VHA Reimagining Veteran Healthcare

Veteran Segmentation and Landscape Analysis

June 2021

Table of Contents

Overview and Methodology

This document examines ***existing data sources and research*** to ***understand how Veterans currently use and experience VA and VHA, care considerations in a post pandemic environment, and how to better serve all Veterans.*** It provides insights into specific populations of Veterans ***to engage with during the next ethnographic research portion of the Reimagining Veteran Healthcare effort.***

Objectives and Approach

As part of the Reimagining Veteran Healthcare effort, this report seeks to ***guide research efforts*** around which initial Veteran ***segments to engage*** with and ***key questions to ask*** during ethnographic field research. It will help to ***better understand current needs, behaviors, and expectations*** of all Veterans in a post-pandemic environment. Identifying key segments will help ***focus scope*** and drive research around potentially ***underserved Veterans***

OBJECTIVES

- Develop a **preliminary list of Veteran segments** to engage with during ethnographic research given population trends and usage information – placing Veterans at the forefront of this work
- Identify **key questions to drive ethnography,** rooted in gaps in current data and/or discrepancies between trends, usage, and experience across Veteran segments
- Identify **initial health care delivery improvement opportunities for VA/VHA** based on current and forecasted Veteran needs

APPROACH

- Analyzed **8 key demographics/populations** to understand overall trends, shifts, and intersectionality in Veteran populations – both for enrolled and unenrolled Veterans – across the next 25 years
- Supplemented quantitative analysis with secondary research and stakeholder interviews to determine **ongoing efforts and initial opportunities for improvement**
- Determined **initial list of segments** to connect with during ethnographic research

Where This Fits

The Veteran Segmentation is one component of the larger Current State Assessment. It helps direct ethnographic field research, provides a baseline understanding in the Veterans and VHA of today, and sets the tone for VHA's path forward

CURRENT STATE COMPONENTS

Ecosystem mapping and applicable legislation: Documentation that uncovers changes taking place in VA's market and helps understand the current shape of VA delivery system

Veteran Segmentation: This deliverable provides insights into specific populations of Veterans – enrolled and unenrolled – to engage during the ethnographic field research phase

Forthcoming Current State Components

Trends/Benchmarking Analysis: Research that uncovers changes taking place in VA's market and innovation shaping the future of health care

Key Considerations

"It is clear that the **Veteran population and their needs are changing faster** than we realize. For the first time in 40 years, half of our Veterans are under the age of 65. Of 20 million Veterans, 10% are women and the number of Women Veterans receiving care has tripled. The new generation is computer savvy and **demands 21st-century service efficiently delivered and available when needed**."

-Secretary Robert Wilkie, September 2018

KEY CONSIDERATIONS:

Data imperfections:
The existing data does not consider eligibility of the total Veteran population. Therefore, the number of unenrolled Veterans includes Veterans who may not be eligible for VA benefits. Other issues include limited availability of official data on LGBT-identified Veterans. Additionally, various data sources and secondary sources were used and, depending on when the numbers were calculated, could have slight variations

Moment in time:
This information represents a snapshot of today; it is ever-changing and will be frequently revisited and challenged over time as new data sets and information become available

Veteran intersectionality:
While the demographics identified may be true for some Veterans, they do not fully describe the interconnected nature of all characteristics that may affect individual care needs or preferences. The last section of this report details some key findings around intersectionality, and this analysis will continue to evolve moving forward – supplemented with additional data findings from ethnographic field research

Identity and Demographics:
While this analysis focuses heavily on demographics, it is important to note that demographics are not always accurate predictors of behavior and should be supplemented with qualitative information. Additionally, data capture of demographics is not a perfect representation of Veterans' identities as not all Veterans disclose all information about themselves, and VA does not currently collect true representative information about all Veterans (i.e., non-binary)

Resources Used

The following list reflects the data sources, publications, studies, research efforts, and stakeholder interviews consulted in performing this analysis

DATA SOURCES

Original data collection stemmed from the following sources:

United States Census

- Data for Total Veteran, Total U.S., and Total Non-Veteran Populations for 2010, 2015, and 2019
  - **Note:** While the 2010 Census data is based on robust sampling per the usual 10-year Census, the 2015 and 2019 Census data are estimates created by U.S. Census Statisticians, based on linear and nonlinear projections of population growth patterns

VHA – Veteran Support Service Center (VSSC)

- Data for the Enrolled and User (any patient who used VHA services within the last three years) populations were collected and provided by VHA Data Analysts from VSSC's Enrollment Data Cube
  - **Note:** To see how categories and subcategories were combined to enable analysis, see the Category Consolidation Cross-Walk slides in the Appendix

VA – Corporate Data Warehouse (CDW)

- All service-related and demographic intersectionality data were collected through SQL queries; data was verified later by a VHA Data Analyst

PRIMARY RESEARCH

- 29 stakeholders interviewed across VA/VHA
- 11 conferences, listening sessions, and Senate hearings

SECONDARY RESEARCH

- Reviewed 53 secondary resources, including but not limited to:
  - VEO - VSignals Outpatient Services Surveys: Women Veterans Analysis
  - SECVA Dashboard March 2021
  - RAND
  - PEW Research Center
- For a full list of secondary research sources see the References slides in the Appendix

Veteran Population: Overview

The overall Veteran population is ***projected to decline over the next 25 years***. Alongside that decline, the ***demographic makeup of Veterans will also shift***: an increase in the ratio of female to male Veterans, a more even spread across age ranges, increased racial diversity, and changes in service connection. To best serve this changing Veteran population, VA has the opportunity to ***better understand Veteran needs and design innovative solutions to meet Veterans where they are***.

A Changing Veteran Population

A declining Veteran population - coupled with shifting demographics - indicates that health care needs of the future Veteran will differ from those of today's Veteran

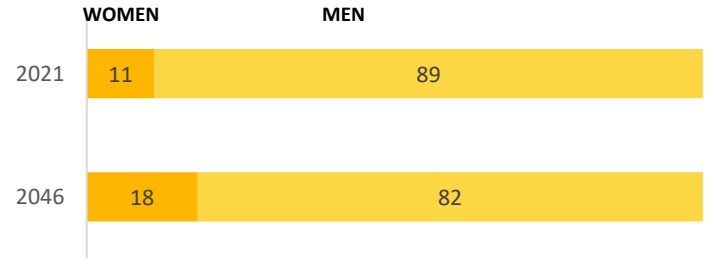
The number of Veterans in the U.S. is decreasing:

TODAY	IN 2046
19 mil	**12.5 mil**
living Veterans	living Veterans

Alongside this decline, the demographic makeup of the Veteran population will also change:

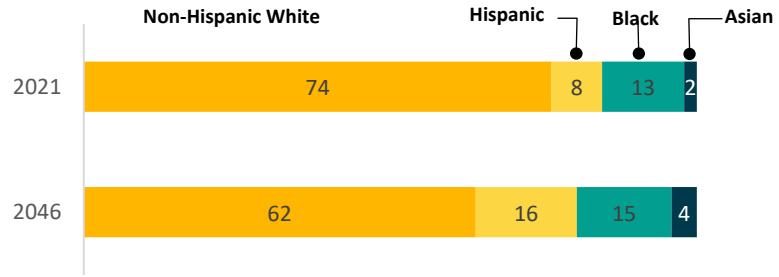
Gender

There will be a greater proportion of female Veterans by 2046



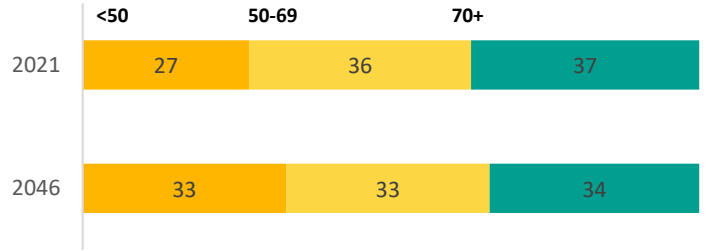
Race/ Ethnicity

The Veteran population will become much more diverse



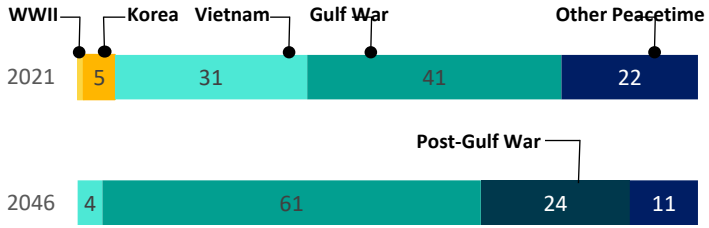
Age

The Veteran population will be more evenly spaced between ages in the future, rather than skewed toward older demographics



Era of earliest service

Service-connected medical conditions will change by 2046

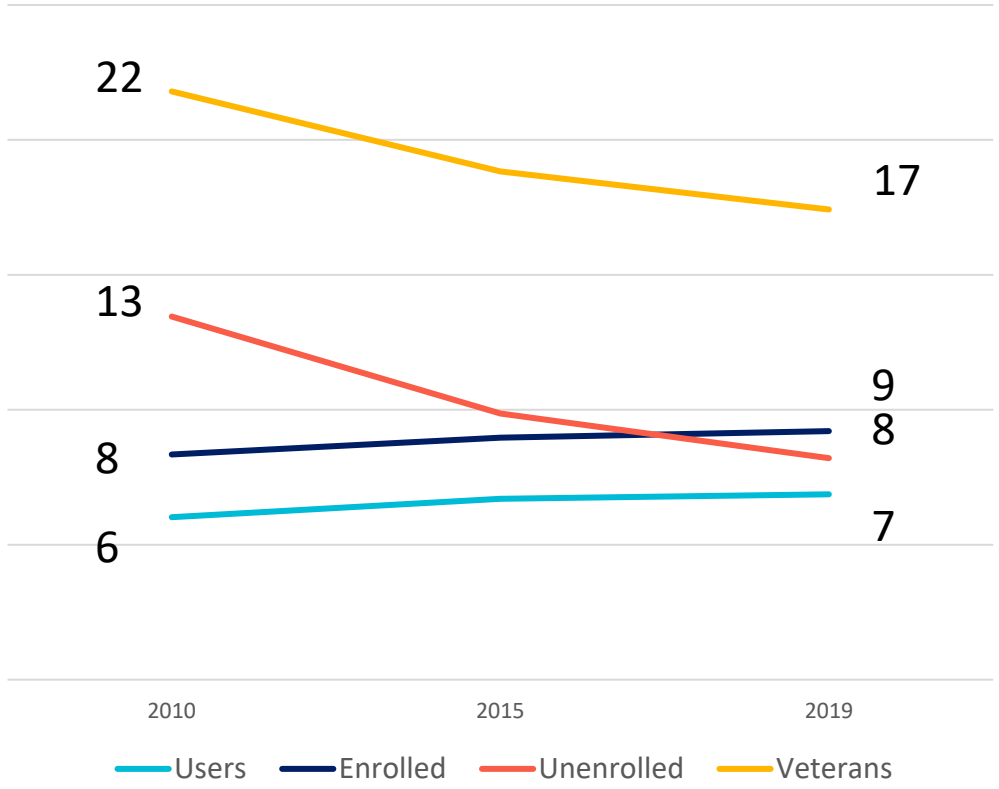


Clearly understanding the shifts in expectations and behaviors of this future population, both enrolled and unenrolled, will help us focus on specific segments to engage with – placing Veterans' who will be most at need at the forefront

Who VHA is Serving

VHA can potentially increase its user base by assessing why unenrolled Veterans may not seek out VA services, and how to increase usage by those who are enrolled. This engagement will study each of these populations to comprehensively understand drivers behind VA enrollment, and subsequent experiences and usage.

