

VA



U.S. Department
of Veterans Affairs

Focus on Health Equity and Action:

Findings from the VISN 4 Hypertension Racial Disparities Quality Improvement Project

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CHERP
CENTER FOR HEALTH EQUITY
RESEARCH AND PROMOTION
VA HSR&D CENTER OF INNOVATION



Veterans Health Administration
Office of Health Equity



Audience Poll Questions #1

What is your primary role?

1. Veteran
2. Researcher
3. Clinician
4. Management/policy maker
5. Other





PURPOSE OF SESSION

- ❖ Highlight the partnership of OHE, VISN 4 and CHERP in pursuit of health equity including how the project was conceived
- ❖ Describe the nature and intensity of specific strategies implemented at individual facilities to reduce blood pressure disparities
- ❖ Discuss the barriers and facilitators to implementing specific strategies
- ❖ Present data regarding the impact of the project on disparities over time. The presentation will conclude with a discussion of recommendations gleaned from the project to guide future quality improvement efforts focused on disparities in health or health care





OHE-CHERP MOU

- ❖ CHERP investigators in partnership with the OHE
- ❖ Conduct a rigorous evaluation of the VISN4 Hypertension Racial Disparity Project
- ❖ Inform future efforts by the OHE and others committed to improving the quality and equity of health care delivery for Veterans with hypertension and other common medical conditions





OHE-CHERP MOU - SPECIFIC AIMS

- ❖ To document the development and roll-out of the VISN 4 Race Disparity Dashboard - including all relevant meetings with facility leaders, quality improvement staff, and providers
- ❖ To describe the nature and intensity of hypertension control interventions implemented at facilities, and assess barriers and facilitators to implementation
- ❖ To assess the impact of the various interventions on disparities in blood pressure control among black and white Veterans with hypertension at the VISN and facility-level





OHE-CHERP MOU - RESPONSIBILITIES

- ❖ CHERP responsible for evaluation design, evaluation, protocol, data collection, data analysis, interpretation of evaluation results, and compilation of final report and other evaluation products
- ❖ OHE executive director along with two other key personnel designated by OHE worked with the evaluation team during the process
- ❖ OHE funded the evaluation
- ❖ VISN 4 funded the QI projects
- ❖ VISN 4 facility teams operationalized the QI





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





☐ Transformational Actions:

- 2.2.a. VHA will aspire to the “Triple Aim” (Better Health, Care, and Value), and Focus Performance Measurement on Strategic Outcomes.
- 3.2.a. Implement a Population Health Program.
- 7.2.b. Advance Knowledge on Improving Individual and Population Health.
- 6.2.d. Implement *Personalized* Health Plans.
- 7.2.h. Rapidly Translate Research Findings and Evidence-Based Treatments into Clinical Practice.
- 8.2.d. *Collaborate Authentically* with State and Community-based Organizations that Serve Veterans.
- 8.2.f. Encourage More Effective Integration of Care with Community Partners through Data Sharing





OHE INVOLVEMENT - HEALTH EQUITY ACTION PLAN

- ❑ **Awareness:**
 - *Attention to the Racial disparities in HTN control among Veterans + Crucial Strategic Partnerships to address it + real-time evaluation*

- ❑ **Leadership:** Health equity in all policies ...
 - *VISN 4 leadership incorporated Health Equity in FY performance target*
 - *Commit resources to implement HEAP*
 - *Revenue stream to fund health equity projects with outcome evaluation strategies*

- ❑ **Health System Life Experience:** Incorporate social determinants of health ...
 - *Impact of Race on the HTN control disparities for Veterans in VISN 4*
 - *Promote understanding of social determinants of health and their impact on health status*
 - *Identify measures of access & gaps in health system related to health equity +develop strategies*

- ❑ **Cultural and Linguistic Competency:**
 - *Understand the barriers to reaching the goal in African American Veterans in VISN 4*

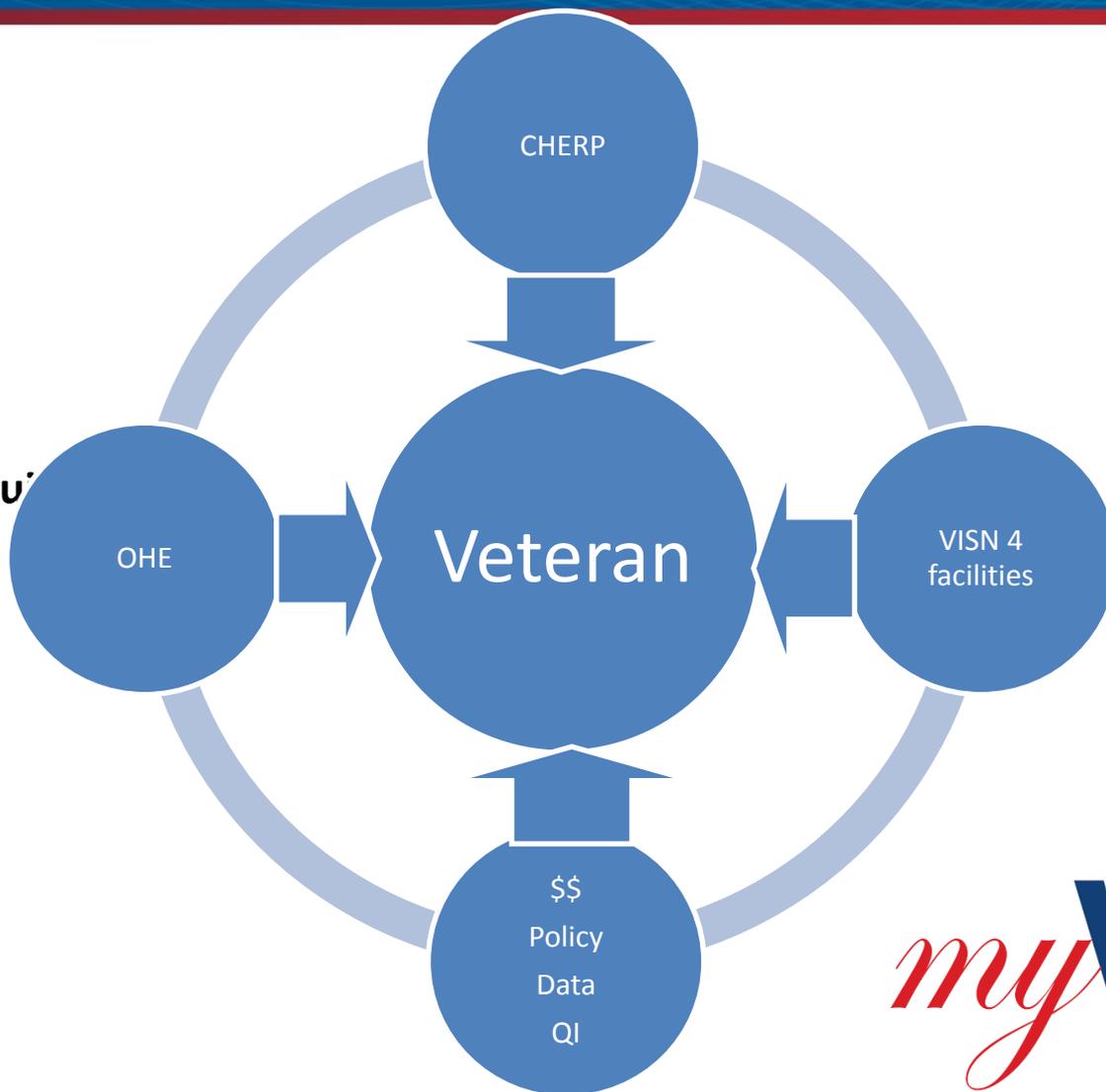
- ❑ **Data, Research and Evaluation:**
 - *Analyzed race data to identify disparities + intervention*
 - *SME health equity researchers for real time evaluation - CHERP*
 - *Inform policy, operations and other projects*
 - *Develop and/or implement products and strategies to impact equity*





THE VETERAN IN THE CENTER

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Veterans Health Administration
Office of Health Equity

All hands on deck >> SYNERGY >> POSITIVE RESULTS

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Acknowledgements – It took a village

- Operations, Clinical, and Research Partners:
 - VHA Office of Health Equity
 - Veterans Integrated Service Network (VISN) 4
 - VA Pittsburgh Healthcare System, Center for Health Equity Research and Promotion (CHERP)

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Judith Long

Disclaimer

- The views expressed in this presentation are those of the presenter and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government.

