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National Veteran Health Equity Report – Black or African American Veteran Chartbook

Focus on Veterans Health Administration
Patient Experience and Health Care Quality

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

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National Veteran Health Equity Report – Black or African American Veteran Chartbook

Focus on Veterans Health Administration Patient Experience and Health Care Quality

Prepared for:

Office of Health Equity
Veterans Health Administration
Washington, DC

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Veterans Health Administration
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Foreword

Racial and ethnic minority Veterans are a growing proportion of the Veteran population, and Black Veterans are a large part of this group. Addressing health disparities among Veterans is essential to achieving health equity for all Veterans at VA. In my many years working in VA as an attending physician, VA's Medical Inspector, and now VA's Chief Medical Officer, I observed many of the health disparities experienced by Black Veterans that VA is working to eliminate. I am thankful the Veterans Health Administration Office of Health Equity has prepared the Black Veterans Chartbook.

The chartbook provides valuable data on patient experiences and health care quality, which are key elements of patient care. Addressing disparities in these areas will help improve health care outcomes for Black Veterans who receive care at VHA. In turn, this work will help us reduce Veteran health disparities overall. This chartbook will help guide the work of care providers, decision-makers, and stakeholders within and outside the VA. Equally as important, this chartbook provides specific examples of what VA is doing to address disparities focused on three elements: workforce development, social supports, and quality of care.

The three pillars of health equity promotion within VA are aimed towards addressing specific disparities of care that may be experienced by Black Veterans and Veterans overall. VA has a robust history of, and continues to expand upon, efforts to address social determinants of health and connect Veterans with social support resources. VA embraces initiatives to address disparities in health outcomes, by collaborating directly with providers to improve clinical care for minority Veterans and focus on the specific needs of Black Veterans. Within the data contained in this report, we see signs of progress towards the goal of equitable care for all Veterans. By working with staff to ensure an inclusive environment, and building a skilled, diverse workforce reflective of the Veteran population, the VA is directly addressing disparities that may be experienced by Veterans receiving care through VHA. Black Veterans ages 18 to 44 now report feeling health care staff are respectful at a rate 1.6 percentage points above that reported by their White counterparts.

Our work is far from complete. But the first step towards providing equitable care for all Veterans is collecting and analyzing data, drawn directly from Veterans' experiences and clinical metrics, and then disseminating this knowledge to provide a firm foundation for continuing health equity programs. The publication of this chartbook on the patient experiences and health care quality of Black Veterans reinforces VA's place at the forefront of the collective effort to eliminate health disparities.

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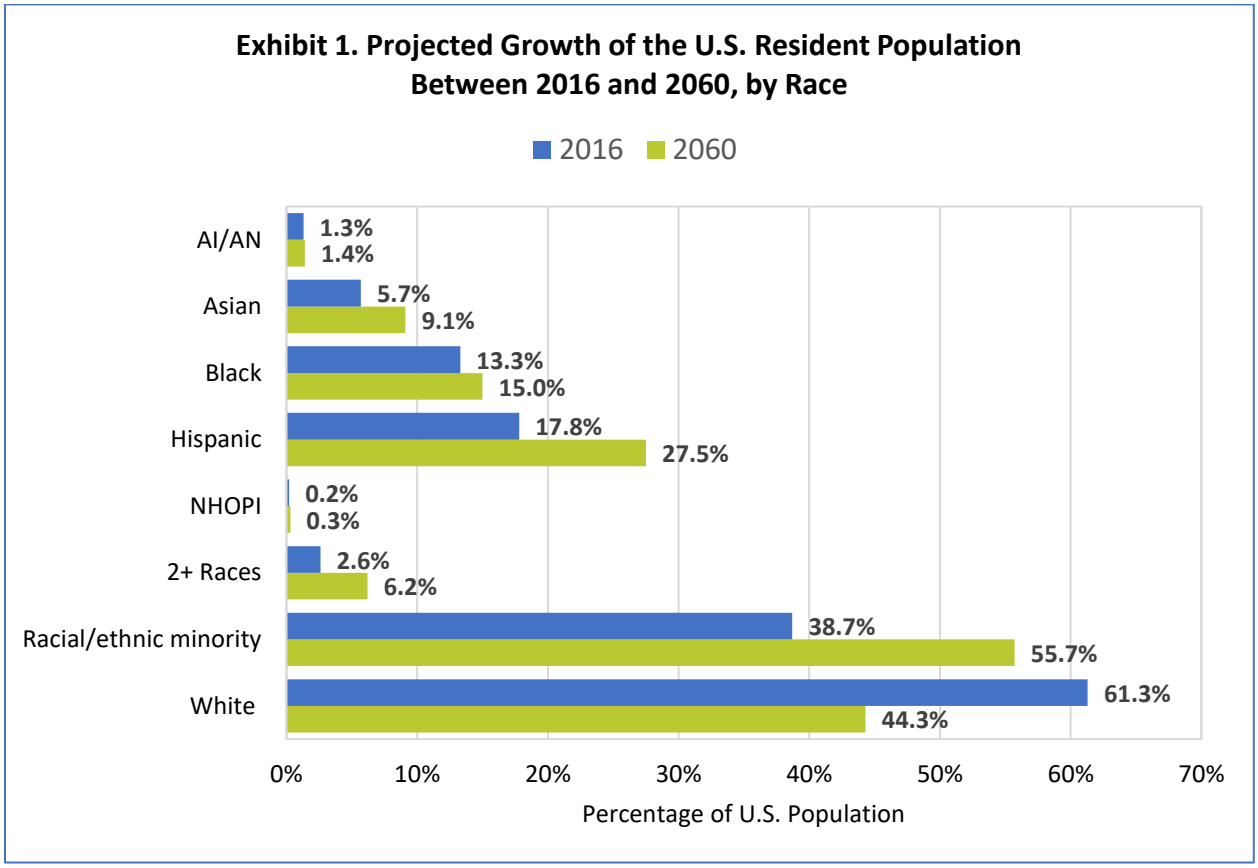
Section I: Background

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

This chartbook focuses on experiences of care and health care quality of Black or African American Veterans receiving care in VHA. Data in this report is from the fiscal year 2016 to fiscal year 2019 Department of Veteran Affairs (VA) Survey of Healthcare Experiences of Patients (SHEP)-Patient Centered Medical Home survey instrument, and the fiscal year 2016 to fiscal year 2019 VA External Peer Review Program quality monitoring program.

Black or African American individuals comprised 13.3% of the American population in 2016.[2] It is currently estimated that by 2060 the Black or African American population will grow to 15.0% of the total U.S. population.[2]

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



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

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

Categories are not mutually exclusive; therefore, percentages may add to more than 100 percent. Racial categories other than 2+ Races exclude people reporting two or more races. Whites are non-Hispanic only; all other categories may include Hispanics. Minority includes all groups other than the non-Hispanic White population. Race and ethnicity groups are reported as mutually exclusive. All individuals with indication of Hispanic ethnicity are included in the "Hispanic" race and ethnicity group regardless of their race, and the remaining race and ethnicity groups contain Veteran patients who have identified as "non-Hispanic." For simplicity, the labels used here identify only the race. For example, "White" is used as shorthand for non-Hispanic White, and "Black" for non-Hispanic Black or African American Veterans, respectively.

Source: U.S. Census Bureau., Population Division. Projected Race and Hispanic Origin: Main Projections Series for the United States, 2017 to 2060. https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html.

Section II: Patient Demographics

Black or African American Veteran VHA Users

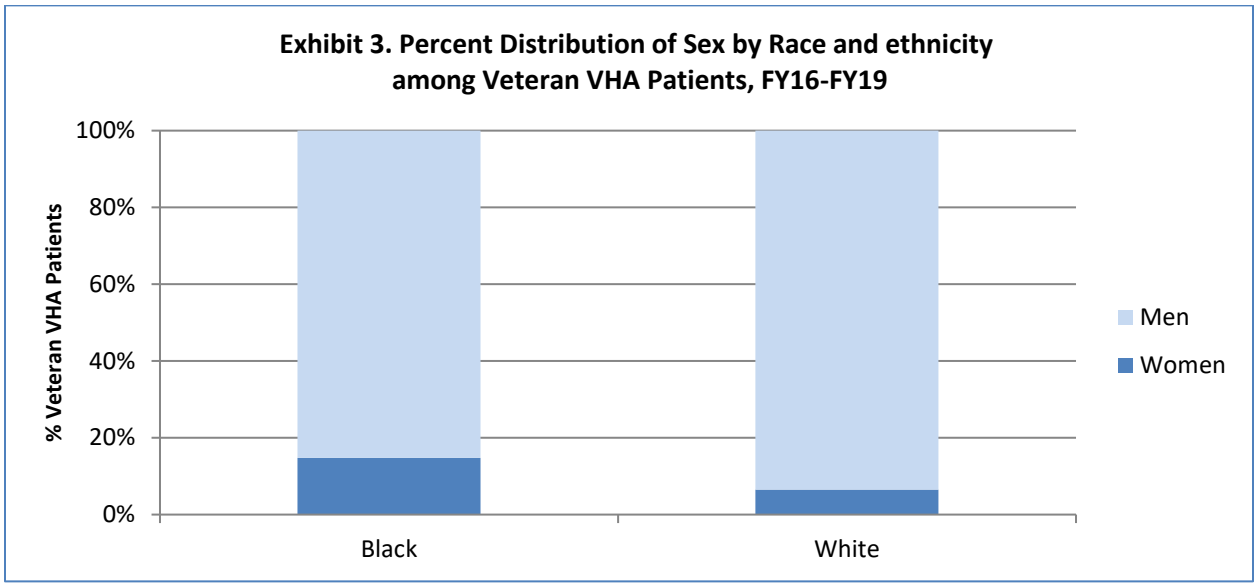
Exhibit 2. Distribution of Black Veteran VHA Patients, FY16-FY19.

Race and ethnicity	Percentage
Black or African American	16.0%

Findings:

- Black or African American Veterans comprise 16.0% of all Veterans using VHA care in FY16-FY19.

