# VA Connection Plans: An Introduction in Clinical Training on a Social Connection Intervention

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Ralf Schneider: Welcome everyone. This is the Mental Health Recovery and Wellness Webinar Series. This series is made possible by the VA Office of Mental Health and Suicide Prevention, Psychosocial Rehabilitation and Recovery Section, and the VISN 5 Mental Illness Research Education and Clinical Center, that's the MIRECC, in partnership with the Employee Education System. The planning committee members for this Webinar series include Daniel Bradford, Valerie Fox, Spencer Glipa, Catherine Lewis, Marty Oexner, Kathryn Peacock-Dutt, Donna Russo, Tim Smith, Samantha Hack, and myself, Ralf Schneider. Today's Webinar is entitled, "VA Connection Plans, An Introduction in Clinical Training on a Social Connection Intervention." Our presenters for today's Webinar are Drs. Amanda Peeples, Samantha Hack, and Anjana Muralidharan. Dr. Amanda Peeples is an ethnographic gerontologist who joined the VA in 2014. She's a research investigator and the Director of the Qualitative and Mixed Methods Research Units at the VISN-5 MIRECC. Dr. Peeples' research interests focus on the needs and experiences of older Veterans with serious mental illness. Dr. Hack is a research health scientist and Associate Director at the VISN-5 MIRECC. Her background is in social work and her research focuses on patient activation and patient centered mental healthcare. Dr. Muralidharan is clinical psychologist and researcher at the VISN-5 MIRECC. The focus of her research is on aging with serious mental illness, peer support and recovery oriented and person-centered care. She is currently testing a peer delivered coaching intervention to promote participation in supervised fitness training among older adults with serious mental illness and she's

an avid mindfulness meditation practitioner and believer in the power of compassion and human connection as an ultimate source of joy and healing. So, at this time I'm happy to turn the Webinar over to our presenters. Thank you. Dr. Amanda Peebles: Thank you for that introduction Ralf. This is Amanda Peeples and I will be giving the first part of our presentation today. So I'm hopefully, yep, I got control, great. Everything is working as it should be. So, to start out with, we have no disclosures to report, and the views expressed today are our own and not those of the Department of Veteran's Affairs. We'd like to begin with a land acknowledgment statement, and Samantha just posted it in the chat so you can read along or follow along. We gather her today on Turtle Island, the indigenous term for the North American continent. We acknowledge that we, the presenters, live and work on the unceded land of the Piscataway tribe people in Baltimore City. We humbly offer our respects to the elders and past and present citizens of the Cedarville Band, of the Piscataway Conoy, the Piscataway Indian Nation and the Piscataway Conoy Tribe, all Algonquian peoples. This land was stolen from the Piscataway people through the direct and indirect violence of settler societies, colonialism and genocide, historical processes of disposition, which are ongoing. We make this acknowledgment to honor indigenous peoples and to disrupt our complacency as participants in and beneficiaries of colonial systems. So, here is the outline for our presentation today. We're going to be discussing social isolation and its effect on health and briefly touch on the impacts of the COVID-19 pandemic and social and physical distancing. My colleagues will then introduce the Connection Plans, which is a brief intervention for addressing social isolation and

give some tips for using Connection Plans with your Veterans. So, we do have a quick poll here, so if you could launch this poll I would appreciate it. It's pretty simple, just, Is Loneliness Something that You Discuss and/or Assess with the Veterans That You Work With? The options, I see people are starting to fill it in… yes all the time; sometimes if indicated; and no, it doesn't come up. Okay, so it seems like most people are either all the time or at least if indicated – a few people saying no, it doesn't come up. Great. I can't see the number of attendees now, but I think we're reaching with our responses about the total numbers, so we can go ahead and stop that poll. Thank you for that. Okay, so it seems like people are at least, for the most part, discussing it at least if it comes up and, you know, some folks are actually asking about it more proactively maybe. So hopefully this presentation today and this intervention of VA Connection Plans is something that you will be able to use in part or in whole moving forward in your own practice. So, to begin with, just to lay down some definitions, when people say social isolation, there's multiple aspects that they can be talking about, different facets that they could be talking about. Objective social isolation is characterized by having little contact with other people and it's something that can be objectively measured by things like social network size and frequency of contact with others. Whereas subjective social isolation is the feelings of social isolation, including loneliness, and it perceives inadequately of social support and resources. Both objective and subjective social isolation have negative impacts on health and well-being. I want to note that you can experience objective social isolation while not feeling subjectively social isolated and vice versa. So, for example, someone could

