United States Government Accountability Office

Report to Congressional Committees

December 2019

VA HEALTH CARE

Opportunities Exist for VA to Better Identify and Address Racial and Ethnic Disparities

GAO-20-83

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GAO Highlights

Highlights of GAO-20-83, a report to congressional committees

Why GAO Did This Study

According to VA, in 2016, racial and ethnic minority veterans represented about 22 percent of the total veteran population of 18.6 million. VA projects racial and ethnic minority veterans will make up 36 percent of its total veteran population by 2040. VA has identified racial and ethnic disparities in its health care outcomes, mirroring trends seen across the United States.

House Report 115-188 included a provision for GAO to review whether VHA provides quality, equitable care for minority veterans. GAO's report examines, among other issues, (1) the extent to which VA has taken steps to advance health equity for racial and ethnic minority veterans, and (2) VA's efforts to use race and ethnicity data to identify and address disparities in health care outcomes involving minority veterans. GAO reviewed relevant documents, such as strategic and operational plans and peer-reviewed research studies; assessed VA's health equity action plan against criteria identified in GAO's body of work on effectively managing performance; and interviewed VA officials familiar with VA's health equity efforts, as well as race and ethnicity data.

What GAO Recommends

GAO is making two recommendations to VA to (1) ensure that any health equity action plan includes performance measures to assess progress, and clear lines of accountability designating responsibility to specific offices, and (2) conduct an assessment to determine how to address weaknesses identified with the completeness and accuracy of race and ethnicity data in the electronic health record, and implement corrective actions as necessary. VA agreed with GAO's recommendations.

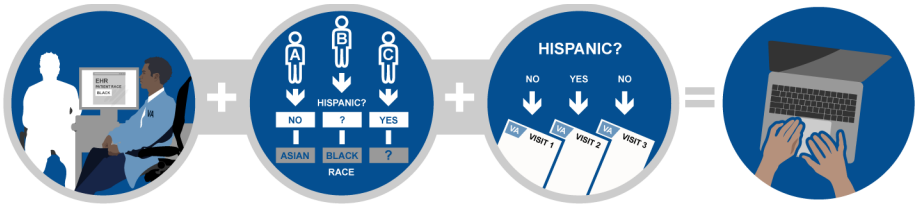
View GAO-20-83. For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

What GAO Found

The Department of Veterans Affairs (VA) has taken steps to reduce disparities in health care outcomes linked to race and ethnicity, but lacks mechanisms to measure progress and ensure accountability for results. In 2012, VA established the Office of Health Equity to identify and address health care outcome disparities and to develop an action plan to achieve health equity. This office issued an action plan in 2014 that identified activities to make improvements in five focus areas, such as increasing awareness of the significance of disparities and strengthening leadership for addressing them. However, GAO found that the extent of VA's progress in implementing the action plan and advancing health equity is unknown because the action plan lacked performance measures and clear lines of accountability for specific offices. For example, although VA's action plan included a list of "success criteria" for each of the five focus areas, these criteria were not measurable, and were not linked to specific activities or to offices responsible for implementation.

VA funds research efforts that have identified disparities in health care outcomes involving minority veterans, but rely on data that VA officials and researchers noted have weaknesses in completeness and accuracy. One concern is that race and ethnicity information can be labeled incorrectly in VA patients' electronic health records as "self-reported", a highly reliable method of collection, when data were actually collected based on the less reliable method of VA staff observation. Other reported concerns include missing values on patients' race and conflicting race and ethnicity information. VA researchers told GAO they account for some of these concerns by using data from other sources, such as Medicare, but such work-arounds are time intensive. Further, VA officials reported that data weaknesses limit their ability to identify and address disparities in health care outcomes in their medical centers. Despite recognizing weaknesses related to the quality of race and ethnicity data, VA has not implemented corrective actions to address them. Without doing so, VA medical center officials cannot readily identify and address disparities in health care outcomes by race and ethnicity.

Concerns Raised by Department of Veterans Affairs (VA) Officials about the Completeness and Accuracy of VA Race and Ethnicity Data



VA cannot determine whether race and ethnicity information in the EHR is self-reported or based on the observation of VA staff

Missing values in race data affect reliability

Conflicting race and ethnicity information within a veteran's record makes it difficult to determine which is accurate

VA cannot ensure the accuracy of race and ethnicity information entered into the electronic health record

Source: GAO analysis of Department of Veterans Affairs' information. | GAO-20-83

Note: Concerns about the completeness and accuracy of race and ethnicity information were raised by officials from VA's Office of Health Equity, Veterans Experience Office, and Health Services Research & Development.

Contents

Letter		1
	VA Established a Program Office and Issued an Action Plan to Advance Health Equity, but Lacks Mechanisms to Measure and Ensure Accountability for Implementation	6
	VA Funds Research to Identify Disparities in Health Care Outcomes, but Weaknesses in Race and Ethnicity Data Impede Medical Centers' Ability to Address Them	12
	VA Collects Patient Experience Feedback from Veterans, including Minority Veterans, through Surveys and VA Medical Center Patient Advocates	20
	Conclusions	23
	Recommendations for Executive Action	23
	Agency Comments	24
Appendix I	Comments from the Department of Veterans Affairs	25
Appendix II	GAO Contact and Staff Acknowledgments	28

Figures

Figure 1: Veterans Health Administration (VHA) Office of Health Equity (OHE) Budget and Staffing Levels, Fiscal Years 2012 through 2019 8

Figure 2: Concerns Raised by Veterans Affairs (VA) Officials about the Completeness, Accuracy, and Reliability of VA Race and Ethnicity Data 15

Abbreviations

EHR	electronic health record
GPRA	Government Performance and Results Act of 1993
HEC	Health Equity Coalition
HSR&D	Health Services Research and Development
OHE	Office of Health Equity
PATS	Patient Advocate Tracking System
SHEP	Survey of Healthcare Experiences of Patients
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

December 11, 2019

The Honorable John Boozman
Chairman
The Honorable Brian Schatz
Ranking Member
Military Construction, Veterans Affairs, and Related Agencies
Committee on Appropriations
United States Senate

The Honorable Debbie Wasserman Schultz
Chairwoman
The Honorable John R. Carter
Ranking Member
Military Construction, Veterans Affairs, and Related Agencies
Committee on Appropriations
House of Representatives

Within the Department of Veterans Affairs (VA), the Veterans Health Administration (VHA) operates one of the nation's largest health care systems, providing care to veterans at its 172 VA medical centers. In 2016, racial and ethnic minority veterans—hereafter referred to as minority veterans—comprised about 22 percent of the total veteran population of 18.6 million; VA projects minority veterans will make up 36 percent of its total veteran population by 2040.[1] Additionally, minority veterans' use of VA's health care services increased about 9 percent from 2005 to 2014, according to the most recent VA data available.[2]

[1]In this report, the terms, "racial and ethnic minority veterans" refer to the same racial and ethnic categories VA uses, which are based on the 1997 U.S. Office of Management and Budget standards on race and ethnicity. These standards include two ethnic categories (Hispanic or Latino, and Not Hispanic or Latino) and five racial categories (American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White). These standards permit the reporting of more than one race. Non-minorities are White non-Hispanic; all other race categories are included in the minority classifications.

National Center for Veterans Analysis and Statistics, *Profile of Veterans: 2016. Data from the American Community Survey*. (Washington, D.C.: February 2018): 1, 2, 4, 35.

