COMMENTARY

I*DEA in the VA: Optimizing the Physician Workforce to Enhance Quality of Care

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Background: The demographic characteristics of veterans has changed significantly in recent years and continues to become more diverse. To enhance the quality of health care for the current community of enrolled veterans, it is critical that the physicians and health care leaders of the Veterans Health Administration (VHA) understand the changing demographics and health care needs of the veteran population.

Observations: Studies have shown that increased inclusion, diversity, and equity among clinicians are associated with improved clinical outcomes. Diversity encompasses more than race and gender. Although the VHA workforce is relatively diverse, the same cannot be said about its leadership. The I*DEA (inclusion, diversity, equity, and access) Council is a new program that aims to eliminate gaps in VHA care and benefits to ensure that historically underserved veteran communities receive fair treatment.

Conclusions: Optimizing I*DEA strategies—inclusion of diverse perspectives and ideas, equity of opportunities and accessibility within the VHA workforce—may help to enhance the quality of health care for veterans.

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Fed Pract. 2024;41(8). Published online August 18. doi:10.12788/fp.0492

Enhancing the quality of care for the evolving American veteran population is critical: many are vulnerable as a result of unique psychological and physical exposures, and many are increasingly coming from populations the federal government considers "potentially vulnerable."[1] To ensure that the needs of veterans enrolled in the Veterans Health Administration (VHA) are met, the US Department of Veterans Affairs (VA) workforce must be aware of shifts in the demographics of those who served.

The I*DEA (inclusion, diversity, equity, and access) Council is a new VHA equity team that aims to eliminate gaps in health care and benefits to ensure that historically underserved veteran communities receive the treatment they need. The Council is the oversight body for veteran and employee-facing I*DEA programs, policies, and initiatives.[2] One strategy to achieve better health outcomes for enrolled veterans is to prioritize the VA health care workforce. In this capacity, the I*DEA Council examines obstacles to hiring, promoting, and retaining employees from underserved communities.

This article discusses how diversity encompasses more than gender and ethnicity and proposes applying of the following I*DEA strategies to leadership positions within the VA health care workforce: inclusion of diverse perspectives and ideas, equity of opportunities, and accessibility to leadership roles within VHA facilities. Implementing these actions may help attract and retain qualified clinicians as health care leaders and enable the VHA to better serve the diverse veteran population.

VETERAN DEMOGRAPHICS

Characteristics of the current population of veterans differ significantly from those of individuals who served in previous eras. Since 2016, Gulf War era veterans have comprised the largest share of the veteran population, even larger than the share of Vietnam War era veterans.[3] Among Gulf War veterans, 47% of women and 39% of men are aged < 35 years.[4] Another notable change is the increase in the number of female veterans. In 1992, only 4% of veterans were female.[5] Now, about 11% of veterans are female, a number projected to grow to 18% by 2046 (Table 1).[3]

With respect to race and ethnicity, about 74% of the current veteran population identifies as White, 13% as Black, 8% as Hispanic or Latino, and 2% as Asian.[3,6] In addition, about 30% of veterans have ≥ 1 disability.[7] About 1 million current veterans (3%) identify as lesbian, gay, bisexual, transgender, queer, and/or questioning (LGBTQ+).[8] Almost 1 in 4 veterans—about 4.4 million—reside in rural communities, and 55% of these rural veterans are aged > 65 years.[9] Of the 4.4 million veterans who live in rural areas, 61% are enrolled in VA health care, and among those individuals 8% are women and 10% are minorities.[9]

Studies have found that age, sex, race and ethnicity, disability status, and LGBTQ+

identification all significantly affect health care access and outcomes in the general population.[10-16] Female patients are more likely to have their symptoms downplayed or dismissed, and are often less likely to receive aggressive treatments when compared with male patients. They are also frequently underrepresented or even excluded from clinical trials.[11] Female veterans have unique health care needs and report preferences for being treated by female clinicians.[17,18]

Higher rates of chronic health conditions and reduced access to mental health services are found among Black Americans compared to White Americans.[13] Black veterans are also denied VHA benefits more often than White veterans.[19] Patients with disabilities have barriers to accessing care, including difficulty with transportation and a lack of knowledge among clinicians regarding the best course of care.[14] Additionally, veterans who identify as LGBTQ+ are less likely than veterans who are cisgender and heterosexual to access Veterans Health Administration (VHA) care.[20] Veterans in rural communities experience more challenges to accessing health care; up to one-third of veterans in this population are unable to access the internet at home.[9]

To optimize care for the evolving veteran population, VHA clinicians and leaders need to be aware of the changing demographic characteristics and unique health care needs of the veteran population. Increased inclusion, diversity, and equity within the health care workforce is associated with improved quality of care, improved clinical outcomes, and have had positive financial effects on health care institutions.[21-25]

