David: It's a real pleasure to be here with…to talk with my colleagues Naomi _____ [00:00:06] and Amy Kilborn about HSR&D and reflect back on what's happened since the last time we were together. It seems like a decade ago, but it's been 17 months of pandemic and longer than that since we last met in Washington. And if I've learned anything it's how much I miss the chance to meet all of you in person. And so here's to hoping that that's in our near future. Next slide. I'm going to talk about four things over what I hope will be 25 minutes. Sort of some reflections on what I think we learned. Some celebrations of all that we've accomplished. A quick review of trends in funding an HSR&D and OR&D. And then I'll close with where we are with some strategic planning exercises and then turn it over to Naomi and Amy. Next slide.

So bottom line up front, this is a technique everyone in VACO has learned to use, so that people can come away with some points and then go back to keeping up with their email. I think we've learned that COVID revealed many of the flaws of US healthcare. I don't need to belabor those, but it just emphasize that we still have deep health disparities. We have a fragmented healthcare system that can make it hard to respond in crisis. We have underestimated in…under invested in public health, and on top of all that, our polarized politics have hampered our ability to balance questions of science with questions or values.

The good news for us in the VA is I do think we were better able to respond for a number of reasons. We were well-equipped to use our national data. We could surge resources from one parts of the country to the other. We were even able to take in nonveterans in areas that were overwhelmed by COVID. And we were able to implement effective policies earlier such as policies barring visitors into nursing homes and other measures. I think we were really demonstrably ahead of the game. It'll take more time for us to actually get hard data on whether the outcomes in VA were demonstrably better. But I think we have many signals that they were.

The research community both in VA and outside did amazing things in this. And I would claim that many of the best COVID data either came from national health systems often in places like the UK or Denmark or it came from the VA. And so the lesson I hope we'll take away from this is that we need to work hard to retain what worked. We need to learn from things we tried that maybe didn't work. And that means, continue to build on our strong data infrastructure, promote the ability to work together collaboratively in teams, and to continue the hard work of reducing the administrative regulatory obstacles. Next slide.

So if we had to summarize up to 2020, the Rotten Tomatoes review would be pretty simple. Next slide. But I think we should understand that for all the hardships that we went through, it really was an important year of change. We certainly didn't perform well in many important ways, but science

progressed amazingly. We had along with this an important reckoning over where the lack of progress we've made on important issues of racial progress. We've navigated unevenly online learning. And we seem to have hopefully finally have gone through contentious election period. Next slide.

So I want to talk a little bit about COVID and what we've done both in ORD and HSR&D. And I think of sort of three phases of research. The first phase we were desperate to find anything to work and to get up studies, vaccine trials. ORD set up a workgroup within days of when we went into remote work and when the pandemic was declared. This was across service workgroup. We joined Operation Warp Speed efforts to stand up trials. We used VA data to see if there was any signal that some of the medications that clinicians were trying were having any effect. Hydroxychloroquine being the most notorious example of that. And we started to brief studies using VA data about modeling who's at risk.

In phase two when we started to have evidence of some effective therapies such as steroids and possibly remdesivir, we became part of an FDA collaborative to develop some real-world effect in this work. Our basic science colleagues and colleagues in MVP stood up studies to understand the basic physiology. We continue to build the research infrastructure. Cooperative studies stood up a large inception cohort with DoD to enroll thousands of newly infected patients. And we stood up some new investigational treatment trials. And now I would say we're sort of in phase three where we are focusing on the rollout of vaccines, trying to understand the impact of new variants, looking at vaccine hesitancy. And I'll talk a little bit about some HSR&D efforts on these last two issues. Next slide.

HSR&D really was a major contributor to our overall COVID efforts. Began with the evidence synthesis program which stood up very early on a website that has over 7000 international reviews about COVID and review protocols. Our colleagues at Vinci stood up to COVID, share data resource to provide curated data including many elements that are not easily available in CDW, but that are essential for studying outcomes of COVID. We initiated a rapid response mechanism where we could offer supplements or short-term funding to try to study various aspects of the pandemic. We had over 100 applications and funded 25 projects under that and learned of a lot of interesting things. A number those studies were about COVID and mental health. And we drew together people who were interested in modeling efforts and continue to work that.

Right now I would say the HSR&D efforts are focused in three broad areas. We have a solicitation out and are reviewing 15 projects to look at the impacts of the delayed and deferred care during the pandemic. We know already that overdose deaths are up. Reassuringly, suicide deaths do not seem to be up. But there are many things we don't know about what happened when care was interrupted for our vulnerable patients. We are conducting a

national mortality study to look at the changes in all-cause mortality and try to figure out how much of that is COVID and how much of it may be other factors.

