David Atkins: Hi. This is David Atkins, the Director of Health Services Research and I'm joined here by Steph Guerra, an AAAS fellow who's been with us for two years and who has been leading this; and our Scientific Program Manager, Stephen Marcus, who directs our research on health systems and which a lot of these projects are likely to end up in his portfolio.

So, before Steph walks you through the genesis of this, I just wanted to take one minute to talk about what we're trying to do in this important line of COVID research. When COVID broke--and shortly thereafter--it wasn't long before people started to raise concerns about disrupted care and the effect on immediate and long-term health outcomes, and we addressed that in a series of different ways. We had a solicitation for rapid response projects, those involved new projects, year-long projects or supplements; and a number of those addressed questions about how the disruptions of clinical care might be affecting patients, especially in the mental health space.

Subsequent to that, just recently, we had a solicitation for supplements to ongoing projects; we reviewed 20 projects and funding announcements are just about to go out for those; those are supplements to existing projects lasting up to a year. We also have a solicitation--the ITS period has closed for that--to fund a long-term outcome project--Steph will be talking a little about that--in a coordinating center.

So, this specific RFA is meant to fill the remaining space, which is how we do a deeper dive into not only describing what's happening, but actually understanding why it's happening and the mechanisms by which changes in care are or are not leading to changes in healthcare outcomes. This solicitation is different in a couple of ways: the projects are limited to two years and to $700,000; we also expect these projects to work in close partnership with our clinical program partners; you have the option of getting letters of support from those partners in your submissions, but we wanted to have this cyber seminar as an opportunity for them to talk about the questions that are really concerning them.

These are not projects intended to generate immediate answers--hopefully, some of our supplements are providing shorter-term--but these are meant to provide a rigorous and deeper dive into understanding what really happens when you have a disruption like the pandemic. We hope it'll provide information relevant to COVID, but also relevant to other situations when care is disrupted.

So, with that, Steph, take it away.

Steph Guerra: Great. Thank you so much, David. So, before we get started, I'm just going to go over what to expect from today's session. The purpose of today's session is to briefly go over this new RFA; you'll find more

information, of course, in the solicitation itself. But the major purpose of this session is really to connect you to the partners that are listed here; each partner will be given a brief presentation about the important questions and priorities within disrupted care underneath their purview. And so, I will get started now just giving a brief overview about the solicitation, and then we'll be handing it off to partners at the end; we hope to have time at the end for additional questions.

So, as we all know, since the start of the COVID pandemic last year, there have been almost 600,000 excess deaths reported over previous years during the same time period; and CDC classifies these deaths in three primary ways: first, is direct death which is the result of the COVID-19 infection; second is partially-attributable deaths, which is death that is attributed to a combination of COVID-19 as well as a comorbidity; and then the third bucket are referred to as indirect deaths; and so indirect deaths during the COVID-19 pandemic may be a result of undiagnosed COVID-19 or could be related to pandemic-related disruptions or deferments of care; and these disruptions could be due to patient factors, community factors, or facility-level decisions and conditions.

And we believe that VHA has important assets to study this particular type of patient, looking specifically at disrupted care. VHA is an integrated health care system; we have an excellent electronic health record; we have a strong research program; and so, what we're hoping to do with our research program on disrupted care is really allow research to add value to our partners, identify lasting conclusions, basically figuring out not just what happened but why it happened, and then allow those conclusions to influence and improve the delivery of care moving forward throughout the COVID-19 recovery and beyond.

And so, David alluded to our research program examining disrupted care previously. There are really four primary sections or types of funding we've provided to look at this type of care. First is our COVID-19 Rapid Response Projects which were funded last year, many of which look specifically at the care of non-COVID health conditions during the pandemic. We've also recently funded supplements to existing IIRs that would expand the scope of those projects to examine research questions and health outcomes during the pandemic itself. Third, we will be funding--and are in the process of selecting--a national mortality study and coordinating center that will act as a central hub for this type of research; and then today, we're speaking about the service-directed RFA for disrupted and deferred care. In particular, we'll be focusing, as you could tell from our list of partners, on mental healthcare settings in today's session.

