VETERANS HEALTH ADMINISTRATION

Office of Health Equity

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OFFICE OF HEALTH EQUITY

Created in 2012

Vision: To ensure that VHA provides appropriate individualized health care to each Veteran in a way that-

- Eliminates disparate health outcomes and
- Assures health equity

OFFICE OF HEALTH EQUITY GOALS

1. **Leadership:** Strengthen VA leadership to address health inequalities and reduce health disparities.
2. **Awareness:** Increase awareness of health inequalities and disparities.
3. **Health Outcomes:** Improve outcomes for Veterans experiencing health disparities.
4. **Workforce Diversity:** Improve cultural and linguistic competency and diversity of the VHA workforce.
5. **Data, Research and Evaluation:** Improve data and diffusion of research to achieve health equity.

OFFICE OF HEALTH EQUITY POPULATIONS

Veterans who experience greater obstacles to health related to:

- Race or ethnicity
- Gender
- Age
- Geographic location
- Religion
- Socio-economic status
- Sexual orientation
- Mental health
- Military era
- Cognitive /sensory / physical disability

OFFICE OF HEALTH EQUITY WEBSITE

https://www.va.gov/healthequity

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Office of Health Equity

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NATIONAL CENTER FOR HEALTH STATISTICS

Among adults with underlying diabetes, veterans are more likely to be diagnosed by a health professional

95.1% Veterans

73.5% Nonveterans

NEW LGB Chartbook | Health Equity Video | Veteran Diabetes Data

Veteran Diabetes Data

Recent data analysis describes diabetes among Veterans and Nonveterans. Source: Healthy People 2020.

Learn more »

VHA Office of Health Equity

Equitable access to high-quality care for all Veterans is a major tenet of the VA healthcare mission. The Office of Health Equity (OHE) champions the elimination of health disparities and achieving health equity for all Veterans. OHE supports the VHA's vision to provide appropriate individualized health care to each Veteran in a way that eliminates disparate health outcomes and assures health equity

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Enhancing Primary Care Experience in Patients with Homeless Experience and Chronic Pain

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Enhancing Primary Care Experience in Patients with Homeless Experience and Chronic Pain

