

Focus on Health Equity and Action:

## Race/Ethnicity Data Collection in the Veterans Health Administration

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**Veterans Health Administration**  
Office of Health Equity

Have you seen the VHA Health Equity Action Plan ?

1. Yes
2. No
3. Not sure



**VA**



U.S. Department  
of Veterans Affairs

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Race/Ethnicity Data Collection in the  
Veterans Health Administration

Discussion of Poll Question #1

[http://www.va.gov/HEALTHEQUITY/  
Health\\_Equity\\_Action\\_Plan.asp](http://www.va.gov/HEALTHEQUITY/Health_Equity_Action_Plan.asp)



**Veterans Health Administration**  
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# SESSION OVERVIEW

- Background
- Project
- Findings
- Discussion





# OHE PROGRAM OFFICE SCOPE

- ❖ OHE champions the advancement of health equity and reduction of health disparities through 5 key focal areas\*:
  - ❑ Leadership
  - ❑ Awareness
  - ❑ Health Outcomes
  - ❑ Diversity and Cultural Competency of the Workforce
  - ❑ Data, Research, and Evaluation
  
- ❖ Strategic Alignments
  - ❑ VHA Strategic Plan Objective 1(e)—Quality & Equity: Veterans will receive timely, high quality, personalized, safe, effective and equitable health care, irrespective of geography, gender, race, age, culture or sexual orientation
  - ❑ Blueprint for Excellence strategies 2.2a, 3.2a and 7.2b

\*VHA Health Equity Action Plan



# VULNERABLE POPULATIONS

- Racial or Ethnic Group**

- Gender

- Age

- Geographic Location

- Religion

- Socio-Economic Status

- Sexual Orientation

- Military Era /Period of Service

- Disability – Cognitive, Sensory, Physical

- Mental Health

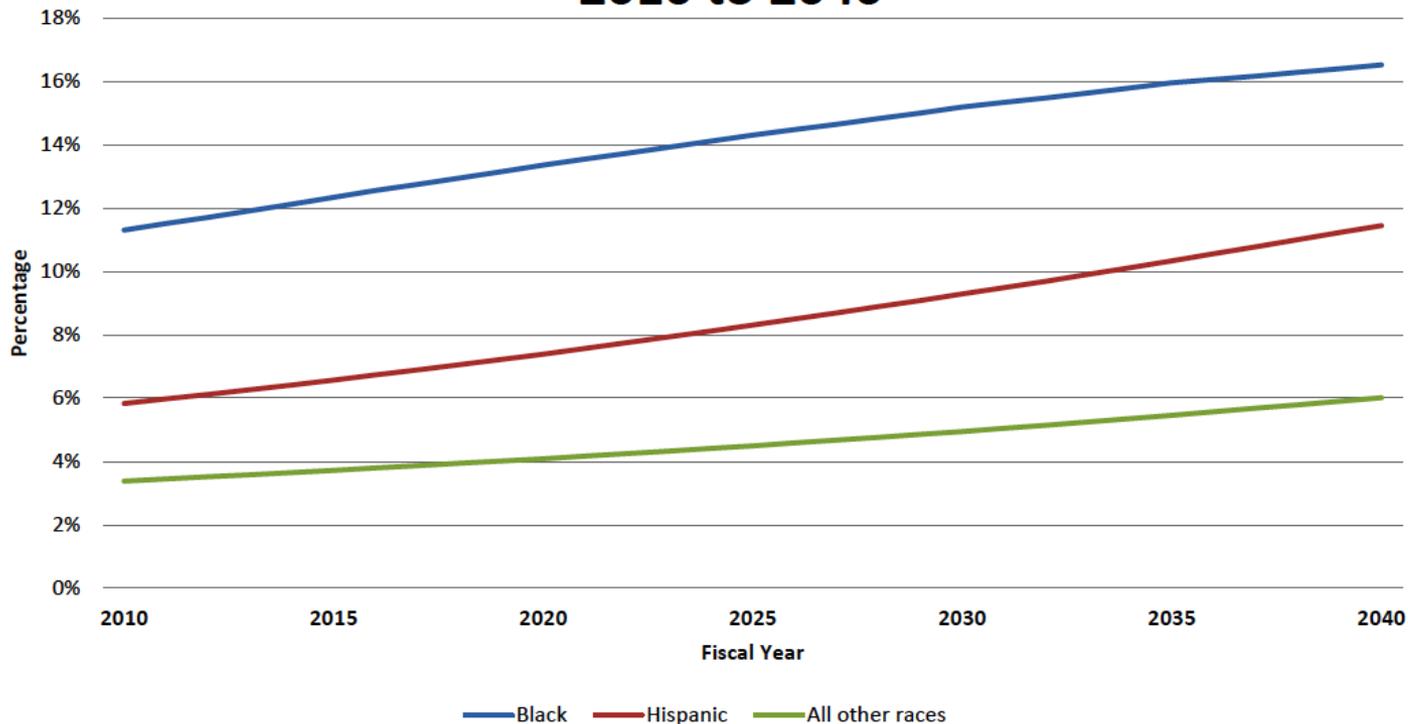
- Other characteristics historically linked to discrimination or exclusion





