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Focus on Health Equity and Action:

Chronic Health Conditions among Vulnerable Veterans: Current Research and Action

- **Jessica Y. Breland, PhD**
- **Donna L. Washington, MD, MPH**
- **Uchenna S. Uchendu, MD**



Thursday June 29, 2017 @ 3PM ET



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SESSION OUTLINE

- Introduction
 - VA Health Equity Action Plan - HEAP
 - OHE Operational and Research Partnerships
 - Background
- Demographic Variability & Chronic Conditions
- Recent Publications – Overview and Highlights
 - Obesity Epidemic in VHA – Prevalence in Key Populations
 - Persisting Racial/Ethnic Disparities in the VHA PCMH
- Using VA data to systematically characterize health & healthcare disparities
- Discussion with Q &A





WHY HEALTH EQUITY @ THE VA?



- VA offices championing efforts for advocacy/outreach for **equal** access to care and/or benefits for specific groups:

VA

- Center for Minority Veterans
- Center for Women Veterans
- Office of Diversity and Inclusion
- Tribal and Government Relations
- Faith-based & Neighborhood Partnerships

VHA

- Health Services Research
- Office of Rural Health
- Homeless Program Office
- Office of Mental Health
- VHA Office of Patient Care Services
 - Women's Health Services *****
 - LGBT Program Coordinators

***The 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**

- These efforts have made significant progress for specific groups in certain areas but did not eliminate health and health care disparities among Veterans

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




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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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BACKGROUND RESOURCES

Breland JY, Phibbs CS, Hoggatt KJ, Washington DL, Lee J, Haskell S, Uchendu US, Saechao FS, Zephyrin LC, Frayne SM. (2017). **The Obesity Epidemic in the Veterans Health Administration: Prevalence among Key Populations of Women and Men Veterans.** *Journal of General Internal Medicine*, 32(1):11-17.

Hernandez SE, Taylor L, Grembowski D, Reid RJ, Wong E, Nelson KM, Liu CF, Fihn SD, Hebert PL. (2016). **A First Look at PCMH Implementation for Minority Veterans.** *Medical Care*, 54(3), pp.253-261.

VA 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>.

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Washington DL, Steers WN, Huynh AK, Frayne SM, Uchendu US, Riopelle D, Yano EM, Saechao FS, Hoggatt KJ. (2017). **Racial And Ethnic Disparities Persist At Veterans Health Administration Patient-Centered Medical Homes.** *Health Affairs*, 36(6):1086-1094.



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VHA NATIONAL VETERAN HEALTH EQUITY REPORT - SNAPSHOT OF TOP DIAGNOSES

- Racial/Ethnic (Exhibit 3-15): * **Higher** % than in reference group
 - 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***
 - Lumbo-sacral 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**



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HEALTH EQUITY - DATA & ACTION

OHE examples of making **data available at the facility-level** including racial/ethnic breakdowns with **data visualization tools**:

<https://www.va.gov/HEALTHY/Tools.asp>

- **Diabetes Mellitus** (Electronic Quality Measure) – Top reported condition among Veterans according to the NVHER and business case to reduce related disparities {**According to American Diabetes Association (2013), “the total estimated cost of diagnosed diabetes in 2012 is \$245 billion, including \$176 billion in direct medical costs and \$69 billion in reduced productivity; The \$245 billion is a 41% increase from our previous estimate of \$174 billion in 2007 ...”*}
- Mental health data for **PTSD and Suicide** for appropriate strategies.
- Veteran’s Hepatitis C Virus & Advanced Liver Disease Visualization Tool

Opportunity –

- **Consistently reporting, 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 the accountability agency priority and bolster trust
- **Innovative Health Equity Projects**
- **Discussions underway with PACT stakeholders...**



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Poll Question 1



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POLL QUESTION 1

- According to the 2016 National Veteran Health Equity Report - FY 2013 data identified the following as highly prevalent diagnoses across Veteran populations except:

- Diabetes Mellitus
- Hypertension
- Obesity
- Lipid Disorders
- None of the Above



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Obesity among Veterans Using VHA Primary Care



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Focus on Health Equity and Action: Obesity among Veterans Using VHA Primary Care

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VA HSR&D Center for Innovation to Implementation (Cizi)

VA Palo Alto Health Care System

Thursday June 29, 2017

Funders for program evaluation: VA Office of Women's Health
Services & VA Office of Health Equity

VA HSR&D CDA 15-257



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DISCLOSURES

No conflicts of interest.

Views represented here are my own and do not represent those of VA or the US government.

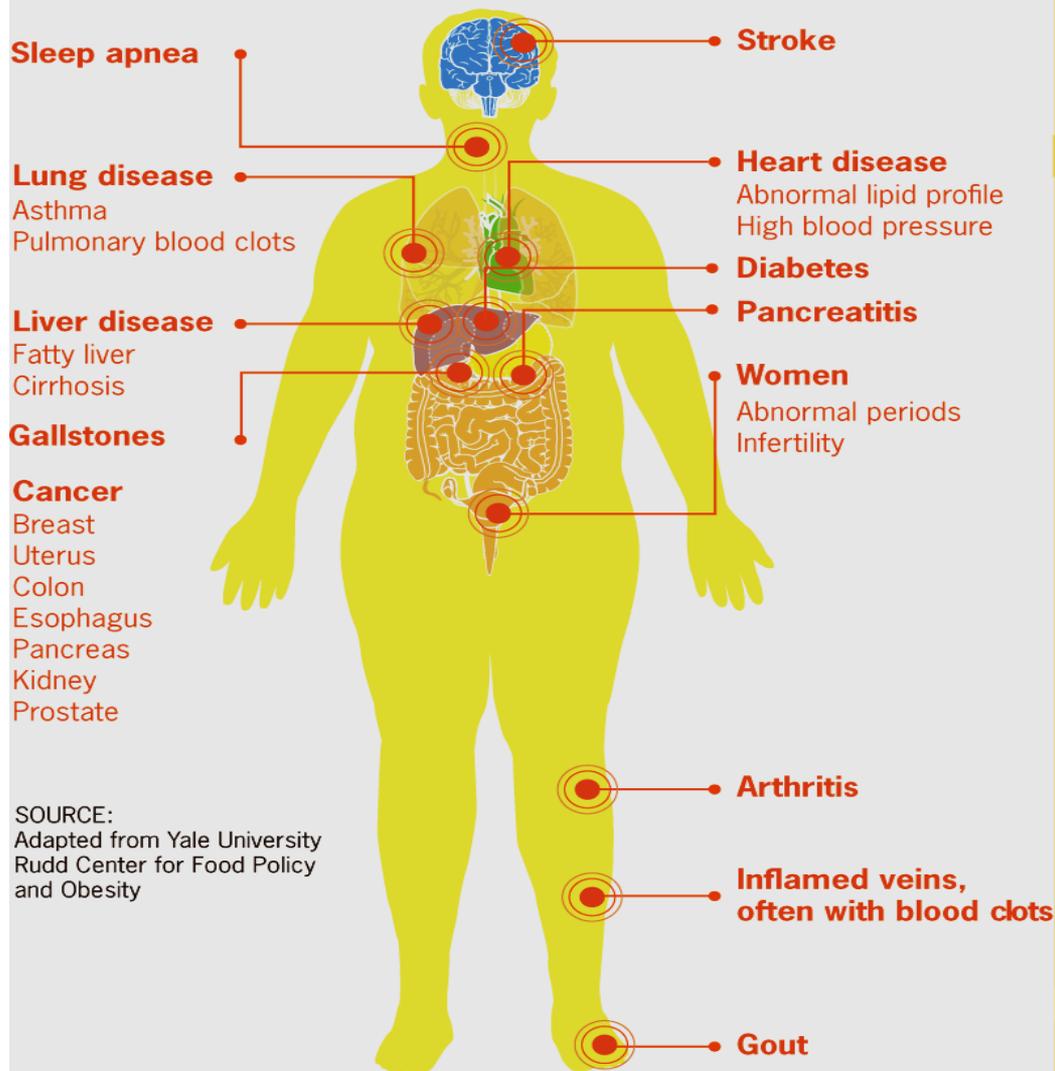


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OBESITY AND HEALTH

Medical Complications of Obesity



SOURCE:
Adapted from Yale University
Rudd Center for Food Policy
and Obesity

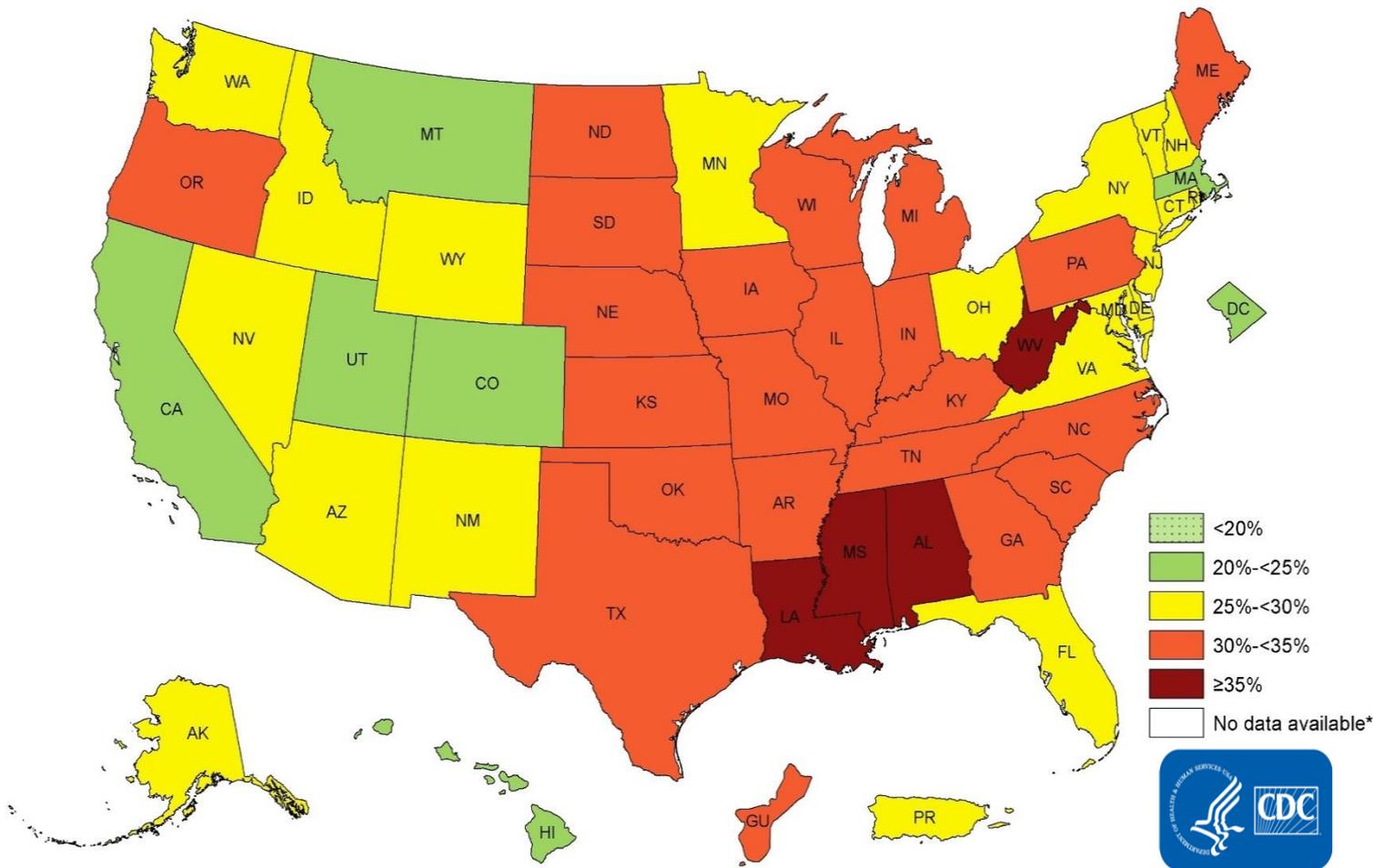


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PREVALENCE* OF SELF-REPORTED OBESITY AMONG U.S. ADULTS BY STATE AND TERRITORY, BRFSS, 2015



