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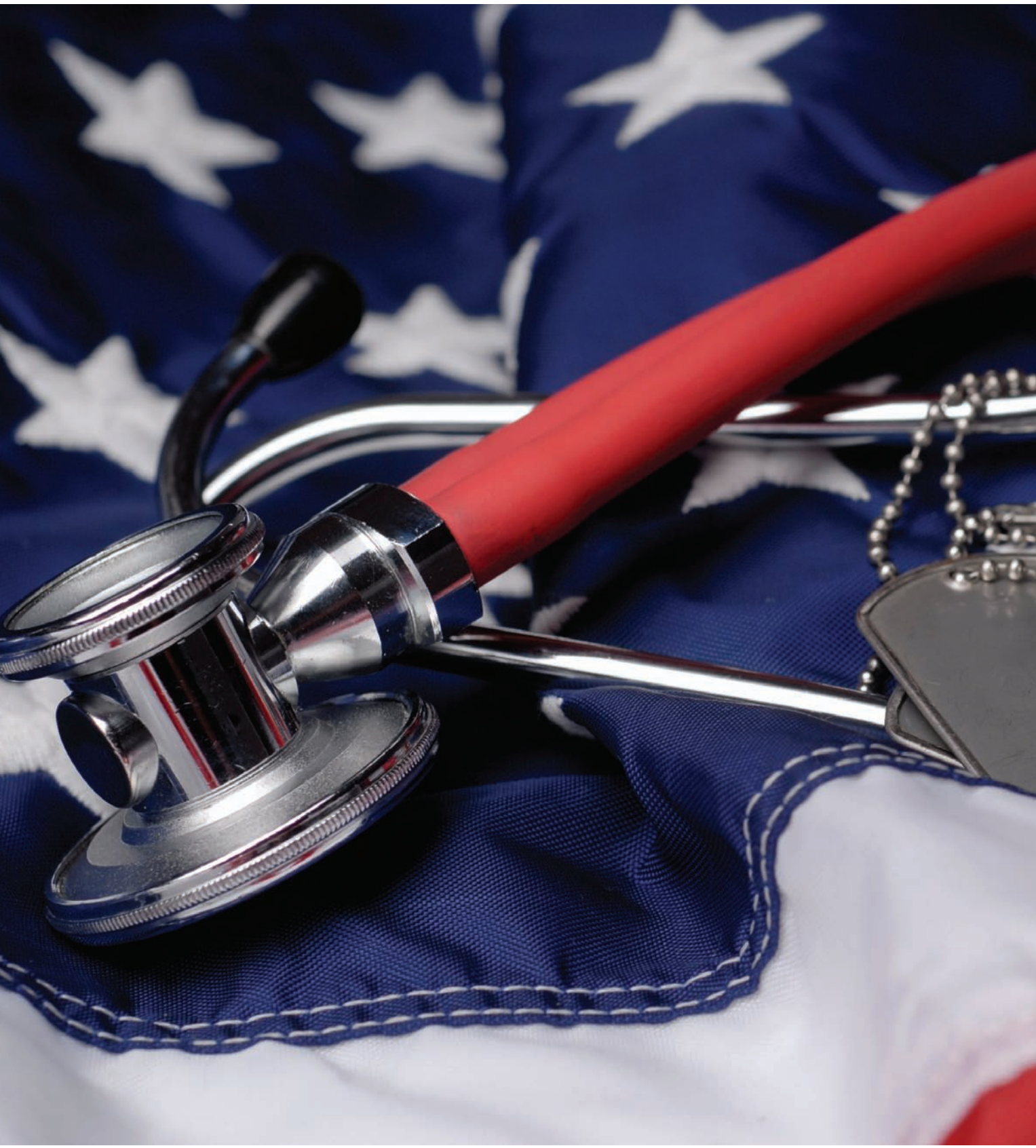

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Meeting the complex healthcare needs of veterans

Abstract: More than half of US veterans seek care outside of the Veterans Health Administration. Physical and mental healthcare needs can be complicated by experiences during military service. Community clinicians can deliver more holistic and comprehensive care to veterans through understanding the unique needs of the veteran population.

