FORUM *translating research into quality health care for veterans*

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New Veterans and New Challenges

By Michael J. Kussman, M.D., M.S., M.A.C.P., Deputy Under Secretary for Health

The conflicts in Iraq and Afghanistan have brought a renewed sense of mission to Veterans Health Administration (VHA) employees, as we begin to see more and more young men and women with war-related wounds and trauma at our health care facilities. While we are all saddened by their injuries and illnesses, the good news is that modern military medicine has brought better care than ever to the front lines—saving lives, increasing the numbers of service members that can be returned to combat, and improving the prognosis of many who must be returned home for further medical treatment.

VA employees have excelled at finding new ways to cut through red tape and to operate as teams to ensure that discharged service members are seamlessly transitioned from active duty to veteran status—and that they receive the timely benefits and medical care they are entitled to. I am particularly proud of our outstanding efforts to help the heroes whose care has been entrusted to us by the Department of Defense (DoD), even before their discharge from service. Many of these badly wounded men and women have received personalized care on a level that VHA has never before provided to veterans of any war.

Now, however, is the time to apply the lessons learned from the Seamless Transition process to all of the heroes it is our privilege to serve. Our efforts should no longer be differentiated by periods of service—or limited to those recently returned from combat. To be of value, VA must provide exemplary care to all who are entitled to our care, whenever it is needed. We must now begin to institutionalize and expand the processes we have put into place to serve Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans.

One lesson we've learned is that the best mechanism to coordinate care and benefits for new veterans is to reach out early and often before they have separated from military service. We have stationed VA employees at major military treatment facilities as a resource to those requiring information about VA benefits, and to facilitate coordination with our health care system. These employees have unsnarled red tape, improved communications, and generally made the transition from service member to veteran a far simpler task than their parents or older siblings faced.

To improve this transition further, hospital directors and other senior leaders should routinely reach out to nearby military facilities and offer to speak about VA benefits and services. Current service members are, in many cases, our future clients—even those who select Tricare as their option for care when they return to civilian life. And our health services researchers should begin to look at non-traditional means for collaborating with DoD to produce not only healthier soldiers by creating strategies to improve short-term health outcomes, but also healthier veterans through strategies that will improve long-term outcomes for active duty service members.

Once OIF and OEF veterans have separated from service, the Secretary of Veterans Affairs

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Director's Letter

We are pleased to welcome Joel Kupersmith, M.D., as our new Chief Research and Development Officer (CRADO). Dr. Kupersmith brings years of experience as a cardiologist, researcher, policy expert, and academic leader to the position. We look forward to working closely with Dr. Kupersmith on health services research and in support of the full spectrum of research across the Office of Research and Development.

At the same time, we express our heartfelt appreciation to Stephan D. Fihn, M.D., who demonstrated extraordinary dedication and leadership as Acting CRADO since July 2004. In June, Jonathan B. Perlin, M.D., Ph.D. presented Dr. Fihn with the VHA Exemplary Award for his outstanding service.

We also are delighted that both Dr. Perlin and Michael J. Kussman, M.D., M.S., M.A.C.P., have been confirmed as Under Secretary for Health and Deputy Under Secretary for Health, respectively. Both have been extremely supportive of health services research, and we look forward to continuing a productive relationship as we strive to improve the cost, quality, and effectiveness of health care for veterans.

In this special supplement, we turn our attention to the challenges presented by our newest generation of veterans, those who have served or are now serving in Afghanistan and Iraq. Many of these young men and women are returning from combat with severe injuries that require extensive hospitalization and rehabilitation. VA is a leader in providing the specialized care needed by these veterans and in offering the support needed by their families. In this issue, we discuss just some of the recent and ongoing research and activities that will help VA to better understand and meet the important challenges presented by these new veterans and improve the care and outcomes for all veterans that we serve.

