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October 2020

VA HEALTH CARE

Better Data Needed to Assess the Health Outcomes of Lesbian, Gay, Bisexual, and Transgender Veterans

GAO-21-69

GAO Highlights

Highlights of GAO-21-69, a report to congressional committees

October 2020

VA HEALTH CARE

Better Data Needed to Assess the Health Outcomes of Lesbian, Gay, Bisexual, and Transgender Veterans

Why GAO Did This Study

VHA provides care to a diverse population of veterans, including women and LGBT veterans. These veterans may experience differences in health outcomes that are closely linked with social or economic disadvantage, and VA considers it important to analyze the services they receive as well as their health outcomes to improve health equity.

House Report 115-188 included a provision for GAO to review VA's data collection and reporting procedures for information on veterans' gender and sexual orientation. This report describes how VHA assesses health outcomes for women veterans and examines the extent to which VHA assesses health outcomes for LGBT veterans.

GAO reviewed VHA directives and VHA's Health Equity Action Plan. GAO interviewed officials from VHA's Women's Health Services and LGBT Health Program, VHA researchers who focus on women and LGBT veterans, and representatives from other health care systems with experience collecting gender and sexual orientation information.

What GAO Recommends

GAO is making four recommendations to VA to consistently collect sexual orientation and SIGI data, and analyze these data to assess health outcomes for LGBT veterans. VA concurred with GAO's recommendations and identified actions it is taking to address them.

View GAO-21-69. For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

What GAO Found

The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) analyzes national-level data by birth sex to assess health outcomes for women veterans. For example, it analyzes frequency data to identify their most common health conditions. However, VHA is limited in its assessment of health outcomes for the lesbian, gay, bisexual, and transgender (LGBT) veteran population because it does not consistently collect sexual orientation or self-identified gender identity (SIGI) data.

VHA officials stated that providers may record veterans' sexual orientation—which can be used to identify lesbian, gay, and bisexual veterans—in non-standardized clinical notes in electronic health records. However, without a standardized field, providers may not be consistently collecting these data, and VHA does not know the total number of these veterans in its system. VHA officials recognize the importance of consistently collecting these data, but have yet to develop and implement a field for doing so.

VHA collects SIGI data—which can be used in part to identify transgender veterans—in enrollment, administrative, and electronic health record systems. Although VHA has worked to improve the collection of these data, GAO found inconsistencies in how VHA records SIGI and, according to VA, 89 percent of veterans' records lack SIGI information. VHA added a field to collect this information in the administrative system; however, these data are not linked to electronic health records. As such, VHA providers cannot see the data during clinical visits when determining the appropriate services for transgender veterans, such as screening certain transgender men for breast and cervical cancers, as required by VHA policy. VHA's plan to link SIGI data across both systems has been postponed several times, and the data remain unlinked.

VHA Sexual Orientation and Self-Identified Gender Identity (SIGI) Data Collection Limitations, Fiscal Year 2020

	Collection system	Data collection limitations
Sexual orientation data	Electronic Health Record	No field for providers to consistently record sexual orientation
SIGI data	Enrollment	VHA enrollment application forms do not contain all SIGI options: male, female, transman, transwoman, other, and chooses not to answer
	Administrative	SIGI from administrative files are not linked to veterans' electronic health records, and SIGI are not consistently recorded
	Electronic Health Record	

Source: Veterans Health Administration (VHA) officials and GAO's analysis of VHA policies. | GAO-21-69

Until VHA can more consistently collect and analyze sexual orientation and SIGI data for the veteran population served, it will have a limited understanding of the health care needs of LGBT veterans, including any disparities they may face.

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Abbreviations

CPRS	Computerized Patient Record System
HEDIS	Healthcare Effectiveness Data and Information Set
LGBT	lesbian, gay, bisexual, and transgender
SIGI	self-identified gender identity
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VistA	Veterans Health Information Systems and Technology Architecture

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October 19, 2020

The Honorable John Boozman
Chairman
The Honorable Brian Schatz
Ranking Member
Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Committee on Appropriations
United States Senate

The Honorable Debbie Wasserman Schultz
Chairwoman
The Honorable John Carter
Ranking Member
Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Committee on Appropriations
House of Representatives

Within the Department of Veterans Affairs (VA), the Veterans Health Administration (VHA) operates one of the nation's largest health care systems and provides services to a diverse population of veterans, including women, and lesbian, gay, bisexual, and transgender (LGBT) individuals.[1] In fiscal year 2018, more than 6 million veterans utilized VHA services. Women represented about 8 percent of these veterans—about 510,000 women veterans.[2] Less is known about the number of LGBT veterans using VHA services. For example, population estimates for LGBT veterans are more than a decade old in some cases and based on non-VA data, such as a 2004 estimate using Census data that roughly

[1]Although other terms also are used to describe LGBT and related identities, including "LGBTQIA," which stands for lesbian, gay, bisexual, transgender, queer, intersex, and asexual, for purposes of this report, we use the umbrella term "LGBT" as that is how VHA commonly refers to these populations.

[2]For purposes of this report, the term "women veterans" refers to veterans whose birth sex is "female" in VHA records. Although this may not include the entire universe of veterans who identify as women, we are using this term as it aligns with VHA's practice of using birth sex to analyze data for women veterans.

one million veterans identified as lesbian or gay, and a 2014 estimate that more than 130,000 veterans identified as transgender.[3]

VA has recognized the importance of ensuring health equity, the ability for all veterans to attain their highest possible levels of health. It has also reported that certain populations of veterans, including women and LGBT veterans, may not experience equitable outcomes.[4] These veterans may experience differences in health outcomes that are closely linked with social or economic disadvantage, and VA considers it is important to analyze the services they receive as well as their health outcomes to improve health equity. VA has taken actions to support women and LGBT veterans, including establishing VHA's Office of Health Equity, Women's Health Services, and the LGBT Health Program.

A report accompanying the Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2018, included a provision for us to review VA's data collection and reporting procedures for information on veterans' gender and sexual orientation, among other things.[5] This report:

1. describes how VHA assesses health outcomes for women veterans; and
2. examines the extent to which VHA assesses health outcomes for LGBT veterans.

For both objectives, we focused our review on VHA, which provides enrolled veterans with health care services. We reviewed VHA policies and documents, such as its National Veteran Health Equity Report and Health Equity Action Plan and Operational Plan to determine what demographic and clinical information VHA collects. We also interviewed officials from VA's Health Services Research and Development Service

[3]G. Gates, *Gay Men and Lesbians in the U.S. Military: Estimates from Census 2000* (Washington, D.C., The Urban Institute, Sept. 28, 2004). G Gates and J. Herman, *Transgender Military Service in the United States,* (Los Angeles, CA: The Williams Institute, May 2014).