Sex by Race and ethnicity

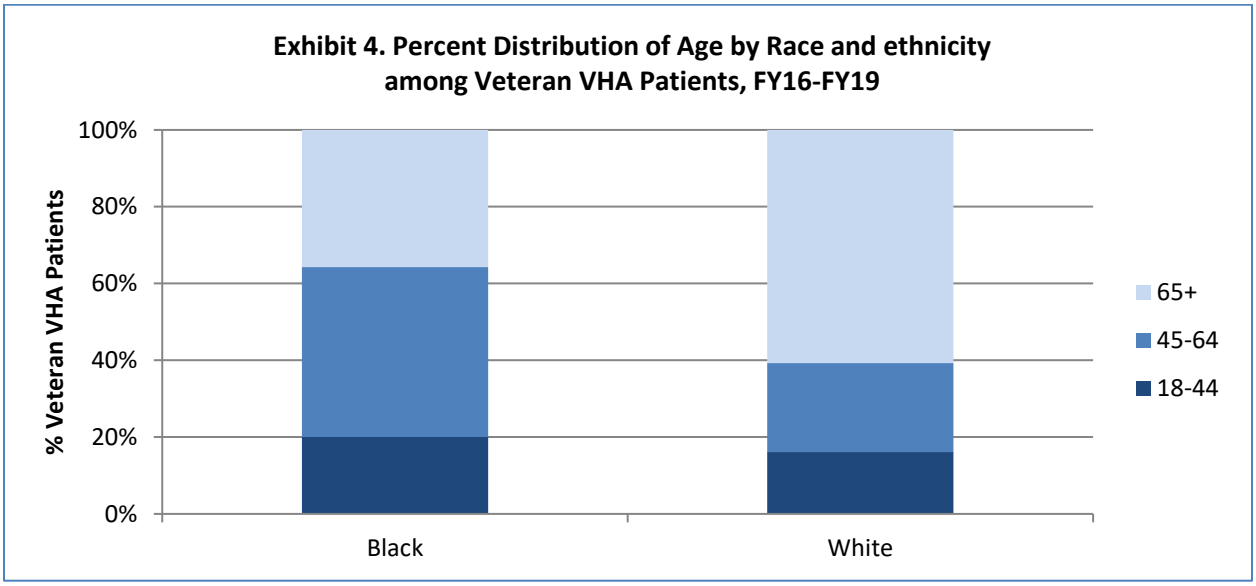


Sex	Black	White
Men	85.2%	93.5%
Women	14.8%	6.5%

Findings:

- Most Veterans are men across all racial/ethnic groups. Women comprise a proportionately greater percentage of Black or African American Veterans than of non-Hispanic White Veterans.

Age Group by Race and ethnicity

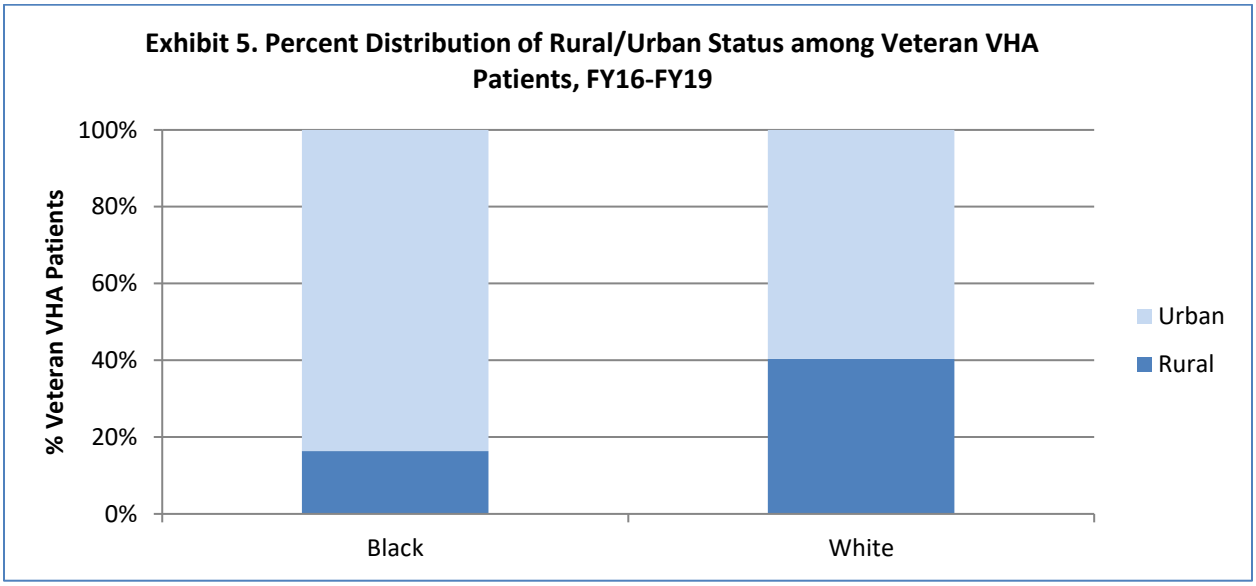


Age	Black	White
65+ years	35.7%	60.7%
45-64 years	44.3%	23.2%
18-44 years	20.0%	16.1%

Findings:

- The largest age group of Black Veterans are those in the 45-64 years age group, whereas the largest age group of non-Hispanic White Veterans are those in the 65+ age category.

Rurality by Race and ethnicity

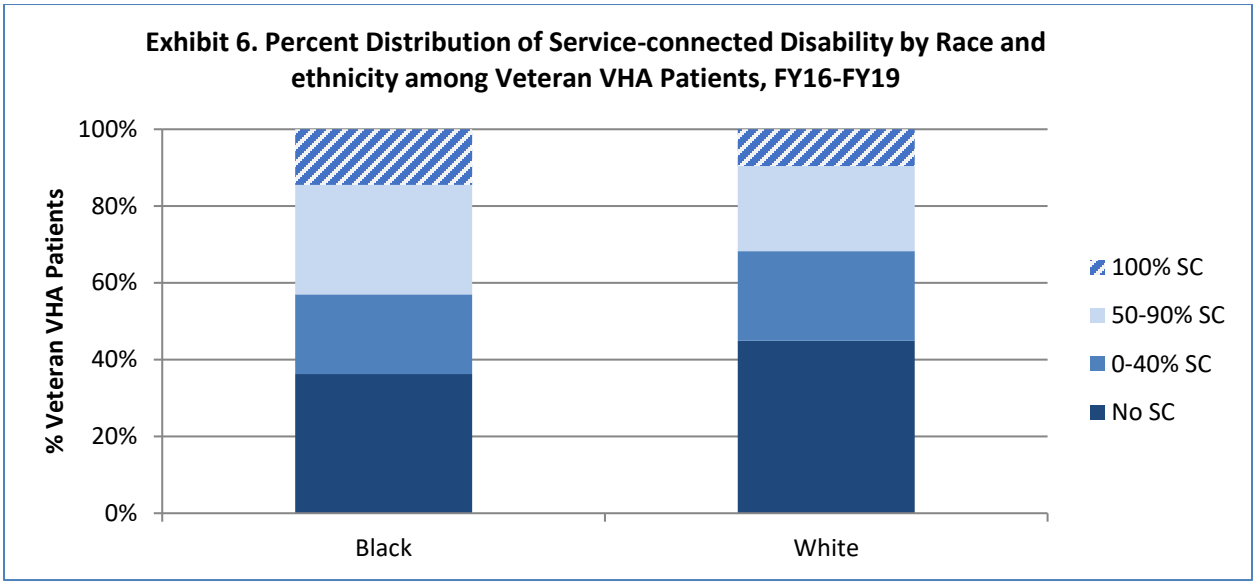


Rural/Urban Status	Black	White
Urban	83.6%	59.6%
Rural	16.4%	40.4%

Findings:

- There were proportionately more Black Veterans from urban areas compared to non-Hispanic White Veterans.

Service-connected Disability Rating by Race and ethnicity



Service-connected Disability Rating	Black	White
100% SC	14.5%	9.6%
50-90% SC	28.5%	22.1%
0-40% SC	20.8%	23.3%
No SC	36.3%	44.9%

Findings:

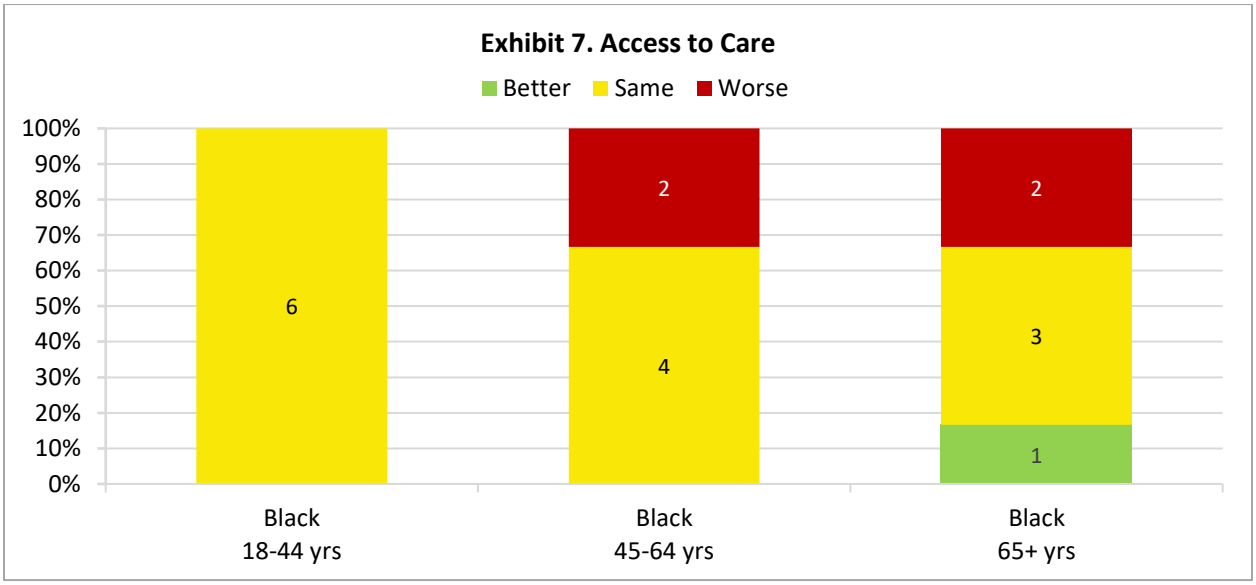
- Black Veterans had a higher proportion with a service-connected disability (63.7%) compared to non-Hispanic White Veterans (55.1%).