So, this solicitation is meant to support research projects to really do a deep dive into specific healthcare settings; particularly, we're interested in examining changes to cause-specific mortality as well as morbidity and determining impacts across different patient populations and geographic regions. The ideal projects will focus on a suite of related health outcomes rather than one specific health outcome; and the reason for this is because we anticipate funding anywhere between three or four projects, and we'd really like to fund a project that's able to give us a large amount of conclusions, have basically a great return on investment. These projects will be developed and conducted in collaboration with partners and the projects are meant to have a short timetable with a focus on partner communication throughout the project. And so, these merit applications, we are soliciting up to two years for a budget that may not exceed $700,000.

Listed here at the priority areas for the solicitation; I've just listed them in brief, but you can look through the solicitation for more details. Some of these include looking at the contribution of disrupted care to specific increases in mortality; examining the quality of care among patients who receive care during the pandemic; examining changes in non-profit health outcomes and how they've been influenced by local severity of COVID-19, as well as state-level responses and patient-level factors; assessing if efforts to mitigate the pandemic were effective in reducing adverse health impacts; and lastly, we're also interested, for this part of the disruptive care research program, on qualitative research that could involve interviews with patients or clinicians to understand behavior changes during the pandemic and how that may influence new practices or new care delivery mechanisms moving forward.

Listed here are eligibility criteria; I won't go through them, but they are listed in the solicitation the same as we have for our parent RFA. And listed here briefly again are the criteria for the selection of these projects. Again, they are very similar to our parent RFA, and you can find more information and specifically what we mean by significance approach, implementation and feasibility in this context on Page 26 of the solicitation.

Here's the timeline for this solicitation. It will be during the normal August 2021 SMRB cycle; grants.gov opens on May 15th with the deadlines for the actual proposal submission in mid-June; the earliest project start date will be January 1st.

And, as with other service-directed solicitations, applications previously submitted through the parent IIR or pilot mechanism may be submitted in response to this RFA if it addresses the priorities; however, if you submit under this new RFA, it will be a new submission. So, it is up to you to, perhaps, speak with your SPMs to decide and strategize on what

makes the most sense, to resubmit an old proposal under your previous panel or to submit it as a new submission under this new IIR. And we anticipate that this mechanism will exist for at least two cycles; so, applications that don't receive fundable scores may be eligible for resubmission.

And, as I mentioned, these applications will be reviewed during August 2021 and the funding decisions will be made independent of other SMRB funding decisions. And Dr. Stephen Marcus is here today, he is the SPM for this particular service-directed RFA.

And so, that was a kind of brief overview of the logistics related to this particular mechanism. However, we wanted to spend the majority of our session today on partner presentations. So, I will hand it off to--well, first of all, let me introduce all of our partners. We have Joe Liberto--Dr. Joe Liberto--who will be speaking about substance use disorders; Dr. Friedhelm Sandbrink, who will be speaking about opioids and pain management; Dr. David Carroll will be talking about care of serious mental illness and PTSD; and Dr. Susan Strickland, who will be talking about suicide risk.

So, I will hand it off to Joe to speak briefly on his topic.

Joe Liberto: Thanks, Steph. I'm also so going to try to incorporate some words about care of serious mental illness--and Dr. Carroll may jump in if I've missed anything, but I'm going to try to combine kind of both those in my presentation with a real focus on SUD.

But, obviously, there's been a significant disruption in both mental healthcare and in the SUD continuum of care during the pandemic. And as we can see here, even pre-pandemic, we were seeing rises in substance use disorders; and I just point out that most of our substance use disorders really fall under an alcohol use disorder diagnostic groups; but then, the pandemic, as you see sort of the end as we move into 2020, a decrease in the number of uniques seen with substance use disorders in general and alcohol use disorders. And that really--

Steph Guerra: And Joe, just let me know when you want to switch slides because I have to do it on my screen.

