Cyberseminar Transcript

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Session: The CIHEC Environmental Scan of CIH Services in VA

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Dr. Stephanie L. Taylor: Good morning, everybody. Thank you for joining in. I’d like to welcome you to the second in our new HSR&D Cyberseminar Series on Complementary and Integrative Health. We are super excited. HSR&D and CIDER has granted this forum to present some really exciting work going on across the nation.

I am pleased today that we are going to be presenting one of our most exciting projects, the Environmental Scan, which is a survey of all VA Medical Centers on the details of the provision of Complementary and Integrative Health. I am also really excited that we have a special VACO guest today, Dr. Ben Kligler. He is--and Ben, I hope to get the title right--he is the director, I think you’re the director of the Integrative Health Coordinating Center, which is in the VA Office of Patient Centered Care and Cultural Transformation. And we partner with Ben and his office on the work that we are going to be presenting today, which is why he so graciously agreed to come in and say a few words. So he is going to say a few words first, and then I am going to just give you a couple of slides on our work with him and his office, under our partnered evaluation center, which is called the Complementary and Integrative Health Evaluation Center, under which this Environmental Scan project that we are presenting today is housed.

So with that, I will turn it over to Ben, Dr. Kligler, to say a few words.

Dr. Ben Kligler: Oh, great. Thank you, Stephanie. And hello, everybody. And yes, you got my title right, great work. So what I wanted to do was just very briefly kind of cover the national landscape in which this Environmental Scan took place and is taking place. Some of you all may know a lot of this already, but I just kind of wanted to put it in context.

So basically, in May of 2017, a policy directive was signed off by the Under Secretary, which mandated that the evidenced-based complementary integrative health approaches be included as part of standard medical benefits for Veterans, where appropriate. And that was a really kind of game-changing event for those of us who are involved with Complementary and Integrative Health and Whole Health, and has led us down the road of lots of work developing infrastructure, clinical models, and evaluation strategies for the deployment of these Complementary Integrative Health therapies in the field.

The decision-making about what constitutes adequate evidence to put something in this category is made by a group by the Integrative Health Coordinating Center Advisory Group, which is made up leadership from a large number of VACO Program Officers and field leadership as well, and we basically look at the literature for each CIH approach as it comes along and decide whether it passes the bar that has been established for deployment in VA.

So there are currently eight plus one Complementary and Integrative Health approaches being offered. I will tell you why it is eight plus one. The eight are: acupuncture, massage, tai chi, yoga, meditation, biofeedback, hypnotherapy, and guided imagery. So those are all part of what we call List One of required CIH approaches. Chiropractic would fit in the same category, except that chiropractic has already been sort of mandated at the mainstream care in VA, based on a Congressional legislation from 2005. So chiropractic fits under that umbrella from a sort of clinical and therapeutic sort of view, but chiropractic is run from a national office that is in rehab. So we work very closely together, but it is not kind of part of our umbrella.

A second development that spurred this forward is the CARA Legislation, the Comprehensive Addiction and Recovery Act which passed in July of 2016, and it specifically mandated an expansion of delivery of Complementary and Integrative Health services to Veterans with a particular emphasis on pain and mental health conditions. So that was a Congressional mandate that came along more or less in parallel to this VA policy mandate, and that has provided a lot of momentum, I think, around the field and it has taken hold, people understanding why this is happening, etcetera, etcetera. Obviously, a lot of other factors are contributing to this major sort of step forward in the integration of these things; the opioid epidemic clearly is a major factor in that everyone is hungry for options for treatment of pain that do not require medications. Demand from Veterans is very high. Input from Congress is quite frequent. Lots of Congresspeople who feel very strongly that the integrative therapies should be part of what is offered to Veterans. So basically a lot of factors contributing to moving this forward in the VA.

An additional major factor is the Whole Health movement. Whole Health is this concept that has now got a lot of momentum in the VA. Complementary Integrative Health approaches are part of Whole Health, but Whole Health is bigger, in the sense that Whole Health is really a total re-thinking of where the major priorities in the care of the Veteran originate, meaning they now should originate from what is most important to the Veteran and what matters to the Veteran. And in the service of that, the CIH approaches are part of the toolbox and are particularly part of the toolbox for self-management, self-care, things like yoga, tai chi, and meditation. So as the Whole Health approach spreads across the country, and this has a lot of support from VA leadership, that is another kind of vehicle through which the Complementary Integrative Health approaches are really able to be deployed quite widely.

So that is kind of the background, and then I just wanted to say a word about the Environmental Scan. It has been a great project, a very labor intensive project, and what I want to point out is that we are going to be, from my office, gathering and reporting on data about the utilization of Complementary and Integrative Health across the VA, and the Environmental Scan is definitely one of the tools we are going to be using. We have other data sources as well, in that we are able to pull from the Corporate Data Warehouse and other databases, looking at utilization. So as we know, the sort of self-reporting from the field is a powerful tool but also a tool that can potentially have gaps. And so as we report out to the field about where we are with the deployment of Complementary Integrative Health, we are going to be integrating the data from this Environmental Scan with data that we have from coding and tracking and utilization databases. So we are looking forward to putting that all together over the next couple of months so that field leadership knows where they are in relationship to the policy directors.

