

PUBLIC HEALTH Matters

NEWSLETTER

PUBLIC HEALTH
STRATEGIC
HEALTH CARE GROUP

Dear Colleagues:

Welcome to the seventh issue of *Public Health Matters*. The Public Health Strategic Health Care Group's (PHSHG) programs continue to focus on improving Veterans' health by promoting sound policy and practices for clinical public health issues. The areas that PHSHG is directly responsible for include HIV, hepatitis C, influenza prevention, smoking and tobacco cessation, and emerging infections of public health interest—including health care-associated infections. Previous newsletters have included articles on related topics.

This newsletter features articles on two subjects of great importance to both Veterans and VA health care providers: integration of smoking cessation into clinical care for Veterans with post-traumatic stress disorder (PTSD), and electronic surveillance for health care-associated infections and influenza.

The PHSHG supports efforts to decrease smoking. Among the more than 400,000 Veterans with PTSD, smoking is a major health issue. In a recently completed VA Cooperative Studies Program, investigators found that integrating smoking cessation into PTSD care improved long-term abstinence rates more than did referral to on-site VA smoking cessation clinics. These results recently have been published in *JAMA* and are summarized in this newsletter.

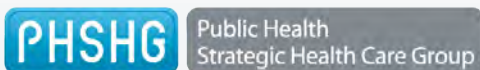
Recognizing that surveillance is essential to infection prevention, the PHSHG has been working to establish the Healthcare-Associated Infections and Influenza Surveillance System (HAISS). In this newsletter's article on HAISS, an overview outlines this innovative program and its contribution to improving patient care. HAISS will improve biosurveillance capabilities within VHA and will likely serve as a model for other national and international health care systems.

Our programs within PHSHG rely on successful collaboration with many VHA program offices, other Federal agencies, and VA clinicians and subject matter experts. We always welcome your suggestions for how we can improve Veteran-centered public health.

For more information on our programs please visit:
<http://www.publichealth.va.gov/about/pubhealth/index.asp>

Wishing you much success and good health.

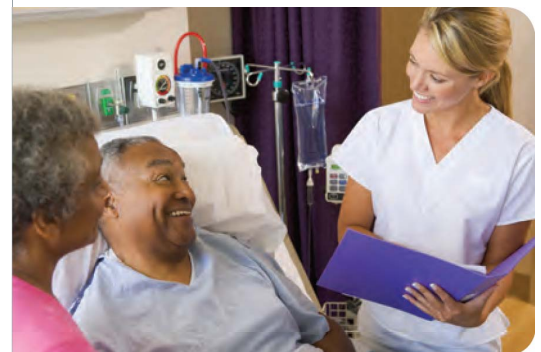
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FEATURED ARTICLES



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Integrating Tobacco Cessation into Clinical Practice for Veterans with PTSD

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Tobacco use remains the single most preventable cause of morbidity and mortality in the United States.¹ Much of the burden of tobacco use falls on individuals with mental illness who smoke at more than twice the rate of the general population.² In the Veterans Health Administration (VHA), smoking rates among Veterans with mental health disorders remain high at nearly 40% (Figure 1).

Smoking Is a Public Health Problem in Veterans with Post-traumatic Stress Disorder

Among the over 400,000 VHA enrollees with post-traumatic stress disorder (PTSD), smoking cessation is a salient issue. Compared to Veterans without PTSD, those with PTSD smoke at higher rates² and more heavily,³ and are less likely to quit successfully.² Individuals with PTSD may smoke to regulate moods and cope with symptoms.³ Depression, a disorder associated with excessive nicotine withdrawal,⁴ is common among those with PTSD.⁵ Thus, multiple quit attempts and management of PTSD and mood symptoms likely are critical for long-term cessation.

