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Commentary

VA Responds to the Needs of Aging Veterans

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Contents

| | |
|---|---|
| Director's Letter | 2 |
| Response to Commentary | 3 |
| Research Highlights | |
| • Supporting Family Caregivers | 4 |
| • Evaluation of the Assisted Living Pilot Program | 5 |
| • SMITREC Initiatives | 6 |
| HSR&D National Meeting Highlights | 7 |

Four decades ago, VA recognized that aging of World War II and Korean War veterans would one day challenge its delivery system. At the time, VA had been focused primarily on inpatient and acute care, and was not prepared to address the long-term care needs of an aging veteran population. In response, VA developed capabilities to meet these needs by building long-term care facilities and by developing cooperative agreements with state veterans' homes.

In the 1980s, VA established the Geriatric Research Education and Clinical Centers (GRECCs) with the specific mission to study those medical conditions associated with aging, train health care providers in the care of the elderly, and to improve the care provided to older veterans. Now situated in 20 VA medical centers across the country, these centers serve a critical role in advancing geriatric expertise across the system.

Shift to Home- and Community-Based Care

In the 1990s, VA began reassessing the care it provided to the elderly and recognized the need to provide a continuum of care rather than providing care in discrete settings (e.g., inpatient acute, long term, etc.). This shift became more urgent with the rapid aging of the enrolled veteran population as well as growing enrollment by aging veterans.

These trends resulted in the landmark 1998 report, *VA Long Term Care at the Crossroads*, which urged a shift in long-term care from inpatient facilities to home- and community-based settings. This shift was further supported by the Veterans Millennium Health-

care and Benefits Act of 1999, which set forth basic benefits of home- and community-based long-term care along with Congressionally-mandated nursing home benefits for select veterans.¹

Over the last decade, VA has focused on implementing the recommendations of the *Crossroads* report and the requirements of the Millennium Act. As a result, VA anticipates a continued expansion of community-based programs over the next five years. Today, VA is focused on implementing a spectrum of services, which includes relatively minor assistance that enables veterans to stay in their homes, skilled nursing care and primary care in the home, and institutional care in VA, state, and community facilities.

Today, every medical center in the VA system must implement a range of non-institutional services. Specifically, medical centers must implement a care coordination program, plus at least six of the following services:

- Homemaker/home health aides
- Skilled home care
- Home-based primary care
- Home respite care
- Home hospice and palliative care
- Community and VA operated adult day care
- Spinal cord home care

VA recently launched a medical foster home program that enables veterans to live in small facilities with a home-like environment. These community residential sites must be approved by VA, and are especially well suited to veterans of Operation Iraqi

Director's Letter



In the past year, HSR&D has announced research initiatives in medical informatics, health services research (HSR) genomics, and translating provider education to improved patient outcomes. For nearly two decades, the VA's electronic medical record has drawn investigators to the VA because it provides such a powerful resource for insight into a wide variety of HSR issues. Unfortunately, much information (e.g., bacteriology, pathology, narrative provider notes, etc.) is available only in text format, which requires reading individual records, a labor intensive task. The goals of the medical informatics initiative are to de-identify text information as completely as possible, and to enable electronic analysis of it by researchers.

The HSR genomics initiative assumes that shortly, certain gene polymorphisms will be unequivocally associated with risk or resilience to common adult diseases, and will predict responsiveness or adverse risk to a variety of medications. The two year goal is to create teams of VA HSR genomic researchers who are prepared to characterize the additional value genomic information provides to diagnosis and treatment, develop ways to educate providers and patients, and address the many other important issues that are already beginning to appear. The recent article by Scheuner, et al. in the *Journal of the American Medical Association* demonstrates that VA's HSR genomics program is already making national contributions.¹

The initiative to translate education into improved patient outcomes recognizes that while substantial research has examined relationships between education and knowledge, few studies have examined the most effective educational approaches to improving patient outcomes. This initiative is particularly complex, since it involves modifying provider behavior in demanding clinical environments where provider-patient time is precious.

The goals of these initiatives will not be attained easily. I expect they will remain in the HSR&D forefront for many years.

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

1. Scheuner M, et al. Delivery of Genomic Medicine for Common Chronic Adult Diseases. *Journal of the American Medical Association* 2008; 299(11):1320-34.

Freedom (OIF) and Operation Enduring Freedom (OEF), who do not want to live in an institutional setting but cannot live independently at home.