# PROJECTED PERCENT OF MINORITY VETERAN POPULATION 2010-2040

## Projected Percent of Minority Veteran Population 2010 to 2040

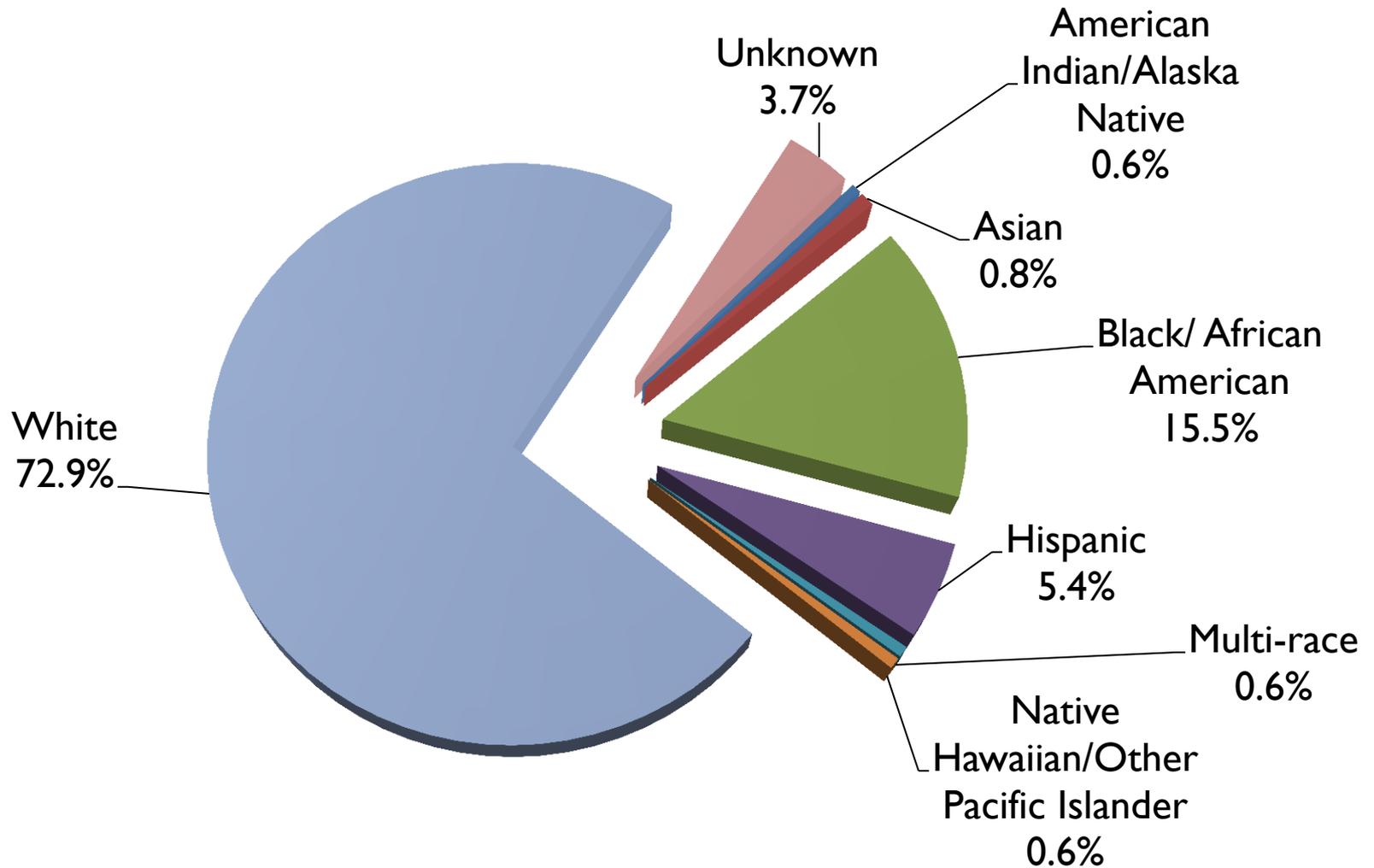


Note: Categories are mutually exclusive. 'Black' and 'All other races' are not Hispanic. 'All other races' includes American Indian/Alaskan Native, Asian, Pacific Islander, and Other.

Source: Office of the Actuary, Veteran Population Projections Model (VetPop2011), Table 3L



# Race/Ethnicity among Veteran VHA Patient, FY13



Denominator: Veteran FY2013 VHA Patients (Courtesy of Women's Health Evaluation Initiative [WHEI])





# OHE KEY QUESTIONS - RACE/ETHNICITY DATA

- ❖ What can we do today with the current data we have?
- ❖ What should we begin to do today so that a few years from now, we are still not saying that we do not have quality race/ethnicity data?





