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Commentary

PTSD Treatment and Suicide Prevention: Clinical Practice Guidelines and Steps Toward Further Knowledge

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The Department of Veterans Affairs (VA) is committed to providing care for Veterans with post-traumatic stress disorder (PTSD) and to preventing suicide among Veterans. VA has undertaken extensive efforts in the last five years to implement enhancements to mental health care, many focused on PTSD care and on suicide prevention. VA is committed to improving and enhancing access to care and the quality of care delivered, and to expanding knowledge through research.

PTSD Treatment

VA develops Clinical Practice Guidelines (CPGs) in conjunction with the Department of Defense (DoD) on a wide array of health care issues, including several mental health diagnoses and problems. The CPGs are developed in a thoughtful, data-driven process, resulting in documents that guide assessment and disease management, and, when possible, prevention of disorders. The most recently revised CPG for PTSD was published in 2010, as an update from the original 2004 CPG for PTSD.

The role of CPGs is to guide clinical decisionmaking, not to dictate clinical care. VA emphasizes that patient preferences must be addressed, with the patient being a full collaborator in treatment planning and decisions. As potentially effective treatment options increase, Veterans can take an active role in deciding how each option fits with their goals, strengths, and challenges.

VA must develop providers who can deliver with clinical skill and fidelity the treatments shown most likely to be effective. To support this, the VA Office of Mental Health Services (OMHS) has taken a lead role in identifying the training needs of VA's mental health work force and developing programs to target those needs. VA has trained thousands of mental health clinicians to provide the psychotherapies rated most effective for PTSD in both the CPG and in an independent 2007 report by the Institute of Medicine: Cognitive Processing Therapy and Prolonged Exposure Therapy. VA's National Center for PTSD (NCPTSD) also delivers training for PTSD treatment providers through a national mentoring program that shares best practices in PTSD care across Veterans Integrated Service Networks (VISNs) and VA medical facilities.

The PTSD CPG must continue to evolve as knowledge progresses through research. For example, many Veterans want their family members more involved in PTSD treatment. While VA has expanded authority to allow family involvement in PTSD treatment, little empirical evidence exists to guide how clinicians may effectively adapt to these preferences. Additionally, the value of the PTSD CPG would be greatly increased by an evidence base to guide adjustments to treatment when clients present with common comorbidities, such as pain, insomnia, anger, substance use disorders, or traumatic brain injury.



Director's Letter: BIG³– Big Data, Big Ideas, Big Research

On March 29, 2012 the White House Office of Science and Technology Policy (OSTP) announced the federal government's Big Data Research and Development Initiative. Included in the initiative are the goals of advancing core technologies for analyzing and sharing huge quantities of data, harnessing Big Data knowledge and technologies to accelerate scientific discovery, using Big Data to transform teaching and learning, fostering public-private Big Data partnerships, and developing a Big Data workforce.

VA investigators are at the forefront of Big Data research, since they have access to vast, detailed Big Data health information (e.g., 2 billion clinical notes, 5 billion laboratory tests), an expanding cadre of Big Data investigators, established non-VA Big Data relationships, a clear mission to apply Big Data methods to improve Veteran health, and strong programmatic support for the Big Data concept. VA investigators are active participants in the Big Data initiative through ORD's support of the CHIR, ProWatch, VINCI, OMOP, iEHR, GenISIS, and MVP programs (download http://www.whitehouse.gov/sites/default/files/microsites/ostp/big_data_press_release_final_2.pdf for details).

Important Big Data issues for VA investigators to consider addressing are: using NLP (natural language processing) to extract useful clinical and research information from the VA's vast text data resources, transforming information into a format that can be readily applied by providers and patients at points of care, expanding the application of Big Data to improve personalized medicine, and using Big Data concepts to predict adverse and beneficial health outcomes.

