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National Veteran Health Equity Report – American Indian or Alaska Native Veteran Chartbook

Focus on Veterans Health Administration
Patient Experience and Health Care Quality

US Department of Veterans Affairs
Veterans Health Administration
Health Equity-Quality Enhancement Research Initiative
National Partnered Evaluation Center
VA Greater Los Angeles Healthcare System, Los Angeles, CA

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National Veteran Health Equity Report – American Indian or Alaska Native Veteran Chartbook

Focus on Veterans Health Administration Patient Experience and Health Care Quality

Prepared for:

Office of Health Equity
Veterans Health Administration
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Section I: Background

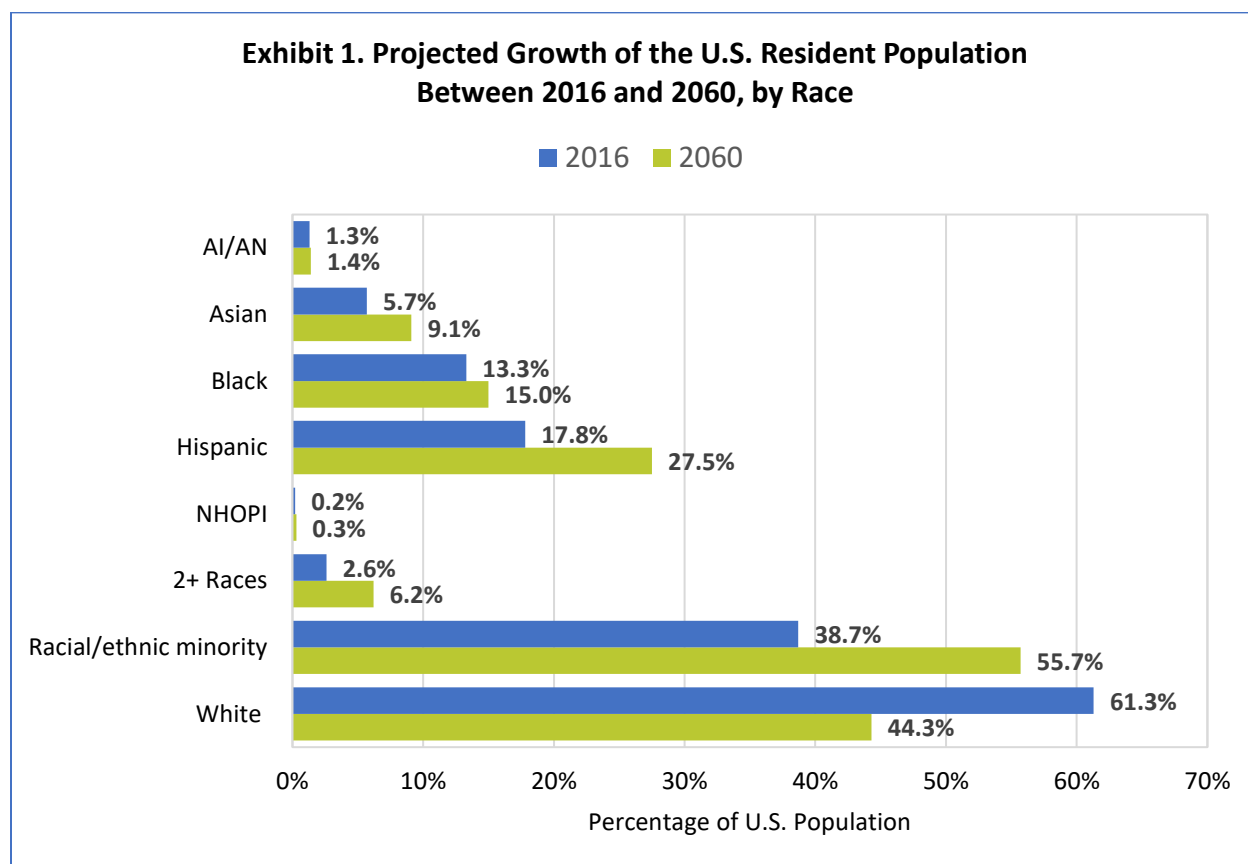
The National Veteran Health Equity Report 2021 provides information regarding disparities in patient experiences and health care quality for Veterans who obtain health care services through the Veterans Health Administration (VHA).¹ Data on disparities are presented by the sociodemographic characteristics of race/ethnicity, gender, age group, rurality of residence, socio-economic status, and service-connected disability rating, and by cardiovascular risk factors of hypertension, hyperlipidemia, and diabetes.

This chartbook focuses on experiences of care and health care quality of single race American Indian and Alaska Native Veterans receiving care in VHA. Data in this report are from the fiscal year 2016 to fiscal year 2019 Department of Veteran Affairs (VA) Survey of Healthcare Experiences of Patients (SHEP)-Patient Centered Medical Home survey instrument, and the fiscal year 2016 to fiscal year 2019 VA External Peer Review Program quality monitoring program. Data focus on single race American Indian and Alaska Native Veterans because data on multiple race Veterans are incomplete.

As of 2016, single race American Indian and Alaska Native people make up about 1.3% of the total U.S. population.² Between 2010 and 2020, this group increased by 27% from 2.9 to 3.7 million Americans.³

People who identify as American Indian and Alaska Native and another race exceed the number of people who identify as single race American Indian and Alaska Native. Together, the American Indian and Alaska Native alone or in combination population grew from 5.2 to 9.7 million Americans between 2010 and 2020.³

Exhibit 1. Projected Growth of the U.S. Resident Population Between 2016 and 2060, by Race



U.S. Population Group	2016 Percentage	2060 Percentage
AI/AN	1.3%	1.4%
Asian	5.7%	9.1%
Black	13.3%	15.0%
Hispanic	17.8%	27.5%
NHOPI	0.2%	0.3%
2+ Races	2.6%	6.2%
Racial/ethnic minority	38.7%	55.7%
White	61.3%	44.3%

Note: AI/AN denotes American Indian or Alaska Native; NHOPI denotes Native Hawaiian or Other Pacific Islander

Categories are not mutually exclusive; therefore, percentages may add to more than 100 percent. Racial categories other than 2+ Races exclude people reporting two or more races. Whites are non-Hispanic only; all other categories may include Hispanics. Racial/ethnic minority includes all groups other than the non-Hispanic White population.

Source: U.S. Census Bureau., Population Division. Projected Race and Hispanic Origin: Main Projections Series for the United States, 2017 to 2060.

<https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html>.

Section II: Patient Demographics

American Indian or Alaska Native Veteran VHA Users

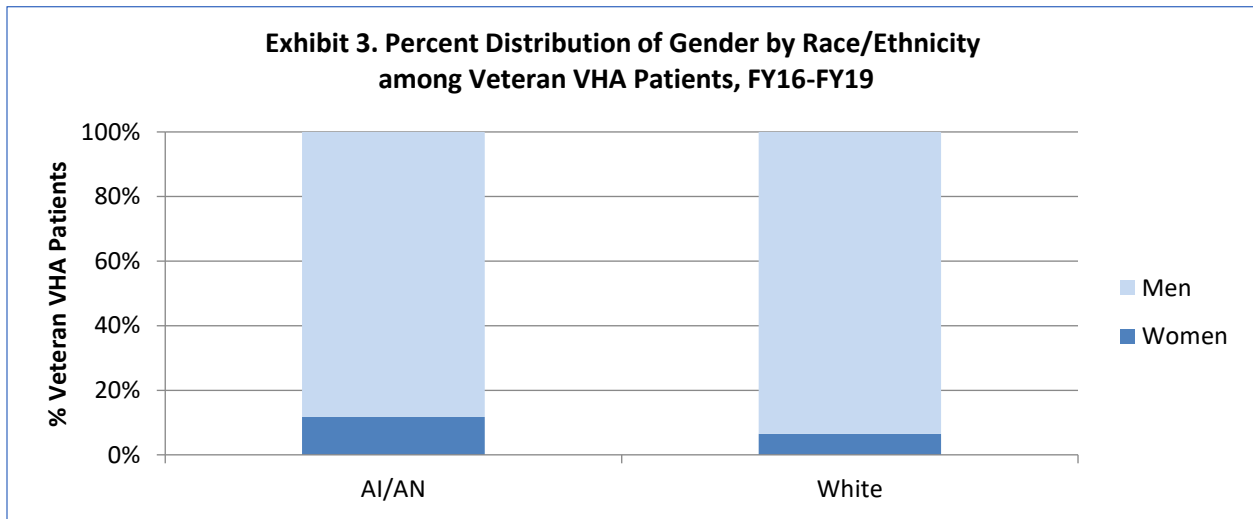
Exhibit 2. Distribution of American Indian or Alaska Native Veteran VHA Patients, FY16-FY19.

Race/Ethnicity	Percentage
American Indian or Alaska Native	0.7%

Findings:

- American Indian or Alaska Native Veteran comprise 0.7% of all Veterans using VHA care in FY16-FY19.

Gender by Race/Ethnicity



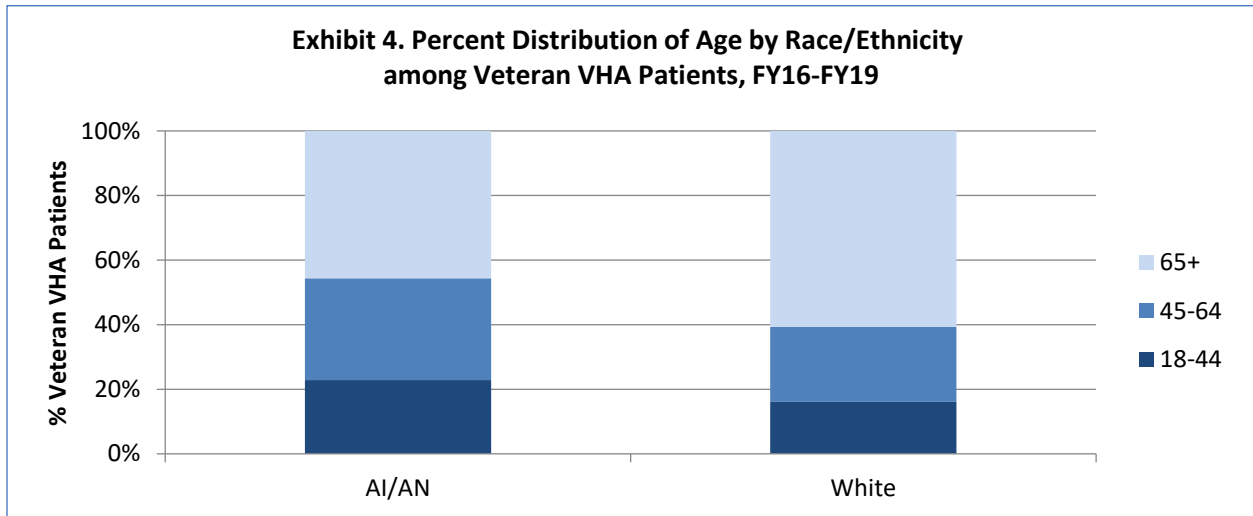
Gender	AI/AN	White
Men	88.3%	93.5%
Women	11.7%	6.5%

Note: AI/AN denotes American Indian or Alaska Native

Findings:

- Most Veterans are men with a slightly higher proportion of non-Hispanic White Veterans being men compared with American Indian or Alaska Native Veterans. There was a higher proportion of American Indian or Alaska Native women Veterans compared to non-Hispanic White women Veterans.