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Of the 19 million US veterans, many face unique social, mental, and physical struggles related to their military service placing them as a vulnerable population.[1] Some will struggle with interpersonal relationships, family life, employment, and housing. Anxiety, depression, suicidality, substance use disorder (SUD), and posttraumatic stress disorder (PTSD) are among some of the mental health conditions veterans experience at a greater rate than the general population. Many will suffer the physical toll of service including trauma, early arthritis, traumatic brain injury (TBI), or chronic pain. Occupational, environmental, and infectious exposures that service members experience can have lasting effects on their health.

The Veterans Health Administration (VHA), a part of the Department of Veterans Affairs (VA), is America's largest integrated healthcare system which provides care to 9 million veterans. VHA has 1,293 healthcare facilities which include: 171 medical centers and 1,112 outpatient sites of care of varying complexity.[2] In 2016, the VA granted full-practice authority to advanced practice registered nurses, excluding certified registered nurse anesthetists, increasing its ability to deliver safe, efficient, and timely healthcare to veterans.[3] This is particularly noteworthy in rural and underserved areas of the country.

Most veterans are eligible for VHA healthcare coverage; however, most receive care from providers in the community.[4] Veterans may have employer insurance within a specific healthcare network that they choose to use, specific specialty care may not be available at their closest VHA facility, or VHA care may not be available in a timely fashion.

Community providers are crucial to meeting veterans' healthcare needs. Unfortunately, veteran-centric competencies are not widely integrated into the curriculum of health professional schools, leaving a gap in community providers' confidence and knowledge about treating veterans' unique needs.[5-7] Additionally, there can be gaps in the exchange of health information of veterans seeking both VHA and community care.

It is crucial for community providers to ask about military service as it influences nearly every aspect of a veteran's

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life; however, many providers do not ask about, and may not be aware of, their patients' military service.[8] An understanding of a patient's military experience can help providers build trust, establish connection, and engage the patient in shared decision-making.

Musculoskeletal conditions

Musculoskeletal (MSK) conditions are common among the veteran population, with more than half of all veteran visits at VHA medical centers focused on an MSK condition.[9] The most common MSK conditions that veterans experience include back pain, joint pain, and osteoarthritis.[10] While the burden of MSK conditions in general society is substantial, veterans have an even greater incidence of MSK conditions. Not only are MSK conditions nearly twice as common in the veteran population, but they also occur at a younger age than in the civilian population.[10] Understanding the nature of injuries sustained on active duty is crucial to understanding MSK conditions among veterans.

While the burden of MSK conditions in general society is substantial, veterans have an even greater incidence of MSK conditions.

Injuries can be separated into combat- and noncombat-related injuries. While injuries received in combat are typically more severe, noncombat-related injuries are six times more common.[12] Blast injuries account for more than 75% of combat-related MSK injuries with gunshot wounds making up 15%-20%. Several factors have contributed to a survivability of battle injuries of 90%. Body armor reduces injury to vital organs; however, many who survive a blast injury will experience a traumatic injury to the extremities, including soft tissue injuries, fractures, or amputations.[12]

Service members are at risk for nonbattle injuries during training, while engaged in their military occupation, and during sport or recreation. Military training is physically demanding and can result in acute traumatic injury, repetitive stress, or overuse injury.[11] During basic training, approximately half of all soldiers will experience an MSK injury, most commonly involving the low back, knee, and ankle. Between 2% and 32% of trainees suffer a lower extremity stress fracture. Shoulder dislocation and anterior cruciate ligament injury occur at a greater incidence in the military population in comparison to civilians.[12]

During training, service members may be wearing heavy loads and body armor while marching, parachuting, or running, putting them at risk for noncombat MSK injury.[11] Military occupational hazards, such as heavy machinery work, military vehicle crashes, or falls, can result in MSK injury.[10] Nearly 90% of the MSK injuries sustained during deployment are noncombat-related.

