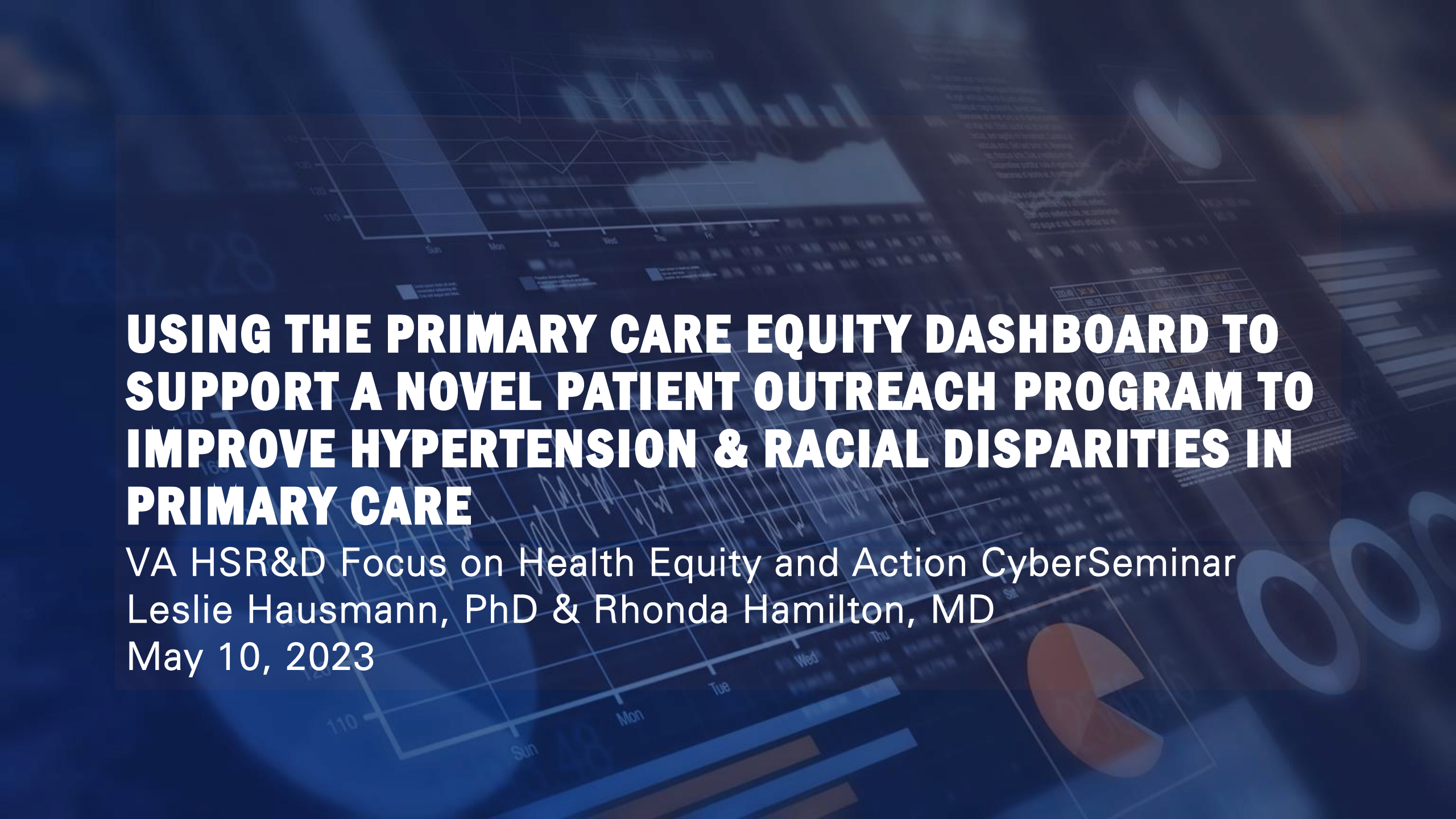


USING THE PRIMARY CARE EQUITY DASHBOARD TO SUPPORT A NOVEL PATIENT OUTREACH PROGRAM TO IMPROVE HYPERTENSION & RACIAL DISPARITIES IN PRIMARY CARE

VA HSR&D Focus on Health Equity and Action CyberSeminar

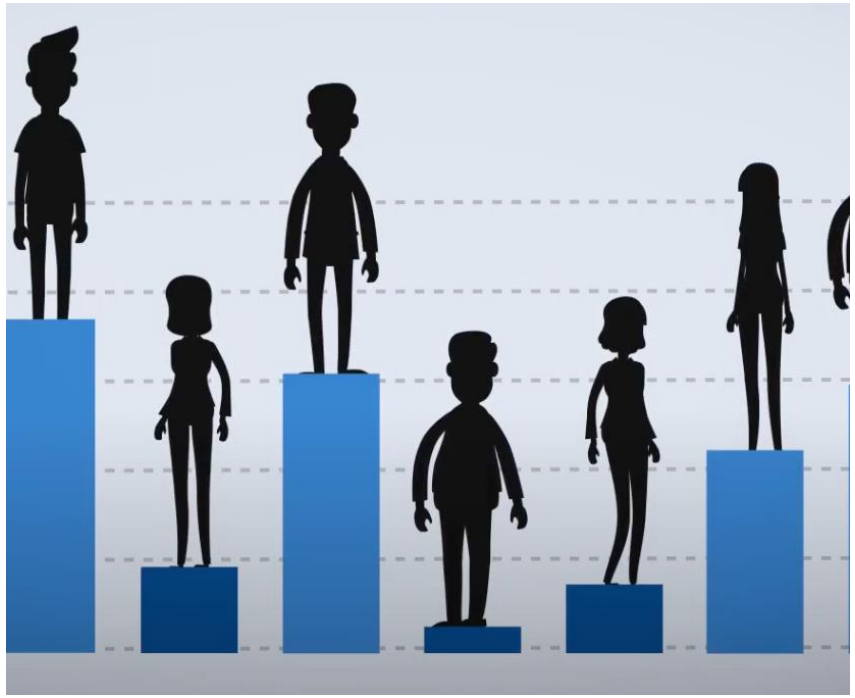
Leslie Hausmann, PhD & Rhonda Hamilton, MD

May 10, 2023

SUPPORTED BY

VA Office of Health Equity and VA HSR&D RVR 19-492
(Principal Investigator: Leslie Hausmann, PhD)

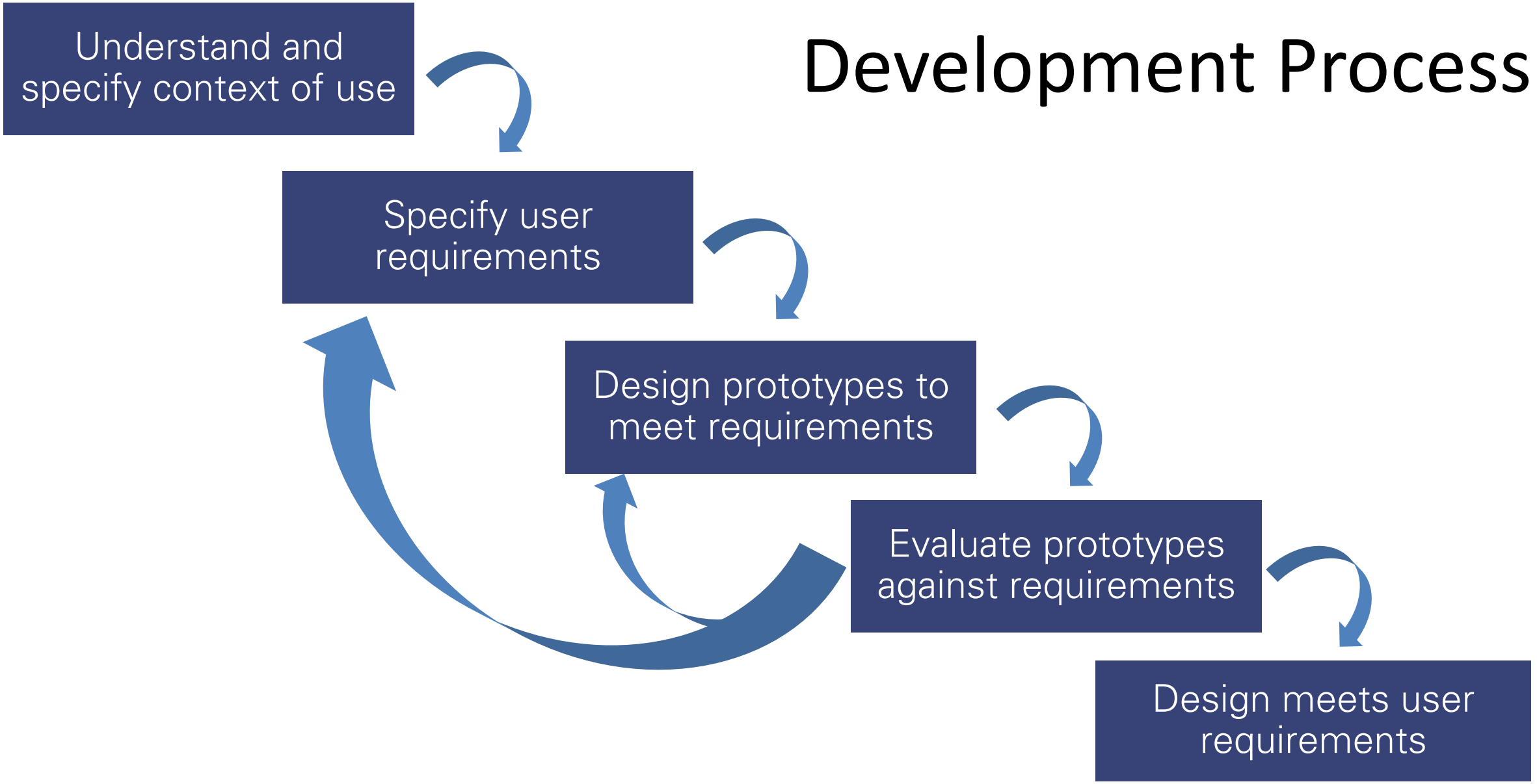
Primary Care Equity Dashboard



PURPOSE

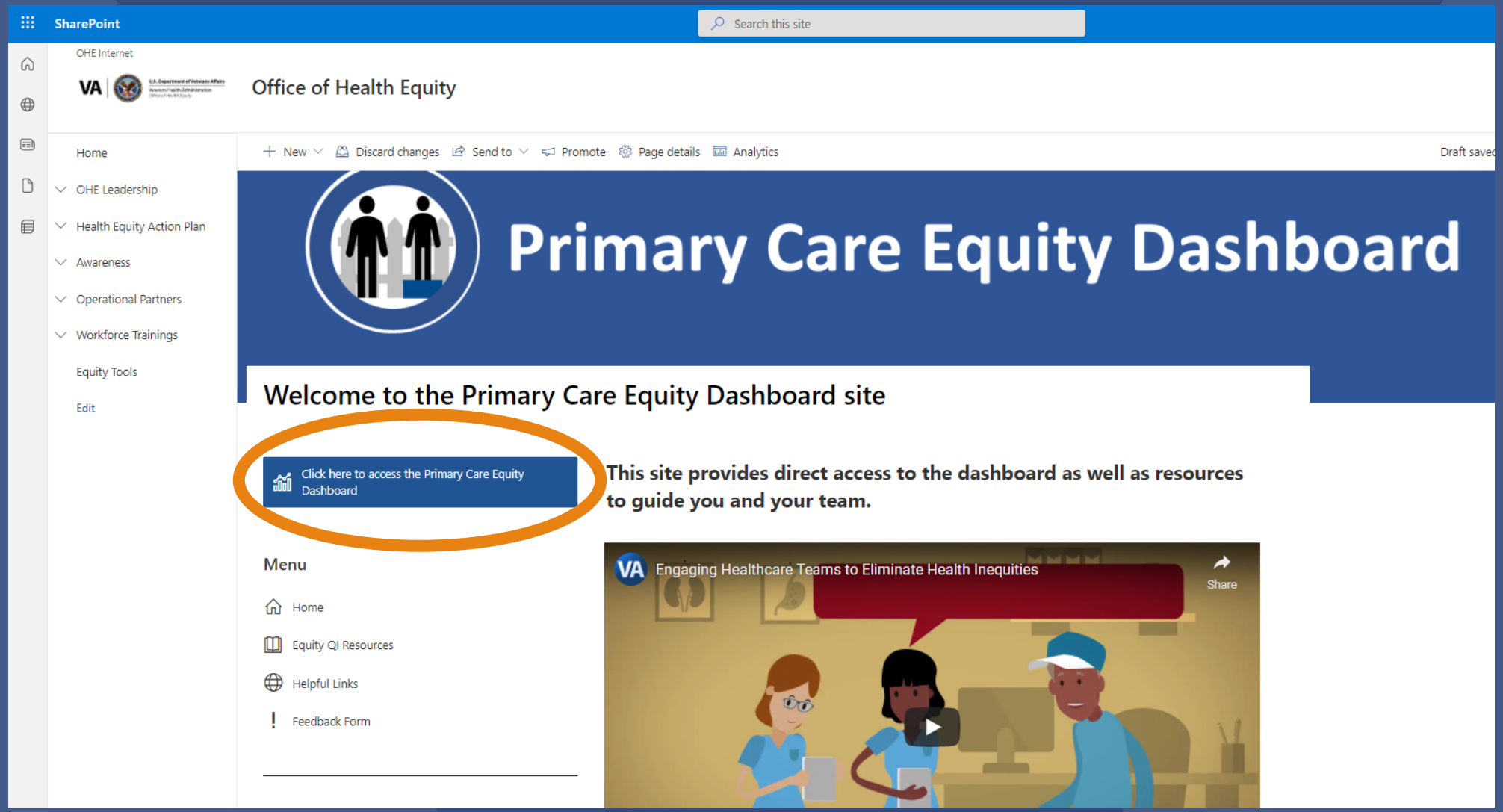
The Primary Care Equity Dashboard was developed to engage the VA healthcare workforce in the process of identifying and addressing inequities in their local patient populations

Development Process



ACCESS THE PCED VIA THE OFFICE OF HEALTH EQUITY SHAREPOINT PAGE:

https://dvagov.sharepoint.com/sites/VACOVHAOHE/SitePages/Test.aspx



WELCOME PAGE / BEFORE YOU BEGIN

File Export Get insights Subscribe ···

Primary Care Equity Dashboard

- Before you Begin
- VISN Opportunity Matrix
- Equity Data Visualizations
- Education and Interventions
- Glossary
- FAQs

Go back

Welcome to the Primary Care Equity Dashboard!

Thank you for joining in the effort to eliminate health inequities and provide the best care possible to all Veterans. This tool is designed to give primary care clinicians and staff the data they need to identify and address health inequities among their patients.

Before you begin, check out the videos on the right and review an **introductory tutorial** containing tips on navigating the dashboard. Continuing education credit for completing the tutorial is available.

Use the navigation menu on the left to view the different reports presented in the dashboard.

The **VISN Opportunity Matrix** section contains VISN-level score cards allowing users to easily identify measures, facilities, and demographic subcategories on which to focus equity-driven interventions.

The **Equity Data Visualizations** section contains reports to help you identify disparities in health outcomes across different patient populations, health measures, and VA facilities.

The **Education and Interventions** section contains resources to help guide possible interventions for the disparities you have identified in the data.

