

**ACHIEVING HEALTH EQUITY FOR  
AMERICA'S MINORITY VETERANS**

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**HEARING**

BEFORE THE

**SUBCOMMITTEE ON HEALTH**

OF THE

**COMMITTEE ON VETERANS' AFFAIRS**

**U.S. HOUSE OF REPRESENTATIVES**

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# ACHIEVING HEALTH EQUITY FOR AMERICA'S MINORITY VETERANS

TUESDAY, FEBRUARY 11, 2020

U.S. HOUSE OF REPRESENTATIVES  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON VETERANS' AFFAIRS  
*Washington, D.C.*

The subcommittee met, pursuant to notice, at 2:32 p.m., in room 210, House Visitors Center, Hon. Julia Brownley [chairwoman of the subcommittee] presiding.

Present: Representatives Brownley, Lamb, Brindisi, Rose, Cisneros, and Dunn.

Also present: Representative Roe.

## OPENING STATEMENT OF JULIA BROWNLEY, CHAIRWOMAN

Ms. BROWNLEY. Good afternoon and welcome to the Subcommittee on Health's hearing on Achieving Health Equity for Minority Veterans.

In the next 25 years, America will be a majority minority country. Today, minorities disproportionately serve in the U.S. military. As America changes, so too will the veteran population, and so must the institution that provides their health care. The types of services, the competencies it develops, and the manner of outreach it conducts must meet the unique needs of its patients.

To better meet new needs, VA must address current struggles, from implicit bias in medical providers and front-line staff, to incomplete and missing data. VA should be the leader in American health care that can dynamically meet the needs of an increasing diverse and intersectional patient population.

The GAO report from December 2019 found VA's Health Equity Action Plan, originally drafted in 2014 and reissued again in 2018, had no measurable outcomes to date. No one is accountable for the success or failure of its efforts and, to make matters more concerning, VA's data on race and ethnicity is inconsistent, if not all together missing.

Last month, I traveled to Cheyenne River and Standing Rock Indian Reservations, where I heard numerous concerns from veterans of culture insensitivity and racial bias perpetrated by VA patients and staff. At last week's joint hearing, we heard how women's experiences with VA can have a deeply discouraging impact on their willingness to continue to receive care at the VA. As this committee knows all too well, no veteran is immune from harassment and assault inside facilities.

We know racial bias in health care contributes to different outcomes and increased fatalities. Providers with unconscious or conscious stereotypes about minorities may contribute to how they respond to a patient's concern. We know the legacies of horror such as Tuskegee experiments and the forced sterilization of Native women, compounded with experiences of racial bias and culturally insensitive providers contribute greatly to mistrust of health systems by people of color.

Ms. Williams highlighted in her written testimony during focus groups participants reported that VA providers take the pain and symptoms of people of color, particularly women, less seriously than those of their white counterparts, providing a barrier to correct health diagnoses and contributing to a lack of trust. It is the undoing of bias and the building of trust that VA must work toward.

VA's patients are only becoming more female and more ethnically and racially diverse. The realignment of a system built to serve white, straight men has to be a priority from a matter of patient safety to customer satisfaction. VA should be the leader in closing the chasm between minority and white health status in the United States.

With that, I would like to recognize Dr. Dunn for 5 minutes for any opening remarks he may wish to make.

#### **OPENING STATEMENT OF NEAL P. DUNN, RANKING MEMBER**

Mr. DUNN. Thank you, Chairwoman Brownley, and thank our witnesses for spending time with us today. It is a pleasure to be back here in the committee room with you again this year.

As the veteran population continues to diversify, we must ensure that the Department of Veterans Affairs is equipped to provide all those who have bravely served our great Nation with equitable, high-quality health care.

Last year, this subcommittee held a hearing to discuss how the VA is caring for a growing number of women who are seeking VA care, and today we are discussing how the VA is caring for a growing number of veterans who are members of racial and ethnic minorities. By 2040, military veterans are expected to be majority minorities in the country. Concerns about the disparities in health care for minorities have long existed; it is not unique to the VA either.

I will note that the VA's Office of Health Equity received increased funding and staff allocations in 2019 to support its important mission of identifying and eliminating inequities in care for minority veterans. The office's work culminated last Fiscal Year in the release of a new version of its Health Equity Action Plan. I look forward to hearing this afternoon about how the VA is going to track the progress in implementation of that plan and what metrics they plan to assess.

I think all of us, the VA, Congress, veterans themselves, all want to ensure that every single one of the brave men and women who have served our country and worn its uniform are well taken care of. Service and patriotism know no race or gender.

I am grateful to the witnesses and audience members for being here today. I look forward to a productive conversation.

I will apologize to the Chairwoman in advance that I must leave early; however, it is in the service of veterans. We have a veterans STEM bill that is being signed into law this afternoon, so I am going to be attending that ceremony.

With that, I yield back.

Ms. BROWNLEY. Thank you, Dr. Dunn.

We have one panel today. With us is Dr. Carolyn Clancy, she is the Deputy Under Secretary for Discovery, Education, and Affiliate Networks at the Veterans Health Administration. She is accompanied by Dr. Ernest Moy, the Executive Director of Health Equity, and Dr. Donna Washington, an attending physician at the Greater Los Angeles Health System.

Then we also have Ms. Kayla Williams. She is a Senior Fellow and Military, Veterans, and Society Program Director at the Center for a New American Security.

Last, but certainly not least, Ms. Melissa Bryant, the Legislative Director for The American Legion.

Welcome all of you, thank you for being here. With that, I recognize Dr. Clancy.

#### STATEMENT OF CAROLYN CLANCY

Dr. CLANCY. Good afternoon, Chairwoman Brownley, Ranking Member Dunn, and distinguished members of the subcommittee. I appreciate the opportunity to discuss our continued progress in achieving health equity for minority veterans.

I am accompanied today by Dr. Ernest Moy, the Executive Director of the Office of Health Equity, and Dr. Donna Washington, Attending Physician and Researcher at the Greater Los Angeles Healthcare System.

Our goal at VA is to shorten the distance veterans need to go for care and to leave no one behind. Health equity means that all veterans receive timely access to safe, high-quality care that helps them achieve their highest level of health regardless of age, gender, race, ethnicity, sexual orientation, and geography.

Overall, there are few differences in the quality of services delivered to veterans by Veterans Health Administration (VHA) related to race and ethnicity. Preventive care and care for chronic diseases are delivered similarly for all groups within VHA, in contrast to the private sector where systematic disparities are too common.

While the delivery of services is equitable, outcomes of care for racial and ethnic minority veterans in our system often lag behind outcomes achieved by non-Hispanic white veterans. For example, despite receiving comparable services, racial and ethnic minority veterans with diabetes are more likely to have poor glucose control and less likely to have good control of blood pressure and cholesterol.

There are also interactions between gender, race, and ethnicity in these outcomes. For example, non-Hispanic black veterans with diabetes are less likely than non-Hispanic white veterans to have good blood pressure and glucose control regardless of sex. Among veterans with heart disease, women, regardless of their demographic background, are less likely to have good cholesterol control compared with either non-Hispanic black or white men. In comparison to commercial plans, achievement of control of these cardio-

vascular risk factors are much better in VA, but we are not done yet.

Health equity also includes factors outside the direct provision of care that impact patient outcomes, including individual's education, income, geography, and other factors. The Office of Health Equity has a broad charge, including analyzing data on disparities, raising awareness about veterans' equity issues, working with our medical centers to improve outcomes for all veterans, and supporting workforce diversity and inclusion within VHA.

We have successfully addressed what are often referred to as the social determinants of health on a large scale; for example, reducing homelessness and food insecurity among veterans. We also, unlike most health care systems, have the capacity to address other determinants such as education, employment, and social isolation in conjunction with the Benefits Administration and Veterans Service Organizations, and others. Consequently, the Office has supported the development of two unique tools, one allows our medical centers to identify and address social determinants in their particular populations, a second actually is an equity-guided improvement strategy, which uses equity information at VA medical centers to identify specific groups of veterans at a higher risk of receiving lower quality of care.

In the December 2019 GAO report, there was a recommendation that the Office develop performance measures and clear lines of accountability to track progress toward equity for veterans, and to assess and improve the accuracy of racial and ethnic coding in VA systems.

In response to the first, the Office, along with the Health Equity Coalition, which is comprised of leaders across the Department of Veterans Affairs, have updated the Health Equity Action Plan, laying out a roadmap for the future.

In response to the second recommendation, the Office is partnering with researchers and supporting two assessments, the first led by Dr. Washington will formally determine the quality of coding by comparing existing racial and ethnic coding in the electronic record with self-reported survey information, because the self-report is considered the gold standard. A second assessment will collect race and ethnicity information in VA medical centers directly from veterans using an iPad, which will minimize staff discomfort when asking for this information, particularly in a situation where there are a lot of people around.

It is worth noting that race and ethnicity data are missing on about 7 percent of our veterans, which is better than that seen typically in the private sector.

We are also proud to report our progress in fostering a more inclusive patient experience for women and lesbian, gay, bisexual and transgender (LGBT) communities. The Office works with our Office of Women's Health Services to support assessments of equity issues faced by women veterans and share data. I think you have heard about the research we are supporting that involves close collaboration between researchers, providers, and the women patients themselves. The Office also works with LGBTQ coordinators to support assessments of equity issues by these veterans.



The Office has also served as VA's point of contact with the Health Care Equality Index, a major benchmarking tool throughout the health care industry, and is sponsoring work with the CDC to examine LGBT veterans, because they cannot be systematically identified in our current data systems. It is our expectation that it will be possible once Cerner is implemented to capture that information systematically.

Our goal is to meet veterans where they live and work, so we can work with them to ensure they achieve their goals by teaching them skills, connecting them to resources, and providing the care they need along the way. We are committed to advancing our outreach and empowerment to further restore the trust of veterans every day and continue to improve access to care.

We agree with the Chairwoman's statement that VA should lead in this area and that is exactly our aspiration. Our goal is to give our Nation's veterans the top quality experience and care that they have earned and deserve. We appreciate this committee's continued support as we identify challenges and find new ways to care for our veterans, and look forward to your questions.

[THE PREPARED STATEMENT OF CAROLYN CLANCY APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you very much.

I now recognize Ms. Williams for 5 minutes.

#### **STATEMENT OF KAYLA WILLIAMS**

Ms. WILLIAMS. Chairwoman Brownley, Ranking Member Dunn, distinguished members of the subcommittee, thank you so much for this opportunity to discuss this under-explored topic.

Overall, I fully agree that VA is an excellent source of health care, boasting low wait times, high quality, military cultural competence, and low cost. However, not all groups of veterans find VA to be equally welcoming, accessible, or adequate.

My testimony is drawn primarily from the forthcoming Center for New American Security (CNAS) report New York State Minority Veteran Needs

Assessment, supported by the New York State Health Foundation. Given the time limit, today I will focus my spoken remarks on racial, ethnic minority, and LGBT veterans.

As mentioned, racial minorities experience bias in health care that can and does lead to worse outcomes, such as the higher maternal mortality rates among African American and American Indian and Alaskan Native women. Racial bias in health care causes preventable deaths.

Stereotypes about minority individual's pain tolerance and symptoms have been reported to influence medical providers and to dis-regarding complaints by minority patients, and CNAS focus group participants express beliefs that these challenges extend into the VA system. Some reported that VA medical providers take the pain and symptoms of people of color, particularly women, less seriously than those of their white counterparts, creating a barrier to correct diagnoses and contributing to a lack of trust.

Advocates for minority veterans also argued that VA providers are inadequately culturally knowledgeable, negatively affecting the provision of care. For example, a number of participants emphasize

the need for providers to understand a lower willingness in the African American community to seek out mental health care. One participant said, "In black culture, there is not a lot of tendency to seek help for mental incapacity. You can not just have a doctor say, here is a service, come and get treatment. If they at VA understood the cultural aspects, they have to understand talking to a person that there is a reason they are not accessing services."

Implicit and explicit biases of health care providers negatively affect minority veterans. Participants felt that they received substandard treatment by doctors.

LGBT veterans also face barriers in accessing VA health care, including staff with inadequate knowledge and openly hostile fellow patients. This is particularly concerning given that a higher percentage of gay servicemembers suffer from Post Traumatic Stress Disorder (PTSD) and other mental health conditions.

Importantly, while LGBT status is not causal for PTSD or suicide, it is a risk factor. Stigma, prejudice, and discrimination create a hostile and stressful social environment that causes mental health problems, a phenomenon known as minority stress.

Gender confirmation surgery is specifically excluded from the VA medical benefits package. This is not in alignment with accepted standards of care for gender dysphoria. Because VA health care is minimum essential coverage under the Affordable Care Act, veterans who are enrolled in VA health care do not qualify for subsidies in the health insurance marketplace. Accordingly, these veterans may be unable to enroll in a plan that would provide this medically necessary. Crucially, there are dramatic reductions in suicide among transgender individuals who receive appropriate transition-related care, denying it violates VA's stated commitment to suicide prevention.

Additionally, VA does not provide IVF for same-sex couples, another discriminatory practice that should be eliminated.

VA should work to become more welcoming for all minority veterans by implementing trauma-informed and dignity-affirming care, including effective cultural awareness training for employees, updating waiting room reading material, posters, and television channel default settings to be more inclusive; increasing Veterans Experience Office efforts to alleviate disparities in the experiences of minority veterans; expanding the nascent End Harassment Campaign to include the harassment of LGBT and racial/ethnic minority veterans; and replicating VA's existing secret shopper model of ensuring that front-line staff members are aware of resources for MST survivors to also include minority veteran coordinators and LGBT veteran care coordinators at VA medical centers nationwide.

Additionally, VA should carefully review all policies and provisions of the medical benefits package to eliminate those that discriminate against women and LGBT individuals. Should VA be unwilling or unable to take these actions independently, I urge Congress to pass legislation requiring VA to cover gender-confirmation surgery and IVF for same-sex couples.

VA is a top-tier provider of health care. Identifying and eliminating any barriers that make it less welcoming and effective for the rapidly growing population of minority veterans is an impor-

tant part of ensuring health equity for all who have served our great Nation.

Thank you, and I look forward to any questions you may have.

[THE PREPARED STATEMENT OF KAYLA WILLIAMS APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you very much, Ms. Williams.

I now recognize Ms. Bryant.

#### **STATEMENT OF MELISSA BRYANT**

Ms. BRYANT. Staff Sergeant Herman A. Day fought in the Italian campaign of World War II. He was assigned to the 92d Infantry, the Buffalo Soldiers, the Colored Division. Reports at the time cited poor combat performance, low morale, and malinger. The 92d Infantry Division was considered of inferior quality by both German and U.S. commands.

Many historians have begun to reevaluate the combat record of the 92d Division as concurrent reports of its honorable performance have continued to surface. Numerous veterans at the division believe that the reports of poor performance were motivated by racist sentiments present within the senior officer ranks. To wit, the 92d Division commander asked the Army—or advised the Army, rather, against ever again using African American soldiers as combat troops. Even as evidence mounts in support of the division’s honorable conduct, some still seek to suppress these facts.