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*Prevalence

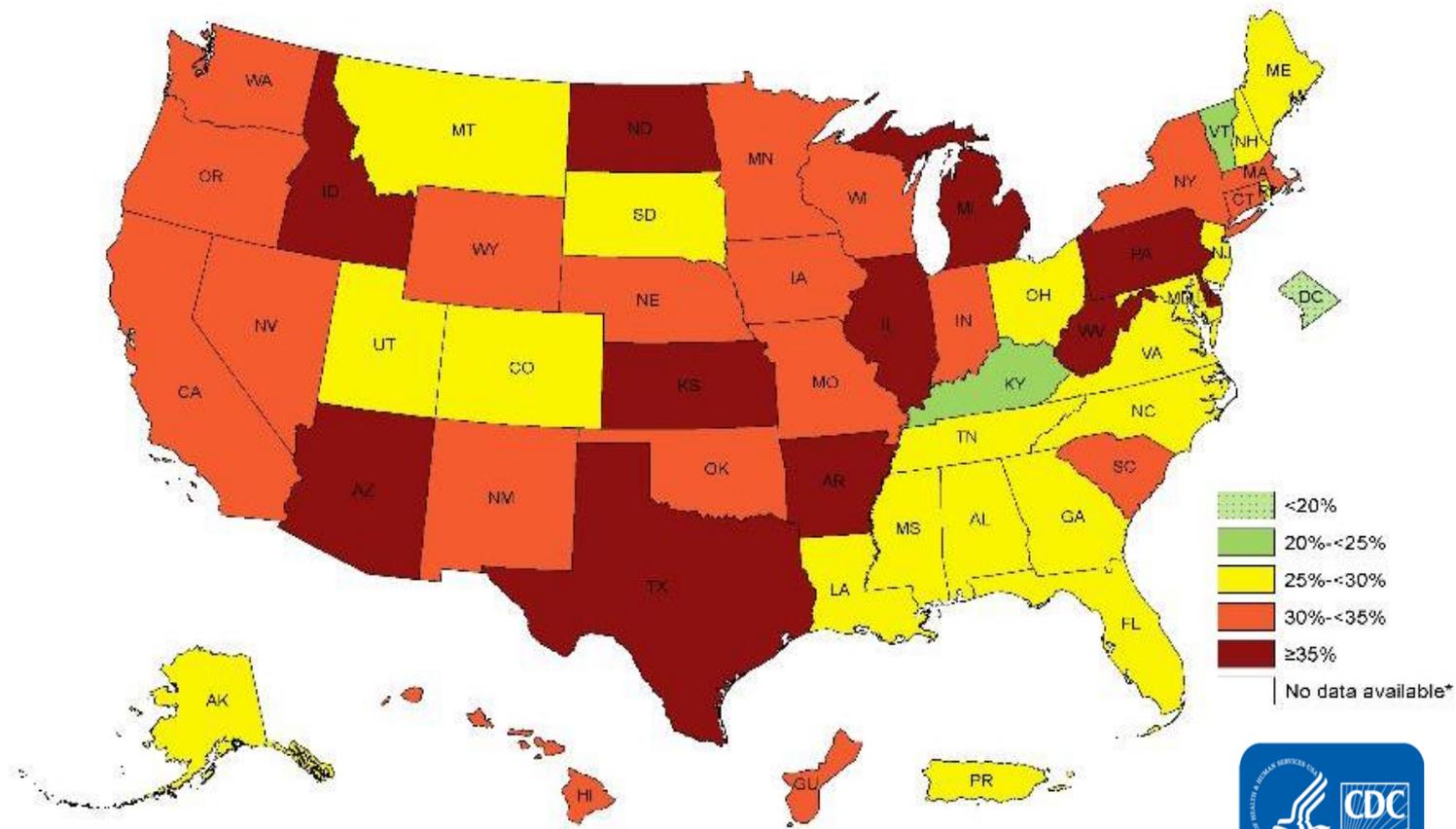
These estimates should not be compared to prevalence estimates before 2011

<http://www.cdc.gov/obesity/data/prevalence-maps.html>

Sample size <50 or the relative standard error (dividing the standard error by the prevalence) ≥ 30%.



PREVALENCE OF SELF-REPORTED OBESITY AMONG HISPANIC ADULTS, BY STATE AND TERRITORY, BRFSS, 2013-2015



*Sample size <50 or the relative standard error (dividing the standard error by the prevalence) ≥ 30%.

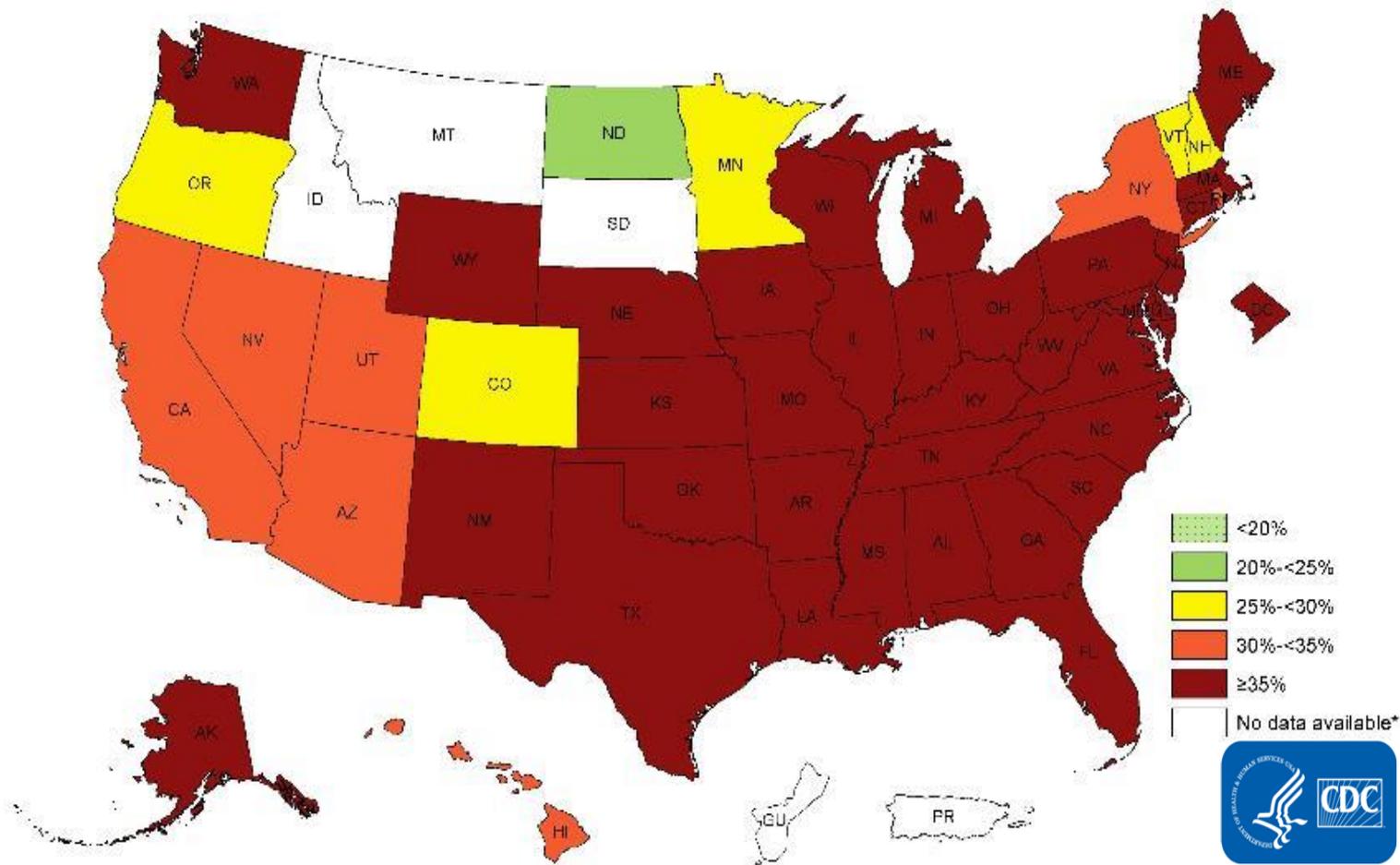


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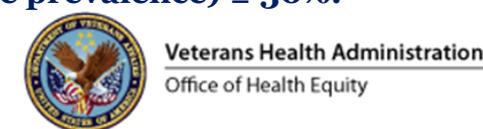
<http://www.cdc.gov/obesity/data/prevalence-maps.html>



PREVALENCE OF SELF-REPORTED OBESITY AMONG NON-HISPANIC BLACK ADULTS, BY STATE AND TERRITORY, BRFSS, 2013-2015



Sample size <50 or the relative standard error (dividing the standard error by the prevalence) $\geq 30\%$.



<http://www.cdc.gov/obesity/data/prevalence-maps.html>



PRESENT WORK

What is obesity prevalence among
Veterans using primary care
services in the Veterans Health
Administration (VHA)?



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COHORT

- Veteran VHA primary care users in FY2014
 - 347,112 women
 - 4,567,096 men

- Obesity: BMI ≥ 30 kg/m²
 - Based on modal height, weight closest to first primary care visit in FY2014





POPULATIONS

- Gender Stratification
- Subpopulations
 - Race/Ethnicity
 - Age
 - Urban/Rural status
 - Physical & mental health conditions
 - Disability status
 - Service era





