate in the planning and execution of change activities of the WHS Learning Collaborative to help integrate WH into daily work and leadership strategies, thereby, reinforcing its importance and modeling commitment. At minimum, one executive leader is a member of the Core Team, and where Patient Centered Care, Organizational Health or other related steering council is in place, actively participates as a chairperson or member. Leaders and supervisors support staff engagement by permitting a reasonable amount of work time spent in WH transformation work. Veteran engagement, as well, is encouraged and supported through the implementation of a Veteran and Family Advisory Council and/or inclusion of Veteran advisors on key facility committees or WHS element teams.

FY 19 and Beyond

Undoubtedly, each of the VISN flagship sites will embark on its unique journey toward implementation of the WHS, and will have experienced varying degrees of measurable success as FY 18 draws to a close. The Core Team, at minimum, will continue to attend one to two face-to-face Learning and Innovation Forums annually, and assume progressive roles in the collaborative process and mentor new sites. The OPCC&CT and FIT will continue to support flagship involvement in the WH Collaborative Series and local work groups for education, measurement, and implementation, as well as conduct evaluation activities with the field and other partners.

Key aspects of deployment to hold gains, further implementation of the WHS, and foster spread beyond FY18 include:

- Integrate WH into daily work and leadership strategies, thereby, reinforcing its importance and modeling leadership commitment;
- Utilize assessment tools, including the VA Guidebook to Patient Centered Care, to determine progress and any need for course correction and/or additional education;
- Schedule and deliver continuing WH education, i.e., WH 201 and 301 level education as determined;
- Participate fully in the long-term national evaluation of the WH model
- Establish sustainment and ongoing implementation plans, including a plan for WH and CIH education, and the development of education champions and faculty;
- Staff and Veteran engagement in developing and implementing sustainment plans for the application of learned concepts and the WHS;
- Acquiring Specialty Certifications as needed; and
- Core teams leading ongoing facility-based efforts and assisting other facilities within their Region/VISN with implementing, sustaining, and evaluating progress toward the WHS.

Details regarding structure(s) in place for continuous support of the implementation, sustainment and spread of successful practices within the WHS will be defined in the 3rd quarter of each
subsequent year (FY19 and FY20), and communicated in the 4th quarter. OPCC&CT FIT will provide post-education course support and continue to work with facilities to execute implementation, communication, education, sustainment, and evaluation plans.

### 18 in 18 Deployment Sketch

<table>
<thead>
<tr>
<th>TIMELINE</th>
<th>Field</th>
<th>OPCC&amp;CT Office</th>
<th>OPCC&amp;CT FIT</th>
<th>Potential Partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 FY17</td>
<td>VISN Identifies Site</td>
<td>Planning 18 in FY18: education, implementation, evaluation</td>
<td>Assign PC to site (Follow typical FIT Field Engagement Process)</td>
<td>EES</td>
</tr>
<tr>
<td>Q2 FY17</td>
<td>Site identifies CORE Team 3-4 people</td>
<td>Planning committee for collaboratives</td>
<td>Follow FIT Engagement Process resulting in 18 in 18 Focused TOP</td>
<td>NCCD NCP</td>
</tr>
<tr>
<td>April 2017</td>
<td>Initial Meeting with CORE Team/18 sites: Core Team/Larger Team I.D.</td>
<td>Implementation Guide</td>
<td>PC and Analytics Team Support in concept Design/Measurement</td>
<td>WH DLS</td>
</tr>
<tr>
<td>FY17 Q3</td>
<td>FY17 Q4 (Jul – Sep)</td>
<td>Planning for Initial Meeting with CORE Team/18 sites</td>
<td></td>
<td>VHA Tr.C</td>
</tr>
<tr>
<td>FY17 Q4</td>
<td>FY18 Q1 (Oct – Dec)</td>
<td>Initial F3 Learning Circle</td>
<td></td>
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<tr>
<td>FY18 Q1</td>
<td>FY18 Q2-2 (Oct – Mar)</td>
<td>Action Period</td>
<td></td>
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<tr>
<td>FY18 Q2</td>
<td>FY18 March 2018</td>
<td>Learning Circle (F2F or Virtual)</td>
<td></td>
<td></td>
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<tr>
<td>FY18 Q3</td>
<td>FY 18 Sept 2018</td>
<td>Action Period</td>
<td></td>
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<tr>
<td>FY18 Q4</td>
<td>FY 19 and Beyond</td>
<td>Learning Circle (F2F or Virtual)</td>
<td></td>
<td></td>
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<tr>
<td>Q1 FY19</td>
<td>Phase 2 – Sustain</td>
<td>Phase 3 - Spread</td>
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</table>

