Ernest Moy: So, good morning everyone. I would like to welcome everyone to January’s focus on health equity and action cyber seminar – on the recently released chartbook on healthcare for veterans. This project is a collaboration between VA and the agents for healthcare research and equality. I’ll make my remarks very brief, so you have more time to listen to our speakers. But I wanted to explain why we though this joint project was important to do.

I came to VA about two and a half years ago from the Department of Health and Human Services. Because I wanted to do more than just write and speak about health inequities. I wanted to do something about them. And VA has lots of researchers and clinicians focused on improving the health and healthcare of veterans. We are ideally situated for dealing with issues of equity. And we have tons of data on veterans in our systems for equity interventions. However, one gap I observed is that we have less information about the 60% of veterans not enrolled in our system. These might be veterans who come in and out of our system, as their needs and insurance changes over time. These might be veterans who have left VA because they were not satisfied with the care they got here. But mostly I think these are veterans who simply don’t know VA care is right for them. I think we have a duty to help old veterans. And so we should have awareness of the health and healthcare of those not under our care at this time. Next slide.

Whitney Lee: I’m sorry Dr. Moy which slide are we supposed to be on right now?

Ernest Moy: I’m sorry. Slide number three.

Whitney Lee: Yeah so, we are.

Ernest Moy: Okay I’m sorry. I guess I don’t – simply don’t see that. Coming from the Department of Health and Human Services, I knew exactly where to turn to for help, understand issues related to access, quality and disparities of care that can help us, help the veterans better. The Agency for Healthcare Research and Quality produces an annual report to Congress on the status and progress of quality and disparities in healthcare in the US. And while they have not focused on veterans in the past, they have the ability to do so. So I reached out to Dr. Jeff Brady, our first speaker, and his center that produced National Healthcare Quality Disparities Report and was thrilled when they agreed to help us. Dr. Brady was a Navy Physician and Admiral in the Public Health Services Commission Core. He is now the Director of the Center for quality Improvement Patient Safety. He will be followed by Dr. Abby Woodroffe who led the team at Impact International that produced the chartbook under the direction of Arc. While she is not old enough to work on the first national healthcare quality and disparities report, we do not hold that against her. A staff at impact have however, worked for decades on these reports. And then finally are discussing – next slide please.

Requires a little introduction. You may know that Dr. Carolyn Clancy was the Director of Arc, until VA stole her from us to serve our veterans. She has twice served as a second in charge and is currently the assistant under Secretary for Health for Discovery Education and Affiliate Networks. More easily stated as the DEAN.

You may not know that at Arc, she was the executive sponsor for the First National Healthcare Disparities Report about twenty years ago. And with that, I’m going to have you turn the ball over to our first speaker, Dr. Jeff Brady.

Dr. Jeff Brady: Okay well hello everybody, can you hear me okay?

Whitney Lee: Yes, we can.

Ernest Moy: Yep.

Dr. Jeff Brady: Thank you for that, okay. Well thank you Dr. My. I am so please to be with you today to share this overview of AHRQ’s program and discuss our collaboration with the veteran’s – Health Administration Office of Health Equity. I am also encouraged that the issues of health and healthcare equity are thankfully receiving more and more attention. This particular seminar is meaningful for me because it offers an opportunity to share the virtual podium with colleagues who have taught me so much about healthcare safety quality, and equity. And who in fact, are responsible for several innovations in this space. I think Dr. Moy in particular, is modest in terms of his role. He’s really kind of shaped before he left AHRQ, not only the healthcare quality and disparities report, but also that entire program. So Dr. Moy and Dr. Clancy I’d like to also acknowledge my Arc colleague, Commander Karen Chavez and her team. We collaborated with others including Dr. Woodroffe to produce the chartbook that we’ll describe today.

Okay. Bear with me. Okay so I’d like to start by describing AHRQ and our role. AHRQ as hopefully many know is the lead federal agency that’s tasked with health services research and also proving the safety and quality of the nation’s healthcare system. We certainly do not do this alone, that’s a tall task. So we work with several throughout government and throughout the entire healthcare ecosystem. Several other agencies and organizations such as the VA also carry out explicitly healthcare services research. So, we have enjoyed many collaborations such as this with them. Fundamentally, AHRQ’s goal and the reason we exist is it’s going to improve the lives of patients. So, that’s essentially the why of our work. Sort of looking upstream, the aim that supports our goal is Arc’s focus on helping healthcare systems and professionals deliver care that is safe, high quality and also has value. That is sort of what we do.

