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Commentary

Whole Health: Focusing on What Matters

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The Veterans Health Administration (VHA) has made a system-wide commitment to Whole Health, an approach to healthcare that empowers and equips Veterans to take charge of their health and well-being to live their lives to the fullest.¹ This commitment is in response to a recognition that our country has built a healthcare system that is effective at treating many diseases – but does not focus enough on creating and supporting health and well-being, and does not do very well at addressing chronic pain, depression, loneliness, and the rising rate of suicide.

Because of its focus on high-tech disease treatment, the United States spends far more than any other country on healthcare but ranks only 32nd in life expectancy.² The COVID-19 pandemic has brought into focus even more clearly the need to create a **health** system that encourages self-care and builds well-being – rather than just a disease care system.

At VA, we are expanding our understanding of what defines healthcare by developing a Whole Health System that provides both the highest quality disease-oriented care and that supports health and well-being creation. The Whole Health System also provides a tool to address what Don Berwick called the “moral determinants of health” by addressing the impact of structural and social determinants of health on Veteran well-being.³

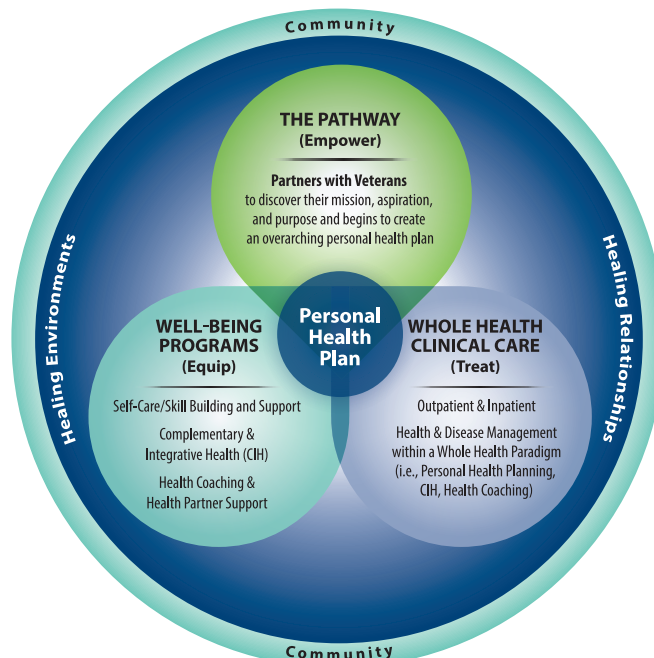
The question “what’s the matter with you?” has generally been the guiding principle in our find-it/fix-it problem-based approach to healthcare. Whole Health shifts the focus to the question “what matters to you?” Whole

Health places the Veteran at the center of the health creation team, and assumes that if everyone, including the Veteran, is aware of what they feel they need their health FOR, the plans they make as a team will have a much greater chance of becoming reality.

This Whole Health approach has three key components: the Pathway, Well-being Programs, and Whole Health Clinical Care (see Figure 1). In the Pathway, Veterans meet with fellow Veterans who are trained as peer facilitators to discuss what matters to them in their lives. Together, they discuss the Veteran’s strengths and where they might need help to get to what matters.

This peer-to-peer approach is critical in changing the conversation. The second component is the Well-being Program, where Veterans have access to covered evidence-based complementary and integrative health approaches like acupuncture and meditation, and learn new skills for self-management like yoga and Tai Chi. Veterans can also work with a Whole Health coach to make plans for how to address areas of their lives that need change. The third component is Whole Health Clinical Care, where Veterans continue to have their disease issues addressed and to access health promotion and prevention services. The key distinction is that these services are now delivered by clinical teams trained in how to

Figure 1. The Whole Health System



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DIRECTOR'S LETTER



The idea that medicine should focus on the person and not the disease, and on prevention rather than cure, is not new. A quote attributed to both Hippocrates and William Osler notes, “It’s far more important to know what person has the disease than what disease the person has.” Hippocrates sounds downright modern in promoting the importance of diet and exercise

over medical treatments (of course the discovery of penicillin was 2,000 years off). But if you want a picture of modern discontent with the medical establishment, simply examine the Goodreads list of “Books every doctor should read.” More than half the titles are variations on the idea that modern medicine, in particular the pharmaceutical companies and their allies, are making us less healthy. While discontent with modern medicine spans a wide spectrum, a certain set of themes recurs frequently:

- A focus on treating illness has reduced attention to promoting positive health.
- Emphasizing quantifiable metrics of illness (for example, HbA1c) devalues what is truly important to the patient.
- Empowering the patient to take part in their own health is essential.
- Clinicians need to understand each patient’s goals if they want their care to advance those goals (and those goals are never “to improve my HbA1c”).

VA established the Office of Patient Centered Care and Cultural Transformation (OPCC&CT) in January 2011, with a goal of developing and advancing [Whole Health](#) for Veterans. The Office title

itself makes clear two central concepts about Whole Health: that it puts the patient at the center and that it requires a transformation in the culture of healthcare. Because patients were already incorporating non-traditional approaches such as acupuncture into their care, OPCC&CT also has become home to the growing program of complementary and integrative healthcare (CIH) for Veterans.

Thanks to the foresight of Dr. Ranjana Banerjee in HSR&D, and the inspired leadership of Drs. Tracy Gaudet and Ben Kligler (the founding and current Director, respectively, of OPCC&CT) research has been an active partner in this transformational journey since the beginning. This has included partnerships with the [Evidence Synthesis Program](#) to develop evidence maps on a wide range of complementary therapies (search by “complementary”); a State of the Art conference and [journal supplement](#) on non-opioid therapies for pain; partnered [evaluations](#) of the Whole Health flagship sites through the QUERI program; support for the [Pain Management Collaboratory](#) with NIH and DoD; and multiple individual HSR&D [research projects](#). These include studies of [CIH interventions](#), such as mindfulness, massage, acupuncture, and yoga for conditions including pain and PTSD, and also provide more holistic patient-centered approaches like “goals of care” interventions in older Veterans. The growth of the Whole Health program owes a lot to the energy, passion, and vision of its leaders. Those leaders recognized the importance of building the scientific evidence to show how Whole Health will benefit Veterans and VA and how it can grow across a diverse healthcare system. As the articles in this issue make clear, the future for research on Whole Health, CIH, and their role in transforming VA care remains bright.

David Atkins, MD, MPH, Director, HSR&D

ask about what matters to each Veteran, and how to place what matters at the center of the Veteran’s treatment and well-being plan.

