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Session: Using Veterans’ Stories to Promote Health Equity and Reduce Disparities

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Dr. Uchenna Uchendu: Thank you, everyone, for joining us. If you've been doing the series with us, you would know that we usually call for timely health equity topics on these sessions. And today I promise you you’ll be excited with the work that Dr. Houston and his group has done and what we are doing with it going forward, as well as the new retro patient health equity training modules which we'll be showing you today. This is what you can expect. The background is VHA Health Equity Action Plan, otherwise called the HEAP. Then we'll tell you about using patient stories to reduce hypertension-related disparities. That’s the research work of Dr. Houston and his team. I will give you some snippets about the virtual patient health equity training modules with the hope that you'll go back and actually do the modules yourself. We were hoping to do some demo. We may succeed or not, depending on how technology rewards our efforts. Otherwise, it’s also available to you to access. And then we’ll discuss some possible next steps and possibilities, and of course, we are always open to your input as well.

This is about the Office of Health Equity. Forgive me if you've heard it before, but we can’t say it enough because it’s our mission to advance health equity and reduce health disparities for all Veterans. And we're doing that through multiple avenues, one of which we are showcasing today, which is capitalizing on existing networks. That will be the fourth bullet, the third bullet down on the mission to advance health equity. We don’t intend to recreate the wheels. We tap into resources that are within our system as well, and we champion the efforts both within and outside of VHA. The intent is the ultimate outcome for the Veteran. These are the Veteran vulnerable populations that we tend to refer to. I won’t read them to you, but again, you will notice that today's discussion will touch on many of these vulnerable groups.

And then, of course, the Health Equity Action Plan, the base on which this dialogue is coming off of. I want to underscore here that many of the areas are also highlighted in today’s discussion. The awareness part about the items we'll be sharing with you today advances our awareness for health equity. There are pieces of it that will touch the health system life experience of Veterans. I mean the idea of using the Veterans stories to create, to do research and to create a product that will advance Veterans health. We also will be touching on social determinants of health on some of the aspects of it, and of course, we show the partnership between research and program office and operations at its best. So you can see that the tenets of today’s discussion align very much with the Health Equity Action Plan.

And so with that, Molly, you will be getting the audience engaged for the first poll question.

Molly: Thanks, Uchenna! Thank you so much. And for our attendees, as you can see on your screen, there is a poll question up. How often do you use Veterans stories or narratives in your work? Do you always use them, sometimes use them, or rarely or never use them in your work? Please just go ahead and click at the, on the circle right there on your screen next to your response. And it looks like we have already had 70% reply, so that’s great. Give people a few more seconds to get their responses in. Alright, I am going to go ahead and close this out and share those results. So 15% always use them, 44% sometimes do, and 41% rarely or never do. So, thank you to those respondents. And we are back on your slides, Uchenna.

Dr. Uchenna Uchendu: Okay, great, you can still see my screen?

Molly: Correct.

Dr. Uchenna Uchendu: Okay. Thank you, everyone, for responding. I am glad that some people do, and hopefully after listening to us today, you will do so even more. And with that, I'll be turning it over to Dr. Thomas Houston already introduced earlier by Molly, and you will hear his voice next.

Dr. Thomas Houston: Great! Well, thanks very much. So, Molly, you can hear me okay?

Molly: Yeah, you sound great. Thank you.

Dr. Thomas Houston: Great! So I'm going to talk about using Veterans stories to promote health equity and reduce disparities. So we have funding from the Department of Veterans Affairs, the Health Services Research and Development group, and we have done a project that basically goes into the community, talks to Veterans, and helps understand their stories of success of how they have controlled their blood pressure. And then what we do is we package them and deliver them to other Veterans as an intervention, as an interactive DVD.

So you can see on this slide is our team of investigators from multiple sites across the VA. And so, in addition to the funding we have received from VA, we've also done projects funded by NIH and the Robert Wood Johnson Foundation. And this study is built on a previous project that was a single site study done in Birmingham, Alabama, funded by Robert Wood Johnson Foundation, published in the Annals of Internal Medicine, where we found that these stories telling DVDs could help people better control their blood pressure.

So we can switch slides. And so, just as a background, so African Americans do have higher rates of hypertension and higher rates of uncontrolled hypertension compared to whites. Educational interventions themselves may have some benefit, but they really have limited success in controlling blood pressure alone. And so initiating, beginning with some discussions, gosh, over 10 years ago now, we started talking about telling stories and how stories are a way we make meaning out of our lives and how we live through stories. And we learn through stories.

