Leslie Hausmann: Good day, everybody. Thank you for taking the time to tune into our session this afternoon. My name is Leslie Hausmann. I am an Associate Professor of Medicine at the University of Pittsburgh and a Health Services Investigator at the VA Pittsburgh Center for Health Equity, Research and Promotion.

For the last several years, I've been leading an initiative to bridge the gap between research and practice when it comes to identifying and addressing healthcare inequities. And the centerpiece of this work has been the development of a tool that is specifically designed to draw attention to disparities that are happening at multiple levels at VA facilities across the nation and to support teams who are interested in doing the difficult work of understanding why those disparities are happening at the local level, and then coming up with innovative and evidence-based solutions for closing the gap in care.

And so, I'm delighted today to be serving as the moderator of this session which features a report out for the first demonstration project that used the Primary Care Equity Dashboard to identify disparity and then to support a team who was committed to reducing that disparity. So, you'll be hearing one of the first new cases for this novel tool and getting ideas of how you might also be able to do similar work like this at your own facility.

So, I'm joined today by two individuals. I'm going to first start with introducing Jamie Estock. Ms. Estock is a Human Factor Scientist with 17 years of experiencing leading to improve the design of products and processes in safety critical domains.

Her primary areas of expertise are in human factors, evaluations, human performance assessment, human-centered design and safety. She's a full-time employee within the Research & Development service line at VA-Pittsburgh healthcare facility where she's created, implemented and currently manages a Human Factors Evaluation Program to ensure the safest use of medical products in the delivery of care to veterans.

Ms. Estock will be around for the question and answer period at the end. And I am very grateful for all of the work she has contributed to the User Center Design process that was used to develop Primary Care Equity Dashboard that was used to support the products and projects you're going to be hearing about.

The person who I'm going to pass the mic to next is Dr. Beth DeStanzo (SP). Dr. DeStanzo is currently a Clinical Pharmacist Specialist in Primary Care at VA-Pittsburgh Healthcare and is a board certified Pharmacal (SP) Therapy Specialist.

She has been employed with the VA for 18 years and currently works in the Primary Care setting to manage diabetes, hypertension, hypolipidemia, obesity, COPD and tobacco use disorder in the veteran population.

She serves as a preceptor for Pharmacy students, residents and fellows. And she's been involved with Quality Improvement metrics that impact patients in the Primary Care setting. And she is the representative for the team and who conducted the first demonstration project using the Primary Care Equity Dashboard. And I'm delighted to have her sharing the preliminary results of that work with us today.

Dr. DeStanzo, are you ready?

Dr. Beth DeStanzo: I am ready! Thank you.

Leslie Hausmann: Okay. Please take it away.

Dr. Beth DeStanzo: Thank you for the kind introduction. As mentioned, my name is Beth DeStanzo. And in general, finding ways to identify and address healthcare disparities that might exist within veteran populations at VA medical centers is important because it helps insure that all veterans receive high quality care.

So, today's focus on Health, Equity and Action cyber seminar will highlight the results of the first demonstration project using the Primary Care Equity Dashboard. And this is to support an equity-focused quality improvement initiative to reduce racial disparities and stagnate (SP) adherence amongst our veterans with cardiovascular disease.

This leads into my objectives that we will discuss today. We will first review the prevalence of cardiovascular disease in a general population.

We will discuss the role of each HMG-CoA reductase inhibitors—also known as statin medications—and cardiovascular events. We will review the Primary Care Equity Dashboard or PCED.

We will identify the disparities and statin adherence amongst black versus white veterans and we will highlight the role of the PCDE in supporting the Quality Improvement Initiative aimed at reducing racial disparities in statin adherence.

So, for some background, I've included a photo of VA-Pittsburgh. And I think it is important here to understand our VA Medical Center. We're a large healthcare facility. We have two main campuses.

I work at the University Drive campus which is located in Pittsburgh, Pennsylvania. We also have five community-based outpatient clinics that are in more rural settings. But to focus on our University Drive campus here in Pittsburgh, it's a very large urban academic VA Medical Center.

On campus we're fortunate to have the Center for Health Equity Research and Promotion—also known as CHERP. And these folks have been integral in helping with these sorts of quality improvement initiatives here at VA-Pittsburgh.

VA-Pittsburgh provides Primary Care along with numerous other services. And I am located in the Primary Care department. I'm a Pharmacist. But I am assigned to what's called a Patient Aligned Care Team or a PACT.

