Key Insights and Lessons Learned about Training VA Clinicians on Whole Health Approaches

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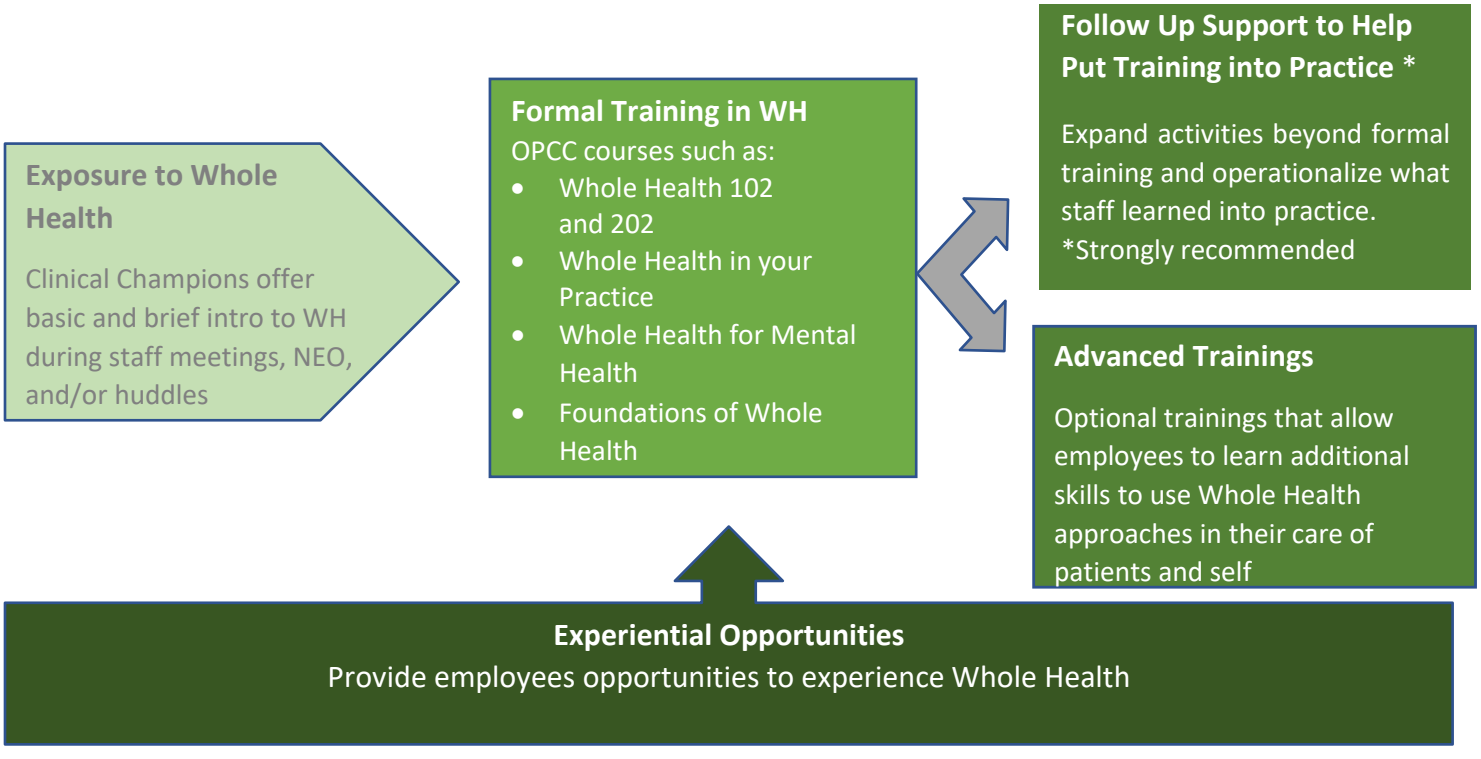
At a Glance: Training Clinicians on Whole Health Approaches- Lessons learned

*Over the course of 3 **years**, the EPCC team studied approach and progress 18 VA Flagship sites made towards transforming facilities into WH systems of care. The following summary points highlights a number of important lessons to consider for widescale training in primary care and mental health services.*