# OHE - HEROIC INTENTION

- ❖ Address the gap in complete, reliable and consistent measurement of racial and ethnic data
- ❖ Identify patient and provider attitudes, challenges and preferences for how to collect race/ethnicity information
- ❖ Develop and validate statistical approaches to address missing race/ethnicity data





# THANK YOU VETERANS!



**I CARE**  
DEPARTMENT OF VETERANS AFFAIRS



**myVA**  
Putting Veterans First

- Veteran/Customer Experience
- Employee Experience
- Support Service Excellence
- Performance Improvement
- Strategic Partnership



### Five Priorities



- Access
- Employee Engagement
- Best Practices and Consistency
- Development of a High Performance Network
- Restore Trust and Confidence



**Veterans Health Administration**  
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# Obtaining Race/Ethnicity Data in the Veterans Health Administration

Chanita Hughes Halbert, PhD and Mulugeta Gebregziabher, PhD

Supported by the  
Office of Health Equity





# AUDIENCE POLL QUESTIONS #2

How important is it for the VAMC to obtain patient race/ethnicity data?

1. Not at all important
2. A little important
3. Somewhat important
4. Very important



# Health and Health Care Disparities

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- ...differences that occur by gender, race or ethnicity, education or income, disability, living in rural localities or sexual orientation (Healthy People 2010)
- ...differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the US (NIH)
- “...racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences and appropriateness of intervention” (IOM, Unequal Treatment. 2003; pp. 31-32)

# Is Race the Most Effective Way to Address Disparities?

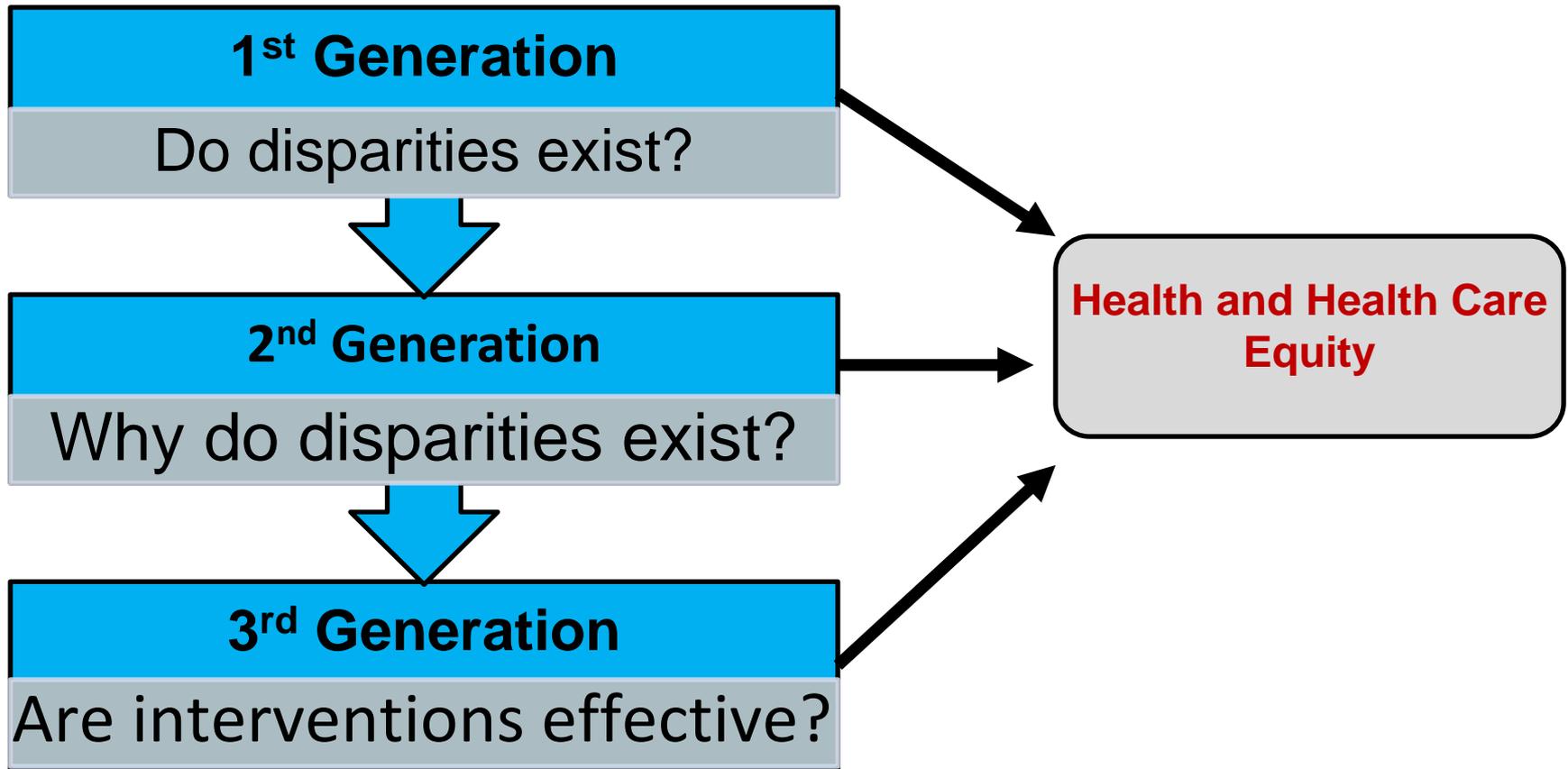
- Race is not used consistently across studies
- Race is used to measure a number of different factors (e.g., proxy for SES, measure of biological variation, indicator of cultural factors) in different settings
- Comparing minority to non-minority racial groups may stigmatize and label minority populations as being deviant
- Attributing disparities to race may imply that racial background is the underlying cause of health outcomes
- Focusing on race may divert attention from other causal factors (e.g., racism, SES)
- Race is often confounded with SES; it may be difficult to separate the effects of these variables on health outcomes