And finally, various competencies that AHRQ has developed over the years support our aim, and ultimately our goal. And these competencies include things like health systems research, experience with practice improvement, actually on the ground improvement at points of care, and also data analytics that are relevant to healthcare quality. And these competencies represent how we work to support the field and better care.

So one example of a program and resources that Arc supports is the National Healthcare Quality and Disparities Report. The NHQDR is an annual report to Congress that’s required by Arc’s authorizing legislation and the overarching purposes to describe a status of healthcare quality and disparities in the United States. It’s produced by a small, but mighty king at Arc that has the guidance and input of the teams inner-agency work group, which includes representatives from the VHA Office of Health Equity. And again we’re please that Dr. Moy continues to influence the reports through his representation on the inner agency workgroup.

So, how is this report unique? The NHQDR draws from multiple data sources in an effort to focus attention on the overall status and trends of healthcare quality and disparities. And this is the report and the team take a very sort of macro perspective on healthcare quality and disparities. And they seek to apply that perspective using available data and information that collectively offers sort of representative picture of healthcare quality.

In addition, to this more comprehensive kind of over-arching view on the status and trends of healthcare quality and disparities the report and its associated products also offer various views and insights that you could consider to be sort of at a meso level. And some examples of those include grouping to measures that address things such as the quality of care in different healthcare settings. So, in hospital, ambulatory care, nursing home, long term care, etc. Another grouping would be quality of care about conditions. And those include examples of both acute and chronic conditions. Again, to be sort of representative on both of those fronts since the course healthcare services both of those needs.

And then other examples of the quality of preventive care services. I think many have observed for years, decade that moving upstream in the disease process and trying to climb more preventive care services is definitely part of healthcare qualities that add another dimension, that again, offer one of these sort of mid-level views.

And then finally, issues such as access to care also represented. We seek to provide insides about disparities and care for various populations for each of these same groups of measures. So I think that alignment between your perspectives on healthcare quality and sort of applying that to news on disparities actually is one of the strengths of now, a combined report. This now single report used to actually be two different reports. So, I think hopefully the combination that’s occurred over the last few years to a single report, also represents more integration around this important issue of health equity. And when the various perspectives all come together in the report and the associated products and tools that you can see here on the screen at the bottom, policymakers and other users can hopefully more clearly see gaps in areas that require more attention and kind of support that on the groundwork that Dr. Moy referred to in his opening remarks.

So the report covers as I’ve already described, a broad range of topics across the entire quality continuum. There are more than 250 measures within the measure set that makes up the report. And as is shown on the slide, we organize and define the measures according also to the quality domains of patient safety, patient centered care, care coordination, effective treatment, healthy living and affordable care. So these are sort of yet even more kind of grouping’s of measures that hopefully provide a more insightful few on healthcare overall. And again, the same organization of approach is applied not only to the work on healthcare disparities, but it’s what was used in the chartbook for veterans that you’re going to hear more about.

So the latest full report was just published in December of 2020. And it’s available at the AHRQ website for your review. And this year annual report features more federal sources and includes a discussion on disparities in US healthcare and US healthcare work force. In addition to the report, the team that produces the report also generates states map shots. And those are really of high interest. Again as a drill down if you will on the national healthcare quality picture. Obviously states have a role in healthcare quality and different activities that are intended to advance healthcare quality. And so providing those state level views often is another set of comparisons that really add some richness to the report.

We also have data spotlights, which focus on select measures and different key topic areas. And then lastly, chartbooks, again that’s the focus of today. And I want to just mention that the links are included in the slides that hopefully you’ll be receiving or have already received; so hopefully this will be easy for you to get to.

So one of our most recent collaborations of course, is what we’re talking about today. And again, it couldn’t have been a more productive undertaking with the Office of Health Equity at the VHA. So work originated back in May of 2019. So, it took a lot of time and energy between then and now to get us to the point we are today; so thanks to everybody that contributed to that. And since then you know the close working relationship we had, I think is responsible for what you’re going to hear more about.

This is the first time that the quality and disparities report team has reported on the healthcare quality and access issues for veterans. Obviously, an important group within our country. They have health system that’s intended to support you know, their needs, and so that alignment is something we’re excited about to be able to report at a level that aligns with in fact, the healthcare system that’s designed to care for these important individuals.

