FORUM *translating research into quality health care for veterans*

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There's No Place Like Home: Coordinating Care for Veterans

By Adam Darkins, M.D., M.P.H.M., Chief Consultant for Care Coordination

VA's new Office of Care Coordination (OCC) has an ambitious mission: ensuring that all patients receive the right care in the right place at the right time. Although few would argue with that sentiment, the devil lies in the details.

How do we know what constitutes the right care, the right place, and the right time for any given patient? That's where health services research and the vital work of HSR&D come in.

OCC's vision—that the home should be the preferred place of care, whenever appropriate—places the environment of care on center stage. But the combinations and permutations of people, places, care provision, and timing of care across the VA system are virtually infinite. Care coordination is a mammoth undertaking, and one where the journey is the destination.

In VA, care coordination involves the use of telehealth, disease management, and health informatics technologies to enhance and extend care and case management activities. VA is initially focusing its care coordination effort on the home and using home-telehealth technologies. We describe this range of activities as care coordination/home telehealth (CCHT). We are finding these technologies particularly useful for extending care in rural and underserved areas.

Why is care coordination being adopted throughout the health care system? Ask your colleagues, friends, and relatives about their experiences with the health care system. I would be astounded if you don't hear stories of people who have suffered or died unnecessarily. Anecdotal data, you say? The meta-analysis of such stories becomes the evidence for avoidable medical errors.

Individual components of care are not necessarily at fault, whether they are located in the home, clinic, inpatient unit, operating room, or radiation therapy suite. Unfortunately, there are cracks in what is popularly called the continuum of care, and patients are falling through them. Poor coordination of care is causing harm to patients, as well as inconvenience and unnecessary cost, and it must be rectified. Until it is, the term "health care system" seems a misnomer. Sadly, the fragmentation of the health care system means that the whole adds up to far less than the sum of its parts.

This brings us back to the environment of care. In the nineteenth century, hospitals were places of sanctuary. Throughout most of the twentieth century, human and capital assets in health care were concentrated in hospitals as the locus of health care delivery moved from the community to institutional care. Average life expectancy in the U.S. improved over the same period—because of better living conditions and nutrition, and proper sanitation, and not because of changes in health care delivery.

By focusing on CCHT, VA is addressing fundamental questions about the relative mix of primary, secondary, and tertiary prevention. If HSR&D is to follow care in this next phase as it moves out into the home, the possibilities for the future design of our health care system are fascinating.

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Director's Letter

I am pleased to announce that HSR&D has decided to fund three new Centers of Excellence.

The first of these centers will be located at the Boston VAMC and will focus on management research. Martin Charns, D.B.A., will lead this new center. Dr. Charns had been director of our Management Decision and Research Center (MDRC) for the last 10 years. This decision underscores the importance HSR&D places on the science of management and the need to develop more evidence-based management.

The other two centers will focus on implementation research, an increasingly important area for HSR&D, in particular, and VA in general. The two centers will be based at the Iowa City VAMC and the Indianapolis VAMC. The directors of the centers are Gary Rosenthal, M.D., and Brad Doebbeling, M.D., M.Sc., respectively.

Congratulations to the three new directors, their staffs, and their facilities. The competition was rigorous, with several excellent proposals received. This will bring to a total 16 Centers of Excellence funded by HSR&D.

We also are pleased to announce four special academic partnership awards to enhance implementation research. The awardees are Rod Hayward, M.D., Ann Arbor VAMC; Joseph Conigliaro, M.D., M.P.H., Pittsburgh VAMC; Lisa Rubenstein, M.D., M.S.P.H., Sepulveda VAMC; and Fran Weaver, Ph.D., Hines VAMC. Congratulations to all.

Finally, as many of you know, I will retire on July 2, after serving as HSR&D Director for almost seven years. As I prepare to leave, I want you all to know what an honor it has been for me to serve in this capacity. I thank the entire HSR&D community in Central Office and in the field for their support, cooperation, and hard work.

Together, we have accomplished much. HSR&D has grown from a $33 million research enterprise to one with more than $60 million dollars. Another $10 million in medical care funds have been awarded for our Quality Enhancement Research Initiative (QUERI) projects and other implementation research endeavors.

Across the board, we can see how HSR&D has grown: Funded projects have increased in number from 109 to 150; we've nearly doubled our career development awards, from 37 to 70; and we've added seven Centers of Excellence over the years. We have instituted new centers (Resource Centers, the Research Enhancement Awards Program, and the Targeted Research Enhancement Program); awarded career development for non-clinical Ph.D.s (the Merit Review Entry Program); and, of course, successfully implemented QUERI. This continued expansion would not have been possible without the significant increase in our funding.