So, I would say that when I was in medical school, one of the primary ways that I learned was through stories. I certainly read text books, but talking to the other doctors was an important way I learned. And it enhances the relevance. Right? And it makes it personally meaningful if you hear from someone who is, like you, telling stories. African Americans patients definitely have strong oral traditions, which makes stories essential part of their communication. And narrative communication, which is another way of saying storytelling, is an important intervention strategy. And so, you know, if you introduce it with, start with facts, sometimes people can begin to counter argue. But if you begin with a story, people get emotionally engaged and interested, and then you can follow up with education.

So we'll go to our next slide. So we conducted a trial, a randomized trial, of three sites in the VA of a storytelling intervention. So what we did was compared it with an education-only control. So our hypothesis was that compared with an education-only control, a stories plus education intervention would result in lower blood pressure at six months.

So how did we do the study? So this is the scientific methods. So we randomized at the patient level. And we had three sites, and each site had separate randomization. So in addition to analyzing the overall study, we could un-analyze by site. We wanted to do better than our single site study, the study that had gone before, and in a couple of ways. One was being more than one site and seeing if we could roll something out and scale it more nationally as compared to a single place. And the other is to have a stronger comparison and very strong educational control group. And the third was to collect better information about mediating factors, so how the DVD might be working.

And so then we started on this step study, and so what we did is we recruited 619 African Americans with uncontrolled blood pressure, based on their medical record at three sites across the VA. And as I said, we had this strong education-only control group, and the intervention had the same educational information plus actual stories of African American Veterans talking about how they had controlled their blood pressure.

So this is a screen shot of the first page of the DVD, the main screen. And so what people could do is choose which story, which person they wanted to view first, and then after each story they were able to learn more information about the person, and then they could choose to watch as many stories as they wanted. So on average, people watched about three stories of the five stories you see here. And one of the most fun parts of the project is we worked with people in the theater arts. So there's a number of interventions, or actually theater presentations that had people come and tell their own stories instead of, like famous people coming and telling their stories. Real people from the community.

So there's one in Baltimore, Maryland, that's called The Stoop, and they have people, and it’s been running for over 15 years now, that come and tell their stories. And so the folks from The Stoop storytelling tradition in Baltimore helped us think about how to use theater arts techniques and not to put words in people’s mouths, but how to take good storytellers and help them tell great stories through a little bit of storytelling coaching. The other thing that you'll notice is that these Veterans are in clinic settings, and so we really tried to make the videos as real as possible, sort of in the theme of reality TV. Right? So we didn’t put them in a studio, make the lighting perfect. The Veterans were in the settings where Veterans would be familiar with coming to the VA hospital.

So data collection. So we conducted surveys at baseline and then right after viewing the DVDs and 6 months follow-up. And then we had formal testing of blood pressure using a standardized protocol with three blood pressure measurements and an average at baseline and at 6-month follow-up.

So who were the Veterans we recruited? So 92% of our Veterans were male. So they, again, just to remind everyone, these were all African Americans with uncontrolled hypertension. Ninety-one percent of them were over 50 years old, 47 had diabetes, 92% had high school graduation or beyond. It was a vulnerable population, 53% earning less than $20,000 a year. Twenty-two percent reported that they were unstably housed, and 35% did not think their blood pressure was under control, and 40% reported that they had inadequate health literacy based on a standard instrument. And there were no significant differences in these characteristics between the intervention and control groups, which basically means randomization was nicely balanced.

 And so this is our first step. So this is immediately after watching the DVD, we asked people a set of questions. And this is a scale that we published and used before that asks about the, both the intellectual and emotional engagement in stories and how relevant the stories are to your daily lives. And what we found before is that stories are emotionally engaging, and that is one of the primary ingredients by which the stories work. And so we found that, again here, so based on our scale, which is a transportation scale, which means how much you were transported into the story.

The first row shows that the scale was higher in the intervention than control, and so the DVD affected people emotionally. There was also a borderline significant difference in emotional, I mean in personal relevance, that the DVDs were personally relevant, which would make sense because both the people that we had, the Veterans telling the stories, were designed to be similar to the Veterans we were delivering the story back to. And then, we did not find a difference in the intellectual engagement, which is consistent with our prior work. So the good news is that on our initial assessment of these behavioral constructs, people said that the stories were very emotionally engaging and relevant, which is what we expected.