OVERVIEW	
Training is an iterative process. WH training is not a "one and done exercise" and many sites developed a tiered approach to training. **Executive and mid-level leadership must support training goals.** Gaining buy-in and support from mid-level managers, i.e. service chiefs was critical to facilitate staff participation. **It is crucial to set and communicate expectations for staff who take part in training.** **Sites must provide adequate support and infrastructure for training.** This includes protected time, resources to support recruitment and training set up, and support documenting staff participation in WH courses. **Timing of WH training requires special consideration.** Having a basic infrastructure with Whole Health components in place before training begins may make a difference in how Whole Health is implemented by staff.	**Whole Health leadership need to customize training activities to meet trainees "where they are at."** Some sites found the use of change management tools to be helpful in determining an appropriate level of training. **Engaging and training sites in teams may aid in generating excitement and momentum of Whole Health implementation.** It is easier to change the culture of care together than alone. **Qualities of selected trainers is crucial for generating enthusiasm and buy-in of the Whole health approach.** Consider the audience and think through the right person to provide the training (i.e., physician to physician or nurse to nurse). **Monitoring who has been trained is important and challenging.** Requiring trainees to register in TMS was the best way to keep track of who has been trained, but logistically challenging.

A Recommended Training Approach Based on Experiences of Flagship Sites



Background

Over the course of three years, the Evaluating Patient Centered Care (EPCC) Implementation Evaluation Team studied the approach and progress 18 VA Flagship sites made towards transforming their facilities into Whole Health Systems of Care. The evaluation entailed systematically gathering data via an on-line survey and qualitative interviews on a quarterly basis as well as review of Whole Health training and service utilization data. Periodically the qualitative interviews focused specifically on training clinical and other staff on Whole Health concepts and practices. Interviews explored each site's general approach to training, the role of the Facility Education Champions, and key lessons learned. This report provides an overview of what was shared with the EPCC Implementation Evaluation Team during these conversations that may be of use to training VA clinicians in Whole Health approaches of care.

Approach to Training

Most Flagship sites experienced a major shift in their thinking about what it means to be trained in Whole Health concepts over the study period. With the exception of one or two sites who were further along in their implementation at baseline, many sites started off with the goal of getting all clinical staff at their facilities to take part in the Whole Health for Clinical Practice or equivalent foundational training. Some sites were successful in getting a large portion of their clinical staff to take part in this course. This was possible in the few facilities where leadership either mandated the training or provided adequate support to block out clinics on designated days so staff could participate. Some sites attempted a strategic role out of training, focusing on specific service lines, clinical teams or roles over time. Others had a volunteer approach, often mixed with outreach to service line chiefs and supervisors to encourage staff participation. No one approach stood out as better than another.

Regardless of approach, gaining buy-in and support from mid-level managers (i.e., service chiefs and supervisors) was critical. Some sites needed to tailor trainings to facilitate participation by breaking longer ones up into multiple, shorter sessions. Few sites reported the ability to suspend entire clinics for a half or full day for training. Understanding service line needs and tailoring trainings to meet those needs was important.

Training is an Iterative Process

One of the most important lessons learned about Whole Health training is that it is not a "one and done" exercise. A single training, whether it be two or eight hours, was not sufficient to support clinicians in moving from conceptual understanding to practice. By the end of the Flagship grant period, several sites had developed a tiered approach to training. We categorized these into several broad tiers.

Tier 1: Exposure to Whole Health. The first tier represents a low barrier and easily integrated effort to introduce a large number of staff to Whole Health. By the end of Flagship study period, most sites had integrated a basic introduction to Whole Health into their New Employee Orientation. This was a way of introducing new employees to the approach and culture shift that the Flagship site was trying to make. In some sites, Whole Health Leaders or Education Champions attended staff meetings to provide a high-level overview of what Whole Health means (i.e., introducing the Wheel of Health) and core components of a Whole Health System of Care. Over time, some Whole Health Leaders noted that they were increasingly being asked to attend a staff meeting and talk about burnout and stress reduction strategies. This provided a more experiential exposure to Whole Health. These brief introductions were sometimes conceptualized as a recruitment strategy for staff to sign up

for more formal training in Whole Health or as a way to lay the foundation for a mandatory training that was on the horizon.

