Maria: Okay, go ahead.

Rani: Thank you. Thank you so much, Maria, and welcome, everyone, to our Complimentary and Integrative Health Cyberseminar Series that we’ve now been hosting with the help of CIDER for four years. We’re so excited to have our presenters here today.

 We have Lauren Byma who is the Whole Health Program Manager at the James J. Peters VA Medical Center in the Bronx in New York and a Vision II Whole Health Education Coordinator.

 In addition to overseeing Whole Health implementation at the Bronx VA, Lauren manages the Resilience & Wellness Center. She is a CIH—Complimentary Integrative Health—Practitioner, is a board certified music therapist, registered yoga teacher, and a VA Calm Mindfulness instructor. For those of you who are regular attendees, we’ve had a couple of presentations on VA calm here in our cyber seminar series.

 We also have Dr. Fatemeh Haghighi who is a professor with Tenure in the Department of Neuroscience ICAN School of Medicine at Mount Sinai and a Senior Researcher at the Bronx VA. Her research focuses on understanding how environmental exposures such as stress and injury result in molecular changes contributing to risk of suicide.

 Dr. Haghighi is also a founding member of the Resilience & Wellness Center, a daily four-week outpatient complimentary integrated health program for veterans at higher risk for suicide at the Bronx VA where she is actively involved in the development of suicide treatment interventions that target at-risk veterans towards the goal of suicide prevention.

 As always, we always have Allison Whitehead here who is the Program Lead for the Integrative Health and Coordinating Center in the Office of Patient-Centered Care and Cultural Transformation in the VA. Allison joins us for our cyber seminar series on complimentary integrative health each session, so that she can provide a perspective on what we’ve just heard from the research presentation in the context of what is happening throughout the VA enterprise in terms of complimentary integrative health.

 So, we’ll hear from Allison at the end of the presentation. After we hear from Allison, we’ll have a Q&A period. So, we want to encourage—as Maria mentioned—to put your questions into the Q&A panel throughout, so that you don’t forget them. We promise that we won’t lose them and we’ll be asking those questions at the end.

 So, welcome to Dr. Haghighi and Lauren Byma to present to us on Telehealth Delivery for Multi-Modal Complimentary and Integrative Health Interventions for Suicide Prevention.

Lauren Byma: Thank you so much, Rani, and thank you for having us today. We’re very excited to talk about our program. Thanks to all of you for showing up and being interested.

 We’re going to start with a brief poll because we want to see who’s in the room today.

Maria: That poll is open. “What is your profession?” “Psychiatrist”, “psychologist”,. “CIH Practitioner for example: yoga, reiki, etc.”, “a nurse”, “a nurse practitioner”, “RN/LPM”, “DM or Dos”, “Social worker, researcher or other”. If you’re going to put in “other”, put in your remarks in the Q&A. Do not forget to click “Submit” after making your selection.

 I see that the attendees are slowly responding. As soon as that slows down I’ll go ahead and close that poll.

 Okay. We have one last person. Okay. I’m going to go ahead, and close that poll, and share those results with you.

 What I see is 3% said “psychiatrist”, 15% “psychologist”, 15% “CIH practitioner”, 24% “nurse”, 3% “doctors”, 9% “social workers”, 29% “researchers”, 21% say “other”. The others include a veteran, and a social science program coordinator, and whole health coach.

 Okay, back to you.

Lauren Byma: Great, thank you so much. So, before we get stared and share about our program, just some brief background information. We all know that suicide is a major public health problem specifically for veterans.

 Although suicide rates have decreased in the most recent years, there still remains an average of about 17 veteran suicides per day. We know that veterans with complex psychiatric conditions, the traditional psychotherapeutic approaches for suicide prevention have had historically very high attrition rates.

 It’s been really difficult to keep veterans engaged in these treatments for the full course of the treatment as demonstrated in the research of what can be effective for patients. Alongside this data, VA has seen an increased use of complimentary and integrative health services with very compelling utilization rates.

 Among these chronic conditions—mental health diagnoses and pain. So, our team at the Bronx VA wanted to know, “Can we keep veterans more engaged in their health by tapping into an interest in CIH—in Complimentary Integrative Health?” Sorry. Thus, improving mental health and reducing suicide risk factors.

 So, we created a team under our former directors office of many different departments that came together. Dr. Haghighi can share more about that as well.

 But really, the time that we were starting in this venture in 2018 was the time that whole health was really beginning to take root within VA from the non-flagship sites to the rest of the sites. Whole health as we see here, focuses on skill building to empower and equip veterans to take charge of their health and well-being. We use this to develop a concept that focuses on classes in education rather than traditional therapy.

 We created a program that was not under the Auspices of Mental Health, but truly a standalone one to bypass any stigma that veterans might have with seeking mental health care and to also receive referrals from primary care where we know physicians there see veterans who are high risk for suicide who are not seeing mental health care.

 Also like whole health, we wanted our program to focus on all of the components of health and self-care that you see here on the circle of health both in the classes that we offered as well as the approach to each class within each class really having a biopsychosocial spiritual approach.