So now we are going to talk about our main outcomes. So we had main outcomes, follow-up on the majority or our participants, so 527 of the 619. And so at baseline you can see that in the control group the blood pressure was 139/81.1, and the intervention was 137.8/80.2. And so there was no significant difference in the blood pressure readings among the intervention and the control group. And so then we fast forward 6 months later and we see that there was now a difference. So now there is a 3 millimeter mercury difference in systolic blood pressure and a 1.8 millimeter difference in diastolic blood pressure. And so the diastolic blood pressure was not statistically significantly different, but the systolic blood pressure was at a p=0.05. So we were really excited about this result.

And in conclusion, these patients who viewed the patient stories through the interactive DVD had significantly higher emotional engagement. Further, the stories resulted in a difference in blood pressure at follow-up, comparing the intervention and control. And so our main outcome manuscript for this study is currently under review, and we have a number of other publications that we would be happy to share with folks.

So changing behaviors to improve hypertension is difficult, and education alone is often not completely effective. So we found through this and other projects that patient stories can be an effective intervention component to approve, improve, sorry, patient intentions to change behavior, and this effect is likely mediated through emotional engagement. So, like, if you say how do the stories work because they emotionally engage the person. It’s just not, not just like lecturing. And the DVDs of patient stories may tap into the effect of peer intervention, but as opposed to having a live person talk with every Veteran, this is sort of easier to scale at a lower intensity and lower cost. And so then behavioral intentions are associated with clinical outcomes, and are, as we just showed, our preliminary analysis of the stories intervention suggests that there are differences in systolic blood pressure at six months’ follow-up.

So, ok, yup, yup.

Dr. Uchenna Uchendu: Thank you so much. With that transition, we are back to you, Molly, for poll question number two.

Molly: Thank you very much, Uchenna. So for our attendees, as you can see on your screen, there is the second poll question. Please just go ahead and click the circle next to your response. The question being how familiar are you with the Virtual Patient Training Modules developed by VA Office of Health Equity? I am very familiar, I am somewhat familiar, I am not familiar. And it looks like we've got a very responsive audience. About 66% have replied so far. We'll give people a few more seconds. Alright, it looks like we've capped off at right around 75%, so I'm going to close this out and share those results. Seven percent of our respondents said they were very familiar, 11% said somewhat familiar, 82% said not familiar. So thank you, and we are back on your slides, Uchenna.

Dr. Uchenna Uchendu: Thank you, Molly, and thank you, everyone. I think that gauge allows us to get an idea of how much we are able to get the word out. So with that I will make a transition into the next segment, and Dr. Houston is definitely staying on for questions and for the discussion toward the end, and you will see the connection between the two segments as well.

The slide you are currently looking at is a project that we undertook, with permission and agreement with Dr. Houston’s team, on the videos that they developed as part of the research project he just described to you to package that's in a format that makes it possible to reach Veterans beyond the cohorts that they were able to reach within the research. We figured if it’s that useful and that engaging and can impact people’s quality of life engagement in their care, we shouldn’t limit it to the 619 participants that had the benefit of being in the study.

And so the link you see here and just went live thanks to the EES program that worked with us, and thanks again to Steve Jones in my office, who was able to make the connection for our website. But you are welcome to look at it later, but that is next stages, going on with the video. So it’s a gift that’s going to keep on going, giving. There are some publications that Dr. Houston mentioned that will be coming out for those in the research community but also in aware of engaging Veterans and translating the work that the researchers do into a product that Veterans can touch and feel. This is definitely a great example of that.

I think I'm moving, okay. So the videos I mentioned, I will not go over them again, but these are some of the take-home points that we have put out on the website that I gave you the link on. As far as the other resources as well so that it just doesn’t end with watching the video but taking away elements from it. And again, this is [XXXX, 20:52.5] just beyond VA employees, it’s going to Veterans, their families, or anyone else who, you know, has issues with hypertension. I think there's something to take away from that.

And in creating, again, the environment of using stories to advance different causes or to get people to engage or to do better, what you see here on two panels is the panel on your left is taken verbatim from one of the publications that is related to the work that Dr. Houston and his group have been doing. Can stories influence African American patients’ intentions to change hypertension management behaviors, a randomized control trial which was published last year. And the link on the office of Health Equity page I showed you earlier on our tools page has the link to the full study. But what we did here was just take a snippet of some of the highlights from that on the left. I won’t read them to you, but the intention of putting that side by side with the virtual patient stories is the virtual patient training modules that I'm about to share with you as well involve collecting stories of Veterans' experiences that were related to social determinants of health and unconscious biases. And then the stories are intended to invoke reflection and engagement. I think some key words are coming out there. The virtual patient cases also use the menu of options to reflect a cross section of vulnerable populations.

The modules are easily accessible as you will find out. They are available online, and the virtual patient cases maximize the use of technology to impart knowledge and skills in a realistic decision-making simulation.