Regardless of your current research interests, your careers will be impacted by the Big Data initiative, and the concepts and projects it will spawn. I encourage you to watch the two hour scientific discussion of the rationale and vision for the initiative, posted on the National Science Foundation's website. Please visit http://www.nsf.gov/news/news_videos.jsp?cntn_id=123607&media_id=72174&org=NSF.

Seth Eisen, M.D., M.Sc.

Director, HSR&D

Suicide Prevention

Suicide prevention is integral to VA's mental health efforts. Currently, a suicide prevention CPG is under development with the DoD, and should provide invaluable clinical guidance. The 2008 recommendations of a Blue Ribbon panel of suicidology experts have contributed to development of these guidelines. The foundation for effective suicide prevention is good mental health care—for PTSD and for all diagnosable mental illness and other emotional challenges. At the core of VA's program is VA's Crisis Line, a 24/7 phone line run in collaboration

with SAMHSA's Lifeline, established in 2007. Veterans, or those concerned about a Veteran, can call 1-800-273-8255 and then press 1 to be connected to a VA mental health professional trained to work with those in crisis or who may be potentially suicidal. Since its founding, the Crisis Line has received over 500,000 calls and initiated over 19,000 rescues. Such rescues involve dispatching emergency personnel to the site of an imminent suicide, securing the person and any others in the area, and ensuring the person receives urgent care.

One invaluable feature of VA's Crisis Line is that staff can link to the Veteran's Electronic Health Record, if the Veteran is willing to share his or her name and social security number. This feature allows the Crisis Line responder to link the caller to mental health providers who have seen the Veteran previously and to get immediate help. In addition, VA employs Suicide Prevention Coordinators (SPCs) at every facility and large clinic to arrange immediate local response. The SPCs follow up with Veterans to ensure they continue care and receive the support they need, and to develop safety plans.

Building on the success of the call line, VA has opened a written Chat Service at www.veterancrisisline.net and a texting service, at 838255, both of which connect those seeking care directly to mental health professionals who staff Crisis Line calls. These services especially appeal to younger Veterans, for whom these communication options are familiar and preferred.

Numerous opportunities for research remain. Many relationships between suicidality and diagnosed mental illness are known, but there is much to learn, particularly about the same issues of chronicity and comorbidity that are central for PTSD care. In addition, one of the most challenging issues is that a large proportion of suicides occur in those without any known mental illness. Often such suicides occur after a primary care visit, and without any obvious warning signs that the individual is at risk for suicide. Research focused on the underlying issues for such patients, how to identify them, and what care could best prevent suicide in this group would be invaluable for VA and for the nation.

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Response to Commentary

PTSD Treatment and Suicide Prevention: VA Research Contributions and Priorities

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In this issue's commentary article, Dr. Zeiss discusses expansion of VA Mental Health Services and post-traumatic stress disorder (PTSD) treatment initiatives in the VA; she points out the importance of Clinical Practice Guidelines as a means for improving clinical care. She further discusses how the VA has not only published and updated PTSD treatment guidelines in conjunction with the DoD, but has also taken impressive, practical steps to ensure that guideline recommendations can be implemented.

Following the growing evidence for psychotherapies for PTSD, the VA leadership chose not to simply rely on dissemination of guidelines to make changes in VA clinician practices—but proceeded with a massive and unprecedented effort to “train up” and support VA mental health clinicians in providing these established PTSD psychotherapies.¹ Starting in 2005-2006, the VA increased its mental health workforce capacity—hiring additional clinicians, beginning ongoing, systematic training of these clinicians, and conducting systems reorganization to support the provision of evidence-based psychotherapies.

As of May 2010, over 2,700 VA mental health clinicians had received training in either Prolonged Exposure (PE) or Cognitive Processing Therapy (CPT) for PTSD, through multi-day, in-person trainings, and weekly systematic consultation and small group supervision. VA has also placed local evidence-based psychotherapy coordinators at each medical facility to champion implementation of these treatments and to work with site leadership to organize clinic flow for improved treatment implementation. Importantly, an implementation model that established structures and processes to maintain the use of these therapies after the initial training period was developed.

