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Veteran Health Equity:

Reflecting on Patient Experiences and Unmet Health Needs Among Veterans of Color

This research is funded in part from Johnson & Johnson's Our Race to Health Equity initiative. The contents of this publication are solely the responsibility of the authors.

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EXECUTIVE SUMMARY

Research has consistently demonstrated the presence and severity of racial health disparities in the U.S., particularly for Black Americans. Many of the root causes of these disparities are complex and associated with various forms of structural discrimination.[1] This study examines the health experiences of veterans of color, particularly their interactions in the VA and Military Health system to better understand racial/ethnic disparities across disease burden, mortality, and indicators of patient healthcare experiences.

Previous research indicates there are racial/ethnic health disparities among veterans across various health indicators.[2] Veterans of color disproportionately represent those diagnosed with PTSD, obesity, and hypertension compared to their white veteran peers.[3] Additionally, evidence shows all-cause mortality disparities among American Indian/Alaskan Native (AI/AN) and non-Hispanic Black veterans.[4]

These documented health disparities offer important context for providers' consideration, especially since Black, Hispanic, and Native Hawaiian/Pacific Islander veterans are more likely to receive a majority of their care from the VA compared to non-Hispanic white veterans.[5] Studies also found that, overall, veterans experience similar rates of perceived racial discrimination compared to nonveterans and that there was no difference in rates of perceived racial discrimination between veterans who use the VA and those who do not.[6]

Overall, a majority of study participants had positive patient experiences from the VA and community providers. Although most participants' perceptions of their patient experiences were largely positive, there was substantial variation in patient experiences when we accounted for gender, and interviews with veterans of color highlight several barriers to care, qualities of both positive and negative healthcare encounters, and considerations for delivering culturally competent care to veterans.

Insights from this study:

THEME 1: BARRIERS TO CARE

Barriers to accessing care, including lack of timely appointments, limited providers, distance to care, and high administrative burden, are perceived as widespread challenges that potentially result in veterans delaying care or experiencing gaps in treatment.

- Veteran survey respondents reported limited availability of providers, providers not listening to their symptoms, and inadequate care coordination as barriers to accessing high-quality care.
- Veterans of color describe their difficulties accessing timely care as a "systemic" problem related to VA resource constraints.
- Distance, travel time, and lack of affordable and reliable transportation were noted as barriers to accessing care for some veterans.
- Administrative burden creates barriers for veterans seeking care.

THEME 2: PATIENT EXPERIENCES

Veterans consider a range of factors when evaluating the quality of their patient experiences and healthcare.

- Veterans of color noted clear communication, timely appointments, and access to Complementary and Alternative Medicine (CAM) as positive attributes of their healthcare interactions.

- Veterans of color cited difficulty obtaining timely appointments, dismissive providers, rude administrative staff, record sharing constraints, complex referral practices, and insistence on prescribing pharmaceutical interventions as characteristic of poor healthcare interactions.
- Limited access to technology, including limited access to the internet or email, and issues accessing medical records constrain veteran agency and impact veteran care.
- Participants described significant gaps in care related to the VA referral process.

THEME 3: CULTURALLY COMPETENT CARE

Veterans of color seek a multidimensional application of culturally competent care, which considers a range of factors, and have implemented strategies to address gaps in receiving culturally competent care.

- One in five veteran of color survey respondents reported they do not receive culturally competent care from their providers and 24% believe their providers do not understand the unique health needs veterans have.
- Factors for consideration in delivering culturally competent care vary situationally, by individual, and may or may not include race as a salient or dominant factor for consideration.
- Veterans of color, especially women, have implemented strategies that confront veteran, racial, and gender stereotypes.
- Some veterans of color intentionally seek care from providers who have experience with military and veteran communities or who themselves have underrepresented identities and/or are from historically underserved communities to feel more understood by their providers.

Recommendations

1. **Improve access to care.** Ensure oversight in accessing care and align providers and support staff with demand. Expand access to telehealth services and reduce barriers to accessing community providers by easing reimbursements and establishing clearer prior authorization rules.
2. **Enhance cultural competency.** Mandate comprehensive cultural competence training for all VA employees who regularly interact with veterans and offer continuing education credits for community care providers in the Veterans Community Care Program. Train providers to understand the unique health needs of veterans of color to ensure more culturally sensitive and effective care.
3. **Support veteran agency.** Improve patient navigation resources within the VA to reduce administrative burden and enhance veterans' ability to manage their health. Increase funding for language translators in communities with high densities of non-English speakers and encourage the use of non-verbal communication cues to bridge communication gaps.
4. **Conduct future research.** Implement strategic plans to improve administrative health equity data collection and evaluation and invest in human-centered approaches to identify current health inequities. Explore geographic variations in racial/ethnic differences in patient experiences and investigate the importance of agency in veteran health to inform evidence-based policy and practice.

INTRODUCTION

Understanding Race and Health Disparities Among Veterans

Previous research indicates that there are racial/ethnic health disparities among veterans across various health indicators.[7] Veterans of color disproportionately represent those diagnosed with PTSD, obesity, and hypertension compared to their white veteran peers.[8] Additionally, evidence shows all-cause mortality disparities among American Indian/Alaskan Native (AI/AN) and non-Hispanic Black veterans.[9]

These documented health disparities offer important context for providers' consideration, especially since Black, Hispanic, and Native Hawaiian/Pacific Islander veterans are more likely to receive a majority of their care from the VA compared to non-Hispanic white veterans.[10] Studies also found that veterans experience similar rates of perceived racial discrimination compared to nonveterans and that there was no difference in rates of perceived racial discrimination between veterans who use the VA and those who do not.[11]

Several hypotheses can explain why researchers may expect to find limited evidence of racial health disparities among veterans. First, on average, veterans are selected into the military because they meet Department of Defense (DoD) standards for good health. In theory, veterans should have minimal racial/ethnic health differences because they had similar health at the start of their military service.[12] Similarly, unlike disparities related to barriers to accessing care in the private sector or from private community-based providers, access to VA care is largely determined by standardized benefit eligibility and, in theory, should be less likely to be impacted by factors such as race or socioeconomic status.[13]

However, as we outlined above, there is evidence that racial health disparities among veterans persist. Veterans of color have likely faced racism and other SDOH prior to their selection into the military that would not disqualify them from serving but might have long term impacts on their health. Some of the negative impacts associated with the social determinants of health may be mitigated or buffered by the standardization of the military (e.g., equal pay, similar housing, benefit eligibility) but it may not eliminate inequities. One possible explanation for the persistence of inequalities is that military accession standards do not account for risk factors that contribute to future health problems. For example, an applicant may meet all accession standards but have been exposed to poor air quality, a risk factor associated with various cancers, cardiac disease, and respiratory diseases.[14] Racial and ethnic minorities are more likely to live in counties with poor air quality,[15] suggesting that racial/ethnic minority applicants may have risk factors for poor health that are not assessed in recruitment standards and may help explain observed health disparities among veterans. Another possible explanation is that legislative standards for equal eligibility for healthcare benefits do not necessarily result in equal access or utilization of benefits. Determination of benefit eligibility is still susceptible to discrimination.[16] And once eligible, veterans' access to care is impacted by several social determinants of health (SDOH), like proximity to the VA or internet access, that create barriers to accessing care and may help explain health disparities among veterans (a point that is explored more fully in the themes and key insights below).

So, while disparities in veteran health outcomes may exist by race, the reasons behind these population level differences are complex and nuanced.

Theoretical Framework

This study aimed to address the paradox of racial/ethnic disparities in health outcomes among veterans. While the analysis of survey data and interview content considers social determinants of health and how race may influence determinants as a crucial aspect of this study, personal agency in health behaviors is also emphasized in the analysis with the goal of improving patient experiences and health outcomes for veterans.

