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Commentary

VHA: Designing Tomorrow's Veteran-Centered Model of Care

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During the 1990s, the Veterans Health Administration (VHA) underwent a major transformation, balancing inpatient care with outpatient services, ensuring Veterans had access to standardized benefits, and improving population health. Since those years, VHA has continued to make many incremental improvements. Faced with enormous changes within health care, future financial constraints on government, and evolving Veteran expectations, VHA must move beyond problem-based disease care to patient-centered health care, based on relationships between the patient, his or her family, and the health care team. This new system must also be safe, of high quality, and efficient.

Today, VHA is embarking on our next major transformation, one that places the Veteran and his or her family at the center. This means focusing holistically on optimizing health and not just the treatment of disease; designing the delivery system around the needs of our Veterans and not around a medical model; and being responsive to the desires of our patients rather than designed for our convenience.

A Vision for Continuing to Deliver 'The Best Care Anywhere'

Veterans have told us that they want a system that they can trust to reliably provide all necessary services to restore health and functionality, but that is well coordinated and conveniently available—both in terms of being timely and close to home. They want a relationship with a personal clinician, some choice in their options for care, and above all else, they want to be treated with respect

and dignity. Yes, VHA has made enormous improvements over the last couple of decades; but if we are to continue to deliver “The Best Care Anywhere,” we must be bold in our vision of the future.¹

Patient Aligned Care Teams (PACT) will be the patient-centered medical home for enrolled Veterans—the hub that helps patients develop and meet personal health goals, coordinates services and hand-offs, and ensures that patients have access to the right care, at the right time, in the right place, and by the right provider. We know that systems that have implemented similar models, particularly for patients with chronic disease, have been able to improve outcomes while reducing costs.² While they did not call it PACT or medical home, VISN 23 implemented similar changes six years ago. Over the next five years, their admissions for ambulatory sensitive conditions fell 14 percent while the rest of the country increased 5 percent. But PACT will not succeed without new strategies to fully engage Veterans in the management of their own health.

The VHA system must develop processes to better help patients manage their chronic conditions. Telehealth, secure messaging, and mobile communication strategies can better link clinicians and patients through a web of support. Deployment of new technologies, such as the PTSD applet for the iPhone, will help improve the lives of VHA patients. The applet allows Veterans to track PTSD symptom severity and offers resources to those in need. Additional applications are being developed as part of VHA's iPad-based “clinic in a hand,” which will be piloted next year.



Directors Letter: The Impact of Health Care Reform on VA Research

The VA health care system has many advantages for Veterans—quality care that equals or exceeds care in the civilian environment; a broad range of health care services; expertise in managing the health consequences of war; and an electronic health care record that improves access and continuity of care—all provided at low cost to Veteran patients.

However, the cost advantages to Veterans of obtaining health care from the VA may change in the next few years with the full implementation of the Patient Protection and Affordable Care Act of 2010 (i.e., health care reform). Increasing numbers of Veterans may seek care outside the VA health care system, and VA enrollment may decline.

To continue to thrive in an increasingly competitive health care environment, the VA will need to emphasize quality health care and service even further. VA investigators will have an important role in helping to ensure the VA's success. As investigators develop their individual research projects, it is imperative that system impact be considered. It is no longer sufficient to think only of the issues addressed in individual research projects. Rather, investigators must design their projects with a vision as to what additional research efforts may be required to improve the VA health care system. Innovative and inspired ideas will be needed.

The Veterans Health Administration (VHA) has an appropriately proud history of care. Health services research will remain an important component of continuing success.

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Director, HSR&D

From Medical Home to a Patient-Centered Community

To ensure seamlessness, VHA must design the rest of the health care neighborhood around that medical home. Specialty services must be available in real-time, and be designed to better serve the needs of patients and primary care clinicians. Several innovative ways of providing better subspecialty support for patients and primary care teams are currently being piloted. The first, Specialty Care Access Networks (SCAN), modeled after the University of New Mexico's ECHO project, provides virtual specialty consultation for non-urgent issues, which improves access and enhances the ability of primary care teams to manage complex conditions, especially for those patients living in

rural areas. Second, *eConsult* pilots provide specialty help to primary care clinicians without requiring a patient visit. These pilots are modeled after innovative work done by the Mayo Clinic, which estimated that 30 percent of their consults could be done with a virtual visit. Finally, specialists are providing just-in-time support to primary care clinicians through phone consults.