Staff Sergeant Herman A. Day was killed in action in Italy 75 years ago on February 10th, 1945; he was my grandfather.

I never had the opportunity to ask him about the racial prejudices he faced during his service, but it is well documented what he endured. Despite Presidential executive order to desegregate the Armed Forces in 1948, the stain on the U.S. military history lives on, and reflects the racial and ethnic biases many minorities still face when using the Veterans Health Administration services, hence why I share this personal story.

Chairwoman Brownley, Ranking Member Dunn, and distinguished members who serve on the subcommittee, on behalf of our National Commander, James W. “Bill” Oxford, we thank you for the opportunity to discuss the topic of how VA addresses health inequities for minorities across the Veterans Health Administration. I proudly represent the The American Legion and appreciate the opportunity to assist this subcommittee in better understanding this critical topic.

We must ensure that the institutions we built to care for our Nation’s veterans give every veteran, regardless of gender, race, sexual orientation, or creed, the quality of care and support that they deserve. Why? Because recent studies show that racial and ethnic minority veterans represent nearly 22 percent of the total veteran population. VA projects that the minority population will continue to rise over the next few decades and reach an estimated 35 percent of the total veteran population by 2040.

Often the only woman-of-color officer in my units, I can point to many occasions where I have helped soldiers who came to me for advice, counsel, or reporting of incidents dealing with racial, gender, sexual orientation discrimination, harassment, or even assault within the ranks.

My service was also during the time of Don't Ask, Don't Tell, where I had the truly unfortunate duty of separating troops from service due to their sexual orientation. This is relevant, because, depending on discharge status, LGBT would not have the same access to veteran benefits, adding an overall distrust of the military and veteran health care systems. Notably, The American Legion is the only Veterans Service Organization that assists veterans with discharge upgrades and represents them before service discharge upgrade boards and hearings.

Many clinical outcomes have significant racial gaps in data collected for conditions such as hypertension, cardiovascular events, diabetes, and labor and delivery. A grim example of disparity in health care outcomes as due to racial bias is in the nationwide maternal mortality rate in minority women, who are two to three times more likely to die from pregnancy-related causes than white women. A widely publicized U.S. Supreme petition last year unsuccessfully challenged the Feres doctrine, *Daniel v. United States*, which involved the death of a Navy nurse who died in childbirth in the same labor and delivery board in which she served at Bremerton Naval Base. This is a chilling example of where the deceased was also a racial minority, her pain was ignored, and it shows how this nationwide trend can be reflected in our military and in our veterans, and may color the perception of disparate care provided to minority women at both military and veteran medical centers.

I should also note that the petitioner in this case, the widower, Walter Daniel, is my classmate and friend of over 20 years.

It becomes necessary to ask why these care inequities exist in the microcosm that is our community; in research, to what extent these disparities are attributable to negative outcomes.

Chairwoman Brownley, Ranking Member Dunn, and distinguished members who proudly serve on this subcommittee, The American Legion thanks you for the opportunity to illuminate the positions of the nearly 2 million veterans of this organization. It is the priority of The American Legion that all of our Nation's veterans receive the same quality of care and support we expect from the VA. By action of this committee, we can see that it is a priority for you as well.

As we unpack the myriad reasons why minority veterans on the whole report either negative health care outcomes or unequal treatment under the law at the VA, The American Legion stands ready to support this subcommittee with observations and expertise.

Thank you.

[THE PREPARED STATEMENT OF MELISSA BRYANT APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Ms. Bryant, and thank you for sharing your story and your grandfather's story with us here today. I appreciate it.

I will now recognize myself for 5 minutes.

The first question that I had, I want to go to actually the application for health benefits, which I think is probably, maybe one of the VA's first touches, you know, on a VA, and the application asks for a lot of information, sex, gender identity, and so forth. In reading through this, in question box number 4 it says, "Are you Spanish, Hispanic, or Latino?" I am just wondering if Spanish, is that a mis-

take? I do not think Spanish is an ethnicity. I do not think the U.S. Census Bureau uses it as an ethnicity, Office of Management and Budget (OMB). Is that a mistake or—

Dr. CLANCY. I will have to take that for the record. I would point out that about two thirds of people who sign up for our health care system are actually signing up in person and are probably being asked that question verbally, but I will check on that. I had not actually seen that application. Thank you.

Ms. BROWNLEY. OK. Well, let me just point out a couple of other things that you can take back. One is, when asking race, there is a box for American Indian or Alaska Native, but they do not ask for the tribe, which is an important piece of information. Nowhere on the form does it talk about the language needed to use with either the veteran or the veteran's family. We have heard many, many stories of particularly our Native veterans who, you know, go back to their land and speak their language and, as they grow older, they have not spoken English in a very, very long time, and that becomes a barrier to their health care. I think that would be a good question to ask.

Then also on the back of the form, it also asks if you are eligible for Medicaid. It does not ask the question if you are eligible for Indian Health Services, which I think is an important piece of information to have. Having just traveled to Indian country, it is very clear that the VA does not have a good handle on our Native veterans and where they are getting their health care, whether it is the VA or Indian Health Services, or a combination of both; the counts are very, very difficult to attain.

If you could take that back, because I feel like, as you said, when they first sign up, this is probably something that they are asked, but this is certainly an important touch point and I just think that there is more information that needs to be included.

I wanted to ask you, Dr. Clancy, also you mentioned in your testimony that the VA collects the survey of health care experiences of patients, which is the VA's sort of national standardized publicly reported patient survey, but it goes on to say that we do not really collect the racial and ethnic groups because the number of minority veterans responding to this survey is too small. Is that an accurate statement?

Dr. CLANCY. There are two sources of information that we get from veterans on the out-patient basis, one is the survey you just referenced, the other is real-time information where veterans can go to a kiosk in any of our facilities and report on their experience that day, and we think that that is—it is called V-Signals—we think that is very important in terms of service recovery and so forth. It is that survey, not the Survey of Healthcare Experience of Patients (SHCEP) survey, which actually very few people are actually indicating their race or ethnicity.

I think that as we look into sources of missing data, we might be able to pick that back up, but this is like real-time, very short surveys that are now being deployed at all our facilities.

Ms. BROWNLEY. Do they ask ethnicity and gender and—

Dr. CLANCY. They do, but I do not believe that many people fill it out. We have some work to do there.

Ms. BROWNLEY. Well, it just seems to me in terms of the survey, I think that, you know, if we do not have many minority veterans filling out the survey and/or putting that data onsite—

Dr. CLANCY. Right.

Ms. BROWNLEY.—you know, I wonder what the problem is and why that is, and I just feel like it is something that we should— if that is an issue where we can not collect the data, what are we going to do, what are we going to do to make sure that we do collect the data, because the data, you know, is really the starting point in terms of providing high-quality health care to each and every one of our veterans, particularly our minority veterans.

Do you have an answer for that or—

Dr. CLANCY. No, but I will get back to you—

Ms. BROWNLEY. OK.

Dr. CLANCY.—with a more thorough answer. This is relatively new information, but it is especially important because it actually gets at a dimension that the SHCEP surveys do not, because it actually gets more at veteran trust in our system and in the Department, which is hugely important to health care outcomes. We will get back to you.

Ms. BROWNLEY. OK. If I run out of time—I have run out of time, so I will yield back and yield to Ranking Member Dunn.

Mr. DUNN. Thank you very much, Madam Chair.

I will direct my first question to Dr. Washington, if I may. You know, we have read that minority vets are less likely to be treated for hepatitis C, even though they—I mean, with the same instance, so why do you think that is and what are we doing to try to correct that?

Dr. CLANCY. I am sorry—

Mr. DUNN. I directed the question to Dr. Washington. I think you are the attending physician on the wards, right? Hit your microphone.

Dr. WASHINGTON. Thanks for that question. I am the attending physician, that is correct. Your question is, why are minority veterans less likely to be treated for hepatitis C?

Mr. DUNN. I assume that is, you know, per capita. Of 100 cases, minority get—they get treatment less often, why would that be?

Dr. WASHINGTON. That is a really excellent question. I actually do not have the answer for that. I do know certainly that is the case that minority veterans are more likely to have hepatitis C, that though they had very high treatment rates in comparison to treatment rates outside of the VA, that there are definitely racial/ethnic differences, as you mentioned, within the VA.

Mr. DUNN. Do you have any eyes on that, Dr. Moy? Any insights?

Dr. MOY. I do not have anything to add to that.

Mr. DUNN. Dr. Clancy.

Dr. CLANCY. No, except to note that at one point we were doing special outreach to Hispanics with hep C for treatment, because we were very concerned that we were missing them.

I will say that for every facility in our system, every facility got a list of the veterans who were hep C positive, so that they could do outreach. I have not seen it stratified by minority status, but would be happy to look into that.

Mr. DUNN. Also, Dr. Clancy, you know, when these new hep C treatments—and there are a number of them—started becoming available some 5 or 6 years ago, what steps did the VA take to include those in the, you know, treatment for minorities and in fact all of your population? You had to be progressive—it was expensive, but what would you—

Dr. CLANCY. Well, it was expensive and, it was so expensive, we had to come back to the Congress to say we actually need more resources, and to Congress who was swiftly responsive, for which we are very, very appreciative. Fast forward several years, we have cured 100,000 veterans of hepatitis C, which I do not think any health care system can claim. I simply have not seen the data in terms of—

Mr. DUNN. Just stratify—

Dr. CLANCY. Yes.

Mr. DUNN.—do you have a sense of how many are untreated?

Dr. CLANCY. I believe that we have reached the vast majority of people who are eligible for treatment. That brings up the question, what do I mean, eligible for treatment? People who do not have ongoing substance use or other disorders that would make treatment a bit risky for them, or people who actually refuse to be treated, but we have been able to reach a very high proportion of the veterans with hep C.

Mr. DUNN. That is a counseling problem.

Dr. MOY, let me ask you a question here. Do the patient satisfaction rates vary between minority veterans and white veterans?

Dr. MOY. Yes, they do. The SHCEP surveys do indicate that minorities tend to be less satisfied with the patient-provider communication than—

Mr. DUNN. Can you quantify that?

Dr. MOY. Yes, we can quantify it. Actually, Dr. Washington is our expert—

Mr. DUNN. OK.

Dr. MOY.—on the SHCEP by race and ethnicity.

Mr. DUNN. Great. Dr. Washington.

Dr. WASHINGTON. I am regretting that I did not bring those exact numbers with me. We can certainly get back to you with the exact numbers.

Mr. DUNN. I would like to—but do you have a ballpark?

Dr. WASHINGTON. I will have to look at—

Mr. DUNN. OK.

Dr. WASHINGTON.—my numbers, I do not want to—

Mr. DUNN. We are going to hold you to it, though—

Dr. WASHINGTON.—misspeak.

Mr. DUNN.—I want to see those numbers.

How about the cost? Can you compare the cost of treating minority veterans with the cost of treating non-minority?

Dr. WASHINGTON. We did not look at cost in our analyses.

Mr. DUNN. That might—Dr. Clancy, would you speculate on that? Does that have any bearing on the rate of treatment or—

Dr. CLANCY. Well, cost is important, but as a system with more or less a global budget, right, where sort of simulating what things would cost, the biggest issue of concern to us is are people not getting treatments because we did not try hard enough, because they

did not trust us when we spoke to them and said we are recommending that you get treated with this regimen or medication, or whatever it is.

In general, I think the larger concern in the field of health equity is that in fact it costs less because of the factors I just mentioned.

Mr. DUNN. Yes, curing the disease is generally—

Dr. CLANCY. Yes.

Mr. DUNN.—cheaper than treating it chronically.

Dr. CLANCY. Yes.

Mr. DUNN. You do not see any deliberate attempt to not treat minorities given costs; is that fair to say?

Dr. CLANCY. Yes.

Mr. DUNN. OK. With that, I yield back. Thank you.

Ms. BROWNLEY. Thank you, Dr. Dunn.

Mr. Cisneros, you have 5 minutes for questioning.

Mr. CISNEROS. Thank you, Madam Chairwoman, and thank you all for being here today.

Dr. Clancy, the Health Equity Committee created in 2012 and chaired by the Director of the Office of Health Equity was created as a steering committee dedicated to minority veteran health issues, amongst others, in order to oversee timely completion of initiatives and ensure the commitment of appropriate organizational resources. However, between the years of 2015 and 2019, that committee did not meet on a regular basis. How can it provide adequate oversight of the VA's minority veteran health initiatives if it does not meet for 4 years.

Dr. CLANCY. I think it is fair to say that with new leadership in place that we have a reason to have much, much higher expectations. I think that would be the easiest way to respond to your question.

You are absolutely right. If the committee does not meet, how can they possibly do anything? Under current leadership for VHA with Dr. Stone, where he is putting a very, very high premium on consistency across our system; not good for this State compared to others, but, you know, good for all veterans regardless of where you get your care. This sometimes is called highly reliable care. We now have a framework to actually move forward and make sure that disparities and tracking that in performance are routinely included.

Mr. CISNEROS. When is the next meeting scheduled, when is that committee scheduled to meet?

Dr. CLANCY. Dr. Moy.

Dr. MOY. March 2nd.

Mr. CISNEROS. March 2nd?

Dr. MOY. Yes.

Mr. CISNEROS. Are they going to meet on a regular basis now or how often will they meet?

Dr. MOY. Yes, we have been meeting monthly for about the last year. Then we are just tapering down to every 6 weeks, because we have finished our Health Equity Action Plan update, as well as our operational plans for the fiscal year.

Mr. CISNEROS. OK. In 2014, Office of Health Equality (OHE) identified activities to make improvements in five focus areas, but VA could not track progress because there were no performance



measures and are no clear lines of accountability for offices. How can we track improvement and track performance if we do not create any performance measures? Has that changed?

Dr. MOY. Yes. With the guidance of the Health Equity Coalition, we have created a 5-year Health Equity Action Plan that was endorsed by our Under Secretary this past fall and we just finished creating our Fiscal Year 2020 operational plan. The Health Equity Coalition at the end of our Fiscal Year will compare what we said that we would do with what we actually did. I think we are highly accountable at this point.

Mr. CISNEROS. All right. Can you share that with us?

Dr. MOY. Yes. It is on our website, but, yes, we would be glad to do that.

Mr. CISNEROS. All right.

Dr. CLANCY. I would just add that it is under Dr. Moy's leadership that really we have got facility-specific information routinely provided and I think that is a very key picture, right? Because if you are just looking at a global national report, we all know the response to that is, we are doing great, but it must be those other people, right? When it is about where you provide care, it says a very different implication.

Mr. CISNEROS. According to the December 2019 Government Accountability Office (GAO) report, the VA cannot ensure the accuracy of race and ethnicity information labeled in the electronic health records. Dr. Clancy, how has this impacted the VA's ability to gather retrospective data in order to measure the effectiveness of minority health care?

Dr. CLANCY. I am going to turn to Dr. Washington, who is going to be helping us a lot with this as we try to make improvements.

Dr. WASHINGTON. Thanks for that question. We have a study underway, the study to which Dr. Clancy referred to in response to the GAO report, that is looking to exactly quantify what that rate of missing data is, as well as inaccurate data, and we will be retrospectively reevaluating some of our measures of differences by race and ethnicity to look at the impact of those inconsistencies in race and ethnicity data coding.