Joe Liberto: Okay. I'm sorry I thought I was switching. Very good. Thank you. So, we're at the second slide right now?

Steph Guerra: Great.

Joe Liberto: For drug use disorders, in particular, you see the kind of, again, the rises primarily in cannabis use disorder primarily and also significantly

amphetamine use disorders; but again, across the board, that decrease in uniques during the pandemic. Next slide.

Now, in terms of the continuum of care impact, in mental health in general, we've seen a drop in inpatient admissions and that hasn't completely bounced back; there was certainly a big disruption in residential program operations leading to reduced access to residential VA services. Our initial data suggested that the average wait times for admission to residential treatment has grown significantly with some veterans seeking care in the community, and other veterans opting to delay admissions. We are beginning to reopen our residential programs and so, hopefully, we'll see at least some rebound in some capacity; but I think probably aiming for about 50 percent capacity initially.

There was a shift, during the pandemic, to largely telehealth-based treatment approaches; we expect that telehealth will play a larger role post-pandemic because, in part, some patients prefer telehealth; and also, we certainly know that improved telehealth access can help us improve access to underserved populations such as veterans in rural settings. Probably still the most impacted is our group encounter technology via telehealth; we continue to be impacted there because of technology barriers for groups; and while there has been a significant rebound in individual telehealth visits, not as much in the group encounter sector.

There's also been an increase in the community with alcohol and drug use disorder; we're certainly seeing more of this through our brief addiction monitors and BHL data within VA specifically, but we've noticed a drop in the use of the patient-reported outcome measures. We expect, therefore, that we may actually see some increased volume of SUD patients post-pandemic as some of the patients who haven't accessed treatment but have had increased problems with alcohol and other drug use, start to re-emerge as the pandemic restrictions ease. Next slide, please.

Now, we know that opioid and cocaine-related fatalities have been increasing; this is information that's showing even during the pandemic, particularly for opioids, the synthetic opioids, and cocaine, and psychostimulants, we're seeing an increase in the number of fatalities. Next slide, please.

And particularly troubling in VA, that we've seen even pre-pandemic, overdose fatalities for opioids and cocaine increasing. Here's data showing that basically, among all veterans, there's been an increase--in the US nationally, there has been an increase in overdose fatalities, but those fatalities have been more pronounced within VHA-treated populations.

And we certainly have also learned, from the annual suicide report that came out in November of 2020, that among mental health diagnoses, opioid use disorder and bipolar disorder are clearly--you have the highest rates of suicide, so clearly identifying opioid use disorder as a major potential contributor to suicide and focusing on OUD treatment to suicide prevention.

So, there are four kinds of overarching major research priorities, from my perspective, that we should be looking into. One is identifying the best approaches to virtual care delivery of evidence-based SUD care, including medications for opioid use disorder, and contingency management, and cognitive behavioral therapy for stimulant use disorder. And this is especially given the high fatality rates and the associations with suicide that I just mentioned. I think that such approaches should address expanding access to underserved populations in efforts to address not only geographical barriers, but also racial equity issues. And conducting feasibility studies for streamlined or new virtual-based SUD care approaches, and measuring provider patient satisfaction with these approaches.

Finally, I think there's a need under that heading of identifying best approaches, to identify more streamlined technologies for group encounters where we've really seen the biggest drop-off in care during the pandemic.

The second theme would be virtual testing and screening; we want to identify point of care testing for oral fluid toxicology testing; we expect that, as I said, the new normal is going to have a greater reliance on telehealth issues--and this is particularly important for evidence-based modalities such as contingency management, so developing a process for point-of-care oral fluid testing that can be interpreted by the provider in a virtual care environment, I think is a priority, as well as validating a short drug screen that could be used across settings including primary care.

