



**REACHING ALL WHO SERVED:
AN ANALYSIS OF DEPARTMENT OF VETERANS AFFAIRS
LGBT HEALTH POLICIES**



BY ANDREW CRAY, J.D.

EDITED BY F. JOSEPH JEFFERSON, MPH

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National Coalition for LGBT Health staff
Kaye Gooch
Hutson W. Inniss
Matthew Rose

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I. INTRODUCTION

This report provides an overview of and recommendations for improving the statutory, regulatory, and departmental policy that shapes the lives of those Lesbian, Gay, Bisexual and Transgender (LGBT) people who receive VA medical services and benefits. It will highlight the strides that the Department has made in providing exemplary care, and will also underscore the need for policymakers to amend and adjust policies to achieve the Department's mission, and provide equal treatment and protection for LGBT beneficiaries and their loved ones.

This report is the product of research and input from a diverse coalition of stakeholders advocating on behalf of LGBT individuals, families, service members, and veterans. This collaborative process incorporated considerations pertaining to the particular needs of LGBT veterans and their families. Additional focus was placed on the current developments in the repeal of the US military's Don't Ask, Don't Tell policy, and the probable impact on 'out' LGBT veterans who will seek services at VA facilities.

Extensive review of statutes, regulations, and policy directives pertaining to veterans benefits reveals a vast array of programs, services, administrative systems, and facilities that touch upon the lives of all veterans, including those who are lesbian, gay, bisexual, or transgender. It is with this wide view of the needs of former servicemembers and their loved ones that these findings and recommendations have been developed across twelve categories:

- Antidiscrimination and Anti-Harassment Policy
- Treatment of Parent-Child Relationships
- Treatment of Marital and Other Committed Relationships
- Institutional Infrastructure for Population-Specific Needs
- Population-Specific Treatment Protocols and Benefits Package Composition
- Cultural Competency Training
- Policy on Amendment of Patient Records
- Inclusion in Outreach and Specialty Grant Initiatives
- Data Collection
- Treatment of Certain Discharges for Eligibility Determination Purposes
- Confidentiality Policy
- Community Relations Practice

These topic areas will be discussed as sections of this analysis, and will contain an overview of the relevance of a given policy area to LGBT veterans, an analysis of the current statutory, regulatory and administrative rules on the subject area, and specific policy recommendations for each subject area.

II. ANALYSIS OF DEPARTMENT OF VETERANS AFFAIRS BENEFITS STATUTES, REGULATIONS, AND POLICIES – WITH POLICY RECOMMENDATIONS

A. ANTIDISCRIMINATION AND ANTI-HARASSMENT POLICY

OVERVIEW AND ANALYSIS

Currently, antidiscrimination regulations and policies for VA programs and facilities offer significant protections and recite – often in significant detail – rights that are to be granted in VA and VA-affiliated facilities. These statements of policy are invaluable to patients and beneficiaries seeking access to care and assistance. They offer notice at the individual level of rights, remedies, and systems of self-advocacy. These policies also inform staff of their duties and responsibilities, and provide structures for internal resolution of treatment in violation of the prescribed guidelines. Furthermore, the naming of specific characteristics to be protected or acts to be foregone or required, provides insight into larger organizational principles of patient-centered care, and allows for development of policies and practices to expand equal treatment and diversity promotion efforts with the Department.

However, when assessing the degree of protection granted specifically to LGBT veterans, there are significant gaps in the VA’s antidiscrimination policy. Though the Joint Commission now requires patient non-discrimination for hospitals on the basis of sexual orientation and gender identity, the VA has not yet instituted a policy directive, regulation, or statutory provision that provides explicit patient protections on the basis of sexual orientation or gender identity. This leaves gay, lesbian, and bisexual patients lacking certainty of safety and equality, insofar as they have no notice of rights to be free from different treatment on the basis of sexual orientation, and without an identifiable basis to request recourse in the event of discriminatory treatment.

Second, while VHA Directive 2011-024 is a significant statement of support and protection for transgender patients by requiring nondiscriminatory provision of health services and maintenance of a zero-tolerance policy for harassment on the basis of gender identity,¹ it falls short of a comprehensive guarantee of equal treatment. The Directive, due to its express application to veteran beneficiaries, does not currently extend to services and benefits provided to dependents of veterans (e.g. CHAMPVA medical care, life insurance payments).

Additionally, Directive 2011-024 expires November 30, 2012, thus only providing a guarantee of protections for one year from the time of its issuance. This may not be a sufficient amount of time to grant notice to transgender veterans who are enrolled in VA programs of their rights, or to allow for adequate accommodations to be implemented during its applicable enforcement period. Extending and expanding the Directive and policies of its kind are thus essential for the continued future of gender identity antidiscrimination protections at the VA.

POLICY RECOMMENDATIONS

1. Revise anti-discrimination requirements and schedules of protected rights.

Many preexisting regulatory provisions pertaining to antidiscrimination requirements and patients’ rights could easily be adapted to include more explicit protections for beneficiaries who are LGBT. First, existing regulations on patients’ rights in VA care facilities,² State nursing homes,³ and adult day health care

¹ Department of Veterans Affairs, VHA Directive 2011-024, June 9, 2011 [Hereinafter VHA Directive 2011-024].

² Protection of Patient Rights, 38 C.F.R. § 17.33 (2005)

³ Nursing Home Care of Veterans in State Homes Resident Rights, 38 C.F.R. § 51.70 (2009)

programs in State homes⁴ contain comprehensive schedules of protected rights for enrollees in these programs and patients in VA controlled or funded facilities. However, none of these provisions contain explicit prohibitions of discrimination on the basis of sexual orientation or gender identity. All three of these regulations should be amended under the Secretary's authority to "prescribe all rules and regulations which are necessary or appropriate to carry out" the Department's activities.⁵ Inclusion of express language prohibiting discrimination on grounds including sexual orientation and gender identity would strengthen the impetus for caretakers and providers to ensure antidiscriminatory and culturally competent administrative and caregiving systems, and provide direct notice of beneficiary rights and staff responsibilities. Regulatory provisions containing requirements for approval and operation of residential care facilities and adult day health care also contain anti-harassment and abuse requirements.⁶ These should also be amended to explicitly include a prohibition on abuse and harassing treatment on the basis of sexual orientation and gender identity. These amendments would address deficiencies in addressing gender identity in VHA Directive 2011-024 by adding a greater degree of visibility and permanence, and will also help in ensuring compliance with requirements set forth by the Joint Commission on Accreditation of Healthcare Organizations.⁷ Additionally, inclusion of these antidiscrimination statements in coordinated notice of patients' rights required to be given to all patients and direct contact staff members in VA facilities⁸ would provide patients with adequate notice of their rights and avenues for obtaining redress in the event of discriminatory action.

2. Revise CHAMPVA provisions to include sexual orientation and gender identity protections.

Regulations relating to the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)⁹ should be augmented to include antidiscrimination provisions including gender identity and sexual orientation. Amending these regulations would ensure that all VA beneficiaries, including dependents as well as veterans themselves, would be entitled to respectful treatment regardless of identity traits. The CHAMPVA program should also issue a policy directive pertaining to respectful treatment of LGBT patients in VA facilities, similar in nature to the Directive recently issued for VHA programs and facilities.

3. Revise regulations governing patient abuse to include sexual orientation and gender identity as protected classes.

Regulations on the relationship between employees, beneficiaries, and claimants generally prohibit abuse toward patients, members, or other VA beneficiaries.¹⁰ Relevant regulations should be amended to include a more comprehensive list of impermissible bases for abusive treatment, such as through a non-exhaustive articulation of protected classes inclusive of sexual orientation and gender identity.

4. Reform disability ratings assessment procedure.

Regulatory provisions pertaining to attitudes of officers performing disability ratings mandate that ratings officers "must not allow their personal feelings to intrude" on the objective assignment of ratings.¹¹ This section should also be amended to encourage ratings officers to contain the scope of their assessment to the

⁴ Adult Day Health Care of Veterans in State Homes Participant Rights, 38 C.F.R. § 52.70 (2002).

