Borne the Battle

Borne the Battle BONUS: COVID Update #9

Vaccine Acceptance Successes, Building Trust with the Minority Veteran Community

https://blogs.va.gov/VAntage/89034/borne-battle-bonus-covid-update-9-vaccine-acceptance-successes-building-trust-minority-veteran-community/

(Text Transcript Follows)

[00:00:00] Music

[00:00:03] Opening Monologue:

Tanner Iskra: Oh, it's a bonus. Borne the Battle brought to you by the US Department of Veterans Affairs, the podcast that focuses on inspiring Veteran stories and puts a highlight on important resources, offices, and benefits for our Veterans. I'm your host, Marine Corps Veteran Tanner Iskra. COVID update number nine. I didn't know if we were going to get to do another one of these, and I'll be glad when we no longer have to. However, an interesting doctor reached out to me within VA, not a veteran, but a doctor with some interesting information about healthcare inequities in the country, healthcare disparities, how VA is studying that, how it all relates to COVID, how it related to the presentation of information behind COVID vaccines, and what VA has seen in vaccine acceptance and different groups when compared to other healthcare systems in the country. So, it's a data conversation/ episode, and I thought I'd share it with you as a bonus. Please feel free to email me at podcast@va.gov, and let me know if you'd like more sidebar conversations like this in relation to COVID-19 or anything else you might like now. Prior to joining the VA, our guest was a medical officer in the Office of Analysis and Epidemiology at the National Center for Health Statistics at the CDC. There he studied rural health disparities, analyzed linked hospital vital statistics data to identify care patterns that place patients at high risk for opioid poisoning, death Prior to CDC, he was the Director of the Division in the Center for Quality Improvement and Patient Safety at the Agency for Healthcare Research and Quality that designed and produced the National Healthcare Quality and Disparities report that is submitted annually to Congress. He's also an assistant professor at the University of Maryland School of Medicine, and he's also an emergency care physician at the Baltimore VA Medical Center. Our guest is also a graduate of Harvard College, the New York University School of Medicine and

at Columbia University's School of Public Health. He was a General Internal Medicine fellow at Columbia University and a Robert Wood Johnson Healthcare Finance Fellow at Johns Hopkins University. Dude is wicked smart. His research interests include disparities in access and quality of care, particularly in the application of the electronic health records, machine learning, and system science modeling to improve healthcare. And now for VA he is the Executive Director for the Office of Health Equity for VA Healthcare. So, without further ado—that was a lot of ado—I bring to you, Dr. Ernest Moy. Enjoy.

[00:02:47] Music

[00:02:53] PSA:

Man: I was a Gunner's Mate, Tonkin Gulf.

Woman: Logistics, Ramstein.

Woman: Medic, Kandahar

Narrator: As a Veteran, it doesn't matter when or where you served—

Man: Infantry, Camp Pendleton.

Narrator: —or what you did. The VA has benefits that may be useful to you right now. See what VA can do for you. To learn what benefits you may be eligible for, visit www.va.gov [Link: www.va.gov]. That's www.va.gov.

[00:03:23] Music

[00:03:28] Interview:

Tanner Iskra (TI): Doctor, how long have you been with VA?

Dr. Ernest Moy (EM): I've only been with VA for about three years, but I've been in federal service for over two decades.

(TI): I saw that, through the extensive bio that is on the website there. Now, you're not a Veteran, but before joining VA Healthcare, like you said, you've had a couple stints within other government agencies concerning healthcare disparities, given reports annually. Also, you've given reports annually to Congress. During that time, you've been at the Agency for Healthcare Research and Quality. What were you starting to—that's a whole mouthful of beltway speech if I've heard one. What were you starting to discover that you were including in your reports to Congress?

(EM): Sure. So, I spent a long time with AHRQ—that's what we call it. That's easier to say than the full agency name. But the first interest in looking at disparities, you know, started way back in the VA. Like many of us, I trained at the VA—VA Manhattan during my medical school and Philadelphia during residency. And then my first job was at VA Baltimore. And one of the things, you know, I observed was that you do see disparities among different groups of Veterans, and they tended to be larger outside of VA cause they all have affiliates than inside of VA, and this really sparked a lot of my interests in disparities. You know, what can we do to address disparities to make sure everyone gets the care that they need. And my first federal position was at the at AHRQ and one of our tasks was to inform Congress about the status of quality of care as well as disparities in quality of care across the nation. And we produced reports every year. And what we saw was basically on what I had originally described, which is there are differences. Not everyone gets the same care. Not everyone achieves the same health outcomes. There are ways for us to address that. And now it's just a matter of putting that into practice.

