## Winter 2017-2018 • THIS ISSUE: The Returning Veteran

### From the Chief Research and Development Officer

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### A Chat With Our Experts

How intimate partner violence affects women Veterans  

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Any health information in this newsletter is strictly for informational purposes and is not intended as medical advice. It should not be used to diagnose or treat any condition.
Supporting our returning Veterans

The VA motto is a quote from Abraham Lincoln, “To care for him who shall have borne the battle and for his widow, and his orphan.” While some have raised the point that President Lincoln did not anticipate women service members, the sentiment that we should care for our Veterans is timeless.

As the numbers of women serving in the military grow, so too does the need to develop programs that will address the unique needs of these Veterans. In “Chat with Our Experts” we interview Dr. Katherine Iverson, a researcher at the National Center for PTSD. Dr. Iverson’s research focuses on women Veterans who have experienced intimate partner violence (IPV). Women Veterans are at higher risk for IPV than the general population, and sometimes, may experience serious head injuries as a result. Dr. Iverson is working to educate both VA providers and women Veterans on the consequences of IPV. Along with her colleagues, she is developing a counseling program to help women who have experienced IPV—covering topics ranging from safety planning and self-care, to connecting with resources in the community, to asking for social support, to understanding the effects of IPV.

We also speak with Dr. Joseph Frank, a researcher at the VA Eastern Colorado Health Care System and a Career Development awardee. In the midst of an opioid epidemic, VA continues to treat Veterans who are living with chronic pain and who may be taking opioids for their condition. As a primary care physician, Dr. Frank is very interested in learning how—and in what cases—we can safely reduce or stop opioid pain medications. While there is a great push to reduce the number and duration of opioid prescriptions in the U.S., Dr. Frank and his colleagues have found that the scientific evidence on the best way to taper opioids in people already being treated with them is limited, and that physicians and Veterans face challenges when trying to safely taper opioids. As he progresses in his research and career, Dr. Frank plans to include input from Veterans themselves in future research to develop safe opioid tapering programs.

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VA has made a strong commitment to reduce the rate of homelessness among Veterans. According to a 2017 report from the U.S. Department of Housing and Urban Development, Veteran homelessness declined nationally by 46 percent during the period 2010–2016. And three states—Connecticut, Delaware, and Virginia—have effectively ended Veteran homelessness. However, we still have more work to do to end homelessness and to give homeless Veterans a voice. A research team led by Dr. Keri Rodriguez at the VA Pittsburgh Healthcare System is studying the use of photography to help homeless and marginally housed Veterans express themselves visually. Study participants appreciated the chance to interact with the research staff and said they were surprised at the strong emotions that surfaced as they took pictures that symbolized healthy behaviors.

Our Veterans put their lives on the line for our country, and some return home from combat with a limb amputation. VA researchers are working to make discoveries that will help these Veterans regain the function of their lost limbs. In a study led by Dr. Linda Resnik, a research scientist with the Providence VA Medical Center, investigators asked Veterans who had an upper-limb amputation to test an advanced prosthetic arm at home. The DEKA arm—also known as the LUKE arm—was developed through a joint endeavor with the Department of Defense and DEKA Integrated Solutions Corp. It is the first artificial upper limb that is capable of performing multiple movements, like bending your elbow and moving your wrist at the same time. The DEKA arm makes it possible for Veterans to do tasks that a more conventional, body-powered artificial arm simply cannot do. But that does not mean that the DEKA arm is better than the conventional prostheses at everything: the researchers found that Veterans chose to use the DEKA arm for some tasks and their conventional prostheses for others. We are happy that Veterans now have more options, and we’ll continue to support work that results in ever better artificial limbs.

In this issue of VARQU, we also share several editorials by VA scientists and highlight awards given for outstanding leadership and research efforts. Ultimately, VA research contributes to the VA mission to care for and support Veterans through good health and the challenges that service and life may bring. We hope you enjoy reading about this important work.

Rachel B. Ramoni, D.M.D., Sc.D.
Chief Research and Development Officer
How intimate partner violence affects women Veterans

Dr. Katherine Iverson is a clinical psychologist and researcher in the Women’s Health Division of the National Center for PTSD. She is also a researcher at the Center for Healthcare Organization and Implementation Research (CHOIR); both centers are located at the VA Boston Healthcare System. In addition, she is an associate professor of psychiatry at Boston University School of Medicine. Her research focuses on women’s health and trauma—in particular, interpersonal violence and intimate partner violence. In 2014 she received the Presidential Early Career Award for Scientists and Engineers (PECASE) for her research into the effects of violence on women’s health and associated health care needs.

VARQU spoke with Iverson about the work she is doing with women Veterans who have experienced intimate partner violence, and those who have sustained a traumatic brain injury as a result of a violent encounter with an intimate partner.

KEY POINTS:

- Women Veterans who experience IPV are much more likely to have a diagnosis of depression or PTSD, compared with their male counterparts.
- Women Veterans are at higher risk for IPV, compared with women who have not served in the military.
- Women are often strangled or sustain blows to the head during assaults by intimate partners, yet that type of head trauma is often not recognized as a cause of TBI.
- The first step to helping women who have experienced interpersonal violence is to develop programs in the VA that will screen for IPV and identify those Veterans who can benefit from treatment.

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Welcome, Dr. Iverson. Can you tell us about the presentation that you gave in December 2017 at the National Institutes of Health on intimate partner violence and TBI in women Veterans?

It was definitely an honor to be invited to this event on understanding TBI and violence among women. The overall goal of the NIH conference was to understand gaps in knowledge as it relates to the issue of TBI experienced by women. There’s been a lot of focus on the issue of TBI following sports injuries, as you’ve surely seen in the media, and a lot of focus on military personnel. But often the samples are male-dominated. So, it is not too often that people look at the health issues of women that result in concussion and more severe forms of TBI.

Some of my recent work focuses on women Veterans who experience TBI as a result of intimate partner violence. In my clinical work I found that women are often strangled or choked by intimate partners during their assaults. Or they might be badly punched or elbowed to the head, face, or neck, or have their head bashed against the wall. Unfortunately, this kind of head trauma isn’t uncommon, yet it often isn’t detected by women or the health system as being a cause of TBI. But it is actually quite prevalent among women who have experienced IPV.

Do women experience TBI differently than men?

