VETERANS HEALTH ADMINISTRATION

Office of Health Equity

Lauren Korshak, DHealth(c), MS, ACSM-CEP, EIM
Director of Education
Office of Health Equity

Lauren.Korshak@va.gov

Created in 2012

Vision

All Veterans will attain equitable health through high-quality health care and support for their social needs.

Mission

OHE advances health equity and ensures social needs are met for all Veterans through leadership, data analysis, education, tool development, and quality improvement initiatives.

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.

VETERAN 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

The Relationship Between Health System Quality and Racial and Ethnic Disparities in Diabetes Care

CYBERSEMINAR PRESENTERS

Justin List, MD, MAR, MSc, FACP
Director of Health Care Outcomes,
VHA Office of Health Equity

Email: Justin.List@va.gov

Michelle Wong, PhD
Health Science Specialist and Investigator
HSR Center for the Study of Healthcare Innovation, Implementation & Policy (CSHIIP), VA Greater Los Angeles Healthcare System

Email: Michelle.Wong6@va.gov

DEFINITIONS

Equality
Equality means each individual or group of people is given the **same resources or opportunities**.

Equity
Equity recognizes that **each** person has different circumstances and is **allocated the exact resources and opportunities needed to reach an equal outcome**.

Health disparity or inequity
A health disparity is a particular type of **health difference that is closely linked with social or economic disadvantage**. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment.

Health equity
Health equity is the **attainment of the highest level of health for all people**, valuing everyone equally, but focusing efforts and resources to reach equal outcomes. This entails addressing avoidable inequalities and historical and contemporary injustices.

EQUALITY VERSUS EQUITY

We're not all in the same place. **Equity** is reaching out to those in need, so no one is left behind.

Equality

Equity

Leave No Veteran Behind

EQUITY-GUIDED QUALITY IMPROVEMENT

- Improving population health
- Enhancing care experience
- Reducing costs
- Improving the work life of health care providers
- Advancing health equity

The Quintuple Aim
For health care improvement

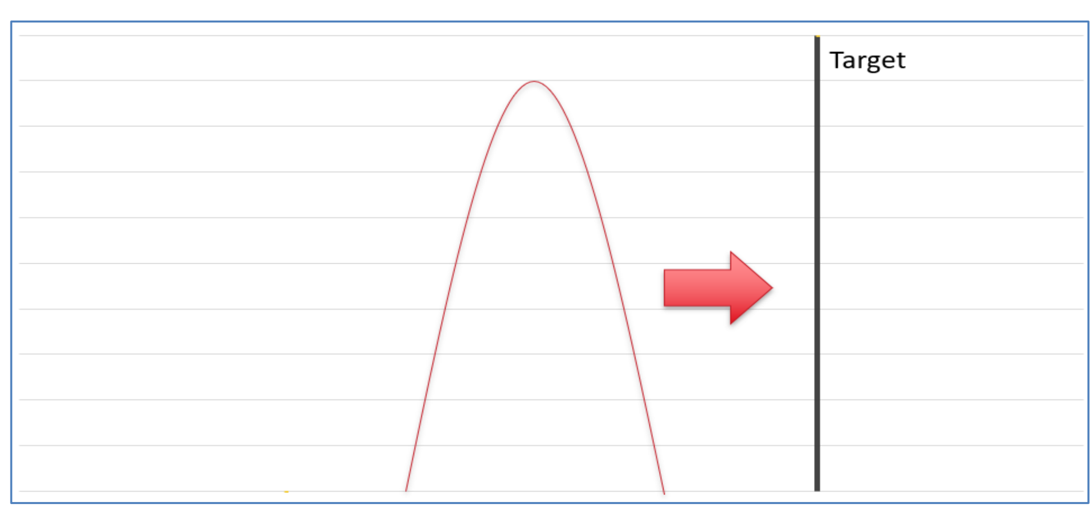
Improving population health
Enhancing the care experience
Care team well-being
Advancing health equity
Reducing costs

References: https://pubmed.ncbi.nlm.nih.gov/25384822/; https://pubmed.ncbi.nlm.nih.gov/35061006/

