

Diversity, Equity, Inclusion, and Justice: Findings & Policy Impacts in PEPReC's Work

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Bottom Line Up Front

The Partnered Evidence-based Policy Resource Center (PEPReC) developed an initiative to review, incorporate, and uplift a diversity, equity, inclusion, and justice (DEIJ) lens into the center’s work and culture. This brief considers findings by PEPReC-affiliated investigators related to inequity in Veterans Health Administration (VHA) and how policy changes can broadly improve access to care and mortality risk factors for Veterans with marginalized identities.

Introduction

In May 2021, the White House released a Request for Information asking the Office of Management and Budget, in partnership with federal agencies, to identify effective methods for assessing if agency policies and actions equitably serve all eligible individuals and communities.¹ This came with a particular focus on Veterans that are currently or historically underserved.

This inspired PEPReC to pursue an internal assessment of DEIJ considerations within our current projects, evaluating if/how various individual identifying characteristics are accounted for, such as race/ethnicity, age, sex, socioeconomic status, housing insecurity, and rurality.

Our findings so far illuminate potential disparities for Veterans of a wide range of identities, suggesting that a number of VHA-related services may need to shift in order to provide high-quality, efficient care for all. We also encountered a number of structural and internal hurdles to conducting these analyses. This brief will highlight PEPReC learnings from completed evaluations and highlight implications for policy practice, by topic area.

DEIJ Factors for Consideration

The list to the right is used to categorize various identities and experiences within the Veteran population that can impact health. While many of these factors are already considered in VHA research and evaluation, some are considered more often than others.

Access to Care

Veteran Directed Care Program (VDC)² Rurality

PEPReC conducted a study to understand whether there are differences in health outcomes between rural and urban Veterans who access personal care services. Specifically, researchers compared VDC, a self-directed VHA-paid care program, and other VHA-paid home- and community-based personal care services.

Findings

Rural VDC recipients had **significantly fewer** VHA-paid acute care admissions and emergency department visits, compared to recipients of other VHA-paid personal care services. The VDC program was also associated with reduced VHA or VHA-paid community nursing home admissions for both rural and urban recipients compared to other VHA-paid personal care services.

Identifying Characteristics

- Race/Ethnicity*
- Age*
- Sex*
- Gender Identity
- Sexual Orientation
- Disability
- Socioeconomic Status*
- Housing Insecurity
- Religious Affiliation
- Criminal Justice Involvement
- Rurality (Access, Technology)*
- Military Sexual Trauma
- Military Experience

**PEPReC has produced research in these areas.*

Policy Implications

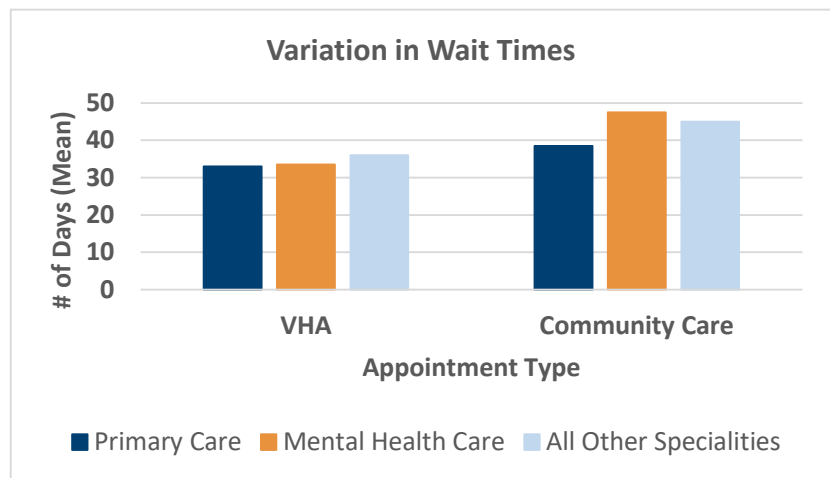
The flexibility and choice of care options provided by the VDC program is appropriate and uniquely beneficial for Veterans living in rural areas. Self-directed programs may alleviate some of the rural/urban disparities observed in prior literature.³⁻⁵

Wait Times in Various Health Care Specialities⁶ Rurality

This study was conducted to determine whether liberalized access to community care under the Choice Act and the MISSION Act would result in lower regional wait times.⁷⁻⁸ Evaluators examined the geographic variation in wait times experienced by Veterans for primary care, mental health care, and all other specialties, comparing VHA care to community care. VHA medical centers are organized into regions called Veterans Integrated Services Networks (VISNs).