Veteran Population (in Millions), 2010-2019



Overall Veteran Population: The number of living Veterans continues to decline and is **projected to reach 12.5M by 2046 – 35% fewer than present day.** VA has the potential to consider how shifts in services may better meet the needs of the more modern Veteran

Unenrolled Veteran Population: Only ~53% of Veterans enroll in VHA benefits. While this may be due to eligibility requirements, VHA has an opportunity to increase the number of enrolled Veterans. This effort seeks to understand why those who are unenrolled and eligible opt out of VHA care

Enrolled Veteran Population: ~53% of Veterans have enrolled in VHA services, yet only ~39% of Veterans are active users, (had an interaction with VHA in the last three years). VHA has the potential to increase the number of Veterans who actively use services. This effort seeks to understand why those who have enrolled may not be active users, and what experiences they might have had to influence their usage. This effort also seeks to understand the demographic and physiographic changes that may impact this group and the services they receive

This research effort seeks to better understand Veteran populations who are using, not using, and under using VHA services, regardless of current enrollment status.

Note: See References slides in Appendix for sources

Demographic Deep Dives

This report provides a ***breakdown of demographic segments within the Veteran population***. This includes overall trends, how certain segments use and view VA/VHA, and potential implications for research. Honing in on unique Veteran segments will ***better define ethnographic research objectives.****

**Demographics are not always accurate predictors of behavior and should be further supplemented with qualitative data/research methods*

Rationale for Spotlighted Demographics/Populations

This document analyzes 8 key demographics or populations as an initial way to focus scope. There are other demographics and aspects of a Veteran that should be considered when designing health care, which will continue to be explored throughout this effort.

Sex and Gender

Biological needs have a direct connection to overall care needed. VA typically uses the term gender, though in most cases is referring to those assigned female at birth; thus, sex and gender were grouped together. Research focuses on females since health care has historically been geared towards the needs of males, and females have been an underrepresented and marginalized group

Race and Ethnicity

Historical discrimination towards people of color across the U.S. impact nearly all facets of life, particularly health care. Stakeholders expressed a lack of diversity in VHA employees and leadership, and how that may impact Veteran care. Race and ethnicity are also key intersections that often inform behavioral differences between groups

Age

Different age groups each have varying needs and preferences to consider when designing innovative solutions. Understanding projections around age can inform the types of services and care that will be in higher demand in the future

Location

Location refers to where a Veteran lives and receives care, specifically urban or rural. Location is important to consider for field research because needs differ based on home location and correlate with trends around income, access, education, etc.

LGBTQIA+

There are health considerations unique to the needs of the LGBTQIA+ population. The military has a history of discriminating against this population, meaning many of their needs may not have been met. VA does not yet actively collect data on the LGBTQIA+ population and many Veterans may not feel comfortable disclosing this information to VA. It is therefore difficult to get an accurate count of how many Veterans identify as LGBTQIA+ or use VHA, a finding in itself

Disability Status

Disability status is referring to Veterans' service-connection, a term that means a Veteran is disabled due to injury or illness that was incurred in or aggravated by military service. Veterans with high service connection are more eligible for VHA services and may need more or specific services from their health care provider(s). VA is recognizing more mental health disorder - a huge problem within the Veteran population - which impacts the care that is needed

Homelessness

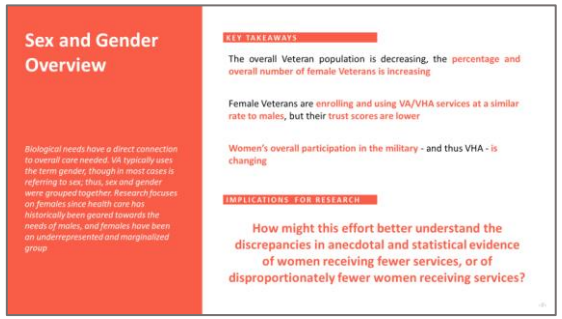
Homelessness is a problem that disproportionately impacts Veterans. Overall, this is a hard-to-research but high-need group that have unique care needs. While some VA efforts have been successful, there are still many Veterans who need help finding and maintaining stable housing – particularly in a post pandemic environment

Caregivers and Families

Caregivers and families play a major role in the health and life of Veterans, especially those with high levels of service-connection. During research, many stakeholders expressed concern over the lack of involvement of caregivers and families in Veteran care due to the system making it difficult for interaction and care collaboration

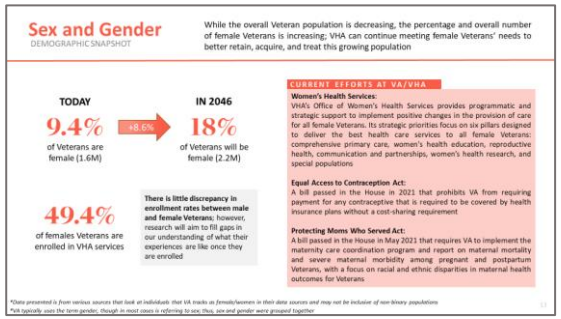
Demographic Deep Dives: How to Read

KEY TAKEAWAYS



The key takeaways slide provides a summary of the key information that is to come on the following demographic and utilization snapshot slides, and the additional considerations slide for the specific demographic / population that is being discussed.

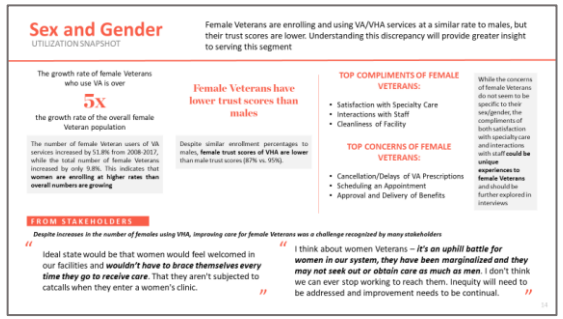
DEMOGRAPHICS SNAPSHOT



The demographic snapshot slide provides an overview for the current make-up of that demographic across the Veteran population and any projections for the future, when available

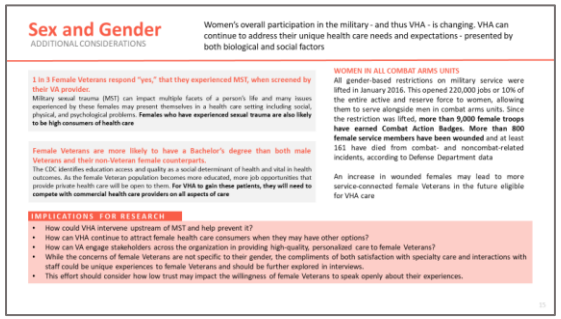
There is also an overview of a few current efforts that address needs of the demographics across VA, VHA, and policy. Please note these may not be inclusive of all relevant efforts

UTILIZATION SNAPSHOT



The utilization snapshot slide provides an overview of how the demographic is currently using VA/VHA services and other relevant insights related to their use of these services. These can include factors such as trust in these services or key stakeholder thoughts on how these groups interact with these services

ADDITIONAL CONSIDERATIONS



The additional considerations slide provides any additional information about the demographic that may be helpful to understand their behaviors or care needs.

This section also contains implications for research - including questions and/or focus areas to further examine during ethnographic research

Sex and Gender Overview

Biological needs have a direct connection to overall care needed. VA typically uses the term gender, though in most cases is referring to those assigned female at birth; thus, sex and gender were grouped together. Research focuses on females since health care has historically been geared towards the needs of males, and females have been an underrepresented and marginalized group

KEY TAKEAWAYS

While the overall Veteran population is decreasing, the **percentage and overall number of female Veterans is increasing**

Female Veterans are **enrolling and using VA/VHA services at a similar rate to males**, but their **trust scores are lower**

Women's overall participation in the military - and thus VHA - **is changing**

IMPLICATIONS FOR RESEARCH

How might this effort better understand the discrepancies in anecdotal and statistical evidence of women receiving fewer services, or of disproportionately fewer women receiving services?

Sex and Gender

DEMOGRAPHIC SNAPSHOT

While the overall Veteran population is decreasing, the percentage and overall number of female Veterans is increasing; VHA can continue meeting female Veterans' needs to better retain, acquire, and treat this growing population

TODAY

9.4%

of Veterans are female (1.6M)

+8.6%

IN 2046

18%

of Veterans will be female (2.2M)

49.4%

of females Veterans are enrolled in VHA services

There is little discrepancy in enrollment rates between male and female Veterans; however, research will aim to fill gaps in our understanding of what their experiences are like once they are enrolled

CURRENT EFFORTS AT VA/VHA

Women's Health Services:
VHA's Office of Women's Health Services provides programmatic and strategic support to implement positive changes in the provision of care for all female Veterans. Its strategic priorities focus on six pillars designed to deliver the best health care services to all female Veterans: comprehensive primary care, women's health education, reproductive health, communication and partnerships, women's health research, and special populations

Equal Access to Contraception Act:
A bill passed in the House in 2021 that prohibits VA from requiring payment for any contraceptive that is required to be covered by health insurance plans without a cost-sharing requirement

Protecting Moms Who Served Act:
A bill passed in the House in May 2021 that requires VA to implement the maternity care coordination program and report on maternal mortality and severe maternal morbidity among pregnant and postpartum Veterans, with a focus on racial and ethnic disparities in maternal health outcomes for Veterans

**Data presented is from various sources that look at individuals that VA tracks as female/women in their data sources and may not be inclusive of non-binary populations*

***VA typically uses the term gender, though in most cases is referring to sex; thus, sex and gender were grouped together*

Sex and Gender

UTILIZATION SNAPSHOT

Female Veterans are enrolling and using VA/VHA services at a similar rate to males, but their trust scores are lower. Understanding this discrepancy will provide greater insight to serving this segment

The growth rate of female Veterans who use VA is over

5x

the growth rate of the overall female Veteran population

The number of female Veteran users of VA services increased by 51.8% from 2008-2017, while the total number of female Veterans increased by only 9.8%. This indicates that **women are enrolling at higher rates than overall numbers are growing**

Female Veterans have lower trust scores than males

Despite similar enrollment percentages to males, **female trust scores of VHA are lower** than male trust scores (87% vs. 95%).

