U.S. Department of Veterans Affairs

Focus on Health Equity and Action:

Incorporating Social Determinants of Health into VHA Patient Care and Electronic Health Records

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Thursday March 30, 2017 @ 3PM EST

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WHAT YOU CAN EXPECT

- Background
  - VA Health Equity Action Plan - HEAP
  - Social Determinants of Health - SDOH
- Incorporating SDOH into Electronic Health Records (EHR) & Personalized Health Plan
- VA Data Sources related to SDOH
- Addressing SDOH - HPACT example
- Discussion with Q &A

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VA HEALTH EQUITY ACTION PLAN - HEAP

OHE along with key partners developed the HEAP which Aligns with MyVA, the VHA Strategic Plan (see Objective 1E Quality & Equity), and other agency and national strategic goals. The HEAP focal areas are

- **Awareness**: Crucial strategic partnerships within and outside VA
- **Leadership**: Health equity impact assessed for all policies, executive decision memos, handbooks, procedures, directives, action plans and National Leadership Council decisions
- **Health System Life Experience**: Incorporate social determinants of health in personalized health plan
- **Cultural and Linguistic Competency**: Education & training on health equity, cultural competency to include unconscious bias, micro inequities, diversity & inclusion
- **Data, Research and Evaluation**: Develop common definitions and measures of disparities and inequities; Develop strategies for capturing data on race, ethnicity, language, and socioeconomic status and other variables needed to stratify the results for all quality measures and to address disparities; Incorporate health equity into Strategic Analytics for Improvement and Learning (SAIL)

THE COMMISSION ON CARE REPORT 2016

- RECOMMENDATION #5 – Eliminate health care disparities among Veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the **VHA Health Equity Action Plan (HEAP) is fully implemented**. According to the Commission, despite unique assets that secure VA's position as an industry leader in today's healthcare market, the challenges it faces in ensuring timely access to high quality, equitable healthcare for all Veterans remain real and in need of more action. The Commission made additional sub recommendation to address such challenges:

  - VHA work to eliminate health disparities by establishing health care equity as a strategic priority;
  - VHA provide the Office of Health Equity (OHE) adequate resources and level of authority to successfully build cultural and military competence among all VHA Care System providers and employees;
  - VHA ensure that the HEAP is fully implemented with adequate staffing, resources, and support;
  - VHA increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority Veterans and other vulnerable Veteran populations with strong surveillance systems that monitor trends in health status, patient satisfaction and quality measures.

- VA Administrative Changes for Implementation of Recommendation #5: **Make health equity a strategic priority by directing the implementation of the VHA HEAP nationwide and designating a leader and health equity clinical champions** within each VISN and VAMC for whom part of their respective FTE position descriptions includes focusing on health equity issues…

VULNERABLE POPULATIONS

- ❑ Racial or Ethnic Group*
- ❑ Sex*
- ❑ Age*
- ❑ Geographic Location*
- ❑ Religion
- ❑ Socio-Economic Status
- ❑ Sexual Orientation
- ❑ Military Era/Period of Service
- ❑ Disability – Cognitive, Sensory, Physical
- ❑ Mental Health*
- ❑ Other characteristics historically linked to discrimination or exclusion

*Covered in the National Veteran Health Equity Report - NVHER

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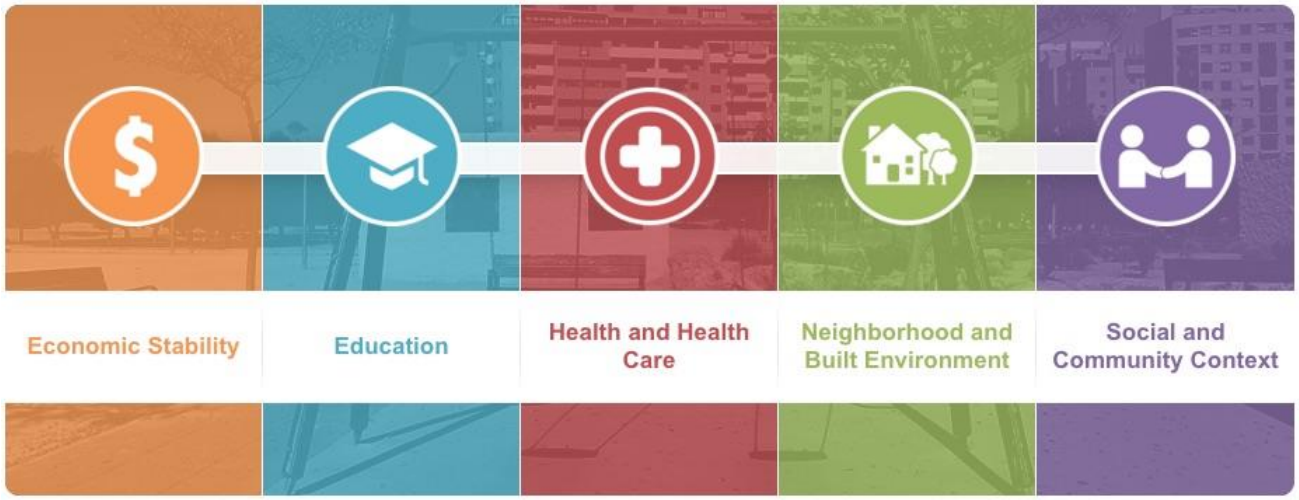
SDOH - HEALTH EQUITY & SEC VA PRIORITIES

1. **Accountability** Legislation – *Implement Commission on Care Recommendation #5 – Eliminate Health Disparities among Veterans: Make Health Equity a Strategic Priority by Implementing the HEAP*
2. Extend the Choice Deadline Past August
3. **Choice 2.0 Legislation**: Eliminate the 40/30 Rule - *Consider any disparate impact of Choice on the vulnerable groups*
4. **Infrastructure Improvement and Consolidations** - *Consider any disparate impact of Choice on the vulnerable groups*
5. **Enhance Foundational Services in VA** - *Embed HEAP implementation into foundational services*
6. **VA/DOD/Federal Coordination** - Veterans health equity data collection/trends
7. **EMR Interoperability and Modernization** - *Incorporate SDOH in the new EHR with connection to DoD & actionable data for vulnerable groups*
8. **Breakthrough in Suicide Prevention -** *Apply equity lens to 2016 suicide mortality report to inform culturally appropriate and tailored prevention strategies for vulnerable Veteran populations as appropriate*
9. **Appeals Modernization** – *Consider disparate impact of appeals on the vulnerable*
10. **Accelerating VBA Performance on Claims** –VA *Benefits provided to Veterans and their families (Income, Housing, Education etc.) impact SDOH*

SOCIAL DETERMINANTS OF HEALTH

- Useful concept for describing the availability and distribution of economic, social, and physical conditions that impact people's health and health care
- Complex components of an individual's health that are key determinants of the well-being of individuals and the communities in which they live
- Personal behaviors, social interactions, and matrix of an individual or population, and the physical environments that **influence an individual's access to care and opportunity to attain the highest level of health and wellbeing**



