

OIA

Office of Informatics & Analytics
Office of Analytics and Business Intelligence

Department of Veterans Affairs

Comparing the Care of Men and Women Veterans in the Department of Veterans Affairs

March 12, 2012

Steven M. Wright, PhD
Jim Schaefer, MPH
Evelyn Reyes-Harvey, MS
Joseph Francis, MD, MPH



VA
HEALTH
CARE

Defining
EXCELLENCE
in the 21st Century

CONTENTS

Executive Summary.....	1
Introduction	2
Methods	2
Results	5
Discussion.....	7
References.....	9
Appendix A	10
Table 1	10
Table 2	11
Table 3	12
Table 4	13
Table 5	14
Table 6	15
Table 7	16
Appendix B	17

Executive Summary

The U.S. Department of Veterans Affairs (VA) works hard to provide the highest quality of health care to all Veterans – both women and men. As part of that effort, we are pleased to share the results of a comprehensive report, “Comparing the Care of Men and Women Veterans in the Department of Veterans Affairs.”

Equal Care for Women and Men

The number of women Veterans is growing. VA is committed to providing women the best health care possible and, as a result, studies the care women receive from VA in comparison to men. VA looks at the quality of the health care it provides and also measures whether Veteran patients are happy with their care.

This report finds that the quality of health care for women and men Veterans is quite similar. It also shows that, in many cases, the quality of health care women receive from VA is considerably higher than the care offered by the private sector.

While there is room for improvement in some areas, VA is proud to provide quality health care to all Veteran patients.

What the Report Shows

Closing the Gender Gap

The report uses the latest performance scores, which find VA health care for women and men Veterans is quite similar, and that the quality of care that women receive continues to improve. When women and men receive the same type of medical care from VA, the quality of that care varies by less than five percent in most cases. The report shows VA is closing gender gaps in care quality that existed in the past. Trends from the last four years demonstrate improvements in care for women related to depression, post-traumatic stress disorder (PTSD) and colorectal cancer. The data also shows VA provides women with timely retinal exams, pneumococcal immunizations and flu immunizations at rates similar to its male patients.

Satisfaction

Survey results for the last two years indicate satisfaction levels for women are similar to those for men when rating the inpatient and outpatient care they receive from VA. Additionally, younger and better educated Veterans report lower satisfaction levels; this is equally true for male and female Veterans.

Compared to Non-VA Care

Performance measurements show the health care VA provides to all Veterans is equal to or better than care offered through Medicare, Medicaid and commercial health care sectors. This is particularly true for VA care for women generally, and for care that is specific to women, such as cervical cancer screening and mammography.



Room to Improve

While gaps in care quality are shrinking, VA can continue to improve the care it provides for women in certain areas. These areas include glycemic control, ischemic heart disease, influenza immunizations for those older than 65 and cholesterol control related to attaining the right levels of low-density lipoprotein (LDL) for diabetes patients.



The report also finds that dissatisfaction with VA health care depends less on gender and more on the age and higher education level of women Veterans. VA sees the concerns these women have raised as an early warning sign that the 21st century VA needs to become more responsive to younger and better educated Veterans of both genders.

Moving Forward

The positive results found in this report show that performance measurements, patient feedback and accountability measures are making a positive impact on the lives of women Veterans through the improved health care they receive from VA. We will continue using these measurements to improve care for women and ensure all Veterans have access to the best care available.

Introduction

On a broad range of measures of quality, the Department of Veterans Affairs (VA) health care system performs at a very high level. On measures for which comparisons with health systems in the private sector is possible, performance within VA is nearly always similar or superior. VA is committed to ensuring equity in health care for all Veterans.

More women Veterans are using VA health care than ever before (Frayne SM et al, 2010). Performance comparisons support the conclusion that the quality of care provided to women has been considerably higher in VA than for care in the private sector, based on both gender-specific measures (e.g., screening for cervical and breast cancer) and for gender-neutral measures (e.g., management of hypertension and diabetes, treatment of elevated cholesterol, and screening for colorectal cancer)¹. Additionally, internal studies support the finding that in general VA care for men and women is similar². Despite these positive results, there are some consistent gaps between men and women Veterans on important outpatient quality measures (Vimalananda et al, 2011; Washington et al, 2011).

The VA is also actively engaged in collecting data on various aspects of the patient experience through the Survey of Healthcare Experiences of Patients (SHEP). In FY09 the SHEP program transitioned to the CAHPS surveys, the industry standard instruments widely used in the public and private health care settings. Both the outpatient and hospital (HCAHPS) instruments provide the capability to assess men and women on key patient-centered care measures such as communication with providers and the overall rating of the hospital or health care experience.

We now report on results of an additional round of analysis using the most recent VA data on clinical quality and patient experience at the National and Veterans Integrated Service Network (VISN) level. Variation in scores across VISN and trends over time will be also examined.

Methods

We assessed two major sources of data on VA quality: clinical quality measures of outpatient care and patient experiences with care in the outpatient and inpatient setting.

Outpatient Clinical Quality Measures

Outpatient clinical data was obtained through VA External Peer Review Program (EPRP). Data was collected through detailed reviews of Veterans' medical records by trained abstractors. EPRP samples were drawn monthly from a sample frame of "established" users of VA health care. Established users have had an encounter with the system in the year prior to the monthly sample. These established patients also represented a user population similar to "enrollees" in private health plans. There was a core random sample (Nexus Sample) of all established users. To ensure representation of patients with important clinical and patient attributes, several augmented samples were drawn from cohorts of diabetics, patients with Acute Myocardial Infarction (AMI) and women. The Nexus sample included only a small proportion of women (5 percent) thus requiring the special augmented sample of women ages 40 to 69. Population based weighting was used to correct the augmented samples.

We calculated scores for 23 gender-neutral clinical measures that were either part of the Health Effectiveness Data and Information Set (HEDIS) or, in the case of behavioral health, part of established VA-DoD clinical practice guidelines³ (See Figure 1). These are well established, standardized measures of outpatient quality related to prevention and screening, and treatment of conditions such as diabetes and ischemic heart disease (IHD). We also aggregated individual measures to create five outpatient composites: Behavioral Health Screening, Diabetes, IHD, Prevention, and Tobacco. These composites are based on "opportunity scoring", meaning that the overall composite score is based on the sum of all numerators (number of patients receiving an evidence-based care process) divided by the sum of all denominators for each of the measures within a composite (the denominator represents the number of eligible patients or opportunities, which can vary by measure) (NQF, 2009). All metrics within a given composite were included regardless of the number of cases in the measure.

Comparisons of clinical quality are based on standardized measures of prevention, screening and treatment of conditions such as diabetes and heart disease.

¹ VHA Facility Quality and Safety Report 2010, www.va.gov/health/HospitalReportCard.asp, p 16.

² Ibid., p 22.

