Modern Military Association of America

Modern Military Association of America
1725 I Street NW, Suite 300
Washington, DC 20006

STATEMENT OF

JENNIFER L. DANE, M.A.

EXECUTIVE DIRECTOR

MODERN MILITARY ASSOCATION OF AMERICA

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON HEALTH

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"Beyond Deborah Sampson: Improving Healthcare for America's Women Veterans in the 117th Congress"

Chairwoman Brownley, Ranking Member Bergman, and Members of the House Committee on Veterans' Affairs, Subcommittee on Health, I am Jennifer Dane, an Air Force veteran, and the Executive Director of the Modern Military Association of America (MMAA) – the nation's largest LGBTQ military and veteran non-profit dedicated to advancing fairness and equality. MMAA appreciates the opportunity to present a written testimony addressing, "Beyond Deborah Sampson: Improving Healthcare for America's Women Veterans in the 117th Congress."

On behalf of our 85,000 members and supporters, my testimony will highlight the intersectionality of women Veterans and particularly women Veterans how are lesbian, bisexual, transgender, intersex, and gender-expansive. It will include recommendations for VHA employees as well.

Key points:

- Estimates suggest there are more than one million Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning (LGBTQ)* Veterans in the United States.
- LGBTQ Veterans are at an increased risk for healthcare disparities, including suicide.
- An Internal Task Force will help develop a system reflective of LGBTQ Veteran and Employee input (i.e., human-centered design).
- Standardized staff training is needed. A provider's knowledge of a patient's LGBTQ status is essential to providing appropriate prevention screening and care.
- The Corporate Equality Index (CEI) benchmarks are recommended for identifying workforce protection criteria and ensuring an inclusive employee health benefits package.
- Full-time equivalent employee (FTEEs) is necessary at all systemic levels (VACO, VISN, and Facility) to implement initiatives and identify long-term solutions. A Clinical

Implementation Lead is recommended for overseeing systemic efforts at expanding affirmative care.

- All VHA facilities should have full-time LGBT Veteran Care Coordinators (LGBT VCCs).
- The Medical Center Director is recommended to participate in the annual Healthcare Equality Index (HEI).
- Family building should be accessible to all LGBTQ women who are partnered, married, or single.

Research Regarding Healthcare Disparities for LGBTQ Veterans

While VHA's ability to assess the exact numbers of LGBTQ Veterans is limited at the system level (e.g., US Government Accountability Office report, October 2020), the startling statistics about LGBTQ healthcare disparities have been well established within the literature.

When compared to the general population, LGBTQ Veterans are at an increased risk for mental health concerns, substance abuse, sexually transmitted infections (STIs, including HIV), intimate partner violence (IPV), and suicide (e.g., Blosnich, Mays, & Cochran, 2014). Minority stress theory indicates that adverse health care outcomes and maladaptive coping mechanisms (e.g., substance abuse) among LGBTQ individuals are largely attributable to stigma and social stress that the larger heterosexual population (Hampton & Pachankis, 2018). Barriers to receiving culturally competent healthcare contribute to worse health outcomes for LGBTQ individuals.

Many LGBTQ Veterans do not disclose their sexual orientation and/or gender identity to healthcare providers, contributing to several salient LGBT health concerns and cultural prejudices being overlooked by many practitioners. Concealment of identity is strongly

associated with internalized stigma and cultural prejudice (e.g., Pistella, Salvati, Ioverno, Laghi, & Baiocco, 2016), which can have devastating impacts on one's life and hinders one's ability to mitigate the impact of external stressors (Tishelman, & Neumann-Mascis, 2018). LGBTQ individuals who served in the military can experience unique minority stressors due to forced concealment of identity stemming from homophobic/transphobic military policies (Ramirez & Sterzing, 2017). Chronic stress experienced from microaggressions, discrimination, overt harm, and stigma substantially impacts overall wellness and healthcare engagement. One study highlighted that 24% of LGBT Veterans had not disclosed their sexual orientation or gender identity status to any VA provider (Sherman, Kauth, Shipherd, & Street, 2014), suggesting that many practitioners may overlook the disproportionate prevalence of LGBTQ health concerns and cultural prejudices. A lack of awareness of unique healthcare needs by both the Veteran and healthcare provider further perpetuates these healthcare disparities.

