Laura Zimmerman: Welcome back everybody. Thank you to everybody who participated in our great breakout groups. I know the COVID one we had some really great conversation and some really great ideas. I’m really excited to hear from the other two groups as well. So the plan, we’re going to have about 20 minutes for each group, they give us their recommendations, tell us what the conversation was. I’m thinking if we have time for questions or if you have any comments I think the easiest thing to do is just throw those in the chat and we’ll address those as we go along. I told Mike and Travis I was going to put them on the spot so they can get us started and they said about 20 minutes for each group.

Travis Lovejoy: You remember Laura telling us she was going to put us on the spot?

Laura Zimmerman: Oh I guess I only told mike.

Mike Ohl: And I told you that you were on the spot.

Travis Lovejoy: So I’m finding out now. Alright here we go, let me share the screen. We’ll be presenting on the recommendations from the COVID-19 workgroup. I will admit that this isn’t very fancy. Mike encouraged me to incorporate some animation but that wasn’t going to happen when I had about ten minutes to put this together. We’ll do bare bones here. I wanted to extend a really large thank you to this very engaged group of members. We had some wonderful discussions. There were several points that came up during the two days that we met that I think are important to note that I didn't incorporate onto the slides.  
  
Our workgroup is called the COVID-19 workgroup but really we saw our task as identifying ways that the VA and its affiliated health networks could best serve rural veterans in the context of public health emergencies. Not necessarily the emergency that has happened, but emergencies that have yet to happen and that we don’t know when they’re going to happen so it’s really building that understanding of the infrastructure, the gaps in care that failed rural veterans during the COVID pandemic and how we can better position the VA and its affiliated networks to better address the needs of rural veterans when these events happen in the future because they likely will happen again.  
  
We also talked to some extent about this specific rural RFA. We had a lot of topic and discussion that concerned rural of course but we considered whether or not they belonged in a rural RFA per say. So there were some things that we have a general understanding about but maybe there’s a little bit more left to investigate and we thought rather than warrant inclusion in a rural specific RFA that perhaps it would better suited as a supplement to an existing or upcoming RFA from HSR&D and we certainly have the benefit of Laura and Karen McNamara and others from HSR&D in the room at various points when we’re having these discussions and they were able to share some of their own internal knowledge so that really helped inform our group.  
  
So what we ended up doing is we presented what we thought were the most important questions and certainly would then leave it up to HSR&D to decide where, if at all, those particular topics would be included in an RFA or supplement.  
  
We also grappled a little bit with the cross cutting items because some of the focus areas that we identified were specific to a cross cutting item such as mental health. And we even went so far as to exclude that from our list of cross cutting agenda items and through various iterations it worked its way back in but we grappled with that a little bit. So we had a list of cross cutting agenda items that may have differed slightly from what was originally presented in terms of access, diversity, equity, inclusion, cultural considerations, and mental health. So we are going to be providing those notes to HSR&D in terms of what we thought were some of the either additional or supplemental cross cutting agenda items we thought would be important.  
  
But in terms of our focus areas, we ultimately identified three. And so this first focus area has to do with David when he presented yesterday morning said is it a knowledge gap? We just don’t know what we need to do or do we already know what we need to do and the question is really rapid implementation. So we framed our focus areas in terms of that. The knowledge gaps or the implementation aspects.  
  
And this first one has to do with a knowledge gap. Based on our discussions, we identified just a general understanding of access to VA and non-VA healthcare networks for rural veterans and the cost effects of COVID-19 has been highly important and this is both the acute care networks as well as the chronic care networks for veterans who may be experiencing, for example, long COVID. But we also recognize that veterans are impacted by the COVID pandemic in ways other than necessarily being infected with the virus. And so we recognize that there are long term systems of care at play with those as well.  
  
So you can see in A through D here we have some specific questions that we suggest may be appropriate for inclusion in an RFA around this specific topic. So, question A, what were the treatment settings, individual rural community factors, quality and outcomes of care for rural veterans with severe acute COVID-19 during case surges as well as post-acute COVID-19 or what some call past or long COVID. And so we recognize that there two things at play here. We have this acute care phase that there’s a significant need with acute care and triage and transfer that is happening and a lot of the rural veterans are getting this type of care within the community. Sometimes being transferred to the VA or denied transfer. So there are a lot of systems at play going on here that we thought it's really unclear whether or not that capacity is there and ways to improve those particular systems to address the acute care need. But then of course there’s the longer-term car needs as well, And so, those community and VA care systems also play into that.  
  
