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Session:  VA Women’s Health Research Network: Accelerating Research Impacts and Advancing Learning Healthcare System Principles

Presenter: Susan Frayne, MD, MPH; Alison Hamilton, PhD, MPH; Elizabeth Yano, PhD, MSPH

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Moderator: And without further ado I would like to introduce our speakers today. Joining us, Dr. Becky Yano. She’s the director and senior research career scientist for VA HSR&D Center for the Study of Healthcare Innovation, Implementation and Policy, known as CSHIIP. Also the deputy associate chief of staff for Health Services Research at the VA Greater Los Angeles Healthcare System and director of Women’s Health Research Network, director of the women’s health CREATE, adjunct professor of Health Policy and Management at the UCLA Fielding School of Public Health. Joining her today we have Dr. Susan Frayne. She’s core investigator for the Center for Innovation to Implementation and the director of the VA Women's Health Practice Based Research Network and a professor in the Division of Primary Care and Population Health at Stanford University School of Medicine. And finally joining us today we have Dr. Alison Hamilton. She’s the associate director for the Implementation Science and director for Qualitative Methods Group at the VA Center for Study of Innovation, Implementation and Policy also at the VA Greater Los Angeles. And an associate research anthropologist, at the Department of Psychiatry and Biobehavioral Sciences at UCLA in Los Angeles.

So without further ado, I would like to turn it over to Dr. Becky Yano and if I misspoke on any of the roll or affiliations please do feel free to correct me. And Becky, you should have that pop-up now.

Dr. Elizabeth Yano: Yes thank you. And thank you so much for joining us today. We have not actually done a Cyberseminar on the Women’s Health Research Network for quite some time and thought we were overdue especially given that we are enjoying the opportunity to accelerate research impacts and advance learning healthcare system principles and we have a lot to share and offer.

So what we’ll do today is remind folks why we have a VA Women’s Health Research Network to begin with and then we’re going to each speak to what the core components, the consortium that I lead, the practice based research network that Dr. Frayne leads and a component on multilevel stakeholder engagement that Dr. Hamilton leads. We’ll have a brief epilogue and then open it up for audience questions.

So why a Women’s Health Research Network? Well when we got started in this, and what is actually true today as well is that most research is on men. And that’s true in and outside the VA. And that means that the resulting evidence may not always apply to women. And it’s very important to increase the equitable benefit of VA research through a greater inclusion of women Veterans. We also noticed that there was a lack of evidence around women Veterans’ health and healthcare so it was key and clear that we needed to help increase funding of research focused on women Veterans as well. That required an infrastructure to support multisite research and that’s really because you can get enough men with heart disease for example in a single VA but because women Veterans are roughly 10% or fewer of the population of VA users, you’d need dozens of VAs to get the same number of women. Women Veterans research was also extremely limited when we started this out. Virtually all women Veterans research was descriptive so the prevalence of conditions, and 69% was focused on mental health and women Veterans are much more than PTSD, depression and anxiety as you might imagine.

It was also true that most VA researchers were already excluding women. They worried they’re too few or too hard to recruit or they weren't really able to recruit enough to look at effects by gender. Maybe it’s possible they weren’t really interested in gender difference to begin with and that may have been a result of also not understanding their different healthcare needs, not understanding how they use VA care and not being familiar with VA women’s health policy. For those researchers who were interested in women’s health they were having difficulty getting funded. The reviewers were unfamiliar with this territory. And they were also having trouble getting their women Veterans’ research published.

So this all began with women’s health research agenda that was, in all honesty, a combination of serendipity, clinical demand given the increased numbers of women coming to the VA, persistent gender disparities in quality of care that the VA was struggling with. And it was all lit by a match by literally the wife of the secretary who was a woman Veteran at the time, asking is the VA doing anything in women’s health research. And that set forth a host of activities that you can see here that culminated in a women’s health research agenda across all types of research.

So we had workgroups convened in a national consensus development conference. Shortly thereafter, across all four of the VA Office of Research and Development Services, and we included an infrastructure group of expert researchers and research administrators to get their perspectives on how to build research in this arena. And they said you have to build capacity through networking collaboration and RFPs and mentorship. You have to address the methodological limitations and barriers that have kept people from including or focusing on women in the meanwhile including suggestions for our practice based research network, and you have to increase the visibility and awareness of everyone to the importance of this area with the goal of improving and increasing the number of people involved in this kind of research, the number of grants getting published and the number of papers. I’m sorry, the number of grants getting funded and the number of papers being published.

And we documented the journey along the way in terms of putting out thought pieces, publishing the agenda itself and so on.

