NCIOM

Task Force on Veterans' Health

Project Learning Period Summary

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The North Carolina Institute of Medicine (NCIOM) is a nonpartisan source of analysis and advice on important health issues facing the state. The NCIOM convenes stakeholders and other interested people from across the state to study these complex issues and develop workable solutions to improve health care in North Carolina.

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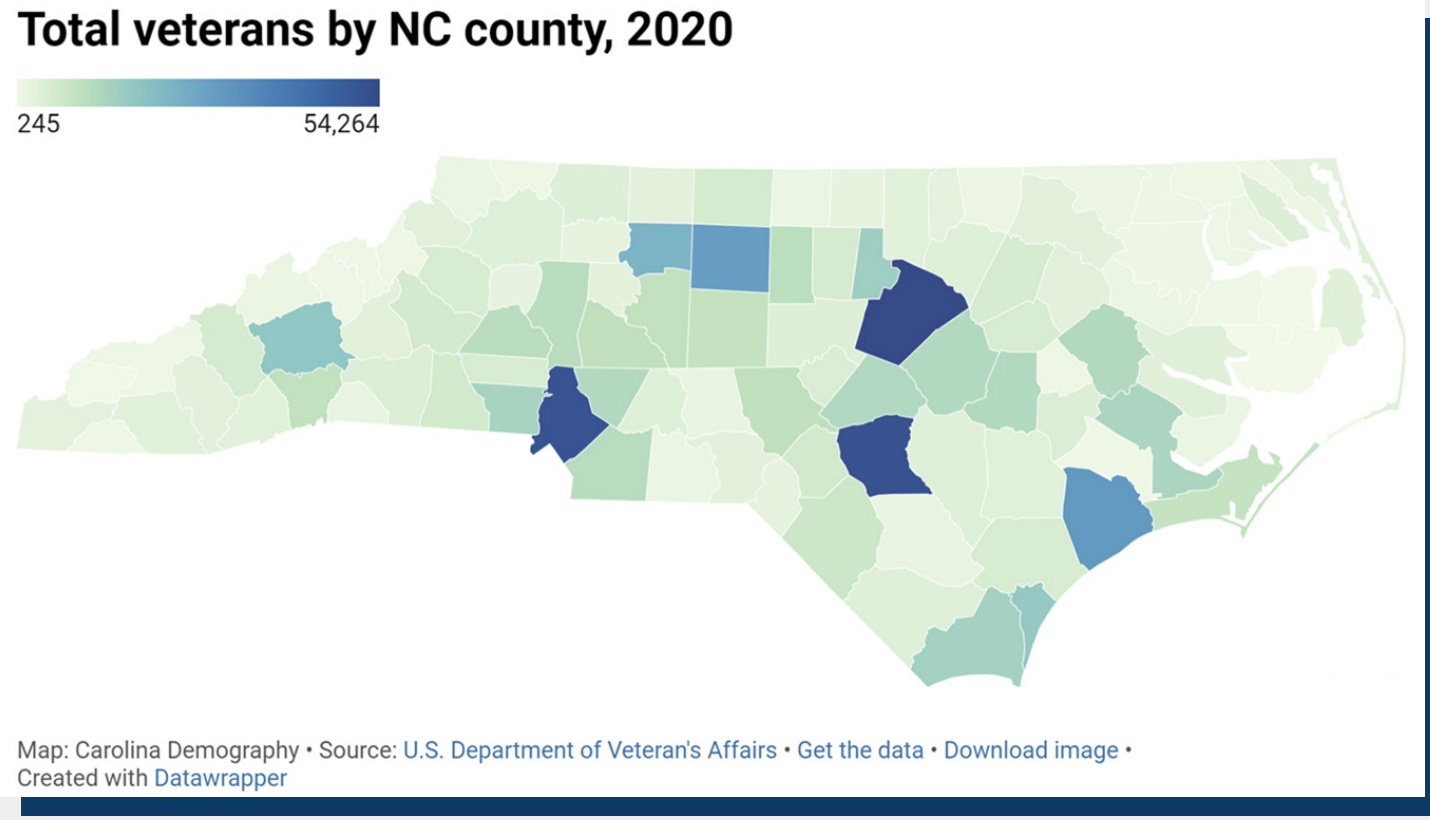
Introduction

North Carolina is home to the 8th largest number of military Veterans in the United States, with approximately 619,000 Veterans living in our state, around 8% of our population.[1] Counties with the highest numbers of Veterans are:[2]