LGBTQ-related military investigations (also known as "witch hunts") were known and feared for many Veterans. Don't Ask, Don't Tell (DADT) was originally intended to be a progressive compromise for the military. It meant that service members would no longer be asked about sexual orientation; however, DADT led to secrecy and fear that others would learn about LGBTQ identity. Recently, the debate of open service has centered on transgender and gender-diverse service members. Serving under anti-LGBTQ military policies can contribute to unique minority- and military-related stressors such as concealed identity, harassment, trauma exposure, social isolation, internalized stigma, mistrust of others, and ongoing emotional difficulties (e.g., Ramirez & Sterzing, 2017).

Provider-focused education and inclusive facility policies are beginning to raise awareness among providers about the unique needs and healthcare disparities for LGBTQ Veterans. There

is growing support that these systemic methods have contributed to improved LGBTQ Veteran experience with VHA services (Kauth, Barrera, Latini, 2018). Despite progress in educating providers, LGBTQ individuals continue to experience worse healthcare outcomes than their heterosexual and cisgender counterparts. For instance, 36% of LGBT Veterans view the VA hospital as "somewhat or very unwelcoming" (Sherman, Kauth, Ridener, Shipherd, Bratkovich & Beaulieu, 2014). While VHA may not have been involved in negative military experiences, the organization is tasked with providing a corrective emotional experience for those who served. National initiatives have largely focused on provider education and policy development; research supports that these efforts lead to improved perceptions of VHA (Kauth, Barrera, & Latiti, 2018). Yet, LGBT Veterans are often unaware that these changes are happening and that VHA is committed to improving the experience for all.

Current VHA Policy and Directives

In 2012, the Office of Patient Care Services established the LGBT Health Program (10P4Y) to develop and refine policy recommendations, provider education programs, and encourage patient-driven healthcare for LGBT Veterans. In 2016, a national program was created for a point of contact for LGBTQ Veterans in the form of LGBT Veteran Care Coordinators (LGBT VCC). Each VHA facility has at least one designated LGBT VCC tasked with implementing national and VISN-level LGBT-related policies, among other duties. The designated facility LGBT VCC is responsible for facilitating staff cultural and clinical competency for working with LGBT Veterans. Notably, this is a collateral position with no mandated protected time or structured clinical implementation support for program development.

Several VHA policies are inclusive of LGBTQ Veterans and Employees. Currently, there are four LGBTQ-specific policies (https://www.patientcare.va.gov/LGBT/VA_LGBT_Policies.asp):

VHA Directive 1340: Health Care for Veteran who Identify as Lesbian, Gay, or Bisexual

> "It is VHA policy that all staff provides clinically appropriate, comprehensive, Veteran-centered care with respect and dignity to LGB Veterans. Clinically appropriate care includes assessment of sexual health as indicated with all patients, and attention to health disparities experienced by LGB people."

VHA Directive 1341: Providing Health Care for Transgender & Intersex Veterans

> "Veterans are treated based upon their self-identified gender. Care can include: Hormonal therapy, mental health care, preoperative evaluation, and medically necessary post-operative and long-term care following sex reassignment surgery. VHA does not pay for nor perform Gender Confirming Surgeries."

Rights and Responsibilities of VA Patients and Residents of Community Living Centers

> "You will be treated with dignity, compassion, and respect as an individual… you will not be subject to discrimination for any reason, including for reasons of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression."

Rights and Responsibilities of Family Members of VA Patients and Residents of Community Living Centers

> "When a loved one is involved in support and care of a VA patient or CLC resident, VA considers a patient or CLC resident's family to include anyone related to the patient or CLC resident in any way (for example, biologically or legally) and anyone who the patient or CLC resident considers to be family."

VHA Task Force for Achieving Health Equity and Inclusivity

While there are identifiable problems and proposed recommendations throughout this document, they are insufficient in addressing the historical and systemic contributors to LGBTQ healthcare disparities and experienced discrimination. Therefore, to achieve health equity and inclusivity for LGBTQ Veterans and Employees, an internal task force is strongly recommended. The proposed

model is based upon examples found among professional organizations (e.g., APA; 2009) that have a history of developing task forces responsible for establishing standards of care.

