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Improving the integration of whole health into a veterans affairs outpatient primary care clinic.

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Improving the Integration of the Whole Health Approach into a VA Primary Care Clinic

By

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Abstract

The annual $4.1 trillion price tag for healthcare with a simultaneous decline in patient health outcomes is the catalyst to change the current healthcare culture from disease-focused to a Whole Health wellness and prevention model. Transforming to preventative care would remedy the current costly healthcare system, thus Veterans Health Administration (VHA) set forth a mandate to implement Whole Health (WH) system wide. The purpose of this project was to provide a training program that facilitated the implementation of WH and improve the documentation of WH in the electronic health record (EHR). A needs assessment provided to the Fort Knox VA community based primary care clinic revealed a basic knowledge of the WH clinical documentation indicator (CDI), but no utilization of the indicator, an awareness of the WH benefits, but a concern for time constraints. There was a knowledge gap about WH services and documentation, but a desire to incorporate WH into their healthcare practice. The investigator hypothesized that a Whole Health and Documentation training program would change the Fort Knox staff's documentation behavior and influence the integration of WH into the care of Fort Knox veterans. The VHA Whole Health Dashboard was used to track percentages of unique encounters into the WH and Complementary Integrative Health services. Chi-Square analysis was used to assess the staff's documentation behavior change by using chart audits pre-intervention and post-intervention at 4- and 12-weeks for the WH narrative documentation X^2 (2, N=105)=14.01 p <.001, for WH education block marked within the CDI X^2 (2, N=105)=11.67 p=.003, and use of the WH CDI reminder in the EHR showed a marginal significance X^2(2, N=105)=5.46 p=.065. The training intervention did influence the staff's documentation behavior

and increased the Fort Knox veteran's unique encounters into WH and Complementary Integrative Health services from 1.5% to 3.4%.

Keywords: patient-centered care, Whole Health, Veterans Affairs, patient empowerment, self-efficacy, communication barriers, and integrative medicine or complementary medicine

Improving the Integration of the Whole Health Approach into a VA Primary Care Clinic

There is an over-all consensus that a transformation of our current disease-focused, biomedical healthcare system is imperative (Bokhour et al., 2020; Kligler et al., 2022; Krejci et al., 2014; Langevin, 2022; Wade & Halligan, 2017). The antiquated approach to healthcare is fractured, costly and reactive with treatments that focus on the presenting disease but fails to address the other systemic factors that will eventually lead to poor health outcomes, chronic disease, and profit loss for businesses and providers (Hecht et al., 2022; Langevin, 2022). The United States' annual healthcare cost for chronic disease and productivity loss from chronic illnesses is greater than $3.7 trillion, which is 20% of the nation's gross domestic product (Hecht et al., 2022; Moses III et al., 2013). In 2024, the Center of Medicare and Medicaid Services (CMS) calculates the annual health care price tag higher by adding mental health illnesses reaching $4.5 trillion and calculates the individual's annual expense at $13,493 (CMS.gov, 2024). According to the Center of Disease Control website, by 2030, 170 million Americans will suffer from three or more chronic health conditions, thus raising healthcare expenditure 267% to 47 trillion dollars (Hacker, 2024; Hecht et al., 2022). Due to excessive cost of care with less than impressive patient outcome measures in comparison to other countries, there is an urgency to revamp the system to better monitor and measure true value of healthcare and quality of care (Krejci et al., 2014; Moses III et al., 2013).

Problem

The cost of pharmaceuticals and healthcare is overwhelming for the aging person who is living longer on a retired fixed income and is predicted to have three or more chronic illnesses. The literature search points to transforming the healthcare system to a biopsychosocial model that promotes patient-physician shared decision making, encourages preventative care and non-pharmacologic choices for health management. The trending Whole Health model is a personalized, patient-driven agenda that improves quality of care, includes education about unhealthy lifestyles with a focus on personal health goal achievement and the use of complementary and integrative health services as more cost-effective treatment option. Hecht et al., (2022), goes on to say that in 2018 to 2019, the data collected on veterans engaged in VA Whole Health Services not only reported higher satisfaction, decreased opiate use, and decreased stress, but also had a 24% reduction in healthcare costs in the first 12 months. Those veterans not engaged in VA Whole Health services had a 6% rise in healthcare costs (Hecht et al., 2022). Responding, the United States Department of Veterans Affairs has taken the lead and set forth a strategic goal to integrate Whole Health throughout their facilities by 2024 (VA.gov, 2023). The challenge is to find the best integration method with the recipe that healthcare providers can easily implement to blend their current routine with a complementary Whole Health approach.

Literature Review

The World Health Organization's definition of health is "…a state of complete physical, mental and social well-being not merely the absence of disease or infirmity" (WHO, 2020). Wade and Halligan (2017) note that the biopsychosocial model of healthcare, which was conceptualized by Engel in 1977, embodies this definition of health and focuses on patient-centered care addressing the social, psychological, and behavioral aspects of disease. What is important to note is the biopsychosocial model of healthcare does not replace the biomedical approach, it only joins and enhances the original practice already in place (Wade & Halligan, 2017). It was not until 2001 with a national trend towards patient-centered care and embracing Whole Health, that the National Academy of Medicine (NAM) identified patient-centered care as one of six pillars of quality care (Bokhour et al., 2020). The Veterans Health Administration (VHA) looks to the future and begins its quest to change their healthcare philosophy and mission "to honor American's Veterans by providing exceptional health care that improves their health and well-being" and since 2015, has been promoting patient-centered care through the integration of Whole Health into their VA facilities (Bokhour et al., 2020; Kligler et al., 2022; Krejci et al., 2014). Propelled by the 2016 Comprehensive Addiction and Recovery Act (CARA) funding, in 2017, the Veterans Health Administration Policy Directive was published mandating coverage of evidence based complementary and integrative Health services (Bokhour et al., 2020; Reed II et al., 2022; VHA Directive 1137, 2022). Even with the current inflated cost of healthcare, the VA continues its commitment to providing care for 19.3 million veterans across the country including their pharmaceuticals. Of the 19.3 million veterans, 8,926,027 are over the age of 65 years