TOP COMPLIMENTS OF FEMALE VETERANS:

- Satisfaction with Specialty Care
- Interactions with Staff
- Cleanliness of Facility

TOP CONCERNS OF FEMALE VETERANS:

- Cancellation/Delays of VA Prescriptions
- Scheduling an Appointment
- Approval and Delivery of Benefits

While the concerns of female Veterans do not seem to be specific to their sex/gender, the compliments of both satisfaction with specialty care and interactions with staff **could be unique experiences to female Veterans** and should be further explored in interviews

FROM STAKEHOLDERS

Despite increases in the number of females using VHA, improving care for female Veterans was a challenge recognized by many stakeholders

> "Ideal state would be that women would feel welcomed in our facilities and ***wouldn't have to brace themselves every time they go to receive care***. That they aren't subjected to catcalls when they enter a women's clinic."

> "I think about women Veterans – ***it's an uphill battle for women in our system, they have been marginalized and they may not seek out or obtain care as much as men***. I don't think we can ever stop working to reach them. Inequity will need to be addressed and improvement needs to be continual."

Sex and Gender

ADDITIONAL CONSIDERATIONS

Women's overall participation in the military - and thus VHA - is changing. VHA can continue to address their unique health care needs and expectations - presented by both biological and social factors

1 in 3 Female Veterans respond "yes," that they experienced MST, when screened by their VA provider.

Military sexual trauma (MST) can impact multiple facets of a person's life and many issues experienced by these females may present themselves in a health care setting including social, physical, and psychological problems. **Females who have experienced sexual trauma are also likely to be high consumers of health care**

Female Veterans are more likely to have a Bachelor's degree than both male Veterans and their non-Veteran female counterparts.

The CDC identifies education access and quality as a social determinant of health and vital in health outcomes. As the female Veteran population becomes more educated, more job opportunities that provide private health care will be open to them. **If VHA wants to gain these patients, they will have to compete with commercial health care providers on all aspects of care**

WOMEN IN ALL COMBAT ARMS UNITS

All gender-based restrictions on military service were lifted in January 2016. This opened 220,000 jobs or 10% of the entire active and reserve force to women, allowing them to serve alongside men in combat arms units. Since the restriction was lifted, **more than 9,000 female troops have earned Combat Action Badges. More than 800 female service members have been wounded** and at least 161 have died from combat- and noncombat-related incidents, according to Defense Department data

An increase in wounded females may lead to more service-connected female Veterans in the future eligible for VHA care

IMPLICATIONS FOR RESEARCH

- How could VHA intervene upstream of MST and help prevent it?
- How can VHA continue to attract female health care consumers when they may have other options?
- How can VA engage stakeholders across the organization in providing high-quality, personalized care to female Veterans?
- While the concerns of female Veterans are not specific to their gender, the compliments of both satisfaction with specialty care and interactions with staff could be unique experiences to female Veterans and should be further explored in interviews.
- This effort should consider how low trust may impact the willingness of female Veterans to speak openly about their experiences.

Race and Ethnicity

Historical discrimination towards people of color across the U.S. impact nearly all facets of life, particularly health care. Stakeholders expressed a lack of diversity in VHA employees and leadership, and how that may impact Veteran care. Race and ethnicity are also key intersections that often inform behavioral differences between groups

KEY TAKEAWAYS

The Veteran population will become **much more diverse** over the next 25 years

Some segments (e.g., Black Veterans) **enroll and use some VHA services at greater rates** than White Veterans

The pandemic has highlighted persistent **health inequities in non-White communities**

IMPLICATIONS FOR RESEARCH

How might this effort better understand the factors that are similar across experiences of non-White Veterans and what factors are unique to the experience of each racial/ethnic group?

Race and Ethnicity

DEMOGRAPHIC SNAPSHOT

The Veteran population will become much more diverse over the next 25 years, giving VA the opportunity to expand on its diversity efforts related to providing equitable care

TODAY		IN 2046
74% of Veterans are **Non-Hispanic White**	↓	**62%** of Veterans will be **Non-Hispanic White**
8% of Veterans are **Hispanic**	↑	**16%** of Veterans will be **Hispanic**
13% of Veterans are **Black**	→	**15%** of Veterans will be **Black**

CURRENT EFFORTS AT VA/VHA

Center for Minority Veterans (CMV):
An inter- and intra-agency effort to **provide all Veterans with equitable service and care**. The CMV makes recommendations to VA leadership, sponsors research into the needs of minority Veterans, analyzes minority Veteran complaints, and aims to improve services for minority Veterans

Partnerships with Minority Serving Institutions:
VA is affiliated with 1,800 colleges and universities, of which more than 200 are Minority-Serving Institutions (MSIs). These partnership programs **help make the next generation of health care providers more diverse**. Trainees can gain experience caring for a diverse group of Veteran patients such as Veterans with unstable housing, and Veterans with HIV

Native VetSuccess at Tribal Colleges and Universities Pilot Program Act:
A congressional bill from April 2021 that requires VA to carry out a five-year pilot program to **provide on-campus benefits assistance and counseling** to eligible students at tribal colleges and universities

Minority Veterans Programs Coordinators
Located at Regional Offices, Health Care Facilities, and National Cemeteries, Minority Veteran Program Coordinators are responsible for **increasing local awareness of minority Veteran related issues** and **developing strategies for increasing their minority Veteran participation in existing VA benefit programs**.

Race and Ethnicity

UTILIZATION SNAPSHOT

Some segments (e.g., Black Veterans) enroll and use some VHA services at greater rates than White Veterans. VA has the opportunity to better address inequitable care and varying institutional trust among racial and ethnic groups

14.8%

of total VHA enrollees are Black Veterans, but they only make up 12.3% of total Veterans

92%

VA trust score among White, Asian, and Latino Veterans, which may impact service usage *(highest of any race or ethnicity – recreate the factors that contributed to high trust)*

65.3%

of total VHA enrollees are White Veterans, but they comprise 81.4% of total Veterans

86% + 88%

VA trust score among American Indians or Alaskan Natives and Native Hawaiians or Pacific Islanders *(lowest of any race or ethnicity – these groups may not feel heard)*

FROM STAKEHOLDERS

> "The diversity pieces need to be looked at in such a way that the population that we're serving are reflected in our employees. That doesn't always happen, especially in leadership positions. ***We don't have 1 Black network director (out of 18). It really is the old White boys' club and that's not correct; that's not America.***"

> "The other population is racial/ethnic minorities – how well can we reach them? I don't think we can ever stop working to reach them. ***Inequity will need to be addressed and improvement reach continual.***"

Race and Ethnicity

ADDITIONAL CONSIDERATIONS

The pandemic has highlighted persistent health inequities in non-White communities. Research suggests that these issues may be replicated inside VHA's system, pointing to an opportunity to transform care delivery for underrepresented minorities

ACROSS THE NATION

Racism is a public health crisis, including police violence

Homelessness disproportionately impacts people of color

COVID-19 disproportionately impacts Black, Latinx, and Native American populations

White doctors are more likely to perform unnecessary surgeries on patients of color

ACCESS TO CARE

Black service members were **at least 1.29 and as much as 2.61 times more likely** than their White peers **to face military punishment**, which can contribute towards negative feeling about the government or military, and/or a bad paper discharge that **impacts their ability to access VHA care**

CARE CONSIDERATIONS

Recent events have **underscored health disparities, implicit bias, and institutional racism** in the U.S.; **trauma informed care that's culturally relevant** has become a priority in serving non-White Americans

2020 RACISM WITHIN VA GAO AUDIT

A lack of representation among VHA leadership combined with **a 2020 GAO audit into racism within VA** itself indicates that a robust and **deliberate hiring of providers of color**, plus **stringent antiracism trainings and policies**, is urgently needed

IMPLICATIONS FOR RESEARCH

- How will VHA work to close the racial gaps in access to care?
- How is the perception of VHA impacted by Veterans of color being disproportionately punished and discharged with bad paper?
- How does racism within VHA reflect racism in America as a whole?
- How does racism within VHA impact the care it provides to non-White Veterans?
- Does the over-representation of Black and other underrepresented minority Veterans using some services point to something that VHA is doing well, or that these populations are underserved outside VHA?

Age

Different age groups each have varying needs and preferences to consider when designing innovative solutions. Understanding projections around age can inform the types of services and care that will be in higher demand in the future

KEY TAKEAWAYS

In the future, the **overall age spread of the Veteran population will even out**

Trust in VHA and use of its services varies by age – middle-aged Veterans use services more frequently, but older Veterans have more trust in VHA

Health needs and care delivery preferences of younger Veterans will **differ due to their age, war of service, and cultural expectations moving forward**

IMPLICATIONS FOR RESEARCH

How might this effort help VHA better understand younger Veterans needs and expectations as the Veteran population gets younger?

Age

DEMOGRAPHIC SNAPSHOT

In the future, the overall age spread of the Veteran population will even out; as a result, VHA may consider planning for a potential decline in demand for aging-related services and increased need for services that meet younger Veterans' expectations

TODAY		IN 2046
5 mil Veterans are <50		**4.2 mil** Veterans will be <50
27% of Veterans are **<50**	↑	**33%** of Veterans will be **<50**
36% of Veterans are **between 50 and 69**	↓	**33%** of Veterans will be **between 50 and 69**
37% of Veterans are **>70**	↓	**34%** of Veterans will be **>70**

CURRENT EFFORTS AT VA/VHA

Home Based Primary Care (HBPC):
A program providing health care services to Veterans in their home. It is for Veterans who are homebound due to severity of illness, isolation, or their care giver is experiencing burden. **Eligibility is based on clinical need and availability of services**

Medical Foster Homes:
Private homes where a trained caregiver provides services to individuals 24x7; alternative to a nursing home. To be eligible for a Medical Foster Home you need to be enrolled in Home Based Primary Care, and a Home needs to be available. This service is **not provided or paid for by VA**

Peer Support:
VA employees in recovery from mental illnesses and substance abuse disorders who help other Veterans to successfully engage in mental health and substance use treatment. **Services are received based on availability**

VA Office of Geriatrics & Extended Care:
The office oversees and provides policy direction for the development, coordination, and integration of geriatrics and long-term care clinical programs. It also advances these areas through research and evaluation of clinical models. The **services also apply to those diagnosed with chronic health issues and/or life-limiting illness**

Age

UTILIZATION SNAPSHOT

Trust in VHA and use of its services varies by age – middle-aged Veterans use services more frequently, but older Veterans have more trust in VHA; VHA has the opportunity to better understand these variances and better meet each group's unique needs

UTILIZATION

Veterans aged 70 and up account for:

37% of all Veterans

21% of all VHA encounters

Veterans aged 50-69 account for:

36% of all Veterans

52% of all VHA encounters

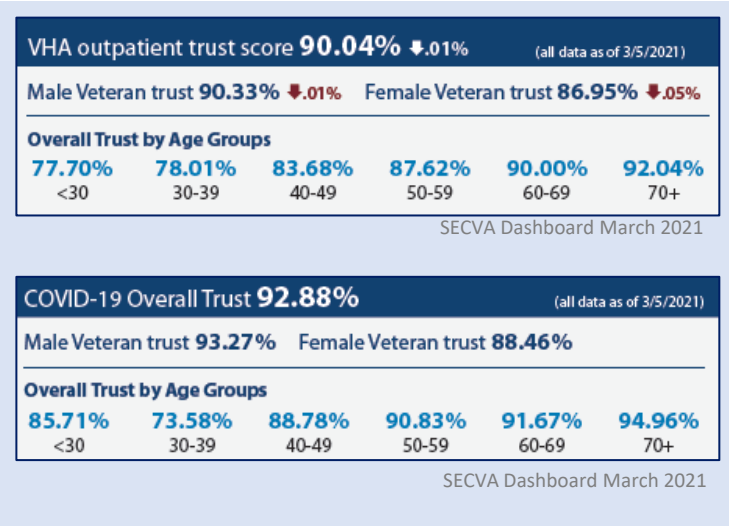
Older Veterans are underutilizing VHA services, while middle-aged Veterans are using them at higher rates than other age groups. The relationship between age and utilization should be explored further to understand if it is due to need, perception of VHA, or other underlying reasons

TRUST

According to SECVA dashboard data, **trust in VHA grows with Veteran age**. This generally correlates with VHA encounters – i.e., the more encounters an age group has with VHA, the more Veterans of that age group trust VHA

However, this is untrue for COVID. **Among Veterans under 30, trust in VHA's COVID response is roughly 8 percentage points higher than in VHA outpatient care**. Veterans aged 40+ recorded similar comparative increases in trust, from roughly 2 to 5 percentage points per age group

Confoundingly, **Veterans aged 30-39 noted a 5-point decrease in trust in VHA's COVID response** relative to VHA outpatient care



How can VHA preserve the best aspects of its COVID response to continue to improve its trust score among all Veterans, particularly the youngest Veterans?

Age

ADDITIONAL CONSIDERATIONS

Health needs and care delivery preferences of younger Veterans will differ due to their age, war of service, and cultural expectations moving forward; VHA must continue to meet the needs of the current Veteran while adapting for the Veteran of the future

4.5x

higher risk of suicide among Veterans transitioning earlier

Veterans transitioning after shorter careers are at an increased risk of suicide. Specifically, Veterans transitioning after 17-19 years of service proved 4.5 times at risk of suicide compared to Veterans transitions after 40 years of service

Establishing a lasting relationship with younger Veterans may be key to providing crucial mental health services to at-risk Veterans throughout their lives

IMPLICATIONS FOR RESEARCH

- Are there any indications that age of when a Veteran connects with VA is linked to lower touchpoints needed later in life?
- How can VHA design care that works for both advanced aged Veterans and younger Veterans?
- Recognizing more younger Veterans will be served in the future, how can VHA predict the needs of younger Veterans to proactively set up care models?
- Misaligned measurement categories across data sources can create confounding information; isolating Veteran populations in more precise and fungible categories will provide a clearer picture of the degree to which each age group interacts with VA/VHA
- VHA encounters may not be an ideal measurement for tracking VHA care received across age groups since some age groups, such as those 65+ may have more encounters due to their higher age
- The degree to which age groups receive VHA services may be a result of any number of different factors. For example, pregnant women or the elderly are likely to require specific care and services. Identifying Veteran need and interest in seeking services may be crucial to better understanding the implications of this usage data

Location

Location refers to where a Veteran lives and receives care, specifically urban or rural. Location is important to consider for field research because needs differ based on home location and correlate with trends around income, access, education, etc.

KEY TAKEAWAYS

While **most Veterans live in urban areas, rural areas have a higher proportion of enrolled Veterans**

Rural Veterans enrolled in VHA are **older and are using urgent care services more** than urban Veterans

Rural Veterans face unique challenges and risks to a degree that urban Veterans do not

IMPLICATIONS FOR RESEARCH

How might this effort help VHA understand why rural Veterans enrolling at higher rates than urban Veterans and how to meet their unique needs?

Location

DEMOGRAPHIC SNAPSHOT

While most Veterans live in urban areas, rural areas have a higher proportion of enrolled Veterans. By designing accessible care solutions for rural Veterans, VHA will also be improving accessibility for urban Veterans

24%

(4.7M) of all Veterans live in rural communities

58%

of rural Veterans are enrolled in VHA, compared to 37% of urban Veterans; however, urban Veterans constitute 67% of total VHA enrolled Veterans

SHRINKING RURAL AREAS

The **U.S. population is becoming less concentrated in rural areas**, suggesting the future of care will continue to be administered in urban areas

ACCESSIBILITY

Rural communities are more isolated than urban ones. Consequently, it is **important that services and care are accessible for rural Veterans, especially niche services**, such as women's health services which are vital to good health

CURRENT EFFORTS AT VA/VHA

Office of Rural Health (ORH) Veterans Rural Health Resource Centers (VRHRC):
Centers focused on **understanding rural Veterans' challenges** and formulating programs and practices to address these challenges

ORH VETERANS INTEGRATED SERVICE NETWORKS (VISN) Rural Consultants:
Consultants that **implement rural projects** related to a VISN and **advise on matters** impacting rural Veterans

The Sgt. Ketchum Rural Veterans' Mental Health Act (April 2021):
A bill that establishes **new VA rural mental health programs** and supports research on rural Veteran mental health care needs

Women's Health Mini-Residency for Primary Care Rural Providers and Nurses:
A multi-year training program to **increase rural providers' and nurses' knowledge of and skills related to women's health**. VA's Women's Health Services (WHS) and ORH) collaborated to design and deliver a mini-residency program to rural medical care teams nationwide

Location

UTILIZATION SNAPSHOT

Rural Veterans enrolled in VHA are older and are using urgent care services more than urban Veterans. VHA can continue innovating care options for older Veterans in rural communities

55%

of VHA enrolled rural Veterans are aged 65+, compared, to 50% of total enrolled Veterans being 65+

Older Veterans in rural locations may have unique needs compared to young rural Veterans or older urban Veterans

46%

of patients using VHA's urgent care service are rural Veterans, despite only accounting for 32% of all unique patients

This could indicate a greater need for service or a lack of consistent care options - leading to the high use of urgent care

TARGET STATES FOR RESEARCH

In addition to looking at rural locations, there are a few states with a high percentage of Veterans and a low utilization of VHA services. Field research can focus on these states to better understand why Veterans are not using VHA and what other health care options they may be turning to. States with the lowest utilization compared to overall Veteran population include:

- Colorado
- Delaware
- Hawaii
- Maryland
- New Hampshire
- Ohio
- Pennsylvania
- Virginia
- Washington

"Many hospitals in rural areas are closing. ***We have to collaborate with that community a lot more.***"

"***Rural health which is a special population, our reach is not as good.*** We do pretty well with 60 minutes or 60 miles. Rural, it's a longer distance to drive especially if they need specialty care. ***How do we provide that service, via telehealth; to provide [rural Veterans] with greater access.***"

Location

ADDITIONAL CONSIDERATIONS

Rural Veterans face unique challenges and risks to a degree that urban Veterans may not; VHA should keep these in mind when considering health care innovations to maintain equitable accessibility - regardless of geographic location

20%

rural Veterans face a 20% greater risk of suicide than urban Veterans

ORH funds a suicide prevention initiative. Continued collaboration with ORH on the **provision and accessibility of mental health services** for rural Veterans is a strong connection point to this Veteran segment

26%

of rural enrolled Veterans do not have access to the internet at home

As the world increasingly shifts to telehealth due to the pandemic and technology trends, **VHA has the opportunity to build on its efforts to meet Veterans where they are and provide greater broadband access** to rural communities

49%

of rural enrolled Veterans earn less than $35,000 annually

Many rural Veterans earn below the average U.S. salary; thus, **VHA has the opportunity to make sure services remain affordable and that Veterans are effectively supported** so that they avoid financial problems in the future

IMPLICATIONS FOR RESEARCH

- With the increasing prevalence of telehealth, how can VHA better support rural Veterans with limited broadband in accessing care?
- How can VA think beyond the telehealth of today to deliver virtual preventative health care digitally?
- How can VHA provide convenient, inclusive, and quality care to rural Veterans when and where they need it?
- Why are rural Veterans enrolling at higher rates than urban Veterans? Is VHA the health system of choice for rural Veterans? Are they more likely to be eligible for VHA? Or is it simply due to a lack of other options?
- Knowing the income disparities between rural and urban Veterans, what can VHA do to better educate rural Veterans on their health care coverage and options?

LGBTQIA+

There are health considerations unique to the needs of the LGBTQIA+ population. The military has a history of discriminating against this population, meaning many of their needs may not have been met. VA does not yet actively collect data on the LGBTQIA+ population and many Veterans may not feel comfortable disclosing this information to VA. It is therefore difficult to get an accurate count of how many Veterans identify as LGBTQIA+ or use VHA, a finding in itself

KEY TAKEAWAYS

LGBTQIA+ Veterans comprise a larger share of the military when compared to the general population

It is difficult to assess how many LGBTQIA+ Veterans have or would like to use VHA services as there is **no standardized process for collecting romantic, sexual, and gender identities data**

There is a **potential influx of LGBTQIA+ Veterans who will need care if their discharge upgrade process is successful**

IMPLICATIONS FOR RESEARCH

How might this effort help VHA create a standardized and affirmative process for collecting data on LGBTQIA+ Veterans and creating a culture of comfort and inclusivity for these Veterans?