Reference: https://www.pwc.com/ca/en/industries/healthcare/system-fit-for-purpose.html

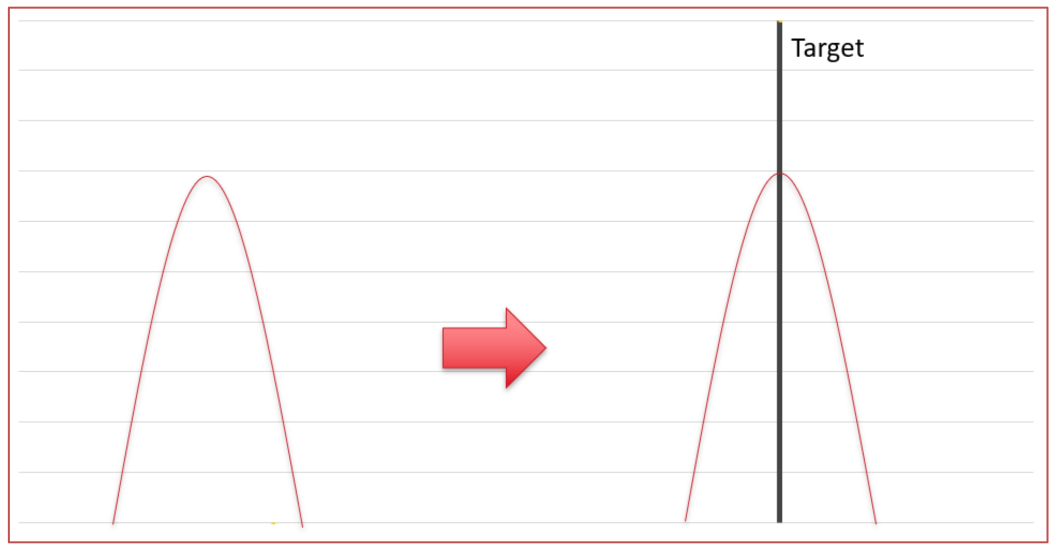
Equity-guided QI leverages existing quality improvement infrastructure

Traditional Quality Improvement



Redesigns processes to move a homogeneous population closer to target

Equity-Guided Improvement Strategy



Customizes processes to move an underperforming subset of a heterogeneous population closer to target

EQUITY-GUIDED QUALITY IMPROVEMENT FY2023

SGLT2i/GLP-1 RA Community of Practice

- QI Pilot Awards went to 5 project teams for FY23
- Diverse geography of participating VAMCs
- Projects include provider and patient education, pharmacist-driven improvement activities, addressing patient concerns
- Using a CoP/QI collaborative model for project teams to learn and problem solve with one another

Clinical/Equity Characteristics for QI Project Focus	Site A	Site B	Site C	Site D	Site E
DM2	X	X	X	X	X
CKD	X				
HF	X		X	X	
ASCVD	X	X			
High risk for ASCVD	X	X			
Race/ Ethnicity	X		X	X	
Gender			X		
Geography			X		X

EQUITY-GUIDED QUALITY IMPROVEMENT FY2023

Reducing Statin Utilization and Adherence Disparities Community of Practice

- QI Pilot Awards went to 5 project teams in FY2023
- Teams used the Primary Care Equity Dashboard
- Diverse geography of participating VAMCs
- Projects include provider and patient education, pharmacist-driven improvement activities, addressing patient concerns
- Using a CoP/QI collaborative model for project teams to learn and problem solve with one another

Clinical/Equity Characteristics for QI Project	Site A	Site B	Site C	Site D	Site E
Gender	X	X	X	X	
Race/Ethnicity	X			X	X
Measure: statn1_ec*			X	X	
Measure: statn4_ec	X	X		X	X
Measure: statn7_ec*		X	X	X	
Measure: statn8_ec				X	X