have a very large social network and frequent contacts with others, but if the perceived quality of the social interactions is poor they could still be feeling lonely and experiencing subjective social isolation and, likewise, someone could have a very low number or frequency of contacts, but if those contacts and relationships are of a high quality, they would not necessarily feel socially isolated. I think that a year plus into pandemic and lockdowns around the country and around the world, we're all sort of generally aware that social isolation does have a potentially negative impact on health and well-being overall. Some of the negative outcomes that are associated with social isolation include poor mental health, so things like higher rates of clinically significant anxiety, depression, suicidal ideation, unhealthy behaviors, so, lower physical activity, poor sleep quality, poor diet. Some evidence of higher rates of tobacco use and heavy alcohol use among people who are socially isolated. Poor physical health – so, you know, heart disease, stroke, functional decline are all higher with social isolation. And then even mortality, both from suicide and from other causes. For example, heart failure patients who are experiencing social isolation are more likely to die, and also social isolation is associated with a 25% increase risk for cancer mortality. So, you can see that social isolation really has pretty wide-ranging impacts on people's lives, which is why it is something that is so important to address. It's really been brought into the spotlight, you know, during the COVID-19 pandemic and lockdowns and such, the social isolation has come along with that for many people. But I want to make the point that social isolation was recognized as an important public health issue prior to the pandemic. Even in that as things returned to "normal", as vaccination rates

and things like that are increasing, and people are starting to go out and about more, the social isolation is still going to be a problem for many people moving forward. It can particularly be a problem for older folks and folks with serious mental illness, which is the target and the focus of the clinical demonstration project that we're dealing with VA Connection Plans. So, people with mental illness do experience more social isolation than the general population. People with severe mental illness or SMI have smaller and less satisfactory social networks, and that's both objective and subjective social isolation, and their networks are also more likely to include people like family members and professional caregivers, like case workers, peer support specialists, congregate housing workers, things like that. People with mental health conditions are actually 8X more likely to be lonely than people without, and about half of people with SMI do report feeling lonely. Again, this is pre-COVID, pre-lockdown numbers. There are several factors that contribute to social isolation for people with serious mental illness, things like skills deficits, not being comfortable in knowing how to talk to people, symptoms like intrusive thoughts or high anxiety that can make it difficult to connect with others, constricted social networks – they just have fewer opportunities to interact with others through normal activities, lack of friendships. Stigma – and this is both the stigma of serious mental illness and fear of the mentally ill by community members, which can make it difficult to form networks, but also self-stigma or even anticipated stigma can be a barrier to making social connections. And just generally poor community integration – so unemployment, living in subsidized or group housing and also poverty really can contribute to social isolation for folks with SMI.

Older adults are also a group that are likely to experience both objective and subjective social isolation. In recent surveys, again pre-COVID surveys, about a quarter of community dwelling adults age 65 and older were socially isolated. And about one-third of it involved age 45+ and 43% of those age 60+ reported feeling lonely. An irony is that the people who are most at risk for social isolation are difficult to identify and reach precisely because they are socially isolated, but because most older adults engage with healthcare and healthcare system, that's been identified as a key partner in trying to address social isolation among older adults. Some of the factors that contribute to social isolation for older adults include chronic illness, not feeling well or having mobility problems and things like that can make it difficult to go out and about, living alone, loss of friends and family. Losing a spouse is especially detrimental for people's social connections. Hearing and vision loss – it's just difficult to communicate with other people and keep up those relationships, especially during COVID-19. That was a large problem for people. Transportation issues, so like giving up driving or having trouble navigating public transportation if public transportation even exists where you live. Retirement is a big one, losing that sort of daily interaction with work, colleagues and networks, and caregiving responsibilities, so just being responsible for caring for a spouse, providing assistance to your adult children or grandchildren currently limit your ability, and also your energy to go out and connect with others. There has been some research on interventions designed to target both subjective and objective social isolation for a different population, including older adults and people with SMI. But in general, the research evidence is not very strong, so it's hard to make

