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Honoring Service and Ensuring Care for North Carolina's Veterans, Families, and Caregivers

Task Force on Veterans' Health

Supported by

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

AARP® North Carolina

The North Carolina Institute of Medicine (NCIOM) is a nonpolitical 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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Suggested Citation:
North Carolina Institute of Medicine. Honoring Service and Ensuring Care for North Carolina's Veterans, Families and Caregivers. Chapel Hill, NC: North Carolina Institute of Medicine; 2026

Funded by The North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities, and Substance Use Services and AARP North Carolina.

Any opinion, finding, conclusion, or recommendations expressed in this publication are those of the task force and do not necessarily reflect the views and policies of the task force funders. The North Carolina Institute of Medicine recognizes the broad range of perspectives, priorities, and goals of the individuals and organizations who have contributed to the process and report of the task force; while we strive to reach and reflect consensus, participation in the task force does not indicate full endorsement of all final recommendations.

Credits:
Report design and layout: Catherine Immanuel

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NCIOM

Acknowledgements

The North Carolina Institute of Medicine (NCIOM) Task Force on Veterans' Health was convened from July 2025 to May 2026. Funding for the task force was provided by the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities, and Substance Use Services and AARP North Carolina.

The task force was co-chaired by **Secretary Jocelyn Mitnall Mallette,** JD, MA, Secretary of the North Carolina Department of Military and Veterans Affairs; **Margaret Chamberlain Wilmoth,** PhD, MSS, RN, FAAN, Professor, University of North Carolina at Chapel Hill School of Nursing and President, Reserve Organization of America; and **Paul Berry,** Director of Strategic Partnerships and Integration, Veterans Bridge Home. Their expertise and insight were vital to the success of the task force.

The NCIOM would also like to thank the members of the task force, work groups, and steering committee who shared their time and experience on this critical topic. The members of the steering committee provided crucial assistance in planning the scope of the task force's work and identifying task force members and expert guest speakers. A full list of task force, work group, and steering committee members is provided on the following pages.

The Task Force on Veterans' Health heard presentations from several expert speakers and spoke with a variety of individuals throughout the task force process who contributed to deeper knowledge and expertise on special topics, provided personal stories, and shared information about initiatives and research related to Veterans' Health. The NCIOM would like to thank the following people for sharing their knowledge and experience (names are listed in alphabetical order by last name; positions listed are as of the date of presentation, discussion, or other contribution):

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In addition, we convened several advisory groups on special topics of interest, including access to lethal means safety, novel treatments for PTSD, women Veterans' experience of care, military and veteran survivor needs, and health care provider training on military culture and military-connected health conditions. The NCIOM would like to thank the following people for sharing their knowledge and experience in one or more of these advisory groups (names are listed in alphabetical order by last name positions listed are as of the date of participation):

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In addition to the speakers, interviewees, and advisory group participants, the staff of the North Carolina Institute of Medicine contributed to the task force research and development of this report. **Michelle Ries,** President and CEO, and **Ayana Simon,** Associate Director, guided the work of the task force, facilitated discussions, and provided insight to the task force and recommendation process. **Brieanne Lyda-McDonald,** Project Director, served as Project Director for the task force and was primary author of the final task force report. **Patrick Tang,** Project Director, facilitated meeting discussions and contributed to recommendation development. **Brady Blackburn,** Communication Director, provided copy editing for the final task force report and developed communications strategies for dissemination. **Don Gula,** former Director of Operations, **Emily Hooks,** Program and Evaluation Manager, **Deidre Bishop,** Executive Assistant, **Ruby Brinkerhoff,** Assistant Managing Editor of NCMJ, and **Sarah Dancausse,** Research Specialist provided additional project support. **Austyn Kobs,** Project Intern, contributed extensive time, effort, and personal experience in the development of the project and writing of the final task force report.

Initial drafts of portions of this report and potential research sources were developed with the assistance of Claude Sonnet 5.

Special thanks to Catherine Immanuel for final task force report design and formatting.

Recommendations: Responsible Parties and Partners

X = Responsible party **O** = Partner

Abbreviations are defined on the following page.

Strategy	NCDMVA	NCDHHS (DMH/ DD/SUS)	NCGA	Veteran service organizations	Health care providers/ orgs	NC AHEC	Other responsible parties and partners
Recommendation 1: Enhance access to available services and support through more robust engagement with Veterans, their families, and caregivers.							
1.1	O	O	X				
1.2							County and local elected officials and leaders
1.3	O	O					Healthy Vets sustainer
1.4				X			Federal VA partners
1.5			X				
Recommendation 2: Increase Veteran family and caregiver awareness of available services and programs.							
2.1	X			X			
2.2	X						Ask Me NC, NC Serves, NC Caregiver Portal, Administrators of VDC programs
2.3							VetREP
Recommendation 3: Help the children of Veterans access the supportive services they may need.							
3.1							LEAs; Veteran student organizations; Health professional student organizations
3.2	X	X					NC DPI
Recommendation 4: Improve Veteran access to health care providers, services, and programs to meet their mental and physical health needs and eligibility status.							
4.1	X						***Partners:*** VISN 2, County VSOs, ACA Marketplace Navigators, SHIIPs
4.2			X		X		NCMB; NCDS; NCOHC; NCDHA; NCDAEA; NCDAA
4.3	X			X			NCAOC; NCJB; County VSOs
Recommendation 5: Enhance the network of health care providers in community-based health care settings that are available to Veterans.							
5.1							UNC Gillings
5.2			O			X	***Partner:*** VISN 2
5.3							ROOTS Hubs
Recommendation 6: Improve community-based health care provider knowledge about Veteran culture and military-connected conditions.							
6.1							NC health professional training programs; UNC and Community College Systems
6.2	X					X	NC Governor's Institute, Ask Me NC
6.3		O				O	SR-AHEC; SEAHEC; ***Partners:*** Ask Me NC, NC Governor's Institute
6.4							NC health insurance carriers, NC Medicaid
6.5							Veteran student organizations; health care professional student organizations; UNC system nursing or other health professional program
Recommendation 7: Consistently identify Veterans, their families, and caregivers within health care systems to improve the care Veterans receive.							
7.1					X		
7.2							NCHF
7.3							***Partners:*** VA medical centers, NCHIE
Recommendation 8: Activate new and ongoing attention to the health needs of Veterans.							
8.1							NC Governor
8.2							Healthy Vets sustainer

Abbreviations Used in the Table of Recommendations

ACA = Affordable Care Act

County VSOs = County Veteran Service Officers

DMH/DD/SUS = Division of Mental Health, Developmental Disabilities, and Substance Use Services

DPI = Department of Public Instruction

Healthy Vets sustainer = Organization chosen to sustain the University of North Carolina Healthy Vets Community Project's work

LEAs = Local educational agencies

NC AHEC = North Carolina Area Health Education Centers

NCAOC = North Carolina Administrative Office of the Courts

NCDAA = North Carolina Dental Assisting Association

NCDAEA = North Carolina Dental Assistant Educators' Association

NCDHA = North Carolina Dental Hygienists' Association

NCDHHS = North Carolina Department of Health and Human Services

NCDMVA = North Carolina Department of Military and Veterans Affairs

NCDS = North Carolina Dental Society

NCGA = North Carolina General Assembly

NCHF = North Carolina Healthcare Foundation

NCHIE = North Carolina Health Information Exchange

NCJB = North Carolina Judicial Branch

NCMB = North Carolina Medical Board

NCOHC = North Carolina Oral Health Collaborative

ORH = Office of Rural Health

ROOTS = Rural Health Transformation grant Rural Organizations Orchestrating Transformation for Sustainability

SEAHEC = South East Area Health Education Center

SHIIPs = State Health Insurance Information Programs

SR-AHEC = Southern Regional Area Health Education Center

UNC Gillings = University of North Carolina at Chapel Hill Gillings School of Global Public Health

VDC = Veterans Directed Care

VetREP = Veteran Research Engagement Panel

VISN 2 = Veterans Integrated Service Network 2



EXECUTIVE SUMMARY

North Carolina is home to over 615,000 Veterans, representing roughly 7% of the state's total population, along with nearly 284,000 active duty, National Guard, and reserve members, spouses, and children who may one day become Veterans in the state.[1,2] As Veterans transition from active duty to civilian life and age into older adulthood, they can face complex and intersecting challenges that affect their health, well-being, and quality of life. Health care and other supports for Veterans are layered and involve the federal Department of Veterans Affairs (VA), VA Medical Centers, state Veteran services, county Veterans Services, community-based health care providers, and a range of nonprofit and social service organizations. Navigation of services requires knowledge, persistence, self-advocacy, and often word-of-mouth knowledge sharing. This complexity, combined with gaps in community-based health care provider preparedness to serve Veterans and systemic coordination challenges, means that many Veterans in North Carolina struggle to receive the care and services they need.

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This report presents the recommendations of the North Carolina Institute of Medicine (NCIOM) Task Force on Veterans' Health. The task force focused on issues of access, experience, and quality of health care for Veterans, their families, and caregivers in community-based settings. The goal of this report and the task force recommendations is to highlight the unique mental and physical health needs of Veterans in North Carolina and motivate state, community, and health care system action to ensure optimal Veteran health and well-being.

For the purposes of task force discussion and this report, a Veteran is defined as anyone who has served in the uniformed services, regardless of discharge status. This inclusive definition is intended to focus on the experience of uniformed service itself, rather than legal status or self-identification.

Health Challenges Unique to Veterans

Veterans carry a unique health burden shaped by their service experiences. Some of the most prevalent and consequential conditions are:

- **Post Traumatic Stress Disorder (PTSD):** Lifetime prevalence for general Veteran population is 7% compared to 6% for general population, however rates are higher for younger Veterans (15% ages 18-29 and 10% ages 30-44) and women (13%).[3]
- **Traumatic Brain Injury (TBI):** Nearly 1 in 4 US Veterans screen positive for probable TBI.[4]
- **Military Sexual Trauma (MST):** Around 1 in 3 women report they have experienced MST, while about 1 in 50 men report experiencing MST at some point during their military service.[4]
- **Substance Use Disorder (SUD):** Around 14% of Veterans report having at least one substance use disorder.[5]
- **Moral Injury:** The psychological harm that can result from actions or experiences that violate a person's deeply held moral beliefs.

Veterans are also at higher risk for other health challenges related to their service. These include:

- **Chronic Musculoskeletal Pain:** Multiple studies have found higher rates of musculoskeletal pain among Veterans compared to non-Veteran populations.[6]
- **Toxic Exposure:** Over one-third of Veterans may have been exposed to toxic substances during their military service.[7,8]

- **Tinnitus and Hearing Loss:** In 2024, tinnitus was the most common condition for which Veterans received benefits and hearing loss was the fifth most common.[9]
- Disproportionately higher self-reported rates of obesity, stroke, cancer, chronic obstructive pulmonary disease (COPD), arthritis, kidney disease, and diabetes.[10]

Suicide continues to be one of the most pressing public health concerns in the Veteran community. In North Carolina, the suicide rate for Veterans age 18-34 is 97.0 per 100,000 compared to 15.6 for non- Veterans.[11] While younger Veterans are at markedly elevated risk of suicide, data indicates that older Veterans represent one of the highest-risk groups by rate.[11] The suicide rate among Veterans age 75 and older in North Carolina is 54.1 per 100,000 population compared to 14.3 for non-Veterans.[12]

Rise of Community-Based Care for Veterans

Veterans do not automatically qualify for health care through the Veterans Health Administration (VHA). In general, eligibility is based on length and type of military service, the presence of a health condition related to service, and income level. In 2023, around 9.2 million Veterans (roughly half of all living U.S. Veterans) were enrolled in VHA, and around 6.1 million received care through VHA.[13]

In addition to care provided directly at VA facilities, the VA refers and pays for Veterans to receive care from private-sector providers in communities where Veterans live ("community care"). This approach is used when the VA cannot provide timely or geographically accessible care on its own. VA spending on community care grew from about 12% in 2014 to 20% of all VHA medical spending in 2021.[14] The increase in reliance on community care has continued with a 4.1% increase in the number of community care appointments in FY 2025 compared to FY 2024.[15] In FY 2025, $1.5 billion was spent on VA Community Care in North Carolina.[15]

Needs of Veterans in Community-Based Health Care Settings

Veterans often do not disclose their military service to health care providers in community-based settings. This may be out of humility, a belief that providers will not understand their experiences, an unwillingness to seek help that they perceive as belonging to those who "really suffered," or not seeing the relevance of their service to their health care. However, when providers do not know about Veteran status, the clinical picture is incomplete. Evidence-based, Veteran-specific risks and interventions may not be considered, and Veterans may not be connected to the benefits and programs for which they qualify.

