U.S. Department of Veterans Affairs

Focus on Health Equity and Action:

Advancing Health Equity Through Partnered Evaluation and Action

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- Katherine Hoggatt, PhD
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Thursday November 16, 2017 @ 3PM ET

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DISCLOSURE

- The presentation in this session are those of the authors who are responsible for its contents and do not necessarily represent the views of the Department of Veterans Affairs or the United States Government. Therefore, no statement in this document should be construed as an official position of the Department of Veterans Affairs.

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SESSION OUTLINE

- Background
  - Taking Action to Advance Health Equity with Partners
  - VA Health Equity Action Plan & VA Priorities
  - Connecting the dots through partnered evaluation initiative
- Patterns of Mortality
  - Suicide
  - Mental Health
- Differences across population in rates of medical conditions
  - Race/Ethnicity
  - Gender
  - Age
  - Other: Mental Illness, Geography & Service Connection
- Discussion with Q&A

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PARTNERED EVALUATION CALL FOR CONCEPT PAPER - 2014

- OHE partnered with ORD via the QUERI mechanism to solicit submissions in 2014
- **Intent** - To evaluate the extent to which there are observed gaps in quality and outcomes of care across major health conditions facing Veterans
- **Mechanism** - Up to $200,000 awarded by OHE each year for up to two years to the Center, with additional supplemental funding available from QUERI in the amount of $50,000/year
- Key Dates for the OHE-OUERI Partnered Evaluation Center Review Process:
  - October 31, 2014: Call for concept papers released
  - December 1, 2014: Concept papers due, selection of review panel
  - February 2, 2015: Proposals due in eRA Commons
  - March 2, 2015: Funding decision

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OHE PARTNERED EVALUATION CONCEPT - WHY? - 2014

- **The Problem/Issue -** Briefly describe the current knowledge regarding disparities and gaps in quality across key conditions associated with increased morbidity and mortality among Veterans, with a particular focus on national VA care

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OHE PARTNERED EVALUATION CONCEPT – TARGET AIMS - 2014

- **Specific Aims** - Describe the primary and secondary aims of the evaluation center, based on the following key questions:
  - Nationally, what are current *gaps in morbidity and mortality by vulnerable group status*, including race/ethnicity, military era/service connection, socio-economic status, etc. among the Veteran patient population *across major conditions that are considered the principal causes of disability and/or mortality*, including heart disease, suicide, accidents/injuries, cancers, infectious diseases, pain, cerebrovascular disease, metabolic disorders, mental/neurological disorders, substance use disorders, and respiratory diseases?

  - What are the *major gaps in quality of care among Veteran users by race/ethnicity, military era/service, socio-economic status or other vulnerable population status among these* major causes of morbidity and mortality? To what extent has *quality of care improved over time* for these conditions and across treatment settings?

  - To what extent are **new models of care "beyond the clinic walls"** (e.g., e-health, telemedicine, peer support, community health workers) reducing gaps in quality of care especially for vulnerable Veteran populations?

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OHE PARTNERED EVALUATION – KICKOFF - 2015

- Multiple submissions with seasoned researchers with strong partners for support including data sources
  - OHE has worked with team to refine path, provide letters and support to secure necessary data access in order to build foundation for the subsequent data analyses
  - Ongoing dialogue with OHE with relevant input, discussions – alignment with OHE goals and shifts in response to evolving VA priorities (e.g. suicide mortality)
  - Products - Health Affairs 2017 + **More in the works**
    - Preview of some of the results in today's session ...

❖ VA Greater Los Angeles & VA Palo Alto Team Members awarded in 2015 - Principal Investigator Donna L. Washington, MD, MPH

- ✓ *A population health approach to examine the distribution of diagnosed health conditions, mortality, and healthcare quality across the entire VA healthcare system, as defined by Veterans' membership, or not, in vulnerable population groups*
- ✓ *Evaluate whether characteristics of the healthcare delivery settings (e.g., geography, treatment setting) and of the types of care that individuals use, including new models of care such as Telehealth, influence the quality of care that Veterans receive*