Injuries continue to affect many veterans with chronic disability and pain well after military discharge.[12] Chronic pain impacts more than 40% of veterans.[10] Of veterans receiving service-related disability benefits from the VA, nearly one-third—one million veterans—are receiving them for a chronic MSK condition or disability.[9]

Veterans have an increased risk for chronic diseases such as obesity, diabetes, or cardiovascular disease with decreased function and sedentary lifestyle due to chronic pain and disability.[13] Veterans also have an increased rate of healthcare utilization, reduced quality of life, and long-term disability. Many veterans with chronic pain and disability may also be affected by comorbid mental health conditions such as PTSD, anxiety, or depression or by TBI, which can have a negative effect on chronic pain and disability, further contributing to decreased physical function and risk for chronic disease.[10]

Traumatic brain injury

TBI is a significant problem among the veteran population, affecting approximately 20% of veterans, which can result from a direct impact to the skull, a blast injury (for example, improvised explosive devices), or an acceleration/deceleration injury.[14] TBIs can occur with either open or closed head injuries and range from mild, or concussion, to severe.[15] Symptoms of TBI can range from nausea, headaches, dizziness, concentration problems, impaired memory, fatigue, insomnia, and tinnitus. Depending upon the location of the brain injury, the veteran may experience personality changes causing emotional lability including severe mood swings, flat affect, aggressive behavior, inflexibility, and compulsive behavior.[16,17]

TBI may impact pituitary gland function causing neuroendocrine effects such as disordered mood and cognitive effects, cardiovascular changes, sleep disturbances, and changes in metabolism.[15-17] Nearly half of all veterans experience chronic pain in comparison to only 25% of civilians. Veterans who have experienced PTSD or a TBI have a substantially elevated risk for development of chronic pain. For those veterans with coexisting PTSD and TBI, their symptoms of PTSD may be exacerbated because of the TBI. This can be especially true with blast injuries during combat deployments.[15]

Mental health

Within military culture, there is a stigma around mental illness and mental health care. Service members may be dissuaded from seeking help due to concern about being viewed as weak or worry about military occupations being affected.[18] This mindset persists in the veteran community as many veterans quietly struggle with mental illness. Among the most common mental health disorders facing veterans today are depression, PTSD, and SUD.[19]

Depression

Depression, one of the common mental health disorders among veterans, is associated with elevated mortality and morbidity.[14] Depression is linked to cardiovascular disease, diabetes, chronic pain, and disability among veterans.[14,19] Eleven percent of veterans are affected by major depressive disorder (MDD) compared with only 7% of the general population. Factors such as separation from family, stress from deployment, trauma, injury, PTSD, TBI, or military sexual trauma (MST) can provoke a new onset or exacerbate underlying depression.[16] Difficulty transitioning to civilian life, lack of healthy coping skills, and lack of positive supports may worsen depression.[14,19]

Veterans should be screened for symptoms for depression. The number and type of deployments (for example, combat) can increase the risk of depression. The symptomology of depression may contribute to the mental and physical health concerns many veterans experience. Veterans with MDD have 2.5 times greater odds for chronic pain. A high comorbidity exists with TBI, PTSD, SUD, and other medical conditions such as cardiovascular disease or diabetes.[14,16,17]

Posttraumatic stress disorder

PTSD can develop after experiencing a traumatic event such as sustaining a serious injury or near-death experience or witnessing a death. Veterans can develop PTSD from events occurring during their service, including combat, or from nonmilitary trauma, such as interpersonal violence. Among veterans who served in the military between the Vietnam War and the war in Afghanistan, the incidence of PTSD is approximately 10%-25%.[14,16]

PTSD symptoms usually begin within 3 months of the traumatic event; however, they can start years afterward. Symptoms can interfere with work and relationships and may include flashbacks or reexperiencing the event through nightmares or frightening thoughts. Veterans may exhibit avoidance behaviors such as staying away from places, events, or objects that are reminders of the traumatic experience.[17] Arousal and awareness symptoms include being easily startled, feeling tense or on edge, and having difficulty sleeping or angry outbursts. Cognitive and mood symptoms such as trouble remembering the event, negative thoughts about oneself or the world, guilt or blame, and inability to enjoy activities can also impact veterans' lives.[20]

