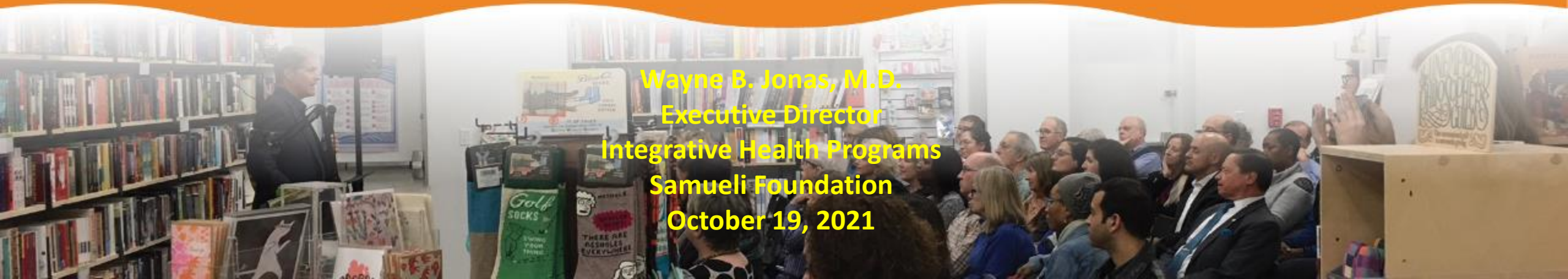
Transforming our Model of Care

Recommendations from the COVER Commission



Wayne B. Jonas, M.D.
Executive Director
Integrative Health Programs
Samueli Foundation
October 19, 2021

COVER COMMISSION
Creating Options for Veterans' Expedited Recovery

Report Released January 24, 2020

In accordance with the Comprehensive Addiction and Recovery Act (CARA, Sec 931), the **Creating Options for Veterans Expedited Recovery (COVER) Commission** provided recommendations to the President of the United States, the United States Congress, and the Secretary of Veterans Affairs.

COVER COMMISSION
Creating Options for Veterans' Expedited Recovery

Diverse and Experienced Members

- Thomas (Jake) J. Leinenkugel, Chair
- RADM Thomas (Tom) E. Beeman, PhD, U.S. Navy (Ret.), Cochair
- Col. Matthew (Matt) F. Amidon, U.S. Marine Corps Reserve
- The Honorable Thomas E. Harvey, Esq. Ltc.
- Wayne B. Jonas, MD, U.S. Army (Ret.) LtCol
- Jamil S. Khan, U.S. Marine Corps (Ret.)
- Matthew (Matt) J. Kuntz, Esq.
- Shira Maguen, PhD
- Maj. Michael (Mike) J. Potoczniak, PhD, U.S. Army Reserve
- CAPT John (Jack) M. Rose, U.S. Navy (Ret.)

Broad Charge

COVER COMMISSION
Creating Options for Veterans' Expedited Recovery

"The COVER Commission's charge required far-reaching examination of the treatment models used by VA in treating veterans' mental health. Throughout its research and deliberation processes, the commission put the needs of veterans at the heart of its work. **The commission strove to conduct a comprehensive, evidenced-based review of key treatment modalities; held public meetings; met with a broad range of organizations and clinical providers; made site visits to VA facilities in different regions; and, perhaps most importantly, directly engaged veterans throughout the nation using a variety of channels, including listening sessions and focus groups."**

MODELS AND METRICS

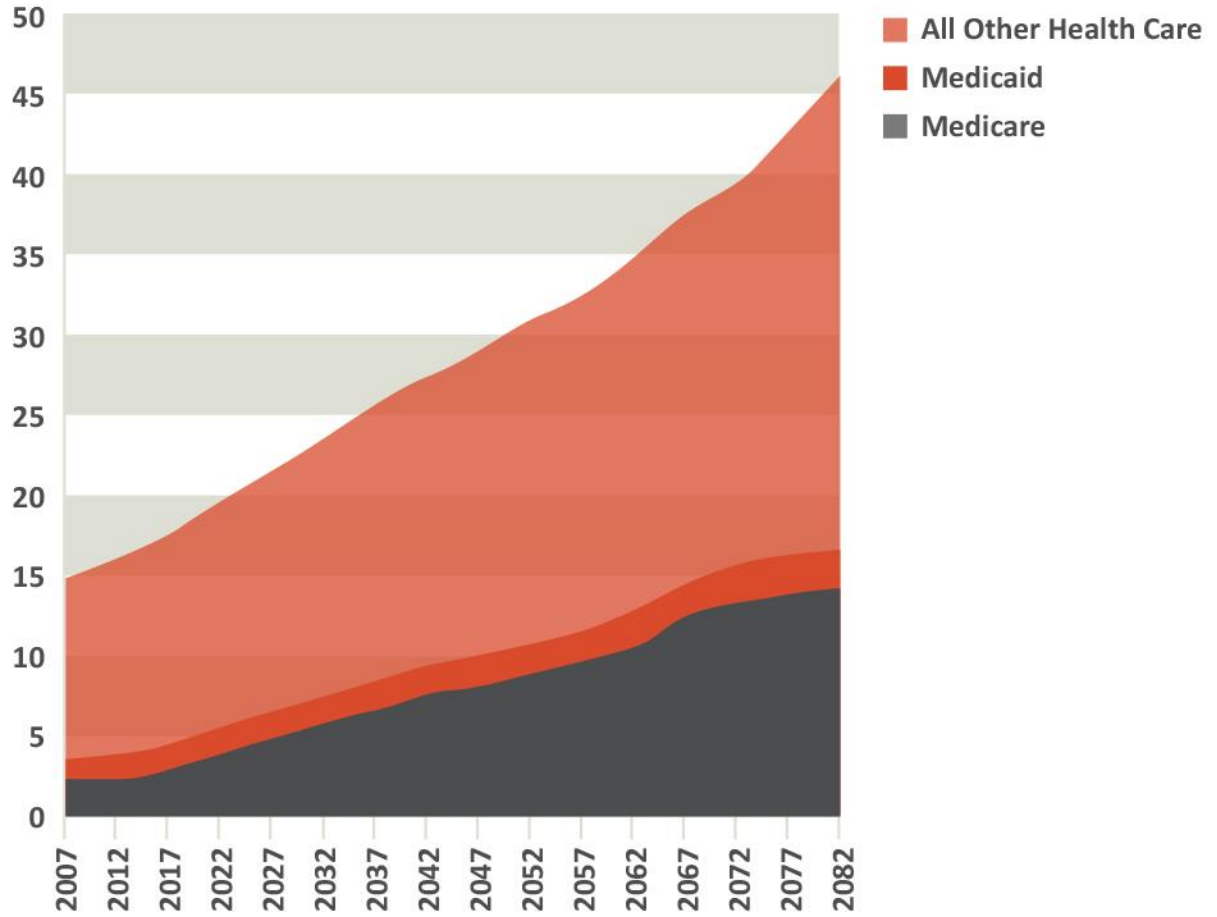
- **Mental Health**
  - Model – STEPPED Care Principles and
  - Metrics – SAIL
- **Primary Care**
  - Model – PACT and PCMH Standards.
  - Metrics – CMS Advanced Primary Care, PCMH Tools, AAFP Advance Primary Care
- **Whole Health and CIH**
  - Model – Whole Health and reviews of CIH and Mental Health
  - Metrics – Whole Health metrics being tracked – health & wellbeing
- **Integration Models**
  - PCMHI, Whole Health and Mental Health
  - Models of Learning and Quality Improvement
- **Integrated Metrics**
  - Quadruple AIM Metrics – Cost/Quality/Outcome/Satisfaction/Burnout
  - Veteran Specific Metrics and Experience
  - Wellness Metrics
  - Overall Quality of Care Ratings Comparing VA to Civilian System
  - Others looking at Consistency, Population Health/Social Determinants, Community Integration

