PRE DECISIONAL DRAFT

Decision Brief:
Eliminating Racial and Ethnic Health Disparities in the Military Health System

Michael-Anne Browne, MD
Chair, Health Systems Subcommittee
November 29, 2023

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Overview

- Membership
- Tasking
- Summary of Activities to Date
- Report Overview
- Findings and Recommendations

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Membership

**CHAIR
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David Classen, MD

Robert Kaplan, PhD, MS

Catherine McCann, PhD, MS

Rhonda Medows, MD*

Jayakanth Srinivasan, PhD, MS

*****Board Member**

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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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Tasking: Background

- 24% of Active Duty personnel self-identify as a racial minority

- 16% of Active Duty personnel self-identify with Hispanic ethnicity

- Physical and mental health inequities exist in the MHS despite its universal health care benefit

Tasking: 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 (1/4)

Meeting Date	Discussion Topics
Mar 30, 2022: DHB Meeting	Racial and Ethnic Health Disparities in the MHS
Jun 28, 2022: Subcommittee Kickoff Meeting	• 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	• MHS Data Systems and Race/Ethnicity Data • Addressing Racial and Ethnic Health Disparities in the U.S.
Aug 10, 2022: DHB Meeting	• Update of report to DHB members • Veterans Health Administration efforts to promote health equity
Aug 24, 2022: HS Meeting	• 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	• NPIC and NSQIP 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 (2/4)

Meeting Date	Discussion Topics
Nov 30, 2022: DHB Meeting	• Report update to DHB members: Emerging themes • Data collection and availability issues
Dec 5, 2022: HS Meeting	Mental Health Disparities Research: • 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	• Mayo Clinic Health Equity Initiatives • Potential Recommendations
Feb 16, 2023: HS Meeting	• Overview of informational teleconferences • Report Development: Outline and Recommendations
Mar 2, 2023: Visit to Naval Medical Center San Diego	NMCSD 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 (3/4)

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 Under Secretary of Defense (Health Affairs) to inform Leadership and Structure for Sustainability chapter
June 7, 2023: HS Meeting	Report Development: Recommendations & Leadership Chapter
June 28, 2023: DHB Meeting	Report update to DHB members: Emerging Findings and Recommendations
July 12, 2023: HS Meeting	DHA Medical Affairs briefing on efforts to integrate race and ethnicity data within MHS GENESIS and concerns related to accuracy of DEERS

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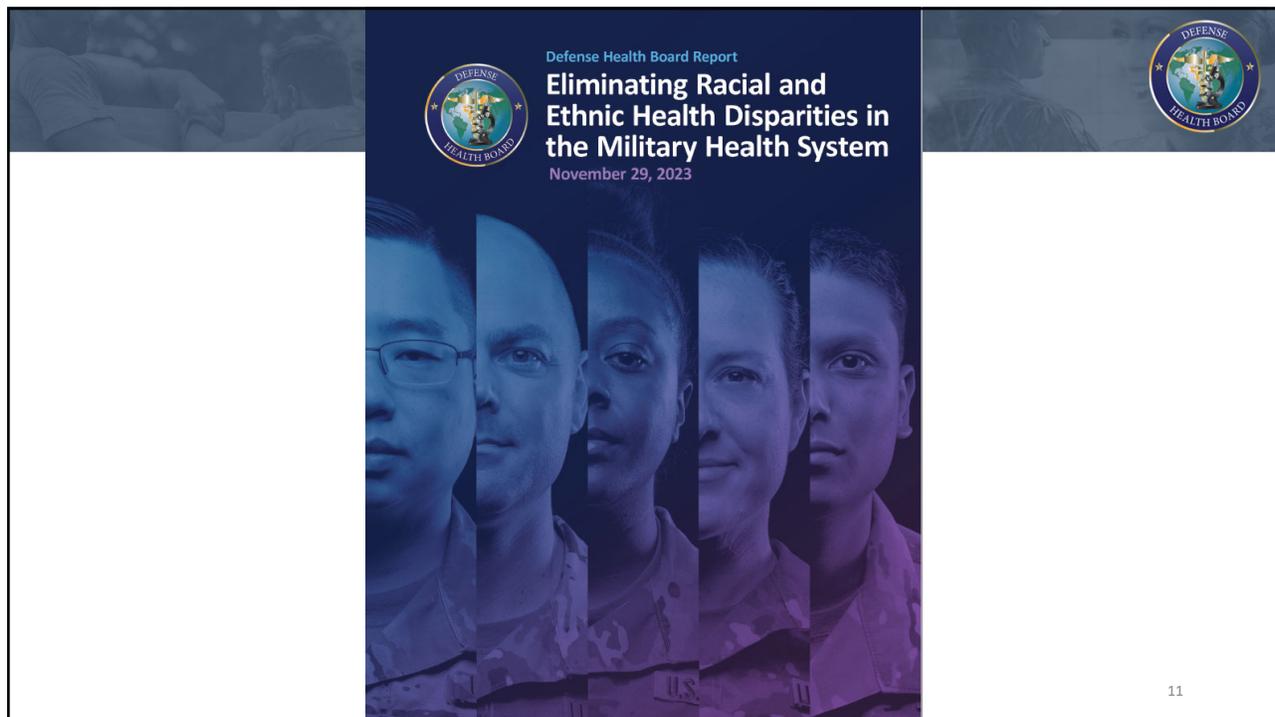# Summary of Activities to Date (4/4)