EQUITY-GUIDED QUALITY IMPROVEMENT FY2024

Chronic Disease Prevention and Management Project Titles
Utilizing the entire team to improve blood pressure in Black female veterans
Impact of Proactive Pharmacist-Delivered Education and Follow-Up to Improve Minority Veteran Hypertension Management and Care Engagement
Reducing Disparities in Hypertension: "Get Low" and "Let's Talk About Blood Pressure"
Integrating PACT Outreach and Whole Health Programming as a Diabetes Management Intervention to Reduce Race/Ethnicity-Based Disparities
Using Virtual Care and Home Telehealth to Improve Diabetes Control in Veterans Living in Rural Areas
Improving zoster vaccination rates in Black Veterans

Cancer Screening Project Titles
The Boost Team: SERVICE Act Outreach & Cancer Care Navigation
Improving Overall Colorectal Cancer Screening Rates and Practices in Women
Improving Colorectal Cancer Screening for Veterans Experiencing Homelessness

EQUITY-GUIDED QUALITY IMPROVEMENT TAKE AWAYS

- Practicing equity-informed health care delivery values **every** individual, regardless of background, tailoring care to help them reach their healthiest outcomes
- Equity-guided QI is tailored QI, using stratified data to inform diverse, tailored strategies to improve overall population health and reduce disparities among different groups
- Unlike research, equity-guided QI, like traditional QI, allows for rapid tests of change when encountering barriers during a project/approach
- Equity-guided QI is meant to be accessible for busy people and can be done at the frontline level up to the executive level

CSHIIP
Center for the Study of Healthcare Innovation, Implementation & Policy

The Relationship between Health System Quality and Racial and Ethnic Disparities in Diabetes Care

Michelle S Wong, PhD

Cyberseminar ● OHE Focus on Health Equity and Action Series
July 10, 2024

Disclosures

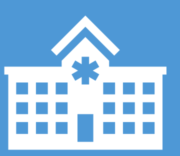
Authors have no conflicts of interest to report

This study was funded by the Department of Veterans Affairs, Health Services Research & Development Service (grant no. IIR 17-289).

The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or of the United States.

Background

- Healthcare systems rely on healthcare quality measures that are often calculated for the overall patient population
- Overall measure of quality may mask disparities



For example:
In a hospital with overall high quality, some patient groups may still receive suboptimal care
Looking at overall quality measures obscures this disparity!

Objective

Quality and equity relationship in diabetes care in Veterans Health Administration (VA)

- Diabetes: known racial and ethnic disparities
- VA: national learning healthcare system that prioritizes improving care quality

Study Objective: Are there racial and ethnic differences in diabetes care based on VA facility-level measure of quality?

Methods: Data & Sample

Sample: Veterans who used VHA ambulatory care between Mar 2020 – Feb 2021 & eligible for diabetes quality measure (age 18-75 & evidence of diabetes)

Data:

- Electronic medical record data
- VA Medical center (VAMC) quality: 2020 VA Strategic Analytics for Improvement and Learning Value Model (SAIL) report card: selected quality measures publicly reported for each VAMC

Methods: Measures

Independent variables:

1. VAMC performance: SAIL report card measure relevant to diabetes: diabetes and ischemic heart disease control composite
2. Veteran self-identified race and ethnicity

Methods: Measures

Dependent variables:

1. Poor diabetes care: Glycosylated hemoglobin (HbA1c) > 9% OR no diabetes testing

2. No diabetes testing

Process measure

3. HbA1c > 9 % (among those tested)

Outcome measure

Methods: Analysis

Mixed effects logistic regression model

- Multi-level data: Veterans nested in VAMCs
- Cross-level interaction: VAMC performance level x Veteran race and ethnicity

Sensitivity analyses

1. Controlled for age and sex
2. Independent variable: VAMC performance level based on diabetes composite component of the SAIL measure

(remember… SAIL measure used was diabetes control and ischemic heart control composite)