POPULATIONS

- **Gender Stratification**

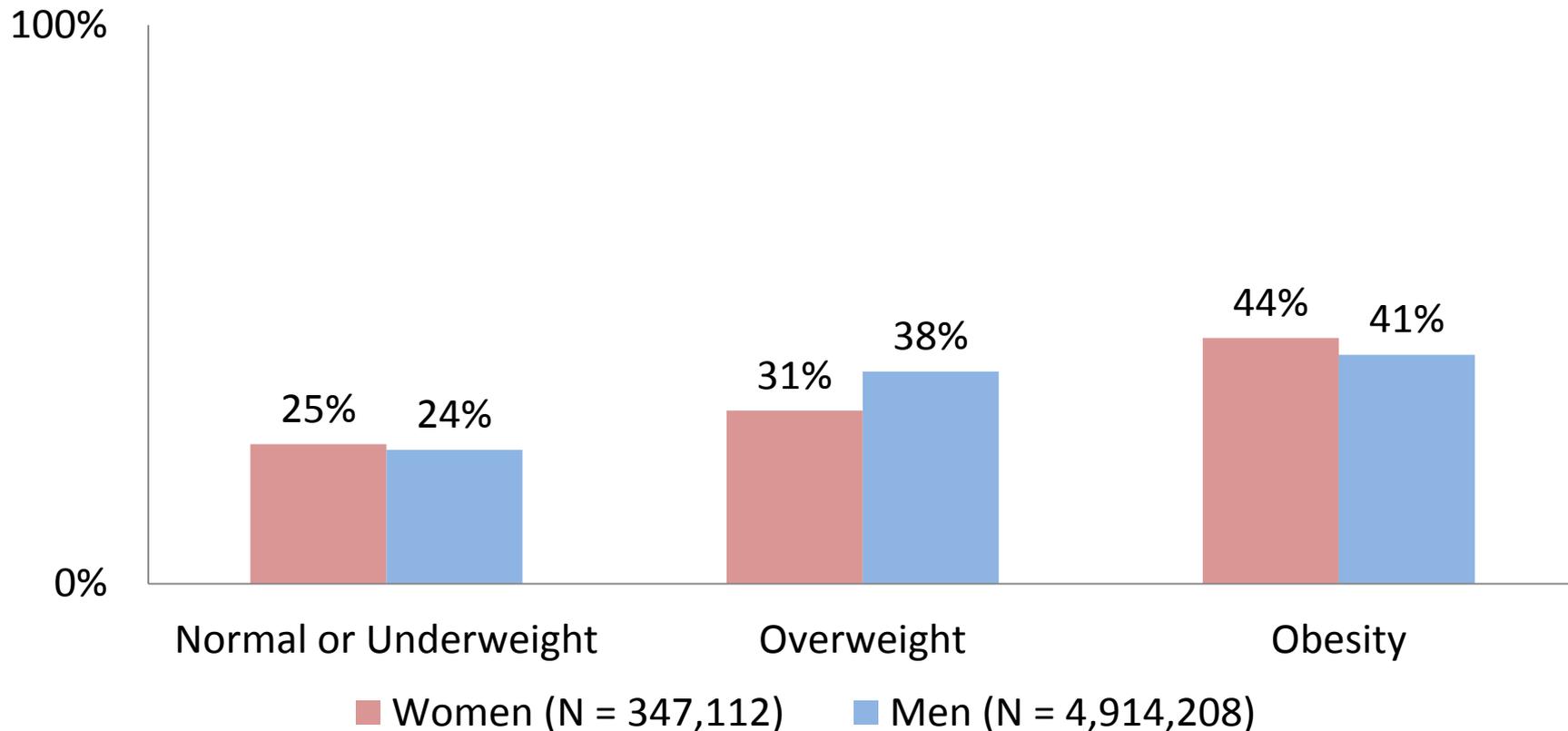
- **Subpopulations**
 - **Race/Ethnicity**
 - **Age**
 - **Urban/Rural status**
 - **Physical & mental health conditions**
 - **Disability status**
 - **Service era**