LGBT*

DEMOGRAPHIC SNAPSHOT

LGBTQIA+ Veterans comprise a larger share of the military when compared to the general population, though VA does not yet collect a significant amount of data on this segment; VHA has the opportunity to lead efforts that better serve and track this segment's needs

Military		General Population
6.1% of active-duty military identify as LGBT**	>	**5.6%** of Americans in the general population identify as LGBT
1 in 5 transgender Americans are in the military or have served	>	**1 in 10** of the general American population are in the military or have served

CURRENT EFFORTS AT VA/VHA

PRIDE in All Who Served:
A 10-week health education program designed to **improve LGBTQ+ Veterans' wellness and help them engage with services** that relate to their personal needs. One black, trans, male Veteran participant credited the group with preventing him from attempting suicide

VHA LGBTQ+ Veteran Care Coordinator (VCC) Program:
A program specifically for LGBTQ+ Veterans that has a **care coordinator at each facility who helps provides a variety of health services** and promotes best practices for serving LGBTQ+ Veterans

FY2021 Strategic Plan:
Aims to **increase culturally competent services** to LGBTQ+ populations and deliver diversity and inclusion training related to LGBTQ+ issues

Younger Americans are more likely to identify as LGBT*

15.9% Gen Z identifies as LGBT > **9.1 %** Millennials identify as LGBT > **3.8%** Gen X identifies as LGBT

**Reporting for data was limited to LGBT and not LGBTQIA+*
***Estimate*

LGBTQIA+
UTILIZATION SNAPSHOT

It is difficult to assess how many LGBTQIA+ Veterans have or would like to use VHA services as there is no standardized process for collecting romantic, sexual, and gender identities data; VA can pioneer this process and create comfort around discussing LGBTQIA+ health

VHA does not actively collect or track data on LGBTQIA+ service people and Veterans

2020 GAO Report: Clinicians do not have a standardized method of noting sexual orientation in health records, meaning there are many unknowns about how people in these groups feel about their care and health outcomes.

FROM MILITARY HEALTH SYSTEM

60%
of military health care providers are comfortable speaking about sexual health needs with active duty LGB* individuals

5%
of military health care providers routinely obtain sexual history, including questions pertaining to same-sex sexual activity from AD service members

>33%
of military health care providers ever received training on LGB* health topics

~80%
of military health care providers are looking for better guidelines from the Department of Defense on screening and documentation of same-sex activity

**Study only referenced LGB individuals*

LGBTQIA+

ADDITIONAL CONSIDERATIONS

There is a potential influx of LGBTQIA+ Veterans who will need care if their discharge upgrade process is successful; as a result, VHA has the opportunity to build trust with these Veterans by providing them with the services and experiences that they need

~114,000

Veterans have been **discharged** "other than honorably" or "dishonorably" **because of their sexual orientation**

75%

rise in requests for help **navigating the discharge upgrade process**, since the pandemic's start, from Veterans **who were denied benefits because of their sexual orientation**

IMPLICATIONS FOR RESEARCH

- How can VHA lead the effort for creating an affirmative and meaningful, standardized process for collecting sexual orientation and gender identity data?
- How can VHA address the health needs and preferences of LGBTQIA+ Veterans given that this is a harder research population to recruit?
- How can VHA protect the privacy of LGBTQIA+ Veterans in research?
- How might VHA set the gold standard for health care for transgender, agender, and other gender nonconforming people?
- How might VHA be a leader in inclusive training within medical education?
- How can VA/VHA promote a more inclusive environment for all romantic, sexual, and gender identities and expressions within VHA?
- How can VHA focus on what is meaningful to the LBGTQ+ community (i.e. family planning, mental health and resiliency, sexual health, celebrating the LGBTQ+ community, and self-expression)?
- How can VA/VHA get ahead of prevalent issues in the LGBTQIA+ community, such as HIV/AIDS, mental illness, and intimate partner violence?
- How can VA/VHA address historical biases and trauma that LGBTQIA+ Veterans faced and normalize their identities?

Disability Status

Disability status is referring to Veterans' service-connection, a term that means a Veteran is disabled due to injury or illness that was incurred in or aggravated by military service. Veterans with high service connection are more eligible for VHA services and may need more or specific services from their health care provider(s). VA is recognizing more mental health disorder - a huge problem within the Veteran population - which impacts the care that is needed

KEY TAKEAWAYS

Veterans are **receiving higher service-connected disability ratings**, making them eligible and **in need of more support from VHA**

The likelihood of service-connected Veterans seeking VHA Health Care generally **increases with the Veteran's disability rating**

TBI, PTSD, and other mental illnesses are prevalent among Veterans, especially post-9/11 Veterans

IMPLICATIONS FOR RESEARCH

How might this effort better understand the unique care and care coordination needs of Veterans with a service-connected disability?

Disability Status

DEMOGRAPHIC SNAPSHOT

Veterans are receiving higher service-connected disability ratings, making them eligible and in need of more support from VHA; this gives VHA an opportunity to plan for and adapt to the needs of Veterans with a service-connected disability

ALL VETERANS

25%

of Veterans have a service-connected disability (4.7M)

41%

of all Veterans with a service-connected disability report a disability rating of 60% or higher

POST-9/11 VETERANS

41%

of post-9/11 Veterans have a service-connected disability (1.7M)

~50%

of post-9/11 Veterans with a service-connected disability report a disability rating of 60% or higher

The percentage of those Veterans with service-connected disabilities is increasing

Researchers believe the higher percentage of post-9/11 service-connected Veterans is primarily due to:

1. Advances in battlefield medicine that have resulted in more Veterans surviving wounds that would have killed them in previous wars
2. The recognition and diagnosis of Traumatic Brain Injuries (TBI) and mental health disorders resulting from post-traumatic stress

CURRENT EFFORTS AT VA/VHA

VA Office of Geriatrics & Extended Care: *(see slide 23)*
The office oversees and provides policy direction for the development, coordination, and integration of geriatrics and long-term care clinical programs for **those diagnosed with chronic health issues and/or life-limiting illness**. It also advances these areas through research and evaluation of clinical models.

VA Disability Compensation (Pay):
VA offers a monthly tax-free payment to Veterans who got sick or injured while serving in the military and to Veterans whose service made an existing condition worse; **eligibility and amount is dependent on service-connection level**

PAWS for Veteran Therapy
A bill that passed the House in May 2021 that **implements a program and a policy related to service dog therapy for Veterans** and requires VA to implement a five-year pilot program to assess the effectiveness of addressing post-deployment mental health and PTSD; it also authorizes VA to provide service dogs to Veterans with mental illnesses, regardless of whether they have a mobility impairment

Disability Status

UTILIZATION SNAPSHOT

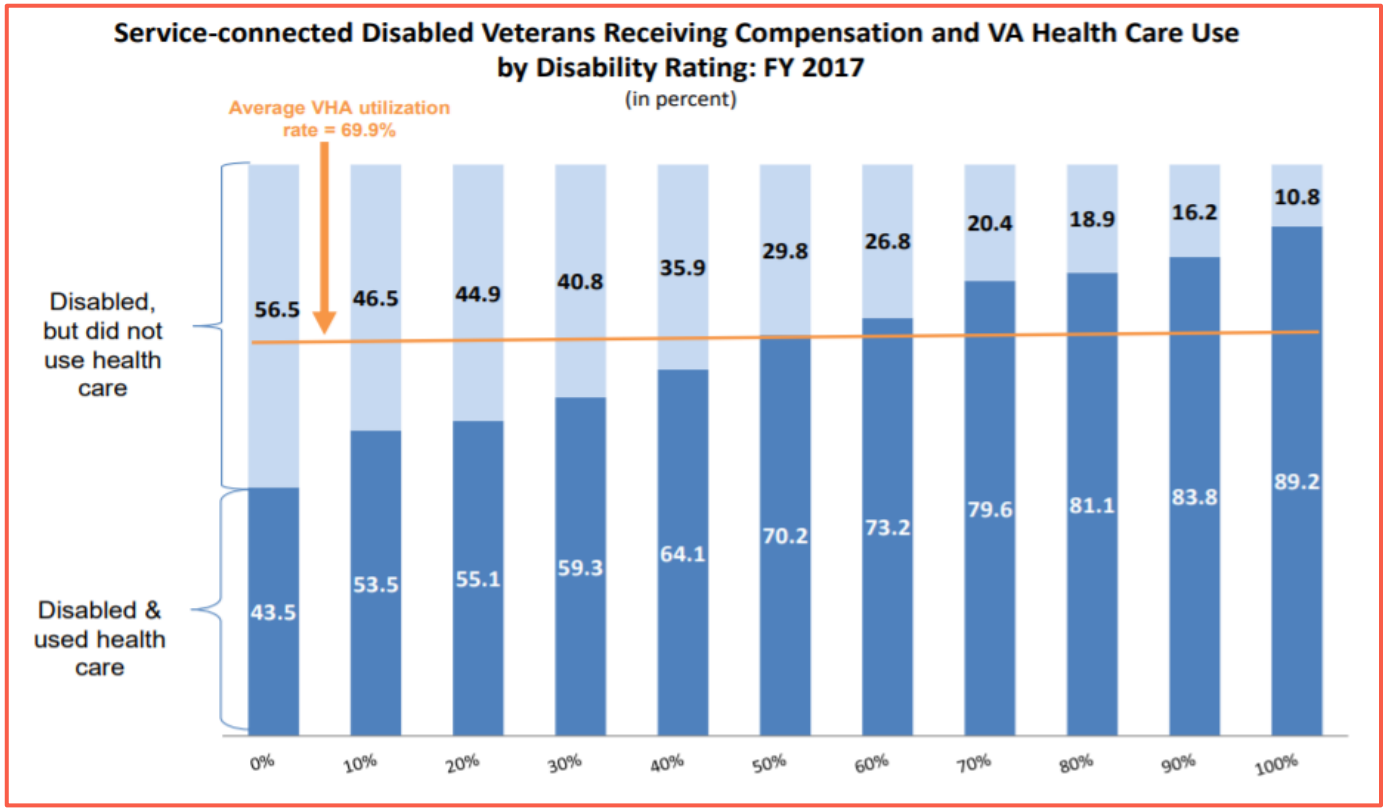
The likelihood of service-connected Veterans seeking VHA Health Care generally increases with the Veteran's disability rating; VHA can develop more advanced care coordination to meet these needs

93%

of service-connected Veterans were enrolled in VHA Health Care system in 2017

70%

of service-connected Veterans in 2017 used VHA health care, compared to 60% in 2008



NEED FOR MORE CARE COORDINATION

Veterans with a higher disability status are more likely to need more complex care; one stakeholder identified **care coordination as the "biggest clinical priority for me"** and **"if there is a high-risk transition of care, ensuring those transitions are appropriately managed"**

Disability Status

ADDITIONAL CONSIDERATIONS

TBI, PTSD, and other mental illnesses are prevalent among Veterans, especially post-9/11 Veterans. As a result, it is important for VA to consider eligibility and access to VHA services for all Veterans to help prevent Veteran suicide

16%

Of service members separated for misconduct from 2011-2015 had been diagnosed with PTSD or TBI during the two years prior to separation; likely many more service members had PTSD or TBI that went undiagnosed

Marines who were deployed to combat zones and were diagnosed with PTSD were:

11 times
more likely to be discharged for misconduct

8 times
more likely to be discharged for substance use

compared to Marines who were not deployed or were not diagnosed with a mental health condition

With more recognition and diagnosis of mental health disorders, VA has the opportunity to get in front of Veteran suicide.

