U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Health Equity

PRIMARY HEALTHCARE EXPERIENCES OF LESBIAN, GAY, AND BISEXUAL VETERANS

Prepared By

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TABLE OF CONTENTS

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PREFACE

Without data about the LGBTQ+ Veterans we serve in VA, we cannot know the size of this population nor their unique health care needs or experiences. This challenge is not unique to VA. Most health care agencies have not historically collected data about patient's sexual orientation and gender identity and have only recently begun to do so. This information is important because minoritized sexual orientation and gender identities have been associated with health disparities in research studies of Veterans, mostly using convenience samples.

Since the start of the LGBTQ+ Health Program at the Veterans Health Administration, one of our primary goals has been to include sexual orientation and gender identity questions in health-related surveys and include these data fields in VA health records. This report is the result of an early success in getting sexual orientation and gender identity questions added to the VA Survey of Healthcare Experiences of Patients (SHEP). For the first time as described in this report, VA has data from the SHEP survey about lesbian, gay, bisexual and queer (LGBQ) Veterans' health care experiences. Not surprisingly, there are notable differences between the self-reported health care experiences of heterosexual Veterans and LGBQ Veterans. These results tell us where we need to do more work to improve health care at the VA.

In the meantime, VA has worked to improve collection of data in electronic health records on Veteran's sexual orientation and gender identity, as well as name-to-use and gender pronouns. Veterans' name-to-use and gender identity are now visible in the legacy electronic health record if that information has been populated. A sexual orientation field is expected to go live in August 2022. The new health record system (Cerner) already has these fields and has begun its roll out to facilities. Collection of data on name-to-use and gender identity will be improved by a new feature of VA.GOV which allows Veterans to enter and edit this information themselves through their VA.GOV profile. These data will then be displayed in the Veteran's health record.

In addition, VA has appointed at least one LGBTQ+ Veteran Care Coordinator (VCC) at every facility to create a more welcoming, affirming clinical health care environment. LGBTQ+ VCCs work to raise awareness about the needs of LGBTQ+ Veterans, educate staff and providers, guide Veterans to clinical services, and link with community LGBTQ+ services. LGBTQ+ VCCs are the frontline support staff who help ensure that VA health care policies are enacted.

The next steps will be a collaborative effort among many program offices to use the data described in this report to push for more affirming, equitable care to LGBTQ+ Veterans in VA. We thank the Office of Health Equity for leading the charge in identifying and addressing health disparities among Veterans and conducting the analyses for this report. Together we will address health care inequities. Addressing the gaps identified in these reports will help VA provide LGBTQ+ Veterans the health care that is right for them. All Veterans should receive health care that is tailored to their individual needs.

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INTRODUCTION

The U.S. Department of Veterans Affairs' (VA), Veterans Health Administration (VHA) provides high-quality care for all Veteran populations, including those with minoritized racial identities, gender identities, sexual orientations, religions, and other patient characteristics. Within VHA resides the Office of Health Equity (OHE), whose mission is to eliminate health disparities among diverse Veteran populations and ensure health equity for all those in the care of VHA.

Sexual minority Veterans (SMVs), specifically those identifying as lesbian, gay, bisexual, or queer (LGBQ), are a vulnerable population within the VHA and may be at risk of receiving less-than adequate care. Poor health outcomes are not uncommon in the LGBQ population due to higher rates of stigma and discrimination (Meyer, 2003; McGirr, Jones, & Moy, 2021; Lynch, Shipherd, Gatsby, DuVall, & Blosnich, in press). However, a later study found that most LGBQ Veterans felt comfortable disclosing their sexual orientation to their VHA provider (Kauth et al., 2018). While this may be a promising trend, there is room for improvement.

Given that an increasing number of Veterans are choosing the VHA as their healthcare provider, receiving care in an environment where Veterans feel welcome and comfortable is critical to receiving appropriate care tailored to their needs (Shipherd, Darling, Klap, Rose, & Yano, 2018). Consequences of feeling unwelcome or uncomfortable may result in missed appointments or failure to seek care altogether and may result in poorer health outcomes in the LGB population of Veterans (Shipherd, Darling, Klap, Rose, & Yano, 2018; Ruben, Livingston, Berke, Matza, & Shipherd, 2019; Berke, Ruben, Liautud, Meterko, Kauth, & Shipherd, 2022).

To assess which Veterans may be at greater risk of feeling unwelcome and uncomfortable, VHA must be able to identify this population of Veterans. However, self-identification of sexual orientation requires improvement within the VHA. A 2020 GAO report cited VA for not routinely collecting data on sexual orientation or gender identity, making it difficult to analyze the health and related health disparities of these Veterans. Approximately 89% of Veterans' health records lacked data on gender identity, creating gaps in appropriate health screenings and identification of health disparities among the population. VHA is aware of this issue in data collection and has been working on rectifying the problem by increasing data collection efforts.

This report utilizes the 2020 Survey of Healthcare Experience of Patients (SHEP) to compare healthcare experiences of Veterans self-identifying as veterans self-identifying as sexual minorities and heterosexuals. This survey is among the first assessments of the SMV population regarding their healthcare experiences. In this report, we have identified several measures across four domains (person centered care, access to care, care coordination, and general health) to assess differences in healthcare experiences between the SMV and heterosexual populations of Veterans.

NOTABLE KEY FINDINGS

The SHEP survey is one of the first of its kind to collect self-reported data on sexual minority Veterans seeking care at VHA facilities. Data findings are discussed in the sections to follow.

Key findings include:

- Approximately 66% of sexual minority Veterans who responded to the SHEP survey are 65 years of age or older.
- Approximately 34% of sexual minority Veterans self-reported their sexual orientation as “other”.
- When compared to heterosexual Veterans, sexual minority Veterans reported more problems across multiple measures of person centered care, access to care, and care coordination.
- When compared to heterosexual Veterans, sexual minority Veterans tend to report poorer mental or emotional health.

POPULATION DEMOGRAPHICS

DISCUSSION ON DEMOGRAPHICS

The demographics described in the subsequent section are based on self-identified responses provided on VA's Survey of Healthcare Experience of Patients (SHEP) in 2020. The SHEP is a national patient experience tool that is the VA's adapted version of the Agency for Healthcare Research and Quality's Consumer Assessment of Healthcare Providers and Systems (CAHPS). After a clinic or hospital visit, the Veteran may receive a survey about their experience, such as how much time their provider spent with them and whether they discussed the Veteran's medications. This information is provided to facility managers to improve the delivery of care. Of the respondents, 1,935 veterans identified as sexual minority and 64,413 veterans identified as heterosexual. Demographics such as age, sexual orientation, self-identified gender identity, sex assigned at birth, race/ethnicity, and educational attainment are reported for Veterans identifying as sexual minority and heterosexual.

Characteristics of Sexual Minority Veterans:

- Veterans identifying as sexual minority were older than those identifying as heterosexual.
- Sexual minority Veterans are more likely to identify as female compared to heterosexual Veterans.
- Both sexual minority and heterosexual Veterans are similarly likely to be white, self-identify as a man, and have attained some college or hold a 2-year degree.
- Compared to their heterosexual counterparts, sexual minority Veterans are more likely to have more than a 4-year degree.