Tier 2: Experiential opportunities. Some Flagship sites approached training in Whole Health by "making it personal" first. They provided an overview of Whole Health in Your Life, led participants through a process of creating their own Personal Health Inventory and setting Personal Health Goals, and offered a range of Complementary and Integrative Health opportunities (e.g., yoga, tai chi, mindfulness, aromatherapy) for staff to try. At least one site offered this personalized training approach through a one-day staff retreat, most often held on a Saturday. Others created trainings of various lengths, ranging from 2-8 hours. The theory behind this approach was that staff may be more likely to support and buy into a new approach if they experience it for themselves. Although not everyone was reached through these experiential trainings, those that did participate often became enthusiastic supporters that championed the work in their own departments/service lines.

Tier 3: Formal training. Most Flagship sites considered a formal training on Whole Health to encompass participation in a course developed by OPCC (e.g., Whole Health in Your Practice, Whole Health for Mental Health, Whole Health for Pain and Suffering). These trainings are the foundation for learning as they typically provide a standard overview of VA's Whole Health approach, its rationale, and key practices associated with it (e.g., Personal Health Inventory, Personal Health Goals, evidence for Complementary Integrated Health services). Flagship sites either provided these trainings as developed or adapted them for their local facility. They varied in length, from 2 to 8 hours and provided on single or multiple days. During the initial Flagship period, many sites hosted an OPCC staff member to lead more formal trainings or sponsored people to attend such trainings at another site. Over time, Facility Education Champions and others obtained training and support to provide these trainings at the local level. In many cases, this expanded the capacity to train staff more formally.

Tier 4: Support putting training into practice. We observed that Flagship sites that were further along in their transformation started expanding their activities beyond formal training to include practice and skill development. Sometimes this started at the end of a formal training, and sometimes at a follow up meeting (e.g., during a subsequent staff training). The goal was to not let too much time pass before staff start trying to operationalize what they learned into practice. In some sites, Clinical Champions were used to connect with staff after a training and support their use of Whole Health approaches by answering questions and role modeling when possible. Follow up after a training can also help identify challenges or resistance points related to personal competencies, interpersonal dynamics within clinics and/or with patients, structures and processes of care, availability of resources, among others. Understanding where the points of resistance were and dedicating time to talk through them (ideally as a clinic or team) was important for implementation. This service-level mentorship model was recommended by those who used it.

Tier 5: Advanced Trainings. A final tier of training focuses on providing interested staff with more advanced trainings in Whole Health approaches. These trainings provide a "deeper dive" into different Whole Health approaches, including complementary and integrative health, and/or an opportunity to learn more about how to overcome challenges with putting the approach into practice. Some advanced trainings are available through TMS. Some sites organized their own trainings or supported staff to attend OPCC-led trainings. Supporting enthusiastic staff to get additional training is a way of cultivating more champions within the system. These

individuals are primed to identify barriers to implementation and opportunities to advocate for changes to address them or tailor the approach to make it feasible.

Lessons Learned and Considerations

There was a fair amount of experimentation and pilot testing of ideas for how to engage staff in Whole Health trainings. Busy service lines, like primary care, often did not have a lot of bandwidth to allow staff to take part in trainings, nor to work on developing new clinic flows, referral protocols, and other components needed to fully provide Whole Health care once trained. Flagships sites who were further along in their implementation were nimble in their approach, looked for opportunities to train wherever possible, and tailored their approach as needed. As planning proceeds for a large scale roll out of Whole Health approaches in primary care and mental health, some of the lessons learned from Flagship sites may be of interest to consider.

#1 Training is not a "one and done" experience.

We have already highlighted one of the most important lessons learned from Flagship sites which is that training clinical staff and others on Whole Health approaches is an iterative process that requires dedicated, strategic thinking and action. Aligned with this lesson though are several others, described in brief below.

#2 Executive and mid-level leadership must support training goals.

Training clinical staff on Whole Health approaches and practices requires time away from clinics to take part in trainings. This requires either closing clinics to allow staff to get trained or thinking strategically about how to cover shifts when staff are in training. Some sites had executive leadership support to mandate trainings for clinical staff. In one site they closed clinics for several half days in order to enable facility-wide staff training. One site was able to get their executive leaders to mandate all staff to complete a one-hour Whole Health Personal Experience training available on-line through TMS. Although more of an "exposure training," the hope was that participation would catalyze interest in further training. Several sites attempted to get support for mandatory trainings but were not able to get buy-in from executive leaders.

