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Improving affirming care for sexual and gender minority veterans

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Abstract

Lesbian, gay, bisexual, and transgender (LGBT) populations face a range of health disparities that all health care systems must address. In response to known health disparities, the LGBT Health Program of the Veterans Health Administration (VHA) developed policies supporting the provision of affirming care to LGBT veterans. To support policy implementation, the program launched the LGBT Veteran Care Coordinator (LGBT VCC) Program in 2016, requiring every VHA facility to appoint at least one clinical staff member to serve as an LGBT VCC. This quality improvement project reports on LGBT VCCs' perspectives on the state of affirming care at their facilities in the first year of the program. LGBT VCCs (n=79) completed a brief online survey, including qualitative questions on barriers and facilitators to implementation, and general recommendations for the program. The Consolidated Framework for Implementation Research (CFIR) guided directed content analysis of reported facilitators and barriers. The highest proportion of facilitators and barriers reported by the LGBT VCCs were coded under leadership engagement, available resources, other personal attributes, organizational culture, and networking

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and communications. LGBT VCCs requested additional support in securing adequate designated administrative time, engaging with facility leadership, improving networking and communication, tailoring programing, and providing professional advancement opportunities. Organizing findings using the CFIR enabled the LGBT Health Program to effectively promote facilitators and address barriers experienced during the startup year of the LGBT VCC Program. VHA's efforts to reduce LGBT veteran health disparities may serve as a model for other health care systems.

Keywords

LGBT; veterans; policy; cultural competency; consolidated framework for implementation research

Sexual and gender minority populations face wide-scale disparities in physical and mental health (Jackson, Agénor, Johnson, Austin, & Kawachi, 2016; Meyer, 2013; Valentine & Shipherd, 2018). The abbreviation "LGBT" (lesbian, gay, bisexual, and transgender) is used here as an umbrella term that encompasses a range of sexual and gender minority identities, including related identities such as queer, asexual, genderqueer, and gender fluid/non-binary/non-conforming. Observed health disparities among LGBT people include an increased prevalence of obesity and stroke among sexual minority women, hypertension and heart disease among sexual minority men, and functional limitations among sexual minority men and women (Jackson et al., 2016). Likewise, sub-groups of LGBT-identified individuals are more likely to report engaging in health-related risk behaviors such as smoking, heavy drinking, sexual risk behaviors, or illicit drug use (James et al., 2016; Medley et al., 2015; Ward et al., 2014). LGBT-identified individuals are also more likely to experience psychological distress (James et al., 2016; Medley et al., 2015; Ward et al., 2014), and more likely to attempt suicide compared to heterosexual or cisgender individuals (James et al., 2016; Lea, de Wit, & Reynolds, 2014). LGBT individuals also experience higher rates of interpersonal violence across the lifespan (Balsam, Rothblum, & Beuchaine, 2005; James et al., 2016).

Research conducted within the Veterans Health Administration (VHA), the healthcare sector of the United States Department of Veterans Affairs (VA), suggests additional disparities among LGBT veterans, compared to LGBT non-veterans as well as non-LGBT veterans. For example, among 365 women using VHA care, LGB veterans were more likely to have experienced sexual trauma in the military (31%) than non-LGBT (13%) women (Mattocks et al., 2013). Similar results were shown in two large community samples of veterans, LGB veterans were nearly twice as likely to have experienced sexual assault while in the military compared to non-LGB veterans (Lucas, Goldbach, Mamey, Kintzle, & Castro, 2018) and among transgender veterans, high rates of military sexual assault were found among both transgender women (15%) and especially transgender men (30%; Beckman et al., 2018). LGBT veterans are at greater risk for depression, PTSD, and alcohol abuse relative to non-minority veterans (Cochran, Balsam, Flentje, Malte, & Simpson, 2013). Compared to heterosexual women veterans, sexual minority women veterans have higher risk for mental distress and smoking compared to heterosexual women veterans and have three times the risk of poor physical health (Blosnich, Foynes, & Shipherd, 2013). Further, veterans with a

medical record diagnosis of Gender Identity Disorder had a 20 times greater risk for suicide-related events relative to the general VHA population (Blosnich, Brown, et al., 2013).

Disparities in physical and mental health outcomes between cisgender heterosexual populations and LGBT populations reflect the deleterious effects of *minority stressors* faced by these marginalized groups (Boehmer, 2002; Hendricks & Testa, 2012; Meyer, 2013). Meyer's (2013) minority stress theory asserts that stigmatized social groups experience additional stress because of their marginalized social position. Minority stressors for LGBT people include externally-originating stressful events or conditions (e.g., violence, discrimination), anticipation of potential stressful events (e.g., expectations of rejection) at both the interpersonal and institutional levels. Additional minority stressors include the internalization of society's negative views about LGBT people (i.e., internalized homophobia/transphobia), and stress associated with identity concealment (Meyer, 2013).

Not only do LGBT populations experience health problems because of discrimination, but they also have less access to care to treat or prevent those problems. At the most basic level, there is a lack of training for providers about the unique health needs of LGBT people (e.g., Matza, Sloan, & Kauth, 2015). Healthcare employees may themselves endorse negative societal attitudes toward LGBT people, which could adversely affect quality of care. For example, 28% of transgender individuals reported being verbally harassed in a medical setting (James et al., 2016), and LGBT populations report experiencing discrimination in healthcare settings (especially in rural areas), including being denied services, discouraged from discussing sexuality or gender with their provider, and seclusion from cisgender heterosexual populations in residential treatment (Willging, Salvador, & Kano, 2006). In a small study of LGBT veterans, nearly 75% of participants feared experiencing prejudice and discrimination at the VHA because of their sexual or gender minority identity (Sherman et al., 2014). Among women veterans, sexual minorities were more likely to avoid seeking needed medical treatment due to fear of harassment at VHA as compared with heterosexual women veterans (Shipherd et al., 2018).

