



Chapter 3

Health and Healthcare for Veterans in VHA by Race/Ethnicity

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Section I: Significance & Background

Racial/Ethnic Health and Healthcare Disparities

Racial/ethnic disparities in healthcare have persisted over time in the U.S. for a wide range of conditions,^{1,2} and are associated with worse health outcomes and the presence of unmet healthcare needs.^{3,4,5} The Veterans Health Administration (VA) serves a patient population that is increasingly racially and ethnically diverse. Racial/ethnic diversity is particularly prominent in some subgroups such as women or Veterans receiving care in certain geographic regions.^{6,7} While equitable access to high-quality care for all Veterans is a major tenet of the VA healthcare mission, evidence for ongoing racial/ethnic disparities exist, though evidence for the extent of these disparities in VA has been mixed, especially since financial barriers to healthcare use are diminished for VA users^{8,9,10}

Racial/ethnic variations in use of any VA healthcare (compared with VA non-use) has been described, and examined in association with self-reported unmet healthcare needs.¹¹ Black or African-American Veterans (referred to as Black Veterans in this chapter) and Hispanic Veterans, compared with White Veterans, were more likely to depend upon the VA to provide all or some of their healthcare.^{12,13} Across all Veterans (VA users and VA non-users), significant disparities were detected between traditionally underserved racial/ethnic groups and White Veterans in their ability to obtain needed medical care, e.g., with greater proportions of American Indian/Alaska Native, Hispanic, and Black Veterans reporting barriers to care.¹⁴ Use of VA healthcare (versus VA non-use) reduced the magnitude of those racial/ethnic disparities.¹⁴ That research provided support for the role of VA as a medical safety net provider for vulnerable Veterans, but suggested that racial/ethnic differences in Veterans' health cannot be attributed solely to differences in healthcare access.

Prior research has examined trends in quality of VA care for Black and White Veteran VA healthcare users.¹⁵ A key finding was that after the VA's organizational transformation of the mid-1990s, VA achieved important performance improvements in process of care measures (i.e., receipt of recommended care) for both White and Black Veterans; however, racial gaps in clinical outcomes persisted for hypertension, cardiovascular care, and

- 1 Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. 2013 National Healthcare Disparities Report. *AHRQ Publication No.14-0006*. [online]. (May 2014) {cited 2015 Feb 4}
- 2 Weinick RM, Zuvekas SH, Cohen JW. Racial and ethnic differences in access to and use of healthcare services, 1977 to 1996. *Med Care Res Rev.* 2000;57 Suppl 1:36-54.
- 3 Otten MW, Teutsch SM, Williamson DF, Marks JS. The effect of known risk factors on the excess mortality of Black adults in the United States. *JAMA.* 1990;263:845-50.
- 4 Nickens HW. The health status of minority populations in the United States. *West J Med.* 1991;155:27-32.
- 5 Centers for Disease Control and Prevention. CDC Health Disparities and Inequalities Report – U.S. 2013. *Morbidity and Mortality Weekly Report – Supplement.* 2013;62(3).
- 6 Washington DL, Bean-Mayberry B, Riopelle D, Yano EM. Access to care for Women Veterans: Delayed healthcare and unmet need. *J Gen Intern Med.* 2011;26(Suppl 2):S655-61.
- 7 Egede LE, Gebregziabher M, Hunt KJ, et.al. Regional, geographic, and racial/ethnic variation in glycemic control in a national sample of Veterans with diabetes. *Diabetes Care.* 2011;34(4):938-43.
- 8 Saha S, Freeman M, Toure J, Tippens KM, Weeks C. Racial and ethnic disparities in the VA healthcare system: a systematic review. *VA HS-R&D Evidence Synthesis Pilot Program.* 2007.
- 9 Quinones AR, O'Neil M, Saha S, Freeman M, Henry S, Kansagara D. Interventions to Improve Minority Healthcare and Reduce Racial and Ethnic Disparities. VA-ESP Project #05-225; 2011.
- 10 Rose DE, Farmer MM, Yano EM, Washington DL. Racial/ethnic differences in cardiovascular risk factors among women Veterans. *J Gen Intern Med.* 2013;28(Suppl 2):S524-8.
- 11 Washington DL, Harada ND, Villa VM, et.al. Racial variations in Department of Veterans Affairs ambulatory care use and unmet healthcare needs. *Mil Med.* 2002;167:235-41.
- 12 Washington DL, Villa V, Brown A, Damron-Rodriguez J, Harada N. Racial/ethnic variations in Veterans' ambulatory care use. *Am J Public Health.* 2005;95:2231-7.
- 13 Harada ND, Damron-Rodriguez J, Villa VM, Washington DL, Dhanani S, Shon H, et.al. Veteran identity and race/ethnicity: influences on VA outpatient utilization. *Med Care.* 2002;40:S117-28.
- 14 Washington DL, Harada ND, Villa VM, et.al. Racial variations in Department of Veterans Affairs ambulatory care use and unmet healthcare needs. *Mil Med.* 2002;167:235-41.
- 15 Trivedi AN, Grebla RC, Wright SM, Washington DL. Despite improved quality of care in the Veterans Affairs health system, racial disparity persists for important clinical outcomes. *Health Aff (Millwood).* 2011;30(4):707-15.

diabetes care.¹⁵ Other research has found racial disparities in diabetes care processes.¹⁶ There is mixed evidence on racial disparities in VA cancer care.^{17,18} An examination of racial/ethnic differences in types and amount of VA healthcare services used may provide insight on some of the underlying factors associated with previously documented VA racial/ethnic healthcare disparities.

Most of the research on racial/ethnic disparities among Veterans has focused on single clinical conditions or on limited racial/ethnic minority group comparisons.¹⁹ There is limited evidence on health and healthcare for racial/ethnic groups of Veterans other than Black and White.^{19,20} The goal of this chapter, which systematically examines demographic characteristics, types and amount of VA services used, and rates of diagnosed health conditions among Veteran VA users by race/ethnicity, is to begin to fill that information gap. The findings in this chapter can advance our understanding of Veteran racial/ethnic health and healthcare disparities.

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- 16 Heisler M, Smith DM, Hayward RA, Krein SL, Kerr EA. Racial disparities in diabetes care processes, outcomes, and treatment intensity. *Med Care*. 2003;41(11):1221-32.
- 17 Samuel CA, Landrum MB, McNeil BJ, Bozeman SR, Williams CD, Keating NL. Racial disparities in cancer care in the Veterans Affairs health-care system and the role of site of care. *Am J Public Health*. 2014;104 Suppl 4:S562-71.
- 18 Zullig LL, Jackson GL, Weinberger M, Provenzale D, Reeve BB, Carpenter WR. An examination of racial differences in process and outcome of colorectal cancer care quality among users of the Veterans affairs healthcare system. *Clin Colorectal Cancer*. 2013;12(4):255-60.
- 19 Saha S, Freeman M, Toure J, Tippens KM, Weeks C. Racial and ethnic disparities in the VA healthcare system: a systematic review. *VA HSR&D Evidence Synthesis Pilot Program*. 2007.
- 20 Kramer BJ, Jouldjian S, Washington DL, Harker JO, Saliba D, Yano EM. Healthcare for American Indian and Alaska Native women: The roles of the Veterans Health Administration and the Indian Health Service. *Wom Health Issue*. 2009;19(2):135-43.

Distribution of Race and Ethnicity Among Veteran VHA Patients

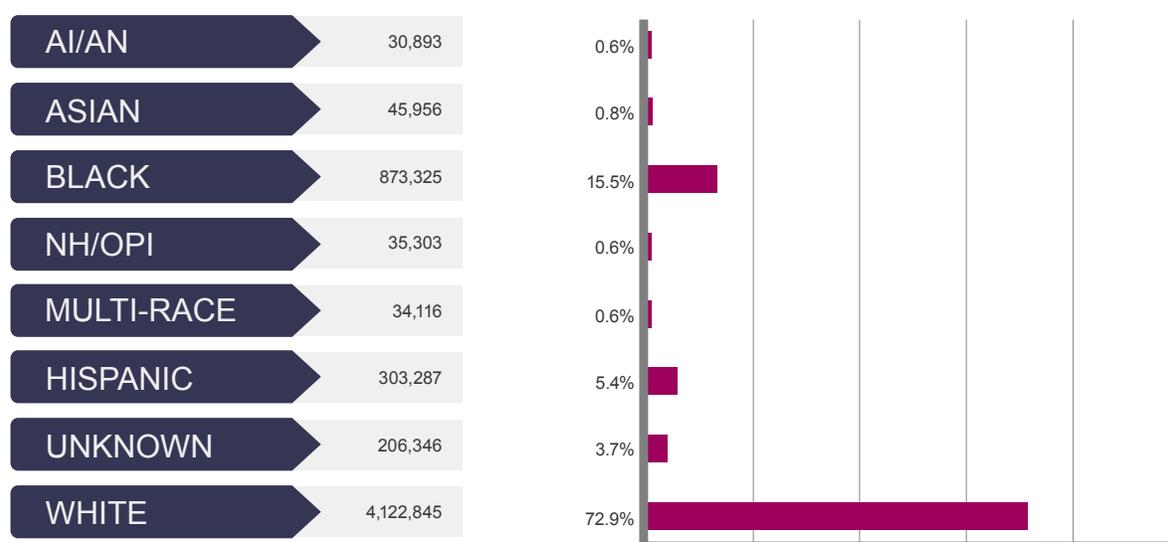
The racial/ethnic distribution of Veteran VA healthcare users in fiscal year (FY) 2013 is shown below

([Exhibit 3-1](#)).²¹

Overall, among FY13 Veteran VA healthcare users, 23.5% were members of a racial/ethnic minority group, 72.9% were White, and 3.7% were unknown race/ethnicity. In descending order of frequency, representation of racial/ethnic minorities was: 15.5% Black or African-American (referred to as Black in tables and figures); 5.4% Hispanic; 0.8% Asian; 0.6% Native Hawaiian or other Pacific Islander (NH/OPI); 0.6% multi-race; and 0.6% American Indian or Alaska Native (AI/AN).

EXHIBIT 3-1

DISTRIBUTION OF RACE/ETHNICITY AMONG VETERAN VHA PATIENTS, FY13



Abbreviations applied throughout this chapter: AI/AN = American Indian or Alaska Native; Black = Black or African-American; NH/OPI = Native Hawaiian or other Pacific Islander.

Denominator: All Veterans who used any VHA care in FY13 (VHA outpatient care, inpatient care, pharmacy care, or Non-VA [Fee] Medical Care), referred to as “Veteran FY13 VHA patients” (Data source: WHEI Master Database).

