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Contents



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# Post Traumatic Stress Disorder (PTSD) as Metaphor

*By Ira R. Katz, M.D., Ph.D., Deputy Chief Patient Care Services Officer for Mental Health, Office of Patient Care Services*

PTSD can be both a specific disorder and a metaphor for all deployment- and stress-related disorders and difficulties. Veterans with severe, or even moderate, and persistent symptoms of PTSD, and everyone who has had professional or personal contact with them, must recognize the suffering and disability it can cause. VA research has led to effective strategies for diagnosis, treatment, and rehabilitation. But this isn't the whole story. In addition to PTSD, deployment and related stresses can give rise to other mental health conditions, a spectrum of milder and more self-limiting conditions, and problems in returning and readjusting to the family, work, education, and life in the community.

Although America has not yet reached the point where mental illness is free from stigma, the media and the public are starting to recognize that, no matter how strong and well trained, our service men and women can be vulnerable to PTSD. Framing requests for care in terms of PTSD may make it easier for some veterans to come to the VA for help. Therefore, one of the first steps in evaluating veterans who express concerns about PTSD must be to determine whether or not they have it. They may. But they may have depression or panic disorder or generalized anxiety or a self-limiting adjustment disorder or symptoms related to mild traumatic brain injury or mild and non-specific symptoms of stress. Moreover, it isn't "either-or." All too often, veterans may have two or three of these conditions.

While the media and the public may not make these distinctions, providers must. People who are concerned that they may have PTSD require and deserve comprehensive clinical evaluations. They may have PTSD, some other condition, or they may have a normal reaction to abnormally stressful and difficult experiences. Regardless, the VA is here to provide care for them.

PTSD is the most common of the provisional mental health diagnoses in those returning veterans who are seen in medical facilities. From the start of the conflict in Afghanistan in 2002 through the end of September 2006, the VA saw about 34,000 veterans with a provisional diagnosis of PTSD in its medical centers and clinics. This figure represents about 10 percent of the number of veterans with PTSD who are seen in VA medical centers and clinics in any given year. Although the number of these patients is substantial, they are by no means flooding the VA system.

Many returning veterans with symptoms of PTSD have been seen in both medical facilities and Vet Centers, and an additional 5,000 have been seen only in Vet Centers. The medical facilities and the Vet Centers complement each other in providing mental health care. In a sense, the VA has two separate but interacting mental health systems for combat veterans. Most basically, the medical facilities provide treatment for mental health conditions, either in mental health specialty services or, increasingly, in primary care. In contrast, the Vet Centers provide counseling for mental health problems, focusing on readjustment issues. Both systems provide evidence-based

continued on page 2

## Director's Letter

As this, my first FORUM letter goes to press, I am fast approaching my six-month anniversary as Director of VA's Health Services Research and Development Service (HSR&D). It is an exciting and challenging time for me and I am proud to follow in a long line of outstanding Directors that includes Peter Goldschmidt, Dan Deykin, and more recently John Demakis. I hope to build on their experience and leadership.

I am an epidemiologist by training and I have been a clinician/researcher in VA since the late 1970s. My first HSR&D funded project was born out of work with colleagues at St. Louis VA and Washington University, when we came up with the idea to develop a patient pill monitoring device to evaluate the role of medication adherence on blood pressure control. Since that time my research interests have evolved from examining patient and provider behavior, to examining the short and long term effects of war on medical and psychiatric health, examining medication adverse effects, and now addressing pharmacogenomic related issues.

Ensuring data security and protection, always a major component of VA research, has been an especially high priority in my first few months as Director. VA has adopted new security policies and procedures, security training has been mandated, and all investigators have certified their commitment to the highest standards of protection. While challenging, this thorough privacy and security review and enhancement will improve our systems and ensure that we are doing all that we can to protect the privacy of the veterans we serve and to preserve their trust in us.

