HSR&D
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FORUM
Translating research into quality health care for Veterans

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Commentary

Post-Deployment Injuries: A Core Responsibility and Challenge

Robert L. Jesse, M.D., Ph.D., Principal Deputy Under Secretary for Health, Washington, D.C.

Contents

Director's Letter 2

Co-Occurrence of Post-Deployment Health Problems 3

Research Highlight
- Findings from an HSR&D Funded Study of TBI 4

Research Highlight
- Pain Management and Post-Deployment Care 5

Research Highlight
- Women and Post-Deployment Health 6

HSR&D National Meeting Emphasizes Collaboration 7

Shekelle Receives 2011 Under Secretary's Award for Outstanding Achievement in Health Services Research 7

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History has long acknowledged the immediate and physical wounds of war. The less visible wounds have also been recognized throughout history, with each war bringing a unique perspective to the same fundamental problem – an often debilitating reaction to the stress of combat. An expanding knowledge of the nature of combat stress has led to a greater appreciation of the range and complexity of both the visible and less visible and/or delayed wounds of war. The management of these unique aspects of "deployment-related injuries" has been a core responsibility of the Veterans Health Administration (VHA) dating back to the Civil War.

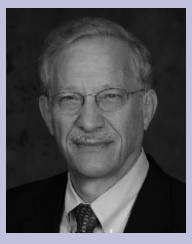
VHA has become increasingly focused on providing a patient-centered approach to care when addressing the short-term needs of the newly returning Veteran as well as the long-term needs of an aging Veteran population, including the treatment of acute illness and injury and the management of chronic diseases. However, all combat-related injuries, both physical and psychological, can impact the health of the Veteran in unique ways.

Deployment Health

Deployment health is increasingly recognized as a complex constellation of issues that involves a variety of physical, mental, and environmental exposures. According to the Institute of Medicine, deployment health is defined as health issues that arise prior to, during, and following armed forces deployments.[1] These health issues include specific diagnosable conditions, e.g., conditions associated with Agent Orange (AO) exposure, radiation exposure, prisoner of war status, Gulf War associated conditions, and others. Seemingly unexplained symptoms, both physical and mental, affect health-related quality of life, can impair family and social relationships, and can contribute to substance use disorders. These are among the more significant sequelae attributed to combat injuries. While some of these health challenges are immediately apparent when Veterans return from deployment, others may not arise until much later.

Mental health conditions once referred to as "soldier's heart," "shell shock," "war neurosis," and "combat fatigue" are now better understood as discrete illnesses secondary to Post Traumatic Stress (PTS). Mental health experts are still not in full agreement as to when PTS becomes a disorder, commonly known as Post Traumatic Stress Disorder (PTSD). Further, the myriad manifestations of traumatic brain injury (TBI) are better recognized, including its late complications. Yet, even as new treatment approaches have been put in practice and research into disease mechanisms and potential treatments has yielded encouraging opportunities, there remains much to learn.

With regard to environmental exposures, the nation became more aware of deployment health risks when it was acknowledged that Agent Orange was associated with a number of human health disorders including cancer, diabetes, and heart disease. Veterans' concerns about exposure to pollutants associated with burning trash (and oil wells) in the Persian Gulf conflicts have increased interest in both their potential ill-effects as well as the appropriate management of waste at these sites. Because the health effects of these



Director's Letter

Thousands of Veterans returning from deployment in Afghanistan and Iraq have a spectrum of injuries and illnesses that present challenges for both Veterans and the VA health care system. Many have complex comorbid medical problems that might include traumatic brain injury (TBI), limb amputation, vision and hearing loss, chronic pain, as well as mental health and adjustment issues. VA researchers are dedicated to discovering solutions to the multiple health issues that result from the unique brutality of modern warfare, such as polytraumatic injuries from improvised explosive devices (IEDs).