Shirley Meehan, Ph.D., M.B.A.
Acting Director, HSR&D

sends each one a letter, thanking them for their service to our Nation, and providing information on VA benefits and health care. Nearly 300,000 such letters have been sent; it is now time to extend this program to all newly separated veterans, whether or not they served in a theater of combat operations. Non-combat veterans, too, may be eligible for our care and we need to reach out to them at our earliest opportunity.

"VHA is committed to growing and learning from our experiences in serving our newest generation of veterans. There is much we can be proud of in our performance thus far."

Another lesson we have learned is that the expectations of this new generation of service members and veterans are different from those who have come before them. Today's armed services embrace and enfold members and their families in a blanket of service and support. This approach allows service members to focus on their assignments and the military's explicit missions. OIF and OEF patients and their families have made it clear they expect the same level of service and support from VA, as they transition to VA health care. We must listen to those needs and determine, as an organization, the best ways to respond to those expectations for all of the veterans we serve.

VHA is committed to growing and learning from our experiences in serving our newest generation of veterans. There is much we can be proud of in our performance thus far. But we must now use our new-found knowledge to improve our ability to care for all veterans, from every era, who entrust us with the awesome responsibility of providing them with the world-class health care their service and sacrifices for our Nation have entitled them to. ■

About the Author

Brig. Gen. Michael J. Kussman, M.D., (U.S. Army Ret.) was recently appointed Deputy Under Secretary for Health. In this capacity, he has broad responsibility for the clinical policy and programs within the VA system. He brings to his position the pragmatism of an experienced executive with the compassion and acumen of a seasoned clinician.

Dr. Kussman became the Army Surgeon General's chief consultant in internal medicine and governor for the Army Region of the American College of Physicians in 1988. Dr. Kussman went on to command Walter Reed Health Care System in Washington, D.C., where he was promoted to brigadier general. He later served as commander of the Europe Regional Medical Command, command surgeon for U.S. Army Europe, and TRICARE lead agent for Europe. In this capacity, he was responsible for Army health care throughout Europe, the Middle East, and Africa.

Dr. Kussman received many military decorations, including the Distinguished Service Medal (the highest award given in peace time). Dr. Kussman received the prestigious "A" designator from the Army Surgeon General, which identifies professorial rank, and the Laureate Award from the American College of Physicians/American Society of Internal Medicine, as well as being selected as a Master of the College. He is board certified in internal medicine and serves on the faculty of the Uniformed Services University of Health Sciences.

This past spring, HSR&D released new research priorities for funding through fiscal year 2006. These priorities are intended to address the needs and challenges of all veterans that we have the privilege to serve, including our new veterans with unique needs. For full details about these funding priorities, visit the HSR&D Web site at www.hsrd.research.va.gov/for_researchers/funding/solicitations.

Response to Commentary

VA Research: Meeting the Challenge of a New Generation of Veterans

By Stephan D. Fihn, M.D., Director, Seattle HSR&D Center of Excellence

During its transformation over the past decade from a collection of loosely organized and inefficient hospitals to a tightly integrated network of 157 hospitals, 869 outpatient clinics, and 134 nursing homes, VA has become a far more responsive and nimble organization. Once a provider of mainly episodic inpatient care, the VA system now emphasizes coordinated primary care guided by explicit performance measures.

Far from the lethargic bureaucracy that many critics once derided, VA is constantly evolving in an attempt to provide better and more efficient health care. The return of thousands of wounded veterans from the ongoing conflicts in Iraq and Afghanistan has created a powerful imperative for further change and improvement. And as Dr. Kussman elucidates in his commentary, VA has rapidly undertaken a number of ambitious initiatives to meet this challenge.

Active Outreach Characterizes Response

It might seem relatively straightforward to cope with this influx of new patients. Hasn't VA been receiving large numbers of wounded veterans for more than half a century? And isn't the number of ill veterans who have returned from the Gulf relatively small in relation to the more than 5 million veterans who currently receive care in the VA system? Although the answer to both questions is yes, Dr. Kussman describes a response that is very different from the manner in which VA provided care to returning veterans in the past. The VA's response to the newest generation of returning combat veterans involves active outreach, coordination of care with other departments, and recognition that these veterans have sustained injuries and developed problems that are unique to this war.

