Moderator: Welcome to the VA HSR&D Investigator Insights Podcast series. In this episode, QUERI Dissemination Coordinator, Diane Hanks, speaks with Allyson Varley and Stefan Kertesz, affiliate investigators with the VA Birmingham Medical Center. They're discussing work, understanding, and surveying homeless Veterans' experiences with patient-aligned care teams that are tailored towards homeless Veterans' needs.

Diane Hanks: I wanted to start with what may be a simple question or not. How do you define vulnerable Veterans who that being transgender homeless, opioid use disorder? Is it all encompassing or is it more defined?

Allyson Varley: In our project, it's a little bit more defined, right, Dr. Kertesz? I'll let you explain.

Stefan Kertesz: Yeah.

Allyson Varley: Because I know you know a lot more about the cohort than I do.

Stefan Kertesz: Well, we set out to reach individuals who had been homeless. And in truth, the interest is in homeless individuals, and the care of individuals who are homeless. But we recognize that if you want a very large representative sample of VA users who are currently homeless, meaning thousands, that's probably going to be incredibly expensive. Because you'd have to somehow start dealing with the fact that a lot of them don't have any method of contact, at least some contingency –

Diane Hanks: Right.

Stefan Kertesz: – Of them.

Diane Hanks: Right.

Stefan Kertesz: What we chose to do is to seek a very large, random sample of people who had been homeless or were potentially, currently homeless, but at least were enrolled in VA primary care since the study was about their experience in primary care. And we recognized up front that some of those people would be already housed, and settled, and perhaps only partly reflective of the population of interest. And some of them would be less settled, and potentially more reflective of the most vulnerable.

Diane Hanks: And you used a survey. Tell us about that.

Allyson Varley: Dr. Kertesz created a measure of primary care quality for homeless experienced individuals.

Stefan Kertesz: Yeah. Yeah. At the outset of the first version of this study ten years ago, my goal was to take it off-the-shelf primary care experience survey, and compare the experience of homeless patients in different kinds of clinics. Because we wanted to understand, if specialized clinics that purport to really offer special services for the homeless succeed in building better relationships with those patients?

 And at the time I was planning the study, a well, a historically very important VA researcher, Carol Ashton, and Dr. Ashton said, "Nah, I don't think you can just take an off-the-shelf survey for this population. You're going to have to build one yourself." And I was definitely displeased by her advice because it meant, essentially, we threw three or four years of work into instrument development.

Diane Hanks: Right.

Stefan Kertesz: That the tool that resulted from a process of qualitative interviews, and field testing, and item response theory, and confirmatory factor analysis was a 33-item survey of primary care questions that actually are quite a bit easier to answer than standard SHEP or CAHPS items, and also highly focused on issues that were flagged to be important, and relevant to people who –

Diane Hanks: Were at home.

Stefan Kertesz: – Had been homeless. These are Likert type items with agree, disagree. One of the question was if I could not get to this place, they would reach out to try to help me get care. That's a question that's designed to address accessibility of services. It doesn't presume that you have a telephone. It doesn't presume that you walked in even. In that case it's actually about what happens when things fall apart.

 And the patient's assessment of whether the clinic would reach out to try to help them get care is potentially very, very important for a population that's highly unstable. And yet, the way the question is worded, it doesn't even presuppose that we know exactly how that would be done. It turns out that different homeless PACTs, which operate in the VA, different ones use going out to places where their patients sometimes congregate or to the low-rent districts where the VA has placed them in HUD-VASH housing, or calling them by telephone, or asking their friend if they've been seen.

Diane Hanks: Right, right. Can you talk about some of the findings from your study?

Stefan Kertesz: Or do you want to hear about the recruitment?

Diane Hanks: Talk about the recruitment first.

Allyson Varley: To recruit homeless experienced Veterans, we contracted with a survey research group who helped collect the data, correct, in recruitment. It's hard for me; I'm going to have to look at my notes, too, now.

Stefan Kertesz: You have time, we're not live.

Diane Hanks: Yes.

Allyson Varley: Right, I know. That's all right.

Stefan Kertesz: Seeing an audience, it's not –

Allyson Varley: That's what, it's, like, so good.

Stefan Kertesz: It's not \_\_\_\_\_ [00:05:07].

