

Eliminating Racial and Ethnic Health Disparities in the Military Health System

Michael-Anne Browne, MD
Chair, Health Systems Subcommittee
June 28, 2023



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Overview



- Membership
- Tasking
- Background
- Objectives and Scope
- Summary of Subcommittee Activities to Date
- Findings & Recommendations
- Way Ahead

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Membership





CHAIR
Michael-Anne Browne, MD*



Maria Caban Alizondo, PhD, MA*



David Classen, MD



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Catherine McCann, PhD, MS



Rhonda Medows, MD*



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Tasking



On May 12, 2022, the Assistant Secretary of Defense for Health Affairs directed the Defense Health Board ("the Board") to **provide recommendations to address racial and ethnic health disparities within the Military Health System (MHS).**

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Background



- 31% of Active Duty personnel self-identify as a racial minority
- 16% of Active Duty personnel self-identify with Hispanic ethnicity
- Many MHS studies demonstrate narrowing, or even elimination, of disparate health outcomes across race and ethnicity over a wide range of conditions and age groups
- Physical and mental health inequities persist despite the MHS universal health care benefit

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Objectives and Scope



- Review the existing literature on disparities in health outcomes of Active Duty Service members and other MHS beneficiaries by race and ethnicity. Compare those disparities to those experienced in other U.S. health care systems.
- Identify systemic barriers to eliminating racial and ethnic health outcome disparities within the MHS, considering policy, processes, staffing, and training.
- Provide recommendations to address health disparities by race and ethnicity within the MHS.

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Summary of Activities to Date ^(1/3)



Meeting Date	Discussion Topics
Mar 30, 2022: DHB Meeting	Racial and Ethnic Health Disparities in the MHS
Jun 28, 2022: HS Subcommittee Kickoff Meeting	<ul style="list-style-type: none"> Expansion on racial and ethnic health disparities in the MHS Improving Health Equity via Recruiting, Retention and Education at Uniformed Services University of the Health Sciences
Jul 27, 2022: HS Meeting	<ul style="list-style-type: none"> MHS Data Systems and Race/Ethnicity Data Addressing Racial and Ethnic Health Disparities in the U.S.
Aug 10, 2022: DHB Meeting	<ul style="list-style-type: none"> Update of report to DHB members Veterans Health Administration efforts to promote health equity
Aug 24, 2022: HS Meeting	<ul style="list-style-type: none"> Health outcome disparities in the MHS Efforts to address health disparities at Naval Medical Center Portsmouth
Sep 28, 2022: HS Meeting	DoD Inspector General advisory on non-compliant race coding values in the MHS Data Repository
Oct 26, 2022: HS Meeting	<ul style="list-style-type: none"> NPIC and NSQP reporting on MHS race and ethnicity data Racial and ethnic disparities in maternal health research and recommendations

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Summary of Activities to Date ^(2/3)



Meeting Date	Discussion Topics
Nov 30, 2022: DHB Meeting	<ul style="list-style-type: none"> Report update to DHB members: Emerging themes Data collection and availability issues
Dec 5, 2022: HS Meeting	Mental Health Disparities Research: <ul style="list-style-type: none"> Psychiatric Conditions During Pregnancy and Postpartum Minority Adolescent Mental Health Diagnosis Differences
Jan – Feb 2023: Informational Teleconferences	Cleveland Clinic; Institute for Healthcare Improvement; Rush University; Kaiser Permanente; Boston Medical Center; Providence
Jan 19, 2023: HS Meeting	<ul style="list-style-type: none"> Mayo Clinic Health Equity Initiatives Potential Recommendations
Feb 16, 2023: HS Meeting	<ul style="list-style-type: none"> Overview of informational teleconferences Report Development: Outline and Recommendations
Mar 2, 2023: Visit to Naval Medical Center San Diego	NMCS D initiatives to identify and address racial and ethnic health outcome disparities
Mar 16, 2023: HS Meeting	Report Development: Outline, Recommendations, and Background