There is research to suggest that women may experience more severe symptoms following TBI. My colleagues and I at VA Boston have done some studies in this area. We were able to look at Operation Enduring Freedom/Operation Iraqi Freedom Veterans who were evaluated for TBI within the VA and found to have confirmed deployment-related TBI. We compared men and women on their current health symptoms using the neurobehavioral symptom inventory, as well as their psychiatric diagnoses from their VA medical records. We did find—this was published in Women’s Health Issues.
in 2011—across the board, women did report significantly more severe health symptoms than their male partners when adjusting for demographic variables and blast exposure, including more severe cognitive symptoms, affective symptoms, vestibular symptoms, and somatosensory symptoms.

Another thing that we found was women were much more likely to have diagnoses of depression, in particular, as well as PTSD with comorbid depression, than their male counterparts. One of the take-homes was that while fewer OEF/OIF women overall experienced TBI during deployment, we need to be careful not to ignore these women or minimize what they’ve experienced. Because when they do experience TBI, they appear to have worse psychosocial symptoms and a more complex clinical presentation.

Is IPV more prevalent in women Veterans than the general population?

There is research being done by our colleagues in VA on that question, especially that of my wonderful collaborator Dr. Melissa Dichter at the Center for Health Equity Research and Promotion. She has documented that women Veterans are at higher risk for IPV compared to women who have not served in the military. We know from our studies that IPV is not only common for women Veterans across the lifespan, but that some of the forms of violence that they experience are quite severe. So they are a vulnerable population in terms of experiencing IPV. We just don’t know why that is.

There are probably a lot of reasons for that and I think it’s complicated. For one thing, women Veterans may simply have more risk factors for IPV. We know in general that having parents who have experienced IPV, witnessing violence in the home, and being a victim of childhood sexual abuse or childhood physical abuse puts you at higher risk for IPV later in life. We also know that people who’ve had these adverse experiences in childhood are more likely to go into the military. So that’s one potential explanation, but it hasn’t been studied empirically.

And then there are issues related to the military and the training environment—being trained in using violence—that may be playing a role in terms of conflict. Also, women Veterans and women who serve in the military are more likely to partner with or marry other service members or Veterans, who are a population that is at higher risk of using IPV. It’s complicated; we are not really sure of the exact reasons why that is the case. Regardless, there are many opportunities to intervene within health care systems, such as VA.
What are some typical symptoms of IPV that women might experience?

Well, in addition to the physical symptoms that I mentioned earlier related to physical injury, there may be gastrointestinal (stomach) problems and sexual health problems. And then we often see a lot of mental health symptoms. Depression is extremely common, as is PTSD. So of course we want to be able to recognize and treat those conditions and symptoms, in addition to addressing any ongoing IPV.

What we find depends on the woman’s history and the nature of the abuse she experienced. Anyone who has worked with women who have experienced chronic IPV knows that they can be colossally self-invalidating and critical of themselves. Sometimes a woman might learn to distrust her feelings about things. If you’ve been put down enough and told that you are crazy, you can start feeling like that. So I think an important part of what clinicians can do is validate for women that their experiences are legitimate; that they don’t deserve to be treated like that; that it’s not their fault; and that there are programs that can help.

For Veterans who are in the VA health system and are experiencing IPV, what is the first touch-point for them?

If they have a provider that they feel comfortable with, like a primary care or mental health provider, we’d encourage them to talk to their provider about it. There has been a tremendous effort in VA to educate providers about IPV. They are being encouraged to talk with their patients about IPV and let them know that help is available both within and outside VA. An increasing number of VAs across the country have what’s called an IPV coordinator. These coordinators are tasked with educating providers about IPV, teaching them how they can screen for IPV, and how they can provide supportive responses for women who disclose IPV. Some IPV coordinators are available to do assessment and intervention for women who disclose IPV. They really are the experts on connecting with community services.

But every position works differently at every VA. I would definitely encourage women Veterans, physicians, and other health care providers to find out if they have an IPV coordinator at their VA—to connect with them, and ask them to come in to talk to the clinic staff. They should also find out if they can make referrals for individuals who have experienced IPV. IPV coordinators are just a wonderful resource that I think will continue to evolve over time.
VA providers can also contact the national IPV Assistance Program for more information. The manager for this program is Dr. LeAnn Bruce.

Can you talk about the research that you are doing to promote a health care-based response to IPV?

Part of what I do in terms of my research agenda is, first, understanding the scope of IPV. How often do we see it in our patient population? What types of IPV do we most often see? How does it impact women’s health? We know that it impacts their health in many ways. Women who experience IPV are twice as likely to attempt suicide. They are two to four times more likely to have diagnoses of PTSD and depression and to use alcohol—perhaps as a way of coping with the IPV they experience.

We know that IPV is prevalent in this population, we know it is impacting their health, so the next question becomes is there something that we can do as a health care system to tackle this issue? We know that women who experience IPV use a lot of health services. They use a lot of primary care services, for example, at higher rates than women who haven’t experienced IPV. So that becomes an important opportunity within primary care to possibly identify women who are experiencing IPV and connect them with health and social services that they may need. Oftentimes the IPV is not what they are coming in for, but it is impacting their health over time, in many different ways. Yet, patients and providers may not make that connection.

We have an important opportunity to identify and help these women, especially in VA, where we have an integrated health care system that has very accessible mental health and social work services. I think we are in a very good position to safely and sensitively identify women who experience IPV—asking them about these experiences, educating, and supporting them. Just by asking these questions we are educating women that this is an important health issue for which help is available. If women feel ready to disclose IPV, we can offer them additional services, both within the VA and with our community partners. VA has Women’s Health Services and the IPV Assistance Program, and Women’s Mental Health Services, [all of which] work very closely with important partners in the community, such as the National Domestic Violence Hotline, to make more resources available for male and female Veterans who have experienced IPV.

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In terms of future research on IPV, can you tell us what you are working on?

We have a new project funded by VA Health Services Research and Development that we started a few months ago, that we are really excited about. There are many things that we can do as an integrated health care system to address IPV. Some of it is education and basic information, but also I have been interested in developing a brief counseling intervention for women who disclose IPV within VA. We have developed a modular-based intervention: there are six different topics ranging from safety planning and self-care, to connecting with resources in the community, to asking for social support, to understanding the effects of IPV. These are all modules or topics that women can decide to focus on in counseling.

We know that not every woman needs the same thing; every situation is different. Some women may need extensive safety planning, and other women may not need that at all. They may be more interested in getting treatment for mental health symptoms related to abuse that may have already ended. So we have to figure out how we tailor interventions to the needs of the woman sitting in front of us, and how to make it acceptable and feasible to deliver in VA. We are not a domestic violence shelter; that’s not the role that we play in VA. But we can play a very important role in helping women understand symptoms that they experience, to recognize IPV, to know where to seek help, to get help for their own symptoms so that they can make decisions that are best for themselves and their children. Essentially, we focus on enhancing the tremendous strengths and resilience that women Veterans already have.

