Unidentified Male: To talk about changes in care that we have been seeing in the pandemic and how that might be affecting health outcomes. Many of you may have seen reports outside the VA about the increase in all cause mortality during the pandemic that have indicated that it is above and beyond what is directly attributable to COVID. So this initiative is really to try to understanding where the disruptions in care may have actually contributed to changes in veteran health outcomes.

This initiative is going to be different which is why we are having this cyber seminar--these proposals are shorter--they are only two years. We are hoping they can use existing data although there is the option to use survey data. We want these proposals to work with partners during the process of the research and not just at the end of the research when the results are all cleaned up. And we hope that these proposals will work collaboratively together. We are funding a coordinating center under a separate solicitation which will help coordinate data uncommunication and we hope these projects will learn from each other as they study different aspects.

So I'm going to turn it over to Steph Quera, who has really been leading this initiative to walk you through a little more of the background and the details. Then we will be hearing from a succession of our clinical partners about the questions that they are most interested in. Take it away, Steph.

Steph, are you on mute?

Steph: Yes. Here I am. Thank you again, David. So, the purpose of today's session is just to give you a brief overview of the solicitation that we have recently put out for the August 2021 [00:02:04]cycle. And then the bulk of the hour will be spent with our partners where they will give you a brief overview, preview of their priorities they are interested in learning more about when it comes to disruptive care. So let's get started. As David mentioned, since the start of the pandemic last year there has been almost 600,000 excess deaths from previous years during the same time period according to the CDC. And the CDC categorizes these excess deaths in three primary categories. First, are direct deaths with are directly attributable to the COVID 19 disease. Second, are partially attributable deaths which is related to a combination of COVID 19 infections as well as other existing comorbidities.

And lastly, is a group known as indirect deaths, and this is what this particular solicitation aimed to learn more about. So, indirect deaths during the COVID 19 pandemic may be a result of undiagnosed COVID 19 or it could also be related to pandemic related disrupted and deferred care due to a number of factors including, patient factors and decision making, community factors, facility level decisions and conditions And what is

important to note is that VHA has a lot of important assets that make us uniquely position to study deferred and disrupted care or integrated healthcare systems, we have a strong electronic health medical record and we have a very strong research infrastructure with lots of connections between our clinical and policy partners.

And so, what we hope to do with these research programs is really leverage these assets to be able to figure out not just what happened during the pandemic and how it influenced health outcomes and care deliveries but how we can use those lessons to improve health outcomes and care delivery moving forward in a pandemic recovery response and beyond.

And so, we have four primary streams of funding that we have been using to fund research projects specifically on deferred and disrupted care. One is the COVID `19 rapid response project which were funded last year and are wrapping up in the next few months.

Second, are disrupted care supplements, which we recently funded which were meant to expand the scope of existing IARs to examine health outcomes during the pandemic and really leverage existing data sets with additional analysis related to the pandemic.

A third stream is as Steve had mentioned, a national mortality study and coordinating center meant to act as a central hub that coordinates and builds bridges between researchers doing similar studies on disrupted care as well as researchers and partners. And then today, what we are talking about is our service directed RFA, which is going to be funded through our existing scientific merit review processes.

So here is just a brief solicitation description and you can find the link to the RFA through our VA internet site. It is listed underneath our other HS RMD RFAs for this cycle. This solicitation is meant to support research projects that really do a deep dive into specific healthcare settings to examine cause specific mortality and morbidity as well as impact across different patient population and geographic regions. What is important about our research at VA is we don't just describe what is happening but we try to dig deeper to figure out why it is happening and so that is what we are hoping that these projects will be able to do.

The ideal project will focus not just on one specific health outcome but rather a suite of related health outcomes from different care settings. So, for example, we might want something that is examining not just heart disease but perhaps a number of different chronic care conditions in which care is delivered in a primary care setting, for example. The project ideally would be developed and conducted in collaboration with partners and we purposely given them a short time table to focus in on that desire. So as

David mentioned, these merit applications will be for up to two years and the budgets may not exceed $700,000.

And listed here are some of the priority areas for this solicitation but again, you can look at the solicitation for more details and feel free to reach out to us in the HS RMV office if you have additional questions. I won't' go through all of these just in the interest of time but you can see we are interested not only in data analysis of healthcare outcomes but also interested in conducting qualitative research including interviews of patients. Overall, the main goal is really to assess what happened during the pandemic but also to figure out how we can leverage what we have learned to increase care delivery and health outcomes moving forward.