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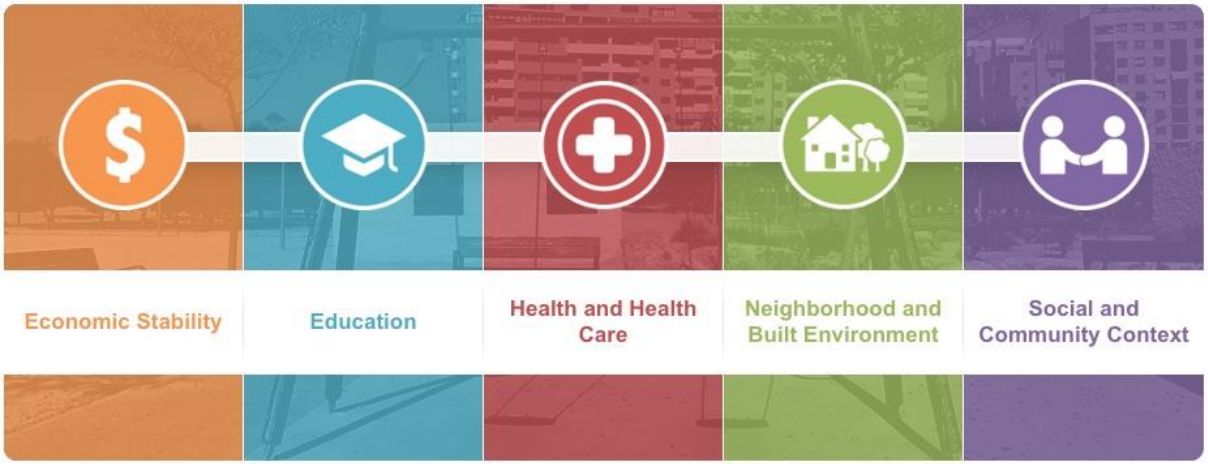
SDOH



❑ Economic Stability

- Poverty
- Employment
- Food security
- Housing stability*

❑ Education includes:

- High School graduation,
- Enrollment in Higher Education language and literacy
- Early childhood education and development

❑ Social and Community Context

- Social cohesion
- Civic participation
- Perceptions of discrimination and equity
- Incarceration/institutionalization

❑ Health and Health Care

- Access to health care
- Access to primary care
- Health literacy

❑ Neighborhood and Built Environment

- Access to healthy foods
- Quality of housing
- Crime and violence
- Environmental conditions

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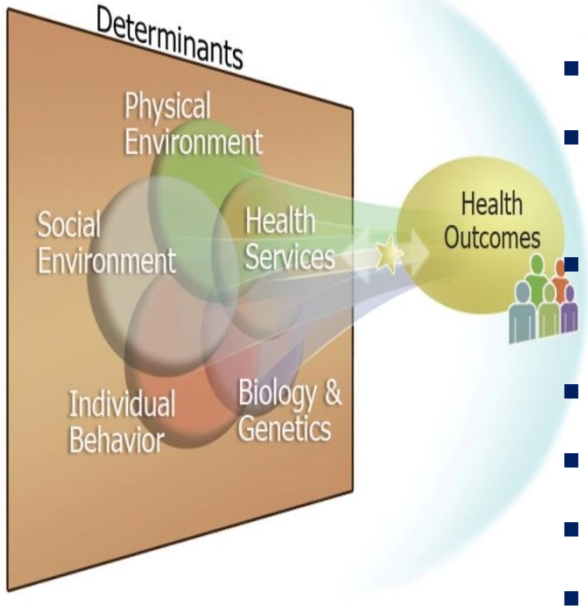
*Social Determinants of Health_ Robert Wood Johnson Foundation

WHY SDOH IN EHR?

❑ Issue

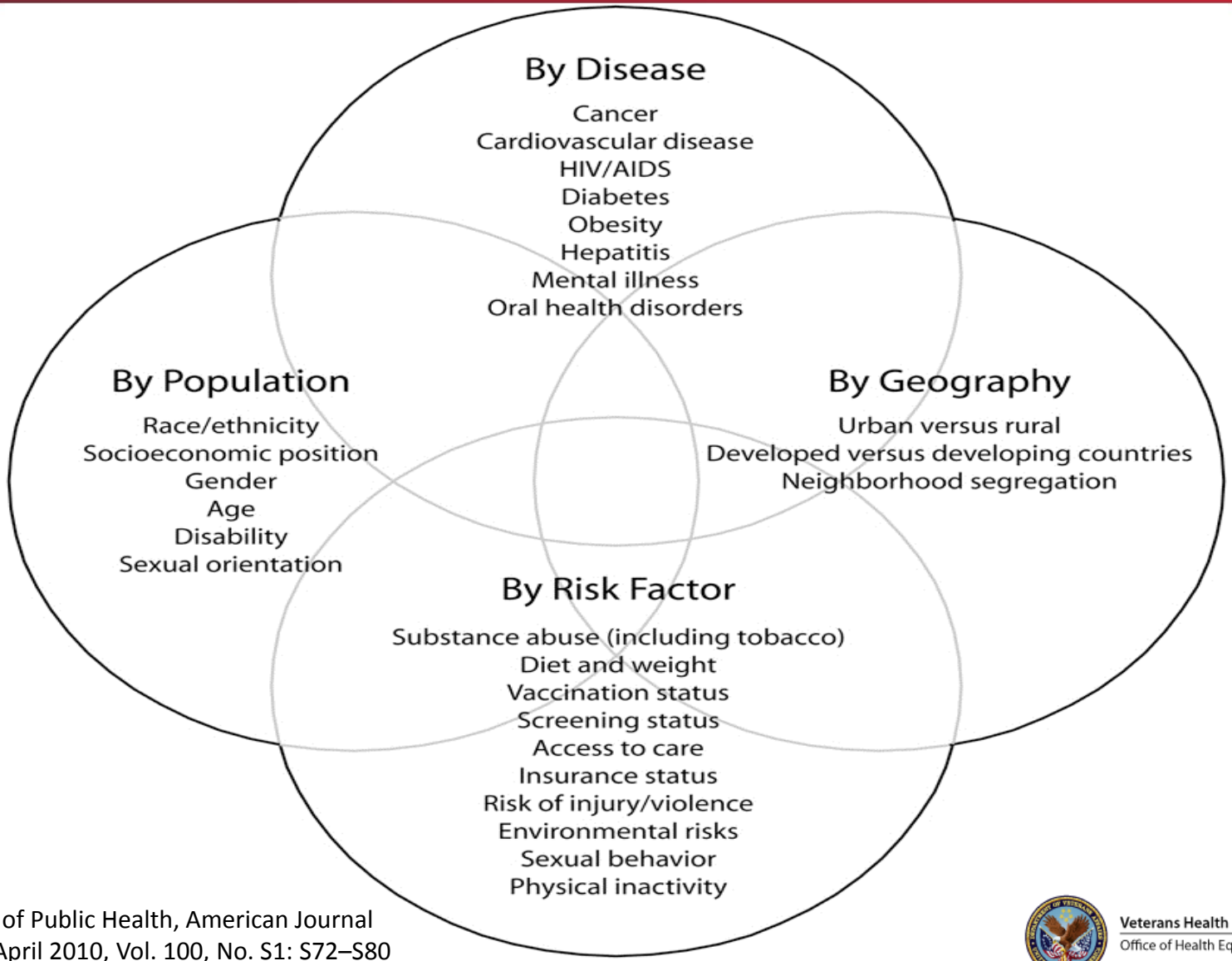
- SDOH factors are not routinely/systematically incorporated in EHR frameworks
- Patients and families with multifaceted social and individual needs are managed without identifying essential data that affect health
- Health care setting disconnected from resources that can help the patients achieve their highest level of health



❑ SDOH in EHR

- Identify, measure, monitor, and risk stratify patients
- Assist clinicians to identify the SDOH factors that are prevalent to their patient population
- Create opportunity to improve the data collection and monitoring of SDOH
- Enable robust coordinated intervention strategies
- Enhance quality of preventive care
- Address health disparities in vulnerable groups
- Comprehensive health record >Personalized Health Plan
- Bridge gap between medical and public health
- Unique opportunity in VA with *Benefi*ts and *Health* arms

"TRANSLATING RESEARCH EVIDENCE INTO PRACTICE TO REDUCE HEALTH DISPARITIES: A SOCIAL DETERMINANTS APPROACH"



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SUGGESTED RESOURCES

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Poll Question 1

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POLL QUESTION #1

- How often does your work focus on social determinants of health affecting Veterans?