(TI): Very good. You were also a medical officer at the CDC in the Office of Epidemiology at the National Center for Health Statistics. Again, another beltway label if I've ever heard one. There again, you study healthcare disparities focusing on rural health care. What were the biggest disparities between, I mean, what were you seeing as far as between urban and rural healthcare? What were some of the things that you were discovering there?

(EM): Okay. So, you know, as for other kinds of disparities there are many, many, many different kinds of disparities. And one of the things that the center that I was at that we'll do is we manage all the death certificates and birth certificates. And so we were looking at mortality data and trying to look at differences in mortality, and we see huge differences in mortality rates between urban and rural areas. And then they're not getting smaller. They are persistent. They are longstanding. We see that the healthcare resources available in rural areas is getting worse, you know, rural hospitals closing or not enough doctors. These are things that are not actually getting better. And so, this is a major area of interest for us.

(TI): I'm seeing that in my hometown and back in Hoquiam, you know, Aberdeen, Washington, they're talking about closing down the local hospital there. So, I definitely see it from my hometown point of view. Were there any benefits that you saw in rural healthcare versus suburban or urban healthcare?

(EM): So, one of the things we do observe is that rural residents tend to have close relationships with their doctors, when they have doctors. They rate them more highly. They, you know, they feel like they, those doctors, maybe because there's fewer of them, you know, really know them. They will follow the advice of their doctors. And so, that is that is a benefit of having a smaller community. Urban centers, you know, like you come to the VA, I think we're pretty good. I mean, you know, you usually get the same doctors that you are used to seeing, but it's often as a team. They are handled as, and I think that's just less often in the rural area.

(TI): Very good. You also linked hospital vital statistics to data to identify care patterns that place patients at high risk for opioid poisoning, death, and develop new data visualizations and partnerships for disseminating health statistics. I had to read that because it's a mouthful of words that I didn't know go together. Can you give me an example of what you were talking about there?

(EM): Okay. So, part of the focus on rural areas—some of the things that, you know, brought to us to our attention, even though, you know, rural people say we've been tracking these differences long standing. But, you know, in the last decade we saw a lot of rise in death rates due to opioids and other substances in rural areas.

(TI): Yeah.

(EM): People talked about this increase in deaths of despair. There's been a lot of them concentrated in rural areas, at least initially. And that was a lot of the focus of these activities specifically trying to identify if there are specific populations or specific places that this is the big situation at highest risk. In a lot of ways, it mirrors some of the things you do inside of VA where we also do this kind of modeling to try to identify Veterans at high risk for an adverse outcome from opioids.

(TI): Okay.

(EM): And the difference—one of the reasons I came to the VA is when we do this modeling outside, we do our models and we say, “Okay, yeah. These people we have to be worried about, and healthcare providers, you need to be pay attention to this.” Right? Where as inside the VA, it's like we can do the same thing and say, “These people are high risk.” And now it's healthcare providers, “Do something,” but there are healthcare providers. And so they can actually do something, and they actually do.

(TI): Yeah.

(EM): And we use these—they use these algorithms to review rates of adverse events.

(TI): So, with the opioid epidemic, were you seeing it not just as a Veteran issue? Cause you know, we did have a problem with that in the Veteran population, but were you also seeing that in the greater population as well?

(EM): Yeah, definitely. It was not—it's not a Veteran issue. This is a generic, nationwide kind of issue. You know, so like so many of the things that we see affecting Veterans—we can do things once they get into our system, but they live in communities. And so, the same things that are affecting their communities affect our Veterans. And until we can bring them into our system and do our magic on them, their rates, their circumstances or risks mirror what they experience in the community.

(TI): Doc, I bring all this up to give whoever may be listening some background in that you've studied healthcare disparity in America for a very long time. For how about how many years?

(EM): Oh, 25, 30 years.

(TI): 25?

(EM): Yeah, I know. Right?

(Both): [Laughter]

(EM): I have the most boring career of all, right? I just keeps focusing and studying the same thing.

(TI): Well, that's how you become an expert in certain things. If that's your focus, you're laser focused on it. You're going to be someone that people look to in a specific areas of focus. Absolutely.

(EM): And having that long view of it, we can also—I can also talk about, you know, changes that have happened over that time course, which may not be as apparent to people who are only looking at it as a shorter time frame. So, a lot of people, you know, complain and we'll do this all the time saying, “Oh, well, you know, it's just been—we've known about disparity for such a long time and it hasn't changed.” But it actually has changed. And so, when we first started looking at disparities, you know, twenty-five, thirty years ago, we would get pushback saying this really doesn't exist. This is just an artifact. We don't believe it exists. And over time as we've

developed the information and really shown healthcare providers that this is not just some theoretical construct but this is your care to these patients. And look, there are disparities here. I think we've reached a point where most of the healthcare system understands there are disparities, and now they're focused more on how to deal with them. And that's the challenge, as opposed to the state of denial that have been doing this.