[2]U.S. Department of Veterans Affairs, Office of Data Governance and Analytics. *Minority Veterans Report: Military Service History and VA Benefit Utilization Statistics.* (Washington, D.C.: March 2017).

As its veterans' population is becoming increasingly more diverse, VA has acknowledged the importance of ensuring health equity—the ability for all veterans to attain their highest possible levels of health. However, VA has identified racial and ethnic disparities in its health care outcomes, mirroring trends seen across the United States.[3] For example, in 2011, VA found outcomes for controlling blood pressure, blood glucose, and cholesterol levels were significantly worse for Black or African American veterans than they were for White veterans.[4] Additionally, VA has noted racial and ethnic disparities in reported patient experiences. For example, in 2013, VA researchers found higher rates of negative experiences at VA medical centers reported by Asian, Native Hawaiian/Pacific Islander, American Indian/Alaska Native and multiracial veterans compared with other minority veterans and White veterans, particularly in areas of doctor and nurse communication, speed of receipt of care, and overall rating of health care.[5] More recently, in 2019, VA reported evidence of disparities in health care outcomes within VA medical centers in the form of lower survival rates for African American veterans with cancer and cardiovascular-related illnesses compared with other minority veterans and White veterans.[6]

A report accompanying the Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2018, included a provision for us to review whether VA provides quality, equitable health care for minority veterans, among other things.[7] In our report, we

1. examine the extent to which VA has taken steps to advance health equity for minority veterans;

[3]U.S. Department of Health and Human Services. Agency for Health Care Research and Quality. *National Healthcare Quality and Disparities Report.* (Rockville, Md: July 2018): 82, 89, 94, 97.

[4]Trivedi, Amal N., Regina C. Grebla, Steven M. Wright, and Donna L. Washington. "Despite Improved Quality of Care in the Veterans Affairs Health System, Racial Disparity Persists for Important Clinical Outcomes." *Health Affairs* 30, no. 4 (2011): 707, 712, 713.

[5]Hausmann, Leslie RM, Shasha Gao, Maria K. Mor, James H. Schaefer Jr, and Michael J. Fine. "Understanding Racial and Ethnic Differences in Patient Experiences with Outpatient Health Care in Veterans Affairs Medical Centers." *Medical Care* (2013): 532, 533, 534, 535, 537, 538.

[6]Wong, Michelle S., et.al., "Racial/Ethnic Disparities in Mortality Across the Veterans Health Administration." *Health Equity* 3, no. 1 (2019): 99, 103, 104.

[7]H.R. Rep. No. 115-188, at 56-57 (2017).

2. examine VA's efforts to use race and ethnicity data to research and address disparities in health care outcomes involving minority veterans; and
3. describe the feedback VA collects from minority veterans on their patient experiences.

For the first two objectives, we reviewed agency documents such as the VHA Strategic Plan, VHA operational plan, and reports by the Advisory Committee on Minority Veterans.[8] We also reviewed the Commission on Care report, a 2016 report that included recommendations for improving VA's health care system, including its efforts to address health equity and disparities.[9] We reviewed VA-funded research related to identifying and reducing disparities in health care outcomes. Based on this review, we interviewed researchers about their efforts to identify disparities in health care outcomes involving minority veterans and achieving health equity. We also spoke with VA Central Office officials, including officials from the Quality Enhancement Research Initiative, the Center for Health Equity, Research, and Promotion, and the Office of Patient Centered Care and Cultural Transformation. In addition, we reviewed written responses to questions we provided to the Advisory Committee on Minority Veterans, in lieu of an interview, since the Committee meets only twice per year.

To examine the steps taken to reduce disparities in health care outcomes involving minority veterans to advance equity, we reviewed relevant

[8]VA's Advisory Committee on Minority Veterans was established in 1994 under the Veterans' Benefits Improvements Act of 1994, Pub. L. No. 103-446, § 510, 108 Stat. 4645, 4668 (1994) (codified as amended at 38 U.S.C. § 544). Pursuant to 38 U.S.C. § 544(e), the Advisory Committee on Minority Veterans will expire on September 30, 2022. The Committee consists of: 1) representatives of minority veterans, 2) individuals who are recognized authorities in fields pertinent to the needs of minority veterans, 3) minority veterans with and without experience in a military theater of operations, and 4) women minority veterans who have recently separated from service. The Secretary of VA is required to consult with and seek advice from the Committee on VA's administration and provisions of health care and other benefits, and the Committee is required to produce a report for the Secretary and Congress by July 1 of every other year. The report must include an assessment of minority veterans' needs, a review of VA programs designed to meet these needs, and any appropriate recommendations. Committee members also make periodic site visits to VA facilities and hold town hall meetings with veterans to address their concerns.

[9]The Commission on Care was an independent entity that issued a report in 2016 based on the evaluation of veterans' access to VA health care and assessed how veterans' care should be organized and delivered during the following 20 years. Commission on Care, *Final Report of the Commission on Care*. (Washington, D.C.: June 30, 2016).

documents from VA that describe the efforts of the Office of Health Equity (OHE), which is responsible for advancing VA health equity goals across the agency. These documents included information on OHE's budget from fiscal years 2013 through 2019, and OHE staffing levels during this time. We also assessed the efforts of OHE to implement the health equity action plan, VA's action plan to address health equity across the agency. We assessed the health equity action plan against relevant criteria from GAO's body of work on effectively managing performance under the Government Performance and Results Act of 1993 (GPRA), as enhanced by the GPRA Modernization Act of 2010.[10] We interviewed OHE officials about these topics, including the extent to which they had assessed implementation of the action plan, as well as future plans for the office.

In addition, to examine VA's efforts to use race and ethnicity data to research and address disparities in health care outcomes involving minority veterans, we compared VA's efforts to the recommendations made by the 2016 Commission on Care report, which advised VA to increase the availability, quality, and use of race, ethnicity, and language data. We reviewed VA webinar presentations on race and ethnicity data.[11] To determine how race and ethnicity data are collected and to obtain perspectives on the completeness and accuracy of such data, we conducted interviews with five VA researchers, who are also data experts, selected based on their publications in peer-reviewed journals on disparities in health care outcomes and knowledge of race and ethnicity research at VA medical centers. We interviewed officials from two Veterans Integrated Service Networks (VISN) in order to obtain their perspectives on using race and ethnicity data to assess health care

[10]GAO, *Managing For Results: GPRA Modernization Act Implementation Provides Important Opportunities to Address Government Challenges*, GAO-11-617T (Washington, D.C.: May 10, 2011); *Executive Guide: Effectively Implementing the Government Performance and Results Act*, GAO/GGD-96-118 (Washington, D.C.: June 1996); and *Managing For Results: Executive Branch Should More Fully Implement the GPRA Modernization Act to Address Pressing Governance Challenges*, GAO-13-518 (Washington, D.C.: June 26, 2013).

