

FORUM

VA HEALTH SERVICES RESEARCH & DEVELOPMENT

JUNE 2000

DIRECTOR'S LETTER

This issue of Forum highlights the importance that HSR&D places on special populations. The homeless and, to some extent, racial minorities and women receive less care and fewer procedures in the VA than do their Caucasian male counterparts. The difficult question that the VA must address is: Why is this occurring?

HSR&D is attempting to answer this and related questions through a series of studies. During the past four years, just under \$6 million has been committed to investigating causes of disparity. We have highlighted several ongoing studies in this issue, some of which include interventions for narrowing these differences.

One important study investigates why African American patients both within and outside VA are less likely than whites to receive carotid endarterectomy to prevent ischemic stroke. With the growing number of women serving in active duty over the past two decades, another highlighted study looks at women's health needs and what's required of VA to provide quality health care to women. Interventions that reach out and provide care to homeless veterans are critical. Another study looks at the case management and residential treatment programs for the homeless and still another looks at how racial and ethnic differences affect access and utilization of VA ambulatory care.

HSR&D will continue to look for causes and interventions that will help eliminate disparities among groups of veterans and that aim to provide the highest quality health care to all veterans.

*John G. Demakis, M.D.
Director, VA HSR&D Service*

COMMENTARY

Special Populations and the VA: Serving Veterans in a Multi-Cultural Society

*By Robert H. Roswell, M.D., Network Director, VISN 8, and
John Dandridge, Jr., Network Director, VISN 9*

VA is the largest health care delivery system in the world; it may also be the most diverse. We serve people of virtually all races and cultural backgrounds, including African Americans, Hispanic Americans, Native Americans, Asians and Pacific Islanders, and whites. In addition, we are serving growing numbers of women. Going beyond race and gender, VA also provides services to many patients who are poor and have no other source of care. These patients frequently have special needs, and a significant number of them are homeless.

VA's mission is to provide the best possible care to all American veterans. Yet our own research has documented substantial racial, ethnic, and gender-based variations in care within the VA service population. As a result, we know that many veterans — for a variety of reasons, some of which are rooted in socio-economic factors — are not getting needed services. But there is still a great deal that we do not know, because solid evidence on the causes and implications of these variations is lacking.

Sweeping changes within VA highlight key steps that VA has taken to address this issue — and, at the same time, underscore the need to do even more. Fueled by the vision of former VA Under Secretary for Health Kenneth Kizer and aided by new eligibility legislation, VA during the past few

years has evolved from an archaic collection of hospitals into a comprehensive, state-of-the-art health care system. Greater emphasis on outpatient-based primary care and hundreds of new community-based clinics have helped make the VA system more accessible to our patients.

Our own research has documented substantial racial, ethnic, and gender-based variations in care within the VA service population.

Not only do veterans have better access to the VA health care system, but VA providers also have better access to their veteran patients, in terms of their ability to treat the whole patient and not just his or her service-connected condition, thanks to recent eligibility reform legislation. As a result, for the first time in VA's history, we have the opportunity to focus on preventive care and services, and a new opportunity to more fully address the health of our nation's veteran population.

Coupled with these changes, we have made tremendous strides in our ability to monitor the health

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care delivery process. With the help of new clinical practice guidelines and clinical outcomes monitoring systems, we can track the effects of an array of preventive services and chronic disease interventions that are now routinely provided to our veteran patients.

Despite Progress, Challenges Remain

Clearly, when we improve the system as a whole, all of our patients benefit. But we have to do even more if we are to fully meet the needs of all veterans. We must couple the significant improvements in our infrastructure and regulatory environment with an equally expansive understanding of the cultural, gender-based, and ethnic influences on veterans' preferences, utilization, and outcomes associated with health care delivery. Without this vital knowledge, our efforts to provide high-quality, patient-focused care will fall short.