Listed here is eligibility criteria. This should look familiar to those of you who have already applied for HS RMV funding. It is our typical eligibility criteria so that is listed there. And our criteria for selection of projects is listed here. Again, similar to what we used during our typical parent RFA criteria. But you can look a t page 26 of the solicitation for more information about the specific questions and how we think about significant approach, implementation and feasibility in this particular study .

The timeline for this RFA is here with the ITS window closing on May 7th and our due dates for the full proposal in mid-June. This will be reviewed in August 2021 and typically our earliest project start dates are January 1st, 2022 for this merge cycle.

Unidentified Male: And Steph, can I just say that talk projects can start earlier. Some of these projects may be considered exempt if they are dealing mostly with secondary data.

Unidentified Female: Yeah, thank you. We also want to note that applications that have been previously submitted through the parent IAR or pilot mechanism may be submitted in response to this new RFA if it addresses the priorities. However, if you submit under this new RFA it will be considered a new submission. So no response o review are allowed. So it is up to you to decide, perhaps in collaboration with your SPM whether or not it makes the most sense to resubmit under your previous panel or to submit a new submission under this new RFA. And we anticipate that the mechanism will exist for at least two cycles. So if you do not receive a fundable score you will be eligible for resubmission.

So as I said, the applications will be reviewed during the August 2021 merge cycle. The funding decisions will be made independent of other scientific merit review board funding decisions and SPM for this panel will be Steven Marcus who is on the call today. I do want to also note that this

effort is a team effort. So if you have questions related to this particular RFA you should reach out to our disrupted care email address which is listed on this slide here and we will be able to get this question answered for you more quickly if you email it to our specific mailbox.

So with that, I want to leave the most time possible for our partner presentations. We have presentations from both acute and chronic care settings and preventative care settings. And they are going to just each briefly give us about five minute overview of some of the priorities and questions that they have been thinking about as it relates to disruptive care and their specialties and it is our hopes that you will get a preview of the questions that they are most interested in and this might help you understand what is most important and what types of research problems we would be interested in funding under solicitation.

So with that, we are going to start in this order on this slide so we will start with Dr. Mel Anderson from hospital medicine.

Mel Anderson: Thanks so much, Steph. Can you hear me okay?

Steph: Yes.

Mel Anderson: Great. I was hoping that maybe for all of us you could say sort of a little bit more about how what each of us and maybe all of us collectively might talk about--how that will be useful. So thanks for the outline for the RFA and the details of the funding cycle. But how might our contributions today intersect submissions that will likely come from others. I want to make sure that whatever I might talk about that it achieves the goals that you and your colleagues have set out for this conversation today.

Unidentified Male: So Mel, I will dive in first. I think just reflecting on sort of what you already know. And you may have shared in December but this is a new audience. What are things that you are already seeing that you are worried about--whether it is changes in the quality of care for regular care in the hospital other things that you are seeing in the way the pressure of the pandemic or the changes in the utilization may be affecting the patient experience or staff experience.

So just reflecting on sort of what do you feel like you already know and what are the things that you don't know where research could help you with? In explaining, some of this is going to be retrospective but some of it is we hope will be you know, looking forward as we recover from the pandemic and prepare for other future disruptions? So you know, what are the things that keep you up at night but you are not actually sure why things are happening and research may be able to help you?

Mel Anderson: Thanks so much. It sounds like in helping to provide a little bit more detail for the program leadership here about what the topics might be that they can see in the form of submissions for the field?

Unidentified Male: Yes.

Mel Anderson: Got it. Thank you. So the--I have the luxury of going first cause I am probably going to say things that are applicable to almost all of us the answers are being inclusive I will do so. The term disrupted care is a broad one. Knowing that we want to focus on disruptions related to the pandemic is quite helpful cause certainly we encounter disruptive care challenges in the no pandemic times related to transitions across the facilities especially those not linked on the same PMR, patients transferred from the inpatient setting to other facilities for procedures and back and the impact of care on the community outside of direct connection to an inpatient sort of care ___ [00:14:22]in terms of accessing those records and the impact on quality of care.

