Cyberseminar Transcript

Date: June 29, 2017

Series: Focus on Health Equity and Action

Session: Chronic Health Conditions Among Vulnerable Veterans: Current Research and Action

Presenters: Jessica Breland, PhD; Uchenna Uchendu, MD; Donna Washington, MD, MPH

*This is an unedited transcript of this session. As such, it may contain omissions or errors due to sound quality or misinterpretation. For clarification or verification of any points in the transcript, please refer to the audio version posted at* [http://www.hsrd.research.va.gov/cyberseminars/catalog-archive.cfm](file:///C%3A%5CUsers%5CVHAISLBloomK%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CTemporary%20Internet%20Files%5CContent.Outlook%5CNFGY1RXB%5Cl)

Note: The first 15 minutes of the audio and video are missing from this presentation archive.

Dr. Jessica Breland: Across a number of populations. So, we started by stratifying our population by gender, because we know that women and men Veterans who use VA are different from one another, and that the women tend to be younger, and they tend to have more comorbid conditions, so we wanted to look at obesity prevalence separately. Once we split the sample into men and women, we then looked at a number of sub-populations that are related to obesity or health, in general, including race/ethnicity, age, urban and rural status, because there’s some evidence that rural residence have higher obesity prevalence than urban residence.

We also looked at a number of physical and mental health conditions. Disability status is measured by service connection, and the Veteran’s service era. Because of the limited time today, I’m just going to talk about the populations in red. I’ll talk about men and women separately, and I’ll also talk about race/ethnicity, age, and urban and rural status. And you can find information on all those other subgroups – information about overweight, as well, in the manuscript. And I should note that age and service era are pretty highly correlated, so I’m inadvertently talking a little bit about that.

To get into results, I wanted to start with just a broad overview of the BMI distribution among women and men Veteran primary care users in fiscal year 2014, starting with obesity. You can see that 44% of the women, who are in red, and 41% of the men, who are in blue, had obesity. 31% of the women, and 38% of the men were overweight. Which means that about 75 to 80% of Veterans who are using primary care at VA are overweight or obese, which leaves about a quarter who are normal weight or underweight. In terms of looking at the sub-populations, I’ll start with women, looking at it in terms of race and ethnicity. And on this slide, you’ll notice some of the bars are a darker color, and those represent populations where their obesity prevalence differed from mean obesity prevalence by at least 5%¸which is what we used as our cut-off for clinically significant difference.

So, what this slide tells us is that Black or African American women that are in kind of high obesity prevalence at 51% was the highest of any racial or ethnic subgroup among men or women. And that the native Hawaiian/other Pacific Islander women Veterans also had a pretty high obesity prevalence at 47%. And you can see at the bottom that Asian women Veterans had a relatively low obesity prevalence at 21%. The remaining racial and ethnic subgroups, the American Indian/Alaska native women, women of unknown race or ethnicity, multiracial women, white women, and Hispanic women all had rates fairly close to that 41% population mean.

Looking at the race and ethnicity data for men, you can see there’s some similarities, some differences from the women. So, similar to women, the Asian men Veterans had a pretty low obesity prevalence at 25%. The top groups are a little bit different. For the men, it was the American Indian/Alaska native Veterans who had high obesity prevalence of 47%, as did men with unknown race or ethnicity, who also had prevalence at 47%, with the remaining racial and ethnic groups falling fairly close to that 41% mean.

With regard to age, when we look at the women, we can see high obesity prevalence among the middle-aged group. The women Veterans age 45 to 64 had a 49% obesity prevalence, and we see lower prevalence among the 65 and older group of 37%, and a relatively low prevalence, or lower prevalence among the younger veterans at 18 to 44 years, who had a 40% obesity prevalence. When we think about obesity prevalence by age among men, again, there are some similarities and some differences. So again, it’s that middle-age group that has the higher obesity prevalence at 48%. We also see relatively low obesity prevalence among the men Veterans who are 65 or older, their obesity prevalence was 36%, and while the younger men Veterans didn’t quite meet our clinical significance cut-off, their rate is relatively high at 46%.