concrete recommendations but there is some support for the idea of interventions that are educational or that have an active role for the person being targeted, maybe the most effective, which is sort of where the VA Connection Plan fits that niche, because as you will learn later in this presentation, it is a very active intervention for folks and it gives them the tools to actually make changes for themselves. So next I want to just very briefly touch on the impacts that COVID-19 has had on social isolation. Obviously everybody over the past year plus has experienced, almost everybody, has experienced more social isolation than they did during pre-COVID times, but people who were already at risk for social isolation had an even greater risk for the effects of social isolation during that time. and it's really a double-edge risk for people who are older or have mental health conditions. First, there's the socioeconomic behavioral factors that it more like to be exposed to COVID-19, so living in nursing homes, groups homes, shelters, congregate housing of any kind, was a significant risk. Also, experiencing poverty, and that could be in the form of folks who are working low wage "essential" jobs – grocery store workers, fast food workers, things like that, who can't afford to skip a shift at work to protect themselves, and also these jobs that put people at greater risk of exposure to COVID-19, as well as things like poverty in terms of not being able to afford to take advantage of some of these low contact modalities that have really taking off during the pandemic, like curbside pick-up or delivery of groceries, those often come with either fees or an order minimum that you need to meet to take advantage of those services, and that's not always something that people can do. Second, just the preexisting health conditions that are associated with age, and that are also more

prevalent among people with SMI lend themselves to an increased risk of negative outcomes if these folks do acquire a COVID-19 infection. We know generally that the older people were at greater risk for severe illness or death from COVID-19 and then there's conditions like smoking, obesity, diabetes, cancer, heart disease, these preexisting health conditions that are prevalent among both older adults and people with SMI and we're all associated with a greater risk of negative outcomes. I put up here, and if you download the slides you can get these links. If you're interested in learning more about the implications of COVID-19 and social distancing for folks with SMI in older adults, I can recommend these articles – they're all fairly quick reads, pretty short, and accessible. So, if you are interested in reading more, I encourage you to go ahead and do so and that is my time, so I'm going to hand things over to Dr. Samantha Hack. Dr. Samantha Hack: Thanks Amanda. All right, so I'm going to give you an overview of what the VA Connection Plan Intervention looks like, and some of the techniques that are used in it. So, I want to acknowledge that in addition to Dr. Van Orden's article, we also were very appreciative of input that we got from clinicians, staff and Veterans at the VA Maryland Healthcare System, specifically from geriatric and extended care, the Psychosocial Recovery and Rehabilitation Center, and the Veteran's Stakeholder Forum at the VISN-5 MIRECC. So, I want to tell you, there are two theoretic models, the VA Connection Plan is built on, and that's Cognitive Behavioral Therapy and VA Whole Health. Most are familiar with CBT and that it's main principles are the ideas that emotional distress is at least partially caused by unhealthful ways of thinking and unhealthful learned patterns of behavior that we engage in. So what that means for social

isolation and for VA Connection Plans, is that we are looking for opportunities to identify negative self-talk about loneliness, or our social relationships, where being mindfully aware of our bodies, and identifying the sensations that might be enhancing those feelings of stress and loneliness, and we're looking at what behaviors we're engaging in, either unhelpful or helpful, so that either interfere with social connections or support our goals of social connection. For those of you who are familiar with VA Whole Health, I hope you'll take an opportunity to get familiar with it because we are in the process of a massive system transformation to the new way of providing care for. Folks who like recovery-oriented care, they usually like Whole Health. There is a lot of shared value. So Whole Health is the VA's holistic approach to care that centers around getting to know the Veteran as a person before working with the Veteran to develop a personalized health plan that's based on their values, needs and goals. And so what that means for VA Connection Plans, is that we want this intervention to be very Veteran centered. IT focuses on integrated health. We're not following physical health or mental health, but we're recognizing health as they're all interconnected. We use a lot of mind / body connection interventions and exercises to help the Veterans challenge their feelings of isolation and loneliness. And then additionally, if you look at the whole heath model, you'll see that there are two blue circles on the outside, and that's also very important because VA Connection Plans is about understanding the Veteran in their environment. What communities are they part of, be it geographical, social, cultural that are meaningful to them and that we connect with more through Connection Plans. So, I'm going to touch on some of the skills that are used. These are key

clinical skills – and ones that I'm sure many of you have mastered, but they're very important for Connection Plans. So, active listening, were fully attending to the Veteran, what they're telling us and also what they're not telling saying; the use of open-ended questions – so open-ended questions are any question that can't be answered with a yes or a now. And therapists are particularly helpful for VA Connection Plans because they help bring forward information that you might not have thought to ever inquire about. So, for example, instead of asking "Are you happy with your day-to-day life?" yes/no… we can ask "Tell me what you like or don't like about your day-to-day life", and we're really listening to their value and perception. And then finally, reflective statements. So reflections are statement that mirror back what we thing we're hearing from the Veteran, and these are great because they provide an opportunity to catch misunderstandings where we say, "Oh, it sounds like you really miss the other Veteran that you see when you go to the VA, and the Veteran can say, "Oh, well, sort of, but you know I'll tell you who I really miss are my two friends from the group therapy I was going to." Okay, well that's important information and it's leading to more specification that we can then use in the goal setting. So slightly more advanced is some of the therapeutic modality skills that we use. Cognitive restructuring, smart goals and mind/body connection. So cognitive restructuring is a big part obviously of CBT and it's the process of identifying inaccurate or negative thoughts and then changing them. A lot of people call that catch it, check it, change it. For example, you'll hear a Veteran as they are talking about their life say, "My kids and their families never visit anymore because I'm not fun to hang out with and they just would rather be