The second area is looking at long-term outcomes of COVID. This is sometimes called long COVID or PASC. Post-acute symptoms of COVID. And we have a collaboratory called CORK, which is managing that work and they are conducting a multiyear study to look at outcomes up to 24 months using medical record data and surveys. And then lastly, we're doing work looking at vaccine attitudes. We know uptake among our older veterans has been quite good, but there is still…we still have the same pockets of vaccine hesitancy, which is a complicated mix of different issues. And we are launching a major trial to see if we can have an effective primary care based intervention to address vaccine hesitancy. Next slide.

So the coins contributed, and this is a bill, so if you could just scroll through gradually. Contributed in multiple ways to the fight against COVID. We had studies that implemented…that affected VA policy such as our important study that looked at Pulse Ox devices showing that the readings in patients with pigmented skin—African-American—patients were systematically different than in white patients. Next slide. We had many of you clinician researchers were involved in the direct clinical response at your facility. Aaron Krebs led to primary care COVID response. Eli Prince _____ [00:09:16] Iowa City as an infectious disease epidemiologist and clinician was a major part of their response and many more. Too many to mention. Next slide.

We did important research to understand the pandemic. A study in Indianapolis documented that as ICUs got filled to capacity, the mortality seemed to go up. A study from our Ann Arbor colleagues showed that even after discharge, complications of COVID were frequented and readmissions were frequent, but actually no higher than readmissions for equally ill patients who had gotten influenza. Multiple teams looked at important questions of racial disparities in testing and mortality. And I think the take-home message is that there were disparities in the risk of getting COVID, but reassuringly in VA, getting tested for COVID and surviving if you got infected with COVID did not show differences between white, Hispanic, and Black patients. So we have not conquered social disparities of health, but VA has done a good job in providing comparable access and outcomes. Next slide.

The work involved working directly with program partners and query stood up three teams at the request of the National Center for Health Promotion and Prevention, which is leading the immunization campaign to study vaccine hesitancy. Next slide. And then finally, VA researchers were a critical part of making sure we had good data to guide this pandemic. Makoto Jones, researcher from Salt Lake City has really been working full time making sure

VA's COVID data in the national surveillance tool was reliable and dealing with the many complications of how testing and test results are recorded and data coming in from outside the VA. Next slide.

I just want to highlight a small handful of studies that got a lot of attention. This was a study showing that there certainly was a higher risk among Black and Hispanic patients for getting COVID as we know often related to the social determinants of health or people's roles as essential workers or living in more crowded situations. Jim Rudolph's team documented that the way we were screening for COVID using temperature was not successful in elderly veterans, and that led the policy that changed…lowered the temperature threshold for raising suspicions of infection. Next slide. Among multiple researchers, the team out in Seattle developed a model using all seven million veterans to try to model who is at risk of dying of COVID with the idea that this could be used in prioritizing vaccine. An interesting model that combined both risk of getting COVID and risk of progressing to severe disease.

And as I mentioned, our systematic review done by our evidence synthesis program looked at racial and ethnic disparities both in the VA and outside the VA. And interestingly looked at previous pandemics for context showing the important role of social despair…social determinants of health and how pandemics effect different groups. Rachel Warner one of our investigators, however, did publish an important study outside VA in COVID that the care provided to patients especially in places like New York City did show evidence of…I'm getting a message about my connection.

Unidentified Female: We're hearing you without a problem.

David: Okay, great. I just wanted to make sure there wasn't an interruption. Next slide. So what did we learn about research in all this? Well, it's critical that we have season researchers with access to well curated data. Bottom-up innovation is great, but I think we learned in the pandemic that standards are important and coordination across teams is beneficial. We did know that COVID produced a lot of bad science along with the great science. There are hundreds of retractions if you tend to follow those things. And I think we worked in the VA to make sure that things that were coming out…we were not controlling what people were publishing, were working hard to make sure that we were aware of it and that we were using the best data possible. So in the end, some combination of pre-existing infrastructure, a mixing of top-down priorities and bottom-up innovations, and mechanisms for collaboration seem to be the secret of things that worked during COVID. Next slide.