Getting to our final sub-population I’ll talk about today, urban and rural status, you can see among the women there was pretty minimal variation from highly rural to rural to urban to highly urban among the women. They were all pretty close to the mean. And on this next slide you can see the same thing, actually, for the men across all the different rural/urban categories, obesity prevalence was pretty similar. So, that was a lot of a, kind of, whirlwind tour of our findings, so I wanted to highlight a couple of key points, which is that we found high obesity prevalence among middle-aged Veterans, Black women Veterans, native Hawaiian/other Pacific Islander women Veterans, American Indian/Alaskan native men Veterans, and men with unknown race/ethnicity. And then we found low obesity prevalence among men Veterans who are over age 65, and among Asian women and men Veterans.

Now, it’s sort of natural when you hear all of these prevalences listed, or you see them, to want to make comparisons to epidemiological data we might have from the general U.S. population, but I want to caution against that because it’s difficult to make those head-to-head comparisons because of known differences between Veterans who use VHA and other U.S. residents. Namely, by definition, Veterans who use the VA are people who are seeking treatment, and they also tend to be older and in poorer health than the general U.S. population. So, we can’t directly compare them. At the same time, I think it’s worth noting a few differences as areas for future investigation. And one of those areas is the high obesity prevalence we found among our young men Veterans who had an obesity prevalence of 46%. That’s higher than what you’d see in similar age groups for the average U.S. citizen who has, those men tend to have an obesity prevalence around 32%. Certainly, some of that difference is due to the fact that military service people, when they leave the military and become Veterans, probably have, on average, a higher muscle mass than the average American, but I think the difference is big enough to merit some future investigation. Conversely, we found high prevalence among the Black women Veterans who used VA primary care at 51%. And this actually matches what you see in the general U.S. population, where Black women have a statistically significantly higher risk of obesity than other U.S. women. But, the prevalence at 51% among the Veterans actually seems to be a bit lower than the estimates for the average Black woman in America, which is at 58%, so I think that difference is also worth investigating.

And I also wanted to highlight the low obesity prevalence among the Asian women and men. This also matches what you see in the general U.S. population, where Asian Americans tend to have lower obesity prevalence, but in the general U.S. population, that prevalence is closer to 12 or 13%, whereas, in our Veteran population, we’re seeing 20 or 25%, so I think we’ll want to take a look at, try to understand why that might be. I also wanted to bring up the obesity prevalence among the Asian veterans because it’s important to note that BMI or obesity category may confer different risk across different racial and ethnic groups. So, you may have greater risk for negative health outcomes at the same BMI number for Asians, versus, for example, African Americans. And this means that we have to eventually look beyond just prevalence rates. They’re only one piece of the puzzle. We also have to think about what are the actual health outcomes, because that’s why we care about BMI, is because of its relation to other outcomes, not in-and-of itself.

So, this leads us into a few limitations. As I said, BMI is an imperfect predictor of health. Perhaps potentially when we’re comparing across racial and ethnic groups. These were also cross-sectional analyses, which means that we don’t know why we found these differences. We just know that they seem to exist. Racial and ethnic groupings are almost always problematic. I actually think that, in this work, we had much finer-grain detail about race and ethnicity than we normally see in these kinds of projects, so I think our racial and ethnic groupings are ultimately a strain, but at the same time, we, for example, put all Asian Veterans into one group, which could have masked some differences there. And, as I’ve noted a couple times, it’s not possible to compare these results I just presented to those from the general U.S. population, so I want to highlight that again, because it’s very important to remember.

Getting into future directions, which are really important because identifying health disparities is not enough. We need to, then, do something with that information to try and reduce the disparities and promote health equity. And along those lines, important next steps, I think, include understanding treatment use among high-risk populations, understanding whether people in these high-risk groups are using weight-management services at rates commensurate with their risk. And then, if not, that may lead to interest in developing tailored outreach or intervention efforts to make sure people are getting the services they need. And I think this work is going to have to consider intersectionality, which is this idea that people’s identities fall at the intersection of multiple groups. And those groups can include race and ethnicity, age, sexual orientation, gender, socioeconomic status, potentially Veteran status, and that all these different identities infer different kinds of privilege or oppression. And so, it’s really important to consider how these agencies interact, and even more important, to consider how these identities and their interaction affect access to healthcare and subsequent health outcomes; to not look at any of these groups in isolation.