The third area, overarching, would be developing health services approaches to assessing the impact of bed closures on long-term substance use disorder treatment outcomes. Certainly, in an effort to provide services, some programs during the pandemic elected to offer greater access to intensive outpatient services in lieu of residential treatment; it's not clear if this change sufficiently addressed the veterans' treatment needs and whether veterans served through intensive outpatient programs offered via virtual modalities still required residential treatment. Of particular interest to study, from a program office's perspective, are healthcare cost assessment including the use of care in the community when VA beds are not available; ways of ensuring timely access for residential treatment for SUD with an emphasis on priority

admissions; and integration of medically-monitored withdrawal management as a part of SUD care provided during residential treatment.

And then, finally, the fourth overarching theme would be the development of implementation strategies for harm reduction. I think this is particularly going to take on importance in the priorities of our new administration efforts, including the use of things like fentanyl strips, naloxone distribution, and syringe service programs, I think are worthy of assessment.

And with that, I'll stop.

Steph Guerra: Great. Thank you so much. I'm going to leave this slide--go ahead.

Joe Liberto: I would just say, Dr. Carroll, if you're on, I don't know if there's anything else that you feel like needs to be highlighted.

David Carroll: No, nothing at this point, Joe. Thank you.

Steph Guerra: Great. So, I will leave this slide up here for the rest of our speakers; we have a mailbox for specifically our disrupted care research program. So, if you have questions, please reach out there and you'll be able to get those questions answered. So, now, I'm going to pass it over to Dr. Friedhelm Sandbrink, who will speak about opioids and pain management.

Friedhelm Sandbrink: Thank you. So, first of all, for organizing this; I think this is a really important aspect of what we have to do relative to COVID. I think we have, on one hand, the concern about these clearly demonstrated overdoses that have happened in an increased number during this time, but also, it is actually a somewhat unique situation we can study the impact; maybe give us also a larger perspective of some of the care that we are providing about what makes sense, what has been helpful, and what it's been doing as it is being disrupted, has been truly missing.

I just want to add on a little bit more information about opioid prescribing as it happened during the pandemic. So, over the last--really, since we started the Opioid Safety Initiative, we've seen a more or less steady decline in opioid prescribing, and the reduction has been very, very consistent over the last what... five or six years, with a reduction of pretty much 15,000 to 20,000 patients fewer and more opiates at the end of a quarter than at the beginning of a quarter. But in Q3 Fiscal Year 2020, we saw a sudden rather significant dip in reduction. So, during that time, reduced opiate prescribing in the VA suddenly, by about 40,000 veterans instead of the usual 15,000. And interestingly, in the quarter thereafter--so, this is really by Q4 Fiscal Year 2020--those veterans--at least just looking at the straight line, I mean those seem to have

recovered, right? So, from Q3 to Q4 Fiscal Year 2020, we actually saw an increase in opiate prescribing again. So, it went from 8.5 percent in Q2, to 7.84 percent of veterans with receipt of opioids in Q3, and then back to 8.02 percent in Q4.

And what I'm pointing out here is that with this particular dip, obviously, that happened, we should look at these patients in particular and try to understand what this opiate prescription interruption or prescribing interruptions really, what happened here, right? What happened to those patients? Not just why they possibly couldn't get obviously access to their primary care providers who was prescribing, but also, I mean, were those patients the ones who have metastatic morbidities, they are the ones who end up using street drugs, stimulants other medications from friends, or families, or... what happened to those patients? And were those the ones that were particularly affected possibly by opioid overdoses? So, I think we need to understand what happened at that time.

But we also need to understand our risk-mediation strategies that happen during that time--and this comes from the provider side--if we haven't really done your own drug screen at that time initially, many have put that on hold, we still haven't recovered that, and we're relying really on virtual care; and that is now for both opioid prescribing, but also for pain care delivery in general.

So, what we need to understand is obviously, what is the impact of these interruptions of face-to-face delivery of pain care modalities, which one of those modalities can be safely and just as effectively transitioned to virtual care, but also which ones cannot? And what is the impact of the interruptions there if you don't make that transition.