Another part of my role as Director—and one that I find immensely informative—is the review of all HSR&D manuscripts accepted for publication. These manuscripts are submitted by our investigators and I review each to determine which might require special briefings for VA senior leadership. In just my first few months, I received more than 80 manuscripts on diverse topics such as the Gulf War, diabetes, and health care disparities that were accepted for publication in all sorts of journals. It is clear to me from this amazing productivity that VA HSR&D investigators are among the top investigators in the nation.

This was certainly evident in March, when the Scientific Merit Review Board reviewed 128 proposals. Of these, we expect to fund 26. In addition, we expect to fund 12 of the 39 excellent applications for Career Development Awards. I encourage all VA investigators to keep sending us your high quality research proposals and notification of articles accepted for publication. Your efforts continue to improve the health and care of veterans. I look forward to working with you.

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

psychotherapy for PTSD. With two systems, and two ways of providing care, the VA is more likely to reach those in need.

Who are the veterans with provisional diagnoses of PTSD? These veterans' symptoms led a provider to enter a diagnosis or a "rule out" diagnosis on the medical record on at least one occasion, including many for whom the diagnosis reflects the patients' concerns. Many of these veterans do have PTSD, but not all. What sort of care should the VA provide? The VA should provide the care the veterans need and want as determined by diagnoses and findings derived from clinical evaluations, as well as their preferences and values. For some, it may be provided in specialty mental health care settings; for others, it may be provided in primary care; and for still others, it may involve readjustment counseling in Vet Centers.

"In addition to PTSD, deployment and related stresses can give rise to other mental health conditions, a spectrum of milder and more self-limiting conditions, and problems in returning and readjusting to the family, work, education, and life in the community."

What about veterans without specific diagnoses or problems? Here, there is a need to balance reassurance with caution. Sometimes providers underestimate the importance of telling patients that their responses are normal, and that they are okay. However, we also need to recognize that PTSD can have a delayed onset, maybe more frequently in patients with mild and non-specific symptoms, and that even milder symptoms, when persistent, can take a toll. Care for these veterans should include education about stress and resilience, information about available resources and the effectiveness of treatment, and ongoing monitoring of both symptoms and day-to-day functioning.

PTSD can be a serious illness, but there is much more to the mental health of returning veterans than the identification and treatment of PTSD. The VA's focus on clinical programs and research on PTSD is important, both for returning veterans and the country as a whole. So is its attention to the rest of the story. ■

## Response to Commentary

# The Returning Veteran: Research Required

*By Josef I. Ruzek, Ph.D., National Center for PTSD, VA Palo Alto Health Care System*

Dr. Katz reminds us that while the label post traumatic stress disorder or "PTSD" can be applied in a narrow technical sense, it often serves as a broader metaphor representing an array of post-deployment difficulties that can challenge veterans. Our task is to help veterans with a range of post-deployment problems in living, not just with PTSD. If we are to do this, it is crucial that research be used to help us better understand what is happening to veterans in their "readjustment" environments: in the family, at work, at school, and in the larger community.

### Readjustment Tasks

What happens in the family interactions of those with PTSD and other post-deployment problems? What is the process through which couples cope with stressors and mental health symptoms? How do mental health problems affect workplace performance? What determines variation in work functioning among those experiencing significant symptoms? Why do some veterans cope well after deployment, especially those who do well in the face of continuing mental health symptoms? The broader impact of PTSD symptoms and other trauma-related problems in various domains of functioning, and the processes by which those problems affect functioning, has not received the degree of research attention necessary to inform efforts to improve outcomes.

### Clinically-Relevant Research

Dr. Katz alerts us to the need to provide comprehensive care, and most of the issues that he highlights can only be addressed adequately if we know something about them, that is, if research is mounted that describes and models them. If we are to provide effective care and function as a learning organization that can systematically improve its processes, we will need research examining veterans' and families' perceived needs, treatment preferences, perceptions of stigma, and mental health help-seeking behaviors. We will need to know more about approaches to patient education, family involvement in treatment, psychological and pharmacological interventions, and aftercare/relapse prevention. We will need an expansion of research on assessment methods to encompass not only traditional topics like differential diagnosis, but also the processes by which assessment information is used to inform treatment planning and implementation.