Findings

There was substantial variation in wait times across care type, care setting, and geography. VHA wait times in a majority of VISNs were **lower** than those for community-based clinicians. Although half of appointments with community-based clinicians met MISSION Act-imposed wait time standards, about 44% of appointments with VHA clinicians **exceeded** wait time standards, meaning Veterans got in for appointments faster than is required by law.



Geographically, the southern region of the United States had the **longest** overall average wait times in community care of at least 50 days. However, mental health care in the community was worse in VISN 5 (Maryland, D.C., West Virginia) with a wait time of 65 days. In contrast, the Northeast (VISN 2 - New York, New Jersey) had the shortest wait for mental health services at 29 days. This regional discrepancy was also visible within primary care: VISN 15 (Kansas, Missouri) had the longest wait time of 52 days, while VISN 23 (North Dakota, Minnesota, South Dakota, Nebraska, Iowa) had the shortest (25 days).

Policy Implications

Evaluators discovered that liberalized access to community care **may not** equate to lower wait times for Veterans, suggesting that VHA should also consider ways to improve access to VHA care.⁶ Policies and interventions, such as physician relocation incentives, virtual care, or mobile deployment units may be needed to increase the number of ways Veterans in underserved regions, such as rural areas, can interact with the health care system.

Virtual Care Use in Outpatient Mental Health Care⁹ Rurality Age

VHA expanded virtual care services significantly since the COVID-19 pandemic, enhancing access to care. Despite increases in use and availability, in-person care remains prevalent for mental health services. PEPReC explored the extent to which VHA in-person visits may be substituted with virtual care.

Findings

While most Veterans **exclusively used** virtual care for outpatient mental health appointments in 2022, 30% of Veterans living in rural areas solely chose in-person care. Older Veterans (65+ years) were less likely than younger Veterans (18-39 years) to use virtual care as well.

Policy Implications

These findings suggest that one care modality may not suit all Veterans' needs for outpatient mental health care. However, virtual care use depends on providers offering it and there may also be logistical challenges for certain populations, such as older adults in rural areas who might struggle with technology or internet access. Nonetheless, virtual care **has potential** to address existing access disparities for marginalized groups. Further analysis is needed to determine virtual care's impact on Veterans with other individual-level identifying factors and its use in other care settings.

State Health Insurance Assistance Program (SHIP)

Rurality

Race/Ethnicity

Age

Socioeconomic

The federal State Health Insurance Assistance Program (SHIP) offers in-person, one-on-one counseling, and education about Medicare coverage options. This study evaluated whether there were potential inequities in access to SHIP services. For instance, it was unclear if these services were in areas with a high concentration of Medicare-eligible individuals and if they equitably served both low-income and high-income individuals.¹⁰

Findings

Compared to the populations living in areas with SHIP services, those living in areas without SHIP services were **more likely** to be older than 65 years old, be eligible for Medicare, have fewer years of education, be below 200% of the federal poverty limit, and self-report race as American Indian, Alaskan Native, or Black.

Policy Implications

People living in areas without SHIP services are more likely to face structural disadvantage and have minoritized identities. They may also benefit the most from SHIP services given their eligibility. Further expansion of areas for in-person SHIP services may be one option to improve availability of navigation services to the individuals most impacted. Meanwhile, other strategies to support individuals who are eligible for Medicare should be identified.

Mortality and Risk Factors¹¹

All-Cause Mortality during COVID-19

Race/Ethnicity

This study identified the extent to which Veterans experienced increased all-cause mortality during the COVID-19 pandemic, stratified by race and ethnicity.

Findings

Veteran mortality rates were 16% above normal during March-December 2020, equating to 42,348 excess deaths. However, there was substantial variation by racial and ethnic group. Veterans from racial and ethnic minorities experienced **higher rates** of mortality during the COVID-19 pandemic compared to non-Hispanic White Veterans.