Evidence is mounting that the Whole Health approach is working for Veterans. Preliminary outcomes research on a three year Congressionally-mandated demonstration project at 18 “Whole Health flagship” sites around the country has shown this in several ways:⁴

- 31 percent of Veterans with chronic pain at the flagship sites engaged in Whole Health services.
- The average opioid dose among comprehensive Whole Health users decreased 38 percent compared with only an 11 percent decrease among those with no Whole Health use.

- Compared to non-Whole Health users, Veterans who used Whole Health services reported greater improvements in perceived stress – indicating improvements in overall well-being – as well as greater improvements in engagement in life meaning and purpose.

This last finding – an increase on a validated measure of life meaning and purpose (the Life Engagement Test) – is especially important given the ongoing epidemic of Veteran suicide. Loss of purpose in life is a known risk factor for suicide. The Whole Health approach could have a significant role in helping address this epidemic by restoring a sense of purpose to Veterans who have lost it.

Impact of the COVID-19 Pandemic

The COVID-19 pandemic has led to some significant shifts in the Whole Health initiative. The intense workload and pressure experienced by VA staff during the pandemic has underscored the critical importance of caring for VHA staff. For several years we have been developing and supporting an employee Whole Health initiative that encourages VHA staff to adopt healthy behaviors, promotes self-care and well-being, reduces the incidence of preventable illness and injury, and that fosters a culture of employee engagement in order to ensure the best care and improved access for Veterans.⁵ Preliminary research from the Whole Health flagship sites shows that employees who reported involvement with this Whole Health

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What Health Services Researchers Can Do to Inform the Implementation of VA's Whole Health System of Care

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In this month's lead commentary, Dr. Benjamin Kligler has outlined VA's effort to implement the Whole Health (WH) System of Care throughout VA. Such large-scale transformation is highly complex, and the Office of Patient Centered Care and Cultural Transformation (OPCC&CT) has engaged in a wide range of implementation strategies to spread the use of WH throughout VA. Gaining the buy-in of policy makers, VISN leadership, and medical centers requires evidence that investing in this transformation will, in fact, improve the health of Veterans. As VA embraces the core tenets of a learning healthcare system, program offices have sought the expertise of VA's large cadre of expert health services researchers to evaluate these types of initiatives. QUERI Partnered Evaluation Initiatives serve as a critical pathway for developing these partnerships between operations and researchers. Since 2013, our team at the Center for Evaluating Patient Centered Care in VA (EPCC) has partnered with OPCC&CT to evaluate the development and implementation of a healthcare system focused on providing care aligned with what matters most to each individual Veteran.

As Dr. Kligler notes, the aim of this revised system is to provide care aligned with patients' goals, preferences, and priorities, and to partner with patients to achieve well-being. These changes take time. Our team has found that over a three-year period the 18 WH flagship sites made great strides towards implementation, yet only one site reached advanced implementation.¹ Moreover, implementation does not equal cultural transformation, which, as others have argued, takes 7 to 10 years to achieve in an organization. QUERI researchers who have studied the implementation of individual evidence-based practices understand the complexity and need to develop successful strategies to truly change provider and patient behavior. The changes proposed in the WH

system of care are multi-faceted, and thus require more strategies and greater effort to generate change.

It is important to understand the conceptual grounding for how the WH system can in fact improve the well-being of Veterans. In partnership with OPCC&CT, we developed a logic model, in which we posit that a WH approach begins its impact by improving Veterans' experiences of care and in turn, improving their engagement with healthcare services and self-care. The model further posits that the WH approach helps patients reach their own personal health goals and improves patients' sense of well-being in the world. And, yes, such engagement may impact longer term disease-based outcomes. Preliminary analyses of our longitudinal survey of patients receiving WH care during a six-month period demonstrate that exposure to at least two WH services results in more positive perceptions of care and greater engagement in healthcare and self-care.

Yet many questions remain, and health services researchers are well-positioned to address them. While Dr. Kligler notes some preliminary evidence of the impact of exposure to WH services on Veterans with chronic pain, further research is needed to understand how different components of the system of care contribute to improved outcomes, and whether these vary for different populations of Veterans. Moreover, a question remains about whether individual services have greater overall value when delivered within the context of a system of care that fully embraces a WH approach.

The Whole Health Pathway relies, in part, on engaging peers in the delivery of WH. VA has a long history of engaging Peer Support Specialists in mental health and substance abuse services. The use of peers to help Veterans engage in the Whole Health Pathway may be critical to helping Veterans identify what matters most. We have learned that peer

delivery of the "Taking Charge of My Life and Health" program, a curriculum facilitated by peers to help Veterans explore their "mission, aspiration, and purpose" and develop a personal health plan had a positive impact on the Veterans who chose to engage.² Yet establishing these groups and securing patient participation remains challenging. The field pivoted during COVID-19 to offer this program via telehealth, and we have learned from Veterans that there may be great benefits and some drawbacks to participating remotely.

Well-being programs encompass many different types of group and individual programs. Questions remain regarding the use of complementary and integrative health (CIH) services. Utilization data show great engagement in many types of CIH, and our partner QUERI center, the Complementary and Integrative Health Evaluation Center, led by Drs. Stephanie Taylor and Steven Zeliadt, continues to assess the spread and impact of CIH services on Veterans. Questions also remain regarding the impact of these services on different populations of Veterans. Further, WH coaching continues to expand throughout VA. Early studies have demonstrated that WH coaching can lead to improvements in well-being.³ Understanding more about the value and impact of this model of coaching, who should provide coaching, and how coaching impacts different populations of Veterans requires further examination. How does this model compare to other models of health coaching? How does it compare to usual care?

A truly transformed system of care requires that a WH approach become part and parcel of every Veteran interaction at VA. How clinicians embrace a WH approach in their interactions with patients may in fact be at the core of truly transforming the culture of care. As Kligler notes, the integration of the WH approach into primary care and mental healthcare is a primary goal for the next several years. How this occurs, and what implementation strategies are effective in

The VA QUERI Complementary and Integrative Health Evaluation Center (CIHEC)

Guided by the VA Office of Patient Centered Care and Cultural Transformation (OPCC&CT), VA is in the midst of a healthcare transformation, shifting from a disease-oriented healthcare model to one that addresses the whole Veteran. Providing complementary and integrative health (CIH) therapies is an integral part of this Whole Health transformation. Eight CIH therapies are in the standard VA medical benefits package: acupuncture, biofeedback, clinical hypnosis, guided imagery, meditation, Tai Chi/Qigong, therapeutic massage, and yoga (VA considers chiropractic care as allopathic). Veterans often ask for non-pharmacological options, such as CIH therapies, to help manage their health. However, VAMCs often need support implementing CIH therapies. Additionally, relatively novel CIH therapies are emerging for which there is limited evidence of effectiveness.