(VA.gov, 2023). The VHA has a unique aging population of retired and discharged military persons dating back to the WWII conflict. The VA cares for eligible soldiers post intense training, exposure to chemically toxic environments, and skirmishes both foreign and domestic. Post Traumatic Stress Disorder (PTSD) can impact more than 23% of the 19 million veterans that receive care through the VHA (Mori et al., 2019; Reed II et al., 2022). Those who suffer with PTSD usually suffer from a host of other psychosocial and health related issues that may include tobacco use, substance use, hypertension, obesity, diabetes, and premature aging (Mori et al., 2019). Often, there are veterans that are resistant to the therapies provided or not receptive to trauma-based recovery, as such, an alternative non-trauma focused treatment is needed. Whole Health provides a wellness group intervention that proves to be a low-cost alternative treatment for veterans with PTSD and may improve health behaviors and coping skills. Research shows that veterans engaged in the wellness groups improved in three of the eight whole health domains of relaxation, mindfulness, and relationships (Mori et al., 2019). Veterans with chronic pain and PTSD comorbidities experience higher pain levels, anxiety, depression, and sleep disorders. Veterans with higher pain levels have increased opioid use (Hecht et al., 2022; Reed II et al., 2022). Veterans engaged in Whole Health decreased their use of opioids by 38% compared to 11% for those engaged in conventional treatment. Whole health demonstrated benefits with improved perceptions of care, perceptions of life meaning, purpose, and perceived less stress as compared to veterans in the conventional treatments (Kligler et al., 2022). A priority for the CARA was to address the nation's opioid crisis by providing funding for complementary and integrative health therapies as non-pharmacological options for pain management. These same non-pharmacologic modalities may address the PTSD psychological and physiological factors to improve the veteran's symptoms (Reed II et al., 2022).

Interventions from the Literature

Throughout the literature review, education and communication were themes that were evident and necessary to push the agenda of Whole Health. The concept of using a biophysiological approach to health, shared-decision making, and patient-centered care will require training and communication education for both the providers and the patients. Shamblen et al. (2018) shares the value of integrative medicine (IM) and the need to utilize it as an integral part of healthcare services as it brings together conventional and complementary health and healing. Training healthcare providers to focus on health and wellness instead of disease, and to address non-pharmaceutical approaches (Cronbach's Alpha of .79, P=.001) are statistically significant factors that had the strongest impact on intentions to engage with Whole Health practice (Shamblen et al., 2018). Dillon et al. (2017) suggests that shared decision making is less evident with those of limited schooling and lower social economic status who are less likely to have a collaborative relationship with their healthcare provider. Encouraging patients to ask questions, take notes during their office visits, and bring a third party to their office appointments are interventions to promote conversation during the routine visit (Dillion et al., 2017). Refreshing the health provider's skills for effective communication using open-ended questioning and motivational interviewing will enhance the patient-physician shared decision making for designing personalized health goals for the patient (Dillion et al., 2017; Duhn et al., 2020). Training new hire employees and residents about Whole Health with early indoctrination of the Whole Health agenda will improve the integration of the Whole Health philosophy in their assigned units. Noting the results of the research by Gragnani et al. (2018), the best orientation

method of post-graduate residents was to provide small groups with experiential learning modules when doing physician/staff education of Complementary and Integrative Medicine approaches with a result of increased integrative medicine referrals. Using teaching techniques that include experiential (interactive participation) and providing teaching modalities that stimulate the different senses will keep the audience engaged and improves learning (Tai-Seal et al., 2016).

The Whole Health clinical documentation indicator (CDI), found in the electronic health record, is one way to monitor the VA outpatient clinic's progress of starting the conversation using the prompt question for *what matters most to the patient*. Asking this question at the start of the appointment may lead to the healthcare provider's discussion of barriers that may prevent the patient from achieving their personal health goals and keep them from doing what matters most to them. The CDI reminder is linked to the visit encounter which gives the provider billing credit for time spent discussing Whole Health. Over time, the VA has produced tools for the providers to use for integrating Whole Health into their routine visits, but a lack of traction for integration continues. The Personal Health Inventory tool is a thorough, patient self-assessment about the eight Whole Health domains. An article written in the interest of the primary care provider's perceptions of barriers and benefits to the personal health inventory, found that although three quarters of the provider respondents felt the personal health inventory was important, more than half of the respondents did not intend to use it. They believed that time constraints caused a barrier of its use (Howe, 2017). Suggestions made in response to the allegation was to have the patient fill out the PHI prior to the doctor's appointment and to utilize the nursing staff to start the conversation of Whole Health journey (Howe et al., 2017).

Primary Care Provider and Staff Training

Complementary and integrative healthcare (CIH) options are evidence based and provide a variety of techniques and medical approaches to include meditation, yoga, Tai-Chi, deep breathing, massage, and acupuncture. There are risks and benefits for each of these services and the patient looks to the health provider for their input. If the primary care provider is unaware of CIH provisions available to them, then likely the provider will not suggest or recommend alternative treatment choices. At a time of rising healthcare costs, it is imperative that providers give lower cost treatments options as a choice. Educating the staff and providers about complementary and integrative healthcare options is necessary if there is to be a shift to Whole Health wellness and disease prevention. In a quest to increase Whole Health referrals for CIH, Gragnani et al. (2018) studied medical student residents in two random, small group learning sessions about Complementary and Integrative Healthcare. Group one had a10-minute practice of Yoga, biofeedback and acupressure incorporated with their learning and group two had the traditional lecture. After conducting a post-class test assessing for knowledge and a post-class survey for teaching satisfaction, the findings supported that the residents in the learning session that had 10-minute demonstrations of the CIH are more likely to incorporate them into their professional practice. Physicians that experience complementary and integrative healthcare and alternative medicine personally are more likely to incorporate these approaches into practice (Gragnani et al., 2018).