Meeting Date	Discussion Topics
July 26, 2023: HS Meeting	Report Development: Findings and Recommendations
August 9, 2023: HS Meeting	Full Report Discussion
August 23, 2023: HS Meeting	Findings and Recommendations & Executive Summary Discussion
September 11, 2023: DHB Meeting	Report Deliberation
October 2, 2023: HS Meeting	DHB Feedback Discussion
October 13, 2023: HS Meeting	Findings and Recommendations; Full Report Discussion
October 27, 2023: HS Meeting	Findings and Recommendations; Full Report Discussion
September – October 2023	Teleconferences with: • DHA Chief Information Officer/DHA Chief Health Informatics Officer • Defense Manpower Data Center • DHB members

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Defense Health Board Report
Eliminating Racial and Ethnic Health Disparities in the Military Health System
November 29, 2023

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Report Overview and Updated Sections

- Review of MHS health disparities literature
- **DoD and MHS race and ethnicity data***
- Prioritization of interventions to address inequities
- Data use and misuse, including Artificial Intelligence
- Social Determinants of Health **and Health-Related Social Needs***
- Training and workforce initiatives to reduce inequities
- Leadership accountability and proposal for sustainable progress

***New or updated content from September 11, 2023, deliberation**

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MHS Health Disparities Literature Review

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- Review included 60 published articles or DHA information briefs
- Literature suggests racial and ethnic health care disparities are more narrow or less apparent in the MHS compared to other U.S. health systems
- Statistically significant disparities in maternal health outcomes by race are evident – and warrant immediate attention and action
- Race and ethnicity data for beneficiaries are often missing or incorrect
- Many MHS disparities studies are one-time data pulls conducted by individuals with little institutional support
- Physical and mental health inequities exist in the MHS despite its universal health care benefit

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Race and Ethnicity Data in the DoD

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- DoD includes innumerable data systems and databases for managing demographic and health-related data
- 1997 Office of Management and Budget Statistical Policy Directive No. 15 (OMB SPD 15): Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity
- Currently some data sets used for disparities research contain categories that do not follow guidance set by OMB SPD 15
- Service members may self-report and correct their race and ethnicity through their Service personnel office, but not directly in DEERS
- Dependent beneficiaries may not self-report their race and ethnicity through either the Service personnel office or directly in DEERS. These dependents may be able to inquire and request corrections to their race and ethnicity in MHS GENESIS by working with Military Treatment Facility personnel, but they cannot self-view or self-correct
- This leads to large numbers of "unknown" entries for race among dependent beneficiaries

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Service Member, Dependent, and Retiree Race and Ethnicity Data

- Service members self-identify race and ethnicity upon accession into the Armed Forces
- The Military Services provide these data to Defense Manpower Data Center (DMDC)
- DMDC incorporates these data into the Defense Enrollment Eligibility Reporting System (DEERS) which transmits these data to other systems, including the Military Health System (MHS)
- DD Form 1966: Allows for more than one race to be selected

