

August 2013

Commentary

## A Transformation in VA Post-Deployment Care

Stephen C. Hunt, M.D., M.P.H., VA Puget Sound Health Care System and  
Lucille Burgo-Black, M.D., Director and Co-Director, Post-Deployment Integrated  
Care Initiative, VA Connecticut Health Care System

### Contents

Director's Letter	2
The Value of Polytrauma Interdisciplinary Care	3
Barriers to Mental Health Treatment among Returning OEF/OIF Veterans	4
Mild Traumatic Brain Injury: Screening and Comorbidities	5
Peer Outreach for National Guard Soldiers—Assessing the BuddytoBuddy Program	6
Accelerating Innovation and Translation through Strategic Partnerships: CREATE and COIN	7

A publication of the VA Office of Research & Development, Health Services Research & Development Service, Center for Information Dissemination and Education Resources, in conjunction with AcademyHealth. This and past issues of FORUM are available on the web at [www.hsr.d.research.va.gov/publications/forum](http://www.hsr.d.research.va.gov/publications/forum).

Chiseled into the granite facade of VA's Central Office are the words of Abraham Lincoln: "To care for him who shall have borne the battle and for his widow and orphan." With the growing number of women serving in the military, including many who have experienced combat exposure, we revise those words in our hearts and minds to clarify our core VA mission: "To care for those who shall have borne the battle and for their families and loved ones." What is our approach to accomplishing that mission? As VA and as a Nation, what is our approach to post-combat care?

Nearly 2.5 million U.S. troops have been deployed to the Iraq and Afghanistan theaters of conflict since 9/11. Many have had several deployments, often lasting more than a year, with downward trends in the intervals between deployments. The health concerns of those returning from deployment span a spectrum of co-occurring conditions, such as physical injury with chronic pain, diagnosable and sub-threshold mental health conditions, residuals of traumatic brain injuries, hearing loss, concerns about environmental exposures, and impairments in psychosocial functioning.

### A Systematic, Integrated Model

Building on lessons learned from the experiences and needs of Veterans from earlier conflicts, particularly those who served in the Vietnam War and Gulf War I, VA has transformed its approach to post-deployment care, moving to a much more systematic, structured, and integrated approach. The approach involves interdisciplinary teams conducting collaborative assessments

of post-deployment physical, psychological, and psychosocial functioning through a primary care team-based, integrated model of care that ultimately has served as a model for VA's Patient Aligned Care Teams (PACT). This model of care is Veteran-centered, beginning with an expression of appreciation for the Veteran's service, an acknowledgment of the sacrifices that service has involved for the Veteran and his/her family, and attentiveness to the Veteran's story. The Post-Deployment Integrated Care Initiative (PDICI) model, launched in 2008, was shaped by clinical and epidemiological research on similar populations with complex presentations and co-occurring health concerns that involve physical, psychological, and psychosocial impairments. Since then, PDICI has undergone continuous adaptation and improvement in response to ongoing clinical, epidemiological, and implementation research. A 2010 study revealed that, within 18 months of PDICI implementation, 84 percent of VA Centers nationally had put in place integrated care platforms, teaming up medical providers, mental health providers, and social workers; the data also revealed enhancements in team function on the care teams.

### Recent Developments in Post-Deployment Care

Several developments in post-deployment care have emerged from the Iraq and Afghanistan conflicts, including the OEF/OIF/OND Program, the Polytrauma System of Care, the Primary Care/Mental Health Integration Program, enhanced mental health services, substance abuse and pain management services, and education/tertiary care support for



## Director's Letter

The VA motto, derived from Lincoln's second inaugural address, includes the obligation "to care for him who shall have borne the battle ...." Although some of the injuries associated with modern military deployments have changed in the era of OEF and OIF—for example, the prevalence of blast-related TBI—others such as PTSD have been described as far back as the Civil War and earlier. Indeed, some writers have noted classic features of PTSD in Homer's description of the grief of Achilles after the death of Patroclus in *The Iliad*. Given that the health consequences of deployment may persist long after active service, post deployment health is a critical area of focus for VA research. Outside funders have recently increased their support of research on high-profile conditions such as TBI and PTSD, but VA has a unique stake in improving treatment for the full range of health problems affecting returning servicemen and women, from tinnitus to severe polytrauma.