So I think that is all I wanted to say, Stephanie, so I will hand it back over to you, and I look forward to hearing the presentation.

Dr. Stephanie L. Taylor: Thanks, Ben. That was really helpful. Nice framing of the situation. There is a lot going on, and this really is a super exciting time for Integrative Health and for the VA.

So I am going to switch now to just give you a couple of slides on the Partnered Evaluation Center that I mentioned earlier, that we have with Ben and his office at the VA Office of Patient-Centered Care and Cultural Transformation. We call it CIHEC, the Complementary Integrative Health Evaluation Center, and let's see, how do I forward my slides, Rob? I am sort of lost.

Rob: Stephanie, you may want to put your slides into slideshow mode, but click inside the slide and then you will be able to forward them.

Dr. Stephanie L. Taylor: There we go. Okay. There we go. Thank you. I like the way you hold my hand all the time. So our CIHEC, our evaluation center, Rani Elwy and I are the directors, and we have several incredible investigators who are involved with this all over the nation and our primary partner, as already mentioned, is VA OPCC&CT.

In the last two years, we conducted four projects for them. The first is what Melissa and I, and Anita Yuan and Mike McGowan worked on. It’s called the Environmental Scan. Melissa is presenting it today. But we also conducted four other projects, as you can see up here. And we presented these, I believe, in previous Cyberseminars. We have a Cyberseminar in the Pain Series coming up where we present our work, project number three on that screen, Battlefield Acupuncture, its implementation and effectiveness. I think that is coming up in early February.

Then moving forward, as Ben alluded to, his office has got to report to Congress and other very key stakeholders on the state of CIH implementation, so we are moving forward with his office to conduct two major activities. The first is to do a deep dive in the Corporate Data Warehouse to look at existing data on Integrative Health utilization. And then outside in the CHOICE data, that effort is being led by Steve Zeliadt in Seattle, and he’s got a host of people there working on that, frantically. Not frantically, but intensely. And then the second part of this picture, so that first part was CIH Utilization. What Melissa is going to be presenting today is CIH Provision, right? What is being offered in the facilities, and there is a team there that has been working on it. And I believe that is it. I just wanted to make sure that everybody knew that there is a lot of very exciting work that we are doing in service to help Ben’s office. And with that, I will turn it over to Melissa.

Dr. Melissa M. Farmer: Thank you. Thank you, Stephanie. I am Melissa Farmer. And thank you, Ben, also for setting this up so nicely for us. Can everybody see my slides? Rob, am I okay?

Rob: You are perfect.

Dr. Melissa M. Farmer: Fantastic. Thank you so much. So it is my pleasure today to present you the results from our national organizational survey, the CIHEC Environmental Scan of Complementary and Integrative Health Approaches in the VA.

First, I would like to acknowledge the project team as well as our partners in the funding.

With the national attention on the importance of Complementary Integrative Health, or CIH, approaches for non-pharmacologic treatment and prevention, the VA has responded by increasing the approaches available to the Veterans. So the objective of our survey was to assess what CIH approaches are available to our Veterans. Specifically, we wanted to examine the degree to which the approaches are implemented nationally, and highlight some of those implementation barriers and challenges that the sites are facing.

With this rapid expansion of CIH at the VA though, conducting a national survey was not straightforward. The most important question in any survey is, “Who do you survey?” So we needed to identify those leading the CIH efforts at the individual sites, but there was no national point of contact list of all the leaders. So our first task was to develop that list.

So how did we do it? We went on to VA national calls asking for leadership information. We worked with the CIH field implementation team liaison, asking about leadership and having them help us identify the leaders at the individual sites. We also worked with the VISN leads in CIH. We posted on the national CIH Listserv, asking for people to contact us, and we worked in VA Pulse, trying to identify the leaders, too. And then in our survey administration, we went ahead and used the snowball methodology so we could continuously identify new leaders as we went. Right now, as of today, we have worked with over 400 people to identify leaders across the nation.

So we wanted to learn about a lot of different types of CIH approaches that were offered across the country. So at first we wanted to include asking about approaches, well, that fall under Ben’s list one, so that includes the acupuncture and the battlefield acupuncture, the biofeedback, chiropractic care, guided imagery, hypnotherapy, massage therapy. We broke it out and asked about mindfulness-based stress reduction as well as two different types of meditation, mantram and then other, and then also asked for mindfulness programs that might be in place besides the MBSR, and then we also looked at tai chi and yoga.