Table 1: Sociodemographic characteristics of Sexual Minority Veterans and Heterosexual Veterans

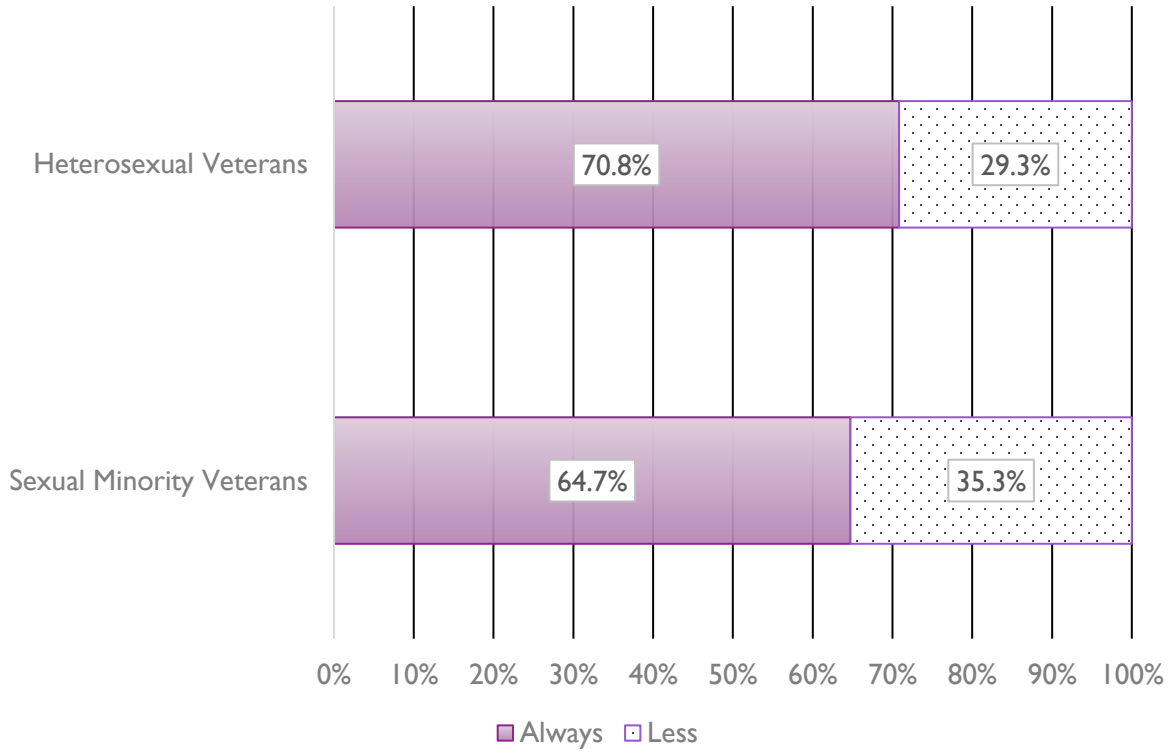
	Sexual Minority Veterans (n=1,935)		Heterosexual Veterans (n=64,413)		p-value
Characteristics	**Count (N)**	**%**	**Count (N)**	**%**	
Mean Age (years), SD	70.5, 14.1		67.8, 11.5		p<0.0001
Age Groups (years)					p<0.0001
18-34	63	3.3	597	0.1	
35-44	88	4.5	1504	2.3	
45-54	150	7.8	3743	5.8	
55-64	363	18.8	9572	14.9	
65-74	670	34.6	27204	42.2	
75 and older	601	31.1	21793	33.8	
Sexual Orientation					
Gay	411	21.2	0	0	
Lesbian	176	9.1	0	0	
Bisexual	333	17.2	0	0	
Other	660	34.1	0	0	
I'm not sure	355	18.3	0	0	
Self-Identified Gender Identity					p<0.0001
Man	1530	79.1	60649	94.2	
Woman	309	16.0	3608	5.6	
Transgender*	29	1.5	14	0	
Non-binary	19	1.0	0	0	
Other	24	1.2	8	0	
Missing	24	1.2	134	0.2	
Sex Assigned at Birth					p<0.0001
Female	329	17	3600	5.6	
Male	1606	83	60813	94.4	

	Sexual Minority Veterans (n=1,935)		Heterosexual Veterans (n=64,413)		p-value
Characteristics	**Count (N)**	**%**	**Count (N)**	**%**	
Race/Ethnicity					p<0.0001
AIAN	19	1.0	413	0.6	
Asian	30	1.6	494	0.8	
Black/African American	202	10.5	5297	8.2	
Latino	165	8.5	3580	5.6	
More than one	51	2.6	1110	1.7	
NHOPI	14	0.7	213	0.3	
Unknown	68	3.5	1614	2.5	
White	1386	71.6	51692	80.3	
Educational Attainment					p<0.0001
8th grade or less	78	4.0	933	1.4	
Some high school, but did not graduate	106	5.5	2640	4.1	
High school graduate or equivalent	574	29.7	20480	31.8	
Some college or 2-year degree	692	35.7	24994	38.8	
4-year degree	200	10.3	7265	11.3	
More than 4-year degree	253	13.1	7518	11.7	
Unknown	32	1.7	583	0.9	

NOTE: * TRANSGENDER INCLDUES BOTH TRANSGENDER WOMEN AND MEN, STANDARD DEVIATION (SD), AMERICAN INDIAN/ALASKAN NATIVE (AIAN), NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER (NHOPI)

PERSON CENTERED CARE

PROVIDER STAFF SHOWED RESPECT



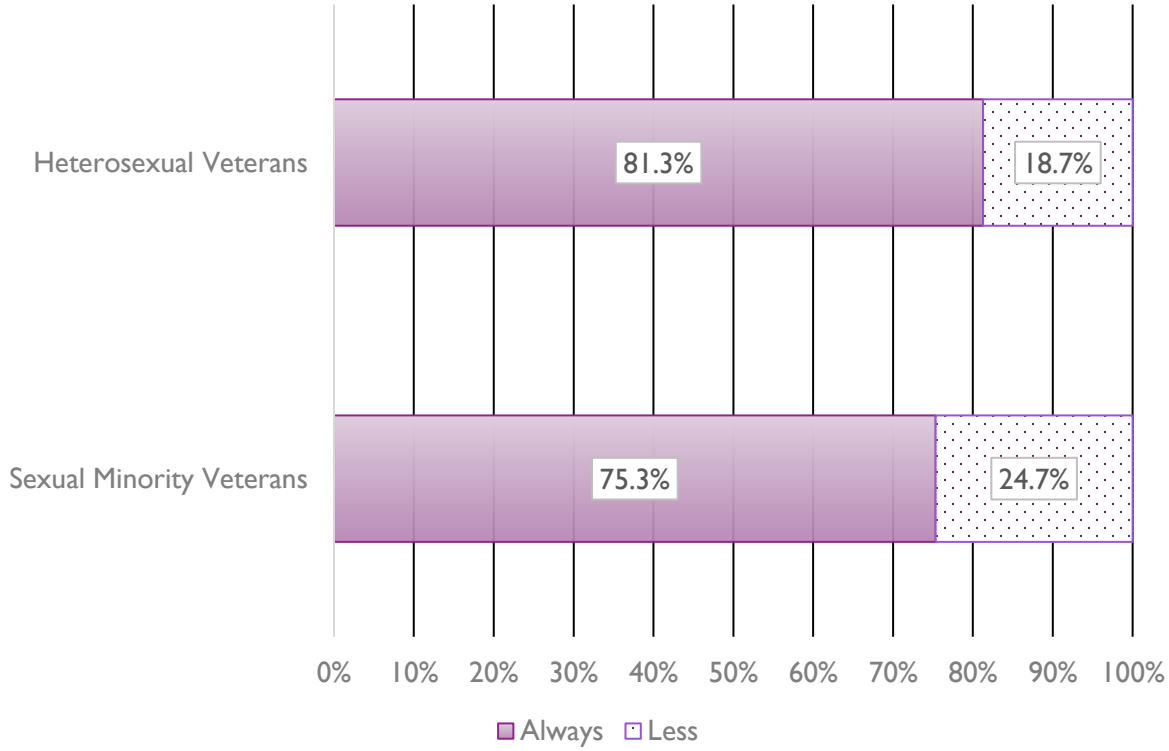
NOTE: SEXUAL MINORITY VETERANS REFERS TO INDIVIDUALS WHO SELF-IDENTIFIED AS LESBIAN, GAY, OR BISEXUAL (LGB).

