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Appendices: Whole Health System of Care Evaluation – A Progress Report on Outcomes of the WHS Pilot at 18 Flagship Sites

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Table of Contents- Appendices

The following are appendices to the "Whole Health System of Care Evaluation- A Progress Report on Outcomes of the WHS Pilot at 18 Flagship Sites". These appendices provide additional detail on methods that lead to the findings presented in the main body of the report, as well as more detailed data.

Appendix 1 Table of Contents

General Appendices

Acronyms Table

AES	All Employee Survey
CARA	Comprehensive Addiction and Recovery Act of 2016
CIH	Complementary and Integrative Health
OPCC&CT	Office of Patient-Centered Care & Cultural Transformation
PHP	Personal Health Plan
SAIL	Strategic Analytics for Improvement and Learning
SHEP	VA Survey of Healthcare Experiences of Patients
VHLS	Veteran's Health and Life Survey
VISN	Veterans Integrated Service Network
WHS	Whole Health System of Care
WH	Whole Health

Descriptive Table of 18 Whole Health Flagship Sites

VISN	VA Flagship Site	Region	Number of Care Sites (e.g. hospitals, CBOCs)[1]	Patient Volume (# unique patients as of FY18Q4)[2]	Complexity Level[3]
1	**Boston**	Northeast	8	63,284	1a
2	**New Jersey**	Northeast	12	57,216	1b
4	**Erie**	Northeast	6	22,062	3
5	**Beckley**	Southeast	1 + supports 2 Vet Centers	14,255	2
6	**Salisbury**	Southeast	4	93,220	1c
7	**Atlanta**	Southeast	15	118,246	1a
8	**Tampa**	Southeast	8	99,151	1a
9	**Tennessee Valley**	South	18	106,026	1a
10	**Saginaw**	Midwest	12	37,720	3
12	**Tomah**	Midwest	5	26,806	3
15	**St. Louis**	Midwest	8	68,208	1a
16	**Central Arkansas**	South	10	76,592	1a
17	**San Antonio**	South	16	96,535	1a
19	**Salt Lake City**	West	11	67,410	1a
20	**Portland**	West Coast	12	102,148	1a
21	**Palo Alto**	West Coast	10	70,306	1a
22	**Tucson**	South West	8	59,251	1a
23	**Nebraska-Western Iowa**	Midwest	9	58,323	1b

[1] Reported as of January 2020 on facility website.
[2] As reported on the FY18Q4 PRP Report
[3] Complexity Level Definitions:
Level 1: High Complexity (high patient risk, high levels of teaching and/or research, high Veterans Equitable Resource Allocation (VERA) pro-rated persons)

1a: Largest levels of volume; patient risk; teaching and research; number and breadth of physician specialties; and contain level 5 ICUs.
1b: Very large levels of volume; patient risk; teaching and research; and contain level 4 and 5 ICUs.
1c: Large levels of volume; patient risk; teaching and research; and contain level 4 ICUs.

Level 2: Medium Complexity (medium number of VERA pro-rated persons, medium levels of teaching/research activity, medium patient risk, contain level 3 and 4 ICUs)
Level 3: Low Complexity (low levels of patient complexity, smallest level in terms of volume, little or no teaching/research, lowest number of physician specialists per pro-rated person, contain level 1 and 2 ICUs)

Appendix 2 Table of Contents

Implementation of the Whole Health System of Care

Implementation Study - Methodology

Introduction

In this section we provide a detailed explanation of the methodology used to assess each Flagship site's stage of implementation throughout the study period (October 2017-September 2020). A primary purpose for the implementation study was to develop a greater understanding of how move through stages of implementation, including major facilitators, barriers and modifications required. The study has also helped to refine implementation milestones and outcomes for future studies.

Phases of Transformation

An organizational transformation, such as the one VA is making towards Whole Health, is complex and requires cycles of change over 7 to 10 years. We have conceptualized the [1]process of change as having three major phases:

Table 2.1: Phases of Implementing a Whole Health System of Care

Implementation (~3 Years)	• Infrastructure Development – hiring personnel, employee training, developing clinics and establishing clinical codes • Creation of communication materials and marketing approach • Implementation of the core components of a Whole Health System of Care (e.g., Whole Health Coaching, Complementary Integrative Health services) in at least some sites and service lines/departments
Integration (~4-7 Years)	• Integration of all the components of a Whole Health System of Care across all sites and departments/service lines and in all approaches to care • On-going training and professional development
Transformation (~7-10 years)	• All sites of care and service lines use a Whole Health approach in the care of Veterans. • Clinical and system-level incentives are aligned to support the approach • Steady improvements in patient and employee outcomes

Within the three-year period of this funding cycle, our expectation is that Flagship sites will progress along the first major phase of transformation - Implementation. We developed an implementation rubric (see Appendix 2-B) and study instruments (see Appendices 2-C and 2-D) that are grounded in this initial and important phase of work.

Overview of Methodology

The EPCC Implementation Team used a Rapid Assessment, Response and Evaluation (RARE) approach to assess each Flagship sites' stage of Whole Health Implementation at multiple time points[1,2]. Rapid assessment relies on systematic data collection and analysis techniques, using a combination of complementary qualitative and quantitative data collection and rapid assessment performed by a trained team of researchers. For this study, an implementation team comprised of five researchers collected quantitative implementation data through an online tracking tool and conducted follow-up qualitative interviews with key Whole Health leaders at each site on a quarterly basis. These two data sources formed the core data set for our rapid

analysis, supplemented by training and service utilization data. In three sites we were also able to supplement our assessment with direct observations and interviews conducted during site visits. Each of these methods are described in greater detail below.

Whole Health Implementation Rubric (Appendix 2-B)
During the first quarter of funding, the evaluation team worked with leaders within OPCC&CT to develop a Whole Health implementation rubric that outlines criteria and milestones for each component of the Whole Health System of Care by stage of implementation. The rubric consists of 5 major Whole Health components: *Infrastructure, Pathway, Well-Being, Clinical Care, and Whole Health Coaching*. Infrastructure was pulled out as a separate category because there are milestones that are critical to the development of a Whole Health System of Care that span all core components. Whole Health Coaching was treated as a stand-alone category because the guidance for which component it fell under was still being considered at the time of rubric development. This category has since been placed under the Well-Being component, but we retained it as a stand-alone category for purposes of consistency.

For each component, we tracked the: a) availability of a service or approach, b) service capacity (i.e., the number of Veterans that *could* participate in a service in a given week), c) the availability of services across sites of care (i.e., VA hospital and outpatient clinics) and d) Veterans' utilization of services (as data became available). A brief description of the rubric components is below, and the full rubric is in Appendix 2-B.

Table 2.2: Brief Description of Implementation Tracking Rubric

Whole Health Component	Description
Infrastructure	This component focuses on the foundational elements that need to be in place in order for a Whole Health System of Care to be implemented. Key aspects include: organization and functioning of a governance body, leadership commitment and support, hiring and allocation of protected time for core Whole Health staff, allocation of space and other resources, and involvement of and integration with employee health and wellness.
Pathway	This component is comprised of two types of offerings: Whole Health Orientation and exploration of mission, aspiration and purpose (MAP). To progress along the implementation continuum, sites must offer the Taking Charge of My Life and Health group course but could also offer opportunities to explore MAP on an individual basis.
Well-Being	In this component we track the availability and capacity to provide 11 complementary integrative health services, including those that are required to be offered by all VA facilities as per VHA Directive 1137[3] Required services include Chiropractic, Acupuncture, Mindfulness/Meditation, Yoga and Tai Chi, among others. These can be offered on campus or in the community, paid for by VA.
Whole Health Clinical Care	Given limitations in being able to consistently observe clinical interactions, we relied on measures of capacity to provide Whole Health clinical care. These measures included: participation of staff in various Whole Health trainings, offered by OPCC&CT and locally; availability of personal health inventories and plans

	in the medical record; training on how to refer Veterans to CIH and other Whole Health services; and use of Whole Health clinical champions to support the spread of the approach in clinical care.
Whole Health Coaching	The capacity to provide Whole Health Coaching included: number of Whole Health coaches hired and trained; availability of Whole Health coaching across the system (e.g., main hospital and outpatient clinics); and integration of Whole Health Coaches into clinical care teams.

Data collection: Implementation Assessment Instruments (Appendices 2-C and 2-D)
There are 5 main sources of data that are used to assess each site's stage of implementation. A brief description of these tools is included below and, when indicated, are available for review in subsequent appendices.

Implementation Tracking Tool (Appendix 2-C)
This instrument was developed to assist with assessment of the capacity to provide a Whole Health approach to care at each site. It consists of 38 root questions and up to 77 sub-questions that may need to be answered depending on responses to the root questions. Core domains explored in this instrument include:

- Staffing (hiring of core Whole Health team members, allocation of protected time for implementation activities, approximate number of hours per week spent on implementation activities)
- Infrastructure (governance committee and status within the facility, involvement of leadership in Whole Health implementation, identification and availability of space for Whole Health staff and services, establishment of Whole Health clinical codes, and involvement of the facility's employee wellness for staff)
- Training (staff participation in any of the nine core Whole Health trainings and/or additional ones, as well as who delivered each training (e.g., OPCC&CT staff, locally trained staff))
- Pathway Component (two types of services were asked about under this component: Orientation to Whole Health and opportunities to explore mission, aspiration and purpose in group or individual settings; in addition to availability, we asked about numbers of patients who could participate each week and locations where available)
- Well-Being Component (the availability of 11 common complementary integrative health services (CIH) and 8 well-being educational classes were asked about, including the number of patients who could participate each week and locations where available. There is also space to report additional CIH services and classes provided at the site)
- Whole Health Coaching (number of Whole Health coaches hired and formally trained, locations where coaching is available, and established referral procedures)
- Whole Health Clinical Care Component (number of staff trained in the use of Whole Health approaches, staff involved in developing personal health plans, availability of personal health plans in the medical record, and the number of Whole Health clinical champions)

The Implementation Tracking Tool was programmed in REDCap and sent to each site's Whole Health program evaluation assistant via electronic link embedded in an email. In general, we

collected data on a quarterly basis, with a few exceptions due to holidays and scheduling considerations. Each site had approximately 10 days to provide data through the tracking tool once requested.

Qualitative Interviews (a sample interview guide can be found in Appendix 2-D)
Qualitative interviews conducted after receiving data from the Implementation Tracking Tool provided an opportunity to clarify information learned through the Implementation Tracking Tool and gain a deeper understanding of the implementation approach, including factors that facilitated and/or hindered progress. Interview guides are tailored each quarter to capitalize on new or emerging trends, commonly observed issues, or questions needed to be explored for more accurate staging. All interviews are conducted by phone and audio-recorded for the purposes of creating detailed notes. Interviews last one hour.

Participation in Whole Health Training
On a quarterly basis, the implementation team requested Whole Health training data from the VA's Talent Management System (TMS). There are a growing number of Whole Health-related trainings that are available in-person or online, and that are developed by OPCC&CT or by local facilities. During the study period, there were nine core in-person Whole Health trainings developed by OPCC&CT for which we tracked participation as well as role-specific trainings (e.g., Whole Health Facilitated Groups), trainings available online, and locally developed trainings that were set up for enrollment through TMS. It is important to note that not all locally developed trainings were set up in TMS, so we also needed to rely on information reported in the Implementation Tracking Tool to understand the spread of training at a given site.

Utilization Data
In December of 2018, OPCC&CT launched the Whole Health Dashboard. This dashboard provides utilization data for all Whole Health services at a site that have been coded with specific primary or secondary stop codes (139 or 159), CHAR4 codes or CPT codes. Coding of Whole Health-related services is relatively complicated in VA. The accuracy of data in the Dashboard has improved over time as sites have iteratively reviewed data in the Dashboard and then worked with their local clinical coding teams to recode or add new codes to services that are not appearing in the Dashboard. Given the variability in quality and accuracy of data in the Dashboard at this point, the implementation team primarily used these data to triangulate or verify what we understood about spread and reach of services from the Implementation Tracking Tool and qualitative interviews.

Site Visits
During the summer of 2019, the implementation team conducted site visits to Flagship facilities at or near an advanced stage of the implementation phase for a Whole Health System of Care. Site visits provided an opportunity to see and observe a Whole Health System of Care in action, providing depth to our understanding of what was in place, how different components were being integrated, and the complexity of system transformation. While on site visits, team members conducted interviews with a range of staff involved in Whole Health System transformation, including hospital leaders, Whole Health staff, clinical champions, education champions, and frontline providers. We also observed classes, trainings, committee/staff meetings, and clinical interactions when possible. Interviews were audio-recorded or documented through notes.

Data Collection and Analysis - Rapid Assessment Approach:
Each of the 18 Flagship sites was assigned a team of two researchers to consistently work with for the duration of the study. All data collection instruments, qualitative interviews, and other communications were disseminated through the assigned research team in order to facilitate working relationships and build cumulative knowledge and understanding about each site.

Upon completion of the quarterly Implementation Tracking Tool, each team reviewed the data for their respective sites and identified any potential errors or inconsistencies from prior reporting periods (e.g., a service was reported to be offered in a prior reporting cycle but not the current one). A list of questions was compiled and sent back to the responsible reporter for a site, with the request for clarification and potential modification. This process was necessary to ensure accurate reporting.

Within one month of data collection through the Implementation Tracking Tool, each team also conducted a qualitative interview with the Whole Health Clinical Director, Program Manager and other core staff. These interviews provided an opportunity to learn more about how each site was approaching implementation, major barriers and facilitators, modifications or tailoring of the Whole Health guidance, and lessons learned. Interviews were audio-recorded and detailed notes were taken for each conversation.

Each team then reviewed data provided through the Implementation Tracking Tool and qualitative interviews to develop an initial assessment of each site's overall stage of implementation and by component. The Whole Health Implementation Rubric (Appendix 2-B) was used to guide the staging process. The team used a categorical scoring system which corresponded with each stage of implementation.

> 0 = Not Started: No planning efforts or activities have been initiated.
> 1 = Getting Started: Planning efforts have begun but there is little to no infrastructure or resources in place (e.g., hiring of key personnel) yet.
> 2 = Foundational: Key personnel are hired or identified. Planning efforts are underway, with small scale pilot testing of approaches started.
> 3 = Early: Whole Health approaches and service delivery has moved beyond the piloting phase and are being offered in at least the main hospital and some tertiary sites of care. The site continues to refine their approach as they roll out Whole Health approaches across their system.
> 4 = Advanced: Whole Health services and approaches are implemented across most sites of care and spreading to different departments/service lines. Site regularly monitors implementation and uses information to inform improvements. The focus has begun to shift from initiation to sustainment.

Each component of a Whole Health System of Care was categorized within a stage of implementation. Within each stage, they were further categorized along a continuum, from low to high, which helped denote forward or backward movement within each stage of implementation. In order for a site to move up to a next stage of implementation (e.g., from Foundational to Early Implementation), all components (i.e., Infrastructure, Pathway, Well-Being, Coaching and Clinical Care) had to be in that next stage. We opted for this conservative

approach given the interconnectedness of each component to the overall function of a Whole Health System of Care.

Once each team reviewed and synthesized the data for their respective sites, they brought their initial assessments to the larger group for discussion. Each team spent 30-45 minutes discussing their categorization of each site. As they discussed the rationale for the categorization assigned to each component, they brought up questions or challenges faced during the staging process. Challenges often centered around a site's tailoring of an approach that fell outside of the initial implementation guidance. Occasionally the team delayed final staging until more information was gathered or an approach was discussed with OPCC&CT staff to determine appropriateness. Through discussion of all 18 sites, the implementation team was able to discuss how to handle modifications or deviations from OPCC&CT guidance and assure consistency in categorization across sites.

In Year 2, additional data became available to use in the assessment of each site's stage of implementation. The implementation team was able to obtain records of participation in formal OPCC&CT-led or approved trainings through the VA's Talent Management System. These data helped confirm each site's reported training activity provided on the Implementation Tracking Tool. OPCC&CT also worked to create a Whole Health Dashboard that brought together a number of different data sources from the VA's medical record system to provide information about the utilization of different Whole Health services, including complementary integrative health services and educational classes. These data were generally used to triangulate our understanding of the reach of Whole Health services to each site's patient population.

Member Checking

Twice a year, the implementation team prepared a summary implementation report for each site. This report highlighted where the overall stage of implementation the team determined the site was in and the stage of implementation for each component (e.g., Infrastructure, Pathway, Well-Being, etc.). A brief narrative of what was known about each component was also provided. These reports also included a summary of training and utilization data, when available. Reports were sent to the Whole Health Clinical Director and Program Manager. They were asked to review the reports and let the team know if there were any discrepancies or errors in our understanding. Adjustments were made as appropriate.

Whole Health System of Care
Implementation Tracking Rubric
VERSION October 2019

Overview of this Document:
This Implementation Tracking Rubric is to be considered a living document. It is periodically updated as the Implementation team gains more clarity around the different approaches each Flagship site is taking to develop their Whole Health System of Care, variation in terminology, and the accessibility and feasibility of proposed measures or indicators. The indicators that appear in this rubric are ones that the Implementation team can measure. It is important to note that this is not an exhaustive list of all the work that needs to go into each stage of development. Note, this rubric was first developed in 2016, prior to the current designation model rubric. Thus, implementation stages and benchmarks may be different from those found in the designation model rubric.

We have identified 6 stages of implementation that will be applied to each Whole Health component and to a site's system overall. They are as follows:

- NS = Not Started
- GS = Getting Started
- F = Foundational Stage
- EI = Early Implementation
- AI = Advanced Implementation
- AV = Aspirational Vision (represents what a fully transformed system would look like and is described for each component to serve as a benchmark to help determine how far each site is from this goal)*

*Note that for this progress report, we do not discuss AV.

INFRASTRUCTURE	
Core Domain	**Indicators**
Steering Committee for Whole Health System that guides implementation and oversight	**GS =** Site is identifying individuals to serve on the WH Steering Committee. Developing mission and scope of work for the committee. Completing paper work to obtain formal hospital recognition. Figuring out meeting times and schedules. **F**= Steering Committee members are identified and include the WH Clinical Director and/or Program Manager. Steering Committee has a defined mission and scope of work (this could be in a charter or equivalent, preferably written). Has begun to meet regularly. **EI**= WH Steering Committee meets on regular basis to discuss implementation of all WH core components; examples include reviewing utilization and training data to inform quality improvement activities, credentialing of CIH and well-being providers, and other critical components of the WHS. Role of the committee largely shifts from start-up activities to oversight and refinement of the WH system of care. **AI**= The Whole Health Committee is recognized as a formal committee of the hospital (e.g., they have an approved Charter). WH Steering Committee meets regularly to discuss implementation and impact of WHS. Focus of the Steering Committee shifts to sustainability and institutionalization of the approach to care. For example, figuring out how to shift grant funded positions to permanent positions, permanent space for WH approaches, continuity of operations when key people leave. The SC is either collecting and analyzing WH data themselves or ensuring it is being done by others and are then using the data for continuous quality improvement. The SC ensures that there is a mechanism in place for collecting data and feedback from Veterans and stakeholders about various aspects of WH, for example about space, design, healing environment, types of WH offerings, etc. *Note: Role of SC is to ensure and oversee various monitoring activities (e.g. service capture, utilization, feedback). Specific monitoring activities embedded across the individual components. **AV =** SC meets regularly and is focused on the sustainability of WH. It oversees a robust system that measures and monitors WH activities, efficiency of delivery, and organization's financial health. There is evidence that data is regularly used in steering committee meetings and other levels of leadership to guide organizational planning and planning specific to WH. Additionally, robust mechanism(s) exists for a broad range of veterans and other stakeholders to provide feedback and input on WH. There is evidence of meaningful consideration and influence of the feedback.
Hospital leaders demonstrate commitment to	**GS =** Discussions with members of the hospital's Executive Leadership team (e.g., Triad, Pentad, Quadrad) have started regarding education around a Whole Health approach to care, the scope of work for implementation, and resources that might be needed to plan, launch, and implement WH at the site.

developing, implementing, and sustaining a Whole Health System of Care	**F=** At least one member of the Executive leadership team has participated in a Whole Health training or otherwise demonstrates familiarity, awareness, and/or support for Whole Health concepts. At least one member of the Executive leadership team is involved in the planning for WH implementation, which could include sitting on the WH Steering Committee (or equivalent) or having a direct report on activities. They are beginning to allocate resources (financial, space, or personnel) to WH and helping to solve problems (e.g., hiring, space, etc.). **EI=** At least one member of the hospital's Executive Leadership Team (Triad, Quad, Pentad) is considered a champion of Whole Health (e.g., discuss WH in all staff meetings, require staff to be trained in WH, incorporating WH activities into practice). Visible leadership support has started in the form of messaging, allocation of resources, etc. **AI=** Visible leadership support for WHS is evident across the entire site (e.g., sends messages to all staff about WH, allocates space for WH services, etc.). Leadership presence is felt at WH activities. Leaders are demonstrating commitment by their own example. Begin to see evidence that WH is influencing policies and practices and major site decisions. Most staff within all levels of leadership (specifically Pentad/Quadrad and service chiefs) have been trained in WH. A plan is in place to train all new leaders in WH and periodically re-educate existing leaders' training in whole health principles (including managers, service chiefs, etc). Leadership has demonstrated commitment to sustaining the Whole Health System of Care beyond grant funding. **AV=**Leaders regularly attend WH related activities to demonstrate support and knowledge of the system of care. Through messaging and modeling, leadership demonstrate their commitment to WH (provide time, space and expectations for staff to attend to their own self-care). Evidence of WH is woven throughout the organization's strategic plan, policies, procedures, meeting agendas and minutes, and evaluation metrics and WH concepts are part of hiring and performance appraisals. Additionally, there is evidence that leadership has aligned WH with the organization's other (local and National) strategic priorities. As a result, WH is allocated resources, such as space, staff, and funding. All levels of leaders (Quad, service chiefs, program directors) have been trained in or have experienced Whole Health. There is a robust process in place for training new leaders on WH and continually refreshing training for current staff.
WHS key staff and site leaders are actively engaged and working on implementation of WHS ***Key staff Include** *WHS Clinical*	**GS =** Site is hiring or identifying existing staff to fill key positions (WHS Clinical Director, WHS Project Manager, Education Champions and Admin Assistant) and/or beginning to plan for how responsibilities of these key positions will be filled. **F**= Most WHS key staff positions (WHS Clinical Director, WHS Project Manager, Education Champions and Admin Assistant) are filled and/or someone has been designated to fulfill these responsibilities. Persons filling these roles may be doing so in an Acting capacity. **EI** = All Key Staff have been hired and/or someone has been designated to fulfill these responsibilities. Key staff have taken part in formal WH training (e.g., completed OPCC's trainings on WH 101, WH in My Practice, WH in Your Life). Key staff are engaged in outreach and education to clinical and non-clinical teams. Key staff begin to develop a process for developing,

Director, WHS Project Manager, and WHS Program/Admin Assistant	disseminating, and reviewing appropriate coding and documentation. **AI**= Roles and responsibilities for key staff are established, they complete activities with protected time, and there is stability, consistency and continuity across these roles. If someone leaves a key position, they work to fill it and there is a thoughtful process in place for maintaining continuity when there is turnover amongst key staff. Education, training, and outreach around WHS are core components of their work (rather than collateral duties). Outreach and engagement of community partners to coordinate, support and extend the reach of WHS. Key WH staff: Have a plan in place to ensure WH staff are appropriately trained and credentialed; have a plan to ensure supply and demand for WH services is monitored and evaluated and that site can accommodate increases in WH demand; and that they or their designee monitor use of codes, making sure what they think is being offered is being captured, done regularly, and by designated people. **AV=** All key staff are in place with designated staff members permanently supporting the work so that the organization's needs are fully met. Key WH staff ensure they can accommodate increases in WH demand, including through key partnerships with community organizations, and ensuring properly trained and credentialed staff are added as needed. Additionally, key WH staff ensure that staff at all levels within the organization receive thorough orientation/onboarding to general WH concepts and to their more specific, job-related roles, including experiential components. Periodic refresher courses and other opportunities for learning and experiences are offered and attended. Key WH staff or designee collaborates with designated staff (i.e. CAC, DSS, Business Office) and oversees a formal process to ensure a robust coding and documentation monitoring system.
Whole Health communication strategy	**GS=** Site is developing communication and outreach strategies to raise awareness about Whole Health approach to care at the site. **F=** Sites are developing and implementing broad education and awareness campaigns, minimally targeting VA employees. Use of multiple strategies to get information out to employees. **EI=**Continued implementation of broad awareness campaigns/ strategies targeting employees; Development and implementation of experiential learning opportunities for employees to learn about WH; Development and implementation of broad awareness campaigns/strategies for Veterans **AI=** Same as above (EI). Addition of more targeted education campaigns or strategies to specific populations that have been hard to engage in WH (late adopters). Outreach and education initiated for community-based providers and/or directly to Veterans living in community settings. Overall, site has started to utilize a multimodal, iterative, coordinated communication strategy across their entire system. **AV=** Site implements, maintains and regularly updates a comprehensive internal and external communication, marketing and outreach strategy to raise and sustain an ongoing high level of awareness of WH at the site and in the community, and to reach target populations. This includes ensuring alignment with the site's strategic priorities and key programs. Sites have developed strategies for helping staff of all levels to communicate a consistent message about WH with veterans. There is a

	robust network of interagency partnerships (including VSO, NGOs, CBOs etc.) to outreach to veterans to orient them to the VA's new WHSoC.
Integration of Whole Health into Employee Health Services	**GS=** Sites are developing ideas for integrating or aligning WH approaches in the delivery of Employee Health Services. **F=** WH Key Staff have initiated discussions with employee health service on incorporating WH into employee wellness services and programs **EI**= The site pilots at least one WH program or service for employees (e.g. well-being, group TCMHL programs for staff, and/or PHP development with staff) **AI**= Evidence exists that leadership is promoting employee self-care (e.g. building in time for mindfulness at meetings). There are multiple opportunities for employees to learn about WH and apply it to their own life. Site has integrated at least one aspect of the WHS into the Employee wellness program and continue piloting other aspects. Site works to identify and disseminate information about community-based services that are available for staff. Self-care concepts for employees are woven into orientations and meetings and promoted in multiple ways throughout the system (e.g. screen savers, posters etc.). All employees have access and exposure to WH/wellness activities and concepts. Supervisors begin to normalize discussion of employee personal goals and self-care in meetings. **AV=** All VA employees, including volunteers and contractors, are indoctrinated with WH self-care concepts via NEO and ongoing through staff and other meetings. Multiple WH and wellness activities are offered across the site for staff. Incentives are offered to encourage employee self-care and there is evidence of staff utilization of internal or external well-being offerings. Supervisors include employee well-being as part of their progress meetings or in other venues ("is there an aspect of your PHP/well-being I can support?"). Leadership model and encourage through messaging participation in health and well-being activities and actively recognizing employees for their well-being achievements. VA recognized as an employer of choice for its Whole Health benefits and impact on employee lives.
Whole Health Services have adequate space to deliver services	**GS =** Site is beginning to identify what the site's space needs might be for each of the components of WH and for WH staff. **F=** Environmental scan of space (on-site and off-site) that might be available for each of the components of WH and for WH staff has been performed. Discussions regarding necessary space for services with leadership, resource & space committees are taking place. **EI** = Plan for obtaining space for WH staff and services is developed. Some WH services have assigned space, on-site and/or off-site through contracts or MOUs (e.g., borrowed space). Some WH services may still have "floating space." WH staff have sufficient space/resources to perform their work. **AI**= Space is regularly assigned and available at the main hospital and *most* CBOCs/other healthcare sites (HCSs) for Whole Health services. This may be on or off-site. If off-site, agreements with community agencies are in place. Thought is being

	given to creating Healing Environments within the facility. **AV=** Sufficient space is available to conduct WH work onsite or through offsite agreements as appropriate. This space is accessible for all the site's patients, wherever they receive care across the system. There is a robust network of interagency partnerships (including VSO, NGOs, CBOs etc.) to facilitate Whole Health services (e.g. lead yoga at YMCA) and provide space for telehealth (e.g. tai chi led by VA employee, televised at a college campus). Stakeholder feedback is incorporated into space planning and design. As space throughout the site is improved it is with the goal of creating healing environments.

PATHWAY: WHOLE HEALTH ORIENTATION & EXPLORING MAP

Veterans and family members are made aware of the philosophy of Whole Health, the broad range of programs and services that are available to support their well-being, and how to access WH programs and services. This component also includes processes that allow Veterans and family members to connect with staff and resources that support sustained health and well-being. Core components include the Whole Health Orientation and Taking Charge of My Life and Health (TCMLH) programs.

Core Domain	Indicators
Development and Implementation of a comprehensive Orientation to Whole Health	**GS =** Site is developing an Orientation to WH that provides a basic introduction to their WH approach and overview of services offered. May be developing a new Orientation or adapting one that OPCC has created in response to the Executive Order (2018) **F=** Site has developed an Orientation to WH that provides a basic introduction to WH approach, an overview of the services that are available for Veterans at the facility, and how to access them. NOTE: The Orientation must be available to new and existing patients but could also be used to meet the requirements of the Executive Order. **EI=** Whole Health Orientation sessions are offered at least 2 times per month in person; Orientation information may also be available on-line; There is a process established for referring Veterans to the Orientation. **To move higher:** orientations are beginning to be spread to additional locations beyond the main hospital (which could be accomplished through telehealth or online). **AI=** Whole Health Orientation is open and accessible to *all* new and current patients (at least) and is available on a regular basis, frequently enough to meet demand. It available at *most* sites of care and as needed in the community via multiple formats (e.g. in-person, via telehealth, on-line). At least one trained Veteran peer paraprofessional (Partner, Coach, Volunteer) is facilitating or co-facilitating and there is a system in place to track or document participation. The site is engaged in widespread recruitment with a strategy in place to reach targeted groups. A process is in place to understand the supply-demand issue for the WH Orientation with strategies and structures to respond to shifts in demand, expanding, contracting or shifting modality as needed. The site can articulate their strategy for continually assessing and growing their Orientation strategy and outreach.

	AV= Whole Health Orientations are tailored to a site's population and context and proactively planned. New ways to deliver services are developed based on needs and demand. Orientation is easily accessible to *all* new and current patients, as well as their family members or caregivers: it is available at or through *all* site locations and via community partnerships as needed; it is available in a variety of formats, such as offering online. A formal system is in place for on-going marketing and recruitment.
Development and Implementation of Opportunities to Explore Mission, Aspiration and Purpose (MAP)	**GS =** Site is hiring or identifying Partners (or equivalent) and Partner Leads (supervisor) to lead TCMLH classes and other Pathway services. Developing vision for their Pathway services at their site and how these services will be delivered (e.g., # of sessions/weeks that they will offer TCMLH curriculum). **F**= WH Partners/Peer Specialists (or equivalent) are hired or identified to implement Pathway services. At least some WH Partners/Peers complete Whole Health Facilitated Group training (or equivalent). Site is developing a process to refer Veterans into the Pathway. Working with CACs or equivalent support staff to develop STOP, CPT and CHAR4 codes for relevant clinics. Some TCMLH groups or one-on-one sessions may have started. Developing a plan or protocol to share Veterans' mission, aspiration and purpose (PHI) with clinical teams. At this stage, TCMLH groups may only be available to a specific population or program (e.g. piloting with chronic pain, only in RRTP). **EI=** TCMLH groups sessions are offered at least 1x/week. **To move higher:** Groups need to start expanding beyond the main hospital, being offered at least at *some* sites of care. At this stage, TCMLH groups should be available to more than a specific patient population/captive audience and spread should have begun. Opportunities to explore MAP may be offered on an individual basis. Group and individual meetings are led or co-led by at least one trained Veteran peer paraprofessional (Partner, Coach, Volunteer). The referral process for Pathway services (e.g., TCMLH) is being implemented. There is evidence that STOP, CPT and/or CHAR4 codes for Pathway programs/services are being used. Site has initiated plans to share Veterans' mission, aspiration and purpose (PHI) with clinical teams. **AI =** Opportunities to explore MAP in a designated, structured way (TCMLH group AND individual sessions) are available to *all* patients (as opposed to patients with pain or in the Dom, etc.) on a weekly basis, frequently enough to meet demand. Offerings are available at *most* sites of care and as needed in the community via multiple formats (e.g. in-person, via telehealth, on-line); and led or co-led by at least one trained Veteran peer paraprofessional (Partner, Coach, Volunteer). There is a dedicated supervisor (e.g. Partner Lead, clinical staff) that oversees the work of Partners and other Pathway services. Sessions must include education, completion of a holistic assessment, such as the PHI that leads to exploration of MAP, and initiation of the personal health planning process. *Note: To be included as part of a site's Pathway, MAP exploration needs to be done in an intentional way, distinct from on-going Health Coaching or other WH activities. A process is in place to understand the supply-demand issue with strategies and structures in place to respond to shifts in demand, expanding, contracting or shifting modalities as needed. The site is actively engaged in widespread recruitment strategies to bring Veterans into these Pathway services and they adapt their approach and strategies as needed. Referral

	processes are set-up, which include multiple ways "in" for ease of access. There are explicit processes to connect patients from the Pathway to other Whole Health or health care services, and to routinely share Veterans' MAP or PHI with clinical teams. **AV=** Site is actively working to develop a shared understanding by Veterans and providers/staff that WH and exploration of MAP and personal health planning process will help them lead fulfilling lives. Veterans are engaged in self-care and can connect with WH approaches and health care via MAP/Plan, which is in medical record. Offerings to explore MAP are planned proactively and tailored to site's population and context. Ways to deliver Pathway services based on changing needs and demand are developed. MAP offerings are available to *all* patients at or through *all* VA locations, including a network of community partnerships (as needed). Services are easily accessible through a variety of means such as telehealth, online classes/resources, unique scheduling options, etc. Patients can receive on-going support in exploring their MAP and connecting with services. Procedures and mechanisms to seamlessly connect patients to WH or other health care services in a timely manner are utilized and in-place for all points of entry into the system. The site is recognized for their innovative approaches to availability, delivery and effectiveness of Pathway offerings.
Utilization of Pathway Services	*We assume that there will be an increasing number of Veterans who are taking part in Pathway services over time, including TCMLH group and one-on-one sessions with a Partner/Peer. Proposed benchmarks are*: **GS**= none **F =** Orientation and TCMLH classes have started and Veterans are beginning to enroll **EI =** Veterans are attending Pathway services. **AI**= Attendance at WH Orientation is increasing and target groups are participating. There are an increasing number of patients participating in TCMLH or individual sessions. **AV**= WH Orientation and TCMLH (or individual sessions) offerings are regularly well-attended. *Note: Collecting this data qualitatively. Sites generally track program attendance and pull internal reports and therefore have some sense of service utilization.

WELL-BEING PROGRAMS

The Well-Being Programs focus on equipping Veterans with skills to support self-care and well-being. Core components include the availability of Complimentary Integrative Health approaches and Well-Being classes.