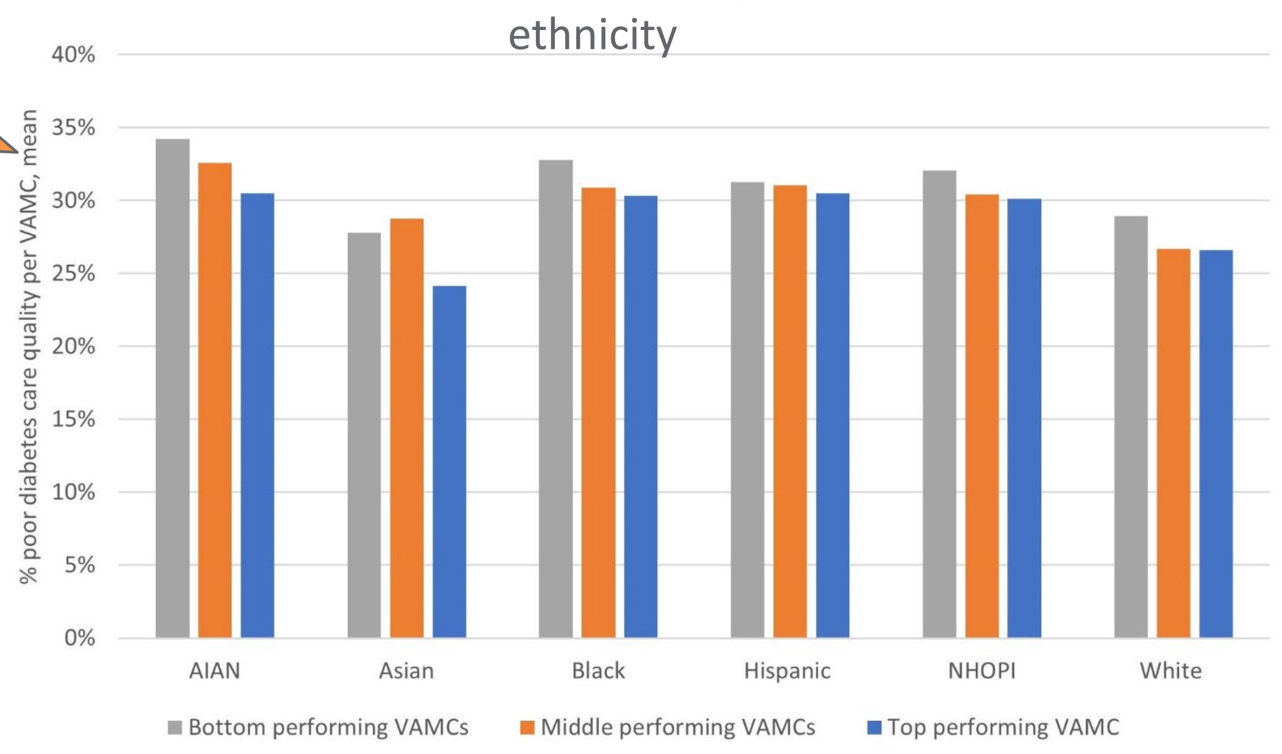
Results: Differences in VAMC racial and ethnic composition

	Top-performing VAMCs (Top Quintile)	Middle-performing VAMCs (Q 2- 4)	Bottom-performing VA (Bottom Quintile)
Total # of VAMCs	28	86	29
Mean # VA-users eligible for diabetes quality assessment per VAMC (SD)	7885.9 (4656.7)	6542.2 (2080.9)	4921.1 (2381.7)
Racial and ethnic composition of VA-users eligible for diabetes quality measurement assessment, %			
American Indian or Alaska Native	0.7	0.7	1.2
Asian	1.2	1.0	0.9
Black or African American	25.5	24.1	14.0
Hispanic	10.3	6.6	7.0
Native Hawaiian or Other Pacific Islander	0.8	1.0	0.7
Other (Multi-race, missing)	5.2	4.3	5.5
White	56.3	62.3	70.7

VA U.S. Department of Veterans Affairs
VA Greater Los Angeles Healthcare System

Results: Poor diabetes care decreases with better VAMC performance

Lower % is better!

