Serving Those Who Served: Enhancing Veteran Healthcare in Civilian Systems

Presenters:

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Description

• High quality health care requires clinicians to align regimens with their patients’ cultural backgrounds.

• Military service becomes a component of veterans’ cultural perspectives that impact their health status and utilization of health services.

• This session will describe the organizational strategies, success factors (including the expertise of network employees who are veterans) and outcomes of a civilian health network-based population health project.
Learning Outcomes

• Learning Outcomes: Demonstrate defined population health management opportunities driven by:
  – Disparities in health care provided to the veteran community.
  – Bio/psycho/social/cultural considerations of the veteran community and their impact on patient-provider interactions.
  – Barriers to patient-provider communications with veterans and their families.
Bottom Line Up Front

AHA 123 Equity of Care Pledge
Why are we referencing this? (Healthcare Disparities)

1. 1000 Hospitals signed, no comprehensive solution to implement except WCH
2. WCH, through our reach and advocacy, made sure that Veterans were included in the Statement and Pledge
3. This happened in March 2016

AHA 7 Principles for a Care Delivery System – Why are we referencing this?

1. Hospitals and health care systems are striving to achieve the Triple Aim –
   1. Improving the patient experience of care (including quality and safety)
   2. Improving the health of populations
   3. Reducing the per capita cost of health care

2. To achieve these goals, hospital leaders are designing new care delivery systems.

3. Adoption of these new systems center on individual and community needs, rewarding high-quality with desired individual and population health outcomes.
"In 2016, the policies, strategies and resources required to address and eliminate disparities in health and health care are at critical crossroads. A new way of thinking and acting will be required by the nation’s hospitals, health systems, and providers to address the disparities that exist within and among vulnerable populations.

While race, ethnicity, and language preferences have traditionally framed the approaches undertaken to address disparities in health care; the future of population health in a value based care model will dictate broader considerations of cultural backgrounds that have traditionally been a part of diversity and inclusion (D&I) work.

Specifically, there is a growing awareness that culturally diverse communities (i.e., Veterans, LGBTQI, and Persons with Disability/Differing Abilities) represent an expansion of the D&I universe and should be uniformly included in the health care disparities discussions, thinking, and policies going forward.

Effective population health management requires that health care systems identify, learn, engage, and connect with each vulnerable community in its service area; in order, to improve the delivery of effective and quality culturally-responsive, community-focused, and patient-centric care".

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Making the Case for Targeted Population Health: The Need for Veteran Healthcare in Civilian Systems
The Problem: A National Shame

22 million veterans of U.S. military service bear the invisible scars of a “working environment” that will affect them the rest of their lives.

Somehow people who go to war young, bright, outgoing and in great health return without so much as a scratch but nevertheless are dull, sick, depressed, reclusive, isolated and old before their time.

Undiagnosed, they and their families - 74 million Americans - “drive on.”
A Culture Within Cultures

The military is a distinctive culture with distinguishing signs and symbols.

However, each warrior belongs simultaneously to many additional cultures as well.

Understanding the interplay between and among the co-existing cultures of a warrior is critical to establishing tailored and effective health care services and outcomes.

- Culture, ethnicity, lingo, and military/combat experience affect population health management strategies.

- The techniques used to learn and understand veterans can be used to understand other patients with diverse backgrounds.
Lack of Cultural Competency makes Veterans a Vulnerable Population

• Cultural competency means medical practitioners understand military mores, language and background, and provide correct diagnosis and deliver appropriate care for illnesses unique to the military.

Why are Veterans a Vulnerable Population?

- Symptoms: 27% of Veterans
- Rationed Care: VA
- Unaware Care: +70% of Veterans
- Commercial Hospital
“Battle Worn”
30 Years and Counting