RESULTS – BMI – MEN & WOMEN

BMI Distribution among Women and Men VHA Primary Care Users in FY2014

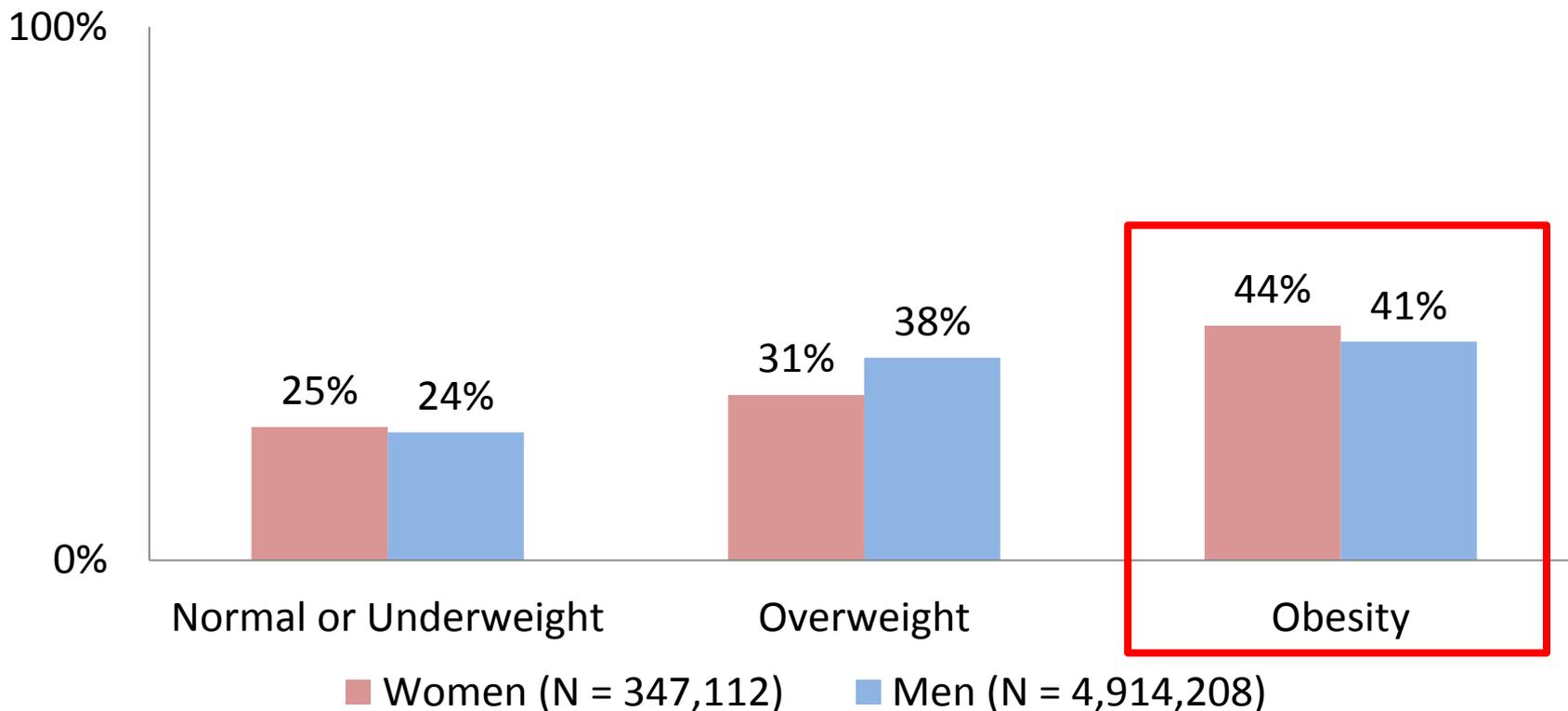


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RESULTS – BMI – MEN & WOMEN

BMI Distribution among Women and Men VHA Primary Care Users in FY2014

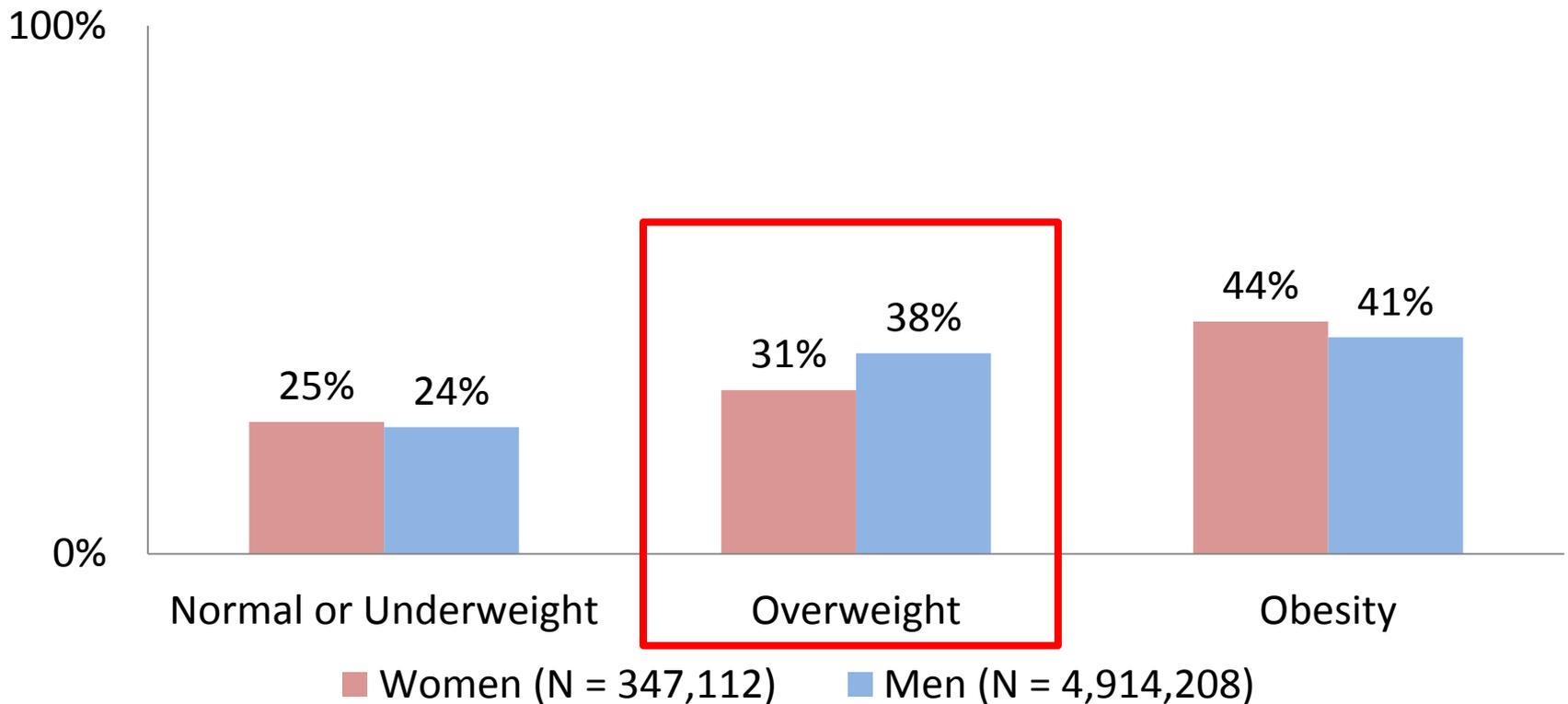


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RESULTS – BMI – MEN & WOMEN

BMI Distribution among Women and Men VHA Primary Care Users in FY2014

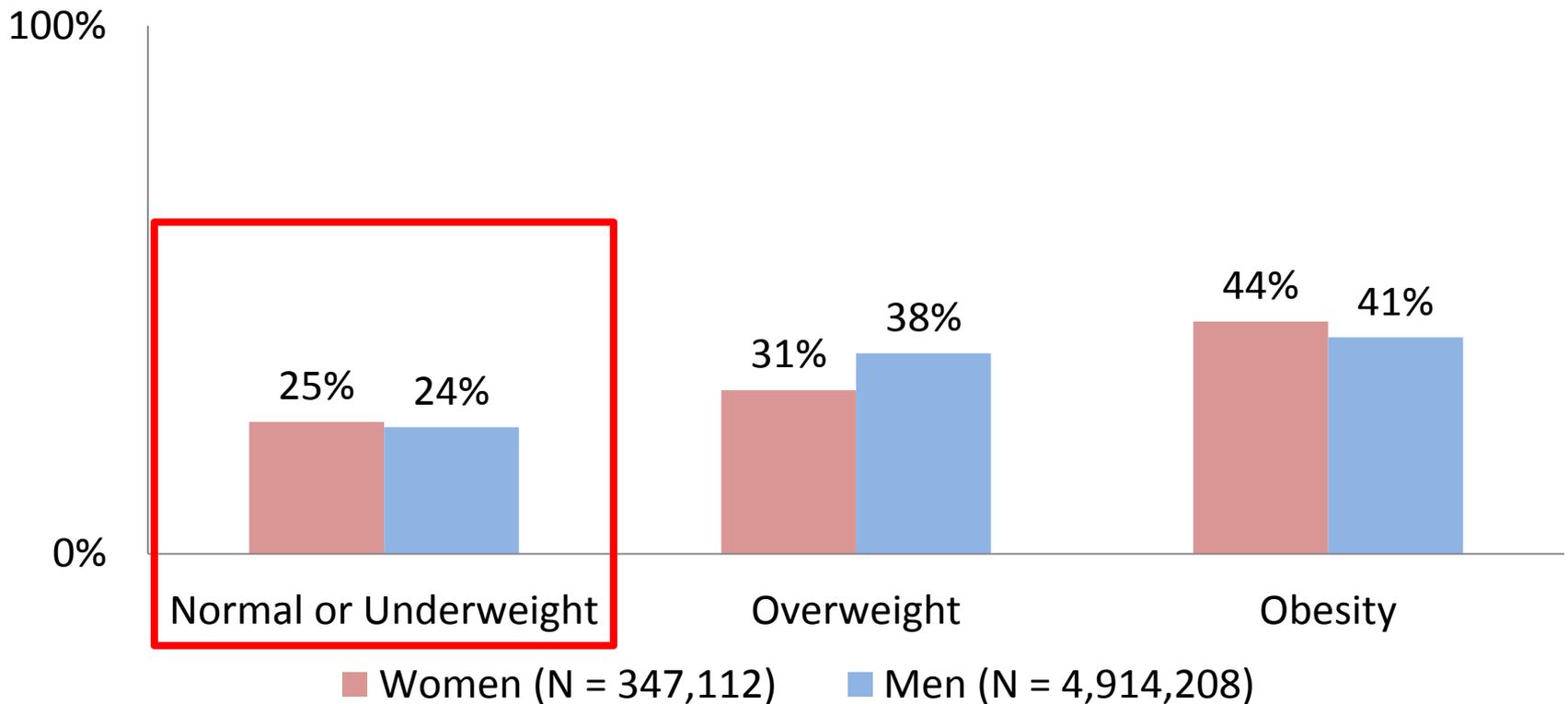


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RESULTS – BMI – MEN & WOMEN

BMI Distribution among Women and Men VHA Primary Care Users in FY2014

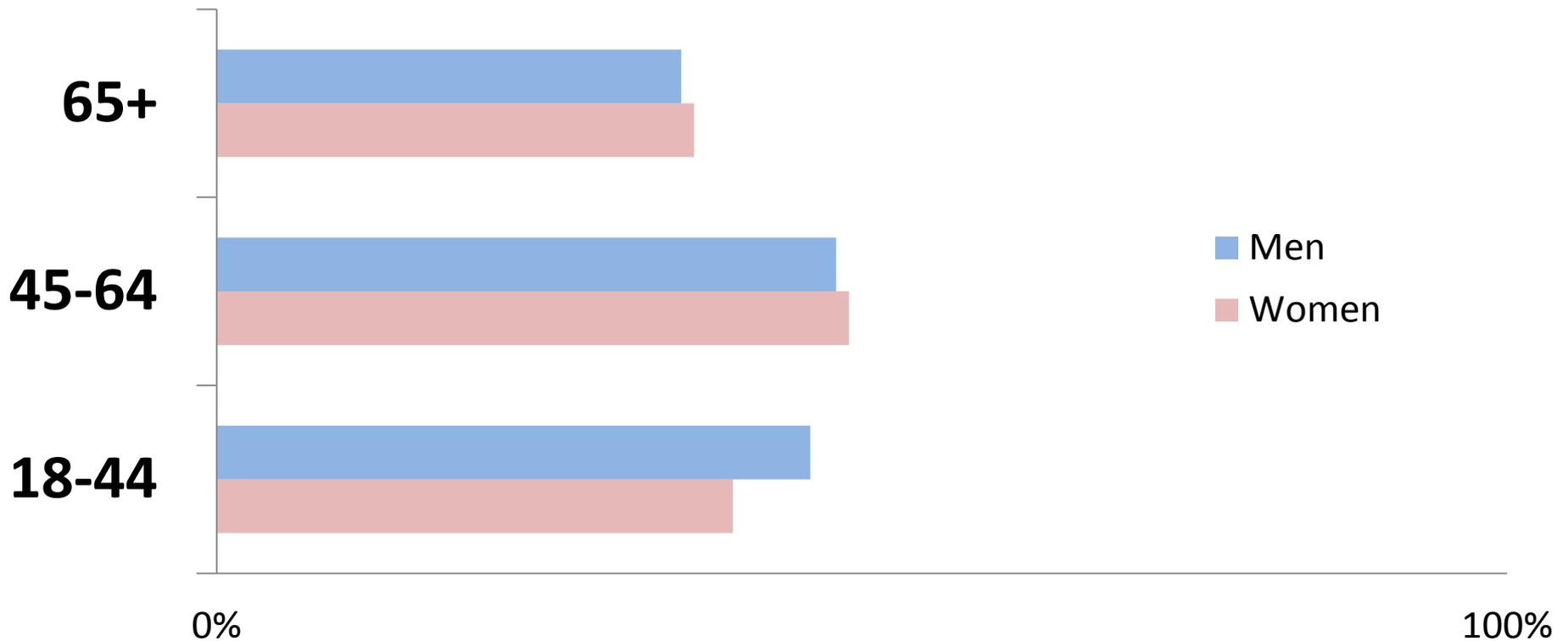


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RESULTS – OBESITY BY AGE

Obesity Prevalence by Age among Women & Men VHA Primary Care Users in FY2014

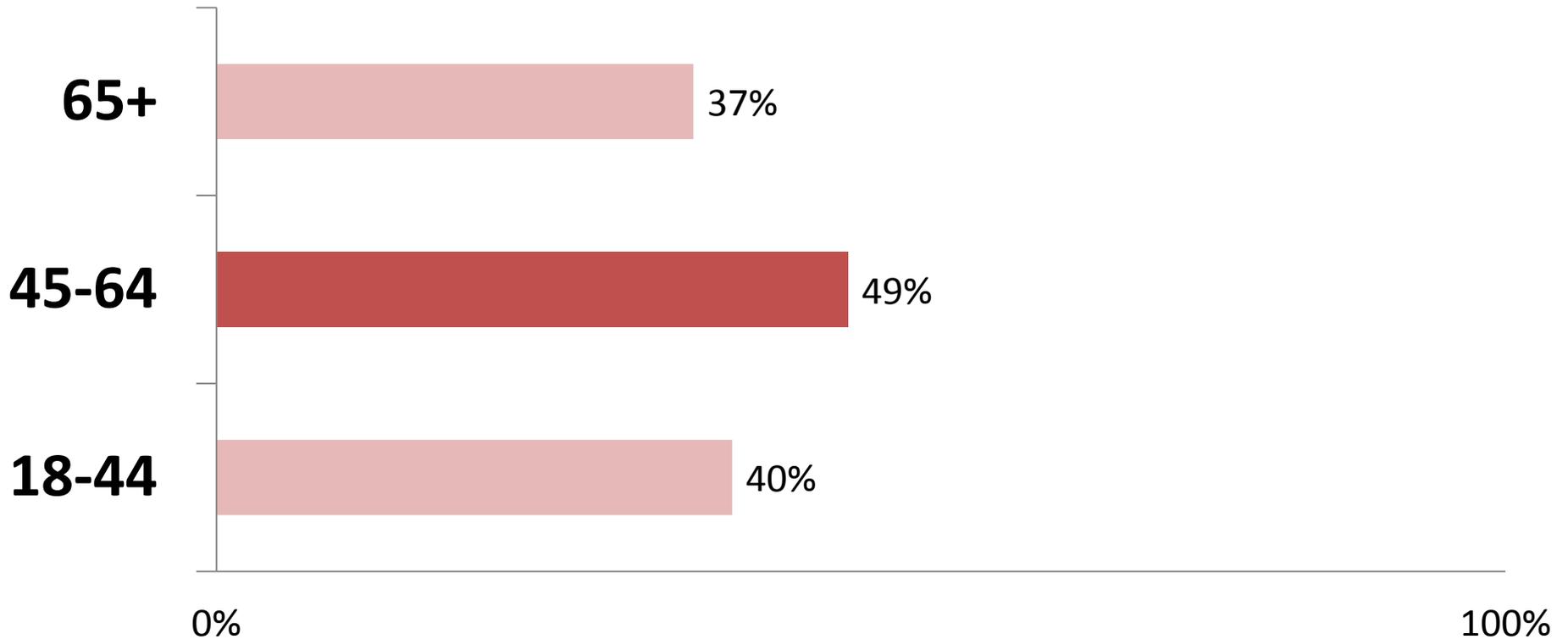


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RESULTS – OBESITY BY AGE AMONG WOMEN

Obesity Prevalence by Age among Women VHA Primary Care Users in FY2014



Darker colors indicate $\geq 5\%$ difference from population obesity mean (41%)

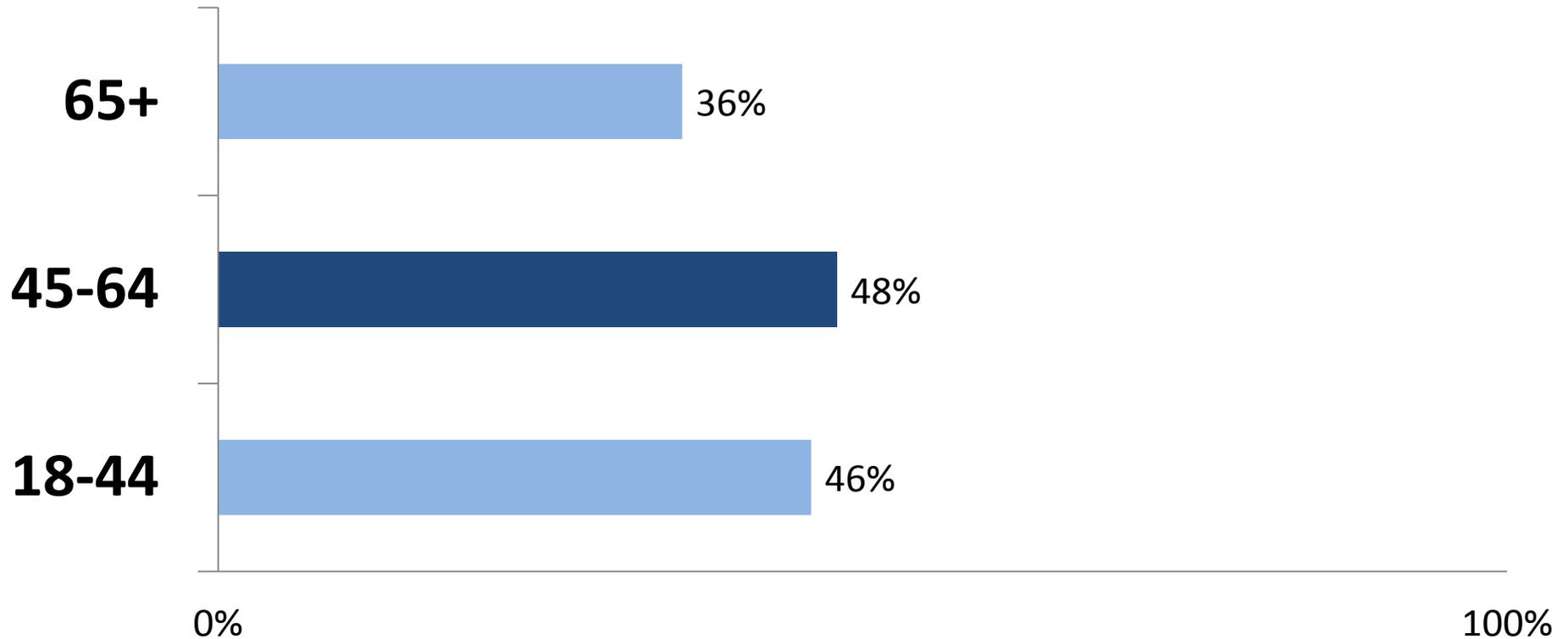


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RESULTS – OBESITY BY AGE AMONG MEN