And the goal of the PACT is to provide Primary Care to veterans with team-based care consists of a provider whether that be a physician, nurse practitioner, physician assistant along with nurses, LPN's, pharmacists, dieticians, social workers, Behavioral Health. So, we have a very broad range of specialties that, you know, help serve veterans in the Primary Care arena.

And as the Clinical Pharmacy Specialist, I will speak a little more in Pharmacy terms going through some of the presentation because I am a Pharmacist by trade.

So, to understand a little bit about what led this initiative, you need to understand cardiovascular disease and the role of statin or HMG-CoA reductase inhibitors. So, cardiovascular disease is the leading cause of death in the United States. Coronary heart disease and myocardial infarction encompass cardiovascular disease and are responsible for 690,000 deaths looking at 2019 data.

Statin medications—or HMG-CoA reductase inhibitors—are a class of medications that are known to lower cholesterol. The American College of Cardiology and the American Heart Association have specific guidelines that outline the use of statin medications and preventing cardiovascular deaths.

And essentially, there's several main branches of groups of people that we would use to treat statin therapy. Patients that have had a primary cardiovascular event such as a stroke, a myocardial infarction, coronary artery disease—these folks would receive statin type medications along with a secondary group of patients—patients that may have high risk for cardiovascular disease.

This encompasses folks such as diabetics or patients with elevated LDL cholesterol levels that are found to have a high risk score for having a cardiovascular event. These folks would also benefit from statin medications. And additionally, folks found to have a bad cholesterol or LDL of above 90 are folks that would benefit from statin medications.

But essentially, to have the benefit from a statin medication--which is to lower cardiovascular disease, stroke and death—patients need to be adherent with them. And adherences specifically of the sized (SP) in the American College of Cardiology's in terms of use of statin medications.

Unfortunately, statin adherence is problematic—20.9% of the U.S. patient population with cardiovascular disease was found to be non-adherent to their prescribed statin therapy based on a study done by Nicole (SP) Antonio and 17% of all veterans with

cardiovascular disease receiving care with the VA were found to be non-adherent to their prescribed statin based on data from the EQM dashboard in January of 2021.

Additionally, it's been found that racial disparities exist between black and white patients. A 2009 study found that black Medicare beneficiaries were 24% more likely to be non-adherent to statins than white Medicare beneficiaries. Additionally, a 2019 study conducted within the VA showed that black veterans were 42% more likely to be non-adherent to statins compared to white veterans.

This brings us back to the Primary Care Equity Dashboard which allowed us to investigate 1) Do we have a statin adherence problem within our patients with cardiovascular disease at VA-Pittsburgh Healthcare? And 2) Do we have a racial disparity that could be contributing to the problem?

So, here you will see a slide of the PCED—the Primary Care Equity Dashboard. If you look to the left side of this slide you will see the performance snapshot.

So, we were able to use the Primary Care Equity Dashboard to assess our adherence here at VA-Pittsburgh with statin therapy. And if you look where it says "timeframe", we are looking at the school year '20-'21 data from Portal 1 which is October of 2020-December of 2020.

And what they show, so I've highlighted this in blue for VA Pittsburgh. It shows that VA-Pittsburgh's University Drive campus was 2.6% below the national average on statin adherence for all patients with cardiovascular disease.

And you can see the score showing it 80.3%--80.3 of all of these patients were adherent and that amounts to the score showing in the red—the 2.6% below the national average that I had mentioned.

So, going a step further looking on the left side of your screen, you see the equity deep dive on the PCED. So, this leads us into a more detailed look at the demographic characteristics of our patient with cardiovascular disease.

So, listing what's on the site based on the PCDE is adherence to statin therapy. And you can see that our black veterans—67.7% of them were adherent which means that 32.3% of them were non-adherent versus our white veteran population where 84.4% of them were adherent versus, you know, inversely reported 15.6% were non-adherent to their statin.

Furthermore, that white veteran population at VA-Pittsburgh Healthcare University Drive exceeded the VA national average of 82.5% whereas our black patient population was 15.2% below the benchmark. And you can see looking at the PCED that's highlighted in red with the 15.2%.

Realizing that we had a problem here at VA-Pittsburgh—notably a disparity between our black versus white veterans—we developed a project in that improving statin

adherence rates amongst black veterans at VA-Pittsburgh. And also, reducing the disparity between our black and white veteran populations.