Enhancing Communication

Changing the healthcare provider's routine dialog by asking the patient *what matters most to them* and focusing on the symptoms preventing them from doing what matters most, will encourage the patient to share information. If the provider allows the patient to share and steer the conversation about their healthcare needs by asking questions during their office visits and

communicating verbally and non-verbally, the information exchange promotes shared decision making (Dillion et al., 2017; Elwy et al., 2020). Shared knowledge and shared decision-making enhance the provider-patient relationship and increases patient knowledge. This exchange of information encourages patient self-efficacy which leads to a greater quality of life, satisfaction, and psychological health (Tai-Seale et al., 2016).

Another communication intervention used to assist the veteran's achievement of their personal health goals is motivational interviewing (MI). A Whole Health coach has been trained to use motivational interviewing techniques to discover what is most important to the veteran and why he or she wants to improve their health. Motivational interviewing (MI) dissects the veteran's health goal, breaks it into attainable steps to achieve the final goal, and uses frequent follow up for counsel to overcome barriers. The coach turns their health goal into a specific, measurable, attainable, realistic, and timely (SMART) goal. Li et al. (2020) found that there was an advantage using motivational interviewing group lecture versus the traditional group lecture for achieving effectiveness with helping patients overcome problem areas dealing with their diabetes. The researchers concluded that the group that had the motivational interviewing fostered social support, role modeling, and group problem-solving (Li et al., 2020). Although MI would be ideal, due to the extensive training and practice required and the time constraints of the DNP project, the Whole Health intervention included training for the providers and their team members about the WH services available at the Robley Rex VA Medical Center, documentation training, and WH Clinical Documentation Indicator (CDI) training with the intent to increase patient complexity and awareness of the CPT codes appropriate for WH education and referral. The use of the CDI in the electronic health record prompts coding for patient complexity and is a tool that

documents preventative counsel and patient-centered care for value-based care reimbursements. VHA uses the CDI as a tracking measure for WH integration into the primary care clinics.

Knowledge Gap from the Literature

In an article written by Langevin (2022), she discusses the challenge for researching Whole Health and the impact on healthcare. There is a need to develop ways to measure and research the variables impacting whole-person health and the interconnectedness to disease. Defining the health outcomes for what matters most to the patient and placing a relevant measure to self-care will be challenging (Langevin, 2022; Bokhour et al., 2020). There is little evidence for strategies supporting the healthcare providers as they navigate the integration of Whole Health as a complementary approach into their practice. Only one article was found that the author investigated the perceptions of the healthcare providers making the transition from disease focused model to a biopsychosocial complementary and integrative medical approach (Howe, 2017). Attempting to ease into the WH transition and to design a program effective for the Fort Knox primary care clinic's needs, a pre-intervention assessment was obtained. The assessment revealed a desire, of the primary care patient aligned care team (PACT), for training about Whole Health, effective strategies for documentation of Whole Health, and training for putting in a referral to the CIH services such as acupuncture, battlefield acupuncture, and chiropractic.

Transtheoretical Model of Behavior Change

The Transtheoretical Model of Behavior Change (TTM) is a purposeful framework typically used for changing an individual's maladaptive behavior, however, it can be applied

during a systemic change and is a model often chosen for organizational quality improvement (Geonnotti et al., 2015).

Change is not a single event; it is a process. Even at our best efforts, the maladaptive behaviors slip back into our routine and cause relapse and the process starts again. Because the behavior change stages can oscillate, the TTM helped to clarify the phases of change as the Fort Knox PACT transitions from their current practice to the integration of Whole Health. The pre-intervention assessment looked at the current TTM change stage for the Fort Knox providers and team members which assisted with tailoring the DNP intervention message. The stages of change are *precontemplation* defined as a lack of awareness and failure to see that there is a problem, *contemplation* phase is characterized by an awareness of the problem and weighing pros and cons, the *preparation* phase is marked by the participant making intentions for change and setting goals, the *action* phase, as the name indicates, is modification of the problematic behavior towards the preferred behavior, and the *maintenance* phase is determined when the desired behavior is sustained indefinitely and there is resistance to relapse (Giordano, 2021; Hashemzadeh et al., 2019).

Robley Rex Veterans Affairs Medical Center (RRVAMC) started circulating Whole Health information, training, and promotion before 2019. Unfortunately, with COVID-19 restrictions and limited patient-provider interaction, the WH efforts diminished. In 2022, there was a resurgence of WH attention and funding. The providers started getting trickle down information and strong nudges toward Whole Health integration. The pre-intervention survey indicated that 100% of the respondents felt that Whole Health would be beneficial to the patients and 66% of the responders said they would incorporate Whole Health into their practice. The Fort Knox primary care staff has gradually moved from pre-contemplation, contemplation, and

preparation into the action stage. Applying the TTM *action phase* to the Fort Knox primary care, they are ready to incorporate the WH conversation, provide education about WH, and document the PACTs efforts by utilizing the WH CDI reminder as part of their patient visit routine. The DNP training intervention helped the providers and nurses to integrate Whole Health into their practice with prompts to utilize the Whole Health CDI reminder in the EHR and tips for improving provider and staff documentation. It was emphasized that accurate coding and improved documentation would lead to an increased reimbursement for the care provided.

Purpose and Aim of the DNP Project

The purpose of the intervention was to Improve Integration of Whole Health into the Primary Care at the Fort Knox Veteran Affairs (VA) Community Based Outpatient Clinic (CBOC) by using a training program for the providers and PACTs about WH and documentation to enhance the comfort level for initiating a conversation and education about Whole Health and documenting their patient encounter with accurate coding. As the literature suggests, education and communication between the provider and the patient leads to improved patient health outcomes, promoting shared-decision making and fostering the provider-patient relationship. When looking at integrating the Whole Health approach into the primary care practice, evaluating the individual provider's attitude and perception of Whole Health integration barriers, assessing the provider's perception of the patient's attitude toward Whole Health, and knowledge about complementary and integrative health options are key to making a change of practice (Howe et al., 2017; Shamblen et al., 2018). As part of this DNP project, a pre-intervention needs assessment was emailed to seven Fort Knox PACT members (n=20) with a 50% response from the providers and PACT members (N=10). The needs assessment, titled Perceived Barriers and Benefits to Whole Health Integration into the Primary Care Setting, was used to identify the Fort Knox

PACT member's TTM phase of change and as a needs assessment to individualize the DNP project intervention to the stage and concerns of the Fort Knox PACTs.