  - ❑ Frequently
  - ❑ Occasionally
  - ❑ Rarely
  - ❑ Never

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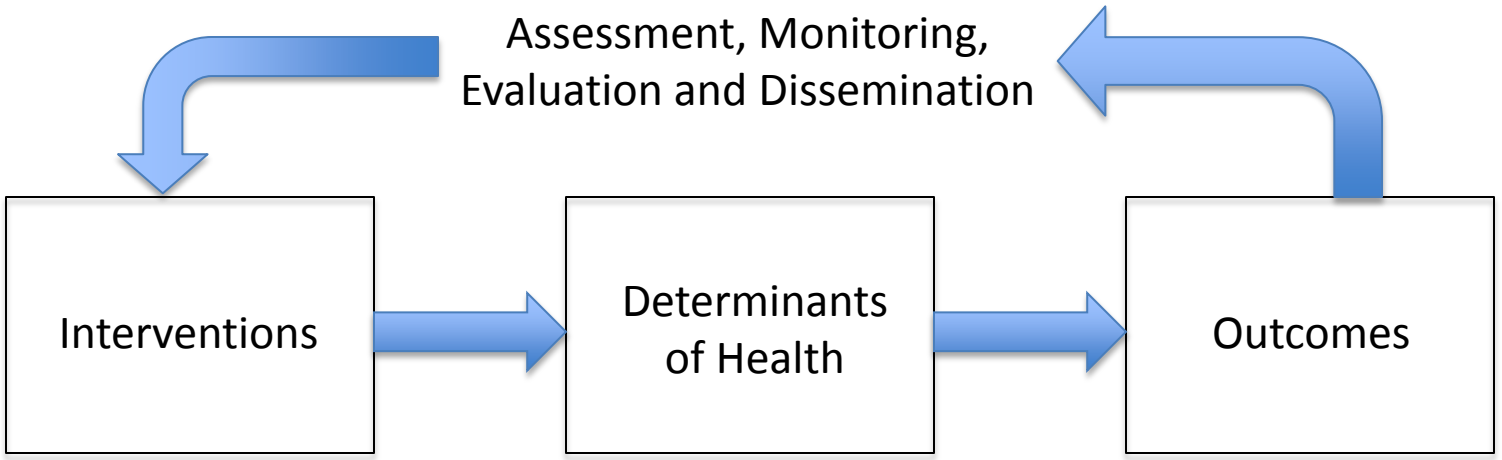
Action Model to Achieve Healthy People 2020



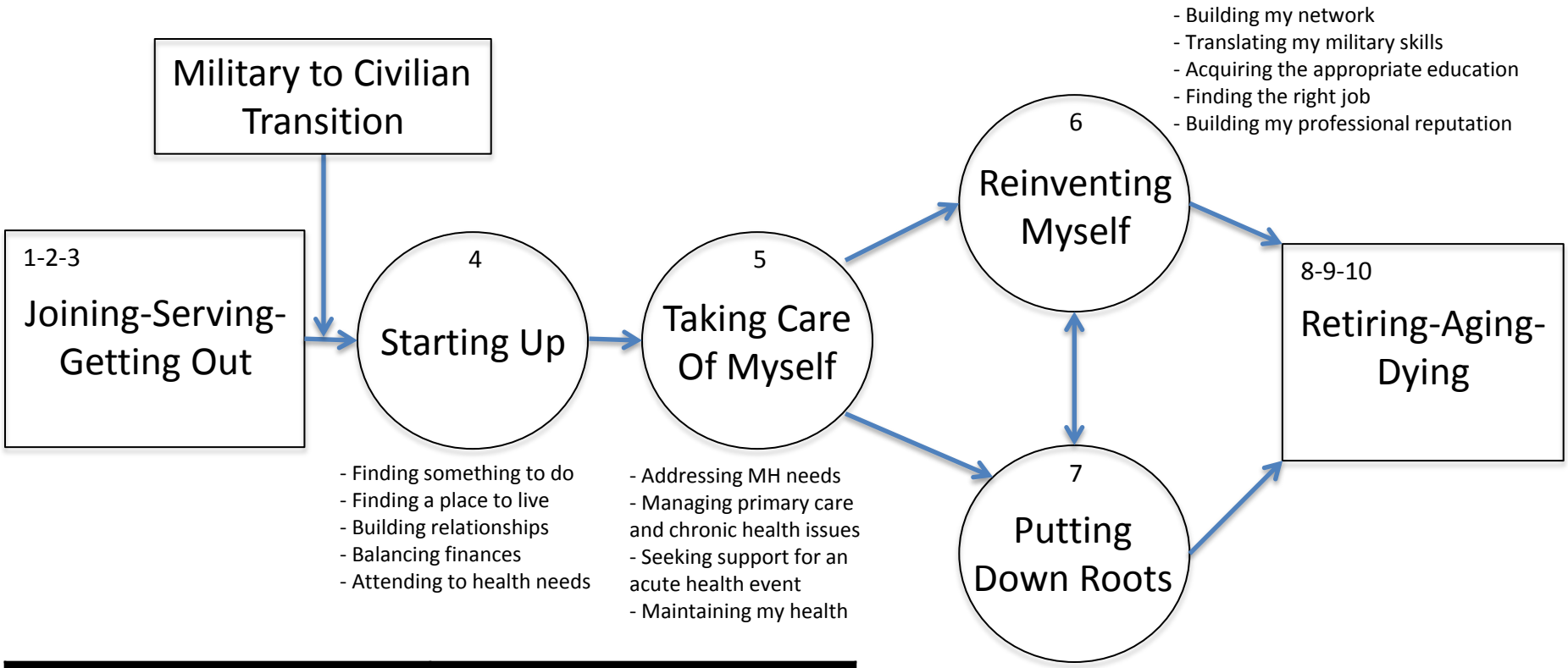
- Policies
- Programs
- Information

- Innate Individual Traits
- Individual Behaviors
- Social, Family and Community Networks
- Living and Working Conditions
- Broad Conditions and Policies

- Behavioral Outcomes
- Specific Risk Factors, Diseases and Conditions
- Injuries
- Well-Being and Health-Related Quality of Life
- Health Equity

Source: The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020, Department of Health and Humans Services, 2008.
Prepared by National Center for Veterans Analysis and Statistics