One of the things I’m really interested in is you know, anybody that is interested in doing more on healthcare equity, this is the kind of information that is often a starting place. We talk about it as hypothesis generating in many cases. You won’t find all the answers in the report. But hopefully this is an important pathway to the answers that we know people need to generate in order to group healthcare quality and disparities.

So, now I’m going to turn things over to Dr. Abigail Woodroffe. She’s the Project Director and was the lead also on the chartbook. And she’s going to tell you more about the key findings. So bear with me Woodroffe, I’m going to pass the ball to you.

Dr. Woodroffe: Thank you Dr. Moy and Dr. Brady for the introduction. Thanks for giving me the opportunity to share the work that we did on the chartbook. As we’ve heard from the previous speakers the NHQDR, the National Healthcare Quality Disparities Report is supported by a series of resonated chartbooks. In the past, chartbooks covered topics such as access to care, priority areas, healthcare populations and of course the topic of this presentation is the veterans chartbook.

As we’ve heard it was a collaboration between Arc, VHA and Interagency Work Group. The VHA Office of Health Equity was created in 2012 and their goal is to promote the advancement of health equity and reduction of health disparities where they’re defining how equity is defined as the attainment of the highest of self for all people. And health disparities are health differences that are closely linked with social or economic disadvantage.

I’ll give a brief overview of veterans. This audience as you’re likely aware, veterans differ from non-veterans in demographic and other factors. Some veterans who receive healthcare through VA and as I’ll show in subsequence sides there are times when the VHA user also differ from veterans who do not use VHA.

And lastly, evidence suggests that disparities in healthcare access and quality exists between these different groups. So between veterans and non-veterans within the veteran population across demographic characteristics and then also within VHA populations.

So, as I just mentioned this next couple slides will give a little bit of background on some of the differences between those three populations, between non-veterans, veterans and then the VHA population. For example, females make up about half of the non-veteran population. But only make up 9% of the veteran population and only 7% of the VHA population.

The age distribution is also very different where veterans and VHA are on average much older. As we see in the slide, nearly half of the non-veteran population is 18 to 44 years old. Whereas the veteran in VHA users are slightly more than 50% or right around 50%, 65 and older.

For the – when we’re looking at race/ethnicity, the non-veteran population is more diverse than the veteran population. Non-veterans more likely to be black or Asian, other race, multi-race demographic groups.

We also looked at where veterans and non-veterans lived in the world and urban location. And non-veteran population is about 20% rural; however a quarter of the general population over one-third of the VHA users they live in rural areas. In terms of disabilities the veteran population has about twice the percentage of \_\_\_\_\_ [00:17:50] with a disability than the non-veteran population between 14% and very – almost 30%.

The next couple slides are going to talk about the chartbook methodology. So as I just talked about there are three populations that we are interested in looking at. The veterans, non-veterans and veterans who use VHA services. Amongst those we created three contrast or three types of comparisons. So contrast one, we’re looking at veterans compared to non-veterans. And as we just showed on the other slides, there’s differences in ages and genders between veterans and non-veterans and made sure to standardize those two demographic characteristics.

Contrast two was just subsetting to veterans and then within that veteran population looking at characteristics such as age, gender, race. And then for number three was veterans who use VHA services. And again, just looking at that population but looking across different characteristics.

And then we – because we were looking at different populations, we did use some different data sources. We use the – for contrast one and contrast two we use the National Healthcare Interview Survey, which was a national survey that provides information about health status and access to care. We also use MEPS and Medicare expenditure panel survey, actually a subset of the NHIS population. In both cases due to self-reported by the interviewee or by a proxy for the interviewee.

And then for contrast three, this is the one we were just \_\_\_\_\_ [00:20:01] VHA population. We pulled our information from the Survey of Healthcare Experiences of patients. This is a patient experience survey, similar to Paps. We also for the larger check list we also looked at VHA administrative mortality data. It is not presented here. Just in the interest of time, but if you are – would like to see chartbook online.

The data that we received from Arc, CDC or VHA were already aggregated, however we did perform some analytics to prepare the data, so that we could prepare across the different measures and across different data sources. So the first thing we did was to align the metrics, so that higher rate is better. We also determined the reference group for each of the comparisons. Please note that not all comparisons were conducted for all measures, it varies by data source. Some data sources didn’t have certain information and then also there were some limitations in terms of sample sizes and work responsiveness.