⁵ Rules and Regulations, 38 U.S.C. § 501(a) (1996).

⁶ Approval of Community Residential Care Facilities, 38 C.F.R. § 17.63(h) (2011); Adult Day Health Care for Veterans in State Homes Participant Behavior and Program Practices, 38 C.F.R. § 52.90 (2002).

⁷ Standard RI.01.01.03, Joint Commission on Accreditation of Healthcare Organizations (2010).

⁸ 38 C.F.R. 17.33, *supra* note 26.

⁹ 38 C.F.R. § 17.270 et. seq.

¹⁰ Standards of Ethical Conduct and Related Responsibilities of Employees Other Conduct on the Job, 38 C.F.R. § 0.735-11 (1993).

¹¹ Attitude of Rating Officers, 38 C.F.R. § 4.23 (1976).

disability at issue, rather than unnecessary consideration of sexual orientation, gender identity, or other non-relevant applicant traits.

5. Provide cultural competency training.

While VA regulations do not currently address harassment and abuse between patients in great depth, staff manuals and training programs should make clear that staff safety responsibilities include managing harassing behavior of patients toward LGBT patients as they would in the case of any other discriminatory behavior.

Regarding its facilities, the VA should institute comprehensive policies that prohibit discrimination in the delivery of services to gay, lesbian, bisexual, and transgender clients. These policies should ensure that all staff, written forms, policies, and other materials use culturally appropriate language when dealing with LGBT individuals and families. As stated previously, these policies should include an expansive definition of “family” and “families” that is not limited to blood, adoption, or federally-recognized marriage. Moreover, these policies should apply to all individuals entering these facilities, including family and associates of patients or other beneficiaries. Specific recommendations for maximizing the Department’s potential in this area include:

- 1. Disseminate policies that expressly state that Department of Veterans Affairs non-discrimination policy on the basis of sexual orientation or gender identity in the provision of services at all of its facilities.*
- 2. Post conspicuous antidiscrimination policies in all languages appropriate to the populations served by the facility, and inclusion of policies in brochures, informational and promotional materials.*
- 3. Adopt procedures to ensure that nondiscrimination policies and procedures are appropriately conveyed to all clients, including those with disabilities and those for whom English is not their primary language.*
- 4. Disseminate and explain these policies to all VA employees, including agreement to comply with Department antidiscrimination statements and procedures used to ensure their execution.*

The following policy recommendations are designed to ensure efficacious implementation of accessible, comprehensive, and effective procedures for filing and resolving patient and beneficiary complaints concerning violation of antidiscrimination policies.

- 1. Develop written complaint forms clearly stating the complaint process, made accessible to all beneficiaries that explicitly include discrimination based on sexual orientation or gender identity.*
- 2. Designate employees or patient advocates responsible for ensuring compliance with policies.*
- 3. Disseminate to all employees notification that discrimination in the delivery of services based on sexual orientation and gender identity constitutes a violation of standards of care delivery, and is subject to appropriate discipline.*
- 4. Post conspicuous complaint procedures and inclusion of procedures in informational materials given to clients and their families.*
- 5. Provide translation of complaint procedures and forms in all languages appropriate to populations the facility or program serves.*

B. TREATMENT OF PARENT-CHILD RELATIONSHIPS INVOLVING SAME-SEX OR DE FACTO PARENTS

OVERVIEW AND ANALYSIS

Establishing parent-child relationships under VA regulations is essential to eligibility for numerous significant benefits that can be received by both parents and children. Children of veterans are eligible for three particularly significant benefits: 1) health care services and supplies through CHAMPVA, as survivors or dependents of certain veterans¹²; 2) monthly benefits as survivors of certain deceased veterans through dependency and indemnity compensation (DIC)¹³; and 3) payments under Servicemembers' Group Life Insurance or Veterans' Group Life Insurance.¹⁴ Parents of veterans are also eligible for several, albeit fewer, benefits by virtue of their relationship with an eligible veteran, including: 1) monthly benefits as survivors of certain deceased veterans through DIC¹⁵ and; 2) payments under Servicemembers' Group Life Insurance or Veterans' Group Life Insurance.¹⁶

Currently, the statutorily-defined term "child" for the purposes of determining eligibility for CHAMPVA and DIC benefits includes only "legitimate" children, legally adopted children, stepchildren, and illegitimate children who have been acknowledged by their biological father.¹⁷ For the purposes of eligibility for Servicemembers' Group Life Insurance and Veterans' Group Life Insurance, eligible children are further limited to relationships established by legitimacy, legal adoption, illegitimacy as to the mother, or illegitimacy and acknowledgement by the biological father.¹⁸ Regulations providing definitions for these terms impose additional restrictions on the scope of eligible parent-child relationships. In particular, "stepchild" is defined in VA regulations as being a legitimate or illegitimate child of an eligible veteran's "spouse."¹⁹ "Spouse" is defined by VA regulations, and federal law, to include only "a person of the opposite sex,"²⁰ whose marriage is valid under the law of the State where the parties resided at the time of the marriage.²¹

The effect of this regulation is that it is impossible for a same-sex parent, even if in a marital relationship recognized under the laws of their resident State, to have a presumed stepparent relationship, thus requiring legal adoption in order for eligibility to vest in the child. Same-sex couples face obstacles to adoption in many states, including explicit prohibitions,²² and legal barriers to adoption combined with systemic hostility and financial barriers can make it difficult for same-sex couples to obtain the necessary legally binding judgments to satisfy the requirements of these regulations. In addition to these, sometimes insurmountable, obstacles to obtaining adoption and satisfying requirements to establish a stepparent relationship, Board of Veterans' Appeals case law pertaining to the definition of "parent" further indicates that legal guardianship of a veteran over non-biological children will not suffice to establish eligibility for the child under VA regulations.²³

¹² 38 U.S.C. § 1781 et. seq.; 38 C.F.R. §§ 17.270-17.278.

¹³ 38 U.S.C. § 12; 38 C.F.R. §§ 3.5 –3.22.

¹⁴ 38 U.S.C. § 1965 et. seq.

¹⁵ 38 U.S.C. § 12; 38 C.F.R. §§ 3.5 –3.22.

¹⁶ 38 U.S.C. § 1965 et. seq.

¹⁷ 38 U.S.C. 101(4).

¹⁸ Servicemembers' Group Life Insurance Definitions, 38 U.S.C. § 1965(8) (2008).

¹⁹ Pension, Compensation, and Dependency and Indemnity Compensation Relationship Child, 38 C.F.R. § 3.57(b) (2007).

²⁰ 38 U.S.C. § 101(31) (emphasis added).

²¹ Pension, Compensation, and Dependency and Indemnity Compensation Definitions 38 C.F.R. 3.1(j) (2006).

²² See e.g., Miss. Code Ann. § 93-17-3(5) (2007); Utah Cod Ann. § 78B-6-117 (2011).

²³ See e.g. Burch v. Brown, 6 Vet App 512 (1994).

The definition of “parent” poses similar problems for same-sex couples who are parents of veterans. For the purposes of DIC eligibility, the definition of “parent” is slightly broader than for children. The statutory definition includes: 1) both “natural”²⁴ and “illegitimate” mothers and fathers; 2) mothers or fathers by legal adoption²⁵; and 3) individuals “who for a period of not less than one year stood in the relationship of a parent to a veteran.”²⁶ The last clause essentially establishes a parental entitlement relationship for those who have stood *in loco parentis* with a veteran. However, the definition goes on to state that “if two persons stood in the relationship of a father or a mother for one year or more, the person who last stood in the relationship of father or mother” will have sole eligibility.²⁷ Regulations further clarify that “not more than one father and one mother, as defined, will be recognized in any case.”²⁸ While the *in loco parentis* style language may capture some individuals who would otherwise be excluded under the definition of “parent,” the clause imposing a limit to one eligible mother and one eligible father presents a significant barrier, even if unintended, to establishing eligibility for both same-sex parents of a veteran.