In terms of broader implications, we found pretty high obesity prevalence across almost all groups, which suggests that a population health approach to weight-management is warranted in VA. And that’s certainly part of the approach that’s being taken, and that all Veterans who are obese have access to an evidence-based behavioral weight-loss treatment that doesn’t have a co-pay. At the same time, it’s going to be important to remember that high-risk groups may require special attention to make sure that these broad populations health and systems-level improvements don’t inadvertently increase health disparities. And that gets into some of the quality versus equity argument that Dr. Uchendu mentioned at the beginning. So, for example, we saw high obesity prevalence among middle-aged Veterans. And these are people in a life stage where they are likely to work, or have young children to care for, or be caring for older family members. And so, they may need virtual or after-hours care, without which, they might have difficulty accessing services. So, if we take a totally blanket approach and only provide services during the day, it may be hard for them to get care, and we may end up inadvertently increasing that disparity, instead of treating it. So, it’s going to be important to both target everyone with these broad approaches, while also watching for people who fall into these special populations so that we can make sure we are treating and preventing obesity among everyone so that we can ultimately reduce disparities and promote health-equity as our long-term goal.

So, with that, I’d like to say thank you to funders: Women’s Health Services, Office of Health Equity, HSR&D, the Women’s Health Evaluation Initiative, all the co-authors from this manuscript, and everyone who helped with getting the slides together, and also the manuscript itself, and they are listed here. My contact information is here, as is, as I mentioned, a link to the manuscript, which describes all these data and more. And with that, I’d like to finish with a poll question. I’m curious to know what people think might be the most important future direction for this sort of work? And if you choose something else, please feel free to let us know, because we’d love to hear it. So, thank you.

CIDER Staff: Thank you, Dr. Breland. I have the second poll question up, and quite simply the question is what do you think is the most important future direction. Please select one: 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, or something else.

I’m going to go ahead and close the poll. We just about have 80% answering, so sharing it back out. 45% answered outreach efforts tailored to specific populations. 33% weight-loss programs tailored to specific populations, only 6% statistical analyses to describe differences among VHA populations, 8% analyses to compare VHA and non VHA obesity prevalence, and 8% something else. And now, we’ll be turning things over to Dr. Donna Washington. Donna, can I turn it over to you?

Dr. Donna Washington: Absolutely.

CIDER Staff: Okay, there you go.

Dr. Donna Washington: I do not see the pop-ups.

CIDER Staff: Okay, one moment.

Dr. Donna Washington: Can you see my screen? Here we go, the pop-up is here now. Thank you.

CIDER Staff: Okay. Thanks, Donna.

Dr. Donna Washington: Great. So, thank you very much. It’s wonderful to be here and to have the opportunity to share this information on addressing racial and ethnic disparities in VA in hypertension and diabetes control. As Dr. Uchendu mentioned, I’ll be presenting work conducted through the Office of Health Equity QUERI Partnered Evaluation Center. I would like to acknowledge my collaborators, whose names appear on this slide, and this Partnered Evaluation Initiative is funded by Office of Health Equity, who is also the primary operations funder. It’s also funded, in part, by QUERI, and data for this analysis comes from the Women’s Health Evaluation Initiative and from OABI. I have no conflicts of interest to declare, and the views expressed here are solely mine and do not necessarily represent those of the VA or the U.S. government.

So, the premise behind this evaluation of racial/ethnic disparities in VA is that quality improvement initiatives have the potential to reduce disparities, such as disparities in control of chronic conditions like hypertension and diabetes. In fact, following the first VA quality transformation in the mid-1990s, quality improved in both processes of care and in some intermediate clinical outcomes. Despite that, Black/White disparities were still present for hypertension control and for diabetes control. Since that time, Patient-Centered Medical Homes have been developed and widely promoted as permanent care delivery models have achieved better patient outcomes. In 2010, VA began nationwide implementation of its own Patient-Centered Medical Home model known as the Patient-Aligned Care Team, or PACT, initiative. Now, there are a lot of reasons why PACT might succeed in reducing disparities where earlier quality improvement initiatives did not. Components of medical homes thought to lead to better outcomes include team-based care with the focus on enhanced access, continuity, coordination, and alignment of incentives with quality and patient safety.