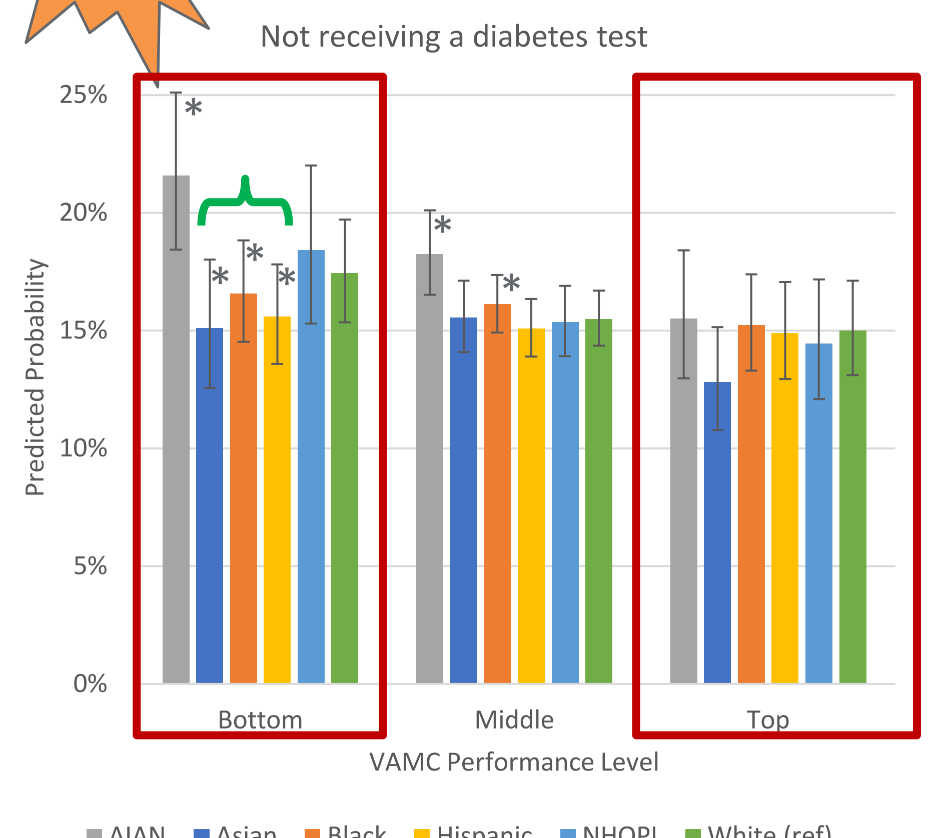


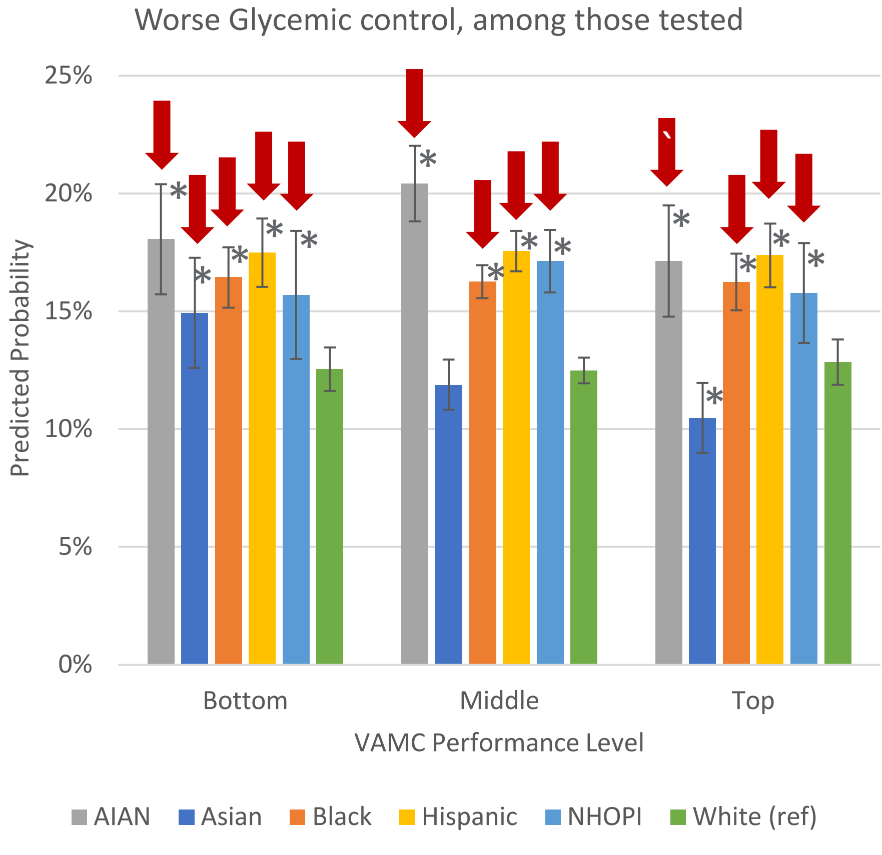
Results: Disparities in diabetes care across all VAMC performance levels