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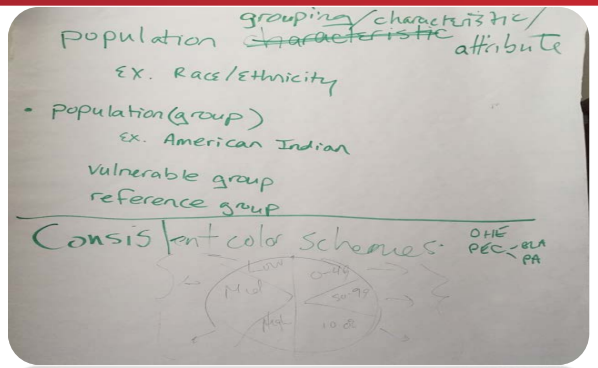
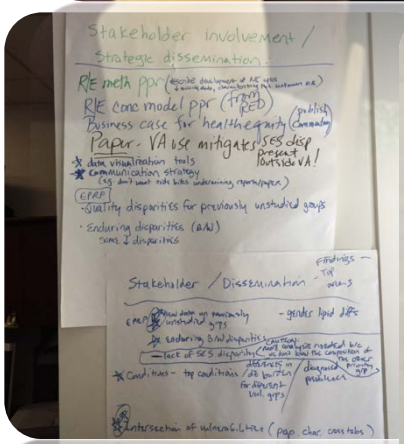
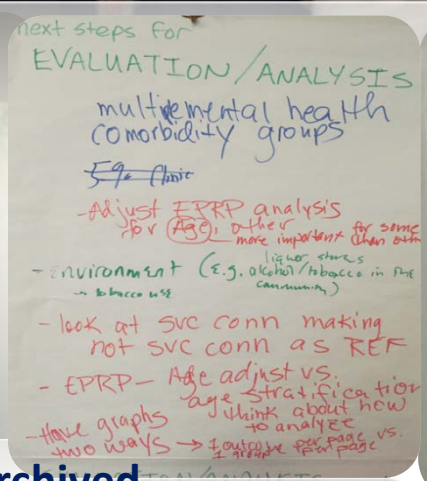
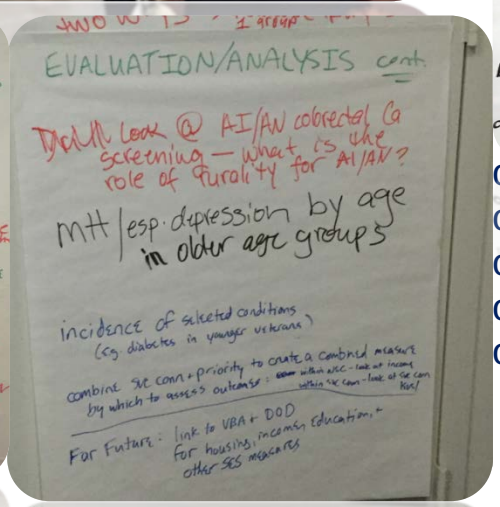
OHE - PEC FACE 2 FACE MEETING DC - 2016

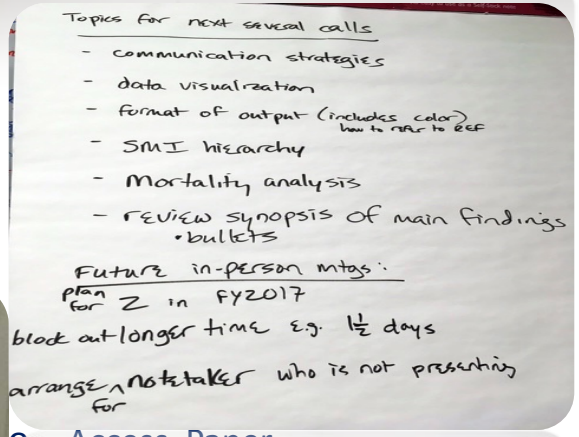
OHE Bulletin











- Access Paper
- Intersectionality Paper
- Diabetes measures disparities
- Methods Paper on Race
- **HTN & DM Disparities in PACT**

FHEA Sessions – archived

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VA HEALTH EQUITY ACTION PLAN - HEAP

OHE along with key partners developed the HEAP which Aligns with Sec VA Priorities, My VA, 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)

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SECVA PRIORITIES & HEALTH EQUITY

- **Greater Choice**
  - Consider any disparate impact on vulnerable Veteran populations.
  - Empower Veterans through transparency of information

- **Improve Timelines**
  - Consider any disparate impact on vulnerable Veteran populations.

- **Suicide Prevention**
  - Apply equity lens to 2016 suicide mortality report to inform culturally appropriate and tailored prevention strategies for vulnerable Veteran populations as appropriate. More details in the FHEA 07.17.2017 Archive

- **Accountability /Efficiency**
  - Implement Commission on Care Recommendation #5 – Eliminate Health Disparities among Veterans: Make Health Equity a Strategic Priority by Implementing the HEAP.
  - Data transparency by assessing any disparate impact and making data on vulnerable Veterans publicly available.
  - Go beyond collecting and analyzing disparities to actually addressing them in order to diminish or eliminate the gaps

- **Modernization**
  - Embed HEAP implementation into foundational services.
  - Incorporate social determinants of health in the new EHR with connection to DoD & actionable data for vulnerable groups.
  - Consider disparate impact of appeals on the vulnerable.
  - Develop partnerships with community organizations to improve health equity.

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VA PRIORITY – SUICIDE PREVENTION

Table 1 Risk factors for veteran suicide [1-4, 11-1, 187]

Individual	Environmental	Familial
Male gender	High combat stress exposure	Relationship problems
Females with military history	Long and multiple deployments	Financial problems
White	Exposure to traumatic events	
Age (young and elderly)	Availability of weapons	
Mood and substance abuse disorders	Skill using firearms	
Untreated PTSD and depression	Rural residence	
Comorbidity		
Legal problems		
Health problems (pain, disabling chronic medical illness, traumatic brain injury)		
Daily life limitations		
Psychiatric hospitalization (12 weeks)		
Medication changes (12 weeks)		

Psychiatr Q
DOI 10.1007/s11126-012-9241-3

ORIGINAL PAPER

Veteran-Specific Suicide Prevention

Janet A. York · Dorian A. Lamis · Charlene A. Pope · Leonard E. Egede

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VHA NATIONAL VETERAN HEALTH EQUITY REPORT - SNAPSHOT OF TOP DIAGNOSES