Poll question #2

- Are you involved (directly or indirectly) in managing care for hypertension among Veterans? Please select one:

Yes

No

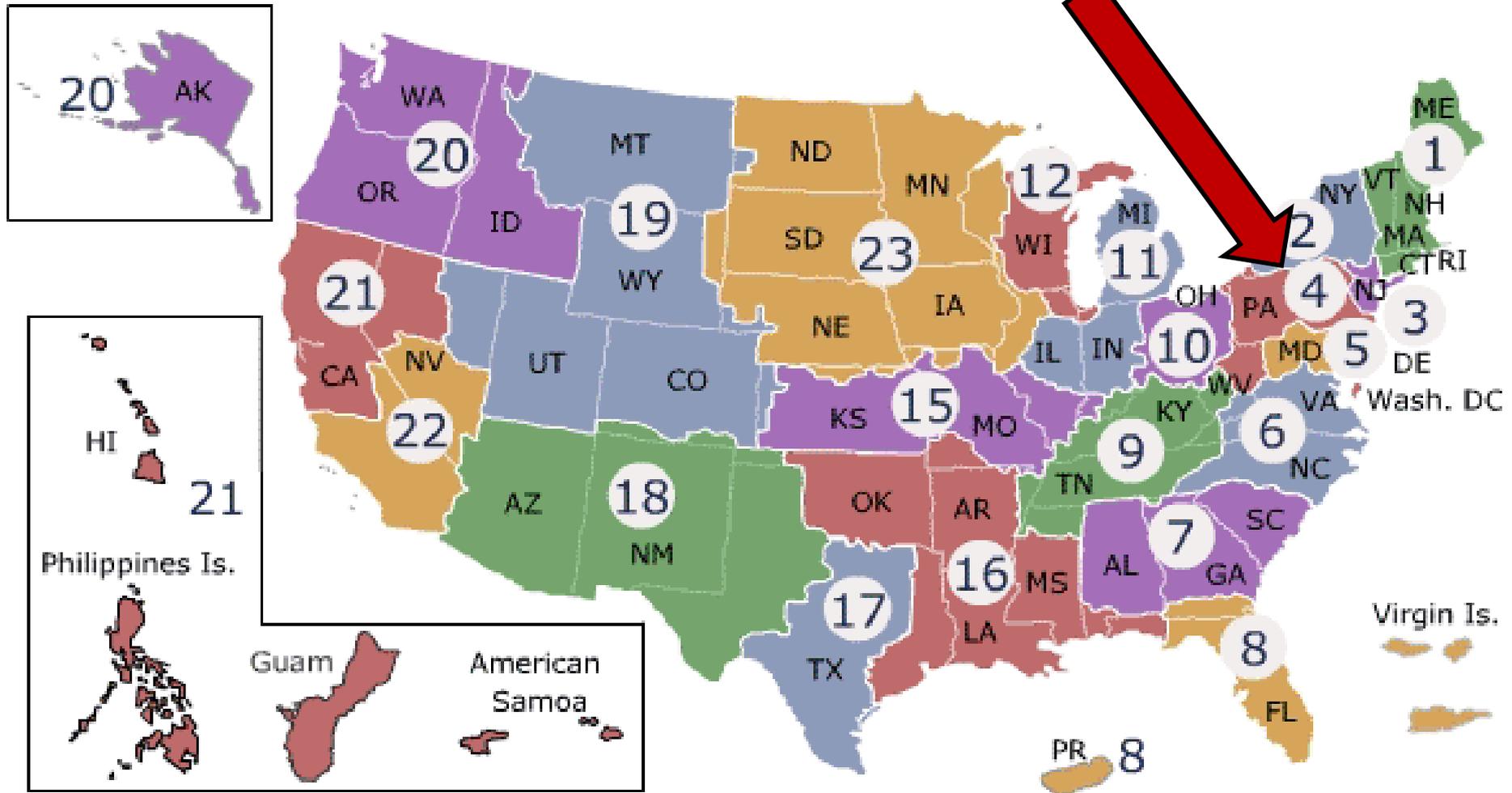
Poll question #3

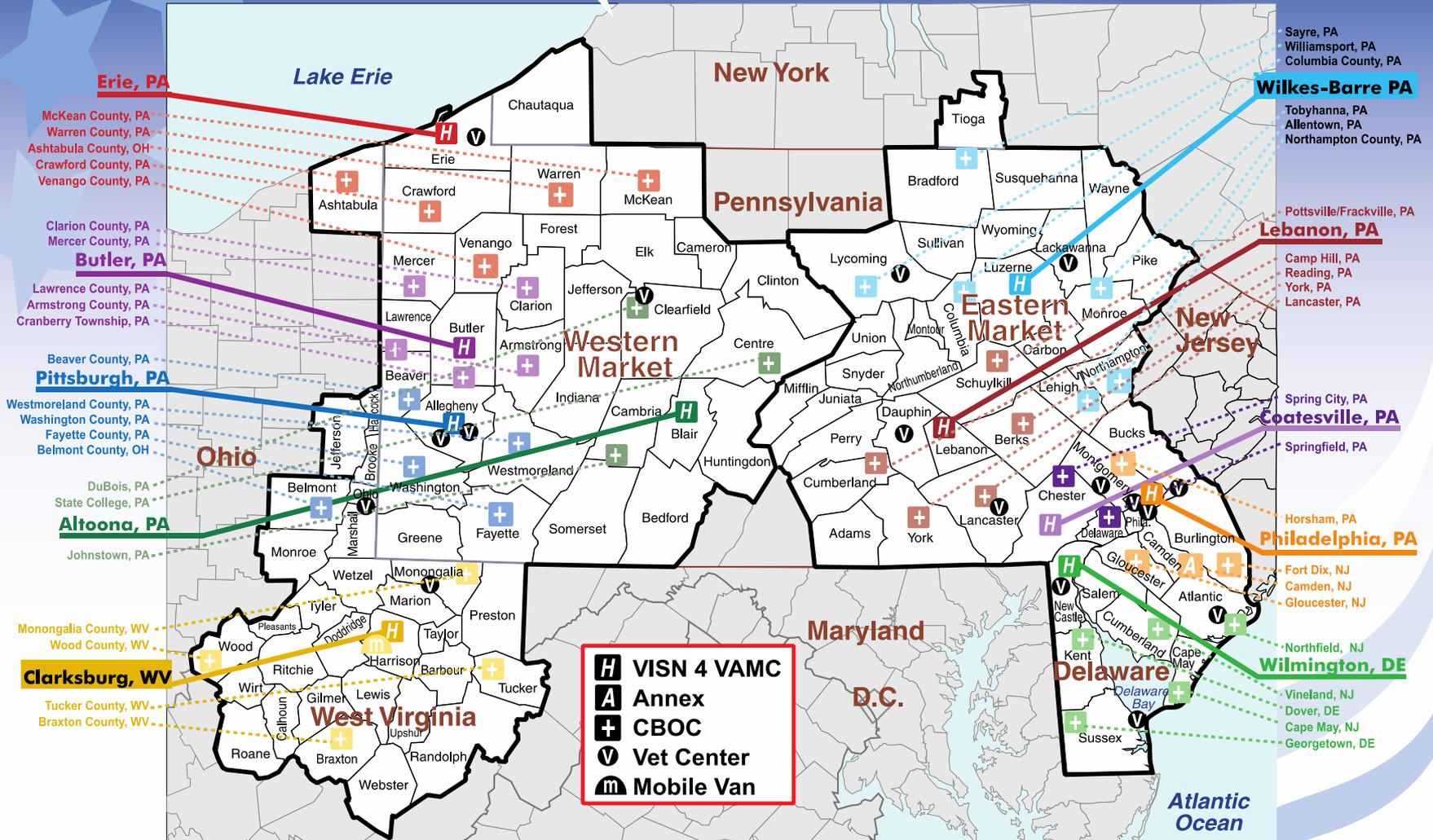
- Did you attend the September 24, 2014 CyberSeminar titled, *Partnership in Pursuit of Health Equity: Focus on Minority Veterans*, in which I described how this project originated? Please select one:
 - Yes, and I've been looking forward to this follow-up ever since
 - Yes, but I need to be reminded of the details
 - No, but I am looking forward to hearing about it today

