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BEFORE THE
SUBCOMMITTEE ON HEALTH
HOUSE VETERANS AFFAIRS COMMITTEE**

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Good afternoon Chairwoman Brownley, Ranking Member Dunn, and distinguished Members of the Subcommittee. I appreciate the opportunity to discuss our continued progress in achieving health equity for Minority Veterans. I am accompanied today by Dr. Ernest Moy, Executive Director, Office of Health Equity, and Dr. Donna Washington, Attending Physician at the Greater Los Angeles Healthcare System.

Introduction

The health and well-being of our Nation's men and women who have served in uniform are the highest priority for VA. VA is committed to providing timely access to high-quality, recovery-oriented, evidence-based health care that anticipates and responds to Veterans' needs and supports the reintegration of returning Servicemembers and to shorten the distance between people in need of Veterans services. At VA, we are working to increase our reach among all Veterans, regardless of age, gender, race, ethnicity, and sexual orientation to ensure all of our Veterans receive and find access to quality and inclusive care from our health care systems. Today, I will talk about some of the successes and challenges we face in achieving health equity for Veterans, some of the programs that make this happen, and how the recent GAO report is guiding future improvement.

Care for Minority Veterans

VA has worked hard to try to get all Veterans the care they need. We are proud of our successes, but understand that there is still much work to be done. Overall, there are few differences¹ in the quality of services delivered to Veterans by VHA related to

¹ Trivedi AM, 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.* 2011 Apr;30(4):707-15.

race and ethnicity. Preventive care and care for chronic diseases are delivered at comparable rates inside VHA, in contrast to care in the private sector where disparities are common. For example, ²prior to the launch of VHA's Health Equity Action Plan, rates of colorectal cancer screening for Black Veterans who used VHA lagged rates for White Veterans. Now, ³there are no significant differences in rates of colorectal cancer screening among White, Black, and Hispanic Veterans who use VHA, and the overall rate is about 80 percent; in the private sector, disparities are common and overall rates lower, averaging, for example, 60-65% among commercial health plans that provide data to NCQA. Within VHA, colorectal cancer screening rates among American Indian/Alaska Natives are 75%; while superior to the private sector, additional study is needed to understand why this rate differs from other groups within VHA. While delivery of services is equitable, ⁴outcomes of care for racial and ethnic minority Veterans in VHA often lag behind outcomes achieved by non-Hispanic White Veterans. For example, while receiving comparable services, racial and ethnic minority Veterans with diabetes are more likely to have poor glucose control and less likely to have good control of blood pressure and cholesterol. There are sex, race, and ethnicity differences in these outcomes. For example, non-Hispanic Black Veterans with diabetes are less likely than non-Hispanic White Veterans to have good blood pressure and glucose control, irrespective of sex. Among Veterans with heart disease, women, irrespective of race and ethnicity, are less likely to have good cholesterol control compared with either non-Hispanic Black or non-Hispanic White male Veterans. In comparison to commercial plans, achievement of control of these cardiovascular risk factors are much higher with VA, and VA racial and ethnic disparities are smaller.

⁵Mortality differences favoring non-Hispanic White Veterans also exist although they are typically smaller than mortality differences among the U.S. population as a whole. For example, heart disease and cancer are the leading causes of death for women in both VA and the U.S. general population – accounting for about one-half of

² Trivedi AM, 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 Affairs*. 2011 Apr;30(4):707-15.

³ May FP, Yano EM, Provenzale D, Steers WN, Washington DL. Race, Poverty, and Mental Health Drive Colorectal Cancer Screening Disparities in the Veterans Affairs Healthcare System. *Medical Care*. 2019 Oct;57(10):773-780.

⁴ Washington DL, Steers WN, Huynh AK, Frayne SM, Uchendu US, Riopelle D, Yano EM, Saechao FS, Hoggatt KJ. Racial And Ethnic Disparities Persist At Veterans Health Administration Patient-Centered Medical Homes. *Health Affairs*. 2017 Jun 1;36(6):1086-94.