So, we also, I think, have to look at the provider side and how teams and providers, what their workflow is. I think in the traditional setting, I think many of us had a very established workflow, we know about primary care and pain clinics working in collaboration, did that get disrupted? And then, in particular, truly did we still provide multimodal pain care, interdisciplinary pain care? And then, obviously moving forward, how can we do interdisciplinary pain care in the practice of virtual pain care?

I think one particular aspect that we've heard repeatedly from our providers in the field is the challenges in regard to suicide prevention, the screening that we do routinely in pain clinic settings at initial evaluations, and the challenges that often then come to that as we identify this. But we also don't know if the system prevention screens actually still happen, if providers truly adhere to the guidance that we provide to them.

I think, Joe, you talked a lot about, obviously, how to optimize opiate use disorder treatment; I think we should specifically look at that obviously in the setting of patients with chronic pain. And, again, I talked about this aspect of collaborative pain care in general, how to do this over telehealth, how to do this in the virtual care setting where we are--and this is not just between primary care and the pain clinics and pain clinics themselves, but also, as I mentioned, the integration of mental health, for instance, as we identify risks.

So, those are just my overview of the different kinds of possibilities to consider.

Steph Guerra: Great. Thank you so much. I will pass it off to Dr. Carroll now.

David Carroll: Thank you. And good afternoon, everyone. I appreciate the opportunity to talk with you and certainly thanks to Dr. Sandbrink, Dr. Liberto, and Dr. Strickland who are part of this.

I do not have slides. I'm just going to make a few points to follow up on what Dr. Liberto talked about previously. Specifically, with regard to SUD care and care for the serious mental illness, we have seen some drop-off in care during the pandemic, whereas for SUD care, there has been some rebound--perhaps, not 100 percent; I think we are still struggling in terms of SUD care, in particular for two types of care, our residential services as well as for outpatient intensive care that relies heavily on the use of group therapy modalities.

And I think the questions in my mind are how do we recover, what is that telling us? I think some veterans in some situations have said, "We're fine for now, we would like to come back when we can actually get together in person." But there are other veterans for whom we know that is not the case, that they need the care and, for whatever reason, our pivot to virtual has not gone well; and in some cases, it may be because of the technology, either their own challenges or discomfort with technology; we have worked very closely with the Office of Connected Care to really eliminate barriers that have to do with technology; although in some areas, it may not be possible to have the bandwidth, and I think, again with Connected Care, we're looking to see what we can do.

But the pivot to telehealth has not been as successful for SUD care in general as it has for the rest of mental health; and so I think that the questions in my mind are how can we improve that and what does that tell us about the future? I think we know--I believe the most recent of information that I've seen is around 35 percent of veterans actually are preferring virtual care, telemental health over coming in in-person; we know that we have anecdotes as well as satisfaction data that has,

overall, suggested that it's been a very important part of care, and it's not going away, we're not just going to like go back to business as usual someday, but it's here to stay.

But I think truly trying to understand for whom does it make the most sense; and specifically, for what groups of veterans with what kinds of constellations of problems from a mental health perspective? Is virtual care going to work well or we really need to go back to in-person care? So, I think that that's kind of a range of concerns or questions I would put on the table for your consideration.

As well as, in terms of the residential programs, there's been a delay in admission; we have tried to offer more outpatient services. Again, what, if any, of that constellation has been effective and what is not; and what do we really need; what are the services that we simply need to make available in person, either in an outpatient setting or in a residential setting, for care that that we can't seem to do virtually?

Related to that--Dr. Liberto mentioned this, but I'm going to circle back to it--is the decline in patient-reported outcome measures, our measurement-based care initiatives. We've had a relatively robust effort in that sphere, with SUD care, that's been a priority area for us over the last few years. But, in general, we've seen a decline in the use of patient-reported outcome measures or measurement-based care initiatives, and is that just because people are distracted because of the pandemic and trying to do things differently or is there something more systemic that we're going to need to address, because that is vitally important to making sure that the clinical care we are providing is effective, that we know what works for veterans so we can plan our care for the future as well.