### Integrated Treatments, Partial PTSD, and Dissemination Are Top Priorities

Most of our veterans have more than one problem, so that treatment of co-occurring disorders (e.g., PTSD and depression, panic disorder, generalized anxiety disorder, or traumatic brain injury) will be the rule rather than the exception. In recent years, integrated treatments for PTSD and substance abuse have received increasing research attention, and it is important to accelerate this trend within a range of co-morbidities. Studies will be needed as well to better investigate the impact of sub-threshold or partial PTSD, so that those without diagnosable disorders who nonetheless experience difficulties after deployment will get the help they need.

The increasing evidence base on treatment for PTSD and other mental health problems has charged us with developing and studying systems for dissemination of empirically-supported practices. But this is a relatively new field, inside and outside the VA, so that researchers can make significant contributions by studying dissemination methodologies and a large set of issues related to the dissemination task (e.g., the degree to which evidence-based treatments can be modified for the real-world of treatment delivery without diminished effectiveness).

### Towards Systematic Treatment Improvement

Evidence-based care will also require development of more sophisticated systems within VA mental health for the ongoing monitoring of symptoms and functioning, and for outcome measurement. Dr. Katz also notes that our patients may be seen in primary care or mental health clinics, in VA service settings and Vet Centers. What is the nature of the care that is being offered in those treatment environments, and what variables influence the effectiveness of that care? What determines how our veterans move through the system, and how do the parts of the system interrelate? How can they be made to complement one another?

Arguably, we need much more research specific to our veteran population and to our health care system. But that research must be designed specifically to inform the development of our helping interventions and systems of care; it must focus on issues and variables susceptible to deliberate change, and as Dr. Katz argues, address a full range of post-deployment problems in living, including PTSD. Many believe that research must influence practice. Now is the time for researchers to demonstrate their central importance to the systematic improvement of services. ■

# Post Traumatic Stress Disorder: To Screen or Not to Screen

*By Kathryn M. Magruder, M.P.H., Ph.D., and Derik E. Yeager, M.B.S., both with the Ralph H. Johnson VA Medical Center, Charleston, South Carolina, and the Medical University of South Carolina*

Screening is an important aspect of prevention and early intervention for many diseases and conditions. The World Health Organization describes ten criteria for initiating a screening program. Below, we discuss each criterion along with issues that should be considered in the VA for clinically effective post traumatic stress disorder (PTSD) screening.

***The condition should be an important health problem.*** With prevalence in the VA of approximately 11.5 percent, PTSD is considered an important health problem for veterans. Veterans with PTSD have significantly worse functioning status in every domain when compared to their counterparts who do not suffer from this condition. PTSD prevalence in the VA is likely growing due to the influx of veterans who served in Southwest Asia and the fact that those with PTSD may disproportionately seek VA care. A recent study found that 13 percent of Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF, Afghanistan) veterans had a clinical diagnosis of PTSD. The true prevalence is likely higher.

***There should be a treatment for the condition.*** Effective treatments exist for PTSD, including cognitive behavioral therapy and medications (especially SSRI's). The VA and DoD have jointly published treatment guidelines that recommend implementation of evidence-based practices.

***Facilities for diagnosis and treatment should be available.*** Within VA, there are PTSD and mental health specialty clinics with excellent capability for PTSD diagnosis and treatment. Their capacity, however, is limited and will be sorely taxed as routine screening is implemented and as the VA "catches up" on PTSD screening for veterans of all war eras—not just those who served in OIF or OEF.

***There should be a latent stage of the disease.*** It is unclear whether actual symptoms of PTSD worsen over time; however, previous studies found an increased risk of both medical comorbidities and psychiatric comorbidities, especially substance use disorders.

***There should be a test or examination for the condition.*** A number of excellent screening tools exist, including the PTSD Checklist (PCL), the SPAN, and the four-item Primary Care PTSD Screen (PC-PTSD). In addition, there are diagnostic tools such as the Clinician Administered PTSD Scale (CAPS), as well as the PTSD modules of the Structured Clinical Interview for DSM-IV (SCID) and the Composite International Diagnostic Interview (CIDI).

