EDITORIAL

The Struggle for Health Equity: The Sustained Effort by the VA Healthcare System

The Veterans Health Administration is the largest integrated health care system in the United States, established in 1930 by the Roosevelt administration to "consolidate and coordinate government activities affecting war veterans." Even though the Department of Veterans Affairs (VA) has historically struggled to provide high quality medical care,[1] and is currently facing highly publicized challenges in ensuring timely veteran access to health care, studies document remarkable strides in delivery of high quality health care in the VA relative to the private sector.[2–5] For example, diabetes care in the VA is superior to that provided in the private sector,[4] and VA patients are more likely than Medicare patients to receive life-saving cardiac care.[5] VA performance on many process-of-care quality measures across the full spectrum of health care services (prevention, screening, diagnosis, treatment, and follow-up) is better than in non-VA health care systems.[2] Finally, veterans report higher levels of satisfaction with VA health care than their counterparts receiving care in the private sector.[6]

This progress is driven by the VA's emphasis on patient-driven, proactive, personalized health care and its sustained commitment to equitable delivery of high quality health care to all veterans, including those most vulnerable for disparities in health care and health outcomes (i.e., historically underserved veterans [e.g., women, racial and ethnic minorities, rural residents], veterans with permanent disabilities, cohorts with shared military experience, and veterans whose living arrangements pose special challenges to their health or health care delivery [e.g., homeless]). This commitment to equity is evident in the preponderance and diversity of research and quality improvement initiatives focused on vulnerable veteran populations, in dedicated VA offices charged to ensure the equity of VA health care and services, in publicly reported data on patient health care experiences stratified by race and gender, and in VA's primary care delivery model that uses strategies effective in reducing disparities. VA health care delivery is supported by centralized administration; a high value, evidence-based pharmacy benefits plan; and a national health information technology platform that enables innovative and interactive use of the electronic health record and clinical and administrative data for intervention, evaluation, and tracking of patient care. These unique assets secure VA's position as an industry leader in today's health care market, despite the challenges it faces in ensuring timely access to high quality, equitable health care for all veterans.

IN THIS SUPPLEMENT OF THE *JOURNAL*

The collection of original research articles featured in this supplement highlight VA's commitment to continuous improvement in the delivery of quality health care across a broad range of vulnerable veteran populations. Each study maps neatly onto a widely used conceptual framework to advance the field of health equity research through three sequential generations[7]: detecting disparities in health and health care (first generation), understanding the determinants of such disparities (second generation), and reducing disparities (third generation). First generation research involves identifying and quantifying disparities in health or health care between recognized and emerging vulnerable populations and their nonvulnerable counterparts. Second generation research involves identifying and understanding the multifactorial determinants of these disparities. Third generation research involves designing and testing targeted interventions; assessing their efficacy, effectiveness, safety, and cost; broadly implementing successful interventions; evaluating the implementation process and outcomes; and translating successful interventions into widespread clinical practice and policy. The research published in this supplement spans the generations of health disparities research conducted within the VA and with veterans. Below we briefly outline the primary objectives, key findings, and the main conclusions for selected studies from this supplement.

First Generation Studies

Blosnich et al. compared rates of suicidal ideation and attempts among lesbian, gay, and bisexual (LGB) and heterosexual veterans.[8] Although there were no significant differences in recent suicidal ideation and lifetime suicide attempts, LGB veterans had higher odds of lifetime suicidal ideation than heterosexual veterans. The authors conclude that suicide prevention efforts for LGB veterans could

benefit from a life-course perspective regarding suicide risk.

Backus et al. assessed HCV screening and prevalence among veterans and estimated the potential impact of complete birth cohort screening.[9] They report that more than five million veterans received HCV screening and that the prevalence of the virus was highest among African Americans, particularly those born during 1945 to 1965. They also found that incident HCV infection was higher in male than female veterans in 2012. The authors conclude that HCV prevalence is markedly elevated among veterans born during 1945 to 1965, with substantial variation based on race and gender.