This ambitious effort raises new questions regarding systems change and maintenance. Both CPT and PE require weekly delivery of treatment sessions for multiple weeks—presenting a challenge in busy VA clinics facing rising numbers of returning Veterans from the OEF/OIF conflicts. Engaging Veteran patients in completing treatment is also a challenge, with HSR&D researchers recently reporting that only a small minority (9.5 percent) of OEF/OIF Veterans with new PTSD diagnoses attended nine or more VA mental health sessions within 15 weeks in the first year following their diagnosis.² Moving to decentralized training and maintaining clinician expertise over time presents additional challenges. VA implementation scientists have the opportunity to substantially contribute in these areas, studying factors that affect the maintenance and improvement of the system capacities to provide these complex psychotherapies to increasing numbers of Veterans with need.

The commentary article's co-author, Dr. Kemp, outlines a second area of considerable effort on the part of VA Office of Mental Health Services—suicide prevention. As she discusses, suicide prevention is integral to the VA mental health services efforts, and enormous resources have been devoted to decreasing suicide among VA Health System users and among Veterans in the community. These efforts have included increasing overall mental health capacity and quality, such as the efforts described above to improve capacity and care for PTSD. Efforts have also included suicide-specific interventions, such as the Veteran Suicide Hotline and placing Suicide Prevention Coordinators (SPCs) and Care Managers at each VA facility. The VA Crisis Line is one of the few crisis lines that can, with the Veteran's permission, integrate the call into the Veteran's medical record and facilitate the connec-

tion of callers to VA care through outreach by Suicide Prevention Coordinators.

However, despite these efforts, the evidence base for suicide prevention interventions remains limited and the goal of rapidly reducing the suicide rate has remained elusive—both within the VA and nationwide.

VA HSR&D researchers have conducted a synthesis of the evidence-based literature on suicide prevention, finding that although some approaches—such as multi-component intervention in military populations—are promising, the quality of evidence for this and most other suicide prevention strategies is low, meaning that further research is likely to have an important impact on or change the estimate of the effect.³ Unfortunately, insufficient studies exist of suicide prevention programs specifically in Veterans from which to draw conclusions, and no studies exist that assessed the specific effectiveness of hotlines, outreach programs, peer counseling, treatment coordination programs, and other important care initiatives on suicide rates.

Thus, there is a clear need for further randomized controlled trials and high-quality observational studies to advance knowledge in the area of suicide prevention. HSR&D research is well-positioned to contribute in this high priority area for the VA, working in tandem with the Office of Mental Health Services on evaluating the impact of current efforts to reduce suicide risks and on implementing the strategies that are most effective.

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Research Highlight

Suicidal Behavior among Those with TBI and PTSD

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Like individuals from previous Veteran cohorts, military personnel serving in Iraq and Afghanistan are being exposed to physical and psychological traumas that place them at risk for traumatic brain injury (TBI) and/or post-traumatic stress disorder (PTSD). Both of these conditions are associated with negative outcomes. Recent research suggests that Veterans with TBI and/or PTSD may be at risk for self-directed violence (SDV) such as suicide attempts and death by suicide.

Death by Suicide among Those with TBI¹

Although previous studies supported the relationship between history of TBI and suicide in the general population, no research had been conducted to explore TBI as a risk factor for SDV among those seeking care at Veterans Health Administration (VHA) facilities. Using data from VHA electronic medical records and the National Death Index (NDI), we examined the relationship between history of TBI and death by suicide among individuals who had sought VHA care between 2001 and 2006. Analyses included all individuals with a history of TBI (n = 49,626) plus a 5 percent random sample of patients without TBI (n = 389,053). VHA users with a history of TBI were 1.55 times more likely to die by suicide than those without a history of TBI. The increased risk was not explained by the presence of psychiatric disorders or demographic factors. This finding suggests that history of TBI had an independent influence; thereby highlighting the possibility that injury-specific factors such as cognitive dysfunction or TBI-related psychosocial stressors (e.g., loss of employment, marital discord) may contribute to risk.