COVER COMMISSION
Creating Options for Veterans' Expedited Recovery

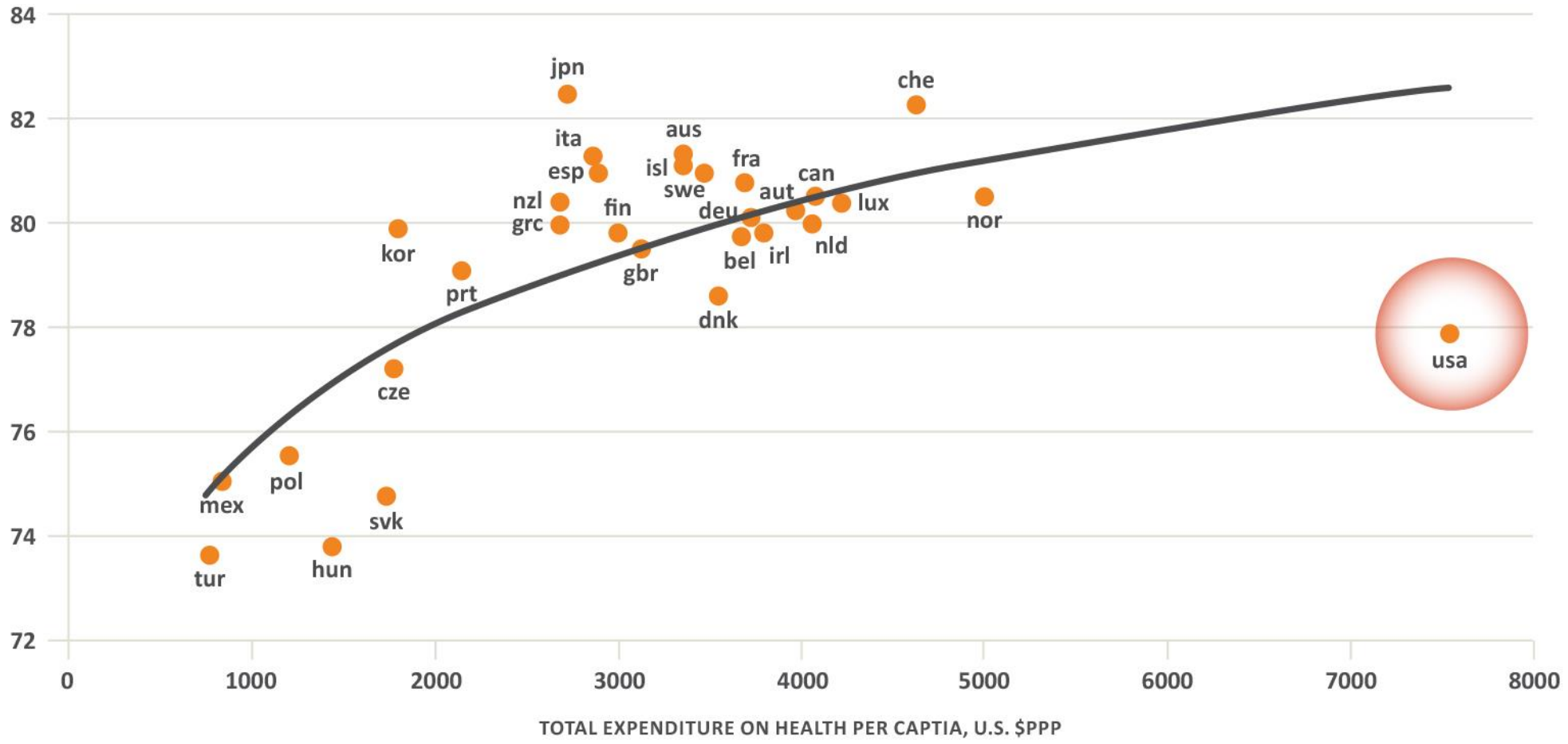
How do we get from delivering ***health care*** to creating ***health and wellbeing***?

CHALLENGES TO OUR CURRENT HEALTH CARE SYSTEM

- We are **FIRST** in spending
- **37th** in health by WHO
- **20%** of the GNP by 2025
- Health disparities are **INCREASING**

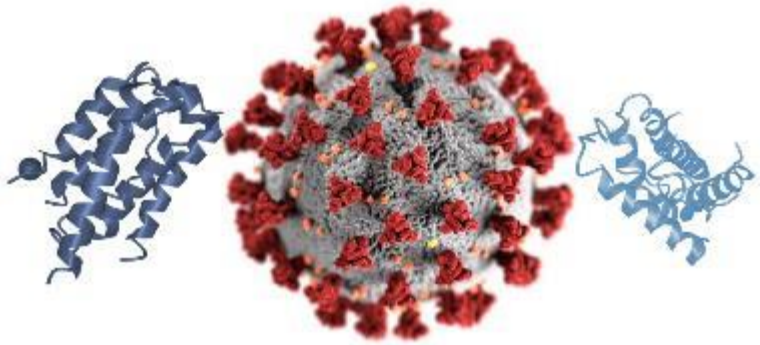


PER CAPITA HEALTH EXPENDITURES & LIFE EXPECTANCY

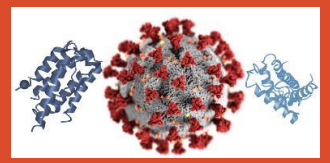


Source: *Institute of Medicine. For the Public's Health: Investing in a Healthier Future. Committee on Public Health Strategies to Improve Health, Board on Population Health and Public Health Practice. Washington, DC: National Academies Press, 2012*

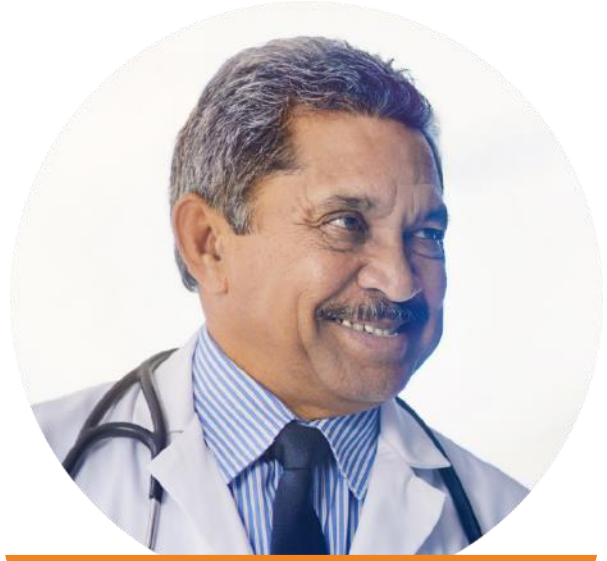
COVID-19



SARS-COV-2



COVID AND OUR CURRENT HEALTH CARE SYSTEM



PRIMARY CARE PHYSICIANS

By the end of 2020,

- 25% permanently lost practice members
- 41% have unfilled staff roles
- 48% report mental exhaustion

Primary Care Collab. Covid Survey, Larry Green Center, Nov-Dec 2020

FAMILY DECISION MAKERS

- More mental health crises
- More obesity, addiction, community violence
- Increases in racial disparities