Veterans with PTSD may have overlapping psychological disorders, such as SUD, depression, and anxiety, as well as TBI.[15,17,20] A 2020 study by Loignon et al. found that the rate of military personnel developing PTSD after a TBI was 37% while for civilians the rate was less than half at 16%.[16] Veterans with PTSD have a higher medical utilization rate and a higher degree of physical health conditions such as hypertension, obesity, MSK disorders, and cardiovascular disease.[21] Risk of suicide, self-injury, homicide, and substance use are greater for veterans with PTSD than without.[22,23]

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Substance use disorders

Unfortunately, among veterans, SUD is relatively common. Risk factors for SUD include combat exposure, PTSD, and TBI.[20] Frequent deployments and family separation can also contribute to risk. Factors that increase

female veteran SUD risk include intimate partner violence, childhood trauma, sexual abuse, or MST.

Nicotine, alcohol, and cannabis are among the most used substances by military veterans, while prescription and nonprescription drug use is somewhat less common.[20] Tobacco is readily available during deployment and often used for stress relief. It is more widely used among veterans than civilians.[20] Veterans with mental health conditions (for example, PTSD or MDD) have a higher degree of nicotine dependence and opiate use.[24] Substance use has been associated with high-risk behavior and is common among veterans who attempt or die by suicide or engage in self-injurious behaviors.[25]

Hoggatt et al. studied substance use among 6,000 veterans from 30 VA health systems across the US and identified alcohol as the most-used substance over the past 12 months, at 24%.[26] Eleven percent drank alcohol daily in the past 3 months. The second most common was cannabis, at 12%; 5% used cannabis daily in the past 3 months. Thirteen percent met the formal criteria for SUD with the greatest prevalence among veterans who were young and unemployed.

Suicide and self-injurious behavior

The Operation Iraqi Freedom campaign (2003) marked the beginning of an upward trend in suicide among members of the military, ultimately surpassing the civilian suicide rate.[20] The 2019 veteran suicide rate was 31.6 per 100,000 approximately twice as high as the general population rate of 16.8 per 100,000. Veteran suicide remains a significant problem with nearly 20 deaths daily.[27]

Veterans seeking healthcare outside of the VHA are at greater risk for suicide than those receiving care within the VHA.

Veterans seeking healthcare outside of the VHA are at greater risk for suicide than those receiving care within the VHA. Most will have had contact with a primary care provider but not a mental health provider.[20] Providers should consider suicide risk with every veteran. Factors impacting suicide risk include combat exposure, MST, traumatic injury, and difficulty reintegrating back into civilian life. Untreated or undertreated mental illness and SUD increase the risk of suicide and/ or self-injurious behavior. Most veterans who die by suicide are middle-aged or older adults.[20]

Veterans with PTSD, depression, SUD, and access to lethal means such as firearms and who lack positive social support are the most vulnerable for suicide. Other factors are associated with increased risk for suicidal behavior, such as a previous suicide attempt, positive family history for mental illness, and stressful life experiences (for example, conflict with family or partner, illness, or pain). Depression is the strongest predictor for suicide, but substance use, poor impulse control, psychological factors (such as, aggressiveness, anhedonia, high emotional reactivity), and personality disorders play a role.[20,27] Veterans with combined MDD and PTSD have a greater rate of suicide ideation (11-fold increase) and suicide attempt (2.5-fold increase) in comparison to veterans with PTSD alone.[21]

Military sexual trauma

MST can take a variety of forms ranging from remarks about a person's body, to unwanted sexual advances, unwanted touching, or nonconsensual or forced sexual intercourse. Some do not report or disclose their experience because of fear of not being believed, shame, or worry about retaliation. One in 50 males and up to 1 in 3 females experience MST while in military service; however, it is believed to be significantly underreported.[28]

Veterans who have experienced MST may experience symptoms such as fatigue, difficulty sleeping, chronic pain, poor attention, eating disorders, difficulty with memory, headaches, sexual dysfunction, or gastrointestinal complaints. Difficulty with interpersonal relationships as well as SUD may be present.