Moreover, among individuals whose data were included in the study, significant differences were identified in the rate of all psychiatric diagnoses (e.g., PTSD) between those who died by suicide and those who did not. In addition, the rate of PTSD was significantly greater (p < .0001) among those with TBI who died by suicide (21.9 percent) versus those with TBI who did not die by suicide (9.81 percent). This suggests that a diagnosis of PTSD may increase risk for death by suicide among those with a history of TBI.

PTSD and Suicide Attempt History among Those with and without TBI²

We also looked at the relationship between PTSD and suicide attempt history in those with and without TBI who were using VHA mental health services. Electronic medical records were used to identify history of TBI, PTSD, and/or suicide attempt. Findings suggested that a history of PTSD was associated with suicidal behavior among those with and without a history of TBI. Specifically, the odds of a suicide attempt for those with a history of PTSD were 2.8 times that of the odds for those without PTSD. Similarly, for those with both PTSD and TBI the likelihood of a suicide attempt was 3.3 times greater than for those with a TBI alone.

Recommendations for Clinical Practice

Findings from the presented studies suggest that continued research is needed to increase understanding regarding the complex relationship between TBI, PTSD, and suicidal behaviors. It is likely that factors associated

with increased risk (e.g., history of risky behavior, executive dysfunction) vary by TBI severity (i.e., mild, moderate, severe) and are exacerbated by PTSD symptoms. Mild TBI versus moderate/severe TBI are distinct conditions. Knowledge regarding differences associated with TBI severity will allow clinicians to appropriately conceptualize the degree to which the injury sustained would be expected to impact functioning. Regardless of injury severity, the focus of treatment should be rehabilitation/recovery oriented.

Based on the presented results, sufficient data exist to: 1) support screening for TBI among those with PTSD; 2) support screening for PTSD among those with TBI; and 3) consider PTSD and/or TBI as potential risk factors for suicidal behavior. For more recent Veterans, TBI screening procedures are in place; however, further work is required to identify psychometrically sound screening strategies for Veterans from previous cohorts. If a history of TBI is identified, clinicians are encouraged to evaluate for injury-related factors that may be contributing to increased risk. Those with moderate to severe injury often face challenges both at home and at work. Job loss and divorce are common. In addition, organic injury may contribute to increased impulsivity and aggression, and poor decisionmaking—all risk factors for suicidal behavior. Development of safety and treatment plans with these contributors in mind is recommended. For educational materials and information about current VISN 19 Mental Illness Research, Education and Clinical Center (MIRECC) research regarding TBI, PTSD, and suicide please visit www.mirecc.va.gov/visn19/.

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Research Highlight

Gender and PTSD

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Reviews and meta-analyses of the post-traumatic stress disorder (PTSD) literature consistently find that women experience PTSD at rates approximately twice that of men. In the general population, the prevalence of PTSD is about 5.2 percent among women and 1.8 percent among men. This gender difference is largely a function of the type of traumas women experience and their social roles. Women are disproportionately more likely than men to be exposed to traumatic events such as intimate partner violence and sexual abuse, which are often in the context of intimate interpersonal relationships, serial in nature, may increase in severity over time, and pose a high conditional risk for PTSD. Research with survivors of natural disaster, a seemingly gender neutral event, has found that women in cultures with more traditional gender roles, or women in social roles of wife and mother, are more likely to experience PTSD.