Core Domain	Indicators
Development and Implementation of Infrastructure for Well-Being Programs	**GS =** Sites are beginning to conduct an environmental scan of existing CIH services and approaches. Identifying gaps in the availability of core CIH services (acupuncture, chiropractic, yoga, tai chi/qi gong, meditation). Starting to think about approach to setting up clinics in VISTA (STOP Codes, CHAR 4 codes, note titles) for CIH and Well-Being classes. **F=** Sites have the ability to report on the availability of most CIH and Well-Being services at their site. Establishing a protocol to refer Veterans to well-being programs and services; could include consults, other provider referrals, or self-referral. Some clinics are set up in VISTA (i.e., STOP Codes, CHAR4 codes, note titles) and there is evidence that they are being used. Some clinics for CIH or Well-Being classes may still be in the process of getting set up. At least some CIH providers (acupuncturists, chiropractors, yoga, tai chi, and meditation instructors) are hired, contracted, or designated to provide CIH services. At least 2 of the 5 originally required CIH services (acupuncture, chiropractic, yoga, tai chi, and meditation) are offered **EI=** At least 4 of the original required (tier 1) CIH approaches (acupuncture, chiropractic, yoga, tai chi, and meditation) and some (# not specified yet) Well-Being classes are offered on a weekly basis. Other CIH approaches are offered and documented using appropriate clinics codes and note titles (note: in this phase we expect sites are still working on appropriately capturing their WH services and approaches). During this phase, the number of CIH services and Well-Being classes should be expanding to other facilities and patient populations. **To move higher:** services are beginning to be spread to additional locations beyond the main hospital (which could be accomplished through telehealth as applicable). **AI=** At least all 5 of the original required tier 1 CIH approaches are offered regularly, frequently enough to meet patient demand and are accessible to *all* patients as appropriate. Services are available in some capacity at *most* sites of care, including in-person, via telehealth, or through community partnerships. All 8 starter Well-Being class tracks are offered using either the PIRE curriculum or "other" approved curriculum (e.g. locally-developed). Starter classes are available and accessible to *all* patients and are being offered at *most* sites of care in some capacity. There is a process is in place to understand the supply-demand issue for CIH and well-being services, with strategies and structures in place to respond to shifts in demand, expanding, contracting or shifting modalities as needed. Referral processes for off-site services are established and there is an established process to obtain feedback on Veteran's participation in community services. This could be done multiple ways and does not have to be formal (i.e. via the electronic medical record). The site is considering ways to formally track or monitor patients receiving CIH/well-Being services in the community. Explicit processes are in place to communicate a Veteran's MAP, PHI, and PHP to Well-Being providers, and to routinely share Veterans' participation in CIH/well-being services

	with their clinical team when possible. **AV=** Robust set of CIH offerings and Well-being classes (all WB classes, starter and intensive to all patients at all locations) exist, are available to *all* Veterans (as appropriate) through a variety of mechanisms e.g. telehealth, online, etc. within VA and in the community. Supply is aligned with demand- real ability to adapt to accommodate ebbs and flows in demand (systems set up to monitor demand and create capacity where needed). CIH and Well-Being services are interwoven between VA and community providers who are trained in whole health—mechanisms are in place to refer back and forth (VA to community and vice versa), coordinate care and share PHPs. There are comprehensive and efficient referral processes to CIH and Well-Being services and programs both within and outside the VA and from CIH and Well-Being services and programs to other components of the WH System. A robust system is in place to track participation in CIH and Well-Being services within and outside the VA. There is evidence that these referral and tracking mechanisms are regularly used. A robust system for sharing PHI/MAP/PHP within VA among clinical providers, partners, coaches, and well-being and CIH providers both inside and outside the VA is in place. There is evidence that these are being accessed and used regularly.
Utilization Targets	**GS=** None expected **F=** Veterans are beginning to enroll in CIH services **EI=** Veterans are participating in CIH and Well-Being services. **AI=** There is an increase in interest and participation in CIH/Well-Being services across the site's system of care. **AV=** CIH/Well-Being services are regularly well-attended. *Note: Collecting this data qualitatively. Sites generally track program attendance and pull internal reports and therefore have some sense of service utilization.

CLINICAL CARE

Whole Health Clinical Practice acknowledges what is important to Veterans (mission, aspiration, and purpose), attends to the full range of physical, emotional, mental, social, spiritual, and environmental influences that affect a person's health, and works collaboratively with Veterans to develop shared goals for health and well-being.

Core Domain	Indicators
Development and	**GS=** Site is beginning to plan for the implementation of a WH Clinical Care approach. Beginning to identify Clinical Champions. May begin identifying the types of Whole Health or related trainings that have already been offered to clinical team members.

implementation of a WH clinical care approach: -Identifying Clinical Champions -Training Clinical Teams on WH approaches -Incorporating WH approach into practice across services and locations, including Personal Health Planning -Setting up WH referral processes for clinicians	**F=** Site is able to articulate a strategy for implementing the Whole Health Clinical Care approach. Clinical Champions are identified and at least some have participated in WH trainings. Site has identified tools to support the development of personal health plans with Veterans and a strategy for working with Veterans to complete them. Sites are working on creating a template in CPRS for the PHPs so that all providers can view them (may have an alternate strategy for sharing PHPs, but need to specify). Training ambulatory care staff on Whole Health approaches has been started. Site is developing a strategy and plan for WH referrals and for training clinical providers on these referral mechanisms. **EI** = Site reports implementing at least some components of its strategic plan for the Whole Health Clinical Care component. Training for primary care providers during the early stages of implementation may include a combination of outreach and "exposure to Whole Health" efforts AND intensive training (OPCC approved) on how to integrate Whole Health approaches into care. Training is also beginning to be offered across multiple service lines/departments and locations. There is some sense or awareness of who has been trained across the system—both exposure and formal/intensive training (e.g. A majority of mental health staff to formal WH training and doing seminars with increasing number of PACTs.). There is a defined strategy for training staff across the system that likely includes Education Champions, Clinical Champions, or other clinical staff across the system. WH leaders are aware of the efforts of these individuals. A template for PHPs has been created in CPRS, which is easily accessible for providers (or an alternate strategy has been implemented that allows ALL providers to view PHPs). Training for providers on the PHP purpose, approach, and tool is underway and there is a continual effort to provide this training to all providers. A robust strategy is in place for on-going training of clinical providers on local PHP instruments and processes for use. Development of PHPs with Veterans has also begun and increases over time (ideally in Primary Care, though sites may have good reason to start in another service line). Site can articulate a defined strategy for clinical providers to refer patients to WH services and training on this process has started. Referrals from primary care, other clinical providers to a Whole Health Orientation, Pathway, Well-Being, and Coaching have started and are increasing. **AI =** Site reports that they are fully implementing their strategic plan for the Whole Health Clinical Care component. Site is fully implementing a training strategy that includes a combination of outreach and "exposure to Whole Health" efforts AND intensive training (OPCC approved) on how to integrate WH approaches into care. Training is offered through multiple modalities. Booster and advanced trainings for clinical providers are available and there is a systematic strategy for training all new clinical providers on WH approaches to care. Participation in WH training is supported in primary care and across most outpatient clinical services lines/departments and locations. There is a robust peer to peer education strategy and program routinely implemented by Education Champions, Clinical Champions or other clinical staff. WH leaders are aware of the efforts of these individuals and involve them in strategic planning. Site also has a strategy in place to track and monitor staff participation in WH trainings (exposures and more formal offerings). This information is used to inform modifications to site's training approach and to target and tailor outreach efforts

	for trainings. A robust strategy for Veterans to develop a PHP is in place and entails all staff being trained to look for a PHP and know the process to develop one with a Veteran if one is not found. There should also be a strategy for updating the PHP as needed, but at least annually. Training on these local PHP processes is underway and clinical providers are aware of their site's process for PHP. The site monitors how staff are using the PHP and uses this information to develop a targeted training strategy. There is evidence of widespread and continual use of PHPs across providers in most service lines/departments. WH leaders should be able to articulate a strategy for monitoring and understanding use of PHPs in Primary and Specialty Care. This includes a regular review of data about who is using PHPs in care, so they understand the extent to which it is being used. For example, they may be monitoring Health Factor reporting for each provider to understand the volume and spread of use. Referral processes to WH services are fully implemented and their use is monitored. There is strong evidence that clinical providers across the system are referring patients to WH programs or services (Pathway, CIH/Well-Being, Coaching). Processes are in place to continually monitor and oversee progress in clinical care. Sites may use any number of patient experience measures or other metrics to understand how Whole Health approaches are affecting patient experience of clinical care. Information is used to inform additional training to staff or other organizational changes. **AV=** With a mature Whole Health Clinical Care system well established, the WH approach is integrated across multiple service/product lines (ideally to include inpatient and outpatient) and evidenced by documentation and tracking strategies that all providers are integrating WH into their practice. Because the Veteran's MAP is the foundation for planning Veterans' care, health care is clearly aligned (through Shared Goal setting) with the Veteran's MAP, the Veteran feels valued and a shared commitment to goal achievement. The clinical team and Veteran partner together to use the MAP and/or PHP to guide delivery of personalized care via WH Clinical Care and when relevant: integrates the use of Complementary Integrative Health (CIH) approaches to support health and well-being; utilizes Whole Health coaching to aid a Veteran in achieving his/her goals, and/or incorporates the use of well-being approaches, health education, group services, etc. in addition to standard clinical intervention. The site has Whole Health clinical leaders that serve as subject matter experts and has established training programs for the WH approach (e.g., offering resident training, clinical rotations for clinical staff and teams). The clinicians, CIH staff, and health coaches collaborate regularly to integrate seamless delivery of care to the Veteran using the Veteran's MAP and/or PHP as the foundation. This is evidenced by clinical documentation and increasing referrals to CIH and well-being approaches when appropriate (not only to treat illness but to support health, well-being, and self-care).

	Note: *Some sites will focus initially on a specialty care site (e.g., pain clinic). We decided that our goal is to have system transformation. In order for that to happen, WH approaches need to be in Primary Care, though we will also track training across system.*
Health Coaching *"Health Coaches may be embedded within a clinical care team, work with the health and well-being programs, or may be seen on a consultative basis. The ideal state includes utilization of certified health coaches in many different settings. In the interim, there may be many staff already trained in health coaching skills that can be a part of the newly developed process. Clinician coaches provide coaching in both individual and group settings and are available for individual case consultation. Once Health Coaches have been trained, the clinical care team needs to create the process whereby the team can refer the Veteran to health coaching for further support of that Veteran's health goal. Encourage use of non-traditional encounters to meet demand, such as shared medical appointments, telehealth, telephone encounters and secure messaging." (from OPCC WHSoC Implementation Guide)*	
Core Domain	**Indicators**
Whole Health trained coaches work with Veterans to develop a PHP and then check in via phone or in person on a weekly basis to discuss progress towards meeting goals, trouble shoot challenges faced, and revise action plans as needed	**GS=** The site is developing a plan for Whole Health Coaching services including identifying number of coaches to be hired, their primary service line, and the scope of their practice. **F** = Site hires or identifies individuals who can serve as WH coaches. They are developing a CPRS consult and/or referral process for WH coaching services. **To move higher:** Most individuals identified complete WH Coaching training. WH Coaching services (one on one and/or group coaching) are initiated. At this stage, sites should begin preparing the system for coaching, including introducing coaching to providers and preparing for them for implementation of coaching. This work should lay the foundation for future coordination between coaches, whole health services, and clinical providers/staff, as coaches largely serve as boundary spanners across the components of the Whole Health System of Care. At this stage, sites may use a range of individuals in a coaching role as they begin to pilot coaching; however, by the advanced stage they will be required to fill coaching roles using paraprofessional peers rather than clinically-trained staff (or otherwise determined by OPCC). **EI** = All individuals providing Whole Health coaching services are trained. Capacity to provide coaching services to Veterans increases, and coaching workloads are expanding. Coaching services are available beyond the main facility and happening in at least *some* CBOCs. **To move higher:** services are beginning to be spread to additional locations beyond the main hospital (which could be accomplished through telehealth). Coaches have begun to work in their roles and are learning to how to work within the system, including working across silos at the site. There is a process in place to get Veterans into coaching from any other WH system component. There is evidence that Whole Health Coaches are integrated into clinical care teams and/or are communicating with clinical care teams to support the health of Veterans. There is clear infrastructure in place to readily expand coaching, including having approved position descriptions in place. At this stage, sites may use a range of individuals in dedicated coaching roles; however, by the advanced stage they will be required to fill coaching roles using paraprofessional

	peers rather than clinically-trained staff (or otherwise determined by OPCC). **AI** = Whole Health Coaches are a part of the site's system of care. They enhance the work of clinical care teams and contribute to the overall approach to care for the Veterans they are working with. There is evidence that coaches have been integrated into the system, serving as boundary spanners to facilitate communication and coordination across the WH components and with clinical teams as part of their daily practice. Coaching provided to patients is based on what matters most to patients to help them achieve their personalized health goals. At this stage, individuals filling dedicated coaching roles need to meet OPCC's criteria (paraprofessional peers; not clinically-trained staff or staff incorporating coaching skills into their routine practice with Veterans). Coaching is available at *most* locations (which could be achieved through telehealth), and there are enough coaches to meet demand – this can partially be determined by considering whether there are coaches available to every PACT team. There is a process is in place to understand the supply-demand issue for Coaching services, with strategies and structures in place to respond to shifts in demand, expanding, contracting or shifting modalities as needed. **AV**= At this stage, coaching is available at all locations. There are enough coaches to meet demand and coaching services can readily be expanded in response to demand. Coaches are fully integrated into the healthcare system and serve to coordinate care across the components of the whole health system and with clinical providers/teams. Infrastructure and formalized processes are in place to routinely facilitate integration, communication, and coordination. Veterans can access coaching services from any point of entry into the whole health system, and there is strong integration between coaching and all whole health components. Coaches ground their work with Veterans in what matters most to each Veteran served and use the personal health plan to guide the services they provide. *Note: We may develop an indicator for the capacity to provide Whole Health Coaching services. This is TBD.*

Whole Health System – Implementation Tracking Tool (ITT)
Version 04-16-19

Center for Evaluating Patient Centered Care in VA
QUERI Partnered Evaluation Initiative

Live Whole Health.

Site Name: _____

Today's Date: _____ **Name of Person Completing Form:** _____

A. INFRASTRUCTURE

Whole Health Staff

1. Please provide information about the Whole Health leaders and staff that have been hired to support the development and oversight of your Whole Health System of Care. There are two spaces for each role. If only one person is filling the role, please leave the second space blank. ***If a role is filled, please enter information for ALL blank fields and answer ALL questions for that role***.

Role	What is this person's name?	What is this person's email?	What is this person's pay scale and level *[Note: if individual is on General Schedule, use GS-XX. If on Title 38 Schedule, use T38-XX. If on other pay scale and level, please specify]*	When did her/his work on Whole Health begin? (month/ year)	Is this person fulfilling the responsibilities of this position in a: (*select 1*)	Which of the following best characterizes how this person is meeting the responsibilities of this position:	Since completing the last ITS, approximately how many hours in a typical week did this person spend on activities related to the development and oversight of your Whole Health System? (do not include clinical time or program/service delivery)	Has this person *ever* participated in *any* of the core Whole Health trainings?* (see below)
Whole Health Clinical Director *Clinician who is charged with integrating WH approach into practices and processes of facility*					☐ Temporary Role ☐ Permanent Role	☐ Protected time for WH ☐ Collateral duty		☐ Yes ☐ No
Whole Health Clinical Director (second position, if applicable)					☐ Temporary Role ☐ Permanent Role	☐ Protected time for WH ☐ Collateral duty		☐ Yes ☐ No
Whole Health Program Manager					☐ Temporary Role ☐ Permanent Role	☐ Protected time for WH		☐ Yes ☐ No

Person supporting the roll out of WH across the facility; works with WH Clinical Director and key staff						☐ Collateral duty		
Whole Health Program Manager (second position, if applicable)					☐ Temporary Role ☐ Permanent Role	☐ Protected time for WH ☐ Collateral duty		☐ Yes ☐ No
Program Evaluation Assistant *Person hired to assist the EPCC evaluation team with data collection*					☐ Temporary Role ☐ Permanent Role	☐ Protected time for WH ☐ Collateral duty		☐ Yes ☐ No
Program Evaluation Assistant (second position, if applicable)					☐ Temporary Role ☐ Permanent Role	☐ Protected time for WH ☐ Collateral duty		☐ Yes ☐ No
Whole Health Administrative Support *Person who provides admin support on WH-related activities (e.g., organization of WH trainings, setting up telehealth, WH paperwork)*					☐ Temporary Role ☐ Permanent Role	☐ Protected time for WH ☐ Collateral duty		☐ Yes ☐ No
Whole Health Administrative Support (second position, if applicable)					☐ Temporary Role ☐ Permanent Role	☐ Protected time for WH ☐ Collateral duty		☐ Yes ☐ No
Physician Education Champion *MD/DO responsible for ongoing Whole Health training programs to site and VISN-level employees*					☐ Temporary Role ☐ Permanent Role	☐ Protected time for WH ☐ Collateral duty		☐ Yes ☐ No
Physician Education Champion (second position, if applicable)					☐ Temporary Role ☐ Permanent Role	☐ Protected time for WH ☐ Collateral duty		☐ Yes ☐ No
Non-Physician Education Champion *Non-MD/DO Health Professional responsible for ongoing Whole Health training programs to site and VISN-level employees*					☐ Temporary Role ☐ Permanent Role	☐ Protected time for WH ☐ Collateral duty		☐ Yes ☐ No
Non-Physician Education Champion (second position, if applicable)					☐ Temporary Role ☐ Permanent Role	☐ Protected time for WH ☐ Collateral duty		☐ Yes ☐ No
Whole Health Partner Lead *Person who manages Pathway activities and supervises those who deliver them (e.g., Partners, Peers, volunteers)*					☐ Temporary Role ☐ Permanent Role	☐ Protected time for WH ☐ Collateral duty		☐ Yes ☐ No

Whole Health Partner Lead (second position, if applicable)					☐ Temporary Role ☐ Permanent Role	☐ Protected time for WH ☐ Collateral duty		☐ Yes ☐ No
Other Whole Health Staff: *Person supporting your Whole Health System (non-service)*					☐ Temporary Role ☐ Permanent Role	☐ Protected time for WH ☐ Collateral duty		☐ Yes ☐ No
Other Whole Health Staff: *Person supporting your Whole Health System (non-service)*					☐ Temporary Role ☐ Permanent Role	☐ Protected time for WH ☐ Collateral duty		☐ Yes ☐ No
Other Whole Health Staff: *Person supporting your Whole Health System (non-service)*					☐ Temporary Role ☐ Permanent Role	☐ Protected time for WH ☐ Collateral duty		☐ Yes ☐ No
Other Whole Health Staff: *Person supporting your Whole Health System (non-service)*					☐ Temporary Role ☐ Permanent Role	☐ Protected time for WH ☐ Collateral duty		☐ Yes ☐ No
Other Whole Health Staff: *Person supporting your Whole Health System (non-service)*					☐ Temporary Role ☐ Permanent Role	☐ Protected time for WH ☐ Collateral duty		☐ Yes ☐ No

(*Whole Health 101, Whole Health in Your Practice, Whole Health in Your Life, Whole Health Coaching, Eating for Whole Health, Whole Health for Pain and Suffering, Nursing Engagement)

COMMENT BOX

Please enter any comments/information about your site's staffing.

Steering Committee

2. Does your site have a Steering Committee that focuses on developing a Whole Health System of Care for your hospital system? (*Note: Each site may have a different name for their Whole Health Steering Committee. We are interested in knowing if you have a designated group of people who are meeting to plan for and oversee the implementation of a Whole Health System of Care at your site.)*

   ☐ No

   ☐ Under Development

   ☐ Yes

   ☐ Yes, but currently revising organization and/or membership

If Yes,

2a. Which of the following does your Whole Health Steering Committee (or equivalent) have in place to guide its work? (check all that apply)

- ☐ A shared understanding among members of the purpose of the committee, its goals, and targeted activities
- ☐ A written document that outlines the purpose of the committee, its goals, and targeted activities
- ☐ A Charter (or equivalent) that allows your institution to recognize the Whole Health Steering Committee (or equivalent) as a formal entity within the hospital
- ☐ Official recognition of the Whole Health Steering Committee (or equivalent) with authority associated with a steering committee

COMMENT BOX

Please enter additional information about the purpose and authority of your Steering Committee (or equivalent) and its recognition by hospital leadership.

2b. How many times has the committee met over the last month?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4 or more

2c. If you have a Steering Committee, please provide names of all current Steering Committee members and their primary roles, including any Whole Health staff that are considered members of the Steering Committee (or equivalent):

Name	**Primary Role**

Communications and Marketing

3. Does your site have a formal communications plan that outlines your approach to educating patients and employees about Whole Health approaches and service offerings?
   - ☐ No
   - ☐ In process of developing
   - ☐ Yes

   3a. **If Yes**, Where are you in the process of implementing your communications plan?
   - ☐ Not yet started
   - ☐ Some materials and strategies have been developed and are being implemented
   - ☐ Most materials and strategies have been developed and are being implemented
   - ☐ All materials and strategies have been developed and are being implemented

4. What **patient-facing** materials or strategies have you used to raise awareness about the Whole Health System of Care at your site since the last ITS was completed? (check all that apply)
   - ☐ Presentation on Whole Health is integrated into all New Patient Orientation sessions
   - ☐ Formal welcome letters to patients and caregivers that include information about Whole Health
   - ☐ Information sessions about Whole Health for Veterans and/or caregivers
   - ☐ Veteran Monthly newsletters (or articles that appear in monthly newsletters) that include information about Whole Health
   - ☐ Awareness campaigns about Whole Health
   - ☐ Information about Whole Health communicated via flyers and pamphlets
   - ☐ Information about Whole Health shared with Veterans via social media
   - ☐ Veteran Town Hall meeting that includes info about Whole Health
   - ☐ Person-to-person outreach about Whole Health (e.g., tables set up in main area of the hospital, targeted outreach to programs)
   - ☐ Wellness Fair that includes Whole Health information or activities
   - ☐ Whole Health demonstrations or other experiential opportunities that are not otherwise part of your Whole Health System of Care
   - ☐ Other: _____

- ☐ None of the above

5. What **employee-facing** materials or strategies have you used to raise awareness about the Whole Health System of Care at your site since the last ITS was completed? (check all that apply*)*
   - ☐ Formal letters to employees that include information about Whole Health
   - ☐ Information sessions for employees that include education about Whole Health
   - ☐ Monthly newsletters (or articles that appear in monthly newsletters) for employees that include information about Whole Health
   - ☐ Awareness campaigns about Whole Health
   - ☐ Information about Whole Health communicated to employees via flyers and pamphlets
   - ☐ Information about Whole Health shared via social media
   - ☐ Information about Whole Health shared via email
   - ☐ Employee Town Hall meeting that includes information about Whole Health
   - ☐ Person-to-person outreach (e.g., clinical champions) about Whole Health
   - ☐ Information shared during staff meetings about Whole Health
   - ☐ Presentation about your site's Whole Health System of Care at New Employee Orientation
   - ☐ Staff retreats that provide an overview of Whole Health
   - ☐ Demonstrations of Complementary and Integrative Health services, Well-Being programs and Pathway activities or other experiential learning opportunities
   - ☐ Other: _____
   - ☐ None of the above

6. Since the last ITS was completed, have you marketed your Whole Health System of Care to any individuals or organizations outside your VA (e.g., YMCA, VSO, DoD Events)?
   - ☐ No
   - ☐ Yes >> **If Yes**, please describe: _____

COMMENT BOX

Please enter any comments/information about your site's Steering Committee *or* communications plan.

Whole Health Trainings

7. Since the last ITS was completed, have any employees, contractors, or volunteers from your site participated in the following Whole Health trainings?

Training Type	Any participated since last ITS?	Where did the training take place?	Who provided training?	Estimated # of participants from facility
Whole Health 101 8-hour foundational course for clinicians to explore and apply Whole Health approaches to optimize health and well-being for themselves and the Veterans they serve.	**N Y** **Do not know**	**[ ]** On-site (Your Flagship Facility) **[ ]** Off-site (Another VAMC or agency)	**[ ]** OPCC **[ ]** Your Education Champions **[ ]** Someone else from facility **[ ]** Other _____	
Whole Health 102F: Whole Health for You and Me (Flagships) 4-hour session for all staff (clinical and non-clinical) to understand what Whole Health is and how a Whole Health System can support the health and well-being of Veterans. Also helps staff explore their own health and well-being, which is foundational to a Whole Health approach to care.	**N Y** **Do not know**	**[ ]** On-site (Your Flagship Facility) **[ ]** Off-site (Another VAMC or agency)	**[ ]** OPCC **[ ]** Your Education Champions **[ ]** Someone else from facility **[ ]** Other _____	
Whole Health 202: Implementing Whole Health in Clinical Care Highly practical 4-hour experience for busy VA clinicians and clinical teams that provides a quick-start guide for helping patients optimize their own health and well-being and making clinical practice more effective, efficient and satisfying.	**N Y** **Do not know**	**[ ]** On-site (Your Flagship Facility) **[ ]** Off-site (Another VAMC or agency)	**[ ]** OPCC **[ ]** Your Education Champions **[ ]** Someone else from facility **[ ]** Other _____	
Whole Health in Your Practice 3-day course for providers (MDs, DOs, NPs, PAs) and other clinicians to help them advance skills in the delivery of personalized, proactive, patient-driven care.	**N Y** **Do not know**	**[ ]** On-site (Your Flagship Facility) **[ ]** Off-site (Another VAMC or agency)	**[ ]** OPCC **[ ]** Your Education Champions **[ ]** Someone else from facility **[ ]** Other _____	
Whole Health in Your Life 2-day course designed to introduce VA clinicians and clinical staff to the Whole Health approach by directly applying it to their own lives.	**N Y** **Do not know**	**[ ]** On-site (Your Flagship Facility) **[ ]** Off-site (Another VAMC or agency)	**[ ]** OPCC **[ ]** Your Education Champions **[ ]** Someone else from facility **[ ]** Other _____	
Whole Health Coaching, Part 1 First 3 days of a 6-day intensive training in communication and coaching skills.	**N Y** **Do not know**	**[ ]** On-site (Your Flagship Facility) **[ ]** Off-site (Another VAMC or agency)	**[ ]** OPCC **[ ]** Your Education Champions **[ ]** Someone else from facility	

			[ ] Other ___________	
Whole Health Coaching, Part 2 <u>Second</u> 3 days of a 6-day intensive training in communication and coaching skills	**N Y** **Do not know**	[ ] On-site (Your Flagship Facility) [ ] Off-site (Another VAMC or agency)	[ ] OPCC [ ] Your Education Champions [ ] Someone else from facility [ ] Other ___________	
Eating for Whole Health: Functional Approaches to Food and Drink 2-day clinical course designed as an advanced, stand-alone education course to introduce VA clinicians to the Whole Health approach as it relates to nutrition.	**N Y** **Do not know**	[ ] On-site (Your Flagship Facility) [ ] Off-site (Another VAMC or agency)	[ ] OPCC [ ] Your Education Champions [ ] Someone else from facility [ ] Other ___________	
Whole Health for Pain and Suffering: An Integrative Approach 2-day course provides education and skills-based practice on a Whole Health approach to pain and suffering using complementary and integrative therapies.	**N Y** **Do not know**	[ ] On-site (Your Flagship Facility) [ ] Off-site (Another VAMC or agency)	[ ] OPCC [ ] Your Education Champions [ ] Someone else from facility [ ] Other ___________	
Nursing Engagement Course providing an overview of the role of nurses in Whole Health. Topics include: information on the Whole Health model; incorporating a personalized, proactive patient-driven approach into nursing care; and implementing holistic strategies that support Veteran well-being and promote wellness.	**N Y** **Do not know**	[ ] On-site (Your Flagship Facility) [ ] Off-site (Another VAMC or agency)	[ ] OPCC [ ] Your Education Champions [ ] Someone else from facility [ ] Other ___________	
Other Whole Health Training: ________________	**N Y**	[ ] On-site (Your Flagship Facility) [ ] Off-site (Another VAMC or agency)	[ ] OPCC [ ] Your Education Champions [ ] Someone else from facility [ ] Other ___________	
Other Whole Health Training: ________________	**N Y**	[ ] On-site (Your Flagship Facility) [ ] Off-site (Another VAMC or agency)	[ ] OPCC [ ] Your Education Champions [ ] Someone else from facility [ ] Other ___________	
Other Whole Health Training: ________________	**N Y**	[ ] On-site (Your Flagship Facility) [ ] Off-site (Another VAMC or agency)	[ ] OPCC [ ] Your Education Champions [ ] Someone else from facility [ ] Other ___________	

8. Has a current member of your hospital executive leadership team (e.g., quadrad or pentad) <u>*ever*</u> taken part in <u>*any*</u> of the core Whole Health trainings listed above?

- ☐ Yes
- ☐ No

COMMENT BOX

Please enter any comments/information about your site's Whole Health Trainings.

Coding and Documentation

9. For which of the following services has your site set up Stop codes and CHAR4 codes? (check all that apply)
   - ☐ Pathway: Whole Health Orientation
   - ☐ Pathway: Exploring mission, aspiration and purpose (e.g., Taking Charge of My Life and Health course, meeting with Whole Health Partner or equivalent)
   - ☐ **Some** Complementary and Integrative Health services
   - ☐ **All** Complementary and Integrative Health Services
   - ☐ **Some** Well-Being classes
   - ☐ **All** Well-Being classes
   - ☐ Whole Health Coaching services
   - ☐ Other: _____
   - ☐ None of the above

10. Which of the following additional mechanisms does your site use to document Whole Health services or approaches in CPRS? (check all that apply)
    - ☐ None
    - ☐ Health Factors
    - ☐ CPT Codes
    - ☐ Other: _____

COMMENT BOX

Please enter any comments/information about how your site documents Whole Health services.

Space

11. Has your site gone through a process of identifying your Whole Health space needs?
    - ☐ No
    - ☐ In progress
    - ☐ Yes

12. To what extent is limited space preventing you from being able to hire the Whole Health staff you need?
    - ☐ Not at all
    - ☐ To some extent
    - ☐ To a great extent

13. Do you have sufficient space available for your Whole Health Pathway programs, including Orientation and group sessions like Taking Charge of My Life and Health?
    - ☐ No
    - ☐ Yes, for some programs
    - ☐ Yes, for all programs

14. Do you have sufficient space to provide WH Coaching services?
    - ☐ No
    - ☐ Yes, for some services
    - ☐ Yes, for all services

15. Do you have sufficient space for your Complementary and Integrative Health approaches, including rooms for individual and group classes or services?
    - ☐ No
    - ☐ Yes, for some classes/services

- ☐ Yes, for all classes/services

16. Do you have sufficient space for your Well-Being classes?
    - ☐ No
    - ☐ Yes, for some classes
    - ☐ Yes, for all classes
17. Is there dedicated space for your CIH approaches and Well-Being classes?
    - ☐ No
    - ☐ In process of developing/identifying
    - ☐ Yes, for some
    - ☐ Yes, for all

18. Has your site's leadership dedicated resources to create and/or maintain Healing Environments at either your hospital or CBOCs?
    - ☐ No
    - ☐ Yes

COMMENT BOX

Please enter any comments/information about space for Whole Health services at your site.

B. PATHWAY: WHOLE HEALTH ORIENTATION

19. Does your site offer one or more orientations designed to explain your site's Whole Health System of Care?
    - ☐ No
    - ☐ In process of developing
    - ☐ Yes

If Yes,

19a. Which of the following is included in your orientation(s) to Whole Health? (check all that apply)

- ☐ Overview of the Whole Health approach

- ☐ Information about Pathway activities and programs
- ☐ Information about Complementary and Integrative Health (CIH) services
- ☐ Information about Well-Being classes
- ☐ Information about Whole Health Coaching services
- ☐ Opportunity to explore the Personal Health Inventory (PHI) and/or the Circle of Health
- ☐ Other: _____

19b. Who can attend the orientation? (check all that apply)

- ☐ Transitioning service members
- ☐ New patients
- ☐ **All** current patients
- ☐ **Some** current patients >> Please specify: _____
- ☐ Other: _____

19c. Where do you offer the orientation to Whole Health? (check all that apply)

- ☐ In-person at the main VA hospital(s)
- ☐ In-person at **some** CBOCs and/or other VA healthcare sites
- ☐ In-person at **all** CBOCs and/or other VA healthcare sites
- ☐ In-person in a community setting/facility
- ☐ Via telehealth
- ☐ Online
- ☐ Other: _____

19d. How many Whole Health orientation sessions are offered per month? # _____

19e. How many people could participate per orientation session? # _____

20. What is your process for referring patients to the Whole Health orientation? (check all that apply)

- ☐ Do not have a process
- ☐ CPRS Consult
- ☐ Warm hand-off

- ☐ Self-referral
- ☐ Direct Scheduling
- ☐ Other: _____

COMMENT BOX

Please enter any comments/information about your site's Whole Health orientation

C. PATHWAY: EXPLORING MISSION, ASPIRATION AND PURPOSE

NOTE: We consider a Veteran having the opportunity to explore their mission, aspiration and purpose (MAP) to be the essence of the Pathway component. This can be done in a number of ways, including using the formal Taking Charge of My Life and Health (TCMLH) curriculum or individual sessions with a Whole Health Partner, Coach, or other trained staff/volunteer.

21. Does your site currently offer opportunities for patients to explore their mission, aspiration and purpose (MAP)?
    - ☐ Yes
    - ☐ No

If Yes,

21a. Are opportunities to explore mission, aspiration and purpose (MAP) offered through group sessions, such as Taking Charge of My Life and Health (TCMLH) classes?
- ☐ Yes
- ☐ No

If Yes,

→ Do you use the Taking Charge of My Life and Health (TCMLH) curriculum in group sessions?
- ☐ Yes

- ☐ No

→ Who can currently participate in group sessions? (check all that apply)

- ☐ Transitioning service members
- ☐ New patients
- ☐ **All** current patients
- ☐ **Some** current patients >> Please specify: _____
- ☐ Other: _____

→ Where are the group sessions offered? (check all that apply)

- ☐ In-person at the main VA hospital(s)
- ☐ In-person at **some** CBOCs and/or other VA healthcare sites
- ☐ In-person at **all** CBOCs and/or other VA healthcare sites
- ☐ In-person in a community setting/facility
- ☐ Via telehealth
- ☐ Online
- ☐ Other: _____

→ Who facilitates the group sessions? (check all that apply)

- ☐ Partner/Peer Specialist
- ☐ Whole Health Coach
- ☐ Volunteer
- ☐ Other: _____

→ What is your process for referring patients to group sessions? (check all that apply)

- ☐ No process set up
- ☐ CPRS Consult
- ☐ Warm hand-off
- ☐ Self-referral
- ☐ Direct Scheduling
- ☐ Other: _____

→ Across your healthcare system on a given week, how many group sessions are offered? # _____

→ On average, how many patients can participate in a group session? # _____

COMMENT BOX

Please enter any other information about your site's group sessions (locations, frequency, population, etc.).

21b. Are opportunities to explore mission, aspiration and purpose (MAP) offered through individual sessions? (*Note: Exploring MAP is distinct from or a precursor to Whole Health coaching; it focuses on discussing the components of the Wheel of Health and identifying what matters most.)*

- ☐ Yes
- ☐ No

If Yes,

→ Please provide a description of how mission, aspiration and purpose is explored in individual sessions with patients.

→ Who can currently participate in individual sessions? (check all that apply)

- ☐ Transitioning service members
- ☐ New patients
- ☐ **All** current patients
- ☐ **Some** current patients >> Please specify: _____
- ☐ Other: _____

→ Where are the individual sessions offered? (check all that apply)

- ☐ In-person at the main VA hospital(s)
- ☐ In-person at **some** CBOCs and/or other VA healthcare sites
- ☐ In-person at **all** CBOCs and/or other VA healthcare sites

- ☐ In-person in a community setting/facility
- ☐ Via telehealth
- ☐ Online
- ☐ Other: _____

→ With whom do patients explore their MAP in individual sessions? (check all that apply)

- ☐ Partner/Peer Specialist
- ☐ Whole Health Coach
- ☐ Volunteer
- ☐ Other: _____

→ What is your process for referring patients to individual sessions? (check all that apply)

- ☐ No process set up
- ☐ CPRS Consult
- ☐ Warm hand-off
- ☐ Self-referral
- ☐ Direct Scheduling
- ☐ Other: _____

→ <u>Across your healthcare system on a given week,</u> how many patients are able to explore their MAP in individual sessions? # _____

21c. Use this space to tell us any other ways your site explores mission, aspiration and purpose (MAP) with patients.

21d. Approximately how many VA staff/volunteers are currently designated to explore mission, aspiration and purpose (MAP) with patients (group and/or individual)? # _____

→ How many of these individuals have been formally trained to lead patients through this process (e.g., Whole Health Facilitated Group, Whole Health Partner, and/or Whole Health Coaching training)?

- ☐ None
- ☐ A few

- ☐ Some
- ☐ Most
- ☐ All

22. Thinking about your site's overall Pathway component, what is your recruitment strategy for bringing patients into Pathway programs (including Orientation and MAP)? (check all that apply)
    - ☐ No strategy developed
    - ☐ Presentation at New Patient Orientation sessions
    - ☐ Presentation at Patient Town Hall meetings
    - ☐ Outreach/marketing in community settings (e.g., local YMCAs, Veteran Service Organizations, etc.)
    - ☐ Outreach/marketing on military bases
    - ☐ Marketing/advertising directly to patients
    - ☐ Marketing/advertising directly to clinical teams
    - ☐ CPRS Consults
    - ☐ Other: _____

COMMENT BOX

Please enter any comments/information about your site's Pathway component.

D. WELL-BEING PROGRAMS

Complementary and Integrative Health approaches

23. Which of the following Complementary and Integrative Health approaches do you currently offer? (*Please include all CIH modalities happening across all locations, even if they are not yet affiliated with your Whole Health System of Care. Also, please include services such as yoga, tai chi, or meditation classes in this section, even if they are offered as well-being classes.*) Please note that we ask about services offered through Choice in a separate question.

