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HEALTH EQUITY IN VETERAN POPULATIONS

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LEARNING OBJECTIVES

- Describe the demographic characteristics of the Veteran population
- Articulate the differences in health risks and needs among military service eras
- Discuss the ways in which social determinants of health differ between Veteran and non-Veteran populations
- Describe differences between Veterans who use the U.S. Department of Veterans Affairs (VA) healthcare system and those who do not, and how this affects health equity
- Describe the ways in which intersectionality impacts Veteran health outcomes

INTRODUCTION

Veterans of the U.S. military are a unique population, with military service–related experiences and exposures conferring increased medical and mental health risks. In 2018, there were an estimated 20 million living U.S. Veterans (National Center for Veterans Analysis and Statistics [NCVAS] 2019). The Veterans Health Administration (VHA) is the largest integrated healthcare system in the U.S., with approximately six million Veteran enrollees using VA healthcare services each year. However, a larger number of Veterans use healthcare settings outside of VA for some or all of their healthcare (Frayne et al., 2018). Therefore, both VA and non-VA healthcare providers must be proficient in addressing the healthcare needs of U.S. Veterans.

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HEALTHCARE PROVIDERS IN COMMUNITY (NON-VA) HEALTHCARE SETTINGS: IDENTIFYING VETERANS AND OBTAINING A MILITARY HEALTH HISTORY

For healthcare providers outside of the VA, screening patients about military service (current or past) at initial healthcare visits is important, because many Veterans will not volunteer information about military service, and some will not identify as Veterans.

This screening may be accomplished by asking, "Have you ever served in the military (e.g., on active duty in the U.S. Armed Forces, Reserves, or National Guard)?"

To facilitate obtaining information to help understand patients' military service–related health problems and concerns, VA has developed online resources for obtaining a military health history—Military Health History Pocket Card for Clinicians (Office of Academic Affiliations, 2019).

DEMOGRAPHIC CHARACTERISTICS AND USE OF VA HEALTHCARE

The composition of the U.S. military and the nature of military service have changed over time. Accordingly, the Veteran population is heterogeneous across periods of military service with respect to demographic characteristics, military exposures and sequelae, and their use of VA and non-VA healthcare services. Veterans' demographic characteristics by period of military service are given in Table 15.1. The largest cohort of Veterans, comprising one-third of the Veteran population, are those who served during the Vietnam Era. The median age of Veterans overall, 64 years in 2016, is 20 years older than the median age of non-Veterans. Overall, the size of the Veteran population has declined over time due to aging and military downsizing, decreasing by 23% since 1995 (Eibner et al., 2015). While the overall Veteran population is projected to continue to decrease, the number who served in Iraq or Afghanistan post-9/11 is projected to increase, from 12% in 2014 to 19% to 24% by 2024 (Eibner et al., 2015). The proportionate representation of women has increased and is also expected to continue increasing. Women comprised 8.6% of the 2016 Veteran population and are projected to increase to 11% by 2024 (Eibner et al., 2015). Racial/ethnic minorities comprise 22.3% of all Veterans, but are a steadily growing proportion of Veterans of each of the recent military eras (see Table 15.1). Women Veterans are younger and more racial/ethnically diverse than male Veterans (Frayne et al., 2018; Washington, Bean-Mayberry, Hamilton, Cordasco, & Yano, 2013).

Despite the decreasing size of the Veteran population, the use of VA healthcare has increased over time. For example, between 2005 and 2015, the annual number of Veterans using VA increased from 4.8 million to 5.9 million (Frayne et al., 2018). Overall, 34.9% of Veterans use VA healthcare, though with variation in VA use by military service era cohort (see Table 15.1). With this increase in VA use, the demographic characteristics of VA users have been changing. Women are the fasting growing group, with a 90% increase in the number of women using VA services between 2005 and 2015 in contrast to a 19% increase in the number of men using VA in that time frame.

