Chapter 8

National Veteran Health Equity Report Highlights

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"I concur with 15 of the 18 Commission recommendations… These include areas such as … eliminating disparities in how health care is delivered to Veterans from different backgrounds…"

(President Barack Obama's message to Congress on the VA Commission on Care Report)[1]

President Barack Obama's message to Congress on the VA Commission on Care Report concurred with most of the recommendations, one of which called for eliminating disparities among Veterans and full implementation of the VHA Health Equity Action Plan.[2] The VHA Health Equity Action Plan is the VA's roadmap for achieving health equity for all Veterans, especially the most vulnerable. This inaugural VHA National Veteran Health Equity Report provides baseline data against which VHA actions to eliminate health disparities may be measured. This effort capitalizes on the expertise of existing networks of advocates for vulnerable Veteran populations.

The VHA National Veteran Health Equity Report is a major milestone in the Office of Health Equity's efforts to implement the Health Equity Action Plan. Specifically, it advances the Health Equity Action Plan goals of awareness, leadership, cultural competency and data – all key areas in the pursuit of health equity. One of the intentions of the Health Equity Action Plan is to catalyze, synergize, and coordinate VHA programs, projects, and initiatives to effectively identify, understand, seek and implement solutions to diminish, and where possible eliminate, health disparities.

The report systematically describes sociodemographic characteristics, health care utilization patterns, and the medical conditions for which Veterans are treated in VHA, and it does this for sub-populations of Veterans as defined by their race/ethnicity, gender, age group, rurality of residence, and mental health diagnoses. Currently, the report does not reflect all of the vulnerable Veteran populations. For example, VHA does not collect sexual orientation and gender identity data. However, efforts are underway to include appropriate fields in the electronic health record to monitor the care of these Veterans.

All data in this report come from centralized, national VHA administrative databases of enrollment, outpatient, inpatient, and Non-VA (Fee) medical care,[3] but do not include long-term care services or care received privately by VHA users. This report describes Veterans receiving VHA care in Fiscal Year 2013 (FY13). While the following are highlighted findings, detailed findings for each Veteran sub-population are described within the respective section of each chapter.

1 The White House Office of the Press Secretary. Letter from the President – Report of the VA Commission on Care. https://www.whitehouse.gov/the-press-office/2016/09/01/letter-president-report-va-commission-care. September 1, 2016. Accessed September 16, 2016.

2 Commission on Care. Commission on Care: Final Report. https://commissiononcare.sites.usa.gov/files/2016/07/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf. Published June 30, 2016. Accessed September 16, 2016.

3 This was formerly known as "Fee" or "Fee-basis" care. VHA now refers to this type of service as "Non-VA Medical Care." This report uses the convention of adding the word "Fee" in parentheses to this term so as to distinguish this type of non-VA care from other types of care that VHA patients might receive outside of VHA (e.g., care funded through Medicare, Medicaid, private insurance, or other non-VA sources).

Highlighted Findings

Sociodemographics

Race/Ethnicity: Among FY13 Veteran VHA users, 23.5% were racial/ethnic minority group members, 72.9% non-Hispanic White, and 3.7% were unknown race/ethnicity. The Census Bureau projects that by 2044, the U.S. population will become "majority minority" (49.7% White, 25.0% Hispanic, 12.7% Black or African-American, 7.9% Asian, 3.7% multi-racial).[4] Reflecting U.S. population projections, the Veteran VHA user population is expected to continue to become increasingly racially and ethnically diverse.

Gender: Women represent an extreme numeric minority group in VHA; in FY13, they made up only about 7% of VHA patients. However, their numbers in VHA have more than doubled since the turn of the millennium (140% growth), far outstripping the 63% growth seen among men over the same period.[5] The age distribution of Veteran VHA patients differs markedly by gender, with the mean age of women being 15 years younger than that for men (48 versus 63 years). Women represent 18.1% of Veteran VHA patients under age 45 years. Among Veteran VHA patients, substantially more women than men belong to a racial/ethnic minority group (37.0% vs. 22.4%).

