PERSPECTIVE

Coming Home from War

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Many American military personnel who served in the Iraq and Afghanistan wars will need long-term management of war-related conditions. There is pressing need for expertise in veterans' care outside of the Military Health System (MHS) and Department of Veterans Affairs (VA), as many will seek care elsewhere: Veterans receive free MHS care only while on active duty; enhanced eligibility for VA healthcare ends 5 years after military discharge; many veterans eligible for VA healthcare use non-VA services instead; and the Affordable Care Act will expand Medicaid coverage for uninsured veterans. Families of veterans also may need care for conditions related to war service. Most medical schools lack veteran-focused curricula beyond VA clerkships, which often do not provide specific training on service-related conditions. The VA, Department of Defense (DoD), veterans groups, and medical professional organizations should partner to develop technical competencies in veteran and family health care for clinicians at all career stages, and cultural competencies to ensure contextually appropriate care. National and state licensing boards should assess these competencies formally. Partnerships between VA, DoD, and the community for care delivery can improve transitions and the quality of veterans' post-deployment care.

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Since September 11, 2001, more than 2.3 million American military personnel deployed to Iraq, Afghanistan, and other countries in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND).[1] The United States withdrew forces from Iraq in December 2011 and pledged to end its combat role in Afghanistan in 2013. Many OEF/OIF/OND veterans will require long-term management of mental and physical wounds sustained in these wars.[2] Their families also may need care for related conditions.

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Severely disabled veterans and veterans with service-connected medical conditions likely will obtain care through the Department of Veterans Affairs (VA), while veterans remaining on active duty are eligible for care in the Military Health System (MHS). But many OEF/OIF/OND veterans eligible for free VA or MHS care seek care elsewhere, as do most family members. As demand for care beyond the VA and MHS grows, other providers will need to gain competence in caring for these populations.

MEDICAL NEEDS OF VETERANS AND FAMILIES

As in previous veteran cohorts, mental health problems are common among OEF and OIF veterans, with a prevalence of 37 % among veterans entering VA health care from 2002 to 2008.[3] But OEF/OIF/OND veterans differ from their predecessors. Many sustained concussion—or mild traumatic brain injury (TBI)—from improvised explosive device blasts. The Institute of Medicine estimates that 10–20 % of OEF/OIF soldiers and Marines experienced a concussive event that may have long-term health implications.[4] About 50 % of soldiers and marines serving in Afghanistan and Iraq reported being within 50 m of a blast.[5]

Many OEF/OIF/OND veterans deployed multiple times, and served longer tours than previous veteran populations. Forty-three percent deployed more than once, while 17 % served three or more tours.[1] Thirteen percent of OEF/OIF veterans served a combat tour lasting 1 year or longer.[1] In a 2010 military survey, soldiers serving their third or fourth tour in Afghanistan were more than twice as likely as those on their first tour to meet screening criteria for acute stress, depression, or anxiety, and more than three times as likely to use mental health medications.[5]

The military also has relied heavily on Reserve and National Guard forces, which constitute 44 % of the OEF/OIF/OND veteran population.[6] These "citizen soldiers" face additional challenges in transitioning between civilian life and combat service. In post-deployment health assessments, Reserve and National Guard soldiers returning from Iraq were more than twice as likely to be identified as having a mental health problem as active duty soldiers.[7]

Family members of OEF/OIF/OND veterans also bear war wounds. Fifty-three percent of OEF/OIF veterans are married, and more than 2 million children have a parent

who served in OEF or OIF.[1] Research suggests that combat deployment can worsens family members' psychological health. In one study, for example, wives of soldiers who deployed to Afghanistan or Iraq for up to 11 months and more than 11 months were at 19 % and 27 % increased risk, respectively, of receiving a mental health diagnosis compared to wives of husbands who did not deploy.[8] Similarly, among children aged 3–8 years who were enrolled in the MHS during 2006–2007, the rate of behavioral and mental health visits was 11 % higher when a parent was deployed than when the parent was not deployed.[9]

BEYOND THE DEPARTMENT OF VETERANS AFFAIRS AND MILITARY HEALTH SYSTEM

Veterans and family members may require care after enhanced eligibility for free federal healthcare expires. Twenty percent of forces who deployed to OEF/OIF already have separated from the military[1], and enhanced eligibility for free VA care is guaranteed only for 5 years after discharge. The VA then determines enrollment priority based on several factors, including disability rating and income. Those veterans who choose to receive care at the VA and have significant deployment-related health concerns would likely obtain a service connection for their condition(s) and be eligible for ongoing care.

However, veterans eligible for VA healthcare may not use it. In the VA's 2010 National Survey of Veterans, 37 % of OEF/OIF veterans who had completed active duty service indicated they had ever used VA healthcare.[10] In the previous 6 months, 43 % had received healthcare but had not used VA services; 70 % of those who had received mental health care during the previous 6 months had not used VA services.[10] (Among all veterans who had never used VA health care benefits, the most commonly cited reason was lack of awareness of those benefits.[10]) Only 16 % of veterans planned to use the VA as a primary source of health care.[10] VA utilization data reports that 55 % of OEF/OIF/OND veterans have obtained VA health care since 2002.[6]

Family members of OEF/OIF/OND veterans are eligible for MHS care only while their service member remains on active duty. As more insurance plans cover mental health care (to comply with the Affordable Care Act of 2010), cost will become less of a barrier to family members seeking mental health care, and demand for private sector services could rise. Family members do not typically receive care through the VA.