³ VA-DoD Evidence-based clinical practice guidelines may be viewed at www.healthquality.va.gov

Figure 1

FY2011 Clinical Outpatient Composites and Measures				
Behavioral Health Screening Composite (5 items)	Diabetes Composite (7 items)	Ischemic Heart Composite (3 items)	Prevention Composite* (5 items)	Tobacco Composite (3 items)
MDD - Patients (pts) screened annually for depression	DM - Annual HbA1c (HEDIS)	BP <140/90 (HEDIS)	Obese pts offered weight management	Pts using tobacco who have been offered medication in past year
PTSD - Pts screened at required intervals for PTSD	DM - HbA1 ≥ 9 or not done (poor control) in past year** (HEDIS)	LDL-C measured (HEDIS)	Pneumococcal immunization (HEDIS)	Pts using tobacco provided with counseling in past year
SUD - Pts screened for alcohol misuse with AUDIT score ≥ 5 who received timely counseling	DM - Outpt - LDL-C LT 100 (HEDIS)	LDL-C <100 (HEDIS)	Influenza immunization, ages 50–64 (HEDIS)	Pts using tobacco offered referral to cessation program
SUD - Pts screened annually for Alcohol Misuse	DM - Outpt - BP LT 140/90 (HEDIS)		Influenza immunization, ages ≥ 65 (HEDIS)	
Combined scores for timely suicide risk evaluation if screening is positive for PTSD or MDD	DM - Outpt - Retinal exam, timely by disease (HEDIS)		Colorectal Cancer Screening (HEDIS)	
	DM - Outpt - LDL-C measured (HEDIS) w/ 1 yr review			
	DM - Outpt - Renal Testing (HEDIS)			

MDD: Major depressive disorder; PTSD: Post traumatic stress disorder; PC-PTSD: SUD: substance use disorder; AUDIT: Alcohol Use Disorders Identification Test; DM: Diabetes mellitus; HbA1c: glycosylated hemoglobin; LDL-C: Low density lipoprotein cholesterol; BP: blood pressure; HTN: hypertension

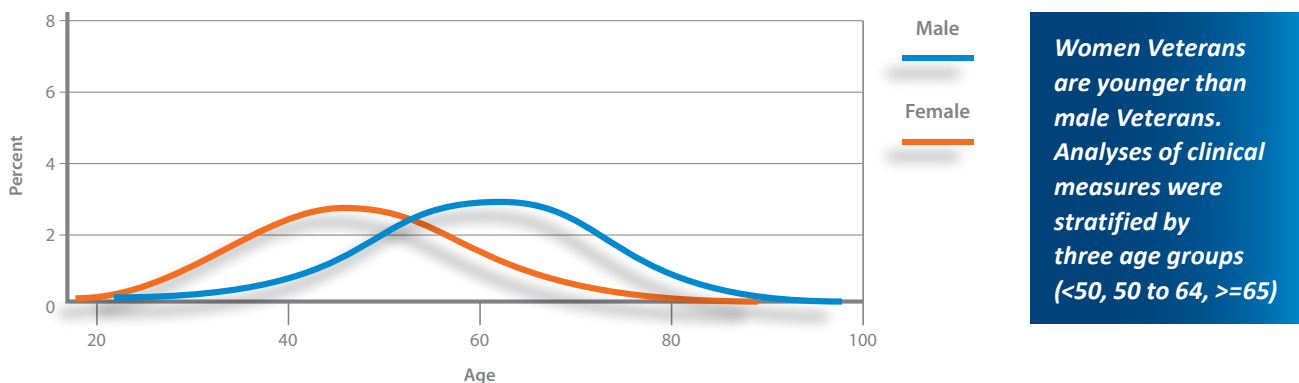
* Does not include Women specific measures (screening for breast and cervical cancers)

**Reversed coded to reflect higher is better

Women represent a small proportion of current VA users and there are considerable differences in their demographic characteristics compared to men. Although the EPRP sampling design augments the number of women available for analysis, on average women are significantly younger than the sample of men (See Figure 2). The graph below highlights the different age distribution for all the men and women sampled in Nexus and the diabetes, AMI and women augments.

Figure 2

Age Distribution of Men and Women



This is representation of EPRP samples and not of VA user population.

National and VISN scores were calculated for the individual quality measures and the composites. All scores were weighted (population weights derived at point of sampling) to correct for the disproportionate number of cases obtained from the augmented samples. Weighting, however, does not adjust scores to account for the different demographic characteristics of gender groups. Due to the known dissimilarity in the age distribution of men and women, some results in this report are stratified into three age groups (<50, 50–64, ≥65). Differences were calculated as the score for men minus the score for women. For purposes of this report statistical significance was not calculated. Based on prior methodology, differences of ±5 points were viewed as clinically significant.

Sampling of the EPRP contributes to considerable variability across the organization (i.e., National, VISN, or facility) in the size of the denominators for each of the clinical measures. The number of cases in the denominator influences how well the sample “estimates” the true score in the sampled population. The national estimates for all the HEDIS outpatient measures will be acceptable for both men and women (confidence interval within ±5 points of the true score for the population). Estimates at the VISN level will be less precise as there will be fewer women in the denominator of some measures (i.e. confidence intervals can be ±10 to 20 points). Thus to avoid unreliable comparisons between men and women, some of the VISN results are suppressed when there are fewer than 200 women in the measure denominator.

Facility measurement is limited by small denominators and is not sufficiently accurate for comparisons between men and women.

In addition to the cross-sectional reporting of the HEDIS scores we compared the results for FY11 with differences in scores reported for FY08 to FY10. We also conducted a special analysis of the LDL control measures by rescored the prior data based on the new clinical action measures defined as LDL <100 or moderate dose statin use. This is based on emerging evidence that a “cholesterol control” measure that simply uses a cut point may encourage overtreatment (Hayward, 2012) and that the use of a moderate dose statin significantly lowers cardiovascular risk. Such an approach to quality measurement is being increasingly accepted by professional societies (AHA/ACC, 2011) and is consistent with VA clinical practice guidelines⁴.

Patient Experience with Care

The CAHPS outpatient surveys were developed by the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) and are widely used in public and private health care settings. The following CAHPS composites will be calculated for the outpatient setting: Getting Needed Care, Getting Care Quickly, How Well Doctor/Nurses Communicate, and Shared Decision Making. These composites are composed of two to four individual questions, most of which have a response scale of Never, Sometimes, Usually, or Always. The site score for each question is first computed as the percentage response in the “Top Box” or “Always” response scale. The site composite score then is the average for the questions assigned to each composite. There are other CAHPS “reporting measures” that are not composites but rather single survey items: Overall Rating of Healthcare, Overall Rating of Personal Doctor/Nurse, and Overall Rating of Specialists.

Outpatient satisfaction results for VA facilities are reported based on a risk adjustment model developed for VA users that takes into account those factors known to influence patient’s experience with care including age, education, self-reported health status, and facility characteristics (Wright, 2006). This methodology allows for comparisons of CAHPS composites and item scores across VA facilities and VISNs, but cannot be used for external comparisons to non-VA facilities as there is, as of yet, no methodology for valid adjustment of outpatient CAHPS scores across other health systems and payers.

The survey for VA inpatient users follows the guidelines described in the “HCAHPS Quality Assurance Guidelines” published by The Centers for Medicare & Medicaid for the mail-only mode of survey administration. The data presented here use “Top-Box” scoring. The “top-box” is the most positive response to HCAHPS survey questions. The “top-box” response is “Always” for five HCAHPS composites (Communication with Nurses, Communication with Doctors, Responsiveness of Hospital Staff, Pain Management, and Communication about Medicines) and two individual items (Cleanliness of Hospital Environment and Quietness of Hospital Environment), “Yes” for the sixth composite, Discharge Information, “‘9’ or ‘10’ (high)” for the Overall Hospital Rating item, and “Would definitely recommend” for the Recommend the Hospital item.