If minority stress is the mechanism by which access to and quality of care for people in the LGBT community are affected, then the most direct way to decrease disparities in health is to decrease minority stressors and foster resilience. Because minority stressors are a result of negative societal actions and attitudes, creating an environment in which LGBT identifying individuals feel safe and accepted may reduce the effects of minority stress on health outcomes. As such, researchers call for changes in policy associated with an expansion of health services for LGBT populations, increased provider education on LGBT issues, promotion of health-related research in LGBT communities, and the development of safe and welcoming environments for LGBT individuals (Mayer et al., 2008; Romanelli & Hudson, 2017). One study found that a year after Massachusetts legalized same-sex marriage, healthcare costs and utilization decreased, as did the prevalence of depression and hypertension—these findings support the claim that systemic policy changes have an impact on the health and well-being of LGBT people (Hatzenbuehler et al., 2012). Thus, policy and culture changes within and outside of the healthcare system may have an impact on health outcomes of LGBT people.

In addition to having inclusive non-discrimination policies for patients, Mayer and colleagues (2008) suggest that health care institutions use intake forms that inquire about sexual and gender identities. Prominently displaying LGBT affirming brochures and posters in waiting and examination rooms that describe LGBT health risks may prompt open discussion during healthcare visits. Although these seem like micro-level changes rather than systemic, these changes help create an affirming and welcoming healthcare environment for LGBT individuals who look for visual cues of ‘safety’ when entering spaces where they might anticipate rejection or mistreatment. Similarly, the Health Equality Index (HEI)—a voluntary self-assessment for healthcare organizations on their responsiveness to LGBT patients and staff—encourages facilities to provide LGBT patients the ability to self-identify in their health records and to actively recruit LGBT employees (Human Rights Campaign Foundation, 2018).

The VHA has recently engaged in several efforts to support Veterans with LGBT and related identities. As an example of initiatives being carried out at a local VHA facility, Ruben and colleagues (2017) implemented changes to increase LGBT cultural competency within the VA Boston Healthcare System. The initiative focused on forming a diversity committee, creating local policies to protect LGBT staff and patients, conducting studies on the system’s readiness for change and areas to improve, as well as participating in the HEI self-study. Among 97 VHA facilities that participated in the HEI in 2018, 59 received 100% rating on the HEI criteria and were designated 2018 LGBTQ Healthcare Leaders, and 25 had very high scores, achieving Top Performer status (U.S. Department of Veterans Affairs, 2018a). The VHA LGBT Health Program was established in 2012 to promote quality care for LGBT veterans, including continuous policy review to incorporate LGBT-inclusive language, training programs for VHA staff on issues in LGBT health, inclusion of signs and symbols to welcome LGBT veterans to the facility, and outreach to LGBT populations in the form of healthcare fact sheets specific to certain gender and sexual orientations (Kauth & Shipherd, 2016). Policies, fact sheets and trainings are available to the public (U.S. Department of Veterans Affairs, 2018b).

In 2016, the VHA LGBT Health Program launched the LGBT Veteran Care Coordinator (LGBT VCC) Program to promote policy implementation and to disseminate best practices for serving LGBT veterans. The three goals of this project were 1) to understand key barriers and facilitators to providing LGBT affirming care at VHA facilities as well as 2) key barriers and facilitators to carrying out role and responsibilities of the LGBT VCC in the first year of the program. We also aimed to 3) gather feedback on how to improve the LGBT VCC Program.

Methods

Participants and Procedures

The LGBT VCC Program mandates that all VHA facilities appoint at least one LGBT VCC (a clinical provider), and that this person has time set aside to fulfill the administrative duties. The amount of allocated time is negotiated by the VCC and their facility director. VHA facilities vary in size and complexity. Sometimes, the facility is centralized in one hospital, but more often a facility includes surrounding smaller community-based outpatient

clinics that can be several miles away from the main hospital. By maintaining a flexible policy, the facility director is able to appoint multiple LGBT VCCs in these locations or allocate more time to the LGBT VCC to travel to all sites encompassed in the facility.

The roles of the LGBT VCC are to: (1) monitor the environment of care and provide corrective actions as needed, (2) provide staff training and consultation to facilitate cultural competency in serving LGBT veterans, (3) participate in LGBT-related outreach and community events, (4) serve as a point person to advocate for LGBT veterans and bring about solutions to challenges relating to LGBT inclusion, (5) develop relationships with VHA Patient Advocates and other key stakeholders (e.g., facility police) to coordinate care and resolve conflicts for LGBT veterans, (6) communicate with leadership in the VHA and community organizations, (7) implement policies to ensure LGBT veterans experience appropriate care, and (8) create a safe and affirming environment for LGBT veterans. These responsibilities are key strategies for improving quality affirming care and access to services.

All LGBT VCCs (N=170) were invited by email to participate in an online quality improvement survey in the spring of 2017. Participation was voluntary, and we did not collect identifying information. This project was determined to be a non-research activity by the Research & Development Committee of the VA Boston Healthcare System as the data were coordinated there as a part of ongoing quality improvement of the national program. Therefore, the project was exempt from review by the Institutional Review Board.