So, leading into how we did this—any type of intervention we would want to implement, we had to identify best of what we were going to do. So, in this instance, we were able to use the Primary Care Equity Dashboard again.

Looking on the left column again, you can see equity of resources and we were able to use this website with links to help figure out what may work best for our veteran population here at VA-Pittsburgh.

As part of our literature review, you can see that Equity/QR Resources page lists a number of different resources that can be helpful for clinicians. It's easy to use and easy to highlight.

Specifically for our project, what's listed first under Patient Education is a fact sheet for patients on the risks and benefits of taking a Statin which is something that we thought could be instrumental in going forward with an intervention on our patients. We were able to search literature and find literature that supports education from a pharmacist as a possible intervention at improving statin adherence.

So, we did a literature search that had noted other studies that have shown pharmacist education on a targeted disease state can have a positive impact on medication adherence.

Looking at hypertension, for example, pharmacist education specifically focusing on the blood pressure medications has been shown to lead to lower blood pressures and higher percentages of medication refills for that particular hypertension patient population. Additionally, prescribing education on the disease state itself and the importance of why patients should take medications that's been shown to be beneficial.

So, our team sought to improve statin adherence rates amongst the black veterans and then also reduce the disparity between our black and white veteran population using an educational intervention with pharmacists based on the literature reviews that we were able to do.

So, looking specifically at the role of the pharmacist, here at University Drive, VA—Pittsburgh there's three packed clinical pharmacy specialists—myself and two others for three total. We sought to develop an educational consult template in our electronic medical record known as CPRS.

We actually gave this a special new title as Pharmacy, Stock (SP) and Health Equity project to help make it easier going forward which patients did receive education from us. And we conducted 30 minute phone education consults specifically targeting statin therapy.

In developing this project, essentially getting it off the ground we started with developing a computerized consult template. And what we really looked to develop in this consult template was providing answers in our visit with the patient on these major questions. "What is a statin therapy?" "How do statins help those with established cardiovascular disease?" "How should patients take statins focusing specifically on the adherence of statin medications?" And then, what to do if they miss a dose. And "What are the common adverse side effects of the statin medication?" And "How should patients report these to providers?"

So, we developed a standardized script that we used when we talked with these patients just to be standardized given that three pharmacists were providing the educational consult. And this is an example of what we used and how we spoke with our patients.

So, just going into my patient role, I'll speak for a moment. "Hi, my name is Beth DeStanzo and I'm calling from VA-Pittsburgh. I'm one of the pharmacists in the Primary Care Clinic. I was wondering if you had a moment to talk about one of your medications that is on your medication list called Atorvastatin.

I am calling to make sure that you understand why we have prescribed a statin for you. As someone with cardiovascular disease, statins help lower the bad cholesterol levels and increase the good cholesterol levels in your blood. This lowers your risk of suffering from a heart attack, stroke and death by about 20-25%."

And we went through this template. I will spare you the entire visit that we did with the patient. But I'd be happy to share with the participants if anyone was interested in the template with all we reviewed with the patients that essentially targets on those four main questions, "What is a statin?" "How do statins help those with established cardiovascular disease?" "How should patients take statins?" And "What are the common adverse effects of statin medication?"

I wanted to show you what we developed in CPRS in the medical record. And this is a test patient, but we developed this progress note again, titled Pharmacy Statin Health Equity Project to make it easy to find.

But you can see on this screenshot, it was the reason for why we were doing this that this is part of a quality improvement project. It does pull in a CPRS medication. And last, you can see on this particular test patient he was prescribed Simvastatin.

Scrolling further down the template, it pulled in key pertinent lab values of note cholesterol values would be what we're interested in. And it helped pull in the narrative of what we talked about with the patient during the visit.

What I do want to highlight is on this screen. You'll see that we ask the patients two different questions to help determine if there were any adherence barriers.

So, these particular questions were, "What do you find challenges when your providers ask you to remember to take your medication every day?" And "What can

we do as a healthcare system that would be helpful for you to remember to take your statin?"

And I'll discuss the results of this a little bit further during my presentation. But I did want folks to see what our note template looked like. This is also nice because it helped us easily document the patients that we spoke with.

So, once we had developed this educational tool that we were going to use along with documentation of it in a progress note, we had to, you know, figure out who are our eligible veterans.