Age Group by Race/Ethnicity



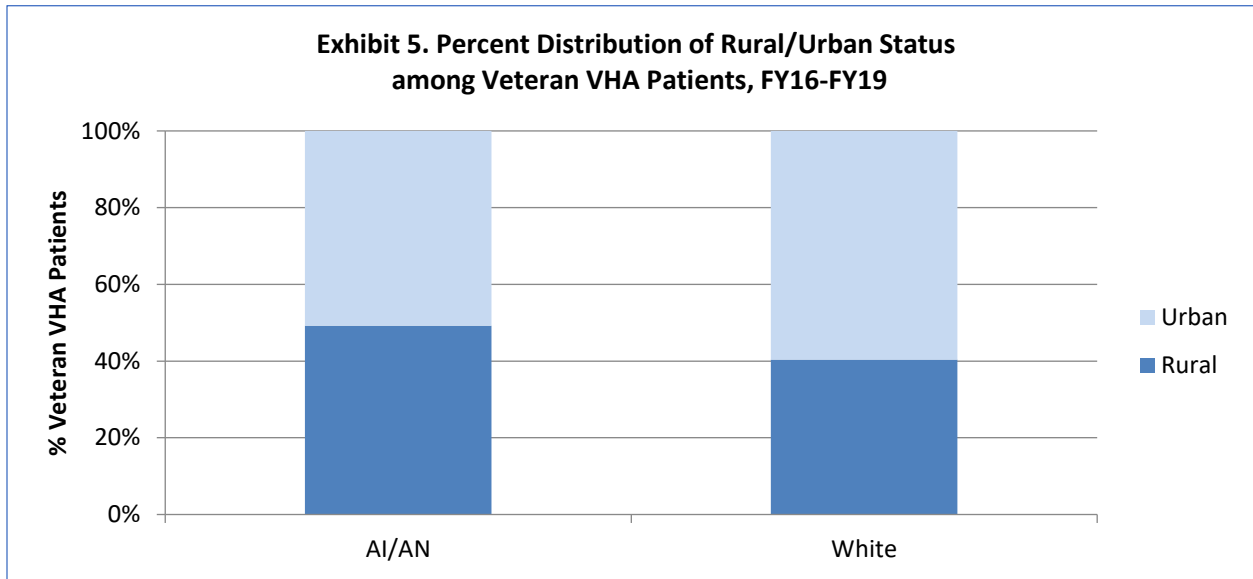
Age	AI/AN	White
65+ years	45.6%	60.7%
45-64 years	31.6%	23.2%
18-44 years	22.8%	16.1%

Note: AI/AN denotes American Indian or Alaska Native

Findings:

- American Indian or Alaska Native Veterans were younger than non-Hispanic White Veterans. Less than one-half of American Indian or Alaska Native Veterans were 65 years and older, whereas over 60% of non-Hispanic White Veterans were in that age group.

Rurality by Race/Ethnicity



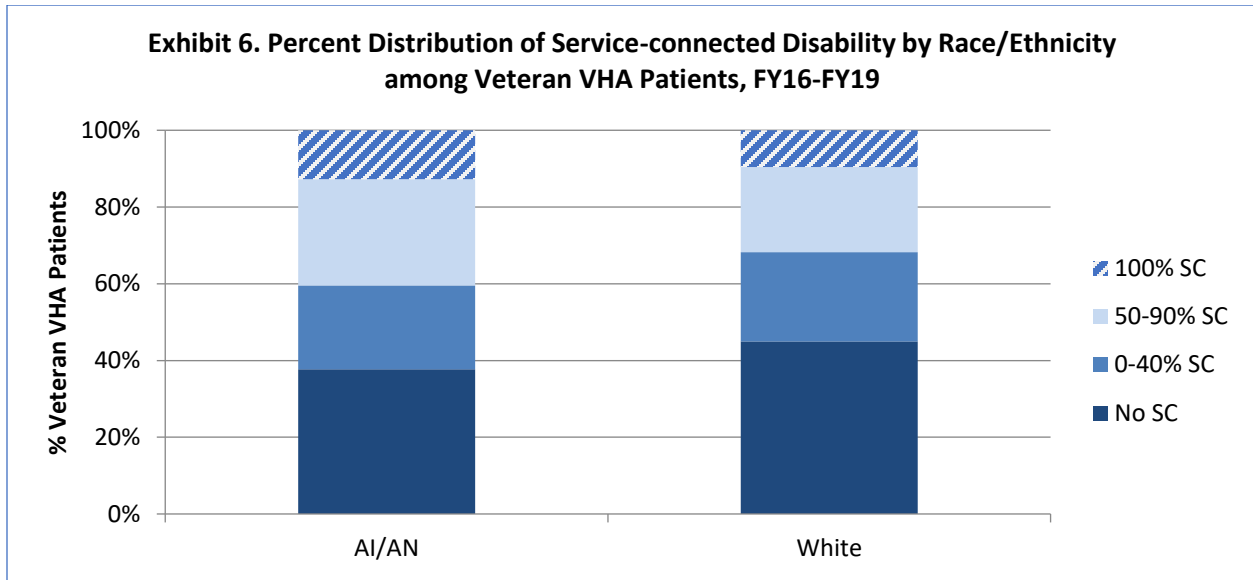
Rural/Urban Status	AI/AN	White
Urban	50.8%	59.6%
Rural	49.2%	40.4%

Note: AI/AN denotes American Indian or Alaska Native

Findings:

- Geography of residence for American Indian or Alaska Native Veterans was almost evenly split between rural and urban areas. A higher percentage of American Indian or Alaska Native Veterans lived in rural settings compared with non-Hispanic White Veterans.

Service-connected Disability Rating by Race/Ethnicity



Service-connected Disability Rating	AI/AN	White
100% SC	12.7%	9.6%
50-90% SC	27.7%	22.1%
0-40% SC	21.8%	23.3%
No SC	37.7%	44.9%

Note: AI/AN denotes American Indian or Alaska Native

Findings:

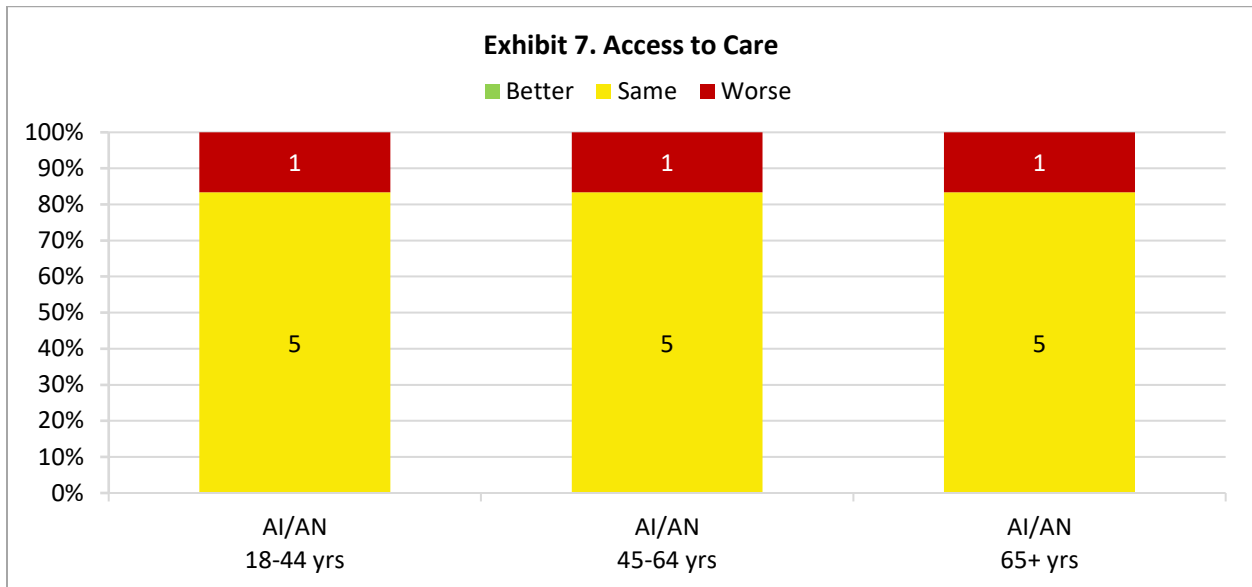
- Overall, American Indian or Alaska Native Veterans were more likely than non-Hispanic White Veterans to have a military service-connected disability. Among Veteran VHA users with a service-connected disability, American Indian or Alaska Native Veterans, compared with non-Hispanic White Veterans, were proportionately more likely to have a disability rating of 50-90% or 100%.

Section III: Patient Experiences

See Appendix for methods and guidelines for interpretation

Variations in VHA Patient Experience of Access to Care by Veteran Race/Ethnicity

Exhibit 7. Number and percentage of measures for which American Indian or Alaska Native Veteran VHA patients of specified age groups experienced better, same, or worse access to care compared with non-Hispanic White Veteran VHA patients



Comparison	AI/AN 18-44 years	AI/AN 45-64 years	AI/AN 65+ years
■ Worse	1	1	1
■ Same	5	5	5
■ Better	0	0	0

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group

Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2019 data

Note: AI/AN denotes American Indian or Alaska Native

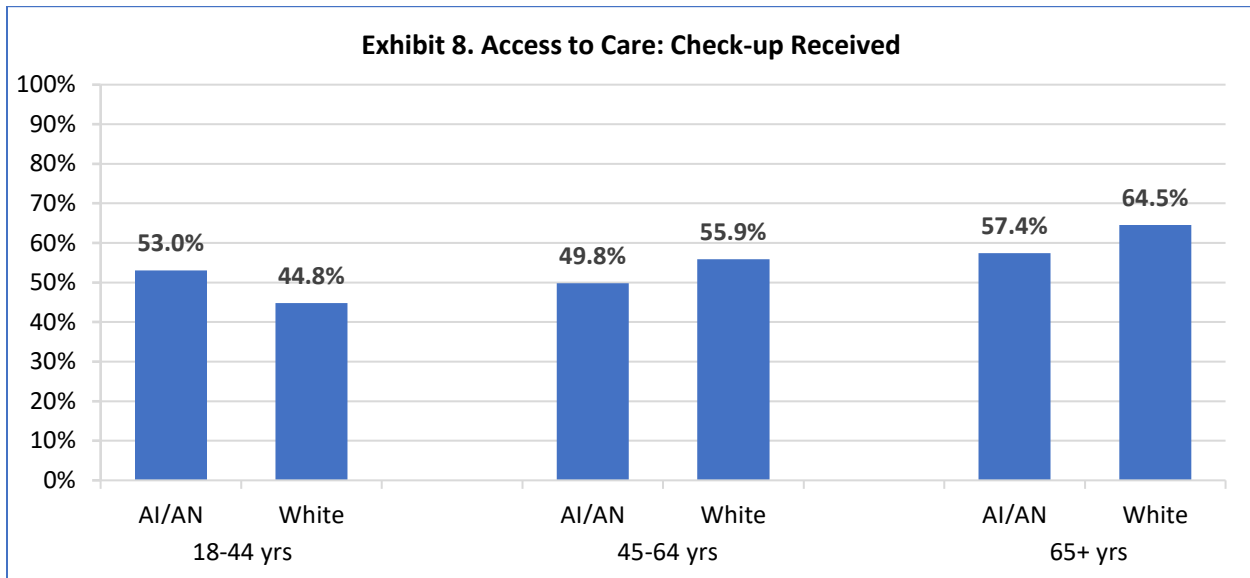
Importance:

- Access to high quality healthcare is the first important step towards improved individual and population health.⁴

Findings:

- Among Veterans ages 18-44 years, 45-64 years, and 65 years and older, AI/AN Veterans experienced worse access on 1 measure and the same access on 5 measures compared to non-Hispanic White Veterans.