Taskforce membership would be comprised of:

- Internal providers on all levels (VHA facility, VISN, VACO) who are considered subject matter experts (SMEs) in their respected field
- LGBTQ staff members who are knowledgeable about employee benefits packages and/or equal employment opportunity (EEO) policies
- external veteran service organization (VSO) representatives
- LGBTQ Veterans.

To ensure fairness and diversity of perspectives among SMEs, recommend that a board of reviewers choose from a select candidate pool. These reviewers would not be eligible to serve on the task force. Recommended to consider the rotation of LGBTQ Veterans at each task force meeting to diversify input from the community, which will increase representation from the subgroups and other intersecting minority groups (e.g., race/ethnicity, religion/spirituality, geographical location, etc.). The committee members would nominate a chair among themselves. The proposed model ensures systemic change is based upon human-centered design principles with input from LGBTQ Veteran stakeholders.

The task force would serve to ensure that policymakers are not designing a healthcare system based upon assumptions of LGBTQ Veteran and Employee wants and needs. Rather, the task force would ensure diverse input from stakeholders across systemic levels to define a path for achieving health equity and inclusivity.

The task force is recommended to meet for one year, with adequate protected time for each member to meet this ambitious deadline. During this time, the following products are recommended for consideration: 1) standards of care for services essential to LGBTQ Veteran Care (e.g., mental health, primary care, endocrinology, sexual health, caregivers, intimate partner violence, gender-affirming surgical interventions, whole health), 2) develop implementation strategies for clinical standards of care for replication at VHA facilities across the country, 3) establish user-friendly one-page fact sheets for all major areas identified, 4) provide recommendations to create a national LGBT Health program that has adequate resources and interdisciplinary staffing, comparable to other VACO-level program offices (e.g., Women's Health), 5) develop a plan for dissemination of provider and staff trainings, and 6) identify opportunities for outreach and barriers to healthcare enrollment for LGBTQ Veterans. In all of the objectives, the task force will need to identify how to balance safety and privacy needs with identifying sexual orientation and gender identity status for health care and program planning purposes.

Notably, these recommendations for the task force are based upon current research findings and information gathered from those LGBTQ Veterans and Employees who were/are willing to come forward and share their experiences. The task force objectives should be flexible enough to be shaped by what is learned over time.

While the task force would be utilized for the planning of lasting systemic enhancements, there are immediate steps that can be taken to remedy specific healthcare disparities. Monitoring the impact of initial interventions is recommended to determine the effectiveness and potential adjustments needed; in other words, the system should be shaped by what we learn from LGBTQ Veterans and Employees.

VHA Systemic Recommendations

Without systemically asking about sexual orientation and gender identity (GAO, 2020), the complexity and care needs of the LGBTQ Veteran community remain unknown. The following recommendations provided are based upon currently recognized gaps and the need for more dedicated personnel to build a comprehensive program across levels of the system.

Allocate Resources, Time, and Staffing

Currently, the LGBT Veteran Health Program (10P4Y) is underfunded and understaffed. It has been difficult to advocate for systemic intervention without dedicated personnel to develop metrics for standardization, establish benchmarks for the field, and distribute the resources necessary to meet those benchmarks. The LGBT Veteran Health Program needs more Full-Time Equivalent Employees (FTEE), comprised of interdisciplinary subject-matter experts, who can provide insight into solutions for gaps of care (e.g., mental health, primary care, endocrinology, affirming surgical interventions). A VACO-level clinical implementation lead would oversee program planning and dissemination of affirmative care best practices to the field. More clinical guidance is needed to ensure consistency across facilities. More financial support for outreach events and symbols of safety (e.g., lanyards, magnets, posters) is needed to legitimize the program.