The objectives of the DNP intervention were to improve the WH documentation habits of the Fort Knox PACTs, increase the percentage of referrals into Whole Health and Complementary Integrative health services, increase the use of the CDI reminder in the electronic health record by 10% from baseline, the number of WH unique encounters by 10% reflecting new patients engaging in some way with the WH services, the marking of the WH education block in the CDI reminder by 10% from baseline, and the marking of the WH conversation block by10% from baseline.

Methods

Design

The DNP project was a descriptive quantitative assessment of the Whole Health and Documentation program designed to assist the integration of Whole Health and Complementary and Integrative Health services into a traditional VA primary care clinic. The training program focused on the biopsychosocial medical approach of Whole Health versus a traditional, biomedical disease treatment model and documentation.

The 45-minute training program included training about the WH CDI reminder in the electronic health record and how to use the indicator and the benefits of the reminder for coding patient complexity. The training program included a 5-minute video from the VHA about the National Department of Veterans Health Administration Strategic Plan to prioritize Whole Health integration as a complement to the current healthcare model and a 20-minute power point presentation about Whole Health and Complementary and Integrative Health (CIH) options within our Robley Rex Louisville VA Medical center. A non-pharmacologic approach to clinical

conditions reference sheet was provided. The trainer was made available to meet with each provider individually throughout the project for any questions, concerns or follow up needed for the information provided during the intervention. Accordion folders were provided to each PACT with information sheets about the different complementary and integrative health options provided by the Robley Rex VA Medical Center and how to make a referral to Whole Health services. Commonly used CPT codes were presented with the corresponding time and documentation requirements. The inclusion criteria for the project were licensed staff members within the seven primary care PACT and patients receiving healthcare at the Fort Knox Community Based Outpatient Clinic (CBOC) delivered within the walls of the clinic. Exclusion criteria from the study was patient care delivered by telephone or telehealth.

Consent form, for the PACT staff, was not necessary as the introduction of Whole Health into the provider's individual practice was and remains voluntary and at their discretion. There was no risk to the participants exposed to the DNP intervention. There was no PACT or patient personal identifying data collected or used.

Setting and Sample

The Fort Knox CBOC primary care has seven Patient Aligned Care Teams (PACTs) each are made up of a provider (MD/DO, APRN, PA), registered nurse (RN), licensed practical nurse (LPN) and a medical scheduling specialist (MSA) with an empanelment of approximately 1,000 patients each. The teams have 14 to 16 patient care appointment slots daily with additional telephone appointments and secured messaging. The Fort Knox clinic's population is entitled military veterans identified as male, female and transgender, 24 years of age to 101 years of age, with the average age of 64 years (VA.gov, 2023). Upon the patient's arrival, the veterans check into the clinic and are escorted to their assigned examination room. The veteran is triaged by the

LPN with vital signs and completion of any Clinical Documentation Indicators (CDI). The triage process takes an average of 15-minutes. The provider then sees the patient to address their healthcare needs and concerns. The RN is typically assigned to the team's phone messages, walk-in triage and secured messaging.

Context

There are **s**takeholders invested in the WH training programs and integration of WH into the primary care clinics. All veterans enrolled in the primary care at the Fort Knox Community Based Outpatient Clinic (CBOC), The Fort Knox healthcare providers and their PACT members. The administrative staff including the Whole Health coordinator, Nancy Korfhage, the Whole Health champion for primary care providers and women's health, Dr. Rouchka, the Fort Knox clinic manager, Carrie Brown, and the VA Director at Robley Rex VA Medical Center promoting the strategic plan for Whole Health integration by 2024.

Integration Gap

The current gap for integration of Whole Health is finding a time efficient, rhythm for asking what matters most to the patient and what keeps them from doing what they enjoy. Changing the routine conversation pattern to a new Whole Health conversation, education, and promotion will take practice. The challenge is getting buy-in from the providers to make the change in their daily patient routine to include investigating the patient's healthcare goals to keep the patient doing what matters most to them. There is an administrative gap to solve the shortened time element of the provider-patient encounter that now requires added documentation. There is a knowledge gap of the purpose and use of the Whole Health CDI to improve coding of the Whole Health education, and preventative care for value-based reimbursement.

Facilitators

Whole Health promotion materials are posted on the veteran's web page about the Whole Health initiative encouraging patients to ask their providers questions about alternative and complementary medicine options. Although Fort Knox CBOC does not have a WH champion, the WH champions from other VA CBOC's are encouraging. The providers at Fort Knox are peers and demonstrated willingness to participate in the intervention for WH integration which may boost WH documentation effort. Having support from the clinic supervisor is helpful for promotion of the staff meeting date and time and gathering the participants the day of the staff meeting.

Barriers

Patients with more than two co-morbidities may delay the providers starting the conversation due to time constraints. Frustrations with excessive charting demands may cause the provider to decline participation. Patient cancelations and not showing for their appointments are barriers. Staffing issues, holiday time off and episodic absences of the PACT members will be a barrier to the WH integration.

Ethical Considerations

A VA Electronic Determination Aid (VAEDA) Portal was used as a preliminary determination of whether an IRB review is needed for the quality improvement capstone project.

Based on the answers submitted, the project does not meet the regulatory definition of research. The VAEDA stipulates that there are no restrictions to publishing the results of the program evaluation project, but there can be no use of the term *research* in the abstract, presentation, or publication. A privacy review was obtained by a VA privacy officer and pledged adherence to the VA privacy guidelines assuring deidentified patient's personal identification information for chart reviews. Stewardship of any data collected will be saved in a CAC Card protected VPN secure computer. Chart review data included no patient identifiers. There was a process for both the RRVAMC education department and the university to satisfy the requirement for dual credentialing as an DNP student and employee of the RRVAMC.