Source: VHA National Health Equity Report 2016

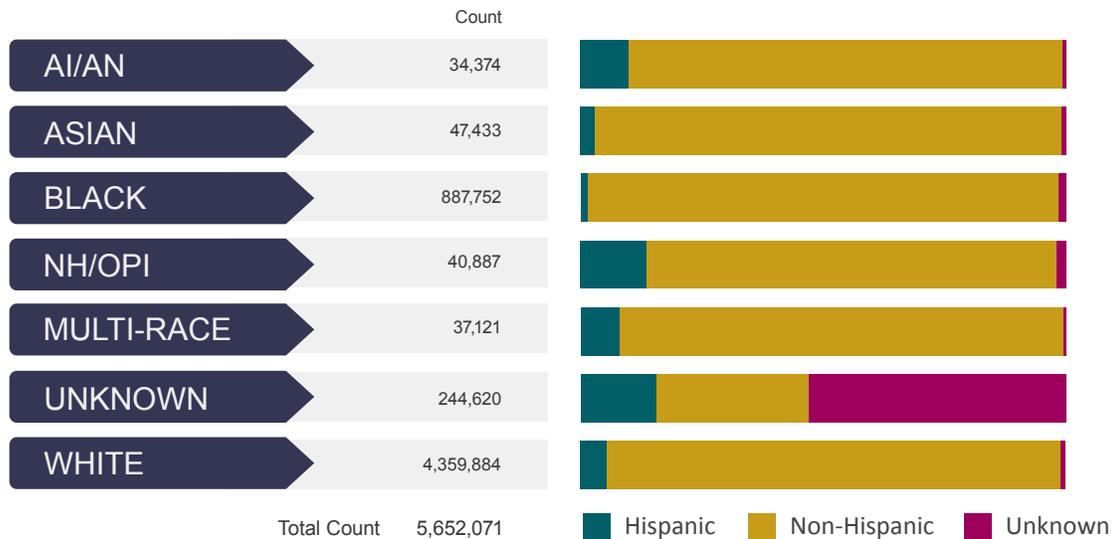
²¹ Race and ethnicity was assessed separately, then combined to create the race/ethnicity measure. The Hispanic group is comprised of all individuals reporting Hispanic ethnicity; all other groups are defined by race plus non-Hispanic ethnicity (or race plus Hispanic ethnicity missing). The unknown group is comprised of individuals where no specific race/ethnicity could be identified (i.e., because the only values for race and ethnicity were “unknown”, “other”, “none”, or “declined”, or if there were no values [i.e., missing] in any record for race and ethnicity). For complete reporting, the data is included for the group with unknown race/ethnicity; however, findings for this group are not discussed. The technical specifications for the race/ethnicity measure are described in more detail in the technical appendix.

In 1997, OMB issued its revised recommendations for the collection and use of race and ethnicity data by Federal agencies (Policy Directive 15) (Office of Management and Budget. Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. Federal Register, October 30, 1997. Available at: https://www.whitehouse.gov/omb/fedreg_1997standards). The OMB stated that its race and ethnicity categories were not anthropologic or scientifically based designations, but instead were categories that described the sociocultural construct of our society (OMB, 1997). Though ethnicity and race are assessed separately, there is not a consensus on whether race/ethnicity should be collected and reported as single versus separate identifications (see Issue 3 of: Office of Management and Budget. Standards for the Classification of Federal Data on Race and Ethnicity. Federal Register, August 28, 1995. Available at: https://www.whitehouse.gov/omb/fedreg_race/ethnicity/). Office of Management and Budget. Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. Federal Register, October 30, 1997. Available at: https://www.whitehouse.gov/omb/fedreg_1997standards), and many research and other reports present race and ethnicity data in the combined format. Since a component of monitoring disparities in VA is to benchmark against non-VA data, this chapter reports race and ethnicity data in the combined format. These categories will facilitate comparisons with published clinical studies and data collected by other agencies.

Compared with White Veterans, among NH/OPIs and AI/ANs, a much larger percentage are Hispanic (13.7% and 10.1%, respectively), and among Blacks and Asians, a much smaller percentage are Hispanic (1.6% and 3.1%, respectively) ([Exhibit 3-2](#)).

EXHIBIT 3-2

DISTRIBUTION OF ETHNICITY BY RACE OF VETERAN VHA PATIENTS, FY13



Note: AI/AN = American Indian or Alaska Native; Black = Black or African-American; NH/OPI = Native Hawaiian or other Pacific Islander. Missing = 1,235
Denominator: All Veterans who used any VHA care in FY2013 (VHA outpatient care, inpatient care, pharmacy care, or Non-VA [Fee] Medical Care), referred to as "Veteran FY2013 VHA patients" (Data source: WHEI Master Database).
Source: VHA National Health Equity Report 2016

IMPLICATIONS Based on U.S. Census projections, in 2010, 32.2% of the U.S. adult population (18 years and older) were a race or ethnicity other than non-Hispanic White alone (including 13.9% Hispanic).²² This group, referred to as "racial/ethnic minorities" increased in size by 29% over the past decade. The Census Bureau projects that by 2044, the U.S. population will become "majority minority" (49.7% White, 25.0% Hispanic, 12.7% Black, 7.9% Asian, 3.7% multi-racial).²³ The Veteran VA user population is somewhat less racially and ethnically diverse than the U.S. adult population, likely related to the age distribution of Veterans. However, reflecting U.S. population projections, the Veteran VA user population is expected to continue to become increasingly racially and ethnically diverse. The VHA Blueprint for Excellence describes themes, strategies, and activities that include improving performance (anticipating and meeting the unique needs of enrolled Veterans) and delivering high quality, Veteran-centered care. To meet these challenges for the increasingly diverse Veteran patient population, VA should monitor and report out quality and patient experience data by race/ethnicity. To facilitate measurement, tools for measuring parameters of interest by race/ethnicity should be incorporated into the next generation of the VA electronic health record user interface.

22 Population: Estimates and Projections by Age, Sex, Race/Ethnicity. Table 12. Resident Population Projections by Race, Hispanic Origin Status, and Age: 2010 and 2015. Available at: http://www.census.gov/compendia/statab/cats/population/estimates_and_projections_by_age_sex_raceethnicity.html.
 23 U.S. Census Bureau. Projections of the Size and Composition of the U.S. Population: 2014 to 2060. Current Population Reports. 2015;25-1143. Available at: <https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf>.

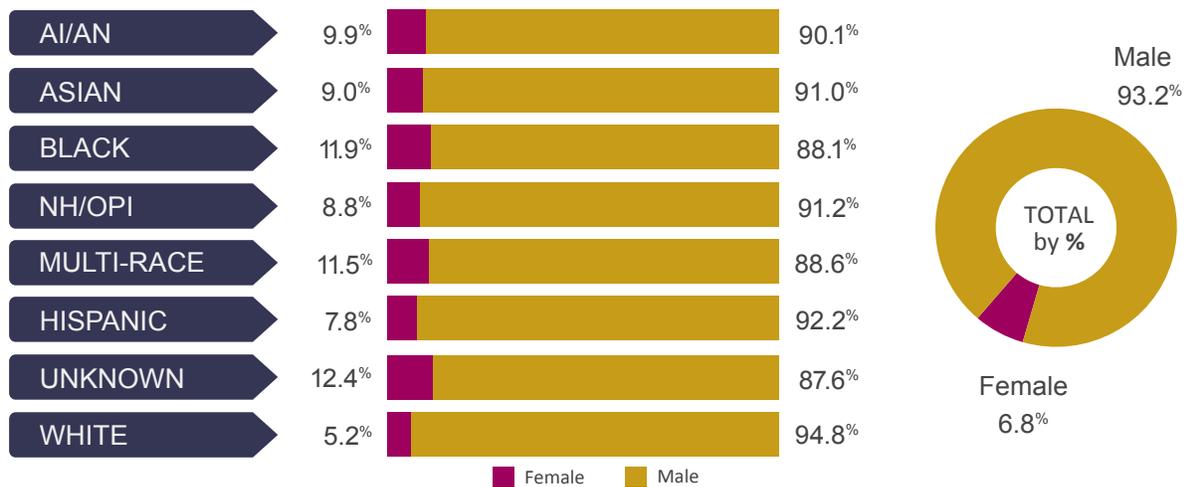
Section II: Sociodemographics

Gender by Race/Ethnicity

Overall, among FY13 Veteran patients, 6.8% were female. All racial/ethnic minority groups had much greater representation of females compared with Whites ([Exhibit 3-3](#)). In descending order of female representation, 11.9% of Blacks, 11.4% of multi-race individuals, 9.9% of AI/ANs, 9.0% of Asians, 8.8% of NH/OPIs, and 7.8% of Hispanics were female, in contrast to 5.2% of Whites.

EXHIBIT 3-3

PERCENT DISTRIBUTION OF GENDER BY RACE/ETHNICITY AMONG VETERAN VHA PATIENTS, FY13



Note: AI/AN = American Indian or Alaska Native; Black = Black or African-American; NH/OPI = Native Hawaiian or other Pacific Islander. Missing = 1,235

Denominator: All Veterans who used any VHA care in FY2013 (VHA outpatient care, inpatient care, pharmacy care, or Non-VA [Fee] Medical Care), referred to as "Veteran FY2013 VHA patients" (Data source: WHEI Master Database).

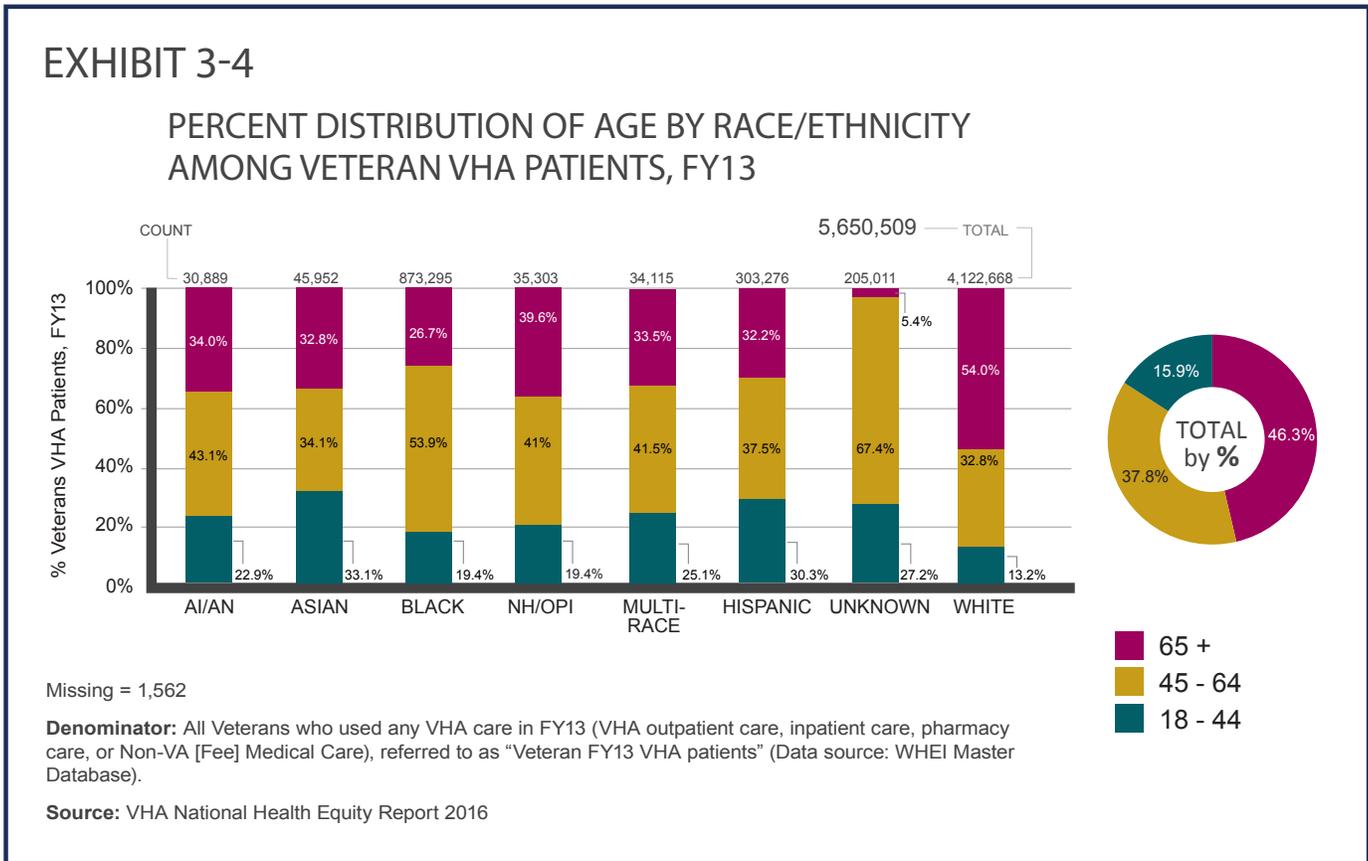
Source: VHA National Health Equity Report 2016

IMPLICATIONS The gender representation of women among racial/ethnic minority groups compared with Whites highlights the need for VA healthcare services that are both gender-sensitive and culturally-sensitive.²⁴ As non-VA care takes on a larger role in healthcare for Veterans, VA should identify strategies for arranging non-VA care that is also sensitive to the needs and healthcare delivery preferences of a diverse Veteran patient population.