And this was driven also by the reality that the number of women Veterans in VA were rapidly growing. And these are data from Dr. Frayne’s Women’s Health Evaluation Initiative that demonstrates this substantial growth over time. And in fact the first agenda was in part responding to the volume and the growth back in 2004. And as you can see that has only continued over time.

So VA HSR&D funded this infrastructure to build women’s health research capacity initially. And that included the Women’s Health Research Consortium that I direct. And the Women’s Health Practice Based Research Network that Dr. Frayne directs out of VA Palo Alto. As we continue this work, the VA HSR&D service renewed us to increase the achievement of research in each one of those agenda items that we put forward as well as to increase research impacts and see what we could do to really scale some of the work that we were doing with individuals investigators and mentees as well as within the PBRN to increase multisite research and the like.

To do that we also included then Dr. Hamilton in our team who leads the multilevel stakeholder engagement activities to help us accelerate implementation of research into practice and policy [unintelligible 7:16] under the Women’s Health Research Network.

So let me give you a brief overview of the consortium itself that I co-lead with Dr. Ruth Klap who provides very strong methodology expertise across the consortium.

Our basic fundamental goals were to build a national consortium of researchers and other stakeholders, so clinician educators, women Veteran program managers, women’s health medical directors, primary care directors and the like, including folks all the way up to central office, capable of pursuing women’s health research in the VA. To do that meant improving the awareness of the importance of including women in VA research and increasing the ability of VA researchers to include women. So that has involved training and education, mentorship and both technical support in study designs and research methods as well as dissemination with the goal of making it easy, making it something that people are incentivized to pursue, enhancing collaboration, as needed corralling people and also partnering along the way. We also focus very much on increasing communication, dissemination on the path to implementation and spread, all of which are also enabled by the other components you’ll hear about this morning.

So our first step was to actually create a women’s health services research agenda. And as you can see that involved women’s health services and a lot of strategic planning, an updated systematic review and partnerships in a new agenda setting conference that included the Institute of Medicine now called the National Academy of Medicine and the like with HSR&D. And so the new agenda came out and went beyond mental health, although mental health is still a very substantial and important component of the whole portfolio of research to pursue.

So we convened conferences including the 2010, another one in 2014, and other workshops along the way among researchers, clinicians, policy makers and women Veterans to increase visibility and to come to consensus on high priority topical areas to pursue in research and evaluation. And as I mentioned we involved other departments such as the Department of Defense, Department of Health and Human Services, Department of Labor, and other agencies and institutes. We launched a national VA HSR&D Cyberseminar series. And there are nearly 90 under the Spotlight on Women’s Health series that CIDER fosters. And the web link is there. We also established a national mentoring network to support junior researchers and trainees to prime the pipeline of folks maybe interested in doing more work in this area. And we created a seminar series on how to apply for a CDA that has since been adopted by the CDA enhancement program for all applicants.

We also provided technical support to improve the design and fundability of new research proposals focused on women’s health and/or gender differences. Initially that included expertise including Dr. Hamilton in qualitative methods. That was actually a very high-demand area, survey research, oversampling procedures for including women Veterans, intervention design and implementation science since so much of the work had been purely descriptive at the outset. We also generated medical journal supplements focused exclusively on women Veterans’ health research in response to the early difficulty in publishing. And we are on our sixth supplement currently. And I cannot emphasize enough the importance of the annual strategic planning to review our progress, to identify ongoing gaps, to involve new partners along the way and to adapt the agenda to changing needs and priorities including for example suicide prevention.

So let me give you that as an example of one of our most recent groups. Obviously, this is a top priority in VA and a top priority in VA Office of Research and Development and as a result also for HSR&D. There’s wide-ranging expertise. This is not an area that we in the consortium have expertise in, but there are wonderful groups out there and individual investigators at, for example the National Center for PTSD, the Rocky Mountain MIRECC for Veteran Suicide Prevention, CIVIC which is at the Portland HSR&D center and the VISN 2 Center of Excellence for Suicide Prevention. And then other people who are single investigators in centers that may not generally focus in this area. So we put together an ad hoc women Veterans suicide prevention work group with that same goal of improving research collaboration, grants and publications, ultimately knowledge of strategies of suicide prevention on a path to implementing evidence-based practice.

So as we brought this group together, one of the things the consortium does is provide pre-submission scientific scans to try and increase the fundability of grants. Really focused on methods since again we don’t really have specific suicide research expertise in this particular work group. We were very pleased that two studies got funded right away. Not at our centers. Again this is a national collaborative. And one IIR and one pilot have already been started and there are multiple other proposals under way.

