

FORUM

VA HEALTH SERVICES RESEARCH & DEVELOPMENT

JUNE 2001

DIRECTOR'S LETTER

In my first FORUM Director's Letter published in June 1998, I mentioned that one reason I decided to leave the field after 27 years and come to Headquarters was because of the unprecedented opportunities that were available to VA health services researchers. Today, those opportunities are brighter than ever.

During the last several months, HSR&D has issued several solicitations providing researchers with new and exciting opportunities. First, in November, we requested proposals for at least one new Center of Excellence (COE).

Second, in December, HSR&D invited solicitations for the Research Enhancement Award Program (REAP). VA facilities that do not presently have a COE but have at least three funded projects may apply for up to \$200,000 per year for four to five years.

Third, in January, we requested proposals for a COE in Rehabilitation Outcomes. For the first time, VA's Rehabilitation Research and Development Service and HSR&D are collaborating on a center that will bring together experts in rehabilitation research and outcomes research under one roof to learn from each other and collaborate.

Finally, in February, a solicitation was jointly released with the National Cancer Institute (NCI) and VA's Quality Enhancement Research Initiative (QUERI) to fund a new VA Cancer QUERI. This new QUERI group will be funded by NCI but based at a VA facility.

With all of this exciting work to be done, I look forward to working with our investigators as HSR&D continues to play a key role in the pursuit of quality health care for veterans.

John G. Demakis, M.D.
Director, VA HSR&D Service

COMMENTARY

Improving Access to Care in the VA Health System: A Progress Report

By Laura J. Miller, M.P.A., Assistant Deputy Under Secretary for Health,
Veterans Health Administration

With the implementation of veterans integrated service networks (VISNs) and the shift toward community-based primary care, VA has made tremendous strides in improving access to veterans' health care. We know, for example, that the number of veterans served by VA increased 30 percent from 1996 to 2000. In addition, more than 400 VA community-based outpatient clinics (CBOCs) currently provide care to veterans throughout the system. Moreover, 87 percent of veterans who enroll for VA health care services are able to be seen by a VA provider within 30 miles of their home. These are substantial accomplishments!

Technological advances are also helping VA improve access to care. Telephone triage and advice programs have been implemented at all VA hospitals, and health education is available to veterans on the Internet. Last year, VA provided more than 350,000 consultations via telemedicine. Telemedicine and in-home teleconsultation programs have also been implemented for spinal cord injury patients. In 1998 and 1999, the Vet Center program implemented the Vet Center-Linked Primary Care Project, which uses telemedicine to make primary care more accessible for high-risk, under-served veterans.

In addition, the use of computers and electronic communication is improving care coordination and

cutting through barriers of care. One new software program, Web Top, allows VA physicians and nurses to view patient records from other sites. With "real-time" information sharing, the medical decision-making process is expedited and patients receive the services they need faster.

VA has also made it easier for veterans to apply for VA health care by eliminating nearly three-quarters of the forms we once required for application and enrollment. Veterans may now obtain applications for enrollment and medical care on the Internet. In addition, they can send the forms electronically to the VA health care facilities of their choice, or they can print out the completed forms and mail them.

Shortening Waiting Times

While eligibility reform and community clinics have enhanced access, in some areas the demand for services has outpaced recruitment, resulting in extended waiting times for appointments. Here again, VA is making progress.

We have developed a new data system and performance goals for waiting times — commonly known as "30-30-20" — that fully support patient expectations for timely access to care. Our strategic goal is

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Commentary

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to provide 90 percent of new primary care and specialty care visits within 30 days, and see 90 percent of patients within 20 minutes of their scheduled appointment time. Currently, VA is working with the Institute for Healthcare Improvement (IHI) on a major initiative to promote activities within each VISN for achieving the 30-30-20 performance goals in the six clinics highlighted in the network performance contracts (audiology, orthopedics, urology, cardiology, eye care, and primary care). Already, VA has seen system-wide improvements in average clinic waiting times since the initiative's launch in April 2001.

Despite these accomplishments, we still have a great deal of work to do to ensure and improve access to care for all veterans. Perhaps most importantly, we need to understand the populations we serve — who they are, what they need, and what they're likely to need five, 10, and 15 years from now. There is a tendency to try to freeze the system at a certain point in development — to maintain the current number of beds or hospitals, for example — because we've arrived at a place where we feel comfortable.