24 Washington DL, Farmer MM, Mor SS, Canning M, Yano EM. Assessment of the Healthcare Needs and Barriers to VA Use Experienced by Women Veterans. *Med Care*. 2015;53:S23-S31.

Age by Race/Ethnicity

All racial/ethnic minority groups were substantially younger than Whites, with the mean age by race/ethnicity being: 57 for AI/ANs; 55 for Asians; 56 for Blacks; 59 for NH/OPIs; 56 for multi-race individuals; 55 for Hispanics; 51 for the group with unknown race/ethnicity; 64 for Whites; and 62 overall. In descending order by percent in the youngest age group, 33.1% of Asians, 30.3% of Hispanics, 25.1% of multi-race individuals, 22.9% of AI/ANs, and 19.4% each of Blacks and NH/OPIs were in the 18-44 year age group, in contrast to 13.2% of Whites ([Exhibit 3-4](#)). For all racial/ethnic minority groups, the most populous age group was the 45-64 year age group. By contrast, a majority of Whites (54.0%) were in the 65+ age group. The proportion of racial/ethnic minorities age 65+ was: 26.7% of Blacks, 32.2% of Hispanics, 32.8% of Asians, 33.5% of multi-race individuals, 34.0% of AI/ANs, and 39.6% of NH/OPIs.



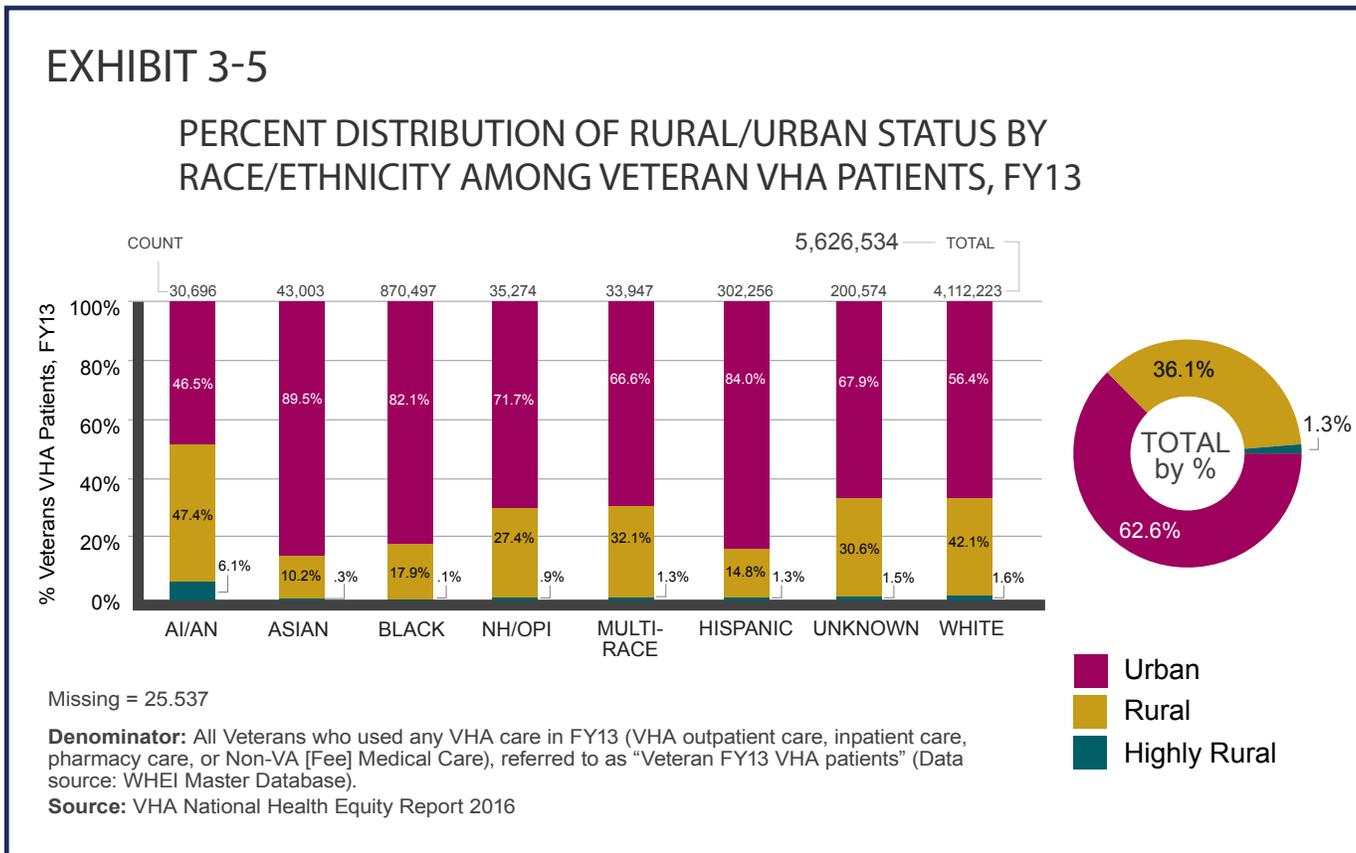
IMPLICATIONS With the influx into VA of an increasingly racially and ethnically diverse cohort of younger Veterans, attention should be directed toward the needs, risk behaviors, and psychosocial challenges of Veterans who are still relatively early in their life course. For example, in the National Survey of Women Veterans, barriers to care differed by age group.²⁵ These challenges might be compounded for racial/ethnic minorities.

25 Washington DL, Farmer MM, Mor SS, Canning M, Yano EM. Assessment of the Healthcare Needs and Barriers to VA Use Experienced by Women Veterans. *Med Care*. 2015;53:S23-S31.

Rural/Urban Status by Race/Ethnicity

Overall, 37.4% of Veteran patients lived in rural or highly rural settings. However, these percentages were much higher for American Indian/Alaska Native Veterans, with a majority (53.5%) of these Veterans residing in rural or highly rural settings ([Exhibit 3-5](#)). Among AI/AN Veteran patients, 6.1% lived in highly rural settings, in contrast to 1.6% of White Veteran patients, and 1.3% of Veteran patients overall. Other racial/ethnic groups were less likely than White Veteran patients to live in rural or highly rural settings.

Asian (89.5%), Hispanic (84.0%), and Black or African-American (82.1%) Veteran patient groups had particularly high percentages residing in an urban environment. This was in contrast to White (56.4%) and AI/AN (46.5%) Veteran patient groups.



IMPLICATIONS Rural residing residents often experience geographic challenges to accessing healthcare. The VA and Indian Health Service (IHS) have executed an agreement to share resources to improve access and health outcomes for AI/AN Veterans. In fiscal years 2002 and 2003, of IHS enrollees who used VA and/or IHS, 25% used both healthcare organizations, 28% used VA only, and 46% used IHS only.²⁶ VA should continue identifying strategies to address healthcare access and care coordination targeted toward rural-residing Veteran patients.

Urban residence may have its own set of challenges, particularly for racial/ethnic minority groups that live in residentially segregated, highly urban environments.^{27, 28} VA research should be directed toward investigating neighborhood effects and the effects of other social determinants of health on the health behavior and outcomes of racially/ethnically diverse Veteran patients.

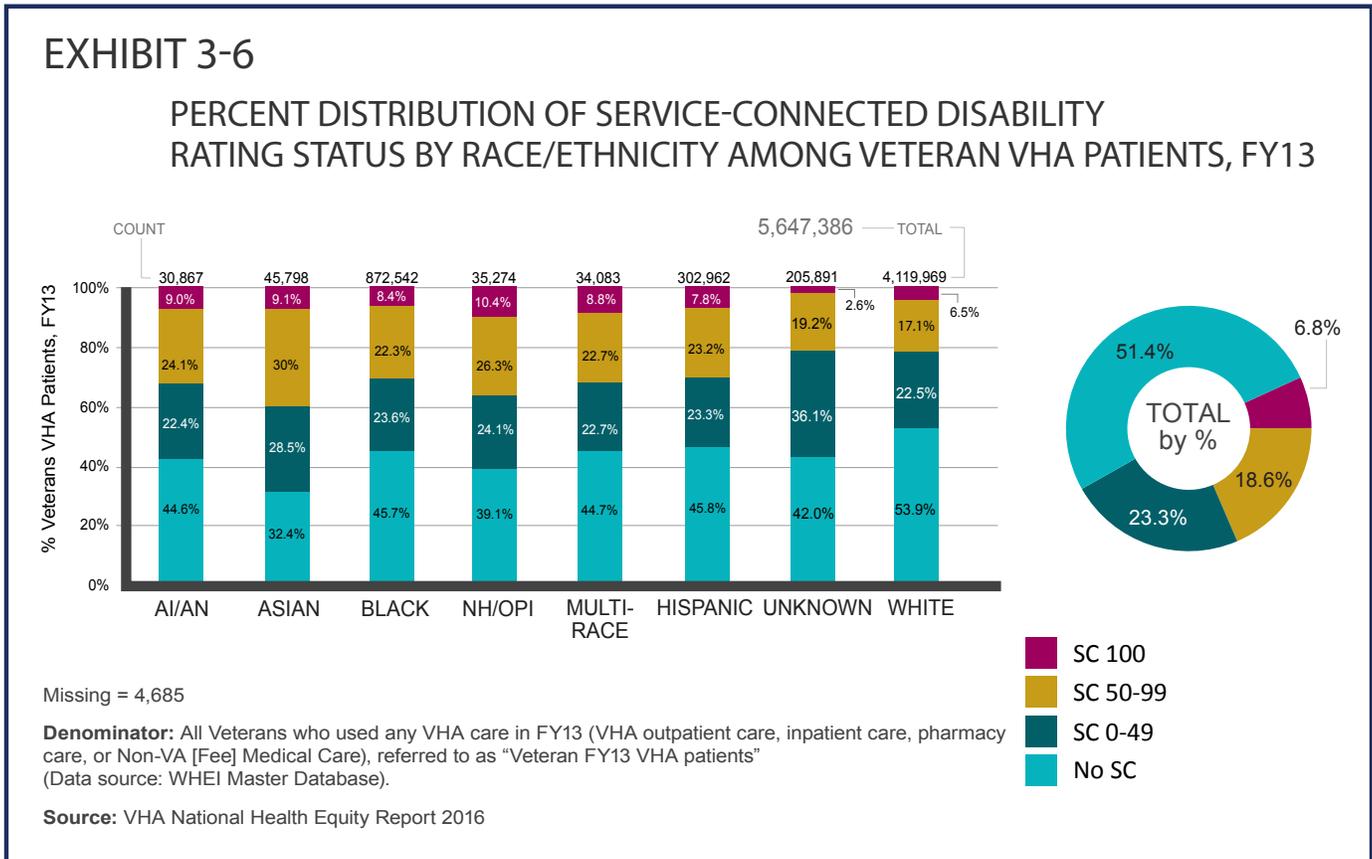
26 Kramer BJ, Wang M, Jouldjian S, Lee ML, Finke B, Saliba D. Veterans Health Administration and Indian Health Service: healthcare utilization by Indian Health Service enrollees. *Med Care*. 2009;47(6):670-6