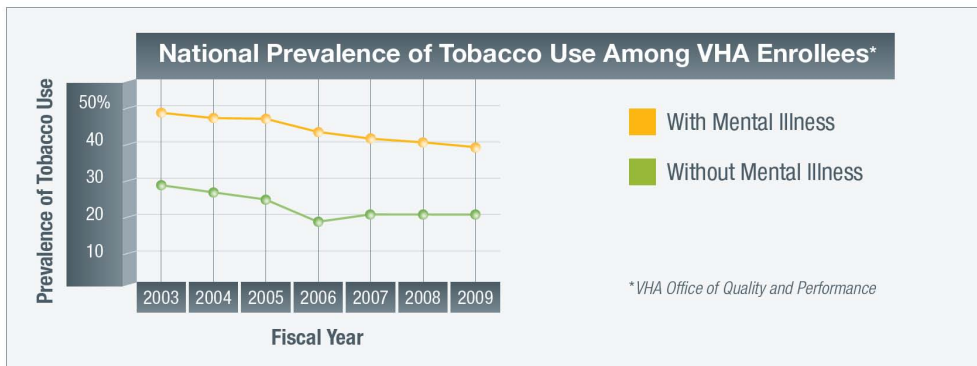
Treatment Barriers

Health care organizations, including VHA, struggle to treat tobacco use in individuals with mental illness. Smokers are infrequently referred to specialized cessation clinics,⁶ and those who are often fail to attend^{6,7} or to complete treatment.⁷ Primary care clinics historically have not provided the frequent follow-up contacts⁸ necessary for cessation in this population.

Integrating cessation interventions into PTSD care, so that both disorders are treated concurrently, offers the following advantages:

- Ongoing treatment, allows for multiple quit attempts, per expert guidelines⁹

Figure 1



- Relapse monitoring and timely reapplication of treatment
- Mental health provider expertise to address the dynamic interaction of smoking and psychiatric symptoms^{10, 11}

What Is Integrated Care?

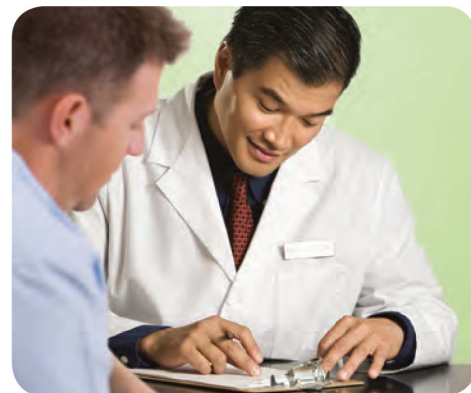
Integrated Care prioritizes tobacco cessation in mental health clinics. The manualized treatment, modeled after clinical practice guidelines,⁹ is delivered by Veterans' primary mental health providers and consists of five core individual counseling sessions that prepare patients to quit smoking by providing:

- education about smoking and benefits of quitting, and
- behavioral and problem-solving skills to aid quitting, cope with craving, secure social support, and prevent relapse.

Following their quit date, Veterans attend three weekly follow-up visits, followed by brief, monthly booster sessions, to support abstinence and manage relapse. A Participant Workbook reinforces session topics and prompts use of coping strategies between visits. Integrated Care encourages use of cessation medications in accordance with practice guidelines⁹ while allowing latitude for personalized medication choices.

Multisite Effectiveness Trial

Between 2004 and 2009, VA Cooperative Studies Program #519 (CSP #519), a randomized clinical effectiveness trial, tested whether integrating smoking cessation treatment into PTSD care improved long-term abstinence rates in Veterans with PTSD more than did referral to on-site VA smoking cessation clinics.¹²



Veterans with current PTSD who smoked were recruited from 10 VA outpatient PTSD clinics. Veterans using non-cigarette tobacco, and those with other major mental health and substance use disorders or severe psychiatric instability or cognitive impairment, were excluded. Veterans were randomized to Integrated Care delivered by their PTSD care providers or to smoking cessation clinics. Outcomes were assessed for a minimum of 18 months.

Smoking Outcomes. The primary outcome was one-year abstinence from tobacco between six and 18 months after enrollment. This rigorous primary end point ensured that outcomes were clinically meaningful with known health benefits.

Veterans assigned to Integrated Care were more than twice as likely to achieve one-year abstinence as were those referred to smoking cessation clinics, with 73 (15.5%) Veterans in Integrated Care and 33 (7.0%) in smoking cessation clinics self-reporting abstinence ($p < 0.001$). Prolonged abstinence rates bio-verified by carbon monoxide and/or nicotine metabolite were lower in both conditions but still favored Integrated Care (Integrated Care: 8.9%, smoking cessation clinic: 4.5%, $p = 0.004$). Likewise, Veterans in Integrated Care were twice as likely as those in smoking cessation clinic to achieve seven-day abstinence between three and 18 months ($p < 0.001$; Figure 2).

