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SUBCOMMITTEES ON HEALTH

Hearing on Achieving Health Equity for America's Minority Veterans

Conclusions from CNAS' New York State Minority Veterans Needs Assessment

BY

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Despite criticisms VA is an excellent source of health care, boasting low wait times, high quality, cultural competence, and low cost for many veterans.[1] Studies have shown that wait times at VA facilities are shorter than in the private sector.[2] Systematic studies have examined the relative quality of care between the Veterans Health Administration (VHA) and outside health care providers and shown that VA provides better or equal outcomes in regard to safety and effectiveness for patients.[3] VA also provides substantially better-quality mental health care, a prime consideration for many veterans.[4] However, not all groups of veterans find VA to be equally welcoming, accessible, or able to provide adequate care. There can also be significant variation across VA Medical Centers (VAMCs), and there are widely acknowledged challenges gaining initial access to the VA system. The following testimony centering on disparities among minority veterans – women, racial/ethnic minorities, and LGBT individuals – using VA health care is drawn primarily from the forthcoming CNAS report *New York State Minority Veterans Needs Assessment*.[5]

Different veteran populations use the VA at different rates. This may partly be because not all veterans have the same knowledge base about how to access VA health care or disability assistance, particularly those who transitioned out of the military before the Veterans Opportunity to Work (VOW) to Hire Heroes Act mandating improvements to the Transition Assistance Program was signed into law in 2011. Veterans' own perception of self may also influence their comfort or willingness in seeking out care and benefits from VA: previous experiences specific to minority group populations can deter veterans from using VA for their health care at all. Minority and underrepresented groups, in particular women, racial/ethnic minorities, students, and veterans in rural areas, tend to be at increased risk for negative health care outcomes in large part due to lack of awareness, ineligibility for certain programs, and concerns about stigma against them or lack of confidentiality.

Accordingly, as the veteran population changes, so must training and assumptions of VA staff and even fellow patients, as well as what types of care are covered and how outreach is conducted.[6]

Women Veterans

Overall health outcomes for military-affiliated women have been deteriorating over the last 15 years, for both physical and mental health challenges and conditions.[7] Of particular concern for this hearing because it can affect willingness to seek care at VA facilities, military women experience sexual harassment and assault at significantly higher rates than; military sexual trauma (MST), the umbrella term that covers both severe or pervasive sexual harassment and sexual assault experienced during service, is correlated with a range of negative health outcomes.[8] According to a DoD survey, in 2018, 6.2 percent of active-duty women and 0.7 percent of men experienced a past-year sexual assault.[9] The same survey estimated that 24.2 percent of women and 6.3 percent of men had experienced sexual harassment in the previous year, and 16 percent of women and 2.3 percent of men had experienced gender discrimination. Nationwide, over the course of a lifetime, an estimated 27.5 percent of women and 11 percent of men experience unwanted sexual contact; women veterans are also at increased risk of having experienced pre-service sexual assault. Accordingly, women veterans may have complex trauma due to exposure to multiple traumatic events prior to, during, and after military service. MST is also more strongly correlated to PTSD than either combat trauma or civilian sexual assault; following the high rates of exposure in service, a significant percentage of women veterans screen positive for MST.[10]

Experiences with fellow patients and VA staff can affect veterans' willingness to engage with the system, trust the care they receive, and seek care in the first place. For example, 25 percent of women veterans reported inappropriate/unwanted comments or behavior by men veterans while at VA.[11] Women veterans who reported harassment were less likely to report feeling welcome to VA, which related to delaying and/or missing care. One stakeholder in CNAS interviews said about experiencing harassment at VA: "A veteran doesn't necessarily go back to VA. If they have a negative experience, they're not coming back." Women with a history of MST are more likely to find this to be an insurmountable barrier to care. Women veterans strongly encouraged each VA center to have a women's care coordinator employed to change the all-male culture of VA centers. While each VAMC is required to

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have a women veterans program manager to advise and advocate for women veterans, the amount of influence that individual has within the facility varies substantially.

As a smaller share of the veteran population, women veterans have historically not felt informed of their benefit entitlement or welcomed at VA facilities. A vast disparity between VA users and nonusers illustrated lack of awareness that specifically addressed women's health services: 67 percent of users received information compared with only 21 percent of nonusers.[12] One of the biggest factors, according to interviews with stakeholders and advocates for women veterans, is barriers to receiving care. One example given was, "When women show up, they are challenged whether they served; they're asked questions that their male counterparts aren't asked."