 Suicide is a difficult problem to solve because there are a confluence of risk factors. So, we decided that we wanted to develop an immersive, intensive multi-modal CAH program that would reduce suicide risk factors by targeting specific evidence-based CIH therapies that address each of these suicide risk factors.

 So, here on the left side you see the major suicide risk factors in the literatures and then their representative CIH intervention that we felt would help to meet that need and address that area of risk.

 So, you see at first, social isolation is a major issue with many veterans struggling with depression. We thought first and foremost that it needed to be a cohort model to help veterans feel like they were part of something and that they weren’t just doing them for themselves. But they were working together because we know from the research that when people feel like they are a part of a team, that that helps to buffer stress response and increases resilience.

 Depression and PTSD symptoms—we look to research in music therapy, movement both. We have dance, but we started off doing exercise. We switched to dance because it’s much more fun than exercise and yoga, as well as mindfulness.

 For pain, looked at mindfulness, nutrition, yoga. For stress, other stress, meditation, mindfulness. For diet we have both nutrition and cooking classes and for sleep disturbance sleep hygiene class.

 Of course, this is not, for example, music therapy can also help with pain. But we really wanted to be thoughtful in how we put together our interventions.

 So, we’re going to move into a second poll question here.

Maria: That poll is currently open. “What CIH interventions do you practice personally?” “Acupuncture”, “yoga”, “meditation or mindfulness”, “aromatherapy”, “massage therapy”, “music therapy”, “horticultural therapy”, “reiki”, “biofeedback”, “hypnotherapy” or “other”. You can put “other” in the Q&A.

 Those responses are coming in rapidly. So, once that slows down I’ll go ahead and close the poll.

 They’re still coming in. So, we’ll give them just a few more seconds.

 Okay. It slowed down. So, I’m going to go ahead, and close that poll, and share the poll results.

 Okay. What we see is 20% answered “acupuncture”, 54% answered “yoga”, 68% responded to “meditation and mindfulness”, 27% say “aromatherapy”, 39% indicated “massage therapy”, 24% “music therapy”, 15% “horticultural therapy”, 7% “reiki”, 2% “biofeedback”. Nobody answered “hypnotherapy” and 24% answered “other”.

In the “other”, let’s see. We have “expressive art” and “animal assisted”. Okay. Back to you.

Lauren Byma: That’s so helpful for us to see. I’m noticing in some ways that the level of participation and interest in these approaches actually mirrors a lot of what we heard from the veterans who were starting our program as well.

 Now that we’ve asked what you do personally, we’re curious what you do professionally in your own setting with your veterans. So, what modalities are you into your practice or what therapies do you do full-time in your work?

Maria: I’ll read those answers out loud while everybody’s responding again. So, we have “acupuncture”, “yoga”, “meditation and mindfulness”, “aroma therapy”, “massage therapy”, “music therapy”, “horticultural therapy”, “reiki”, “biofeedback”, “hypnotherapy” and “other” again. You can check all that apply.

 So, while we give everybody a few moments to respond and it’s actually slowing down. Okay. I’m going to go ahead and give it just another second. I see people still responding.

 I’m going to close that poll right now and share the poll results. Let’s see here. For professionally, I see 8% are saying “acupuncture”, 33% “yoga”, 71% “meditation and mindfulness”, 17% “aromatherapy”, 4% “massage therapy”, 8% “music therapy”, 4% for “horticultural therapy”, 4% “reiki”, 4% “biofeedback”, 0% on “hypnotherapy” and 21% say “other” on a professional level.

 Some of those answers are “breath work”, “none of the above” somebody put down and “Tai-Chi”. Okay, back to you.

Lauren Byma: Thank you so much, Maria. So, as we’ve been leading up to so far, the Resilience & Wellness Center was born in October of 2018 to start receiving patients. The Resilience & Wellness Center is—as we conceptualized it—a four-week daily outpatient program, daily meeting Monday through Friday where veterans who are having difficulty really coping with stress, environmental stressors, or very isolated, or lonely can come every day to the VA from 10:00 a.m. to 2:00 p.m. and take classes in Complimentary & Integrative Health offerings anything from nutrition, exercise. Those I was illustrating in the before slides.

 This was in-person at that time. We’re moving towards sharing how we pivoted to a virtual program. But at first, with this, veterans were given lunch vouchers and metro cards. So, that wasn’t a barrier for treatment for them.

In this program, we actually published our in-person program data in Spring of last year and found that we had veterans data from 126 veterans. They demonstrated statistically significant improvements in depression and hopelessness.

For those with a history of suicidal ideation or attempt, we also found significant improvements were noted in pain, PTSD, anxiety symptoms and stress coping mechanisms.

So, if you’re interested, you can go check that out. But as we all know, what happened in 2020, we had to shift our program to fully virtual.

Our last cohort that we offered was in March of 2020 and we got off the ground doing a fully virtual program in June of 2020 which was not an easy task. The barriers to this were that we are located in the Bronx and many veterans did not have access to devices with internet access. They did not have Wi-Fi. There was a discomfort with technology.