DATA SOURCE: DEPARTMENT OF VETERANS AFFAIRS, SURVEY OF HEALTHCARE EXPERIENCES OF PATIENTS: SHEP PRIMARY CARE, 2020

Data Findings: Sexual minority Veterans are less likely to report their provider showed respect during the appointment than heterosexual Veterans. There is a statistically significant difference in the responses between heterosexual Veterans and sexual minority Veterans ($p<0.0001$). When compared to sexual minority Veterans, 70.8% of heterosexual Veterans indicated that their provider *always* showed respect, while 64.7% of sexual minority Veterans responded the same.

Implications: Feeling respected by healthcare providers may contribute to greater comfort levels with the provider and associated staff, and therefore may result in better health outcomes and more effective treatment. Greater provider empathy toward patients may be impactful in providing more effective care and treatment (Etingen, Miskevics, & LaVela, 2016).

PROVIDER LISTENED TO PATIENT



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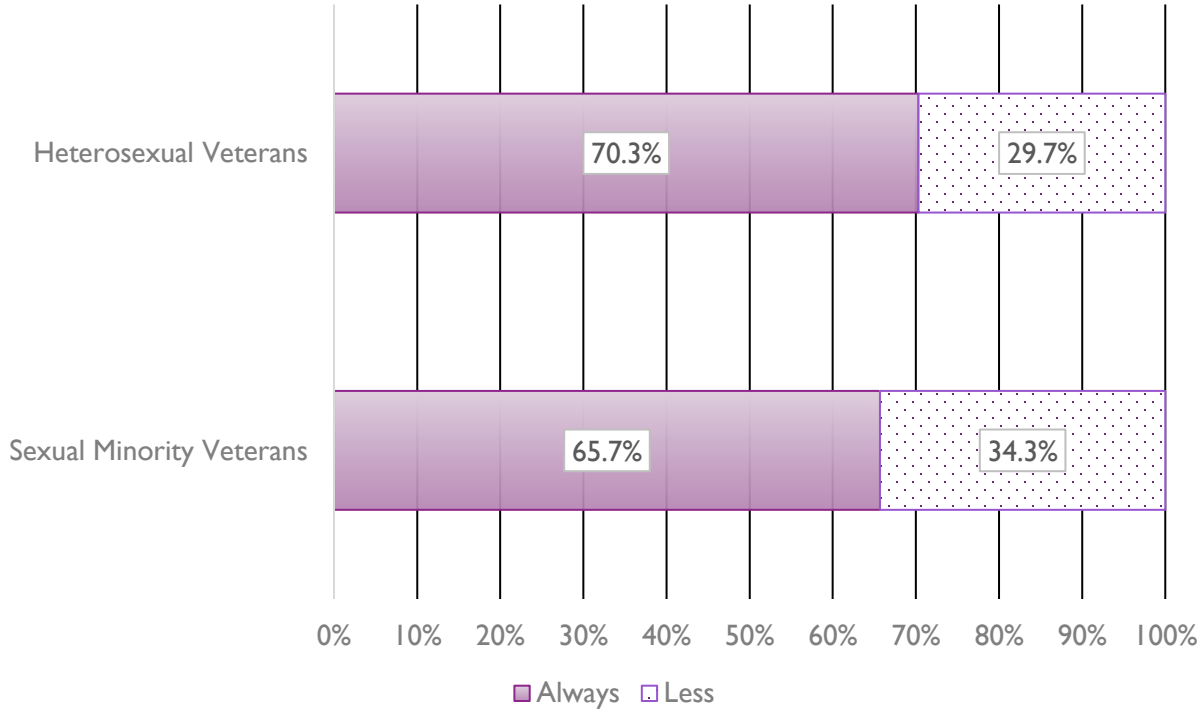
DATA SOURCE: DEPARTMENT OF VETERANS AFFAIRS, SURVEY OF HEALTHCARE EXPERIENCES OF PATIENTS: SHEP PRIMARY CARE, 2020

Data Findings: Sexual minority Veterans are less likely to report that their provider listened to them ($p<0.0001$) when compared to heterosexual Veterans. Compared to sexual minority Veterans, 81.3% of heterosexual Veterans indicated that their provider *always* listened, while 75.3% of sexual minority Veterans responded the same.

Implications: Patient-provider communication is a central tenant in providing, effective, tailored healthcare. Research shows that effective communication has been associated with greater patient satisfaction and improved health outcomes (Wolf, Lehman, Quinlin, Zullo, & Hoffman, 2008). Open and clear communication between patient and provider may reduce apprehension regarding disclosure of sexual orientation/gender identity, help reduce experiences of discrimination for sexual minority Veterans, and help build trust between patient and provider (Ruben, Livingston, Berke, Matza & Shipherd, 2019).

PROVIDER AWARE OF PATIENT'S MEDICAL HISTORY



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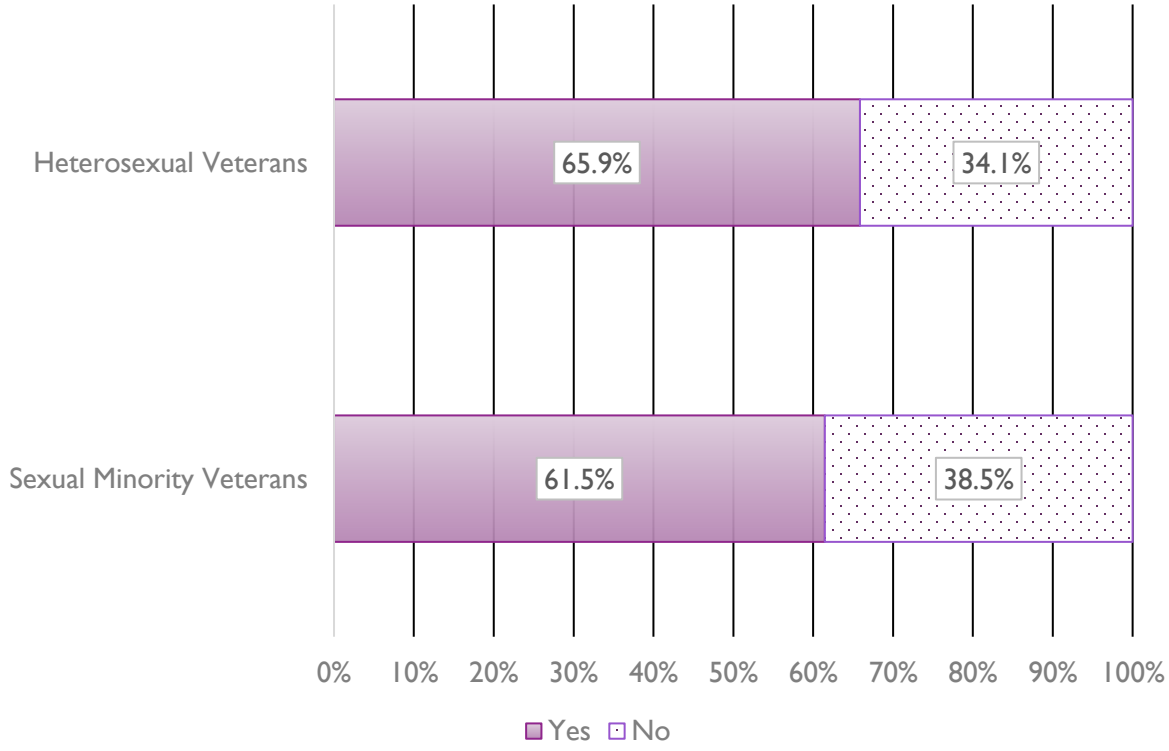
DATA SOURCE: DEPARTMENT OF VETERANS AFFAIRS, SURVEY OF HEALTHCARE EXPERIENCES OF PATIENTS: SHEP PRIMARY CARE, 2020

Data Findings: Heterosexual Veterans are more likely to respond their provider was aware of their medical history than sexual minority Veterans ($p<0.0001$). When compared to sexual minority Veterans, 70.3% of heterosexual Veterans indicated that their provider were *always* aware of their medical history, while 65.7% of sexual minority Veterans responded the same.