Collaborative Support (Structure/Resources, Coordination, High Level Guidance, Accountability, Reporting)

Primary Consultant and Ad Hoc Specialty Team Support (WH Clinical, CIH, Analytics, WH Partnership, Education Support)
Section 8: Whole Health Education Options

A comprehensive, broadly accessible Whole Health and Complementary and Integrative Health curriculum is a critical factor in educating the VHA workforce to deliver whole health care and empower and equip Veterans with the knowledge and skills they need for sustainable behavior and lifestyle change and improved health outcomes.

A standardized suite of Whole Health (WH) education programs are available for the 18 flagship sites to teach WH core competencies to specific target audiences. Curricula progress from basic awareness, knowledge, and skills, to advanced education for highly specialized care delivery (See the WHS Implementation Toolkit for a table of core competencies and target audiences). The Field Implementation Team consultant assigned to each flagship site assists facility leadership in assessing the current state of educational preparedness at the site and developing a tailored, site-specific education plan aligned with VISN and facility priorities.

WH educational offerings include programs for Veterans and their families, Whole Health Partners, Whole Health Coaches, general staff, leadership, and clinical staff. Different core competencies and levels of competency are needed according to the target audience. Existing programs such as New Veteran Orientation, New Employee Orientation and staff retreats, that touch the broadest target audiences, will be revised to integrate basic levels of Whole Health competencies at the flagship facilities. Best practices from other VA Medical Centers, Program Offices, and OPCC&CT’s WH education programs, serve as examples for incorporation. The progressive education programs, core competencies, and target audiences are represented in the graphic below.

Figure 8. OPCC Whole Health Education Programs
CORE CLINICAL EDUCATION PACKAGE

The core education package for staff involved in clinical care include programs offered locally at each facility by OPCC&CT-affiliated faculty and several offered regionally, bringing together staff who will serve as Whole Health Partners and Whole Health Coaches at the sites. For more information about the programs, see the table under Addendum B in the WHS Implementation Toolkit.

On-Site Offerings
- Whole Health 101
- Whole Health in Your Practice (capacity 50 per session)
- Whole Health in Your Life (capacity 50 per session)

Off-Site/Centralized Offerings
- Whole Health Partner training
- Taking Charge of My Life and Health
- Whole Health Coaching (capacity 40 per session)

In addition to the core education programs, there are several online programs through TMS that provide a convenient way for clinical staff to learn the basics about Mindfulness, Complementary and Integrative Approaches, and Clinician Self-Care. There are also several advanced programs that a facility may select from, in consultation with their Field Implementation Team consultant. These are listed in the WHS Implementation Toolkit.

FACULTY AND EDUCATION CHAMPIONS

A successful education plan is not realized without highly trained and skilled educators and faculty. OPCC&CT provides faculty for Whole Health programs through a contract with the Pacific Institute for Research and Evaluation (PIRE) and their Complementary and Integrative Health and Health and Wellness Coaching master instructors. In addition, OPCC&CT is building a national pool of internal faculty, known as Education Champions, to meet current needs and future growth and sustainment of Whole Health education. Whole Health education programs will initially be delivered at each facility by PIRE/OPCC&CT faculty and the national pool of Education Champions.