** **Higher** % than in reference group*

- ❑ Racial/Ethnic (Exhibit 3-15):
  - AI/AN - Hypertension| Lipid Disorders| **Diabetes Mellitus***
  - Asian - Hypertension| Lipid Disorders| Diabetes Mellitus
  - Black - **Hypertension***| Lipid Disorders| **Diabetes Mellitus***
  - NH/OPI – **Hypertension***| Lipid Disorders| **Diabetes Mellitus***
  - Hispanic - Hypertension| Lipid Disorders| **Diabetes Mellitus***
- o Lumbosacral spine disorders* >20% for all except Asian & White Veterans
  - **Obesity – while not in the top was prevalent across multiple groups**
- ❑ Women (Exhibit 4-14): Hypertension| Lipid Disorder| **Depression| Joint & Spine Disorders**
- ❑ Age 65+ (Exhibit 5-13): Hypertension| Lipid Disorders| Diabetes Mellitus & Coronary Artery Disease; Age 18-44 : High prevalence of spine disorders
- ❑ Rural (Exhibit 6-13): Lipid Disorders| Hypertension| Diabetes Mellitus
- ❑ Serious Mental Illness (7-16): Hypertension| Lipid Disorders| **Tobacco Use**

https://www.va.gov/HEALTHEQUITY/NVHER.asp

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BACKGROUND RESOURCES

- Office of Health Equity. (2016). *National Veteran Health Equity Report—FY2013*. US Department of Veterans Affairs, Washington, DC. Available online at http://www.va.gov/healthequity/NVHER.asp.

- York, J. A., Lamis, D. A., Pope, C. A., & Egede, L. E. (2013). Veteran-specific suicide prevention. *Psychiatric Quarterly*, 84(2), 219-238.

- Related HSR&D Cyberseminars
  - Chronic Health Conditions Among Vulnerable Veterans: Current Research and Action – June 29, 2017 (Breland, Uchendu, Washington)
  - Using VA Data to Characterize Health and Healthcare Disparities in VA – June 20, 2017 (Washington)
  - State of VHA Care for Vulnerable Veterans – January 26, 2017 (Frayne, Otoole, Saechao, Saliba, Uchendu, Washington, Yano)

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Poll Question 1

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POLL QUESTION 1

How familiar are you with the patterns of suicide mortality among Veteran VHA patients?

- ❑ No prior knowledge
- ❑ Some knowledge: I'm familiar with some of the groups that have high suicide mortality rates
- ❑ Considerable knowledge: I've read up on or studied the patterns of suicide among Veterans
- ❑ Expert knowledge: My work focuses on suicide or I work with patients at risk for suicide

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Katherine Hoggatt, PhD

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OVERVIEW: MENTAL HEALTH AND MORTALITY

- Prevention of suicide is a priority for VA
- Suicide rates notably high for patients with mental health (MH) conditions
- Patients with MH conditions may also have high all-cause mortality rates
- Goal:
  - To examine the differences in suicide mortality rates by race/ethnicity, urban/rural residence, service connection, and mental health conditions
  - To examine disparities in all-cause mortality for patients with mental health conditions

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METHOD: STUDY GROUP AND OUTCOME DEFINITION

- Cohort:
  - FY2009 Veteran VHA User Cohort (N = 5,030,722)
  - All Veterans who used any VHA care in FY2009 (outpatient, inpatient, pharmacy, or Non-VA [Fee] medical care)

- Mortality follow-up:
  - Start date: Veterans' initial FY2009 visit
  - End date: Date of death or end of follow-up (12/31/2011)

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METHOD: STUDY GROUP AND OUTCOME DEFINITION

- Mortality ascertainment:
  - All-cause mortality: VA Vital Status file
  - Cause-specific mortality: Linkage with National Death Index

- Cause-of-death:
  - Defined in terms of ICD 10 codes
  - Focus on suicide and malignant neoplasms (cancer) as specific causes of death for this presentation

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METHOD: DEFINITION OF VULNERABLE GROUPS

- Race/ethnicity:
  - American Indian/Alaska Native, Asian, Black, Hispanic, Multi-race, Native Hawaiian/Other Pacific Islander, White (reference)
- Rurality:
  - Highly rural, rural, urban (reference)
- Service-Connection:
  - No SC, 0%-49%, 50%-99%, 100% (reference)
- Mental health hierarchy
  - SMI, Depression/Anxiety, Other MH Condition, No MH Conditions (reference)
  - ICD 9 codes documented in FY2009
  - Categories defined hierarchically (mutually exclusive)
  - Depression/Anxiety is without SMI; Other MH disorders are without SMI or Depression/Anxiety

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METHOD: ANALYSIS FOR MORTALITY AMONG PATIENTS WITH MH CONDITIONS

- Compute **all-cause mortality rates** by MH condition hierarchy
  - Crude and age- and sex-standardized

- Estimate **all-cause mortality hazard ratios** comparing patients with MH conditions (SMI, depression/anxiety, other MH conditions) to patients with no MH conditions
  - Age- and sex-adjusted

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METHOD: ANALYSIS FOR SUICIDE MORTALITY

- Compute **suicide mortality rates** by MH condition hierarchy
  - Crude and age- and sex-standardized
- Compute **suicide mortality rates** by race/ethnicity, rurality, and service-connection
  - Crude and age- and sex-standardized
- Estimate **suicide mortality hazard ratios** comparing disadvantaged groups to the reference group
  - Age- and sex-adjusted

