CHAPTER 1

Introduction

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Background

The largest integrated healthcare system in the U.S., the Veterans Health Administration (VHA) delivers care to a broad segment of the American public in every state and territory—young adults and old, men and women, virtually all races and ethnicities, those with serious mental illness and without, in large urban and remote rural locations, and regardless of sexual and gender minority status. In many respects, the diversity of Veteran VHA enrollees reflects the diversity of all Americans through the lens of those who have given of themselves through military service.

Of the roughly 22 million U.S. Veterans, approximately 9.1 million are enrolled in the VA healthcare system and receive services either directly through one or more VA healthcare facilities or through arrangements with providers in the community as needed. Enroll is linked to eligibility criteria established through compensation and pension exams and other means testing, with those Veterans with service-connected disabilities having the highest priority for care. The VA healthcare system has been transitioning from a solely “bricks and mortar” infrastructure to a health plan over the past 20 years, starting with VA’s “quality transformation” of the mid-1990s, with increased volumes of purchased care in the community in addition to growth of VA community-based outpatient clinics to ensure access to needed care within 30 minutes of Veterans’ homes.

While the VA healthcare system represents an essentially equal access system, driven by service-connected disability and other eligibility parameters that are less impacted by socioeconomic factors linked to access to private-sector care, disparities in some aspects of care in VA persist. The drivers of these disparities differ with respect to the sociodemographics (e.g., age, gender, race/ethnicity, socioeconomic status), location (e.g., urban/rural location, distance to nearest VA facility), and other factors, which may be more or less studied or understood. Systematically tackling disparities requires better awareness and understanding of their determinants, so that programs and policies may be designed to ameliorate them in systematic and meaningful ways.

Overview of Report Purpose and Content

This report is designed to provide basic comparative information on the sociodemographics, utilization patterns and rates of diagnosed health conditions among the groups over which the VHA Office of Health Equity (OHE) has responsibility with respect to monitoring, evaluating and acting on identified disparities in access, use, care, quality and outcomes. Chapter 2 summarizes the OHE’s charge and actionable steps related to this report. Chapters 3-7 describe comparative data in subgroups of Veterans:

- Chapter 3 focuses on racial/ethnic disparities;
- Chapter 4 focuses on gender disparities;
- Chapter 5 focuses on disparities among older Veterans, comparing and contrasting different age groups;
- Chapter 6 focuses on disparities among Veterans who reside in rural vs. urban areas; and
- Chapter 7 focuses on disparities among Veterans with and without serious mental illness.

These chapters rely on centralized analyses of VA administrative data (sociodemographics, utilization patterns, health conditions) for FY13 (October 1, 2012 through September 30, 2013). Chapters were also developed in partnership with appropriate VA program offices where available. For example, chapter 4 was developed with Women’s Health Services in the Office of Patient Care Services, while chapter 6 was written by leaders in the VA Office of Rural Health.

- **Chapter 8** highlights the findings from all of the other chapters, including major findings and gaps, and describes recommended next steps in terms of future data needs, and potential research and evaluation responses to information presented in each chapter.

We have also included a **Technical Appendix** that includes the methods used to generate the tables and summaries within our data-focused chapters.

**Brief Overview of Methods and Guidelines for Interpretation**

Utilization of VA administrative data to generate epidemiologic analyses of utilization patterns and the prevalence of health conditions has a longstanding history given that the national VA datasets reflect the census of all Veteran users of the VA healthcare system. Nonetheless, expertise in their use is required given variations in the quality of individual data elements, their utility, and appropriate coding and programming to ensure the highest possible quality of reporting. Data analyses were conducted by a team overseen by Dr. Susan Frayne, at the VA Palo Alto Healthcare System, who directs the Women’s Health Evaluation Initiative (WHEI). WHEI has created national uniform datasets extracted, organized and cleaned from source VA databases for use in evaluating patterns of VA care delivery that served as the foundation for this report.

We have included a series of methodological points necessary for appropriate interpretation of the material presented in each chapter. An overarching methodological distinction that is important to interpretation is that data presented in this report’s Tables are unadjusted. Therefore, in Chapter 4, gender differences are not adjusted for age, so it is not possible to determine whether differences in women vs men are driven by gender or age (or both) or by other factors. Several other methodological issues are worth mentioning:

- **Race/ethnicity.** Race/ethnicity categories reported here are mutually exclusive. All individuals with indication of Hispanic ethnicity are included in the “Hispanic” race/ethnicity group regardless of their race. The remaining race/ethnicity categories contain Veteran patients who have identified as “non-Hispanic,” but for simplicity, the label identifies only the race. For example, “White” is used as shorthand for non-Hispanic White, and “Black/African American” is used as shorthand for non-Hispanic Black or African American. The multi-race category is comprised of non-Hispanic individuals who identify more than one race.