		If yes: Who provides this service as part of the Whole Health System of Care? (check all that apply)	*If yes:* Where are these services provided? (check all that apply)	*If yes:*
Acupuncture	**N Y**	[] VA Employee [] Contracted service [] Volunteer	[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility (contracted service)	How many patients could receive this service per week? _____
Battlefield Acupuncture	**N Y**	[] VA Employee [] Contracted service [] Volunteer	[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility (contracted service)	How many patients could receive this service per week? _____
Chiropractic	**N Y**	[] VA Employee [] Contracted service [] Volunteer	[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility (contracted service)	How many patients could receive this service per week? _____
Massage	**N Y**	[] VA Employee [] Contracted service [] Volunteer	[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility (contracted service)	How many patients could receive this service per week? _____
Healing Touch	**N Y**	[] VA Employee [] Contracted service [] Volunteer	[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility (contracted service)	How many patients could receive this service per week? _____
Biofeedback	**N Y**	[] VA Employee [] Contracted service [] Volunteer	[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility (contracted service)	How many patients could receive this service per week? _____
Tai Chi classes	**N Y**	[] VA Employee [] Contracted service	[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites	How many classes are available per week? _____

		[] Volunteer	[] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility (contracted service) [] Via telehealth	How many patients could participate per class? _____
Yoga classes	**N Y**	[] VA Employee [] Contracted service [] Volunteer	[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility (contracted service) [] Via telehealth	How many classes are available per week? _____ How many patients could participate per class? _____

Meditation	**N Y**	[] VA Employee [] Contracted service [] Volunteer	[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility (contracted service) [] Via telehealth	Which of the following formats are used? ☐ 1-on-1 >> How many patients could participate in this service per week? _____ ☐ Group >> How many group sessions are available per week? _____ >> How many patients could participate per group session? _____
Guided Imagery	**N Y**	[] VA Employee [] Contracted service [] Volunteer	[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility (contracted service) [] Via telehealth	Which of the following formats are used? ☐ 1-on-1 >> How many patients could participate in this service per week? _____ ☐ Group >> How many group sessions are available per week? _____ >> How many patients could participate per group session? _____
Hypnosis	**N Y**	[] VA Employee [] Contracted service [] Volunteer	[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility (contracted service) [] Via telehealth	Which of the following formats are used? ☐ 1-on-1 >> How many patients could participate in this service per week? _____ ☐ Group >> How many group sessions are available per week? _____

				>> How many patients could participate per group session? _____
Other CIH approach: _____	**N Y**	[] VA Employee [] Contracted service [] Volunteer	[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility (contracted service) [] Via telehealth	Which of the following formats are used? ☐ 1-on-1 >> What is the total number of patients that could receive/participate in this service per week? _____ ☐ Group >> How many group sessions are available per week? _____ >> How many patients could participate per group session? _____

Other CIH approach: _____	**N Y**	[] VA Employee [] Contracted service [] Volunteer	[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility (contracted service) [] Via telehealth	Which of the following formats are used? ☐ 1-on-1 >> What is the total number of patients that could receive/participate in this service per week? _____ ☐ Group >> How many group sessions are available per week? _____ >> How many patients could participate per group session? _____
Other CIH approach: _____	**N Y**	[] VA Employee [] Contracted service [] Volunteer	[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility (contracted service) [] Via telehealth	Which of the following formats are used? ☐ 1-on-1 >> What is the total number of patients that could receive/participate in this service per week? _____ ☐ Group >> How many group sessions are available per week? _____ >> How many patients could participate per group session? _____

24. Are any of the following CIH approaches offered through referral to Choice provider? (check all that apply)
    - ☐ None
    - ☐ Acupuncture
    - ☐ Chiropractic

- ☐ Massage
- ☐ Other: _____

25. Do you have a process for referring patients to Complementary and Integrative Health (CIH) approaches/services?
    - ☐ No
    - ☐ Yes, for some services
    - ☐ Yes, for all services

25a. **If Yes to some or all**, What is the referral method for CIH services/approaches? (check all that apply)

- ☐ CPRS Consult
- ☐ Warm hand-off
- ☐ Self-referral
- ☐ Direct Scheduling
- ☐ Other: _____

COMMENT BOX

Please enter any comments/information about your site's Complementary and Integrative Health (CIH) services.

Well-Being Class Tracks

26. Do you offer classes to patients related to the following Well-Being topics? (*Please note: This section refers to skill-building classes aligned with each component of the Circle of Health. Classes are primarily educational and include experiential activities and opportunities to set goals aligned with the components. There is a designated curriculum developed by PIRE. But your site may offer classes using a locally-developed curriculum. Please do not include well-being classes focused on provision of a CIH modality, such as yoga, in this section.)*

	Do you currently offer an introductory	*If yes:* How many introductory/	*If yes:* How many patients could	*If yes:* Where is this type of introductory/starter class currently offered? (check all that apply)	*If yes or no:* Do you currently offer a more

	or starter course on this topic?	starter classes are available per week?	participate per class?		intensive, multi-week class on this topic?
Power of the Mind	[] No [] Yes, using PIRE Curriculum [] Yes, Other			[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility [] Via telehealth [] Online	[] No [] Yes, PIRE Curriculum [] Yes, Other
Working the Body	[] No [] Yes, using PIRE Curriculum [] Yes, Other			[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility [] Via telehealth [] Online	[] No [] Yes, PIRE Curriculum [] Yes, Other
Food & Nutrition	[] No [] Yes, using PIRE Curriculum [] Yes, Other			[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility [] Via telehealth [] Online	[] No [] Yes, PIRE Curriculum [] Yes, Other
Surroundings	[] No [] Yes, using PIRE Curriculum [] Yes, Other			[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility [] Via telehealth [] Online	[] No [] Yes, PIRE Curriculum [] Yes, Other
Personal Development	[] No [] Yes, using PIRE Curriculum [] Yes, Other			[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility [] Via telehealth [] Online	[] No [] Yes, PIRE Curriculum [] Yes, Other
Recharge	[] No			[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites	[] No [] Yes, PIRE Curriculum

	[] Yes, using PIRE Curriculum [] Yes, Other			[] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility [] Via telehealth [] Online	[] Yes, Other
Spirit and Soul	[] No [] Yes, using PIRE Curriculum [] Yes, Other			[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility [] Via telehealth [] Online	[] No [] Yes, PIRE Curriculum [] Yes, Other

Family, Friends and Co-workers	[] No [] Yes, using PIRE Curriculum [] Yes, Other			[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility [] Via telehealth [] Online	[] No [] Yes, PIRE Curriculum [] Yes, Other

26a.

Are there any other Well-Being classes currently offered?		*If yes:* How many classes are available per week?	*If yes:* How many patients could participate per class?	*If yes:* Where is this type of class currently offered? (check all that apply)
Other Well-Being class: _____	**N Y**			[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility [] Via telehealth [] Online
Other Well-Being class: _____	**N Y**			[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility [] Via telehealth

				[] Online
Other Well-Being class: _____	**N Y**			[] At the main VA hospital(s) [] At **some** CBOCs and/or other VA healthcare sites [] At **all** CBOCs and/or other VA healthcare sites [] In a community setting/facility [] Via telehealth [] Online

27. Do you have a process for referring patients to Well-Being classes?

- ☐ No
- ☐ Yes, for some services
- ☐ Yes, for all services

27a. **If Yes to some or all**, What is the referral method for Well-Being classes? (check all that apply)

- ☐ CPRS Consult
- ☐ Warm hand-off
- ☐ Self-referral
- ☐ Direct Scheduling
- ☐ Other: _____

COMMENT BOX

Please enter any comments/information about your site's Well-Being class offerings.

E. WHOLE HEALTH COACHING

NOTE: In this section, we are interested in learning more about Whole Health Coaching approaches that you have developed at your site. A Whole Health Coach is someone who has been formally trained in Whole Health coaching skills and uses those skills to support individuals and/or groups in working towards their mission, aspiration and purpose (MAP). Whole Health Coaches may also work closely with members of a patient's clinical team to support achievement of personal health goals.

28. Does your site offer Whole Health Coaching services (see definition above) either on an individual or group basis?

- ☐ No
- ☐ In process of developing
- ☐ Yes

If Yes,

28a. Where are Whole Health Coaching services offered? (check all that apply)

- ☐ In-person at the main VA hospital(s)
- ☐ In-person at **some** CBOCs and/or other VA healthcare sites
- ☐ In-person at **all** CBOCs and/or other VA healthcare sites
- ☐ In-person in a community setting/facility
- ☐ Via telehealth
- ☐ Online
- ☐ Other: _____

28b. What components of your Whole Health System of Care are your coaches most involved with? (check all that apply)

- ☐ Pathway: Whole Health Orientation
- ☐ Pathway: Exploring mission, aspiration and purpose (e.g., Taking Charge of My Life and Health course)
- ☐ Complementary and Integrative Health approaches
- ☐ Well-Being classes
- ☐ Clinical Care
- ☐ Other: _____

28c. How many individuals have been identified/hired to provide Whole Health Coaching services? # _____

28d. How many of these individuals have been formally trained in Whole Health Coaching (OPCC's Whole Health Coaching training or equivalent)? # _____

28e. On average, how many patients could receive Whole Health Coaching services per week? # _____

29. Do you have a process for referring patients to Whole Health Coaching services?

- ☐ No
- ☐ Yes, for some services

☐ Yes, for all services

29a. **If Yes to some or all,** What is the referral method for Whole Health Coaching services? (check all that apply)

- ☐ CPRS Consult
- ☐ Warm hand-off
- ☐ Self-referral
- ☐ Direct Scheduling
- ☐ Other: _____

COMMENT BOX

Please enter any comments/information about your site's Whole Health Coaching services.

F. CLINICAL CARE

NOTE: In this section, when we refer to the "Whole Health Clinical Care Approach" we mean the integration of Whole Health concepts (e.g., Asking: "What matters most to you and how can we help you live your best life?") into traditional healthcare service delivery including into conversations between patients and their clinical service providers.

30. Does your site have a plan for implementing a Whole Health Clinical Care approach that is aligned with the strategic plan of your VISN and facility?

- ☐ No
- ☐ In process of developing
- ☐ Yes

30a. **If Yes**, Where are you in the process of implementing your plan?

- ☐ Not yet started
- ☐ Some strategies are being developed and implemented
- ☐ Most strategies are being developed and implemented

31. Where have your efforts to develop a Whole Health Clinical Care approach been focused up to this point? (check all that apply)

- ☐ Outpatient Primary Care

- ☐ Outpatient Specialty Care
- ☐ Inpatient Care
- ☐ Outpatient Mental Health Care
- ☐ Inpatient Mental Health Care
- ☐ Other: _____

32. Where else will you be focusing efforts to develop a Whole Health Clinical Care approach in the future? (check all that apply)
    - ☐ Outpatient Primary Care
    - ☐ Outpatient Specialty Care
    - ☐ Inpatient Care
    - ☐ Outpatient Mental Health Care
    - ☐ Inpatient Mental Health Care
    - ☐ Other: _____

33. Does your site have Clinical Champions with explicit responsibilities to lead change within their departments, motivate colleagues, and coordinate use of Whole Health approaches to care?
    - ☐ No
    - ☐ In process of identifying champions
    - ☐ Yes – in some departments of focus
    - ☐ Yes – in all departments of focus

If Yes,

33a. Approximately how many Whole Health Clinical Champions does your site have? # _____

33b. About how many Clinical Champions have *ever* been trained in *any* of the core Whole Health trainings? (Whole Health 101, Whole Health in Your Practice, Whole Health in Your Life, Whole Health Coaching, Eating for Whole Health, Whole Health for Pain and Suffering, Nursing Engagement)

- ☐ None
- ☐ Some
- ☐ Most
- ☐ All

34. Do you have a process for training primary care providers to refer patients to Whole Health services and programs (e.g., CIH modalities, Well-Being classes, Pathway)?
    - ☐ No
    - ☐ In development
    - ☐ Yes

    34a. **If Yes,** Approximately how many primary care providers do you estimate have been trained on this referral process?
    - ☐ 0% (haven't started yet)
    - ☐ 1-25%
    - ☐ 26-50%
    - ☐ 51-75%
    - ☐ 76-100%

COMMENT BOX
Please enter any comments/information about your site's Clinical Care component.

G. PERSONAL HEALTH INVENTORY AND PERSONAL HEALTH PLANNING

NOTE: In this final section we are asking for information about tools that your site may be using to support patients' exploration of their mission, aspiration and purpose (i.e., what matters most to them). We refer to this as a Personal Health Inventory (PHI). We are also interested in opportunities that sites create for patients to develop personalized health goals aligned with what matters most to them. We refer to this as a Personal Health Plan (PHP).

35. Which of the following tools are you using to help patients identify what matters most to them? (check all that apply)
    - ☐ None
    - ☐ My Story PHI
    - ☐ Brief PHI
    - ☐ Whole Health Review of Systems from Boston
    - ☐ Reviewing the Circle of Health/Components of Health & Well-Being

- ☐ Health*e*Living Assessment (HLA)
- ☐ Other: _____

35a. Where or with whom are patients using these tools? (check all that apply)

- ☐ Orientation to Whole Health
- ☐ Taking Charge of My Life and Health programs
- ☐ Well-Being classes
- ☐ Whole Health Coaches
- ☐ Whole Health Partners
- ☐ Primary Care Teams
- ☐ Other: _____

36. Does your site offer opportunities for patients to work with clinical or non-clinical providers to create Personal Health Plans (PHPs) based on what matters most to them?

- ☐ Yes
- ☐ No

36a. **If Yes,** Where or with whom are patients developing PHPs? (check all that apply)

- ☐ PACT team members
- ☐ Specialty care providers
- ☐ Whole Health Coaches
- ☐ Whole Health Partners
- ☐ Other: _____

37. Do you have a way to document patients' Personal Health Inventories (PHI) in CPRS (medical record)?

- ☐ No
- ☐ In process of developing
- ☐ Yes

38. Do you have a way to document patients' Personal Health Plans (PHP) in CPRS (medical record)?
    - ☐ No
    - ☐ In process of developing
    - ☐ Yes

COMMENT BOX

Please enter any comments/information about the Personal Health Inventory or Personal Health Plan at your site.

Thank you for completing this survey. We appreciate you taking the time to provide this information for your site and for the Whole Health initiative.

Exemplar Whole Health Implementation Interview Questions
January 2018-October 2019

The questions provided below represent a mix of the different types of qualitative questions we ask Whole Health leads on a quarterly basis. Not all questions are asked in one interview. Rather we pulled together a sample of different types of questions that we have asked during different interviews to provide a sense of the information gathered.

Overall Whole Health System of Care (e.g. structure, plans, general progress)

1. We would like to get a general sense of your overall vision and plan for rolling out the Whole Health System of Care at your facility. Have you created a Tailored Organizational Plan (TOP) or other type of implementation plan yet? If so, briefly summarizing it would be helpful here. If not, please share your general sense of your plans for developing this system at your site.

2. Where do you hope to be in your implementation of Whole Health a year from now?

3. Since we last talked, what would you say has been the major focus of your Whole Health implementation efforts?
    a. What new advances or successes have you been able to make? What has facilitated these advances?
    b. What new (or existing) challenges have you faced?

4. At this point in time, how do you describe your approach to rolling out a Whole Health System of Care?
    a. What has worked well about your approach and what would you have done differently?
    b. What would you recommend to other sites that are launching a Whole Health System of Care?

5. How does your system of Whole Health intersect with other services at your site? (e.g. mental health, pain clinic)
    a. Have you developed formal processes or understandings with these other services? If so, please explain.

6. Since we last talked, what costs (other than personnel) have you incurred in the development or implementation of the Whole Health System of Care, if any? For example, travel for training (what does it cost on average to send someone to training?), space, technology, equipment?

Whole Health System of Care Components *(Probe for clarity in the following areas as needed.)*

Infrastructure

Next, I'm going to ask some specific questions about what we consider to be the infrastructure that you are putting into place to support the implementation of your Whole Health System of Care.

1. I'd like to start by asking you about your Whole Health Steering Committee.
    a. How often are you meeting at this point?
    b. What role does it play in your Whole Health implementation efforts? What do you attribute to it playing this kind of role?
    c. What are you focusing on in your Steering Committee meetings? In other words, what do you do in your meetings?

2. How involved are your hospital's leaders (Triad, Quad, Pentad) in the design and implementation of your Whole Health System of Care?
    a. What role do you think they play at this point?
    b. To what extent have they been involved in efforts to design, implement, and spread this approach to care?

3. We are interested in your opinion about the key staff that the Office of Patient-Centered Care thought would be important to have in place as you implement a Whole Health System of Care. These include: Clinical Director, Program Manager, Admin Support, Program Evaluation Assistant, Education Champions, and Lead Whole Health Partner. To what extent have these key positions been useful at your site? What has been challenging? What has worked well?

4. One thing we have talked less about with most sites is if and how your Whole Health implementation efforts involve Employee Health Services at your site. To what extent has Employee Health Services been involved in implementation efforts? What have you tried? What has been most/least successful?

5. The last question about infrastructure is just to confirm what we understand about where Whole Health sits within your organization. We believe that you are located within [_____] service line or department. What do you think are the strengths/challenges of this organizational structure?

Pathway

We have asked a number of questions about the Pathway on the Implementation Tracking Tool (ITT). We have just a few questions to confirm what we understand or fill in some of the blanks when needed.

6. Interviewer recount and confirm what you understand about Orientation. Make sure you have a good sense of who is receiving an Orientation to Whole Health and what sites offer an Orientation.

7. With respect to exploration of Mission, Aspiration and Purpose (MAP)- we understand that your site has [group and/or individual] opportunities to explore MAP with Veterans.
    a. Where are the group opportunities available? Who is leading the groups? How do you assess the quality of group sessions? (i.e., are there any checks or on-going training provided?)
    b. If site offers on an individual basis – please provide some more detail about how this actually works in practice? How are Veterans engaged? What engages them in MAP? What length of time is spent exploring MAP? What do you see as differences in the content delivered between the individual and group sessions?

8. To what extent are Pathway services utilized at your site? What kind of interest and/or demand do you see for these services? Why do you think this is?

Well-Being

9. Interviewer confirm what you understand about where CIH services are located across the system. Focus specifically on Tier 1 services if short on time.

10. Discuss the Well-Being classes: Who is leading them? If they have started classes, how are they going? If they have their own, to what extent are they aligned with the starter classes?

Clinical Care

11. It is probably the most challenging for us to understand how sites have approached transforming clinical care to use a Whole Health approach. How are you approaching the transformation of your clinical care? What does a Whole Health approach look like in practice at your site? To what extent do you think care is currently driven by personal health plans?
    a. What has been challenging with clinical care?
    b. What has been most successful?
    c. What does training look like?
    d. Ask about locations/sites where things are transforming?

12. Can you remind me again how Personal Health Inventories (PHI) and Personal Health Plans (PHP) are done at your site? Where and with whom is it done? Where could a provider find it in the medical record? How is it used (updated regularly, access to inform care)?

Whole Health Coaches

13. We are learning that there is a lot of variation in how Health Coaches are being implemented at each site. What is your current thinking about the role that Health Coaches will play in your Whole Health System of Care?
    a. What are/will the coaches (be) doing? (e.g., focusing on MAP, developing PHPs)
    b. Who else is involved in these activities?

Patient Recruitment and Utilization

1. Please describe any specific outreach you are doing with patients with different conditions or with specific clinics (e.g. pain)?

2. What particular group(s) of veterans, if any, are taking most advantage of Whole Health services?

3. What is your experience using Whole Health approaches with individuals that are struggling with meeting their basic needs (e.g., food insecurity, unstable housing, limited income)?
   a. To what extent is this a consideration in your approach?
   b. To what extent do you think social determinants of health impact adoption of a Whole Health approach?
   c. How do you tailor Whole Health approaches to support individuals who have social and economic challenges?

Balancing Supply and Demand in the Whole Health System of Care

1. We are interested in understanding how sites determine how many classes and services they need to create to meet demand. (By this we mean classes and services for all Whole Health-related activities like Whole Health Orientation, Taking Charge of My Life and Health type classes, Complementary and Integrative Health, Well-being and Whole Health Coaching.) In the ITT, you have told us what your capacity is for each of the Whole Health services/activities- can you tell us how you determined how many classes to offer for each?
   a. Do you have a system or process in place to determine what demand for these services is? If so, please describe. (probe: Do you think there is more demand for your services than you are currently meeting?)
   b. Do you have the capability/flexibility to expand or contract services as needed? If so, please describe how this is done.
   c. If not, are there plans to develop a process to determine demand and adapt supply of Whole Health activities?

Impact of the Whole Health System of Care

1. Thinking about your Whole Health efforts, what would you say have been the major impacts of your transformation efforts at this point? (Probe: Perspective of Veterans, Employees, Hospital System as a whole)

Overview of Flagship Sites' Progress Towards Whole Health Transformation by Quarter

The figure below provides a high-level overview of each Flagship sites' progress towards transformation in the Implementation Stage. The left side of the figure (red), indicates very early stages of transformation. The right side of the figure (dark green) represents advanced stages of transformation.

Site	Y1Q1	Y1Q2	Y1Q3	Y1Q4	Y2Q1	Y2Q2	Y2Q3/Q4*
D							
A							
E							
L							
H							
I							
K							
J							
B							
G							
R							
M							
F							
O							
P							
Q							
C							
N							

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Figure 2.1: Progress Towards WH Transformation by Quarter- Flagship Sites. **In Year 2, we combined quarters 3 and 4 to reduce data collection burden on sites who were requested to complete multiple study surveys during this period.*

Reference List

1. Trotter R, Needle R. RARE Project Field Assessment Training Methods Workbook. 2000.
2. Trotter R, Needle R, Goosby E, Bates C, Singer M. A Methodological Model for Rapid Assessment, Response, and Evaluation: The RARE Program in Public Health. Field Methods. 2001;13(2):137-159.
3. U.S. Department of Veterans Affairs, Veterans Health Administration. VHA Directive 1137: Provision of Complementary and Integrative Health. Washington, D.C., May 18. 2017.

Appendix 3 Table of Contents

Utilization of Whole Health System Services During Flagship Pilot

1) Overview

We used the VA Electronic Health Record (EHR) and other administrative data sources to identify WHS services provided at the 18 WHS pilot sites from Q1 FY2016 – Q3 FY2019. We looked for records of 10 types of Whole Health services – Core Whole Health (including the Whole Health Pathway, Education, and Coaching), Chiropractic Care, and List 1 CIH services (Acupuncture, Battlefield Acupuncture, Massage, Meditation, Yoga, Tai Chi, Hypnosis, Biofeedback, and Guided Imagery). We use this data in two ways:

1. To assess changes in utilization of WHS services at pilot sites prior to and during the pilot WHS rollout
2. To define sub-populations of Veterans at the WHS pilot sites who utilized WHS services

The pilot sites received significant support to implement the WHS during the pilot period with the goal of increasing patient access to WHS services; changes in utilization of services are one way to gain insight into how access to services is changing throughout the pilot period. This data is combined with qualitative data about implementation to create a fuller picture of the development of the WHS at each of the flagship sites.

One focus of this evaluation is to assess the impact of the WHS on Veteran health outcomes. To accomplish this, we needed to determine which Veteran VA users at the 18 pilot sites were also users of WHS. We used patient-level utilization data to determine membership in 4 overlapping groups of WHS users and compared outcomes among users to Veterans from the same time periods who did not use WHS services.

2) Cohort definition

In each quarter from Q1 FY2017 to Q3 FY 2019 we defined a cohort of Veteran VA users at the 18 flagship sites. Users entered the cohort by having a qualifying outpatient primary care (Primary Stop Codes: 322, 323, 348, 350), mental health (Primary Stop Code: 502, 509, 510, 513, 533, 534, 539, 540, 550, 562, 565), or pain clinic (Primary Stop Code: 420) visit in the quarter. We report quarterly utilization among this derived cohort. Each patient in the quarterly cohort was associated with an index date – the date of their qualifying visit in the quarter. If a patient had more than 1 qualifying visit in the quarter their latest visit date was used as their index date.

We also defined 3 high impact clinical patient populations. We identified patients with **Chronic Pain** using an algorithm developed by the VA-DoD Pain Management Collaboratory. We used a set of diagnosis (ICD10) codes related to musculoskeletal (MSK) pain to identify patients with documented MSK pain. Codes were selected by their ICD10 Code category and subcategory and included codes in the following categories (a subset of the categories identified by Goulet, *et al*, 2016)[1] :

Table 3.1: **Pain Categories Included in Chronic Pain Cohort**

Back pain
Neck pain
Limb/extremity pain, joint pain and arthritic disorders - include all subcategories except: - Gout and other crystal arthropathies - Neuropathic arthropathy
Fibromyalgia

Headache: include only Tension Type Headache (TTH)
Orofacial, ear, and temporomandibular disorder pain
Musculoskeletal chest pain
Other Painful conditions: include only General Pain

To include a veteran in the Chronic Pain cohort, we looked for one occurrence of these diagnosis codes in the year prior to (and including) the date of their quarterly index visit. To be included in the cohort, veterans were also required to have 2 moderate-to-severe pain severity scores (NRS >=4) in the year prior to the index visit, separated by at least 30 days.

We included patients with a diagnosis for anxiety, depression, or PTSD in a **Mental Health** cohort. We adapted ICD10 diagnosis codes from an ICD9 diagnosis code list developed by the VA's Primary Care Analytics Team (PCAT)[2] using AHRQ's MapIT tool (available at https://www.qualityindicators.ahrq.gov/Resources/Toolkits.aspx) and the FY2018 mapping of ICD9 to ICD10 codes. If a patient had a documented diagnosis in the year prior to their quarterly index visit, they were included in the Mental Health cohort.

We included patients with a diagnosis for cardiovascular disease (excluding hypertension), chronic obstructive pulmonary disease (COPD), diabetes, or obesity in a **Chronic Conditions** cohort. These diagnosis sets were chosen because self-management is emphasized in care for these conditions. We adapted ICD10 diagnosis codes from the ICD9 codes in the Elixhauser comorbidity index[3] using the AHRQ MapIT tool.

Each quarter in the evaluation period, approximately 500,000 veterans had a qualifying visit at one of the 18 flagship sites. A description of the Q3 2019 cohort is presented in Table 1, below. Note this table also includes information about WH user categories. Definitions for those categories can be found below in section 4.

***Table 3.2* Quarterly Cohort Patient Demographics** (Example of Quarterly Cohort for Quarter 3 FY2019)

			WHS User Category			
Variable	**Overall**	**No Use**	**Low Intensity**	**CIH Intensive**	**Core WH Intensive**	**Comprehensive**
N	531858	492651	39207	24644	5220	3768
Gender: N (%)						
Female	55109 (10.4)	47591 (9.7)	7518 (19.2)	4830 (19.6)	1227 (23.5)	1027 (27.3)
Male	476749 (89.6)	445060 (90.3)	31689 (80.8)	19814 (80.4)	3993 (76.5)	2741 (72.7)
N	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Age: N (%)						
18-39	67660 (12.7)	61092 (12.4)	6568 (16.8)	4267 (17.3)	501 (9.6)	443 (11.8)
40-54	88500 (16.6)	78499 (15.9)	10001 (25.5)	6559 (26.6)	1298 (24.9)	1089 (28.9)
55-64	97674 (18.4)	88226 (17.9)	9448 (24.1)	5737 (23.3)	1581 (30.3)	1107 (29.4)
65-74	173807 (32.7)	163644 (33.2)	10163 (25.9)	6248 (25.4)	1502 (28.8)	915 (24.3)
75-90	94937 (17.9)	92026 (18.7)	2911 (7.4)	1770 (7.2)	330 (6.3)	211 (5.6)

			WHS User Category			
Variable	**Overall**	**No Use**	**Low Intensity**	**CIH Intensive**	**Core WH Intensive**	**Comprehensive**
NA	9280 (1.7)	9164 (1.9)	116 (0.3)	63 (0.3)	8 (0.2)	3 (0.1)
Race: N (%)						
White	394799 (74.2)	366074 (74.3)	28725 (73.3)	18312 (74.3)	3352 (64.2)	2408 (63.9)
Black	93146 (17.5)	85482 (17.4)	7664 (19.5)	4444 (18.0)	1565 (30.0)	1133 (30.1)
Asian	4145 (0.8)	3725 (0.8)	420 (1.1)	304 (1.2)	37 (0.7)	32 (0.8)
Multiple	34 (0.0)	31 (0.0)	3 (0.0)	2 (0.0)	0 (0.0)	0 (0.0)
Missing	31407 (5.9)	29741 (6.0)	1666 (4.2)	1078 (4.4)	174 (3.3)	129 (3.4)
Other	8327 (1.6)	7598 (1.5)	729 (1.9)	504 (2.0)	92 (1.8)	66 (1.8)
Hispanic: N (%)						
Yes	30982 (5.8)	28615 (5.8)	2367 (6.0)	1446 (5.9)	305 (5.8)	212 (5.6)
No	480337 (90.3)	444671 (90.3)	35666 (91.0)	22434 (91.0)	4796 (91.9)	3464 (91.9)
Unknown	20539 (3.9)	19365 (3.9)	1174 (3.0)	764 (3.1)	119 (2.3)	92 (2.4)
Marital Status: N (%)						
Married	311137 (58.5)	289286 (58.7)	21851 (55.7)	14114 (57.3)	2694 (51.6)	2015 (53.5)
Not Married	215057 (40.4)	197987 (40.2)	17070 (43.5)	10338 (41.9)	2499 (47.9)	1736 (46.1)
NA	5664 (1.1)	5378 (1.1)	286 (0.7)	192 (0.8)	27 (0.5)	17 (0.5)
Pain Category: N (%)						
Back pain	16639 (3.1)	14850 (3.0)	1789 (4.6)	1131 (4.6)	162 (3.1)	93 (2.5)
Fibromyalgia	337 (0.1)	295 (0.1)	42 (0.1)	26 (0.1)	6 (0.1)	3 (0.1)
Headache	43 (0.0)	38 (0.0)	5 (0.0)	4 (0.0)	0 (0.0)	1 (0.0)
Limb/extremity and joint	30591 (5.8)	29042 (5.9)	1549 (4.0)	702 (2.8)	304 (5.8)	127 (3.4)
Musculoskeletal chest	3649 (0.7)	3505 (0.7)	144 (0.4)	49 (0.2)	29 (0.6)	5 (0.1)
Neck pain	1894 (0.4)	1720 (0.3)	174 (0.4)	107 (0.4)	12 (0.2)	5 (0.1)
Orofacial, ear, and TMJ*	309 (0.1)	284 (0.1)	25 (0.1)	16 (0.1)	1 (0.0)	2 (0.1)
Other	1920 (0.4)	1713 (0.3)	207 (0.5)	105 (0.4)	46 (0.9)	31 (0.8)
More than one	97008 (18.2)	76537 (15.5)	20471 (52.2)	13535 (54.9)	2846 (54.5)	2561 (68.0)
None	379468 (71.3)	364667 (74.0)	14801 (37.8)	8969 (36.4)	1814 (34.8)	940 (24.9)
Chronic Pain Cohort: N (%)						
Yes	152390 (28.7)	127984 (26.0)	24406 (62.2)	15675 (63.6)	3406 (65.2)	2828 (75.1)

			WHS User Category			
Variable	**Overall**	**No Use**	**Low Intensity**	**CIH Intensive**	**Core WH Intensive**	**Comprehensive**
Mental Health Cohort: N (%)						
Yes	222974 (41.9)	197572 (40.1)	25402 (64.8)	15870 (64.4)	3829 (73.4)	2884 (76.5)
Chronic Condition Cohort: N (%)						
Yes	297763 (56.0)	274972 (55.8)	22791 (58.1)	13629 (55.3)	3785 (72.5)	2549 (67.6)

*TMJ = Temporomandibular joint disorder

3) Quarterly Measures of WHS Service Utilization

In each quarter from Q1FY2017 to Q3FY2019 we use the method described above to identify a quarterly cohort of VA healthcare users as a denominator and we calculate two metrics to describe the level of WHS service utilization for each quarterly cohort. Across the 18 Flagship sites this denominator was approximately 500,000 Veterans and represents the number of VA healthcare users during each quarterly time period. Note Veterans can be in multiple quarterly cohorts if they used other VA healthcare services (primary care, mental health or specialty pain care). For each quarterly cohort we calculated two measures of WHS utilization:

A. Same quarter use: What percentage of the quarterly cohort had a WHS visit in the same quarter as using other VA primary, mental health or pain care.
B. Any concurrent or prior use: What percentage of veterans in the quarterly cohort have ever used a WHS service (beginning from October 2015 to the quarter of interest).

We calculate these metrics for each individual WHS service, overall for any WHS service overall, overall for Whole Health Core services, and overall for any CIH service.

4) WHS User Definitions

In each quarter from Q1FY2017 to Q3FY2019 we use the utilization data to categorize cohort members into WHS user categories. These measures require assessing how much WHS utilization each Veteran has participated in. For this calculation we examine the cumulative WHS utilization in the 12 months prior to their index date (e.g. last primary care/mental health visit) in the quarter.

Table 3.3: **Utilization Criteria for WH User Categories**

WHS User Category	**Use Criteria (cumulative use of WHS 12 months prior to quarterly index/last visit date)**
Comprehensive WHS Use	>= 8 total WH touches (>= 2 Core Whole Health touches + >= 2 CIH touches)

Whole Health Intensive Use	>= 4 Core WH, any CIH
CIH Intensive Use	>= 4 CIH, any Core WH
Any 2+ WHS Use	>= 2 of any WHS service or self-reported use
No WHS Use	All Veterans with 0 or 1 WHS visits

A single Veteran who appears in multiple quarterly cohorts could be in a different user category in each quarter, depending on when they received WHS services. These utilization categories are used to define patient populations for comparisons of outcomes between users and non-users (see the Veteran Impact section in main report and Appendix 4). For the PRO survey analysis, data from the electronic health record is supplemented with patient survey responses about WHS utilization to develop a final WHS user category.

5) Detailed Definitions of Types of WHS services

We used the EHR to identify WHS visits beginning October 2015. We looked for records of 10 types of Whole Health visits in the VA EHR – Core Whole Health (including the Whole Health Pathway, Education, and Coaching), Chiropractic Care, and List 1 CIH services (Acupuncture, Massage, Meditation, Yoga, Tai Chi, Hypnosis, Biofeedback, and Guided Imagery). We used CPT codes (if applicable), clinic stop codes (if applicable), clinic names, CHAR4 codes, note titles, health factors, and community care billing information (by CPT code – chiropractic care, acupuncture, and massage only). See below for details on how we identified provision of each service.

We used guidance from OPCC&CT, input from the flagship sites, and feedback from subject matter experts to develop search terms for each of the 10 types of visits across multiple domains within the VA EHR. Records for the same patient on the same day were combined into a single episode of utilization. While some VA data sources have a shared visit identifier that could be used to link across data sources, others do not. Thus we grouped similar types of visits appearing on the same day from different data sources, based on assumption that a patient only has one visit for a particular modality on a single day. For example if we found one or more CPT codes for acupuncture and a CHAR4 code for acupuncture on the same day, this was coded only as a single acupuncture encounter.

CPT codes, Char4 codes, and Clinic Stop Codes are structured data fields, so we search for visits using the code lists we developed. Clinic Names, Note Titles, and Health Factors are unstructured data fields, so for each modality we develop a set of string patterns to search for in semi-structured data fields in the VA EHR.

We also developed exclusion strings to ensure that we did not count records associated with no show visits or referrals to community care (care received in the community was analyzed separately).

Core Whole Health Coding in EHR. We define a subset of Whole Health Services as Core WH – this includes Pathway, Coaching, or WH Education/Skills classes and services. We exclude

from this category List 1 CIH services and Chiropractic Care because they are analyzed separately (see below) and other services that sites may roll out as part of their Whole Health programs (e.g. Reiki, Animal-assisted therapy, Movement therapy although these services may have been coded as "Whole Health-Reiki") because we have little information about how these services are similar or different across locations. In addition, we do not break out utilization by subtype of Core WH (e.g. generate counts for Pathway vs. Coaching) because we know that a single visit may incorporate elements of multiple types of WH services and because we know that there is variation between sites in terms of how such services are categorized.

We search for Core WH visits using the following search terms:

Table 3.4: **Search Terms Used to Determine Core WH Visits**

CPT	-
Char4	HTAC, HTFC, RLFX, WCDC, WCEC, WCHC
Stop Code	-
Search Strings	'TAKING CHARGE', 'TCMLH', 'INTRODUCTION TO WHOLE HEALTH', 'ORIENTATION', 'WHOLE HEALTH INTRODUCTION', 'PEER', 'PARTNER', 'PERSONAL HEALTH INVENTORY', 'PHI', 'PERSONAL HEALTH PLAN', 'PHP', 'PATHWAY', 'COACH', 'WHOLE HEALTH EDUCATION', 'EVP', 'EMPOWER VETERANS', 'EDUCATION'

Because non-Core WH or non-WH visits may also be associated with these search strings, we embed this search within a larger search that excludes CIH visits, non-Core WH visits, administrative visits (e.g. Integrative Health Consults), and non-WH visits (e.g. visits with "Orientation" in the name that are not associated with WH Orientation).