Obesity Prevalence by Age among Men VHA Primary Care Users in FY2014



Darker colors indicate $\geq 5\%$ difference from population obesity mean (41%)

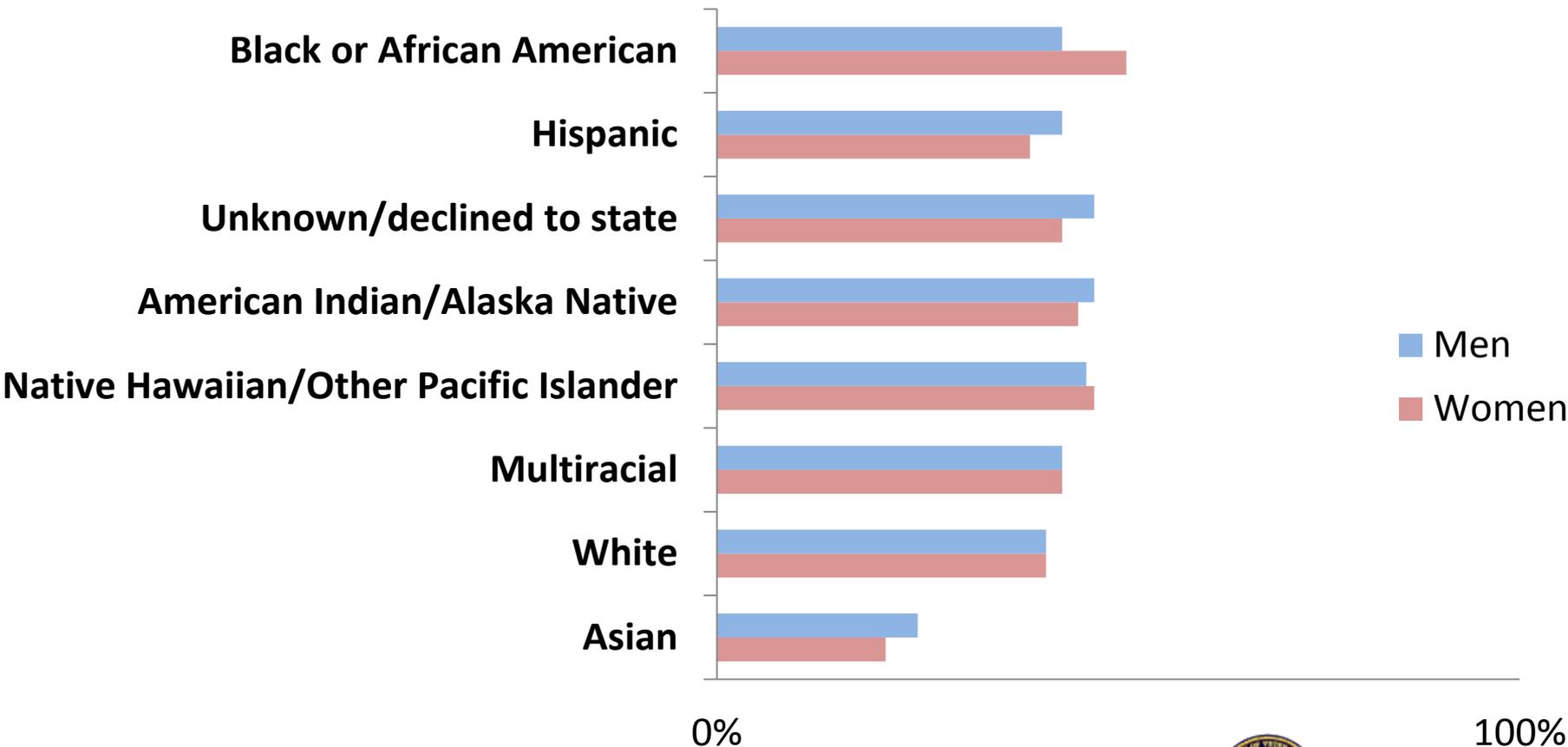


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RESULTS – OBESITY BY RACE/ETHNICITY

Obesity Prevalence by Race/Ethnicity Status among Women & Men VHA Primary Care Users in FY2014



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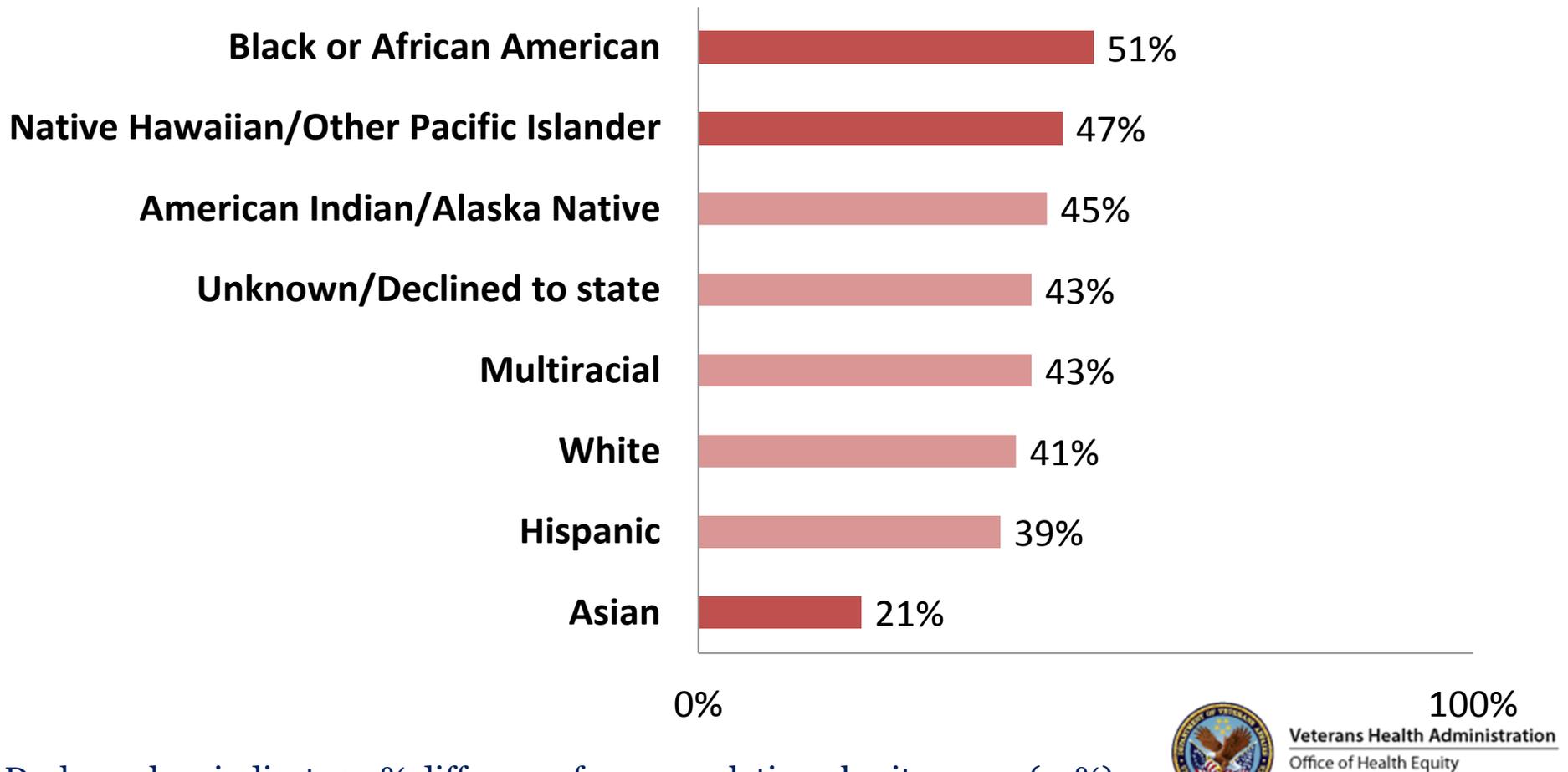
100%

0%



RESULTS – OBESITY BY RACE/ETHNICITY: WOMEN

**Obesity Prevalence by Race/Ethnicity Status among Women VHA
Primary Care Users in FY2014**



Darker colors indicate $\geq 5\%$ difference from population obesity mean (41%)

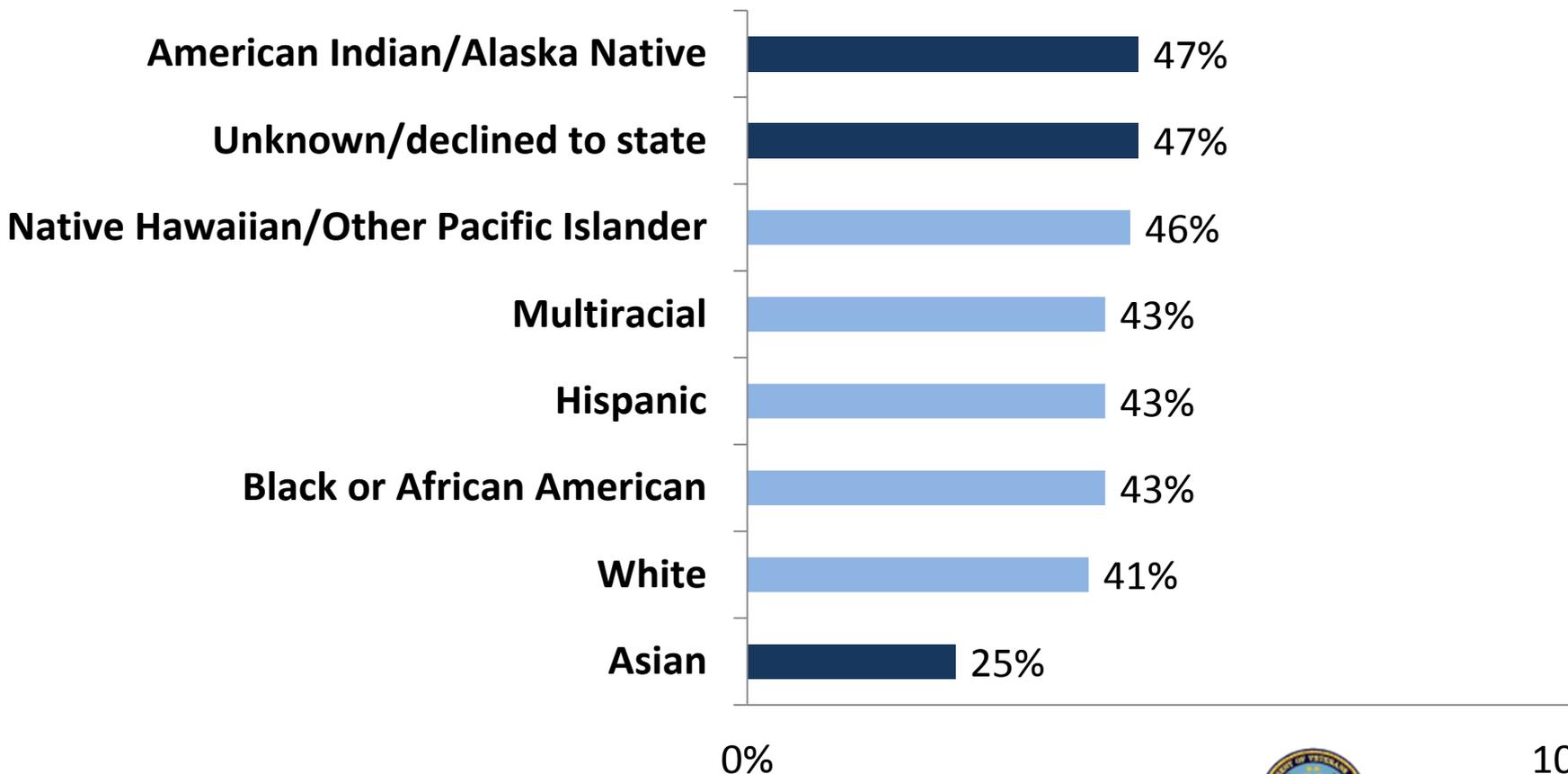


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RESULTS – OBESITY BY RACE/ETHNICITY: MEN