And at the bottom is what I already explained to you. The research team developed the DVDs like Dr. Houston explained earlier. Office of Health Equity partnered with Employee Education Service to repackage in a way that we can reach a wider audience.

These modules that I'm about to introduce you to are training modules that connect social determinants, conscious and unconscious biases, and also in health care in order to inform a well-rounded patient-centered equitable care plan and ultimate outcome. So far with the soft release I think the poll today shows that we haven’t gotten to as many of you as we would want to, but that’s good feedback. But so far, the people who has seen it, there has been some very positive feedback from Veterans and their families, from VA employees. The Military Health System Speaker Series featured portions of it recently. It’s available actually on YouTube as well. The American Academy of Medical Colleges picked it up for the med education portal, and then some of the public health communities, some federal agencies, and others. And so, we expect to reach those who we have not reached yet because I think these modules are useful for a lot of reasons.

We were able to use the simulation platform on that education, employee education service contract. The platform allowed us to do storytelling with the branching of the narrative, and then it’s interactive to elicit active participation that is not typical when you do a didactic format of instruction. And we provided content matter expertise and developed the modules from scratch. The scenarios are evolving and people depending on which, what you click or the answers you give, it takes you through different branches. The good news, however, is it allows you to come back to things you have missed because the system has the ability to notice that you missed some of those things, and so that’s the interactive nature of it. It allows reflection and reasoning, and it is easily accessible from about anywhere. It also provides an element that’s often important with health equity related training. The psychological safety of doing it on your own so that the pressure of, you know, how you react or what you may have done differently. You have that reflection by being able to engage on this module if you don’t chose to do it in a group setting.

There are two modules. One is rated E for everyone. It’s not a movie, but you know, just trying that analogy. So you can, you don’t have to be a clinician to benefit from that. In fact, I'm encouraging anyone who is a caregiver or who has ever been a patient or will be a patient to take a look at them. And then it contains multiple stories that illustrate variety of concepts. The menu of options with the stories allowed us to touch multiple vulnerabilities and sometimes one person represented an intersection of more than one vulnerability. For instance, someone who is female and who is Native American and who happens to live in a rural area, that you know, multiple intersection of vulnerabilities.

And then the second one is a module that targets clinicians primarily, but I've also had people who were non-clinicians who looked at it and took away elements from it. So whereas it’s walking through a primary care visit, it’s not your typical clinician focused primary care visits. We were not trying to teach people how to manage hypertension or manage diabetes. The intent of it was to pull out the social determinant elements that are often missed in such visits.

And these are some of the faces. None of them are real Veterans. I mean they are real people, but we, the stories were modified and so the stories don’t match the people or the names. I intended to put that disclaimer on the slide. So any likeness to any real person is purely coincidental.

And this is just giving you some snippets of what you will find in the modules. The one that is for everyone takes people through the social determinants of health. The social determinants definitions and depiction you see here is one that was developed by the Robert Wood Johnson Foundation. Interestingly, you heard Dr. Houston speak earlier about a portion of their work leading up to the current one also having been funded by some others including Robert Wood Johnson Foundation. There’s other depictions of it, but I felt like this one captured the essence much more than the others, and you will find it also on the elements.

And I stop on this slide often to remind people that actually the VA is uniquely positioned because we touch multiply elements of this. If you look beyond the health care aspect, the VA has impact on income from disability and pensions that Veterans get, disability-related income and pensions. And then also education; the VA has a GI bill on the, and then we provide healthcare. And so we, and then we also provide housing loans. And that's outside of the homelessness piece that has been a present, that was a presidential initiative with President Obama and I believe has continued.

So just remember that sometimes with social determinants people think of things outside the healthcare system. And I am sure you notice here that access is also part of it. But as a unit in VA, we actually touch multiple elements of the social determinants. What we need to do is harness those efforts well enough to connect the dots.

I wanted to share some definitions here because that’s part of what you'll see in the modules as we go through the elements involved. These definitions are not mine, they’re actually dictionary definitions of the terminologies. Stereotypes are efficient knowledge structures people use to categorize others based on socially agreed upon normative beliefs about the group. And prejudice is the acceptance and endorsement of prevailing stereotypes. Discrimination occurs when people act upon the prejudices. If you notice they are flowing one after the other for a reason because I am trying to make the connection of the dots in there. Additionally, bias, the noun, is prejudice in favor of or against one thing, person, or group compared to another, usually in a way that is considered unfair or lacks neutral viewpoint. You noticed I had bias the verb and bias the noun for a reason. The verb is action, and so the noun defines the word bias, but causing people to feel or show inclination of prejudice for or against someone or something is the action part of the bias. And so having a bias in itself is not necessarily an issue, it’s what you do with the bias that becomes the issue, and that’s the point I wanted to highlight there.