[4]Veterans Health Administration, *National Veteran Health Equity Report-FY2013* (Washington, D.C.: 2016). VHA's Office of Health Equity has identified other categories of veterans who may not experience equitable outcomes, including veterans of racial and ethnic groups. For more information on VHA's efforts to address health disparities by race and ethnicity, see GAO, *VA Health Care: Opportunities Exist for VA to Better Identify and Address Racial and Ethnic Disparities*, GAO-20-83 (Washington, D.C.: Dec. 11, 2019).

[5]H.R. Rep. No. 115-188, at 72 (2017).

and VHA's Office of Health Equity; Office of Reporting, Analytics, Performance, Improvement and Deployment; Office of Member Services; and Health Eligibility Center on their processes for collecting data and assessing veteran's health outcomes. In addition, we interviewed representatives from two veterans service organizations—Disabled American Veterans and Transgender American Veterans Association—to gain additional insights.

To describe how VHA assesses health outcomes for women veterans, we reviewed the Women's Health Services *Sourcebook: Women Veterans in the Veterans Health Administration*, which contains information about women veterans including demographics, diagnoses, and utilization.[6] In addition, we interviewed VHA's Women's Health Services officials about their work to assess health outcomes for women veterans, including monitoring conditions and conducting research. Informed by our interviews with VHA officials, we identified and interviewed VHA researchers who have conducted research to identify and address health disparities for women veterans. We also reviewed information on clinical health outcome measures identified by VHA, including quality measures such as, immunization rates, and condition prevalence such as, frequency of cardiovascular disease among VHA patients.[7]

To examine the extent to which VHA assesses health outcomes for LGBT veterans, we reviewed VHA's policies for collecting sexual orientation and self-identified gender identity (SIGI) data and providing care to LGBT veterans. We also collected information from VA offices, such as VHA's Office of Veterans Access to Care and LGBT Health Program, about VHA's processes for collecting these types of data. Additionally, we interviewed officials from the LGBT Health Program about VHA's processes for assessing health outcomes and VA-funded research on the health of LGBT veterans. Based on a review of VA-funded LGBT research and discussions with LGBT Health Program officials, we identified and interviewed VHA researchers conducting work to assess health outcomes and identify disparities for LGBT veterans. We assessed

[6]Veterans Health Administration, *Sourcebook: Women Veterans in the Veterans Health Administration. Volume 4: Longitudinal Trends in Sociodemographics, Utilization, Health Profile, and Geographic Distribution* (Washington, D.C.: Feb. 2018).

[7]For the purposes of this report, we focused on health outcomes that are clinical in nature. Clinical outcomes include medical events that occur as a result of disease or treatment, such as cancer remission, and generally involve a diagnosis or assessment by a health care provider.

VHA's actions against relevant VHA policies and federal standards for internal control for information and communication, specifically the principle that management should use quality information to achieve the entity's objectives.[8] We also interviewed representatives from two health systems about their practices, challenges, and lessons learned in collecting sexual orientation and SIGI data—University of California, Davis Health System (Sacramento, California) and Fenway Institute (Boston, Massachusetts). We identified them through our interviews and review of research as having relevant experience collecting these data.

We conducted this performance audit from August 2019 to October 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

As a system originally designed to serve mainly men, VHA has reported that it has previously struggled to provide sufficient sex-specific services and an environment of care sensitive to women's privacy needs.[9] Since its inception in 1988, VHA's program for women veterans—Women's Health Services—has focused on addressing the health care needs of women veterans and ensuring that comprehensive health care services are provided nationwide.[10] According to VHA, Women's Health Services' mission is to ensure women veterans receive clinical care equal to that provided to men when using VHA services, among other things. In recent

[8]GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: Sept. 10, 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

[9]See Department of Veterans Affairs, Veterans Health Administration, *National Veteran Health Equity Report-FY2013*, (Washington, D.C.: 2016). In 2016, we found weaknesses in VHA's oversight of the environment of care for women, which could affect the privacy, safety, and dignity of women veterans when they receive care at VA facilities. We made two recommendations to strengthen policies and guidance for its environment of care inspections and to monitor women veterans' access to sex-specific services. As of July 2020, VA had taken some actions, but additional actions are needed to fully address these recommendations. See GAO, *VA Health Care: Improved Monitoring Needed for Effective Oversight of Care for Women Veterans*, GAO-17-52 (Washington, D.C.: Dec. 2, 2016).

[10]Department of Veterans Affairs, Veterans Health Administration, VHA Directive 1330.01 (3) Health Care Services for Women Veterans, (Feb. 15, 2017, updated June 29, 2020).

years, the number and percent of women veterans who enrolled in or utilized VHA services has continued to grow. (See table 1.)

Table 1: Number of Women Veterans Who Were Enrolled in and Utilized VHA Health Care, Fiscal Years 2015-2019

	Enrollment		Utilization	
Fiscal year	**Total number of veterans**	**Number of women veterans (percent)**	**Total number of veterans**	**Number of women veterans (percent)**
2015	**8,381,441**	628,055 (7.5)	**5,891,311**	439,791 (7.5)
2016	**8,677,659**	668,424 (7.7)	**5,968,544**	463,191 (7.9)
2017	**8,996,262**	711,826 (7.9)	**6,009,533**	484,317 (8.1)
2018	**8,406,340**[a]	731,304 (8.7)	**6,070,860**	510,179 (8.4)
2019	**8,469,122**	762,954 (9.0)	-	-

Source: GAO analysis of Veterans Health Administration (VHA) data. I GAO-21-69

Note: Fiscal year 2019 utilization data were not available at the time we conducted our work.

[a]The decrease in enrollment counts from fiscal year 2017 to fiscal year 2018 was the result of a Department of Veterans Affairs effort in 2018 to identify deceased veterans and update their records.

According to a 2011 Institute of Medicine (now the National Academy of Medicine) report, LGBT individuals in general face barriers to equitable health care or experience stigma, prejudice, discrimination, and violence, which may affect the care they receive and their health outcomes.[11] Although the "Don't Ask, Don't Tell Repeal Act of 2010" allowed gay, lesbian, and bisexual people to serve openly in the United States Armed Forces, VHA acknowledges that these veterans may still face stigma, stress, and discrimination.[12] In 2012, VA created the LGBT Health Program, which provides policy recommendations, provider education programs, and clinical services to support personalized health care for LGBT veterans. VHA policy notes that all people have both a gender identity and a sexual orientation. Furthermore, according to VHA, while LGBT individuals may share similar experiences of stigma and discrimination, those who are lesbian, gay, and bisexual may have

[11]Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (Washington, D.C.: The National Academies Press, 2011): p.13.