Patient needs and populations, however, are neither static nor the same across VISNs. Every VISN has to be concerned about providing appropriate access for specialized groups, including service-connected veterans; veterans with post-traumatic stress disorder; women veterans; and Persian Gulf War, Agent Orange, and Ionizing Radiation veterans. In addition, our population is aging, and our patients will need not only more services but more specialized services.

New developments in information technology can help us stay on top of veterans' health care needs and quickly identify new trends. The VHA Meta Data Registry (MDR) is being developed to provide a national repository of infor-

mation about VHA enterprise data assets. The MDR is a Web-based, centralized repository that will improve the quality and speed of service to all veterans and dependents who submit applications and related paperwork to the VA. The MDR will serve as the focal point for data business definition and processes, resulting in streamlined operations and value-added productivity improvements.

Allocating Resources To Improve Access

The VA will continue to carefully assess its resources so that they are allocated wisely and efficiently to the networks. Some VISNs have already seen increases in both funding and staffing allocations; others have had to accept decreases due to a declining veteran population. However, all are continuously identifying more efficient ways of providing care while maintaining quality.

We already know that many of our patients, particularly those who are elderly or who have specialized needs, require a substantial amount of specialty care. We've come a long way in improving access to primary care, but we must also provide the right mix of specialty care so that our patients get the services they need when they need them. In addition, VA is implementing a number of requirements outlined in Public Law 106-117, the *Millennium Health Care and Benefits Act*, which extends authorities and ensures additional services for veterans.

Mental health is one specialty area where VA has made inroads. When we made the transition to VISNs in 1996, the planning process included a review of mental health needs. Mental health intensive case management services are also becoming incorporated into CBOC models. This is allowing improved access to mental health services even to veterans in rural areas. A VHA Directive on Mental Health Intensive Case Management

was issued in October 2000. VISNs were required to provide implementation plans, which are currently being reviewed.

Patient satisfaction data show that veterans recognize the difference in VA services, both in terms of the comprehensiveness of those services and access. For instance, in VA's most recent survey, 82 percent of patients report they left their ambulatory care appointments feeling they had discussed all of their concerns with their provider. Also in the same survey, about 70 percent of outpatients reported they were involved in decisions about their care as much as they wanted to be.

A Role for Health Services Research

Research by HSR&D can help VA continue to meet the challenges of ensuring and improving access to veterans health care. We need to know more about our referral patients — how much of what services we are providing, and where. We should also take a closer look at access for specialized groups, such as women veterans and certain ethnic minorities. We need research-based knowledge that can help us develop strategies to provide care to vulnerable populations, including the homeless, the mentally ill, the aged, and those infected by the hepatitis C virus.

Conclusion

Now more than ever, VA is in the truest sense a health care system. With the VA's new focus on populations rather than facilities, we are doing a better job of bringing needed services to patients in a timely manner. We are also making more efficient use of our resources — increasing the benefits provided to patients. We will continue to be challenged by competing and conflicting forces of change, but addressing these challenges is part of our task in keeping the promise to America's veterans.

Selecting the Best Strategies for Improving Access to Care in Rural Areas

*By John Fortney, Ph.D., HSR&D Center for Mental Healthcare and Outcomes Research
Central Arkansas Veterans Healthcare System*

To help ensure organizational survival, VA needs to attract new enrollees from rural areas (and, to a lesser extent, some inner-city areas). How can VA make high-quality care more accessible over long distances? What has research shown to be our most cost-effective options? What evidence do we have on the use of different technologies to reach more veterans?

— *Al Perry, M.H.A., FACHE,
VA Central California Healthcare System*

Improving access to high-quality outpatient services for rural veterans will be a critical challenge for VA in coming years. Poor access to clinical services in rural areas limits VA's ability to attract new enrollees from rural market areas and reduces the continuity and quality of care provided to existing enrollees. With the shift in VA's focus of care from inpatient to outpatient settings, travel barriers have become a greater obstacle to ensuring both high-quality care and continuity of care for rural veterans. As a result, VA may find it difficult to compete in the outpatient arena with local providers in rural regions, especially for elderly veterans who are eligible for Medicare.