The current structure of collateral LGBT Veteran Care Coordinator (LGBT VCC) positions hinders the ability to track sexual orientation and gender identity metrics and contributes to lack of protected time to fulfill the defined responsibilities for the role [VHA Directive 1340(2), Appendix B]. The LGBT VCC role is inadequately funded and supported, hindering ability to proactively deal with healthcare disparities in a manner that promotes health equity. Collateral

positions create the following difficulties: 1) the role is filled by staff with varying cultural competency, skill level, interest, program planning ability, protected administrative time, and competing duties; 2) the role is often not incorporated into the employee's functioning statement and not evaluated as "essential" duties; 3) the employee's main position can drastically impact effectiveness and ability to protect administrative time to fulfill the LGBT VCC duties;

4) alignment of the LGBT VCC position often defaults to the employee's main position and provides widespread variability of how the role is performed; and 5) there is a lack of systemic accountability on program planning and clinical implementation of best practices.

"LGBT VCCs are constantly being called on to provide services that fall under the purview of other staff, just because the issue is related to LGBTQ veterans. Without real investment and open support, the VCC role can feel more like being a janitor, called in to mop up a problem. This prevents us from doing what we are told to do: advance and support LGBTQ Care in VA." – *Anonymous VHA Employee*

LGBT VCCs across the country fulfill this collateral position because of a passionate desire to promote health equity yet, campaigning for reform and health equity is a known contributor to activist burnout among professionals (Chen & Gorski, 2015). The role lacks the protected time, resources, skills, and training for many to feel effective in the role. The facility-level experience is often mirrored for VISN-level LGBT VCC Leads, who experience the same variability in support and resources. <u>it is paramount to fund the LGBT VCC role as a full-time position at every VHA facility with comparable funding for positions on the VISN-level.</u>

"I certainly think there are many more barriers LGBT VCCs face than just insufficient time (and problems/barriers vary by site) but I think a full-time position would go a long way in legitimizing the work we are doing and ensuring folks have adequate time to address the growing list of things LGBT VCCs are expected to do." – Anonymous VHA Employee

Consideration of position description and alignment of the position is essential. Often, the LGBT VCC is defaulted under the Mental Health & Behavioral Services (MH&BS) line, which furthers stigmatizes sexual orientation and gender identity. Furthermore, this alignment under MH&BS means that LGBT VCCs are often tasked with being the sole referral source for psychotherapy of LGBTQ Veterans. If a referral for mental health would not be based solely on other diversity-related factors (e.g., race/ethnicity), it is discriminatory for this to occur for this population. To promote affirmative care being available in every care appointment, it is recommended that a full-time LGBT VCC position be aligned under the Chief of Staff (COS). Several VHA facilities are spearheading full-time positions with success (e.g., Hampton VAMC; VISN6) and can be utilized as a model for replication.

Standardization of the LGBT VCC position description would allow for systematized metrics and future benchmarking goals for improvement. The proposed staffing changes would require considerations of training needs for all LGBT VCCs. It is recommended that an annual conference for all LGBT VCCs be funded and supported to provide training on field best practices, program implementation, and skill development.

"I get absolutely no guidance here, no navigation on how to accomplish these tasks, and I have no authority or political capital or resources to propose such things. I do all I can." – Anonymous VHA Employee

"I wonder whether it is reasonable to expect folks with such a disparity of training, authority, knowledge, and skills to perform the same functions. Should we not be training VCCs in these skills and teaching us how to use our formal, institutional authority?" – Anonymous VHA Employee

"There is a real disparity of institutional authority and leadership training among VCCs. Some of us are clinicians, some are administrative staff, some have been in VA for a long time, some have been in their role for decades, some are brand new at their jobs. We need skill-building and investment in making the VCCs' authority clear and actionable." – Anonymous VHA Employee

Standardize Staff Trainings

A provider's knowledge of a patient's sexual orientation and gender identity status is essential to providing appropriate prevention screening and care. To raise awareness of unique health considerations for the LGBTQ Veteran community, voluntary educational offerings have been available to VHA staff across the country through the Talent Management System (TMS). Several VHA facilities offer ongoing in-person staff trainings, which is often provided by the LGBT VCC. In addition, relevant resources can be accessed through two internal SharePoint sites.

