Behavioral medicine translation in the Veterans Health Administration: editorial to the special section on the Department of Veterans Affairs

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The Veterans Health Administration (VHA) within the Department of Veterans Affairs (VA) is a national leader in the systematic translation of basic and clinical science to clinical practice, rapidly advancing the quality of health care for Veterans. The VHA is the nation's largest fully integrated health care system and this organization makes the translation of evidence-based behavioral medicine possible on a national scale [1]. An early adopter of behavioral medicine almost from its inception in the 1970s, the VHA supported clinical practice and research targeting health risk factor reduction interventions for tobacco and obesity, psychological factors associated with cancer, and on integrated medical and behavioral treatment of pain [2]. In 1995, the VHA established a national office to support many of its behavioral medicine programs through the National Center for Health Promotion and Disease Prevention (NCP), within the VHA Office of Patient Care Services [3]. More recently, responding to VA Secretary Erik K. Shinseki's transformational initiatives for the twenty-first century in 2009, the VHA expanded its capacity to provide Veterans with behavioral medicine services establishing the position of Chief Consultant for Preventive Medicine and hiring two additional behavioral medicine professionals for each of its 153 medical centers—a behavioral health specialist and a health behavioral coordinator [3, 4].

AN ENVIRONMENT FOR TRANSLATION

The VHA has a rich history that provides a unique context for the translation of science to practice. The concern for the well-being and health care of Veterans and their family members is longstanding in the USA, going back to the civil war. In his second inaugural address, President Abraham Lincoln resolved "...to care for him who shall have borne the battle and for his widow and his orphan." However, the VA as it exists today was shaped when Veterans' health and rehabilitation benefits were first established in 1917 for Veterans with World War I-related injuries and disabilities during a time when health insurance and community support for disability did not exist. The Veterans Administration was established in 1930 to provide more consolidated and comprehensive management of these benefits [1].

The contemporary VA was established in 1989 when management was centralized within the federal government [5]. In the 1990s, Dr. Kenneth Kizer, VHA Undersecretary for Health, introduced initiatives that transformed the VHA from a highly centralized bureaucratic structure to a highly integrated system of regional networks with an electronic medical record, reducing fragmented and impersonal care and improving the quality and efficiency of services [6]. During the last decade, the VHA initiated quality programs and built informatics resources beyond those of other health care systems [1]. Especially with its emphasis on high quality, efficient care, and its national data resources, VHA today offers an unparalleled environment for clinical translation.

There are several current initiatives within the VHA that exemplify its intense focus on translation. First, the research arm of the VHA, the Office of Research and Development, especially through its Health Services Research and Development Service (HSR&D), has initiated the integration of implementation research, including the translation of behavioral medicine, into clinical and operational structures and processes of the VHA [7–9]. Through its Quality Enhancement Research Initiative (QUERI) program and the Center for Implementation Practice and Research Support (CIPRS), a resource center for implementation science, the VHA has provided structures and methods for collaboration between researchers and clinical and operational partners to move evidence-based practices into the field [10–12]. HSR&D investigators have generated new conceptual models for translation [8, 13, 14], innovations in evaluation methodologies [15, 16], and working laboratories that facilitate change in health care delivery [11, 17, 18]. The co-location of research and clinical activities within the VHA and the emphasis on quality and implementation provides an environment where findings from clinical research in behavioral medicine can be applied in clinical settings with close collaboration between researchers and clinicians during the translation [9].

Second, the VHA capacity in informatics, long known for innovation, has expanded dramatically in the last several years. The VHA has moved beyond the first generation of its electronic health record and its extensive national administrative

datasets and is now developing second and third generation informatics products for VHA clinicians, patients, managers, and scientists. Administrative data are available for rapid identification of unintended consequences of health care policy [16] and adverse events [19], threats to patient safety [20], and access to care barriers [11, 15]. Clinical datasets with the administrative data support large-scale epidemiological research and observational studies of interventions. In addition to health information technology for clinicians and managers in the VHA, Veterans using VHA services have access to a personal health record, health decision support integrated in the health record, electronic health applications for their personal computers and mobile devices, and behavioral medicine interventions delivered through telehealth modalities [21–24].

WHO ARE THE VETERANS CARED FOR IN THE VHA?

