David Atkins: So, I’m going to try to take just twenty minutes to reflect on what I learned during my four month that turned into fourteen months sojourn, out of HSR&D. Then, reflect on the new environment and potential implications for HSR&D.

I was thinking about this when I read a piece in the Times art section about the studio executive from Sony who got forced out when her emails got hacked and she had to reinvent herself as a producer. She commented that as a studio director you don’t actually do that much. You worry about budgets and marketing but you’re not really the creative force. So, I thought about that and really you are the writers and the directors and the producers of HSR&D. You’re the people we count on. So, I think of this as our Sundance. That of course, makes me Robert Redford, so I’ll live on that for a while. So, trying to think about, I was not actually eager to serve as acting CRADO but I’m glad I did it and it was and interesting time to do it.

It was the end of the Obama administration. This was April a year ago. They were eager to show the impact they’d had in science. So, they launched a personalized medicine initiative now called All of US and cancer moonshot and there was a flurry of activity in the White House and the Office of Science and Technology and the various data geeks that had been brought in to run it. It was sort of like a festive atmosphere and very busy like this which is the streets of Pamplona. But, what you sort of forget is as you walk up the street amongst the people who are walking sort of casually you eventually get to the some people who are running really hard at the horns of a bull. That’s often what central office feels a little more like. You’re trying mostly to keep from getting trampled or gored or becoming a statistic.

So, as we think about and as we get to higher level decision making in D.C. the pace is very fast in central office but it’s often very reactive and, I think, at odds with what we think our strengths are as researchers. So, there’s a continual tension of trying to bring evidence in a very time sensitive environment and it often is hard to focus on the long game. You spend a lot of your time sort of managing threats and turf and budget and grabbing the occasional opportunity. That is true. If you’re famous you can just grab them and support for VA research remains strong. So, that’s the good news.

But, I think, especially as of today, support for continual ways of operating are not strong. I think there’s a direct push against things that look too traditional. So, there’s an assumption that we’re going to have to show the value of our research and think about ways to do that that go beyond and deeper than our tradition sort of dissemination. It is important just to show up. So, as Woody Allen said ninety percent of life is just showing up and getting known. But, we do need to think about more effective ways to really document the many ways that we influence things.

Then, lastly, I think, which has come up in a number of the panels about partnership is that our influence relies on that combination of relationships and data. So, relationships without data isn’t sufficient. I think, if you’ve been in any meetings with the secretary or higher level leadership they are very numeric and data centric. But data without relationships also doesn’t work. So, it’s what we hope we’ve made progress on and I think we have over the last three years is really trying to foster and incentivize those relationships that make your data more believable and more influential. So, the good news is we’ve made real progress. I think we’re the only agency that has strong bipartisan support both for our leadership and for our mission.

We have an acting Undersecretary who’s very engaged in Dr. Poonam Alaigh. As I mentioned, unfortunately, she and the secretary are off in Europe meeting about Veteran affairs. Tomorrow you’ll be meeting Rachel Ramoni, our very engaged and dynamic chief research officer. A very interesting pedigree. She trained as a dentist at Harvard and got a PhD in epidemiology. I think the nice thing is almost ever research service can claim her as one of theirs. I certainly claim her as the health services researcher. She helped invent Fire, the interoperability language for sharing data and she’s quite interested in our big data. I think we also, as both an agency and our research mission, have strong congressional support and the media narrative is improving. But, as the secretary is careful to say we haven’t turned the corner yet. Just two days ago there was a Boston Globe spotlight about problems at the Manchester VA. Within a day that leadership was replaced. So, there is still the need to show that VA has really learned its lessons and trying to fight things that are perceived as sort of longstanding obstacles.

So, that’s an opportunity there in that I think we have leadership that’s willing to try to break some china to try to make things happen. Sometimes our problems are self-inflicted but we may actually have an opportunity to try to get past some of those. So, the good news is the strengths of our research program are the same as they’ve always been. Our integrated health system with a dedicated research budget. Our colleagues at Kaiser would love or Intermountain would love to have the dedicated stream of funding that we have. They might not like the oversight from congress that we also have but you can’t get one without the other. I think we still have unmatched research capability in terms of our data. In terms of the mix of clinical and administrative data that now will be matched with genomic data. We have a budding partnership with the Department of Energy which may really take that to scale. It’s not going to happen immediately.