It wasn't just COVID of course. I want to acknowledge that throughout this all, we continue to do our research. We had over 2,000 publications from over 380 active projects. I want to just call out a few notable projects. Next slide. So these were papers from the Indianapolis team that has been working on stroke for over ten years. Quality improvement intervention that improved

outcomes for patients with new ischemic stroke. An important study showing the effect of social workers in primary care teams to reduce emergency care visits. Next slide. One of our most highly cited studies was one showing that empiric anti-MSR. Anti-Mercer therapy actually increased mortality in patients. Again, emphasizing the need for antibiotic stewardship and more targeted antibiotic use.

And then a paper that's actually important to very current conversations showing a temporary financial assistance, improved the ability of homeless veterans to become stably housed. That was in the discussions on Congress recently as we worry about the eviction…the suspension of evictions being lapsed. And they were very concerned that we continued assistance for veterans so that they don't end up homeless again. Next slide. Couple other highlights. We had two new service directed initiatives on social determinants of health and opioid safety. We launched a collaboration to study the implementation of Cerner. We launched our fourth consortium of care on virtual care and a smaller collaboration led by Kristin Maddox to coordinate our study on Mission Act. That helped contribute to a special journal supplement in medical care on VA community care. And we released a special supplement from a symposium on embedded research. Next slide.

I want to quickly callout awardees during this period. We had Will Yancey got best paper. Health System Impact award was shared by Adam Gordon and Hilde Hagedorn for their work on medication therapy for opioid use. And Ruth Clapp with the Women's Health Research Network who did some critical work looking at harassment of female veterans. Got a lot of attention on the Hill. And Matt Sheneman was recognized for a long career of being an outstanding mentor at Chirp on his work on mental health and substance use disorders. Next slide. I have the luxury of recognizing not one but two undersecretary awards. Matt Seymour who received the 2019 award for his work at the intersection of infectious disease antibiotic use and data science and health information technology.

And just recently—next slide—had the pleasure of announcing the 2020 undersecretary award for Donna Washington out of greater L.A. who devoted long career to studying the most honorable populations in the VA both racial, and ethnic minorities, the homeless, and women veterans. Next slide. And I won't go through all of these, but just highlight Donna Selman for her best methods article and Stephon _____ [00:18:39] was recognized by _____ [00:18:40] for his advocacy for patients. Both homeless patients, patients with substance use, and mental health conditions. Next slide.

So I want to talk a little bit about funding and then move on to some strategic planning. So this is the funding trajectory over the last seven years. It just basically parallels the funding trajectory for the Office of Research and Development, so that's good news. The next slide. This shows that we've had a stable supply of applications running around a hundred applications per

cycle. And because of our funding, we've been able to maintain what I think is a generous approval funding line of 20 percent or more. This is above the other services in an ORD. Next slide. If we look at where we're spending our total budget, you can see that the vast majority of our budget is spent on merit reviewed research. We have grown slightly our research…our capacity building which covers career development and research career scientist, and we've had a slight uptick in our funding for centers. This reflects the addition of four cores and of the Dole Center on caregiving research in San Antonio.

I think the one change that does standout a little bit is that there has been more rapid growth in that component of our merit review research, which has a more partnered or directed component. Next slide. So for to summarize this all that we've had a steady increase in our budget, but if we take in account the growth, inflation, and salary growth it's really only slightly been above steady. We have nonetheless been able to launch new COVID initiatives and these other new initiatives such as the cores of rivers without cutting into our funding for our investigator initiated research. If there's been a shift, it's been to that component of investigator of research that has more of a partner involved component or some directed towards priorities coming from HSR&D.

Naomi will talk more about the need in all of this to expand our efforts to address diversity and equity among our research community. And I would just close by saying that I do think there are areas of our portfolio that are ripe for a refresh. We are getting two new scientific program managers. One in aging and long-term services supports and one in health informatics who be talking about this. Next slide. How is the organizational context for HSR&D changing? We are within a group called, Dean that includes four components. We are working with our partners in the Office of Academic Affiliations who fund our HSR&D fellowships. And that solicitation is out now with some revised learning components organize towards research and a learning healthcare system.

We are also working with our partners in what is now dubbed the Office of Healthcare Innovation and Learning. This includes innovations Sim Learn and the Center for Care and Payment Innovation. This is something that was part of the Mission Act that wanted the VA to study different ways of paying for care that could be cost neutral but beneficial. So I think this has created some new opportunities for us to infuse research into these other activities that are within the Dean organization. Next slide. So I'm going to close now with some comments. I probably only have to rush this into five minutes, but to say, where do we go from here? So I think the first question as we look forward is to think, what is the business that we're in? And sometimes this is framed as a tension between are we about generating knowledge or are we about solving problems? And I would say we're about solving problems.