7. A. ETHNICITY (X one)	7. B. RACE (Check all that apply)	
☐ (1) HISPANIC OR LATINO	☐ (1) AMERICAN INDIAN/ ALASKA NATIVE	☐ (4) NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☐ (2) NOT HISPANIC OR LATINO	☐ (2) ASIAN	☐ (5) WHITE
	☐ (3) BLACK OR AFRICAN AMERICAN	

DD Form 1966
"Record of Military Processing – Armed Forces of the United States"

- DD Form 1172-2: Application for ID Card/DEERS Enrollment (for dependents) **does not** have fields for race or ethnicity

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DEERS Data Feeds to MHS

- DEERS is one source of race and ethnicity data for the MHS
- DEERS sends data to many sources through different streams
- Data sent from DEERS to MHS GENESIS is in standard OMB SPD 15 categories, e.g., "Asian" and "Native Hawaiian or Other Pacific Islander"
- DEERS data feed to MHS GENESIS also includes "Other" race category
- Defense Manpower Data Center plans to update non-MHS GENESIS data feeds to display OMB SPD 15 categories beginning December 2023
- No current funding to correct legacy data
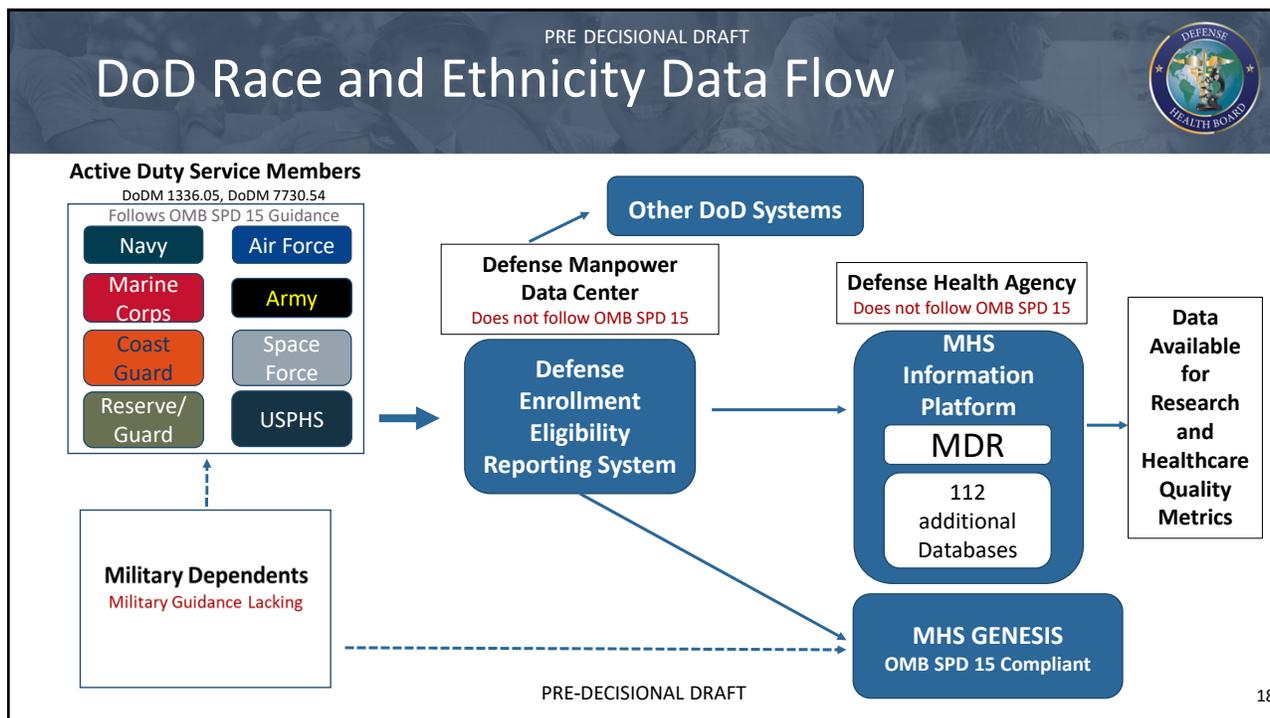
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Opportunities for Improving Race and Ethnicity Data