Stefan Kertesz, MD with Allyson Varley, PhD

@StefanKertesz & @AllysonVarley

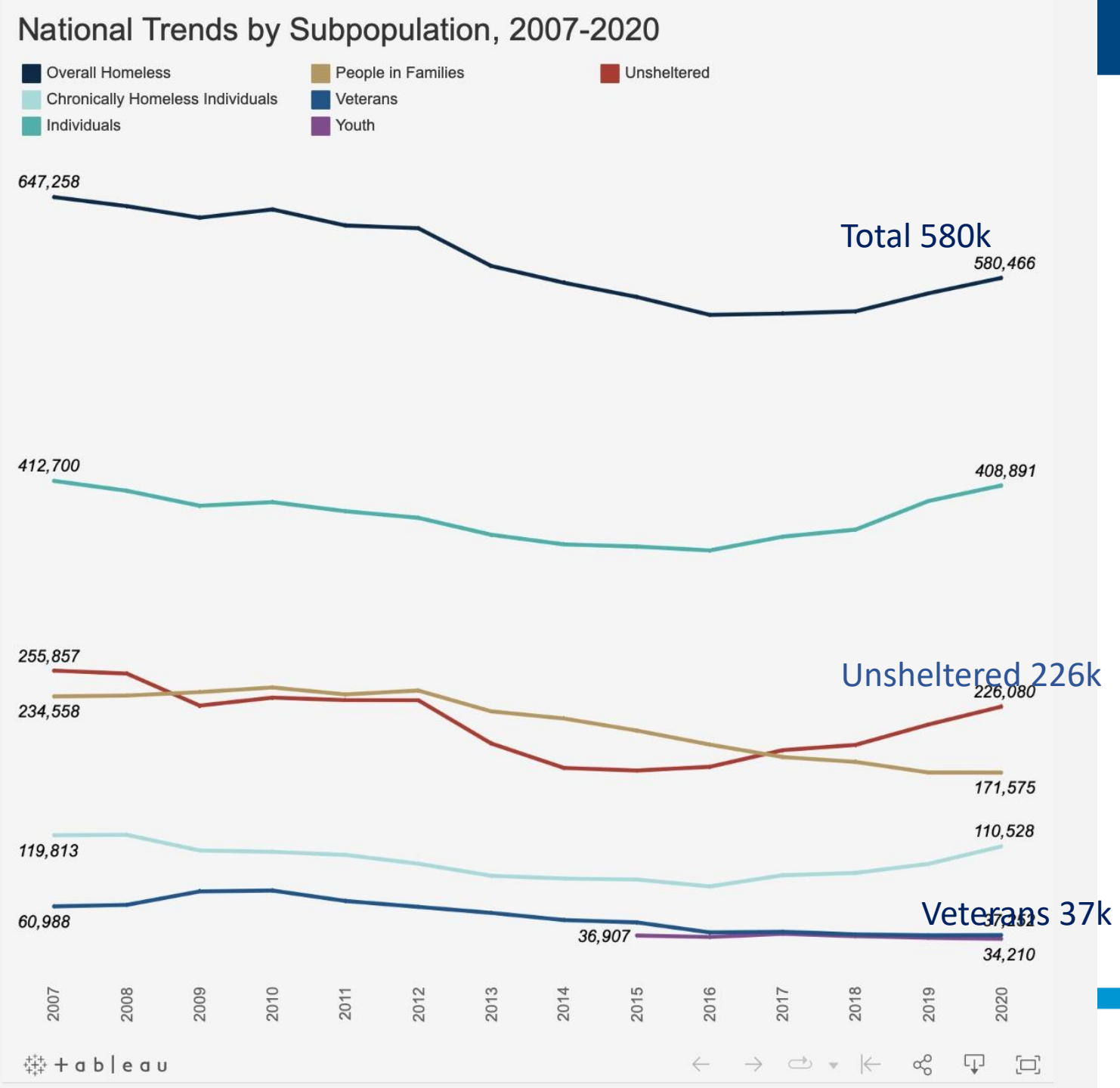
Birmingham VA Healthcare System

Work supported by VA HSR&D 15-065 and by a Pain & Opioid Core Rapid Startup Funding Program

Attendees will be able to

- Describe unique health and social issues that raise equity concerns for the primary and pain care of homeless populations
- Describe the pressures on health systems that may cause these equity concerns to be set back
- Identify evidence-based resources to measure care experiences for Veterans experiencing homelessness
- Detail the unique role of pain in affecting the equity of primary care for Veterans experiencing homelessness

Background



- A fall, then a rise in persons counted as homeless
- Unsheltered rising more steeply
- Veteran numbers (overall) not rising
- Point-in-time count likely underestimates actual phenomenon (i.e. urban gentrification pushes people out of sight)

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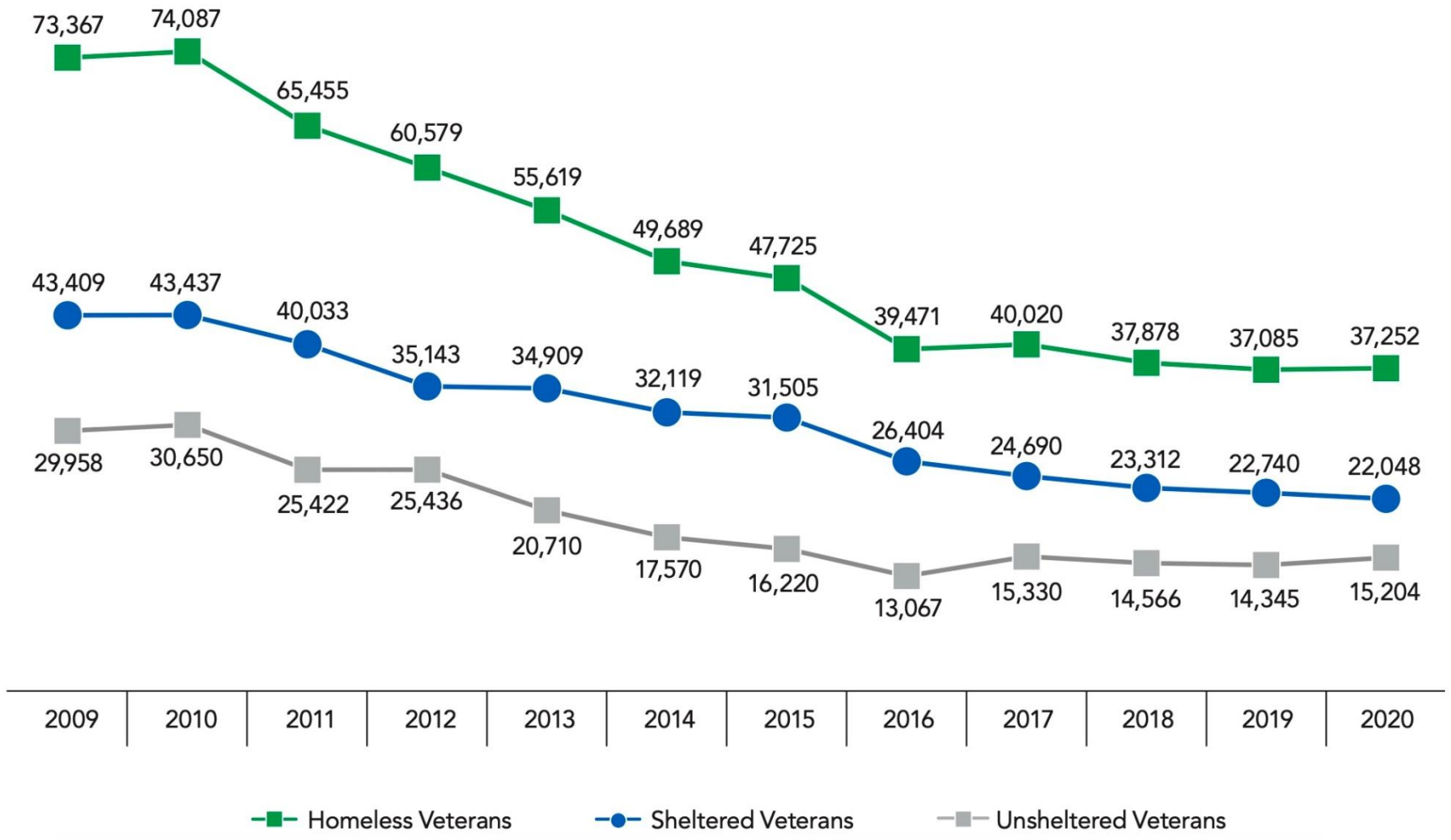
EXHIBIT 5.1: PIT Estimates of Homeless Veterans
By Sheltered Status, 2009–2020