Predicted Probability of having poor diabetes care for each racial and ethnic group, stratified by VAMC performance level

Results: Disparities driven by poor glycemic control

Lower % is better!



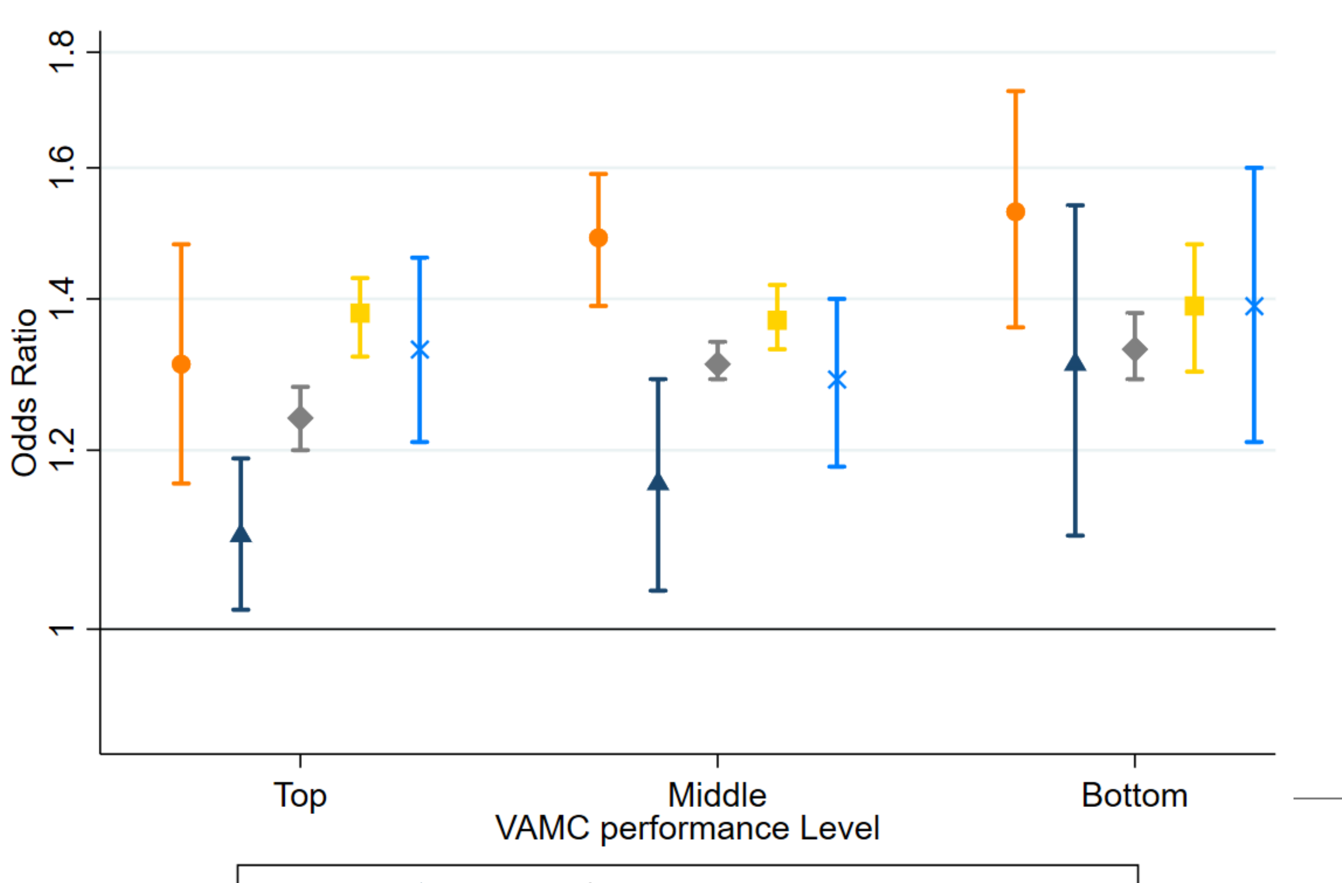


Sensitivity analysis: Few differences with age and sex adjustment

	Model 1: Unadjusted			Model 2: Age and Sex Adjusted		
	OR	95%CI	p-value	OR	95%CI	p-value
Race and Ethnicity						
White	1	(ref)		1	(ref)	
AIAN	1.22	(1.09,1.36)	<0.05	1.19	(1.07,1.33)	0.002
Asian	0.8	(0.73,0.88)	<0.05	0.72	(0.66,0.80)	<0.05
Black	1.16	(1.14,1.19)	<0.05	1.09	(1.06,1.12)	<0.05
Hispanic	1.22	(1.18,1.26)	<0.05	1.12	(1.08,1.17)	<0.05
NHOPI	1.11	(1.00,1.23)	0.05	1.05	(0.94,1.16)	0.396
Race and ethnicity * VAMC performance level interaction						
AIAN * Middle	1.25	(1.10,1.42)	0.001	1.21	(1.07,1.38)	0.003
AIAN * Bottom	1.19	(1.02,1.38)	0.023	1.16	(1.00,1.35)	0.053
Asian * Middle	1.23	(1.09,1.37)	<0.05	1.22	(1.09,1.36)	0.001
Asian * Bottom	1.25	(1.07,1.46)	0.004	1.19	(1.02,1.39)	0.03
Black * Middle	1.03	(1.00,1.06)	0.042	1.03	(1.00,1.06)	0.022
Black * Bottom	0.97	(0.92,1.01)	0.12	0.97	(0.93,1.01)	0.136
Hispanic * Middle	1.00	(0.95,1.05)	0.957	1.00	(0.95,1.04)	0.885