Right now we are getting a lot of feedback from women Veterans and VA providers on how best to use the intervention. We will be testing it in two VA medical centers, here at the VA Boston Healthcare System and at the VA Connecticut Healthcare System in West Haven. We are hopeful that this intervention will ultimately enhance care and health outcomes for our women Veterans.
Dr. Joseph Frank is a primary care physician at the VA Eastern Colorado Health Care System in Denver. He is also a health services researcher at the HSR&D Center of Innovation for Veteran-Centered and Value-Driven Care. His research is focused on improving the safety and effectiveness of chronic pain care for Veterans. As a physician, he is particularly interested in how VA can provide chronic pain care in primary care settings.

VARQU spoke with Frank about the work he is doing to help Veterans who are living with chronic pain.

**KEY POINTS:**

- Tapering or stopping long-term opioid medications in Veterans who have chronic pain can be a challenging process.

- The scientific evidence guiding the assessment of the risks and benefits of long-term opioid therapy and/or dose reduction or discontinuation for individual patients is limited.

- A team-based approach to multimodal pain care could help both physicians and their patients.

- Further research is needed to identify the systems and resources that are necessary to adequately support physicians and patients as they consider opioid tapering.

**Welcome, Dr. Frank. Can you tell us about the three different lines of research that you are pursuing?**

The first of those is for patients who are taking opioid medications long term. For these patients, the process of stopping or reducing those medications—sometimes referred to as opioid tapering—can be very challenging. We need to understand how to deliver high-quality pain care during and after opioid tapering.
Spotlight on Career Development Awardees

The second line of research focuses on who delivers this care. As with many chronic conditions, primary-care physicians are most effective when working as part of a team. I am interested in how we should design teams in primary care to deliver pain care that is patient-centered and effective.

And finally, as a primary care physician, I know it’s critical that we help patients get involved in and lead their own plans for pain management. As a researcher, I believe this means we must also help patients get involved in pain research; therefore, I am very interested in how we can better involve patients in all phases of the research process.

You have received a VA Career Development Award to study tapering opioid medications for patients on long-term therapy. What areas will you be investigating as part of this award?

We will be investigating several different areas. The first of those is a national survey of Veterans who are on long-term opioid medications to learn more about their perceptions of and experiences with opioid tapering. We know that opioid prescribing rates are decreasing over recent years within VA. But we don’t know how these changes are affecting Veterans who have been on these medications long-term. And we don’t know what their goals are as it relates to their own use of opioid medications.

The second aspect of this work is to engage Veterans in the development of a primary care-focused program to support opioid tapering. We will be gathering Veteran stakeholders as well as VA provider stakeholders to conduct a series of meetings and incorporate their perspectives in the development of a program to provide patient-centered opioid-tapering support.

And finally, the long-term goal is to pilot this intervention and understand what it means for Veterans. As I mentioned, pain care is changing rapidly in the VA. So I think a challenge in the years ahead will be to continue to learn quickly from research that is ongoing and to make sure that the intervention that we are developing will take advantage of the latest science in this area. With our approach to engaging Veterans early in the process, we will have a unique opportunity to incorporate both the latest science as well as Veterans’ experiences to come up with something that is valuable to the Veterans that we serve.

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What is the VA policy for tapering or reducing opioid use in Veterans?

VA policy is guided by the most recent guidelines released by the departments of Veterans Affairs and Defense. The guideline was released just last year, in 2017. The guideline recommends that for patients who are on long-term opioids, it is important to assess the risks and benefits of ongoing treatment with opioid medications for the individual Veteran. That guideline also notes that it is important to assess the risks and benefits of tapering. This is challenging currently because we don’t have much evidence to help providers assess those risks and benefits. So the decision-making is challenging, but importantly should focus on the individual Veterans and their unique needs.

Importantly, what that policy does not include is a recommendation to reduce opioid dose based on dose alone or without attention to individual risks and benefits. I think a place where we risk getting beyond the evidence, beyond the VA guidelines, and other related guidelines is by unilaterally making changes to medications that don’t take into consideration an individual patient’s unique needs.

Can you tell me about the benefits and limitations of using opioid medications long-term for chronic pain?

I think the goal of using medications, any medications, particularly opioids long-term for a condition like chronic pain, is that they improve function and quality of life. I think we are moving away from measuring pain severity on a simple zero to 10 scale, and trying to think more broadly about individual patients’ long-term goals, especially as it relates to their ability to do the things they want to do. So I think when they are beneficial, it is because they are helping patients function well and improve their quality of life.

I think important risks often travel alongside those benefits. We have seen in prior studies that people may take these medications with some ambivalence, as they experience both benefits and some side effects. Side effects differ based on the individual patient, but can include decreased energy, cognitive impairment, and some other meaningful side effects that they experience day to day.

And then I think the risk of serious harms such as overdose or a new opioid use disorder diagnosis are front and center in the minds of policymakers and providers. In our prior work talking with patients, they told us that the pain they experience day to day is more salient than the more abstract
risks for future harms. And so it can be a real challenge for physicians and providers to get on the same page prioritizing goals and concerns about potential future harms.

You published a paper that discussed the scientific evidence on strategies to safely taper opioid medications. Can you tell us what you found?

This was a systematic review conducted by a great team of VA researchers doing work on this topic. Together, we identified 67 studies that examined opioid tapering and came to three key conclusions. First, the quality of evidence was very low for each of our key questions. Health care systems and health care providers are working to take urgent action to prevent opioid-related harms. However, for patients taking these medications long-term, it’s important that we balance this urgency with caution, because we have so little evidence to guide opioid tapering currently.

I think the second key point is that we found very few studies that addressed the effect of opioid tapering on important adverse events such as overdose. We want to find effective strategies to prevent harms such as overdose, and we need to learn more about how tapering affects this risk.

And third, we found that opioid tapering may improve pain, function, and quality of life for some patients. Importantly, the fair-quality studies that showed these positive results examined voluntary tapering in the context of multidisciplinary pain management programs. More work is needed to better understand the effects of tapering when it occurs in primary care, which is where most of our pain management is happening in VA.

In a different study, you interviewed a group of primary care physicians to find out about their experiences with tapering opioid therapy. What did they say are their greatest challenges?