elsewhere." We can then say, "You know I heard you say that, do you think that's really true? What evidence do you have to support that belief?" And maybe we can help identify and change that to something more realistic like "I remember how expensive and hard traveling with children can be." "You know, in-person visits aren't the only way to show love, and my kids and I enjoy really talking on the phone." Smart goals. That stands for Specific, Measurable Achievable, Relevance, and Time-bound, and what we know is that generic goals are rarely effective if the person sets a goal of "I'll take walks more often" – they're unlikely to execute that plan. Whereas, if we set the SMART goal of I will walk around my block every day after breakfast for one week, then we have time points that might cue them in to remember their goal. "I can walk around the block", that's really reasonable, so they're more likely to carry out those goals. And then finally, the mind / body connection. So, this refers to the interconnection between our thoughts, feelings, behaviors and physical sensations. This is heavily baked into all of the assumptions were making about goals and how they will impact people's feelings of loneliness and connection and in the exercises that we recommend. We will recommend a lot of whole health mind / body exercises or worksheets that people can incorporate into their goals. All right, so let's talk a little bit about what does a VA Connection Plan look like as an intervention. So, we have envisioned it as a brief intervention where there's a session, two weeks after that a phone check in, and then two weeks after the phone check in, the second session. So obviously, this can be easily modified. So, let me tell you a little bit about what each session looks like. So, in session one, you're introducing Connection Plans and getting buy in from the

Veteran. Then you use a good chunk of time to get to know the Veteran when using the opened ended questions and the reflective statements to really learn about their life and their lived experience. And then from that, we use that information to start tailoring into setting goals, to identifying what their needs are and to setting goals to meet those needs. We break those up into body, mind, and connection goals. So then at the mid-point check in, a brief check-in with the Veteran, how are things going? What's been successful with the Connection Plan? Have you been having any problems? We do a little problem solving and remind them that we'll be checking in at two weeks. These frequent check ins are helpful, because a lot of times it is easily for people to focus on goals if they know that there's going to be outside accountability. And then the third session, again, you're reviewing and reacquainting with the Veteran to find out how the Connection Plan has been going, what challenges they have been having, and then if necessary we go again through…not if necessary, you definitely go through each of the goals – that is necessary to problem solve around what barriers they have been having, or maybe they recommit to those goals or they want to set new goals at that point. So, let's talk in depth again about session one because as you saw, there's a lot of repetition of the material from session one. So that will help you understand what to do in the other sessions. So, for getting to know the Veteran, as Amanda touched on before, we're not interested in assessing the number of people in their social support network or the frequency of contact – we're really wanting to understand what their experience of loneliness or isolation has been, what barriers they see to connecting, and what they're trying to achieve socially, what they value in meaningful

relationships. So, I was recently talking with a Veteran – he doesn't want to have in depth emotional conversations, but he really misses watching movies with his children and kids. Just that shared time together in the room is deeply socially meaningful for him. So that's important to let that be the guide in these goals. And similarly, to think about how are we conceptualizing the goals of what they are trying to achieve as far as reducing the isolation or loneliness or increasing their feelings of self-efficacy. We've identified a few brief measures with this need for measurement-based care. Within the manual we have links to all of these measures, and you can see they're very brief, 3 or 4 items, and we do recommend doing those at the beginning of the first and second sessions so that you can show the Veteran either changes in things that are relevant and meaningful to them. Here's a picture of what the section plan worksheet looks like. And you can see it's very accessible, not daunting at all. There's a simple section for the goals and a place where the Veterans can write it down by hand, and then they stick this one page on their refrigerator or someplace where they can easily see it and remember "I have these brief goals that I'm gonna try and tackle." So not meant to be overwhelming. So, let's talk a little bit about what kind of goals you can put in each of these sections. We started out with body because we feel like it can be a little complicated to engage in things like cognitive restructuring, but everybody has that understanding that their body and the idea of your muscles feeling tense or feeling anxious. So, some of the goals that you can help people to set around changing their body sensations are engaging with all five senses so that can be listening to music, lighting a scented candle, looking at pictures that are beautiful and uplifting. Those