And the same would apply to PTSD care, that was the other domain that, I guess, I wanted to just touch upon for a moment. I think, again, we have seen some--there have been aspects of the pandemic that have caused disruption not only in care, but perhaps in dealing with PTSD for veterans, people wearing masks, people who were starting to, perhaps, get accustomed to being around other people are now distant again, and we're going to need to work with them again to regain that confidence and sense of safety around being around other people. And what do we need to know; how can we improve that care?

And then related to that, we also know that there are veterans who have been able to engage in care in a more robust way because they don't have to travel across town, they don't have to come into a facility and sit alongside in a room with other people. And so, I think the fundamental premise here is understanding--I think this is an opportunity for us to understand what types of care, what types of care modalities, in

particular, are going to be helpful for different groups of veterans with different problems, and how can we factor that into our clinical care planning going forward.

So, I'll leave it at that unless there are any questions.

Steph Guerra: Great. Thank you. And we'll do some questions at the end. So, now, let's go to our last partner on the call today, Dr. Strickland.

Susan Strickland: Hi, everyone. So, let me just say a few things about suicide prevention as it relates to some of the things that Dr. Carroll, and Dr. Sandbrink, and Liberto have shared as well. Right now, as you all know, we have a lag in suicide death data; it's a two-year lag till we really know--and we don't have any indications right now that there's been an increase in suicide in veterans or in the population, but we do have some research that's showing that large groups of people on surveys have reported increased suicidal thinking, thoughts, we have experienced a reduction in presentations to the ED for suicide attempts over the pandemic; that doesn't mean that there's less attempts or less deaths by suicide, we're just not aware of that data just yet because of the lag and people not presenting to the emergency room at this point during the pandemic.

Some of the things that we do know is that is, from early on in the pandemic, some studies are coming out now that are looking back at last March, April, May, June, and assessing people and kind of writing up and publishing those results now. But as you know, we're way past that; we've gone through several waves, since then, of fear, and lockdown, and quarantine, and then some easing up of that, and then another wave of lockdown, masks, and quarantine since then. So, we really do need to look at, over time, the impact of the isolation, and the quarantine, and the anxieties and fears that people have experienced as part of those interventions--those community-based interventions--and how they've impacted folks over a year's time, and then now into the next phase of recovery here.

We do also know that gun sales have gone through the roof over the last year; it began to escalate last February, and March, and April, and then, again, they leveled off a bit, and then, again, this past January. And well, since the election, actually--December and January. So, that piece may not be related to the pandemic as much to other factors political factors that may have moved that, but it does say that there are a lot more guns in the hands of a lot more folks in homes. In homes where there's a lot of stress and strain, another risk factor for suicide is interpersonal violence, and anger and frustration, with a lot of folks at home losing jobs, working less, and that creates kind of a toxic mix for some folks.

So, some of the areas that we would like some focus from the research community is, as Dr. Carroll said earlier, kind of that shift that pivot to telehealth; and I would also add group interventions via telehealth. How effective have those been in meeting the needs of our patients and veterans that are at high risk for suicide? There's a couple of best practices out there, but we really need more information on who it works for and what barriers exist for them, especially elderly or older veterans and their access to broadband, to virtual modalities, and their preference for those, and how that's impacting them.

Another piece is that we'd love some attention in the research on our interactions with community providers and community entities. We talk a lot about social determinants of health, loneliness, community connection, engagement within the community, and all of those things have been impacted severely during COVID, during this time. So, what does that look like; how has that impacted care and access to care; and how has that impacted transitions of care handoffs from VA to the community, and community to the VA? Because we know that those transitions in care are high-risk times for our veterans.

Lethal means. Always looking for further attention around access to firearms and then safe storage during this time of frustration within the home. Also, interactions between the risk factors and protective factors. What's increased stress and strain; what's decreased stress and strain; and what's worked over the long term for our veterans?