Allyson Varley: And I don't want to be slow. Yes. We contacted, we contracted with a professional survey research organization. And what they did was – so you, Dr. Kertesz, your team, pulled all of the potential cohort addresses from the CDW, and then gave them….

Diane Hanks: Which is the corporate data warehouse.

Allyson Varley: Yes.

Diane Hanks: Right.

Allyson Varley: Yes. And then, we gave these addresses to the survey research organization. And then they went and validated all of them. To do that, the thing, I think the first step was they went and checked to see if it was even, like, it could be sent through the post office? They updated it so that it was up to post office standards. And I think they did that for about 65% of the addresses.

Stefan Kertesz: If it would fix them.

Allyson Varley: Yeah.

Diane Hanks: They would be addresses where it was sure to get mailed –?

Allyson Varley: Yes.

Diane Hanks: – And reach the Veteran?

Allyson Varley: Yes. Then they coded everything as either residential or business addresses. And for the addresses that weren't valid, they used a commercial address.

Stefan Kertesz: One of them was called Melissa Data.

Allyson Varley: Yes.

Stefan Kertesz: It's just a commercial service. If you have a name, and maybe a phone number, and you want to find an address that was pinged by a commercial source or governmental source in the last year for that individual, Melissa Data will provide it.

Diane Hanks: Wow.

Stefan Kertesz: They ran, so where they had some trouble with the VA address, they went to Melissa Data.

Allyson Varley: Yes. Then if the Melissa Data –

Diane Hanks: It's like detective work.

Allyson Varley: – One didn't work – yes – if the Melissa data one didn't work, they would use premium white pages.

Stefan Kertesz: Where you can manually check individual.

Allyson Varley: Yes. Yes. Then, if none of those worked, they would revert back to the VA address, and then use phone calls to try, and get in touch with the participants. That was quite labor intensive. But not only did they do that, they sent out our surveys in these waves. It was pretty rigorous recruitment strategy.

 The first thing they sent out was a notification that said, "We're going to be sending you a survey," or, "We're doing this study and we're going to send you a survey." Then, like, a week later, they sent a survey with a dollar. And if they didn't, if the participant didn't respond to that, they were sent another reminder letter. If they didn't respond to that, they were sent a second copy of the survey. And if after those four contacts they hadn't responded, they started calling people.

Diane Hanks: What was the response rate?

Allyson Varley: It was 40%.

Diane Hanks: Yes.

Stefan Kertesz: Our goal was 40%. And we were sitting at 39.7% or 39.6.

Diane Hanks: Yes.

Stefan Kertesz: And the study coordinator, Aaron, recognized that, actually, maybe about 200 people had died at the time that we sent the survey out to them. Because you pull, you do a data poll –

Diane Hanks: Right.

Stefan Kertesz: – You're sitting on this data.

Diane Hanks: Right, right.

Stefan Kertesz: – Thinking they're alive. They're not alive at the moment you first…. You said, "We can reasonably subtract from the denominator –"

Diane Hanks: Yes.

Stefan Kertesz: "– The people who are dead at the – "

Diane Hanks: Right.

Stefan Kertesz: "– Moment we sent the survey."

Diane Hanks: Right.

Stefan Kertesz: And then that reduces on how many – and we went –

Diane Hanks: Yes.

Stefan Kertesz: – And used 40.2%. The other thing that, kind of, came through for me. We always wanted to have a certain percentage who were reached by telephone. And the reason for that is we knew a lot of homeless individuals. Actually, it's already been shown by another VA researcher, Keith McInness, that lots –

Diane Hanks: Yes.

Stefan Kertesz: – Of Veterans who are homeless have telephones.

Diane Hanks: Yeah.

Stefan Kertesz: And we're….

Allyson Varley: I think it's, like, 90%.

Stefan Kertesz: Ninety percent.

Diane Hanks: Ninety percent?

Allyson Varley: Yes.

Stefan Kertesz: They're having government programs to provide phones for people –

Diane Hanks: Right, for homeless.

Stefan Kertesz: – Who are engaging in benefits programs.

Diane Hanks: Right.

Stefan Kertesz: But I don't think that's the full story. A lot of people have some income and that's a pretty important part of life. But the thought we always had was, if we're assessing the experience of individuals who are homeless in primary care, and we know that our sample just by its nature is enriched with people who won't, who currently have homes, we have to try to do something extra to address the possibility that our sample is biased. In fact, it is biased.

Diane Hanks: Right.