Understanding the various manifestations of post-deployment health problems—and how VHA can best address them—is a fundamental health services research challenge. Research is needed to delineate the complicated interactions between and among initial stressors, the susceptibility or resilience of returning Veterans, the post-deployment environment into which Veterans return, and the models of care available to them. Research can help VA learn how to do a better job at the front end—the transition from active duty to engagement with VA services—while remaining focused on the goal of helping Veterans successfully reintegrate into a full life in their family, their work, and their community regardless of any health challenges. Such research requires an understanding of the unique experience of each Veteran, his or her needs and capabilities, and the clinical and social resources that can best support the individual. This is the ultimate definition of patient-centered care.

David Atkins, M.D., M.P.H.  
Director, HSR&D

Veterans and their families through the Office of Public Health and the War Related Illness and Injury Study Centers as well as enhanced overall care integration through PDICI and PACT. VA has undertaken the critical task of hiring program and case managers to assist Veterans in navigating the VHA system, aligning services, developing integrated care plans, and supporting primary care-based team care. As these programs and systems have converged and more effectively collaborated, both in care delivery and research, what has evolved is an integrated system of post-deployment care that far exceeds anything in

place for earlier cohorts of returning combat Veterans. VA no longer has "a bunch of good programs and resources for returning combat Veterans." It has a comprehensive, systematic approach to post-deployment care with strong clinical, teaching, and research components.

The goals of integrated post-combat care include comprehensive evaluation of and treatment for post-deployment health concerns as well as optimal health recovery and reintegration of Veterans into civilian life. By partnering within VA and between VA and non-VA entities, we hope to mitigate as fully as possible—from both

the individual clinical perspective and the population health perspective—the downstream health impacts of deployments on the lives and families of Veterans.

This approach is fully in line with the 2013 IOM report titled *Returning Home from Iraq and Afghanistan: Assessment of Readjustment Needs of Veterans, Service Members, and Their Families*. The report concludes that, to ensure successful readjustment, service members and Veterans need an array of services to meet the challenges they face when returning home. Services include diagnostic, treatment, rehabilitation, education, outreach, and community support. Furthermore, the services must be effectively sequenced and integrated, guided by implementation research and validated by outcomes research.

As a corollary to the process of linking and integrating aspects of direct clinical care, the IOM report "... calls on the DoD and the VA to support comprehensive analysis of both departments' data to answer questions about readjustment that are not addressed by peer-reviewed literature." The IOM report reminds us of the critical importance of linking and integrating data across departments to allow researchers to analyze many of the key questions about readjustment. The transformation of VA's post-deployment care has emerged from the classical partnership of the three Ps: patients, providers, and principal investigators. This partnership builds on the strong tradition of research and evidence-driven continuous quality improvement in Veterans' health care.

## References

1. Spelman, J.F. et al. "Post-Deployment Care for Returning Combat Veterans," *Journal of General Internal Medicine* 2012; 27(9):1200-09.
2. Reisinger, H.S. et al. "A Population Approach to Mitigating the Long-Term Health Effects of Combat Deployments," *Preventing Chronic Disease* 2012; 9:110-16.
3. Amdur, D. et al. "VA Integrated Post-Combat Care: A Systems Approach to Caring for Returning Combat Veterans," *Social Work in Health Care* 50 2011; 564-75.

## Response to Commentary

# The Value of Polytrauma Interdisciplinary Care

David X. Cifu, M.D., National Director, PM&R Program Office,  
Office of Rehabilitation and Prosthetic Services, VA Central Office

Traumatic Brain Injury (TBI) has been termed the “signature injury” of the recent Middle East conflicts. However, the defining condition of combat-exposed service members and Veterans is better captured by the term “polytrauma,” which is defined as two or more injuries to organ systems or parts of the body that create potentially life-threatening injuries and/or disruption to physical, mental, and psychological functioning.