Several important gender issues in PTSD among Veterans have been elucidated by recent studies of the conceptualization of military and deployment related stressors and social contexts. Initial estimates of combat-related PTSD among Vietnam-era Veterans found significantly higher rates among men (15.2 percent) as compared to women (8.5 percent), and these gender differences were largely due to higher rates of combat exposure among men. Increasing focus on women's experiences in Vietnam and subsequent conflicts found experiences such as exposure to death and dying and other elements of the aftermath of battle, difficult living and working conditions, and experiences of sexual assault and harassment were also associated with war-related PTSD. Since Vietnam, the numbers of women in

the military have substantially increased, and their roles have expanded considerably. Conceptualizations of combat exposure have also been expanded, and research has demonstrated that this broader range of stressor experiences is essential for understanding PTSD in both men and women. There is still a higher prevalence of PTSD among male OEF/OIF/OND Veterans in VHA as compared to women OEF/OIF/OND Veterans, though these differences are moderate (22 percent as compared to 17 percent). PTSD symptoms appear to map closely to the degree of exposure to combat stressors, with men and women demonstrating similar levels of resilience.¹ Social factors, such as concerns about disruptions in family and social relationships and post-deployment social support, show a stronger impact on women's post-deployment adjustment as compared to men. Similar to civilian studies, these data highlight the importance of social factors in women's PTSD found in the Veteran population.

As VHA moves toward Veteran-centered care, our challenge is to include a focus on gender in PTSD research, and translate these findings into policies and interventions that will help promote access to and engagement with treatment for PTSD. For example, there is strong anecdotal evidence that many women Veterans prefer female mental health providers or gender-specific treatment settings for PTSD-related care. We need more information on how to quantify and address both gender-specific preferences and trauma-specific treatment preferences for the growing numbers of women seeking care for combat-related PTSD. Similarly, there is little evidence regarding gender-specific treatment issues and preferences among men seeking care for PTSD-related to military sexual trauma (MST).

Families and social networks can help promote access to care among Veterans with PTSD.² As VHA mental health services become more inclusive of family members, research that addresses the importance of family and social factors for women's PTSD can help guide implementation of these expanded services.

Finally, considerations of gender and PTSD need to look beyond the diagnosis to broader domains of health and social functioning. Emerging research suggests that women OEF/OIF/OND Veterans bear an especially heavy burden of medical comorbidity as compared to men. Research examining gender differences and gender-specific interventions in the detection and treatment of PTSD in primary care, and gender specific investigations of the quality of care for Veterans with comorbid conditions are especially important in the reproductive-aged OEF/OIF cohort. Recent research has also identified PTSD, and particularly MST, as risk factors for homelessness among Veteran women, which is an increasing problem among the growing number of female Veterans.³ Gender specific research with homeless and at risk populations should examine interventions to address trauma and PTSD, logistical and clinical issues for women with children, and provision of specialized services in programs that see few women.

While there is still much to learn in relation to gender and PTSD, a number of ongoing HSR&D and VA projects are examining these important issues to ensure that both male and female Veterans continue to have access to quality PTSD care.

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Research Highlight

The Role of Primary Care in Addressing Suicide Risk

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It has been estimated that up to 18 Veterans die each day by suicide. The subgroup of Veterans who receive care within the VA health care system are at greater risk for suicide compared to non-Veterans; the rate of suicide within this subgroup has decreased only slightly in recent years.¹ Well-documented risk factors for suicide include previous suicide behaviors, psychiatric and general medical conditions, male sex, poor psychosocial support, access to means for suicide (especially firearms), losses, and recent psychiatric hospitalization.

VA Suicide Prevention Activities

The VA has developed a comprehensive strategy in an effort to reduce the incidence of suicide. Specifically, the VA has implemented screening for conditions commonly associated with suicide behaviors; developed national performance measures and tools to facilitate assessment of suicide risk; and created a “Veterans Suicide Prevention Hotline” that provides ready access for Veterans and their families to seek and receive help. The VA has also implemented training programs for VA staff and created the Suicide Prevention Coordination Program, which funds suicide prevention coordinators at VA facilities and facilitates monitoring and safety plan development for high risk patients. In addition, through the Primary Care-Mental Health Integration and Translating Initiatives for Depression into Effective Solutions (TIDES) initiatives, the VA has implemented co-located and collaborative mental health care approaches designed to support primary-care based Patient Aligned Care Teams (PACTs), and to enhance primary care patient access to high quality mental health care.