Measures

We developed a brief self-report survey to gather information about the implementation of the LGBT VCC program in its first year (2016–2017). To learn more about our LGBT VCCs, we included questions on sociodemographic information (including whether they self-identified as LGBT or ally), VHA employment history, amount of allocated time for the LGBT VCC role, and major accomplishments of Year 1. We asked 10 questions about the LGBT VCC's self-efficacy in carrying out specific responsibilities (e.g., training employees in LGBT health topics and affirming care, responding to complaints from LGBT veterans, raising concerns about quality of LGBT care with leadership, improving the welcoming environment). We also asked a series of open-text (qualitative) questions (1) to better understand key barriers and facilitators to providing affirming care at the local VHA facility, (2) to better understand barriers and facilitators that LGBT VCC's faced when carrying out their responsibilities, and (3) to gather feedback and recommendations on how to improve the program going forward.

Codebook development and coding

We used the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009) to guide directed content analysis (Hsieh & Shannon, 2005). The CFIR provides a menu of constructs that are associated with successful implementation of new practices. We used the CFIR to identify barriers and facilitators across domains during our initial implementation efforts. CFIR domains include *Characteristics of the Intervention* (e.g., key attributes of the program, ability to adapt the program to local needs), the *Inner Setting* (i.e., variables pertaining to the VHA facility, including leadership engagement & organizational

culture), the *Outer Setting* (i.e., variables pertaining to larger systems, including National VHA and political or cultural climate of the region), Characteristics of Individuals (variables pertaining to the LGBT VCC or VHA individual employees), and the Process (variables pertaining to the evaluative process and reflections). We did not include Process because there is not enough time in year one for LGBT VCCs to conduct local program evaluations.

We refined the codebook based on initial review of transcripts and the aims of this project. For simplicity in presentation, we removed CFIR variables that received no codes during analysis. To assist with the coding process, we provided examples of responses that were assigned each code (see Table 1). We also moved the construct “Needs & Resources of Those Served by the Organization” to the *Inner Setting*, since we were interested in organizational constructs at the facility rather than the national level.

We used directed content analysis (Hsieh & Shannon, 2005) for data on barriers and facilitators, and a rapid coding procedure (Neal, Neal, VanDyke, & Kornbluh, 2015) to organize the feedback received from LGBT VCCs. All transcripts (N=79) were double coded by two doctoral-level researchers (independently) and reviewed at weekly meetings to achieve joint consensus (Bradley, Curry, & Devers, 2007). Each time the codebook was refined, both coders re-rated previously coded transcripts so that all transcripts were coded using the final codebook.

Results

Sample characteristics and accomplishments

In total, 79 out of 170 (46%) LGBT VCCs completed the voluntary survey in the spring/summer of 2017. LGBT VCCs represented a range of disciplines, including social work (38%; $n = 30$), psychology (33%; $n = 26$), nursing (13%; $n = 10$), and other clinical disciplines (17%; $n = 13$; e.g., occupational therapy, audiology, optometry). LGBT VCCs had considerable experience in VHA, with 79% ($n = 63$) employed at VHA for more than 3 years, 31% ($n = 25$) employed at VHA for 6 to 10 years, and 28% ($n = 22$) employed at VHA for more than 10 years. Overall, LGBT VCCs reported high self-efficacy for carrying out the responsibilities of their role ($M=3.68$, $SD=1.03$, with 5 maximum). Most LGBT VCCs (62%; $n = 49$) identified as LGBT, and 100% ($n = 30$) of non-LGBT VCCs identified as an ally.

Although facilities were required to appoint at least 1 LGBT VCC, 32% ($n = 25$) reported that their facility appointed 2 or more LGBT VCCs to meet the needs of their healthcare system. Typically, this occurred when there were multiple campuses in one facility, often spread over some distance. Per the policy, LGBT VCC appointments require allocated administrative time, yet 35% ($n = 28$) of LGBT VCCs reported that no time from clinical work had been set aside for LGBT VCC activities. On average, LGBT VCCs reported 3.5 hours of designated time ($SD=4.7$; Range: 0–25 hours) per week. LGBT VCCs suggested that a minimum of 8 hours would be sufficient to carry out their responsibilities, but the actual time needed (beyond 8 hours) would likely vary by number of LGBT VCCs at a given facility, complexity of the care environment, and amount of pre-existing LGBT-focused initiatives.

In the first year of the program, 31% ($n = 25$) of LGBT VCCs expanded LGBT services at their facilities, including support groups, wellness groups (coping skills, therapy), creating interdisciplinary teams for transgender care, or expansion of telehealth services for rural LGBT veterans. In terms of improving visibility and access, 22% ($n = 17$) of LGBT VCCs added secure messaging to MyhealtheVet (a portal for veterans to communicate directly with providers through the electronic medical record). Specifically, LGBT VCCs created a drop-down option for veterans to directly message the LGBT VCC through their medical record. In addition, 65% ($n = 51$) of LGBT VCCs reported that their facilities had launched websites detailing LGBT-relevant services, VHA policies, and the LGBT VCC's contact information. In terms of staff training, 18% ($n = 14$) of LGBT VCCs worked with their facility leadership to mandate online VHA trainings related to LGBT veteran health, and 53% ($n = 42$) of LGBT VCCs presented to VHA staff regarding LGBT health topics. In terms of creating a safe and welcoming environment, 100% ($n = 79$) of LGBT VCCs distributed program materials such as lapel pins, rainbow lanyards, and posters to create a warm and welcoming environment for our LGBT veterans and 71% ($n = 56$) of LGBT VCCs attended an LGBT-focused community event to promote LGBT veterans' health.

