

Veteran's Health Equity Podcast Transcript

Identifying Differences in COVID-19 Infection, Mortality, and Vaccine Receipt in Veterans

>> I want to welcome everyone and thank you all for joining. My name is Lauren Korshak and I lead Awareness and Translation Activities for V.A.'s Office of Health Equity. The Office of Health Equity champions the advancement of health equity and the reduction of health disparities in veterans. My job means that I get to tell stories about the data we have about veterans and their health.

The V.A. is vaccinating minorities against COVID-19 at higher rates than non-minorities. A lot of research has found that people of color are more affected by COVID-19, and that there are COVID related disparities. Today we'll be digging into these disparities and vaccine disparity research that is currently going on at V.A. This research digs further, how these disparities change over time and space, and vaccine rollout, not just the effects of COVID-19, but how V.A. is trying to fix and address ongoing disparities.

Before we begin, I want to introduce our speakers. Dr. Taona Haderlein is an Investigator at the V.A. HSR&D Center for the Study of Health Care Innovation, Implementation and Policy. Dr. Michelle Wong is an Investigator at the V.A. HSR&D Center for the Study of Health Care Innovation, Implementation, and Policy as well. And Dr. Jacqueline Ferguson is an Investigator at the V.A. HSR&D Center for Innovation to Implementation.

COVID-19 continues to move rapidly through different communities based on region and time, and this is why it's so important to vaccinate. Dr. Haderlein, you've done some work to evaluate V.A.'s, vaccine rollout efforts. Can you share more about your work?

>> Sure, Lauren. So, equitable vaccine access has been a key concern for the U.S. COVID vaccine rollout, which started back in December of 2020. Shortly after the rollout started it became clear, that COVID-19 vaccination rates were lower for Blacks and Hispanics than for Whites. The V.A. began administering COVID-19 vaccines shortly after the U.S. rollout began, which allows us to examine racial ethnic variation and COVID-19 vaccine rates, among racial ethnic minorities, in a managed care system that has few access barriers. And so, our study aimed to examine the association between racial ethnic minority status and V.A. COVID-19 vaccine uptake early in the V.A. vaccine rollout.

Ultimately, we found that Black, Hispanic, and Asian V.A. Veteran users were more likely than White veterans to receive a V.A. COVID-19 vaccination. So, there's a couple potential reasons for this. First, the V.A. is geographically distributed and it's a managed health care system that offers low cost care to qualifying patients. And so, our findings might reflect reduced logistical barriers for V.A. patients compared to private health care.

And also to maximize COVID-19 vaccine access, the V.A. engaged in deliberate outreach activities such as, listening sessions with diverse veterans and staff. They sent targeted electronic communications, and they also engaged in activities like vaccine drives on campuses. V.A. offered technology based and non-technology based appointment scheduling options, walk-in vaccine appointments, and they also called eligible veterans directly to schedule vaccinations.

And so, it's possible that these measures kind of mitigated, common structural barriers, to getting a vaccine like cost, convenience, and supply chain disruptions. It could also reflect greater use of non-V.A.

community care amongst Whites. Also, it's possible that V.A. racial ethnic minorities are more likely to get vaccinated because, higher perceived than actual risk for COVID-19 infection and death.

And, I find that the V.A. makes for an interesting experiment compared to the general U.S. Health Care System. It's a chance to see what happens when health care is more accessible to people from underserved populations.

>> Thank you. V.A.'s efforts to ensure an equitable vaccination effort grew out of COVID-19 infection and treatment disparities that were identified, earlier in the pandemic before vaccines were available. So, why is it still important to study these, disparities?

Dr. Wong, do you have some insight?

>> Well, I'm sure that we're all very aware that we're entering into the third year of the pandemic, and over these three years the pandemic, and our responses to the pandemic has changed so much. It's important to consider whether these changes might reduce or widen disparities.

Just to give you an example of potential changes, that may have affected disparities. You know, we have more treatments for COVID-19, but they're not readily available to everyone who needs them. Additionally, one of the most common risk mitigations is working policies is working from home, but this is not possible for Essential Workers such as those working in health care or the service industry. And we know that many racial ethnic minoritized individuals work in Essential jobs.