[12]Pub. L. No. 111-321, 124 Stat. 3515. Don't Ask, Don't Tell was a Department of Defense policy, codified in law, that prohibited people who "demonstrate a propensity or intent to engage in homosexual acts" from serving in the United States Armed Forces. See 10 U.S.C. § 654. Under this policy, lesbian, gay, and bisexual service members could serve only if they kept their sexual orientation secret and the military did not learn of their sexual orientation. Don't Ask, Don't Tell was repealed in 2010.

different health concerns than those who are transgender. In 2017 and 2018, VHA issued updated directives on collecting data on veterans' sexual orientation and SIGI.[13]

Over the last decade, VHA has recognized the importance of ensuring health equity. For example, in 2012, VHA established the Office of Health Equity to lead its efforts to advance health equity and reduce health disparities throughout its health care system. In 2014, the Office of Health Equity created VHA's first Health Equity Action Plan that identified five focus areas for improvement, such as increasing awareness of the significance of disparities and improving health and health care outcomes for underserved populations.[14] VHA also has taken specific actions supporting women and LGBT veterans. For example, VHA created a nation-wide campaign to end harassment at VA medical centers after one in four women veterans reported having been harassed on VA grounds.[15] For LGBT veterans, VHA established policy that requires each VA medical center to have at least one LGBT Veteran Care Coordinator.[16] The role of these coordinators is to support LGBT veterans by advocating for them and offering recommendations to facility leadership for further action to assist in educating staff and creating a welcoming environment.

[13]Department of Veterans Affairs, Veterans Health Administration, VHA Directive 1341(2) Providing Health Care for Transgender and Intersex Veterans (May 23, 2018, updated June 26, 2020) and VHA Directive 1340(2) Provision of Health Care for Veterans Who Identify as Lesbian, Gay or Bisexual, (July 6, 2017, updated June 26, 2020).

[14]The other focus areas for improvement identified in the Health Equity Action Plan are strengthening leadership; improving the diversity and cultural competency of the health workforce, and improving data availability on outcomes. We recently reported that VHA's Health Equity Action Plan set goals to eliminate health disparities but the extent of progress is unknown due to a lack of performance measures and clear lines of accountability. We recommended that VA ensure that any action plan to achieve health equity includes key elements for successful implementation, such as developing performance measures and clear lines of accountability, among other things. For more information, see GAO-20-83.

[15]Harassment experienced by women veterans can affect care, as those who reported harassment were significantly less likely to report feeling welcome at VA and more likely to delay or miss care. See R. Klap, et al., "Prevalence of Stranger Harassment of Women Veterans at Veterans Affairs Medical Centers and Impacts on Delayed and Missed Care," *Women's Health Issues,* vol. 29 (2019) p. 107-115. VHA's anti-harassment campaign includes anti-harassment posters and staff training.

[16]VHA Directive 1340(2).

VHA's Collection of Veterans' Birth Sex, SIGI, and Sexual Orientation Data

VHA collects data on veterans' birth sex, SIGI, and sexual orientation:

- **Birth sex**—generally the classification of individuals as male or female at birth. Birth sex is demographic data VHA uses to identify women veterans.[17]
- **SIGI**—how individuals think about their gender, including male, female, transman, transwoman, and other. SIGI is demographic data VHA can use, in part, to identify transgender veterans.[18]
- **Sexual orientation**—an individual's physical, romantic, or emotional attraction to others, commonly identified as gay/lesbian (or homosexual), straight (or heterosexual), or bisexual. Sexual orientation is clinical data VHA uses to identify lesbian, gay, and bisexual veterans.

Generally, VHA collects veterans' demographic data, including birth sex and SIGI, through both the enrollment system (when a veteran applies for health benefits) and the administrative system (when a veteran checks in for health care at a VHA facility). VHA collects veterans' clinical data, including sexual orientation, through the electronic health record (when a veteran meets with their provider). (See fig. 1.) Data collected from the enrollment system are shared with the administrative system, which, in turn, are a source of data for veterans' electronic health records.

[17]VHA policy allows veterans to have their birth sex changed in their electronic health records by completing written requests and providing documentation to the appropriate officials, such as a privacy officer, at a VHA facility. See VHA Directive 1341(2).

[18]According to VA, SIGI data alone may not be sufficient to identify transgender veterans, as some transgender veterans may identify as male or female as opposed to transman or transwoman. In its comments on this report, VA noted that, in some cases, using SIGI data in combination with birth sex data and/or proxy variables (e.g., diagnostic codes for transgender care) may be needed to identify transgender veterans in VHA records.

Figure 1: Overview of Systems That VHA Uses to Collect Veterans' Birth Sex, Self-Identified Gender Identity (SIGI), and Sexual Orientation Data, Fiscal Year 2020

Collection system	 **Enrollment** Department of Veterans Affairs Enrollment System	 **Administrative** Veterans Health Information Systems and Technology Architecture (VistA)[a]	 **Electronic Health Record** Computerized Patient Record System (CPRS)[b] interface with VistA
VHA staff	**Enrollment staff**	**Administrative staff**	**Providers**
Data	Birth sex and SIGI	Birth sex and SIGI	Birth sex, SIGI, and sexual orientation
VHA collection process	Enrollment staff collect information from veterans applying for health care benefits in person, or by mail, fax, or phone — or — Veterans provide information to the enrollment system when applying for health care benefits online	Administrative staff collect information from veterans when they check in at a VHA facility	Providers collect information from veterans during a visit

Source: Veterans Health Administration (VHA) officials and GAO analysis of VHA policies. | GAO-21-69

[a]VistA is the single, integrated health information system used throughout VHA in all of its health care settings. It contains patients' electronic health records.

[b]CPRS is a VistA computer application that enables providers to view patients' demographic information from VistA, and to enter, review, and update patients' clinical information.

VHA's Assessment of Health Outcomes for Women Veterans Includes Analyzing Health Condition Frequencies and Clinical Performance Data

VHA analyzes national-level data by birth sex to assess health outcomes for women veterans. In particular, VHA analyzes (1) frequencies of health conditions, and (2) clinical performance data. According to VHA officials and researchers, these comparative analyses by sex have identified areas in which women veterans experience disparities in health outcomes compared to male veterans.

Health Condition Frequencies. VHA analyzes health condition frequency data to identify the most common conditions among women veterans; identify which conditions women are more likely to have than men; and identify the frequencies of health conditions among subpopulations of women veterans, such as women deployed to combat zones, and women belonging to different age groups. According to VHA officials, on an annual basis, the Women's Health Evaluation Initiative compiles the frequencies of health conditions among women veterans who use VHA services.[19] In fiscal year 2018, the most recent data available, the most frequent conditions among women veterans who used VHA services included major depressive disorder and hypertension, and more than a quarter of women veterans had a diagnosis of at least one of these two conditions. See appendix I for a list of the five most frequent health conditions among women veterans who used VHA services from fiscal year 2015 to fiscal year 2018.