Barriers and facilitators to providing quality affirming care for LGBT veterans

LGBT VCCs reported barriers and facilitators to implementation that most commonly fell within the CFIR *Inner Setting* and *Characteristics of Individuals* domains (see Table 2 for full detail). For facilitators, the highest proportion of LGBT VCCs reported leadership engagement (53%; $n = 42$), networks and communications (47%; $n = 37$), available resources (42%; $n = 33$), other personal attributes (34%; $n = 27$), and organizational culture (33%; $n = 26$) as catalysts to providing LGBT-affirming care at their facility. Under barriers, the highest proportion of LGBT VCCs reported difficulties with availability of resources (66%; $n = 52$) leadership engagement (42%; $n = 33$), other personal attributes (39%; $n = 31$), organizational culture (37%; $n = 29$), and individuals' knowledge and beliefs about the innovation (29%; $n = 23$) as limiting the provision of LGBT-affirming care at their facility.

Examples of CFIR *Inner Setting* barriers and facilitators include level of support and LGBT-affirming messaging from the facility director's office, difficulties mandating trainings on LGBT healthcare, the availability of LGBT affirming providers, difficulties blocking clinic time for staff to attend trainings, and the existence of LGBT workgroups or "champions"—dedicated individuals who actively support and believe in LGBT affirming care despite obstacles or resistance (Greenhalgh et al., 2004)—across service lines. Examples of CFIR *Characteristics of Individuals* barriers and facilitators include staff knowledge about LGBT veteran health topics, staff misperceptions that only LGBT "specialists" can provide affirming care, and staff lack of exposure to or biases about LGBT people. LGBT VCCs also highlighted the challenge of identifying the size of the LGBT veteran population served by VHA, since these data are not available through the electronic medical record or other systems of tracking. LGBT VCCs described how data could help them advocate for needed resources. LGBT VCCs also noted that VHA national policies (CFIR *Outer Setting*) were facilitators to provision of affirming care.

Barriers and facilitators to carrying out LGBT VCC role and responsibilities

LGBT VCCs reported barriers and facilitators to carrying out the role and responsibilities that most commonly fell within the CFIR *Inner Setting* and *Characteristics of Individuals* domains (see Table 3 for full detail). Under facilitating factors, the highest proportion of LGBT VCCs reported leadership engagement (52%; $n = 41$), available resources (42%; $n = 33$), networks and communication (39%; $n = 31$), other personal attributes (38%; $n = 30$), individuals' knowledge and beliefs about the innovation and self-efficacy (both 16%; $n = 13$) as catalysts to carrying out the role and responsibilities of being a LGBT VCC. Under barriers, the highest proportion of LGBT VCCs reported difficulties with availability of resources (94%; $n = 74$), leadership engagement (34%; $n = 27$), networks and communications (27%; $n = 21$), other personal attributes (25%; $n = 20$), and organizational culture (18%; $n = 14$) as challenges to carrying out the role and responsibilities of the LGBT VCC. LGBT VCCs also described barriers and facilitators related to the local political (cultural) climate and rurality of the facility, and how this impacted the availability of services in the community for LGBT veterans and staff attitudes towards LGBT people. Given that facility directors selected their LGBT VCCs without any vetting from the national LGBT Health Program, but based solely on the description of duties and candidate qualifications in the memo, we were pleased to find that knowledge was not a primary barrier (10%; $n = 8$).

Examples of CFIR *Inner Setting* barriers and facilitators to carrying out the roles and responsibilities of the LGBT VCC role included amount of designated administrative time and financial support allocated to the LGBT VCC position, quality of communication with and support from facility leadership, support from service line manager (e.g., release from clinical responsibilities to fulfill this administrative role), support of existing LGBT workgroups, the (lack of) perceived need for specific training or services for LGBT veterans, and the size and complexity of the facility covered by one LGBT VCC. Nearly all LGBT VCCs (94%; $n = 74$) identified lack of designated time as a barrier to carrying out the role and responsibilities of the LGBT VCC. In some cases, LGBT VCCs provided examples of leadership or institutional resistance to change (e.g., attitudes that national policies for provision of transgender services are not relevant to their facility; prohibiting [or delaying > 1 year] the display of LGBT affirming signage, delaying agreed-upon initiatives without explanation [i.e., gender neutral bathroom signage], politicizing the LGBT VCC role).

Examples of CFIR *Characteristics of Individuals* barriers and facilitators to the LGBT VCC role included staff biases and chronic burnout (leading to resistance to change in general). LGBT VCCs reportedly received pushback on some initiatives which promoted best practices, wherein providers expressed concerns about stigmatizing clients by asking about sexual behaviors as well as concerns that non-LGBT veterans would react negatively to questions about sexual orientation or gender identities. LGBT VCCs also describe their own personal characteristics, such as self-efficacy in promoting change in the organization, their own knowledge of how to navigate administrative channels and comfort in working with facility leaders, and their own frustration and consignment due to "roadblocks and stagnation" or "over commitment." Some LGBT VCCs raised concern that assuming this role may increase discrimination against themselves (as 62% of LGBT VCCs self-identified

as LGBT; $n = 49$). LGBT VCCs highlighted their strong personal commitment and expertise in LGBT affirming care as key facilitators; they also noted the sense of “community” they gained by participating in the LGBT VCC program and connecting with their local networks.

Recommendations for addressing barriers and facilitators

LGBT VCCs requested additional support from the national LGBT Health Program in securing adequate designated administrative time, engaging with facility leadership, improving VCC-to-VCC networking and communication, tailoring aspects of programming to the needs or “starting points” of facilities, and providing additional educational supports and opportunities for professional development. LGBT VCCs also requested more support for LGBT-related initiatives that are currently not under the LGBT Health Program (e.g., roll-out of a gender identity field, support for participation in the HEI). Recommendations compiled here were integrated into our systematic response to barriers and facilitators.