For the analysis, analytics differed slightly based on data source. The meps data were separated by age, gender strata and were age adjusted gender strata and VA were age gender adjusted. But regardless of the data we received, we compare the priority group or groups to reference group for each category. So for example, we have three different age categories. We compared middle-aged individuals compared to the reference group, which was the youngest group. Then we also had older senior individuals who were also compared to that youngest reference group. And then we used the NHQDR criteria to meaningful differences. So, we looked at the absolute difference with statistically significant and we also made sure that the relevant differences at least 10%.

So now, onto the findings. The first part is going to be contrast one, disparities between veterans and no-veterans. Our findings show that for the 36 veterans we assessed for this contrast, veterans often reported similar care to non-veterans. And so that was – of the 24 of the 36 measures, that’s reported. Veterans also reported worse care for four measures and better care for eight measures. As Dr. Brady showed on one of his slides, NHQDR has priority areas and so we broke down our findings across those six priority areas. And I should have mentioned at the top of this slide, that this is the stop light chart where green indicates that the measures were better for veterans and non-veterans, yellow indicates they were the same and red indicates that veterans have worse access or quality of care than non-veterans.

So when we looked at the measures by the NHQDR priority area we see that all eight of the measures for which veterans supported better care were in healthy living. And I’ll show some specific examples in subsequent slides. For the measures where veterans reported growth care, those were in access, effective treatment and patient safety. Although I do want to note that effective treatment and patient safety the entire bars are red only because there was just one measure in each. One was the effective treatment was opioid prescription; I’ll present that in subsequent slides with patient safety and inappropriate prescription medications.

So just to break down some of the findings that I showed in the previous slide. These were four of the vaccinations – these were the only four vaccination measures that we looked at. There are four of them that fall into the healthy living one, and so all four of them were – the veterans received better quality of care than non-veterans. Actually across all genders, all female groups, male groups and across other four vaccinations – veterans were statistically significantly more likely to get vaccinations than were non-veterans. And then we also looked at three different screenings with partial cholesterol and glucose. Across these the numbers always indicate that veterans receive better quality of care. It was only statistically significant for the male population. There’s sometimes small differences within female veteran versus non – versus female non-veterans. But also it was due in part to the small sample of female veterans for some of these surveys.

As I mentioned there were some access measures where veterans reported worse access to care than veterans. So in this slide higher number actually indicating worse access and the – that veterans more often reported that it was difficult to contact their usual source of care during regular business hours on the phone, than non-veterans. It was pretty consistent across groups and significant for the males 18-44, also the males 45-64.

So this was the measure that I promised to talk about, the effective treatment measure related to billing and opioid prescription. Again, a higher number here actually indicates worse quality of care than veterans reported more often billing and opioid prescription than non-veterans in most of these age gender categories. They’re significant except for the youngest female category and the oldest male category. I also didn’t show the trend data. It’s from the chartbook online if you’re interested. So we did see that the trend analysis for this measure showed the rates decreasing for all age gender categories, except females 45-64. And this is a finding that the VA collaborators were interested in and are exploring.

So contrast two is looking at disparities within the VA population. Again this is a \_\_\_\_\_ [00:27:33] chart and where it shows green indicates better rates for the priority group, same group for the priority group in red. Of course, rates the priority group. As you can see from the slide, we saw a number of disparities that age but fewer by gender and race ethnicity.

And this is looking across at some of the other characteristics including location, disability, education, income and insurance. For this, we solve most disparities by disability status, fewer for some of the other comparisons.

So again, to break down some of these individual measures to give you an idea of what you can see on the chartbook. We compared the rate at which veterans reported having a usual primary care provider. And we noted that middle age and older veterans were significantly more likely to have a PCP than younger veterans. But we did not see differences across gender or race ethnicity.

We looked at some of these other categories and although there was a seven-percentage point difference between limited and non-limited activity status, it was not statistically significant and did not see differences by education income either.

We also looked at veterans who indicated dental visit in the past calendar year. We again, we saw a significant difference by middle age and older veterans more likely to have a dental visit compared to younger veterans. And you know statistical differences of the other groups.

In this one the difference between limited and non-limited activity status was statistically significant, so we saw that veterans with limited activity level were less likely to have a dental visit as were veterans with a high school degree or less. And veterans with low income.