Section III: Patient Experiences

See Appendix for methods and guidelines for interpretation

Variations in VHA Patient Experience of Access to Care by Veteran Race and ethnicity

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



Comparison	Black 18-44 yrs	Black 44-64 yrs	Black 65+ yrs
Worse	0	2	2
Same	6	4	3
Better	0	0	1

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group
Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2019 data

Importance:

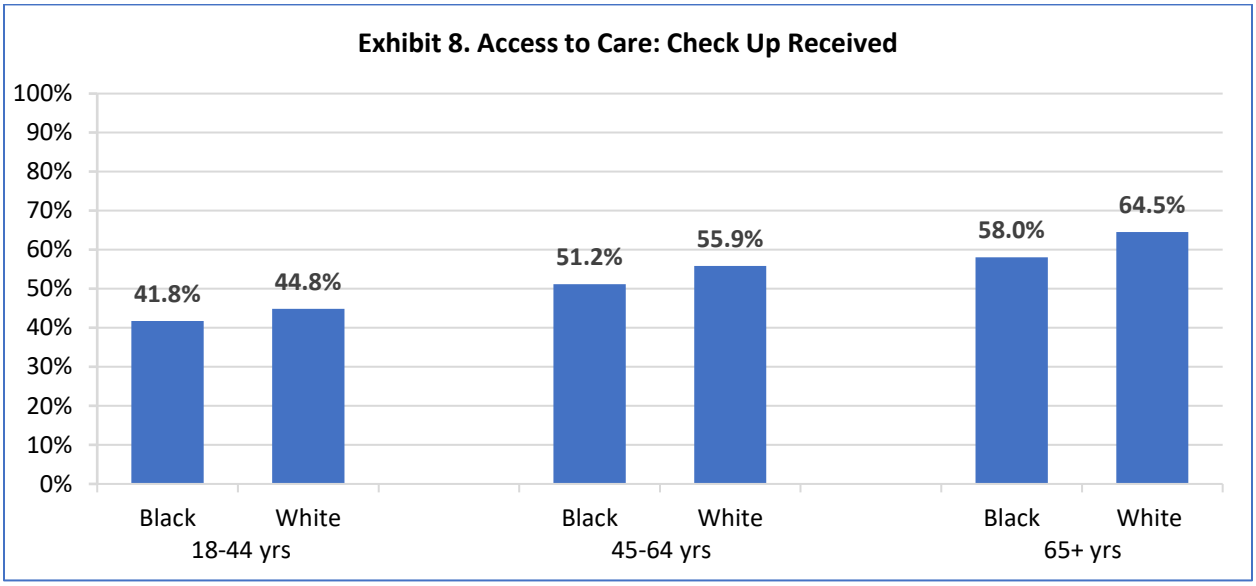
- Access to high quality healthcare is the first important step towards improved individual and population health.[3]

Findings:

- Among Veterans ages 18-44 years, Black Veterans experienced the same access to care on 6 measures compared to non-Hispanic White Veterans.
- Among Veterans ages 45-64 years, Black Veterans experienced worse access to care on 2 measures and the same access on 4 measures compared to non-Hispanic White Veterans.

- Among Veterans ages 65 years and older, Black Veterans experienced worse access to care on 2 measures, better access on 1 measure, and the same access on 3 measures compared to non-Hispanic White Veterans.

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



Age	Black	White
18-44 years	41.8%	44.8%
45-64 years	44.8%	55.9%
65+ years	58.0%	64.5%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group
Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2019 data

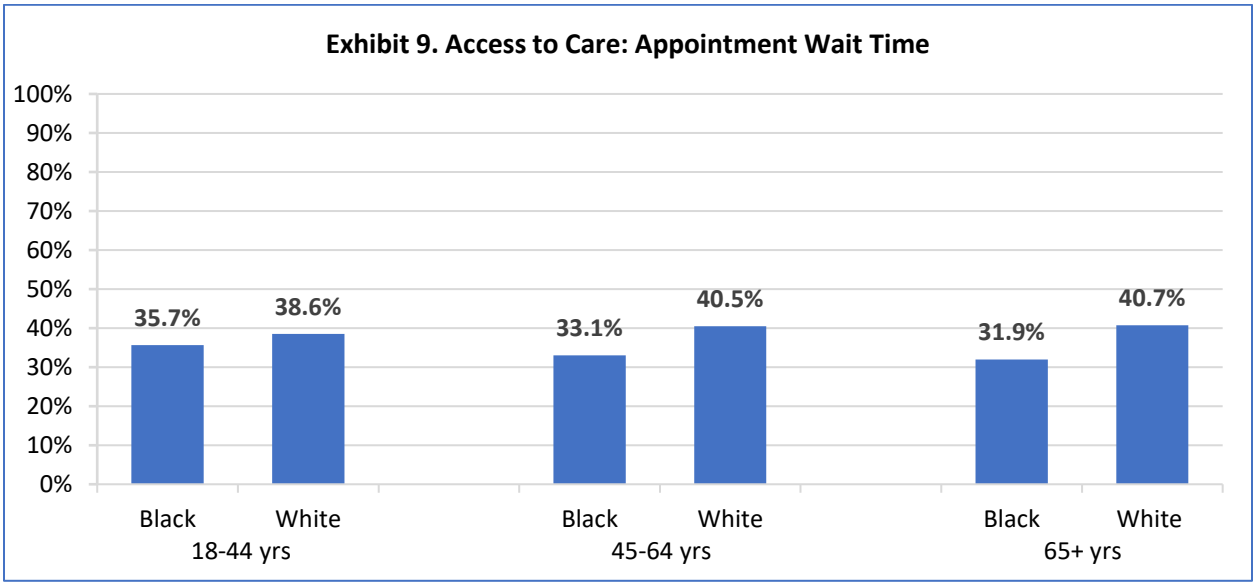
Importance:

- Timeliness of care is a key aspect of quality and delays in healthcare access contribute to poorer physical and mental health, given that untimely access can exacerbate these conditions.[3-5]

Findings:

- Black Veterans ages 45 years and older had lower rates of receiving timely appointments for routine care compared to non-Hispanic White Veterans. Specifically, age group 45–64-year Black (44.8%) versus White (55.9%) Veterans, and age group 65 year and older Black (58.0%) versus White (64.5%) Veterans received timely appointments for routine care.

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



Age	Black	White
18-44 years	35.7%	38.6%
45-64 years	33.1%	40.5%
65+ years	31.9%	40.7%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group
Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2019 data

Importance:

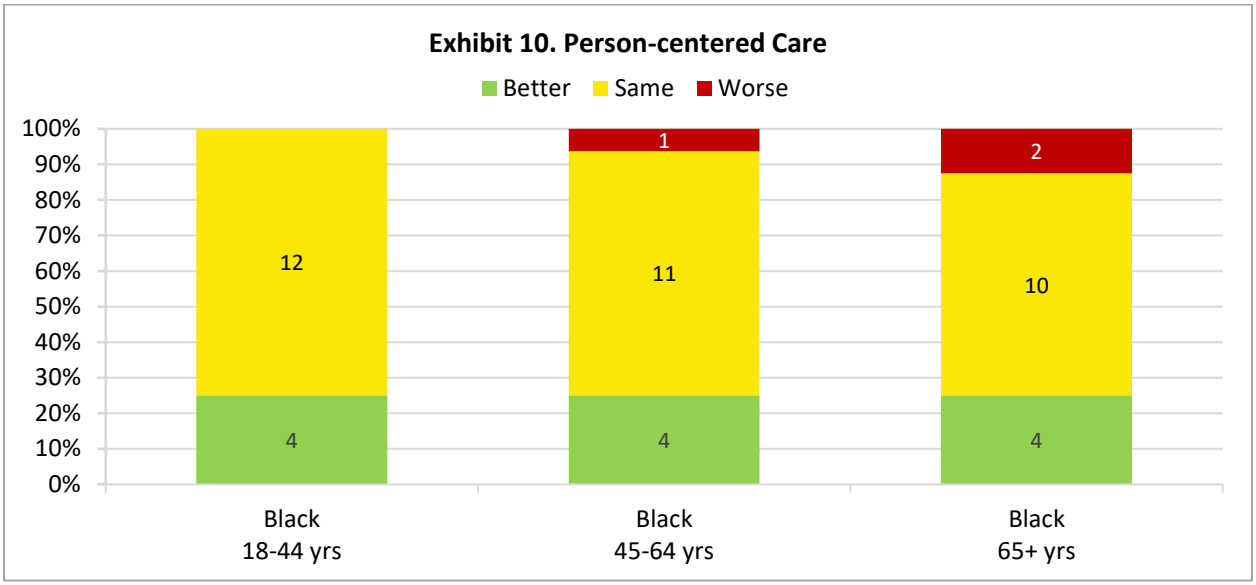
- Long clinic waiting times negatively impact patient satisfaction, patient engagement and the likelihood that patients will recommend the practice to others.[6-7]

Findings:

- Black Veterans ages 45 years and older had lower rates of seeing their provider within 15 minutes of their appointment time compared to non-Hispanic White Veterans. Specifically, age group 45–64-year Black (33.1%) versus White (40.5%) Veterans, and age group 65 year and older Black (31.9%) versus White (40.7%) Veterans were seen by their provider within 15 minutes of their appointment time.