Studies have identified TBI, post-traumatic stress disorder (PTSD), and pain as the major comorbid elements most frequently seen in polytrauma injury.<sup>1</sup> Investigators have noted that, among Operations Enduring Freedom (OEF: Afghanistan through August 2010), Iraqi Freedom (OIF: Iraq through August 2010), and New Dawn (OND: Afghanistan, Iraq, and surrounding regions since September 2010) service members treated at an *inpatient* VA polytrauma rehabilitation unit, 80 to 93 percent were diagnosed with TBI, 81 to 96 percent with pain, and 44 to 52.6 percent with a mental health disorder.<sup>2</sup> And OEF/OIF/OND Service members and Veterans treated for combat-related injuries in VA *outpatient* polytrauma programs were diagnosed with three or more post-concussive symptoms 67 to 97 percent of the time, complained of persistent pain 82 to 97 percent of the time, and were diagnosed with PTSD 68 to 71 percent of the time. A number of other potentially disabling concomitant conditions—including depression and substance abuse—can also accompany TBI and add to the complexity of diagnosis and management. Approximately half of all returning OEF/OIF/OND Veterans who sought care from VA presented with one or more of these diagnoses; interestingly, more than 90 percent of those with confirmed TBI also have PTSD, pain, or both diagnoses.<sup>3</sup>

As with any health condition that has several sources of pathology, layers of physiologic and psychologic underpinnings, and a complex symptomatology, the key to successful understanding and management involves a uniform, interdisciplinary, comprehensive team approach. This approach is well exemplified by the integrated post-deployment care that characterizes VA’s Post-Deployment Integrated Care Initiative (PDICI)—an initiative grounded in the basic tenets of the PACT (Patient Aligned Care Team) model. Drs. Hunt and Burgo-Black eloquently outline the evolution of these approaches in their commentary “A Transformation in VA Post-Deployment Care.”

While it is important to recognize that individuals with significant persistent polytrauma symptoms (or “post-deployment syndrome”) may continue to experience difficulties even in the best of circumstances, they are likely to benefit from the integrated services of the PDICI/PACT approach. Often, there is no simple or quick solution to the complex conditions that may be seen with polytrauma, let alone the magnification and uniqueness of the symptoms and functional deficits that Veterans may experience with two or more conditions. An established team of dedicated professionals with both primary care and specialty care expertise is the most effective approach. Such a team understands the subtleties of diagnoses and care for post-deployment syndrome and can develop a long-term relationship with Veterans. VA’s highly developed mental health services, polytrauma system of care, and pain management services provide the specialty expertise required for particularly challenging or atypical cases.

Ongoing research may provide some insights into: (1) the specifics of the initial injury or exposure (e.g., blast) on treatment selection or outcome; (2) technological advances that will enhance diagnostic accuracy; (3) smart or designer pharmaceuticals that can target specific sites in the brain, spinal cord, or peripheral nervous system to provide symptom relief or enhance recovery; and (4) the relative advantages of specific therapies (e.g., exercise, cognitive, behavioral) for variants of polytrauma. For the time being, we are fortunate to have an established system of care in the Veterans Health Administration (VHA) that addresses the difficulties of Veterans who have returned from combat with complex physical, cognitive, and behavioral dysfunction in a comprehensive and compassionate way. In addition, the intense research focus by the military, VA, the sports world, and academia on the chronic effects of TBI and the potential for neurodegenerative decline many years after single or multiple TBIs may yield specific diagnostic or management paradigms.

More likely than not, any advances in research will reaffirm the value of the PDICI/PACT model of care as outlined in Hunt and Burgo-Black’s commentary, which describes strategies that Veteran-centric teams can use to complement their existing assessment and management tools. The increasing adoption of this interdisciplinary model of health care to diagnose and manage complex conditions is pivotal to VHA’s ongoing success in the 21st century.

## References

1. Lew, H.L. et al. “Prevalence of Chronic Pain, Posttraumatic Stress Disorder, and Persistent Postconcussive Symptoms in OIF/OEF Veterans: Polytrauma Clinical Triad,” *Journal of Rehabilitation Research and Development* 2009; 46(6):697-702.
2. Sayer, N.A. et al. “Rehabilitation Needs of Combat-Injured Service Members Admitted to the VA Polytrauma Rehabilitation Centers: The Role of PM&R in the Care of the Wounded Warrior,” *PM&R* 2009; 1(1):23-8.
3. Cifu, D.X. et al. “TBI, PTSD and Pain Diagnoses in Iraq and Afghanistan Conflict Veterans,” *Journal of Rehabilitation Research and Development*, 2013 (in press).