We were also interested in better understanding some of the geographic and sociodemographic variability of veteran subpopulations as well as rural communities. On some of the plenary talks and I would imagine in your workgroup conversations there’s discussion around the heterogeneity that we see across rural communities. Some have mentioned that rural Maine is not the same thing as rural Mississippi and even within these geographic regions, there’s a considerable amount of diversity. Being able to identify what some of those characteristics are of these rural communities that are ultimately disproportionately affected by COVID-19 and in all likelihood would be disproportionately impacted by future public health emergencies.

We also recognize that there were a number of VA facilities and their affiliated healthcare systems that did an exceptionally wonderful job of addressing the acute and chronic care needs of the rural veterans who were impacted by COVID-19 so we want to understand what these particular facilities and healthcare systems did and to be able to emulate that in the future. Again, building the infrastructure needed to be able to meet the demands during these public health emergencies.  
  
And then we also had a conversation about this idea of rapid research. And this is certainly an area of interest for HSR&D. How do we respond quickly when things are so dynamic and constantly changing? Our group talked about this idea of local quality improvements. How do we increase the capacity of local facilities to be able to ascertain the needs of their rural veterans immediately within the month and determine what are going to be appropriate fixes for their local context? This is a little bit of a methods question but rather than have it be a standalone focus, work it into some of our specific focus areas and some recommendations for types of methodology that could be appropriate for this RFA.  
  
Mike, before I move onto the next focus area, are there any comments that we wanted to add or any other members of the workgroup I would invite as well.

Mike Ohl: I think that’s fantastic, I think that’s, the broad context we were constantly thinking what is the right level of specificity for these questions and I think yeah so I would just keep going.

Travis Lovejoy: Alright so our second focus area concerned telehealth and I think many of us, at least before COVID-19, brought up telehealth as being relatively specific to rural areas. And certainly after COVID, we realized that telehealth is an important delivery medium for all veterans, rural or urban. But we also acknowledge the fact that there are unique differences in terms of access to telehealth and the way that it’s delivered to rural communities. And so we thought this would still be an important standalone focus area and we actually broadened it not just to include telehealth, we had some discussion around whether it should be called telehealth or virtual care to be more all-encompassing and we ultimately decided that that was a more appropriate term to use.  
  
So, really what this focus area addresses is the role of virtual care in preventing or at least mitigating care disruptions. We also talked about care attrition as being an important component here that sometimes gets consumed under care disruptions but we saw as well as being somewhat distinct from these care disruptions so the idea that you have people that are regularly attending their appointments and suddenly drop out of care as a result of these pandemics or other public health emergencies. So, addressing that particular need.  
  
And then another piece that really came up within our group was this idea of resiliency. Kind of this positive view that there are some patients who are quite resilient through these very trying times. And to try to better understand what types of things can promote that resiliency among rural veterans during these public health emergencies.  
  
So, in a similar way to number one, we were really interested in these facility level characteristics and you’ll see this kind of uniformly across our different focus areas. This idea that it’s really important to understand what is it that these facilities that are doing exceptionally well and meeting the needs of rural veterans, what kinds of things are they doing and how can the system emulate these?  
  
So, there are some systems out there, we believe, that were able to really quickly implement virtual care delivery modalities. They had a lot of experience this. We were able to stand it up and get other providers trained and make sure that the care disruptions were minimized for rural veterans during the COVID pandemic. So, what is it that these facilities were able to do and how did they go about doing that? How are they prepared to do that? So again, this idea of trying to better understand how these high performing facilities function.  
  
And we’re also interested in understanding the characteristics of the rural settings that either facilitate or can even impede this rapid transition to virtual care. Again recognizing that there is virtual care to some extent in many places but really it’s not to the place where it needs to be. And so, some places are better at doing this than others. And so we really want to understand again these kind of high performing, high quality organizations.   
  