27 Inagami S, Borrell LN, Wong MD, Fang J, Shapiro MF, Asch SM. Residential segregation and Latino, black and white mortality in New York City. *J Urban Health*. 2006;83(3):406-20.

28 Lee H, Kang HM, Ko YJ, Kim HS, Kim YJ, Bae WK, Park S, Cho B. Influence of urban neighbourhood environment on physical activity and obesity-related diseases. *Public Health*. 2015. pii: S0033-3506(15)00238-3.

Service-Connected Disability Rating Status by Race/Ethnicity

Overall, about one-half (48.6%) of Veteran patients had service-connected disabilities. All racial/ethnic minority Veteran patient groups, compared with Whites, were more likely to have a service-connected disability. In descending order by proportion, the percent of each group having a service-connected disability was: 67.6% of Asians; 60.9% of NH/OPIs; 55.5% of AI/ANs; 55.3% of multi-racial individuals; 54.3% of Blacks or African-Americans; 54.2% of Hispanics; and 46.1% of Whites ([Exhibit 3-6](#)).



IMPLICATIONS Having a service-connected disability rating is an important facilitator of VA healthcare access.^{29,30} This may be particularly relevant for racial/ethnic minority groups that have been traditionally underserved in non-VA healthcare settings.³¹ An important caveat in interpreting data on service-connected disability ratings by race/ethnicity, is that racial/ethnic variations in disability claims were not examined; there is mixed evidence on whether those variations are a concern.^{32, 33}

29 Washington DL, Harada ND, Villa VM, et.al. Racial variations in Department of Veterans Affairs ambulatory care use and unmet healthcare needs. *Mil Med.* 2002;167:235-41.

30 Washington DL, Yano EM, Simon B, Sun S. To use or not to use. What influences why women Veterans choose VA healthcare. *J Gen Intern Med.* 2006;21 Suppl 3:S11-8

31 Murdoch M, van Ryn M, Hodges J, Cowper D. Mitigating effect of Department of Veterans Affairs disability benefits for post-traumatic stress disorder on low income. *Mil Med.* 2005;170(2):137-40.

32 Murdoch M, Hodges J, Cowper D, Fortier L, van Ryn M. Racial disparities in VA service connection for posttraumatic stress disorder disability. *Med Care.* 2003;41(4):536-49.

33 Grubaugh AL, Elhai JD, Ruggiero KJ, Egede LE, Naifeh JA, Frueh BC. Equity in Veterans Affairs disability claims adjudication in a national sample of Veterans. *Mil Med.* 2009;174(12):1241-6.

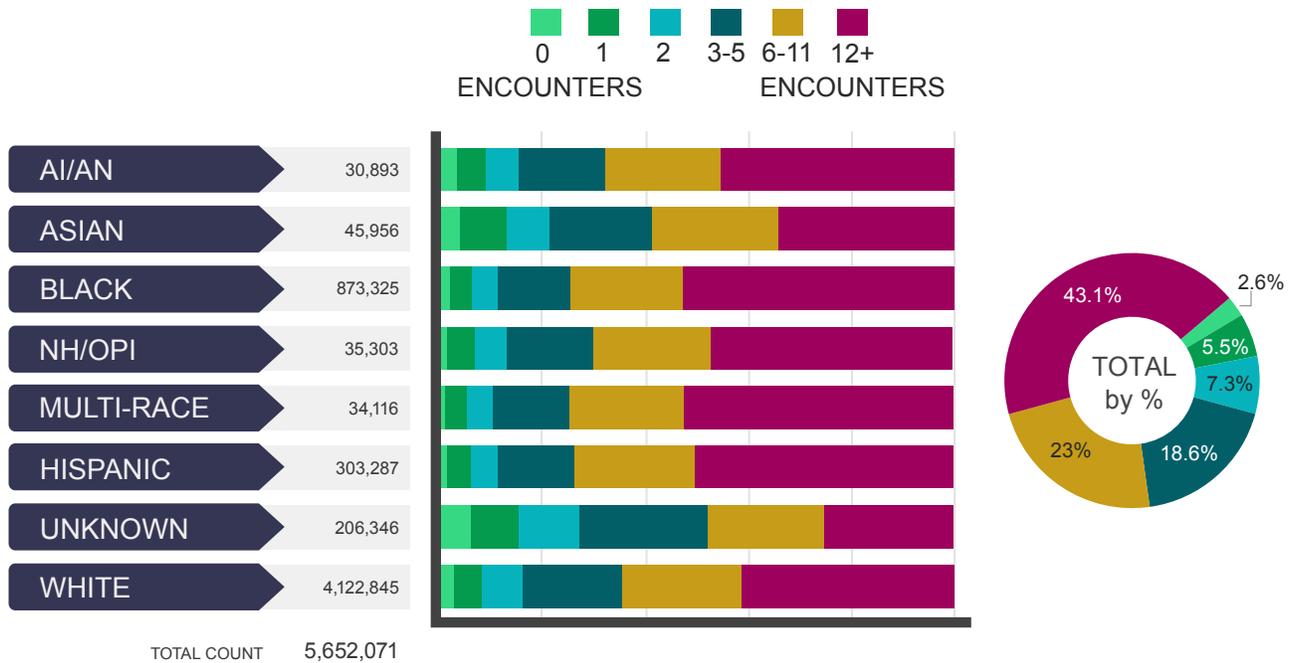
Section III: Utilization

VHA Outpatient Encounters by Race/Ethnicity

VHA outpatient encounters are the portion of care that occurs at VHA facilities (fee outpatient services are presented at the end of this Section on Utilization). The vast majority of FY13 Veteran patients (97.4%) had one or more VHA outpatient encounters. In FY13, approximately two-thirds of Veteran patients (66.1%) had six or more encounters. Multi-race (74.7%), Black or African-American (74.6%) and Hispanic (73.8%) Veteran patients were more likely than White Veteran patients (64.6%) to have six or more encounters, whereas Asian Veteran patients (58.7%) were less likely to have this ([Exhibit 3-7](#)).

EXHIBIT 3-7

PERCENT DISTRIBUTION OF VHA OUTPATIENT ENCOUNTERS BY RACE/ETHNICITY AMONG VETERAN VHA PATIENTS, FY13



Abbreviations applied throughout this chapter: AI/AN = American Indian or Alaska Native; Black = Black or African-American; NH/OPI = Native Hawaiian or other Pacific Islander.

Denominator: All Veterans who used any VHA care in FY13 (VHA outpatient care, inpatient care, pharmacy care, or Non-VA [Fee] Medical Care), referred to as "Veteran FY13 VHA patients" (Data source: WHEI Master Database).

Source: VHA National Health Equity Report 2016

IMPLICATIONS Among Veterans who use VA care, most racial/ethnic minority group members had a greater number of encounters than White Veteran patients. In keeping with the Blueprint for Excellence transformational actions related to improving performance, VA should assure that care delivered is based on Veteran demographics, preferences and care needs and an evolving healthcare delivery model (transformational action 1c).³⁴

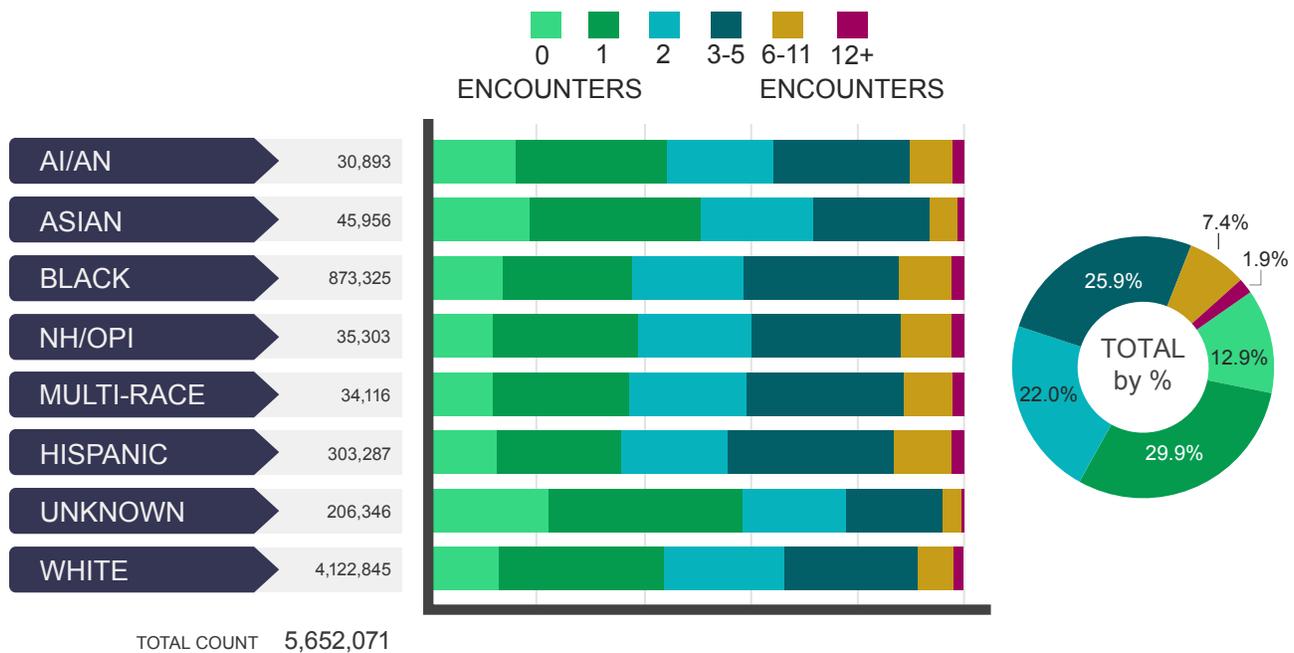
34 Veterans Health Administration, Department of Veterans Affairs. *Veterans Health Administration Blueprint for Excellence*. [online]. (September 21, 2014).