[11]We reviewed several webinars that describe VA's race and ethnicity data, which are publicly available on the OHE and VA Information Research Center websites. These webinars can be found at https://www.va.gov/HEALTHEQUITY/FHEA_Cyberseminar.asp (accessed October 3, 2019) and https://www.hsrd.research.va.gov/cyberseminars/series.cfm#vci (accessed October 3, 2019).

disparities in their networks.[12] We selected these officials because of their prior efforts working with VA researchers to assess race and ethnicity data among their minority veteran populations. The perspectives of these officials are not generalizable. We also interviewed officials from two private health care systems, selected because of their efforts to address health care disparities.[13] We asked them about the methods they use to collect race and ethnicity data, and how they have used these data to assess and address disparities in health care outcomes and patient experience. We interviewed both VA and Department of Defense officials regarding their collaborative efforts and respective plans to implement new electronic health record (EHR) systems and how these systems will capture race and ethnicity data.[14]

To describe what feedback VA collects from minority veterans on their patient experiences, we reviewed how patient feedback survey results are collected and reported. We also interviewed officials from VA's Office of Reporting, Analytics, Performance, Improvement, and Deployment, the Veterans Experience Office, and OHE to obtain information on how the surveys are administered, the type of information they capture, and how results are reported. To obtain information on the types and nature of patient feedback received by patient advocates at VA medical centers, we interviewed VA officials with the Office of Patient Advocacy and conducted interviews with four patient advocate coordinators across four VISNs, and small group interviews with 21 VA medical center patient

[12]VA provides health care services through 18 geographically divided VISNs. Each VISN is responsible for managing and overseeing the medical centers within their networks. We interviewed officials from VISN 8 (VA Sunshine Healthcare Network) and VISN 16 (South Central VA Health Care Network).

[13]Specifically, we interviewed officials with Henry Ford Health System and Massachusetts General Hospital. The 2016 Commission on Care report provided information on the efforts of the Henry Ford Health System to address health equity and stated that VHA should seek to emulate its efforts, which included a research unit on health care disparities. We also elected to interview officials from Massachusetts General Hospital, which created the Disparities Leadership Institute, and provides training for clinicians seeking to improve their use of race and ethnicity data to address issues related to health equity.

[14]Information about veterans' race and ethnicity is stored in VA's EHR. The EHR—VA's authoritative source for all veteran-related care and services—houses individual patient-level clinical data that can include a patient's race and ethnicity, medical history, diagnoses, medications, treatment plans, and test results.

advocates located in 12 medical centers within the four VISNs.[15] We selected these medical centers to provide diversity in geographic regions, number of enrollees' by race per VISN, facility complexity, and racial and ethnic demographics of the veteran population.[16] The perspectives obtained from staff located within the 12 VA medical centers and four VISNs cannot be generalized. In addition, we also interviewed representatives from five veterans service organizations, and received written responses from another to obtain information about the mechanisms minority veterans may use to provide feedback to VA on patient experiences.

We conducted this performance audit from August 2018 to December 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

VA Established a Program Office and Issued an Action Plan to Advance Health Equity, but Lacks Mechanisms to Measure and Ensure Accountability for Implementation

VA has taken several steps in recent years to reduce health care disparities for minority veterans and advance health equity, but lacks mechanisms to ensure accountability for advancing health equity using these or other actions. In particular, VA established a program office and a dedicated steering committee to draft VA's first action plan designed to achieve health equity. However, this initial action plan lacked performance measures and clear lines of accountability; as such, the extent to which it has been implemented and the progress made in achieving its goals is unknown.

[15]We spoke with VA staff from VISN 7 (VA Southeast Network), VISN 10 (VA Healthcare System), VISN 17 (VA Heart of Texas Health Care Network), and VISN 22 (Desert Pacific Healthcare Network).

[16]We used data from the United States Census Bureau to obtain the distribution of populations by race and ethnicity in cities where the medical centers are located as a proxy for the racial and ethnic distribution of the veteran population in those cities.

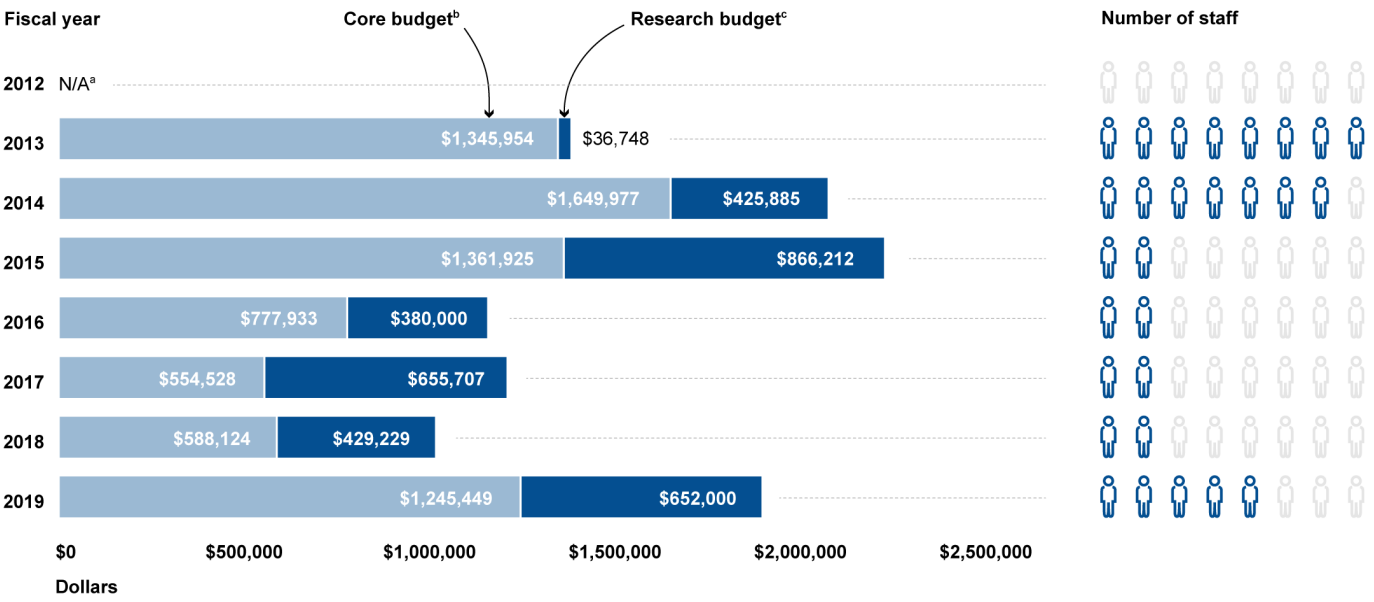
VA Established a Dedicated Program Office to Lead VA's Efforts to Achieve Health Equity

In 2012, VA established OHE to lead the department's efforts to advance health equity and reduce health disparities throughout VA's health care system. At that time, the Principal Deputy Under Secretary for Health—who reports to the Under Secretary for Health—identified health equity as a cross-cutting issue of the highest priority, and as such, he required the Director of OHE to report directly to him. OHE is responsible for several efforts, including providing education, training, research, communications and information; promoting common awareness about health care disparities and working to improve health care outcomes; and representing VA and serving as a liaison to other governmental and non-governmental organizations working to achieve health equity. OHE was also tasked with developing and maintaining a comprehensive action plan to achieve health equity in VA medical centers and improve VA's overall quality of care.

Also in 2012, VA's Principal Deputy Under Secretary for Health created the Health Equity Coalition (HEC). Chaired by the Director of OHE, the HEC is a VA-wide steering committee that is comprised of officials from several VA program offices dedicated to areas such as patient care services, communications, research and development, and minority veteran issues. The HEC advises and assists OHE in developing and implementing plans, sets milestones to review progress to ensure timely completion of initiatives, and ensures that program offices commit appropriate organizational resources needed to meet these goals.