Exhibit 8. VHA users who indicated, in the last 6 months, when they made an appointment with their provider for a check-up or routine care, they always received an appointment as soon as needed



Age	AI/AN	White
18-44 years	53.0%	44.8%
45-64 years	49.8%	55.9%
65+ years	57.4%	64.5%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group

Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2-19 data

Note: AI/AN denotes American Indian or Alaska Native

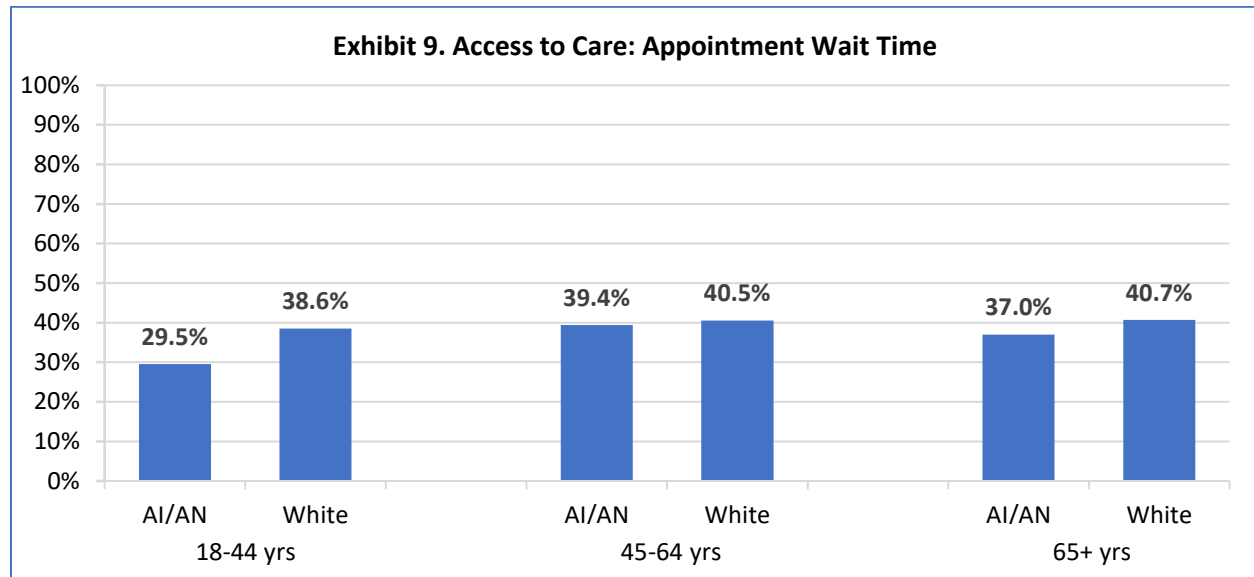
Importance:

- Timeliness of care is a key aspect of quality and delays in healthcare access contribute to poorer physical and mental health, given that untimely access can exacerbate these conditions.⁴⁻⁶

Findings:

- AI/AN Veterans ages 45 years and older had lower rates of receiving timely appointments for routine care compared to non-Hispanic White Veterans. Specifically, age group 45–64-year AI/AN (49.8%) versus White (55.9%) Veterans, and age group 65 year and older AI/AN (57.4%) versus White (64.5%) Veterans received timely appointments for routine care.

Exhibit 9. VHA users who indicated, in the last 6 months, they always saw their provider within 15 minutes of their appointment time



Age	AI/AN	White
18-44 years	29.5%	38.6%
45-64 years	39.4%	40.5%
65+ years	37.0%	40.7%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group

Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2-19 data

Note: AI/AN denotes American Indian or Alaska Native

Importance:

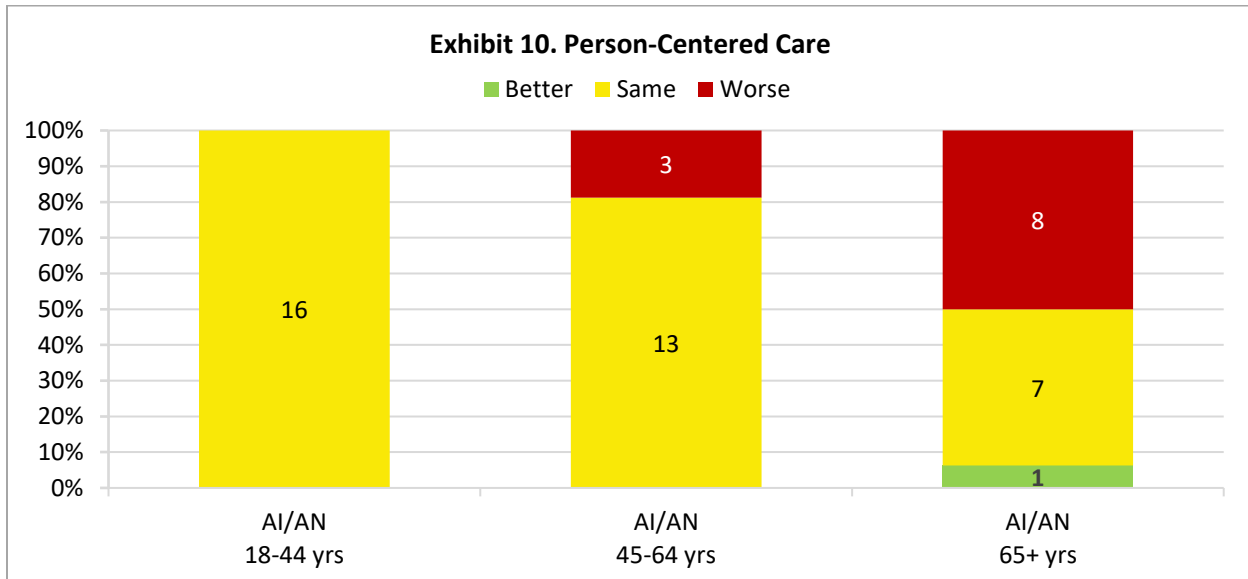
- Long clinic wait times negatively impact patient satisfaction, patient engagement and the likelihood that patients will recommend the practice to others.⁷⁻⁸

Findings:

- AI/AN Veterans ages 18-44 years had lower rates of seeing their provider within 15 minutes of their appointment time compared to non-Hispanic White Veterans. Specifically, 29.5% of AI/AN Veterans compared to 38.6% of non-Hispanic White Veterans were seen by their provider within 15 minutes of their appointment time.

Variations in VHA Patient Experience of Person-centered Care by Veteran Race/Ethnicity

Exhibit 10. Number and percentage of measures for which American Indian or Alaska Native Veteran VHA patients of specified age groups experienced better, same, or worse person-centered care compared with non-Hispanic White Veteran VHA patients



Comparison	AI/AN 18-44 years	AI/AN 45-64 years	AI/AN 65+ years
Worse	0	3	8
Same	16	13	7
Better	0	0	1

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group

Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2019 data

Note: AI/AN denotes American Indian or Alaska Native

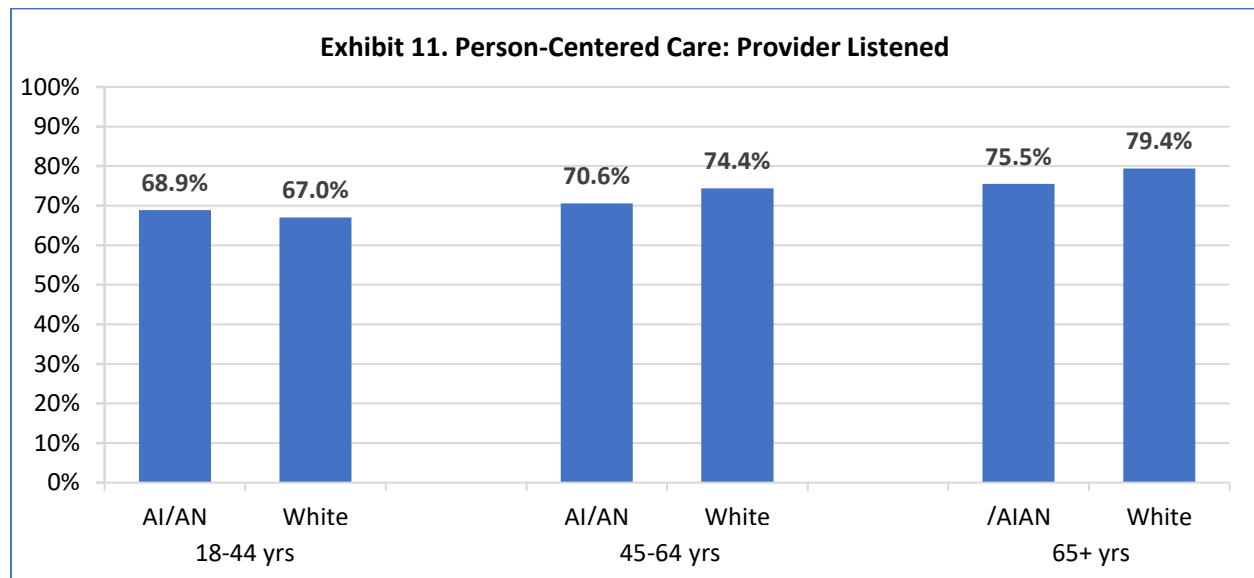
Importance:

- National guidelines define person-centered care as essential for patient engagement and satisfaction to ensure patient's desired outcomes.⁹

Findings:

- Among Veterans ages 18-44 years, AI/AN Veterans received the same person-centered care on 16 measures compared to non-Hispanic White Veterans.
- Among Veterans ages 45-64 years, AI/AN Veterans received worse person-centered care on 3 measures and the same care on 13 measures compared to non-Hispanic White Veterans.
- Among Veterans ages 65 years and older, AI/AN Veterans received worse person-centered care on 8 measures, better care on 1 measure, and the same care on 7 measures compared to non-Hispanic White Veterans.