JOURNEYS OF VETERANS MAP

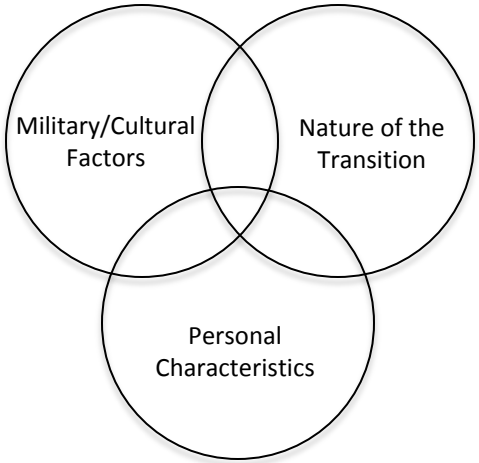


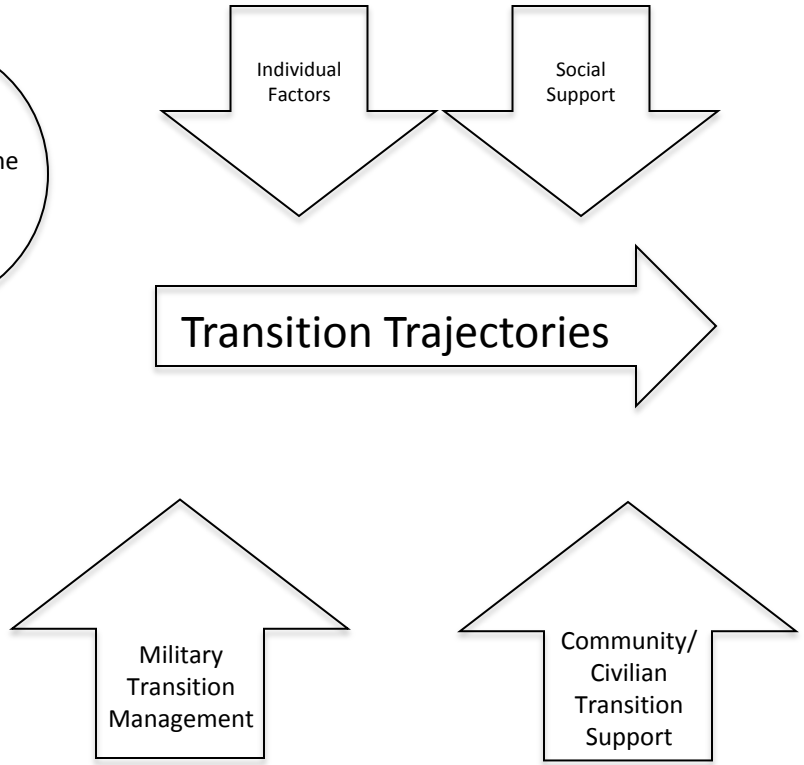
Current & Future Veteran Populations	Degree of Understanding
Subscribers of VA Benefits and Services – roughly 9.6M Veterans	We understand the subscriber population to a high degree.
Non-Subscribers – roughly 12M Veterans	We have little understanding of the non-subscribing population.
Active Duty: roughly 1.3M; Reservists and National Guard: roughly 811K	We have some understanding of the potential population.

Source: VA Veterans Experience Team
Prepared by National Center for Veterans Analysis and Statistics

MILITARY TO CIVILIAN TRANSITION

Approaching Military Transition	Managing the Transition	Assessing the Transition





- Work
- Family
- Health
- General Wellbeing
- Community

Source: Military Transition Theory, Castro and Kintzle (2014)
Prepared by the National Center for Veterans Analysis and Statistics

MILITARY TO CIVILIAN TRANSITION

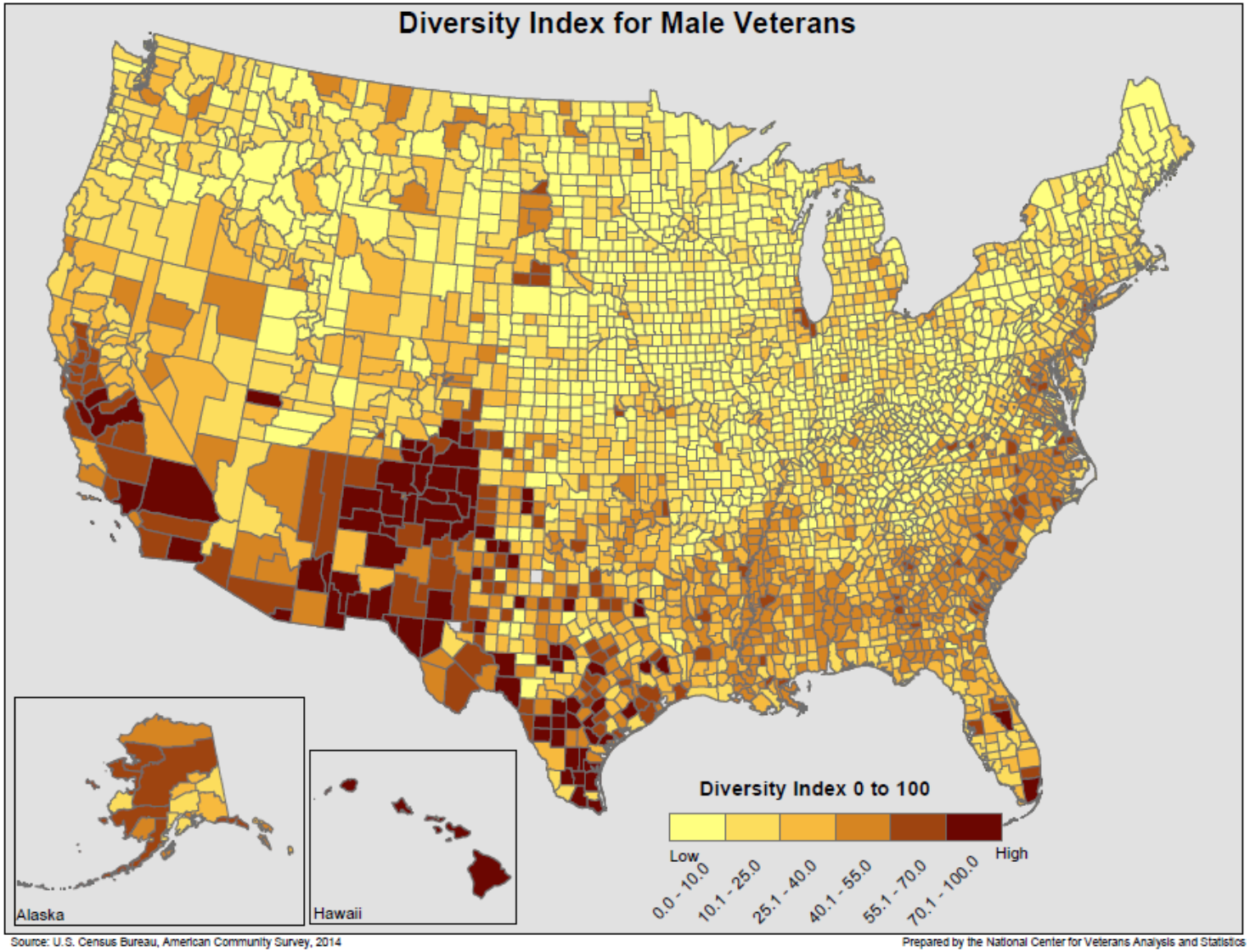
- Conceptual Framework for MCT
- Comprehensive Model for Evaluating MCT across VA and partner organization that make up the Veteran community
- Specific Issues Facing Veteran Groups such as Homeless, Women, Rural, Disabled and LGBT Veterans during MCT

Source: Veterans Policy Research Agenda, 2017
Prepared by the National Center for Veterans Analysis and Statistics

