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# National Veteran Health Equity Report 2021 – Asian and Native Hawaiian and Other Pacific Islander Veteran Chartbook

**Focus on Veterans Health Administration**
**Patient Experience and Health Care Quality**

US Department of Veterans Affairs
Veterans Health Administration
Health Equity-Quality Enhancement Research Initiative
National Partnered Evaluation Center
VA Greater Los Angeles Healthcare System, Los Angeles, CA

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# National Veteran Health Equity Report 2021 – Asian and Native Hawaiian and Other Pacific Islander Veteran Chartbook

## Focus on Veterans Health Administration Patient Experience and Health Care Quality

*Prepared for:*

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Veterans Health Administration
Washington, DC

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# Contents

# Foreword

I was so pleased when I learned that Veteran Health Administration's Office of Health Equity would prepare this analysis of the care that Asian American and Native Hawaiian and other Pacific Islander (NHOPI) Veterans receive through the U.S. Department of Veterans Affairs. The Office of Health Equity has a sterling reputation among practitioners and researchers for the quality, relevance, and usefulness of their work. My high expectations were exceeded, however, by this Asian American and NHOPI Veteran Chartbook. I do not know of another reference that has covered this important subject in such a thorough and thoughtful way. The clear writing and well-designed exhibits are a very nice bonus.

VA has a strong commitment to serve Veterans across all sociodemographic, health, and disability classifications. By making sure we care for underserved Veterans, we are ensuring the care of all others. It is important to know how groups and their experiences differ from each other – while recognizing that the differences within groups are broader than the differences between them.

This chartbook fills an important gap in our understanding of one of our smallest but fastest growing demographic groups. Most importantly, it de-aggregates data to reflect the dissimilarities between Veterans in this group: between Asian Americans, Native Hawaiians, and other Pacific Islanders. This information is needed for the evidence-based decision making that VA relies upon for planning and operations. Without these measurements, it is impossible to tell how well we are meeting Veterans' needs, and how we can better fulfill this mission.

My thanks and gratitude to the Office of Health Equity for taking on this complex project and carrying it through so successfully. This work will be reflected in the lives of our Veterans.

Vivian T. Hutson, FACHE
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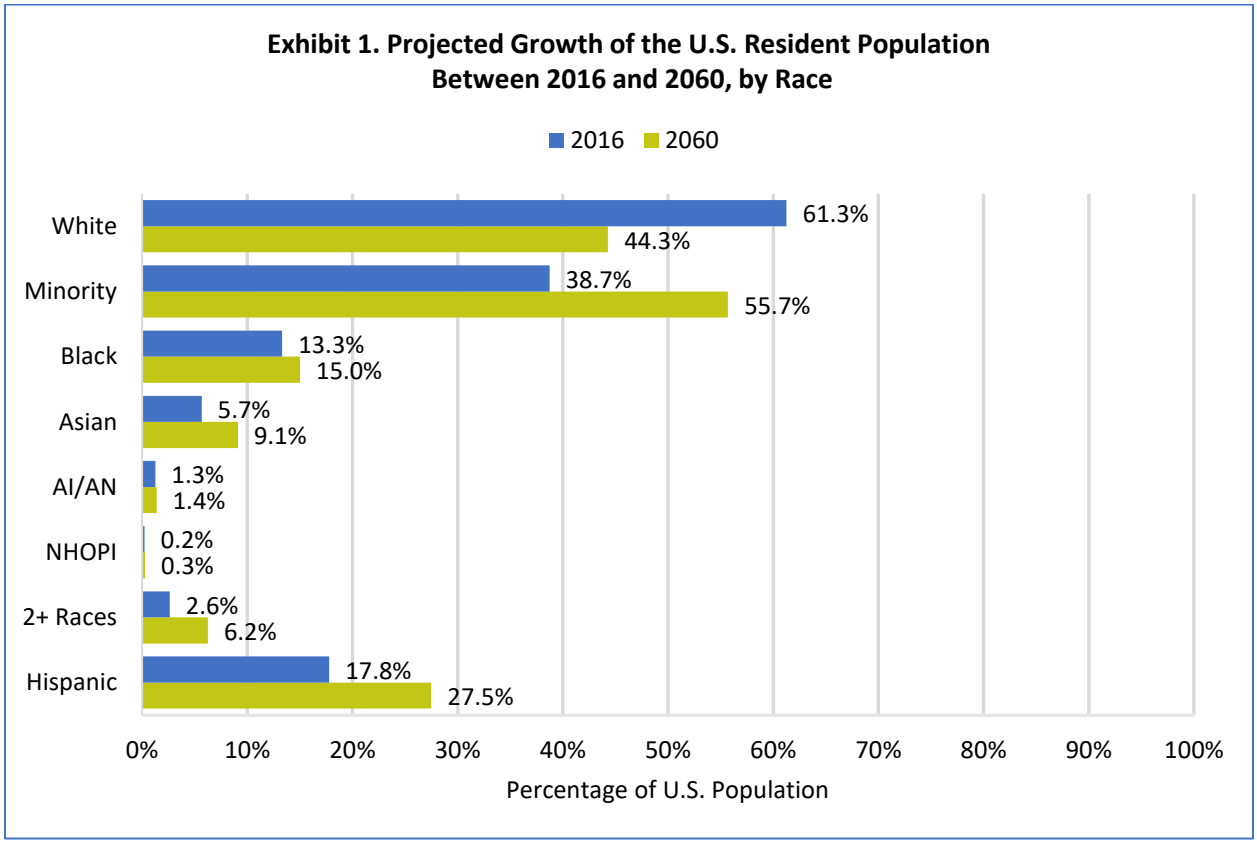
# Section I: Background

The National Veteran Health Equity Report 2021 provides information regarding disparities in patient experiences and health care quality for Veterans who obtain health care services through the Veterans Health Administration (VHA).[1] Data on disparities are presented by the sociodemographic characteristics of race/ethnicity, gender, age group, rurality of residence, socio-economic status, and service-connected disability rating, and by cardiovascular risk factors of hypertension, hyperlipidemia, and diabetes.

This chartbook focuses on experiences of care and health care quality of Asian American and Native Hawaiian and other Pacific Islander (NHOPI) Veterans receiving care in VHA. Data in this report are from the fiscal year 2016 to fiscal year 2019 Department of Veteran Affairs (VA) Survey of Healthcare Experiences of Patients (SHEP)-Patient Centered Medical Home survey instrument, and the fiscal year 2016 to fiscal year 2019 VA External Peer Review Program quality monitoring program.

As of 2017 Asians make up about 5.6% of the total American population, and Native Hawaiian/Pacific Islander make up about 0.2% of the total population. The Asian population is projected to be the second fastest growing racial group in America, only trailing behind those who are two or more races. It is currently estimated that by 2060 the Asian population will grow to 9.1% of the total population in America. [2]

Exhibit 1. Projected Growth of the U.S. Resident Population Between 2016 and 2060, by Race



| U.S. Population Group | 2016 Percentage | 2060 Percentage |
|---|---|---|
| White | 61.3% | 44.3% |
| Minority | 38.7% | 55.7% |
| Black | 13.3% | 15.0% |
| Asian | 5.7% | 9.1% |
| AI/AN | 1.3% | 1.4% |
| NHOPI | 0.2% | 0.3% |
| 2+ Races | 2.6% | 6.2% |
| Hispanic | 17.8% | 27.5% |

*Note:* AI/AN denotes American Indian or Alaska Native; NHOPI denotes Native Hawaiian or other Pacific Islander

Categories are not mutually exclusive; therefore, percentages may add to more than 100 percent. Racial categories other than 2+ Races exclude people reporting two or more races. Whites are non-Hispanic only; all other categories may include Hispanics. Minority includes all groups other than the non-Hispanic White population.

*Source:* Agency for Healthcare Research and Quality, Chartbook on the Healthcare of Asians and Native Hawaiian/Pacific Islanders. U.S. Census Bureau., Population Division. Projected Race and Hispanic Origin: Main Projections Series for the United States, 2017 to 2060. https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html.

# Section II: Patient Demographics

### Asian and Native Hawaiian or other Pacific Islander Veteran VHA Users

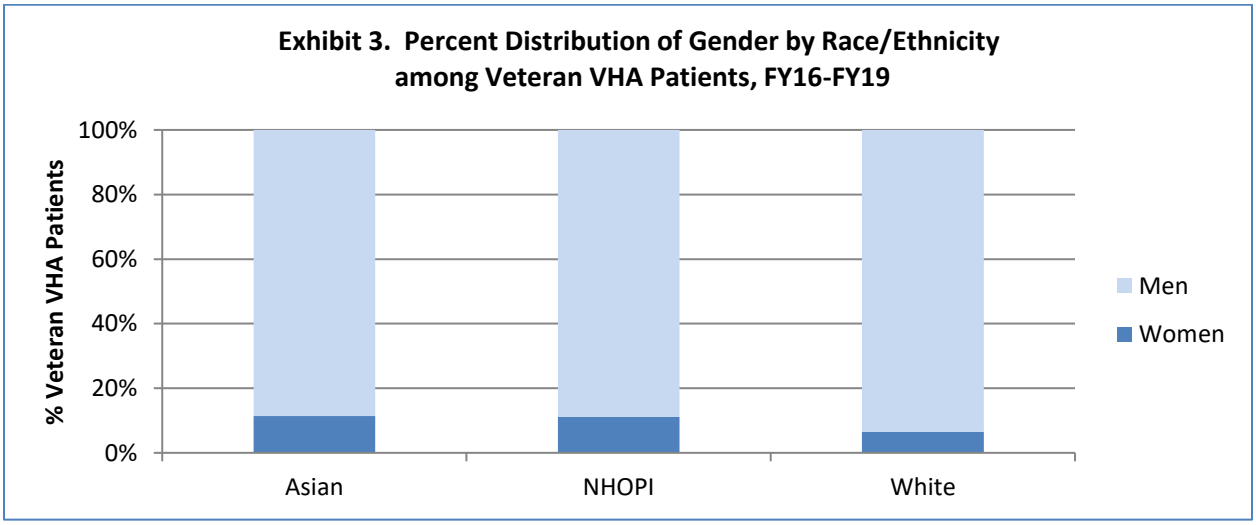
### Exhibit 2. Distribution of Asian and Native Hawaiian or other Pacific Islander Veteran VHA Patients, FY16-FY19.

| Race/Ethnicity | Percentage |
|---|---|
| Asian | 1.1% |
| Native Hawaiian or other Pacific Islander | 0.7% |

Findings:

- These groups are each very small percentages of the Veteran VHA patient population.

### Gender by Race/Ethnicity



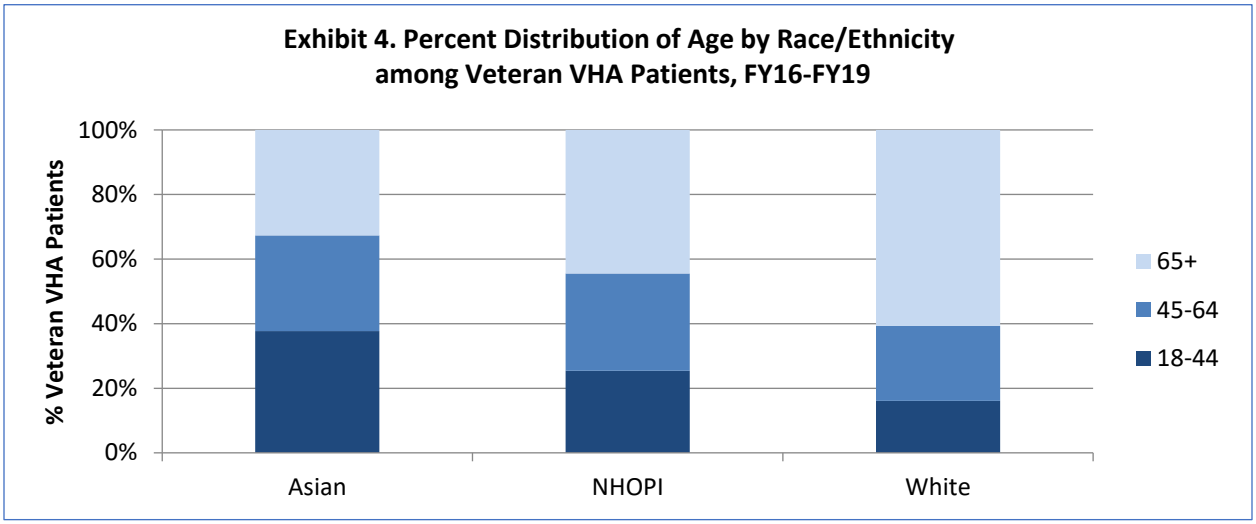

| Gender | Asian | NHOPI | White |
|---|---|---|---|
| Men | 88.6% | 88.9% | 93.5% |
| Women | 11.4% | 11.1% | 6.5% |

*Note:* NHOPI denotes Native Hawaiian or other Pacific Islander

Findings:

- Most Veterans are men across all racial/ethnic groups.