So, basically patients needed to be prescribed a statin, have cardiovascular disease, and have an established Primary Care provider at VA-Pittsburgh Healthcare—specifically at the University Drive campus.

Diving into this a little bit deeper, the patients were prescribed a moderate to high intensity statin within the past year. They were age 21-75 for males or age 40-74 for females with at least one of the following during the prior year. And these would be the cardiovascular disease equivalents.

So, this would be myocardial infarctions, coronary artery bypass graft procedures or CABG's, subcutaneous (SP) coronary interventions or PCI's, other types of revascularization or Ischemic Vascular Disease diagnoses in the medical record.

Adherence was determined by how the patients refilled their statin based on their refill history. So, they were determined to be adherent if they were adherent with refills for greater than 80% of the days in any 12 month period versus non-adherent if they were adherent for less than 80% of the days in the 12 month period.

So, to identify these patients, we were able to go back to Primary Care Equity Dashboard. And again, looking on the left side of your screen here, you see we have highlighted patient outliers. We were able to use this page of the PCED to help identify all veterans at VA-Pittsburgh University Drive with cardiovascular disease who were non-adherent during our particular timeframe. We looked at the timeframe starting in January of 2021.

What we used in terms of our study group was the black veterans who were identified as non-adherent were our study group versus the white veterans who were identified as non-adherent were part of our control group for comparison because the way veterans did not receive any intervention from the pharmacist.

Once we identified our non-adherent veterans, of the black veterans from the period of January-February of 2021, our Clinical Pharmacy Technician contacted the non-adherent black veterans. She scheduled them for a 30 minute education visit with the Clinical Pharmacy Specialist and the Primary Care team. And the PACT Clinical Pharmacy Specialist completed the statin education.

Both the Clinical Pharmacy Technician and the Clinical Pharmacist used the standardized script templates as we discussed earlier in the call. The example of what I read you is the education that we had used at the pharmacists.

So, looking at what all we collected—we looked at statin refills along with adherence rates during our review period. So, statin refills were gathered by using electronic health record refill data or CPRS. They were essentially have refilled their statin if they did refill the statin at any point during the specified timeframe.

But we also looked at the date of the refill. So, did they refill their statin before or after the Clinical Pharmacy Technician's scheduling call or did they refill the statin before or after the Clinical Pharmacy Specialist Education?

And we evaluated the effectiveness of our intervention by comparing a number of black veterans who received the intervention versus the white controlled group who did not.

Additionally, we looked at adherence specifically looking at overall adherence rates for all VAPA-Pittsburgh University Drive patients on a monthly basis. We did look at barriers to adherence which we identified through those particular questions we asked the veterans during our call. "What do you find challenging when your providers ask you to remember to take your medication every day?" And "What can we do as a healthcare system that would be helpful for you to remember to take your statin?" And again, we tracked the disparity in the statin adherence between our black versus white veteran populations.

So, what all did we find after our intervention? So, we were able to identify based on the Primary Care Equity Dashboard that 18 black veterans were eligible as being non-adherent to their statin.

For comparison—and you can see this on the bottom right corner of your slide—our control group had 40 white veterans that were non-adherent to their statin based on the Primary Care Equity Dashboard.

So, of our 18 patients—which you can see the schematic under Identification Phase, all non-adhered veterans listed as #18. Of these 18, three of them were not able to be reached by our Clinical Pharmacy Technician, but were left a voicemail during the scheduling attempt. And that's if you follow the arrow to the right and down. Those are the three.

Three additional black veterans spoke with the Clinical Pharmacy Technician. But they declined to be scheduled for the education consult.

So, if you see where it shows 15 that she actually reached for scheduling, follow the right arrow down from there. Those are the three patients that declined the consult.

The 12 remaining black veterans received the education consult from our pharmacist and that's where it shows "Scheduling Phase, Accepting Consult 12" right in the

center of your screen. Of these 12 veterans—these mind you are 12 black veterans who were non-adherent to their statin—these are the 12 that received the actual education intervention consult from our pharmacists.

Of these 12, three refilled their statin a few days after the Clinical Pharmacy Technician scheduling call, but before they actually met with us the pharmacist for the actual statin education. And that's highlighted following your 12 that accepted the consult. That's following the arrow to the right—the three who refilled after the scheduling call.