Treatment dose. Veterans in Integrated Care attended six more cessation treatment sessions on average than did those in smoking cessation clinics and were more likely to use bupropion, nicotine gum and/or lozenges, and bupropion and nicotine replacement therapy in combination (see Table 1). Total counseling sessions and medication use days explained 29.5% (95% CI: 26.6–32.5) and 9.6% (95% CI: 7.7–11.5), respectively, of the difference in one-year abstinence between treatments.

Psychiatric Symptoms. The possibility that cessation treatment and quitting smoking worsen psychiatric symptoms remains a concern among mental health providers. Over 18 months, PTSD symptoms improved for all participants ($p < 0.001$), with a 10% drop in scores for both conditions. Changes in PTSD severity did not differ between Veterans achieving and not achieving one-year abstinence, with both groups showing improvement. No significant differences were seen in depression scores between the two treatments. Veterans not achieving one-year abstinence worsened slightly on depression

Figure 2

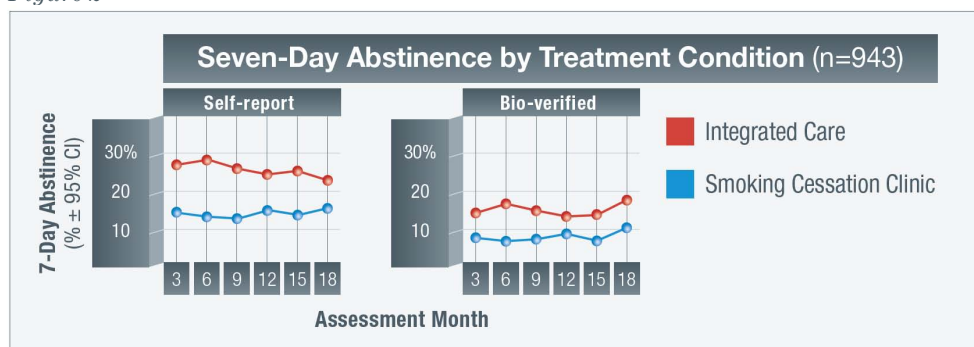


Table 1

Smoking Cessation Treatment Received from Randomization to Month 18			
Intervention	Integrated Care (n=472)	Smoking Cessation Clinic (n=471)	p-value
n (%) or M±SD			
Total smoking cessation treatment sessions ^a	8.8 ± 6.4	2.4 ± 3.2	<0.001
Pharmacotherapy Received, n (%)^b			
Any cessation medication used	383 (84.0)	364 (79.3)	0.07
Bupropion for smoking cessation	188 (41.2)	134 (29.2)	<0.001
Nicotine patch	234 (51.3)	224 (48.8)	0.45
Nicotine gum and/or lozenge	171 (37.5)	140 (30.5)	0.03
Bupropion plus any nicotine replacement medication	100 (21.9)	60 (13.1)	<0.001
Varenicline ^c	56 (12.3)	54 (11.8)	0.81

^a Excludes seven Integrated Care and five smoking cessation clinic patients;

^b Excludes 16 Integrated Care and 12 smoking cessation clinic patients;

^c Varenicline was not available in VHA until year three of the study and was a second line agent.

scores than did those achieving abstinence ($p = 0.03$), whose scores were stable over time.

Significance. CSP #519 demonstrated that mental health providers can deliver cessation treatment as part of routine PTSD care, and that integrating rather than separating treatment improves quit rates and delivers more treatment to Veterans. Although quit rates were modest, probably because smokers with mood and anxiety disorders are highly nicotine-dependent and vulnerable to relapse,¹³ the potential impact of Integrated Care is large given the number of smokers treated in VHA mental health clinics.

Veterans showed no overall deterioration in psychiatric symptoms regardless of treatment assignment and, in fact, improved on PTSD measures over time; an indication

that Integrated Care does not detract from PTSD treatment and corroboration of findings that cessation is not harmful to individuals with mental illnesses.¹⁴

Future Directions

One challenging aspect of improving health care is translating research into clinical practice. Efforts are underway nationally in a group of VA PTSD clinics to train mental health providers in Integrated Care and increase the number of Veterans receiving cessation services. Selected clinics are diverse with respect to populations served and primary treatment modalities; their experiences in delivering treatment and innovations in modifying interventions to fit clinic needs will guide future implementation of Integrated Care in VHA.