Obesity Prevalence by Race/Ethnicity Status among Men VHA Primary Care Users in FY2014



Darker colors indicate $\geq 5\%$ difference from population obesity mean (41%)

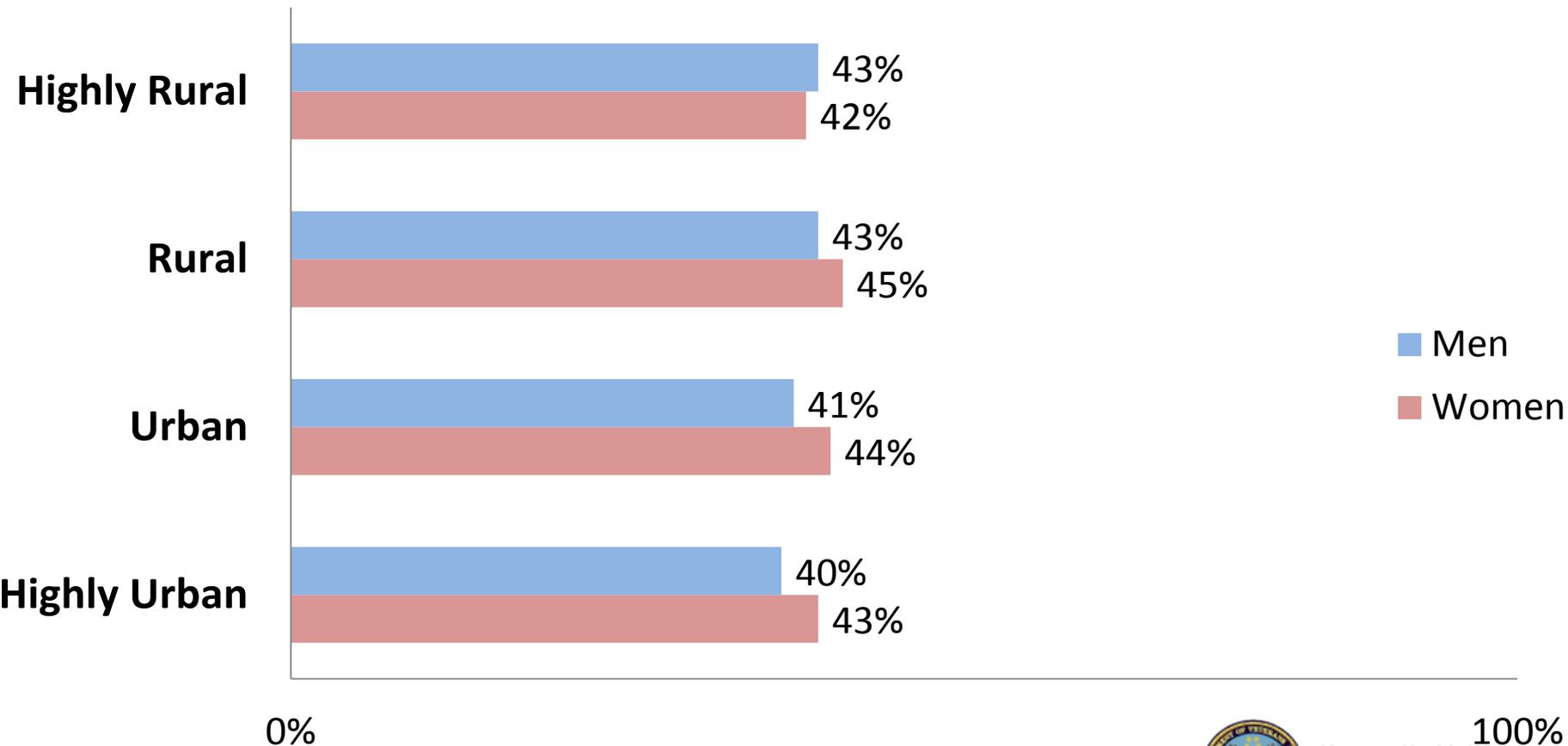


100%
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RESULTS – OBESITY BY URBAN/RURAL

Obesity Prevalence by Urban/Rural Status among Women and Men VHA Primary Care Users in FY2014



100%
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KEY POINTS

- High obesity prevalence:
 - Middle-aged Veterans (age 45-64)
 - Black women (51%)
 - Native Hawaiian/Other Pacific Islander women (47%)
 - American Indian/Alaskan Native men (47%)
 - Men with unknown race (47%)





MORE KEY POINTS

- Low obesity prevalence among:
 - Asian women (21%)
 - Asian men (25%)
- Difficult to make comparisons to general US population due to differences between Veterans using VHA and others in the US





MORE KEY POINTS

- High obesity prevalence among:
 - Young men (46%)
 - Black women (51%)

- Low obesity prevalence among:
 - Asian women (21%)
 - Asian men (25%)





LIMITATIONS

- BMI is an imperfect predictor of health
 - Difficult to compare across racial/ethnic groups
- Cross-sectional analyses
- Racial/Ethnic groupings
- Not possible to compare results to those from general US population





FUTURE DIRECTIONS

- Understand treatment use among high-risk populations
- Develop tailored outreach and/or intervention efforts
- Consider intersectionality





IMPLICATIONS

- Given high obesity prevalence among VHA primary care patients, a population health approach to weight management is warranted
- High risk groups may require special attention to ensure that systems improvements at the population level do not inadvertently increase health disparities





THANK YOU

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- Coauthors: Ciaran S. Phibbs, Katherine J. Hoggatt, Donna L. Washington, Jimmy Lee, Sally Haskell, Uchenna S. Uchendu, Fay S. Saechao, Laurie C. Zephyrin, & Susan M. Frayne
- Elon Hailu



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Link to manuscript – [The Obesity Epidemic in the Veterans Health Administration: Prevalence among Key Populations of Women and Men Veterans](#)



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Poll Question 2



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POLL QUESTION 2

- What do you think is the most important future direction?
 - Outreach efforts tailored to specific populations
 - Weight loss programs tailored to specific populations
 - Statistical analyses to describe differences among VHA populations
 - Analyses to compare VHA and non VHA obesity prevalence
 - Something else



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Addressing Racial and Ethnic Disparities in VA in Hypertension and Diabetes Control



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Focus on Health Equity and Action:

Addressing Racial and Ethnic Disparities in VA in Hypertension and Diabetes Control

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Partnered Evaluation Initiative

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Professor of Medicine, UCLA Geffen School of Medicine



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CSHIIP

Center for the Study of Healthcare
Innovation, Implementation & Policy



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Co-authors:

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DISCLOSURES

- No conflicts of interest
- Views represented here are my own, and do not necessarily represent those of the VA or of the US government



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BACKGROUND – POTENTIAL OF QUALITY IMPROVEMENT TO REDUCE DISPARITIES

- Black-White disparities in hypertension and diabetes control in VA, despite mid-1990s quality transformation and associated overall population-level improvement
- Since that time, Patient-Centered Medical Homes (PCMHs) widely promoted as primary care delivery models that achieve better patient outcomes
- 2010 – VA began national medical home implementation through Patient-Aligned Care Team [PACT] Initiative





REASONS PACT MIGHT REDUCE DISPARITIES

- Components of medical homes thought to lead to better outcomes include team-based care with a focus on enhanced access, continuity, coordination, and alignment of incentives with quality & pt safety.
- PACT included
 - Pt assignment to teamlets consisting of primary care (PC) provider and staff members with expanded care delivery roles
 - Pt access to same day appointments, group visits, and virtual communication with the teamlet
 - Increased nurse care management capacity for high-risk pts
 - Staff training in patient-centered communication





REASONS PACT MIGHT NOT REDUCE DISPARITIES

- PCMH constructs did not include tackling disparities
- Most racial/ethnic minority Veterans using VA are concentrated in a small subset of VA facilities
 - Increases prospect for differential outcomes if implementation varies in systematic ways
- Patient psychosocial factors and social support characteristics associated with race/ethnicity may undermine access to care regardless of the model's implementation





OBJECTIVE

- To determine whether patient-centered medical homes help mitigate national racial/ethnic disparities in clinical outcomes, after adjustment for variable implementation and social determinants of health that may thwart achievement of benefit





SAMPLE AND MEASURES

- Sample: 146,698 Veterans with hypertension and 79,832 Veterans with diabetes using VA care 1-year before or 4-years after start of medical home roll-out (2009, 2014)
- VA EPRP measures:
 - hypertension control (blood pressure $<140/90$ mmHg)
 - diabetes control (glycosylated hemoglobin [HbA1C] $\leq 9\%$)
- Race/ethnicity – combined data from multiple databases to reduce missing data (to 3%); all individuals reporting Hispanic ethnicity classified as Hispanic, all others were classified by their race.[reference: 6/20/17 cyberseminar]
- Co-variates: age, sex, urban/rural residence, neighborhood socioeconomic vulnerability, # primary care visits, site PACT implementation progress index (Pi2)





ANALYSIS

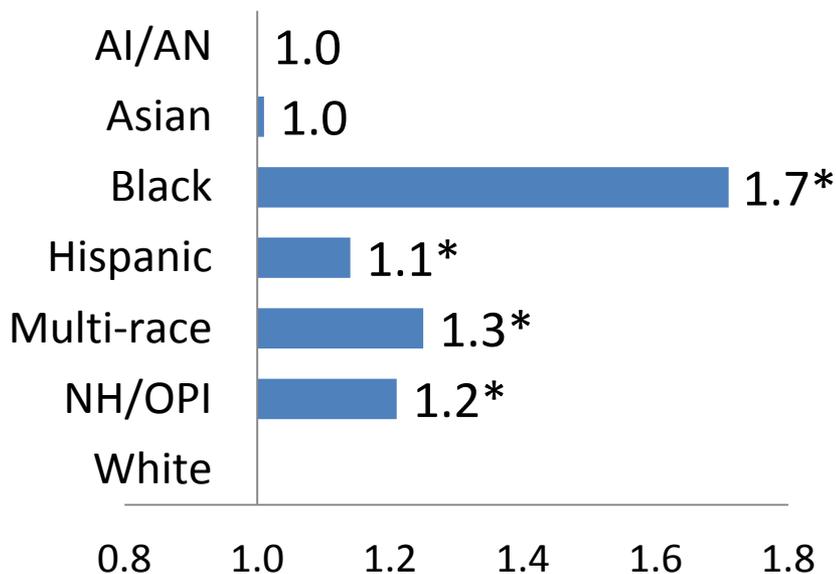
- For each outcome, fit 3 models to estimate single-year disparities, and change in disparities from 2009 to 2014
 - Linear probability model with a binomial error distribution
 - Models included race/ethnicity and product terms for each minority group-by-year interaction
 - Model 1: fixed intercepts for 140 VA facilities to adjust for confounding by facility-level factors
 - Model 2: included demographics + substituted linear term for facility PACT implementation
 - Model 3: added socioeconomic vulnerability + patient PACT exposure
- Results expressed as predicted probabilities of the outcomes and differences (disparities) in outcomes; model-based predictions used to test for change in magnitude of differences