To ensure that differences in HCAHPS results reflect differences in perceived hospital quality only, HCAHPS survey results were adjusted for factors beyond the control of the facility such as: service line (medical, surgical, or maternity care), categorical age, self-reported education, self-reported health status, language other than English spoken at home, age by service line interactions, and percentile response order, also known as “relative lag time,” which is based on the time between discharge and survey completion. In addition, facility characteristics such as

⁴VA-DoD Clinical Practice Guideline for Diabetes Mellitus (2010) – www.healthquality.va.gov/Diabetes_Mellitus.asp

size and nurse turnover rate were also included in the model. It should be noted that the model used to adjust VA Inpatient Overall scores is the same as that used by CMS for Medicare and Medicaid users. This allows VA hospitals to be fairly compared to those hospitals contributing HCAHPS data to CMS Hospital Compare⁵.

Results

Outpatient Clinical Quality Measures

Table 1 (See Appendix A: FY 2011 National Scores for Clinical Outpatient Composites and Measures) presents the scores for individual measures and composites as well as the difference between men and women. Less favorable measures for women Veterans were:

- Glycemic control: 83 percent of men vs. 79 percent of women have glycosylated hemoglobin (Hgb A1c) under 9
- Influenza immunization rates for Veterans over age 65: 79 percent of men vs. 72 percent of women
- Cholesterol control in Diabetes and IHD (see qualifier below)
- Ischemic Heart Disease (IHD) composite (81 percent vs. 75 percent; driven by the individual LDL-C metric)

The largest differences were observed for LDL control in both the Diabetes and IHD cohorts (14 percent and 17 percent, respectively). In FY12, VA replaced the LDL-C <100 measure with one that promoted the use of moderate dose statins, no longer requiring adherence to the LDL-C cutpoint of 100. Taking into account the use of moderate dose statins, which lower cardiovascular risk regardless of measured LDL-C level, reduces the apparent gender difference in cholesterol control by more than half (**See Figure 3**). These results are consistent with what others have found for Medicare and commercial managed care populations (Kim 2006; Ferrara 2008; Turner 2011).

Figure 3

Diabetes Cohort	LDL <100	LDL <100 or Moderate Dose Statin
Men	69%	85%
Women	55%	79%
Difference (M-W)	14	6

Care received by women Veterans was comparable on 19 of 23 individual quality measures and 4 of 5 composites.

Large gender differences in cholesterol control were reduced by more than half when statin use was taken into account.

Table 2 (See Appendix A: FY 2011 National Clinical Outpatient Composites and Measures Scores) provides clinical measure scores by the three age strata. Because women were younger and the augmented sample targeted women age 40 to 69, the age range 50–64 constituted the largest number of women cases for comparison to similarly aged men. However, patterns within all three age strata were consistent with the results from the overall scores. Minor exceptions were found for:

- Differences for the HbA1C measure were more evident in Veterans under 50 years of age (difference of 6 percent and favoring women) than the other two age groups (differences of 3 and 4 percent for ages 50–64 and 65+, respectively, and favoring men).
- Differences in performance for the LDL-C measure for diabetic patients were consistent in the age 50–64 (11 percent) and 65+ (15 percent) groups but less evident in the age <50 group (6 percent), but this may reflect variability due to the smaller sample sizes within each stratum.

Variation across networks is examined in **Table 3** (See Appendix A: Network Variation in the Gap Between Men and Women) which provides the average, minimum, and maximum gender difference for all the outpatient clinical measures. The main differences reported at the national level are supported by the VISN results although there is also considerable variation in the magnitude of the differences by gender. Examples of VISN variation in the deltas between men and women were HbA1C control (ranged -6 to 12 percent), LDL control for diabetics (range 8 to 24 percent), Ischemic Heart Disease Composite (range 2 to 12 percent), and flu immunization age 50–64 (-4 to 12 percent). However, caution should be used in interpreting these variation results as the VISN scores typically were based on a small number of women (ranging from approximately 200 to 500 cases per VISN) and VISN variation is likely due to sampling variation and other sources of random error.

⁵ More information on the HCAHPS patient-mix adjustments can be found at www.hcahpsonline.org/files/January%202012%20PMA%20Web%20Document_508%20appvd.pdf

Table 4 (See Appendix A: FY08 to FY11 Trends in Clinical Outpatient Scores) shows the trends for the last four years by displaying the difference between the scores of men and women for each individual measure and composite. There has been a reduction in the gap between men and women, and the following measures now show a gender difference less than five percentage points:

- Screening for depression
- Screening for PTSD
- Timely retinal exam among diabetics
- Pneumococcal immunization
- Flu immunization
- Colorectal screening

VA Clinical quality measures have showed an overall reduction in the gender gap over time, though variation is still seen across VISNs.

A significant gap between men and women has been evident during the last four years for the LDL-C control measure for the diabetics and IHD cohorts. However, the findings reported earlier regarding the new measure specifying LDL <100 or moderate dose statin use significantly reduced the gap in FY11.

Patient Experience with Care

As noted earlier, women Veterans are younger than their male counterparts. These and other patient attributes, such as self-reported health status and education, are included in the adjustment models because they are known to mediate ratings of patient’s perception of care. As can be seen in the below table of SHEP outpatient results (See Figure 4), the raw scores for Overall Rating of Health Care for both men and women were positively correlated with age and health status, and negatively correlated with education. For example, young males have the lowest scores that increase for each advancing age category ranging from 39 percent for age 18–49 to 66 percent for age 75 or greater. And this pattern is no different for females; younger age equates to lower scores. Women are more educated than males and greater education is associated with lower scores.

Figure 4
FY2011 Outpatient SHEP Scores for Overall Rating of Health Care by Age, Education and Health Status

	Male		Female	
	N	Overall Rating of Healthcare	N	Overall Rating of Healthcare
Age				
18–49	24,246	39	5,163	37
50–64	74,422	56	3,549	53
65–74	86,477	62	1,395	63
75+	42,284	66	736	72
Education				
8th grade or less	9,158	67	35	55
Some high school	17,880	65	131	60
High school grad	78,129	60	2,074	56
Some college	79,346	52	5,351	42
4-yr college grad	19,568	50	1,554	43
GT 4-yr college grad	18,675	51	1,553	40
Health Status				
Poor	18,853	45	716	33
Fair	62,475	50	2,666	36
Good	85,963	56	4,206	43
Very Good	45,830	64	2,466	53
Excellent	10,107	76	652	66

Table 5 (See Appendix A: FY2011 National Scores for SHEP by Gender) presents the scores for outpatient and inpatient composites and reporting measures as well as the differences between the scores for men and women. Results for FY11 CAHPS survey indicate that men and women had similar ratings of care for outpatient and inpatient services. The few exceptions were that men had higher scores for Getting Care Quickly (54 percent vs. 49 percent) and marginally higher scores for Getting Needed Care (55 percent vs. 51 percent) in the outpatient setting. Men had marginally higher scores for Cleanliness of Hospital and Discharge Information in the inpatient setting. Women had significantly higher scores for Quietness of Hospital environment in the inpatient setting.