As a whole, telehealth technology was very under utilized at our VA. So, there was a lot of educational barriers that we had to overcome.

Also, with the increased pandemic stress, that impacts memory and executive functioning as we all know. So, getting veterans to attend a daily program, remembering to log-in and show up, that was a barrier in and of itself.

However, there were some unforeseen benefits. We’re talking about working with veterans who are very isolated. Veterans who wouldn’t even come to the VA for this program in the first place were amenable to this program once it was offered in a virtual format.

So, we were able to reach the veterans who were sometimes the most severely depressed and anxious out of our veteran population. They might’ve had their cameras off for the first couple of days or the first week and we were okay with that. We wanted them to build trust and relationships.

Usually after the first couple of days, then they would remove the camera and be comfortable with their group and in the space. We could also continue to serve veterans who moved out of New York City which we did have quite an exodus from New York City at that time. So, we were able to provide continuity of care.

So, with the nitty gritty—with the logistics—how did we transition to virtual? Here’s how we kind of got over the bridge so to speak.

For the program management staff, there was a lot to learn for us and how to create a program that would still be meaningful and impactful, but not a burden on veterans’ lives. We initially tried moving the three class a day structure online and we quickly learned veterans did not want to sit for three hours online a day. I wouldn’t want to sit for three hours of classes online a day.

So, we moved it to two. We made it just a morning program. So, they would log in at 10:00. They’d end at noon. Back-to-back classes.

We initially started off with scheduling VVC links for every single class. However, once you have 10 classes a week, that gets to be a lot of links and that’s very confusing for veterans receiving these emails especially if it doesn’t say with VVC what the class is.

So, then we did one VVC link per day. Still too confusing. So, then we went to one Zoom link for the entire month with a passcode for just that month to make it easy for everybody including the instructors to keep track of how to get online.

We had to send daily morning emails with reminders with a link of, “Hey, just a reminder. We have class that starts in two hours. Here’s the classes for the day. Here’s the link to join as always.”

We always had the monthly calendar below that. Just again, constant reminders were really needed as well as daily participant outreach for the first week to just really get people into the routine because we found once people were spending more time at home, they weren’t used to going in for appointments and having a daily schedule. They really needed that daily reminder.

I think a lot of clinicians we spoke with were surprised that we were doing that. Like, “Oh, if they don’t show up, just no-show them.” But we really, truly believe that these veterans needed that extra care, that extra call to say, “We care about you. We didn’t see you in class today. Where are you? We really think that if you’re having a tough day, this is where you should be” and we always reiterated that “You never have to feel good enough to come to class. If you’re feeling rough, this is where you should be.”

That went a long way. At the end, when we have our graduation, that is when we heard the payoff of, “Thank you for encouraging me to stick with it.”

For instructors, they had to convert their curriculum to virtual delivery which for some of the classes was really challenging. We had a Creative Writing class that the instructor said, “This is boring. It’s just a lot of dead airtime where we’re just sitting here writing. Why don’t we focus on truly narrative storytelling? Verbal storytelling?”

So, she shifted. She pivoted her program.

The Music Therapy classes ended up focusing a lot on, “How do you build therapeutic playlists for yourself?” “Can you find found sounds in your room like a pill bottle, or like some spoons, or something and play music with what you have in your space?” So, it really pushed the bounds of creativity for our instructors.

For the patients, we were able to connect them with telehealth on call assistance at any time. We have a phenomenal telehealth department and then reach out to providers to place digital divide consults. We were also willing to meet with veterans if we were able to do so, and sit down with them, and show them on their phones.

So, the classes that we offered every day were—I’ll just briefly go through them—Horticulture Therapy. I know you’re going to say, “How do you do Horticulture Therapy online? How does this work?”

I’ll share with you in just a moment. We did Mindfulness, Narrative Therapy, Exercise, Dance and Cardio. That was a physical therapist led that class. She chose really fun, upbeat music and different low impact aerobic exercises.

Oftentimes, family members, or professional, or personal caregivers would participate. We did chair yoga. Again, for the exercise classes, we really reiterated that we needed the cameras to be on just for their own safety.

For Cooking and Nutrition, we took a lot of recipes that were just beloved to patients and really looked at nutrition and cooking from not just a weight loss standpoint, but one that looked at listening to your natural hunger cues, focusing on intuitive eating, looking at the cultural aspect of food.

For Spirituality, that was a class led by our chaplains that was focused on how do you find meaning and purpose in life? It drew on logo therapy with Victor Frankel.

For Sleep Hygiene, we have a psychologist that teaches this course, focuses on different sleep hygiene techniques, uses the insomnia via insomnia coach app and many other resources.

I already shared about how Music Therapy was led. So for Horticulture, we already had an existing partnership with the New York Botanical Gardens where we were taking veterans in person one day a week for Horticulture Therapy at the gardens.