Measures

To determine success of the program, the percentage increase from baseline of the unique encounters into Whole Health and Complementary Integrative Medicine department was evaluated. The unique encounters indicate new veterans utilizing the Whole Health services for the first time or touched in some way by the services offered. The VHA Whole Health dashboard provides updated information of WH integration progress and was monitored pre-intervention, 4-weeks post intervention and 12-weeks post intervention.

On three separate occasions at one month pre-intervention, 4-weeks post intervention and 12-weeks post intervention, a random retrospective chart review of the WH documentation was done using 5 charts from each PACT for a total of 35 charts with a total of 105 charts over the 5-month project. No patient personal health information or identifiers were collected. The EHR was used for dichotomous data collection. The audit questions that were presented were: Was there evidence of Whole Health documentation within the narrative portion of the patient visit encounter? Was a Whole Health referral made? Was there use of the CDI reminder? Was the

conversation block marked within the CDI reminder? And was the education block marked within the CDI reminder? Chi-Square tests were applied to compare the data collected from each audit pre-intervention versus 4-weeks post-intervention and 12-weeks post-intervention for documentation differences after the WH and Documentation training program was completed. The results inferred that the WH education and conversation and documentation behaviors of the PACTs were influenced by the WH and Documentation training program.

Data Analysis

The capstone project was a quality improvement (QI) project evaluating the training intervention provided to the primary care PACT members assisting with the integration of WH into the clinic. Inferential statistics and Chi-Square were used to establish whether the Whole Health and Documentation training intervention made a difference in relation to documentation of WH and utilization of the WH CDI reminder.

The dependent variables included documentation data collected at pre-intervention, 4-weeks post intervention, and 12-weeks post intervention. The data points used for the chart audits within the EHR were the WH CDI reminder, WH conversation block marked within the CDI reminder, WH education block marked withing the CDI reminder, WH narrative documentation, and if WH referrals were made. The statistical Package for the Social Sciences (SPSS) version 27 was used for analysis of the collected data with the significance level set at .05 or less. Monitoring the Whole Health Dashboard provided the percentages of unique encounters into WH. A comparison of those percentages pre-intervention, 4-weeks post intervention, and 12-weeks post intervention were recorded. The Whole Health percentage of the total unique encounters for both Louisville RRVAMC and its satellite clinic, Fort Knox, were watched monthly for trending.

Results

Pre-intervention chart audit

The pre-intervention retrospective documentation audit found that four out of 35 charts utilized the WH CDI reminder for documentation of what mattered most to the patient. The same four charts, which used the CDI reminder, had narrative documentation for WH noted in the EHR. There was zero marking of the conversation block and zero marking of the education block within the CDI reminder. There were zero WH referrals made. Assessment of the unique encounters, monitored by the WH Dashboard, of veterans enrolled in Whole Health services at the Louisville Robley Rex VAMC prior to the capstone project was 15%. The Fort Knox CBOC, which is a small satellite clinic within the Louisville VAMC's domain and the site of the intervention, scored 1.5% of the Louisville 15%. The benchmark for 2024 Louisville RRVAMC was to have 35% of its 42,790 enrolled veterans engaged with Whole Health.

4-weeks post-intervention chart audit

The 4-weeks post-intervention random retrospective chart audit revealed improved CDI reminder use in seven out of 35 charts, improved conversation block marked within the CDI reminder by one and improved education block marked within the CDI in five of 35 charts. Narrative documentation was noted in seven of the 35 charts. Zero referrals were made to WH services. Assessment of the unique encounters, monitored by the WH Dashboard, of veterans enrolled in Whole Health services at the Louisville Robley Rex VAMC at 4-weeks post-

intervention was 23.26% of the 42,790 enrolled veterans engaged with Whole Health which was improved from 15%. The Fort Knox CBOC improved from 1.5% to 2.17% of the total unique encounters.

12-weeks post-intervention chart audit

Improvements are noted with all the documentation variables except for the conversation block marked within the CDI reminder and WH referrals. The 12-week post-intervention retrospective documentation audit found that twelve out of 35 charts utilized the WH CDI reminder for documentation of what mattered most to the patient. There was a decline to zero for marking of the conversation block within the CDI reminder. There were 10 education blocks marked within the CDI out of 35 charts. There were 12 out of 35 charts that had narrative documentation of WH. Zero referrals were made to WH services. Assessment of the unique encounters, monitored by the WH Dashboard, of veterans enrolled in Whole Health services at the Louisville Robley Rex VAMC was 33.37% at 12 weeks post-intervention which is close to the benchmark set for 2024 Louisville VAMC of 35%. The Fort Knox CBOC was improved from 2.17% to 3.44% of the total unique encounters of the 42,790 enrolled veterans engaged with Whole Health.

Table 1

Total unique encounters into the Whole Health and Complementary Integrative Health Medicine Department at Louisville RRVAMC

	Pre-intervention	**1- Month post intervention Weeks 1-4**	**3-Month post intervention Weeks 9-12**
	Total unique encounters into Whole health	*Total unique encounters into Whole health*	*Total unique encounters into Whole health*
Robley Rex Veterans Affairs Medical Center including all satellite clinics/services	6,418 (15%)	9,842 (23%)	14,279 (33%)
Fort Knox Community Based Outpatient Clinic (CBOC) Primary Care- Intervention site	627 (1.5%)	930 (2.20%)	1,472 (3.4%)

Notes. Data percentages are calculated using the total veterans enrolled at Robley Rex VAMC 42,790 (2023 VA Whole Health Dashboard). Whole Health training intervention at Fort Knox CBOC was February 23, 2024, during the routinely scheduled staff meeting.