So, to address this, question, we conducted a study where we examined how patterns in racial ethnic variation in COVID-19 infection and mortality change over time. In our study, we examined these patterns way back in 2020, from approximately March 2020 to November 2020, and we divided these nine months into three time periods. And I know that it's been a while since 2020, so let me refresh your memory of what happened during these three time periods.

The first time period is what we'll call The Early Pandemic, this is from approximately from March to May 2020, when we didn't know much about the pandemic, there was a lot of uncertainty, and most of the country was under shelter-in-place orders. The next time period is Summer of 2020, this is from approximately June to August, when many states started to relax these shelter-in-place orders. There was more summer travel, and many of us thought that we had done enough to contain the pandemic. The third time period, if fall of 2020 from September to November. During this time we realized that COVID was still around. There was a mix of reimplementing or ending restrictions. This was also the beginning of the holiday travel spike, actually this was the first holiday travel spike.

So, what did we find?

Indeed, disparities did change over time. Early in the pandemic we found that there were disparities in infection and mortality among non-Hispanic Black veterans. Then in the summer, we found that more racial, ethnic minoritized groups experienced disparities in both infection and mortality compared to non-Hispanic Whites. And then, in the fall mortality decreased significantly for all groups, and infections were generally similar for most groups. It seemed like over time infection rates equalized.

So, the implications of this study are that with COVID, as well as other emergent and rapidly changing crises, we need to consider how disparities change over time. In addition to the study, my coauthors and I also wrote a companion perspective piece, where we highlight this need to consider the dynamic

nature of disparities. In the perspectives piece, we discussed, that there's also an important geographical component to the pandemic. That means that the pandemic and responses to the pandemic changed both over time and space.

While we did not consider geographic variation in our study, I will hand it over to my colleague, Dr. Jacqueline Ferguson to tell you more about her research that did just that.

>> Thanks, Dr. Wong. As she mentioned, there was an important geographic and temporal component to the pandemic. Essentially where the virus was circulating at a particular time and place, influenced who was most impacted.

In the early phase of the pandemic, when the stronger shelter-in-place orders were implemented, COVID was found in these really large metropolitan areas. This brings to mind the larger outbreak in New York City in April through June of 2020. But by the fall of 2020, the virus had spread into more rural areas, and we see higher rates of COVID-19 in smaller metropolitan areas, semi-urban areas and rural areas. And this time we are seeing outbreaks of COVID-19 among meat processing plants and a lot of community spread.

So, because the populations that live in urban versus rural areas can be quite different, for example, urban areas tend to be younger, more racially diverse than rural areas, we did a study to examine which racial groups were at highest risk for COVID-19 infection, during different surges or waves of the pandemic. And then we looked at these trends in each region separately. And we found a lot of really interesting results in this work, but I'm only going to highlight a few of our most critical findings.

First, we found that Hispanic veterans were more likely to test positive for COVID-19 than White veterans in every region in the U.S., whether that was North, South, Midwest or Northeast, for every time period between February 2020 and August 2021. And here's the really interesting thing, when we saw disparities for other racial minority groups, such as Black veterans decrease over time across all regions. Unfortunately, we're still seeing a higher burden of COVID-19 infection among Hispanic veterans, especially in the Western U.S. as of August 2020, which was last fall.

And why did this occur?

We're still learning and researching this. Higher rates of COVID-19 among Hispanic veterans could be due possibly to overrepresentation in the essential and frontline jobs, that tend to have a higher exposure and precarious employment, so less opportunity to take sick leave.

The second thing that we found in our research was that Asian veterans were less likely to test positive for COVID than White veterans between March and August 2021, especially in the Western U.S. Now this might correlate with higher rates of vaccination among Asian veterans in the V.A. than White veterans. And also could indicate that here might be some differential barriers to care, or lower likelihood of Asian veterans using V.A. services, including getting tested.

One last note, because of the way we've done our research, where we have inherently compared risks of COVID, among one group to another, when we say that disparities are decreasing, it means that both groups are having similar rates and risks of infection, it does not mean that COVID is going away. It's still, critical to get vaccinated, to get boosted, and do everything you can to help prevent the spread of COVID-19.

>> Well, I want to thank you all for sharing all of this really important work that you're doing, to help identify disparities in veterans receiving care through the V.A., and COVID-19.

I want to thank all of our listeners for joining, and I want to remind everyone that if you want to get more information about how to access COVID-19 testing and vaccination, please be sure to speak with your primary care provider.

Thank you.