⁵ Wong MS, Hoggatt KJ, Steers WN, Frayne SM, Huynh AK, Yano EM, Saechao FS, Ziaieian B, Washington DL. Racial/ethnic disparities in mortality across the Veterans Health Administration. *Health Equity*. 2019 Apr 8; 3(1):99-108.

deaths. ⁶In the U.S. population, non-Hispanic Black women have a higher death rate than non-Hispanic White women for all causes, heart disease, and cancer mortality. Among VA health care users, these disparities have been eliminated. Non-Hispanic Black women Veterans who use VHA do not experience higher death rates than White women, unlike non-Hispanic Black women in the U.S. general population.

Smaller disparities in health outcomes among racial and ethnic minority Veterans compared with non-Veterans may be attributed in part to fewer financial barriers to care. A recent Health Affairs article⁷ showed that “Substantial racial/ethnic disparities in cost-related medication nonadherence were consistently present among people with non-VHA coverage, but not among VHA enrollees. For instance, among those with non-VHA coverage, 5.9 percent of whites couldn’t afford a prescription drug, versus 8.6 percent of Hispanics and 10.6 percent of Blacks. However, no significant racial/ethnic differences were present among people with VHA coverage.”

Office of Health Equity Efforts

The Office of Health Equity (OHE) has a broad charge including gathering and analyzing data on disparities among Veterans, developing communication products to raise awareness about equity issues faced by Veterans, working with VA medical centers (VAMC) to improve outcomes of care for all Veterans, and supporting workforce diversity and inclusion within VHA. VA has successfully addressed social determinants of health on a large scale, such as reducing homelessness and food insecurity among Veterans. VA also has the capacity to address other determinants such as education, employment, and social isolation in conjunction with Veterans Service Organizations. Consequently, OHE supported the development of the Accessing Circumstances, Offering Resources for Need (ACORN) project to screen Veterans for a broad range of social determinants, which disproportionately affect communities of color, and match them with appropriate social services. OHE has also developed the Equity-Guided Improvement Strategy (EGIS) which uses equity information at VAMCs to target specific groups of Veterans for quality improvement and connect them with services tailored to their needs.

December 2019 Government Accountability Office (GAO) Report Recommendations and Responses

⁶ Wong MS, Hoggatt KJ, Steers WN, Frayne SM, Huynh AK, Yano EM, Saechao FS, Ziaieian B, Washington DL. Racial/ethnic disparities in mortality across the Veterans Health Administration. *Health Equity*. 2019 Apr 8; 3(1):99-108.

⁷ Gaffney A, Bor DH, Himmelstein DU, Woolhandler S, McCormick D. The Effect Of Veterans Health Administration Coverage On Cost-Related Medication Nonadherence. *Health Aff (Millwood)*. 2020 Jan;39(1):33-40. doi: 10.1377/hlthaff.2019.00481. PubMed PMID: 31905070.

A GAO report released in December recommended that VHA develop performance measures and clear lines of accountability to track progress towards equity for Veterans and assess and improve the accuracy of racial and ethnic coding in VHA systems.

In response to this recommendation, OHE has updated the Health Equity Action Plan (HEAP) and developed an operational plan for Fiscal Year (FY) 2020 with performance measures and clear lines of accountability. These plans were developed with the aid and support of a Health Equity Coalition consisting of a variety of VA health equity stakeholders. This Coalition will assess achievement of performance goals at the end of the fiscal year and assist the development of future operational plans and performance measures.

Race and ethnicity data are missing on about 7 percent of Veterans in VHA, which is better than typically seen in the private sector. The quality of coding is mixed; with the highest missing data rates being 11%, 10%, and 9%, respectively, for Hispanic, Asian, and Native Hawaiian/Other Pacific Islander Veterans, in a recent year. In response to the second GAO recommendation, OHE and Health Services Research & Development are supporting two assessments: one assessment, led by Dr. Washington, will formally determine the quality of coding by comparing existing racial and ethnic coding in the electronic health record with self-reported survey information from VHA's Survey of Health Care Experiences of Patients, since self-reported identification of race and ethnicity is the gold standard; a second assessment will collect race and ethnicity information in VAMCs directly from Veterans using an iPad because staff discomfort with asking for this information has been cited as a major reason race and ethnicity data are missing.