Discussion

For too long, LGBT health has been an unrecognized area of concern, and not just in VHA (Institute of Medicine, 2011). To appropriately address the health care needs of the approximately 15 million LGBT Americans (Newport, 2018), every health care agency must recognize the role of historical social stigma and institutionalized barriers on care for people with LGBT identities, such as unwelcoming and hostile environments, misgendering, failure to acknowledge non-traditional partners and families, and gaps in provider knowledge and training in LGBT health. LGBT veterans are at particularly high risk of feeling unwelcome and discriminated against (Simpson, Balsam, Cochran, Lehavot, & Gold, 2013; Shipherd, Mizock, & Maguen, 2012), in part due to the legacy of anti-LGBT policies within the military. While it is important that VHA is addressing this unique population, only 30% of veterans receive their care at VHA (National Center for Veterans Analysis and Statistics, 2017). Thus, VHA’s efforts may serve as a model to other health care agencies, which also must improve their awareness and inclusion of LGBT patients, especially LGBT veterans.

This project reports on a new VHA program that was designed to reduce health disparities for LGBT veterans. The top barriers and facilitators to implementing a national the LGBT VCC Program at VHA during its first year (2016–2017) are described. The program utilizes LGBT VCCs (appointed by the facility director) at each VHA facility to oversee various initiatives aimed at improving access and quality of care of LGBT veterans. LGBT VCCs reported on challenges specific to their respective VHA facilities. These findings, organized around key implementation elements, were used to develop a plan to best support the implementation of the program. Specifically, we found that organizational culture (VHA facility-level), leadership engagement, available resources (e.g., designated time), and personal attributes of VHA employees (e.g. attitudes toward LGBT people) were important factors associated with providing affirming care at VHA facilities. Similar barriers and facilitators were found across facilities for LGBT VCCs’ ability to carry out their roles and responsibilities. Specifically, LGBT VCCs noted leadership engagement, available

resources, and the strength of local networks and communications as key barriers or facilitators to carrying out their responsibilities.

In early 2018, the national LGBT Health Program met in person to develop a plan for responding to the barriers and facilitators identified in the first year of the program. Some of the barriers were known to us before this formal evaluation, due to issues raised through individual consultation between LGBT Health Program staff and LGBT VCCs and monthly national calls for LGBT VCCs. As such, there were some issues raised in this report that we were able to respond to in real-time, although other responses will require a staged approach. Repeated quality improvement evaluations, such as this one conducted in year one, will help us understand if supportive efforts have facilitated the success of the program.

In response to the lack of designated administrative time for LGBT VCCs, the LGBT Health Program developed facility guidelines for setting a minimum number of hours for the LGBT VCC role (with input from facility leaders) based on facility size and complexity. In April 2018, the VHA released a memo to the field regarding these guidelines. The memo set a minimum number of hours of designated administrative time by size of the patient population served by the facility, clarified the chain of command in reporting (i.e., LGBT VCCs report to facility leadership), and clarified the role of LGBT VCCs in responding to veteran complaints.

To improve leadership engagement, the LGBT Health Program presented on national calls that included regional and facility leadership to introduce (a) the LGBT VCC Program and (b) discuss the memo regarding guidelines for designated administrative time and reporting structure. To ensure the stability of the LGBT VCC role in supporting the implementation of LGBT-focused VHA policies, the LGBT Health Program embedded the LGBT VCC role and responsibilities directly into the national transgender healthcare policy as it was being updated. The LGBT VCC responsibilities will be included in the healthcare policy for veterans identifying as lesbian, gay and bisexual when that policy is next renewed. On monthly calls, the LGBT Health Program and LGBT VCCs discussed strategies for working with facility leadership, including how to find local funding for initiatives.

To improve networks and communication across the program (VCC-to-VCC) and support professional development. The LGBT Health Program began highlighting success stories and inviting LGBT VCCs to share their lessons learned on national calls and via an LGBT VCC group channel on the VA PULSE website (an internal social media platform for VA employees). One innovative solution that came from the field was the creation of a secure messaging mechanism (via MyhealthVet) for veterans to connect with the local LGBT VCC. Highlighting this solution on a national LGBT VCC call led to several facilities adopting this messaging system. Additionally, the LGBT Health Program formally recognized outstanding activities by LGBT VCCs and others by soliciting nominations for VHA's I CARE awards, ultimately receiving 192 nominations and giving 127 awards. Regional level coordinators were encouraged to meet routinely with the LGBT VCCs in their catchment area to work collaboratively on regional challenges, capitalize on regional strengths, and share knowledge. Although some facilities had created LGBT health webpages, content varied considerably. To improve consistent communication to veterans

about LGBT-related VHA services, the LGBT Health Program published a standardized webpage template for facilities to customize.

Many LGBT VCCs reported that some LGBT Health Program expectations were not realistic given the reality of where their facilities were in terms of staff competency in providing affirming care. For some VHA facilities, identifying an LGBT VCC was their first LGBT-focused initiative, whereas other VHA facilities had a history of LGBT-focused activities that spanned decades (e.g., LGBT workgroups, annual events, community outreach). LGBT VCCs from more developed programs also expressed frustration with monthly programmatic calls that seem too rudimentary. In response, the LGBT Health Program discussed on calls with LGBT VCCs different activity expectations based on facility history, VHA leadership support, and available resources. The LGBT Health Program individually consulted LGBT VCCs about setting improvement goals based on the current state of LGBT affirming care at their facility (i.e., establishing a continuous improvement model rather than national benchmarks). LGBT VCCs themselves had varied levels of training in LGBT health topics and awareness of VHA policies, therefore, the LGBT Health Program began requiring new LGBT VCCs to complete a minimal level of training as part of their onboarding process. In addition, given responses and feedback, we modified the survey to function as an annual productivity assessment.