In addition, the Women's Health Evaluation Initiative periodically prepares the *Sourcebook: Women Veterans in the Veterans Health Administration*, which includes analyses of multi-year health-related data on women veterans.[20] Specifically, the Sourcebook includes multi-year analyses of health condition frequencies among women veterans who used VHA services, analyses of changes in condition frequencies over time, and analyses comparing the odds of women veterans being diagnosed with a specific health condition compared to men. For example, in fiscal year 2015, after adjusting for age, women veterans had higher odds of being diagnosed with a range of conditions compared to their male

[19]The Women's Health Evaluation Initiative is a partnership between VA's Health Services Research and Development Center for Innovation to Implementation and VA's Health Economics Resource Center. The initiative conducts analyses to inform women's health policy planning and program development.

[20]See Department of Veterans Affairs, Women's Health Evaluation Initiative, *Sourcebook: Women Veterans in the Veterans Health Administration*, (Washington, D.C.: 2018) for the latest edition of the Sourcebook.

counterparts.[21] Some of the higher odds reported were for conditions, such as breast cancer, that are predominantly seen in women. However, some of the reported differences also may have been caused by women veterans' unique risks or experiences. For example, women veterans had higher odds of being diagnosed with major depressive disorder and anxiety disorders. According to VHA, these conditions can stem from military sexual trauma, which is more common among women veterans than men.

VHA has also conducted research to identify health condition frequencies among particular subgroups of women veterans. For example:

- In 2015, VHA researchers reported findings from more than 20 years of published research on the frequency of substance misuse among subgroups of women veterans, such as by military service era.[22] Researchers found that studies that focused on women veterans who served in either Operation Enduring Freedom or Operation Iraqi Freedom generally reported higher rates of substance misuse, and more specifically, higher alcohol screening scores compared to other women veterans.
- In 2016, VHA researchers reported the frequency of exposure to physical and sexual trauma during military service within specific age groups of women veterans; such exposure had been associated with adverse health outcomes among women veterans.[23] Researchers found that women veterans between 45-54 years of age had the highest odds of trauma exposure during military service compared to the reference group of women veterans older than 65.

[21]The odds of diagnosis for specific health conditions are not adjusted for other characteristics, such as race or ethnicity, that can also influence risk for some conditions. Fiscal year 2015 is the most recent age-adjusted data on the differences in health condition diagnoses between women and men reported in the Sourcebook.

[22]See K. J. Hoggatt, et al., "Alcohol and Drug Misuse, Abuse, and Dependence in Women Veterans," *Epidemiologic Review*, vol. 37, no. 1 (2015): p. 23.

[23]See C. J. Gibson, et al., "Sexual Assault, Sexual Harassment, and Physical Victimization during Military Service across Age Cohorts of Women Veterans," *Women's Health Issues*, vol. 26, no. 2 (2016): p. 225.

In addition, VHA officials and researchers have used frequency data when identifying research priorities for women.[24] Specifically, VHA identified mental health as a research priority in its Women Veterans Research Agenda after reviewing frequency data indicating that women veterans have higher rates of mental health conditions, such as post-traumatic stress disorder and depression, compared to male veterans and nonveterans.[25] In addition, research priorities have previously included understanding women veterans' unique risk factors that may contribute to disparities they experience. For example, in March 2017, VA launched the Women Veterans Suicide Prevention Research Work Group, which seeks to expand research on women veterans' suicide risk factors, after data showed that suicide rates among women veterans had increased by approximately 34 percent from 2005 to 2016 and are nearly double that of civilian women.

Clinical Performance Data. VHA has tracked clinical performance measures to monitor women veterans' health outcomes since 2008, including differences between men and women. For example, VHA officials stated they track quality measures, which use data from electronic health records to measure clinical processes, such as immunization rates. Specifically, these quality measures include the Healthcare Effectiveness Data and Information Set (HEDIS), which contains more than 90 measures across six domains of care, such as effectiveness of care.[26] VHA has an online dashboard that allows staff to view trends and compare clinical performance data by sex—including data on blood pressure rates. Officials from the Office of Health Equity told us they are piloting two additional dashboards that will assist VHA

[24]For more information on VA's process for identifying research priorities, see GAO, *VA Health Care: Efforts to Prioritize and Translate Research into Clinical Practice*, GAO-20-211 (Washington, D.C.: Jan. 23, 2020).

[25]VHA created the Women Veterans Research agenda in 2004 and updated it in 2010. See E. M. Yano, et al., "Toward a VA Women's Health Research Agenda: Setting Evidence-Based Priorities to Improve the Health and Health Care of Women Veterans," *Journal of General Internal Medicine*, vol. 21, suppl. 3 (2006): p. S93; and E. M. Yano, et al., "Using Research to Transform Care for Women Veterans: Advancing the Research Agenda and Enhancing Research-Clinical Partnerships," *Women's Health Issues*, vol. 21, no. 4S (2011): p. S73 for description of the agenda development processes.

[26]HEDIS is a widely used performance improvement tool developed by The National Committee for Quality Assurance, and includes measures collected using electronic clinical data systems.

staff to identify and address health disparities, and have plans to implement them in fiscal year 2021.

According to VHA officials, trends in clinical performance data indicate a general reduction in disparities between men and women. For example, VHA researchers found that from 2008 to 2013 there was a decreasing trend in disparities between women and men veterans on most national quality measures.[27] More recently, in the first half of fiscal year 2020, VHA reported that sex-based disparities continue to narrow in most national clinical performance measures, such as screening rates for post-traumatic stress disorder.[28] However, the same report identified areas, such as immunization rates, where clinically significant disparities between women and men veterans exist. Specifically, during the first half of fiscal year 2020, women veterans older than 65 had a 10 percent lower pneumococcal immunization rate than men.

Moving forward, VHA is working to improve its ability to collect and analyze outcome data for women veterans. For example, according to VHA officials, women veterans may be at a higher risk of maternal morbidity and mortality than other women. VHA has limited data on maternal health outcomes, as it pays for and coordinates maternal health services, but does not provide these services at its facilities. VHA officials stated that they are trying to identify ways to obtain validated maternal health data from community providers to aid in analysis. In 2015, VHA researchers initiated a study examining women veterans' experiences with pregnancy, the process for coordinating care between VA and non-VA providers, and selected maternal health outcomes, such as post–partum depression and low birthweight. According to VHA officials, the study will be completed in March 2021. In addition, VHA researchers stated that moving forward, women veterans' health research should be less descriptive, and instead focus more on evaluating which interventions are most effective in improving health outcomes. For example, VHA anticipates its Enhancing Mental and Physical Health of Women through Engagement and Retention initiative—in which researchers apply tailored interventions related to conditions such as cardiovascular disease and depression—will generate implementation

[27]A. Whitehead, et al., "Improving Trends in Gender Disparities in the Department of Veterans Affairs: 2008-2013," *American Journal of Public Health*, vol. 104, no. S4 (2014): p. S529.