So the last contrast is looking at just within the VHA population across the various characteristics. So this chart is similar to what we looked at for contrast two. And some of the findings are similar. We were looking at the general gay population versus the VHA user population. We found that middle and older VHA users were more often – had better care than younger VHA users. However, different from contrast two, we did find some more discrepancies between females and males. And there were some differences about education.

So there were only limited differences across race ethnicity for VHA users when we looked across all measures. I won’t get into it much in this presentation in the interest of time. But it – as I keep saying there’s more information in the online chartbook. When we broke this down and we looked at access versus quality measures, we did find that access measures that minorities were more likely to report differences in access measures, risk quality measures were pretty similar across all race ethnicity groups.

I should also note that these comparisons showed in this slide and the previous one where among VHA users using the \_\_\_\_\_ [00:31:23] measures which is what we mentioned, access and quality of care. VHA is also working on a report that assesses disparities in process or outcomes of care and VHA, but that has not been put out yet.

A couple measures that we looked at. One was whether VHA users got an appointment as soon as they needed. And as a pattern across a lot of these measures, older and middle age veterans – or VHA users report they’re more likely to get an appointment. Females were statistically less likely to report getting an appointment as soon as needed. There’s no difference by education. VHA users were looking at all race ethnicity, all of them indicated they’re significantly less likely to get an appointment as soon as needed compared to non-Hispanic White users. And then the second measure we looked at and what we’re presenting here was follow-up from providers office after they ordered a blood test x-ray or other test. Similar to what we saw, middle age and older age VHA users reported that they were more likely to receive follow-up. They reported last – and actually VHA users with less than high school were likely. We looked at that same measure across the different race ethnicity categories four of the six priority categories race reported they were significantly less likely than non-Hispanic White VHA users. So Hispanic, non-Hispanic, American Indian, Alaskan Native, non-Hispanic Asian and non-Hispanic Native Hawaiian or other Pacific Islander were all statistically equal than non-Hispanic White.

A couple more slides just to summarize our findings across the entire chartbook. I couldn’t present all here. But the key findings include contrast one, veterans reported better care for 22% of measures, similar care for 67% of measures and worse care for 11% of measures. For better care these generally related to vaccinations and health screenings and all those preventative measures. Whereas the worse care was related to access or to prescribed medications.

When looking for contrast two, we’re looking just within the veteran population. We most often saw disparities across age and disability status, where middle age and older veterans more often had better care when compared with longer veterans. And also veterans with activity limitations were more often reporting worse care than veterans with no activity limitations.

For contrast three looking at just VHA users we again saw differences in age and gender categories where older VHA users and now VHA users reported better access to quality of care. And then as I mentioned earlier, we’re looking at just access measures we saw disparities occurring within racial ethnic categories, but not when we look at all of the measures.

And that is the end of this presentation. So, I will turn it back – I will turn it to Dr. Clancy to provide a wrap up.

Dr. Clancy: Good afternoon everyone. I cannot tell you how much I’ve been looking forward to this cyber seminar today. And Drs. Woodroffe, Moy and Brady you did a terrific job. Especially Dr. Woodroffe, you were both clear and gave people a sense of what a challenge it is with all this data to hit the key compelling messages. I did see one question in the chat box about are these different or the same as CMS measures? I do want to assure you that we’re on a path at VHA that CMS, VA, DOD and so forth will be using the same measures. That’s about as much as I can tell you about it right now because it’s all very much under construction. But I think an important development.

You know, on a personal level this meeting today joins together career experiences and policy issues that are very, very important to me. First, I’m really thrilled about VA’s partnership with our – as you have already heard the project came together in about 18 months. A pace which I think is actually record breaking for the two government organizations. But I also see this evidence of dedication and commitment to both VA and Arc to eliminating disparities in case.

Second, healthcare equity is an issue I have long been passionate about. As the Arc Director Dr. Moy said, it was my privilege to oversee the agencies extensive health services research on this issue, as well as the agencies annual report to Congress. And in fact, that annual report came about as a result of a research study we had funded which was really, really easy for people to understand and the Congress took action pretty rapidly.

Here at VA I’ve had the chance to learn how disparities play out in a large healthcare system and importantly how they impact healthcare outcomes for our nations veterans. My knowledge has deepened and has – my appreciation has grown for the health services researchers focusing on both disparities of both Arc and VA. So what I want to focus on now is where do we go from here? So the chartbook is a really important and promising start, as we move forward.