***The test should be acceptable to the population.*** Though the diagnostic tools may be lengthy and may bring up unwanted memories for some patients, they are considered acceptable in terms of risk and time.

***The natural history of the disease should be adequately understood.*** Veterans with the most severe immediate post-traumatic reactions are at greatest risk for chronic PTSD. While the course of PTSD may vary with relapses and remissions, many veterans will remain symptomatic—some for decades after exposure to a traumatic event.

***There should be an agreed policy on whom to treat.*** In theory, all VA patients who qualify for a PTSD diagnosis could be treated.

***The total cost of finding a case should be economically balanced in relation to medical expenditure as a whole.*** Given the relatively inexpensive screening procedure, the VA in-house capabilities for diagnostic follow-up, the relatively moderate cost of treatment, and the medical and psychiatric problems that are apt to result from lack of treatment, it is likely that the economics will favor screening for PTSD.

***Case-finding should be a continuous process.*** Several studies have shown that PTSD can occur as many as 20 years following the initial traumatic exposure. For OIF/OEF veterans, peak symptom expression may be months or even years following deployment. Thus, it is important to have in place a system that will screen throughout the lifespan.

Many veterans are still unwilling to accept a diagnosis of or treatment for PTSD. Clinicians need to explain screening and diagnostic results in a way that is non-stigmatizing. Providers must offer educational information and motivate veterans to accept treatment. Capacity is yet another problem at PTSD and mental health specialty clinics. Building capabilities in primary care may help to ease both problems, as treatment in primary care is less stigmatizing, more timely, and more integrated into overall healthcare. As the VA implements screening for PTSD, consideration of these issues will help to build a more effective, comprehensive program. ■

*VA/DoD Clinical Practice Guideline for the Management of Post Traumatic Stress available at* www.oqp.med.va.gov/cpg/PTSD/G/ModB_Sum508.pdf.

# Depression in Veterans Returning from Iraq and Afghanistan

*By Karen H. Seal, M.D., M.P.H., Shannon E. McCaslin, Ph.D., and Charles R. Marmar, M.D., San Francisco VA Medical Center*

Joe is a 24 year-old retired marine who was stationed in Baghdad. During his tour, he witnessed the deaths of several close comrades. When a roadside bomb exploded outside of his vehicle he sustained a head injury. Now home, he experiences daily headaches and poor concentration, which have limited his ability to find work. He feels that he is a failure. He has become depressed, has disturbed sleep, intrusive thoughts related to combat, and increased anger and irritability. He feels that he should be strong enough to "deal" with his problems himself and has been embarrassed to seek mental health care.

Unfortunately, Joe's problems are common. Reports in the medical literature and media have highlighted the emergence of mental health disorders, particularly post traumatic stress disorder (PTSD) among veterans of Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF, Afghanistan) (Hoge et al., 2006; Seal et al., 2007). In contrast to PTSD, depression has been less well described in this new generation of combat veterans. Historically, among male Vietnam era combat veterans, rates of depression were three times higher than among civilian men (Jordan et al., 1991).

## Risk Factors for Depression vs. PTSD

Certain combat experiences may be more likely to produce depression than PTSD. These include the loss of comrades, isolation, physical hardships, and personal injury. On returning home, coping with new physical problems and disabilities, changes in core relationships, unemployment, financial stress and PTSD itself may pre-dispose veterans to post-deployment depression. These risk factors are in contrast to factors more likely to produce acute stress and/or PTSD such as witnessing or personally experiencing a life-threatening or traumatic event. Individual veterans, such as Joe, may have experienced a combination of risk factors predisposing them to depression, PTSD, or some combination of the two.

Joe's symptoms of headache and poor concentration following a blast injury are suggestive of traumatic brain injury (TBI). Depression has been shown to occur in 25 to 50 percent of patients with TBI (Jorge et al., 1993) and may represent either primary neurogenic symptoms of TBI and/or psychiatric symptoms secondary to TBI. Depression associated with TBI may manifest as lack of initiative, impaired emotional expressiveness, lower crying threshold, and fatigue.