All VA facilities have MST coordinators that can advocate for and assist veterans with accessing care. VA care for MST is available to all veterans and former service members even if one does not qualify for VA benefits (for example, Other Than Honorable discharge).[28] Alternatively, veterans can communicate with advocates through the Disabled American Veterans organization and obtain assistance and direction for receiving care. Veterans seeking care for MST do not need documentation of the experience to receive treatment through the VA.

Exposures

Those who served in the military are potentially exposed to various hazardous agents that the rest of the

Select list of commonly encountered exposures by war era[31]

OEF/OIF Era	Gulf War Era	Cold War Era	Vietnam War Era	Korean War Era
10/1/2001 to present	8/2/1990 to present	1945 to 1991	11/1/1965 to 4/30/1975	6/25/1950 to 7/27/1953
• Noise	• Noise	• Noise	• Noise	• Noise
• Occupational hazards	• Occupational hazards	• Occupational hazards	• Occupational hazards	• Occupational hazards
• Sand, dust, and particulates	• Sand, dust, and particulates	• Mustard gas	• Hepatitis C	• Cold injuries
• Depleted uranium	• Depleted uranium	• Herbicide testing & storage	• Agent Orange	
• Infectious diseases	• Infectious diseases	• Ionizing radiation	• Other herbicides	
• Traumatic brain injuries	• Chemical and biological weapons			
• Heat and cold injuries	• Oil well fires			
• Burn pits	• Pesticides			
• Rabies	• Heat injuries			

Abbreviations: OEF/OIF—Operation Enduring Freedom/Operation Iraqi Freedom (war in Afghanistan and Iraq)

population are not. Unfortunately, health histories rarely include questions about exposure to these specific agents. Military occupational exposures may include blast and noise-related injuries, infectious diseases, chemicals, radiation, or smoke.[29] Exposures can result in minor acute issues or long-term significant disability and must be inquired about in the health history. (See *Select list of commonly encountered exposures by war era.*)

Infectious diseases

When evaluating risk of exposure to infectious diseases, it is crucial to know the time frame and region where the veteran served. For example, veterans who served in Southwest Asia during the Gulf War era and in Afghanistan in or after 2001 were potentially exposed to malaria, brucellosis, *Campylobacter jejuni*, *Coxiella burnetii* (Q fever), *Mycobacterium tuberculosis*, nontyphoid *Salmonella*, *Shigella*, visceral leishmaniasis, and West Nile virus.[11,20,29] A veteran deployed to this region and exposed to these diseases could have a delayed presentation with vague symptoms.[11]

Blast injuries

According to the US Department of Defense, a blast injury is a "complex type of physical trauma resulting from direct or indirect exposure to an explosion" and can range from "internal organ injuries, including lung and TBI, to extremity injuries, burns, hearing, and vision injuries."[30] Knowledge that a patient has sustained a prior blast injury can guide treatment decisions with any new or lingering symptoms.

Noise-related injuries

Noise-related injuries are common among the veteran population. More than 1.3 million veterans have a service-connected disability due to hearing loss.[31] Exposure to blast from weapons and explosives during training or combat can increase the risk for hearing loss.[11]

Other exposures

Additional occupational exposures include burn pits, asbestos, lead, radiation, industrial solvents, and various types of fuels, among others, and all can negatively impact veterans' health.[11,20,32] Providers should ask veterans if they have been told to participate in any health registries related to exposures as part of their VA medical care or military service.