We specifically exclude the following types of WH associated visits:

Table 3.5: **WH-Associated Visits Excluded for Purposes of Determining WH Core Visits (Search Strings)**

Visit category	**Visit types excluded**
Chiropractic Care	Chiropractic Care
CIH	List 1 (Acupuncture, Massage, Yoga, Tai Chi, Meditation, Hypnosis, Guided Imagery, Biofeedback), Healing Touch, Aromatherapy, Reiki, Expressive Arts, Native American Healing Traditions, Animal-assisted therapy
Not Otherwise Specified	Movement therapy, Nutrition
Clinical Care/Integrative Consult	Healthfactor: Integrative Health Consult (identified by Healthfactor)

CIH Visit Coding in EHR

Table 3.6: **WH-Associated Visits Excluded for Purposes of Determining WH Core Visits (EHR Codes)**

Visit Type	CPT Code	Char4 Code	Stop Code	Search Strings[1]
Chiropractic Care	98940, 98941, 98942, 98943	RHGC	436	*Includes:* 'chiro' *Does not include:* 'acup'
Acupuncture[2]	97810, 97811, 97813, 97814, S8930	*BFA:* IACT *Trad:* ACUP	-	*Traditional Includes:* 'acup' 'acpu' *Traditional excludes:* 'bfa', 'battlefield' *BFA Includes:* 'battlefield' 'bfa' *All excludes:* 'acupressure'
Massage	97124	MSGT	-	*Includes:* 'massage', 'acupressure' 'acupr'
Yoga	-	YOGA	-	*Includes:* 'yoga' *Excludes:* 'irest'
Tai Chi/Qi Gong	-	TAIC	-	*Includes:* 'taichi' 'tai chi' 'taic' 'taiji' 'taiji' 'qigong' 'qi gong'
Meditation[3]	-	MANT MBSR MDTN MMMT	-	*Includes:* 'mindful' 'mantram' 'meditation' 'irest' 'mbsr'
Guided Imagery (GIMA)	-	GIMA	-	*Includes:* 'guided'

				'imagery' 'guided image' *Excludes:* 'biopsy' 'core' 'ultrasound' 'biopsy'
Hypnosis (Hypn)	90880 98960	HYPN	-	*Includes:* 'hypn' 'hypno' 'hypnosis' 'hypnotherapy' *Excludes:* 'hypnotic'
Biofeedback (BioF)	90875 90876 90911 90901	BIOF	-	*Includes:* 'biofeed' 'bio feed' 'neurofeed' 'neuro feed'

[1] Search strings are used to generate lists of Clinic Names (Location Names), Notetitles, and HealthFactor titles utilized at the 18 flagship sites to record each type of visit.
[2] We searched for Battlefield Acupuncture (BFA) separately from traditional acupuncture. Daily utilization was categorized as BFA if any of the data from that day was consistent with BFA. In this report, BFA and traditional acupuncture are combined.
[3] We did not distinguish between the different types of meditation practice offered in the VA such as Mantram Repetition, Mindfulness, Mindfulness-Based Stress Reduction, iRest Yoga Nidra, etc.

Exclusions. We made efforts to exclude records that satisfied our search terms but were associated with no show visits or were administrative visits without provision of care. These could include referrals to VA services, community care, consultations, or other notes.

We employed 3 strategies to exclude these visits:

i) Excluding administrative stop codes associated with Community Care/CHOICE referrals from the outpatient visits queried. We only applied this filter to visit types commonly referred to the community – Acupuncture, Massage, and Chiropractic Care.

Administrative stop codes excluded: 655, 656, 660, 669, 674

ii) Excluding administrative strings from the unstructured searches. We excluded locations, note titles, and health factors that included these strings even if they also included the strings we searched for above.

Strings excluded from unstructured searches:
'research',
'rsch',
'messaging'
'choice'

'community care'
'non va'
'vcp'
'e-consult'
'econsult'
'e consult'
'telephone'
'referral'
'outside'
'no show'

We validated these strings to check that notes including these strings were rarely (<30%) associated with other indicators of service provision. We note that this exclusion is not an overriding exclusion – so a visit with one of these notes that is also associated with a CPT code or health factor consistent with service provision, the visit will count towards utilization.

Because Whole Health Coaching and other services can be provided remotely, we do not exclude the 'telephone' string from the core whole health search.

iii) Applying overarching exclusions. "No show" visits are often noted with a note recorded in the Outpatient visit record. Visits that were only associated with a clinic name and not any other indication of service were queried for to see if they were associated with a "No show" or other administrative note. If so, they were excluded.

The overarching notes excluding location only visits are:
'choice referral',
'community care referral'
'non va referral'
'no show'

The vast majority of visits excluded through this method were associated with "no show" notes.

*Community Care data**.*** Community care provision of chiropractic care, acupuncture, and massage was found using the program integrity tool (PIT) tables. We used the PITProfessionalClaims table to find CPT codes for these services (as listed above). As with the VA data, we count community care utilization on the level of the patient-day, and combined CPT codes of the same type on the same day into a single encounter.

6) Summary of How WHS Services are Coded in EHR - Venn Diagrams

We integrated data from many parts of the EHR to get the fullest possible picture of veteran utilization. We analyzed our data to understand how visits of each type were being recorded in the medical record and found both significant changes over time and differences in patterns between visit types. We visualize these coding patterns using Venn diagrams, where the regions represent a coding method (e.g. CPT Codes, Notetitles, Location Names) and the numbers represent the number of patient-days in a given period that are associate with each method.

The Venn diagrams highlight how rapidly the coding methodology for tracking CIH service provision is changing at the 18 flagship sites. This rapid development must be kept in mind when evaluating our utilization data – some of the increases in utilization that we observe is likely due to improved coding practices at the sites and only to an increase in use. Some visit types may be more prone to this kind of artifact than others. Acupuncture and Chiropractic Care, for example, can be coded using a standardized CPT code and we find that upwards of >=90% of visits we find are associated with this code in both FY2017 and FY2019. We do not think that changes in coding are a large contributor to increases in these services. Yoga and Tai Chi, on the other hand, previously had no standardized code and sites faced significant issues coding these visits and ensuring that the visits entered the EHR. We anticipate that coding changes may contribute more significantly to the trends observed for these modalities.

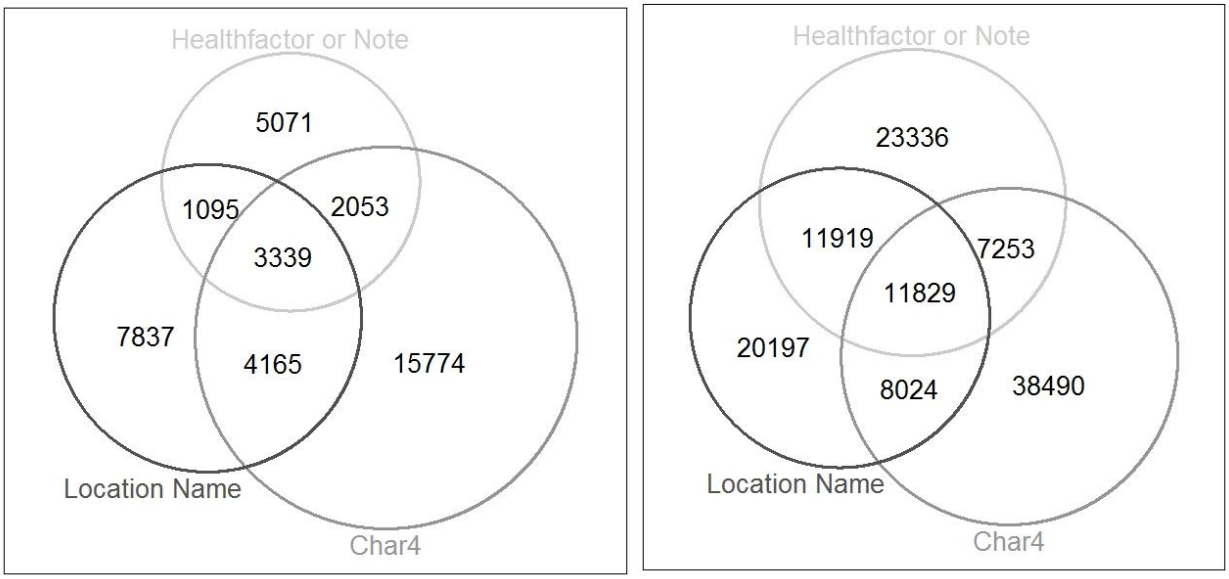

Figure 3.1: 39,334 total visits in FY 2018, 121,048 Core Whole Health visits found in FY2019. *This figure shows the variety of ways Whole Health visits are coded across the EHR. Here we compare to FY2018 and not FY2017 because there were very few (4,163) visits in FY2017.*

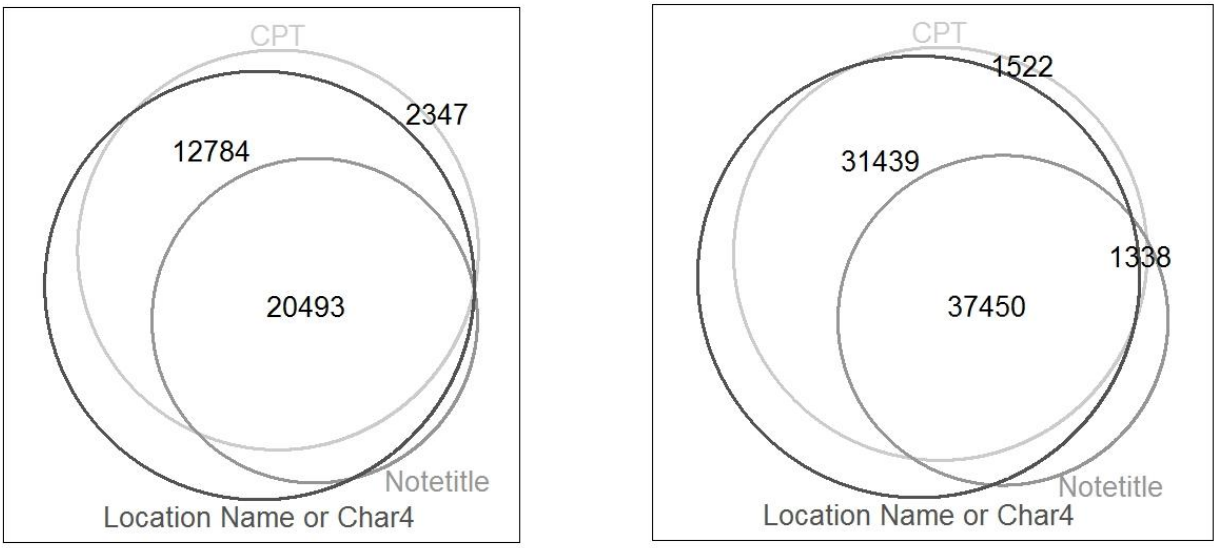

Figure 3.2: Chiropractic care visit coding FY2017 (left), FY2019 (right). *48,115 total visits in FY2017, 90,131 total visits in FY2019. For clarity, only showing CPT-associated visit counts. This figure does not show visits identified only by the 436 stop code (4,219 in FY2017, 1,747 in FY2019).*

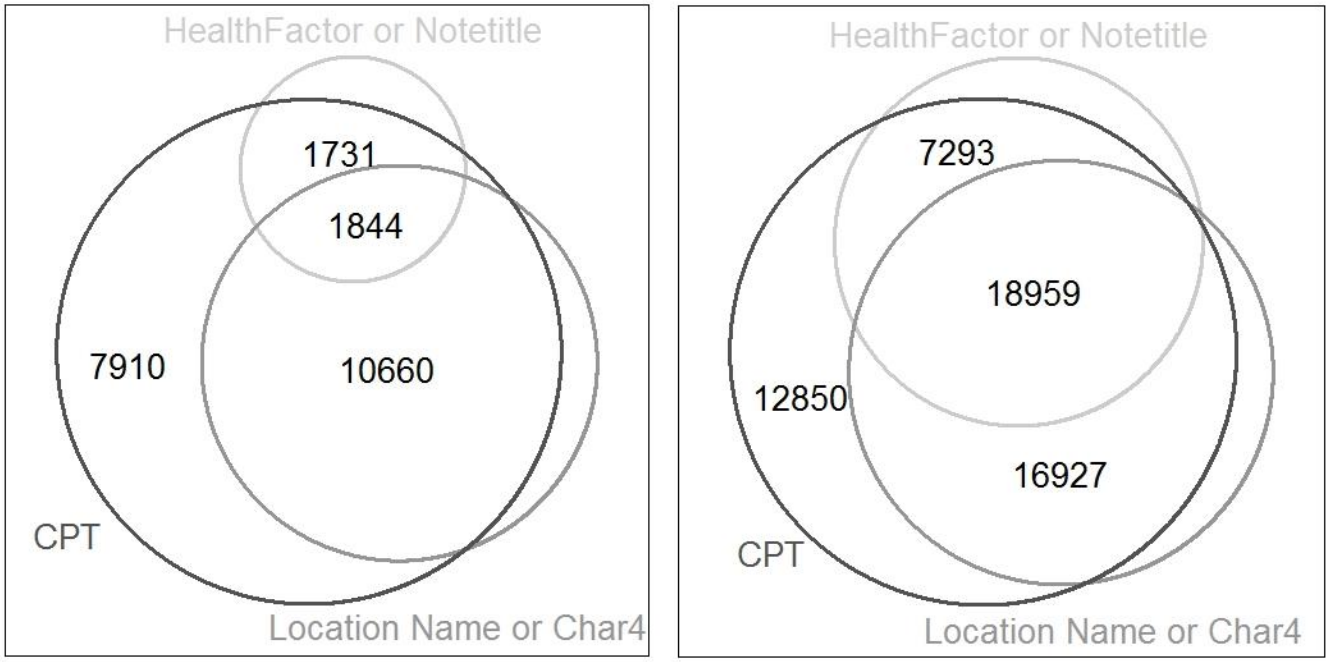

Figure 3.3: Acupuncture visit coding FY2017 (left), FY2019 (right). *For clarity, only showing CPT-associated visit counts. 24,022 total visits in FY2017, 62,479 total visits in FY2019.*

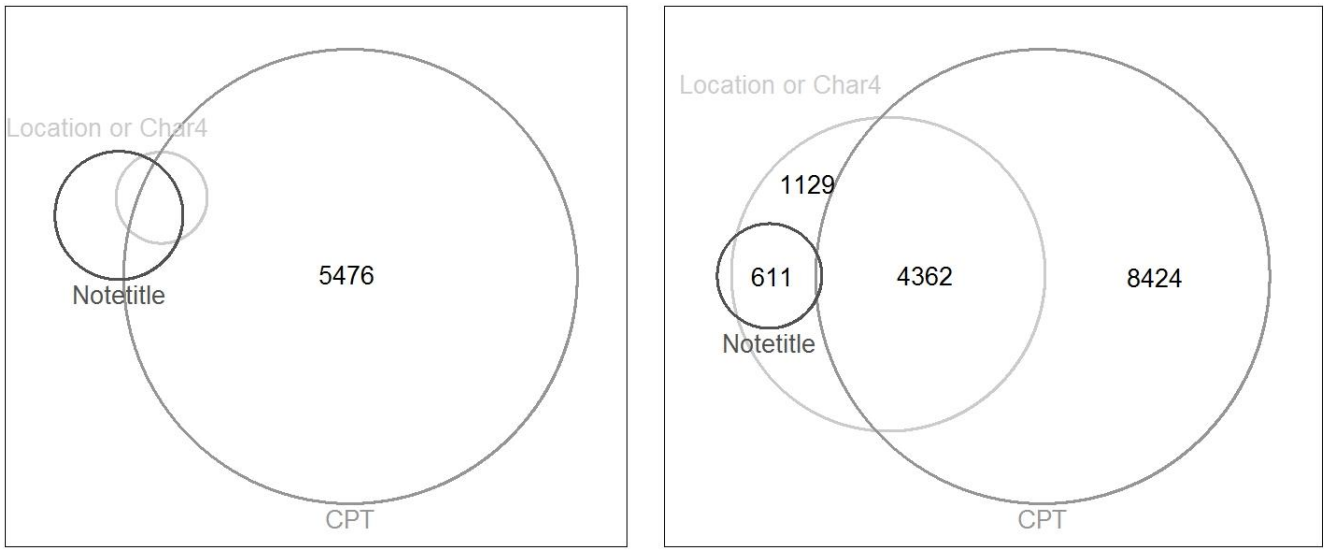

Figure 3.4: Massage visit coding FY2017 (left), FY2019 (right). *6,006 total visits in FY2017, 14,594 total visits in FY2019. For clarity, counts in regions with small contributions to the total are not shown. This Figure highlights changes in coding practices for massage services across the evaluation period.*

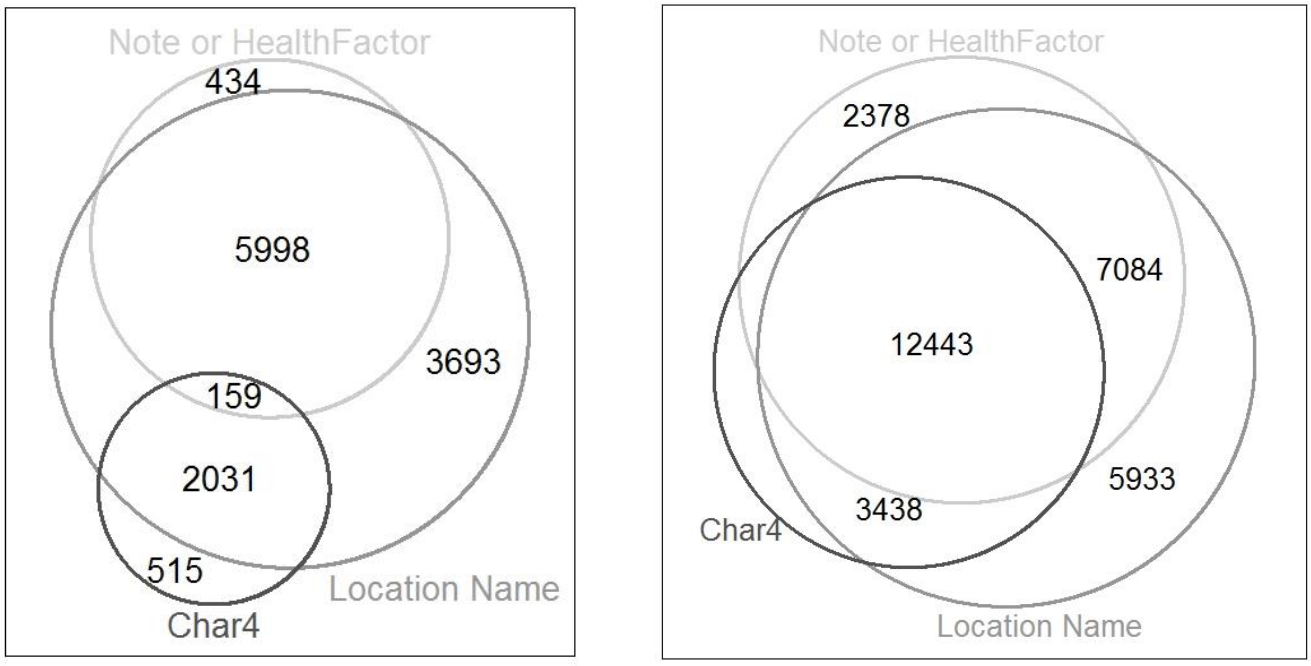

Figure 3.5: Yoga visit coding FY2017 (left), FY2019 (right). *For clarity, counts in regions with small numbers (Char4 only, 619 visits; Char4 and Note or Healthfactor, 1278 visits) in FY2019 are not shown. 12,913 total visits in FY2017, 33,173 total visits in FY2019.*

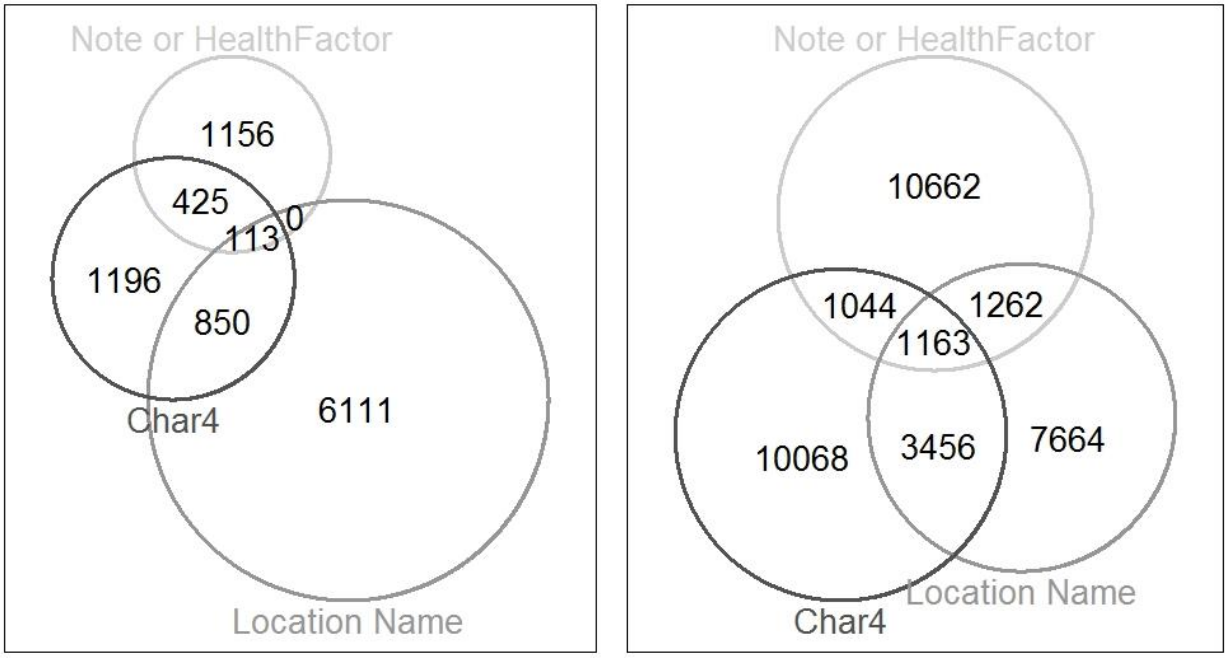

Figure 3.6: Meditation visit coding FY2017 (left), FY2019 (right). *9,851 total visits in FY2017, 35,319 total visits in FY2019. This figure highlights changes in coding practices for meditation services across the evaluation period.*

Figure 3.7: Tai Chi/Qi Gong visit coding FY2017 (left), FY2019 (right). *For clarity, counts in regions with small numbers (Char4 only, 1154 visits in FY2019) are not shown. 7,379 total visits in FY2017, 29,362 total visits in FY2019.*

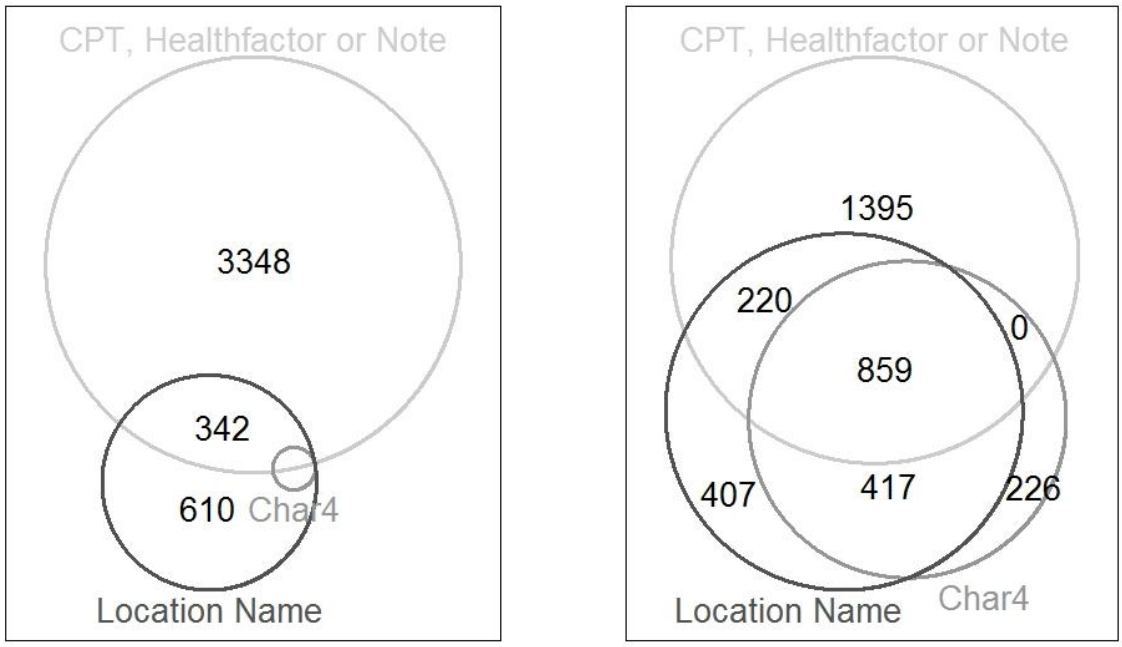

Figure 3.8: Biofeedback visit coding FY2017 (left), FY2019 (right). *4,339 total visits in FY2017, 3524 total visits in FY2019. For clarity, Char4 counts in 2017 (39) not shown. This figure highlights the increase in Clinic Locations tied to Biofeedback across the evaluation period (in Location Name or char4)*

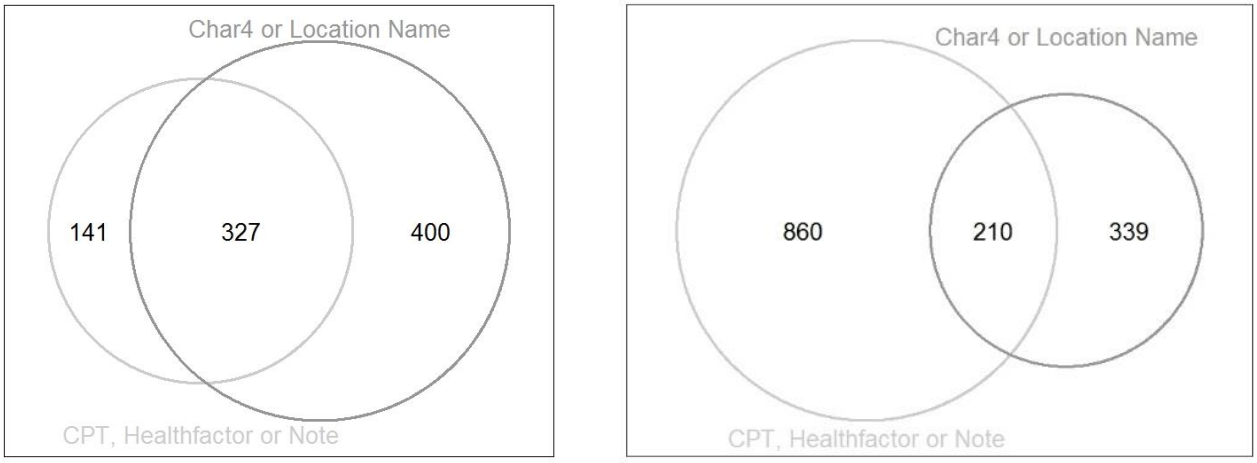

Figure 3.9: Hypnosis visit coding FY2017 (left), FY2019 (right). *868 total visits in FY2017, 1409 total visits in FY2019. Because so few visits are represented, Location-based coding (Location Name and Char4) and encounter-based coding (CPT codes, Notetitles, and HealthFactors) are combined.*

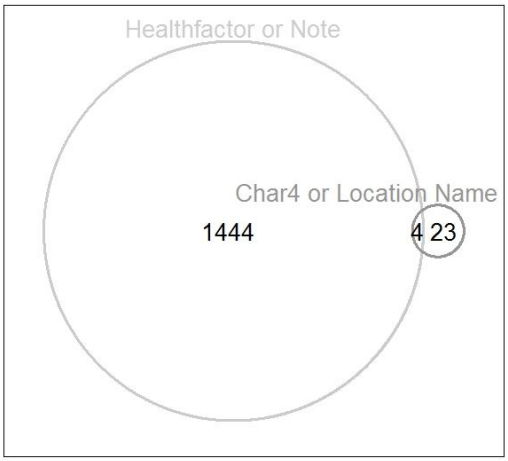

Figure 3.10: Guided Imagery Visit Coding FY2019. *1,471 total visits in FY2019. Due to the extremely small number of visits found in FY2017 (4), no coding comparison to 2017 is presented. Most GIMA encounters are identified through Healthfactors or Notetitles.*

Overview of Cumulative Use of WHS.

In each quarter we identified Veterans who used VA healthcare at the 18 pilot Flagship sites, approximately 500,000 Veterans each quarter. Among these Veterans we assessed whether they had used any WHS service in that same quarter or in a prior quarter going back to Q1FY2015. Summary data are provided for Q1FY17 and Q3FY19. Plots of all quarterly rates of cumulative WHS service utilization are presented below for Veterans with chronic pain and overall among all Veterans who used VA healthcare in the 18 pilot Flagship sites. This metric of cumulative use describes the pilot Flagship success in connecting Veterans with WHS services.

Table 3.7: Q1FY17 to Q3FY19 VA Healthcare Users & Changes in Cumulative Utilization of WHS Services

Cumulative Utilization of WHS Service				
Patient Cohort	**Visit Type**	**Q1, FY17 (%)**	**Q3, FY19 (%)**	**% Change**
All Veterans				
	Any CIH or Core WH	4.44	15.93	259.17
	Any CIH	4.28	12.95	202.49
	Acupuncture (All)	1.53	5.76	277.14
	Chiropractic (All)	2.24	6.51	190.47
	Core Whole Health	0.18	5.58	3,049.41
	Meditation	0.36	1.75	387.30
	Massage (All)	0.49	1.58	222.83
	Yoga	0.24	1.11	361.98
	Tai Chi	0.19	0.85	353.89
	Biofeedback	0.23	0.43	87.15
	Hypnosis	0.06	0.16	159.56
	Guided Imagery	0.00	0.08	n/a
Chronic Pain				
	Any CIH or Core WH	10.48	30.69	192.80
	Any CIH	10.25	26.41	157.71
	Acupuncture (All)	4.18	13.82	230.28
	Chiropractic (All)	5.25	12.75	142.73
	Core Whole Health	0.30	10.58	3,384.58
	Meditation	0.85	3.75	342.48
	Massage (All)	1.26	3.47	174.36
	Yoga	0.55	2.27	315.48
	Tai Chi	0.48	1.88	294.90

Cumulative Utilization of WHS Service				
Patient Cohort	**Visit Type**	**Q1, FY17 (%)**	**Q3, FY19 (%)**	**% Change**
	Biofeedback	0.49	0.87	78.31
	Hypnosis	0.16	0.34	115.67
	Guided Imagery	0.00	0.19	n/a due to 0 at start
Mental Health				
	Any CIH or Core WH	7.44	23.15	211.34
	Any CIH	7.20	19.34	168.80
	Acupuncture (All)	2.62	8.80	236.12
	Chiropractic (All)	3.49	9.34	167.88
	Core Whole Health	0.28	8.17	2,797.57
	Meditation	0.81	3.27	304.14
	Massage (All)	0.77	2.23	189.46
	Yoga	0.51	2.03	296.53
	Tai Chi	0.39	1.49	283.55
	Biofeedback	0.50	0.80	59.08
	Hypnosis	0.14	0.30	119.28
	Guided Imagery	0.00	0.15	n/a due to 0 at start
Chronic Condition				
	Any CIH or Core WH	4.42	16.43	272.10
	Any CIH	4.19	12.83	205.83
	Acupuncture (All)	1.56	5.97	282.90
	Chiropractic (All)	2.07	5.97	188.12
	Core Whole Health	0.25	6.54	2,495.21
	Meditation	0.37	1.88	411.72
	Massage (All)	0.52	1.62	211.89
	Yoga	0.25	1.14	354.77
	Tai Chi	0.22	0.97	349.14
	Biofeedback	0.22	0.43	93.34

Cumulative Utilization of WHS Service				
Patient Cohort	**Visit Type**	**Q1, FY17 (%)**	**Q3, FY19 (%)**	**% Change**
	Hypnosis	0.07	0.18	145.63
	Guided Imagery	0.00	0.10	n/a due to 0 at start

Quarterly changes in documented WHS service utilization across the 18 flagship sites. We calculated the percentage of VA users in each quarter who had documented utilization of WHS services in the same quarter or in any quarter since the beginning of FY2016. The overall percentage of veterans receiving any WHS service increased 259% from Q1 FY2017 to Q3 FY2019, with similar increases among veterans in 3 high priority clinical cohorts – patients with chronic MSK pain (Chronic Pain, 189% increase), mental health conditions including depression, anxiety, and PTSD (Mental Health, 211% increase), and chronic health conditions with a self management component to treatment including cardiovascular disease, COPD, diabetes, and obesity (Chronic Conditions, 272% increase).