Several studies have documented that access to primary care services is associated with better health status, and, more importantly, that the severe adverse effects of income inequalities on health can largely be eliminated by providing primary care. Unfortunately, other studies have shown significant variations based on ethnicity and period of military service in the utilization of VA ambulatory care. Still other studies have documented racial differences in adherence to treatment regimens. As a result, it seems reasonable to conclude that at least some veterans are not realizing the full health benefits of VA's effort to make primary care universally available. More research is needed to clarify these differences in utilization, ascertain their root cause, and implement programs or services that can overcome them.

We must also make an effort to understand differences in clinical outcomes and their implications.

For example, the increased incidence of hypertension and the greater severity of strokes in African Americans is well documented. Yet VA researchers have shown that this group of veterans, who ostensibly have a greater need for clinical intervention, actually receive carotid endarterectomy less frequently than their white counterparts. Part of the reason is a greater aversion among African Americans to this procedure. Although clinician education, practice guideline modification, greater diversity in provider staff, and other interventions are all possible solutions to this problem, our top priority should be to clarify causation. Only through sound research can we devise effective strategies for eliminating these types of racial and ethnic differences in clinical outcomes.

Diversifying the VA Workforce

We must also take a harder look at our workforce. Research indicates that diversity in the general health care workforce affects access to care. For example, several studies have shown that minority physicians are much more likely than non-minority physicians to serve those patients who have the most difficulty getting care: minorities and the poor. In addition, minority patients appear to prefer providers who can relate to them culturally. These findings carry implications for VA as well. We need to consider the composition and deployment of our workforce.

VA has attempted to address this issue in its recruitment of facility and clinical directors whose racial and ethnic backgrounds reflect the communities they are being asked to serve. It is difficult to say whether we have gone far enough in enough areas, especially with respect to communities that have large Spanish-speaking populations. VA is probably doing as much as any other organization in this area – maybe more. But the reality is that more may need to be done.

These are difficult issues to deal with effectively. In fact, outside VA, we are seeing an alarming retreat from efforts to encourage diversity. Several states, for example, have enacted laws ending affirmative action in state university medical education programs. It will probably get worse before it gets better.

Only through sound research can we devise effective strategies for eliminating these types of racial and ethnic differences in clinical outcomes.

VA has an opportunity to provide strategic leadership on medical workforce diversity and shed light on how diverse populations are affected by workforce composition. What we need, first of all, is a didactic root cause analysis of the factors that contribute to our inability to address workforce diversity at the research and policy levels.

We will make better progress if we can advocate outside the box: taking account of those barriers to care that are part of the broader environment in which VA operates and doing what we can to remove them. For example, how does managed care, with its emphasis on cost containment, affect minority populations, which, because of socio-economic factors, are frequently more expensive to serve than other populations? By looking at the broader picture, VA ultimately can become a more effective agent for change.

Research underway within VA's HSR&D will help provide answers to some of these questions. VA has a unique opportunity to improve the health and well-being of all of our nation's veterans. It will not be easy work, but it is necessary work. Our patients deserve no less.

RESPONSE

The Role of HSR&D in Shedding Light on Health Disparities

By Eugene Oddone, M.D., M.H.Sc., Center for Health Services Research in Primary Care, Durham VAMC, and Jay Freedman, Ph.D., VA HSR&D

Concurrent with its special obligation to achieve equity in health care delivery, VA has a history of helping the nation understand the complex reasons for racial and ethnic variations in care. VA investigators were among the pioneers in identifying where these disparities occurred, uncovering significant disparities in the receipt of invasive cardiovascular procedures, screening tests, utilization of primary care services, treatment for mental health disorders, and other health care services. This early research was instrumental in raising national awareness of treatment disparities in an equal access health care system, where the financing of health care did not confound the observed differences.