We conducted focus groups with 40 providers across three health care systems here in Denver, Colorado. We identified three key themes related to their perceived barriers to opioid tapering. First, providers that we spoke with described discussions of opioid tapering with their patients to be uniquely emotionally charged, and at times, exhausting. Health care systems are asking providers to have these conversations more often these days, and it’s important that we recognize the impact on providers as well as the impact on patients.

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Second, providers described a sense that they had inadequate resources to support opioid tapering, specifically, but also chronic pain care generally. They described a lack of training specific to this process, as well as a lack of other team members and resources in their clinics and communities.

And third, they reported that opioid tapering did not go well when there was a lack of trust between their patient and themselves.

*You also mentioned in that study that you identified several best strategies that would help primary care physicians safely taper opioids. What are they?*

In addition to barriers, the primary care physicians that we spoke with also identified strategies that they found helpful. They noted the importance of empathizing with their patients’ experiences—both their experience of pain and their concern about making medication changes. We have learned from patients that this process can be very anxiety-provoking. And so providers noted the importance of acknowledging that anxiety.

Providers also described opioid tapering as a long-term process that benefits from planning and preparation. They described ways in which working with individual patients to think long-term about goals as it relates to the medication was a productive process.

And finally they reported feeling supported by guidelines and local policies that sought to standardize care processes related to opioid prescribing and opioid tapering.

*What types of strategies would you like to see developed to help primary care physicians work with chronic pain patients and assist them in tapering opioids?*

That’s an important question. I think first it takes a team. And in a system like the VA, it will take guidance to help teams develop effective processes in their own local sites. Primary care providers, nurses, psychologists, pharmacists—the list goes on. Each provider has a unique expertise that may be helpful to patients during opioid tapering. The challenge ahead is to create systems that connect each patient with the right team at the right time during opioid tapering and chronic pain management generally.

The VA is leading in this area with some very interesting work to compare different types of teams and to understand which Veterans benefit from which team structure. It will be important that we learn from those ongoing

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studies and as researchers try and help leaders in VA integrate those lessons into routine care as quickly as we can.

I’ll mention two other resources that I think are potentially impactful in VA. The first is an important role for peer support. While I as a primary care physician try to help my patients know what to expect during opioid tapering, I think a fellow Veteran who has been through the process can provide practical insights and support that I just can’t match.

And finally, as we discussed, opioid medications are just one tool in the chronic pain toolkit. I think it’s important that we continue to improve Veterans’ access to the full range of treatments and continue to improve the quality of evidence that guides our approach to multimodal pain care.
The high burden of ‘subthreshold’ PTSD

• Those with subthreshold PTSD have some PTSD symptoms but not enough to meet the criteria for a PTSD diagnosis.

• The findings below are based on data from the National Health and Resilience in Veterans Study.

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<th>Subthreshold PTSD</th>
<th>Probable PTSD (meets full diagnostic criteria)</th>
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<tr>
<td>Lifetime (any time during life)</td>
<td>22.1%</td>
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<tr>
<td>Past month</td>
<td>13.5%</td>
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• Conclusion: “The results of this study suggest that a strikingly high proportion of U.S. veterans – approximately one in three (subthreshold plus full diagnosed PTSD) – experience clinically significant PTSD symptoms in their lifetime.”


Individual Placement and Support for Veterans with PTSD

• Individual placement and support helps Veterans with PTSD find employment through job coaching based on their interests and backgrounds, rather than traditional one-size-fits-all vocational rehabilitation and transitional work placements.

• The results below are from the Veterans Individual Placement and Support Towards Advancing Recovery (VIP-STAR) study of 541 Veterans.

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<tr>
<th></th>
<th>Transitional Work</th>
<th>Individual Placement and Support</th>
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<tbody>
<tr>
<td>Found steady work</td>
<td>23%</td>
<td>39%</td>
</tr>
<tr>
<td>Found competitive jobs</td>
<td>57%</td>
<td>69%</td>
</tr>
<tr>
<td>Average income for study period</td>
<td>$10,989</td>
<td>$14,642</td>
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• Conclusion: “[Individual placement and support] is more successful than [transitional work] at helping unemployed Veterans with PTSD obtain and sustain competitive employment.”

Source: “Effects of Evidence-Based Supported Employment on Achieving Steady Work among Veterans with Posttraumatic Stress Disorder: A Randomized Controlled Trial” JAMA Psychiatry, Feb. 28, 2018. Infographic by VA Research Communications, February 2018. Photo for illustrative purposes only. © iStock/Jean-philippe WALLET
Improving outcomes among medical/surgical inpatients with alcohol use disorders

Investigator: Christine Timko, Ph.D.; Funding period: September 2017–August 2021

Dr. Christine Timko is a research scientist at the VA Palo Alto Health Care System in Menlo Park, California. She will study the effectiveness of a new treatment to help Veterans with alcohol use disorders who transition from the hospital to an outpatient setting. The intervention, called Drinking Options: Motivate, Shared Decisions, Telemonitor (DO-MoST), makes use of motivational interviewing and a decision aid to help Veterans with AUDs plan their care following discharge. Researchers say they will telephone Veterans after they leave the hospital to help them stay motivated and feel supported in their efforts to reduce or stop drinking.

The research team plans to adapt a decision aid currently being used with AUD patients in the private sector for use in hospitalized Veterans with AUD who are being treated at a VA facility. They will test the use of DO-MoST at two VA hospitals, and if successful, evaluate the tool for wider use across different VA health care settings, like outpatient care for Veterans with PTSD.

In 2014, over 57,000 Veterans with a diagnosed AUD were hospitalized in a VA facility. Likely, those numbers are underreported, as researchers say Veterans with AUDs often go unidentified when they are hospitalized for medical or surgical services. Undiagnosed AUDs can be a danger to patients with complex medical conditions, as each can cause the other condition to become worse.
Impact of sexual assault and combat-related trauma on fertility in Veterans

Investigator: Ginny L. Ryan, M.D.; Funding period: February 2015–January 2019

Dr. Ginny Ryan, a physician and researcher with the Iowa City VA Health Care System in Iowa, is investigating the relationship between sexual assault, combat-related trauma, and infertility in male and female Veterans. Her team will interview by telephone a nationwide group of reproductive-aged Veterans. They will then use statistical models to analyze the association between sexual assault, combat-related trauma, and infertility.

The second phase of the study will use semi-structured telephone interviews with Veterans from the original group who are identified as infertile. Researchers will then attempt to understand the complex relationships between trauma exposures and infertility.