## Research Highlight

## Barriers to Mental Health Treatment among Returning OEF/OIF Veterans

Tracy Stecker, Ph.D., VAMC, White River Junction, Vermont

In a study of barriers to mental health treatment among recent OEF/OIF Veterans who screened positive for PTSD but resisted treatment services, Veterans only infrequently pointed to stigma as a reason for resisting treatment. The majority of Veterans who participated in the study had not accessed the VA health care system for treatment of any type before participating in the study, and none had accessed PTSD treatment despite screening positive. Participants agreed to an hour-long telephone session with a trained Ph.D. psychologist to discuss beliefs about seeking treatment. During the session, organized from a cognitive-behavioral framework, participants were asked about their PTSD symptoms, coping skills, beliefs about symptom improvement and beliefs about seeking PTSD treatment. Thoughts about seeking PTSD treatment were discussed in detail, allowing for potential modification of these beliefs. Sessions were tailored and individualized. For example, one participant modified the belief that he could not tolerate talking about his traumatic event, stating that “it’s really hard to talk about that day but I think about it all the time even though I don’t want to and might as well try to get help.”

### Beliefs about PTSD Treatment

Beliefs about PTSD treatment elicited during the telephone sessions were analyzed and grouped according to theme. Four themes emerged, with the first two themes accounting for over 80 percent of discussions. The two most frequently discussed barriers to treatment related to expectations of treatment (i.e., don’t want a medication, don’t want group therapy) and emotional readiness (i.e., don’t feel emotionally ready to discuss traumatic event).<sup>1</sup> The two other themes that

emerged from the data included stigma and logistical issues, such as time and distance to the VA.

Arguably, one of the most frequently cited statements regarding barriers to mental health treatment among returning military personnel is that a stigma persists within military culture toward mental health treatment.<sup>2</sup> While stigma may have historically been a reason for resisting treatment, recent years have seen a significant effort to eradicate the perception among our warriors. For example, military leaders have come forward and admitted their own struggles with symptoms of PTSD. In addition, and perhaps importantly, our culture has responded enthusiastically as troops return home and talk about traumatic memories. In the new age of technology, we have been able to give voice to our warriors and their stories, and our warriors have received the support of family members, friends, and fellow warriors. The perception of stigma associated with PTSD and PTSD treatment might be in flux within military cultures, although stigma may still very well exist for other mental health conditions such as depression and/or addiction.

### Mental Health Treatment Engagement

A change in the perceptions of stigma associated with PTSD and PTSD treatment does not necessarily mean higher treatment rates among OEF/OIF Veterans. Indeed, interventions to improve mental health treatment utilization among Veterans are still warranted. Much of the current work focuses on improving rates of mental health treatment engagement, both initiation and adherence, among VA users identified as in need of treatment

when assessed during a visit to primary care. Yet, requiring Veterans to go through primary care to gain access to specialty mental health care may decrease the number of Veterans who seek PTSD treatment.

Many Veterans are willing to seek treatment, but they do not fully trust the treatment system, which might be understandable in view of the realities and sometimes the complexities of using VA health care. Given that the most frequently cited barrier to treatment was Veterans’ preference not to be prescribed a medication to treat PTSD, any process that requires a route through primary care may not be in Veterans’ best interests. Co-location of services may improve initial engagement rates, but VA needs to do more to ensure that Veterans receive an adequate dose of preferred evidence-based treatments.

Regardless of system changes that may occur within VA, it is important to remember that Veterans make decisions regarding the need for treatment on their own. Decisions regarding treatment engagement and retention are not made easily or lightly. In fact, Veterans continually revisit the decision based on a combination of beliefs about their perceived severity of need, expectations on symptom improvement, and perceptions about providers. While it may be unwieldy to conceive of a treatment system that is individually responsive to Veterans, Veterans make individual decisions on whether or not to engage or continue to engage in the VA health care system. Future outreach and/or retention interventions should be responsive to individual complexities.

### References

1. Stecker, T. et al. “Barriers to Treatment Seeking among Veterans of the Wars in Iraq and Afghanistan Who Screen Positive for Posttraumatic Stress Disorder,” *Psychiatric Services*, 2013; 64(3):280-3.
2. Hoge, C.W. et al. “Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care,” *New England Journal of Medicine* 2004; 351(1):13-22.