Results for FY10 mirror the FY11 findings. There is a slight reduction in the gender differences for Getting Needed Care and Getting Care Quickly. Results are not available for prior years due to the shift to the CAHPS instruments during FY09.

VISN outpatient composite scores are reported in **Table 6** (See Appendix A: FY11 VISN Outpatient SHEP scores by Gender) stratified by men and women. (Note: inpatient scores have insufficient number of women for valid comparisons at the VISN level). Variation across the Networks is examined in **Table 7** (See Appendix A: Network Variation in Gap in FY11 Outpatient SHEP Scores between Men and Women) which provides the average, minimum and maximum gender difference for the outpatient composites. There was considerable variation across VISNs particularly for Getting Needed Care (range -2 to 11) and Overall Rating of Health Care (range -9 to 10) and Shared Decision Making (range -8 to 11). However, small sample size is a primary contributor to variation in scores across VISN.

Discussion

The comparison of the latest available results for HEDIS (calendar year 2010) to VA (FY10-11) shows that VA provided similar or superior care to Veterans. (See Appendix B: External Comparison: VA vs. HEDIS 2009 – 2011). This is particularly true for gender-specific care such as cervical cancer screening and mammography. But it is also true that VA scores for women on key non-gender specific outpatient clinical measures were higher than the national HEDIS scores reported by commercial, Medicare, and Medicaid sectors.

This gender report shows that the clinical quality of care in general is becoming quite comparable for men and women Veterans in those areas that are being measured and reported. In fact, 19 out of 23 individual clinical measures showed differences in performance scores between men and women of less than 5 percentage points. Examination of trends over the last 4 years has shown a reduction in the gender gap for screening for depression, PTSD and colorectal cancer as well as timely retinal exam, pneumococcal immunization, and flu immunization. Additionally, the results from SHEP national surveys of Veterans using VA also showed that ratings of patient experiences with inpatient and outpatient care were similar for men in women during the last 2 years, after adjusting for differences in age, education, and facility characteristics. The positive findings validate the usefulness of performance measurement, feedback, and accountability for making a positive difference in the lives of women Veterans.

Notwithstanding these positive results, this report also identified some persistent gaps in care that are opportunities for targeted quality improvement. The less favorable scores among women for flu immunization in patients greater than age 65 and glycemic control among diabetic patients are examples of measures where VA performs better than the non-VA sectors but the VA scores for women are lower than men and present an opportunity to focus improvement efforts. Additionally, variation in performance is still observed across individual Networks and facilities. We are cautious about drawing conclusions from analysis of smaller units of observation, since some of this difference reflects sampling variation. Nonetheless, we believe continued attention to these metrics and targeted improvement efforts are still warranted to assure consistency in the provision of health services to women Veterans.

The significant difference (14 percentage points) between men and women on the cholesterol control measure has been observed in prior years within VA, but the reasons for that persistent gap have not been clear. As part of the FY11 Network Director Performance Plan (NDPP) most VISNs selected the cholesterol control measure for either diabetes or IHD patients as a key focus area for reducing gender-based disparities in care. Despite progress at many sites in reducing the gap, all of the VISNs that engaged in this effort still had gender-based differences in performance by the end of the reporting period. These observed disparities in LDL control, however, are not unique to VA population as there is a substantial body of research highlighting significantly lower scores for women, particularly in CVD prevention and treatment. One study of patients in Medicare and commercial health

plans who had suffered a prior AMI or had received a CABG or PTCA reported that cholesterol control (LDL-C <100) was significantly poorer for women (45 percent) compared with men (55 percent)(Chou, 2007). The same gender disparity was observed among patients with diabetes (women=38 percent; men=43 percent). Another study of diabetic patients in 2004 also showed significantly lower performance scores for women (38 percent) compared with men (46 percent)(Bird, 2007). These parallel findings indicate that more work is needed in and outside VA to determine the cause of observed differences (Kim 2006; Ferrara 2008; Turner 2011).

Emerging evidence from the analysis of cardiovascular prevention trials, as well as growing appreciation of the downsides and risks of aggressive lipid lowering therapy, are calling into question the appropriateness of a cholesterol control performance measures based solely on achieving a target value of LDL-C (Hayward and Krumholz, 2012). Professional societies now recommend that the adequacy of cardiovascular prevention be judged by the appropriateness of the therapy, rather than the LDL value, and stress that the use of a moderate-dose statin may provide significant patient benefit while avoiding complications such as muscle breakdown that are associated with more aggressive lipid lowering therapy (ACCF/AHA/AMA-PCPI, 2011). For VHA, it is encouraging that a new performance measure that incorporates statin medication use shows a much lower gender disparity. Nonetheless, it still represents a meaningful gap, and the reasons for the gap are unclear. This new clinical action measure is currently being reported to the field as one of the FY12 NDPP quality improvement areas. Further work is also needed to confirm that women Veterans receiving cholesterol-lowering drugs are adherent to their prescribed treatment.

The results for SHEP in FY10 and FY11 surveys indicate that women Veterans reported similar satisfaction as males with both outpatient and inpatient services, once factors such as age, education, and health status were taken into account. The only areas of potential concern were less favorable scores for women outpatients on the CAHPS composites Getting Care Quickly and Getting Needed Care. The gender difference in these indicators may suggest perceived access to timely and responsive care is a greater challenge for women Veterans. There is considerable variation across the networks suggesting opportunities to identify VISNs with best practices that can be studied and validated with the hope of assisting those other networks where the gap exist. One limitation of the CAHPS surveys is that the questions are not specific to women's health needs or their specific experiences within the VA healthcare system. A new CAHPS Patient Care Medical Home instrument will be implemented in the VA later this year and the survey questions may be more sensitive to patient centered care issues for both men and women.

The VA employs robust statistical models to account for patient characteristics known to influence patient perceptions of their care. The inpatient SHEP survey adheres to the CMS HCAHPS adjustment model (allowing direct comparison with non-VA hospitals) and the outpatient SHEP survey uses an adjustment model developed by VA (there is no standardized model yet available in the outpatient CAHPS community). We found that large differences between men and women in the raw scores for some SHEP metrics were mitigated after adjusting for age, health status, and education. The impact of patient attributes other than gender on satisfaction scores is itself an important finding for VA policymakers. Veteran dissatisfaction with health care is explained less by female gender and significantly more by the younger age and higher education of women Veterans as a group. The concerns that have been raised by women Veterans may therefore be an early warning sign that the 21st century VA needs to become more responsive to younger and better educated Veterans of both genders.

Concerns raised by women in Veterans may be an early warning sign that the 21 century VA needs to become more responsive to younger and better educated Veterans.

The cross-sectional results in this report and trending with the findings from earlier years indicate that men and women generally are receiving similar technical quality of care and that Veteran's perceptions of care are generally quite similar by gender. The report summary is limited to existing metrics that are based on two data sources: CAHPS surveys and EPRP based clinical data. There are other measured or unmeasured metrics that may reflect significant opportunities for improvement among women veterans. The Office of Analytics and Business Intelligence will continue to post quarterly gender reports that contain scores for the outpatient clinical measures and composites with age stratified results available for all VISNs and facilities.