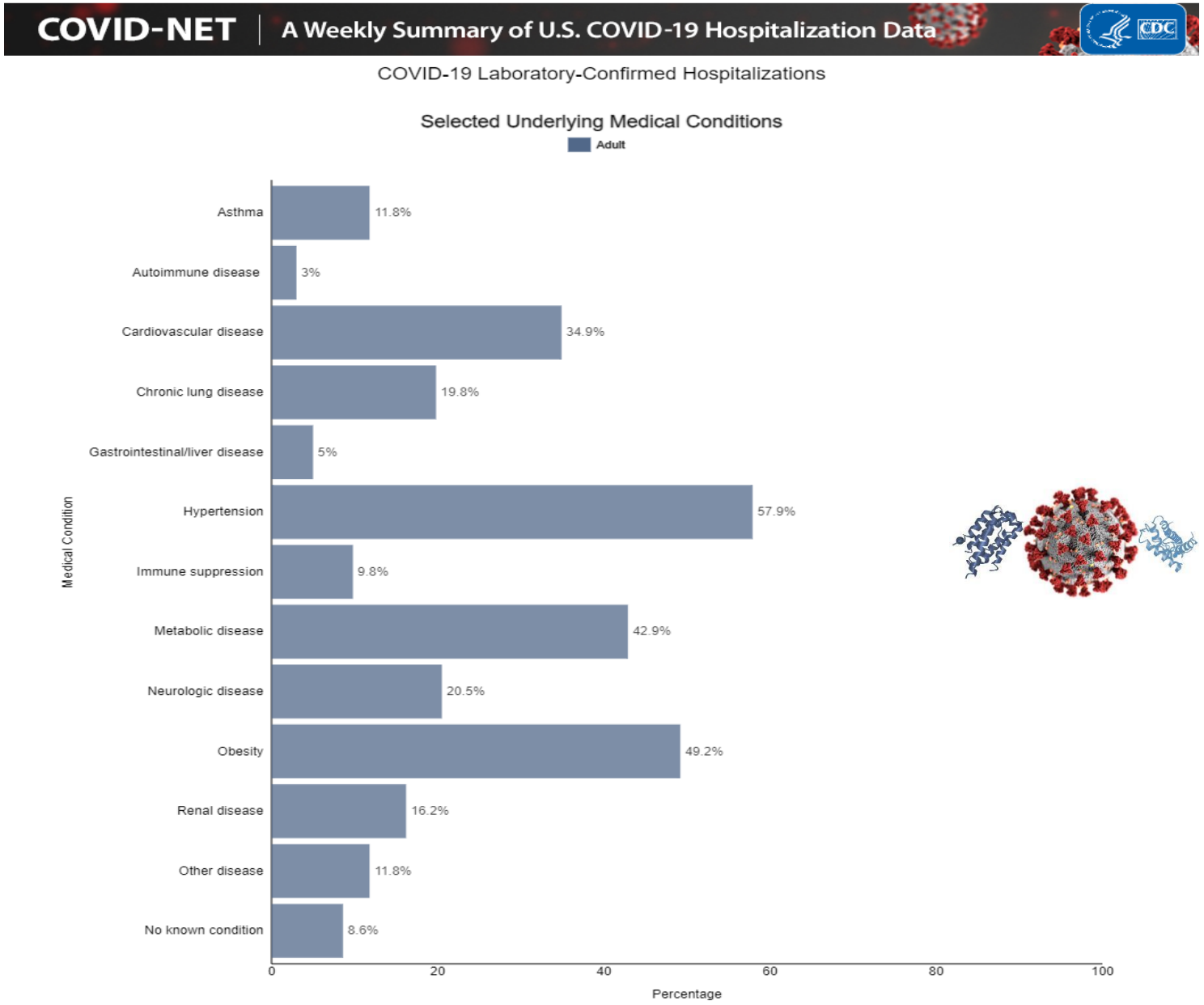
Primary Care Collab. Covid Survey, Larry Green Center, Feb 2021

Disparities, NEJM, July 2020

HEALTH CARE EXECUTIVES

- ICUs at and over capacity
- Revenues have declined
- Rural systems are closing
- Quality improvements on hold

Fierce Healthcare, Feb 2021



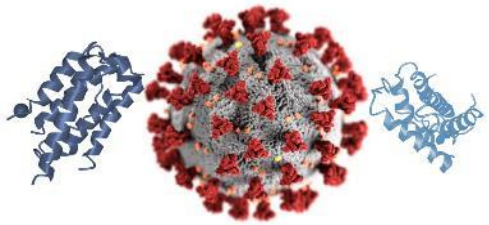
WHO DIES WITH COVID?

THE SAME PEOPLE AS BEFORE COVID

- Elderly
- Chronic Disease
- Blacks
- Hispanics
- Native Americans
- Low Income
- Poor Healthcare
- Service Jobs

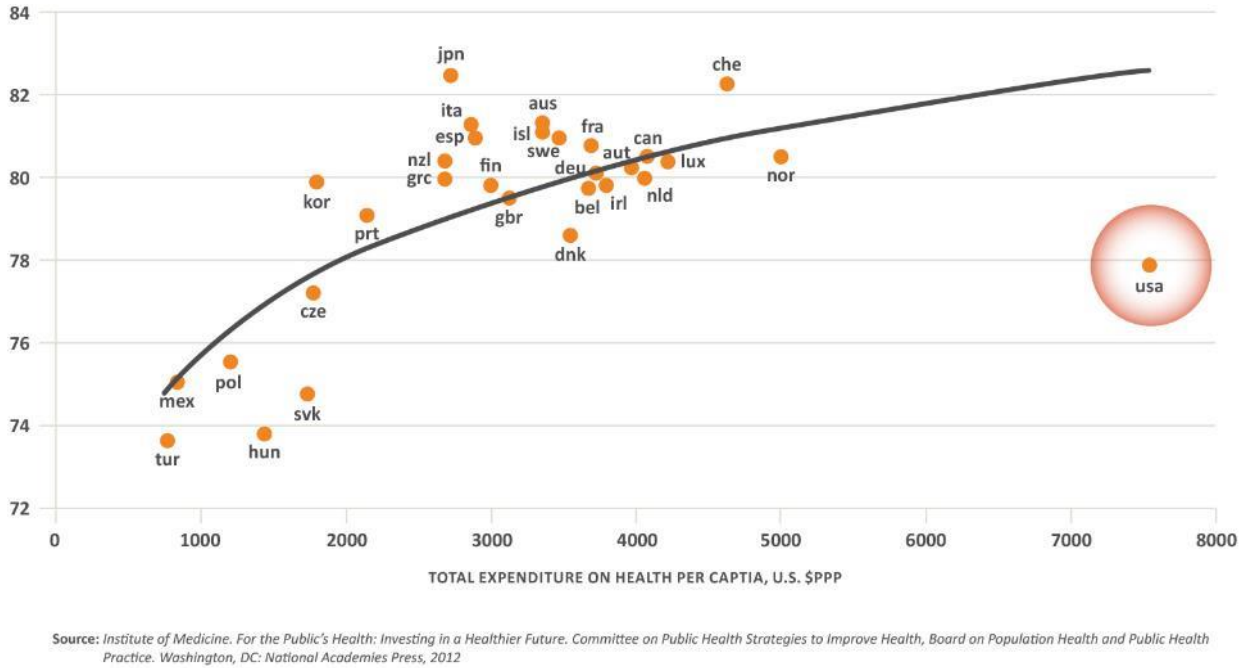
Source: CDC - COVID-NET
https://gis.cdc.gov/grasp/covidnet/COVID19_5.html
Accessed 02/22/2021.

COVID IMPACT ON LIFE EXPECTANCY



- **1-year reduction**
- **3-4 times that in people of color**

We project that COVID-19 will reduce US life expectancy in 2020 by 1.13 y. Estimated reductions for the Black and Latino populations are 3 to 4 times that for Whites. Consequently, COVID-19 is expected to reverse over 10 y of progress made in closing the Black−White gap in life expectancy and reduce the previous Latino mortality advantage by over 70%. Some reduction in life expectancy may persist beyond 2020 because of continued COVID-19 mortality and long-term health, social, and economic impacts of the pandemic.