Veteran Families and Caregivers

The health and well-being of Veterans cannot be fully addressed without considering the families and caregivers who support them. Military families experience their own distinct stressors, including the demands of frequent relocation, periods of deployment-related separation, employment instability, the anxiety of a loved one's service, and the adjustment challenges that accompany a service member's return. A growing body of research documents the psychological and social toll these experiences can take on spouses, partners, and children. The literature on reserve and National Guard families, who navigate these challenges while remaining embedded in civilian communities, remains limited.

NCIOM Task Force on Veteran's Health

The increasing demand for community-based services for Veterans, ongoing changes at the federal level regarding VA operations, the persistence of the disproportionate rate of Veteran suicide, and the 615,000 Veterans who call North Carolina home create an urgent need to assess and strengthen the state's capacity to serve Veterans in community-based health care settings.[1]

With these concerns in mind, the NCIOM convened the Task Force on Veterans' Health to identify actionable strategies for improving access to, and the experience and quality of, care for Veterans and their families in community-based settings.

The task force was supported by the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities, and Substance Use Services and AARP North Carolina. The NCIOM first engaged in a six-month learning period during which staff conducted interviews with dozens of Veterans, providers, advocates, government representatives, and others with direct experience of the issues facing the Veteran community in this state. A summary of this learning period is available at https://nciom.org/task-force-on-veterans-health-project-learning-period-summary/.

The task force was co-chaired by Secretary Jocelyn Mitnall Mallette, JD, MA, Secretary of the North Carolina Department of Military and Veterans Affairs; Margaret Chamberlain Wilmoth, PhD, MSS, RN, FAAN, Professor, University of North Carolina at Chapel Hill School of Nursing and President, Reserve Organization of America; and Paul Berry, Director of Strategic Partnerships and Integration, Veterans Bridge Home.

The three co-chairs helped guide five steering committee members, 45 task force members, and over 62 work group members through insightful conversations that led to the creation of the recommendations in this report. Most of the task force and work group members were Veterans themselves or close family of Veterans.

The final recommendations from this task force are intended to provide guidance that is practical, evidence-informed, and grounded in the real experiences of Veterans and those who serve them across North Carolina. They are offered not as a comprehensive solution to all challenges facing Veterans in this state, but as a focused contribution to an ongoing and necessary effort to ensure that those who have served receive the health-related care and services they deserve.

Connecting Veterans, Families, and Caregivers to the Support They Need

Recommendations in Chapter 2 call for a coordinated statewide effort to bridge the gaps that North Carolina's Veterans, their families, and caregivers can face in finding, accessing, and sustaining the services and supports available to them.

Recommendation 1: Enhance access to available services and support through more robust engagement with Veterans, their families, and caregivers

- **Strategy 1.1:** Increase funding to support Veterans' access to the services they are eligible for
- **Strategy 1.2:** Increase community identification of Veterans
- **Strategy 1.3:** Develop community-based engagement strategies to connect with Veterans
- **Strategy 1.4:** Maintain Veterans Benefit Live events
- **Strategy 1.5:** End predatory Veteran claims services

Recommendation 2: Increase Veteran family and caregiver awareness of available services and programs

- **Strategy 2.1:** Create a family transition navigator program
- **Strategy 2.2:** Improve Veteran caregiver access to information and resources related to available benefits and services
- **Strategy 2.3:** Increase research into Veteran caregiver needs

Recommendation 3: Help the children of Veterans access the supportive services they may need

- **Strategy 3.1:** Enhance the capacity of schools to identify and meet the needs of the children of Veterans
- **Strategy 3.2:** Develop Veteran child peer buddy program

Ensuring Access to Community-Based Health Care for North Carolina's Veterans

Recommendations in Chapter 3 address the structural and geographic barriers that can stand between North Carolina's Veterans and access to health care services.

Recommendation 4: Improve Veteran access to health care providers, services, and programs to meet their mental and physical health needs and eligibility status

- **Strategy 4.1:** Host an annual Veteran health information summit
- **Strategy 4.2:** Increase Veteran access to health services, particularly in rural areas
- **Strategy 4.3:** Assist justice-involved Veterans in accessing available health-related services

Recommendation 5: Enhance the network of health care providers in community-based health care settings that are available to Veterans

- **Strategy 5.1:** Analyze the network of community-based providers available to Veterans
- **Strategy 5.2:** Improve the capacity of smaller health care practices to serve Veterans
- **Strategy 5.3:** Engage the Rural Health Transformation grant to improve access to care for Veterans

Building a Health Care Workforce and System Ready to Serve Veterans

Recommendations in Chapter 4 focus on strengthening both the pipeline and the preparation of North Carolina's health care workforce to better meet Veterans' health care needs.

Recommendation 6: Improve community-based health care provider knowledge about Veteran culture and military-connected conditions

- **Strategy 6.1:** Increase the number of Veterans in the health care workforce
- **Strategy 6.2:** Educate community-based health care providers about the unique mental and physical health needs of Veterans and the social factors that can affect their health
- **Strategy 6.3:** Create and maintain a database of Veteran-ready health care professionals
- **Strategy 6.4:** Incentivize health care providers to increase their knowledge of the unique mental and physical health needs of Veterans
- **Strategy 6.5:** Engage health care professional students in learning about the unique mental and physical health needs of Veterans

Recommendation 7: Consistently identify Veterans, their families, and caregivers within health care systems to improve the care Veterans receive

- **Strategy 7.1:** Ask patients about their military connections
- **Strategy 7.2:** Establish Veteran care improvement mechanisms within hospitals and health systems
- **Strategy 7.3:** Improve community-based provider access to Veteran health information

Leading the Way to Action

Recommendations in Chapter 5 propose strategies to bring attention and continued action to address challenges related to Veterans' health.

Recommendation 8: Activate new and ongoing attention to the health needs of Veterans

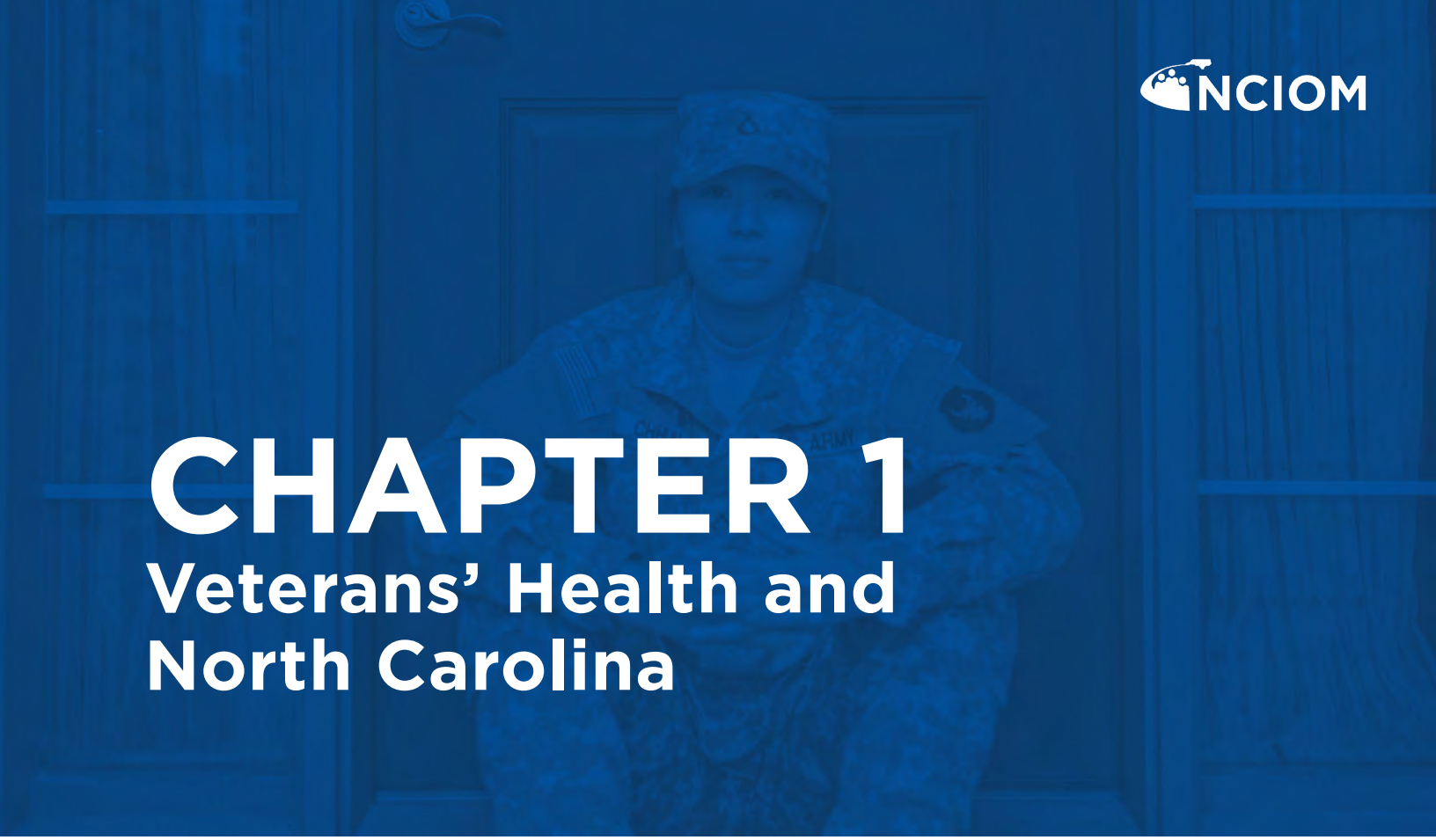
- **Strategy 8.1:** Generate attention to Veterans' health
- **Strategy 8.2:** Identify and sustain a lead organization to facilitate ongoing action

Conclusion

North Carolina's Veterans have earned a system of care that meets them where they live, understands what their service has asked of them, and helps them navigate a path to well-being that is too often complex and disjointed. As community-based care has grown from a supplement to a substantial share of how Veterans receive treatment, so too has the responsibility of the state, health systems, and community providers to ensure that this care is accessible, culturally informed, and consistently high-quality for every Veteran. The stakes of getting this right are made clear by the disproportionate rates of suicide, toxic exposure, and untreated mental and physical health conditions that Veterans carry, and by the families and caregivers who share in these burdens. The recommendations from the NCIOM Task Force on Veterans' Health that were presented in this report offer a practical and evidence-informed roadmap for this work, but a roadmap alone cannot close these gaps. Sustained commitment from state leaders, health care organizations, and communities across North Carolina is needed to ensure that those who have served receive the coordinated, competent, and compassionate care they deserve.

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CHAPTER 1
Veterans' Health and North Carolina

North Carolina is home to over 615,000 Veterans—roughly 7% of the state's population—who have served across every branch and era of the military and live in both urban and rural communities. As they transition from active duty to civilian life and age into older adulthood, Veterans face complex, intersecting challenges to their health and well-being that can be compounded by difficulties navigating a layered system of federal, state, and community-based services. This chapter provides background and context for the remainder of the report, which presents the recommendations of the North Carolina Institute of Medicine (NCIOM) Task Force on Veterans' Health. The task force examined access, experience, and quality of health care for Veterans, their families, and caregivers in community-based settings. The group of 45 task force members worked to illuminate the distinct mental and physical health needs of Veterans and to spur state, community, and health system action to ensure the optimal health and well-being of North Carolina's Veterans.