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RESULTS: FY2009 VHA USER COHORT

- N = 5,030,722 Veteran VHA Users
- T = 14,442,554 person-years at risk
- D = 516,540 deaths observed
- Suicide accounted for ~1.1% of deaths

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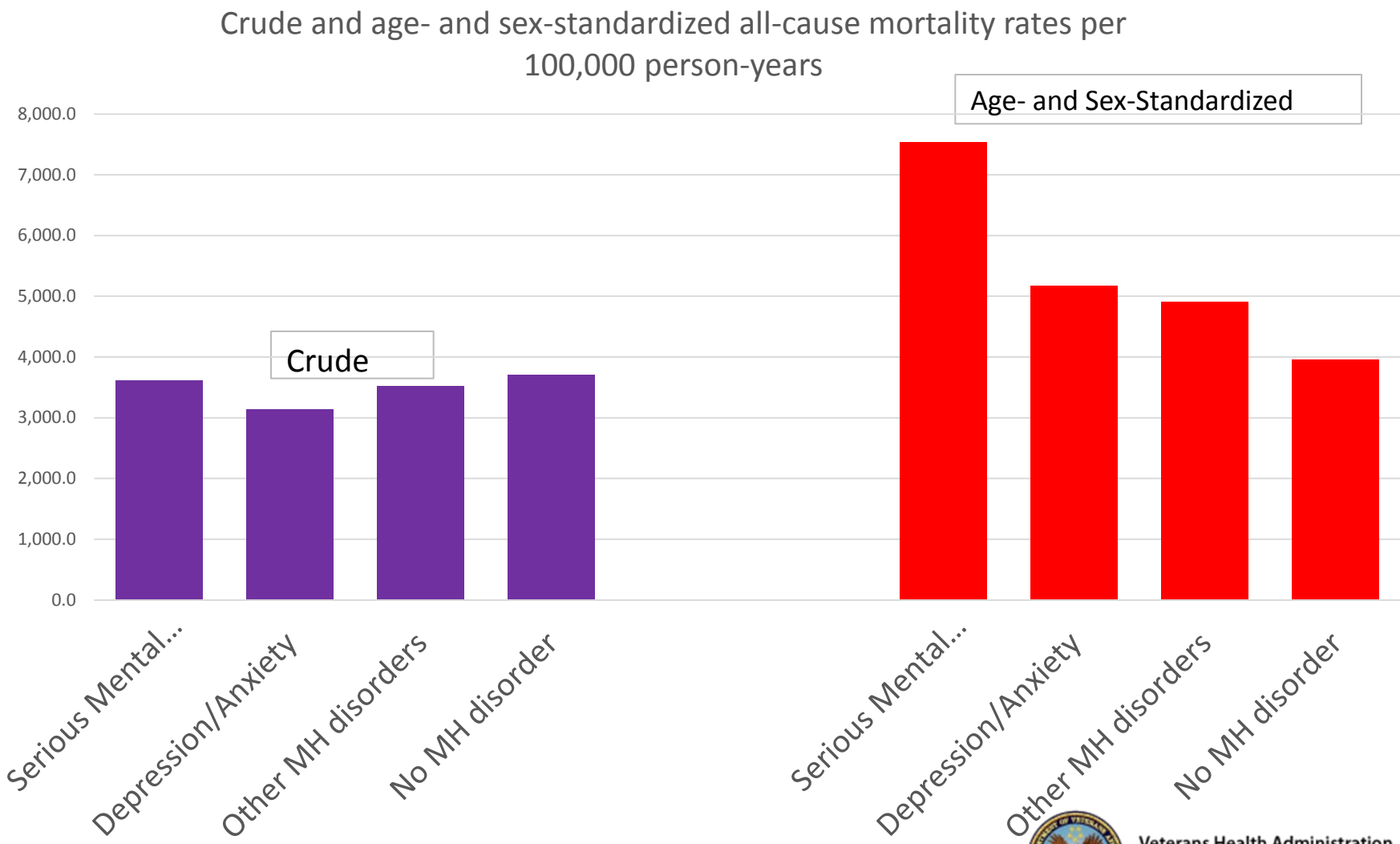
RESULTS: CRUDE ALL-CAUSE MORTALITY, BY MH CONDITION AND SEX



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RESULTS: ALL-CAUSE MORTALITY HAZARD RATIOS BY MH CONDITIONS

- Adjusting for age and sex, **disparities in all-cause mortality rates for patients with**:
  - **SMI**: **HR = 1.87**
  - **Depression/anxiety**, no SMI: **HR = 1.32**
  - **Other MH conditions**, no SMI or depression/anxiety: **HR = 1.38**