For the first time in history, relatively large numbers of soldiers are surviving with multiple amputations, in part due to protection of vital organs by body armor and the availability of prompt, effective medical and surgical care in the field. These injuries are occurring mainly in fit, young soldiers who are highly motivated to resume functional, fulfilling lives. Severe blast injuries caused by improvised explosive devices induce severe disabilities that may include blindness, deafness, and/or cognitive impairment. Prolonged rotations, arduous duty, and omnipresent danger have resulted in an incidence of post-traumatic stress syndrome that is at least as high as in previous major wars and perhaps higher. Led by Dr. Kussman and his staff, VA has aggressively set out to address these problems and to establish new standards for identification, intake, and care of patients entering the health care system.

New Approach Offers Generalizable Model

Health services investigators should view the influx of new veterans in the context of VA's ongoing transformation. As a health care system, we need to become more proactive, both in identifying prospective patients and in anticipating their medical problems. This approach contrasts with the "old" passive system of simply waiting for patients to show up and reacting to their needs. Moreover, this new approach is a generalizable model and one that relies upon surveillance of prospective patients. One could readily envision applying this approach to patients already in the system as well as those entering the system. These evolutionary changes will provide invaluable opportunities for research and, to exploit them, we need to continue to widen our vision as to what constitutes the VA health care system.

We have moved from inpatient to outpatient settings and now we need to think beyond those settings into the home and the community. Potential sites of care should include residential facilities, homes, and community centers, among others. The increasingly ubiquitous Internet, sophisticated but inexpensive wireless devices, and wearable monitoring equipment will provide exciting challenges to rethink how health care is delivered. At this very moment, My HealtheVet is being deployed nationally and will provide an unparalleled opportunity to reach a broad audience, to communicate with patients outside of the usual hospital and clinic settings, and to engage patients more fully in their own health care.

There has, however, been regrettably little involvement by health services researchers in designing or evaluating potential applications for this bold innovation. As with our clinical leaders, investigators must refashion their notions about the very nature of health services. As the world changes, we should not only keep up, but we must help set the pace. ■

HSR&D encourages our investigators to remain veteran-focused in their research and to provide early notification of manuscripts accepted for publication. Timely notification enables HSR&D to brief VA senior leaders and others about your valuable contributions and will help keep our programs vibrant despite budget constraints. For the notification process, see www.hsrd.research.va.gov/for_researchers/pub_notice.cfm#a.

Post-Traumatic Stress Disorder in Primary Care: Barriers to Care

By Kathryn M. Magruder, Ph.D., M.P.H., Ralph H. Johnson VA Medical Center

In a recent study of 746 randomly selected VA primary care patients from four VA hospitals, we found the prevalence of post-traumatic stress disorder (PTSD) to be 11.5 percent.[1] In addition to examining the prevalence of PTSD, we set out to determine the extent to which providers recognize PTSD symptoms in their patients. We used the Clinician Administered PTSD Scale, or CAPS, and a trauma assessment interview as our PTSD diagnostic assessment tools. Of those patients diagnosed with PTSD, a 12-month medical record review indicated that providers identified only 46.5 percent and only 47.7 percent had used mental health specialty services. Patients who suffered from PTSD and who had used mental health care in the past 12 months were more apt to be identified as having PTSD than non-mental health service users (78.0 percent vs. 17.8 percent).

Since 1980, when the diagnosis of PTSD was first codified in the American Psychiatric Association's Diagnostic and Statistical Manual III, VA has been a leader in all aspects of treatment for and research on PTSD. Why, then, did we find that fewer than half of the patients who met criteria for a research diagnosis of PTSD had been either recognized as having PTSD by their providers or used mental health services?