And so on the realm of talking about biases, there are some that are conscious which we're not getting in to today. But the unconscious biases are things that, you know, is important for people to realize and everyone does have unconscious bias. You know, it’s not a matter of, I'm so good I don’t have any unconscious bias. It’s actually natural and normal to have unconscious bias. The difference is what you do with it and the forms of biases are what you see here, the in-group/affinity or affinity grouping, stereotypes, anchoring bias, and confirmation bias. And one of the modules actually used Veterans stories demonstrate each, some of these elements. I won’t be going into all of that today because I am hoping that you'll go back and do the module.

But in a snapshot, these are some of the Veterans stories that fueled the modules. Dennis is an older Veteran who had a stroke and who was living alone. Some of his care became, and some of those elements that made him vulnerable impacted his care or the plan for his care after the stroke. Crystal is a female Veteran inquiring about benefits. Her interaction that day, the vulnerability of being female and people wondering whether you served or didn’t serve played itself out there. Reba was homeless following hurricane Katrina and almost slipped through the cracks with some medical issues because of assumptions that people made based on interaction. Mocco had hepatitis C virus and some preconceived notions of his own because of his Japanese ancestry that was limiting his ability to engage fully. So, again, it’s not a blame game. It’s about understanding how these things play into people’s ability to engage and what we deliver to them. Determinants of Health Training Module is the one that had multiple Veterans stories and that one is E for everyone. The Casting the Health Equity Lens on Routine Check-Up is primarily a clinic visit, and it takes the story of one Veteran, but then this one person is dropping hints about the issues in their social construct as they go through, and the question becomes whether clinicians pick that up, or health care workers pick that up to take that into account.

And so I already mentioned Reba earlier. This is just a little more to show you the screen shot about what you would see in the module. So this is a screen shot of the module. The interactive nature of it, after you read a portion of Reba’s story, it asks you whether you see any vulnerabilities and then as you go along, you will interact on how these vulnerabilities play in. And you have a chance to reflect afterwards and see if you want to change some of the answers you did at the beginning. So, again, that reflection and engagement, with the power of the story of people, hopefully will get people to make the necessary connection.

And these were a couple more screen shots. Jamal looks like a Muslim. He didn’t say he was or he wasn’t, but in the module he never spoke. Just by the way he looked, there were activities around him that suggested that people were uncomfortable. And he became uncomfortable, too, and so on. So, again, and you will see when you go through those pieces it will ask you which one of these is at play. I won’t give away the answers here. I proposed they did a screen shot that didn't have the answers so that when you do the modules you'll see that.

And then for the other two people you see here, it shows side by side differential treatment. If you remember, I talked about bias the verb and bias the noun. Differential treatment of two different people based on someone’s preconceived notion. Again, nothing that the person did or did not do. Gerry comes into the same place and gets admitted without being asked to do an alcohol, to do a test, breathalyzer for alcohol. And Elijah comes in and he is told to do so because the person assumes that people who look like him tend to be alcoholics. And he ended up with zero and the person was oh my God, really, what did, just happened, I couldn’t believe that. So even after the fellow ended up with a zero on breathalyzer, the person who did the screening was still wondering what they were missing. So, again, those biases playing themselves out.

I was going to do a demonstration but we had some technical difficulties at the beginning, so I will let you look at them on the Office of Health Equity website. The link is at the bottom, va.gov/healthequity, and if you go to the tools page, both the Virtual Patient Training Modules will be there as well as the next iteration of the videos from the work that Dr. Houston's team did. That link was just provided to us not too long before this session. So making the other pieces to get it into the sessions was not feasible, but definitely you can watch all the Veterans videos there. And we intend to continue that dialogue with Dr. Houston’s team for other possibilities of where those products of that research could go.

As a summary point, the Determinants of Health and Healthcare for all employees or anyone, will take you about 30 minutes to go through. The one for Casting the Equity Lens on Routine Check-Up will take you about 60 minutes to go through, but I believe that you'll found out it’s well worth your while. I don’t have the times for the various DVD clips, but we broke them up into small units so that if you don’t want to watch the whole thing, you can select one person and where they're talking about medication or you can select another person where they're talking about diet. So breaking it up that way allows you to go to one section you want, but if you go through all of them, that would be great, too.