# Why Does Race Matter?

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- Race captures the history and current practice of inequality and injustice in the US
- Race reflects the history of racism in the US
- Race is an important organizing principle in society
- Race has been (and is still) used to monitor social and economic progress
- Group comparison is a central component of social interaction
- Race has an independent effect on health outcomes after socioeconomic factors (e.g., income, employment) are considered

# Trajectory for Disparities Research



# Disparities Research in the VA

## Health Equity & Rural Outreach Innovation Center

- **First generation:**

- *Identifying facilitators and barriers to lung cancer screening in Veterans (Tanner)*
- *Understanding Dual Use and Other Potential Determinants of Heart Failure Outcomes (Axon)*

- **Second generation:**

- *Ethnic Differences in Medication Adherence & Cost for Elderly Veterans with Type-II Diabetes Mellitus (Egede)*
- *Racial Variations in Communication, Decision-Making, and Diabetes Outcomes (Pope/Egede)*

- **Third generation:**

- *Telepsychology Service Delivery for Depressed Elderly Veterans (Egede)*
- *Personal Health Record-Facilitated Diabetes Self-Management among Rural Veterans (Lynch)*

# Policies for Obtaining Race/Ethnicity in the VA

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- Collection of race/ethnicity is mandated by federal regulation
  - OMB Directive Revision No. 15 (1997)
  - Joint Commission (2010)
- Common race/ethnicity data collection methods are
  - Self identification/report
  - Proxy report
  - Observer
- **Patient self-report** to administrative staff is the preferred method for obtaining race/ethnicity from VA patients

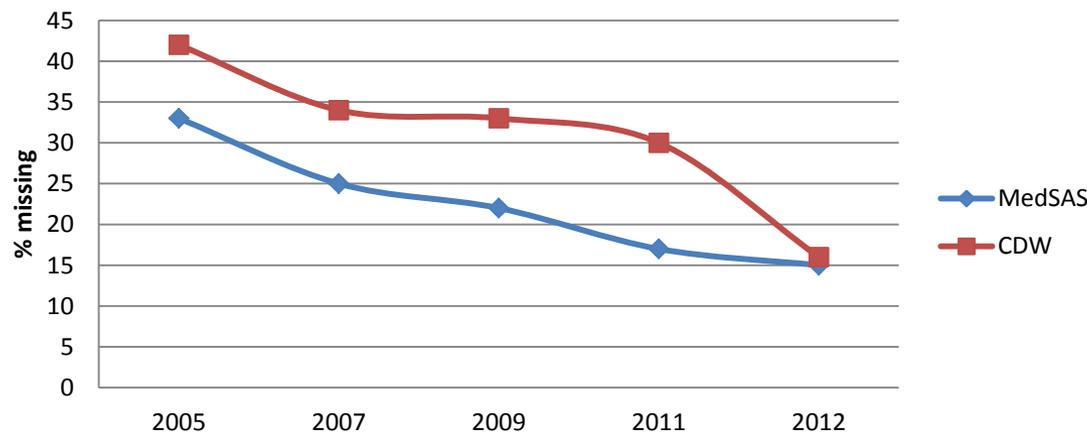
# Sources of Race Data in the VA

- The main sources are
  - **MedSAS files** – inpatient and outpatient visit and event files
    - Race (inpatient and outpatient)
    - Race1-Race7 (outpatient)
    - Ethnic (inpatient and outpatient)
  - **Corporate Data Warehouse (CDW)**
    - PatSub.PatientRace
    - PatSub.PatientEthnicity
  - **Medicare** (for age $\geq$ 65, disabled, CKD)
    - VA vital status file
    - CMS\_race

# Incomplete Race/Ethnicity in the VA

- Despite the **mandate for collection** of race and ethnicity, **missing data on race/ethnicity is common** in VA data (missing or unknown)
  - OMB Directive Revision No. 15 (1997),
  - Joint Commission (2010)),

**Missing Race Data by visit year and source  
(ViRec Webinar, Mor 2014)**



MEDSAS 2015 –only 10%

# Ways to minimize missingness

- Three approaches to **minimize missing data and its impact**
  - Prevention
    - *The best thing to do about missing data is not to have any (Gertrude Cox)*
  - Using multiple sources of data to identify missing values
  - Statistical modeling