The things though that are more directly related to the pandemic that we are seeing that we are worried about that we were even talking about on the call yesterday are a combination of things. So delayed presentations of ___[00:14:44] so again, this is not unique to our companies and published I think start in Italy delayed presentations for cancer disease, mental health disorders.

Two, the affects of prolonged isolation on not just mental health but physical health. And I have a very personal experience with this with my mother who essentially went off the rails the last six to eight months or so through isolation, poor nutrition and affects of prolonged lack of contact with other humans.

And then the effects of the pandemic sort of indirectly on our patients. And I am thinking of the impact on caregivers, the availability of caregivers, rates of substance abuse for example, economic hardship among those in the home and care environment and the impact of both physically and non-physically on our veterans. And sort of a nexus of those direct affects of delayed care. Maybe even independent of disease activity in the community but perceptions as we saw from the ER on down a huge drop in presentations for care. And I think, it feels like right now in our facilities on the acute side that we are seeing the harms that have come from that. So it would be helpful to try to understand you know, identify where that is happening and understand the factors that led to those things happening if indeed they are true. So that for whatever next challenges there may be or whether or an acute pandemic sort or of a chronic sort for example, climate related health challenges so that we can mitigate against them.

Steph: Great. Thank you so much. You will be available for question and answer if folks have that at the end. We will move on now to Dr. --

Mel Anderson: I was going to joke that no, I am leaving right now. But I am not. I am not going anywhere. Going to stay right here.

Steph: Great. We will move on now to Dr. Clay Yarborough who is going to be talking about issues related to critical care and pulmonary.

Unidentified Female: Dr. Yarborough joined us ___ [00:17:21]over toa presenter. Dr. Yarborough, at the top of your screen in audio and video you may need to reconnect your audio. Dr. Goldstein, you may need to do the same. In audio and video you can switch audio and see if we can get you connected there. Okay. Dr. Yarborough is connected. We just need to get him unmuted and he will be able to talk.

Dr. Yarborough: Did that work?

Unidentified Female: That worked perfect. Thank you.

Dr. Yarborough: Okay. Excellent. Okay, sorry I am the national program director forpulmonary critical care and sleep. As you might expect, there is a lot of disruption for critical care. They had expansion, they had a lot more acute respiratory distress syndrome than usual and ___ [00:18:19]that and many more chest tubes and different procedures that had to be performed. Critical care was--didn't stop but it expanded. The pulmonary part I think is what everyone would like to get to. And the most the biggest gorilla is what everyone refers to as long COVID.

Even months after the disease infection people have problems afterwards. In terms of different things. And so, all of the sequala from the infection and whether they get readmitted things like that that would be important. Disruptors had to do with lots of stuff. So we have--we follow lots of chronic diseases, chronic obstructive pulmonary disease, interstitial lung disease and then the distribution of home oxygen, the performance of pulmonary function testing to diagnose things all had you know, disruptions. And then, lung cancer screening. I don't think that the lung cancer evaluations had much of a problem. We took those and used them even during the pandemic. But the people who needed screening may not have come in as much. So lung cancer screening may have been postponed and then, the sleep group we had to stop--we stopped sleep medicine across the VA because we wanted the respiratory therapist and the sleep physicians that were also intensivists to be able to be used in the intensive care unit.

And so we had already started using home sleep test extensively in the VA system over attended sleep studies over polysomnography. So this grew

even greater during the pandemic. So that disruption is also a big area to study as well. I think that covers most of the things--the most--the biggest one being the long COVID what everyone refers to as long COVID. Thank you.

Steph: Great. Thank you so much. We'll move on now to Dr. Chad Kessler, who is going to be talking about emergency care.

Dr. Kessler: Thank you so much. And we did have a slide that we shot in I think may be next on the deck or whatever if you could share that real briefly--just one slide. Yes, there you go. Awesome. And so, again, as Mel had said we are all in that acuate care realm and work together very closely. A lot of the same things would sort of carry over whether starting in the ED up to the inpatient units or ICU. And so we still see about 20% less volume than we had a year ago before COVID and that has sort of stayed. So to Mel's point earlier, where has all the acuity gone? That is the question. We don't see it via triage scoring system in our Eds called ESI, emergency severity index. One being near dead, five being I have a mole on the back of my hand for the past three months. And one might think that although maybe the volumes are lower overall that that would be proportional to the lower ESIs or the less sick--but it hasn't been the case.