Many factors affect the quality of care and service use for mental health conditions encountered in primary care settings. Patients may feel reluctant to discuss mental health problems—especially PTSD—with primary care providers. Some symptoms of PTSD are more somatic than psychological in nature (e.g., sleep disturbance, arousal); patients may report these symptoms to their providers as medical problems as opposed to a mental disorder. Patients may not understand that they have a mental health condition, or, they may understand they are suffering from a disorder but not know that it is appropriate to discuss their symptoms with a primary care provider.

"We need a better understanding of the barriers to treating PTSD, including patients' and providers' knowledge, attitudes, and perceptions of PTSD and its treatment."

Furthermore, patients may feel that mental illness is a stigmatized condition—a sign of weakness, inability to cope, or embarrassment. It may also be difficult to talk about the traumatic events that contributed to PTSD. As a result, many patients feel reluctant to discuss PTSD (and other mental health issues) with their primary care providers and would be reluctant to see a mental health provider.

From the primary care providers' point of view, their training emphasizes medical illness rather than psychiatric disorders. They may not know how to interpret symptoms of PTSD—especially when patients emphasize somatic symptoms. They, too, may feel uncomfortable in addressing mental health issues and traumatic events, and may have concerns about losing their patient's trust by bringing up the topic of mental illness. Or, primary care providers may have doubts about the effectiveness of mental health treatments. Finally, many patients in the VA have multiple medical problems, and providers may find themselves needing to prioritize and make decisions about which problems to address in a single visit. PTSD and other mental disorders simply may not make it to the top of the list.

Last, system factors may also serve as barriers to identifying and treating PTSD. The primary care visit is typically not long enough to address both the medical and psychological problems that veterans have (not to mention preventive health issues). If a patient is suspected of having PTSD, it takes time to investigate the symptoms more thoroughly, educate the patient about the diagnosis, and outline the choices of therapy (including referral to mental health). Furthermore, even if a patient is willing to accept a referral, many facilities have lengthy wait times for mental health appointments; providers may be reluctant to burden the specialty care system.

A number of advances in treatment of PTSD have led to the development of treatment guidelines, including one jointly developed by VA and DoD that includes recognition and treatment of PTSD in primary care settings.[2] Guidelines, however, will not be successful if patients and providers avoid addressing PTSD. We need a better understanding of the barriers to treating PTSD, including patients' and providers' knowledge, attitudes, and perceptions of PTSD and its treatment. Understanding these barriers will provide a framework for developing patient- and system-level interventions that can improve the timeliness and appropriateness of PTSD treatment, as well as acceptance of that treatment by VA patients. ■

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Evaluation of Combat Veterans: Lessons Learned from the War Related Illness and Injury Study Center—Washington, D.C.

By Mitchell T. Wallin, M.D., M.P.H., and Julie C. Chapman, Psy.D., both from the Washington, D.C., VA Medical Center

Wars have long affected the health of veterans in multiple ways. From the Civil War to the Gulf War (GW), a variety of physical and psychological stressors have placed military personnel at high risk for adverse health effects.[1] DaCosta syndrome, effort syndrome, combat stress reaction, post-traumatic stress disorder, and GW illness are some of the war-related illnesses that have been described during the past two centuries.

Veterans of these wars frequently complain of similar symptoms, including fatigue, memory and concentration difficulties, headaches, gastrointestinal complaints, and sleep disorders. These complaints are nonspecific and are also commonly documented in patients who present to general medical facilities.[2] Historically, however, there has never been an identified physiological illness related to combat exposure that does not also have a psychological contribution.

VA introduced two War Related Illness and Injury Study Centers (WRIISC) by a competitive peer reviewed process in 2001 to address the health issues of veterans who have returned from the combat theater (please visit www.va.gov/WRIISC-DC). The centers focus on four topic areas: 1) clinical care, 2) education, 3) research, and 4) risk communication. The clinical program at the WRIISC-DC has evaluated more than 400 veterans who have served in military conflicts through its outpatient and inpatient referral program. A number of conferences and multimedia products have been produced to educate health care providers, veterans, and their families about combat-related health issues.