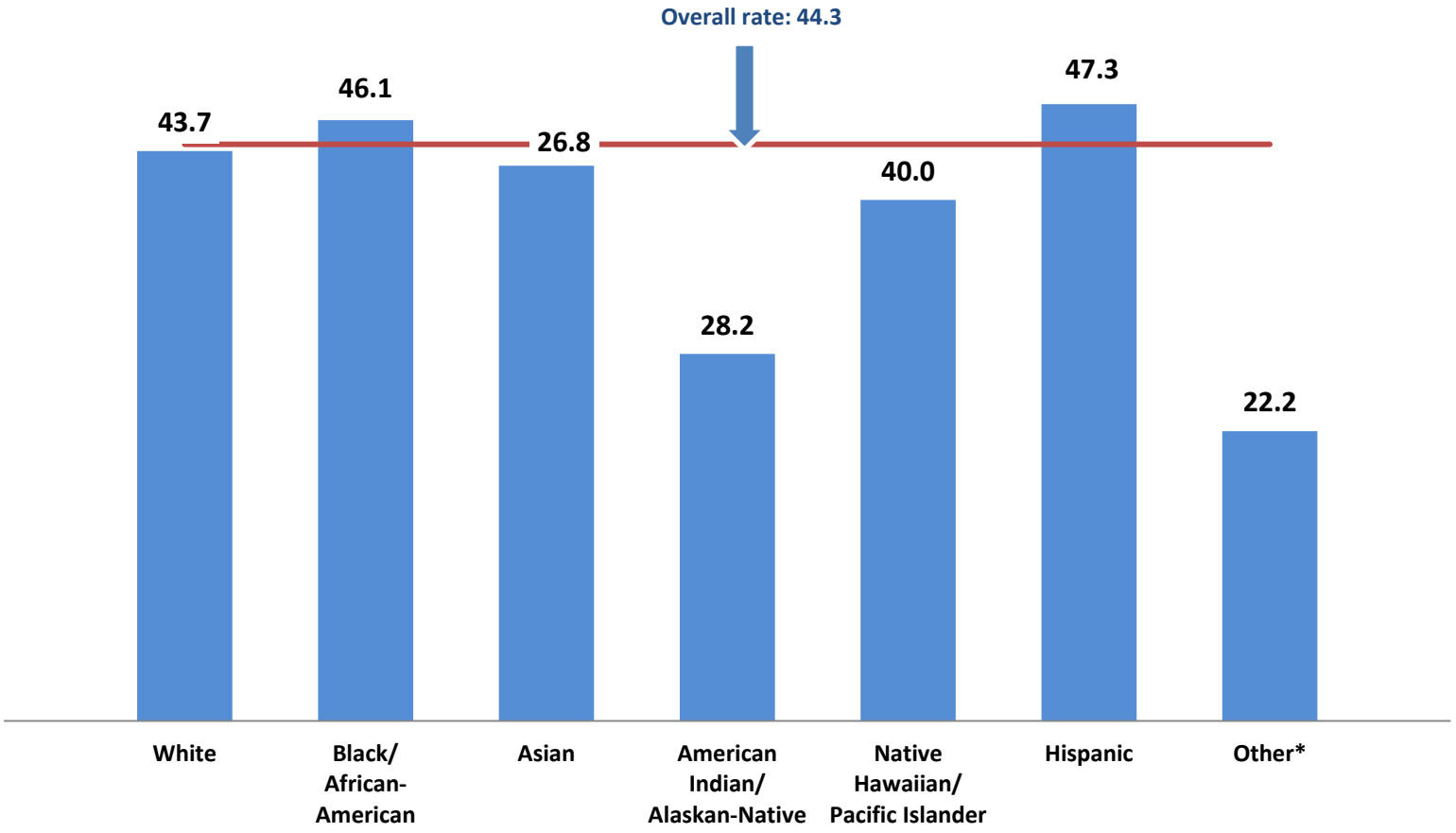
MILITARY TO CIVILIAN TRANSITION

- How does a unified conceptual framework for MCT support the needs and is inclusive of all Veterans?
- How do the specific needs of different Veteran groups affect the utility of such a framework?
- What are the similarities and differences experienced during MCT by specific groups of Veterans?
- How do transition outcomes differ between groups of Veterans with differing needs?

DIVERSITY INDEX MAPS



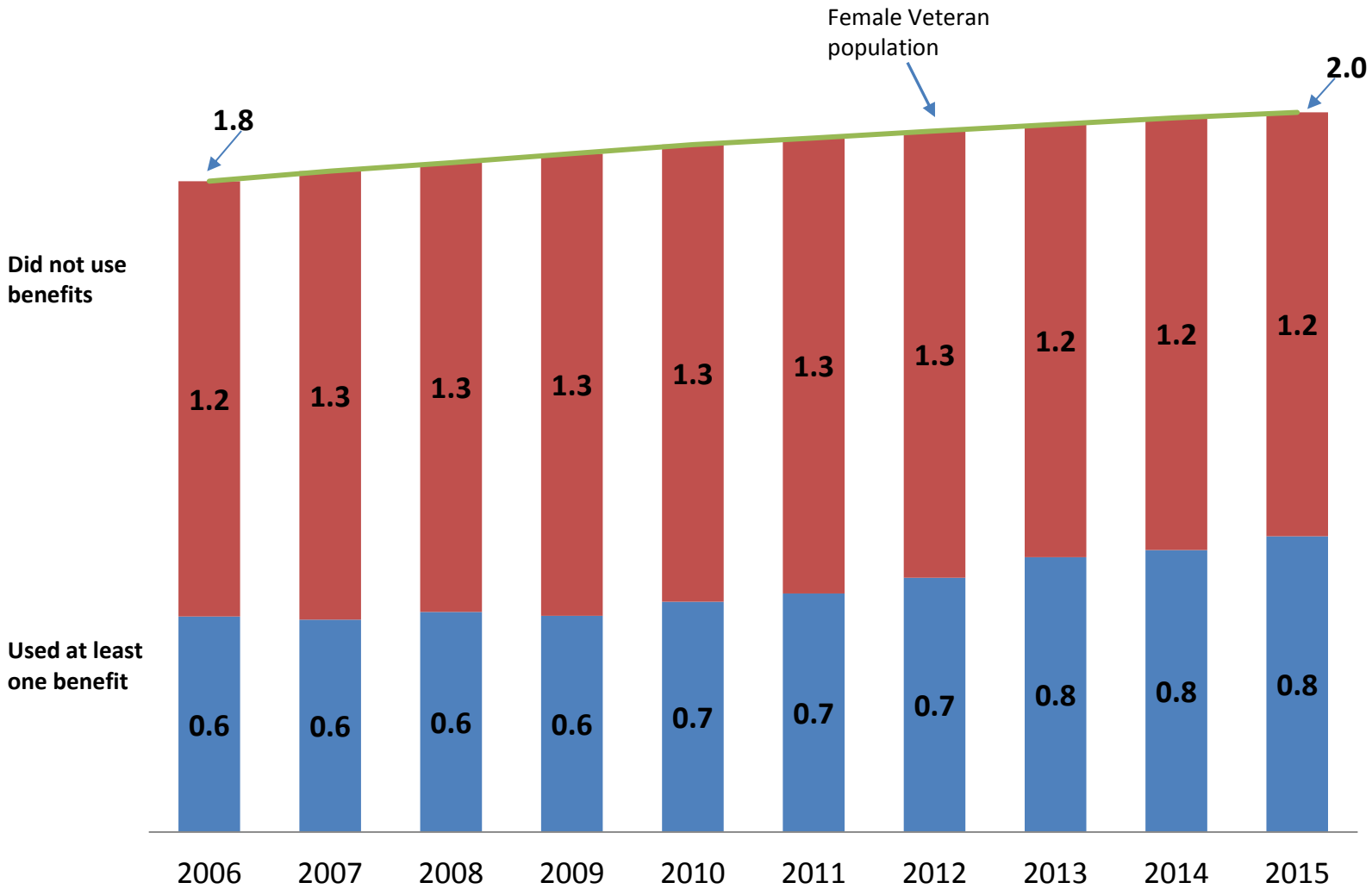
VA UTILIZATION RATE BY RACE AND HISPANIC ORIGIN (IN PERCENT)



*Includes Veterans of two or more races.