Without being mandatory, participation in training often ends up being a special request to a mid-level manager. Clinics have to be covered when staff are taking part in trainings. A few sites noted how important it was for mid-level managers to buy-in to Whole Health approaches and support transformation efforts. Without this support it was difficult to obtain permission for training. Mid-level manager support can vary widely across a facility. Recommendations from Flagship Leads included working strategically with executive leadership on communications with mid-level managers about the importance of Whole Health approaches and the need for staff training. Executive leaders also needed to help allocate resources to support busy clinics when needed. Flagship leaders also found that personal outreach to mid-level managers was valuable in garnering their support for staff to be trained. This was part of a strategy to "meet people where they are at" and build buy-in from that place.

#3 Set and communicate expectations.

Training staff on Whole Health is an investment. It requires resources and adjustments in busy clinics when staff are away. Several Flagship Leads noted the importance of setting expectations for staff who take part in training that they will return to their service lines and put what they learned into practice. This was a difficult lesson learned for some sites who early on supported large numbers of staff to get trained and then found little to no

evidence of implementation in practice. In part, this was related to the need for an iterative training approach. But it also called attention to the need to clearly communicate the goals of training and expectations for actions that follow. At least one site started requiring at least two people from a service line to take part in trainings at a time so that they could develop an implementation plan together and hold each other accountable when they return.

#4 Provide adequate support and infrastructure for training.

In our evaluation work with the Facility Education Champions we learned that one of the biggest challenges to training staff was having adequate time and resources to prepare for trainings. Although most had a small amount of protected time (.2 FTE), it was not enough for all of the tasks associated with setting up trainings. This included logistics (e.g., finding space to hold the training), recruitment (e.g., advertising trainings, getting mid-level management support for participation), and documentation (e.g., recording who participated or assuring information is entered into TMS), among others. One strong recommendation from the Flagship sites is to dedicate administrative support for people who are leading Whole Health trainings at each site. This will free up the trainers' time to focus on refining or tailoring trainings to meet the needs of the groups they are training. We might also recommend requesting guidance from facilities who put on a lot of local trainings and have planning documents that guide training preparations. This "playbook" may help new trainers prepare for the role and prevent at least some challenges.

#5 Timing is everything.

The question of when to train clinical staff on Whole Health approaches is important to consider. During our interviews with Flagship leads we found a lot of variation in the timing of trainings offered at each site. By and large, those that "ran out the gate" and tried to get as many people to participate in trainings as possible quickly realized that they may have acted prematurely. They recommended having some basic infrastructure and Whole Health components in place before trainings begin. This is important for those early adopters who are highly motivated by the training and want to start implementing what they learned immediately. For example, providing training to PACT teams on the role of Whole Health coaches before they are hired and trained can lead to disappointment. Another example we heard was raising awareness about the availability of CIH services before referral processes (e.g., consultation protocols) are in place. Talking about future state (i.e., what things will be like when hiring is complete or systems have changed) can put a damper on training effects. People will forget what they learned or become frustrated and "turned off" by not being able to act on what they learned. Recommendations include training staff on concepts and approaches they are able to immediately put into practice.

#6 Tailor training activities to meet trainees "where they are at."

An early lesson learned among Flagship sites who were engaged in a lot of staff training is that it can quickly become a frustrating activity when there is limited evidence of uptake in practice. Reflecting on the challenges of training, one site noted that they had realized they were training everyone in the same manner and they needed to change their approach. This realization came after some of their Whole Health leadership team took part in change management training. They realized that if they kept trying to train everyone from the same place (i.e., where they expected them to be), they would continue to be frustrated. This site (and several others) were adopting the ADKAR (Awareness, Desire, Knowledge, Ability, Reinforcement) framework to tailor their trainings based on what was needed. If training a group who is resistant to change, the training may need to

focus on building enthusiasm or desire for a Whole Health approach. If the group has a base of knowledge and really needs skills or ability to put it into practice, then a training is tailored to provide opportunities for practice. There are some lessons learned from Flagship sites that adopted change management practices such as ADKAR that are important to share. First, Whole Health leaders and trainers need to recognize that not everyone who takes part in training will begin from the same place of desire, understanding, and skill. Offering different types of trainings with different goals (i.e., create desire, develop knowledge and understanding, improve skills) may help generate more widespread buy-in and stronger implementation across the system. This recommendation is aligned with the "tiers of training" highlighted at the beginning of this document.