When we pivoted to online, we shortened the class. We were at the gardens for four hours in-person to a 90-minute virtual class. We shipped all materials and supplies to veterans in the mail in what we call thrive packs.

They were boxes that were filled with live plant materials, botanicals, aromatherapy oils, other gardening gloves as you see here, a huge, heavy bag of soil.

So, we sent these little packages of love out to everybody to get started and that was a really beautiful introduction to the virtual program because this was also the first class that they had out of the month because it was on a Monday.

So, they’d open up the box. We’d put some sage, some rosemary, so they’d smell it with a little welcome note. So, they really felt like they were a part of something special, I think.

This leads us to we really want to know from you who here has experience with telehealth and delivering CIH interventions via telehealth?

Maria: That poll is currently open. The responses are slowly coming in. “Do you have experience in delivering telehealth CIH interventions?” “Yes or no”?

 So, let’s see. It’s about to slow down. I’m going to go ahead, and close that poll, and share those results.

 Okay. I have 52% say yes and 48% say no. Back to you.

Lauren Byma All right, well, I’m going to hand it off to Dr. Haghighi for the next slides.

Dr. Fatemeh

Haghighi: Thank you, Lauren. Great presentation so far. So, I want to switch gears and talk about measurements of outcome because as Lauren mentioned, at the inception when I am a number of really dedicated VA clinicians across a number of services including social work, reorientation medicine, mental health, really wanted to think about a program to put together that addresses suicide and risk factors of suicide amongst our veterans who are at risk.

 We wanted to think of something that was a bit different, something that really didn’t have the stigma that typically veterans associated with receiving mental healthcare. Complimentary Integrative Health was really a natural progression to that.

 So, we—as Lauren mentioned already—looked at the really key and well-known risk factors for suicide which are social isolation, comorbid mental health conditions such as depression, PTSD, and of course, other serious mental illness, and stress, and sleep.

 That is actually a very significant extreme risk factor for suicide and wanted to identify interventions that can kind of address in reducing these risk factors. As you can see, a lot of these interventions actually cut across various suicide risk factors as well.

 So, we identified the risk factors, our target population. Although, as Lauren mentioned, it was really allcomers. But a really special focus was to really focus on veterans who have had higher history of suicidal ideation or attempt. Next slide.

 So, at the inception of the program, we wanted to make sure that we incorporate ways to measure effectiveness of these interventions by way of looking at what are the symptoms that we have identified that we wanted to target and are they being sort of improved as a consequence of this intervention?

 So, a pre and post program attendance and completion, we had asked veterans to complete a battery of validated clinical symptoms such as symptoms that related to sort of general mental health such as depression, PTSD symptoms whether that’s mental health and then general symptoms for pain, as well as sleep.

 So, we identified these clinical instruments and we gave it to our veterans. They completed it. This is really something that we started within our in-person programming. But we abbreviated it to a smaller number of assessments just being cognizant of potential difficulties and challenges associated with doing this virtually.

 So, this is a more abbreviated version of the instrument battery. Next slide.

 So, initially, what we did is we mailed out these assessment batteries to our veterans and that was resoundingly unsuccessful in terms of getting any responses or a reasonable number of responses from our participating veterans for the pre and post completion.

 So, we switched gears, and kind of looked around, and identified the contracts secure survey platform, and incorporated all of these assessments into contracts. They were provided a link by email or text messaging to complete it.

 We did have a better success with getting these surveys completed. Interestingly enough, over 90% of our veterans completed the program. Of these veterans that have completed the program, we got pre and post completed assessments for about 60 of them. That’s the data that I’m going to present to you next.

 But before we do that, we have another poll question for you which Maria will conduct.

Maria: Okay. That poll is open. “Have you incorporated outcome assessments in your CIH practice either in quality improvement or in a research capacity?” The answers are yes or no. Please don’t forget to click the Submit button.

 Right now I see the attendees are responding pretty rapidly. I’m going to go ahead and give them a couple of more seconds, and then I’ll go ahead, and close that poll.

 Okay. It looks like the poll has slowed down. So, I’ll close that poll and share the results.

 W4e have 52% say yes and 48% say no. Thank you. Back to you.

Dr. Fatemeh

Haghighi: Thank you. That’s terrific. So, we have a good number of people started thinking about and actually are practicing evaluation of these interventions.

 So, let me give you some of our results. For the 60 of veterans who have completed our pre/post assessments, this is the demographic of the veterans. They really do represent a very diverse racial group. That’s really in line with what we see within our community in the Bronx.

 The veterans really are coming from a very diverse population. What really actually peaked our interest is that the number of female veterans who are actually interested in engaging in this program is much higher than what is represented within the VA population.

 So, we had about 39% of our veterans comprising female veterans which is really amazing and great. So, we’re really reaching them with this intervention.

 As noted before, this intervention is really transdiagnostic, so really cuts across a number of different diagnostic groupings. There’s representation of individuals with Post-Traumatic Stress Disorder, depression, serious mental illness, substance use disorder with the majority of the veterans being diagnosed with PTSD while participating in our program. Next slide.