Implications: Full knowledge of a patient's medical history may result in better health outcomes for patients. The observed difference between sexual minority veterans and heterosexual veterans could be attributed to a variety of factors, including patient comfort in disclosing history to the provider or patient concerns about stigma, discrimination, or other forms of judgment. Experiences of discrimination or perceived discrimination may be associated with negative perceptions of healthcare and providers (Polek, Hardie, & Crowley, 2008).

HEALTH GOALS DISCUSSED WITH PATIENT



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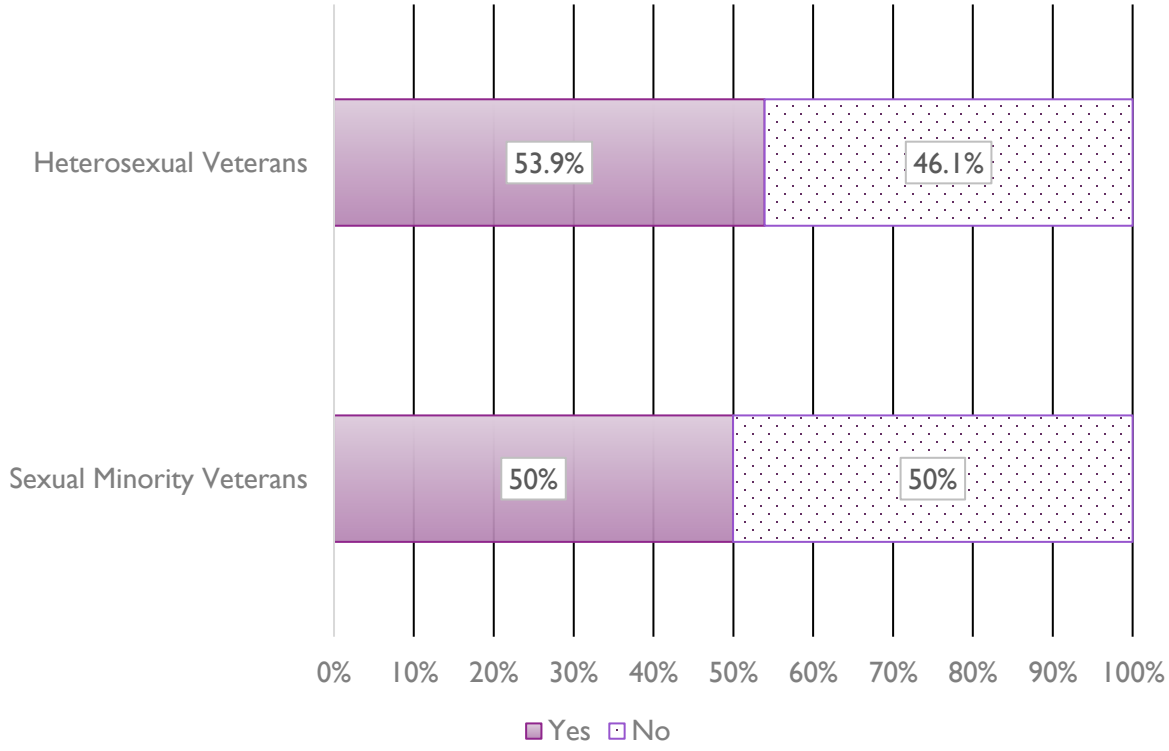
DATA SOURCE: DEPARTMENT OF VETERANS AFFAIRS, SURVEY OF HEALTHCARE EXPERIENCES OF PATIENTS: SHEP PRIMARY CARE, 2020

Data Findings: Heterosexual Veterans are more likely to respond that their health goals were discussed with their provider than sexual minority Veterans (p=0.0002). When compared to sexual minority Veterans, 65.9% of heterosexual Veterans indicated that their health goals were *always* discussed, while 61.5% of sexual minority Veterans responded the same.

Implications: Discussions of health goals with patients may be critical in determining the most appropriate treatment and result in overall better health outcomes with patients. Research shows that discrimination and reports of poorer health may be related (Berke et al., 2022). Therefore, discussion of health goals with patients vulnerable to discrimination may help decrease instances of discrimination and improve the health outcomes of these Veterans.

HEALTH DIFFICULTIES DISCUSSED WITH PATIENT



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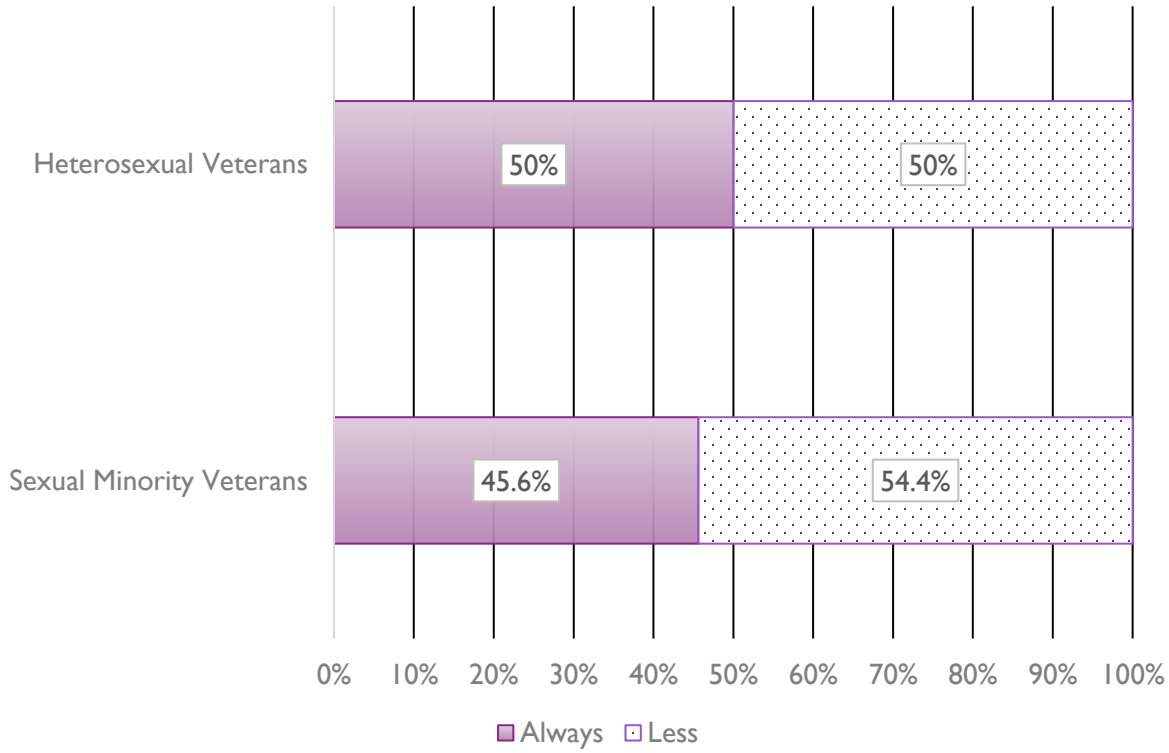
DATA SOURCE: DEPARTMENT OF VETERANS AFFAIRS, SURVEY OF HEALTHCARE EXPERIENCES OF PATIENTS: SHEP PRIMARY CARE, 2020

Data Findings: Heterosexual Veterans are more likely to respond that their health difficulties were discussed with their provider (p=0.0018) than sexual minority Veterans. When compared to sexual minority Veterans, 53.9% of heterosexual Veterans indicated that their health difficulties were *always* discussed, while only 50% of sexual minority Veterans responded the same.