are very accessible to everybody, but if folks maybe have a little bit of experience with mind / body practice, or want something a little more challenging, then there's lots of whole health exercises in the manual about mindful breathing, progressive muscle relaxation, guided imagery, tai chi and yoga. But also, if people just want some sort of physical activity to engage in, you know, just going outside and feeling the sun on your skin and stretching. Those are all great techniques for body goals to help change the way they're feeling. So, for mind goals, you can engage in some of that evaluation of your self-talk. If people are up for that, you know, identifying thoughts that are unhealthful and then interrogating them. Is there another way that I can interpret this situation? Would someone who I respect also view the situation this way or might they have different explanations? Going back to that example of the Veteran who felt like his family didn't want to engage with him as opposed to just they're very busy. If that is not something that people are interested in engaging in for their ways to change perspective. They can also just try and find positive thoughts that they want to spend more time with, you know, so that can be mantras or mottos or slogans that they repeat to themselves, or prayers, poems. Any sort of introducing positive thoughts into their experience. And is there any processes of meditation or reading or prayer that people already are using that are helpful. This is a great opportunity to build on those or to find similar exercises that they might want to try out. And then finally for the connection strategies, I want to say that the biggest thing is that sometimes when people think of the connection goals, they're thinking they've got to be on the phone or spending time with other people, but there's lots of ways to feel more connected to your community, to your social circle,

even if you do not have a robust social support network. So, a big one always is helping others. If you're feeling down, help someone else, it will make you feel better. In the manual we provided a number of remote volunteer opportunities so that even if people can't leave their home easily they can volunteer. There are lots of ways to connect with people, even if they are not physically present, like you can look at pictures or talk to them on the phone. But even you can go outside and take a walk in your neighborhood and greet people you see and remind yourself that you are a part of a community and interacting with other people on a daily basis. So, this is a brief example, just to give you an idea of what a Connection Plan could look like for a specific Veteran. We have Ms. Kay, she's 76-years-old and she lives with her husband who has dementia, and she is his primary caregiver. So, she perhaps finds it hard to leave the house because she has obligations to care for her husband and he can become disoriented when she leaves. She also has her own physical issues that maybe make it a little hard to get out. So, for her, when she was feeling nervous or overwhelmed and tense in her body she likes to listen to, we set the goal of listening to music, and that's something that she can share with her husband, so it's a nice activity for both of them. For the mind perhaps, like her daughter has to help her out with things like grocery ordering and tasks around the house and that kind of transforms into a thought of that "We're a burden", "We're constantly needing things from our daughter", but that can really be reframed as truthfully, her daughter loves her and wants to help out and wants to make sure that they're needs are met. And finally, for deceased feelings of connection and decreased feelings of isolation in the household, she can set up weekly calls with

her grandkids so that she has more interaction with them and, again, as a shared activity with her husband, she can look through old photo albums and look back at family pictures. So that's that idea of what the VA Connection Plans looks like and now I'll turn it over to Anjana. Dr. Anjana Muralidharan: Hello. Hopefully folks can hear me and if not, please let me know. So, thank you very much Samantha and Amanda for providing some great background and foundational information on the Connection Plans Intervention. So, I'm going to now share some of what we've learned from rolling out Connection Plans with Veterans in our clinical demonstration project, so that you all can think about how you might implement this intervention in your context. I'm just going to put the link again to the manual in the chat. The manual is really excellent. We put a lot of work into it. It's very clear. It's well formatted, lots of information, lots of resources. So, I really do recommend that folks go over there and download it. It requires putting in a little bit of information on the website, but then the download comes right after that. So, you know, please check that out. So, we are rolling out Connection Plans in a clinical demonstration project. One thing that is important to note is that you don't have to be a licensed independent provider to do Connection Plans, as long as you have those foundational skills and active listening, reflections and open-ended questions etc. that Samantha shared. And so, we have a team of folks who are mostly not LIP's, although we do have one or two people are licensed. Of course, if you have non-LIP's rolling this out, you'd want it to be under the supervision of someone who could address any clinical issues that might arise. So, we have a team of about 10 people and we're rolling this out and we're targeting Veterans who are