VETERANS' UNIQUE HEALTH RISKS BY MILITARY SERVICE ERA

The current U.S. Veteran population served in the military during military service periods spanning from World War II to the ongoing Gulf War (Operations Enduring Freedom, Iraqi Freedom,

TABLE 15.1 Veterans Demographic Characteristics by Period of Military Service, 2016

MILITARY SERVICE ERA*	NUMBER (MILLIONS)	AGE, MEDIAN (YEARS)	SEX, % FEMALE	RACE/ETHNICITY, % RACIAL/ETHNIC MINORITY	USE OF VA HEALTHCARE, % USING VA HEALTHCARE
Post-9/11	2.6	35	17.0	34.6	36.4
Gulf War 1 Era	3.2	47	14.3	30.4	29.4
Vietnam Era	6.7	68	3.2	17.3	40.7
Korean Conflict	2.0	83	2.7	12.0	38.2
World War II	1.6**	91	4.5	8.3	36.3
Peacetime only	5.4***	59	9.4	21.0	26.8
All Veterans		64	8.6	22.3	34.9
All Non-Veterans		44	54.7	37.9	0.4

*Gulf War 1 Era 8/02/1990—10/06/2001 (includes Persian Gulf War [8/02/1990—4/06/1991]); Vietnam Era 8/04/1964—1/27/1973; Korean Conflict 6/25/1950—7/27/1953; World War II 12/07/1941—12/31/1946.
**Number includes pre–Korean Conflict peacetime.
***Pre–Vietnam peacetime 2.1 million; post–Vietnam peacetime 3.3 million.
SOURCE: Adapted from NCVAS, "Key Statistics by Veteran Status and Period of Service." 2016 American Community Survey Public Use Microdata Sample.

and New Dawn [OEF/OIF/OND]). Table 15.2 lists unique health risks for each U.S. period of military service, and cross-cutting military environmental exposures and occupational hazards.

The World War II Veterans who are alive today are over 90 years old, and Korean War Veterans are in their mid-80s or older. Three to five percent of military personnel during those service periods were female, compared to 17% today. These Veterans, as well as those who served in the early part of the Cold War, experienced unique health risks related to cold injury (e.g., frostbite), chemical warfare agent experiments, and nuclear weapons testing or cleanup. Long-term and delayed sequelae include peripheral neuropathy, skin cancer in frostbite scars, arthritis in involved areas of cold injuries, and increased malignancy risk for those with significant exposure to ionizing radiation. Similar to non-Veterans in their age cohort, Veterans of those military eras are also subject to the health conditions of aging.

Vietnam-Era Veterans are now approximately 65 to 75 years of age. Near the end of the Vietnam War, compulsory enlistment in the military ended, the 2% cap on the percentage of women allowed in the military was eliminated (Public Law 90-130), and participation of women in the military began a steady increase that continues to this day (Washington et al., 2013). Military personnel serving in Vietnam were exposed to many environmental hazards, including Agent Orange and other herbicides. These exposures have been linked to several types of malignancies, porphyria cutanea tarda, peripheral neuropathy, and spina bifida in offspring. The nature of the combat and military environment during the Vietnam Era significantly increased risk for

TABLE 15.2 U.S. Period of Military Service Eras and Associated Health Risks

PERIOD OF SERVICE	HEALTH RISKS
Any military service era	*Military environmental exposures*: asbestos; burn pit smoke; cold injuries; contaminated water (benzene, trichloroethylene, vinyl chloride); endemic diseases; heat stroke/exhaustion; hexavalent chromium; lead; military sexual trauma; mustard gas; nerve agents; pesticides; radiation (ionizing and nonionizing); sand, dust, smoke, and particulates; TCDD and other dioxins *Occupational hazards*: asbestos, industrial solvents, lead, radiation, fuels, polychlorinated biphenels (PCBs), noise/vibration, chemical agent resistant coating (CARC)
World War II: 12/07/1941–12/31/1946	*Unique health risks*: cold injury; chemical warfare agent experiments; nuclear weapons testing or cleanup
Cold War: 1945–1990s	*Unique health risks*: chemical warfare agent experiments; nuclear weapons testing or cleanup
Korean Conflict: 6/25/1950–7/27/1953	*Unique health risks*: cold injury; chemical warfare agent experiments; nuclear weapons testing or cleanup
Vietnam Era: 8/04/1964–1/27/1973	*Unique health risks*: agent orange exposure; hepatitis C; cold injury
Gulf War (Other): 8/02/1990–10/06/2001 (includes Persian Gulf War [8/02/1990–4/06/1991])	Gulf War (OEF/OIF/OND): Unique health risks: animal bites/rabies; blunt trauma; burn injuries (blast injuries); chemical or biological agents; chemical munitions demolition; combined penetrating injuries; depleted uranium (DU); dermatologic issues; embedded fragments (shrapnel); mental health issues; multi-drug resistant Acinetobacter; oil well fires; reproductive health issues; spinal cord injury; traumatic amputation; traumatic brain injury; vision loss *Immunizations*: anthrax, botulinum toxoid, smallpox, yellow fever, typhoid, cholera, hepatitis B, meningitis, whooping cough, polio, tetanus *Infectious diseases/pathogens*: malaria, brucellosis, *Campylobacter jejuni*, *Coxiella burnetii*, Mycobacterium tuberculosis, nontyphoid Salmonella, Shigella, visceral Leishmaniasis, West Nile virus
Gulf War (OEF/OIF/OND): 10/07/2001—ongoing	*Unique health risks*: same as Gulf War (other), plus malaria prevention: Mefloquine—Lariam *Immunizations*: same as Gulf War (other) *Infectious diseases*: same as Gulf War (other)