And for that, we have to thank the outstanding work of our researchers in the field and the impact they have had on our health care delivery system.

Thank you again for all your hard work and dedication. I know you will continue to give that same hard work and dedication to my successors.

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

Again, let's ask: What is the "right" environment for care? If, for example, appropriately selected patients with heart failure are monitored at home and their diuretic medications are adjusted when initial symptoms of breathlessness and signs of weight gain develop, acute hospital stays with probable ICU admissions are avoided. This approach, with corollaries across a wide range of chronic diseases, gives rise to the concept of "just-in-time" care.

In contrast, our traditional model of clinic visits is "just-in-case" care. Clinic visits every three, six, nine, or 12 months are arbitrary and not based on evidence of effectiveness or cost-effectiveness. Rates of unscheduled outpatient clinic appointments and emergency hospital admissions suggest that this model is frequently inappropriate. Are clinic visits really supporting patients, or are they reassuring practitioners?

The hospital and the outpatient clinic will always be vital to our health care system. However, if we use new information, communication, and telecommunications technologies to engage in dialogues with patients, the focal point of care may shift to the home. There is an inexorable logic in educating patients to lose weight, exercise, and stop smoking to ameliorate the progression of cardiac failure—as there is in educating them not to be stoic and wait until they are at death's door before seeking hospital care.

As the demographics of veteran patients change and they live longer while coping with one or more chronic diseases, the salient decisions become whether to treat, when to treat, how to treat, and where to treat. Once again, we are back to the environment of care and the importance of understanding patients and their preferences for care.

Take, for example, falls among the elderly. Why do people fall at home? The generally accepted reasons are extrapolated from research studies on falls in hospitals. Is alcohol use related to depression resulting from living alone and being less mobile a precipitating cause? We don't know, because this question has received less

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attention than treating the fractured necks or femurs that result from falls at home. Should more attention be paid to dealing with loneliness and depression in elders as well as secondary and tertiary care?

These questions have never been addressed adequately, because the relationship between the health care system and the patient has been episodic and based on clinic visits and hospital admissions.

Since implementing the Computerized Patient Record System (CPRS), VA has achieved major improvements in health care quality indicators. CCHT is extending our new electronic patient record system into the home, where CPRS captures and directly incorporates vital sign and disease management data.

Imagine a scenario whereby veterans with chronic diseases can understand the health issues they face in terms of the primary, secondary, and tertiary prevention choices from consistent, coherent, and evidence-based e-health information. Further imagine that these same veterans use this information to make choices based upon data from their own health record. Finally, imagine these veterans engaging with VA practitioners to exercise their preferences for care, based on VA's evidence-based clinical guidelines.

This type of self-management system will soon be possible in VA for appropriate veteran patients. OCC is working with other VA offices to coordinate clinical input into VA's patient handheld record system, MyHealth-eVet; to give e-health information to patients; and to support the caregiver to make these systems work.

HSR&D will be crucial to achieving this agenda. We need solid health services research to inform the design of these systems and ensure that those who cannot use these systems are not disenfranchised. Finally, amidst all these technological developments, we need to maintain our vision of connecting with patients in ways that are human, meaningful, and necessary—whatever the environment of care. ■

Response to Commentary

Shared Goal of Evidence-Based Care Will Spur Improvements in Care Coordination by VA

By Neil Thakur, Ph.D., Assistant Director, Management Consultation, and John G. Demakis, M.D., Director, HSR&D

Dr. Darkins' commentary describes the many ways in which VA's new Office of Care Coordination (OCC) taps into core areas of health services research. He offers us yet another example of the exciting and complex ways in which an intramural health services research program can support health care delivery and innovation.

VA's care coordination agenda hits four broad areas of inquiry central to the HSR&D research agenda. These are:

- chronic disease management;
- organization and delivery of services;
- infrastructure to support and monitor care in home-based settings, including informatics, telehealth, and quality assurance; and
- implementation of new services and models, including training and staffing changes.

HSR&D already devotes considerable resources to these areas. We currently fund more than 40 studies on disease management, management and organizational research, and telehealth. In addition, our Quality Enhancement Research Initiative (QUERI) projects and Veterans Integrated Service Network collaboratives focus on the art of implementation itself. This synergy, as well as new studies, can be used to support and inform the OCC in its work.