Lastly, I think the critical issues for the VA really mirror the critical issues for the country. It’s no long the idea that well, our issues are only of interest to Veterans and their supporters. We really have a chance to solve problems in a way that can help the nation. So, if you think about the opioid crisis, you think about the suicide problem which is the secretary’s number on priority, complex high-cost patients and the problems of an aging population those are really all the things that are at the heart of our contentious healthcare debate. We’ve seen actually all of those in the front lines of the debate about Medicare, the debate about Medicaid and the ACA.

So, I hope the secretary’s priorities are familiar to you. I won’t belabor them but just point out some of the details that choice is going ahead. There is going to be a budget sort of battle about funding it and concern that it not be funded at the expense of supporting core VA businesses. But, there’s a lot of activity that will continue to build a community network to supplement care provided by VA. As part of that is transparency to show how VA facilities compare both in access and in outcomes to the facilities in their market. You may have seen that there’s already a website up where you can go and look and see how the Palo Alto VA compares in terms of access and clinical outcomes to the Stanford University Hospital and other hospitals in the neighborhood.

There’s a commitment to modernizing systems which includes infrastructure improvements and the new EHR. There’s a lot of attention in the current fiscal environment to focusing our resources efficiently and thinking about what are now being called VA Foundational Services. Thinking about does having a VA medical center commit us to providing all the care in that medical care in that medical center or are there some subspecialty services that are better provided in the community. Timeliness is the fourth priority and that’s of course referring to access. I think we’ve made a lot of progress in access but access to specialty care continues.

Then, I hope it’s no surprise to anybody that suicide is a priority. I think the secretary will say it’s his first priority and the White House has even gone so far to say as the success of VA reforms will be based on our progress in bringing VA suicides down. Rachel will be talking about some of her priorities which are just starting to take shape. She’s been here just for six months. One of them is big data which includes both accelerating and continuing to grow the Million Veteran’s Program and our partnership with the Department of Energy to bring data science from the Oakridge lab and other DOA labs to help us improve on our big data science and eventually to improve access not just to VA investigators but to non-VA investigators. She’s also is saddled with trying to improve our tech transfer program which is the way in which we capture intellectual property and returns on that. She is committed to try and increase the efficiency of clinical trials both working with the National Cancer Institute to try and enroll more patients into cancer trials.

But, I think these themes sort of fit with a larger picture. The sense that we need to figure out who the best in class partners are to partner with and learn from and really ensure that our research program continues to be at the leading edge. So, Dr. Cromweld’s [PH] already sort of talked about big data and I think I’ll just make one point that the road to big data the better outcomes really run right through health services research. You can do everything with big data. But, unless you understand how to deliver information to a clinician and to a patient in a way that they can act on it and make the right decisions you’re not going to accomplish anything. I think there’s a big difference between Target using big data to figure out what coupons to print out from you and using big data to try to advice patients about what therapy to start and how to balance benefits and risks.

Ultimately healthcare’s a human interaction and I think the advantage we bring with all your expertise is understanding the human side of data. I think we sometimes, as Steve Asch pointed out, as a question we get a little to enamored with the gismos and the data and the fancy tech talk graphs and sort of forget that in the end it comes down to an individual clinician and the patient making very difficult and very human decisions. How am I doing on time here?

Unidentified Male: \_\_\_\_\_ [00:13:51] left.

David Atkins: Left. All right. So, lesson one. Don’t assume the way we’ve always been doing things are going to be the way we do them tomorrow. I think we always say that but in a world where a president can propose a twenty percent cut to NIH. Not that that’s going anywhere but this is a different world. So, I think it’s safe to say that the fact that we’ve been doing something is no protection for continuing to do it and in some ways it may be actually a deficit. I don’t mean to invent new things just to be new. But, we need to be careful we’re not justifying anything we do because that’s the way we’ve always done it in the VA. So, that’s going to be true in healthcare. We don’t really know how the VHA healthcare is going to change. I think there’s a wide confidence interval around one model where we really consolidate the number of medical facilities, consolidate the range of services that we provide and make much more use of outsourced care. There’s one sort of extreme model and the other is something that would look kind of more like what we’re doing today. Maybe a little more community care and maybe closing some of our smaller facilities.