(TI): Sure. What's been the biggest thing in twenty-five years that you've seen as far as changes in the health care disparity?

(EM): So, we—overall outside of VA, we have seen generally a narrowing of healthcare disparities. At the beginning, the big focus was racial and ethnic disparities. And we still do see those disparities, but we also see many other kinds of disparities as many other populations have received attention. So, 30 years ago, no one thought about looking at, for instance, sexual orientation, you know, as a disparities issue. But when we look at it now, we see that it has a huge effect, that, you know, sexual minority people, in general, are very, very disadvantaged in the care that they get. They're very, very stressed out by the circumstances in which they have to live. And it's something we need even think about looking at, you know, thirty years ago.

(TI): Interesting.

(EM): It's those kinds of changes.

(TI): So, you're looking at different types. You're separating the population by race, by sexual orientation, by socioeconomic issues and trying to figure out better waysto take care of everyone. Now you're applying this knowledge to the current issue of vaccine acceptance. With VA's Office of Health Equity, are you studying the healthcare disparity via socioeconomic, rural versus urban, by race or all of the above?

(EM): You name it. We've looked at it a while. You know, part of it's shotgun because when this all started, we weren't sure what was going to be important because, you know, the beauty of having a big system like the VA with both researchers and healthcare providers is that we can see very, very early on. So more than a year ago, last March, you know, we were seeing that signal that the COVID infection was not evenly distributed across our Veterans—that we were seeing much at that point, much, much higher rates

amongst certain racial, ethnic groups. And so, we knew that we needed to do something about it. We just couldn't leave it to that.

(TI): What were some of the factors? What do you think were some of the factors of that? Was it just living in close quarters? Being in more of an urban environment? What would you think some of the factors were?

(EM): So, there were a lot of factors that we considered, but one of the things, again, as a big system is that we sent our researchers to go and look to see what happened during past pandemics. And I think what's happened during the past pandemics has played out now. What they found is the major determinant is occupational exposure. So, many minorities are more likely to be essential workers. They have to physically go to work and be exposed and have face to face contact. And that is the big thing. It's not that different groups are less likely to do masking and social distancing and washing their hands and all those different kinds of things. It's their exposures.

(TI): The chance to being exposed. Interesting, interesting. In terms of vaccine acceptance, what are you seeing in these factors in these different sections? How is it all breaking down?

(EM): So, what we're seeing now, and this is looking at our data—the VA data, which is different from what's outside—what we're seeing is that our vaccination rates are really good with race ethnicity. So, we're seeing higher rates of vaccine uptake among almost all of our racial and ethnic groups and minority. So, Blacks, Hispanics, Asians, Hawaiians, American Indians are picking up vaccination at a very high rate. And for most of these groups, the rates are even higher than it is for White Veterans. We don't see any differences, really, in the sex either. What we're seeing is that rural Veterans are the ones that are not picking up the vaccine as quickly as the urban Veterans. And so, that's where we see our gap. That's where we see a major focus area.

(TI): So, you're seeing, and that could be across racial lines and ethnic lines and things like that—it's just rural versus urban. There's a lot of that—

(EM): Yes, there is.

(TI): —disparity.

(EM): But we can actually look at it, cut up, sliced up by race, ethnicity, and by rurality. And what we see, for instance, is in the urban areas. It's pretty even across the racial and ethnic groups and in the rural areas is where we see some differences. So, for instance, the American Indians, they're less likely to get vaccinated at VA out in the rural areas. We think that may be in part because Indian Health Services has gotten to them and have gotten their vaccinations, that assistance, more quickly than they could through us.

(TI): Interesting. This is all interesting. So, you're saying that this data, the VA's data, is a little bit different from the outside data. What are you seeing as far as the differences between what VA is doing and what outside VA is doing?

(EM): So, what we hear from outside the VA is that they're seeing significant racial and ethnic differences—that, you know, minority Veterans, minority people are less likely to get vaccinated than White Americans. And we don't—we're simply not seeing that inside the VA.

(TI): Why do you think that is?