over 65, or Veterans who are over 50 and have a serious mental illness. We're accepting clinician referrals in VISN-5 and 16, that's where our teams are. And we're also doing some chart screening, so that's who we're reaching out to, just for context. So, we've already started to learn a lot. So we've learned about how to talk about or how to introduce Connection Plans. This will differ for you all, depending on who you're targeting. But since we're targeting a pretty broad population we aren't necessarily honing in on folks who have endorsed loneliness in social isolation, and we've really learned those words carry a lot of stigma. So even folks who are socially isolated or maybe feeling lonely, they don't always endorse that or feel comfortable sharing that. So, we've learned to really be general in how we describe the intervention, and an example is right there, you know, to help support older Veterans to create positive changes in their lives, we're offering an opportunity to create what's called a Connection Plan. Again, you can look in the manual for more details. Another thing we're doing, is we're sending materials before and after we do the Connection Plan intervention. So beforehand, we just send just basic information about what a connection plan is, as well as a blank connection plan worksheet that the person can fill out when we're talking to them. And then afterwards we send them their completed connection plan, along with tailored resources. So, these are all things that you can think about in your own context and clinic, what might be helpful. The other thing of note that we are learning is that a lot of the language in the manual does make reference to the COVID-19 pandemic and the impacts that it has had on social isolation, and of course that's a rapidly changing context, so it may not be as relevant any more when

you're talking to Veterans and so all of that, you know, you can be flexible in how you explain the intervention, because as Amanda noted, social isolation has been an issue for a very long time – it's not just related to the pandemic. So even as the pandemic hopefully stops impacting our lives quite as much, we still will have a need for this kind of intervention. Okay, so what about screening folks. So, I already told you our criteria, but besides diagnose and age, we're looking for folks who have cognitive capacity to co-create a plan for their well-being. If you routinely use screening measures for cognitive capacity, like the MMSC, and you feel comfortable with those, you can use that, but we're using a very low tech screening process, which does seem to be working – we have screened some folks out using this process, where we explain the project and we ask Veterans to reflect it back to us in their own words, and they have to demonstrate some basic understanding, and if the Veteran doesn't understand after repeated explanation, then we screen them out. Another thing we've been thinking about and talking about a lot, is how to involve social supports in creating connection plans, and so there are many reasons to potentially include social supports. You might be working with Veterans who have auditory impairments or cognitive impairments and so they would benefit from a support person to facilitate communication. We may also be working with Veterans who are dependent on a support person to carry out aspects of their daily routine, and then just generally speaking, support persons can help with brainstorming goals, providing contexts, and providing motivation and accountability for Veterans to implement their connection plans. So, when deciding to involve a support person, we really emphasize that you let the Veteran lead that

decision making process, so ask them if there is someone they would like to involve. And also ask how they would like the person to be involved. The support person does not have to attend the whole connection plan session – they can come for the whole thing, but they could also just come for part of the time. And then you can ask the Veteran specifically what they would like a support person to help with. In the Connection Plan session, if a support person is present, then we really emphasize that you respect the Veteran's autonomy and center their experiences. So, you know, if you're in a situation where a support person is dominating the conversation or speaking on behalf of the Veteran, you might gently ask, "You know, do you mind if I hear from the Veteran first – I'm curious what they think". It's really important that we find out what the Veteran really wants to do to increase their social connections and not just what the support person thinks is best. And if you feel that you're not able to get a true sense of the Veteran's needs with the support person present, you can ask to speak to the Veteran alone for part of the session to check in. While we're centering the experiences of the Veteran, it's also very important to note that support people are going to bring their own stress, especially if they are caregivers, or in a caregiving role for the Veteran. So, they might be experiencing a lot of their own distress, isolation and loneliness. So, we want to acknowledge and validate any distress that the caregiver endorses, emphasize the importance of their own self-care and have on hand resources for caregiver support. These can be shared on the call, or they can be mailed to the caregiver if you're mailing things to the Veteran for their Connection Plan. And then that brings us to the last point – Can support persons make their own

Connection Plan? And the answer is yes. And you can figure out the best way to do this in your clinic. If you have the time and capacity you could set time aside to help a support person do a Connection Plan. Or, you could encourage them to do it on their own, separately, after having sat through the Veteran creating one. So those are some of our thoughts about involving social supports. So, I'd like to talk now about the actual intervention and some of the tips that we've learned about the different sections. I'm not going to have time to go through all the tips, but all of this information is in the manual in these little boxes that say 'tips'. So, again, I encourage folks to go download that and check it out. So, at the beginning, as Samantha said, there's a Get to Know the Veteran section where you're using open-ended questions, active listening and reflections to get a broad idea of what's going on with the Veteran. You're not necessarily asking questions like, "Do you feel lonely?", What's making you feel lonely?", but broader questions like, "What's a typical day like for you?", "What's your day-to-day?", "How is that different from before COVID?", "Are there times of day that are better or worse for you?", and these kinds of things, and see what they endorse. In this section I've encouraged my interventionists to take notes that would help guide goals for body / mind connections later in the session. Another really important component of getting to know the Veteran is keeping it strengthens focused. What's going to happen is you're going to talk to Veterans who feel like they're doing pretty well. They'll say, "I'm fine." "I've been alone for a very long time." "I'm used to it." "I don't really need to change anything." And the last thing we want to be doing is convincing Veterans that they have a problem. So, we're not spending our time