I was just going to, well, this was supposed to be part of the discussion around Lucille’s case, and I’ll just walk you through it briefly. Lucille, in the primary care visit, was new to a particular clinic. She had been to VA before but not that clinic. There were multiple issues that had come up in her prior visit, so the review of her records indicated those. The place she was visiting provided primary care only, and they had the ability to review her records prior to the visit. Lucille was 54. She just moved back into the area because of situations at home which she will tell you during the visit and hopefully will be taken into account in making a health plan for her. She’d gained some weight and there will be snippets during the course of the dialogue with Lucille that gives an idea of what might be fueling her weight gain. And then some medications she was given previously she may not be taking for reasons she will also divulge. But the intent of the module for Lucille’s visit, again, as I mentioned, was not about teaching people to manage hypertension or diabetes, because every clinician whose is licensed to do that already does a good job of that. The piece we wanted to bring in was the aspects, the other aspects of Lucille that might impact her ability to engage fully and her ability to be compliant to the treatment or even that the treatment plan matches what she can’t keep up with.

As so the areas will be, you know, the biologic factors, the behavior and lifestyle issues, social and living conditions. She just moved back to an area which has also impacted her ability to earn an income, her service in the military and some of the experiences from that, and then her health overall and how she chooses to engage in her health care. And I will not show you the video clip, but in video clip one, Lucille was giving her reason for moving back. Her mom was aging and was found wandering with possible dementia. But then she moved back very happily because she had moved away to get away from the area, but now there was a compelling reason to come back. So there’s that piece that she is dealing with. And then she also talks about, at some point, her military history, one of the things we concede to encourage people. We do it well in the VA, but when we send our Veterans out, people may not necessarily take a military history. And just a plug for Office of Academic Affiliations, they have a military history pocket-taking card that walks people through it, that can be inserted into medical record, it can be printed and all that. And it even has what lines to call if people screen positive for anything and stuff like that. But in this case, this was a VA, so getting the military history is not a big deal. Lucille gave that information.

The turning point video, it was another place where building trust played itself out. It took Lucille almost to the end of the visit to explain that Joe, whom she had mentioned a few times during the course of the dialogue as the significant other person in her life, that Joe was actually Jolene and that Jolene is female. But you would, when you watch the videos and you follow it through, you will see the discomfort and when she finally got to that place where she felt comfortable to share that information. Again, it's the nonverbal cues, but it’s also those soft skills that are necessary if you are going to be able to gain people’s trust in order to address some of the issues that's related to them. So I think I gave away most of it, but I hope that that whets your appetite enough to go back and see the rest of it.

The stories of patients come alive in these modules. I encourage you to keep an open mind as you take the journey with the Veterans in the Virtual Patient Health Equity Training Modules. We’re hoping that you reflect on the encounters, apply what you learn, and of course, share with others. And we definitely welcome your feedback.

I don’t think you have this on your slides. I put them on when I realized it wasn’t on the slides I sent in that went out, but I want to make sure that I acknowledge some of the brains and hands and feet behind the Virtual Patient Training Modules. The Veterans, for sure, whose stories and experiences inspired the project, the Office of Health Equity on the subject matter expertise and the labor that went in to it. The VA Employee Education System had the [xxxx 40:34] medical center project team contract that allowed us to build on the decisions team platform which gave us the ability to do the branching and some of those twists and turns that you hopefully find engaging and interesting as you go through the module. The VA Center for Minority Veterans gave me access to some of the Veterans stories that they had received through either complaints and so on, which we have turned into opportunities in using their stories to engage. And then the Office of Travel and Government Relations also helped with some of the dialogue around Native American Veterans.

As so, Molly, with that we come to the last poll question of the session.

Molly: Excellent! Thank you very much. So for our attendees, as you can see on your screen, we have the final poll question up and we’d like to get an idea of how likely will you use Veterans stories or narratives in your work? You would definitely use, will definitely use them in your work, will probably use them in their work, will probably not use them in your work. Looks like people are a little slower to respond, and that’s not a problem. Take your time. We've had about a 50% response rate so far, but we’ll wait a little longer. Alright. We've capped off at about two-thirds of our audience, so I am going to go ahead and close this and share those results. Thirty-eight percent of respondents said they will definitely use them in their work, 59% said probably, and 3% said will not use them. So thank you, and we're back on your slides.

Dr. Uchenna Uchendu: Okay. Thank you, everyone, for those responses and actually this takes us to hear from you further about any questions or comments that you may have, and I'm sure Molly will give you instructions on how to ask the questions since you won’t be able to join us by audio.