Exhibit 11. VHA users who indicated, in the last 6 months, their provider always listened carefully to them



Age	AI/AN	White
18-44 years	68.9%	67.0%
45-64 years	70.6%	74.4%
65+ years	75.5%	79.4%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group

Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2-19 data

Note: AI/AN denotes American Indian or Alaska Native

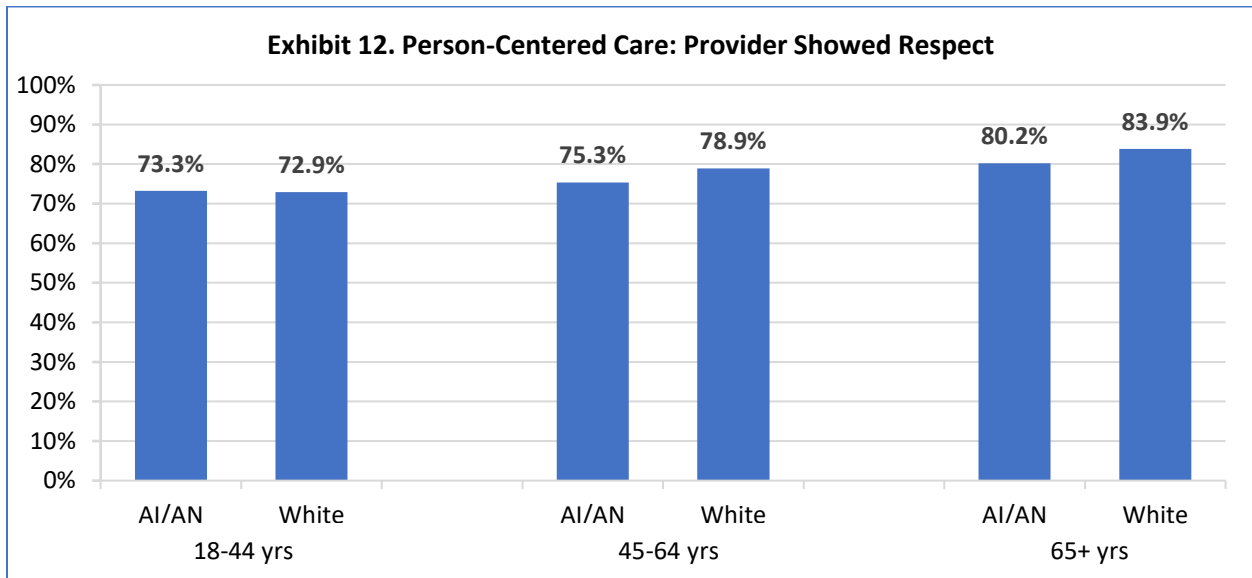
Importance:

- Effective communication between patients and providers is an essential component of person-centered care. Higher patient perceptions of provider communication are linked to improved patient satisfaction and quality of care.¹⁰

Findings:

- AI/AN Veterans ages 45 years and older had lower rates of their provider always listening to them carefully compared to non-Hispanic White Veterans. Specifically, age group 45–64-year AI/AN (70.6%) versus White (74.4%) Veterans, and age group 65 year and older AI/AN (75.5%) versus White (79.4%) Veterans experienced their provider always listening to them carefully.

Exhibit 12. VHA users who indicated, in the last 6 months, their provider always showed respect for what they had to say



Age	AI/AN	White
18-44 years	73.3%	72.9%
45-64 years	75.3%	78.9%
65+ years	80.2%	83.9%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group

Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2-19 data

Note: AI/AN denotes American Indian or Alaska Native

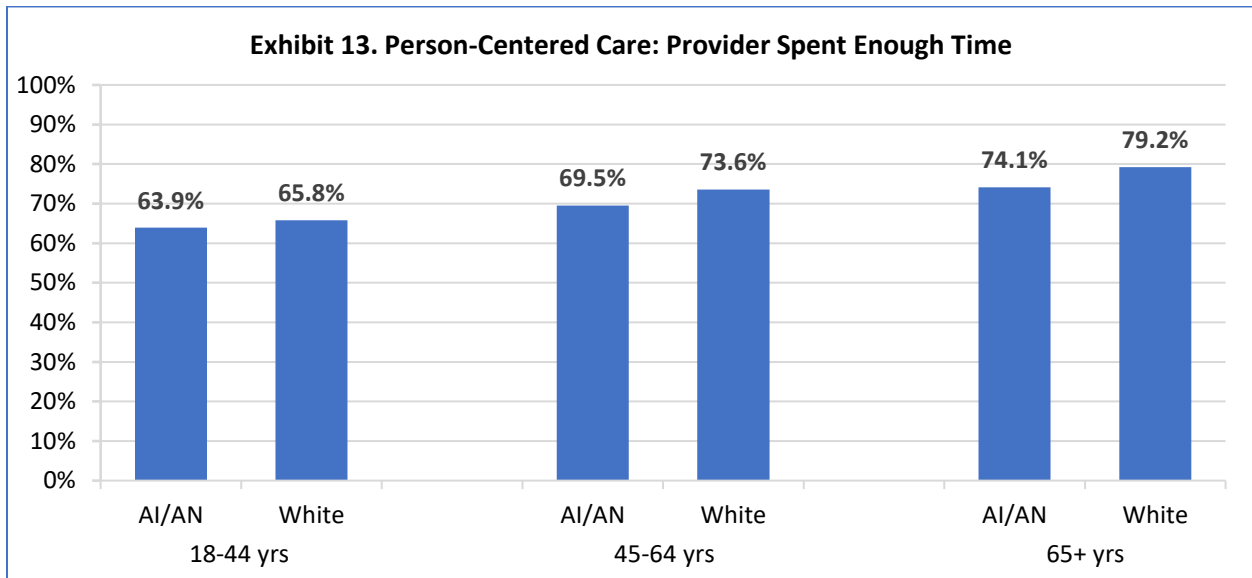
Importance:

- Being treated with respect is considered a core element of a good patient-provider relationship. Good quality communication as measured by many items including being treated with respect has been shown to improve patient adherence and reduce perceptions of treatment burden.¹¹

Findings:

- AI/AN Veterans ages 45 years and older had lower rates of their provider always showing respect for what they had to say compared to non-Hispanic White Veterans. Specifically, age group 45–64-year AI/AN (75.3%) versus White (78.9%) Veterans, and age group 65 year and older AI/AN (80.2%) versus White (83.9%) Veterans experienced their provider always showing respect for what they had to say.

Exhibit 13. VHA users who indicated, in the last 6 months, their provider always spent enough time with them



Age	AI/AN	White
18-44 years	63.9%	65.8%
45-64 years	69.5%	73.6%
65+ years	74.1%	79.2%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group

Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2-19 data

Note: AI/AN denotes American Indian or Alaska Native

Importance:

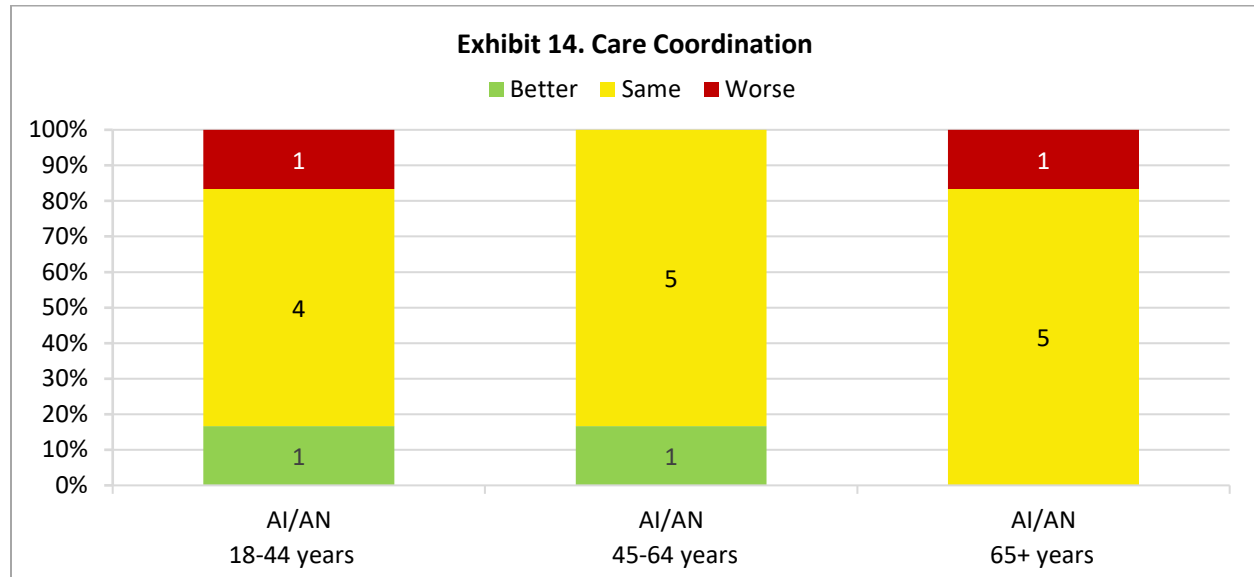
- Person-centered communication care involves adequate time for communication with healthcare providers which is associated with higher patient satisfaction.¹²⁻¹³
- Perceiving that one’s provider has spent enough time is associated with provider satisfaction and potentially even receiving appropriate care such as cancer screening, especially if that time addresses patient questions.¹⁴⁻¹⁵

Findings:

- AI/AN Veterans ages 45 years and older had lower rates of their provider always spending enough time with them during their clinical visit compared to non-Hispanic White Veterans. Specifically, age group 45–64-year AI/AN (69.5%) versus White (73.6%) Veterans, and age group 65 year and older AI/AN (74.1%) versus White (79.2%) Veterans experienced their provider always spending enough time with them during their clinical visit.