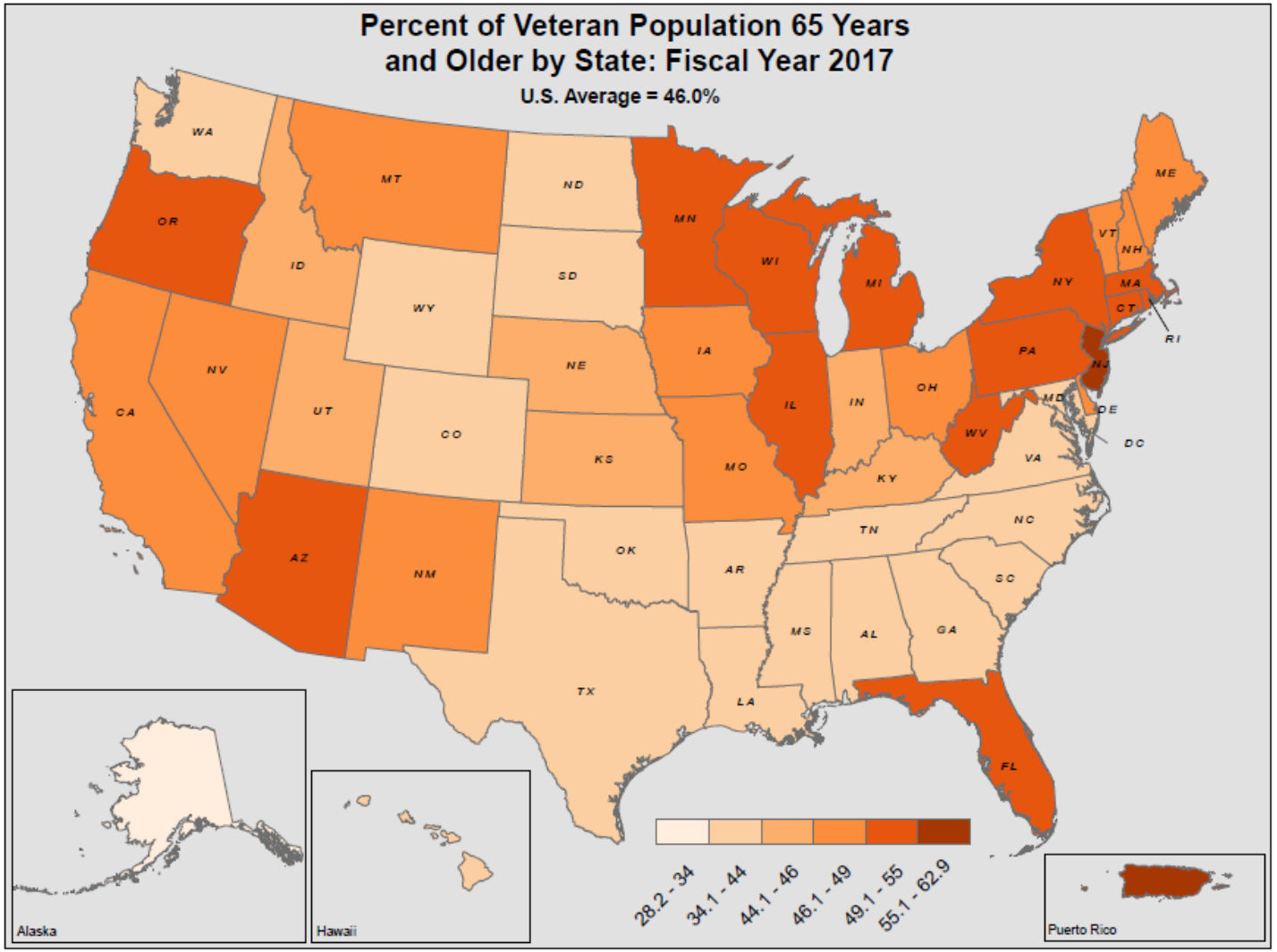
Source: https://www.va.gov/vetdata/docs/SpecialReports/Profile_of_Unique_Veteran_Users_2015.pdf
Prepared by the National Center for Veterans Analysis and Statistics

WOMEN VETERANS USING VA BENEFITS AND SERVICES (IN MILLIONS)



Source: U.S. Veterans Eligibility Trends and Statistics, 2015
Prepared by the National Center for Veterans Analysis and Statistics

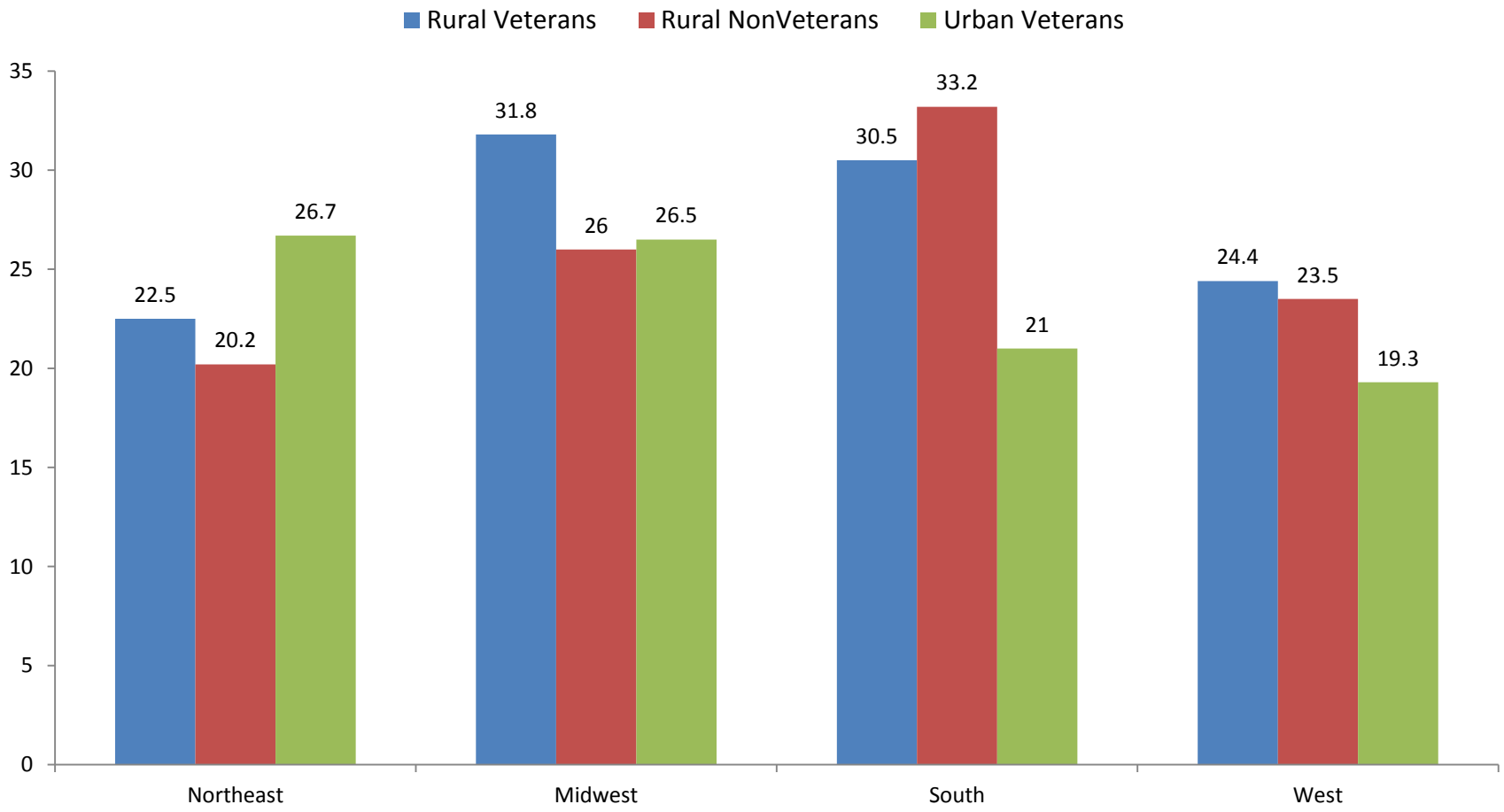
VETERAN POPULATION 65 YEARS AND OLDER (IN PERCENT)



Source: Department of Veterans Affairs, Predictive Analytics and Actuary, Veteran Population Projection Model (VetPop), 2014 as of 09/30/2016

Prepared by the National Center for Veterans Analysis and Statistics

HOUSEHOLDS WITHOUT INTERNET ACCESS (IN PERCENT)