Limitations

Despite the useful findings, there are several limitations with this project. The survey was voluntary and relied on self-report, therefore findings reflect the thoughts and opinions of only a portion of LGBT VCC who served during the initial year. It is possible that individuals who chose not to respond were not engaged or invested in the program, or simply did not have the time available to complete the survey. It is possible that some LGBT VCCs were appointed by their facility leadership to serve the role without being intrinsically motivated to engage in LGBT affirming initiatives—whereas other LGBT VCC's volunteered for the position based on personal commitment. At the start of the program, we did not specify qualifications beyond holding a clinical position. Thus, it is possible that the findings represent the thoughts and opinions of the most engaged LGBT VCCs and do not represent the breadth of experiences of LGBT VCCs in the program. In addition, the survey relied on participation from LGBT VCCs who were in this position at the time of the assessment. However, there was a large amount of turnover in LGBT VCCs in the first year, likely related to initial appointees being a poor fit. Therefore, some LGBT VCCs had only a few months of experience in their role when asked to reflect on their facility activities.

As with all qualitative analyses, there was a potential for bias to be introduced by the coders. Specifically, coders were the current and former director of the LGBT VCC Program, and in these roles, coders often had intimate knowledge of many of the issues raised in the survey through direct consultation with individual LGBT VCCs over the course of the program. To reduce the possibility of bias, we used directed content analysis and adhered closely to the CFIR model. In addition, coders met regularly to attain consensus on codes and made effort to minimize interpretation beyond the data—i.e., relying on the text rather than knowledge gained through director role to assign codes. To further reduce risk of bias, we made sure not

to collect identifying information from LGBT VCCs. By doing so, we reduced the risk that responses could be linked back to an individual LGBT VCC, thus making it less likely that the coders would bring in outside knowledge during the coding process.

Implications and future directions

The primary implication of this project is that it is possible, even in the largest health care system in the world, to implement structural changes to begin to reduce disparities and barriers to care for LGBT patients. Important features of the point of contact program for LGBT veterans are bi-directional communication that aids in identifying and addressing concerns that arise in the field from LGBT VCCs, facility leadership, and regional leads. Subsequent quality improvement projects will aim to gather the thoughts and opinions of all LGBT VCCs in the program, including the use of interview methods rather as well as a survey. In addition, receiving input from other key stakeholders, including veterans will be essential. In some cases, site visits by the LGBT VCC director may allow for more detailed information on problems faced at the facility where perspectives of veterans and facility leadership could also be collected. Unfortunately, rigorous field assessment is not yet possible due to staffing instability within the LGBT Health Program. In the first year, funding uncertainty led to delay in appointing the initial LGBT VCC Director, as well as hiring for this position long-term. Despite limitations related to design and execution of the quality improvement project, our findings demonstrate the importance of listening to and addressing the concerns (as well as applauding the strengths) raised by staff on the frontline.

LGBT VCC responses highlighted the wide variability across facilities in terms of LGBT-affirming cultural climate and leadership engagement with the program. These findings suggest that LGBT VCCs face additional challenges in implementing LGBT-focused initiatives, because they must also work to shift general attitudes toward LGBT people. LGBT VCCs suggested working with leadership (including regional leadership) to require cultural competency trainings for all staff. This has largely not been implemented as the LGBT Health Program does not have the authority to require these trainings nationally, although facility directors can set training requirements for their staff.

On the other end of the spectrum, LGBT VCCs described some facilities that have been identified as leaders in providing affirming care to LGBT veterans. These findings support the need to tailor program implementation to the developmental stage of each facility, and the need to leverage and develop as mentors the LGBT VCCs who have leadership skills and extensive experience in VHA LGBT health initiatives. For example, we are working to pair LGBT VCCs from mature programs as peer coaches with LGBT VCCs who are leading the first initiatives at their facility. Future plans also include making available specialized trainings for LGBT VCCs that are tailored to the development stage of the facility.

Since the VHA does not collect data on sexual orientation in the medical record, and only recently began collecting self-identified gender identity, there is no systematic way to estimate the size of the LGBT veteran population served at VHA. The lack of data on the size of this population may contribute to some of the issues raised by LGBT VCCs at their facility, such as the belief that the LGBT veteran population at their facility was so small that there was no need for LGBT initiatives. LGBT VCCs also reported that some providers did

not perceive the need for LGBT-focused training, as they did not believe this would change their practice. These points raise concerns about the overall visibility of LGBT veterans as well as awareness about health risks—which may exacerbate physical and mental health disparities among LGBT sub-groups. These challenges are not unique to VHA and demonstrate the negative effect of lack of provider training in LGBT health.

While population-level statistics on LGBT veterans' sexual and gender identities may increase providers and facilities' perceived need for affirming LGBT care, direct feedback from LGBT veterans about the LGBT VCC Program would elucidate how the program improves care for LGBT veterans served at VHA facilities. Because there are many intersecting identities that may contribute to health disparities in LGBT veterans, collecting demographic data such as race, ethnicity, religion, and other aspects of identity could enrich our understanding of LGBT veterans' needs. It is essential to understand how LGBT veterans, especially those with multiple marginalized identities, experience their care at VHA facilities in order to fully address the range of factors influencing LGBT veteran health disparities.