Among Veterans with Chronic Musculoskeletal Pain and VA Utilization in the Quarter

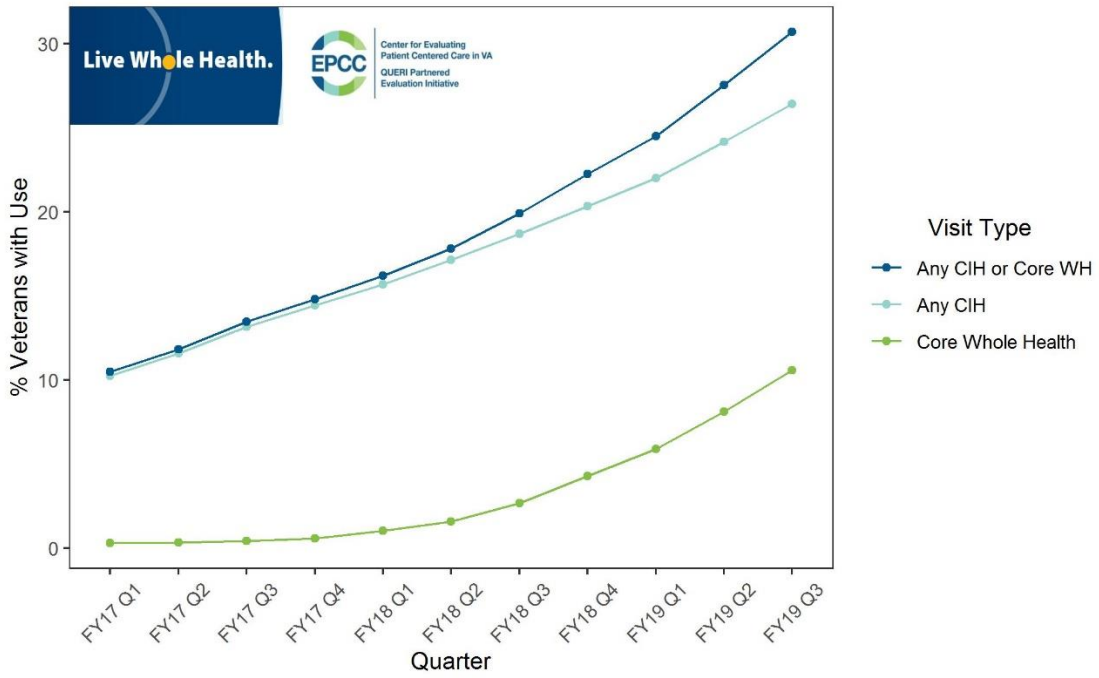

Figure 3.11: Percent of Veteran VA Users at Flagship Sites with Chronic MSK Pain: Any Exposure to WHS Services. *The percent of Veteran VA users at the flagship sites with chronic MSK pain who had any exposure (in the current quarter or at any time prior) to WHS services (Any CIH or Core WH, dark blue) increased over the course of the WHS pilot. By quarter 3 of 2019, 31% of chronic MSK pain patients at the 18 flagship sites had at least 1 WHS visit. Exposure to CIH services (light blue) and Core WH (green) services increased individually as well.*

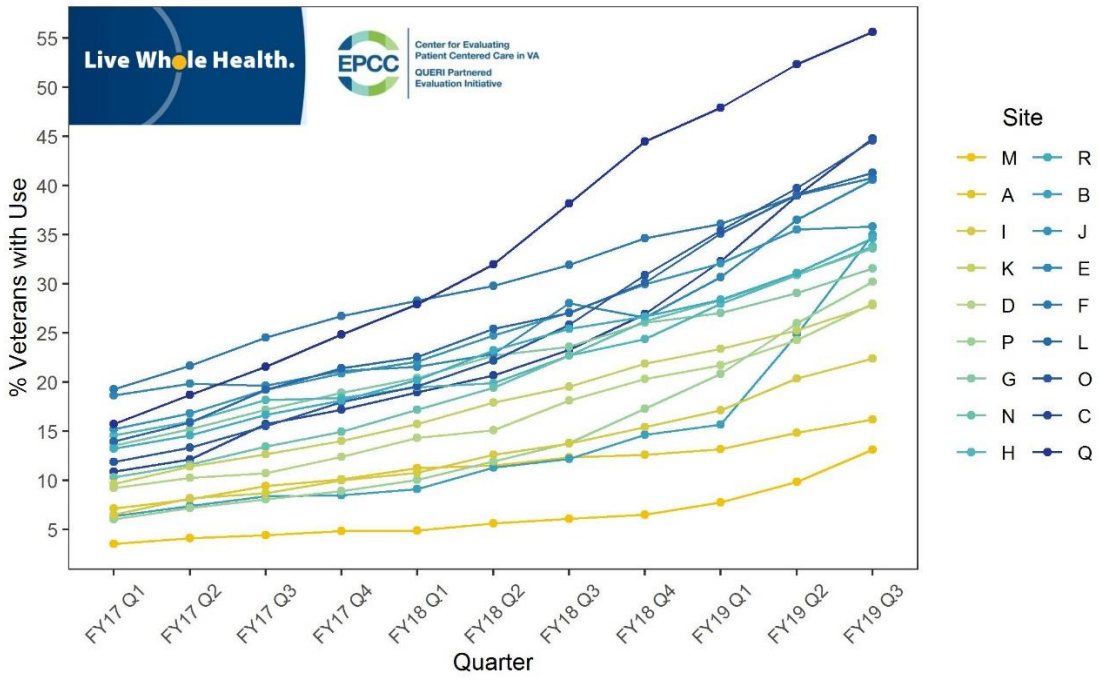

Figure 3.12: Percent of Veteran VA Users with Chronic MSK Pain: Any Exposure to WHS Services, By Site. *Percent of Veteran VA users with Chronic MSK pain at each of the 18 flagship sites with exposure to any WHS services. Exposure increased across all flagship sites, with some sites reaching over 50% of patients with pain. Sites are arranged from lowest (yellow) to highest (dark blue) proportion of use in Q3 2019.*

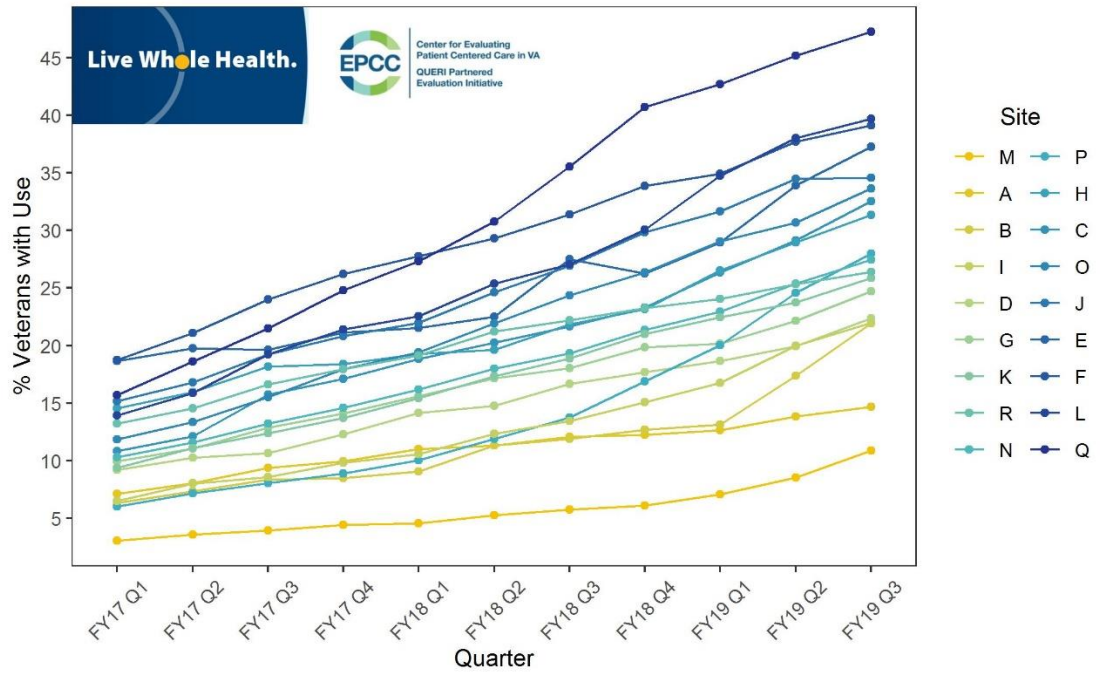

Figure 3.13: Percent of Veteran VA Users with Chronic MSK Pain: Any Exposure to CIH Services, By Site *Percent of Veteran VA users with Chronic MSK pain at each of the 18 flagship sites with any exposure to List 1 CIH services. Sites are arranged from lowest (yellow) to highest (dark blue) proportion of use in Q3 2019.*

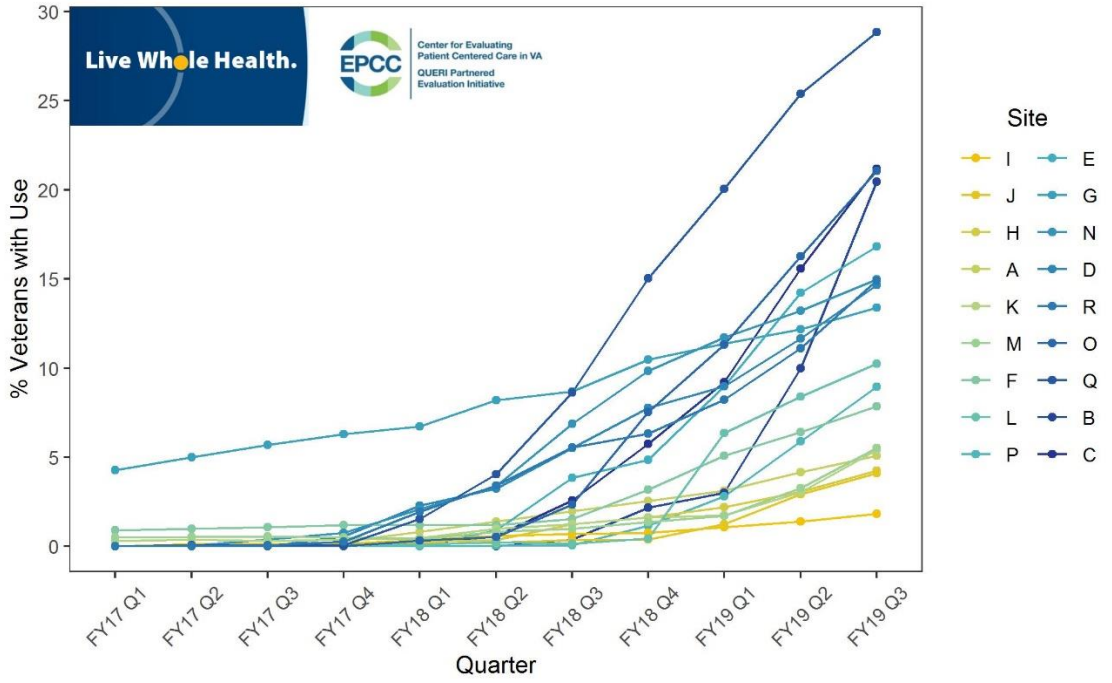

Figure 3.14 Percent of Veteran VA Users with Chronic MSK Pain: Any Exposure to Core WH Services, By Site. *Percent of Veteran VA users with Chronic MSK pain at each of the 18 flagship sites with any exposure to Core WH services. Sites are arranged from lowest (yellow) to highest (dark blue) proportion of use in Q3 2019. Note one site was an initial design site and had a higher starting level of core WH service use.*

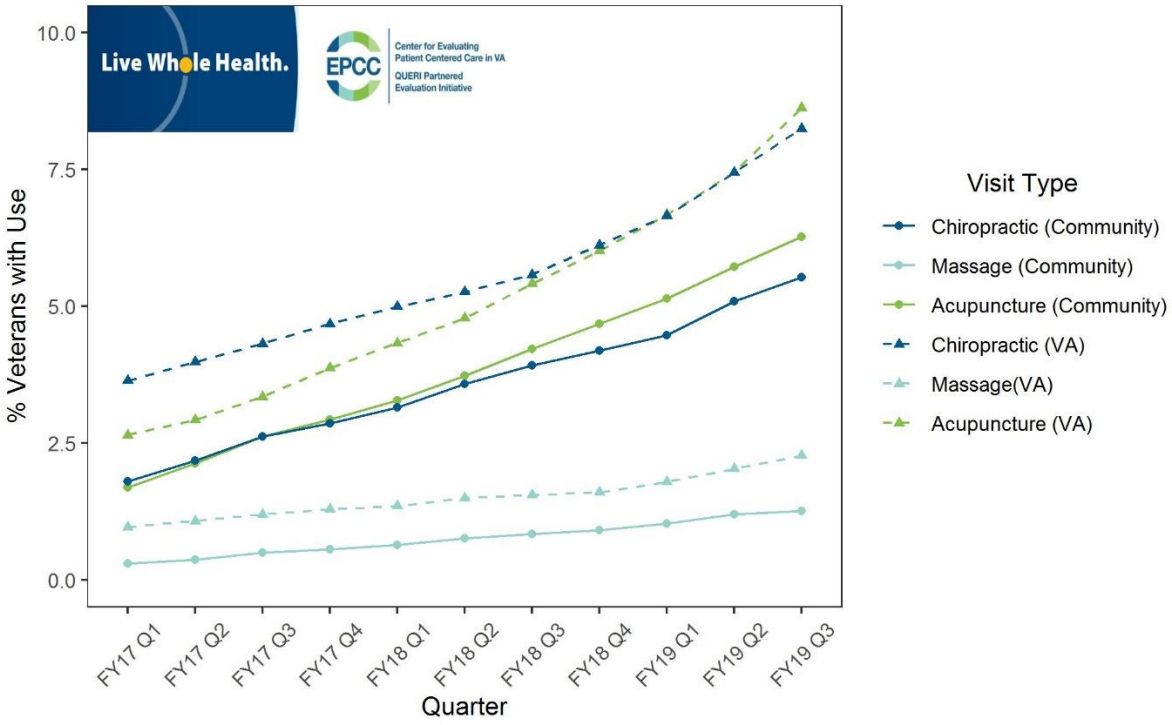

Figure 3.15: Percent of Veteran VA Users with Chronic MSK Pain: Exposure to Select CIH Services in VA and Community Care (Chiropractic, Massage, Acupuncture) *Percent of Veteran VA users with Chronic MSK pain across the 18 flagship sites who have received Chiropractic Care (dark blue), Massage (light blue), and Acupuncture (green). Both VA provided (triangles, dashed line) and community provided (circles, solid line) care has increased, though VA utilization rates are higher at the flagship sites.*

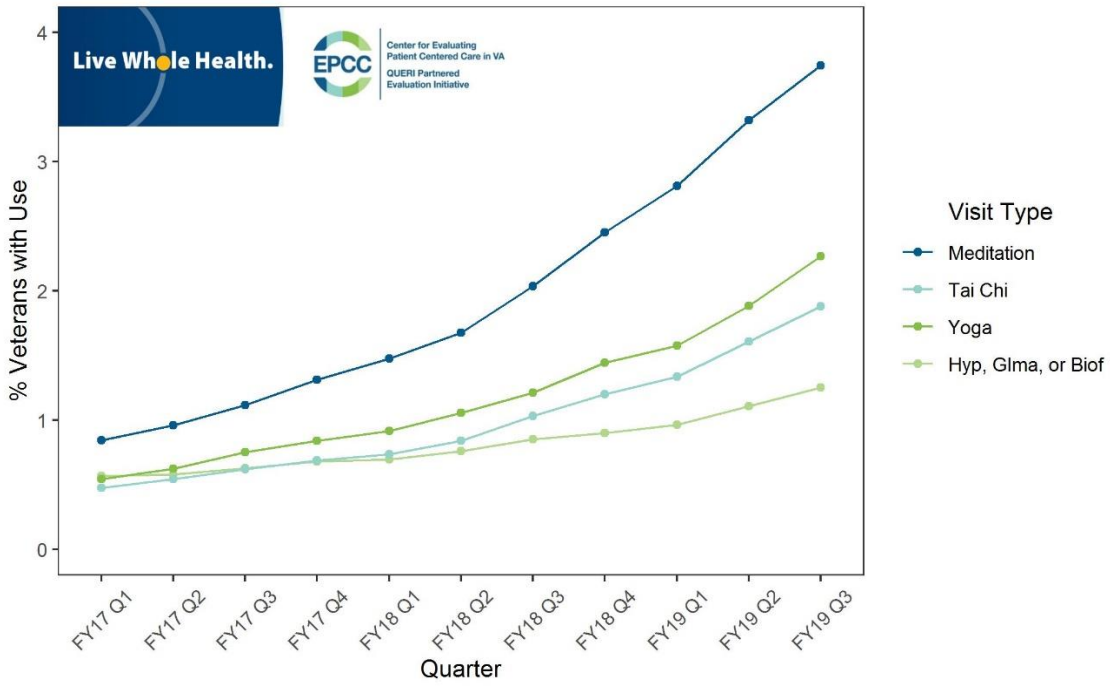

Figure 3.16: Percent of Veteran VA Users with Chronic MSK Pain: Exposure to Select CIH Services (Other than Chiropractic, Massage, Acupuncture) *Percent of Veteran VA users with Chronic MSK pain across the 18 flagship sites who have exposure to List 1 CIH services other than Chiropractic Care, Massage, and Acupuncture documented within the VA. Hypnosis (Hyp), Guided Imagery (Gima) and Biofeedback (Biof) are combined (light green) into one line, Meditation (dark blue), Tai Chi (light blue), and Yoga (green) are shown individually.*

Among All Veterans with VA Healthcare Utilization

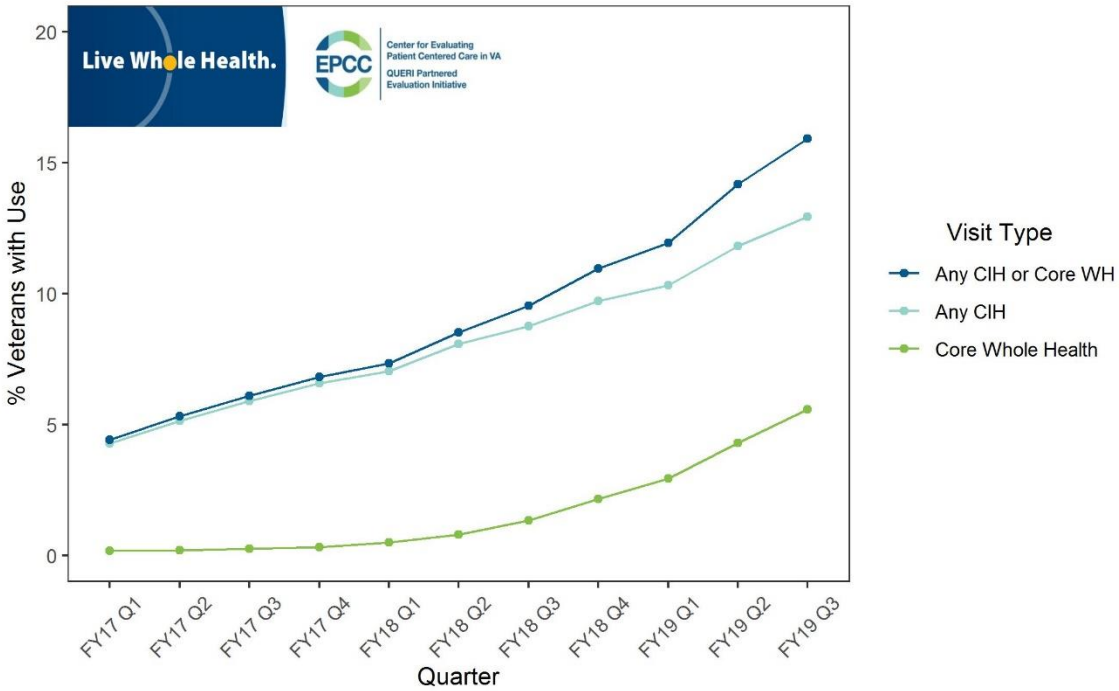

Figure 3.17: Percent of All Veteran VA Users at Flagship Sites: Any Exposure to WHS Services. *The percent of all Veteran VA users at the flagship sites who had any exposure (in the current quarter or at any time prior) to WHS services (Any CIH or Core WH, dark blue) increased over the course of the WHS pilot. By quarter 3 of 2019, 16% of Veterans using services at the 18 flagship sites had at least 1 WHS visit. Exposure to CIH services (light blue) and Core WH (green) services increased individually as well.*

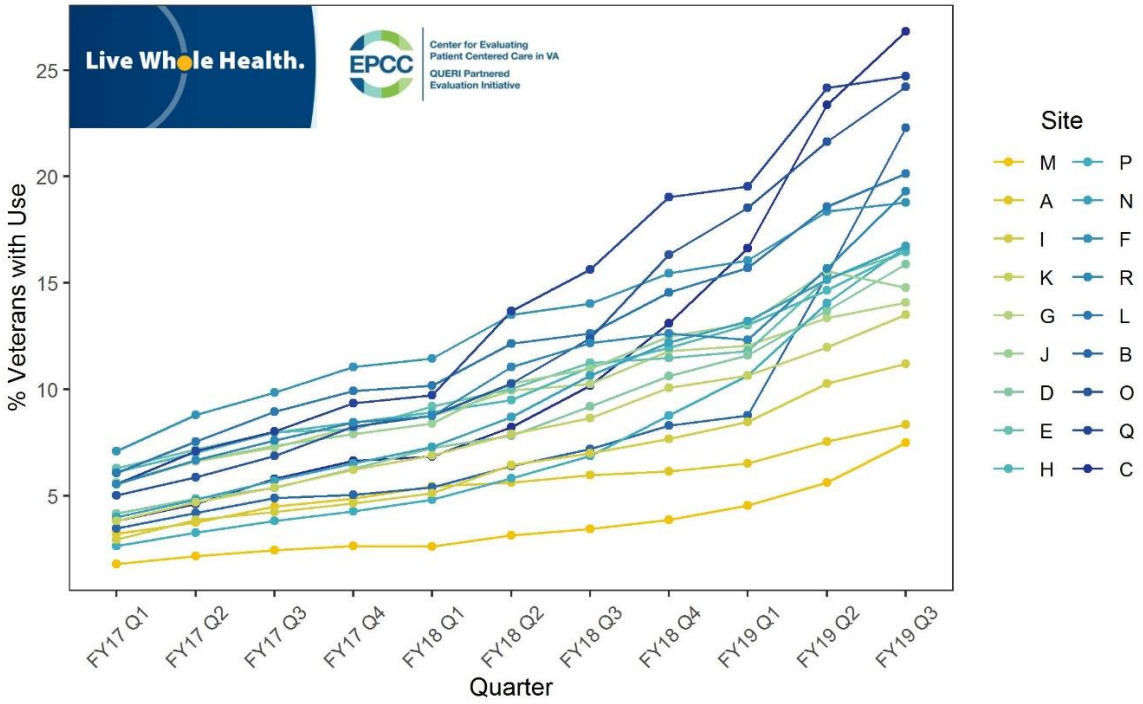

Figure 3.18: Percent of All Veteran VA Users: Any Exposure to WHS Services, By Site. *Percent of all Veteran VA users at each of the 18 flagship sites with exposure to any WHS services. Exposure increased across all flagship sites, with some sites reaching over 25% of patients. Sites are arranged from lowest (yellow) to highest (dark blue) proportion of use in Q3 2019.*

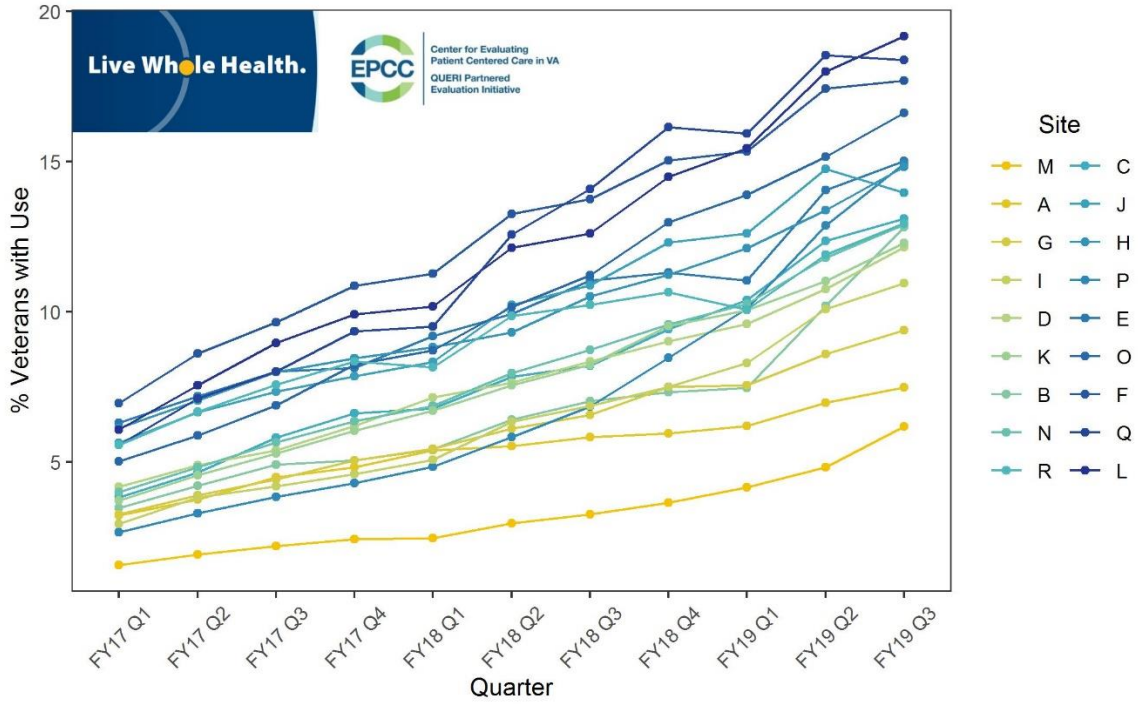

Figure 3.19: Percent of All Veteran VA Users: Any Exposure to CIH Services, By Site. *Percent of all Veteran VA users at each of the 18 flagship sites with exposure to List 1 CIH services. Sites are arranged from lowest (yellow) to highest (dark blue) proportion of use in Q3 2019.*

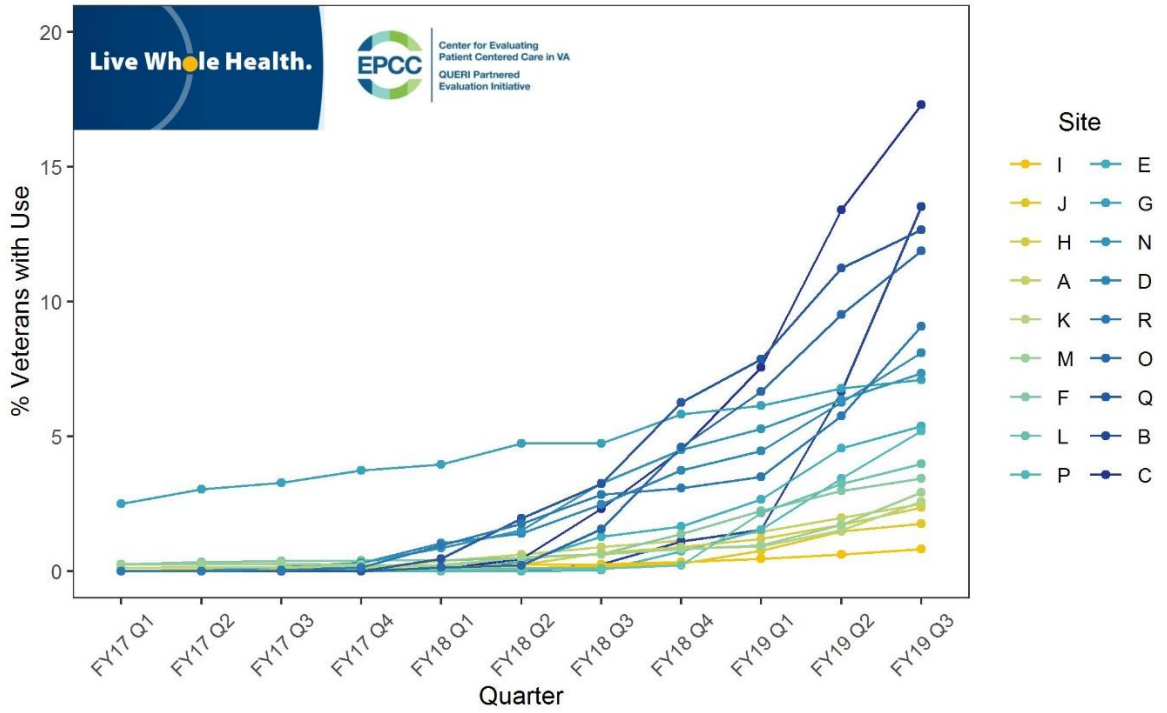

Figure 3.20: Percent of All Veteran VA Users: Any Exposure to Core WH Services, By Site. *Percent of all Veteran VA users at each of the 18 flagship sites with exposure to Core WH services. Sites are arranged from lowest (yellow) to highest (dark blue) proportion of use in Q3 2019.*

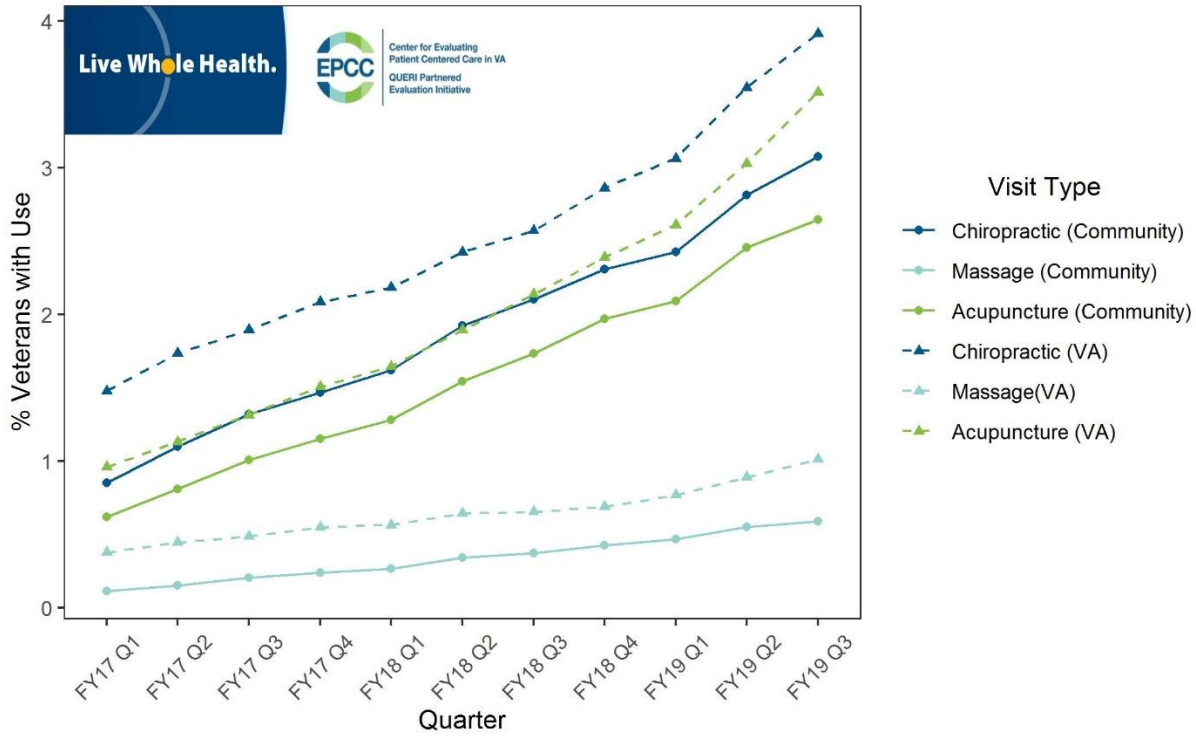

Figure 3.21: Percent of All Veteran VA Users: Exposure to Select CIH Services (Chiropractic, Massage, Acupuncture). *Percent of all Veteran VA users across the 18 flagship sites who have received Chiropractic Care (dark blue), Massage (light blue), and Acupuncture (green). Both VA provided (triangles, dashed line) and community provided (circles, solid line) care has increased, though VA utilization rates are higher at the flagship sites.*

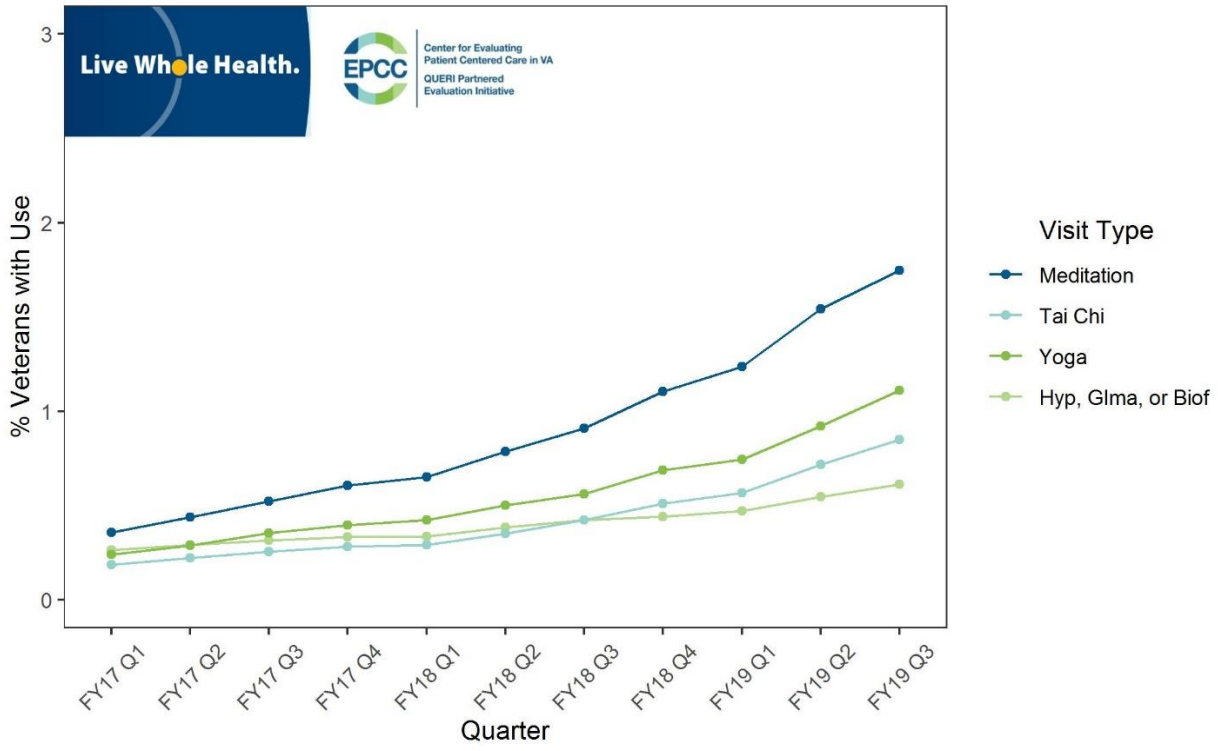

Figure 3.22: Percent of All Veteran VA Users: Exposure to Select CIH Services (Other than Chiropractic, Massage, Acupuncture). *Percent of all Veteran VA users across the 18 flagship sites who have exposure to List 1 CIH services other than Chiropractic Care, Massage, and Acupuncture documented within the VA. Hypnosis (Hyp), Guided Imagery (Gima) and Biofeedback (Biof) are combined (light green) into one line, Meditation (dark blue), Tai Chi (light blue), and Yoga (green) are shown individually.*

Overview and Table of Q1F17 to Q3FY19 Changes in Utilization

Table 3.8: Q1FY17 to Q3FY19 VA Healthcare Users & Changes in Same-Quarter Utilization of WHS Services

Same Quarter Use				
Patient Cohort	**Visit Type**	**Q1, FY17 (%)**	**Q3, FY19 (%)**	**% Change**
All Flagship				
	Any CIH or Core WH	2.07	6.68	223.27
	Any CIH	2.01	4.87	141.81
	Acupuncture (All)	0.75	2.00	167.69
	Chiropractic (All)	1.10	2.32	111.44
	Core Whole Health	0.06	2.68	4,519.06
	Meditation	0.11	0.50	358.67
	Massage (All)	0.16	0.44	168.12
	Yoga	0.09	0.38	318.66
	Tai Chi	0.06	0.30	414.70
	Biofeedback	0.08	0.09	7.56
	Hypnosis	0.02	0.04	74.54
	Guided Imagery	0.00	0.04	n/a
Chronic Pain				
	Any CIH or Core WH	4.99	13.32	167.02
	Any CIH	4.91	10.49	113.72
	Acupunture (All)	2.09	5.01	139.01
	Chiropractic (All)	2.58	4.72	82.88
	Core Whole Health	0.09	4.81	5,017.58
	Meditation	0.24	1.02	325.12
	Massage (All)	0.44	1.01	127.90
	Yoga	0.18	0.76	312.93
	Tai Chi	0.16	0.61	292.57
	Biofeedback	0.16	0.19	19.19
	Hypnosis	0.05	0.07	48.13
	Guided Imagery	0.00	0.07	n/a
Mental Health				
	Any CIH or Core WH	3.38	9.64	184.91
	Any CIH	3.31	7.29	120.45

Same Quarter Use				
Patient Cohort	**Visit Type**	**Q1, FY17 (%)**	**Q3, FY19 (%)**	**% Change**
	Acupunture (All)	1.25	2.99	138.15
	Chiropractic (All)	1.69	3.30	95.99
	Core Whole Health	0.09	3.82	4,156.36
	Meditation	0.24	0.95	292.50
	Massage (All)	0.25	0.65	158.90
	Yoga	0.18	0.66	268.60
	Tai Chi	0.11	0.50	346.99
	Biofeedback	0.17	0.17	-2.27
	Hypnosis	0.04	0.07	67.97
	Guided Imagery	0.00	0.06	n/a
Chronic Condition				
	Any CIH or Core WH	2.02	6.85	239.94
	Any CIH	1.94	4.72	143.19
	Acupunture (All)	0.75	2.05	173.77
	Chiropractic (All)	1.01	2.02	99.95
	Core Whole Health	0.08	3.09	3,622.04
	Meditation	0.11	0.56	401.37
	Massage (All)	0.17	0.42	153.19
	Yoga	0.10	0.39	281.26
	Tai Chi	0.07	0.35	410.23
	Biofeedback	0.08	0.09	12.79
	Hypnosis	0.02	0.03	66.40
	Guided Imagery	0.00	0.04	n/a

Quarterly changes in documented WHS service utilization across the 18 flagship sites. We calculated the percentage of VA users in each quarter who had documented utilization of WHS services in the same quarter as other VA utilization . The overall percentage of veterans receiving any WHS service increased 223% from Q1 FY2017 to Q3 FY2019, with similar increases among veterans in 3 high priority clinical cohorts – patients with chronic MSK pain (Chronic Pain, 167% increase), mental health conditions including depression, anxiety, and PTSD (Mental Health, 185% increase), and chronic health conditions with a self management component to treatment including cardiovascular disease, COPD, diabetes, and obesity (Chronic Conditions, 239% increase).