(EM): Well, I think there's a lot different reasons. I mean, we're a healthcare system first. So that's, that's the biggest difference in my mind. So, a lot of places, you know, you have to figure out if you're eligible for a vaccine. You have to go through all this rigmarole. The sign up around here, it's like click, click, click, click, you know, for days, and then eventually you might get an appointment. And so, it is both impersonal, dependent on the patient, and then difficult. And I think inside the VA, you know, we have a better system. We have a system. And so, first of all, our providers are talking to our Veterans about vaccination way before vaccines available. So, starting in the fall, they're talking to the Veterans. “Oh, won't it be great when this comes becomes available? You won't have to worry as much anymore.” You know, in our system we know our patients, and so we can call them up, and a lot of VA's been doing that. Call them up. “You're eligible for vaccine now. Do you want to get vaccinated?” And if you do, they say, “Oh, when do you want to get vaccinated?” We can see other stuff.

(TI): Much better system. It's a much better system than what I was seeing in the counties back home. And talking to my dad and my grandma and trying to get them both vaccinated, and, you know, cause they're high risk, you know, and I wanted to see them get that. And we were one of the first. But to get through the, you know,

the different systems or the different counties, whereas I think, yeah, you're right. VA was a much, you know, streamlined process throughout the entire country compared to others. I could see where that would be a difference. By now we've seen over 2 million Veterans vaccinated at VA facilities. Refusal rates have been at 3.5%. Is that low or high?

(EM): I think that that is probably right where we are. Let's put it that way. But it's a really squishy number. And so, part of the squishiness relates to the fact that, you know, what is a refusal? So I, being a data person, I looked at the data and I say, “Oh, you know what? There's a chunk of the people who refused, the Veteran's who refused vaccine,” and then they get it. [Laugh] So, the refusal is not definitely, “I'm never going to get this vaccine,” because I see them getting it. It's more a refusal, “I'm not ready to sign up for an appointment to get it right now.” And I also—

(TI): And I think, I was gonna say, I think that's a fair assessment. I think there's different populations that will accept it at different rates. You know, I think the more you, like, you know, there's a certain population that if you press on them more, the more they're going to refuse it, right? Don't make it weird, right? Let's just make it, you know. And some people are gonna wait until FDA's fully approved it, you know. And that's going to be a—you're going to see a big chunk of that as well. I think it's going to be a different rates with different people. And I think people just have to understand that. You know, and just kind of figure that out.

(EM): And a lot of it I think is being vaccinated on your terms. And so, I vaccinate out in the community and I've vaccinated Veterans out in the community outside the VA, you know, in my county. And so, I get back Veterans who refused vaccination at VA, and, you know, obviously they're coming to get vaccinated. So, it's not like they didn't want to get vaccinated, just couldn't get vaccinated on their own terms. So, I had one Veteran who said, “You know, I went to—the VA called me and said I could get Johnson and Johnson, but I didn't want Johnson and Johnson. So, that's why I'm coming to you to get vaccinated.” That's a refusal. [Laugh]

(TI): I think it's great that, you know—I mean, we're really the only country in the world that has three different types of vaccinations. So Americans are getting a little choosy, right? And it's like, “Okay, I want the Moderna, or I want the Johnson and Johnson, or I want the Pfizer.” And they're doing their own research, and that's all good

things, you know. And I think it's—I think we're lucky to be in a country where we have three different types of vaccinations for COVID-19. I'm just—I'm waiting for someone to say, “I want all three,” right?

(Both): [Laugh]

(TI): Just be like one ring to rule them all type of thing, you know?

(Both): [Laugh]

(TI): Why do you think VA has been successful with minority Veterans? And if that is in contrast to other healthcare systems, what sort of lessons can VA share with other healthcare systems about easing the worries of vaccinations with minority groups?

(EM): So, I think that there are things that are passive that we described that were true for all Veterans, but I think that may disproportionately help minority Veterans. And so, these people that we're connected with, and they're not strangers, they trust their providers, they trust other Veterans, that they know the VA system. So, I think that helps us out. But, you know, it's kind of passive. We'd have these systems to go reach out to them and kind of get them in for vaccination and get a passive process. In addition to all of that, you know, VA has been doing some very important things to think actively. So, very early on, we were concerned about a vaccine hesitancy. And so, we designed products that were specifically geared towards different Veterans. So, we had listening sessions with minority Veterans and heard from them, you know. We need for you to get vaccinated. And I think it came down to two things. It came down to trust, and it came down to truth. So they wanted to hear from someone they trusted, their doctor or another Veteran. We can do that. And they need to hear the truth. They want to hear scientific evidence. They didn't want to hear all this rhetoric. So, we have compiled the scientific evidence, for instance, to show that and, you know, yes, in fact, you know, there were tons of minority peoples who participate in vaccine trials, tens of thousands. And it's not like—

(TI): Was there a time when people were under—when minority groups were wondering if they were part of the trials?