References

- ACCF/AHA/AMA-PCPI. 2011 Performance Measures for Adults With Coronary Artery Disease and Hypertension A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Performance Measures and the American Medical Association-Physician Consortium for Performance Improvement. *Circulation*. 2011, 124: 248–270.
- Chou AF, Brown AF, Jensen RE, et al. Gender and racial disparities in the management of diabetes mellitus among Medicare patients. *Women's Health Issues*. 2007; 17: 150–161.
- Bird EC, Fremont AM, Bierman AS, et al. Does quality of care for cardiovascular disease and diabetes differ by gender for enrollees in managed care? *Women's Health Issues*. 2007; 17: 731–738.
- Ferrara A, Mangione CM, Kim C, et al. Sex disparities in control and treatment of modifiable cardiovascular disease risk factors among patients. *Diabetes Care*. 2008; 31: 69–74.
- Frayne SM, Phibbs CS, Friedman SA, et al. *Sourcebook: Women Veterans in the Veterans Health Administration. Volume 1. Sociodemographic Characteristics and Use of VHA Care*. Department of Veterans Affairs, 2010.
- Gouni-Berthold I, Berthold JK, Mantzoros CS, Bohm M, Krone W. Sex disparities in the treatment and control of cardiovascular risk factors in Type 2 diabetes. *Diabetes Care*. 2008; 31: 1389–1391.
- Hayward RA, Krumholz HM. Three Reasons to Abandon Low-Density Lipoprotein Targets: An Open Letter to the Adult Treatment Panel IV of the National Institutes of Health. *Circ Cardiovasc Qual Outcomes* 2012; 5; 2–5.
- Kim C, Kerr EA, Bernstein SJ, Krein SL. Gender disparities in lipid management: the presence of disparities depends on the quality measure. *Am J Manag Care*. 2006 Mar; 12(3): 133–6.
- National Quality Forum (NQF). *Composite Measure Evaluation Framework and National Voluntary Consensus Standards for Mortality and Safety-Composite Measures: A Consensus Report*. Washington, DC: NQF; 2009.
- O'Malley AJ, Zaslavsky AM, Elliott MN, Zaborski L, and Cleary PD. Case-Mix Adjustment of the CAHPS® Hospital Survey. *Health Serv Res*. 2005 December; 40(6 Pt 2): 2162–2181.
- Vimalananda VG, Miller DR, Palnati M, Christiansen CL, Fincke BG. Gender disparities in lipid-lowering therapy among veterans with diabetes. *Womens Health Issues*. 2011 Jul–Aug; 21(4 Suppl): S176–81.
- Washington DL, Bean-Mayberry B, Mitchell MN, Riopelle D, Yano EM. Tailoring VA primary care to women veterans: association with patient-rated quality and satisfaction. *Womens Health Issues*. 2011 Jul–Aug; 21(4 Suppl): S112–9.
- Wright SM, Craig T, Campbell S, Schaefer J, Humble C. Patient satisfaction of female and male users of the Veterans Health Administration services. *J Gen Int Med*, 2006; 21: S26–32.
- Zaslavsky AM, Zaborski LB, Ding L, Shaul JA, Cioffi MH, Cleary PD. Adjusting performance measures to ensure equitable plan comparisons. *Health Care Financing Review*. 2001; 22(3): 109–126.

Appendix A

Table 1: FY 2011 National Scores for Clinical Outpatient Composites and Measures

Measure		Overall		Male		Female		Male Female
Mnemonic	Measure Description	N	Score	N	Score	N	Score	Difference
ALL_BHS	Behavioral Health Screening Composite	488,270	96%	388,749	96%	99,521	96%	1%
MDD40	MDD-Patients (pts) screened annually for depression	137,334	97%	115,487	97%	21,847	96%	1%
PTSD51	PTSD-Pts screened at required intervals for PTSD	114,792	99%	88,557	99%	26,235	98%	1%
SA17	SUD-Pts screened for alcohol misuse with Audit score ≥ 5 who received timely counseling	11,761	78%	10,408	78%	1,353	77%	0%
SA7	SUD-Pts screened annually for Alcohol Misuse	212,656	97%	165,450	97%	47,206	97%	1%
SRE1	Combined scores for timely suicide risk evaluation if screening is positive for PTSD or MDD	11,727	78%	8,847	78%	2,880	76%	2%
ALL_DM	Diabetes Composite	451,743	88%	419,170	88%	32,573	85%	3%
C9H	DM-Annual HbA1c (HEDIS)	64,548	98%	59,893	98%	4,655	98%	0%
DMG23H**	DM-HbA1 ≥ 9 or not done (poor control) in past year **(HEDIS)	64,548	83%	59,893	83%	4,655	79%	5%
DMG25H	DM-Output-LDL-C LT 100 (HEDIS)	64,511	69%	59,860	69%	4,651	55%	14%
DMG27H	DM-Output-BP LT 140/90 (HEDIS)	64,548	81%	59,893	81%	4,655	82%	-1%
DMG31H	DM-Output-Retinal exam, timely by disease (HEDIS)	64,521	90%	59,871	90%	4,650	89%	1%
DMG32H	DM-Output-LDL-C measured (HEDIS) w/ 1 yr review	64,519	97%	59,867	97%	4,652	97%	0%
DMG34H	DM-Output-Renal Testing (HEDIS)	64,548	95%	59,893	95%	4,655	93%	2%
ALL_ISC	Ischemic Heart Composite	216,703	80%	196,370	81%	20,333	75%	5%
HTN9H	BP <140/90 (HEDIS)	130,946	78%	114,253	78%	16,693	76%	1%
IHD16H	LDL-C measured (HEDIS)	42,882	96%	41,062	96%	1,820	93%	3%
IHD18HN	LDL-C <100 (HEDIS)	42,875	71%	41,055	72%	1,820	55%	17%
ALL_PRV	Prevention Composite*	444,194	87%	367,318	87%	76,876	88%	-1%
MOV5	Obese pts offered weight management	162,144	95%	118,044	95%	44,100	96%	0%
P1	Pneumococcal Immunization (HEDIS)	64,049	94%	61,583	94%	2,466	89%	4%
P22H	Influenza immunization, ages 50–64 (HEDIS)	41,972	65%	34,221	65%	7,751	63%	2%
P25H	Influenza immunization, ages ≥ 65 (HEDIS)	30,558	79%	29,451	79%	1,107	72%	7%
P61H	Colorectal Cancer Screening (HEDIS)	145,471	82%	124,019	82%	21,452	80%	3%
ALL_TOB	Tobacco Composite	182,091	96%	140,031	96%	42,060	96%	0%
SMG10	Pts using tobacco who have been offered medication in past year	60,697	94%	46,677	94%	14,020	94%	0%
SMG8	Pts using tobacco provided with counseling in past year	60,697	97%	46,677	97%	14,020	97%	0%
SMG9	Pts using tobacco offered referral to cessation program	60,697	97%	46,677	97%	14,020	97%	0%

*Does not include Women specific measures (screening for breast and cervical cancers)