In this issue of *FORUM*, we are honored to have Robert Jesse, M.D., Ph.D., Principal Deputy Under Secretary for Health, discuss VA's commitment to providing optimal post-deployment health care. Part of this includes focusing on patient-centered care, including the development of Patient-Aligned Care Teams (PACT). Dr. Jesse also emphasizes the importance of collaborative research, so that clinicians, policymakers, and researchers work together to improve the quality of VA care. Also in this issue, Nina Sayer, Ph.D., Director of VA/HSR&D's Polytrauma & Blast-Related Injuries Quality Enhancement Research Initiative (PT/BRI-QUERI), discusses the need to address questions about co-occurring post-deployment health problems. For example, how should clinicians prioritize Veterans' multi-system problems? This issue also features articles on women and post-deployment health, pain management, and TBI screening.

HSR&D researchers continue to prioritize deployment-related health care. Current areas of investigation include: TBI, mental health (e.g., depression, PTSD), rehabilitation, community reintegration, substance use disorders, and issues unique to women Veterans. For more information about our research, please go to www.hsrd.research.va.gov.

Seth Eisen, M.D., M.Sc.
Director, HSR&D

practices may come to light years and even decades after the time of exposure, it is extremely difficult to develop conclusive epidemiologic evidence linking a specific exposure to specific disease(s).

In addition, out-of-U.S. deployments can lead to infectious disease exposures rarely encountered at home. Despite efforts to inoculate troops against endemic agents common at the sites of deployment, much is left uncovered. That, along with social behaviors of troops deployed in foreign lands, can create unique problems for a specific cohort of patients not recognized until late after demobilization (e.g., hepatitis C in Vietnam Veterans).

Integrated, Patient-Centered Care

VHA strives to understand and manage the secondary contribution that deployment-related conditions like TBI, PTSD, and depression have on the incidence and progression of chronic diseases such as ischemic heart disease, heart failure, diabetes, etc. VHA has implemented system-wide health screening for all Veterans who come to VA for health care services with a focus on depression, PTSD, military sexual trauma, TBI, risk of suicide, and problem drinking, with the explicit intent to both understand and to provide treatment for these conditions and their sequelae. In recent years, VHA has enhanced its mental health and suicide prevention teams to facilitate mental health care access through integration into primary care in order to identify problems early, to offer appropriate intervention, and to destigmatize the need to seek help for mental health issues.

A recent initiative focused on improving patient-centered care is the development of Patient Aligned Care Teams (PACT), designed to improve access, care coordination, communication, and continuity of care. A principal goal of PACT is that Veterans take an active role in their health care by utilizing enhanced communications and building long-term relationships with their care team. VHA has supported the development of a number of unique PACT care models, which in collaboration with VA researchers, will be evaluated to determine the most effective approaches for enhancing Veterans' care.

Toward the Future

An improved understanding of Veterans' health care issues, which includes the development of new approaches to treatment and the appropriate research tools, is a priority for VHA. These tools include registries, cohort management studies, and an understanding of the genomic contribution to disease. For this reason, the Million Veteran Program (MVP), which utilizes strict privacy and confidentiality controls, was established to provide one of the largest databases of genetic, military exposure, lifestyle, and health information. By combining knowledge of the human genome with longitudinal data from the electronic health care record, researchers will have the tools to develop greater understanding of disease risk and insight into the fundamental etiologies that provide the foundation for new potential treatments. This will indeed be a national treasure!

Another example is the active medical surveillance program associated with Veterans who served at the Qarmat Ali water treatment facility near Basrah, Iraq, between April and November of 2003. Environmental health physicians will examine these Veterans at regular intervals to determine in particular the status of the respiratory system and skin – areas known to be affected by exposure to hexa-valent chromium. The examination will focus on nasal-septal ulcerations and chronic irritation; reactive airway disease and other

Continued on page 8

Response to Commentary

The Challenges of Co-Occurrence of Post-Deployment Health Problems

Nina A. Sayer, Ph.D., Polytrauma/Blast-Related Injury QUERI, Minneapolis VA Medical Center

Over 2.2 million U.S. service members have participated in Operation Iraqi Freedom and Operation Enduring Freedom (OEF/OIF), about half of whom have left active duty and become eligible for VA services. Since 2002, the proportion of OEF/OIF Veterans using VA has been increasing such that by September 2010, 625,384 (approximately 50 percent) OEF/OIF Veterans had obtained health care through VA. OEF/OIF Veterans now comprise approximately 7 percent of VA users.