But we also recognize that the way to deliver care to rural veterans is not just through telehealth. There needs to be other innovative strategies, innovative modalities, to be able to help rural veterans receive the care that they need. And so some of the things that our group talked about were nontraditional care networks. We talked about faith-based organizations. We talked about VSOs, veteran service organizations. A variety of other community resources that are not historically directly connected to the VA but their organizations, their entities that our veterans utilize and access on a pretty regular basis. How can we partner with these entities to be able to provide optimal care that may not be available to rural veterans through the traditional means? Through the VA whether it’s it’s in person or telehealth, or VA community providers, how do we access these? And so that was really another area of focus that we thought would be really important to be able to address the rural healthcare needs. Mike, anything to add for focus area number two?

Mike Ohl: I think one thing we struggled with or discussed here is this issue of care disruption and mitigation sufficiently specific to the rural area to be included in a rural RFA. There’s already a query SDR on care disruptions and I think what the conversation came to was that there’s probably some work going on that’s descriptive epidemiology or description of care disruptions that includes rural as a variable. However, we think that these strategies that would be appropriate to mitigate care disruptions could be different in the rural context because of resources, structural differences and access, other rural context factors so we thought yes, care disruptions and the way telehealth or other virtual care play into this may look sufficiently different in rural settings from an intervention point of view. But it rose to the top of the rural RFA.

Travis Lovejoy: Thanks for that. Moving onto our third focus area. Now this was an area that we really, like number two, I did mention but that was really more of an implementation focus area. This is also more of an implementation focus area. It’s a balance between implementation and effectiveness. And so this particular focus area addresses this idea of how do we encourage the adoption of public health recommendations during these emergency or crisis times. We recognize that there are disparities, urban rural disparities between the uptake of what has been recommended by public health authorities in terms of ways to mitigate disease spread, improve care, reduce morbidity and mortality and so forth. And so this was an area of focus. We have many of the interventions in terms of the medical interventions or public health interventions that work and it’s just a matter of implementing them. But we also recognize that sometimes the ways to do this are as of yet unknown.   
  
So what we really wanted to focus on in this particular one is how do we improve uptake of some of the public health recommendations during these times of crisis. Recognizing that within the rural sphere, just like in the urban sphere but certainly in the rural sphere there’s a diversity of culture and political and beliefs that oftentimes impact decision making around adoption of public health recommendations. And so this is a really important area. This conversation really started primarily around vaccines related to COVID but we thought that it was much more broad. And we also though that vaccines still warranted their own separate bullet. And we think about this as not just vaccines around COVID but there are other vaccines that are recommended. Influenza for example and we know there are disparities in uptake of influenza vaccines. So we thought that this type of work would have greater application even beyond COVID vaccines.   
  
Our second bullet underneath this particular focus area has to do specifically with that, improving the vaccine access and uptake among rural veterans to reduce that disparity that we see. Mike had commented on this idea that COVID vaccines are going to be part of everyday life moving forward. It’s likely going to be something that everyone is recommended or suggested that they do on an annual basis. And so, are there ways that we can learn from what happened during the more acute phases of COVID-19 to be able to, I see Kristen put in the chat another booster, to be able to address some of those uptake barriers that we’ve seen developing. Mike, anything to add to this one?

Mike Ohl: Well said. I think in terms of vaccination we thought not just thinking about attitudes, beliefs, motivation to use the vaccine, nut not to forget about structural differences in access. Geographic and otherwise to vaccines. We didn't want it just to be about so-called hesitancy but about rural urban differences in vaccine access and implementation research to reduce disparities.

Travis Lovejoy: Thank you. So those are our three focus areas. We are at the end of the slides. Laura I am not sure if you want to, at this point we’re going to go through, have all the presentations happened? Or if you would like us to pause and field any questions from the group.

Laura Zimmerman: Yeah let’s just, I think we’ve got a couple of minutes right now if we have any specific to this group and then we can either put that in the chat or if anyone wants to you can ask. And then at the end if we’ve got any time left, we can pick any broader questions over the whole thing. Any questions for Travis or Mike? And if you think of something later you can just pop those in the chat and we can always come back to them. Nothing right now, thanks Mike and Travis I think that was a really great summary of what we talked about.

So, next we’ll move on then to our community care breakout group and Kristin and Naomi were our facilitators for that. So again you have about 20 minutes.