We want to be valuable to the VA not just published papers but solving those

problems where the problem is due to a knowledge gap. And this is to point out that not all the problems VA and maybe not even the majority of problems that the VA confronts are a problem of knowledge. Many of them are problems of implementing what we already know and that's like we have a program like QUERI, which Amy will be talking about. But the second point is that research can help strengthen these other ongoing activities whether they are a valuation, quality improvement, or renovation because we can collect deeper data than they can typically do in their activities. And as a result of that kind of partnership, we can understand not just what happened, but why it happened.

Many of our partners have good data. They can tell us whether their programs have and implemented, but they often aren't able to understand what went well and what didn't go well. Next slide. Sorry. Next slide. So what other things can we take away about what our unique capabilities are in a learning healthcare system? And these are recommendations from a conference two years ago on embedded research with partners like Kaiser or funded by ARCH and PCORI and the VA. And they had six sort of recommendations about how to make research within a living healthcare system successful. The first was to strengthen bidirectional relationships with healthcare leaders and research to understand what the system priorities are and where there is potential alignment with research. That if we want to serve our health system partners, we probably need to have a portfolio of projects with different funding streams and timing.

Not everything can be answered or is well-suited to a four year IIR. There should be some shared governance. We probably need to expand our toolbox of study designs to match system need. And we need to develop new career trajectories for embedded researchers. And I think we already see this in programs like QUERI and elsewhere were often patients…often our researchers do some research. They're interested in implementation and sometimes they get funding directly from partners. Next slide. So I want to close with just some reflections on some strategic planning. And I think it's important to think, what problem are we trying to solve with a strategic plan. And I think there are a number things. One is we want to increase our impact on VA practice.

We have many examples of impact on VA practice, but we want to make that the rule rather than the exception. We have a finite budget that I think implies we have to be strategic in investing research dollars. And specifically we want to make sure we're targeting gaps based on a systematic review of what we have funded and what knowledge gaps there are. I do think we have opportunity to capitalize more consistently on the unique capabilities of the VA system that involves our national scope, our high-quality data, and the specifics of our population. I don't think we need to be doing single site interventions on single chronic diseases. Territory that's well covered by NIH. We want to think about scope and scale. I think there's an opportunity

to expand our effective partnerships with other funders. We've done this well with the pain management collaboratory, and hopefully we can expand on that. And none of this will work unless we make VA the most attractive place to do health services research. Next slide.

What have I heard from CRN directors as we've gone on this journey? I think they had four important comments. One. We need to balance top-down and bottom-up approaches otherwise we'll risk losing innovative research NIH. And so I want to reassure people that even as we promote more partnered research and more targeted initiatives, we are going to preserve a substantial component of our research budget for bottom-up innovative ideas. We are also cautioned about setting priorities based on partners alone. Partners change. Their focus is often short-term or driven by budget. So their input is critical, but it can't be the sole driver of our research. These partnerships take time and investment. Not all of them are going to succeed. And lastly, I think this may be the most important point, a real role is our ability to bring evidence to the change process in the VA.

Those of you who have been in the VA for a long time know that VA change. The pendulum swings back and forth. Different things get momentum. Some of them based on the trends of the day. Not all of them based on evidence. Research can help protect against obsession with what something that looks like a shiny new thing. And we can help verify when an innovation is really an improvement. Next slide. So I'm going to close with just what our three goals from our strategic planning are. One is to ensure that we generate high quality…research that generates practice. And this has two objectives under it. Increasing the ability to target research to well-defined critical evidence gaps. And to revise update our funding criteria to emphasize studies that leverage unique capabilities of the VA. Next slide.

Goal two is improving research efficiency. This is not news to anybody. And I think there is strong support for this. We want to reduce obstacles in HR and IT. We want to increase computing capacity and data support so that we can do cutting edge data science. And we want to be able to allow researcher to build on the work of their peers to make it easier to reuse data. And hopefully many of you heard about Cypher which is a database to help reuse data algorithms and definitions. Next slide. Last goal is about the research week workforce. And this will tee up a discussion from Naomi because we need to improve our ability to recruit a diverse and talented workforce and retain them. And we specifically need to look at incentives to retain our best researchers and recruit new talent into the VA.

So my last slide. Next slide. So where are we going from here? We're going to be standing up three workgroups to develop specific strategies around these. I envision that we will be expanding various exercises to develop some more systematic review of our research portfolios and identify specific priorities. This will expand on tools like the _____ [00:30:52] and the core

led agenda setting exercise. We hope this will inform a standing program announcement in the fall of 2022. And most importantly, many of these issues will be aligned with ORD level efforts to look at diversity and to look at research efficiency. And with that, I'll turn it over to Naomi.