The VA HSR&D Service was quick to embrace these findings, launching a special research initiative to support projects that would go beyond the simple observation of differences and explore their root causes. Since 1996, 10 projects throughout the country have been funded to address areas of access to care, health care-seeking behavior, complex medical decision making, and the impact of provider recommendations on receipt of care. This represents a commit-

ment of just under \$6 million to investigate disparities among patient groups that include African Americans, Hispanic Americans, American Indians, and Asians and Pacific Islanders.

Other organizations have followed VA's lead. A major new component of the Department of Health and Human Services' *Healthy People 2010* program sets specific goals for reducing ethnic and racial differences in six specific areas: infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV infection/AIDS, and immunizations.

To achieve equity in access to care and improve health outcomes, we must now move beyond the first generation of descriptive studies to test interventions designed to achieve parity. Effective interventions are likely to be multidimensional and must be tested within a wider context of race relations. This makes our overall goal both complex and, at times, politically sensitive. Successful interventions must take into account a wider range of factors, some of which are difficult to measure, including clinical appropriateness, patients' preferences, cultural differences in

communication and health literacy, and the role of providers.

Although it is difficult to define the extent to which prejudice accounts for racial differences in health care, we must explore the nature of patient-provider interaction more fully. We must also consider the extent to which improving the cultural competency of health care providers leads to reduced racial disparities in health care.

VA has a long tradition of leadership in the area of race and health. Our large and racially diverse population is unencumbered by the financial forces that often cloud the picture of race research in other health care settings. This makes the VA system the perfect laboratory to test and export effective interventions. In the same way that VA achieved the goals of *Healthy People 2000* ahead of any other health care agency, we are poised to embrace the more difficult goals of achieving parity in the areas defined in *Healthy People 2010*. In partnership with patients, providers, administrators, and health service researchers, we can help the nation understand the importance of achieving parity in care for all its people.

SGIM Recognizes HSR&D's Shirley Meehan with Elnora M. Rhodes Award

HSR&D Deputy Director Shirley Meehan, M.B.A., Ph.D., who played a critical role in building HSR&D's career development program and supporting primary care research at VA, is the recipient of the prestigious Elnora M. Rhodes SGIM Service Award for the year 2000. The Society of General Internal Medicine presents the annual award to an individual for outstanding service to the society and to its mission of advancing patient care, research, and education in primary care internal medicine.

Stephan Fihn, M.D., M.P.H., Past President of SGIM and current Director of the HSR&D Center of

Excellence in Seattle, presented the award. He noted Dr. Meehan's tireless work on behalf of the many SGIM members who call VA home for their clinical activities and health services research. Dr. Meehan joined HSR&D in 1972 and has since helped develop and guide HSR&D programs that contribute to quality health care in VA. "This year's Rhodes award," Dr. Fihn said, "recognizes [Dr. Meehan's] steadfast service." Dr. Meehan thanked HSR&D leaders for their support, and urged SGIM members who are interested in health services research to consider VA HSR&D.

R **RESEARCH HIGHLIGHT**

HSR&D Study Investigates Racial Differences in Use of Carotid Endarterectomy

*By Eugene Oddone, M.D., M.H.Sc.,
Center for Health Services Research in Primary Care, Durham VAMC*

Stroke is the third leading cause of death and a leading cause of disability among adults in the U.S. Of the approximately 750,000 people who have a stroke every year, about one-third die. Half of those who survive have significant residual disabilities.

African Americans are at higher risk of stroke than whites, and recent reports indicate that stroke mortality among African Americans may be increasing. Although new treatments for acute stroke seem promising, preventive practices are particularly important for reducing overall disease burden. Carotid endarterectomy (CE) is known to be effective in preventing ischemic stroke for many patients with high-grade carotid artery stenosis. Despite their higher risk for stroke, African American patients both within and outside VA are only one-third to one-fourth as likely as whites to receive CE.

Led by a research team in Durham, VA HSR&D investigators recently shed new light on the underlying causes for the steep racial disparity in CE utilization. Using clinical appropriateness criteria for CE developed by RAND, they examined the interaction between patients' signs and symptoms as potential mediators in explaining the racial difference in CE use.