# Ways to minimize missingness

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- Stroupe et al (2010) showed that **supplementing with Medicare race data** improves the problem of missing race data in MedSAS by **about 9%** (using data 2004-05)
- But, this approach **only helped Medicare patients** and was **poor in identifying non-African American minority** subjects

# Ways to minimize missingness

- Recent recommendations by VIREC (Feb 2014 Webinar)
  - Supplement **inpatient race and ethnicity with outpatient** data when using MedSAS files
    - When multiple sources of race and ethnicity exist
      - Use self-identified race and ethnicity, if available
      - Use data from the old collection method, only if data from the new collection method are not available
  - Use the **RACE variable** to obtain ethnicity and race collected by **MedSAS**
  - Use **Sub.PatientRace** to obtain ethnicity collected by **CDW**
  - Use of **Medicare + Other sources (DOD)** to reduce the problem of missing race

# Project Objectives

- I. Identify patient attitudes and preferences for how to report their race/ethnicity as part of obtaining medical care in the VA
- II. Determine the perception of patients, providers, and staff regarding barriers and facilitators to obtaining race/ethnicity
- III. Develop and validate statistical methods for addressing missing race/ethnicity data in health equity research that uses VHA data

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# PART 1

# Project Setting and Methods

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- Ralph H. Johnson VAMC, Charleston, SC
- African American, white, and Hispanic patients, health care providers, and clinic staff
- Qualitative strategies were used to identify patient and provider preferences, attitudes, and practices
  - Importance
  - Concerns/reasons
  - Experience
- Statistical methods to impute for missing race/ethnicity data

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# Health Care Providers

# Is Race/Ethnicity Important?

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- All Veterans should get equal medical care
  - Race is important...but, only if indicated for treatment of medical conditions and clinical care
- Health care providers should be color blind and the patient's race/ethnicity should not matter
- Not provider's responsibility to ask patients for race/ethnicity when it is missing

# Is Race/Ethnicity Important?

- *I think it's important in situations where it is not entirely clear to the provider what race the person is, it could help the provider arrive at a list of diagnoses. In many cases it is somewhat clear, but in those cases where it is less clear and makes a difference is regarding outcomes for many treatment-related decision making processes based on race and ethnicity. It's important to be able to study, track and try to bridge that.*
- *I don't think collecting race/ethnicity data is important. From the medical side of things it's more culture, religion and what they will accept for medical care. I think it is important because race and ethnicity, especially cultures, approach health in different ways...*

# Perceptions about Obtaining Race/Ethnicity

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- Awkward to ask patient about his/her racial/ethnic background
- Clinical judgment (e.g., observation) is used to determine race/ethnicity
- Race/ethnicity should be obtained as part of a psychosocial assessment...and by someone else
- Providers are not able to correct missing data

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# Patients

# Perceptions about Providing Race/Ethnicity

- Mixed views about the importance of race/ethnicity
  - *Yes and no – I don't think race should matter, when I was on a ship I didn't look at the color of my brother...*
  - *We look at common things that happen to people of common races - heart attack, stroke - more in the African American community. You need to know where and how a person grew up together with economic status; how much they had, exposure to education.*
  - *It's very important because we are not all the same. African Americans built different from whites; some things you have is more based on race. Race/ethnicity affects a lot of issues; better for treatment.*

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# Clinic Staff

# Perceptions about Race/Ethnicity

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- Important for the VA to collect information about race/ethnicity from patients
  - Some Veterans do not like to be asked
  - Not enough options
  - “Other” is used for many different reasons (e.g., patient refuses to self-report race/ethnicity)

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## **PART 2**

# **Statistical Approaches to Deal with Missing Race Data**



# AUDIENCE POLL QUESTIONS #3

In your research, what do you commonly do to deal with missing race/ethnicity data?

1. Delete those with missing values
2. Include them with another category
3. Multiple imputation
4. Other statistical techniques



# Common Race/Ethnicity Classification

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- In research studies we typically summarize race/ethnicity data as:
  - NHW
  - NHB
  - Hispanic
  - Other (Asian, Pacific Islanders, Native Americans, Unknown)
  - Missing

# Data Examples

- Examples from three studies

Race/ethnicity was retrieved from **outpatient and inpatient [Medical SAS]** data sets. When missing or unknown, the variable was supplemented using the **inpatient race1-race6 fields from the 2003 [Medical SAS]** data sets, the **outpatient race1-race7 fields from the 2004 [Medical SAS]** data sets, and the **VA Vital Status from CMS field** for race.

<b>Race/Ethnicity</b>	<b>Diabetes</b> (n=892223)	<b>Cohorts</b> <b>CKD</b> (n=4096541)	<b>TBI</b> (n=104644)
<b>NHW</b>	<b>0.62</b>	<b>0.68</b>	<b>0.55</b>
<b>NHB</b>	<b>0.12</b>	<b>0.11</b>	<b>0.12</b>
<b>Hispanic</b>	<b>0.14</b>	<b>0.03</b>	<b>0.02</b>
<b>Other</b>	<b>0.02</b>	<b>0.02</b>	
<b>Missing</b>	<b>0.10</b>	<b>0.16</b>	<b>0.30</b>

For the CKD cohort, missing rate was reduced **from 28% to 16%** by adding vital status file from CMS to MedSAS and CDW.