Outline for Remaining Session

- Project overview
- Evaluation aims and methods
- Qualitative findings
- Quantitative findings
- Future recommendations

Project Overview – Where is VISN 4?

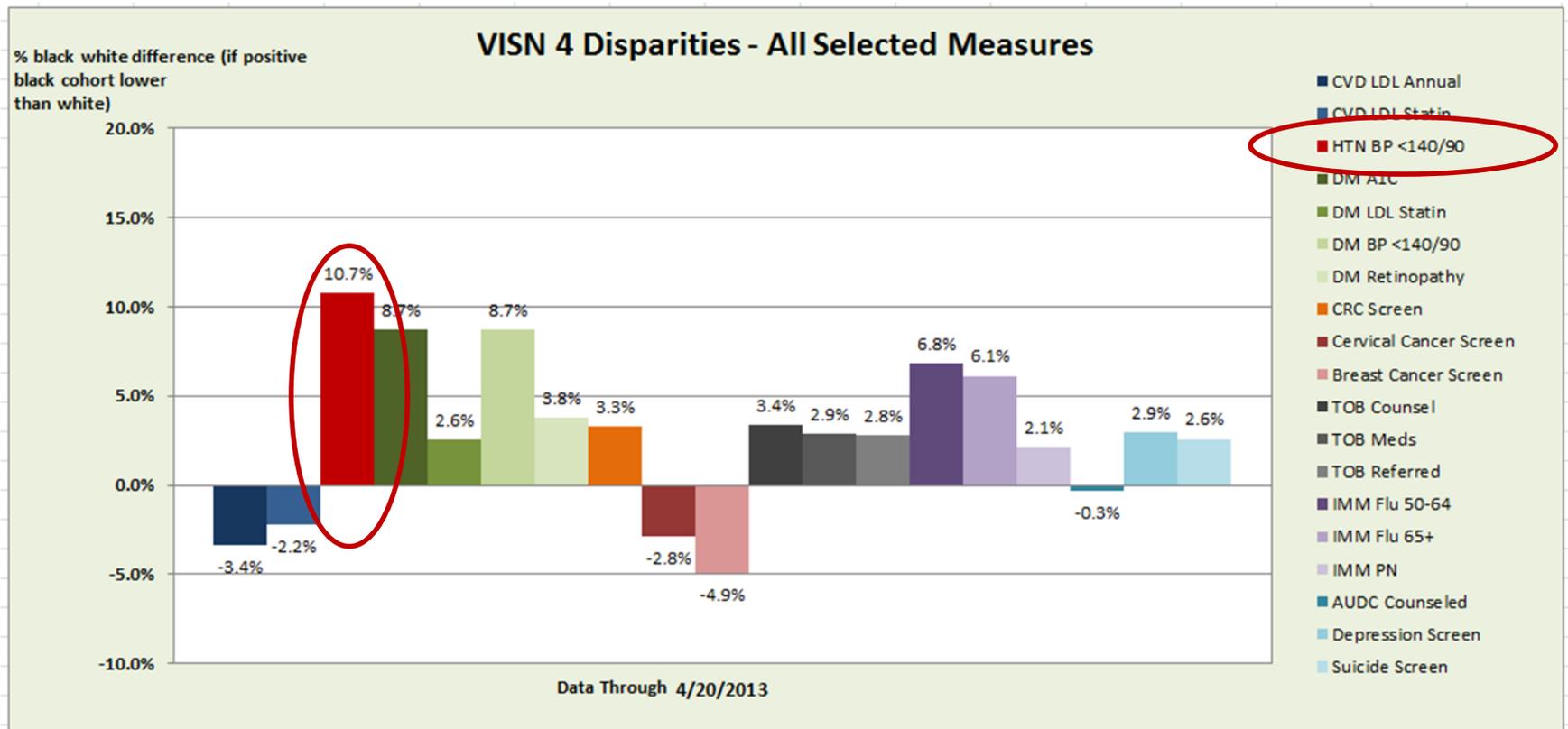




Commitment to Reducing Disparities

- VISN 4 included objectives to reduce disparities in performance plan for Fiscal Year (FY) 2013
 - Develop a VISN-wide Race Disparity Dashboard
 - Distribute the Dashboard to VISN 4 facility leaders
 - Use the Dashboard to identify specific opportunities for quality improvement
 - Implement initiatives to reduce disparities and monitor their impact

VISN 4 Race Disparity Dashboard – Initial Findings



Black-White Differences in 19 Primary Care Quality Measures as of April 20, 2013

VISN 4 Disparities Objectives for FY14

- Carry out a VISN-wide quality improvement effort to reduce racial disparities in hypertension (HTN) control
- Specific target: Reduce the number Black Veterans with severe (i.e., Stage 2) HTN in VISN 4 by the end of FY14
 - Why Black Veterans?
 - National targets for HTN control were being met for Whites, but not Blacks, at most VISN 4 facilities
 - Why Stage 2 HTN (≥ 160 systolic or 100 diastolic)?
 - Patients with Stage 2 HTN are at greater risk for vascular morbidity

The VISN 4 Hypertension Racial Disparities Project was Born

- VISN Project Lead appointed
 - VA Pittsburgh Physician with past experience improving racial disparities in HTN control
 - Task: Coordinate efforts across VISN
- Facility Project Leads appointed at each VA Medical Center (VAMC)
 - All involved in primary care delivery, but specific role varied
 - Task: Oversee project activities at their VAMC and Community Based Outpatient Clinics (CBOCs)