But we wanted to catch the breadth of approaches offered, so we included the services that are highlighted here in red. We also asked about acupuncture, acupressure, aromatherapy, Native American healing, reflexology, relaxation techniques, healing touch. And we also included an “other” approach right here so that if we missed something, people could write in and tell us about what other services they are offering.

So for each of those 27 approaches, we asked a series of questions. Where was it offered? What department? Who provides it? Who are those instructors and providers? What are some of the implementation issues? Are the resources sufficient? What are those challenges as they implement it at their site? We also asked about strategies for outreach. How do they capture the patients and give them the information about CIH? We asked about telephones, so the use of the phone or the video link, and whether they used that to deliver CIH approaches. And each questionnaire then, the last question was to request for additional points of contact for each one of those approaches so that we can identify other people at their sites to survey.

So given this, it is understandable that the survey was long and it was detailed. We wanted to cover the 27 approaches, so it was long. And of course, the more approaches a respondent led out of their site, the longer their survey. So I just have to say thank you to all of the respondents who took their time to provide us this valuable information because I know that they worked hard.

So the survey was administered from a web-based program. We used REDCap here at the VA. We started in August of 2017, and we kept it open for one year. The link to the survey was sent via email, and we followed up with three email reminders; the third one, being a message from Ben at OPCC&CT trying to explain how important it was to respond. We also sent out reminders on those listservs and those national calls asking people to respond. As I mentioned earlier, with the snowball methodology, as we identified a new contact, we then started the process over again.

So we had 193 respondents representing 278 sites. I just want to make a note there that we did have multiple sites per responder, meaning that we could have, and we did have one respondent who actually answered “yoga” for three different sites, and that was seen in many places, but we also had multiple points of contact at one site. So for instance, we might have had one person who answered about yoga and tai chi but then another respondent who answered us about the mindfulness program. So we had data on 27 different types of approaches, and it represents a total of 1,559 CIH programs nationally.

So getting to the results, the number of CIH approaches offered at the sites, our sites offered an average of six CIH approaches. And it looks like my graphics are missing. I will see if I can reset them. There they are. We had 19% had one approach, 59% had two or nine approaches, and we had 22% of our sites actually offer 10 or more approaches at their site. The upper end of the range was 23. We did have one site that offered 23 different CIH approaches.

Looking that the top eight most frequently offered programs, we had relaxation techniques at the top, with 139 sites offering it; 134 sites offered mindfulness; 124 guided imagery; and 119 for yoga. Meditation was offered by 112; tai chi at 98; and battlefield acupuncture, or BFA, and acupuncture at 92 and 83. So what you see on this slide is that there are a lot of different programs offered at a lot of different sites.

We wanted to see if it was really concentrated in one part of the country, but what we found, and is shown in this map, is that it really was dispersed across the country. Twenty percent of the overall programs were seen in the West, 26% in the Midwest, 22% in the Northeast, 23% in the Southeast, and 10% in the Southwest. So CIH wasn’t a one region thing. We saw it across the board.

Taking a little deeper dive into some of the individual approaches, here is the information on relaxation techniques. So these programs, again, we had 139 of them, you see that a large concentration of them, 38 in the Southeast, followed by 33 in the Northeast, 27 sites had it in the Midwest, 25 in the West, and 16 programs in the Southwest.

Here it is for mindfulness. We see the Southeast has 38, followed by the Northeast at 29.

Guided imagery, the Northeast and the Southeast both having 34; Midwest at 23; West at 17; and the Southwest in 16.

Yoga programs, the West had 31 programs, followed by the Northeast at 29, the Southeast at 28.

When we looked at meditation, it was the Midwest that had the most at 27, but the Southeast, Northeast, and the West were all in the 20s and the Southwest in 14.

So where is the CIH--where are these approaches offered? We asked respondents what departments are these housed under, and we did get that some approaches are under multiple departments, so this reflects multiple responses. So 549 of the programs were found under mental health, 334 under physical medicine and rehabilitation, 276 under primary care, 211 in a pain clinic. This is an integrative health well-being standalone clinic, 202. The outpatient and inpatient, 170 and 106. Seventy-two were not attached to a department, but we also saw 54 in specialty care and 11 in surgical and anesthesia. This "other" category right here, the 202, this varied significantly by the type of approach. So for example, in acupressure, acupuncture, and the BFA, the "other" departments that were mentioned were extended care and rehabilitation and palliative care. For animal and creative arts therapy, the others included voluntary services and recreation therapy. For yoga, the other included women’s health, recreation therapy, and MOVE! and CHOICE was selected, which is not surprising, for chiropractor and acupuncture.

Who is providing the approaches? The vast majority are seen in the VA non-MD clinical staff, followed by the VA physicians; 170 were offered by volunteers and 38 were provided by community providers. Again, here this "other" category, it did vary significantly by approach. Just some examples of it: physical therapists were mentioned for acupressure, mindfulness, qigong, and tai chi. Psychologists were mentioned for animal therapy, biofeedback, guided imagery, hypnotherapy, and meditation.