VHA must also design care around the specific needs of patients instead of organ systems. Bohmer and Lawrence suggested we should be designing "clinical production" around the unique needs of patient cohorts in ways that improve integration, predictability, and reliability.³ Oncology services are often arranged this way. We know that most patients with cancer need

certain services over the course of their illness. Interdisciplinary teams have clinic together and coordinate services through a common treatment plan. Why not build similar care models for other unique patient populations?

Duke University cardiologists have developed such a program for patients with advanced congestive heart failure.⁴ Highly integrated with primary care, these multidisciplinary teams have improved clinical outcomes and reduced costs by more than \$8,000 per patient-year. They have successfully incorporated registries, protocols, and telehealth into their model.

I can see a very different VA health care system 10 years from now, one that is truly designed around the Veteran. Places that excel at patient-centered care, such as Griffin Hospital in Connecticut, engage patients in ways that we find hard to imagine. In the ICU at Griffin, there are no visiting hours. Even the family dog is welcome. Families stay overnight in a "hotel room" immediately adjacent the patient's ICU bed. Common family rooms and kitchenettes bring families together to support one another. They are invited to be present during invasive procedures and even at codes. The hospital's approach reflects a fundamental belief about the primacy of the patient. For the past 10 years, Griffin Hospital has been on Fortune Magazine's list of *Top 100 Employers of Choice*. Although many may wonder if VHA can make this journey, or even if we should, I am confident that in the future we will fulfill Lincoln's promise to America's Veterans in powerful new ways.

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Response to Commentary

VHA Transformation Challenges and Lessons

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As Dr. Tuchschildt affirmed, VHA is undertaking a major transformation aimed at creating a comprehensive array of interlinked, technologically advanced services centered on Veteran needs and preferences, with VHA's infrastructure of primary care practices serving as the hub. Termed Patient Aligned Care Teams (PACT) and initiated in early 2010, this reorganization envisions both a higher quality of primary care and integration of specialized care into the primary care setting. To accomplish these goals, PACT aims to push VHA's already advanced technologies and staff training capabilities to new levels.

The magnitude of the PACT reorganization is staggering. Unlike non-VHA examples of primary care redesign, PACT engages an entire highly developed national system, with participants located in hundreds of local primary care practices, in over a hundred different medical systems, and in more than twenty administrative regions. PACT changes are occurring in sites that are reluctant or enthusiastic, urban or rural, academic or non-academic. These diverse participants must build PACT into established and sometimes rigid clinical, information system, financial, and human resource functions. In this context, VHA's highly developed technological and human infrastructure is both a resource and a barrier to change.

The Power of Disruptive Innovation

Changes of the magnitude being undertaken in VHA PACT have been termed disruptive innovations by Clayton Christensen and other organizational theorists.¹ Provision of self-serve gasoline or ATM technology, for example, increased customer access, decreased costs, and drove major reorganization of the respective industries. Disruptions such as these occur when gaps between needs or

preferences and offered services or products are too large to allow linear change. In health care, successful disruptive innovation would reduce costs, increase access, and place a greater share of health care tools and technology in the hands of patients. In accomplishing these goals, the innovation would also reduce morbidity and mortality disparities; focus medical workforce training and evaluation on competency and performance; make waste reduction a core cultural value; and clearly define and articulate rights and responsibilities of providers and patients.² PACT goals are thus in-line with disruptive innovation principles.

The motivations in VHA for undertaking disruptive innovation are compelling. First, VHA exists in order to be “the best care anywhere” for Veterans. As Dr. Tuchschildt points out, we have yet to fully exploit the enormous VHA system capabilities, especially in terms of optimal responsiveness to Veteran needs and preferences. Another is flattening or slight deterioration in VHA primary care quality and satisfaction in recent years. Most care provided to most patients is either primary care or accessed through primary care—unsatisfactory primary care is a major threat to the system's viability. Finally, the opportunities for improving VHA's primary care models and the threats from not achieving it are occurring within a broader context of upcoming increases in both affordable insurance choices for Veterans and in federal budget constraints.