Since 2016, CIHEC, a QUERI Partnered Evaluation Initiative conducted in collaboration with OPCC&CT, has been addressing these issues by examining the implementation of evidence-based CIH therapies and the effectiveness of novel CIH therapies for Veterans and VA employees. CIHEC includes eight investigators at six sites, who, with OPCC&CT, create a shared agenda to address VA's most pressing evaluation needs. Much of CIHEC's work stems from an earlier project examining the challenges that VA providers face when implementing CIH therapies and the successful strategies they used to overcome those challenges (Taylor, Bolton, Hyunh, et al., 2019). CIHEC's work is in response to and informs Congress of progress made by VA in response to legislation such as the Comprehensive Addiction and Recovery Act, Veteran Mental Health Care Improvement Act, and Whole Veteran Act. CIHEC's projects and dissemination strategies are summarized below.

Studying the Implementation and Provision of CIH Therapies

National Survey of Veteran Interest in, Use of, and Satisfaction with CIH Therapies.

In 2016, CIHEC investigators collaborated with the VHA's Office of Analytics and Performance Integration to conduct the first large-scale survey on Veterans' interest in, use of, and satisfaction with 27 CIH therapies. Capitalizing on VA's Veterans Insight Panel, CIHEC determined Veterans' interest in and use of CIH therapies during a time of major expansion of CIH therapy provision in VA. Results showed over half of Veterans were interested in trying or learning more about six therapies (massage therapy, chiropractic, acupuncture, acupressure, reflexology, and progressive relaxation). In fact, many of these Veterans had used CIH therapies in the past year, and cited pain and stress reduction as the most frequent reasons for using CIH therapies. The majority were unaware of specific CIH therapies available at VA (Taylor, Hoggatt and Kligler, et al., 2019).

The Environmental Scan of CIH Provision at VAMCs Nationally.

CIHEC next conducted the first large-scale survey to determine VAMCs' provision of 27 CIH therapies in 2017-18. For each therapy, the survey asked 17 questions to assess the organization and provision of CIH therapies. Results showed widespread CIH therapy provision, with half the sites offering six or more therapies. Sites reported eight most frequently offered therapies: relaxation techniques, mindfulness, meditation, guided imagery, yoga, Tai Chi, Battlefield Acupuncture, and traditional acupuncture. These sites offered the majority of therapies in Mental Health, Physical Medicine and Rehabilitation Services, Primary Care, Pain clinics, and Integrative Health/Well-Being clinics (Farmer, McGowan, Yuan, et al, 2021).

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Key Points

- The provision and use of complementary and integrative health (CIH) therapies is a key component of VA's Whole Health transformation.
- Eight CIH therapies are included in the VA medical benefits package: acupuncture, biofeedback, clinical hypnosis, guided imagery, meditation, Tai Chi/Qigong, therapeutic massage, and yoga.
- This article provides a summary of CIHEC's projects and dissemination strategies.

CIH Data Nexus. Determining CIH therapy provision on a large scale is difficult because coding can be inconsistent and CPT4 codes are unavailable for some types of therapy. As such, CIHEC created a national cohort of VA healthcare users to determine the prevalence and effectiveness of CIH therapy use, and the demographic and health characteristics of Veteran users. CIHEC investigators routinely extract, clean, and analyze VA EHR and CHOICE community care data nationally. They produce in-depth reports for VA OPCC&CT and the public annually, with the first being the 2020 [Compendium on Use of Complementary and Integrative Health Therapies and Chiropractic Care at the VA](#), found on OPCC&CT's website.

Battlefield Acupuncture Implementation

(BFA). BFA is a rapid protocol-based, auricular (ear) acupuncture therapy developed in 2007 to provide instantaneous pain reduction. It is intended to be delivered alongside other pain treatments and is noted for its ability to be administered with ease by a variety of BFA-trained providers without requiring intensive acupuncture training. Given anecdotal evidence of BFA's effectiveness, VA trained over 2,400 providers to deliver BFA. CIHEC examined both BFA's effectiveness (noted below) and

implementation. To study implementation, investigators conducted interviews with BFA providers to determine their implementation challenges and strategies, and found providers were experiencing eight main implementation challenges, but had several successful strategies to overcome those challenges (Taylor, Giannitrapani, Ackland, et al., 2018).

Improving Patient and Provider Knowledge of CIH Therapies. CIHEC investigators learned from their earlier work on CIH implementation issues that most patients and providers are unfamiliar with many CIH therapies. As such, CIHEC conducted a project to determine the information providers and patients most wanted to learn about CIH therapies and in what format they wanted that information. The aim was to develop provider and patient educational materials to facilitate CIH therapy decision-making processes. Investigators used qualitative and quantitative methods to iteratively pilot-test and revise yoga and meditation education materials. Providers and Veterans were rather consistent in the specific content and format they wanted the materials to have, which differed between providers and Veterans (Taylor, Giannitrapani, Yuan, et al., 2018).

Studying the Effectiveness of CIH Therapies

Evidence Maps. As thousands of studies have been conducted on CIH therapies for many health conditions, it can be difficult to quickly grasp the state of the science for particular therapies. As such, CIHEC investigators partnered with the VA Evidence Synthesis Program to produce several “evidence maps,” which are visual depictions of the effectiveness, quality, and size of the scientific literature. These include evidence maps of

acupuncture, mindfulness, Tai Chi, and CIH for pain and are on [OPCC&CT’s website](#).

The Effectiveness of Battlefield Acupuncture for Pain. CIHEC investigators conducted four examinations of BFA effectiveness, one qualitative and three quantitative (Taylor, Giannitrapani, Ackland, et al., 2021). The first used interviews with BFA providers on their perceptions of BFA effectiveness (Giannitrapani, Ackland, Holliday, et al., 2020). They reported that BFA provided temporary pain reduction for many patients, and that pain relief subsequently led to increased provider-patient trust and communication, and increased patients’ willingness to try other “alternative” therapies for their pain. The first of three quantitative examinations of BFA effectiveness focused on a large BFA clinic (Federman, Thomas, Carbone, et al., 2018). Results showed that pain decreases were common in both group and individual settings. The second examination was among 11,431 Veterans receiving BFA at 57 VAMCs and showed that pain scores decreased 2.1 points (0-10 scale) (Zeliadt, Thomas, Olson, et al., 2020). The third used that same large sample and examined whether use of BFA led to use of traditional acupuncture, which can have a more long-lasting effect. Results showed it did lead to an increase in the use of traditional acupuncture (Thomas, Zeliadt, Coggeshall, et al., 2020).