Another way that a few sites are tailoring their trainings to meet people where they are at is to start with issues or concerns that are of importance to departments/service lines/teams and weave in Whole Health concepts along the way. For example, in one site with a multi-disciplinary team of Facility Education Champions, offered shorter 45 minute to 1-hour trainings that were designed to meet pressing needs, such as burnout, resiliency, collaboration, or relationships among staff. They approached these issues through a Whole Health framework, giving people a chance to experience self-care first. As concepts are woven together, they raised awareness about how the approach could be used in practice as well. These are more akin to "experiential" efforts, which have helped to create some interest and traction where there was resistance.

#7 Qualities of trainers is important.

Selecting who will lead staff in trainings is critical for generating enthusiasm and buy-in for a Whole Health approach. When selecting trainers, consider the audience: Who are the types of people that are most likely to influence a change in perspective and practice? If peers are critical (e.g., MDs training MDs) and/or leaders (e.g., Chief of Staff), ensure they are present and able to talk knowledgeably and enthusiastically about Whole Health. People who use Whole Health approaches in their own practice are also critical for trainings. They can share personal stories and examples of use that can make abstract concepts tangible. This is more powerful than hypothetical situations. Given recommendation #6 (meet people where they are at), it is also important to have trainers who can also adjust training materials "on the fly" and adjust messaging to fit the needs of participants. Some sites recommended having a diverse team of trainers that are able to work together to adapt to the needs and interests of specific service lines/departments. For example, one site had a team of 5 Facility Education Champions that included a clinician, psychologist, chaplain, and 2 nurses (one in inpatient and one in rehab). They each brought different skills and abilities to Whole Health training efforts that enabled the site to tailor their approach for specific needs and stages of readiness.

#8 Train people in teams or departments/service lines

Many sites struggled with getting time allocated for clinical staff to be trained in Whole Health concepts and approaches. This is particularly true in places where access to care is a major priority for hospital leadership. Closing clinics for a half or full day so that an entire staff can be trained was often not an option. Many Flagship sites offered trainings to anyone who was interested and able to attend. One of the challenges that a few Whole Health leaders noted with this approach was that when people attended trainings alone (i.e., without others from their departments or service lines), they left feeling excited and energized. But getting others on board is a big responsibility and challenge, despite their enthusiasm about bringing training information back to their

departments/service lines. Inertia is a powerful force and changing it requires more than one person. Sites recommend training in teams. Some recommended the tiered training approach (noted above), which can provide "exposure" training for departments/service lines as a first step in raising awareness and generating excitement. Then getting a few people to more formal trainings and creating a strategy for them to bring back what they learned to their service lines. The general recommendation is to start by raising awareness among many, engaging a train (or teams) in more formal training, helping them develop an implementation strategy, and then supporting that strategy in a variety of ways.

Other important considerations for evaluating Whole Health trainings

During our conversations, Whole Health leaders raised a couple of additional considerations or challenges that they faced when training staff at their facility. The first challenge centers on monitoring who has been trained at their facility. A few Whole Health leads talked about the unexpected challenge of getting a good estimate of the percentage of staff trained at their site. Figuring out the denominator is harder to do than expected. For one, there often is not an accurate list of all people in a certain job category and/or service line or department. Some people have different job titles, or people fall in two different service lines. Although some sites have done a good job keeping logs of who has participated in training (which is a recommendation to do), it's been harder to figure out the percentage trained at a level more granular than all staff.

A related consideration is understanding who should be trained. This also affects the denominator. Some Whole Health leads were uncertain if they should try and train everyone – from scheduling clerks and MSAs to nurses and clinicians – or focus in on clinical staff. In part, this question was difficult to answer in the beginning because sites were actively working out what their processes would be for completing Personal Health Inventories, developing Personal Health Plans, making referral processes, etc. Anyone involved in core components of the Whole Health system were recognized as being important priorities for core training. However, all staff likely need some training or exposure to Whole Health concepts and approaches. Clarity in expectations for training and recommendations for the types of training staff in different roles may need will be important for VA facilities.