The natural history of depression, PTSD, and co-morbid depression and PTSD varies. O'Donnell et al. (2004) found that depression alone is more likely to remit than either PTSD alone or comorbid depression and PTSD. Grieger et al. (2006) found that among OIF/OEF soldiers who had sustained severe combat-related physical injuries, 79 percent of those screening positive for PTSD and depression at 7 months had not yet met criteria for either disorder one month after their injury. These findings highlight the importance of repeated screening for both depression and PTSD several months post-deployment.

Evidence-based early treatment of depression, PTSD, and co-occurring disorders may be combined effectively to prevent chronic mental illness. Selective serotonin reuptake inhibitors (SSRIs) are considered first-line pharmacotherapy for both PTSD and depression. Cognitive behavioral therapies, which have demonstrated effectiveness for the treatment of both isolated depression and PTSD, have also been shown to decrease co-morbid symptoms in veterans.

## New Approaches Needed

Despite the availability of evidence-based treatments for combat-related depression and PTSD, Hoge et al. (2004) noted that only a minority of OIF/OEF soldiers and marines who screened positive for psychiatric disorders had received mental health care, largely due to stigma. In fact, stigma regarding mental health treatment was shown to be greatest among personnel most in need of care. Stigma, as well as other barriers to care, highlights the need to develop new approaches to identification and provision of mental health treatment. Integrating mental health into the primary care setting as well as internet or telephone-based psychotherapy has become increasingly important in the treatment of depression and PTSD.

A significant number of returning OIF/OEF veterans such as Joe will suffer from depression and/or PTSD with or without concurrent TBI and will be reluctant to seek traditional mental health care. The VA is on the forefront of supporting translational research to test and implement novel approaches to increase early mental health treatment engagement and retention among OIF/OEF veterans. Continued support of these research and clinical endeavors ensures that veterans, such as Joe, do not develop chronic mental illness and disability. This, in turn, may prevent unnecessary personal suffering, costs for the VA, and public health burden. ■

# Substance Use in OIF/OEF Veterans: Substance Use Disorder (SUD) QUERI Initiatives

*By Patrick Calhoun, Ph.D., VISN 6 MIRECC and Durham VAMC, Lisa Najavits, Ph.D., National Center for PTSD and Boston VAMC, Thomas Kosten, M.D., SUD QUERI and Houston VAMC, Daniel Kivlahan, Ph.D., SUD QUERI and VA Puget Sound*

The mental health needs of our newest veterans include not only post traumatic stress disorder (PTSD) and depression but also co-occurring and independent substance use conditions. Recent Department of Defense (DoD) data on active duty personnel suggest that we need to anticipate substance use problems among returning veterans.[1]

Thirty-two percent of the active duty personnel surveyed by DoD reported current smoking and, among those, 40 percent indicated that they intend to quit in the next six months. This finding suggests the importance of following VA policies to offer and provide improved access to evidence-based smoking cessation treatments. While the survey reported less other drug use over the past month than in age-matched civilians, use of analgesics (3.3 percent) were most common and three times higher than use of marijuana (1.3 percent). Given concerns about pain management among post-deployment veterans, analgesic abuse is likely to warrant immediate clinical attention.

The concern of alcohol misuse in 24 percent of all anonymous survey respondents (AUDIT scores > 8) is intensified since almost half of those under 26 also reported binge drinking (five or more drinks per occasion) in the past month. In addition to young age, service branch (Army and Marine Corps) and deployment within the last year (e.g. PTSD risk) predict this binge drinking.

## High Prevalence of Alcohol Misuse

Among Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF, Afghanistan) veterans currently receiving VA care, initial evidence also reflects high prevalence of alcohol misuse, according to a recent analysis of responses to the 2005 Survey of Health Experiences of Patients (SHEP).[2] Although the 21 percent SHEP response rate (1508 of 7156 eligible) warrants cautious interpretation, 18 percent of responding OIF/OEF veterans screened positive for moderate to severe alcohol misuse based on the AUDIT-C (total score > 4 for women; > 6 for men) with an additional 22 percent screening positive for mild to moderate misuse. Of all 605 patients who screened positive, only 31 percent indicated that within the past 12 months a VA health care provider had advised them to drink less or to not drink alcohol.