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Summary of Activities to Date ^(3/3)



Meeting Date	Discussion Topics
March 22, 2023: DHB Meeting	Report update to DHB members: Emerging Findings and Recommendations
April 12, 2023: HS Meeting	Report Development: Findings and Recommendations
April 26, 2023: HS Meeting	Report Development: Findings and Recommendations
May 10, 2023: HS Meeting	Report Development: Recommendations & Social Determinants of Health
May 24, 2023: HS Meeting	Report Development: Recommendations & Data Use
May 26, 2023: Informational Teleconference	TCON with Dr. Terry Adirim, former Undersecretary of Defense (Health Affairs) to inform Leadership and Structure for Sustainability chapter
June 7, 2023	Report Development: Recommendations & Leadership Chapter

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Emerging Finding ^(1/11)



1. MHS data systems do not fully capture race and ethnicity data to fully describe the beneficiary population. Most MHS family member beneficiaries either have an incorrect or missing value for race and ethnicity in MHS data systems or have their race and ethnicity inferred from their active-duty Sponsor. The MHS GENESIS source for race and ethnicity data is the Defense Enrollment Eligibility Reporting System (DEERS). Evidence shows that Service members and beneficiaries are currently unable to view or edit race and ethnicity in their DEERS record. If a beneficiary or clinic staff attempts to update MHS GENESIS with race or ethnicity, it will be overwritten by DEERS at the next update. Due to these limitations, studies using current MHS data often have limited ability to determine whether disparities exist or do not exist.

On January 1, 2023, the Joint Commission's (JC) requirement for hospitals and other health care programs to collect race and ethnicity for all patients took effect. The Joint Commission encourages organizations to use the five race and two ethnicity categories from the Office of Management and Budget (OMB) Statistical Policy Directive 15 (SPD 15), at a minimum. First, DEERS currently does not comply with the OMB reporting requirement due to its combination of the "Asian" and "Native Hawaiian or Pacific Islander" into a combined "Asian or Pacific Islander" category. Secondly, DEERS includes an "Other" race category.

(Draft Recommendations 1. A-E on next slide)

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Draft Recommendations



1. A: DoD should conform to the JC requirement by collecting self-identified race and ethnicity data for all beneficiaries – and not just active-duty Service members – through DEERS. Harmonize all race and ethnicity data between all administrative data sources, including MHS GENESIS.
1. B: Empower Service members and their beneficiaries to view, self-identify, and correct race and ethnicity data in DEERS.
1. C: DoD should conform with the OMB SPD 15 Federal Minimum Standards for Race and Ethnicity. DEERS and the Military Health System Data Repository (MDR) must separate the “Asian or Pacific Islander” category into the two OMB compliant categories “Asian” and “Native Hawaiian or other Pacific Islander.” We further recommend DEERS and the MDR replace its current “Other” category with “Multiracial” and eliminate its “Unknown” category.
1. D: Health facility staff should assist patients to review their MHS GENESIS race and ethnicity data and help them update DEERS and MHS GENESIS when changes are needed.
1. E: We strongly recommend for these and other reasons, that DoD replace DEERS with a modern personnel and beneficiary database. Whatever system replaces DEERS should be able to communicate with the medical system and allow for beneficiary self-service updates to demographic information.

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Emerging Finding (2/11)



2. Insufficient analysis of explanatory variables - such as socioeconomic status (approximated as rank in the MHS), geographic location (e.g., urban/rural), or primary language - that may correlate with race and ethnicity limit the interpretation and response to research findings of racial and ethnic health outcome disparities in the MHS.

Draft Recommendation

2. DHA and Uniformed Services University, through their research funding, research oversight, and Institutional Review Boards, should ensure that the design of DoD-conducted and DoD-funded research on MHS racial or ethnic health outcome disparities include socioeconomic status (or surrogates thereof), a measure of regional health services availability, and primary beneficiary language as explanatory variables.