The study enrolled 803 patients from four geographically diverse VA medical centers who had a diagnosis of stroke or transient ischemic attack. Half of the patients were white and half were African American. African Americans were more likely than white patients to present with stroke (78 percent versus 55 percent) but less likely to present with transient ischemic attack (22 percent versus 45 percent). There was no racial difference in medical comorbidity or pre-operative risk.

The researchers found that many patients were missing a key diagnostic step in determining appropriateness for CE: African American patients were less likely to have an imaging study of their carotid arteries (67 percent versus 79 percent). Race remained an independent predictor of imaging, even after adjusting for important clinical factors. Because of the higher prevalence of significant carotid artery stenosis, however, whites were significantly more likely than African Americans to be assessed as appropriate candidates for surgery, using the RAND criteria (18 percent versus 4 percent).

These findings indicate that, after controlling for clinical presentation, patient race is still a significant influence on the decision to have carotid artery imaging, which is a critical step in determining eligibility for CE. Adjustment for appropri-

ateness of CE reduces but does not eliminate the importance of race.

It appears that patient preferences and racial dynamics in patient-physician communication may play important roles in explaining racial differences in use of CE. HSR&D researchers have found that African Americans appear to have a strong preference for less invasive care. In addition, other researchers outside VA have found that physicians may have different thresholds for referring patients for invasive tests that vary by race. HSR&D is funding studies to address these two important research questions. Results from these studies, expected this fall, will further advance our understanding of race and health. We will then need to fashion interventions directed at patients and/or physicians to fully achieve our goal of high-quality care for all patients.

Under Secretary's Award for Health Services Research Presented to Nelda Wray

Nelda P. Wray, M.D., M.P.H, received the year 2000 Under Secretary's Award for Outstanding Achievement in Health Services Research. Thomas L. Garthwaite, M.D., Deputy Under Secretary for Health, presented the award at the VA HSR&D Annual Meeting, March 22-24, in Washington, DC.

Dr. Wray is an active clinician, pre-eminent researcher, respected mentor, and vigorous contributor to HSR&D. This award recognizes her outstanding career accomplishments, particularly her work on the use of administrative databases to assess and improve the quality and effectiveness of health care, and the development of techniques to better understand patient preferences and incorporate them into health care decision making. Throughout an exceptional career, Dr. Wray has applied these methodologies to areas of particular importance to veterans, such as heart failure and prostate cancer. In addition, as a teacher and mentor she has inspired new investigators, while enhancing the visibility and reputation of VA research nationally. Continuing her work at the Houston Center of Excellence, Dr. Wray has created an environment and infrastructure that fosters interdisciplinary health services research.

R **RESEARCH HIGHLIGHT**

Homeless Veterans Benefit from Case Management and Residential Treatment Programs

By Robert Rosenheck, M.D., VA Northeast Program Evaluation Center and Yale Medical School

On any given night, as many as 250,000 American veterans sleep on the streets or in shelters. Perhaps twice as many experience homelessness over the course of a year. The veterans at highest risk for homelessness entered the military after the establishment of the All Volunteer Force in 1973. At that time, military service was unpopular and the prevalence of mental illness, including substance abuse and anti-social personality disorders, was higher among recruits than among civilians of similar age. Nearly 40 percent of homeless veterans suffer from severe, persistent, and disabling mental illnesses. Half of them also have substance abuse disorders.

The VA is the single largest direct care provider for homeless people in the U.S. It operates two major programs for homeless veterans: the Domiciliary Care for Homeless Veterans (DCHV) Program, which provides residential treatment on VA grounds, and the Health Care for Homeless Veterans (HCHV) programs, which emphasize community-based outreach and provide residential treatment through contracts with community agencies. Both programs grew out of the original Homeless Chronically Mentally Ill (HCMI) program.