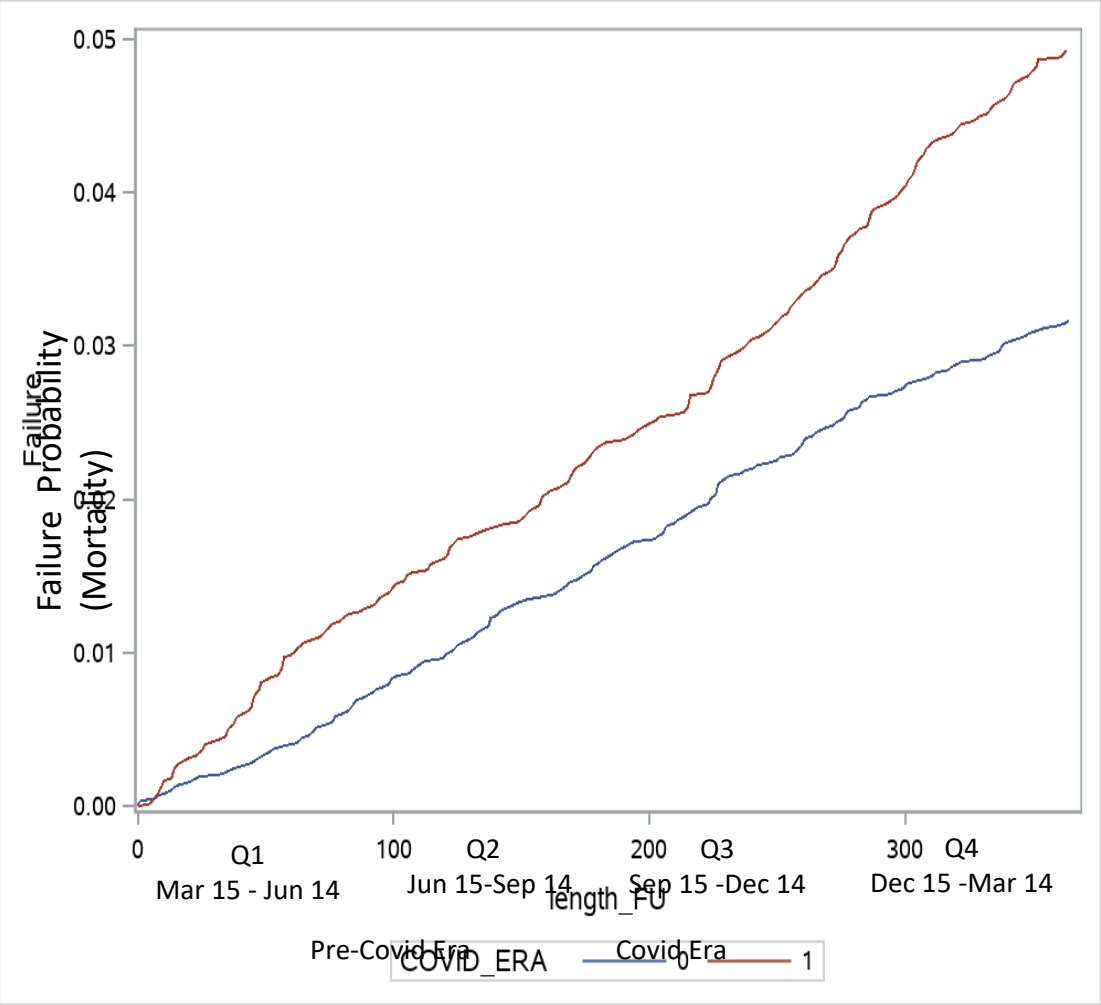


Mortality

- Homeless Veteran Deaths: 10-year follow-up from 2000-2010 : 2.9 times greater hazard of death, among young and middle-aged Veterans (Schincka, 2018)
- Many non-VA studies show mortality 3-8 times higher among persons experiencing homelessness

Death among Veterans with Experiences of Homelessness during first COVID year

- In 2018, we surveyed 5766 Veterans with experience of homelessness
- 5619 alive on 3/15/2019
- Pre-COVID: 178 (3.2%) died
- Post-COVID: 268 (4.9%) died
- 60% higher
  - (OR 1.6, 95% CI 1.3-2)
  - Adjusting for age, sex, race



Care challenges

Many challenges make care for unhoused people unique

- Access
  - Continuity/discontinuity
  - Barriers (logistics, payment, immigration)
- Needs
  - Complexity, severity
  - Social, medical, psychological
- Quality
  - Prior health system trauma and stigma