Age: In FY13, 46.3% of Veterans were age 65 and older; overall, 7.4% of Veteran VHA users were aged 85 and older. Longer life spans and aging "Baby Boomers" (adults born between 1946 and 1964) will combine to double the population of Americans aged 65 years or older during the next 25 years.[6] The age distribution of Veteran VHA users is expected to shift as well.

Rural Residence: Over one-third of Veterans served by VHA reside in rural (including highly rural) areas (1.3% highly rural; 35.9% rural; 62.3% urban). Older (age 65+) Veterans were more likely to live in rural locations (40.7%) compared to their younger counterparts (36.8% of 45-64 year olds; 29.4% of 18-44 year olds). In contrast to other racial/ethnic groups, a majority of American Indian/Alaska Native Veteran VHA users lived in rural areas (53.5%, versus 42.6% of Whites, and smaller percentages of other groups).

Service-Connected Disability: Almost one-half (48.6%) of Veteran VHA patients had a service-connected disability. All racial/ethnic minority Veteran patient groups, compared with Whites, were more likely to have a service-connected disability. A higher proportion of women Veteran patients than men had a service-connected disability. Increasing age group was inversely associated with having a service-connected disability. Rural and urban Veterans were largely similar in their distribution of service-connected status category. A higher percent of the Veterans in care with serious mental illness (SMI), a mood or anxiety disorder, or PTSD had a service-connected disability compared to all other groups.

Serious Mental Illness: Among FY13 Veteran VHA patients, 4.6% had an SMI diagnosis. Overall, 33.2% of Veteran VHA patients had one or more mental health diagnoses. Not only is the rate of mental illness diagnoses, and SMI in particular, higher in VA compared to the general adult population (where SMI is estimated to be present in approximately 4%),[7] the VA numbers include only those Veterans with the diagnosis who are in care in a particular fiscal year, and therefore the burden of mental health disorders in Veterans may be higher. Women and

4 U.S. Census Bureau. Projections of the Size and Composition of the U.S. Population: 2014 to 2060. Current Population Reports. 2015 March. P25-1143. Available at: https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf.

5 Frayne, S. M., et al. (2010). Sourcebook: Women Veterans in the Veterans Health Administration. Volume 1. Sociodemographic Characteristics and Utilization of VHA Care. Women's Health Evaluation Initiative, Women Veterans Strategic Health Care Group, Veterans Health Administration, Department of Veterans Affairs, Washington DC. December 2010. Available at: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2455.

6 Centers for Disease Control and Prevention. The State of Aging and Health in America 2013. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2013.

7 NAMI. Mental health facts in America. 2015; https://www.nami.org/getattachment/Learn-More/Mental-Health-By-the-Numbers/General-MH-Facts-4-12-15.pdf. Accessed August 14, 2015.

Blacks/African-Americans were over-represented among Veteran VHA patients diagnosed with SMI, whereas those age 65+ were under-represented.

Utilization

VHA Outpatient Encounters are the portion of care that occurs at VHA facilities (in contrast to Non-VA (Fee) medical care). The vast majority of FY13 Veteran patients (97.4%) had one or more VHA outpatient encounters, and 43.1% had twelve or more encounters. By race/ethnicity, gender, and age, Veteran groups with 50% or more of the group having twelve or more outpatient encounters were: Blacks/African-Americans, multi-race individuals, and Hispanics (versus 41.4% of Whites having over twelve encounters); women (versus 42.6% of men); and 45-64 year olds (versus <40% of both younger and older age groups). Highly rural Veterans were least likely to have over twelve outpatient encounters (37.7%, versus 44.5% of urban Veterans). The Veteran population with SMI in VA care is notable for its particularly high proportion having over twelve outpatient encounters (78.1%, versus 31.2% of the group with no mental health diagnosis), though greater than 50% of all groups with mental health diagnoses had over twelve outpatient encounters.