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Emerging Finding ^(3/11)



3. Disparities in medical and dental outcomes could cause disparities in readiness by race and ethnicity. Readiness reports for DoD leadership do not currently provide health information stratified by race and ethnicity.

Draft Recommendations

3. A: Establish a program to monitor racial and ethnic disparities in medical and dental readiness.
3. B: If there are disparities, hold leaders with command authority accountable to address and eliminate persistent racial and ethnic disparities in medical and dental readiness.

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Emerging Finding ^(4/11)



4. Most of the literature on MHS health equity/disparities derives from individual-initiated, one-time data analysis, or local Quality Improvement projects and are neither sustained nor systematized efforts. The MHS' and DHA's centralized outcomes tracking – internally and through external reporting in national registries – does not include racial and ethnicity stratification or make such analyses easy to access.

The subcommittee also observed high variation in outcomes across MHS sites including mental health, maternal health, and surgical outcomes. Without racial and ethnic stratification of these outcomes, the subcommittee could not identify which sites had disparities attributable to race and ethnicity, which prevents the development of targeted recommendations to eliminate them.

(Draft Recommendations 4. A-D on next slide)

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Draft Recommendations



4. A: DHA and the MHS should add race and ethnicity to their existing standardized process for continuous quality management, registries, and other data sets used in the measurement, monitoring, and visualization of health and safety outcomes. All quality reporting (e.g., Joint Commission, NCQA, HEDIS, registry reports, Patient-Reported Outcome Measures) should include racial and ethnic stratification of results as well as analysis of progress in reducing disparities.
4. B: Given the complexity of accessing the relevant datasets and to perform the required analyses, MHS should identify and designate dedicated staff, such as a centralized group of trained statisticians, to perform statistical analysis of potential racial and ethnic disparities. This group could also stay abreast of findings in the civilian sector, and be a resource for other analysts and clinicians in the MHS who want to conduct their own assessments of racial and ethnic disparities.
4. C: Design of initiatives and countermeasures to improve overall health outcomes should incorporate specific interventions to reduce and eliminate existing and prevent new disparities – by race, ethnicity, region, Sponsor rank, or other factors.
4. D: Work with all national registries that the MHS participates in, such as NPIC and NSQIP, to allow MHS systemwide race and ethnicity reporting. This will help to inform actions to decrease the variation in outcomes between facilities throughout as well as overall disparities.

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Emerging Finding (5/11)



5. When selecting clinical areas for improvement efforts it is preferable to target areas with the most likely impact.

Draft Recommendation

5. We suggest the following priorities be used when selecting initial clinical areas of improvement with most likely impact on disparities:
- Clinical conditions that affect a large population
 - Clinical conditions that affect large number of actual or quality of life-years lost
 - Clinical conditions that impact readiness of the force
 - Clinical areas of known racial or ethnic disparity. Preliminary evidence suggests the existence of disparities by race in these areas:
 - i. Cardiovascular (e.g., hypertension, heart disease, diabetes)
 - ii. Obstetrics (e.g., maternal and infant health)
 - iii. Pediatrics (e.g., vaccination, well-child visits, obesity)
 - iv. Oncology (e.g., screening and outcomes)
 - v. Mental Health (e.g., access and outcomes)

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Emerging Finding (6/11)



6. Evidence shows that clinical care affects only approximately 20% of variation in health outcomes while as much as 50% of variation in health outcomes come from Social Determinants of Health (SDOH). SDOH screenings are necessary but insufficient to truly understand the lived experience of MHS beneficiaries who attempt to access and receive care and manage their health.