Parental eligibility for Servicemembers’ Group Life Insurance includes only: 1) “legitimate” mothers and fathers; 2) adoptive fathers and mothers; 3) biological mothers of illegitimate children and; 4) acknowledging fathers of illegitimate children who have proof of paternity of child support order.²⁹ This definition has been given a narrow reading in adjudication, being held to exclude stepparents and persons *in loco parentis* from the scope of eligibility.³⁰

POLICY RECOMMENDATIONS

1. Amend regulations to expressly include eligibility for children of veterans standing in loco parentis.

These deficiencies in acknowledging the genuine supportive and stable relationships between same-sex couples and their children should be addressed at the regulatory level. With regard to the eligibility for children of veterans, action may be taken in two areas. The VA should amend regulations to expressly include eligibility for children of veterans standing *in loco parentis*. The viability of determining such relationships by VA benefits administrators is proven by provisions defining parents, and likewise by the successful implementation of other federal laws and regulations establishing eligibility by *in loco parentis* relationships.³¹ The VA has the authority to act in this manner by amending DIC regulations defining “child”³² to include language mirroring the *in loco parentis* language used in the regulations defining “parent” – “the child of a veteran who for a period of not less than 1 year stood in the relation of a parent.”

2. Amend regulatory language to strike undue restrictions on stepparent-stepchild relationships.

Amending regulatory language to strike undue restrictions on stepparent-stepchild relationships would permit recognition of the parent-child relationship between same-sex partners and children from previous relationships. Defining “stepchild” to contain reference only to the statutorily defined “spouses” restricts the possible scope of eligible relationships beyond what is necessary to avoid conflict with the Defense of Marriage Act (DOMA). Regulations pertaining to stepfamily relationships should be amended to include “partners” of veterans as individuals who establish presumptive step-parent relationships. This change would

²⁴ See 38 C.F.R. § 3.59(a).

²⁵ Pension, Compensation, and Dependency and Indemnity Compensation Relationship Parent, 38 C.F.R. § 3.59(a) (1979).

²⁶ 38 U.S.C. § 101(5).

²⁷ *Id.*

²⁸ 38 C.F.R. § 3.59(b).

²⁹ 38 U.S.C. § 1965(9).

³⁰ *Nunn v. Nunn*, 81 NM 746 (1970).

³¹ See e.g. Family Medical Leave Act Coverage, 29 C.F.R. § 825.122(c)(3) (2008).

³² 38 C.F.R. § 3.57.

expand recognition of parent-child relationships to parents who are not married, or whose marriages are not currently recognized under Federal law.

3. Amend regulations defining “parent”.

The VA must reflect the diversity of families who should be entitled to cross-program benefits. First, regulatory language limiting veterans to one eligible mother and one eligible father should be eliminated. These undue restrictions can be replaced with language indicating that veterans are limited to a maximum of two eligible parents, but that eligibility through parental relationship is to be determined without consideration of the sex of either respective parent. Second, while regulations permitting the use of *in loco parentis* relationships for the purposes of determination are invaluable in incorporating same-sex parent families into VA benefits programs, it is key to include language in these regulations, or through issuance of an interpretive policy directive, indicating that the determination of eligibility on this basis is to be made without discrimination based on the sex of the parent or the nature of the relationship between parents.

4. Amend application forms and other documents pertaining to above policies.

Amended forms and other related documents will help facilitate benefit designations determinations. Moreover, recordkeeping of parental relationships should utilize the language that acknowledges the diversity of families accessing VA benefits and services.

C. TREATMENT OF MARITAL AND OTHER COMMITTED RELATIONSHIPS

OVERVIEW AND ANALYSIS

The treatment of marriages in VA benefits administration becomes complex in the context of LGBT veterans and their families; both because of restrictions imposed by federal law and by the treatment of some relationships in State courts. To ensure that VA programs can serve diverse families of veterans, regulations and policy need to take into consideration both the possibilities for establishing eligibility for same-sex couples, and the treatment of marriages involving transgender spouses.

1. SAME-SEX SPOUSES AND RELATIONSHIPS

Currently, federal law restrains federal agencies by restricting federal definition of marriage to only “a legal union between one man and one woman as husband and wife” and similarly defining spouse to refer “only to a person of the opposite sex who is a husband or wife.”³³ In observation of this limitation, VA regulations define “spouse” by tracking the language of the federal statute.³⁴ These narrow definitions act to deny an array of VA-administered benefits to dependent same-sex spouses of veterans, including: dependency indemnity compensation, death pensions, and access to medical services and products through CHAMPVA.

Further, although VA regulations are in accord with the Defense of Marriage Act³⁵ in defining “spouse” as a person of the opposite sex whose marriage meets other statutory requirements,³⁶ there is no policy or regulatory provision protecting individuals from affirmative discrimination on the basis of relationship status. Amending VA regulations or issuing an interpretive policy directive clarifying treatment that is prohibited against same-sex couples can be helpful in ensuring that the definition of “spouse” is not read to require discriminatory treatment greater than required by federal law.

Despite these restrictions, there are several ways that the Department of Veterans Affairs can provide greater access and support to couples in the LGBT community while maintaining compliance with the requirements of federal law.

POLICY RECOMMENDATIONS

1. Issue Interpretive Policy Directive that ensures same-sex couples receive benefits commensurate with married heterosexual couples.

A new regulation or directive should state that, notwithstanding the ineligibility of same-sex spouses for satisfaction of the statutory definition of “spouse,” being a party to a same-sex marriage, civil union, domestic partnership, or other relationship structure shall not serve as a basis for discrimination in the provision of benefits to an otherwise eligible veteran or dependent.

2. Allow designation of same-sex partner as “primary provider of personal services”.

Regulations defining “family member” for the purposes of primary caregiver designation,³⁷ should be amended to include same-sex partners, domestic partners, and parties to a civil union. This inclusion does not constitute a recognition of a spousal relationship in contravention of the Defense of Marriage Act – which

³³ 38 U.S.C. § 101(3).

³⁴ 38 C.F.R. § 3.50.

³⁵ Definition of “Marriage” and “Spouse,” 1 U.S.C. 7 (1996).

³⁶ Veterans’ Benefits Definitions, 38 U.S.C. § 101(31) (2008); Pension, Compensation, and Dependency and Indemnity Compensation Relationship Spouse and Surviving Spouse, 38 C.F.R. § 3.50 (1997).

³⁷ Approval and Designation of Primary and Secondary Family Caregivers, 38 C.F.R. § 71.25 (2011).

does not impose restrictions on the definition of “family” - and acknowledges the reality of same-sex partners as the close family of veterans, and not merely full-time occupants of the same housing.

Although same-sex spouses are denied access to medical services through CHAMPVA as spouses, they may be eligible as designated primary providers of personal care services for veterans.³⁸ The enabling statute for CHAMPVA provides that the Secretary is authorized to provide medical care for individuals who are designated as primary providers of personal care services.³⁹ The section defining primary providers of personal care services states that each eligible veteran may have a designated “family member” who will be deemed the primary provider of personal care services for such eligible veteran, subject to certain statutory requirements of competency, approval, and consent.⁴⁰ “Family member,” for the purposes of this section, includes an individual who lives with the veteran, but is not a parent, “spouse,” child, step-family member, or extended family member.⁴¹ Thus, same-sex partners who provide care services for their veteran partner, though not related by blood or even legally recognized relationship, may be able to receive VA-provided medical services through CHAMPVA as a “primary provider of personal services.”

2. Add regulatory provisions to extend to same-sex couples all hospital visitation rights available to heterosexual couples.

Last year, HHS issued regulations prohibiting hospitals and other facilities receiving HHS funds from prohibiting visitation privilege on the basis of sexual orientation and gender identity.⁴² These regulations also require funding recipients to take affirmative action to inform patients of their rights to have visitation by same-sex partners and spouses on a basis equal to heterosexual partners.⁴³ However, these regulations do not directly and explicitly apply to facilities operated or funded by the Department of Veterans Affairs, and VA has not incorporated the hospital visitation rules by regulation or policy directive.

Action should be taken to ensure that visitation rights at VA facilities, State homes, and adult day health care programs incorporate language inclusive of same-sex partners. This can be done through regulatory language applying to VA programs and services as a whole, or by adding provisions to regulations for veteran’s health services programs, CHAMPVA services, adult day health care,⁴⁴ and State Homes.⁴⁵

3. Revise policies to ensure same-sex spouses and partners receive equal residential accommodations in VA care facilities.