The VA Northeast Program Evaluation Center (NEPEC), which has studied homelessness among veterans since 1987, has evaluated these programs and continues to monitor their operation. Participation in both is associated with significant improvement in psychiatric distress, alcohol and drug use, employment, and housing status. Duration of involvement in case management and participation in residential treatment were found to be associated with superior outcomes.

As part of an economic evaluation of the HCHV program, com-

prehensive cost data were obtained on 1,748 veterans from nine program sites. General VA health care costs, including inpatient and outpatient psychiatric and medical care, increased significantly, from \$6,414 per patient per year in the year before first outreach contact to \$7,269 in the year after entry. When HCMI program costs for case management (\$315) and residential treatment (\$1,115) were added, total per-patient costs in the year after first outreach contact rose to \$8,699. That represents a 35.6 percent increase from the previous year. These data show that, especially when effective, outreach can be costly. This is not surprising since the very reason for conducting outreach is to enhance access to services for the underserved.

A comparison was also made of veterans admitted to residential treatment and veterans who only received case management. Out-

comes were generally superior in the residential treatment group. General VA medical and mental health costs, exclusive of HCMI program costs, were not significantly different between those admitted to residential treatment (\$9,053/year) and those who were not (\$8,205/year). However, when special program costs for case management and residential treatment are included, costs for those admitted to residential treatment were substantially higher than for those who were not (\$13,693/year versus \$8,978/year). HCMI contract residential treatment is thus associated with significantly better outcomes at 53 percent greater cost.

Additional research is needed to identify other interventions that will foster exit from homelessness, long-term housing stability, and vocational rehabilitation. Evaluations of several programs designed to address those needs are underway.

HSR&D's Peter Ubel Garner's Presidential Award

Peter A. Ubel, M.D., is among the distinguished scientists to receive this year's Presidential Early Career Award for Scientists and Engineers. These awards recognize some of the finest scientists and engineers who, while early in their research careers, show exceptional potential for leadership at the frontiers of scientific knowledge. President Clinton describes the Presidential Award as "the highest honor bestowed by the U.S. government on outstanding scientists and engineers beginning their independent careers." The awards are conferred annually at the White House, following recommendations from participating agencies, which include the National Science Foundation, NASA, the Department of Veterans Affairs, the National Institutes of Health, and others.

Dr. Ubel's research explores the overlap between medical ethics and decision psychology. Specifically, he is interested in measuring moral attitudes toward health care rationing and in understanding how people faced with rationing dilemmas decide how to resolve their dilemmas. In addition to his many other awards and honors, Dr. Ubel is a recipient of VA's HSR&D Career Development Award.

PERSPECTIVE

Changing Role of Women Veterans Raises Issues About Health Care Service Delivery

By Joan Furey, Center for Women Veterans

Twenty-five years ago, the face of the U.S. military was virtually all male. But that is starting to change, not only as more women continue to enlist in the armed forces, but also as they take on increasingly responsible and diverse roles. This trend holds important implications for the development of VA health care benefits and delivery models.

Prior to 1973, women accounted for only 2 percent of the active duty military and the military occupations open to them were limited. Today, women make up more than 15 percent of the active duty forces and 20 percent of new recruits. Women are being deployed in greater numbers throughout the world, and in a wider variety of military occupations than ever before in the history of our country.

Today, women make up more than 15 percent of the active duty forces and 20 percent of new recruits.

VA projects that by the year 2010, women veterans will make up over 10 percent of the veteran population — more than double the current number. This increase, combined with questions surrounding the impact of military service on women’s health, explains why VA has designated women’s health as a special emphasis program

Over the last 15 years, VA has invested considerable effort in enhancing its programs for women. For the most part, these efforts have been very successful. During the past eight years, the number of women using VA health care pro-

grams has surged by 64 percent. Yet, as the VA reorganization continues, there is concern that the progress made in health care for women veterans will be lost and that, once again, women veterans will find themselves treated as “one of the boys.”