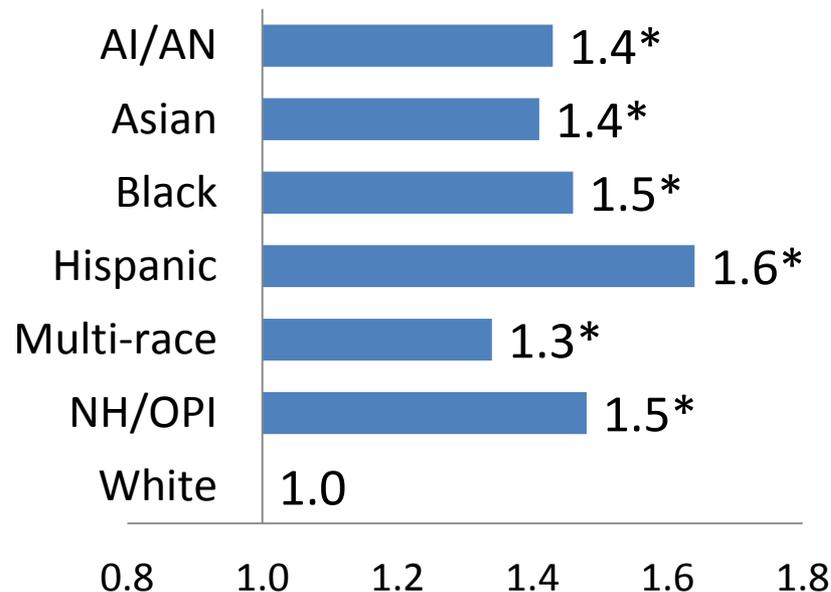


DIAGNOSED HYPERTENSION AND DIABETES BY RACE/ETHNICITY

**Hypertension Diagnosis:
Age-adjusted Odds Ratio**



**Diabetes Diagnosis:
Age-adjusted Odds Ratio**



*p<0.05 for all comparisons with White

- Hypertension: #1 diagnosis in VA users (51% vs. 30% in U.S.)
- Diabetes: #3 diagnosed condition in VA users (24% vs. 11% in U.S.)



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RESULTS: SAMPLE CHARACTERISTICS

- Racial/ethnic minority groups, compared with white Veterans were:
 - Younger
 - Higher percent female (most groups)
 - More likely to receive primary care from sites that had lower PACT implementation scores, though mean differences modest (0.3-0.9 on -8 to 8 scale)
 - Most had greater number of primary care visits
 - Most had greater area deprivation

*Blood pressure < 140/90 mmHg;
glycosylated hemoglobin (HbA1C) \leq 9%



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INFLUENCES ON OUTCOMES

- For both hypertension and diabetes samples:
 - Greater medical home implementation associated with Veterans achieving better control
 - Veterans residing in economically challenged areas experienced worse control
 - Veterans under 65 years old had worse control

*Blood pressure < 140/90 mmHg;
glycosylated hemoglobin (HbA1C) ≤ 9%

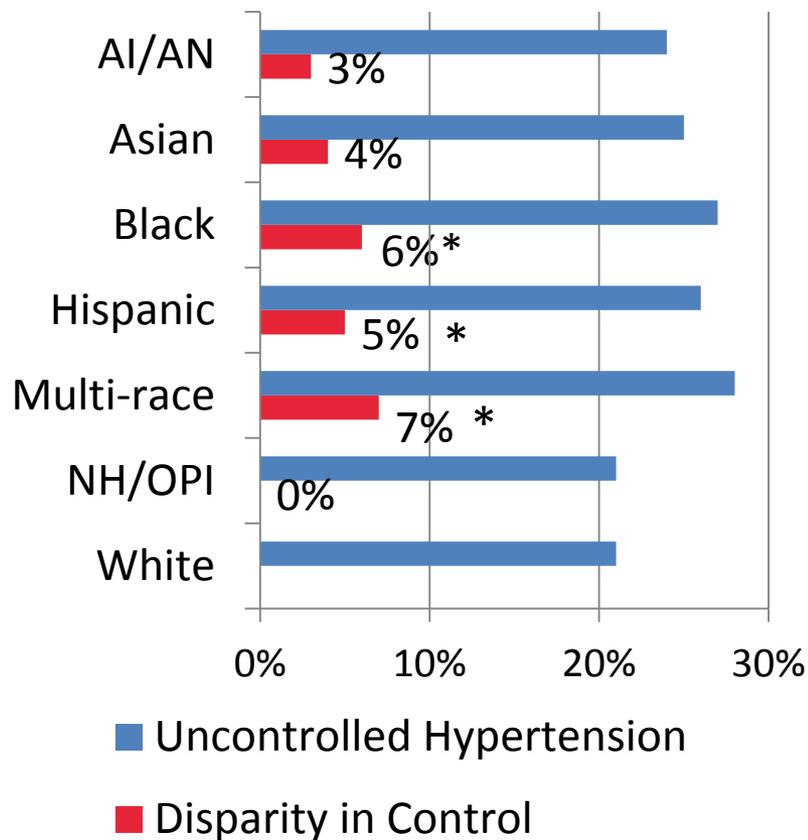


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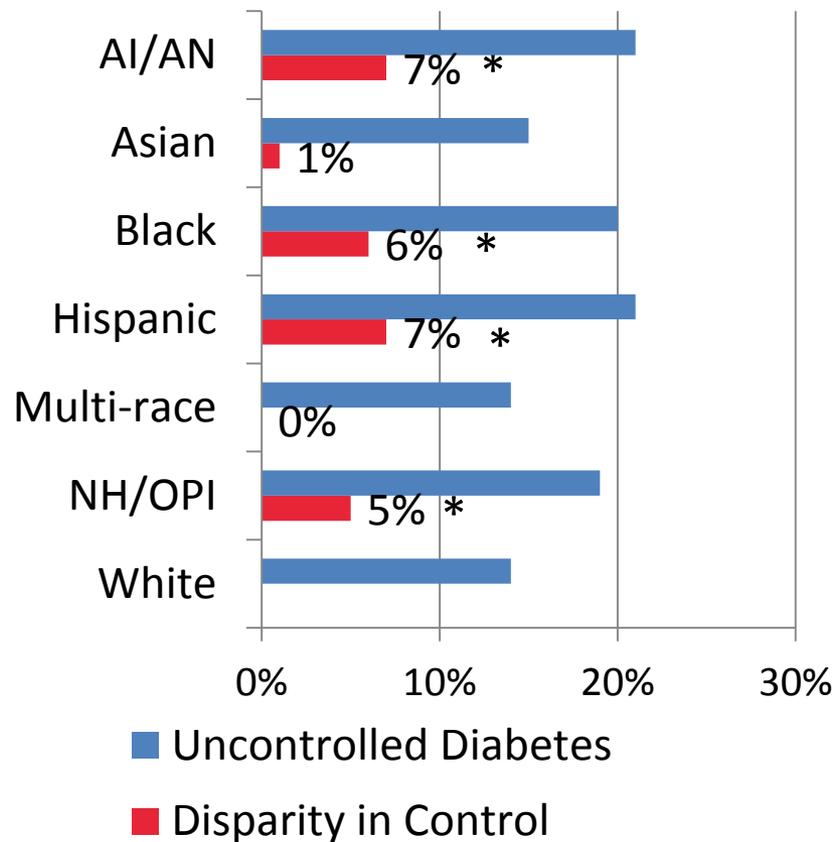


2009 – DISPARITIES BY RACE/ETHNICITY

2009 Hypertension



2009 Diabetes



*p<0.05 for all comparisons with White



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Adjusted Change from 2009 to 2014 in Disparities in Achieving Clinical Control for Hypertension

	Model 1	Model 2	Model 3
White	Ref	Ref	Ref
AI/AN	3.6	2.8	4.2
Asian	-3.6	-2.8	-3.8
Black	0.5	0.3	0.3
Hispanic	-2.9*	-3.0*	-2.2
Multi-race	-5.3	-5.6	-6.2
NH/OPI	4.1	3.8	0.8

Model 1 adjusted for VA facility.

Model 2 adjusted for facility-level PACT implementation, and individual age, sex, and residence in an urban area.

Model 3 additionally adjusted for annual number of primary care visits and area deprivation index.

* $p < 0.05$. Negative numbers mean that disparity decreased over time.



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ADJUSTED CHANGE FROM 2009 TO 2014 IN DISPARITIES IN ACHIEVING CLINICAL CONTROL FOR DIABETES

	Model 1	Model 2	Model 3
White	Ref	Ref	Ref
AI/AN	2.3	2.0	-1.5
Asian	2.8	2.0	-0.6
Black	-0.01	-0.4	-1.2
Hispanic	-2.0	-1.6	-1.9
Multi-race	3.7	4.9	4.3
NH/OPI	-2.7	-0.9	-2.6

Model 1 adjusted for VA facility.

Model 2 adjusted for facility-level PACT implementation, and individual age, sex, and residence in an urban area.

Model 3 additionally adjusted for annual number of primary care visits and area deprivation index.

Negative numbers mean that disparity decreased over time.

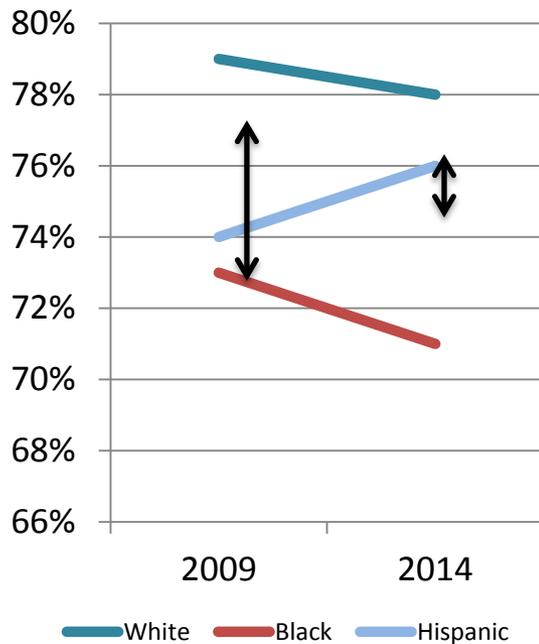


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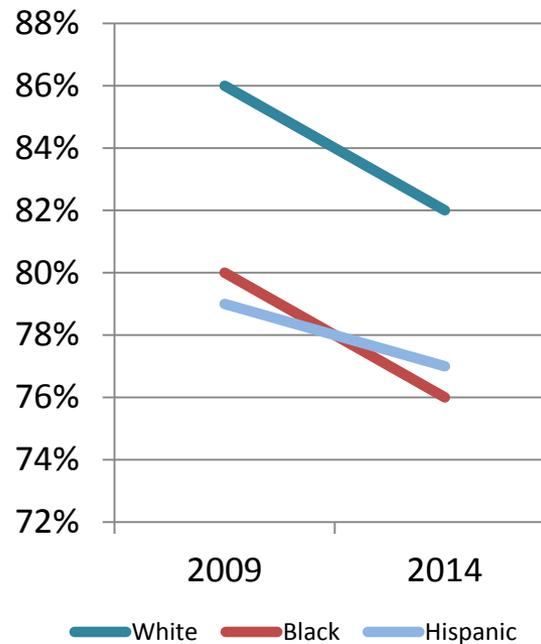