For Telehealth, we found that 13% of our sites, or 27 sites, offered any kind of CIH via Telehealth, and we asked them to give us information about it. This summarizes some of the information we received. They did a mindful warrior program, mindfulness meditation, yoga, tai chi and qi gong, guided imagery, and relaxation.

We also asked about resources and whether they are sufficient always, usually, sometimes, rarely, or never. So here are the overall responses for space. We asked them, “How much of the time was space sufficient in the past year?” Twenty-four percent of our respondents said that the space was usually or always sufficient in the last year, but 55% said it was rarely or never sufficient.

Moving on to supplies, “Supplies were usually or always sufficient,” only 9% of the respondents said that. Flipping to that, “The supplies were rarely or never sufficient,” for 72% of the respondents.

We asked about funding and whether it was sufficient in the past year and found that 29% said it was “usually or always sufficient” and 55% said it was “rarely or never sufficient”.

The last two focused on staffing and whether the number of providers was sufficient and the number of support staff was sufficient. Here, we found 30% said that the number of providers were “usually or always sufficient,” and 39% said that for the number of support staff. But on the flip side, 46% said it was “rarely or never sufficient” for number of providers, and 38% said the number of support staff was “rarely or never sufficient”.

As I mentioned earlier, we wanted to focus on some of the challenges to implementing CIH at the individual sites, so we asked them a number of potential challenges. Here are the top answers. So 38% of our respondents said that hiring instructors and providers was “moderately or extremely challenging” for them; 32% said that it was really challenging to position CIH as a national and local priority for them. Human resources and credentialing, as well as vetting and validating the training of the providers was at 27 and 26%. Having too many interested patients in the services was moderately or extremely challenging to 23% of the respondents. Trying to market CIH was challenging for 22%; 21% was obtaining that leadership support they needed. Sixteen percent said demonstrating the effectiveness of CIH was moderately and extremely challenging. Down here at the bottom, the referral process, only 11%. Nine percent said the documenting it in the medical record or the reluctance of the VA providers to refer was challenging. And only 6% said that they were having trouble getting enough interested patients.

We also wanted to ask them how they do their outreach. What outreach activities have they done in the past year? Education was one of the top focuses. Educating the primary care providers 32%. And educating the specialists about what CIH services are offered at their site, 27% said they had done that. They also displayed posters, 30%, and used social media to contact patients, 20%. Nineteen percent of them had used an outreach to the VSOs, the Veteran Centers, the Welcome Homes and Stand Downs. Eleven percent used the mailed brochures and newsletters, and 9% had done a focus group. Six percent, though, only had used their email to inform patients about CIH.

So in summary, we found that the provision of CIH approaches is widespread. We saw it across the country, it wasn’t concentrated in one region, and half of our responding VA sites offer six or more approaches. The most frequent approaches offered are relaxation techniques, mindfulness, guided imagery, and yoga. The lack of sufficient resources was evident, though. We found that space, supplies, and funding were challenging in terms of the needed resources being available. The top challenges to implementation focused on this hiring, credentialing, and training the providers. Those were in the top on all categories. Also, we found that they had a challenging time positioning CIH as a priority at their site.

So CIH at the VA is rapidly changing, as Ben mentioned earlier. The data we presented here is from July 2017 to July 2018, and that is what it represents: what happened during that time period. And for those who responded early, and they might have changed by the end of 2018 also, so we know things are rapidly changing in terms of new services being offered at the VA constantly. So because of that, the data collection will begin again later this year so that we can updated this information and know what new services have been added since that time. We found in this data there is lots of opportunity to expand the work about learning more details on what is happening with these individual approaches, but what we also found is that we need to understand how these approaches are being offered in combination. Either CIH approaches in combination with another CIH approach or CIH in combination with other medical treatments. We need to understand how that can be done.

We identified a number of implementation challenges for the VA, and these have become targets for future strategic initiatives. But we think that these challenges that the VA is facing could be very informative to the CIH as it rolls out outside of the VA also. I think that is it for me. Thank you very much. Rob, I will turn it back over to you.

Rob: Well, we do not have any pending questions at this time. Sometimes...

Dr. Ben Kligler: Rob, I do have a couple more comments, if I could. It’s Ben.

Rob: Go ahead.

Dr. Ben Kligler: Great. So I think--thank you, Melissa. It is really so interesting what we are learning from the survey. I think one thing it really points to is the challenge of actually getting complete data about what is actually happening in the VA, especially as it relates to something that is relatively new like CIH. And so as I look at the data, for example, and I see, you know, what we learned from this scan about the number of facilities doing acupuncture, but then what we see and hear from other sort of data sources about that, it kind of points to the fact that although we did our best finding the points of contact at all the facilities that should or would know what was going on, there are things going on at some of those facilities that we were not able to tap into through this methodology.