<table>
<thead>
<tr>
<th>Year(s)</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>1983</td>
<td>Invasion of Grenada</td>
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<tr>
<td>1989-1990</td>
<td>Invasion of Panama</td>
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<tr>
<td>1990-1991</td>
<td>Persian Gulf War (Gulf 1) – Iraq</td>
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<tr>
<td>1992-1994</td>
<td>Operation Restore Hope – Part of Somali Civil War</td>
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<tr>
<td>1993-1995</td>
<td>Bosnian War - Part of the Yugoslav War</td>
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<tr>
<td>1999</td>
<td>Kosovo War – Part of the Yugoslav War</td>
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<tr>
<td>2001-2014</td>
<td>Afghanistan War (Gulf 2 - War on Terror) (Operation ENDURING FREEDOM)</td>
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<tr>
<td>2003-2011</td>
<td>Iraq War (Gulf 2 - War on Terror) (Operation IRAQI FREEDOM)</td>
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<tr>
<td>2014-???</td>
<td>Iraq (ISIS/ISIL) - Gulf 3 - Operation INHERENT RESOLVE (OIR)</td>
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<tr>
<td>2014-???</td>
<td>Afghanistan - Gulf 3 – Operation RESOLUTE SUPPORT (ORS)</td>
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<td></td>
<td>- Operation FREEDOM’S SENTINEL (OFS)</td>
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Health of Gulf War and Gulf War Era Veterans: A Sample Gap

What is Gulf War Illness?

**Undiagnosed** illnesses with symptoms that may include but are not limited to:
- abnormal weight loss
- fatigue
- cardiovascular disease
- muscle and joint pain
- headache
- menstrual disorders
- neurological and psychological problems
- skin conditions
- respiratory disorders
- sleep disturbances

79% of Veterans reported at least one chronic medical condition (82% in deployed Veterans and 78% in non-deployed Veterans).

<table>
<thead>
<tr>
<th>CHRONIC ILLNESSES</th>
<th>Deployed</th>
<th>Non-deployed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GULF WAR ILLNESS</strong></td>
<td></td>
<td>20.3%</td>
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<tr>
<td><strong>HYPERTENSION</strong></td>
<td></td>
<td>43.9%</td>
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<tr>
<td><strong>FUNCTIONAL DYSPEPSIA</strong></td>
<td>15.9%</td>
<td>40.0%</td>
</tr>
<tr>
<td><strong>DERMATITIS</strong></td>
<td></td>
<td>27.4%</td>
</tr>
<tr>
<td><strong>IRRITABLE BOWEL SYNDROME</strong></td>
<td></td>
<td>27.7%</td>
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</table>

The average number of self-reported chronic medical conditions was 3.5 (3.7 in deployed Veterans and 2.9 in non-deployed Veterans).

All of these symptoms are treated individually in hospitals / health systems – however, rarely together as a chronic set of connected conditions with considerations for unique occupational and environmental exposures. **70+%** of Veterans receive health care from local practitioner offices and hospitals which are **unaware, untrained and unable to care** for our Veterans.
**Why WCH: Commercial Healthcare is on the hook to bridge the care gap**

| Only 26.8% of veterans are registered and receive health care from the Dept. of Veteran Affairs annually | Over 70% of veterans are receiving health care and supportive services in the civilian-commercial community | Over 10 million healthcare providers and practitioners in the commercial sector have quantifiable capability gaps in serving the veteran communities |

**Systemic Issues**

**Available Opportunity**

**Market Differentiation**

10 million | 5,000+

[Warrior Centric Health (WCH)](https://www.warriorcentrichealth.com)
Figure 2. Health insurance coverage among men aged 25-64, by age group and veterans status: United States, 2007-2010

NOTE: Coverage includes private health insurance, Medicaid, Medicare, other government-sponsored health plans, or military plans. Persons with only Indian Health Service coverage are considered to have no health insurance coverage. SOURCE: CDC/NCHS, National Health Interview Survey, 2007-2010
Figure 1. Two or more chronic conditions among men aged 25–64, by age group and veteran status: United States, 2007–2010

NOTE: Conditions include diabetes, hypertension, heart disease, cancer (excluding nonmelanoma skin cancer), stroke, chronic bronchitis, emphysema, asthma, and kidney disease.
<table>
<thead>
<tr>
<th>War Era</th>
<th>Population</th>
<th>Current Mean Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>WWII Era (09/1939 - 10/1946)</td>
<td>1,593,955</td>
<td>92.0</td>
</tr>
<tr>
<td>Korean War Era (06/1950 - 07/1953)</td>
<td>2,277,078</td>
<td>82.5</td>
</tr>
<tr>
<td>Gulf War I Era (08/1990 - 08/1991)</td>
<td>3,581,223</td>
<td>69.0</td>
</tr>
<tr>
<td>Gulf War II Era (09/2001 &amp; Later)</td>
<td>2,649,691</td>
<td>62.5</td>
</tr>
<tr>
<td>Veterans NOT counted in a Specific War Era of Service</td>
<td>3,291,413</td>
<td></td>
</tr>
</tbody>
</table>