Introduction

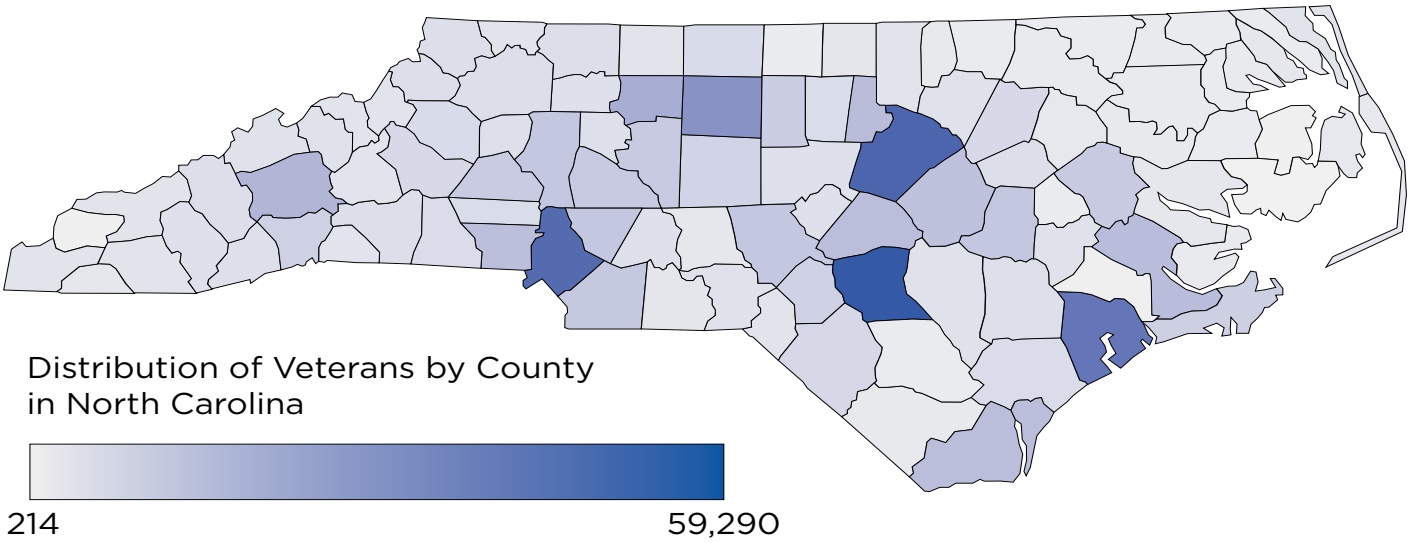
North Carolina is home to over 615,000 Veterans, representing roughly 7% of the state's total population, along with nearly 284,000 active duty, National Guard, and reserve members, spouses, and children who may one day become Veterans in the state.[1,2] These men and women have served in every branch of the military, across periods of peace and conflict, and they reside in both urban centers and rural areas throughout the state. As Veterans transition from active duty to civilian life and age into older adulthood, they can face complex and intersecting challenges that affect their health, well-being, and quality of life.

Health care and other supports for Veterans are layered and involve the federal Department of Veterans Affairs (VA), VA Medical Centers, state Veteran services, county Veteran services, community-based health care providers, and a range of nonprofit and social service organizations. Navigation of services requires knowledge, persistence, self-advocacy, and often word-of-mouth knowledge sharing. This complexity, combined with gaps in community-based health care provider preparedness to serve Veterans and systemic coordination challenges, means that many Veterans in North Carolina struggle to receive the care and services they need.

Purpose of This Report

This report presents the recommendations of the North Carolina Institute of Medicine (NCIOM) Task Force on Veterans' Health. The task force focused on issues of access, experience, and quality of health care for Veterans, their families, and caregivers in community-based settings. The goal of this report and the task force recommendations is to highlight the unique mental and physical health needs of Veterans in North Carolina and motivate state, community, and health care system action to ensure optimal Veteran health and well-being.

Figure 1. Veteran Population by North Carolina County, 2023



Source: Gamez-Gomez E. North Carolina Veterans: 2024 Snapshot. Carolina Demography. November 13, 2025. https://carolinademography.cpc.unc.edu/2025/11/13/nc-veterans-2024-snapshot/

Veterans in North Carolina

682,186
Total People

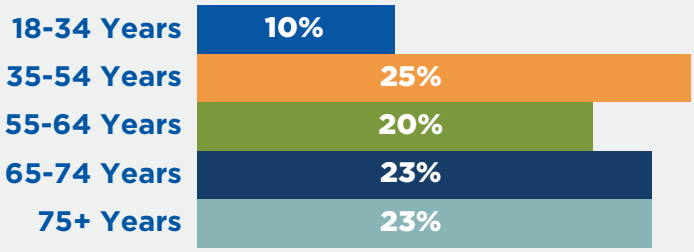
7%
of North Carolina's Population

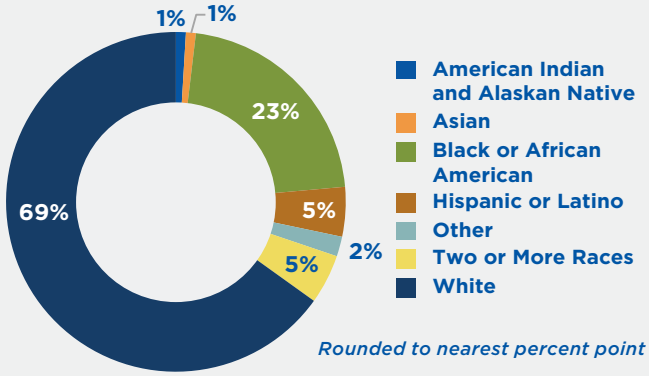
87%
Male

13%
Female

Nearly Half are

65+ **years old**





Rounded to nearest percent point

Economic Snapshot

4.1%
Unemployment
(10,162 Veterans age 18-64 unemployed)

$52,418
Median Income

7.3%
Below Federal Poverty Level
(47,387 Veterans)

Veteran Benefits and Disability Status

35,897
Veterans
in higher education in NC using GI Bill

83%
are attending public universities

$7.4B
Total VA Compensation & Pension paid to NC Veterans

37%
of NC Veterans have a Service Connected Disability (252,349 Veterans)

Sources: Geographic Distribution of VA Expenditures (GDX) Report. US Department of Veterans Affairs, National Center for Veterans Analysis and Statistics. 2024. https://www.va.gov/vetdata/expenditures.asp, Veterans Strategic Analysis & Research Tool (V-START): State Report. Accessed May 11, 2026. https://ivmf.syracuse.edu/research-analytics/data-insights-tools/v-start/v-start-dashboards/#statereportdash; NC Department of Military and Veterans Affairs. North Carolina Veterans Insights Report. 2024. https://www.milvets.nc.gov/north-carolina-veterans-insight-report/open

Who is a Veteran

For the purposes of task force discussion and this report, a Veteran is defined as anyone who has served in the uniformed services, regardless of discharge status. This inclusive definition is intended to focus on the experience of uniformed service itself, rather than legal status or self-identification.

The federal definition that is applied to Veteran benefits and services is less inclusive. Under federal statute 38 U.S.C. § 101(2), a Veteran is defined as "a person who served in the active military, naval, air, or space service, and who was discharged or released therefrom under conditions other than dishonorable." Eligibility for specific federal Veterans' benefits can vary from this legal definition.

Further complexity arises from the scope of uniformed service itself. In addition to the six branches of the US Armed Forces, there are eight total US Uniformed Services, including the US Public Health Service (USPHS) Commissioned Corps and the National Oceanic and Atmospheric Administration (NOAA) Commissioned Officer Corps. The USPHS and NOAA are frequently overlooked in policy discussions that use the terms "military" or "armed forces," and can therefore be unintentionally excluded from accessing state-level benefits. However, USPHS and NOAA members are considered Veterans for the purpose of receiving VA health benefits.[3]

Another complicating factor in identification of Veterans is that some individuals who meet the criteria do not self-identify as Veterans, leading to potential undercounts and gaps in care. These groups and reasons can include:

- Women, who may have had negative experiences with military sexual trauma and/or gender discrimination during their service.[4]
- National Guard and Reserve members who were never mobilized to active duty and have historically been more limited in consideration of federally designated Veteran status.[5]
- Those whose service occurred decades ago or never involved combat deployment.
- Those who view the label negatively or feel a stigma associated with it.

Health Challenges Unique to Veterans

Veterans carry a unique health burden shaped by their service experiences. Some of the most prevalent and consequential conditions are:

- **Post Traumatic Stress Disorder (PTSD) –** Lifetime prevalence for general Veteran population is 7% compared to 6% for general population, however rates are higher for younger Veterans (15% ages 18-29 and 10% ages 30-44) and women (13%).[6]
- **Traumatic Brain Injury (TBI) –** Nearly 1-in-4 US veterans screen positive for probable TBI.[7]
- **Military Sexual Trauma (MST) –** Around 1 in 3 women report they have experienced MST, while about 1 in 50 men report experiencing MST at some point during their military service.[7]
- **Substance Use Disorder (SUD) –** Around 14% of Veterans report having at least one substance use disorder.[8]
- **Moral injury –** The psychological harm that can result from actions or experiences that violate a person's deeply held moral beliefs.

Veterans are also at higher risk for other health challenges related to their service. These include:

- **Chronic Musculoskeletal Pain:** Multiple studies have found higher rates of musculoskeletal pain among Veterans compared to non-Veteran populations.[9]
- **Toxic Exposure:** Over one-third of Veterans may have been exposed to toxic substances during their military service.[10,11]
- **Tinnitus and Hearing Loss:** In 2024, tinnitus was the most common condition for which Veterans received benefits and hearing loss was the fifth most common.[12]
- Disproportionately higher self-reported rates of obesity, stroke, cancer, chronic obstructive pulmonary disease (COPD), arthritis, kidney disease, and diabetes.[13]

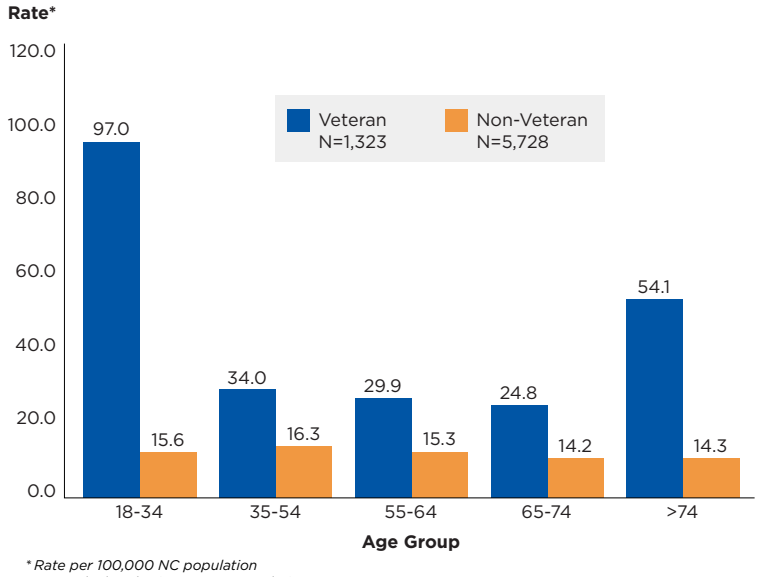
Veteran Suicide

Suicide continues to be one of the most pressing public health concerns in the Veteran community. The first 18 months after separation from the military carry the highest risk for Veteran suicide. This period, known as the "deadly gap," is a time of great transition that can leave some Veterans feeling isolated without the camaraderie and purpose they felt in the military.[14] In North Carolina, the suicide rate for Veterans age 18-34 is 97.0 per 100,000 compared to 15.6 for non-Veterans (see Figure 2).[15] While younger Veterans are at markedly elevated risk of suicide, data indicates that older Veterans represent one of the highest-risk groups by rate.[15] The suicide rate among Veterans age 75 and older in North Carolina is 54.1 per 100,000 population compared to 14.3 for non-Veterans.[16] This higher risk for death by suicide is attributable to:

1. Higher rates of suicidal ideation among Veterans due to a variety of challenges related to mental health status and military-connected experiences.
2. Higher rates of firearm ownership in the Veteran population and the lethality of suicide attempt by firearm. Veteran firearm ownership is 120% higher than the general population.[17,18]

These factors point to the importance of implementing lethal means safety techniques and connecting Veterans who need mental health treatment with adequate resources.

Figure 2. Suicide Rates by Veteran Status and Age Group, NC VDRS, 2019-2023



** Rate per 100,000 NC population*
Rates calculated using census population

Source: NC DHHS Injury and Violence Prevention Branch. NC Violent Death Reporting System. Veteran Suicide in North Carolina, 2019-2023. https://www.dph.ncdhhs.gov/chronic-disease-and-injury/injury-and-violence-prevention/veteran-suicide-fact/open

Veteran groups and the VA have implemented efforts related to awareness, advocacy, research, and services to help address this issue. One example is the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program, which "expands suicide prevention efforts beyond clinical settings to address both mental health and social determinants of health, such as economic hardship, social connectedness, and access to care."[19] In North Carolina, Asheville Buncombe Community Christian Ministry, Inc. and Veterans Bridge Home are grantees. Services that the grant can support include:

- "Outreach to identify eligible Veterans at risk of suicide.
- Baseline mental health screening.
- Education on suicide risk and prevention for families and communities.
- Clinical services for emergency treatment.
- Case management services.
- Peer support services.
- Assistance in obtaining any VA or other federal, state, or local benefits the Veteran and their family may be eligible to receive, including assistance with emergent needs.
- Nontraditional, innovative, or other services as defined in the Notice of Funding Opportunity and approved by VA."[19]



Dispelling a Myth: Veteran Suicide Is Not Always the Result of Combat Trauma

Excerpt from Everytown Research & Policy report "Those Who Serve: Addressing Firearm Suicide among Military Veterans"

"Suicide risk in veterans is commonly assumed to result from exposure to traumatic incidents while deployed to combat. On the contrary, among veterans who served during the Iraq and Afghanistan Wars, those who were not deployed to those war zones were at higher risk for suicide than those who were. Combat trauma has a complex relationship with suicide risk among veterans, and while research shows that certain conditions like post-traumatic stress disorder (PTSD) can contribute to suicide risk—whether derived from combat or from other events—there is no clear association between combat exposure generally and the risk of dying by suicide.