Implications: LGB individuals are more likely to have more stressful and negative experiences in health care settings, suggesting that providers' prejudicial attitudes may serve as barriers to health and result in poorer access to health care (Graham, et al., 2011). Discussing health difficulties with patients may result in better health outcomes and aid in reducing negative health experiences.

ACCESS TO CARE

MEDICAL QUESTIONS ANSWERED



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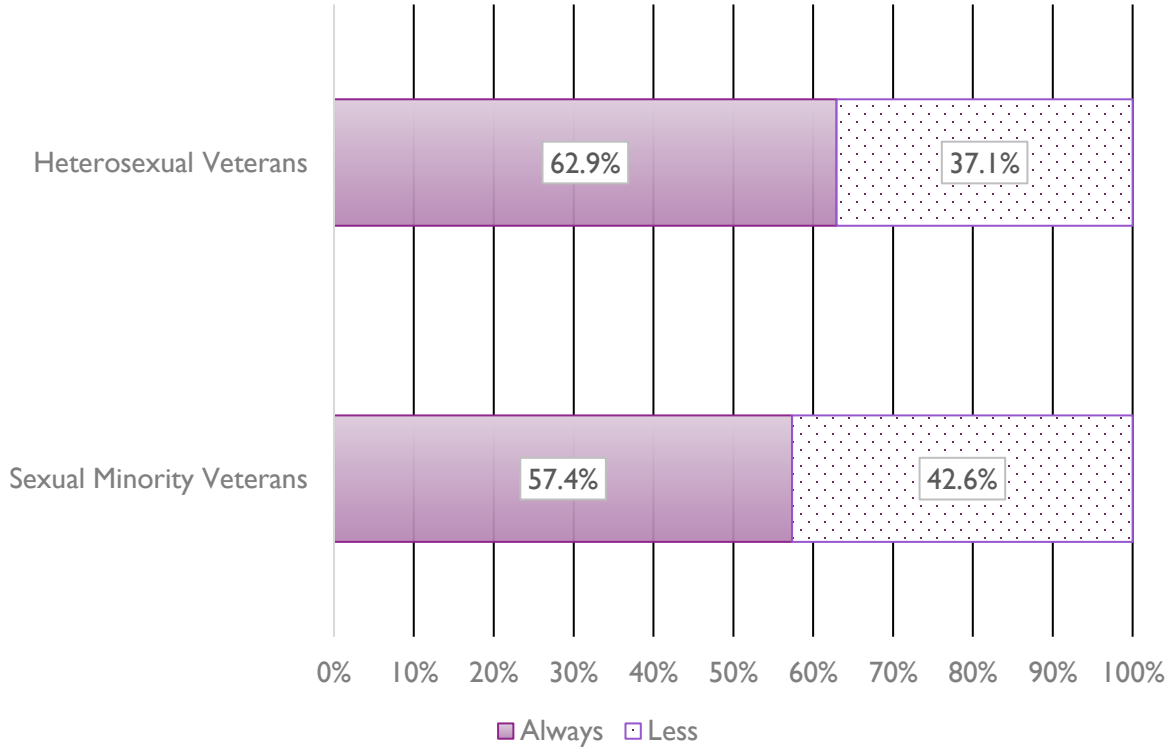
DATA SOURCE: DEPARTMENT OF VETERANS AFFAIRS, SURVEY OF HEALTHCARE EXPERIENCES OF PATIENTS: SHEP PRIMARY CARE, 2020

Data Findings: Heterosexual Veterans are more likely to respond that their medical questions were answered by their provider (p=0.012) than sexual minority Veterans. When compared to sexual minority Veterans, 50% of heterosexual Veterans indicated that their medical questions were *always* answered, while only 45.6% of sexual minority Veterans responded the same .

Implications: Addressing patient concerns fully may help improve patient experiences within VHA and contribute to overall better patient satisfaction. However, research has shown that "Veterans who received PTSD treatment exclusively within VHA reported higher satisfaction with their PTSD treatment than Veterans who received their PTSD treatment exclusively outside VHA" (Shipherd, Ruben, Livingston, Curreri, & Skolnik, 2018). Differences observed in this data may be related to a specialization in PTSD treatment in VHA. Patient perceptions of their provider may differ depending on the problem areas addressed by various VHA healthcare providers.

FOLLOW-UP CARE RECEIVED



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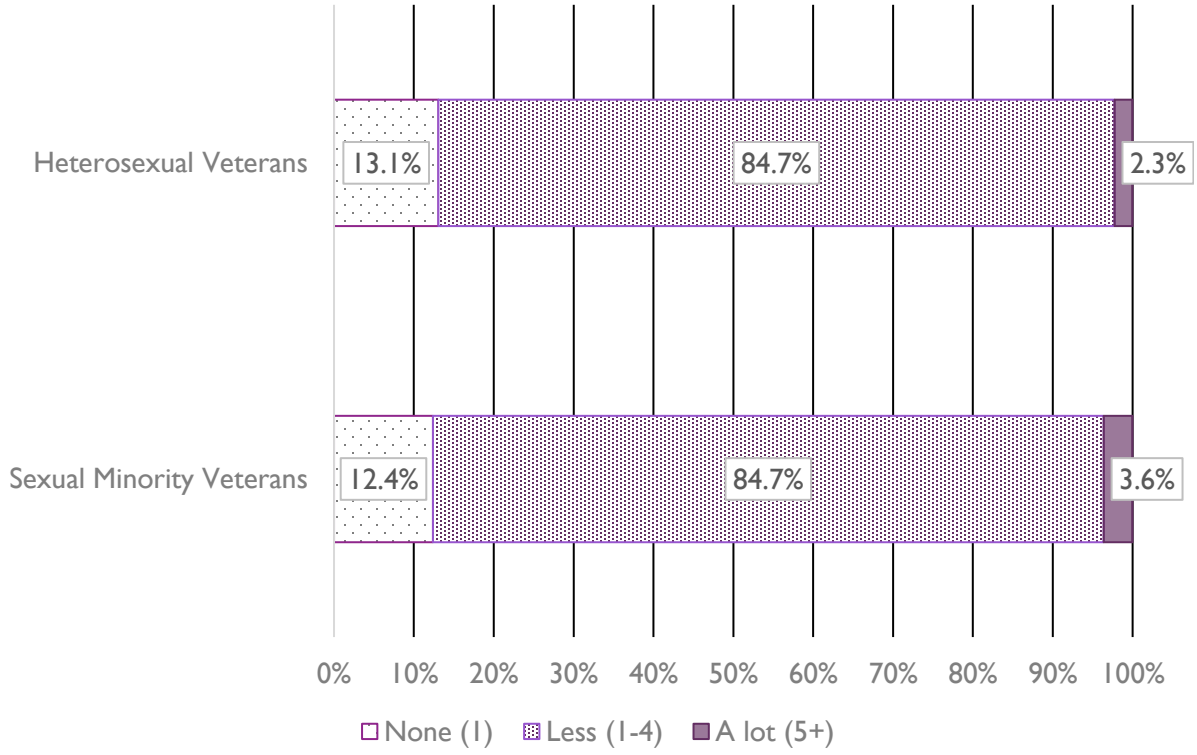
DATA SOURCE: DEPARTMENT OF VETERANS AFFAIRS, SURVEY OF HEALTHCARE EXPERIENCES OF PATIENTS: SHEP PRIMARY CARE, 2020

Data Findings: Heterosexual Veterans are more likely to respond that follow-up care was received ($p<0.0001$) than sexual minority Veterans. When compared to sexual minority Veterans, 62.9% of heterosexual Veterans indicated that they *always* received follow-up care, while 57.4% of sexual minority Veterans responded the same.