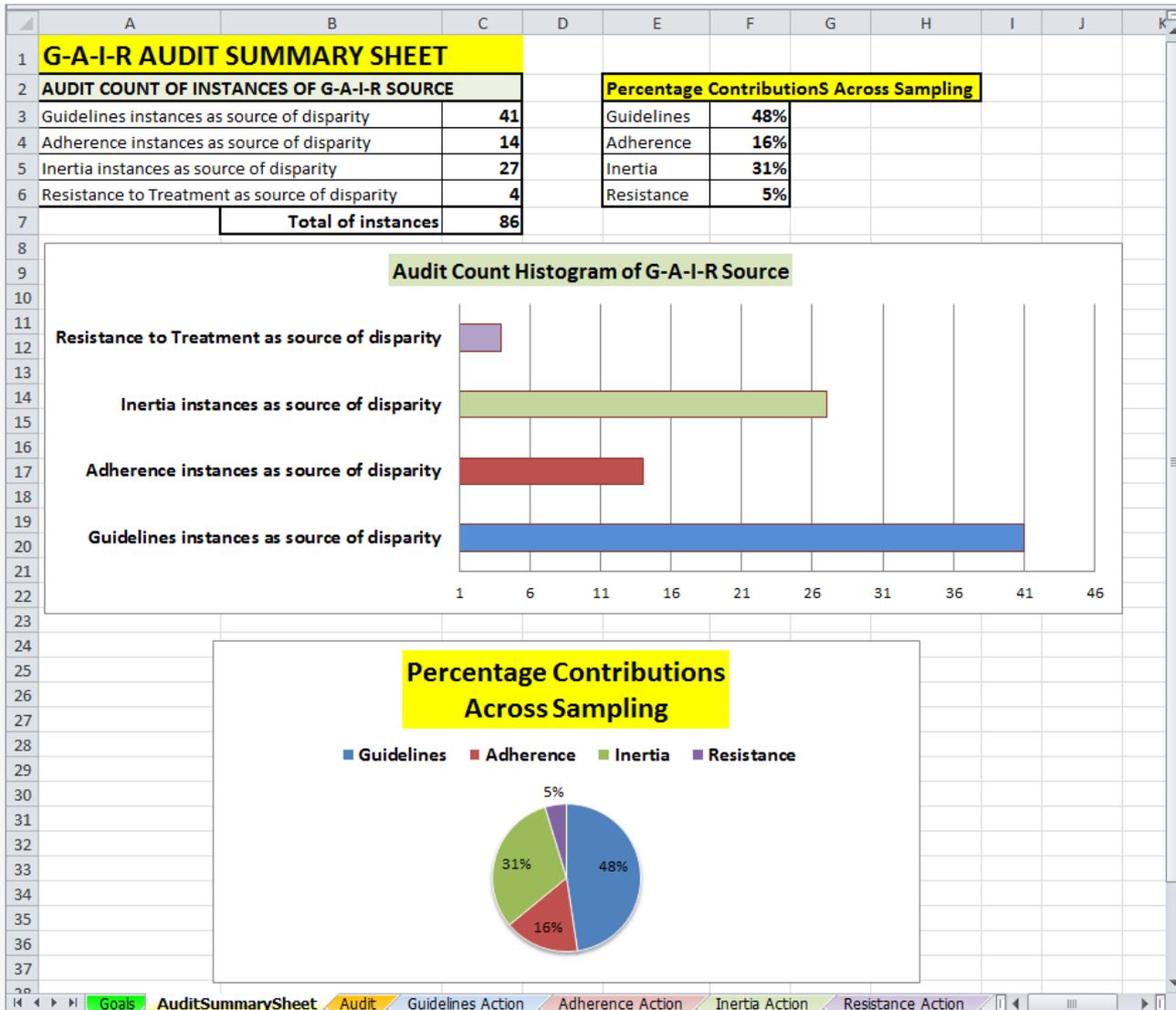
First Step – **GAIR** Analysis

- Identify factors underlying Black-White HTN disparities at each facility
 - Provider use of current clinical **G**UIDELINES
 - Patient **A**DHERENCE to medication and lifestyle modification
 - Provider clinical **I**NERTIA (a lack of urgency) in treating patients with HTN
 - Patient **R**ESISTANCE to standard medication management

GAIR Audit Worksheet

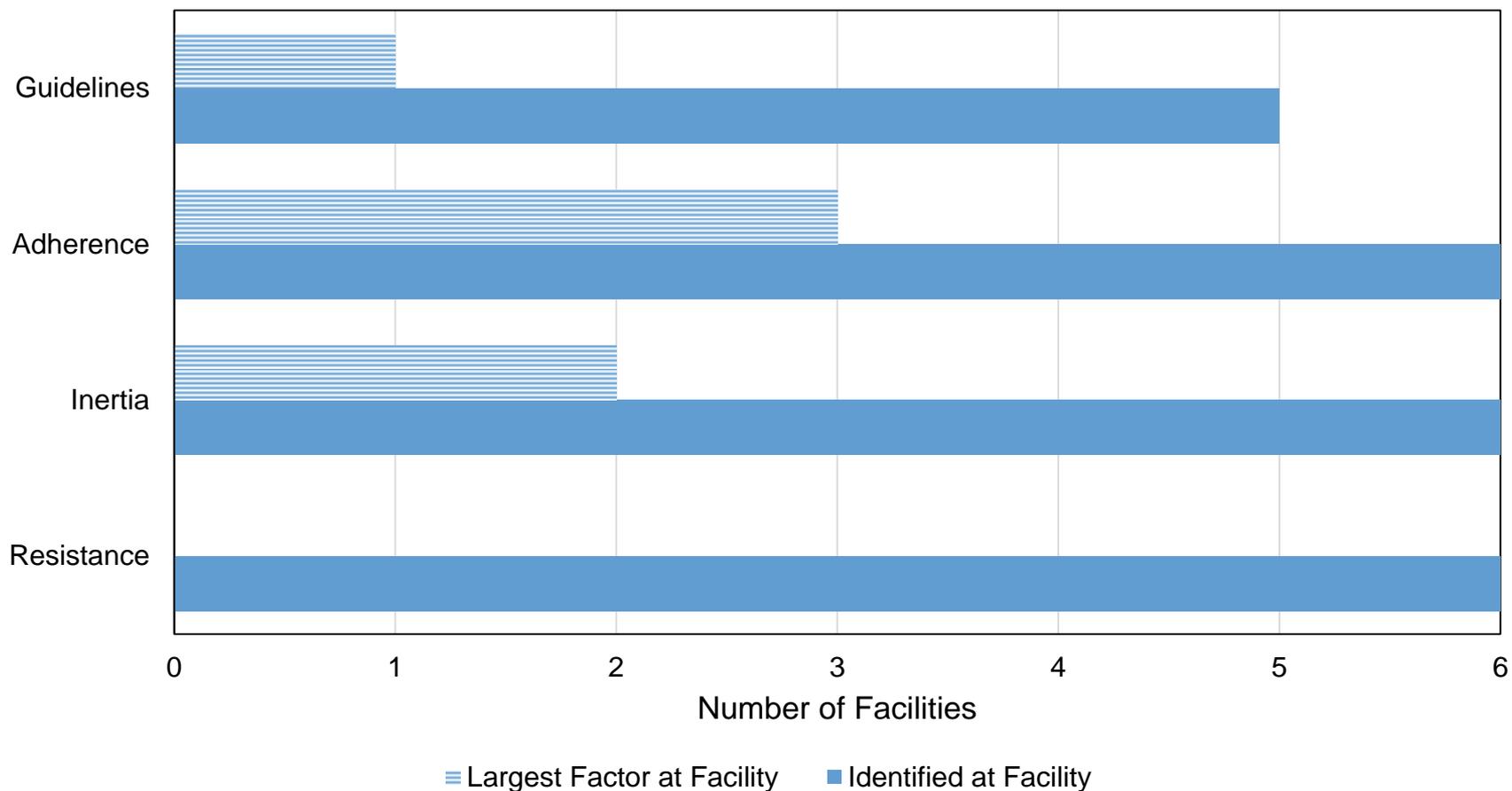
	A	B	C	D	E	F	G	H	I	J						
1		G-A-I-R AUDIT WORKSHEET														
2	After randomization,	Enter the number 1 in corresponding cell for each GAIR instance				AUDIT LEXICON Guidelines: JNC-7 clinical guidelines are referred to here. Pay particular attention to whether Black patients are on ACE inhibitors or ARBs without the benefit of either a CCB or a diuretic. Adherence: Known previously as 'patient compliance', you want to look for evidence that patient has missed follow-up appointments for intended care of his/her hypertension. Inertia: Even though the notion of 'inertia' is in the eyes of the beholder, you might want to establish that 'inertia' is evident when the follow-up interval that is documented in the CPRS progress note exceeds 6-8 weeks. Stage 2 hypertension should be seen as an urgent phenomenon. Addressing inertia will entail creating additional opportunities for patients to receive care at shorter intervals. Therefore, this component will likely require the greatest amount of creative thinking and work. Resistance: Resistance to usual forms of treatment in amount and in variety is unusual and can point to secondary causes of hypertension. Resistance should not be posted for an individual record if JNC-7 step care guidelines have not been followed.										
3	audit sequence number	Guidelines	Adherence	Inertia	Resistance											
4	1	41	14	27	4											
5	2															
6	3															
7	4															
8	5															
9	6															
10	7															
11	8															
12	9															
13	10															
14	11															
15	12															
16	13															
17	14															
18	15															
19	16															
20	17															
21	18															
22	19															
23	20															
24		41	14	27	4											
25																
26				Aggregate Total of GAIR instances												
27					86											
28																
29																
30																
31																
32																