Eight veterans refilled their statin after their scheduled appointment with the pharmacist. So, that's on the very far right of your screen—the circle of the eight veterans who have refilled after the consult.

And I should note that this makes a total of eight veterans out of nine who the pharmacist spoke with refilled their statin which is 89% versus 22 out of 40 white veterans in the control group which is 55%.

You can see that there was one veteran on the top right who even after speaking with the pharmacist did not refill their statin medication. What I did want to note here in this slide, you can see where the red arrow is pointing. We've highlighted the subset of patients in like a beige color.

I wanted to bring to light that seven of 18—which makes 39%--of black veterans, they received their refill of the statin after the pharmacy technician called them to schedule. And of note, three of these veterans were not reached by the Clinical Pharmacy Technician to even call to explain, you know, that she wanted to schedule.

But of these three, two of them still refilled their statin. An additional three veterans spoke with the Pharmacy Technician, did not want a Clinical Pharmacy Specialist Education visit. But two of those still refilled their statin after speaking with our technician.

And then, additionally, three veterans accepted a consult with the Clinical Pharmacy Specialist for Education, refilled their statin after talking with our Pharmacy Technician, but before they actually spoke with us—the pharmacists—and received education on why their statin was important.

So, I think that that's interesting to note those seven patients. We'll keep that in mind for later in the presentation.

In terms of looking at what feedback the veterans provided of the 12 that we spoke with and actually provided education to, three of them said that they learned very important information from their statin that they did not know before. Specifically, they learned that taking statins provided more benefit than just lowering cholesterol and they can decrease the risk of having a cardiovascular event. And then, one veteran specifically commented that he would've been more adherent had he known these additional benefits of statins.

It should be noted that four veterans did identify some barriers to adherence. I'm going to summarize these on the next slide.

So, these are four veterans. You can see Veteran 7 and Veteran 10 provided responses to both what we would consider challenges along with healthcare improvements. So, these are those questions we asked the veteran.

First, looking at challenges, "What do you find challenging when your provider asks you to remember to take your medication every day?" Veteran 7 just said in general remembering. Also, they had been falling asleep before they were taking their statin because they were taking it at bedtime and they were just forgetting to order refills.

Veteran 10 found challenges in terms of just feeling overwhelmed. They were aware of why they were taking a statin and why it was important. And they also weren't sure of the proper timing of when to take it.

Looking to the second question which is more of a health system improvement type question, we had input from four veterans total that two of them being two that provided responses to the first question we asked. But you can see here one veteran suggested we provide automatic refills for their statin therapy.

One suggested like cellular phone access to basically let our patient refill request portal be more accessible for folks that work in the Primary Care setting. They might be familiar with My HealtheVet and that's what they were referencing.

Another veteran said that prescribers—whoever it may be—should provide enough refills on their statin prescription, so the patients don't run out of refills. And then, another veteran had said to make sure that the provider educates the patient on the risks and benefits of the statin, and why taking it is important. So, these were some good feedback comments that we did receive to these questions.

So, looking at our intervention—and again, going back to the Primary Care Equity dashboard—we were able to look at performance trends. On the left side of the screen you can see the tab there. And we were able to use this page to obtain a quick look at whether our intervention of Pharmacist Education helped to improve statin adherence in our black veterans. And did this help close the gap in the performance between our white versus black veterans in terms of this measure?

So, you'll see this chart. The blue arrow represents the month--which was January of 2021--when we implemented the initiative. So, again, it should be noted that this is reporting on who was adherent. And we should note that there was an increase in the rate of statin adherence in our black veterans with cardiovascular disease during the first two months post-implementation of our education.

So, you can see this data in our black veterans. In January of 2021, we were at 64.9% of veterans who were adherent to their statin. Listed right below that is the 83% of our white veterans for comparison during the same period.

Following the months in this intervention, looking at February and March, statin adherence amongst the black veterans increased to 70.3% up to 75% in March of 2021 and leveled off from there. I'm looking at the white veterans for comparison. As I mentioned 83% in January of 2021 to start with a slight uptrend to 85% in February leveling there.

So, that was noteworthy looking at the graphic. So, where does this bring us using the Primary Care Equity dashboard and looking at our specific intervention here in the Primary Care setting?

So, we were limited by a small sample size. If you recall, you know, 18 total patients were identified as not adherent of our black veteran population. So, we did have a small sample size that was limited specifically to the VA-Pittsburgh University Drive campus black veterans with cardiovascular disease. And again, being non-adherent to their statin therapy.