Since its establishment, OHE has experienced changes in budget and staff levels from year to year. OHE's core budget, which VA officials told us is spent on salaries, travel, and supplies, fluctuated between 2013 and 2019; staffing levels began decreasing in 2014 and subsequently increased in 2019. (See fig. 1.) VA officials told us that staff reductions were due to transfers and reassignments of OHE staff to other offices and positions, which coincided with a shifted focus from equity issues to other issues such as veteran wait times and modernization efforts. In addition, OHE was also repositioned to a lower level within the organization from VHA's Office of the Principal Deputy Under Secretary for Health to the Office of the Deputy Under Secretary for Health for Organizational Excellence.

Figure 1: Veterans Health Administration (VHA) Office of Health Equity (OHE) Budget and Staffing Levels, Fiscal Years 2012 through 2019



Source: Department of Veterans Affairs. | GAO-20-83

[a]According to OHE officials, OHE was established in fiscal year 2012 and was not allocated funding in VHA's budgeting process until fiscal year 2013.

[b]According to Veterans Affairs officials, the core budget represents monies spent on salaries, travel, supplies, etc.

[c]According to OHE officials, the research budget must be used to fund research activities in the field and OHE can apply these monies to any appropriate research activities it wishes to support.

VA's Health Equity Action Plan Set Goals to Eliminate Health Disparities, but Extent of Progress Is Unknown Due to a Lack of Performance Measures and Clear Lines of Accountability

In February 2014, VA released its first Health Equity Action Plan (action plan), drafted by OHE and the HEC to document VA's approach for eliminating health disparities and achieving health equity. The action plan included five focus areas, or goals, in which VA intended to direct its efforts to improve the overall quality of care for all veterans, including minority veterans:

- **Awareness:** increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health care outcomes for racial, ethnic, and underserved populations.
- **Leadership:** strengthen and broaden leadership for addressing health disparities at all levels.

- **Health system and life experience:** improve health and health care outcomes for racial, ethnic, and underserved populations.
- **Cultural and linguistic competency:** improve cultural and linguistic competency, and the diversity of the health-related workforce.
- **Data, research, and evaluation**: improve data availability; and coordination, utilization, and diffusion of research and evaluation outcomes.

OHE and the HEC included between two to 14 "implementation activities" in each of the five focus areas to describe specific plans and tasks VA could undertake to advance health equity. For example, under the "data, research, and evaluation" focus area, examples of implementation activities included, "identify limitations of existing data, barriers to access to data, and data collection methodologies that affect VA's ability to describe disparities," and "develop a strategy for prioritizing identified disparities." In addition, all five focus areas also included "success criteria" to measure success, a list of resources needed in order implement the activities, and identified stakeholders.

However, despite documenting elements needed to make improvements in the five focus areas, the extent of VA's progress in implementing the action plan and advancing health equity is unknown because the action plan lacks performance measures and clear lines of accountability. Performance measures and clear lines of accountability are among the criteria identified in GAO's body of work on effectively managing performance under GPRA.[17] Without such mechanisms, VA cannot be assured that the plan has been implemented or will ultimately be effective in addressing health equity. In particular, we found that VA's plan did not include the following mechanisms:

- **Performance measures.** Our past work on effectively managing performance shows that performance measures should demonstrate how well the organization is meeting its goals and should be linked directly to offices that have responsibility for the program or activity.

[17]GAO, *Managing For Results: GPRA Modernization Act Implementation Provides Important Opportunities to Address Government Challenges*, GAO-11-617T (Washington, D.C.: May 10, 2011); *Executive Guide: Effectively Implementing the Government Performance and Results Act*, GAO/GGD-96-118 (Washington, D.C.: June 1996); and *Managing For Results: Executive Branch Should More Fully Implement the GPRA Modernization Act to Address Pressing Governance Challenges*, GAO-13-518 (Washington, D.C.: June 26, 2013).

As previously noted, although VA's action plan included a list of "success criteria", such criteria were not measurable, and were not directly linked to the specific implementation activities or to the responsible lead office for any of the five focus areas. For example,

- under the "leadership" focus area, the action plan identified "development of process tools for monitoring in FY 2014" as one of the success criteria, but it was not clearly linked to one of this focus area's specific implementation activities and did not identify who among the list of lead offices and stakeholders was responsible for it.
- under the "data, research, and evaluation" focus area, the action plan identified "developed standards for collecting data used to understand disparities" and "improved on-going data sharing between programs" as two of the success criteria, but they were not linked to one of this focus area's implementation activities, nor were they specifically assigned to one or more of the lead offices and stakeholders listed as responsible for achieving them.

- **Clear lines of accountability:** Our past work on effectively managing performance also shows that designating a lead official or office to be responsible for coordinating efforts to achieve results for each goal or action creates clear lines of accountability. This is critical to implementing change to achieve goals and marshaling resources needed to improve management. In contrast, VA's action plan listed for each of the five focus areas:
  - a broad group of lead offices and stakeholders responsible for the entire focus area, in general, (for example, HEC members and their respective offices, VISN officials, and VA medical center directors) but did not designate specific offices or officials responsible for coordinating efforts to complete specific implementation activities.
  - vaguely described resources—such as leadership support, time, money, and travel—needed to execute all of the implementation activities under each of the five focus areas, but did not designate specific lead offices or stakeholders responsible for committing specific resources needed to implement each activity.

Without such performance measures or lines of accountability, VA lacked the means to measure specific progress in implementing and achieving the action plan's goals. Moreover, according to VA officials, following the release of the action plan and the reduction in number of OHE staff, the frequency of HEC meetings decreased and the last regular meeting

before it reconvened in January 2019 occurred in early 2015. As such, VA officials told us that there was no formal involvement or oversight following the release of the action plan to ensure that coalition members were meeting their responsibilities, including committing the organizational resources needed to ensure implementation.

In recent years, there have been several recommendations from stakeholders, urging VA to provide OHE with the resources needed to fully implement its action plan. Specifically, the 2016 Commission on Care report recommended that VA commit additional resources to address the causes of the problem and ensure the action plan is fully implemented. The Secretary of VA at the time concurred with the Commission's recommendation and said that VA would identify health equity leaders and clinical champions in each VISN and VA medical center who could catalyze and monitor actions to implement the action plan and further advance the elimination of health disparities.

More recently, VA has signaled renewed interest in supporting the advancement of health equity by increasing OHE's budget and staffing levels in fiscal year 2019, and reconvening the HEC in January 2019.[18] According to OHE officials, the reconvened HEC has held regular meetings and approved an updated action plan in September 2019. In October 2019, OHE officials told us that the action plan had been sent to VHA leadership for review, which they anticipated would be completed within the first fiscal quarter of 2020.

[18]According to a December 2018 memo from the Acting Principal Deputy Under Secretary for Health, the reconvened HEC includes representatives from the same 16 VA and VHA offices that served on the original Coalition, as well as five additional offices.

VA Funds Research to Identify Disparities in Health Care Outcomes, but Weaknesses in Race and Ethnicity Data Impede Medical Centers' Ability to Address Them

Both OHE and other VA programs fund research conducted by VA clinicians and staff to identify disparities in health care outcomes.[19] However, VA officials and researchers have noted problems with the completeness and accuracy of the data on veterans' race and ethnicity. These weaknesses, in turn, limit VA's ability to assess and address health care disparities at the VA medical center level.