Then, in research, I think they’ll be continuing and I think with justified pressure, to figure out where is our critical advantage in research. What’s the research that only VA can do and only VA will do or that we can do better than anybody else. In a world where research funding is tight everywhere we’re trying to make sure that we’re spending all of our dollars on things that are critical to the Veteran. As you will continue to see, connecting everything we do directly to a Veteran’s experience is going to be increasingly important.

We are undergoing a reorganization and modernization plan at central office. Our central office will be shrinking. Some of that may be justified. The down side is we are under a hiring freeze again. So, we’ll be leaning heavily no you in the field to do things that we don’t have the bandwidth to move forward. Actually, that’s probably the way it should be anyway. The idea of decentralizing decisions that have been sort of arrogated to Washington probably makes sense. There will be a reduction in the number of \_\_\_\_\_ [00:16:37]. How much a reduction? So, it’s the usual sort of pendulum swinging back in a number of ways. There’s already been some reorganization of central offices. Some of your partners are now sitting in new offices or combined with other offices. There, as I mentioned, will be work about defining what the foundational services are. I mean, the good news is I think most of the stuff we study is going to fall in the core of our business whether it’s primary care, women’s health or mental health. Those issues are clearly going to be foundational. If you’re a researcher studying neurosurgery outcomes this might not be the greatest time to start your career in the VA.

We’re going to be focused on how to administer choice effectively and we’re going to have a transition to electronic health records, which I think eventually when we get there will actually help some of our chronic IT problems. But, the transition is going to be challenging. So, lesson number two is I think a good news item. The primary threats to research are not budgetary. The president proposed a five percent cut in our budget that was better than what was proposed for any other kind of research organization in government. Just to remind people who don’t live in Washington and live and breathe this. The congress sets the budget. The president’s budget is sort of a political statement. The good news is that support for research from our congressional committees remains strong. Even under the worse-case scenario of a five percent cut I think the funding for the services will be relatively stable. But the congressional committee yesterday or the day before, the senate passed a recommendation, what they call the mark, for a budget that actually increased our budget by fifty million dollars. Which is fifty million on a six hundred and seventy million base. I can’t do the math. Several percent.

The other good news it may in congress an attempt to show they actually get something done may try to pass a VA budge again. They clearly are going to have a hard time agreeing on a lot of the other budgets like budget for HHS and everything else. So, it looks like they’re going to have an easier time coming to agreement on those agencies like DOD and VA where they’re actually planning to increase the budget. So, if we get our budget the news is good. If they don’t pass a budget and we end up in a continuing resolution we may be stuck with a shrunken budget at least until we actually get a passed budget. So, that’s a little bit more inside baseball than you probably need. This is just to show that our research funding has been relatively stable, which is sort of a bad news story. Because we know with inflation purchasing power erodes. So, even if we end up in 18 with the same budget we had in 13 that means we probably have about a fifteen percent lower purchasing power than we did. This is the problem throughout government.

So, lesson number three. The outlook is good but our success isn’t guaranteed and we shouldn’t assume that the threats to research aren’t real. So, what does that mean? Well, we need to understand what our leadership expects of research. So, I’ve told the story that Secretary Shulkin who two years ago in Philadelphia had just arrived as the Undersecretary. His first public appearance was at our HSR&D Query meeting. It’s hard to believe that’s only been two years. So, he’s not a patient person. That’s probably what you need in these days. We put out a press brief on a study that I think was highlighted in the morning’s introduction about risk factors for suicide shortly after discharge. We put that brief out on Friday. On Saturday he had emailed Dave Carroll [PH] the head of Mental Health Services and said what are we doing about this and just talking about it doesn’t count doing about it. So, he is ready and looking for action when there’s an important research finding. Our job is to try to steer leadership to findings we thing are actionable and avoid jumping on every finding and especially early ones.

So, they want metrics for progress and impact. They clearly want faster results. We have a lot of expectations management to do. They want bolder goals. I initially, I always blanch a little bit about bold research, a lot of research is built on incremental things. But, Ashish Jha at the Academy of Health made a comment that stuck with me. He was talking about pay for performance plans and performance incentives. He says as researchers we always think about unintended consequences and he thinks that’s kept us from being as bold as we need to be. He was making the point that if you have a pay for performance thing where three percent of your income is at risk. Well what do you expect? Why not test things where twenty-five percent of people’s income is at risk for improvement. I that’s something we can continue to think about is are there places where we’ve shied away from things that are more innovative and bold just because we feel we have to inch up to them.