Stefan Kertesz: We consume that. And reaching those people who have phone only and no address –

Diane Hanks: Right.

Stefan Kertesz: – Seemed like a very important step.

Diane Hanks: Right.

Stefan Kertesz: We had designed it. And that we weren't going to get most of them that way, but we figured we would have a subset that were by phone. And it was the contractor who said, "Look, we're going to call everyone we don't hear from rather than some subset randomly selected."

Diane Hanks: Right.

Stefan Kertesz: And they just did it. Under the contract, they, kind of, expanded their work but they didn't –

Diane Hanks: Yes.

Stefan Kertesz: – Demand extra payment. They just wanted to produce the right number of surveys.

Diane Hanks: That's \_\_\_\_\_ [00:09:57].

Stefan Kertesz: And you'd think, "Okay, so we're going to do surveys by phone." Yes, some people did it by phone, computer assistant stuff.

Diane Hanks: Right.

Stefan Kertesz: And they'd do that to maybe 7% of our data. But a lot of people reached by phone said, "No, you can get me to survey by mail. Wouldn't you mail it here?"

Diane Hanks: Yes.

Stefan Kertesz: A lot of phone outreach just simply led to an instruction for a different address. Because even people who are homeless still receive mail. It wasn't just the telephone people necessarily who are homeless. It was, there were people who just had addresses, maybe an ex-girlfriend or a –

Diane Hanks: Right.

Stefan Kertesz: – Shelter or a case worker or a lawyer, and they would have their mail get to some place. And they still seemed on average to like the idea of, "I'll fill this out on paper, but just please mail it to the address I specify."

Diane Hanks: Right. Right. What were at the findings?

Allyson Varley: The findings were, I mean, the biggest one was that we had a goal of recruiting, of a 40% response rate. And we achieved that. And we did, but we achieved that because of these strategies we used for recruitment. We did get a little bit of, we gained a little bit of knowledge about what VA addresses look like. Aerin deRussy, who, this was kind of her project. She's on maternity leave and so I'm here on her behalf right now.

 She went and did, like, a pretty large literature review on, like, how these CDW addresses have been used before. And to her knowledge, and our knowledge, no one has really gone in there, and looked at, like, how valid the addresses were.

Diane Hanks: Right.

Allyson Varley: I think, what was it, 80%?

Stefan Kertesz: Were quite good– so the VA provided address is pretty good. That's the first lesson here.

Diane Hanks: Right.

Allyson Varley: It needs to be updated to post office standards because –

Stefan Kertesz: Yes.

Allyson Varley: – Like I said, about 65% of –

Diane Hanks: Right.

Allyson Varley: – The addresses were updated. But we ended up retaining the VA addresses. They can be used to reach harder to reach populations.

Stefan Kertesz: They could add a comment about the recruitment and then go to the study first as a study. The other elements of recruitment is to recognize that when we say we're looking for homeless experienced people, we're relying on the presence or absence of interaction with VA's homeless services at some point in the past or a homeless diagnosis in their record. Well over 90% of people in our sample said, "Yes, I have been homeless."

Diane Hanks: Yeah.

Stefan Kertesz: There is a high plausibility at least to using that as a tool to find that population. However, there were individuals who contacted us during the course of the recruitment process to say, "I've never been homeless. Why are you contacting me? This is upsetting." And in fact, because they had –

Diane Hanks: Yes.

Stefan Kertesz: – Other experiences with the VA where they felt their records were messed up, and this –

Diane Hanks: Right.

Stefan Kertesz: – Would contact for the survey itself was then annoying.

Diane Hanks: Right.

Stefan Kertesz: And I had to sometimes go right back into the VA chart and figure out what was it that might have triggered –?

Diane Hanks: Yes.

Stefan Kertesz: – This diagnostic designation? And it turns out that if you come in to a VA, and maybe you need temporary assistance with being about to lose your apartment or being unable to pay your electric bill, and they might send you to a clinical social worker who's tied to homeless services to help with that short-term issue. And they may very well put in a diagnostic code that's not actually homeless, but it's in that same family.

Diane Hanks: It's an indication that it might. Yeah.

Stefan Kertesz: These are. There's a Z59 family under the ICD-10. There was a V60 family under the ICD-9 coding system. And sometimes people get these diagnoses that are really about temporary economic need. And I personally provided letters to some of these patients to assure them this is what happened. No, you were not designated homeless by the VA, which for some people is very stigmatizing.