Primary Care: The majority (87.1%) of FY13 Veteran patients utilized primary care. Across sociodemographic and mental health categories, the groups that were least likely to use primary care were: Asians (18.1% with no primary care encounters); 18-44 year olds (19.7%); and those with no mental health diagnoses (15.8%). The amount of primary care utilization varied, with 9.3% of Veteran patients having six or more primary care encounters. Across sociodemographic and mental health groups, the largest differences in frequent utilization were based on age group (5.3% of 18-44 year olds, versus 10.7% of 45-64 year olds and 9.5% of those age 65+ having over six encounters) and mental health diagnoses (19.3% of the SMI group, >10% of other mental health groups, and 6.1% of those with no mental health diagnosis having over six primary care encounters).

Mental Health And Substance Use Disorder (SUD) Care: One-quarter (25.2%) of FY13 Veteran patients utilized VA care for mental health and substance use disorders. Racial/ethnic minorities, women, younger age groups, urban dwelling Veterans, and not surprisingly, those with mental health diagnoses, were all more likely to use this type of care. Groups that were least likely to have mental health and SUD encounters were older patients (age 65+) and Veterans residing in highly rural areas.

Emergency Department Care: Overall, 18.2% of FY13 Veteran patients utilized VHA emergency department care, though there was considerable variation in use. Among Veterans diagnosed with SMI, 37.7% had one or more emergency department encounters, and 4.1% had over six encounters. Among Black/African-American Veteran patients, 28.6% utilized VHA emergency departments. The lowest use of VHA emergency departments was among highly rural Veterans, with 9.6% having one or more emergency department encounters.

Telephone Encounters: More than one-half (56.9%) of Veteran patients had one or more VA telephone encounters in FY13. There was variation by race/ethnicity, gender, age group, and mental health diagnosis in use of VA telephone care, but not by rural/urban status. One in eight (12.5%) Veteran patients had 6 or more telephone encounters.

Non-VA (Fee) Outpatient Services: In FY13, 17.6% of Veteran patients used one or more Non-VA (Fee) outpatient service, and 6.2% used twelve or more. Across sociodemographic and mental health categories, the groups that were most likely to use Non-VA (Fee) medical care were women (31.4%, versus 16.6% of men) and highly rural dwelling Veterans (36.9%, versus 19.4% of other rural Veterans and 16.1% of urban Veterans). Groups that were most likely to be the heaviest utilizers of Non-VA (Fee) services (using over twelve services) were: Native Hawaiian or other Pacific Islanders (9.9%); women (8.9%); the oldest old (8.2% of those age 85+); highly rural Veterans (12.4%); and those diagnosed with SMI (12.0%).

Conditions

Categories of Diagnosed Conditions: Overall, the top seven categories of diagnosed medical conditions (diseases or symptoms organized primarily by organ system) were each diagnosed in one-third or more of FY13 Veteran patients. These condition categories were: #1 Endocrine/Metabolic/Nutritional (diagnosed in 63.6%); #2 Cardiovascular (60.6%); #3 Musculoskeletal (49.8%); #4 Other (46.8%); #5 Sense Organ (42.6%); #6 Gastrointestinal (34.7%); #7 Mental Health/Substance Use Disorder (33.2%).