PACT implementation includes patient assignment to teamlets consisting of primary care provider and staff members with expanded care delivery roles. People operating at the top of their license is one way I’ve heard it described. PACT also includes patient access to same day appointments, group visits, and virtual communication with the teamlet. It includes increased nurse care management capacity for high-risk patients, and staff training in patient-centered communication. So, in theory, PACT gets at many of the care needs that disproportionately affect racial/ethnic minority groups. Having said that, there are also several competing reasons that might prevent PACT from reducing disparities. First and foremost, Patient Centered Medical Home construct did not include specifically tackling disparities as one of their goals. When we consider PACT from the perspective of where it’s delivered, we see that most racial/ethnic minority Veterans using VA are concentrated in a subset of VA facilities. The way the population is distributed increases the prospect for differential outcomes if PACT implementation varies in systematic ways. Patient factors may also have an effect with certain psychosocial factors and social support characteristics associated with race/ethnicity, potentially undermining access to care, and that’s regardless of how completely the medical home model might be implemented.

Given that, our objective with this evaluation was to determine whether Patient-Centered Medical Homes help mitigate national racial/ethnic disparities in clinical outcomes, and that’s after adjustment for variable implementation and social determinants of health that might thwart achievement of benefit. To achieve this objective, we examined clinical control measures in over 140,000 Veterans with hypertension, and close to 80,000 Veterans with diabetes who used VA in the 1-year before the start of VA’s medical implementation, and 4-years after start. So, we looked at data for 2009 and 2014. The VA measures hypertension control and diabetes control through its external peer-review program. Hypertension control is defined as blood pressures less than 140/90, and diabetes control is glycosylated hemoglobin less than or equal to 9%.

To identify patient race/ethnicity, we combined data from VA and other administrative databases, and we were able to reduce missing race/ethnicity data to an astounding 3%. For those who are interested in our methods for achieving this level of data completeness, we conducted a cyberseminar on June 20th, 2017 that’s available in the cyberseminar archives. For race/ethnicity measure, we classified all individuals reporting Hispanic or Latino ethnicity as Hispanic, and we classified all other individuals based on their race. Co-variates that we examined included individual level age, sex, urban/rural residence, and neighborhood socioeconomic vulnerability. We also included number of primary care visits in the year studied. For our facility or our site-level variables, we looked at the PACT implementation program index, which is a validated measure of the effectiveness of VA PACT implementation. For both hypertension control and diabetes control outcomes, we fit 3 models to estimate single-year disparities and the change in the disparities from 2009 to 2014. We fit linear probability models with a binomial error distribution. All models included race/ethnicity and product terms for each minority group-by-year interaction. In model 1, we included fixed intercepts for the 140 VA facilities, and that’s to adjust for confounding by facility-level factors, or another way to think of it is clustering of patients by facility. Model 2 included demographics and substituted a linear term for the facility PACT implementation. And then model 3 added socioeconomic vulnerability and patient PACT exposure. In all models, we expressed a result as predicted probabilities of the outcome, and of the differences or disparities in outcomes, and then we also used these model-based predictions to test for the change from 2009 to 2014 in the magnitude of differences and disparities.

Now, before I launch into the main findings on differences in hypertension and diabetes control, I want to highlight differences by race/ethnicity in the diagnosed prevalence of these conditions. We heard from Dr. Uchendu that hypertension’s the number one diagnosis and diabetes the number three in VA users. What you can see on this slide is that the diagnosed prevalence is much higher among VA users than in the general U.S. population, and they’re more common in racial/ethnic minority group members. So, these figures show the age-adjusted odds for each group compared with Whites. On the left, looking at hypertension age-adjusted odds ratios, we see that Black, Hispanic, multi-race and native Hawaiian/other Pacific Islander groups have higher odds of hypertension than Whites. And the figure on the right shows that each and every racial/ethnic minority group has higher age-adjusted odds of diabetes compared with Whites.

Racial/ethnic minority groups differed from Whites in all of the other sample characteristics that we examined. They were younger, most groups had a higher proportion that were female, they were more likely to receive primary care from sites that had lower PACT implementation scores. Most had a greater number of primary care visits, and most resided in neighborhoods that had greater area deprivation, which is our measure of socioeconomic vulnerability.

This is the first of several slides that reported hypertension and diabetes control outcomes. We found several influences on these outcomes. For both hypertension and diabetes samples, greater implementation of the medical home model at a VA site was associated with Veterans at that site achieving better control. However, Veterans residing in economically challenged areas experienced worse control, and those under age 65 also had worse control.