Variations in VHA Patient Experience of Care Coordination by Veteran Race/Ethnicity

Exhibit 14. Number and percentage of measures for which American Indian or Alaska Native Veteran VHA patients of specified age groups experienced better, same, or worse care coordination compared with non-Hispanic White Veteran VHA patients



Comparison	AI/AN 18-44 years	AI/AN 45-64 years	AI/AN 65+ years
■ Worse	1	0	1
■ Same	4	5	5
■ Better	1	1	0

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group

Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2019 data

Note: AI/AN denotes American Indian or Alaska Native

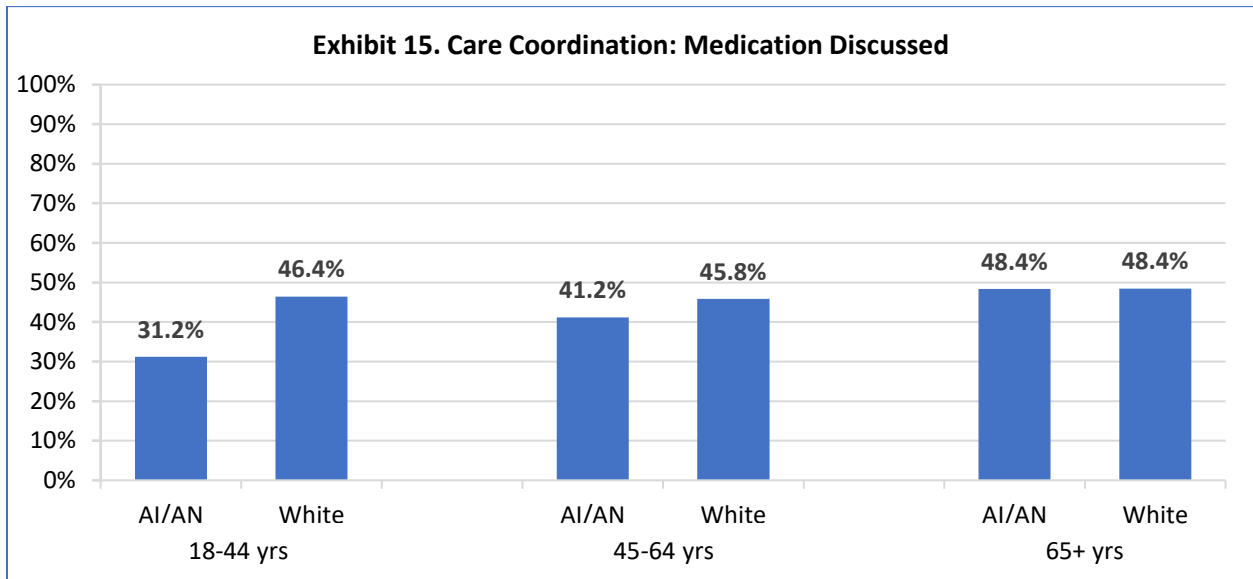
Importance:

- Excellent care coordination prevents fragmentation of communication, information and clinical services in order to ensure high quality care.¹⁴

Findings:

- Among Veterans ages 18-44 years, AI/AN Veterans had worse care coordination on 1 measure, better coordination on 1 measure, and the same coordination on 4 measures compared to non-Hispanic White Veterans.
- Among Veterans ages 45-64 years, AI/AN Veterans had better care coordination on 1 measure and the same coordination on 5 measures compared to non-Hispanic White Veterans.
- Among Veterans ages 65 years and older, AI/AN Veterans had worse care coordination on 1 measure and the same coordination on 5 measures compared to non-Hispanic White Veterans.

Exhibit 15. VHA users who indicated, in the last 6 months, that someone from their provider's office always spoke with them about all the prescription medicines they were taking



Age	AI/AN	White
18-44 years	31.2%	46.4%
45-64 years	41.2%	45.8%
65+ years	48.4%	48.4%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group

Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2-19 data

Note: AI/AN denotes American Indian or Alaska Native

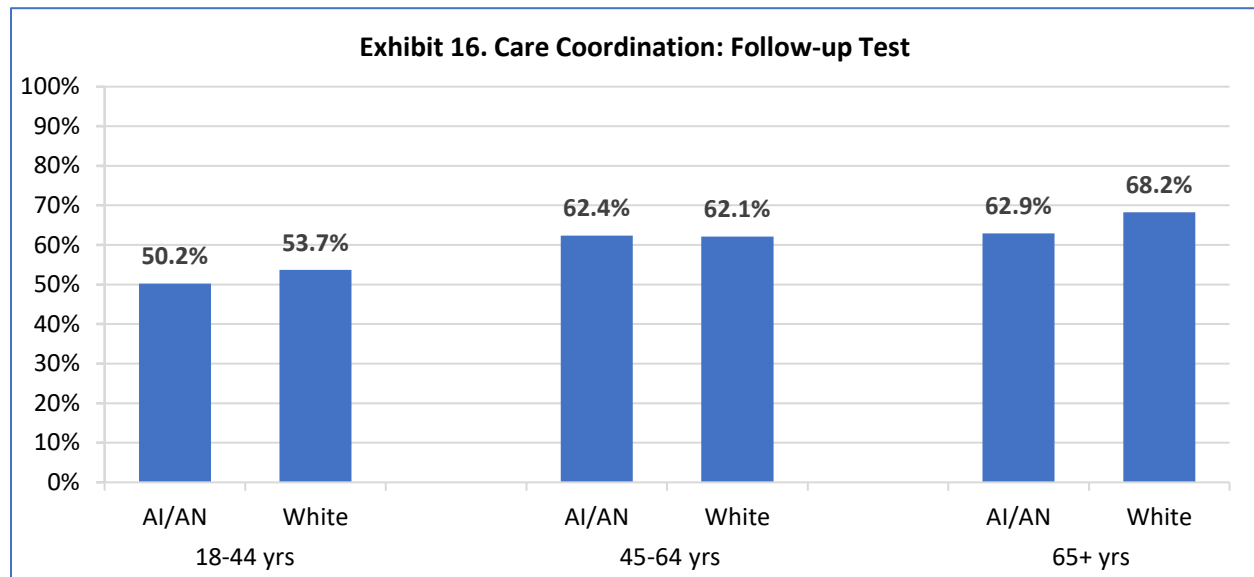
Importance:

- A systematic approach to prescribing and monitoring medications that is advocated by the World Health Organization can help minimize poor quality and erroneous prescribing. Steps in this approach include providing information, instructions, and warnings, and evaluating therapy regularly, including monitoring treatment results.¹⁶⁻¹⁷

Findings:

- AI/AN Veterans ages 18-44 years had lower rates of someone from their provider's office always discussing with them medications they were taking compared to non-Hispanic White Veterans. Specifically, 31.2% of AI/AN Veterans compared to 46.4% of non-Hispanic White Veterans experienced someone from their provider's office always discussing with them medications they were taking.

Exhibit 16. VHA users who indicated, in the last 6 months, that when their provider ordered a blood test, x-ray, or other test for them, someone in their provider's office always followed up to give them the results



Age	AI/AN	White
18-44 years	50.2%	53.7%
45-64 years	62.4%	62.1%
65+ years	62.9%	68.2%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group
Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2-19 data

Note: AI/AN denotes American Indian or Alaska Native

Importance:

- Failure to follow up on test results is associated with worse health outcomes due to loss of timely diagnosis and workup of serious medical conditions.^{14,18}

Findings:

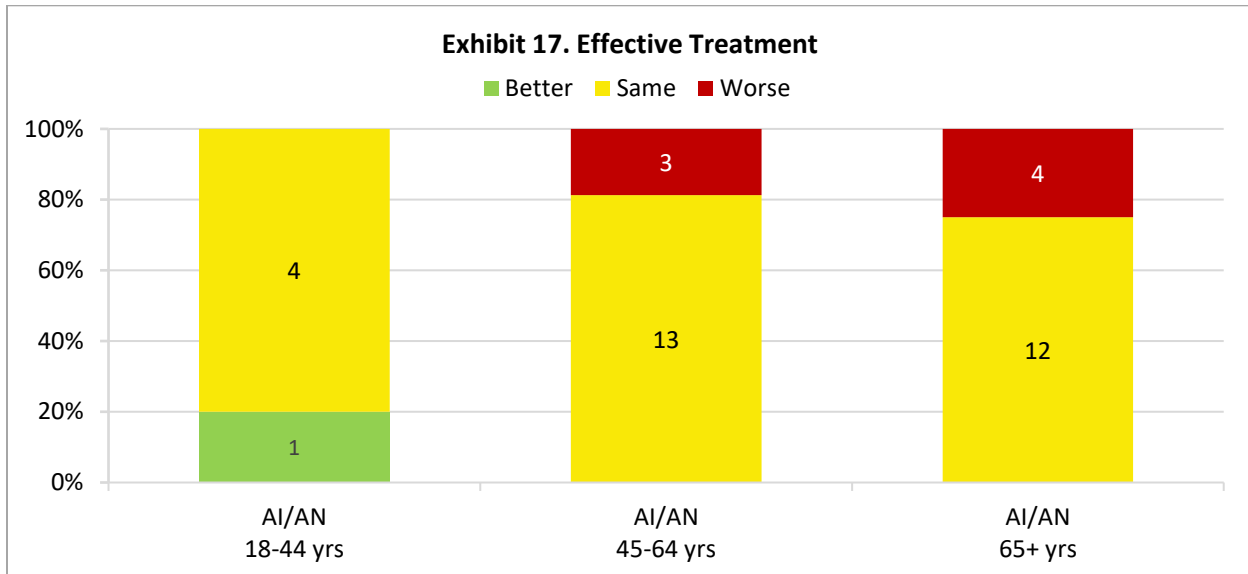
- AI/AN Veterans ages 65 years and older had lower rates of receiving follow-up on test results from someone in their provider's office compared to non-Hispanic White Veterans. Specifically, 62.9% of AI/AN Veterans compared to 68.2% of non-Hispanic White Veterans received follow-up on test results from someone in their provider's office.

Section IV: Health Care Quality

See Appendix for methods and guidelines for interpretation

Variations in VHA Health Care Quality of Effective Treatment by Veteran Race/Ethnicity

Exhibit 17. Number and percentage of measures for which American Indian or Alaska Native Veteran VHA patients of specified age groups experienced better, same, or worse effective treatment compared with non-Hispanic White Veteran VHA patients



Comparison	AI/AN 18-44 years	AI/AN 45-64 years	AI/AN 65+ years
■ Worse	0	3	4
■ Same	4	13	12
■ Better	1	0	0

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group

Source: Health Equity/QUERI Partnered Evaluation Center analysis of EPRP FY2016 – FY2019 data

Note: AI/AN denotes American Indian or Alaska Native

Importance:

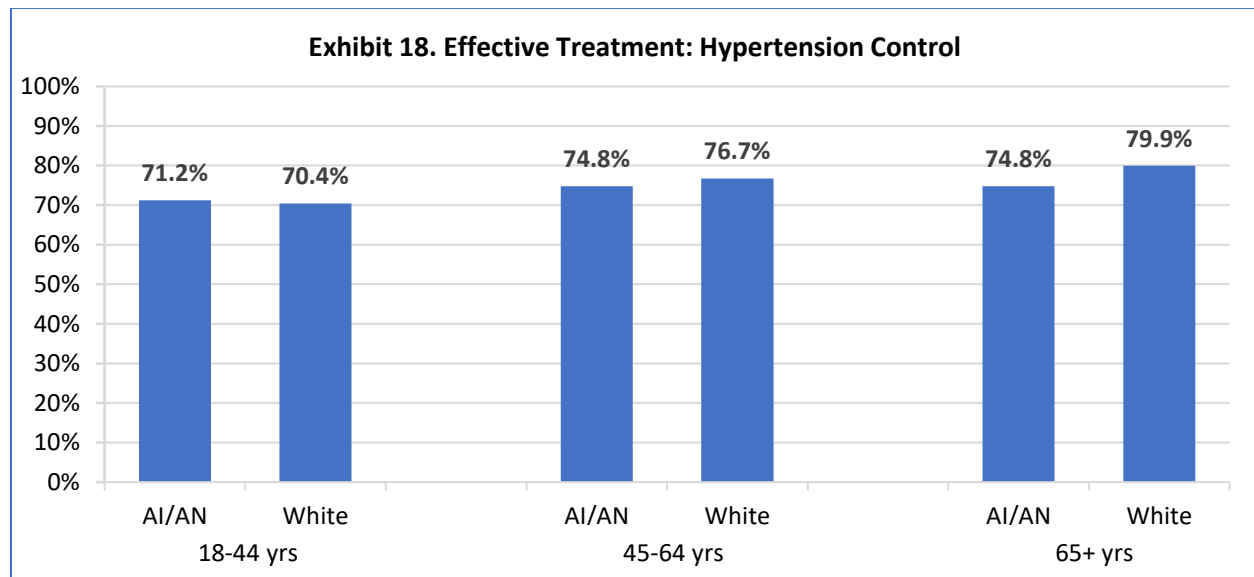
- Effective treatment is essential to ensuring high quality care with good patient outcomes.⁹

Findings:

- Among Veterans ages 18-44 years, AI/AN Veterans experienced the same effective treatment on 4 measures and better effective treatment on 1 measure compared to non-Hispanic White Veterans.