# Common Practices

- Pooling those with **known and unknown race into Other category** (some times those who declined are included in 'Other') could lead to bias (**misclassification bias**)
- Analyzing '**missing**' as separate category could also lead to bias (Greenland 1998)
- Complete case analysis (CCA) – ignoring the missing data
  - Valid when missing data is completely at random
  - Can lead to unbiased estimates in situations when missingness does NOT depend on the outcome
  - Less efficient or less precise- loss of power
- Using statistical methods for missing data analysis

# Overview of missing data analysis

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- The overall goals of missing data analysis
  - Minimize **bias**
  - Maximize use of available information
  - Obtain appropriate **estimates of uncertainty**
- These goals depend on:
  - Magnitude of missing data (lower is better)
  - Mechanism of missing data
    - MCAR, MAR, MNAR
  - Methods used to deal with missing data
    - Maximum Likelihood, Multiple Imputation, Sensitivity analysis

# Missing Data Mechanisms

- Understanding the missing data mechanism is a key step in data analysis
- Let  $X = \text{Race}$ ,  $Y = \text{A1C}$ ,  $Z = (\text{age, gender, etc})$  and we define:
  - **MCAR** =  $\Pr(X \text{ missing} | X, Z, Y) = \Pr(X \text{ missing})$ 
    - A random sample of people have missing race values
  - **MAR** =  $\Pr(X \text{ missing} | X, Z, Y) = \Pr(X \text{ missing} | Z, Y)$ 
    - Missing race varies by gender and A1C
  - **MNAR** =  $\Pr(X \text{ missing} | X, Z, Y) = \Pr(X \text{ missing} | X)$ 
    - Some race groups are selectively not reporting their race
- Our data does not help us to determine these but we have to make reasonable assumptions to do missing data analysis

# Statistical Approaches

- Maximum Likelihood
  - Valid under MCAR and MAR
- Multiple Imputation
  - Valid under MCAR and MAR
- Sensitivity analysis (Carpenter and Kenward 2013)
  - Useful to test how plausible our MAR assumptions are by testing against MNAR scenarios
  - For example, the **tipping point approach** is like a **progressive stress-testing** to assess how departures from MAR must be severe in order to overturn conclusions from the primary analysis (Yuan 2013)

# When is CCA Valid?

- Let  $R$  denote whether a subject has  $X$ =race information ( $R=1$ ) or not ( $R=0$ )
- If missingness depends on  $X$  but given  $X$  it is independent of  $Y$   $\{P(R|X, Y)=P(R|X)\}$  then CCA is **unbiased** for estimating the relationship between  $Y$  and  $X$

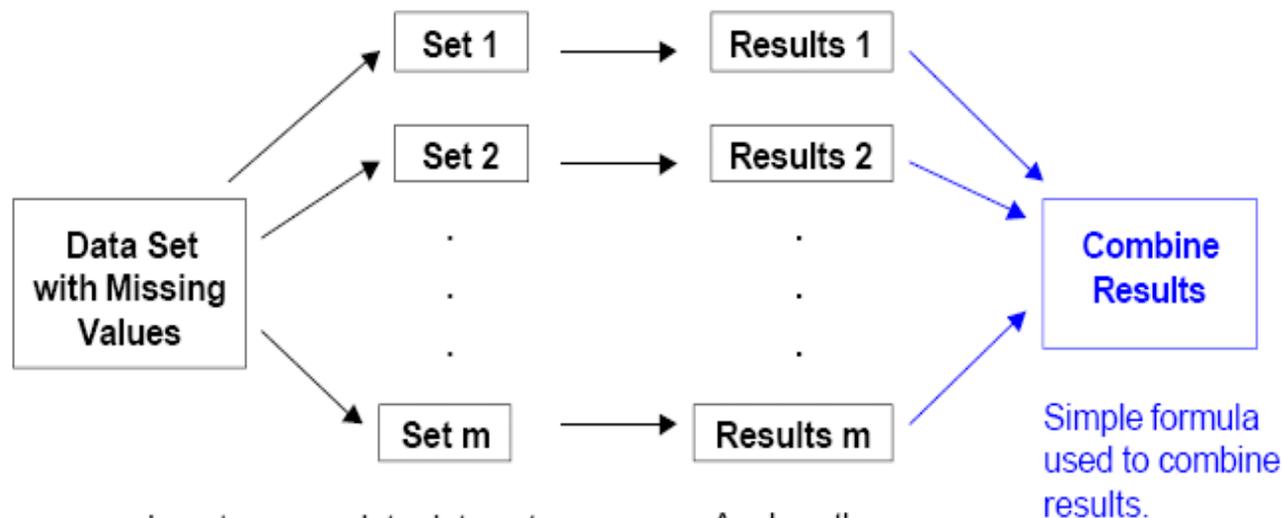
$$\begin{aligned}f(Y | X, R = 1) &= \frac{f(Y, X, R = 1)}{f(X, R = 1)} \\&= \frac{f(R = 1 | X, Y) f(X, Y)}{f(R = 1 | X) f(X)} \\&= \frac{f(R = 1 | X) f(X, Y)}{f(R = 1 | X) f(X)}, f(R = 1 | X, Y) = f(R = 1 | X) \\&= f(Y | X)\end{aligned}$$