## Age Group by Race/Ethnicity



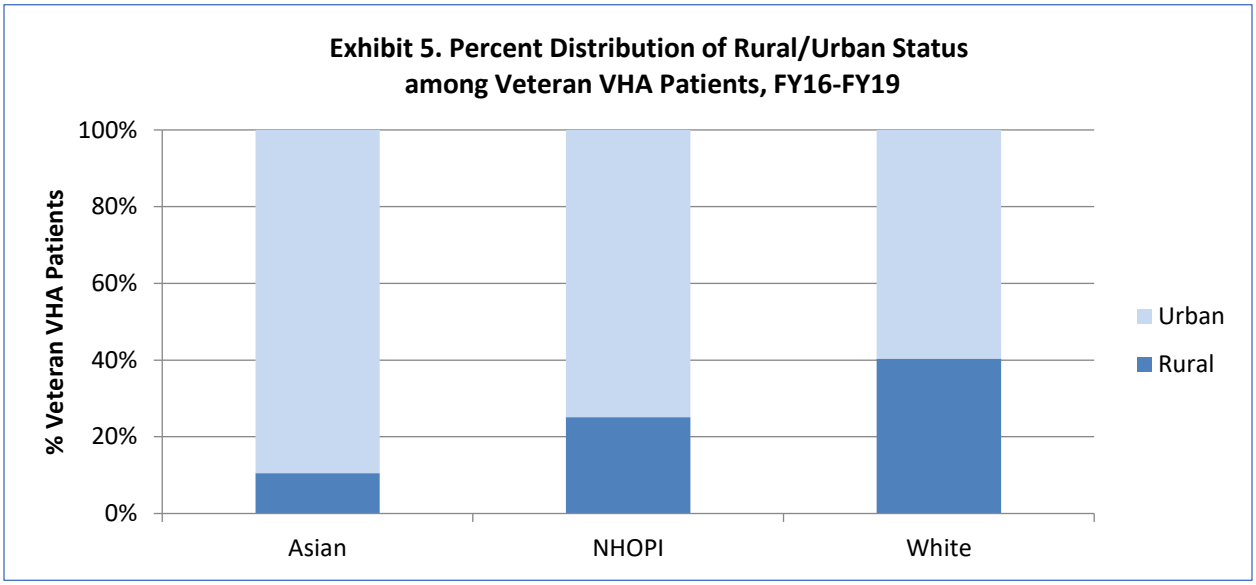

| Age | Asian | NHOPI | White |
|---|---|---|---|
| 65+ years | 32.7% | 44.5% | 60.7% |
| 45-64 years | 29.6% | 30.1% | 23.2% |
| 18-44 years | 37.7% | 25.4% | 16.1% |

*Note:* NHOPI denotes Native Hawaiian or other Pacific Islander

Findings:

- There was a higher proportionate representation of Asian American and NHOPI Veterans in the 18-44 age group than among non-Hispanic White Veterans. Non-Hispanic White Veterans had the highest proportionate representation in the age 65+ group.

## Rurality by Race/Ethnicity



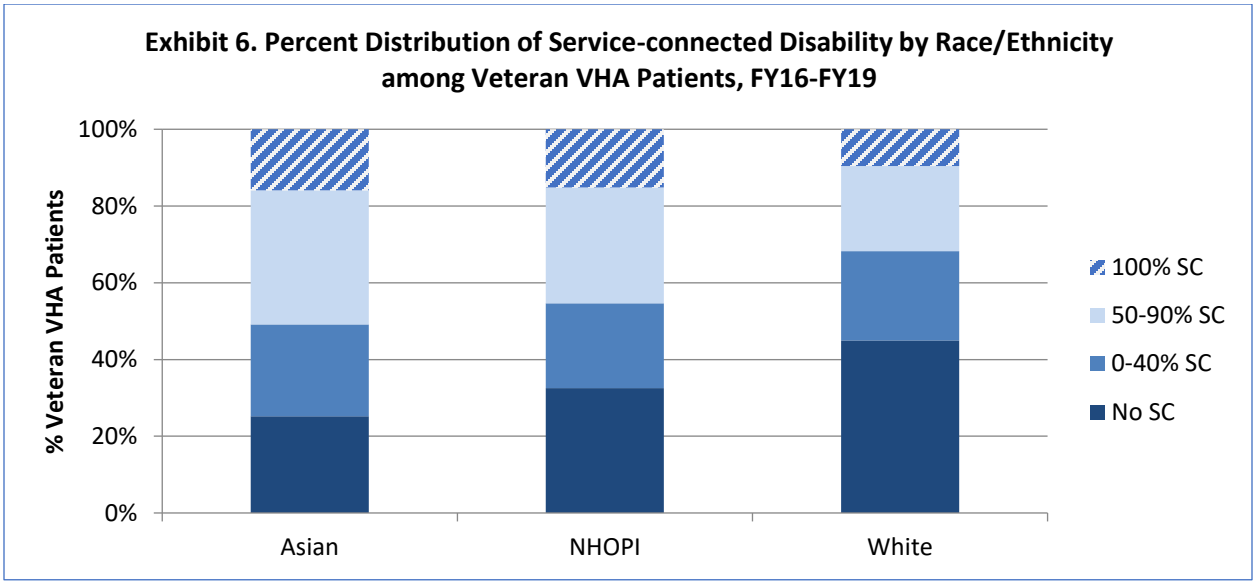

| Rural/Urban Status | Asian | NHOPI | White |
|---|---|---|---|
| Urban | 89.5% | 74.9% | 59.6% |
| Rural | 10.5% | 25.1% | 40.4% |

*Note:* NHOPI denotes Native Hawaiian or other Pacific Islander

Findings:

- There were proportionately more Asian American and NHOPI Veterans from urban areas compared to the other racial/ethnic groups. Non-Hispanic White Veterans were more likely to be from rural areas compared to the other racial/ethnic groups.

## Service-connected Disability Rating by Race/Ethnicity




| Service-connected Disability Rating | Asian | NHOPI | White |
|---|---|---|---|
| 100% SC | 15.9% | 15.2% | 9.6% |
| 50-90% SC | 34.9% | 30.2% | 22.1% |
| 0-40% SC | 23.9% | 22.1% | 23.3% |
| No SC | 25.2% | 32.5% | 44.9% |

*Note:* NHOPI denotes Native Hawaiian or other Pacific Islander; SC denotes service-connected disability rating

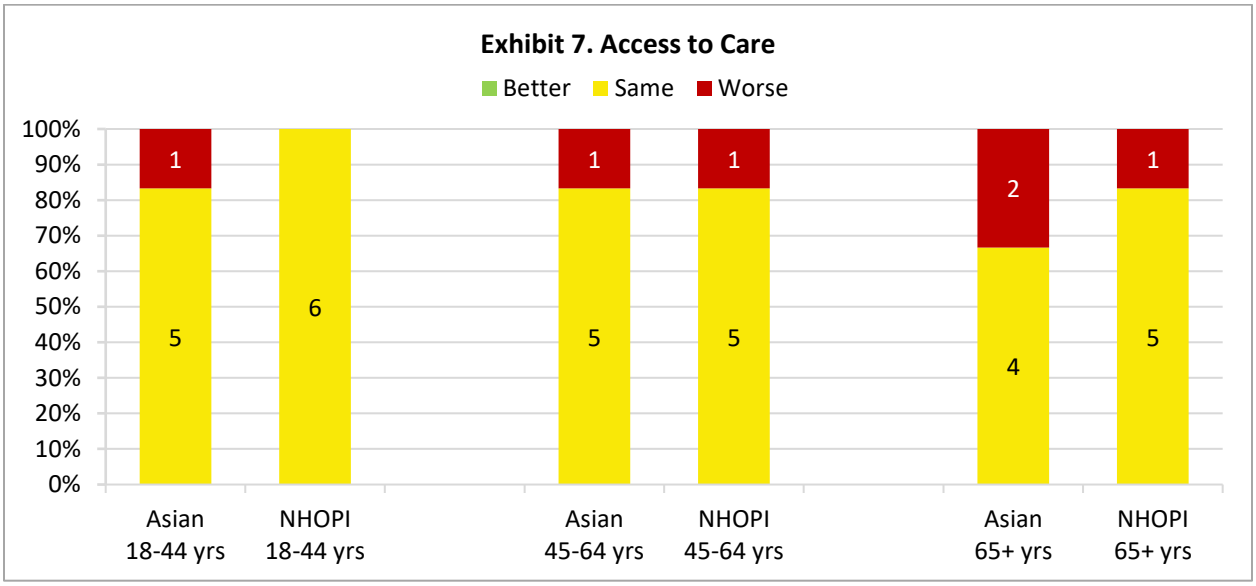
Findings:

- Asian Veterans had the highest rates of service-connected disability compared to the other racial/ethnic groups. White Veterans had the highest rates of no service-connected disability compared to the other racial/ethnic groups.

# Section III: Patient Experiences (see Appendix for methods and guidelines for interpretation)

## Variations in VHA Patient Experience of Access to Care by Veteran Race/Ethnicity

Exhibit 7. Number and percentage of measures for which racial/ethnic minority Veteran VHA patients of specified age groups experienced better, same, or worse access to care compared with reference group




| Comparison | Asian 18-44 yrs | NHOPI 18-44 yrs | Asian 45-64 yrs | NHOPI 45-64 yrs | Asian 65+ yrs | NHOPI 65+ yrs |
|---|---|---|---|---|---|---|
| Worse | 1 | 0 | 1 | 1 | 2 | 1 |
| Same | 5 | 6 | 5 | 5 | 4 | 5 |
| Better | 0 | 0 | 0 | 0 | 0 | 0 |

*Reference group:* Non-Hispanic White Veteran VHA patients of corresponding age group
*Source:* Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2019 data

*Note:* NHOPI denotes Native Hawaiian or other Pacific Islander

Importance:

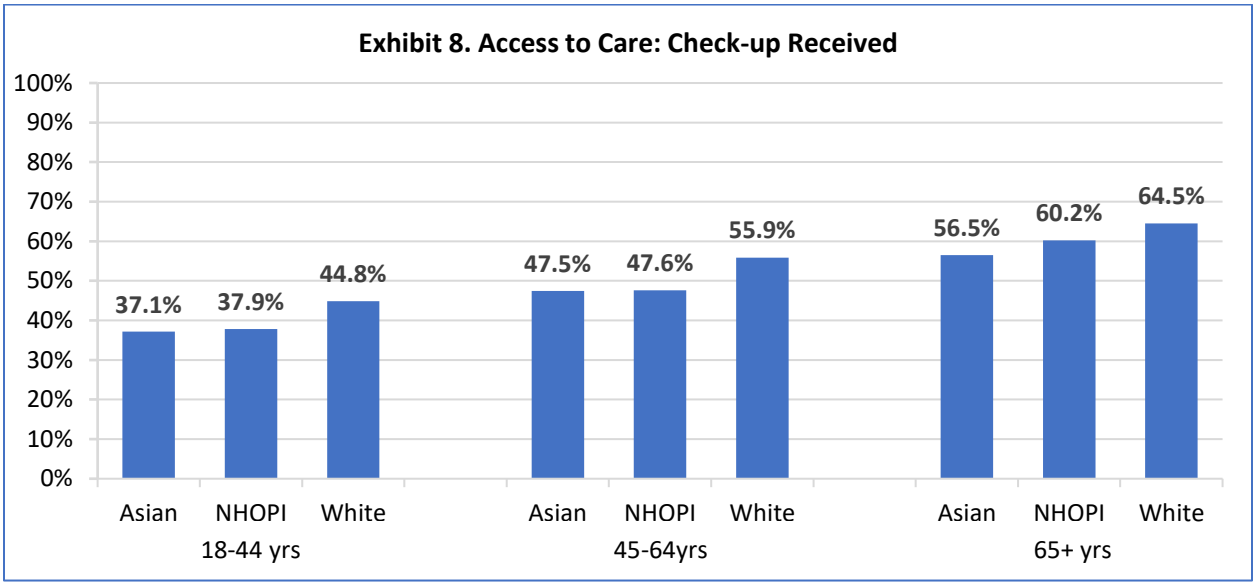
- Access to high quality healthcare is the first important step towards improved individual and population health.[2]

Findings:

- Compared with non-Hispanic White Veterans ages 18-44, Asian Veterans experienced worse access on 1 measure, whereas NHOPI Veterans experienced similar access on all 6 measures.
- Among Veterans ages 45-64, Asian and NHOPI Veterans experienced similar access on 5 measures and worse access on 1 measure compared to non-Hispanic White Veterans.