Lauren Byma: Fatemeh, I do just want to interject and say that a diagnosis was not required to be a part of the program at all. We made the consult very broad, so that we could capture everybody that might need it.

Dr. Fatemeh

Haghighi: Well yeah, no, absolutely. So, here’s some sort of summary of the results that we have for the different symptoms that we have focused on and the corresponding instruments.

 So, we did see significant reduction in depression and PTSD symptoms across all of our groups. Now I’m going to get into “Why Me?” (SP) groups.

 As I mentioned, we also wanted to really focus on veterans at risk—those with a history of suicidal ideation or attempt. So, we really grouped these veterans separately from those with no history of suicide to see whether our intervention was actually effective in these mostly at risk veterans.

 We do see reduction in mental health symptoms across these veterans as well as amongst those veterans who basically have had a history of suicidal ideation attempt, they improve their stress management skills, as well as their pain.

 Unfortunately, we did not make any movement or improvement in symptoms related to sleep quality. That’s really in line with what we had seen in our in-person programming when we provided sleep hygiene in a similar fashion.

 Now just to kind of point your attention, there’s a table there that gives you the statistical significance of these results and corrected for multiple testing as well. We also provide effect sizes for these outcomes because I think in the CIH literature, this is really important for us to really start documenting these statistics, so that our future studies can build on this in sort of the power calculation for randomized clinical trials. Next slide.

 So, let’s dig into the sleep issue, right? Sleep is actually a very significant, extreme risk factor for suicide .We wanted to dig deep a little bit and see why did it not work in this case, right?

 Now I’m showing data from our in-person programming on the left separated by the groups as well as our telehealth programming separated by our average grouping. As you can see, with a definition of clinically significant sleep problem with the Pittsburgh Sleep Quality Index of 10 or greater, that’s a clinically significant level. The majority of our veterans actually meet this criteria and above, right?

 Everyone—at least within the clinical sleep medicine field—has widely recognized that sleep hygiene isn’t really affected for improving sleep quality for individuals who are clinically significant or suffer from really clinically significant sleep problems.

 So, this has now allowed us to really think about ways that we can connect our veterans to more sleep focus interventions such as receiving cognitive behavioral therapy for insomnia either in-person which we know it’s very difficult given trained clinician availability within the VA or alternatively with these recently developed apps and programs that the VA has developed such as Insomnia Coach or Path to Better Sleep. Next slide.

 So, in addition to administering validated clinical assessments to measure outcomes, we really thought it was also quite important to ask the veterans directly how they felt about the care that they received while they participated in the program.

 So, this is our program evaluation. Across a range of sort of items such as whether the programming was accessible, easy to understand, whether the practitioners were attentive, and helpful, and so on, the majority of veterans strongly felt that all of these were met and beyond. So, that was very encouraging for us. Next slide.

 So, what’s the takeaway from what you have taken your time to sort of engage with us and listen? So, over the time period that we have had the good fortune of putting the program together and administering it to our veterans, over 300 veterans have been served to date with this visa line (SP) symbol as programing.

 We have seen significant improvement in mental health as well as general health symptoms. This has really encouraged us to think about how this program can be moved up to the next step in thinking about really assessing its efficacy using randomized clinical trial frameworks and looking at different target populations such as female veterans, veterans with a history of military sexual trauma, elderly, and so forth.

 So, I think from my standpoint as a researcher, these quality improvement studies that we have done today really have legs and it’s allowing us to think about the next step. Next slide.

 We have another—

Lauren Byma: Since you just mentioned next steps, I do want to share that we felt that it wouldn’t be enough for veterans to just go through this four-week program and have that be an isolated, wonderful experience for them, that we did not want to have a drop-off because once we create this social environment of their learning, their growing, to then go to, “Now I don’t have a schedule and there’s nothing.”

 We integrated a next steps class that is led by our health coach who goes over all of the different weekly whole health offerings, creates a personalized plan and a schedule with the veterans while they are supported in the program, so that when they are done, they are supported. We are seen as the takeaway.

 So, the veteran continues to stay engaged in these whole health offerings. They drop by our office now. They stay in touch with one another through text, through phone call. They are able to maintain from what we’ve seen engagement in their own health and well-being.

 So, we want to know have we convinced you? That’s our final poll question or do you need more data.

Maria: So, that poll is currently open. You have yes, no, “I need more data”. So, go ahead and once you select your response, click “Submit”.

 I see the responses are coming in. We’ll just give them just a couple more seconds before I close the poll. When it slows down, let’s see.

 The poll’s slowing down, so I’m going to close it. Share the poll results. We have 85% yes.

Dr. Fatemeh

Haghighi: All right, wow!

Maria: So, zero said no and 12% say “I need more data”. So, we’ll send it back to you guys.

Lauren Byma: We’re working on it—more data. So, before we close off our Q&A. We just really want to acknowledge first of all, the participating veterans for really trusting us with their time, and their energy, and dedication.