Audit Summary (Example)



GAIR Summary – 6 Facilities

GAIR Factors Found Across Facilities



Action Plan for Each GAIR Factor

	A	B	C	D	E	F	G
1		GUIDELINES	Action Plan				
2			Barriers	1	Lack of thorough application of JNC8 and knowledge of new guidelines among providers		
3				2	Absence of African American specific treatment recommendations in former JNC7 guidelines		
4				3	For CBOCs, lack of Chlorthalidone on contracted formularies at non-VA pharmacies serving CBOCs		
5				4			
6				5			
7			Resources	1	JNC-8 Recommendations that now highlight guidelines directed at the treatment of African American hypertensives		
8	D-o-D (1-5)			2	VISN SharePoint database which displays Veteran HTN Outliers		
9	L-o-P (0-3)			3	Pre-clinic conference for interns and residents		
10	Owner(s)			4	UD attendings available every other Friday during Primary Care Provider meeting		
11	TD-o-C			5	Local hypertension expertise (e.g., Matthew Muldoon)	Done	
12		Level 1 Action Steps	Action for Barrier	1	Development of educational plan for providers using JNC8 recommendations		
13			Action for Barrier	1	Outline what should be included on a Pocket Guide (or one page document) which displays key guidelines/recommendations for academic detailing	done	
14			Action for Barrier	2	Develop plan to create a VHAPHS HTN management Standard of Care that includes African American specific treatment recommendations		
15			Action for Barrier	3	Discover process for establishing Chlorthalidone as a formulary at non-VA pharmacies serving CBOCs	done	
16		Level 2 Action Steps	Action for Barrier	1	Implement education plan for PCPs using JNC8 recommendations during pre-clinic conferences & Primary Care Provider Friday meetings		
17			Action for Barrier	1	Distribution of Pocket Guide (or one page document) displaying guidelines/recommendations to PCPs along with academic detailing		
18			Action for Barrier	1	Implement the process for distribution of the VISN Veteran HTN Outliers		
19			Action for Barrier	3	Implement the actions needed to establish Chlorthalidone as a formulary at non-VA pharmacies serving CBOCs		
20		Level 3 Action Steps	Action for Barrier	1	Reinforce knowledge of education with one-on-one PCP drug detailing and/or information sharing via provider huddles.		
21			Action for Barrier	1	Hyperlink Pocket Guide (or one page document) to "tools" in CPRS and distribute to all new providers and service lines.		
22			Action for Barrier	1	Reinforce utility of using HTN outlier list		
23			Action for Barrier	3	Establish Chlorthalidone on formulary for non-VA pharmacies serving CBOCs		
24							
25		Measure of Success:					
26		MOS Periodicity:					
27		Audit Pareto Baseline:		48%			
28							
29							
30							
31							
32							

Second Step – Implement Local Action Plans

- VISN Project Lead served as a model and provided support
 - Encouraged facilities to implement strategies to fit local needs and resources
- VISN provided tools to generate lists of patients with Stage 2 HTN
 - Stage 2 HTN defined as average blood pressure (BP) $\geq 160/100$ in 6 months prior to last visit
 - Lists could be sorted by race, last BP, provider, etc.
- VISN also distributed monthly progress reports

Screenshot from April 2014 Report

VA HEALTHCARE - VISN 4																
FY14 ECF ce5b3: Population Health Management - Racial Disparity Hypertension Average BP																
Network Target: Improvement Over Baseline First Month FY14 by EOY FY14																
African American Stage II Hypertension Average BP Outlier Count by Facility																
	Baseline	ECF Measure Target	Aspirational Target	# Needed for Aspirational Target	from Baseline to Meet Asp. Target	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	*Sep
	6	5	1	5	83%	6	5	9	11	8	12					
	15	14	1	14	93%	15	16	18	20	18	13					
	7	6	1	6	86%	7	6	5	7	8	8					
	43	42	11	32	75%	43	42	47	42	39	39					
	18	17	5	14	75%	18	19	19	17	17	17					
	68	67	17	51	75%	68	59	58	58	58	62					
	600	599	400	200	33%	600	569	587	552	566	540					
	155	154	39	116	75%	155	160	154	154	159	149					
	39	38	5	34	87%	39	38	34	34	27	20					
	155	154	39	116	75%	155	144	133	139	139	124					
VISN 4	1106	1105	518	588	53%	1106	1058	1064	1034	1039	984					

Shows monthly progress towards goal of reducing number of Black Veterans with Stage 2 HTN at each facility and in the VISN overall.

Evaluation Opportunity – VISN 4 / CHERP / OHE Partnership



- CHERP partnered with OHE and VISN 4 to document the process and impact of this network-wide effort to reduce race disparities in HTN

Evaluation Aims

- Document development and roll-out of the Dashboard
 - Covered in previous CyberSeminar
- Describe HTN control intervention strategies implemented at VISN 4 facilities and barriers to implementation
- Assess impact of intervention strategies on disparities in BP control among Black and White Veterans with HTN

Evaluation Methods – Qualitative

- CHERP qualitative expert documented project-related calls
 - VISN-wide calls (8 held from Oct. 2013 – Dec. 2014)
 - Quality assurance huddles with VISN (1-2 at 7 facilities in Feb. and Apr. 2014)
 - Formal local project meetings (8 at 2 facilities, 1 at 1 facility, 0 at 6 facilities that held informal meetings)
- Conducted semi-structured telephone interviews with facility project leaders (Sept. 2014)
- Coded meeting and interview notes for barriers and strategies using modified grounded theory approach

Evaluation Methods – Quantitative

- Used data abstracted from electronic medical records to assess change in BP control for Black and White Veterans with HTN over FY14
- To the extent possible, examined how intervention strategies undertaken by facilities were related to changes in BP control and disparities in BP control

Qualitative Findings, Part 1 – Formative Evaluation (4 months in)