Video: How to Apply Equity Quality Improvement in the VA

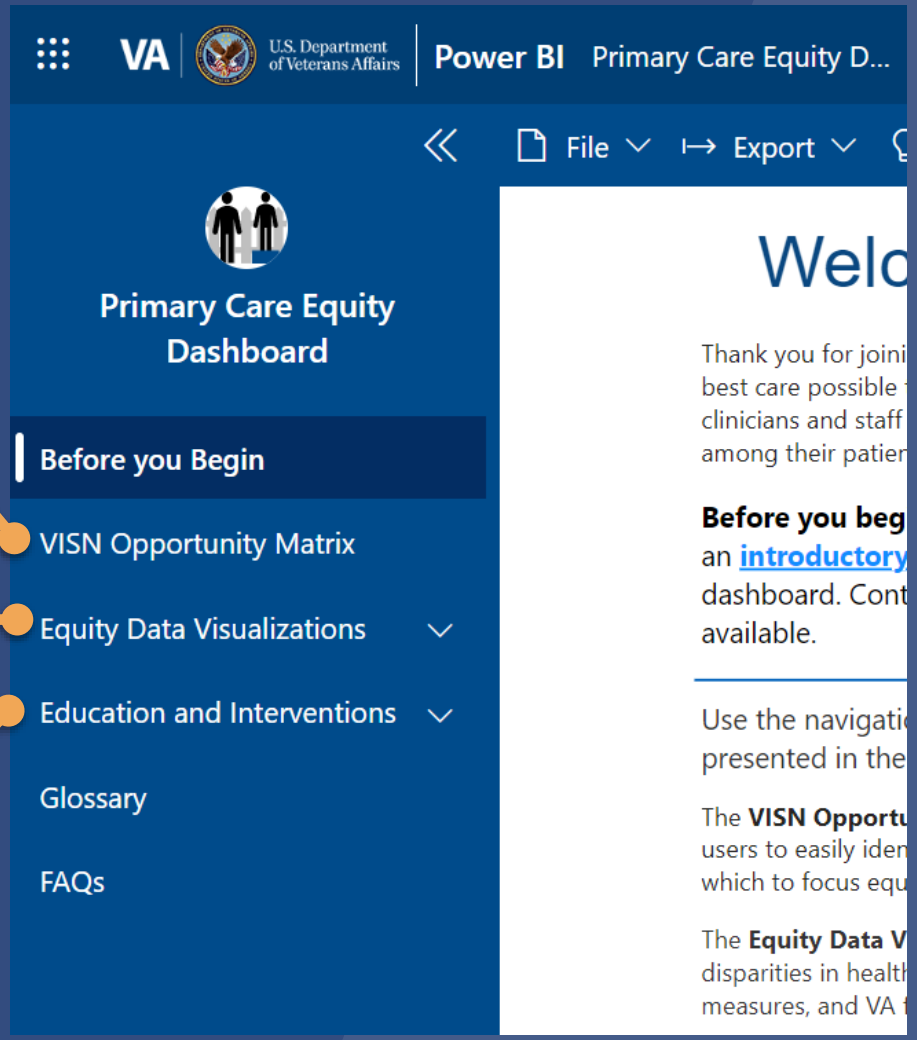
Video: Antiracism Resources and the Impact of Racism within VA

NAVIGATION MENU

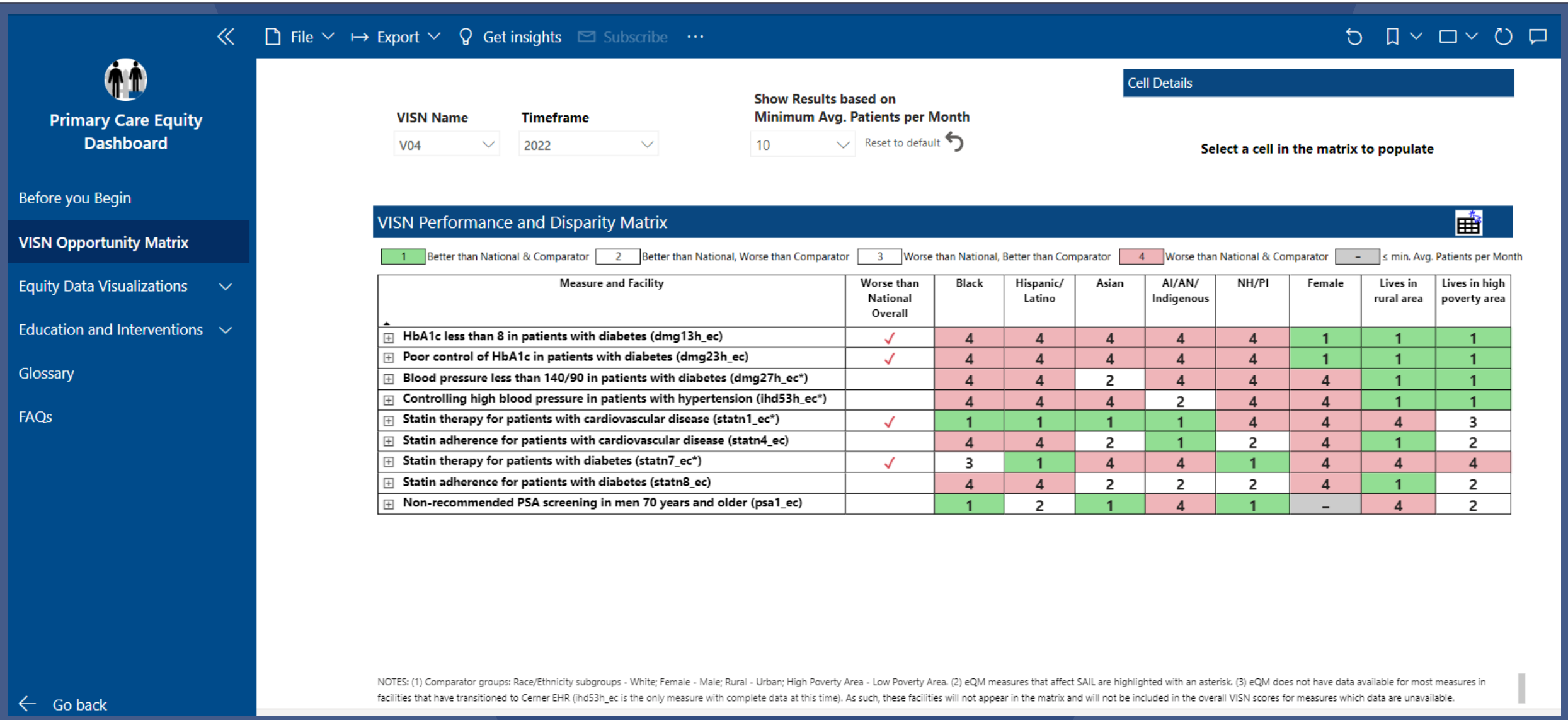
VISN-level score cards allowing users to easily identify measures, facilities, and demographic subcategories on which to focus equity-driven interventions

Facility-level reports allowing users to identify and track disparities in quality across subpopulations

Resources to help guide action planning and interventions to act on disparities identified in the data

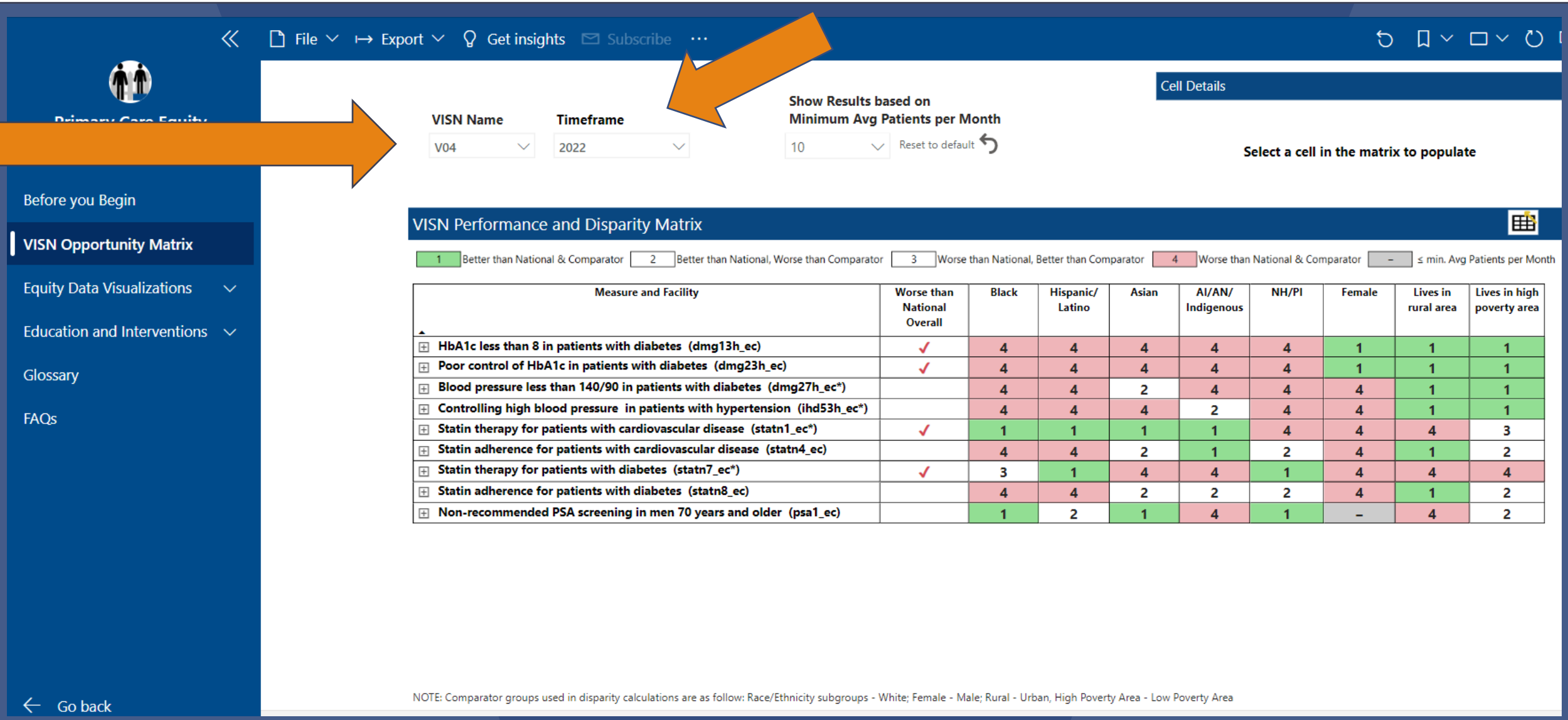


VISN OPPORTUNITY MATRIX – NEW THIS YEAR



Measure and Facility	Worse than National Overall	Black	Hispanic/ Latino	Asian	AI/AN/ Indigenous	NH/PI	Female	Lives in rural area	Lives in high poverty area
HbA1c less than 8 in patients with diabetes (dmg13h_ec)	✓	4	4	4	4	4	1	1	1
Poor control of HbA1c in patients with diabetes (dmg23h_ec)	✓	4	4	4	4	4	1	1	1
Blood pressure less than 140/90 in patients with diabetes (dmg27h_ec*)		4	4	2	4	4	4	1	1
Controlling high blood pressure in patients with hypertension (ihd53h_ec*)		4	4	4	2	4	4	1	1
Statin therapy for patients with cardiovascular disease (statn1_ec*)	✓	1	1	1	1	4	4	4	3
Statin adherence for patients with cardiovascular disease (statn4_ec)		4	4	2	1	2	4	1	2
Statin therapy for patients with diabetes (statn7_ec*)	✓	3	1	4	4	1	4	4	4
Statin adherence for patients with diabetes (statn8_ec)		4	4	2	2	2	4	1	2
Non-recommended PSA screening in men 70 years and older (psa1_ec)		1	2	1	4	1	–	4	2

FILTER BY VISN AND QUARTER/YEAR



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Blood pressure less than 140/90 in patients with diabetes (dmg27h_ec*)		4	4	2	4	4	4	1	1
Controlling high blood pressure in patients with hypertension (ihd53h_ec*)		4	4	4	2	4	4	1	1
Statin therapy for patients with cardiovascular disease (statn1_ec*)	✓	1	1	1	1	4	4	4	3
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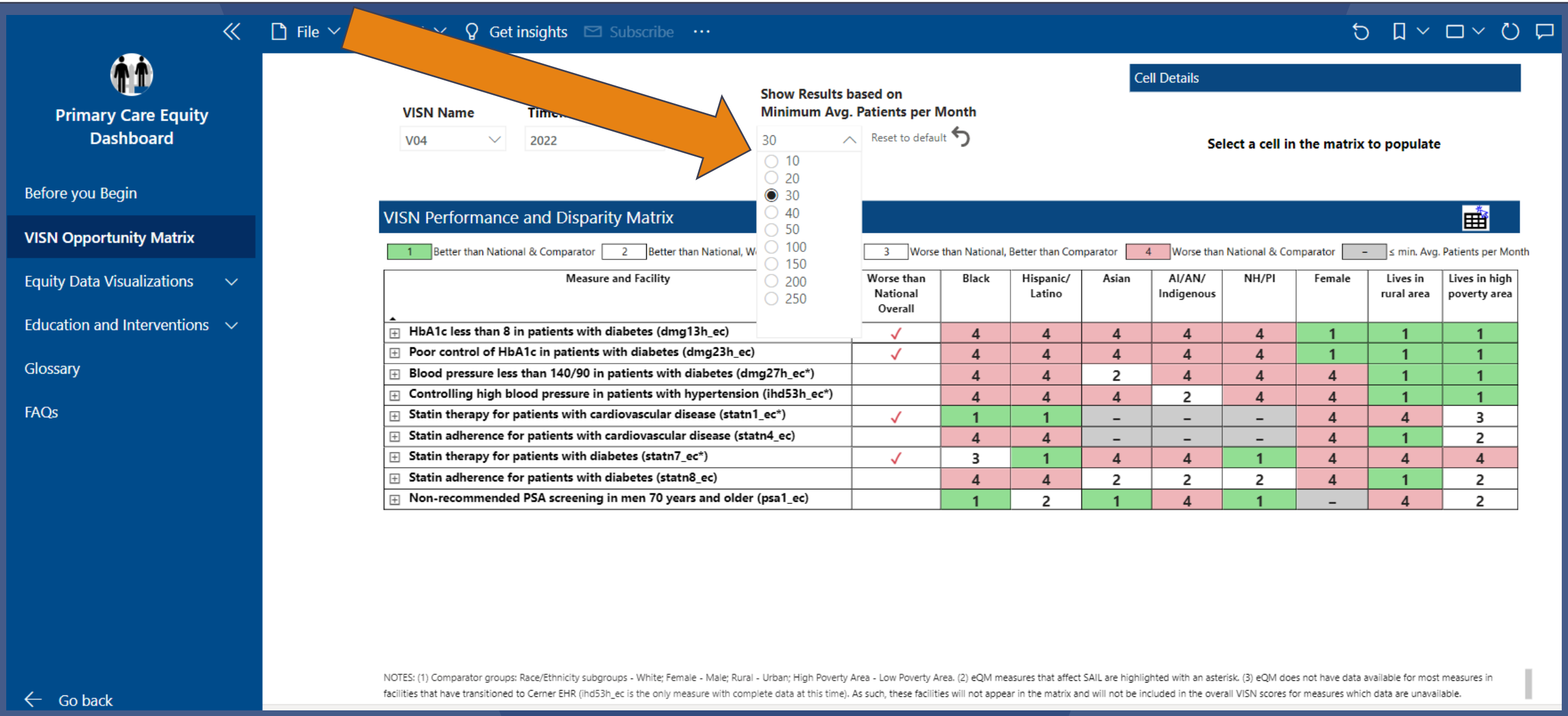
Non-recommended PSA screening in men 70 years and older (psa1_ec)		1	2	1	4	1	–	4	2