- Among Veterans ages 45-64 years, AI/AN Veterans experienced worse effective treatment on 3 measures and the same effective treatment on 13 measures compared to non-Hispanic White Veterans.
- Among Veterans ages 65+ years, AI/AN Veterans experienced worse effective treatment on 4 measures and the same effective treatment on 12 measures compared to non-Hispanic White Veterans.

Exhibit 18. VHA patients with diagnosed hypertension whose most recent blood pressure was less than 140/90 mmHg (or less than 150/90 mmHg for patients age 60-85 without a diagnosis of diabetes)



Age	AI/AN	White
18-44 years	71.2%	70.4%
45-64 years	74.8%	76.7%
65+ years	74.8%	79.9%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group

Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2-19 data

Note: AI/AN denotes American Indian or Alaska Native

Importance:

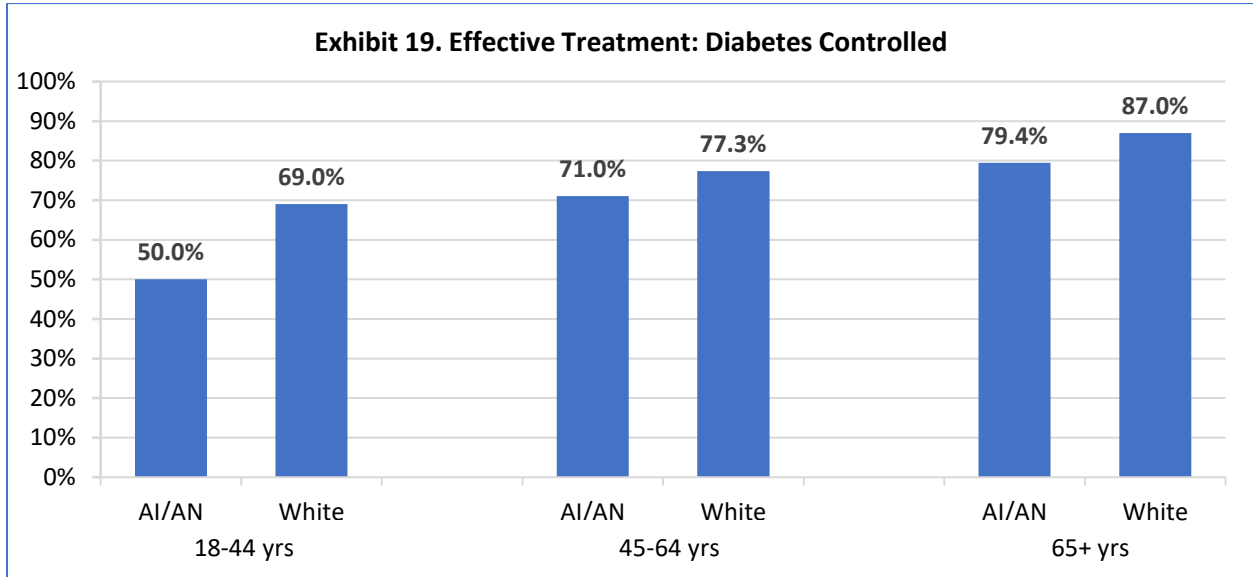
- Hypertension is one of the most commonly diagnosed medical conditions among Veterans using VHA care.¹⁹
- Effective blood pressure control is associated with decreased risk for complications from hypertension such as coronary heart disease, heart failure, stroke, and death.²⁰

Findings:

- AI/AN Veterans ages 65 years and older had lower rates of hypertension control compared to non-Hispanic White Veterans. Specifically, 74.8% of AI/AN Veterans

compared to 79.9% of non-Hispanic White Veterans had lower rates of hypertension control.

Exhibit 19. VHA patients with diagnosed diabetes whose glycosylated hemoglobin (HbA1C) was measured in the prior year, and was less than 9%



Age	AI/AN	White
18-44 years	50.0%	69.0%
45-64 years	71.0%	77.3%
65+ years	79.4%	87.0%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group
Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2-19 data

Note: AI/AN denotes American Indian or Alaska Native

Importance:

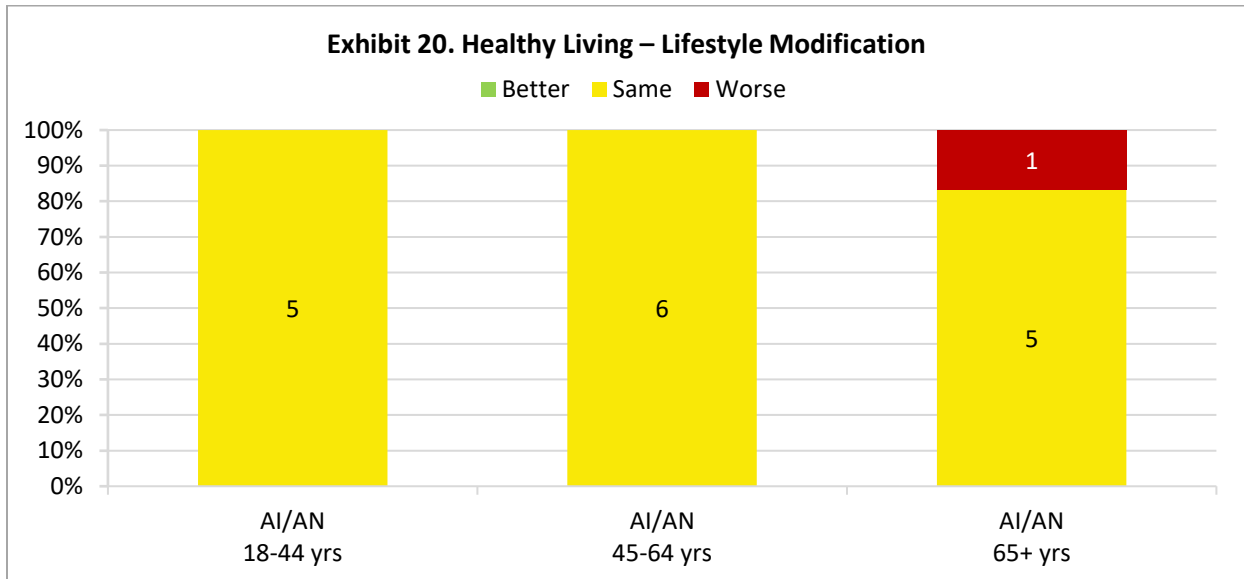
- Patients with diabetes have an increased risk of cardiovascular and kidney disease. Control of diabetes is essential in preventing long term complications such as myocardial infarction, stroke, chronic kidney disease requiring hemodialysis, and death. ²¹⁻²²

Findings:

- AI/AN Veterans of all age groups had a lower percentage of diabetes being controlled compared to non-Hispanic White Veterans. Specifically, age group 18–44-year AI/AN (50.0%) versus White (69.0%), 44–64-year AI/AN (71.0%) versus White (77.3%) Veterans, and age group 65+ year AI/AN (79.4%) versus White (87.0%) Veterans had diabetes controlled.

Variations in VHA Health Care Quality of Healthy Living – Lifestyle Modification by Veteran Race/Ethnicity

Exhibit 20. Number and percentage of measures for which American Indian or Alaska Native Veteran VHA patients of specified age groups experienced better, same, or worse healthy living – lifestyle modification compared with non-Hispanic White Veteran VHA patients



Comparison	AI/AN 18-44 years	AI/AN 45-64 years	AI/AN 65+ years
■ Worse	0	0	1
■ Same	5	6	5
■ Better	0	0	0

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group

Source: Health Equity/QUERI Partnered Evaluation Center analysis of EPRP FY2016 – FY2019 data

Note: AI/AN denotes American Indian or Alaska Native

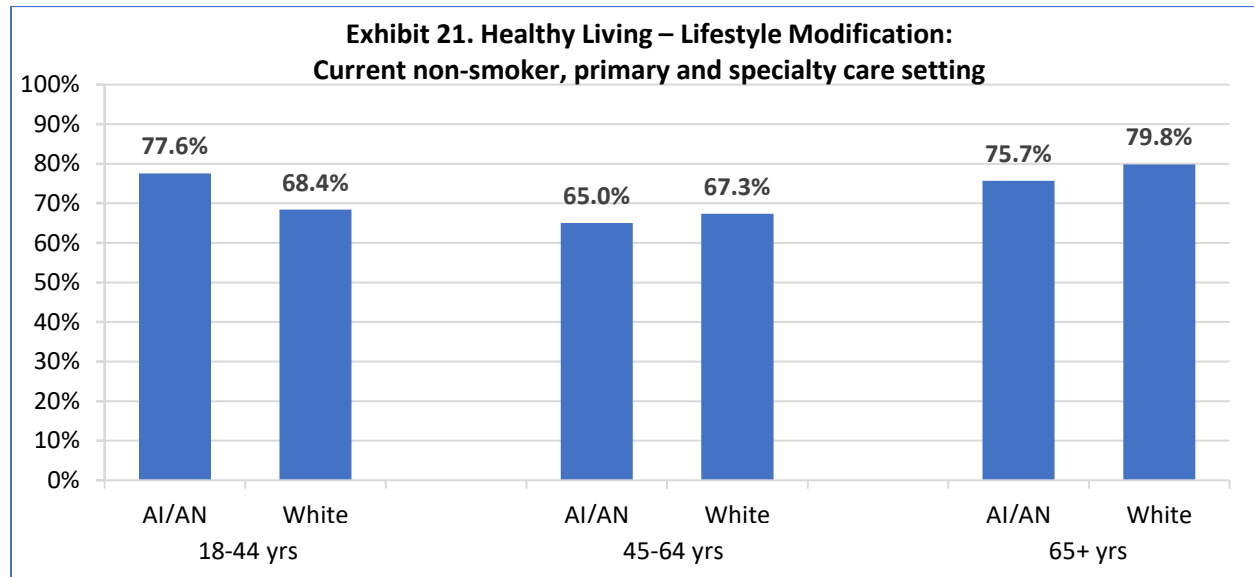
Importance:

- Lifestyle modification is an important part of the prevention and treatment of disease.²³

Findings:

- Among Veterans ages 18-44 years, AI/AN Veterans experienced the same lifestyle modification on 5 measures compared to non-Hispanic White Veterans.
- Among Veterans ages 45-64 years, AI/AN Veterans experienced the same lifestyle modification on 6 measures compared to non-Hispanic White Veterans.
- Among Veterans ages 65+ years, AI/AN Veterans experienced worse lifestyle modification on 1 measure and the same lifestyle modification on 5 measures compared to non-Hispanic White Veterans.