National Tele-Whole Health Evaluation. In collaboration with the Evaluation of Patient-Centered Care QUERI PEI (PI: Bokhour), CIHEC is conducting a mixed-methods, large-scale evaluation of the effectiveness and implementation of tele-Whole Health, of which CIH therapies are a part.

Dissemination Strategies

CIHEC developed and manages three national CIH dissemination mechanisms that enable VA clinicians, researchers, and staff to keep abreast of research being conducted on Veterans and CIH therapies, and to foster CIH collaborations and future research. The strategies are listed below, and the documents are available on [OPCC&CT’s website](#).

Library of Research Articles on Veterans and Complementary and Integrative Health Therapies and Chiropractic Care.

CIHEC created and now maintains a publicly available, electronic [library](#) of peer-reviewed scientific papers. Updated annually, the library includes 27 CIH therapies and 9 key clinical and implementation outcomes.

Registry of Current Research on Veterans and Complementary and Integrative Health Therapies and Chiropractic Care.

CIHEC created and maintains a [registry](#) of the VA-, NIH- and DoD-funded research being conducted as of 2016 among Veterans and CIH therapies. Updated biannually, the registry focuses on eight CIH therapies and six health conditions, and contains information on the PI, PI institution, project title, and funding amount.

HSR&D CIH Cyberseminars. CIHEC developed and manages this successful bi-monthly cyberseminar series for researchers from inside and outside VA to present their latest effectiveness and implementation CIH therapy research to providers, leaders and researchers across VA. OPCC&CT leadership attends each cyberseminar, providing VA program and policy information related to the presentation. Contact cyberseminars@va.gov to sign up for CIH cyberseminars.

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integrating WH concepts into current practice patterns still need to be considered. HSR&D researchers who study how to change provider behavior have lots to contribute to this effort. Moreover, to truly transform a system, this approach to care must be delivered throughout the care system, including specialty care services. It remains unclear how WH can and should be integrated into specialty care services.

VA has begun to embrace WH for employees as an important pathway to improving the well-being of our workforce. We recognize employee well-being as an important area for research to understand how facilities engage with employee WH efforts, and how this impacts employees and the Veterans they serve. Questions regarding WH are now included in the All Employee Survey; additional approaches to

assessing implementation of, and engagement in, WH for employees are needed.

Finally, if HSR&D researchers are to embrace the goal of WH to improve the health and well-being of Veterans, we must embrace metrics that reflect that goal. Designing studies with outcomes that are purely disease-based results in a more fragmented system of care for

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Findings from the COACH Trial: Implications for an Expanded Role for VA Whole Health Coaches and Peer Specialists

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With the introduction of VA Whole Health Coaching and Veteran Peer Specialists, more Veterans are receiving coaching and peer support for behavioral (e.g., weight) and mental health concerns. Many Whole Health Coaches and Veteran Peer Specialists (“peers”) in VA are trained in Motivational Interviewing (MI), an evidence-based, affirming, and patient-centered approach for facilitating behavior change. Whole Health Coaches and peers use MI-informed communication (or Motivational Coaching) and the VA Whole Health Model to help Veterans explore their values, develop personal health plans, and make progress toward personal health goals.

Both Whole Health Coaches and peers work to cultivate warm, supportive, non-hierarchical relationships with their Veteran patients, which may come naturally to peers who share experiences with other Veterans and who “speak the same language.” With the broad promotion and dissemination of Whole Health and peer coaching within VA, questions arise about which Veterans are best served by coaches and peers and how health coaching can bridge Veterans’ access to VA mental health services, including suicide prevention, particularly among rural Veterans.

Rural Veterans experience significantly worse mental health outcomes and are 65 percent more likely to die by suicide than their urban counterparts, yet only 20 percent of rural Veterans engage in mental health treatment. Low mental health engagement among rural Veterans has been attributed to poor access, including stigma and stoicism,

with rural Veterans preferring to address mental health conditions within families, religious communities, and with their peers. Thus, among rural Veterans, non-clinician peer coaches may be effective in facilitating engagement in mental health care because they have rural Veterans’ trust as insiders rather than outside experts.

COACH [CRE 12-083; Seal, PI] was a randomized controlled trial funded by HSR&D that sought to determine the effectiveness of Veteran peer-delivered telephone motivational coaching to improve mental health treatment engagement among rural Veterans, and secondarily to assess change in rural Veterans’ mental health symptoms.¹ At the start of the COACH trial, we assessed Veteran participants not engaged in mental health treatment, and enrolled those who screened positive for one or more mental health conditions (e.g., depression, post-traumatic stress disorder, anxiety, substance use disorders) in COACH. A peer coach then provided them with feedback about their mental health screen results and a referral to one or more mental health services. Thereafter, we randomized participants to receive the control condition (no further follow-up with the peer coach) or the intervention: four sessions of peer-delivered telephone motivational coaching. We found that among the 272 Veterans who screened positive for a mental health condition and received feedback and a referral, 45 percent of those receiving peer telephone motivational coaching versus 46 percent of controls initiated mental health treatment, indicating no between-group difference. However, compared to controls, Veterans receiving peer motivational coaching achieved significantly greater improvements in the study’s secondary outcomes including improvements in depression, post-traumatic stress disorder, and cannabis use symptom scores; quality of life domains; and initiation of self-care strategies.

Key Points

- VA’s Whole Health Coaches and Veteran Peer Specialists assist Veterans in developing their personal health plans and making progress toward their health goals.
- This article examines the COACH trial that found Veterans who received peer motivational coaching achieved greater improvements in outcomes such as improvements in depression, post-traumatic stress disorder, and cannabis use symptom scores; quality of life domains; and initiation of self-care strategies.
- The effectiveness of these approaches suggests the need for further research that explores the feasibility, effectiveness, and costs of an expanded therapeutic role for Whole Health Coaches and peers embedded in VA clinical services.

Although COACH demonstrated no difference in treatment engagement between the intervention and control groups, Veterans in both study arms had twice the rate of mental health treatment engagement (> 40 percent) observed in other rural Veteran populations (20 percent), pointing to the potential role of mental health assessment, feedback, and referral (in this case, by a Veteran peer) as a key contributor to improved treatment engagement. This finding replicates prior studies showing that assessment and feedback about mental health symptoms, in itself, can prompt engagement in mental health treatment. That this could be done effectively by a Veteran peer was a novel finding.