Diane Hanks: Yes.

Stefan Kertesz: It's truly a matter of we had this methodology that tends to sweep up people a little more generously. And that's how you wound up in this, but it does not –

Diane Hanks: Right.

Stefan Kertesz: – Indicate that the VA views you as homeless.

Diane Hanks: Right.

Stefan Kertesz: I do think once you were going to reach thousands of Veterans through a survey, there has to be people who are ready to respond individually to the things that will come back at you –?

Diane Hanks: Right.

Stefan Kertesz: – Including, why are you contacting me?

Diane Hanks: Yes.

Stefan Kertesz: No one was terribly upset, but one person needed a letter from me. In terms of the findings, our goal was to assess these homeless patient-aligned care teams. These are teams that were set up in 2012. They had a special primary care service, which is they involved extra time, smaller panel size, the ability to do outreach. The clinics had access to resources like food and sometimes clothing, showers that have had very tight connections to the local VA homeless services, or also to non-VA homeless, and social services.

 And our hypothesis was that patients who are homeless-experienced who are receiving primary care in these kinds of clinics would have a better primary care experience using our survey than those who are homeless-experienced using mainstream primary care. And it's key to understand that at any given VA, even when there is a homeless PAC team like this –

Diane Hanks: Yes.

Stefan Kertesz: – Only 15 to 20% of people who are homeless-experienced wind up in the homeless PAC team. And it's not that – yes, the homeless PAC team sometimes will reach people whilst they're entering shelter or something, but to some degree it's a little bit of randomness. There's people just bouncing around the system, and they get, some get channeled to the homeless PACT, and some have always been connected to a different primary care service.

Diane Hanks: There's not a screening process that will –?

Stefan Kertesz: That will force, no.

Diane Hanks: – Follow those people? No.

Stefan Kertesz: And it can be informal things. Sometimes if a Veteran goes to a particular social worker in Homeless Services, they maybe, very well say, "If you don't have primary care, we're going to send you here." But they would be loath to interrupt, typically, an –

Diane Hanks: Right, right.

Stefan Kertesz: – Existing primary care relationships.

Diane Hanks: An existing relationship, yeah.

Stefan Kertesz: That randomness, it's not exactly random; that quasi-randomness meant –

Diane Hanks: Yes.

Stefan Kertesz: – That there's always comparable homeless PACT patients –

Diane Hanks: Right.

Stefan Kertesz: – And homeless-experienced patients who are in mainstream primary care at –

Diane Hanks: Yes.

Stefan Kertesz: – The very same VAs. Now, you have two groups getting care in different models in the same locations.

Diane Hanks: Exactly.

Stefan Kertesz: We looked at 26 different VA Medical Centers. There are actually 29 homeless PACTs. Our sample was about two-thirds of people in these homeless PACTs, and a third not.

Diane Hanks: Yes.

Stefan Kertesz: It's a 5,776 respondent pool.

Diane Hanks: It's pretty large.

Stefan Kertesz: It's several thousand in each group.

Diane Hanks: Yes.

Stefan Kertesz: We not only assess the primary care experience, we assessed a wide range of characteristics, emotional factors, social factors that might confound the relationship between where you see primary care and how you ready. You can imagine that if you're very depressed, and maybe the people in the H sector are systematically depressed. Maybe they rate their relationships with primary care providers worse because they just feel down.

Diane Hanks: Yeah.

Stefan Kertesz: You want to control for that.

Diane Hanks: Yes.

Stefan Kertesz: In our comparative analysis, the first thing we saw was that not adjusting for anything, primary care was rated better on every scale, if it's in an HPACT compared to a mainstream primary care. Adjust for everything, including the site, including characteristics associated with responding or not responding to the survey, that relationship gets a little stronger, and a little more self-evident.

 We then looked at the actual categorical outcome of an unfavorable experience on people who answer frankly negatively to items that are positive. Like, if there's a question – one of the items, "Does my primary care provider listen to me?"

Diane Hanks: Yes.

Stefan Kertesz: If you disagree with that, that's negative. And we usually get two or three frankly negative items on any given scale.

Diane Hanks: Right.

Stefan Kertesz: We view that as an unfavorable experience.

Diane Hanks: Right.