We also asked the workgroup themselves what would be useful to them. And they said well, many of us have not worked together. Some have, and it would really be great to get an in-person meeting. So we requested funds from HSR&D and we actually just a few weeks ago convened an in-person meeting in VA Central Office. And as a result were able to include Women’s Health Services Office of Mental Health and Suicide Prevention leaders, folks in the epidemiology office as well who are leading major studies including suicidality, and also a number of defense health agencies and Department of Defense representatives all in one meeting to come together to create a research agenda and strategic plan for research in this area. And members of this group also suggested that it would be helpful to have a journal supplement given our prior success in these. So we negotiated with Medical Care, whose editorial board has agreed to be the home for a new journal supplement on suicide research among women Veterans, active duty Servicewomen and civilian women. And HSR&D agreed to fund this new journal supplement as well, and so hopefully you’ll be seeing the call for papers later is this fiscal year.

So this approach to systematic research development has really had its anchor and its goal in using research to transform women’s care to examine gender differences in health and health care, to determine what interventions need to be gender-tailored, to build partnerships to increase implementation of research evidence. We’ve also more recently engaged the Women Veterans Council for input and ideas all across these agenda areas as strategic priority areas. And within these we have work groups of people from across the country including both researchers and often clinician educators and operations leaders in the areas of trauma, substance use, suicide now our newest group, cardiovascular risk reduction, reproductive health and along the way we’ve supported an LGBT group which is almost among the largest nationally, with new work in community care and disparities.

We’re also focusing on reporting by gender increasingly. So as many of you know, NIH already regulates and monitors inclusion of women and minorities. And NIH has found that women are actually enrolled more than men outside the VA in trials. In the VA, the percent of women enrolled is actually greater than the percent seen in VA, but the problem is both inside and outside the VA, investigators are not publishing sex-specific findings. So the VA Cooperative Studies Program funded Women’s Health Research Network in a new journal supplement. This is being led by Karen Goldstein at the Durham VA. And in this case the call for papers said that papers must report sex and gender differences in VA clinical trial results as well as health services research studies with the goal of getting new data on treatment effectiveness among women. So were hoping that this is a carrot rather than a stick.

So I’m going to turn it over to Dr. Frayne now for the next section on the PBRN.

Dr. Susan Frayne: Great, thanks so much. So I’m going to tell you about the Practice Based Research Network that’s led by myself and Diane Carney who has decades of experience that she brings to this work.

So the next slide, the Women’s Health PBRN is a national network of 60 VA facilities that are partnering together to promote and support the conduct of multi-site research and quality improvement. So we support projects that specifically focus on women Veterans and/or their health care, but we also support studies that are not specifically women’s health studies but that are seeking to over-sample women to make gender analyses possible. There’s a Women’s Health PBRN site lead at each facility who’s primed for PBRN research and committed to improving the health and health care of women Veterans. The site lead has connections with local clinicians, clinic managers, facility leaders and researchers. And then our National PBRN Coordinating Center in Palo Alto fosters a strong national community of site leads and likewise supports researchers who are interested in using the PBRN for multi-site studies or program evaluation projects. All of our efforts occur in close collaboration with the Women’s Health Research Network consortium and engagement arms.

So I’ll paint a little picture of how all this works from first describing the PBRN’s core activities in relation to the sites, our 60 sites provide capacity for women Veterans health care research and multilevel stakeholder engagement. And then I’ll briefly describe our core activities in relation to researchers, explaining how we support their multi-site research efforts.

Okay, so first the sites. So the PBRN is a network composed of 60 of the 140 VA facilities for the United States. Our PBRN Coordinating Center in Palo Alto supports site development activities. And at the heart of this network are the PBRN site leads and co-site leads who are typically commissioned and are researchers and who share a common commitment to improving care for women Veterans.

On the next slide what do the site leads do? Site leads contribute to the national PBRN community as one of their roles. We see them directly networking with each other in [unintelligible 18:03] and making presentations on national TV or in calls. Another of their important roles is to support the local component of multi-site studies. So sometimes they do this as the site PI, but often they’re in the role of a site co-investigator or a site consultant guiding the PI on local recruitment issues and the local lay of the land and helping the PI to make local connections with clinicians, managers and researchers. A third key site lead role is to build their local PBRN community which may be composed of clinicians, researcher and managers. There is cross-site variability [unintelligible 18:38] local sites development but these activities can include for example local presentations about the PBRN or sharing information from national PBRN calls with local team members and so forth. And then site leads can also oversee local data collection and support of operations priorities which I’ll describe briefly on the next slide.

One example of local site PRBN-based data collection is the practice scan. This is a brief organizational survey that describes some aspect of the women’s health care delivery system. For example, one of our practice scans asked about LGBT screening practices at each site in our network. The second type of local data collection is a Veteran feedback project where sites administer anonymous questionnaires to [unintelligible 19:29] women patients coming to a primary care clinic visit. And in a recent Veteran feedback project where we asked women about their experiences with stranger harassment while on VA grounds, we collected more than 1,000 feedback forms across more than 20 sites with just a two-week data collection period. And then a third we have recently launched quality improvement collaboratives wherein a group of sites sign up to jointly work on QI projects in a high-priority area such as culture change or abnormal mammogram follow-up using evidenced-based quality improvement methods.