With its emphasis on epidemiologic studies, the WRIISC-DC has provided a new catalyst for collaborative research on deployment-related illness and injuries. Members from our center have addressed morbidity and mortality in GW veterans through a number of studies. Preliminary data from veterans serving in Operation Iraqi Freedom and Operation Enduring Freedom reveal high rates of mental disorders and post-traumatic stress disorder.[3]

"With its emphasis on epidemiologic studies, the WRIISC-DC has provided a new catalyst for collaborative research on deployment-related illness and injuries."

In reviewing the research experience of GW veterans, many studies have used highly selective samples of patients that present to referral programs. The participants in these studies may not be representative of the deployed troops. Bias introduced through the selection process limits the accuracy and generalizability of results. Consequently, we would argue that population-based epidemiologic data is the preferred source for assessing the health of veterans.

The current authors and colleagues were funded by VA Health Services Research and Development Service to evaluate the cognitive health of a population-based sample of GW veterans. Cases were deployed to the GW theater and met Centers for Disease Control and Prevention criteria for multisymptom illness. Controls were also deployed to the GW theater, but did not meet criteria for multisystem illness. All subjects completed a day of neuropsychological evaluation, including measures of premorbid ability and effort. The case and control groups did not differ significantly on demographic variables. Interim analysis revealed that cases differed from controls primarily on self-reported measures of symptoms. Specifically, on self-reported measures of physical, emotional, and social functioning, the case group endorsed significantly poorer functioning than the control group. None of the primary neuropsychological outcome variables differed significantly between groups. Final analysis is under way and results will be forthcoming.

In order to continue to meet the needs of combat veterans, future research studies will require careful attention to the specific questions asked and the appropriateness of the population and methods used. The WRIISC-DC serves as a resource for VA investigators interested in the health outcomes of combat veterans. ■

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Weinberger Receives John M. Eisenberg Excellence in Mentorship Award

Morris Weinberger, Ph.D., a VA Health Services Research and Development Service (HSR&D) Career Scientist Awardee and a faculty member of the School of Public Health at the University of North Carolina at Chapel Hill (UNC), has won the 2005 John M. Eisenberg Excellence in Mentorship Award from the Agency for Healthcare Research and Quality (AHRQ). The award recognizes faculty serving in a mentoring capacity at institutions participating in training programs of the National Research Service Award (NRSA). AHRQ awards NRSA fellowships and training grants to foster health services research training opportunities across the country.

"Morris is interested in the growth of students as researchers and as professionals," said Timothy Carey, M.D., director of UNC's Cecil G. Sheps Center for Health Services Research and the AHRQ fellowship at the University of North Carolina. "His legacy will not just be the papers he has authored or the research he has led, it will be the generations of researchers whose work he has supported."

The award was named for the late John M. Eisenberg, M.D., who directed AHRQ from 1997 to 2002.

Evidence-Based Research Priorities to Improve the Health and Health Care of Women Veterans

By Elizabeth M. Yano, Ph.D., M.S.P.H., Sepulveda HSR&D Center of Excellence for the Study of Healthcare Provider Behavior, and Linda R. Lipson, M.A., HSR&D Central Office

Women now comprise 20 percent of new military recruits, 15 percent of active duty forces, and 17 percent of reserve and National Guard forces. They are among the fastest growing segment of new users in the VA health care system and represent new challenges to the design and delivery of health care that has traditionally focused on men. The VA's research enterprise provides a valuable opportunity to improve our understanding of women veterans' special health care needs and to foster research that acts on priority areas. As a result, the Department of Veterans Affairs tasked the VA Office of Research & Development with developing the first women's health research agenda designed to map research priorities to the needs of women veterans and to position VA as a national leader in women's health research.