Table 2

Retrospective Electronic Health Records (EHR) Reviewed for Indicators Suggesting Utilization of the Whole Health Clinical Documentation Indicator (CDI) Reminder

	Baseline 30 days prior to intervention	**1-month post-intervention (weeks 1-4)**	**3-months post-intervention (weeks 9-12)**
	Frequency (%)	Frequency (%)	Frequency (%)
Use of the EHR Whole Health Clinical Documentation Indicator (CDI) reminder	4 (11.4)	7 (20.00)	12 (34.29)
Whole Health conversation block marked within the CDI reminder	0 (0)	1 (2.85)	0 (0)
Whole Health education block marked within the CDI reminder	0 (0)	5 (14.28)	10 (28.57)
Whole Health narrative documentation	0 (0)	7 (20.00)	12 (34.29)
Whole Health referral	0 (0)	0 (0)	0 (0)
Total	**4 (11.42)**	**20 (57.14)**	**32 (91.42)**

Note. Thirty-five retrospective electronic medical records audits performed by the investigator. Five random charts reviewed for each PACT team pre-intervention and following the intervention at 4 weeks and 12 weeks. N= 7 Patient Advocate Care Teams (PACT)

WH CDI Reminder Utilization

Data analysis of the documentation variables was done by crosstabulation. Analysis using Chi-Square tests to compare the three different chart audits at pre-intervention, 4-weeks post-intervention, and 12-weeks post intervention looking for a difference (see Figure 1). The WH CDI reminder used within the electronic health record X^2 (2, N=105)= 5.46 p=.065 indicating a marginal significance after the training intervention to the post-intervention data. There was an adjustment for the small sample size (see Figure 2).

Figure 1

*Clinical Documentation Indicator used * Time of Measurement Crosstabulation*

			Time of measurement			
			Pre	4-week post	12-week post	Total
Clinical Documentation Indicator used	no	Count	31_a	28_a	23_a	82
		Expected Count	27.3	27.3	27.3	82.0
		% within Clinical Documentation Indicator used	37.8%	34.1%	28.0%	100.0%
		% within time of measurement	88.6%	80.0%	65.7%	78.1%
	yes	Count	4_a	7_a	12_a	23
		Expected Count	7.7	7.7	7.7	23.0
		% within Clinical Documentation Indicator used	17.4%	30.4%	52.2%	100.0%
		% within time of measurement	11.4%	20.0%	34.3%	21.9%
Total		Count	35	35	35	105
		Expected Count	35.0	35.0	35.0	105.0
		% within Clinical Documentation Indicator used	33.3%	33.3%	33.3%	100.0%
		% within time of measurement	100.0%	100.0%	100.0%	100.0%

Note. Each subscript letter denotes a subset of time of measurement categories whose column proportions do not differ significantly from each other at the .05 level.

Figure 2

Chi-Square tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	5.456[a]	2	.065
Likelihood Ratio	5.488	2	.064
Linear-by-Linear Association	5.294	1	.021
N of Valid Cases	105		

Note. 0 cells (.0%) have expected count less than 5. The minimum expected count is 7.67.

		Value	Approximate Significance
Nominal by Nominal	Phi	.228	.065
	Cramer's V	.228	.065
	Contingency Coefficient	.222	.065
N of Valid Cases		105	

WH Conversation Block Marked within the CDI reminder

Using crosstabulation (see Figure 3) for comparison of the 3 chart audits, the WH conversation block marked within the CDI reminder, there was no significant difference comparing pre- and post-intervention at 4-and 12-weeks. No Chi-Square was done for this variable.

Figure 3

*Whole Health Conversation Block Checked * Time of Measurement Crosstabulation*

			Time of measurement			
			Pre	4-week post	12-week post	Total
Whole Health conversation block checked	no	Count	35$_a$	34$_a$	35$_a$	104
		Expected Count	34.7	34.7	34.7	104.0
		% within Whole Health conversation block checked	33.7%	32.7%	33.7%	100.0%
		% within time of measurement	100.0%	97.1%	100.0%	99.0%
	yes	Count	0$_a$	1$_a$	0$_a$	1
		Expected Count	.3	.3	.3	1.0
		% within Whole Health conversation block checked	0.0%	100.0%	0.0%	100.0%
		% within time of measurement	0.0%	2.9%	0.0%	1.0%
Total		Count	35	35	35	105
		Expected Count	35.0	35.0	35.0	105.0
		% within Whole Health conversation block checked	33.3%	33.3%	33.3%	100.0%
		% within time of measurement	100.0%	100.0%	100.0%	100.0%

Note. Each subscript letter denotes a subset of time of measurement categories whose column proportions do not differ significantly from each other at the .05 level.

WH Education Block Marked within the CDI Reminder

Using crosstabulation (see Figure 4) and Chi-Square for comparison of the 3 chart audits, the WH education block marked within the CDI reminder, there was a significant difference comparing pre-intervention and post-intervention at 4- and 12-weeks X^2 (2, N=105)=11.67 P=.003).

Figure 4

*Whole health Education Block Checked * Time of Measurement Crosstabulation*

			Time of measurement			
			Pre	4-week post	12-week post	Total
Whole health education block checked	no	Count	35_a	$30_{a, b}$	25_b	90
		Expected Count	30.0	30.0	30.0	90.0
		% within Whole health education block checked	38.9%	33.3%	27.8%	100.0%
		% within time of measurement	100.0%	85.7%	71.4%	85.7%
	yes	Count	0_a	$5_{a, b}$	10_b	15
		Expected Count	5.0	5.0	5.0	15.0
		% within Whole health education block checked	0.0%	33.3%	66.7%	100.0%
		% within time of measurement	0.0%	14.3%	28.6%	14.3%
Total		Count	35	35	35	105
		Expected Count	35.0	35.0	35.0	105.0
		% within Whole health education block checked	33.3%	33.3%	33.3%	100.0%
		% within time of measurement	100.0%	100.0%	100.0%	100.0%

Note. Each subscript letter denotes a subset of time of measurement categories whose column proportions do not differ significantly from each other at the .05 level.

Figure 5

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	11.667[a]	2	.003
Likelihood Ratio	15.537	2	<.001
Linear-by-Linear Association	11.556	1	<.001
N of Valid Cases	105		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.00.

		Value	Approximate Significance
Nominal by Nominal	Phi	.333	.003
	Cramer's V	.333	.003
	Contingency Coefficient	.316	.003
N of Valid Cases		105	

WH Narrative documentation

Data analysis of the WH narrative documentation was done by crosstabulation (see Figure 6) with further analysis using Chi-Square tests to compare the three different chart audits at pre-intervention, 4-weeks post-intervention, and 12-weeks post-intervention looking for a difference and adjusting for the small sample size (See Figure 7). There was a significant difference between the three audits assessing the WH narrative within the EHR X^2 (2, N=105)=14.01 $p<.001$.