## Research Highlight

# Mild Traumatic Brain Injury: Screening and Comorbidities

Bridget M. Smith, M.P.A., Ph.D., and Charlesnika T. Evans, M.P.H., Ph.D.,  
Center for Management of Complex Chronic Care (CMC3), Edward Hines, Jr.  
VA Hospital, Hines, Illinois

Approximately 15 to 20 percent of military personnel deployed to Iraq or Afghanistan—Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF)—have experienced a mild traumatic brain injury (TBI).<sup>1,2</sup> Symptoms that occur following a mild TBI may include headaches, sleep problems, irritability, sensitivity to light, and dizziness. While symptoms resolve shortly after injury for the majority of individuals who experience a mild TBI, some Veterans experience long-term symptoms. In addition to experiencing mild TBI, a substantial number of OEF/OIF Veterans have comorbid mental health conditions such as PTSD and depression. To identify Veterans who might benefit from additional evaluation of their symptoms, VA implemented a national clinical reminder in 2007 to screen for TBI. The reminder includes four questions that address TBI-related exposure and symptoms.

In our HSR&D-funded study, “Evaluation of TBI Screening Processes and Healthcare Utilization” (SDR 08-409), we used VA administrative data to examine the association between Veterans’ characteristics, including their comorbidities, and their likelihood of completing the clinical reminder for TBI screening and achieving a positive result. The study identified comorbidities including PTSD, depression, and other mental health conditions. We also examined VA health care utilization and costs for a one-year period. Our sample included approximately 170,000 OEF/OIF Veterans who used VA care between 2007 and 2008.

## Mild TBI, Comorbidities, and TBI Screening

The majority of Veterans in our study were white and male, with a mean age of 33 years. A substantial number of study participants had a diagnosis of a mental health condi-

tion. Among Veterans who received a screen, 18 percent had a PTSD diagnosis, 12 percent had depression, and 4 percent had a substance-related disorder. Overall, 92 percent of OEF/OIF Veterans received the TBI screen. Veterans with PTSD, depression, or substance abuse were more likely to receive a TBI screen than Veterans without such diagnoses. Of the Veterans receiving a TBI screen, almost 21 percent had a positive result. During the screen, the most frequently reported symptoms included sleep problems, irritability, and headaches. For Veterans with comorbid mental health conditions, those with PTSD, depression, anxiety disorders, adjustment disorders, or substance-related disorders were likely to have a positive TBI screen. Other characteristics associated with a positive screen included male gender, service in the army, and several deployments.<sup>3</sup>

## TBI Screening, Comorbid Conditions, and Costs

Veterans who received a positive TBI screen experienced more health care utilization than patients who screened negative or did not receive the TBI screen. Veterans who screened positive averaged 3.3 primary care visits compared with 2.6 visits for Veterans who screened negative and 1.6 visits for Veterans with no TBI screen. The most common inpatient admitting diagnosis among all three TBI screening groups was PTSD, followed by alcohol dependence. Veterans who screened positive also received more medications from VA pharmacies than Veterans who screened negative or had no screening. Average total health care costs per patient for a year were nearly double for Veterans who screened positive (\$9,610) compared to the mean cost for Veterans who screened negative (\$5,184) and nearly three times the costs for Veterans who did not have the TBI screening (\$3,399). Approximately 80 percent of total health care costs were related to outpatient visits. Among Veterans

who had the TBI screen, total health care costs to VA for treating those patients exceeded \$918 million during the 12-month period following the TBI screening. While 21 percent of Veterans receiving the TBI screen received a positive result, they accounted for 33 percent of the total cost (nearly \$304 million).

Veterans with comorbidities use more VA services and at higher cost than other Veterans in this study. Among the comorbidities, psychoses and substance use disorder had the greatest association with costs, followed by depression and PTSD. Veterans with psychoses were 222 percent more likely to be hospitalized, with costs \$5,094 higher than for Veterans without this condition. Veterans with substance use disorder had a 220 percent greater likelihood of hospitalization, with costs \$2,690 higher than for Veterans without this condition.