- Early challenges identified and reviewed with VISN Project Lead:
 - Turnover in project leadership at facilities made it difficult to initiate project-related activities
 - Confusion and concerns about the performance metric
 - Discomfort about focusing special efforts on a subset of patients (i.e., Black patients with Stage 2 HTN)
 - Perceived lack of resources

Response to Formative Evaluation

- VISN Project Lead:
 - Created FAQ document addressing major challenges
 - Reviewed FAQ and held Q&A at next VISN-wide call
 - Redoubled effort to engage facilities and help troubleshoot

Qualitative Findings, Part 2 – Barriers to Implementation

- 19 different barriers identified across facilities (median=4, range=2-9)
- Fell into 4 categories
 - Project Implementation Barriers
 - Patient-Level Barriers Related to HTN Management
 - Provider-Level Barriers Related to HTN Management
 - System-Level Barriers Related to HTN Management

Project Implementation Barriers

- Related to overall implementation of the VISN 4 HTN Racial Disparity Project, including those impeding local action plans

Specific Barrier	# Facilities
Provider discontent or lack of understanding of performance metric	5
Project leadership lacking/turnover	4
Provider resistance/lack of project buy-in	3
≥ 1 of the above	8

Patient Barriers to HTN Management

- Related to patients' personal, social, environmental, and economic characteristics

Specific Barrier	# Facilities
No-show/getting patients to attend BP visits	5
Medication non-adherence	3
Not open to changing HTN management plan	2
Patient burden (e.g., travel, copay)	2
Lack understanding of importance of BP management and taking BP medications	1
VA not patient's primary source of health care	1
Difficulty contacting patients	1
≥ 1 of the above	6

Provider Barriers to HTN Management

- Health care provider skills, attitudes, and/or behaviors regarding HTN management

Specific Barrier	# Facilities
Providers not taking/logging BP properly or appropriate number of times	3
Provider knowledge lacking (e.g., lack of provider clarity about managing patients with uncontrolled BP regarding medications, follow-up)	1
Provider variation in effectiveness in managing BP	1
Difficulty contacting providers by email about patient lists	1
≥ 1 of the above	5

System Barriers to HTN Management

- Health care system characteristics, such as policy, organizational factors, and structural factors, related to HTN management

Specific Barrier	# Facilities
Inadequate time/resources for providers	5
Lack of teamwork/coordination/staff continuity	2
Inadequate tools in <i>Computerized Patient Record System</i>	1
Inadequate staff/expertise on Patient Aligned Care Teams	1
Diffusion of Black patients across providers	1
<u>≥1 of the above</u>	6

Qualitative Findings, Part 3 – Strategies Used to Reduce Disparities

- 22 specific strategies identified across facilities (median=6, range=4-10)
- Fell into 7 broad categories
 - Provider education
 - Use lists of patients with Stage 2 HTN
 - Patient outreach
 - Patient education about BP management
 - Increase uptake of existing services
 - Establish new type of HTN appointment
 - Use CPRS to prompt action

Provider Education

- Activities to provide information to VHA providers (e.g., nurses, physicians, and pharmacists), via email and face-to-face

Focus of Education	# Facilities
HTN definitions (guidelines/quality improvement initiative)	6
How to take BP readings	5
BP management (medications, lifestyle, targets)	5
Pharmacy changes (e.g., formulary)	1
≥ 1 of the above	9

Use lists of patients with Stage 2 HTN

- Ways in which facilities created and used the lists of patients with Stage 2 HTN to facilitate BP management

How Lists were Used	# Facilities
Lists generated	8
Lists given to providers	8
Specific recommendations given for patients on lists	4
≥ 1 of the above	8

Patient Outreach

- How facilities engaged patients in new and unique ways to improve BP management

Nature of Outreach	# Facilities
Telephone	4
Mail	1
Address medication noncompliance with diabetic patients	1
≥ 1 of the above	5

Patient Education about BP Management

- Strategies facilities used to inform patients about BP and the importance of HTN management

Type of Education	# Facilities
Basic counseling by pharmacist	2
Tailored education by pharmacist and PACT	1
HTN information packet from nurse (facility-wide)	1
Education about risks and complications by provider or nurse	1
≥ 1 of the above	4

Increase Uptake of Existing Services

- Efforts to connect patients with existing programs or services that could help manage their HTN without creating additional staff burden

Type of Service	# Facilities
Referral to nephrology's HTN clinic	1
Referral to MOVE!	1
Collaborate with behavioral health and pharmacy	1
Medication Management Clinic	1
≥1 of the above	3

Establish New Type of HTN Appointment

- Creation of new clinics or methods (e.g., shared group visits) to facilitate efficient follow-up with patients regarding HTN management

Type of Appointment	# Facilities
New HTN clinic	2
Refer to PharmD	1
Shared visit	1
≥ 1 of the above	2

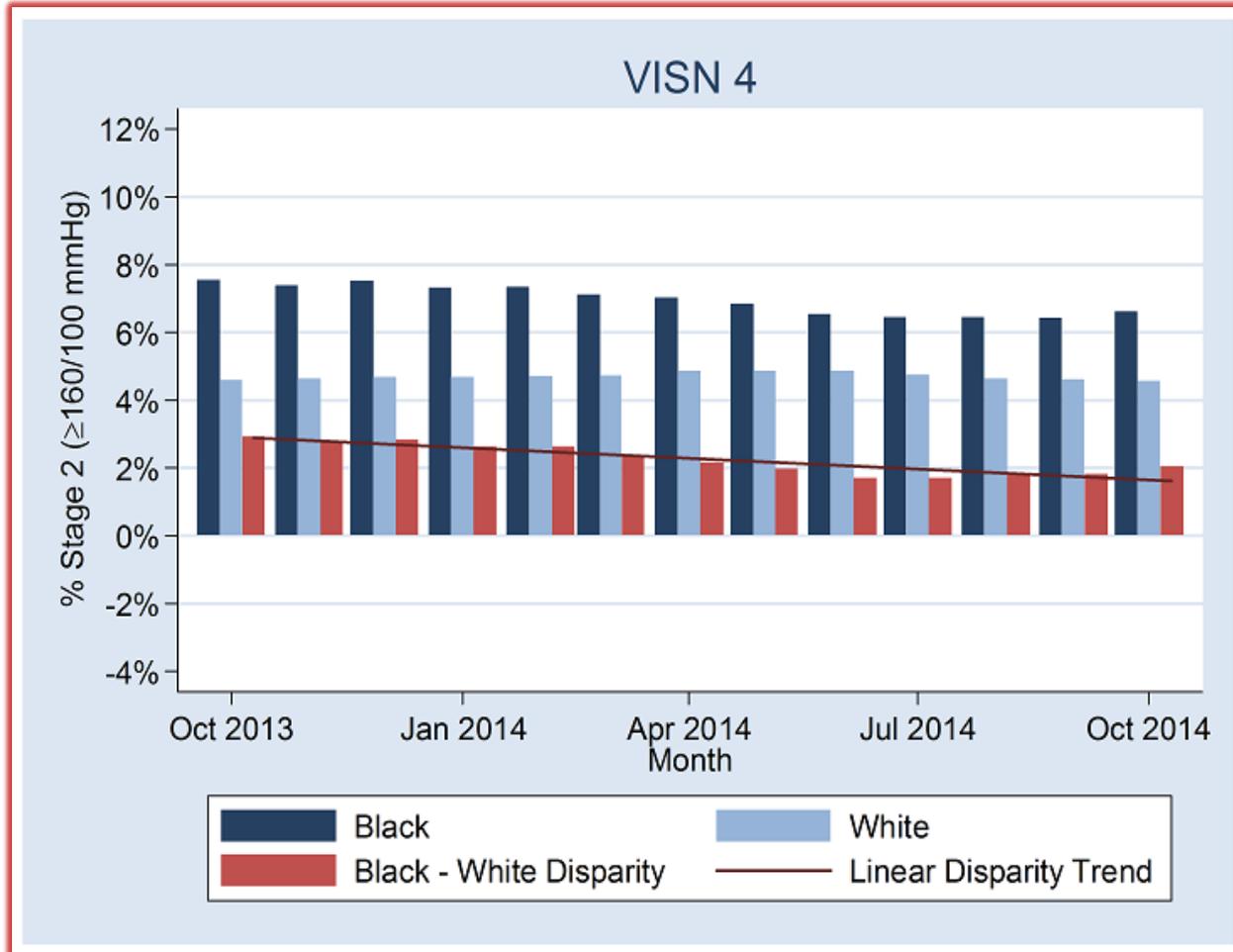
Use of CPRS to prompt action

- Working with informatics to create CPRS reminders and additional user-friendly processes to facilitate follow up