Ryan, an associate professor of reproductive endocrinology and infertility at the University of Iowa, is interested in better understanding the root causes behind infertility in Veterans and helping them access better treatment. Veterans from the military campaigns in Iraq and Afghanistan tend to be younger, are more often female, and are more likely to have suffered extreme injuries. Researchers say these Veterans are at greater risk of infertility because of their experiences with sexual assault, PTSD, physical trauma to the genital area, and chemical exposures.
Research suggests that yoga can benefit women Veterans with PTSD who have been sexually assaulted while in the military. (Photo for illustrative purposes only. @iStock/Alvarez)

Dr. Ursula Kelly is a VA research scientist and nurse practitioner at the Atlanta VA Medical Center. She has started a clinical trial to study the benefits of yoga for Veterans who have experienced military sexual trauma and who also have posttraumatic stress disorder. These Veterans typically suffer symptoms that can include chronic pain, insomnia, and depression. Current treatments for PTSD include cognitive processing therapy—a form of psychotherapy that teaches Veterans to change the way they think about upsetting events. However, not all Veterans agree to participate in or respond well to this type of therapy.

Researchers will recruit women Veterans who are seeking treatment for PTSD related to military sexual trauma and who have chronic pain and trouble sleeping. They aim to evaluate the effectiveness of a trauma-sensitive yoga program compared to traditional CPT therapy in reducing Veterans’ symptoms. They will also seek to find out if yoga is better than CPT at improving Veterans’ quality of life and social functioning. Finally, they will examine the effect of yoga on the body’s response to stress and the hyper-reactivity that is typical of PTSD.

VA estimates that 21 to 40 percent of women Veterans who seek care at a VA health care facility have experienced military sexual trauma. Researchers say military sexual trauma is the most common cause of PTSD in women Veterans.
Noteworthy Publications

Helping homeless and marginally housed Veterans through photography

A research team led by Dr. Keri L. Rodriguez with the Center for Health Equity Research and Promotion at the VA Pittsburgh Healthcare System examined the use of photography to help homeless or marginally housed Veterans express their feelings about their health. Most study participants said they felt positive about their experiences taking photographs.

There are different types of “homelessness,” according to the National Health Care for the Homeless Council. A Veteran who is “marginally housed” could be sleeping temporarily on a friend’s couch, with no permanent home of his own.

The researchers enrolled 20 homeless or marginally housed Veterans who were receiving health services through the Pittsburgh VA Homeless Patient Alignment Care Team (HPACT). The HPACT is a patient-centered medical home that provides both medical care and housing assistance for homeless Veterans. Study participants completed initial social and health questionnaires and were given digital cameras with photo-taking prompts. They were asked to take 15 to 20 photos on the topics of health and health-related behaviors.

After two weeks Veterans returned their photographs, which were then printed and used to facilitate 30- to 60-minute semi-structured interviews with the researchers on the subjects of health and healthy behaviors. The study participants were then instructed to take another set of photographs that illustrated health care quality and access.

Following completion of the interviews, Veterans were asked to take an exit survey that was designed to assess their overall experiences with the study and with taking photographs. Most participants agreed that taking

“\'I’ll refer to this as the ‘track of health.’ You might have some stops, some slowdowns, like a train may have to stop or slow down in certain places or certain situations. Just like your health, you may have something to slow you down ... then you get healthy again. And you move on with your health.\'”

(\textit{Photo taken by a marginally housed, post-Vietnam era Veteran})
the photographs was not difficult or time-consuming. Veterans indicated that they appreciated the opportunity to take photographs and to connect with the research staff. Many of the Veterans said the process of taking photographs prompted unexpected or intense emotions.

Visual-based research, like the method used in this study, is becoming popular among health-services researchers, according to Rodriguez and her colleagues. The combination of patient-generated photographs and interviews with researchers allows for a more intimate understanding of patient experiences. For homeless Veterans who are poor and disadvantaged, and who often have chronic pain, researchers say using photography allows them to have a voice by expressing themselves visually.

The study will be published in a future issue of the Patient Experience Journal. Previous work on the effectiveness of photo-elicitation interviewing in substance use recovery was published in the October–December 2017 issue of Substance Abuse.

*In 2015, the VA Pittsburgh Healthcare System highlighted a photo-narrative study that asked homeless Veterans to take photographs representing how they felt about their own health. To see the slideshow, view: “Photos Give ‘Voice’ to Homeless Veterans Health.”

Reintegration experiences for National Guard members

National Guard members can experience unique challenges when returning to the United States and their civilian lives, say researchers with the VA Ann Arbor Health Care System. Adding to the body of work already done by VA, Dr. Rebecca K. Sripada and colleagues interviewed 78 Operation Enduring Freedom/Operation Iraqi Freedom NG service members about their experiences with reintegration. Nearly three-quarters of study participants said...
they experienced problems after returning home, while 27 percent of participants said they did not. Many said they had problems with anger and alcohol use, difficulties communicating with family members, and reluctance to ask for help with mental health issues.

The study, published in Military Behavioral Health, January 2018, identified eight areas that held potential reintegration challenges for NG members:

- Culture shock
- Mental health issues—anger or irritability and alcohol misuse
- Emotional conflict with family members
- Limited emotional sharing
- Employment or financial problems
- Lack of purpose or meaning
- Housing instability
- Reluctance to seek help from friends or family

Sripada and her colleagues noted that the study participants reported problems that ranged from mild and transitory to major life hardships that disrupted their quality of life. The most frequently cited burdens were related to the unique circumstances of NG service. Guardsmen live in both civilian and military communities, and as a result can suffer both job insecurity and social isolation. Because they do not return to life on a military base, they miss out on base amenities and services. They also do not have continued access to unit members who could offer moral support.

The researchers recommend several ways to help NG members with reintegration hurdles.

They say strengthening both military and civilian social networks could help guardsmen better process emotional issues, and potentially make it easier to ask for help when needed. In addition, access to mental health educational services, like Coaching into Care, is very important for families. Guardsmen can be reluctant to admit they are feeling emotionally vulnerable, especially men who feel stigmatized by admitting to “emotional weakness.” Very often, it is family members or spouses who recognize that the service member is having troubles.

Finally, employment services for NG members are vital. Previous studies have found 15 to 40 percent of returning Veterans report unemployment or
Noteworthy Publications

financial problems. Sripada and her colleagues note concerns among study participants with employment issues like underemployment or not getting along well with employers. Very often employment problems coexist with mental health issues. They suggest VA psychiatrists partner with career counselors to encourage participation in mental health services.