The association of race/ethnicity with hypertension and diabetes control in 2009, that was, if you recall, the year prior to the start of PACT implementation, is shown in these figures. For each condition, the blue bar for each group represents the predicted probability of not achieving control of that condition. For example, looking at the figure on the left, if you look at this top blue bar for American Indian/Alaska natives, you see that 24% had uncontrolled hypertension. For each race/ethnicity minority group, the dark orange bar is the difference, it actually is red, I’m sorry, not orange, is the difference in predicted probabilities between that group and Whites for the condition. And differences that are statistically significant are indicated with an asterisk. So, the first finding I want to draw your attention to is just the overall picture on this slide, which is that for both conditions, the predicted probability of each racial/ethnic minority group having uncontrolled hypertension or uncontrolled diabetes was either higher or similar to Whites. In other words, looking at these bars, then you can see the white bar is the shortest in both of these figures. And so, we’ll refer to all differences as disparities. For hypertension, Black, Hispanics, and multi-race groups had statistically significant differences compared with Whites. And then for diabetes, American Indian/Alaska native, Black, Hispanic, and native Hawaiian/other Pacific Islander groups had statistically significant differences. And, all of these differences are magnitude of 5 percentage points or more, so these are clinically relevant differences. Now, keeping these disparities in mind, we show the change from 2009 to 2014 in the disparities in achievement control of hypertension on this slide and diabetes on the next. We calculated the change as the 2014 disparity minus the 2009 disparity, so a negative number means the disparity decreased over time.

Model 1 adjusts for clustering of patients in VA sites, and the only statistically significant difference we see is for Hispanics, where there was a 2.9 percentage point decrease in the disparity. Model 2, which has the additional adjustments listed here, has the results that are fairly similar. Once again with the Hispanic decrease in disparity by 3 percentage points being the only statistically significant finding. And then model 3, which additionally adjusts for annual number of primary care visits and for area deprivation index shows that with these adjustments, the prior significant decline in disparity is no longer evident.

These are the results for diabetes, and the adjusted change from 2009 to 2014 in disparities in achieving control of diabetes are presented here for the same three models. None of the models show the significant reduction in disparities over time, although some of the point estimates were consistent with the narrowing of disparities for some of the groups.

Now this slide displays graphically the change from 2009 to 2014 for selected racial/ethnic groups, and the percentage of Veterans who achieved clinical control of hypertension in the graph on the left, and diabetes in the graph on the right. Starting with the plot on the left, the line on top represents White Veterans, the middle line represents Hispanic or Latino Veterans, and the bottom line represents Black or African American Veterans. You can see that in both 2009 and 2014, Black and Hispanic Veterans had lower rates of hypertension control. Looking on the right, you see a similar picture that, in comparison to White Veterans, Black and Hispanic Veterans had lower rates of diabetes control. In other words, for both conditions, disparities that were present in 2009 persisted in 2014. Though disparities were present in both years for both conditions, we did find that by 2014, the hypertension disparity for Hispanic Veterans had narrowed by 3 percentage points. So, these arrows are just showing graphically what the numbers in the prior couple of tables showed. The disparity is a difference between the 79 and 74 percent here, and you can see the narrowing by 2014.

So, the change from 2009 to 2014 in disparities in achieving clinical control are also shown for the same selected racial/ethnic groups here, and the point of this illustration is to show the relationship of some of these changes in disparities. For example, looking at the dashed blue line, that represents hypertension control disparities narrowing for Hispanics, and that was a statistically significant narrowing. This occurred because outcomes improved for Hispanics between 2009 and 2014, and that’s what you would want – for outcomes to get better for the minority or other vulnerable groups. By contrast, when you look at the solid line, which represents the trend toward decreased diabetes control disparities for Hispanics, this decrease in disparities actually occurred because outcomes got worse for all groups, not a desired effect, but there was a greater decline in outcomes among Whites.

So, there are several limitations to consider when interpreting our findings. The relatively small size of the American Indian/Alaska native, Asian, multi-race, and Native Hawaiian/other Pacific Islander groups may have precluded identification as statistically significant - a change in disparities that could be clinically relevant. Their primary care visits could reflect comorbidity, which is associated with worse outcomes, as well as increased access, which is actually a good thing. And findings may reflect the contribution of factors other than PACT implementation. For example, between 2009 and 2014, there was a significant growth in patient volume in the VA, close to 700,000 new VA users over that time, and here social determinates of health.