Figure 6

*NARRATIVE-Documented in the electronic health record * time of measurement Crosstabulation*

			Time of measurement			
			Pre	4-week post	12-week post	Total
NARRATIVE-Documented in the electronic health record	no	Count	35_a	28_b	23_b	86
		Expected Count	28.7	28.7	28.7	86.0
		% within NARRATIVE-Documented in the electronic health record	40.7%	32.6%	26.7%	100.0%
		% within time of measurement	100.0%	80.0%	65.7%	81.9%
	yes	Count	0_a	7_b	12_b	19
		Expected Count	6.3	6.3	6.3	19.0
		% within NARRATIVE-Documented in the electronic health record	0.0%	36.8%	63.2%	100.0%
		% within time of measurement	0.0%	20.0%	34.3%	18.1%
Total		Count	35	35	35	105
		Expected Count	35.0	35.0	35.0	105.0
		% within NARRATIVE-Documented in the electronic health record	33.3%	33.3%	33.3%	100.0%
		% within time of measurement	100.0%	100.0%	100.0%	100.0%

Note. Each subscript letter denotes a subset of time of measurement categories whose column proportions do not differ significantly from each other at the .05 level.

Figure 7

Chi-Square

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	14.009[a]	2	<.001
Likelihood Ratio	19.263	2	<.001
Linear-by-Linear Association	13.748	1	<.001
N of Valid Cases	105		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.33.

		Value	Approximate Significance
Nominal by Nominal	Phi	.365	<.001
	Cramer's V	.365	<.001
	Contingency Coefficient	.343	<.001
N of Valid Cases		105	

WH referrals documented

Using crosstabulation (see Figure 8) for comparison of the 3 chart audits for the WH referrals documented, there was no significant difference comparing pre-intervention and post-intervention at 4- and 12-weeks. The WH referral count remained zero for all three chart audits.

Figure 8

*Whole Health Referral into Integrative Medicine * Time of Measurement Crosstabulation*

			Time of measurement			
			Pre	4-week post	12-week post	Total
Whole Health referral into integrative medicine	no	Count	35_a	35_a	35_a	105
		Expected Count	35.0	35.0	35.0	105.0
		% within Whole Health referral into integrative medicine	33.3%	33.3%	33.3%	100.0%
		% within time of measurement	100.0%	100.0%	100.0%	100.0%
Total		Count	35	35	35	105
		Expected Count	35.0	35.0	35.0	105.0
		% within Whole Health referral into integrative medicine	33.3%	33.3%	33.3%	100.0%
		% within time of measurement	100.0%	100.0%	100.0%	100.0%

Note. Each subscript letter denotes a subset of time of measurement categories whose column proportions do not differ significantly from each other at the .05 level.

Discussion

Summary

The purpose of the QI project was to provide an intervention that would move the Fort Knox primary care clinic from the *Preparation* phase to the *Action* phase and the *Maintenance* phase of the TTM for integrating Whole Health into their individual practices. The key point to *change* is that recycling through the various stages of the TTM of change are normal. In the *Action* phase, the Fort Knox primary care clinic was receptive to the integration of the Whole Health approach and had started implementing conversations toward identifying what matters most to the patient. The providers and their support staff started educating veterans about WH, but found it difficult to provide the referral into the WH and Complementary Integrative Health Services. The intervention was successful for changing the documentation behavior of the Fort Knox PACTs. Improved documentation of WH was significant by utilizing the CDI reminder. The *Maintenance* phase will happen with continued practice and the overall culture shift throughout the VA system. Continual growth of the WH and CIH department with added alternative medicine options and patients giving positive feedback about their whole health journey, will boost the efforts for WH integration.

Interpretation

The data analysis showed significant differences for the documentation data points at pre-intervention compared to 4- and 12-week post-intervention inferring a documentation behavior change with use of the CDI reminder, narrative documentation within the EHR and marking the WH education block within the CDI reminder. Data collection extending to 12-weeks post-intervention with continued improvement of documentation influenced by the training, shows that the training program is a sustainable and viable method for integrating WH into the

Primary Care. Post the WH and Documentation training program intervention, the unique encounters for the veterans enrolled at the Fort Knox CBOC increased from 1.5% to 3.4% indicating their patient's desire to utilize alternative treatments and indicative of PACT's encouragement to utilize the WH services. Literature review indicated that transitioning to value-based, preventative care improves patient health outcomes and improves patient satisfaction. Although the number of unique encounters into WH increased, it is disappointing that the WH referrals provided by the Fort Knox PACT remained at zero percent throughout the entirety of the quality improvement project. It is suspected that the Fort Knox patients made self-referrals, or the referrals were provided by another clinic at their request.

Limitations

The main limitation to the project was the sample size. Efforts were made to assure that all PACT members received the WH and Documentation training, but attention and viewing of the training power point was dependent on the participant's interest and discretion. It is noted that 1 member from each PACT was absent from the training day staff meeting. One provider was on extended leave and replaced with a surrogate provider that did not receive the training.

Conclusion

A Whole health and Documentation training program was a successful intervention to improve the integration of WH into the primary care clinic at VA Fort Knox Healthcare Clinic. The Fort Knox Primary Care Clinic went from 1.5% to 3.4% total unique encounters into the Whole Health Services. The intervention was specific to the needs of Fort Knox, measurable using the CDI reminder as a tool to track providers efforts for education and encouragement into WH services, realistic and time efficient. The continued improvement over time from 4-weeks post-intervention to 12-weeks post-intervention, shows sustainability. This same program can be

used for other primary care clinics to improve the integration of Whole Health. In the future, it would be beneficial to train Motivational Interviewing IMI) techniques to the providers and their team members as this was noted in the literature as a valuable skill set to engage patients in WH (Li et al., 2020). A standardized WH training program that includes MI and coding for accurate CPT-codes reflective of integrating WH should be considered. Further research for the best alternative medicine approaches for chronic illnesses predominate in the veteran population such as PTSD and chronic pain could be explored.