State homes supported by the VA provide residential care to veterans who may be involved in a relationship with another veteran of the same sex. While regulations permit shared rooms for “spouses” in these homes, there is no policy for same-sex spouses or partners.⁴⁶ Statutory authority for State homes contains no language restricting eligibility for housing on spousal status. Thus, there is no requirement that the regulatory language be limited to definitions excluding partners of the same sex.

³⁸ Assistance and Support Services for Caregivers, 38 U.S.C. § 1720G(a)(7)(A) (2010).

³⁹ See 38 U.S.C. § 1781(a)(4).

⁴⁰ 38 U.S.C. § 1720G(a)(7)(A).

⁴¹ 38 U.S.C. § 1720G(d)(3)(B).

⁴² Conditions of Participations for Hospitals, 42 C.F.R. § 482.13(h)(3) (2010); Conditions of Participation: Critical Access Hospitals, 42 C.F.R. § 485.635(f)(3) (2011).

⁴³ 42 C.F.R. § 482.13(h)(2); 42 C.F.R. § 485.635(f)(2).

⁴⁴ 38 C.F.R. § 52.70(h), *supra* note 28.

⁴⁵ 38 C.F.R. § 51.70(j), *supra* note 27.

⁴⁶ 38 C.F.R. 51.70(m).

2. TRANSGENDER SPOUSES

Marriages where one or both spouses are transgender may present different issues. Most such marriages fall into one of two scenarios. In one scenario, a couple marries as a husband and wife, and at some later time, one spouse transitions from one gender to another. In the other common scenario, a person transitions from one gender to the other and subsequently marries someone of the gender opposite their transitioned gender. These circumstances can cause confusion for benefit administrators who may be unsure of applicable rules under state and federal law.

The Veterans Benefits Manual currently outlines a procedure for assessing the validity of marriages involving a transgender spouse. The Manual states that it is possible in some jurisdictions to establish a valid marriage involving a person who has undergone gender transition.⁴⁷ The validity of the marriage is assessed by development of medical evidence establishing gender reassignment surgery and any other relevant evidence, such as an amended birth certificate or legal name change.⁴⁸ After development of this evidence, the Regional Counsel then gives an opinion addressing the issue of the validity of the marriage under State law, but no administrative decision is required.⁴⁹ This current policy is flawed in three respects.

First, it treats benefit claims involving transgender spouses as though they are inherently complex and require a Regional Counsel opinion to resolve. In fact, in the vast majority of cases such marriages are valid under state and federal law and this can be verified easily through submission of government-issued documentation, such as a birth certificate or court order. Kansas is the only state with a clearly established public policy prohibiting legal recognition of gender transition for purposes of marriage,⁵⁰ and even Kansas has no law barring interstate recognition of a marriage that was entered into as a marriage between a man and a woman in another state.

Second, the current VA guidance requires development of medical evidence regarding whether an individual has undergone surgical treatment in every case. This highly personal medical information is often legally irrelevant,⁵¹ and government-issued documentation such as a birth certificate or court order reflecting gender change is typically sufficient to establish marital validity pursuant to state law.⁵²

Third, the current VA guidance fails to address the common situation where a couple enters into a heterosexual marriage and one of the spouses subsequently transitions. Such a marriage, valid at its inception, should continue to be valid under state and federal law, and the Office of Personnel Management (OPM) recently issued guidance clarifying that such a marriage continues to be valid for purposes of federal employee benefits.⁵³ Couples in this situation have frequently encountered confusion and difficulty in establishing benefit eligibility with various agencies including the VA, and guidance is needed.

⁴⁷ VA Adjudication Procedures Manual Rewrite, M21-1MR, Part III, Subpart iii, Chapter 5, Section D.

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *See In re Estate of Gardiner*, 273 Kan. 191, 42 P.3d 120 (Kan. Mar 15, 2002).

⁵¹ *See, e.g.*, § 15 of 2011 ch. 104, codified as 18 Vt. Stat. Ann. § 5112 (providing for amendment of birth records based on “surgical, hormonal or other treatment appropriate for that individual for the purpose of gender transition”).

⁵² *See, e.g.*, *In re Lovo Lara*, 23 I&N Dec. 746 (BIA 2005) (holding that where state law provides for amendment of sex designation on birth certificates, amended certificate is sufficient to establish gender change for purposes of marriage).

⁵³ U.S. Office of Personnel Management, Guidance Regarding the Employment of Transgender Individuals in the Federal Workforce (May 2011), <http://www.opm.gov/diversity/Transgender/Guidance.asp>.

POLICY RECOMMENDATIONS

1. Revise and clarify guidance regarding marriages involving transgender spouses.

These revisions should incorporate three key principles:

- The validity of a marriage should be determined with reference to the circumstances existing at the time of marriage, and in accordance with state law.
- Gender change for the purposes of marriage eligibility should be established by one of several methods – amended birth certificate, court order or legal recognition of gender change, or documentation of medical treatment consistent with applicable state public policy for recognizing gender change, as evidenced by state law or policy for amending gender designations on birth certificates. If applicable state public policy (as in, e.g., Georgia) applies a standard of sex reassignment surgery, documentation of such surgery will be sufficient to establish gender transition for purposes of marriage; whereas if applicable state policy applies a standard of appropriate clinical treatment (as in, e.g., Washington State), documentation of such treatment will be sufficient.
- As an exception to the previous principle, where parties have married and continue to reside in Kansas, a Regional Counsel opinion should be requested. Finally, in all cases, the status of marriage where one party underwent gender transition subsequent to the marriage should be determined with reference to the time at which the marriage was celebrated. If a marriage was a valid, different-sex marriage at the time of celebration, it should remain valid for VA eligibility purposes.

2. Amend VA insurance applications, patient forms, and administrator processing materials.

These amendments should clearly state that, for the purposes of beneficiary designation for the receipt of life insurance payments, designated beneficiaries may include same-sex spouses, domestic partners, or individuals connected to a veteran through a non-marital relationship without violation of federal law and without penalty to the individuals.

In addition, these amendments will ensure that veterans entering into life insurance contracts or changing the designated beneficiary understand the permissibility of such designations, and are assured that no adverse action will be taken as a result of their valid beneficiary designation. Such a clarification would not be a departure from existing regulation or policy of the Department, and serves the sole function of clarifying and providing notice of rights to beneficiaries. Furthermore, ensuring that insured parties understand that same-sex partners may be designated beneficiaries does not create a legal recognition of the spousal relationship triggering application of the Defense of Marriage Act, and instead is routine administration of preexisting VA policy.

D. INSTITUTIONAL INFRASTRUCTURE TO SUPPORT LGBT VETERANS' NEEDS

OVERVIEW AND ANALYSIS

Promoting information access, dynamic policy adaptation, processing patient and beneficiary complaints and periodic assessment of equal-access efforts will require continuous efforts by a dedicated group of officials and administrators at the Department of Veterans Affairs. As with racial and ethnic minority and women veterans, addressing the needs of this unique population of individuals requires institutional support. There are a variety of ways that the VA could address this need for support, including dedicating staff to LGBT issues, designating regional LGBT patient advocates, assembling an LGBT advisory council at the department level, or inclusion of LGBT issues in the activities of the Center for Minority Veterans. Any of these options would increase the capacity of Department programs and staff to meet the demands of LGBT beneficiaries. Dedicated staff, councils, or the Center could serve as a hub for department activities pertaining to LGBT beneficiaries, sexual orientation and gender identity antidiscrimination efforts, and performing outreach and coordination both within the Department. These would also be key in providing outreach to potential benefits enrollees, as well as LGBT community organizations that serve and advocate for gay, lesbian, bisexual, and transgender veterans.