OEF/OIF/OND, Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn; TCDD, tetrachlorodibenzodioxin.

SOURCE: Adapted from Office of Academic Affiliations, Department of Veterans Affairs. (2019). Military health history pocket card for clinicians. Retrieved from: https://www.va.gov/OAA/pocketcard

post-traumatic stress disorder (PTSD) and substance use disorder. The Vietnam War was the first U.S. war in which Veterans returned home to a hostile civilian environment, which contributed to readjustment problems and exacerbation of mental health disorders.

Gulf War Veterans, both those who served prior to 2001 and those who served in southeast Asia (Afghanistan, Kuwait, Iraq) in OEF/OIF/OND, are subject to several unique health risks related to combat, the military environment, and mental health sequelae (see Table 15.2). Physical injuries due to combat include amputations, spinal cord injury, and traumatic brain injury (TBI). TBI is an injury to the structure or functioning of the brain from head trauma that immediately results in loss of consciousness, loss of memory for events before or after the event, neurologic deficit or intracranial lesion, or altered mental state (VA, 2016). In contrast to amputations and spinal cord injury, which are generally readily apparent, mild TBI may be missed initially. Common symptoms of TBI may be vague and include cognitive (e.g., poor concentration, difficulty completing tasks), neurosensory (e.g., paresthesia, visual or hearing problems), physical (e.g., dizziness, headache), and psychological (e.g., insomnia, anxiety) effects (VA, 2016).

CHARACTERISTICS OF VETERANS COMPARED TO NON-VETERANS

Veterans differ from U.S. adults who have not served in the military on many social determinants of health, behavioral health risk factors, and prevalence and severity of health conditions that are also present in the general U.S. population. At the time of selection into the military and after completing basic training, military personnel are generally healthier than their same age civilian counterparts, a phenomenon known as the "healthy soldier effect" (McLaughlin, Nielsen, & Waller, 2008). However, after separation from military service, Veterans have a decline in their health over time, such that there is a crossover effect, where their health status is worse than that of non-Veterans (Waller & McGuire, 2011). This crossover effect has been demonstrated in both male and female Veteran populations (Washington, Bird, et al., 2016; Wilmoth, London, & Parker, 2010). Risks for declines in Veterans' health include adverse sociodemographic characteristics and behavioral risk factors, along with the effects of military service. In addition, characteristics of military culture that may be strengths or adaptive behavior while deployed may contribute to vulnerabilities that adversely affect physical or mental health after reintegration into civilian life (Table 15.3). Overall, compared with non-Veterans, Veterans are disproportionately older, male, and less healthy (Eibner et al., 2015).

Social Determinants of Health

Veterans who use VA healthcare, compared with non-Veterans, are more likely to be unemployed (12.6% male Veterans, 12.2% female Veterans, vs. 10.3% male non-Veterans, 9.1% female non-Veterans). College educational attainment was similar for males (percent with college degrees: 30.3% male Veterans; 31.5% male non-Veterans), but female Veterans had higher educational attainment than non-Veterans (percent with college degrees: 48.1% female Veterans; 33.9% female non-Veterans). Veterans using VA are less likely than non-Veterans to have income below the federal poverty level (8.5% male Veterans; 12.3% female Veterans; 12.9% male non-Veterans; 15.3% female non-Veterans; Eibner et al., 2015).