Okay, so what does the PBRN [unintelligible 20:08] Center to help sites build their local capacity for supporting future studies and contributing to a national learning healthcare system? One thing we do is to provide training in research and quality improvement methods and multilevel engagement techniques. The consortium, PBRN and engagement arms present on national PBRN calls and post materials on the PBRN SharePoint site. We also promote the learning healthcare system by giving PIs the opportunity to solicit stakeholder input on national PBRN calls, so as to ensure that there’s timely study findings that are disseminated that are relevant to front line providers, managers and leaders. And we do that in several ways including on research-in-progress presentations, and national PBRN calls were site leads have an opportunity to provide input to investigators about their study design, methods or findings. And then another important thing we do is to get the word out, sharing results and information as they become available so as to facilitate the faster movement of findings into practice. Researchers and QI teams present their results on monthly national PBRN calls and encourage site leads to spread the word in their local teams. We also disseminate information through our monthly newsletter and whenever possible we give the sites data collected from their local site benchmarked against national data.

Okay so now I’m going to turn to a brief description of how we support researchers. So first, at the study development phase we work with PIs to select the sites that are right for their study design, drawing upon our substantial knowledge of the site’s characteristics. So we connect researchers with the site leads who are the boots on the ground. Sometimes during the grant preparation phase we help the investigators to enlist stakeholders at the local site who are willing to provide input into development of the research design [unintelligible 22:06] type of community-engaged research. And we also provide technical consultation on multi-site research methods and clinic-based recruitment of women Veterans and connect investigators with the consortium for consultation around gender-tailored methods, or with the engagement arm of the Women’s Health Research Network for help with multilevel engagement methods. Once they get funded we help to support their study efforts through ongoing technical consultation and we help them address site-level issues like turnover of staff. We do have a thin interface model that is we don’t get involved in the actual execution of the study but instead help broker the relationship between the PI and a site lead. And then the PI takes it from there. When a study is drawing to a close we’re able to help investigators get the word out quickly about study findings through PBRN mechanisms like the national PBRN site leads calls and then the site leads in turn can share findings with their local PBRN community of clinicians and researchers. And then meanwhile the consortium has multiple pathways to promote dissemination and the engagement can help get the word out to women Veterans themselves.

So I’ll give you a few specific examples of ways that the PBRN can help researchers. First, because women represent a numeric minority group in VA it can be difficult to recruit enough women who meet inclusion criteria at a single VA [unintelligible 23:33]. Since the PBRN now represents over half of the women Veterans in the VA, enlisting multiple PBRN sites can help investigators to overcome the problem of an insufficient sampling frame of women Veterans.

This is especially important [unintelligible 23:52] investigators trying to ensure that diverse groups of women are included. For example, this graph shows one bar for each of the 60 PBRN sites demonstrating that the proportion of women Veterans from a racial ethnic minority group varies markedly by PBRN facility. Ranging from 4% to 92%.

The PBRN can help investigators who are planning an implementation study by providing them with connections to diverse practices that represent the range of real-world settings for women Veterans who seek care in VA. Our network includes small facilities with less than 1,000 women and large [unintelligible 24:30] with over 10,000. We have rural and highly urban ones and some deliver women’s healthcare in comprehensive women’s health centers whereas others provide care for women in integrated gender-neutral clinics. There’s 21 that are affiliated with HSR&D Centers but we also have many sites that are located at facilities that often are not included in our research. And in many cases we have multiple sites within a single VISN which can be helpful for studies with cluster randomized control designs.

Again and again PIs tell us how much they value our wonderful PBRN site leads who have tremendous commitment to building the evidence base so that they can then help to improve the quality of care provided to women Veterans. Site leads know how the women’s health delivery system works at their local VA and they maintain relationships with clinicians and leaders at their sites. This can really help the PI with multilevel stakeholder engagement efforts and the site lead can help the PI navigate the local site effectively, avoiding any local landmines.

Next slide. Another of the ways that we add value for PIs is that we know our sites and we can help the PI identify sites well suited to their research question rather than just having to rely on the convenient set of places where the PI happens to know someone. We help investigators identify the sites that will be a good fit for their study, we turn to our site database where we curate data from multiple data sources about patients, providers and facility characteristics. Once we know which sites the PI is interested in approaching, we can help the PI to craft a brief description of the study that includes things that we anticipate the site leads are going want to know. And then I go ahead and sent an email to each of the candidate sites to provide basic information about the study and see if they’re willing to discuss their potential participation in the study with the PI.