**Veteran Population by War ERA vs Mean Current Age by War ERA**
A Veteran’s Health: The Transition from DOD Service to VA and Non-VA Care

Environmental Exposures:
- Asbestos
- Burn Pit Smoke
- Contaminated Water (benzene, trichloroethylene, Vinyl chloride)
- Endemic Diseases
- Hexavalent Chromium
- Ionizing and Non-Ionizing Radiation
- Jet Fuel
- Lead
- Mustard Gas
- Nerve Agents
- Particulate Matter
- Pesticides, TCDD and other Dioxins

- Animal Bites/Rabies
- Combined Penetrating
- Blunt Trauma
- Burn Injuries (Blast Injuries)
- Dermatologic Issues
- Embedded Fragments (shrapnel)
- Leishmaniasis
- Mental Health Issues
- Multi-Drug Resistant Acinetobacter
- Reproductive Health Issues
- Spinal Cord Injury
- Traumatic Amputation
- Traumatic Brain Injury
- Vision Loss
A Veteran’s Health: The Transition from DOD Service to VA and Non-VA Care

**Gulf War** *(Operation Desert Shield/Operation Desert Storm)*
- Chemical or Biological Agents
- Dermatologic Issues
- Infectious Disease (i.e., Leishmaniasis)
- Reproductive Health Issues
- Depleted Uranium (DU)
- Immunization
- Oil Well Fires

**Vietnam, Korean DMZ and Thailand**
- Agent Orange Exposure
- Hepatitis C

**Cold War**
- Nuclear Weapons Testing (Atomic Veterans)

**WWII and Korean War**
- Cold Injury
- Chemical Warfare Agent Experiments
- Exposure to Nuclear Weapons (Including Testing or Cleanup)

DOD/VA Routine Service Interface with Civilian Health Networks

Veterans Administration

Veterans Health Administration

1,700 hospitals, clinics, and long-term care facilities serving 9 million veterans

Demand far outstrips capacity, so a priority system is mandated by Congress

Currently 8 Priority groups. Rankings include not only health status, but income and age

Dept. of Defense

Defense Health Agency

The military – the Army, Navy, Air Force, Marines, and Coast Guard – has its own integrated health care system

The military's health facilities cannot accommodate the demand for care by all active duty service people, their dependents, and retirees (many of whom are NOT eligible for VA services).

Government-provided insurance plan, called TRICARE, for those who cannot get care at a military health hospitals or clinics

Direct Purchase Programs

TRICARE Referrals
Example: Tricare Prime

Third Party Administrator (TPA)-
(e.g., HealthNet Federal Services)

VA Referrals
Examples: PCCC, PC3

Civilian Health Networks
Knowing all of this, why aren’t we all capturing veteran status from our patients and looking at targeted population health strategies?
Lehigh Valley Health Network:
Our Approach to Enhancing Veteran Healthcare
Lehigh Valley Health Network: Who We Are

- 5 Hospital Campuses
- Children’s Hospital Within a Hospital
- 136 Physician Practices
- 17 Community Clinics
- 13 Health Centers
- 9 ExpressCARE Locations
- 34 Testing and Imaging Locations
- 13,100 Employees
- 1,340 Physicians
- 582 Advanced Practice Clinicians
- 3,700 Registered Nurses
- 60,585 Admissions
- 208,700 ED visits
- 1,161 Acute Care Beds
Lehigh Valley Health Network: Who We Are

...And there are 5 other hospitals and health systems in the Lehigh Valley; we all take care of veterans, military, and their families so we MUST work together as we partner with the VA and DOD in care delivery

- 5 Hospital Campuses
- Children’s Hospital Within a Hospital
- 136 Physician Practices
- 17 Community Clinics
- 13 Health Centers
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### Principles for Creating a Care Delivery System

1. **Design the care delivery system with the whole person at the center.**

2. **Empower people and the care delivery system itself with information, technology and transparency to promote health.**