SET THE DESIRED MINIMUM GROUP SIZE



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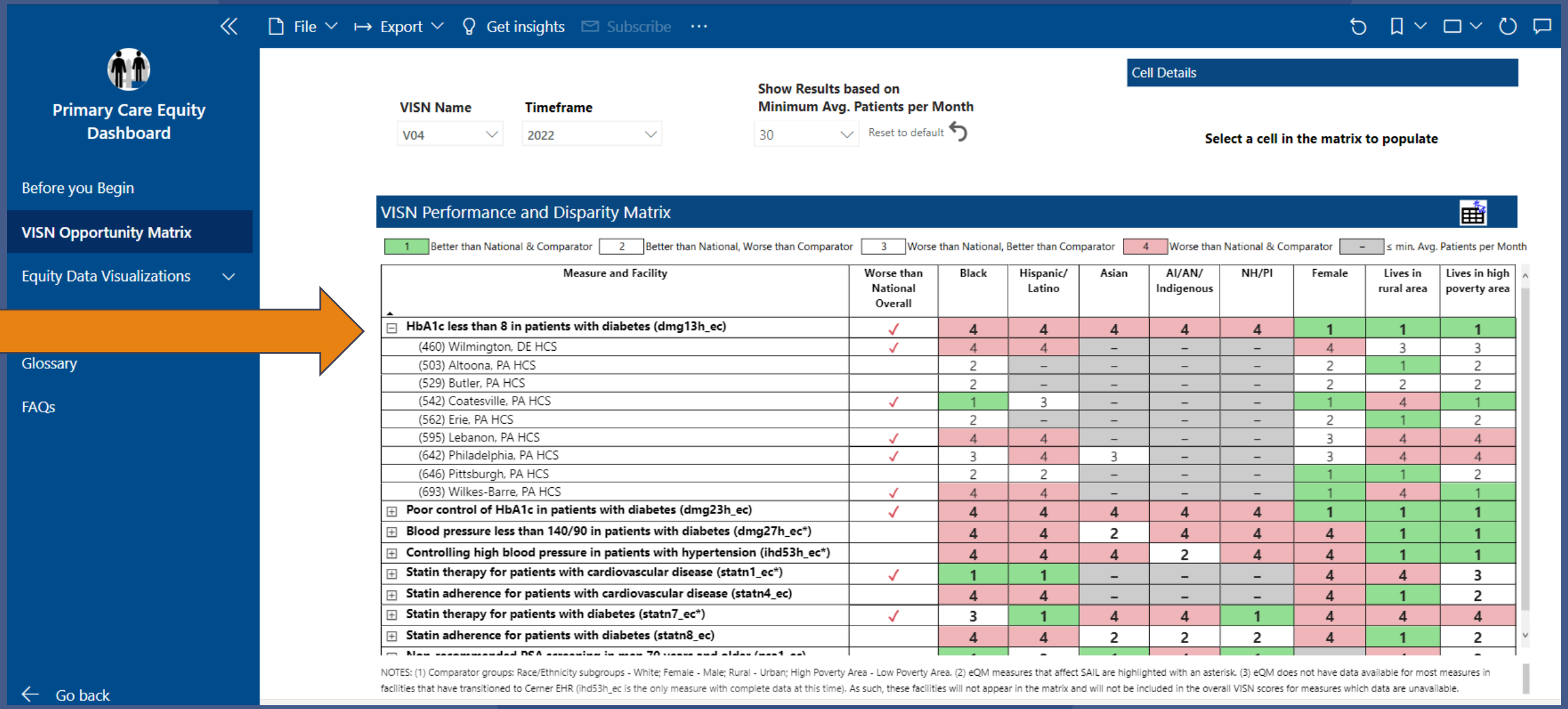
Poor control of HbA1c in patients with diabetes (dmg23h_ec)	✓	4	4	4	4	4	1	1	1
Blood pressure less than 140/90 in patients with diabetes (dmg27h_ec*)		4	4	2	4	4	4	1	1
Controlling high blood pressure in patients with hypertension (ihd53h_ec*)		4	4	4	2	4	4	1	1
Statin therapy for patients with cardiovascular disease (statn1_ec*)	✓	1	1	–	–	–	4	4	3
Statin adherence for patients with cardiovascular disease (statn4_ec)		4	4	–	–	–	4	1	2
Statin therapy for patients with diabetes (statn7_ec*)	✓	3	1	4	4	1	4	4	4
Statin adherence for patients with diabetes (statn8_ec)		4	4	2	2	2	4	1	2
Non-recommended PSA screening in men 70 years and older (psa1_ec)		1	2	1	4	1	–	4	2

VIEW MATRIX FOR VISN AND FACILITIES



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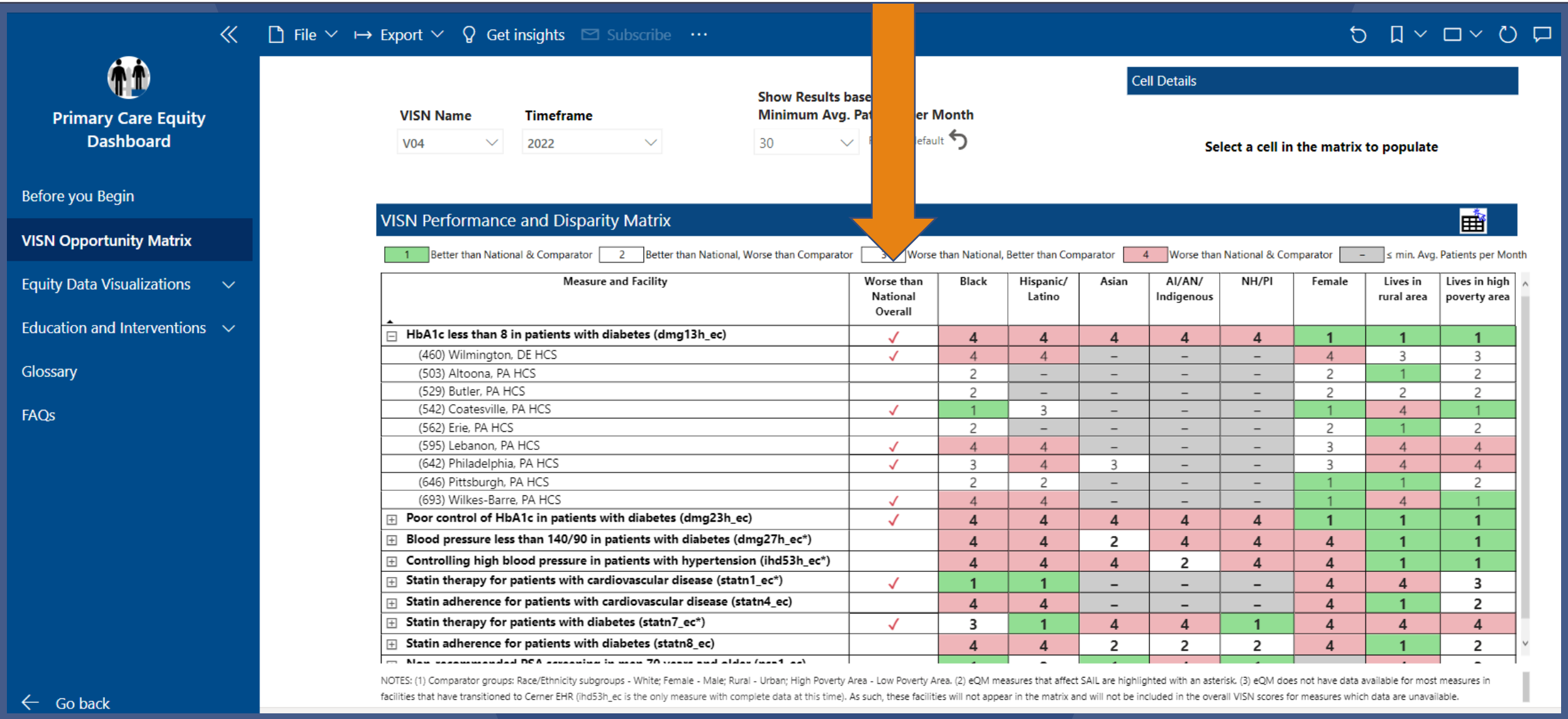
(460) Wilmington, DE HCS	✓	4	4	–	–	–	4	3	3
(503) Altoona, PA HCS		2	–	–	–	–	2	1	2
(529) Butler, PA HCS		2	–	–	–	–	2	2	2
(542) Coatesville, PA HCS	✓	1	3	–	–	–	1	4	1
(562) Erie, PA HCS		2	–	–	–	–	2	1	2
(595) Lebanon, PA HCS	✓	4	4	–	–	–	3	4	4
(642) Philadelphia, PA HCS	✓	3	4	3	–	–	3	4	4
(646) Pittsburgh, PA HCS		2	2	–	–	–	1	1	2
(693) Wilkes-Barre, PA HCS	✓	4	4	–	–	–	1	4	1
Poor control of HbA1c in patients with diabetes (dmg23h_ec)	✓	4	4	4	4	4	1	1	1
Blood pressure less than 140/90 in patients with diabetes (dmg27h_ec*)		4	4	2	4	4	4	1	1
Controlling high blood pressure in patients with hypertension (ihd53h_ec*)		4	4	4	2	4	4	1	1
Statin therapy for patients with cardiovascular disease (statn1_ec*)	✓	1	1	–	–	–	4	4	3
Statin adherence for patients with cardiovascular disease (statn4_ec)		4	4	–	–	–	4	1	2
Statin therapy for patients with diabetes (statn7_ec*)	✓	3	1	4	4	1	4	4	4
Statin adherence for patients with diabetes (statn8_ec)		4	4	2	2	2	4	1	2

CHECK MARK INDICATES LOWER PERFORMANCE



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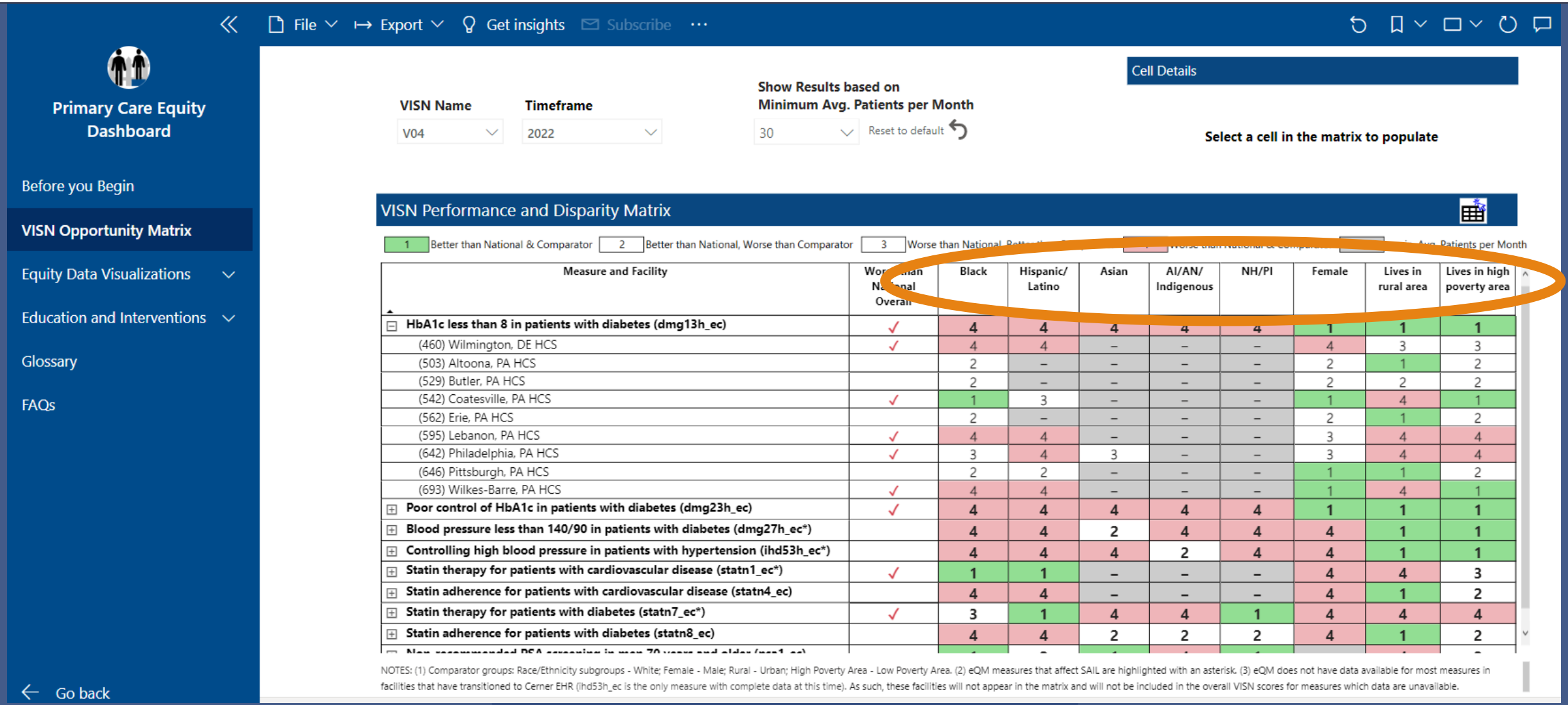
(460) Wilmington, DE HCS	✓	4	4	–	–	–	4	3	3
(503) Altoona, PA HCS		2	–	–	–	–	2	1	2
(529) Butler, PA HCS		2	–	–	–	–	2	2	2
(542) Coatesville, PA HCS	✓	1	3	–	–	–	1	4	1
(562) Erie, PA HCS		2	–	–	–	–	2	1	2
(595) Lebanon, PA HCS	✓	4	4	–	–	–	3	4	4
(642) Philadelphia, PA HCS	✓	3	4	3	–	–	3	4	4
(646) Pittsburgh, PA HCS		2	2	–	–	–	1	1	2
(693) Wilkes-Barre, PA HCS	✓	4	4	–	–	–	1	4	1
Poor control of HbA1c in patients with diabetes (dmg23h_ec)	✓	4	4	4	4	4	1	1	1
Blood pressure less than 140/90 in patients with diabetes (dmg27h_ec*)		4	4	2	4	4	4	1	1
Controlling high blood pressure in patients with hypertension (ihd53h_ec*)		4	4	4	2	4	4	1	1
Statin therapy for patients with cardiovascular disease (statn1_ec*)	✓	1	1	–	–	–	4	4	3
Statin adherence for patients with cardiovascular disease (statn4_ec)		4	4	–	–	–	4	1	2
Statin therapy for patients with diabetes (statn7_ec*)	✓	3	1	4	4	1	4	4	4
Statin adherence for patients with diabetes (statn8_ec)		4	4	2	2	2	4	1	2

NOTES: (1) Comparator groups: Race/Ethnicity subgroups - White; Female - Male; Rural - Urban; High Poverty Area - Low Poverty Area. (2) eQM measures that affect SAIL are highlighted with an asterisk. (3) eQM does not have data available for most measures in facilities that have transitioned to Cerner EHR (ihd53h_ec is the only measure with complete data at this time). As such, these facilities will not appear in the matrix and will not be included in the overall VISN scores for measures which data are unavailable.

COLUMNS INDICATE QUALITY & EQUITY

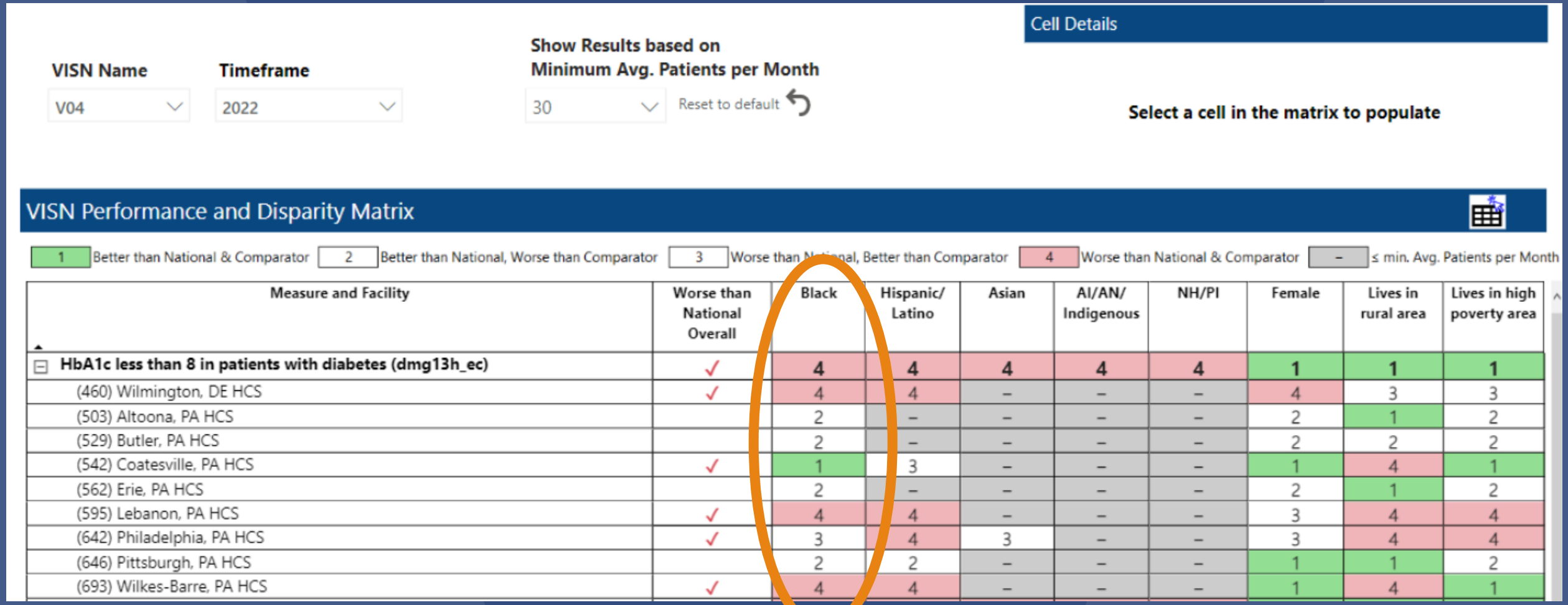


COMPARATOR GROUPS & CATEGORIES

Minoritized or Underserved Demographic Group	Comparator Group
American Indian/Alaska Native, Asian, Black, Hispanic, Native Hawaiian/Pacific Islander	White
Female	Male
Rural	Urban
High Poverty Area	Low Poverty Area