I was looking back at some presentations I made when I was Arc, and I found a slide that caught my attention. This was to a group of physician assistants in a sort of premier program for physician assistants at Wake Forest. And what I was focused on there was patient centered communication and health literacy. And towards the end of that I outlined three key points. First is that neighborhood solutions are the key for achieving the elimination of healthcare disparities. I’m from Boston and there’s a very famous politician many of you are way too young to remember Tipp O’Neil. But I will simply say that he was one of the things he’s remembered for saying all the time, “All politics is local.” Well it turns out a lot of healthcare is local, as well.

The reason this is so important is that many causes of disparities and priorities for addressing those vary across the country. And I think addressing disparities in a meaningful way will require community-based projects and solutions. And to say the communication is vital, you can’t overstate that. And a compelling case really comes from our current pandemic. As many experts have observed, the pandemic has served to amplify pre-existing disparities and care among the general population and would they be right about that. The same is true among the veteran population. With studies showing veterans of color more likely two to three times more likely to test positive for Covid.

The good news, if we can call it that is that among veterans, we have seen no significant differences in mortality. The footnote there for those of you who are very interested in the details is in general we’re looking at in hospital mortality, right? Because we don’t have an easy way to track any veterans if they’re not in the hospital. I expect that we will learn and know more about that over time. But in terms of real time information, it’s all about hospital admission.

At the same time, listening sessions with veterans as well as supporting veteran service organizations reveal a pretty troubling lack of clarity and information about Covid. From how to reduce risk to whether it’s safe to get a vaccine. And I think the vaccine issue is especially sensitive given our history for many minority communities. And the need for customized messaging for veterans from their local VA came across loud and clear. You know, I like to say that before this pandemic, VA was a bit of a loose federation. So if you asked any employees “Do you work for VA?” They’d say – they look at you kind of funny and say, “Well I work for the DC VA” or “I work for the Pittsburgh VA”, you know because everyone was different. The pandemic has forced us to act more like a system for many, many issues. But at the same time for disparities it’s still very, very important to have that local lens.

So the conversation that Dr. Moy and I have a lot is, okay we’ve got this great data and at a system level we do pretty well. So that’s good news. We see some disparities overall, but in general less than the private sector. So we can stretch our arms to pat ourselves on the back. But the question is how do you get better than that? And what’s the mechanism to do that? And we’ve had conversations about you know, having champions at every facility and what does that look like and so forth. But a lot of that has crystalized around an idea called an equity guided improvement strategy. That is to say to identify specific groups of veterans at individual facilities where equitable outcomes are falling short. We know that at every one of our facilities we have people tracking data on quality. But if we could also combine that by stratifying for racial and ethnic background, we could actually help understand whether under performance in a given facility for particular metric is evenly distributed across the patient population, or whether under performance is largely attributable to peer received by a specific group.

If that sounded complicated, I would just say that getting to this is not so easy. But I think very important we’ve got the data and I’m pretty optimistic that this strategy, this equity guided improvement strategy will be moving forward as we transition to a new administration. At VA we began the foundation for incorporating equity into quality improvement or prior to the pandemic and have continued our work throughout these past several months. And I look forward to sharing more with you about it as this unfolds.

So, let me just conclude by thanking the presenters again. The chartbook marks another important milestone towards achieving healthcare equity in the beginning of what I think will be an ongoing strong collaboration between VA and Arc. For those of you who are data geeks, let me also say that a byproduct of this is that we will know more for many, many kinds of studies about veterans. And that’s important, because until not too long ago the national health interview survey which is this huge survey from which others with more depth are drawn from the same sample, how they identify veterans was with the single question “have you ever served?”

Now first of all the question served might be prone to being misunderstood by people. All of us know from the veterans we serve that in fact, which branch of the service matters a lot. And as well as some other features. So now there will be better data for all kinds of research and improvement efforts. So my congratulations and immense appreciation to the many VA in our staff who worked hard to make this happen. Thank you and stay safe. Interested in questions.

Whitney Lee: All right. Thank you, Dr. Clancy and thank you Dr. Woodroffe and Brady. We have a few questions lined up here. This question I believe refers to Dr. Woodroffe’s presentation. Is this all veterans or only those who receive VHA care?

Dr. Woodroffe: Hi. So it’s dependent on the contrast. For contrast two that is looking at all veterans. Contrast three is looking at VHA users. So we looked at both.