3. **Build care management and coordination systems.**

4. **Integrate behavioral health and social determinants of health with physical health.**

5. **Develop collaborative leadership.**

6. **Integrate care delivery into the community.**

7. **Create safe and highly reliable health care organizations.**


(2015 AHA Committee on Research; 2015 Committee on Performance Improvement; January 2016)
## Beyond the Moral Imperative: Operationalizing “Thank You for Your Service” in Non-Governmental Health Care

<table>
<thead>
<tr>
<th>AHA 7 Principles</th>
<th>The Imperatives</th>
<th>Strategies</th>
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<tbody>
<tr>
<td>1. Design the care delivery system with the whole person at the center</td>
<td>Moral: It’s the right thing to do for our military men and women; they enter military service as the healthiest of Americans and can leave as some of the most broken. The aim of the hospital/health network should be to create a level of trust.</td>
<td>Screen for and capture veteran status at health care system points of entry: A veteran must be identified to ensure the best possible outcomes (“You must know me to treat me®”); once identified as a veteran, “the 6 critical questions” should be asked in the exam room.</td>
</tr>
<tr>
<td>2. Empower people and the care delivery system itself with information, technology, and transparency to promote health</td>
<td>Patient Safety: Veterans come to the private health care setting guaranteed to have received care in multiple systems, generating multiple medical records; risk are high for duplicate testing and workups, gaps in care, and other care continuum challenges</td>
<td>Pursue Healthcare Information Exchange (HIE) opportunities with both the VA and DOD/TRICARE: Meaningful use planning across major medical record platforms suggests systems are already interoperable sufficient to support bidirectional records sharing</td>
</tr>
<tr>
<td>3. Build care management and coordination systems</td>
<td>Population Health: Ensuring veterans receive timely, seamless access to the best possible care with the best possible outcomes can be challenging; care managers with skillsets uniquely tailored to veterans needs are paramount when care eligibility/delivery crosses multiple systems.</td>
<td>Provide targeted case management and population health resources to support cross-systems navigation: Programs that integrate non-governmental, VA, and DOD-based access to care are a responsibility that the civilian health care sector must share; veterans are a cross-representation of every American race, ethnicity, gender identity, sexual orientation, culture, and subculture—if we can treat veterans effectively, we should be able to treat ANY patient effectively.</td>
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<tr>
<td>4. Integrate behavioral health and social determinants of health with physical health</td>
<td>Knowledge: Our health care professionals may not be able to become subject matter experts in veteran and military medicine, but they must achieve and maintain a baseline understanding of the complex comorbidities and unique cultural backgrounds of veterans.</td>
<td>Address Proficiency Gaps: Integrate Warrior Centric Health (WCH)® bio/psycho/socio/cultural methodologies in trainings and assessments; improve clinical proficiencies by capitalizing on clinicians and administrative personnel in your organization that are military/veterans; share resources in your community; invest in veteran-centric grand rounds, webinars, conferences.</td>
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<tr>
<td>5. Develop collaborative leadership</td>
<td>Leadership: No health care system can do this alone; regional partnerships across competitive health care systems and VA/DOD/other vital stakeholder collaborations are crucial. All must respond to and act upon the “1 2 3 Equity of Care Pledge.”</td>
<td>Regional Innovation and Leadership: All health care is local; health enterprises can seek common ground with competitors to launch regionalized initiatives and/or create alliances to serve military members, veterans and their families.</td>
</tr>
<tr>
<td>6. Integrate care delivery into the community</td>
<td>Financial: We must find a way to provide the best possible care to our military men and women without breaking the bank and in fact, while realizing a measurable cost savings; this can be achieved through an integrated care delivery model that incorporates population health strategies and that assesses veteran utilization patterns, disease prevalence, etc.</td>
<td>Data Sets/Utilization Review/Contracts: Analyze your veteran population health and utilization dynamics; assess current (and future opportunities for) decentralized versus centralized veteran care; ensure targeted case management/discharge planning expertise and community resources are aligned; assess and address organizational knowledge and productivity gaps; and use veteran health program improvements to execute/strengthen DOD/VA contracts.</td>
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<tr>
<td>7. Create safe and highly reliable health care organizations</td>
<td>National Security: Conversations in American homes have shifted; parents are increasingly less concerned about their children serving in harm’s way and more concerned that they will not receive the care they require after service; health care systems across the U.S. must partner more deliberately with the VA and DOD in ensuring a ready, willing, and able military force.</td>
<td>Networks/Clinicians respond to Military Operational Tempo: Understand and respond to military/DOD and VA objectives; be ready to respond to the complex evolution of a military service member’s lifelong care requirements; continuously assess current military conflicts and their impact on service members, veterans and family members.</td>
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LVHN: Organizational Strategies and Success Factors