While the increased availability of home- and community-based services has had the desired effect of reducing inpatient demand, VA is still experiencing significant need for nursing home services. In addition to its own nursing home facilities, VA contracts with CMS-certified community nursing homes to

provide care for veterans. Typically, a veteran is placed in a community nursing home on a short-term VA contract, ultimately transitioning to Medicaid for long-term care. VA also has a nationwide program with state homes, paying a per diem for each day a veteran is a resident of a state home.

Advances in the application of technology to care delivery, such as wireless devices and the Internet, also play a role in meeting the needs of the aging patient population.

Home telehealth offers significant potential to veterans, particularly in overcoming time and distance barriers in rural areas. One example is VA's teleretinal imaging program, launched in 2007. The program offers initial screening for eye disease to veterans with diabetes. Under this program, retinal images are taken in primary care settings and sent to an image reading center where they are evaluated by an eye care specialist.

Trends Point to Research Needs

The rapidly aging veteran population poses several important research opportunities. The satisfaction of veterans and families with the care they receive in home- and community-based settings is largely unknown. In addition, the impact of care provision in these newer settings in reducing emergency room and hospital usage is an important potential consequence that we need to better understand. And while we know, in general, that home- and community-based settings are less expensive than inpatient settings, we do not have data on the relative cost of care across these care settings.

“The rapidly aging veteran population poses several important research opportunities. The satisfaction of veterans and families with the care they receive in home- and community-based settings is largely unknown.”

While VA has successfully negotiated with pharmaceutical manufacturers to get their best prices, the cost of drugs continues to rise. It is quite common for individuals over 65 to have multiple medications. Unfortunately, clinical trials typically do not include the elderly, so we suffer from limited data on the safety and efficacy of drugs for this population.

Patient access to information on the Internet has had quite an impact. Some of this information is quite reliable and timely, but other information is dangerous and inaccurate. VA could play a larger role in sorting this out for veterans. My HealtheVet offers an important opportunity for veterans to

continued on page 8

Response to Commentary

Defining Better Care for Aging Veterans

Joseph Francis, M.D., M.P.H., VA Central Office, Washington, D.C.

VA was among the first health systems to recognize how aging would impact care and costs, and, presciently, it prepared by adopting innovative approaches to research, education, and clinical care. Recently, national policies and customer demand have stimulated new measures focusing on providing care in more home-like settings that better match the needs and values of patients and families.

Those of us who care for older veterans feel passionately about the approaches that VA has adopted. Yet, when we step into our administrative or research personae, questions linger. Who really benefits? What will it cost? Is it sustainable? Could our finite resources be used in better ways? The “market-based” indicators outside VA are discouraging—with the exception of academic settings (where graduate medical education requirements demand minimal exposure to model geriatric care), the numbers of practicing geriatricians have been declining.

For the researcher or administrator seeking to define better care for aging veterans, three principles are key.

First, we must get further into the “black box” of our interventions. VA’s care delivery is based on a model of primary care, which has been indisputably effective in improving the quality and coordination of our care. Yet, a dozen years ago, a VA-sponsored multi-site trial showed this intervention increased, rather than reduced, the use of inpatient care. VA did not abandon primary care based on these results, but ongoing work continues to probe deeper to better understand how structures (e.g., makeup of teams) and processes of care (e.g., fidelity to evidence-based practices) determine outcomes.

Models of geriatric care demand similar scrutiny. At one time, home-based primary care and comprehensive geriatric assessment were considered the “magic bullets” of caring for complex older patients—yet trials within VA have shown either modest benefits or substantial costs.^{1,2}

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As with primary care, we now must “muddle through”—probing with quantitative and qualitative methods to understand what aspects of care make a difference, and which patients benefit. In the absence of an accepted “gold standard,” much variation exists across VA in geriatric care. Harnessing that variation for self-inquiry requires that the entire delivery system be engaged in practice-based learning.

Second, complex chronic illness, not aging itself, is the challenge. A century of geriatric bioscience has demonstrated that age is a poor surrogate for physiological function, and that the stronger determinant of quality of life is chronic illness. But there is growing evidence that care focused on only a single disease leads to inadequate attention to other problems, to the patient’s detriment. Our knowledge base for managing complex, co-occurring problems is sparse, and demands response from the research community.

New methods of inquiry, such as “real world” trials that do not exclude patients with comorbid illness, and large scale observational studies that tap into electronic health records, are needed to understand such complexity. The physical and psychological effects of combat trauma surely have impact over the lifespan and must be studied—in both older and younger veterans.