OEF/OIF VA users are demographically distinct from other Veteran cohorts. For example, approximately 70 percent are 31 years old or younger; 12 percent are female; and 46 percent deployed to OEF/OIF from Reserve/National Guard components of the military. Most have access to the Internet and use it daily. As Dr. Jesse points out in his commentary, OEF/OIF Veterans may also have deployment-related health problems, many of which are not visible, but which VA is uniquely equipped to diagnose and treat. These problems include the sequelae of psychological and physical trauma in the war zone. Furthermore, even in the absence of diagnosable disorders, OEF/OIF Veterans may have difficulty adjusting to civilian life after combat experiences and these reintegration difficulties may have implications for health, health behaviors, and outcomes.

Innovations in Post-Deployment Care

VA has implemented significant innovations to help ensure that the visible and invisible problems of these returning Veterans are identified and treated. Dr. Jesse referred to national screening for a range of post-deployment health concerns, new patient registries, and suicide prevention. Additional innovations include a system of care for Veterans with Traumatic Brain Injury (TBI)/polytrauma and, more recently, a separate system of care for Veterans with amputation, primary care clinics specializing in OEF/OIF Veterans' issues, improved collaboration with the DoD to facilitate Veterans' transition across health care systems and to share information, and expanded programs for family caregivers, particularly but not exclusively for the family caregivers of those with severe war-related injuries. These initiatives have also created new opportunities for researchers to expand the evidence-base for practice and to partner with clinicians, VA, and DoD leaders to improve post-deployment health care.

It has been almost ten years since 9/11. Research on post-deployment health in U.S. Veterans conducted over the past decade spans numerous medical and social science domains. One finding across studies stands out as warranting particular attention because of its implications for health care delivery – the co-occurrence of post-deployment health concerns in OEF/OIF Veterans. That is, VA researchers are not only shedding light on the prevalence of specific post-deployment health disorders but also on the fact that deployment-related health problems do not occur in isolation. In fact, co-morbidity of conditions that cut across specialty medical areas is the rule rather than the exception. This finding is illustrated in the case of Veterans who have a history of combat-related TBI. VA researchers are showing that Veterans with probable mild TBI usually have Post Traumatic Stress Disorder (PTSD) or another mental health disorder and pain-related diagnoses.[1, 2] We also know that dual (auditory and visual) sensory impairment is common in Veterans with deployment-related mild TBI.[3]

The finding of co-occurrence of post-deployment health problems creates challenges for health care systems and interventional strategies organized around specific conditions or diseases. How is care for these Veterans with multiple deployment-related problems best coordinated or sequenced? How should clinicians prioritize these Veterans' multi-system problems and conceptualize their ongoing symptoms and functional difficulties? Research protocols and clinical practice guidelines typically focus on single disorders and therefore may offer less guidance than needed (e.g., there are separate clinical practice guidelines for PTSD, mild TBI, and pain). How should they be altered to ensure that VA garners the evidence it needs and Veterans with multi-system comorbidities receive evidence-based care? Dr. Jesse's commentary brings our attention to the PACT care model. How should PACT and specialty care teams interact to meet the needs of complex OEF/OIF patients who may require a range of behavioral as well as medical interventions?

Importance of Collaboration

I was pleased that Dr. Jesse ended his commentary by noting the importance of collaboration with researchers. Addressing questions about the models of care and treatment protocols for OEF/OIF Veterans with multiple deployment-related morbidities will require partnership among clinicians, policymakers, and researchers. In addition, it will be important for researchers and policymakers to work together to determine whether VA can extend its reach to OEF/OIF Veterans who do not yet use VA but could benefit from its expertise in post-deployment health. Indeed, VA researchers have an important role to play in helping VA achieve its goal of providing this new cohort of Veterans with data-driven, patient-centered care.

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Research Highlight

Findings from an HSR&D Funded Study of Traumatic Brain Injury

Ann Hendricks, Ph.D., Health Care Financing and Economics, Boston, MA

Traumatic Brain Injury (TBI) is a leading injury among forces deployed since 2001 to combat areas such as Afghanistan and Iraq. Deployed service members are currently eligible for up to five years of health care services through the Veterans Health Administration (VHA), with no co-payments regardless of income or disability. In recent years, 20 percent to 25 percent (400,000 or more) of these eligible service members have used VHA care.[1] Therefore, identifying TBI among VHA patients is essential, so that timely and appropriate treatment can alleviate its physical, emotional, and cognitive effects.