It is also notable that Veterans assigned to Veteran peer coaching had modest but significant improvements in mental health symptoms, quality of life, and initiation of a variety of self-care strategies to reduce stress (e.g., walking, gardening). In qualitative exit interviews, Veterans named several benefits of peer motivational coaching, including peers’ help with

“When she opened up that she was a Veteran... I let my guard down a lot more. It gave me more freedom to express myself and actually talk.”

– COACH Trial Participant

problem-solving, providing community or web-based mental health resources, and providing encouragement and accountability to meet personal goals. Participants also reported that Veteran peers asked and cared about them and seemed less judgmental than the mental health professionals they had encountered in the past.

During the COACH trial, researchers measured peer coaches' fidelity to MI using the Motivational Interviewing Treatment Integrity scale (MITI). While overall fidelity to MI was rated as "fair," Veteran peers scored highest on "partnership," perhaps because of the collaborative and non-hierarchical relationship between the Veteran peers and participants. For example, one participant reported, "*To me it was actually kind of therapeutic to talk to someone about it all. Just having that person*

available to talk to, to learn stuff, someone who is able to talk to you as real person... Just kind of, relaxing – no judgment, no biases, to me it was really calming."

As is well known, one of the greatest drivers of mental health treatment engagement is having more severe mental health symptoms; and hence, a greater perceived need to seek treatment. Veterans who received peer motivational coaching that resulted in reductions in their mental health symptoms may have perceived the peer coaching itself to be therapeutic, thus reducing perceived need for clinician-directed mental health treatment. One COACH participant described the Veteran peer coach as helping them, "*catch [the problem] quickly, without it getting so out of hand that I have to call somebody for mental health. That was – to me – the highlight of all this."*

Other recent small studies have demonstrated the effectiveness of Whole Health coaching to improve Veterans' psychological well-being, mental health symptoms (depression, PTSD, perceived stress, and anxiety), and perceived health competency, which, in turn, has been shown to be protective for suicidality.^{2,3} As with the COACH trial, in these studies qualitative interviews found high levels of satisfaction with the coach-Veteran relationship and many participants thought of their coach as providing a therapeutic intervention that, in itself, improved their mental health. Participants suggested that Whole Health Coaching could be an option for Veterans who are struggling with stress and mood concerns but are not willing or ready to engage in formal treatment. Multiple participants explicitly noted that coaching

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initiative also reported their facility as a 'best place to work', and experienced lower voluntary turnover, lower burnout, and greater motivation. A VHA-wide expansion of the employee Whole Health initiative is a high priority in the next two years.

A second major COVID-19 related shift was the rapid pivot in delivery of Whole Health from in-person settings to virtual. Total Tele-Whole Health visits grew from 12,058 visits by 3,679 unique Veterans in FY19 to 309,553 visits by 58,353 Veterans through the third quarter of FY21. VHA's ability to deliver Whole Health services virtually was an unexpected development, as has been the extremely positive feedback from Veterans who are now able to access services like Whole Health coaching, Tai Chi, and meditation from the comfort of their homes. In response, many VISNs have built Whole Health services into their Clinical Resource Hubs in order to increase VISN-wide access. We anticipate continued rapid growth in the use of virtual technologies to deliver Whole Health services to Veterans.

What's Next for Whole Health?

With the flagship demonstration project now completed, VHA will focus next on a national

initiative to fully integrate the Whole Health approach into primary care and mental health settings across VHA over the next three years. This initiative is being driven by the Modernization Lane of Effort "Transforming Healthcare Delivery," and is supported by the offices of Primary Care, Mental Health and Suicide Prevention, and Patient Centered Care & Cultural Transformation. The goal of this initiative is to ensure that every Veteran will walk away from each and every primary care or mental health visit feeling that the team knows what matters most to them in their life, and that the plan for treatment and well-being was informed by that knowledge. We are seeking to move beyond an exclusively disease and treatment-oriented model to one that is truly Veteran-centered. VHA is implementing this initiative at the 18 flagship sites, and will implement this approach at every VAMC over the course of two subsequent waves.

Another important focus for the coming year is developing a strategy for measuring well-being as part of routine clinical care. Working with HSR&D colleagues, we are piloting a brief measure of well-being that can be incorporated into routine care to provide a tool to assess the impact of Whole Health and

other interventions on overall Veteran well-being. As part of this effort, VHA co-sponsored a virtual meeting with colleagues from the National Center for Complementary and Integrative Health at NIH to begin discussions regarding the best strategies for measuring well-being in both clinical and research settings. Our belief is that developing and implementing simple ways for clinicians to ask about and measure well-being will help facilitate VHA's "cultural transformation" towards Whole Health.

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Evidence for Trauma Sensitive Yoga as a Treatment for PTSD Related to Military Sexual Trauma in Women Veterans: Findings from a 5-year RCT

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Current first-line treatments for PTSD are trauma-focused psychotherapies, specifically prolonged exposure (PE) and cognitive processing therapy (CPT). These therapies have the highest quality evidence for effectiveness, and VA has conducted robust national rollouts of these treatments. However, dropout rates in clinical practice and research are high. As many as one-half do not achieve clinically meaningful improvement, and more than half of those who complete these treatments continue to meet the criteria for PTSD.¹ Additionally, well-established barriers to PTSD-treatment seeking among military sexual trauma (MST) survivors (e.g., stigma, institutional betrayal, avoidance of trauma cues) inhibit initial treatment seeking and engagement in these therapies. The need for additional evidence-based treatment options is well recognized. The goal of this study was to address this need for treatment options and barriers to care by investigating a non-trauma-focused, complementary and integrative health (CIH) treatment option for women Veterans with PTSD related to MST.

Yoga is widely used in VA and by Veterans in the community for wellness and for clinical conditions and symptoms, including PTSD treatment. In our recent HSR&D-funded study, we sought to determine if yoga, specifically Trauma Center Trauma Sensitive Yoga (TCTSY), could provide similar outcomes to the current gold standard treatment, CPT, for women Veterans with PTSD related to MST. TCTSY was developed specifically for civilian women with chronic PTSD who were survivors of complex trauma, specifically childhood sexual trauma. TCTSY, a Hatha style yoga, focuses on interoception, i.e., the sense of the physiological condition of the body, and addresses themes related to establishing safety, individual choice, being present, and taking effective action.² TCTSY is a therapeutic intervention for PTSD symptoms and differs from the use of yoga for overall health and well-being, relaxation,

or other clinically non-specific purposes. Unlike cognitively-based trauma focused psychotherapies, i.e., PE and CPT, TCTSY is an embodied non-trauma focused PTSD treatment. It is based on trauma theory, attachment theory, and neuroscience.