- Non-retired Service members can currently update race and ethnicity through their personnel office, including an online portal
  - DEERS records contain a variety of information for Service members and instructions to view data such as Social Security Number, date of birth, sex, marital status, Personnel, Service records, Benefits, and contact information
  - DEERS website currently does not provide information about updating race and ethnicity with Service personnel office, as they currently do for name, gender, Social Security Number, or date of birth corrections
- There is no race and ethnicity field on the DEERS dependent enrollment form
- There is no current mechanism for dependent beneficiaries to view or update race and ethnicity in DEERS
- TRICARE does not collect race and ethnicity at enrollment, leading to unknown data for patients who access the "purchased care" network

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DoD Race and Ethnicity Data Flow

Active Duty Service Members
DoDM 1336.05, DoDM 7730.54
Follows OMB SPD 15 Guidance

Navy · Air Force · Marine Corps · Army · Coast Guard · Space Force · Reserve/ Guard · USPHS

Other DoD Systems

Defense Manpower Data Center
Does not follow OMB SPD 15

Defense Enrollment Eligibility Reporting System

Defense Health Agency
Does not follow OMB SPD 15

MHS Information Platform

MDR

112 additional Databases

Data Available for Research and Healthcare Quality Metrics

Military Dependents
Military Guidance Lacking

MHS GENESIS
OMB SPD 15 Compliant

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Race and Ethnicity Data Use and Misuse

- Studies show the inappropriate use of race in clinical decision algorithms and medical equipment design can lead to significant errors that contribute to disparate health outcomes
- Assumptions built into Artificial Intelligence (AI) can magnify health disparities
- Race and ethnicity data can be used appropriately to inform clinical decision-making for individuals, but must be placed in context
- The federal government and DoD have issued guidance for appropriate development and use of AI

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Social Determinants of Health and Health-Related Social Needs

- MHS beneficiaries' life experiences affect their current health status
- Social Determinants of Health (SDOH) explain much of the variation, including by race and ethnicity
- SDOH data is essential to addressing beneficiary health
- Even with MHS universal health benefits, SDOH impact health across all domains among current Service members and beneficiaries
- Health-Related Social Needs (HRSN) are related to, but distinct from SDOH and are "…specific adverse social conditions that are associated with poor health," such as housing instability, housing quality, food insecurity, employment, personal safety, and lack of transportation

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Social Determinants of Health and Health-Related Social Needs (cont.)

- Addressing HRSNs often falls outside areas of medical care
- Health systems can address HRSNs through:
  - Understanding which ones their patients face
  - Connecting patients to local community services
  - Partnering with community-based organizations
  - Developing their own interventions that would most benefit their unique patient populations
- Unlike disease screening tools, HRSN screening does not lead to an objective conclusion about a patient's social risks – "health care professionals must respect each patient's decision to seek, or not seek, assistance for social needs." (Garg, 2023)

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Training and Workforce

- Increased patient-provider racial and ethnic concordance according to patient preference enables a better patient care experience through improved communication, greater cultural competency or humility, and reduced implicit bias
- Health care patient-provider racial and ethnic concordance is not a panacea, and many factors impact outcomes
- It is important to expand the recruiting pathways for pre-health careers and STEM among institutions whose students represent the ethnic, racial, and geographic diversity of the nation

References: (Shen, 2018; Takeshita, 2020; Saha, 2020)

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Slide 23

# Leadership, Accountability, and Structure for Sustainable Progress

- Lack of a central authority and governance specific to racial and ethnic health disparities within DHA has led to uneven efforts to measure and reduce these disparities
- Best Practices suggest institutions should:
  - Designate accountable leaders and establish a reporting structure
  - Implement a framework for analysis of health equity within the organization
  - Proactively look for disparities through primary research and revisiting conclusions derived from standard statistical analyses
  - Engage with institution leadership, health care providers, patients, and community leaders to identify community needs and institutional capabilities
  - Establish goals at the organizational level to reduce disparities and measure progress in eliminating any disparities
  - Devote resources necessary to accomplish the goals