- Wake
- Cumberland
- Mecklenburg
- Onslow
- Guilford
- Forsyth
- Buncombe
- New Hanover
- Durham
- Gaston



Source: Carolina Demography. Memorial Day snapshot: Who are NC's veterans? May 27, 2021. https://carolinademography.cpc.unc.edu/2021/05/27/who-are-north-carolinas-veterans/

As individuals transition from active duty to Veteran status, and as they age, they can face challenges navigating health care benefits, as well as receiving care that is well-coordinated between the civilian health sector and the Veterans Affairs (VA) health system. In addition, some Veterans have ongoing behavioral health care and substance use treatment needs and may need assistance with other drivers of health such as housing and employment.

The passage of the PACT Act in 2022 brought an increase in the number of Veterans who are eligible for care through the VA system. This increase, along with previously existing challenges and changes being discussed at the federal level related to VA funding, workforce, and increase of referrals to community-based providers, brings an urgency to identify actionable strategies for improving access to care, care coordination, and developing the right workforce to meet Veterans' health care needs across their lifespans.

The North Carolina Institute of Medicine (NCIOM) began convening a task force in the summer of 2025 to identify actions to improve access to and the experience of care in community-based health care settings for those who have served in the military, their families, and caregivers. The goal of this work is to address:

- Systems around community health care provision for Veterans.
- Community health care provider Veteran cultural competency and provider capabilities related to billing common payers for Veteran care.
- Health-related needs of Veteran family members and caregivers.
- Veteran knowledge of health-related service availability.
- Capacity of health-related services for Veterans.
- Transition experiences from active duty to civilian or reserve status.
- Empowerment of community-level efforts to support Veteran and family member health and well-being.

To inform the development and scope of the task force, NCIOM staff undertook a six-month learning period to better understand the landscape of Veteran services and needs in North Carolina. This report summarizes the lessons learned from this period.

Learning Period Methods

From December 2024 to June 2025, NCIOM staff engaged in a variety of learning and research activities to improve staff understanding of Veteran services and needs in North Carolina and to direct the scope of task force objectives. These activities included:

- Interviewing dozens of people with direct experience, both personally and professionally, of the services and health care needs of Veterans.
- Participating in two Veteran cultural competency training courses.
- Attending the VFW Winter Council of Administration meeting as a vendor in January 2025.
- Attending the Governor's Working Group SMVF Network Summit in March 2025.
- Attending the Voices for Veterans event hosted by Cardinal & Pine in May 2025.
- Observing meetings of the North Carolina General Assembly House Committee on Homeland Security and Military and Veteran Affairs.
- Conducting a focus group with North Carolina State University Veteran students.
- Attending an educational series titled "Enhancing Economic Stability for Service Members, Veterans, and Their Families."
- Convening a steering committee for the Task Force on Veterans' Health.

NCIOM staff developed an initial list of contacts for interviews based on internet searches and a small group of advisors. Additional individuals were identified by those who were interviewed and as specific organizations or topics arose from interviews.

To prepare for interviews, NCIOM staff developed a list of possible questions to probe with those being interviewed. While these questions proved helpful with initial engagement, they were not used prescriptively. Rather, NCIOM staff began by asking interviewees to describe their experience as Veterans, when applicable, and their role or perspective related to Veteran health-related needs and services. This method helped to identify the spectrum of perspectives and allowed common themes to surface. Interviewees were also asked about their thoughts on possible solutions to the challenges they raised.

Interviews were conducted remotely via Zoom and were auto-transcribed for the sole purpose of staff notetaking. Names and organizations of interviewees are not being shared to enhance the ability of interviewees to speak freely about their experiences and perspectives and to ensure privacy. Interviews were conducted with representatives from state government (including elected officials and representatives from state agencies), Veteran service agencies, academia, health care, and the criminal justice system.

The following sections highlight common themes from these interviews and include quotes to illustrate important points. All quotes are anonymous to ensure privacy of those interviewed.

Summary of Statewide Entities Serving Veterans in North Carolina

North Carolina Department of Military and Veterans Affairs (NC DMVA)

The NC DMVA is a state agency designed to build and maintain the relationship between North Carolina and its military installations and Veterans. It "is focused on protecting North Carolina's military installations, working with communities around military bases, helping military families and veterans get the support and services they need, and helping connect veterans with jobs."[3] The NC DMVA has qualified benefits specialists in 12 offices throughout the state, an established relationship with County Veterans Officers who are in most counties in the state, and an established relationship with the Federal Department of Veterans Affairs."[4]

VA Medical Centers

VA Medical Centers provide comprehensive health care services to eligible registered Veterans. These services include primary care, mental health services, specialized care, and physical therapy. They also act as referral hubs for community-based providers.[5] There are VA medical centers in four locations in North Carolina: Asheville, Durham, Fayetteville, and Salisbury.