Even the ones and twos the very sick are not coming in as much. And this is not just VA this is across the board. And so we are waiting and seeing if we are volume is going not pick up in the community, in academia and in VA. So far, it hasn't. So you wonder sort of where has all the acuity gone.

Let me just touch on a few other things. We are lucky enough to have a researcher in residence at EM. Actually, we have had two or three now. Eric Able is currently with us--some great people in emergency medicine research like Mike Ward so together we sort of put together some thoughts. We also have a wonderful ____[00:22:56.3] thanks so much to Dr. Atkins and the team. It is going to be a blast. We are really going to highlight emergency medicine research not just for emergency medicine docs but of the entire team with focus and research in the ED. So we are looking at things like ambulatory provided by EADDs and outpatient. Also, the ties to community care. We spent over a billion dollars in community care emergency medicine--what kind of quality are folks getting out there?

That kind of consistency? Do we know about these cases? We just developed a dashboard with our community care partners that has a lot of intel that you can look at to see how many patients in ___[00:23:38.2] or medicine center or even primary care doc, say Kessler, how many times my patient has gone out to the community for emergency medicine visit within a year or any time frame. And it is quite striking how many people within VA even the PCPs

still go out to the community for emergency care spending millions of dollars. So we need to do a little more research and figure out why that is happening, what we can do--is it the right resource or is something where we can pull people back in super utilizers.

What kind of models inside and outside, a lot of telehealth and how we are looking at that for tele urgent care, tele emergency medicine for now and for 2021 and the future. And I think the quality of care VA now, as I mentioned before, prepandemic, post pandemic extremely important. We can take a look and hope that we do and hope people are really interested. If you are more interested and it is not answering now or the time after. Please, don't hesitate to contact me. A lot of folks in EM really interested in research now across the board chad.kessler@va.gov. Got ___[00:24:47.9] during the pandemic, prepandemic, post pandemic--what are we going to see in the future, 50 EDs in urgent care centers and again, access is always in terms of minorities, in terms of diversity, what do we see with EDs partnering in ___[00:25:04.1] now Mr. Holdbren and Diversity Inclusion office should be really grand.

So again, just scratching the surface. Emergency medicine is everyone. We are really excited to have some people interested. More questions please reach out, only so much we can talk about in five minutes. The team and I are always here. Thanks so much Steph, and thanks, David. Pleasure to be on.

Steph: Great. Thanks so much. I also just want to remind folks we are at the halfway point of partners but if you have any questions feel free to put them in the Q&A chat and we will be able to address them at the end. We will go on now to Dr. Richard Scofield and he is going to speak about cardiology.

Dr. Scofield: Yes, hello. Can you hear me?

Steph: Yes.

Dr. Scofield: Okay, great. I really appreciate the opportunity to meet with you all. Thank you you for the kind invitation and I am happy to contribute whatever I can related to cardiology related disruptions in care from COVID. So I mean, this has already been mentioned--there are enormous disruptions across the board in medicine. Certainly it has been the case in cardiology right from the outset of the pandemic we started to see reports of dramatic reductions of cath line activations, acuate stemi alerts across the country. We started to see the reports of you know, increases in unexplained deaths at home. Probably many of them cardiac in places like New York City.

But we also have VA specific data. There are published literature that has shown significant reductions in VA specific admissions for acute stroke

and heart failure over the early parts of the last calendar year on the order of 40 or 50%. These are really significant.

One thing that is maybe a little different about cardiology we are fortunate have a you know, an internal data registry for our cath lab procedures called CART. I am sure you are familiar with CART. From looking at the CART data we are able to show for the early half of 2020 a 43% reduction in PCI volume compared to a previous time interval over the preceding year in the VA. And we published that and as a brief report with Steve also last year. After about eight weeks after the pandemic the volumes for PCI begin to trend up. They still have not reached the prepandemic level. And actually, I looked at CRT right before we got on the call today--if we continue our current trend for FY21 we are still going to e only about 78% of the PCI volume for this fiscal year compared to FY19. The last full fiscal year that we updated prior to the pandemic. So that is concerning and in because CART only tracks outcomes for patients that had a procedure in a cath lab. We had no idea about the patients who never made it to the cath lab. And so, you know, some kind of understanding of what is going on there would be really important for us.

