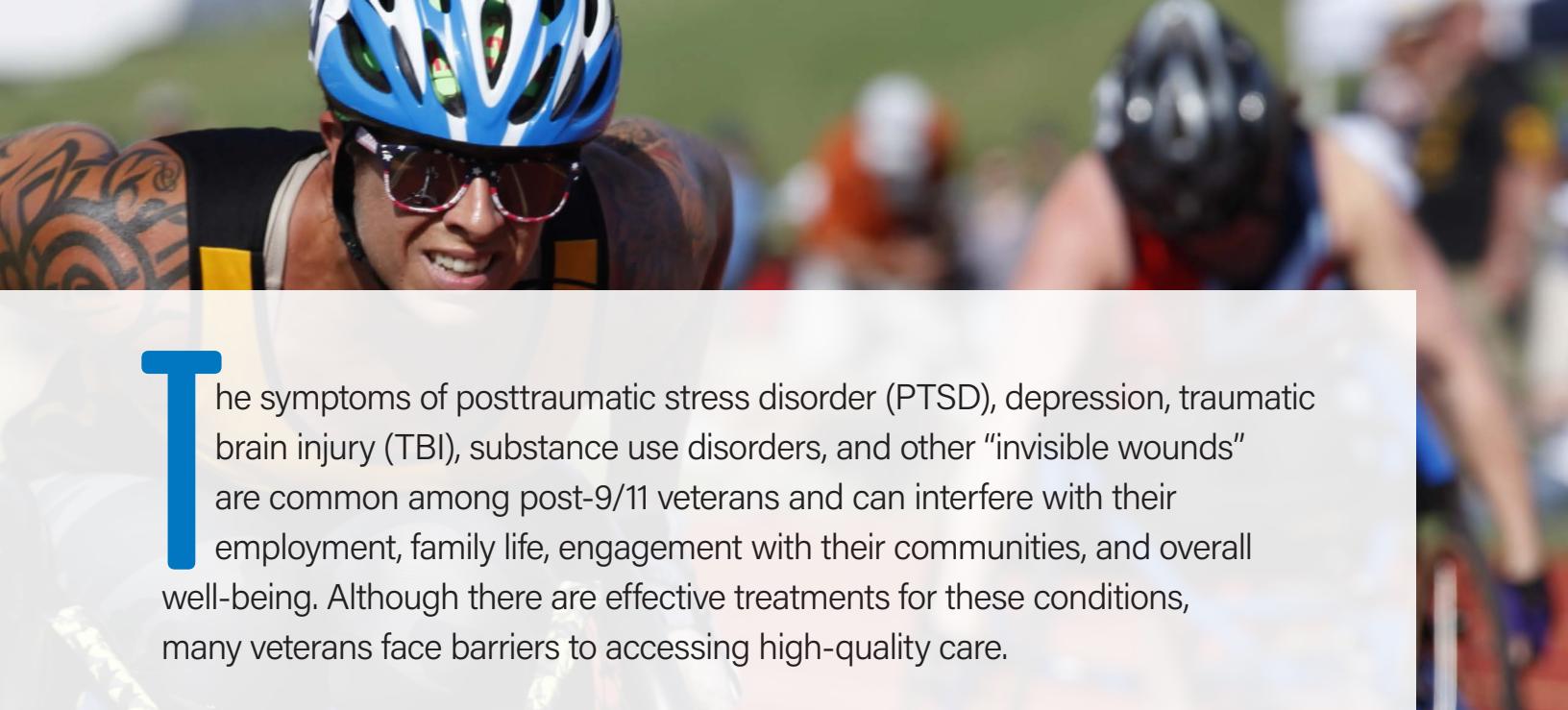




SETTING STANDARDS FOR DELIVERING **HIGH-QUALITY CARE** TO VETERANS WITH INVISIBLE WOUNDS



The symptoms of posttraumatic stress disorder (PTSD), depression, traumatic brain injury (TBI), substance use disorders, and other “invisible wounds” are common among post-9/11 veterans and can interfere with their employment, family life, engagement with their communities, and overall well-being. Although there are effective treatments for these conditions, many veterans face barriers to accessing high-quality care.