(EM): Yes. So that was—

(TI): Interesting.

(EM): —a big thing. It's like, okay, well, you know, we know a lot of clinical trials is basically affluent white males in trials and if this is like that we don't actually know what is relevant to us.

(TI): Interesting.

(EM): But these vaccine trials are different. They have tens of thousands of people participating, and all these actions have crowds. We have very, very good evidence that it's safe and effective for everybody. And so, that, you know, was one of the things that we targeted to make sure that information was available to debunk any kind of potential issues related to that. We also did outreach. So, we spoke to different kinds of groups so that we can talk to them specifically about the vaccination, its importance, and try to overcome some of these vaccine hesitancy issues.

(TI): What were some of the issues that you were seeing? What was like some of the larger—what were some of the larger myths that you had to debunk? Well, one being the, you know, the fact that nobody was in trials—that no minority groups were in the trials. I'm sure it was probably pretty easy to debunk. What are some, what was—give me another one. What was another?

(EM): See, another big one that we had was they told us that, especially African-American Veterans, that you had to talk about Tuskegee. You can't talk about, you know, trials or anything that's experimental without addressing Tuskegee. And so, we do.

(TI): What's that mean?

(EM): Oh, so in these Tuskegee trials—this is from decades and decades ago—African-Americans were enrolled in these syphilis trials, and they weren't trials. They were there monitoring people with syphilis overtime to see what happened to them. And even after treatment became available, even after effective antibiotics were developed, they weren't offered treatment.

(TI): Wow.

(EM): So, they never got treatment. And yeah, this is a black eye, obviously, in medical research.

(TI): Yeah.

(EM): You know, what we emphasize is the issue then was they were never given the autonomy and the right to decide for themselves about what they wanted, what kind of care they want, what they

want in treatment. And right now, we're trying to do the reverse. We are trying to make sure that everyone has the information they need to make an informed decision about vaccination, the right ones for them and their families. We're not saying it has to be us, because I don't think it has to be us. I mean, “I know I want to wait.” That's not unreasonable if you can protect yourself.

(TI): Yeah.

(EM): Making sure that it is in the Veteran's hands to make that decision. So, we argue that it's a total opposite to Tuskegee where they weren't given the right to decide. Here we’re trying to make sure everyone has the right to decide.

(TI): And I think we're going to be at a point now, soon, that the supply is going to overwhelm the demand, and we're actually going to have some leftover and it's like, “Okay, whenever you want it, it's there.” All good things.

[00:24:23] Music

[00:24:26] PSA:

Man: The VA does a very good job on the medical side. I don’t know of anybody that has any complaints. My primary care doctor’s probably the best doctor I’ve ever had in my life.

Woman: My friend, a good patient of mine, he only comes once a week, but I enjoy him.

Man: She comes in special, early in the morning.

Woman: Yes, I do. Early in the morning—

Man: —Just for me. That’s exactly why I choose VA.

Narrator: Choose VA today. Visit va.gov [Link: va.gov].

[0:24:55] Music

[0:25:01] Closing Monologue:

(TI): I want to thank Dr. Moy for reaching out to me. You can find more information about Dr. Moy and find the email to reach out to him at va.gov/healthequity/OHE_leadership.asp [Link: va.gov/healthequity/OHE_leadership.asp]. That is all we have for this episode. As always, if you like this podcast episode and you want to hear more as they come out, hit the subscribe button. We're on iTunes, Spotify, Google Podcast, IHeartRadio. Pretty much any podcasting

app known to phone, computer, tablet, or man—or those, you know, those Echoa, those Dots, we're on those as well. For more stories on Veterans and Veteran benefits, check out our website, blogs.va.gov [Link: blogs.va.gov]. And follow the VA on social media: Facebook, Instagram, Twitter, YouTube—which there is a whole playlist of Born the Battle on there—RallyPoint, LinkedIn, Pinterest. DPTVetAffairs, US Department of Veterans Affairs, no matter the social media, you can always find us with that blue check mark. And, as always, I'm reminded by people smarter than me to remind you that the Department of Veterans Affairs does not endorse or officially sanction any entities that may be discussed in this podcast nor any media products or services they may provide. I say that because the song you're hearing now is called "Machine gunner," which is courtesy of the non-profit Operations Song. And it was written by Marine Veteran Mick McElhenny, Nashville songwriter Jason Sever, and Mykal Duncan. Thank you again for listening, and we'll see you right here on a regularly scheduled Monday episode coming up. Until then, take care.

[0:26:34] Music

(Text Transcript Ends)