The Biden Plan has identified suicide as a key area of focus to restore VA as the premier agency for ensuring our Veterans' overall well-being. There has been great emphasis across VA on addressing Veteran suicide and **data suggests the rate of suicide among Veterans who recently received some type of VA care decreased 2.4% from 2017 to 2018**, compared to 2.5% increase in Veterans with no connection to VA care. This suggests that VA's recent efforts have made a difference

IMPLICATIONS FOR RESEARCH

- Why are ~23% of enrolled Veterans with a service-connected disability not using VHA health services?
- Knowing post-9/11 Veterans have the highest rate of service-connected disability of any group of Veterans, how can VHA prepare now to handle the increased needs of these Veterans as they age?
- What does care coordination mean to Veterans with disabilities and where can VHA improve?
- How can VA reach out to and provide services to Veterans with a bad paper discharge who may be eligible for services?

Homelessness

Homelessness is a problem that disproportionately impacts Veterans. Overall, this is a hard-to-research but high-need group that have unique care needs. While some VA efforts have been successful, there are still many Veterans who need help finding and maintaining stable housing – particularly in a post pandemic environment

KEY TAKEAWAYS

While VA has made great strides to help Veterans overcome homelessness, there are still many who experience it, **especially male Veterans, Black Veterans, and those across four states (CA, FL, TX, WA)**

VA support services to Veterans experiencing homelessness have helped many Veterans; however, **this population is not utilizing VHA health care as highly as others**

Some prior efforts to aid Veterans experiencing homelessness have **been very successful when this population can be reached**

IMPLICATIONS FOR RESEARCH

How might this effort uncover solutions that can eliminate homelessness for all Veterans?

Homelessness

DEMOGRAPHIC SNAPSHOT

While VA has made great strides to help Veterans overcome homelessness, there are still many who experience it, especially male Veterans, Black Veterans, and those across four states (CA, FL, TX, WA). VHA can focus its homelessness alleviation efforts on these populations

37,252

Veterans experiencing homelessness in Jan. 2020, a <1% increase YTD

50%

decline in number of Veterans experiencing homelessness since 2010

91%

of Veterans experiencing homelessness in 2020 were men

1/3

Black Veterans make up one-third of all Veterans dealing with unstable housing

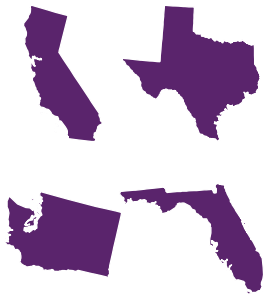
VETERAN HOMELESSNESS STATISTICS

6%

Percent of Veterans that make up the U.S. population

8%

Percent of Veterans that make up the U.S. homeless population



California, Florida, Texas, and Washington accounted for 48% of all Veterans experiencing homelessness in the U.S., but only 29% of the total U.S. population.

CURRENT EFFORTS AT VA/VHA

VA's Homeless Programs Office (HPO):
An office that **assists Veterans and their families in obtaining permanent and sustainable housing** with access to high-quality health care and supportive services; it oversees programs related to health care, mental health services, housing assistance, and employment programs for homeless Veterans

Homeless Veterans with Children Reintegration Act:
A bill that passed the House in May 2021 that directs the Department of Labor to **give homeless Veterans with dependents service priority** under homeless Veterans' reintegration programs

VA is actively **monitoring the impacts of COVID on housing stability for Veterans** and have requested more than **$2.6 billion for homeless prevention and support programs** in the fiscal 2022 budget, an increase of about 14.5%.

Homelessness

UTILIZATION SNAPSHOT

VA support services to Veterans experiencing homelessness have helped many Veterans; however, this population is not utilizing VHA health care as highly as others. VHA can explore new solutions to reach this population during the research and design process

8%

of Veterans experiencing homelessness receive VHA care

~150,000

Veterans receive services under VHA Health Care for Homeless Veterans (HCHV) annually

90,749

Veterans with active U.S. Dept. of Housing and Urban Development-VA Supportive Housing (HUD-VASH) vouchers in FY 2019

SUPPORTING VETERANS EXPERIENCING HOMELESSNESS

"When I think of serving compromised or homeless Veterans, even the fact that we require them not be using drugs or alcohol – they're going to be using drugs and alcohol – it's not helpful. ***We have to be available because those people need us the most.***"

VA/VHA SERVICES/PROGRAMS FOR HOMELESS Veterans*:

HUD-VASH: The program provides rental assistance vouchers for privately-owned housing to homeless Veterans who are eligible for VA health care services. VA case managers may connect these Veterans with support services

Homeless Providers Grant and Per Diem (GPD) Program: VA funds agencies to provide beds and other support services to homeless Veterans

Supportive Services for Veteran Families (SSVF): Provides very low-income Veterans with case management and services to prevent imminent home loss or to identify an improved housing situation; or to rapidly re-house Veterans and their families who are homeless and might remain that way without this assistance

**Non-exhaustive list of VA efforts around combatting homelessness*

Homelessness

ADDITIONAL CONSIDERATIONS

Some prior efforts to aid Veterans experiencing homelessness have been very successful when this population can be reached. VHA has an opportunity to replicate and scale successful efforts to reach and provide Veterans experiencing homelessness with care

Ending Veteran homelessness is possible

3

states (CT, DE, VA) and 82 communities have ended Veteran homelessness as of March 2021

ENDING HOMELESSNESS CASE STUDY: BUILT FOR ZERO[1]

There are multiple **initiatives focused on alleviating Veteran homelessness**; one of these initiatives is called Built for Zero

Built for Zero: An alliance between Community Solutions, VA, and local community partners that has **brought the homeless Veteran population to functional zero**, with fewer Veterans in need of housing than services available, in **12 communities**

The Approach:

- Use a regional team to coordinate services across partners and service providers
- Catalog the housing status of Veterans to inform resource allocation
- Allocate resources (and additional funding from CARES Act etc.) to integrate the expansion of shelter and financial support services

IMPLICATIONS FOR RESEARCH

- If so many Veterans are receiving services to prevent or eliminate housing instability, why are only 8% of Veterans experiencing homelessness engaging with VHA?
- 40% of Veterans are unsheltered, how does this effort reach these Veterans if they are unsheltered?
- How have VA and alliances like Built for Zero virtually eradicated homelessness and how can these practices be applied to other communities?
- Are there other partnerships and solutions for tackling Veteran homelessness that can be explored?

Caregivers and Families

Caregivers and families play a major role in the health and life of Veterans, especially those with high levels of service-connection. During research, many stakeholders expressed concern over the lack of involvement of caregivers and families in Veteran care due to the system making it difficult for interaction and care collaboration

KEY TAKEAWAYS

Caregivers are linked to cost savings and improved health outcomes; however, they **require increased support services due to the high demand and burdens they face**

Caregivers and families of Veterans are often **forced to seek support elsewhere and separated from their Veteran's care because VHA is typically unable to treat them**

Caregivers to Veterans, particularly to post-9/11 Veterans, must **care for their Veteran for decades and face higher likelihood of depression**

IMPLICATIONS FOR RESEARCH

How might this effort help uncover the support that caregivers need in order to effectively care for their Veteran and ways to better include caregivers and families in Veteran health care decisions?

Caregivers and Families

DEMOGRAPHIC SNAPSHOT

Caregivers are linked to cost savings and improved health outcomes; however, they require increased support services due to the high demand and burdens they face. VHA has an opportunity to better provide these services

~5.5M American family caregivers are assisting Veterans

- **~3.5 days per month** of missed worked days for care givers
- **4x** increased risk of developing depression
- **60%** of military caregivers are women

VALUE OF FAMILY CAREGIVERS

Research has shown that family caregivers can help Veterans with disabilities **delay or avoid the need for high-cost institutional care** and, in certain situations, can actually **help transition them out of those facilities**

CURRENT EFFORTS AT VA/VHA

Program of Comprehensive Assistance for Family Caregivers (PCAFC):
A program that provides caregivers to Veterans who have incurred or aggravated a serious injury in the line of duty on or before May 7, 1975 or on or after September 11, 2001 with resources, education, support, a financial stipend, health insurance (if eligible), and beneficiary travel (if eligible). The **Veteran must have a VA disability rating (individual or combined) of 70% or higher**

Program of General Caregiver Support Services (PGCSS):
A program that provides resources, education, and support to caregivers of Veterans. The **Veteran does not need to have a service-connected condition**, for which the caregiver is needed, and **may have served during any era**

Caregivers and Families

UTILIZATION SNAPSHOT

Caregivers and families of Veterans are often forced to seek support elsewhere and separated from their Veteran's care because VHA is typically unable to treat them. VHA can explore solutions to this during the research and design process

SUPPORT FOR MILITARY CAREGIVIERS

While there are **120+ programs nationwide** supporting military caregivers*, only:

3% of programs supporting military caregivers **provide health care,** and the health care provided would not be through the same system they work with to get their Veteran health care – **complicating logistics** around health care support

7% of programs supporting military caregivers **provide respite care.** This limited access to respite care **increases the stress on the caretaker** if they were to get sick and need help while caring for the Veteran

10% of programs supporting military caregivers **provide mental health services** despite caregivers being at **an elevated risk for developing mental health disorders**

FROM STAKEHOLDERS

> "Fragmented family care - VA care model, inherently, separates the Veterans from their family as far as traditional primary care/family models. ***Family is a huge input into someone's critical care pathway - so removing them from the equation can be detrimental.***"

> "By involving the Veterans and their spouses and primary care physicians in their decisions for health care, that also contributes to safety. ***Oftentimes, a family member is the one who's the last line of defense for recognizing potentially unsafe events.*** Having a program that involves them contributes to making it a more reliable, safer system."

**A military caregiver refers to someone who provides care and assistance for, or who manages the care of, current or former military service member*

Caregivers and Families

ADDITIONAL CONSIDERATIONS

Caregivers to Veterans, particularly to post-9/11 Veterans, must care for their Veteran for decades and face higher likelihood of depression. VHA has the chance to support these caregivers by offering care or more support services

CAREGIVERS TO PRE-9/11 VETERANS…

Are typically **middle-aged women** taking care of a parent

Are more likely to help the Veteran with physical injuries from service and old age

CAREGIVERS TO POST-9/11 VETERANS…

Are typically **spouses**, but **parents** and **close friends** are also common

Often **help Veterans remember things, cope with trauma and stress** due to a higher incidence of mental health issues in this group, and **complete paperwork**

Are **4x more likely to develop depression** compared to the general population

May need to **provide care for many years**

IMPLICATIONS FOR RESEARCH

- What specific types of care / services / support do caregivers want or need?
- How can VHA include military caregivers and families in Veteran health care decisions to create a more inclusive, reliable, and safer system?
- How can VHA offer more programs for health, respite, and mental health care to military caregivers?
- How can VA/VHA tailor the unique services that pre- and post-9/11 Veterans are more likely to need to reduce the burden on caregivers?