Draft Recommendations

6. A: Institute SDOH screenings of MHS beneficiaries throughout the life course by integrating annual standardized SDOH screening tools and workflows in MHS GENESIS particularly in adult primary care, pediatrics, and obstetrics.
6. B: In addition to SDOH screenings, the MHS should use Patient-reported outcomes and other methods to better understand the experience of MHS beneficiaries as they navigate the MHS.
6. C: Offer trainings to clinicians on SDOH and appropriate documentation. Incorporate this into health professional education.
6. D: Proactively analyze results of SDOH screenings MHS-wide, throughout the Direct Care system, by Market, MTF, and TRICARE region, and then promote resources and interventions to address the needs of MHS beneficiaries.
6. E: Promote culturally appropriate health literacy initiatives designed for specific audiences at each location based on health outcomes data, community input, and best practice health messaging.

Reference: US Department of Health and Human Services, 2022

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Emerging Finding (7/11)



7. All virtual visits in REVCYCLE require entering the patient's preferred language, but in-person visits have no such requirement. Therefore, clinic staff spend time during the appointment attempting to connect to interpretation services or serving as interpreters themselves. Language barriers play a role in patient experience which contributes to variation in health outcomes.

Draft Recommendation

7. Make patient's preferred language a required field when making in-person appointments and ensure appropriate interpretation services are available for all visits.

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Emerging Finding (8/11)

8. Race and ethnicity are relevant variables for some health conditions and should be carefully considered in the context of all variables affecting patients' health. Artificial Intelligence (AI) and Clinical Decision Support (CDS) tools have great potential to improve health outcomes. However, biases in the underlying data stemming from study design, data collection and entry, algorithm choice, and dissemination of results can contribute to health disparities. Some medical risk calculators, decision-making tools, and equipment in use by MHS health care personnel introduce inappropriate or unjustified racial and ethnic bias.

Draft Recommendation

8. A. In order to proactively ensure their CDS tools do not misuse race and ethnicity data, the MHS should create a centralized mechanism to review data use, new protocols, and equipment to prevent inappropriate incorporation of race-informed components of MHS clinical practice, and replace or eliminate existing race-biased tools, protocols, AI, Machine Learning algorithms, and equipment with the best-performing race-agnostic alternatives. Ensure clinical guidelines support providers' ability to appropriately use race and ethnicity data for CDS by weighing these data as part of the full context of patients' health including, at a minimum, symptoms, family history, and genetic screening results.

8. B. The DoD should ensure that all clinical trials and health research studies it supports include patients and participants from diverse populations.

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Emerging Finding (9/11)

9. There is limited data on the direct impact of health equity training initiatives on health outcomes. Some training methods appear to promote empathy and reduce bias which can influence health outcomes.

Draft Recommendation

9. Carefully consider the qualities of any health equity training before implementing it. Measure the training's impact on patient experience as well as outcomes. Select vendors that have a proven record of delivering effective health equity training programs.