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HAISS: Detecting and Monitoring Health Care-Associated Infections in VHA

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The Institute of Medicine has estimated that close to two million patients, approximately 5% percent of all hospitalized patients each year in the United States will develop a health care-associated infection (HAI). Over the past three decades infections caused by microorganisms resistant to commonly used antimicrobial drugs have become the norm, adding to the complexity and expense of treating these infections effectively.

In the Veterans Health Administration (VHA), the Public Health Strategic Health Care Group, Office of Public Health Surveillance and Research has prepared the groundwork to leverage VHA's advanced electronic medical record and national, integrated health care system to establish a comprehensive electronic surveillance system to monitor health care-associated infections (HAIs); organism resistance trends; emerging infectious diseases, such as influenza; and syndromes associated with bioterrorist activities. The Healthcare-Associated Infection and Influenza Surveillance System (HAISS) comprises the HAISS Data Warehouse and two software programs: the QC PathFinder™ (QCP) electronic HAI detection application and the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) biosurveillance application. Both of these web applications will use data accessed from VistA and stored within the HAISS Data Warehouse.

Infection preventionists and hospital epidemiologists have long understood the important role of focused, intensive surveillance in the prevention of health care-associated infections. However, they are also very aware of the barriers to performing high-quality surveillance, such as limited resources, conflicting priorities, and variability in methodologies, that have made it increasingly difficult to accurately detect and monitor HAI trends. In VHA health care facilities, a tremendous amount of attention is paid to monitoring multidrug-resistant



organisms (MDROs) such as methicillin-resistant *Staphylococcus aureus* (MRSA). To meet these enhanced surveillance requirements, the VHA Infection Prevention workforce has been expanded to include specialists in MRSA infection prevention and monitoring, known as MRSA Prevention Coordinators (MPCs). The success of these efforts has led to a strong push to ramp up tracking for other microorganisms that contribute significantly to health care-associated morbidity, such as *Clostridium difficile*. In many cases, increased attention to surveillance, monitoring, and control of these microorganisms pays off in reducing infection rates but not without considerable time and expense. The scenarios on the following page compare manual methods of routine HAI surveillance with the automated methods VHA hopes to achieve by implementing HAISS.

In these scenarios, the point is made that manual HAI surveillance is time-consuming, and that inter- and intra-observer variability can occur, thus hindering the ability of infection prevention specialists to perform needed critical quality improvement activities. The HAISS program has been built to address this issue as well as tracking

“VA should be the nation’s leader in health care-associated infection control and quality improvement.”

Jonathan Perlin, MD

Former VHA Under Secretary for Health

and reporting infections requiring public health notification, and to provide situational awareness of emerging and evolving health threats, such as future pandemics and other natural and man-made occurrences (e.g., the Deepwater Horizon Gulf oil spill and bioterrorist events).

Another area in which improvements in efficiency and quality are widely recognized as being necessary, but in which progress has been slow, is antimicrobial stewardship. Many hospitals have instituted limited

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antimicrobial stewardship programs that are able to address concerns at the facility level only. With its national formulary and fully electronic health record, VHA is in a position to create the first national, integrated antimicrobial stewardship program. The VHA's National Infectious Diseases Program Office (IDPO) is working to develop VA-wide guidance for antimicrobial stewardship. The HAISS automation will provide the necessary tools to VHA clinicians, pharmacists, and epidemiologists: the ability to access resistance data to guide

antimicrobial treatment choices and to track microorganism resistance patterns alongside antimicrobial prescribing trends by facility and VISN and across VHA facilities. Enabling these activities through HAISS will allow the National IDPO and the PSHG's Office of Public Health Surveillance and Research to implement a national VA program to promote optimal selection of appropriate antimicrobial treatment, thereby maximizing patient outcome and potentially minimizing the emergence of antimicrobial resistance while saving money.