- Compared to non-Hispanic White Veterans ages 65+, NHOPI Veterans experienced similar access on 5 measures and worse access on 1 measure, and Asian Veterans experienced similar access on 4 measures and worse access on 2 measures.

Exhibit 8. VHA users who indicated, in the last 6 months, when they made an appointment with their provider for a check-up or routine care, they always received an appointment as soon as needed




| Age | Asian | NHOPI | White |
|---|---|---|---|
| 18-44 years | 37.1% | 37.9% | 44.8% |
| 45-64 years | 47.5% | 47.6% | 55.9% |
| 65+ years | 56.5% | 60.2% | 64.5% |

*Reference group:* Non-Hispanic White Veteran VHA patients of corresponding age group
*Source:* Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2019 data

*Note:* NHOPI denotes Native Hawaiian or other Pacific Islander

Importance:

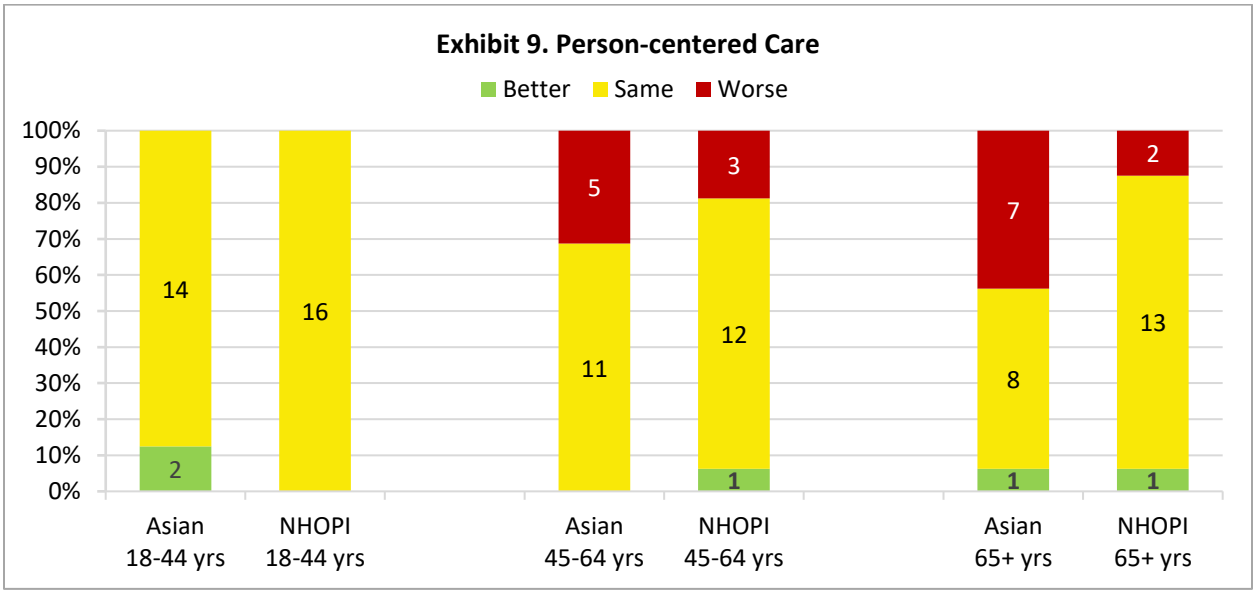
- Timeliness of care is a key aspect of quality and delays in healthcare access contribute to poorer physical and mental health, given that untimely access can exacerbate these conditions.[3-5]

Findings:

- Compared with non-Hispanic White Veterans (44.8%), Asian (37.1%) Veterans ages 18-44 experienced worse access to check-up or routine care.
- Compared with non-Hispanic White Veterans (55.9%), Asian (47.5%) and NHOPI (47.8%) Veterans ages 45-64 experienced worse access to check-up or routine care.
- Compared with non-Hispanic White Veterans (64.5%), Asian (56.5%) and NHOPI (60.2%) Veterans ages 65+ experienced worse access to check-up or routine care.

## Variations in VHA Patient Experience of Person-centered Care by Veteran Race/Ethnicity

Exhibit 9. Number and percentage of measures for which racial/ethnic minority Veteran VHA patients of specified age groups experienced better, same, or worse person-centered care compared with reference group




| Comparison | Asian 18-44 yrs | NHOPI 18-44 yrs | Asian 45-64 yrs | NHOPI 45-64 yrs | Asian 65+ yrs | NHOPI 65+ yrs |
|---|---|---|---|---|---|---|
| Worse | 0 | 0 | 5 | 3 | 7 | 2 |
| Same | 14 | 16 | 11 | 12 | 8 | 13 |
| Better | 2 | 0 | 0 | 1 | 1 | 1 |

*Reference group:* Non-Hispanic White Veteran VHA patients of corresponding age group
*Source:* Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2019 data

*Note:* NHOPI denotes Native Hawaiian or other Pacific Islander

Importance:

- National guidelines define patient-centered care as essential for patient engagement and satisfaction to ensure patient's desired outcomes.[6]

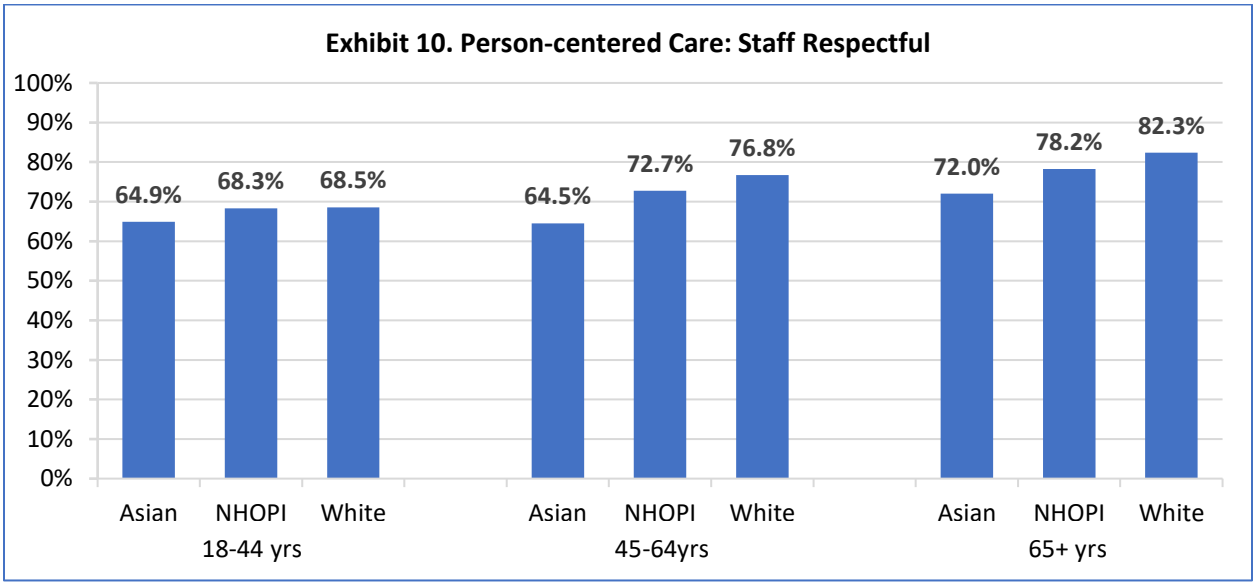
Findings:

- On most measures of person-centered care, both Asian and NHOPI ages 18-44 had the same experience of patient-centeredness as non-Hispanic White Veterans. NHOPI Veterans ages 18-44 received the same person-centered care on 16 measures compared to non-Hispanic White Veterans. On 14 measures, Asian Veterans ages 18-44 had the same person-centered care and better care on 2 measures of patient-centeredness compared to non-Hispanic White Veterans.
- Compared to non-Hispanic White Veterans ages 45-64, Asian Veterans experienced the same person-centered care on 11 measures and worse care on 5 measures of patient-centeredness. NHOPI Veterans experienced the same person-centered care on 12

measures, better care on 1 measure and worse care on 3 measures of patient-centeredness compared to non-Hispanic White Veterans.

- NHOPI Veterans ages 65+ experienced the same person-centered care on 13 measures, better care on 1 measure, and worse care on 2 measures of patient-centeredness compared to non-Hispanic White Veterans. On 8 measures, Asian Veterans experienced the same person-centered care, better care on 1 measure, and worse care on 7 measures of patient-centeredness compared to non-Hispanic White Veterans.

Exhibit 10. VHA users who indicated, in the last 6 months, clerks and receptionists at their provider's office always treated them with courtesy and respect




| Age | Asian | NHOPI | White |
|---|---|---|---|
| 18-44 years | 64.9% | 68.3% | 68.5% |
| 45-64 years | 64.5% | 72.7% | 76.8% |
| 65+ years | 72.0% | 78.2% | 82.3% |

*Reference group:* Non-Hispanic White Veteran VHA patients of corresponding age group
*Source:* Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2019 data

*Note:* NHOPI denotes Native Hawaiian or other Pacific Islander

Importance:

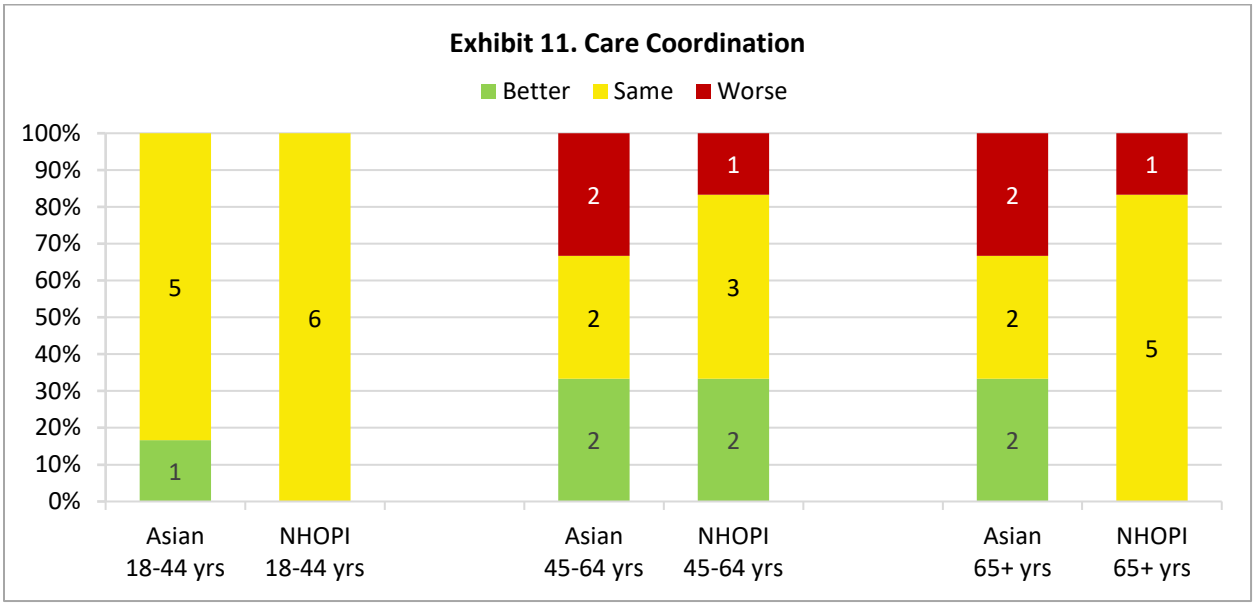
- Communication is an important component of person-centered care. Metrics for good communication include not only how well providers communicate with patients, but also how helpful and respectful office staff are in their interactions with patients.