VA Funds Research Aimed at Identifying Disparities in Health Care Outcomes Involving Minority Veterans

VA funds research aimed at identifying health care outcome disparities involving minority veterans. According to OHE officials, annually OHE receives a research budget separate from its core budget, and can apply monies from this separate budget to any appropriate research activities it wishes to support. As an example, in fiscal year 2019, OHE officials told us it provided funds to the Quality Enhancement Research Initiative, VA's Center for Health Equity, Research, and Promotion, and two VISNs. In addition to OHE-funded research, VA's Health Services Research & Development (HSR&D) has spent about $12 million to fund research studies related to identifying and reducing disparities in health care outcomes between minority and other veterans since 2014.[20] This research has identified disparities in health care outcomes for minority veterans. Research funded by HSR&D includes the following studies:

[19]For example, according to VA officials, VA clinicians and staff submit research proposals to be considered for funding from VA's Health Services Research & Development (HSR&D). They told us that these proposals are reviewed and scored every six months by expert panels, and HSR&D officials then review the scored proposals to determine which may address VA's areas of interest. According to HSR&D officials, about 20 percent of research proposals are funded.

[20]HSR&D supports research that addresses all aspects of VA health care, including patient care, cost, and quality. About 1,000 VA researchers conduct studies addressing a variety of topics, including health equity and disparities among traditionally underserved populations, including racial and ethnic minorities, as well as rural and homeless veterans. Within the health equity portfolio, research is focused on understanding the reasons for disparities in care and developing interventions to reduce disparities. Research on disparities has been a long-term priority for HSR&D, and is listed in its current program announcement of HSR&D priorities for fiscal year 2019.

- A 2017 report focused on whether changes in the way VA delivered primary care were effective in addressing racial and ethnic disparities in health care outcomes. Using VA data from 2009 and 2014, the study found lower rates of control of hypertension and diabetes among veterans who were African American, Hispanic, American Indian/Alaska Native, and Native Hawaiian and other Pacific Islanders compared with White veterans.[21]
- A 2016 report examined why minority veterans with mental health and substance abuse disorders are less likely to use mental health and substance abuse services, and to complete mental health and substance abuse treatment. The study, which used 2013 data, found health disparities between White veterans and Black, Hispanic, and American Indian or Alaskan Native veterans with mental health and substance abuse disorders on several quality measures, including access to care. The study also found disparities by race and ethnicity in patients' experiences communicating with providers and office staff.[22]
- A 2017 systematic review of 351 studies published between 2006 and February 2016 examined the prevalence of disparities in health care outcomes experienced by veterans, including health disparities based on race and ethnicity.[23] This systematic review concluded that a large

[21]Washington, Donna L., et al., "Racial and Ethnic Disparities Persist at Veterans Health Administration Patient-Centered Medical Homes." *Health Affairs* 36, no. 6 (2017): 1086, 1089, 1090, 1091.

When discussing the studies referenced in this section of the report, we refer to the race and ethnicity categories used in the article. These categories may differ from the 1997 U.S. Office of Management and Budget standards on race and ethnicity used elsewhere in the report. These U.S. Office of Management and Budget standards include two ethnic categories (Hispanic or Latino, and Not Hispanic or Latino) and five racial categories (American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White).

[22]Jones, Audrey L., et al., "Racial/Ethnic Differences in Primary Care Experiences in Patient-Centered Medical Homes Among Veterans with Mental Health and Substance Use Disorders." *Journal of General Internal Medicine* 31, no. 12 (2016): 1435, 1436, 1443.

To obtain information on patients' experience communicating with providers and staff, the study reported on several variables, such as how often the provider explained things in a way that the veteran could understand, provided information that was easy to understand to address his or her heath questions or concerns, and showed respect for what they had to say. Additionally, the report provided information on whether the clerks and receptionists treated the veteran with respect and were as helpful as the veteran thought they should be.

[23]Kondo, Karli, et al., "Health Disparities in Veterans: a Map of the Evidence." *Medical Care* 55 (2017): S9, S10.

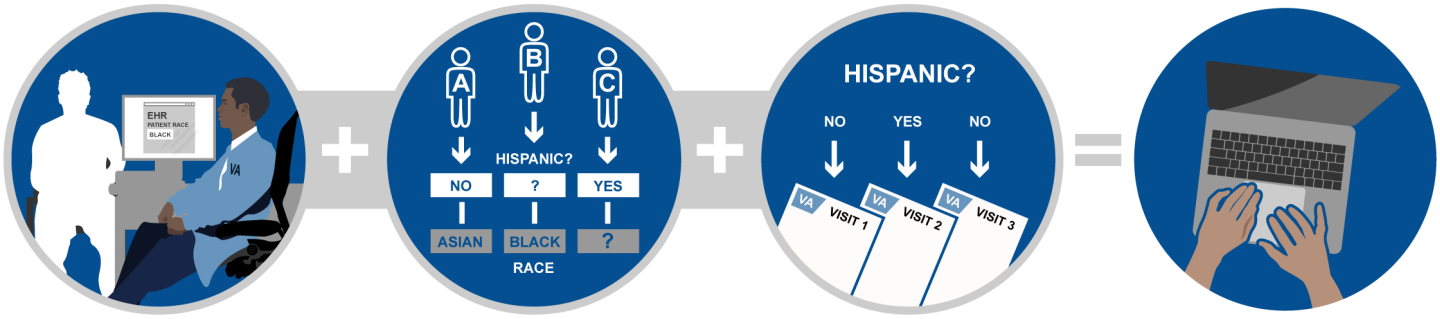
proportion of the research conducted has focused on differences between Black or African American and White veterans and suggested that future targeted research is needed to capture the unique characteristics of American Indian or Alaska Natives and Native Hawaiian or other Pacific Islanders.

Despite VA's funding of numerous studies to identify health disparities and to explore interventions to potentially reduce or eliminate them, health disparities continue to persist among VA's patient population. HSR&D officials told us that VA has faced difficulties translating research into practice in clinical settings, including their research findings about disparities in health care outcomes. HSR&D officials told us that they have recently undertaken new efforts aimed at implementing research findings, including those focused on disparities in health care outcomes. Among these efforts is the development of a new program to provide additional funding (for up to two years) for research projects that are completed or close to completion so that researchers can: 1) develop tool kits that others can adopt, and 2) implement research in additional VA medical centers in order to facilitate the sharing of information about successes and failures to make the impact of research more effective.

VA Officials and Others Have Identified Weaknesses in Veterans' Race and Ethnicity Data

Generally, VA collects and records race and ethnicity information in veterans' EHRs when they enroll in VA health care online, by mail, fax, or telephone applications, or through self-service touch-screen kiosks at VA medical centers. Intake clerks may also collect and record race and ethnicity information when assisting veterans with enrollment, as well as when checking a veteran in at a clinic for an outpatient appointment, or registering a veteran for an inpatient hospital admission. However, VA researchers and officials have identified weaknesses in the completeness and accuracy of VA's patient data on race and ethnicity, which has raised data reliability concerns. (See fig. 2)

Figure 2: Concerns Raised by Veterans Affairs (VA) Officials about the Completeness, Accuracy, and Reliability of VA Race and Ethnicity Data



VA cannot determine whether race and ethnicity information in the EHR is self-reported or based on the observation of VA staff

Missing values in race data affect reliability

Conflicting race and ethnicity information within a veteran's record makes it difficult to determine which is accurate

VA cannot ensure the accuracy of race and ethnicity information entered into the electronic health record

Source: GAO analysis of Department of Veterans Affairs' information. | GAO-20-83

Note: Concerns about the completeness and accuracy of race and ethnicity information were raised by officials from VA's Office of Health Equity, Veterans Experience Office, and Health Services Research & Development.