Female veterans

The role of the female service member has expanded substantially in the past few decades. While we may think of secretaries, switchboard operators, or nurses as historical roles of women in the military, in today's military, women can hold forward leaning

Veteran health resources for community providers

Community Care Provider Education and Training Resources	www.va.gov/COMMUNITYCARE/providers/EDU_Training.asp
Community Provider Toolkit	www.mentalhealth.va.gov/communityproviders/
Military Health History Pocket Card	www.va.gov/OAA/archive/Military-Health-History-Card-for-print.pdf
Military Health System	https://health.mil/
VA/DoD Clinical Practice Guidelines	www.healthquality.va.gov/
Veterans Benefits Administration	https://benefits.va.gov/benefits/
Veterans Health Administration	www.va.gov/health/
Veterans Health Information Exchange	www.va.gov/VHIE/For_Providers.asp

Abbreviations: DoD, Department of Defense; VA, Department of Veterans Affairs

combat or combat support roles. Females have been formally authorized to serve in ground combat roles since 2015.[33]

The number of females on active duty, and subsequently the number of female veterans, has increased, with 14%-16% of the military comprised of females. Female veterans are at greater risk for service-related disabilities, endocrine disorders, MSK injuries or disorders, and mental illness than males. Despite this, less than a quarter of female veterans receive care through the VHA.[33,34]

Community care

Congress enacted the Veterans Access, Choice, and Accountability Act of 2014 (Veterans Choice Act) to expand healthcare access for veterans.[35] The Veterans Choice Act expanded the ability of veterans to obtain medical care through approved non-VHA healthcare facilities under specific conditions.[35]

The Veterans Choice Act was replaced by the VHA Maintaining Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act). The MISSION Act permanently authorized the Veterans Community Care Program.[4] Veterans who are enrolled in VHA care or eligible for VHA care only need to meet one of six criteria to be eligible for community care including: 1) needing a service not available at a VHA facility; 2) living in a US state or territory without a full-service VHA facility; 3) qualifying under the legacy provision related to distance eligibility for the Veterans Choice Program; 4) the VHA cannot provide care within certain designated access standards; 5) the veteran's best medical interests; or 6) a VHA service line does not meet certain quality standards.[35,36] If eligible for community care, the veteran can select a community provider in the VHA's network, or the VHA can select one for the veteran.[37] Prescriptions written by community providers may be paid for or filled by the VHA.[36]

Health information exchange

Section 132 of the MISSION Act authorizes the VHA to share "veteran's confidential VA medical records with non-VA entities, including private entities and other federal agencies, for the purposes of providing health care."[38] Unfortunately, communication issues were not immediately resolved between community providers and the VHA. One area where this has become evident is among veterans requiring maternity care. Mattocks et al.'s study of pregnant female veterans and childbirth using VHA benefits found many believed their non-VHA obstetrician had little information about their VHA past medical history. Interestingly, 92.4% of the subjects in the study planned to return to the VHA for healthcare in the future.[39]

The VHA is working to overcome these communication deficits through the Veterans Health Information Exchange (VHIE). The overarching goal of the VHIE is to build a national network of electronic medical information. The VHIE enables a veteran's comprehensive health summary to be shared between the VHA and community providers, thus eliminating unnecessary medical care duplication.[40]

Currently, there are two ways for community providers to become involved in the VHIE. The first program is VA Exchange, which allows for bidirectional sharing of patient information.[40] The second is VA Direct Messaging, a web-based tool used across the entire VHA system that allows VHA staff members to safely send and accept veteran health records with non-VHA providers who are a part of the DirectTrust Network.[40]

Resources for community providers

The VHA has a wealth of resources available for community healthcare providers to increase their

understanding of the unique healthcare needs of veterans (see *Veteran health resources for community providers*). One of the simplest, yet most practical, tools available is the VHA's military health history pocket card. This printable tool is useful to guide community clinicians through asking difficult or sensitive military health-related questions. Several additional valuable VHA-developed resources for community clinicians are available, including online education and training on clinical practice guidelines.

Summary

Veterans can have unique challenges due to their military service that can add complexity to their healthcare needs. While most veterans are eligible for healthcare within the VHA system, which is of excellent quality, more than half of all veterans will seek healthcare in the community in lieu of or in addition to VHA care. Because most community healthcare providers do not understand veterans' unique needs, gaps in community care for veterans may exist. The healthcare needs of the 10 million veterans who seek care outside of the VHA can be better addressed by community healthcare providers if they have a greater understanding of the unique physical, social, and psychological needs of those veterans. NP

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