Although the VHA is a unique healthcare system, we believe that our findings are relevant to challenges faced by other healthcare systems aiming to implement affirming care for LGBT patients, including LGBT veterans. Our use of the CFIR was intentional, in that this framework has been used in many types of healthcare settings and systems and provides a common nomenclature for predictors of implementation (as well as potential barriers, facilitators, and outcomes). As such, we imagine that factors such as leadership engagement and allocation of resources (especially staff) time are important facilitators regardless of the healthcare setting. Further, the vast majority of LGBT veterans receive their care outside VHA. As such, we encourage non-VHA healthcare systems to use the CFIR to guide their implementation evaluations and draw similarities and comparison to our case.

Conclusions

Implementation of a new national program across 158 VHA facilities is not quick or easy. The CFIR provided a useful conceptual structure for assessing facilitators and barriers experienced during the startup year. Identifying these barriers and facilitators were key to affecting the implementation of a new national program placing LGBT VCCs in every VHA facility. Organizing findings in this way enabled the LGBT Health Program to effectively promote identified facilitators and respond to key barriers, such as the lack of allocated time for fulfillment of the job duties. Variability across facilities in the first year helped the LGBT Health Program to recognize that at this stage of implementation each facility is best measured against itself. A tailored approach to continuous improvement will help each facility meet their goals as well as work toward national program goals.

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Impact Statement

We report on barriers and facilitators to implementing national policies for providing affirming care to lesbian, gay, bisexual, and transgender (LGBT) veterans served by the Veterans Healthcare Administration (VHA). Our findings highlight the central importance of leadership engagement, resource allocation (especially protected time), and building strong organizational networks when supporting large initiatives aimed at reducing LGBT health disparities. This approach may serve as a model for other health care systems.

Table 1

CFIR domains operationalized for this project

CFIR Domain and Construct	Brief CFIR Definition	Examples
INNOVATION CHARACTERISTICS		
Adaptability	The degree to which an innovation can be adapted, tailored, refined, or reinvented to meet local needs.	Concerns about the applicability of the VCC medical center initiatives to rural clinics.
Design Quality & Packaging	Perceived excellence in how the innovation is bundled, presented, and assembled. Include statements regarding the quality of the materials and packaging.	Visibility of LGBT individuals and community in the facility through events, posters, rainbow lanyards and pins, and other "LGBT-safe signals"
OUTER SETTING		
External Policy & Incentives	A broad construct that includes external strategies to spread innovations including policy and regulations (governmental or other central entity), external mandates, recommendations and guidelines, pay-for-performance, collaboratives, and public or benchmark reporting	National VHA healthcare and patient nondiscrimination policies, including VHA's prohibition on gender confirming surgeries Best practices and professional policies at local, state, or national level that directly influence VA practices or lives of LGBT veterans.
INNER SETTING		
Networks & Communications	The nature and quality of webs of social networks, and the nature and quality of formal and informal communications within an organization. Include statements about general networking, communication, and relationships in the organization, such as descriptions of meetings, email groups, or other methods of keeping people connected and informed, and statements related to team formation, quality, and functioning.	Communication between facility service lines (e.g., Medicine and Mental Health) Infrastructure for LGBT programming locally (e.g., facility leadership quadrad, advisory committee support, LGBT specific initiatives, stakeholders identification, LGBT employee groups) and connections to local, regional and national networks.
Needs & Resources of Those Served by the Organization	The extent to which the needs of those served by the organization (e.g., patients), as well as barriers and facilitators to meet those needs, are accurately known and prioritized by the organization. <i>NOTE: Typically considered Outer Setting in CFIR (moved to Inner Setting for this project)</i>	Organizational (facility) awareness of the needs of LGBT Veterans, and the need for LGBT-affirming practices. Identification of LGBT Veteran patient population. Perceived need for LGBT services.
Culture	Norms, values, and basic assumptions of a given local organization.	LGBT affirming / inclusive organizational culture. Level of LGBT cultural sensitivity among leadership, providers, and front line staff. Inclusive/exclusive environment.
Implementation Climate	The absorptive capacity for change, shared receptivity of involved individuals to an innovation, and the extent to which use of that innovation will be rewarded, supported, and expected within their organization. Include statements regarding the general level of receptivity to implementing the innovation.	Organizational receptivity to changes in practice. Expectations of staff to adopt these changes. Mandatory LGBT care trainings. Responsiveness to requests to complete LGBT initiatives.
Tension for change	The degree to which stakeholders perceive the current situation as intolerable or needing change. Include statements that (do not) demonstrate a strong need for the innovation and/or that the current situation is untenable, e.g., statements that the innovation is absolutely necessary or that the innovation is redundant with other programs.	Sense of urgency for change. Motivation of staff, clinicians, leadership, and Veterans to gain competency in LGBT healthcare.
Relative Priority	Individuals' shared perception of the importance of the implementation within the organization. Include statements that reflect the relative priority of the innovation, e.g., statements related to change fatigue in the organization due to implementation of many other programs.	Level of priority placed on LGBT healthcare in the facility. Additional duty of the LGBT VCC position. LGBT VCC feeling overcommitted due to multiple roles, as a clinician and a VCC