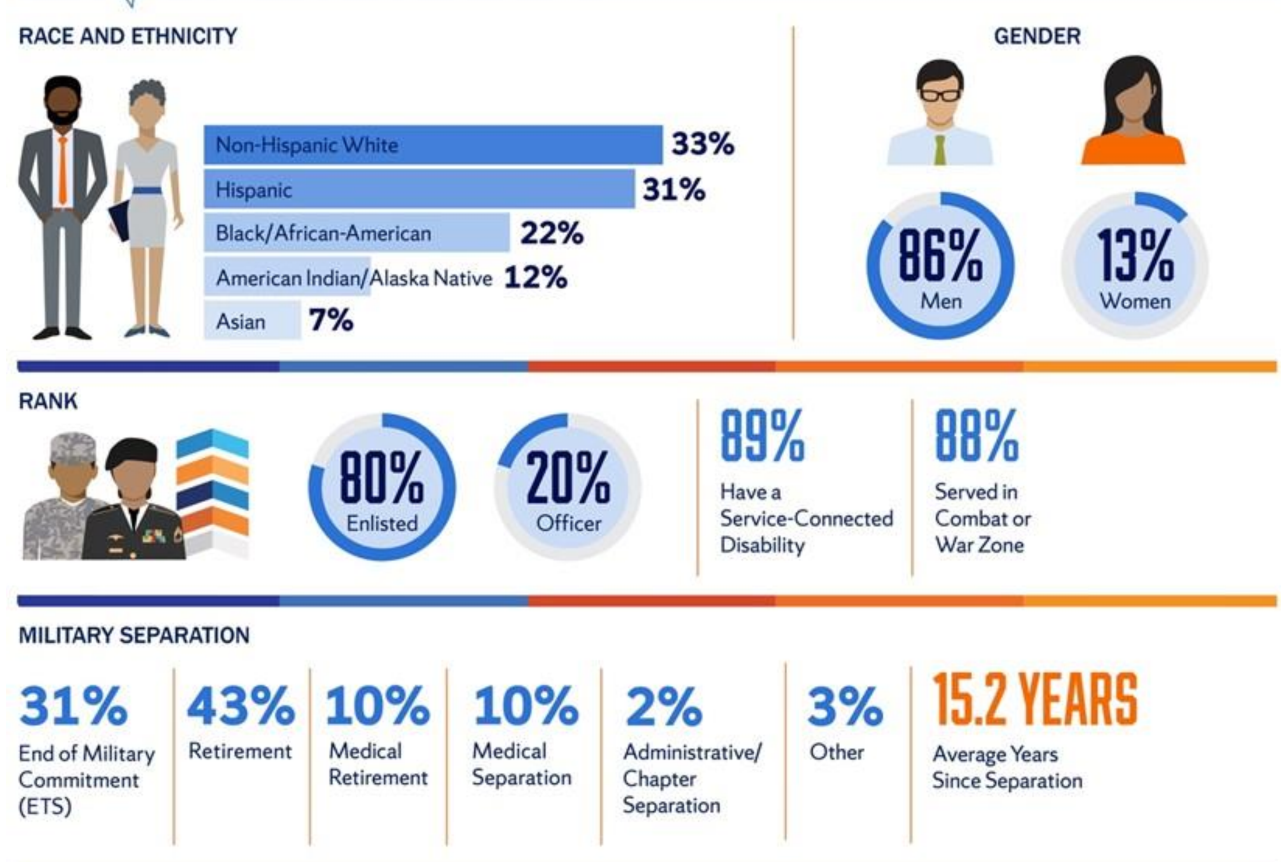
Disparities in access to care and health outcomes for veterans warrant understanding their complexity. First, we use a social determinants of health (SDOH) framework, which emphasizes a range of social factors that are thought to shape an individual's health but are largely out of one's control.[17] This perspective has been applied to the study of veteran health in recent years to discuss the myriad social factors, such as socioeconomic conditions and neighborhood safety, that can influence health but are not necessarily directly linked to medical or clinical factors.[18] Additionally, the SDOH perspective needs to be complemented by another perspective that acknowledges that although many people live in conditions and structures that are outside of their control, all humans have agency, or the capacity for "reflective, purposive, and intentional" action.[19]

Particularly, "human agency" for health-related choices was a prominent theme that emerged throughout discussions with veterans of color who participated in this study. This study considers SDOH and agency together because while SDOH is helpful for understanding factors that influence veteran health that are outside veterans' control, agency is helpful in understanding health-related behaviors.[20] Considering both SDOH and individual agency over health simultaneously acknowledges that the capacity for agency over the actions veterans take is constrained by the structures they live in and that balancing the tension between SDOH and human agency can positively shape veteran health outcomes. This report prioritizes veterans' reflections on barriers to care that they have faced, their patient experiences, including experiences with receiving culturally competent care, and identifying their most pressing unmet health needs. We conclude with recommendations for healthcare providers and practitioners based on these insights.

STUDY METHODS

Phase 1: Understanding the Diverse Needs and Experiences of Veterans Survey

Phase one consisted of online survey distribution, which was made available from October 26 to December 11, 2023, and asked respondents about health, basic demographic information, and was also a recruitment tool for Phase 2 of the study (detailed below). Survey respondents were recruited using convenience sampling through Syracuse University's D'Aniello Institute for Veterans and Military Families (IVMF)'s listserv and social media channels (n=219).[21] More than two-thirds of the sample identified as a veteran of color (American Indian/Alaska Native; Asian; Black/African American; Hispanic; Middle Eastern or Northern African; Native Hawaiian or other Pacific Islander; or "some other race or ethnicity") and approximately 33% of the sample identified as non-Hispanic white.[22] Veteran respondents ranged in age from 29 to 79 years old with an average age of 54 years old. On average, survey respondents reported being diagnosed with four chronic conditions or illnesses (e.g., high blood pressure, diabetes, depression, etc.). Approximately 86% of survey respondents identified as men and 13% identified as women.[23] Sixty-eight percent of survey respondents had a bachelor's degree or greater. More than half of all survey respondents reported being employed full-time or part-time (52%), with 21% unemployed, and 27% retired from the workforce.



Overall, survey respondents in Phase 1 are primarily E5-E9 (64%), and 43% are retired from the military.[24] Figure 1 describes the military service and demographic characteristics of Phase 1 survey respondents.

Since the survey recruitment method employed convenience sampling, there are notable differences between survey respondents in this study and the general veteran population that may impact responses to health-related questions. For example, the survey sample is, on average, younger than the national veteran population.[25] Additionally, most respondents in the Phase 1 study sample received a majority of their health services at the VA and 43% were military retirees, which is higher than the national average.[26]

Phase 2: Focus Groups and One-on-One Interviews

In addition to the survey, this study included qualitative interviews with veteran respondents of color. Focus groups and in-depth one-on-one interviews were conducted over Zoom, and collected detailed information about health decisions, patient experiences, and health outcomes. Aligning with the exploratory nature of this study, focus groups and interview discussions were semi-structured to allowed flexibility for the researchers to probe respondents on (1) elements of their healthcare experiences and (2) their agency in health decisions, alongside race and social determinants of health.[27]

Veteran participants in the focus groups and one-on-one interviews were recruited from the survey in Phase 1.[28] Eligibility to participate in Phase 2 included: (1) participating in Phase 1 of the study, (2) identifying as a person of color (i.e., veteran survey respondent selected at least one racial/ethnic identity other than white), and (3) indicating interest in participating in the qualitative portion of our study at the conclusion of the survey. All veteran respondents who met our inclusion criteria were invited to participate in focus groups or interviews. Between November 15 and December 12, 2023, we conducted five one-on-one interviews and five focus groups via Zoom (n=17). Participants were interviewed in a focus group or one-on-one setting based on scheduling availability and participant preferences.[29] Focus group and interview sessions were recorded with consent from participants, and audio transcripts and notes from the sessions were analyzed to identify key themes in the discussions.

Phase 2 participants included a subsample of participants from Phase 1. Unlike Phase 1, Phase 2 participants are all self-identified as veterans of color: 59% of focus group and interview participants identified as Black, 29% as Hispanic, 18% as American Indian/Alaskan Native, and 6% identified as Asian. Phase 2 participants were of similar age to the overall sample from Phase 1, with participants' ages ranging from 41 to 77 years old and an average age of 54 years old. Phase 2 participants also reported a slightly higher average number of chronic conditions and illnesses (5.4) compared to the overall sample in Phase 1. Nearly 35% of Phase 2 participants were women[30] (n=6) and 65% were men (n=11). Veteran participants in Phase 2 served an average length[31] of 19 years and 59% reported being retirees and 12% reported being medically separated (i.e., having a DoD disability rating of 30% or less and/or having fewer than 20 years of service). Among Phase 2 participants, more than 70% were enlisted, and approximately 88% had a service-connected disability. Finally, 59% of Phase 2 participants reported receiving a majority of their care from the VA.

Healthcare Settings and Understanding Veteran Patient Experiences

Veterans may be eligible to receive their healthcare across various settings, including the VA, Military Treatment Facilities (MTFs), and private or community-based providers.[32] Each healthcare setting has its own eligibility criteria, resources, and set of services and treatments that they offer, all of which may contribute to barriers to care, patient experiences, and quality of care, as well as cultural competency. Understanding the key differences between these healthcare settings provides important context to this study's insights.

Where veterans receive their care is important for understanding health disparities among veterans. Not all veterans go to the VA; only 20% of men and 23% of women veterans receive most of their care from the VA.[33] When studies exclude non-VA healthcare users, we limit our understanding of veteran health needs. It is also important to note, not all healthcare settings are created equal – the VA, MTFs, and community providers each have varying resources, funding, personnel, treatment options, and insurance networks. Finally, not all providers are equipped to address the unique health needs of veterans. For example, only 65% of providers in New York State reported feeling prepared to manage half of the conditions common among veterans.[34] Because understanding where veterans receive their care is important to understanding health disparities, we note the care setting when possible.

Overall, 69% of survey respondents received the majority of their care from the VA. This is much higher than the national average of veterans who receive a majority of their care through the VA.[35] While many of the insights shared throughout this report reflect experiences from the VA, it is important to note that, on average, most veterans do not receive a majority of their care from the VA.

When asked about where they usually go for primary healthcare, 68% of respondents used the VA, 26% used a community-based provider, and 4% used MTFs. When it comes to specialty care, 61% of respondents used the VA, 42% used community-based providers, and 8% of respondents used MTFs.

Veteran survey respondents reported satisfaction with care from private community providers and the VA more frequently compared to care from MTFs.

In this study, we observed that perceptions of quality of care and medical distrust vary widely by race, gender, and the setting in which veterans received their care. Satisfaction with care and trust in providers is associated with several important behaviors including motivation to seek care, greater adherence to treatment plans, and patient's willingness to disclose sensitive information, all of which have been linked to positive health outcomes.[36]

During Phase 1, veteran survey respondents were asked to assess three dimensions of satisfaction with care by indicating their (1) satisfaction with the overall quality of care they receive, (2) satisfaction with communication from their provider and their office, and (3) if they believe that they receive the information and resources they need to manage their care.