TABLE 15.3 Impact of Military Culture and Healthcare

STRENGTH	GUIDING IDEA	VULNERABILITY
Placing welfare of others above one's own welfare	Selflessness	Not seeking help for health problems because personal health is not a priority
Commitment to accomplishing missions and protecting comrades in arms	Loyalty	Survivor guilt and complicated bereavement after loss of friends
Toughness and ability to endure hardships without complaint	Stoicism	Not acknowledging significant symptoms and suffering after returning home
Following an internal moral compass to choose "right" over "wrong"	Moral code	Feeling frustrated and betrayed when others fail to follow a moral code
Becoming the best and most effective professional possible	Excellence	Feeling ashamed (denial or minimization) of imperfections

SOURCE: U.S. Department of Veterans Affairs. (2015). Military culture: Core competencies for healthcare professionals: Self-assessment and introduction to military ethos (Module 1). Retrieved from https://www.ptsd.va.gov/professional/continuing_ed/military_culture_competencies_hcp.asp

Though several socioeconomic characteristics are more favorable for Veterans compared with non-Veterans, Veterans are over-represented among the homeless population (NCVAS, 2012). In 2010, Veterans accounted for 10% of the U.S. adult homeless population. With VA and federal attention to homelessness, by 2014, the overall number of homeless Veterans declined by 33%; however, the number of homeless women did not show the same decline (U.S. Department of Housing and Urban Development [HUD], 2014). Women Veterans are three to four times more likely to become homeless than non-Veteran women, with risk factors including unemployment, disability, poor physical and mental health, and sexual assault during military service (Washington et al., 2010).

Behavioral Risk Factors

The Behavioral Risk Factor Surveillance System (BRFSS) is an annual national population-based telephone survey that collects data on Veteran status, and several measures of sociodemographic, health, and healthcare utilization characteristics. The 2010 BRFSS found that after adjusting for differences in sociodemographic factors, both male and female Veterans were more likely than non-Veterans to report tobacco use, whereas only male Veterans were more likely to report heavy alcohol use (Hoerster et al., 2012; Lehavot, Hoerster, Nelson, Jakupcak, & Simpson, 2012). Veterans had modestly more physical activity than non-Veterans; however, a longitudinal analysis of women Veterans in the Women's Health Initiative found that Veterans, compared with non-Veterans, had steeper declines over time in their level of physical activity (Bouldin & Reiber, 2012; Washington, Gray, et al., 2016). A majority of both Veterans and non-Veterans were overweight or obese, but this was reported more often in both male (75%) and female (64%) Veterans compared with non-Veterans (70% of males, 57% of females). However, after adjusting for sociodemographic differences, Veteran status was not independently associated with obesity.

Health Conditions

The Medical Expenditure Panel Survey (MEPS), which collects nationally representative data on health conditions and other characteristics of individual households and their members, provides evidence on differences between Veterans and non-Veterans in the prevalence of diagnosed health conditions (MEPS, n.d.-a, n.d.-b). In the 2006 to 2012 MEPS, hypertension (#1) and lipid disorders (#2) were the top two conditions in both groups. Other commonly diagnosed conditions in Veterans (by rank: 1-hypertension; 2-lipid disorders; 3-diabetes mellitus; 4-mental health conditions; 5-cancer; 6-ischemic heart disease; 7-low back pain; 8-gastroesophageal reflux disease) were also among the top ten diagnosed conditions in non-Veterans, though the rank ordered differed somewhat (rank in non-Veterans: 1-hypertension; 2-lipid disorders; 5-diabetes; 3-mental health conditions; 8-cancer; 9-ischemic heart disease; 4-low back pain; 6-gastroesophageal reflux disease).