Variations in VHA Patient Experience of Person-centered Care by Veteran Race and ethnicity

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



Comparison	Black 18-44 yrs	Black 45-64 yrs	Black 65+ yrs
Worse	0	1	2
Same	12	11	10
Better	4	4	4

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group
Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2019 data

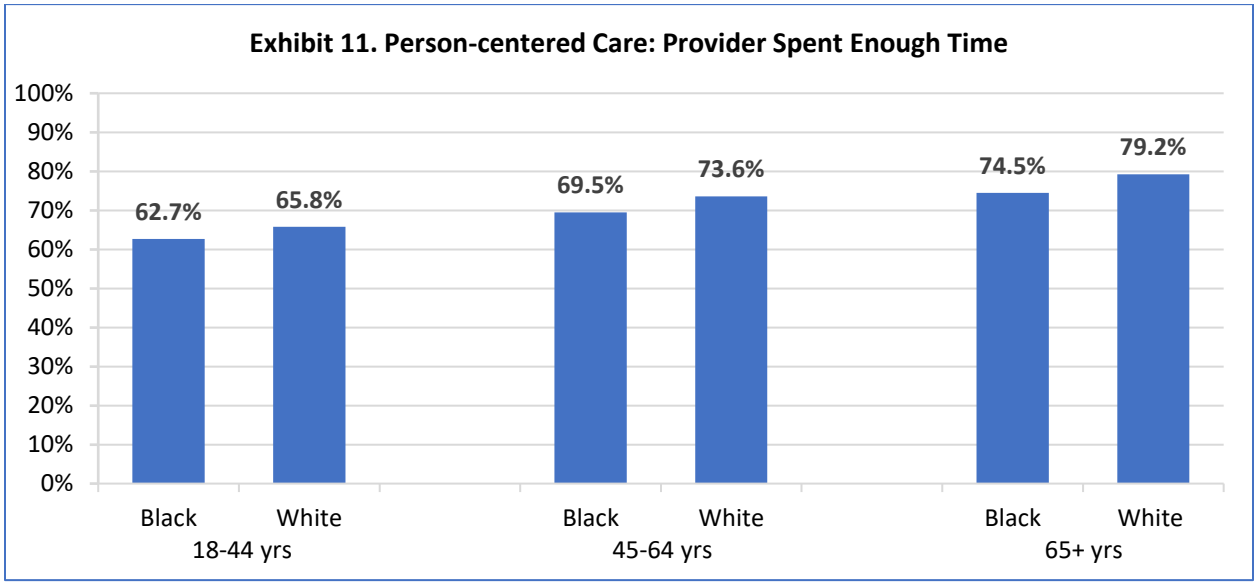
Importance:

- National guidelines define patient-centered care as essential for patient engagement and satisfaction in order to ensure patient's desired outcomes.[8]

Findings:

- Among Veterans ages 18-44 years, Black Veterans received the same person-centered care on 12 measures and better care on 4 measures compared to non-Hispanic White Veterans.
- Among Veterans ages 45-64 years, Black Veterans received worse person-centered care on 1 measure, better care on 4 measures, and the same care on 11 measures compared to non-Hispanic White Veterans.
- Among Veterans ages 65 years and older, Black Veterans received worse person-centered care on 2 measures, better care on 4 measures, and the same care on 10 measures compared to non-Hispanic White Veterans.

Exhibit 11. VHA users who indicated, in the last 6 months, their provider always spent enough time with them



Age	Black	White
18-44 years	62.7%	65.8%
45-64 years	69.5%	73.6%
65+ years	74.5%	79.2%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group
Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2019 data

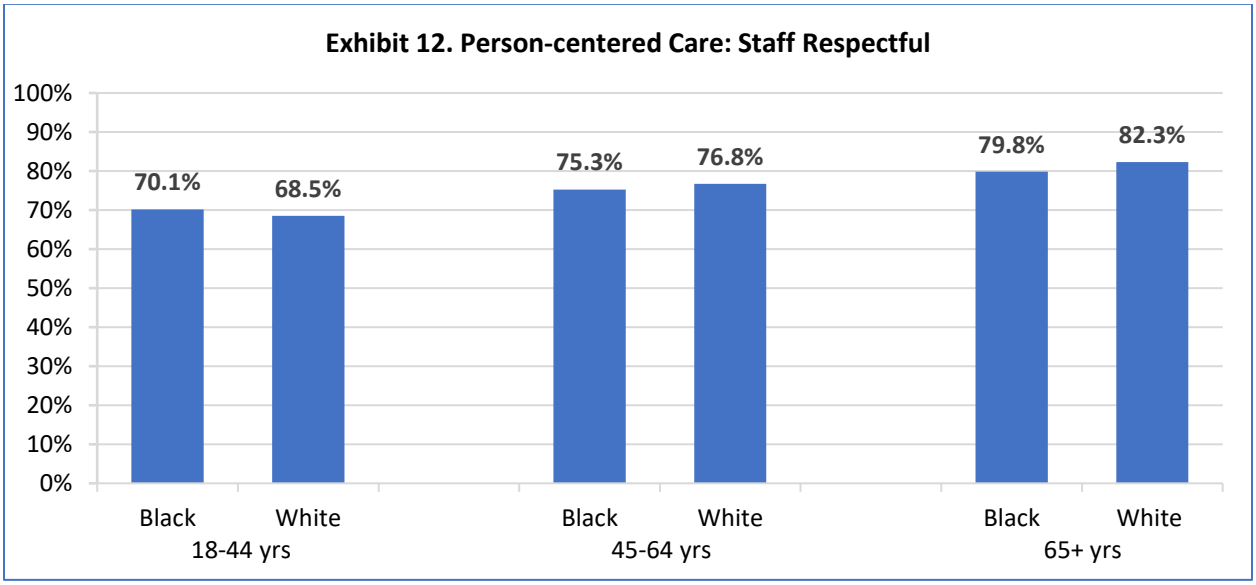
Importance:

- Person-centered communication care involves adequate time for communication with healthcare providers which is associated with higher patient satisfaction.[9,10]

Findings:

- Black Veterans ages 45 years and older had lower rates of their provider always spending enough time with them compared to non-Hispanic White Veterans. Specifically, age group 45–64-year Black (69.5%) versus White (73.6%) Veterans, and age group 65 year and older Black (74.5%) versus White (79.2%) Veterans experienced their provider always spending enough time with them.

Exhibit 12. VHA users who indicated, in the last 6 months, clerks and receptionists at their provider's office always treated them with courtesy and respect



Age	Black	White
18-44 years	70.1%	68.5%
45-64 years	75.3%	76.8%
65+ years	79.8%	82.3%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group
Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2019 data

Importance:

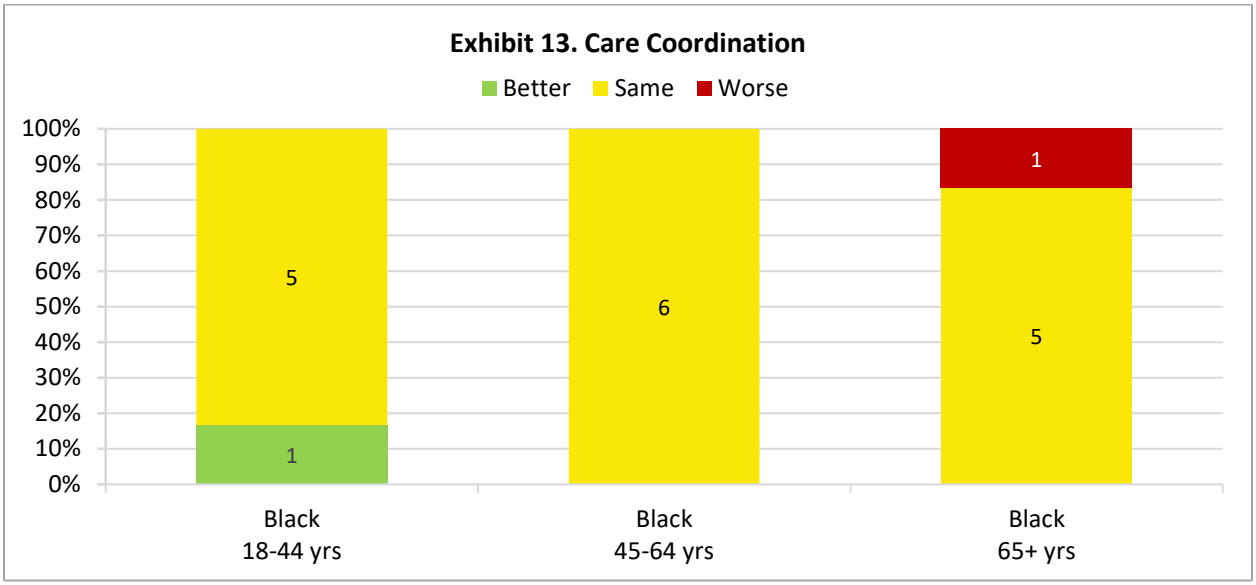
- A key aspect of person-centered care is interpersonal interactions, particularly between healthcare staff and patients. Metrics for good communication include how helpful and respectful office staff are in their interactions with patients.

Findings:

- Black Veterans ages 65 years and older had lower rates of clerks and receptionists at their provider's office always treating them with courtesy and respect compared to non-Hispanic White Veterans. Specifically, age group 65 year and older Black (79.8%) versus White (82.3%) Veterans experienced clerks and receptionists at their provider's office always treating them with courtesy and respect.

Variations in VHA Patient Experience of Care Coordination by Veteran Race and ethnicity

Exhibit 13. Number and percentage of measures for which Black or African American Veteran VHA patients of specified age groups experienced better, same, or worse care coordination compared with non-Hispanic White Veterans



Comparison	Black 18-44 yrs	Black 45-64 yrs	Black 65+ yrs
Worse	0	0	1
Same	5	6	5
Better	1	0	0

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group
Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2019 data

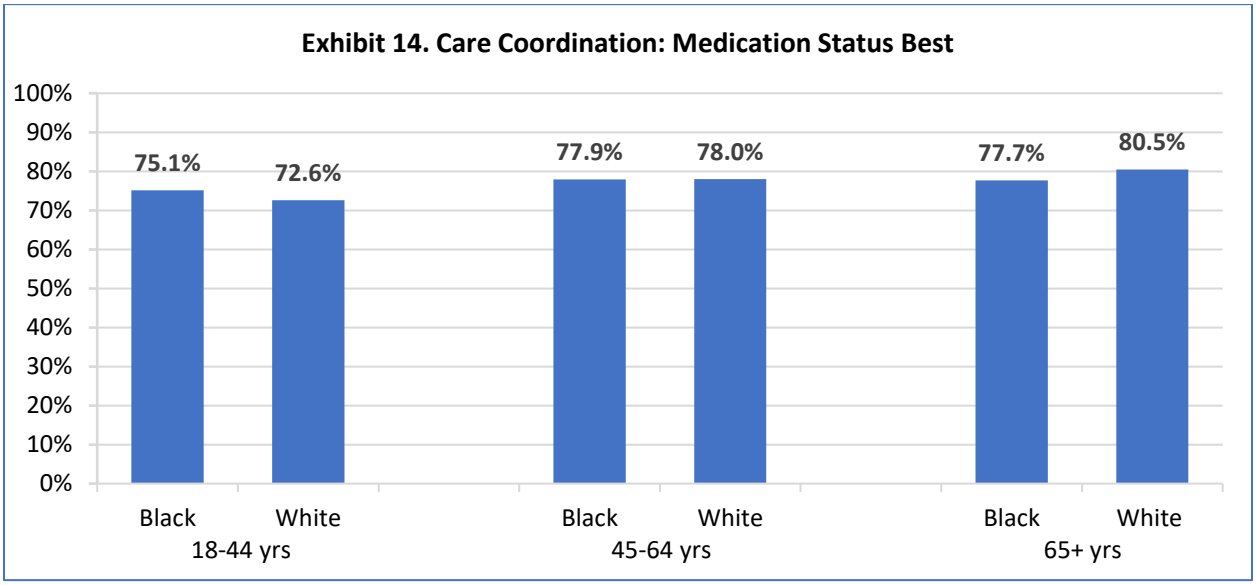
Importance:

- Excellent care coordination prevents fragmentation of communication, information and clinical services in order to ensure high quality care.[11]

Findings:

- Among Veterans ages 18-44 years, Black Veterans had the same care coordination on 5 measures and better coordination on 1 measure compared to non-Hispanic White Veterans.
- Among Veterans ages 45-64 years, Black Veterans had the same care coordination 6 measures compared to non-Hispanic White Veterans.
- Among Veterans ages 65 years and older, Black Veterans had worse care coordination on 1 measure and better coordination on 5 measures compared to non-Hispanic White Veterans.