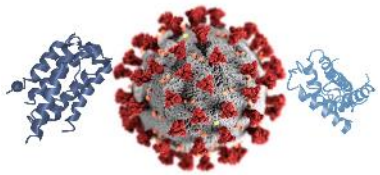


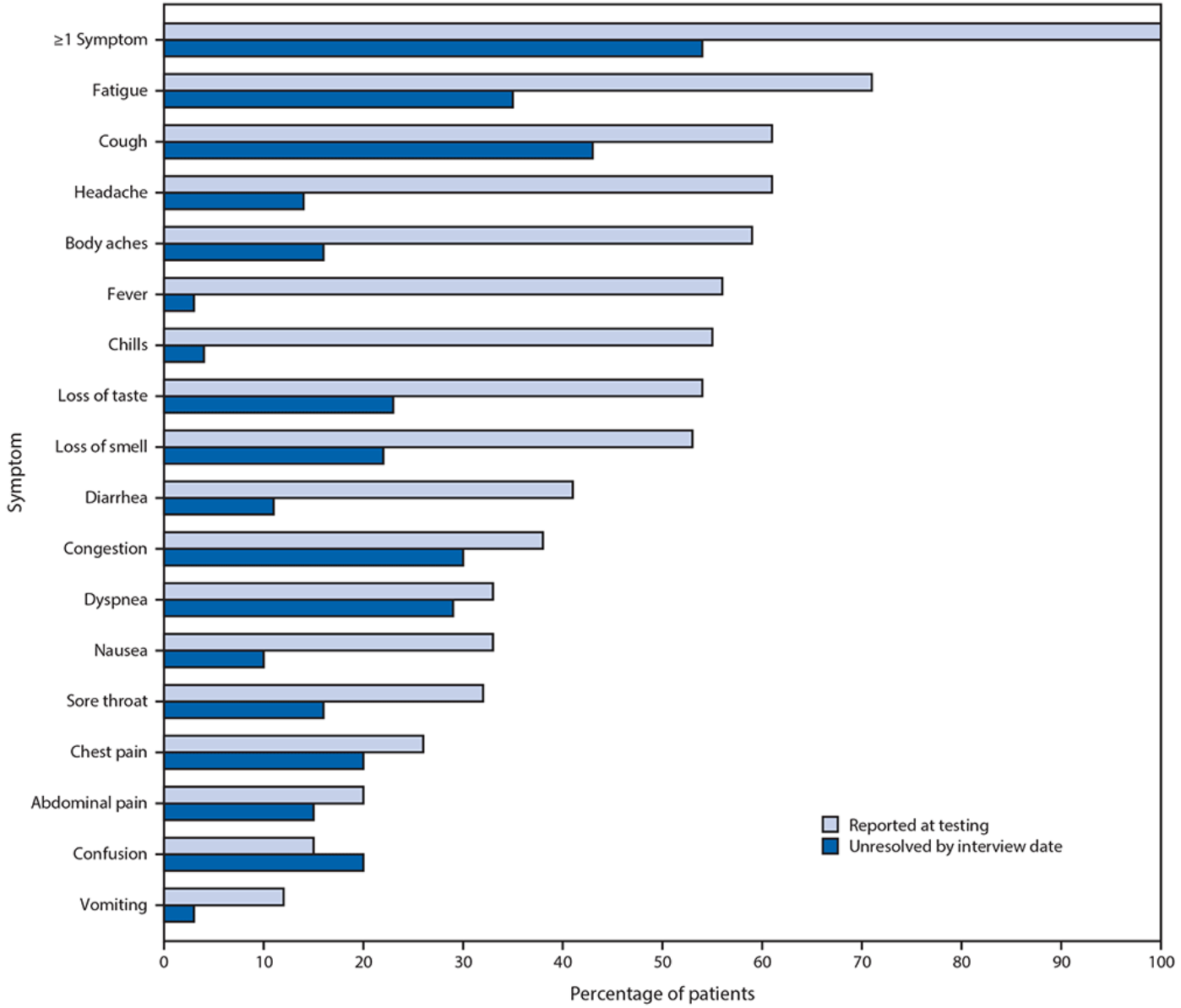
Source: *Institute of Medicine. For the Public's Health: Investing in a Healthier Future. Committee on Public Health Strategies to Improve Health, Board on Population Health and Public Health Practice. Washington, DC: National Academies Press, 2012*

Theresa Andrasfay and Noreen Goldman. Reductions in 2020 US life expectancy due to COVID-19 and the disproportionate impact on the Black and Latino populations. *PNAS* February 2, 2021 118 (5) e2014746118. https://doi.org/10.1073/pnas.2014746118

PERSISTANCE OF SYMPTOMS

One third to one half of post-COVID patients have significant symptoms 20-60 days after the infection.





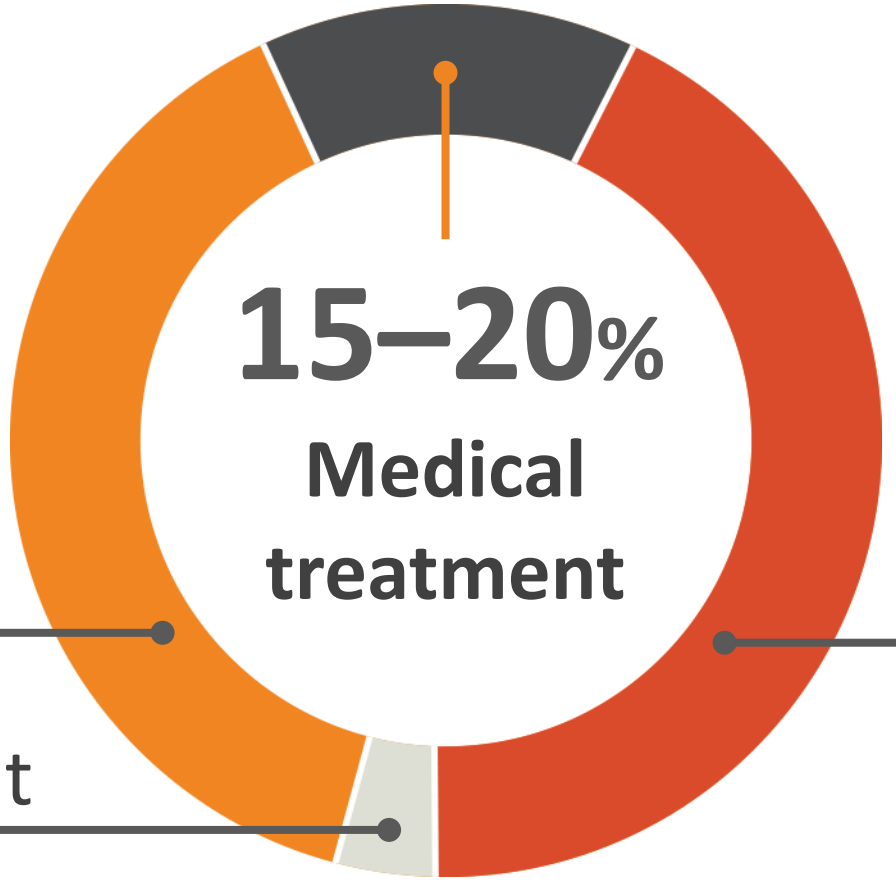
Tenforde MW, Kim SS, Lindsell CJ, et al. Symptom Duration and Risk Factors for Delayed Return to Usual Health Among Outpatients with COVID-19 in a Multistate Health Care Systems Network — United States, March–June 2020. MMWR Morb Mortal Wkly Rep 2020;69:993-998. DOI: http://dx.doi.org/10.15585/mmwr.mm6930e1external icon.