Mr. CISNEROS. Will you be asking individuals to self-identify, so we can get—

Dr. WASHINGTON. Actually the Survey of Health Care Experiences of Patients does ask individuals to self-identify. We will be using several years of that data as sort of the gold standard for race and ethnicity data, and we will be combining that with the electronic health record report of race and ethnicity, so that we can see not only what the overall national inaccuracies are, but we will be able to hone in at the health care system level, so that we can identify if there are particular areas or particular sites in which we need to look more closely at the practices.

Mr. CISNEROS. All right. With that, I yield back my time.

Ms. BROWNLEY. Thank you, Mr. Cisneros.

I now recognize Mr. Rose for 5 minutes.

Mr. ROSE. Thank you, Madam Chairwoman.

Ms. Williams, thank you for—I am looking at this New York State assessment. If you were crowned Empress of New York for

a day, give me two or three things that you think New York needs to change as quickly as possible as it pertains to this issue?

Ms. WILLIAMS. Among the things that I think are most important to realize are that veterans do not leave the military and go and live in veteran bubbles. We do not live in veteran barracks and work in veteran-employment situations only. All of the situations that can be challenging for minorities in the broader community also affect veterans who happen to be minorities. I think it is imperative at the State level, given the current national situation, to carefully seek to identify any laws or policies that are going to be disproportionately affecting minorities at the Federal level and do what they can at the State level to address those.

For example, New York already provides some protections for LGBT folks that are not available at the national level. Seeking out additional areas like that I think is incredibly important.

Mr. ROSE. What do you think that the VA should be doing in New York?

Ms. WILLIAMS. I think VA nationally should address the inequities already identified, such as the lack of provision of gender-confirmation surgery. There are also some disproportionate challenges for women, such as the fact that women vets can be charged copayments for birth control in VA, which cannot happen in—

Mr. ROSE. Are there any ways the VA looks worse than the rest of—in New York it looks worse than the rest of the country?

Ms. WILLIAMS. Unfortunately, we are not able to assess it on the health level, and that is the primary area that VA is able to provide care. We are really excited to hear that VA is releasing a report soon, I think that is going to be really beneficial for all of us.

I also do want to give one quick shout-out to VA on other areas; this is broader than New York, but there are some areas of real strength. For example, the Minority Veterans Program, which is collecting genetic data from veterans, is doing some really groundbreaking research that is also beneficial in this area. They recently released, for example, a report on levels of anxiety and identified genetic loci that are different between African American and white veterans.

VA is doing some great things, and I want to continue to support and encourage that across the board, in New York and nationally.

Ms. BRYANT. You mean the Million Veteran Program?

Ms. WILLIAMS. I am sorry, that is what I meant.

Ms. BRYANT. Yes.

Ms. WILLIAMS. Thank you very much, Melissa.

Ms. BRYANT. You are welcome.

Ms. WILLIAMS. It was a long week.

Mr. ROSE. Sure. Thank you.

Ms. WILLIAMS. Million Veteran Program. Thank you.

Mr. ROSE. One thing that I have noticed in New York and around the rest of the country is that, while indeed, you know, Global War on Terrorism (GWOT) veterans look like the country and the beautiful cultural mosaic that it is, but our Vietnam vets and Korean War vets of color experienced particular trauma, you know, fighting for freedom abroad, not exactly finding that same freedom here at home. In your analyses, what particular challenges

have you seen for veterans of color who are older, from those earlier conflicts?

Ms. WILLIAMS. When we did a focus group in Northwestern New York, we definitely encountered older veterans of color who were struggling with serious economic problems that are, again, related to the economic conditions in the region, and some of the Federal-level protections that try to help with that, so Federal hiring preferences, for example, are less relevant to those veterans, because there are not very many Federal jobs there.

Finding ways that we can improve the economic outcomes of minority veterans in Upstate New York where, you know, things are not as vibrant economically as say in the city, I think is really incredibly important, especially as they are reaching, you know, in some cases the end of their earning years and are going to be looking at ways to manage moving forward. That definitely is something that is a challenge, although, of course, that population does tend to be whiter.

Mr. ROSE. Sure.

Ms. WILLIAMS. Yes, the social supports are not as strong for minority veterans.

Mr. ROSE. Would anyone else like to touch on—

Ms. BRYANT. I would—

Mr. ROSE.—that point? Yes.

Ms. BRYANT.—please, Representative Rose. I completely concur with everything that Kayla said and, in addition to that, on the benefits side there is impact to health care outcomes. Studies have historically shown that there is racial bias, implicit bias that is injected into lower rating decisions that are given for service-connected claims.

There is automatically, as I touched on in my opening statement, there is a distrust that follows in particular the African American community, but it flows into the Hispanic community for those that are bilingual speakers, and it really does go back for the history of our country's Armed Forces to where that distrust lives on through generations.

For the Vietnam era, as you articulated already, they came home to an unwelcome environment. If you think of those who were fighting through the civil rights movement at the same time of fighting through battles in Vietnam, when they came home, they were automatically distrustful of the VA. That is compounded by the overall distrust of the VA by the Vietnam generation to begin with, but when they got older and they started filing their claims and they started going to claims officers.

Last year, we have seen at The American Legion as reported through our System Worth Saving program, as reported to our service officers who are out in the field, that there is a bias that can be injected into claims that are submitted by minorities.

Mr. ROSE. Fantastic. Thank you.

Ms. BROWNLEY. Thank you, Mr. Rose.

No other members are present, so I have a few more questions that I would really like to ask.

The first question is, in 2016, the VA Health Equity Report, it states that most of the research on racial/ethnic disparities among veterans has focused on single clinical conditions or on limited ra-

cial/ethnic minority groups comparisons. There is limited evidence on health and health care for racial/ethnic groups of veterans other than black and white.

Dr. Clancy or Dr. Washington, is there more research going on, research on disparities that have occurred since then or anything that is currently underway?

Dr. WASHINGTON. Yes. Actually, there is quite a bit underway. With respect to the single conditions, then what we have done is to systematically look at all different medical conditions—I should say, diagnosed medical and mental health conditions by race and ethnicity, as well as by sex and rural residence in rural geographic areas, and have catalogued that across the VA. That information is available in the National Veterans Health Equity Report, which is publicly available on the Office of Health Equity website.

In addition, then we have looked beyond diagnoses to start looking at differences in mortality by race and ethnicity. In fact late last year then we published a report that compares disparities in all cause mortality, as well as cardiovascular and cancer mortality, by race and ethnicity among veterans with similar conditions in the broader U.S. population.

That information is available. We were gratified to find that many of the racial and ethnic differences present outside of the VA are either smaller or nonexistent within VA.

Ms. BROWNLEY. Thank you.

You know, I lead a Women Veterans Task Force and so we have been talking a lot around issues that impact women veterans and trying to find inequities and address those. One of the issues that always tends to come up is that, if women are a minority, and then breaking down women, you know, African American women, LGBT women, Asian women, Latina women, and it does not seem like we—you either have, you know, Latinas and women, but not—you can not break that out.

Dr. CLANCY. Well, we are starting to support more research on that and in fact we saw a publication just the other day, which we will get you a copy of. What I found striking was, while it might be plausible to imagine, if you are female and you are a member of one of these other groups, that that would be additive, it actually was not a consistent pattern. I think we have a lot to learn about why that is, why is it that it would look one way for diabetes and a different way for mental health, and so forth. But I think that is why the work that Dr. Washington is going to do helping us to make sure that that data on race and ethnicity are accurate would be most important.

Ms. BROWNLEY. Thank you for that.

Ms. Bryant, in terms of The American Legion, do they have programs that are, you know, reaching out to minorities that maybe we could learn from?

Ms. BRYANT. The American Legion does have their programs that reach out to all veterans, of course, and recognizing the intersectionality that you just mentioned, myself being one of them, being a woman of color, but there are also specific measures that we even recognize internally that we should probably look at in order to ensure that outreach is appropriate.

Through all of our programs, whether it is on the economic opportunity side or on the health care side, through our System Worth Saving program where we ferret out information of what is happening down at the Veterans Integrated Services Network (VISN) and down at the medical center level, we try to find where those systemic challenges may come, nine times out of ten it is involved with outreach. Then what we are looking at doing is looking even within our resolution process, as we are a resolution-based organization, in what we should be doing to give greater attention to minority veterans.

Ms. BROWNLEY. Thank you for that.

Ms. Williams, too I am, you know, very interested in the findings that you have shared and the focus groups that you are doing and finding, determining things like veterans of color were taken less seriously for pain concerns than white veterans. I think this is very valuable information and, just from your vantage point, how should the VA move forward, you know, to provide more patient-centered competent care like that?

Secondary to that question, I would be interested if the VA is doing any kind of focus groups like Ms. Williams' organization is doing to understand some of the disparities and maybe biases and other kinds of things that exist.

Ms. Williams.

Ms. WILLIAMS. I think VA has a great opportunity to use the existing survey data that it has to identify where there may be pockets that are particularly problematic, particular VISNs or medical centers. The Veterans Experience Office, which is also collecting a great deal of survey data, is another source that they can draw on to identify challenges and try to explore how to improve them.

My experience at VA is that VA is swimming in data, the challenge is analyzing it and then figuring out how to take appropriate action.

One step that I would put forward that undercuts my previous position. When I ran the Center for Women Veterans at VA, there is a Women Veterans Program governance board that has all of the senior leaders across VA sit on this governance board. It is supposed to meet periodically and address cross-cutting issues, because some of these problems that we are talking about, they cross departments within the agency, right? Something can be a health issue, but also have a benefits component. Having folks from across the different business lines sitting together to tackle problems is beneficial.

My belief at this point is that it should be reconfigured to be a governance board for all traditionally under-served populations with subcommittees for women, racial/ethnic minorities, LGBT veterans, Military Sexual Trauma (MST) survivors, others that may have these cross-cutting challenges, so that teams across VA can come together and identify the best way to solve the problems, and communicate publicly about what they are doing to solve the problems and deal with all the nuances of the issue.

Thank you.

Ms. BROWNLEY. Yes, thank you.

Dr. CLANCY. We will take that back. I agree with you, because, I mean, one way to effectively—to create a perception that maybe

we are minimizing problems is to cut it into too many little pieces and I think bringing it together, there is a lot of value in that.

Thanks.

Ms. BROWNLEY. Dr. Clancy, back to the other question that I had, is the VA doing any kind of focus groups to understand, you know, what the experiences are for our minority population amongst veterans. If we can collect—I think the collecting of the data is obviously critically important, I do not want to discount that, but we could have, you know, perfect data—

Dr. CLANCY. Right.

Ms. BROWNLEY.—but if we are not applying what we are learning to the practice in terms of servicing our veterans, then it is really useless, because we know with those component pieces there are cultural competencies and other issues.

I am just wondering if the VA does sort of take a deeper dive in looking at focus groups to help determine that?

Dr. CLANCY. Focus groups are a very consistent feature of much of the research we are doing on disparities in health care and certainly a very big part of what we are doing in terms of the End Harassment Campaign.

One reason I am such a fan of Dr. Washington's work with Dr. Yano—and I am pretty sure that you have heard about this—is this notion that the research itself starts with a collaboration between researchers, providers, and patients, so that when patients do bring up issues it is easy or relatively straightforward to say, gosh, we had not thought about that when we wrote this application, but that does not mean we can not act on it now.

To do a survey to ask how many times have you felt discriminated against or gotten some kind of communication you thought was biased, that is hugely important.

The other technique that we have used in some circumstances that grew out of research, but is actually part of ongoing operations, is so-called standardized patients. In about five or six facilities now veterans are given the opportunity to bring in an audio recorder to their encounters and this is used under peer-review protections, but the primary care clinicians get a lot of feedback about did they miss cues from the patient. For example, just using Melissa's example about mental health. When you said, gosh, what you need to do is go see the mental health provider, this patient was kind of telling you that it is not easy for me. You know, it is very much a collegial kind of conversation.

We have also trained actors in some settings, particularly for resource referral centers related to the homeless program, to try to find out, are there systematic issues. Interestingly—I am sorry Representative Rose left—older African Americans were an issue and the program made changes to fix that.

Ms. BROWNLEY. Thank you, thank you for that.

I just think this is really important, because I know the VA will say, you know, we have collected the data, we are doing training, but how to really—you know, really be able to sort of see in and witness in the examination room or in a mental health setting, wherever it might be, that these practices and what we are learning are actually being applied I think is really important.

I mentioned in my opening comments that I recently visited Cheyenne River and Standing Rock. Well, I have also been to the American Territories in the Pacific and have been to Puerto Rico to look at VA health services there. It is abundantly clear when you go to these locations that the quality of care for our veterans who have served our country is less than what we see in the continental United States, and I think some of that is definitely a cultural divide, you know, without question. I think we just—you know, we need to do a deeper, deeper dive.

In a day or two we are going to have a hearing on our community care networks and we still do not even have someone who is going to take care of Hawaii and American Territories. You know, my first reaction to that is that should be first on the list and not last on the list, because it is where—you know, it is hitting where the most desperate needs are. I think the VA has got to do a better job and be more vigilant and be sort of a model of continuous improvement in terms of these cultural competencies, because we are—the veteran population is changing and I do not think that we are fully prepared.

I am going to be anxious to see, you know, what kind of—from the data, how that data gets applied to real applications, so that our—you know, our veterans are feeling welcomed to the VA, all of our minority veterans, you know, being able to, as we were talking about, crossing over. I think Ms. Williams' idea is an excellent one, but there is a lot more work that needs to be done.

Just before I close and let everybody go home, I just wanted to point out, and I think that this is pretty alarming, but there was a recent Military Times poll that found that more than half of active duty minority servicemembers have personally witnessed examples of white nationalism or ideological-driven racism within the ranks. I think, as Ms. Bryant's written testimony confirms, that we can only assume that this experience will continue on, continues on into the veteran community. This is alarming to me. I guess the question is, are we thinking about effective strategies for addressing this issue in the veteran space, and also what are the health impacts of experiencing white nationalism and ideological-driven racism.

Ms. Williams. Dr. Clancy. Dr. Washington.

Ms. BRYANT. I will just quickly dovetail on your point, ma'am, and that is I often find myself saying this in testimony, that what happens when we are in uniform does not change when we come off of uniform. I can speak for myself, I can speak for being a representative of focus groups when I worked in DOD and when I worked in a government capacity where, again, that—first of all, there is an isolationism that sort of happens when you are a minority and when you are an intersectional minority such as I am, you are often the only one in the room and you are the only one who is the representative for others to come to as well.

I can certainly assure that I saw tattoos, that I saw plenty of people who were affiliated with white nationalism and it saddens me—I have been out since 2009—that it is still being reported today. I am glad that you raised that, because I was actually reading as a part of my research for this testimony a Guardian article

that speaks to the same challenges in the Royal Air Force (RAF) with our friends in the UK.

Clearly, this is a problem of racism that still persists and I—again, without getting too emotional in my plea, I can not imagine that my late grandfather would imagine his granddaughter still talking about the same issues that he faced 75 years ago.