Primary Care Encounters by Race/Ethnicity

The majority (87.1%) of FY13 Veteran patients utilized primary care. However, primary care use was somewhat lower for Asian Veteran patients (81.9%) than for other groups. The number of primary care encounters varied by race/ethnicity. One-third (33.8%) of White Veteran patients made three or more primary care encounters, whereas Hispanic (44.5%), Black or African-American (41.4%), multi-race (40.9%), and NH/OPI (40.0%) Veteran patients were more likely to have three or more primary care encounters ([Exhibit 3-8](#)). Asians (28.5%) were less likely than Whites to have three or more primary care encounters; and AI/ANs (35.8%) had similar numbers of primary care encounters as Whites. Less than 10% of Veteran patients had six or more primary care encounters. The groups that were most likely to have six or more encounters were Hispanics (13.0%) and Blacks or African-Americans (12.1%); this was in contrast to 8.6% of Whites and 6.5% of Asians.

EXHIBIT 3-8

PERCENT DISTRIBUTION OF PRIMARY CARE ENCOUNTERS BY RACE/ETHNICITY AMONG VETERAN VHA PATIENTS, FY13



Abbreviations applied throughout this chapter: AI/AN = American Indian or Alaska Native; Black = Black or African-American; NH/OPI = Native Hawaiian or other Pacific Islander.

Denominator: All Veterans who used any VHA care in FY2013 (VHA outpatient care, inpatient care, pharmacy care, or Non-VA [Fee] Medical Care), referred to as "Veteran FY2013 VHA patients" (Data source: WHEI Master Database).

Source: VHA National Health Equity Report 2016

IMPLICATIONS The primary care clinical setting, utilizing Patient-Aligned Care Teams (PACT), is the preferred setting within VA for coordinating care delivery for most patients, particularly those with complex care needs. Racial/ethnic minority groups other than Asians, have a similar or greater number of VA primary care encounters as White Veteran patients. Achievement of PACT initiative goals varies across VA sites, with greater PACT implementation associated with higher patient satisfaction, higher care quality, and lower ambulatory care sensitive hospitalizations and emergency department use.³⁵ Future steps in evaluating VA primary care use by race/ethnicity should examine variations in these important correlates of PACT implementation by race/ethnicity.

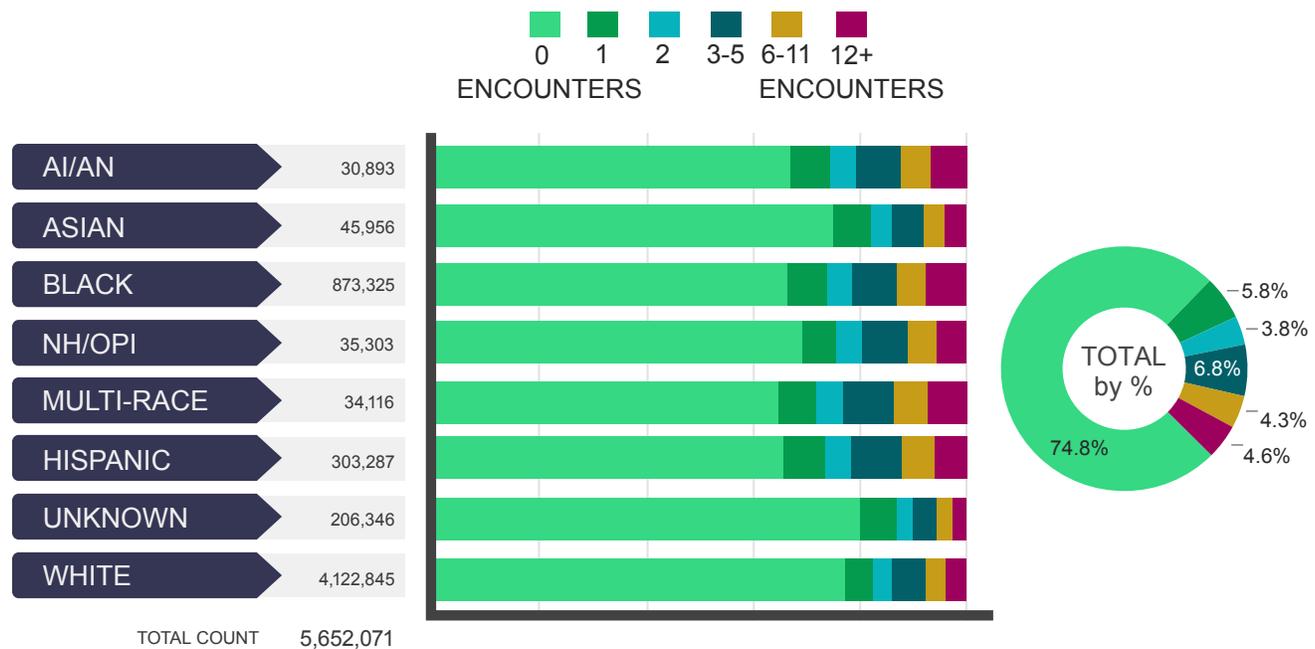
35 Nelson KM, Helfrich C, Sun H, Hebert PL, Liu CF, Dolan E, et. al. Implementation of the patient-centered medical home in the Veterans Health Administration: associations with patient satisfaction, quality of care, staff burnout, and hospital and emergency department use. *JAMA Intern Med.* 2014;174(8):1350-8.

Mental Health/Substance Use Disorder Encounters by Race/Ethnicity

One-quarter (25.2%) of FY13 Veteran patients utilized VA care for mental health and substance use disorders. All racial/ethnic minority groups were more likely than White Veteran patients to utilize this care. The percent of each group who had one or more mental health or substance use disorder encounters, in descending order, was: multi-race (35.4%), Hispanic (34.5%), Black or African-American (33.8%), AI/AN (33.4%), NH/OPI (31.0%), and Asian (25.0%) ([Exhibit 3-9](#)). Overall, 8.9% of Veteran patients had six or more encounters for mental health and substance use disorder care. Among Veteran patients with one or more encounters for mental health and substance use disorder care, 35.1% had six or more encounters, including: 39.0% of Blacks; 38.8% of multi-race individuals; 37.4% of AI/ANs; 35.7% of NH/OPIs; 35.5% of Hispanics; 34.2% of Whites; and 31.9% of Asians.

EXHIBIT 3-9

PERCENT DISTRIBUTION OF MENTAL HEALTH/SUBSTANCE USE DISORDER ENCOUNTERS BY RACE/ETHNICITY AMONG VETERAN VHA PATIENTS, FY13



Abbreviations applied throughout this chapter: AI/AN = American Indian or Alaska Native; Black = Black or African-American; NH/OPI = Native Hawaiian or other Pacific Islander.

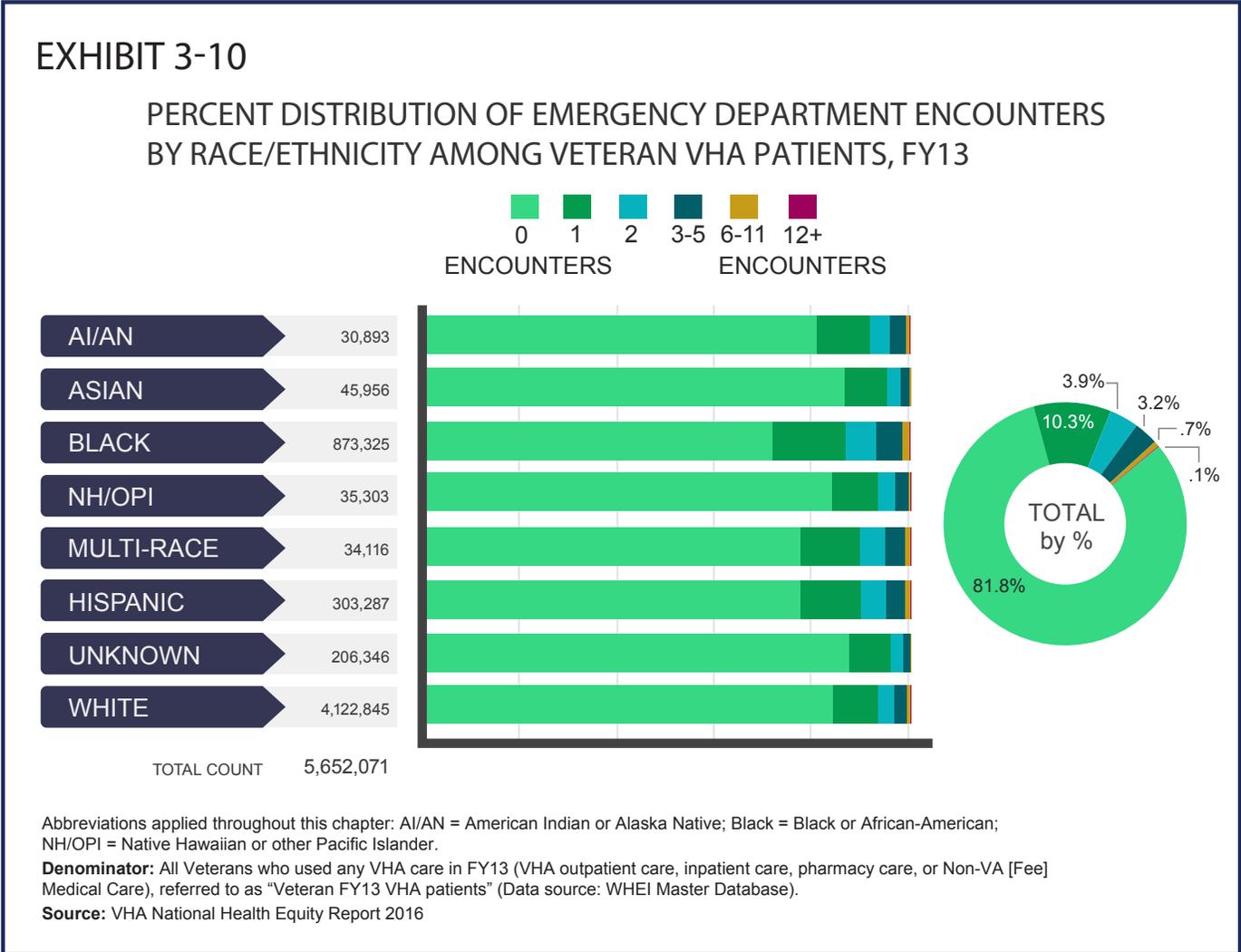
Denominator: All Veterans who used any VHA care in FY13 (VHA outpatient care, inpatient care, pharmacy care, or Non-VA [Fee] Medical Care), referred to as "Veteran FY13 VHA patients" (Data source: WHEI Master Database).

Source: VHA National Health Equity Report 2016

IMPLICATIONS Racial/ethnic minority group members were more likely than White Veteran patients to have encounters for VA mental health and substance use disorder care. Data on this use should be correlated with mental health and substance use disorder diagnoses and symptoms to gauge if this level of use meets need for this care. For patients who initiate care for mental health and substance use disorders, retention in care is sometimes a concern. Though retention in care was not assessed with this data, there were not wide variations by race/ethnicity in the proportion of users of mental health and substance use disorder care with six or more encounters.