In addition to the creation of dedicated institutional resources for addressing concerns of LGBT veterans, incorporating the needs of LGBT individuals into offices dedicated to other identity groups would constitute a significant step towards addressing a diverse array of population-based disparities. To this end, the Office of Women Veterans and the Center for Minority Veterans should also develop the capacity to serve the unique needs of women and minority veterans. Resources such as the regional women's health services coordinators, for example, could be utilized to: 1) determine the needs of women veterans who are lesbian, bisexual, or transgender; 2) plan strategies to meet these needs; 3) coordinate appropriate training for individual facilities' staff; and 4) provide guidance to VA facilities in the area for conducting appropriate outreach for these women.⁵⁴ Additionally, providing opportunities for LGBT informational and cultural competency training for staff and administrators at these offices, and throughout the Department, will aid in incorporating the needs of LGBT people into programming, planning, and face-to-face interactions with beneficiaries.

POLICY RECOMMENDATION

- 1. Institute cultural competency and capacity-building activities in the Center for Minority Veterans and Office of Women Veterans, and across other Department offices and facilities.*

The Secretary is authorized to "prescribe all rules and regulations which are necessary or appropriate to carry out the laws administered by the Department and are consistent with those laws."⁵⁵ The Secretary should utilize appropriate regulatory and intra-department procedures to establish dedicated staff and resources for addressing the needs of LGBT beneficiaries, and to implement programs and trainings in other population-based offices at the Department.

⁵⁴ Coordination of Services, 38 U.S.C. § 1710 note, 102 P.L 585 § 108 (1992).

⁵⁵ Rules and Regulations, 38 U.S.C. § 501(a).

E. POPULATION-SPECIFIC TREATMENT PROTOCOLS AND BENEFITS PACKAGE COMPOSITION

1. TREATMENT PROTOCOL AND BENEFITS PACKAGES INCLUSIVE OF THE NEEDS OF LESBIAN, GAY, AND BISEXUAL PATIENTS

OVERVIEW AND ANALYSIS

While patients who are lesbian, gay, and bisexual have many of the same general health needs as heterosexual patients, health care providers often lack sufficient knowledge to address their particular health needs adequately. For example, providers generally require additional training in order to take accurate and complete medical and sexual histories⁵⁶, administer appropriate preventive screenings, and, in general, provide effective and culturally competent care. Moreover, fear of discrimination may lead LGB patients to avoid or delay seeking medical care. To encourage patients to pursue timely preventive and acute care, it is essential that VA health care professionals provide a treatment environment that is equitable, inclusive, and welcoming for these patients, allowing them to speak openly about health issues related to their LGB status. Providers at VA facilities need to receive training that addresses the specific needs of LGB patients in order to effectively serve their needs and maximize positive health outcomes.

POLICY RECOMMENDATION

- 1. Develop clinician practice and treatment guidelines as well as competence training to address the needs of lesbian, gay, and bisexual patients.*

These guidelines and training should utilize independent Department resources as well as existing professional protocols and trainings that provide best practices for addressing the medical needs of this population. In addition, providing LGB patients with external resources tailored to the unique health needs, risks and disparities that LGB individuals face will support appropriate self-care and bolster their engagement with preventive screenings.

2. TREATMENT PROTOCOL AND BENEFITS PACKAGES INCLUSIVE OF THE NEEDS OF TRANSGENDER PATIENTS

OVERVIEW AND ANALYSIS

As with LGB patients, providers need to be adequately informed regarding appropriate sexual health screening and treatment associated with the gender identity and medical transition status of the individual patient. Practitioners also must be conscious of the needs of transgender patients with regard to upkeep of hormone treatment, pre- and post- surgical care, and other needs associated with medical transition. Especially primary care providers must be educated in the appropriate screening, risks, and drug interactions associated with the supervised use of hormones. VA providers must be capable of providing treatment responsive to those needs, and informed to a sufficient degree to prevent contraindication or other potential adverse reactions in the course of patient treatment. Finally, this care must be provided in a manner that is culturally competent and utilizes language that is reflective of the patient's gender identity.

VHA Directive 2011-024 establishes general guidelines regarding respectful treatment of transgender veterans enrolled in the VA health care system or otherwise eligible for VA care.⁵⁷ This directive takes admirable strides toward guaranteeing necessary medical treatment for transgender veterans and granting respectful treatment to those receiving care in VA patient treatment facilities. The Directive further explains

⁵⁶ LUMSDAINE, PRINGLE, AND SCOTT, SEXUAL EXCLUSION – HOMOPHOBIA AND HEALTH INEQUALITIES: A REVIEW OF HEALTH INEQUALITIES AND SOCIAL EXCLUSION EXPERIENCED BY LESBIAN, GAY AND BISEXUAL PEOPLE (UK Gay Men's Health Network 2010).

⁵⁷ VHA Directive 2011-024.

that the medical benefits package granted to veterans includes medically necessary hormone therapy, mental health care, and pre- and post-operative care and evaluation.⁵⁸ However, this directive expires November 30, 2012, makes no alteration to the regulatory exclusion of sex reassignment surgery under the veterans medical benefits package,⁵⁹ and does not itself prescribe the appropriate protocol to be followed in the treatment of transgender patients. Moreover, Directive 2011-024, issued by VHA, applies only to veterans, and not to dependants receiving care under CHAMPVA.⁶⁰ The effect is that it remains uncertain whether CHAMPVA beneficiaries are eligible to receive similar care for transition-related medical care under the program, and regulatory restrictions on sex reassignment surgery and other services for CHAMPVA beneficiaries remain in effect.⁶¹

POLICY RECOMMENDATIONS

1. Develop a treatment protocol appropriate for treatment in VA facilities, or incorporate preexisting provider resources.

To adequately address the needs of transgender patients, VA clinical staff should either independently develop a treatment protocol appropriate for treatment in VA facilities, or incorporate preexisting provider resources, such as the primary care protocol for transgender patients developed by the Center of Excellence for Transgender Health.⁶² Providers should also be held to the highest standard in embracing the requirements of respectful provision of care demanded by VHA Directive 2011-024, by referring to patients using self-identified gender,⁶³ granting room assignments based on self-identified gender,⁶⁴ providing necessary transition-related hormone treatment,⁶⁵ and administering pre-and post-surgical care for transgender patients.⁶⁶

Requirements for respectful treatment should also be applied to the CHAMPVA program, either by promulgation of appropriate regulation or additional policy directive. Due to the restrictive nature of CHAMPVA benefits package regulations, issuing a CHAMPVA Directive mirroring VHA Directive 2011-024 will not be sufficient to ensure adequate protections and coverage for transgender beneficiaries who are not veterans. Removing the broad-based prohibition on benefits that are “services or supplies” related to gender transition will permit use of a similar policy directive ensuring coverage for necessary transition-related hormone treatment and other care. While issuing a Directive addressing respectful treatment, patient records, and room assignments would advance important equality objectives for transgender patients, ensuring equal treatment for transgender beneficiaries in the CHAMPVA program will require both regulatory and policy-based changes.

2. Eliminate barriers to sex reassignment surgery and transition-related care.

The VA cannot adequately serve transgender patients while categorically excluding medically necessary and long-accepted treatments that many patients need. Transition-related care, including sex reassignment treatment, is regularly “determined by appropriate healthcare professionals” to “promote” and “preserve” the “health of the individual” and has been performed “in accord with generally accepted standards of medical

⁵⁸ *Id.*

⁵⁹ Medical Benefits Package, 38 C.F.R. § 17.38(c)(4) (2011).

⁶⁰ Established at 38 U.S.C. § 1781.

⁶¹ CHAMPVA Benefits Limitations/Exclusions, 38 C.F.R. § 17.272(a)(23) (2008).

⁶² UNIVERSITY OF CALIFORNIA, SAN FRANCISCO, DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE, PRIMARY CARE PROTOCOL FOR TRANSGENDER PATIENT CARE (Center of Excellence for Transgender Health, 2011).

⁶³ VHA Directive 2011-024(4)(b)(1)(a).

⁶⁴ *Id.*

⁶⁵ VHA Directive 2011-024(b)(1).