Ongoing local training at each facility will be supported by two Facility Education Champions; one MD/DO and one Complementary and Integrative Health professional (Holistic Nurse, Clinical Psychologist, MSW, etc.). See Appendix D in the WHS Implementation Toolkit for the criteria for Facility Education Champions. Facility Education Champions are supported at 0.2 FTEE through OPCC&CT CARA-dedicated funds which will be provided to the facility. Facility Education Champions receive comprehensive faculty development training under the supervision of the PIRE/OPCC&CT education staff. After completing the training, they will offer ongoing training at their site, as well as at the VISN level and perhaps even national level, as needed. In addition,
faculty at flagship facilities involved in TEACH and MI training programs, will provide additional support and mentoring as available.

The Education Champions at each facility, in collaboration with the Clinical Lead, the Program Manager, and the OPCC&CT FIT consultant, will review the facility education plan every six months to evaluate the need for refinement in the plan or for additional educational interventions at the site. Regular updates on the deployment of the education plan including estimates of the number of facility staff trained in WH will be included in the template for CARA-related reporting, coordinated by OPCC&CT.
Section 9: Evaluation Strategy

Evaluation Plan for 18 in 18

Evaluation of the outcome of the 18 in 18 demonstration project is a critical component of the program and in fact is specifically mandated by Congress in the CARA legislation and the VHA CARA plan.

A detailed evaluation plan is being developed nationally by OPCC&CT in collaboration with HSR&D and QUERI. This plan includes specific strategies for gathering outcomes in the areas of patient satisfaction, patient-reported health outcomes, clinical outcomes, staff engagement and burnout, and utilization and cost.

This plan will be presented to the flagship sites on one of the initial Community of Practice calls for the Collaborative, and then in much greater detail at the first meeting of the Collaborative. Each site will receive VACO CARA-targeted dollars to hire a full-time Research Coordinator to assist with implementation of this national evaluation agenda under the direction of our QUERI team. Some sites may also choose to hire a Research Associate, for which VACO CARA dollars may be used as well. These facility-based research staff will undergo training with the HSR&D research team and will work under the joint supervision of facility leadership and the OPCC&CT/QUERI research group. The following are brief descriptions of plans for the evaluation in each of the five domains.

**VETERAN SATISFACTION**

We are working with the Survey of Health Experience of Patients (SHEP) team and with our QUERI partners to develop strategies to analyze the impact of CIH implementation on Veteran satisfaction.

- To compare satisfaction outcomes at WH facilities before and after implementation.
- To compare satisfaction outcomes with similar facilities not implementing WH actively.
- Pilot work is ongoing with QUERI in testing new items for SHEP survey that will specifically capture the impact of WH/CIH on Veteran satisfaction.

**PATIENT-REPORTED OUTCOME MEASURES**

Working with our QUERI partners, we have identified a core set of specific measurement tools based on the domains of Veterans’ life experience most likely to be impacted by the Whole Health System interventions. A feasibility pilot currently underway at five Whole Health pilot sites in conjunction with QUERI Bedford using these measures (listed below). The target for this feasibility project is 300 total Veterans at five sites.
- Goal will be to collect a much larger sample at the flagship—comparison can be before and after WH as well as to matched controls at the site not participating in WH. We expect to be looking for approximately 300 Veterans per site over the first 12-18 months. Veterans in this cohort will be followed for 6-12 months.
- We are currently exploring with QUERI, the Mental Health Measurement Based Care Initiative, and the Office of Nursing Services possible strategies for collecting some patient-reported health outcomes as part of the routine process of care rather than separately by a research associate. More information will be available on this for 18 in 18 sites wishing to join this aspect of the evaluation effort as the project develops. Strategies currently being examined or evaluated include MSA or LPN involvement in outcome data collection, iPads or tablets in waiting room, and online or App-based strategies.