Among Veterans with Chronic Musculoskeletal Pain and VA Utilization in Same Quarter

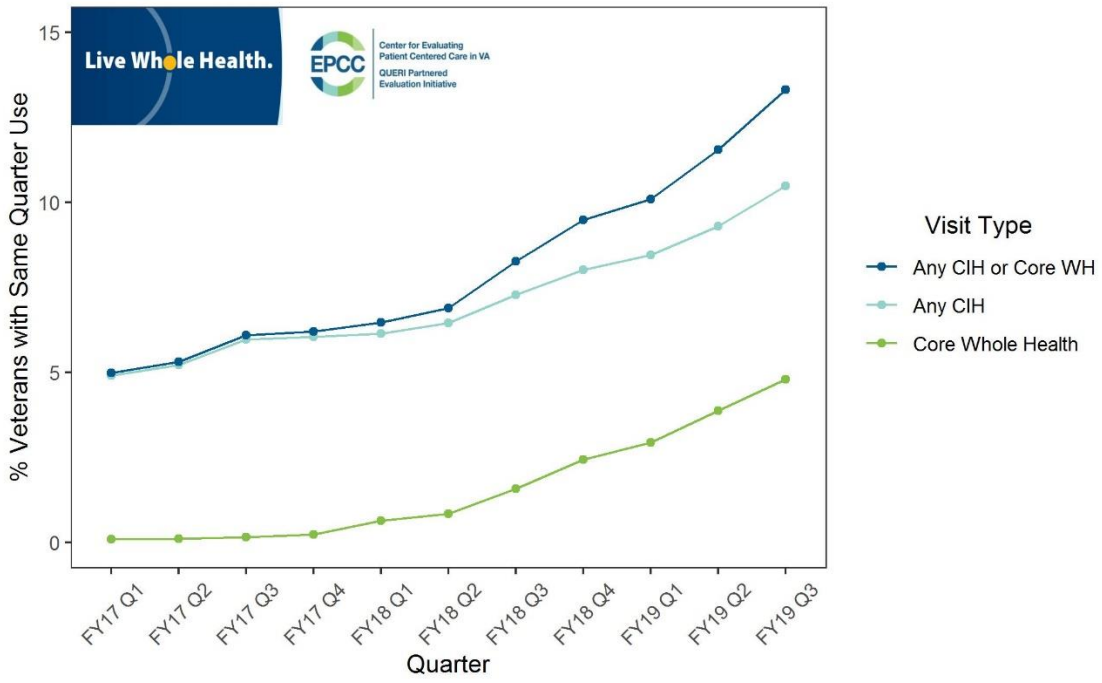

Figure 3.23: Percent of Veteran VA Users at Flagship Sites with Chronic MSK Pain: Any Same-Quarter WHS Visit. *The percent of Veteran VA users at the flagship sites with chronic MSK pain who also used WHS services (Any CIH or Core WH, dark blue) increased over the course of the WHS pilot. By quarter 3 of 2019, almost 10% of chronic MSK pain patients at the 18 flagship sites had at least 1 WHS visit in the same quarter as their qualifying visit. Exposure to CIH services (light blue) and Core WH (green) services increased individually as well.*

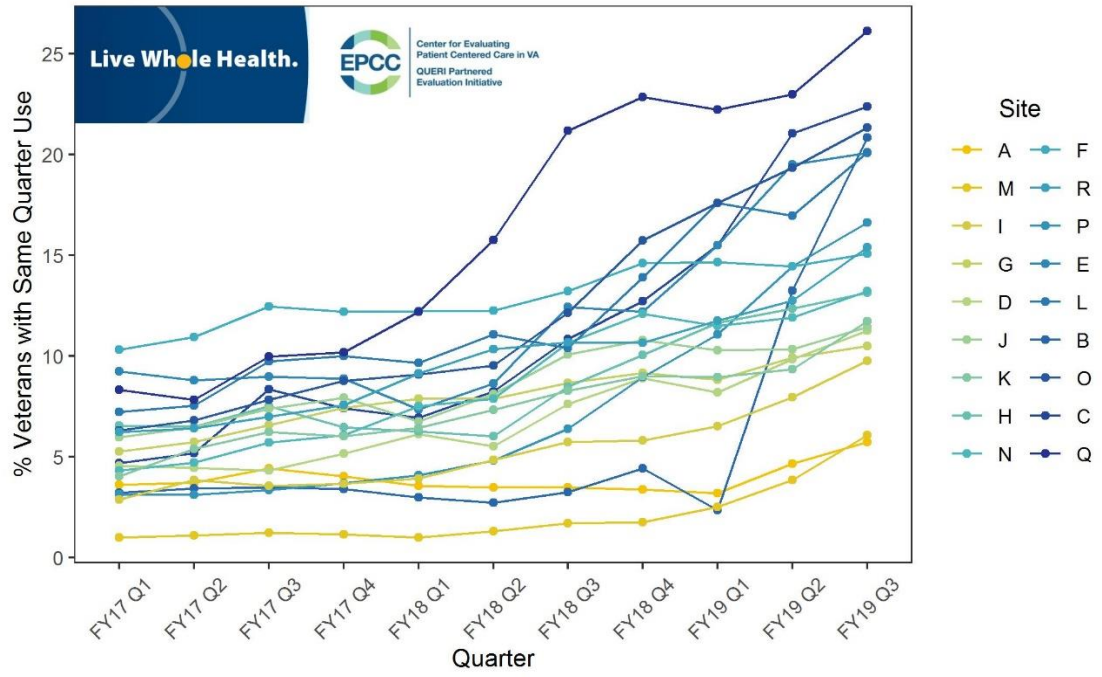

Figure 3.24: Percent of Veteran VA Users with Chronic MSK Pain: Any Same-Quarter WHS Visit, By Site. *Percent of Veteran VA users with Chronic MSK pain at each of the 18 flagship sites with exposure to any WHS services in the same quarter as qualifying utilization. Exposure increased across all flagship sites, with some sites reaching over 25% of patients with pain in each quarter. Sites are arranged from lowest (yellow) to highest (dark blue) proportion of use in Q3 2019.*

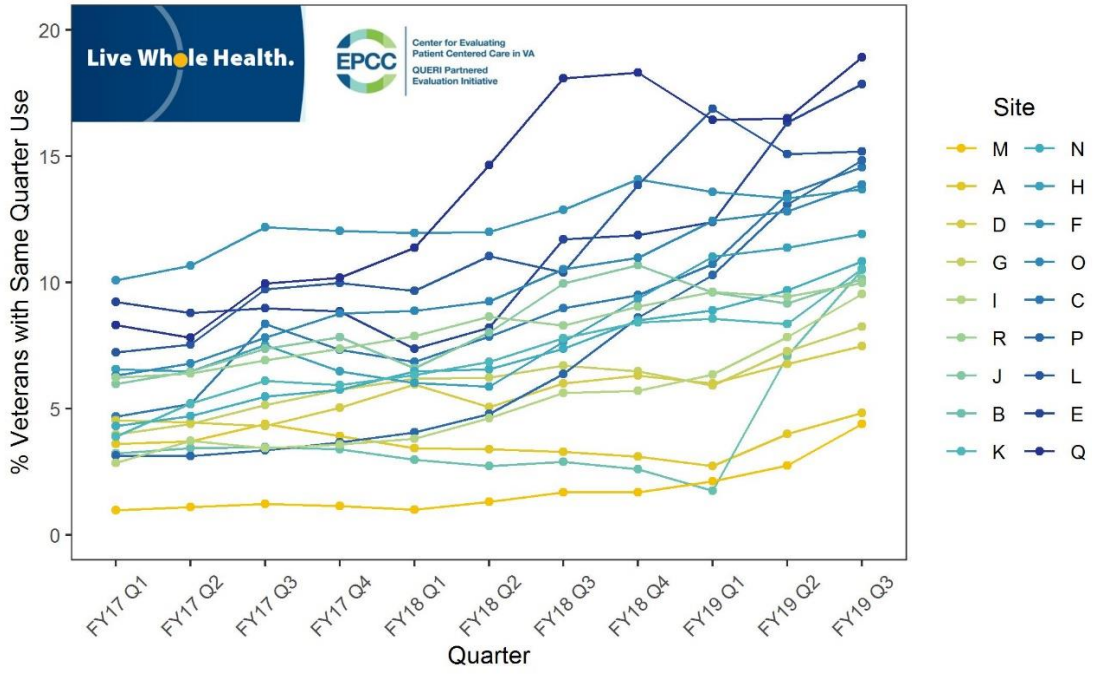

Figure 3.25: Percent of Veteran VA Users with Chronic MSK Pain: Any Same-Quarter CIH Visit, By Site. *Percent of Veteran VA users with Chronic MSK pain at each of the 18 flagship sites with exposure to List 1 CIH service in a single quarter. Sites are arranged from lowest (yellow) to highest (dark blue) proportion of use in Q3 2019.*

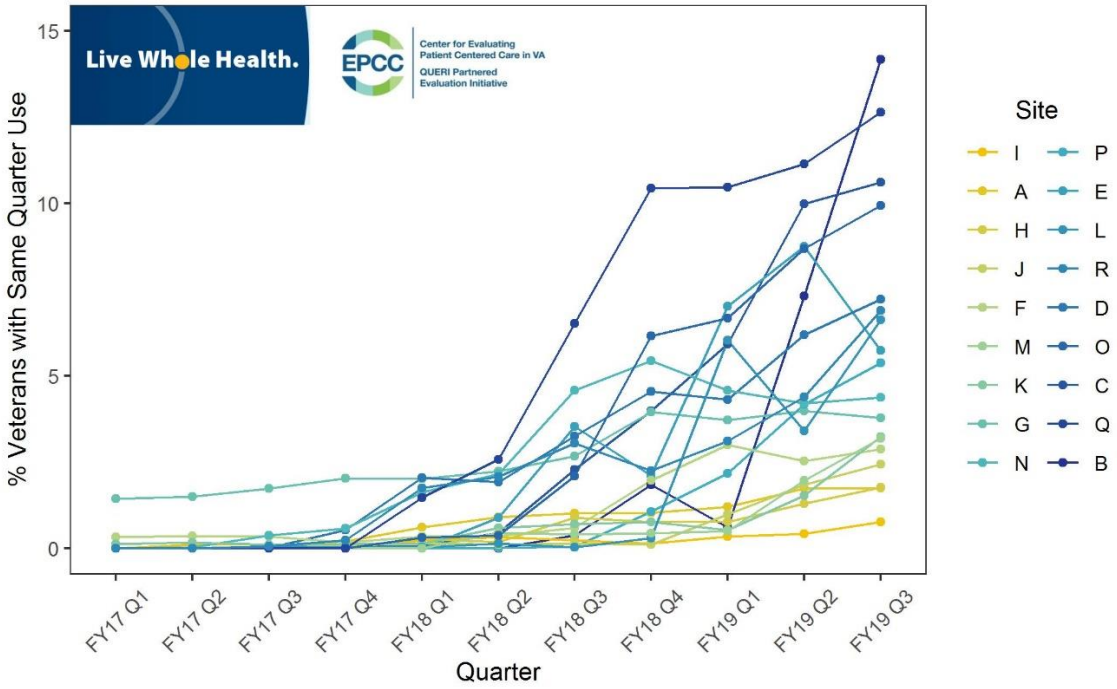

Figure 3.26: Percent of Veteran VA Users with Chronic MSK Pain: Any Same-Quarter Core WH Visit, By Site. *Percent of Veteran VA users with Chronic MSK pain at each of the 18 flagship sites with exposure to Core WH service in a single quarter. Sites are arranged from lowest (yellow) to highest (dark blue) proportion of use in Q3 2019.*

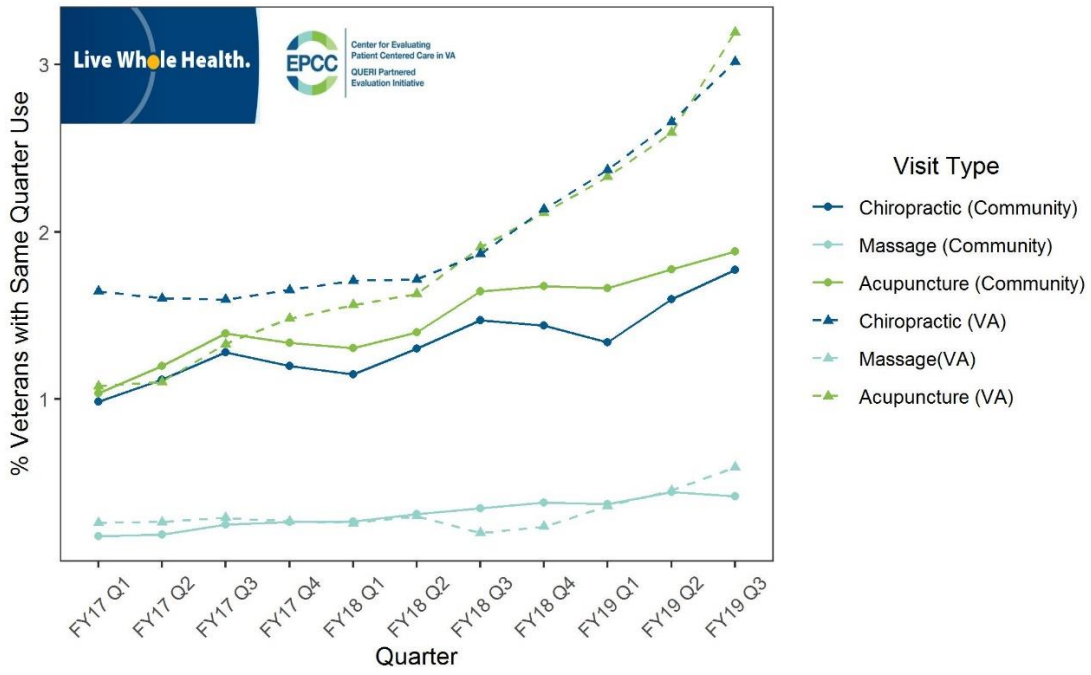

Figure 3.27: Percent of Veteran VA Users with Chronic MSK Pain: Any Same-Quarter Visit for Select CIH Services in VA and Community Care (Chiropractic, Massage, Acupuncture). *Percent of Veteran VA Users with Chronic MSK pain across the 18 flagship sites who have received Chiropractic Care (dark blue), Massage (light blue), and Acupuncture (green) in the same quarter as other VA utilization. Both VA provided (triangles, dashed line) and community provided (circles, solid line) care has increased, though VA utilization rates are higher and increasing faster than Community Care utilization rates at the flagship sites.*

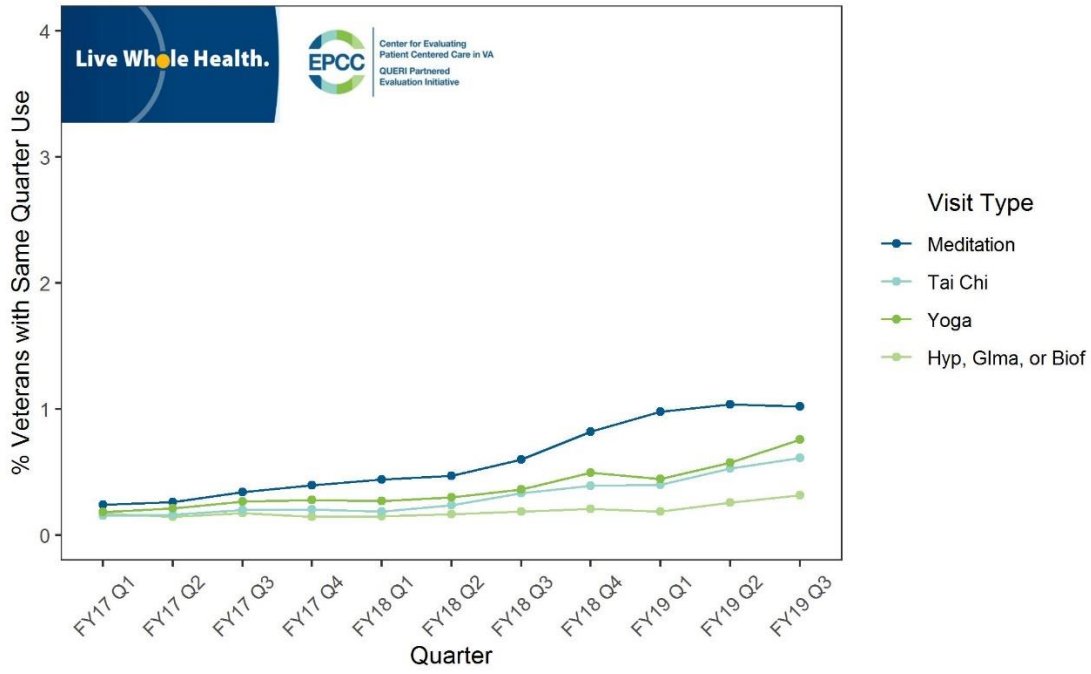

Figure 3.28: Percent of Veteran VA Users with Chronic MSK Pain: Any Same-Quarter Visit for Select CIH Services in VA and Community Care (Other than Chiropractic, Massage, Acupuncture). *Percent of Veteran VA Users with Chronic MSK pain across the 18 flagship sites who have exposure to List 1 CIH services other than Chiropractic Care, Massage, and Acupuncture documented within the VA in the same quarter as other VA utilization. Hypnosis (Hyp), Guided Imagery (Gima) and Biofeedback (Biof) are combined (light green) into one line, Meditation (dark blue), Tai Chi (light blue), and Yoga (green) are shown individually.*

Among All Veterans with VA Utilization in Same Quarter

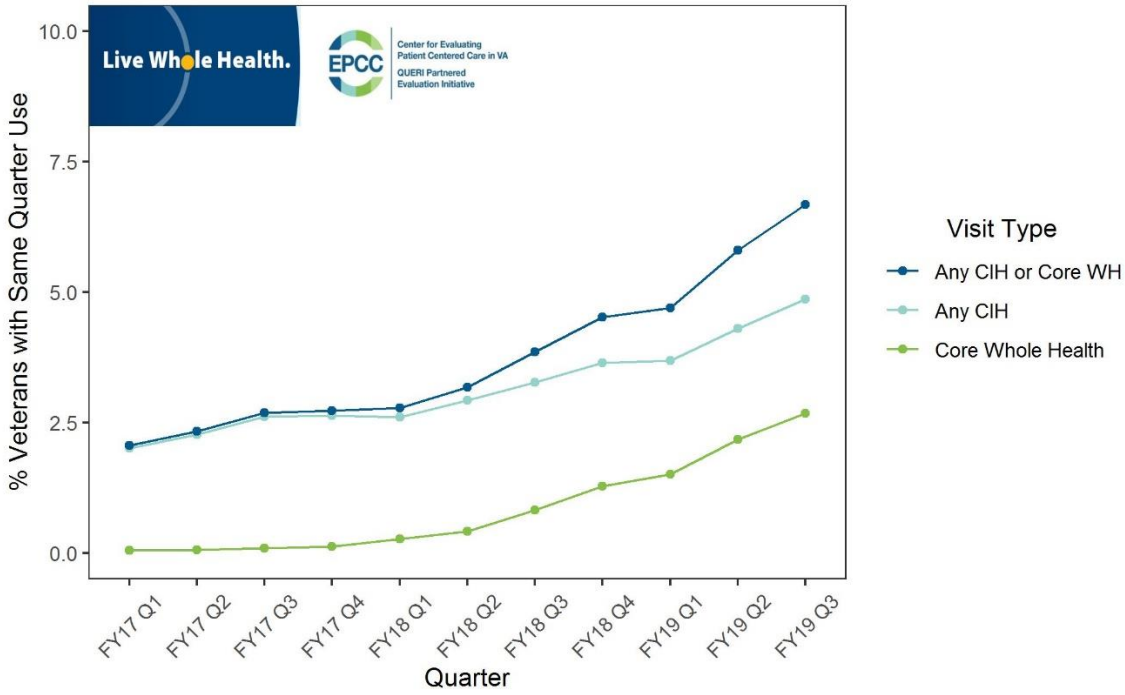

Figure 3.29: Percent of All Veteran VA Users at Flagship Sites: Any Same-Quarter WHS Visit .*The percent of all Veteran VA users at the flagship sites who also used WHS services (Any CIH or Core WH, dark blue) increased over the course of the WHS pilot. By quarter 3 of 2019, almost 7% of all patients at the 18 flagship sites had at least 1 WHS visit in the same quarter as their qualifying visit. Exposure to CIH services (light blue) and Core WH (green) services increased individually as well.*

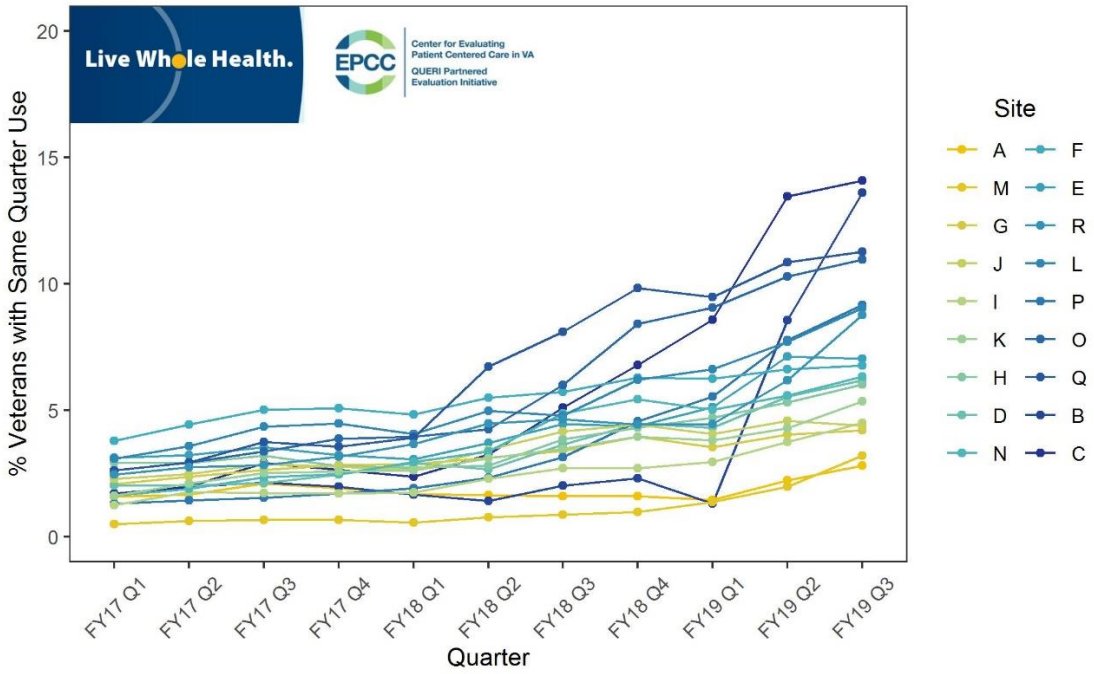

Figure 3.30: Percent of All Veteran VA Users: Any Same-Quarter WHS Visit, By Site. *Percent of all Veteran VA users at each of the 18 flagship sites who also used WHS services in the same quarter as qualifying utilization. Sites are arranged from lowest (yellow) to highest (dark blue) proportion of use in Q3 2019.*

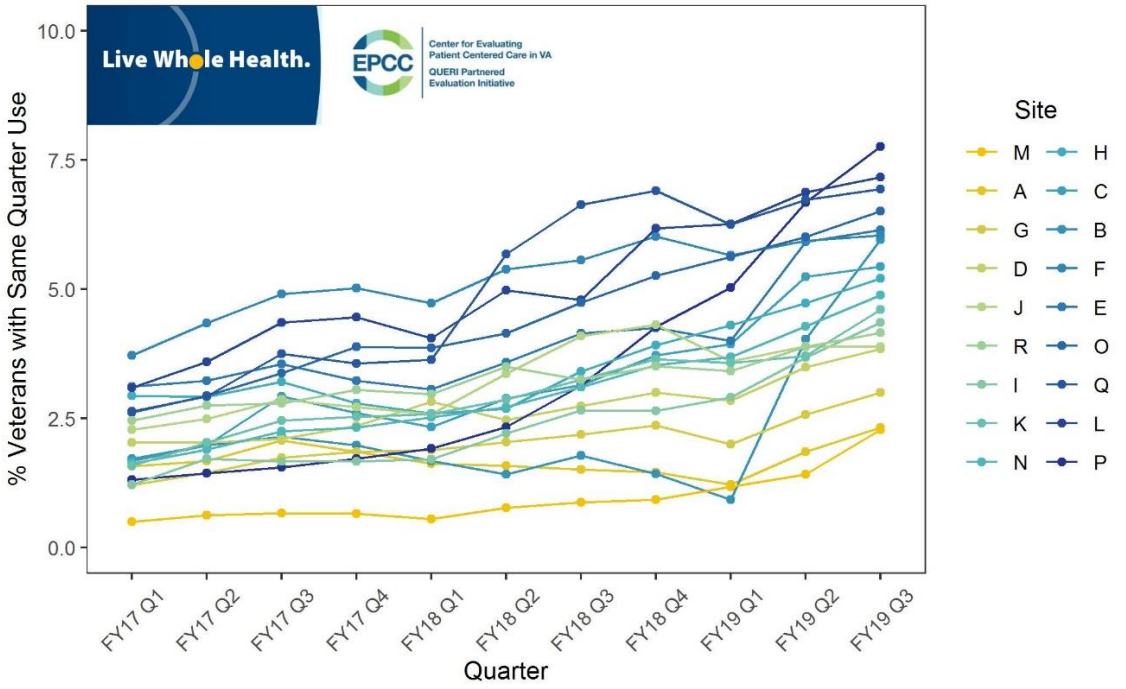

Figure 3.31: Percent of All Veteran VA Users: Any Same-Quarter CIH Visit, By Site. *Percent of all Veteran VA users at each of the 18 flagship sites who also used List 1 CIH services in the same quarter as qualifying utilization. Sites are arranged from lowest (yellow) to highest (dark blue) proportion of use in Q3 2019.*

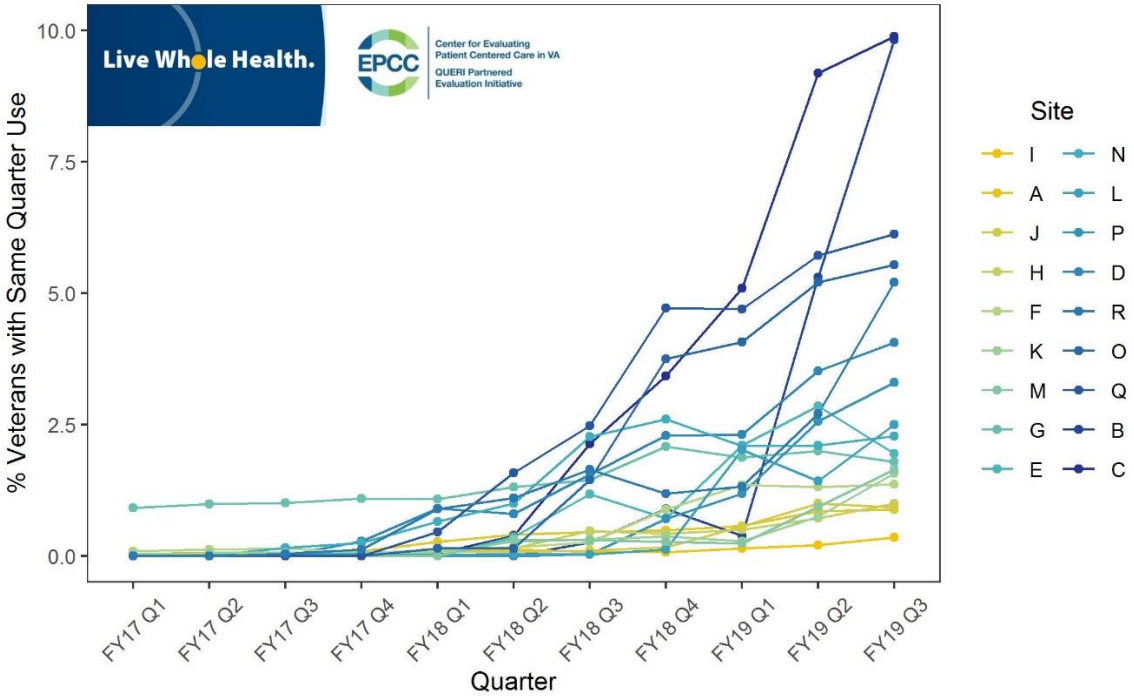

Figure 3.32: Percent of All Veteran VA Users: Any Same-Quarter Core WH Visit, By Site. *Percent of all Veteran VA users at each of the 18 flagship sites who also used Core WH in the same quarter as qualifying utilization. Sites are arranged from lowest (yellow) to highest (dark blue) proportion of use in Q3 2019.*

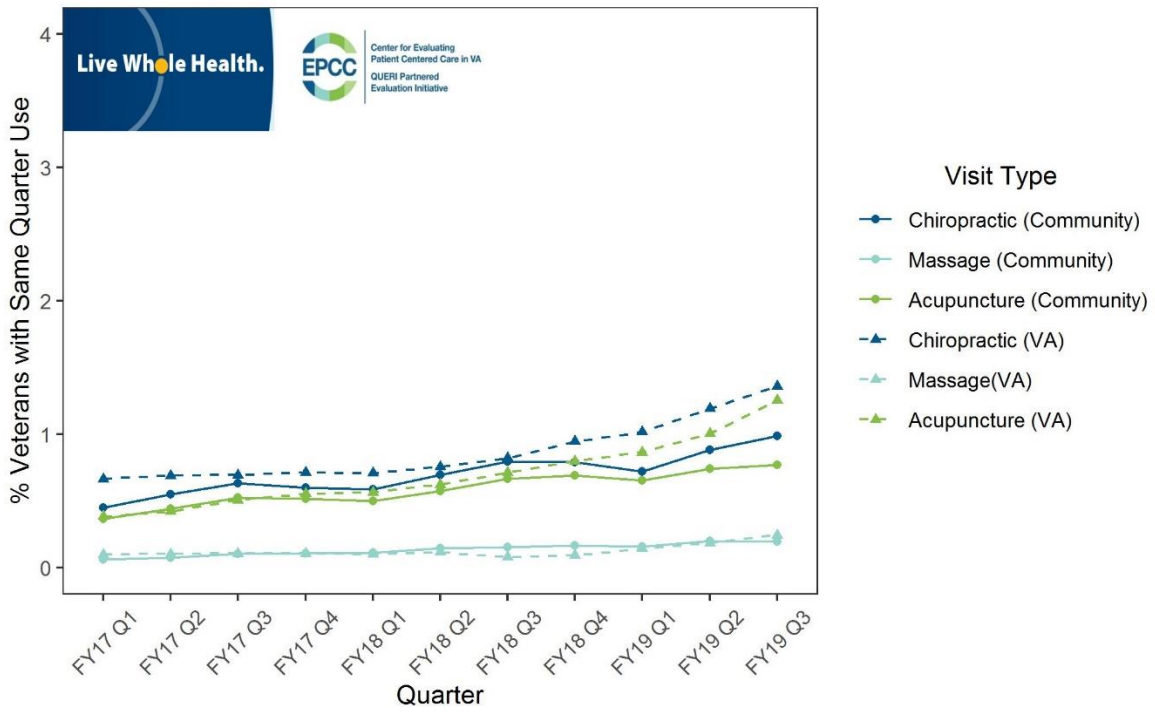

Figure 3.33: Percent of All Veteran VA Users: Any Same-Quarter Visit for Select CIH Services in VA and Community Care (Chiropractic, Massage, Acupuncture). *Percent of all Veteran VA Users across the 18 flagship sites who have received Chiropractic Care (dark blue), Massage (light blue), and Acupuncture (green) in the same quarter as other VA utilization. Both VA provided (triangles, dashed line) and community provided (circles, solid line) care has increased.*

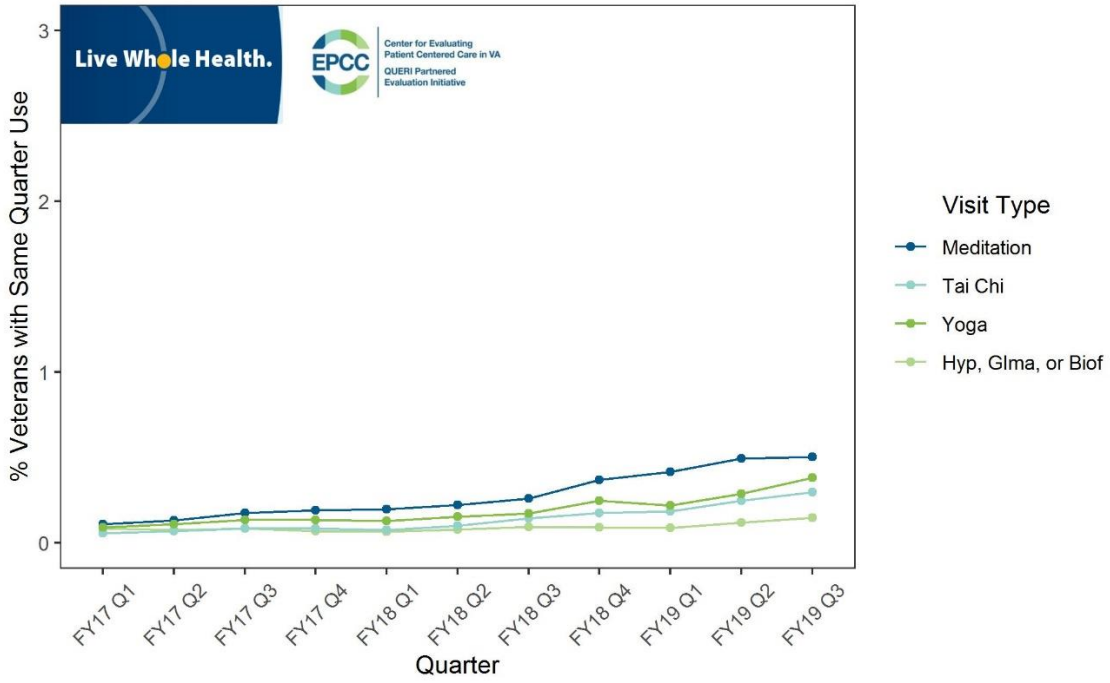

Figure 3.34: Percent of All Veteran VA Users: Any Same-Quarter Visit for Select CIH Services in VA and Community Care (Other than Chiropractic, Massage, Acupuncture). *Percent of all Veteran VA Users across the 18 flagship sites who have exposure to List 1 CIH services other than Chiropractic Care, Massage, and Acupuncture documented within the VA in the same quarter as other VA utilization. Hypnosis (Hyp), Guided Imagery (Gima) and Biofeedback (Biof) are combined (light green) into one line, Meditation (dark blue), Tai Chi (light blue), and Yoga (green) are shown individually.*

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2. Quan H, Sundararajan V, Halfon P, et al. Coding algorithms for defining comorbidities in ICD-9-CM and ICD-10 administrative data. *Medical care.* 2005;43(11):1130-1139.
3. Goulet JL, Kerns RD, Bair M, et al. The musculoskeletal diagnosis cohort: examining pain and pain care among veterans. *Pain.* 2016;157(8):1696-1703.

Appendix 4 Table of Contents

Impact on Veterans

Overview

The EPCC evaluation team partnered with OPCC&CT to develop a strategy for collecting patient reported outcomes among patients participating in WHS services as the 18 pilot Flagship sites began implementation and reach additional levels of implementation success. A key goal was to survey a group of Veterans as sites were beginning implementation to serve as a baseline comparison group before WHS services were broadly implemented. The original plan was to support 18 coordinators, one at each of the 18 Flagship sites, to administer the patient reported outcome survey to Veterans, however this strategy was replaced by a national centralized survey conducted by mail to ensure standardization of data collection and reduce costs. The questionnaires were developed in a prior QI project (measures are described in Table 4.1 below).

Sampling

General Population Sampling – Launch of WHS Pilot. Veterans with chronic musculoskeletal pain between ages 18-89 at the 18 pilot Flagship sites were identified beginning in March 2018 based on use of VA including primary care, mental health or pain clinic visits. The sampling rate increased as personnel were available to mail out and track surveys starting with a weekly volume of 200 surveys being mailed out increasing to 600 surveys per week. A total of 12,986 baseline surveys were mailed out to unique Veterans, with a baseline response rate of 49.3% and a response rate for the 6-month follow-up survey of 74.2%. The 12-month follow-up survey is currently underway.

Whole Health Service User Sampling. A second sampling wave focused on identifying Veterans using WHS services began January 2019. Veterans using VA including primary care, mental health or pain clinic who also had a visit with a Whole Health service (Stopcode 139) were identified and randomly sampled. This wave began with identifying Veterans at the 9 Flagship sites that had made the most progress in implementing WHS services and was expanded to all 18 sites in March 2019. A total of 7,207 baseline surveys were mailed out to unique Veterans with a baseline response rate of 50.5%. Some 6-month surveys for this cohort are included in the current report, however 6-month surveys are ongoing for this sampling wave. 12-month surveys will begin in January 2020.