⁶⁶ *Id.*

practice”⁶⁷ for decades. The American Medical Association has publicly urged that this care be covered by private and public insurance plans.⁶⁸ Accordingly, the VA’s current coverage exclusions for such surgeries applied to veterans – the exclusion for “gender alterations”⁶⁹ – should be removed. VA medical providers should be permitted to exercise their professional judgment in determining the appropriate care for their patients. Similarly, because transition-related care, including surgery, is “medically necessary and appropriate”⁷⁰ for some patients, regulations excluding such treatment from permitted benefits for CHAMPVA patients⁷¹ should also be eliminated.

⁶⁷ 38 C.F.R. § 17.38(b).

⁶⁸ H-185.950 Removing Barriers to Care for Transgender Patients," American Medical Association, GLBT Advisory Committee, 2008.

⁶⁹ 38 C.F.R. § 17.38(c)(4).

⁷⁰ 38 C.F.R. § 17.272(a).

⁷¹ 38 C.F.R. § 17.272(a)(23).

F. CULTURAL COMPETENCY TRAINING FOR VA PROVIDERS, ADMINISTRATORS, AND VETERANS' SERVICES MANAGERS

OVERVIEW AND ANALYSIS

Incorporating the needs of the LGBT population into veterans' benefits and medical treatment is not complete with mere assessment of Department policy and the substance of benefits to be granted to these beneficiaries. The manner by which services are provided to LGBT veterans can mean the difference between an individual being comfortable and capable of accessing all benefits to which they are entitled, and delaying or deferring access to services or payments to the detriment of their health and wellbeing.

1. MEDICAL TREATMENT

Lack of cultural competency on the part of staff or providers may contribute to a Department culture that reinforces existing institutional barriers to accessing adequate and equal services, and undermines policy-level antidiscrimination efforts developing at the VA. Particularly with regard to health care providers who interact face-to-face with patients, training in delivering LGBT-knowledgeable care is essential to maintaining and improving the health status of LGBT veterans and their loved ones. Despite this, one study reveals that approximately one-half of medical professionals receive absolutely no training on LGBT cultural competency, and those that do only average two and a half hours of classroom time dedicated to the subject.⁷²

POLICY RECOMMENDATION

1. Incorporate into existing competency training a Department-wide LGBT competency component.

The cultural competency training should include content on the use of respectful and accurate terminology, including names and personal pronouns. As well, it should contain an accurate overview of Department policies respecting the rights and responsibilities of LGBT patients, beneficiaries, and dependents, emphasizing that there is no room for administrative discretion in the provision of benefits to which an individual is entitled. At a minimum, cultural competency trainings for all staff should stress that no service or benefits determinations may include judgments inappropriately based on sex, sexual orientation, gender identity, or gender expression. Providers should also have access to cultural competency and protocol training at the facility where they will be practicing, and should be encouraged to pursue continuing education touching upon topics of concern to LGBT patients.

2. INTAKE AND ASSESSMENT

Patient care facilities should develop and implement, or revise preexisting intake and assessment procedures to ensure full inclusion of the needs of lesbian, gay, bisexual and transgender clients and their families. Methods for achieving this goal should include:

POLICY RECOMMENDATIONS

1. Train all reception, intake and assessment staff in the use of culturally appropriate language.

This may include: 1) asking whether an individual is in a relationship, rather than if they are married; 2) Using terms such as "partner," (rather than spouse), "loved one," and "caregiver" to avoid implicit

⁷² GAY AND LESBIAN MEDICAL ASSOCIATION (GLMA), HEALTHY PEOPLE 2010 COMPANION DOCUMENT FOR LESBIAN, GAY, BISEXUAL, AND TRANSGENDER (LGBT) HEALTH 57-58 (2011) (citing: A. E. Harrison, *Primary Care of Lesbian and Gay Patients: Educating Ourselves and Our Students*, Family Medicine 28(1), 57-58 (1996)).

assumptions about an individual's sexual orientation; 3) Avoid using terminology in the workplace that discriminates or creates a hostile environment for individuals on the basis of sexual orientation or gender identity; and 4) Allowing individuals to identify using their own preferred terms, including names, honorifics, and personal pronouns.

2. *Develop and implement intake and assessment forms providing optional space for designating self-identification in all categories of gender identity, sexual orientation, marital, partnership and family status, and providing the opportunity for further written explanation.*
3. *Institute evaluation methods to ensure guideline compliance by all reception, intake and assessment staff.*

3. SERVICE PLANNING AND DELIVERY

For direct care and case management staff to appropriately meet the needs of gay, lesbian, bisexual and transgender clients, they must competently identify and address, within the scope of their field of practice, specific health disparities and treatment needs for LGBT people. Moreover, they must be prepared to develop and administer appropriate, outcomes-driven treatment and treatment plans – and to provide appropriate referrals when necessary.

POLICY RECOMMENDATIONS

1. *Provide comprehensive ongoing training for direct care staff to identify and address LGBT health issues within their field of practice.*
2. *Identify and utilize staff with an expertise in and sensitivity to LGBT issues.*
3. *Provide training to direct care staff regarding appropriate referrals and placements for LGBT patients and their families.*
4. *Develop a comprehensive resource list for appropriate referrals for special LGBT health concerns.*

G. UNIFORM POLICY AND PROCEDURE FOR THE AMENDMENT OF PATIENT RECORDS FOR NAME AND SEX

OVERVIEW AND ANALYSIS

Obtaining documentation that accurately reflects patients' identities is critically important for transgender patients and advances larger efforts to promote personalized, patient-centered care. Current VA regulations provide that any individual may request amendment of their VA patient records.⁷³ However, the procedures for reviewing such requests, for making a determination on the request, and for appeal of adverse decisions, are left to the discretion of the administrators or staff at the office that has jurisdiction over the records.⁷⁴ The recent VHA Directive on transgender patients states that veterans' documented sex "should be consistent with the patient's self-identified gender."⁷⁵ At the same time, this Directive references another 2006 Directive, which states that "legal documentation (amended birth certificate, court documents, etc.) must be required" to change gender in patient identity data.⁷⁶ This apparent contradiction has caused confusion in implementing the recent Directive. Furthermore, a requirement of legal documentation is inconsistent with federal policies for updating gender in personnel records and in U.S. passports and consular records of birth abroad.⁷⁷

POLICY RECOMMENDATIONS

Several policy changes should be implemented to clarify the documentation requirements for changing recorded name and sex, as well as to provide for informal use of a patient's preferred name and gender identification.

1. Clarify document requirements governing person name changes.

Consistent with federal policies for updating Federal personnel records and U.S. passports,⁷⁸ VA should accept certified court orders, state-issued identity documentation, or federal government documents, such as a passport, as proof of a name change.

2. Clarify document requirements for changing documented gender.

Consistent with federal policies for updating personnel records and U.S. passports,⁷⁹ VA should accept State-issued identification, federal government documents, such as passports, or a letter from a licensed physician stating that the patient has had appropriate clinical treatment for gender transition as proof of a gender change.

3. Permit patients to designate a preferred name and self-identified gender (where using a patient's officially documented name and gender are not required).

This modification will allow veterans who have not obtained the necessary documentation to be referred to in a way that is respectful and may avoid unnecessary publicity of their transgender status. Use of a form for designating preferred name and gender is one means by which this could be achieved.

⁷³ Amendment of Records, 38 C.F.R. § 1.579(a) (1996).

⁷⁴ 38 C.F.R. 1.579(b).

⁷⁵ VHA Directive 2011-024.

⁷⁶ VHA Directive 2006-036, Data Quality Requirements for Identity Management and Master Patient Index Functions.

⁷⁷ U.S. Office of Personnel Management, *Chapter 4: How to Reconstruct a Personnel Folder*, in THE GUIDE TO PERSONNEL RECORDKEEPING 4-1, 4-5 to 4-13 (2011), available at

http://www.opm.gov/feddata/Ch4_ReconstructPersonnelFolder.pdf; U.S. State Department Foreign Affairs Manual, 7 FAM 300 Appendix M: Gender Change, <http://www.state.gov/documents/organization/143160.pdf>.