[28]Veterans Health Administration, *VHA Clinical Performance Measures Gender Disparity Update – FY 20 thru 2nd Quarter* (Washington, D.C.: 2020).

guidance for future evidence-based women's health programs and policies.

VHA's Assessment of Health Outcomes for LGBT Veterans Is Limited Due to Its Inconsistent Collection of Sexual Orientation and SIGI Data

VHA is limited in its ability to assess health outcomes for the LGBT veteran population who use its services because it does not consistently collect sexual orientation and SIGI data. With inconsistent data and limited information on health outcomes, VHA may not be able to fully identify and address any health disparities faced by LGBT veterans, or provide them clinically appropriate, comprehensive care.

Inconsistent sexual orientation data collection. VHA lacks in its electronic health record system a sexual orientation data field that it can use to identify lesbian, gay, and bisexual veterans. VHA policy directs providers to ask veterans about their sexual orientation as part of routine health care and provide appropriate follow-up.[29] In addition, the policy directs providers to discuss with veterans how sexual orientation will be included in their health records.[30] VHA officials told us providers may document veterans' sexual orientation in non-standardized clinical progress notes within veterans' electronic health records.[31] However, VHA's electronic health record system, the Computerized Patient Record System (CPRS), does not have a standardized field for providers to record this information, and VHA does not know how many records contain sexual orientation data.[32] Federal internal control standards call for management to obtain relevant data on a timely basis.[33] According to VHA officials, the absence of such a standardized sexual orientation field in CPRS is due to a system created many years ago when society greatly

[29]VHA 1340(2).

[30]Per VHA 1340(2), a veteran may elect not to include the information if its omission will not affect care.

[31]Providers use progress notes to document their observations, patient progress, patient's response to and changes in treatment, and subsequent assessments of the patient's response to care, among other information. See Department of Veterans Affairs, Veterans Health Administration, VHA Handbook 1907.01, *Health Information Management and Health Records* (Mar. 19, 2015).

[32]VHA officials stated that providers might not ask about sexual orientation during every visit as they may run out of time or may feel uncomfortable asking such questions. VHA's LGBT Health Program has developed voluntary trainings for providers on how to ask veterans about sexual orientation and educational materials for veterans about the importance of discussing sexual orientation with their providers.

[33]GAO-14-704G.

stigmatized lesbian, gay, and bisexual identities, and the military still had a ban on service by openly gay or lesbian personnel.

Although VHA has noted the importance of consistently collecting these data, officials told us that, as of July 2020, it has not yet developed a sexual orientation field for CPRS.[34] Until VHA is able to consistently collect this information, providers' ability to deliver appropriate care may be affected, which could also affect veterans' health outcomes. For example, without sexual orientation information, providers may not conduct needed screenings for their gay and bisexual male patients, who according to VHA, may be at a higher risk for anxiety and depression.[35]

VHA officials also told us they cannot identify the total number of lesbian, gay, or bisexual veterans in the VHA system, nor can they track the services they receive, and therefore, VHA is unable to systematically analyze data to assess the health outcomes of these veterans. Federal internal control standards call for management to process data into quality information, which it should use to make informed decisions.[36] VHA researchers have conducted research that identified health disparities for lesbian, gay, and bisexual veterans, such as a higher likelihood of suicide ideation compared to their heterosexual peers.[37] However, researchers we spoke with reported that without consistent sexual orientation data their work was limited to small, convenience samples.[38] Without the ability to assess health outcomes for the entire

[34]According to officials, VHA is planning to collect sexual orientation through a patient intake form in the Cerner system—a commercial electronic health record system developed by Cerner Government Services, Inc. However, transition to Cerner is projected to take a decade to complete and VA will continue to use Veterans Health Information Systems and Technology Architecture (VistA) and CPRS during this time. See GAO, *Electronic Health Records: VA Needs to Identify and Report Existing System Costs*, GAO-19-679T (Washington, D.C.: June 25, 2019) and GAO, *Electronic Health Records: Ongoing Stakeholder Involvement Needed in the Department of Veterans Affairs' Modernization Effort*, GAO-20-473, (Washington, D.C.: June 5: 2020).

[35]VHA 1340(2).

[36]GAO-14-704G.

[37]See J. Blosnich, V. Mays, and S. Cochran, "Suicidality Among Veterans: Implications of Sexual Minority Status," *American Journal of Public Health,* 104, S4, (2014): S535-S537. See also, K. Lehavot, et al., "Association of Alcohol Misuse with Sexual Identity and Sexual Behavior in Women Veterans," *Substance Use & Misuse*, (2016).

[38]A convenience sample is a type of non-probability sampling method in which the people sampled are those who are easy to reach and are thus convenient sources of information for researchers.

population of lesbian, gay, and bisexual veterans, VHA may be limited in its ability to make informed decisions about addressing health disparities or improving outcomes for these veterans at the national level.

Inconsistent SIGI data collection. VHA does not consistently collect veterans' SIGI—that it can use in part to identify transgender veterans—across the enrollment, administrative, and electronic health record systems. Whereas VHA considers sexual orientation to be clinical data that providers record in CPRS, it considers SIGI to be demographic data. VHA policy requires that staff record veterans' SIGI in the Enrollment System and the Veterans Health Information Systems and Technology Architecture (VistA), the administrative system, using these six options: male, female, transman, transwoman, other, or individual chooses not to answer, and that records be accurate and consistent.[39] In addition, providers may also record SIGI in CPRS. VHA has made progress standardizing the collection of SIGI, such as by adding a field to VistA in 2017. However, we found limitations in the processes VHA uses to collect these data. (See fig. 2.)

[39]Department of Veterans Affairs, Veterans Health Administration, VHA Directive 1604, *Data Entry Requirements for Administrative Data* (Apr. 22, 2016).

Figure 2: VHA's Processes for Collecting Veterans' Self-Identified Gender Identity (SIGI) Data, Fiscal Year 2020

Collection system	 **Enrollment** Department of Veterans Affairs Enrollment System	 **Administrative** Veterans Health Information Systems and Technology Architecture (VistA)	 **Electronic Health Record** Computerized Patient Record System (CPRS) interface with VistA
VHA staff	**Enrollment staff**	**Administrative staff**	**Providers**
VHA collection process	Application form for health care benefits	Manual entry by facility staff during intake process	Non-standardized clinical progress note
Data collection limitations	Enrollment application forms do not contain all options for SIGI identified in policy[a]	SIGI from administrative files are not linked to veterans' electronic health records and providers cannot view these data	

Source: Veterans Health Administration (VHA) officials and GAO analysis of VHA policies. | GAO-21-69

[a]VHA policy identifies six SIGI options: male, female, transman, transwoman, other, and individual chooses not to answer.