CHANGE FROM 2009 TO 2014 IN PERCENTAGE OF VETERANS IN VA PACT WHO ACHIEVED CLINICAL CONTROL OF HYPERTENSION AND DIABETES

Hypertension control in 146,698 Veterans



Diabetes control in 79,832 Veterans



Disparities persisted

- In both 2009 and 2014, Black and Hispanic Veterans had lower rates of hypertension and diabetes control than white Veterans
- Disparities also present in 2014 for American Indians / Alaska Natives (for both conditions) and Native Hawaiian / other Pacific Islanders (for hypertension)

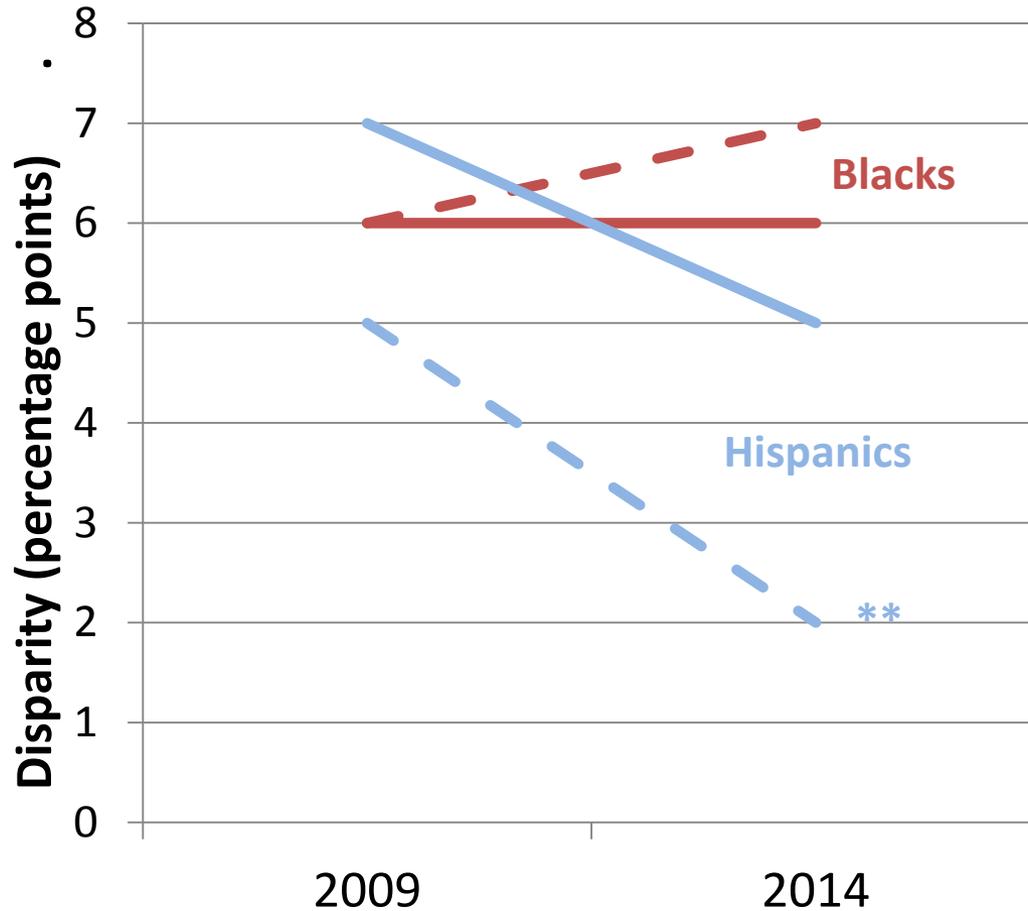
■ However, by 2014, hypertension disparity decreased 3 percentage points for Hispanic Veterans



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CHANGE FROM 2009 TO 2014 IN DISPARITIES IN ACHIEVING CLINICAL CONTROL FOR HYPERTENSION AND DIABETES



**p<0.05 for decrease in disparity

- Hypertension control disparities narrowed for Hispanics from improved outcomes for Hispanics (a desired effect)
- Diabetes control disparities trended downward for Hispanics due to worse outcomes for all groups (an undesired effect) with a greater decline in whites



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LIMITATIONS

- Relatively small size of AI/AN, Asian, Multi-race, and NH/OPI groups may have precluded identification as statistically significant a change in disparities that could be clinically relevant
- Primary care visits may reflect comorbidity, which is associated with worse outcomes
- Findings may reflect contribution of factors other than PACT implementation, e.g., growth in patient volume, social determinants of health





ADDRESSING RACIAL/ETHNIC DISPARITIES THROUGH PACT

Greater PACT implementation associated with better hypertension and diabetes control, but most racial/ ethnic disparities persisted – to promote health equity:

- Identify underlying determinants of poor hypertension and diabetes control
- Explore potential for tailored strategies that account for underlying determinants
- Monitor outcomes for racial/ethnic groups





OFFICE OF HEALTH EQUITY-QUERI PARTNERED EVALUATION INITIATIVE

For further information:

- **Donna L. Washington, MD, MPH**

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http://www.queri.research.va.gov/partnered_evaluation/equity.cfm



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U.S. Department
of Veterans Affairs

Focus on Health Equity and Action:

Chronic Health Conditions among Vulnerable Veterans: Current Research and Action

Poll Question 3



FHEA 06.29.2017



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POLL QUESTION 3

- What are your ideas and/or suggestions for tackling the disparities discussed in today's FHEA Cyberseminar?



- Write your response in the chat box





PRESENTER INFORMATION

- ❑ Uchenna S. Uchendu, MD: Uchenna.Uchendu2@va.gov
- ❑ Donna L. Washington, MD, MPH: Donna.Washington@va.gov
- ❑ Jessica Y. Breland, PhD: Jessica.Breland@va.gov

THANK YOU!



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HEALTH EQUITY DATA & ACTION –TAKE HOME

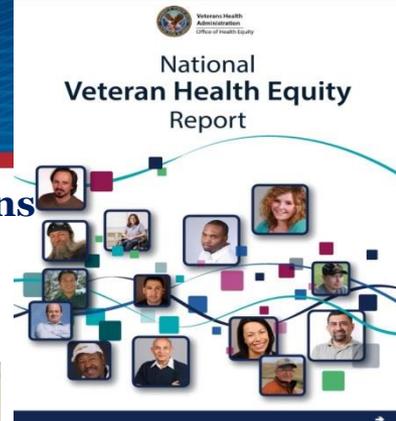
- Consistently report, monitor, trend, and track key metrics along vulnerability lines to include gender/sex, race/ethnicity, rural/urban, military era/period of service, etc.
 - Doing so will allow transparent monitoring of the progress for the vulnerable groups, support the accountability agency priority and bolster trust
 - Innovative Health Equity Projects to tackle issues identified
 - Discussions underway with PACT stakeholders and other champions
 - **Send your ideas to OHE : [healthequity @va.gov](mailto: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.*



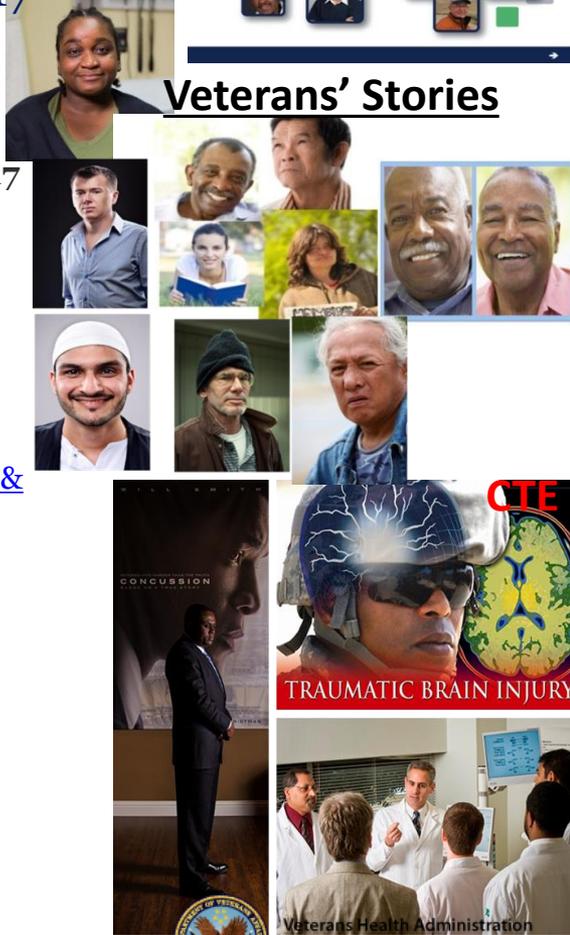
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FOCUS ON HEALTH EQUITY AND ACTION CYBER SEMINAR SERIES



Veterans' Stories



- ❑ **06/29/2017 3-4P ET: Chronic Health Conditions among Vulnerable Veterans**
Today's Session – Archive coming soon
- ❑ **Future Sessions – Mark your calendars to join us from 3-4PM ET on the following Thursdays: **07/27/2017 **08/31/2017 **09/28/2017**
- ❑ **Past Sessions – Archived**
 - [Military Service History and VA Benefit Utilization for Minority Veterans](#) - 04/27/2017
 - [Incorporating Social Determinants of Health into VHA Patient Care and EHR](#) - 3/30/2017
 - [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



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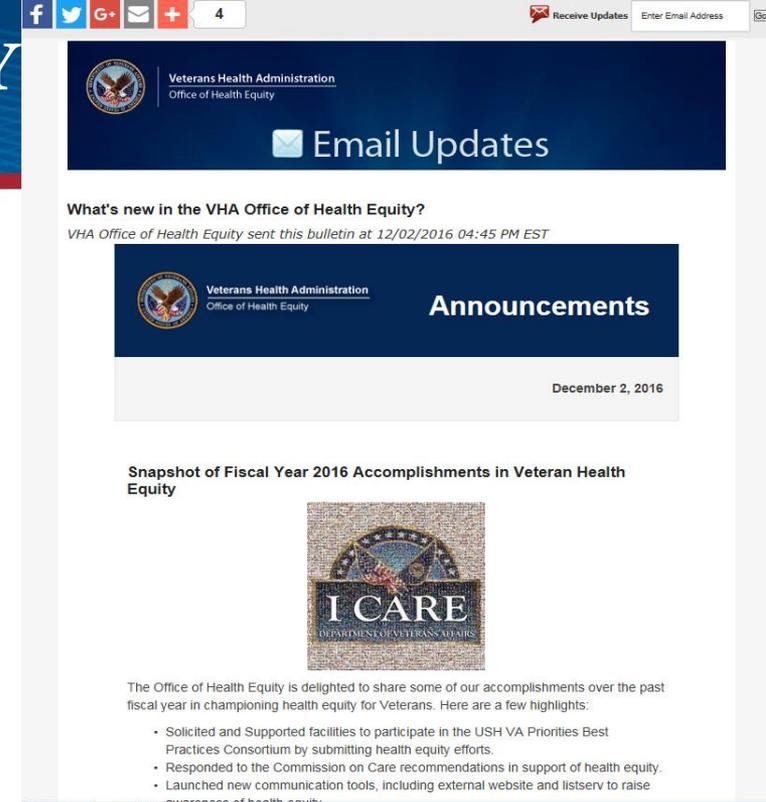


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www.va.gov/healthequity

- OHE Listserv sign up link:
<http://www.va.gov/HEALTH EQUITY/Updates.asp>



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