Staff education is largely voluntary and often reaches an audience who is already motivated to enhance personal knowledge. Unfortunately, there are instances in which inadequate care is

provided due to provider claims of not possessing "specialty knowledge" about the LGBTQ Veteran community. From the onset, if a provider does not ask about sexual orientation and/or gender identity, then the Veteran does not get access to appropriate and culturally informed care. Minimum standards for training on LGBTQ health are needed to develop baseline competency for all staff and providers.

Additionally, it is essential that LGBTQ Veterans have access to health literacy programming so that they can be informed about how sexual orientation and gender identity matter in healthcare (Lange et al., 2020). This, coupled with comprehensive training efforts, will promote the provider and patient to communicate in an informed and productive manner.

"It is not uncommon for LGBTQ people (not just veterans) to live stealth. You won't actually know the size of the Veteran population if providers are not asking specific questions about sexual orientation and gender identity." – Anonymous VHA Employee

Beyond minimum standards for the education of all staff, areas of care require advanced training (e.g., evaluations of readiness, hormone therapy). Levels of competency can be established to designate the extent of knowledge in an area of practice, and these designations can be identified by providers during the privileging process. Identification of qualified staff, beyond the LGBT VCC, would assist in standardizing best practices across VHA facilities.

Clarification Regarding "Right of Conscience" in relation to LGBTQ Veteran Care

Right of Conscience (ROC) permits providers to avoid potentially morally objectionable issues (e.g., abortion, contraception, or sterilization). The National Center for Ethics in Health Care serves an "authoritative resource for addressing the complex ethical issues that arise in patient

care, health care management, and research" (U.S. Department of Veterans Affairs, 2021a). Regardless of the provider's personal objections, there remains an obligation to ensure medically appropriate care is provided to the patient; there is a process that must be followed if an objection arises. Importantly, aspects of identity (i.e., sexual orientation, gender identity) are not considered morally objectionable. It is recommended that clarification be provided to the field regarding equitable delivery of services, enhancing provider standards for culturally competent care, and clear consequences for refusal of care based on ROC.

Healthcare Equality Index (HEI)

The Healthcare Equality Index (HEI), by the Human Rights Campaign, "is a national LGBTQ benchmarking tool that evaluates healthcare facilities' policies and practices related to the equity and inclusion of their LGBTQ patients, visitors, and employees" (HRC, 2020b). The well-known reference highlights and encourages the use of best practices and policies for LGBTQ inclusive care. Healthcare facilities are evaluated in four domains: 1) Non-Discrimination & Staff Training, 2) Patient Services and Support, 3) Employee Benefits & Policies, and 4) Patient and Community Engagement. Earning the coveted "LGBTQ Leader" status indicates that a hospital or medical center achieved a perfect score on the measure and did not engage in activities that would undermine LGBTQ patient care.

In 2020, 59 VHA Facilities earned perfect scores and the status of "Leader in LGBTQ Healthcare Equality" (HRC, 2020b). The number of Leaders demonstrate successful progress in advancing affirmative care. Currently, VHA participation in this measure is encouraged at all facilities. It is recommended that all VHA facilities are required to complete the HEI, with accountability placed upon the Medical Center Director. The results of the HEI provide feedback

on organizational needs, identified areas for improvement, and establish system-wide standards. Notably, the public-facing results are accessible to LGBTQ Veterans.

Expand Opportunities for Research and Quality Improvement

Research and quality improvement projects serve to increase visibility and awareness of LGBTQ health care needs within VHA. It is recommended that specific funding be allocated for Health Services Research and Development Service (HSR&D) and quality improvement grants be made available for front-line staff championing innovative clinical interventions. An annual conference on LGBT Veteran Health would promote collaborations and dissemination of findings among the field.

LGBTQ Employees and Beneficiaries Recommendations

LGBT Special Emphasis Program Manager (LGBT SEPM)

The Office of Resolution Management, Diversity, and Inclusion (ORMDI; 2021) established specific programs to promote an inclusive workforce. The LGBT Special Emphasis Program Manager (LGBT SEPM) serves as a point of contact for sexual and gender minority employees and engages in cultural activities to raise awareness of diversity and inclusion efforts. It is widely recommended that this position has protected time but, similar to the LGBT VCC role, there is widespread variability. It is recommended that all LGBT SEPM's have appointment letters with protected time, with duties included in performance standards. Furthermore, funding should be provided for LGBT SEPM attendance at an approved external conference (e.g., Out & Equal Workplace Summit) in order to identify workplace inclusion efforts that may translate to VHA.