A summary on the next page provides detailed information regarding the four “pillars” of surveillance being developed within HAISS. Users of HAISS will include a variety of health care professionals across VHA, both in the field and at the national VACO level: infection preventionists, MRSA coordinators, hospital epidemiologists, infectious diseases physicians, pharmacists, and national program offices, such as the PSHG's Office of Public Health Surveillance and Research, the VHA's National Infectious Diseases Program Office, and VA Pharmacy Benefits Management Services. In 2011, HAISS is being validated in prototype format using data from the VA Palo Alto Health Care System and VISN 20 Data Warehouse. HAISS beta-testing will be initiated at several VA medical centers over the coming year. It is anticipated that in 2012, the VHA will be positioned to roll out HAISS to all VA medical facilities.

Surveillance Scenarios

Manual Surveillance Scenario

- A MRSA Prevention Coordinator (MPC) is in charge of monitoring all HAIs at each facility, and providing a report on the number of MRSA infections per 1,000 bed days of care hospital-wide, for each quarter. These reports are reviewed locally, by the Infection Control Committee at each hospital, and are made available nationally via the Aspire Dashboard, a web-based dashboard that documents progress toward quality and safety goals for all VA hospitals. (<http://www.app.hospitalcompare.va.gov/index.cfm>)
- To prepare this report, the MPC pores through printouts of microbiology reports and reviews numerous patient charts to evaluate clinical signs/symptoms. Based on complex definitions, the MPC attempts to classify each positive culture in terms of whether it meets the established criteria for “infection” and, if so, what type. After many hours spent classifying infections, the MPC reports this infection rate data through hand entry into a web-based system. Due to the time it takes to create these reports, the MPC is usually at least one month behind in these surveillance activities, thus limiting the MPC's ability to use surveillance data effectively to break the transmission cycle, or to make ward rounds to work with clinical staff to improve MRSA-prevention practices.
- In an attempt to evaluate data across all VA facilities to identify best practices and target areas for improvement, VACO subject matter experts attempt to evaluate the MRSA infection data being posted. They discover that the infection definitions are not applied in precisely the same way at each facility, making interfacility comparisons difficult and unreliable.

HAISS Automated Surveillance Scenario

- The MPC checks the QCP dashboard each morning and notices that on one particular day, there is an alert for an unusual number of MRSA infections in the ICU. After quickly gathering additional information, such as the incidence of MRSA from the ICU over the past year, the MPC goes up to the ICU and investigates the problem, soon discovering some critical breaks in established infection control techniques that are then addressed with the ICU clinical staff. No further MRSA infections occur on the unit for the rest of the quarter. Back at the office, in a few clicks, the quarterly MRSA infection report is ready to be transmitted to the VHA MRSA Prevention Program and for posting to the Aspire Dashboard. The MPC is already aware of what is being reported, and is confident that Infection Control has taken the appropriate measures to effectively control MRSA in the facility.
- At VACO, a subject matter expert reviews the quarterly data coming in from the MPC's work site and is pleased that this facility has done so well in preventing MRSA infection. Knowing that the automated data collection method is standardized at each facility, the MPC is confident that this facility's rate is truly reflective of good infection prevention practices.

Summary of HAISS Pillars

Pillar 1

CDC's National Healthcare Safety Network (NHSN) Healthcare-Associated Infections Surveillance

ICU device-associated infection and surgical site infection surveillance are defined using NHSN infection definitions and methodology. Allows all appropriate VHA facilities to participate actively in NHSN surveillance activities, create VHA benchmarks within NHSN using electronic data collection and infection determination, with data transmittal to CDC via the NHSN web-based application. Provides aggregation of data for analysis to evaluate effectiveness of interventions and to compare infection control strategies VHA-wide.

Pillar 2

Biosurveillance/Syndromic Surveillance

Surveillance for influenza-like illness (ILI) and other conditions included in the seven syndrome groups characteristic of illnesses potentially caused by Category A bioterrorist agents or emerging pathogens:

- Respiratory: cough, pneumonia, ILI, URI
- Gastrointestinal: vomiting, diarrhea
- Neurological: meningitis, botulism-like
- Dermatologic: hemorrhagic
- Dermatologic: vesicular (smallpox-like)
- Fever, malaise, sepsis
- Coma/sudden death

Provides situational awareness to VHA to allow early event detection (including outbreaks of seasonal influenza and emergence of pandemic influenza) and monitoring of disease outbreaks (magnitude, location, rate of spread), with aggregation and tracking of data at the local and national VHA level.