Lessons from Prior Reorganizations

VHA's ability to undertake disruptive innovation has already been demonstrated. Prior to 1994, the VHA system was a natural experiment in providing access to specialty and hospital care, but not to primary care, because

federal regulations prohibited the system from delivering primary care. This hospital-centric care configuration was typical of safety net systems of the time. While specialty care was often high quality, access to general care, even for serious symptoms, was a major problem. The rapid bottom-up and top-down reorganization of the VHA system to correct these problems (beginning around 1990 prior to legalization of VHA primary care and extending through the next decade) was both disruptive and highly productive.^{3,4}

PACT implementation shares some, but not all, features of the 1990's reorganization. First, in the earlier reorganization, the large resources freed up by reducing preventable hospital admissions were available for building primary care. Currently, VHA rates of preventable hospitalization, such as for ambulatory care sensitive conditions, are low. Second, the models of the 1990s were preliminarily built and tested from the bottom up prior to full system implementation; PACT lacks this level of prior bottom up development. Third, the prior reorganization could achieve improvements even when it did not deliver full biopsychosocial care to vulnerable patients. For PACT, these patients may provide the largest remaining opportunities for improvement. Overcoming these challenges will require ongoing bottom-up local innovation, as well as top-down guidance, but can lead the way to better, more efficient, and more patient-centered health care models for the 21st century.

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Research Highlight

Relational Coordination: Harnessing the Transformative Power of Relationships to Improve VA Health Care

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Mr. LW, an 83-year-old WW II Veteran is about to be discharged from the VA hospital four days after presenting with a deep vein thrombosis (DVT), for which he has been treated with warfarin, an anticoagulant that requires close post-discharge monitoring. Past medical history includes a distant traumatic brain injury (TBI) that resulted in mild cognitive impairment. His discharge includes: a visit by a pharmacist who tells him to take his medication as prescribed in the hospital (10mg), and reminds him to have his blood levels checked next Thursday at the warfarin clinic. Ten minutes later, a nurse tells him that she will follow up with his daughter (although he lives with his wife who is his health care proxy). Finally, a second-year medical resident gives him a written discharge summary, and instructs him to break in half the 10mg tablets he will receive. He reminds him to follow up at the warfarin clinic next Wednesday. Mr. LW is not seen again until four weeks later when he is again admitted, this time for a DVT in his left leg.

It would be easy to conclude from this actual case that Mr. LW's care is an isolated example of individual break-downs in communication. However, it is estimated that up to 20 percent of hospitalized patients like Mr. LW are re-admitted for problems which could have been prevented had communication and coordination been more effective. Health services researchers, and others interested in quality and safety, have pinpointed the increasingly complex web of human/machine interactions that comprise health care delivery today. This web has expanded to the point where it makes less sense to blame single individuals and weed out "bad apples," than it does to study the behavior of clinical "microsystems," the smallest functional work unit in a hospital or clinic.¹ Incorporating a systems approach extends our understanding of high reliability health care as a complex constellation of interrelated actions and activities rather than the addition or subtraction of a single individual's performance.

Recognizing the critical need for new care delivery models, the Institute of Medicine (IOM) in 2001 published a highly influential monograph entitled "Crossing the Quality Chasm: A New Health System for the 21st Century."² In that document, the IOM

asserted that patient-centered care—i.e., care that establishes a continuous partnership among practitioners, patients, and their families to ensure high quality accessible services—was one of six indicators of quality.

One response to the IOM report has been the rapid growth of the patient-centered medical home (PCMH), also known in the VA as the Patient Aligned Care Team (PACT). Rather than viewing a patient's care as episodic and the responsibility of several to many unconnected individuals operating across time and space, the PACT views the care process as a continuum, from primary to specialty care, from hospital to home, and from the clinic to the community. The potential payoff from the PACT model is to provide patients with a seamless care experience whether it is in the hospital, clinic, or at home. Realizing this potential is a huge technological, logistical, and cultural challenge.