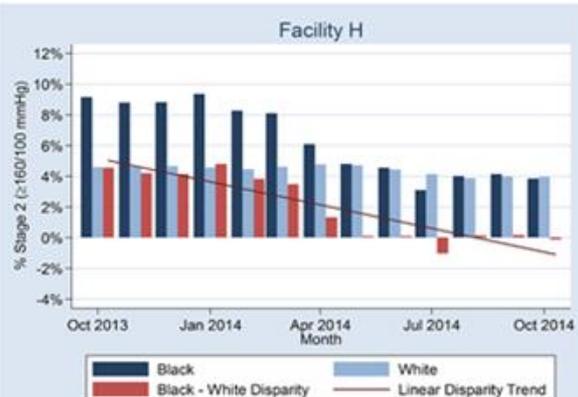
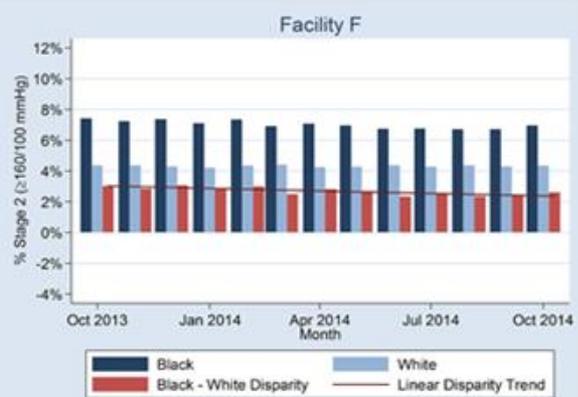
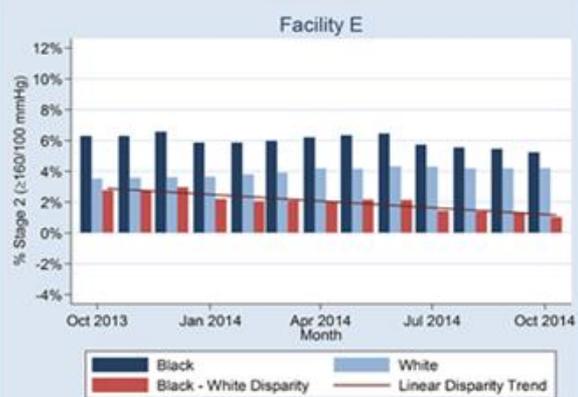
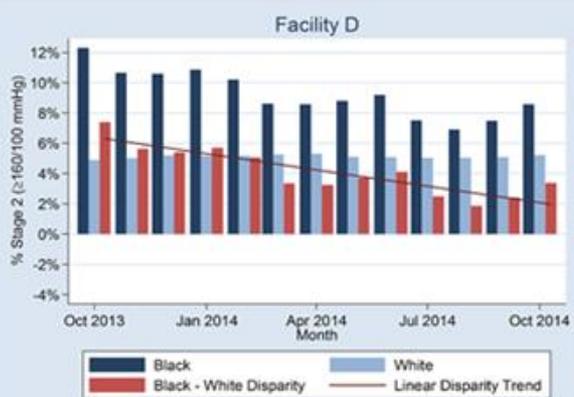
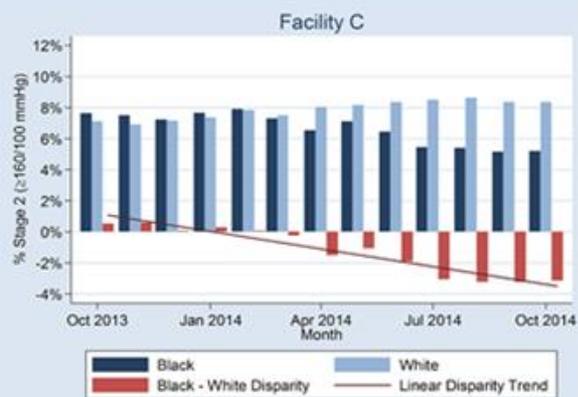
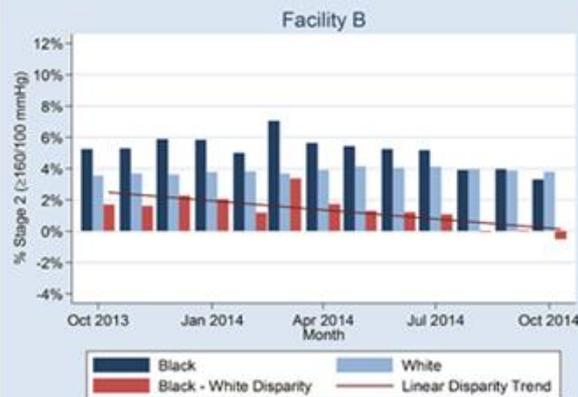
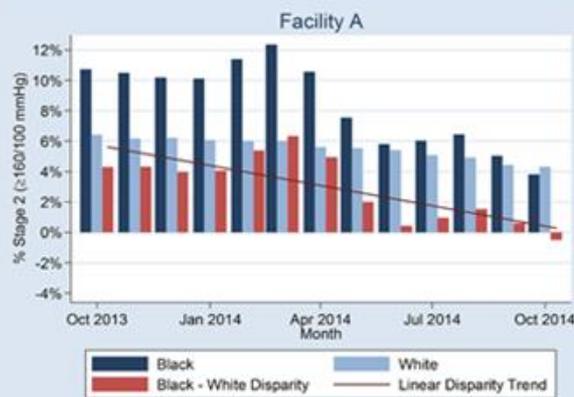
Type of Change	# Facilities
Change clinical reminders for Stage 2 HTN patients	1
Create consult with RN/Case Manager	1
Change info about HTN guidelines and order set	1
Add radio button to trigger follow up with nurse immediately after provider visit	1
Add quick orders for HTN class, nutrition consult, and home BP cuff	1
≥ 1 of the above	2

Quantitative Findings – Did BP Change?

Time Trends in Stage 2 HTN among Black and White Veterans in VISN 4



Stage 2 HTN = average BP \geq 160/100 mmHg



Adjusted Odds of Changes in Stage 2 HTN Overall and in Disparities

	Model 1*†		
	OR	(95% CI)	
Black Race	1.80	(1.73-1.87)	← Blacks more likely than Whites to have Stage 2 HTN
1 Year Change in HTN	0.96	(0.93-0.99)	← Decrease in proportion of White Veterans with Stage 2 HTN between 10/1/13 and 10/1/14
Change in HTN by # Strategies			
3 Strategy Categories	--	--	
4 Strategy Categories	--	--	
5 Strategy Categories	--	--	
1 Year Change in Disparity	0.84	(0.78-0.89)	← Reduction in Black-White disparity in Stage 2 HTN between 10/1/13 and 10/1/14
Change in Disparity by # Strategies			
3 Strategy Categories	--	--	
4 Strategy Categories	--	--	
5 Strategy Categories	--	--	

*Random intercept for facility accounted for differences across facilities in proportion of Veterans with Stage 2 HTN.