Support for Gender-Specific Care Wanes

Why the concern? With the implementation of the primary care treatment model, some VA facility directors felt that the general women’s health clinic was no longer necessary. Thus, women’s clinics were discontinued and women veterans were assigned to the new primary care teams on a rotating basis. This practice, often referred to as “mainstreaming,” is based on the assumption that any primary care practitioner, regardless of gender, can provide basic primary care to any veteran.

Although this practice may work well in the private sector, I believe that a number of factors need to be addressed before we adopt it in VA. Consider:

- Women make up more than half of most private practitioners’ primary care panels; by contrast, women veterans represent less than 5 percent of the VA patient population treated.

- Women veterans’ clinics and comprehensive care centers were established because VA primary care providers rarely provided care to women and were generally less familiar with women’s health issues and less skilled in routine gender-specific care than private-sector practitioners.

- Mainstreaming further reduces the ratio of women to men in any

one VA practitioner’s caseload. That makes it less likely that the clinician will gain the clinical exposure necessary to develop and maintain expertise in women’s health.

The high rate of sexual trauma among women veterans is another important issue. Research has shown that 30 to 50 percent of women veterans using VA services report experiencing at least one incident of sexual trauma during their lifetime. Studies also indicate that the physical, emotional, and psychological consequences of sexual assault may persist for many years.

These experiences commonly give rise to complex health needs. Women who have a history of sexual trauma often feel greater discomfort and distress when seeking routine health care than other women. In VA, this discomfort is often compounded by the disparate ratio of men to women in VA health care settings. The failure of a clinician to recognize or secure treatment for the psychological and physical consequences of sexual trauma may well lead to higher use of all health care services by these women — which ultimately increases the cost of health care delivery.

These few factors underscore the need for VA to develop creative and innovative approaches to providing health care for women veterans. Fortunately, VA has a cadre of health care professionals with expertise in assessing and addressing the health care needs of women veterans. Given the opportunity, these professionals can help inform VA’s strategic planning activities on the local, regional, and national levels to ensure high-quality, comprehensive health care services for women veterans.

R RESEARCH HIGHLIGHT

The VA Women's Health Project: Identifying the Health Care Needs of Women Veterans

By Katherine Skinner, Ph.D., Center for Health Quality, Outcomes and Economic Research, Bedford VAMC

Little is known about the military experiences and post-military health of women. Recent findings from the VA Women's Health Project indicate that the health care needs of women veterans are very different from those of male veterans. Funded by HSR&D, this project was designed to characterize the health status of women veterans and to examine the effects of military duty on women.

Respondents were randomly selected from all women veterans who had a VA outpatient visit between July 1, 1994, and June 30, 1995. Data were collected from 3,632 women who completed a mailed questionnaire.

A *lthough VA has done a great deal to enhance services for women veterans, more may still need to be done to assure that this minority population feels welcome.*

We asked detailed questions about various aspects of women veterans' military experience. Respondents said that they volunteered for the military to learn new job skills, to travel, or to receive financial aid for college. Many women reported difficulties when re-entering civilian life, including health problems, difficulty getting a job, feeling depressed, or feeling lost for a time. Strikingly, 23 percent of women reported that they were sexually assaulted while they were in the military. The military experience of those women, as well as their physical, mental, and social functioning, varied significantly from those of other women veter-

ans. Accordingly, we recommend that VA health care providers routinely screen all women veterans for a history of sexual assault.

In comparing male and female veterans, we found that women VA users were younger (average age of 52 for women, versus 62 for men), better educated (65 percent of women attended college, versus 35 percent of men), and less likely to be married (26 percent of women versus 48 percent of men). Women veterans reported higher physical functioning scores but consistently lower emotional and social functioning. Almost two-thirds of women using VA services received all or most of their health care through the VA, although most (80 percent) had private health insurance, Medicare, or Medicaid. Most women (69 percent) rated the location of VA facilities and the ease of making appointments for outpatient care as good or excellent. Yet one out of five women reported that she did not feel welcome as a woman

receiving care at the VA. Although VA has done a great deal to enhance services for women veterans, more may still need to be done to assure that this minority population feels welcome.