So just as an example, there are facilities that are sending out acupuncture to the community from the pain clinic, and it could very well be that the person we identified as the contact who would be knowledgeable happened to not know that. So when we at our office are doing this kind of upcoming effort to get a really, as complete a picture of what is being delivered at each facility as we can, it kind of demonstrates why we need to be triangulating with different data sources. So we are looking at this data, we are looking at data from services delivered inside the VA as they reflect in coding and tracking from CVW, and then we also have to look at data from CHOICE and community care. And those data sources, as you all probably know, are just not well-integrated in any single stream. We are working hard to find a way to pull them together in a way that makes sense. And this is important, mostly because of understanding deployment and implementation, but then ultimately also in terms of understanding outcomes, so if we want to--and Stephanie is doing some of this work going forward--if we want to be looking at a population of patients who is accessing more Complementary Integrative Healthcare, or specific constellations or combinations of care, we really need to have complete information about what people are accessing.

So it is a big challenge, and I think what is interesting is because VA is the first health system out front in taking on this challenge on a national scale, we are really encountering some of these infrastructure barriers that haven’t been tackled yet. Just as one example, because Medicare has never covered yoga, tai chi, meditation--just as one example--and they haven’t been considered part of standard clinical care, there are no CPT codes. So as those of you out there who do health services research know, CPT codes are the primary vehicle for sort of raking in data about what happens in clinical encounters. That’s what insurers use. That is what health services researchers use, etcetera. But here we have some core components of our clinical portfolio that don’t have CPT codes. So we are actually right now doing applications to AMA for new CPT codes for several of the CIH approaches, and we will see how that goes. But the good news about that is if we are successful in building that kind of data capturing approach within the VA, that will be a tool that people in other health systems can use as they follow this model and try to roll it out in other places.

So yes, a very interesting challenge, and it is sort of a challenge that falls in between health services research and health services implementation because we have to get the field to really do a complete job documenting and capturing the care that is going out. It is a big challenge, and so anyway, I really want to thank Melissa and Stephanie and their team for filling in this part of the puzzle for us.

Dr. Stephanie L. Taylor: Well, we had a great time doing it, but yes, it was challenging. It was one of the most exciting projects we’ve ever done with you, so thank you for those notes. Rob, did anybody sign in with any questions?

Rob: Yes, there is a few questions, and a few more are coming in. Audience members, if you would like to submit a question, there is a white section in the GoToWebinar dashboard on the right-hand side of your screen where you can enter questions. If it is collapsed, you can click on the triangle-shaped button and it will open back up, and you can even pull it out and make it bigger. So the first question, this person says tremendous work. Is it going to be available in document form?

Dr. Stephanie L. Taylor: Yes, so we are producing--this is Stephanie--we are producing a report for Ben and his office, so Patient Centered Care, as part of our job. And then Ben, of course, we as academics, Melissa and I turn into peer review publications, but Ben, what would you be doing with this? Would this be publicly available before we publish it, or what are your thoughts on that?

Dr. Ben Kligler: Well, I think it depends if you think it’s--I mean, it’s definitely going to be available within the VA, because when we report out to VISNs and facility leadership about whether they are in compliance with the CIH directive, this is going to be one of the data sources we point to, so in that sense it will be available inside the VA. I don’t know if we had planned to make it available outside the VA until you guys publish it.

Dr. Stephanie L. Taylor: Right.

Dr. Ben Kligler: Probably not, I think would be my guess, but yeah, we do expect that it will be available to people inside the VA, including the research community.

Dr. Stephanie L. Taylor: And whoever posed that question, Melissa and I and our team, we are rapidly going to turn this into publications and get them out there, so hopefully, in the next several months.

Rob: Thank you. Did you collect data about CIH approaches specific to older veterans, 75+?

Dr. Stephanie L. Taylor: No, so the 27 different--I’m sorry, Melissa, do you want to respond?

Dr. Melissa M. Farmer: Sure. No, at this point we didn’t do anything by age categories in the Environmental Scan level. It just added too much complexity. We also wanted to ask individual questions about offering just for women versus men, too, but that will have to come later because when it came down to the 27 approaches, it was too much to dive into any more detail at this time.

Dr. Stephanie L. Taylor: Yeah, as it was, I think that we asked something about like 20 or more questions for each of the 27 different integrative health approaches, so already the survey was incredibly long, and that was one of the things we had to cut.

Rob: Thank you.

Dr. Melissa M. Farmer: But it is something that can be explored when we get any kind of documentation in the medical records. We could start looking at the patient characteristics.

Dr. Stephanie L. Taylor: I’m glad you said that, Melissa. You are absolutely right. Steve and his group with us are going to be doing exactly that, looking at utilization for different portions of the population.

Rob: Next question. Do you feel that respondents were able to differentiate between the different types of mindfulness?