Third, meaningful quality measures must be developed and validated. Arguably, the greatest contributor to VA’s quality transformation over the past decade has been the systematic use of evidence-based measures of quality. Quality measures have also been used as surrogate outcome measures to test delivery system innovations. Little is known about measuring the quality of care rendered to patients with complex, chronic illness, and concerns have been raised that individual metrics may be inappropriate for frail elderly. Recently, RAND investigators constructed a quality index from 21 process-of-care indicators and showed its association with survival among older managed care patients.³

While the RAND population was not as frail as VA’s, and not all measures would be relevant to older veterans, the potential utility of the RAND approach is obvious. The major barrier to executing such an approach, the burden of collecting multi-dimensional indicators, could be substantially mitigated through appropriate use of VA’s electronic health record.

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Research Highlights

Finding Better Ways to Support Family Caregivers

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Family caregivers are estimated to reach 37 million by 2050, an 85 percent increase from 2000. Of these, about 20 percent provide care to individuals with dementia. The number of individuals needing dementia care will rise from 4.5 million to 13.2 million by 2050. Of the 500,000 veterans with dementia, 155,000 sought care in 2006; this figure is expected to increase to 218,000 by 2017.

Caregiving is characterized by diverse challenges. Caregivers are at moderate risk for adverse outcomes in multiple domains, but not extreme risk in any one outcome. However, these multiple risks erode health and quality of life. Caregivers suffer more from depression and mental health problems than non-caregivers. Caregivers to individuals with dementia report more emotional, physical, social, and financial problems than other caregivers, and have increased risk of mortality.¹

Dementia Caregiving

Dementia caregiving has been the focus of recent federally funded studies and initiatives. The National Institute on Aging (NIA) and National Institute of Nursing Research (NINR) project, Resources for Enhancing Alzheimer's Caregiver Health (REACH II), was the first multi-site, randomized controlled trial to test the efficacy of a multi-component intervention for diverse racial/ethnic caregivers. The six-month REACH II intervention of 12 individual in-home and telephone sessions and five telephone support group sessions targeted areas linked to caregiver risk and quality of life: burden, emotional well-being, self-care/healthy behaviors, social support, and patient problem behaviors. Control caregivers received two brief phone calls.

Compared to controls, Latino/Hispanic and White/Caucasian intervention caregivers ex-

perienced significantly greater improvement in quality of life, as did Black/African-American intervention spouse caregivers. Clinical depression prevalence was also significantly lower for intervention caregivers.² An underlying assumption was that the intervention would reduce caregivers' stress and improve their ability to manage behavior problems, leading to decreased time spent in caregiving activities. At six months there was a significant difference for intervention, compared to control, caregivers in reported hours providing care. The incremental cost effectiveness ratio showed that intervention caregivers had one extra hour per day not spent in caregiving at a cost of \$5 per day.³

This time finding was borne out in the HSR&D-funded Memphis VAMC CONNECT study, a randomized clinical trial of telephone support groups vs. usual care for African-American/Black and Caucasian/White dementia caregivers, who were either providing care to a veteran or were themselves a veteran. As in REACH II, the study focus was on caregiver burden, emotional well-being, self-care/healthy behaviors, social support, and patient problem behaviors. However, the intervention was delivered through a low staffing, low technology telephone support group model, with each group including a group leader and 5 to 6 caregivers. The 14 one-hour sessions over one year were semi-structured with education, coping skills, cognitive restructuring, and support components. On average, from baseline, intervention caregivers reported 0.46 fewer hours of caregiving time per day compared to usual care caregivers who reported 1.3 hours more.

In addition to caregiver outcomes, telephone support also improves patient cost

outcomes. The HSR&D-funded, Telehealth Education Program (TEP) dementia caregiver telephone support/education intervention in VISN 2 has shown a significant health care cost savings of \$2,768 per patient at six months. TEP was composed of 10 weekly telephone support groups covering topics similar to the REACH II trial but focused on spousal caregivers living with veterans with moderate to severe dementia.

Growing Federal Commitment

Results from studies like these have encouraged increased commitment by Congress and the VA to support caregivers. The Office of Geriatrics and Extended Care has convened recent workgroups to develop best practice recommendations for VHA concerning dementia training materials, clinical care, care coordination, and administrative practices. In FY08, Congress and the VA awarded nearly \$4.7 million to eight caregiver assistance pilot programs to expand and improve health care education and provide needed training and resources for caregivers who assist disabled and aging veterans in their homes. One of these projects, REACH VA, is a clinical translation of the REACH II study that will provide services to 350 caregivers at 20 sites.