Corporate Equality Index (CEI)

The Corporate Equality Index (CEI), by the Human Rights Campaign, "is a national benchmarking tool measuring policies, practices and benefits… and is a primary driving force for LGBTQ workplace inclusion" (HRC, 2020a). The CEI evaluates large businesses in three domains: 1) Non-discrimination policies across business entities, 2) Equitable benefits for LGBTQ workers and their families, and 3) Supporting an inclusive cultural and corporate social responsibility. The VA does not participate in the CEI. It is recommended that CEI benchmarks are used as a framework for identifying workforce protection criteria, an inclusive employee health benefits package (e.g., transgender-inclusive healthcare coverage, domestic partner benefits, inclusive benefits for beneficiaries), as well as the implementation of organizational competency programming and educational efforts to promote an inclusive workforce.

"Despite progress, 46% of LGBTQ workers nationwide remain closeted on the job. Retaining workers is largely about everyday experiences on the job." – Corporate Equality Index, 2021

"When a hospital takes steps to provide equitable treatment and inclusion for LGBT employees, it benefits the entire workforce." - Joint Commission, LGBT Field Guide

LGBTQ Veterans and Beneficiaries Recommendations

*Affirmative Care***

Defined as "an approach to health and behavioral health care that validates and supports the identities stated or expressed by those served" (Natasha et al., 2020), affirmative care is much more than good intentions. Affirmative care actively embraces LGBTQ identities while recognizing the impact of systemic discrimination and oppression in healthcare services (Lange,

2020). LGBTQ care services should be standardized based upon affirmative care best practices (e.g., APA, 2015; WPATH, 2017). All providers should be engaging in topics related to sexual orientation and gender identity because LGBTQ status matters in health care. It is recommended that there are increased funding opportunities for affirmative care invention development and standardization.

While affirmative care principles should be integrated within all routine care appointments, access to specialty care services can be expanded with the development of an identified interdisciplinary clinical team. Utilizing the systemic structure of VISN Clinical Resource Hubs (CRH), interdisciplinary clinical teams can offer specialty care services (e.g., evaluations of readiness, hormone therapy) for the LGBTQ Veteran population across geographical locations. It is recommended that these teams prioritize health promotion and wellness, care coordination, patient navigation, and transgender-specific healthcare needs (e.g., evaluations of readiness, voice therapy). Funding for these positions would need to be secured.

Beyond inclusive healthcare policies and provider training, patient health education is an affirmative care method for encouraging positive health behavior choices. Research largely supports that improving patient health literacy contributes to personal empowerment in overcoming barriers to health and well-being (e.g., Nutbeam, 2000). Veteran-focused LGBTQ health education, such as "PRIDE In All Who Served", is needed to advance health outcomes, impact health behavior, increase social connectedness, and ensure improved healthcare access and service delivery for this often-invisible group of Veterans (Lange et. al., 2020).

Inclusive Benefits Package

The recent Message from the VA Secretary message to staff (02/23/21) indicated that gender affirmative surgical interventions may be included in the medical benefits package. Access to medically necessary services (e.g., electrolysis, mastectomy, breast augmentation, orchiectomy, tracheal shave, vaginoplasty, vulvoplasty, metoidioplasty, phallosplasty, etc.) should be considered affirmative and not cosmetic. It is recommended that gender affirmative surgical interventions be conducted within VHA facilities; should referral to the community be necessary (CHOICE Act), a point of contact/representative should be identified within the Office of Community Care to ensure these services and care coordination is done according to best practices and with WPATH Standards of Care (WPATH, 2017). Furthermore, aspects of biological sex (sex assigned at birth) impact VHA clinical reminders, and therefore, appropriate reminders for medical screenings should be modifiable by care providers to ensure gender-diverse Veterans have access to appropriate routine care screenings and services.