Noe et al. surveyed 27 VA health care facilities to assess organizational readiness and capacity to adopt and implement Native American specific services and to profile the extent of American Indian and Alaska Native (AI/AN) veteran program availability, interest, and resources.[10] They found several variables predictive of VA staff perceptions that their facilities are meeting the needs of AI/AN veterans, but no variables predictive of greater implementation of Native-specific services. The authors concluded that their findings may be helpful in developing strategies to promote the adoption and implementation of promising Native-specific programs and services for AI/AN veterans.

Second Generation Studies

Samuel et al. examined cancer care disparities within the VA Healthcare System and assessed whether observed differences occurred within or between hospitals.[11] Disparities in cancer care were present for seven of 20 measures and primarily attributable to within-hospital differences. For example, compared with Whites, Blacks had lower rates of early stage colon cancer diagnosis, curative surgery for stages I to III rectal cancer, three-year survival for colon and rectal cancer, and curative surgery for early stage lung cancer. The authors conclude that disparities in VA cancer care remain and are primarily attributable to within-hospital differences.

Copeland et al. examined factors associated with suicidal behavior and ideation in a sample of more than 89 000 veterans who underwent major surgery between October 2005 and September 2006.[12] They found that African American veterans were at increased risk for suicidal behavior and ideation, while Hispanic veterans were not. They also identified risk factors for suicidal behavior and ideation, including schizophrenia, bipolar disorder, depression, posttraumatic stress disorder, pain disorders, postoperative new-onset depression, and postoperative complications; while female gender and married status were found to be protective. The authors concluded that the postoperative period may be a time of heightened risk for suicidal behavior and ideation among high-risk veterans.

Blosnich et al. examined the association of military service history with suicidal ideation and mental distress among a probability-based sample of adult participants in the 2010 Behavioral Risk Factor Surveillance System survey from five states.[13] They found that military history status among those aged 40 to 64 years was associated with both suicidal ideation and mental distress. No such associations were observed among younger or older age groups. The authors concluded that differences in suicidal ideation between military and nonmilitary experienced individuals are most likely to occur in midlife.

Whitehead et al. examined gender disparities in VA performance measures from 2008 to 2013 after the national implementation of a strategic plan focusing on VA women's health care.[14] They found decreasing trends in gender inequities on most HEDIS performance measures, with near elimination of the disparities in screening for depression and posttraumatic stress disorder. The authors concluded that various strategies employed by the VA (e.g., VA data reporting by gender, electronic reminders, and population management dashboards) have reduced gender disparities in VA health care.

Third Generation Studies

Burgess et al. examined whether a smoking cessation intervention designed to overcome barriers to tobacco treatment is effective at increasing smoking cessation among African American veterans.[15] Their intervention led to higher quit rates among African American than White veterans (13% vs 9%; $P < .006$). The authors conclude that African Americans in the VA Healthcare System quit at higher rates than do Whites, in large part because of the VA's concerted effort to reach all patients and provide equitable access to smoking cessation programs.

Lastly, McInnis et al. examined the feasibility of sending mobile phone text appointment reminders to homeless veterans to increase their engagement in VA health care.[16] The authors found that veterans were generally highly satisfied with the text message reminders, had very few technical difficulties, and indicated a desire for it to continue. The intervention also reduced patient cancelations and no-shows, emergency room visits, and hospital admissions. The authors conclude that text messaging appears to be a feasible means of reaching homeless veterans and may help improve the quality and equity of care for this highly vulnerable population.

In summary, the original research featured in this supplement demonstrates the importance of continued first and second generation studies to detect and understand disparities across a broad range of vulnerable veteran populations, including racial and ethnic minorities, women, LBG and transgender, and the homeless. Furthermore, despite the dearth of third generation VA studies in the past, two of the studies reported here demonstrate promising strategies to support smoking cessation among African Americans and engagement in health care for the homeless. As the VA Healthcare System works to address issues of access to and timeliness of health care for our nation's veterans, it must ensure that these dimensions of quality are equitably achieved for all veterans. ■

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