Finding better ways to support family caregivers, who are the largest source of long-term care services in the United States, is a major public health challenge. These projects highlight the VA's commitment to caregivers and VHA's leadership in research implementation, the translation of research findings into clinical practice and personal behavior.

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Research Highlights

Evaluation of the Assisted Living Pilot Program

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Assisted living and related community-residential care programs such as adult family homes are of growing importance. These programs offer the promise of serving persons needing long-term care in settings that can meet their needs while maximizing autonomy and privacy in a home-like setting.¹

While assisted living primarily serves those who can pay out-of-pocket, the majority of states have moved to make some Medicaid funds available to allow those with lower incomes to access these programs.

VA is another possible funding source to extend assisted living services to moderate and low income individuals. Long known as a leader in providing an extensive continuum of long-term care services, VA was authorized in Public Law 106-117 to provide these services as part of a pilot demonstration and evaluation to assess the “feasibility and practicability of enabling veterans to secure needed assisted living services as an alternative to nursing home care.”

Findings from the Evaluation of the ALPP

The Northwest VISN, VISN 20, implemented the Assisted Living Pilot Program (ALPP) in seven Medical Centers in four states: Anchorage, Alaska; Boise, Idaho; Portland, Ore.; Roseburg, Ore.; Spokane, Wash.; Puget Sound Health Care System (Seattle and American Lake, Wash.); and White City, Ore. Investigators from the Northwest and Hines HSR&D Centers of Excellence conducted the evaluation. ALPP was designed to contract with existing community facilities to serve the needs of the VA patient population while reducing costs

to the system by transitioning residents to private pay or Medicaid after an initial period of VA payment.

The main findings from our evaluation of the ALPP program follow.

- ALPP was successfully implemented. From January 29, 2002 through December 31, 2004, 789 veterans were placed in 142 ALPP facilities, indicating that ALPP was able to attract an impressive number of veterans and is a feasible program based on this criterion.
- Veterans were admitted as planned to all types of community-based programs licensed under state Medicaid-waiver programs: 56 percent to Assisted Living Facilities, 28 percent to Residential Care Facilities, and 16 percent to Adult Family Homes.
- The average ALPP veteran was a 70-year-old, unmarried, white male who was not service connected, was referred from an inpatient hospital setting, and was living in a private home at referral.²
- ALPP veterans showed very little change in health status over the 12 months after enrollment. Health status typically deteriorates over time in a population in need of residential care; this finding suggests that ALPP may have helped maintain veterans’ health over time.
- Veterans, caregivers, ALPP providers, and VA staff were very satisfied with ALPP services.
- The mean ALPP cost per day was \$84.89 and the mean length of stay paid for by VA was 65.5 days. This finding, as well as the next two, is based on the data for only those participants who completed the informed consent for use of their data in publications.

■ The total cost per veteran of all health care paid for by VA during the 12-month follow-up period was \$29,812 which was significantly higher by \$11,533 than the cost per comparison group veteran, controlling for baseline differences. This difference was the result of additional ALPP facility (\$5,560) and case management (\$2,830) costs plus significantly higher primary care, specialty care, emergency care, phone care, and pharmacy costs for patients who participated in ALPP. While the ALPP group had significantly fewer nursing home days and lower cost for nursing home care, the latter was not statistically significant.

■ 53 percent of veterans stayed in ALPP facilities at the end of the VA payment period and 50 percent of surviving veterans were still in an ALPP facility at 12 months.

“These programs offer the promise of serving persons needing long-term care in settings that can meet their needs while maximizing autonomy and privacy in a home-like setting.”

Our overall assessment was that ALPP could fill an important niche in the continuum of long-term care services at a time when VA is facing a steep increase in the number of chronically ill elderly who will need increasing amounts of long-term care.

VA presented a report describing the results of the pilot evaluation to Congress with an accompanying letter from the Secretary of Veterans Affairs.³

This letter highlighted study findings and stated that VA was “not seeking authority to provide assisted living services believing that this is primarily a housing function. VA is, however, actively coordinating outpatient and home-based medical services for veterans in assisted living facilities in a variety of locations.”