Kristin Mattocks: Okay great can people see our not fancy slide? Okay. So we didn't quite get the memo that we’re supposed to put it on fancy slides, so Travis you get extra points for that, we’re a little bit lower key. So, probably like the other two groups, our group came up with, and if somebody wants to mute their mic that would be good. Our group came up with a number of ideas in terms of RFP priorities and Naomi strongly suggested we narrow it down. So, we really tried to narrow it down to two but we came up with three or four so I’ll just go through these quickly.  
  
So I think one of the most important questions that Naomi asked us was to carefully consider existing evidence and what had been done and what hadn’t been done and as a result, what we’d like to see. So, as much as we were really interested in ideas like care coordination, we started to really realize that probably things like care coordination had been something that had been studied a little bit more. So we chose to focus on things we felt like there was very little evidence across the board.

So, in terms of the first thing that we felt like there really very little evidence is really our relationship and direct work with community entities who do provide care to veterans in rural areas. And types of places that do that can be certainly FQHCs, Union Health Services, rural health clinics, other community clinics, military treatment facilities, among many other types of things. And so, somebody in our group asked what we all thought was a very important question of how do we at the VA support these non-VA entities? So, what types of incentives are given? What types of partnerships can be formed with these entities? And across the board we really came to the realization that we really had very few solid working partnerships with a lot of these community agencies and as a matter of fact we’re still trying to figure out who these community entities are. So we felt like that was very important.  
  
We wanted to know more information we thought it was more important to know how do we share data? How was that data shared? What are the veteran perspectives and knowledge of these community entities? Someone talked about the importance of laws and payment models and how those are different depending on what community agencies we’re talking about and centers. We know that there’s a separate workforce group and so we had a detailed conversation about workforce but we figured we would leave that to all of you to talk about in more detail. But I think there was definitely an acknowledgement that workforce issues were possibly more challenging at some of the more rural facilities so we thought we would throw that in. And then obviously care coordination.   
  
We did share our final list of priorities with OCC last night just to get their take on what we thought some of the priorities were to make sure that we were consistent with what they thought. And they agreed with our list of important priorities but they did caution us that it’s important to differentiate between types of entities around the community. So there’s places that are specifically under CCN contracts like federally qualified health centers. And then there’s other types of places like Indian Health Services that operate under slightly different types of relationships such as sharing agreements. So they thought that in the final RFP, we should just make sure that we thought carefully about those differences and how the research questions might be different across those different entities.  
  
Another incredibly important area we thought there was very little research with the exception of a few studies was veterans decisions and preferences about where they receive care. We did acknowledge that there are existing programs that are being rolled out in the VA to help veterans make informed choices about whether they stay in the VA or they get community care. One of the biggest ones, it’s launched across the country right now but still needs an enormous amount of evaluation is the referral coordination initiative which is sort of a program to really help veterans understand basically what their non-VA choices are and the wait times associated with those versus what the VA choices are. And so, it seems like there’s quite a movement in the VA right now to help veterans better understand what their options are.  
  
But unfortunately very little has been written about that and some of the evaluations of the referral coordination imitative are really just getting underway. So, we really thought that much more needed to be known about that.  
  
We also agreed that there are difference about what types of care veterans, particularly in rural areas, may choose to get in the VA versus in the community. One of those examples was mental health. And so we thought it would be important to know more about that. Satisfaction is always an issue and we thought that, again, evidence specifically for rural veterans about what’s known there.   
  
One of the other important issues that came up is just the realization that oftentimes veterans don’t even know what types of care are available in the community and again, what their options are. And so we really thought that this was an important thing to evaluate. And a cross cutting issue across all of our priority areas is certainly women in other special populations.  
  
The third incredibly important issue that is not well studied particularly for rural veterans is the quality of care provided by non-VA providers. There is also some work underway to get provider level quality data from contractors in the VA. In the original mission legislation said that it would think more carefully about the quality of care provided by non-VA providers. But unfortunately that data is basically data provided by the contractors. And there’s a good number of problems associated with that data. But it’s incredibly important to know the quality of care that the veterans are getting. And again, as always, how far veterans have to travel for that care and that type of thing. Especially in rural areas. The quality of different types of care and as always, the patient experience as related to quality so that’s important as well.  
  