Primary Care Interactions with Veterans at Risk

Primary care clinicians have a critical role to play in addressing suicide risk of Veterans by detecting and treating important mental and general medical conditions, and being prepared to identify and respond to opportunities to intervene when Veterans are at high risk. Prior research indicates that a considerable proportion of individuals who die by suicide make contact with health care clinicians prior to death. According to multiple studies, half of individuals make contact with primary care providers in the month prior to death, while a much smaller proportion make contact with mental health care clinicians during that month. During these contacts, it is not clear whether patients are specifically seeking help for emotional distress versus seeking care for general medical conditions, although several recent studies suggest that emotional issues are frequently not addressed at these last visits.^{2,3} In a study using a small sample of Veterans from Oregon who subsequently died by suicide, we found that less than one-third of the patients acknowledged suicidal ideation even when they were asked about it during last visits with primary care clinicians.²

Mental disorders are common among Veterans treated by primary care clinicians, and these disorders, as well as general medical conditions, increase risk for suicide behaviors. Key conditions for primary care clinicians to detect and treat include depression, anxiety, and substance use disorders. These conditions have been well-documented to increase risk for suicide behaviors, and many Veterans who receive treatment for these disorders receive it only in primary care settings. Less clear is the relationship between PTSD and

suicide—while some studies have shown PTSD increases risk for suicide, others have found weaker associations between PTSD and suicide. Traumatic brain injury, which is often comorbid with PTSD, may also be an important risk factor for suicide. However, to date there are few data available to support this relationship; studies examining this question are in progress. Finally, other studies have shown that chronic pain frequency and intensity may be associated with a two-fold increase in rates of suicide behaviors. Importantly, insomnia and anxiety may further increase risk for suicide among individuals who have pain or other comorbid conditions.

Further innovation and research is needed to optimize the role of PACTs in suicide prevention. We need to further develop and implement training programs that enhance PACT members’ ability to: a) address and treat depression, anxiety, substance use disorders, chronic pain, and insomnia; b) recognize and respond to suicidal ideation as well as other warning signs of patient distress; and c) use motivational interviewing techniques to help high-needs patients transition to specialists when specialty care is indicated. At a systems level, it is important that the VA continue to support development and testing of sustainable collaborative approaches, including decision support and care management for conditions that increase the risk for suicide behaviors. Development of additional processes that facilitate communication and coordination among PACTs, mental health clinicians, and Veterans as Veterans make transitions between care settings is also needed.

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Research Highlight

Compensation and Pension Examination for PTSD

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The approval of a claim for service-connected post-traumatic stress disorder (PTSD) results in priority access to VA health care and financial compensation. Veterans currently receive over \$4 billion dollars annually in compensation for PTSD. The number of Veterans in 2010 with service-connected PTSD was 386,882, a 222 percent increase from 1999. The trend for rapidly rising costs of service-connected PTSD prompted an investigative report in 2005 by the VA Office of Inspector General. The report found that compensation for PTSD out-paced all other conditions and that wide regional variations exist in the rates of service-connected PTSD. The report attributed this wide variation across the network of VA medical centers in part to variation in compensation and pension (C&P) examinations.

In studies on PTSD, the Clinician-Administered PTSD Scale (CAPS) has been used in hundreds

of research protocols, resulting in CAPS becoming the gold standard for diagnosis.¹ Standardized administration is accomplished through carefully worded prompts and scale anchors with explicit behavioral referents. Initial prompt questions target each core symptom of PTSD, and follow-up prompts help clinicians clarify the linkage between symptom and trauma. Similarly, the World Health Organization Disability Assessment Schedule II (WHODAS-II) is a standardized interview of functional impairment.² Given that these evidence-based, standardized, diagnostic tools are used routinely to enhance the validity of research studies on PTSD, the incorporation of these diagnostic methods may likewise produce greater accountability and consistency in the disability examination for PTSD.