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Appendix A

Letter of Support

September 16, 2022

Dr. Jaclyn Engelsher, DNP, APRN
Family, Mental Health, TCM
ACOS, Mental Health
Robley Rex VAMC
Louisville, KY

To the University of Louisville DNP Program Board for DNP Project approval,

I give approval for Diana L. Blair FNP-BC, PMHNP to do her DNP project at the Louisville Robley Rex VAMC and/or a Satellite Clinic of the Robley Rex VAMC to carry out her project.
Diana is an employee of Louisville VAMC and is under my direction at the time of her DNP project Proposal. As such, she has been assigned to an interdisciplinary task force group that fits her DNP focus and Project needs. Diana will be under the guidance of Tamatha Hiemer our Graduate Nurse Preceptorship Coordinator at the Robley Rex VAMC Education Department.

Diana's DNP Project will be a process improvement project to integrate Veterans to the Whole Health Pathway/Circle of whole health by filling an identified gap in our current process.

Current identified DNP project:

1. Use the interdisciplinary task force group to identify interventions that can be used for creating a process improvement to increase veterans' engagement into Whole health. Diana would like to produce research data based on the number of referrals made to whole health after her chosen intervention to improve the process of engaging veterans and primary care providers.
2. Work with a focused workgroup to look at other sites that are currently successful with integration of Whole Health into their primary care and engaging patients to start their journey in Whole Health.

JACLYN ENGELSHER Digitally signed by JACLYN ENGELSHER
Date: 2022.09.16 12:39:08 -04'00'

Appendix B

E-Mail for Permission

From: Federman, Daniel <Daniel.Federman@va.gov>
Sent: Monday, October 31, 2022 10:51 AM
To: Blair, Diana L. <Diana.Blair@va.gov>
Subject: RE: Fed Pract. 2017 May; 34(5): 23–26. The Personal Health Inventory: Current Use, Perceived Barriers, and Benefits

Of course you can use that. I am hopefully you are successful in your endeavors.

We didn't validate the questionnaire.

D

From: Blair, Diana L. <Diana.Blair@va.gov>
Sent: Friday, October 28, 2022 4:26 PM
To: Federman, Daniel <Daniel.Federman@va.gov>
Subject: Fed Pract. 2017 May; 34(5): 23–26. The Personal Health Inventory: Current Use, Perceived Barriers, and Benefits

Dr. Federman,

My name is Diana Blair ARPN at the VA Healthcare Center Grayson CBOC -Robley Rex VAMC in Louisville, KY. I am working on a process improvement project to improve enrollment of our veterans into their *Whole Health pathway* journey. I have identified one of the barriers as *starting the Whole Health conversation* in the primary care setting. I am interested in using the questionnaire "Perceptions of primary barriers and benefits of using the personal health inventory."

The response of our primary care providers and primary care nurses will assist in the development of interventions that will hopefully increase our veteran's enrollment into Whole Health. I am requesting permission to use figure 1 tool in the article to conduct a pre assessment and post assessment. Additionally, to assure validity, how did you validate the provider questionnaire?

Thank you in advance for your assistance,

Diana Blair

Appendix C

Needs Assessment Pre-Intervention

Perceived Barriers and Benefits to Whole Health Integration into the Primary Care Setting

The information from this survey will be used for a DNP capstone project as a needs assessment and program evaluation for integrating the ***whole health*** approach into the primary care setting. Your time and participation are appreciated. Thank you in advance.

1. To what degree do you see the benefits of incorporating the **whole health** approach into the primary care setting during routine patient visits?

	No Benefit	Unlikely Benefit	Neutral	Likely a Benefit	Absolute Benefit
There is a greater focus on what the patient wants.	○	○	○	○	○
There is improved communication between patients and providers.	○	○	○	○	○
There will be better patient health outcomes.	○	○	○	○	○
There will be a focus on preventative health care.	○	○	○	○	○
It is easy to make the appropriate referrals to whole health to address the patient's self-care.	○	○	○	○	○

2. How easy is it for you to incorporate the ***whole health*** approach conversation into your primary care visits with your patients?

	Extreme Unease	Not Easy	Neutral	Easy	Very Easy
Asking "What matters most to you?"	○	○	○	○	○
Asking "What's your healthcare goal so you can keep doing what matters most?"	○	○	○	○	○
Asking "Do you want to make a personal health plan?"	○	○	○	○	○

3. How are you currently incorporating the ***whole health*** approach into your practice?

4. Did you know there is a ***whole health*** clinical documentation indicator (CDI) reminder in the electronic health record that provides prompt questions to start the ***whole health*** conversation?

- ○ Yes
- ○ No

5. If you have used the ***whole health*** clinical documentation indicator (CDI) reminder, was it helpful for initiating and documenting your ***whole health*** conversation with the patient?

- ○ Yes
- ○ No
- ○ Not applicable

6. How concerned are you about the following barriers to integrating the ***whole health*** approach into your routine primary care patient visits?

	1=not concerned at all	2=minimal concern	3=Neutral	4= concerned	5=Very Concerned
There is not enough time.	○	○	○	○	○
I am uneasy about discussing whole health topics with my patients.	○	○	○	○	○
I do not think that adding the whole health conversation will improve patient outcomes.	○	○	○	○	○
I am unaware of what whole health services are available and how to utilize them.	○	○	○	○	○
The process for finding and making a referral to whole health is confusing.	○	○	○	○	○
I am unsure what alternative modalities will help for certain patient complaints.	○	○	○	○	○

7. What other barriers have you recognized to integrating the **whole health** conversation during the primary care routine visit?

8. Do you plan to incorporate the ***whole health*** approach discussion with your patients during their primary care visit?

○ Yes

○ No

9. What is your age?

10. What is your scope of practice?

- ○ MD
- ○ DO
- ○ APRN
- ○ PA

11. What is the length of time you have been working for the Veteran Affairs (VA)?

- ○ Less than 1 year to 5 years
- ○ 6 years to 10 years
- ○ 11 years to 20 years
- ○ > 21 years