 Again, 319 veterans showed up almost every day five days a week for four weeks and that cannot be understated. Also, the Resilience & Wellness instructors, the VAMC Services that we collaborate from and that have given their staff to us for an hour or two a week to teach the classes.

 Also, the key contributors to this work. Of course, Dr. Haghighi, and Kadrea Kamesh (SP), and \_\_\_\_\_[00:38:35], Dr. Hank Gabelli (SP), Dr. Evan Pottalog (SP), Ann Faber (SP), and Dr. Rachel Huot (SP).

 Vic, is there anything that you wanted to share before we moved to Q&A?

Dr. Fatemeh

Haghighi: No, let’s see what people have to say.All right. Thank you for your attention, everybody.

Maria: Thank you.

Rani: Thank you so much Lauren and Dr. Haghighi for this wonderful presentation. Obviously, your data have convinced many people that this is a way to go. For those who like data, they would like to see more of it. This is such a wonderful start.

 We’re going to turn to Allison Whitehead who wants to sort of describe some thoughts that she has over what you’ve just presented in the context of all of the other work that’s happening in the complimentary integrative health space also within Whole Health. Allison, are you there?

Alison Whitehead: Yes, I am. I need no convincing of this project. One of the other roles that I have in our office is actually a co-lead for our Tele Whole Health Task Force.

 So, I was very excited for this presentation as I am for all. But since this has that kind of merging of those two big areas that I really love working in.

 So, I have just a few notes about sort of tele whole health. Nationally we’re seeing expansion. No surprise to everyone given everything that’s been happening over the past few years.

 We had really started to track tele whole health in 2017 and this telehealth technology’s really enabled us to expand integrative health services when in-person care’s not available or when COVID in-person services were potentially shut down.

 We have seen the data that I have for Fiscal Year 2021. We had a threefold increase in our whole health component to our integrative health encounters from Fiscal Year 20.

 We had a total of 386,938 tele whole health encounters in 2021 which to me is amazing and the numbers seem to continue to grow. This is going from early on when we would have maybe tens of thousands of encounters.

 The top tele whole health activities that we’ve seen sort of nationally over the past few years include health coaching, whole health education, yoga, Tai Chi and whole health clinical care. It was really exciting to hear about some of the Bronx program offerings which are a little bit different and unique.

 And then, just a couple of other things I wanted to mention. Our office actually worked this past year on a five-year tele whole health strategic plan and road map. We had input from a number of people from the field and researchers as well.

 So, hopefully we’ll have that available to share with folks in the near-ish future. Just a quick plug for a couple of our other virtual tools in addition to using VVC or VA video connect for live virtual sessions.

 We also have a whole health mobile app where you can input your personal health inventory, start to develop goals, things like that, be connected to resources. We also have our #LiveWholeHealth Self-Care Series on the Vantage Point blog. If you even just Google “Live Whole Health that should bring it up.

 That’s a series that gets posted weekly, goes out publicly and includes a well-being topic of the week and also imbedded video exponentials for people to follow along with.

 So, thanks again. Fantastic presentation. I’ll stop talking, so we can hear what questions folks on the call have.

Rani: Thanks so much, Allison. Obviously, you had so much to add to that. I’m sure that there was more that you could say. We appreciate you at least providing that brief insight into what’s going on from your office.

 If there are questions that people have that are more appropriate for the Office of Patient Centered Care and Cultural Transformation, Allison will be able to help you with those questions.

 But we have several questions that have come in for Dr. Haghighi and Lauren. So, I’m going to start with a clarifying question. So, this question—and you may have addressed it, but just to make sure we clarify it completely. “When you say ‘multimodal’, do you mean multiple complimentary integrative health approaches—music, mindfulness, nutrition, yoga, etc.—or do you mean using in-person and virtual modalities together? I see this term used in many different ways and wanted to clarify.”

Lauren Byma: So, we meant using multiple CIH interventions. Not—

Rani: Okay.

Unknown: Not a hybrid model part online, part in-person.

Rani: Okay, great. Yeah, that’s good. Another question, when you talked about your program evaluation. Did you use an existing measure for participant program evaluation or did you need to create one?

Dr. Fatemeh

Haghighi: I think the existing measure, we wanted to really take a look at validated instruments that people routinely also use within the research setting for assessment of say depression using either the PHQ9. or they’ve got depression inventory, for example, or PTSD symptoms using the PTSD checklist, and so forth.

 So, these type of assessments that we chose were really targeting the specific symptoms that we wanted to move the needle with these interventions to see improvement. We wanted to make sure that they were validated because to make up something on your own when there isn’t any sort of reproducibility data out there, then it doesn’t really allow other clinicians in other settings to take this and actually try to take the program in an intervention and replicate it in a meaningful, reproduceable way, right?

 So, these are all validated clinical assessments that are typically used in different settings.

Rani: Well, I will say though I’m wondering, Dr. Haghighi, if they’re talking about the actual post-session program eval that we presented to you. Do you feel like you can comment there?

Dr. Fatemeh

Haghighi: Well, that’s something we came up with, obviously because we wanted to just get a gauge on the veteran’s experience and the programming if that’s the question.