Recently, VA has experimented with several strategies for improving access to outpatient services in rural areas. Mobile health units — such as buses — have been evaluated as one way to bring primary care services to remote areas, but this approach was found not to be cost-effective. In addition, there were problems with staff turnover, poor access to medical records, limited pharmaceutical supplies, and performance of routine diagnostic tests.

In contrast, preliminary analyses suggest that community-based outpatient clinics (CBOCs) may be

a cost-effective mechanism for providing primary care services to veterans living in rural areas (see related article on page 4). Encouragingly, no substantial differences in satisfaction and quality of care were found between CBOCs and the primary care clinics of parent facilities. Primary care costs were found to be higher for CBOC patients than for patients in the primary care clinics of parent facilities. But, importantly, total health care costs were lower for CBOC patients because of lower use of ancillary services. Likewise, CBOC patients used fewer specialty outpatient and inpatient services than primary care patients at parent facilities.

Although CBOCs were originally intended to improve access for existing enrollees, CBOC patients were much more likely to be new enrollees than were primary care patients treated at parent facilities. These findings suggest that CBOCs represent a cost-effective mechanism for attracting new enrollees.

In many cases, it may not be feasible to establish VA-staffed CBOCs in remote rural areas. However, CBOCs operated by community providers through a contractual relationship with VA can increase access for veterans living in even the most remote rural areas. By partnering with local rural providers, VA can effectively gain market share while minimizing direct competition with the private sector.

Although CBOCs attract new enrollees by improving access to primary care services, they do not necessarily improve access to specialty services. Patients who require highly specialized care still must travel to parent facilities for those services.

But for those patients with somewhat lower levels of severity

and comorbidity, telemedicine may help extend the treatment capacity of primary care providers. Through the use of electronic medical records, phone-based communications, interactive video stations, and other technologies, telemedicine can provide support to primary care providers at

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CBOCs from specialists at parent facilities. Research suggests that for some specialties, such as psychiatry, CBOC patients could be effectively referred for interactive video encounters with appropriate specialists at parent facilities. For high-cost patients with chronic illnesses, it may also prove cost-effective to place telemedicine equipment in veterans' homes.

Although VA has several cost-effective mechanisms at its disposal for providing high-quality services to veterans in rural areas, the real challenge lies in maintaining an efficient balance of resources between current enrollees and new enrollees. For example, one objective of CBOCs is to shorten appointment waiting times at parent facilities — a goal that serves new and existing enrollees alike. We cannot focus our resources on attracting new enrollees from rural areas at the expense of serving current enrollees who live in urban areas.

R **RESEARCH EVALUATION**

VA Community-Based Outpatient Clinics Improve Access to Care and Increase Patient Satisfaction

By Michael K. Chapko, Ph.D., and Carol VanDeusen Lukas, Ed.D.

Over the years, the VA health care system has shifted focus dramatically. Once chiefly a provider of acute, episodic, inpatient-based care, the VA has adopted a more comprehensive approach that attempts to bring preventive, primary, and specialty-based care to veterans in the communities where they live.

A fundamental goal of this transition was to improve access to care. In the early 1990s, VA satellite clinics operated under serious constraints: They had to be at least 100 miles or three hours' travel from the nearest VA facility and they had to handle at least 3,000 visits per year. In 1995, the VA established the first Community-Based Outpatient Clinic (CBOC), which generally is smaller than the traditional satellite clinic and less restricted geographically. By the end of 1998, 175 CBOCs had been established, and by 2001 that number had grown to about 400 nationally. Recently, the larger satellite clinics were designated as CBOCs.

In most cases, CBOCs are affiliated with a "parent" VA medical facility, which usually provides a wider range of services — including primary, specialty, and inpatient care — than the CBOC. CBOCs may be staffed by VA providers or they may use community providers through a contractual relationship.

CBOCs have several national objectives:

- Reduce the need to travel long distances to receive care, thus improving access for veterans and reducing beneficiary travel expenditures.
- Redirect patients currently served at medical center clinics and thereby shorten waiting times or relieve congestion at these treatment sites.
- Shorten waiting times for follow-up care.

- Shift emphasis from episodic treatment to prevention, health promotion, and patient education.

