Work Group: Population Health
Group Membership

- Stephen Blumberg, PhD (CDC)
- Barbara Bokhour, PhD (VHA)
- Timothy Brindle, PhD (VHA)
- Ryan Britch, MPA (VHA)
- Reena Duseja, MD, MS (VHA)
- Timothy Goliver (VBA)
- Maria Carolina González-Prats, PhD (VBA)
- Deborah Gurewich, PhD (VHA)
- Shari Ling, MD (CMS)
- Justin List, MD, MAR, MSc, FACP (VHA)
- Tara McMullen, PhD, MPH (VHA)
- Kaitlin Richards (VBA)
- Aaron Schneiderman, PhD, MPH, RN (VHA)
- Hill Wolfe, PhD, MPA (VHA)
- Steven Zeliadt, PhD, MPH (VHA)
- Rani Elwy, PhD (VHA)
- Mark Meterko, PhD (VHA)
Key Priority/Issue #1

• Key issue: Incorporating veteran voice into the development of measures for well-being and whole health outcomes

• Barriers/Strategies to Overcome Barriers:
  • Barrier: Trust / Strategy: “Closing the Loop”
  • Barrier: Tokenizing / Strategy: Diverse representation of voices through out process of what measures are considered meaningful
Key Priority/Issue #1

• Research ideas:
  • What groups of Veterans should be represented?
  • Intersectional representation and awareness of intersections that are important for stratification

• Policy recommendations:
  • Center the Veteran voice in measure design – they should be in alpha and beta testing of measures for wording and comprehension
  • Veterans should know why this data is being collected and how it will be used to help them and this should be explained by parties collecting the data
Key Priority/Issue #1

• Dissemination strategies:
  • Reaching diverse Veteran channels to encourage inclusive participation

• Responsible program/office(s):
  • VBA
  • Veteran Experience Office
  • Veteran Insight Panel (SHEP)
  • Veteran focus groups
  • Office of LGBTQ+ Health, Center for Minority Veterans, Office of Diversity, Equity, and Inclusion, Office of Health Equity
Key Priority/Issue #2

• Key issue: Determining a framework and/or logic model that underpins measures for well-being.

• Barrier/Strategies to Overcome Barriers:
  • Barrier: Understanding VA’s diverse datascape
    • Strategy: Environmental scan to create a proof of concept
  • Barrier: Determining what domains are meaningful to Veterans/VA
    • Strategy: Qualitative interviews (cognitive interviewing) and framework consensus development
  • Barrier: Determining what parsimonious set of measures would add value and be meaningful.
    • Strategy: CDC Healthy Days Measure, Well-Being Signals, PROMIS, Veteran Engagement DEs
    • Assess risk adjustment/strata, item reliability, time horizon for assessment (entry points)
**Key Priority/Issue #2**

- **Research ideas:**
  - Creating a composite well-being measure from current VHA/VBA measures and possibly creating a summary star rating to incentivize the performance of the measure.
  - Grounding of measure with populations outside the VA to test and align to benchmark against other groups.
  - Tracking measures that are sensitive to change and function equally for everyone. Rolling these up into new VA DEs.

- **Policy recommendations:**
  - Uniform data collected across VHA/VBA (e.g., such as sex assigned at birth AND how people identify their gender).
  - Moving away from the target-driven medical approach of data collection to a more holistic measurement approach.
  - Taking into consideration the lifecycle of measure development and implementation. The sense is that action is needed now but testing and proof are also needed—take time.
Key Priority/Issue #2

• Dissemination strategies:
  • Utilize current data sources such as SHEP, V-signals, and VBA data sources.
  • Ensuring underrepresented communities are stakeholders in measure testing and rollout.

• Responsible program/office(s):
  • Veteran Service Organization (VSO)
  • Veteran Insight Panel (SHEP)
  • Health Service Research and Development Service (HSR&D)
  • Office of Analytics and Performance Integration (API)
  • Office of Health Equity (OHE)
  • Veterans Benefit Administration (VBA)
Key Priority/Issue #3

• Key issue: How are SDOH accounted for within a well-being measure?

• Research ideas to address barriers:
  • Is the social determinant an outcome, an intermediate process, or could it be used to adjust (stratify)?
  • Which social needs are an important part of Whole Health outcomes?
  • Maslow's hierarchy of SDOH and well-being: some things are more foundation and need to be addressed first.
  • Logic model- understanding of what are the inputs of Whole Health and what is the logic of the model to understand the logic for improvement.
  • What percent does SDOH play into population health and well-being outcomes?
  • Exploring engagement strategies such as the #Bethere campaign.
  • Social Prescribing (UK; Puget Sound) and Social Health Strategy (Canada).
  • Are services bringing value- VERA funding at the VISN-level.
Key Priority/Issue #3

• Policy recommendations:
  • Focus on the five SDOH DEs collected by Federal partners: housing, transportation, food insecurity, utility difficulty, and intimate partner violence.
  • Should the VA purchase and gather data to attach to records to assess well-being?
  • Procuring incentives to support data collection and reporting.

• Dissemination strategies:
  • Ensuring data completeness and quality- and sound implementation.
  • Moving beyond screenings and offering support across the Veteran’s journey.

• Responsible program/office(s):
  • ACORN, Veteran Service Organization (VSO), Veteran Insight Panel (SHEP), Health Service Research and Development Service (HSR&D), Office of Analytics and Performance Integration (API), Office of Health Equity (OHE), VBA, Office of Minority Veterans, Veterans Experience Office (VEO)
Issues/priorities that came up

• Importance of addressing/assessing social connection, social purpose, sense of belonging for well-being

• Need crosswalk for clinical-population health measures to avoid duplication and lead to harmonization

• Methodologic issues – e.g., using geospatial data for demographic differences between veterans and non-veterans

• How to look at financial well-being and who is responsible for it in VA

• VA is positioned to think innovatively about value-based payment and incentives for well-being in a way different from non-VA payors
Issues/priorities that came up

• Community characteristics and partnerships are critical to inform what’s happening outside of VA for the Veteran

• Whether or not to use individual measures versus portfolio approach – consider ease for use by clinician and focus on adding only measures that have high value

• We need to know why we are collecting selected measures – authority and intent of measure selection are crucial

• Sense of institutional pride versus betrayal based on identity (e.g., LGBTQ+ veteran experience)

• Be mindful of potential unintended consequences of generalizations extrapolated from a measure
Issues/priorities that came up

• Veteran perception that their responses may affect the services they may be eligible for – “Will I lose access to services if my answer changes over time?”

• Trust in federal government may impact access and utilization of services

• Veterans might be afraid to speak up for their own needs (related to military culture of not complaining or voicing needs)

• Equity issues in communities that impact measure sensitivity – e.g., redlining

• Understanding population health vis-a-vis diverse reasons for joining military (e.g., access to benefits/social mobility vs. draft vs. sense of duty, etc.)
Issues/priorities that came up

• Collecting data on family structures and period of service as constituent elements of overall well-being

• Measuring navigation processes that take a Veteran from problem identified to connected to service to address outcome

• Measuring well-being should be tied to knowing what we’ll do with the data and how it will inform resource allocation and efficiency

• Measures needs to serve everyone, especially mindful of minoritized populations

• Research on benefits and services and how they come together