The Veteran Wellness Alliance, an initiative of the George W. Bush Institute, is a coalition of seven veteran peer network organizations and nine clinical provider organizations that aims to improve access to high-quality care for post-9/11 veterans with invisible wounds. The alliance collaborated with RAND researchers to develop a shared definition of high-quality care and identify corresponding standards of care for treating invisible wounds.

There are four components of the shared definition of high-quality care for veterans with PTSD, depression, substance use disorders, and TBI:

- 1. Veteran-centered care:** High-quality care accounts for veterans’ unique needs, values, and preferences. Providers are culturally competent and assess veterans’ experiences, engage them in shared decisionmaking, and involve family members and caregivers in their treatment.
- 2. Accessible care:** High-quality care is both accessible and timely.
- 3. Evidence-based care:** High-quality care is based on the best available research and adheres to clinical practice guidelines. Providers perform a comprehensive assessment to guide treatment; conduct screenings; and take an interdisciplinary, team-based approach to care.
- 4. Outcome monitoring:** High-quality care promotes the use of validated measurement tools to assess and monitor clinical outcomes and veterans’ well-being, guide treatment decisions, and facilitate coordination.

Although the definition is useful for establishing the essential tenets of high-quality care, operationalizing the definition through a set of standards of care can allow veterans, policymakers, providers, and payers to identify clinical providers who serve veterans and are currently delivering high-quality care. Standards of care are more specific than a definition and are intended to set a benchmark for what should be considered high-quality care. Standards of care can also provide a target for quality improvement: Providers who are not currently delivering high-quality care can identify gaps in the care they provide by comparing their care with the standards and implement necessary practice changes.

To arrive at an evidence-based, useful set of standards of care, RAND researchers conducted a rigorous literature review and interviewed Veteran Wellness Alliance clinical partners to expand the definition of *high-quality care for invisible wounds* to include depression and substance use disorders, in addition to PTSD and TBI.

A collaborative process informed the operationalization of the high-quality care definition into standards of care. The first step was to identify existing quality measures that assess the performance of health care providers in delivering high-quality care to veterans with invisible wounds. These measures were an important source of information about what should be considered best practices or standards of care. The next step was to translate these existing measures into standards while retaining the measure concept and setting aside any specifications that were not relevant to high-quality care for veterans (e.g., inclusion criteria, numerator, and denominator). Where no measures existed, RAND researchers proposed standards of care based on their expertise and previous research.

Characteristics of Standards of Care for Invisible Wounds

For standards of care to be useful, they must be feasible to apply and must address important aspects of care.

Feasibility

From an initial list of 103 potential high-quality care measures and standards, 33 were *feasible* to collect—that is, the necessary data were available, and collecting these data resulted in a minimal burden on programs and providers.

Importance

Standards of care were considered *important* if clinicians and administrators rated them as

addressing a very important element of high-quality care. Ambiguous standards and those that applied to only a subpopulation of veterans were considered of low importance. Of the 33 standards of care that were considered feasible, 17 were rated as highly important.

Recommended Standards of High-Quality Care

Incorporating feedback from clinical providers, administrators, and policymakers, the researchers consolidated and edited standards for clarity, parsimony, and specificity and recommended a set of ten standards of care (shown below) that address each of the pillars of high-quality care and all four conditions.

Veteran-centered care

- Veterans report being told about treatment options.
- Program/clinic staff who interact with veterans have completed training in military cultural competence.



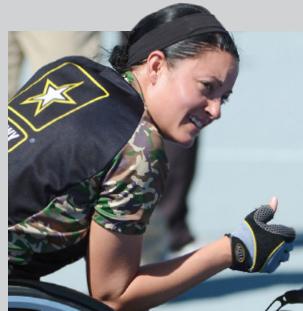
Accessible care

- Care is available at no or minimal cost to veterans: Program accepts insurance, has resources to support veterans without insurance, or is free.
- Veterans who request a new outpatient appointment are seen within 30 days.