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Slide 24

Under Secretary of Defense for Personnel & Readiness
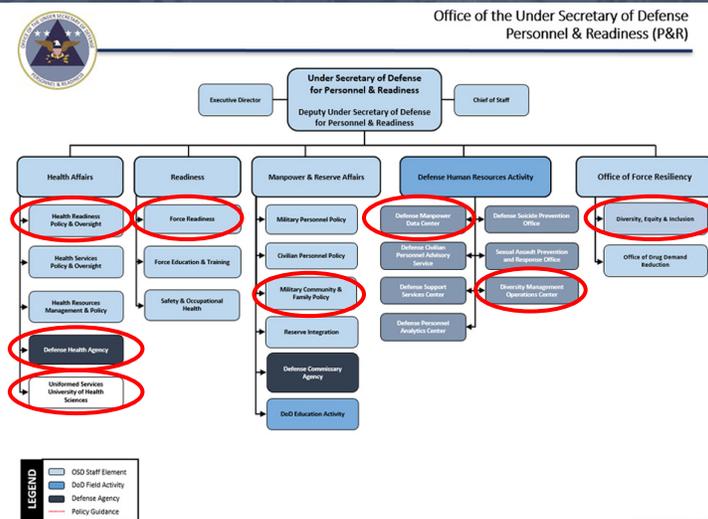
As of: March 1, 2023

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Findings and Recommendations

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Finding 1

Military Health System (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. Others have their race and ethnicity inferred from their active duty sponsor in the Defense Enrollment Eligibility Reporting System (DEERS), which serves as DoD's personnel, enrollment, and eligibility system. DEERS data feeds into MHS GENESIS. Although active duty Service members may be able to correct their race and ethnicity through their Service personnel office, they and their civilian dependents are currently unable to view or edit race and ethnicity in their DEERS or MHS records. DoD does not transmit race and ethnicity data to TRICARE Purchased Care contractors, and TRICARE does not require its Purchased Care contractors to collect race and ethnicity from beneficiaries. Studies using current MHS data, therefore, are often unable to determine whether disparities exist or do not exist due to lack of self-reported data and lack of harmonization across information systems.

As of January 1, 2023, the Joint Commission (JC) requires hospitals and other health care programs to collect race and ethnicity for all patients. The Office of Management and Budget (OMB) Statistical Policy Directive 15 (SPD 15) states that self-reported race and ethnicity data is the preferred method for collecting these data. The JC encourages organizations to use the five race and two ethnicity categories from OMB SPD 15, at a minimum. DEERS does not comply with the OMB reporting requirement because: (1) it combines the "Asian" and "Native Hawaiian or Pacific Islander" into a combined "Asian or Pacific Islander" category; (2) it includes a race category of "Other."

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Recommendations 1A – 1B

1.A. The DoD, through DEERS and MHS GENESIS, should comply with the OMB SPD 15 Standards for the Classification of Federal Data on Race and Ethnicity, and that best practice includes collecting self-reported race and ethnicity, for all beneficiaries. DEERS and MHS GENESIS should contain self-reported race and ethnicity for dependent civilians, not only active duty Service members. Establish mechanisms for non-Service member beneficiaries, such as civilian dependents and retirees, to conveniently view and correct their race and ethnicity as reported in DEERS. Establish mechanisms for all beneficiaries to conveniently view and correct their race and ethnicity in MHS GENESIS. Develop communication, training, and awareness of these mechanisms to view and self-correct race and ethnicity.

1.B. Comply with the OMB SPD 15 Standards for the Classification of Federal Data on Race and Ethnicity by separating the "Asian or Pacific Islander" category into the two categories "Asian" and "Native Hawaiian or other Pacific Islander."

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Recommendations 1C – 1F

1.C. Replace the "Other" category with "Multiracial" when reporting a record that contains more than a single race.

1.D. Allow civilian dependent beneficiaries to "Decline to State" their race or ethnicity by creating a category for this variable in DEERS and MHS GENESIS.

1.E. Include race and ethnicity on TRICARE enrollment forms.