- Shorten hospital length of stay through pre-admission work-up or by providing post-discharge follow-up care closer to the patient's home.

- Reduce the operating cost of providing care — for example, by providing care at a lower cost in a community ambulatory care setting rather than in a hospital-based clinic.

- Improve customer satisfaction.

Evaluating CBOCs

With the rapid growth of CBOCs, VA leaders and Congress were interested in monitoring CBOC performance to determine whether they were meeting their objectives and whether some types of CBOCs were more effective than others. As a result, in 1998, the Under Secretary for Health asked HSR&D through the Management Decision and Research Center to conduct a systemwide evaluation of CBOCs.

The resulting CBOC Performance Evaluation Project established a set of CBOC performance measures in consultation with a national advisory committee, conducted a survey of CBOCs to determine their characteristics, and assessed CBOC performance in six domains identified by the advisory committee. Those performance domains are access, mental health, quality of care, patient satisfaction, utilization, and cost. The performance evaluation obtained data from several sources, including VA administrative databases, the VA national customer feedback survey, and medical record reviews. The study focused on the 139 congressionally reviewed CBOCs that were operational when the study began

and that had served at least 50 veterans in the first half of fiscal 1998.

The survey we conducted in 1998 as part of the evaluation project offers a snapshot of the CBOCs that were in operation at that time. We found, for example, that some CBOCs were quite close to their parent facilities — less than a mile away — while others were as far as 253 miles away from their parent facilities. The median distance was 57 miles. Most CBOCs (61 percent) were located in urban areas, with 39 percent in rural areas. While urban CBOCs were predominantly VA-staffed (71 percent), rural CBOCs were more equally split between VA-staffed (53 percent) and contract (47 percent).

Ninety-eight percent of CBOCs offered primary health care, 28 percent reported offering primary health care and primary mental health care, and 2 percent offered only primary mental health care. While 54 percent of VA-staffed CBOCs offered both primary health and mental health care, only 18 percent of contract CBOCs offered both types of services.

CBOCs Show Favorable Results

To assess CBOC performance, we compared each CBOC with its parent VA medical center across the six performance dimensions. Following is a summary of our findings.

Access. CBOCs improved patient access. For veterans who used a CBOC, the average distance between their home and the CBOC was 15 miles, compared with an average distance of 56 miles to the parent VA medical facility. More patients were seen within 20 minutes of their scheduled appointment time at a CBOC (83 percent)

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R ESEARCH EVALUATION

than at a parent facility (62 percent). However, that difference was insignificant when the appointment was for a follow-up visit after a hospitalization.

Utilization and Cost. Compared with patients seen at parent facilities, patients at VA-staffed CBOCs had more primary care visits but fewer specialty care visits and fewer hospital bed days. The cost per primary care visit was slightly higher at the CBOC compared to the parent facility. All of this translated into higher total primary care costs at the CBOC because of the higher cost per visit and greater number of visits. But the total cost of care was lower for CBOC patients because of their substantially lower number of specialty care visits and hospital days. (Reliable data were not available to analyze the costs of contract CBOCs.)

Mental Health Services. The percent of CBOC patients receiving a mental health diagnosis was equal to the percent of primary care patients at a parent facility receiving a mental health diagnosis. We took this to mean that mental health issues received comparable attention at CBOCs and parent facilities. Likewise, the percent of patients seen within 30 days following a psychiatric discharge was equal at the two facility types.

Quality of Care. Fewer CBOC patients (75 percent) than parent facility patients (83 percent) reported that one provider or team was in charge of their care. Although this finding raises some concerns with regard to continuity of care, it probably reflects the fact that CBOC patients are more likely to view the CBOC and parent providers as two separate teams because of their physical separation. However, CBOC patients actually reported few problems with care coordination.

The quality of preventive care is roughly equivalent among CBOCs and their parent facilities. We assessed the delivery of preventive care by determining the percent of

primary care patients who appropriately received Pneumovax, influenza vaccination, prostate cancer screening, colon cancer screening, tobacco use screening, tobacco use counseling, and alcohol use counseling. We also determined the percent of patients with chronic diseases receiving appropriate screening for hypertension, obesity, and diabetes. In the aggregate, CBOCs and their parents differed significantly on only one preventive measure: A smaller percent of CBOC patients (40 percent) with diabetes received appropriate eye examinations compared to patients seen at a parent facility (54 percent).