Despite substantial rates of binge drinking, few (~4 percent) OIF/OEF veterans who use VA have been diagnosed or treated for a SUD. Several reports indicate the reluctance of OIF/OEF veterans to seek SUD care, but among those veterans with a diagnosis, approximately one-third have received SUD specialty care; this figure is consistent with treatment rates among other veterans with SUD. The reluctance to seek care may be decreasing and the number of OIF/OEF patients treated for SUD has more than doubled from 1,430 in FY05 to 3,047 in FY06.

## Importance of Systematic Screening for Alcohol Misuse

Together, these data highlight the importance in VA of ongoing systematic screening for alcohol misuse and appropriate clinical follow-up. With active SUD QUERI involvement, VA has successfully implemented annual screening for alcohol misuse with the AUDIT-C.[3] However, increased screening alone is insufficient and new performance measures are being considered for FY08 that will emphasize appropriate follow-up of AUDIT-C screening results. Other SUD QUERI initiatives are focusing on the implementation and evaluation of provider education efforts including a web-based training program in motivational interviewing led by Ken Weingardt from the Palo Alto VAMC.

SUD QUERI is actively addressing effective intervention strategies for OIF/OEF veterans with SUD and comorbid PTSD. Lisa Najavits of the SUD QUERI is leading National Center for PTSD collaborators from Boston and Palo Alto, investigators from the Mental Illness Research, Education and Clinical Centers in VISNs 1, 6, 20, and 21, and the VISN 2 Center for Integrated Healthcare to address co-occurring PTSD and SUD in OIF/OEF veterans. Her "Seeking Safety" treatment program for SUD complications of the post-deployment readjustment process is being actively disseminated by the SUD QUERI throughout VA nationally, and evaluations are ongoing. The SUD QUERI will continue to develop and implement best practice models like hers to effectively identify and treat SUD in these at-risk veterans. ■

References
1 Bray RM, Hourani LL, Rae Olmstead KL, et al. 2005 Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel, December 2006.
2 Calhoun PS, Straits-Troster K, Kudler K. Prevalence of Hazardous Alcohol Use and Risk Reduction Counseling Among OIF/OEF Veterans. Presented at the National HSR&D Meeting, February, 2007.
3 Bradley KA, Williams EC, Achtmeyer CE, et al. Implementation of Evidence-based Alcohol Screening in the Veterans Health Administration. *American Journal of Managed Care* 2006; 12(10):597-606.

# A Recap of the HSR&D National Meeting

More than 550 researchers, clinicians, and policy makers participated in VA's Health Services Research & Development Service (HSR&D) 25th National Meeting held February 21-23 in Arlington, Va. The meeting, with the theme "Managing Recovery and Health through the Continuum of Care," focused on a range of issues related to improving care across the diverse veteran population, including the needs of a new generation of OIF/OEF veterans. The meeting showcased more than 90 paper sessions and workshops, and HSR&D investigators viewed 128 posters on veteran-related health care issues.

Hosted by HSR&D's Rehabilitation Outcomes Research Center for Veterans with Central Nervous System Damage (located in Gainesville, Fla.), the conference addressed health care issues critical to managing long term recovery, which is particularly important to VA's newest generation of veterans, some of whom may face years of rehabilitation. This urgent topic was addressed by a panel titled "Changing the Environment of Care for the Returning OIF/OEF Veteran." Other presentations addressed a myriad of long term care issues, including hypertension, diabetes, HIV screening, telehealth applications in cardiac care, and adherence to antipsychotic medications for those veterans suffering from serious mental illness.