1	Better than National & Comparator Group
2	Better than National, Worse than Comparator Group
3	Worse than National, Better than Comparator Group
4	Worse than National & Comparator Group
–	Average patients per month in subgroup is less than or equal to the minimum selected

EXAMPLE



Cell Details

Select a cell in the matrix to populate

VISN Name V04

Timeframe 2022

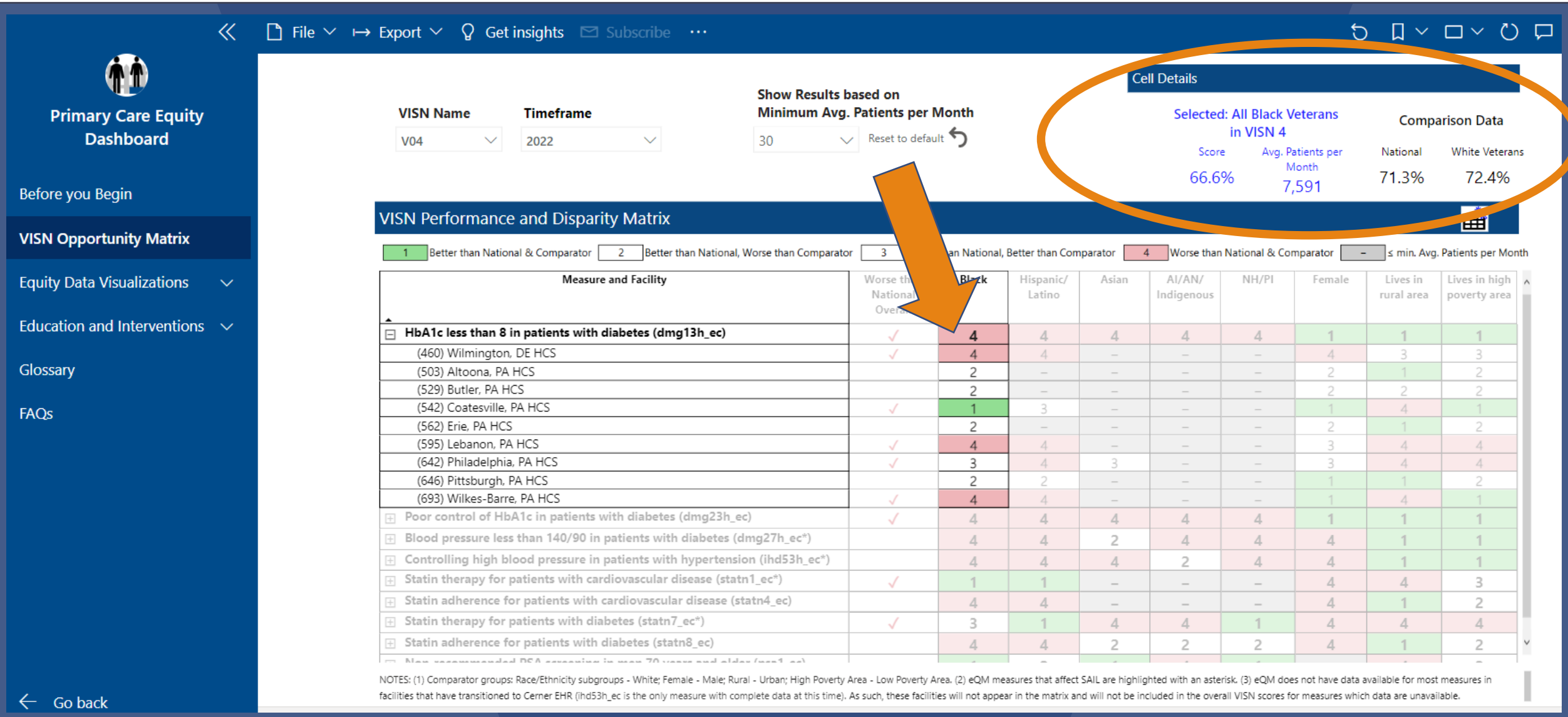
Show Results based on Minimum Avg. Patients per Month 30 Reset to default

VISN Performance and Disparity Matrix

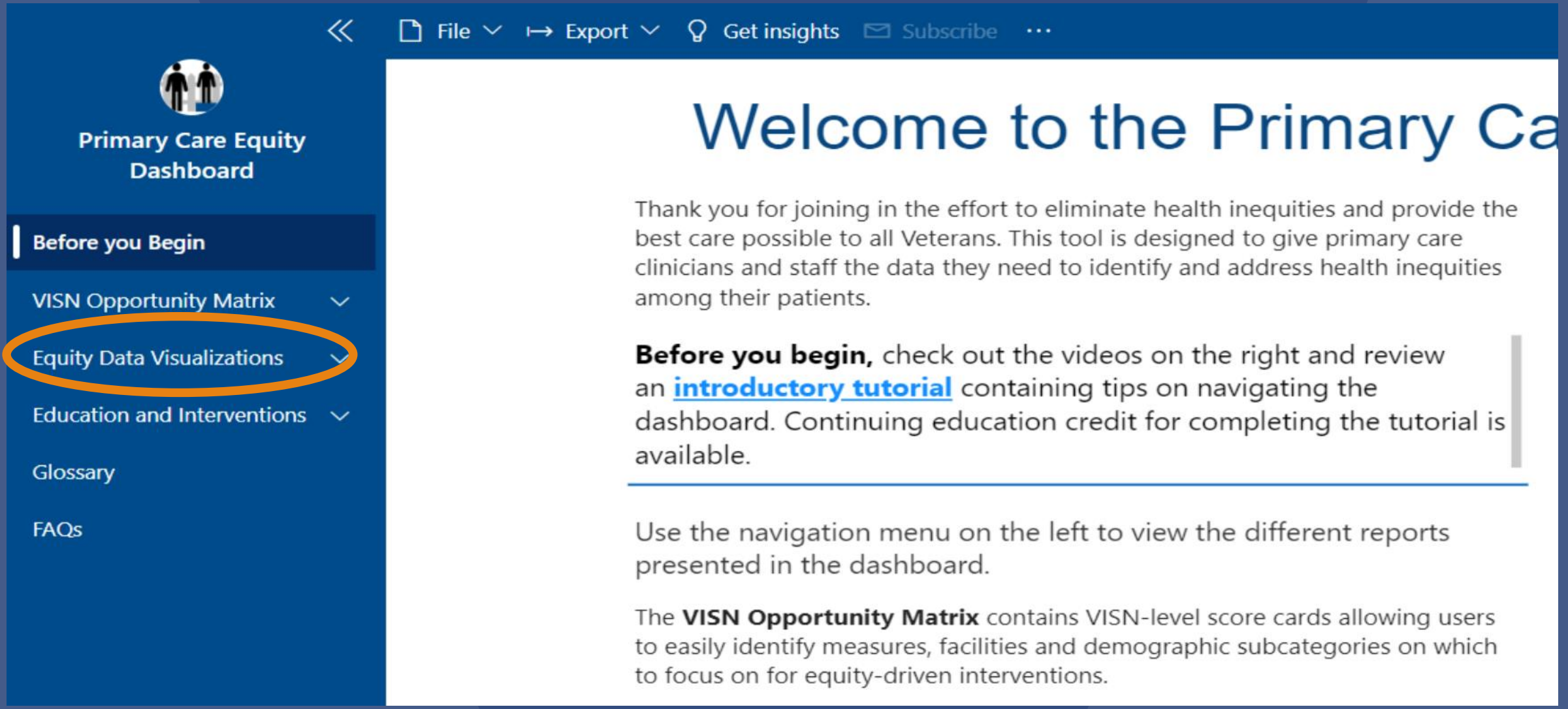
1 Better than National & Comparator | 2 Better than National, Worse than Comparator | 3 Worse than National, Better than Comparator | 4 Worse than National & Comparator | – ≤ min. Avg. Patients per Month

Measure and Facility	Worse than National Overall	Black	Hispanic/ Latino	Asian	AI/AN/ Indigenous	NH/PI	Female	Lives in rural area	Lives in high poverty area
HbA1c less than 8 in patients with diabetes (dmg13h_ec)	✓	4	4	4	4	4	1	1	1
(460) Wilmington, DE HCS	✓	4	4	–	–	–	4	3	3
(503) Altoona, PA HCS		2	–	–	–	–	2	1	2
(529) Butler, PA HCS		2	–	–	–	–	2	2	2
(542) Coatesville, PA HCS	✓	1	3	–	–	–	1	4	1
(562) Erie, PA HCS		2	–	–	–	–	2	1	2
(595) Lebanon, PA HCS	✓	4	4	–	–	–	3	4	4
(642) Philadelphia, PA HCS	✓	3	4	3	–	–	3	4	4
(646) Pittsburgh, PA HCS		2	2	–	–	–	1	1	2
(693) Wilkes-Barre, PA HCS	✓	4	4	–	–	–	1	4	1