And I’m going to just include a fourth one even though I think we only agreed to three. But it’s hard to think about any of these things without basically make versus by decisions at rural facilities. And at rural facilities as I was talking to our group about, this can change on a dime. You can have a neurologist but given that you're only one deep in most specialties if any specialties, once that neurologist leaves, it instantly becomes not really a make decision, it becomes instantly a by decision. And so veterans may one day be able to see a neurologist and two weeks later find out that that neurologist has left and they’ll have to go into the community. So we really think that these make by decisions need to be more carefully evaluated at rural facilities in how they deal with that. And what are the tradeoffs in make versus by decisions?  
  
Echoing the first group, one of the most important things that we thought, especially in terms of make versus by decisions is the importance of telehealth as a way to make those services in house. But even if they’re not necessarily in your house, they’re in somebody else’s house perhaps at a different VA in a different state. But that is really an important component of make versus by decisions. And we know that both the office of community care and the office of veteran’s access to care, the new IVC is very interested in the idea of how telehealth can help keep some of that care in the VA as opposed to going out. And again, sort of the idea of the special idea for CBox and about how CBOX may need to use more of these clinical resource hubs versus community.   
  
Naomi also challenged us to really think carefully about potential funding sources that could also help fund this work. And so we talked, especially given that we’re interested in community entities that we partner with, we thought that HRSA, SMHSA, perhaps National Association of Community Health Centers, Indian Health Services, would be important partners. We had a lovely conversation with Nancy from the Office of Rural Health about really the expansive funding opportunities that the Office of Rural Health offers and is interested in many many of these areas. And so, as a group we made the decision that we really need to expand our existing partnerships, for example, with Office of Rural Health to leverage existing work and to expand it in partnership with HSR&D. So, I have page two but I’m not going to get into that because we have to only do a few. But that’s what we have. Do any of my partners or group members want to chime in and add something that I’ve missed? Nope. Okay.

Naomi Tomoyasu: Perfect, if not, this is Naomi, I just want to thank everybody. The members of this group, we got some terrific discussions facilitated by Kristin and got a lot of great ideas in terms of, many ideas in terms of the priorities but also very very innovative ideas in terms of funding mechanisms. So I want to really say thank you to everybody. I was in this somewhat, I don't know, unusual role of trying to keep my mouth shut because I’m trying to listen to as many good ideas as possible. On the other hand, I was in the role of being a co facilitator although I think Kristin did a fabulous job at that.  
  
But I do want to just really highlight one of the many great ideas that this group came up with. And this is something that HSR&D has been promoting and supporting all along, and that’s expanding partnership. New partnerships. And I believe that when we take a look at all of the RFAs that we have put out, we typically have some partnerships with our programs, clinical programs. But we don’t have too many partnerships with outside community entities like FQHCs and IHC that Kristin mentioned. But we also really do need to take a look at other funding partners. I understand that that takes a long time but I think that certainly with Office of Rural Health that has been funding many many of our researchers already, we really do need to formally strengthen our relationship with them as they are our key program partner as well as our funding partner. So I just want to mention the importance of partnerships and that was raised and I thought beautifully discussed within this group. Thank you.

Laura Zimmerman: Yeah thanks for that excellent breakdown. We’ve got a few minutes if anybody has any questions you can ask or put in the chat or comments or anything about the community care workgroup. Okay.

Carolyn Turvey: I just have one. Is there any opportunities in this RFA to think about, what is it called, the AIC, what was the recent market assessment and is there any need for HSR&D researchers to explore that and its implications for VA and community care?

Kristin Mattocks: We definitely had that conversation, especially given that mine is one of the facilities that wants to be shut down.

Carolyn Turvey: Do you want to be shut down? There’s lots of lovely real estate in Iowa Kristin. Go Hawkeyes.

Kristin Mattocks: We did talk about it. We talked about it a little bit just in context of, not really a research issue as much but just the repercussions of those announcements being made to veterans at a local community who read the headlines and see that their local VA that they’ve been going to for 50 years is going to be shut down. And there’s an enormous amount of panic in our community. And there’s a fine text under the recommendation that the North Hampton VA should be shut down, that we’re building a giant new clinic 20 miles away. But I don’t think the veterans are understanding that. So I do think it’s important for the VA to think carefully about just the impact of those communities where veterans read the headline and understand that their VA is being shut down. It’s really sad actually. So, that’s all I had.