Veterans use advanced DEKA (LUKE) arm to supplement conventional prostheses

Veterans with upper-limb loss can benefit from using an advanced prosthesis like the DEKA arm, at least for part of their day, say researchers at the Providence VA Medical Center in Rhode Island. In a study published in July 2017 in Prosthetics and Orthotics International, Dr. Linda Resnik and colleagues followed 17 Veterans as they used the DEKA prosthetic arm during a three-month trial of home use. The researchers wanted to find out if using an advanced artificial arm could substitute for or supplement the use of a conventional artificial arm.

Prior studies have looked at the amount of time amputees use or wear their prostheses. Resnik and her team believe that some people wear an artificial arm, but do not actively use it to complete tasks. For that reason, the researchers asked Veterans to keep daily diaries that recounted how much time they wore the DEKA arm and their own personal prostheses.

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Veterans were also asked to keep track of how much time they used each device, and for which tasks.

Resnik’s team found that the DEKA arm performed as expected 98 percent of the time during the home trial. Overall, Veterans said they wore the DEKA arm 81 percent of the time that it functioned, and used it for 73 percent of that wear-time. That translated into less wear-time for the DEKA arm (4.2 hours per day), compared to baseline use for existing personal prostheses. That may be due to the heavier weight of the DEKA arm, say researchers. However, they note, the study results suggest that Veterans find advantages in using different types of prostheses—both conventional and advanced—for different tasks.

Examples of daily activities that study participants said they could do only with the DEKA arm include scratching their head, painting their nails, folding clothes, using a fork or knife, and chopping vegetables.

Examples of activities that study participants said they could do only with a personal prosthesis include carrying groceries, rock climbing, heavy hammering, driving a car, and getting down on hands and knees.

New guidelines for rehabilitation of people who have lost an upper limb recommend the use of more than one type of prosthesis. Many amputees use both a body-powered device and a myoelectric device—a prosthetic arm that is controlled using electrical signals from the user’s own muscles.

The DEKA arm—now marketed as the LUKE arm—is an advanced prosthetic arm that was developed by DEKA Integrated Solutions Corp. with funding from the Defense Advanced Research Projects Agency (DARPA), part of the Department of Defense. It is the first computer-driven artificial arm that is able to simultaneously perform different movements. It was approved by the FDA in 2014 for commercial use.

In 2017, two Veterans became the first VA patients to be prescribed the LUKE arm by VA. One was Purple Heart recipient Fred Downs. He was a platoon leader in Vietnam and lost his arm as a result of combat injuries. Downs, who had gone on to work for VA many years as the chief of prosthetics, noted in an interview with CNN's New Day that the LUKE Arm is a prime example of VA research that ultimately helps both Veterans and civilians.

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In another study published in January 2018 in *PLoS ONE*, Resnik and her colleagues asked how upper-limb amputees fared using the DEKA arm, compared with a conventional prosthesis. They found that study participants had less perceived disability and felt more engagement in everyday household tasks when using the DEKA arm. However, initially, they were slower at performing tasks using the DEKA arm.
Editorials from VA Research Scientists

Weight loss maintenance: a losing battle?


Maintaining long-term weight loss in individuals who struggle with obesity is a major challenge, one that the public often views as a losing battle.

Dr. Jennifer C. Kerns, co-director of bariatric surgery at the Washington D.C. VA Medical Center, suggests that first defining successful weight loss maintenance may be a better approach to weight loss. In an *editorial* published in *Nutrition Research*, she argues that long-term maintenance of a modest weight loss may be a more realistic goal for an obese individual, and can bring real health benefits. She says studies show that losing just 5 percent of a person’s body weight has been associated with reducing the risk of developing type 2 diabetes and providing improvements in blood pressure, serum lipids, and mood.

Kerns notes that there are few randomized controlled studies that address long-term maintenance of weight loss. She suggests that the *National Weight Control Registry*, a database of more than 10,000 people who have lost at least 30 pounds and kept it off for at least one year, is a good resource for physicians and patients. Based on the data from the NWCR, Kerns says regular vigorous exercise (60 minutes per day), limited screen time, and a low-fat diet all contribute to weight loss maintenance.

The rising prevalence of early onset colorectal cancer: Ready and FIT to tackle?


The incidence of early-onset colorectal cancer (under age 50) has been rising over the past several decades. Individuals in this group now account for 8 to 10 percent of CRC diagnoses. They also tend to have more advanced illness and less favorable outcomes than do people who are over the age of 50.
Dr. Thomas Imperiale, a researcher at the Roudebush VA Medical Center in Indianapolis, Indiana, asks in an editorial in *Gastrointestinal Endoscopy* whether clinicians should start screening at an earlier age for CRC. He notes that the answer isn’t always simple, and should involve an analysis of cost, harms, and benefits, starting at different ages.

Early screening that surveys only people who are at high risk could spare unnecessary testing for those at low risk, says Imperiale. But what metric should be used to identify high risk for early onset CRC? Early onset CRC is not associated with a high-risk family history of CRC. Likewise, testing people under age 50 with a fecal immunochemical test (FIT) is not a panacea either. Studies do not conclusively show a benefit from early FIT testing, and the U.S. Preventive Task Force recommends that screening starting at age 50 is the best approach.

Imperiale concludes that public education on the signs and symptoms of CRC and the increasing risk for younger people would be more helpful than across-the-board screening. Primary care physicians need to have a dialogue with their patients and ask them to report suspicious symptoms, he says. Physicians should also consider adjusting the threshold at which they work up reported symptoms like blood in the stool.

**Social media as a tool to increase the impact of public health research.**


In an editorial published in the *American Journal of Public Health*, Dr. Jessica Breland and associates assert that social media can be an important tool for health researchers to share their work with the public and promote social discourse. Breland, who is a researcher with the VA Palo Alto Health Care System, in Menlo Park, California, and her team point out that roughly 69 percent of U.S. adults use some kind of social media. That number rises to Continued on next page
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90 percent for adults under age 30. Yet, despite the degree of social media saturation, one study showed only 47 percent of U.S. scientists had ever used social media to share their research.

Breland’s team says there are multiple benefits that come from using social media channels like Facebook, Twitter, YouTube, and web blogs. 1) Social media can help disseminate the results of public health research by expanding readership to a wider audience. 2) Social media can be used to correct public health misinformation. 3) Social media can help influence health policy. 4) Social media can be used to facilitate public health research. 5) Social media can enhance professional development, e.g., public health chats on Twitter.

There are a few caveats to consider if researchers do choose to use social media, says Breland’s team. Social media posts are open to the public, and create searchable records. Therefore, any transgression, like breaching the boundary between public and private social media accounts, may have serious consequences.