A surprising lack of rigorous studies exists on evidence-based, standardized assessment for disability. We addressed this evidence gap by

conducting a cluster randomized controlled trial in a sample of Veterans seeking PTSD disability compensation from the VA—the Enhancing Equitable and Effective PTSD (E3-PTSD) Disability Assessment Study. The trial compared typical clinical interviews with standardized assessments that incorporated the CAPS for PTSD diagnosis and the WHODAS-II for functional impairment. We expected that Veterans in the standardized assessment condition would receive more complete and accurate assessment of the DSM-IV-TR diagnostic components of PTSD and related functional impairment compared with Veterans in the usual practice condition.

Our study found that administering a standardized disability assessment resulted in more complete assessment of functional impairment and diagnostic coverage of PTSD. Standardized assessment elicited an increase in relevant information for each of the core diagnostic criteria, and nearly eliminated variation between examiners and medical centers. Furthermore, the study found that standardized assessment substantially diminished the uncertainty in diagnosis, and increased concordance of diagnosis with the NC-PTSD experts.

The CAPS added 15-20 minutes to the assessment process. A majority of the clinicians found the CAPS useful and would support making it a routine part of the assessment (56 percent support/25 percent oppose/19 percent ambivalent). The vast majority of clinicians did not find the WHODAS useful and would oppose making it a routine requirement. Clinicians' primary objection was that the WHODAS was not specific enough for functional impairments attributable to PTSD.

Reflections and Looking Forward

In a survey of VA clinical examiners, we found that the CAPS or other structured interview methods are rarely used in Veteran C&P disability assessment.³ The more routine and common practice is the open-ended, unstructured clinical interview concurrent with the use of a report writing template. The findings of our study indicate that evidence-based, standardized disability assessment for PTSD would enhance the clinician's determination of a PTSD diagnosis and functional impairment, and make the disability examination process more reliable and valid.

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Yano Receives 2012 Under Secretary's Award for Outstanding Achievement in Health Services Research



Elizabeth Martin Yano, Ph.D., M.S.P.H., will receive 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.

Dr. Yano's research focuses on organizational influences on quality and the implementation of evidence-based practice. She is working to inform VA's efforts to implement and evaluate VA Patient-Aligned Care Teams (PACTs). She also serves as principal investigator for the National VA Women's Health Research Consortium and Practice-Based Research Network, which provides infrastructure for advancing VA research to improve the organization, quality, and impacts of the delivery of VA health care services to meet women Veterans' needs.

Dr. Yano serves as co-Director of HSR&D's Center for the Study of Healthcare Provider Behavior in Sepulveda, CA, and has been a part of the Center since its inception. Dr. Yano is a scholar, mentor, and prolific author, generating more than 100 peer-reviewed publications. The Under Secretary's Award will be presented to Dr. Yano at the HSR&D/QUERI National Meeting in July.

FORUM

Translating research into quality health care for Veterans

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The E3-PTSD study was formulated to meet the need of the Veterans Benefits Administration and the Veterans Health-care Administration to inquire about variations in the C&P examination process. We encountered challenges in navigating the two worlds of research and operations, and in overcoming the hurdles of multiple Institutional Review Boards. We also faced difficulty in embedding a study within pure facility operations of C&P and the realities of completing examinations within a 30-day window of time. During the course of the study, we had to adjust to volatile events resulting in suspension and then surveillance of PTSD research, and contend with policy changes on conceding PTSD stressors. These challenges resulted in slowing study enrollment and then flooding VHA with PTSD examinations. As HSR&D moves toward more partner service-directed research,

new studies will face similar challenges. In E3-PTSD, we submitted progress reports and held debriefings with the VA leadership. Our greatest impact to date has been the timely transfer of knowledge, which has allowed leadership to properly debate the study implications and incorporate them into consideration and formulation of policy.

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