"What drives this noteworthy difference is not entirely clear, though some evidence suggests the 'healthy warrior effect,' where soldiers are screened for psychological resilience early in their careers. Recruits are trained in an intense environment that may reveal traits or disorders ill-suited for a war zone, which is a consideration for deployment later in their careers. One study of Marines deployed in Iraq and Afghanistan found that all psychiatric conditions except PTSD occurred at higher rates in nondeployed soldiers, suggesting that resilience is observed before deployment. Since veterans with mental health diagnoses have a higher suicide rate than veterans without, such psychological resilience may be an important protective factor.

"Additionally, aspects of being in the military separate from combat exposure can contribute to a veteran's suicide risk. Military service can provide soldiers with positive experiences and skills, such as leadership, decision-making, working with a team, and commitment. However, the culture that leads to success in the military—prizing discipline, group needs, and close bonds with other soldiers—may be lacking in US society when a soldier then transitions to become a veteran. Physical conditions that may result from military service can prove challenging as well; chronic pain, sleeplessness, increased health problems, and decreased physical ability are all risk factors for suicide. Research shows that without support, veterans risk feeling disoriented and without identity or meaning when they transition to civilian life."

Source: Tetons P. Those Who Serve: Addressing Firearm Suicide among Military Veterans. Everytown Research & Policy. October 2019. Those Who Serve: Addressing Firearm Suicide among Military Veterans | Everytown Research & Policy

Foundations for Veteran Well-Being

Veteran well-being and suicide risk are shaped by a broad range of upstream social factors that extend well beyond clinical diagnoses. Research has demonstrated the following:

- Food insecurity, housing instability, and homelessness are significantly associated with higher suicide risk among Veterans.[20–22]
- Lack of transportation access is associated with greater suicidal ideation and suicide attempts, as well as increased all-cause mortality.[23,24]

- Unemployment and financial instability are associated with suicide morbidity in Veteran populations.[23]
- Veterans discharged with Other Than Honorable status carry significantly higher odds of moderate to high levels of suicidal ideation than those honorably discharged.[25]
- Social isolation is consistently associated with worse mental and physical health outcomes among Veterans.[26–28]
- Rural Veterans face compounding risks, including a greater likelihood of PTSD symptoms, higher perceived stigma around seeking mental health care, and lower rates of service utilization compared to urban peers.[29,30]

Meanwhile, the following factors are protective for Veteran well-being.

- Veterans with a college degree show lower odds of a suicide attempt compared to those without a degree.[20]
- Civic engagement and volunteering have demonstrated protective effects, including reductions in PTSD and depression symptoms, lower loneliness, and greater life satisfaction.[31]
- When experienced positively, religion and spirituality can serve as protective factors against suicidal ideation and suicide attempts.[32]
- Access to green spaces and outdoor recreational activities has been identified as a promising avenue for reducing health disparities and improving well-being among Veterans.[33]

VA Health Care

Although the overall Veteran population has decreased as fewer Americans serve in the armed forces, the number of Veterans using VA health care has grown over time as eligibility policies have addressed the need to treat Veterans who have been exposed to toxic substances during their service.[34] Lower-income Veterans, those without health coverage from other sources, Veterans with worse overall health, and those living in rural areas tend to rely on the VA for a greater share of their health care than other Veterans.[35] Veterans who use VA health care are more likely to have service-related injuries and chronic conditions including TBI, cancer, diabetes, high blood pressure, and PTSD.[35] These increased physical and mental health challenges partially explain the higher rate of suicide among Veterans who are enrolled in VA care. However, research shows that Veterans who had a VA visit within the past year are less likely to die by suicide than those who have not had a recent visit, with 61% of VA-enrolled Veterans who died by suicide in 2023 having not had a visit in the past year.[36]

Eligibility for VA Health Care

Veterans do not automatically qualify for health care through the Veterans Health Administration (VHA). In general, eligibility is based on length and type of military service, the presence of a health condition related to service, and income level. Veterans who served in active military duty and were discharged under conditions other than dishonorable may be eligible but must elect to "opt in" to VA health care, either during the separation process or at some future point. Those who enlisted after September 7, 1980, typically must have served at least 24 continuous months to be eligible, unless they were discharged due to a service-related disability or hardship.[39] Current and former reserve and National Guard members "must have been called to active duty by a federal order and completed the full period for which [they] were called or ordered to active duty" to be eligible.[39]

Once determined eligible, Veterans are placed into one of eight "priority groups" that determine the level of financial contribution required for their care. Those with the most severe service-connected disabilities and ex-prisoners of war receive the highest priority. Veterans who earn above a certain income threshold and have no service-connected disabilities are placed in lower priority groups and pay more out of pocket.[39]

In 2022, the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act significantly broadened eligibility for VA health care by extending coverage to Veterans exposed to burn pits, Agent Orange, and other toxic substances during their service.[40]

Veterans Health Administration
an integrated health care system



170
medical centers



1,193
outpatient sites[37]

9.2M
Veterans
enrolled
(roughly half of all living U.S. Veterans)

6.1M
Veterans
received care[38]

Discharge Status and VA Benefits

Based on federal statute, discharge status serves as a gatekeeping criterion for Veteran benefits and services. In practice, a dishonorable discharge disqualifies an individual from receiving VA disability benefits and most VA services. However, the range of service characterizations is broader than a simple honorable/dishonorable binary. Service members may also receive characterizations of general, under other than honorable conditions, bad conduct discharges, or entry-level separations. These characterizations may trigger a Character of Service Determination by the VA, and eligibility for specific benefits can vary depending on the outcome of the review by the VA.

Yet, service characterization is not necessarily permanent. Veterans may apply to have their discharge characterization upgraded through the military's Discharge Review Boards or Boards for Correction of Military Records. Upgrades may be granted for a variety of reasons, including evidence that the original discharge was inequitable or improper, recognition that a service member's misconduct was connected to an undiagnosed or untreated mental health condition such as PTSD or traumatic brain injury, or acknowledgment of historical patterns of unjust discharges, such as those issued to LGBTQ+ service members prior to the repeal of "Don't Ask, Don't Tell."[i]

[i] Requests for Upgrade of Discharge Characterization > U.S. Department of War > Article | U.S. Department of War. Accessed May 11, 2026. https://www.war.gov/Contact/Help-Center/Article/Article/2742507/requests-for-upgrade-of-discharge-characterization/

Rise of Community-Based Care for Veterans

In addition to care provided directly at VA facilities, the VA refers and pays for Veterans to receive care from private-sector providers in communities where Veterans live ("community care"). This approach is used when the VA cannot provide timely or geographically accessible care on its own.

Community care has expanded dramatically following two major pieces of legislation:

1. The Veterans Access, Choice, and Accountability Act of 2014 was passed after media reports revealed long wait times at VA facilities nationwide, creating the Veterans Choice Program and establishing the VA Office of Community Care.[41]
2. The VA MISSION Act of 2018 further expanded eligibility for community care and consolidated earlier programs into the Veterans Community Care Program (VCCP).[42]

VA spending on community care grew from about 12% in 2014 to 20% of all VHA medical spending in 2021.[43] The increase in reliance on community care has continued with a 4.1% increase in the number of community care appointments in FY 2025 compared to FY 2024.[44] In FY 2025, $1.5 billion was spent on VA Community Care in North Carolina.[44]

Under current rules, enrolled Veterans may access community care when:

- VA does not offer the needed service;
- The Veteran's drive to a VA provider exceeds 30 minutes for primary care or 60 minutes for specialty care;
- VA cannot offer an appointment within 20 days for primary care or 28 days for specialty care;
- A VA provider and Veteran mutually agree that outside care is in the Veteran's best interest; or
- VA care does not meet certain quality standards.

Source: Eligibility For Community Care Outside VA | Veterans Affairs. Accessed May 10, 2026. https://www.va.gov/resources/eligibility-for-community-care-outside-va/

As community care has grown from a supplement to a substantial portion of Veterans' health care, questions about access, experience, and quality have taken on heightened importance. For example, Black and Hispanic Veterans are less likely than White Veterans to use community care for primary care and experience longer wait times when they do.[45] Veterans with mental health conditions report worse experiences with community care than Veterans without mental health conditions, including overall satisfaction, access to timely appointments, communication with providers, and care coordination.[46] These examples raise concerns that expanded access policies may have had differing impacts on populations.

Needs of Veterans in Community-Based Health Care Settings

Veterans often do not disclose their military service to health care providers in community-based settings. This may be out of humility, a belief that providers will not understand their experiences, an unwillingness to seek help that they perceive as belonging to those who "really suffered," or not

seeing the relevance of their service to their health care. However, when providers do not know about Veteran status, the clinical picture is incomplete. Evidence-based, Veteran-specific risks and interventions may not be considered, and Veterans may not be connected to the benefits and programs for which they qualify.

Veteran cultural awareness is inconsistently present among community-based providers. Earning a Veteran's trust is a precondition for effective care, and trust is built through demonstrated understanding of military culture, service experiences, and the particular ways in which Veterans may present or communicate about their health. Providers who care for Veteran patients without this foundation risk missing important clinical information and failing to establish therapeutic relationships that support ongoing engagement with care.

Administrative barriers compound these clinical challenges. Community-based providers who are contracted through VA's Community Care program have reported inconsistent communication across VA Medical Centers, delayed referral authorizations, and confusion about paperwork requirements. These challenges have, in some cases, discouraged community-based providers from accepting VA referrals altogether, reducing the capacity of this care network to serve Veterans in need.

> **"The more you know about it, the hope is, the better care and the more access to services will happen because 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."**
>
> –Senior home health executive

Veteran Families and Caregivers

The health and well-being of Veterans cannot be fully addressed without considering the families and caregivers who support them. Military families experience their own distinct stressors, including the demands of frequent relocation, periods of deployment-related separation, employment instability, the anxiety of a loved one's service, and the adjustment challenges that accompany a service member's return. A growing body of research documents the psychological and social toll these experiences can take on spouses, partners, and children. The literature on reserve and National Guard families, who navigate these challenges while remaining embedded in civilian communities, remains limited.

Children of Veterans represent a population that is often invisible to health care and educational systems. Without systematic inquiry, such as asking whether a patient or student has a family member who has served in the military, providers and schools may be unaware of the forms of stress or trauma a child may be carrying. Early identification and support are difficult to provide in the absence of this information.

Family members, particularly spouses and adult children, frequently serve as primary decision-makers for Veterans who may be reluctant or unable to navigate complex health care systems on their own. These caregivers need access to information about available resources, assistance understanding the VA and community care systems, and support for their own mental and physical health. The same cultural competency that is required of providers working with Veterans directly is needed when working with their families. This includes an understanding of military culture, the dynamics of military family life, and the range of challenges that Veterans and their families may face.

NCIOM Task Force on Veterans' Health

The increasing demand for community-based services for Veterans, ongoing changes at the federal level regarding VA operations, the persistence of the disproportionate rate of Veteran suicide, and the 615,000 Veterans who call North Carolina home create an urgent need to assess and strengthen the state's capacity to serve Veterans in community-based health care settings.[1]

With these concerns in mind, the NCIOM convened the Task Force on Veterans' Health to identify actionable strategies for improving access to, and the experience and quality of, care for Veterans and their families in community-based settings.

The task force was supported by the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities, and Substance Use Services and AARP North Carolina. The NCIOM first engaged in a six-month learning period during which staff conducted interviews with dozens of Veterans, providers, advocates, government representatives, and others with direct experience of the issues facing the Veteran community in this state. A summary of this learning period is available at https://nciom.org/task-force-on-veterans-health-project-learning-period-summary/.