Ms. WILLIAMS. I think you are absolutely right. Minority stress is real. Having to endure discrimination is bad for health outcomes. We see that white nationalism and sexism and homophobia and transphobia, they often hang together. If we are seeing spikes in any of these, we are likely to see them in others. That is why I recommended that the End Harassment campaign that VA has launched, which is a terrific start for dealing with sexism and gender discrimination and sexual harassment, that as more is learned about what messaging is effective that that should be expanded to also tackle racial harassment and homophobic and transphobic harassment within VA facilities as well, because it is incredibly important that the place that folks go to get health care, if nowhere else, should be a place where they are safe, where they are welcomed, they are comfortable, and they do not have to endure these types of experiences.

Certainly, VA, unlike other sectors of care, has an obligation to care for all veterans, even those who behave inappropriately toward their fellow patients, but there systems in place that can be used to ensure that folks who do behave inappropriately can be put into the disruptive patient behavior management system and have escorts or whatever may need to be done to ensure that those around them are able to access care safely.

Thank you.

Ms. BROWNLEY. Thank you.

Dr. Washington or Dr. Clancy, anything else to add?

Dr. CLANCY. I think it is fair to say we share your concerns and a lot of this comes back to what kind of trust, do veterans trust that we have got their backs, that we will provide them the appropriate care regardless of their background. If you have had such negative experiences, there is a lot of research that shows that you are not going to come in immediately presuming trust.

I was mentioning earlier the V-Signals, which is part of the Veterans Experience Office, is giving us the opportunity to address issues that people raise with us in something close to real time, not literally that instant, but—and I will say that a lot of our network and facility leaders have been surprised, not particularly related to minority issues, but areas where they thought things were working pretty well. The veteran said, well, actually, no, it is not, and they made changes and so forth.

I can not change how people—no one can change how people think. I do think two things need to happen: one is that we need to act on the information when people share their concerns and, if we do not, that is a failure, because we will lose an opportunity to gain trust, and that is really the most important aspect of what we can do.

Having worked in the field of disparities for a number of years before I came to VA, one of the advice when people would say, well, what would you tell patients to do right now and a lot of it is to



speaking up and to just say I am worried that I am still having pain, for example, to use your example, and I know you gave me medicine, but it is really not working, can we talk about other solutions. But if people speak up and we do not hear them, that will not be effective.

Ms. BROWNLEY. Well, we have to create a culture where it is safe to speak up and say that. You are right, we can not change how people think, but we can ensure that once a veteran enters a VA space that it is free of bias and it is not tolerated and that has to be left at the door.

Oh, I am sorry.

Ms. WILLIAMS. No, I am so sorry. I wanted to mention that—well, of course, my bias is to worry about how veterans are receiving care and the environment of care for them, I think we should also be concerned about VA providers. I understand in the health care system more generally for health care providers being on the receiving end of racist and sexist comments is also a problem. So let us be concerned about the staff and making sure that they also are able to perform their jobs in an environment where they are being treated with dignity and respect.

Ms. BROWNLEY. Yes, thank you for bringing that up, because that is an important component piece of it.

Well, I want to thank you all for being here. I think this is the first time we have had a hearing on minority veterans I think in a very, very long time. Having an afternoon hearing is always difficult, because there are too many competing circumstances, but it was important I think to at least begin to start to have this conversation and I want to continue the conversation.

Dr. WASHINGTON, thank you for traveling from LA to here to join us today. I am surprised I did not see you on the airplane, because I usually do.

Dr. WASHINGTON. I was looking for you.

Ms. BROWNLEY. Any way, I appreciate everyone being here and I look forward to continuing this conversation through the Subcommittee on Health and also through the Women Veterans Task Force. Thank you.

With that, we will adjourn.

[Whereupon, at 3:39 p.m., the subcommittee was adjourned.]



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**A P P E N D I X**

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## PREPARED STATEMENT OF WITNESSES

### Prepared Statement of Carolyn Clancy

Good afternoon Chairwoman Brownley, Ranking Member Dunn, and distinguished Members of the Subcommittee. I appreciate the opportunity to discuss our continued progress in achieving health equity for Minority Veterans. I am accompanied today by Dr. Ernest Moy, Executive Director, Office of Health Equity, and Dr. Donna Washington, Attending Physician at the Greater Los Angeles Healthcare System.

#### Introduction

The health and well-being of our Nation's men and women who have served in uniform are the highest priority for VA. VA is committed to providing timely access to high-quality, recovery-oriented, evidence-based health care that anticipates and responds to Veterans' needs and supports the reintegration of returning Servicemembers and to shorten the distance between people in need of Veterans services. At VA, we are working to increase our reach among all Veterans, regardless of age, gender, race, ethnicity, and sexual orientation to ensure all of our Veterans receive and find access to quality and inclusive care from our health care systems. Today, I will talk about some of the successes and challenges we face in achieving health equity for Veterans, some of the programs that make this happen, and how the recent GAO report is guiding future improvement.

#### Care for Minority Veterans

VA has worked hard to try to get all Veterans the care they need. We are proud of our successes, but understand that there is still much work to be done. Overall, there are few differences<sup>1</sup> in the quality of services delivered to Veterans by VHA related to race and ethnicity. Preventive care and care for chronic diseases are delivered at comparable rates inside VHA, in contrast to care in the private sector where disparities are common. For example, <sup>2</sup>prior to the launch of VHA's Health Equity Action Plan, rates of colorectal cancer screening for Black Veterans who used VHA lagged rates for White Veterans. Now, <sup>3</sup>there are no significant differences in rates of colorectal cancer screening among White, Black, and Hispanic Veterans who use VHA, and the overall rate is about 80 percent; in the private sector, disparities are common and overall rates lower, averaging, for example, 60–65 percent among commercial health plans that provide data to NCQA. Within VHA, colorectal cancer screening rates among American Indian/Alaska Natives are 75 percent; while superior to the private sector, additional study is needed to understand why this rate differs from other groups within VHA. While delivery of services is equitable, <sup>4</sup>outcomes of care for racial and ethnic minority Veterans in VHA often lag behind outcomes achieved by non-Hispanic White Veterans. For example, while receiving comparable services, racial and ethnic minority Veterans with diabetes are more likely to have poor glucose control and less likely to have good control of blood pressure and cholesterol. There are sex, race, and ethnicity differences in these outcomes. For example, non-Hispanic Black Veterans with diabetes are less likely than non-Hispanic White Veterans to have good blood pressure and glucose control, irre-

<sup>1</sup>Trivedi AM, Grebla RC, Wright SM, Washington DL. Despite improved quality of care in the Veterans Affairs health system, racial disparity persists for important clinical outcomes. *Health Aff.* 2011 Apr;30(4):707–15.

<sup>2</sup>Trivedi AM, Grebla RC, Wright SM, Washington DL. Despite improved quality of care in the Veterans Affairs health system, racial disparity persists for important clinical outcomes. *Health Affairs.* 2011 Apr;30(4):707–15.

<sup>3</sup>May FP, Yano EM, Provenzale D, Steers WN, Washington DL. Race, Poverty, and Mental Health Drive Colorectal Cancer Screening Disparities in the Veterans Affairs Healthcare System. *Medical Care.* 2019 Oct;57(10):773–780.

<sup>4</sup>Washington DL, Steers WN, Huynh AK, Frayne SM, Uchendu US, Riopelle D, Yano EM, Saechao FS, Hoggatt KJ. Racial And Ethnic Disparities Persist At Veterans Health Administration Patient-Centered Medical Homes. *Health Affairs.* 2017 Jun 1;36(6):1086–94.

spective of sex. Among Veterans with heart disease, women, irrespective of race and ethnicity, are less likely to have good cholesterol control compared with either non-Hispanic Black or non-Hispanic White male Veterans. In comparison to commercial plans, achievement of control of these cardiovascular risk factors are much higher with VA, and VA racial and ethnic disparities are smaller.

<sup>5</sup> Mortality differences favoring non-Hispanic White Veterans also exist although they are typically smaller than mortality differences among the U.S. population as a whole. For example, heart disease and cancer are the leading causes of death for women in both VA and the U.S. general population – accounting for about one-half of deaths. <sup>6</sup> In the U.S. population, non-Hispanic Black women have a higher death rate than non-Hispanic White women for all causes, heart disease, and cancer mortality. Among VA health care users, these disparities have been eliminated. Non-Hispanic Black women Veterans who use VHA do not experience higher death rates than White women, unlike non-Hispanic Black women in the U.S. general population.

Smaller disparities in health outcomes among racial and ethnic minority Veterans compared with non-Veterans may be attributed in part to fewer financial barriers to care. A recent Health Affairs article<sup>7</sup> showed that “Substantial racial/ethnic disparities in cost-related medication nonadherence were consistently present among people with non-VHA coverage, but not among VHA enrollees. For instance, among those with non-VHA coverage, 5.9 percent of whites couldn’t afford a prescription drug, versus 8.6 percent of Hispanics and 10.6 percent of Blacks. However, no significant racial/ethnic differences were present among people with VHA coverage.”

#### **Office of Health Equity Efforts**

The Office of Health Equity (OHE) has a broad charge including gathering and analyzing data on disparities among Veterans, developing communication products to raise awareness about equity issues faced by Veterans, working with VA medical centers (VAMC) to improve outcomes of care for all Veterans, and supporting workforce diversity and inclusion within VHA. VA has successfully addressed social determinants of health on a large scale, such as reducing homelessness and food insecurity among Veterans. VA also has the capacity to address other determinants such as education, employment, and social isolation in conjunction with Veterans Service Organizations. Consequently, OHE supported the development of the Accessing Circumstances, Offering Resources for Need (ACORN) project to screen Veterans for a broad range of social determinants, which disproportionately affect communities of color, and match them with appropriate social services. OHE has also developed the Equity-Guided Improvement Strategy (EGIS) which uses equity information at VAMCs to target specific groups of Veterans for quality improvement and connect them with services tailored to their needs.

#### **December 2019 Government Accountability Office (GAO) Report Recommendations and Responses**

A GAO report released in December recommended that VHA develop performance measures and clear lines of accountability to track progress toward equity for Veterans and assess and improve the accuracy of racial and ethnic coding in VHA systems.

In response to this recommendation, OHE has updated the Health Equity Action Plan (HEAP) and developed an operational plan for Fiscal Year (FY) 2020 with performance measures and clear lines of accountability. These plans were developed with the aid and support of a Health Equity Coalition consisting of a variety of VA health equity stakeholders. This Coalition will assess achievement of performance goals at the end of the Fiscal Year and assist the development of future operational plans and performance measures.

Race and ethnicity data are missing on about 7 percent of Veterans in VHA, which is better than typically seen in the private sector. The quality of coding is mixed; with the highest missing data rates being 11 percent, 10 percent, and 9 percent, respectively, for Hispanic, Asian, and Native Hawaiian/Other Pacific Islander

<sup>5</sup> Wong MS, Hoggatt KJ, Steers WN, Frayne SM, Huynh AK, Yano EM, Saechao FS, Ziaean B, Washington DL. Racial/ethnic disparities in mortality across the Veterans Health Administration. *Health Equity*. 2019 Apr 8; 3(1):99–108.

<sup>6</sup> Wong MS, Hoggatt KJ, Steers WN, Frayne SM, Huynh AK, Yano EM, Saechao FS, Ziaean B, Washington DL. Racial/ethnic disparities in mortality across the Veterans Health Administration. *Health Equity*. 2019 Apr 8; 3(1):99–108.

<sup>7</sup> Gaffney A, Bor DH, Himmelstein DU, Woolhandler S, McCormick D. The Effect Of Veterans Health Administration Coverage On Cost-Related Medication Nonadherence. *Health Aff (Millwood)*. 2020 Jan;39(1):33–40. doi: 10.1377/hlthaff.2019.00481. PubMed PMID: 31905070.

Veterans, in a recent year. In response to the second GAO recommendation, OHE and Health Services Research & Development are supporting two assessments: one assessment, led by

Dr. Washington, will formally determine the quality of coding by comparing existing racial and ethnic coding in the electronic health record with self-reported survey information from VHA's Survey of Health Care Experiences of Patients, since self-reported identification of race and ethnicity is the gold standard; a second assessment will collect race and ethnicity information in VAMCs directly from Veterans using an iPad because staff discomfort with asking for this information has been cited as a major reason race and ethnicity data are missing.

### **Women and LGBTQ Veterans**

VA is making progress in fostering a more inclusive patient experience for women and our Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) community. A recent study set out to identify patterns of risk and resilience by the intersections of race/ ethnicity (a combined measure in that study) and sexual orientation in mental health symptom severity, sexism, and social support among women Veterans.<sup>8</sup> The study found that among women Veterans, minority race/ethnicity or minority sexual orientation were associated with higher levels of mental health symptoms and experiences of sexism, when compared with White, heterosexual women Veterans. As the study noted, "However, women Veterans with both minority race/ethnicity and minority sexual orientation did not always fare worse than White, heterosexual women Veterans," with respect to severity of symptoms, suggesting that women at the intersection of these minority identities may develop resilience from their lived experience.

OHE works with VHA Women's Health Services to support assessments of equity issues faced by women Veterans. Data sources are often shared; for example, the Women's Health Evaluation Initiative data base that was developed to monitor equity issues for women Veterans, was adapted and expanded to create the National Veterans Health Equity Report (which reported on equity issues by race/ethnicity, sex, rurality of residence, mental health disorders, and age). OHE also works with the LGBTQ coordinators, present at every VAMC, to support assessments of equity issues faced by LGBTQ Veterans. OHE has served as the VA point of contact with the Healthcare Equality Index, the major national LGBTQ benchmarking tool, and is sponsoring work with the Centers for Disease Control and Prevention to study LGBTQ Veterans because they cannot be identified systematically in VHA's current data systems. However, in the new Cerner Electronic Healthcare Record system, it will be possible to capture information on sexual orientation in a systematic fashion.

### **Patient Experience**

VA recognizes the importance of patient experience, communication, and trust. We understand that patients who trust their clinicians and care teams are more likely to modify their health behaviors and have better outcomes. When Veterans respond to certain Veterans Experience Office (VEO) surveys, they have an opportunity to self-identify their race and ethnicity. VEO analyzed Veteran feedback based on self-identification of race as Asian, American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, or White. VEO also analyzed Veteran feedback based on identification of their ethnicity as Hispanic or Latino versus not Hispanic or Latino. The results showed the following insights about Veteran experience based on age, gender, and self-reported race and ethnicity:

- Veterans ages 70 and over in the Outpatient Surveys had the highest percentage reporting that they had trust in VA facilities for meeting their healthcare needs; Veterans under 30 had the lowest percentage reporting trust. Additionally, male Veterans report higher trust than female Veterans. Trust for all age groups as well as both men and women has increased since the third quarter of Fiscal Year 2017.
- Veterans who self-identify as White show the highest trust in the Outpatient Surveys; Veterans who self-identify as American Indian or Alaskan Native Veterans show the lowest trust. Additionally, Veterans who identify as non-Hispanic or Latino show higher trust than Veterans who identify as Hispanic or

<sup>8</sup>Lehavot K, Beckman KL, Chen JA, Simpson TL, Williams EC. Race/Ethnicity and Sexual Orientation Disparities in Mental Health, Sexism, and Social Support among Women Veterans. *Psychol Sex Orientat Gen Divers*. 2019;6(3):347-358. doi: 10.1037/sgd0000333. PubMed PMID: 31435497; PubMed Central PMCID: PMC6703561.