Care experiences are often poor

- Interviews with 36 patients (VA and non-VA) and 24 health care professionals, about aspirations in primary care (2010-12)
- Access disrupted by costs, transport, competing demands, unwelcome feelings
- Struggle with appointments, desire to walk in

Stigma and projections related to pain

- "The other side of that is having somebody that looks at your records and using them in a punitive way as **not to treat you but to cure you of something that you may not need** to be cured of. In my case, I had already kicked my drug habit and I was trying to deal with my problems that was part of **the wreck** as a result of my drug use. And rather than her address those needs, she took a different attack in dealing with me"
- From context
  - Pain issues related to a wreck, itself attributed by patient to drug use
  - The patient's (and/or clinician's) understanding of pain care might well have involved opiods
- This 2009 interview predates the downward prescribing of opioids

Varley et al. QHR, 2020.

Stefan Kertesz, MD: Let's survey the primary care experiences of patients experiencing homelessness!

A survey you can use! (PCQ-H)

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How do clinics, programs or funders “get it right?”

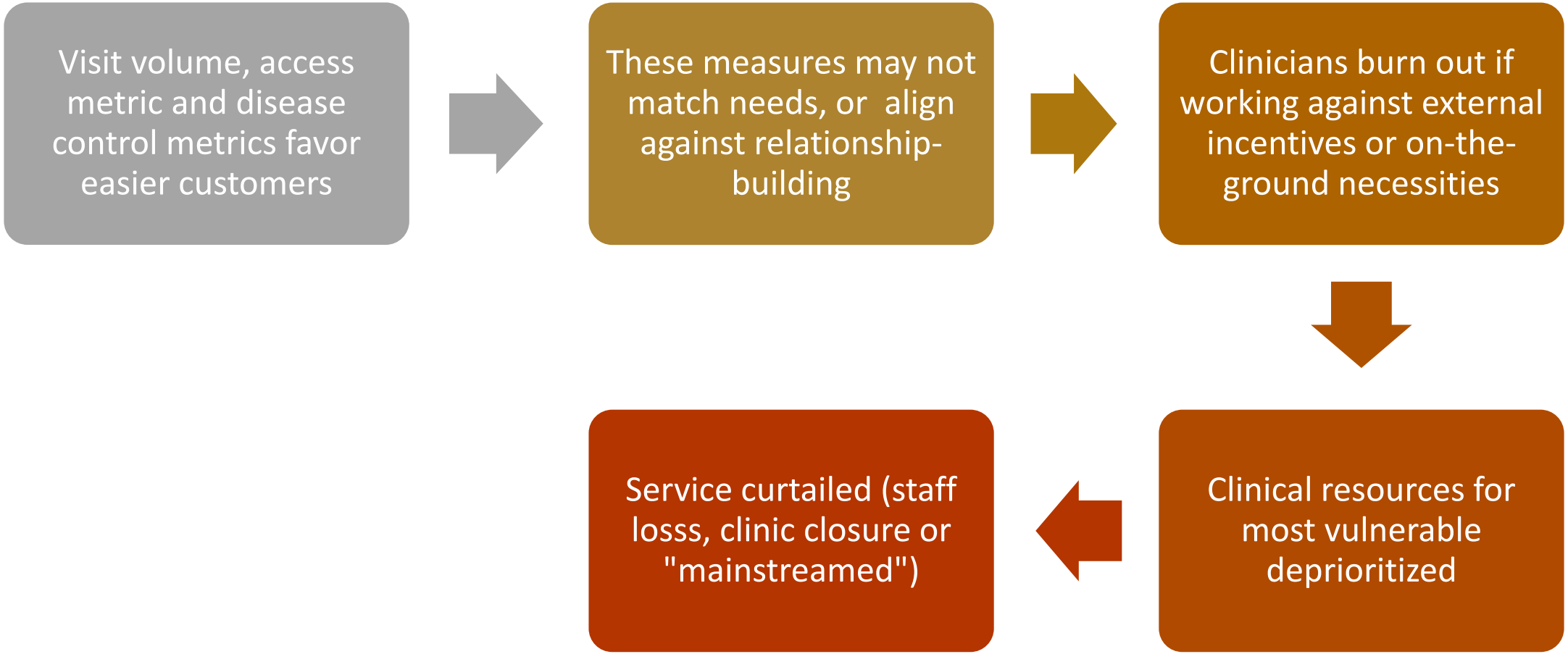
HCH and VA’s “H-PACTs” do some unique work

Birmingham VA's H-PACT

Boston’s street team

- It’s responsive to specific, common human & contextual challenges
- One that’s missed by most metrics

Risks to not measuring what matters



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How do we measure the value of the image on the left?