- Shared vision
- Leadership endorsement
- Engage champions
- Assess current state

- Patient screening
- Clinical education
- Sustainability
- Collaborative efforts
Engage “Veteran Champions”

• Employees who are veterans
• Supportive non-veteran employees ("patriots")
• Internal website with "biographies"
• Ad hoc support, linkage to local resources
• Veteran Service Corps
Have you served on active duty in the U.S. Armed Forces and/or were you activated, into active duty, as a member of the National Guard or as a Reservist?

—Yes, No, Declined/Refused, Unable to Answer

When examining our 2014 inpatient data, we found that approximately 1 in 10 of our unique patients were veterans
Warrior Care: Dynamics/Potential Impacts

Based on our veteran patient data, we now know that 1 in 10 of our patients might be experiencing:

**Post-Traumatic Stress Disorder (PTSD)**

New DSM 5 Revisions:
- Persistent and distorted blame of self or others; and, persistent negative emotional state
- Reckless or destructive behavior

**Psychiatric Illness after Traumatic Brain Injury (TBI)**

12 months after the event: 31%
- 22% suffered disorders they never had before

**Iraq and Afghanistan War Lung Injury (IAW-LI)**

**Dismounted Complex Blast Injuries (DCBI)**

**Post-Traumatic Osteoarthritis (PTOA)**

**Chronic Multi-symptom Illness (CMI)**

**Genitourinary Trauma**
Warrior Care: Dynamics/Potential Impacts

Moral Injury and Survivor Guilt

Moral Compass
Inner sense that distinguishes right from wrong (conscious, ethics, belief system)

Religiosity – refers to the numerous aspects of religious activity
Knowing (cognition in the mind)
Feeling (affect to the spirit)
Doing (behavior of the body)

Spirituality – process of transformation
Separate from religious institutions
Internal experience of the individual
Spiritual but not religious
Once we captured veteran status, and we knew who our veteran patients were, what did we do differently?
“I understand you are a veteran. Tell me what I need to know about your military experiences so that I can provide you with the best possible care.”
After Capturing Veteran Status, There Are “Six Critical Questions” Recommended

1. Have you or someone close to you served in the military?
2. When did you serve?
3. Where did you serve?
4. What did you do?
5. Do you believe your service has affected your health?
6. Have you received medical care for this condition from any other provider, including the military and/or VA?
Success Factors:
What this veteran patient data has leveraged...
Launching a Veteran-Centered Medical Home Through Improved Care-Coordination Protocols

SELECT Capstone Project

Keith A. Groshans
9 March 2016
Methodology

• Retrospective analysis of calendar year 2014 inpatient data

• Veteran versus non-veteran admission rates
  • Primary ICD-9 codes
  • Diagnosis-Related Group (DRG) codes

• Data further stratified by age and sex
  • Conflict-specific comorbidities
  • Potential skew of predominantly male veteran population
Methodology

• Top ten ICD-9 and DRG codes compared
• Categories: veteran and non-veteran
• Chi-square analysis with p<0.05 denoting significance
• Comparison of three conditions by age groups
  • Major joint replacement
  • Heart failure
  • Chronic obstructive pulmonary disease
Our Veterans: Admissions and Readmissions

• Veterans accounted for:
  • 9% of unique patient admissions
  • 10.4% of total admissions

• Total Readmissions:
  • 36% of veterans were readmitted
  • 25% of non-veterans were readmitted
Our Veterans: 
DRG Code Trends

• Significantly higher admission rates favoring veterans for most codes
  • Cardiovascular
  • Pulmonary
  • Renal
  • Musculoskeletal

• Majority of differences remained when only males included
The Business Case:
Our Veterans Are Not
A Significant Financial Writeoff
Veteran versus Non-veteran financial performance FY'15 June YTD