The Veterans cared for in the VHA are central to the interest in translation of behavioral medicine in the VHA, and for many clinicians and scientists, the primary reason for their work in the VHA. Today, there are over 21.9 million military Veterans residing in the USA including over two million Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Veterans [25, 26]. Veterans cared for in the VHA include those with service-connected injuries and conditions and those whose incomes are low enough to qualify them for care in the VHA. Eligibility for VHA care is given to special categories of Veterans such as former prisoners of war and those exposed to environmental toxicities such as Agent Orange [27]. Based on these eligibility requirements, many Veterans cared for in the VHA are poor, have limited resources, and have lower levels of educational attainment [27]. However, the Veterans Health Care Eligibility Reform Act of 1996 freed the VHA to provide medical care to Veterans in any medically appropriate setting for any of a Veteran's health conditions allowing the VHA to serve a very broad group of Veterans and to provide high-quality care for all regardless of socioeconomic status [1]. In support of this aim, legislation has permitted VHA to collect reimbursement for services provided in VHA settings from private payers and Medicare and to pay for services in the community when services, particularly highly specialized services, are not readily available in VHA settings.

Unlike Veterans of earlier eras, today's Veteran population includes women, and women are accessing VHA services in increasing numbers because of the availability of women's health clinics, affordability, and quality of care [28]. VHA transformational initiatives have focused on the emerging needs of contemporary women Veterans, and this has included the implementation of evidence-based behavioral medicine services [29, 30].

A substantial proportion of contemporary Veterans cared for in the VHA have conditions associated

with significant lifestyle, behavioral, or psychological factors. In addition, mental health and neurological problems among Veterans cared for in the VHA, including post-traumatic stress disorder and traumatic brain injury, are highly prevalent and are often comorbid with pain, obesity, substance use, and other health risk behaviors [26, 31–33]. Three common conditions treated with behavioral medicine interventions—pain, smoking, and obesity—are highly prevalent among Veterans and among those cared for in the VHA. Of those seen in VHA primary care clinics, 50% of male Veterans and 75% of female Veterans report the presence of pain [34]. Veterans are more likely than non-Veterans to ever be smokers [35]. Among the total population of Veterans, 24% are obese and 48% are overweight, and those cared for in the VHA have higher rates of obesity than non-VHA users [36]. Thus, the availability of evidence-based behavioral medicine interventions in VHA clinical setting is especially significant for Veterans cared for in the VHA.

CONTENT OF THE SPECIAL SECTION

Because of resources for translation available in the VHA and the significance of behavioral medicine to the Veterans cared for in the VHA, we are delighted to serve as the editors for this special section of *Translational Behavioral Medicine*. The section highlights the contributions of VHA behavioral medicine scientists, clinicians, and policy makers working to implement evidence-based behavioral medicine practice in VHA clinical settings. The section features empirical research, case studies, conceptual models, and commentaries that illustrate the substantial translational efforts that have been initiated in the VHA. In selecting papers for the special section, we paid attention to the unique characteristics of the VHA that facilitate the implementation of evidence-based behavioral medicine, such as its informatics capacity and its ability to test new models of care across many different health care facilities. We included several papers that highlight the MOVE! Program, a nationally disseminated intervention targeting obesity and overweight that emphasizes physical activity and dietary change. We included papers from the primary office responsible for the national implementation of MOVE!, and we included efforts that innovate upon the basic MOVE! Program by adapting it for local institutional structures and patients. We also considered the challenges of translation, and several articles bring out lessons learned in the VHA clinical setting. One paper in particular illustrates how health services research identified an unintended adverse consequent of health policy and describes how this research was used to improve practice on a national scale. The papers selected for the special section illustrate the breadth and depth of behavioral medicine translation as well as demonstrate how behavioral medicine has been integrated within the delivery of medical care in the VHA.

In conclusion, we would like to express our deep appreciation to our colleagues who contributed to this special section of *Translational Behavioral Medicine*. They contributed their best work for review during a time when many of them were highly engaged in responding to transformational initiatives within the VHA. Our special section reviewers, often VHA clinicians and investigators themselves, devoted their time and expertise to provide highly insightful and well-considered feedback to further strengthen the invited manuscripts. Finally, we found this a wonderful opportunity to collaborate with each other on an endeavor that was highly rewarding and meaningful on many levels. We hope that these articles inspire you to consider the VHA as a catalyst for accelerating the implementation of behavioral medicine within the VHA and beyond. We also hope that you apply these lessons learned from the VHA, a uniquely rich environment for advancing the practice of evidence-based behavioral medicine.

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