- Brett Feldman, PA, Keck/USC Street Team
- COVID-19 vaccine, hill country over LA

- Birmingham VA vaccination site January-March, 2021
- Up to 900 vaccinations / day
- At the United Way

With permission from Brett Feldman (USC Photo/Gus Ruelas)

It’s our patients who can tell us

Ellen Dailey met me in a Boston shelter when I advocated for her thyroid to be removed, working across Boston teaching hospital

Founding member Boston and National Consumer Advisory Board for National Health Care for the Homeless Council

She became the expert at holding Boston HCH, Boston Medical Center and others to account

What is our primary care experience survey

- 2011-2014: survey for patients with **recent homeless experience** who are obtaining **primary care**
- Key facts :
  - Started with 60 interviews, 4 focus groups
  - Draft items to N=563, then reduced
  - Items are **simple**, no skips, 7th grade reading
  - "Strongly Disagree" to "Strongly Agree" (+don't know)
  - Surveys can be **face to face** or **written**
  - We have 33-item and 12-item versions, English & Spanish
  - It's **free** (PDF, Word)
  - You don't have to be "homeless" etc, that day. We were careful

MEDICAL CARE
Official Journal of the Medical Care Section, American Public Health Association

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ORIGINAL ARTICLES

Development of the Primary Care Quality-Homeless (PCQ-H) Instrument

A Practical Survey of Homeless Patients' Experiences in Primary Care

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Author Information

Medical Care: August 2014 - Volume 52 - Issue 8 - p 734-742
doi: 10.1097/MLR.0000000000000160

This is a resource pack

- It includes survey tools
- It includes a separate folder of scientific papers
- Includes scoring tools
- This work was funded by US taxpayers (VA)
- It’s free

4 Scales

- Relationship (with the “clinician”)
- Cooperation (among the care team, as perceived)
- Accessibility & Coordination of Services
- Homeless-specific needs

4 Scales

- **Relationship (with the "clinician")** *(15 items, or 4 items)*
  - If my primary care provider and I were to disagree about something related to my care, we could work it out
  - I can be honest with my primary care provider if I use drugs or alcohol
- Cooperation (among the care team, as perceived)
- Accesssibility & Coordination of Services
- Homeless-specific needs

4 Scales

- Relationship (with the "clinician") *(15 items, or 4 items)*
- **Cooperation (among the care team, as perceived)** *(3, or 2 items)*
  - I have been frustrated by lack of communication among my primary care and other health care providers
- Accessibility & Coordination of Services
- Homeless-specific needs

4 Scales

- Relationship (with the "clinician") *(15 items, or 4 items)*
- Cooperation (among the care team, as perceived) *(3, or 2 items)*
- **Accessibility & Coordination of Services** *(15 items, or 4 items)*
  - This place helps me get care without missing meals or a place to sleep
  - I have to wait too long to get the health care services my primary care provider thinks I need
- Homeless-specific needs

4 Scales

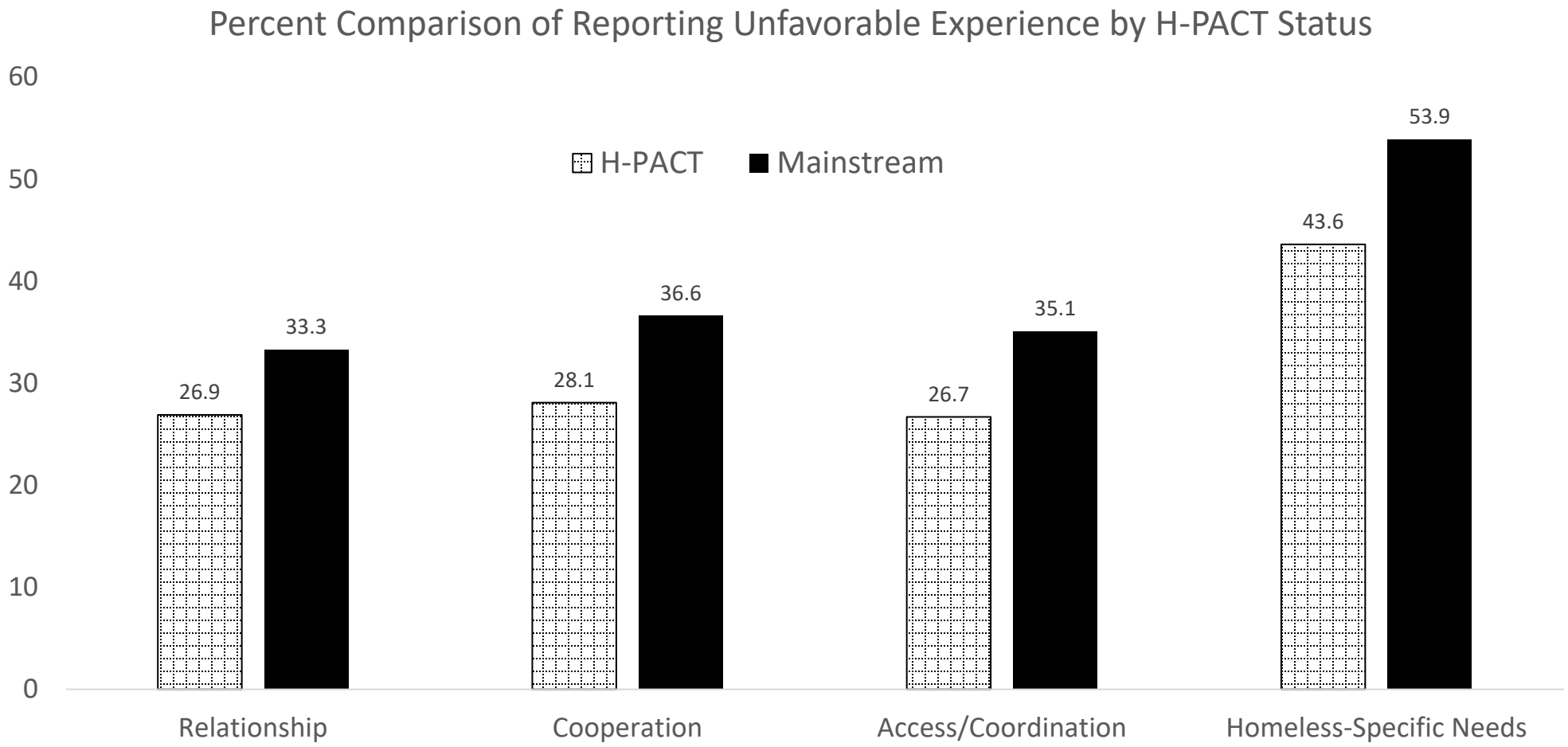
(number of items for 33- and 12-item version)