Outreach and Suicide Prevention

Collaboration between LGBT VCCs and Suicide Prevention Coordinators (SPCs) is essential. Reducing the risk of suicide for LGBTQ Veterans also requires institutional interventions, such as outreach (Wilder & Wilder, 2012). Many LGBTQ Veterans are uncertain or reluctant to come to VHA for healthcare. Therefore, it is recommended that funding and resources for outreach be provided to all LGBT VCCs. Specialized training may be necessary for staff to provide outreach to geographical areas consisting of older or rural Veteran populations.

"When veterans opt not to receive care, it may be because they perceive bias. We must ensure that we are promoting and sustaining an equitable healthcare system that is welcoming to LGBTQ Veterans." – Anonymous VHA Employee

Caregiver Support Program

Rejection by family of origin has been well-established in the research as a predictor for suicide attempts, substance abuse, depression, and sexual risk behavior among LGBTQ individuals (e.g., Klein & Golub, 2016). It is a common experience for the coming out process to be complicated by concerns of family rejection and loss of connection to loved ones. Within the LGBTQ community, many have found ways to provide a support system to one another. An inclusive definition of family allows LGBTQ individuals to build their network, thus developing a protective factor against suicidal ideation and healthcare disparities.

According to VA Policy, "family" or "family member" includes anyone who is important to the Veteran, which may include people not legally related (*Rights and Responsibilities of VA Patients and Residents of Community Living Centers*). However, to be eligible for VA Caregiver Support, a family caregiver must be either: 1) a spouse, daughter, parent, stepfamily member, or extended family member of the Veteran; or 2) someone who lives full-time with the Veteran or is will to do so if designated as a family caregiver (U.S. Department of Veterans Affairs, 2021b). It is recommended that the definition of "family" for caregiver support be inclusive of LGBTQ Families of Choice.

Intersectionality

Intersectionality refers to the connection and overlap between social identities (e.g., gender, race, ethnicity, social class, religion, sexual orientation, ability, gender identity) and with systems of power within the larger community (Collins & Bilge, 2020). It is essential that systemic interventions aimed at health equity and inclusivity for LGBTQ individuals take into consideration all aspects of diversity. It is recommended that every VHA facility have an appointed Diversity & Inclusion Officer to ensure collaboration between efforts from key positions [e.g., LGBT VCC, Women Veterans Program Manager, Equal Employment Opportunity (EEO) Manager, LGBT Special Emphasis Program Manager (LGBT SEPM), Minority Veteran Program Coordinator (MVPC)] and can oversee an interdisciplinary committee aimed at holistically addressing systemic needs for health equity.

The intersection of LGBTQ status and spiritual identity is a salient matter for many LGBTQ Veterans (Kopacz, Nieuwsma, Wortmann, Hanson, Meador, & Thiel, 2019). Affirmative chaplaincy services exist throughout the VHA system. However, certain chaplain endorsements do not permit providing services to LGBTQ individuals. VHA should take a clear affirmative stance on employment expectations and spiritual care services that are provided to all Veterans. <u>It is recommended that the National VA Chaplain Service appoints a panel of reviewers to ensure that all Chaplain endorsements are inclusive of LGBTQ Veterans and determine the course of action for those staff members with restrictive endorsements.</u>

Discharge Upgrades

Anti-LGBTQ military policies contributed to many sexual and gender minorities to experience formal discipline, career consequences, dishonorable discharges, harassment, violence,

retaliation, and fear. The history of these policies [e.g., Don't Ask, Don't Tell (DADT), Transgender Military Ban] continues to impact Veterans and their perceptions of VHA healthcare. It is recommended that there is collaboration and coordination between Veterans Benefits Administration (VBA) and the Department of Defense (DoD) for identification of those individuals who are eligible to update discharge status or pursue reparations from being "forced out" from military service. VA Health Care Enrollment and Eligibility outlines minimum service requirements; it is recommended that individuals with discharges connected to sexual orientation and/or gender identity are included in the medical benefits packages in order to pursue treatment and/or counseling related to conditions stemming from the experience. It should be the responsibility of the DoD and VBA to contact those who are eligible for discharge upgrades stemming from anti-LGBTQ military policies.

Electronic Health Record (EHR)

VA has prioritized the modernization of the electronic health record (EHR) through its partnership with Cerner. While the new EHR will allow for more data capturing of relevant health information for LGBTQ Veterans (i.e., sexual orientation, gender identity, and biological sex), there are complexity of care that needs to be considered.