Stefan Kertesz: Unfavorable experiences were about a third less common in the HPACTs than in mainstream primary care for this population. We then, sort of, cordoned off a subgroup of respondents, both in the HPACTs and the non-HPACTs. We've looked at people who are very vulnerable in terms of four things that often make primary care particularly difficult: a recent unsheltered experience, severe chronic pain –

Diane Hanks: Yes.

Stefan Kertesz: – A personal history of overdose in the last three years, which signifies a serious addiction problem –

Diane Hanks: Right.

Stefan Kertesz: – And severe emotional distress.

Diane Hanks: Yes.

Stefan Kertesz: If you had two or more of those, we said, those are very vulnerable people. And first of all, for people, regardless of whether they were very vulnerable or not, HPACTs outperformed the mainstream primary care. For people who are very, particularly vulnerable in terms of having two or more of these vulnerabilities, overdose, severe emotional distress, unsheltered homelessness, severe chronic pain, Homeless PACTs were, less commonly had these unfavorable experiences compared to mainstream.

 And there was an interaction on two of our four scales. We have a scale for the perceived relationship to the provider, the difference between HPACTs and mainstream primary care was even greater for these very vulnerable patients, if they were in an HPACT versus mainstream compared to the less vulnerable.

 There was a real interaction there. Similarly, for patients for the scale on perceptions of cooperation among your caregivers, we actually asked about whether patients see cooperation among the people taking care of them?

Diane Hanks: Yes.

Stefan Kertesz: And I should note that's not a question that's asked in the CAHPS or the SHEP at all. But for people, that particular little three-item scale, unfavorable experiences are always very common. Patients routinely see that people aren't working well together. But there was a much larger difference in favor of the HPACTs for these high vulnerability people.

 For the two other scales, one was on accessibility and coordination of services. The other was on homeless-specific needs. Yes, HPACTs did better than mainstream, but it wasn't a bigger difference.

Diane Hanks: Right.

Stefan Kertesz: Those findings are quite large. I think –

Diane Hanks: Right.

Stefan Kertesz: – Unfavorable experience for the high vulnerability people, well over 50 percent of those people have unfavorable experiences in mainstream primary care, and it falls for around 28 to 30% in HPACT. It's a really big difference.

Diane Hanks: Big difference…. Do you think it's because the HPACT team either has more empathy, more interest, or they're, the team has a mission, a cohesive mission? Do you think that's why there is this?

Allyson Varley: We're working on figuring that out. Not only did they collect all of this data from the patients of these clinics, we also surveyed 52 HPACT providers, and did somewhat of an organizational assessment.

Stefan Kertesz: We're trying to develop scales that will assess the properties of the HPACTs as organizations so that ultimately, we'll be able to assess, at least for correlations between characteristics of the HPACTs. You remember, this is 29 HPACTs.

Diane Hanks: Yes.

Stefan Kertesz: And I told you when we had an imbalanced sample with more HPACT respondents –

Diane Hanks: Right.

Stefan Kertesz: – It was because of this. We want to be able to –

Diane Hanks: Yes.

Stefan Kertesz: – The next analysis we want to do is to ask, okay, we've assessed the HPACTs using a handmade tool that we're currently working on validating the scales within it.

Diane Hanks: Right.

Stefan Kertesz: And then we'll be able to say, what really stands out that seems to be most associated with better patient experiences is A versus B.

Diane Hanks: Right.

Stefan Kertesz: But just to give you a sense of the things we're looking at, we have a set of questions about the accessibility of other services that primary care needs to make happen for you. Like, how close or how easy is it for your patients to access specialty medical care or addiction care or pain care?

 We have a set of questions that are really much more focused on team identity and team-ness of the people in the HPACTs. They're, sort of, how much do you guys feel like you're in this for a special purpose – ?

Diane Hanks: Right.

Stefan Kertesz: – And then you really care about these folks? We have questions about ease of access in terms of how readily can you accommodate somebody who walks in, which gets a little bit at the smaller panel size? Right now, officially, we don't have a scientific finding that speaks to that. There are two things that I anticipate matter.

 One is that it is true that they have smaller panel sizes. And that HPACT panels are, kind of, running from about 50 to 600, but most of them are between 200 and 400 in size. The medical acuity using standard VA make Nosos scores, is usually two to three times higher in HPACTs than in VA's primary care as a whole.