Satisfaction. Patient satisfaction tends to be higher in CBOCs. CBOC patients reported fewer problems with their care than parent facility patients in terms of access, timeliness of care, patient education, provider receptivity to patient input, emotional support, coordination of care, and courtesy. In addition, the percent of patients rating their health care as “very good” or “excellent” was slightly higher at CBOCs (92 percent) than at parent facilities (89 percent). Although most CBOC patients must obtain their specialty care at a parent facility, there was no difference in reported ease of access to specialty care between CBOC patients and parent facility patients.

Comparing VA-Staffed and Contract CBOCs

On most dimensions, VA-staffed and contract CBOCs performance was similar. For veterans who used a VA-staffed CBOC, the average distance from their home to the CBOC was 39 miles less than the distance between their home and the parent

VA facility. The comparable difference in distance for contract CBOCs was 47 miles — probably because contract CBOCs are more frequently located in rural areas and therefore tend to serve patients who live further from the parent facility. There was little difference between VA-staffed and contract CBOCs with regard to percent of patients seen within 20 minutes of their scheduled appointment time. There are also significant differences. VA-staffed CBOCs were able to see patients three days earlier following hospital discharge compared to contract CBOCs. Also, a smaller percentage of contract CBOC patients received a mental health diagnosis compared to VA-staffed CBOC patients, raising the question of whether less attention is devoted to mental health issues at contract CBOCs.

Summary of Findings

The findings from our evaluation are encouraging. CBOCs are meeting most of their objectives — indicating that CBOCs offer a promising strategy for providing accessible, cost-effective care to veterans outside the traditional hospital setting. CBOC performance should continue to be monitored, however, for two reasons. First, our assessment was done only on a subset of CBOCs using data that are quickly becoming outdated. New analyses should be done with current data on all CBOCs. Second, there are many questions that our study did not answer. For example, we could not adequately analyze the costs of contract CBOCs. In addition, new users that CBOCs have brought into the VA system should be tracked to determine if their low initial use increases over time or remains low.

The CBOC evaluation was conducted by a team of researchers from three HSR&D Centers of Excellence. The study team included: Michael Chapko, Ph.D., Ashley Hedeem, M.D., and Matthew Maciejewski, Ph.D., of Seattle; Steven Borowsky, M.D., M.P.H., of Minneapolis; and John Fortney, Ph.D., of Little Rock. The project produced five reports of its findings. Reports can be found on the VA Intranet at <http://vaww.va.gov/resdev/cboc.htm>.

R **RESEARCH REVIEW**

Telemedicine: What Do We Know and What Do We Need To Know?

By Adam Darkins, M.D., M.P.H., F.R.C.S., Acting Chief Consultant for Telemedicine, VHA

Telemedicine stands poised to revolutionize health care in much the same way the telephone did a century ago. Nobody today would seriously suggest abandoning the use of the telephone in health care, even though that use has never been systematically evaluated. As equipment costs continue to fall and bandwidth availability further increases, telemedicine use will become ubiquitous. For VA, the main question is not whether telemedicine will be implemented but how.

That said, however, it would be wise to take a close look at what the scientific evidence tells us regarding the effectiveness of telemedicine before implementation of this medium gets ahead of itself. In that way, we can do a better job of ensuring that telemedicine is used appropriately and for the greatest possible benefit of patients.

First, let us be clear on what we are talking about when we discuss telemedicine. The VA has adopted the Institute of Medicine's definition of telemedicine: "the use of electronic information and communications technologies to provide and support health care when distance separates the participants." VA chose this definition specifically because it emphasizes telemedicine as a medium for supporting health care and not as a health care intervention in itself. This distinction is crucial in order to correctly assess the evidence on the use of telemedicine, which facilitates the delivery of health care services to remote settings.

Assessing the Effectiveness of Telemedicine

There is a fundamental obstacle to establishing the clinical effectiveness of telemedicine: Most of the health care interventions it supports are not themselves grounded

in scientific evidence. This poses a considerable methodological challenge for telemedicine research. If the effectiveness of a given health care intervention supported by telemedicine is unknown, then studying the effect of telemedicine may be confounded by the presence of a second independent variable. Many telemedicine research studies compare the effect of telemedicine on clinical practice with traditional face-to-face consultation as a way around this problem. In doing so, such studies usually assume that the "status quo" is implicitly "effective," and so they fail to assess telemedicine in terms of its objective effect on patient outcomes.