Veterans had higher diagnosed rates of all conditions except mental health conditions (see Figure 15.1). Compared with non-Veterans, Veterans had double the prevalence of diagnosed

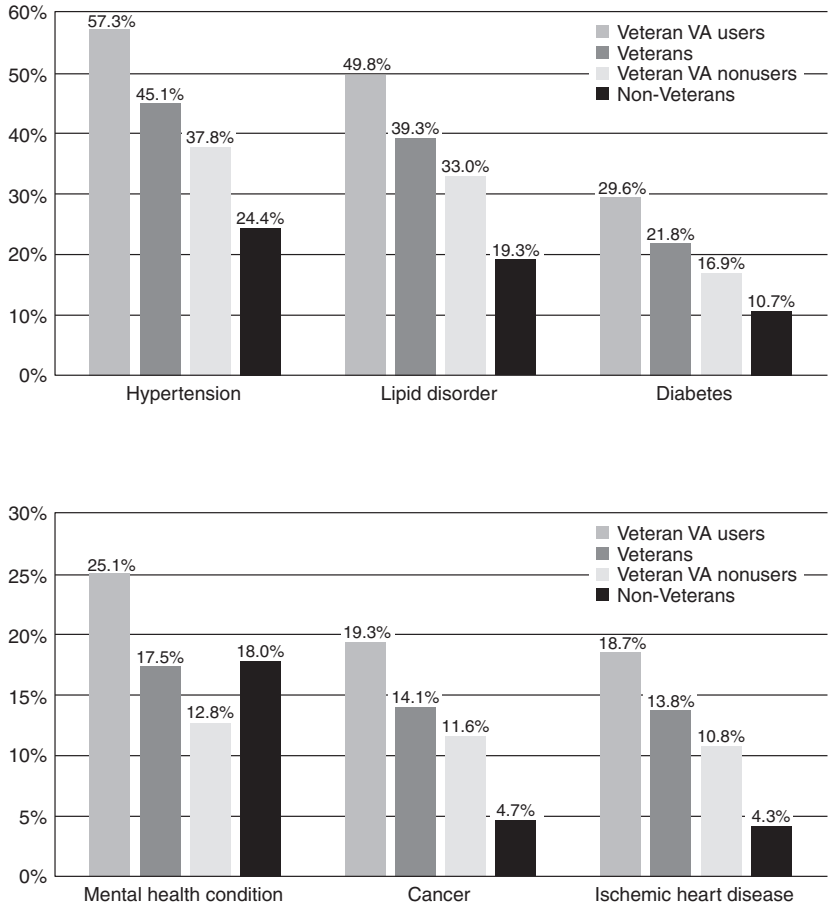

FIGURE 15.1 Comparisons between Veterans and non-Veterans and between Veteran VA healthcare users and non-users in prevalence of common health conditions.

SOURCE: Data from RAND analysis of MEPS 2006–2012 data. Eibner C, RAND Health, 2015.

hypertension, lipid disorders, and diabetes mellitus, and triple the prevalence of diagnosed cancer and ischemic heart disease. Though diagnosed prevalence of mental health conditions in the MEPS survey was similar between Veterans and non-Veterans, there were differences in prevalence of specific mental health conditions. For example, PTSD was diagnosed in 3% of Veterans, in contrast to less than 1% of non-Veterans. Other data sources, that incorporate physical examinations and screeners for active conditions, have identified a higher diagnosed prevalence of physical and mental health conditions among Veterans.

These differences in diagnosed prevalence rates reflect differences between Veterans and non-Veterans in demographic characteristics, healthcare access, and effects of military service. Veterans are older (median age 64 vs. 44) and are comprised of a higher proportion of men (93% vs. 40% in MEPS 2006–2012 data), and therefore would be expected to have higher rates of chronic conditions associated with aging. VA healthcare is available to Veterans with reduced financial barriers to healthcare use compared with healthcare in the broader U.S.; therefore, VA users, to the extent that their eligibility translates into greater healthcare use, may have greater opportunity than non-Veterans to have conditions diagnosed. As noted previously, military service is associated with both service-connected conditions and onset or exacerbations of other chronic conditions. Though it is unclear the extent to which each of these factors contributes to a higher prevalence of diagnosed conditions, these comparisons suggest that healthcare providers and systems that care for Veterans must plan for their greater needs.

Health Status

Findings from the 2010 BRFSS indicated that Veterans had worse health and functioning than non-Veterans on several health indicators. Male Veterans, compared with male non-Veterans, more often reported fair or poor overall health (21% vs. 14% of non-Veterans), and limited activities due to physical, mental, or emotional problems (30% vs. 17% of non-Veterans; Hoerster et al., 2012). Female Veterans, compared with female non-Veterans, had similar proportions with fair or poor overall health (each 18%), greater proportions with limited activities (30% vs. 22%), and more often had frequent poor physical health (15% vs. 12%) and mental distress (16% vs. 12%; Lehavot et al., 2012).