Likewise, we don't have honestly, a great handle on quality of care for outpatient care, cardiovascular medicine things like and utilization as well--things like clinic visits, echoes, ___[00:28:58.1] things like that we really don't know what those trends have been over time or what outcomes might have been in regard to outpatient care. So you know, something that would give us insight to that would be really critical. And just as Clay has mentioned, the long COVID syndrome has many manifestations. A lot of them pulmonary and cardiac certainly are very closely linked. We would expect honestly, related to COVID in the coming years an explosion of chronic cardiac conditions like hypertension, heart failure, coronary disease, eurythmies we know that the affects of COVID on the cardiovascular system are significant and will promote those kinds of things.

But I am not aware of that specifically tracking our own patients that have had COVID, something like a data registry that would track patients the veterans with COVID over time, look at their quality of care, look at their outcomes, look at the affects of long COVID in those patients that are more symptomatic that would really be intriguing.

And the other thing--it may not be what you are looking for--but many academic centers have already opened up post COVID recovery clinics and things like that. I am not aware of any initiatives like that in the VA. But anything that would promote the kind of focus on risk reduction in the COVID population would be really helpful. So those are some immediate

things that come to mind. I can give you some bulleted points there really quick before I hand it over for the next speaker.

Number one for us would be really disease specific examination of utilization of quality of care for cardiovascular disease patients is impacted by COVID. Asi mentioned, w we have a data registry for cath lab procedural patients but we do not have anything for outpatient cardiovascular care or inpatient care that is not lined to a procedure. So something that looked at that would be helpful. A data registry of COVID positive patients I think would be important. I think, as already been mentioned, with this whole massive shift towards virtual care has been a big part of the response to COVID. You know, cardiology naturally lends itself well to virtual care and our numbers are quite high nationwide and our numbers of visits that kind of thing. I am not aware of a whole lot of data that links virtual care use to quality or outcomes. So it is something that would link that specific to cardiovascular patient would be very helpful.

And then one last point a lot of concerns about access through the canceled and disrupted care during COVID. The VA is still struggling to catch up to backlogs. Honestly, I think our scheduling processes and that kind of thing are very clunky and do not help us in that regard. The private sector has dealt with the backlog months ago. They are back to full speed. And we still seem to be struggling with that a little bit. So sometimes it is examination of our scheduling processes and delays and you know that kind of thing towards quality of care or timeliness of care would be important. And I will stop there.

Steph: Great. Thank you. Now I will move on to Dr. Angela Diantolis, hopefully I didn't mess that up too badly, who is going to speak to us about primary care settings.

Unidentified Female: Hi, Steph. That was not bad at all, thank you. Yes, so as Dr. Anderson predicted I think there is a lot of overlap among us. I actually had isolation as my number one item to start with and -- and really so true that many of our veterans have been physically isolated into their homes, unable to come into clinics or even when able still fearful of coming in for risk of infection. And many of our veterans are alone. So they are fortunate if they have caregivers, children or siblings--but many of our veterans are alone and primary care is kind of their lifeline. So they will come into their clinic and or call to just talk to their nurse because they have established a relationship with their provider.

During the pandemic, many primary care staff have been diverted to cover inpatient you know, LCs, testing clinics, vaccination clinics so that lifeline

for that veteran is disrupted an di am definitely worried about how they are holding up. And how they would answer that question about how are you holding up, how has this been for you. And just the physical going into the clinic to get their lab drawn or get an X-ray and that socialization that they get with their you know, their fellow veterans whether it is in the lobby or they get a cup of coffee in the cafeteria we are just really missing that.

Another thing that primary care does to help socialize as a number of other folks do, I sour group medical appointments. So we don't have that. they don't have that comradery. Many facilities and clinics have tried to continue to have those group medical appointments virtually. I know ___[00:35:23.5] has been effective holding veteran town halls virtually with hundreds of veterans. And so you know, I think anything that we can show you know, value we know it is valuable if we can show the value those interactions and that socialization I think would be great. Obviously, preventive health is a big deal for primary care but I am going to avoid the temptation to talk about it because my coll3auge Dr. Goldstein comes up next and we have done some super things that he is going to talk about and share his concerns as well. I would also say, you know, in primary care we there is a lot of chronic disease management. So we hope that we have kept up on much of that but we know looking at data that when was the last time that a hemoglobin A1C was obtained, when was the last time a repeat blood pressure was obtained, kidney function obtained for our diabetics and patients with renal disease. That has been disrupted.