Latino. Trust for all self-reported races and ethnicities has increased since the third quarter of Fiscal Year 2017.

### Conclusion

VA's goal is to meet Veterans where they live and work so VA can work with them to ensure they can achieve their goals by teaching them skills, connecting them to resources, and providing the care need along the way. We are committed to advancing our outreach and empowerment to further restore the trust of Veterans every day and continue to improve access to care. Our objective is to give our Nation's Veterans the top-quality experience and care they have earned and deserve. We appreciate this Committee's continued support and encouragement as we identify challenges and find new ways to care for Veterans.

### Prepared Statement of Kayla Williams

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

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

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

### Women Veterans

Overall health outcomes for military-affiliated women have been deteriorating over the last 15 years, for both physical and mental health challenges and condi-

<sup>1</sup>Terri Tanielian, Coreen Farris, Caroline Epley, et al., "Ready to Serve: Community-Based Provider Capacity to Deliver Culturally Competent, Quality Mental Health Care to Veterans and Their Families" (RAND Corporation, 2014), [https://www.rand.org/content/dam/rand/pubs/research\\_reports/RR800/RR806/RAND\\_RR806.pdf](https://www.rand.org/content/dam/rand/pubs/research_reports/RR800/RR806/RAND_RR806.pdf).

<sup>2</sup>Madeline Penn, Saurabha Bhatnagar, and SreyRam Kuy, "Comparison of Wait Times for New Patients Between the Private Sector and United States Department of Veterans Affairs Medical Centers," JAMA (January 18, 2019), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2720917>.

<sup>3</sup>Claire O'Hanlon, Christina Huang, Elizabeth Sloss, et al., "Comparing VA and Non-VA Quality of Care: A Systemic Review," Journal of General Internal Medicine, 32 no. 1 (July 2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5215146/>.

<sup>4</sup>Katherine Watkins, Brad Smith, Ayse Akincigil, et al., "The Quality of Medication Treatment for Mental Disorders in the Department of Veterans Affairs and in Private-Sector Plans," Psychiatric Services, 67 no. 4 (April 2016), <https://www.ncbi.nlm.nih.gov/pubmed/26567931>.

<sup>5</sup>Nathalie Grogan, Emma Moore, Brent Peabody, Margaret Seymour, and Kayla Williams, "New York State Minority Veterans Needs Assessment," (Center for a New American Security, February 2020), forthcoming.

<sup>6</sup>Rebecca Price et al., "Comparing Quality of Care in Veterans Affairs and Non-Veterans Affairs Settings," Journal of General Internal Medicine, 33 no. 10 (October 2018), 1631–1638, [https://www.rand.org/pubs/external\\_publications/EP67588.html](https://www.rand.org/pubs/external_publications/EP67588.html).



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

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

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

Stakeholders routinely reported that women are often reluctant to seek services at VA Medical Centers as they are, or are perceived to be, male-dominated spaces and thus less sympathetic, understanding, or welcoming to women. Women veterans reported being mistaken for a spouse or partner of a veteran rather than veterans themselves, or otherwise questioned as to why they are entitled to veterans' benefits. Women who have experienced military sexual assault are particularly

<sup>7</sup> Kate Hendricks Thomas and Kyleanne Hunter, eds., *Invisible Veterans: What Happens When Military Women Become Civilians Again* (Santa Barbara, CA: Praeger, 2019), 57.

<sup>8</sup> S.G. Smith, J. Chen, K.C. Basile, L.K. Gilbert, M.T. Merrick, N. Patel, M. Walling, and A. Jain, "The National Intimate Partner and Sexual Violence Survey: 2010–2012 State Report" (Centers for Disease Control and Prevention, April 2017), <https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf>; and "Military Sexual Assault Fact Sheet," Protect Our Defenders, <https://www.protectourdefenders.com/factsheet/>.

<sup>9</sup> Smith et al., "The National Intimate Partner and Sexual Violence Survey: 2010–2012 State Report."

<sup>10</sup> Deborah Yaeger, Naomi Himmelfarb, Alison Cammack, and Jim Mintz, "DSM-IV Diagnosed Posttraumatic Stress Disorder in Women Veterans With and Without Military Sexual Trauma," *Journal of General Internal Medicine*, 21 no. 3 (March 2006), S65-S69, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1513167/>; and "Military Sexual Trauma in Recent Veterans," U.S. Department of Veterans Affairs, <https://www.publichealth.va.gov/epidemiology/studies/new-generation/military-sexual-trauma-infographic.asp>.

<sup>11</sup> 2015 VA Health Services Research and Development, through an interview with 1,387 women veterans in 2015. Of the women reporting an incident on VA grounds, 61 percent reported harassment, 16 percent reported that their veteran status was questioned, 7 percent reported both harassment and that their veteran status was question, and 5 percent reported threatening/criminal behavior.

<sup>12</sup> "Study of Barriers for Women Veterans to VA Health Care" (U.S. Department of Veterans Affairs, April 2015), [https://www.womenshealth.va.gov/docs/Womens\\_Health\\_Services\\_Barriers\\_20to\\_20Care\\_20Final\\_20Report\\_April2015.pdf](https://www.womenshealth.va.gov/docs/Womens_Health_Services_Barriers_20to_20Care_20Final_20Report_April2015.pdf).

untrusting of VA care and often elect not to reenter a military environment; however, few providers in the civilian setting are familiar with the effects of MST.

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

### **Racial/Ethnic Minority Veterans**

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

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

Despite these perceived challenges, between 2005 and 2014, minority veterans enrolled in VA health care at much higher rates, an increase of 43 percent, while non-minority veterans enrollment increased only 24 percent.<sup>18</sup> The causes for this differential increase in enrollment are unclear and could indicate greater need for VA health care due to economic factors or be a reflection of growth in the minority veteran population. Increases in VA utilization overall likely reflect enhanced outreach and changes to eligibility that expand access to all combat veterans for 5 years after service. The overall VA benefit usage rate was 49 percent: Native Hawaiian/Other Pacific Islander veterans were the most likely to use VA (59 percent), followed by

<sup>13</sup> "VA Utilization Profile Fiscal Year 2016," 7–9.

<sup>14</sup> <https://thehill.com/opinion/healthcare/418102-congress-should-enhance-reproductive-health-care-for-women-veterans>

<sup>15</sup> Roni Caryn Rabin, "Huge Racial Disparities Found in Deaths Linked to Pregnancy," *The New York Times*, May 7, 2019, <https://www.nytimes.com/2019/05/07/health/pregnancy-deaths.html>.

<sup>16</sup> Kelly Hoffman, Sophie Trawalter, Jordan R. Axt, and M. Norman Oliver, "Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites," *Proceedings of the National Academy of Sciences*, 113 no. 16 (2016), 4296–4301, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4843483/>.

<sup>17</sup> "African American Mental Health," National Alliance on Mental Illness, <https://www.nami.org/find-support/diverse-communities/african-americans>.

<sup>18</sup> "Minority Veterans Report: Military Service History and VA Benefit Utilization Statistics" (U.S. Department of Veterans Affairs' National Center for Veterans Analysis and Statistics, March 2017), [https://www.va.gov/vetdata/docs/SpecialReports/Minority\\_Veterans\\_Report.pdf](https://www.va.gov/vetdata/docs/SpecialReports/Minority_Veterans_Report.pdf).

black (54 percent) and Hispanic veterans (53 percent).<sup>19</sup> American Indian / Alaska Native (45 percent) and Asian (42 percent) veterans were the least likely to use VA benefits. American Indian and Alaska Natives are more likely than their non-Native veteran counterparts to lack health insurance and proper health care.<sup>20</sup> (Native American veterans present a unique case as they are covered by three jurisdictions – Federal, State, and tribal. Due to these complexities, we recommend a separate hearing specifically focused on their access to care.)

### LGBT Veterans

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

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

<sup>19</sup> “Profile of Veterans: 2017,” 39.

<sup>20</sup> Kevin J. Allis, Chief Executive Officer of the National Congress of American Indians, testimony to the Subcommittee on Health, Committee on Veterans’ Affairs, U.S. House of Representatives, October 30, 2019, 2, <https://docs.house.gov/meetings/VR/VR03/20191030/110128/HHRG-116-VR03-Wstate-AllisK-20191030-U2.pdf>.

<sup>21</sup> “Sexual Assault and the LGBTQ Community,” Human Rights Campaign, <https://www.hrc.org/resources/sexual-assault-and-the-lgbt-community>.

<sup>22</sup> Meadows et al., “2015 Department of Defense Health Related Behaviors Survey (HRBS).”

<sup>23</sup> “Annex 1: 2018 Workplace and Gender Relations Survey of Active Duty Members Overview Report.”

<sup>24</sup> Carrie Lucas, Jeremy Goldbach, Mary Rose Mamey, Sara Kintzle, and Carl Andrew Castro, “Military Sexual Assault as a Mediator of the Association Between Posttraumatic Stress Disorder and Depression Among Lesbian, Gay, and Bisexual Veterans,” *Journal of Traumatic Stress*, 31 no. 4 (August 7, 2018), <https://onlinelibrary.wiley.com/doi/10.1002/jts.22308>.

<sup>25</sup> Criteria include patient and employment nondiscrimination, equal visitation, patient services and support, and training in LGBTQ patient-centered care, among others. “Healthcare Equality Index,” U.S. Department of Veterans Affairs’ Office of Health Equity, [https://www.va.gov/HEALTH/EQUALITY/Healthcare\\_Equality\\_Index.asp](https://www.va.gov/HEALTH/EQUALITY/Healthcare_Equality_Index.asp).

<sup>26</sup> “Military Service by Transgender People: Data from the 2015 U.S. Transgender Survey.”

These barriers to care are particularly concerning for the LGBT veteran population given that among the active duty force, a significantly higher percentage of gay service members suffer from PTSD (53 percent) compared with heterosexual service members (17 percent). This is even more acute for lesbian service members, 67 percent of whom suffer from PTSD compared with 19 percent of heterosexual female service members.<sup>27</sup> While LGBT status is not causal for PTSD or suicide, sexual orientation is considered a risk factor.<sup>28</sup> LGBT individuals are more likely to have reported binge drinking, cigarette smoking, moderate to severe depression, and suicidal ideation and attempts.<sup>29</sup> Rates of suicidal ideation are two to three times higher for the LGBT community and suicide attempts two to seven times more frequent. Those with gender dysphoria attempt suicide at a rate 20 times higher.<sup>30</sup> Research has shown that “stigma, prejudice, and discrimination create a hostile and stressful social environment that causes mental health problems,” known as minority stress; efforts to reduce homophobia and transphobia are an important component of broader efforts to improve mental health in the veteran community.<sup>31</sup>

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

Discharge status may have an outsized impact on LGBT veterans, who may have been involuntarily separated from the military under the DADT policy. If separated with an OTH discharge, these veterans would not have the same access to veteran benefits, compounding an overall distrust of the military and veteran system and a feeling of unwelcome. The approximately 14,000 service members separated from the military under DADT may need to appeal their discharge status.<sup>35</sup> While these individuals can now request a discharge upgrade, they may have been denied access to care and benefits for many years, and the upgrade process takes time. Members of the LGBT community repeatedly report fear and mistrust in deciding whether to access their VA services. One stakeholder noted that an administrative separation code indicates when a discharge was related to homosexual behavior even when a veteran retains access to benefits. Many veterans fear that involuntarily “coming

<sup>27</sup> Meadows et al., “2015 Department of Defense Health Related Behaviors Survey (HRBS).”

<sup>28</sup> Wendy Lakso, “VA sets standards in suicide risk assessment, offers support to community providers,” Vantage Point blog on blogs.VA.gov, January 2, 2019, <https://www.blogs.va.gov/Vantage/55281/va-sets-standards-in-suicide-risk-assessment-offers-support-to-community-providers/>.

<sup>29</sup> Meadows et al., “2015 Department of Defense Health Related Behaviors Survey (HRBS).”

<sup>30</sup> Thomas and Hunter, *Invisible Veterans*, 115–117; State of California, Department of Insurance, “Economic Impact Assessment: Gender Nondiscrimination in Health Insurance,” Regulation File Number: REG–2011–00023, April 13, 2012, <http://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf>.

<sup>31</sup> Ilan H. Meyer, “Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence,” *Psychological Bulletin*, 129 no. 5 (2003), 674–697, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2072932/>.

<sup>32</sup> U.S. Department of Veterans Affairs, *Providing Health Care for Transgender and Intersex Veterans*, VHA Directive 1341 (May 23, 2018), [https://www.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=6431](https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=6431).

<sup>33</sup> Eli Coleman, Walter Bockting, Marsha Botzer, Peggy Cohen-Kettenis, Griet DeCuypere, Jamie Feldman, Lin Fraser, et al., “Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7,” *International Journal of Transgenderism*, 13 no. 4 (2012), 165–232, [https://wpath.org/media/cms/Documents/SOC\\_20v7Standards\\_20of\\_20Care\\_V7\\_20Full\\_20Book\\_English.pdf](https://wpath.org/media/cms/Documents/SOC_20v7Standards_20of_20Care_V7_20Full_20Book_English.pdf).

<sup>34</sup> “The Affordable Care Act, VA, and You,” U.S. Department of Veterans Affairs, <https://www.va.gov/health/aca/FAQ.asp>; and Coleman, Bockting, Botzer, Cohen-Kettenis, DeCuypere, Feldman, Fraser, et al., “Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7.”

<sup>35</sup> “Don’t Ask, Don’t Tell Is Repealed,” U.S. Department of Defense, 2011, [https://archive.defense.gov/home/features/2010/0610\\_dadt/](https://archive.defense.gov/home/features/2010/0610_dadt/).

out” to health care providers due to service records will lead to less than optimal care from a provider who does not support their identity or sexual orientation.

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

A damaging misconception is that VA facilities do not include any LGBT health services. While the absence of available gender confirmation surgery negatively impacts transgender veterans who have not medically transitioned, other LGBT health care options at the VA do exist. Lack of trust in health care providers is insidious and leads to suboptimal health outcomes. For example, providers do not always advertise that they offer pre-exposure prophylaxis (PrEP), making it less likely LGBT patients will obtain a prescription for this vital HIV-prevention drug. Providers also may not explicitly offer screening for sexually transmitted diseases (STDs), putting the onus on the patient, which can be a charged request and difficult without a trusting relationship. A second layer of challenges LGBT veterans face is discrepancies with health care itself. Many LGBT veterans experience a lack of consistency across VA facilities. Each VA Medical Center is supposed to have an LGBT veteran care coordinator (VCC) on hand to serve as a patient advocate and assist LGBT-sensitive staff trainings. However, quality of VCCs varies widely. CNAS site visits identified significant variation in the LGBT-focused materials available in waiting rooms, ranging from confusion over the acronym “LGBT” to comprehensive informational material, welcoming posters, and competent staff. Additionally, other patients can contribute to VA Medical Centers being unwelcoming: One representative of a veteran-serving nonprofit reported witnessing transgender veterans being subjected to inappropriate verbal and nonverbal behavior from fellow patients because of their transgender status.