Developing the Evidence Base

To build an evidence base that aligns VA research priorities with the needs of women veterans, we capitalized on VA's extensive data repositories to obtain gender-focused analyses that would frame a portrait of their needs. We then partnered with the Southern California Evidence-based Practice Center to commission a literature review. For secondary analyses, we sought to determine high-prevalence, high-cost and/or high-impact conditions, as well as conditions with disproportionate burden among women (e.g., osteoporosis) or with distinct clinical presentations in women (e.g., coronary artery disease). More than 15 research centers responded to our requests, demonstrating both the capacity and commitment to furthering the VA women's health research agenda. Top diagnoses included post-traumatic stress disorder (PTSD), arthritis, chronic low back pain, hypertension, chronic lung disease, and depression. Similarly, the literature synthesis demonstrated knowledge gaps regarding women veterans' specific health risks and quality of care, as well as limited data on efficacious treatments for key high-prevalence conditions.

Achieving Consensus on Priorities

The resulting gap analysis provided a foundation for an agenda-setting conference among VA and non-VA women's health researchers. Workgroups generated priorities for biomedical, clinical, rehabilitation, and health services research, and recommendations for improving the capacity for conducting VA women's health research.

- The Biomedical Workgroup emphasized the need for research on sex-based influences on prevention, induction, and progress of diseases relevant to women veterans, with special emphasis on: 1) mental health (especially PTSD, stress, addiction, sexual trauma, and depression), 2) military occupational hazards (especially injury/rehabilitation, wound healing/tissue remodeling, vaccine development, and biological/chemical exposures), 3) chronic diseases, 4) cancer, focused on etiology and response to treatment for exposure-related cancers, and 5) reproductive health.

- The Clinical Sciences Workgroup found the lack of high-quality epidemiological data on women veterans, prior to and through military exposures to their status post-discharge, to be a hindrance to clinical research. Priority recommendations included creating VA/Department of Defense data-use agreements to capitalize on their inception cohorts. Barring that, researchers should create a prospective cohort of women upon discharge from the military, modeled after the Nurses' Health Cohort Study.

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Seamless Transition in VA

By Jennifer Perez, LICSW, Office of Seamless Transition, VA Central Office

Like never before, the Department of Veterans Affairs (VA) is collaborating with the Department of Defense (DoD) to provide a seamless transition for the health care and delivery of benefits to returning service members from Military Treatment Facilities to Veterans Health Administration (VHA) facilities and Veterans Benefits Administration (VBA) Regional Offices.

In August 2003, VA's Under Secretary for Benefits and Under Secretary for Health created a Taskforce for the Seamless Transition of Returning Service Members. The Taskforce was charged with:

- improving communication, coordination, and collaboration, both within VA and between VA and DoD, in providing health care and benefits to returning veterans from Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF);
- ensuring that VA staff is educated about the needs of OIF/OEF veterans, particularly those severely ill or injured as result of military service; and
- ensuring that policies and procedures are in place to enhance access to health care and benefits.

In January 2005, VA established a permanent Seamless Transition Office to assume the duties of the Taskforce. Composed of representatives from VHA and VBA, the Seamless Transition Office coordinates departmental activities related to the transition of returning service members. The VA is partnering with DoD to enhance the activities of the Seamless Transition Office. To aid in this effort, an active duty Marine colonel has been assigned to the Seamless Transition Office.

In providing high-quality health care and access to benefits, VA has established strategies, policies, and programs to provide timely, appropriate services to returning service members and veterans. The cornerstone of this initiative is the assignment of full-time VA staff at DoD Military Treatment Facilities to provide onsite education and counseling about VA services. Social workers and benefits counselors are assigned to eight major Military Treatment Facilities, including Walter Reed Army Medical Center and the National Naval Medical Center-Bethesda. They collaborate closely with Military Treatment Facility treatment teams to provide consultation for complex patient care needs and to coordinate the transfer of active duty service members and recently discharged veterans to appropriate VA health care facilities. Benefits counselors provide early counseling and assist with applications for benefits to which a service member may be entitled.