- Unbiased as long as missingness does not depend on  $Y$  or factors associated with  $Y$  (including in some MNAR cases)
- **Problem**: it will be less precise

# Multiple Imputation (MI)

- MI is a convenient and flexible paradigm for analyzing data with missing values (Rubin 1987, Schafer 1999)
- It involves three steps (Little and Rubin 1987)
  - Filling in missing values with plausible values via an imputation model
  - Analysis of the imputed data sets using standard methods
  - Pooling the results together via the Rubin's rule

# Multiple Imputation (Rubin 1987)



Impute a complete data set:

- Fill in missing values with a value "drawn" from the distribution of your data.
- Each drawn value will be different for the missing item.

Analyze the imputed data set.

- MI is not just about guessing correct values for the missing
- It tries to make the distribution of imputed values to look like the missing values

# Imputation Models

- Should be **congenial** with analysis models (Meng 1995)
  - Eg. If interaction term is required in the analysis model, it would be recommended to include the interaction in the imputers model
- For classification variables like race/ethnicity, to impute the missing values, we could use
  - Logistic regression models-MI
  - Latent class models - LCMI
- Steps in LCMI (Gebregziabher and DeSantis 2008)
  - Fit a **latent class model** to the observed data
  - Sample from **the posterior distribution of latent class** given the observed data
  - Sample from **the distribution of the missing data** conditional on that latent class
  - Use a within latent class posterior sampling to impute the missing class.
- LCMI can be implemented via PROC LCA and MI in SAS

# Sensitivity Analysis

- Multiple imputation usually assumes MAR
- It is important to examine the sensitivity of inferences to departures from the MAR assumption, because this assumption cannot be verified using the data.
- Recent development – **we can do sensitivity analysis within the framework of multiple imputation**
  - Tipping point approach (Carpenter and Kenward 2013)
    - adjust imputed values using specified **shift parameters** for a set of selected observation.
      - $P(Y|X=x+a, R=0) = P(Y|X=x, R=1)$ , where  $a$  is the shift parameter
    - If this scenario leads to a conclusion different from that of inference under MAR, then the MAR assumption is questionable
      - **MNAR assumption:  $P(Y|X, R=0) \neq P(Y|X, R=1)$**

# Sensitivity Analysis

- In SAS 9.3, PROC MI has added a new **MNAR statement** that imputes missing values assuming the missing data are MNAR.

```
proc mi data=data seed=1234 nimpute=10 out=outmi;  
  class race comorbid;  
  monotone logistic (race/link=glogit);  
  mnar adjust(race(event='1\') / shift=2; *tippingpoint;  
  mnar model(race/modelobs=(comorbid='0')); *PMM;  
  var race x1-x10;  
run;
```

- The MNAR statement has two options: MODEL and ADJUST.
- The ADJUST option is used to **specify an imputed variable and adjustment parameters** (such as shift and scale) for adjusting the imputed variable values of a specified subset of observations.
- the MODEL option is used to specify a **subset of observations** from which imputation models are to be derived for race.

# Type 2 Diabetes Study

- Diabetes Cohort of  $n=629,563$  (on meds).
- Random sample of 5% = 31,478
- ~10% missing race data
- Outcomes:
  - MNA – medication adherence
  - A1C – HgbA1C control
  - Mortality
- We analyzed the data using the following approaches
  - CCA
  - MI
  - Sensitivity analysis

# Results

Table: Comparison between those with missing and non-missing race

Characteristic	Non-Missing (n=28,807)	Missing (n=2,671)	P-value
Age (mean $\pm$ sd)	66.56 $\pm$ 10.66	53.25 $\pm$ 7.74	<0.0001
Comorbidity Count (mean $\pm$ sd)	2.01 $\pm$ 1.45	1.32 $\pm$ 1.09	<0.0001
Service Connected Disability (%)			
$\geq$ 50%	12.42	8.54	<0.0001
< 50%	87.58	91.46	
Mean A1c	7.5	8.1	<0.0001
MNA (MPR<80%)	36.1	43.3	<0.0001

- Patients with missing race values are more likely to be younger, with less comorbidity burden and less service connected
- Patients with missing race values are less adherent and with higher A1c  
**(missingness depends on outcomes)**