 Small panels, actually it looks like low work productivity for the management –

Diane Hanks: Yes.

Stefan Kertesz: – But patients are vastly sicker, and vastly more morbid than –

Diane Hanks: Yes.

Stefan Kertesz: – Typical primary care. I think that's going to matter. But we did a lot of site visits just to collect, to begin to think about how to build our own instrument, and its team identity, and the way the staff feel in relation to each other's of great interest to each other, and to us. We think that the team that laughs together and cries together –

Diane Hanks: Yes.

Stefan Kertesz: – And can celebrate together –

Diane Hanks: Yes.

Stefan Kertesz: – And can boost each other up –

Diane Hanks: That makes a difference.

Stefan Kertesz: – Might matter, but in principle, we don't know that until –

Diane Hanks: Yes.

Stefan Kertesz: – We've gotten a chance to test.

Diane Hanks: Right.

Stefan Kertesz: We assessed. We presented about 140 different organizational items to these 52 people in 29 HPACTs. Not all of them are good, not all those items can be used for the analysis. And then they have to be clumped into scales that work plausibly, statistically, and also intellectually. That's a process we've been doing for the last couple of months.

Diane Hanks: Carol Ashton's recommendation was a good one?

Stefan Kertesz: Yes. I think that it was a good one for two reasons in terms of my career development, first of all.

Diane Hanks: Yes.

Stefan Kertesz: That I was forced to learn about qualitative research.

Diane Hanks: Yes.

Stefan Kertesz: I had never learned about. I was supposed to – I had to learn about scale development. Her suggestion honored my gut instinct, which was that standard metrics often don't work when –

Diane Hanks: Right.

Stefan Kertesz: – We're trying to talk about extremely vulnerable populations.

Diane Hanks: Right.

Stefan Kertesz: The goal should be to make measurable what is good rather than to apply typical measures that don't capture what actually matters.

Diane Hanks: Right.

Stefan Kertesz: The challenge going forward is that when you have a unique scale, we will have to go through a lot of bureaucracy to make that scale one that people in the VA can use without breaking a rule. Then to use a new survey in the VA, it has to go through review by the Office of Management and Budget. We have to carry it through such a bureaucratic process in order for VA HPACTs to use it as part of medical care. We haven't done that yet.

Diane Hanks: Which leads me to my final question. Barriers and facilitators as researchers working within VA, we have rich data sources, but we also have bureaucracy. Does everything balance out?

Allyson Varley: I think so. I have just now celebrated my one-year anniversary working for Dr. Kertesz. And there is a lot of bureaucracy. There's a lot of things that make things go slower than we would like. But as a young, relatively new researcher, to work for one of the most advanced healthcare systems in the world is, like, such an amazing place to be. I would say, yes, it balances out.

Stefan Kertesz: I think one of the key barriers when you want to understand how a healthcare system works is –

Diane Hanks: Yes.

Stefan Kertesz: – You should be able to pay the people who work within the system to participate in your research. In order for me to really understand the HPACTs, we had to survey HPACT staff. But we are prohibited from compensating them, from answering our surveys if the answers are being provided during ordinary work hours, which is when most of the work actually happened.

Diane Hanks: Yes, right.

Stefan Kertesz: And I think there should be a little carve-out for people doing a survey to get some modest valued reward –

Diane Hanks: Right.

Stefan Kertesz: – For contributing to the research endeavor –

Diane Hanks: Right.

Stefan Kertesz: – Without it breaking some rules that currently apply.

Diane Hanks: Yes.

Stefan Kertesz: As things stand, of 59 targeted individuals, 52 agreed to go through a 45-minute interview by phone with a live human being. That took a year to accomplish and required a lot of persistence. But I think it might have been a little faster –

Diane Hanks: Right.

Stefan Kertesz: – If we could legitimately just reward them for that.

Diane Hanks: Right, right. But it does speak to their dedication.

Stefan Kertesz: Their dedication must be high that so many –

Diane Hanks: Right.

Stefan Kertesz: – Were willing to put up –

Diane Hanks: Yes.

Stefan Kertesz: – With us on the phone.

Moderator: The views and opinions expressed in the preceding podcast are concerned with the scope of recently concluded or ongoing VA HSR&D funded research and do not necessarily reflect current or to be implemented VA policy. To learn more about this research visit the VA HSR&D website at www dot hsrd dot research dot VA dot gov. Thank you.

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