TRANSFORMATION

- Change our focus
- Change our thinking
- Change our tools
- Change our care models
- Change our metrics
- Change our payment
- Change = improve

CHANGE OUR FOCUS

Determinants of Healing



Behavior & Lifestyle Impacts

Social & Economic Impacts

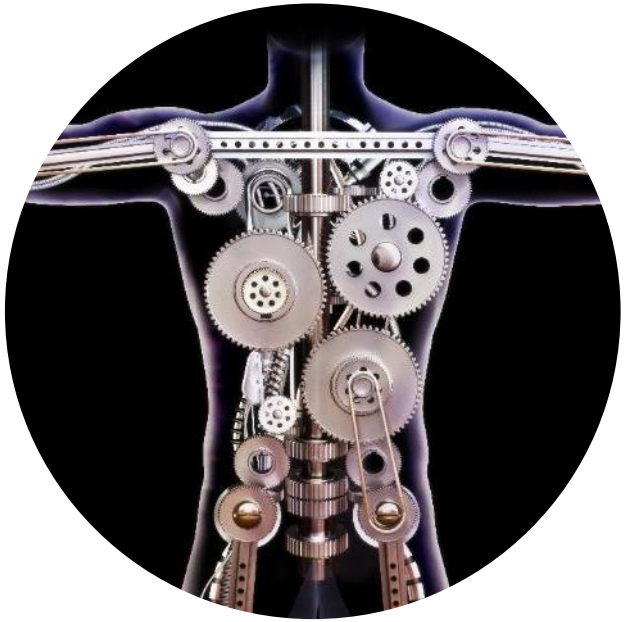
Environment

Source: *McGinnis JM, Williams-Russo P, Knickman JR. The Case For More Active Policy Attention To Health Promotion. Health Aff (Millwood). 2002 Mar-Apr;21(2):78-93. doi: 10.1377/ hlthaff.21.2.78*

CHANGE OUR THINKING

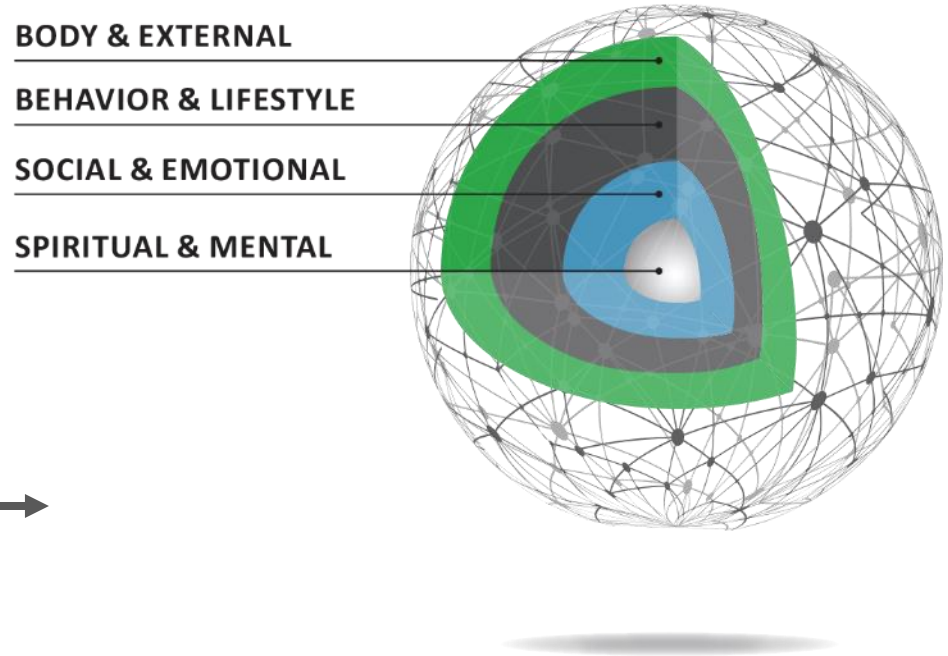
Mechanical Mindset

Parts of People



Ecological Mindset

Whole People and Communities



Acute Care Thinking

Chronic Care Thinking

CHANGE OUR TOOLS

THE SOAP NOTE

SUBJECTIVE, OBJECTIVE, ASSESSMENT, PLAN

Making the medical diagnosis and treatment plan

Asking "What's the matter?"

- ***Subjective*** **– what the patient describes**
- ***Objective*** **– what you observe and test**
- ***Assessment*** **– the diagnosis and CPT code**
- ***Plan*** **– your treatment and its access**

THE HOPE NOTE

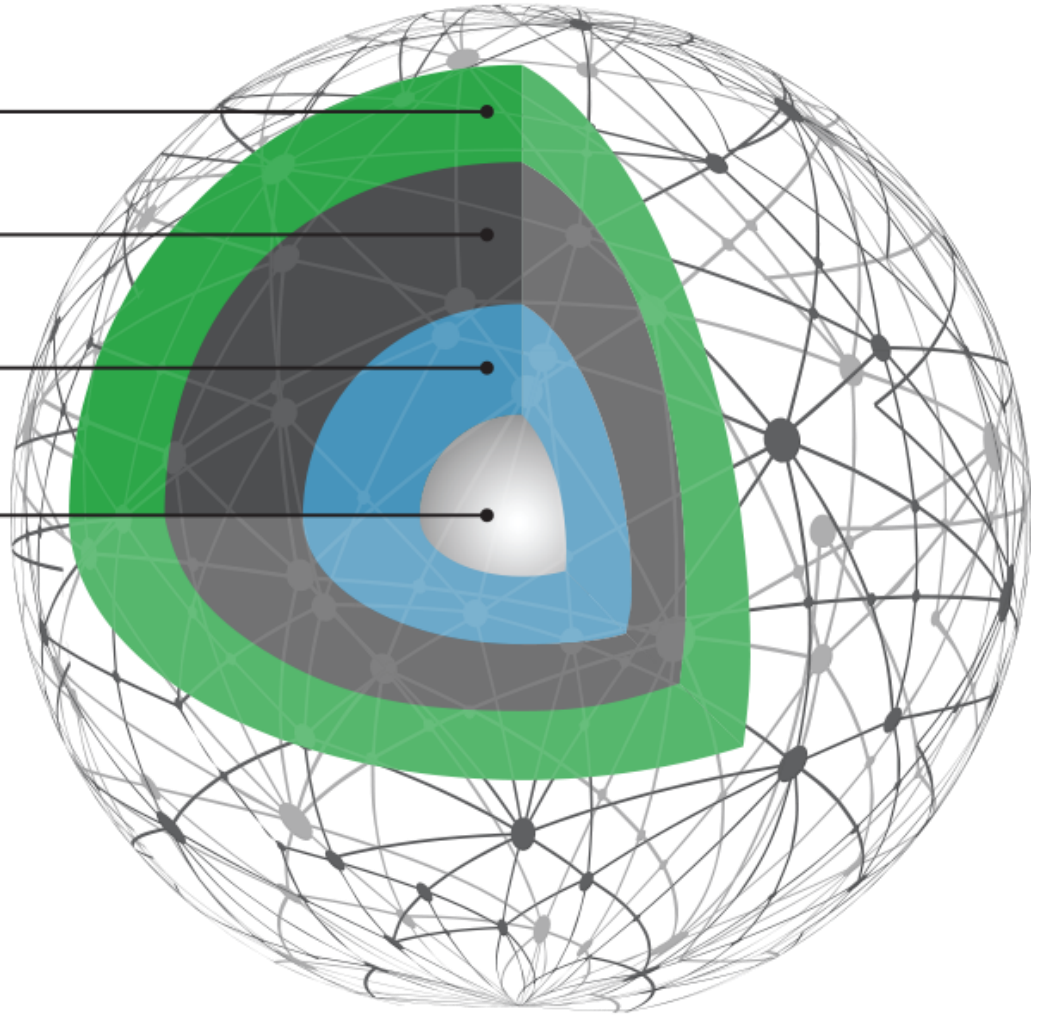
HEALING ORIENTED PRACTICES AND ENVIRONMENTS