1.F. Ensure MTF patient check-in workflow requires confirmation of patients' current race and ethnicity categorization in MHS GENESIS and includes a mechanism for helping patients update their data when needed.

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Recommendation 1G

1.G. Formally evaluate DEERS, DMDC data systems, and MHS GENESIS to:
- Harmonize the communication of all identity and demographic data throughout the DoD
- Communicate identity and demographic data throughout the DoD using current national standardized nomenclature wherever possible
- Create a means of convenient beneficiary (including civilian dependent) self-service updating of demographic data

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Finding 2

Most of the literature on MHS health equity/disparities has been created by ad hoc, individual-initiated, one-time data analyses, or local Quality Improvement projects. These are neither cumulative nor systematic efforts. The MHS' and DHA's centralized outcomes tracking – internally and through external reporting in national registries – does not consistently include racial and ethnic stratification or make such analyses easy to access.

The subcommittee observed high variation in outcomes across MHS sites including mental health, maternal health, and surgical outcomes. Such high variation may have a disproportionate impact on racial and ethnic minority groups, particularly those also experiencing adverse Social Determinants of Health. Without racial and ethnic stratification of patient outcomes, the subcommittee could not identify sites whose disparities were attributable to race and ethnicity. These data limitations prevented the subcommittee from making more targeted recommendations.

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Recommendations 2A – 2C

2.A. DHA should include racial and ethnic stratification of results in all internal and applicable external patient care reporting (e.g., Joint Commission metrics, National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS®), registry reports, Patient-Reported Outcome Measures) as well as analysis of progress in reducing identified disparities and comparisons of the MHS health disparity data with national benchmarks.

2.B. DHA should identify and designate a centralized group of epidemiologists, statisticians, and analysts (such as personnel in the Armed Forces Health Surveillance Division) to investigate potential racial and ethnic health disparities. This group should stay abreast of findings in the civilian sector and be a resource for other analysts and clinicians in the MHS. These investigations should be prioritized according to areas of greatest impact for the DoD and in areas of known disparities.

2.C. Design initiatives and countermeasures to improve overall health outcomes by incorporating specific interventions (by race, ethnicity, region, Sponsor rank, or other factors) to reduce and eliminate known disparities and prevent future disparities when new treatments are introduced.

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Recommendations 2D – 2E

2.D. Work with all national registries that the MHS participates in, such as the National Perinatal Information Center, National Surgical Quality Improvement Program, and the American College of Surgeons National Cancer Database to allow MHS systemwide race and ethnicity reporting and analysis. This will help to inform actions to decrease the avoidable variation in outcomes between facilities throughout as well as overall disparities.

2.E. Standardize to best practice throughout the MHS to reduce variation and improve outcomes across the MHS.

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Finding 3

The DHB could find little evidence of systematic and sustained efforts to reduce racial and ethnic health disparities across the MHS.

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Recommendations 3A-3B

3. A. While waiting for DHA disparities data to improve, the DHB recommends that DHA start now to address the documented disparities in maternal and infant health by adopting known best practices in the MHS systemwide to reduce the demonstrated racial disparities in these outcomes.

3. B. Prioritize additional clinical areas for improvement in disparities by those which have the greatest likely impact:
- 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 and ethnicity in these areas among others:
  - 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, asthma)
  - iv. Oncology (e.g., screening and outcomes)
  - v. Mental Health (e.g., access and outcomes)

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Finding 4

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 clinical treatments and health outcomes. However, biases in the underlying data stemming from poor study design, data collection and entry, algorithm choice, and dissemination of results can contribute to health disparities. This is also true for tools used in the calculation of health care costs. For example, one algorithm to predict a patient's medical needs used health care costs as a surrogate for degree of illness. But Black patients, having lower access to care, incurred lower health care costs than non-Black patients. The algorithm's use of health care costs as a surrogate for degree of illness disadvantaged Black patients as candidates for care intervention and, therefore, lowered their access to it (Obermeyer, 2019).

Some medical risk calculators, decision-making tools, and equipment in use by MHS health care personnel introduce inappropriate or unjustified racial and ethnic bias. The U.S. Government has outlined standards for the appropriate development and use of AI, including for health (Executive Order - October 30, 2023; Blueprint for an AI Bill of Rights, 2023).