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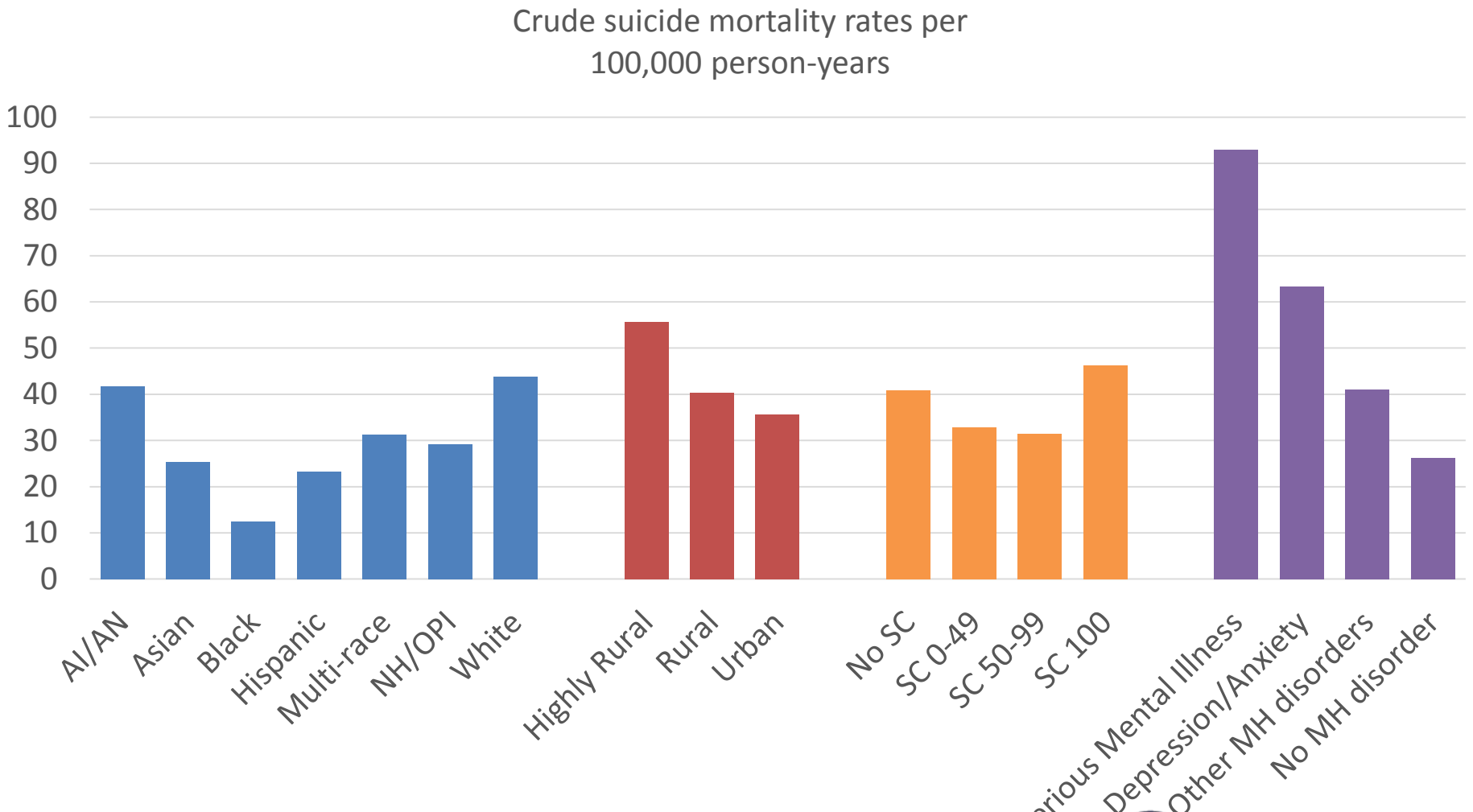
RESULTS: CRUDE SUICIDE MORTALITY RATES BY VULNERABLE GROUP