A Promising Approach

One promising research approach to transforming performance within and across settings is "relational coordination," a term coined by Jody Gittel, a professor of management at Brandeis University. Relational coordination refers to, "a mutually reinforcing process of interaction be-

tween communication and relationships carried out for the purpose of task integration." Gittel first applied the concept to studying Southwest Airlines and found that the company's success lay primarily in its ability to encourage and support high levels of communication across multiple job classifications and management. Her latest work has been in health care where she has shown that organizations with high levels of relational coordination have better care outcomes and lower overall costs.³

Using the concept of relational coordination, we can return to Mr. LW's discharge and ask whether improved relational coordination could have led to a different outcome. It is clear that the health professionals caring for Mr. LW had different information and ideas about the post-discharge plan. One improvement might have been to connect the health care professionals to one another sequentially, each briefly noting in VA's Computerized Patient Record System what was discussed. Another approach might have been to start each conversation by asking Mr. LW who else had already talked with him about discharge and what the content of the discussion was. A third approach might have been to ask which family member he would prefer to be contacted with follow-up information and appointment reminders. Finally, asking Mr. LW to repeat back his understanding of the discharge plans (also known as a teach-back or a talk-back) might have uncovered discrepancies in the information he had been given and perhaps have prevented some of the confusion he experienced.

Relational coordination is not about blaming individuals for poor performance, but rather encouraging us to recognize the immense complexity of creating coordinated experiences for the billion patient visits in the United States each year. Doing so requires everyone's best collective efforts and creativity; to do less may put the future of patients like Mr. LW, and our current medical culture, at risk.

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Research Highlight

The Critical Role of Caregivers Providing Care to Veterans with Dementia

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Optimal care and outcomes for chronic medical illnesses often depend not only on the Veteran and medical provider but also on a caregiver who is responsible for much, if not most, of the Veteran's daily care. Both members of the Veteran/caregiver unit, called a dyad, have needs that must be addressed. Without a foundation of family caregivers to provide long-term care and support, the VA would not be able to meet the care needs of these Veterans. To underscore the critical role of informal caregivers for Veterans, the VA has enacted several clinical and research initiatives. The research initiatives call for interventions that aim to improve the health of the Veteran and caregiver who are struggling with psychological and physical ailments, such as Alzheimer's disease and other dementias.

Importance of Interventions for both the Veteran and Caregiver

The negative impacts of dementia can affect many facets of family life, including physical health, emotional health, social relationships, and legal and financial issues.¹ Although not all caregivers experience these negative effects, most exhibit declines in their emotional and physical health, are unable to maintain work and family responsibilities, and experience social isolation. These "role and intra-psychic strains" can be attributed to burdens associated with the Veteran's symptoms and care. Caregivers may not perceive a relationship between these consequences and the Veteran's symptoms and care, though negative impacts on general well-being may be evident. Examples of such negative outcomes are increased depression, deterioration in health status, increased health care service use, and increased risk for illness and death.

Caregivers are not well-positioned to provide optimal care for a Veteran if their well-being is impacted by a large number of these negative effects or by any number of them to a debilitating degree. In fact, high levels of caregiver burden have been associated with hospitalization and death among community-dwelling elders. Accessing the variety of services necessary to address the care needs of a Veteran with dementia as well as his or her own needs is particularly challenging, but important, for a family caregiver. Interventions targeting both members of the care dyad are the ideal approach to address well-being for both the Veteran and his or her caregiver. Dyadic interventions that address the negative effects of caregiving through greater access to support services are imperative to help caregivers have improved mental health, provide quality care to Veterans, and continue to provide care for Veterans in the community rather than in high-cost institutions and facilities.

Partners in Dementia Care Intervention

The Partners in Dementia Care (PDC), care-coordination intervention is an innovative, telephone-based coaching program originating from the Chronic Care Model.² The goal of PDC is to address the unmet care needs of Veterans with dementia and their family caregivers across all dementia stages. PDC provides information and assistance to facilitate access to formal services, mobilizes family members and friends, and offers emotional support and coaching. PDC was implemented through formal partnerships between a dementia care coordinator at a VA medical center and a care consultant from a local Alzheimer's Association chapter.

A total of 508 Veterans age 60 and over with Alzheimer's disease and other dementias and 486 of their informal family caregivers participated in the

PDC intervention. Preliminary analysis of data collected at enrollment for the intervention, and six and 12 months after enrollment, has focused on psychosocial well-being outcomes for both Veterans and their caregivers. Overall, Veterans and their caregivers have significantly improved across all domains measured: most important subjective stressor; factors affecting stress level; role and intra-psychic strain; and general well-being. Most of these benefits were observed after 6 months in PDC and maintained at the 12-month follow-up. Of note, after 6 months in PDC, Veterans exhibited a 25 percent reduction in scores on the measure of embarrassment about memory problems, and caregivers experienced a 15 percent decrease in depression symptoms. Furthermore, caregivers in the intervention group had an average of five fewer unmet dementia-related needs than caregivers in the comparison group after six months.