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Recommendations 4A – 4C

4.A. Create a centralized mechanism within the MHS to review data use, new protocols, and equipment to prevent inappropriate incorporation of race-biased algorithms in MHS clinical practice. At a minimum, AI algorithms and CDS tools should include individual patient symptoms, family history, and genetic screening results. Follow guidance from the federal government on appropriate development and use of AI. The DHB recommends that DHA participate in groups such as the Coalition for Health AI (CHAI™), which is developing guidelines and principles for the transparent, appropriate, and equitable use of AI in health care.

4.B. Use this centralized mechanism to review, replace, or eliminate existing race-biased tools, protocols, AI, Machine Learning algorithms, and equipment with the best-performing race-agnostic alternatives.

4.C. Develop, implement, and monitor clinical guidelines that include the outcome of AI and CDS tools, to be applied in the context of individual patients' symptoms, family history, and genetic screening results.

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Finding 5 & Recommendation 5

Finding 5: Clinical trials are often conducted with homogeneous patient populations, leading to insufficient understanding of potential impacts of treatments on diverse populations. The DoD is a significant source of national funding for clinical trials and health research.

Recommendation 5: DoD should ensure that investigators include patients and participants from diverse and minority racial and ethnic populations in DoD-supported clinical trials and health research as appropriate to the scientific study under question.

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Finding 6

Evidence shows that up to 50% of variation in health outcomes is attributable to Social Determinants of Health (SDOH) factors. The MHS, like civilian systems, is at risk of disparate outcomes due to SDOH. SDOH screenings are necessary and must be supported by other data to truly capture the lived experience of MHS beneficiaries who attempt to access and receive care and manage their health. Addressing Health-Related Social Needs (HRSN) allows health systems to proactively reduce disparities due to SDOH. Most studies of MHS racial and ethnic health disparities omit other potential explanatory variables - such as socioeconomic status (approximated as rank in the MHS), geographic location (e.g., urban/rural), or primary language. Such variables may correlate with race and ethnicity and their omission limits the interpretation and response to research findings. The DoD has implemented Service-specific community and family support programs that address SDOH and HRSN.

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Recommendations 6A – 6C

6.A. Institute SDOH screenings and documentation of SDOH indicators of MHS beneficiaries by integrating annual standardized SDOH screening tools and workflows in MHS GENESIS, particularly in adult primary care, pediatrics, and obstetrics. The MHS should use best practice standardized SDOH measurement tools that apply to the military population and ensure that the collected SDOH data are embedded within MHS GENESIS. These tools and emerging best practices should be kept current through regular updates on a 3-5 year cycle. Recorded data must be accessible and reportable.

6.B. Use Patient-reported Outcome Metrics and Patient-reported Experience Metrics, in addition to SDOH screenings, to better understand the experience of MHS beneficiaries as they navigate the MHS and access community resources.

6.C. Offer trainings to clinicians on SDOH and appropriate documentation in the medical record. Incorporate this into MHS health professional education.

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Recommendations 6D – 6E

6.D. Proactively analyze results of SDOH screenings MHS-wide, to assess needs and trends, by Military Treatment Facility (MTF) and by TRICARE region, and then connect patients to resources and interventions to address the specific needs of MHS beneficiaries.

6.E. Include socioeconomic status (or surrogates thereof), a measure of regional health services availability, and beneficiary's primary language when analyzing health outcomes.

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Recommendations 6F – 6G

6.F. Evaluate HRSN factors to identify and prioritize the most pressing needs of the beneficiary population and provide priority areas to address the factors that are contributing to racial and ethnic health disparities. Examine military-wide programs, such as Total Force Fitness, Service-specific programs (such as Army Community Services, Marine Corps Community Services, Navy Fleet and Family Support, Airman and Family Readiness, and Coast Guard Work-Life Program), and community-based partnerships to select those that best assist in addressing these needs.

6.G. 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.

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Finding 7 & Recommendation 7

Finding 7: All virtual visits in the MHS revenue, registration, and scheduling system 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 can contribute to adverse patient experience, a driver of variation in health outcomes.