Screening for TBI

To identify patients who may have had TBI, VHA policy is to screen all individuals who report OEF/OIF deployment, using sets of questions about events (e.g., blast, fall, vehicle accident) associated with increased risk for TBI, immediate symptoms after the event, new or worsening symptoms following the event, and symptoms in the past week. A screen is positive if a person responds positively to any question within each set.

Not all patients who screen positive have TBI. Positive screens may be due to other conditions, such as PTSD or inner ear injury. Based on its experience with Veterans from past conflicts, VHA screening aims to be inclusive, referring patients with lower probability of having TBI for comprehensive evaluations to ensure that those needing care receive appropriate assessment and treatment. Using a defined protocol administered by a clinician, the Comprehensive TBI Evaluation collects information about the origin of the injury, assesses neurobehavioral symptoms, includes a targeted physical examination and psychiatric history, confirms or rules out a diagnosis of TBI, and lists possible follow-up care.

Our HSR&D-funded, service-directed research study examined the screening, evaluation, and utilization records for more than 216,000 patients seeking VHA services between April 2007 and March 2009. The proportions with positive screens, by gender, were 10.5 percent for women (who comprised one eighth of the patients) and 21.3 percent for men.[2] Approximately 5 percent of women (n = 1,912) and 11 percent of men (n = 31,873) who were screened for TBI subsequently participated in a Comprehensive TBI Evaluation. Of these, nearly equivalent proportions of women (34 percent) and men (37 percent) were confirmed to have deployment-related TBI. Of note, blast exposure (compared to non-blast events such as vehicle accidents) increased the odds of having PTSD, alcohol-related disorders, or PTSD with comorbid depression. Blast exposure also increased the odds of having severe affective (e.g., irritability, frustration) and cognitive (e.g., forgetfulness, poor ability to concentrate) neurobehavioral symptoms.

We found that women with deployment-related TBI report more severe postconcussive symptoms, especially if they have experienced blast exposure. In terms of PTSD, although women had lower odds of having a PTSD diagnosis in univariate analyses between gender and PTSD (59.6 percent of the women had a PTSD diagnosis compared to 67.8 percent of the men), this difference was not maintained after controlling for blast exposure.

Sensory Impairment and TBI

Among those with TBI, self-reported sensory impairment rates were: 34.6 percent for dual sensory (both hearing and vision) impairment, 31.3 percent for hearing impairments only, 9.9 percent for vision impairments only, and 24.2 percent for none/mild sensory impairment.[3] Patients with TBI and blast exposure had the highest rate of dual sensory impairment, suggesting that for these patients in particular, VA clinicians should collaborate to maximize rehabilitation for these senses.

In the year following screening, the vast majority of screened patients received VHA health care services (from 88 percent to 98 percent). Amounts or intensity of services were higher for those with TBI and PTSD. Women tended to receive more outpatient care (about four visits) than men, but men received more inpatient care (about nine more days for the approximately 9 percent of men and women who received any inpatient care).

Our study found that VHA's TBI screening and evaluation process succeeded in being inclusive, providing follow-up care for service members who screened positive for possible TBI. Because the study population was large, we identified important differences between injured men and women in the services as well as establishing that those with mild deployment-related TBI report high rates of dual sensory impairments. The study does not generalize to all OEF/OIF-deployed service members, just to those who seek VHA health care. Future analyses will examine factors related to variations across VHA medical centers regarding specific diagnoses or conditions, types of referrals and follow-up care for specific conditions (e.g., PTSD), as well as differences by gender, military services (e.g., Army, Navy) and the number of events (both blasts and non-blasts).