Once again, veterans may be fearful to come in for a lab draw that is an in person you know, you can't do that virtually. And so, we certainly may be missing out on worsening disease that an intervention could help. And some of those are definitely silent killers and we just may not know about it.

I think another thing that we are all responsible for is care transitions. So if the patients have not been coming in for care we might miss something that has been missed in a care transition whether it is going from CLC to home, they weren't able to come back in for a visit for primary care face to face so we might not notice something we would notice in person. Hospitalization, phone calls and video visits are great. How diligent have we been able to be with those follow ups to care transitions when many primary care staff are diverted for other viable duties in the Department. So care transitions is definitely another one.

And then I have also wound care. So while we can definitely observe wounds on a video with actually great resolution sometimes better than in person if it is a photo or an iPhone, I would be really interested to know how much if amputations have increased, wound debridement those types

of things where we catch them when we see them in person that are our veterans and their family members avoiding coming in for rechecks of a would for fear of reinfection or you know, other fears.

So I will leave it at that. Those are sort of the things that I float to the top for me. And thank you, Steph.

Steph: Great. Thank you. And last but not least, we will turn it over to Dr. Michael Goldstein who is going to be speaking about preventative care. I think you are on mute.

Dr. Goldstein: How am I now? Can you hear me now?

Steph: Yes.

Dr. Goldstein: Oh, great. So I appreciate ___[00:39:30.4] it has been both ___[00:39:33.6] and also a little bit scary, honestly, hearing about all the different ways in which care has been disrupted by my colleagues. But ___[00:39:43.2] medicine there is already an initiative under way a collaboration between our program office and primary care and other program offices including specialty care that are ___[00:39:59.3] care, podiatry, to address what has been called a preventive ___[00:40:07.7]. So it is ___[00:40:09.8].

There is a hope and expectation that by focusing on 10 specific measures that are associated with 10 types of services e we will be able to do our best to try and catch up but evaluating this initiative is going to be critically important. Let me tell you what the 10 things are. It is colorectal screening, breast cancer screening, cervical cancer screening and immunizations for flu, although we are at the end of the season now it still will be pick up, I'm sure, again as we move towards all the ___[00:40:54.6] some chronic illness care as ___[00:40:59.3] mentioned there has been challenges, obviously with people who have been A1C so that is a care--a patient with diabetes we will be looking at hemoglobin A1C ___[00:41:11.2] virtual foot exams even, retinol exams, renal function and then hypertension screening and screening for suicide among those that have been identified as high risk in other ways.

Those are 10 areas and specific services that we are trying to systematically address by having a note template on making it a priority it is actually an ___[00:41:45.9] performance plan to look at the measures the ___[00:41:50.9] services and in some ___[00:41:56.6] panels so that you can identify people who haven't had these services and then come up with some innovations that will hopefully close the gap. That is particularly where I think there is some room for evaluation and research to help us understand what types of service delivery strategies like +___[00:42:22.9] care for example or thinking about ways to reach out and proactively

encourage veterans to think about restoring care. The opposite of disrupted care to come back and start to take care of their routine care to address their preventive care and chronic illness care. So it will be nice to have collaborators who are interested in helping us test the impact of some of the strategies we are using to identify the gap.

___[00:43:02.0] patients to and types of visits to address the gap. And also about veterans perceptions about what is important for them. And in general, in our program office we are interested in both the behaviors as well as the perceptions about __- obviously, in the midst of a pandemic right now with responsibility to help with COVID vaccination we are interested in all the factors that contribute towards if somebody is interested and confident in getting the vaccine--well, that remains true we are all ___[00:43:40.3] preventive measures that I mentioned we will be tracking but also many, many others. The other screening tests, the other immunizations that are so obviously critically important. How has the COVID pandemic impacted patient's perceptions about the ___[00:44:00.3] patients interest in pursing screening and immunization for other conditions, how has it affected their perceptions and risk perceptions specifically about tobacco use, alcohol use, diet, weight and how has their interest in participating in services? What is it that they are most interested in? What are their priorities for preventive care and chronic illness care for that matter? So management of their chronic ___[00:44:37.2] and how can we build on any increased interest that there might be to offer services in a way that satisfies that need but at the same time helps them to follow through or behaviors will prevent subsequent illness and disease?