One last point that I'll make, and that is looking at financial issues, financial stress, and strain. We also know that the accumulative effect of all of these things on individuals really can cause increases in wishes to die or wishes to end one's life; and so, thinking about the cumulative effect of financial stress and strain--job loss, unemployment, money, interpersonal violence, and then, of course, lethal means in that mix.

So, let's stop there and I'll be able to field any questions as needed. Thank you.

Steph Guerra: Great. Thank you so much. Before we move on to questions, I just want to note that we have another session this week on Thursday at 2 PM, and that will be with partners related to acute care settings and chronic and preventative care settings. So, feel free to join us then if you'd like to hear those perspectives.

Heidi, are you going to be moderating the Q&A or is that something I should do?

Heidi Schlueter: Nope, I can definitely do that. For the audience, we do have about 15 minutes left here for questions. If you do have any questions, please

submit those into the Q&A screen. We do have a couple here, but we are always looking for a few more. The first question that we have: "Where is the link to the RFA?"

Steph Guerra: Yes. So, the RFA is listed on our internet site where all RFAs are; it's underneath HSR&D. I believe it's the last one in that list labeled "Pandemic-related Disrupted and Deferred Care.

Heidi Schlueter: Thank you. The next question that I have here. I apologize there are a lot of abbreviations in here and I am not a subject expert, so I'm totally going to butcher this question and I really hope you guys understand what they're asking here. "Were there some VAMCs or VISINs that did a particularly good job of connecting veterans who needed residential TX or IOP with community care? Where I was, the VA Medical Center shut down the DOM and other programs, but didn't facilitate veterans access and community care?"

Joe Liberto: This is Joe. I don't know off the top of my head; I certainly can look at that and talk with Dr. Burden who probably has a better handle on which facilities around the country may have done better and get back to you.

David Carroll: Yeah, agree, Joe. There was variability, I think, in some places; there may be comparable or similar levels of care in the community and other places in the country, there just aren't. The VA is the only place that offers it and I think the pandemic, itself, may have affected places where they just needed to shut the [RRTP] program down. I don't know that we're going to have a clear picture of why things happened the way they did, but we can ask jen to see if there are any trends.

Heidi Schlueter: Thank you. And the next question here, "Dr. Strickland mentioned group interventions via telehealth. Could she or others speak about what those group interventions are?"

Susan Strickland: Sure. Project Life Force is a suicide prevention-focused group intervention that's been piloted and tested by Dr. Marion Goodman up in the New York area, and she also did some adaptation of that intervention for COVID support; it is heavy on safety planning and it's done in a virtual format, and then gives veterans a chance in a group format--virtual group format--to engage with each other, and help one another, and support one another. And I haven't seen or talked to her in the last few months about any recent data out of that, but the data last fall and earlier in the pandemic was looking pretty good. Veterans were very pleased; they felt supported, they felt like they had an outlet. So, that's one of the suicide prevention-specific group interventions.

Friedhelm Sandbrink: About group interventions. Obviously, within the field of pain management--and I assume in mental health, in general, I mean we have

a lot of groups going on. It starts from educational classes, pain schools, to certainly CBTCP protocols, CBT for Chronic Pain protocols--is done in group settings. And then, in particular also, for our [00:47:16]-accredited interdisciplinary pain rehabilitation programs, we have 20 in the country and they all moved over to virtual care deliveries; and some of them were done then individually, but many have now transitioned into a good process to do group therapeutic approaches for pain rehabilitation, and we would certainly like to know how to optimize those processes.

Joe Liberto: And for substance use disorders, I think similarly with what Dr. Sandbrink was talking about, we've really had a focus within substance use disorder treatment to provide ongoing group therapy, weekly therapy, usually for patients who are in after care and in recovery. And, in addition, our intensive outpatient programs, particularly during the pandemic, needed to shift to virtual care and a lot of those are done in a group setting, including cognitive-behavioral therapy kinds of approaches as well as educational and motivational approaches. So, it's really gamut.