Emergency Department Encounters by Race/Ethnicity

Overall, 18.2% of Veteran patients had one or more VA emergency department encounters in FY13. There was significant variation by racial/ethnic group in use of VA emergency department care, with 28.6% of Black or African-American, 22.9% of Hispanic, 22.7% of multi-race, 19.5% of AI/AN, 16.2% of NH/OPI, 16.0% of White, and 13.6% of Asian Veteran patients making one or more encounters in FY13 ([Exhibit 3-10](#)).



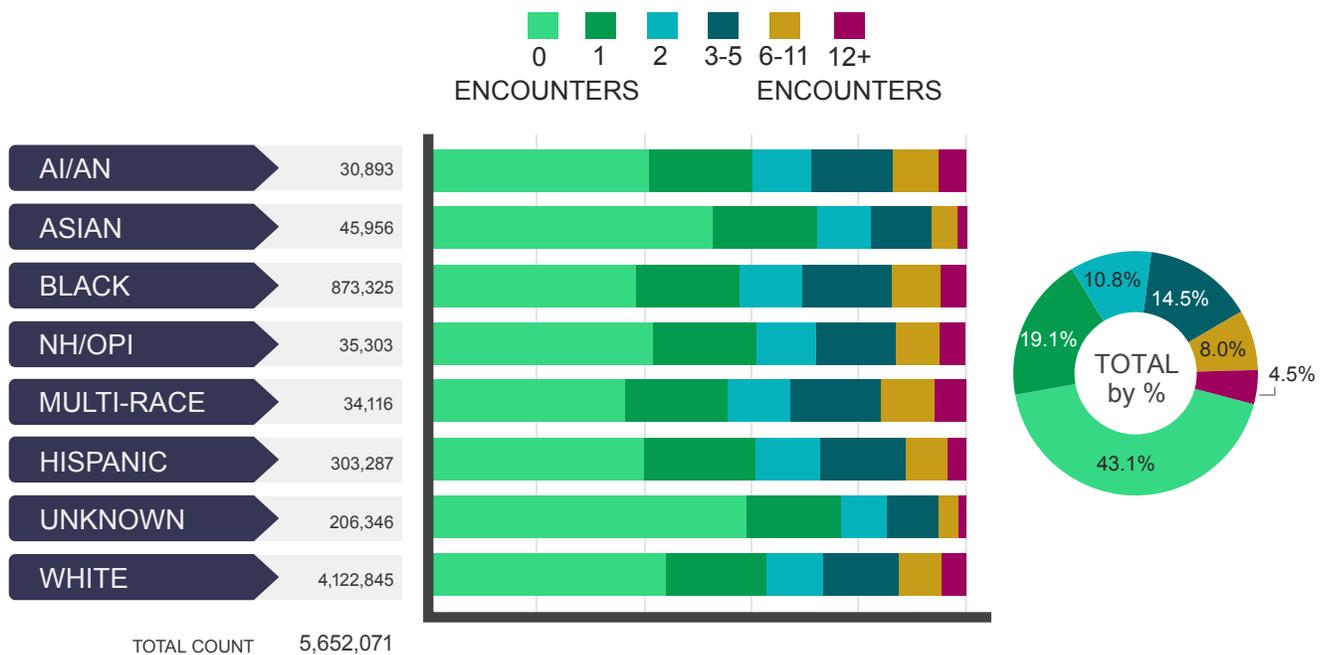
IMPLICATIONS Emergency department use may be a marker for primary care access barriers, poor care coordination, or unmet needs. Characteristics of emergency department users and encounters should be explored, to better understand the correlates and outcomes of the racial/ethnic variations in VA emergency department use.

Telephone Encounters by Race/Ethnicity

More than one-half (56.9%) of Veteran patients had one or more VA telephone encounters in FY13. There was variation by racial/ethnic group in use of VA telephone care, with 64.0% of multi-race, 61.9% of Black or African-American, 60.4% of Hispanic, 59.4% of AI/AN, 58.6% of NH/OPI, 56.3% of White, and 47.5% of Asian Veteran patients having one or more telephone encounters in FY13. One in eight (12.5%) of Veteran patients had six or more telephone encounters ([Exhibit 3-11](#)). The frequency by race/ethnicity of having 6 or more telephone encounters was similar to the rank order for any use of telephone care.

EXHIBIT 3-11

PERCENT DISTRIBUTION OF TELEPHONE ENCOUNTERS BY RACE/ETHNICITY AMONG VETERAN VHA PATIENTS, FY13



Abbreviations applied throughout this chapter: AI/AN = American Indian or Alaska Native; Black = Black or African-American; NH/OPI = Native Hawaiian or other Pacific Islander.

Denominator: All Veterans who used any VHA care in FY13 (VHA outpatient care, inpatient care, pharmacy care, or Non-VA [Fee] Medical Care), referred to as "Veteran FY13 VHA patients" (Data source: WHEI Master Database).

Source: VHA National Health Equity Report 2016

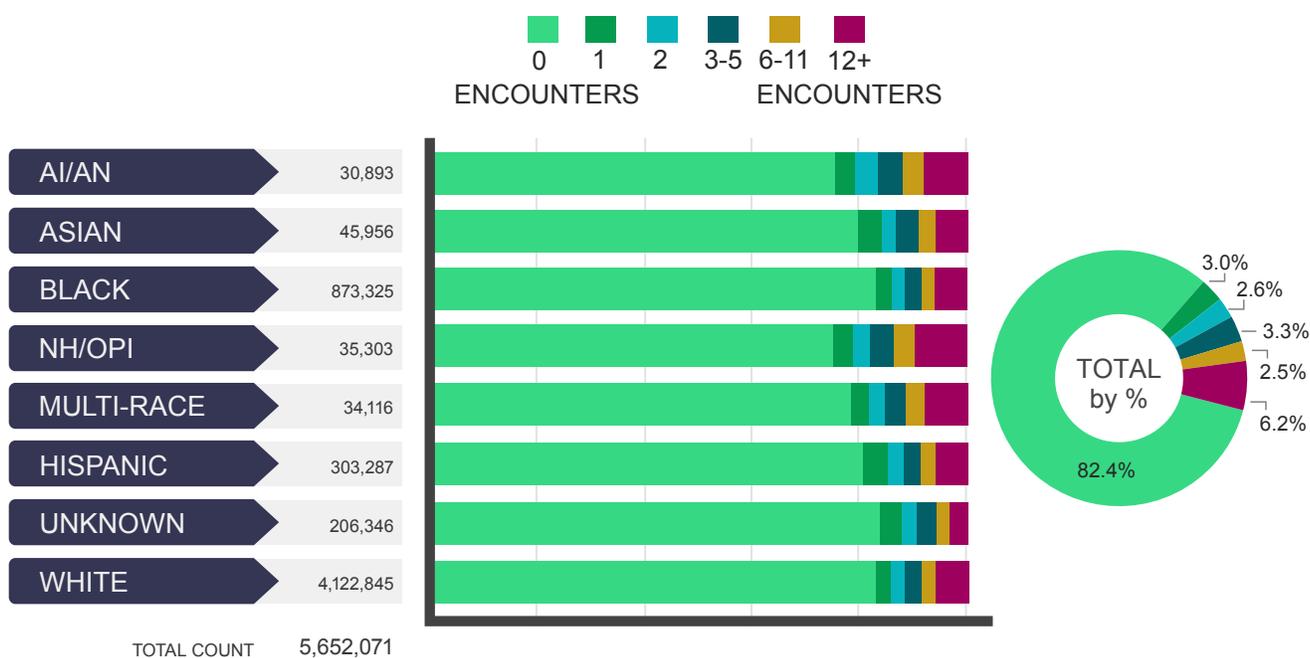
IMPLICATIONS Telephone care is an important part of remote communication between VA patients and their providers. This modality of care appears to be somewhat more important for most racial/ethnic minority groups compared with White Veteran patients.

Fee Outpatient Services by Race/Ethnicity

In FY13, 17.6% of Veteran patients used one or more fee outpatient services and 8.7% used six or more. There was significant racial/ethnic variation in use of fee outpatient services, with most racial/ethnic groups using a greater number of fee services than White Veteran patients (*Exhibit 3-12*). The percent of each group who used one or more fee outpatient services, in descending order, was: NH/OPI (25.2%), AI/AN (24.8%), multi-race (21.9%), Asian (20.5%), Hispanic (19.8%), White (17.4%), and Black or African-American (17.3%). The percent of each group who used six or more fee outpatient services had a similar rank order – NH/OPI (13.8%), AI/AN (12.1%), multi-race (11.7%), Asian (9.3%), Hispanic (8.8%), White (8.8%), and Black or African-American (8.5%).

EXHIBIT 3-12

PERCENT DISTRIBUTION OF FEE OUTPATIENT SERVICES BY RACE/ETHNICITY AMONG VETERAN VHA PATIENTS, FY13



Abbreviations applied throughout this chapter: AI/AN = American Indian or Alaska Native; Black = Black or African-American; NH/OPI = Native Hawaiian or other Pacific Islander.

Denominator: All Veterans who used any VHA care in FY13 (VHA outpatient care, inpatient care, pharmacy care, or Non-VA [Fee] Medical Care), referred to as “Veteran FY13 VHA patients” (Data source: WHEI Master Database).

Source: VHA National Health Equity Report 2016

IMPLICATIONS VA fee care is an important adjunct to VA outpatient services for many of the Veterans served by VA. Higher rates of fee use by NH/OPI and AI/AN Veteran patients may relate to geographic characteristics of their residential areas. There are also select services for which VA fee care is often used and use of fee care could vary by patient characteristics that are correlated with need for these services. Unlike VA outpatient services that are delivered on-site, the quality of VA fee care is not systematically monitored. VA should identify strategies for systematically monitoring the quality of VA fee care, particularly given the lower quality of care and greater racial/ethnic disparities in care that have been documented in community settings compared to VA outpatient care. As VA monitors the patient experience of care, they should include assessments of VA fee care stratified by race/ethnicity.

Section IV: Conditions

This section reports on diagnosed conditions (202 clinically meaningful groups of ICD-9-CM diagnosis codes) for each racial/ethnic group. To facilitate comparisons among groups, data on diagnosed conditions are summarized in three ways. First, as described in detail in the technical appendix, conditions were grouped into 17 broad, higher-order major disease categories. The percent of each racial/ethnic group that received one or more diagnoses in each category in FY13 is given in [Exhibit 3-13](#). This is followed by [Exhibit 3-14](#), which provides the details of the percent of each racial/ethnic group that was diagnosed with each condition. Second, the conditions diagnosed in 20% or more of each racial/ethnic group are listed in [Exhibit 3-15](#). Third, for the overall top 20 diagnosed conditions in FY13, the difference in percent diagnosed between each racial/ethnic group and White Veteran patients is given in [Exhibit 3-16](#).

Categories of Diagnosed Conditions by Race/Ethnicity

The categories of diagnosed conditions and the percent of each racial/ethnic group that received one or more diagnoses in each category are listed in [Exhibit 3-13](#). The diagnosed conditions within each category are listed in [Exhibit 3-14](#).