Pillar 3

Organisms/ Infections of Epidemiologic Significance

Includes surveillance for multidrug-resistant organisms (MDROs) such as MRSA, vancomycin-resistant *Enterococcus*, and multidrug-resistant gram negative organisms; clustering of organisms of epidemiologic significance such as *C. difficile*, group A streptococcus, *Legionella*, and tuberculosis; and infectious diseases/conditions reportable to local, state, and national public health authorities. Allows VHA (at local facility and national level) to monitor and detect trends in transmission of infection and to identify and report infections/conditions that require notification to public health authorities.

Pillar 4

Antimicrobial Usage and Decision Support Tools

Tracks antimicrobial usage trends and organism resistance patterns, by antimicrobial, facility, and locations within the facility. Identifies bacterial pathogen/antibiotic choice mismatch. Promotes appropriate antimicrobial use by allowing VHA (i.e., the IPDO and HAISS as well as at the local facility level) to monitor antimicrobial prescribing and resistance trends and recognize antimicrobial misuse. Provides aggregation of data for analysis to evaluate effectiveness of interventions, and to compare antimicrobial use and ordering patterns across VHA medical facilities.



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What's New in Public Health

Hepatitis C Testing Practices in a High-risk Cohort

A consortium of investigators, including researchers from the VA HIV/HCV QUERI, determined rates of HCV testing and HCV seropositivity among high-risk urban patients, using a population-based retrospective cohort study. Of almost 9,600 outpatients seen at a public hospital over a 2 month period, about 3,800 (40%) had been tested at least once for antibodies to HCV. About 440 (11.5%) of the cohort was seropositive. Risk factors for both having been tested and for a positive result included: born in the high-prevalence 1945-1964 cohort; a history of substance or alcohol abuse; a diagnosis of cirrhosis, HIV infection, or end-stage renal disease; or an elevated serum concentration of alanine transaminase. The authors conclude that clinicians use a risk-based strategy to identify patients with HCV infection.

Southern, W. N., Drainoni, M. L., Smith, B. D., et al. (2011). Hepatitis C testing practices and prevalence in a high-risk urban ambulatory care setting. *Journal of Viral Hepatitis*, vol. 18. Advance online publication. doi: 10.1111/j.1365-2893.2010.01327.x

National Quality Forum (NQF) Performance Measures High for Veterans with HIV/AIDS

In a review of 21,564 Veterans in care for HIV/AIDS in 2008, performance rates for 10 NQF measures were determined at the national level and at 73 facilities. National rates were over 80% for six measures. Overall rates were lower for annual syphilis and TB screening, receipt of *Pneumocystis* prophylaxis, and HIV RNA control. African Americans and hard drug users were less likely to access care, including HIV-specific care. The Clinical Case Registry serves as an excellent method to identify strengths as well as areas for improvement in HIV care across the VA health care system.

Backus L. I., Boothroyd, D. B., Phillips, B. R., et al. (2010). National quality forum performance measures for HIV/AIDS care: The Department of Veterans Affairs' experience. *Archives of Internal Medicine*, 170(14), 1239–1246.

PrEP to Prevent HIV Transmission in At-Risk MSMs

Among the estimated 56,000 people newly infected with HIV in the United States each year, over 50% of cases occur in men who have sex with men (MSM). This landmark study of daily preexposure chemoprophylaxis (PrEP) to prevent transmission of HIV enrolled 499 at-risk MSMs who were randomized to receive tenofovir (TDF) and emtricitabine (FTC) daily or a placebo. In the interim analysis, TDF/FTC was shown to be safe and partially effective in preventing HIV acquisition. There was a 44% reduction in HIV infection among those on TDF/FTC vs. placebo (i.e., 36/1224 vs. 64/1217 acquired HIV). Implementation of PrEP raises many issues, including targeting high-risk MSMs, the need for ongoing participation in prevention services, risk reduction, and retention care.

Grant, R.M., Larna, J.V., & Anderson, P.L., et al. for the iPrEx Study Team. (2010). Preexposure chemoprophylaxis for HIV prevention in men who have sex with men. *New England Journal of Medicine*, 363: 2587–2599.