Laura Zimmerman: Questions or comments for the community care group? We can always come back to that. Okay so now I’m going to turn it over to Matt and Charlene to talk about the workforce breakout group.

Matt Vincenti: Thanks Laura, I’ll try sharing our, we didn't get the memo either regarding the fancy slides. So, kudos to Travis for his great presentation. So, I’m just going to go through our basic questions and recommendations and Charlene please jump in at any time to fill in the gaps. But I wanted to start by really thanking the dream team of collaborators we had on this workgroup. We had folks from rural primary care providers, rural researchers, and rural portfolio managers. Some of those folks wore all those hats or several of those hats. So I think we’ve got a really diverse perspective on what the workforce challenge looks like in rural areas.  
  
And so, from that we developed three main questions but within those questions we also wanted to highlight certain focus areas or contextual factors that we think are important to be focused on that will help clearly and definitively answer the main question. So the first question really came out of extensive discussions about what the mindset is like and what the environments is like for a rural provider. And understanding that towards developing better approaches to recruiting rural providers and maintaining them within the VA for a long period of time.  
  
So, the first question is what are the different rural context and individual community factors that affect rural providers and recruitment retention and impact clinical capacity and service coverage? So, it’s kind of a mouthful but the goal is to really understand all those factors that are rural specific but also are specific to the communities in which those providers practice in. Because those are going to be different from Maine to Arizona. And so we need to understand how the providers community impacts their view of their practice and what the stressors are related to their everyday work. That will inform how we first get them into the system? How do we retain them in the system? And how do we maintain an environment where they feel that they can perform their jobs effectively and are supported by the system that they’re working in? This will be done, or could be done through global mechanisms to facilitate provider engagement in CME or non-CME. And all forms of career development so that they feel that they’re really supported by the VA in their career development and they’re getting the type of career development that is not just in the VA’s interest but also in the provider’s best interest towards the advancement of their own careers.   
  
And that also would require developing a leadership culture that promotes personal growth, provides mentorship and develops a community practice so those providers feel part of a team that they want to stay with. And also identifying providing rural, regional community context and factors to engage potential rural providers. It’s great to understand how to keep providers happy once they’re there. But you also have to figure out a way how to entice them in. And some of that involves understanding in a rural environment what’s going to be attractive to a potential provider and what are the things that they individually require and value that can be used to recruit and retain them in those areas. So I’ll stop there. Charlene did you have any more to add?

Charlene: No I think you summed it up.

Matt Vincenti: Okay thanks. So, the second question was sort of formulated out of a couple of identified gaps in knowledge and acknowledged areas of deficiencies for rural workforce in the VA. And those were understanding staffing shortages and understanding how referrals in rural areas are affected and different than they might be in urban areas. And so, using those as sort of pivot points to understand where you move forward in this area, trying to define innovations in infrastructure and human capital that can address these disparities in the needs of the workforce.  
  
Okay and so when we say infrastructure, we’re saying everything from the facilities and the resources made available by the VA. And the human capital is clearly the folks that are in the VA and the people within the VA that support the people that do the clinical work. All this has to be assessed within the context of what type of clinical environment are these innovations being developed in. Is this for in person care, virtual care, non-VA care? And this is an area where I think there’s probably a lot of crossover to the community care workgroup because non-VA care is really a critical aspect of understanding what the clinical environment is in a given rural area.  
  
Obviously there are differences between inpatient outpatient care, specialty care, primary care, and mental health. In addition, the support staff that sustained the clinical enterprise and that’s everything from facilities and such that maintain the environments so that clinicians can do the job that they need to do.  
  
And our third area of focus and question was framed by I guess a frustration by a lot of folks in the group about the lack of good coordination between the research enterprise and the operation alone enterprise in the VA. And this, I think manifested itself not just in the execution of the research but also in the adoption of the research and integration of the research findings into operational improvements. And I think this is particularly relevant for the workforce part of this endeavor because workforce is sort of a Venn Diagram of a lot of different operational partners. They’re the clinical offices but there’s also academic affiliations for career development and training. There’s workforce management and consultant. There’s integrated veterans care office, how does care get dispersed out into the community? All those offices are going to have an impact on how well we develop our workforce.  
  