Creating a clinical option for specialty providers (e.g., Endocrinologists, LGBT VCCs) to specify biological sex characteristics (both primary and secondary) would promote accurate preventative screening and care. For example, a biological female who identifies as male, but has not undergone gender affirmative surgery, still requires preventative care like routine breast examinations and PAP smears. It is recommended that providers have the ability to adjust

clinical reminders for anatomy, which would ensure accurate care referrals for Veterans who were born Intersex or have pursued gender-affirming surgical interventions.

Name and gender marker changes are interconnected with privacy officers, who ensure compliance with record-keeping regulations are maintained. While there are laws about the use of legal name within the healthcare settings, there are ways to make the EHR more affirming for LGBTQ Veterans and any other Veteran who has navigated the process of name change (e.g., Women Veterans). Additionally, there are barriers to being able to change these identifiers on legal documents (e.g., financial, state laws regarding birth certificates). It is recommended that a standardized form be created for Veterans to pursue having the EHR reflect name, pronouns, and gender identity; this information is clinically relevant and promotes a better quality of care. The form should be a function of the Benefits department to oversee the process and ensure care is provided to the intended recipient. It is recommended that Veterans have the ability to submit this request through MyHealth*e*Vet (and in the future, My VA Health) to update name, pronouns, and gender identity.

"As an employee, one of the biggest challenges is that our systems do not have an area for identifying a veteran's preference for preferred title, gender, or name. I think that is something that would be a beneficial investment for our LGBTQ community because there is nothing more embarrassing as an employee than to call a Veteran on the phone and unintentionally offend them. I want to be respectful, but the system doesn't help me do that. I should be able to update this in the chart." – Anonymous VHA Employee

While there may be reservations about systemic approaches that readily identify individuals as LGBTQ, it is necessary in healthcare. LGBTQ status is confidential protected health information

(PHI). "Because information about a patient's sexual orientation and gender identity is often very relevant – and sometimes absolutely crucial – to the provision of healthcare, it is protected by the federal privacy rules as well" (Lambda Legal, 2003). Regarding standardization of documentation, the following recommendations are provided: 1) all intake paperwork, forms, and electronic templates include sexual orientation and gender identity; and 2) standardized LGBTQ Health clinical reminders and note templates are made available to every VHA facility. Currently, there are note templates that automatically populate data related to demographics (e.g., race, age, sex, or gender) making it easy for providers to misgender someone accidentally. It is recommended that guidelines be updated to prevent automatic gender/sex input into facility-level notes. To reduce healthcare disparities and ensure individualized care, primary care providers and mental health treatment coordinators should have the ability to update gender identity and sexual orientation in the medical record.

Expand Accessibility to Family Building

Currently, the VA provides in vitro fertilization (IVF), assisted reproductive technology (ART), and other infertility services for Veterans with certain service-connected conditions. However, a Veteran must meet these specific needs: Service-connected condition that causes infertility, you are legally married, male spouses can produce sperm, female spouses have an intact uterus and can produce eggs. For LGBTQ veterans, the denial of access to marriage for same-sex couples has adversely affected individuals and families' health and well-being (Herdt & Kertzner, 2006). The same stigmatization of being legally married and also have a male spouse that can produce sperm further limits LGBTQ Veterans' accessibility to family building. Expanding access to Intrauterine insemination (IUI), IVF, and ART for women Veterans who are single, in same-sex

relationships, and meets the needs of service-connected infertility have the ability to use benefits they deserve.

Thank you, Chairwoman Brownley, Ranking Member Bergman, and Members of the House Committee on Veterans' Affairs, Subcommittee on Health. It is an incredible honor to submit testimony on behalf of the Modern Military Association of America – the nation's largest LGBTQ military and veteran non-profit regarding the "Beyond Deborah Sampson: Improving Healthcare for America's Women Veterans in the 117th Congress."

** LGBTQ is used as an all-inclusive acronym for all individuals who identify as sexual minorities and/or gender diverse.*

*** All proposed systemic advancements and changes in this document stem from an affirmative care stance.*

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