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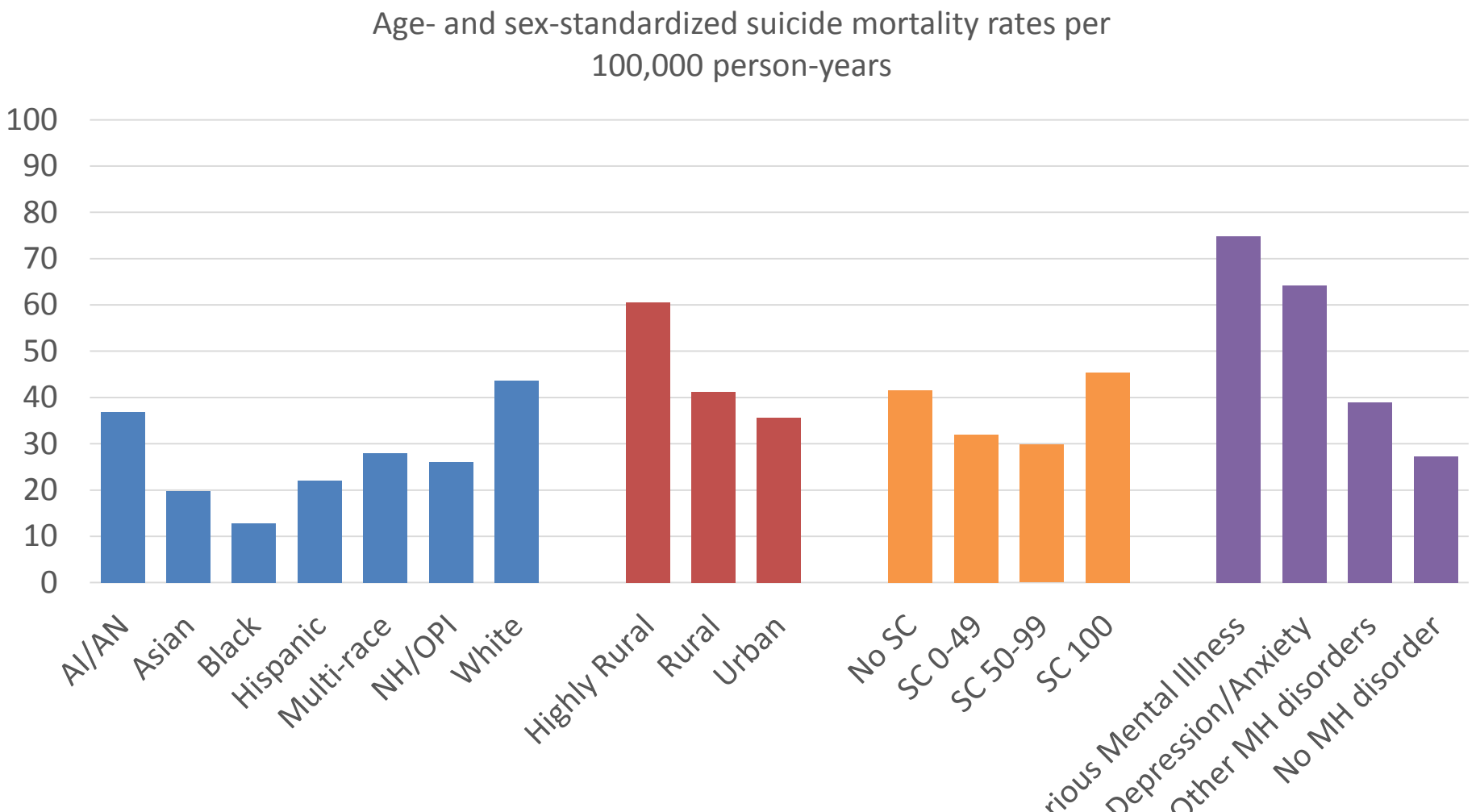
RESULTS: AGE- AND SEX-STANDARDIZED SUICIDE MORTALITY RATES



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RESULTS: SUICIDE MORTALITY HAZARD RATIOS BY MH CONDITIONS

- Adjusting for age and sex, **disparities in suicide mortality rates for patients with**:
  - **SMI**: **HR = 3.59**
  - **Depression/anxiety**, no SMI: **HR = 2.46**
  - **Other MH conditions**, no SMI or depression/anxiety: **HR = 1.46**

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RESULTS: SUICIDE MORTALITY HAZARD RATIOS BY OTHER VULNERABLE GROUPS

- Adjusting for age and sex, **disparities in suicide mortality rates** for patients with:
  - Highly-rural residence: **HR = 1.61**
  - Rural residence: **HR = 1.15**

- Adjusting for age and sex, **suicide mortality rates were lower** for other groups of patients:
  - Asian: **HR = 0.52**
  - Black: **HR = 0.26**
  - Hispanic: **HR = 0.48**
  - NH/OPI: **HR = 0.64**

  - No service connection: **HR = 0.89**
  - 0-49% service connection: **HR = 0.68**
  - 50-99% service connection: **HR = 0.66**

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CAVEATS

- Cause-of-death (COD) identified based on death records with ICD-10 codes
  - Potential for under- or over-coding of specific CODs
  - Potential for greater under-coding for stigmatized CODs (e.g., suicide)
- Mortality hazard ratios adjusted for age and sex – residual confounding?
- This analysis does not examine the pathways or factors mediating the disparities

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CONCLUSION

- Suicide mortality rates high for Veteran VHA Users who are White, highly-rural, 100% service-connected, have MH conditions (particularly SMI)
- Patients with MH conditions (particularly SMI) also have higher rates of all-cause mortality
- Some groups with high suicide mortality not considered traditionally "disadvantaged"
  - Reinforces importance of universal suicide screening with appropriate follow-up
- Patients with MH conditions have higher mortality rates, not limited to suicide
  - Also important to track quality of general medical care for patients with mental health conditions, particularly SMI

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Poll Question 2

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POLL QUESTION 2

- How familiar are you with what medical conditions have especially high prevalence among subgroups of Veterans in the following categories?
  - **Race/ethnicity**: American Indian/Alaska Native; Asian; Black/African American; Hispanic; Multi-race; Native Hawaiian/Other Pacific Islander; White
  - **Rural/urban status**: Highly rural; Other rural; Small urban; Large urban
  - **Service-connected (SC) status**: Non SC; SC 0-49; SC 50-99; SC 100 percent
  - **Sex**: Women; Men
  - **Age**: 18-44; 45-64; 65+ years old
  - **Serious mental illness status**: Serious Mental Illness (SMI); Depression/Anxiety; Other Mental Health Disorder; No Mental Health Disorder

- ❑ I am **very familiar** with medical conditions in all of these subgroups
- ❑ I am **somewhat familiar** with medical conditions in some but not all of these subgroups
- ❑ I am **not familiar** with medical conditions in a number of these subgroups

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OVERVIEW

- Goal:

  To identify medical conditions that may have special importance for specific subgroups of Veteran VHA patients, based upon:

  - Race/ethnicity
  - Rural/urban status
  - Service-connected status
  - Sex
  - Age
  - Serious mental illness status