Naomi: Thank you David. I hope everybody can hear me. Thanks so much for the opportunity to provide a very brief update on diversity, equity, and inclusion nationally as well as within HSRD and ORD. This is our first, hopefully our last virtual State of HSRD meeting. I like David and many others hope that we can meet at the next meeting so we can see each other and interact and discuss at a deeper level. So next slide please. Okay, so here's the bottom line up front. David has his, I have mine. Everybody knows that pretty much there had been a good number of demonstrated racial and ethnic disparities in healthcare in the United States. And these disparities unfortunately continuing the VA healthcare system despite the fact that we're trying to minimize financial barriers for our veterans. And most notably as David mentioned, we have had COVID, which has really highlighted again the health disparities experienced by veterans from underrepresented groups.

Despite this though however, health services researchers continue to address at risk veterans and they've quickly pivoted to adapt an approach that helped to address the needs of veterans. But the bottom line is, much more needs to be done. We have made improvements and there are also notable positive changes that have been occurring at the national level as well as within HSRD and ORD. But a lot more needs to be done. So here's the bottom line. Bottom, bottom line from my advocacy days. We're doing better. A lot more needs to be done, but in order to address DI, we need more money. Next slide. Thank you. So before I go on, I'm going to highlight a couple of the data pools that our mighty DEI ORD data subcommittee folks have gathered.

I want to give kudos to them because they have had the opportunity and also the privilege to look through all of our resources. Data resources to look for information about past and current funding patterns by race, ethnicity, as well as health diversity topics. And they are by…as they have relay to me that there are lots of challenges in terms of using these data resources because many are missing data. So the first graph that you see in front of you was compiled by our data subcommittee. And these are studies funded between 1988 through the present and they are pulled by race and ethnicity of the principal investigator. As you can see, it's not a surprise to anybody that the majority of funded studies during this time period have been white. About 10 percent Asia Pacific Islander, about 1.3 percent Hispanic, and less than 1 percent have been black and/or American Indian, Alaska Native principal investigators. So in this area, we really do need to revamp and just essentially emphasize our efforts related to DEI research. Next slide.

David: Naomi. That's ORD not HSR&D. Correct?

Naomi: That's right. ORD wide. Thank you. So again, this is again ORD wide. We took a look at about 10,000 studies between the period of 1988 and present and across ORD, we gathered all the data that we had from ERA and RAFT and as you can see, the majority are male PIs. About 26 percent are female and like with the ethnicity and race PI data, we have a lot of missing data. And we're trying to address that now through our HSRD DEI workgroup to see why it is that many for whatever reason or another are not entering their ethnicity race or gender data. Next slide please. Okay, so we also took a look at what we have been funding or not funding for the last 10 years, and we're taking a look at the topical areas of the studies that we funded. Again, this was then led by our ORD DEI workgroup, subcommittee data. And we did two pools.

The first data pool we used search terms like based on minority health, race, ethnicity, and sexual orientation. And the second data pool we use general health disparities terms like, disparities, equity, race, and racism. And again, the data sources that we pulled this data across ORD was from ERA and we confirmed some of the funding and project status with RAFT. Next slide please. Okay, so if you take a look at this graph here, you'll find that between FY 2011 and '21 when we entered these terms based on race, ethnicity, sexual orientation, we pulled about 546 projects and of this, 71 were funded. And that's about maybe 13 percent, which is not a lot. We're trying to improve that. But we are funding.

But what is notable is that HSRD and BLRD if you take a look on the left-hand side, there have been a number of applications. Quite a number that have been submitted. And although HSRD funds the most, we can certainly do a lot more. It's about a 16 percent funding rate. And if you look on the right-hand side, if you take a look of the 546 projects related to minority health, most have been completed. So we really do need to revamp our DEI portfolio so that we have more active projects. Next slide. Okay, so this is the second data pool that we conducted. We used as I mentioned health disparity terms equity, racism, structural racism and we were able to pull 622 projects of which 88 were funded. That's about 14 percent. Again, when you take a look at the status of these projects that were funded, most are completed. Again, we need to revamp our DEI activity so that we have more active projects.