Exhibit 14. VHA users who indicated that when they talked about starting or stopping a prescription medication, the provider asked them what they thought was best for them



Age	Black	White
18-44 years	75.1%	72.6%
45-64 years	77.9%	78.0%
65+ years	77.7%	80.5%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group
Source: Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2019 data

Importance:

- High quality person-centered doctor communication is associated with high overall patient satisfaction which improves health behaviors, treatment adherence and health status.[10,12]

Findings:

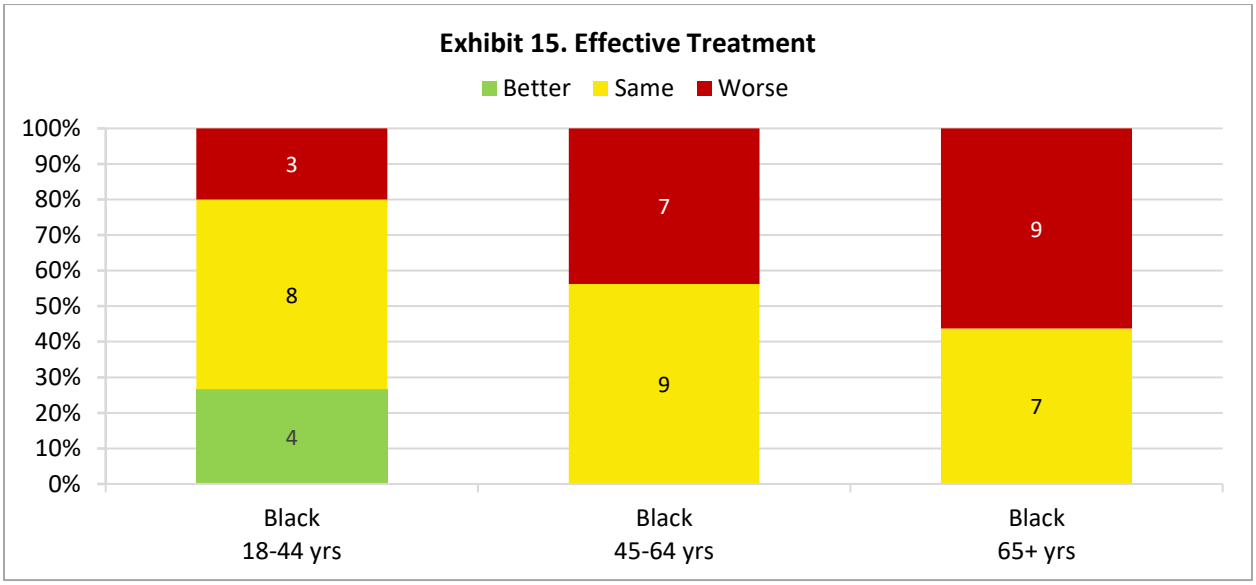
- Black Veterans ages 65 years and older had lower rates of their provider asking them what they thought was best for them when they talked about starting or stopping a prescription mediation compared to non-Hispanic White Veterans. Specifically, age group 65 year and older Black (77.7%) versus White (80.5%) Veterans experienced their provider asking them what they thought was best for them when they talked about starting or stopping a prescription mediation.

Section IV: Health Care Quality

See Appendix for methods and guidelines for interpretation

Variations in VHA Health Care Quality of Effective Treatment by Veteran Race and ethnicity

Exhibit 15. Number and percentage of measures for which Black or African American Veteran VHA patients of specified age groups experienced better, same, or worse effective treatment compared with non-Hispanic White Veterans



Comparison	Black 18-44 yrs	Black 45-64 yrs	Black 65+ yrs
Worse	3	7	9
Same	8	9	7
Better	4	0	0

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group
Source: Health Equity/QUERI Partnered Evaluation Center analysis of EPRP FY2016 – FY2019 data

Importance:

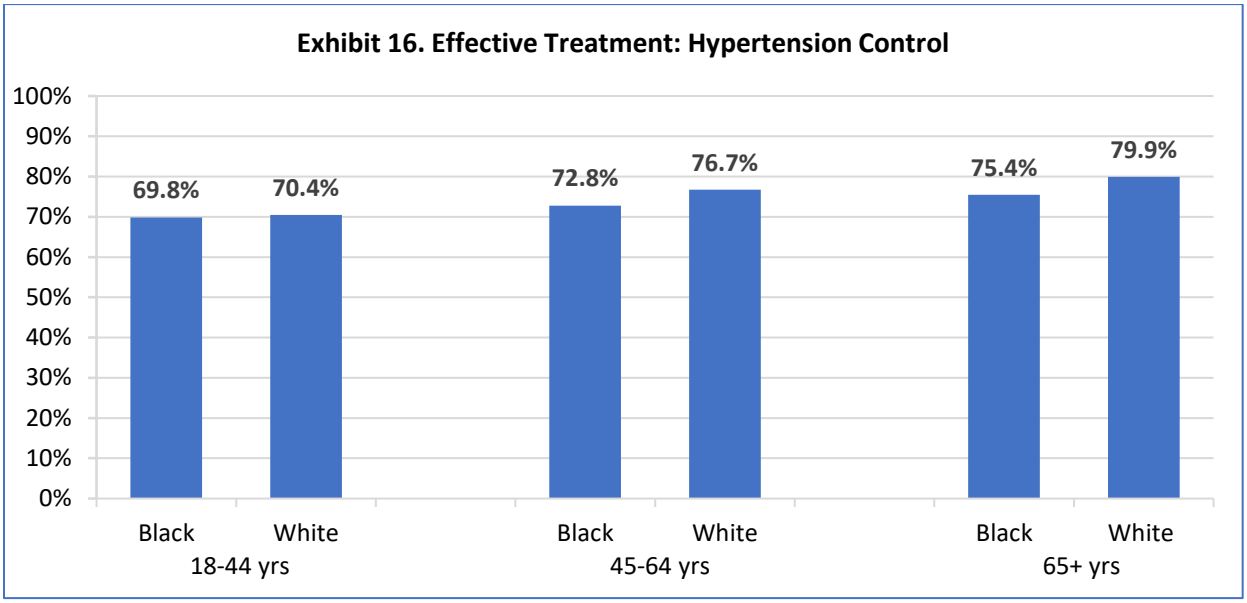
- Effective treatment is essential to ensuring high quality care with good patient outcomes.[8]

Findings:

- Among Veterans ages 18-44 years, Black Veterans experienced worse effective treatment on 3 measures, better treatment on 4 measures, and the same treatment on 8 measures compared to non-Hispanic White Veterans.
- Among Veterans ages 45-64 years, Black Veterans received worse effective treatment on 7 measures and the same effective treatment on 9 measures compared to non-Hispanic White Veterans.

- Among Veterans ages 65 years and older, Black Veterans received worse effective treatment on 9 measures and the same effective treatment on 7 measures compared to non-Hispanic White Veterans.

Exhibit 16. VHA patients with diagnosed hypertension whose most recent blood pressure was less than 140/90 mmHg (or less than 150/90 mmHg for patients age 60-85 without a diagnosis of diabetes)



Age	Black	White
18-44 years	69.8%	70.4%
45-64 years	72.8%	76.7%
65+ years	75.4%	79.9%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group
Source: Health Equity/QUERI Partnered Evaluation Center analysis of EPRP FY2016 – FY2019 data

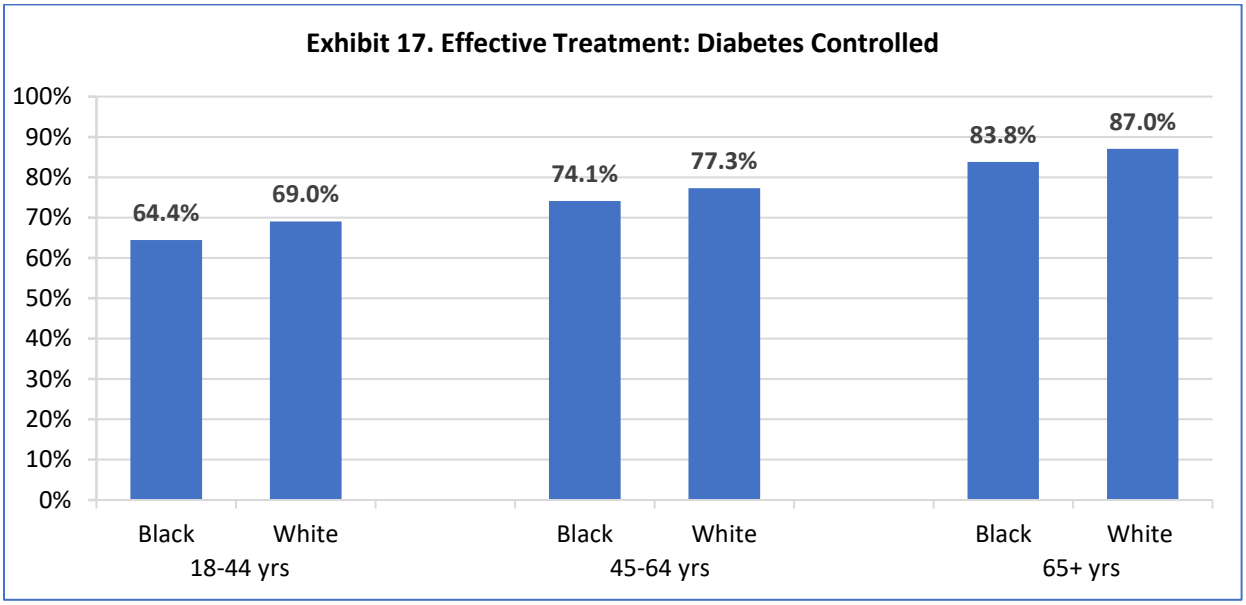
Importance:

- Hypertension is one of the most commonly diagnosed health conditions among Black or African American Veterans using VHA care.[13] Effective blood pressure control is associated with decreased risk for complications from hypertension such as coronary heart disease, heart failure, stroke, and death.[14]

Findings:

- Black Veterans ages 45 years and older with diagnosed hypertension had lower rates of hypertension control compared to non-Hispanic White Veterans. Specifically, age group 45–64-year Black (72.8%) versus White (76.7%) Veterans, and age group 65 year and older Black (75.4%) versus White (79.9%) had lower rates of hypertension control.