Whitney Lee: Thank you. And the next question is I think also pointed towards that. Why were those limited to just one sub measure each?

Dr. Woodroffe: Why were they limited to one sub measure? I’m not sure I fully understand that question. What’s meant by sub measure?

Whitney Lee: Well in the meantime, we’ll give someone time to follow up on that. We’ll move on to the next question. Are all these bar charts showing worse, same, better based on simple statistical significance if N was 150,000 totals, not balanced, fairly small differences could be statistically different. What were –

Dr. Woodroffe: Yeah, that’s a great question. And it varied by data sources. Like I said there were three different data sources, MEPS, NHIS, and SHEP. SHEP had the – I believe it was a larger size than NHIS, NHIS is about 90,000 I believe. SHEP is a little bit more than that. MEPS is about 30,000 and these are across everybody, not just the veteran population. Within MEPSis the smallest sample size. I think the number of veterans was about 7,000. In terms of did we just look at statistical significance? We did not just look at it. In the methodology section we get a little bit more detail. But we did – we checked for statistical MEPS significance, but we also require that there was a difference with at least 10%. So that was hopefully to accommodate you know, differences just based on large end.

Whitney Lee: All right, thank you. So our next question is do you have data on disparities in advance care planning completion, palliative care and/or hospice enrollment?

Dr. Woodroffe: I’ll answer that question in terms of the chartbook. We did not analyze those measures. I’ll defer to others in terms of what measures they have outside the chartbook.

Dr. Jeff Brady: Hi this is Jeff Brady. I’ll just say in general on the broader national healthcare quality disparities report, we do have measures that relate to those topics. I think data availability is always the challenge when we look at special populations like the VA. So our interest is in reporting as much as is available. So we do have those in the broader report, the measure set. I think is \_\_\_\_\_ [00:47:58]

Whitney Lee: Thank you. What is being done to lessen care of male and female vets? Like availability products that are geared to the female body versus male.

Dr. Clancy: This is Dr. Clancy. I will say under the direction of Dr. Patty Hayes and her team, there is a lot that’s being done. I think it’s pretty self-evident that you know say going back 10 years when we started to have more and more women veterans enrolled in our system, that it became rapidly clear that we built the system for me, right? So even issues about which exam rooms were big enough to do pelvic exams and things like that were pretty tricky. But over the years with lots and lots of training and frankly the relentless determination of Dr. Hayes and her colleagues, we have seen improvements. I don’t know if the questioner had something specific in mind about differences in equipment. The example that pops into my brain relates to prosthetics. What we have very focused research initiative focused on foot prosthesis for women. Who by the way, just don’t want to wear one pair of shoes all the time? So you could, as a result of some of these investments women can actually use different shoes, which frankly is of great appeal to some people. But I don’t know if that’s actually what the person asking the question had in mind.

Whitney Lee: Thank you. Are there measure on cancer care?

Dr. Woodroffe: We did include in the chartbook there is mortality measures and so there’s a couple measures – mortality measures looking at cancer. If I remember correctly, we looked at prostate cancer, breast cancer, and lung cancer.

Dr. Clancy: I will say, this is Dr. Clancy again, within VA there’s very happy news about prostate cancer. Where we see no differences in mortality between black and white veterans. We’ve got a huge effort going on now in precision oncology to try to offer cutting edge treatments based on biomarkers and genetic and tumor markers and so forth. And there’s a very strong focus on disparities or you know, not having disparities from the outset, right? Both with respect to racial and ethnic background and very importantly to where the veterans live, right? Because we have a lot of veterans in rural areas.

Ernest Moy: You can correct me if I’m wrong. But didn’t we include cancer screening measures in the report? Good news with cancer screening as well, so we tend to have very high rates for instance, the baseline for colorectal cancer screening rate is over 80%, which I think is far higher than the private sector.

Whitney Lee: Thank you. Our next question is I’m curious about the AHRQ used of the term gender. When in use they were referring to sex, is there any thought of being more precise in terminology concurrently highlighting the need to gather, analyze data about those and gender identity?