**Reversed coded to reflect higher is better

Table 2: FY 2011 National Clinical Outpatient Composites and Measures Scores

Measure Description	Age < 50				Age 50 – 64				Age 65 & Older			
	Male		Female		Male		Female		Male		Female	
	N	Score	N	Score	N	Score	N	Score	N	Score	N	Score
Behavioral Health Screening Composite	42,122	95%	49,940	95%	180,364	96%	42,802	96%	166,263	97%	6,779	97%
MDD-Patients (pts) screened annually for depression	9,662	95%	10,288	95%	50,073	97%	9,596	96%	55,752	97%	1,963	97%
PTSD-Pts screened at required intervals for PTSD	10,029	98%	13,567	97%	40,167	99%	10,993	98%	38,361	99%	1,675	99%
SUD-Pts screened for alcohol misuse with Audit score ≥5 who received timely counseling	2,156	78%	862	77%	5,714	77%	465	78%	2,538	77%	26	-
SUD-Pts screened annually for Alcohol Misuse	18,611	96%	23,503	96%	79,264	97%	20,675	97%	67,575	98%	3,028	98%
Combined scores for timely suicide risk evaluation if screening is positive for PTSD or MDD	1,664	80%	1,720	78%	5,146	77%	1,073	73%	2,037	78%	87	-
Diabetes Composite	21,045	82%	6,466	83%	227,783	87%	21,349	85%	170,342	90%	4,758	87%
DM-Annual HbA1c (HEDIS)	3,007	98%	924	98%	32,546	99%	3,051	98%	24,340	99%	680	98%
DM-HbA1 ≥9 or not done (poor control) in past year **(HEDIS)	3,007	68%	924	74%	32,546	82%	3,051	79%	24,340	89%	680	85%
DM-Outpt-LDL-C LT 100 (HEDIS)	3,005	53%	923	47%	32,530	68%	3,048	57%	24,325	75%	680	60%
DM-Outpt-BP LT 140/90 (HEDIS)	3,007	82%	924	87%	32,546	80%	3,051	80%	24,340	81%	680	81%
DM-Outpt-Retinal exam, timely by disease (HEDIS)	3,007	85%	924	88%	32,533	90%	3,048	89%	24,331	90%	678	89%
DM-Outpt-LDL-C measured (HEDIS) w/ 1 yr review	3,005	96%	923	95%	32,536	97%	3,049	98%	24,326	98%	680	98%
DM-Outpt-Renal Testing (HEDIS)	3,007	93%	924	89%	32,546	95%	3,051	94%	24,340	96%	680	96%
Ischemic Heart Composite	9,030	73%	4,786	74%	98,398	79%	12,854	75%	88,942	83%	2,693	78%
BP <140/90 (HEDIS)	6,844	73%	4,316	76%	56,305	77%	10,404	77%	51,104	80%	1,973	78%
LDL-C measured (HEDIS)	1,093	95%	235	91%	21,050	97%	1,225	94%	18,919	96%	360	95%
LDL-C <100 (HEDIS)	1,093	51%	235	50%	21,043	69%	1,225	54%	18,919	76%	360	62%
Prevention Composite*	17,555	94%	22,415	96%	182,082	84%	45,843	84%	167,681	89%	8,618	87%
Obese pts offered weight management	17,554	94%	22,415	96%	73,531	96%	19,473	96%	26,959	96%	2,212	96%
Pneumococcal Immunization (HEDIS)	-	-	-	-	-	-	-	-	61,583	94%	2,465	89%
Influenza immunization, ages 50–64 (HEDIS)	-	-	-	-	34,221	65%	7,751	63%	-	-	-	-
Influenza immunization, ages ≥65 (HEDIS)	-	-	-	-	-	-	-	-	29,449	79%	1,107	72%
Colorectal Cancer Screening (HEDIS)	-	-	-	-	77,035	80%	18,789	79%	46,984	86%	2,663	85%
Tobacco Composite	23,046	95%	20,991	95%	84,306	97%	19,485	96%	32,679	96%	1,584	98%
Pts using tobacco who have been offered medication in past year	7,682	93%	6,997	93%	28,102	95%	6,495	95%	10,893	94%	528	97%
Pts using tobacco provided with counseling in past year	7,682	96%	6,997	96%	28,102	98%	6,495	97%	10,893	97%	528	98%
Pts using tobacco offered referral to cessation program	7,682	96%	6,997	96%	28,102	98%	6,495	97%	10,893	97%	528	98%

*Does not include Women specific measures (screening for breast and cervical cancers)

**Reversed coded to reflect higher is better

Table 3: Network Variation in the Gap Between Men and Women

Measure Mnemonic	Measure Description	Average Difference	Minimum Difference	Maximum Difference
ALL_BHS	Behavioral Health Screening Composite	1	-1	1
MDD40	MDD-Patients (pts) screened annually for depression	1	0	4
PTSD51	PTSD-Pts screened at required intervals for PTSD	1	-1	2
SA17	SUD-Pts screened for alcohol misuse with Audit score ≥ 5 who received timely counseling	-	-	-
SA7	SUD-Pts screened annually for Alcohol Misuse	1	-1	2
SRE1	Combined scores for timely suicide risk evaluation if screening is positive for PTSD or MDD	2	1	3
ALL_DM	Diabetes Composite	3	0	6
C9H	DM-Annual HbA1c (HEDIS)	0	-1	2
DMG23H	DM-HbA1 ≥ 9 or not done (poor control) in past year ** (HEDIS)	4	-6	12
DMG25H	DM-Outpt-LDL-C LT 100 (HEDIS)	15	8	24
DMG27H	DM-Outpt-BP LT 140/90 (HEDIS)	-1	-7	5
DMG31H	DM-Outpt-Retinal exam, timely by disease (HEDIS)	1	-5	9
DMG32H	DM-Outpt-LDL-C measured (HEDIS) w/ 1 yr review	0	-3	2
DMG34H	DM-Outpt-Renal Testing (HEDIS)	3	-1	8
ALL_ISC	Ischemic Heart Composite	5	2	12
HTN9H	BP <140/90 (HEDIS)	1	-2	5
IHD16H	LDL-C measured (HEDIS)	-	-	-
IHD18HN	LDL-C <100 (HEDIS)	-	-	-
ALL_PRV	Prevention Composite*	-1	-4	0
MOV5	Obese pts offered weight management	0	-2	1
P1	Pneumococcal Immunization (HEDIS)	-	-	-
P22H	Influenza immunization, ages 50–64 (HEDIS)	2	-4	12
P25H	Influenza immunization, ages ≥ 65 (HEDIS)	-	-	-
P61H	Colorectal Cancer Screening (HEDIS)	3	-2	8
ALL_TOB	Tobacco Composite	0	-1	2
SMG10	Pts using tobacco who have been offered medication in past year	0	-3	2
SMG8	Pts using tobacco provided with counseling in past year	0	-1	3
SMG9	Pts using tobacco offered referral to cessation program	0	-1	3

* - * indicates no VISNs with minimum 200 cases required to calculate M–F difference

Note: A negative number indicates a higher score for women, a positive number indicates a higher score for men