- By race/ethnicity, there were only minor variations in the rank order of condition categories; however, there were sizable differences (> 5%) in the percent of each group receiving diagnoses. American Indian/Alaska Native, Black or African-American, Native Hawaiian or other Pacific Islander, multi-race, and Hispanic Veteran groups all were diagnosed with musculoskeletal and mental health/SUD conditions more than were White Veterans, whereas Asian Veterans received similar or lower rates of these diagnoses as Whites.
- There were sizable gender differences as well as age group differences in the diagnosis rates across condition categories. The #1 condition category in women was musculoskeletal (diagnosed in 57.1% of women, 49.3% of men), and the #3 category was mental health/SUD (46.2% of women, 32.3% of men).
- Among the domains with sizable differences across age groups, for seven domains, the rates increased with age (endocrine/metabolic/nutritional, cardiovascular, urinary, reproductive health, cancer, hematologic/immunologic, and sense organ). For three domains, the rates were highest in the middle age group (gastrointestinal, musculoskeletal, and other). For one domain (mental health/SUD), the rate was highest in the youngest age group.
- The five leading categories of diagnosed conditions were the same among highly rural, rural, and urban Veterans.
- The SMI group was defined such that 100% of that group would have a mental health diagnosis. The #2 condition category for that group is "other", diagnosed in 72.6% versus in 36.5% of the no mental health diagnosis group. The "other" domain includes both psychosocial factors and residual codes. Psychosocial factors encompassed a broad range of issues including, but not limited to, unemployment, history of abuse, family circumstances, identity disorder, relationship problems, legal circumstances, and psychological stress. The SMI group, compared with the no mental health diagnosis group, also had higher diagnosis rates for musculoskeletal disorders (59.8% versus 43.1%) and gastrointestinal conditions (47.5% versus 29.7%).

Individual Diagnosed Conditions: Overall, the top three diagnosed conditions were: hypertension (diagnosed in 51.0%); lipid disorders (47.3%); and diabetes mellitus (23.8%). By race/ethnicity, the highest diagnosed condition rate for hypertension was among Blacks/African-Americans (55.7%), for lipid disorders it was among Whites (50.2%), and for diabetes mellitus there was relatively less variation. 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, diagnosed in 20.7% of American Indian/Alaska Natives 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. The top diagnosed conditions for women were also hypertension and lipid disorders, though the diagnosis rates were lower than that for men by a margin of more than 20%. The third through fifth most commonly diagnosed conditions in women were diagnosed more frequently in women than in men (depression, 26.2% versus 15.2%; lower extremity joint disorders, 23.1% versus 15.7%; and lumbosacral spine disorders, 21.8% versus 17.5%). There were not vast differences between rural and urban Veterans in the diagnosis rates of individual conditions. Among Veterans diagnosed with SMI, diagnosis rates for the top two conditions (hypertension and lipid disorders) were similar to the rates for the no mental health diagnosis group.

However, overall, among the top 20 diagnosed conditions, diagnosis rates for the SMI group exceeded that for the no mental health group for 17 conditions, including exceeding it by a margin of >10% for seven conditions. The largest disparities were in tobacco use disorder, psychosocial factors, spine disorders, and housing insufficiency.

Implications for Policy, Practice, Evaluation and Research

Sociodemographics

- The changing demographics of the Veteran VHA patient population, with increasing racial/ethnic and gender diversity, reinforces the need for ongoing attention to health care delivery and the environment of care to assure that it is culturally and gender sensitive, and that it reflects the preferences and care needs of the diverse population of Veteran VHA users.
- To track achievement and maintenance of this objective, VA should monitor and report patient experience data and quality of care by race/ethnicity and gender.
- With the projected growth in the number of Veterans in older age groups, Veterans who use VHA care will likely have increasing levels of functional dependency and disability; the concomitant need for long-term services and supports will likely increase. Functional limitation may reflect disparities in access to services that forestall or prevent decline. Future work needs to explore functional status, access to long-term services and supports, and multi-morbidity.
- Older Veterans were more likely to live in rural settings than younger Veterans, which could potentially compound access issues. VA should continue identifying strategies to address healthcare access and care coordination targeted toward rural-residing Veteran patients. Addressing the healthcare needs of patients who may face healthcare disparities due to multiple vulnerabilities related to age, racial/ethnic, gender, and rural factors may require additional efforts to develop and deliver innovative, culturally-sensitive care models.
- The over-representation of women and Blacks/African-Americans among Veterans diagnosed with SMI highlights the need to apply recommendations regarding gender and cultural sensitivity within the mental health services line and other settings of care. With younger Veterans entering VA care, there has been an influx of parents and spouses in need of education and support to understand the mental illness of their loved one. Training for staff and clinicians (e.g., couples counseling, family education, shared decision making training) and adjustments to clinic work space (e.g., group rooms, toys for children) will need to be considered.