Implications: Differences observed between LGB and heterosexual Veterans in regard to receipt of follow-up care may be attributed to various factors. A potential reason may be attributed to lower patient satisfaction with care received due to perceived or experienced stigma and/or a lack of adequate communication with the provider (Simpson, Balsam, Cochran, Lehavot, & Gold, 2013). Irregular access to health care may increase the prevalence of riskier health behaviors and result in poorer health outcomes due to inadequate screenings, diagnostic tests, etc. (Ruben, Livingston, Berke, Matza & Shipherd, 2019).

PROVIDER VISITS



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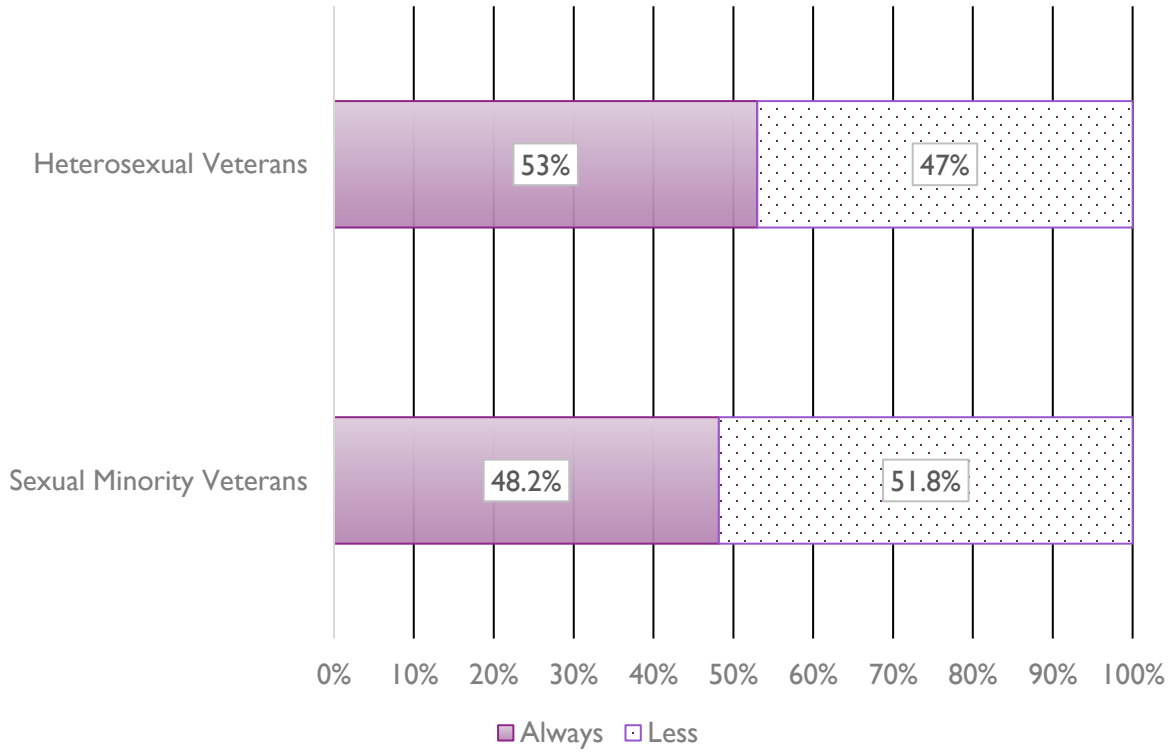
DATA SOURCE: DEPARTMENT OF VETERANS AFFAIRS, SURVEY OF HEALTHCARE EXPERIENCES OF PATIENTS: SHEP PRIMARY CARE, 2020

Data Findings: Responses between heterosexual Veterans and sexual minority Veterans differed when asked to quantify the number of times they visited their provider ($p<0.001$). When compared, 13.1% of heterosexual Veterans, and 12.4% of sexual minority Veterans indicated that they visited their provider one time or less; 84.7% of heterosexual and sexual minority Veterans indicated that they visited their provider between 1 to 4 times; 2.3% of heterosexual Veterans indicated that they visited their provider five times or more, while 3.6% of sexual minority Veterans indicated the same.

Implications: Frequency of provider visits may be related to patient satisfaction with care received or perceived care. LGB Veterans are likely to have experienced some discrimination while seeking health care (Ruben, Livingston, Berke, Matza, & Shipherd, 2019), consequently resulting in a decreased rate of care sought at VHA by this population. Research has shown that providers and patients have witnessed SMV patients receive substandard care or no care due to their sexual orientation (Sherman, Kauth, Shipherd, & Street Jr, 2014; Berke et al., 2022).

CARE COORDINATION

PROVIDER DISCUSSED MEDICATION WITH PATIENT



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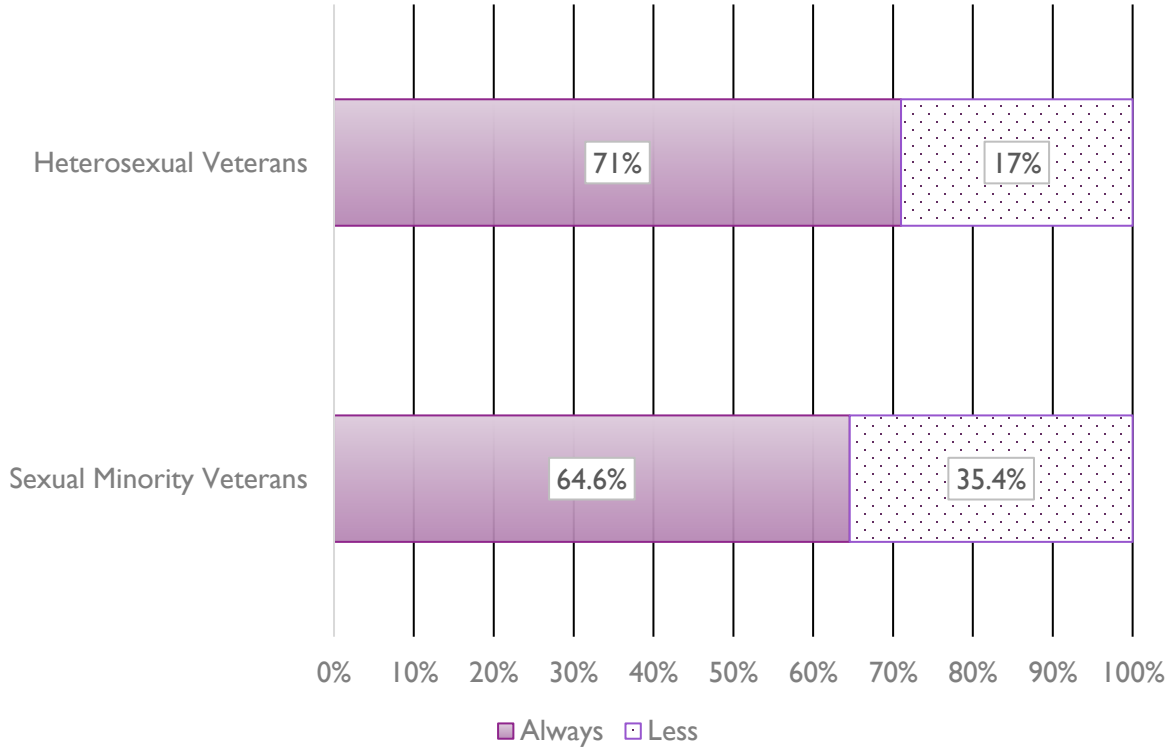
DATA SOURCE: DEPARTMENT OF VETERANS AFFAIRS, SURVEY OF HEALTHCARE EXPERIENCES OF PATIENTS: SHEP PRIMARY CARE, 2020

Data Findings: Heterosexual Veterans are more likely to respond that their medications were discussed with them (p=0.0002) than sexual minority Veterans. When compared to sexual minority Veterans, 53% of heterosexual Veterans indicated that their medications were *always* discussed, while 48.2% of sexual minority Veterans responded the same.