Findings:

- Asian Veterans (68.3%) and NHOPI veterans (64.9%) ages 18-44 had similar rates as non-Hispanic White Veterans (68.5%) in feeling that staff in their provider's office treated them with courtesy and respect.
- Among Veterans ages 45-64 and 65+, Asian and NHOPI Veterans were less likely than non-Hispanic White Veterans to experience that staff in their provider's office treated them with courtesy and respect.
- Among Veterans ages 45-64, 72.7% of NHOPI Veterans and 64.5% of Asian Veterans felt that their provider's office treated them with courtesy and respect, compared to 76.8% of non-Hispanic White Veterans.
- Among Veterans age 65+, 78.2% of NHOPI Veterans and 72.0% of Asian Veterans felt that their provider's office treated them with courtesy and respect, compared to 82.3% of non-Hispanic White Veterans.

## Variations in VHA Patient Experience of Care Coordination by Veteran Race/Ethnicity

Exhibit 11. Number and percentage of measures for which racial/ethnic minority Veteran VHA patients of specified age groups experienced better, same, or worse care coordination compared with reference group




| Comparison | Asian 18-44 yrs | NHOPI 18-44 yrs | Asian 45-64 yrs | NHOPI 45-64 yrs | Asian 65+ yrs | NHOPI 65+ yrs |
|---|---|---|---|---|---|---|
| Worse | 0 | 0 | 2 | 1 | 2 | 1 |
| Same | 5 | 6 | 2 | 3 | 2 | 5 |
| Better | 1 | 0 | 2 | 2 | 2 | 0 |

*Reference group:* Non-Hispanic White Veteran VHA patients of corresponding age group
*Source:* Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2019 data

*Note:* NHOPI denotes Native Hawaiian or other Pacific Islander

Importance:

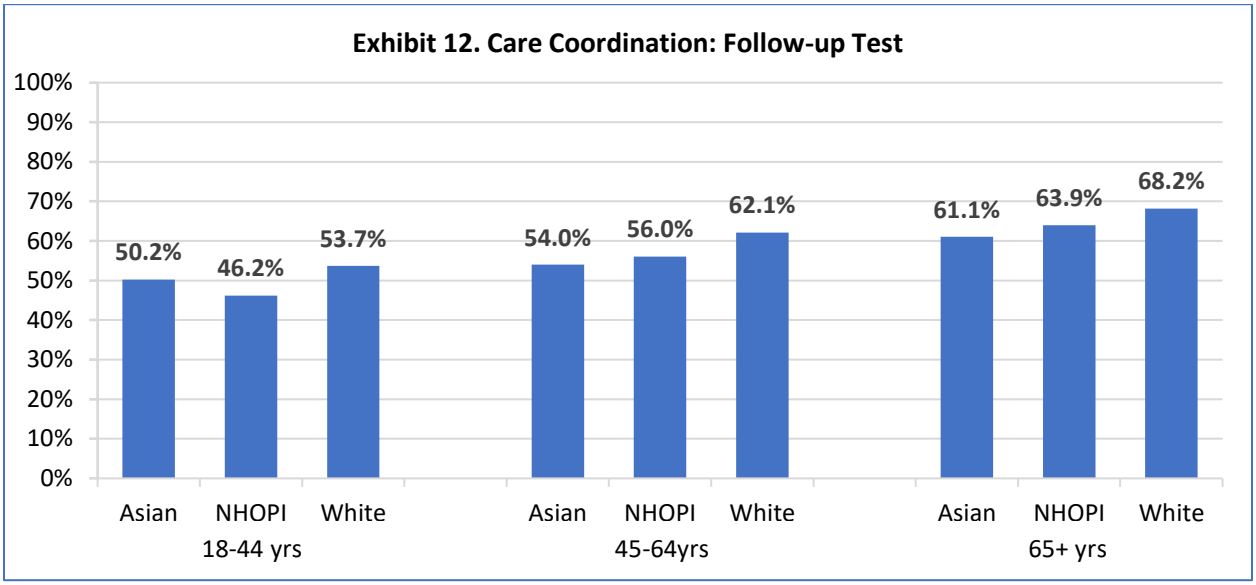
- Excellent care coordination prevents fragmentation of communication, information, and clinical services to ensure high quality care.[7]

Findings:

- NHOPI Veterans ages 18-44 reported similar care coordination as non-Hispanic White Veterans on all 6 measures. Asian Veterans had the same experience as non-Hispanic White Veterans on 5 measures of care coordination and better coordination on 1 measure.
- NHOPI Veterans ages 45-64 reported similar coordination on 3 measures, better on 2 and worse on 1 measure of coordination as non-Hispanic White Veterans. Asian Veterans ages 45-64 reported similar coordination of care on 2 measures, better on 2 and worse on 2 measures compared with non-Hispanic White Veterans.

- NHOPI Veterans ages 65+ reported similar coordination of care on most measures and worse on 1 measure. Asian Veterans ages 65+ reported better coordination of care on 2 measures, worse on 2, and the same on 2.

Exhibit 12. VHA users who indicated, in the last 6 months, that when their provider ordered a blood test, x-ray, or other test for them, someone in their provider's office always followed up to give them the results




| Age | Asian | NHOPI | White |
|---|---|---|---|
| 18-44 years | 50.2% | 46.2% | 53.7% |
| 45-64 years | 54.0% | 56.0% | 62.1% |
| 65+ years | 61.1% | 63.9% | 68.2% |

*Reference group:* Non-Hispanic White Veteran VHA patients of corresponding age group
*Source:* Health Equity/QUERI Partnered Evaluation Center analysis of SHEP-PCMH FY2016 – FY2019 data

*Note:* NHOPI denotes Native Hawaiian or other Pacific Islander

Importance:

- Failure to follow up on test results is associated with worse health outcomes due to loss of timely diagnosis and workup of serious medical conditions.[7,8]

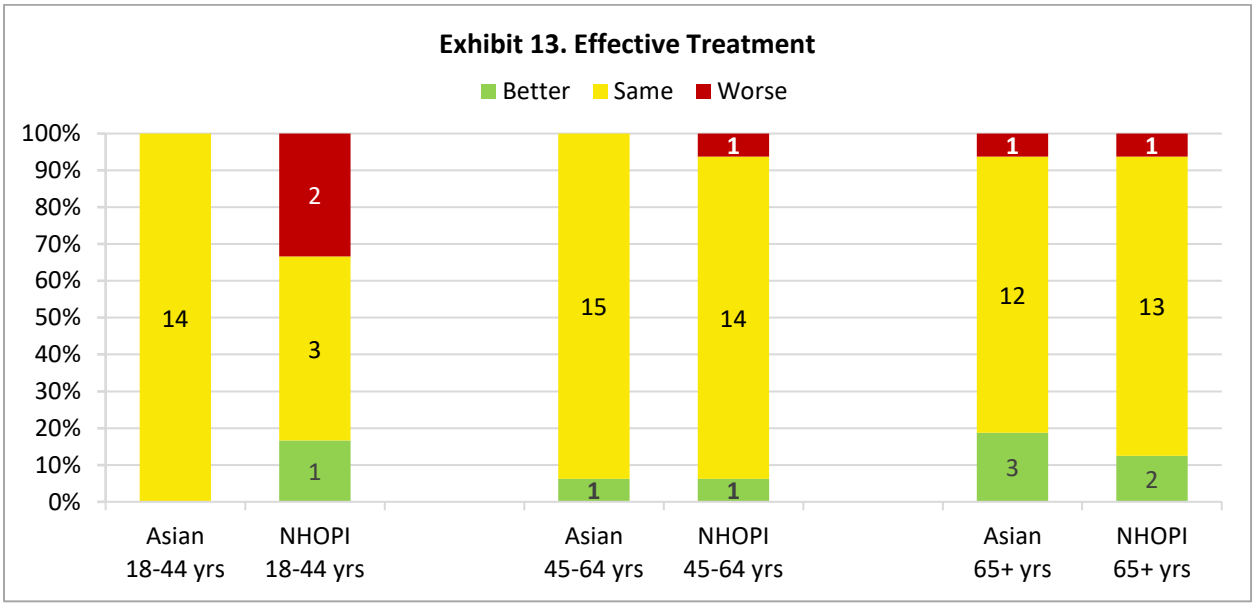
Findings:

- Asian Veterans (50.2%) and NHOPI veterans (46.2%) ages 18-44 had similar rates as non-Hispanic White Veterans (53.7%) in receiving follow-up on test results from someone in their provider's office.
- Among Veterans ages 45-64 and 65+, Asian and NHOPI Veterans were less likely than non-Hispanic White Veterans to report receiving follow-up on test results from someone in their provider's office.
- Among Veterans ages 45-64, 54.0% of Asian Veterans and 56.0% of NHOPI Veterans reported receiving follow-up on test results from someone in their provider's office, compared to 62.1% of non-Hispanic White Veterans.
- Among Veterans age 65+, 61.1% of Asian Veterans and 63.9% of NHOPI Veterans reported receiving follow-up on test results from someone in their provider's office, compared to 68.2% of non-Hispanic White Veterans.

# Section IV: Health Care Quality (see Appendix for methods and guidelines for interpretation)

## Variations in VHA Health Care Quality of Effective Treatment by Veteran Race/Ethnicity

Exhibit 13. Number and percentage of measures for which racial/ethnic minority Veteran VHA patients of specified age groups experienced better, same, or worse effective treatment compared with reference group




| Comparison | Asian 18-44 yrs | NHOPI 18-44 yrs | Asian 45-64 yrs | NHOPI 45-64 yrs | Asian 65+ yrs | NHOPI 65+ yrs |
|---|---|---|---|---|---|---|
| Worse | 0 | 2 | 0 | 1 | 1 | 1 |
| Same | 14 | 3 | 15 | 14 | 12 | 13 |
| Better | 0 | 1 | 1 | 1 | 3 | 2 |

*Reference group:* Non-Hispanic White Veteran VHA patients of corresponding age group
*Source:* Health Equity/QUERI Partnered Evaluation Center analysis of EPRP FY2016 – FY2019 data

*Note:* NHOPI denotes Native Hawaiian or other Pacific Islander

Importance:

- Effective treatment is essential to ensure high quality care with good patient outcomes.[6]

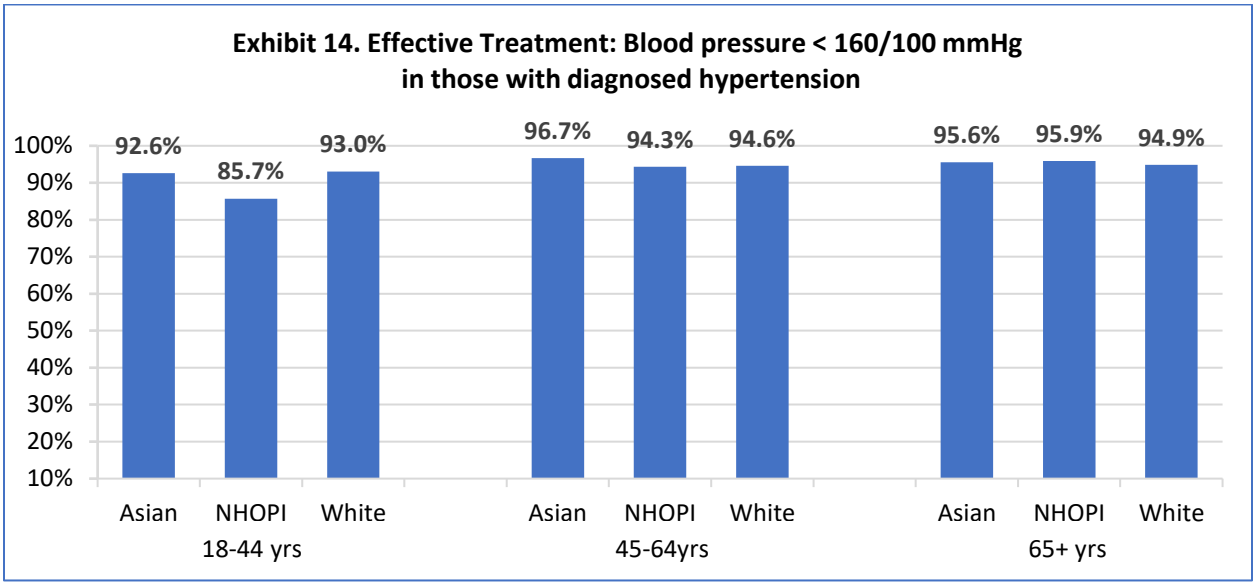
Findings:

- On most measures of effective treatment (14 measures), Asian Veterans ages 18-44 received the same effective treatment as non-Hispanic White Veterans. Compared to non-Hispanic White Veterans, NHOPI Veterans received the same effective treatment for 3 measures, worse for 2 measures and better for 1 measure.
- On most measures of effective treatment, Asian (15 measures) and NHOPI (14 measures) Veterans ages 45-64 received the same effective treatment as non-Hispanic

White Veterans. Asian and NHOPI Veterans each received better effective treatment compared to non-Hispanic White Veterans on 1 measure, whereas NHOPI Veterans received worse effective treatment on 1 measure.