Featured New Public Health Products

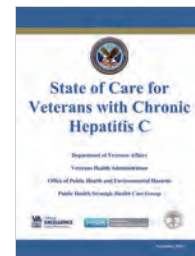
Quit Tobacco. Make Everyone Proud



The Public Health Strategic Health Care Group and the National Center for Prevention are pleased to announce the availability of a new web-based tobacco cessation resource. The U.S. Department of Defense has partnered with VHA to provide Veterans with access to the TRICARE tobacco cessation resource,

the **Quit Tobacco. Make Everyone Proud** website. This website provides online tobacco cessation tools such as live chat services, savings calculators, and personalized quit plans at <http://www.ucanquit2.org>. As part of ongoing tobacco cessation care that includes counseling and smoking cessation medications, we recommend that clinicians also provide Veterans with information about this new online resource to assist them with quitting. Veterans can click on “VA Veterans” at the site to access VA-specific information. To help promote **Quit Tobacco. Make Everyone Proud**, we have developed wallet cards for Veterans as well as posters that can be downloaded or ordered from VHA publications. For details on these materials, please go to: <http://www.publichealth.va.gov/smoking/publications.asp>. We hope that this new online tool will help even more Veterans with quitting tobacco use for good.

HCV State of Care Report



This report provides a population-based description of Veterans with chronic HCV in VHA care. The report describes basic demographic information, pharmacologic

treatment, and other conditions commonly seen in Veterans with chronic HCV; and details healthcare quality indicators specific to HCV care in VHA.

<http://www.hepatitis.va.gov/provider/policy/hcv-state-of-care-2010.asp>

Welcome to PSHHG

Dr. Lorenzo McFarland



Dr. McFarland joined PSHHG on May 23, 2010, in the position of Senior Public Health Program Manager. He is a retired Air Force

Veteran with 20 years of experience in public health. Dr. McFarland's educational endeavors include a master's in social work (MSW), a doctorate in health administration (DHA), and a certification as a Project Management Professional (PMP).

Thomas Williams Sr.



Mr. Williams joined PSHHG on December 7, 2009, in the position of Staff Program Support Assistant. He is an Iraqi Combat Veteran

with 18 years of service in the Army. He also served as a Medical Specialist. Mr. Williams' educational background consists of two Certifications in Business, one in business management and the other in applied business principles. He is working on a bachelor's degree in business administration at Northern Virginia Community College.

Transitions

Since our last issue, **Dr. Ron Valdiserri** has accepted a position as the Deputy Assistant Secretary for Health, Infectious Diseases with the U.S. Department of Health and Human Services (HHS). In this capacity, he has a central role in implementing the National HIV/AIDS Strategy and continues to work closely with VA and other partnering agencies.

After a 14-year career with CDC, Dr. Valdiserri joined the VA in 2006 as Chief Consultant of the Public Health Strategic Health Care Group. Among his many accomplishments, was his instrumental role in changing VA HIV testing policy.

Dr. Valdiserri's HHS appointment is a well-deserved honor and will benefit the entire public health community. Nevertheless, we will certainly miss his passion, commitment, and expertise, which brought a high level of clarity and excellence to the broad mission of the PSHHG.

We wish him well in this new phase of his career.

New VHA Public Health Portal Links of Interest

National HIV/AIDS Strategy, Operational Plan 2011

<http://www.aids.gov/federal-resources/policies/national-hiv-aids-strategy>

Department of Veterans Affairs, National HIV/AIDS Strategy, Operational Plan 2011

<http://www.aids.gov/federal-resources/policies/national-hiv-aids-strategy/nhas-operational-plan-va.pdf>

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Contact/Comments

If you have any comments or suggestions, we welcome your feedback. We will read and consider all comments and suggestions, but due to the large volume of correspondence received, we may not be able to reply to each individual directly. Comments about this newsletter can be addressed to publichealth@va.gov.

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Mission Statement

The Public Health Strategic Health Care Group (PHSHG) is a key organizational component of the Office of Public Health and Environmental Hazards, U.S. Department of Veterans Affairs (VA).

The PSHHG's mission is to improve the health of Veterans and their families by providing leadership, expertise, and services for the VA by promoting sound policy and practices for current and emerging public health issues.

This is accomplished through population-based surveillance, performance measurement and other assessments, quality improvement initiatives, clinical practice guidelines, education and outreach, policy development, and research.

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