- **VA cannot ensure that race and ethnicity information labeled in the EHR as self-reported is accurate.** VA follows standards outlined by the Office of Management Budget, which state that self-reported information is the preferred method for obtaining an individual's race and ethnicity, because it is more accurate than data collected by observation of a third party.[24] However, a VA data expert with HSR&D's Center for Health Equity Research and Promotion, and officials at one of the VISNs in our review told us that they are aware that intake clerks sometimes enter information based on observation, which may be inaccurate, because they feel uncomfortable asking veterans for their race and ethnicity information in case the veterans find it offensive. Adding further to potential inaccuracies, because VA's EHR default setting automatically records all race and ethnicity information as self-reported, observational data are only accurately labeled as such if a clerk manually changes the default setting to 'observational'. The VA data expert from HSR&D's Center for Health Equity Research and Promotion told us that, based on her research,

[24]Executive Office of the President. U.S. Office of Management and Budget. *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*. (Washington, D.C.: Oct.30, 1997).

almost all of the information collected electronically in the EHR is automatically assigned as self-reported, the default setting, even when it is collected by observation of VA staff. This expert also told us that research efforts at VA medical centers have indicated that the default setting is rarely changed and that some clerks had never changed the setting because they do not know how. VA research has indicated that observational data is more accurate for Blacks or African Americans and Whites than other racial groups, and that studies focused on other racial groups may be especially vulnerable to misclassification bias.[25] As such, VA lacks reasonable assurance that the identification of race and ethnicity as "self-reported" is accurate.

- **Data on veterans' race are often incomplete.** Race and ethnicity information is collected as two separate categories in the EHR, and as previously stated, is generally obtained when a patient enrolls in VA health care, or seeks care at a VA medical center or clinic. Two VA researchers told us that ethnicity data—based on veterans' designation of whether they are Hispanic or non-Hispanic—are often more complete than race data. They said that one reason for this is that the order in which the questions are asked may be problematic; specifically, the ethnicity question is asked first, followed by a second question to request a race designation. Veterans may self-report that they are "Hispanic" upon enrollment or check-in for an inpatient admission or outpatient medical visit, and then leave the race field empty because they believe that they have already provided this information. Missing data on race impedes VA's ability to identify potential disparities in health care outcomes.
- **Conflicting race and ethnicity information in a veteran's medical records makes it difficult to determine which information is accurate.** According to VA researchers we spoke with, because a patient's race and ethnicity information is uploaded from his or her EHR after each inpatient admission and outpatient appointment, there can be multiple records for each patient's race and ethnicity data in

[25]Sohn, Min-Woong, et al., "Transition to the New Race/Ethnicity Data Collection Standards in the Department of Veterans Affairs." Population Health Metrics 4, no. 7 (2006): 7.

Hamilton, Natia S., David Edelman, Morris Weinberger, and George L. Jackson. "Concordance Between Self-Reported Race/Ethnicity and that Recorded in a Veteran Affairs Electronic Medical Record." NC Med 70, no. 4 (July/August 2009): 296-300.

VA databases.[26] These patient records often conflict with one another, and may result from the use of both observational and self-reported data. As such, officials stated that it can be difficult to determine which of the multiple race or ethnicity records are accurate.

To account for the issues with completeness and accuracy, VA researchers have used various approaches. VA researchers we spoke with told us that while they use data entered into VA's EHR, which are then uploaded into various databases, they also must use a variety of methods, often time-intensive, to enable the use of race and ethnicity data due to concerns about its completeness and accuracy. These methods include using veterans' patient records that may be several years old and from multiple VA health care settings, and looking at patient race and ethnicity information captured across multiple years and VA facilities. In addition, researchers also described using multiple non-VA data sources to supplement VA's race and ethnicity information, such as Medicare data, and data from the Department of Defense's roster of veterans from recent military operations.

VA officials and other stakeholders representing veterans' interests have recognized the weaknesses in VA's race and ethnicity data and the importance of improving those data in order to address disparities and improve health equity. For example,

- VA's first action plan included a goal to improve data availability, supported by implementation activities to "identify limitations of existing data, barriers to access to data, and data collection methodologies that affect VA's ability to describe disparities" and "identify strategies for capturing data on race, ethnicity, language…needed to stratify the results for all quality measures and to address disparities."

[26]Race and ethnicity information is entered into the EHR, and then uploaded into the VA databases, which comprises data from several VA clinical and administrative systems. In this report, we reference two VA data sources, the Corporate Data Warehouse and VA Medical SAS Dataset. The Corporate Data Warehouse is a large-scale data warehouse used by VA for "business management, clinical and administrative research, and health-care system innovation." A select set of data collected during patient health care encounters are electronically transferred from health care facilities' EHRs to a centralized data warehouse. VA data analysts use these data to construct VA Medical SAS Dataset data tables, which are used by VA researchers. Race and ethnicity information is also included in the Veterans Integrated Service Network Support Service Center database which provides veterans' enrollment information, and use of VA services at any VA facility nationwide.

- in 2016, the Commission on Care recommended that VA increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans, as well as utilize systems that monitor trends in health status, patient satisfaction, and quality measures.
- in its 2015 annual report, the Advisory Committee on Minority Veterans recommended that VA enhance its existing data collection processes to include the reporting of race and ethnicity data for all benefits and utilization programs to ensure the identification of delivery gaps and potential disparate levels of service. Furthermore, in its 2017 annual report, the Committee again highlighted ongoing concerns with VA's inconsistency in collecting race and ethnicity data and stated that it impedes VA's ability to adequately identify health disparities and to ensure minority veterans are receiving quality care and services throughout VA's system.

VA is currently collaborating with the Department of Defense to implement a new EHR system. As yet, they have not yet addressed how the EHR will store race and ethnicity information. The new EHR system is to provide both departments with a common EHR platform that is intended to support the provision of seamless care and create a single health record for service members and veterans. VA officials from the Office of EHR Modernization told us that this collaboration is still in the very early stages and that while race and ethnicity information will be included in the new EHR system, the new EHR will take 10 years to fully implement.

VA Officials Have Reported that Data Weaknesses Limit the Ability to Identify and Address Disparities in Health Care Outcomes at VA Medical Centers

Data weaknesses, including incomplete and inaccurate data have limited VA's ability to advance health equity and patient care in its medical centers, according to VA officials. Unlike VA researchers, who report being able to account for missing and inaccurate race and ethnicity data, most VA medical centers do not have the research staff and data specialists needed for these efforts, according to a VA researcher from HSR&D's Center for Health Equity Research and Promotion and officials from a VISN included in our review. As a result, the inaccurate and missing data have limited the ability of VISN and VA medical center staff to identify and address disparities in health care outcomes by race and ethnicity at the medical center level.

VISN officials we spoke to discussed the challenges they encountered when trying to obtain complete and accurate data on health care

outcomes by race and ethnicity to identify disparities involving their minority veteran populations. For example,

- one VISN official told us that she began an effort to analyze disparities in health care outcomes by race and ethnicity in fiscal year 2018, but encountered challenges in obtaining complete and accurate data for minority veterans. She said she contacted OHE officials for assistance, who provided data for diabetes and hypertension by race and ethnicity, but these data were 2 years old and available only at the national level. According to the VISN official, complete and accurate health care outcomes data by race and ethnicity were not available for minority veterans that received care in her region. The official told us that she subsequently contacted both VISN-level and national data specialists, but was still unable to obtain the data to assess health care outcomes by veterans' race and ethnicity at the regional or local level.
- other VISN officials we spoke to explained that they had a similar experience when they explored using race and ethnicity data to design a dashboard for a VISN-funded project to track efforts to address disparities in ambulatory care readmissions involving minority veterans. They also told us they too contacted regional and national data specialists, but were told that the readmissions data were missing and inaccurate by race and ethnicity and therefore not useable for their efforts.