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Emerging Finding (10/11)	
<p>10. Increased clinician-patient racial and ethnicity concordance can lead to improved patient care experiences through better communication, greater cultural competency, and reduced inadvertent implicit bias. The U.S. Government has committed to expanding ROTC programs to Historically Black Colleges and Universities (HBCU) with Science, Technology, Engineering, Mathematics (STEM) programs and without ROTC programs as a pathway to more under-represented minorities in the Armed Services. There is an opportunity to expand this effort to training to become a health professional.</p>	
Draft Recommendations	
<p>10. A: Add the presence of nursing, pre-medical, and other pre-health career curricula to criteria for HBCU ROTC program expansion.</p> <p>10. B: Promote workforce diversity through recruitment activities focused on underrepresented in medicine affinity academic organizations.</p> <p>10. C: Collaborate with existing groups that are already promoting workforce racial and ethnic diversity in healthcare.</p> <p>(Continued next slide)</p>	
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Emerging Finding (10/11)	
<p>10. Increased clinician-patient racial and ethnicity concordance can lead to improved patient care experiences through better communication, greater cultural competency, and reduced inadvertent implicit bias. The U.S. Government has committed to expanding ROTC programs to Historically Black Colleges and Universities (HBCU) with Science, Technology, Engineering, Mathematics (STEM) programs and without ROTC programs as a pathway to more under-represented minorities in the Armed Services. There is an opportunity to expand this effort to training to become a health professional.</p>	
Draft Recommendations (cont.)	
<p>10. D: Leverage Virtual Health to increase the options patients have to select health care providers of their racial and ethnic preference.</p> <p>10. E: Assess the effectiveness of these efforts by documenting change in supply of clinicians underrepresented in medicine.</p> <p>10. F: Measure impact of interventions to increase clinician-patient race and ethnicity concordance by a range of stratifications including location and clinical service type.</p>	
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Emerging Finding (11/11)	
11.	<p>Based on the DHB's review of best practices to promote health equity, and as required by the Joint Commission (JC) and recommended by the U.S. Centers for Medicare & Medicaid Services (CMS), successfully reducing disparities demands leadership and requires commitment and sustained effort at all organizational levels.</p> <p>To reduce disparities, the JC requires:</p> <ul style="list-style-type: none"> • Designating an individual to lead activities to reduce disparities for the organization's patients • Assessing patients' health-related social needs • Stratifying quality and safety data by sociodemographic characteristics • Develop a written action plan to describe how it will address disparities • Inform leaders and staff about progress to reduce disparities at least annually
Draft Recommendations	
11. A:	<p>DHA leadership should commit to achieving the goal of eliminating any racial and ethnic health disparities among all MHS beneficiaries by:</p> <ul style="list-style-type: none"> • Measuring disparities • Setting goals to reduce disparities by specific dates • Allocating sufficient resources to eliminate disparities • Regularly assessing progress
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Emerging Finding (11/11)	
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Draft Recommendations (cont.)	
11. B:	<p>MHS needs to add a racial and ethnic stratification to all quality reporting including hospital, ambulatory, patient satisfaction, and patient-reported outcomes.</p>
11. C:	<p>The USD(P&R) will be accountable for health disparities. To support the USD(P&R), DoD should establish a Health Equity Steering Committee, to monitor and guide the implementation of the recommendations in this report to eliminate racial and ethnic health disparities by a targeted date. The Health Equity Steering Committee will:</p> <ul style="list-style-type: none"> • Report progress toward eliminating health disparities • Include representative groups

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Emerging Finding (11/11)	
11.	<p>Based on the DHB's review of best practices to promote health equity, and as required by the Joint Commission (JC) and recommended by the U.S. Centers for Medicare & Medicaid Services (CMS), successfully reducing disparities demands leadership and requires commitment and sustained effort at all organizational levels.</p> <p>To reduce disparities, the JC requires:</p> <ul style="list-style-type: none"> • Designating an individual to lead activities to reduce disparities for the organization's patients • Assessing patients' health-related social needs • Stratifying quality and safety data by sociodemographic characteristics • Develop a written action plan to describe how it will address disparities • Inform leaders and staff about progress to reduce disparities at least annually
Draft Recommendations (cont.)	
11. D:	<p>The Assistant Secretary of Defense for Health Affairs (ASD(HA)) should report health outcomes, stratified by race and ethnicity, and report on ongoing initiatives to eliminate disparities, to the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) no less than annually. The ASD(HA) should do this by submitting an annual health disparities report card to the Health Equity Steering Committee and USD(P&R). MHS should report Clinical Quality, Health Outcomes, and Patient-Reported Outcomes by race and ethnicity at least quarterly to the ASD(HA).</p>
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Emerging Finding (11/11)	
11.	<p>Based on the DHB's review of best practices to promote health equity, and as required by the Joint Commission (JC) and recommended by the U.S. Centers for Medicare & Medicaid Services (CMS), successfully reducing disparities demands leadership and requires commitment and sustained effort at all organizational levels.</p> <p>To reduce disparities, the JC requires:</p> <ul style="list-style-type: none"> • Designating an individual to lead activities to reduce disparities for the organization's patients • Assessing patients' health-related social needs • Stratifying quality and safety data by sociodemographic characteristics • Develop a written action plan to describe how it will address disparities • Inform leaders and staff about progress to reduce disparities at least annually
Draft Recommendations (cont.)	
11. E:	<p>Incorporate Health Equity performance metrics and goals into quality and patient incentive programs for personnel providing care and managing military health services, such as those found in the Integrated Resourcing and Incentive System.</p>
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SPRCDDCS(0 Confirming this part of the recommendation.