Dr. Stephanie L. Taylor: I feel that they were. We worked with the staff in Ben’s office to come up with very clear descriptions of each type of integrative health therapy so that it was clear to the clinicians that are overseeing those programs. I mean if you are delivering MBSR, you know that you are delivering MBSR, and you are not delivering mantram meditation, right? So it wasn’t as difficult trying to get valid responses from that audience. It would be much more difficult to have a Veteran tell us if they are receiving MBSR or mindfulness or mantram, but yeah, I feel pretty good about the validity of those responses. Melissa, do you want to say anything?

Dr. Melissa M. Farmer: I agree. I think we made it very clear that MBSR was something separate and then other programs besides the MBSR to get in the mindfulness program. The one area where I think there is a lot more information needed is in terms of the Telehealth. And here it wasn’t quite as specific a question. We just asked them to write us and tell us about what kind of programs they are doing. So there I think that some of the mindfulness, we are not quite sure exactly what is offered, and so that is an exciting area to get back into and ask some more detailed questions about how they are offering these services through Telehealth and what parts of the approaches are they covering remotely.

Dr. Stephanie L. Taylor: That’s a really good point, Melissa. And I just wanted to add one last thing. I think mindfulness is a great example, right? Mindfulness in one setting, as we know, is not necessarily mindfulness in another setting. MBSR is a very regimented or structured standardized approach to delivering one type of mindfulness. But it is not that--not everybody is universal with delivering MBSR, because it is very intensive. They tend to be delivering a different version of mindfulness, and that version we just know is going to vary somewhat across the facilities, but we don’t have the level of detail on what that exactly looks like.

Dr. Melissa M. Farmer: Right.

Rob: Thank you. The next one is more of a comment, but I think it may prompt some discussion. And it is a little bit long, so bear with me, okay? You make a great point about triangulation of potential sources for collecting data. I think you have done an excellent job doing the first scan for VA nationally. I think each future survey wave will demonstrate the knowledge you gained. Looking at CHOICE two years ago would have made your survey methodology much more complicated and your response would have likely been lowered.

Dr. Stephanie L. Taylor: Absolutely.

Dr. Melissa M. Farmer: I fully agree. You know, when we started this, CHOICE was not quite as integrated as it was a few months later. So yes, CHOICE was one of those issues that definitely needs to be in the next round to understand what is offered through CHOICE or what was offered through CHOICE.

Rob: Thank you.

[Brief crosstalk]

Dr. Ben Kligler: Sorry, Rob. Just a second word about that, which is that when we look at kind of implementation nationally and some of the other data sources that we have, a huge amount of these therapies, especially acupuncture and massage, are happening through CHOICE because until recently it wasn’t easy for facilities to hire folks even with the right credentials to do that. So a lot of that is happening in the community, and chiropractic as well. So yeah, we do know that there is a gap there in terms of if we consider a facility to be offering, let’s just say, acupuncture when they are referring it out to the community, which we do, integrating that information is definitely a challenge and going to continue to be.

One thing I will say on this, which is great news, is that at least in regions one through three where United has just gotten the community care contract, United and Optum--so OptumLabs is sort of an entity that works within that company--they have done a lot of work with looking at trends of use and patterns around CIH, chiropractic in particular. But there are people there that are very interested in the question of how do you track data and how do you discover trends in the utilization of CIH that can then be used to even guide service delivery. So we are kind of looking for an opportunity to talk to them about the options for using their, working with them directly to use their data, even rather than having to come through the Community Care Office, which is how we have been doing it so far.

Dr. Melissa M. Farmer: Yeah. And I think our data does represent some--we do know that people did respond that they offer acupuncture and they offer it through CHOICE. We just don’t know if other people who did it through CHOICE indicated that they didn’t offer it because it was through CHOICE. So that was the one thing that is missing in this, and we can capture it through other data, hopefully, as we move forward and then make it more clear in the next round that offering it through CHOICE, we would also want them to answer.

Rob: Great. Thank you. Stephanie, somebody is asking for contact information. Should I provide email addresses for you and Melissa and Ben as well?

Dr. Stephanie L. Taylor: Oh, yes. I am so--yeah, I am so sorry. I intended to put that up there and I also intended to make two announcements about that. So yeah, Rob, do you have our email addresses or do you want me to just say what they are?

Rob: You can say what they are. I am writing them down right now, but you can go ahead and say what they are.

Dr. Stephanie L. Taylor: Okay, so yeah, I am Stephanie, S-T-E-P-H-A-N-I-E dot Taylor T-A-Y-L-O-R 8 at VA.gov. And if each of you guys want to say your email, and then I have a couple of announcements to make about that. Melissa?

Dr. Melissa M. Farmer: Sure, my email is Melissa M-E-L-I-S-S-A dot Farmer F-A-R-M-E-R at VA.gov.

Dr. Ben Kligler: And I am Benjamin dot Kligler K-L-I-G-L-E-R at VA.gov. I am the only one with a name even remotely spelled like that, so you should be able to find me in the system.

Rob: Is that everybody, Stephanie?