CFIR Domain and Construct	Brief CFIR Definition	Examples
Readiness for Implementation	Tangible and immediate indicators of organizational commitment to its decision to implement an innovation. Include statements regarding the general level of readiness for implementation.	Amount of work previously completed towards LGBT initiatives.
Leadership Engagement	Commitment, involvement, and accountability of leaders and managers with the implementation of the innovation.	Support from leadership (facility director, supervisors, advisory committee members) Leadership's willingness to go beyond what is mandatory to follow LGBT directives. Access to/availability of facility leadership.
Available Resources	The level of resources organizational dedicated for implementation and on-going operations including physical space and time. Include statements related to the presence or absence of resources specific to the innovation that is being implemented.	Amount of designated administrative time for LGBT VCCs. Amount of funding allocated to LGBT initiatives. Availability of competent/trained/LGBT-affirming providers.
Access to Knowledge & Information	Ease of access to digestible information and knowledge about the innovation and how to incorporate it into work tasks.	Training requirements for all staff. Access to providers/frontline staff to provide education on LGBT healthcare/cultural competency.
CHARACTERISTICS OF INDIVIDUALS		
Knowledge & Beliefs about the Innovation	Individuals' attitudes toward and value placed on the innovation, as well as familiarity with facts, truths, and principles related to the innovation.	Focus on knowledge of LGBT health concerns, and the importance of affirming practice. Attitudes towards changing current practices / policies. (NOTE: <i>if referring to personal beliefs about LGBT people, then code as "Other Personal Attributes."</i>) Level of experience working with LGBT populations. Knowledge of the facility / VHA system. Awareness of LGBT culture in the military. Level of staff competency in LGBT healthcare.
Self-efficacy	Individual belief in their own capabilities to execute courses of action to achieve implementation goals.	Knowledge about facility systems. Experience in other LGBT initiatives. Level of confidence providing LGBT specific care, education and advocacy.
Individual Stage of Change	Characterization of the phase an individual is in, as s/he progresses toward skilled, enthusiastic, and sustained use of the innovation.	Provider comfort with asking about LGBT and related identities; comfort with advocating for change.
Other Personal Attributes	A broad construct to include other personal traits such as tolerance of ambiguity, intellectual ability, motivation, values, competence, capacity, and learning style.	Individual commitment to LGBT initiatives. Level of staff resistance due to age, religion, etc. Provider/staff burnout and turnover. Staff biases and attitude towards LGBT individuals.

Note. CFIR domains and definitions from Damschroder et al. (2009). CFIR = Consolidated Framework for Implementation Research; VCC = Veteran Care Coordinator; LGBT = lesbian, gay, bisexual, and transgender (inclusive of individuals who identify as sexual or gender minorities); VHA = Veterans Health Administration; VA = United States Department of Veterans Affairs.

Table 2

Facilitators and barriers to providing affirming care for LGBT veterans

Code	Total ^a <i>n</i>	Facilitator ^b <i>n</i> (%)	Barrier ^c <i>n</i> (%)
Innovation Characteristics			
Adaptability	11	0 (0)	11 (14)
Design Quality & Packaging	3	1 (1)	2 (3)
Outer Setting			
External Policy & Incentives	17	6 (8)	11 (14)
Inner Setting			
Networks & Communications	55	36 (47)	19 (25)
Needs & Resources of Those Served by the Organization	16	5 (6)	11 (14)
Culture	53	25 (33)	28 (37)
Implementation Climate	21	3 (4)	18 (23)
Tension for Change	4	2 (3)	2 (3)
Relative Priority	13	1 (1)	12 (16)
Readiness for Implementation	9	8 (10)	1 (1)
Leadership Engagement	73	41 (53)	32 (42)
Available Resources (e.g., time, financial)	83	32 (42)	51 (66)
Access to Knowledge & Information	30	12 (16)	18 (23)
Characteristics of Individuals			
Knowledge & Beliefs about the Innovation	34	12 (16)	22 (29)
Self-efficacy	7	4 (5)	3 (4)
Individual Stage of Change	12	4 (5)	8 (10)
Other Personal Attributes	56	26 (34)	30 (39)

Note. LGBT = lesbian, gay, bisexual, and transgender (inclusive of individuals who identify as sexual or gender minorities).

^aNumber of times this factor was coded as either a facilitator or a barrier

^bProportion of sample (N=77) that identified this code as a facilitator

^cProportion of the sample (N=77) that identified this code as a barrier

Table 3

Facilitators and barriers to carrying out the roles and responsibilities of the LGBT VCC

Code	Total ^a <i>n</i>	Facilitator ^b <i>n</i> (%)	Barrier ^c <i>n</i> (%)
Innovation Characteristics			
Adaptability	3	1 (1)	2 (3)
Design Quality & Packaging	1	1 (1)	0 (0)
Outer Setting			
External Policy & Incentives	11	7 (9)	4 (5)
Inner Setting			
Networks & Communications	51	30 (39)	21 (27)
Needs & Resources of Those Served by the Organization	4	0 (0)	4 (5)
Culture	23	9 (11)	14 (18)
Implementation Climate	13	2 (3)	11 (14)
Tension for Change	4	2 (3)	2 (3)
Relative Priority	16	3 (4)	13 (17)
Readiness for Implementation	5	4 (5)	1 (1)
Leadership Engagement	68	40 (52)	26 (34)
Available Resources (e.g., time, financial)	104	32 (42)	72 (94)
Access to Knowledge & Information	12	5 (6)	7 (9)
Characteristics of Individuals			
Knowledge & Beliefs about the Innovation	20	12 (16)	8 (10)
Self-efficacy	19	12 (16)	7 (9)
Individual Stage of Change	4	9 (0)	4 (5)
Other Personal Attributes	48	29 (38)	19 (25)

Note. LGBT = lesbian, gay, bisexual, and transgender (inclusive of individuals who identify as sexual or gender minorities); VCC = Veteran Care Coordinator.

^aNumber of times this factor was coded as either a facilitator or a barrier

^bProportion of sample (N=77) that identified this code as a facilitator

^cProportion of the sample (N=77) that identified this code as a barrier