Intersections of Demographics

No person is made up of solely one demographic. ***To truly understand Veteran needs,*** this effort seeks to understand how ***different demographics may impact individual experiences.*** While quantitative data can provide some general indications, ***ethnographic research and qualitative data will provide a greater level of clarity.***

Insights in this section - that highlights demographic intersections – are based on:

- Availability of preliminary data
- Indication from preliminary data analysis that they had significant and meaningful differences between demographics
- Understanding that race, ethnicity, gender, age, and geographic location may explain behavioral differences

Race and Gender: Black Females

Black female Veterans make up the majority of unique female patients for 27 VHA services; VHA has the opportunity to uncover why this segment is particularly using housing, mental health, and women's health services among others, and better tailor these services to their needs

1 Housing and Homelessness Services

46% of female unique patients for **homelessness-related services** (e.g., treatment, rehabilitation, etc.) **are Black females**, representing the largest racial group among female Veterans.*

Considerations for Field Research:

- How does VA design solutions that get at the root cause of homelessness?

2 Mental Health Services

33% of female unique patients for **mental health-related services** (e.g., mental health therapy, PTSD consultation, etc.) are **Black females**, comprising a greater portion of service recipients than their overall makeup of the female Veteran unique patient population (22%).**

Black female Veterans are also the **largest racial group among female Veterans for some of these services**.

Considerations for Field Research:

- Are higher usage rates of these services among Black female Veterans driven by trust in VHA or lack of accessible options?

3 Women's Health Services

37% of female unique patients for **obstetrics, gynecology, mammograms, women's primary care, and women specific preventive care services are Black females**, comprising a greater portion of than their overall makeup of the female Veteran unique patient population (22%).

Considerations for Field Research:

- Why are Black female Veterans more likely to seek these services?

**Homelessness-related codes were referenced against an FY14 DSS ID document; the scope of some codes may have changed since this document's creation, but current code titles matched the 2014 document*
***Codes that referenced the words mental health, acronyms for mental health, and mental health disorders such as PTSD were included in calculations*

Race and Gender

American Indian or Alaskan Native female Veterans have not had as positive of a Veteran experience as other female racial groups; uncovering the reasons for these differences across groups will allow VHA to tailor its services to the needs of unique groups and improve overall experience

1 Trust Among Female Veterans*

88% trust score among Asian female Veterans (highest among all female racial groups).

79% trust score among American Indian or Alaskan Native (AIAN) female Veterans (lowest among all female racial groups).

Considerations for Field Research:

- Why do AIAN female Veterans have lower trust scores, give less compliments, and express more concerns?

2 Compliments Among Female Veterans*

70% of Native Hawaiian or Pacific Islander female Veterans gave compliments on outpatient surveys (highest among racial groups).

59% of AIAN female Veterans gave compliments on outpatient surveys (lowest among racial groups).

Considerations for Field Research:

- Why do Native Hawaiian or Pacific Islander female Veterans give more compliments and express less concerns and how can VHA make this same impact on other groups?

3 Concerns Among Female Veterans*

26% of AIAN female Veterans voiced concerns on outpatient surveys, (highest among racial groups).

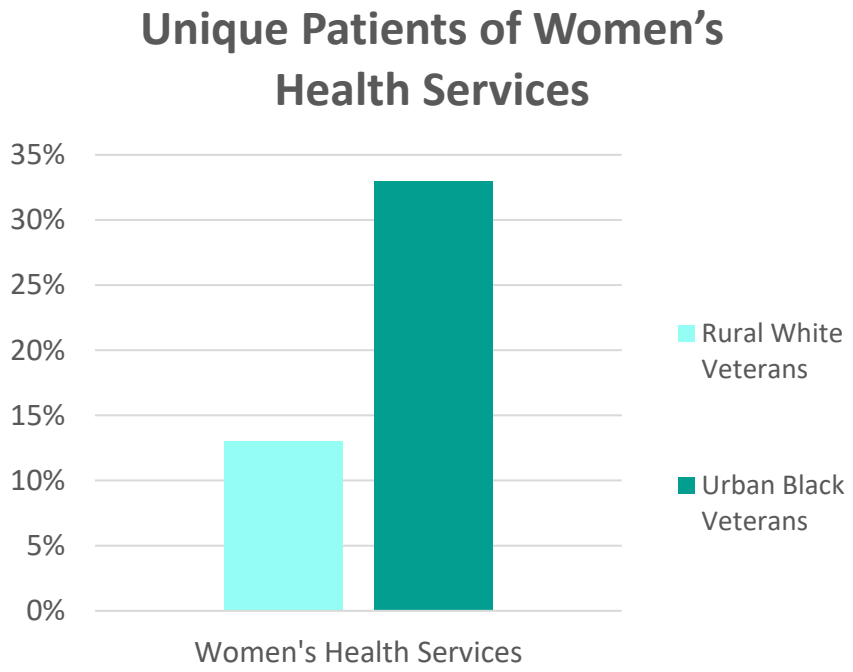
19% of Native Hawaiian or Pacific Islander female Veterans voiced concerns on outpatient surveys, (lowest among racial groups).

Considerations for Field Research:

- Does each group already have specific solutions to their concerns in mind, and do they differ?

Location and Race

Urban Black Veterans disproportionately use women's health services when compared to their share of total unique patients; on the other hand, rural White Veterans are significantly underutilizing these services, providing VHA an opportunity to uncover whether this phenomenon is due to preference or need



INSIGHTS

- **Urban Black Veterans disproportionately make up unique patients for women's health services** (33%) in comparison to their share of overall unique patients across all services (14%)
- **Rural White Veterans are under-utilizing women's health services** – 13% of unique patients for these services are rural White Veterans yet they represent 26% of unique patients overall

Implications for Research

- Are urban Black Veterans using women's health services at higher rates due to preference or need?
- Are rural White Veterans under-utilizing women's health services due to inaccessibility or preference?

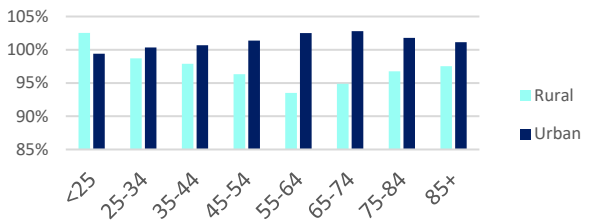
**Women's health services included are: Comprehensive Women's Primary Care Clinic, Obstetrics, Gynecology, Women's Stress Disorder Team, Women Gender Specific Preventive Care, and Mammogram*

Location and Age

Most Veterans are concentrated in urban areas; however, rural Veterans require unique considerations given their isolation and need for urgent care services. Additionally, both urban and rural Veterans use telehealth services in proportion to their share of total unique patients, giving VHA a mandate to continue providing these services to all Veterans regardless of location

1 Higher Urban Utilization Rates

For all age groups except <25, urban Veterans had higher utilization rates of VHA services than rural Veterans.



Considerations for Field Research:

- Are rural Veterans using services less than their urban counterparts due to lack of accessibility or other reasons?

2 Older Rural Veterans

55% of rural Veterans enrolled in VA's health care system and 60% of rural unique patients are aged 65+. Older Veterans are more likely to be diagnosed with diabetes, heart conditions, etc. that require more frequent and costly care.

The next generation of Veterans also has medical and combat-related issues which will require ongoing care access.

Considerations for Field Research:

- How can VHA improve access to specialty care and timely services for rural Veterans aged 65+?

3 Telehealth Service Usage Mirrors Location Composition

Across Ages and Locations, the percentage of unique patients for telehealth services* is consistent with the rural and urban Veteran share of the total unique patient population (e.g., urban Veterans under age 35 accounted for 77% of telehealth service unique patients and 78% of all unique patients under age 35).

Considerations for Field Research:

- How can VHA continue to make telehealth services more accessible to those who prefer them?

**Telehealth-related services include 38 service codes that had references to telehealth or telephone-related care/services in their titles*

Proposed Research Segments

The demographic deep dives served as guides in ***determining key Veteran segments to engage with during field research.*** The list of segments is preliminary and can be adjusted based on in field findings.

Field Research Groups

Based on the findings from analyzing Veteran demographics, there are considerations around conducting interviews with the groups listed below; however, this is not the exhaustive list of all Veterans that will be interviewed

Black Females: Black Females are heavy users of VHA services - particularly mental health and women's health services - and research could help uncover if that is because they have a preference for VHA services or if they lack other options

American Indians or Alaskan Natives, specifically females: American Indian or Alaskan Native Identifying Female Veterans had the highest percent of concerns and the largest percent of recommendations. Engaging with this population could provide insight into their unique experiences and what they would like to see changed

Bad Paper Discharges: Specific populations receive more bad paper discharges (LGBT, TBI or PTSD, enlister); research efforts around Veterans facing this issue will provide diversity in needs and experiences. Engaging with this population could highlight if they have a desire to enroll in VHA

Rural Veterans, specifically ages 65 and older: Rural Veterans are the minority of Veterans, but they enroll at higher rates, are typically 65+, and can offer insights into VHA's reach and the accessibility of services

Younger Veterans: As the overall Veteran population becomes younger, it will be helpful to understand what young Veterans want from their health care

Veteran Caregivers and Families: There is not very much data or research available on the needs and behaviors of this group, yet they are pivotal to Veteran health care

More field research groups will be considered and added as additional insights are gleaned during subsequent research phases

Next Steps

1. Continue to acquire data on usage and experience of Veterans through internal and external VHA sources
2. Use the information presented to plan ethnographic field research and identify specific populations of Veterans to interview
3. Integrate findings from segmentation into the Trends and Benchmarking deliverable
4. Continue conversations with key stakeholders to better understand VHA's goals around the ideal make up of Veterans served by VHA (e.g., all Veterans, all eligible Veterans, Veterans needing specialty care, Veterans who lack access to any other care, etc.)