Implications: Effective communication between providers and patients may help improve health outcomes, patient satisfaction, and may result in a decrease in negative perceptions of VHA care (Ruben et al., 2019). Additionally, comfort interacting with SMVs is improved with training and experience talking about sexual orientation with patients (Sloan & Shipherd, 2019).

FOLLOW-UP RESULTS DISCUSSED WITH PATIENT



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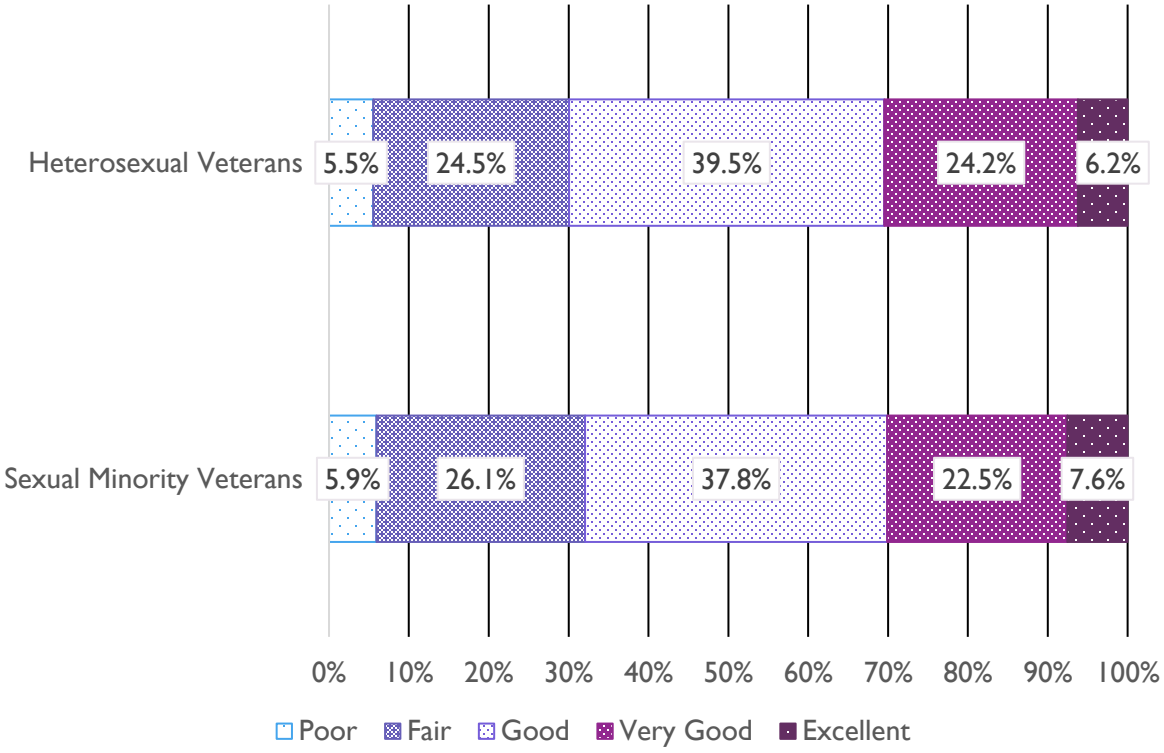
Data Findings: Heterosexual Veterans are more likely than sexual minority Veterans, to respond that their follow-up test results were discussed with them ($p<0.0001$). When compared to sexual minority Veterans, 71% of heterosexual Veterans indicated that their follow-up test results were *always* discussed, while 54.6% of sexual minority Veterans responded the same.

Implications: Like the implications of follow-up care received and whether the provider discussed patient concerns, discussions about follow-up results may strengthen the patient-provider relationships that may result in more positive perceptions about VHA care and improved patient satisfaction. Timely discussions of follow-up results may contribute to increased compliance with treatment and ultimately greater health outcomes for patients vulnerable to receiving less than adequate treatment or no treatment at all.

GENERAL HEALTH

SELF-REPORTED GENERAL HEALTH



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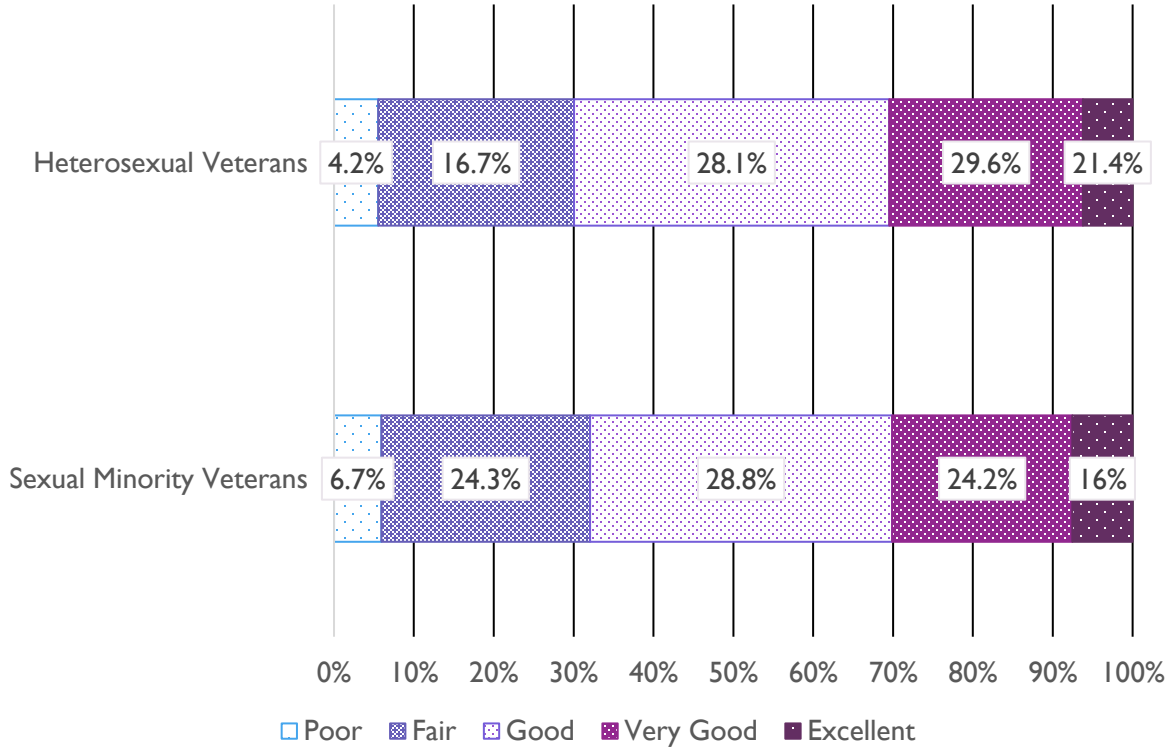
DATA SOURCE: DEPARTMENT OF VETERANS AFFAIRS, SURVEY OF HEALTHCARE EXPERIENCES OF PATIENTS: SHEP PRIMARY CARE, 2020

Data Findings: The difference in self-reported general health between sexual minority Veterans and heterosexual Veterans is statistically significant (p=0.02). Most respondents (SMV and heterosexual) indicated their general health to be *Fair* or *Good*. Approximately 5% of each population indicated their general health to be poor, and approximately 6.5% of each population indicated their general health to be excellent.