Satisfaction with the overall quality of care that veteran respondents receive varies. While health services through the VA, MTFs, or community providers depend on veteran individual's eligibility to be seen, approximately 75% of

veteran respondents reported being satisfied with their care from the VA, 80% were satisfied with their care from private civilian or community providers, and 64% were satisfied with the overall quality of care they receive from MTFs. When comparing overall satisfaction across various health settings by race/ethnicity, we find that 78% of veterans of color survey respondents are satisfied with their VA care compared to 70% of white veteran respondents. Comparatively, 76% of veterans of color reported satisfaction with their care from community providers compared to 87% of white veteran respondents.[37]

When it comes to satisfaction with communication from providers' offices, including returning phone calls and following up with test results, satisfaction differed by care setting. About half of survey respondents reported satisfaction with their provider's communication at MTFs, 71% reported satisfaction with the VA's communication, and 77% reported satisfaction with communication from private civilian or community providers. Proportionally, a greater percentage of veterans of color reported satisfaction with communication within the VA (74%) compared to white respondents (66%), whereas a lower percentage reported satisfaction with communication from community providers (73%), relative to white respondents (85%).[38]

Additionally, 58% of veteran survey respondents who receive care at MTFs believe their providers give them the resources and information necessary to manage their health, compared to 72% of VA patients and 80% of private civilian or community provider patients. Overall, we observed survey responses indicating a poorer performance across a variety of measures of satisfaction with care quality from MTFs. We also observed a substantial majority of veteran survey respondents being satisfied with the VA.

While our data suggest veterans are most frequently satisfied with care received from community providers, numerous studies have found that the VA provides as good or better quality care compared to other healthcare settings.[39] This contrast to earlier findings may reflect that our sample evaluates their satisfaction using different metrics than those used to assess the quality of clinical care, safety, and patient experiences in previous studies. These differences underscore the importance of considering care settings in understanding how veterans evaluate the quality of care that they receive.

THEME 1: BARRIERS TO CARE

Barriers to accessing care, including lack of timely appointments, limited providers, distance to care, and high administrative burden, are perceived as widespread challenges that potentially result in veterans delaying seeking care or experiencing gaps in treatment.

Veteran described limited availability of providers, providers not listening to their symptoms, and inadequate care coordination as barriers to accessing high quality care.

When asked to identify barriers to care (not specific to any one healthcare setting) that they have experienced, veteran survey respondents identified the following three barriers most frequently: (1) limited qualified providers available in their geographic area (22%), (2) providers do not listen to their symptom descriptions or take them seriously (14%), and (3) providers do not coordinate to develop treatment plans or share records (10%).

When it comes to reasons why veteran survey respondents sought care outside of the VA, two barriers to accessing care were frequently cited: (1) long wait times to schedule an appointment (20%) and (2) they live too far from the nearest VA (17%). Addressing barriers to VA care is critical to addressing veteran health disparities as previous studies have established that the VA provides higher quality care than non-VA settings.[40]

Veterans of color describe their difficulties accessing timely care as a "systemic" problem related to VA resource constraints.

Lengthy Waits to Schedule Appointments

Barriers to timely appointments are a national problem across all care settings and have been more pronounced since availability was severely impacted during the height of the COVID-19 pandemic. In 2024, there continues to be a shortage of providers, with estimates suggesting a nationwide deficit reaching 124,000 physicians by 2034.[41] As the PACT Act helps to expand the population of veterans eligible for care, and as the Veterans Community Care Program continues to expand access to covered care from community providers, careful attention must be paid to wait times to ensure that veterans do not experience delays in care.

Appointments and provider availability are metrics often used to evaluate patient access and quality of care.[42] When comparing appointments through the VA system versus community providers, on average, veterans experience shorter wait times for VA appointments. In primary care, veterans wait, on average, 27.9 days for a VA appointment versus 34.8 days to see a community provider. In mental health care, the differences are 34.6 days versus 40.4 days. While the VA system, on average, outperforms community providers for appointment wait times, there is also substantial geographic variation.[43] Additionally, while the national average wait time for an appointment for primary care and mental health care is lower for the VA than for community providers, only 53% of primary care and 41% of mental health care appointments met legislative standards of waits to schedule appointments within 20 days or less as outlined in the MISSION Act.[44] Moreover, there are existing studies that found a significant increase in the racial/ethnic disparities in VA wait times, with Black and Hispanic veterans having longer waits compared to non-Hispanic white veterans.[45]

Long wait times present challenges for veterans, and delays in diagnosis or treatment due to long wait times can contribute to poor health outcomes. For example, every month delayed in cancer treatment can raise the risk of death by around 10%.[46] This increased risk is notable for veterans in particular since cancer diagnosis has been more prevalent among veterans compared to the general population due to service-related factors.[47]

Interviewees Reflect on Wait Times and Delays

In Phase 2, participants described the difficulties and the length of time it takes for them to establish care and receive an appointment with the VA. Getting established as a VA patient took one interviewee more than a year from the time they left service until their first appointment. However, once a veteran is an established patient, they may continue to face delays. An Air Force National Guard veteran remarked that it "takes a long time for the VA to schedule appointments." An interviewee in California explained that she had to wait six months for a psychiatric appointment, and another veteran described waiting three months to receive their prescribed compression socks. These delays were described as "frustrating" and contributing to wavering confidence in the VA's capacity to provide care among several focus group participants. An interviewee further reflected on the consequences of long wait times for healthcare services, commenting, "if you can't get [compression] socks right, how are you going to get a heart attack right?"

These reflections parallel existing research pertaining to medical distrust (e.g., skepticism or lack of confidence that patients have towards providers or the healthcare system).[48] On average, medical distrust is higher among Black patients compared to white patients in the general population.[49] A recent study also found that distrust in the VA healthcare system, in the context of the 2014 waitlist scandal, was higher for Black women compared to white women and higher among Black and Hispanic men compared to white men.[50] Similarly, we also observed a statistically significant difference reflecting higher medical distrust scores among veterans of color respondents and non-Hispanic white veterans respondents. As noted earlier, these racial/ethnic differences in medical distrust are important because distrust can contribute to gaps in care, conformity to treatment plans, and poor health

outcomes.[51] Unfortunately, several of the Phase 2 participants described this barrier as "systemic" and attributed the problem to the VA having too few providers and being resource constrained. While our study was not an evaluation of the VA or other healthcare settings and we cannot evaluate if any barrier is in fact systemic, the fact that participants perceived timeliness as a systemic barrier to accessing care is important in understanding how to address barriers to care for veterans of color.[52] Despite the VA having shorter average wait times than community providers, participants perceive timeliness as a widespread or "systemic" challenge suggesting that improvements in wait times made by the VA may not be felt by all and points to opportunities for further investigation.

Having to travel long distances and lacking affordable and reliable transportation remains a barrier to accessing care for some veterans.

Transportation Barriers and Rural Veterans

Transportation barriers (e.g., having to travel long distances for appointments and lack of access to reliable and affordable transportation) prevent 3.6 million Americans from receiving care every year.[53] Some populations, such as rural communities, are often disproportionately impacted by transportation barriers. More than 66% of all areas designated as having primary healthcare workforce shortages are in rural areas and impact more than 37 million Americans.[54] Workforce shortages may force patients to travel long distances in order to receive care. Proximity to VA and community-based providers may be especially challenging for rural veterans seeking to access care.[55] According to the VA's Office of Rural Health, 4.4 million veterans live in rural areas, and 48% have enrolled with the VA for care. Among rural veterans enrolled with the VA, 10% are racial/ethnic minorities and 8% are women.[56] American Indian/Alaskan Native veterans may be especially susceptible to transportation barriers given that 49% of American Indian/Alaskan Native veterans live in rural communities.[57]

Limited Health Services Linked to Travel Time, Distance, and Cost

In addition to the transportation barriers faced by rural veterans, veterans living in urban areas also face challenges with long travel times, distances, and costs associated with traveling to and from appointments. In this study, an Army retiree explained that "access to care includes getting there," and veterans who "don't have a car or money for the bus" may face additional barriers to receiving care. While the MISSION Act expanded coverage for care from in-network community providers in instances when the average drive time is greater than 30 minutes for primary care or greater than 60 minutes for specialty care, several interviewees who reside in urban communities in Colorado, Texas, and Virginia all recounted their experiences of driving more than an hour to get to their VA appointments. Lengthy travel times may result in additional transportation costs in the form of lost wages if veterans need to take further time off from work.

Participants discussed proximity to VA services as a barrier to accessing care while reflecting on their personal experiences. A former Army officer explained that their local VA center does not offer surgical services. Routine procedures, such as colonoscopies, require a three-hour round trip drive and require that they be accompanied by another adult. In these instances, participants preferred their VA provider refer them to a local private provider because they would "much rather do [the surgical procedures] in the community [in which they reside]." This example illustrates how transportation barriers may limit a veteran's agency in managing their own health by limiting their choice of providers.

Administrative burden creates barriers for veterans seeking care.

Veterans Experience Administrative Burdens that Parallel Those Faced by Non-Veterans

An additional barrier that emerged during focus group and interview discussions is the barrier imposed by administrative burden and red tape. In general, the U.S. healthcare system and relevant social safety nets are plagued by administrative burden and red tape. Administrative burden includes learning costs for understanding program eligibility, insurance networks, and benefits, compliance costs for accurately filling out relevant paperwork, seeking prior authorizations, and disputing billing errors.[58] Administrative burden is a barrier that has been shown to impact access to care for patients from racial/ethnic minority backgrounds and low-income households.[59]

Similar to challenges non-veterans face when searching for in-network providers, veterans struggle with finding community providers that participate in the Veteran Community Care Program. Of survey respondents who use VA care benefits, approximately 40% reported having difficulty finding community providers who accept their VA benefits. Specifically, interviewees described spending significant time searching for in-network providers who accept TRICARE or participate in the Veterans Community Care Program. Even after successfully navigating the referral process for covered community care, some interviewees described further challenges with billing. For example, an interviewee described their experience disputing billing errors due to their dual status as both a retiree (using the VA) and a military spouse (using TRICARE) and reflected that the administrative burden was too costly to overcome and forgone care altogether. This reflection from the participant demonstrates how administrative barriers can impact health and undermine a veteran's agency in managing their health.[60]

Navigating the VA's Bureaucracy

In addition to the administrative burden barriers that are pervasive for all healthcare users, veterans may face further challenges specific to navigating the large and complex VA healthcare system. A former Navy reservist described the administrative burden barrier as "one of the biggest problems that the VA has [because] there is no manual for how to navigate it." One interviewee described their first visit to the VA, which took nearly six hours, while being "totally confused," and "running around the building to get information from anybody who might be willing to help."