# Results

Table: Analysis results for MNA as outcome: under MCAR/MAR assumptions

Characteristic	CCA			LCMI		
	OR	SE	P-value	OR	SE	P-value
Race						
Non-Hispanic white (REF)						
Non-Hispanic black	1.610	0.022	<0.0001	1.493	0.018	<0.0001
Hispanic	1.252	0.031	<0.0001	1.309	0.026	<0.0001
Other race	0.970	0.107	0.7779	1.124	0.082	0.0766
Living Situation X Race Interaction						
Rural X Non-Hispanic black	0.920	0.046	0.1718	0.965	0.037	0.1631
Rural X Hispanic	1.193	0.074	0.0179	1.161	0.059	0.0055
Rural X Other race	1.713	0.183	0.0033	1.528	0.140	0.0012

- Odds of MNA in NHB is 49% higher than NHW
- Odds of MNA in urban Hispanics is higher than urban NHW and it is even much higher in **rural Hispanics** compared to NHW

# Sensitivity Analysis

```
proc mi data=he1.p4miss seed=34857 nimpute=5
  out=he1.p4sens_white;
class sens_race region male mstat urban
  svcpcctge50 rmna_1 rmna_2 rmna_3 rmna_4
  rmna_5;
monotone logistic (sens_race / link=glogit);
mnar adjust( sens_race (event='1') /shift=2);
var rmna_1 rmna_2 rmna_3 rmna_4 rmna_5
  mean_a1c1 mean_a1c2 mean_a1c3 mean_a1c4
  mean_a1c5 age count region male mstat urban
  svcpcctge50 sens_race; run;
```

- This was run under different values of event (event=1,2,3) and different shift values (-2,-1,0,1,2) to do sensitivity analysis

# Results

Table: Sensitivity analysis results for MNA as outcome: under different MNAR assumptions

Characteristic	Event='1'			Event='2'			Event='3'		
	OR	SE	P-value	OR	SE	P-value	OR	SE	P-value
Race									
Non-Hispanic white (REF)									
Non-Hispanic black	1.532	0.021	<0.0001	1.497	0.020	<0.0001	1.535	0.021	<0.0001
Hispanic	1.205	0.031	<0.0001	1.240	0.031	<0.0001	1.209	0.030	<0.0001
Other race	0.948	0.105	0.6126	1.009	0.103	0.9337	1.095	0.079	0.2470
Living Situation X Race Interaction									
Rural X Non-Hispanic black	0.946	0.045	0.2234	0.906	0.040	0.0142	0.928	0.044	0.0890
Rural X Hispanic	1.209	0.074	0.0104	1.181	0.073	0.0223	1.211	0.071	0.0075
Rural X Other race	1.687	0.182	0.0044	1.626	0.179	0.0066	1.288	0.137	0.0651

LCMI		
OR	SE	P-value
1.493	0.018	<0.0001
1.309	0.026	<0.0001
1.124	0.082	0.0766
0.965	0.037	0.1631
1.161	0.059	0.0055
1.528	0.140	0.0012

There is no much difference between MAR and the results from sensitivity analysis

# Summary

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- Make every effort to minimize the magnitude of missing data – multiple sources of data
- Multiple imputation could be a reasonable approach when implemented jointly with sensitivity analysis

# Future Directions

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# Potential Quality Improvement Strategies

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- Increase the number of choices for self-identification of race/ethnicity among Veterans
- Create standard templates for collecting race/ethnicity from patients
- Educate patients, providers, and clinic staff about the importance of SIRE by providing a rationale for asking SIRE questions to increase the level of comfort with providing this information

# Potential Quality Improvement Strategies

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- System alerts/reminders to update demographic data annually and to update SIRE data if those fields are not populated
- Linkage and sharing of SIRE data from research studies to VHA clinical and administrative systems from which health-related data are being collected
- Develop methods to validate race/ethnicity data obtained previous to implementation of quality improvement strategies

# Quantitative Strategies for Addressing Missing Race Data

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- MI using machine learning algorithms
- Comparing machine learning (random forest) to GLM based imputation approaches for missing race data

# Collaborators

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- Leonard Egede, MD, MS
- Aleatha Fields, B.A.
- Cheryl Lynch, MD, MPH
- Charlene Pope, PhD, RN
- Rebekah Walker, PhD
- Elizabeth Payne, PhD



# CONTACT INFORMATION + WEBSITE + Q & A

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## Thank you!

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<http://www.charleston.va.gov/services/heroic.asp>



Veterans Health Administration  
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# FOCUS ON HEALTH EQUITY AND ACTION CYBERSEMINAR SERIES

- ❑ November 19, 2015 – Archived
- ❑ January 21, 2016 - Archived
- ❑ February 25, 2016 – Archived
- ❑ March 24, 2016 - Archived
- ❑ April 28, 2016 – Archive coming soon
  
- ❖ Mark your calendars and join us at 3-4PM EST for the last session in the series for Fiscal Year 2016 on
- ❑ June 30, 2016
- ❖ For more details go to  
[http://www.va.gov/HEALTHEQUITY/News\\_Events.asp](http://www.va.gov/HEALTHEQUITY/News_Events.asp)





# GET INVOLVED!

- The pursuit of Health Equity should be everyone's business.
- It is a journey that takes time and 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!