BODY & EXTERNAL

BEHAVIOR & LIFESTYLE

SOCIAL & EMOTIONAL

SPIRITUAL & MENTAL

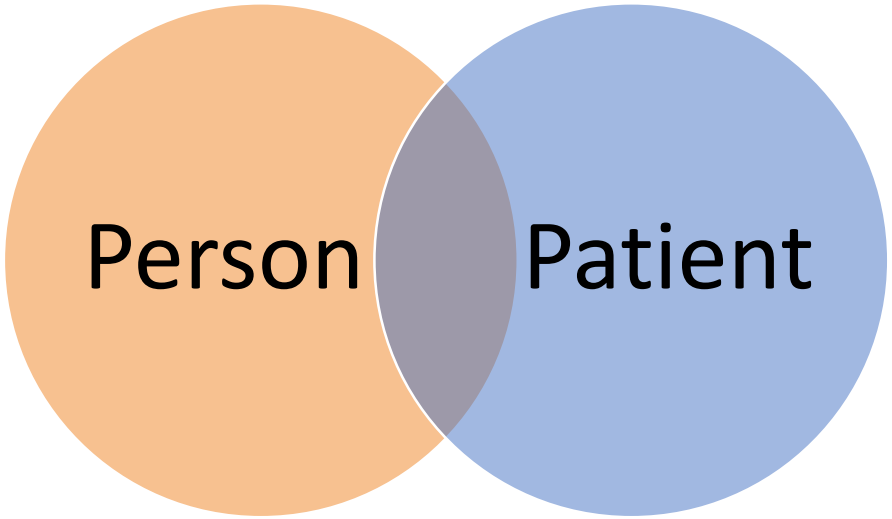


Exploring a patient's personal determinants of healing

Asking "What Matters?"

CHANGE OUR CARE MODEL

Models that integrate ***healing*** and ***curing***?



Salutogenesis and Pathogenesis

COVER COMMISSION
Creating Options for Veterans' Expedited Recovery

Ten Recommendations

Overarching Recommendation

"Commissioners agreed that a cross-cutting range of improvements are needed, but most importantly that the VA must transform its delivery model to one that is person-centered, relationship-based, and focused on veterans' whole health.

Additionally, the COVER Commission recognizes the need for a substantial investment in continued mental health research. There is shared belief that many promising therapies exist, but there continues to be limited understanding of exactly what the optimal mix of treatments might be for any particular condition."

COVER COMMISSION
Creating Options for Veterans' Expedited Recovery

Characteristics of the VA Transformation Model

1. Shift from a Medical-Centered to a Person-Centered Care Model: The Veteran Administration (VA) should accelerate its shift from an episodic, medical-centered model (patient-centered) to a model of care that is centered on what is most important to each veteran (person-centered).

a. **Focus on "What Matters" to the Veteran through the Personal Health Inventory (PHI).**
b. **Use the Personal Healing Plan (PHP) in All Encounters.**
c. **Create CHANGE TO USE Standard PHP Implementation Tools**.
d. **Embed the PHP into the Electronic Health Record.**
e. **Use all Health Technologies to Facilitate Delivery**.

Recommendation 3, pp. 60–77.

COVER COMMISSION
Creating Options for Veterans' Expedited Recovery

Characteristics of the VA Transformation Model

2. Shift from a Disease-Focused to a Recovery-Focused Model: For treating acute disease and saving lives, our current pathogenic (disease-oriented) model of care is stellar, and the VA should not abandon that. However, for the management of chronic and complex disease, this approach is failing. Therefore, for the prevention and treatment of chronic and complex conditions, the VA should shift from a pathogenic model to a **salutogenic (recovery-oriented) model** of care that taps into the veteran's inherent healing capacity.

a. **Use a Whole Person Assessment**.
b. **Re-Design Veteran Care Coordination.**
c. **Invest in Community Care.**
d. **Expand Peer and Group Support**.

Recommendation 3, pp. 60–77.

COVER COMMISSION
Creating Options for Veterans' Expedited Recovery

Characteristics of the VA Transformation Model

3. Shift from a Transactional to a Relationship Model: Currently, health care uses transactions that are restricted by time and money and so drive volume. However, the most effective health care models have shifted to relationship-based team approaches, where members of the care team take **personal responsibility** for the success of the patient's improvement and the patient is held accountable for their engagement in health behaviors and treatment plans.

a. **Re-design and Expand Peer-to-Peer Support:**
   A ratio of 1 care support specialist of this type for every 200 veterans is recommended.
b. **Hire Veterans who Understand Veterans.**
c. **Pay for Caring.**
d. **Re-organize the Electronic Health Record.**
e. **Quality Assessment Should be Person Centered using PROs**

Recommendation 3, pp. 60–77.

COVER COMMISSION
Creating Options for Veterans' Expedited Recovery

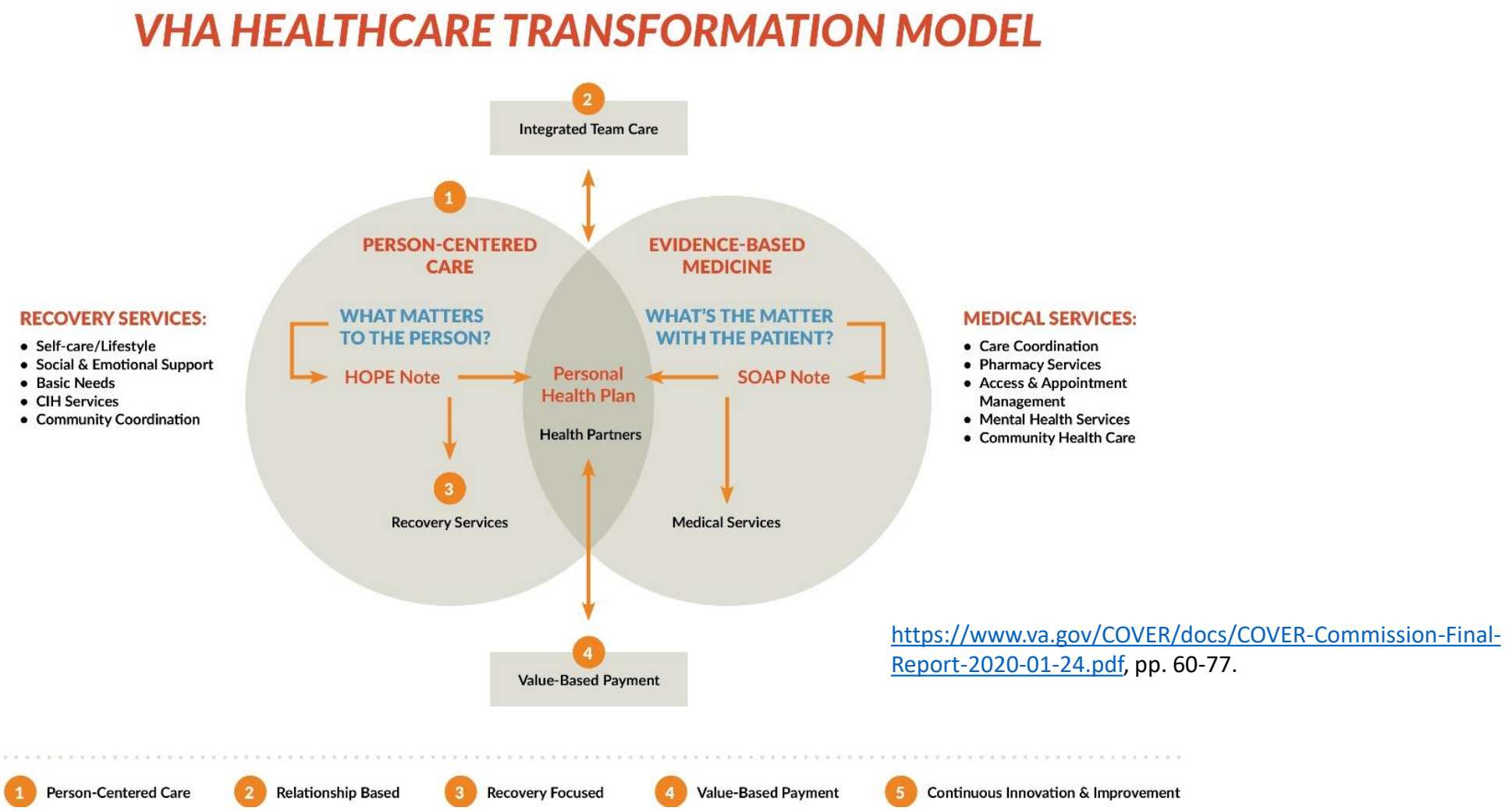
Characteristics of the VA Transformation Model