Unique Veteran Patients/MRNs
  Inpatient = 9.5% of all patients
  Outpatient = 5.8%

Veteran Net Revenue
  Inpatient = 11.9% of net revenue for all patients
  Outpatient = 10.2% of net revenue

Per capita, veterans represent greater source of revenue than their non-revenue counterparts. We should ensure we retain them—and maximize opportunities to draw more into our services.
## Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-12</td>
<td>• Project Conception&lt;br&gt;• Vet Champion Meeting&lt;br&gt;• 1&lt;sup&gt;st&lt;/sup&gt; Special Event</td>
</tr>
<tr>
<td>2013-14</td>
<td>• Internal Communication&lt;br&gt;• Patient Screening Launch&lt;br&gt;• Payer Contracts</td>
</tr>
<tr>
<td>2015-16</td>
<td>• Project Operationalization&lt;br&gt;• Collaborative Clinical Education&lt;br&gt;• Data Analysis</td>
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It’s a journey, not a destination…
The Warrior Centric Health Imperative....and Opportunity

Enhancing Veteran Healthcare in Civilian Systems
Warrior Centric Health = Veteran Population Health

• What are our key activities?
  – eLearning
    • Veteran-centric clinical and administrative training
  – Recognition Programs
    • Compliance Criteria, Baseline Scans, and Annual Audits
    • Decision Support Data
    • Marketing and Operations Action Plans and Assistance
    • Veteran Community Outreach Programs

• Whom do we serve?
  – The commercial healthcare community who implements diversity, community, and population care programs and are compelled to care for and serve Veterans in a healthcare environment

• Definition of Success
  – Warrior Centric Health is the national Standard of Care and Center of Veteran Population Health Excellence for professional medical practitioners and commercial medical facilities to serve veterans in a healthcare setting.
The Solution: Commercial Healthcare Systems that are

- **Aware** of the problem
- **Capable** of solving the problem
- **Visible** to the veteran population

Enabled by **Warrior Centric Health**

- Enterprise Population Health Program
- Scalable, culturally sensitive clinical and operational eLearning courses
- High need market solution: The *means* to care for a large under-served population – the Veterans
WCH Use Cases: 5 Motivations

**C-Suite Veteran Advocate** - Direct Military Affiliation and/or Citizen Patriot

**Population Health ROI** - Improved Quality Metrics and Clinical/Financial Outcomes

**Optics of Marketing, Strategic** - Market Positioning for Forecasted Business, Political, and/or Community Engagement Objectives

**Optics of Marketing, Tactical** - Market Positioning with an identified Patient Population vs. competitors

**Community Benefit** - Meet IRS Schedule H Requirements to Maintain Not-for-Profit Hospital Status
Relationship of WCH Data and Analytics to Population Health

**Surveillance and assessments** to determine Veteran population needs and patterns, and track Veteran population level health changes or trends resulting from WCH Programs

**Identification** of Veteran population sub-groups in need of particular WCH Programs (e.g. 9+1 Deadly Veteran Diseases)

**Monitoring** of WCH Program processes, procedures, and implementation

**Evaluation** on WCH Program effect on designated clinical, behavioral, community, health systems, and economic outcomes
Call To Action

• We must accept the challenges we face:
  – Veterans are our patients
  – We must know them to treat them

• Strategic actions:
  – Form a “veteran champion” network in your org
  – Begin screening for/capturing veteran status
  – Utilize the Warrior Centric Health® Program
  – Apply Triple Aim/7 Principles/1 2 3 Equity of Care Pledge
"In 2016, the policies, strategies and resources required to address and eliminate disparities in health and health care are at critical crossroads. A new way of thinking and acting will be required by the nation’s hospitals, health systems, and providers to address the disparities that exist within and among vulnerable populations.

While race, ethnicity, and language preferences have traditionally framed the approaches undertaken to address disparities in health care; the future of population health in a value based care model will dictate broader considerations of cultural backgrounds that have traditionally been a part of diversity and inclusion (D&I) work.

Specifically, there is a growing awareness that culturally diverse communities (i.e. Veterans, LGBTQI, and Persons with Disability/Differing Abilities) represent an expansion of the D&I universe and should be uniformly included in the health care disparities discussions, thinking, and policies going forward.

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For More Information

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