Source: U.S. Census, 2015 American Community Survey
National Center for Veterans Analysis and Statistics

NATIONAL SURVEY OF VETERANS

Popul Res Policy Rev
DOI 10.1007/s11113-015-9358-9

Duty, Honor, Country, Disparity: Race/Ethnic Differences in Health and Disability Among Male Veterans

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Abstract Given their unique occupational hazards and sizable population, military veterans are an important population for the study of health. Yet, veterans are by no means homogeneous, and there are unanswered questions regarding the extent of, and explanations for, racial and ethnic differences in veterans' health. Using the 2010 National Survey of Veterans, we first documented race/ethnic differences in self-rated health and limitations in activities of daily living among male veterans aged 30–84. Second, we examined potential explanations for the disparities, including socioeconomic and behavioral differences, as well as differences in specific military experiences. We found that Black, Hispanic, and other/multiple race veterans reported much worse health than White veterans. Using progressively adjusted regression models, we uncovered that the poorer self-rated health and higher levels of activity limitations among minority veterans compared to Whites were partially explained by differences in their socioeconomic status and by their military experiences. Minority veterans are a vulnerable population for poor health; future research and policy efforts should attempt to better understand and ameliorate their health disadvantages relative to White veterans.

Keywords Veteran health · Health disparities · Race/ethnicity · Military

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Published online: 21 March 2015

Springer

Source: Population: Research and Policy Review, March 2015
National Center for Veterans Analysis and Statistics

CONSUMER EXPENDITURE SURVEY - BLS

- The **Consumer Expenditure Surveys (CE)** program provides data on expenditures, income, and demographic characteristics of consumers in the United States. The CE program provides these data in tables, databases, news releases, reports, and public-use microdata files.
- CE data are collected by the Census Bureau for BLS in two surveys, the Interview Survey for major and/or recurring items and the Diary Survey for more minor or frequently purchased items. CE data are primarily used to revise the relative importance of goods and services in the market basket of the Consumer Price Index. Researchers and government agencies also use CE data to study consumers' spending habits and trends. Here is an overview of the CE program and its methods.

Source: https://www.bls.gov/cex/home.htm
National Center for Veterans Analysis and Statistics

CONTACT INFORMATION - NCVAS

Department of Veterans Affairs
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National Center for Veterans Analysis and Statistics (NCVAS)

For general inquiries, please email us at VANCVAS@va.gov.

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Poll Question 2

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POLL QUESTION #2

- Provide examples or suggestions of how the Department of Veterans Affairs can use household survey data (e.g., Consumer Expenditure Survey) to improve benefits and services and health outcomes of Veterans.

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PAPER REVIEW:

Tailoring Care to vulnerable populations by incorporating social determinants of health: the Veterans Health Administration's "Homeless Patient Aligned Care Team" Program

Preventing Chronic Disease, Volume 13, E
February 2016
www.cdc.gov/pcd/issues/2016/15

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  - Riccardo Aiello
  - Vincent Kane
  - Lisa Pape

HOMELESS PERSONS HAVE HIGH BURDENS OF DISEASE AND DIFFICULTY ACCESSING CARE

Need

- 66% chronic medical problem
- 33% 2 or more mental health problems
- 3.5X higher age-adjusted mortality
- 40% used ER in past year
- 25% hospitalized in past year

Barriers

- Transportation
- Fragmentation of services
- Difficulty scheduling/ keeping appointments
- Perceived/actual stigma
- Lack of trust
- Social isolation
- Competing sustenance needs

BUILDING HEALTH SYSTEMS DELIVERY MODELS AROUND POPULATION NEEDS

- Homeless Medical Homes (HPACTs)
  - Enhanced low-threshold access to care
  - Integrated services
    - Clinical (PC, MH, SW, SUDS)
    - Sustenance (food, housing, clothes, hygiene)
  - Community integrated intensive case management
  - Ongoing staff training/cultural competency
  - Data-driven accountability, quality improvement

HPACT MODEL FOR TREATMENT ENGAGEMENT

Disengaged/Disenfranchised from Care

Unstable Sheltering
Significant Treatment Barriers
Health Care Low Priority
High Rate of ED & Inpatient Care
Premature Morbidity/Mortality

Treatment Engagement

Housing First
Facilitated Access
Care Management of Conditions leading to and perpetuating Homelessness
Address Competing Needs

Stabilization

Chronic Disease Management
Prevent Recidivism
Early Identification of New Needs

Identification & Referral

Emergency Departments

Inpatient Wards

Community Outreach & Referrals

Intervention

Homeless PACT

Enhanced, Open Access

Intensive Case Management

Designated staff with specialized training

One-Stop Care/Wrap around services: Addressing Competing Needs

Disposition

Homeless Situation Stabilized:
Transfer to general PACT team with Specialty Care

Homeless Situation not Stabilized:
Remain in H-PACT due to ongoing homelessness/risk of homelessness

Homeless Situation Stabilized:
Transfer to Special Population PACT:
SMI PACT
Women's Health PACT
HIV PACT

SOCIAL DETERMINANT OF HEALTH INTEGRATION INTO CLINICAL CARE DELIVERY

- Programming that addressed competing sustenance needs
  - Food security, clothing,
- Programming that facilitated physical, mental and social recovery and stabilization
  - Housing assistance, legal assistance, vocational training, assistance with disability claims
- Programming that facilitated treatment engagement
  - Interventions to reduce stigma, hassle, and inconveniences associated with seeking care

STUDY QUESTION

- Description of the national implementation of a “homeless medical home” within VHA
- Correlate patient health outcomes with characteristics of high performing sites
  - High performance defined by net reductions in acute care use by >30% ED use; >20% hospitalizations

DATA SOURCES

- 33 HPACT sites
  - Operating at lest 18 months and with at least 100 patients enrolled during study period
  - 2014 Program Assessment Clinical Survey instrument: 6 domains related to program implementation, clinic structure
- 3,543 homeless veterans
  - Site specific health care utilization data
  - Capture period: October, 2013 to March 2014

RESULTS

Demographics	August 2014
Total Panel Size • % OEF/ OIF / OND • % Women • % > age 65	**14,088** 8.82% 4.10% 11.04%
DCG Intensity Score (average)	**0.954**
HPACT Primary Care Visits • Average Number HPACT PCP Visits/patient	**47,982** 3.4
Specialty Care Visits • Average Number Specialty Care Visits/patient	**21,289** 1.5
HPACT Team Visits (excluding PCP visits) • Average HPACT Team Visits (excluding PCP visits)/patient	**83,588** 5.9
% Receiving Mental Health Services (homeless programs, mental health, substance abuse)	**82.07%**

RESULTS

❑Site Classifications

- High Performing
  - ED(1) use pre/post (or) >20% reduction in hospitalizations
- Mid Performing
  - 0-30% reduction in ED use pre/post (or) 0-20% reduction in hospitalizations
- Low Performing
  - Increase in ED use/hospitalizations post-enrollment

RESULTS

Site-Specific Survey Response	*High (N=17)	*Mid (N=9)	*Low (N=7)	P value
Access				
Availability >20 hours/week	76.5% (13)	62.5% (5)	50.0% (3)	0.20
After-hours care/ consult capacity	76.5% (13)	62.5% (5)	50.0% (3)	0.20
<14 days to access MH (2)	76.5% (13)	62.5% (5)	66.7% (4)	0.62
Multiple ways to access care	94.1% (16)	75.0% (6)	83.3% (5)	0.40
Team characteristics				
>50% Full time equivalent (3) (FTE) primary care provider	82.4% (14)	50.0% (4)	50.0% (3)	0.10
>50% FTE nursing	88.2% (15)	75.0% (6)	16.7% (1)	<0.01
>50% FTE social work	70.6% (12)	75.0% (6)	33.3% (2)	0.09
Integrated homeless program staff	88.2% (15)	87.5% (7)	66.7% (4)	0.21