Hispanic * Bottom	0.93	(0.87,0.98)	0.013	0.93	(0.87,0.98)	0.011
NHOPI * Middle	1.08	(0.96,1.22)	0.212	1.07	(0.95,1.21)	0.253
NHOPI * Bottom	1.06	(0.89,1.26)	0.49	1.03	(0.87,1.23)	0.697

Sensitivity analysis: Disparities at all VAMC performance levels

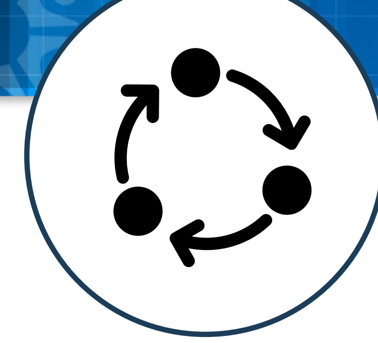
Sensitivity analysis: Odds ratio of poor diabetes care (vs. White Veterans) stratified by VAMC performance level **based on diabetes composite of SAIL measure**



Conclusion:
Diabetes Care Quality

- Racial and ethnic disparities in diabetes care exists even in top-performing VAMCs
- Diabetes care for White Veterans at bottom-performing VAMCs was similar to, or better than some minoritized groups at top-performing VAMCs
- Disparities consistent at all performance levels for some racial and ethnic groups

Conclusion: Process vs. Outcome



- Disparities in diabetes care driven by HbA1c control rather than by monitoring
  - Advantages for some racial and ethnic groups in bottom performing VAMCs: interventions to improve glycemic control
  - Top performing: good diabetes monitoring
- Disparities by VAMC performance level varies by race and ethnicity… implications for interventions!