These efforts are facilitated by VA's natural strengths. Data and planning efforts are relatively easy to centralize in VA, compared to the private sector. The process of collecting and disseminating research and quality improvement findings unfolds within clearly defined boundaries. The particular strategies of the OCC suggest the opportunity to create home-based care patient registries and databases that open up new research opportunities. Most importantly, VA has natural organizational divisions (facilities and networks) that allow the simultaneous implementation of different strategies that can be scientifically compared.

Dr. Darkins' agenda presents exciting opportunities for OCC and HSR&D researchers to advance a goal fundamental to both groups: that care, organization, and management of clinical services for veterans should be evidence-based. To make this happen, we will need to address immediate operational needs and begin our longer-term planning.

First, our mutual commitment to evidence-based decisions means care coordination should be implemented in stages, with concurrent summative and formative evaluations. These evaluations will determine which aspects of care coordination work and should be expanded, and how best to expand them. This strategy may lead to implementation of different aspects of the model in different networks and/or for different disease groups, possibly on a randomized basis. HSR&D field programs can facilitate the design and execution of these efforts.

Second, HSR&D needs to begin research now on the issues that OCC will face in the next five to 10 years. We look to our field investigators to design studies that are mindful of the major shifts in care delivery that the OCC proposes, and to explore opportunities with local clinical sites for potential improvements to care coordination.

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Telemedicine Technologies: What is the Cost of Improving Access to Health Care Services in Rural Areas?

By Julie Lowery, Ph.D., VA HSR&D Center of Excellence, Ann Arbor, MI

"What are some of the more effective and less expensive telehealth technologies that can be used to provide VA care for the many veterans who live in rural America?"

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

Of the two major types of telemedicine systems available—store-and-forward vs. real-time videoconferencing—store-and-forward is much less expensive, but probably just as effective. (I say "probably," because we really don't know—more on that later.)

Store-and-forward systems consist of the collection of clinical data (in electronic format) by the patient, caregiver, or provider at the patient's home or health care facility, that are then transmitted to a Web site, e-mail address, or remote storage device for review by the telemedicine physician at a later time. The clinical data can be in the form of digital photographs, video streams, direct output from peripheral devices for measuring vital signs, and/or simple text.

Videoconferencing systems require the installation of more expensive equipment, including video capture and display units, at both ends of the communications link. These systems also need greater bandwidth for the real-time transmission of video and audio. Plus there's the challenge of coordinating patients' and providers' schedules. In that sense, videoconferencing is similar to in-person visits between patient and provider.

By contrast, the equipment used in store-and-forward applications (such as digital cameras, PCs, or laptops) is much less expensive (or already available), more reliable, and easier to use than videoconferencing equipment. In addition, the store-and-forward method can be more convenient for providers, enabling them to review the data when they have the time to do so, without the delays associated with late appointments or patient no-shows for videoconferencing consultations.

Furthermore, the data can be easily stored in an electronic database for subsequent retrieval and review. Some more sophisticated (and expensive) store-and-forward applications have the added benefit of a computer program that analyzes the data and flags those items requiring immediate attention, thereby precluding the need for the telemedicine provider to review all of the data submitted.

The primary disadvantages of store-and-forward applications, in contrast to videoconferencing, are: lack of direct communication between patients and their telemedicine providers; and, in cases requiring the review of patients' physical characteristics, the inability to request different/additional views in real time.

Both store-and-forward and videoconferencing systems can be used to collect and transmit data from patients in their homes or patients seen in rural health care facilities. The former is necessarily more expensive, because the equipment has to be installed in many more locations. Equipment placed in rural health care facilities, in contrast, can serve multiple patients. However, systems based in homes maximizes patients' access to care, and may be the only option for veterans who live many miles from a primary care clinic.

Unfortunately, rigorous evaluations of telemedicine applications—both store-and-forward and videoconferencing—are few and far between. Rarely do evaluations of a telemedicine intervention include a control group for comparison, let alone randomization between intervention and control. So, while most "evaluations" of telemedicine applications show benefits, the methods and results should be carefully reviewed.

"We still don't know for certain whether telemedicine will prove cost-effective, in terms of reducing morbidity, mortality, visits, or admissions to tertiary care facilities, or at improving patients' quality of life."