Stakeholders routinely reported that women are often reluctant to seek services at VA Medical Centers as they are, or are perceived to be, male-dominated spaces and thus less sympathetic, understanding, or welcoming to women. Women veterans reported being mistaken for a spouse or partner of a veteran rather than veterans themselves, or otherwise questioned as to why they are entitled to veterans' benefits. Women who have experienced military sexual assault are particularly untrusting of VA care and often elect not to reenter a military environment; however, few providers in the civilian setting are familiar with the effects of MST.

Despite these challenges, there has been a rapid and significant increase in VHA usage by women veterans— a 45.4 percent increase since 2007, though the women veteran population has increased only by 7.7 percent.[13] It is imperative that VA strategically plan for the substantial and ongoing growth in the population of women veterans it serve. In particular, given the high rates of mental health conditions and MST, the Office of Mental Health Services and Suicide Prevention should develop a strategic plan to support women veterans' mental health needs within the PACT model as well as with increased funding and training for providers. Additionally, VA should modify or eliminate two discriminatory policies: the medical benefits package bars abortion and abortion counseling, with no exceptions for rape, incest, or life endangerment of the woman; and VA may charge a co-payment for birth control for some patients.[14] This is out of alignment with all other federally-provided health care and medical best practices.

Racial/Ethnic Minority Veterans

In the United States more broadly, studies have shown that racial minorities experience bias in health care that can and does lead to increased fatalities. As the Centers for Disease Control and Prevention published in May 2019, maternal mortality is three times higher among African American and AIAN women than white women in the general population, demonstrating that racial bias in health care causes preventable deaths.[15] The legacy of the Tuskegee experiments also contributes to lingering mistrust of the health care system among people of color more broadly. Stereotypes about minority individuals' pain tolerance and symptoms have been reported to influence medical providers into disregarding complaints by minority patients.[16] A few CNAS focus group participants specifically reported that medical providers at VA centers take the pain and symptoms of people of color, particularly women, less seriously than those of their white counterparts, providing a barrier to correct health diagnoses and contributing to a lack of trust.

Advocates for minority veterans also argued that providers, representatives, and VSOs are not culturally knowledgeable and are unable to offer culturally competent care. Focus group participants perceived providers as not sufficiently trained on cultural differences or adequately connected to the minority populations they are serving. A number of participants emphasized a lower willingness in the African American community to seek out mental health care, and this cultural difference needs to be examined by leadership to better care for black veterans suffering from mental health issues: "In black culture there isn't a lot of tendency to seek help for mental incapacity. You can't just have a doctor say here's a service, come and get treatment. If they understood the cultural aspects, they have to understand talking to a person that there's a reason they're not accessing services."[17] Similar to the experiences of minority communities, civilian and veteran alike, across other life domains, implicit and explicit biases of health care providers negatively affect minority veterans. Participants felt they received substandard treatment by doctors.

Despite these perceived challenges, between 2005 and 2014, minority veterans enrolled in VA health care at much higher rates, an increase of 43 percent, while nonminority veterans enrollment increased only 24 percent.[18] The causes for this differential increase in enrollment are unclear and could indicate greater need for VA health care due to economic factors or be a reflection of growth in the minority veteran population. Increases in VA utilization overall likely reflect enhanced outreach and changes to eligibility that expand access to all combat veterans for five years after service. The overall VA benefit usage rate was 49 percent: Native Hawaiian/Other Pacific Islander veterans were the most likely to use VA (59 percent), followed by black (54 percent) and Hispanic veterans (53 percent).[19] American Indian / Alaska Native (45 percent) and Asian (42 percent) veterans were the least likely to use VA benefits. American Indian and Alaska Natives are more likely than their non-Native veteran counterparts to lack health insurance and proper health care.[20] (Native American veterans present a unique case as they are covered by three jurisdictions – federal, state, and tribal. Due to these complexities, we recommend a separate hearing specifically focused on their access to care.)

LGBT Veterans

LGBT veterans are more likely to have experienced sexual assault and trauma prior to and during service, influencing health and well-being outcomes post-service, and the LGBT community on the whole is at higher risk of stigma and violence than other groups.[21] While health-care-related data regarding LGBT veterans is limited due to historical policy barriers to the disclosure of sexual orientation and gender identity, the Health Related Behaviors Survey has shown that among active-duty personnel, LGBT individuals were more likely to report having ever experienced physical abuse or unwanted sexual contact.[22] Similarly, a significantly higher percentage of LGB service members reported past-year sexual assault than did their non-LGB counterparts in the 2018 Workplace and Gender Relations Survey (WGRA) of Active Duty Members (which tracked LGB but not transgender service members): 9 percent of LGB women compared with 4.8 percent of non-LGB women and 3.7 percent of LGB men compared with 0.4 percent of non-LGB men.[23] LGB service members in another study were twice as likely to experience military sexual assault, which was directly linked to PTSD and depression among LGB veterans: 40 percent of LGB veterans have PTSD symptoms compared with 30 percent of non-LGB veterans.[24]