Under the Affordable Care Act, it has been estimated that nearly half of the nation's 1.3 million uninsured non-elderly veterans would be eligible for expanded Medicaid coverage and another 40 % would qualify for subsidized coverage through state health insurance exchanges.[11] The need for expertise in veteran-specific care outside of the VA and MHS is pressing.

ATTAINING COMPETENCE IN CARE

With more OEF/OIF veterans and family members seeking medical care beyond the VA and MHS, providers should attain competence in caring for these populations. Yet, technical proficiency in managing conditions associated with war service is essential, but insufficient. To deliver contextually appropriate care[12], providers also must view war service in a broader set of factors contributing to clinical problems. For example, a provider might recognize how a veteran's war experience contributes to smoking or other unhealthy behaviors, or to a family caregiver's distress. Or, a provider might identify previous trauma, and not war experience, as the root cause of post-traumatic stress disorder symptoms.

Additionally, veterans and family members may seek guidance from providers in identifying medical assistance programs for which they are eligible. Federal, state, and local governments, and private organizations offer many programs for OEF/OIF veterans and families, but whether they have effectively communicated about these programs to their target populations is unclear.[4]

While many U.S. medical schools have an affiliation with a VA hospital, trainees may not receive specific training on the identification of service-related conditions and the complex care coordination required to manage them. Most medical schools lack stand-alone veterans' care curricula.[13] Practicing physicians who will be treating OIF/OEF/OND veterans and their family members may not have the required knowledge and cultural competence, and continuing medical education (CME) in veterans' care is scarce.[13]

To ensure clinicians can appropriately care for OEF/OIF/OND veterans and their families, the VA, Department of Defense (DoD), veterans groups, and medical professional organizations should collaborate to develop evidence-based educational curricula and identify best practices for clinicians in all stages of training and practice. In one major initiative, part of a broader White House campaign to support service members and their families, Joining Forces, the American Association of Medical Colleges (AAMC) secured the commitment of 112 US medical schools to focus education, research, and care on meeting unique needs of veterans. In conjunction with Veterans Day in November 2012, the AAMC hosted a series of webinars on military cultural competence, traumatic brain injury, post-traumatic stress disorder, military families, and women veterans' health developed and presented by experts in the fields. The AAMC also facilitates the sharing of educational resources that address caring for military personnel, their families and veterans on iCollaborative, a free non-peer reviewed web repository.

However, once developed, high-quality educational resources may go underutilized. Only about a third of medical schools that pledged to support Joining Forces participated in the webinars and/or offered an event on campus in conjunction with the series (A Navarro, personal communication, December 14, 2012). Schools may struggle with integrating curricula on veteran-specific care in already-crowded curricula. Content could be efficiently introduced by incorporating standardized patients or cases for small group discussion involving veterans and/or their family members into existing cultural competence curricula. High-quality, peer-reviewed online modules can facilitate distance learning. Task forces or workgroups at medical schools, including students and faculty with ties to the military, as well as VA faculty, may serve as champions for threading content through the curriculum. Basic competencies could include:

- Obtain a focused military history or uncover a family member's military history as part of the social history on any patient.
- Elicit health concerns that a patient believes may be service-related, identify relevant clinical syndromes (e.g. post-traumatic stress disorder, traumatic brain injury), and make appropriate referrals.
- Identify and assess stressors in a service member, veteran or family member's life and make recommendations to mitigate these.

Competencies should be assessed formally; for example, with standardized patients and licensing examination questions.

In graduate medical education, increasing rotations in VA health care facilities, including medical centers and community outpatient clinics, can provide greater exposure to the veteran population and capitalize on the VA's expertise in veteran-specific care. To ensure the development of clinical competence, additional learning opportunities in military cultural competence and veteran specific-care should be offered apart from the VA training experience as residents may have heterogeneous exposure to important clinical conditions. For example, ambulatory clinic discussions could cover the care of returning veterans or their family members; required online modules could cover the latest updates in traumatic brain injury management. Mainstreaming these competencies would also emphasize that one need not work in a VA to encounter veterans or family members who deserve physicians with expertise in these areas.

More continuing medical education opportunities in veterans' care are needed. Educational resources and programs need to be developed and disseminated. For instance, Spelman and colleagues have recently published a comprehensive clinical guide to post-deployment care in this journal (September, 2012)[2] which can serve as an excellent resource for the practicing physician. State licensing boards could help disseminate continuing medical education materials and resources and incorporate veteran-specific care into maintenance-of- certification programs. Even within the VA, faculty development programs on military cultural competence and updates on the latest advances in the understanding of veteran-specific conditions could better prepare staff to guide trainees and provide additional patient care insights.

In addition to partnerships for enhanced education, partnering between DoD, VA, and the greater medical community is warranted to improve care delivery, particularly in rural areas where access to VA medical care may be limited. Some states have developed DoD/VA/State and community partnerships to enhance access and the quality of services that veterans and family members receive in the community. The DoD and VA are collaborating to create an integrated electronic health record (iEHR), with plans to replace their respective EHRs by 2017. Already, certain VA medical centers are piloting information sharing among the VA, DoD, and selected private health care providers over the Nationwide Health Information Network. These promising partnerships help integrate VA health care with other health care systems, improving care transitions and the quality of post-deployment care. Importantly, this integration at all levels, both within and between care settings, is critical to improving the care we provide to our nation's veterans.

The war-related medical needs of OEF/OIF /OND veterans and families will span decades, but the window of opportunity to ensure effective care beyond the VA and MHS may be small. Encountering providers who understand their war-related medical needs, veterans and family members will feel more encouraged to voice their needs and participate in care. Providers who do not understand these needs may have the opposite effect.

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