The literature on telemedicine follows two distinct approaches. The first approach examines telemedicine as a broad generic medium. The second approach looks at telemedicine in relation to how it supports specific areas of care delivery — assessing, for example, the results of telecardiology or teledermatology.

Several comprehensive reviews of the telemedicine literature have tried to address the general and specific applicability of telemedicine in terms of whether it is a) effective, b) cost-effective, and c) appropriate to use in health care settings. According to these reviews, the jury remains very much "out" with respect to the appropriateness and effectiveness of telemedicine in delivering both general and specialist care.

Furthermore, these reviews could not address inconsistencies in the standards of clinical practice, technology, and management of telemedicine programs. To attribute outcomes to an intervention, we must first know that the intervention was consistently applied. Several organizations have

developed or are currently involved in developing standards for telemedicine, including the Joint Commission on Accreditation of Healthcare Organizations, the American College of Radiology, the National Electrical Manufacturers Association, the American Telemedicine Association, and VA.

Developing a Research Agenda

In view of the unanswered questions surrounding telemedicine, a clear research agenda is needed. As a world leader in telemedicine development, VA is in a unique position to contribute to this agenda. VA offers a unique clinical base from which to study the appropriateness, effectiveness, and cost-effectiveness of the clinical, technical, and managerial dimensions of telemedicine. In addition, because VA is an integrated health care system, research questions testing different models for the diffusion of telemedicine can be applied across various health care settings within VA.

In many respects, the development of telemedicine is reminiscent of that of the Internet before 1995. The use of the Internet was pioneered in the public sector, but robust systems and processes were needed for the transition into the private sector, where its use exploded. That work was achieved mainly by a partnership between the federal government and academia.

Diffusion of a new technology frequently takes on a life of its own. It is important, however, for the leaders in telemedicine implementation to step up to the plate and ensure that telemedicine works safely and effectively to the benefit of patients. VA can play an important role in introducing needed rigor and consistency in this effort.

RESEARCH HIGHLIGHT

VA Researchers Test Integrated Care Model for Substance-Abusing Patients

By Andrew J. Saxon, M.D., Daniel R. Kivlahan, Ph.D., and Donelle Howell, B.S.

Preliminary findings from an ongoing study at VA Puget Sound underscore the difficulties of getting addictions patients — particularly ethnic minorities and those with less severe medical problems — to obtain needed primary care. As the study progresses, VA researchers hope to clarify whether an integrated care model that makes primary medical care available at addictions treatment clinics can enhance access to care, improve clinical outcomes, and reduce health care costs.

Veterans seeking treatment for alcohol and drug addictions typically have multiple medical conditions, yet many of these patients are new to VA and do not have an established relationship with a primary medical provider. For the addictions patient, maneuvering through a large health care system can be overwhelming. As a result, many addictions patients use the emergency room when they need care — leading to poor continuity of care and potentially higher health care costs.

Researchers at VA Puget Sound are conducting a randomized trial comparing primary medical care provided within an Addictions Treatment Center to the standard of referring patients to a primary care clinic. Several hundred veterans beginning addictions treatment will be followed for one year to evaluate medical and addictions outcomes, health-related quality of life, and total health care costs.

Participants are veterans starting addictions treatment who lack a primary medical provider and have a condition — such as high blood pressure — that requires primary care. After an initial research appointment assessing health status and addiction severity, veterans are randomly assigned to a primary care appointment at either the

Addictions Treatment Center (ATC) or the General Internal Medicine Clinic.

During the first 14 months of recruitment, virtually all ATC patients presented with medical conditions. Half had no primary care provider. Nearly 70 percent reported additional psychiatric conditions. The majority of participants — 62.1 percent — were Caucasian, 28.2 percent were African-American, 4.5 percent were Hispanic, 3.4 percent were Native American, and less than 1 percent were Asian-Americans or Pacific Islanders.