Okay so next slide. To summarize, there’s a number of ways that the PBRN adds value to investigators who are doing multi-site research in the PBRN. We know our sites well and can help the PI select sites suited to their study needs. And we have strong connections with our national site leads community so the site leads are very responsive when we do the warm handoff of the PI to the site leads. Overcoming the problem of small n, the PBRN gives PIs access to sufficient numbers of women Veterans, helping the PI to meet mandates for inclusion of women. And then we can provide technical expertise around strategies for recruitment of women Veterans from clinical practices. The PBRN also gives PIs an entree into a diverse set of

clinical practices representative of the range of real-world settings where women Veterans receive care nationally in the VA. Of particular importance for intervention and implementation research, the PBRN provides investigators with primed sites that have already been working or developing local connections and engaging clinicians and leaders in the mission to improve women Veterans’ health care through research and quality improvement. We’re also able to help investigators with proposal development by providing practice-based data preparatory to research. And increasingly we’re offering investigators the opportunity to enlist the input of various stakeholders such as clinicians, leaders and, particularly going forward, women Veterans themselves, through the engagement arm of the Women’s Health Research Network. And finally, we’re committed to developing processes that will increasingly allow us to use the PBRN first spread of promising practices and evidence-based interventions.

Okay so putting it all together. If you’re a PI who’s interested in applying to use the PBRN, please contact Diane Carney who’s the program manager of the PBRN and cc me. Ideally if you can contact us at least 2 months before your grant is due, that maximizes our ability to be helpful. And then we’ll send you a short form so you can provide us with information about your study, after which we’ll have an exploratory call to look at the fit of your study with the PBRN. If it looks like the study will be a good fit, then Becky Yano and I would prepare a letter of support for your proposal, indicating how the Women’s Health Research Network will be involved. In some cases a PI wants to specify sites in their grant proposal and that takes more lead time that we can facilitate contacts with those sites to determine their willingness to participate and if so, the PI works directly with the site lead to negotiate the specifics of the site lead’s role, local budget if applicable and so forth.

Okay so our PBRN coordinating center team in Palo Alto is happy to hear from you so please do reach out to Diane Carney and myself as early in the grant preparation process as possible. And now I’ll turn it over to Dr. Hamilton for an overview of the engagement component of the Women’s Health Research Network.

Dr. Alison Hamilton: Thank you Dr. Frayne and thank you Dr. Yano for managing our slides. My pleasure to share with you just a little bit about our multilevel stakeholder engagement component of the Women’s Health Research Network. I do want to point out that what I’ll be sharing is explained in greater detail on a couple of other Cyberseminars, the dates of which are on the slide. So I’m just going to give you some highlights from what I shared during those Cyberseminars.

So first I just want to briefly describe to you our adaptive model of community-engaged research and then give you a flavor for some of our results from the study that my colleagues and I conducted about multilevel stakeholder engagement. Looking at real briefly researchers’ perspectives on engaging patients and providers, and how do we do a better job of increasing Veteran engagement in research, looking at some of the consistent themes that came up across this research.

So what we did overall in the Women’s Health Research Network was look at a model of community engaged research, sort of on the spectrum of engagement in terms of one end being community based participatory research all the way to one end, and then non-engaged research on the other end. And this is probably considered by most to be more of a middle of the road model of community engagement. And what this model depicts here is how our efforts to understand multilevel engagement from the perspective of stakeholders and all of the components of that that have been shown in the literature, such as increasing in trust and respect and shared language, relationship building, that the results of this work will help to infuse and inform the consortium and the PBRN that you’ve already heard about so that overall we’re looking at a stronger stakeholder/researcher partnership and stakeholder responsive research and more and more stakeholder driven or funding evaluation, which we are hoping will lead to increased intervention, implementation and high-impact research. And this is a model that we adapted from Isler and Corbie-Smith on community engaged research.

So this study that I conducted was a PBRN study, so it just kind of reinforces the points that Dr. Frayne brought up about the PBRN where we were really fortunate to have the involvement of five PBRN sites and lots of incredible support, couldn’t have done it without them at the sites including those site leads and other folks who were interested in helping us and willing to make the connections that we needed. So many thanks to those sites and personnel.

So what we did, just really briefly, was we conducted interviews, qualitative telephone interviews with researchers, mostly implementation scientists and health services researchers. And then at the PBRN sites we conducted interviews with women Veterans, primary care providers and administrators, and transcribed all of the interviews and summarized them and are still in the process of analyzing them.