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Research Highlight

Pain Management and Post-Deployment Care

Robert D. Kerns, Ph.D., and Alicia Heapy, Ph.D., VA Connecticut Healthcare System and Yale University

Emerging data document that painful musculoskeletal and connective tissue disorders are the most common cluster of diagnosed conditions of Veterans enrolled for care in VHA following deployment in Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND). At the same time, persistent pain is increasingly appreciated as only one of several highly co-prevalent clinically important problems or diagnosed disorders among this population of Veterans. Data document that a constellation of problems including chronic pain, persistent post-concussive symptoms, post-traumatic stress disorder (PTSD), depressive disorders, substance use disorders, and sleep disorders are particularly common. Walker and colleagues from the James Haley Veterans Hospital – a group that has served a particularly important role in documenting these comorbidities in this population of Veterans – have offered the label of "Post-Deployment Multi-Symptom Disorder" to best characterize this complex array of problems confronting a large proportion of OEF/OIF/OND Veterans.[1] These VHA health services investigators have called for the development and evaluation of readily accessible and Veteran-centered approaches to assessment and treatment – novel approaches that emphasize interdisciplinary, integrative, and coordinated care.

Role of Patient Aligned Care Teams

VHA has established pain management as a high priority and has recently published policy guidance that calls for implementation of a stepped-care approach to pain management.[2] The stepped-care model is an evidence-based and population-based approach that is consistent with OEF/OIF/OND Veterans' pain management needs and expectations. The model calls for most common pain conditions to be assessed and managed by interdisciplinary Patient Aligned Care Teams (PACTs). For Veterans with complex chronic pain conditions that cannot be managed in the PACT setting – including those with comorbid mental health and medical conditions and those identified as at greatest risk for disability, addiction, and suicide – timely access to secondary specialty care is required. Pain medicine, rehabilitation medicine, mental health and substance use disorders treatment, and specialty medical and surgical services are among those that must be readily available to support PACTs and Veterans who require this level of specialty care. Finally, the stepped model calls for building tertiary, interdisciplinary pain centers in each VISN by September 2014. These centers are expected to have the capacity to provide the highest level of advanced pain medicine diagnostics and interventions, chronic pain rehabilitation, and treatment for Veterans with comorbid complex chronic pain and substance use disorders, especially prescription opioid dependence and addiction.

PACTs are well suited to provide this kind of integrated and coordinated care due to the increasing availability of additional resources that can be brought to bear on addressing military-related issues and comorbid mental health and substance abuse problems. These resources include OEF/OIF/OND support teams, polytrauma support clinical teams, post-deployment clinics and teams, and mental health-primary care integration teams. Substantial efforts are underway to strengthen PACT members' competencies and to build PACT capacity for pain management. Simultaneously, health services investigators in conjunction with their service delivery and operations partners are developing and evaluating novel approaches to delivering efficient chronic pain assessment and management in these settings. Among these initiatives are those that incorporate the use of telehealth and other technological advances to promote safe and effective use of medications and delivery of non-pharmacological interventions. These include evidence-based psychotherapies, structured exercise and healthy living programs, and complementary and alternative medicine services such as acupuncture and meditation. In this context, research designed to promote the development and implementation of integrated interventions that target Veterans with chronic pain and comorbidities such as depression and PTSD – and that meet these Veterans' expectations for timely, efficient, and effective care – is a high priority.[3]

New PACT-Specialty Care Access Network

A new VHA initiative called PACT-SCAN (Specialty Care Access Network) will soon be implemented to further support the development of competencies of PACT teams for the assessment and management of chronic pain conditions, among other complex chronic diseases. The PACT-SCAN initiative will sponsor multidisciplinary specialty teams at regional hubs that will use advanced videoconferencing technologies to provide didactics and case-based learning opportunities for PACTs in rural areas and other settings where access to specialty care is lacking. A partnership with health services investigators is envisioned to provide high fidelity program evaluation that will be necessary to assure that the program functions optimally to build PACT members' competencies, to improve access to specialized care for Veterans, and to promote cost-efficiencies in this mode of delivering specialty care.

Meeting the expectations for pain management of Veterans returning from deployment in Iraq and Afghanistan represents a serious challenge to health care providers in VHA and to their health services investigator partners. Having recognized the challenge, there is reason for optimism that these partnerships will yield important advances in our knowledge about how best to assess and manage complex chronic pain and to rapidly implement improvements in effective Veteran-centered pain care.