Molly: Excellent! Thank you so much. So for our attendees that joined us after the top of the hour, to submit any questions or comments you may have, please use the GoToWebinar control panel located on the right-hand side of your screen. Just click the plus sign next to the word questions. That will expand the dialogue box and you can submit them there. We do have several pending questions now, so I will jump right into them.

Does the VA utilize community-based participatory research, CBTR, in promoting health equity and in addressing health disparities?

Dr. Thomas Houston: So I would say definitely, so our work in collecting these stories is an effort to go into, directly into communities and engage with Veterans. But they, so Health Services Research and Development has a major initiative currently that all of our Centers of Innovation, which are the major centers that support health services research. Each one is required to have a Veteran engagement panel and work with Veterans as they’re planning the types of proposals that they submit and the measures that they're going to obtain. There is also a rich history of VA investigators working with Veteran service organizations.

Molly: Thank you for that reply. The next question, how did you form a connection with The Stoop and/or similar organizations?

Dr. Thomas Houston: So that’s a really good question. So there's a number of these organizations now throughout the US, and so what happened was that we had published this paper in the Annals of Internal Medicine about storytelling in Birmingham, Alabama. And then it was picked up by the Boston Globe and the leaders of The Stoop read that article and called us, and then we actually engaged them and used some of our VA funding to support them to be engaged in the study. And we actually have an article that’s published about this. So Dr. Fix, Gemmae Fix, from the Bedford VA, is the lead author. And the title has, like, Using Theatre Arts in Storytelling Interventions. And so that's, so it's sort of connects them through our previous work and to the media, but they were extremely helpful. It was a wonderful experience having them come talk to us.

Molly: Excellent! Thank you.

Dr. Uchenna Uchendu: If I might add they’re not directly on this work. Interestingly, the first half of my day was spent at American Academy of Medical Colleges, where they had a session today called Building a System Approach to Community Health and Health Equity for Academic Medical Centers. And my office and the Office of Health Equity at the AAMC had, you know, exchanged some ideas along these lines, and the whole day has been devoted to this systems approach. VA had a presentation there but there were multiple academic medical centers. Again, many of the discussions this morning were around how best to engage within the community and also identifying the aspects within the community because an organization like that will be an asset. So in the community needs health assessment, the plan should not just be in identifying the needs of the community but also identifying the strength of the community and then bringing it to bear in the work to advance health equity.

Molly: Thank you. The next question: Tom, how do you account for the differences in the fact that over 90% had high school or greater education but over one third had poor health literacy?

Dr. Thomas Houston: Yeah, gosh, that a good question. So if we had it interactive, I would probably do what the mentor usually does, and say what do you think about that? But yeah, I mean I think that the educational system in the United States needs to do a lot more work on addressing, understanding health literacy. And it's certainly possibly that you can graduate from high school and still not have good health literacy.

Molly: Thank you. The next question is when the VA identifies food insecurity, is action taken? Would a visiting nurse or social worker report food insecurity to someone or an agency that could assist the Veteran?

Dr. Uchenna Uchendu: That is a question that is probably outside the scope of the presenters on this particular Cyberseminar. We can take that and come back to the person. I don’t want to speak generally for the agency on that, but I know that there was some discussions around the homelessness program about setting up community partners to support with regards to putting security, and I think that some of the medical centers have actually hosted events. Not just providing clothes and shoes and so on but actually providing healthy food as well. But I don’t have the specifics on that, and so if the person would write in to either of us, our information will be at the end or to Molly, we can get specific answers to that.

Molly: Thank you. In the perspective study presented initially, looking at the outcomes of BP management among patients who received both didactic education and stories intervention, how did you account for potential cofounders in influencing the favorable outcomes observed in the intervention arm? For example, patient-provider relationship, frequency of follow-ups, etc.

Dr. Thomas Houston: Right, so that is a really good question. So it is a randomized trial. So it was randomized at patient level, and through randomization we anticipate the number of those confounders would be balanced. However, it is always possible that they were not and some of these unmeasured issues could be unbalanced. So in the article that was published in Patient Education and Counseling by Dr. Bokhour, it actually reports more information than I provided today and demonstrates that one of the effects of the storytelling was to encourage, that patients were activated to ask more questions of their providers, and so that is actually one of the pathways by which we think the DVDs worked. A number of the Veterans in the stories talked a lot about one of the most important thing in their strategies for controlling hypertension was talking to their doctor. And so that was an emphasis of our storytellers and potentially was one of the ways that the stories, so I would not consider that a confounder. I would actually consider it a mediating variable.

Molly: Thank you. Can the previous speaker please repeat the name of the academic medical center she was at earlier today?