Utilization

- 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. 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.[8] Future steps in evaluating VA primary care use should examine variations in these important correlates of PACT implementation by race/ethnicity.
- Women are disproportionately represented among heavy users of primary care (6+ visits per year) despite the fact that they have a younger average age than men. This finding supports VHA policy requiring downward panel size adjustments for primary care providers who see women patients.[9]
- Given that the causes of mental health issues differ by gender (for example, rates of military sexual trauma and its sequelae are far more common in women than in men[10]), and given that health care preferences may differ by gender,[11] further inquiry is warranted regarding any additional adaptations to VHA mental health/SUD delivery systems that would better meet women's treatment needs. In addition, education on trauma-informed approaches to care should be developed for staff in mental health, primary care, specialty care and other clinical settings.
- Ensuring access to preventive and specialty health services among older adult Veterans may require tailoring the structure of VA care to extend its reach to Veterans who may not be able to travel regularly to a medical center.
- Prior research found that significant disparities are present between traditionally underserved racial-ethnic groups and White Veterans in their ability to obtain needed medical care,[12] e.g., with greater proportions of American Indian/Alaska Native, Hispanic, and Black/African-American Veterans reporting barriers to care and unmet need.[13] Data on use of mental health/SUD care should be correlated with diagnoses and symptoms to gauge if observed levels of use are sufficient to meet need for this care.
- As Non-VA (Fee) medical care (e.g., Veterans Access, Choice and Accountability Act of 2014) 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. The quality of Non-VA (Fee) medical care is not systematically monitored. VA should identify strategies for systematically monitoring the quality of that 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 Non-VA (Fee) medical care stratified by race/ethnicity.

8 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.

9 Veterans Health Administration (2010). Health Care Services for Women Veterans (VHA Handbook 1330.01). Washington, DC, US Department of Veterans Affairs.

10 Kimerling R, Street AE, Pavao J, et al. Military-Related Sexual Trauma Among Veterans Health Administration Patients Returning From Afghanistan and Iraq. *Am J Public Health.* 2010.

11 Kimerling R, Bastian LA, Bean-Mayberry BA, et al. Patient-centered mental health care for female Veterans. *Psychiatr Serv.* 2015;66(2):155-162.

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

Conditions

- Veteran VHA users had higher diagnosed rates of many conditions compared with the broader U.S. population, including higher rates for the top three diagnosed conditions – hypertension, lipid disorders, and diabetes mellitus. These conditions are each a major risk factor for coronary heart disease, which is the leading cause of mortality for both men and women. Prior VA data, limited to Black-White comparisons, found durable disparities in control of each of these cardiovascular risk factors.[14] These conditions have also affected the SMI population in particular, due to the side effect profile of the second generation antipsychotics.[15]
- Severity of each condition and rates of guideline-adherent management of these conditions were not examined in the current report—these should be the focus of systematic evaluations. There have been efforts in VA to monitor and address the metabolic syndrome, including successful efforts to tailor and implement weight management programs for the population with the cognitive deficits associated with SMI.[16] VHA efforts should continue to focus on preventing, detecting, and controlling these disorders, including tailoring programs for African-Americans, SMI populations, and other Veteran groups that prior research has identified as having worse outcomes. Associated health outcomes should be examined by race/ethnicity, gender, and other sociodemographic characteristics, while accounting for the different age distributions in each group. The Office of Health Equity-Quality Enhancement Research Initiative (OHE-QUERI) Partnered Evaluation Center, established in 2015, will fill some of these information gaps by systematic evaluating variations in VA performance and mortality across the entire VHA user population by vulnerable population characteristics.
- 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. Measurement science research should include studies to identify valid improvements to or alternatives to diagnosis-based metrics for high morbidity conditions that have disparities in diagnosis, treatment or outcomes.
- Health-related behavior and social factors are thought to contribute much more than medical care to overall health, and they are influenced by environmental and socioeconomic factors.[17] Therefore, VA research and quality improvement evaluations should be directed toward investigating the effects of other social determinants of health on the health behavior and outcomes of diverse Veteran patients. For instance, one of the many opportunities currently untapped is the linkage of VA benefits and health in order to better incorporate the social determinants of health in the whole care and personalized health plan for the Veteran.