We conducted a five-year randomized controlled trial at the main study site, the Atlanta VAHCS, prior to the COVID-19 pandemic-related shutdowns. We added the VA Portland HCS (Belle Zaccari, PhD, Site PI) in 2020 and conducted all research procedures and intervention sessions virtually due to COVID-19 related restrictions. This report includes only the Atlanta results, where we enrolled 152 women Veterans with PTSD related to MST who were VA users, and retained 103 for the intent to treat analytic sample. The majority of enrolled Veterans were African American (90 percent) – a rarity in yoga studies – and their mean age was 48.4 years. TCTSY-certified facilitators and VA clinicians certified in CPT conducted the interventions in weekly group sessions. We used the *Clinician Administered PTSD Scale-5 (CAPS-5)* and the *PTSD Checklist for DSM-V (PCL-5)* to assess current PTSD diagnosis and symptom severity, including overall PTSD and four symptom clusters. Participants completed up to four assessments, from baseline through three months post-intervention. In addition to PTSD symptoms, we assessed commonly associated symptoms (e.g., depression, chronic pain), functioning and quality of life, as well as outcomes related to potential mechanisms of action of yoga, including cytokines and heart rate variability. Analysis of these outcomes is underway, as is the analysis of the outcomes for the Portland site, which will enable us to compare outcomes between face-to-face versus virtual delivery.

PTSD Outcomes

The findings reported here are interim results from the Atlanta site. Study dropout after randomization and prior to the first

Key Points

- Additional evidence-based treatment options for military sexual trauma survivors are needed.
- The article discusses a study that examined a non-trauma-focused, complementary and integrative health treatment option for women Veterans with PTSD related to military sexual trauma.
- Trauma sensitive yoga was found to be both a viable and effective PTSD treatment option for women Veterans with military sexual trauma-related PTSD.

intervention session was higher in the CPT group (20 percent) than in TCTSY (10 percent). Both groups had clinically meaningful decreases (≥ 10 points) in total PTSD symptom severity and all four symptom clusters (criterion scores) on the CAPS-5 and PCL-5 over time in all five multilevel linear models without significant differences between groups.³ Effect sizes for total symptom severity were large for TCTSY and CPT. The TCTSY symptom trajectory of earlier (mid-intervention) and continuous symptom improvement differed from the CPT trajectory, in which symptoms did not significantly improve until two weeks post-intervention. Treatment completion was higher in TCTSY (60 percent; $\geq 7/10$ sessions) than in CPT (38 percent; $\geq 8/12$ sessions).

Discussion

TCTSY performed equivalently to a current gold-standard treatment, CPT (one modality was no better or worse than the other), supporting TCTSY as an additional evidence-based treatment option for PTSD, specifically for women Veterans with PTSD related to MST. These study results are highly relevant to clinical care and health services delivery and research.

Clinical care: TCTSY is not only a viable and effective PTSD treatment option for

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women Veterans with MST-related PTSD, but also likely could serve as an intervention to increase patient engagement and retention in PTSD treatment, an ongoing challenge in VA. The TCTSY results in the predominantly African American sample in this study broaden the applicability of the findings to an understudied population.

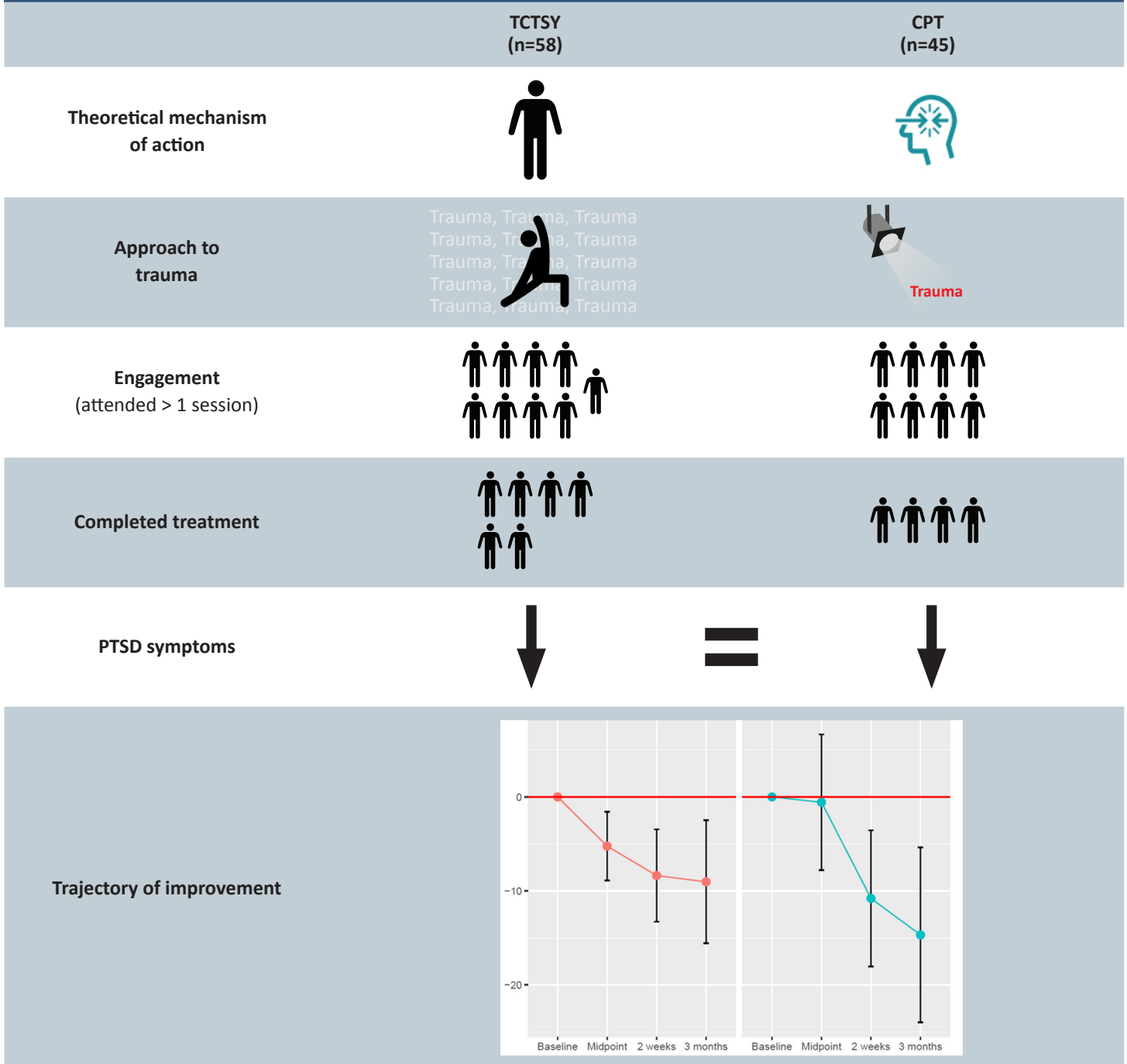
Health services delivery: TCTSY is less costly, easier to deliver, lacks the barriers posed by trauma-focused psychotherapy, and is scalable.