Eligibility for VA health care is based on certain service requirements and, in some cases, income to determine priority group categories. Key factors include the length and nature of active-duty service, discharge status, and potential service-connected disabilities. Around half of Veterans in the United States are enrolled in VA health care.

NCServes

"NCServes is North Carolina's first coordinated network of public, private, and nonprofit organizations working together to help Veterans, service members, and their families across the care and support they deserve. From housing and employment to mental health and legal aid, [NCServes] streameline[s] connections to trusted providers across the state."[6]

The Division of Mental Health, Developmental Disabilities, and Substance Use Services in the North Carolina Department of Health and Human Services is the primary funder for NCServes.[6]

Veteran Services of the Carolinas (VSC)

A division of the Asheville Buncombe Community Christian Ministry, VSC offers transitional housing, employment assistance, case management, and peer support to Veterans across North and South Carolina. Through programs like Support Services for Veteran Families (SSVF), Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP), Healing Outreach Partnerships for Empowerment (HOPE), and Partnerships for Assistance in Transition from Homelessness (PATH), VSC works to prevent and end Veteran homelessness and foster long-term stability and support for Veterans and their families.[7]

Veterans Bridge Home

Based in Charlotte, North Carolina, Veterans Bridge Home assists transitioning service members and Veterans in connecting to community services and social networks. By coordinating support in areas such as employment, housing, health, and recreation, the organization helps Veterans successfully reintegrate into civilian life and build a strong foundation for the future.[8]

Building Veteran-Healthy Communities Project

In collaboration with the UNC Gillings School of Global Public Health, the Building Veteran-Healthy Communities Project is a statewide initiative focused on, "[engaging with] communities across North Carolina to foster collaboration, set priorities, and inform local actions to improve the community conditions affecting Veteran wellness." It emphasizes partnerships among public health agencies, health care providers, and Veteran-serving organizations across the state to address social drivers of health, increase cultural competency, and promote holistic wellness for Veterans.[9]

North Carolina Veterans Treatment Courts

"Veterans Treatment Court [works] with military service Veterans with a substance use, mental health, or co-occurring disorder... The structure of VTC is similar to that of drug treatment and mental health courts in that they involve cooperation and collaboration with court officials, community partners, and law enforcement. The goal is to connect eligible veterans with benefits and treatment earned through military service."[10]

Key Findings from Interviews

Transition to civilian life

The transition from military to civilian life is a period marked by significant challenges, including disorientation, lack of structural support, identity shifts, unmet needs in health care, employment, and social reintegration. Across interviews, participants underscored how this transition often lacks support by existing systems, leading to lasting effects not only for the Veteran, but for their families as well. Although individuals separating from the military typically attend the Transition Assistance Program (TAP), which is administered through the Department of Defense, most of those interviewed shared the experience that TAP was a "firehose of information," and that as they attended the program they were not focused on what their needs would be as a Veteran.

One health care administrator emphasized the need for an improved transition process, noting that health care access is a key difficulty for those transitioning from military service to civilian life. This is a complication exacerbated by a lack of cultural competency among community clinicians, a gendered disparity in treatment at VA medical centers, and the difficulty Veterans experience when trying to build community. The interviewee argued that the transitioning Veteran is ultimately likely to experience challenges navigating the health care space. This is emphasized by the fact that shared knowledge among Veterans is the primary way most Veterans learn about available resources and benefits.

A Marine Corps Veteran who works directly with military Veterans described the transition challenges more structurally. Drawing on his experience in managing Veteran housing, suicide prevention, and community-based reintegration programs, he highlighted the importance of holistic, community-grounded support. He noted that, in his experience working with programs like NCServes, the reintegration process must extend beyond the Veteran to include social drivers of health and family support. "[W]e're not just treating the Veteran, we're treating the whole Veteran household, which is a holistic approach to care."