While this is a limitation, it was an intentional small specific sample size, so that we could evaluate our proposed intervention efficiently with the existing resources that we already have here at VA-Pittsburgh. It should also be noted that this is limited to sites that have Clinical Pharmacy Specialists already integrated in the current team with direct care patient activities as we do here at VA-Pittsburgh.

One limitation that we did find during this study period was the narrative that we used from the Clinical Pharmacy Specialist perspective did not really explicitly highlight gaps in the statin refill because specifically when we ask those questions to determine barriers to their statin adherence, many of the veterans in the Education group did not identify any type of healthcare system process that could've been done to improve their overall adherence.

So, essentially what we learned going forward is we may want to change our narrative to more explicitly bring to light why we're calling them, you know, why we're giving them a statin education call. And then, specifically highlighting the gaps in their refills of their statin medication, you know.

We may want to say to our veteran, you know, "We realize you haven't filled your Atorvastatin since, you know, October of 2020. Could you tell me more about that?" to really get a better picture of why our veterans may be non-adherent to their statin.

Another limitation that we found was the primary outcome measure that was used in this project was the statin refills. The EQM measure of statin adherence was on different timelines for refills. And therefore, it can take a while for intervention to basically it influenced the measure to assess the impact of the intervention that we used.

So, we would expect to see an improvement in the disparity over time with this measure. But the dashboard was able to help us identify that there is a problem and a

disparity here at VA-Pittsburg and therefore to implement some sort of intervention to help.

So, moving forward to future directions of where we could go with statins. The responses that we received from veterans who identified barriers were very valuable, you know. It can help guide future interventions that may help improve adherence for our veteran population. Specifically refills where the common theme that we saw in looking at those barriers.

What we also found is if you recall the slide where our Clinical Pharmacy Technician contacted veterans for that initial scheduling call to get them set up with a pharmacist? What we found was that that brief interaction with our technician actually resulted in veterans refilling their statins.

Some of them refilled right after our technician called them. Some of them spoke with the technician, declined the consult with the pharmacist, but still refilled their statin.

So, what we found is that shorter focused contact with veterans may be effective in improving their statin adherence. And that, you know, going forward, short reminder calls utilizing other staff may be able to be something we could do looking at, you know, future directions for improving statin adherence.

Additionally, we found that the Primary Care Equity dashboard is a very valuable tool as I've illustrated through this clock (SP). And we can use this to help identify other disparities and then track progress going forward following an intervention.

So, the statin measure we used was the Statin 4 measure which looks at statin use in veterans with established cardiovascular disease. There's a Statin E (SP) measure which looks at statin adherence in veterans with diabetes. And that may be something to look at going forward and use the Primary Care Equity dashboard to help identify disparities..

So, in conclusion, what we found in our project is that a pharmacist with statin educational consult appears to be an effective tool to improve our statin adherence. We found that any focused contact with veterans with a healthcare team member regarding statin adherence was beneficial as evidenced by our Pharmacy Technician.

And the Primary Care Equity Dashboard—or PCDE—is a valuable tool that can help clinicians easily identified disparities in healthcare cross-populations. With that, I am including our contact information if anybody on this call would like to reach out to one of us individually.

And at the end of the presentation, I've included some references as well that you can review at your leisure. But I'll leave our contact information up.

And at this time our team will take any questions from the field.

Unknown: Hi, we have a few questions that are queued up here. And one of those questions, "Can the deep dive look at combined variables such as ethnicity and morality (SP)? For example, distance to medical center."

Leslie Hausmann: Hi, everyone. This is Leslie Hausmann. I can answer that question. So, in the Equity Deep Dive page, it is designed, so that if you click on a row within each of the race, gender or morality tables, it will then filter the remaining tables to just show the performance of the group you selected. So, that in essence does allow you to see the interactions between race and morality, as well as gender.

Unknown: Okay. The next question, I don't know if this is exactly a question or a comment. It says, "When the providers medication for the vets, they don't get educated on what, why and prevention by the providers." Can you expand on that?

Dr. Beth DeStanzo: So, speaking from a Primary Care Pharmacist perspective, I work in the PACT clinic. I do see patients here. I think, you know, the focus of my visit particularly is improving their adherence to medications whether it be diabetes, or lipids, or whatever it may be.