Jeff Brady: We follow the current federal standards, and you know, currently that’s a practical reason because it depends on how data is collected. But of course as a federal agency we also follow the federal standards. So I think you know we’re certainly aware of these issues that are quite important and still evolving of course. So, the bottom line is you know, our reports stand ready to you know, integrate and include data that adds you know, any helpful information to our assessment of disparity. And I think my prediction is that will be one to watch and hopefully will see increasing ability to add more helpful information to that picture, in terms of how we assess gender, and most importantly for our critics, healthcare quality and healthcare disparities issues related to evolving nature of gender.

Dr. Clancy: Yeah, and this is Dr. Clancy just to add onto that. It turns out that assessing identity for the purposes of surveys was a little more complicated than people had in mind. But I’m pretty confident that we will as a country get there. Very, very strong interest in VA and doing just that. And I will also note and just want to pay compliment to Arc because I never had a chance when I used it a couple of years ago. They actually did some case studies that they posted online about the potential safety issues and you know, very negative impacts on patient experience when providers did not respect patients preferred identity. You know use the wrong name and so forth. So we’re certainly have been trying to work that out in our system. I am not 100% current on where this stands in terms of our transition to Cerner, but certainly a priority for VA for sure.

Ernest Moy: I can’t not do a shout out to some work that we’re doing, not looking at the trans gender population, but looking at the LGB population. So we don’t have that information systematically within VA. And so we also looked at outside data sources and so over on National Health Interview Survey there’s a veterans health website. And there are dozens and dozens of measures that have been stratified now by veteran and non-veteran status, but also sexual minorities, \_\_\_\_\_ [00:54:51]

Whitney Lee: Thank you. For those of us that are data geeks, where can we view the actual data?

Jeff Brady: So Whitney I’ll ask Dr. Woodroffe to correct me if I’m wrong, but I think that the slides that we shared have links to the HRQ website. I think there’s also a place on the VA website for the chartbook. So, hopefully those links will be accessible to all of you in the presentation.

Whitney Lee: All right, thank you. This question is how do you define equity?

Ernest Moy: That sounds like that’s a question for me, this is Ernest Moy the Director of the Office of Health Equity. And we define equity very broadly. So we are looking to ensure that all veterans, regardless of their demographic or social determinant situation can receive high quality healthcare and achieve comparable health outcomes. That’s how we – the concept of health equity.

Whitney Lee: Thank you Dr. Moy. This one is comment and a question. The work the VA has done to reduce homelessness has been outstanding. Is the VA integrating with homeless management information systems to improve population health efforts?

Ernest Moy: So this is Ernest and I’ll say that in general, \_\_\_\_\_ [00:56:46] is not able to drill down to \_\_\_\_\_ [00:56:50] We do work with the homeless office and we work with other offices in VA to try to elevate the role of social determinants, both the identification social determinants as well as the \_\_\_\_\_ [00:57:02] identified through those different screeners. So we have a big initiative to go beyond homelessness and \_\_\_\_\_ [00:57:10] for instance where veterans are screened for a broad range of social determinants, and provide information and referrals to social work, to help with other social determinants that are identified. We do appreciate that this is a very high priority for the VA.

Whitney Lee: Great thank you. So we have one minute left. I just have time for one more question. So what kind of formal ongoing diversity training particularly implicit bias do stakeholders receive?

Dr. Clancy: That has been a sensitive topic for a while. In fact at this moment in time there is actually an executive order that says this kind of training cannot be mandated or required. I would say there is very, very strong interest. So at an executive level for all VHA, we are very actively exploring not only what is possible, but you know how can we clearly communicate that?

I expect that that situation will give off over time as in the next few weeks. But that’s where we are right now. It is very, very hard to imagine that implicit bias doesn’t affect a huge amount of what we do in healthcare.

Jeff Brady: Very briefly, more broadly outside the VA we actually summarize some work that is conjunction with graduate medical education. I think the Office for Civil Rights and Department of Health and Human Services has supported. That’s in the broader national healthcare quality report. I think it is part of the national session if you will, and national action there are you know, various initiatives that are trying to shed more light and add practical training, to help improve the situation.

Ernest Moy: And this is Ernest, so we have some training posted on the Office of Health Equity website that relates to implicit bias. We can’t require people to take it, but we do make it available.

Whitney Lee: Thank you. So we are just right after the end of the hour. Drs Moy, Clancy, Woodroffe and Brady do you guys have any closing comments?

Dr. Clancy: I would just say thank you for joining us today and stay tuned.

Jeff Brady: Thank you.

Ernest Moy: We’re always looking for partners, so if you have an interest in equity, please track us down.