Between July 2025 and May 2026, the full task force met six times. The task force was supported by four work groups that convened four times each to discuss the following topics and develop possible recommendations:

1. Veteran access to community-based care
2. Care and resource coordination
3. Health care provider preparedness to serve Veterans
4. Veteran family and caregiver health-related needs

In addition, NCIOM staff convened many topic-specific meetings and advisory groups and conducted individual interviews to reflect on draft recommendations (See Figure 3). Advisory group topics included Veteran suicide and access to lethal means safety, novel treatments for PTSD and TBI, health care provider training, military and Veteran family survivors, and Veteran women's health.

The task force was co-chaired by:



Secretary Jocelyn Mitnall Mallette
JD, MA, Secretary of the North Carolina Department of Military and Veterans Affairs



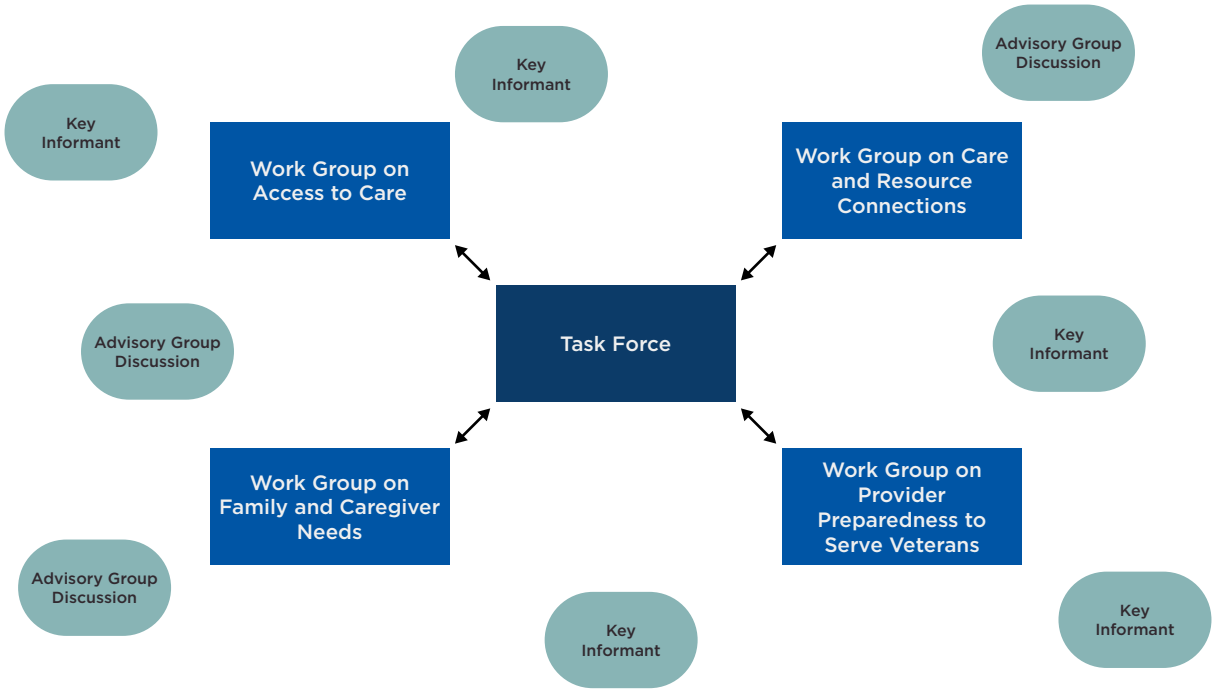
Margaret Chamberlain Wilmoth
PhD, MSS, RN, FAAN, Professor, University of North Carolina at Chapel Hill School of Nursing, President, Reserve Organization of America



Paul Berry
Director of Strategic Partnerships and Integration, Veterans Bridge Home

The three co-chairs helped guide five steering committee members, 45 task force members, and over 62 work group members through insightful conversations that led to the creation of the recommendations in this report. Most of the task force and work group members were Veterans themselves or close family of Veterans.

Figure 3. Structure of the NCIOM Task Force on Veterans' Health



The final recommendations from this task force are intended to provide guidance that is practical, evidence-informed, and grounded in the real experiences of Veterans and those who serve them across North Carolina. The pages that follow present the task force's findings and recommendations. They are offered not as a comprehensive solution to all challenges facing Veterans in this state, but as a focused contribution to an ongoing and necessary effort to ensure that those who have served receive the health-related care and services they deserve.

Recommendations from the task force are described in Chapters 2–5 of this report:

CHAPTER 2
Connecting Veterans, Families, and Caregivers to the Support They Need

Recommendations in this chapter call for a coordinated statewide effort to bridge the gaps that North Carolina's Veterans, their families, and caregivers can face in finding, accessing, and sustaining the services and supports available to them.

CHAPTER 3
Ensuring Access to Community-Based Health Care for North Carolina's Veterans

Recommendations in this chapter address the structural and geographic barriers that can stand between North Carolina's Veterans and access to health care services.

CHAPTER 4
Building a Health Care Workforce and System Ready to Serve Veterans

Recommendations in this chapter focus on strengthening both the pipeline and the preparation of North Carolina's health care workforce to better meet Veterans' health care needs.

CHAPTER 5
Leading the Way to Action

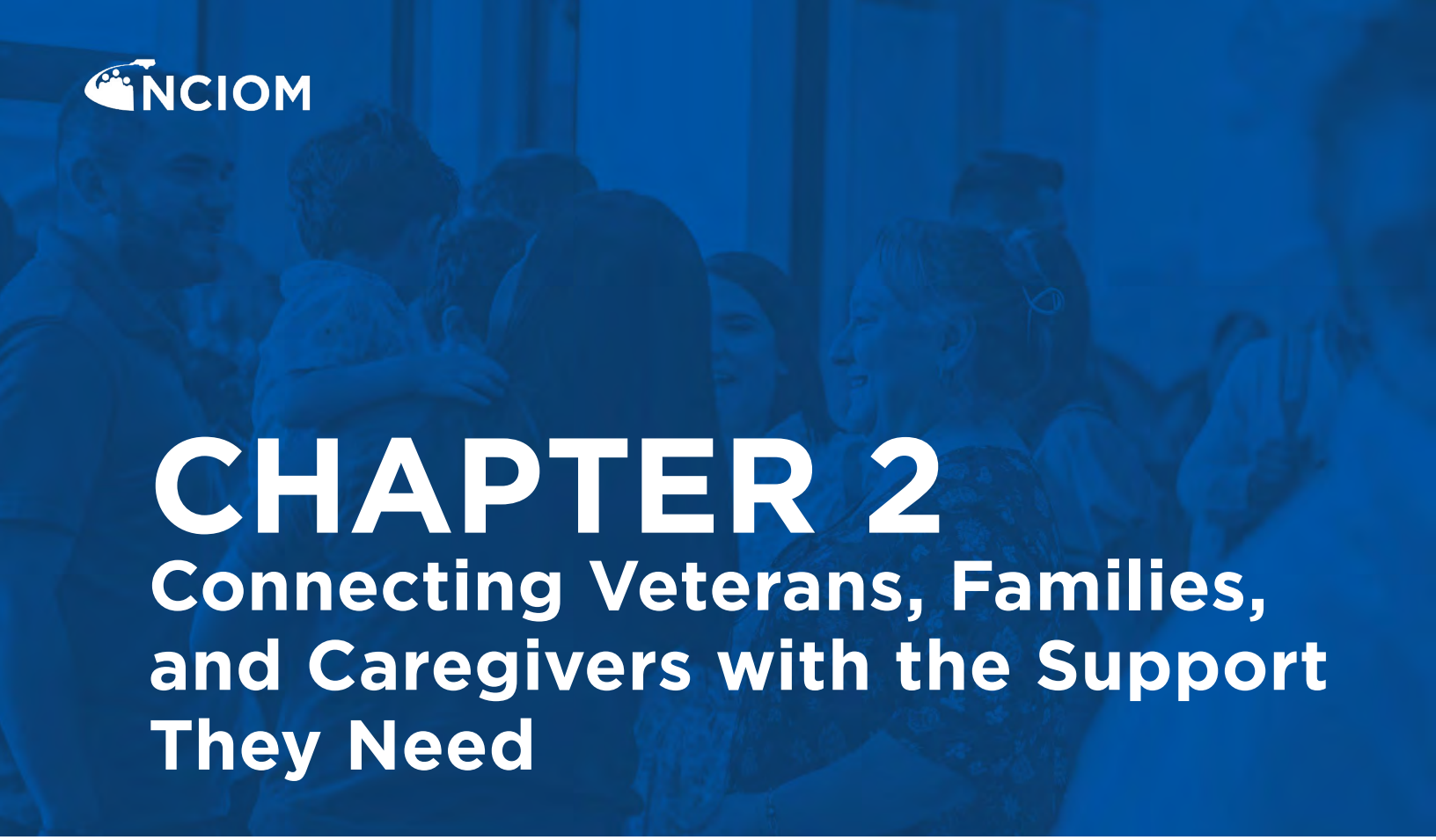
Recommendations in this chapter propose strategies to bring attention and continued action to address challenges related to Veterans' health.

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CHAPTER 2
Connecting Veterans, Families, and Caregivers with the Support They Need

North Carolina's Veterans, their families, and caregivers can face barriers to identifying, accessing, and sustaining the support available to them. This is often not because those resources don't exist, but because awareness is fragmented, navigation is difficult, and stigma too frequently stands in the way. This chapter's recommendations call for a coordinated statewide effort to bridge those gaps by expanding and better equipping Veteran Service Officers, amplifying campaigns like Ask Me NC, smoothing the transition from military to civilian life, ensuring that the family and caregivers of Veterans are recognized as having distinct needs, and safeguarding Veterans from predatory claims processors. Together, these strategies reflect a shared conviction that the strength of North Carolina's Veteran support system depends not only on what services exist, but on whether every Veteran and their loved ones can find and use them.

Statewide Entities Serving Veterans in North Carolina

The governmental and nonprofit entities listed below provide services and supports to Veterans across the state. Many other organizations provide similar resources on a local level.

North Carolina Department of Military and Veterans Affairs

The North Carolina Department of Military and Veterans Affairs (NCDMVA) is a state agency designed to build and maintain the relationship between state entities and military and Veteran families and military installations. The NCDMVA has benefits specialists in 12 offices throughout the state and established relationships with County Veterans Service Officers and the federal Department of Veterans Affairs (VA).[1]

NCDMVA Mission Statement

"To support the uniformed military, both active and reserve, and their families and installations and communities as well as military veterans, their families, facilities and services in North Carolina by providing timely and responsive engagement; to enhance North Carolina's current military and veteran friendly environment and foster and promote business, technology, transportation, education, economic development, and healthcare by facilitating assistance and coordination between the Federal Government, the State, its political subdivisions and collaborative and supporting agencies."[2]

Governor's Working Group on Service Members, Veterans, and their Families

The North Carolina Governor's Working Group on Service Members, Veterans, and their Families is the state's leading collaborative forum for advancing the health, well-being, and quality of life of North Carolina's military-connected communities. The working group brings together leaders from state and federal agencies, health care systems, nonprofit organizations, academia, local governments, and community partners to identify emerging needs, reduce barriers to care and services, eliminate duplication of effort, and maximize the collective impact of available resources. Through this collaborative approach, the working group strengthens access to health care, behavioral health, suicide prevention, housing, education, employment, legal and financial resources, and earned benefits while informing strategies that improve outcomes for service members, Veterans, and their families during all phases of transition and life.[3]

VA Medical Centers

VA Medical Centers (VAMCs) provide comprehensive health care services to eligible registered Veterans. These services include primary care, mental health services, specialized care, and physical therapy. VAMCs also act as referral hubs for community-based providers.[4] There are VAMCs in four locations across North Carolina: Asheville, Durham, Fayetteville, and Salisbury. There are also:

- **VA community-based outpatient clinics (CBOCs)** throughout the state that are aligned with each VAMC and provide basic outpatient care. There are three CBOCs associated with the Asheville VAMC, 10 with the Durham VAMC, 15 with the Fayetteville VAMC, and three with the Salisbury VAMC.

- **Vet Centers** that provide community-based counseling, outreach, and referral services to certain Veterans and their families. These are located in Charlotte, Fayetteville, Greensboro, Greenville, Jacksonville, and Raleigh.