Despite these limitations, this study provides some insights in addressing racial/ethnic disparities through Patient-Aligned Care Teams. Greater PACT implementation was associated with better hypertension and diabetes control, but most racial/ethnic disparities persisted, and this suggests that to promote health equity, we should identify the underlying determinates of poor hypertension and diabetes control, and then explore the potential for incorporating tailored strategies into quality improvement activities, or initiatives that account for these underlying determinates of disparities. In addition, evaluations at medical homes should monitor outcomes for racial/ethnic groups. After all, if you don’t monitor for disparities in outcomes, you’ll miss the opportunity to address them.

So, I’ve listed my contact information here. You can also get further information about this analysis from our June 2017 Health Affairs paper that’s referenced on the background resources slide that Dr. Uchendu presented. I’m going to thank you for your attention, and with that, I will go to poll question #3.

CIDER Staff: Thank you, Dr. Washington. I have poll question #3 up, and it’s a little bit different. Dr. Uchendu would like you to provide some ideas or suggestions that you have. In order to do that, you can use the questions pane, as if you’re asking a question. Go ahead and write them in, and our presenters today will receive them when we send them their numbers. So, that can happen any time. I’ll go ahead and close that. You can, again, send your ideas via the questions pane of the GoToWebinar dash board, and we have about 10 minutes left, and we’ll launch into questions right now.

Dr. Donna Washington: Great. By the way, in your slide deck, you’ll see the presenter information for each of the three of us so that if anyone has questions, they can contact us afterwards. And, I want to turn this over to Dr. Uchendu again.

Dr. Uchenna Uchendu: Hey, thank you Donna, and thank you Jessica, too. That was a lot of information to cover in a very short time, but I dare say you did an awesome job of it. Not that it excuses people from pulling out the papers and reading the rest of it. And, of course, we’re hoping to continue the discussion, and that’s why you got that 3rd poll question. And we will definitely take those into account as we plan appropriate next steps. So, I wanted to leave some take-home points on the action portion of this [unintelligible 34:54] we do these cyberseminars and the Office of Health Equity engages different partners and different experts to bring their expertise to bear to address health disparities for Veterans. And one of the areas we’re definitely hoping is that there’ll be consistent reporting and monitoring. You had Dr. Washington close out with that, as well, that if we don’t track and trend these things, we will not, we will miss the opportunities to be able to do something about them. And, you know, the various [unintelligible, 35:26] that we talk about under the same umbrella of various subpopulations that may not get the best treatment all the time, or who systematically have suffered marginalization, and taking those into account ahead of time instead of as an after-thought becomes necessary, and doing so will allow transparent monitoring and for the progress, and it will support accountability, which is something that is definitely important to the agency, and to everyone, really. And they will boost that trust, and the trust is not, you know, just within, but also outside of our agency. And we’re, again, hoping that the idea here we’re submitting will give us innovative ideas and collectively we do better when we put our heads together and come up with ideas on what to do. And I know that the PACT was aware of this paper coming out, and we have been engaging in discussions for the things that are possible to do within the healthcare system, knowing fully-well that we may not be able to fix all of the social constructs, but at least for those elements that we have control within our system, that we champion and make insertions to be able to do that. And so, I continue to encourage people that the [unintelligible, 36:43] of health equity is everybody’s business. It’s a journey that’s going to take time and effort, and, you know, we keep asking what can each of us do. And at a minimum, if you take these things into account, you will not be increasing the disparity. So, at this point, I was hoping that the typing that was going on would have occurred, and maybe people who have questions, Rob will be able to access them, and we can hear them. Thank you.

CIDER Staff: We have a few questions. This one came in early on, so it’s probably for Dr. Breland. Was any consideration given to using age-adjusted BMI to adjust for wasting associated with advanced age?

Dr. Jessica Breland: Hi. We did not do that for these analyses, but that’s a really important point, and is another limitation that we list in the paper, and is something, hopefully, we’ll be able to do in analyses in the future.

CIDER Staff: Thank you. The next question that came in: how is the VA partnering with groups like the YMCA or similar facilities that would provide discounts to be part of these groups?

Dr. Uchenna Uchendu: I’m not sure I understand the question. Are they asking how the VA is partnering with YMCA that allows discounts to be a member of the group? I’m trying to see the relationship, but they are talking about where people can go and do exercises with regards to obesity, and I guess you don’t have the answer, either, because you just received the question. Would the person who asked it please put clarification?

CIDER Staff: Thanks Dr. Uchendu. Next question: were analyses for Asian Veteran obesity rates adjusted for known differences for the cut-points for obesity and overweight based on BMI?