I think the problems that we are experiencing are the difficulties from the provider's standpoint at really being able to utilize the virtual modalities in a way that kept patients engaged; so, it was a bit complicated and, I think, probably more so than in other kinds of settings--the group settings struggled the most technologically.

Heidi Schlueter: Thank you. And that is all of the questions that we have right now. I don't know if any of our--

David Atkins: Heidi, this is David Atkins. So, I had a comment and then a question. So, in terms of where the RFA is, to clarify Steph's comments, so on our HSR&D internet site, it's under Funding; and then under that "Merit Award RFAs," but the link is to our intranet site, only available behind the VA firewall; and we'll send that link out along with the notes of the meeting.

A question for Joe. I can't remember if you had mentioned it or I saw it somewhere else, but we know we've seen an increase in overdose deaths. Do we know anything more about what's underlying that in terms of are there particular patients who seem to be at risk? And my understanding was that trend was more obvious in the spring, in the early part of the pandemic than recently?

Joe Liberto: I mean most of the data that we have is during sort of the summer part of the pandemic, maybe a little bit later, and most of it shows--this is not VA specific data, but national data--shows increases in stimulant overdoses particularly amphetamine overdoses and opioid overdoses still

with synthetic opioids, fentanyl kind of leading the way. So, I think that--I don't have a lot of more recent data and we don't have any VA-specific data that I can speak to. Most of the data that we do have is pre-pandemic.

David Atkins: Thank you.

Heidi Schlueter: And just wanted to check if any of our presenters have any other closing remarks or any other thing they would like to add before we close today's session out.

Friedhelm Sandbrink: So, this is Dr. Sandbrink, just one comment. It has been very challenging for us in the age of telehealth to get the same outcome measures as we've had before. I mean traditionally, patients, at least in the pain clinics, they come to the follow-up appointment, they often get a piece of paper filled out, depression, anxiety, pain scores things like that. And I think that, in itself, trying to understand what are the outcomes that we can measure easily over telehealth? What is the best stuff? I mean that certainly is a universal interest, not at all limited for pain but in general. I think it's a challenge though; I mean we don't usually have _____ [00:52:18] on our patients anymore, certainly, many, many of our traditional measures are not being accounted for.

David Atkins: Thanks. So, I'd like to just thank our presenters and note that--I think a number of them have sort of touched on issues that clearly are going to be relevant even post-pandemic. So, one is the whole nature of the move to telehealth and who does that work for, which patients may not do well with that, what are the possible benefits and downsides of an environment where even post-pandemic, we are using more telehealth.

Another is understanding about changes in supply, things like when we reduce care to inpatient mental health care, those issues about how many mental health beds we should have aren't going to go away post-pandemic; and so, this is sort of a natural experiment to see what happens when you reduce those, where do those patients go to get care, what happens if they aren't getting care, how does it impact our costs if we have to provide that care outside of the VA?

So, I think in our ideal world, we'll be learning some important things for our partners specific to COVID, but we will also be learning things that relate to providing care in different ways that will be relevant post-COVID in a normal world, and that certainly will be relevant if we face another situation, whether it's a hurricane or, god forbid, another pandemic, or any other event where care is interrupted.

And then I think a prevailing interest within the mental health world is always, given how diverse a population they are, are there ways to

identify those folks who are most at risk so that we can proactively reach out to them in the way that we've done with REACH VET. Are there other interventions that we can do to take care of the patients for whom we think these kinds of disruptions pose the greatest risk?

So, Steph, do you want to give some closing comments just about how to send questions, what they'll be getting as follow-up? And I assume this webinar is recorded?

Steph Guerra: It will be recorded and we'll send along slides after--Heidi will make sure that the slides get out to attendees. And like I said before, you should see this email address on your screens as well; you can email this email address if you have any specific questions related to your project ideas; and this email address is also within the solicitation itself that's posted on our intranet site.

And yeah, that's really everything I have to say. I hope to see some of you on Thursday as well. And thank you again to all of our partners for joining us and further continued discussion about this important topic.