Evidence-based care*

- Veterans are assessed for suicide risk at each visit.
- Veterans with depression/PTSD receive evidence-based psychotherapy and/or pharmacotherapy for depression/PTSD.
- Veterans with substance use disorder are offered a psychosocial intervention.
- Veterans with co-occurring conditions (e.g., mental health and substance use, mental health and TBI) receive integrated care.
- Program offers or facilitates coordinated, interdisciplinary rehabilitation for veterans with TBI.



Outcome monitoring

- Program uses validated instruments to assess clinical symptoms during regular measurement periods (e.g., every 4 months).



* Examples of evidence-based treatments

- Evidence-based psychotherapies for depression include acceptance and commitment therapy, behavioral therapy/behavioral activation, cognitive behavioral therapy (CBT), interpersonal therapy, mindfulness-based cognitive therapy, and problem-solving therapy.
- Evidence-based trauma-focused psychotherapies for PTSD include prolonged exposure, cognitive processing therapy, eye movement desensitization and reprocessing, CBT for PTSD, brief eclectic psychotherapy, narrative exposure therapy, and written exposure therapy.
- Psychosocial interventions for substance use disorder include behavioral couples therapy, CBT, the community reinforcement approach, motivational enhancement therapy, and 12-step facilitation. Psychosocial interventions are recommended for alcohol, cannabis, and stimulant use disorders. The evidence is unclear on the benefit of psychosocial interventions for opioid use disorder.

Operationalizing Standards of High-Quality Care to Improve Treatment and Support for Veterans

A shared definition and standards for high-quality care can help organizations that support veterans better assist in their recovery from invisible wounds. And widespread adoption and use of these standards can spur improvements in the quality of care that veterans receive and subsequent improvements in their quality of life. The following recommendations are intended to help put these standards into practice.

Disseminate the Definition of High-Quality Care and Standards for Applying It

Broad dissemination of the definition and standards can improve veterans' outcomes by distinguishing high-quality care that meets these standards from care that does not. There are numerous established approaches to treatment for invisible wounds that have been extensively researched and should always be used as first-line treatments. As the field evolves, a focus on evidence-based care as a key component of high-quality care will lead to better outcomes for veterans with invisible wounds.

Provide Resources and Incentives for Quality Improvement

Providers who do not meet the standards of high-quality care need to address gaps in quality, which will require training, resources, and incentives for quality improvement.

Start with a Minimum Set of Standards

Before the standards can be applied, there must be processes in place to collect data on care quality. For example, for several standards, data collection could require adding questions to existing patient-experience surveys or adding fields to administrative databases. It might be difficult for some providers to collect data for all ten standards of high-quality care without additional funding and resources. An initial focus on three key standards that apply to all four components of high-quality care can serve as a first step in operationalizing the full set of standards:



1. Demonstrate that veteran-facing clinical staff have received training in military cultural competence. Specific military cultural competence training allows providers to consider the unique experiences, concerns, and values of veterans and to incorporate veterans' goals and preferences into care plans.
2. Demonstrate that the care provided is evidence based. Those who provide care for veterans with PTSD or depression must deliver an evidence-based psychotherapy or pharmacotherapy. Providers who treat veterans with substance use disorder must offer a psychosocial intervention, and those who treat TBI must provide or facilitate interdisciplinary rehabilitation. Ideally, evidence-based care should also include regular monitoring of clinical symptoms with a validated instrument.
3. Collect data and report on timeliness to ensure that veterans seeking care can be seen by a provider within 30 days.

Although clinicians who care for veterans should aim to meet all ten high-quality care standards, these three represent the minimum, essential set of standards that providers should meet to demonstrate that they provide high-quality care.

This brief describes work done in RAND Health Care and documented in *Recommended Standards for Delivering High-Quality Care to Veterans with Invisible Wounds*, by Carrie M. Farmer, Sierra Smucker, Natalie Ernecoff, and Hamad Al Abrahim, RR-A1728-1, 2022 (available at www.rand.org/t/RRA1728-1). To view this brief online, visit www.rand.org/t/RRA1728-1.

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