A greater percentage of ATC patients (57.7 percent) showed up for their initial primary care appointment than did general clinic

patients (42.3 percent). Primary drug or presence of another psychiatric condition was not related to primary care attendance. At both clinics, patients who showed up for their initial primary care appointment were more likely to be Caucasian, have more severe medical conditions, and to be actively obtaining addiction-focused treatment in the addictions treatment center.

CORRECTION:

(FORUM, November 2000, page 4)
The QUERI Lipid Project included 24 medical centers and 41,366 patients. Other results and conclusions change slightly. See the corrected article at <http://www.va.gov/resdev/prt/fornov00.pdf> or on the VA Intranet at <http://vaww.va.gov/resdev/prt/fornov00.pdf>.

Lisa Rubenstein Receives Under Secretary's Award for Health Services Research

Lisa Rubenstein, M.D., M.S.P.H., received the year 2001 Under Secretary's Award for Outstanding Achievement in Health Services Research. Thomas L. Garthwaite, M.D., Under Secretary for Health and VHA's Chief Executive Officer, presented the award at the VA HSR&D Annual Meeting, Feb. 14-16, in Washington, DC.

Dr. Rubenstein's exemplary record demonstrates her unwavering commitment to veterans and to the improvement of VA health care. She is a prominent proponent of translating research findings into practice, and she combines her extensive practical knowledge of ambulatory care management with evidence-based interventions to advance positive changes in both VA and non-VA settings. Nationally recognized as a leader in the design and evaluation of systems to improve health care quality, Dr. Rubenstein has spearheaded the development of several innovative health services research methods, including functional status computer feedback, scale-based methods of quality of care and sickness assessment, and structured implicit review.

Dr. Rubenstein also effectively implemented outcomes research at the organizational level long before it became popular, and her success as Chief of Evaluation for the Pilot Ambulatory Care and Evaluation (PACE) project at the Sepulveda VA helped make that Center a national model for VA's critical shift toward primary care. She has served as Director of the HSR&D Center for the Study of Healthcare Provider Behavior, part of the VA Greater Los Angeles Health Care System, since 1994.

R ESEARCH HIGHLIGHT

Exploring Links in Veteran Identity with VA Health Services Use

By Nancy Harada, Ph.D., VA Greater Los Angeles Healthcare System

How does the way in which veterans identify with their experiences and status as veterans affect their use of VA health services? That is the question that the Veteran Identity Program (VIP) is trying to answer.

The VIP defines "veteran identity" as an individual veteran's self-concept that derives from his or her military experience, within the socio-historical context of that experience. Because of the known association between race and ethnicity and health services use, the VIP is particularly interested in the interface of veteran and ethnic identification as they relate to health services use among different war cohorts. Veteran identity may vary by race and ethnicity because the socio-historical context of military experience varies by race and ethnicity.

To begin to understand how veteran identity influences VA outpatient services use, VIP investigators used a three-pronged research approach: secondary analysis of the 1992 National Survey of Veterans, focus groups, and primary data collection through a telephone survey. Secondary analysis was used to document baseline levels of health status and use of VA outpatient care by racial and ethnic groups. VIP researchers have found that

African American and Hispanic veterans are more likely to report worse self-rated health and functioning than non-Hispanic white veterans. Although these groups are more likely to use VA outpatient care, they also report greater unmet health care needs than non-Hispanic white veterans.

Focus groups were then used to explore relationships between military experience, racial and ethnic background, and VA health care services use. The main veteran identity themes related to military status, military experience, and perceptions of the veteran experience. These themes were incorporated into the development of a telephone survey that was administered to veterans in the Veterans Integrated Service Network 22 (Southern California and Southern Nevada). Analysis of the survey data is underway. Preliminary results indicate that aspects of veteran identity, such as membership in veterans' organizations and veteran influence on daily life, are significantly associated with preferences to use VA outpatient care. Once the veteran has become a VA user, the number of visits is most strongly determined by health status.

VIP researchers plan to extend their studies to the American Indian veteran community in

upcoming months. Better understanding of veteran identity could help VA leaders improve both access to VA care and the quality of VA care. For example, outreach strategies that take into consideration aspects of veteran identity may be more effective in reaching veterans of different racial and ethnic groups. In addition, interpersonal care could be improved by educating clinicians about veterans' experiences during military service.



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