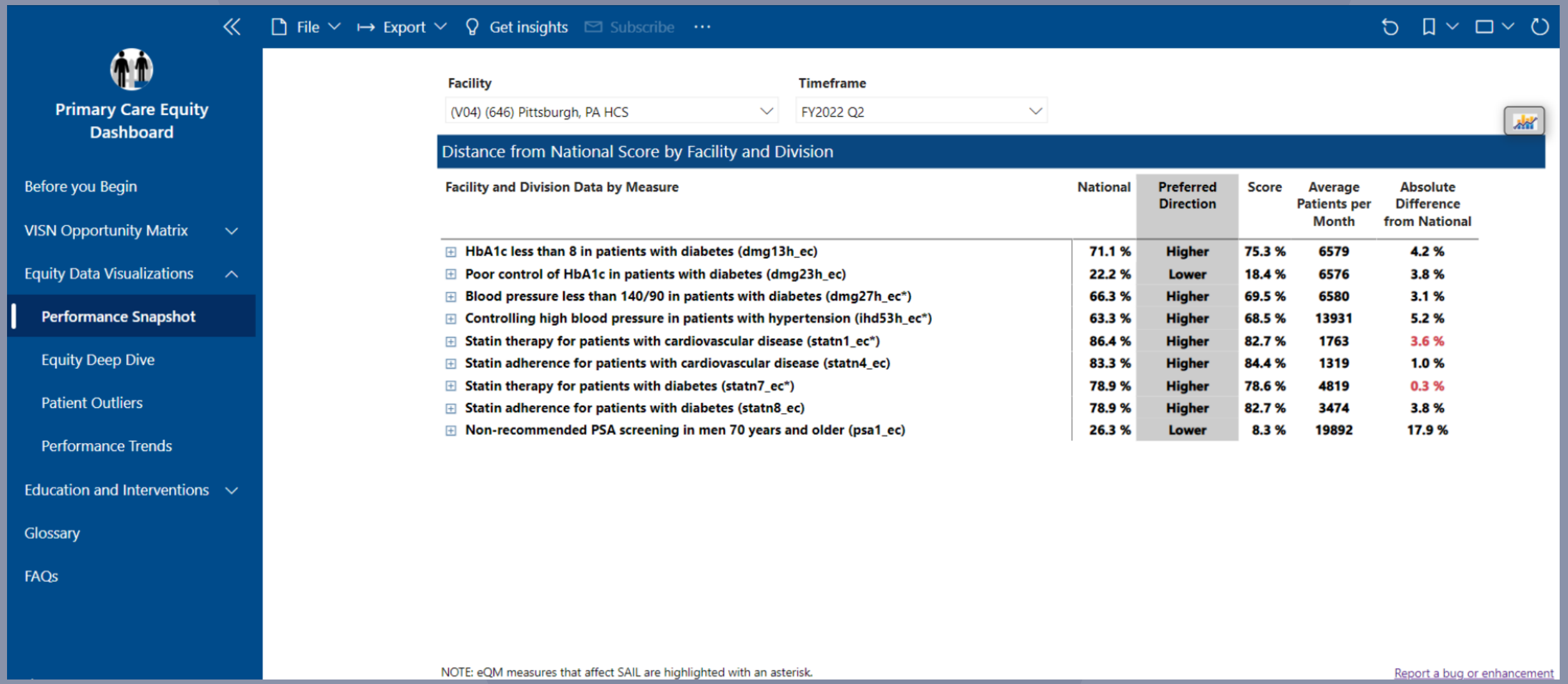
CLICK FOR MORE DETAILS



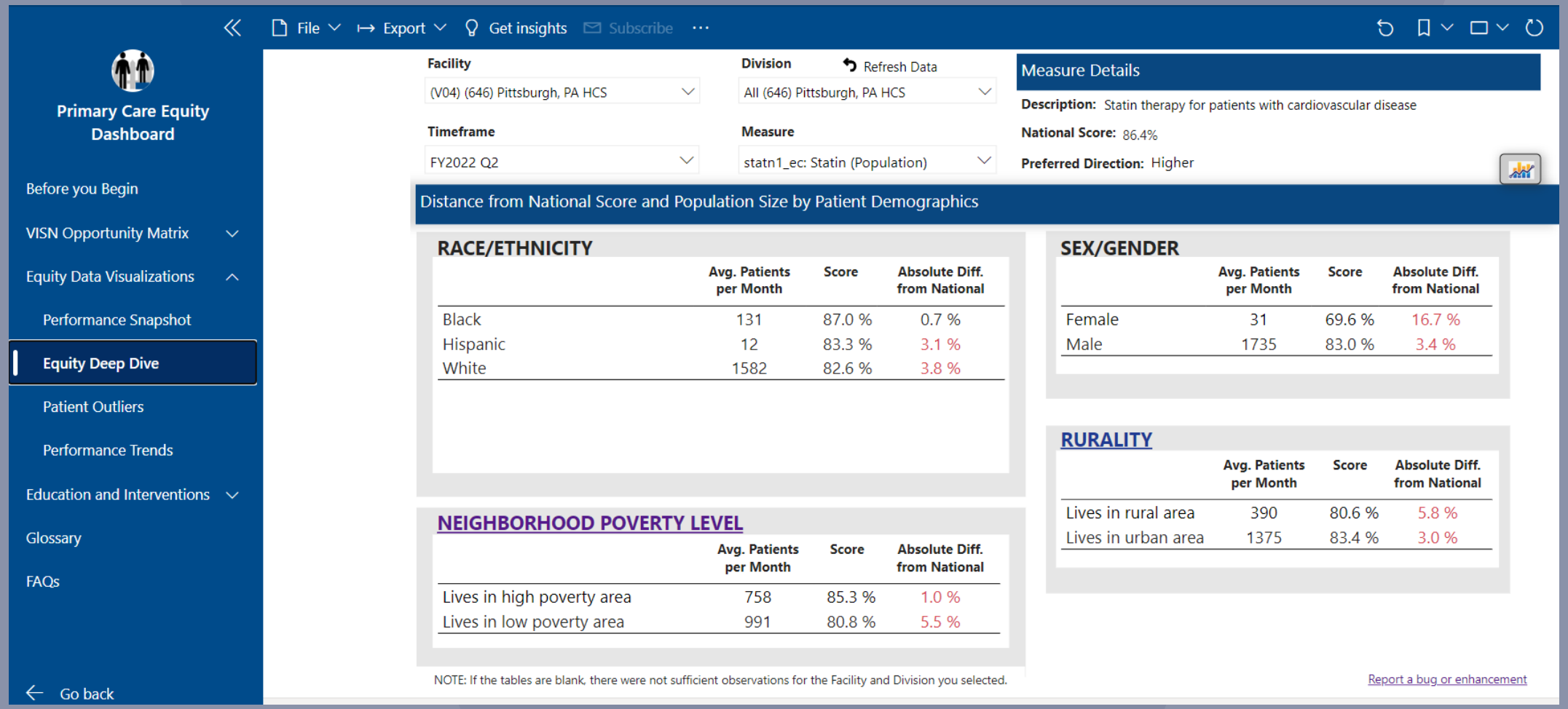
NAVIGATE THE DASHBOARD



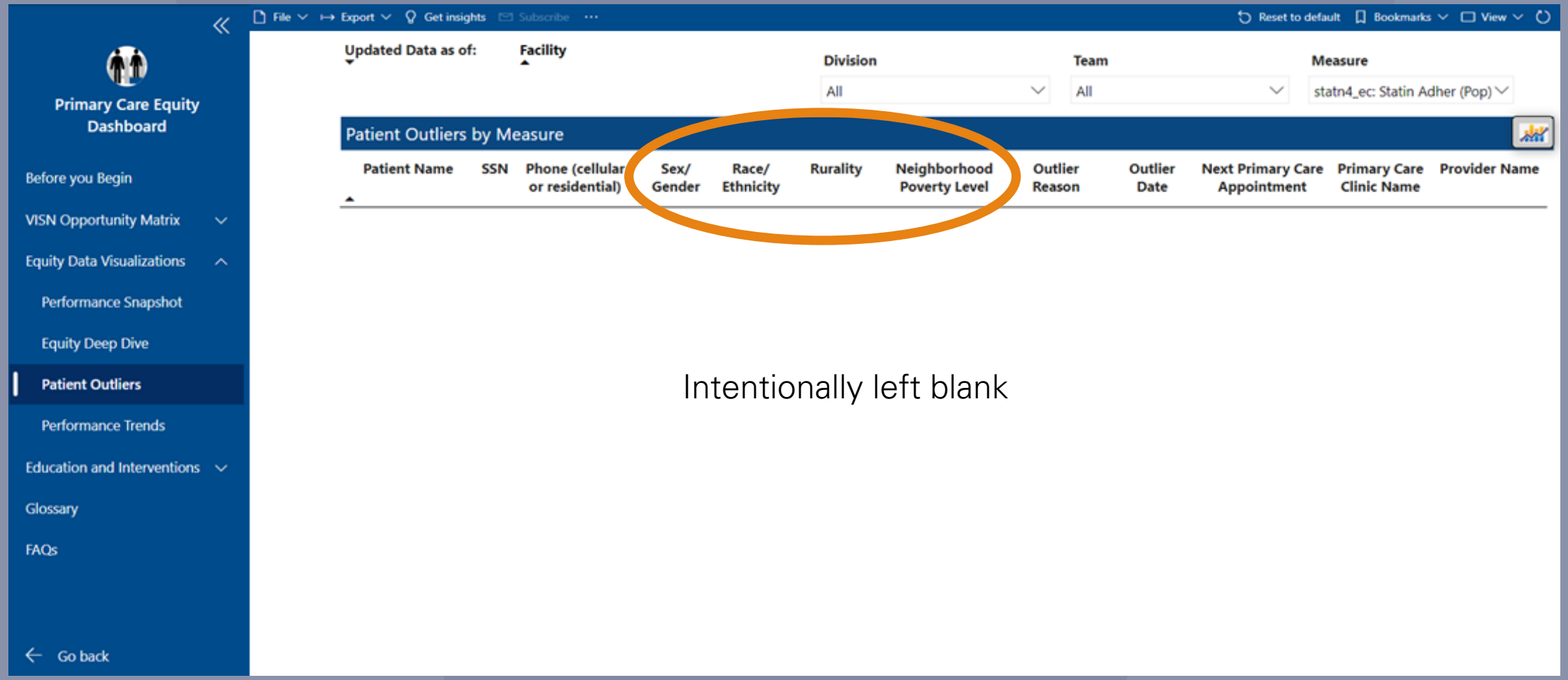
PERFORMANCE SNAPSHOT



EQUITY DEEP DIVE



PATIENT OUTLIERS



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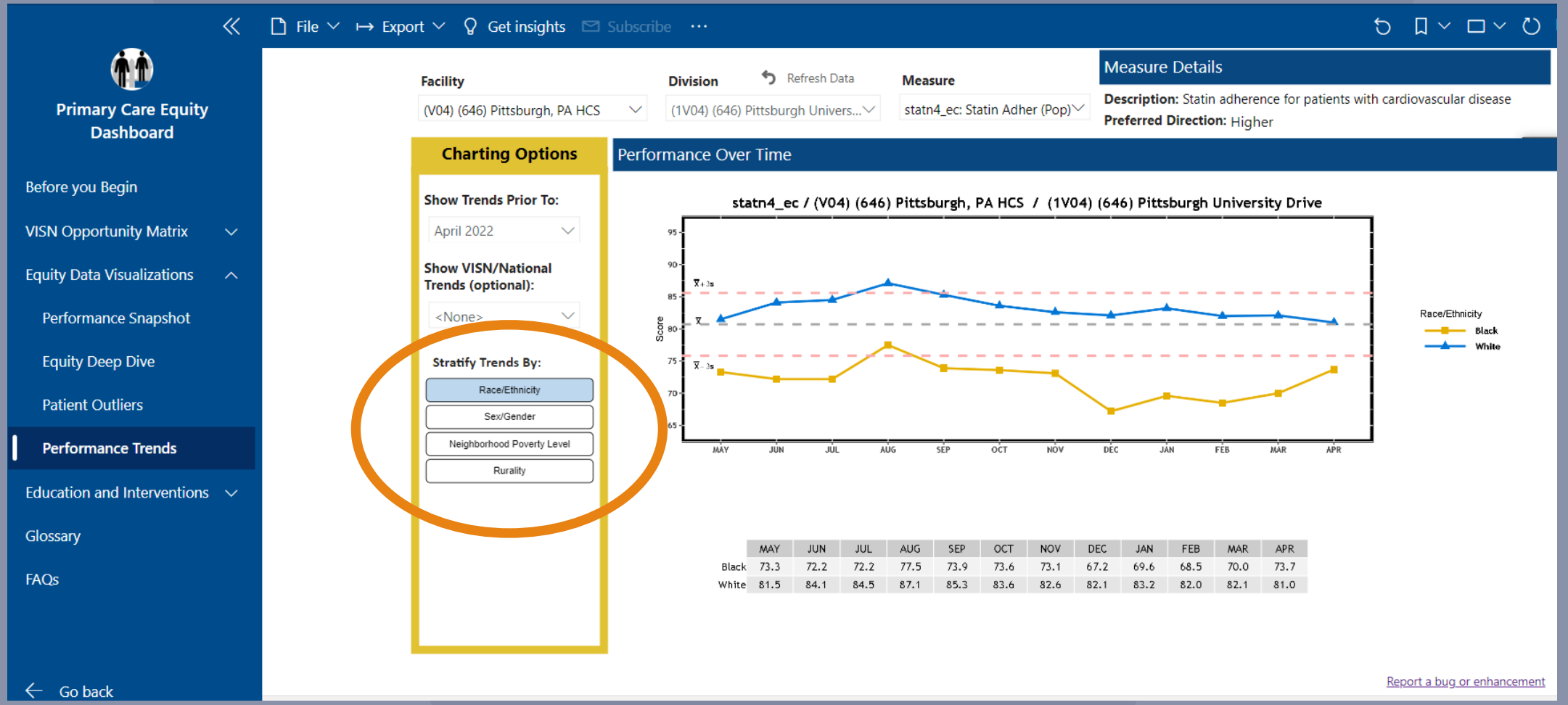
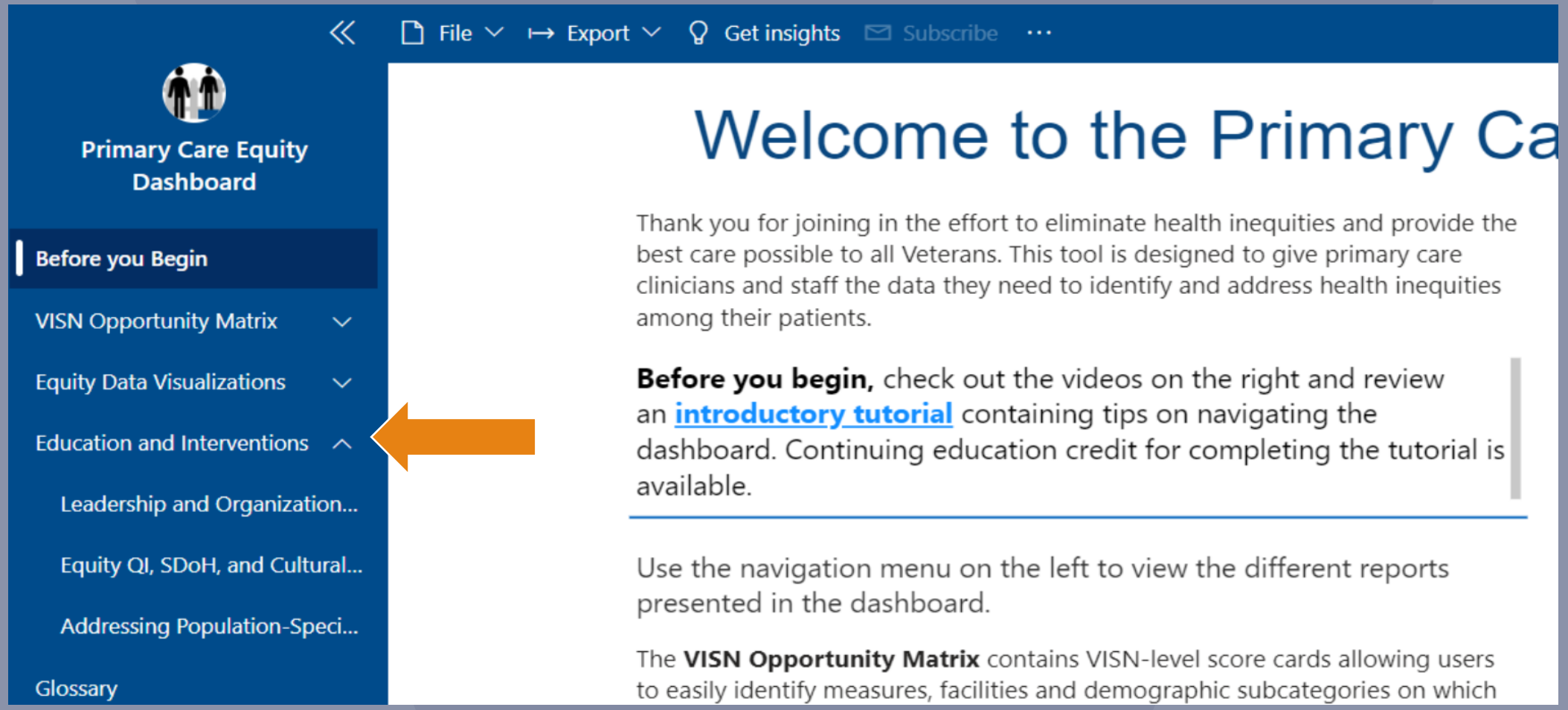
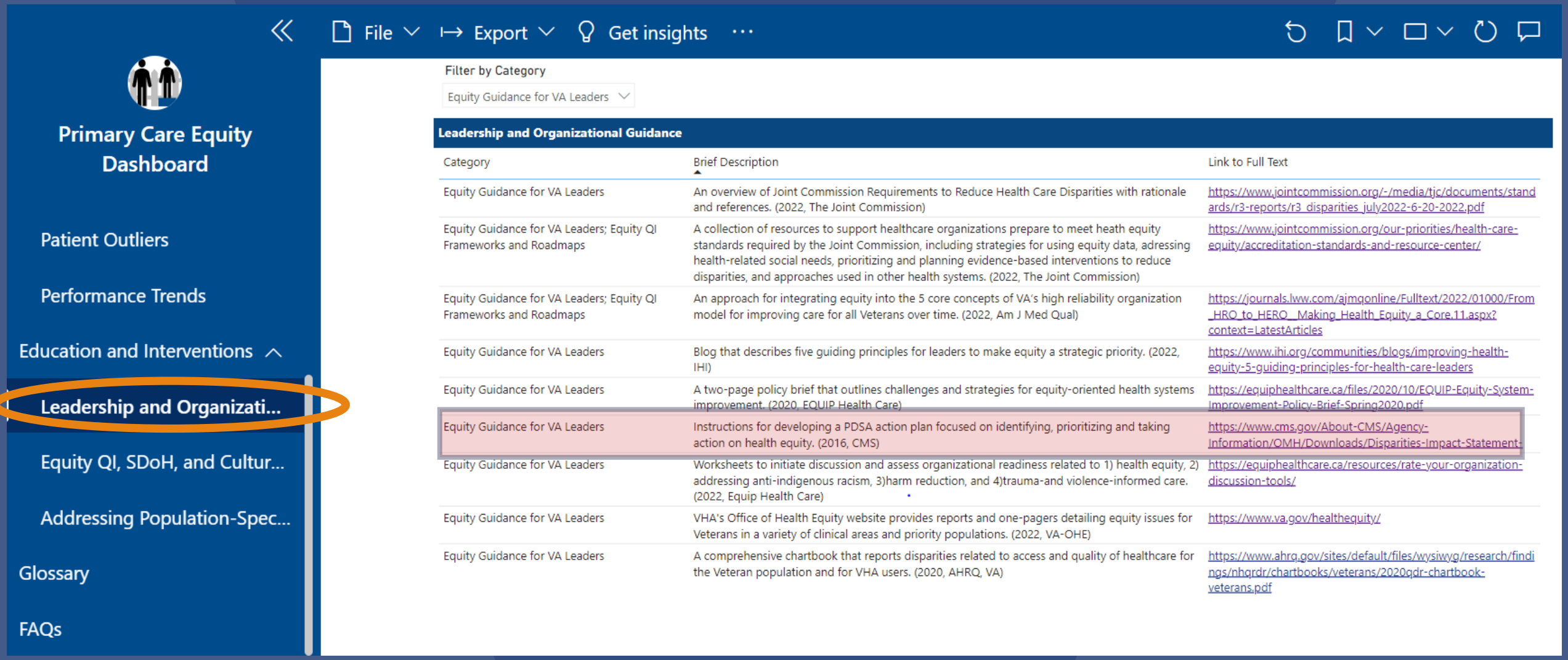
PERFORMANCE TRENDS