So, I know from a pharmacist perspective we educate on what the medication's for, how it works, the dosing, when to take it. But we also have the luxury of a 30 minute visit that's specifically targeted at treating their diabetes or their lipid disorder versus not speaking for all Primary Care providers, but a lot of times complex veterans have many different problems they're seeking a cure for.

And, you know, when you have a 30 minute visit with a patient and you have numerous medical conditions to address, you know, giving that specific focused education may not be realistic in a visit. Not that providers don't do it, but they may not get the same depth that they would as if they had a targeted visit to deal with medications.

Veterans within VA do have the luxury of having pharmacists in all VA medical centers—at least within VA-Pittsburg—if they don't have a scheduled visit with me, if they go to pick up their medications, they have the opportunity to meet with a pharmacist. They have to meet with a pharmacist to have their medication processed at which time those veterans are educated by the pharmacist who is processing the medication for them.

But not all patients stop to see a pharmacist when they leave a provider visit, you know. Many patients will say, "Oh, I want to have my medication mailed to me, you know. It'll come to me in a week." And those patients are not receiving direct-targeted education other than what a provider may have time in their visit to address which may just be, "Oh, your cholesterol's high. A

statin lessens your chance of having a stroke. I'm going to start you on the Atorvastatin". And that's mentioned in the midst of five other medication changes which could easily be overlooked by a patient, or forgotten about, or, you know, just glazed over by the patient.

So, not speaking for every provider. But I think we're at the luxury of within VA, we do have patient-aligned care teams that have members of the team that can provide specific, focused instruction, you know. A provider is not going to have time to discuss a low cholesterol diet with a patient whereas that's what on a PACT team, we have a dietician to specifically target and help with.

So, I'm not sure if that answers the question, but it explains a little bit about how a PACT team functions at VA.

Unknown: Okay. Here's another comment. It says, "Good afternoon and thank you for the insightful presentation. Looks like your team experience has sustainable improvement. Any opportunities to monitor impacts since completion of the study? And any collateral improvement with other refills of other medications?" And they have HTNDM.

Dr. Beth DeStanzo: Oh, hypertension and diabetes.

Leslie Hausmann: Yeah. We specifically collected this data, you know, for a presentation that was done in the spring in May of 2021, you know. Having the Health Equities dashboard available, this is certainly something we can track going forward.

And again, future directions we did identify that, you know, just having that refill reminder was something that patients did benefit from. So, you know, future directions we were thinking of involving our nurse team here to kind of help provide refill reminder calls for those who are non-adherent based on the Equities dashboard.

But I think essentially those measures are things that if sites identify a disparity or if you're performing below national average, the dashboard is a great tool because it allows you to drill down, and really see where your disparity lies, and then design an intervention to target that group. So yes, this could be done for hypertension or really any of the monitors that appear on the dashboard. Uncontrolled diabetes, for example.

Unknown: Okay. Someone made a comment here. "I was aware of disparities at our facility in Little Rock and future population in the two parent facilities. This is a constant battle also. So, anything to discuss with PC providers for enhancing statin use and improving adherence is welcome."

And they ask for a copy of the presentation. I just want to let everybody know that the presentation, you can download it from your reminder email this morning. And if you look in your chat and the Q & A, the link is also there for you to copy and paste.

And another question is, "How frequent is data updated? Is this real-time data?"

Dr. Beth DeStanzo: So, in regards to the targeted education, I would be happy to share with the group our progress note template that we used along with the specific scripts we used for, you know, performing the education both the pharmacist scripted role and then the technician scheduling role.

As for the data update, I will actually let one of my other team members address that as they're more familiar with the innerworkings of the dashboard.

Leslie Hausmann: Hi, everyone. This is Leslie again. I can answer that question about how often the data are updated. All of the quality measures that are currently featured in the dashboard are calculated on an ongoing basis by the VA Electronic Quality Management or Measurement Program.

And we update our dashboard with those measures on a weekly basis. And so, the, you know, the data get refreshed each week.

And then, while I have the mic, I will also just draw attention to those of you who are interested in the slides. The last two pages of the slide deck for today include instructions on how to request access to the Primary Care Equity dashboard.

As I mentioned in my opening comment, the dashboard is available to have data with regard to VA facilities nationwide. And it should be available to anyone who is a VA, you know, on the VA workforce.