VA officials told us they are taking steps to provide VA medical centers with data on health care outcomes at their facilities. These officials told us that they are currently developing two health equity dashboards that will use VA's data on race and ethnicity to provide information on health care outcomes, which would allow VA staff to identify any disparities in these outcomes at the VISN and VA medical center levels. The two health equity dashboards are in different stages of development and, as of September 2019, VA did not have a timeline for completion and implementation across VA medical centers for either dashboard. According to VA officials, the development of these dashboards will not address the accuracy and completeness of the race and ethnicity data in the VA's EHR. In order to maximize the effectiveness of these dashboards, VA needs to ensure that underlying data weaknesses are addressed by ensuring that race and ethnicity data in the EHR are complete and accurate.

VA Collects Patient Experience Feedback from Veterans, including Minority Veterans, through Surveys and VA Medical Center Patient Advocates

VA collects patient experience feedback from veterans, including minority veterans, through the following surveys:

- **The Survey of Healthcare Experiences of Patients (SHEP)** is VA's national, standardized, and publically reported patient experience survey that comprises up to 83 questions that are used to collect information about patients' experiences in various inpatient care settings. The SHEP covers topics to assess patients' perceptions of their experience using the Consumer Assessment of Health Providers and Systems Survey, which is the health care industry standard.[27] According to VA officials, the response rate for the SHEP is just under 40 percent, and on average, 95 percent of respondents complete survey questions about their race and ethnicity. SHEP survey results are reported publically at the national, VISN, and VA medical center level.

  VA does not report survey data for specific racial and ethnic groups because, according to VA officials, the number of minority veterans responding to the SHEP is too small to report. In 2012, a memo establishing the OHE recommended that VA send the SHEP survey to a higher number of veterans from racial and ethnic minority groups so there are enough responses to report survey results by those minority groups. However, VA officials told us that they were not aware of this recommendation and had not addressed it. Currently, VA officials told us that VA staff can access SHEP data by race and ethnicity in four broad categories: Hispanic, White, African American or Black, and other, which includes American Indian or Alaskan Native, Asian, and Native Hawaiian or other Pacific Islander racial groups. VA officials told us these data can be accessed on VA's intranet and are updated on a monthly basis.
- **The Survey of Veteran Enrollees' Health and Use of Health Care** comprises questions about a range of issues, such as enrollee's health status, insurance, VA and community health care use, and attitudes and perceptions of VA services. The survey is generally conducted on an annual basis, and achieved a 32 percent response

[27]The Consumer Assessment of Health Provider Systems surveys are a program of the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services.

rate in 2018.[28] VA publically reports these survey results by race and ethnicity at the national level, and also provides survey results by race and ethnicity for each VISN. For example, one indicator in the 2018 survey results showed that Native Hawaiians were far less satisfied with their ability to get referrals compared to other minority groups. According to VA survey documentation, VA requires a minimum number of survey responses to draw conclusions across the VA enrollee population; the number of survey responses must be aggregated at the VISN level to meet this minimum number.

- **Veterans Signals** is a VA survey intended to collect immediate targeted feedback on veterans' experiences with outpatient services on an ongoing basis. VA officials told us that about one to two million survey invitations are sent out via email each week to veterans who recently received outpatient services, and have provided their email addresses to VA. These short surveys include eight to nine questions and focus on a particular area related to veterans' recent experiences with VA health care services, such as scheduling appointments, pharmacy wait times, and proficiency of provider communication about veteran concerns during appointments. VA officials told us that the surveys have a response rate of about 20 percent, and of the responses received, 44 percent of respondents provide their race and ethnicity information. [29] VA officials told us that VA medical center staff have access to survey results in real-time and can review results by race and ethnicity for their individual medical centers.

In addition to these surveys, VA collects patient experience feedback from veterans, including minority veterans, through its patient advocates located at its medical centers. Each of VA's 172 VA medical centers is responsible for making at least one patient advocate available to respond to veterans' feedback and for ensuring feedback is recorded in its Patient Advocate Tracking System (PATS)—an electronic system used to

[28]The Survey of Veteran Enrollees' Health and Use of Health Care reports on topics such as private and public health insurance coverage, prescription drug coverage, and enrollees' views on VA health care. The survey includes seven questions to assess veterans' perception of availability, accessibility, and general experience with VA health care services.

[29]In general, of those veterans that respond, approximately 85 percent identify as White, and 17 percent identify as a minority. VA officials told us the total of those that identify their race and ethnicity does not equal 100 percent because a respondent may select multiple options. VA officials said it does not require respondents to answer race and ethnicity questions, as they do not want to overburden the respondents by asking for information they already have.

describe and track the resolution of veterans' feedback across VA medical centers. Patient advocates enter veterans' feedback in PATS and assign one or more issue codes that generally describe the nature of the feedback.[30] Of the 21 patient advocates we interviewed across 12 VA medical centers, most said they generally do not include race and ethnicity information in PATS when filing a veteran's complaint, but a few patient advocates said they will include such information if it pertains directly to the complaint. For example, a patient advocate told us she may include race and ethnicity information in PATS in the case of a concern that discrimination occurred.

We found that some veteran complaints may not be consistently coded and reported under the correct PATS issue codes in a manner similar to inconsistencies we have identified in prior work.[31] According to VA officials from the Office of Patient Advocacy, two PATS codes were created in 2017 that, in particular, may specifically apply to issues affecting minority veterans: (1) discrimination concerns, and (2) diversity concerns. Of the 21 patient advocates we interviewed about these two specific issue codes, nine were not familiar with or had never used them. VA officials told us that they expected to see patient advocates use these codes more often in 2019 as a result of updates to their patient advocate training curriculum, required for newly hired patient advocates and available to all others.

Patient advocates that we interviewed often told us that they review PATS data to report systemic issues to their VA medical center leadership, and a few said they report on a weekly or monthly basis. Additionally, VISN patient advocate coordinators use the PATS data to determine whether there are any trends in PATS data across the medical centers in their networks.

[30]According to VHA Directive 1003.04 *VHA Patient Advocacy*, patient advocates are allowed, but not required to include demographic information, including race and ethnicity, in the PATS record of a veteran's complaint.

[31]GAO *VA Health Care Improved Guidance and Oversight Needed for the Patient Advocacy Program*, GAO-18-356 (Washington, D.C.: April 12, 2018). We reported that: 1) VHA needed to improve guidance and oversight for the patient advocacy program and recommended that VHA monitor PATS data-entry practices to ensure all complaints are entered into PATS, and 2) veterans' feedback should be coded consistently, and recommended that PATS data to assess program performance and identify potential system-wide improvements should systematically be reviewed. These recommendations remain open.

Conclusions

As one of the nation's largest health care systems, VA has a unique opportunity to gain a better understanding of the reasons that disparities in health care outcomes occur. VA signaled its commitment to reducing disparities for racial and ethnic minorities and achieving health equity by establishing a responsible program office, creating an action plan, and funding research toward this goal. As the number of minority veterans receiving VA health care services continues to increase, it is important that VA enhances and strengthens its efforts to identify and address disparities in health care outcomes to ensure that all veterans receive equitable care.