The category with the highest diagnosed condition rate was *endocrine/metabolic/nutritional*, which was the #1 category of diagnosed conditions for all racial/ethnic groups except for Blacks or African-Americans, for which it was the #2 diagnosed condition category. Across most groups, 59–66% of Veterans received diagnoses in that category (with highest diagnosed condition rate being 65.7% for NHO/PIs and 65.6% for Whites), though the diagnosed condition rate in Asians was somewhat lower (51.9%).

Two other categories with diagnosed condition rates of approximately 48–62% for each racial/ethnic group were the *cardiovascular category* and the *musculoskeletal category*. For Blacks or African-Americans, the *cardiovascular category* was the category with the highest diagnosed condition rate. In the *cardiovascular category*, the highest diagnosed condition rates were 62.3% for Whites and 62.0% for Blacks or African-Americans. In the *musculoskeletal category*, all racial/ethnic minority groups other than Asians had higher diagnosed condition rates compared with White Veteran patients. These musculoskeletal diagnosed condition rates ranged from approximately 54–57% for most groups, compared with approximately 48% for Whites and Asians.

In the *sense organ category* (which includes vision and hearing conditions), 40–44% of each racial/ethnic group received a diagnosis.

There were racial/ethnic variations in the diagnosed condition rates for the *mental health/substance use disorder category*; greater than 40% of multi-race (43.2%), AI/AN (42.5%), and Hispanic (41.3%) Veteran patients received diagnoses in that category, in contrast to 31.5% of White Veteran patients.

Across all categories, Asian Veteran patients tended to have the lowest diagnosed condition rate.

EXHIBIT 3-13

PERCENT DISTRIBUTION OF DIAGNOSED CONDITION CATEGORIES
BY RACE/ETHNICITY AMONG VETERAN VHA PATIENTS, FY13

	AI/AN	Asian	Black	NH/OPI	Multi-race	Hispanic	Unknown	White	TOTAL
Count	30,893	45,956	873,325	35,303	34,116	303,287	206,346	4,122,845	5,652,071
CONDITION	%	%	%	%	%	%	%	%	%
Infectious Disease	21.8	15.1	28.8	22.1	26.0	24.5	13.8	19.8	21.3
Endocrine/ Metabolic/ Nutritional	59.0	51.9	59.8	65.7	62.1	62.7	44.7	65.6	63.6
Cardiovascular	53.4	46.0	62.0	60.4	57.8	51.9	37.7	62.3	60.6
Respiratory	27.2	22.9	28.2	27.8	30.6	25.3	18.3	27.9	27.4
Gastrointestinal	33.0	25.4	35.1	33.8	36.2	35.2	23.9	35.2	34.7
Urinary	14.4	12.2	19.0	17.6	17.2	15.9	7.1	16.4	16.4
Reproductive Health	20.6	18.5	29.3	23.5	25.4	23.6	14.0	24.2	24.5
Breast	0.9	0.5	1.3	0.9	1.1	0.8	0.7	0.7	0.8
Cancer	7.7	5.0	9.7	9.2	9.1	7.5	3.4	10.9	10.2
Hematologic/Immunologic	9.4	6.1	13.1	10.6	11.3	9.8	4.5	10.2	10.4
Musculoskeletal	54.6	47.8	56.6	55.0	57.3	53.6	41.8	48.3	49.8
Neurologic	25.2	20.4	25.2	25.4	27.2	25.5	13.9	24.6	24.3
Mental Health/SUD	42.5	28.1	39.9	38.5	43.2	41.3	24.8	31.5	33.2
Sense Organ	40.9	41.5	40.2	44.0	42.5	42.2	26.7	43.9	42.6
Dental	9.9	9.5	11.8	11.9	11.9	10.6	3.9	7.4	8.2
Dermatologic	19.9	16.8	20.1	21.5	23.3	20.1	13.6	22.8	21.9
Other	51.3	40.2	54.3	49.3	54.3	49.2	37.1	45.4	46.8

Denominator: All Veterans who used any VHA care in FY13 (VHA outpatient care, inpatient care, pharmacy care, or Non-VA [Fee] Medical Care), referred to as "Veteran FY13 VHA patients" (Data source: WHEI Master Database).

Source: VHA National Health Equity Report 2016

Individual Diagnosed Conditions by Race/Ethnicity

Exhibit 3-14 contains the percent distribution of diagnosed conditions by race/ethnicity among Veterans and is available in the supplemental materials ([Exhibit 3-14](#)).

IMPLICATIONS A majority of Veteran patients in most racial/ethnic groups were diagnosed with conditions in the endocrine / metabolic / nutritional, cardiovascular, and musculoskeletal categories. Despite their younger age (Exhibit 3-6 and Exhibit 3-7), Black or African-American, NH/OPI, multi-race individuals, and Hispanics had similar or near similar rates of diagnosed conditions as White Veteran patients in endocrine / metabolic / nutritional or cardiovascular categories. Racial/ethnic differences in risk factors for conditions in these categories, and variations in prevention activities should be explored.

The musculoskeletal category was an important source of diagnosed conditions for a majority of racial/ethnic minorities. Inadequate pain control and the potential for opioid overuse are both important concerns for Veterans with musculoskeletal conditions.^{36, 37} The higher diagnosed prevalence of musculoskeletal conditions among racial/ethnic Veteran patients suggests the potential for those issues to have greater relevance for racial/ethnic minority groups; further work should be done to evaluate the extent of these concerns.

The mental health category was also an important source of diagnosed conditions for a higher proportion of racial/ethnic minorities than for White Veterans. Care for mental health / substance use disorders is an area that VA has special expertise in, particularly for conditions related to military service. Healthcare systems outside of VA often have less coverage and services for care of mental health / substance use disorders, and when they do provide that coverage, they often have less focused expertise on treatment of issues related to service-connected disability.³⁸

Several categories with lower diagnosed condition rates are nonetheless also important causes of disability (e.g., cancer) and impaired health related quality of life (e.g., dental issues).

36 Pletcher MJ, Kertesz SG, Kohn MA, Gonzales R. Trends in Opioid Prescribing by Race/Ethnicity for Patients Seeking Care in US Emergency Departments. *JAMA*. 2008;299(1):70-78.

37 Trafton JA, Lewis ET. Improving Opioid Prescribing Practices. *VA Health Services Research & Development Forum*. 2012 August. Available at: <http://www.hsrd.research.va.gov/publications/forum/aug12/aug12-3.cfm>.

38 Fredricks TR, Nakazawa M. Perceptions of Physicians in Civilian Medical Practice on Veterans' Issues Related to Healthcare. *J Am Osteopath Assoc*. 2015;115:360-8.

Conditions Diagnosed in $\geq 20\%$ of a Racial/Ethnic Group

Eleven of the conditions were diagnosed in 20% (rounded) or more of one or more racial/ethnic groups ([Exhibit 3-15](#)). The top three diagnosed conditions in rank order in each racial/ethnic group were: #1 hypertension; #2 lipid disorders; and #3 diabetes mellitus. The highest diagnosed condition rate for hypertension was among Blacks or African-Americans (55.7%). The highest diagnosed condition rate for lipid disorders was among Whites (50.2%). There was relatively less variation in the diagnosed condition rate for diabetes mellitus, which was diagnosed in 22-28% of each group. Spine and joint disorders were an important cause of disability, as were refraction (vision) disorders and hearing problems. Post-traumatic stress disorder (PTSD) and depression were more commonly diagnosed among AI/ANs than White Veteran patients (with PTSD diagnosed in 20.7% of AI/ANs, 12.1% of the overall Veteran VHA user population, and 11.1% of Whites).

EXHIBIT 3-15

CONDITIONS DIAGNOSED IN $\geq 20\%$ OF A RACIAL/ETHNIC GROUP

Count	AI/AN 30,893	Asian 45,956	Black 873,325	NH/OPI 35,303	Multi-race 34,116	Hispanic 303,287	Unknown 206,346	White 4,122,845	TOTAL 5,652,071
CONDITIONS	%	%	%	%	%	%	%	%	%
Hypertension	43.9	39.3	55.7	51.8	48.7	44.5	31.0	51.7	51.0
Lipid Disorders	39.7	37.4	39.3	48.5	44.0	43.7	31.1	50.2	47.3
Diabetes Mellitus	26.1	22.1	26.2	28.3	24.9	26.7		23.6	23.8
Refraction Disorders			19.9	20.4	20.9	21.2			
Dermatologic Disorders – Other					19.6				
Spine Disorders – Lumbosacral	20.7		21.6	21.0	22.3	22.2			
Hearing Problems								20.3	17.6
Joint Disorders - Lower Extremity	19.5		21.9		20.3				
Depression, Possible – Other	19.7				20.6				
Overweight / Obesity						19.8			
PTSD	20.7								

Key: Grayed out cells indicate conditions in which the diagnosed prevalence in a group is $< 20\%$ (rounded).

Denominator: All Veterans who used any VHA care in FY13 (VHA outpatient care, inpatient care, pharmacy care, or Non-VA [Fee] Medical Care), referred to as “Veteran FY13 VHA patients” (Data source: WHEI Master Database).

Source: VHA National Health Equity Report 2016

IMPLICATIONS Veteran VHA users had higher diagnosed rates of many conditions compared with the broader U.S. population, including rates for the top three diagnosed conditions – hypertension, lipid disorders, and diabetes mellitus. Potential explanations for this finding include higher underlying rates of these disorders, and higher diagnosis rates. The U.S. Department of Health and Human Services estimated that approximately 8% of U.S. adults have undiagnosed hypertension, 8% have undiagnosed hypercholesterolemia, 3% have undiagnosed diabetes, and 15% have one or more of the three conditions undiagnosed.³⁹ In NHANES 1999-2006 data, the proportion of U.S. adults who had undiagnosed hypertension, hypercholesterolemia, or diabetes was similar across racial/ethnic groups. Given the systematic preventive screening in place in VHA, these rates of undiagnosed conditions are not likely to be higher than U.S. population estimates. Thus, compared with the broader U.S. adult population, Veteran VHA users appear to have a higher underlying prevalence of these disorders.

HYPERTENSION. In the National Health and Nutrition Examination Survey, United States, 2007-2010, the age-adjusted prevalence of hypertension among adults aged ≥ 18 years (age adjusted to the 2000 U.S. standard population) was 29.6% overall.⁴⁰ By race/ethnicity, the age-adjusted prevalence of hypertension among U.S. adults was: 28.6% among non-Hispanic Whites; 41.3% among non-Hispanic Blacks; and 27.7% among Hispanics. Compared to the U.S. population, the diagnosed rate of hypertension is much higher among Veteran VHA users, though the Black-White difference in those rates is significantly attenuated. Among U.S. adults with hypertension, the rates of blood pressure control (defined as an average systolic blood pressure <140 mmHg and an average diastolic blood pressure <90 mmHg) in 2007-2010 was: 48.0% overall; 52.6% among non-Hispanic Whites; 42.5% among non-Hispanic Blacks; and 34.4% among Hispanics – indicating a racial/ethnic disparity in hypertension control. Prior VA data, limited to Black-White comparisons, found durable disparities in blood pressure control. Given the high rates of diagnosed hypertension, and the known racial and ethnic disparities in hypertension control in the U.S. population, current rates of hypertension control should be systematically assessed within VHA for all racial/ethnic groups.