We hope this study can assist in moving toward the long-term goal of designing the optimal system of residential care services

continued on page 8

Research Highlights

Depression and Suicide in Aging Veterans: SMITREC Initiatives

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Older adults comprise the fastest-growing segment of the U.S. population, with the most significant growth among those over age 80. The percentage of older veterans is even higher than in the general population (37 percent vs. 13 percent), and from 2000 to 2010, veterans age 85 plus will triple to 1.3 million. A considerable number of older veterans experience depression which is associated with substantial suffering, disability, suicide risk, and decreased health-related quality of life. The majority of elders with depression receive treatment in primary care settings where depression is often inadequately treated.

Depression Diagnosis and Treatment

While depression in elderly patients is highly treatable, the complexity of patients' clinical presentations may result in underdiagnosis and undertreatment, which, in turn, lead to poor outcomes and increased health care utilization. SMITREC investigators have found low rates of diagnosis of mental disorders such as depression in the elderly among primary care providers.¹ A screening tool increased rates of diagnosis and intervention, but did not alter age-related disparities.

Patient factors, such as medical illness, neuropsychiatric comorbidity, and patient beliefs, also interact with provider factors to produce less than optimal management and outcomes. SMITREC investigators have found significantly lower rates of depression detection by treating physicians among subjects with coexisting dementia and depression.² Only 35 percent of the coexisting dementia and depression group were correctly diagnosed and receiving adequate

“A considerable number of older veterans experience depression which is associated with substantial suffering, disability, suicide risk, and decreased health-related quality of life.”

treatment for their depression. Treatment inadequacy had both provider-level (lack of guideline-concordant antidepressant titration) and patient- and caregiver-level (lack of adherence) contributions. Patient ethnicity may also play a role: SMITREC investigators have documented significantly lower rates of depression diagnoses in older African Americans as compared to older white and Hispanic patients.

Antidepressant treatment is as efficacious for major depression in elderly patients as in younger adults. However, many elderly patients discontinue medications prematurely; SMITREC investigators have found that up to a third of depressed older veterans did not consistently fill antidepressant prescriptions during acute treatment. Thus, while we have effective treatments for depression for elderly veterans, many veterans do not adhere to them for multiple reasons, including cognitive impairment and beliefs that are often culturally mediated. A current Investigator-Initiated Research grant led by SMITREC investigators is examining the relationship between clinical factors (such as anxiety, polypharmacy, and executive impairment) that may be key modifiable determinants of antidepressant non-adherence for older veterans with depression. Our goal is to develop

a framework for new interventions to improve adherence among this vulnerable population.

Patients with severe depression, as well as dementia and depression or other neuropsychiatric symptoms require additional pharmacological management. However, in 2005, the FDA warned that use of atypical antipsychotics to treat neuropsychiatric symptoms of dementia was associated with increased mortality. SMITREC investigators found that antipsychotic medications were associated with increased mortality in patients with dementia compared to most other medications used for neuropsychiatric symptoms.³ This association is not well understood, and may be due to a direct medication effect or to the pathophysiology underlying neuropsychiatric symptoms that prompt antipsychotic use. A current NIMH R01 grant led by SMITREC investigators is exploring the relationship of antipsychotic use, mortality, and underlying cognitive impairment severity and neuropsychiatric symptoms further within the older veteran population.

Aging and Suicide

SMITREC investigators also are leading two federally funded grants that examine suicide among veterans in depression treatment. Overall, veterans in depression treatment had a suicide rate of 88.25 per 100,000 person-years over a five year observation period. Patient-level predictors of suicide among this treatment population were generally congruent with predictors in the general population; however, suicide risks associated with age differed. In this depression treatment population, younger veterans (aged 18–44 years) had a moderately higher rate of suicide than did middle-aged patients (94.98 versus 77.93 for patients aged 45–64 years) and also modestly higher rates than elderly patients (94.98 versus 90.06 for patients aged 65 years or older).⁴ The reasons for these findings are unclear, but suggest that when older patients are actively engaged in depression treatment, their suicide risks may be no higher than that of other patients.

continued on page 8

Highlights of the 2008 HSR&D National Meeting

“Implementation Across the Nation: From Bedside and Clinic to Community and Home” was the theme of the 26th VA HSR&D National Meeting that was held February 13-15, 2008 in Baltimore, Md. Hosted by HSR&D’s Center for Research in the Implementation of Innovative Strategies in Practice (Iowa City), the meeting included 580 researchers, clinicians, and policymakers who participated in more than 30 paper sessions and workshops, and viewed 120 posters on an array of veteran-related health care issues, as well as several exhibits. This national forum provided many opportunities for discussion, collaboration, and the development of strategies that will improve health care for veterans, including our new generation of veterans returning from Iraq and Afghanistan.