North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities, and Substance Use Services

The Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS) funding and partnership supports a variety of Veteran services in North Carolina, including the Governor's Institute, NCServes, and MilVet Academy. In 2025, DMH/DD/SUS also began supporting free access to the Connections: Recovery Support app for peer-backed recovery support.[5]

Governor's Institute

Despite its name, the Governor's Institute is a non-governmental, nonprofit organization. Their work focuses on improving prevention, treatment and recovery of substance use disorders for North Carolinians. Specific to Veterans, they work with state and federal partners on projects and programs that connect service members, Veterans, and their families with needed behavioral health and other community services.[6] The Governor's Institute's MilVet Academy hosts the Veteran Support Specialist and Mental Health First Aid training programs.[7]

NCServes

NCServes is a coordinated network of public, private, and nonprofit organizations that offer services ranging from housing and employment to mental health and legal aid for Veterans, service members, and their families.[8] Their referral platform connects to over 3,000 service providers across the state. During their first decade (2014-2024), NC Serves served over 61,000 people in the military-connected community in North Carolina.[8]

Veteran Services of the Carolinas

A division of the Asheville Buncombe Community Christian Ministry, Veteran Services of the Carolinas (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.[9]

Veterans Bridge Home

Based in Charlotte, Veterans Bridge Home (VBH) "connects, leads, and advocates in communities to ensure service members, veterans, and their families thrive."[10] They "partner with a wide network of organizations to help service members, veterans, and their families successfully transition and thrive in civilian life."[10] By coordinating support in areas such as employment, housing, health, and recreation, VBH helps Veterans successfully reintegrate into civilian life and build a strong foundation for the future.[10] VBH serves communities in North and South Carolina and served 3,512 clients in 2025 across their markets.[11]

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."[12] The project 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.[12]

Barriers to Connecting to Services

When Veterans leave military service, a wide range of support exists, but many never connect with available resources. Some Veterans and their families simply don't know what is available or who to ask. More than half of Veterans report little or no understanding of their benefits, and a quarter are unaware that free help navigating VA claims exists at all.[13] Beyond awareness, the culture of military service itself plays a role in the lack of connection to services. Service members are trained to be self-reliant and to solve problems independently, which can make seeking out services or asking for guidance feel at odds with a Veteran's identity.

The transition out of military service also creates a structural awareness problem. Each year, thousands of service members leave active duty and receive an overwhelming amount of information about available benefits and programs. At the same time, they are managing the upheaval of leaving their military community, relocating families, and adjusting to an unfamiliar civilian world. Research shows that nearly a quarter of service members don't complete mandatory transition briefings, and most begin the process too late.[14]

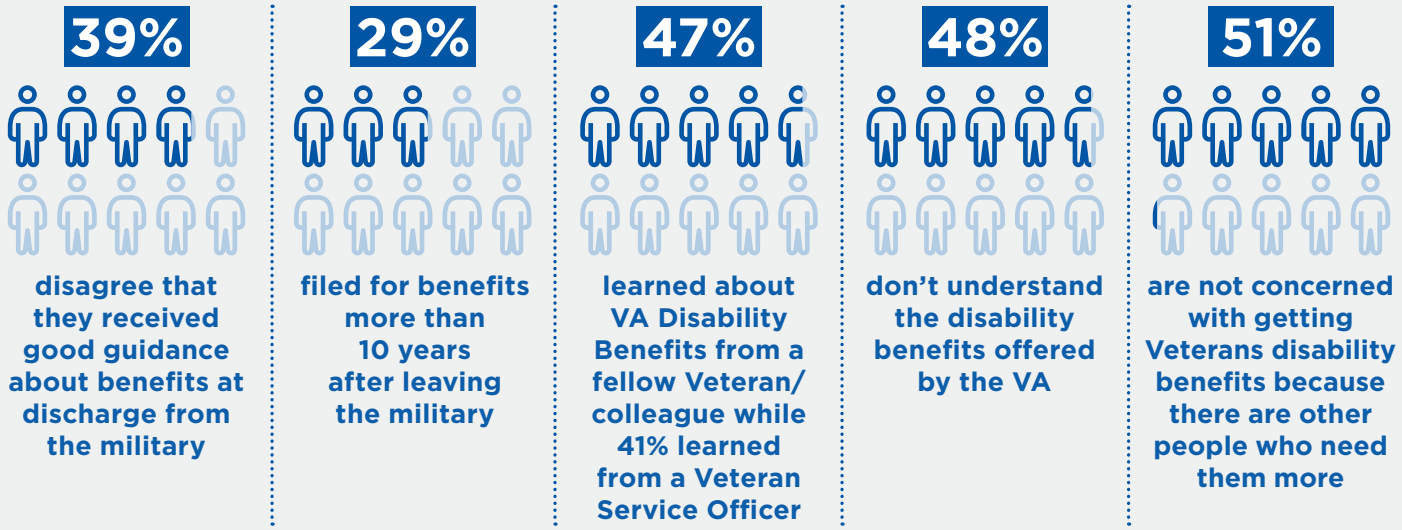
Once Veterans are settled, they often have no clear idea where to turn or who to contact. Reaching Veterans effectively means going beyond a single handoff at separation, through trusted channels like peer networks and community organizations, and providing guidance that is easy to act on long after the transition is complete. Improving the transition period for service members may also require more of an individualized approach and attention to the experience of family members, in addition to the service member.

Surveyed Veterans Say...



Source: Veteran.com. 2025 Veteran Voices: Summer Feedback Giveaway. Accessed April 17, 2026. https://veteran.com/wp-content/uploads/2025/10/veterans-voices-va-disability-survey.pdf

Surveyed Veterans Say...



Allsup. Navigating VA Disability Benefits: Reporting on Veterans' Experiences When Leaving the Military Accessed April 17, 2026. https://www.allsup.com/media/jftmrdbh/allsup-veterans-survey-report-nov2022.pdf

Findings from the US Government Accountability Office (GAO)

"Servicemembers preparing to leave the military generally must participate in the Transition Assistance Program (TAP). [Department of Defense] DOD service branches have implemented elements of TAP, such as ensuring that servicemembers meet with a TAP counselor, attend tailored 2-day classes, and participate in a counseling pathway tailored to the level of transition support a servicemember needs.... GAO's December 2022 analysis of TAP data from April 1, 2021, to March 31, 2022, showed that **nearly a quarter of servicemembers who were required to attend a 2-day TAP class did not do so**. GAO also found that **most servicemembers (70 percent) did not start TAP more than 1 year in advance**, as generally required. Additionally, DOD and the service branches were not using available performance data to understand root causes of poor participation and take appropriate corrective action."

Source: Military and Veteran Support: Programs to Help Servicemembers and New Veterans Transition to Civilian Life Could Be Enhanced. GAO-24-107083. Published: Oct 18, 2023. https://www.gao.gov/products/gao-24-107083

With these gaps in Veteran knowledge and engagement with the services they may be eligible for, the task force makes the following recommendation.

RECOMMENDATION 1:

Enhance access to available services and support through more robust engagement with Veterans, their families, and caregivers.

Strategy 1.1: Increase funding to support Veterans' access to the services they are eligible for

Strategy 1.2: Increase community identification of Veterans

Strategy 1.3: Develop community-based engagement strategies to connect with Veterans

Strategy 1.4: Maintain Veterans Benefit Live events

Strategy 1.5: End predatory Veteran claims services

STRATEGY 1.1: Increase funding to support Veterans' access to the services they are eligible for

The North Carolina General Assembly should support Veterans' health by increasing funding to the following cabinet agencies for these specific purposes:

A) **The North Carolina Department of Military and Veteran Affairs (NCDMVA) to hire additional Veteran Service Officers (VSOs), enhance training opportunities for all VSOs, and support engagement activities with transitioning service members, Veterans, and their families.**

B) **The North Carolina Department of Administration (NCDOA) to establish a permanent Tribal Veterans Services funding allocation for federally recognized tribes. Funding should support transportation assistance, disability claims clinics, outreach events, Veteran engagement initiatives, cultural programming, digital access, and other services designed to overcome the geographic and systemic barriers faced by Tribal and rural Veterans.**

C) **The North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS) to market the Ask Me NC campaign, increase public awareness about where Veterans can connect to mental health services, and reduce mental health stigma among Veterans with the support of NCDMVA, NCServes, Veterans Bridge Home, and Veteran Services of the Carolinas.**

Desired Result

Increased state funding equips NCDMVA, NCDOA, and NCDHHS to expand VSO capacity, establish dedicated Tribal Veterans Services support, and strengthen mental health outreach—ensuring Veterans, including Tribal and rural Veterans, can more easily access the benefits, services, and care they've earned.

Potential Measures of Success

- Year-over-year budget increases
- Establishment of a permanent, recurring funding line (yes/no) for Tribal Veteran Services
- Improved state-level VSO staffing levels
- Increasing number of VSOs completing enhanced training programs
- Increasing number of transitioning service members and families reached through engagement activities
- Increasing public awareness of the Ask Me NC campaign (e.g., survey-based awareness metrics, website traffic, social media reach)
- Increasing partner-organization referrals;
- Increase in mental health service utilization rates among Veterans

Context for Increased Funding for NCDMVA

The NCDMVA is legislatively tasked with a variety of activities related to military installations in the state and Veteran services. Among the many activities included are:

- "Provid[ing] active outreach to the United States Department of Defense and the United States Department of Homeland Security… in order to support the military installations and activities in the State, to enhance North Carolina's current military-friendly environment and foster and promote business, technology, transportation, education, economic development, and other efforts in support of the mission, execution, and transformation of the United States government military and national defense activities located in the State."
- "Provid[ing] active outreach to the United States Department of Veterans Affairs, the veterans service organizations, and the veterans community in North Carolina to support and assist North Carolina's veterans in identifying and obtaining the services, assistance, and support to which they are entitled, including monitoring efforts to provide services to veterans, newly separated service members, and their immediate family members and disseminating relevant materials."
- "Monitor[ing] and enhanc[ing] efforts to provide assistance and support for veterans living in North Carolina and members of the North Carolina National Guard and North Carolina residents in the Armed Forces Reserves not in active federal service in the areas of (i) medical care, (ii) mental health and rehabilitative services, (iii) housing, (iv) homelessness prevention, (v) job creation, and (vi) education."
- "Manag[ing] and maintain[ing] the State's veterans nursing homes and cemeteries and their associated assets to the standard befitting those who have worn the uniform of the Armed Forces according to federal guidelines. Plan for expansion and grow the capacity of these facilities and any new facilities as required pending the availability of designated funds."[15]

The NCDMVA budget for 2026-27 is $9,350,864, with $5,373,764 dedicated to Veterans Affairs services.[16, 17]

In North Carolina, as of March 2026



96,000
Active Duty
(4th highest in the country)

Total (does not include family or caregivers) = 732,013 people



20,504
National Guard/ Reserve Population

Around $12.77 per military-connected individual ($9,350,864 / 732,013)



682,186
Veterans
(8th highest in the country)

Around $8.73 per Veteran ($5,373,764 / 615,509)

Source: DoD Personnel, Workforce Reports & Publications. Defense Manpower Data center. March 2026. https://dwp.dmdc.osd.mil/dwp/app/dod-data-reports/workforce-reports; Geographic Distribution of VA Expenditures (GDX) Report. US Department of Veterans Affairs, National Center for Veterans Analysis and Statistics. 2024. https://www.va.gov/vetdata/expenditures.asp

Meanwhile, connecting Veterans to the benefits they have earned not only helps them thrive, but has a positive impact on the local and state economy.

In 2024, total direct Veterans Affairs (VA) expenditure in North Carolina was $13.07 billion, which includes approximately:

$7.3 BILLION
in Compensation and Pensions

$4.7 BILLION
in Medical Care

$569.5 MILLION
in Education & Vocational Rehabilitation/ Employment

$446.8 MILLION
in Dependency & Indemnity Compensation and Survivors Pension

$18.6 MILLION
in Specially Adapted Housing and Automobiles and Adaptive Equipment

$2.1 MILLION
in Loan Guaranty

VA expenditure per county ranged from $1.56 billion to $2.7 million.

Source: Geographic Distribution of VA Expenditures (GDX) Report. US Department of Veterans Affairs, National Center for Veterans Analysis and Statistics. 2024. https://www.va.gov/vetdata/expenditures.asp

Role of Veteran Service Officers

Veteran Service Officers (VSOs) serve as a critical first point of contact for Veterans navigating the complex landscape of benefits, services, and care to which they may be entitled. North Carolina's VSO infrastructure includes both county-level VSOs that are present in most of the state's 100 counties and the NCDMVA's network of twelve regional benefits offices staffed by trained benefits specialists.[17]

These specialists are equipped to assist Veterans with the full range of benefit claims and service connections and maintain established relationships with both county officers and the federal VA system. Despite this infrastructure, awareness of VSO services remains uneven, particularly among rural Veterans, Veterans from historically underrepresented populations, and those who separated from service before robust outreach efforts were in place.