VHA's collection of SIGI data through the Enrollment System is inconsistent with policy, in that enrollment applications do not include all six required options.[40] Specifically, the current version of the 10-10EZ application form for health benefits only includes two of the required SIGI options, male and female. In addition, the 10-10EZ online application form does not contain a field to record the data. Without all SIGI options consistently available across all enrollment methods, VHA may be inaccurately recording the information, contrary to its policy.[41] In addition,

[40]VHA 1604.

[41]VHA officials stated that if a veteran enrolls in person, enrollment staff could ask veterans to choose from all six SIGI options. However, officials stated that veterans who submit the 10-10EZ via mail or fax only have two options—male and female. In these cases, when enrollment staff receive the application, they would enter into the system the SIGI information as it appears on the form.

inconsistently collected enrollment data could affect data in other systems—for example, data collected in the Enrollment System that are shared with VistA. VHA officials told us they do not know why the 10-10EZ does not include all six SIGI options as staff have turned over since this field was initially added to the application form in 2017. To ensure consistency with policy, VHA officials told us they are planning to include all six required options on a future version of the 10-10EZ to be published in late 2020. However, as of July 2020, officials had not produced documentation of these plans.

VHA also collects SIGI in both VistA and CPRS.[42] However, these data are not consistently collected. In particular, VHA officials told us VistA includes all six required options, but CPRS does not include a field for providers to record the data. According to VHA officials, SIGI is demographic data that can have clinical implications and providers may enter the data in non-standardized progress notes in CPRS, but it is not required. Although CPRS generally enables providers to view veterans' data from VistA, this is not the case with SIGI data. VHA officials told us that SIGI data are not linked across the two systems and therefore providers cannot view this information. VHA officials stated they developed an update to VistA that will allow providers to view these data in CPRS. Although officials expect to implement this update in fiscal year 2021, they also stated that VHA has postponed it several times in the last four years due to competing information technology priorities. Until providers can view SIGI data from VistA, they cannot use them to determine appropriate preventive screens to offer patients, in accordance with VHA policy.[43] For example, according to VHA policy, a transgender man should be screened for breast and cervical cancers, if that anatomy is present.[44]

In addition, until the update is complete, VHA officials stated they are not promoting SIGI collection by administrative staff because they want to minimize the number of veterans who disclose transgender identities to administrative staff and then do not receive any provider follow-up. As a result, VHA has minimal information about veterans' SIGI. For example, according to VA, 89 percent of veterans who used VHA services from

[42]VA officials also told us they are planning to collect gender identity data in the Cerner system, which they plan to transition to over the next 10 years.

[43]VHA 1341(2).

[44]VHA 1341(2).

June 2016 through May 2020 did not have any SIGI information in their records. VHA officials stated they are developing oversight plans to be implemented once changes are made to ensure that administrative staff are asking veterans about their gender identity.[45]

VHA is unable to systematically analyze data to assess the health outcomes for transgender veterans receiving its services. VHA has conducted some research on this population, which has indicated significant disparities in depression and suicide ideations.[46] However, VHA researchers we spoke with reported similar challenges in conducting research related to transgender veterans as in conducting research related to lesbian, gay, and bisexual veterans. For example, due to a lack of SIGI data in veterans' records they rely on proxy variables, such as diagnostic codes for transgender care, or collecting their own data using small, convenience samples. Similar to lesbian, gay, and bisexual veterans, inconsistently collected data and incomplete knowledge of health disparities may affect transgender veterans' health outcomes. For example, without information on health outcomes VHA may be unable to alert providers to potential disparities they should be attentive to in the care of their transgender patients. Federal internal control standards call for management to process data into quality information, which it should use to make informed decisions.[47]

VHA Office of Health Equity officials told us that until there is sufficient sexual orientation and SIGI data to analyze, they would continue to look for alternative approaches to assess the health of this population. For example, the Office of Health Equity is planning to complete a literature review by fall 2020 to determine how, if at all, non-VA researchers and other health systems identify this population, such as by searching electronic health records for common keywords—such as transgender,

[45]According to VHA officials, this plan could include working with administrative support offices and program offices, such as Women's Health Services, to encourage staff to ask every veteran about their SIGI and provide training. VHA has developed training for staff on how to ask veterans about their SIGI and educational materials for veterans that stress the importance of discussing SIGI with their providers.

[46]See G. Brown, and K. Jones, "Mental Health and Medical Health Disparities in 5135 Transgender Veterans Receiving Healthcare in the Veterans Health Administration: A Case–Control Study," *LGBT Health*, (2015). Also see, S. Carter, et al., "Discrimination and Suicidal Ideation among Transgender Veterans: The Role of Social Support and Connection," *LGBT Health*, Vol. 6, No. 2 (2019).

[47]GAO-14-704G.

"his husband," or "her wife"—that could be used to describe LGBT individuals.

Conclusions

VHA has recognized the importance of identifying and reducing health disparities for LGBT veterans. However, VHA does not consistently collect data on veterans' sexual orientation or gender identity. Without these data to analyze, VHA is unable to systematically assess health outcomes, determine health needs, and address health disparities for LGBT veterans. These deficiencies could negatively affect patient care, including providers' ability to recommend appropriate preventative health screenings. This, in turn, could negatively affect health outcomes for LGBT veterans. VHA officials have stated they know little about the population size or health of these veterans, and while VHA is planning to more consistently collect sexual orientation and gender identity data, it has yet to fully develop plans or implement the changes needed to accomplish this. Until VHA is able to consistently collect and analyze data on sexual orientation and gender identity, it will be unable to ascertain fully the health care needs of LGBT veterans and therefore will remain limited in its efforts to adequately address any health disparities these veterans may face.

Recommendations for Executive Action

We are making the following four recommendations to VA:

The Undersecretary for Health should consistently collect sexual orientation data in VHA's health record system, which could include adding a field for providers to input veterans' sexual orientation. (Recommendation 1)

The Undersecretary for Health should analyze veterans' sexual orientation data in order to assess health care outcomes for lesbian, gay, and bisexual veterans. (Recommendation 2)

The Undersecretary for Health should consistently collect veterans' self-identified gender identity data within and across record systems. (Recommendation 3)

The Undersecretary for Health should analyze veterans' self-identified gender identity data in order to assess health care outcomes for transgender veterans. (Recommendation 4)

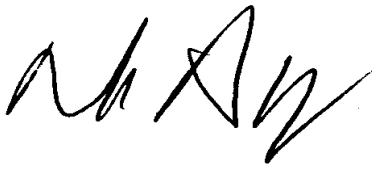
Agency Comments

We provided a draft of this report to VA for review and comment. VA provided written comments, which are reprinted in appendix II. In its comments, VA concurred with all four of our recommendations and

identified actions it is taking to address them. These actions include forming a workgroup to establish goals, plans, and timelines for consistently collecting sexual orientation and SIGI data. In addition, VA described actions it is taking to create a welcoming environment for LGBT veterans, LGBT health educational resources and training it is offering to health care providers, and updates it is implementing to a VHA survey to evaluate veterans' satisfaction with care, among other things. VA also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Veterans Affairs, the Under Secretary for Health, and other interested parties. In addition, the report is available at no charge on the GAO website at https://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.