### Whole Health Patient Reported Outcome Measurement Package

<table>
<thead>
<tr>
<th>Key Outcomes</th>
<th>Likely Measures</th>
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<tbody>
<tr>
<td>Sense of life meaning and purpose</td>
<td>• Life Engagement Test</td>
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<tr>
<td></td>
<td>• IHI/100 Million Healthier Lives measure</td>
</tr>
<tr>
<td>Engagement in health care and management</td>
<td>• Perceived Health Competency Scale</td>
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<tr>
<td></td>
<td>• Patient Activation Measure (PAM)</td>
</tr>
<tr>
<td></td>
<td>• IHI measure</td>
</tr>
<tr>
<td>Goal setting and attainment</td>
<td>• Goal attainment questions adapted from the FY15 PHP survey</td>
</tr>
<tr>
<td>Perceived improvement in health and well-being</td>
<td>• Perceived Stress Scale (PSS)</td>
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<td></td>
<td>• PROMIS-10 (functional outcomes)</td>
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<tr>
<td></td>
<td>• Defense and Veterans Pain Rating Scale (DVPRS)</td>
</tr>
<tr>
<td>Patient Centered Care (Healing relationships)</td>
<td>• CollaboRATE</td>
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<tr>
<td></td>
<td>• Consultation and Relational Empathy (CARE)</td>
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**Clinician and Staff Engagement and Satisfaction**

OPCC&CT is working with Occupational Health and NCOD to include new questions on burnout in AES. We will plan to compare staff engagement/burnout before and after implementation at WH sites and compare WH sites to non-WH sites.

**Clinical Outcomes**

Our QUERI/HSRD partners have already tested a methodology to pull relevant clinical outcomes from CDW on an ongoing basis and evaluate the impact of WH programs on specific clinical parameters. These can and will include outcomes such as BMI, blood pressure, lipids, HgbA1C, pain
scores, and any other regularly documented clinical outcome potentially impacted by the Whole Health System.

**COST AND UTILIZATION OUTCOMES**

The Managerial Cost Accounting Office (MCAO) has established a new cohort (Whole Health) and is developing a cost and utilization tracking mechanism that will come online in Oct 2017. This will provide aggregate cost and utilization data year-to-date for the following: Total Cost; Total inpatient cost; Total outpatient cost sliced by Primary Care Stop Codes, Rehab (PT, OT), Orthopedics, Mental Health, Radiology, Surgical Procedures, Laboratory, Pharmacy (Opioid use). Metrics will include average cost/patient, average cost per encounter, total and average costs for the cohort and include cost breakouts for direct and indirect cost, number of admissions, bed days of stay (Lengths of Stay), Emergency Department (ED), and Urgent Care (UC) encounters, and Readmissions. These parameters serve as ongoing program quality measures and will also allow us to evaluate the impact of deploying the WH system on cost and utilization at each facility and also nationally.

**Additional Evaluation Strategies**

In addition to participating in the national evaluation, flagship sites may choose to develop additional evaluation strategies pertinent to site-specific priority outcomes not addressed in the national plan. The FIT PC and other subject matter experts are available to the flagship sites to provide assistance in implementation and associated milestones, as well as, facilitate the development of this site-specific measurement plan for facilities that want to expand on the national evaluation targets.

Separate from the facility evaluation plan, the WH Series Collaborative coordinators will administer a survey to the staff of each flagship site to evaluate awareness and understanding of WH concepts and the implementation of the WHS at the conclusion of FY 18. This survey is one of the change management software tools contained in the PROSCAR Suite available to the field through the National Center for Organizational Development (NCOD). The survey will be repeated at the conclusion of FY 2020. Survey results can yield useful information to identify pockets of acceptance or non-acceptance from which the site can explore the rationale underlying the results to guide next steps in implementing the Whole Health System.