Exhibit 17. VHA patients with diagnosed diabetes whose glycosylated hemoglobin (HbA1C) was measured in the prior year, and was less than 9%



Age	Black	White
18-44 years	64.4%	69.0%
45-64 years	74.1%	77.3%
65+ years	83.8%	87.0%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group
Source: Health Equity/QUERI Partnered Evaluation Center analysis of EPRP FY2016 – FY2019 data

Importance:

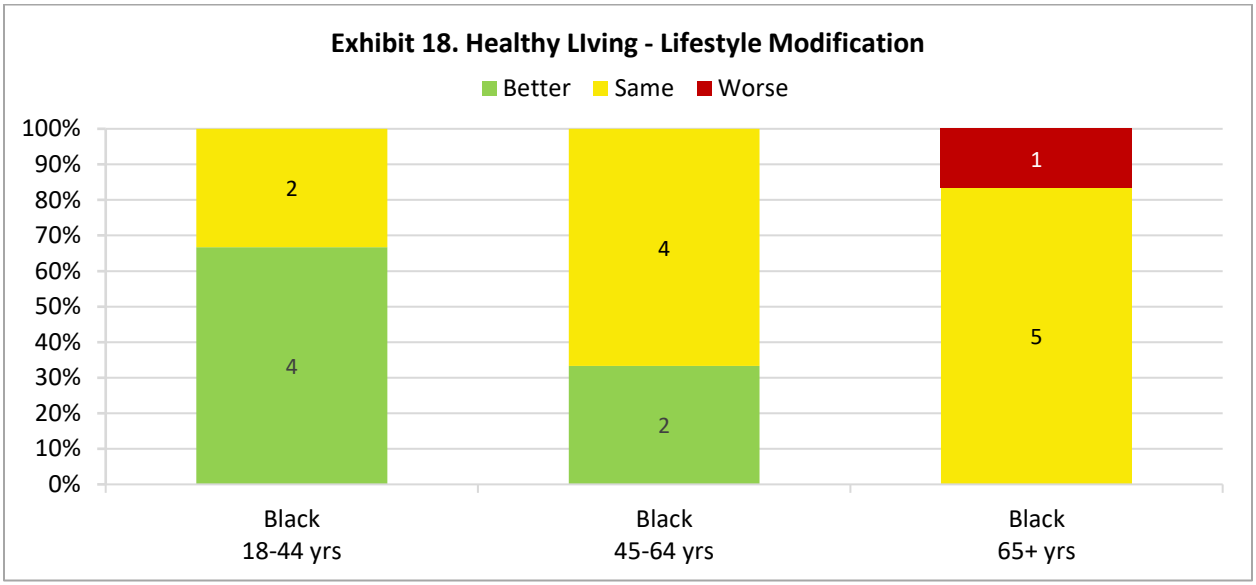
- Patients with diabetes have an increased risk of cardiovascular and kidney disease. Maintaining control of diabetes can reduce the risk of complications from these conditions.[15]

Findings:

- Across all age groups, a lower percentage of Black Veterans with diagnosed diabetes had diabetes controlled compared to non-Hispanic White Veterans. Specifically, age group 18-44-year Black (64.4%) versus White (69.0%) Veterans, age group 45-64-year Black (74.1%) versus White (77.3%) Veterans, and age group 65 year and older (83.8%) versus White (87.0%) Veterans had diabetes controlled.

Variations in VHA Health Care Quality of Healthy Living – Lifestyle Modification by Veteran Race and ethnicity

Exhibit 18. Number and percentage of measures for which Black or African American Veteran VHA patients of specified age groups experienced better, same, or worse healthy living – lifestyle modification compared with non-Hispanic White Veterans



Comparison	Black 18-44 yrs	Black 45-64 yrs	Black 65+ yrs
Worse	0	0	1
Same	2	4	5
Better	4	2	0

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group
Source: Health Equity/QUERI Partnered Evaluation Center analysis of EPRP FY2016 – FY2019 data

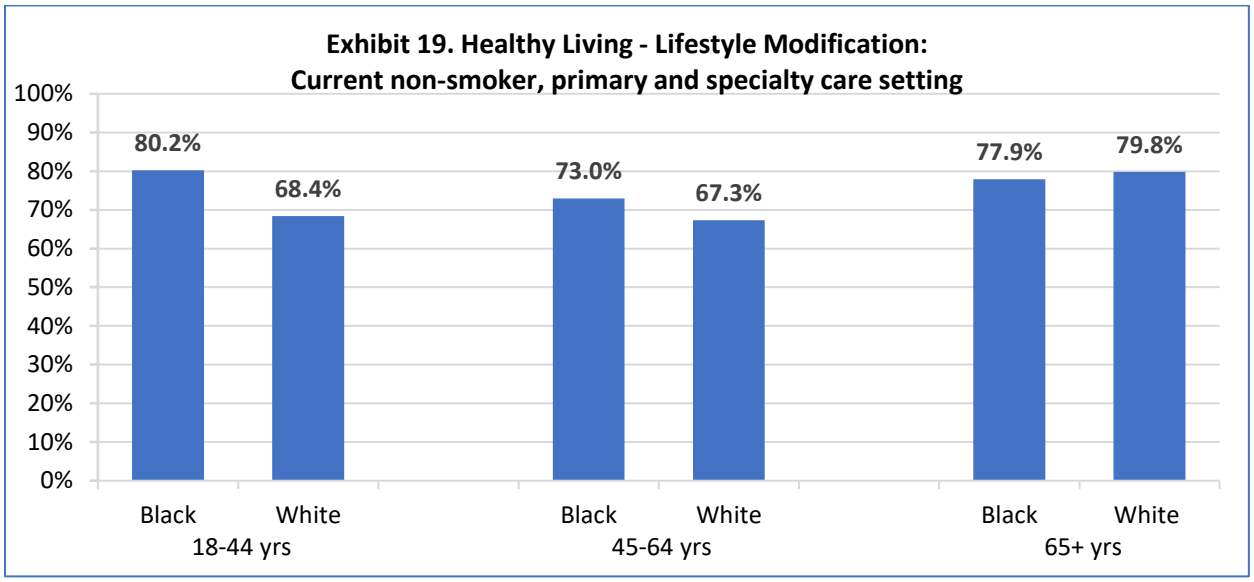
Importance:

- Lifestyle modification is an important part of the prevention and treatment of disease.[16]

Findings:

- Among Veterans ages 18-44 years, Black Veterans experienced the same lifestyle modification on 2 measures and better lifestyle modification on 4 measures compared to non-Hispanic White Veterans.
- Among Veterans ages 45-64 years, Black Veterans received the same lifestyle modification on 4 measures and better lifestyle modification on 2 measures compared to non-Hispanic White Veterans.
- Among Veterans ages 65 years and older, Black Veterans received worse lifestyle modification on 1 measure and the same lifestyle modification on 5 measures compared to non-Hispanic White Veterans.

Exhibit 19. VHA outpatients in a primary care or specialty care clinic who were screened for tobacco use and did not use tobacco any time during the past 12 months



Age	Black	White
18-44 years	80.2%	68.4%
45-64 years	73.0%	67.3%
65+ years	77.9%	79.8%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group
Source: Health Equity/QUERI Partnered Evaluation Center analysis of EPRP FY2016 – FY2019 data

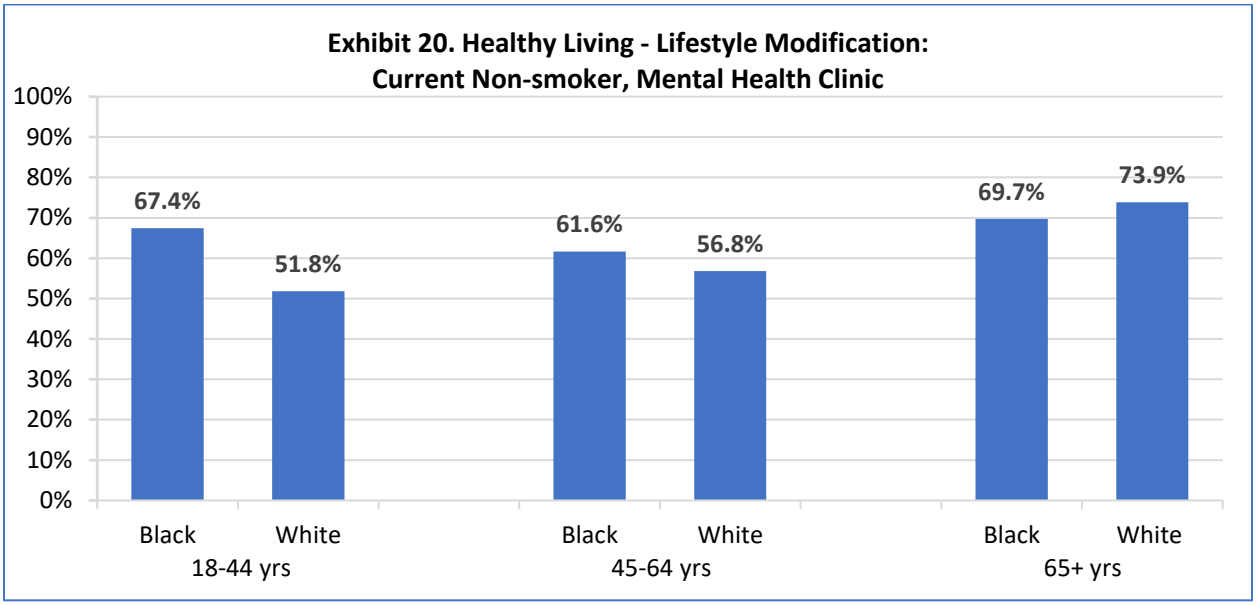
Importance:

- Smoking is the leading preventable cause of premature disease and death in the United States.[17]

Findings:

- Black Veterans ages 18-64 years in a primary care or specialty care clinic who were screened for tobacco use had higher rates of no tobacco use in the past 12 months compared to non-Hispanic White Veterans. Specifically, age group 18-44-year Black (80.2%) versus White (68.4%) Veterans and age group 45-64-year Black (73.0%) versus White (67.3%) Veterans had higher rates of no tobacco use in the past 12 months.