Many interviewees described the VA as a "complex machine" and noted that some veterans "have more resources than others" to help them navigate the complexity. For example, an Air Force National Guard veteran with nearly 28 years of service experience explained that because of their leadership position and long length of service, he "knew what [he] was getting into when [he] retired." Challenges associated with navigating the VA bureaucracy may constrain a veteran's agency in managing their health and additional patient navigation resources may be necessary to support them.

Ultimately, veteran survey respondents and veterans of color interviewees highlighted several barriers to care and described how these barriers have impacted their patient experiences and limited their agency in managing their health. In their reflections, when prompted about the possible role of race in experiencing barriers to accessing care, many veterans of color emphasized resource constraints and the confusing nature of the VA health system as the primary explanation behind challenges accessing care that they experienced.[61] Importantly, of the interviewees who noted that race may have a role in shaping barriers to care, they primarily identified as women veterans of color. This difference, at the intersection of race and gender, is further explored in Theme 3.

THEME 2: PATIENT EXPERIENCES

Veterans consider a range of factors in evaluating the quality of their patient experiences and healthcare.

Survey responses and focus group and interview discussions demonstrate that veterans consider a range of factors when evaluating the quality of their care and their patient experiences. In assessing quality of care, veteran survey respondents were asked to compare their healthcare to other veterans. One in ten respondents revealed that they believed the healthcare they received is worse than the care other veterans receive, while 63% reported they believe the care that they received is the same as other veterans. Women veteran respondents reported receiving worse healthcare compared to other veterans more frequently (23%) than men (8%).[62]

Additionally, one in five survey respondents reported feeling that their healthcare concerns are not listened to or taken seriously. Feeling like their concerns are not listened to or taken seriously was more frequently reported by respondents who do not receive the majority of their care from the VA (27%) compared to those who do receive a majority of their care from the VA (18%).[63]

As part of the Phase 2 interviews, participants were asked to reflect on their healthcare experiences broadly, which helped illustrate the salient factors considered by veterans of color in assessing their care and evaluating their patient experiences. Specifically, these insights identify elements of patient experiences and quality of care that have been satisfactory for this population as well as factors that point to opportunities for improvement. Several elements that emerged throughout their reflections parallel objective quality of care metrics used in healthcare assessments, while other elements are more focused on patient experiences lending to a holistic reflection for interviewees.[64] In the section below, we first share commonly identified attributes of positive patient experiences and then discuss the shared attributes of poor patient experiences among veterans of color interviewees.

Veteran interviewees noted clear communication, timely appointments, and access to Complementary and Alternative Medicine (CAM) as attributes of their positive healthcare interactions.

Shared characteristics of good experiences by veteran of color interviewees include clear communication with their provider or provider's staff, receiving timely appointments, being offered non-pharmaceutical treatment options, and patient friendly record sharing policies. A Marine Corps veteran described having "very clear communication about what to expect" during their VA appointment. A long serving Air Force National Guard veteran described having access to helpful resources through TRICARE, such as the diabetes management support program. Another shared attribute of positive experiences includes patient friendly record sharing practices. Interviewees have also described their civilian providers referring them to other providers of alternative medicine as characteristic of positive patient experiences.

A common thread throughout discussions of positive healthcare experiences was the importance of agency and the ability for a patient to exercise that agency in making healthcare decisions. Further reflection from interviewees revealed that veterans of color valued being able to choose providers who were the right fit for their healthcare needs. Several interviewees expressed resistance to pharmaceutical intervention and preferred working with providers who offered alternative treatment modalities. Several participants expressed their preference to not "take pill after pill" and one noted that some cultures are rooted in natural and homeopathic lifestyles. This may be especially true for Native American/Alaskan Native veterans, who may be hesitant to seek care at the VA if they perceive poor alignment with their cultural beliefs and practices.

Interviewees also expressed valuing having an active role in managing their health such as having the agency to obtain their own medical records, working with their providers to develop a treatment plan that aligns with their

individual goals, advocating for their health needs by making appointments and asking for referrals, and being able to educate themselves regarding their health conditions and available or emerging treatment options as important outcomes in healthcare experiences that are considered positive.

Notably, some interviewees also acknowledged that they "may have lucked out" in their overwhelmingly positive experiences. Phase 2 participants voiced concern that these positive experiences may not reflect the experiences of all veterans, for all veterans of color, or of all veterans who use a particular care setting, like the VA. While this was not always their personal experience, veteran interviewees in this study expressed concern over anecdotal examples from veteran peers with constrained agency, who may have greater difficulty in describing positive healthcare experiences. For example, veterans may experience constrained health agency from having a singular source of insurance. Approximately 12% of veterans ages 25-64 have VA care only, and these veterans are disproportionately veterans of color.[65] For veterans who do not have health insurance outside of VA care, their ability to make health and medical choices may be limited to the providers that they can see and the therapies available through VA care.

Veterans of color cited difficulty obtaining timely appointments, dismissive providers, rude administrative staff, record sharing constraints, complex referral practices, and insistence on prescribing pharmaceutical interventions as characteristic of poor healthcare interactions.

In addition to sharing positive healthcare encounters, participants reflected on healthcare experiences they felt needed improvement. While these responses are not necessarily reflective of their overall perception of their quality of care, they point to several issues of consideration among veterans of color in *evaluating* their quality of care and identifying opportunities for improvement across different care settings.

Veteran of color interviewees described difficulty obtaining timely appointments, interactions with dismissive providers and rude administrative staff, and insistence on being prescribed pharmaceutical interventions as part of their negative healthcare interactions that needed improvement.

Limited access to technology and issues accessing medical records constrain veteran agency and impact veteran care.

Internet access is a key determinant of health and a valuable resource in maintaining agency.[66] Rural, aging, and low-socioeconomic status veterans are most likely to have limited access to the Internet and have reduced digital literacy.[67] This means these veterans face additional barriers and are less able to utilize telehealth services, quickly access health-related information, and obtain their electronic medical records. Continual improvements in patient record storage and sharing, such as the conversion to electronic records and the VA's Bridging the Digital Divide initiative to expand access to telehealth services, have been helpful for many, but some veteran patients seeking to access their records continue to face challenges.[68]

Several interviewees highlighted frustration with the inability to access their medical records or their providers' being unable to share their records with other providers in their care team. Patients' ability to access their electronic medical records is part of delivering patient-centered care and is associated with improved patient-provider communication, compliance with treatment plans, and quality of care.[69]

While digital platforms like the VA's My HealtheVet have assisted veterans in scheduling appointments and renewing prescriptions, many veterans continue to struggle with accessing their electronic medical histories. One woman veteran interviewee described challenges with a provider being unable to view their medical records, despite being part of the same provider network. This not only frustrates both patients and providers but also eats

into the valuable and limited time patients have with their providers. Poorly linked medical records also run the risk of requiring patients to recount traumatic events in order to share salient medical information with their providers. Ideally, it would be "easy to share my medical information so I don't have to do a lot of the leg work as a patient trying to get another provider up to speed."

Participants described significant gaps in care related to the VA referral process.

Long wait times for appointments are one of the chief complaints of patients receiving referrals for specialty care. One woman veteran interviewee explained, "my pulmonary care was delayed, specifically so that I could have an in-house appointment," after being referred to a specialist. It was not until May 2023 that the VA established a standard maximum amount of time, 28 days, a veteran must wait for their in-house VA specialty care appointments to take place.[70]

Adding to challenges with the referral process, some providers maintain inaccurate lists used to identify community providers participating in the Veteran Community Care program. A former Marine Corps officer explained that they had to research local specialists themselves to identify an in-network provider after being referred to a specialist who did not work with the VA's Community Care network. This veteran explained that they had to return to their primary care physician at the VA to get a referral for the in-network provider that they identified. While the veteran respondent has the agency to make alternative medical choices in order to obtain the referral they needed, they also described these delays as having both economic, social, and health-related consequences. They described the process as "frustrating," explaining they "can't afford to take off so much time from work and they [VA] don't seem to care about that."

"He seemed to want to harp over the idea of giving me medication. He insisted on me taking medication. After a few different times, I was like, well, he's not listening to me as far as what I want. So, I'll just figure this out on my own and I never went back [to that provider]."

Experiences that participants described as needing improvement underscore the importance of supporting agency in healthcare decisions. For example, respondents emphasized the value of choice in describing their poor experiences with providers who only offered pharmaceutical treatment options. Interviewees also noted that not being able to choose from a variety of available treatment options limits agency. Forcing veterans to choose between adhering to the treatment plan prescribed by their current doctor leads to finding a new provider or discontinuing care altogether. Allowing veterans greater agency (choice) to make their own healthcare decisions, particularly in selecting providers and treatment options, is critical to the continuation of care and possibly addressing disparities in quality of care over the long term among veterans.[71]

THEME 3: CULTURALLY COMPETENT CARE

Veterans seek a multidimensional application of culturally competent care, which considers a range of factors, and have implemented strategies to address gaps in receiving culturally competent care.