The Healthcare Equality Index, developed by the Office of Health Equity in partnership with the Human Rights Campaign, showed only 49 percent of VA Medical Centers were classified as "Leaders," or "Top Performers," the two highest designations awarded, as of 2019.[25] This data is reinforced by input from stakeholders and veterans. A common thread across interviews and focus groups regarding LGBT veterans was the importance of cultural competency and mandatory trainings for VA personnel to better serve the LGBT veteran population. Multiple advocates highlighted the variety of barriers LGBT veterans face in accessing health care, many of which are unique to their sexual orientation and/or gender identity, during CNAS interviews. One described it as, "You're dealing with medical providers that aren't receiving necessary training to properly assess issues that you're going through and provide unnecessary treatments." According to numerous stakeholders, many LGBT veterans tend not to feel comfortable claiming veteran status and are therefore less willing or likely to seek out VA health care. Similar to those barriers for women veterans, LGBT veterans report a reluctance to visit VA medical centers, specifically reporting that they are often dominated by older veterans who typically have more conservative views on sexual orientation and gender identity. One stakeholder noted that LGBT veterans experience disproportionate negative health outcomes not because of their identity but rather because of the stigma and discrimination they face for who they are, or due to providers who "don't understand these implicit things they should about LGBT people." However, according to the 2015 U.S. Transgender Survey, 87 percent of transgender veteran respondents had reported being treated respectfully at the VA all or most of the time.[26]

These barriers to care are particularly concerning for the LGBT veteran population given that among the active duty force, a significantly higher percentage of gay service members suffer from PTSD (53 percent) compared with heterosexual service members (17 percent). This is even more acute for lesbian service members, 67 percent of whom

suffer from PTSD compared with 19 percent of heterosexual female service members.[27] While LGBT status is not causal for PTSD or suicide, sexual orientation is considered a risk factor.[28] LGBT individuals are more likely to have reported binge drinking, cigarette smoking, moderate to severe depression, and suicidal ideation and attempts.[29] Rates of suicidal ideation are two to three times higher for the LGBT community and suicide attempts two to seven times more frequent. Those with gender dysphoria attempt suicide at a rate 20 times higher.[30] Research has shown that "stigma, prejudice, and discrimination create a hostile and stressful social environment that causes mental health problems," known as minority stress; efforts to reduce homophobia and transphobia are an important component of broader efforts to improve mental health in the veteran community.[31]

In terms of transgender-specific health care, gender confirmation surgery is specifically excluded from the VA medical benefits package; additionally, VA does not provide any surgery for strictly cosmetic purposes.[32] This is not in alignment with generally accepted standards of care for those with gender dysphoria.[33] Additionally, because VA health care is considered "minimum essential coverage" under the Affordable Care Act, veterans who are enrolled in VA health care do not qualify for subsidies in the Health Insurance Marketplace; accordingly, these veterans may be financially unable to enroll in a plan that would provide this medically necessary care.[34] Crucially, observational studies have shown dramatic reductions in suicide ideation, suicide attempts, and suicides among transgender individuals who receive appropriate transition-related care. Excluding this care from the VA medical benefits package does not align with standards of care or VA's stated commitment to suicide prevention. Additionally, VA does not provide in vitro fertilization for same-sex couples, another discriminatory practice that should be promptly eliminated.

Discharge status may have an outsized impact on LGBT veterans, who may have been involuntarily separated from the military under the DADT policy. If separated with an OTH discharge, these veterans would not have the same access to veteran benefits, compounding an overall distrust of the military and veteran system and a feeling of unwelcome. The approximately 14,000 service members separated from the military under DADT may need to appeal their discharge status.[35] While these individuals can now request a discharge upgrade, they may have been denied access to care and benefits for many years, and the upgrade process takes time. Members of the LGBT community repeatedly report fear and mistrust in deciding whether to access their VA services. One stakeholder noted that an administrative separation code indicates when a discharge was related to homosexual behavior even when a veteran retains access to benefits. Many veterans fear that involuntarily "coming out" to health care providers due to service records will lead to less than optimal care from a provider who does not support their identity or sexual orientation.