Having said that, the applications most frequently reported in the literature and presented at conferences include: pathology, radiology, psychiatry, home care (for various chronic illnesses), dermatology, and ophthalmology. All have shown promising results. But we still don't know for certain whether telemedicine will prove cost-effective, in terms of reducing morbidity, mortality, visits, or admissions to tertiary care facilities, or at improving patients' quality of life. Certainly, improving patients' access to care is a benefit. But that benefit does not come without a cost. ■

The Benefits of Telehome Care: What Does the Research Show?

By Faith Hopp, Ph.D., and Julie Lowery, Ph.D., Ann Arbor HSR&D Center of Excellence, and Peter Woodbridge, M.D., M.B.A., and Richard L. Roudebush, VAMC

Through the Office of Care Coordination, VA devotes considerable resources to the implementation of home telehealth, under the assumption that, when appropriate, home should be the care setting of choice. As Dr. Darkins points out in his commentary, HSR&D can play an important role in determining when home telehealth is most effective. Many descriptions of telehome care have been reported, and the vast majority show positive outcomes, in terms of both patient and provider satisfaction. However, few studies of this technology have included comparable control groups. In addition, most studies have been conducted outside VA, and most have shown equivocal results.

A large-scale, randomized study conducted by Kaiser Permanente involving home video technology reported a 25 percent decrease in health care costs (excluding those for home care) in the intervention group, compared with patients receiving usual home care. The savings were largely due to a 43 percent decrease in hospital costs, but they were offset by a 36 percent increase in home care costs (including technology) in the group that received the home video technology. No differences in patient satisfaction were found between the telehealth group and usual home care group.

A recently published study randomized congestive heart failure patients to telehome care, telephone follow-up, or usual care to compare use of health resources. Findings suggested that telehome care did not offer an incremental benefit beyond that obtained from usual telephone follow-up. (For more information, see Jerant, et al. in *Medical Care* 2001; 39:1234–45.)

A VA study evaluated a multi-faceted intervention involving the use of care coordinators, home video, and messaging devices. The results showed lower use of hospital services in the intervention group, but the findings were compromised by lack of comparability between the intervention and comparison groups. Moreover, the intervention included both care coordination and telehealth components, making it difficult to tease out the individual contributions of telehealth versus care coordination as predictors of patient outcomes.

The Ann Arbor HSR&D Center of Excellence has conducted VA's only randomized control study of telehome care. Although the study was very small, it showed a significant improvement in mental health ratings among patients receiving telehome care services, compared with patients who received usual home care services. However, no group differences were observed for physical health and patient satisfaction, or for use of health care resources, including inpatient days of care, emergency room visits, in-person home care services, or primary and specialty outpatient services. Like most other studies, patients rated telehome care services positively.

The findings from these studies should not deter us from pursing the laudable goals put forth by the Office of Care Coordination, but we must be cautious in our expectations. Certainly, telehome care can improve patients' access to care, particularly for veterans who live far from VA medical centers. But this will not necessarily translate into reductions in service use or cost savings. In addition, the question of whether improved access from this technology will improve morbidity and mortality remains to be answered. More randomized studies are needed to determine whether telehome care can provide more cost-effective and better strategies for coordinating care of persons with chronic conditions. ■

Under Secretary's Award for Outstanding Achievement in HSR Presented to Carol Ashton

Carol Ashton, M.D., M.P.H., director of Health Services Research and Development's (HSR&D) Houston Center for Quality Care and Utilization Studies, has received the 2004 Under Secretary's Award for Outstanding Achievement in Health Services Research.

In accepting the award, which was presented at HSR&D's National Meeting, Ashton thanked all of HSR&D's "scientists, colleagues, and mentors," as well as "all the veterans who have shared themselves and their stories with me since I became a VA staff physician in 1983, and who never let me lose sight of why I chose to devote my professional life to this system."

The award recognizes a VA researcher whose work has led to major improvements in the quality of veterans' health care, has made significant contributions to the future of HSR&D through excellence in training and mentorship, and has enhanced the visibility and reputation of VA research through national leadership.

Ashton is an exceptional health services researcher, excellent mentor, and respected VA leader. Her dedication to improving veterans' health care has led to the development and implementation of new measures and procedures that improve quality while addressing patients' needs and preferences.

Research Highlight

Telecare Shows Promise for Treating Depression in Rural Primary Care Settings, According to TEAM Study Results

By John Fortney, Ph.D., and Jeffrey Pyne, M.D., Central Arkansas Veterans Healthcare System and Department of Psychiatry, College of Medicine, University of Arkansas for Medical Sciences

"Because of the many treatment barriers facing patients and providers, the clinical outcomes of routine primary care depression treatment are not optimal, especially for rural patients."