Prior research on culturally competent care underscores the importance of provider sensitivity to the unique health needs of veterans.[72] While there is no single agreed upon definition or approach, providing culturally competent care for veterans of color is an approach that can be used to address challenges with barriers to care and poor patient care experiences. But defining culturally competent care is complex and it may not be fully realized when it is not applied across multiple dimensions, or the most salient aspects, of a patient's identity, such as their military affiliation or veteran status. Cultural competence has been defined as the "ability to understand, communicate with, and effectively interact with people across cultures. It is grounded in the respect and appreciation of cultural differences and is demonstrated in the attitudes, behaviors, practices, and policies of people, organizations, and systems."[73]

From discussions of patient experiences with the interviewees, race and gender identity emerged as essential elements participants considered in their own definitions of culturally competent care. The definition and application of culturally competent care should be tailored to address the diverse needs of the veteran population. In the following section, this report presents participants' reflections on culturally competent care and shares the strategies that some veterans have employed to humanize themselves in their patient experiences.

Over a quarter of all veteran survey respondents reported that their healthcare providers do not understand the health challenges that veterans face, pointing towards the need for enhanced understanding of environmental and toxic exposures as well as mental and behavioral health needs when treating veterans.

1 in 5 veteran of color survey respondents reported they do not receive culturally competent care from their providers and believe their providers do not understand the unique health needs veterans have.

Additionally, when examining cultural competency by race and ethnicity, 20% of veterans of color respondents reported that they do not receive culturally competent care from their providers. Receiving culturally competent care may be particularly challenging for women of color veteran survey respondents, with 29% indicating that they do not believe they receive culturally competent care.

Today's veterans are "going to be all different ethnicities. They're going to be female. They can be younger; they can be older." —Army National Guard Veteran

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Although participants did not explicitly use the term culturally competent care, it became clear that race and gender have informed their understanding of what it means to receive culturally competent care as a veteran. When asked about how individual identities may impact care veterans are receiving, a veteran of color interviewee noted that the issue of quality of care may not be as influenced by race as it is by gender, explaining that gender "is a huge discriminating factor when it comes to healthcare." Gender discrimination is not exclusive to a particular healthcare setting or even amongst veterans, with previous studies demonstrating that women of color are at

greater risk of experiencing gender bias in clinical settings.[74] An Army veteran explained that "not listening to women of color is a widespread problem."

Providing culturally competent care to women veterans of color also requires understanding and sensitivity surrounding traumatic experiences, such as Military Sexual Trauma (MST) since more than one in four female veterans screen positive for Military Sexual Trauma (MST).[75] One woman veteran interviewee explained that after discussing their history of MST with a new male provider, they felt so dismissed and traumatized that they waited 19 months before returning to the VA again to seek care. The consequence of delay in care seeking is especially concerning since MST is associated with an increased risk of a variety of health issues, including increased suicide risk, PTSD, Substance Use Disorder, and depression.[76]

Several women who participated in the focus groups and interviews recounted troubling VA encounters that included "feeling more stressed and traumatized than before going [to appointment]," their service being misattributed to their husband, MST being dismissed by male providers. Consistent with negative feedback from interviewees in the study regarding cultural competency among providers, this is a known issue, and there are trainings from the VA for providers to address these challenges.[77]

Veterans of color, and especially women, have implemented strategies that confront stereotypes.

Providing culturally competent care to veterans may require providers to confront certain stereotypes. Some interviewees described facing stereotypes in healthcare settings, such as the "crazy Vietnam vet," "ticking time bombs," and the "angry Black woman."

During the interviews, several participants described intentionally taking measures like attempting to disguise their Spanish accent and wearing high heels and professional attire to avoid stereotypes that interviewees perceive as counterproductive to receiving the kind of medical care they need. For example, an Air Force Retiree explained that she often puts on a "little old lady" persona when she arrives at her appointments. She brings her sewing and tries to be "pleasant" to elicit help from her providers and to avoid being labeled as an "angry Black woman." Another woman veteran interviewee elaborated "I have to be extra polite, otherwise they're going to be like 'I'll get to you when I get to you.'"

An interviewee also explained that they are hesitant to disclose their veteran status to the provider because they fear being stereotyped as a "ticking time bomb." The participant noted that this is especially important when working with community providers because they are likely less familiar with veterans. This veteran's experience counters initiatives like the "Ask the Question Campaign" that aims to promote greater understanding of military and veteran affiliated patient health needs, especially by community providers by asking patients "have you or a family member ever served in the military?"[78] The participant's reflection underscores the importance of bridging gaps between community providers and veteran patients by first dismantling harmful stereotypes about the veteran population and building rapport. Establishing trust between physicians and other healthcare providers and the veteran community is essential to ensuring that veterans feel comfortable in sharing their veteran status with their providers so that they may receive appropriate health screenings and care.

Some veterans of color intentionally seek care from providers with experience with military and veteran communities or those with underrepresented identities or from historically underserved communities to feel more understood by their providers.

Several veteran interviewees described the importance of seeking care from providers (1) who had experience treating veterans or who had a military service background and (2) providers with underrepresented identities or who are from historically underserved communities.

Veterans of color interviewees, overall, noted the importance of receiving care from providers with experience working with military and veteran populations. Some veterans were even advised early in their service careers that they were "going to experience things throughout their career that people just won't understand," so if they want their providers to understand, they need providers who "have like experiences." A Marine Corps retiree explained that they felt they could be "more free and more open" with their fellow veteran mental health counselor compared to their experiences with civilian counselors. While veteran interviewees do not necessarily believe that prior military service is a prerequisite for providers to deliver veterans culturally competent care, participants can perceive civilian doctors as "sometimes not knowing how to approach veteran care." Participants attributed this military-civilian divide to "doctors, nurses, and clinicians being further and further away from the events" that shaped veteran experiences during the time of service.

Some veterans of color participants explained that they, in fact, purposely seek out medical providers with "multiple marginalized identities" because they have been "most receptive to their concerns." This concept is discussed in broader health research as patient-provider concordance. Previous studies have found that patients with racial/ethnic and gender concordance with their providers reported greater patient satisfaction and health outcomes.[79] Our participants explained that providers from racial/ethnic, gender, sexual orientation, and religious minorities often have "insights into being part of that community" and can provide culturally competent care accordingly. These veteran reflections align with previous studies that found racial and gender physician-patient concordance to be associated with positive patient experiences and a greater likelihood of the patient recommending their provider to others.[80] As an Army Reservist explained, "there's something about women [providers] seeing women." When veterans of color seek care from providers from underrepresented and historically underserved communities, they describe feeling understood.

Future Research and Recommendations for Policy and Practice

The themes presented in this report reflect the insights and experiences from a small but unique sample of veterans. While their experiences present opportunities for inquiry around veteran healthcare, it is important to note they do not necessarily reflect the experiences of all veterans or all veterans of color.[81]

This study prioritized race/ethnicity and its relationship to health outcomes and patient experiences using the SDOH framework. However, examples of personal agency in health decisions surfaced as the most salient contributor to veteran health throughout interview participants' reflections. This concept of personal agency was expressed by participants in several ways including a (1) focus on individual health behaviors, within and outside of healthcare settings and (2) participants' use of phrases like "personal accountability" and "it's up to me" to describe their own responsibility in managing their healthcare experiences. While the intent of the study was to explore the role of race in patient experiences and health outcomes with veteran of color participants, some participants did not perceive their racial identity to be a major factor in their interaction with healthcare providers while others agreed that race is an important consideration that may have shaped their experiences. Almost all veteran interviewees mentioned some element of personal agency in obtaining the type of care they deserve and need. Closer examination of attitudes on the impact of race and culturally competent care on health experiences drawing from survey responses and interview reflections revealed several trends:

- Few interviewees reported they had experienced overt racism and more than four in five (83%) veterans of color survey participants do not believe their primary care provider treats them differently because of their race or ethnicity.
- While concepts such as social determinants of health and culturally competent care contribute to analytical frameworks, they might not have resonated with veteran participants. For example, when asked to describe what culturally competent care means to them, some participants stated, "I don't find this concept relevant to me," and "I don't care, I just care about medically competent care."
- Nearly half of all veterans of color who participated in the study are retirees and 20% received a medical separation or medical retirement. There might be inherent differences in managing medical experiences based on retirement status that were not explored in the scope of this project.
- Approximately half of veterans of color in the sample reported a household income of $75,000 or greater (median household income in 2022 was $74,580). Sixty-nine percent of veterans of color in the sample had a Bachelor's degree or higher. These socioeconomic indicators are also important considerations that can be explored in research related to race/ethnicity, personal agency, and veteran health but is beyond the scope of this report.

This study was exploratory and points to several opportunities for future research. First, future studies may consider implementing strategic plans to improve administrative health equity data collection and evaluation. Improvements to health equity data collection and evaluation should consider including actionable plans that designate responsibilities of data collection and evaluation to specific people, offices, or agencies.[82] The collection of complete and accurate patient data is necessary for health equity evaluations. The VA and other large scale health delivery networks should limit missing patient demographic data and commit to regular evaluation of their data to inform policy changes, resource allocation, and service improvements. Results of health equity evaluations should be publicly available to ensure transparency and accountability.

Second, researchers should consider investing in human-centered design (e.g., creative problem-solving approach that prioritizes the needs, preferences, and experiences of patients throughout the design process) approaches to

identify current health inequities and develop corresponding strategic evaluation plans.[83] This approach will re-center veteran agency by engaging with veterans, stakeholders, and healthcare organizations, typically through qualitative research, to identify opportunities to improve patient care experiences for diverse populations.

Third, future research may also want to further explore geographic variation in racial/ethnic differences in patient experiences, such as access to care, to better understand the social structures that may be contributing to inequality and impacting veteran health.