Those are in broad strokes the interest that we have. We look forward to the opportunity to collaborate with any or all of you who are interested in addressing those concepts. In collaboration many of my colleagues have ___[00:45:17.4].

Steph: Thank you so much. Before ewe dive into our Q&A I just wanted to thank again, all of our partners for being here today. I also wanted to emphasize the fact that we are interested in not only these care settings but mental healthcare settings and mental health conditions. We had a similar cyber seminar earlier this week specifically about mental health conditions including things like substance abuse disorder. That is also a priority area for this RFA.

I want to re-emphasize that this RFA and the management is a team effort at our office. So in order to get the best responses we email our dedicated mailbox for disrupted care research which is listed here. And with that I will turn it over to Heidi who can start with the Q&A.

Heidi: Fantastic we do have about 15 minutes left over for Q&A here. I know there are some questions left out there because we type those into the Q&A we have time to handle quite a few of them. The first question that we have--do you have a link for the RFA for those outside of the VA?

Steph: Thank you for that question. We don't. we only post it to the internal VA intranet site. And that is because the only people who can read these studies are those with VA affiliation. So hopefully, you can have one of your colleagues share the solicitation with you.

Heidi: Great. Thank you. The next question we have here--we work with federal grants in the past as part of collaboration. Would we have access to VA data or would we need to bring that to the table?

Steph: Typically, our researchers have access to VA data. You can follow up with me and our team more specifically about ___[00:47:26.8] about your specific situation and we can get you a better answer.

Heidi: Great. Thank you. That is all of the pending questions that I have at this time.

Mel Anderson: Heidi, this is Mel Anderson. I, for some reason, could not issue a question so I wound up forming a question as an answer to that first question. So it was not ___[00:47:55.8] so much a question as a suggestion. It was during Clay's presentation on pulmonary critical care. But I just thought it might be interesting to look at the impact of financial hardship and constancy of housing when a ___[00:48:12.4] O2 use and so far has patients need reliable, electrical source to run their concentrators. And to the extent that that may have been part of the pandemic disruption.

Heidi: I don't know, Clay if you have any comments on that.

Clay: Yeah, a couple of them. This has been a problem for our homeless population for a long time. And if you don't have a house with reliable place to plug in then it is a problem. And it could have been even more with the pandemic I'm not sure. Usually, if you get home oxygen you can deal with the electric company to be a priority. So they will come to your house to fix your electricity first in outages and that works really, really well. But you do have to have a constant home.

Mel Anderson: Making inferences based on the extent to which homelessness in general may have expanded.

Clay: Or moving to in with your relatives. It is just removing from one house to another. You need to move the equipment there get all that arranged and stuff. We usually help with that but you have to tell us that you actually moved it so we can help you in that way. I would guess that a lot of people

that convalesce convalesce at their relatives homes so they have help rather than living alone and having trouble.

Mel Anderson: That is an interesting thought to the extent of which convalescence away from home added impact on access to continuous O2 supplementation.

Clay: Just to I know that someone commented on I think Rich commented on the long COVID and whether or not we are doing anything at present. I know there are a couple of VAs that have started a clinic for convalescent COVID and we are trying right now to put together a work group to form a templated note that would gather information on these patients. And it is a difficult thing to balance you know, the primary care provider or whoever is going to see this patient with filling out a note and that is time consuming for all the data or you know, being able to push them into a clinic and stuff. So if anyone would like to help I think we could certainly pull other people in.

Mel Anderson: To one other point, I think Rich made this as well about having a formal registry for infected patients because we really have the unique opportunity at the national, maybe international stage to try to understand what the national history of this disease looks like after the acuate phase.

Steph: Great. Thank you. I think we have had a few more questions come in.

Heidi: Yes, we have. The next question here--I may not have heard this specifically from the panel, but is there interested topics related to increased use of substance use or populations that are more vulnerable to these issues--homelessness, liver disease?