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Research Highlight

Women and Post-Deployment Health

Anne G. Sadler, Ph.D., R.N., Center for Comprehensive Access and Delivery Research and Education, Iowa City VA Health Care System, Iowa City, Iowa

More than 200,000 women have been deployed and, like their male counterparts, experienced the high stress of deployment, work, or travel in combat areas. While women are not technically in combat roles, their duties and service environments can place them at constant risk. Now comprising approximately 15 percent of the U.S. armed forces overall and 17 percent of Reserve and National Guard (R/NG) forces, women are among the fastest growing groups of new VA users. After a history of caring primarily for males and members of the Regular Military, VA is now challenged with meeting the health care needs of this unique population of women.

Unfortunately, the health effects of combat, post-deployment readjustment, and additive trauma exposure (such as sexual assault) are not yet well characterized in servicewomen, particularly R/NG members. Women Veterans in general report a higher burden of medical illness and worse quality of life outcomes. Studies of military populations posted at permanent bases have had results consistent with research on civilian women in finding higher rates of depression, anxiety, and post-traumatic stress disorder (PTSD) in servicewomen compared to their male counterparts. A potential explanation for this difference is that women are significantly more likely to experience rape during their lifetime than men, and rape is a high risk trauma exposure for PTSD and other mental health sequelae.[1]

A key concern for returning women Veterans is reintegration within family and relationship roles. Little is known about the ways that women warriors struggle to balance family and service. This is especially important given the repeated and prolonged deployments that have characterized OEF/OIF/OND service and that military women are much more likely to be a single parent than male peers. Returning women are demonstrating a higher risk for family readjustment problems as marriages of female troops are failing at almost three times the rate of male service members.[2]

Facilitating post-deployment access to health services, and mental health in particular, for OEF/OIF/OND female Veterans is challenging and has required new outreach approaches. Such interventions to promote prompt access to needed care are urgently needed to mediate the severity of post-deployment mental health conditions and to interrupt the cycle of chronicity found in many with depression and PTSD. In focus groups with a Mid-Western cohort of R/NG and Regular Military servicewomen (Veteran and active duty), fear of an elevated risk of harassment or assault in the VA setting was common as were concerns about confidentiality.[3] Participants reported that entry to VA care is confusing and that they did not know about health care benefits or the availability of gender-specific services.

"You can't just come back home expecting everything to be the way it was before, because one, your family is not the same. You are not the same."

Chicago Enlisted Servicewoman[4]

To attend to access concerns, community outreach by VA OEF/OIF/OND teams has been implemented to promote education and enrollment of returning Veterans. Increasingly, VA is forming partnerships with community services and agencies addressing Veteran needs (e.g., Brain Injury Association, Workforce Development). My HealtheVet was developed to respond to changing generational and societal expectations for greater electronic access to health care and information. Community-based outpatient clinics have been established in Veteran-rich communities along with telehealth services to address distance and other access barriers.

Increase in Gender-Specific Services

Once women are VA-enrolled, services and the environment and process of care must be sensitive to their needs and preferences if women Veterans are to continue to choose, maintain, and endorse VA care. Gender-specific health services have increased in VA and care silos are becoming obsolete as multidisciplinary teams evolve to treat women's complex health issues and decrease fragmentation of care (e.g., Women's Health Clinics, Patient Aligned Care Teams). An unprecedented VA implementation of evidence-based practices and clinician training to treat trauma and mental health consequences is in process. Recognition of the impact of deployment on family reintegration or caretaking roles has resulted in the inclusion of licensed marital and family therapists within mental health teams and recent family caretaker initiatives.

VA has a research agenda and funding that is responsive to the scope, immediacy of health concerns, and readjustment problems women face post-deployment. The establishment of the Women's Health Research Consortium and Practice-Based Research Network is an additional VA investment in the growth of women's health research and in the engagement and mentoring of both new and senior investigators in women's health research.