So I’m just going to give you a little flavor for the types of things that our participants talked to us about in terms of engagement and how to do more related to engagement. The researcher when talking about engaging patients said, “When the patients do speak, either through their collective opinions in focus groups or interviews, or when they're at the table, clinicians and researchers pay attention…They’re the people we're trying to help. So that carries a lot of weight…I don't see it as the norm, but I think as it relates to organizational or system change, it's hugely helpful. You don't do it at your own peril.”

Researchers also talked about the value of engaging patients. Like this researcher said, “Our experience…has really impressed upon me the importance of training researchers on how to actually be present, be honest, be clear about the expectations of what engagement means, but also the incredible promise for what engaging women Veterans in that whole CBPR (community based participatory research) approach could mean.”

As you heard from Dr. Frayne and Dr. Yano’s presentations, we are really committed to engaging providers as well as Veterans and administrators in our research and policy-maker. I won’t get into the details of this slide, but what this researcher is talking about is the critical importance of engaging providers, recognizing that their time is scarce, that we have to study things that are important to them, and that they need to be connected to the end results and if we don’t pay attention to the circumstances of providers then we might not yield the results that we’re interested in.

So just looking across our results, across the women Veteran participants and the primary care providers and the administrators, we did find some common themes that came up across all of these different groups. They’re indicated in the first line there. Number one really being that women are not aware of the opportunities that might be available for them to participate in. That was really a pronounced theme, that people just don’t know and providers don’t know either for that matter. That they distrust research due to a whole combination of factors, that they have a lot of competing priorities that might get in the way of participating in research. And that also might contribute to limited time to be able to participate. Women might have some confidentiality concerns and also fear of exposure and jeopardizing their benefits with concerns about revealing certain information about their health and health care.

Next slide. Fortunately our participants had a lot of recommendations for how to increase the engagement of women Veterans in research. They talked about the potential of using MyHealtheVet as a mechanism for increasing engagement. They talked about the importance of warm hand-offs from providers and staff to Veterans. How to help explain what the research opportunities are. They talked about the idea of developing a recruitment repository where people who are interested in participating in research can provide their information to such a repository and then be notified of studies that they might be interested in. They talked about the potential value of developing a research registry so that more information is out there about what types of research are going on and what those potential opportunities are. And they emphasized over and over again that researchers need to do a better job of communicating the details of research. Why the research is being done, what privacy and confidentiality measures are being taken and what the potential impact of the research will be. And some other ideas that you can see there. Next slide.

Another theme that came up a lot across this study was the importance of disseminating findings and researchers, Veterans, providers and administrators said that researchers are not doing the best job of getting findings back to their participants in ways that are meaningful and that that actually does not help to foster trust in the research endeavor because they feel like we as researchers kind of plunk ourselves down and [unintelligible 37:31] never share what we learned. This researcher said, “Our community partners really keep us honest about bringing back results…Now from the very beginning, we're already planning how we're going to go back and disseminate, so that it doesn't just fall off in the end. Because a lot of times you get to the end and it's like well, we've got to find funding for the next piece or we're doing something else. We write it in as even one of our aims on the community side to make sure we're disseminating in the community venues as well.” So this just exemplifies this point that it really needs to be thought about in the very beginning in a very conscientious fashion and thought through throughout the duration of the project to make sure that there’s a plan for dissemination of results. Next slide.

There was definitely uniform agreement that engaging Veterans, engaging providers, engaging administrators was absolutely valuable and imperative. One researcher said that, “Our [strategic Veteran] council has given us a really strong sense of what their priorities are...That helps us understand how to both frame and prioritize the many analyses and papers we may do out.” And another said, “When you can take your end user and have their input at the beginning of the creation of a product, it’s golden. So I really, quite frankly, have trouble understanding why people don’t employ this systematically.” Next.

And finally, just to close up this segment of our Cyberseminar, a powerful quote. A researcher said, “I don't think stakeholder involvement is something that is going to go away, I don't think it's a passing fad, I think it's going to stay with us and it will evolve and hopefully become even more central and more built-in to what we do.” And that is certainly an attitude that we embrace in the Women’s Health Research Network. So now I’m going to turn it back to Dr. Yano to finish us up.

Dr. Elizabeth Yano: Thank you so much, Alison. So just a last few points about our journey and experience over the last batch of years in leading this work. We’re really pleased [unintelligible 39:38] demonstrate that there has indeed been major increases in VA women's health research funding over the course of the initial agenda setting all the way through our present day in both VA-funded projects and career awards.

There’s also been a major increase in the publication of women Veterans research. The first systematic review of the literature went back to the earliest papers we could even find in the mid-80s and we had it updated through the VA Evidence Synthesis Program and found that more research had been published in the past five years than the previous 25 years combined. And then we requested, in partnership with Women’s Health Services, an updated review that found nearly 500 articles and a dramatic increase in topic diversity to the point that the EFP program indicated that they’d have to do an evidence map rather than systematic review. And in fact that map has been published in the Journal of General Internal Medicine and has pointed to the buckets of literature that we’re now working with our strategic research development work groups to do formal systematic reviews.