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

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

### Conclusion

VA should improve data collection, analysis, and publication on health outcomes of all minority veterans, particularly from an intersectional lens, to enhance Congress’ ability to conduct effective oversight. In addition, VA should work to become

<sup>36</sup> K.A. McLemore, “A minority stress perspective on transgender individuals’ experiences with misgendering,” *Stigma and Health*, 3 no. 1 (2018), 53–64, <https://doi.org/10.1037/sah0000070>.

<sup>37</sup> S.E. James, J.L. Herman, S. Rankin, M. Keisling, L. Mottet, and M. Anafi, “The Report of the 2015 U.S. Transgender Survey” (National Center for Transgender Equality, 2016), <https://www.transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF>.

<sup>38</sup> “Women Veterans: The Journey Ahead” (DAV, 2018), [https://www.dav.org/wp-content/uploads/2018\\_Women-Veterans-Report-Sequel.pdf](https://www.dav.org/wp-content/uploads/2018_Women-Veterans-Report-Sequel.pdf).

more welcoming for all minority veterans. Recommendations include implementing trauma-informed and dignity-affirming care, including effective cultural awareness training for all employees; updating waiting room reading material, posters, and television channel default settings to be more inclusive; expanding Veterans Experience Office efforts using human-centered design concepts to identify and alleviate disparities in the experiences of minority veterans; expanding the nascent End Harassment campaign to include the harassment LGBT and racial/ethnic minority veterans experience; and expanding the “secret shopper” model of ensuring that front-line staff members are aware of resources for MST survivors such as LGBT VCCs, minority veteran coordinators, and women veteran coordinators at VA Medical Centers nationwide.

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

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#### **Prepared Statement of Melissa Bryant**

Chairwoman Brownley, Ranking Member Dunn, and distinguished members who proudly serve on this subcommittee; on behalf of our National Commander, James W. “Bill” Oxford, thank you for the opportunity to discuss the important issue of how the Department of Veterans Affairs (VA) addresses health inequities for minorities across the Veterans Health Administration (VHA). I proudly represent The American Legion and appreciate the opportunity to assist this subcommittee in better understanding this issue, how it impacts minority veterans, and provide recommendations for improvement to the system.

Above all, we must ensure that the institutions we built to care for our Nation’s veterans give every veteran regardless of race, gender, sexual orientation, or creed the quality care and support they deserve.

Recent statistics show that racial and ethnic minority veterans represent nearly 22 percent of the total veteran population, nearly 19 million who are living today. VA projects that the minority population will continue to rise over the next few decades and reach an estimated 35 percent of the total veteran population by 2040. In recent years, VA has made improvements in the advancement of veteran’s health care in VA medical facilities nationwide. However, there is still much work to do to meet the overall health care needs of all veterans. There are also many research gaps that exist, which makes it difficult to identify, analyze, and resolve specific issues in inequities in overall care for the minority veteran population.

Sadly, I can point to my own dealings with harassment and discrimination from my peers, superior officers, and subordinates in my lifetime. It was a double burden I faced while on active duty, when the intersectionality of being both a black and female officer would creep into misogynistic and prejudiced comments made toward me. Now as a veterans advocate, I still hear the misogynistic and prejudicial comments in our community. At best, these comments are casual dismissals of my credentials and expertise to have earned a seat at the table; at worst, these comments mean just what these hurtful comments sound like—flagrant disregard for my service, and ultimately an emotional barrier to seeking additional care through VHA, where the veteran culture often mirrors the experience of minority servicemembers.

To its credit, VA has already identified some of the more prominent issues the department currently faces with attending to minority veterans’ health needs:

#### **Challenges with the Accuracy of Medical Records**

VA has cited concerns about the accuracy of medical records, particularly when referencing the completeness and accuracy of the race and ethnicity data of veterans. These concerns include:

- Difficulty determining if race and ethnicity information is correctly captured in a veteran's health record through either veteran self-reporting or VA staff capture.<sup>1</sup>
- Trouble confirming that relevant race/ethnicity informational values are reliable in the health record because of the possibility of necessary data being missing from the records.<sup>2</sup>
- Conflicting race and ethnic data calls into question the accuracy of information when race or ethnicity information is recorded.<sup>3</sup>

The American Legion is encouraged by the forthcoming improvements in race and ethnicity data collection that will be achieved with the implementation of the Cerner Electronic Health Records Modernization (EHRM) efforts. Accurate data may help dispel or correct any deficiencies in care for minority veterans. The American Legion also will continue to advocate that VA's EHR initiative remains fully and adequately funded and that VA and Cerner regularly report EHR progress and status to Congress.

Supporting American Legion Resolution: Resolution 83 (August 2016): Virtual Lifetime Electronic Record.

### **Problems with Outreach and Trust Among Minority Veterans**

As a military intelligence officer who led women and men in both combat and garrison, some of my most salient experiences are from times when the true beliefs of soldiers you would normally trust with your life in battle would surface. As one of the few, if not only, women officers (and often the only woman of color officer) in my units, I can point to many occasions where I have helped soldiers who came to me for advice, counsel, or reporting of incidents dealing with racial, gendered, or sexual orientation discrimination, harassment or even assault in the ranks. My service was also during the time of the Don't Ask, Don't Tell (DADT) policy era, where I had the truly unfortunate duty of involuntarily separating troops from service due to their sexual orientation.

There are current difficulties among all veterans, including minority veterans, on understanding the eligibility requirements and scope of services available to them. For example, discharge status may have greater impact on Lesbian, Gay, Bisexual, Transgender, or Queer (LGBTQ) veterans, who may have been involuntarily separated from the military under the DADT policy. Depending on discharge status, these veterans would not have the same access to veteran benefits, compounding an overall distrust of the military and veteran system. The American Legion is the only Veteran Service Organization that assists veterans with discharge upgrades and represents them before service discharge upgrade boards and hearings.

VHA must continue to build trust among all veterans and make their system the premier medical provider that veterans desire to go for their healthcare needs. Efforts should include increased communications outreach to all categories of minority and women veterans to inform them of their eligibility for health care. VHA can also increase its information dissemination concerning the development of better community care network (CCN) accesses and health care choices, as provided by the services developed in the MISSION Act of 2019, which include contractor provided services. These services allow increased access to urgent cares, expansions of eligibility for community care, veteran-centered and control of scheduling appointments, as well as better coordination and customer services. VA should also better publicize the Million Veteran Program to its minority and women veteran patients and encourage their participation in the program.

### **Care for Diseases Found More Prevalently in Minority Veterans**

Some diseases have been found to be more prevalent in minority veteran populations, and further study is needed to determine why this may be the case. Prostate cancer is the most commonly diagnosed form of the disease found in veterans; for example, African American veterans are diagnosed at younger ages than the general veteran population. VHA must aggressively work to provide the best treatment and care for any veterans who may be diagnosed with this form of cancer. Some factors that VHA should note are: in general, African American men are at an increased risk of developing prostate cancer than white men or other men of color. They are also at a greater risk of getting an incorrect diagnosis of cancer, and more likely

<sup>1</sup> <https://www.gao.gov/assets/710/703145.pdf>

<sup>2</sup> <https://www.gao.gov/assets/710/703145.pdf>

<sup>3</sup> <https://www.gao.gov/assets/710/703145.pdf>

to die from the disease<sup>4</sup>. Early detection can help contribute to an almost 100 percent cure rate. Efforts must continue to determine if military service and/or combat specific areas of operation have any correlation to increases in prostate cancer diagnosis or any disparities in treatment.

The American Legion continues to advocate for research that continues to assess the possible connections between cancer and any exposures that veterans may have encountered due to their service, including Agent Orange exposures, burn pits and other airborne toxins, radiation exposure, depleted uranium exposure, or environmental and other toxic exposures which may affect veterans.

- Relevant resolutions:
  - o Resolution 130 (August 2016): Radiation Exposure
  - o Resolution 55 (August 2016): Radiation Exposure
  - o Resolution 271 (August 2016): Request Study by the Department of Veterans Affairs on the Medical Effects of Exposure to Depleted Uranium
  - o Resolution 35 (August 2016): Agent Orange
  - o Resolution 118 (August 2016): Environmental Exposures
  - o Resolution 127 (August 2016): ProState Cancer Research and Treatment
  - o Resolution 41 (August 2017): Radiation-Exposed Veterans
  - o Resolution 11 (August 2019): Environmental Exposures at Fort McClellan

### Knowledge Gaps

Many clinical outcomes have significant racial gaps in data collected for conditions such as hypertension, cardiovascular events, diabetes, and labor and delivery. A grim example of the disparity in healthcare outcomes due to racial bias is the nationwide maternal mortality rate in African American, American Indian, and Alaska Native women, who are two to three times more likely to die from pregnancy-related causes than white women – and this disparity increases with age.<sup>5</sup> A widely publicized U.S. Supreme Court petition last year unsuccessfully challenged Feres doctrine, *Daniel v. United States*, which involved the maternal death of an active duty Navy Nurse who died in childbirth in the same Labor and Maternity Ward in which she served at Naval Station Bremerton.<sup>6</sup> In this case, the deceased was also a racial minority, a chilling example of this national trend within the military, which may color the perception of disparate care provided to minority women by both military and veterans medical centers.

It becomes necessary to ask why these instances exist in the microcosm that is our community, and research if disparities are attributable to a higher concentration of minority veterans using lower-performing VA medical facilities, if there is a difference in the quality of care between white and minority veterans receiving care at the same facility, or if there are other factors which have yet to be identified.<sup>7</sup> The American Legion realizes that many significant improvements in VA's health care systems have occurred in recent years, but will continue to advocate for further study that yields a reduction in any disparities which may affect minority veterans and their life expectancy.

Since 2003, The American Legion has conducted over 300 System Worth Saving site visits to assess the quality of care, challenges and best practices of VHA's health care systems at many of its medical centers and community-based outpatient clinics across the country. Although the program's main focus is to gather information from all veterans and provide recommendations for the best possible care for all veterans in VHA's system, these visits continue to highlight examples of minority and women veterans discussing their particular issues during the program's town hall meetings.

- Relevant resolutions:
  - o Resolution 147 (August 2016): Women Veterans

<sup>4</sup> <https://zerocancer.org/learn/about-prostate-cancer/risks/african-americans-prostate-cancer/>

<sup>5</sup> <https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html>

<sup>6</sup> [https://www.supremecourt.gov/opinions/18pdf/18-460\\_1b7d.pdf](https://www.supremecourt.gov/opinions/18pdf/18-460_1b7d.pdf)

<sup>7</sup> <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0074>



**Conclusion**

Chairwoman Brownley, Ranking Member Dunn, and distinguished members who proudly serve on this subcommittee, The American Legion thanks you for the opportunity to illuminate the positions of the nearly two million veteran members of this organization. It is a priority of The American Legion that all our Nation's veterans receive the same quality care and support we expect from VA. By the action of this committee, we can see that it is for you as well. We call on Congress to direct VA to conduct and/or continue existing studies into the inequity or disparities of care—real or perceived—contained within today's testimony, and more. As we unpack the myriad reasons why minority veterans on the whole report either negative healthcare outcomes or unequal treatment under the law at VA, The American Legion stands ready to support this subcommittee with observations and expertise.

As always, The American Legion thanks this committee for the opportunity to elucidate the position of the nearly 2 million veteran members of this organization. For additional information regarding this testimony, please contact Ms. Melissa Bryant, Legislative Director, at MBryant@legion.org or (202) 263-2981.



## STATEMENTS FOR THE RECORD

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### Prepared Statement of National Council on Urban Indian Health

My name is Sonya Tetnowski, I am a member of the Makah Tribe, a U.S. Army Veteran Paratrooper, and the Chief Executive Officer of the Indian Health Center of Santa Clara Valley in California. I'm also the Vice President of the National Council of Urban Indian Health (NCUIH), as well as President of the California Consortium for Urban Indian Health (CCUIH). NCUIH represents the 41 Title V Urban Indian Organizations (UIOs) across the Nation. UIOs provide high-quality, culturally competent care to urban Indian populations, which constitute more than 70 percent of all American Indians and Alaska Natives (AI/ANs). I would like to thank Chairwoman Brownley, Ranking Member Dunn and other distinguished members of the subcommittee for holding this important hearing on the critical issue of health equity for minority Veterans. My testimony will focus on the need for equitable treatment of AI/AN Veterans living in urban communities.

NCUIH believes the single most important thing the Department of Veterans Affairs (VA) can do to improve the equitable healthcare efforts to AI/AN Veterans, is to fully implement the VA and Indian Health Services' Memorandum of Understanding (VA-IHS MOU) and Reimbursement Agreement for Direct Health Care Services. This would allow UIOs to be reimbursed for providing culturally competent care to AI/AN Veterans residing in urban areas. Despite an embattled history between tribal people and the U.S. Government, and as an inherited responsibility to safeguard the lands of their ancestors, AI/ANs serve this country at a higher rate than any other group in the Nation. A significant number of these Veterans live in urban areas and often seek out the high-quality, culturally competent care of their local UIO.

UIOs were formally recognized by Congress following the end of the Termination Era in 1976 under the Indian Health Care Improvement Act (IHCIA) to fulfill the Federal Government's health care-related trust responsibility to Indians who live off the reservation. Each UIO is led by a Board of Directors that must be majority Indian. They are collectively represented by the National Council of Urban Indian Health (NCUIH), which is a 501(c)(3), member-based organization devoted to the development of quality, accessible, and culturally sensitive healthcare programs for AI/ANs living in urban communities. UIOs are a critical part of the Indian Health Service (IHS), which uses a three-prong approach to provide health care: Indian Health Services, Tribal Programs, and Urban Indian Organizations commonly referred to as the I/T/U system.

#### VA-IHS MOU Historical Background

In February 2003, the VA and IHS signed a Memorandum of Understanding (MOU) and updated this MOU in October 2010. The very first paragraph of the MOU states: "the intent of this MOU (is) to facilitate collaboration between IHS and VA, and **not limit initiatives, projects, or interactions between the agencies in any way.**" The MOU recognizes the importance of a coordinated and cohesive effort on a national scope, while also acknowledging that the implementation of such efforts requires local adaptation to meet the needs of individual tribes, villages, islands, and communities, as well as local VA, IHS, Tribal, and **Urban Indian health programs.**"

In December 2012, the two agencies signed a reimbursement agreement allowing the VA to financially compensate IHS for health care provided to AI/ANs that are part of the VA's system of patient enrollment. While this MOU has been implemented for IHS and tribal providers, it has not been implemented for UIOs, despite the fact that UIOs are explicitly mentioned in the original language of the 2010 MOU, and provide healthcare within IHS's own I/T/U system. Leaving out UIOs is a violation of the MOU since the agencies agreed to "not limit initiatives, projects, or interactions between the agencies in any way." Not reimbursing UIOs for services provided to Native Veterans is limiting this vulnerable, underserved population from the healthcare they need and deserve. NCUIH and UIO leaders have been tes-

tifying before Congress for several years to correct this oversight and to fully implement the MOU. Members have said this is an “easy fix,” and “an oversight,” so we are happy to see that there is now a bill to address this issue once and for all. We support the extensive efforts of the Veterans Administration and the work they do but AI/AN Veterans should be allowed to seek care and support that best suits their unique needs, and our UIOs can provide that support. NCUIH supports H.R. 4153, the Health Care Access for Urban Native Veterans Act, introduced by Congressman Khanna along with 27 additional Co—Sponsors. H.R. 4153 is a necessary and critical piece of legislation, one that will make a real meaningful difference in the funding for health care services provided by UIOs across the United States. We maintain that as part of the I/T/U system, the VA already has the authority to reimburse title V UIOs, but we are happy Congress is taking the next step to address this important issue.