Another Marine Veteran who works with justice-involved Veterans whose experiences, including but not limited to their transition difficulties, may have led to legal or behavioral crises, offered a personal testimony to illustrate a trend he's witnessed among the people he's worked with during his time with the Veterans Treatment Court:

"When I was 15, I started drinking and using drugs. I graduated high school with a GPA of 2.0 and [joined] the Marines as the only option… I was sent to Iraq. Then I was hit by an IED [and] sent to Walter Reed, had 32 surgeries, was told I'd never walk again, and I was given a lot of opioids… which turned into a heroin addiction…. And this [experience] is common."

His story highlights how military service is often both an escape and a catalyst for new struggles—and why, when that structure falls away, Veterans can feel stranded.

A judge who works with similar cases noted that many of the social and legal crises they see in Veteran defendants stem less from criminal intent and more from an inability to function without military structure in concert with common societal contributors to crime. "[W]e see all of the social ills played out each day in court… and can rarely resolve… the root of the problem… the substance use, mental health, domestic violence, poverty…"

These accounts illustrate how the transition to civilian life acts as a fundamental identity shift. Veterans emerge from service often physically and psychologically wounded, then face a patchwork of care and opportunity with little guidance.

Care at VA facilities

Many Veterans see the VA as their best source for integrated health care and benefits, as well as a hub of providers with experience working with Veterans. A Veteran who works alongside community providers explained that working with Veterans in any capacity requires a level of cultural competency. "It's a different culture, and you really have to understand that culture if you're going to effectively help people." He continues, noting "[VA health care] is world-class health care…if it's health care, you're going to get it here."

Yet, even while praising the breadth of VA care, the interviewee lamented that Veterans often note administrative challenges related to care. These challenges often stem from procedural breakdowns, functionally derailing access to care. A career health care administrator and Veteran recalled that her VA appointments sometimes slipped through the cracks. She explained that, more often than not, those situations came about due to lapses in communication from the VA, especially in cases of referrals for community care. On more than one occasion, she was not told about appointments made on her behalf with medical providers in the community, an occurrence noted by several Veterans we interviewed. Additionally, she noted that VA medical centers were historically unwelcoming to women, though she has seen recent improvements in that experience.

A representative of an advocacy organization expressed slightly different concerns regarding community care referrals, noting a tendency toward slow processing on the part of the VA, which led to a delayed treatment process for Veterans. "The VA will outsource for specialty care, let's say it's physical therapy, but by the time they get all the paperwork done and the Veteran goes to the physical therapy, [the paperwork] is expired on the VA's end and then you have to start the process over again."

Her experience highlights how administrative challenges with referrals to community providers can delay critical medical services despite the VA's intent to expand access to care.

Care coordination with community-based providers

A Veteran Service Officer who serves as the primary point of contact for Veterans navigating services recounted her experiences navigating the webs of providers, both VA and community based. When a Veteran can't access needed services, she works to resolve issues that range from delayed referrals to timely access to medication. In her words, "I do a lot of problem solving, jumping up the chain for them." She continued:

> ***"The areas that I cover are homelessness and housing insecurity, suicide prevention, intimate partner violence, military sexual trauma, access to mental health and health care resources, how to get connected into the VA system, as well as understanding the whole process with community care."***

She emphasized the importance of ensuring Veterans have access to someone who can assist them with their range of needs. She stressed that assistance is especially necessary in the rural areas of North Carolina where services are often harder to find.

The experience with inconsistent communication between VA facilities, community providers, and their patients outlined in the previous section not only highlights a lapse in communication between Veterans and the VA, but also between Veterans and community providers. The health care administrator also noted the gap in clinical understanding when community clinicians lack the requisite military context to most effectively care for Veterans.

Noting these frustrations, a Veteran, coordinated-care leader, and Veteran advocate, underscored the need for a Veteran-centric referral model that bridges VA and community resources to include medical services. He explained that one of the social services organizations he works with operates as a "high touch model," where after intake they "triage the Veteran's cases, and then… refer out to community partners…" to meet Veteran needs. He continued, describing the Veteran's entry points into this network: "Veterans come to us three ways: they can call us… they can go online… and then the preferred way is our community partners refer to each other."

He noted that, while it is likely impossible to scale to the entire population of North Carolina, their provider-to-provider communication has helped Veterans with more of their social needs (e.g., transportation, food) when they are first connected with a provider in that network rather than only receiving support within that provider's sector (e.g., housing).