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METHOD

- Denominator: All Veterans who used any VHA care in **FY14** (VHA outpatient care, inpatient care, pharmacy care, or Non-VA [Fee] Medical Care)

- Medical conditions: Presence of at least one instance of an ICD-9-CM diagnosis code in FY14 outpatient/inpatient records

- Calculated age-adjusted odds ratios: odds of the condition in the special population group (versus reference group)
  - Note: AOR is different from Prevalence

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RACE/ETHNICITY: AOR 2+ (REFERENCE GROUP: WHITE)

AI/AN	Asian	Black	NH/OPI	Hispanic
➢ TB ➢ Pregnancy w/ diabetes ➢ Pregnancy w/ hypertension ➢ Housing insufficiency	➢ TB (AOR 5+) ➢ Pregnancy w/ diabetes ➢ Cancer-Gastric ➢ Gout/Crystal arthropathy	➢ Sarcoidosis (AOR 5+) ➢ **Renal Failure/Nephropathy*** ➢ HIV/AIDS ➢ TB ➢ **Hepatitis C*** ➢ Fibroids (AOR 5+) ➢ **Vaginitis/Pelvic inflammatory conditions (AOR 3+)*** ➢ **Menstrual disorder*** ➢ **Sexual Dysfunction*** ➢ **Infertility*** ➢ Ectopic pregnancy ➢ Pregnancy w/ hypertension ➢ **Cancer-Prostate*** ➢ Cancer-Gastric ➢ Multiple myeloma ➢ **Anemia*** ➢ **Glaucoma*** ➢ Schizophrenia ➢ Psychotic disorders-other ➢ Housing Insufficiency	➢ Fibroids ➢ Ectopic Pregnancy ➢ Pregnancy w/ diabetes ➢ Gout/crystal arthropathy	➢ Cancer-Hepatobiliary *(TB and Cancer-Gastric nearly met threshold of AOR 2+)*

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GENDER : AOR 2+

- **Women (Ref: Men)**

- Endocrine: Thyroid disorders (AOR 3+), Osteoporosis (AOR 9+)
- Quality of Life: Diarrhea, Constipation and Functional Bowel Disorders; Nausea and Vomiting; Asthma; Headache; and Myalgia/Myositis (including fibromyalgia) (AOR 4+), Urinary incontinence, UTI
- Contraceptive Care Management
- Infertility
- Breast conditions, both benign and malignant
- Cancer-thyroid (AOR 3+)
- Mental health: Dissociative Disorders (AOR 3+), Personality Disorders, and Acute Stress Disorders, as well as Eating Disorders (AOR 10+).
- Low prevalence conditions: Connective Tissue Disease (AOR 5+), Rheumatoid Arthritis and related disease; Multiple Sclerosis
- Allergies/urticaria

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AGE GROUP: AOR 2+

- **Age Group (Ref: 18-24 years old)**
  Many conditions with AOR 2+

- For several high prevalence conditions, AOR increases with advancing age until oldest age groups (e.g., 70s or 80s) then starts to decline again.
  - For example, Hypertension, Hyperlipidemia, Diabetes Mellitus, Overweight/Obesity (which has AOR < 1 after age 80), COPD.
- AOR continues to rise into oldest age groups for:
  - Coronary Artery Disease-Other, Male Genital Disorders, Anemia, Renal Failure, Atrial Fibrillation, Heart Failure, Cerebrovascular Accident/TIA, Dementia.
- Musculoskeletal conditions have particularly high AOR for Veterans in their 50s.
- Sleep apnea AOR is highest for Veterans in their 40s, and also high for Veterans in their 50s, then declines.
- Sexual dysfunction has its highest AORs from age 35-84.
- AOR for Colorectal Polyp increases substantially at age 50, but is much lower by age 85+.
- Hepatitis C has a particularly high AOR for Veterans 50-69.
- Malignancies had various patterns, but generally appeared in the middle/older age groups.
  - Cancers tending to be shifted toward younger Veterans included Cervical, Brain/Nervous System, Testicular.
- Mental health conditions that stood out included
  - Schizophrenia in Veterans 50-64, and Somatoform Disorders in Veterans 35-59.
- Conditions that tended to be shifted toward younger patients
  - Allergies, Liver Disease-Other, Fibroids, Infertility, Pregnancy Complicated by Diabetes Mellitus, Cancer-Cervical, Cancer-Testicular, Connective Tissue Disease, Inflammatory Spondyloarthropathies, Spine Disorders-Cervical, Myalgia/Myositis.