- Among Veterans ages 65+, on most measures of effective treatment, Asian (12 measures) and NHOPI (13 measures) Veterans received the same effective treatment as non-Hispanic White Veterans. Compared to non-Hispanic White Veterans, Asian (3 measures) and NHOPI (2 measures) Veterans received better effective treatment. Compared to non-Hispanic White Veterans, each group of Veterans received worse effective treatment on 1 measure.

Exhibit 14. VHA patients with diagnosed hypertension whose most recent blood pressure was measured in the last 12 months, and was less than 160/100 mmHg




| Age | Asian | NHOPI | White |
|---|---|---|---|
| 18-44 years | 92.6% | 85.7% | 93.0% |
| 45-64 years | 96.7% | 94.3% | 94.6% |
| 65+ years | 95.6% | 95.9% | 94.9% |

*Reference group:* Non-Hispanic White Veteran VHA patients of corresponding age group
*Source:* Health Equity/QUERI Partnered Evaluation Center analysis of EPRP FY2016 – FY2019 data

*Note:* NHOPI denotes Native Hawaiian or other Pacific Islander

Importance:

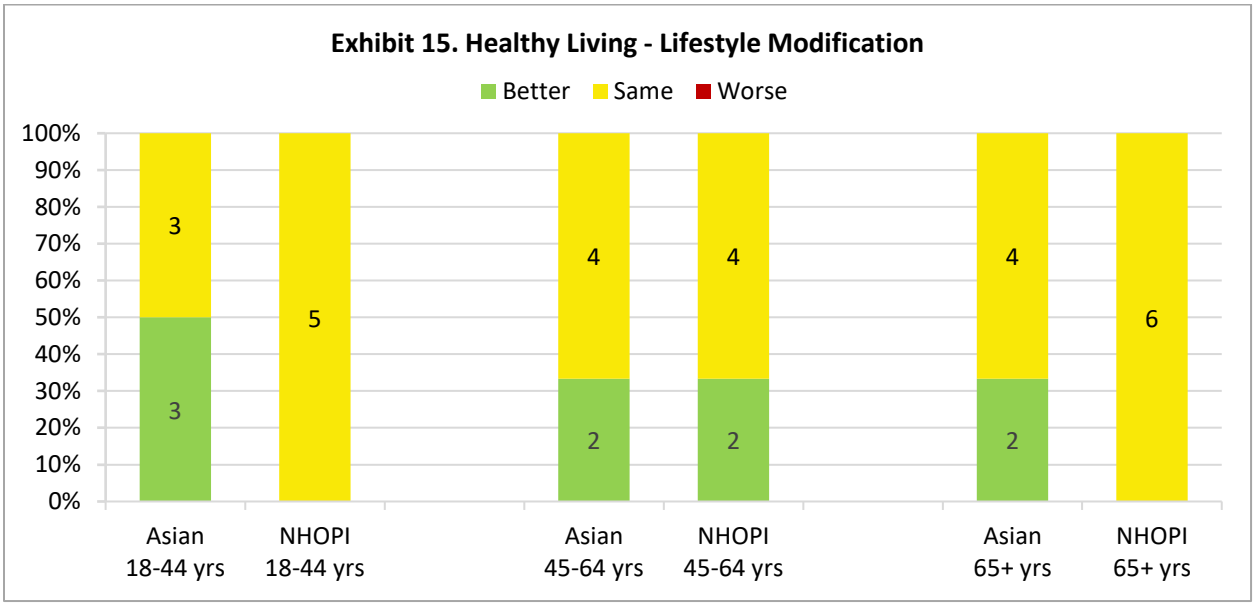
- Hypertension is a risk factor for ischemic heart disease, the leading cause of death.

Findings:

- Among Veterans ages 18-44, Asian Veterans (92.6%) experienced similar rates of effective treatment of hypertension as non-Hispanic White Veterans (93.0%), while NHOPI Veterans (85.7%) experienced lower rates of effective treatment.
- Among Veterans ages 45-64, Asian Veterans (96.7%) experienced higher rates of effective treatment of hypertension than non-Hispanic White Veterans (94.6%), while NHOPI Veterans (94.3%) experienced similar rates of effective treatment as non-Hispanic White Veterans.
- Among Veterans ages 65+, Non-Hispanic White (94.9%), Asian (95.6%), and NHOPI (95.9%) Veterans all experienced a similar rate of effective treatment of hypertension.

## Variations in VHA Health Care Quality of Healthy Living – Lifestyle Modification by Veteran Race/Ethnicity

Exhibit 15. Number and percentage of measures for which racial/ethnic minority Veteran VHA patients of specified age groups experienced better, same, or worse healthy living – lifestyle modification compared with reference group




| Comparison | Asian 18-44 yrs | NHOPI 18-44 yrs | Asian 45-64 yrs | NHOPI 45-64 yrs | Asian 65+ yrs | NHOPI 65+ yrs |
|---|---|---|---|---|---|---|
| Worse | 0 | 0 | 0 | 0 | 0 | 0 |
| Same | 3 | 5 | 4 | 4 | 4 | 6 |
| Better | 3 | 0 | 2 | 2 | 2 | 0 |

*Reference group:* Non-Hispanic White Veteran VHA patients of corresponding age group
*Source:* Health Equity/QUERI Partnered Evaluation Center analysis of EPRP FY2016 – FY2019 data

*Note:* NHOPI denotes Native Hawaiian or other Pacific Islander

Importance:

- Lifestyle modification is an important part of the prevention and treatment of disease.[9]

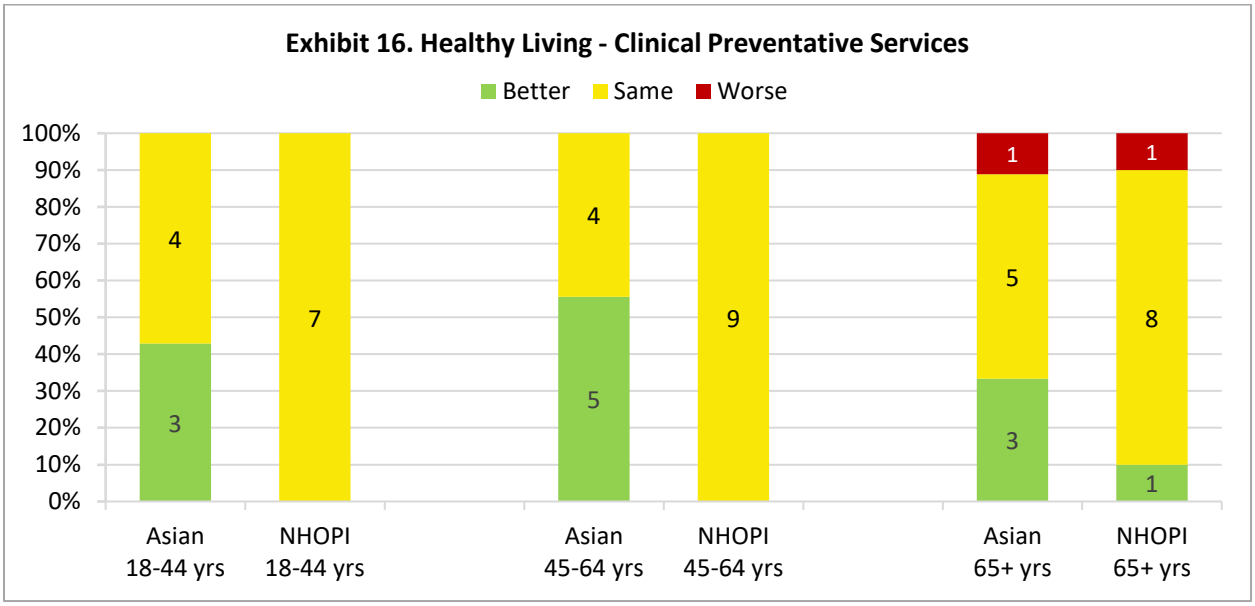
Findings:

- On all measures of lifestyle modification for healthy living, NHOPI Veterans ages 18-44 had the same experience as non-Hispanic White Veterans. On measures of lifestyle modification for healthy living, Asian Veterans report greater achievement of lifestyle modification on 3 measures and the same on 3 measures.
- Asian and NHOPI Veterans ages 45-64 each experienced greater lifestyle modification experiences across 2 measures compared to non-Hispanic White Veterans, and the same lifestyle modification experiences across 4 measures.
- Asian Veterans ages 65+ reported greater achievement of lifestyle modification across 2 measures compared to non-Hispanic White Veterans and the same for 4 measures.

- NHOPI Veterans reported the same lifestyle modification measures as non-Hispanic White Veterans.

## Variations in VHA Health Care Quality of Healthy Living – Clinical Preventive Services by Veteran Race/Ethnicity

Exhibit 16. Number and percentage of measures for which racial/ethnic minority Veteran VHA patients of specified age groups experienced better, same, or worse healthy living – clinical preventive services compared with reference group




| Comparison | Asian 18-44 yrs | NHOPI 18-44 yrs | Asian 45-64 yrs | NHOPI 45-64 yrs | Asian 65+ yrs | NHOPI 65+ yrs |
|---|---|---|---|---|---|---|
| Worse | 0 | 0 | 0 | 0 | 1 | 1 |
| Same | 4 | 7 | 4 | 9 | 5 | 8 |
| Better | 3 | 0 | 5 | 0 | 3 | 1 |

*Reference group:* Non-Hispanic White Veteran VHA patients of corresponding age group
*Source:* Health Equity/QUERI Partnered Evaluation Center analysis of EPRP FY2016 – FY2019 data

*Note:* NHOPI denotes Native Hawaiian or other Pacific Islander

Importance:

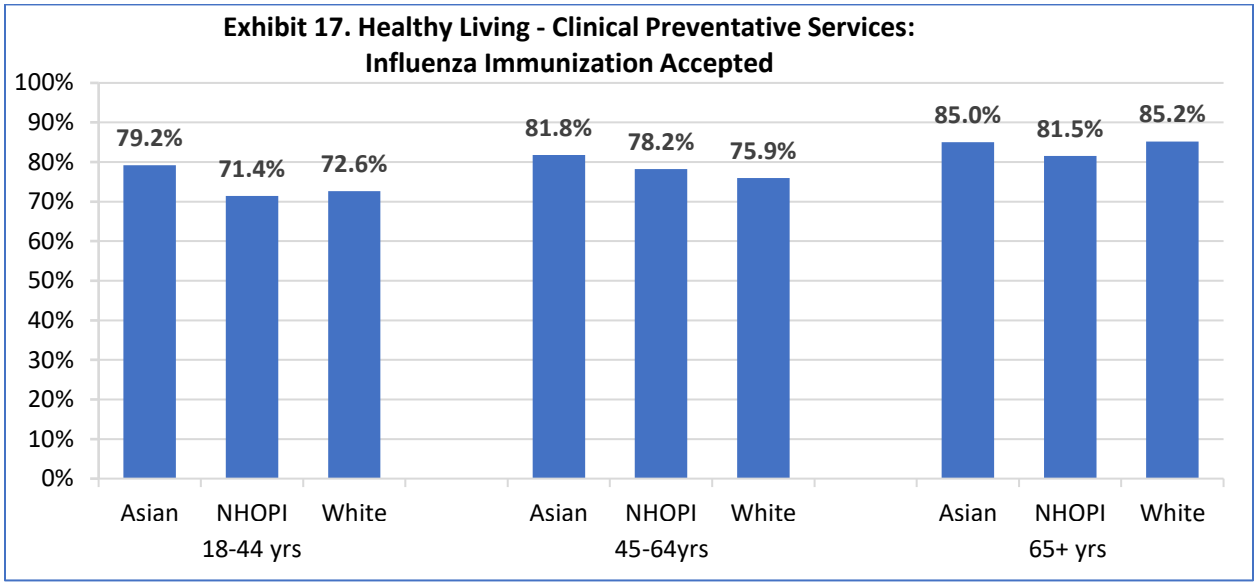
- Clinical preventive services are an essential part of maintaining health and preventing disease. [9, 10]

Findings:

- Asian Veterans ages 18-44 received better (more) clinical preventive services on 3 measures and the same on 4 measures compared with non-Hispanic White Veterans.
- Asian Veterans ages 45-64 received better (more) preventive services compared with non-Hispanic White Veterans on 5 measures and received the same preventative services on 4 measures.
- Among NHOPI Veterans, both those ages 18-44 and those ages 45-64 experienced the same receipt of clinical preventative services as non-Hispanic White Veterans of their respective age groups.

- Asian Veterans ages 65+ received the same clinical preventative services as non-Hispanic White Veterans for 5 measures, better (more) for 4 measures, and worse (less) for 1 measure. NHOPI Veterans ages 65+ received the same preventative services as non-Hispanic White Veterans for 8 measures, better (more) for 1 measure, and worse (less) for 1 measure.

Exhibit 17. VHA patients who accepted influenza immunization. [Note: This measure was assessed FY2017-FY2019]




| Age | Asian | NHOPI | White |
|---|---|---|---|
| 18-44 years | 79.2% | 71.4% | 72.6% |
| 45-64 years | 81.8% | 78.2% | 75.9% |
| 65+ years | 85.0% | 81.5% | 85.2% |

*Reference group:* Non-Hispanic White Veteran VHA patients of corresponding age group
*Source:* Health Equity/QUERI Partnered Evaluation Center analysis of EPRP FY2016 – FY2019 data

*Note:* NHOPI denotes Native Hawaiian or other Pacific Islander

Importance:

- Vaccination can prevent influenza and reduce influenza-related morbidity and mortality.[11]

Findings:

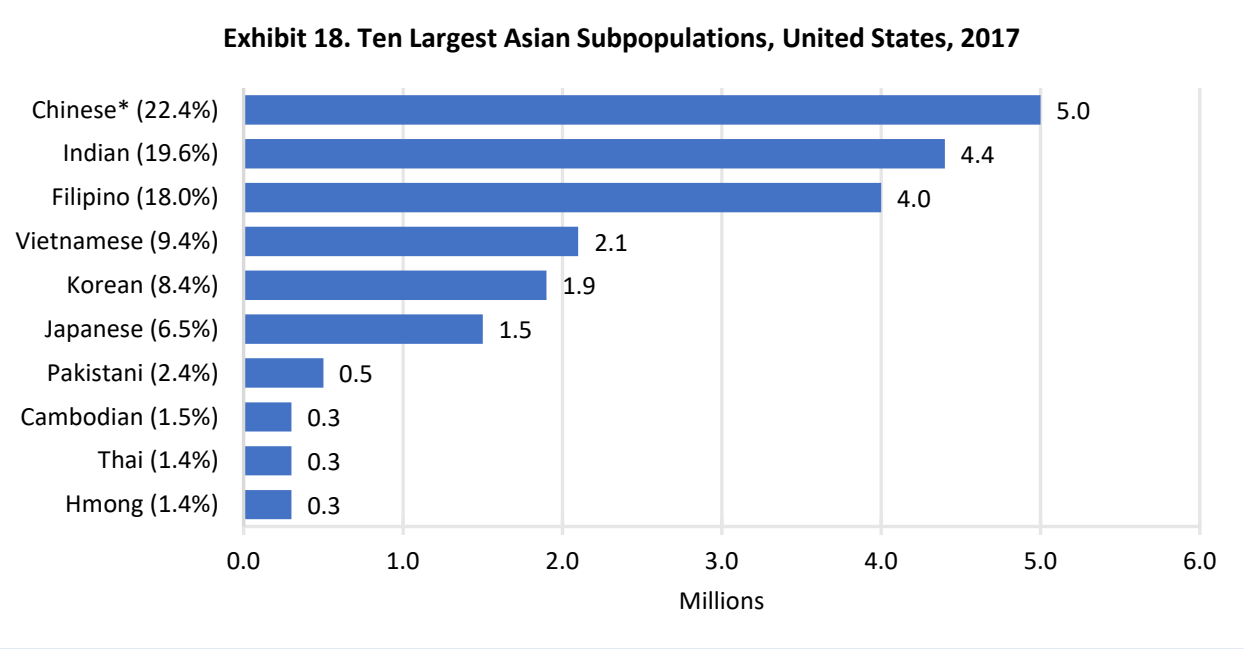
- Among Veterans ages 18-44, compared with non-Hispanic White Veterans (72.6%), Asian Veterans (79.2%) had higher rates of influenza immunization, whereas NHOPI Veterans (71.4%) had similar rates.
- Among Veterans ages 45-64, compared with non-Hispanic White Veterans (75.9%), Asian Veterans (81.8%) had higher rates of influenza immunization, whereas NHOPI Veterans (78.2%) had similar rates.
- Among Veterans ages 65+, compared with non-Hispanic White Veterans (85.2%), Asian Veterans (85.0%) had similar rates of influenza immunization, whereas NHOPI Veterans (81.5%) had lower rates.

## Section V: Granular Ethnicity

There is a large amount of heterogeneity among Asian American and NHOPI populations. VHA does not gather information on granular ethnicities systematically in its electronic health records. Additional work is needed to gather this information from Veterans, but such information could be very useful for understanding and reducing inequities experienced by Asian American and NHOPI Veterans.

Of the overall U.S. Asian American population, in 2017 (Exhibit 18), the Chinese subpopulation was the largest (22.4%), while the Hmong subpopulation was the smallest (1.4%). Among the U.S. Native Hawaiian and Other Pacific Islander population (Exhibit 19), the Native Hawaiian subpopulation was the largest (41.9%), while the Marshallese subpopulation was the smallest (2.4%). There are more than a dozen different subpopulations that are distinct from one another, and each group faces different challenges.

Exhibit 18. Ten Largest U.S. Asian Subpopulations, 2017

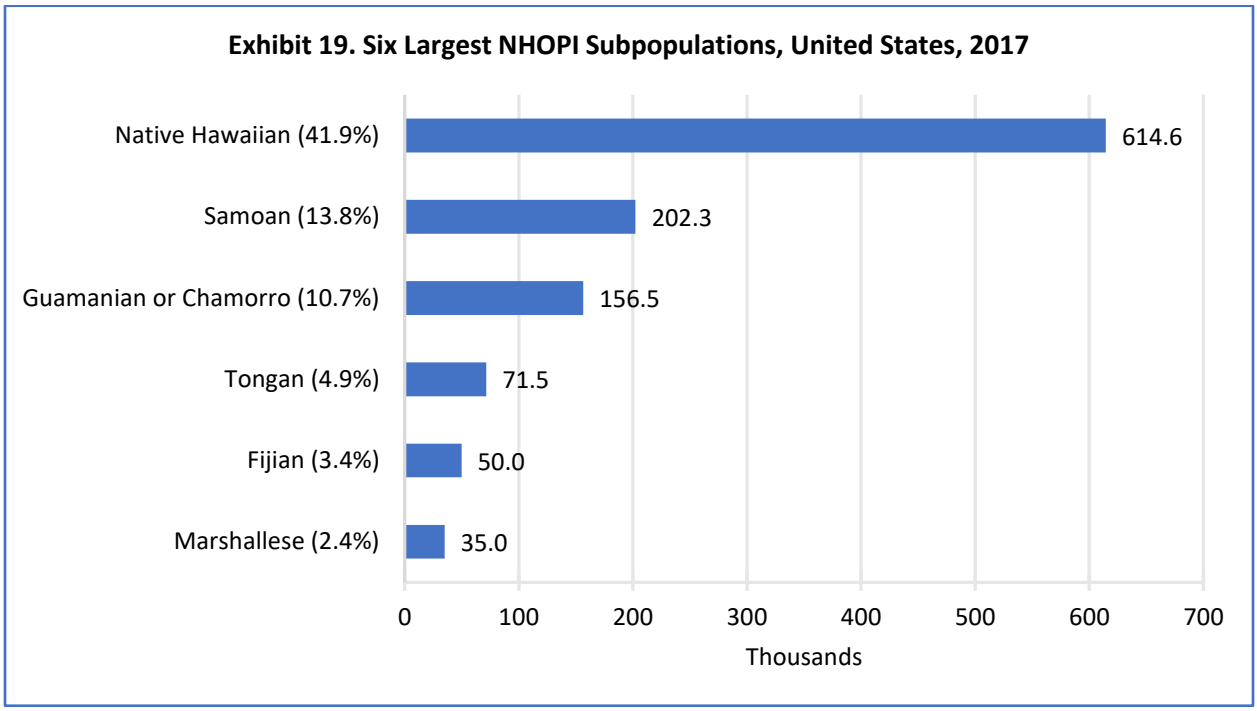



| Subpopulation | Percentage of subpopulation in total U.S. Asian population | Count in millions of subpopulations in total U.S. Asian population |
|---|---|---|
| Chinese* | 22.4% | 5.0 |
| Indian | 19.6% | 4.4 |
| Filipino | 18.0% | 4.0 |
| Vietnamese | 9.4% | 2.1 |
| Korean | 8.4% | 1.9 |
| Japanese | 6.5% | 1.5 |
| Pakistani | 2.4% | 0.5 |
| Cambodian | 1.5% | 0.3 |
| Thai | 1.4% | 0.3 |
| Hmong | 1.4% | 0.3 |

*Excluding Taiwanese

*Source:* Agency for Healthcare Research and Quality, Chartbook on the Healthcare of Asians and Native Hawaiian/Pacific Islanders. 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau. Data include individuals reporting one race alone or in combination with another race. Individuals reporting two or more races comprise 3.3 percent of the total population. Percentages represent each subpopulation as a percentage of the sum of all subpopulations. Because people may have identified with two or more subpopulations, the sum of subpopulations may exceed the total Asian population.