Some interviewees shared frustration with chronic payment delays from the VA to community-based providers. However, it is important to note that while the perception of delayed payments may be based on historical experiences, some interviewees stated that payment delays have been improved or eliminated since the implementation of a different third-party payment administrator. Considering her local providers, a representative from a regional health organization noted, "[One major health practice] is one of the largest practices in our area… [but] they will not see Veterans because of the VA not paying on time." Such reputational damage has sometimes pushed Veterans to rely on other payers, such as Medicare, or avoid VA referrals altogether, thus undermining the goal of integrated Veteran-centric care.

One community-based mental health care provider is contracted to provide services to Veterans from multiple VA medical centers. In her experience, administrative processes and communication vary significantly among the medical centers. These differences have led to frustrations for the community provider, who shared:

"I'm not getting paid any more for all the extra admin work... But the flip side of that is this is the population that I'm passionate about, and I'm not gonna stop serving them, but it is frustrating."

A regional manager for the DMVA underscored how community care referrals can shift Veterans from unfamiliar VA clinics back to trusted local doctors, but not without hurdles. She explained:

"A care-in-the-community authorization is provided, but then the Veteran receives a bill from that provider, and that bill should go to the VA...that becomes another thing that we need to advocate and fix for them." Despite these obstacles, she observed that Veterans value continuity with providers they already know, "[making] it easy for them, and then that continuity of care never gets dropped."

Continuity of care is a vital touchstone of medical care, one which community-based providers have struggled to maintain with the Veterans they serve due to infrequent visits which are ultimately dependent on VA referrals. A representative from the Health Information Exchange (HIE) of North Carolina proposed "real-time notifications" through their NCNotify system: "whenever [a patient] has an encounter... [all providers] get a notification about what happened to them." He emphasized that this method of timely data flow among a patient's network of providers helps medical professionals "prevent further complications, reconcile meds, or follow up on care gaps," making data interoperability a key tool of effective community-based coordination and continuity of care.

Community-based services for Veterans

Despite referral challenges, interviewees had positive responses to the care and services provided by community-based providers and organizations. Informed and personal care were both key when considering Veterans' experiences with providers in community-based settings.

The leader of a Veteran-focused resilience organization emphasized the importance of proactive interventions designed to prevent crises rather than merely responding to them. "We call it left-of-boom, which is kind of crude, but that's the term we use." He added that when Veterans identify needs—whether they are housing, employment, or mental health support—"we'll make sure they know where to go," reflecting a commitment to guiding Veterans through every step of care, another common sentiment shared among interviewees.

Another interviewee from a community Christian ministry shared this mindset, detailing a comprehensive, peer-driven model that delivers both medical and social supports: "We manage… peer-led, Veteran-led outreach programs for the most vulnerable in North Carolina… We do extensive outreach using peer support specialists and community health workers." He identified the importance of community integration and consistent, personal care to fill gaps in both health care access and social needs.

With all of this in mind, a Veteran and former state-level Veteran service official emphasized the importance of a robust informational infrastructure in delivering quality care, for both Veterans and providers. The interviewee and his team identified the need for a centralized portal for navigating benefits and service referrals. Through tools like NC4vets.org, providers and Veterans alike have a unified location through which information, advice, and services can be found to better assist Veterans with finding care and providers with learning how to navigate the unique challenges they may face when working with Veterans.

Community-based health care provider preparedness to serve Veterans

Inefficient processes notwithstanding, a major factor in the divide between the VA and community-based providers is the need for Veterans to be identified as such during visits. A Veteran psychiatric practitioner within the VA health care system underscored the impact of under-identification on clinical care. He noted that many Veterans downplay their service, and if clinicians never ask, "their exposures aren't understood":

"Veterans are never going to ask for help and never going to tell anybody else, especially if they're not Veterans, [that] they need it…[Veterans assume] civilians aren't going to understand, they don't know anything about [their experiences]." He continues, explaining the complexes many Veterans have: "Most Veterans won't even sign up for the VA… [they reply] 'I did serve in the Military and I did deploy to a combat zone, but I didn't do anything. I'm not a hero, and I didn't lose a leg or anything. The VA should be for people… who really were heroes."

The interviewee commented that, because Veterans often have this mentality of humility, it's up to clinicians and providers to ask whether a patient is a Veteran: "if they don't ask, not only does their doctor or any clinician not understand their medical history properly… the resources that are available to Veterans will not be used… because [clinicians] never ask that question."

One Veteran shared her experience with a community-based health care provider who asked if she was a Veteran, but did not seem to have a plan to use that information to improve her care:

"Each time I had surgery the intake assistant asked if I was a Veteran. I said yes. What will you do with that? She said I don't know. I am going to check yes. That was that. She did not even know I was a community care referral. My surgeon did not know I was a Veteran."