Table 4: FY08 to FY11 Trends in Clinical Outpatient Scores

Measure Mnemonic	Measure Description	Male Female FY11	Male Female FY10	Male Female FY09	Male Female FY08
		Difference	Difference	Difference	Difference
ALL_BHS	Behavioral Health Screening Composite	1	1	na	na
MDD40	MDD-Patients (pts) screened annually for depression	1	2	3	6
PTSD51	PTSD-Pts screened at required intervals for PTSD	1	1	4	5
SA17	SUD-Pts screened for alcohol misuse with Audit score ≥5 who received timely counseling	0	-	-	-
SA7	SUD-Pts screened annually for Alcohol Misuse	1	1	1	3
SRE1	Combined scores for timely suicide risk evaluation if screening is positive for PTSD or MDD	2	-	-	-
ALL_DM	Diabetes Composite	3	3	na	na
C9H	DM-Annual HbA1c (HEDIS)	0	1	2	2
DMG23H**	DM-HbA1 ≥9 or not done (poor control) in past year **(HEDIS)	5	5	2	2
DMG25H	DM-Outpt-LDL-C LT 100 (HEDIS)	14	19	17	16
DMG27H	DM-Outpt-BP LT 140/90 (HEDIS)	-1	0	0	0
DMG31H	DM-Outpt-Retinal exam, timely by disease (HEDIS)	1	0	5	7
DMG32H	DM-Outpt-LDL-C measured (HEDIS) w/ 1 yr review	0	0	1	2
DMG34H	DM-Outpt-Renal Testing (HEDIS)	2	3	7	8
ALL_ISC	Ischemic Heart Composite	5	3	na	na
HTN9H	BP <140/90 (HEDIS)	1	1	2	2
IHD16H	LDL-C measured (HEDIS)	3	0	2	3
IHD18HN	LDL-C <100 (HEDIS)	17	15	21	18
ALL_PRV	Prevention Composite*	-1	0	na	na
MOV5	Obese pts offered weight management	0	0	-	-
P1	Pneumococcal Immunization (HEDIS)	4	3	8	8
P22H	Influenza immunization, ages 50–64 (HEDIS)	2	1	5	6
P25H	Influenza immunization, ages ≥65 (HEDIS)	7	-2	7	11
P61H***	Colorectal Cancer Screening (HEDIS)	3	1	7	9
ALL_TOB	Tobacco Composite	0	0	na	na
SMG10	Pts using tobacco who have been offered medication in past year	0	-1	4	1
SMG8	Pts using tobacco provided with counseling in past year	0	0	2	1
SMG9	Pts using tobacco offered referral to cessation program	0	0	2	1

*Does not include Women specific measures (screening for breast and cervical cancers)

**Reversed coded to reflect higher is better

*** Measure specifications changed occurred each year

“ - ” Measure not included in the composite that year

Table 5: FY2011 National Scores for SHEP by Gender

Composites & Reporting Measures	Male		Female		Male Female	Male Female
	N	Score	N	Score	FY2011 Difference	FY2010 Difference
Outpatient						
How Well Doctors/Nurses Communicate	198,625	72	10,079	71	1	-2
Overall Rating of Personal Doctor/Nurse	201,075	74	10,094	75	-1	-3
Getting Needed Care	195,898	55	10,116	51	5	4
Overall Rating of Health Care	227,429	60	10,843	59	1	0
Getting Care Quickly	179,742	54	9,731	49	6	4
Shared Decision Making	113,679	60	6,333	60	0	1
Overall Rating of Specialist	120,161	69	6,881	68	1	0
Inpatient						
Cleanliness of Hospital Environment	48,258	74	2,201	69	5	4
Communication with Doctors	48,620	77	2,225	75	1	2
Communication with Nurses	48,620	72	2,228	72	1	1
Communication about Medication	26,561	61	1,294	57	4	4
Discharge Information	43,529	85	2,016	80	4	4
Overall Rating of Hospital	47,680	68	2,194	68	0	4
Responsiveness of Hospital Staff	18,454	60	1,122	58	2	1
Pain Management	31,002	64	1,721	66	-1	-1
Quietness of Hospital Environment	47,623	52	2,189	59	-7	-5
Willingness to Recommend Hospital	47,956	72	2,193	68	3	5

Note: Scores are adjusted for age, education, self-reported health status, and facility characteristics. A difference of five or more points is considered significant.

Table 6: FY11 VISN Outpatient SHEP scores by Gender

Network	Gender	How Well Doctors/Nurses Communicate		Overall Rating of Personal Doctor/Nurse		Getting Needed Care		Overall Rating of VA Healthcare		Getting Care Quickly		Shared Decision Making		Overall Rating of VA Specialist	
		N	Score	N	Score	N	Score	N	Score	N	Score	N	Score	N	Score
National	Female	10,079	71.1	10,094	74.8	10,116	50.5	10,843	58.9	9,731	48.7	6,333	59.9	6,881	67.7
	Male	198,625	71.7	201,075	73.7	195,898	55.2	227,429	60.2	179,742	54.2	113,679	60.3	120,161	69.2
1	Female	463	72.5	470	75.8	461	51.4	509	65.8	441	54.0	269	63.2	326	67.7
	Male	10,009	73.7	10,134	74.8	9,496	58.0	11,364	62.8	8,728	58.0	5,700	64.2	6,092	71.9
2	Female	258	79.1	255	79.6	275	58.6	291	61.7	259	56.7	164	65.1	191	63.6
	Male	5,582	75.7	5,660	77.6	5,606	60.7	6,729	63.6	5,230	60.0	3,354	62.9	3,429	73.0
3	Female	225	75.1	220	74.1	224	59.9	235	66.3	215	56.5	148	59.6	165	64.9
	Male	7,116	73.4	7,190	76.0	6,843	59.2	7,988	62.7	6,443	58.4	4,048	61.7	4,591	68.1
4	Female	565	76.8	572	79.0	552	60.6	621	65.0	549	57.5	337	62.9	364	75.7
	Male	12,923	75.3	13,186	77.5	12,158	59.7	15,307	63.6	11,239	58.1	7,058	60.6	7,243	70.6
5	Female	235	73.0	236	73.6	236	51.3	247	58.8	229	47.8	159	56.5	151	68.8
	Male	3,378	73.4	3,444	75.1	3,340	57.8	3,905	61.6	3,070	55.8	1,964	61.1	2,170	69.0
6	Female	479	64.5	481	67.9	492	44.0	526	48.8	486	43.7	324	52.9	361	67.5
	Male	8,807	70.5	8,895	71.9	8,589	52.0	9,819	59.3	7,969	51.0	5,019	58.7	5,381	68.5
7	Female	772	68.1	776	69.8	776	53.1	824	55.9	736	48.4	471	61.3	501	69.8
	Male	12,151	72.0	12,257	73.7	11,997	54.2	13,790	61.1	10,956	54.2	6,889	59.9	6,948	68.6
8	Female	765	78.0	761	78.0	740	51.9	808	65.7	694	53.2	457	64.4	522	72.7
	Male	16,231	72.8	16,415	75.8	15,479	55.4	18,169	61.8	13,877	54.9	8,997	60.4	9,817	70.0
9	Female	520	71.9	523	74.8	518	52.0	565	61.1	503	51.1	324	58.3	322	68.4
	Male	10,837	71.6	10,957	72.7	10,555	55.6	12,260	60.7	9,766	55.1	5,980	58.4	6,388	69.1
10	Female	420	72.6	419	77.1	404	51.9	442	56.4	395	53.9	269	61.6	284	69.3
	Male	9,781	71.2	9,880	74.5	9,562	57.5	11,043	61.0	8,752	54.2	5,454	58.6	6,028	69.4
11	Overall	9,315	71.2	9,427	74.8	9,317	55.9	10,733	60.7	8,418	54.0	5,341	60.6	5,641	69.9
	Male	8,938	71.8	9,053	74.6	8,940	58.4	10,325	61.0	8,063	56.8	5,113	60.8	5,390	70.6
12	Female	402	77.2	407	77.9	394	51.8	433	59.3	394	50.0	245	57.0	276	72.3
	Male	8,453	73.6	8,580	74.4	8,302	57.8	9,782	61.8	7,553	57.4	4,994	59.8	4,866	68.1
15	Female	429	73.9	430	78.0	440	50.7	462	58.6	417	48.2	259	66.6	295	69.1
	Male	9,259	68.4	9,370	69.0	9,284	55.5	10,924	56.9	8,537	54.2	5,193	57.6	5,553	66.4