And so, being able to integrate all those levels of operational expertise into the research question and the research execution is going to be critical to success. So, we align with a lot of what OH focus on in their portfolio development in the resource centers, focusing on research, innovation, and dissemination. But also organizational adoption, how does this get information that is found through research studies, get adopted and integrated into operational practice. And a point that was brought up about how the VA grows going forward, how does this integrate into organizational health? That is, does this address a lot of the stuff that is gleaned out of all employee surveys and information that is gleaned out of there? Are we adopting and promoting high reliability organization principles? The HRO principles that big VA espouses to?  
  
I think all these factors will be things that have to be thought about and investigated to understand how we improve this research operational partnership and ultimately make best use out of the research that we generate. So, that’s all I have Charlene. Feel free, or other members of the workgroup that are on the call please feel free to weigh in.

Charlene: I think that we’ve given HSR&D ideas about how these can be framed in RFAs and just a brief reflection to those of you who checked your email, HSR&D’s high priorities for research came out this morning and I went through it quickly and there’s not a mention of rural disparities even in the health equity and social determinants of health section. So I think our message hasn’t actually filtered to the top as much as we want. So these questions may add to their supplementing that.

Laura Zimmerman: Yeah are there any comments or questions for the workforce group? Alright. Well everybody did a fantastic job of giving nice, concise overview of the recommendations. So we’ve got plenty of time if anybody has any questions or comments on anything, anything that we might have missed or anything like that. I’ll give you a second if anybody has anything. Alright well then just to wrap it up, I just wanted to take a moment again to thank everybody for participating. I hope you all enjoyed it as much as I did. Overall, very motivated and feeling good about that because of this meeting. And like it was mentioned at the beginning in our opening plenary is that this is just a first step to really revamp our rural health research. So I’ll probably be calling on a lot of you again as we continue this within HSR&D and ORH as well.  
  
And I really want to thank the planning committee. This was several several months of work getting this organized so thank you all for that and our co facilitators especially have to be brought in half were part of the planning committee, another half we brought in, they just jumped in full on and got us going on this. Yeah.

Naomi Tomoyasu: Laura could I just mention one thing, I do not know the name of the person you just mentioned. I’m looking through the HSR&D priorities document. That was a conversation that we had in our group, the community care group and we full on acknowledge that rural health is not in there. But we are going to put it into the HSR&D priority document. We were waiting to get really good feedback from all three groups. I will say that in terms of the IIR, the RFA, as well as the pilot RFA we have put in, highlighted a couple areas where there is a severe research gap and rural health is definitely listed as one of hose areas. So, stay tuned. Please do not give up. We are making some changes and we are so glad that Laura is here. Not just because she is from a rural area but she’s a fantastic fellow. So, thank you, stay tuned.

John Fortney: Naomi this is John. Another thing you could do that would be really easy and impactful I think would be where you had that section that says make sure that your sample has representation from women veterans and racial ethnic groups. To also add to that have representation from rural veterans.

Naomi Tomoyasu: Yes absolutely.

John Fortney: Two words can make a big difference.

Naomi Tomoyasu: I know.

John Fortney: That way, every research project is focused on, not focused on rural but can contribute to the rural research.

Naomi Tomoyasu: Thank you that’s a good idea. We’ll put it in significant places as well as smaller places. All makes a difference.

David Atkins: So Laura, this is David. I just wanted to make a couple comments. First of all to thank everybody especially the workgroup chairs and Laura for pulling off what I thought was a very successful meeting. I was sort of in and out of workgroups but I was here for all of the summary recommendations which I thought were very helpful and very concise. So, just a few comments. One is we have always conceived of disparities broadly inclusively and to include geography and rurality and if that got neglected from the way it was framed in the priorities document, that’s our mistake. But doesn't really reflect a change in how we’ve been going forward.  
  