- Relationship (with the "clinician) *(15 items, or 4 items)*
- Cooperation (among the care team, as perceived) *(3, or 2 items)*
- Accesssibility & Coordination of Services *(15 items, or 4 items)*
- **Homeless-specific needs** (4 items, or 2 items)
  - This place tries to help me with things I might need right away, like food, shelter or clothing
  - The people who work at this place seem to like working with people who have been homeless

Survey of 2018

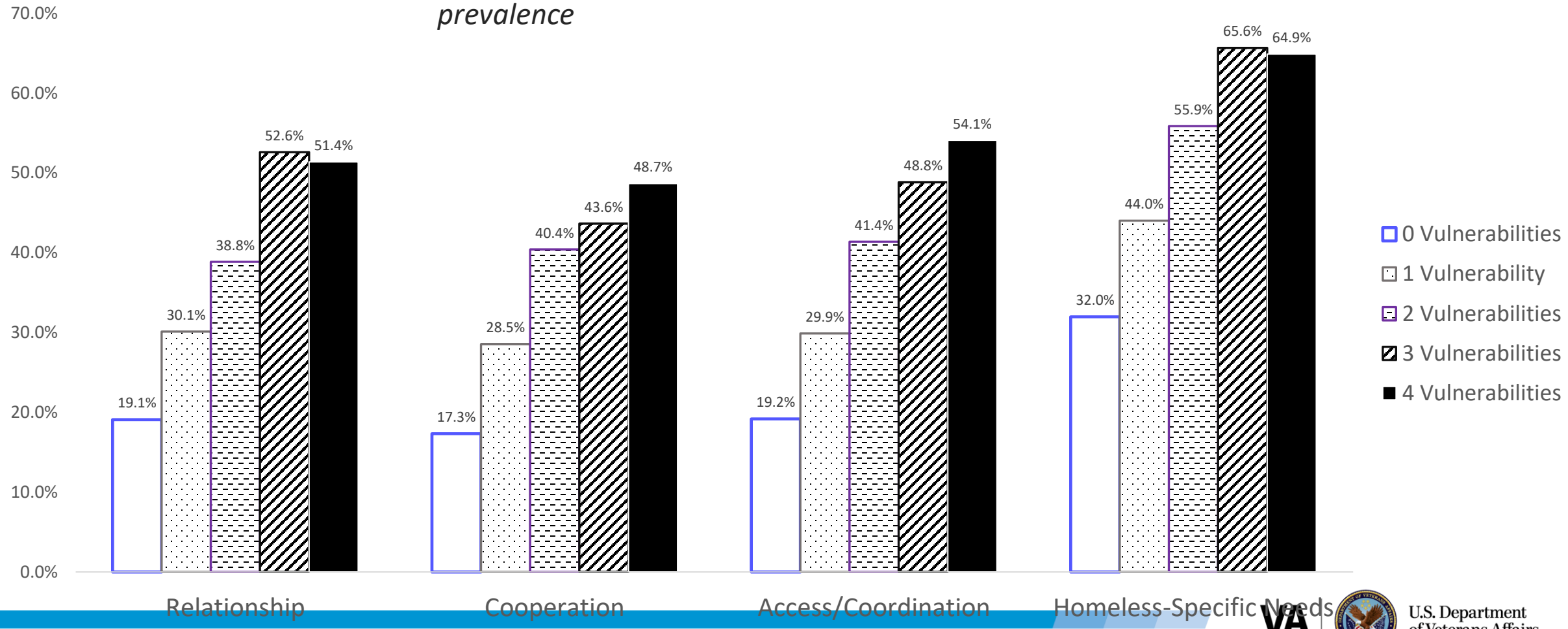
- Objective: Compare care in H-PACTs vs Mainstream Primary Care at the very same facilities for Veterans with homeless experience
- Surveys mailed (with telephone f/u) to 14,340 at H-PACT or a Mainstream PC clinic across 26 VA facilities
- 40.2% response rate (n=5766)
- Binary "unfavorable" indicator for each scale derived from count of frankly unfavorable responses
- All analyses controlled for age, sex, race, chronic homelessness, social support, count of medical conditions (by self-report), social support
- Post-hoc: 4 vulnerabilities that, to us, suggest challenges :
  - Severe chronic pain
  - Severe mental distress (Modified Colorado Symptom Index)
  - History of alcohol/drug overdose in last 3 years
  - Unsheltered homeless experience in the prior 6 months