He’s looking for greater innovation. There are various groups that have popped up that have the mantle of innovation and I take that as sort of an implicit criticism that he’s not always finding it in research. I think we actually have some very exciting innovation in research but it’s something we just need to be aware of highlighting. Obviously, everyone expects our findings to be implemented into Veteran care in a way we can see them and through partnership.

Five minutes. Okay. I’m going to close with three challenges for research. This really builds on the stuff we’ve heard this morning. So, if we need faster results and more efficient results how do we do that. What does it mean to be more responsive and efficient? How do we look more innovative and incremental thinking about what are called branch solutions rather than just each leaf at a time. What are the things that are big branches towards improvement? Then, how do we manage our research portfolios with an idea of bigger and faster impact.

So, what makes our research slow? I think these are familiar to everybody so I won’t belabor them. It’s our review process. Three submissions. We calculated several years ago that it was an average of like six to seven years from first proposal submitted to first publication. That’s a timeline that will put us out of business. Regulatory obstacles. Reinventing the wheel. Each investigator having to invent their own cohorts. There was a great panel this morning about OMOP as ways to try to accelerate that so people can work with common data models and don’t have to do the laborious work of joining data sets. Our serial approach to studies of doing the qualitative work to think about how to design an intervention, testing it in an efficacy study, then expanding it to an effectiveness study and then thinking about implementation. By the time you’re done the world has moved on.

So, how might we speed research? I say don’t freak out. These are random thoughts late at night. So, NIH has limited applications to two. Forced peer review committees to make earlier decisions about stuff that’s exciting or not. I loved Harlan’s idea about proposals that ask you to write your manuscript. Write the headline. Thinking about within our research areas getting a little crisper about the things that we really need to solve and directing research towards them. We are working to try to improve some of the IRB stuff. We may move to allowing singe IRBs. Getting money out earlier. Amy will be talking about a lot of the stuff after me that Query is always doing in this realm to try and get stuff. Query’s been amazing in how quickly they can jump on an issue, facilitating their sharing of data and the reuse and phase funding. So, at as COIN meeting a couple of years ago I used this. Well, research isn’t designed to be your fast QI. Can you really turn a pig into a racehorse? My colleague Sean Tuna [PH] said well maybe all you really need is a fast pig.

So, that’s sort of our goal is to see if we can be a little faster pigs. So, how can we be more innovative? Well, we could focus on a few critical challenges and let people try to really be bold and come in with bolder ideas. That means we have to be ready to fail and we have to fail early so we don’t waste a lot of money on a bad idea. But, ultimately, we’re going to have to think about different ways to peer review, I think. I read an article or I should say I read a headline, is peer review the enemy of innovation. So, I do think there are things about our peer review process that encourage researchers to slice things into the cleanest, narrowest and least relevant slice of a problem.

So, lastly, how can we have a bigger impact on VA care? Well, it’s a plan with goals in mind. Intent, is what I think Harlan said this morning. Build in the policy handoff directly. That’s why we love to see our policy partners here. Think about ways to jump on hot issues and Amy will be talking about those including our ability to learn from natural experiments going on in the healthcare system. I don’t know why it keeps switching away from my slides. Really, you don’t need to see me on the slide. That requires us to understand that we are in a culture of different partners that are responsible both for our success and for impact. So, what’s a way forward? My plan, it may not be three work groups it may be two. Is to bring together three work groups, as I said, to farm this out to the field to help us solve some of these problems. I realize you’re all in the midst of those of you who have COIN, writing your renewal so I’m trying to detach it from the timeline of renewal. Get some ideas on paper and use the COIN meeting in the fall to narrow some of those ideas down to some limited initiatives that we could roll out in spring of 2018.

Last year I used a musical thing. I’d say my highlight last year was my son who’s a tech in San Francisco managed to score us tickets at the Hamilton. I think the take-home message is we’re not going to throw away our shot. So, thank you.

[End of audio]