Unidentified Male: Right. Some of that was commented just a moment ago with Clay and I. But yeah, I think that is another huge area. I don't know if they covered that in the mental health that you had earlier on.

Steph: Yes, definitely. And I would just say quickly that within the RFA it also talks specifically about vulnerable patient populations.

Dr. Atkins: This is David Atkins. Yeah, we did talk specifically about substance use issues in the mental health discussion. That is an area where the VA has documented na increase in overdose deaths so it is a particular area of concern. And it is an area where ewe know care has been disrupted with residential rehab and other things. So if you are interested in that we suggest you go look at the--listen to the recording of the mental health cyber seminar that was done on Monday.

Heidi: Great. Thank you. Next question here--what are recommend ways to reach out to operations partners and demonstrate their involvement in application?

Unidentified Male: I don't know that that means.

Dr. Atkins: I'll take the lead, this is David. We'd like our partners to sort of let us know how they would like to be involved. We are when folks are developing an idea they may want to run it by you or they may when they have a sort of abstract or proposal want to contact you for a letter of support. Don't want to flood you with stuff but we do want to give you a chance to kind of steer people to things that you think are high value questions and maybe the best way would be we can do this offline if you just give a point of contact that we can put into the notes after this call. Heidi, does that make sense?

Heidi: Yes. That archive won't go out for a day or two. We got enough time to add stuff out there. Dr. Goldstein sent in a comment here--there is a presidential innovation fellow, Mary Adley, who is making learning about addressing long COVID her focus of her fellowship.

Dr. Goldstein: Yeah, just mentioned that this is Michael in reasons to the previous comment of the value of learning more about long COVID in veterans.

Unidentified Male: Can I just clarify that -- that we you know, we have a separate this solicitation is specifically for impacts of deferred care. We do have separate--we are welcoming separate proposals to look at long-term outcomes. We have stood up a collaboration that is going to organize that. And so, if you are interested in that line then you contact me and I can steer you to the right people.

Unidentified Male: David, this is ___[00:55:40.2] just thinking about the deferred care part of the disrupted and deferred care it probably already has occurred to you all. I would think about focus groups, one on one interviews cause there is a lot I think of psychology maybe more broadly on what leads to behavior change in general and around the calculus of need or fear that may underly decisions to defer seeking care. I.E. EMR may not tell the story well enough.

Unidentified Male: Yeah, I think we completely agree with that which is why the RFA sort of talks about the value of qualitative research to really dig into why we are seeing certain things.

Unidentified Male: Yeah, this is ___[00:56:39.7] I just want to underline that perceptions and attitudes and beliefs, intentions, motivations all of those things are going to be critically important and assess and they have to start all over again because the whole environment has changed over this past year and fears and concerns have multiplied. Trust unfortunately has decreased overall in the VA. It is going to be really important for us to assess but we need to know what to assess and that is where the qualitative research really helps us.

Unidentified Male: One other follow on thought is that the--those factors may not `be new. It may be an opportunity in this heightened sort of crucible to understand in greater detail and they might be modified even in nonpandemic times to promote engagement.

Unidentified Male: Absolutely.

Heidi: Okay we got two minutes left. I am going to try to sneak in one or two more questions here and then we can close things out. How can the new COVID impacts data coordination center be involved with these applications?

Unidentified Male: Sorry, I'm not sure I know what that is.

Steph: Yeah, there is actually quite a few coordination centers. You are talking about the one that we are funding via central resource hub that is going to have ____[00:58:45.8] and talk about things like metrics that are related to measuring and assessing disrupted care outcomes. And that coordination center will be funded later this summer before these studies are funded.

Heidi: Great. Thank you. And Steph, it looks like you replied to the other question we have so that is all of our questions. Just want to double check if any of our presenters have closing remarks they would like to give before we close out today's session?

Unidentified Male: I just want to thank all of them. We know how busy they are. As we said, we hope these projects are going to stay in communication with you without overwhelming you and that you are--what you are learning from running your clinical programs can feed into what the questions that they are continuing to ask. So thanks to everyone who was able to participate and thanks especially to Steph for organizing this initiative.

Unidentified Male: Thank you for the invitation. It was great.

Unidentified Male: Yeah, thanks, David. Thanks, Steph.

Unidentified Male: Thank you.