Health services research: The next step in establishing TCTSY as an evidence-based nationally available VA PTSD treatment option would be a multi-site implementation science study to evaluate the feasibility of TCTSY implementation in a variety of VA settings, patient engagement, intervention fidelity, treatment completion, and clinical outcomes. Additional studies to investigate TCTSY as a precursor or adjunct to current PTSD psychotherapies are warranted.

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RCT of Trauma Sensitive Yoga v. CPT for PTSD: Comparison of Interventions and Results



Harnessing the Power of Social Relationships to Support Weight Management: A Pilot Study of a Brief, Virtual, Dyadic Intervention for Veterans and Support Persons

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More than 80 percent of VA patients have a body mass index (BMI) >25, which contributes to cardiovascular disease, diabetes, and mortality. Since 2006, VA has offered the MOVE! Weight Management Program, an evidence-based comprehensive lifestyle intervention targeting clinically meaningful weight loss of at least 5 percent, delivered in individual or group formats through in-person or virtual modalities. MOVE! assists Veterans in engaging in healthy eating, being physically active, and developing behavior change skills – like setting goals and monitoring progress – to support even small weight losses. Although lifestyle interventions like MOVE! are effective in the short-term for achieving clinically meaningful weight loss among individuals who participate regularly over several months, few achieve this level of engagement and most regain weight within five years.¹ Therefore, we need additional strategies to help patients make sustainable health behavior changes.

Social Relationships Affect Health Behaviors and Outcomes

Evidence indicates that a person's health behaviors, such as eating habits, engaging in physical activity, consuming alcohol, and smoking, are strongly linked to the behaviors of their partners, family, friends, and coworkers.² Furthermore, changes in the health behaviors of one person increase the chances that someone close to them will also adopt those new behaviors, whether healthy or unhealthy. Participation in behavioral weight loss treatment can prompt these kinds of ripple effects, with research showing untreated spouses of participants experience improvements in eating behaviors, physical activity, and weight despite not receiving the same treatment. Together, this evidence suggests that to be optimally effective, interventions aiming to modify health behaviors should address change not just in

the individual, but also leverage close social contacts to support those changes. However, few behavioral weight loss interventions focus on the communities or close social relationships of the person trying to change their health behaviors and lose weight.

Interventions that intentionally include a support person (e.g., spouse/partner, family, friend) may be one way to leverage social relationships to facilitate and sustain behaviors related to weight loss more effectively. Although evidence suggests this approach may be effective for chronic disease self-management, few studies have investigated dyadic interventions for weight management.³ Two ways in which dyadic interventions can be especially helpful are: 1) capitalizing on (and making explicit) beneficial support behaviors; and 2) intervening on unhelpful behaviors enacted by close others. Addressing unhelpful behaviors, like control, criticism, or enabling, is necessary, because these behaviors can imperil attempts at health changes. Additionally, helpful and harmful behaviors are both often found within the same relationship. Dyadic approaches therefore need to not only provide weight management education to participants and their supporters, but also provide tools to enhance communication and collaboration to meet the specific support needs of the dyad.

Approaches that simultaneously address health behaviors and social relationships are consistent with VA's Whole Health approach to Veteran care. Indeed, relationships are a core component of Whole Health's Circle of Health, yet dyadic or family interventions for weight management are not yet a standard component of VA's offerings.

Together2Lose Pilot Study

To address this gap, our research team developed Together2Lose (T2L), a brief,

Key Points

- More than 80 percent of VA patients are overweight – a risk factor that contributes to cardiovascular disease, diabetes, and mortality.
- While lifestyle interventions are helpful, additional strategies are needed to help Veterans achieve sustainable health behavior changes.
- The authors share findings from a pilot study of a brief, virtual, dyadic intervention among Veterans and a support person designed to enhance support for health behavior change and weight loss.

virtual, dyadic intervention among Veterans and a support person ("partner") of their choosing to enhance support for health behavior change and weight loss. We conducted a mixed-methods pilot study to evaluate the feasibility and acceptability of T2L among Veterans and their partners. The main eligibility criteria for Veterans included a BMI >30kg/m² or BMI >25kg/m² and an obesity-related condition (e.g., diabetes, cardiovascular disease), an eligible and willing cohabitating partner (e.g., spouse/partner, family, friend), and access to an Internet-enabled device with a web camera. Three doctoral-level psychology trainees delivered the four structured sessions through VA Video Connect and two brief check-ins via phone to each dyad individually over an 8-week period. Session content included education on health behavior change adapted from MOVE! and training and practice in communication skills applied to making health changes. Specifically, dyads were coached on evidence-based communication strategies, drawn from partner-assisted therapies that help with

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effective problem-solving and self-disclosure. Each week, study clinicians led dyads through health behavior change and communication skills and assisted Veterans in setting behavioral goals and developing a support plan for those goals in collaboration with their partner.

We measured primary feasibility and acceptability outcomes qualitatively through post-intervention interviews with Veterans and partners separately, and quantitatively through measures of participant satisfaction, recruitment, and retention. Veterans participated in virtual weight checks over VA Video Connect with study staff using a study-provided scale at baseline, 8 weeks, and 16 weeks to preliminarily examine weight change as a secondary effectiveness outcome. Veterans and partners also completed web-based surveys at these timepoints, which included additional secondary effectiveness outcomes (e.g., health behaviors and social support for health behaviors).