EDUCATION AND INTERVENTIONS



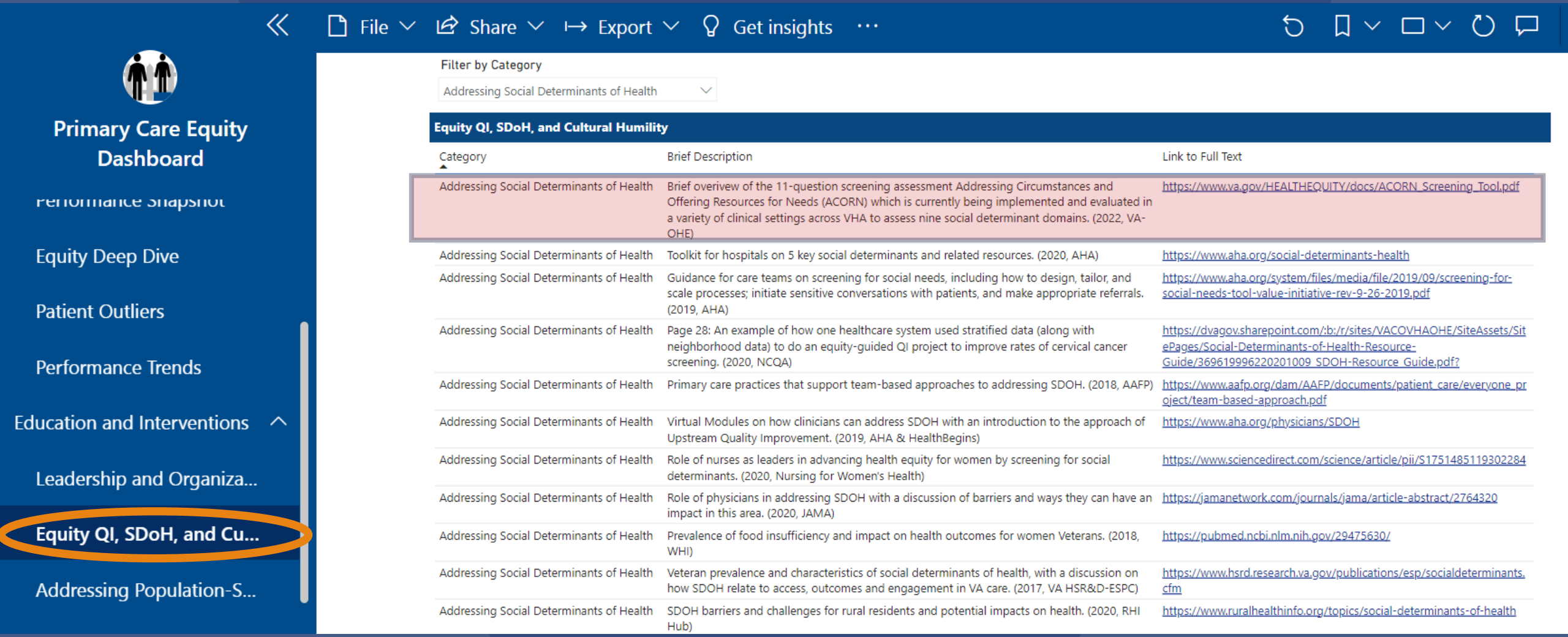
LEADERSHIP AND ORGANIZATIONAL GUIDANCE



Leadership and Organizational Guidance

Category	Brief Description	Link to Full Text
Equity Guidance for VA Leaders	An overview of Joint Commission Requirements to Reduce Health Care Disparities with rationale and references. (2022, The Joint Commission)	https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_disparities_july2022-6-20-2022.pdf
Equity Guidance for VA Leaders; Equity QI Frameworks and Roadmaps	A collection of resources to support healthcare organizations prepare to meet heath equity standards required by the Joint Commission, including strategies for using equity data, adressing health-related social needs, prioritizing and planning evidence-based interventions to reduce disparities, and approaches used in other health systems. (2022, The Joint Commission)	https://www.jointcommission.org/our-priorities/health-care-equity/accreditation-standards-and-resource-center/
Equity Guidance for VA Leaders; Equity QI Frameworks and Roadmaps	An approach for integrating equity into the 5 core concepts of VA's high reliability organization model for improving care for all Veterans over time. (2022, Am J Med Qual)	https://journals.lww.com/ajmqonline/Fulltext/2022/01000/From_HRO_to_HERO__Making_Health_Equity_a_Core.11.aspx?context=LatestArticles
Equity Guidance for VA Leaders	Blog that describes five guiding principles for leaders to make equity a strategic priority. (2022, IHI)	https://www.ihi.org/communities/blogs/improving-health-equity-5-guiding-principles-for-health-care-leaders
Equity Guidance for VA Leaders	A two-page policy brief that outlines challenges and strategies for equity-oriented health systems improvement. (2020, EQUIP Health Care)	https://equiphealthcare.ca/files/2020/10/EQUIP-Equity-System-Improvement-Policy-Brief-Spring2020.pdf
Equity Guidance for VA Leaders	Instructions for developing a PDSA action plan focused on identifying, prioritizing and taking action on health equity. (2016, CMS)	https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-
Equity Guidance for VA Leaders	Worksheets to initiate discussion and assess organizational readiness related to 1) health equity, 2) addressing anti-indigenous racism, 3)harm reduction, and 4)trauma-and violence-informed care. (2022, Equip Health Care)	https://equiphealthcare.ca/resources/rate-your-organization-discussion-tools/
Equity Guidance for VA Leaders	VHA's Office of Health Equity website provides reports and one-pagers detailing equity issues for Veterans in a variety of clinical areas and priority populations. (2022, VA-OHE)	https://www.va.gov/healthequity/
Equity Guidance for VA Leaders	A comprehensive chartbook that reports disparities related to access and quality of healthcare for the Veteran population and for VHA users. (2020, AHRQ, VA)	https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/chartbooks/veterans/2020qdr-chartbook-veterans.pdf

EQUITY QI, SDOH, AND CULTURAL HUMILITY RESOURCES



Category	Brief Description	Link to Full Text
Addressing Social Determinants of Health	Brief overivew of the 11-question screening assessment Addressing Circumstances and Offering Resources for Needs (ACORN) which is currently being implemented and evaluated in a variety of clinical settings across VHA to assess nine social determinant domains. (2022, VA-OHE)	https://www.va.gov/HEALTHEQUITY/docs/ACORN_Screening_Tool.pdf
Addressing Social Determinants of Health	Toolkit for hospitals on 5 key social determinants and related resources. (2020, AHA)	https://www.aha.org/social-determinants-health
Addressing Social Determinants of Health	Guidance for care teams on screening for social needs, including how to design, tailor, and scale processes; initiate sensitive conversations with patients, and make appropriate referrals. (2019, AHA)	https://www.aha.org/system/files/media/file/2019/09/screening-for-social-needs-tool-value-initiative-rev-9-26-2019.pdf
Addressing Social Determinants of Health	Page 28: An example of how one healthcare system used stratified data (along with neighborhood data) to do an equity-guided QI project to improve rates of cervical cancer screening. (2020, NCQA)	https://dvagov.sharepoint.com/:b:/r/sites/VACOVHAOHE/SiteAssets/SitePages/Social-Determinants-of-Health-Resource-Guide/369619996220201009_SDOH-Resource_Guide.pdf?
Addressing Social Determinants of Health	Primary care practices that support team-based approaches to addressing SDOH. (2018, AAFP)	https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/team-based-approach.pdf
Addressing Social Determinants of Health	Virtual Modules on how clinicians can address SDOH with an introduction to the approach of Upstream Quality Improvement. (2019, AHA & HealthBegins)	https://www.aha.org/physicians/SDOH
Addressing Social Determinants of Health	Role of nurses as leaders in advancing health equity for women by screening for social determinants. (2020, Nursing for Women's Health)	https://www.sciencedirect.com/science/article/pii/S1751485119302284
Addressing Social Determinants of Health	Role of physicians in addressing SDOH with a discussion of barriers and ways they can have an impact in this area. (2020, JAMA)	https://jamanetwork.com/journals/jama/article-abstract/2764320
Addressing Social Determinants of Health	Prevalence of food insufficiency and impact on health outcomes for women Veterans. (2018, WHI)	https://pubmed.ncbi.nlm.nih.gov/29475630/
Addressing Social Determinants of Health	Veteran prevalence and characteristics of social determinants of health, with a discussion on how SDOH relate to access, outcomes and engagement in VA care. (2017, VA HSR&D-ESPC)	https://www.hsrd.research.va.gov/publications/esp/socialdeterminants.cfm
Addressing Social Determinants of Health	SDOH barriers and challenges for rural residents and potential impacts on health. (2020, RHI Hub)	https://www.ruralhealthinfo.org/topics/social-determinants-of-health

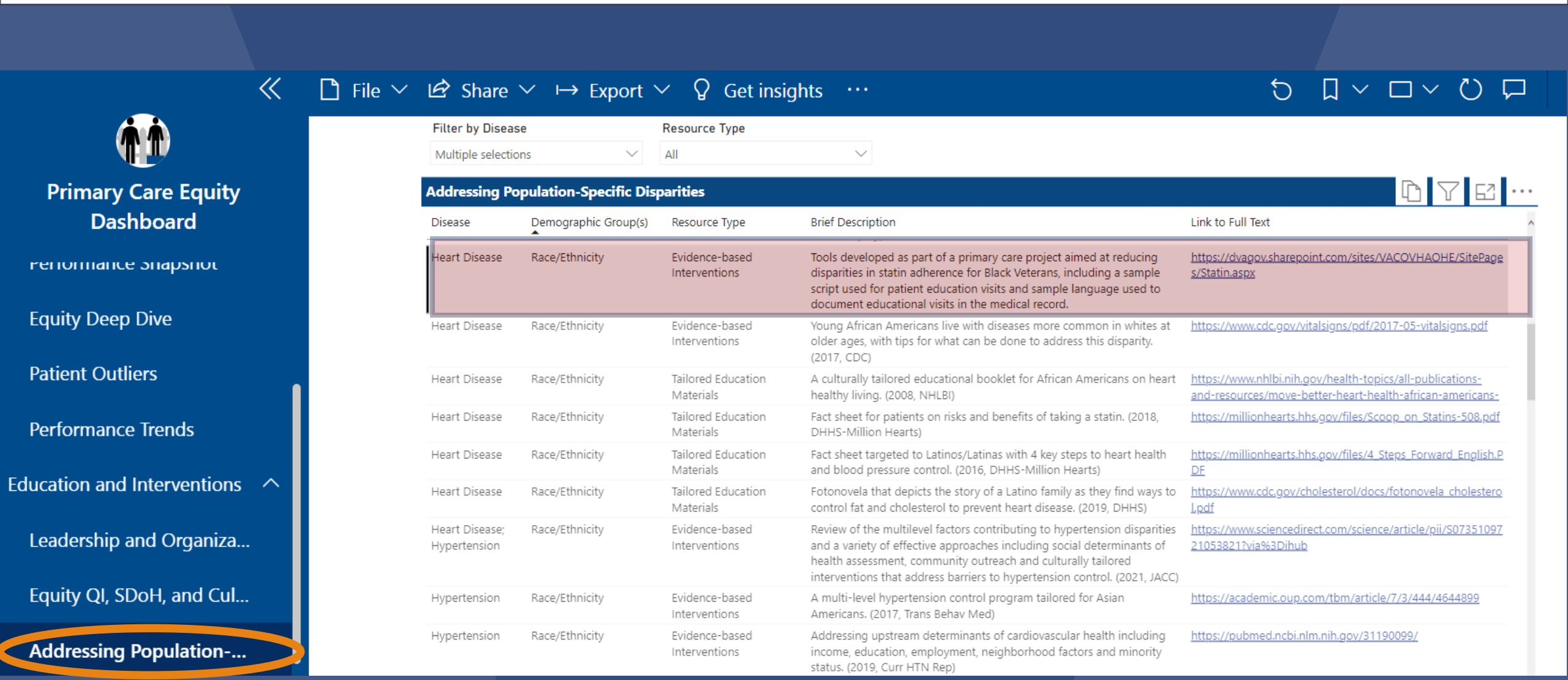
ACORN

(Assessing Circumstances & Offering Resources for Needs)

Systematically identify and address unmet social needs among all Veterans to improve health and advance health equity

https://dvagov.sharepoint.com/sites/VACOVHAOHE/SitePages/Social-Determinants-of-Health.aspx

ADDRESSING POPULATION-SPECIFIC DISPARITIES



Disease	Demographic Group(s)	Resource Type	Brief Description	Link to Full Text
Heart Disease	Race/Ethnicity	Evidence-based Interventions	Tools developed as part of a primary care project aimed at reducing disparities in statin adherence for Black Veterans, including a sample script used for patient education visits and sample language used to document educational visits in the medical record.	https://dvagov.sharepoint.com/sites/VACOVHAOHE/SitePages/Statin.aspx
Heart Disease	Race/Ethnicity	Evidence-based Interventions	Young African Americans live with diseases more common in whites at older ages, with tips for what can be done to address this disparity. (2017, CDC)	https://www.cdc.gov/vitalsigns/pdf/2017-05-vitalsigns.pdf
Heart Disease	Race/Ethnicity	Tailored Education Materials	A culturally tailored educational booklet for African Americans on heart healthy living. (2008, NHLBI)	https://www.nhlbi.nih.gov/health-topics/all-publications-and-resources/move-better-heart-health-african-americans-
Heart Disease	Race/Ethnicity	Tailored Education Materials	Fact sheet for patients on risks and benefits of taking a statin. (2018, DHHS-Million Hearts)	https://millionhearts.hhs.gov/files/Scoop_on_Statins-508.pdf
Heart Disease	Race/Ethnicity	Tailored Education Materials	Fact sheet targeted to Latinos/Latinas with 4 key steps to heart health and blood pressure control. (2016, DHHS-Million Hearts)	https://millionhearts.hhs.gov/files/4_Steps_Forward_English.PDF
Heart Disease	Race/Ethnicity	Tailored Education Materials	Fotonovela that depicts the story of a Latino family as they find ways to control fat and cholesterol to prevent heart disease. (2019, DHHS)	https://www.cdc.gov/cholesterol/docs/fotonovela_cholesterol.pdf
Heart Disease; Hypertension	Race/Ethnicity	Evidence-based Interventions	Review of the multilevel factors contributing to hypertension disparities and a variety of effective approaches including social determinants of health assessment, community outreach and culturally tailored interventions that address barriers to hypertension control. (2021, JACC)	https://www.sciencedirect.com/science/article/pii/S0735109721053821?via%3Dihub
Hypertension	Race/Ethnicity	Evidence-based Interventions	A multi-level hypertension control program tailored for Asian Americans. (2017, Trans Behav Med)	https://academic.oup.com/tbm/article/7/3/444/4644899
Hypertension	Race/Ethnicity	Evidence-based Interventions	Addressing upstream determinants of cardiovascular health including income, education, employment, neighborhood factors and minority status. (2019, Curr HTN Rep)	https://pubmed.ncbi.nlm.nih.gov/31190099/

PCED Users Across VISNs and VACO

1406 unique users (FY23 Q2)

VISN	Frequency	Percent
1	72	5.1
2	74	5.3
3	2	0.1
4	106	7.5
5	65	4.6
6	53	3.8
7	79	5.6
8	69	4.9
9	41	2.9
10	74	5.3
11	1	0.1
12	51	3.6
15	209	14.9
16	36	2.6
17	124	8.8
18	3	0.2
19	29	2.1
20	39	2.8
21	94	6.7
22	68	4.8
23	78	5.5
VACO	39	2.8
Total	1,406	100

Summary and Upcoming Updates

- PCED is a user-friendly tool that is being used to identify and support equity-guided improvement at VA facilities
- Available to all VHA employees, it is being used in VA facilities across the country
- Next release (anticipated Fall, 2023) will include more eQM measures and increased patient outlier access for individuals supporting multiple VA medical centers

Additional Resources Available on SharePoint

https://dvagov.sharepoint.com/sites/VACOVHAOHE/SitePages/Test.aspx

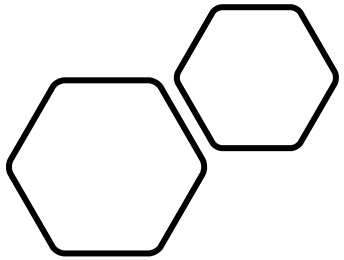
- PCED SharePoint
- Introductory Tutorial (CE credit available)
- Guide for Facilitating Implementation of PCED
- Webinars, case examples, and links to other equity resources in VA

ACORN

- Email: VHAACORN@va.gov
- ACORN Screening Tool
- ACORN SharePoint
- VHA Office of Health Equity
- VHA Social Work

From *Desperation* to Innovation!

Improving Hypertension and Racial Disparities in Veterans at an Academic VA Clinic via a targeted Population Health Strategy



- **Rhonda Hamilton, MD MPH**
- Primary Care, Medical Director, VA Palo Alto
- Clinical Asst. Prof. (affiliated/Clinician Ed) Medicine & Primary Care/Population Health at Stanford Univ. School of Medicine

Blood Pressure (DM) Metric
7/15/21

Rationale	Goal is to increase number of DM patients with BP <140/90
Numerator	Patients with DM and declines BP med; age <75 with either SBP <140 or DBP <90
Denominator	Patients with DM, and age 75 or below
Target	75%
Score Direction	Higher is better

SAIL - eQM

Definition - ⓘ	Score Date 7/15/2021				
Division	Score	Target	Numerator	Actionable Patients	Denominator
DM: BP< 140/90 (dmg27h_ec) ⓘ					
(640) Palo Alto HCS (Palo Alto CA)	44.8 ⊗	75	2,400	2,960	5,360
PALO ALTO, CAC	50.7 ⊗	75	37	36	73
PALO ALTO, FOC	49.3 ⊗	75	458	471	929
PALO ALTO, FRC	34.7 ⊗	75	107	201	308
PALO ALTO, LD	45.8 ⊗	75	132	156	288
PALO ALTO, MOC	39.5 ⊗	75	307	471	778
PALO ALTO, PAD	48.7 ⊗	75	492	519	1,011
PALO ALTO, SJC	38.6 ⊗	75	321	511	832
PALO ALTO, SOC	41.9 ⊗	75	99	137	236
PALO ALTO, STC	49.2 ⊗	75	442	457	899

Blood Pressure (HTN) Metric
7/15/21

Rationale	Goal is to increase number of HTN patients with BP <140/90
Numerator	Patients with either SBP <140 or DBP <90
Denominator	Patients with HTN diagnosis and age 85 or below
Target	89%
Score Direction	Higher is better

Definition - ⓘ	Score Date 7/15/2021				
Division	**Score**	**Target**	**Numerator**	**Actionable Patients**	**Denominator**
HTN: Dx HTN with BP less than 140/90 (ihd53h_ec) ⓘ					
(640) Palo Alto HCS (Palo Alto CA)	59.4 ⊗	89	3,570	2,443	6,013
PALO ALTO, CAC	66.5 ⊗	89	103	52	155
PALO ALTO, FOC	62.7 ⊗	89	694	413	1,107
PALO ALTO, FRC	46.9 ⊗	89	113	128	241
PALO ALTO, LD	66.0 ⊗	89	200	103	303
PALO ALTO, MOC	51.0 ⊗	89	374	359	733
PALO ALTO, PAD	64.4 ⊗	89	820	454	1,274
PALO ALTO, SJC	56.8 ⊗	89	429	326	755
PALO ALTO, SOC	44.8 ⊗	89	197	243	440
PALO ALTO, STC	63.7 ⊗	89	643	367	1,010