4. Shift from a Volume-Based to a Value-Based Payment Model. Value-based models using outcomes (rather than services) as the basis of payment have been shown to lower costs, improve health and enhance quality when properly applied**. Team care models that pay for the coordinated health needs of the whole veteran** should be the basis for payment in the VA and civilian systems who care for veterans.

a. **Shift to Outcome Based Payments**: Use *Quadruple Aim and performance metrics from the patient perspective.*
b. **Pay for Care Team Coordination.**
c. **Pay for Population Health.**
d. **Pay for Mental Health and Behavior Change.**
e. **Pay for Complementary and Integrative Health (CIH).**

Recommendation 3, pp. 60–77.

THE TWO-CIRCLE MODEL



https://www.va.gov/COVER/docs/COVER-Commission-Final-Report-2020-01-24.pdf, pp. 60-77.

COVER COMMISSION
Creating Options for Veterans' Expedited Recovery

Characteristics of the VA Transformation Model

5. Assure that all Veterans are Part of a Continuously Improving System. The VA appears to deliver better quality of care (on average) than non-VA systems for most outcomes and on quality improvement measures. However, quality varies considerably across the VA and in all of health care. Therefore, optimal care of veterans **both inside and outside of the VA** requires robust quality improvement systems that can rapidly adjust care for the veteran using continuous measurement of person-centered wellbeing outcomes.

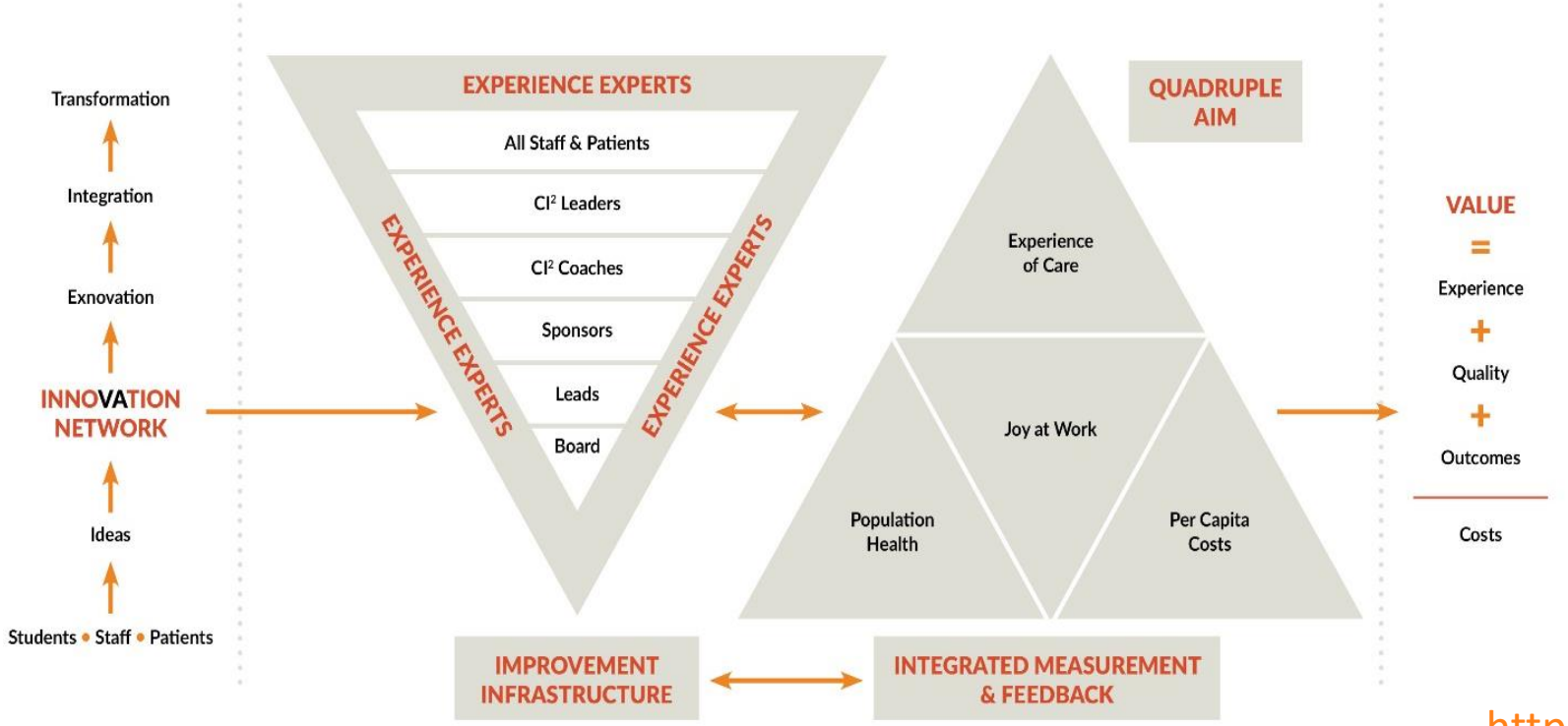
a. **Develop and Use Wellbeing Measures**.
b. **Invest in Continuous Quality Improvement.**
c. **Integrate all Quadruple Aim Metrics**.
d. **Contract with Optimal Systems of Care**.

Recommendation 3, pp. 60–77.

Innovation & improvement

COVER COMMISSION
Creating Options for Veterans' Expedited Recovery

5 CONTINUOUS INNOVATION & IMPROVEMENT (CI²)



Patterned after Current VA and Institute for Healthcare Improvement Approaches

http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx

The COVER Commission analyzed all published studies to date that directly compared VA and private-sector delivery systems. **This analysis showed that of the 295 outcomes reported in these studies 171 (57.9%) of the outcomes were superior in VA compared to the private sector, and 75 (25.4%) were superior in the public sector. The remaining were equal in both systems.** The superiority of VA performance appears to be especially true in mental health care, although the data were more limited in these areas. A huge variability in quality was found across VA. The commission found examples of some of the best and some of the worst health care delivery available in the country.