Women and LGBTQ Veterans

VA is making progress in fostering a more inclusive patient experience for women and our Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) community. A recent study set out to identify patterns of risk and resilience by the intersections of race/ ethnicity (a combined measure in that study) and sexual orientation in mental health symptom severity, sexism, and social support among women Veterans.⁸ The study found that among women Veterans, minority race/ethnicity or minority sexual orientation were associated with higher levels of mental health symptoms and experiences of sexism, when compared with White, heterosexual women Veterans. As the study noted, "However, women Veterans with both minority race/ethnicity and minority sexual orientation did not always fare worse than White, heterosexual women Veterans," with respect to severity of symptoms, suggesting that women at the

⁸ Lehavot K, Beckman KL, Chen JA, Simpson TL, Williams EC. Race/Ethnicity and Sexual Orientation Disparities in Mental Health, Sexism, and Social Support among Women Veterans. *Psychol Sex Orientat Gen Divers*. 2019;6(3):347-358. doi: 10.1037/sgd0000333. PubMed PMID: 31435497; PubMed Central PMCID: PMC6703561.

intersection of these minority identities may develop resilience from their lived experience.

OHE works with VHA Women's Health Services to support assessments of equity issues faced by women Veterans. Data sources are often shared; for example, the Women's Health Evaluation Initiative database that was developed to monitor equity issues for women Veterans, was adapted and expanded to create the National Veterans Health Equity Report (which reported on equity issues by race/ethnicity, sex, rurality of residence, mental health disorders, and age). OHE also works with the LGBTQ coordinators, present at every VAMC, to support assessments of equity issues faced by LGBTQ Veterans. OHE has served as the VA point of contact with the Healthcare Equality Index, the major national LGBTQ benchmarking tool, and is sponsoring work with the Centers for Disease Control and Prevention to study LGBT Veterans because they cannot be identified systematically in VHA's current data systems. However, in the new Cerner Electronic Healthcare Record system, it will be possible to capture information on sexual orientation in a systematic fashion.

Patient Experience

VA recognizes the importance of patient experience, communication, and trust. We understand that patients who trust their clinicians and care teams are more likely to modify their health behaviors and have better outcomes. When Veterans respond to certain Veterans Experience Office (VEO) surveys, they have an opportunity to self-identify their race and ethnicity. VEO analyzed Veteran feedback based on self-identification of race as Asian, American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, or White. VEO also analyzed Veteran feedback based on identification of their ethnicity as Hispanic or Latino versus not Hispanic or Latino. The results showed the following insights about Veteran experience based on age, gender, and self-reported race and ethnicity:

- Veterans ages 70 and over in the Outpatient Surveys had the highest percentage reporting that they had trust in VA facilities for meeting their healthcare needs; Veterans under 30 had the lowest percentage reporting trust. Additionally, male Veterans report higher trust than female Veterans. Trust for all age groups as well as both men and women has increased since the third quarter of FY 2017.
- Veterans who self-identify as White show the highest trust in the Outpatient Surveys; Veterans who self-identify as American Indian or Alaskan Native Veterans show the lowest trust. Additionally, Veterans who identify as non-Hispanic or Latino show higher trust than Veterans who identify as Hispanic or Latino. Trust for all self-reported races and ethnicities has increased since the third quarter of FY 2017.

Conclusion

VA's goal is to meet Veterans where they live and work so VA can work with them to ensure they can achieve their goals by teaching them skills, connecting them to resources, and providing the care need along the way. We are committed to advancing our outreach and empowerment to further restore the trust of Veterans every day and continue to improve access to care. Our objective is to give our Nation's Veterans the top-quality experience and care they have earned and deserve. We appreciate this Committee's continued support and encouragement as we identify challenges and find new ways to care for Veterans.