## Highlights

In his opening remarks, Joel Kupersmith, M.D., VA's Chief Research and Development Officer, described the need for optimal information security, pledging that VA would play a leadership role in this area. Seth Eisen, M.D., M.Sc., newly-appointed Director of HSR&D, reviewed HSR&D research priorities, including implementation, equity, mental health, women's health, long term care, research methodology, and genomics.

Seriously wounded in Iraq in 2003, Captain, U.S. Army (retired), Jonathan Pruden shared with participants his personal story of a lengthy recovery that required 20 surgeries. Captain Pruden described the lessons he has learned from his own experience and in his advocacy work with wounded veterans. He emphasized the desire among today's young veterans to lead full lives. Many of these veterans have suffered amputations and want to do more than learn to walk. These veterans want to run, he said. He also urged that VA physicians outside of specialized polytrauma centers become familiar with the types of wounds sustained by OIF/OEF veterans.

A special luncheon talk was given by VA's Acting Under Secretary for Health, Brigadier General, U.S. Army (retired), Michael Kussman, M.D., M.S., M.A.C.P. He identified several challenges including data security and the complex health care needs of OIF/OEF veterans. Acting Under Secretary Kussman highlighted the challenges associated with post traumatic stress disorder and traumatic brain injury (TBI), and described post-deployment assessment as an important component of meeting these challenges. ■

*To learn more about research presented at this year's National Meeting, visit the HSR&D web site at* www.hsrd.research. va.gov/about/national_meeting/.

The 2008 HSR&D National Meeting will be on "Implementation Across the Nation: From Bedside and Clinic to Community and Home." The meeting is tentatively scheduled for February 20-22 in Washington, DC. Watch the web for details at www.hsrd.research.va.gov

## Owens Receives Under Secretary's Award for Outstanding Achievement

Douglas Owens, M.D., M.S., has received this year's prestigious Under Secretary's Award for Outstanding Achievement in Health Services Research. The award recognizes a VA researcher whose work has led to significant improvements in veterans' health care, has made substantial contributions in training and mentorship, and has enhanced the reputation of VA research through national leadership in the health services research field.

The award recognizes Dr. Owens' research in the areas of HIV and sudden cardiac death. His influential work helped establish that routine HIV screening is cost-effective, even for low-prevalence populations. These findings played an important role in revision of the Centers for Disease Control and Prevention's HIV screening recommendations. Dr. Owens' research has also focused on the methodology of guideline development, and on biodefense and bioterrorism. Dr. Owens is an outstanding mentor and leader, having mentored more than 45 trainees and served as consultant to national and international health care agencies. Dr. Owens has served as a staff physician with the Ambulatory Care Department of the VA Medical Center in Palo Alto, Calif. for the past 20 years.

VA's Acting Under Secretary for Health, Brigadier General, U.S. Army (retired), Michael Kussman, M.D., M.S., M.A.C.P., presented the award at the HSR&D National Meeting.

# Leader Sought for VA Quality Enhancement Research Initiative

VA is undertaking a search for an important leadership position in the Central Office: HSR&D Associate Director for the Quality Enhancement Research Initiative (QUERI). The position is an exciting opportunity to lead QUERI, which has been recognized by the Institute of Medicine as "one of the strongest examples of synthesizing the evidence base and applying it to clinical care..."

QUERI is an evidence-based quality improvement program dedicated to the translation of research findings into better health care practices for veterans. QUERI activities are supported by field-based Coordinating Centers.

The Associate Director will have primary responsibility for providing scientific and administrative oversight of the program, including managing a budget of more than $13 million. In addition, the Associate Director provides programmatic leadership to HSR&D and VA regarding quality of care, and translation, dissemination, and implementation of research findings. Day-to-day responsibilities include: policy development, strategic planning, budget oversight, monitoring all the individual program components, and overall progress of QUERI. The position reports directly to the Director of HSR&D.

The successful candidate will have strong clinical, scientific, and managerial backgrounds and will hold an M.D., or other clinical doctoral degree. Full vacancy announcement and application details may be viewed at www.vhaexecrecruit.cio.med.va.gov. Click on VA Central Office Positions. Please note that the closing date for this position is June 25th.