Dr. Uchenna Uchendu: No, I said I was at the American Academy of Medical Colleges. The head office is right here in Washington, D.C., and they held an event. I can, you know, provide additional information. I'm sure they'll be making their own announcements as well on building a system approach to community health and health equity for academic medical centers. And multiple medical centers were represented. I'm also proud to say that one of our own VA did a presentation to the team about systems redesign approaches that could be applied there.

Dr. Thomas Houston: So the AAMC is the organization for all medical schools.

Dr. Uchenna Uchendu: Correct.

Dr. Thomas Houston: Is that right?

Dr. Uchenna Uchendu: Yeah, it’s the organization that accredits medical schools across the country.

Molly: Thank you. What were some of the challenges you faced with IRB over the pictures? Also, did you conduct a small pilot prior to conducting the three-site study?

Dr. Thomas Houston: So, that’s a great question. So we did our pilot or prior work outside the VA. And so we, our study was actually one of the first that went through the VA’s central IRB. And so it was approved centrally, and we were required as appropriate to give full consent of the Veterans to use their videos, so they, not only did they sign informed consent but also, you know, video consent and audio consent, you know, documents that said that we could use their likeness and their story both in our intervention DVDs and then in future dissemination to other Veterans. So it did take a while to get through central IRB, but it wasn’t as much about the methods of the study as about that central IRB was new when we went through it and they do a great job.

Molly: Thank you. Okay, we just have one question left, and is the EA process to create your own videos for other issues? Is, maybe it says is there a process to create your own videos for other issues such as mental health recovery?

Dr. Thomas Houston: Yeah, so that’s a great question. And so one of the things that we are interested in working with the Office of Health Equity is providing information to the field so that local VAs can do this. So, you know, one of my premises is that, like you know, it's very expensive to take Veterans and put them in a studio and use fancy cameras and techniques to have very, you know, production quality videos, and I actually think that weakens the effect of them because it makes them less real.

Dr. Uchenna Uchendu: Real.

Dr. Thomas Houston: You're taking people out of their normal environments. And there's a reason why so many people watched these sort of grainy lower production-value videos on YouTube because they're more real. So, you know, because of the advancements in technology, it is possible that local VAs could make local stories of local Veterans with their approval, and so I would be very interested in sort of distributing some of our production manuals and sort of a how-to to do that.

Dr. Uchenna Uchendu: Yeah, and additionally, I mean, putting in a plug for the videos on the next level. Many, every, most places have CCTV within the patient areas, and sometimes people can’t agree on what to watch, putting up videos like this with people like them discussing their various conditions that they can actually take something away from. You heard Dr. Houston talk about the activation. I think we will hopefully hope to hear from a lot of people who want access to be able to at least share these videos, these initial ones, as a pilot or as a way of getting into it and then discuss possibilities of doing even more.

Dr. Thomas Houston: Yeah, so in my clinic, it’s often running talk shows or soap operas, so having Veterans tell their stories would be way better than what’s currently in my waiting room to my clinic.

Dr. Uchenna Uchendu: Yeah. Molly, we had some closing slides that we wanted to just round up before people dial out. Our Cyberseminars are continuing, so the slide you see has the information about that and it’s on your slide deck. The next one is on the 30th, and we will actually be talking about Incorporating Social Determinants of Health into VHA Patient Care and Electronic Medical Records, with a special example from homelessness pack. And then, as always, we encourage everyone to think of how you can engage in your particular area. It’s everyone’s business. It’s not just Tom’s team or the Office of Health Equity. There's a lot that each of us can do if we just engage appropriately. At a minimum, don’t widen the disparities.

And here is both of our information if you need to reach either of us directly. Those will be the emails. Notice that we both have a number 2 after our names, such interesting coincidence. But if you are not at the VA, be sure to first name, dot last name, number two, at VA dot gov. And if you are at VA, you can find us in Outlook, and that will be easy for you. And then, of course, please sign up for the Office of Health Equity Listserv. We have the information there as well, www.va.gov/healthequity puts you on our main page, and like I mentioned, the stories that we talked about today, the Virtual Patient Stories Training Module as well as the hypertension stories would be on that page.

Molly: Great! Well, thank you so very much, Dr. Uchendu and Dr. Houston, for coming on and lending your expertise to the field. We very much enjoyed it. For our attendees, please wait just a moment while I close out the session, and take just a second to fill out our feedback survey. It’s just a few brief questions, but we do look closely at your responses and it helps us improve our presentations and the program as a whole. So thank you once again to Tom and Uchenna and for Kenneth Jones for his support as well, and everybody have a great rest of the day. Bye-bye.

[END OF AUDIO]