VA Workforce Demographics

According to the VA Office of Resolution Management, Diversity, and Inclusion, at the end of fiscal year 2020 57% of VA employees identified as White, 25% as Black, 8% as Asian, 7% as Hispanic or Latino, 2% as American Indian or Alaskan Native, and 1% belonged to ≥ 2 races.[26] Women comprise about 60% of the permanent VA workforce.[27] About 12% of VA employees report having a disability, which is similar to the rate of disability among noninstitutionalized civilians in the US (12.7%).[28] Five percent of VA employees identified as LGBTQ+.[29]

TABLE 1 Veteran Demographics

Characteristics	Percentage
Race and ethnicity[3,6]	
White	74
Black	13
Hispanic or Latino	8
Asian	2
Sex[3]	
Male	89
Female	11
Disability status[7]	
≥ 1 disability	30
No disability	70
Live in rural areas[9]	
Yes	25
No	75
Identify as LGBTQ+[8]	
Yes	3
No	97

Abbreviation: LGBTQ+, lesbian, gay, bisexual, transgender, queer, or questioning.

Although the general workforce is relatively diverse, there is not as much diversity within VA leadership, and little data exist about the demographic characteristics of VHA physicians. As of September 2020, there were 494 senior executive service and Title 38 (health care workers) senior executive service equivalent leaders in the VHA.[26] Almost 78% of these leadership positions belonged to white men and women: about 50% to white men and 28% to white women. In contrast, 8% of these positions were occupied by Black men, 7% by Black women, 3% by Asian men, 2% by Asian women, and 2% by Hispanic or Latino men.[26]

I*DEA IN THE VA

The I*DEA Council seeks to eliminate gaps in VHA care and benefits to ensure that historically underserved veteran communities receive fair treatment.[30] In addition to continued attention to racial disparities, the new initiative will also examine challenges experienced by other groups, including women, individuals who identify as LGBTQ+, tribal communities, and veterans who live in rural areas, aiming to eliminate disparities that exist within the VHA.

Published in 2021, the I*DEA Action Plan discusses recommendations to enhance

TABLE 2 Strategies to Enhance I*DEA within the VA

Strategies	Details
Objective criteria for clinical leadership	Must list specific achievements in: quality improvement, clinician education, research, and peer-reviewed publications
Term limits for clinical leadership	Includes Chief of Staff, department heads, clinical service chiefs and committee chairs; leaders may apply for reappointment
Committee transparency	Enable rotating leadership and membership roles when feasible
Exit interviews	To obtain feedback and insight, conduct outside 'home' department
Mentoring	For college students and health care trainees

Abbreviations: I*DEA, inclusion, diversity, equity, and access; VA, US Department of Veterans Affairs.

inclusion, diversity, equity, and accessibility within the VHA. Its mission statement states that the Council aims to "advance an inclusive environment that values and supports the diverse communities we serve" and "cultivates equitable access to care, benefits and services for all" from 2021 to 2025.[31] To achieve better health outcomes for veterans, the I*DEA Council plans to focus on the VHA workforce and examine and address obstacles to hiring, promoting, and retaining employees.[31]

There are several potential benefits of increased I*DEA integration into the health care workforce.[21-25] The inclusion of ideas and perspectives from diverse backgrounds, establishing equity of opportunities for all who are appropriately qualified, and accessibility to leadership roles that enable decision making by fostering culture change are direct components of I*DEA that may be beneficial. Diversity encompasses more than race, ethnicity, and gender, and creating a more diverse workforce involves recruiting qualified clinicians with diverse backgrounds and perspectives. Doing so would better reflect the diversity of veteran patients and could enhance the ability of clinicians to learn from each other and be inclusive, while understanding veterans' unique barriers to accessing health care.

I*DEA integration may reduce the incidence of microaggressions and help transform workplace culture.[32] This would be particularly beneficial for patients, as microaggressions can decrease patient satisfaction and may potentially negatively affect health outcomes.[33,34] In addition, health care professionals (HCPs) would benefit from fewer microaggressions in the workplace and this would foster a more positive, supportive work environment and improve morale.