When speaking to the importance of provider knowledge and cultural competency, a senior home health executive highlighted that a deep knowledge of Veteran culture directly enhances care quality. She noted that, when considering the physical, psychological, emotional and social components unique to Veterans and their medical needs:

> ***"The more you know about it, the hope is, the better care and the more access to services will happen because [when] Veterans come out, they don't always... know themselves the benefits they're entitled to, the resources, how to get them, how to ask... It's kind of a continual dialogue."***

She stressed that, more than anything, providers need to earn a Veteran's trust. "If they don't trust you, you're not getting anywhere," ultimately underscoring the relational foundation, both unique and essential to effective community-based care.

Common health conditions experienced by Veterans

Mental Health Disorders

Many interviewees highlighted the psychological toll of military service, emphasizing depression, anxiety, and post-traumatic stress disorder (PTSD) as some of the most prevalent mental health conditions among military Veterans. One interviewee observed that transitioning Veterans often face "a tremendous sense of loss of identity... then they may have injuries, those invisible wounds that we don't see... depression, anxiety, TBIs, of course PTSD." She also noted the growing recognition of moral injury:

> ***"Moral injury [is] huge as well. If you're a person that struggles with that, and most people in the military [are], I mean, if you have to hurt someone else, you understand this is for your country and the protection of our citizens and our families, [but] it doesn't mean it doesn't wound you... you're the one that has to go to bed at night and see that person's face."***

Suicide

Suicide rates remain alarmingly high among Veterans, with some of the greatest risk observed among the older population. A Veteran working alongside providers underscored this disparity: "Data... that everybody ignores is that the highest group by rate who die by suicide is elderly veterans, and there's not even a close second." This "Hemingway effect," as the interviewee calls it, reflects both age-specific vulnerabilities and the urgent need for tailored prevention strategies for both young and elderly Veterans.

Interviewees across the spectrum noted the correlation between heightened suicide rates among Veterans and their access to lethal means of suicide, a well-documented trend. As noted in the National Veteran Suicide Prevention Annual Report, firearm suicide

rates among Veterans surpass those of all other suicide categories. The report notes that firearm ownership is significantly higher among Veterans (45%) than non-Veterans (19%), making firearm safety and suicide prevention initiatives a crucial aspect of addressing Veteran mental health.[11]

Substance Use Disorders

Substance misuse—ranging from alcohol to opioids and stimulants—was often cited as a pervasive coping mechanism among Veterans. One interviewee noted that "alcohol misuse, drug misuse and abuse… the opioid epidemic… contributed to both suicides and deaths." Another interviewee who works with Veterans in the justice system noted that, "when Vets come in with opioid use disorder, we have amazing success because we have MAT (medication assisted therapy)." He also cautioned that "when [Veterans] enter with meth use and cocaine use, we really struggle… one of the most challenging [populations they face] is the older male population who often have sex addiction and cocaine use, and we do see alcohol across all of them. It's pretty common."

Chronic Pain and Self-Medication

Persistent physical pain, often rooted in combat injuries or service-related strains, drives many Veterans toward self-medication. "We know that Veterans have a lot of pain, and pain treatments are not that effective for everyone," an interviewee reflected, adding that "Veterans say they smoke marijuana to treat their pain and also to treat their PTSD, too." This underscores gaps in both pharmacologic and non-pharmacologic pain management within VA and community systems.

Traumatic Brain Injuries (TBIs)

Though less frequently named among interviewees, TBIs emerged alongside mental-health challenges. As previously noted, one interviewee included TBIs in her description of the invisible wounds many Veterans deal with, highlighting the overlap between head trauma and mental/behavioral health issues. Addressing TBIs' cognitive, emotional, and physical impacts remains a key component of comprehensive Veteran care.

Unique nature of behavioral and mental health challenges in the Veteran population

An interviewee involved with Veterans in the justice system described a cohort of Veterans Treatment Court participants marked by high-risk needs and fragmented life histories. He noted that many participants had "a lot of… childhood trauma, intergenerational trauma [and] challenges growing up, [they] joined the military because they didn't have a lot of options, then struggled in the military, got out, continued to struggle" often because "the work history of our Veterans is not extensive" and "[their] education [level] is usually high school or GED."