*Performing Sites

RESULTS

Site-Specific Survey Response	*High (N=17)	*Mid (N=9)	*Low (N=7)	P value
Care management				
≥3 primary care visits/patient/year	64.7% (11) (4.4 visits/pt.)	77.8% (7) (5.3 visits/pt.)	57.1% (4) (2.9 visits/pt.)	0.73
≥1.5 specialty care visits /patient/year	29.4% (5) (1.3 visits/pt.)	44.4% (4) (1.6 visits/pt.)	0% (0) (1.1 visits/pt.)	0.11
Homeless-specific care				
Clinical protocols				
Post-ED / Hospitalization	58.8% (10)	75.0% (6)	50.0% (3)	0.69
Disease-specific care	52.9% (9)	50.0% (4)	33.3% (2)	0.38
Housing integrated into care plan				
Integrated clinical notes	94.1% (16)	100% (8)	83.3% (5)	0.40
Housing status tracking	82.4% (14)	75.0% (6)	50.0% (3)	0.10

*Performing Sites

RESULTS

Site-Specific Survey Response	*High (N=17)	*Mid (N=9)	*Low (N=7)	P value
On-site social supports				
Transportation	94.1% (16)	87.5% (7)	33.3% (2)	<0.01
Food	64.7% (11)	25.0% (2)	16.7% (1)	0.03
Clothes	76.5% (13)	37.5% (3)	33.3% (2)	0.05
Community Integration				
Clinical outreach	94.1% (16)	62.5% (5)	66.7% (4)	0.08
Community partnership	64.7% (11)	37.5% (3)	33.3% (2)	0.16
Host community events	82.4% (14)	87.5% (7)	33.3% (2)	0.02

*Performing Sites

RESULTS - SUMMARIZED

- HPACTs had high levels of treatment engagement and retention

- High performing sites had….
  - Increased nursing coverage
  - On-site social supports (transportation assistance, food, clothing)
  - Sponsorship/participation in community-based services and events

LIMITATIONS

- High performance used reductions in acute care use as a surrogate – alternatives (housing stability, chronic disease outcomes) and limits (regression to the mean) to this approach
- Control group limits (inter and intragroup comparisons)
- Patient-level factors only nominally controlled
- Social desirability bias to site surveys

CONCLUSIONS

- Population-specific tailoring of clinical care and service delivery has strong face validity
- Addressing Social determinants in clinical care appear to be impactful
  - Treatment engagement
  - Associated with reductions in acute care use

U.S. Department of Veterans Affairs

Focus on Health Equity and Action:

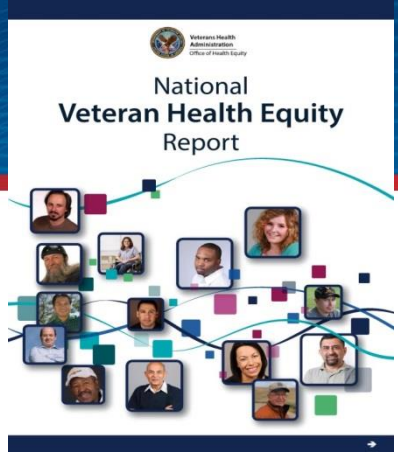
Incorporating Social Determinants of Health into VHA Patient Care and Electronic Health Records

Discussion & Questions

I CARE
DEPARTMENT OF VETERANS AFFAIRS

Veterans Health Administration
Office of Health Equity

FOCUS ON HEALTH EQUITY AND ACTION CYBER SEMINAR SERIES

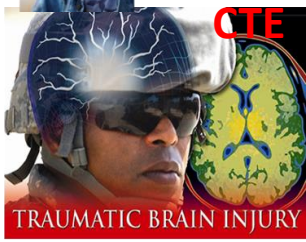


- **04/27/2017 3-4P ET: Military Service History and VA Benefit Utilization for Minority Veterans Register Now!**
  - **Future Sessions – Mark your calendars to join us from 3-4PM ET on the following Thursdays:**

**04/27/2017 **06/29/2017 **07/27/2017
**08/31/2017 **09/28/2017 * *OHE-QUERI PEC 6/20/2017*

- **03/30/2017 – Today's Session- Archive coming soon**
- **Past Sessions – Archived**
  - Using Veterans' Stories to Promote Health Equity and Reduce Disparities - **02/23/2017**
  - State of VHA Care for Vulnerable Veterans - **01/26/2017**
  - Release of the Inaugural VHA National Veteran Health Equity Report – **10/27/2016**
  - National Expert Panel Discussion on TBI & Chronic Traumatic Encephalopathy Morbidity & Mortality among Vulnerable Veterans - **06/30/2016**
  - Race/Ethnicity Data Collection in the Veterans Health Administration - **04/28/2016**
  - Using Data to Characterize Vulnerable Veteran Populations - **03/24/2016**
  - Treatment of HCV-ALD Among VHA Vulnerable Populations - **02/25/2016**
  - Findings from the VISN 4 Hypertension Racial Disparities Quality Improvement Project - **01/21/2016**
  - Office of Health Equity Hepatitis C Virus-Advanced Liver Disease Disparities Dashboard - **11/19/2015**

Veterans' Stories



GET INVOLVED!

- The pursuit of Health Equity should be everyone's business.
- It is a journey that takes time and *sustained* effort.
- What can you do today in your area of influence to improve health equity?
- At a minimum - in all your actions - do not increase the disparity.
- Thank you!

Veterans Health Administration
Office of Health Equity

PRESENTER INFORMATION

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THANK YOU!

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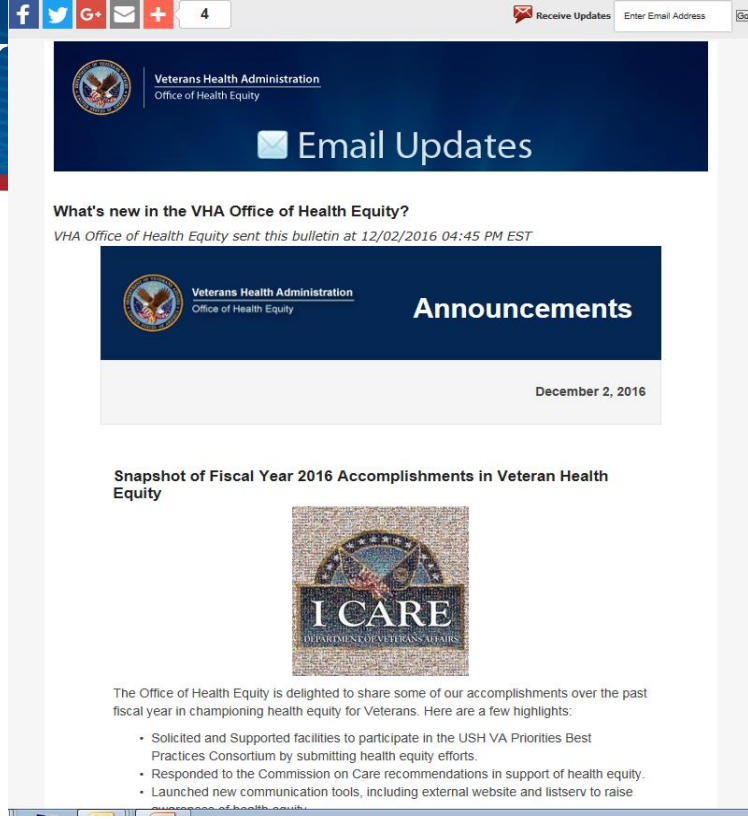
www.va.gov/healthequity

- OHE Listserv sign up link: http://www.va.gov/HEALTHEQUITY/Updates.asp



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