And so, there are instructions on how to request access to the dashboard. And it only takes a moment to click a button and answer a few questions about who you are and where you're practicing within the VA landscape. And then, our team will grand you access within a matter of days.

So, please, if this is something you are interested in picking up at your own facility, the instructions for how to get started are at the end of the slide deck associated with today's presentation.

Unknown: Okay. "How was the veteran data collected? Interviews? Surveys?"

Dr. Beth

DeStanzo: So, the veteran data in terms of the refills, you know, who refilled their statin versus who didn't? That was done through chart review during our specified time period of January-March.

We just looked at those particular veterans, and did they refill, and did they not? When did they refill if they did refill?

In terms of the barriers to adherence? Those were specific questions that we asked during our Pharmacy Education consult visit.

So, I'm just going to pull up the slides here on our little template. These two questions were asked to every patient that we spoke of the 12. "What did you find challenging when providers asked you to remember to take your medication every day?" And "What can we do as a healthcare system that would be helpful to you to remember to take your statin?"

So, that's how we assessed that and we just did that through a chart review of the 12 veterans that we spoke with.

Unknown: Okay. We have another comment. "Very interesting and useful. For those experience psychosocial barriers to adherence, was a PACT SW consult made? And how were those interventions done?"

Dr. Beth DeStanzo: We did not consult the social worker for any of these particular veterans in this project. But that is something interesting going forward if there are psychosocial barriers, you know, whether it be financial, you know, situational within their homes, you know. That's a great role for a social worker. And, you know, had we encountered that, we do have social workers as part of our PACT team members as well that are readily available.

Unknown: Thank you. "What disease conditions can we sort on the PCDE dashboard?"

Dr. Beth DeStanzo: So, I will let again, you know, one of my folks who, you know, knew more of the innerworkings of the dashboard answer this question. But I have pulled up kind of the screenshot of the main PCDE performance snapshot barrier. You can see some of these listed here. But I don't know if Leslie—

Leslie Hausmann: I'm not sure I caught the full question. Was it about PI resources or the measures themselves?

Unknown: They just asked for other conditions.

Leslie Hausmann: Other conditions, okay. So, the measures currently featured in the dashboard pertain to statin adherence as occurred in-depth overview today with regard

to patients with cardiovascular disease. We have a number of diabetes metrics with regards to uncontrolled or poorly controlled HbA1C, as well as blood pressure management, statin use, and renal functioning tests for the diabetic population.

There is an overall hypertension blood pressure management measure. And then, the two sort of outlier or measures in terms of, you know, the ones I already mentioned are really about Chronic Disease Management and intervention of the consequences of poorly controlled cardiovascular disease, diabetes or hypertension.

We also have the influenza vaccine rates as measures in our current dashboard, as well as overuse of cross-TSA testing for prostate cancer in older gentlemen. So, that's the universe of measures that we currently feature in the dashboard.

With regard to the quality improvement resources that are included, we've done our best to tailor the resources that we feature in this tool to align with the types of measures that are being tracked.

So, we have a lot of resources around hypertension management, statin adherence, diabetes management, etc. as well as a number of general quality improvement or Health Equity resources that are more general things like cultural competence and adjusting social determinants of how our needs related to social determinants of health.

Hopefully that gives those on the call more comprehensive understanding of the kinds of resources that are featured at present.

Jamie Estock: This is Jamie Estock. I just want to also jump in for those of you who just as a clarifying point to what Leslie mentioned. For those of you who are familiar with the Electronic Quality Measures—the EQM measures—that are collected at VA facilities, that is what measures are represented in the Primary Care Equity dashboard.

It's not the full set of EQM measures. It's a subset based off of those that were the primary responsibility of Primary Care since we have a Primary Care Equity dashboard at this point. But we are able to pull in any EQM measure into the dashboard. But that's really what plays a limiting factor at this point is the access. We currently have access to those measures.

Leslie Hausmann: Well, it is the top of the hour and I want to thank you very much for taking the time to prepare and present for today. Any questions that haven't been answered, I will forward it on to the presenters.

And for the panelists, do you have any last comments before we close for today?

Dr. Beth DeStanzo: I did not.

Leslie Hausmann: Okay. And for the audience, thanks, everyone, for joining us for today's HSR & D cyber seminar. When I close the meeting you'll be prompting with a survey form. Please take a few moments to fill that out. We really do count and appreciate your feedback. Thank you and have a great day.

[End of Recording]