⁷⁸ *Id.*

⁷⁹ *Id.*

H. INCLUSION OF LGBT POPULATIONS IN SPECIALTY OUTREACH INITIATIVES AND GRANTS

OVERVIEW AND ANALYSIS

In light of a long history of marginalization and discrimination, LGBT individuals are often skeptical of participation in institutionalized systems of care. In the healthcare context, this problem can manifest in delay or avoidance of seeking medically necessary services. A recent national survey found that due to discriminatory treatment and disrespect, 43% of transgender veterans postponed or abstained from seeking treatment during instances of acute illness.⁸⁰ LGBT veterans who are entitled to services and benefits provided by the Department of Veterans Affairs may experience similar hesitance. To combat these fears, and to address anecdotal misinformation about VA policies, targeted outreach directed toward LGBT veterans and loved ones is necessary. Similar focused efforts have been made to extend information and aid in accessing benefits for racial minorities and women. The continued existence and development of initiatives to perform outreach of this kind suggests that the efficacy of population-targeted outreach for VA programs is high.

POLICY RECOMMENDATIONS

1. Designate staff, programs, and/or offices to focus on the needs of LGBT veterans.

Having dedicated resources to address LGBT population needs permits greater attention to appropriate, effective, and culturally responsive outreach for lesbian, gay, bisexual, and transgender veterans and loved ones.

2. Modify outreach currently being conducted by the Department at-large, as well as by the Center for Minority and Office of Women Veterans, to include LGBT populations.

Materials on enrollment and eligibility information to veterans should include antidiscrimination statements including sexual orientation and gender identity.

3. Require veterans outreach program grantees to meet cultural competency standards, and to include affirmative efforts to engage LGBT veterans.

VA grants directed at homeless veteran outreach programs⁸¹ are among the many VA-funded programs that should be targeted for this policy recommendation at the earliest possible date, especially since LGBT people are at an especially high risk for experiencing homelessness.^{82 83}

⁸⁰ Jack Harrison, *Injustice at Every Turn: A Report of the National Transgender Discrimination* (2010) (unpublished raw data, on file with author).

⁸¹ Benefits for Homeless Veterans Grants, 38 U.S.C. § 2011 (2006).

⁸² TRANSGENDER DISCRIMINATION SURVEY, *supra* note 8, at 4.

⁸³ NATIONAL GAY AND LESBIAN TASK FORCE, *LESBIAN, GAY, BISEXUAL, AND TRANSGENDER YOUTH: AN EPIDEMIC OF HOMELESSNESS* (2007). Available at: http://www.thetaskforce.org/reports_and_research/homeless_youth.

I. DATA COLLECTION

OVERVIEW AND ANALYSIS

Until recently, there has been little attention given at the federal level to data collection on sexual orientation or gender identity. Without this information, efforts to track and address health disparities, or to recommend best practices for treatment, are rendered nearly impossible. However, the federal government has been taking note of this lack of data, and acknowledging the need for changes in policy and practices in the area of data collection and research. The Institute of Medicine has lead the call for further efforts to collect data and conduct research on LGBT populations,⁸⁴ and in June of 2011, the US Department of Health and Human Services released a departmental plan to incorporate sexual orientation questions into data collection efforts in 2013, and to develop and test demographic questions on gender identity.⁸⁵ Adding the Department of Veterans Affairs to the growing list of agencies addressing the deficiency in LGBT data collection would contribute to the national effort toward improving knowledge wealth and reducing health disparities. Moreover, data collection inclusive of sexual orientation and gender identity within the VA would be invaluable as an indicator of the demographic composition of the larger population of veterans, and as a guide for future development of LGBT programming and policy within the Department of Veterans Affairs. It is also of great importance to ensure that data pertaining to sexual orientation and/or gender identity is obtained voluntarily from VA beneficiaries, and that appropriate privacy protocols, including those requirements currently in effect for the protection of identifying patient medical records, are maintained

POLICY RECOMMENDATIONS

1. *Revise data collection systems and methodologies to include appropriate measures of sexual orientation and gender identity.*

The Secretary is authorized to collect data regarding participation, provision of services, and categories of beneficiaries under all veterans' benefits programs.⁸⁶ The collection of data on sexual orientation and gender identity fits easily into each of these authorized categories, and is thus appropriate for collection at the Secretary's discretion. The mechanisms for collecting this information also exist, because of the Department's use of computerized recordkeeping and demographic data collection. These resources should be utilized to collect appropriate data on sexual orientation and gender identity. Existing policies, regulations, and laws on privacy and permissible use of these records will also lend adequate protection to patients while permitting the Department to perform this important task.

⁸⁴ The National Academies Office of News and Public Information, *Researchers Need to Engage Lesbian, Gay, Bisexual, and Transgender Populations in Health Studies*, March 31, 2011. Available at: <http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=13128>

⁸⁵ United States Department of Health and Human Services, *Affordable Care Act to Improve Data Collection, Reduce Health Disparities*, June 29, 2011. Available at: <http://www.hhs.gov/news/press/2011pres/06/20110629a.html>.

⁸⁶ Evaluation and Data Collection, 38 U.S.C. § 527 (1991).

J. TREATMENT OF CERTAIN DISCHARGES IN ELIGIBILITY DETERMINATION

OVERVIEW AND ANALYSIS

Under current regulations on the adjudication of the character of discharge for the purposes of determining eligibility for pensions, compensation, and dependency and indemnity compensation, “homosexual acts involving aggravating circumstances or other factors affecting the performance of duty” are among those listed for particular characterization as dishonorable.⁸⁷ Although the addition of the details triggering this characterization were added in 1980 for the purpose of conferring eligibility for benefits for most individuals discharged for homosexual acts,⁸⁸ this section is no longer necessary to serve that purpose. The singling out of misconduct involving homosexual acts sends a stigmatizing message and today serves no continuing purpose. The rule as it currently exists subjects individuals who engage in homosexual conduct to harsher treatment than heterosexual counterparts who engage in similar conduct, and this disparate treatment should be removed.

POLICY RECOMMENDATION

1. *Eliminate all references to “homosexual acts” in discharge provisions.*

The characterization of these activities as constituting other than honorable discharged can be maintained without the need for reference to *homosexual* acts. This provision should thus be eliminated, and aggravated sexual misconduct should be treated the same way by the Department regardless of the sex of those involved.

⁸⁷ Character of Discharge, 38 C.F.R. § 3.12(d)(5) (1997).

⁸⁸ Pensions, Compensation, and Dependency and Indemnity Compensation; Character of Discharge Final Regulation, 45 FR 2318, Jan. 11, 1980.

L. CONFIDENTIALITY POLICY

VA facilities should ensure the confidentiality of patient records and data, including information about sexual orientation and gender identity. VA staff should inform LGBT patients of both the purpose of such data collection and the circumstances under which such information may be used.

POLICY RECOMMENDATIONS

- 1. Develop and disseminate confidentiality policies which explicitly include sexual orientation and gender identity, indicating that such information is to be considered highly sensitive and treated in a manner ensuring an appropriate degree of patient privacy.*
- 2. Issue a statement explaining the designation of sexual orientation and gender identity is at a patient's option on forms and records.*
- 3. Provide comprehensive training for appropriate staff on data collection and reporting issues as they relate to confidentiality.*
- 4. Present to patients a disclosure form explaining when information may or must be disclosed to third parties for payment or other reasons, and in what circumstances such disclosures may include information regarding sexual orientation and gender identity.*
- 5. Permit patients to obtain amendments of those records that reflect changes of name and sex - as well as preferred name and pronouns. Restrictions on amendment of records that are not justified by legal obligations, effective treatment, or security measures should be reduced or removed.*

Regarding LGBT minors eligible for facility-based or offsite medical care services, the VA should provide appropriate, safe and confidential treatment. All patients who are minors shall be informed of their legal rights, and advised of the possible consequences of any statutory or otherwise mandatory reporting.

POLICY RECOMMENDATIONS

- 1. Provide training to staff on the legal rights of LGBT minors.*
- 2. Develop and implement procedures for intake, assessment and treatment of minors that is sensitive to gender identity and sexual orientation throughout childhood and adolescence.*
- 3. Provide written and oral notice to minors regarding mandatory reporting laws and their implications, and of the minor's rights regarding confidentiality and treatment without parental consent.*

K. COMMUNITY RELATIONS PRACTICES

VA programs and facilities should include lesbian, gay, bisexual and transgender people and their families in outreach and health promotion efforts.