Finally, future studies should continue to investigate the importance of agency in veteran health and identify upstream factors or root causes that constrain veteran agency. This research should be used to inform evidence-based policy and practice.

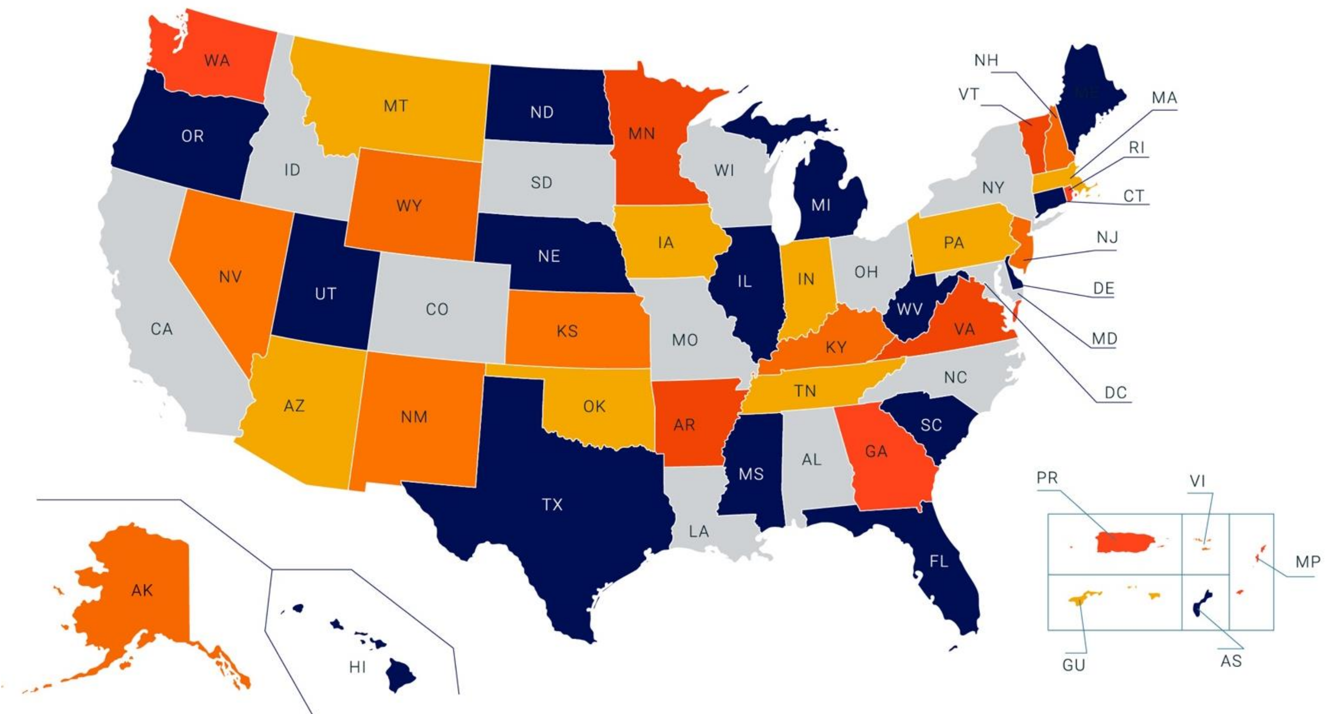
The current study provided insights into patient experiences and unmet health needs among veterans of color. Following insights gleaned from existing research and first-hand reflections from study participants, this report also includes several recommendations for policy and practice. These recommendations are targeted toward various government agencies, medical professionals, Veteran Service Organizations (VSOs), and researchers. Table 1 connects examples provided by participants to instances of constrained agency and presents possible solutions. This study offers the following recommendations as a path forward in advancing veteran health equity.

1. **Improve access to care.** Ensure oversight in accessing care and align providers and support staff with demand. Expand access to telehealth services and reduce barriers to accessing community providers by easing reimbursements and establishing clearer prior authorization rules.
2. **Enhance cultural competency.** Mandate comprehensive cultural competence training for all VA employees who regularly interact with veterans and offer continuing education credits for community care providers in the Veterans Community Care Program. Train providers to understand the unique health needs of veterans of color to ensure more culturally sensitive and effective care.
3. **Support veteran agency.** Improve patient navigation resources within the VA to reduce administrative burden and enhance veterans' ability to manage their health. Increase funding for language translators in communities with high densities of non-English speakers and encourage the use of non-verbal communication cues to bridge communication gaps.
4. **Conduct future research.** Implement strategic plans to improve administrative health equity data collection and evaluation and invest in human-centered approaches to identify current health inequities. Explore geographic variations in racial/ethnic differences in patient experiences and investigate the importance of agency in veteran health to inform evidence-based policy and practice.

Table 1: Veterans Experience Constrained Agency In Healthcare Choices

Example of Constrained Agency	Veteran Provided Examples	Solutions
Timely Appointments	Providers would wait to schedule me with a specialty provider until the maximum allowable amount of time elapsed from a referral in order to keep me within the VA system.	Increase funding for hiring providers and support staff, prioritizing communities with the greatest need, as VA continues to see increased enrollment after passing PACT ACT.
Geographic Barriers	There aren't many providers in my area, so I have to drive a couple of hours to go to the nearest VA.	Expand telehealth availability and reduce barriers to accessing community providers[84] by providing timely reimbursement and clarify rules regarding prior authorization, so that more local providers may be willing to participate in the Veteran Community Care Program.
Intersectional Identities	After sharing my history of experiencing MST with my provider, I felt so dismissed and retraumatized, I waited more than a year to seek care again.	Recruit and retain healthcare professionals from diverse gender and racial/ethnic backgrounds to improve patient-provider gender and racial/ethnic concordance, which is linked to higher patient satisfaction and better health outcomes.
Communication Barriers	I have experienced language and communication barriers in health settings.	Increase funding for language translators in communities with high density of non-English language speakers and encourage medical professionals to use non-verbal communication cues such as eye contact, facial expressions, and tone to help bridge communication gaps.
Physician Rapport with Veteran and Military-Affiliated Populations	I don't always feel comfortable sharing that I am a veteran because I feel like civilian doctors don't know how to treat me and other veterans.	Mandate comprehensive cultural competence training for all VA employees that regularly interact with veterans (e.g., providers, nurses, social workers, medical receptionists) and community care providers participating in the Veterans Community Care Program.
Technology and digital literacy	I know of several veterans who don't use email, so they are not receiving VA newsletters.	Screen patients for home Internet access and connect patients without Internet to services like Digital Divide Consults. Provide resources to support patients wishing to develop their digital and health literacy skills.
Access to CAM	I am Native American and my culture values wholistic interventions and a more natural approach to medicine, but I feel like my providers don't understand that. I really don't want more pills.	Expand funding for CAM and non-pharmacological treatment options. Invest in research to evaluate the effectiveness of CAM and other emerging treatment options. Provide training to providers on culture-related preferences for non-pharmacological treatment options.
Social Support	I did not receive mentorship during transition, I found out about available resources after. Knowing about this stuff [before] would have helped avoid pitfalls.	Connect servicemembers to their local patient advocate and VA social worker immediately upon separation from the military.

Figure 2: State of Residence of Phase 1 Survey Respondents



STATE	COUNT (%)
ALABAMA	2 (1%)
ALASKA	2 (1%)
ARIZONA	5 (2%)
ARKANSAS	3 (1%)
CALIFORNIA	19 (9%)
COLORADO	7 (3%)
CONNECTICUT	4 (2%)
DELAWARE	0 (0%)
DISTRICT OF COLOMBIA	1 (0.5%)
FLORIDA	13 (6%)
GEORGIA	11 (5%)
HAWAII	5 (2%)
IDAHO	2 (1%)
ILLINOIS	9 (4%)
INDIANA	1 (0.5%)
IOWA	1 (0.5%)
KANSAS	2 (1%)
KENTUCKY	2 (1%)

STATE	COUNT (%)
LOUISIANA	5 (2%)
MAINE	0 (0%)
MARYLAND	6 (3%)
MASSACHUSETTS	5 (2%)
MICHIGAN	3 (1%)
MINNESOTA	3 (1%)
MISSISSIPPI	2 (1%)
MISSOURI	2 (1%)
MONTANA	0 (0%)
NEBRASKA	2 (1%)
NEVADA	3 (1%)
NEW HAMPSHIRE	0 (0%)
NEW JERSEY	2 (1%)
NEW MEXICO	5 (2%)
NEW YORK	8 (4%)
NORTH CAROLINA	8 (4%)
NORTH DAKOTA	0 (0%)
OHIO	7 (3%)

STATE	COUNT (%)
OKLAHOMA	4 (2%)
OREGON	1 (0.5%)
PENNSYLVANIA	4 (2%)
RHODE ISLAND	1 (0.5%)
SOUTH CAROLINA	2 (1%)
SOUTH DAKOTA	0 (0%)
TENNESSEE	6 (3%)
TEXAS	24 (11%)
UTAH	4 (2%)
VERMONT	0 (0%)
VIRGINIA	11 (5%)
WASHINGTON	5 (2%)
WEST VIRGINIA	0 (0%)
WISCONSIN	1 (0.5%)
WYOMING	0 (0%)
U.S. TERRITORY	5 (2%)
TOTAL	**218**