14 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 Apr;30(4):707-15.

15 Newcomer JW. Metabolic considerations in the use of antipsychotic medications: a review of recent evidence. *J Clin Psychiatry.* 2007;68 Suppl 1:20-27.

16 Cohen AN, Chinman MJ, Hamilton AB, Whelan F, Young AS. Using patient-facing kiosks to support quality improvement at mental health clinics. *Med Care*. 2013;51(3 0 1):S13.

17 Williams DR, Costa MV, Odunlami AO, Mohammed SA. Moving upstream: how interventions that address the social determinants of health can improve health and reduce disparities. J Public Health Manag Pract. 2008 Nov;14 Suppl:S8-17.

Next Steps

A good understanding of the diverse Veteran populations is imperative if the VA is to genuinely resolve the inequities for those at high risk and with the most need. The World Health Organization, the Institute for Healthcare Improvement and the National Academies of Sciences, Engineering, and Medicine recommendations for achieving health equity and effective population management underscore this imperative.[18, 19, 20] This VHA National Veteran Health Equity Report is part of the effort to identify disparities and knowledge gaps, and seek to understand them in order to effectively tackle the avoidable differences in care and outcomes for vulnerable Veteran populations. It is one of many steps toward addressing disparities by catalyzing necessary research, and shifts in policy and operations, in the largest integrated healthcare system in the United States. If used appropriately, the resultant actions at all levels of the agency will be transformative for the vulnerable Veterans in particular, and the healthcare industry as a whole. It should lead to sustainable policies, processes and procedures, irrespective of shifts in agency priorities, and it will add to the evidence for the business case for health equity, beyond the moral imperative.

This report targeted approximately six million Veterans accessing the VA for care in FY13, though the estimated number of living Veterans is about 22 million. It is therefore important to underscore the role of the non-VA health care systems, care providers, and the American society at large in attaining the highest level of health possible for all Veterans. This is particularly relevant given the 2014 Veterans Access, Choice and Accountability Act, which means that an unprecedented numbers of Veterans eligible for VA health care could seek care beyond the VA.

In conclusion, the foundational work illustrated in this first ever VHA National Veteran Health Equity Report should create awareness, and inform, educate, and empower all stakeholders to take further actions towards addressing health and healthcare disparities among Veterans. Just like the Health Equity Action Plan, this is a starting place, and next iterations of the VHA National Veteran Health Equity Report will continue to evolve in order to meet the unique needs of diverse Veterans who entrust their health care to VA.

18 World Health Organization. Uncovering Health Inequalities: A Path towards Leaving No One Behind. http://www.who.int/features/2016/health-inequalities/en/. May 2016. Accessed September 16, 2016.

19 Institute for Health Care Improvement. Assuring Healthcare Quality: A Healthcare Equity Blueprint. http://www.ihi.org/resources/Pages/Tools/HealthcareEquityBlueprint.aspx. Accessed September 16, 2016.

20 Institute of Medicine. 2014. Capturing social and behavioral domains in electronic health records: Phase 1. Washington, DC: The National Academies Press.