Survey Data Collection

The team conducted a mailed survey at 3 time points: Baseline, 6 months and 12 months. We included a letter and information sheet in the survey stating that the purpose of the project is to understand patients' experiences and outcomes of care. Patients were told that their participation is entirely voluntary, and they were given the option to opt out by contacting the project manager by phone (at number provided). Patients were also informed that information collected will not be shared with their provider, that all information is kept confidential, and that each survey has been tracked with a code so that no personal health identifiers are included in the survey. (The codes are linked to individual names and identifiers, but these are kept separate from the surveys and survey data.) Finally, a $5 gift card was included with each initial survey as payment. For each survey, we used a tailored method of survey administration (cf. Dillman)[1], as follows:

- Pre-notice letter (day -7)
- Initial survey (day 0)
- Postcard reminder (day 14)

- Second copy of survey (day 28)

Survey Measures

Table 4.1: Veteran's Health and Life Survey Measures. *This table shows all measures from the Veteran's Health and Life Survey used in this analysis. The full survey can be found in Appendix 4-B.*

Perceptions of Care		
Quality of Provider Interactions	CARE: Consultation and Relational Empathy[2,3]	10 item measure developed to measure patients' perceptions of relational empathy
Patient-Centered Communication	CollaboRATE[4]	3 item measure focused on the process of shared decision-making communication between providers and patients
Veteran Satisfaction with Care	Satisfaction with care, adapted from VA SHEP survey	1 item question rating a veteran's satisfaction with their VA primary care provider in the past 6 months
Help with Goals	Process questions developed internally	2 items assessing patient goal progress Q1: Discussing goals with provider Q2: Provider being helpful in making progress towards goals
Life Engagement and Engagement in Care		
Engagement- Health Behaviors	ACE-C: Altarum Consumer Engagement- Commitment Sub-Scale[5]	8 item measure of patient engagement including 4 items measuring engagement in healthcare decisions-Commitment (Comm) and 4 items measuring confidence and ability to participate in treatment decisions-Navigation (Nav)
Engagement- Healthcare Decisions	ACE-N: Altarum Consumer Engagement- Navigation Subscale[5]	
Meaning and Purpose 1	LET: Life Engagement Test[6]	6 items with 3 framed in positive direction and 3 negative, intended to measure purpose in life
Meaning and Purpose 2	Single item from Institute for Healthcare Improvement's (IHI) 100 Million Healthier Lives measure[7,8]	IHI single item ("I lead a purposeful and meaningful life.")
Well-Being		
Physical Health	PROMIS-10 Physical Health Subscale[9]	A 10 item measure of self-reported global health developed and validated in multiple populations. Designed to be relevant across all health conditions for the assessment of symptoms and function. Measure includes Physical and Mental Health dimensions.
Mental Health	PROMIS-10 Mental Health Subscale[9]	
Stress	PSS: Perceived Stress Scale[10,11]	4 item version of 14 item scale measuring perceived stress, half worded positive and half negative
Pain	PEG[12,13,14]	Brief 3 item multi-dimensional pain measure that assesses pain intensity (P), interference with enjoyment of life (E), and interference with general activity (G). This measure was designed and validated for use among Veterans.
Other		
Interest in Whole Health	Questions developed internally to gauge interest in Whole Health activities	Internally developed 12-item measure to gauge interest in Whole Health activities.
Pain Site and Chronicity	Questions developed by the Pain QUERI group	Measures used at baseline to refine understanding of patient pain characteristics.
Demographics	Demographics questions developed internally	Demographic variables including race/ethnicity, education, employment, financial, housing and Veteran combat status.

Methods for Categorizing WHS Users – Table of WHS Users among Survey Responders

For this evaluation, 3,266 Veterans had completed both baseline and 6-month follow-up surveys. We identified WHS service utilization as well as reported use in the surveys. There are four levels of WHS service use, which we identified by looking at utilization of WHS services delivered in VA and in the community prior around the time of the 6-month survey. The four categories of WHS use are not mutually exclusive, with patients appearing in the Any Including Low Intensity Use group and all other groups for which they met the use criteria if they had more intensive us.

Table 4.2:Distribution of WH user categories amongst VHLS respondents

WHS User Category	**Use Criteria**	**Survey Respondents** 3,266 Veterans with Chronic Pain
Comprehensive WHS Use	>= 8 total WH touches (>= 2 Core Whole Health touches + >= 2 CIH touches)	128 (4%)
CORE Whole Health Intensive Use	>= 4 Core WH, any CIH	261 (8%)
CIH Intensive Use	>= 4 CIH, any Core WH	617 (19%)
Any Including Low Intensity Use	>= 2 of any WHS service or self-reported use	1515 (46%)
No WHS Use	All Veterans with 0 or 1 WHS visits	1751 (54%)

Preliminary Finding FY'18- Interest in WHS Among Early Survey Respondents

The initial 1395 survey respondents at the launch of the WHS Flagship pilot among the general population of VA healthcare users who had musculoskeletal pain reported high interest in WHS services and relatively low rates of having used any WHS services. Over 97% of Veterans participating in the baseline survey indicated they were interested or currently using at least some WHS services. Below is the level of interest and use at the launch of the Flagship pilot before many WHS services had begun to be offered.

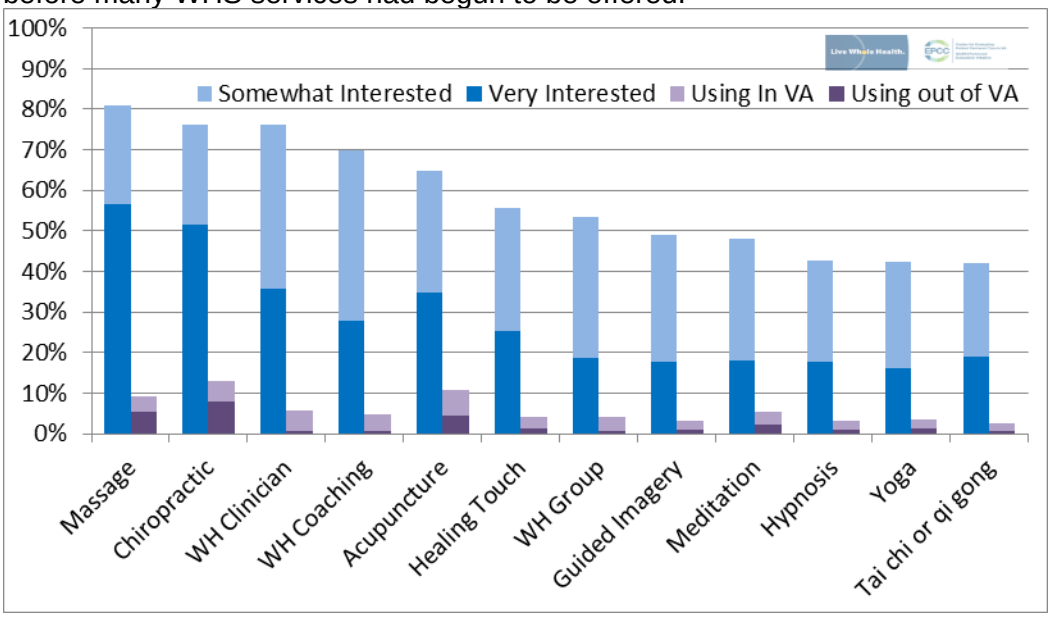


Figure 4.1: Interest in WHS Among Early Survey Respondents. *This figure highlights the high level of interest among early survey respondents and low self-reported use at the beginning of the Flagship pilot, before many WHS services had begun to be offered at sites.*

Demographics of Survey Respondents (n=3266)

Table 4.3: Characteristics of 3266 Veterans who Completed Baseline and 6-Month Follow-up Surveys

			WHS User Category			
Variable	**Overall**	**No Use**	**Any 2+ WHS Use**	**CIH Intensive**	**Core WH Intensive**	**Comprehensive**
N	3266	1712	1554	696	273	145
Gender: N (%)						
Male	2968 (90.9)	1597 (93.3)	1371 (88.2)	586 (84.2)	241 (88.3)	111 (76.6)
Age: N (%)						
18-39	97 (3.0)	28 (1.6)	69 (4.4)	37 (5.3)	6 (2.2)	6 (4.1)
40-54	398 (12.2)	176 (10.3)	222 (14.3)	122 (17.5)	32 (11.7)	27 (18.6)
55-64	759 (23.2)	370 (21.6)	389 (25.0)	196 (28.2)	82 (30.0)	51 (35.2)
65-74	1418 (43.4)	790 (46.1)	628 (40.4)	261 (37.5)	111 (40.7)	51 (35.2)
75-90	594 (18.2)	348 (20.3)	246 (15.8)	80 (11.5)	42 (15.4)	10 (6.9)
Race: N (%)						
White	2656 (81.3)	1412 (82.5)	1244 (80.1)	561 (80.6)	202 (74.0)	112 (77.2)
Black	353 (10.8)	185 (10.8)	168 (10.8)	75 (10.8)	48 (17.6)	20 (13.8)
Asian	11 (0.3)	4 (0.2)	7 (0.5)	3 (0.4)	0 (0.0)	0 (0.0)
Multiple	123 (3.8)	56 (3.3)	67 (4.3)	28 (4.0)	10 (3.7)	8 (5.5)
Other	40 (1.2)	16 (0.9)	24 (1.5)	12 (1.7)	5 (1.8)	3 (2.1)
NA	83 (2.5)	39 (2.3)	44 (2.8)	17 (2.4)	8 (2.9)	2 (1.4)
Hispanic: N (%)						
Yes	183 (5.6)	95 (5.5)	88 (5.7)	41 (5.9)	11 (4.0)	8 (5.5)
In a Relationship: N (%)						
Yes	2223 (68.1)	1173 (68.5)	1050 (67.6)	439 (63.1)	183 (67.0)	92 (63.4)
Stayed Overnight: N (%)						
Yes	30 (0.9)	14 (0.8)	16 (1.0)	7 (1.0)	4 (1.5)	2 (1.4)
Homeless/Transitional: N (%)						
Yes	18 (0.6)	5 (0.3)	13 (0.8)	3 (0.4)	2 (0.7)	1 (0.7)
Working: N (%)						
Yes	770 (23.6)	398 (23.2)	372 (23.9)	167 (24.0)	47 (17.2)	35 (24.1)
Education: N (%)						
High School Dip.	1221 (37.4)	690 (40.3)	531 (34.2)	202 (29.0)	110 (40.3)	32 (22.1)
2 or 4-year Degree	1702 (52.1)	877 (51.2)	825 (53.1)	393 (56.5)	125 (45.8)	89 (61.4)

			WHS User Category			
Variable	**Overall**	**No Use**	**Any 2+ WHS Use**	**CIH Intensive**	**Core WH Intensive**	**Comprehensive**
Grad School	329 (10.1)	140 (8.2)	189 (12.2)	97 (13.9)	36 (13.2)	24 (16.6)
NA	14 (0.4)	5 (0.3)	9 (0.6)	4 (0.6)	2 (0.7)	0 (0.0)
Survey Help: N (%)						
Yes	296 (9.1)	146 (8.5)	150 (9.7)	60 (8.6)	32 (11.7)	13 (9.0)
Served in Combat: N (%)						
Yes	1648 (50.5)	845 (49.4)	803 (51.7)	357 (51.3)	134 (49.1)	66 (45.5)

*Working = working full- or part-time or a homemaker.

*Homeless/Transitional also includes those in prison.

*Stayed Overnight = hospital or drug treatment center.

*Relationship = married, civil union, engaged or in a relationship.

Table 4.4: Descriptors of Pain Characteristics at Baseline among Survey Respondents

			WHS User Category			
Variable	**Overall**	**No Use**	**Any 2+ WHS Use**	**CIH Intensive**	**Core WH Intensive**	**Comprehensive**
N	3266	1712	1554	696	273	145
Length of Pain: N (%)						
Not a Problem	34 (1.0)	20 (1.2)	14 (0.9)	3 (0.4)	3 (1.1)	1 (0.7)
< 3 months	89 (2.7)	58 (3.4)	31 (2.0)	10 (1.4)	5 (1.8)	2 (1.4)
3-6 months	70 (2.1)	42 (2.5)	28 (1.8)	8 (1.1)	3 (1.1)	1 (0.7)
6+ months	2988 (91.5)	1550 (90.5)	1438 (92.5)	662 (95.1)	250 (91.6)	138 (95.2)
Pain Sites: N (%)						
Back	2076 (63.6)	1006 (58.8)	1070 (68.9)	530 (76.1)	176 (64.5)	111 (76.6)
Neck	1156 (35.4)	521 (30.4)	635 (40.9)	313 (45.0)	112 (41.0)	74 (51.0)
Hip	1176 (36.0)	568 (33.2)	608 (39.1)	310 (44.5)	111 (40.7)	81 (55.9)
Knee	1379 (42.2)	710 (41.5)	669 (43.1)	310 (44.5)	122 (44.7)	75 (51.7)
Foot	1069 (32.7)	550 (32.1)	519 (33.4)	238 (34.2)	103 (37.7)	58 (40.0)
Leg	1084 (33.2)	553 (32.3)	531 (34.2)	254 (36.5)	104 (38.1)	58 (40.0)
Shoulder	1079 (33.0)	541 (31.6)	538 (34.6)	249 (35.8)	100 (36.6)	61 (42.1)
Elbow	249 (7.6)	130 (7.6)	119 (7.7)	55 (7.9)	25 (9.2)	15 (10.3)

			WHS User Category			
Variable	**Overall**	**No Use**	**Any 2+ WHS Use**	**CIH Intensive**	**Core WH Intensive**	**Comprehensive**
Wrist	383 (11.7)	203 (11.9)	180 (11.6)	80 (11.5)	31 (11.4)	18 (12.4)
Arm	348 (10.7)	177 (10.3)	171 (11.0)	80 (11.5)	34 (12.5)	23 (15.9)
Face/Jaw	123 (3.8)	52 (3.0)	71 (4.6)	30 (4.3)	13 (4.8)	7 (4.8)
Headache	558 (17.1)	233 (13.6)	325 (20.9)	175 (25.1)	64 (23.4)	51 (35.2)
Num. Pain Sites: N (%)						
2 or Less	1112 (34.0)	624 (36.4)	488 (31.4)	188 (27.0)	76 (27.8)	25 (17.2)
3 to 5	1369 (41.9)	704 (41.1)	665 (42.8)	306 (44.0)	109 (39.9)	61 (42.1)
6 or more	515 (15.8)	217 (12.7)	298 (19.2)	161 (23.1)	62 (22.7)	49 (33.8)
NA	270 (8.3)	167 (9.8)	103 (6.6)	41 (5.9)	26 (9.5)	10 (6.9)
PEG Q1: Mean (SD)	6.51 (1.94)	6.38 (1.99)	6.66 (1.87)	6.69 (1.72)	6.86 (1.94)	6.79 (1.68)
DVPRS: N (%)						
None	29 (0.9)	22 (1.3)	7 (0.5)	2 (0.3)	1 (0.4)	1 (0.7)
Mild	580 (17.8)	341 (19.9)	239 (15.4)	93 (13.4)	40 (14.7)	14 (9.7)
Moderate	1375 (42.1)	732 (42.8)	643 (41.4)	282 (40.5)	97 (35.5)	51 (35.2)
Severe	1242 (38.0)	596 (34.8)	646 (41.6)	311 (44.7)	129 (47.3)	78 (53.8)
NA	40 (1.2)	21 (1.2)	19 (1.2)	8 (1.1)	6 (2.2)	1 (0.7)

*Pain was rated on a scale of 1 - 3 (3 = bothered a lot).

*Pain Site/Num. Pain Sites: patients indicating pain at a 3.

Methods for Assessing 6 Month Change

The data available for this initial evaluation reflect a subset of the data that will be included in the final evaluation of the WHS Flagship pilot. Preliminary analyses focus on calculating the standardized mean differences (SD), also known as Cohen's D Effect Sizes, to assess the associations between WHS user groups (compared to non-use) and changes in measures[14]. The raw and adjusted scaled outcomes (as reported in the tables) have taken the original scale and converted to a 0 to 100 scale so that all measures share a common scale. These can be interpreted as percent values.

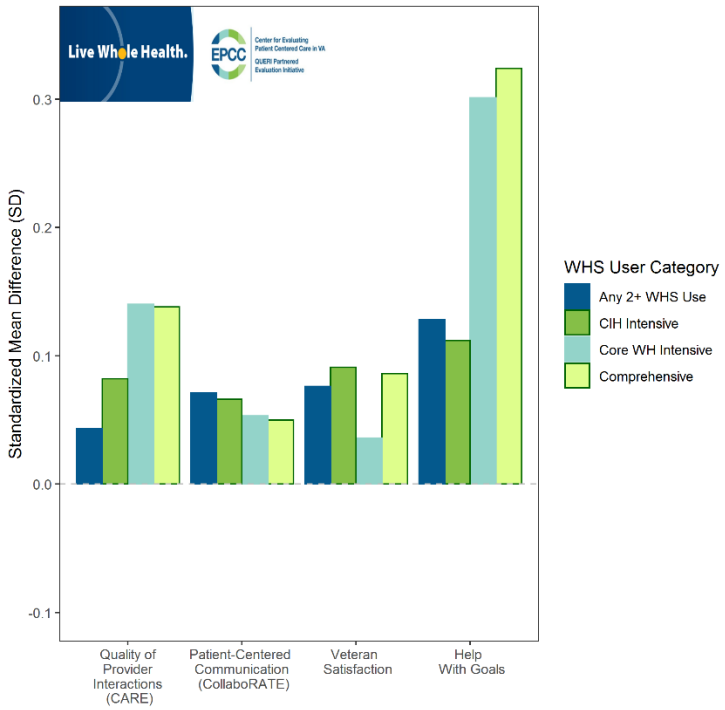


Figure 4.2: Association between levels of WHS service use and perceptions of VA Care.

The changes in reported outcomes shown are relative to the group of survey responders who reported two or fewer uses of WHS services.

Table 4.5: Perceptions of Care Measures-Data Table

			WHS User Category			
	Overall	**No Use**	**Any 2+ WHS Use**	**CIH Intensive**	**Core WH Intensive**	**Comprehensive**
Quality of Provider Interactions (CARE)						
Baseline	37.689	37.656	37.724	37.333	38.595	39.197
6-Months	38.071	37.764	38.413	38.228	40.236	40.441
Change	0.342	0.147	0.56	0.941	1.414	1.466
Raw Group Effect			0.413	0.794	1.267	1.319
Standardized Mean Difference (SD)			0.018	0.044	0.073	0.118
Raw Scaled Group Effect			1.032	1.984	3.166	3.297
Adj. Scaled Group Effect			0.172	0.312	0.742	1.259
Patient-Centered Communication (CollaboRATE)						
Baseline	6.957	7.008	6.902	6.801	7.14	7.196

			WHS User Category			
	Overall	**No Use**	**Any 2+ WHS Use**	**CIH Intensive**	**Core WH Intensive**	**Comprehensive**
6-Months	7.091	7.072	7.112	6.985	7.31	7.364
Change	0.131	0.062	0.206	0.196	0.165	0.163
Raw Group Effect			0.144	0.134	0.103	0.101
Standardized Mean Difference (SD)			0.128	0.112	0.301	0.324
Raw Scaled Group Effect			1.607	1.486	1.145	1.126
Adj. Scaled Group Effect			2.807	2.487	6.501	7.829
Veteran Satisfaction						
Baseline	7.493	7.546	7.435	7.311	7.9	7.662
6-Months	7.579	7.543	7.617	7.522	7.985	7.839
Change	0.079	0.005	0.16	0.19	0.071	0.182
Raw Group Effect			0.155	0.185	0.066	0.177
Standardized Mean Difference (SD)			0.071	0.066	0.053	0.05
Raw Scaled Group Effect			1.556	1.851	0.664	1.77
Adj. Scaled Group Effect			0.923	0.42	0.365	-0.199
Help With Goals						
Baseline	5.658	5.558	5.768	5.844	6.476	6.29
6-Months	5.642	5.419	5.884	5.924	6.866	6.759
Change	-0.012	-0.136	0.124	0.091	0.41	0.507
Raw Group Effect			0.26	0.227	0.546	0.643
Standardized Mean Difference (SD)			0.076	0.091	0.036	0.086
Raw Scaled Group Effect			3.247	2.839	6.826	8.042
Adj. Scaled Group Effect			1.217	1.27	1.042	1.596

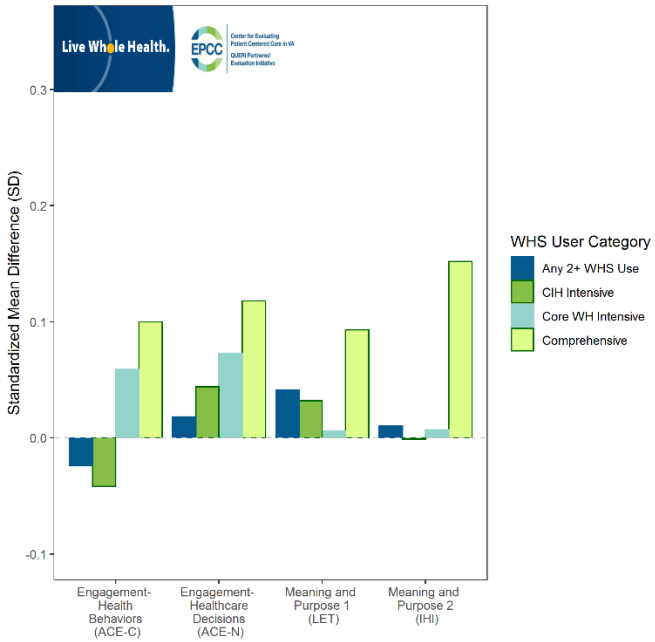


Figure 4.3: Association between changes in patient engagement and meaning and purpose and WH service use.

The changes in reported outcomes shown are relative to the group of survey responders who reported two or fewer uses of WHS services.

Table 4.6: Engagement in Life and Health Measures-Data Table

			WHS User Category			
	Overall	**No Use**	**Any 2+ WHS Use**	**CIH Intensive**	**Core WH Intensive**	**Comprehensive**
Engagement-Health behaviors (ACE-C)						
Baseline	2.41	2.407	2.413	2.35	2.399	2.302
6-Months	2.398	2.402	2.394	2.32	2.422	2.344
Change	-0.013	-0.007	-0.021	-0.032	0.028	0.053
Raw Group Effect			-0.014	-0.025	0.035	0.06
Standardized Mean Difference (SD)			0.01	-0.001	0.007	0.152
Raw Scaled Group Effect			-0.352	-0.633	0.856	1.49
Adj. Scaled Group Effect			-0.047	-0.587	0.295	2.55
Engagement-Healthcare Decisions (ACE-N)						
Baseline	2.675	2.64	2.713	2.696	2.715	2.747
6-Months	2.688	2.649	2.73	2.727	2.76	2.815
Change	0.012	0.006	0.017	0.032	0.048	0.075

			WHS User Category			
	Overall	**No Use**	**Any 2+ WHS Use**	**CIH Intensive**	**Core WH Intensive**	**Comprehensive**
Raw Group Effect			0.011	0.026	0.042	0.069
Standardized Mean Difference (SD)			0.041	0.032	0.006	0.093
Raw Scaled Group Effect			0.268	0.649	1.039	1.719
Adj. Scaled Group Effect			0.677	0.246	0.131	1.111
Meaning and Purpose (LET)						
Baseline	22.343	22.634	22.024	21.706	21.966	21.187
6-Months	22.231	22.443	21.998	21.683	21.83	21.456
Change	-0.113	-0.181	-0.038	-0.067	-0.162	0.142
Raw Group Effect			0.143	0.114	0.019	0.323
Standardized Mean Difference (SD)			0.043	0.082	0.14	0.138
Raw Scaled Group Effect			0.597	0.474	0.079	1.345
Adj. Scaled Group Effect			0.204	0.783	2.035	1.471
Spiritual well-Being (IHI)						
Baseline	4.914	5	4.818	4.65	4.779	4.352
6-Months	4.91	4.988	4.826	4.643	4.78	4.538
Change	-0.006	-0.012	0.001	-0.013	-0.004	0.186
Raw Group Effect			0.013	-0.001	0.008	0.198
Standardized Mean Difference (SD)			-0.024	-0.042	0.059	0.1
Raw Scaled Group Effect			0.209	-0.019	0.137	3.301
Adj. Scaled Group Effect			-0.499	-0.54	0.613	1.744

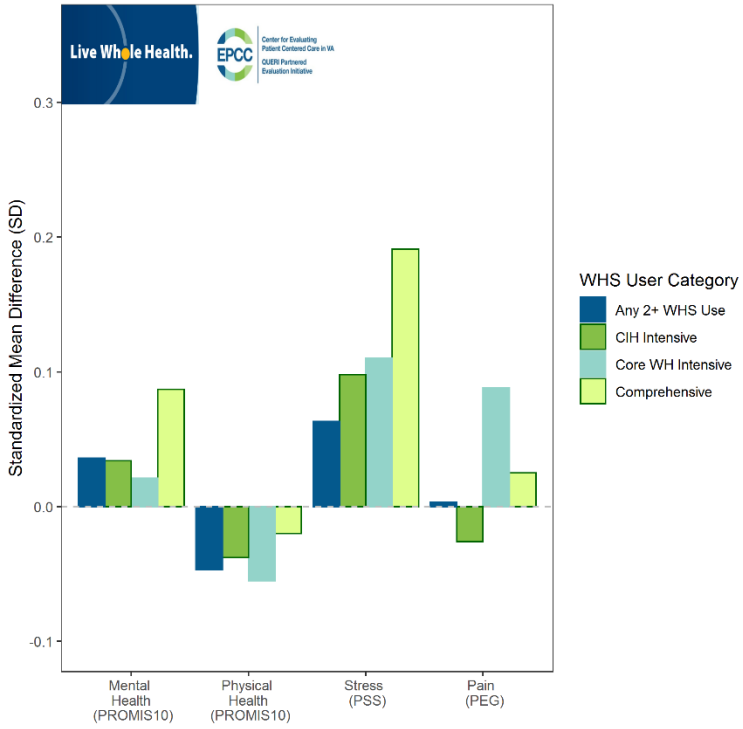


Figure 4.4 Changes in well-being and pain compared to non-users. *Note that any negative SD represents a relative change compared to the non-user group. All measures did improve across all groups.*

The changes in reported outcomes shown in Figure 4.2 are relative to the group of survey responders who reported two or fewer uses of WHS services.

Table 4.7: Veterans Well-Being Measures- Data Table

			WHS User Category			
	Overall	**No Use**	**Any 2+ WHS Use**	**CIH Intensive**	**Core WH Intensive**	**Comprehensive**
Mental Health (PROMIS10)						
Baseline	42.319	43.173	41.374	40.175	40.484	38.55
6-Months	42.245	42.999	41.415	40.207	40.357	38.949
Change	-0.08	-0.178	0.029	0.018	-0.057	0.319
Raw Group Effect			0.207	0.196	0.121	0.497
Standardized Mean Difference (SD)			0.036	0.034	0.021	0.087
Raw Scaled Group Effect			0.436	0.409	0.309	1.237
Adj. Scaled Group Effect			0.13	-0.019	0.308	0.842
Physical Health (PROMIS10)						
Baseline	37.571	38.024	37.071	36.26	36.282	35.839
6-Months	37.723	38.236	37.157	36.371	36.485	35.969

			WHS User Category			
	Overall	**No Use**	**Any 2+ WHS Use**	**CIH Intensive**	**Core WH Intensive**	**Comprehensive**
Change	0.201	0.309	0.083	0.127	0.055	0.213
Raw Group Effect			-0.226	-0.182	-0.254	-0.096
Standardized Mean Difference (SD)			-0.047	-0.038	-0.055	-0.02
Raw Scaled Group Effect			-0.527	-0.433	-0.599	-0.226
Adj. Scaled Group Effect			-0.982	-0.819	-1.37	-0.593
Stress (PSS)						
Baseline	6.007	5.707	6.337	6.59	6.747	7.086
6-Months	6.035	5.812	6.28	6.432	6.595	6.648
Change	0.025	0.106	-0.064	-0.158	-0.166	-0.401
Raw Group Effect			0.17	0.264	0.272	0.507
Standardized Mean Difference (SD)			0.063	0.098	0.11	0.191
Raw Scaled Group Effect			1.059	1.647	1.699	3.167
Adj. Scaled Group Effect			1.024	1.139	1.686	3.594
Pain (PEG)						
Baseline	6.59	6.415	6.784	6.921	6.989	7.005
6-Months	6.442	6.277	6.624	6.834	6.657	6.796
Change	-0.149	-0.147	-0.152	-0.098	-0.31	-0.194
Raw Group Effect			0.005	-0.049	0.163	0.047
Standardized Mean Difference (SD)			0.003	-0.026	0.088	0.025
Raw Scaled Group Effect			0.055	-0.489	1.629	0.476
Adj. Scaled Group Effect			-1.025	-1.801	0.303	-0.545

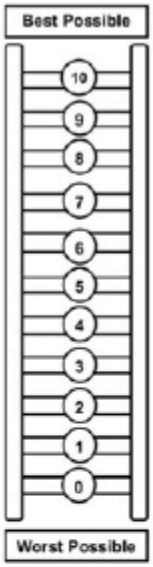
The outcomes for PEG and PSS relative to the 'No Use' group have been reversed so that positive values indicate more improvement.

Veterans Health & Life Survey

Not all measures in this survey were used in preparation of this progress report

Section 1. About your general health and well-being.

Please imagine a ladder with steps numbered from zero at the bottom to ten at the top. The top of the ladder represents the best possible life for you and the bottom of the ladder represents the worst possible life for you.



1. Indicate where on the ladder you feel you personally stand right now.
   0 1 2 3 4 5 6 7 8 9 10

2. On which step do you think you will stand about five years from now?
   0 1 2 3 4 5 6 7 8 9 10

3. Now imagine the top of the ladder represents the best possible *financial situation* for you, and the bottom of the ladder represents the worst possible *financial situation* for you. Please indicate where on the ladder you stand right now.
   0 1 2 3 4 5 6 7 8 9 10

***From* 100 Million Healthier Lives Institute for Healthcare Improvement Measure[7,8]**

4. How well are you able to support yourself and meet your basic needs (food, housing, transportation)?
   1 Not at all 2 3 4 5 Very well

Demographic Question

5. How often do you get the social and emotional support you need?

Always	Usually	Sometimes	Rarely	Never
☐	☐	☐	☐	☐

6. How strongly do you agree with this statement? "I lead a purposeful and meaningful life."

Strongly Agree	Agree	Slightly Agree	Neither Agree nor Disagree	Slightly Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐	☐	☐

7. Please rate how much you agree or disagree with the following statements below.

		Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
a)	Even when life is stressful, I know I can continue to do the things that keep me healthy.	☐	☐	☐	☐	☐
b)	I feel comfortable talking to my doctor about my health.	☐	☐	☐	☐	☐
c)	When I work to improve my health, I succeed.	☐	☐	☐	☐	☐
d)	I have brought my own information about my health to show my doctor.	☐	☐	☐	☐	☐
e)	I can stick with plans to exercise and eat a healthy diet.	☐	☐	☐	☐	☐
f)	I have lots of experience using the health care system.	☐	☐	☐	☐	☐
g)	Different doctors give different advice; it's up to me to choose what's right for me.	☐	☐	☐	☐	☐
h)	I handle my health well.	☐	☐	☐	☐	☐

Altarum Consumer Engagement (ACE) Measure™ [5]

Commitment subscale:
Questions a, c, e, h

Navigation subscale:
Questions b, d, f, g

Section 2. About your medical care.

1. Think about your most recent visit in primary care. Was it (*please mark only one*):
   - ☐ A VA primary care appointment
   - ☐ A non-VA primary care appointment

2. Thinking about the appointment you have just had...

   a) How much effort was made by your provider to help you understand your health issues?

   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9

   No effort was made ... ***Every effort was made***

   b) How much effort was made by your provider to listen to the things that matter most to you about your health issues?

   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9

   No effort was made ... ***Every effort was made***

   c) How much effort was made by your provider to include what matters most to you in choosing what to do next?

   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9

   No effort was made ... ***Every effort was made***

CollaboRATE[4]

3. Still thinking about that same primary care appointment please rate the following.
Please check one box for each statement and answer every statement.

	How good was the provider at...	Poor	Fair	Good	Very good	Excellent	Does not apply
a)	Making you feel at ease... *(being friendly and warm towards you, treating you with respect; not cold or abrupt)*	☐	☐	☐	☐	☐	☐
b)	Letting you tell your "story"... *(giving you time to fully describe your illness in your own words; not interrupting or diverting you)*	☐	☐	☐	☐	☐	☐
c)	Really listening... *(paying close attention to what you were saying; not looking at the notes or computer as you were talking)*	☐	☐	☐	☐	☐	☐
d)	Being interested in you as a whole person... *(asking/knowing relevant details about your life, your situation; not treating you as "just a number")*	☐	☐	☐	☐	☐	☐
e)	Fully understanding your concerns... *(communicating that he/she had accurately understood your concerns; not overlooking or dismissing anything)*	☐	☐	☐	☐	☐	☐
f)	Showing care and compassion... *(seeming genuinely concerned, connecting with you on a human level; not being indifferent or "detached")*	☐	☐	☐	☐	☐	☐
g)	Being positive... *(having a positive approach and a positive attitude; being honest but not negative about your problems)*	☐	☐	☐	☐	☐	☐
h)	Explaining things clearly... *(fully answering your questions, explaining clearly, giving you adequate information; not being vague)*	☐	☐	☐	☐	☐	☐
i)	Helping you to take control... *(exploring with you what you can do to improve your health yourself; encouraging rather than "lecturing" you)*	☐	☐	☐	☐	☐	☐
j)	Making a plan of action with you... *(discussing the options, involving you in decisions as much as you want to be involved; not ignoring your views)*	☐	☐	☐	☐	☐	☐

Consultation and Relational Empathy (CARE)[2,3]

4. Using any number from 0 to 10, where 0 is the worst office visit possible and 10 is the best office visit possible, what number would you use to rate your visits overall with your VA primary care provider during the past six months?

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10
Worst Office Visits Possible										**Best Office Visits Possible**

5. Would you recommend VA primary care services to other Veterans?
   - ☐ Definitely no
   - ☐ Probably no
   - ☐ Probably yes
   - ☐ Definitely yes

6. If you could have free care outside the VA, would you continue to get primary care at the VA?
   - ☐ Definitely would not
   - ☐ Probably would not
   - ☐ Probably would
   - ☐ Definitely would

Satisfaction Questions

7. The VA is working on providing several new services. If available at your VA, how interested would you be in trying the following? For each row, check the answer that best applies.

		Not at all interested	Somewhat interested	Very interested	Already using	
a)	Acupuncture	☐	☐	☐	☐ In VA	☐ Out of VA
b)	Massage	☐	☐	☐	☐ In VA	☐ Out of VA
c)	Chiropractic	☐	☐	☐	☐ In VA	☐ Out of VA
d)	Healing touch	☐	☐	☐	☐ In VA	☐ Out of VA
e)	Hypnosis	☐	☐	☐	☐ In VA	☐ Out of VA
f)	Guided imagery	☐	☐	☐	☐ In VA	☐ Out of VA
g)	Meditation	☐	☐	☐	☐ In VA	☐ Out of VA
h)	Yoga	☐	☐	☐	☐ In VA	☐ Out of VA
i)	Tai chi or qi gong	☐	☐	☐	☐ In VA	☐ Out of VA
j)	Meet with a Whole Health coach to reach your personal health goals	☐	☐	☐	☐ In VA	☐ Out of VA
k)	Attend a group to learn about Whole Health and set a personal health goal	☐	☐	☐	☐ In VA	☐ Out of VA
l)	Discuss with a clinician what matters most to you	☐	☐	☐	☐ In VA	☐ Out of VA

Interest in Whole Health

Section 3. Your Health and Personal Health Goals.

1. Next we would like to ask you some questions about your health in general. Please respond to each question or statement by marking one box in each row.

		Excellent	Very Good	Good	Fair	Poor
a)	In general, would you say your health is:	☐	☐	☐	☐	☐
b)	In general, would you say your quality of life is:	☐	☐	☐	☐	☐
c)	In general, how would you rate your physical health?	☐	☐	☐	☐	☐
d)	In general, how would you rate your mental health, including your mood and your ability to think?	☐	☐	☐	☐	☐
e)	In general, how would you rate your satisfaction with your social activities and relationships?	☐	☐	☐	☐	☐
f)	In general, please rate how well you carry out your usual social activities and roles. *(This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)*	☐	☐	☐	☐	☐

		Completely	Mostly	Moderately	A little	Not at all
g)	To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	☐	☐	☐	☐	☐

	In the past 7 days...	Never	Rarely	Sometimes	Often	Always
h)	How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	☐	☐	☐	☐	☐

	In the past 7 days...	None	Mild	Moderate	Severe	Very Severe
i)	How would you rate your fatigue on average?	☐	☐	☐	☐	☐

PROMIS-10[9]

Physical Health Subscale:
Questions c, g, i

Question 10 of this scale is asked in Section 3, Question 4 (as part of PEG measure) to avoid redundancy

Mental Health Subscale:
Questions b, d, e, h

Your Pain.