Advancing high performance in Veterans Affairs health care.


In an analysis published in *JAMA Internal Medicine*, Dr. David Atkins, director of VA Health Services Research and Development, and Dr. Carolyn Clancy, executive in charge of the Veterans Health Administration, compared patient experiences, outcomes, and mental health measures at VA medical centers with those at non-VA hospitals.

The comparison used data from the Centers for Medicare and Medicaid Hospital Compare website, for the period July 2012–March 2015. VA outperformed public sector hospitals on six of nine patient safety indicators. VA hospitals also had better patient outcomes on mortality and readmission measures and performed as well or better on most clinical metrics. However, non-VA hospitals performed better on measures of patient experience like nursing and physician communication, responsiveness, and pain management.

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The authors suggest that VA’s early adoption of an electronic health record was key in collecting and analyzing system-wide patient data, facilitating research efforts, and improving physician-patient communication. VA also excels at integrating primary care and mental health programs. But they note there is more work to be done, especially in areas where patient satisfaction is a component. To that end, VA is beginning to adopt private-sector practices like setting customer service standards, implementing tools to collect customer feedback, and hiring staff that will be dedicated to improving the health care experience for Veterans.
Awards & Career Milestones

VA researcher Ann McKee named Bostonian of the Year

Dr. Ann McKee, chief of neuropathology at VA Boston Healthcare System, was named 2017 Bostonian of the Year by the Boston Globe, for her groundbreaking work on chronic traumatic encephalopathy (CTE), a condition that occurs after long-term, repetitive injuries to the brain.

McKee is director of the VA-BU-CLF Brain Bank, a joint endeavor between VA, Boston University, and the Concussion Legacy Foundation, and has devoted her research career to understanding traumatic brain injury and Alzheimer’s disease. She is also professor of neurology and pathology at Boston University School of Medicine.

CTE is a degenerative process that occurs in the brain when an individual undergoes repetitive, traumatic strikes to the head. McKee is finding increasing evidence of this condition in professional athletes and also members of the military who were deployed to combat zones and sustained blast injuries.

Her research into the prevalence of CTE has earned increasing public attention over the last few years. In July 2017, McKee and her colleagues published a study on CTE in JAMA. The team examined 202 brains from deceased American football players and found evidence of CTE in 87 percent of those samples. More alarming, 99 percent of the brains belonging to former NFL players—110 out of 111—were diagnosed with CTE. However, these results may not be representative of all football players and may reflect selection bias, caution researchers. Public awareness of the link between CTE and repetitive head injury may have prompted family members to participate in the study.

McKee has been sounding the alarm on traumatic brain injuries in football players for many years, according to the Globe. In 2008, she teamed up with former pro wrestler Chris Nowinski, who was recruiting brain donations from deceased athletes. When McKee autopsied those brains, she found tangles of tau proteins, a biomarker found in people with Alzheimer’s disease and one that is also present in CTE.

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Awards & Career Milestones

“There are many parallels between concussive injury experienced during contact sports and exposure to blast and concussive injury experienced by Veterans. In addition, many Veterans are athletes, and play football, soccer, baseball, volleyball or participate in boxing,” said McKee in an interview with VAntage Point, the official VA blog. “Our research shows that the long-term effects of concussive and blast injuries on the brain can be very similar, regardless of how the brain injuries occurred.”

McKee notes that it is the accumulation of small, sub-concussive injuries that are most damaging to the brain when playing football, and not a concussion itself, according to the Globe. Her work has also shown evidence of brain injury risk in children 6 to 12 years old who play tackle football.

* To find out about Dr. McKee’s work on the neurobiology of Veterans with PTSD, read “Untangling PTSD.” Listen to Dr. McKee speak about her research on CTE in Veterans and professional athletes.

VA psychiatrist Dr. Elaine Peskind receives Paul B. Magnuson Award

Dr. Elaine Peskind has been awarded the VA Rehabilitation Research and Development Service’s highest honor—the Paul B. Magnuson Award. It is given to acknowledge entrepreneurship, humanitarianism, and dedication in service to Veterans.

“Under her leadership,” said Dr. Patricia Dorn, director of RR&D, “Dr. Peskind has improved the lives and functional recovery of Veterans with mild traumatic brain injury and PTSD. She has also been successful in mentoring the next generation of VA researchers.”

Peskind has been recognized for her extensive work on brain and behavioral disorders. Throughout her 35-year career, she has studied a wide range of conditions that affect the brain: including Alzheimer’s disease, PTSD related to combat injuries, and mild traumatic brain injury. She is a prolific investigator, having published more than 340 studies. Since 1998, her work has been continuously funded by either VA or the National Institutes of Health.

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Winter 2017-2018
Peskind is well-known for pioneering methods to collect and store cerebrospinal fluid (CSF) samples for research. Collecting CSF is necessary for studying fluid biomarkers—an essential part of research into degenerative diseases like Parkinson’s and Alzheimer’s disease. She has served as a consultant or member of biomarker committees for organizations like the Michael J. Fox Foundation.

She has also been key in developing the use of prazosin—a blood pressure drug—to treat hypervigilance and nightmares in Veterans with PTSD. She received the Commander’s Award for Public Service from the U.S. Department of the Army for her leadership role in completing a randomized clinical trial on the use of prazosin in active duty soldiers with PTSD. The trial was the first of its kind to examine the use of medication to treat a behavioral disorder in active duty service members.

That study was published in 2013—one of a series of promising trials of the drug. Peskind was also co-principal investigator of a larger trial of prazosin, sponsored by VA’s Cooperative Studies Program that appeared in the New England Journal of Medicine in early February 2018.

In a 2016 study, Peskind and her colleagues discovered that blast exposures in mice caused changes to the cerebellum—an area in the brain—that were similar to structural changes seen in Veterans who sustained blast-related head trauma. Peskind’s team found a correlation between blast exposures and reduced uptake of a chemical tracer that is used in medical imaging. Reduced uptake of the tracer is an indicator of less brain activity in Veterans’ brains. Their findings indicate that when there are more blast injuries to the head, there is less activity in the cerebellum. The researchers say that changes to the cerebellum could be responsible for the mood changes and memory loss seen in Veterans with mTBI.

Studies have shown that people who experience repeated blows to the head are at much greater risk of a brain disease called chronic traumatic encephalopathy (CTE). “We’ve heard a lot about the effects of repetitive-impact mild TBI in professional athletes like boxers and football, soccer and hockey players,” said Peskind to Scientific American. “And we became very concerned that our young service members and Veterans might similarly be at risk for chronic traumatic encephalopathy, a midlife neurodegenerative disorder.”