Role of a Veteran Service Officer

One North Carolina VSO described the practical scope of her work as reaching across virtually every dimension of Veteran need: "The areas 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 described her role as a form of sustained advocacy – "a lot of problem solving, jumping up the chain for them" – that is especially critical in the rural areas of North Carolina, where formal services are harder to find and Veterans are more likely to rely on peer networks to learn about resources.

Context for Increased Funding for Tribal Veteran Services

For the Eastern Band of Cherokee Indians (EBCI), which until 2025 was the only federally recognized tribe in North Carolina, military service remains a deeply rooted tradition grounded in honor, sacrifice, protection of community, and service to both nation and country. The Lumbee Tribe of North Carolina gained federal recognition in December 2025.

Despite this legacy, Cherokee Veterans remain disproportionately underserved by state-funded Veteran support systems. While all 100 North Carolina counties receive funding, staffing support, and access to state-administered Veteran programs, the EBCI currently receives only $2,500 annually dedicated to Veteran outreach services, and only when specifically recognized through legislative appropriations.[19] This funding level does not reflect the size of the Cherokee Veteran population or the scope of services provided by the EBCI Department of Military and Veterans Affairs, which supports Cherokee and non-Cherokee Veterans across a seven-county area of Western North Carolina.[19]

The EBCI Department of Military and Veterans Affairs serves as far more than a Tribal Veteran service office. The department provides direct assistance to eligible Veterans, service members, dependents, survivors, and caregivers, regardless of Tribal enrollment status. Cherokee and non-Cherokee Veterans alike receive assistance with disability compensation claims, pension benefits, survivor benefits, health care enrollment, education benefits, transportation resources, behavioral health referrals, suicide prevention

initiatives, and Veteran advocacy services. In many cases, the department fills critical service gaps in rural communities where Veteran representation and access to accredited assistance may be limited.

Investing in this existing infrastructure would leverage state resources, increase access to earned federal and state benefits, improve behavioral health outcomes, reduce Veteran suicide risk, strengthen rural Veteran services, and honor the service and sacrifice of those who have worn the uniform.

Context for increased funding for DMH/DD/SUS

As mentioned at the beginning of this chapter, funding from the NCDHHS DMH/DD/SUS supports Veteran services such as the Governor's Institute, NCServes, and MilVet Academy. An initiative called Ask Me NC was launched by NCDHHS in November 2025. It is designed to address the gap in identifying Veterans– creating a statewide call to action for health care providers, educators, first responders, housing workers, and others to ask a single question: "Have you or a family member ever served in the military?".[20]

Ask Me NC



The AskMeNC initiative frames identification of individuals with military connections as an act of care rather than a bureaucratic task: connecting an individual to specialized resources, better understanding the context of their health challenges, and building trust by showing interest in their full story. The AskMeNC website connects Veterans to resources, including the NCServes coordinated care network, functioning as a digital hub and single point of entry for a wide range of services available to Veterans and their families across the state. The website also offers guidance tailored to different professional contexts like health care providers, educators, first responders, and housing workers and describes how identifying Veteran or military family status can change the support available to an individual in each setting.

The initiative reflects recognition that most Veterans do not self-identify in community settings, whether from pride, privacy, or simply not knowing how relevant their service history is to the services or care they are receiving. Among the facts highlighted in the campaign: Veterans in North Carolina are 2.5 times more likely to die by suicide than non-Veterans and connecting Veterans to services and care earlier can meaningfully reduce that risk.[21]

When it comes to accessing mental health services, stigma operates as a powerful and often unappreciated barrier for Veterans. It functions at multiple levels simultaneously: in the broader culture's assumptions about Veterans, in the norms embedded in military institutional culture, and in the ways individual Veterans have internalized those norms.

> **Veterans often frame their experiences in comparative terms that foreclose help-seeking: "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.**
>
> -Mental health provider for Veterans explaining a common Veteran mentality

Research shows that military personnel report higher levels of mental health stigma than their civilian counterparts, and that perceived public stigma of treatment-seeking is directly and significantly associated with lower rates of mental health service utilization.[22] The cultural norms of military service such as self-reliance, stoicism, and unit cohesion that are adaptive in operational environments become barriers to care in civilian life. This reluctance is compounded by a characteristic form of self-minimization in which many Veterans discount the severity of their own psychological wounds. Concern about career and security clearance repercussions from a mental health diagnosis or treatment further reinforces this reluctance, particularly among Veterans who remain connected to defense-related employment.[23]

Stigma also operates in the opposite direction: the civilian assumption that every returning Veteran is psychologically damaged can feel to many Veterans as its own form of prejudice. One interviewee for the project working at the intersection of Veteran health and community care challenged this reflex directly:

> **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.**

RESOURCE AND **PARTNERSHIP** POSSIBILITIES

- North Carolina Department of Military and Veterans Affairs
- County Veteran Service Officers
- North Carolina Department of Administration
- Eastern Band of Cherokee Indians Veterans Services
- Lumbee Tribe Veteran Affairs
- North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities, and Substance Use Services
- Veterans Bridge Home
- NCServes
- Veteran Services of the Carolinas
- Governor's Institute

Strategy 1.2: Increase community identification of Veterans

County and local elected officials and local leaders should integrate the Ask Me NC campaign into common points for community member interaction and display information about where Veterans, their families, and caregivers can access resources.

Desired Result

Local integration of the Ask Me NC campaign into everyday community touchpoints increases the likelihood that Veterans, their families, and caregivers are recognized in their communities and connected to the resources and services available to them.

Potential Measures of Success

- Number of county and local government offices displaying Ask Me NC materials
- Number of counties/municipalities formally adopting or endorsing the Ask Me NC campaign
- Number of referrals or connections made to VSOs or Veteran services as a result of community identification
- Survey data showing increased community awareness of how to identify and support Veterans

The Local Economic Case for Connecting Veterans to Their Earned Benefits

When Veterans receive the pension, disability compensation, and other financial benefits they have earned through their service, that money does not simply stay in their bank accounts, it flows directly into local economies. Research from the National Institute on Retirement Security shows that pension and compensation expenditures have powerful ripple effects. Nationally, pension benefit payments collectively supported 7.1 million American jobs and generated $1.5 trillion in total economic output in 2022, with every single dollar paid in benefits producing $2.28 in total economic activity.[24] For smaller communities in particular, this impact is especially meaningful. Studies show that small towns experience a greater relative boost to both GDP and total personal income from pension benefit dollars than either rural or metropolitan areas.[25] In other words, when a Veteran in a small community begins receiving the benefits they've earned, the positive effects on that local economy are proportionally larger than almost anywhere else.

Housing is another area where Veteran benefits create lasting local economic value. The Department of Veterans Affairs (VA) offers home loan guarantees that help Veterans purchase homes, build equity, and put down roots in their communities. In fiscal year 2022 alone, the VA guaranteed more than 746,000 home loans.[26] Among Veterans who currently have a mortgage, about one in three has used a VA-backed loan.[27] Homeownership stabilizes families, supports local property tax bases, and generates spending at local businesses that sustains jobs throughout the community.

Federal spending on Veteran programs totaled $326 billion nationally in 2024, with the vast majority – around $152 billion – representing disability compensation payments to approximately six million Veterans, averaging $25,446 per recipient annually.

Source: Peter G. Peterson Foundation. Spending on Veterans in the Budget. 2025. https://www.pgpf.org/article/spending-on-veterans-in-the-budget/

Research has found that VA spending functions as a return of federal tax dollars to states and localities, injecting money directly into local economies. As one Veteran services official explained, when a Veteran is connected with services and benefits, it contributes to the community because the money coming in goes toward purchasing goods and services like paying rent, buying groceries, purchasing vehicles, or paying bills.[28] The same research noted that connecting Veterans to benefits also reduces homelessness, suicide risk, and financial stress, which in turn add to community safety and well-being.[28]



COMMUNITY ACTION IDEA

Place a QR code linked to Veteran resources on tax bills, school report cards, utility bills, doctor's bills, insurance statements, and in places that people frequent like shopping malls and schools for a low-tech effort that could have a wide impact.

The challenge is that a significant portion of Veterans never receive benefits they have legitimately earned—not because they don't qualify, but because they are not educated on their benefits and don't know to ask. Many Veterans don't realize they have access to financial and medical benefits, and significant funds and services go unclaimed as a result. For example, a VA pension benefit called Special Monthly Pension with Aid and Attendance that is available to Veterans who need help with daily activities can go unclaimed by eligible Veterans and surviving spouses who simply don't know it exists.[29] Unclaimed benefits can include compensation, pension payments, education assistance, and insurance proceeds.

This is why identifying Veterans in the community and connecting them to earned benefits is not just a matter of individual fairness, it is a straightforward local economic development strategy. When community touchpoints such as libraries, health departments, social service agencies, schools, and local government offices routinely ask about Veteran status and display information about available resources, more Veterans can find their way to benefits they've already earned. Every dollar that reaches an eligible Veteran has the potential to stay and grow in the local economy.

The federal government invested over $12 billion in North Carolina Veterans during fiscal year 2023 through compensation, pension, medical care, and other benefits, a nearly threefold increase from $4.2 billion in 2012 reflecting both the growth in the state's Veteran population and expanded eligibility through legislation including the Promise to Address Comprehensive Toxics (PACT) Act.[30]

Housing Programs to Support Veteran Independence

The VA administers five main home modification and housing adaptation programs designed to help Veterans with serious service-connected disabilities live safely and independently. These grants can fund a wide range of adaptations, including accessible bathrooms and kitchens, ramps, widened doorways, lifts, generators for medical equipment, smart home technology, and accessory dwelling units.

1. Specially Adapted Housing (SAH) grant—offers up to $126,526 for Veterans with significant disabilities[i]
2. Special Housing Adaptation (SHA) – offers up to $25,350[i]
3. Temporary Residence Adaptation – for those temporarily residing in a home owned by a family member; up to = $50,961 for SAH, $9,100 for SHA[i]
4. Veteran Readiness and Employment Independent Living – grants for those unable to work due to service-connected disabilities[ii]
5. Home Improvements and Structural Alterations program - between $2,000 and $6,800 for more modest home modifications[iii]

While significant federal funding is available, many eligible Veterans remain unaware of these benefits, underscoring the importance of outreach, education, and partnerships to ensure Veterans can access the home modifications they need to age in place safely and with dignity.

Find more information about these programs in the AARP Veterans and Military Families Home Modification Benefits Guide at https://www.aarp.org/content/dam/aarp/home-and-family/voices/veterans/2024/vmf-homefit-benefits-guide.pdf
i US Department of Veterans Affairs. Disability Housing Grants for Veterans. Accessed August 25, 2026. https://www.va.gov/housing-assistance/disability-housing-grants/
ii US Department of Veterans Affairs. VR&E Independent Living Track. Accessed August 25, 2026. https://www.va.gov/careers-employment/vocational-rehabilitation/programs/independent-living/
iii US Department of Veterans Affairs. Home Improvements/Structural Alterations (HISA). Accessed August 25, 2026. https://www.prosthetics.va.gov/psas/hisa2.asp



RESOURCE AND **PARTNERSHIP** POSSIBILITIES

- North Carolina Association of County Commissioners
- North Carolina Association of Local Health Directors
- Ask Me NC
- UNC Healthy Vets Community Project
- Regional and local philanthropies

Strategy 1.3: Develop community-based engagement strategies to connect with Veterans

The responsible organization identified by the UNC Healthy Vets Project to carry their work forward should create a Veteran-healthy community and organization designation, and partner with the Department of Military and Veteran Affairs, the North Carolina Association of County Commissioners, AARP NC, the Division of Mental Health, Developmental Disabilities, and Substance Use Services, and non-profit Veteran-serving organizations and advocacy groups to:

A) Publicize and distribute the UNC Healthy Vets Project community guide and other tools,

B) Identify strategies for communities to allocate or access financial, human, and in-kind resources to implement Veteran-healthy community development activities, and

C) Distribute available information and resources for trainings and strategies that address lethal means safety to reduce Veteran suicide.

Desired Result

Communities across the state establish Veteran-healthy practices and initiatives to actively support Veteran health and well-being, connect Veterans to local resources, and reduce Veteran suicide.