Dr. Jessica Breland: This is Jessica. No, they weren’t, and that’s why I brought that up as a limitation, because there are differences, and I think it will be important when we’re thinking about this in the future – people using it for intervention for healthy, information to look at those and then to also consider overweight Veterans, or overweight Veterans who have obesity-related conditions for that reason.

CIDER Staff: Okay, thank you. Next question: oh, these are ideas, I’m sorry. Give me a moment. I need to digest this question. Here’s a quick one. For slide 33, what genetic markers are being evaluated in this regard? I think that’s for Jessica.

Dr. Uchenna Uchendu: I think Jessica is probably racing back to see what is slide #33.

CIDER Staff: Yeah.

Dr. Jessica Breland: Thirty three. I don’t think, did I, I don’t think I talked about genetic markers. Yeah. Well, I’m not sure how to answer that one.

CIDER Staff: Okay, the person who asked the question regarding the YMCA just replied. Yes, what I mean is that Vets often don’t live in gated communities or are able to access high-cost health clubs. The YMCA has long been a place that its community comes together.

Dr. Uchenna Uchendu: Okay, that’s good. I thought it might be related to a place where people can do exercise in order to, you know, reach their target-weight or maintain their target-weight. I know VA has partnerships with multiple groups. We have an office at the department level that deals with a lot of partnerships. We also have an office at VHA level which looks at community engagement, but, unfortunately I am not the expert, and so the question I don’t think any of us on the current call can answer the question about whether VA has a partnership. So, my information is at the end of the slides: uchenna.uchendu2@va.gov. If that person would write me directly, I will check into the information and provide you the answer or connect you with the right people. But I know that VA, especially under the current secretary is encouraging us to engage with the communities and the private sector and others to assist the Veterans in reaching their goals.

CIDER Staff: Great. Thank you. This one’s a little bit difficult to digest, but I’ll try. I think this one’s for Dr. Washington. In looking at slide 56, how does the VA envision White and non-White Veterans at-risk in the same geographical communities would work together who are hypertensive or diabetic in order to help each other as mutual supporters to achieve health goals in this regard? He goes on to say, in other words, how is VA seeing the capacity of Veterans from different backgrounds to work together, to hold each other accountable?

Dr. Donna Washington: I’m sorry. Can you re-read the whole question, please?

CIDER Staff: Sure. In looking at slide 56, how does the VA envision White and non-White Veterans at-risk in the same geographical communities would work together who are hypertensive or diabetic in order to help each other as mutual supporters to achieve health goals in this regard?

Dr. Donna Washington: Oh, okay. Well, that’s a great question, and I’m trying to draw from program evaluation and research studies that have done that. I know that here locally, for example, at VA Greater Los Angeles, there are, as part of a QUERI program, there are groups that bring together Veterans from diverse backgrounds to provide, sort of, peer support to each other for addressing cardiovascular risk factors. This is actually part of the Women’s Empower QUERI program. I’m also aware that, as part of PACT, that several sites have instituted group visits. One of the advantages of group visits is that Veterans can support each other and strategize with each other often because they’re in their communities, sort of addressing some of the lifestyle factors, and other self-care factors that are needed to manage diabetes or hypertension. Then they figured out solutions that they can then share with each other.

CIDER Staff: Thank you. That’s all we have for questions, and we’re just about out of time.

Dr. Uchenna Uchendu: I was going to make a quick plug there with regards to also that question on the Office of Health Equity website, there’s a hypertension video that came out of another research project that we presented in the February cyberseminar where it’s a peer-to-peer, people who are telling their stories and journey with hypertension to other people having the same issues. It’s a project that our office partnered after the research was done because it showed that those who engaged in that research project actually did better from learning from their peers. I’m a physician, but it doesn’t hurt my feelings that they learned more from their peers than they did from their physicians, who had probably been hammering them about getting their blood pressure under control. So, there are tools of that nature, and we can also follow-up off-line with the person. So, thank you.

CIDER Staff: Thank you, Uchenna. We’re out of time for today. I’d just like to remind the audience that please to hang on and answer questions in the survey that will come up as soon as I close the webinar. And I’d like to thank Dr.’s Breland, Washington, and Uchendu for presenting today. Have a nice day everybody. Thank you.

Dr. Uchenna Uchendu: Thank you, Rob, for supporting us, and everyone register for the July session. The registration is already open. Thank you.

[END OF AUDIO]