Debra A. Draper
Director, Health Care

Appendix I: Frequency of Health Conditions among Women Veterans Utilizing Veterans Health Administration Services

This appendix contains Table 2, which shows, by year, the most frequent health conditions experienced by women veterans utilizing Veterans Health Administration services.

Table 2: Five Most Frequent Health Conditions among Women Veterans Who Utilized VHA Services, Fiscal Years 2015-2018

Fiscal Year	Condition	Percent of women veterans with condition
2015	Hypertension	27.2
	Depression, possible-other	26.7
	Lipid disorders	25.2
	Joint disorders	23.8
	Spine disorders - lumbosacral	22.8
2016	Hypertension	26.2
	Spine disorders - lumbosacral	25.6
	Major depressive disorder	24.5
	Lipid disorders	23.6
	Joint disorders – lower extremity	23.3
2017	Major depressive disorder	26.8
	Hypertension	26.6
	Spine disorder- lumbosacral	26.4
	Lipid disorders	24.3
	Joint disorders – lower extremity	24.0
2018	Major depressive disorder	28.2
	Spine disorders – lumbosacral	27.7
	Hypertension	27.2
	Lipid disorders	25.2
	Joint disorders – lower extremity	25.0

Source: GAO presentation of Veterans Health Administration (VHA) data. I GAO-21-69

Note: VHA officials mapped International Classification of Disease, Ninth Revision, Clinical Modification diagnoses codes onto 202 conditions based on clinical coherence.

Appendix II: Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON

September 24, 2020

Ms. Debra A. Draper
Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Draper:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: ***VA HEALTH CARE: Better Data Needed to Assess the Health Outcomes of Lesbian, Gay, Bisexual, and Transgender Veterans*** (GAO-21-69).

The enclosure contains general and technical comments and the actions to be taken to address the draft report recommendations. VA appreciates the opportunity to comment on your draft report.

Sincerely,

Brooks D. Tucker

Brooks D. Tucker
Acting Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
VA HEALTH CARE: Better Data Needed to Assess the Health Outcomes of Lesbian, Gay, Bisexual, and Transgender Veterans
(GAO-21-69)

Recommendation 1: The Undersecretary for Health should consistently collect sexual orientation data in its health record system, which could include adding a field for providers to input veterans' sexual orientation.

VA Response: Concur. The Veterans Health Administration (VHA) agrees with the importance of collecting data on sexual orientation in order to better understand the unique health care needs of all Veterans, especially Veterans with lesbian, gay, bisexual (LGB) and related identities. To achieve this goal, VHA's Assistant Under Secretary for Health for Patient Care Services, in coordination with VA's Office of Information Technology (OIT) and the VA Office of Electronic Health Records Modernization (OEHRM) will form a workgroup to establish firm goals, plans and timelines to ensure the capability of consistently collecting and analyzing sexual orientation data in electronic health record systems. Sexual orientation is clinical data. Data collection will need to occur in both Veterans Health Information System and Technology Architecture and Computerized Patient Record System (VistA/CPRS) and Cerner Millennium, which have different current capabilities. For example, Cerner Millennium has a sexual orientation field to collect these data, but VistA/CPRS does not.

At completion, the workgroup will produce and share a report with senior leaders that clearly identifies plans, actions and timelines for project completion in the two electronic health record systems (i.e., VistA/CPRS and Cerner Millennium) and methods for data collection and reporting.

Target Completion Date: October 2021.

Recommendation 2: The Undersecretary for Health should analyze veterans' sexual orientation data in order to assess health care outcomes for lesbian, gay, and bisexual veterans.

VA Response: Concur. VHA agrees with the importance of analyzing sexual orientation data to understand the unique health care needs of Veterans with LGB and related identities. Accomplishing this goal requires the capacity to collect sexual orientation data. VistA/CPRS and Cerner Millennium have different capabilities. Cerner Millennium has a sexual orientation field. Analyses of data from Cerner can begin as early as 6 months post-launch and as Cerner is implemented Nationwide. VistA/CPRS lacks a sexual orientation field. Based on the plans and timelines of the VHA/OIT/OEHRM workgroup (discussed in Recommendation 1), analyses of data from VistA/CPRS can begin as early as 6 months post-release of a sexual orientation field into VistA/CPRS.

Target Completion Date: April 2022.

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Recommendation 3: The Undersecretary for Health should consistently collect veterans' self-identified gender identity data within and across its record systems.

VA Response: Concur. The action plan for Recommendation 1 also applies to this recommendation. VHA agrees with the importance of collecting data on self-identified gender identity in order to better understand the unique health care needs of transgender and gender diverse Veterans. To achieve this goal, VHA Assistant Under Secretary for Health for Patient Care Services, in coordination with OIT and OEHRM, will form a workgroup to establish firm goals, plans and timelines to ensure the capability of consistently collecting and analyzing self-identified gender identity data in enrollment, administrative and electronic health record systems. Self-identified gender identity is viewed as demographic data. Current enrollment platforms, administrative modules and VistA/CPRS and Cerner Millennium have different capabilities. For example, self-identified gender identity is functional in VistA but not in CPRS, and Cerner Millennium has a gender identity field to collect these data, but it is currently social history data (not demographic). In addition, the self-identified gender identity data are not consistent between VistA and Cerner Millennium in data type or response options, including enrollment systems.

At completion, the workgroup will produce and share a report with senior leaders that clearly identifies plans, actions and timelines for project completion. These projects will focus on enrollment and administration of the two electronic health record systems (VistA/CPRS and Cerner Millennium) and methods for data collection and reporting.

Target Completion Date: October 2021.

Recommendation 4: The Undersecretary for Health should analyze veterans' self-identified gender identity data in order to assess health care outcomes for transgender veterans.