Meeting the needs of informal family caregivers providing care for Veterans with dementia represents an important challenge for the VA. For the coming years, the VA has prioritized the development of larger-scale feasibility studies and broader implementation of caregiver support services. Effective dyadic interventions that treat both the Veteran and his/her caregiver can overcome barriers to bridge the gap between caregivers and supportive services available to them. Preliminary findings suggest that PDC is effective at reducing unmet dementia-related needs and improving outcomes for caregivers and Veterans with Alzheimer's disease and other dementias. Access to and utilization of these services are essential to minimize the negative effects of caregiving, ensure well-being of both members of the dyad, and promote continued care at home.

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Research Highlight

Peer-Support Care Models for Patients With Diabetes

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Effective care models for chronic illnesses such as diabetes must include sustained self-management support for patients. Improved clinical outcomes in diabetes depend on patients' self-management behaviors, such as taking prescribed medications, following diet and exercise regimens, self-monitoring, and coping emotionally with the rigors of living with diabetes. Yet many patients face multiple barriers to effective diabetes self-management. These barriers include lack of sufficient knowledge of diabetes or its treatment; lack of self-confidence, motivation, or skills to manage diabetes well; lack of financial resources for medications and supplies; and other comorbidities and physical limitations. In addition, many adults with diabetes lack effective support from their families and friends for their diabetes self-management. Even with frequent face-to-face office visits, they need more sustained support.

Promising Self-Management Models

To address these barriers, care models must include cost-effective ways to extend self-management support beyond clinic visits with health care providers. More frequent telephone contact with a nurse care manager between medical visits is effective in improving clinical outcomes among patients with diabetes, but these programs are labor- and resource-intensive. Many health care systems lack the resources to implement intensive nurse-led case management programs. Peer support among patients with the same chronic health problem may be a particularly effective strategy to complement health professional-led outreach programs. Interventions that mobilize and build on peer support are an especially promising way to improve self-management support for patients with diabetes.

The most effective models combine peer support with a more structured program of education and assistance. To date, most peer support programs have focused on clinic-based group visits, peer-led training sessions, and support groups. Strong evidence supports the benefits of face-to-face group self-management programs that combine discussion of key self-management issues, peer exchange and support, and behaviorally-based approaches to strengthen diabetes care self-efficacy, problem-solving skills, and efforts to set and follow through on specific behavioral goals. Peers serve as excellent role models for participants. Moreover, peer leaders can more easily hold group sessions outside of normal working hours than can health care professionals. Peers can also maintain contact with program graduates, thereby providing them with continued self-management support.

Many peer-led programs follow a model that was first developed and evaluated by Lorig, et al. at Stanford University—the Chronic Disease Self-Management Program (CDSMP), or *Tomando Control de Su Salud*, the Spanish version. The CDSMP is a program for patients with chronic conditions including diabetes, and it involves weekly 2.5-hour sessions over a six week period. Program content includes individualized exercises and cognitive symptom management programs; methods for managing negative emotions such as anger, fear, depression, and frustration; and discussion of topics such as medications, diet, health care providers, and fatigue. Leaders teach the courses in an interactive manner designed to enhance participants' confidence in their abilities to execute specific self-care tasks (self-efficacy) and to promote discussion among participants and with peer leaders.

More recently, several peer-support care models tested in the VA resulted in significantly improved glycemic control when compared to usual nurse care management. These models supplemented periodic face-to-face sessions with peer mentor-led telephone support, or with telephone calls between paired patients facing similar diabetes self-management challenges.¹ Such programs can either have peer mentors or coaches, with a volunteer or paid diabetes patient providing assistance to other diabetic patients, or can be bi-directional peer-support models. Although one of the key mechanisms by which peer support may work is to activate patients by having them help others, few models using this approach have been evaluated.

Internet-based support groups and other uses of the Internet to mobilize peer support have grown significantly over the past decade. Internet-based interventions are promising because of their low cost and ease of dissemination, and they may provide alternatives to more labor- and resource-intensive clinic programs. Results of several recent randomized controlled trials suggest that adding peer-support components (also referred to as “e-community” components) to Internet-based interventions can increase their effectiveness.^{2,3} An example of a successful program is the Internet discussion boards established for patients and their family members by the Joslin Diabetes Center.