saying, “Oh I don’t know, it seems like you’re really isolate though.” But instead keeping it strengthens focused and saying, “It sounds like your doing a lot to cope, that’s great. Let’s see what we can do to build on what you’re already doing to cope. Is there anything that you want to be doing more of? Is there anything new that you want to try?” Again, just keeping it very strengthens focused. Then we’re going to move into actually creating the plan. So here are some general tips. The most important tip I can probably give is that we have to be meeting Veterans where they are and so, you know, sometimes their interventionist come to the table with some preconceived notions about what they might be able to do and what a Veteran ought to be doing to be socially connected. We all have our own values about what it means to be socially connected, and it’s just really important to keep in mind that many Veterans have been isolated for a very long time and they don’t necessarily see it as an issue or what they consider social connection might be very different than what you see as social connection as Samantha mentioned earlier. So, just making sure that the Connection Plan is driven by their goals, their preferences, and their values. And, at the same time, we want to help the Veteran make goals that are specific. And the way that I often guide my interventionists to help Veterans with SMART goals is to visual the goal in their minds and help the Veteran visualizes it. So, if they can picture it – and picture all the details, then they’re more likely to sort of follow through with it. And so if, for example, if a Veteran has a goal of listening to music when they’re feeling down, or listening to music on a regular basis, you might ask a lot of questions about, you know, what time of day is this going to happen, what music is it, where’s the music coming from, what

room are you in, what are doing, are you dancing, are you just listening, are you drinking tea, you know, how long are you going to listen for, do you want to do this after breakfast, before breakfast… that kind of thing, really helping them think through how they'll fit it into their routine. And, if the Veteran is having a lot of difficulty coming up with those specifics, or picturing it, that could be a sign that the goal is actually not a very good fit – it's not realistic, it's not something they can see themselves doing. And so, you can use that as information to help redirect the conversation. And then finally, in writing up the Connection Plan, you want to use first person language. So, what we do is we mail them to the Veteran and so the language is from the Veteran's point of view. I will listen to music in the morning after breakfast for one hour while drinking my tea. The other thing about writing up the plan is that you don't have to have one goal in each section. It's not that rigid, so again you want to meet Veterans where they are. If they're very excited about body goals you can have four or five goals in body and skip mind and connections. So, it's really up to what they're interested in doing. Again, for the sake of time, I'm not going to go through all of these, but I will say that all these tips are in the manual and also in each section we have a great set of resources that you can share with the Veterans that you're working with. I'm particularly proud of our list of physical activity resources because there's a lot of links and handouts and online videos for older adults to do exercise that I think are just really great resources – so please check that out. The only tip that I'm going to emphasize here is the mind-related tip. A lot of the interventionists on our team get a little bit tripped up on mind because they feel like the skill or the goal needs to be a cognitively

based skill or goal. So, you might remember, from when Samantha was sharing about the section that we have three different strategies in the mind section, so I'm going to go back to that slide briefly so you can see. The first one being examine, which goes with cognitive restructuring, which you can certainly try if people are up for it. The second being shift, which is a positive coping statement, and the third being practice, which is using a coping skill. And so, if a Veteran is having difficulty engaging with a cognitively based mind strategy, that is okay. They can do some other skill to help shift their mindset and take their mind off their negative thoughts. And that could very well be a goal that seems like it fits with body, or it seems like it fits with connection, right, like, "Oh, I think I'll call someone when I'm feeling down. I'll for a walk" you know, that kind of thing. But, you know, the categories are, all of this is interconnected. So, you know, stay flexible and go with what the Veteran identifies or is excited about. Okay, very good. I did want to talk about troubleshooting challenges, so I'm going to go over by just a couple of minutes so I can talk about some of this. I think the main one that I want to highlight is getting buy in. So, frequently I come across Veterans who, you know, they agree to do the Connection Plan session with you, but, you know, they're not really sure about doing the Connection Plan Intervention. They're not sure that it's really going to work. They have tried a lot of different things to feel more connected and nothing has really worked for them and so they're frustrated. They feel anxious about trying new things and all that kind of stuff. And so, when that comes up in a Connection Plan Session it can be frustrating for interventionists. So, there are a couple of different scenarios that have come up around getting buy in. One is when you have