There were variations by race/ethnicity in these Veteran/non-Veteran comparisons. Among respondents to the 2007 to 2009 BRFSS, non-Hispanic White, non-Hispanic Black, American Indian/Alaska Native, and Hispanic Veterans all reported more physically unhealthy days than their race/ethnicity-concordant non-Veteran counterparts (comparisons for Asians and Native Hawaiian/Other Pacific Islanders were not reported; Luncheon & Zack, 2012). Non-Hispanic White Veterans and Hispanic Veterans also more often reported mentally unhealthy days than non-Veterans of those race/ethnicity groups.

SCREENING FOR HEALTHCARE NEEDS OF VETERANS

Clinicians providing healthcare to Veterans must screen for both common health conditions and military-related conditions. As noted above, common conditions such as hypertension, and behavioral risk factors such as tobacco use, may occur more frequently among Veterans. The VA in collaboration with the Department of Defense (DoD) and other leading professional

organizations has developed clinical practice guidelines for selected issues affecting military service members and Veterans (www.healthquality.va.gov/; see Discussion Questions for information). Subject areas covered by the guidelines include chronic diseases in primary care, mental health, military-related conditions, pain, rehabilitation, and women's health. Postdeployment health assessments should include screening for combat-related physical injury including TBI, mental health sequelae of military service, chronic pain, substance use disorder (SUD), military sexual trauma, infectious diseases, environmental hazards, and social stressors (Olenick, Flowers, & Diaz, 2015; Roy & Perkins, 2018; Sessums & Jackson, 2013).

POST-DEPLOYMENT AND NEW PATIENT HEALTH ASSESSMENTS

- Physical injury due to combat
  - Amputations and phantom limb pain
  - Traumatic brain injury (TBI) and postconcussion syndrome
- Mental health sequelae:
  - PTSD; depression; generalized anxiety disorder
  - Suicide
  - Chronic multisymptom illness
- Chronic pain
- Substance use disorder
- Military sexual trauma (MST)
- Infectious diseases: Malaria, tuberculosis
- Environmental hazards: Noise-related hearing loss and tinnitus; toxins
- Social stress: Intimate partner violence; divorce; homelessness

Suicide Screening

- Are you feeling hopeless about the present/future?
- If yes, have you had thoughts about taking your life?

TBI is "an injury to the structure or functioning of the brain by an outside physical force that immediately results in one of more of: loss of consciousness, loss of memory for events either before or after the event, neurologic deficit or intracranial lesion, or altered mental state" (VA/DoD TBI clinical practice guideline). Mild TBI has been described by some as the signature event of the current war. Symptoms of TBI (poor concentration, memory problems, dizziness, headache, anxiety, insomnia) overlap with other conditions and may emerge after years; therefore, all Veterans should be screened for this as part of their initial intake.

PTSD is characterized by intrusive thoughts, nightmares, and flashbacks of past traumatic events, avoidance of reminders of trauma, hypervigilance, and sleep disturbance. Several brief

screening instruments are available for rapid assessment during the clinical encounter (e.g., the 4-item Primary Care PTSD screen; see Discussion Questions). Veterans who screen positive for PTSD or depression should be asked about suicidal ideation and intent (see Post-Deployment and New Patient Health Assessments box).

Military sexual trauma (MST) is defined as sexual harassment that is threatening in character or physical assault that is sexual in nature that occurred in the military. The prevalence of MST is much higher in women than men, though given the large proportion of men in the military, the absolute number of Veterans who have experienced MST is similar between men and women. MST is associated with a higher risk of developing PTSD than is combat.