Is There a VA Advantage? Evidence from Dually Eligible Veterans
David C. Chan, David Card, Lowell Taylor, November 2020, Stanford

COVER COMMISSION

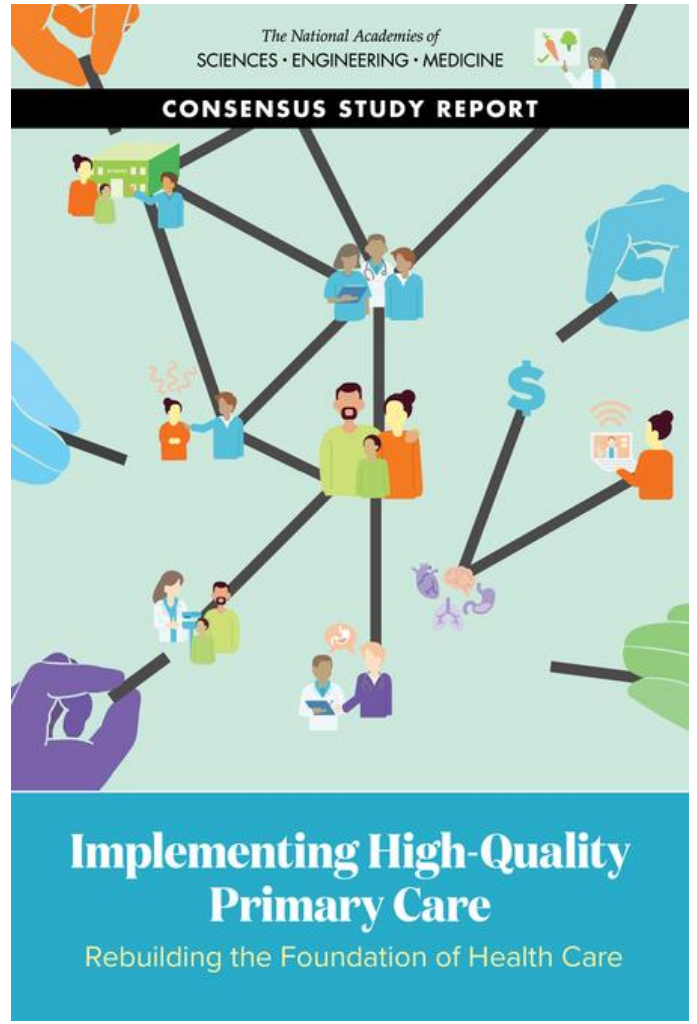
A WHOLE PERSON APPROACH IN PRIMARY CARE

WHAT IS HIGH-QUALITY PRIMARY CARE?

The provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.

RECOMMENDATIONS

1. **Pay for primary care teams to care for people, not doctors to deliver services.**
2. **Ensure that high-quality primary care is available to every individual and family in every community.**
3. **Train primary care teams where people live and work.**
4. **Design information technology that serves the patient, family, and the interprofessional care team.**
5. **Ensure that high-quality primary care is implemented in the United States.**



Implementing High-Quality Primary Care | National Academies

WHOLE PERSON HEALTH CARE FINANCING

The COVID-19 pandemic has highlighted the urgent need to transform our current model of health care financing from a system that rewards the volume of services to one that incentivizes real improvements in personal and population health.

How can we enhance integrated payment models that deliver whole-person health care to a community, as these models fared the best in terms of finances and patient care during the pandemic?

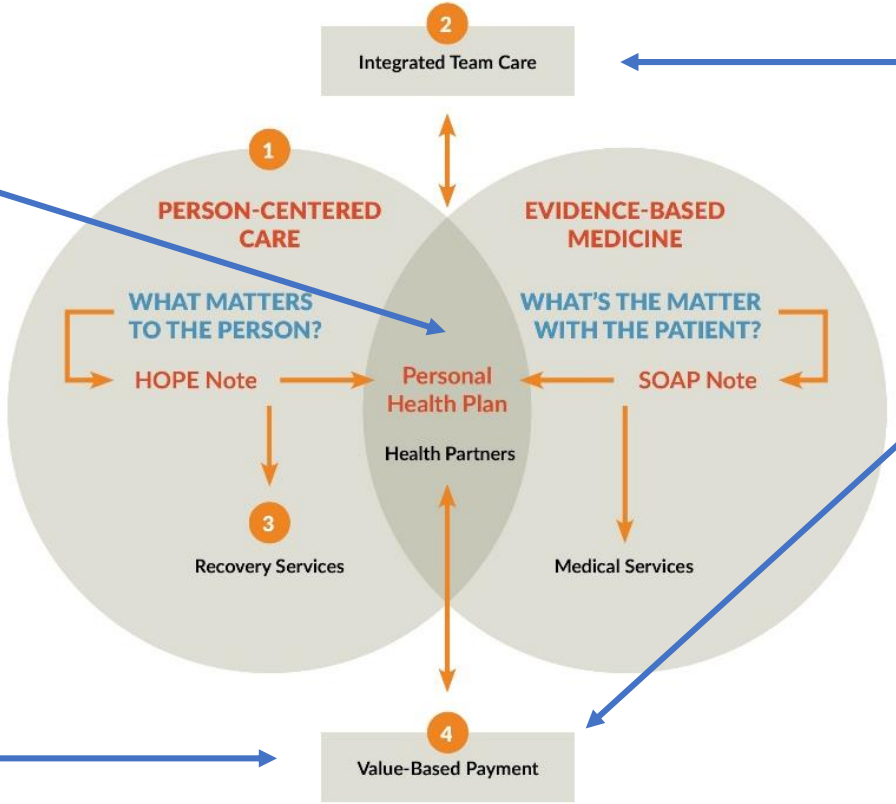
https://nam.edu/financing-that-rewards-health/

NATIONAL TRANSFORMATION

THE TWO-CIRCLE MODEL

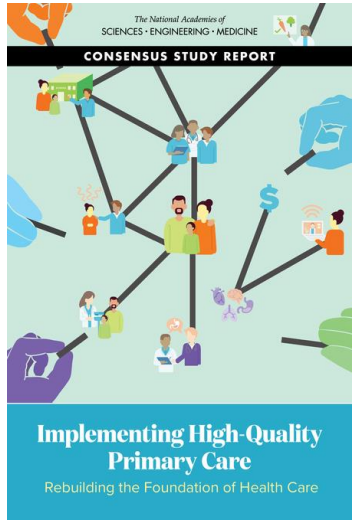
COVER COMMISSION
Creating Options for Veterans' Expedited Recovery

VHA HEALTHCARE TRANSFORMATION MODEL



RECOVERY SERVICES:
- Self-care/Lifestyle
- Social & Emotional Support
- Basic Needs
- CIH Services
- Community Coordination

MEDICAL SERVICES:
- Care Coordination
- Pharmacy Services
- Access & Appointment Management
- Mental Health Services
- Community Health Care



Primary Care

Financing

Financing that Rewards Better Health & Well-Being

U.S. Department of Veterans Affairs

1 Person-Centered Care
2 Relationship Based
3 Recovery Focused
4 Value-Based Payment
5 Continuous Innovation & Improvement

BEYOND THE TASK LIST

COVER COMMISSION
Creating Options for Veterans' Expedited Recovery

U.S. Department of Veterans Affairs

The National Academies of SCIENCES ENGINEERING MEDICINE

Transforming VA Health Care to Create Health for all Veterans

Committee Tasks

1. Where is "Whole Health" currently being implemented?
2. What does Whole Health accomplish?
3. How can effective Whole Health strategies spread?
4. What other factors affect the performance of Whole Health?