To ensure that seamless transition is a reality at the hometown VA Medical Center and VBA Regional Office, OIF/OEF Points of Contact at VHA facilities and OIF/OEF Coordinators at VBA Regional Offices have been identified to expedite and coordinate the transfer of health care and benefits information initiated at the Military Treatment Facility. This role also includes coordinated outreach efforts to the National Guard and Reserve Units as they return from military service.

In a further collaborative effort, Uniformed Army Liaisons have been assigned to VA's four regional Traumatic Brain Injury Lead Rehabilitation Centers that address the unique conditions faced by the multi-trauma combat injured patient. The Army Liaisons assist in the transfer of active duty service members who have sustained severe injuries (e.g., traumatic brain injury, spinal cord injury, loss of limbs, visual impairment) and in expediting the flow of information and communication between Military Treatment Facilities, the VA, service members, and family members. In that spirit, an active duty Marine Liaison Officer has been assigned by the Marine Corps *Marine For Life* Program to the Seamless Transition Office. This officer assists with the transition needs faced by Marines or sailors and their families during the transfer of care from the Marine Corps or Navy to the VA.

"VA is committed to providing a seamless transition from DoD to VA for returning OIF/OEF veterans. VA is reaching out to new combat veterans in unprecedented ways and has no more important mission than to provide the highest quality health care and benefits to our Nation's veterans."

The Marine Liaison Officer has been called upon to provide service member contact information to expedite the delivery of VA benefits and health care when such information has been previously unavailable. As the subject matter expert on Marine Corps issues, this officer provides detailed information and education in resolving complex issues for the service member, family, and VA staff. Such issues may include the nature of military discharge and/or retirement, coordination of military benefits, and assistance with military orders.

VA is committed to providing a seamless transition from DoD to VA for returning OIF/OEF veterans. VA is reaching out to new combat veterans in unprecedented ways and has no more important mission than to provide the highest quality health care and benefits to our Nation's veterans. ■

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■ The Rehabilitation Workgroup established six priority conditions/diseases: 1) arthritis, 2) chronic pain, 3) obesity, 4) osteoporosis and fall-related injuries, 5) amputation, and 6) reproductive challenges for disabled women veterans. Priority areas include prosthetics research adapting to menstrual cycle variability in limb volume and rehabilitation engineering focused on gender-appropriate assistive devices for women with disabilities and gender-specific technologies for urinary incontinence.

■ The Health Services Workgroup recommended evaluations of women veterans' health care delivery models. Priority recommendations focused on assessments of women's chronic illness care needs, including the combined impact of their physical and mental health conditions on utilization and outcomes, as well as analyses of gender-specific barriers to access.

■ The Infrastructure Workgroup recommended improved networking and mentoring of interested researchers, establishment of multi-site collaborative arrangements capable of recruiting adequate samples of women veterans, focused statistical expertise and training, and creation of Web-based dissemination tools. Building bridges to research partners at agencies with long-standing commitments to advancing women's health and improving gender equity also will continue to invigorate the VA research process.

The resulting VA women's health research agenda has yielded a comprehensive set of research priorities for the future, while new partnerships hold promise for creating collaborative synergy that will advance the field. The agenda-setting process itself has created a foundation for fostering new research designed to accelerate the translation of research from the bench to the bedside that meets women veterans' needs. Since most of the 1.7 million women veterans currently living in the United States obtain all or most of their medical care outside VA, where their veteran status is likely unrecognized, all researchers and clinicians have the potential to benefit from this investment in establishing evidence-based research priorities for improving the health and health care of women veterans. ■

Conference proceedings and other updates on VA women's health research are available at www.va.gov/resdev/programs/womens_health/conference/default.cfm. *Also look for the upcoming Journal of General Internal Medicine special issue on VA women's health care.*

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