CHARACTERISTICS OF VETERAN VA HEALTHCARE USERS COMPARED TO VETERAN VA NON-USERS

VA provides comprehensive medical, mental health, and social services with no insurance premium. Visit and pharmacy copayments are required only for Veterans whose household income is above the VA's low-income threshold and who do not have military service–related conditions or enrollment priority factors. Given these reduced financial barriers to VA healthcare use, not surprisingly, demographic factors and health status influence use of VA healthcare (Dursa, Barth, Bossarte, & Schneiderman, 2016; Washington, Villa, Brown, Damron-Rodriguez, & Harada, 2005; Washington, Yano, Simon, & Sun, 2006). Veterans who use VA for healthcare are typically older, sicker, and have greater barriers to accessing healthcare in non-VA settings compared with other Veterans. These healthcare access barriers include having lower income, being uninsured, and residing in rural areas where community non-VA services may be limited. Compared with non-Hispanic White Veterans, racial/ethnic minority Veterans are more likely to use VA for some or all of their healthcare (Dursa et al., 2016; Washington et al., 2005; Washington, Farmer, et al., 2015).

Military service–connected disabilities are medical or mental health conditions that developed during or were exacerbated by military service. Veterans with service-connected disabilities may use VA healthcare without a copayment, and often preferentially seek VA care because they may get specialized care for their conditions, whereas that expertise may not necessarily be available in their local areas. The prevalence of diagnosed health conditions differs significantly by VA healthcare user status, with Veteran VA users having higher rates of all common diagnoses examined (Figure 15.1). These may include both military service–related as well as other health conditions.

RECOMMENDATIONS FOR ACHIEVING HEALTH EQUITY FOR VETERANS

Veterans of the U.S. military are a distinctive population, with strengths developed or honed over the course of their military service, as well as vulnerabilities and military service–related exposures that increase their health risks. Collectively, U.S. Veterans have a higher prevalence than non-Veterans of diagnosed chronic health conditions. Though the older age and male predominance of Veterans may account for many of these differences, these unadjusted comparisons reflect the populations and health conditions that healthcare providers caring for Veterans will need to address. Military service also confers increased risk for physical injury related to combat, and "invisible wounds of war," such as TBI, PTSD, MST, SUD, and suicide. It is essential for healthcare providers in both VA and community (non-VA) settings to screen Veterans for

these "invisible wounds of war" and to be aware of medical services and referrals for Veterans. Education of healthcare professionals should incorporate a Veteran-centered care curriculum to prepare future healthcare providers to address the needs of their Veteran patients (Ross, Ravindranath, Clay, & Lypson, 2015; Lypson, Ravindranath, & Ross, 2014).

Veterans who use VA healthcare are a particularly vulnerable group. Large differences in socioeconomic status, behavioral risk factors, and health status are present between VA users and both Veteran VA non-users and the general U.S. population. The prevalence of diagnosed chronic health conditions is also highest in this group. VA provides comprehensive medical, mental health, and social services to address the complex needs of this group. As VA makes greater use of community care in the future to deliver services to Veterans, providers at those sites should plan for the needs of this group.

RESOURCES FOR VETERANS

- U.S. Department of Veterans Affairs (www.va.gov/)
- Women Veterans Health Care (www.womenshealth.va.gov/; 1-855-829-6636)
- VA/DoD Clinical Practice Guidelines (www.healthquality.va.gov/)
- VA National Center for PTSD (www.ptsd.va.gov/)
- Psychological Health Center of Excellence (PHCoE) (www.pdhealth.mil)
- VA Office of Academic Affiliations (https://www.va.gov/OAA/pocketcard/)

INTERSECTIONALITY SPOTLIGHT

Equitable access to high-quality care for all Veterans is a major tenet of the VA healthcare mission (VHA Office of Health Equity [OHE], 2016). With its reduced financial barriers to healthcare use and its provision of social services, VA care can address some of the barriers to health equity that are present in the broader U.S. In addition, advances over time in the organization and delivery of VA care have been designed to improve overall care quality, which some theorize could reduce disparities (Washington et al., 2017). Examples of such advances include early implementation of electronic health records, and nationwide implementation of patient-centered medical homes (PCMH). While monitoring of VA care quality and outcomes has revealed narrowing of disparities in some areas (Saha et al., 2008; Trivedi, Grebla, Wright, & Washington, 2011), evidence exists for ongoing disparities for several vulnerable Veteran groups (Breland et al., 2017; May, Yano, Provenzale, Steers, & Washington, 2019; Washington et al., 2017; Wong et al., 2019).