Exhibit 19. Six Largest U.S. Native Hawaiian and other Pacific Islander Subpopulations, 2017



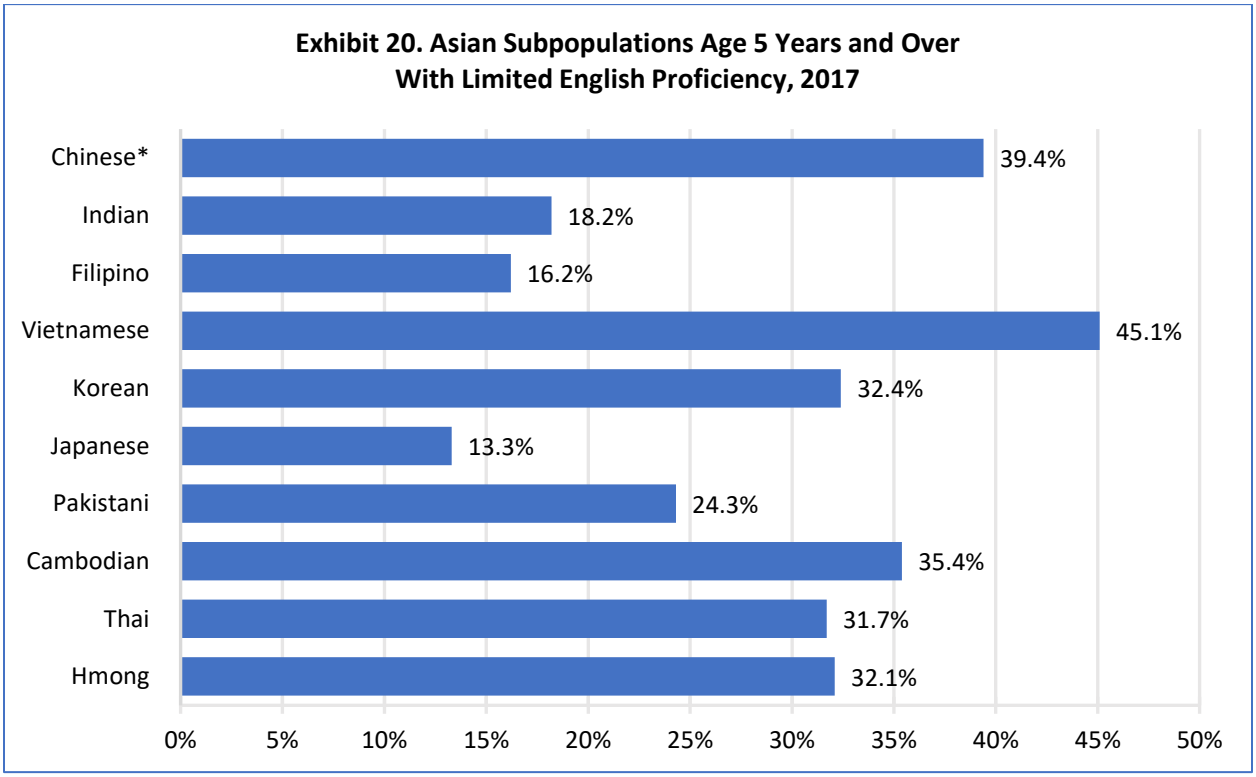

| Subpopulation | Percentage of subpopulation in total U.S. NHOPI population | Count of subpopulation in total U.S. NHOPI population, rounded to nearest thousand |
|---|---|---|
| Native Hawaiian | 41.9% | 614,600 |
| Samoan | 13.8% | 202,300 |
| Guamanian or Chamorro | 10.7% | 156,500 |
| Tongan | 4.9% | 71,500 |
| Fijian | 3.4% | 50,000 |
| Marshallese | 2.4% | 35,000 |

*Source:* Agency for Healthcare Research and Quality, Chartbook on the Healthcare of Asians and Native Hawaiian/Pacific Islanders. 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau.

*Note:* Data include individuals reporting one race alone or in combination with another race. Individuals reporting two or more races make up 3.3 percent of the total population. Percentages represent each subpopulation as a percentage of the sum of all subpopulations. Because people may have identified with two or more subpopulations, the sum of subpopulations may exceed the total NHOPI population.

One challenge many in these groups face is limited English proficiency. The U.S. Vietnamese subpopulation had the highest percentage of those age 5 years and over with limited English proficiency (45.1%), while the Japanese subpopulation had the lowest (13.3%). Many groups in this population, including the Chinese, Korean, Thai, and Hmong subpopulations had percentages for limited English proficiency above 30% (39.4%, 32.4%, 31.7%, and 32.1%, respectively). The NHOPI faced similar challenges on a lesser scale. The Tongan subpopulation had the highest percentage of limited English proficiency (12.7%), while the Native Hawaiian subpopulation had the lowest (2.0%).

Exhibit 20. U.S. Asian Subpopulations Age 5 Years and Over with Limited English Proficiency, 2017



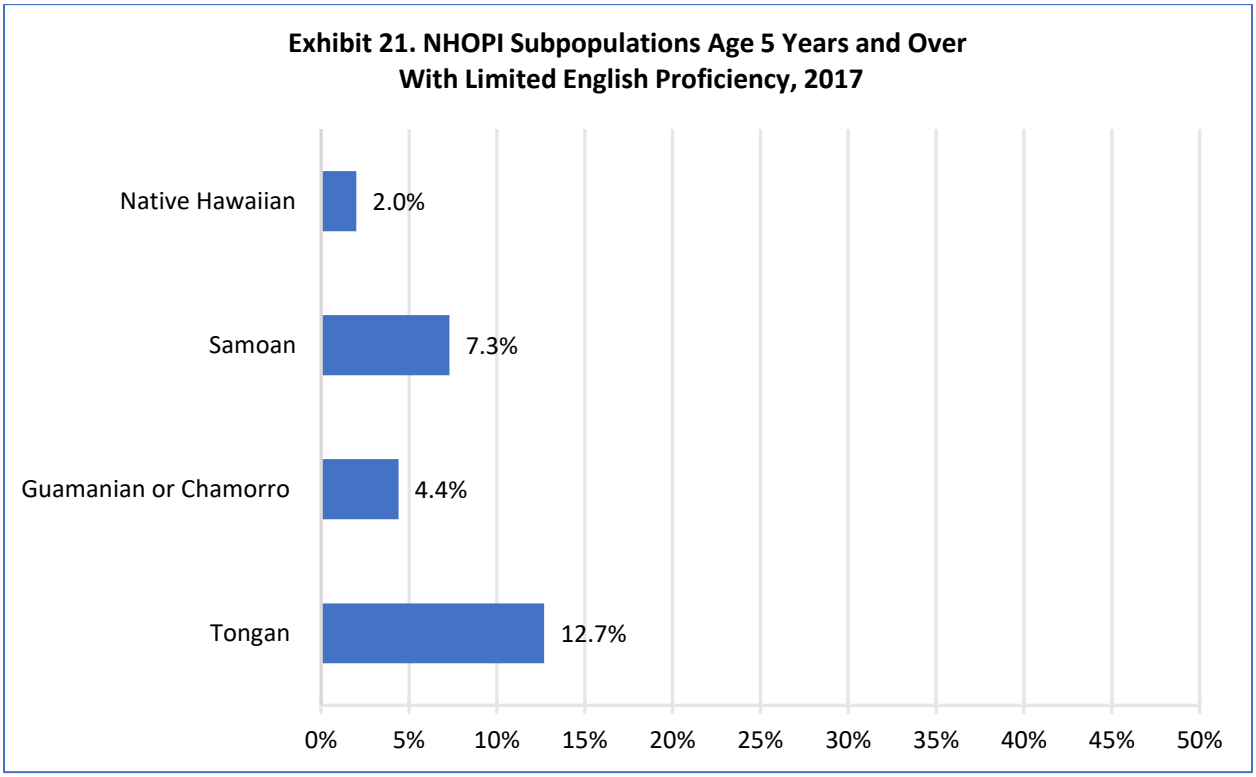

| Subpopulation | Subpopulation 5 years and over with limited English proficiency |
|---|---|
| Chinese* | 39.4% |
| Indian | 18.2% |
| Filipino | 16.2% |
| Vietnamese | 45.1% |
| Korean | 32.4% |
| Japanese | 13.3% |
| Pakistani | 24.3% |
| Cambodian | 35.4% |
| Thai | 31.7% |
| Hmong | 32.1% |

*Excluding Taiwanese

*Source:* Agency for Healthcare Research and Quality, Chartbook on the Healthcare of Asians and Native Hawaiian/Pacific Islanders. 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau.

*Note:* Data include individuals reporting one race alone or in combination with one or more races. Limited English proficiency is defined as people who speak English less than "Very well." Those who speak only English at home are not asked to rate their English proficiency.

Exhibit 21. U.S. Native Hawaiian and other Pacific Islander Subpopulations Age 5 Years and Over with Limited English Proficiency, 2017




| Subpopulation | Subpopulation 5 years and over with limited English proficiency |
|---|---|
| Native Hawaiian | 2.0% |
| Samoan | 7.3% |
| Guamanian or Chamorro | 4.4% |
| Tongan | 12.7% |

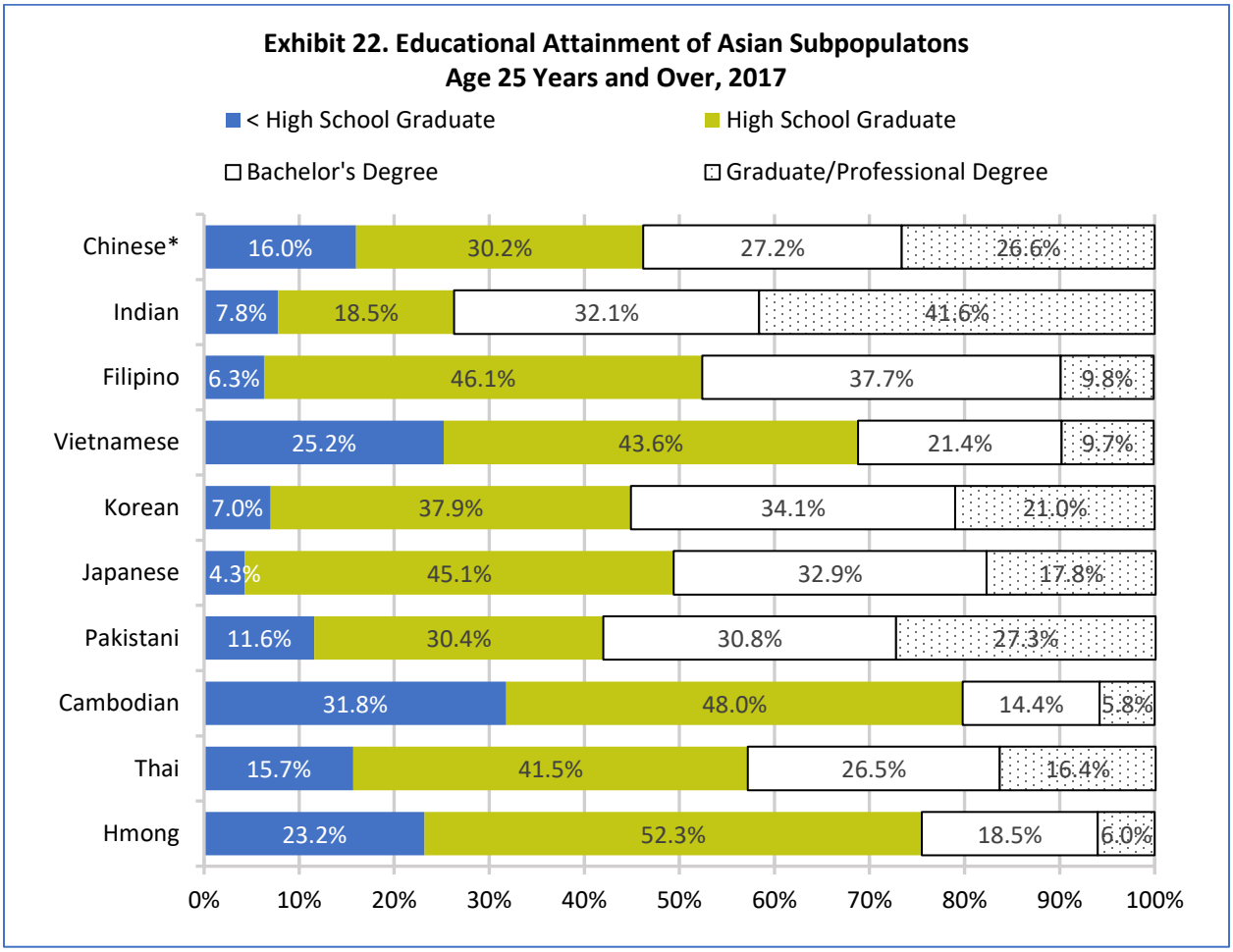
*Source:* Agency for Healthcare Research and Quality, Chartbook on the Healthcare of Asians and Native Hawaiian/Pacific Islanders. 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau.