Despite these efforts, however, without including performance measures or lines of accountability, VA lacks the means to ensure any action plan will be fully implemented to achieve its goals. Further, weaknesses in race and ethnicity data due to problems with the completeness and accuracy continue to limit VA's ability to identify and address disparities in health care outcomes at the VA medical center level. Although VA is developing equity dashboards to provide health care outcomes data by race and ethnicity at the VA medical center level, these efforts will not improve the completeness and accuracy of the race and ethnicity data in VA's EHR. Until VA resolves known weaknesses with the completeness and accuracy of its race and ethnicity data, it will be limited in its ability to assess health equity for veterans receiving care at its facilities.

Recommendations for Executive Action

We make the following two recommendations to VA:

The Under Secretary for Health should ensure that any action plan for achieving health equity includes key elements for successful implementation by consistently applying criteria identified in GAO's past work on effectively managing performance, including developing performance measures to assess progress and creating clear lines of accountability by designating specific offices or officials with responsibility for coordinating efforts to implement actions and committing resources necessary for achieving its goals and objectives. (Recommendation 1)

To ensure the availability of information on health care outcomes by race and ethnicity throughout the VA health care system, the Secretary of Veterans Affairs should conduct an assessment to determine the completeness and accuracy of race and ethnicity data captured in VA's electronic health record, and implement corrective actions as necessary to resolve any identified deficiencies. (Recommendation 2)

Agency Comments

We provided a draft of this report to the Department of Veterans Affairs and the Department of Defense for review and comment. The Department of Defense did not have comments.

VA provided written comments, which are reprinted in appendix I. VA concurred with both of our recommendations—that any health equity action plan should include performance measures to assess progress and that VA should resolve weaknesses identified with the completeness and accuracy of race and ethnicity data. VA further provided information on how the agency intends to address our recommendations, with targeted completion dates of December 2020 and June 2021, respectively.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Veterans Affairs and the Under Secretary for Health, and the Secretary of the Department of Defense. In addition, the report is also available at no charge on GAO's website at http://www.gao.gov.

If you or your staff has any questions regarding this report, please contact me at (202) 512-7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.

Debra A. Draper
Director, Health Care

Appendix I: Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

November 20, 2019

Ms. Debra A. Draper
Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Draper:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report, ***VA HEALTH CARE: Opportunities Exist for VA to Better Identify and Address Racial and Ethnic Disparities*** (GAO-20-83).

The enclosure provides general comments and sets forth the actions to be taken to address the draft report recommendations.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

Pamela Powers
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
VA HEALTH CARE: Opportunities Exist for VA to Better Identify and Address Racial and Ethnic Disparities
(GAO-20-83)

General Comments:

The Department of Veterans Affairs' (VA) mission is to deliver needed health care to all Veterans regardless of race or ethnicity. Recent studies have shown that Veterans receiving health care from VA are more likely to receive needed services than patients in the general population and that differences in health care delivery related to race and ethnicity are small for most groups.[1] [2] However, differences in health outcomes among Veterans Health Administration (VHA) users related to race and ethnicity deserve continued attention, vigilance, and research. For example, VA notes that racial or ethnic minority Veterans are more likely to have poorly controlled diabetes even though they are receiving the same treatments and preventive evaluations as all Veterans. This suggests that standardized disease management protocols may not be sufficiently attuned to the needs of minority populations. One might explore whether diabetes counselling, for instance, is provided in a way that is concordant with a Veteran's values, culture, and environment to enable adherence to medical advice about medications, diet, and exercise. Greater sensitivity to Veterans' racial and ethnic backgrounds may help health care providers communicate more effectively with Veterans and their families and support healthy lifestyle changes.

VHA's Office of Health Equity was established in 2012 to advance health equity for all Veterans, including members of racial and ethnic minority groups. The office works with many partners, notably the VA Center for Minority Veterans, the VHA Center for Health Equity Research and Promotion, and VHA's National Partnered Evaluation Center. Together, we raise awareness of challenges faced by different Veteran groups (https://www.va.gov/HEALTHEQUITY/Race_Ethnicity.asp), develop Equity Guided Improvement Strategy tools to help VA facilities understand and address disparities in their care processes and outcomes, and improve the quality of data for assessing disparities.

[1] May FP, Yano EM, Provenzale D, Steers WN, Washington DL. Race, Poverty, and Mental Health Drive Colorectal Cancer Screening Disparities in the Veterans Health Administration. Med Care. 2019 Oct; 57(10): 773-780. doi: 10.1097/MLR.0000000000001186. PubMed PMID: 31415338.
[2] Backus LI, Belperio PS, Loomis TP, Mole LA. Impact of race/ethnicity and gender on HCV screening and prevalence among U.S. Veterans in Department of Veterans Affairs Care. Am J Public Health. 2014 Sep; 104 Suppl 4: S555-61. doi: 10.2105/AJPH.2014.302090. PubMed PMID: 25100421; PubMed Central PMCID: PMC4151890.

1

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
VA HEALTH CARE: Opportunities Exist for VA to Better Identify and Address Racial and Ethnic Disparities
(GAO-20-83)

Recommendation 1: The Under Secretary for Health should ensure that any action plan for achieving health equity includes key elements for successful implementation by consistently applying criteria identified in GAO's past work on effectively managing performance, including developing performance measures to assess progress and creating clear lines of accountability by designating specific offices or officials with responsibility for coordinating efforts to implement actions and committing resources necessary for achieving its goals and objectives.

VA Comment: Concur. The Veterans Health Administration (VHA) agrees that performance measurement, clear lines of accountability, and commitment of resources are necessary for achieving VHA health equity goals. In response to this recommendation, the VHA Office of Health Equity (OHE) will develop annual health equity operational plans that include performance measures, designate responsible offices for specific activities, and identify needed resources. These operational plans will be developed with the guidance of the office's advisory group, the Health Equity Coalition, and submitted annually to the Under Secretary for Health for review and approval. The Health Equity Coalition will also assess performance against targets. Target Completion Date: December 2020.

Recommendation 2: To ensure the reliability of information on health care outcomes by race and ethnicity throughout the VA health care system, the Secretary of Veterans Affairs should conduct an assessment to determine the completeness and accuracy of race and ethnicity data captured in VA's electronic health record and implement corrective actions as necessary to resolve any identified deficiencies.

VA Comment: Concur. VHA agrees that complete and accurate race and ethnicity data are needed to optimize health outcomes for all Veteran populations. In response to this recommendation, OHE and VHA's Health Services Research and Development (HSR&D) will conduct a study to quantify the completeness and accuracy of race and ethnicity data captured in VHA electronic health records. The Health Equity Coalition, in collaboration with relevant VA program offices and stakeholders, will review study findings and make recommendations to leadership on needed corrective actions. Upon approval, appropriate parties will be charged to implement corrective actions and establish systems to monitor the completeness and accuracy of race and ethnicity data captured in VHA electronic health records. HSR&D anticipates 1 year to complete the study; OHE anticipates 6 months to collaborate with VA and VHA stakeholders to generate recommendations after the study is completed. Target Completion Date: June 2021.

2

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Debra A. Draper, (202) 512-7114, draperd@gao.gov

Staff Acknowledgments

In addition to the contact named above, Ann Tynan, Assistant Director; Michelle Paluga, Analyst-in-Charge; Jennie Apter, Romonda McKinney Bumpus, and Phil Steinberg made key contributions to this report. Also contributing were Kaitlin Farquharson and Ethiene Salgado-Rodriguez.

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