A number of stakeholders referenced the current political environment's impact on minority populations, particularly the LGBT community, and their willingness to access care, in some cases mistaking DoD policy for VA policy. For example, one advocate said debates over the military's "trans ban" affect ability to provide care to the LGBT community at the state level due to mistrust in the community and confusion over legal status. Transgender individuals also express fear of being misgendered by health care practitioners, a microaggression in a space that deals with very personal issues that can lead to a lack of trust in the health care system as a whole. Advocates for transgender veterans note that being misgendered in health care environments can lead to negative mental health outcomes, which is supported by studies relating misgendering to increased stress.[36]

A damaging misconception is that VA facilities do not include any LGBT health services. While the absence of available gender confirmation surgery negatively impacts transgender veterans who have not medically transitioned, other LGBT health care options at the VA do exist. Lack of trust in health care providers is insidious and leads to suboptimal health outcomes. For example, providers do not always advertise that they offer pre-exposure prophylaxis (PrEP), making it less likely LGBT patients will obtain a prescription for this vital HIV-prevention drug. Providers also may not explicitly offer screening for sexually transmitted diseases (STDs), putting the onus on the patient, which can be a charged request and difficult without a trusting relationship. A second layer of challenges LGBT veterans face is discrepancies with health care itself. Many LGBT veterans experience a lack of consistency across VA facilities. Each VA Medical Center is supposed to have an LGBT veteran care coordinator (VCC) on hand to serve as a patient advocate and assist LGBT-sensitive staff trainings. However, quality of VCCs varies widely. CNAS site visits

identified significant variation in the LGBT-focused materials available in waiting rooms, ranging from confusion over the acronym "LGBT" to comprehensive informational material, welcoming posters, and competent staff. Additionally, other patients can contribute to VA Medical Centers being unwelcoming: One representative of a veteran-serving nonprofit reported witnessing transgender veterans being subjected to inappropriate verbal and nonverbal behavior from fellow patients because of their transgender status.

A number of LGBT advocates noted the lack of effective outreach by VA to these populations. This lack of public awareness leads to increased confusion and/or ignorance of entitlements and benefits. VSOs have historically fulfilled this outreach role, helping veterans and transitioning service members navigate online services and file comprehensive claims. According to advocates and LGBT veterans, these spaces and organizations are often hostile or triggering spaces, leaving this community without assistance navigating a cumbersome bureaucracy. Improving these spaces is one recommended solution, though additional outreach to nontraditional veteran spaces may be more useful.

LGBT veterans expressed that VA needed to specifically ask about sexual orientation upon intake to normalize and clarify LGBT status from the beginning. Such a question would remove the "dirty secret" aspect of sexual orientation and make it more clinical, rather than something veterans have to worry about. Veterans also agreed that the location of LGBT veteran care coordinators' offices in VA centers on the mental health floor likened LGBT status to mental health issues. Of trans veterans, 40 percent have received health care through VA, of which 75 percent continue to receive health care.[37] Of these veterans, 72 percent said they were out as trans to their health care provider and 47 percent reported they were always treated respectfully. The majority of trans veterans—79 percent—reported satisfaction with VA care, higher than the satisfaction expressed by ethnic minorities and low-income veterans, despite the challenges noted above.[38]

Conclusion

VA should improve data collection, analysis, and publication on health outcomes of all minority veterans, particularly from an intersectional lens, to enhance Congress' ability to conduct effective oversight. In addition, VA should work to become more welcoming for all minority veterans. Recommendations include implementing trauma-informed and dignity-affirming care, including effective cultural awareness training for all employees; updating waiting room reading material, posters, and television channel default settings to be more inclusive; expanding Veterans Experience Office efforts using human-centered design concepts to identify and alleviate disparities in the experiences of minority veterans; expanding the nascent End Harassment campaign to include the harassment LGBT and racial/ethnic minority veterans experience; and expanding the "secret shopper" model of ensuring that front-line staff members are aware of resources for MST survivors such as LGBT VCCs, minority veteran coordinators, and women veteran coordinators at VA Medical Centers nationwide.

Additionally, VA should carefully review all policies and provisions of the medical benefits package to eliminate provisions that discriminate against women, veterans of color, and LGBT individuals. Should VA be unwilling or unable to take these actions independently, I urge Congress to consider legislation to require VA to cover gender confirmation surgery, a medically necessary and evidence-based treatment for gender dysphoria in transgender individuals; cover in vitro fertilization for same-sex couples; eliminate the blanket ban on abortion and abortion counseling, with no exceptions for rape, incest, or life endangerment of the woman; and eliminate co-payments for birth control. Overall, VA is a top-tier provider of health care. Identifying and eliminating barriers that make it less welcoming and effective for minority veterans is an important part of ensuring health equity for all who have served our great nation.

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