We’re also pleased that the Women’s Health Services research portfolio size and diversity is growing. Obviously we need to continue with important work in PTSD and military sexual trauma as well as intimate partner violence and the like, but as you can see here there is work on gender tailored trauma-sensitive yoga, mindfulness-based stress reduction. There’s important work going on since women Veterans tend to use community care at a higher rate than men do. Recently completed studies on the quality of non-VA or Choice care and what women Veterans experience. There is a career development awardee at VA Palo Alto focused on justice-involved Veterans and she’s looking at both men and women Veterans. A lot of work in homelessness, sleep disorders, both sleep apnea and insomnia, cardiovascular risk reduction, diabetes prevention. Important work that we don’t have time today to review, but Dr. Hamilton is leading the EMPOWER QUERI and that included gender-tailored interventions for CVD risk reduction, diabetes prevention and collaborative care for depression and anxiety. There’s novel work on trauma-sensitive primary care delivery and new studies in reproductive health that are very important. Dr. Borrero at CHERP has probably recently concluded or maybe continuing work on contraceptive use. There’s work on preconception care going on in Seattle, maternity care coordination and pregnancy outcomes at multiple VAs and the like. So just really pleased that the agenda and the work ongoing is representing more of the lifespan of women Veterans’ care.

So in conclusion, the VA Office of Research and Development, and within that VA HSR&D service, have made major inroads in advancing women Veterans research to increasing inclusion of women Veterans in VA research, enabling appraisal of gender differences and gender tailoring of interventions and implementation studies. There’s clearly been an increased emphasis on high-priority topics, in access, suicide prevention, mental health and community care, and increased engagement of women Veterans in research priorities, design and dissemination, as well as increased reporting of research on women’s health and gender differences. In our experience over this journey, collaborative virtual research networks do have the opportunity to contribute important and substantive increases in research impacts and advance learning health system principles.

So we want to make sure that you know where we live. You have an opportunity to contact any or all of us as needed for information or technical support for using the PBRN, for better understanding some of the issues in multilevel stakeholder engagement and the like.

And also that there are resources online that may be helpful as well. So with that, we will conclude and see if there are any questions that come in to the chat box. And thank you all very much for your time and attention today.

Molly: Thank you. So for our attendees that joined us after the top of the hour, to submit your question or comment please use the GoToWebinar control panel located at the right-hand side of your screen. I’m going to pause real quick. Becky, can you put up that last slide please?

Dr. Elizabeth Yano: Yes I can.

Molly: Thank you. So for our attendees down towards the bottom of your control panel is the [unintelligible 44:22] questions, just click the arrow that you find next to questions and that will open up the dialog box and you can then submit your questions or comments there and we jump right into it. The first one that came in, is there a link to view the info in particulars about the individual PBRN sites, staff and efforts?

Dr. Susan Frayne: Hi, this is Susan Frayne. Thanks for that question. So we actually are happy to provide people with the specific sites as needed. We just like to, if you just shoot us an email we can send you a roster of all the sites which tends to be dynamic. We have some turnover occasionally of a site so [unintelligible 45:03].

Molly: Okay, so that would be best directed towards you? [unintelligible 48:08] Frayne.

Dr. Susan Frayne: Thank you.

Molly: Okay. Becky would you mind actually backing up one slide so that we have people’s contact information up as well? Perfect.

Dr. Elizabeth Yano: Absolutely.

Molly: Thank you. So there is your contact info. The next question. How do you apply to the Women’s Research Network to find collaborating sites for a study?

Dr. Elizabeth Yano: Go ahead and email myself and or Ruth Klap. What we have basically is a very large professional network of investigators, clinical educators and operations partners. So what we often get, and we sometimes get a dozen pings a week. Other times it’s a little slower than that. And it will be someone saying I’m interested in cardiovascular risk reduction, I want to do a fellowship project, I want to do a career development award. And we’ll connect you to the folks that are already funded in that area. And if we know that it’s of particular importance to Women’s Health Services or the Office of Mental Health Services and Suicide Prevention within which we partner with the women’s mental health group, we are happy to provide introductions to those folks as well. So just feel free to email us and we will try and connect you to the right folks, including participating in some of those work groups I mentioned earlier. Those are very good venues for identifying other people with whom you might be able to collaborated.

Molly: Thank you. We are still waiting for more questions or comments to come in. So for our attendees, while we have captive presenters please submit any questions or comments you may have. And while we wait for any of those to come in, would any of you like to make any concluding comments? In so specific order, Becky we can start with you.