Exhibit 21. VHA outpatients in a non-mental health clinic who were screened for tobacco use and did not use tobacco any time during the past 12 months



Age	AI/AN	White
18-44 years	77.6%	68.4%
45-64 years	65.0%	67.3%
65+ years	75.7%	79.8%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group

Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2-19 data

Note: AI/AN denotes American Indian or Alaska Native

Importance:

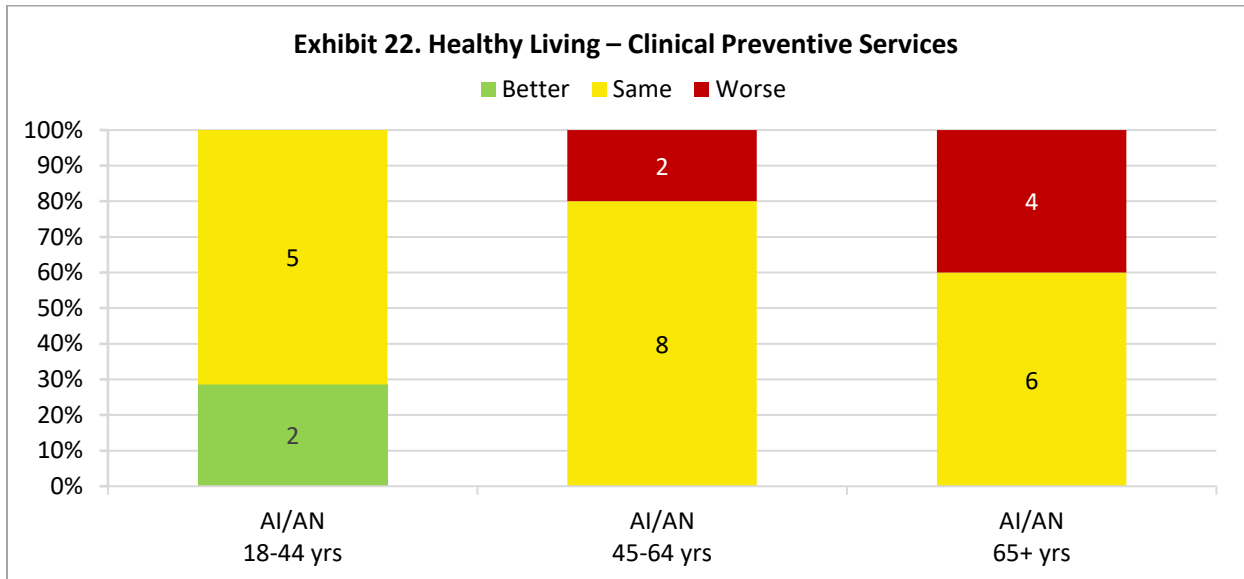
- Smoking is the number one preventable cause of premature disease and death in the United States.²⁴⁻²⁵ Screening for tobacco use is essential to identify individuals who would benefit from evidence-based smoking cessation programs and treatments. Ascertaining current or past heavy smoking, also identifies Veterans who may be appropriate for lung cancer screening.

Findings:

- AI/AN Veterans ages 65 years and older had lower rates of no tobacco use in the past 12 months compared to non-Hispanic White Veterans. Specifically, 75.7% of AI/AN Veterans compared to 79.8% of non-Hispanic White Veterans did not use tobacco any time in the last 12 months.

Variations in VHA Health Care Quality of Healthy Living – Clinical Preventive Services by Veteran Race/Ethnicity

Exhibit 22. Number and percentage of measures for which American Indian or Alaska Native Veteran VHA patients of specified age groups experienced better, same, or worse healthy living – clinical preventive services compared with non-Hispanic White Veteran VHA patients



Comparison	AI/AN 18-44 years	AI/AN 45-64 years	AI/AN 65+ years
■ Worse	0	2	4
■ Same	5	8	6
■ Better	2	0	0

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group

Source: Health Equity/QUERI Partnered Evaluation Center analysis of EPRP FY2016 – FY2019 data

Note: AI/AN denotes American Indian or Alaska Native

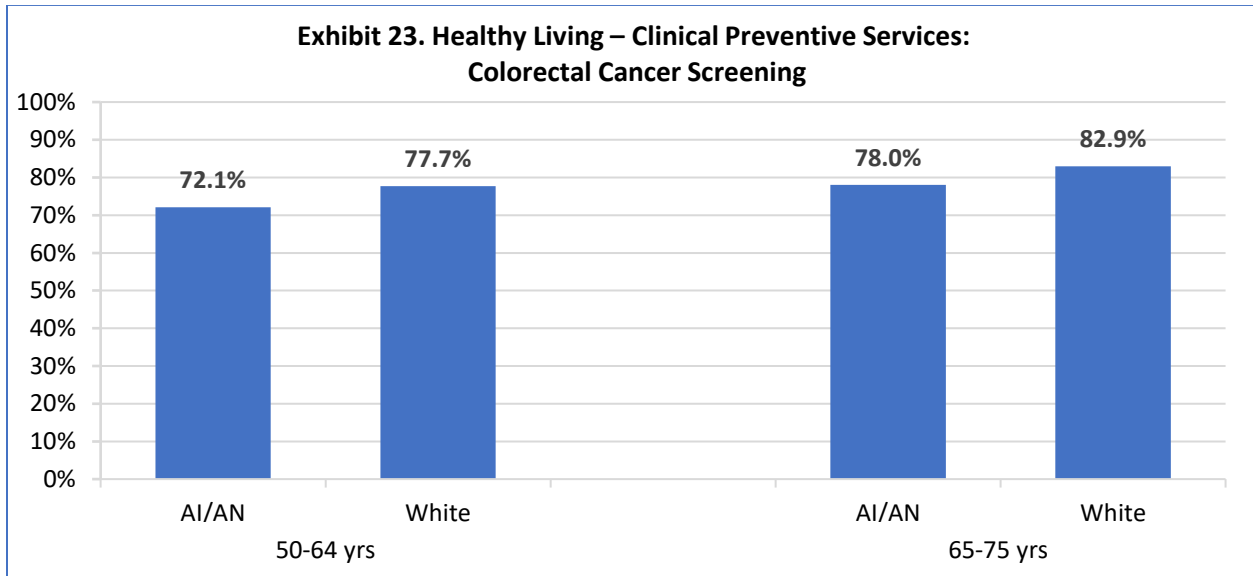
Importance:

- Clinical preventive services are an essential part of maintaining health and preventing disease.^{23, 26}

Findings:

- Among Veterans ages 18-44 years, AI/AN Veterans experienced the same clinical preventive services on 5 measures and better preventive services on 2 measures compared to non-Hispanic White Veterans.
- Among Veterans ages 45-64 years, AI/AN Veterans experienced worse clinical preventive services on 2 measures and the same preventive services on 8 measures compared to non-Hispanic White Veterans.
- Among Veterans ages 65+ years, AI/AN Veterans experienced worse clinical preventive services on 4 measures and the same preventive services on 6 measures compared to non-Hispanic White Veterans.

Exhibit 23. VHA patients ages 50-75, with documentation of colorectal cancer screening that is current based on the screening modality. [Note: Timely screening includes colonoscopy within 10 years, CT colonography or flexible sigmoidoscopy within 5 years, fecal immunochemical-based (FIT)-DNA test or three-card guaiac fecal occult blood test (iFOBT/FIT) within 2 years]



Age	AI/AN	White
50-64 years	72.1%	77.7%
65-75 years	78.0%	82.9%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group

Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2-19 data

Note: AI/AN denotes American Indian or Alaska Native

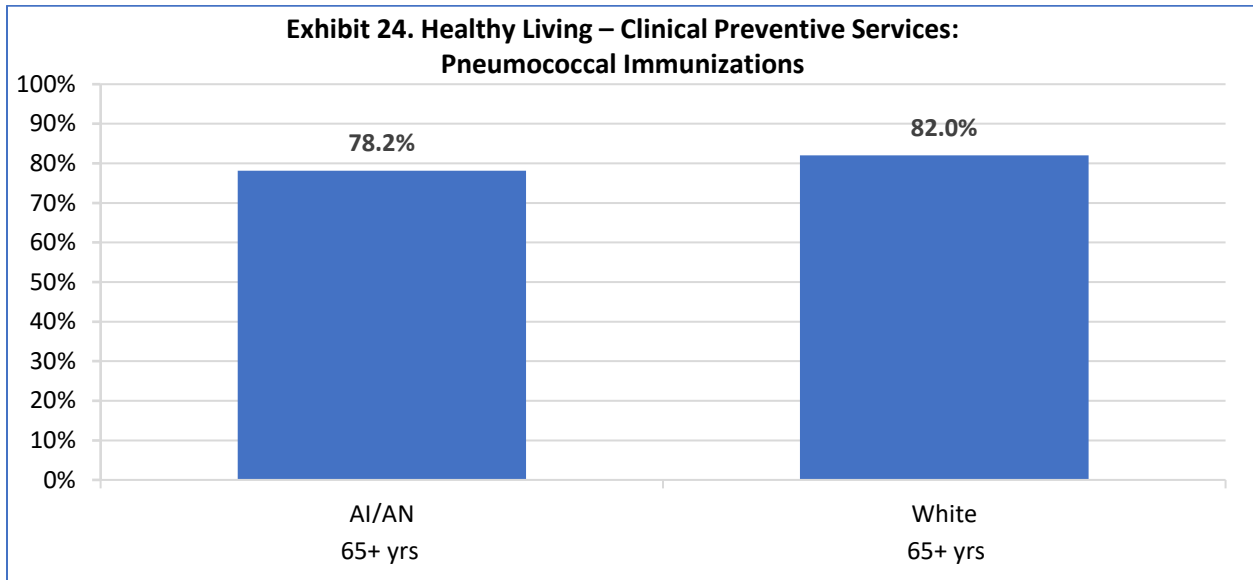
Importance:

- Colorectal cancer (CRC) is the second most common cause of cancer death in the U.S.. Screening for CRC helps both to prevent the development of CRC as well as find CRC early when it is highly treatable and survivable. Several demographic, social, and health characteristics are associated with increased risk for disparities in receipt of CRC screening.²⁷

Findings:

- AI/AN Veterans ages 50-75 had lower rates of colorectal cancer screening compared to non-Hispanic White Veterans. Specifically, age group 50–64-year AI/AN (72.1%) versus White (77.7%) Veterans, and age group 65–75-year AI/AN (78.0%) versus White (82.9%) Veterans received timely colorectal cancer screening.