Drawing on his research into moral injury, another interviewee warned that most Veterans face a profound identity crisis upon leaving service: "You lose sort of who you are and you can't find your way… It's a new culture for these young men and women who transition out [of the military]."

A justice system representative highlighted that the justice system often exposes Veterans' compounded social factors—e.g. substance use, mental health issues, domestic violence,

poverty, homelessness—yet through standard court processes, "we can rarely resolve the root of the problem." Interviewees noted that many Veterans fall into "the most vulnerable [groups] in North Carolina," requiring intensive, peer-led outreach just to reengage them in care.

Social contributors to behavioral and mental health challenges

Social isolation was identified as a primary driver of distress among Veterans: "One of the big, big problems with getting out of the service is you lose your tribe, your sense of purpose, and your sense of belonging," a common talking point among both interviewees who worked with transitioning Veterans, as well as from Veterans who personally experienced the transition process. Additionally, referencing their lack of purpose, an interviewee noted that upon separation, while Veterans are led through employment preparation and financial readiness courses, oftentimes most don't pay attention. "They got the paper signed off, went out, and [were] like 'Wow, what do I do now? How do I budget? How do I interview again? How do I build a resume, and what do I even want to do?'" Because employment, housing and finance is covered during military service, many recently-separated Veterans find themselves unequipped for civilian life, especially considering the lack of social support.

Strategies to address behavioral and mental health challenges

Veteran-serving community-based mental health providers

Breaking down the previously mentioned "Left of Boom" framework, the interviewee proposed four individual quadrants (mental health, tribe, finance/employment, education/training) to intervene early, ensuring Veterans "know where to go" before crises deepen. Along a similar vein, just as many interviewees' programs are geared toward building an integrated network of informed clinicians and support organizations, one interviewee recommended a more holistic preparatory program for community clinicians. A Veteran advocate who works in non-clinical support expertly captured the ethos driving effective community care: "We need to stop handing Veterans a checklist or a list of resources and start handing them a team."

Veteran Treatment Courts

Interviewees who work with Veterans in the justice system described their program as an evidence-based, interdisciplinary court model which replaces incarceration with heavily structured support: "We are a… nonpunitive [program]… so we foster behavior modification through constant accountability every 14 days… They're assigned all these social supports; we're connecting them with pro-social activities, everything from equine therapy and warrior canine [to] animal assisted therapy." Interviewees with experience working in this program affirmed the program's efficacy, noting that "the recidivism rate is so low for people that actually go through intensive recovery while in [this] intensive probation program," and that the court's nonpunitive approach seeks to address the root causes rather than punishing symptoms.

Family member experiences and needs

A medical professional stressed the importance of recognizing family members when considering the health and medical needs of Veterans. She made a point to note that, as primary health care decision-makers in a Veteran's life, family members require the same levels of cultural competency and clear communication from both the VA and community providers, especially considering that they may need to navigate the complex referral processes that their Veterans may or may not be familiar with in order to ensure they receive holistic support. Additionally, if the family members did not previously accompany their Veteran through their treatment and support processes, the responsibility of educating them may fall on their Veteran's providers, hence the importance of communal resources and networks of support.

The stresses of support, both during and after military service are often overlooked, according to a retired Veteran and Veteran advocate. She described the recent level of recognition regarding the unique stresses and trauma of being part of a military family, as well as a major gap in research:

> ***"There's a growing body of literature looking at the stresses and trauma of being a military family, particularly active duty with all their moves… If I'm the spouse… [I'm] taking care of the kids and dealing with my anxieties, their anxiety, trying to keep everything running [at home]… there's very little literature on the Reserves."***

She also noted that children of Veterans often go unrecognized in schools and health care systems, suggesting that without systematic identification—such as asking, "Do you have a family member that serves?" —schools and providers "don't know what trauma they may be carrying forward," thus impeding the chance of early intervention and support. She concluded, "I think if there's something that this task force could do and expand, our health care records don't ask about families."

On the topic of family support, an interviewee who works with the children and families of Veterans emphasized that supporting Veterans requires attending to "All that is around them," including their families and children. She explained: "I really appreciate talking about connectedness. It's not just 'how do we serve Veterans or military service members,' it's all that is around them." To address these needs, her organization helped launch an ongoing support program, "focused on providing summer experiences for the children of military service members and Veterans, particularly for those who are wounded, fallen, or injured," so that children can connect with peers who understand their home lives while parents gain some respite, assured that their children are in a safe, culturally-aware, and competent environment.