Veterans w/DM2 & HTN with controlled BP 10/2021-01/2022

Considered Equity at the start of our intervention

Distance from National Score and Population Size by Patient Demographics

RACE/ETHNICITY

	Avg. Patients per Month	Score	Absolute Diff. from National
Asian	102	62.4 %	3.9 %
Black	183	57.8 %	8.4 %
Hispanic	138	59.2 %	7.1 %
HI/Pac Island	38	50.0 %	16.2 %
White	442	62.9 %	3.3 %

SEX/GENDER

	Avg. Patients per Month	Score	Absolute Diff from Nationa
Female	87	71.3 %	5.1 %
Male	924	59.3 %	7.0 %

NEIGHBORHOOD POVERTY LEVEL

	Avg. Patients per Month	Score	Absolute Diff. from National
Lives in low poverty area	986	60.3 %	5.9 %

RURALITY

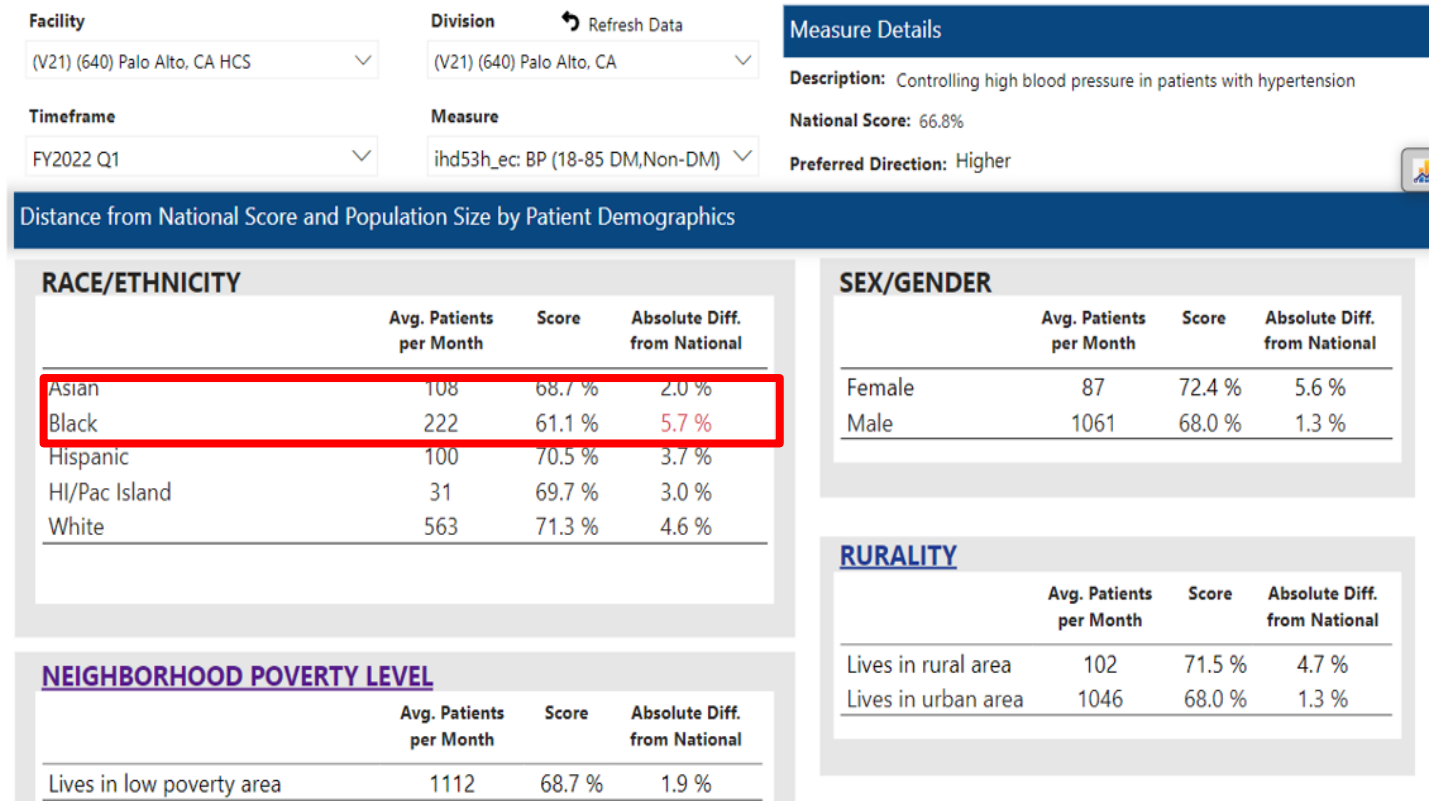
	Avg. Patients per Month	Score	Absolute Diff from Nationa
Lives in rural area	95	57.7 %	8.5 %
Lives in urban area	915	60.6 %	5.6 %

Slide from
Leslie Hausmann PhD, Asst. Dean Medical Student Research, Univ. Pittsburgh Sch Med
Ernest Moy, MD Exec.Dir. Office of Health Equity, VHA,

Veterans w/HTN with controlled BP

10/2021-01/2022

Effectiveness of our Institution relies on Honest Assessment of Disparity



Facility: (V21) (640) Palo Alto, CA HCS

Division: (V21) (640) Palo Alto, CA — Refresh Data

Timeframe: FY2022 Q1

Measure: ihd53h_ec: BP (18-85 DM,Non-DM)

Measure Details

Description: Controlling high blood pressure in patients with hypertension

National Score: 66.8%

Preferred Direction: Higher

Distance from National Score and Population Size by Patient Demographics

RACE/ETHNICITY

	Avg. Patients per Month	Score	Absolute Diff. from National
Asian	108	68.7 %	2.0 %
Black	222	61.1 %	5.7 %
Hispanic	100	70.5 %	3.7 %
HI/Pac Island	31	69.7 %	3.0 %
White	563	71.3 %	4.6 %

SEX/GENDER

	Avg. Patients per Month	Score	Absolute Diff. from National
Female	87	72.4 %	5.6 %
Male	1061	68.0 %	1.3 %

NEIGHBORHOOD POVERTY LEVEL

	Avg. Patients per Month	Score	Absolute Diff. from National
Lives in low poverty area	1112	68.7 %	1.9 %

RURALITY

	Avg. Patients per Month	Score	Absolute Diff. from National
Lives in rural area	102	71.5 %	4.7 %
Lives in urban area	1046	68.0 %	1.3 %

Slide from

Leslie Hausmann PhD, Asst. Dean Medical Student Research, Univ. Pittsburgh Sch Med

Ernest Moy, MD Exec.Dir. Office of Health Equity, VHA,

Student Volunteer Training

Putting Training into Action

Color coding spreadsheet (Who needs a BP cuff sent? Who needs a call back to gather the self-reported BP log?)

Students Strategizing: PDCA (Plan, Do, Check, Act)

Script Amended to meet Veteran's Needs

Call begins

Student: Hello, my name is ____, I am a student volunteer working with your primary care team here at the VA Palo Alto. Is this _____ (patient's name)? Great! I am calling because your primary care team would like to collect home blood pressure readings. Is that ok with you and is this a good time to talk?

Patient: Yes/no

If no: What is the best day and time to call you back?

If yes: Wonderful! Your Care team would like for you to log your blood pressure 10x, which should take about a week.

Student: Do you have a VA issued blood pressure cuff at home?

Patient: Yes/no

If no: That's okay. I will make sure to let your PACT team know, and we will send another one to you free of charge. It will be there in 1-2 weeks and we can schedule a follow up appointment in 2-3 weeks so that we can collect those blood pressure readings. Are you available at _____ (this time and date)? (skip to highlighted part at the bottom)

If yes: Perfect!

Student: Do you have any recent blood pressure readings that you can give us now?

Patient: Yes/no

If no: That's okay we can schedule a follow up appointment in one week to collect the blood pressure readings. Are you available at _____ (this time and date)?

Great! There are a few steps to make sure that we can get an accurate reading for your blood pressure.

First, make sure to rest for 5 to 10 minutes before you take your BP. Make sure to wait until you feel completely relaxed.

Second, make sure that your arm is at the same level as your heart.

The easiest way to do this is to rest your arm on a counter. Then you can push start.

Blood Pressure (DM) Metric
7/15/21 – Highest Risk group, poor control

Rationale	Goal is to increase number of DM patients with BP <140/90
Numerator	Patients with DM and declines BP med; age <75 with either SBP <140 or DBP <90
Denominator	Patients with DM, and age 75 or below
Target	75%
Score Direction	Higher is better

SAIL - eQM

Definition - ⓘ	Score Date 7/15/2021				
Division	**Score**	**Target**	**Numerator**	**Actionable Patients**	**Denominator**
DM: BP< 140/90 (dmg27h_ec) ⓘ					
(640) Palo Alto HCS (Palo Alto CA)	44.8 ⊗	75	2,400	2,960	5,360
PALO ALTO, CAC	50.7 ⊗	75	37	36	73
PALO ALTO, FOC	49.3 ⊗	75	458	471	929
PALO ALTO, FRC	34.7 ⊗	75	107	201	308
PALO ALTO, LD	45.8 ⊗	75	132	156	288
PALO ALTO, MOC	39.5 ⊗	75	307	471	778
PALO ALTO, PAD	48.7 ⊗	75	492	519	1,011
PALO ALTO, SJC	38.6 ⊗	75	321	511	832
PALO ALTO, SOC	41.9 ⊗	75	99	137	236
PALO ALTO, STC	49.2 ⊗	75	442	457	899

Blood Pressure (DM) Metric
8/26/22 – Exceeding Expectations!

SAIL - eQM

Definition - ⓘ	Score Date 8/25/2022				
Division	**Score**	**Target**	**Numerator**	**Actionable Patients**	**Denominator**
DM: BP< 140/90 (dmg27h_ec) ⓘ					
(640) Palo Alto HCS (Palo Alto CA)	68.2 ⊗	75	4,489	2,097	6,586
PALO ALTO, CAC	63.1 ⊗	75	53	31	84
PALO ALTO, FOC	63.4 ⊗	75	711	411	1,122
PALO ALTO, FRC	58.3 ⊗	75	235	168	403
PALO ALTO, LD	77.6 ✓	75	309	89	398
PALO ALTO, MOC	63.5 ⊗	75	587	337	924
PALO ALTO, PAD	77.0 ✓	75	1,018	304	1,322
PALO ALTO, SJC	66.8 ⊗	75	659	327	986
PALO ALTO, SOC	67.5 ⊗	75	181	87	268
PALO ALTO, STC	68.4 ⊗	75	733	338	1,071

Blood Pressure (HTN) Metric
7/15/21 – Poor HTN control across the board

Rationale	Goal is to increase number of HTN patients with BP <140/90
Numerator	Patients with either SBP <140 or DBP <90
Denominator	Patients with HTN diagnosis and age 85 or below
Target	89%
Score Direction	Higher is better

Definition - ⓘ	Score Date 7/15/2021				
Division	**Score**	**Target**	**Numerator**	**Actionable Patients**	**Denominator**
HTN: Dx HTN with BP less than 140/90 (ihd53h_ec) ⓘ					
(640) Palo Alto HCS (Palo Alto CA)	59.4 ⊗	89	3,570	2,443	6,013
PALO ALTO, CAC	66.5 ⊗	89	103	52	155
PALO ALTO, FOC	62.7 ⊗	89	694	413	1,107
PALO ALTO, FRC	46.9 ⊗	89	113	128	241
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PALO ALTO, MOC	51.0 ⊗	89	374	359	733
PALO ALTO, PAD	64.4 ⊗	89	820	454	1,274
PALO ALTO, SJC	56.8 ⊗	89	429	326	755
PALO ALTO, SOC	44.8 ⊗	89	197	243	440
PALO ALTO, STC	63.7 ⊗	89	643	367	1,010

Blood Pressure (HTN) Metric
8/26/22 – Exceeding expectations!

SAIL - eQM

Definition - ⓘ	Score Date 8/25/2022				
Division	**Score**	**Target**	**Numerator**	**Actionable Patients**	**Denominator**
HTN: Dx HTN with BP less than 140/90 (ihd53h_ec) ⓘ					
(640) Palo Alto HCS (Palo Alto CA)	65.2 ✓	63	8,360	4,465	12,825
PALO ALTO, CAC	61.2 ⊗	63	170	108	278
PALO ALTO, FOC	58.2 ⊗	63	1,297	930	2,227
PALO ALTO, FRC	56.9 ⊗	63	449	340	789
PALO ALTO, LD	74.0 ✓	63	608	214	822
PALO ALTO, MOC	56.8 ⊗	63	868	660	1,528
PALO ALTO, PAD	80.5 ✓	63	1,884	455	2,339
PALO ALTO, SJC	65.4 ✓	63	1,271	672	1,943
PALO ALTO, SOC	57.5 ⊗	63	473	350	823
PALO ALTO, STC	64.5 ✓	63	1,343	740	2,083

“A Rising Tide Lifts all Boats.”

Intervention Shaped to meet the needs of Black veterans – improved care for all veterans

Diabetic patients w/HTN Jan 2022- Black pts 8.4 % below National Average of 66.2%

RACE/ETHNICITY

	Avg. Patients per Month	Score	Absolute Diff. from National
Asian	102	62.4 %	3.9 %
Black	183	57.8 %	8.4 %
Hispanic	138	59.2 %	7.1 %
HI/Pac Island	38	50.0 %	16.2 %
White	442	62.9 %	3.3 %

Diabetic patients w/HTN 8/2022- Blacks pts only 0.6% below National Average of 68.7%

RACE/ETHNICITY

	Avg. Patients per Month	Score	Absolute Diff. from National
Asian	118	79.7 %	11.1 %
Black	221	68.1 %	0.6 %
Hispanic	159	71.6 %	3.0 %
HI/Pac Island	50	58.9 %	9.8 %
White	579	71.3 %	2.6 %

Closing Disparities, one Veteran at a time!