Recommendation 7: Request and enter the patient's preferred language as a required field when making in-person appointments. Ensure appropriate interpretation services are available for all visits.

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Finding 8 & Recommendation 8

Finding 8: While data are limited on the direct impact of health equity training initiatives on health outcomes, some training methods appear to promote empathy and reduce bias which can improve health outcomes.

Recommendation 8: Carefully consider the qualities of any health equity training before implementing it and leverage trainings that have demonstrated positive results in practice. Effectiveness should ultimately be measured by the training's impact on reducing racial and ethnic disparities in patient experiences and outcomes.

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Finding 9

Increased clinician-patient racial and ethnic 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 Reserve Officers' Training Corps (ROTC) programs to more minority-serving institutions (MSI) with Science, Technology, Engineering, and Mathematics (STEM) programs as a pathway for careers in the Military Services for more underrepresented racial and ethnic minority groups.

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Recommendations 9A – 9C

9.A. The Services should expand the pathway for military careers as clinicians and allied health professionals for underrepresented in health and medicine racial and ethnic groups through ROTC and other recruitment activities at MSIs such as Historically Black Colleges and Universities, Hispanic-serving institutions, and Tribal Colleges and Universities, particularly those that have nursing, pre-medical, and other pre-health career curricula. Consider ways to expand these recruitment pathways to the community college, vocational, and high school levels.

9.B. Promote workforce diversity through recruitment activities with academic organizations focused on racial and ethnic groups underrepresented in health and medicine.

9.C. Collaborate with existing groups that are already promoting workforce racial and ethnic diversity in healthcare.

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Recommendations 9D – 9F

9.D. Assess the effectiveness of these efforts by documenting changes in the supply of underrepresented clinicians and allied health professionals.

9.E. Measure the impact of interventions to increase the health care workforce and patient race and ethnicity concordance by a range of stratifications including location and clinical service type.

9.F. Leverage Virtual Health to broaden the geographic range of options for patients to select health care providers of their racial and ethnic preference.

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Finding 10

The Joint Commission (JC) requires the following actions to reduce health care disparities:

- Designate an individual to lead activities to reduce disparities for the organization's patients
- Assess patients' health-related social needs
- Stratify quality and safety data by sociodemographic characteristics
- Develop a written action plan to address disparities
- Inform leaders and staff about progress to reduce disparities at least annually

The DHB's review of best practices and the recommendation of the U.S. Centers for Medicare & Medicaid Services (CMS) to reduce health care disparities also stress leadership, and sustained commitment effort at all organizational levels.

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Recommendations 10A – 10C

10.A. Commit to achieving the goal of eliminating any racial and ethnic health disparities among all MHS beneficiaries. The DHA should:
- Measure disparities
- Set goals to reduce disparities by specific dates
- Allocate sufficient dedicated staff at both centralized and local levels to eliminate disparities
- Assess progress regularly

10.B. Ensure racial and ethnic stratification is included in all health care quality reporting, e.g., Joint Commission metrics, NCQA, HEDIS, registry reports, Patient-Reported Outcome Measures, and Patient-Reported Experience Measures.

10.C. Add a racial and ethnic stratification to medical and dental readiness reports to monitor disparities in readiness. If disparities are found, DoD should provide support to command teams to address and eliminate persistent racial and ethnic disparities in medical and dental readiness.

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Recommendation 10D

10.D. Given the breadth of activities and areas of responsibility that impact health and wellbeing, which include not only medical care but also SDOH and HRSNs, the DHB recommends that the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) be the accountable leader for eliminating health disparities. Establish a chartered Health Equity Committee by the end of Fiscal Year 2024 to support the USD(P&R), and to monitor and guide the implementation of the recommendations in this report by a targeted date. The Committee will:
- Report progress toward eliminating health disparities
- Include representative groups
- Report back to the Defense Health Board in three years

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Recommendations 10E-10F

10.E. Assign the Assistant Secretary of Defense for Health Affairs (ASD(HA)) to report health outcomes, stratified by race and ethnicity, and report on ongoing initiatives to eliminate disparities, to the USD(P&R) no less than annually. The ASD(HA) should do this by submitting an annual health disparities report card to the 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).

10.F. 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.

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