Current VHA workforce data reflect changes in the veteran population. The workforce is relatively diverse regarding race and ethnicity, gender, disability, and LGBTQ+ status. However, room for improvement remains with respect to greater inclusion, diversity of perspectives, equity, and accessibility to leadership positions and decision making roles. This would ultimately benefit and improve care for veterans. Prioritizing this within the VHA, as reflected in one of the I*DEA Task Force recommendations, is of great significance.[31]

It can be difficult to accurately assess the progress made in implementing I*DEA strategies at individual institutions within the VHA. While demographic diversity can be gauged using employee statistics, assessing perceptions of inclusion, incorporation of diverse perspectives, equity, and accessibility is more challenging. We recommend continuing to administer questions focusing specifically on these perceptions to current HCPs via the VHA annual All Employee Survey.[35]

Implementation

The VA has begun initiating I*DEA concepts in its workforce, starting with the establishment and usage of Special Emphasis Programs.[36] The goal of these programs is to increase the employment of historically marginalized groups, including women, people belonging to racial and ethnic minorities, people with disabilities, and individuals identifying as LGBTQ+.[28,37-42] For

example, each federal agency has a designated Federal Women's Program whose responsibilities include helping with the recruitment and advancement of female employees.[37]

The VHA also has an affirmative action plan with goals for recruiting and retaining individuals with disabilities.[28] To strengthen equity and inclusion, the VHA offers multiple educational courses (some mandatory), both virtual and in-person, on topics such as understanding microaggressions, managing implicit bias, and understanding the importance of gender and generational diversity.[43] Creating awareness and addressing misconceptions about veteran demographics at VA medical centers is important, as is enhancing awareness among the physician workforce about VA strategies and action plans to increase I*DEA. The VHA has hired officers specifically tasked with focusing on these initiatives.

Workforce Strategies

It is important to recognize overlaps between organizational ethics, quality improvement, and I*DEA initiatives. Establishing an I*DEA Council to ensure the delivery of quality care to veterans is commendable. At the facility level, individual I*DEA officers can make observations and recommendations but are not empowered to effect change. Without participation and buy-in from individuals in leadership positions, the efficacy of I*DEA initiatives is limited.

We propose implementing simple strategies to enhance the inclusion of diverse ideas and perspectives, equity of opportunities, and accessibility to clinical leadership roles within the VHA (Table 2). A competitive selection process with specific, objective criteria to enable the selection of qualified clinical leaders is vital. Specific achievements in or contributions to quality improvement, education, research, professional publications, or diversity enhancing efforts should be required qualifications for clinical leadership roles.[44]

Establishing term limits for clinical leadership positions—something already being implemented at the National Institutes of Health—would be of tremendous value in the VHA.[45-47] Term limits would facilitate I*DEA initiatives and accessibility of leadership roles to qualified clinicians from various demographics. Improving diversity of thought among clinical leaders is especially important, given how buy-in from leadership is critical in transforming the culture of an organization. Term limits would enable access to leadership roles for forward thinking, qualified clinical leaders who could institute and support changes that would promote continuous process improvement initiatives. Leaders could have the option to reapply following the completion of a term, with the ability to demonstrate specific achievements.

Another strategy for increasing equity is to ensure transparency of committee structures, with the rotation of committee members and term limits set for committee chairs whenever possible. This provides access to leadership roles, which enables participation in decision making processes. Residents and fellows who work and train at VA hospitals should have awareness of the facility's organizational structure and the ability to participate in certain committees. The VHA workforce should be regularly informed about educational opportunities, leadership openings, and I*DEA initiatives to increase their access and use.

Exit interviews for clinicians leaving the VA would enable feedback, provide focused reviews of any problematic issues that need to be addressed, and serve as assessments of organizational ethics.[48] Transparency and truth telling could be encouraged by having these exit interviews conducted by staff in the human resources department or others outside the home department of the departing clinician.

Mentorship has played a significant role in exposing individuals from historically underrepresented groups to careers in health care, while also advancing and enhancing their careers after they become health care professionals.[49-51] Implementing and publicizing VA and veteran health care-focused mentorship and volunteer programs targeted at local communities, rural areas, schools, undergraduate programs, and medical students could increase the likelihood that students and trainees from

these groups are exposed to the VHA which may lead them to join the workforce.

CONCLUSIONS

Veterans receiving care from the VHA are becoming increasingly diverse. I*DEA strategies could optimize the VHA workforce and enhance the provision of quality care for veterans. The inclusion of diverse perspectives and backgrounds, equity of opportunities, and accessibility to leadership positions is important. Careful selection of qualified clinical leaders within the VHA—with established term limits for leadership positions, rotation of committee chairs and members, and exit interviews to obtain insights from clinicians who leave the VHA—all align with these strategies. This will foster energy and culture change, create an environment conducive to collaboration, learning, and professional growth and will enable continuous process improvement within individual VA medical centers.

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The authors report no actual or potential conflicts of interest or outside sources of funding with regard to this article.

Disclaimer

The opinions expressed herein are those of the author and do not necessarily reflect those of *Federal Practitioner,* Frontline Medical Communications Inc., the US Government, or any of its agencies.

Ethics and consent

Institutional review board approval was not needed for implementation of this program.

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