†Adjusted for age, sex, marital status, and eligibility.

Adjusted Odds of Change in Stage 2 HTN and Change in Disparities

Predictors	Model 1*†		Model 2**†	
	OR (95% CI)		OR (95% CI)	
Black Race	1.80	(1.73-1.87)	1.81	(1.53-2.14)
1 Year Change in HTN	0.96	(0.93-0.99)	--	--
Change in HTN by # Strategies				
3 Strategy Categories	--	--	1.01	(0.96-1.07)
4 Strategy Categories	--	--	0.97	(0.93-1.01)
5 Strategy Categories	--	--	0.82	(0.76-0.89)
1 Year Change in Disparity	0.84	(0.78-0.89)	--	--
Change in Disparity by # Strategies				
3 Strategy Categories	--	--	0.87	(0.79-0.95)
4 Strategy Categories	--	--	0.77	(0.70-0.85)
5 Strategy Categories	--	--	0.39	(0.27-0.56)

*Random intercept for facility accounted for differences across facilities in proportion of Veterans with Stage 2 HTN.

**Facility-level random intercept for effect for Black race added to account for differences across facilities in proportion of Black Veterans with Stage 2 HTN.

†Adjusted for age, sex, marital status, and eligibility.

Summary

- There were small VISN-wide reductions in the proportion of Black Veterans with Stage 2 HTN and the Black-White disparity over the 12-month evaluation period.
- The reduction in the Black-White disparity was greater for some facilities than for others.
- Facilities that used strategies from more intervention categories showed significantly larger reductions in Black-White disparities over time.

Future Recommendations

- Ensure that race, ethnicity, and other potential risk factors are systematically recorded and made available.
- Include goals to reduce disparities in annual performance plans.
- Provide structure, leadership, and resources to support quality improvement efforts that target disparities.
- Allow facilities to adopt action plans that fit their specific needs.
- Design performance metrics to ensure that they are acceptable and interpretable to those who will be carrying out efforts.
- Incorporate a “formative evaluation” into project plans to identify and address early implementation barriers.



CONTACT INFORMATION + Q & A

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Thank you!





FOCUS ON HEALTH EQUITY AND ACTION CYBERSEMINAR SERIES

- November 19, 2015 – Archived
- January 21, 2016 - Accomplished today

- ❖ Mark your calendars and join us at 3-4PM EST for future sessions on the following Thursdays in 2016:
 - February 25, 2016
 - March 24, 2016
 - April 28, 2016
 - June 30, 2016

- ❖ Thank you to OHE partners within VHA and beyond!



VA



U.S. Department
of Veterans Affairs

Focus on Health Equity and Action:

Findings from the VISN 4 Hypertension Racial Disparities Quality Improvement Project

Additional Slides



CHERP
CENTER FOR HEALTH EQUITY
RESEARCH AND PROMOTION
VA HSR&D CENTER OF INNOVATION

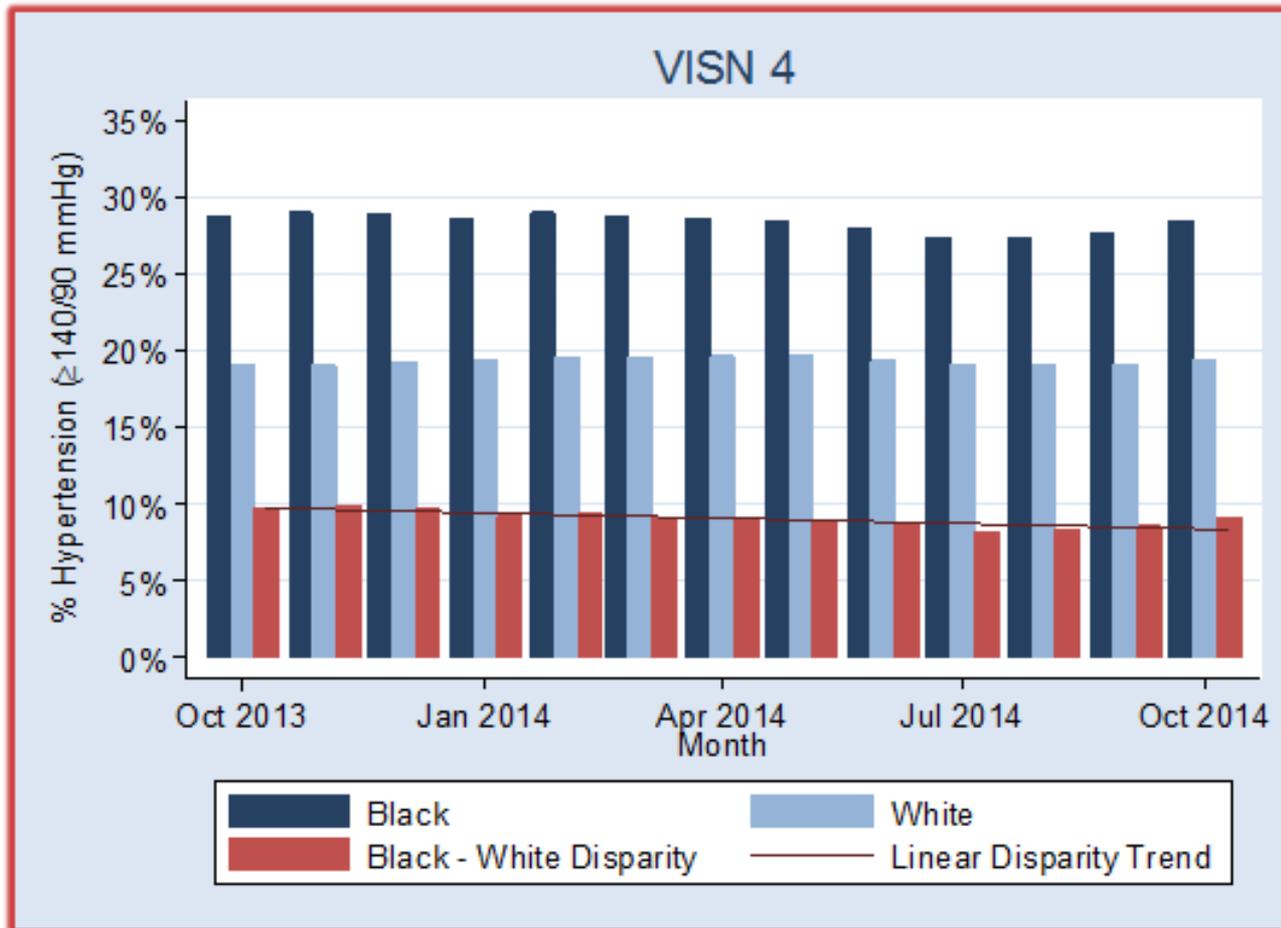


Veterans Health Administration
Office of Health Equity

Limitations

- Single VISN
- Focused only on Black-White disparity
- Focused only on patients with diagnosed HTN
- Qualitative methods may not have fully captured the details of all project-related activities
- Were not able to link specific activities with changes in HTN

Time Trends in Uncontrolled HTN among Black and White Veterans in VISN 4



Uncontrolled HTN = most recent BP \geq 140/90 mmHg