## Implications

The TBI screening rate in VA is high. The results demonstrate the continued importance of screening both for intervention to treat symptoms and for planning to provide for ongoing health care needs. We found that a substantial portion of care during a 12-month period was directly mental health-related, particularly for patients screening positive for TBI. Over 40 percent of their inpatient days in VA facilities were for mental health care. The most common admission codes of PTSD and alcohol dependence suggest the importance of mental health and substance use treatment for affected patients. Understanding health care utilization and cost patterns following TBI screening is important for policymakers as they address the ongoing and future health care needs of returning OEF/OIF Veterans.

## References

1. Hoge, C.W. et al. “Mild Traumatic Brain Injury in U.S. Soldiers Returning from Iraq,” *New England Journal of Medicine* 2008; 358:453-63.
2. Tanielian, T. et al. “Invisible Wounds of War: Psychological and Cognitive Injuries: Their Consequences and Services to Assist Recovery.” Santa Monica, CA: RAND Corporation, Center for Military Health Policy Research, 2008.
3. Evans, C.T. et al. “An Evaluation of the Veterans Affairs Traumatic Brain Injury Screening Process among Operation Enduring Freedom and/or Operation Iraqi Freedom Veterans,” *PM&R* 2013; 5:210-20.

## Research Highlight

## Peer Outreach for National Guard Soldiers—Assessing the BuddytoBuddy Program

Marcia Valenstein, M.D., M.S., HSR&D Center for Clinical Management Research/  
Serious Mental Illness Treatment Resource and Evaluation Center, Ann Arbor, Michigan

At times during the conflicts in Iraq and Afghanistan, National Guard (NG) and Reserve service members have constituted as much as 40 to 50 percent of all U.S. forces in combat zones. Unfortunately, NG Soldiers fare significantly worse than active component Soldiers following their return home. In a recent study, 41 percent of NG Soldiers reported mental health symptoms or psychosocial concerns warranting further evaluation or a continuation of mental health care at the three-month post-return mark.<sup>1</sup>

### NG Soldiers Face Unique Challenges, Needs

Although the reasons for higher symptom levels among NG Soldiers are unclear, NG Soldiers face unique challenges before and after deployment. Their training is more time-limited than that of Soldiers in the active component, and when they return from deployments, NG Soldiers are not stationed on military bases and have fewer built-in supports, such as easy access to peers and military health services. Instead, NG Soldiers are dispersed throughout their home states and must rapidly re-enter their civilian communities and civilian jobs. In the current economy, they have often faced financial difficulties and unemployment, both of which are factors associated with increased risk for PTSD.<sup>2</sup>

To respond to these needs, the Department of Defense, National Guard State Organizations, VA, and local communities have developed a variety of programs to assist returning NG Soldiers with re-integration

challenges. Peer-to-peer services have achieved a particularly high level of acceptance in military circles; as a result, VA and other agencies have developed and implemented several peer programs for NG Soldiers.

One of these peer outreach programs, BuddytoBuddy (B2B), was developed as a joint effort by the Department of Veterans Affairs HSR&D and University of Michigan faculty, Michigan State faculty, Veteran advocates, and National Guard leadership. In the B2B program, volunteer Veterans from the community are trained in communication techniques, confidentiality, and relevant local resources. After training, these volunteer Veterans are available in person to Soldiers in their armories during drill weekends and by telephone between drill weekends. The goal of the B2B program is to provide returning NG Soldiers with a listening ear and to identify Soldiers with emerging needs such as legal, financial, and mental health needs. Volunteer Veterans then connect the Soldiers to appropriate resources. Volunteer Veterans receive ongoing guidance from program staff, and the program contains all elements recommended by an expert consensus on peer interventions in military settings and the Defense Center of Excellence white paper on Best Practices for Peer Programs.<sup>3</sup> B2B program staff are now working with VA leaders to develop plans to expand B2B by partnering with VA facilities in other states.

In 2010, the HSR&D Service funded a formative evaluation of the B2B program (SDP 10-047) to guide ongoing program modifications and facilitate future dissemination efforts. We are using an embedded mixed-methods design to assess B2B implementation in the Michigan Army National Guard (MI ARNG) and a quasi-experimental approach to assess its efficacy.