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[3] There are also patterns of health differences by gender. Among men, veterans of color have greater odds of reporting fair or poor health, greater odds of reporting having functional limitations, and are more likely to report having severe pain, mental health, infectious disease, and kidney conditions and less likely to report having gastrointestinal conditions and cancers compared to non-Hispanic white men.[3] Similar differences are documented among women veterans, with veterans of color are more likely to report fair or poor health and severe pain compared to non-Hispanic white women. Please see the following: Sheehan, C. M., Hummer, R. A., Moore, B. L., Huyser, K. R., & Butler, J. S. (2015). Duty, Honor, Country, Disparity: Race/Ethnic Differences in Health and Disability Among Male Veterans. *Population Research and Policy Review*, *34*(6), 785–804. https://doi.org/10.1007/s11113-015-9358-9 and Ward, R. E., Nguyen, X. M. T., Li, Y., Lord, E. M., Lecky, V., Song, R. J., Casas, J. P., Cho, K., Gaziano, M. J., Harrington, K. M., & Whitbourne, S. B. (2021). Racial and ethnic disparities in U.S. veteran health characteristics. *International Journal of Environmental Research and Public Health*, *18*(5), 1–15. https://doi.org/10.3390/ijerph18052411; Ward, R. E., Nguyen, X. M. T., Li, Y., Lord, E. M., Lecky, V., Song, R. J., Casas, J. P., Cho, K., Gaziano, M. J., Harrington, K. M., & Whitbourne, S. B. (2021). Racial and ethnic disparities in U.S. veteran health characteristics. *International Journal of Environmental Research and Public Health*, 18(5), 1–15. https://doi.org/10.3390/ijerph18052411

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[14] Source: https://www.niehs.nih.gov/health/topics/agents/air-pollution

[15] Source: Jbaily, A., Zhou, X., Liu, J., Lee, T., Kamareddine, L., Verguet, S., & Dominici, F. (2022). Air pollution exposure disparities across US population and income groups. *Nature (London), 601*(7892), 228-233. https://doi.org/10.1038/s41586-021-04190-y

[16] Source: Brennan, Mariah and Graham, Emily. (2023). Serving Those Who Served: Renegotiating Support and Benefits for Veterans with Less Than Honorable Discharges. Lerner Center Population Health Research Brief Series. Issue Brief #64. Accessed at: https://surface.syr.edu/lerner/232

[17] Specifically, The World Health Organization (WHO) defines Social Determinants of Health (SDOH) as “the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems”.

[18] Please see as an example: Wong, M. S., Steers, W. N., Hoggatt, K. J., Ziaeian, B., & Washington, D. L. (2020). Relationship of neighborhood social determinants of health on racial/ethnic mortality disparities in US veterans—Mediation and moderating effects. *Health Services Research*, 55(5), 851-862. https://doi.org/10.1111/1475-6773.13547 Notably, societal structures determine how resources are distributed and can promote (or obstruct) social change that can affect individuals’ health outcomes. Please see https://www.youtube.com/watch?v=Zhn11EGqnGs&t=7s

[19] Source: https://www.youtube.com/watch?v=Zhn11EGqnGs&t=7s

[20] For an example of the association between social determinants and individual agency in the context of veteran health, please see: Zulman, D. M., Maciejewski, M. L., Grubber, J. M., Weidenbacher, H. J., Blalock, D. V., Zullig, L. L., Greene, L., Whitson, H. E., Hastings, S. N., & Smith, V. A. (2020). Patient-reported social and behavioral determinants of health and estimated risk of hospitalization in high-risk veterans affairs patients. *JAMA Network Open*, 3(10), e2021457-e2021457. https://doi.org/10.1001/jamanetworkopen.2020.21457

[21] Participants were not required to answer all questions, so some questions may have fewer respondents than others. States in which respondents reside is provided in Appendix A.

[22] Racial/ethnic identity was a self-report measure that allowed participants to select all applicable racial/ethnic identities that they felt best described them. Because many respondents reported more than one race/ethnicity, the sample’s racial/ethnic composition will not equal 100%.

[23] Less than 1% of our survey respondents self-identified as transgender or nonbinary (n=2).

[24] Retirees receive additional benefits, including a pension and contributions to retirement savings accounts after serving 20 years on active duty. Additionally, 10% of survey respondents are medically retired, distinct from retirees, but also eligible for various benefits.

[25] According to the Department of Labor, the median age of male veterans is 65 years, while the median age of women veterans is 51 years. In comparison, the median age of men in our sample is 54 years and the median age of women is 48 years. Please see https://www.dol.gov/agencies/vets/womenveterans/womenveterans-demographics

[26] On average, nationally, 23% of female veterans and 20% of male veterans receive a majority of their care from the VA. Additionally, in 2017, 7.3% of veterans received military retirement benefits. Sources: Tsai, J., Mota, N. P., & Pietrzak, R. H. (2015). U.S. Female Veterans Who Do and Do Not Rely on VA Health Care: Needs and Barriers to Mental Health Treatment. *Psychiatric services (Washington, D.C.)*, *66*(11), 1200–1206. https://doi.org/10.1176/appi.ps.201400550 & Katherine G. Giefer and Tracy A. Loveless, “Benefits Received by Veterans and Their Survivors: 2017,” Current Population Reports, P70BR-175, U.S. Census Bureau, Washington, DC, 2021.

[27] Source: Melles, M., Albayrak, A., & Goossens, R. (2021). Innovating health care: key characteristics of human-centered design. *International Journal For Quality In Health Care: Journal Of The International Society For Quality In Health Care*, 33(Supplement_1), 37–44. https://doi.org/10.1093/intqhc/mzaa127

[28] All survey participants who self-identified as a veteran of color, by selecting at least one racial/ethnic identity other than white, were asked at the very end of the survey if they were interested in participating in a follow up interview. All eligible respondents who indicated their interest in participating in Phase 2 focus groups and interviews and provided their email were contacted by members of our research team to coordinate the scheduling.

[29] Researchers and interviewees participated in the focus group or interview sessions from a private location to ensure that participants felt comfortable sharing potentially sensitive experiences.

[30] This total includes one veteran who identifies as a transgender woman.

[31] Due to how the question was asked on the survey, length of service cannot be calculated for those who serve in more than one branch. Therefore, average length of service reported refers to the average length of service among participants who served in a single branch. Importantly, these sample descriptives are not representative of a normal distribution of VA users or the veteran population more broadly.

[32] Military Treatment Facilities (MTFs) are part of the Military Health System. MTF hospitals and clinics are operated by the Department of Defense to support the medical readiness of the armed forces and the readiness of medical personnel (Statute 10 U.S.C. §1073d).

[33] Source: Tsai, J., Mota, N. P., & Pietrzak, R. H. (2015). U.S. Female Veterans Who Do and Do Not Rely on VA Health Care: Needs and Barriers to Mental Health Treatment. *Psychiatric services (Washington, D.C.)*, *66*(11), 1200–1206. https://doi.org/10.1176/appi.ps.201400550

[34] Source: Tanielian, Terri, Carrie M. Farmer, Rachel M. Burns, Erin Lindsey Duffy, and Claude Messan Setodji, Ready or Not? Assessing the Capacity of New York State Health Care Providers to Meet the Needs of Veterans. Santa Monica, CA: RAND Corporation, 2018. https://www.rand.org/pubs/research_reports/RR2298.html. Also available in print form.

[35] Source: Tsai, J., Mota, N. P., & Pietrzak, R. H. (2015). U.S. Female Veterans Who Do and Do Not Rely on VA Health Care: Needs and Barriers to Mental Health Treatment. *Psychiatric services (Washington, D.C.)*, *66*(11), 1200–1206. https://doi.org/10.1176/appi.ps.201400550

[36] Please see: Hausmann, L. R. M., Gao, S., Mor, M. K., Schaefer, J. H., & Fine, M. J. (2013). Understanding racial and ethnic differences in patient experiences with outpatient health care in veterans affairs medical centers. *Medical Care*, 51(6), 532-539. https://doi.org/10.1097/MLR.0b013e318287d6e5 & Jones, A. L., Fine, M. J., Taber, P. A., Hausmann, L. R. M., Burkitt, K. H., Stone, R. A., & Zickmund, S. L. (2021). National Media Coverage of the Veterans Affairs Waitlist Scandal: Effects on Veterans' Distrust of the VA Health Care System. *Medical Care*, *59*(2 S), S322–S326. https://doi.org/10.1097/MLR.0000000000001551

[37] The difference in average responses between veterans of color and white respondents is statistically significant for satisfaction with community care, but not statistically significant for VA care.

[38] The difference in average responses between veteran of color respondents and white veteran respondents is statistically significant for the difference in average satisfaction with communication from community providers, but not significant with the VA.