(continued on next page)

(continued from Table 6: FY11 VISN Outpatient SHEP scores by Gender)

Network	Gender	How Well Doctors/Nurses Communicate		Overall Rating of Personal Doctor/Nurse		Getting Needed Care		Overall Rating of VA Healthcare		Getting Care Quickly		Shared Decision Making		Overall Rating of VA Specialist	
		N	Score	N	Score	N	Score	N	Score	N	Score	N	Score	N	Score
16	Female	811	67.2	806	71.9	798	46.0	854	58.1	758	43.4	505	58.2	536	70.2
	Male	14,352	70.7	14,479	73.0	13,921	53.8	16,199	58.9	12,681	51.6	7,911	60.0	8,230	69.9
17	Female	527	66.1	520	70.8	520	50.6	551	56.1	506	46.7	319	50.2	359	61.2
	Male	7,218	69.2	7,295	69.3	7,261	53.9	8,180	60.1	6,675	54.4	4,108	61.4	4,410	69.4
18	Female	452	67.2	452	71.7	478	44.8	509	59.8	469	41.9	287	62.8	323	65.6
	Male	8,615	70.2	8,723	73.7	8,818	49.7	9,948	58.2	8,194	50.2	4,966	61.2	5,413	66.9
19	Female	443	74.9	448	76.1	456	49.9	477	59.1	445	48.9	277	64.2	296	75.2
	Male	8,066	72.4	8,170	74.7	8,302	51.2	9,266	56.8	7,602	48.8	4,877	59.3	4,694	66.8
20	Female	503	63.2	503	68.9	515	44.6	537	50.5	483	41.1	346	56.5	335	59.7
	Male	8,338	68.8	8,457	69.8	8,539	50.9	9,469	53.7	7,854	50.4	5,011	57.8	5,227	65.8
21	Female	568	72.7	571	79.0	571	50.5	601	60.1	563	48.7	369	60.7	423	69.0
	Male	10,048	71.3	10,155	73.3	10,109	56.3	11,163	62.5	9,385	53.3	5,965	61.7	6,905	71.6
22	Overall	7,737	69.6	7,817	72.6	7,989	49.1	8,891	58.3	7,485	47.4	4,668	59.4	5,197	68.6
	Male	7,347	69.6	7,426	71.9	7,592	50.9	8,463	58.0	7,097	49.9	4,403	59.6	4,915	68.8
23	Female	453	71.7	457	77.2	467	51.9	490	64.9	424	49.2	294	63.4	307	70.4
	Male	10,535	75.0	10,692	77.2	10,550	58.4	12,586	62.6	9,459	56.9	6,272	61.8	6,109	69.8

Table 7: Network Variation in Gap in FY11 Outpatient SHEP Scores between Men and Women

Composites & Reporting Measures	Male – Female Differences		
	N	Minimum	Maximum
How Well Doctors/Nurses Communicate	21	-5.54	5.97
Overall Rating of Personal Doctor/Nurse	21	-8.97	3.98
Getting Needed Care	21	-2.27	10.98
Overall Rating of Health Care	21	-9.05	10.49
Getting Care Quickly	21	-0.11	9.33
Shared Decision Making	21	-8.98	11.16
Overall Rating of Specialist	21	-8.43	9.40

Note: A negative number indicates a higher score for women; a positive number indicates a higher score for men

Appendix B

External Comparisons: VHA vs. HEDIS 2009 – 2011

Clinical Indicator	VA Average Percent 2011 ¹	VA Average Percent 2010 ¹	VA Average Percent 2009 ¹	HEDIS Commercial 2010 ¹	HEDIS Medicare 2010 ¹	HEDIS Medicaid 2010 ¹
Breast Cancer Screening	85	87	84	71	69	51
Cervical Cancer Screening	93	94	92	77	n/a	67
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Control (<100 mg/dL)	71	69	67	59	56	41
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening	96	96	96	89	89	82
Colorectal Cancer Screening	82	82	80	63	58	n/a
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	81	82	80	66	62	60
Comprehensive Diabetes Care - Eye Exams	90	91	88	58	65	53
Comprehensive Diabetes Care - HbA1c Testing	98	99	98	90	90	82
Comprehensive Diabetes Care - LDL-C Controlled (LDL-C <100 mg/dL)	69	70	69	48	52	35
Comprehensive Diabetes Care - LDL-C Screening	97	97	96	86	88	75
Comprehensive Diabetes Care - Medical Attention for Nephropathy	95	96	95	84	89	78
Comprehensive Diabetes Care - Poor HbA1c Control (Lower is better)	17	15	16	27	26	44
Controlling High Blood Pressure - Total	78	79	77	63	62	56
Medical Assistance with Smoking Cessation - Advising Smokers To Quit ²	92	91	n/a	77	n/a	74
Medical Assistance with Smoking Cessation - Discussing Medications ²	76	75	n/a	52	n/a	43
Medical Assistance with Smoking Cessation - Discussing Strategies ²	70	69	n/a	45	n/a	39
Flu Shots for Adults (50-64) ²	71	75	n/a	53	na	n/a
Flu Shots for Adults (65 and older) ^{2,3}	84	85	n/a	n/a	67	n/a
Immunizations: Pneumococcal ^{2,3}	86	86	n/a	n/a	69	n/a

SOURCE: Office of Analytics and Business Intelligence 12-19-2011

Note: Due to population differences, and methodology variations not all HEDIS measures are comparable to VA measures — therefore this is not a comprehensive list of indicators but this comparison does contain those indicators that are closely aligned in content and methodology. VA clinical data were obtained by abstracting medical record data using similar methodologies to matched HEDIS methodologies. HEDIS Data were obtained from the 2011 “State of Health Care Quality Report” based on HMO scores (NCQA website: www.ncqa.org).

¹ VA data are provided based on fiscal year. HEDIS and BRFSS data are calendar year.

² HEDIS data were obtained by survey; VA data were obtained by Survey of Healthcare Experiences of Patient (SHEP).

³ External scores based on BRFSS reports (CDC website: www.cdc.gov). BRFSS reports median scores.