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HSR&D National Meeting Emphasizes Collaboration

"Teaming Up for High VAlue Care" was the theme of the 28th VA Health Services Research and Development Service (HSR&D) National Meeting held in February. This year's theme emphasized HSR&D's priority to establish and maintain close collaborative relationships with its VA partners, so that research is more responsive and the findings are more likely to be implemented into practice. The meeting brought together policymakers, clinicians, and researchers, enabling participants to gain exposure to each other's work, to understand each other's needs, and to develop collaborative relationships that will ultimately enhance the health care provided to Veterans.

Partners in Research

More than 650 attendees had access to 90 papers, 21 workshops, and 113 posters on vital health care issues, such as: chronic disease management, mental health, substance use disorders, homelessness among Veterans, women Veterans' health care needs, issues specifically related to deployment in Iraq and Afghanistan (e.g., traumatic brain injury, PTSD) and presentations from HSR&D's Quality Enhancement Research Initiative (QUERI). Many of these studies depend upon partnerships between HSR&D and other VA programs and offices, such as the Office of Quality and Performance, Patient Care Services, and the Office of Information & Technology.

National Meeting Highlights

Meeting highlights included a keynote address by VA's Principal Deputy Under Secretary for Health, Robert Jesse, M.D., Ph.D. The title of his talk was "Transactional Quality" and he spoke about the importance of differentiating between "delivering health care," which is what VA provides to patients, and "health care delivery," which pertains to the systems that enable this care. Other meeting highlights included the presentation of awards. Paul Shekelle, M.D., Ph.D., M.P.H., received the Under Secretary's Award for Outstanding Achievement in Health Services Research (see related article below). Seth Eisen, M.D., M.Sc., Director of HSR&D, presented the Post-Doctoral Poster Award to Lauren Broyles, Ph.D., R.N., of HSR&D's Center for Health Equity Research & Promotion, for her study on alcohol screening.

Looking Toward the Future

Dr. Eisen addressed meeting participants about the future and HSR&D's priorities, which include: engaging VHA partners in health services research; further aligning investigators with the needs of VA; increasing research synergy and reducing scientific overlap; speeding implementation of research findings; and maintaining investigator-initiated research.

The National Meeting was hosted by HSR&D's Northwest Center for Outcomes Research in Older Adults, located in Seattle, WA.

Shekelle Receives 2011 Under Secretary's Award for Outstanding Achievement in Health Services Research

Paul G. Shekelle, M.D., Ph.D., M.P.H., has received this year's Under Secretary's award for Outstanding Achievement in Health Services Research. The award recognizes a VA researcher whose work has met three key criteria: improved our understanding of factors that affect the health of Veterans and improved the quality of their care, contributed to the future of VA health services research by inspiring and training the next generation of investigators, and enhanced the visibility of VA research through national recognition within the research community. Significant research contributions made by Dr. Shekelle include developing methods to assess quality of care, particularly for older adults. For example, five quality indicators he developed are part of VA's benchmarking sets. Through his work at VA's Health Services Research and Development Service (HSR&D) Evidence Synthesis Program, he has added to the overall knowledge regarding how to synthesize evidence in order to reach clinically relevant conclusions by conducting several evidence syntheses targeted toward VA clinical managers.

Dr. Shekelle has been an important part of the VA Greater Los Angeles (GLA) Healthcare System for more than 20 years, where he is Chief of General Internal Medicine. He also leads the HSR&D Evidence Synthesis Program based at GLA, is Director of the Southern California Evidence-based Practice Center, and is Director of the Quality Assessment and Improvement Program at RAND.

Joel Kupersmith, M.D., VA's Chief Research and Development Officer, presented Dr. Shekelle with the highest honor for a VA health services researcher at the HSR&D National Meeting in February.

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Post-Deployment Injuries from page 2

lung abnormalities; skin ulcerations or chronic dermatitis. It will also look for and catalog other health conditions that occur in this well-defined cohort over time in order to identify any potential late complications from this exposure that might not yet be appreciated.

Hand in hand with these new approaches and tools is collaboration with researchers to understand and develop new approaches to improve care for Veterans. This collaboration occurs through a broad spectrum from basic to applied research as well as population health and implementation sciences. VHA's development and sustained focus on deployment health – a focus that engages the Nation's best investigators on the cutting-edge of research – enables VHA to provide the highest quality care for Veterans. This remains a key priority for the Department.

Endnotes

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