Telemedicine technologies may offer an effective means for providing evidence-based depression treatment to veterans living in rural areas, according to preliminary data from the Telemedicine Antidepressant Management (TEAM) study conducted by the HSR&D Center for Mental Health and Outcomes Research (CeMHOR), and the South Central Mental Illness Research Education and Clinical Center (MIRECC).

The purpose of the study is to determine the effectiveness and cost-effectiveness of using telemedicine technologies (e.g., telephones, interactive video, electronic medical records, and the Internet) to improve the outcomes of depression in small rural Community-Based Outpatient Clinics (CBOCs).

Over the last 10 years, 573 CBOCs have been established to improve veterans' access to care. However, specialty mental health services are not provided in 74 percent of rural CBOCs. Because of the many treatment barriers facing patients and providers, the clinical outcomes of routine primary care depression treatment are not optimal, especially for rural patients with poor geographic access to care.

Collaborative care teaming primary care providers (PCPs) and mental health specialists has been identified as the best practice for addressing depression in primary care settings. Originally, collaborative care models were designed for (and evaluated in) large urban primary care practices with on-site mental health specialists. Implementing collaborative care in small rural CBOCs is more challenging because it typically is not feasible to employ mental health specialists on site.

TEAM investigators adapted the collaborative care model for small rural CBOCs using telecare technologies and three types of off-site mental health specialists: depression nurse care managers, mental health clinical pharmacists, and consult tele-psychiatrists. Using telecare technologies, off-site mental health specialists support on-site PCPs in providing evidence-based depression treatment. Within a stepped-care framework, the depression nurse care manager conducts patient education, activation, and barrier assessment, as well as symptom and medication monitoring. The clinical pharmacist provides medication management and treatment recommendations to PCPs. Consult tele-psychiatrists conduct interactive video encounters with patients and provide treatment recommendations to PCPs.

The intervention was implemented at small rural CBOCs in the South Central VA Healthcare Network, with matched CBOCs serving as controls. Six-month follow-up data indicate that the TEAM intervention significantly improved both the process and outcomes of care. More than 16,000 primary care patients were screened for depression, with 6.8 percent screening positive. More than 90 percent of eligible patients enrolled in the study, and 93 percent of those patients completed six-month follow-up interviews.

Intervention patients had more antidepressant trials, reported more days taking antidepressants, and were more likely to experience a greater than 50 percent improvement in their depressive symptoms. Future analysis will focus on the cost-effectiveness of this approach. For more information about the TEAM study, visit our web site at www.va.gov/team/. ■

Telemedicine Systems May Help SCI Patients Get Specialized Care Sooner

By Julie Lowery, Ph.D., Ann Arbor HSR&D Center of Excellence, and Bonnie Wakefield, Ph.D., R.N., Iowa City VAMC

The special needs of spinal cord injury (SCI) patients make it especially difficult for them to travel long distances for care. To improve access for these patients, several VA networks and medical centers have implemented telemedicine systems for monitoring and providing treatment. Research on the effectiveness of telemedicine for SCI patients is still in its infancy, but two VA studies have yielded encouraging—though mixed—results, and more research is underway.

A 2000 study evaluated a telemedicine system established at the VA Palo Alto Health Care System's SCI Center, which served as the "hub," with "spokes" at medical centers in Fresno, Honolulu, and Reno. Patients and their providers in the spoke centers communicated with SCI specialists in Palo Alto via videoconference. Consultation was sought for a variety of conditions, including genito-urinary, pain, gastrointestinal, neurological, functional loss, skin, medication, spasticity, fatigue, and psychosocial issues. Multiple conditions were usually addressed in each telehealth session.

Patient and provider evaluations of the system were extremely positive, and access to care for veterans with SCI improved. Notably, more than half of the telehealth consultations provided were for patients who had never been seen at the SCI Center. More than 70 percent of the telehealth consultations were believed to have expedited diagnosis and treatment of patient conditions, according to the provider evaluations. Patient and provider surveys alike showed telehealth consultation to be a comfortable and desirable way to provide services when patients are located at a great distance from available experts.