But one thing that is noteworthy is that, if you take a look on the left-hand side of the graph, over the last ten years, HSRD has received the most number of applications related to this area. And we have also funded the most number of applications. But clearly the funding rate is much lower compared to the number of applications that have been received. So we're hoping that we can increase the funding for DEI activities. Next slide please. Okay, so even though we have data that shows that we have lots more work to be done, not because of the lack of enthusiasm from the field, but primarily because we're somewhat limited in funding. And we're also trying to engage more

awareness among our investigators as well as within HSRD and ORD leadership. But we have had positive DEI changes. Hopeful changes at the national level as well as within ORD and HSRD. Next slide please.

Okay, so many of you know this. This was a momentous White House executive order, which was released just last month, and this calls for the establishment of a government wide initiative to advance diversity, equity inclusion, and accessibility in all parts of the federal government. It's led by the Office of Personnel Management and the Office of Management and Budget in partnership with the White House and the Equal Employment Opportunity Commission. If you read the executive order, it's not very long but it's very, very comprehensive and extensive. It covers numerous communities that have been historically…been facing employment discrimination and professional barriers.

And these include as you can surmise people of color, women, first generation professionals, and immigrants, individuals with disabilities, LGBTQ plus individuals. Americans living in rural areas, older Americans who face age discrimination. Parents and caregivers who faced employment barriers. People of faith who required religious accommodations at work. Individuals formerly incarcerated, and of course our population veterans and military spouses. So one of the goals as David mention is for ORD and HSRD to increase diversity among our investigators and staff. Next slide please. Okay, so we have a number of first and I'm happy to say that within ORD, we have launched the first…well, anyway. The first formal ORD wide diversity, equity, and inclusion workgroup with a clear mission statement, charter, and stakeholder engagement board. And the aim of this workgroup is to enhance DEI research and recruit and train more diverse workforce.

Now what is really notable about this workgroup is the fact that it's backed with funds from Rachel _____ [00:41:56]. And she has dedicated close to 2.5 million dollars for ORD wide DEI efforts. I think that some of you are already aware and actually have been the recipients of the minority supplements. This was provided to ten outstanding early career investigators from underrepresented groups and their mentors. And I want to give a call out to the four awardees within HSRD that received the minority supplement applications. So I want to give kudos to Drs. Melissa Chinchilla and Alexander Young. Drs. Darius Dawson and Terry Fletcher. Dr. Marva Foster and Keith McInnes. And also Dr. Shamira Rockefeller and Catherine _____ [00:42:45] Smith. And my apologies if I mispronounce your names. But kudos to you all. This was the first and hopefully not the last minority supplements and HSRD researchers achieved…successfully achieve four of the ten outstanding minority supplement funds.

We also had through the ORD DEI workgroup the first proposal writing workshop for early career investigators from underrepresented groups. From all that we heard and from the surveys, it was a phenomenal success. We

intend to have it again next year. I believe that we're going to be tracking those that attended, participate in the workshop to see how they do in the next phase of their funding applications. Whether they apply to CDA's, or pilots, and in their success. We also established links to job boards at minority serving institutions to post ORD wide positions. I've already started. As you know, we have been down three SPM, so I wanted to really check out their services at these minority serving institutions. And there are quite a number of them that we could post. So that is a big step towards diversifying our staff within ORD. And altogether, all of this highlights the extraordinary senior and early career investigators in health services research that are committed to DEI. I cannot express enough the gratitude that I feel in working with you all. Next slide please.

Okay, so and then we had another first. Okay, we have launched the first HSRD DEI workgroup. And the four aims of this workgroup are to educate, train stakeholders on DEI activities at all levels. So we want to training not only staff but also senior leadership, COIN directors, both investigators as well as staff, and we also want to raise awareness related to racism and implicit bias. We also want to develop and support a diverse and inclusive HSRD workforce. That's a major goal of not only ORD but HSRD as well. And we also promote equity-related research as I showed you some of the data related to ten years of funded research across ORD. We really do need to be able to fund more, because the enthusiasm and the commitment from the field is so great. And we also want create an organizational culture supportive of DEI.

I also want to say something about the HSRD DEI workgroup. They're comprised of investigators and directors from COINs. And I don't know if I have time to mention everybody because I may miss others, which is terrible. I have terrible memory. But these are all the folks that are in the HSRD DEI workgroup. I know that without them I would not be able to do my job in furthering DEI activities. They are by far quite an innovative very creative passionate group. I would say that they're not shy and they keep me moving, keep the HSRD moving. And I hope that they continue being on this workgroup so we can do more work. Next slide please.