Appendix

The following section includes greater details on data analysis, sources, and construction behind demographic segments and sub-categories

References

Slide 6: Key Considerations	• https://benefits.va.gov/TRANSITION/docs/mct-report-2018.pdf
Slide 9: A Changing Veteran Population	• https://www.pewresearch.org/fact-tank/2021/04/05/the-changing-face-of-americas-Veteran-population/ • U.S. Census Data and VA VSSC Enrollment Cube Data
Slide 10: Who VHA is Serving	• U.S. Census Data and VA VSSC Enrollment Cube Data
Slide 15: Sex and Gender: Demographic Snapshot	• https://www.pewresearch.org/fact-tank/2021/04/05/the-changing-face-of-americas-Veteran-population/ • U.S. Census Data and VA VSSC Enrollment Cube Data • https://www.congress.gov/bill/117th-congress/house-bill/239?r=134&s=1 • https://www.congress.gov/bill/117th-congress/house-bill/958/actions
Slide 16: Sex and Gender: Utilization Snapshot	• https://www.va.gov/vetdata/docs/Quickfacts/VA_Utilization_Profile_2017.pdf • U.S. Census Data and VA VSSC Enrollment Cube Data • https://blogs.va.gov/VAntage/wp-content/uploads/2021/05/va-trust-report-fy21q2.pdf • VA Stakeholder Interview, 5/25/21
Slide 17: Sex and Gender: Additional Considerations	• https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf • https://www.ptsd.va.gov/professional/treat/type/sexual_trauma_women.asp • https://www.va.gov/vetdata/docs/SpecialReports/education_FINAL.pdf • https://www.cdc.gov/socialdeterminants/about.html • https://www.militarytimes.com/2015/12/03/all-combat-jobs-open-to-women-in-the-military/
Slide 19: Race and Ethnicity: Demographics Snapshot	• https://www.pewresearch.org/fact-tank/2021/04/05/the-changing-face-of-americas-Veteran-population/ • https://www.va.gov/centerforminorityVeterans/about/index.asp • https://blogs.va.gov/VAntage/90079/minority-summit-expands-diversity-partnerships-minority-serving-institutions/ • https://www.congress.gov/bill/117th-congress/house-bill/2878?q=%7B%22search%22%3A%5B%22H.R.+2878%22%5D%7D&s=10&r=1
Slide 20: Race and Ethnicity: Utilization Snapshot	• U.S. Census Data and VA VSSC Enrollment Cube Data • https://federalnewsnetwork.com/Veterans-affairs/2021/06/va-sees-trust-improve-by-24-in-five-years-thanks-to-Veterans-experience-effort/ • VA Stakeholder Interviews, 5/14/21 and 5/25/21
Slide 21: Race and Ethnicity: Additional Considerations	• https://www.protectourdefenders.com/wp-content/uploads/2017/05/Disparity-Report-One-Pager-2.pdf

References (cont.)

Slide 23: Age: Demographic Snapshot	• https://www.va.gov/vetdata/docs/Quickfacts/VA_Utilization_Profile_2017.pdf
Slide 24: Age: Utilization Snapshot	• U.S. Census Data and VA VSSC Enrollment Cube Data • VEO - VSignals Outpatient Services Surveys: Women Veterans Analysis • SECVA Dashboard March 2021
Slide 25: Age: Additional Considerations	• https://www.healio.com/news/psychiatry/20200915/military-service-member-suicide-rates-increase-after-separation-and-vary-by-demographics
Slide 27: Location: Demographic Snapshot	• https://www.ruralhealth.va.gov/aboutus/ruralvets.asp • https://www.pewresearch.org/social-trends/2018/05/22/demographic-and-economic-trends-in-urban-suburban-and-rural-communities/ • https://www.ruralhealth.va.gov/aboutus/vrhrc.asp • https://www.ruralhealth.va.gov/aboutus/vrc.asp • https://axne.house.gov/media/press-releases/axne-iowa-delegation-honor-iowa-Veteran-brandon-ketchum-bipartisan-legislation
Slide 28: Location: Utilization Snapshot	• https://www.ruralhealth.va.gov/aboutus/ruralvets.asp • VA Stakeholder Interviews, 6/7/21 and 5/25/21 • https://www.va.gov/vetdata/
Slide 29: Location: Additional Considerations	• https://blogs.va.gov/VAntage/81205/five-ways-va-supports-rural-communities-covid-19/ • https://www.ruralhealth.va.gov/aboutus/ruralvets.asp
Slide 31: LGBT: Demographic Snapshot	• https://news.gallup.com/poll/329708/lgbt-identification-rises-latest-estimate.aspx • https://blogs.va.gov/VAntage/75500/vha-innovators-network-innovator-month-dr-tiffany-lange-altman-dr-michelle-hilgeman/ • https://www.patientcare.va.gov/LGBT/ • https://www.va.gov/ORMDI/docs/StrategicPlan.pdf
Slide 32: LGBT: Utilization Snapshot	• https://www.military.com/daily-news/2020/10/26/va-falls-short-providing-specific-health-care-lgbt-Veterans-gao-report-finds.html • https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5770088/
Slide 33: LGBT: Additional Considerations	• https://www.marketplace.org/2020/12/23/many-lgbtq-Veterans-face-long-waits-for-access-to-benefits/

References (cont.)

Slide 35: Disability Status: Demographic Snapshot	• https://www.va.gov/vetdata/docs/Quickfacts/VA_Utilization_Profile_2017.pdf • https://www.military.com/daily-news/2019/03/25/post-9-11-vets-have-far-higher-disability-ratings-prior-generations-report.html • https://www.va.gov/vetdata/docs/Quickfacts/SCD_trends_FINAL_2018.pdf • https://www.congress.gov/bill/117th-congress/house-bill/1448?q=%7B%22search%22%3A%5B%22PAWS+for+therapy%22%5D%7D&s=3&r=2
Slide 36: Disability Status: Utilization Snapshot	• https://www.va.gov/vetdata/docs/Quickfacts/VA_Utilization_Profile_2017.pdf • VA Stakeholder Interviews, 6/1/21
Slide 37: Disability Status: Additional Considerations	• https://www.legalservicescenter.org/wp-content/uploads/Turn-Away-Report.pdf • https://www.militarytimes.com/news/pentagon-congress/2020/11/12/suicide-rate-among-Veterans-up-again-slightly-despite-focus-on-prevention-efforts/ • https://www.dav.org/learn-more/news/2021/suicide-prevention-report-updated/
Slide 39: Homelessness: Demographic Snapshot	• https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf • https://www.militarytimes.com/news/pentagon-congress/2021/03/18/the-number-of-Veterans-experiencing-homelessness-rose-slightly-even-before-the-coronavirus-pandemic/ • https://www.va.gov/HOMELESS/about_homeless_programs.asp • https://www.congress.gov/bill/117th-congress/house-bill/240?r=10&s=1 • https://www.militarytimes.com/veterans/2021/06/16/homelessness-among-vets-could-spike-as-pandemic-protections-vanish-advocates-warn/
Slide 40: Homelessness: Utilization Snapshot	• VA CDW Services Data • https://www.va.gov/HOMELESS/docs/HCHV-Fact-Sheet-508.pdf • https://www.va.gov/homeless/for_homeless_Veterans.asp • VA Stakeholder Interview, 5/24/21
Slide 41: Homelessness: Additional Considerations	• https://www.va.gov/homeless/endingvetshomelessness.asp • https://community.solutions/functional-zero/ • https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf
Slide 43: Caregivers and Families: Demographic Snapshot	• https://www.aarp.org/home-family/voices/Veterans/info-2020/caregiver-benefits-expanded.html • https://health.usnews.com/health-care/for-better/articles/caregiving-for-military-Veterans • https://www.caregiver.va.gov/support/support_benefits.asp
Slide 44: Caregivers and Families: Utilization Snapshot	• https://www.rand.org/pubs/research_briefs/RB9764.html

References (cont.)

Slide 45: Caregivers and Families: Additional Considerations	• https://health.usnews.com/health-care/for-better/articles/caregiving-for-military-Veterans
Slide 47: Race and Gender: Black Females	• U.S. Census Data and VA VSSC Enrollment Cube Data • https://www.navao.org/wp-content/uploads/2016/02/FY14-Active-DSS-Identifiers.pdf
Slide 48: Race and Gender	• VEO - VSignals Outpatient Services Surveys: Women Veterans Analysis
Slide 49: Location and Race	• U.S. Census Data and VA VSSC Enrollment Cube Data
Slide 50: Location and Age	• U.S. Census Data and VA VSSC Enrollment Cube Data • https://www.ruralhealth.va.gov/aboutus/ruralvets.asp • https://www.navao.org/wp-content/uploads/2016/02/FY14-Active-DSS-Identifiers.pdf

Data Cleaning Process

How to Read the Category Consolidation Cross-Walk

This section is intended to help readers understand how data was combined from different sources to enable analysis

To recap from Slide 7:

- Data for the Enrolled and Users segments were gathered from VSSC
- Data for the Veteran (total Veteran population) segment were gathered from the U.S. Census
- Data for the Unenrolled segment came from our own calculations and were imputed by subtracting the Enrolled population from the Total Veteran Population

- Given that each data source had its own respective naming conventions and categorical groupings, in order to enable direct comparison between disparate data sources, it was necessary for us to normalize and consolidate these categories and sub-categories

- The following two slides containing the Category Consolidation Cross-Walk present a table that can be read from left to right:
  - The segments used in this report
  - The original data sources
  - The original data category labels as they arrived from the source
  - The new subcategories generated for consolidation
  - The original sub-category names from the original data sources files

Data Cleaning Process (cont.)

Category Consolidation Cross-Walk Part 1

See slide 59 for how to read

Report Segmentation Group	Original Source of Data	Original Source Category Labels	New Sub-Categories	Original Source Sub-Categories
Age	Census	Age	18 to 34 years	18 to 34 years
			35 to 54 years	35 to 54 years
			55 to 64 years	55 to 64 years
			65 to 74 years	65 to 74 years
			75 years and over	75 years and over
	VSSC	Age	18 to 34 years	<25
				25-29
				30-34
			35 to 54 years	35-39
				40-44
				45-49
				50-54
			55 to 64 years	55-59
				60-64
			65 to 74 years	65-69
				70-74
			75 years and over	75-79
				80-84
				85+
				Unknown
Disability Status	Census	Disability Status	With any disability	With any disability
			Without a disability	Without a disability
	VSSC	VA Disability	Unknown	NULL
				Receiving Disability Compensation Unknown
				Unknown
			With any disability	Receiving Disability Compensation
			Without a disability	Not Receiving Disability Compensation

Data Cleaning Process (cont.)

Category Consolidation Cross-Walk Part 2

See slide 59 for how to read

Report Segmentation Group	Original Source of Data	Original Source Category Labels	New Sub-Categories	Original Source Sub-Categories
Ethnicity	Census	Race And Hispanic Or Latino Origin	Hispanic or Latino	Hispanic or Latino
			Not Hispanic or Latino	Not Hispanic
				White alone, not Hispanic or Latino
	VSSC	Ethnicity	Hispanic or Latino	Hispanic or Latino
			Not Hispanic or Latino	Not Hispanic or Latino
			Unknown	Declined to Answer
				Unknown
Gender	Census	Sex	Female	Female
			Male	Male
	VSSC	Gender	Female	Female
			Male	Male
			Unknown	Unknown
Race	Census	Race And Hispanic Or Latino Origin	American Indian and Alaska Native	American Indian and Alaska Native
			Asian	Asian
			Black or African American	Black or African American
			Multiple	Two or more races
			Other	Native Hawaiian and Other Pacific Islander
				Some other race
				Some other race alone
			White	White
	VSSC	Race	American Indian and Alaska Native	American Indian and Alaska Native
			Asian	Asian
			Black or African American	Black or African American
			Multiple	Multiple
			Other	Declined to Answer
				Native Hawaiian and Other Pacific Islander
				Unknown
			White	White
Total Population	Census	Total Population	Civilian population 18 years and over	Civilian population 18 years and over