I’m really intrigued with this idea from the workforce group about connections to research. And that suggests some things like practice-based research networks, connecting rural facilities as a place to both engage rural clinicians in something that is building their skills and also feels like they’re contributing to knowledge. But also as a tool then for disseminating the results of that. We have a women’s health practice-based research network which I do think includes many more rural facilities. I think there’s something like 70 participating sites in that. Someone on here may have a more accurate number.   
  
We are considering setting up a practice-based research network for long COVID clinics and are working with the integrated project team that is responsible for figuring out how we provide long COVID care regardless of where veterans reside and that overlaps the recommendations from the COVID workgroup and from the workforce workgroup. I could easily imagine thinking about a practice-based research network might help us both accelerate our research on rural specific issues, at the same address workforce issues and the implementation arm.  
  
So, I want to thank everybody for the ideas you gave us. I think you’ve given us a great head start on preparing a solicitation for the fall that will really jump start, address some of the deficiencies that you’ve highlighted for us. So, thanks everybody for that and again, thanks to Laura and to the folks who really made this happen, to Naomi and to Song and Parker and our contractors at PFS.

Tom Klobucar: Thanks David. Hey everybody this is Tom and I just want to echo what David had to say. I really appreciate the effort that went into this in two very short days. I think you distilled a really important what I see is a foundation for this mythical rural resurgent that we’ve been in search of for a very long time. So, and that’s my expectation is that not only will this instruct the Office of Rural Health and our Veteran’s Rural Health Research Centers in what our research portfolio across the office and its satellites looks like, but it also can, I think, provide us with that really important \_\_\_\_\_ [0:51:54] for which we can build a research structure as it were that points us in a specific direction.  
  
And frankly, I was really pleased with where you all went and it’s like where we did consider virtual care, it wasn’t an overriding concern because I think that’s what I really liked about the tone that you all set from the very beginning is rural health isn’t telehealth. And I think that’s reflected in what you’ve done here. It’s a part of it. It’s a part of the solution but it’s not all of it. So, and in workforce, in emergency response, and in the care coordination aspects of community care I think you’ve really expressed some really important issues that we need to bring up front. So again, thank you everybody, thank you especially Laura for herding these cats for the Office of Rural Health and for HSR&D over the course of the last several months. It’s been a pleasure. And looking forward to more.

Naomi Tomoyasu: And many many more.

Laura Zimmerman: Great and all of this has been recorded, we’ll have notes, and transcripts and recordings and things like that that’ll be able to be distributed. So, look for more from us in that regard. It looks like we’ve got some things in the chat. Does anybody else have any comments or anything else? I don’t want to shut it down too quick if we still have some conversations going on. It sounds like everyone is pretty excited. Is there a separate rural health research working group? Does anybody?

Tom Klobucar: You’ve snuck into my brains Kristin. The fact of the matter is that there isn’t. And maybe that’s the next step as we explore, I’ve always admired what HSR&D and Women’s Health Office and VHA has put together as far as that research network. Is it possible for us to establish something analogous in the rural space? Golly it sounds like a great idea. And I’m glad that you brought it up because it’s something that, and particularly now with the renewed emphasis where our partners in HSR&D going out with RFAs that will reflect this rural priority, that could be the ideal time to strike while the iron is hot. And create a community.

Laura Zimmerman: Yeah and I think is that Amber that had that comment about standing up research deployed during COVID, that’s something that we talked about in our COVID group on rapid response when it came up. Yes it sounds like Kristin I’ll have to pick your brain on starting those kinds of things and see where we can go from there. Okay any other comments or thoughts or ideas or recommendations? And you can always feel free if you think of something later, shoot me an email and always up for hearing more ideas and more conversation. Mike says that fellowship sites have a rural research training focus that could be included in the rural health networks.

Mike Ohl: Through the recently funded office of academic affiliation, HSR&D fellowship sites have a rural researcher training focus. For us to keep in mind as we make rural networks.

Laura Zimmerman: Any other comments or thoughts? Alright well you guys did a really good job being concise on our reports from the breakout group. So unless there’s anything else, I can give everybody back a half hour today. Have a fantastic meeting and an extra half hour of your day. Thanks everybody and again we’ll have the recordings and everything made available.

Unidentified Female: Thank you.

Matt Vincenti: It was a pleasure

Unidentified Female: Thank you so much.