Okay, we have done a lot, but two major accomplishments that we had started, one is a summer training career development program at CHOIR lead by Dr. Keith McInnes for medical students from underrepresented racial and ethnic groups. This is in partnership with the Boston University School of Medicine. We're hoping that this is a successful pilot so they can expand and enhance their program and possibly if their program is successful, maybe we can use this as a template to spread it out even further. Scale it across the country. We also started a pilot led by Drs. Christina Hartman, Susan Sigmund, and Diana Burgess.

This pilot involves a series of interviews to assist the experiences, insight,

and opinions of researchers and staff from underrepresented ethnic and racial minority groups in the VA. And an additional aim is to identify barriers and facilitators to retaining racial and ethnic minority researchers focusing on both the interpersonal and the structural factors that may benefit some groups over the other. We are so optimistic and very, very excited to see the results of these interviews. And we hope to get them maybe in the next six months. And this will hopefully address some of the reasons why we have so much missing data. We are asking for data on race, and ethnicity, gender, and other related information. But we as you saw, have so much missing data, so we're trying to get to the heart of why it is that people are somewhat reticent to give this kind of information. Next slide please.

Okay, so this is a very busy slide, but a critical slide in that this was developed by the RFA subcommittee within HSRD. And as you can see, I got to thank Sameer, _____ [00:48:15], Susan, Nikki Hastings, and April _____ [00:48:18]. I believe also Michael Fein was also involved in this. There are many, many people from the village here who contributed to the recommendations set forth by this workgroup for funding. The three areas that they proposed additional funding, the first to attract new scientists from underrepresented groups. This could be new RFAs or leveraging existing RFAs. A new RFA could involve supplementing supplements that target underrepresented groups. We can leverage existing RFAs to broaden CDAs and HBCUs CDA legibility criteria so we can expand the number of eligible scientists coming from underrepresented groups.

The second focus of funding is on providing training and peer mentoring that target underrepresented groups. Again, we thought about looking at or modifying NIH summer programs like the NHLBI Pride program to increase diversity. Again, we can leverage existing RFAs or we can develop new RFAs. One idea for a new RFA was for a two year nonresidential scholars program for early career VA HSRD investigators from underrepresented groups. And then the third focus…third recommendation for additional funding was to develop and fund mentors to support underrepresented…scientist from underrepresented groups. We were thinking that possibly we can modify NIH programs like the K24 that provides protected time for mentors.

And again, we can leverage existing RFAs or we can develop new RFAs that hopefully will provide additional support time that protects time so that they could develop and mentor underrepresented groups who are wanting more and who need possibly more mentoring. But because of all the other commitments that our mentors, are investigators, senior investigators are having to do, they just really do need more protective time. And when I raise this this wonderful list of recommendations to our HSRD DEI workgroup I said, we don't have money to cover everything. What is the most important do they think to start off next year? And all of them pretty much said that, providing more… their priority was to fund the protected mentoring time.

And so we're going to try very hard this year to try to identify those funds so that we will be able to either develop new funds or leverage existing mechanism so that we can provide funds for protected mentoring time for scientist from underrepresented groups.

So lastly…next slide please. Bottom line, not upfront, but last. We've been doing a lot of great work both at the HSRD level and ORD level, and I'd like to continue doing this great work, but the issue is time and funds. And our job at HSRD is to identify those funds, because if you take a look at all of the past research and also the past information from ten years back, it's now time to address DEI issues. We've progressed a lot, but we need to do so much more, I welcome any additional ideas from all of you. Please send me and David any information or any ideas that you might have. And also, we're still open to any new members. Any investigator who are interested in joining the DEI HSRD DEI workgroup. Thank you. And unfortunately, I've left very little time for Amy. My apologies.

Amy: No problem Naomi. I think these were really great additions and really great overview of HSR&D and I'm very excited to spend the last six minutes, maybe five minutes to get people some Q&A at the end to talk about QUERI. I'll just mentioned by the way that we really looked to HSR&D as a key leader and DEI and also that in many respects our QUERI investigators have led efforts in DEI and we feel that diversity, equity, and inclusion have always been baked into the culture and the way we assess impacts and the way we do things in QUERI so next slide please. So I'm going to give some brief examples of what we're thinking and what's going on in the state of QUERI and probably have Heidi send the slides to all of you so you can read up on the rest.

But I'm basically going to cover a couple major trends for QUERI and some positive news. And then also just to remind all of our investigators in the field that we are very much open to the more the merrier. We'd love for you to get involved in QUERI projects. And we often…we technically don't do research, but we do partner evaluation and implementation, and that's our way of making an impact. So we've been increasingly recognized as the go to place for cutting edge implementation being a trusted purveyor of the evaluation and quality improvement experience for VA local and national leads. This was evident in the fact that we were delegated some responsibilities for implementation of the foundations for Evidence-based Policymaking Act for the past couple years. And that has also been amplified recently by the White House memo in 2021 that basically assigned and sort of mandated additional requirements focused on the use of evidence and evaluation for programs across all government agencies including VA.