Implications: These data findings are indicative that LGB Veterans and heterosexual Veterans do not have comparable, self-reported health. These results may indicate that the quality of care received by both groups is not equal.

SELF-REPORTED MENTAL OR EMOTIONAL HEALTH



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DATA SOURCE: DEPARTMENT OF VETERANS AFFAIRS, SURVEY OF HEALTHCARE EXPERIENCES OF PATIENTS: SHEP PRIMARY CARE, 2020

Data Findings: The difference in self-reported mental health between sexual minority Veterans and heterosexual Veterans is statistically significant ($p<0.0001$). Approximately 28% of each population indicated their mental health to be as good. Compared with heterosexual respondents, sexual minority Veterans were more likely to report poor mental health and less likely to report excellent mental health.

Implications: These findings suggest that sexual minority veterans are more likely than heterosexual veterans to experience mental health problems. Research shows that sexual minority Veterans are likelier to screen positive for posttraumatic stress disorder (PTSD), depression, and substance abuse problems that may result from anxiety pertaining to their sexual orientation and concealment efforts (Cochran, Balsam, Flentje, Malte, & Simpson, 2013; Shipherd, Lynch, Gatsby, Hinds, DuVall, & Livingston, 2021).

NEXT STEPS

Differences in health experiences exist between sexual minority Veterans identifying as LGB, and heterosexual Veterans. Data from the SHEP survey revealed that LGB Veterans and their heterosexual counterparts have differing responses about access to care, person-centered care received from VHA, care coordination and their overall general and mental health. Various factors could be associated for differences observed. While many LGB Veterans report feeling comfortable disclosing their sexual orientation to their VHA providers (Kauth et al. 2018), some veterans may be concerned about disclosing their sexual orientation to their providers and the potential negative consequences (Sherman, Kauth, Shipherd, & Street, 2014). Additionally, LGB Veterans are more likely to feel unwelcome at VHA (Sherman, Kauth, Shipherd, & Street, 2014) and therefore are more likely to have negative experiences and perceptions of VHA care when compared to their heterosexual counterparts.

To address differences in the care experiences of LGB and heterosexual Veterans and work toward creating more inclusive environments where all Veterans receive the care they deserve, VHA has established initiatives such as the *PRIDE in All Who Served Program.* This program is designed to reduce healthcare disparities, including suicide risk, among the LGB population. Adopting a whole health approach, this program focuses on the overall wellness of each Veteran, to include increasing social connectedness and empowering Veterans to prioritize their personal health goals. LGBTQ+ Veteran Care Coordinators are another resource available to VHA providers and staff. Every VHA medical facility has at least one LGBTQ+ Veteran Care Coordinator, who is available to VHA staff for training, identification of clinical resources, and consultation. As VHA continues to address gaps in health equity among various populations of Veterans, outlined below are several recommendations that may help address the health disparities observed among the LGB group of Veterans.

- Educate staff on how to engage with specific groups of Veterans and address concerns to prioritize inclusivity and create a culturally sensitive environment.
- Implement systematic training requirements for all VHA providers focused on how to properly assess sexual orientation and gender identity as part of routine care and how to use this information to improve care interactions (Sherman, Kauth, Shipherd, & Street, 2014).
- Create more inclusive and welcoming environments through use of gender neutral language and symbols/ images that communicate safe environments (e.g., Quinn et al., 2015).
- Continue to support and expand training programs that develop expertise in LGBTQ+ Veteran health care like the LGBTQ+ Health Postdoctoral Fellowship program.
- Continue to expand the LGBTQ+ Health Program office.
- Continue to support the LGBTQ+ Veteran Care Coordinators through protected time and allocation of resources at the VISN and local levels.
- Continue to support the LGBTQ+ Employee Resource Group.
- Continue to gather information on sexual orientation and/or gender identity as part of Veterans' demographic profiles.

- Continue to expand VHA participation in the Healthcare Equality Index and the Long-Term Care Equality Index available in the fall of 2022.

The health of the LGBTQ+ population is of great importance to the VHA and OHE. With continued efforts in data collection and quality improvement we aim to ensure all who served receive equitable care. As more data becomes available and programs continue to improve, the VHA and OHE will remain committed to their mission of eliminating health disparities and achieving health equity for all Veterans, as well as providing appropriate individualized health care to each Veteran in a way that eliminates disparate health outcomes and ensures health equity.

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BRIEF OVERVIEW OF METHODS AND LIMITATIONS

To produce this report, data from the VHA's Survey for Healthcare Experiences of Patients (SHEP) Primary Care Medical Home (PCMH) 2020 was utilized. Data reported on was collected between October 1, 2019, and September 30, 2020, during fiscal year (FY) 2020.

Veterans utilizing VHA primary care services across the nation were selected at random and provided with paper copies of the SHEP survey via postal mail, Veterans were asked to return the completed survey via an enclosed pre-paid envelope. Data was recorded from surveys returned by Veterans who voluntarily completed the surveys on their own, providing their self—reported information to questions asked.

Data from survey responses were used to report on demographic statistics such as age, sexual orientation, self-identified gender identity, sex assigned at birth, race/ethnicity, and educational attainment are reported for Veterans identifying as sexual minority and heterosexual. The sample size included a total cohort of n=66,348 Veterans, of which n=1,935 Veterans who self-identified as sexual minority (~2.9%), and n=64,413 Veterans self-identifying as heterosexual. Veterans who selected either 'Gay', 'Lesbian', 'Bisexual', 'Other', or 'I'm not sure' were grouped as sexual minorities. Heterosexual Veterans were the referent. The sexual orientation and gender identity items were implemented during the last quarter of data collection for SHEP-PCMH FY 2020.

Visual graphs were produced for various measures identified across the four (4) domains: person centered care, care coordination, access to care, and general health.

Under each of the SHEP-PCMH domains, the various measures presented in this report included 4-levels of ordinal responses ranging from 'Always', 'Sometimes', 'Rarely', and 'Never/Not at all'. These responses were then collapsed into binary outcomes of 'Always' versus 'Less' (which included 'Sometimes', 'Rarely', and 'Never') to present the top-box responses. This classification system is utilized consistently at the VHA when utilizing SHEP data.

In short, we ran descriptive statistics, displaying frequency, means, and standard deviations of categorical or continuous variable. We also performed Pearson's chi-squared tests on categorical variables under each domain to understand any differences by sexual minority status. Our alpha was set at $p<0.05$.

There are several limitations to consider regarding the methods of the data analysis. Limitations such as:

- It may be likely that some Veterans chose not to disclose their sexual orientation status or gender identity in the SHEP survey.
- Prior experiences, or perception of unwelcoming VHA facilities, may make some LGB Veterans less likely to receive care at the VHA. Therefore, these Veterans may not be included. LGB Veterans who share membership in other marginalized groups may have even poorer health care experiences.

Equitable access to high-quality care for all Veterans is a major tenet of the VA healthcare mission. The VHA Office of Health Equity champions the elimination of health disparities and achieving health equity for all Veterans. Please visit www.va.gov/healthequity to learn more about how health equity improves the lives of all Veterans.