Rani: Yes.

Unknown: So, we have a workgroup that I remember back in 2018 sitting down where we were really going through, “What is it that we really want to know from these veterans?”

Dr. Fatemeh

Haghighi: Yeah. Just to add to that actually, we have a room for veterans actually to write something that they want to share with us beyond what’s sort of this structured responses that we have for them.

 There are wonderful responses, sort of qualitative data out there that we collect from the veterans based on their experience in the program.

Rani: I love the combination of qualitative with the actual measurement that you talked about. So, thanks for sharing that with us.

 Oh, another question is, “Is the Resilience & Wellness Center—the RWBC—something that was created for this project, or was it an existing VA clinic, or whole health clinic?”

Dr. Fatemeh

Haghighi: This was created really by—as I was mentioning—really way early on by myself and really a group of really dedicated clinicians within our VA. So, in a way, it was a blank slate that we had to work with.

 I have to say it was very fun to be able to coming from sort of a data nerd on the research side, to be able to interact with clinicians who really didn’t have data experience working with veterans, and really know the nuances of what could or couldn’t work, right?

 So, this was really developed in-house.

Lauren Byma: Yeah, and the fact that it’s not under a department or a service line. It’s really under the Office of the Director gave us a lot of freedom and creativity.

Dr. Fatemeh

Haghighi: Yeah.

Rani: I just want to follow-up on that point, Lauren. Sounds like you purposefully did that at the beginning. But did you have a reason why you knew that would be the right thing? How did you decide that that was the right approach to take?

Lauren Byma: So, I have to say that my predecessor was the one who initially put this together administratively. So, I’m not sure exactly what her intentions were.

Maybe Dr. Haghighi can speak more to this. But I think that it was very much intentional like I said, to bypass any sort of stigma. It was also a special project from our director I believe as well. Do you want to—

Dr. Fatemeh

Haghighi: Yeah.

Lauren Byma: --share more about that?

Dr. Fatemeh

Haghighi: Well, Eric \_\_\_\_\_[00:47:50] was one of our former medical directors. He really supported this program’s development and was really integrally involved.

 The other sort of reason was that we have no money to put this together. So, really it was using the good graces of other services, and contributing time, and effort from the practitioners to put in time to put this program together and the curriculum together, right?

 So, I think you could say it was economically driven, idealistically driven in a way.

Rani: Right.

Dr. Fatemeh

Haghighi: But yeah, absolutely zero funds in a way too that kind of allowed us to put this together. So yeah, Ann Faber’s (SP) a really talented social worker who retired now was really instrumental in getting everyone engaged and putting this program together.

Lauren Byma: Okay, all right. Dr. Lanehoff literally sat down with the service chiefs and said, “We’re doing this. What can you give us?”

Dr. Fatemeh

Haghighi: Exactly.

Lauren Byma: “Can you give us a day for one or two hours a week?” It’s beneficial for them because we’re able to code it in a way for they’re getting the workload credit, but we’re getting the whole health tracking credit. They’re spending an hour they’re awake and they’re getting 10 encounters for that one hour.

 So, it is really a win/win in that way. They’re a labor map to us for I think .3 hours a pay period.

Rani: That’s wonderful strategy. Thank you--

Lauren Byma: Three hours, not .3.

Rani: --for doing that. All right, another question is, “Have you considered volunteer quality—” I’m not sure exactly what this means.” Have you considered volunteer quality practitioners to conduct these intervention therapies such as I think peer support specialists?”

Lauren Byma: So, we did initially have a peer support specialist who was doing a group. But what we found from our post-programming assessments is that the veterans didn’t really enjoy the group.

 Now we do have a very vibrant taking charge of my life veteran volunteer-led program which many of our programs who complete the Resilience Program then go into after for the nine-week weekly class.

 I would be open to using volunteers. But the thing is we also need to document, so we would also need to document them. They also need to be credentialed in whatever modality they practice as well. We’re not against it, but we have those expectations as well.

Rani: Right. Yeah, the credentialing piece is important. Oh, I’m sorry. Dr. Haghighi, go ahead.

Alison Whitehead: No, this is Alison. But I take it as—

Rani: Oh, I’m sorry.

Alison Whitehead: --a compliment to be confused with Dr. Haghighi. I was just going to say nationally we do know that there are some especially things like yoga and Tai Chi classes that oftentimes there are volunteers that come in to lead certain sessions. We do ask that they meet the same requirements that we would of instructors inside the VA or whatever profession that is.

 So, to use our minimum provider guidance or qualifications standards when we have them.

Rani: Great. I have a question for both of you. At the very end of your presentation, Lauren, you talked about some—I’m not sure if you used the term “sustainability”, but you were talking about you didn’t want this program to end and not have anything for your veterans to participate in.

 So, there’s a next step plan that veterans participate in with your whole health coaches. I just wondered from a sustainability perspective because that is such an important part of implementation science, are you tracking any of those efforts about what people attend following your forward program?