Awards & Career Milestones

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Winter 2017-2018
Peskind has been co-director of the VA Northwest Mental Illness Research, Education, and Clinical Center (MIRECC) at the VA Puget Sound Health Care System in Washington since 1997. She is also the Friends of Alzheimer’s Research Endowed Professor at the University of Washington in Seattle, and was the associate director of the University’s Alzheimer’s Disease Research Center from 1998–2017.

VA researcher receives DAV Special Recognition Award

Dr. Elizabeth Yano was honored with the Disabled American Veterans’ Special Recognition Award for her extensive research and work on behalf of the nation’s women Veterans.

“This award recognizes Dr. Yano’s stellar leadership in developing and managing a robust and comprehensive research portfolio focusing on women Veterans,” said Delphine Metcalf-Foster, DAV national commander. Through her efforts to mentor and train researchers who are interested in women’s health, she “has effected positive change for the health and well-being of our nation’s women Veterans,” Metcalf-Foster added.

Yano is a VA senior research career scientist and director of the HSR&D Center for the Study of Health Innovation, Implementation and Policy (CSHIIP) at the VA Greater Los Angeles Healthcare System. She is also an adjunct professor at the UCLA Fielding School of Public Health.

Yano, an epidemiologist and health policy researcher, is a prolific investigator. In addition to the roles mentioned above, she also directs the HSR&D’s Women’s Health CREATE, “Accelerating Implementation of Comprehensive Women’s Health Care.” The CREATE is a group of five interrelated studies that together received $4.5 million in funding from VA. Together with her co-investigators, Yano is seeking the most effective ways to provide health care for women Veterans enrolled in the VA health care system and to attract those who are not.

Yano is also the principal investigator for the Women’s Health Services Partnered Evaluation Center, part of VA’s Quality Enhancement Research

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Initiative (QUERI). She and her colleagues are investigating the value of evidence-based programs in improving the quality of women’s health care in VA.

Women are the fastest-growing segment of Veterans in the U.S.—accounting for nearly 10 percent of the total Veteran population in 2018. They are projected to account for 14 percent of the Veteran population in 2025, and nearly 18 percent in 2040. They have health care needs that can be significantly different from those of their male counterparts. Yano and her colleagues are seeking to better understand those needs by conducting targeted research and encouraging other researchers within VA to enter the field of women’s health.

To that end, Yano is the principal investigator and co-founder of the Women’s Health Research Network, which was created in 2010 to promote research that focuses on the unique needs of women Veterans. It consists of two parts: The Women’s Health Research Consortium and the Women’s Health Practice-Based Research Network (PBRN).

While the consortium was created to boost training for women’s health researchers, the PBRN’s goal was to build infrastructure and draw together a community of clinicians and women’s health researchers. The aim of the program is to make it easier to conduct large, multisite clinical and quality improvement studies that focus on women’s health or include women so they may equitably benefit from research findings.

“VA is an incubator of ideas,” Yano told VA Research Currents in 2014. “Most researchers just hope someone notices their work, but [in VA] we have the capacity to transform our evidence-based practice into evidence-based policy.”

*Listen as Dr. Yano discusses the state of women’s health research in VA. To find out more about the Women’s Health Practice-Based Research Network read “Expanding the focus on women Veterans.”*
Rani Elwy, Ph.D., and Joshua Thorpe, Ph.D., are each recipients of the 2017 HSR&D Best Research Paper of the Year Award, which honors a single article or collection of articles resulting from one or more HSR&D- or QUERI-funded investigations. Research studies also must involve Veterans, with results that are important to Veterans’ health and care, and to the VA health care system.

Published in *JAMA Surgery*, Elwy and colleagues’ article, “Surgeons’ Disclosures of Clinical Adverse Events,” describes a study conducted from January 2011 through December 2013 that assessed surgeons’ reports of disclosure of adverse events and aspects of their experiences with the disclosure process. Surgeons (41 men, 21 women) representing 12 specialties at three VA medical centers completed a web-based survey. Most of the surgeons reported using 5 of the 8 recommended disclosure items in their conversations with Veterans and their families, but those who were less likely to apologize to patients, discuss preventability of the adverse event, or discuss how recurrences of the event could have been prevented were more negatively affected by disclosure than others. Elwy and her colleagues suggest that quality improvement efforts focused on recognizing the association between disclosure and surgeons’ well-being may help sustain open disclosure policies.

Elwy’s article was one of the top 10 downloaded articles in *JAMA Surgery* in 2016 and was mentioned in 45 news stories from 20 news outlets, including *CBS News* and the *Washington Post*. Further, following an early conference presentation of Elwy’s study, Dr. Carolyn Clancy, currently VHA Executive in Charge, arranged for a briefing to VA operational leaders to discuss how VA could move disclosure from a risk management perspective to a patient safety perspective, in order to encourage more surgeons (and other clinicians) to follow VA’s “Disclosure of Adverse Events” policy (*VHA Handbook 1004.08*). Dr. Elwy is part of HSR&D’s Center for Healthcare Organization and Implementation Research (*CHOIR*) in Boston and Bedford, Massachusetts.

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Published in the *Annals of Internal Medicine*, Thorpe and colleagues’ article “Dual Health Care System Use and High-Risk Prescribing in Patients with Dementia” was chosen for several reasons, including its potential to be impactful both inside and outside VA. David Gifford, MD, MPH, wrote an accompanying editorial, noting “On the surface, the study by Thorpe and colleagues seems to be only about medication prescribing for dementia in the VA system, but it could serve as the basis for an entire medical school course on health policy.” Thorpe and colleagues used VA and Medicare data to identify nearly 76,000 Veterans with dementia who were enrolled in both health care systems from 2007 through 2010. They found that compared with VA-only users, Veterans who used both VA and Medicare (dual-users) had more than double the odds of exposure to potentially unsafe medications, demonstrating that receipt of prescription medications across unconnected care systems increases the risk for unsafe prescribing.

Based on the immediate applicability of this article, senior VA leaders in *Geriatrics and Extended Care*, Pharmacy Benefits Management (*PBM*), and the Center for Medication Safety (*VA MedSAFE*) engaged Thorpe to fast-track implementation of new approaches to reduce the risk for potentially unsafe prescribing for Veterans. Thorpe is part of HSR&D’s Center for Health Equity Research and Promotion (*CHERP*) in Pittsburgh.

HSR&D thanks Elwy and Thorpe for their outstanding work and contributions to the literature which will help VA improve the safety of Veterans in VA care.