SERIOUS MENTAL ILLNESS: AOR 2+

- **Serious Mental Illness Domains: (Ref: No mental health condition)**

- Infections
- Endocrine/metabolic: Fluid/electrolyte disorders [AOR 4+]
- Respiratory: Pneumonia [AOR 4+]
- GI: Nausea/Vomiting [AOR 3+; Diarrhea/Constipation/Bowel disorders [AOR 3+]; Hepatitis C [AOR 4+]; Pancreatic disorders [AOR 3+]
- Urinary: UTI [AOR 3+]; Urinary incontinence [AOR 3+]
- Reproductive Health
- Breast
- Cancer
- Hematologic/Immunologic
- Musculoskeletal: Fracture-Hip [AOR 4+]
- Neurologic: Epilepsy/convulsions [AOR 4+]; Parkinson's disease [AOR 4+]; Intracranial hemorrhage [AOR 3+]; Traumatic Brain Injury [AOR 6+]; Dementia [AOR 10+]; Cognitive disorders-other [AOR 9+]
- Dental: Dental caries [AOR 4+]; Gingivitis/Periodontitis [AOR 4+]; Loss of Teeth [AOR 5+]
- Dermatologic
- Other: Sleep disturbance-other [AOR 3+]; Syncope [AOR 3+]; Chronic Pain Syndromes [AOR 3+]; Symptoms-Other [AOR 5+]; Tobacco Use Disorder [AOR 3+]; Poisoning [AOR 5+]; Injuries and Conditions due to External Causes [AOR 3+]; Housing Insufficiency [AOR 8+]; Psychosocial factors-other [AOR 8+]

GEOGRAPHY AND SERVICE CONNECTION

- **Large Urban**
  - Conditions with AOR 2+ (ref: small urban)
    - HIV/AIDS
- **Non service-connected**
  - Conditions with AOR 2+ (ref: 100 percent SC)
    - Housing insufficiency

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CAVEATS

- Medical conditions are identified based upon ICD-9-CM diagnosis codes
  - Potential for under-diagnosis or under-coding of medical conditions
  - Potential for over-diagnosis (e.g., “rule-out” diagnoses or stigmatized conditions)
  - Patients who use VHA infrequently (e.g., who receive part of their care outside of VHA) may have less opportunities to have diagnoses recorded

- Odds ratios are adjusted for age, but not for other characteristics like sex
  - Racial/ethnic heterogeneity is greater among women Veterans than among men Veterans in VHA

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CONCLUSION

- Health profile varies by subgroup

- Some subgroups have lower representation among VHA patients, and have historically received less research attention (examples: AI/AN; Asian; NH/OPI; Women)

  - Clinicians caring for these Veterans may need to familiarize themselves with medical conditions that may appear disproportionately within these subgroups

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Additional Highlights

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Veterans Health Administration
Office of Health Equity

ADDITIONAL HIGHLIGHTS & NEXT STEPS

2017

- **Diagnosed Conditions**
  - Race/ethnicity – What are the conditions that we should be paying attention to?
  - Separate race/ethnic groups and start with groups where little is known (i.e., AI/AN, Asian and NH/OPI
  - Diagnosed conditions by mental health – burden of disease
  - Looking within gender – stratified by race (reproductive health)
  - Mental health conditions in Black Veterans

- **SHEP/EPRP**
  - Prescriptions (ASA/ACE)
  - Incorporate in diabetes paper
  - Change in colorectal cancer screening
  - Gender differences (lipid control—single year, PACT exposure)
  - Disparities by mental health conditions
  - Gender differences in SHEP

- **New Models of Care**
  - Role of telehealth in reducing disparities – Are those who could benefit the most using telehealth (race/ethnicity, age)?
  - Geospatial look at telehealth use for vulnerable population(s)

- 2016
- Access Paper
- Intersectionality Paper
- Diabetes measures disparities
- Methods Paper on Race
- **HTN & DM Disparities in PACT**

Report of the partnered initiative – coming soon

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HEALTH EQUITY DATA – TAKE ACTION

- **Consistently report, monitor, trend, and track key metrics along vulnerability lines to include gender/sex, race/ethnicity, rural/urban, military era/period of service, etc.**
  - **Doing so will allow transparent monitoring of the progress for the vulnerable groups, support accountability, agency priority and bolster trust**
  - **Got ideas for innovative health equity projects to tackle disparities among Veterans? Send your ideas to OHE: healthequity @va.gov**

- ***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.***

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PRESENTER INFORMATION

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THANK YOU!

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www.va.gov/healthequity


Veterans Health Administration
Office of Health Equity

Announcements

November 7, 2017

Veterans and Military Families Month

November 2017

Office of Health Equity Salutes Our Nation's Heroes and Families for National Veterans and Military Families Month

November is National Veterans and Military Families Month. Americans across the country will join and celebrate our nation's heroes for the entire month of November and not just on Veterans Day. This month recognizes, acknowledges, and honors the service, sacrifices, and contributions of Veterans and military families for their courage and commitment to our Nation. The VA has put together a calendar of highlighted events sponsored by the Agency and stakeholders for this month's commemoration. VA medical centers and community based outpatient clinics will also hold open houses.

As a national program office, the VA Office of Health Equity (OHE) has aligned our programming and is highlighting additional activities for National Veterans and Military Families Month. It is the mission of OHE to champion health equity issues for Veterans. Although we do this every day of the year, our November announcements highlight specific programming that we encourage you to attend as we honor our heroes on Veterans Day and throughout the month.

Attend the VA-VMC Health Equity Hub Virtual Open House Preview Sponsored by OHE

- OHE Listserv sign up link: http://www.va.gov/HEALTHEQUITY/Updates.asp
- Next FHEA Cyberseminar 12.18.2017 : 3-4P ET
- FDA Lecture with CE 11.20.2017: 2-3P ET

SIGN UP TO RECEIVE
UPDATES FROM OHE

***The VA Office of Health Equity (OHE) was created in 2012 to champion reduction of health and healthcare disparities and galvanize efforts, enhance synergy across the VA and spur actions towards achieving health equity for all Veterans**

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