LIPID DISORDERS. AI/ANs, Asians, and Blacks had lower diagnosed rates of lipid disorders compared with Whites. This is similar to the Black-White findings reported in NHANES, which reported overall lower levels of hypercholesterolemia among U.S. adults (26.0%), and higher rates in Whites (26.9%), compared with Blacks (21.5%) and Mexican-Americans (21.8%).³⁹

DIABETES. In the United States, 11.3% of adults aged 20 years and older had diabetes in 2010.⁴¹ Non-Hispanic Blacks had the highest prevalence at 12.6% compared with non-Hispanic Whites at 7.1%. Social determinants of health are associated with increased diabetes prevalence in general U.S. populations.⁴² Future research should investigate the role of these factors in diagnosed diabetes rates among Veteran VHA users.

39 Fryar CD, Hirsch R, Eberhardt MS, Yoon SS, Wright JD. Hypertension, high serum total cholesterol, and diabetes: Racial and ethnic prevalence differences in U.S. adults, 1999-2006. NCHS Data Brief, no. 36. Hyattsville, MD. National Center for Health Statistics. 2010. Available at: stacks.cdc.gov/view/cdc/5726/cdc-5726_DS1.pdf.

40 CDC – Gillespie CD, Hurvitz KA. Prevalence of Hypertension and Controlled Hypertension – United States, 2007-2010. *Morbidity and Mortality Weekly Report (MMWR)*. 2013;62(03):144-8.

41 US Department of Health and Human Services, Centers for Disease Control and Prevention. National diabetes fact sheet: national estimates and general information on diabetes and prediabetes in the United States, 2011. 2011. Available at: <http://www.cdc.gov/diabetes/pubs/factsheet11.htm>. Accessed July 20, 2015.

42 Gaskin DJ, Thorpe RJ, McGinty EE, Bower K, Rohde C, Young JG, et al. Disparities in Diabetes: The Nexus of Race, Poverty, and Place. *Am J Public Health*. 2014;104:2147-55.

Continued from previous page

SPINE DISORDERS and JOINT DISORDERS. There are cultural variations in how musculoskeletal disorders are viewed, and there are racial/ethnic variations in their management.^{43,44,45} VA research and interventions should continue to focus in this area so that variations in care for these disorders reflect Veterans' informed choices.

PTSD and DEPRESSION. AI/ANs were the racial/ethnic group with the highest diagnosed rates of PTSD, and among the highest diagnosed rates of depression. Of note, AI/ANs are also the group that has the greatest proportion residing in rural and highly rural settings. These rural settings may be further from VA mental health services, and may also have limited mental health service availability in the private sector. Prior research found that VHA-Indian Health Service (IHS) dual users were more likely to receive primary care from IHS and to receive diagnostic and behavioral healthcare from VHA.⁴⁶

43 Ibrahim SA, Siminoff LA, Burant CJ, Kwok CK. Variation in perceptions of treatment and self-care practices in elderly with osteoarthritis: a comparison between African American and white patients. *Arthritis Rheum.* 2001;45(4):340-5.

44 Kramer BJ, Harker JO, Wong AL. Arthritis beliefs and self-care in an urban American Indian population. *Arthritis Rheum.* 2002;47(6):588-94.

45 Ibrahim SA. Racial and ethnic disparities in hip and knee joint replacement: a review of research in the Veterans Affairs Healthcare System. *J Am Acad Orthop Surg.* 2007;15 Suppl 1:S87-94.

46 Kramer BJ, Wang M, Jouldjian S, Lee ML, Finke B, Saliba D. Veterans Health Administration and Indian Health Service: healthcare utilization by Indian Health Service enrollees. *Med Care.* 2009;47(6):670-6.

Overall Top 20 Diagnosed Conditions by Race/Ethnicity

The overall top 20 diagnosed conditions are listed in [Exhibit 3-16](#). This listing includes the 11 conditions with diagnosed condition rates of at least 20% (rounded) in one or more racial/ethnic groups, plus an additional 9 conditions that were each diagnosed in 12% or more of Veteran patients overall. This exhibit lists the difference between each racial/ethnic minority group and Whites in the percent diagnosed for each condition (note that for each racial/ethnic group, the percent diagnosed is listed in).

A higher diagnosed condition rate for a racial/ethnic group is indicated by a percent > 0 , whereas a lower diagnosed rate for a racial/ethnic group is indicated by a negative percent. Among the overall top 20 diagnosed conditions, the only condition in which the diagnosed rate in a racial/ethnic group exceeded that for Whites by a margin of 10% was PTSD (bolded and boxed in the exhibit), diagnosed in 20.7% AI/ANs and in 11.1% of Whites. For several conditions and racial/ethnic groups, the diagnosed condition rate was lower than that for Whites by a margin of 10% or more (these are negative numbers that are bolded and highlighted).

EXHIBIT 3-16

DIFFERENCE BETWEEN EACH RACIAL/ETHNIC GROUP AND WHITE VETERAN VHA PATIENTS IN PERCENT DIAGNOSED, FOR OVERALL TOP 20 DIAGNOSED CONDITIONS IN FY13

	AI/AN – White	Asian – White	Black – White	NH/OPI – White	Multi-race – White	Hispanic – White	Unknown – White
Condition	%	%	%	%	%	%	%
Hypertension	-7.8	-12.4	4.0	0.2	-3.0	-7.1	-20.7
Lipid Disorders	-10.5	-12.8	-10.9	-1.7	-6.2	-6.5	-19.1
Diabetes Mellitus	2.5	-1.5	2.6	4.7	1.3	3.1	-11.1
Refraction Disorders	-0.3	-0.1	1.3	1.8	2.3	2.6	-6.6
Dermatologic Disorders - Other	-2.7	-4.5	-1.7	-1.2	0.7	-2.4	-7.7
Esophageal Disorders	-3.1	-8.6	-3.9	-3.1	-1.5	-3.4	-7.9
Spine Disorders - Lumbosacral	4.0	1.8	4.9	4.4	5.7	5.5	-1.7
Hearing Problems	-3.9	-1.7	-12.6	-3.6	-6.0	-6.0	-9.8
Eye Disorders – Other	-0.8	-0.9	0.6	2.1	1.2	-0.1	-8.5
Cataract	-2.2	-4.9	-1.5	0.6	-0.5	-2.1	-11.3
Joint Disorders - Lower Extremity	4.6	-0.1	7.0	4.2	5.5	4.5	-0.6
Depression, Possible - Other	4.3	-3.2	3.1	1.8	5.2	3.9	-3.7
Coronary Artery Disease	-5.7	-9.9	-9.9	-3.8	-5.0	-8.4	-13.9
Overweight/Obesity	0.6	-5.8	2.6	1.6	2.5	5.0	-1.2
Joint Disorders - Unspecified or Multiple Joints	1.6	-2.6	2.4	1.3	2.0	-0.4	-4.3
Tobacco Use Disorder	2.7	-6.7	2.7	-0.9	2.9	-3.8	-2.0
Residual Codes	-0.2	-1.5	3.6	1.3	2.1	1.0	-5.3
Male Genital Disorders	-3.8	-5.3	-2.9	-2.1	-2.3	-2.0	-8.6
PTSD	9.6	1.3	3.9	6.6	6.9	6.4	-4.3
Endocrine, Metabolic and Nutritional Disorders – Other	-0.3	-3.5	-0.6	0.2	0.2	1.3	-4.0

Key: Bolded and boxed cells indicate conditions in which the diagnosed prevalence in a group exceeded that in Whites by 10% (rounded) or more; bolded cells (without boxes) indicate conditions in which the diagnosed prevalence in a group was 10% (rounded) or lower than that in Whites.

Denominator: All Veterans who used any VHA care in FY13 (VHA outpatient care, inpatient care, pharmacy care, or Non-VA [Fee] Medical Care), referred to as “Veteran FY13 VHA patients” (Data source: WHEI Master Database).

Source: VHA National Health Equity Report 2016

IMPLICATIONS The diagnosed condition rate for racial/ethnic minority populations is lower than that for White Veteran patients. These racial/ethnic differences are in contrast to diagnosed rates in the U.S. populations, and most likely relates to the racial/ethnic variations in demographic characteristics of Veteran patients, with racial/ethnic minorities being younger and having a higher proportion of women.

Section V: Conclusions

The Veteran VHA user population is increasingly racially/ethnically diverse, with at least 23.5% of FY13 Veteran users being a racial/ethnic minority group member. This chapter systematically examined demographic characteristics, types and amount of VA services used, and rates of diagnosed health conditions among Veteran VA users by race/ethnicity. Racial/ethnic minority groups, compared with White Veteran patients, have a greater representation of women, younger Veterans, and Veterans with service-connected disabilities. With the exception of AI/AN Veterans, who were the most likely to be rural dwelling, most racial/ethnic minority groups were less likely than Whites to dwell in rural areas. Despite their younger age, Black or African-American, Hispanic, and multi-race Veteran patients had similar or greater use of multiple types of VA services compared with White Veteran patients. NH/OPI and AI/AN Veteran patients, compared with White Veteran patients, had much greater use of fee services, and somewhat higher use of telephone and emergency department visits. Asian Veteran patients had lower use of several types of services compared with White Veterans. All racial/ethnic minority groups had greater use of mental health/substance use disorder services compared with Whites.

The top three diagnosed conditions across racial/ethnic groups – hypertension, lipid disorders, and diabetes mellitus – are each a major risk factor for coronary heart disease, which is the leading cause of mortality for both men and women. Severity of each condition and rates of guideline-adherent management of these conditions were not examined in the current report. VHA efforts should continue to focus on preventing, detecting, and controlling these disorders. Associated health outcomes should be examined by race/ethnicity. Most racial/ethnic minority groups, compared with White Veteran patients, had lower diagnosed condition rates. This is likely due to the younger age distribution of racial/ethnic minorities within VA, though under-diagnosis may be correlated with race/ethnicity.

The findings in this chapter advance our understanding of Veteran racial/ethnic health and healthcare disparities. The VHA Blueprint for Excellence describes actions needed to transform VHA care from being provider-centric to being Veteran-centric; these activities include anticipating and meeting the unique needs of enrolled Veterans, and delivering high quality, Veteran-centered care. For diverse populations, Veteran-centered care includes delivery of culturally-sensitive and gender-sensitive care in all of the settings that VA delivers care. To meet these challenges, VA should monitor and report out quality and patient experience data by race/ethnicity, including conducting assessments of fee services. The Office of Health Equity-Quality Enhancement Research Initiative (OHE-QUERI) Partnered Evaluation Center, funded in 2015, will continue to fill some of these information gaps by evaluating diagnosed conditions, VA performance, and mortality for vulnerable Veteran patient populations. To facilitate ongoing measurement of VA-delivered care, tools for measuring parameters of interest by race/ethnicity should be incorporated into the next generation of the VA electronic health record user interface. VA research should identify causes of racial/ethnic disparities in Veterans health and healthcare for groups and conditions that have not been examined, and as this evidence-base develops, interventions to reduce health and healthcare disparities should be implemented and evaluated.