Between 2012 and 2015, the VA reimbursed over \$16.1 million for direct services provided by IHS and Tribal Health Programs covering 5,000 eligible Veterans under the IHS-VA MOU. In spite of the Federal trust responsibility to AI/ANs, the VA had decided to deem UIOs ineligible to enter into the reimbursement agreement under the IHS-VA MOU. For context, UIOs are already extremely underfunded and receive less than \$400 per patient from IHS, versus national health expenditure rates of almost \$10,000 per patient. In 2018, UIOs received a total of \$51.3 million to support 41 programs, and that is before IHS’s administrative costs are removed, which is already less than 1 percent of the total IHS budget. UIOs only receive one line-item appropriation in the IHS budget—the urban Indian health line item. UIOs don’t receive purchase and referred care dollars, Federal Tort Claims Act (FTCA) coverage, 100 percent Federal Medical Assistance Percentage (FMAP), or facilities funding. In fact, a few UIOs temporarily closed during the shutdown due to the lack of parity within the IHS system. VA reimbursement, even half of the \$16.1 million, would drastically help our facilities. It is time to fix this issue for good.

Today, AI/AN service members face some of the lowest health outcomes and the largest barriers to quality and culturally competent health services. AI/AN Veterans are more likely to be uninsured, homeless, and impoverished than Veterans of other ethnicities. The high rates of mental and behavioral health disorders such as depression, suicide, and post-traumatic stress disorder (PTSD) is linked to the predisposal that AI/AN people have to these same disorders without facing combat. AI/AN Veterans deserve clear and careful attention in order to ensure they receive the highest quality of care our country can afford to provide them.

In urban areas, AI/ANs may experience difficult geographical distances from their homelands and from their traditional practices. UIOs serve as important centers for health care services and as cultural support and provide a sense of community while providing primary care, dental, and behavioral health services to AI/AN Veterans. The national interest of serving AI/AN Veterans will be best carried out when Congress extends the collaborative arrangements already agreed to by the VA and IHS to include the bulk of our Nation’s AI/AN Veterans.

Thank you again for holding today’s hearing and for the Sub-committee’s support of urban Indian health care issues. I am available, along with NCUIH staff, to answer any questions related to this testimony or related urban Indian health issues.

#### **Prepared Statement of National Indian Health Board**

Chairwoman Brownley, Ranking Member Dunn, and Members of the Sub-committee, thank you for holding this important hearing on “Achieving Health Equity for America’s Minority Veterans.” On behalf of the National Indian Health Board (NIHB) and the 574 federally recognized sovereign Tribal Nations we serve, I submit this testimony for the record.

By current estimates from the Department of Veterans’ Affairs (VA), there are roughly 146,000 American Indian and Alaska Native (AI/AN) Veterans, with Native Servicemembers enlisting at higher rates than any other ethnicity nationwide. Indeed, the Department of Defense continues to acknowledge the indispensable role of AI/AN Servicemembers throughout American history. Native Veterans are highly respected throughout Indian Country, in recognition of what they have sacrificed to protect Tribal communities and the United States. Yet despite the bravery, sacrifice, and steadfast commitment to protecting the sovereignty of Tribal Nations and the entire United States, Native Veterans continue to experience among the worst health outcomes, and among the greatest challenges in receiving quality health services.

Overall, our communities face the starkest health disparities and among the lowest health outcomes. Life expectancy for our people is 5.5 years less than the na-

tional average, while in some states our people are dying as much as two decades earlier than Whites.<sup>1</sup> Overall, AI/ANs have higher rates of death associated with most types of cancer, chronic liver disease and cirrhosis, type II diabetes, drug overdose deaths, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases.<sup>2</sup> From 1999 to 2015, AI/ANs experienced the highest percentage increase in drug overdose deaths overall at 519 percent.<sup>3</sup> Infant mortality rates for AI/ANs are 1.3 times the national average, with infant mortality rates having declined for all ethnicities from 2005 to 2014 *except* among AI/ANs.<sup>4</sup>

Health disparities among Native Veterans are equally dire, if not worse in certain cases. In a 2016 consultation report from the U.S. Department of Veterans' Affairs, access to medical care was consistently ranked as the top priority for Tribal Nations and Native Veterans.<sup>5</sup> Compared to White Veterans, Native Veterans are 1.6 times more likely to be uninsured; twice as likely to experience delays in care; and 2.9 times more likely to experience transportation challenges in accessing care.<sup>6</sup>

Destructive Federal Indian policies and unresponsive human service systems have left Native Veterans and their communities with unresolved historical and intergenerational trauma. From 2001 to 2015, suicide rates among Native Veterans increased by 62 percent (50 in 2001 to 128 in 2015).<sup>7</sup> In Fiscal Year 2014, the Office of Health Equity within VHA reported significantly higher rates of mental health disorders among Native Veterans compared to non-Hispanic White Veterans, including in rates of PTSD (20.5 percent vs. 11.6 percent), depression symptoms (18.7 percent vs. 15.2 percent), and major depressive disorder (7.9 percent vs. 5.8 percent).<sup>8</sup>

Among all Veterans, Native Veterans are more likely to have a disability, service-connected or otherwise.<sup>9</sup> Native Veterans are exponentially more likely to be homeless, with some studies showing that 26 percent of low-income Native Veterans experienced homelessness at some point compared to 13 percent of all low-income Veterans.<sup>10</sup> There exists a paucity of Native Veteran specific health, housing, and economic resources and programs that are accessible and culturally appropriate. It is essential that the VHA work with IHS and Tribes to create more resources specifically for Native Veterans.

The VA's Veteran Outreach Toolkit lists AI/ANs as an "at-risk" population, citing this troubling suicide rate. Additionally, AI/ANs grapple with complex behavioral health issues at higher rates than any other population—for children of AI/AN veterans, this is compounded by the return of a parent who may suffer from post-traumatic stress disorder (PTSD). Outreach events for AI/AN communities should be a VA priority to increase wellness, decrease stigma, and prevent suicide. It is essential that the VHA continue to engage with Tribal leaders, through consultation, to assist in carrying out these activities.

### Federal Trust Responsibility

Over the course of a century, sovereign Tribal Nations and the United States signed over 300 Treaties requiring the Federal Government to assume specific, enduring, and legally enforceable fiduciary obligations to the Tribes. The terms codi-

<sup>1</sup> U.S. Department of Health and Human Services, Indian Health Service, Fiscal Year 2019, Justification of Estimates for Appropriations Committees, CJ-147, [https://www.ihs.gov/budgetformulation/includes/themes/responsive2017/display\\_\\_objects/documents/FY2019CongressionalJustification.pdf](https://www.ihs.gov/budgetformulation/includes/themes/responsive2017/display__objects/documents/FY2019CongressionalJustification.pdf)

<sup>2</sup> Ibid

<sup>3</sup> Mack KA, Jones CM, Ballesteros MF. Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas—United States. *MMWR Surveill Summ* 2017;66(No. SS-19):1–12. DOI: <http://dx.doi.org/10.15585/mmwr.ss6619a1externalicon>

<sup>4</sup> T.J. Mathews and Anne K. Driscoll, "Trends in Infant Mortality in the United States, 2005–2014," National Center for Health Statistics, Division of Vital Statistics, March 2017, at 1, <https://www.cdc.gov/nchs/data/databriefs/db279.pdf>.

<sup>5</sup> U.S. Department of Veterans' Affairs. 2016. Tribal Consultation Report. [https://www.va.gov/TRIBALGOVERNMENT/docs/VA-2016-Consultation-Report\\_508\\_FINAL.pdf](https://www.va.gov/TRIBALGOVERNMENT/docs/VA-2016-Consultation-Report_508_FINAL.pdf)

<sup>6</sup> Johnson, P. J., Carlson, K. F., & Hearst, M. O. (2010). Healthcare disparities for American Indian veterans in the United States: a population-based study. *Medical care*, 48(6), 563–569. doi:10.1097/MLR.0b013e3181d5f9e1

<sup>7</sup> VA, Veteran Suicide by Race/Ethnicity: Assessments Among All Veterans and Veterans Receiving VHA Health Services, 2001–2014 (Aug. 2017) (citing CDC statistics).

<sup>8</sup> Lauren Korshak, MS, RCEP, Office of Health Equity and Donna L. Washington, MD, MPH, Health Equity-QUERI National Partnered Evaluation Center, and Stephanie Birdwell, M.S.W., Office of Tribal Government Relations

<sup>9</sup> U.S. Department of Veterans Affairs. (2015a). American Indian and Alaska Native Veterans: 2013 American Community Survey. Retrieved from <https://www.va.gov/vetdata/docs/SpecialReports/AIANReport2015.pdf>

<sup>10</sup> US Department of Housing and Urban Development, US Department of Veterans Affairs, National Center on Homelessness Among Veterans. *Veteran Homelessness: A Supplemental Report to the 2010 Annual Homeless Assessment Report to Congress*. Washington, DC.2011:56

fied in those Treaties – including for provisions of quality and comprehensive health resources and services – have been reaffirmed by the United States Constitution, Supreme Court decisions, Federal legislation and regulations, and even Presidential executive orders. These Federal promises have no expiration date, and collectively form the basis for what we now refer to as the Federal trust responsibility. Moreover, the United States has a dual responsibility to Native Veterans – one obligation specific to their political status as members of federally recognized Tribes, and one obligation specific to their service in the Armed Services of the United States.

In 1955, Congress established the Indian Health Service (IHS) in partial fulfillment of its constitutional obligations for health services to all AI/ANs. The IHS is charged with a similar mission as the VHA as it relates to administering quality health services, with the exception of the following differences: (1) the Federal Government has Treaty and Trust obligations to provide health care for all American Indians and Alaska Natives; (2) IHS is severely and chronically underfunded in comparison to the VHA, with per capita medical expenditures within IHS at \$4,078 in Fiscal Year (FY) 2017 compared to \$10,692 in VHA per capita medical spending that same year<sup>11</sup>; and (3) unlike IHS, the VHA has been protected from government shutdowns and continuing resolutions (CRs) because Congress enacted advance appropriations for the VHA a decade ago.<sup>12</sup>

Tribal Nations have consistently communicated that the VA must do significantly more to meet its trust obligations to Native Veterans. Our people serve at higher rates than any demographic nationwide, and should not be afforded the worst health outcomes. Congress must act on the legislative and policy priorities outlined below in order to reduce health disparities among Native Veterans.

#### **Funding Levels for IHS versus VHA: The Need for Advance Appropriations**

##### **1. Tribes and NIHB strongly urge Congress to pass bipartisan legislation that would enact advance appropriations for Indian programs**

By the most recent estimates, federally operated IHS facilities, Tribally operated health facilities and programs, and urban Indian health programs collectively serve roughly 2.6 million AI/ANs nationwide. In comparison, the VHA serves roughly 6.9 million Veterans through 18 regional networks. In Fiscal Year 2019 discretionary appropriations for IHS equaled roughly \$5.8 billion; in comparison, spending within the VHA totaled over \$76 billion. In effect, this means that while the VHA service population is roughly only three times the size of the Indian health system, its discretionary appropriations are *approximately 13 times higher* than for IHS.

According to the IHS Tribal Budget Formulation Workgroup, IHS appropriations must reach nearly \$38 billion – phased in over 12 years – in order to fully meet current health needs. In other words, even if today IHS were fully funded at the level of need identified by sovereign Tribal Nations, it would only equal half the total Fiscal Year 2019 discretionary appropriation for the VHA. Indeed, the Federal Government's continued abrogation of its trust responsibility for health services for AI/ANs is clearly exemplified by the gravity of the divide in health funding for the VHA versus IHS.

Although the IHS budget has nominally increased by 2–3 percent each year, these increases are barely sufficient to keep up with rising medical and non-medical inflation, population growth, facility maintenance costs, and other expenses. According to a 2018 report by the Government Accountability Office (GAO–19–74R), from 2013 to 2017, IHS annual spending increased by roughly 18 percent and per capita spending increased by roughly 12 percent; in comparison, annual spending under the VHA increased by 32 percent and per capita spending increased by 25 percent during the same time period.<sup>13</sup> The widening gap in funding levels between IHS and the VHA only serves to perpetuate the disproportionately higher levels of health disparities experienced by Native Veterans and AI/ANs overall.

Unequivocally, the U.S. Federal Government has a moral and ethical obligation to ensure all U.S. Veterans can access quality health services – and it must continue to honor this responsibility. But the U.S. also has a Trust obligation to ensure all AI/ANs, including Native Veterans, can receive quality health services, that it continuously fails to honor. It is long past due for the Federal Government to make good on its constitutional obligation to Native Veterans and all AI/AN Peoples.

<sup>11</sup>The full IHS Tribal Budget Formulation Workgroup Recommendations are available at [https://www.nihb.org/docs/04242019/307871\\_NIHB%20IHS%20Budget%20Book\\_WEB.PDF](https://www.nihb.org/docs/04242019/307871_NIHB%20IHS%20Budget%20Book_WEB.PDF)

<sup>12</sup>See 38 U.S.C. 117; P.L. 111–81

<sup>13</sup>Government Accountability Office. 2018. Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs. Retrieved from <https://www.gao.gov/assets/700/695871.pdf>

The discrepancies do not end with chronic underfunding of IHS. Of the four major Federal healthcare entities, IHS is the only one subject to the devastating impacts of government shutdowns and continuing resolutions (CRs). This is because Medicare and Medicaid receive mandatory appropriations, and the VHA was authorized by Congress to receive advance appropriations nearly a decade ago. As a result, the VHA has been insulated from every government shutdown, CR, and discretionary sequestration over the past decade. While it is true that no sector of government is fully spared by the repercussions of endless shutdowns and CRs, those repercussions are neither equal nor generalizable across all entities. In fact, the worst consequences are levied on Indian Country.

For instance, during the 2013 Federal budget sequester, the IHS budget was slashed by 5.1 percent—or \$221 million—levied on top of the damage elicited by that year's government shutdown. In fact, IHS was the only federally funded healthcare entity that was subject to full sequestration because Congress had already exempted the VHA when it authorized it to receive advance appropriations. Once again, during the most recent 35-day government shutdown—the Nation's longest and most economically disastrous—IHS was the only Federal healthcare entity to be shut down. While direct care services remained non-exempt, providers were not receiving pay. Administrative and technical support staff—responsible for scheduling patient visits, conducting referrals, and processing health records—were furloughed. Contracts with private entities for sanitation services and facilities upgrades went weeks without payments, prompting many Tribes to exhaust alternative resources to stay current on bills.