PRACTICE RECOMMENDATION

- 1. Develop and implement communications plan, including broad promotion of antidiscrimination policies (regarding sexual orientation, gender identity and gender expression) and the high-quality and culturally competent services available LGBT clients and their families.*

III. CONCLUSION

This report presents the Department of Veterans Affairs with a preliminary analysis of its benefit statutes, regulations, and policies most immediately and directly pertaining to LGBT veterans, their families, spouses, dependents, and beneficiaries. This analysis is the product of research and input from a diverse coalition of stakeholders advocating on behalf of LGBT individuals, families, service members, and veterans. This collaborative process incorporated considerations pertaining to the particular needs of LGBT veterans and their families.

The report further presents discrete policy recommendations across twelve distinct categories. These recommendations contain discrete actions in most cases – though there are some unavoidable overlapping actions in other cases. Taken together, these proposed recommendations would improve the health and well being of LGBT veterans and their loved ones. Moreover, once implemented, these policies will further enhance the VA’s role as a leader among Federal Departments in the provision of appropriate, fair, and effective care and treatment for *all* veteran populations.

APPENDIX A:
VHA DIRECTIVE 2011-024

Department of Veterans Affairs VHA DIRECTIVE 2011-024
Veterans Health Administration
Washington, DC 20420 June 9, 2011

THIS VHA DIRECTIVE EXPIRES NOVEMBER 30, 2012
VHA DIRECTIVE 2011-024
June 9, 2011

PROVIDING HEALTH CARE FOR TRANSGENDER AND INTERSEX VETERANS

1. **PURPOSE:** This Veterans Health Administration (VHA) Directive establishes policy regarding the respectful delivery of health care to transgender and intersex Veterans who are enrolled in the Department of Veterans Affairs (VA) health care system or are otherwise eligible for VA care.

2. **BACKGROUND:** In accordance with the medical benefits package (title 38 Code of Federal Regulations (CFR) Section 17.38), VA provides care and treatment to Veterans that is compatible with generally accepted standards of medical practice and determined by appropriate health care professionals to promote, preserve, or restore the health of the individual.

a. VA provides health care for transgender patients, including those who present at various points on their transition from one gender to the next. This applies to all Veterans who are enrolled in VA's health care system or who are otherwise eligible for VA care, including: those who have had sex reassignment surgery outside of VHA, those who might be considering such surgical intervention, and those who do not wish to undergo sex reassignment surgery, but self-identify as transgender. Intersex individuals may or may not have interest in changing gender or in acting in ways that are discordant with their assigned gender.

b. VA does not provide sex reassignment surgery or plastic reconstructive surgery for strictly cosmetic purposes.

c. Definitions

(1) Sex. Sex refers to the classification of individuals as female or male on the basis of their reproductive organs and functions.

(2) Gender. Gender refers to the behavioral, cultural, or psychological traits that a society associates with male and female sex.

(3) Transgender. Transgender is a term used to describe people whose gender identity (sense of themselves as male or female) or gender expression differs from that usually associated with their sex assigned at birth.

(a) Transsexual (Male-to-Female). Male-to-female (MTF) transsexuals are individuals who are male sex at birth, but self-identify as female and often take steps to socially or medically transition to female, including feminizing hormone therapy, electrolysis, and surgeries (e.g., vaginoplasty, breast augmentation).

(b) Transsexual (Female-to-Male). Female-to-male (FTM) transsexuals are individuals who are female sex at birth, but self-identify as male and often take steps socially or medically transition to male, including masculinizing hormone therapy and surgeries (e.g., phalloplasty, mastectomy).

(4) Sex Reassignment Surgery. Sex reassignment surgery includes any of a variety of surgical procedures (including vaginoplasty and breast augmentation in MTF transsexuals and mastectomy and phalloplasty in FTM transsexuals) done simultaneously or sequentially with the explicit goal of transitioning from one gender to another. This term includes surgical revision of a previous sex reassignment surgery for cosmetic

purposes. NOTE: This term does not apply to non-surgical therapy (e.g., hormone therapy, mental health care, etc.) or Intersex Veterans in need of surgery to correct inborn conditions related to reproductive or sexual anatomy or to correct a functional defect.

(5) Gender Identity Disorder (GID). GID is a conflict between a person's physical sex and the gender with which the person identifies.

(6) Intersex. Intersex individuals are born with reproductive or sexual anatomy and/or chromosome pattern that doesn't seem to fit typical definitions of male or female. People with intersex conditions are often assigned male or female gender by others at birth (e.g., parents), although the individual may or may not later identify with the assigned gender.

3. **POLICY:** It is VHA policy that medically necessary care is provided to enrolled or otherwise eligible intersex and transgender Veterans, including hormonal therapy, mental health care, preoperative evaluation, and medically necessary post-operative and long-term care following sex reassignment surgery. Sex reassignment surgery cannot be performed or funded by VHA or VA.

4. ACTION

a. Veterans Integrated Service Network (VISN) Director. Each VISN Director must ensure that necessary and appropriate health care is provided to all enrolled or otherwise eligible Veterans based on the Veteran's self-identified gender, regardless of sex or sex reassignment status.

b. Medical Center Director and Chief of Staff. The Medical Center Director and Chief of Staff are responsible for ensuring that:

(1) Transgender patients and intersex individuals are provided all care included in VA's medical benefits package, including, but not limited to: hormonal therapy, mental health care, preoperative evaluation, and medically necessary post-operative and long-term care following sex reassignment surgery to the extent that the appropriate health care professional determines that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally-accepted standards of medical practice:

(a) Patients will be addressed and referred to based on their self-identified gender. Room assignments and access to any facilities for which gender is normally a consideration (e.g., restrooms) will give preference to the self-identified gender, irrespective of appearance and/or surgical history, in a manner that respects the privacy needs of transgender and non-transgender patients alike. Where there are questions or concerns related to room assignments, an ethics consultation may be requested.

(b) The documented sex in the Computerized Patient Record System (CPRS) should be consistent with the patient's self-identified gender. In order to modify administrative data (e.g., name and sex) in CPRS, patients must provide official documentation as per current VHA policies on Identity Authentication for Health Care Services and Data Quality Requirements for Identity Management and Master Patient Index Functions.

(c) Sex reassignment surgery, as defined in subparagraph 2b(4), will not be provided or funded.

(d) Non-surgical, supportive care for complications of sex-reassignment surgery will be provided.

(e) While care is delivered to the Veteran based upon that Veteran's self-identified gender, there may be health issues associated with some transgender patients that necessitate appropriate sex specific screenings and/or treatments. For example, a MTF transsexual patient over the age of 50 may require breast cancer and prostate cancer screening. A FTM transsexual patient may require screening for breast and cervical cancer.

(f) A diagnosis of GID, or other gender dysphoria diagnoses, is not a pre-condition for receiving care consistent with the Veteran's self-identified gender.

(2) All other health services are provided to transgender Veterans without discrimination in a manner consistent with care and management of all Veteran patients.

(3) All staff, including medical and administrative staff, are required to treat as confidential any information about a patient's transgender status or any treatment related to a patient's gender transition, unless the patient has given permission to share this information.

(4) Mandated diversity awareness is maintained and a zero-tolerance standard for harassment of any kind.

5. REFERENCES

a. Title 38 CFR § 17.38 (c).

b. VHA Directive 2009-051, Plastic Reconstructive Surgery.

c. VHA Directive 2007-037, Identity Authentication for

6. **FOLLOW-UP RESPONSIBILITY.** The Office of Patient Care Services (10P4) is responsible for the contents of this Directive. Questions related to medical care may be referred to Specialty Care Services (10P4E) at (202) 461-7120. Questions related to mental health care may be referred to the Office of Mental Health Services (10P4M) at (202) 461-7310.

7. **RESCISSIONS.** None.

This VHA Directive expires November 30, 2012.

Robert A. Petzel, M.D.
Under Secretary for Health

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