*Note:* Data include individuals reporting one race alone or in combination with one or more races. Limited English proficiency is defined as people who speak English less than "Very well." Those who speak only English at home are not asked to rate their English Proficiency. Data are not available for Fijian and Marshallese populations due to low data reliability.

The educational differences between each subpopulation are vast as well. Among the U.S. Asian population age 25 years and over, the Cambodian subpopulation had the highest percentage of those with less than a high school diploma (31.8%), while the lowest subpopulation was the Japanese subpopulation (4.3%). The trend for those with a graduate/professional degree was different: the Indian subpopulation had the highest percentage (41.6%), and the Cambodian subpopulation had the lowest (5.8%). The NOHPI population showed less of a range. The subpopulation with the highest percentage of those with

less than a high school diploma was the Tongan subpopulation (11.8%), and those with the lowest percentage was the Native Hawaiian subpopulation (7.0%).

Exhibit 22. Educational Attainment of U.S. Asian Subpopulations Age 25 Years and Over, 2017



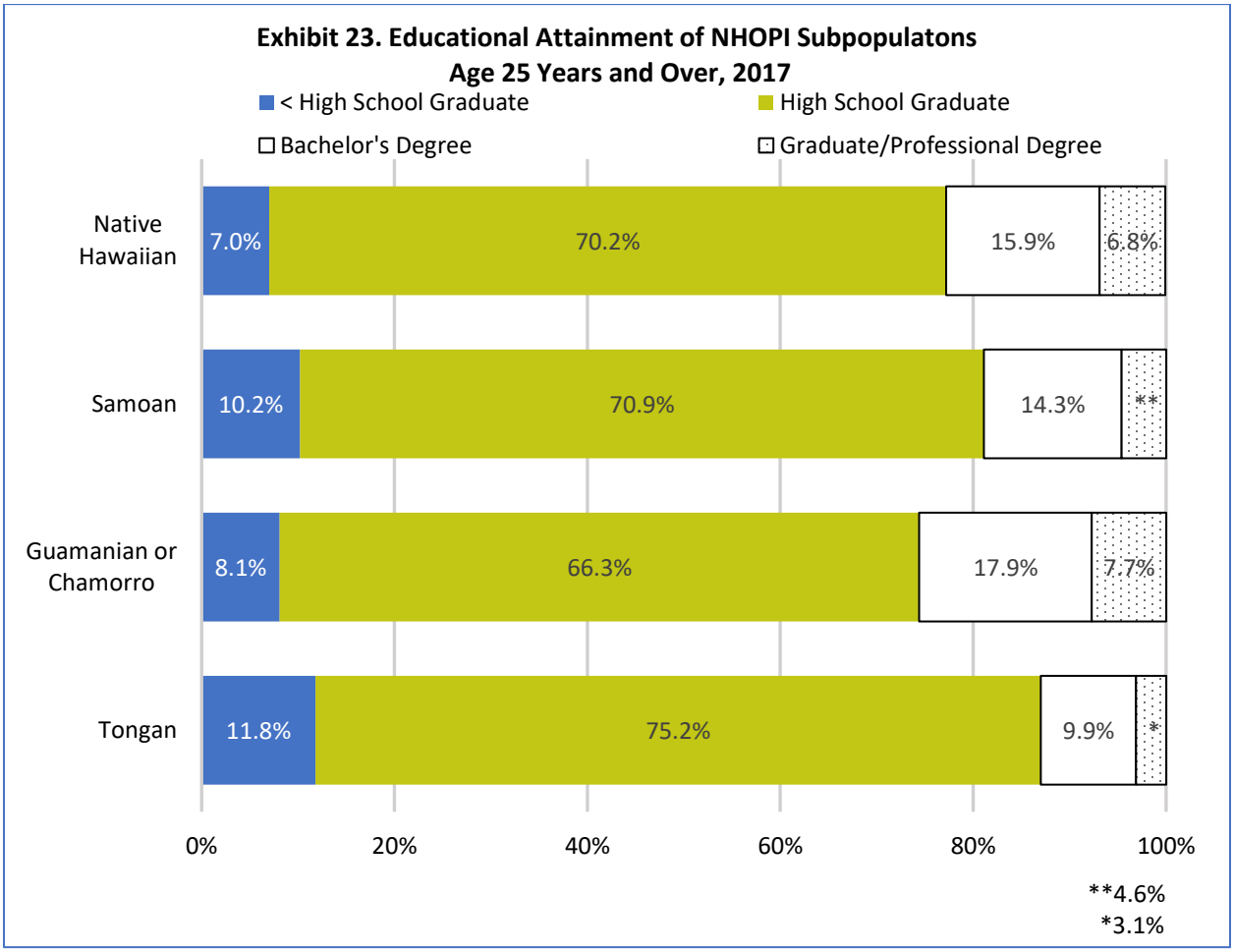

| Subpopulation | < High School Graduate | High School Graduate | Bachelor's Degree | Graduate/Professional Degree |
|---|---|---|---|---|
| Chinese* | 16.0% | 30.2% | 27.2% | 26.6% |
| Indian | 7.8% | 18.5% | 32.1% | 41.6% |
| Filipino | 6.3% | 46.1% | 37.7% | 9.8% |
| Vietnamese | 25.2% | 43.6% | 21.4% | 9.7% |
| Korean | 7.0% | 37.9% | 34.1% | 21.0% |
| Japanese | 4.3% | 45.1% | 32.9% | 17.8% |
| Pakistani | 11.6% | 30.4% | 30.8% | 27.3% |
| Cambodian | 31.8% | 48.0% | 14.4% | 5.8% |
| Thai | 15.7% | 41.5% | 26.5% | 16.4% |
| Hmong | 23.2% | 52.3% | 18.5% | 6.0% |

*Excluding Taiwanese

*Source:* Agency for Healthcare Research and Quality, Chartbook on the Healthcare of Asians and Native Hawaiian/Pacific Islanders. 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau.

*Note:* Data include individuals reporting one race alone or in combination with one or more races.

Exhibit 23. Educational Attainment of U.S. Native Hawaiian and other Pacific Islander Subpopulations Age 25 Years and Over, 2017




| Subpopulation | < High School Graduate | High School Graduate | Bachelor's Degree | Graduate/Professional Degree |
|---|---|---|---|---|
| Native Hawaiian | 7.0% | 70.2% | 15.9% | 6.8% |
| Samoan | 10.2% | 70.9% | 14.3% | 4.6% |
| Guamanian or Chamorro | 8.1% | 66.3% | 17.9% | 7.7% |
| Tongan | 11.8% | 75.2% | 9.9% | 3.1% |

*Source:* Agency for Healthcare Research and Quality, Chartbook on the Healthcare of Asians and Native Hawaiian/Pacific Islanders. 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau.

*Note:* Data include individuals reporting one race alone or in combination with one or more races. Data are not available for Fijian and Marshallese subpopulations due to low data reliability.

# Section VI: Conclusions

Asian American and NOHPI Veterans often report more problems with access to care, person-centered care, and care coordination compared with White Veterans. Fewer differences are evident among health care quality measures. Analyses are limited by the dearth of information on granular ethnicities among Asian American and NOHPI Veterans.

Work is needed to improve the Veteran experience of care among Asian American and NOHPI Veterans. Better information on Asian American and NOHPI Veterans, including granular ethnicity, could be helpful in understanding and addressing observed disparities.

# Appendix: Brief Overview of Methods and Guidelines for Interpretation

These chapters rely on centralized analyses of VA administrative data for FY2016 – FY2019 (October 1, 2015, through September 30, 2019). Veteran sociodemographic characteristics and medical diagnoses were derived from the administrative and electronic health record (EHR) data in the Corporate Data Warehouse. Patient experience measures were derived from Survey of Healthcare Experiences of Patients (SHEP)-Patient Centered Medical Home surveys for FY2016 – FY2019. Quality measures were obtained from the External Peer Review Program (EPRP).

We created separate SHEP and EPRP cohorts. For each of these cohorts, we linked the four fiscal years of data; for individuals with observations in more than one year, we retained only the most recent year of data. We next linked Veteran characteristics from the VA administrative data and EHR. For time varying measures, e.g., age, we used the fiscal year of administrative data that corresponded to the SHEP or EPRP record.

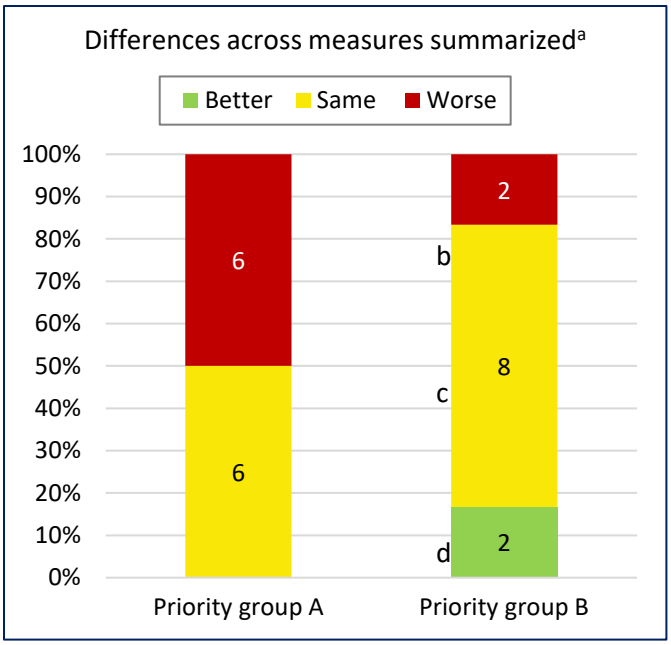
To facilitate comparisons between VHA data and publicly available data representing the U.S. population, we report race and ethnicity groups as mutually exclusive. All individuals with indication of Hispanic ethnicity are included in the "Hispanic" race/ethnicity group regardless of their race, and the remaining race/ethnicity groups contain Veteran patients who have identified as "non-Hispanic." For simplicity, the label identifies only the race. For example, "White" is used as shorthand for non-Hispanic White, and "Asian" and "NHOPI" are non-Hispanic Asian and non-Hispanic NHOPI Veterans, respectively.

To analyze data, we first aligned metrics so that for all measures a higher rate indicated better patient experiences or better quality. We next dichotomized responses to the response corresponding to the best care versus all other responses. We stratified all cohorts by age group (18-44 years; 45-64 years; and 65+ years), then conducted age-stratified analyses, comparing each priority (comparison) group and reference group within an 18-44 years, 45-64 years, and 65+ years strata. Several of the quality measures only applied to certain age groups, and therefore some groups (generally, the 18–44-year age group) had fewer comparisons.

To categorize a difference as a disparity (or an advantage, if the difference favored the priority group), we applied two criteria for a meaningful difference: an absolute difference that was statistically significant with a p-value <0.05 on a two-tailed test, AND a relative difference of at least 10%, where the relative difference is the difference between the priority group gap in care and the reference group gap in care, divided by the reference group gap in care. Both criteria had to be satisfied for a difference to be categorized as a disparity. These criteria are based on the standard applied by the Agency for Healthcare Research and Quality (AHRQ) in their annual National Healthcare Quality and Disparities Report for the U.S. population.[12]

The format for presenting comparisons between priority groups and the reference group for each patient experience domain of care or quality domain of care is to use 100% stacked bar graphs. For each domain (e.g., person-centered care) and priority group, the number and percent of measures for which the priority group has better, same, or worse outcomes compared to the reference group is summarized in the 100% stacked bar graph. The example below illustrates comparisons for a Veteran characteristic where there are two priority groups. In this example, there are 12 measures in the domain.

Exhibit 24. Illustration of Domain Summary Figure




| Comparison | Priority group A | Priority group B |
|---|---|---|
| Worse | 6 | 2 |
| Same | 6 | 8 |
| Better | 0 | 2 |

[a] 12 measures in this domain

[b] Priority group B has worse outcomes on 2 measures (17% of measures) compared to the reference group (i.e., does better or same on 83% of measures in this domain)

[c] Group B has same outcomes on 8 measures

[d] Group B has better outcomes on 2 measures

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