H-PACTs: fewer unfavorable experiences

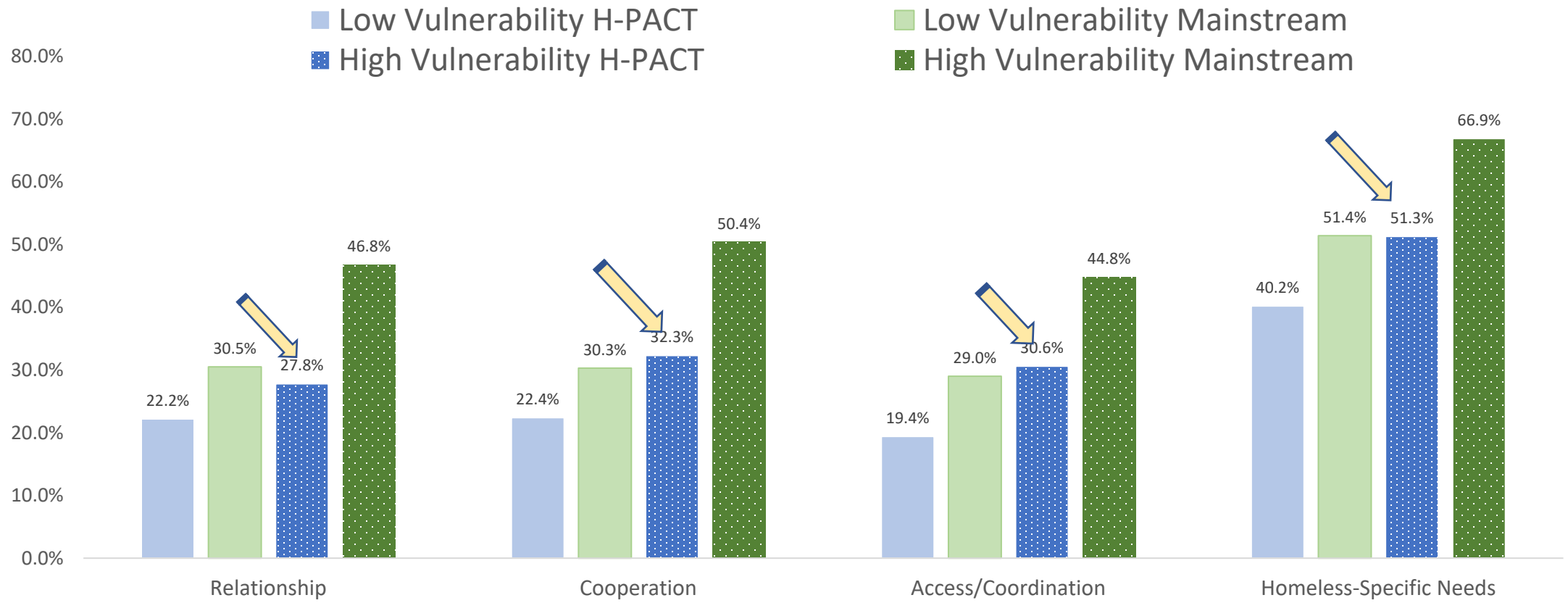


% Reporting Unfavorable Experience in Relation to Number of Assessed Vulnerabilities

- *As vulnerabilities rises, so does unfavorable experience prevalence*



Percent reporting unfavorable experience for HEV's with Differing Vulnerability Levels (multivariable-adjusted)



Conclusions

- H-PACT patients are less likely to report unfavorable patient care experiences than their Mainstream PC counterparts, regardless of whether they are highly vulnerable or not
- For two scales (Relationship to provider and perception of Cooperation among providers), that difference is more pronounced when vulnerability is high rather than low
- Limitations
  - Our findings don't attempt to show disease control
- Policy Implications:
  - Specialized clinical service (especially primary care) requires investments and protection

Pain/Opioid Core Rapid Start-up Project
Dr. Allyson Varley

How do pain and substance use issues both affect the primary care experience?

We offer a 4-group comparison

Pain/Opioid Core Rapid Start-up Project

Objective: Compare patient-reported primary care experiences between 4 groups:

- Veterans with both self-reported chronic pain and substance use problems
- Veterans with just self-reported chronic pain
- Veterans with just self-reported substance use problems
- Veterans that report neither chronic pain or substance use problems

among 3500 VHEs (Veterans with Homeless Experience) in the PCQ-HoST study

Hypothesis: Primary care experiences will be **worse** for CP+substance use problem compared to the other 3 groups.

Objective (exploratory): Explore relationship between pain-specific services and primary care experience.