Exhibit 20. VHA outpatients with a mental health diagnosis who were screened for tobacco use and did not use tobacco any time during the past 12 months



Age	Black	White
18-44 years	67.4%	51.8%
45-64 years	61.6%	56.8%
65+ years	69.7%	73.9%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group
Source: Health Equity/QUERI Partnered Evaluation Center analysis of EPRP FY2016 – FY2019 data

Importance:

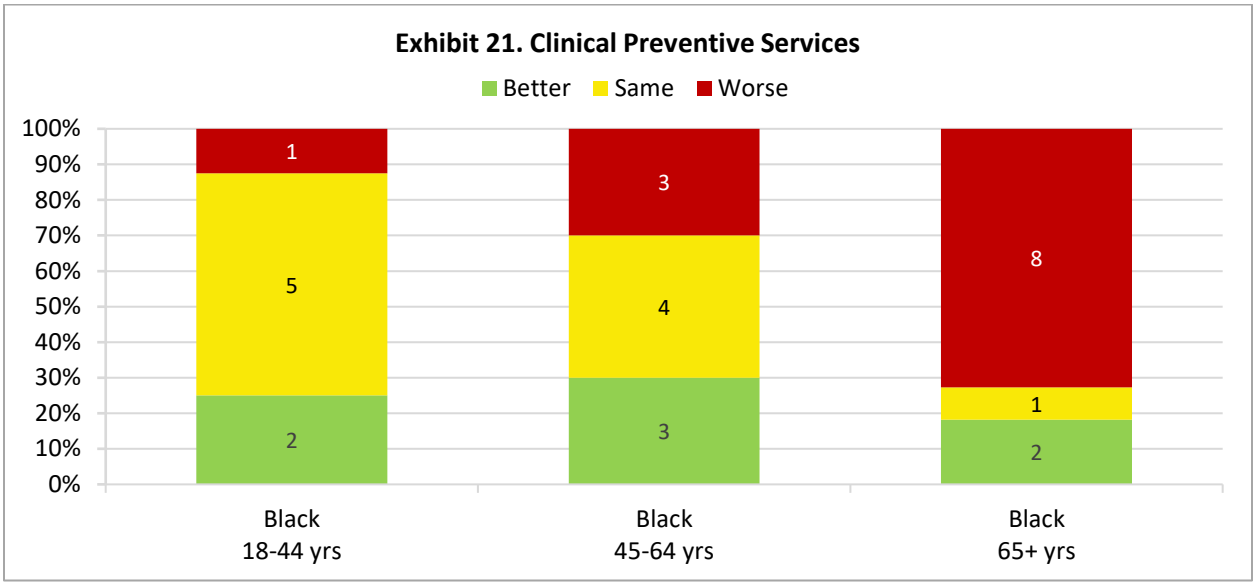
- Smoking is the leading preventable cause of premature disease and death in the United States.[17]

Findings:

- Black Veterans ages 18-64 years with a mental health diagnosis who were screened for tobacco use had higher rates of not smoking in the past 12 months compared to non-Hispanic White Veterans. Specifically, age group 18-44-year Black (67.4%) versus White (51.8%) Veterans and age group 45-64 years Black (61.4%) versus White (56.8%) Veterans had higher rates of being a non-smoker in the past 12 months
- Black Veterans ages 65 years and older with a mental health diagnosis who were screened for tobacco use had lower rates of not smoking in the past 12 months compared to non-Hispanic White Veterans. Specifically, 69.7% of Black Veterans compared to 73.9% of White Veterans had lower rates of being a non-smoker.

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

Exhibit 21. Number and percentage of measures for which Black or African American Veteran VHA patients of specified age groups experienced better, same, or worse healthy living – clinical preventive services compared with non-Hispanic White Veterans



Comparison	Black 18-44 yrs	Black 45-64 yrs	Black 65+ yrs
Worse	1	3	8
Same	5	4	1
Better	2	3	2

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group
Source: Health Equity/QUERI Partnered Evaluation Center analysis of EPRP FY2016 – FY2019 data

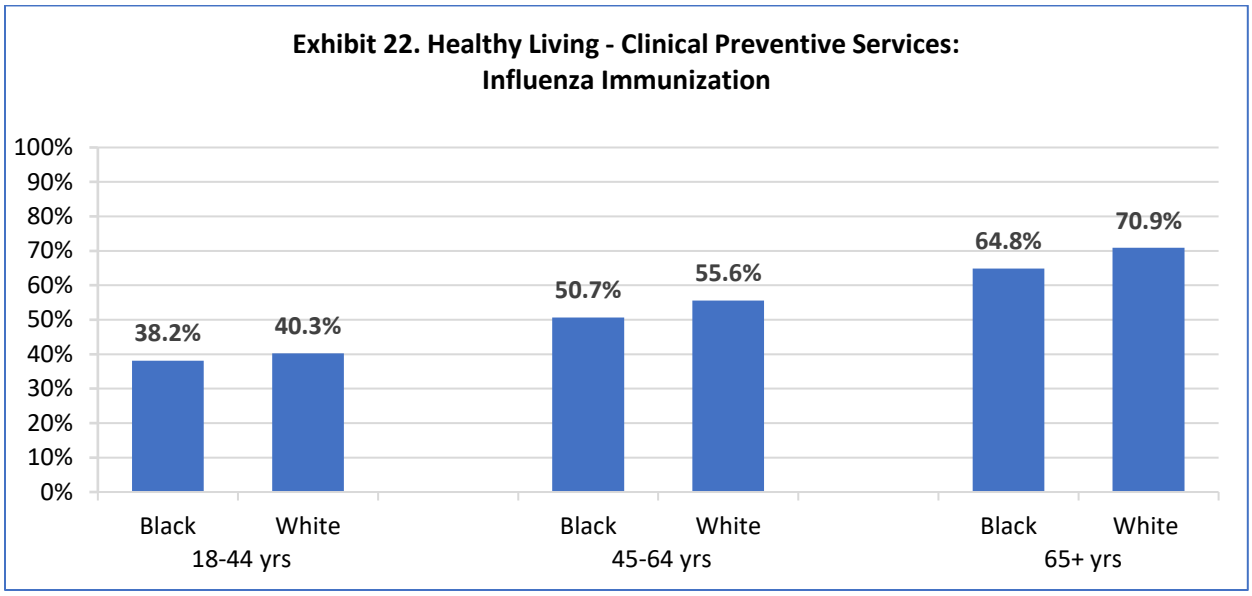
Importance:

- Clinical preventive services are an essential part of maintaining health and preventing disease. [16,18]

Findings:

- Among Veterans ages 18-44 years, Black Veterans experienced worse clinical preventive services on 1 measure, better services on 2 measures, and the same services on 5 measures compared to non-Hispanic White Veterans.
- Among Veterans ages 45-64 years, Black Veterans received worse clinical preventive services on 3 measures, better services on 3 measures, and the same services on 4 measures compared to non-Hispanic White Veterans.
- Among Veterans ages 65 years and older, Black Veterans received worse clinical preventive on 8 measures, better services on 2 measures, and the same services on 1 measure compared to non-Hispanic White Veterans.

Exhibit 22. VHA patients who received an influenza vaccination during July through March of the measurement year [Note: This measure was assessed FY2017-FY2019]



Age	Black	White
18-44 years	38.2%	40.3%
45-64 years	50.7%	55.6%
65+ years	64.8%	70.9%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group
Source: Health Equity/QUERI Partnered Evaluation Center analysis of EPRP FY2016 – FY2019 data

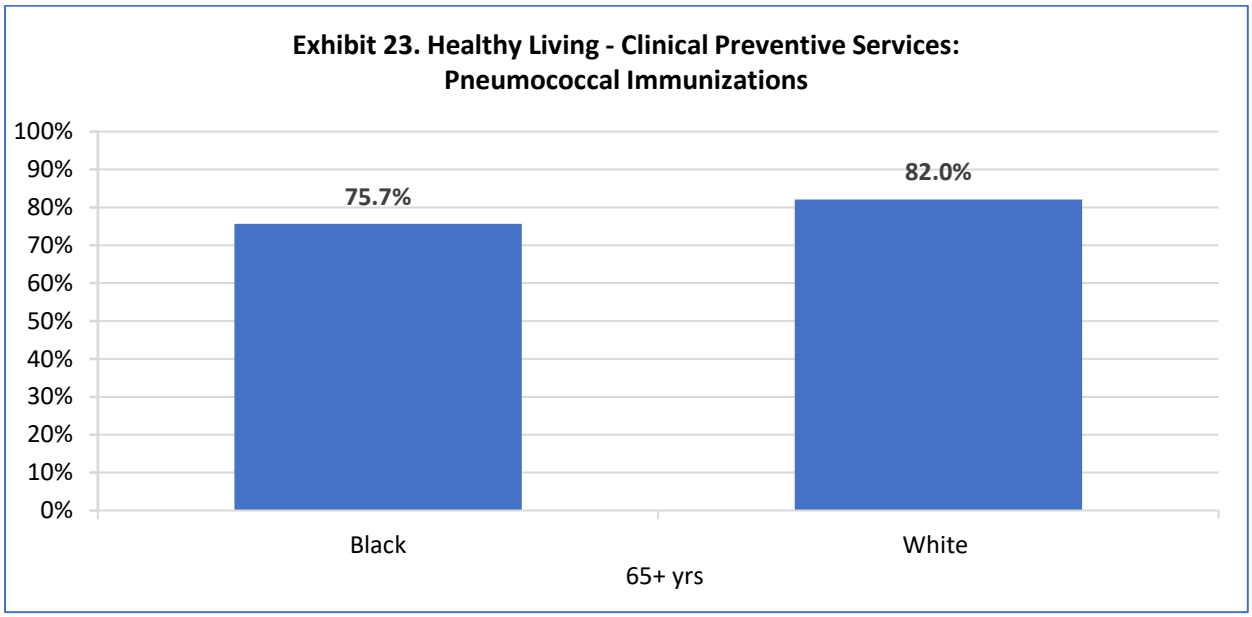
Importance:

- Vaccination can prevent influenza and reduce influenza-related morbidity and mortality.[19]

Findings:

- Across all age groups, a lower percentage of Black Veterans received an influenza immunization compared to non-Hispanic White Veterans. Specifically, age group 18-44 years Black (38.2%) versus White (40.3%) Veterans, age group 45-64 years Black (50.7%) versus White (55.6%) Veterans, and age group 65 year and older (64.8%) versus White (70.9%) Veterans received an influenza immunization.