The number of women serving on active duty has increased steadily since 1973. Although only 4 percent of current VA users are women, this proportion will certainly increase as the number of women serving in the military grows, as women become more aware of services provided by VA, and as VA health care continues to become more user-friendly for women. The findings from this study point out key differences in the health care needs of male and female veterans. It is important for health care providers to understand the complex medical and mental health needs of women veterans and to develop the knowledge, skills, and sensitivity required to provide them with high-quality health care.

Seminar Explains the Ins and Outs of Government Databases for Researchers

The use of federal and state databases in health services research is the topic of a seminar that HSR&D is co-sponsoring with the Academy for Health Services Research and Health Policy this fall. The seminar will take place Oct. 30-Nov. 1 at Georgetown University Conference Center in Washington, DC, and will feature six to eight databases over the three-day period. The agenda for the first day includes an overview, lessons learned from the field, the status of federal data privacy regulations, and state perspectives on protecting patient privacy. For each of the following two days, participants will enroll in a full-day course on a selected database. The objectives of the seminar are to facilitate the use of federal and state databases by health services researchers; to provide an opportunity for participants to learn from others' experience in using these databases and to ask questions of the experts; and to network with other researchers and professionals in the field. The seminar is the third in a series being offered by AHSRHP. For registration information, please contact Kari Root, tel. 202/292-6745, email kroot@ahsrhp.org, or visit the AHSRHP website at www.ahsrhp.org/seminars/fall2000.

R ESEARCH HIGHLIGHT

Study Highlights Importance of Veteran Identity in Use and Perceptions of VA Care

By Herb Shon, M.S.W., West Los Angeles Healthcare Center

Race-ethnicity and military experience appear to play a role in veterans' perceptions of VA health care quality, according to preliminary findings from research at the West Los Angeles Healthcare Center on how racial-ethnic differences affect access and utilization of VA ambulatory care. Researchers of the Veteran Identity Program (VIP) are finding that minority veterans have different military experiences that appear to shape their perceptions of VA ambulatory care. These observations point to the need for targeted outreach that takes into account veteran identity based on military history, race-ethnicity, and medical assessment.

Now in its third of four years of HSR&D funding, the VIP was designed to 1) establish baseline levels of ambulatory care utilization among minority veteran groups; 2) identify sociodemographic, health-related, and military service predictors of ambulatory care utilization and determine how these predictors vary among racial-ethnic groups; 3) understand how factors related to race-ethnicity and veteran identity influence utilization of

ambulatory care services and how these factors vary among racial-ethnic groups; and, 4) use these findings to develop program and practitioner interventions for improving access of minority veterans to ambulatory care.

Sociodemographic, health-related, and military service factors are being assessed as predictors of ambulatory care utilization among four racial-ethnic groups: African Americans, Asian Americans, Hispanic Americans, and White Americans. Study researchers are using a triangulated methodology that consists of a secondary analysis of the 1993 National Survey of Veterans, in-depth interviews and focus groups, and a targeted telephone survey of minority veterans.

Results from this study are already being used to help VA staff provide more culturally sensitive care to veterans of different racial-ethnic backgrounds and military experiences. For example, a 20-minute video based on 32 hours of focus group discussions highlights veterans' perceptions about their military experience, the advantages and disadvantages of military service, VA

health care, and medical care in general. This video and supporting material will be included as part of an intervention to educate VA staff and remove cultural and other barriers to care for minority veterans. Further dissemination is planned following completion of this study.

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Forum is a Publication of the VA Office of Research & Development, Health Services Research & Development Service, Management Decision and Research Center, in conjunction with the Academy for Health Services Research and Health Policy.