Racial and ethnic disparities in the VA were the subject of a 2008 systematic review (Saha et al., 2008). Most of the studies examined differences between African American and White Veterans. That review identified that disparities were most prevalent for medication adherence, surgery and other invasive procedures, and processes of care that are likely to be affected by provider communication and shared decision-making. A study that focused on Black–White differences in achievement of quality of care measures from 2000 to 2009 found that for most processes of care, disparities were no longer present, whereas for clinical measures of hypertension

(*continued*)

control and diabetes control, disparities persisted (Trivedi et al., 2011). A subsequent study that included all racial/ethnic groups evaluated whether these racial/ethnic disparities in hypertension and diabetes control persisted with VA implementation of PCMHs (Washington et al., 2017). It found that despite modest improvements in overall quality, racial/ethnic disparities narrowed somewhat for Hispanics, but persisted for African American, American Indian/Alaska Native, and Native Hawaiian Other Pacific Islander groups.

Racial/ethnic disparities in mortality across the VA were also evaluated and contrasted to racial/ethnic mortality disparities in the U.S. (Wong et al., 2019). A key finding was that patterns in disparities differed between VA and U.S. populations. Black–White disparities in all-cause mortality were present for men in both populations, though disparities were lower in the VA. Black–White disparities in all-cause mortality that were present for women in the U.S. were not evident in the VA. For American Indian/Alaska Native male Veterans, disparities in all-cause mortality were present in the VA, but not the U.S. population. In sum, these findings suggest that "equal-access" type healthcare systems such as VA may partially address health disparities, but that other non-healthcare factors should also be explored.

Among Veteran VA users, there are sizable sex differences in the prevalence of diagnosed conditions (Frayne et al., 2018; VHA OHE, 2016). Though hypertension, lipid disorders, and diabetes are leading diagnoses among men, for women Veteran VA users, conditions associated with musculoskeletal pain were most common. The VA promotes evidence-based complementary and integrative health (CIH) therapies as nonpharmacologic approaches for chronic pain. Among Veterans ages 18 to 54 with chronic musculoskeletal pain, women are more likely than men to use CIH therapies (Evans et al., 2018). At the same time, Black women are less likely than women of other races/ethnicities to use these nonopioid therapies to treat chronic pain (Evans et al., 2018). Sex and gender differences in Veterans' health and VA care has been examined for several other conditions and was the subject of a June 2019 supplement to *Women's Health Issues*.

CASE STUDY LONG-STANDING IMPACT OF WAR ON A VETERAN'S MENTAL HEALTH

A 64-year-old man presents for a follow-up visit with a chief complaint of feeling more tired and worsening back pain. He has been your patient for the past 5 years, but you note that he has not been in the office for the past 9 months despite having poorly controlled diabetes mellitus and hypertension. He was laid off from his job last year and since that time he has been struggling with feeling sad and has isolated himself from his friends and family. He mentions his sleep has also been poor and that he has been having nightmares and flashbacks that remind him of his time spent in Vietnam. You ask him more about his time in the service including where he was stationed, military occupation, environmental exposures such as Agent Orange, and lastly about his combat experience. Upon further questioning he was in combat for 2 years and he witnessed many of his friends being killed. When he returned home he did not find that any of his friends or family were able to relate to his experiences, and therefore he suppressed these memories. He recently saw a news story about the ongoing fighting in the Middle East, and since that time he has felt his mood and anxiety heighten. He is coming to you to ask you for assistance.

DISCUSSION QUESTION

- What are good options for approaching this patient's worsening mood and social isolation?

CURRENT EVENTS

ACCESS TO VA SERVICES

In recent years, there has been significant public attention drawn to wait times and true accessibility of VA healthcare services. Issues of wait times and distance to care are particularly salient for rural Veterans, who may have no other access point to receive healthcare. The VA has responded by supporting transportation networks and increased presence of telehealth-based VA clinics in local communities.

Discussion Question: What other approaches could be used to increase access to care for rural Veterans? What other groups may be particularly affected by challenges in accessing care?

DISCUSSION QUESTIONS

- Why should health professionals ask about military service?
- What are common health problems affecting returning military personnel?
- Where can Veterans obtain information about accessing and managing their VA benefits and healthcare?
- Where can community (non-VA) healthcare providers learn about medical services for Veterans and obtain Veteran-related health information?

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