2. Next we would like to ask you some questions about your experience of pain. Please check one box for each row below.

	During the **past 4 weeks**, how much have you been bothered by pain in your...	Not bothered at all	Bothered a little	Bothered a lot
a)	Back	☐	☐	☐
b)	Neck	☐	☐	☐
c)	Hip	☐	☐	☐
d)	Knee	☐	☐	☐
e)	Foot	☐	☐	☐
f)	Leg	☐	☐	☐
g)	Shoulder	☐	☐	☐
h)	Elbow	☐	☐	☐
i)	Wrist	☐	☐	☐
j)	Arm	☐	☐	☐
k)	Face/jaw	☐	☐	☐
l)	Headache	☐	☐	☐
m)	Other:	☐	☐	☐

Site of Pain Question

3. How long has pain been an ongoing problem for you?
   - ☐ Not at all
   - ☐ Less than 1 month
   - ☐ 1-3 months
   - ☐ 3-6 months
   - ☐ 6 months-1 year
   - ☐ 1-5 years
   - ☐ More than 5 years

Pain Chronicity Question

Please circle the number that best answers each question.

4. What number best describes your pain on average in the past week:

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

5. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

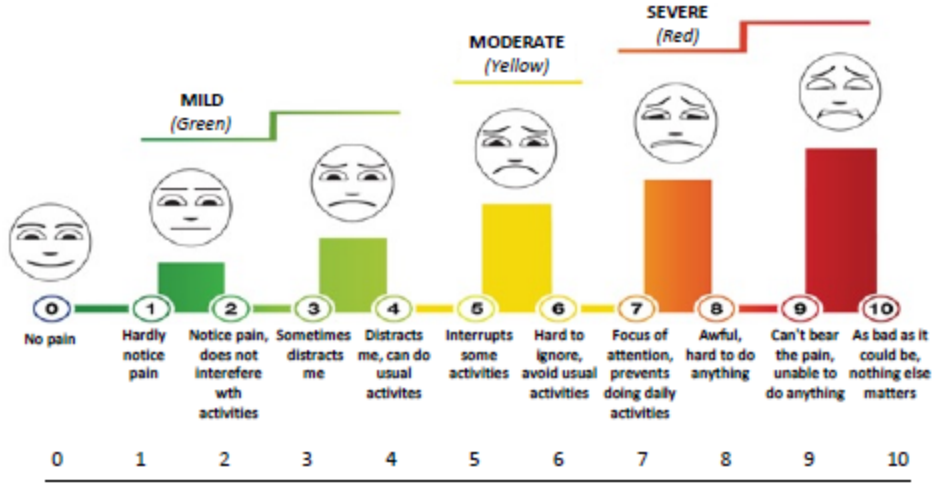
0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

6. What number best describes how, during the past week, pain has interfered with your general activity?

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

PEG (**P**ain intensity, interference with **E**njoyment of life, interference with **G**eneral activity)[12,13,14]

7. Now, circle the number that describes how much pain you have had during the past 24 hours. Please circle the number on the number line below the image.



Defense and Veterans Pain Rating Scale (DVPRS)

Your personal health goals.

8. Many people get healthcare to help them meet personal health goals. Look at the list of goals below. Think back over the **past 6 months.** *For each goal that is important to you, mark the box that shows how much progress you have made towards that goal. If the goal is not a goal for you, mark the box that says "N/A or not a goal at this time." Please mark as many goals as apply and add any goal you may have that is not listed.*

Goal Attainment Measure

	Personal Health Goal	N/A or not a goal at this time	Getting worse	Almost no progress	A little progress	Some progress	A lot of progress	Goal reached or almost reached
a)	Be able to work *(get or keep a job, earn a living)*	☐	☐	☐	☐	☐	☐	☐
b)	Engage in enjoyable or meaningful activities *(such as hobbies or other leisure activities, volunteering, sports, school)*	☐	☐	☐	☐	☐	☐	☐
c)	Connect with my faith community, feel spiritually connected	☐	☐	☐	☐	☐	☐	☐
d)	Strengthen my relationships with friends and family	☐	☐	☐	☐	☐	☐	☐
e)	Find greater meaning and purpose in my life	☐	☐	☐	☐	☐	☐	☐
f)	Maintain or improve my current housing conditions *(for example: make home repairs, clean up)*	☐	☐	☐	☐	☐	☐	☐
g)	Manage my stress	☐	☐	☐	☐	☐	☐	☐
h)	Engage in mindfulness activities *(such as yoga, tai chi, or meditation)*	☐	☐	☐	☐	☐	☐	☐
i)	Improve my sleep and feel more rested	☐	☐	☐	☐	☐	☐	☐
j)	Find ways to relax	☐	☐	☐	☐	☐	☐	☐
k)	Maintain or increase exercise	☐	☐	☐	☐	☐	☐	☐
l)	Eat healthier food	☐	☐	☐	☐	☐	☐	☐
m)	Drink less alcohol	☐	☐	☐	☐	☐	☐	☐
n)	Smoke less or quit smoking	☐	☐	☐	☐	☐	☐	☐

	Personal Health Goal	N/A or not a goal at this time	Getting worse	Almost no progress	A little progress	Some progress	A lot of progress	Goal reached or almost reached
o)	Engage in treatment for my drug addiction	☐	☐	☐	☐	☐	☐	☐
p)	Become more involved in my healthcare *(for example: keep appointments more often, ask more questions, monitor my vital signs, attend classes or treatments more regularly)*	☐	☐	☐	☐	☐	☐	☐
q)	Manage my long-term health condition such as diabetes, high blood pressure, multiple sclerosis (MS) or other condition	☐	☐	☐	☐	☐	☐	☐
r)	Lose weight	☐	☐	☐	☐	☐	☐	☐
s)	Manage my anxiety or depression	☐	☐	☐	☐	☐	☐	☐
t)	Manage my pain	☐	☐	☐	☐	☐	☐	☐
u)	Manage my PTSD	☐	☐	☐	☐	☐	☐	☐
v)	Other (please specify):	☐	☐	☐	☐	☐	☐	☐

Goal Attainment Measure continued

9. In the **past 6 months**, how often have you discussed your goals with any VA healthcare provider?
   - ☐ Never
   - ☐ Rarely
   - ☐ Occasionally
   - ☐ Frequently
   - ☐ Always

10. In the **past 6 months**, how helpful were your VA healthcare providers overall in helping you make progress towards your personal health goals?
   - ☐ Not very helpful
   - ☐ Somewhat helpful
   - ☐ Moderately helpful
   - ☐ Helpful
   - ☐ Very helpful

Help with Goals Process Questions

Managing your health and life.

11. How strongly do you agree with the following statements? Be as honest as you can throughout, and try not to let your response to one question influence your response to other questions. There are no right or wrong answers.

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
a)	There is not enough purpose in my life.	☐	☐	☐	☐	☐
b)	To me, the things I do are all worthwhile.	☐	☐	☐	☐	☐
c)	Most of what I do seems trivial and unimportant to me.	☐	☐	☐	☐	☐
d)	I value my activities a lot.	☐	☐	☐	☐	☐
e)	I don't care very much about the things I do.	☐	☐	☐	☐	☐
f)	I have lots of reasons for living.	☐	☐	☐	☐	☐
g)	I am able to do things for my health as well as most other people.	☐	☐	☐	☐	☐
h)	It is difficult for me to find effective solutions to the health problems that come my way.	☐	☐	☐	☐	☐

Life Engagement Test (LET)[6]

Perceived Health Competency Scale (PHCS-2)

12. The next questions ask you about your feelings and thoughts during the last month.

In the last month, how often have you felt...		Never	Almost Never	Sometimes	Fairly Often	Very Often
a)	That you were unable to control the important things in your life?	☐	☐	☐	☐	☐
b)	Confident about your ability to handle your personal problems?	☐	☐	☐	☐	☐
c)	That things were going your way?	☐	☐	☐	☐	☐
d)	Difficulties were piling up so high that you could not overcome them?	☐	☐	☐	☐	☐

Perceived Stress Scale (PSS)[10,11]

13. People sometimes look to others for companionship, help, or other types of support. How often was each of the following kinds of support available to you if you needed it during the last month?

During the last month, did you have...		None of the Time	A little of the Time	Some of the Time	Most of the Time	All of the Time
a)	Someone to help with daily chores if you were sick	☐	☐	☐	☐	☐
b)	Someone to love and make you feel wanted	☐	☐	☐	☐	☐
c)	Someone to confide in or talk about yourself or your problems	☐	☐	☐	☐	☐
d)	Someone to have a good time with	☐	☐	☐	☐	☐
e)	Someone to give you information to help you understand a situation	☐	☐	☐	☐	☐
f)	Someone to give you money if you needed it	☐	☐	☐	☐	☐
g)	Someone to help you if you could not get out of bed	☐	☐	☐	☐	☐
h)	Someone to take you to the doctor	☐	☐	☐	☐	☐

Social Support Measure

Section 4: Facts about you.

We are almost finished with our survey. Before we end, we would like to know a little more about you. Please remember that any information you share is kept confidential.

1. What is your current relationship status? (Please select only one.)
   - ☐ Married or in a civil union
   - ☐ Engaged or in a relationship
   - ☐ Single (never married or in a civil union)
   - ☐ Separated
   - ☐ Divorced
   - ☐ Widowed

2. Where did you stay in the past 30 days? (Please select all that apply.)
   - ☐ My own apartment or house
   - ☐ Friend or relative's apartment or house
   - ☐ School or dormitory
   - ☐ Hospital, domiciliary, or drug treatment center
   - ☐ Nursing home/assisted living
   - ☐ Transitional housing
   - ☐ Homeless shelter
   - ☐ Car or street
   - ☐ Jail/prison
   - ☐ Other

3. Are you currently... (Please select all that apply.)
   - ☐ Working for pay full-time (30 hours or more per week)
   - ☐ Working for pay part-time (less than 30 hours per week)
   - ☐ Working as a volunteer (no pay)
   - ☐ Not working, but actively looking for work
   - ☐ Not working and not looking for work
   - ☐ Unable to work due to disability
   - ☐ Student in high school, job training, or college degree program
   - ☐ Homemaker
   - ☐ Retired

Demographic Questions

4. What is the highest grade or level of school that you have completed?
   - ☐ 8th grade or less
   - ☐ Some high school, but did not graduate
   - ☐ High school graduate or GED
   - ☐ Some college or 2-year degree
   - ☐ 4-year college graduate
   - ☐ More than 4-year college degree

5. Did you ever serve in a combat or war zone?
   - ☐ Yes
   - ☐ No

6. Are you of Hispanic or Latino/a origin or descent?
   - ☐ Yes
   - ☐ No

7. What is your race? (You may select more than one.)
   - ☐ White
   - ☐ Black or African American
   - ☐ Asian
   - ☐ Native Hawaiian or other Pacific Islander
   - ☐ American Indian or Alaska Native

8. What kind of help did you get, if any, to complete this survey? (Please select all that apply.)
   - ☐ None
   - ☐ Help reading the questions
   - ☐ Help understanding the questions
   - ☐ Help remembering what happened
   - ☐ Help deciding on an answer
   - ☐ Help marking the answers
   - ☐ Survey was completed entirely by a spouse, family member, or friend

Thank you for helping us to make improvements in VA care for you and other Veterans!

Demographic Questions continued

Methods – Pharmacy Costs and Opioid Use

Veteran User Cohort Sampling

In order to assess broad patterns of care associated with WHS services, we identified VA users from the Electronic Health Record (EHR) across the 18 pilot flagship sites who were regular VA healthcare users in FY18 and continued to use VA healthcare in the first half of FY19. Among these regular VA healthcare users, we identified those who had not previously used any WHS services before the midpoint of this evaluation (April 2018). Because this component of the evaluation is focused on EHR outcomes, we required several inclusion criteria. First, to be included in the evaluation a Veteran had to be a continuous VA healthcare user with at least one primary care, mental health or pain clinic visit in the 6 month period of October 2017-March 2018, another visit in the 6 month period between April 2018 – September 2018, and at least a third visit in the 6 month period from October 2018 – March 2019. These criteria were used to ensure all Veterans included in the sample had similar levels of opportunity to use WHS services and to ensure complete ascertainment of EHR-based outcomes. Second, any Veteran who used the WHS prior to April 2018 or after September 2018 was excluded as the goal of this evaluation was to identify changes in outcomes associated with initiating use of WHS services.

Categorizing Levels of WHS Use

This identified a sample of 114,357 Veterans with chronic pain, 149,621 Veterans with anxiety, depression and PTSD, and 215,423 Veterans with a common chronic condition from among a cohort of 358,253 Veterans who used care during this period. The methods for identifying Veterans with chronic pain diagnoses, mental health conditions or chronic conditions are previously described in Appendix 3-A. Each of these Veteran healthcare users were classified as either a non-user of WHS services or as a WHS user based on their WHS service use beginning in April 2018. EHR outcomes were then ascertained for the 6 month period prior to using WHS services (October 2017-March 2018) and the 6 month period one year later (October 2018 – March 2019).

Table 4.8: WHS Users among VA Healthcare Users. *(October 2017-March 2019) with Chronic Pain, Mental Health Conditions, and Chronic Conditions.*

		114,357 Veterans with Chronic Pain	149,621 Veterans with Anxiety, Depression, PTSD	229,646 Veterans with Chronic Conditions
Comprehensive WHS Use	>= 8 total WH touches (>= 2 Core Whole Health touches + >= 2 CIH touches)	601 (0.5%)	583 (0.4%)	574 (0.2%)
Core Whole Health Intensive Use	>= 4 Core WH, any CIH	961 (0.8%)	1005 (0.7%)	1155 (0.5%)
CIH Intensive Use	>= 4 CIH, any Core WH	4198 (3.7%)	3833 (2.6%)	3727 (1.6%)
Any 2+ WHS Use	>= 2 of any WHS service or self-reported use	6594 (5.8%)	6187 (4.1%)	6288 (2.7%)
Single WHS Use	Used 1 WHS service	2155 (1.9%)	2073 (1.4%)	2479 (1.1%)
No WHS Use	All Veterans with 0 WHS visits	105,608 (92.3%)	141,361 (94.5%)	215,423 (93.8%)

16) Methods – Opioid and Pharmacy Cost Data among VHA Healthcare Users

Pharmacy data for the Veteran VA user cohort was accessed through the Pharmacy Managerial Cost Accounting National Data Extract (MCA). We only analyzed outpatient prescriptions and not medications administered during inpatient admissions.

Opioid prescriptions were identified using the VA drug class code CN101 – buprenorphine and non-tabular forms of methadone (liquid, solution, and injectable) were excluded because these are most often used to treat opioid dependence and not pain. Because of known issues tracking administration of injectable drugs in the VA, we excluded fills for injectable fentanyl. Prescriptions without named formulations (e.g. unspecified codes) were excluded from analysis because it was not possible to convert these prescriptions into a standardized dose based on drug type. Dosages were extracted from the standardized drug name in the MCA file. Positive quantity fields in the data were corrected for outliers by drug name at the 95% and replaced with the 95% value. Negative quantities (representing returns) were rare enough that no reliable threshold could be determined and were not corrected.

Opioid fills were converted into a mg morphine equivalent (mg ME) using the Sept. 2018 Centers for Disease Control and Prevention Opioid MME tables[16] based on drug name, dosage, and quantity extracted from the MCA tables. For analysis, we summed total mg ME filled per patient per quarter (mg ME/patient-quarter).

Average pharmacy costs for the EHR cohort were analyzed using the same pharmacy data. Reported total costs are the sum of the reported drug product cost and dispensing cost (“act cost” and “disp cost” in the MCA tables). Total cost outliers within each VA drug class were detected using a threshold equivalent to 1.2 times the maximum price reported in the Pharmacy Benefit Manager (PBM) price file for that drug class. Both negative and positive product costs with a magnitude greater than the threshold were replaced with the median product cost for that class. Dispensing costs over a prescribed threshold of $100 were replaced with the median dispensing cost of the corresponding drug class.

In all analyses using the opioid and pharmacy data, a prescription fill is included if it occurs in a quarter where the recipient is in the VA healthcare user cohort (as described above). All results are reported as an average per patient quarter – patient quarters in the denominator are determined by the VA Veteran User cohort.

Table 4.9: Pharmacy Cost Trends by WHS User Category

Patient Cohort	WHS User Category	Number of Patients	Period before WHS Use	Period started WHS Use	Period After WHS Use	% Change
All Veterans						
	Non-Users	344,364	549.10	595.14	624.51	13.7
	Single Use	3,713	682.88	749.75	846.45	24.0
	Any 2+ WHS	10,176	681.40	727.14	788.92	15.8
	CIH Intensive	6,371	651.93	698.24	747.28	14.6
	Core WH Intensive	1,512	796.82	823.14	907.25	13.9

Patient Cohort	WHS User Category	Number of Patients	Period before WHS Use	Period started WHS Use	Period After WHS Use	% Change
	Comprehensive	827	843.59	868.31	910.04	7.9
Chronic Pain						
	Non-Users	105,608	757.89	820.77	847.76	11.9
	Single Use	2,155	802.77	870.42	937.00	16.7
	Any 2+ WHS	6,594	760.88	812.49	889.87	17.0
	CIH Intensive	4,198	706.07	763.29	845.75	19.8
	Core WH Intensive	961	871.74	937.77	1001.72	14.9
	Comprehensive	601	846.48	935.15	980.15	15.8
Mental Health						
	Non-Users	141,361	555.79	599.41	623.08	12.1
	Single Use	2,073	669.87	727.99	813.32	21.4
	Any 2+ WHS	6,187	674.29	736.97	804.79	19.4
	CIH Intensive	3,833	634.83	681.27	749.35	18.04
	Core WH Intensive	1,005	845.57	892.15	922.56	9.1
	Comprehensive	583	932.41	948.60	964.70	3.5
Chronic Condition						
	Non-Users	215,423	628.64	686.45	728.21	16.0
	Single Use	2,479	742.67	839.01	989.44	33.2
	Any 2+ WHS	6,288	784.54	840.72	909.83	16.0
	CIH Intensive	3,727	788.45	829.49	882.79	12.0
	Core WH Intensive	1,155	807.68	851.55	947.40	17.3
	Comprehensive	574	960.32	985.99	1001.52	4.3

Pharmacy cost trajectories did not differ overall between users and non-users in the EHR cohort. Notably, among Veterans with mental health conditions or which chronic health conditions, pharmacy costs increased less among those patients with Comprehensive use of WHS services than among Non-Users or other user groups. These patients also start with the highest costs.

Table 4.10: Change in Opioid Dose by WHS User Level Among Veterans with Chronic Pain. *(October 2017-March 2019).*

WHS User Category	% of Veterans (in EHR)	Mg Dose Period Before Using WHS	Mg Dose Period Started WHS	Mg Dose Period After WHS Use	Mg Decrease (Before-After)	% Change
No Use	105,608 (92.3%)	634	593	563	-72	-11%
Single Use	2,155 (1.9%)	977	906	888	-89	-9%
Any WHS use (2+)	6,594 (5.8%)	759	683	583	-176	-23%
CIH Intensive	4,198 (3.7%)	710	626	529	-181	-26%
Core WH Intensive	961 (0.8%)	557	453	346	-211	-38%
Comprehensive	601 (0.5%)	658	496	410	-248	-38%

This table demonstrates that overall opioid levels have decreased among Veterans attributable to multiple opioid reduction efforts across VHA. Opioid levels decreased more among Veterans who used more WHS services.

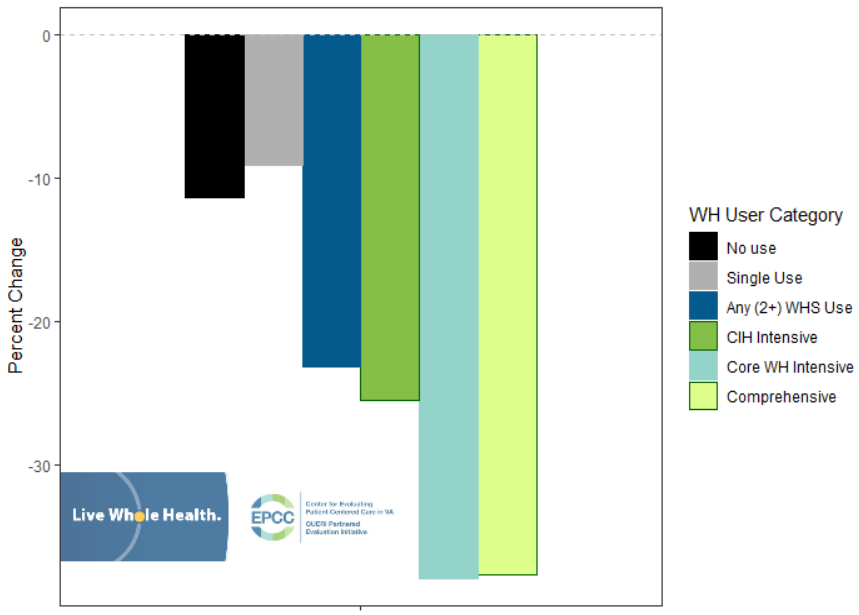


Figure 4.5: Comparison of WHS Use Levels and Percent Change in Opioid Dose Levels Between April 2017-March 2018 and April 2018-March 2019 Among Veterans with Chronic Pain Who are Continuous VA Healthcare Users

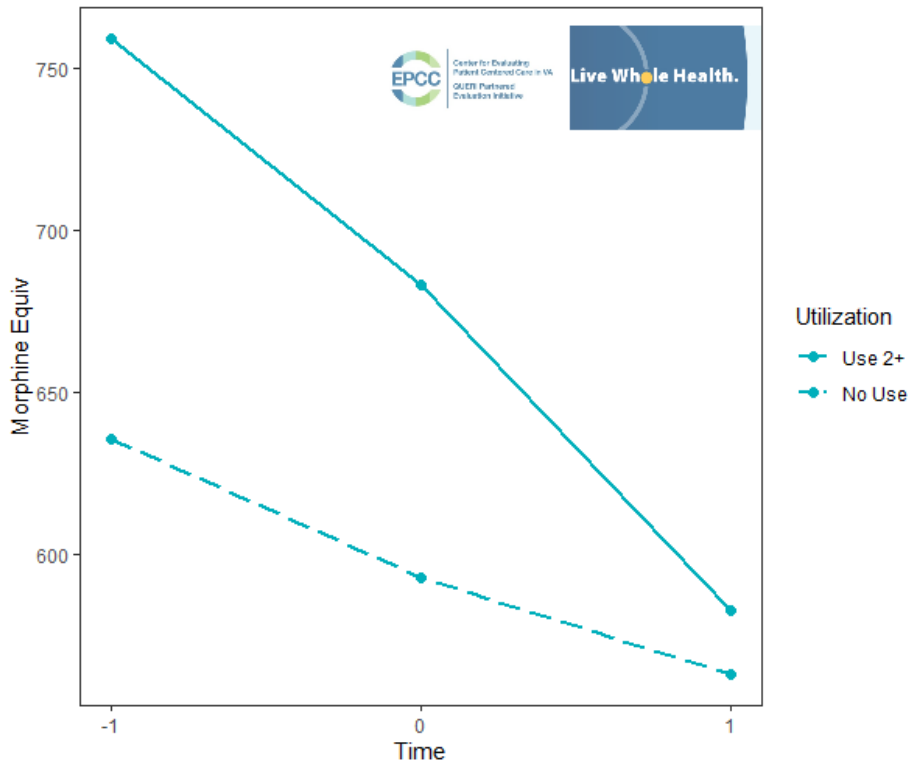


Figure 4.6: Opioid Dose Levels Before and After Starting to Use WHS Services Among Veterans with Chronic Pain Who are Continuous VA Healthcare Users and Veterans with Chronic Pain Who Did Not Use WHS During the Same Periods. *(Time 0 is when Veterans began using WHS services.) The outcome is average quarterly morphine equivalents of opioid prescriptions.*

19) National Time Trends in Opioid Dose Patterns

We analyzed the average quarterly opioid received (mg ME/patient-quarter) per opioid patient (Veteran with any opioid fill in that quarter) at each of the 18 flagship sites from Q1 FY16 – Q2 FY19. The starting average opioid dose across the 18 flagship sites varies widely, and all sites saw their average decline. This finding is consistent with national trends, which have led to widespread changes in opioid prescribing across the VHA.

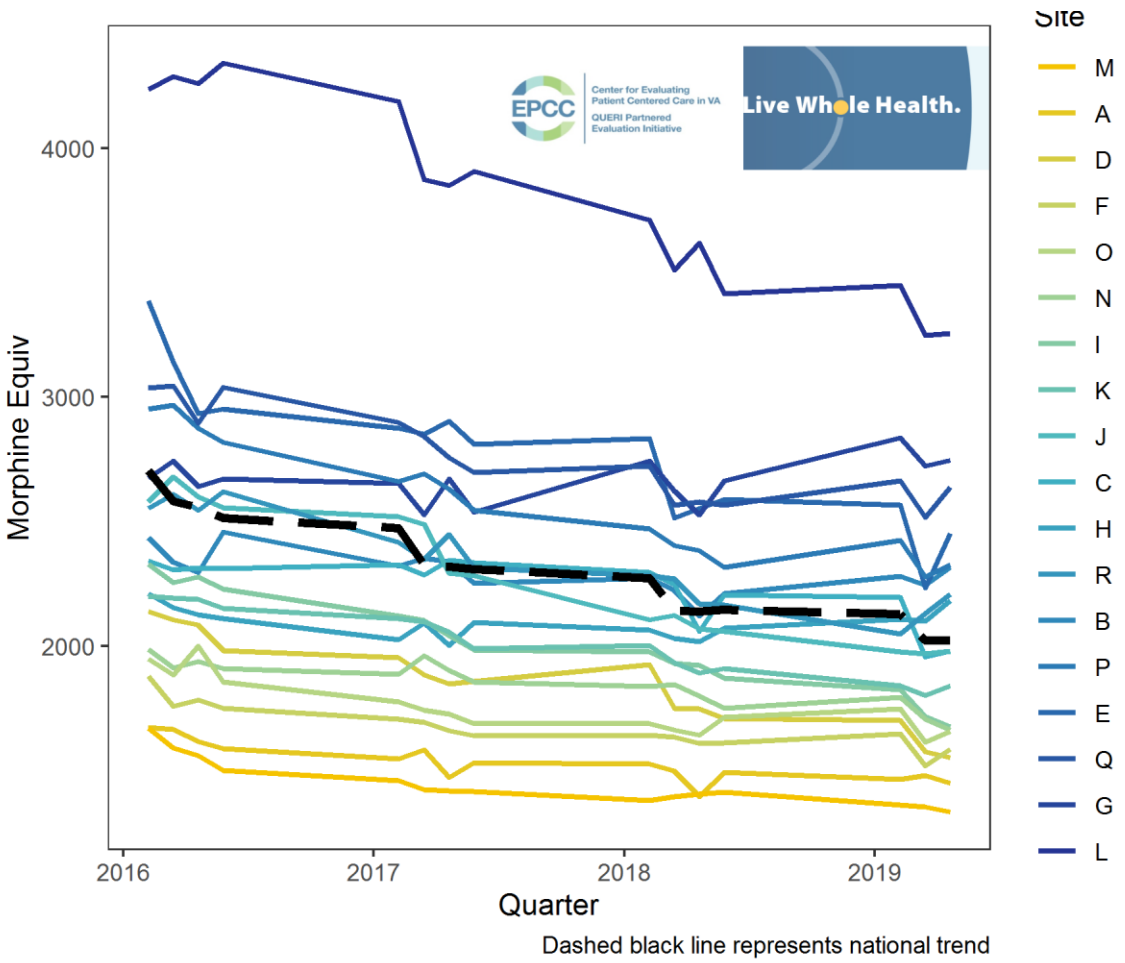


Figure 4.7: National Time Trends in Opioid Dose Patterns. *Average quarterly opioid dispensed (mg Morphine Equivalent) per opioid patient at each of the flagship sites, which are ordered and colored by their final average dosage (blue is highest, gold is lowest). Dashed black line represents the national trend, derived from the Academic Detailing Opioid Safety Initiative dashboard.[17] The dashboard reports the % of pharmacy patients dispensed opioids and the average total mg ME per Pharmacy patient dispensed. We combined these numbers to derive the national average total mg ME dispensed per opioid patient.*

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Appendix 5 Table of Contents

Whole Health System of Care Impact on Employees

All Employee Survey (AES).

Data collection. The AES is an anonymous, voluntary, and confidential census survey administered once per year to all VA employees. The survey was fielded in June 2018 and 2019 within the Department of Veterans Affairs[1]. We focus our reporting on results on the 18 flagship sites. One of the first questions employees are asked is to identify their occupation. Using this self-reported information, respondents who indicated they were a clinician were provided the opportunity to respond to the Whole Health System (WHS) module of the survey. In 2018, the response rate was 63.54% out of 54,840 possible respondents. Among the total respondents, 59.41% (n=20,701) were clinicians who completed the WHS module. In 2019, the response rate was 64.19% out of 55,605 possible respondents with 60.71% (n=21,667) of respondents being clinicians answering the survey items.

Measures. Items and response options are presented in Appendix 5-B. In 2018 and 2019, the WHS survey asked employees to respond to a series of statements about their involvement with WHS at their facility. Seven different options were presented that ranged from not being familiar to participating in planning for implementation. Respondents were asked to select "all that apply." To be considered as being involved in whole health, a positive response to one of six possible practices was required.

As part of the demographic section of the survey, respondents also select one primary service area. This item was then used to group and examine differences by clinical service areas.

Using responses to the other survey items on the AES, we created four specific measures to represent Best Places to Work, a global measure of job satisfaction consisting of three items. Drivers of Engagement included factors identified as relating to employee work engagement and represented intrinsic motivation, senior leadership, and supervisor relations. Each measure consisted of five items demonstrating good internal consistency. To assess organizational withdrawal, an item on turnover intentions and two items on burnout were used.

Patient-centered care

Data collection. VA regularly conducts the Survey of Patient-Centered Medical Home Experiences (CAHPS PCMH). The survey assesses patient experiences of healthcare quality and represents a number of number of domains, such as access to care, communications with provider and care coordination. Patients are eligible to receive a survey if they had a primary care visit. Data for FY19 was used for the analysis. The national-level response rate was 35.7%.

Measures. For our analysis, we selected two items identified as relating specifically to Whole Health Systems practices. Both items were from the self-management support of the SHEP. The first item asked "In the last 6 months, did anyone in this provider's office talk with you about specific goals for your health?" and the second item asked: "In the last 6 months, did anyone in this provider's office ask you if there are things that make it hard for you to take care of your health?" Both items had a response option of "Yes" or "No". A medical-center average score was computed as the percentage of "Yes" responses divided by total number of responses. The average flagship score was 68.39 (SD=4.08) and 55.67 (SD=2.97) for the questions on care goals and difficulty taking care of health items respectively.

Turnover

To compute turnover, we used the Human Resource Turnover cube to examine turnover rates for FY19. Turnover is defined as the number of turnover actions divided by the average onboard employees. We used the "quit rate" measure which represents employee resignations and losses to another federal agency. The measure excludes losses due to retirement, death, or termination. Given that clinical employees responded to the survey, we restricted our analysis to represent three groups defined on the basis of occupation assignment codes: medical officer (0601), nurse (0610) which are subsets of the larger medical and dental group (0600). The average voluntary turnover rates by occupation were: physician: 5.2% (SD=2.4%); nurse: 5.3% (SD=2.4%), and all medical staff: 6.4% (SD=2.0%).

Hospital Performance

A global measure of hospital performance was obtained using the Veterans Health Administration ratings on the Strategic Analytics for Improvement and Learning (SAIL) measure. The measure was created to include and reflect key measures used by private sector and additional measures representing priority areas for VHA. There are 10 composite domains representing: mortality, adverse events, length of stay and throughput, care transitions, patient experience, employee satisfaction, access, mental health, performance measures, and efficiency and capacity. VA assigns a rating to each medical center based on its relative performance and improvement compared metrics from one year ago. Star ratings ranging from 1 to 5 are assigned to each site to create a distribution where approximately 20% of sites are in each star category. In the most recent data (FY19Q3), among the flagship medical centers, there were five one-star facilities, 4 two-star facilities, 4 three-star facilities, and 5 five-star facilities.

Measures from the Impact on Employees Evaluation

Whole Health Systems Involvement

The Whole Health System of Care is a new initiative rolling out across VA. During the past twelve months, in what ways have you been involved with your facility's Whole Health (WH) approach to care? (**Check all that apply**)

a. I am not familiar with Whole Health approach to care
b. I have participated in training about Whole Health.
c. I have discussed how to incorporate Whole Health approaches with my co-workers
d. I have incorporated a Whole Health approach into my work with patients
e. I have worked with patients to develop a Personal Health Plan (PHP)
f. I have referred patients to a Whole Health service or approach (e.g., Whole Health peer led groups, coaching, well-being classes, or Complementary Integrative Health)
g. I have participated in planning for implementation of Whole Health approaches

Service

What is the main type of service you provide? (please select only one option)

Service options for VHA or VACO respondents

- Administrative (Non-Clinical)
- Finance
- Dental
- Emergency Medicine (Urgent Care, Emergency Department)
- Facility Management Services
- Home or Community Care
- Imaging (Radiology, Nuclear Medicine)
- Acute Care Inpatient
- Intensive Care Unit- Critical Care
- Laboratory and Pathology
- Law Enforcement
- Medical Specialty
- Mental Health
- Community Living Center
- Pharmacy
- Primary Care
- Prosthetics or Sensory Aids
- Rehabilitation Services
- Research
- Spinal Cord Injury
- Surgery, Anesthesiology or Surgical Specialty Care
- Other Clinical Service

Table 5.1: Measures based on the Federal Employee Viewpoint Survey

Measure	Item	Response scale	Coding
Best Places to Work	1. Considering everything, how satisfied are you with your job? 2. Considering everything, how satisfied are you with your organization? 3. I recommend my organization as a good place to work.	1= Strongly Disagree; 2= Disagree; 3= Neutral; 4= Agree; 5= Strongly Agree; 6=Do Not Know	Responses of 4, 5 coded positively with value of 1 and responses of 1,2,3 coded with a value of 0. Multiple each item by a proprietary weighting formula and sum for each respondent.
Employee Engagement: Intrinsic motivation	1. I feel encouraged to come up with new and better ways of doing things. 2. My work gives me a feeling of personal accomplishment. 3. I know what is expected of me on the job. 4. My talents are used well in the workplace. 5. I know how my work relates to the agency's goals and priorities.		
Employee Engagement: Leaders lead	1. In my organization, leaders generate high levels of motivation and commitment in the workforce. 2. My organization's leaders maintain high standards of honesty and integrity. 3. Managers communicate the goals and priorities of the organization. 4. I have a high level of respect for my organization's senior leaders.	1= Strongly Disagree; 2= Disagree; 3= Neutral; 4= Agree; 5= Strongly Agree; 6=Do Not Know	Responses of 4, 5 coded positively with value of 1 and responses of 1,2,3 coded with a value of 0. Compute average across items
	5. Overall, how good a job do you feel is being done by the manager directly above your immediate supervisor/team leader?	1= Very Poor; 2= Poor; 3= Fair; 4= Good; 5= Very Good; 6= Do Not Know	
Employee Engagement: Supervisors	1. Supervisors/team leaders in my work unit support employee development. 2. My supervisor/team leader listens to what I have to say. 3. My supervisor/team leader treats me with respect. 4. I have trust and confidence in my supervisor.	1= Strongly Disagree; 2= Disagree; 3= Neutral; 4= Agree; 5= Strongly Agree; 6=Do Not Know	Responses of 4, 5 coded positively with value of 1 and responses of 1,2,3 coded with a value of 0. Compute average across items
	5. Overall, how good a job do you feel is being done by your immediate supervisor/team leader?	1= Very Poor; 2= Poor; 3= Fair; 4= Good; 5= Very Good; 6= Do Not Know	
Turnover intent	Are you considering leaving your job within the next year, and if so why?	1= No ; 2= Yes but taking another job within VA ; 3= Yes, to retire 4= Yes, to take another job within the Federal government; 5= Yes, to take another job outside the Federal government ; 6= Yes, other	Response value of 1 coded as non-turnover and responses of 2-6 coded for turnover intent
Burnout	1. I feel burned out from my work 2. I worry that this job is hardening me emotionally	1= Never; 2= A few times a year or less; 3= Once a month or less; 4= A few times a month; 5= Once a week; 6= A few times a week; 7= Every day	A response of 4,5, 6, or 7 to either item would be coded to reflect burnout.

Reference List

1. Osatuke K, Draime J, Moore SC, Ramsel D, Meyer A, Barnes S, Dyrenforth SR, Organizational development in the Department of Veterans Affairs. *In T. Miller (Ed.), The Praeger handbook of veterans health: History, challenges, issues and developments, volume IV: Future directions in veterans healthcare* Vol. 4. 2012, Santa Barbara, CA: Praeger. 21-76.