Dr. Elizabeth Yano: Well we just, this has been I’d say a remarkable journey to really understand how to engage frontline providers, their staff, managers, leaders, researchers and women Veterans in collaborative research design, priority setting and conduct and dissemination. It’s been an extraordinary experience in terms of both pipeline and in terms of what it takes to build a consortium of people interested in making research impacts. The timing for today’s talk was particularly important because this week we have the HSR&D Center of Innovation or COIN directors’ meeting. And because of the work that’s been ongoing in this area, there has been substantial interest in organizing additional collaborative virtual research networks. And this has really helped us think hard about the aspects of the work that we’ve done that could be translated into other topical areas that are high priority. So this is not just even the people that you have on the screen, it’s hundreds and hundreds of people across the country who engage in different ways to advance evidence-based practice that we can improve population health. Anyone who’s interested in joining on any level, do know that this is a very collaborative group and we’re very happy to help. Susan?

Molly: Oh, actually I’m going to interject real quick. Thank you for that. We do have a question that came in for Dr. Hamilton. Where can we find full report of the stakeholder engagement study? Either Cyberseminar or publications or something else?

Dr. Alison Hamilton: Thank you for that question. There are a couple of Cyberseminars. One that presented more of the researcher results and then another that presented the results from women Veterans. It was a joint Cyberseminar last spring with Melissa Dichter on including women Veterans in research. The dates were on the first slide of my section. Of course I don’t remember them off the top of my head but if you look for my name in the Cyberseminar catalog you’ll find those couple of Cyberseminars. And then, the full reports are forthcoming in terms of publication that we’re working on now. And so hopefully those will be coming out in the literature within 2019.

Dr. Elizabeth Yano: And the two dates were October 12, 2016 and June 6, 2018. So they would be on the HSR&D Cyberseminar archived list.

Dr. Alison Hamilton: Thank you.

Molly: Thank you for plugging that ladies. So for anyone that has a mentor archive page, in the upper right-hand corner is a search function so you can type in any of these presenters’ names or women’s health and you will get a complete list of everything that’s been done since 2012. [inaudible 50:05] that’s helpful. And looks like again, while we wait for any more we can just move right along. Susan do you have any concluding comments you’d like to make?

Dr. Susan Frayne: Yeah, I think I’d just echo what Dr. Yano said that really the big picture in the Women’s Health Research Network is the commitment to long-term relationships and collaboration. And that goes between different disciplines, between clinicians, managers and researchers. It goes vertically between national and regional leaders and front line staff. And it goes horizontally across sites. And it’s really what makes all of this work in service to women Veterans’ health care. So we’re really glad for all the people who are on the call today and you’re interested in kind of being part of all of this work, so thank you.

Molly: Thank you. And I’m going to interject one more time with a question. Can you say more about the evidence map of the WV health research and how we can find it.

Dr. Elizabeth Yano: You can basically, I don’t have the URL memorized, but if you Google VA Evidence Synthesis Program, it will bring you directly to the web link for the ESP and within that you can also search on women’s health and it will come right up, the full report. If anyone wants the specific paper we’re happy to, just email me and we’ll send you the PDF of the Journal of General Internal Medicine paper that resulted from that systematic review. From that evidence map.

Molly: Thank you. And while we wait for anymore, Dr. Hamilton would you like to conclude with anything?

Dr. Alison Hamilton: Sure, thank you so much Molly. I think the one thing that I would like to mention that I didn’t have time to before with regard to engagement is that this work that we’re doing in the Women’s Health Research Network is really connected to a larger context of increased focus on engagement and research by HSR&D and a national work group that we have on this topic. We’ve had it for about three years now. The work of Sarah Ono and Justeen Hyde and team on the SERVE Initiative where they put out a toolkit on increasing Veteran engagement. So there are many, many efforts going on in this direction and we are really thrilled to be a part of that and our focus on women Veterans but just an overall increased focus by HSR&D and VA on increasing engagement in research which we’re very happy to be a part of. So thank you for that opportunity.

Molly: Well thank you so much to the three of you coming on and lending your expertise and giving us your valuable time. And of course thank you to our attendees for joining us and to Ruth Klap who helps organize the Women’s Health Cyberseminars, which by the way we have two more coming up this month, so please check your emails for those marketing emails. And with that, I am going to close out the session in just a moment. For our attendees please wait while the feedback survey populates on your screen. It’s just a few questions, but we look closely at your responses and it helps us to improve presentations as well as the program as a whole. So once again, thank you very much everybody and this does conclude today’s HSR&D Cyberseminar. Thank you Alison, Becky and Susan.

[END OF AUDIO]