[39] Source: Shekelle P, Maggard-Gibbons M, Blegen M, et al. VA versus Non-VA Quality of Care: A Living Systematic Review. Washington, DC: Evidence Synthesis Program, Health Services Research and Development Service, Office of Research and Development, Department of Veterans Affairs. VA ESP Project #05-226; 2023

[40] Source: Apaydin, E. A., Paige, N. M., Begashaw, M. M., Larkin, J., Miake-Lye, I. M., & Shekelle, P. G. (2023). Veterans Health Administration (VA) vs. Non-VA Healthcare Quality: A Systematic Review. *Journal of general internal medicine*, *38*(9), 2179–2188. https://doi.org/10.1007/s11606-023-08207-2

[41] Source: https://www.aamc.org/news/press-releases/aamc-report-reinforces-mounting-physician-shortage

[42] Source: Six Domains of Healthcare Quality. Content last reviewed December 2022. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/talkingquality/measures/six-domains.html

[43] Source: Feyman Y, Asfaw DA, Griffith KN. Geographic Variation in Appointment Wait Times for US Military Veterans. JAMA Netw Open. 2022;5(8):e2228783. doi:10.1001/jamanetworkopen.2022.28783

[44] Ibid. Feyman Y, Asfaw DA, Griffith KN. Geographic Variation in Appointment Wait Times for US Military Veterans. JAMA Netw Open. 2022;5(8):e2228783. doi:10.1001/jamanetworkopen.2022.28783

[45] Source: Gurewich D, Beilstein-Wedel E, Shwartz M, Davila H, Rosen AK. Disparities in Wait Times for Care Among US Veterans by Race and Ethnicity. *JAMA Network Open.* 2023;6(1):e2252061. doi:10.1001/jamanetworkopen.2022.52061

[46] Source: Hanna T P, King W D, Thibodeau S, Jalink M, Paulin G A, Harvey-Jones E et al. Mortality due to cancer treatment delay: systematic review and meta-analysis *BMJ* 2020; 371 :m4087 doi:10.1136/bmj.m4087 and https://www.bmj.com/company/newsroom/every-month-delayed-in-cancer-treatment-can-raise-risk-of-death-by-around-10/

[47] Source: Laudon Thomas, M. (2020). Veterans with cancer: Providing care in the community. *Clinical Journal of Oncology Nursing*, 24(3), 331-334. https://doi.org/10.1188/20.CJON.331-334

[48] Source: Griffith, D. M., Bergner, E. M., Fair, A. S., & Wilkins, C. H. (2021). Using Mistrust, Distrust, and Low Trust Precisely in Medical Care and Medical Research Advances Health Equity. *American journal of preventive medicine*, *60*(3), 442–445. https://doi.org/10.1016/j.amepre.2020.08.019

[49] Source: Bazargan, M., Cobb, S., & Assari, S. (2021). Discrimination and Medical Mistrust in a Racially and Ethnically Diverse Sample of California Adults. *Annals of Family Medicine*, *19*(1), 4–15. https://doi.org/10.1370/afm.2632

[50] Source: Jones, A. L., Fine, M. J., Taber, P. A., Hausmann, L. R. M., Burkitt, K. H., Stone, R. A., & Zickmund, S. L. (2021). National Media Coverage of the Veterans Affairs Waitlist Scandal: Effects on Veterans' Distrust of the VA Health Care System. *Medical Care*, *59*(2 S), S322–S326. https://doi.org/10.1097/MLR.0000000000001551

[51] Ibid.

[52] For a study that examined the relationship between perceived access to care and medical mistrust among Black women patients please see: Small, L. A., Godoy, S. M., & Lau, C. (2023). Perceptions of healthcare accessibility and medical mistrust among black women living with HIV in the USA. *Culture, Health & Sexuality*, 25(10), 1295-1309. https://doi.org/10.1080/13691058.2022.2155706

[53] Source: Health Research & Educational Trust. (2017, November). Social determinants of health series: Transportation and the role of hospitals. Chicago, IL: Health Research & Educational Trust. Accessed at www.aha.org/transportation

[54] Source: Designated Health Professional Shortage Areas Statistics at https://www.ruralhealthinfo.org/topics/health-care-workforce

[55] Source: https://www.ruralhealthinfo.org/topics/healthcare-access

[56] Source: https://www.ruralhealth.va.gov/aboutus/ruralvets.asp#:~:text=Almost%20a%20quarter%20of%20all,to%20reside%20in%20rural%20communities.

[57] Source: Washington DL (ed). National Veteran Health Equity Report 2021. Focus on Veterans Health Administration Patient Experience and Health Care Quality. Washington, DC: VHA Office of Health Equity; September 2022.

[58] Source: Herd, P., & Moynihan, D. (2021). Health care administrative burdens: Centering patient experiences. *Health Services Research*, 56(5), 751–754. https://doi.org/10.1111/1475-6773.13858

[59] Source: David C. Radley et al., Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance (Commonwealth Fund, Nov. 2021). https://doi.org/10.26099/ggmq-mm33

[60] Source: "How Administrative Burdens Can Harm Health, " Health Affairs Health Policy Brief, October 2, 2020. DOI: 10.1377/hpb20200904.405159

[61] Our methodologies (survey sample size and no comparison group for focus groups/interviews) do not permit us to determine if these barriers described throughout the study are related to race or if they are a product of systemic racism. When possible, we point to existing research to demonstrate how barriers to care may disproportionately impact veterans of color.

[62] This difference between men and women survey respondents was not found to be statistically significant. No statistical significant difference between these responses is likely due to sample size and readers are cautioned against interpreting the lack of statistical significance as being no true difference.

[63] The difference in average response between survey respondents who receive a majority of their care from the VA and those who do not is not statistically significant.

[64] Source: Six Domains of Healthcare Quality. Content last reviewed December 2022. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/talkingquality/measures/six-domains.html

[65] Source: Cohen RA, Boersma P. Financial burden of medical care among veterans aged 25–64, by health insurance coverage: United States, 2019–2021. National Health Statistics Reports; no 182. Hyattsville, MD: National Center for Health Statistics. 2023. DOI: https://dx.doi. org/10.15620/cdc:124453.

[66] Source: Early J, Hernandez A. Digital Disenfranchisement and COVID-19: Broadband Internet Access as a Social Determinant of Health. Health Promotion Practice. 2021;22(5):605-610. doi:10.1177/15248399211014490

[67] Source: Luger, T. M., Hogan, T. P., Richardson, L. M., Cioffari-Bailiff, L., Harvey, K., & Houston, T. K. (2016). Older Veteran Digital Disparities: Examining the Potential for Solutions Within Social Networks. *Journal of medical Internet Research*, 18(11), e296. https://doi.org/10.2196/jmir.6385

[68] For further information about the VA's Bridging the Digital Divide, please see: https://telehealth.va.gov/digital-divide

[69] Source: Trivedi, N., Patel, V., Johnson, C., & Chou, W. S. (2021). Barriers to accessing online medical records in the United States. *The American Journal of Managed Care*, 27(1), 33-40. https://doi.org/10.37765/AJMC.2021.88575

[70] Source: https://www.gao.gov/products/gao-23-105617

[71] Future research is necessary to determine the best approach to expanding provider options available to veterans. Previous studies of the general U.S. population found that enrollment in Medicare Advantage plans decreased when beneficiaries had more plan options to chose from. Careful consideration must be given to which CAM treatment options should be made available to veterans so that CAM may be used to address veteran-specific health needs while protecting vulnerable patients from being encouraged to pursue sham treatments. McWilliams, J. M., Afendulis, C. C., McGuire, T. G., & Landon, B. E. (2011). Complex Medicare advantage choices may overwhelm seniors--especially those with impaired decision making. *Health affairs (Project Hope)*, *30*(9), 1786–1794. https://doi.org/10.1377/hlthaff.2011.0132

[72] Source: Tanielian, Terri, Coreen Farris, Caroline Batka, Carrie M. Farmer, Eric Robinson, Charles C. Engel, Michael W. Robbins, and Lisa H. Jaycox, Ready to Serve: Community-Based Provider Capacity to Deliver Culturally Competent, Quality Mental Health Care to Veterans and Their Families. Santa Monica, CA: RAND Corporation, 2014. https://www.rand.org/pubs/research_reports/RR806.html. Also available in print form.

[73] Source: CSSP (2019). "Key Equity Terms and Concepts: A Glossary for Shared Understanding." Washington, DC: Center for the Study of Social Policy. Available at: https://cssp.org/resource/key-equity-terms-concepts/.

[74] Source: https://www.rand.org/pubs/commentary/2023/01/gender-biases-in-health-care-listen-to-women-about-their.html

[75] Source: Sumner, Jennifer A., Kristine E. Lynch, Benjamin Viernes, Jean C. Beckham, Gregorio Coronado, Paul A. Dennis, Chi hong Tseng, and Ramin Ebrahimi. 2021. "Military Sexual Trauma and Adverse Mental and Physical Health and Clinical Comorbidity in Women Veterans." *Women's Health Issues* 31(6):586–95.

[76] Source: https://www.dav.org/wp-content/uploads/Women-Veterans-Study-2024.pdf

[77] The VA has virtual training tools to help address gaps in delivering culturally competent care. However, it is unclear if these trainings are mandatory for all VA providers and staff who regularly interface with veterans (e.g., social workers or medical administrative staff). To find a list of these courses: https://www.va.gov/ORMDI/DiversityInclusion/Diversity_Inclusion_Training.asp

[78] For additional information: https://www.askthequestion.nh.gov/

[79] Source: Ku, L., & Vichare, A. (2023). The Association of Racial and Ethnic Concordance in Primary Care with Patient Satisfaction and Experience of Care. *Journal of General Internal Medicine*, *38*(3), 727–732. https://doi.org/10.1007/s11606-022-07695-y

[80] Source: Takeshita J, Wang S, Loren AW, et al. Association of Racial/Ethnic and Gender Concordance Between Patients and Physicians With Patient Experience Ratings. *JAMA Network Open.* 2020;3(11):e2024583. doi:10.1001/jamanetworkopen.2020.24583

[81] This is because the sample was skewed by certain demographic characteristics. For instance, the specific demographics of this sample may not reflect the experiences of all women, those who are younger, veterans with only several years of service, or those from junior enlisted ranks.

[82] Source: https://www.gao.gov/products/gao-20-83#summary_recommend

[83] Source: Melles, M., Albayrak, A., & Goossens, R. (2021). Innovating health care: key characteristics of human-centered design. *International Journal for Quality In Health Care: Journal Of The International Society For Quality In Health Care*, 33(Supplement_1), 37–44. https://doi.org/10.1093/intqhc/mzaa127

[84] Source: Mattocks, K. M., Kroll-Desrosiers, A., Kinney, R., Elwy, A. R., Cunningham, K. J., & Mengeling, M. A. (2021). Understanding VA's Use of and Relationships with Community Care Providers Under the MISSION Act. *Medical care*, *59*(Suppl 3), S252–S258. https://doi.org/10.1097/MLR.0000000000001545

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