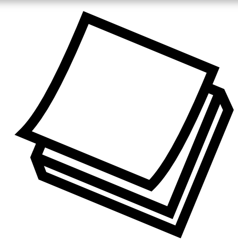
Strengths and Limitations

LIMITATIONS

- Overlapped with COVID-19 pandemic
- Considered only one condition and one type of disparity
- Limited generalizability to US population

STRENGTHS

- National data from a diverse patient sample within a learning healthcare system
- Included smaller racial and ethnic groups often excluded from other national studies
- Case study to demonstrate discordance between quality and equity



Implications

- High quality ≠ equitable care
- Increasing recognition e.g., The Joint Commission elevated health equity as a new National Patient Safety Goal
- Healthcare quality measures should include separate equity measures
- Differences by race and ethnicity: tailored approach to diabetes care

Implications: for Quality Improvement (QI)

- Incentivize equity efforts
  - SAIL measure on equity???
- Incorporate health equity into quality improvement (QI) projects:
  - QI measures: Process, outcome, balancing…equity?
  - Equity measures, dashboards, and tools

Brainstorming opportunity: how to incorporate health equity into QI

Acknowledgements

Funding:

Department of Veterans Affairs, Health Services Research and Development Service (grant no. IIR 17-289)

Co-authors:

- Chi-Hong Tseng
- Ernest Moy
- Kenneth T. Jones
- Amit J. Kothari
- Donna L. Washington

Manuscript forthcoming

EMERGING & GLOBAL HEALTH POLICY

JOURNAL ARTICLE ACCEPTED MANUSCRIPT

Relationship between health system quality and racial and ethnic equity in diabetes care

Michelle S Wong, PhD, Chi-Hong Tseng, PhD, Ernest Moy, MD MPH, Kenneth T Jones, PhD, Amit J Kothari, MD, Donna L Washington, MD, MPH, FACP

Health Affairs Scholar, qxae073, https://doi.org/10.1093/haschl/qxae073

Published: 04 June 2024 **Article history ▾**

Questions?

Link to manuscript here

Contact:

Michelle.Wong6@va.gov

Follow me on Twitter @Mychellss

APPENDIX

SAIL Diabetes composite

- **Diabetes composite:** HbA1c annual testing, blood pressure <140/90, HbA1c >9 or no evidence of test (reverse coded so that higher achievement is better), renal testing, statin therapy for patients with diabetes
- **Ischemic heart disease composite:** blood pressure <140/90 among patients age 18-59 with active diagnosis of hypertension, blood pressure <140/90 among patients age 60-85 with diagnoses of both hypertension and diabetes, blood pressure <150/90 among patients age 60-85 with diagnosis of hypertension and no diagnosis of diabetes, statin therapy for patients with cardiovascular disease

Sensitivity Analysis

	Model 1: Unadjusted			Model 2: Age and Sex Adjusted		
	OR	95%CI	p-value	OR	95%CI	p-value
VAMC performance level						
Low performing	1	(ref)		1	(ref)	
Medium performing	1.00	(0.89,1.13)	0.939	1.01	(0.90,1.14)	0.81
High performing	1.13	(0.97,1.30)	0.108	1.14	(0.99,1.32)	0.075
Sex						
Male				1	(ref)	
Female				0.85	(0.83,0.87)	<0.05
Age categories						
19-24 years				1	(ref)	
25-29 years				0.76	(0.60,0.97)	0.028
30-34 years				0.67	(0.53,0.85)	0.001
35-39 years				0.61	(0.48,0.77)	<0.05
40-44 years				0.55	(0.43,0.69)	<0.05
45-49 years				0.49	(0.39,0.62)	<0.05
50-54 years				0.43	(0.34,0.55)	<0.05
55-59 years				0.39	(0.31,0.49)	<0.05
60-64 years				0.35	(0.27,0.44)	<0.05
65-69 years				0.32	(0.25,0.40)	<0.05
70-75 years				0.25	(0.05,1.27)	0.095