Exhibit 24. VHA patients ages 65 or older who received pneumococcal immunizations



Age	AI/AN	White
65+ years	78.2%	82.0%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group

Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2-19 data

Note: AI/AN denotes American Indian or Alaska Native

Importance:

- Pneumococcal infections cause substantial morbidity and mortality, including from pneumonia, meningitis, bacteremia, and other infections. Pneumococcal vaccination helps to prevent the leading bacterial cause of pneumonia worldwide.²⁸

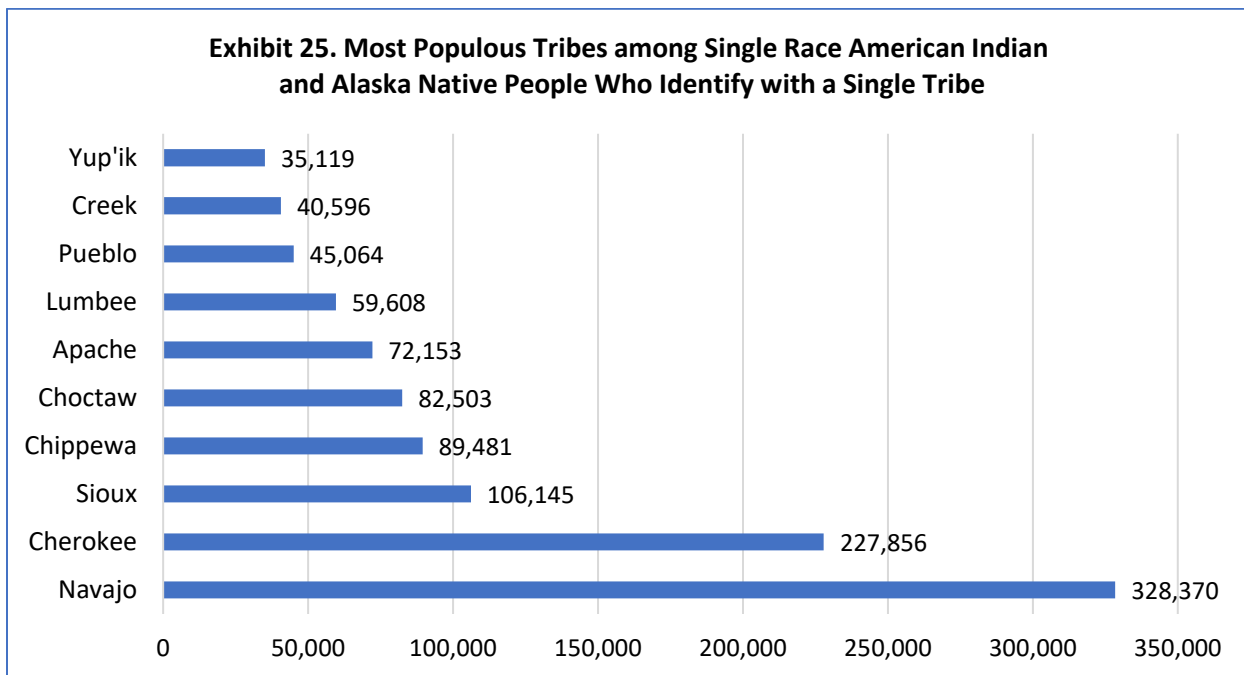
Findings:

- AI/AN Veterans ages 65 years and older had lower rates of receiving pneumococcal immunizations compared to non-Hispanic White Veterans. Specifically, 78.2% of AI/AN Veterans compared to 82.0% of non-Hispanic White Veterans received pneumococcal immunizations.

Section V: Granular Tribal Affiliations

Both the Office of Management and Budget and the United States Census categorize the American Indian and Alaska Native population as those with origins stemming from any of the original peoples of North and South America and maintains tribal affiliation or community attachment. Often, this group is viewed as a monolithic entity without taking into consideration the diverse needs and differences of each tribal group. There are currently 574 federally recognized tribes, and each tribe has unique healthcare needs.

The five largest tribes among single race American Indian and Alaska Native people who identify with a single tribe are the Navajo, the Cherokee, the Sioux, the Chippewa, and the Choctaw (Exhibit 25). These tribes have vastly differing levels of poverty and English facility. The Cherokee and Choctaw tribes have one of the lower rates of poverty among this population, with levels of 18.1% and 18.5% respectively. The Navajo and Sioux tribes, however, have the highest rates of poverty, with levels of 37.0% and 38.9%. The Chippewa tribe is in between at 23.7% poverty. Fewer than 5% of the Cherokee, Sioux, Chippewa, and Choctaw tribes speak a language other than English at home in contrast to 24.5% of the Navajo tribe. Differences in rates of cancer, diabetes, and end stage renal disease have also been described between different groups of American Indian and Alaska Native groups.²⁹



American Indian or Alaska Native tribe	Count among single race people who identify with a single tribe
Yup'ik	35,119
Creek	40,596
Pueblo	45,064
Lumbee	59,608
Apache	72,153
Choctaw	82,503
Chippewa	89,481
Sioux	106,145
Cherokee	227,856
Navajo	328,370

Source: American Indian and Alaska Native Alone for Selected Tribal Groupings. American Community Survey 2021 1-Year Estimates Detail Tables.

<https://data.census.gov/cedsci/table?q=American%20Indian%20and%20Alaska%20Native&tid=ACSDT1Y2021.B02014>

Section VI: Conclusions

American Indian and Alaska Native Veterans report experiencing more challenges with access to care and person-centered care when compared with non-Hispanic White Veterans. Disparities were more widespread for those in the age 65 or older age group. Disparities were also notable for the care quality domains of effective treatment and clinical preventive services. For example, American Indian and Alaska Native Veterans with diabetes are less likely to be under good control. Analyses are limited by the scarcity of information on tribal affiliation among American Indian and Alaska Native Veterans. Findings highlight areas of focus for VHA equity-guided improvement strategies.

Work is needed to improve the Veteran experience of care among American Indian and Alaska Native Veterans. Better information on American Indian and Alaska Native Veterans, including tribal affiliation, could further understanding and elimination of observed disparities.

Appendix Brief Overview of Methods and Guidelines for Interpretation

These exhibits rely on centralized analyses of VA administrative data for FY2016 – FY2019 (October 1, 2015, through September 30, 2019). Veteran sociodemographic characteristics and medical diagnoses were derived from the administrative and electronic health record (EHR) data in the VA Corporate Data Warehouse. Patient experience measures were derived from Survey of Healthcare Experiences of Patients (SHEP)-Patient Centered Medical Home surveys for FY2016 – FY2019. Quality measures were obtained from the External Peer Review Program (EPRP).

We created separate SHEP and EPRP cohorts. For each of these cohorts, we linked the four fiscal years of data; for individuals with observations in more than one year, we retained only the most recent year of data. We next linked Veteran characteristics from the VA administrative data and EHR. For time varying measures, e.g., age, we used the fiscal year of administrative data that corresponded to the SHEP or EPRP record.

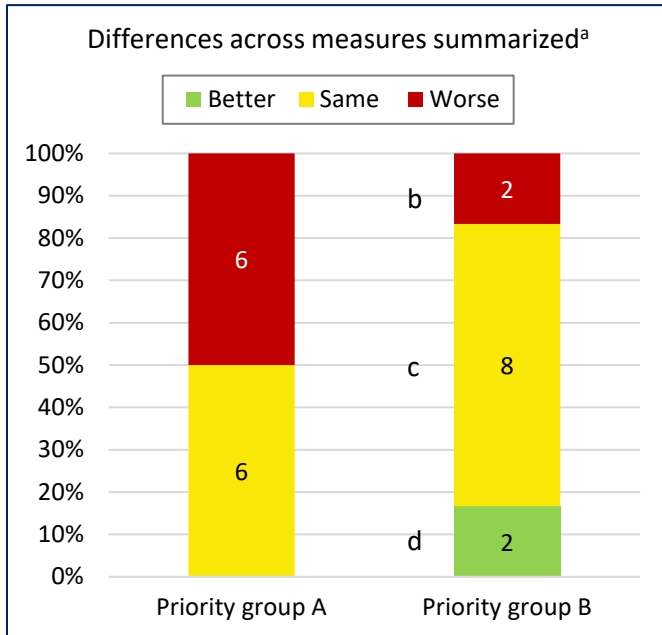
To facilitate comparisons between VHA data and publicly available data representing the U.S. population, we report race and ethnicity groups as mutually exclusive. All individuals with indication of Hispanic ethnicity are included in the “Hispanic” race/ethnicity group regardless of their race, and the remaining race/ethnicity groups contain Veteran patients who have identified as “non-Hispanic.” For simplicity, the label identifies only the race. For example, “White” is used as shorthand for non-Hispanic White, and “AI/AN” for non-Hispanic American Indian or Alaska Native Veterans, respectively.

To analyze data, we first aligned metrics so that for all measures a higher rate indicated better patient experiences or better quality. We next dichotomized responses to the response corresponding to the best care versus all other responses. We stratified all cohorts by age group (18-44 years; 45-64 years; and 65+ years), then conducted age-stratified analyses, comparing each priority (comparison) group and reference group within an 18-44 years, 45-64 years, and 65+ years strata. Several of the quality measures only applied to certain age groups, and therefore some groups (generally, the 18–44-year age group) had fewer comparisons.

To categorize a difference as a disparity (or an advantage, if the difference favored the priority group), we applied two criteria for a meaningful difference: an absolute difference that was statistically significant with a p-value <0.05 on a two-tailed test, AND a relative difference of at least 10%, where the relative difference is the difference between the priority group gap in care and the reference group gap in care, divided by the reference group gap in care. Both criteria had to be satisfied for a difference to be categorized as a disparity. These criteria are based on the standard applied by the Agency for Healthcare Research and Quality (AHRQ) in their annual National Healthcare Quality and Disparities Report for the U.S. population.³⁰

The format for presenting comparisons between priority groups and the reference group for each patient experience domain of care or quality domain of care is to use 100% stacked bar graphs. For each domain (e.g., person-centered care) and priority group, the number and percent of measures for which the priority group has better, same, or worse outcomes compared to the reference group is summarized in the 100% stacked bar graph. The example below illustrates comparisons for a Veteran characteristic where there are two priority groups. In this example, there are 12 measures in the domain.

Exhibit 26. Illustration of Domain Summary Figure



^a12 measures in this domain

^b Priority group B has worse outcomes on 2 measures (17% of measures) compared to the reference group (i.e., does better or same on 83% of measures in this domain)

^c Group B has same outcomes on 8 measures

^d Group B has better outcomes on 2 measures

Comparison	Priority group A	Priority group B
Worse	6	2
Same	6	8
Better	0	2

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