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Way Ahead

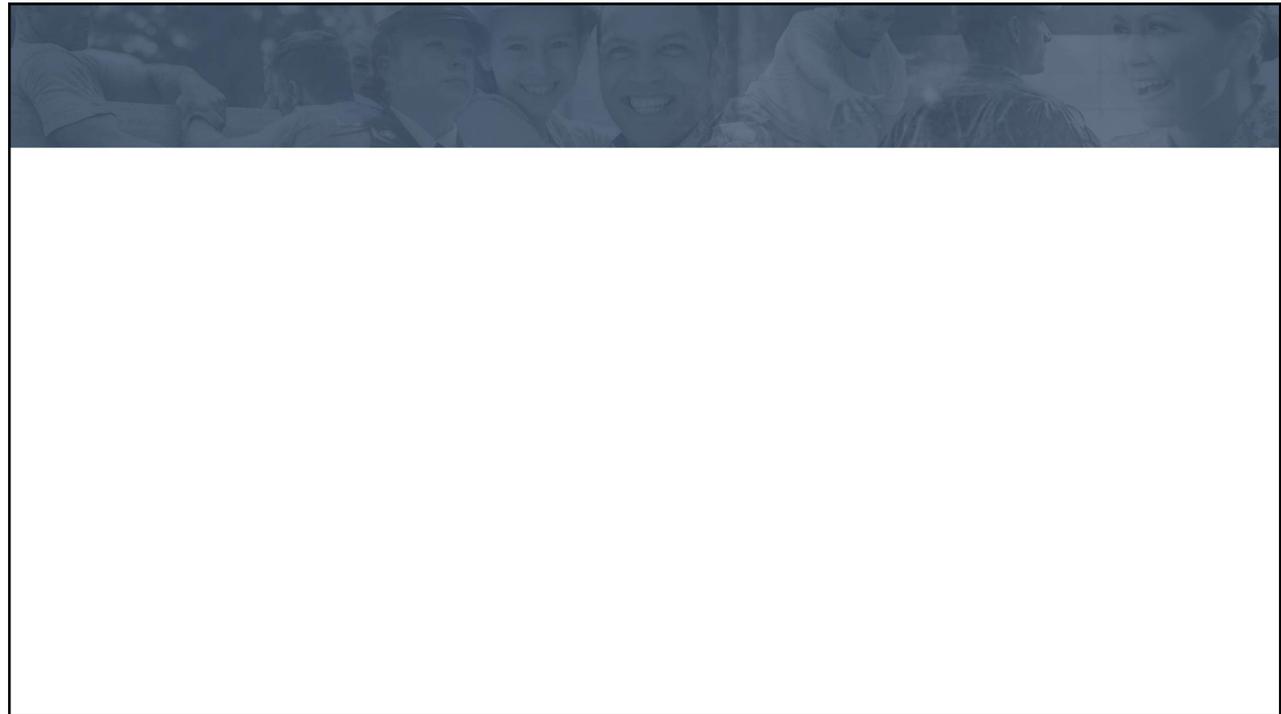


- Report development meetings:
 - July 12, 2023
 - July 26, 2023
 - August 9, 2023
 - August 23, 2023
- Anticipated pre-decisional draft delivery to DHB: August 28, 2023
- DHB deliberation: September 11, 2023

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