Dr. Stephanie L. Taylor: That’s everybody, and then I wanted--I am really glad somebody asked that because I wanted to make sure that--I said this on most of our Cyberseminars, but I wanted to make sure that the attendees were aware of two very important things. One is that if you are an investigator out there doing integrative health research, Rani and I, Rani Elwy and I are looking for more presenters to line up for the Cyberseminar series, so please email her. I believe it is just Rani dot Elwy at VA.gov, but shoot me an email because I don’t have her email address with me. And then the second thing is please email me if you are interested, if you are a researcher interested in integrative health research. We have a listserv that we send out opportunities and publications through. And there you go. I like that you’ve posted it, Rob. Thank you. Let me look up Rani’s email real quickly.

Rob: It is R-A-N-I dot E-L-W-Y at VA.gov.

Dr. Stephanie L. Taylor: Thank you.

Rob: So moving on. Will you be sharing which facilities are offering each of the CIH modalities? There was a report some years ago that summarized by facility what was offered at that time. I would like to see an update possibly. Thank you.

Dr. Stephanie L. Taylor: Right, and that is what Ben was referring to. Our publications that Melissa and I will be producing for peer review will not include that level of detail, but Ben’s report would, the report we do for him.

Dr. Melissa M. Farmer: Yes, we prepared a report that is a spreadsheet of all the facilities that responded and all of the approaches that they said they offer. So he has that information and it will be up to OPCC&CT how they distribute that information. But when we publish it, we would not publish anything at that level.

Dr. Ben Kligler: Yeah, and what I’ll say to that is what we will probably provide, happily, is the information that we will be sort of pulling together once we have integrated the Environmental Scan with the data we are going to be pulling from VA Corporate Data Warehouse and the data we are getting from CHOICE. And because that is the data that we will be providing out to network directors and facility directors, I think we won’t be sharing the data from this survey extremely widely because of what we know about some of the gaps and we wouldn’t want a given facility to say, “Wait a minute, you say I’m not offering this, but all you have to do is look in the CHOICE data to show that I am”.

And so I think we are planning, from my office, to do that kind of triangulated assessment of what therapies are being offered at every site to the best that we can. That is going to happen probably over the next month. And then that will probably be something that--I mean, that is going to go out to network directors and facility directors. That is probably something that researchers--we will figure out a way for the research community to access it for sure. It is not going to have numbers of encounters, although we have some of that data, but it is too unreliable at this moment for us to be sort of really claiming that it is gospel. So it is going to mostly--it is going to have sort of, is a given facility offering these therapies? Yes/no.

It will probably be limited to the nine list one therapies, the required ones, and not including some of the things like healing touch and other ones that are being done here and there. And it is kind of complicated and political as to why we are not necessarily going to really push that information out. It is sort of a vulnerability in the program. We don’t want to make, we don't want to--hmm, I will say no more about that. If someone wants to know more about that, they can contact me offline. But what we are going to be providing, and I expect it to be ready in mid-February, is a database that shows every facility, are they offering the nine required CIH approaches, including chiropractic? Yes/no. And that should be something that people will be able to access. I hope that answered the question. Sorry that was a long answer.

Rob: This next one is quite similar. They start out asking will facility-specific information be shared, and I know you have addressed that, but they go on to say that they are curious what facilities are successful with 10+, and even one with 23 modalities, are interested in best practices for implementation. I am not sure if you have more comments on that.

Dr. Melissa M. Farmer: Can you just repeat that again? I mean there...

Rob: Sure. I will read the whole thing.

Dr. Melissa M. Farmer: Sure.

Rob: Will facility-specific information be shared? I am curious what facilities are successful with 10+ and then even one with 23 modalities. I am interested in best practices for implementation.

Dr. Melissa M. Farmer: Okay, so right, it is an implementation question being that how are they best implementing these things? What are the differences between facilities? What are the facilities that have 26+ or even 10 doing so successfully that potentially other sites are not, are struggling with, is how I am reading that question. Ben, I will just say one thing about that and then turn it over to you. For OPPCC&CT, my team and I did a large-scale study, a project, where we interviewed a lot, a lot of people to find out how they were doing it. What were some of the best implementation strategies they were using that were successfully getting these in place? We produced a paper and fed that information to Ben’s office, and they have been taking with it and running it, and Ben, do you want to speak to your army of implementation team experts? You’ve got a massive effort going on.

Dr. Ben Kligler: Yeah, sure. I think, so in our office, which is Office of Patient Centered Care, we have both my team, which is the Integrated Health Coordinating Center, and then we have about 35 folks who are called field implementation team consultants, each of whom has anywhere from four to six or seven facilities assigned to them. And their job is to help assist those facilities in moving forward Whole Health and Complementary and Integrative Health. So I think what I would say is if you are a researcher interested in--if you are interested in best practices overall, nationally, that is stuff that is coming out of our office. And so bottom line, if you have a specific question on that, we are probably the best repository of information on that, as in we know that this is going well in St. Louis, and this is going well in Iowa City. If you are interested in a specific facility and what is going on there, then probably the easiest way to access that information is to have us connect you with the field implementation consultant for that facility because they are going to know. So I would put that in the category of, you know, feel free to reach out to me with specific questions, and we will see what we can do to help. But that is a lot of our job in my office is to assess where the best practices are, mostly so that we can spread them. Right? We can share the information. That is kind of our mandate really.