We are surveying all MI ARNG soldiers who returned from overseas deployments between July 2010 and December 2012 at approximately 6 and 12 months following their return. To date, we have had a 51 percent response rate and have collected over 1,379 surveys at 6 months and 854 surveys at 12 months. Data collection from MI ARNG units is scheduled for completion in October 2013. With the goal of guiding implementation and program modifications, study investigators meet regularly with NG leaders to present aggregate data on Soldier well-being and participation in the program.

### Peer-to-Peer Program Findings

Preliminary data from our surveys and B2B program records indicate that mental health symptoms remain an issue for many NG Soldiers at 12 months following their return. However, the B2B program is achieving reasonable levels of uptake within the MI-ARNG.

The B2B program currently relies on 83 active volunteers in 35 armories, and the numbers of volunteer contacts with individual Soldiers is rapidly increasing. Study surveys indicate that approximately 10 to 15 percent of returning National Guard Soldiers have talked to a volunteer Veteran about re-integration issues, and that Soldiers who have talked to volunteer Veterans report high levels of satisfaction.

Several papers are in progress that outline findings from baseline survey data. A recently submitted paper uses data from this Service Directed Project along with

*Continued on page 8*

## Organizational Profile

# Accelerating Innovation and Translation through Strategic Partnerships: Collaborative Research to Enhance and Advance Transformation and Excellence (CREATE) and Centers of Innovation (COIN)

Sara J. Knight, Ph.D., Deputy Director, Health Services Research and Development, Office of Research and Development, Department of Veterans Affairs

The Veterans Health Administration (VHA), Health Services Research and Development Service (HSR&D) launched two transformational initiatives in the past year, both designed to accelerate the translation of VA research findings in clinical practice and community settings. The Collaborative Research to Enhance and Advance Transformation and Excellence (CREATE) program aims to identify and bridge significant gaps in health care delivery through three to five independent, yet coordinated, research projects that are closely aligned with health care system problems of importance to VHA. The new Centers of Innovation (COIN) build from the successful HSR&D Centers of Excellence. COIN seeks the rapid advancement of the translation of research findings by supporting independent investigators conducting novel research as well as groups of investigators collaborating to address significant clinical, policy, and methodological questions whose answers will lead to improvements in Veterans health care and health outcomes.

Why is a transformational approach needed? While health services research has made rich contributions to the organization of health care, its relevance and usefulness to key decision makers in health care systems is sometimes unclear; moreover, the translation of evidence from health services research is often slow and inconsistent. Few mechanisms are in place to align health care research with the needs of health care policymakers and administrators.<sup>1</sup> In this respect, CREATE and COIN are transformational; they support not only collaborative researchers but also the VHA managers, or stakeholders, likely

to use the results of the research. Researchers and stakeholders work together throughout the course of a study—from the formulation of research questions to the analysis and interpretation of the results. When the research is complete, VHA managers will be poised to use the results to improve practice.

Partnered research is not new and has played an important role in several approaches to research, including comparative effectiveness research, community-based participatory research, and action research.<sup>2,3</sup> In fact, the Patient Protection and Affordable Care Act of 2010 and the creation of the Patient-Centered Outcomes Research Institute (PCORI) both recognize the importance of engaging community members, patients, caregivers, clinicians, and administrators in research. PCORI's directive calls for it to engage a range of stakeholders as it develops its mission, foci, and initiatives, and the researchers funded through PCORI are required to engage their stakeholders throughout the research process.

What is new about CREATE and COIN is their emphasis on high-level health care system partners, such as VHA's national and regional managers and health care executives. Researchers are required to link their studies with those who make decisions about how health care is organized and resourced. Among the partners of the newly funded CREATEs and COINs are VHA's national offices of Public Health, Mental Health, Primary Care, Specialty Care, Informatics and Analytics, and Women's Health. Given that CREATE and COIN partners are deeply con-

nected with the research, they will likely have a greater stake in using the resultant evidence for policy development, health care system redesign, and implementation of clinical initiatives.