Peer-support care models appear to provide a low-cost, flexible means to supplement formal health care support. When carefully designed and implemented, peer-support interventions can be a powerful way to help patients with chronic diseases live more successfully with their conditions.

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Research Highlight

Home Telehealth: Looking Under the Hood

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Telehealth is use of communication technology to deliver health services where the care recipient and care provider are separated by distance. Altering the communication channel between providers and patients can overcome geographic barriers and improve access to health services. A common use of telehealth technologies is to deliver care from a distance that would normally be provided face-to-face. Thus, rather than traveling to the medical center, a Veteran can be seen by a specialist via clinical video telehealth at a clinic location closer to home, while still receiving the same care that would be provided in a face-to-face encounter. The VHA Office of Telehealth Services supports three kinds of technology-facilitated care: 1) clinical video telehealth (typically physician delivered clinic visits provided using interactive video to distant clinics); 2) store and forward (generating and uploading image data for viewing by specialists); and 3) home telehealth, employing technology-facilitated monitoring along with care management in Veterans' homes. Technologies used in home telehealth include videophones, messaging devices, interactive voice response, and devices that record and transmit vital sign data only. The remainder of this article will focus on home telehealth.

A New Model of Care

Home telehealth enables a new model of care that was not previously available or efficient for patients or providers. That is, while patients theoretically could telephone a nurse or physician each day with vital sign information, that approach is impractical when large numbers of patients need monitoring. Home telehealth technologies can be incorporated into a variety of care management programs. A number of studies have evaluated the effectiveness of home telehealth in chronic disease management, and

results have been mixed. These mixed findings likely reflect variation in program design and implementation across studies. Home telehealth programs are often bundled interventions that may also include home visits, clinic visits, and other modes of communication such as email, telephone, and use of patient portals, in addition to patient data transmission. Interventions vary in terms of interaction between a patient and care manager via video/telephone, the specific content delivered via a messaging device, or whether vital sign data only are transmitted.

The type of intervention that care managers deliver in response to patient data presents an important source of variability in currently published studies. Thus, it can be difficult to ascertain the mechanism of effect in successful programs, or what is missing in ineffective programs. A systematic review of interventions used in multi-component outpatient heart failure management programs found that the number of individual interventions across studies ranged from one to seven. Although the most commonly used interventions were patient education, symptom monitoring by study staff, symptom monitoring by patients, and medication adherence strategies, these were not used in all studies.¹ Although not all of the studies in the review included a telehealth component, similar variation is found in reviews of home telehealth studies. Variation also exists in workload (number of patients assigned to a care manager), type and acuity of patient needs, and the design of the workflow of reviewing and responding to patient-reported variances.

Further Research Needed

Currently published literature describing trials of home telehealth programs does not provide sufficient detail on individual pro-

gram components to enable identification of the appropriate number and combination of interventions needed to improve outcomes or translate findings to practice. Researchers identify eight domains to describe chronic disease management programs: 1) risk status, demographics, and comorbidities of the sample; 2) the primary target(s) of the program (patients, informal caregivers, clinicians, and/or systems of care); 3) individual components of the intervention, e.g., patient education, medication management, post-discharge care; 4) who is involved in intervention delivery, both clinical and non-clinical staff; 5) method of communication, such as face to face, audiovisual, and/or electronic or telecommunication technology; 6) frequency of provision of the intervention delivery components, duration of the intervention, and the mix of program components for each intervention target; 7) location(s) where each intervention component is delivered, including the hospital, clinic, patient home, or community-based; and 8) outcomes, including clinical, resource, and patient-centered measures, such as adherence.² Consistent reporting of program components and interventions is needed to determine what works.

Finally, organizational characteristics of successful telehealth programs are consistent with implementation of other types of health services interventions. These characteristics include senior management support, formally established staff responsibilities for the program, program evaluation with feedback to staff, flexibility, creativity in developing and implementing new programs, and a business plan that supports the mission of the organization.³

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New ESP Reports Published

The VA Evidence-based Synthesis Program (ESP) was established to provide timely and accurate syntheses of targeted health care topics of particular importance to clinicians, managers and policymakers, as they work to improve the health and health care of Veterans. Recent report topics include minority health care and racial disparities; delirium screening; serious mental illness; and complementary and alternative medicine for PTSD. All ESP reports available as PDFs at: www.hsrd.research.va.gov/publications/esp.

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