a Veteran who does say they're distressed, they're having quite a hard time, but they feel like there's nothing that can really work, or all the suggestions that you make are not really helpful, and so that can be quite frustrating because you really want to do something to help, but they don't seem to be receptive to your suggestions. So, the number one recommendation is, of course, to be validating, be flexible, be patient and you can both emphasize that creating and following through on the plan is totally voluntary, but also stay really positive and hopeful and say, "You know this is something that other Veterans have used and like and it helps them, I don't know if it will help you, and it sounds like you've tried a lot of different things, it's very frustrating and, you know, maybe we can just try to think of some new things together and you can try them over the next couple of weeks. If you don't try them, that's fine too", you know… what do you think? So really meeting the person where they are, you know, tuning into your own frustration, taking a deep breath, and then coming back to validating their experience. Another scenario that might come up is a Veteran who just sort of says that everything is fine. So, "I think I'm doing okay. I don't really see anybody but I think everything is just fine and I think we'll just, you know I think I'm coping fine" and that kind of thing. And so that person may not really be amenable for setting new goals, so my recommendation in that case is that you can write down what the Veteran is already doing and that can be the plan. So, it's very strengthens focused right, you say, "Wow, it sounds like your coping really well, that's great. What are all the things your doing to cope for body and mind and connection? That's excellent – I'm going to write that down and, you know, what do you think about doing a little

bit more of some of this or trying something new? Oh, okay, you don't want to. That's all right, I'm gonna go ahead and mail this to you, and you keep trying this, doing this stuff, and I'm just gonna check in in a couple of weeks and see if you want to add anything new then." So again, meeting people where they are. It's okay if we're just reinforcing the coping skills that they're already using – that in itself is empowering, right? And then the third tip that I often give folks is if you are in the place where you feel like you're not getting buy in from the Veteran, one question you can always ask is "You know, it doesn't really seem like your interested in setting a lot of goals for this plan, and I just want to know how you feel like this conversation is going?" And so just getting an idea from them about whether they feel really frustrated and they want to hang up, they don't think it's gonna work, or if they're like, "Oh, you know what, I really enjoyed talking to you." You know, and may be the conversation in itself is feeing comforting and reassuring in some way. Or something in the middle, right? And so again, we're meeting folks where they are and working from there. Okay, so I've gone a bit over, my apologies. But I'll just talk about this final slide briefly. In case I haven't given you the message enough, please go download the manual, give it a try. We're really, really open to feedback from folks, so if you could share your thoughts after trying it, in our survey, the link is right there. And then we're going to be offering consultation office hours on Teams at the dates specified on the slide – so there's instructions there on how to join our VA Connection Plan Team on Teams, and so in that space you'll receive notices about the office hours, and you can join through there. Any many thanks to our big team. I'll stop now for questions. Thanks. Ralf

Schneider: Great. I see John had a question, actually two questions that he posed. Not sure, I thought I saw Samantha fielding that. One was asking about if in the Connection Plans Manual there is a template or example available, and there's the template. Great. And I know you all provided examples during the presentation. Dr. Samantha Hack: Yep. So, I just wanted to touch on that this is what the My Connection Plan templates looks like, and this is available in the manual, as well as completed examples. And I'm gonna progress, if you forward to, this was the case study that we included and you can see these are some examples of what a completed Connection Plan Goal may look like. Ralf Schneider: Right, great. And John's follow-up was also thinking ahead to the MBC side, measurement-based care, are those tools available in CPRS? Do you have any other thoughts on those? Dr. Samantha Hack: Yeah, so, I don't know if those are specifically in CPRS. The list of measurement-based care evaluation that we recommend is in the manual along with links to the actual full measure so that you can use those. And then I was responding and I saw that Steven XXXXX said "Can you go back to the definitions of objective versus subjective social isolation?" So, I pulled up that slide that Amanda can probably talk more. Dr. Amanda Peebles: I don't know if we need to discuss this more – it's really just getting at the idea that the objective social isolation is like measurable things like, you know, the actual number, like counting the number of people that are in somebody's social network or the frequency of the contacts that they have with those people, whereas subjective is the feelings that go along with social isolation such as loneliness or perceiving that the social support your receiving is not adequate for what your needs are. Ralf Schneider: Great.

Thanks for that clarification Amanda. And, we are running out of time, so, I believe you all have access to the link to Connection Plans, but also our presenters would love your feedback as you try it out [audio cut out], and we will see you all then. Thank you.

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