Even though the emphasis on key decision makers as partners is highly innovative, the focus on managers and administrators may suggest limited representation of patient and clinician perspectives. To avoid a top-down approach, CREATEs and COINs advocate for diversity in stakeholder engagement. However, the simultaneous engagement of patients, clinicians, and other stakeholders in research is potentially complex and costly. To address such challenges, Hoffman and colleagues proposed several principles for multiple-stakeholder participation, including: (1) balancing representation among all stakeholder groups; (2) ensuring the understanding and acceptance of roles across stakeholders; (3) providing expert facilitation of discussions; (4) building from connections among stakeholders; and (5) investing in sustained stakeholder engagement. The development of these and other principles of stakeholder engagement and of new conceptual frameworks for partnered research are essential as diverse stakeholders participate in research processes.

Both CREATE and COIN aim to influence change in the VHA health care system and to build evidence that influences health care delivery in VHA and beyond. Expanding the partnered research vision to include a wide variety of stakeholders will trigger considerations such as tailoring the complexity of information presented to various stakeholder types (e.g., Veterans, clinicians, VHA executives) in order to facilitate their informed contributions. However, the involvement of a diversity of partners in research will likely permit the alignment of research aims with the potentially competing needs of patients, clinicians, and managers.

## References

1. Kupersmith J. and S. Eisen. "A New Approach to Health Services Research," *Archives of Internal Medicine* 2012; 172(13):1033-4.
2. Hoffman, A. et al. "How Best to Engage Patients, Doctors, and Other Stakeholders in Designing Comparative Effectiveness Studies," *Health Affairs* 2010; 29(10):1834-41.
3. Kitson, A. et al. "Knowledge Translation within a Population Health Study: How Do You Do It?" *Implementation Science* 2013; 8:54.

# FORUM

Translating research into quality health care for Veterans

Center for Information Dissemination and Education Resources  
VA Boston Healthcare System (152C)  
150 South Huntington Avenue, Boston, MA 02130-4893

data from earlier cross-sectional surveys completed by study investigators to assess changes in reported barriers to care over time. The percentages of Soldiers reporting treatment barriers related to negative beliefs about mental health treatment or stigma declined significantly over the three periods of data collection.

Study of B2B implementation continues, and more complex analyses that examine factors influencing various units' adoption of B2B are pending. Our goal remains to use the rich data being collected to inform VA Central Office of Mental Health Services, the DoD, and other interested organizations about peer program imple-

mentation and sustainability in addition to providing preliminary data on program effectiveness.

## References

1. Milliken, C.S. et al. "Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning From the Iraq War," *Journal of the American Medical Association* 2007; 298(18):2141–8.
2. Riviere, L.A. et al. "Coming Home May Hurt: Risk Factors for Mental Ill Health in US Reservists after Deployment in Iraq," *British Journal of Psychiatry* 2011; 198:136–42.
3. Money, N. et al. *Best Practices Identified for Peer Support Programs*. Washington DC: Defense Center of Excellence, 2011.

## FORUM

Geraldine McGlynn, Editor-in-Chief  
Margaret Trinity, Editor

### Editorial Board

Peter L. Almenoff, M.D., FCCP,  
Director of Operational  
Analytics and Reporting, Office  
of Informatics and Analytics,  
Washington, D.C.

David Atkins, M.D., M.P.H.,  
Director, HSR&D  
VA Central Office,  
Washington, D.C.

Cynthia Caroselli, Ph.D., R.N.,  
Associate Director for Patient  
Services & Chief Nurse  
Executive, VA New York  
Harbor Health Care System,  
New York, NY

Martin P. Charns, D.B.A.,  
Director, VA HSR&D Center  
of Excellence, Boston, MA

Seth A. Eisen, M.D., M.Sc.,  
Past Director, HSR&D  
VA Central Office,  
Washington, D.C.

Joseph Francis, M.D., M.P.H.,  
Director of Clinical Analytics  
and Reporting, Office of  
Informatics and Analytics,  
Washington, D.C.

Skye McDougall, Ph.D.,  
Chief Medical Officer  
VAMC Long Beach,  
Long Beach, CA

Richard Owen, M.D., Director,  
VA HSR&D Center of  
Excellence, Little Rock, AR

DeAnne M. Seekins, MBA, VA  
Medical Center Director,  
Durham, NC

Frances Weaver, Ph.D.,  
Director, VA HSR&D Center  
of Excellence, Hines, IL