In response to these findings, the Spinal Cord Injury Telehealth Consultation Program has become firmly established at the Palo Alto VAMC and continues to show benefits by providing care to new patients and reducing the need to travel to Palo Alto. A similar system has been established between the Iowa City and Hines VAMCs in which Iowa City patients are seen via videoconference by wound care specialists at Hines.

"Research on the effectiveness of telemedicine for SCI patients is still in its infancy, but two VA studies have yielded encouraging—though mixed—results, and more research is underway."

Investigators at the Ann Arbor HSR&D Center of Excellence completed a study assessing the accuracy of using digital photographs for evaluating chronic wounds, including pressure ulcers in SCI patients. Although the diagnoses made from the digital images were not as accurate as they had hoped, the study investigators concluded that the technology is a viable way to increase access to specialized wound care services.

Based on these findings, the Ann Arbor COE is conducting a pilot study of a "store-and-forward" telehealth system that provides treatment recommendations from a specialized wound care team in the Ann Arbor VA Medical Center to wound care nurses in referring primary care facilities. (For more information on "store-and-forward" technologies, see the Dialogue article on page 4.) The study researchers hope to use the results from the pilot study to submit a proposal for conducting a randomized controlled trial comparing the costs and effectiveness of the store-and-forward system versus the usual referral process.

Investigators at the Palo Alto SCI Center also are examining the use of telehome care for patients with SCI. Specifically, they have been evaluating the use of telephone and telephone plus video care for assessing three secondary conditions common in patients with SCI (pressure sores, transfer mobility, and spasticity). The results of the telephone and televideo assessments will be compared with findings from an in-person assessment. Data analysis from the study is underway, and the findings are expected to contribute substantially toward the validation of telemedicine approaches in home settings.

It comes as no surprise that a number of VA medical centers have already implemented telemedicine systems to help provide specialized care to SCI patients in remote areas. However, much more research is needed to determine the benefits of these systems relative to their costs. A comparison of store-and-forward versus videoconferencing technology would be particularly helpful to VA managers who are considering these systems for their facilities. ■

HSR&D National Meeting 2004: Meeting the Changing Needs of Veterans

"Meeting the Changing Needs of Veterans: The Quality/Cost Equation" was the theme of VA's Health Services Research & Development Service (HSR&D) 22nd National Meeting, held March 9–11, in Washington, D.C. During the meeting, nearly 600 researchers, clinicians, and policymakers participated in an array of activities, including plenary paper sessions, exhibits, workshops, and a poster session—all focusing on meeting the changing health care needs of veterans while providing high-quality, cost-effective care.

Hosted by HSR&D's Center for Health Quality, Outcomes, and Economics Research (Bedford, Mass.), the conference addressed a broad spectrum of health care issues, such as: the relationship between research and practice, health care disparities, use of patient-centered data to improve quality, mental health care coordination, comprehensive care for women veterans, and doctor-patient communication. Researchers also addressed a wide array of diseases and conditions affecting veterans, including chronic pain, colorectal cancer, diabetes, hypertension, HIV/AIDS, problem drinking, suicidal risk, and stroke.

Jonathan Perlin, M.D., Ph.D., VA's Deputy Under Secretary for Health and Acting Chief Research and Development Officer, addressed participants about the remarkable improvements in quality of care within the VA health care system, such as better diabetes control, increased screening for cervical cancer, and higher use of beta blockers for heart attack patients at discharge from hospital. Other meeting highlights included the presentation of the 2004 Under Secretary's Award for Outstanding Achievement in Health Services Research to Carol M. Ashton, M.D., M.P.H., director of HSR&D's Houston Center for Quality of Care and Utilization Studies. The keynote address, "Assessing Quality of Care for Persons with Disabilities," was given by Lisa Iezzoni, M.D., M.Sc., with Harvard Medical School and the Beth Israel Deaconess Medical Center. This is a topic of great importance, especially for veterans who return from war with substantial, long-term impairments.

This year's meeting also included a special tribute to John G. Demakis, M.D., who will retire as director of VA's Health Services Research early this summer. Dr. Demakis was presented with the Under Secretary's Exemplary Service Award—the highest honor this office bestows.

Response *continued from page 3*

HSR&D can work with the OCC to develop and better focus this agenda.

The challenges ahead are considerable. Care coordination draws from multiple areas of health services research, and HSR&D will have to be especially creative and collaborative.

Fortunately, both tasks are mutually reinforcing, leading to shared success, wider support of HSR&D and the OCC, and further progress toward evidence-based care. The ultimate winners will be veterans and their caregivers. ■

FORUM

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