Preliminary Results

Fifty-one Veterans who we contacted by mail opted out of the study, 35 of whom selected a reason for non-participation consistent with ineligibility (e.g., lived alone). We assessed 279 Veterans for eligibility over the phone, of whom 112 were ineligible and 155 declined. We enrolled 12 dyads in the

intervention, including 8 women and 4 men. Nine dyads were romantic partners (including one same-sex couple) and three included a Veteran parent and adult child. One dyad disenrolled from the study before receiving their first intervention session; remaining dyads completed all intervention sessions and 8-week surveys and weight checks. Data collection is ongoing for 16-week outcomes.

During post-intervention qualitative interviews, both Veterans and partners expressed high satisfaction with T2L. They appreciated the flexibility of a virtual intervention and experienced few technological challenges. They found content on healthy eating and how to effectively communicate with each other regarding healthy eating most beneficial. Veterans, as well as their partners, reported changes in their health behaviors, especially healthy eating. Importantly, they described improvements in communication that helped support these changes and also applied these communication skills to other relationships. Even dyads who were perceived as having good communication at baseline identified benefits of this brief intervention. Several participants described a desire for additional tailoring of weight management education to their level of knowledge and their individual barriers to making health behavior changes, such as mental health symptoms.

Future Directions

Our preliminary results demonstrate that it is feasible and acceptable to integrate support persons into behavior change programs and interventions at VA. Remote delivery of such programs may reduce some barriers to participation and enhance feasibility of dyadic interventions, addressing a common concern with dyadic approaches. Although efficacy trials are needed, even brief interventions like T2L may effectively incorporate support persons to help facilitate and sustain behavior change among Veterans, as well as their loved ones. Similar strategies could be considered for other health conditions necessitating difficult and long-lasting lifestyle changes, such as cardiovascular disease, diabetes, chronic pain, and mental health conditions. Our team is pursuing opportunities to extend this work to developing and evaluating dyadic interventions for other conditions affecting the health and well-being of Veterans in service of a Whole Health approach to Veteran-centered care.

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focuses more on strengths than problems and does not carry the stigma of mental health treatment; thus, Whole Health or peer coaching may be a more attractive option for Veterans who are reluctant to pursue formal mental health treatment.

Currently, the Office of Patient-Centered Care and Cultural Transformation is partnering with VA Primary Care Operations and the Office of Mental Health and Suicide Prevention to explore better integrating coaches within healthcare teams in an effort to improve patient-centered

care. Such integration would potentially better meet patients where they are, and strengthen referral pathways between coaching and VA's primary care and mental health services. Thus, there is a real-time, practical need for further health services and implementation research that explores the feasibility, effectiveness, and costs of an expanded therapeutic role for Whole Health Coaches and peers embedded in VA clinical services.

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Innovation Update

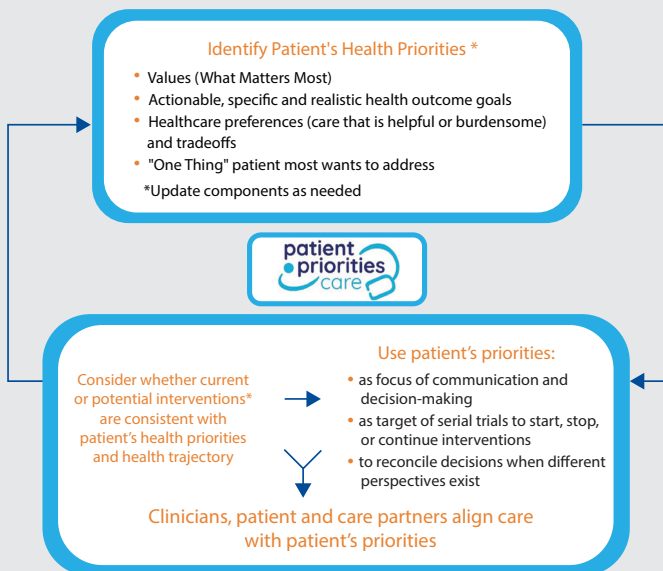
Aligning Care with What Matters Most to Veterans with Multiple Chronic Conditions

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As Veterans age, they confront an increasing number and complexity of chronic conditions and disabilities. Nearly two-thirds of older adults live with multiple chronic conditions (MCC). The current approach to managing MCC, based on adherence to single-disease clinical practice guidelines, fails to provide optimal care. Veterans with MCCs face increased risks of adverse outcomes with the application of multiple single-illness guidelines, including guidelines for drug-drug and drug-disease interactions and the harms of polypharmacy. Treatment decisions fail to focus on outcomes most important to Veterans, including living independently in one's home and engaging in meaningful social relationships. Further, patients, caregivers, and clinicians endure the workload of multiple disease guidelines, particularly when this burden does not align with patients' goals. As Ken Rockwood eloquently stated, "the speciousness of the 'my-problem-list is longer than yours' approach is betrayed by the need to do something with the problems so identified."¹ The situation demands a paradigm shift in decision-making that results in provision of the appropriate amount of care to achieve what matters most for patients and their families.

Consistent with the priorities of VACO Geriatrics and Extended Care and VA Whole Health, Patient Priorities Care cultivates personalized, patient-centered care whereby clinicians recommend the care that achieves the priorities of Veterans with MCC. Patient Priorities Care is an approach that aligns treatment decisions with patients' health priorities rather than disease guidelines. PPC (see Figure) is a structured process whereby a facilitator first guides patients to identify their priorities: a) values (what matters most), b) specific, actionable, realistic health outcome goals, c) healthcare preferences (what patients are willing and able to do or receive), and d) the 'one thing' that the Veteran most wants to

address to achieve what matters. Then clinicians determine if current care is consistent with the patient's identified health priorities and trajectory. Clinicians can use the patient's health priorities as a focus for communication with the patient, as the goal for serial trials to start, stop, or continue interventions, and to reconcile differing recommendations and clinical tradeoffs. The PPC approach significantly reduces treatment burden, encourages deprescribing and the use of home and community services that align with patients' priorities compared with usual care.^{2,3} The PPC approach is a recognized Whole Health clinical care practice. We are currently conducting a randomized clinical trial of the PPC approach in VA primary care at the Michael E. DeBakey and West Haven VA medical centers. Patient Priorities Care is a feasible and innovative approach to care that achieves what matters most for Veterans with chronic conditions.



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Veterans. Thus, researchers should consider well-being as a primary outcome for the interventions they study. Measuring patient-reported outcomes in the course of clinical care is also a fruitful area for research, as is the feasibility of doing so with VA's new EHR.

In sum, VA's Whole Health System of Care implementation could be truly transformative for the health and well-being of Veterans. It is incumbent on health services researchers to critically examine WH's implementation and its associated outcomes to inform VA's investment in this expansive effort.

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