Hypothesis: We hypothesized that patients with pain who received specialized pain management services would be less likely to report an unfavorable experience

How groups were defined:

CHRONIC PAIN

Please **circle the number** that best describes your pain on average in the past week (≥4) **AND**
Do you currently have bodily pain that has lasted for **more than 3 months**? (yes)

ALCOHOL OR DRUG USE

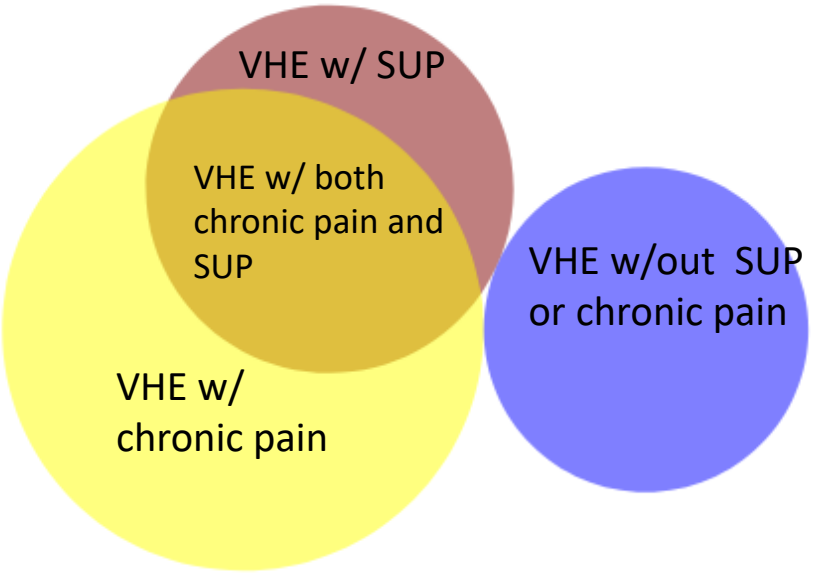
In the last **12 months**, have you ever drunk alcohol or used drugs more than you meant to? **OR**
Have you felt you wanted or needed to cut down on your drinking or drug use in the **last 12 months**?

Sources: *Pain items derived from combination of Landmark (22), Merlin (23) and Krebs PEG-3 (26). Alcohol/drug derived from Brown et al Two-Item Conjoint Screen (1995, 2001)*

Methods

- Explored **prevalence** of substance use problems, chronic pain, both, or neither in HPACT clients
- Multivariable logistic regression was used to model likelihood of **having an unfavorable experience** in clients reporting either substance use problems or moderate to severe chronic pain
- Then….
  - Focused on cohort of clients with moderate to severe chronic pain. Multivariable logistic regression was used to model likelihood of **having an unfavorable experience**.

Results



- Of the 3,281 H-PACT survey respondents with complete data:
  - 12% (n=382) had SUP only
  - 37% (n=1213) had chronic pain only
  - 24% (n=780) had **both** chronic pain and SUP,
  - 28% (n=906) had neither chronic pain or SUP

- The prevalence of unfavorable experience was higher on all 4 scales for patients reporting chronic pain (with or without SUP) (all $p<0.001$), but not for SUP alone compared to VHEs with neither.
- VHEs with chronic pain alone had nearly identical ORs to those with combined chronic pain and substance use problems (ORs=1.56 vs 1.50) on overall unfavorable experience, relative to having neither.
- The similarity in results between patients reporting chronic pain with or without SUP indicates there is not an interaction between chronic pain and substance use
  - Chronic pain is a more important predictor of unfavorable experience.

Results

- We found several services that reduced the odds of having an unfavorable care experience.
- **Long term opioid therapy** (defined as 4 Quarters in last year with ≥56 days of opioid coverage): unfavorable experience less likely
  - **OR= 0.54 / 95% CI, 0.37-0.79**
- Evidence of **any visit to occupational therapy**: less likely **OR= 0.80 / 95% CI, 0.67-0.95**
- There were no significant associations between unfavorable primary care experience and evidence of a visit to a pain clinic or physical therapy.

Pain/Opioid CORE VEP Feedback/Recommendations

- Patients with chronic pain carry worry and anxiety about treatments **not** working; they're skeptical **before** even going to the appointment that the provider **won't be able to help** with pain.
- Chronic pain often takes longer to diagnose and treat. "Substance abuse is more straightforward"
- Components of positive experiences: tried different treatments for pain, was given adequate time, easy to reach via phone or MyHealthEVet, asks if there are treatments the patient wants to try
- Services they are accessing: chiropractic, physical therapy, acupuncture, meditation, medications
- Listening is so important!

Conclusions

- Tailored primary care clinics matter immensely.
- Tailored primary care clinic likely DO require protection and investment.
- Measuring what matters is key when assessing quality of primary care in Veterans with multiple vulnerabilities.
- Whereas substance use problems alone do not correlate with poor primary care experiences H-PACTs, chronic pain (with or without substance use problem) **does**.
  - Long term opioid receipt and any use of occupational therapy **decreased** likelihood.
- The Pain/Opioid Core Veterans Engagement Panel provided meaningful recommendations in the interpretations of these results.
- HPACTs are small primary care teams. They sit in an ecosystem of VA pain and opioid related interventions.
  - Patients in HPACTs serve may not find it easy to use or benefit from those interventions or services, unless they also have that dedicated primary care team

Acknowledgements

- Thank you
  - HSR&D
  - Office of Health Equity
  - Pain and Opioid Core
  - PCQ-Host team