Several Tribes shared that they lost physicians to hospitals and clinics not impacted by the shutdown. Some Tribal leaders even shared how administrative staff volunteered to go unpaid so that the Tribe had resources to keep physicians on the payroll. These are just a few examples of the everyday sacrifices and ongoing struggles that widen the chasm between the health services afforded to AI/ANs and those afforded to the Nation at large. While it is impossible to measure the full scope of adversity brought on by the 35-day government shutdown, one reality remains clear—Indian Country was both unequivocally and disproportionately impacted.

In 2018, GAO released a report examining the benefits of authorizing advance appropriations for the IHS and thus establishing parity between IHS and the VHA (GAO-18-652). The report outlined how Congress has been forced to use short-term or full-year CRs in all but four of the last 40 years. In fact, only once in the past two decades—in Fiscal Year 2006—has Congress successfully passed the Interior, Environment, and Related Agencies appropriations package (which funds IHS) before the end of the fiscal year. As a result, year after year, the Indian health system is curtailed from making meaningful improvements toward the availability and quality of health services and programs, further restraining efforts to advance quality of life and health outcomes for AI/ANs.

While a CR is always preferable to a government shutdown, they are not devoid of obstacles that directly impact patient care. Because of budget authority constraints under a CR, IHS is prohibited from initiating any new activities or projects that were not expressly authorized or appropriated in the previous fiscal year. In addition, under a CR, IHS must exercise significant precaution over expenditures, and is generally limited to simply maintain operations as opposed to improve them. When you compound the impact of chronic underfunding and endless use of CRs, the inevitable result are the chronic and pervasive health disparities seen across Indian Country. As such, **Tribal Nations and NIHB strongly urge Congress to pass bipartisan legislation that would authorize advance appropriations for Indian programs.**

#### **Lack of IHS and VHA Care Coordination and Reimbursement Agreements**

##### **1. NIHB recommends that Congress clarify statutory language under section 405(c) of the Indian Health Care Improvement Act and make explicit the VHA's requirement to reimburse IHS and Tribes for services under Purchased/Referred Care (PRC).**

By law, an AI/AN Veteran is eligible for services under both the VHA and IHS. A 2011 report showed that approximately one-quarter of IHS-enrolled Veterans use the VHA for health care, commonly receiving treatment for diabetes mellitus, hypertension or cardiovascular disease from both Federal entities.<sup>14</sup> According to the VA,

<sup>14</sup>Kramer, BJ, Wang M, Jouldjian S, Lee ML, Finke B, Saliba D. Healthcare for American Indian and Alaska native veterans: The roles of the veterans health administration and the Indian Health Service. Medical Care.

more than 2,800 AI/AN Veterans are served at IHS facilities.<sup>15</sup> In instances where an AI/AN veteran is eligible for a particular health care service from both the VA and IHS, the VA is the primary payer. Under section 2901(b) of the Patient Protection and Affordable Care Act (ACA), health programs operated by the IHS, Tribes and Tribal organizations, and urban Indian organizations (collectively referred to as the “I/T/U” system) are payers of last resort regardless of whether or not a specific agreement for reimbursement is in place.

Section 407(a)(2) of the Indian Health Care Improvement Act (IHCA) reaffirms the goals of the 2003 Memorandum of Understanding (MOU) between the VHA and IHS established to improve care coordination for Native Veterans. In addition, during permanent reauthorization of IHCA, section 405(c) was amended to require the VHA to reimburse IHS and Tribes for health services provided under the Purchased/Referred Care (PRC) program. In 2010, the VHA and IHS modernized their 2003 MOU to further improve care coordination for Native Veterans by bolstering health facility and provider resource sharing; strengthening interoperability of electronic health records (EHRs); engaging in joint credentialing and staff training to help Native Veterans better navigate IHS and VHA eligibility requirements; simplifying referral processes; and increasing coordination of specialty services such as for mental and behavioral health.

According to a 2019 GAO report (GAO-19-291), since implementation of the 2010 MOU, the VHA has reported entering into 114 signed agreements with Tribal Health Programs (THPs), along with 77 implementation agreements to strengthen care coordination. While a single national reimbursement agreement exists between federally operated IHS facilities and the VHA, THPs continue to exercise their sovereignty by entering into individual agreements with the VHA. From 2014 to 2018, those reimbursement agreements with THPs alone increased by 113 percent.

VA reimbursements to IHS and THPs overall during that same time period increased by 75 percent, reaching \$84.3 million in total. Yet these increased reimbursements still represent just a fraction of 1 percent of the VA’s annual budget. While recent increases in the quantity of agreements and reimbursements demonstrates a positive trend, there continue to be significant challenges in care coordination between the VHA and IHS. The 2019 GAO report highlighted three overarching challenges related to care coordination: ongoing issues in patient referrals between I/T/U facilities and the VHA; significant problems in EHR interoperability; and high staff turnover within both VHA and IHS. These complications continue to stifle Native Veterans’ access to health care, erodes patient trust in both IHS and VHA health systems, and obstructs efforts to improve health outcomes.

These issues are exacerbated by VHA claims that no statutory obligation exists for reimbursement of specialty and referral services provided *through* IHS or THPs. To clarify, the VHA currently reimburses IHS and THPs for care that they provide *directly* under the MOU. Despite repeated requests from Tribes, the VA has not provided reimbursement for PRC specialty and referral care provided through IHS/THPs. This is highly problematic, as AI/AN Veterans should have the freedom to obtain care from either the VA or an Indian health program. If a Veteran chooses an Indian health program, that program should be reimbursed even if the service could have been provided by a VA facility or program in the same community.

But because that doesn’t happen, it creates greater care coordination issues and burdensome requirements for Native Veterans. For example, if a Native veteran goes to an IHS or THP for service and needs a referral, the same patient must be seen within the VA system *before* a referral can be secured. This means the VHA is paying for the same services twice, first for those primary care services provided to the Veteran in the IHS or THP facility, and then again when the patient goes back to the VHA for the same primary care service to then receive a VHA referral. This is neither a good use of Federal funding, nor is it navigable for veterans. In order to provide the care that Native Veterans need, many THPs are treating Veterans or referring them out for specialty care and paying for it themselves so that they can be treated in a timely and competent manner. For those Veterans that do go back to the VHA for referrals, there is often delayed treatment and a significantly different standard of care provided.

As a step toward mitigating the confusion surrounding reimbursement for care provided by the VHA, NIHB recommends the VHA include PRC in future IHS/THP reimbursement agreements, so that there is no further rationing of health care provided by IHS and THPs to Native Veterans and other eligible AI/ANs. Ultimately, however, NIHB recommends that Congress clarify the statutory language under section 405(c) of IHCA and make explicit VHA’s requirement to reimburse under PRC.

<sup>15</sup> VA/IHS listening session held on May 15, 2019



**2. NIHB also strongly supports the GAO recommendation that the VHA work with IHS to create written policy or guidelines to clarify how referrals from IHS and THP facilities to VHA facilities for specialty care should be managed, and to establish specific targets for measuring action on MOU performance measures.**

The GAO report cited how, for example, facilities reported conflicting information about the processes for referring Native Veterans from IHS or Tribal facilities to VHA, and VA headquarters officials confirmed that there is no national policy or guide on this topic. One of the leading collaboration practices identified by GAO is to have written guidance and agreements to document how agencies will collaborate. Without written policy or guidance documents on how referrals should be managed, neither agency can ensure that VHA, IHS, and Tribal facilities have consistent understanding of the options available for referral of Native Veterans for specialty care.

As is currently the case, the result is duplicative care for Native Veteran and duplicative costs for the Federal Government. NIHB has heard that some Native Veterans prefer to *simply hand carry their EHR records from their IHS provider to their VHA provider to avoid having to receive the same care twice*. In short, lack of written policy perpetuates this burdensome, pointless, and complicated process that only serves to frustrate patients, worsen administrative red tape, and increase expenditures.

For numerous Tribes, and especially for the Veterans themselves, it is an undue barrier to constantly have to refer patients back and forth to the VA that ultimately wastes time and delays access to care. The GAO identified that IHS and VA lack sufficient measures for quantifiable assessments of progress toward MOU goals and objectives. Although the VHA and IHS have created 15 performance measures, no specific targets or indicators have been established that allow Tribes to measure progress toward achieving the goals and objectives of the MOU.

**3. Tribes and NIHB have strongly recommended that the VHA consult with Tribes and work through their MOU with IHS to create and publish a living list of available Veterans Liaisons/Tribal Veterans Representatives across all IHS and VHA regions**

The VHA must do more outreach and education with Native Veterans to improve care coordination. Tribes and NIHB have consistently stressed the need for VHA to create toolkits and guides to assist Native Veterans in navigating care access. The paucity of currently available newsletters, outreach workers and liaisons such as Tribal Veteran Service Officers (TVSOs), and online resources specifically for Native Veterans also sends the message that care for Native Veterans is not a priority. But despite repeated Tribal demands, the agency has yet to implement this request.

A closely related issue is the fact that Native Veterans are still charged copays and deductibles when receiving services under the VHA. The Federal Government's trust responsibility for health services extends to all Native Veterans. In recognition of this, AI/ANs do not have copays or deductibles for services received at an I/T/U facility. Additionally, the ACA further affirmed the trust responsibility when it included language at Section 1402 to exempt all AI/ANs under 300 percent of the Federal poverty level from co-pays and deductibles on plans purchased on the health insurance Marketplace.

**4. Congress should pass legislation exempting Native Veterans from copays and deductibles**

Section 222 of IHCA prohibits cost sharing of AI/ANs in cases where an AI/AN receives a referral from the from an IHS or THP under the PRC program. Like IHS and the Marketplace, the VHA is another means by which the Federal Government must uphold its trust responsibility to AI/ANs. As such, it is imperative that Congress enact legislation that requires the VHA to similarly exempt AI/AN Veterans from copays and deductibles in the VA system in recognition of the Federal trust responsibility. Importantly, copay costs should not be shifted to IHS or Tribes. The VHA must absorb these costs on behalf of AI/AN Veterans in recognition of their Trust and Treaty obligations to AI/AN Peoples.

**5. Congress should pass the bipartisan H.R. 2791 – Department of Veterans Affairs Tribal Advisory Committee Act of 2019**

Tribal Nations and NIHB have also strongly advocated for the seating of a Tribal Advisory Committee (TAC) within the Office of the Secretary at the VA. Establishing a Veteran TAC is essential for strengthening the government-to-government relationship, and improving VA accountability to Native Veteran health needs.

Through the seating of a TAC, top VA officials would have the ability to hear directly from Tribal leaders about the unique health priorities and challenges that impact Native Veterans. In addition, it would help prevent the development of new rules or policies that would adversely affect care for Native Veterans. As such, Tribes and NIHB strongly support the bipartisan H.R. 2791, introduced by Representative Deb Haaland, and urges the House VA Committee to vote to pass this significant legislation.

## **EHR Interoperability and Health Information Technology (IT) Modernization**

### **1. Congress must ensure parity between the VA and IHS in appropriations and technical assistance for health IT modernization**

The Resource and Patient Management System (RPMS) – which is the primary health IT system used across the Indian health system – was developed in close partnership with the VHA and has become partially dependent on the VHA health IT system, known as the Veterans Information Systems and Technology Architecture (VistA). The RPMS is an early adoption of VistA for outpatient use, and the legacy system was designed with the decision to keep the same underlying code infrastructure as VistA. IHS began developing different clinical applications for their outpatient services, and the VHA adopted code from RPMS to provide this functionality for VistA.

RPMS eventually began to use additional VistA code as the need for inpatient functionality increased. This type of enhancement and support for both the IHS and VHA was made possible because VistA's software components were designed as an Open Source solution. The RPMS suite is able to run on mid-range personal computer hardware platforms, while applications can operate individually or as an integrated suite with some availability to interface with commercial-off-the-shelf (COTS) software products.

Currently, the RPMS manages clinical, financial, and administrative information throughout the I/T/U, although, it is deployed at various levels across the service delivery types. However, in recent years, many Tribes and even several Urban Indian Health Programs (UIHPs) have elected to purchase their own COTS systems that provide a wider suite of services than RPMS, have stronger interoperability capabilities, and are significantly more navigable and modern systems to use. As a result, there exists a growing patchwork of EHR platforms across the Indian health system.

When the VA announced its decision to replace VistA with a COTS system in 2017 (Cerner), concentrated efforts to re-evaluate the Indian Health IT system accelerated, and arose significant concerns as to how VHA and I/T/U EHR interoperability would continue. In 2018, IHS launched a Health IT Modernization Project to evaluate the current I/T/U health IT framework, and to, through Tribal consultation, key informant interviews, and national surveys, develop a series of next steps and recommendations toward modernizing health IT in Indian Country.

Difficulties in achieving IT interoperability among VA, IHS, and THP facilities pose significant problems for Native Veterans' care coordination. Unfortunately, the VHA and IHS have yet to identify a systemic solution toward increasing EHR interoperability between I/T/U and VHA hospitals, clinics, and health stations. A resulting scenario includes situations where a THP provider – having treated a Veteran and referred them to the VHA for specialty care – would not receive the Veteran's follow-up records as quickly as if they had streamlined access to each other's systems.

Now that the VHA is transitioning to the Cerner system, it has worsened concerns around care coordination and sharing of EHRs between I/T/U and VHA systems. The fact is, Native Veterans are suffering today from the lack of health IT interoperability. **It is shameful that Native Veterans are put in a position where they have to find their own solutions to streamline EHR sharing, most shockingly exemplified by anecdotes of AI/AN Veterans hand carrying their health records between their IHS and VHA provider.**

Congress must ensure that the Indian health system is fully integrated across the development and implementation of the VHA's transition to Cerner; however, thus far it has failed to do so. By the most current estimates, the transition to Cerner will take up to 10 years to fully implement, with a current price tag of roughly \$16 billion. None of the existing estimates include calculations of how much it will cost to include IHS in this transition; however, through its Health IT Modernization Project, IHS is attempting to arrive at an estimated dollar figure for this cost.

Tribes and NIHB were pleased to see that the Fiscal Year 2020 President's Budget included a request for a new \$20 million line item in the IHS budget to assist

with health IT modernization, and that this request was included in the House-passed Fiscal Year 2020 Interior Appropriations package. But in comparison, the Fiscal Year 2020 House Military Construction Appropriations bill budgeted \$1.6 billion to assist VHA in its transition. Ensuring EHR interoperability between I/T/U and VHA health systems will be impossible if Congress fails to establish parity in appropriations for VHA and IHS health IT modernization.

**Conclusion**

The Federal Government has a dual responsibility to Native Veterans that continues to be ignored. As the only national Tribal organization dedicated exclusively to advocating for the fulfillment of the Federal trust responsibility for health, NIHB is committed to ensuring the highest health status and outcomes for Native Veterans. We applaud the House VA Subcommittee for Health for holding this important hearing, and stand ready to work with Congress in a bipartisan manner to enact legislation that strengthens the government-government relationship, improves access to care for Native Veterans, and raises health outcomes.