Exhibit 23. VHA patients age 65 or older who received pneumococcal immunizations



Age	Black	White
65+ years	75.7%	82.0%

Reference group: Non-Hispanic White Veteran VHA patients of corresponding age group
Source: Health Equity/QUERI Partnered Evaluation Center analysis of EPRP FY2016 – FY2019 data

Importance:

- Pneumococcal infections cause substantial morbidity and mortality, including from pneumonia, meningitis, bacteremia, and other infections. Pneumococcal vaccination helps to prevent the leading bacterial cause of pneumonia worldwide.[20]

Findings:

- Black Veterans ages 65 years and older had lower rates of pneumococcal immunization compared to non-Hispanic White Veterans. Specifically, 75.7% of Black Veterans compared to 82.0% of White Veterans received pneumococcal immunizations.

Section V: Addressing Disparities

The VA champions the elimination of health disparities and promotes equity. VA uses three key pillars to promote equity: (1) workforce development, working with staff to ensure a diverse and inclusive work environment; (2) social supports, identifying social risks and addressing social determinants of health (SDOH) that contribute to risks; and (3) quality of care, working with providers on interventions to reduce health inequities in health care and improve health outcomes.

The National Veterans Health Equity Report 2021 indicates that by race and ethnicity, along with American Indian or Alaska Native Veterans, Black or African American Veterans had the greatest disparities in care quality compared with non-Hispanic White Veterans.[1] Key findings from fiscal year 2016 to fiscal year 2019 VA SHEP-PCMH survey instrument include that Black Veterans ages 45 years and older report lower rates of receiving timely appointments for routine care and lower rates of seeing their provider within 15 minutes of their appointment time, as well as lower rates of experiencing that their provider always spent enough time with them compared to non-Hispanic White Veterans. Additionally, Black Veterans ages 65 years and older reported lower rates of clerks and receptionists at their provider's office always treating them with courtesy and respect as well as lower rates of their provider asking their input when discussing starting or stopping a prescription mediation, compared to non-Hispanic White Veterans. Clinical data from the fiscal year 2016 to fiscal year 2019 VA External Peer Review Program quality monitoring program reveals key findings including that Black Veterans ages 45 years and older had lower rates of hypertension control, and lower percentages of diabetic Black Veterans across all age groups had an A1C measured in the prior year and less than 9% compared to non-Hispanic White Veterans. However, findings also include that Black Veterans across all age groups, either with or without a mental health diagnosis, had a lower rate of no tobacco use compared to non-Hispanic White Veterans. Continued efforts are needed to improve the experience of care and clinical quality outcomes for Black Veterans. Examining current examples of VA work under the three pillars will help guide future efforts in reducing disparities.

Workforce Development

VA addresses disparities in patient experiences, such as those reported by Black Veterans in the SHEP-PCMH data discussed here by implementing workforce development and diversity efforts. For example, VA offers multiple online trainings on unconscious biases as part of efforts to ensure staff and providers recognize and address any implicit biases in their clinical practice and interactions with patients.[21] In addition, VA staff across the field are working to address disparities that Black Veterans and staff experience. Examples of workgroups include

- Inclusion, Diversity, Equity, and Access Committee (IDEA), Durham, NC;
- Jesse Brown for Black Lives Task Force, Chicago, IL; and
- Social Work Service Diversity Action Committee, San Diego, CA.

These teams are interdisciplinary and address workforce competence, outcomes, clinical interventions and more. In addition, VA supports programs to market VA as an employer of choice and emphasize health equity in care to Black students and recent graduates including fellowship and training programs that partner with Historically Black Colleges and Universities (HBCUs). Also, VA is an official member agency of the White House Initiative on Advancing Educational Equity, Excellence, and Economic Opportunity through HBCUs.

Social Supports

The Assessing Circumstances and Offering Resources for Needs (ACORN) Initiative screens Veterans to determine and address social needs to prevent adverse effects on health outcomes.[22] The ACORN screener covers the following domains:

- Education
- Employment
- Food Security
- Housing
- Legal
- Social Isolation & Loneliness
- Transportation
- Technology
- Utilities

The domains align with the social determinants of health. Prior to screening, VA teams build resource guides that include VA, federal, and local programs that provide services and resources to address the unmet needs of Veterans. The guides are tailored to a Veterans' geographic location. ACORN works in partnership with OHE and the National Social Work Program to improve health outcomes and promote health equity.

In an effort to address negative mental health outcomes Veterans of color experience, VA researchers developed and implemented a race-based stress and trauma (RBST) group intervention to assist providers with cultural competence while addressing clinical issues.[23] Facilitators, group discussions, and psychoeducation are used to explore themes of racial identity, shared stories, coping strategies, systemic and interpersonal racism, along with resilience and empowerment. RBST is intended to supplement evidence-based treatments and adjustments may be needed if implemented more widely to address specific needs.

The VA has multiple programs and initiatives in place to propel this integral work. For example, in VISN 17, an interventional program works to address the disparity in hypertension control among Black Veterans by offering telehealth programs, healthy kitchen demonstrations, individual appointments with Registered Dieticians and Pharmacists, and health coaching to Black Veterans experiencing hypertension.[24] A VA research team supported by The Office of Health Equity (OHE) created a series of videos featuring Veterans offering peer to peer advice on controlling hypertension, and a 2016 impact study reported that after viewing the videos Black Veterans expressed greater intentions to engage in healthy behaviors and follow their prescribed medication regimens.[25]

Quality of Care

The Primary Care Equity Dashboard (PCED) is a tool that helps VA Medical Centers (VAMCs) address disparities by providing data specific to the VAMC and Veteran Integrated Service Network (VISN) on quality measures.[26] VAMCs can compare their performance to national standards and filter by sex, rurality, race, and neighborhood poverty level. Measures include diabetes and blood pressure control, and statin therapy and adherence which are key to reducing health disparities in Black Veterans. Quality improvement (QI) tools assist providers in improving care and outcomes. The VA Palo Alto Healthcare System led a QI project that utilized data from the PCED to help identify and address a disparity in blood pressure control for Veterans who receive care from VA Palo Alto when compared to national averages for VA facilities nationwide. The Palo Alto team was able to utilize advance features of the Dashboard to determine variations across racial and ethnic groups. Black Veterans were identified as one

of two of the largest groups who were below the national average. The team used equity resources and toolkits provided in the PCED to plan and implement a program that involved outreach between student interns and Veterans. Using a script designed in part by Veterans of Color, students communicated with Veterans regularly via telephone and helped them check, monitor, and request services to control their blood pressure. Over a six-month period, VA Palo Alto was able to improve their overall performance for blood pressure control and decrease the disparity among Black Veterans at their facility. The project used the PCED to tailor their intervention to meet the needs of the Veterans most affected in their community. The PCED is available to all VA staff and providers and can be used to implement and scale patient-centered projects to improve quality of care for all Veterans.

Section VI: Conclusions

Among Veteran VHA patients, healthcare experiences and achievement of quality metrics varied across patient characteristics of race and ethnicity and age group. Black or African American Veterans in all but the youngest age category experienced greater deficits in perceived access than non-Hispanic White Veterans of the same age group. For the patient experience domains of person-centered care and care coordination, perceptions of care were similar between Black and White Veterans for several measures.

Race disparities in healthcare quality were primarily present for measures of effective treatment and measures of clinical preventive services. In these domains, there were age-related differences in race disparities, with the most widespread disparities present for the age 65 and older group, in contrast to more comparable measures between Black and White Veterans in the 18 to 44 years age group. Work is needed to improve the Veteran experience of care among Black or African American Veterans. Findings highlight areas of focus for VHA equity-guided improvement strategies.

Appendix: Brief Overview of Methods and Guidelines for Interpretation

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

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

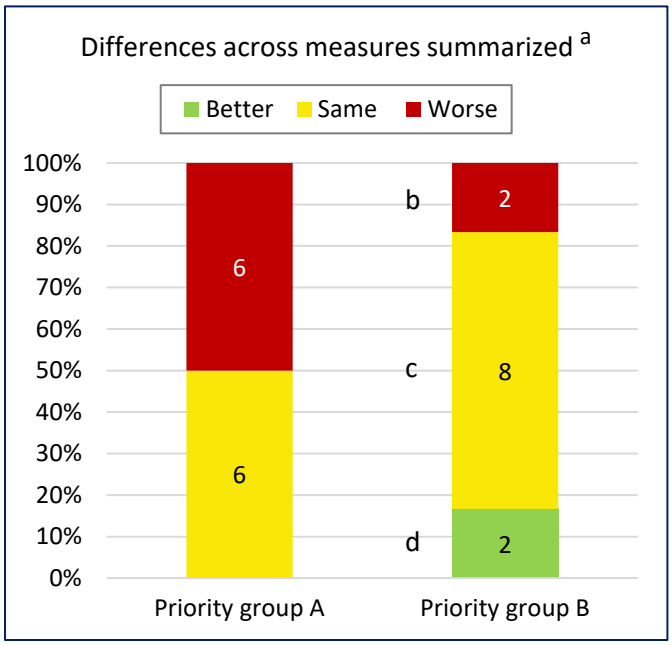
To facilitate comparisons between VHA data and publicly available data representing the U.S. population, we report race and ethnicity groups as mutually exclusive. All individuals with indication of Hispanic ethnicity are included in the "Hispanic" race and ethnicity group regardless of their race, and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

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

To categorize a difference as a disparity (or an advantage, if the difference favored the priority group), we applied two criteria for a meaningful difference: an absolute difference that was statistically significant with a p-value <0.05 on a two-tailed test, AND a relative difference of at least 10%, where the relative difference is the difference between the priority group gap in care and the reference group gap in care, divided by the reference group gap in care. Both criteria had to be satisfied for a difference to be categorized as a disparity. These criteria are based on the standard applied by the Agency for Healthcare Research and Quality (AHRQ) in their annual National Healthcare Quality and Disparities Report for the U.S. population.[27]

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

Exhibit 24. Illustration of Domain Summary Figure



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

[a] 12 measures in this domain

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

[c] Group B has same outcomes on 8 measures

[d] Group B has better outcomes on 2 measures

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