Policy Implications

While global pandemics are out of one's control, findings suggest there must be changes to make sure minority Veterans do not bear the brunt of it. Careful consideration of how care is being offered and delivered to Veterans of color will be key to further eliminating disparities and improving access to equitable care for all Veterans. This stands to have compounding benefits, particularly as minority racial and ethnic groups within the Veteran population are forecasted to increase in the upcoming decades.¹²

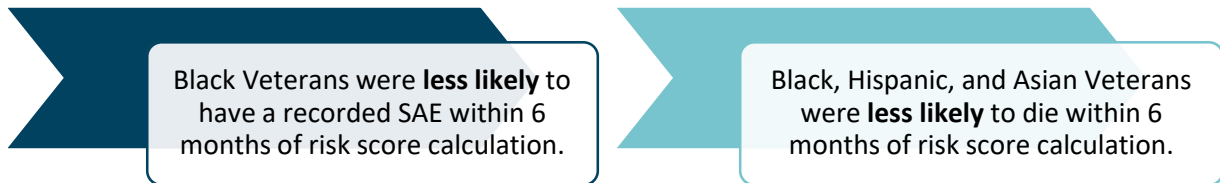
Excess All-Cause Mortality among VHA enrollees (March-December 2020)		
Race/Ethnicity	Enrollees	Mortality Increase
Native American	69,658	40%
Black	1,303,735	32%
Hispanic	573,616	26%
Asian/Pacific Islander	172,525	20%
White	5,681,590	17%
All Veterans	7,801,124	16%

Predicting Suicide and Overdose Risk Factors¹³ Race/Ethnicity

PEPReC conducted a study using VHA's risk prediction model, Stratification Tool for Opioid Risk Mitigation (STORM). The VHA uses risk prediction models to estimate the likelihood of future opioid-related severe adverse events (SAEs), initiate case reviews, and take proactive, personalized measures to support Veteran wellbeing. STORM uses a variety of inputs to calculate a risk score, and the model goes through regular updates to try and better reflect the true risk a Veteran is in. This study probed the overall reliability of STORM and looked specifically at differences in rates of mortality and SAEs across race and ethnicity among Veterans with similar STORM scores.

Findings

There were racial and ethnic differences in all-cause mortality and SAEs among Veterans who received similar scores from VHA's STORM risk prediction model. Compared to White Veterans with similar risk scores, Black Veterans were less likely to have a recorded SAE. Black, Hispanic and Asian Veterans were less likely to die within 6 months of risk score calculation.




Policy Implications

While results varied by race and ethnicity, STORM scores and case review helps to identify Veterans with differences in SAE and mortality outcome. While this holds true for the current model, clinical usage of older versions of STORM may not lead to equitable inclusion in mandated Veteran case review. VHA continues to update the model and, in the process of updating, STORM may benefit from additional evaluations of inputs shaping the model like outcomes and bias.

Limitations

PEPReC evaluators ran into several challenges when working to incorporate DEIJ into analyses. First, funders do not often request that PEPReC consider DEIJ factors in the analysis plan. Thus, PEPReC researchers are including DEIJ analyses as supplements, consequently allocating less resources to them.



Secondly, there are gaps in how and what federal data are recorded. For instance, there can be significant variation in how variables like race and ethnicity are recorded. PEPReC documented these challenges in a data dictionary (available upon request), and the document can be shared with new PEPReC data analysts to help them understand data challenges.

Conclusion

PEPReC evaluators have started to incorporate DEIJ analyses in their projects, with an initial focus on the following identifying characteristics: race/ethnicity, age, rurality, and socioeconomic status. There are plans to produce a follow up to this brief as PEPReC builds in more DEIJ considerations into projects, as well as communicate these findings, policy and practice implications, and interventions to partners and stakeholders through further publications, briefings, and conference presentations. This work will assist VHA in providing equitable, high-quality health care to all Veterans.

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ABOUT PEPRc POLICY BRIEFS

This evidence-based policy brief is written by Partnered Evidence-based Policy Resource Center (PEPRc) staff to inform policymakers and Veterans Health Administration (VHA) managers about the evidence regarding important developments in the broader health system and economy. PEPRc is a Quality Enhancement Research Initiative-funded resource center that collaborates with operational partners to design and execute randomized evaluations of VHA initiatives, develops and refines performance metrics, and writes evidence-based policy briefs.

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