Unique challenges among historically marginalized or underrepresented populations

As previously identified, there is a history of gendered bias within the VA, a situation corroborated by a high-ranking Veteran. She recalled that when service members returned from Vietnam, "the public was told there were no women in Vietnam… so [women who served] were not eligible for care in the VA." She continued, noting that while "more VA's are making accommodations for women to have their primary care and GYN and appropriate environments," many are still "sent to the public sector for pregnancy for labor and delivery," forcing women to navigate the fragmented structure of care across systems. Additionally, several interviewees noted the unfortunate reality affecting those Veterans who embody dual marginalized identities. It was frequently noted that women of color were less likely to be asked if they are a Veteran, underscoring the role of intersectionality and care in the Veteran community.

One Veteran leader who was interviewed served on a task force which enabled LGBTQ+ and transgender individuals to serve openly in the military. Due to her intimate familiarity with the related issues, she stressed the importance of asking about, and accommodating, gender identity in VA settings: "I don't know how well our VAs in North Carolina have been prepared to care for transgendered individuals…I think you could clearly ask those questions." Her observations point to ongoing gaps in cultural competence and the need for VA clinics to create competent, safe, respectful environments for people of all gender identities.

A Veteran working alongside the health care community summarized the way that service members and Veterans from marginalized groups face implicit biases, while also challenging the stereotypes often associated with Veterans. He urged providers to extend the same cultural awareness to Veterans that they would any other demographic: "We have this implicit bias that a Veteran who's coming back today [has] a mental health challenge. We automatically place a stigma on them right off the bat… We have to stop doing that… We perceive people as black, white, transgender, Christian, Hindu like it's the same thing… We have to apply it with Veterans the same way." Through this comparison, he not only highlights the unique stereotypes associated with Veterans, he also touches on the role of intersectionality among Veterans from marginalized groups.

Conclusion

The six-month learning phase conducted by NCIOM staff was vital to becoming familiar with the challenges Veterans experience with access to health care and their experiences with that care. This time allowed for an initial understanding of Veteran culture for NCIOM staff who were less familiar with this population. The learning period also helped NCIOM staff to make connections and begin to earn trust with those working in the field of Veteran services and health care. Interviewees helped to make connections with others in the field, even outside of North Carolina.

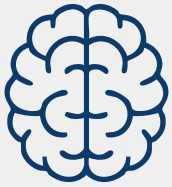
The variety of perspectives shared by interviewees and participants in other learning phase activities highlighted the need to carefully craft the scope of the task force. Many times, task force processes encompass such a broad range of issues related to the task force topic that it can become challenging to focus on any one issue. One example in this work is that the learning phase emphasized the role that social drivers of health play in the lives of Veterans, beginning at separation from the military. Issues such as housing, transportation, and employment contribute to the health and well-being of Veterans. Yet, the magnitude of these issues is such that including them in the scope of the task force would not allow for adequate attention to be focused on them.

After discussing learning period findings with steering committee members, the scope of the NCIOM Task Force on Veterans' Health will address:

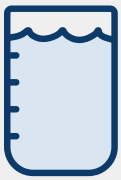
Systems around community health care provision for Veterans

Community health care provider Veteran cultural competency and capabilities related to billing common payers for Veteran care

Health-related needs of Veteran family members and caregivers



Veteran knowledge of health-related service availability



Capacity of health-related services for Veterans

Transition experiences from active duty to civilian or reserve status

Empowerment of community-level efforts to support Veteran and family member health and well-being

The task force will include a central body responsible for the final recommendations. This group will be informed by four work groups focused on topics related to the areas of focus listed above and inclusive of all aspects of Veteran health (i.e., physical, mental, behavioral, dental, and vision).

1. Veteran access to community-based care - Will address issues of insurance status (eg Medicaid), provider acceptance of common Veteran payers, broader issues of access (eg rural areas), workforce pipeline development
2. Care and resource connections for Veterans - Will address issues related to knowledge of services, care and resource coordination, and addressing stigma
3. Health care provider preparedness to serve Veterans - Will address issues of provider cultural awareness, ability to accept common Veteran payers, coordination with VA Care in the Community, workforce pipeline development
4. Veteran family and caregiver health-related needs - Will address issues related to child and family mental health, knowledge of benefits, caregiver challenges, school connections

The task force will meet six times between July 2025 and May 2026 and work groups will meet three to four times each between September 2025 and March 2026. A final report with recommendations from the task force will be published in November 2026.

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