Lauren Byma: We’re not. We haven’t created a formal mechanism to track it. We’re actually in the process of hopefully hiring a data analyst to also help with more of the long-term measurements in that way.

 But we see the veterans who are involved in the program. We continue to just anecdotally. We see them almost every day in some sort of whole health offering.

 So, if we don’t, just we take it upon ourselves—the health coach and I—that if we lose track of one of the veterans who finishes the program, we do just an outreach call and check in with them, see if there’s anything they need. They’re always welcome to do this program again if they feel like they need a jump start, they’re in a slump. So, we’ve done informal tracking.

Dr. Fatemeh

Haghighi: If I may add to that, I think that’s a super important issue and question. But I think given the confounds of what we’re working with here which is a clinical program is a quality improvement project that continues because we think that is really important to make sure that we keep confessing (SP) and calibrating the treatment of care.

 But I think some of these questions are really important to address in a research setting looking at the clinical trial whether we do this and look at individuals three months, say six months, 12 months post participation.

 I think that probably the office of Research and Development should start really thinking about really incorporating and funding whole health type interventions because they do really cross boundaries with looks like therapeutic, sort of general health because whole health isn’t just focused on a single specific intervention or symptom.

Lauren Byma: I think what also helps with the sustainability of keeping these veterans engaged is that we communicate with their referring providers and just really their treatment team as much as we can for after they’re finished with the program. We let them know they completed it. They attend the graduation. This is their plan moving forward.

 We’re signing them up for these classes that they want to attend just so that they know and they can ask about it. We do get tagged on many, many, many notes of providers saying, “Patient’s going to yoga class. Loves it. Attended Resilience & Wellness Center. Had a positive experience.”

Rani: Well, that alone sounds like something that as you said, if you get your data analyst who could be doing that tracking. Having people tag you like that, the data’s there. It’s just you need to get it in a way that you can actually analyze it. But I see that in your future and that’s really exciting.

 I just wanted to know if any sites have reached out to you to see how they might start this kind of program? I’m—from an implementation perspective—just wondering how other people. I know that there’s not a lot of money involved. It required a lot of leadership support to make this happen. What are your next steps in terms of spreading potentially this type of program across other VA sites?

Dr. Fatemeh

Haghighi: Lauren, you want to go with that one?

Lauren Byme: Yeah. I’ll add a little bit. So, before the pandemic happened, it was a vision to network director priority that two additional sites would start Resilience & Wellness centers. We had been working with two sites. One was not able to with their staffing and then one was going to be doing a modified version of this.

 We did present this to all the different sites in our vision. It really did come down to a lot of staffing issues—who would be overseeing the program. For most of the whole health program managers, it was just a step too far to say, “Now you also have to manage this daily clinic in addition to the whole health implementation.”

 When COVID happened, that was really put on pause. Since then, I don’t believe we’ve had—at least from my end. I haven’t had any other facilities reach out to us to see if we could mentor them.

 We did create a toolkit that was just created--

Dr. Fatemeh

Haghighi: Right, yeah.

Lauren Byme: --amongst them too that was very thorough even talking about coding, how you can recruit staff to be a part of your instructor team.

 So, we have that available for anybody. We’re happy to share it with anybody who could benefit from it.

Rani: We have a question. I’m not sure what this means, so maybe you do. “Does your program utilize other RCAT disciplines?” I’m not sure what RCAT means. Do you know?

Lauren Byme: Oh! RCAT? Recreation Therapy/Creative Arts Therapy?

Rani: Oh okay. That’s what that means. Yeah.

Lauren Byme: Yeah. So, we would have a recreation therapist sometimes sub in for some of the movement classes or yoga classes if an instructor had to be out. But really, it was just Creative Arts Therapy. I have it on my wish list to have our therapy as part of the modalities once we’re back fully in-person. But for right now, the virtual program is pretty packed to the gills for the classes that we offer.

Rani: I’ll just say someone just asked a question about obtaining VA mindfulness CLEM (SP) certification. That, we have a lot of information from our previous cyber seminars on that. Maybe if Allison is able to, she can put some information in the chat?

 I just want to note that we’re getting close to the top of the hour. We would like people to complete a feedback form on this talk.

 So, I want to give people time. But I want to end with a compliment. Everyone is just so excited about this project. One person has said, “I hope you are so proud of this project. It’s beautiful and the COVID pivot deserves major praise. This is a great project.”

 So, I think all of us feel the same way. Thank you so much for taking the time to share your wonderful program, your results, your next steps with us.

 I’m going to turn it over to Maria to provide the last statement.

Maria: To the presenters, thank you so much for taking the time to prepare and present today. For the audience, thank you, everyone, for joining us for today’s HS R&D cyber seminar.

 When I close the meeting, you’ll be prompted with a survey form. Please take a few moments to fill that out. We really do count and appreciate your feedback.

 Our next session will be in September. Have a great summer and stay safe!

Rani: Thank you again.

Unknown: Thank you all.

Unknown: Thanks, everybody.

[End of Interview]