The theme reflects the need to extend what we have learned about the dissemination of information and the implementation of new interventions in clinics and hospitals to a broader range of delivery settings and to new veteran populations. Other research presentations focused on diseases/conditions that are prevalent among veterans, and interventions, including: home-based monitoring to improve blood pressure control, post-traumatic stress disorder (PTSD), pain management, racial differences in type 2 diabetes, traumatic brain injury in OIF/OEF veterans, and reducing the risk of cardiovascular disease.

Meeting Highlights

The meeting featured special guest speakers: Carole Estabrooks, R.N., Ph.D., Professor of Nursing at the University of Alberta, who spoke about the state of implementation science; and Garth Stewart, a recent veteran injured in Iraq, who told attendees about his experiences with both DoD and VA health care. Carolyn Clancy, M.D., Director of the Agency for Healthcare Research and Quality (AHRQ) gave the keynote address, “Quality at All Bedside.”

Her comments focused on getting clinical research to the bedside quickly—providing the right care to the right patient at the right time. She also discussed AHRQ and VA’s joint projects, including Partners in Patient Safety Improvement Corps, which works to identify the root causes of adverse events.

David Atkins, M.D., M.P.H., the new director of VA HSR&D’s Quality Enhancement Research Initiative (QUERI), addressed the importance of bringing research into day-to-day practice. Director of HSR&D, Seth Eisen, M.D., M.Sc., discussed the importance of implementation science, in addi-

tion to focusing on HSR&D research priorities that include VA/DoD collaborations, genomics, and health issues affecting veterans, particularly the importance of pre-deployment data to understanding the etiology of conditions affecting these veterans. Joel Kupersmith, M.D., VA’s Chief Research and Development Officer, emphasized the importance of health services research in the field of genomics, as well as a new virtual informatics consortium that will allow even better use of VA’s electronic medical record.

Next year’s HSR&D national meeting is planned for February 2009 under the theme, “Defining Optimal Care: Balancing Quality, Cost and Patient Preferences.” A call for abstracts will be disseminated this summer. Watch the HSR&D website for dates and details.

Asch Receives 2008 Under Secretary’s Award for Outstanding Achievement

David A. Asch, M.D., M.B.A., has received this year’s prestigious Under Secretary’s Award for Outstanding Achievement in Health Services Research. The award recognizes a VA researcher whose work has led to major improvements in the quality of veterans’ health care, has made key contributions to the future of health services research through excellence in training and mentorship, and has enhanced the visibility and reputation of VA research through national leadership.



Through nearly twenty years as a VA health services researcher, exceptional mentor, and leader, Dr. Asch has exemplified the qualities the Award represents. Dr. Asch is the co-Director of HSR&D’s Center for Health Equity Research and Promotion (Pittsburgh-Philadelphia), whose mission is to reduce disparities and promote quality in health and health care among veterans and other populations. Dr. Asch’s research aims to understand how physicians and patients behave and make medical choices in clinical, financial, and ethically-charged settings, including the adoption of new pharmaceuticals or medical technologies, the purchase of insurance, care at the end of life, organ transplantation, genetic testing, and equity. His research combines elements of economic analysis with moral and psychological theory and marketing. Dr. Asch practices internal medicine at the Philadelphia VA Medical Center and teaches health policy at the Wharton School at the University of Pennsylvania.

In the above photo, Dr. Joel Kupersmith is shown presenting the award to Dr. Asch at the HSR&D National Meeting.

Commentary
continued from page 2

add information on their conditions and for providers to monitor their patients. Finally, while VA has relatively limited authority to provide support to caregivers, we can offer training to family members and other caregivers. Research on the most effective training modalities for caregivers would be helpful.

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Assisted Living
continued from page 5

that provides persons with chronic illnesses or disabilities a choice of high quality programs that best meet their unique needs while making the best use of finite resources.

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SMITREC Initiatives
continued from page 6

SMITREC continues to address critical issues to the older veteran with depression. Future SMITREC efforts will be directed to developing and implementing best practice models to effectively identify and treat later-life depression in our aging veteran population.

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