Dr. Stephanie L. Taylor: Right. And if anybody wants to look at the work that we did and what the sites told us and what is really working well for them, the paper was just published this year in Journal of Alternative and Complementary Therapies. So again, if you are interested in those implementation strategies--this is Stephanie--just shoot me an email and I can send you the paper.

[Silence 50:12 to 50:22]

Rob: I’m sorry, I’m having a little bit of technical difficulty. Can you hear me?

Dr. Stephanie L. Taylor: Yes, we can hear you.

Rob: Okay, great. Give me a second to pull these questions back up. Thank you. Okay, primary care and PMR staff are still learning these different modalities. Do you think you can provide a brief provider overview webinar of the different types of CIH programs as unique presentations to clinical operations and research staff at VA?

Dr. Melissa M. Farmer: Are they asking to provide a version of this presentation to clinical audiences?

Rob: I believe so. Let me read it one more time. Do you think you could provide a brief provider overview webinar of the different types of CIH programs, as unique presentations...

[Crosstalk]

Dr. Ben Kligler: That one is for me, and the answer is we are providing those pretty much constantly, both nationally in the VISNs--our office, Office of Patient Centered Care and Cultural Transformation, has a very large education program, in-person courses, online courses. We have a lot of community practice calls. So I think what I would encourage you to do, assuming you are inside VA, is go to the intranet site, in other words, the behind the firewall site for our office, and go to the education area. And you will see lots and lots and lots of resources, both community practice calls, but then in-person courses, written stuff, videos, all kinds of stuff. So we have got a very active education program. What I would say additionally is if you are at a facility or if you are part of a group of researchers that you think would be interested in a presentation, please let me know. That is what I am here for. So just as one example, I did a presentation for the GRECCs recently, for a whole group of researchers. I did another one for one of the MIRECs that was interested in what was going on. We are more than happy to get that--that is part of our job is to share information about Complementary Integrative Health and the evidence and the approaches with the field, so if that is something you could just take a look at the website and then if you don’t find what you are looking for, reach out to me.

Rob: Okay, that is the last question that we have pending unless I lost one when my computer decided to do what it did, so if you are out there and you asked a question that didn’t get addressed, please go ahead and type it back in, and I apologize. But in the meantime, this is probably a good opportunity for you guys to give closing comments, and why don’t we start with Melissa. Do you have anything to say in closing, Melissa?

Dr. Melissa M. Farmer: No, I just want to reiterate my thanks to all of the responders who worked so hard to give us this information. It is very valuable information and thank you for working with us over the year to make sure we get your information recorded. So thank you.

Dr. Stephanie L. Taylor: And I just wanted to say thanks to two people. I wanted to say thank you to Melissa; Melissa led this effort. It was an incredibly intensive effort, much more intensive than we ever thought, with one of the prime issues being just identifying all 400 program officers, people who are running these integrative health programs across the nation. It was incredibly intensive but incredibly rewarding. And I wanted to thank Ben Kligler and his office for giving us an opportunity to do this. We--this has been the most exciting piece of work that I have to say I have ever done in my career, where we are doing--I mean just as an academic, to really be helping an operations office to collect information that they need, that they are going to use, is rewarding to Melissa and I, so we are just grateful for the chance.

Rob: Ben?

Dr. Ben Kligler: Well, I think we covered everything important to me. I would just reiterate that people should really feel free to get in touch with us. Our role in my office is to support clinical implementation and training but also to support the research community. There is a lot of momentum and interest, particularly in HSR&D, around understanding more about how CIH works in the VA. Stephanie and her team are part of leading that, obviously, but it is also part of my job to help support people and connect the dots for people who are researchers out in the field who are interested in this. So please feel free to get in touch and I will--if I am not available to help you on my own, I will probably know where to steer you for the help you are looking for. Yeah, and thank you guys for the great work, Stephanie and Melissa, and thank you, Rob, for your gracious hosting as always.

Rob: Wonderful. Thank you all for this very important Cyberseminar and your work in general. And thanks to Mike McGowan for standing by for technical help. When I close the Cyberseminar, attendees, please do stick around and fill out the very short survey. We really do rely on you and your answers to continue to bring you high-quality Cyberseminars. And with that, I will say have a good day everybody.

Dr. Melissa M. Farmer: Thank you, Rob.

Dr. Stephanie L. Taylor: Thanks, everybody. Thanks, Rob.

[ END OF AUDIO ]