- **Urban/rural location.** In FY13 (and prior), VA defined rurality by using the three category URH scheme, which gave each Veteran the designation of urban, rural, or highly rural based on U.S. Census Bureau information and Veteran residence. The URH scheme is used throughout this report. This classification system was updated in FY15 to the US Department of Agriculture (USDA) and Department of Health and Human Services (HHS) Rural-Urban Commuting Area (RUCA) methodology to allow for increased consistency across federal agencies in the definition of rural designation.

- **Utilization.** Veteran users of VA healthcare services may also use healthcare outside the VA (e.g., reimbursed through Medicare, Medicaid, private insurance, or other non-VA sources). Utilization represented in this report may therefore underestimate the total amount of care Veterans receive from all sources combined. Further, long-term nursing home care and VA pharmacy services are not included in any counts of utilization. However, utilization data in this report include care outsourced and paid for by VA through the non-VA (Fee) medical care system. These data pre-date changes in coding enacted through implementation of the Veterans Choice Act. When interpreting differences in utilization based, on age, gender, race/ethnicity, or other population characteristics, it is important to
recognize that these analyses represent unadjusted comparisons of proportions, without adjustment for patient characteristics such as number of medical conditions, which may influence conclusions regarding between-group differences in use of VA services.

- **Conditions.** Condition rates are based on ICD-9 diagnostic codes, with denominators representing counts of the number of patients using VHA for any reason (e.g., outpatient care, inpatient care, and outsourced VHA care). Use of FY13 data preceded implementation of ICD-10 diagnoses. Use of diagnosis codes to ascertain prevalence of health conditions results in our use of the term “rate of diagnosed X,” where X represents the medical or mental health condition of interest.

**Report Team**

The VHA OHE engaged VA health services researchers at the Health Services Research & Development (HSR&D) Centers of Innovation at the VA Greater Los Angeles and VA Palo Alto Healthcare Systems. A nationally recognized expert in health equity and disparities in care, **Donna L. Washington, MD, MPH,** is Director of the OHE/Quality Enhancement Research Initiative (QUERI) Partnered Evaluation Center and 2015 recipient of the Herbert Nickens Award for Excellence in Health Disparities from the Society of General Internal Medicine. She is also a Core investigator at VA Los Angeles’ HSR&D Center for the Study of Healthcare Innovation, Implementation & Policy (CSHIIP) and Professor of Medicine at the UCLA Geffen School of Medicine. Dr. Washington took a leading role in editorial oversight for the report chapters. **Uchenna S. Uchendu, MD,** directs the VHA OHE as VA’s Chief Health Equity Officer. Dr. Uchendu proposed the idea of the report, engaged the report team and was closely involved in report planning, editing and policy review. She explored options and worked with the VA Employee Education System (EES) to transform the report into an electronic format and educational tool. **Susan Frayne, MD, MPH,** is Director of the Women’s Health Evaluation Initiative (WHEI), and oversaw analyses supporting report content. She is a core investigator at VA Palo Alto’s HSR&D Center for Innovation to Implementation (Ci2i) and a Professor of Medicine at Stanford University. **Fay Saechao, MPH,** is the project manager for WHEI and lead technical writer of the WHEI Sourcebook Volume 3, including its extensive Technical Appendix. **Deborah Riopelle, MSPH,** is a senior project director at CSHIIP and a core staff member of the OHE/QUERI Partnered Evaluation Center. She served as the project director for the report, supported chapter and report authors, and oversaw draft report formatting and completion. **Kenneth T. Jones, PhD,** is a program analyst in the OHE and coordinated the effort to turn the draft report into an interactive versatile electronic format. He worked closely with the VA EES graphic designers on behalf of the OHE to accomplish the final report. **Elizabeth M. Yano, PhD, MSPH,** is the Director of CSHIIP, and Professor of Health Policy and Management at the UCLA Fielding School of Public Health. She conceptualized the report, designed its content, and secured and organized Chapter author teams.

The report team would not have been successful without the contributions of each chapter authorship team, each member of which donated their time to chapter completion.