Veterans w/HTN (all comers) Jan 2022 – 5.7%
Disparity (compared to Nat'l avg of 66.8%)

RACE/ETHNICITY

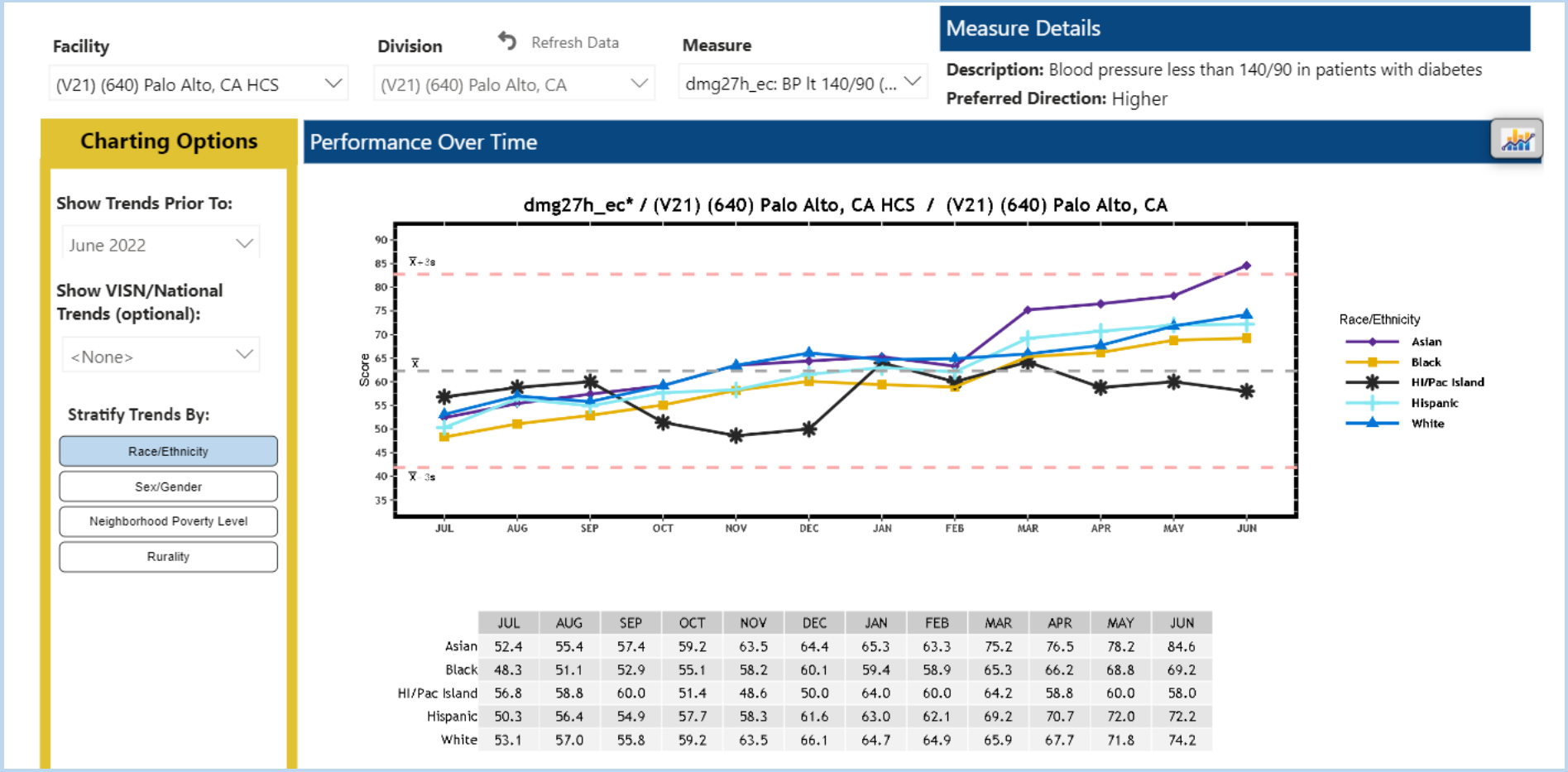
	Avg. Patients per Month	Score	Absolute Diff. from National
Asian	108	68.7 %	2.0 %
Black	222	61.1 %	5.7 %
Hispanic	100	70.5 %	3.7 %
HI/Pac Island	31	69.7 %	3.0 %
White	563	71.3 %	4.6 %

- Veterans w/HTN (all comers) Aug 2022- Disparity Closed! (compared to Nat'l avg of 65.9%)

RACE/ETHNICITY

	Avg. Patients per Month	Score	Absolute Diff. from National
Asian	202	75.6 %	9.7 %
Black	367	71.4 %	5.5 %
Hispanic	199	71.8 %	5.9 %
HI/Pac Island	68	71.1 %	5.2 %
White	1164	73.3 %	7.4 %

Trends-Race/Ethnicity: Jun 2022 and prior year, Palo Alto Division, Blood pressure in patients with diabetes



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
Asian	52.4	55.4	57.4	59.2	63.5	64.4	65.3	63.3	75.2	76.5	78.2	84.6
Black	48.3	51.1	52.9	55.1	58.2	60.1	59.4	58.9	65.3	66.2	68.8	69.2
HI/Pac Island	56.8	58.8	60.0	51.4	48.6	50.0	64.0	60.0	64.2	58.8	60.0	58.0
Hispanic	50.3	56.4	54.9	57.7	58.3	61.6	63.0	62.1	69.2	70.7	72.0	72.2
White	53.1	57.0	55.8	59.2	63.5	66.1	64.7	64.9	65.9	67.7	71.8	74.2

*Trends data thru June 2022 is the most recent PCED has available

Trends-Race/Ethnicity: Jun 2022 and prior year, Palo Alto Division, Blood pressure in patients with hypertension

Facility (V21) (640) Palo Alto, CA HCS

Division (V21) (640) Palo Alto, CA — Refresh Data

Measure ihd53h_ec: BP (18-85 DM,...

Measure Details

Description: Controlling high blood pressure in patients with hypertension
Preferred Direction: Higher

Charting Options

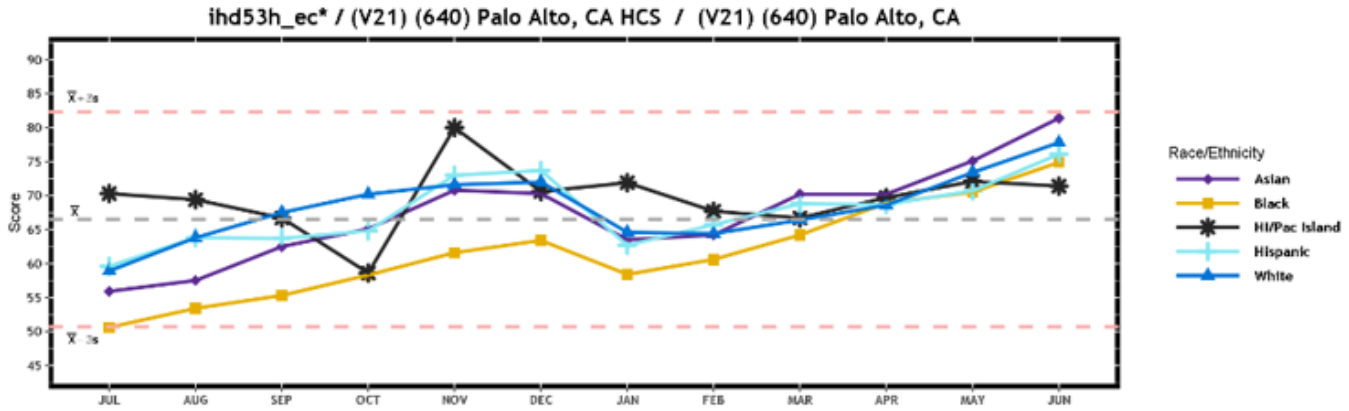
Show Trends Prior To: June 2022

Show VISN/National Trends (optional): <None>

Stratify Trends By:

- Race/Ethnicity
- Sex/Gender
- Neighborhood Poverty Level
- Rurality

Performance Over Time

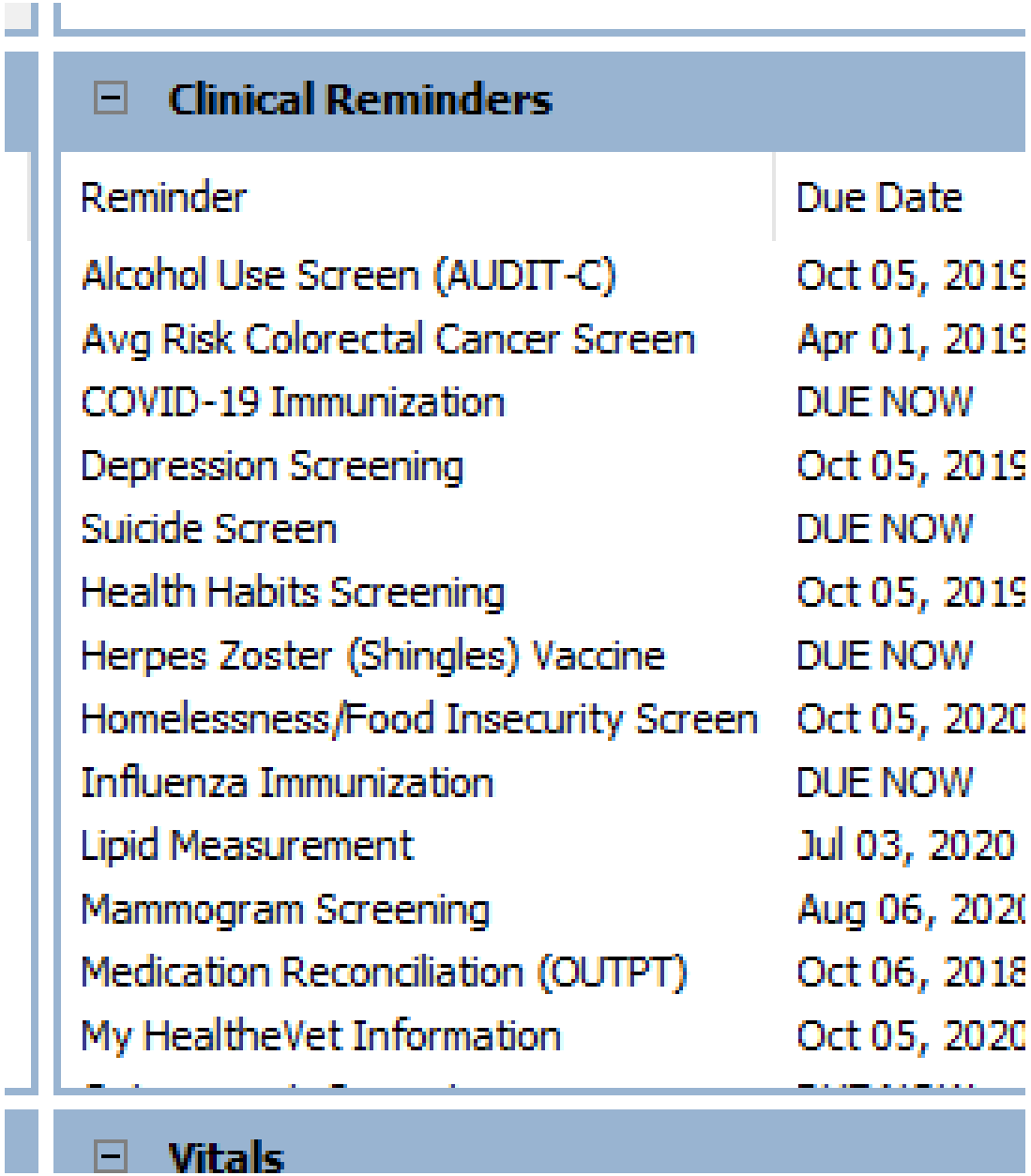


	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
Asian	55.9	57.5	62.5	65.1	70.8	70.3	63.5	64.2	70.2	70.2	75.1	81.4
Black	50.6	53.4	55.3	58.3	61.6	63.4	58.4	60.6	64.2	68.9	70.5	74.9
HI/Pac Island	70.3	69.4	66.7	58.6	80.0	70.6	71.9	67.7	66.7	69.7	72.1	71.4
Hispanic	59.6	63.8	63.7	64.8	73.0	73.7	62.7	65.7	68.8	68.7	70.7	76.1
White	58.9	63.8	67.5	70.2	71.6	72.0	64.6	64.4	66.4	68.6	73.4	77.8

*Trends data thru June 2022 is the most recent PCED has available

Prevention Clinic

The Asynchronous Resolution of Reminders!!

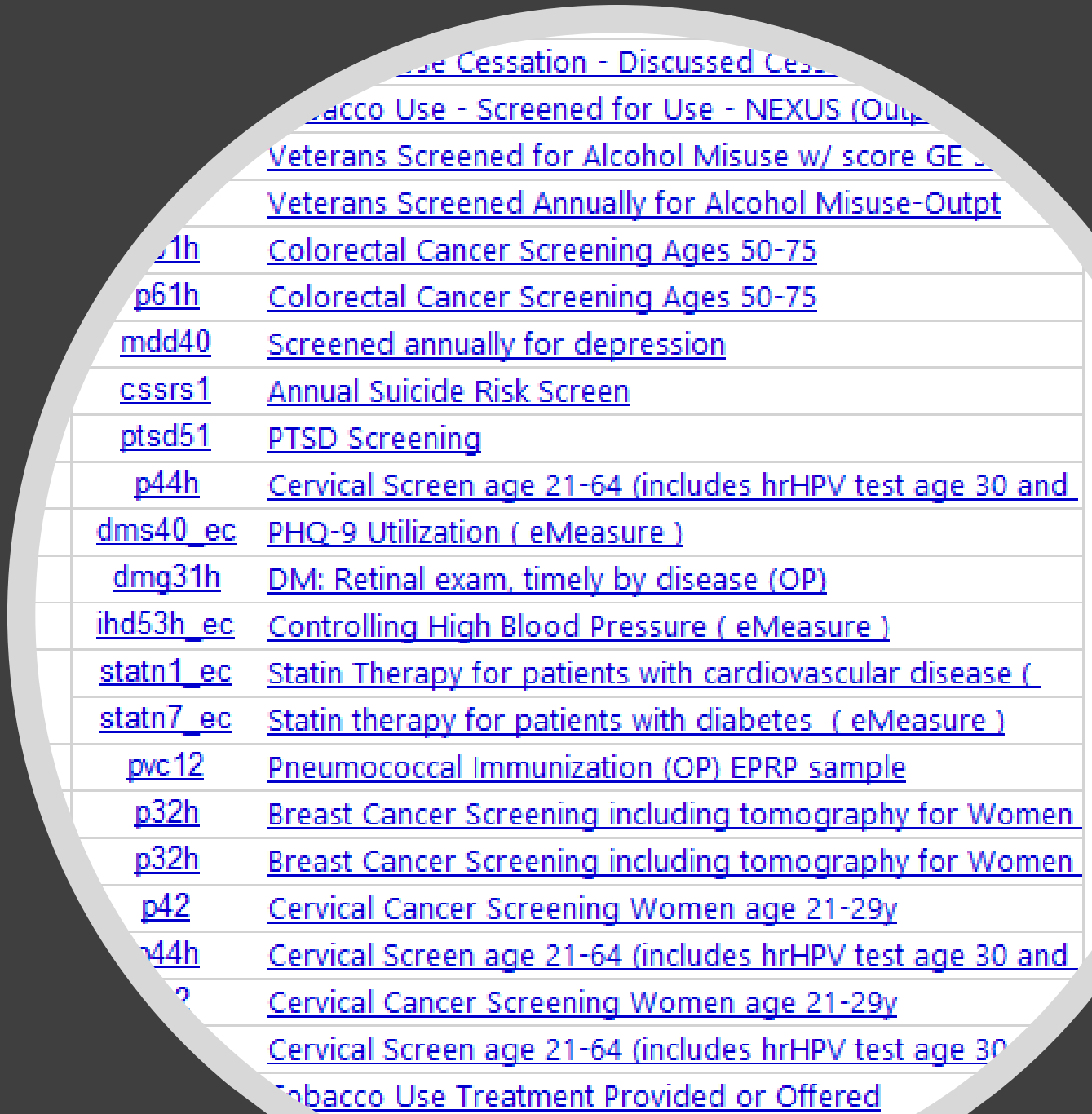


Clinical Reminders

Reminder	Due Date
Alcohol Use Screen (AUDIT-C)	Oct 05, 2019
Avg Risk Colorectal Cancer Screen	Apr 01, 2019
COVID-19 Immunization	DUE NOW
Depression Screening	Oct 05, 2019
Suicide Screen	DUE NOW
Health Habits Screening	Oct 05, 2019
Herpes Zoster (Shingles) Vaccine	DUE NOW
Homelessness/Food Insecurity Screen	Oct 05, 2020
Influenza Immunization	DUE NOW
Lipid Measurement	Jul 03, 2020
Mammogram Screening	Aug 06, 2020
Medication Reconciliation (OUTPT)	Oct 06, 2018
My HealtheVet Information	Oct 05, 2020

Vitals

SAIL Metrics Are Captured by *CLINICAL REMINDERS!*



	Cessation - Discussed Ces
	acco Use - Screened for Use - NEXUS (Out
	Veterans Screened for Alcohol Misuse w/ score GE
	Veterans Screened Annually for Alcohol Misuse-Outpt
1h	Colorectal Cancer Screening Ages 50-75
p61h	Colorectal Cancer Screening Ages 50-75
mdd40	Screened annually for depression
cssrs1	Annual Suicide Risk Screen
ptsd51	PTSD Screening
p44h	Cervical Screen age 21-64 (includes hrHPV test age 30 and
dms40_ec	PHQ-9 Utilization (eMeasure)
dmg31h	DM: Retinal exam, timely by disease (OP)
ihd53h_ec	Controlling High Blood Pressure (eMeasure)
statn1_ec	Statin Therapy for patients with cardiovascular disease (
statn7_ec	Statin therapy for patients with diabetes (eMeasure)
pvc12	Pneumococcal Immunization (OP) EPRP sample
p32h	Breast Cancer Screening including tomography for Women
p32h	Breast Cancer Screening including tomography for Women
p42	Cervical Cancer Screening Women age 21-29y
44h	Cervical Screen age 21-64 (includes hrHPV test age 30 and
2	Cervical Cancer Screening Women age 21-29y
	Cervical Screen age 21-64 (includes hrHPV test age 30
	bacco Use Treatment Provided or Offered

Hard Wire Improving Disparities

Measure & Assess Equity & Disparities at our Institution to inform each Health Care initiative to improve our Organization's Effectiveness

Integrate Asynchronous Prevention Clinic into Stanford Residency Rotations & forge relationships w/Nursing/PA Schools

Recruit Student Volunteers from Communities of Color, Community Colleges, Churches