In addition to that, we also have been increasingly asked to do national what we call high-priority big-ticket evaluations that are part of congressional legislation such as the National Defense Authorization act, study on women

employment, women veteran employment as well as on the _____ [00:54:56] and other budget proposals such as the _____ [00:54:59] that have focused more on issues of access to care for veterans who are vulnerable and marginalized as well as obviously women veterans as well. We also are very much interested in promoting new and continued opportunities for early career investigators. We don't think that you need to make a choice between doing quality improvement and having a research career. You can do both. You can have your cake and eat it too.

And the way we do that in QUERI is we set the stage so that essentially first of all, we have a new advancing diversity and implementation leadership funding opportunity to basically increase the pool of talent in QUERI and working with QUERI investigators focused on implementation, quality improvement, and evaluation science. That is going to be ongoing and probably increasing in terms of opportunities over the next several years. And in addition to that, we've always, always encouraged multiple PI roles and team science when we have national program implementation and policy violations. And in fact, many of our partnered evaluation centers use those mechanisms to basically mentor other more _____ [00:56:03] investigators on working with partners and also having a research career.

All of our funded…all our competitive funding mechanism used…pretty much used center grant mechanism so that when you go to your medical school Dean, they'll see that essentially, you're getting the equivalent of a P50 center grant. And also, we've also created the QUERI program mentoring cores and learning hubs to really promote the use of implementation research that we do not believe…we don't believe in its card-carrying and you have to be implementation scientist official to do implementation science. We can train you. We can provide that guidance as well. Okay, I have two minutes, so I'm going go and maybe to the next two slides please. Next one.

I just want to highlight…oh, the one before that sorry. I'm just going to stop at this one and just highlight some of our great accomplishments of our core investigators. So yes, we had a number of new QUERI partner evaluation centers. We have over 40 centers. We have new QUERI programs and learning hubs have been funded. Oh, then congratulate Dr. Washington on her Undersecretaries award. She represents the tenth QUERI affiliate investigator getting such an award at least. And then we also have had…the NIH has also selected highly competitive in a highly competitive way key faculty to be faculty leaders in our Implementation Research Institute, which is a highly competitive opportunity for implementation scientist. So I do want congratulate Lindsey Zimmerman, Charles _____ [00:57:30] Evans, Allen Hamilton in sales and John Kirshner for that opportunity.

And basically, wanted to also callout the impact words that David called out earlier. We also have a terrific rapid response team led by Ronnie Elway,

Nina _____ [00:57:44] and Charles _____ [00:57:45] Evans have done fantastic work on understanding the nuances of the COVID-19 vaccine. I'll just basically…I'll just stop here. It's just too much to share. We're very excited about QUERI. I think we have a very bright future ahead of us. We're increasingly being called to do a lot of great work. And we are…basically, let us know if you're interested in applying for QUERI opportunities. So I'll stop there and turn it over to our host. Thank you.

David: And Amy, I think we need to schedule a special seminar just on QUERI because I think there's so much going on that it really deserves its own cyber seminar to talk about the directions you've taken it. So apologies that there was too much to cram in even to an hour.

Amy: Don't worry.

David: So Heidi, I can stay on. I don't know whether with the WebEx mechanism we want to extend this or have people enter questions into chat that we could answer off-line. What is the best approach? I know we're at time.

Heidi: We are at time right now. I have received several questions in here and it's probably going to be easiest just as respect everyone's time and software limitations, why don't I gather these questions up and I'll send them over to the three of you. For the audience, if you do have any questions that you did not get submitted to Q&A, feel free to send that into cyberseminar@va.gov and I'll get that included on the list sent over to David, Naomi, and Amy. And we'll get responses out to everyone as quickly as we can. Does that work for you all?

David: Yes. And I just want to let the audience know that we have put in a… CIDER is developing an application for an in-person meeting in 2022. Obviously, a lot of uncertainty around both whether large meetings will be able to be held and whether the VA will support our approach. But we are hoping to see you all in person within the next year. We'll keep you posted on that.

Heidi: Fantastic. Thank you everyone. And with that, we're going to close out today's session. Thank you everyone for joining us. When I close the meeting out, you will be prompted with a feedback form. Thank you all.