VA Response: Concur. VHA agrees with the importance of analyzing self-identified gender identity data (in addition to other data elements) to understand the unique health care needs of transgender and gender diverse Veterans. Accomplishing this goal requires the capacity to collect self-identified gender identity data. Current enrollment platforms, administrative modules and CPRS and Cerner Millennium have different capabilities. In addition, the self-identified gender identity data are not consistent between VistA/CPRS and Cerner Millennium in data type or response options. Based on the plans and timelines of the VHA/OIT/OEHRM workgroup (discussed in Recommendation 1), the self-identified gender identity data will be made consistent across enrollment platforms, administrative and enrollment modules, in VistA/CPRS and in Cerner Millennium. Analyses of data from Cerner can begin as early as 6 months

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post-launch and continue as Cerner is rolled out Nationwide. Self-identified gender identity is functional in VistA but not in CPRS and not fully functional in enrollment platforms. Based on the plans and timelines of the VHA/OIT/OEHRM workgroup, analyses of data from enrollment and VistA/CPRS can begin as early as 6 months post-release of a functional self-identified gender identity field. Self-identified gender identity field will be used in combination with other data elements (e.g., birth sex, gender dysphoria) to assess health care outcomes for transgender Veterans.

Target Completion Date: April 2022.

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General Comments:

Creating a Welcoming Environment

Partly due to the legacy of military policies, including bans on service for openly Lesbian, Gay, Bisexual and Transgender (LGBT) people, research shows that LGBT Veterans expect to experience prejudice and discrimination in VHA care. Thus, VHA facilities must work harder to ensure that Veterans with LGBT and related identities feel welcome. All staff have a responsibility to make Veteran patients, including LGBT Veterans, feel welcome.

- Several offices within VHA, including the LGBT Health Program, have collaborated to develop visual signs (e.g., LGBT awareness posters, LGBT health fact sheets) and symbols (e.g., rainbow lanyards and lapel pins) that can be displayed throughout the facility to publicly promote a welcoming environment for sexual and gender minority Veterans. Examples of activities include:
  - Women Veterans are over-represented in the LGBT Veteran community (relative to the male counterparts). The LGBT Health Program and Women's Health have worked collaboratively on welcoming environment products for LGBT women Veterans as well as inclusivity of fertility resources.
  - Suicide is a health disparity for LGBT people and for Veterans. VHA's Office of Mental Health and Suicide Prevention and LGBT Health partnered to develop and disseminate LGBT-specific suicide prevention materials. Please visit: https://www.patientcare.va.gov/LGBT/docs/FactSheetVeterans_LGBTCampaign4-29-19.pdf#.
- VHA's Office of Health Equity has organized VA Medical Center (VAMC) participation in the Healthcare Equality Index (HEI) annually since 2012.
- HEI, administered by the Human Rights Campaign, recognizes health care facilities that demonstrate equitable treatment and inclusion for sexual and gender minority patients and staff. VA participation in HEI has increased each year.
  - In 2020, 64 VAMCs met full criteria and achieved Leader status, and 34 facilities met 80 percent or better of criteria to achieve Top Performer status in the HEI survey.

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Educational Resources and Training

VHA has identified an opportunity to increase training for health care providers to address the unique health care needs of Veterans with LGBT and related identities, due to a lack of training during their professional education. To address this gap, VHA offers a variety of educational resources on-demand to all staff.

- Currently, VHA offers trainings on how to assess birth sex and self-identified gender identity including how to respond to questions from Veterans.
- VHA has 12, 20-minute topic-focused online trainings on transgender health, a course for primary care providers on the assessment of sexual orientation and how to conduct a sexual health history. Four 20-minute courses on LGB Veteran health, with four more modules under development.
- Live trainings include the "At Ease" course, which is designed to be delivered in person, and several live webinars on LGBT health throughout the year.
- VHA supports 10 postdoctoral psychology interprofessional LGBT health fellowships at VA facilities across the country, in which fellows receive an intensive one-year training in the unique needs of LGBT Veterans.

Transgender Health Care

Transgender health can be complex. To increase VHA's capacity to provide excellent transgender health care, providers have multiple resources available to assist them, including the items listed below.

- VHA trained 899 interdisciplinary providers in transgender care across 178 facilities between 2014-2018 in a multi-session didactic and case-based course on transgender care.
  - Collaboration with VHA's Office or Rural Health allowed for specific outreach and training for 146 providers in 65 small or rural facilities for the course described above.
- Providers new to transgender care and providers managing complex cases need consultation with more experienced providers. Since 2014, VHA has supported interfacility e-consultation on transgender care through the electronic health record, responding to nearly 1400 consults to date, which helps ensure high-quality transgender care, even when transgender health is new to an individual provider.
- Transgender-specific prosthetic devices are an essential part of care for some Veterans. VHA's Prosthetic and Sensory Aid Office has worked with LGBT Health to develop information for providers about what devices are available and the steps to order medically necessary items.

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LGBT Veteran Care Coordinators and Outreach to LGBT Veterans

- Every VAMC has at least one LGBT Veteran Care Coordinator (VCC), who serves as a point of contact for Veterans with LGBT and related identities. LGBT VCCs are the facility subject matter experts for promoting a welcoming environment for LGBT Veterans, ensuring availability of care, educating staff, coordinating HEI completion and coordinating outreach with community LGBT organizations.
- Every VHA Veterans Integrated Service Network (VIISN) has an LGBT VISN Lead to oversee and coordinate activities across facilities.
- VHA's "Make the Connection" testimonial videos include the voices of LGBT Veterans at https://maketheconnection.net/whats-new/supporting-lgbt-veterans.
- Veteran-facing fact sheets about unique health risks for Veterans with LGBT and related identities and how to speak openly with their VHA provider about sexual orientation and gender identity have been developed and disseminated through these channels and through the public facing website: https://www.patientcare.va.gov/LGBT/index.asp.
- Information about how VHA uses the self-identified gender identity field versus the birth sex field so that Veterans can make informed choices about how to share their information.
- A Women's Health podcast, "She Wears the Boots," was created for Veterans with LGBT and related identities. Additional podcasts are in development.

Evaluating Veteran Satisfaction with Care

- The Survey of Healthcare Experiences of Patients (SHEP) Program collects over 1.6 million surveys annually from Veterans who received care.
  - A pilot study to test the phrasing of sexual orientation and gender identity (SOGI) items and assessing Veterans' level of comfort with answering these questions was conducted and the results showed that Veterans were generally comfortable answering SOGI items.
  - In July 2020, VHA updated SHEP surveys to include questions asking Veterans to self-report their sexual orientation and gender identity.
  - Including the SOGI items in the SHEP surveys will make it possible to assess the care experiences and satisfaction of LGBT Veterans as compared to that of straight and cisgender Veterans. This comparison data will provide results from a comprehensive set of domains including access, patient/provider communication, support for health self-management and coordination of care.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Debra A. Draper, (202) 512-7114, draperd@gao.gov

Staff Acknowledgments

In addition to the contact named above, Janina Austin (Assistant Director), Q. Akbar Husain (Analyst-in-Charge), Jennie Apter, and Kelly Turner made key contributions to this report. Also contributing were Sonia Chakrabarty, Kaitlin Farquharson, Giselle Hicks, Diona Martyn, and Vikki Porter.