Potential Measures of Success

- Establishment of a formal Veteran-healthy community/organization designation (yes/no)
- Number of communities and organizations achieving the designation
- Number of communities/organizations that receive or download the community guide
- Survey data on community awareness of the guide and its tools
- Number of communities implementing Veteran-healthy development activities
- Case studies or documented examples of successful resource strategies replicated across communities
- Veteran and community satisfaction with designation program and resources
- Number of lethal means safety trainings conducted
- Reduction in Veteran suicide rates involving lethal means (long-term outcome measure)

UNC Healthy Vets Project

The Healthy Vets Community Project, based at the UNC Chapel Hill Gillings School of Global Public Health, is a statewide initiative dedicated to engaging communities to improve the conditions that shape Veteran wellness. The project's approach extends beyond individual health care encounters to address the social, economic, and institutional conditions that either support or undermine Veterans' ability to thrive where they live, work, and age.[12]

The project has unfolded across two phases:

- **Phase 1,** known as the **Building Veteran Healthy Communities Project,** focused on fostering partnerships, setting community priorities, and guiding local action around the social determinants of Veteran mental health. Community engagement efforts in Rocky Mount and Alamance and Wake counties produced early tangible outcomes, including securing reduced bus fares for Veterans, the organization of inaugural Veteran Resource Fairs, and the launch of art exhibits featuring original work by Veterans in the community.
- **Phase 2,** known as the **Healthy Vets Community Project,** builds on Phase 1 by conducting GIS mapping of Veteran resources in all 100 North Carolina counties, developing practical guides to help resource registries become more navigable for Veterans, and launching a Community Recognition System to formally acknowledge and incentivize local efforts to build more Veteran-healthy communities. A key product of this phase will be a **Community Facilitation Guide** that will include "training materials, facilitation tools, sample agendas, and engagement activities. These resources will support community leaders in convening local partners and leading structured implementation processes."[31]

Why Create Veteran-Healthy Communities?

Community Benefits from Veteran Residents

Intentional community efforts to serve Veteran needs can benefit the Veteran, their family, and the community itself. As discussed in Strategy 1.2, Veterans represent a significant and measurable economic force in North Carolina's communities. Disability compensation, pension payments, VA health care expenditures, and GI Bill education benefits all circulate through the communities where Veterans live, supporting households and local businesses alike.

Veterans themselves also contribute as earners and workers. Data from the 2024 American Community Survey, compiled by the Carolina Demography at UNC-Chapel Hill, shows that North Carolina Veterans had a higher median income than non-Veterans – $55,011 compared to $40,159 This reflects what researchers describe as a military wage premium, in which military service often yields skills, credentials, and work experience that translate into above-average civilian earnings.[32] Among the 621,063 Veterans living in the state as of 2024, those between the ages of 35 and 64 represented the largest group of employed Veterans – a cohort with significant spending power embedded in communities across the state.[32]

Case Study: Local Implementation of the Healthy Vets Community Project in Jackson County, North Carolina

"In Jackson County, interaction with local organizations and Veterans in the community provided insight into what Veterans and Veteran organizations were looking for in regards to access to resources," said Rashaun Baldwin, an MPH student, US Marine Corps Veteran, and graduate assistant with the Healthy Vets Community Project. "They really wanted that access to resources and were concerned about their geographic isolation, VA enrollment, getting to VA appointments, and getting connected with resources in the community."

In Jackson County, North Carolina, the Healthy Vets Community Project is working with community partners to explore opportunities for more coordinated support for Veterans. These efforts are part of a broader initiative to develop resources and tools that communities and organizations can use to strengthen systems of support, with a new Digital Learning Platform launching in January 2027.

- The **Community Awareness Guide** is being designed to help individuals understand Veteran well-being and consider how their existing roles and activities can contribute to a more supportive community. It introduces the Vital Conditions Framework—basic needs for health and safety, humane housing, meaningful work and wealth, lifelong learning, belonging and civic muscle, reliable transportation, and a thriving natural world—as a platform to help people identify opportunities to build relationships, connect Veterans with resources, and support community needs
- The **Community Facilitator Toolkit** will offer practical activities, examples, and guidance for bringing people together across organizations and perspectives. The goal for this toolkit will be to help communities identify shared priorities, recognize local strengths, facilitate conversations and workshops, and coordinate efforts to address challenges.

"For myself, I think it was the understanding of coming into knowing who you are and your role, and the public perception of that role," said Baldwin. "Having a Veteran background and living in Western North Carolina, and having the understanding of rural Western North Carolina, cultural values, and bringing both of those to the forefront of community engagement work—I think that has been really pivotal in the success of this project and the building of community trust and collaboration."

Veteran Mental Health

Mental health stigma and access to care can be a significant challenge for Veterans, with the ultimate indicator being a higher rate of suicide among Veterans than non-Veterans. The mental and behavioral health challenges Veterans face rarely emerge from a single cause. They are shaped by a complex interplay of pre-service history, the nature of military service itself, the profound disruption of the transition to civilian life, along with many other factors.

- The **experience of military service** itself carries meaningful psychological risk. Combat exposure, military sexual trauma,

physical injury, and the accumulated stress of deployment cycles all contribute to the mental health burden many Veterans carry well beyond their service.

- The **transition from active duty** to civilian life magnifies these challenges substantially, producing what interviewees consistently described as a profound loss: of identity, of community, and of structured purpose.
- **Social isolation** is one of the most significant drivers of mental health distress following military separation. Without the built-in community of military service, many Veterans struggle to rebuild meaningful social connection in civilian life. Research on Veterans with PTSD supports this picture: social connectedness and community integration are among the most powerful protective factors against both PTSD and suicidality, and their absence dramatically elevates risk.[33]

> **"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."**
>
> –Military Veteran

However, it is important not to assume that any individual Veteran struggles with specific mental health challenges. Many Veterans feel this stigma and assumption about them. Additionally, combat exposure does not make a Veteran more likely to die by suicide:

> **"Suicide risk in veterans is commonly assumed to result from exposure to traumatic incidents while deployed to combat. On the contrary, among veterans who served during the Iraq and Afghanistan Wars, those who were not deployed to those war zones were at higher risk for suicide than those who were. Combat trauma has a complex relationship with suicide risk among veterans, and while research shows that certain conditions like post-traumatic stress disorder (PTSD) can contribute to suicide risk—whether derived from combat or from other events—there is no clear association between combat exposure generally and the risk of dying by suicide."**
>
> –Tetons P. Those Who Serve: Addressing Firearm Suicide among Military Veterans. Everytown Research and Policy. October 2019. https://everytownresearch.org/report/those-who-serve/

Veteran Suicide and Lethal Means Safety

> **Easy access to firearms during a moment of crisis can mean the difference between life and death. Personal or household gun ownership triples suicide risk. Firearms are a particularly lethal means of self-harm, and most people who survive a suicide attempt do not go on to die by suicide. Limiting gun access in a moment of acute crisis can ensure veterans live on as valued and valuable community members.**
>
> –Everytown for Gun Safety. Those Who Serve: Addressing Firearm Suicide Among Military Veterans. February 24, 2025. https://everytownresearch.org/report/those-who-serve/

Lethal means safety (LMS) is a cornerstone of evidence-based strategy in Veteran suicide prevention, rooted in the understanding that reducing access to highly lethal methods during a crisis can save lives. Firearms are the most commonly used and most lethal method of suicide among Veterans, making safe storage and counseling around firearm access a critical intervention point. Training clinicians, community members, and Veterans themselves to have open, non-stigmatizing conversations about firearm storage is increasingly recognized as an essential complement to addressing the Veteran suicide rate. Several national and North Carolina-based programs are leading this work through training, outreach, and material support.

By the Numbers: Veterans and Firearms



51% of Veterans own a firearm[34]

32% of Non-Veterans own a firearm[35]

Veterans are 3X more likely to die by suicide with a firearm than non-Veterans[36]

In 2023



79% of Veteran Suicides in North Carolina involved a firearm[37]

63% of All Suicides in North Carolina involved a firearm[37]

228 Veterans died by suicide in North Carolina[37]

> "[M]ore than half (52.9 %) [of military Veteran firearm owners] reported some form of unsafe or mixed-security firearm storage practices, including storing firearms loaded and/or in non-secure locations.... Psychiatric morbidities emerged as some of the strongest correlates of unsafe firearm storage. Veterans who screened positive for a probable lifetime history of major depressive and alcohol use disorder had approximately twice and one-and-a-half times higher odds, respectively, of storing firearms unsafely (loaded and in a non-secure location) versus safely (unloaded in a secure location)."
>
> **Source:** Nichter B, et al. Firearm storage practices among military veterans in the United States: Findings from a nationally representative survey. Journal of Affective Disorders, April 15, 2024, Volume 351, Pages 82-89. https://doi.org/10.1016/j.jad.2024.01.179

- **CALM America (Counseling on Access to Lethal Means) –** A nationally recognized organization that trains clinicians to hold collaborative conversations about safe firearm storage with at-risk individuals and their families.[38] They also offer gatekeeper training for community members, firearms literacy training for clinicians, and community organizing to bridge the suicide prevention and firearms communities.[39]
- **The National Guard –** Requires a Suicide Intervention Officer for every 50 soldiers and mandates yearly suicide prevention training with lethal means safety as a core topic.
- **Centerstone virtual LMS workshops –** This mental health provider that specializes in care for military-connected individuals offers online training for mental health clinicians and collaborates with Strong Star on "Face the Fight" LMS trainings held regularly throughout the year.
- **UNC Suicide Prevention Institute –** The Institute is implementing CALM training across clinical and non-clinical staff throughout the UNC hospital system statewide.

Community-level programs further extend LMS strategies beyond clinical settings. Examples include:

- **NC SAFE –** This initiative provides free gun locks and safe firearm storage education materials statewide and has partnered with the NC National Guard to distribute these materials at Yellow Ribbon events.
- **Lock. Call. Live. –** Wake County media initiative, supported by Stop Soldier Suicide and local partners, promotes firearm safety messaging to Veterans and their families.[40]
- **Fayetteville VA Medical Center –** The Fayetteville VA has developed a comprehensive local model, including firearms safety teams, CALM trainings, gun cleaning mats printed with LMS information, gun lock distribution, storytelling events to build shared resilience, and a new Safeguard pilot program in Cumberland County.

Taken together, these programs demonstrate that no single approach fits every community, and that effective lethal means safety efforts require a layered strategy that can combine clinical training, community gatekeeper education, accessible material resources like gun locks, and culturally sensitive outreach.

RESOURCE AND **PARTNERSHIP** POSSIBILITIES

- Regional and local philanthropies
- North Carolina Department of Military and Veteran Affairs
- North Carolina Association of County Commissioners
- AARP NC
- North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities, and Substance Use Services
- Veteran-serving organizations and advocacy groups

Strategy 1.4: Maintain Veterans Benefit Live events

State Veteran service organizations and federal VA partners should ensure that Veteran Benefits Live events continue to occur across the state with VA disability and compensation raters in attendance.

Desired Result

Veterans Benefits Live events will continue to help Veterans across North Carolina have direct, in-person access to expedited claims processing and benefits support.

Potential Measures of Success

- Year-over-year consistency or growth in the number of events held Geographic distribution of events across the state (urban, rural, Tribal communities)
- Number/percentage of events with VA disability and compensation raters in attendance
- Number of claims filed or processed on-site during events
- Veteran satisfaction ratings with event experience and outcomes

What Are Veterans Benefits Live Events?

Veterans Benefits Live (VBL) events are typically multi-day, in-person outreach events designed to reduce the barriers between Veterans and the federal benefits they have earned. These collaborative events include representation from the Veterans Health Administration, Veterans Benefits Administration, state departments of Veterans Affairs, and community partners working together to offer one-on-one personalized assistance for Department of Veterans Affairs (VA) benefits and health care, crisis support, community services, and peer-to-peer connections. At the local level, events are organized through partnerships between VA Regional Offices, state agencies such as the North Carolina Department of Military and Veterans Affairs, county Veterans Services offices, and Veterans Service Organizations such as the American Legion and Veterans of Foreign Wars.

At these events, Veterans and their family members can file new VA claims, get updates on pending claims, ask questions about appeals and eligibility, enroll in VA health care, and connect with a broad range of community support services. Some events also featured mobile compensation and pension examiners on site, allowing Veterans to complete medical examinations during the event itself.

North Carolina was the first state to begin hosting events of this type, in partnership with the VA and the American Legion, and Veterans consistently travel from across the state and the country to attend and receive services at North Carolina's VBL events.[41]

"These events create a space where the veteran can be heard and feel valued. Common feedback received is the veteran felt like "for the first time someone was listening to them and doing something about it." They also allow the VA team to put a face to some of the many veterans they work with every day and to apply a personal approach. Many times, they do not get to personally interact with the veterans they assist, and the VBL provides a sense of reality and worth to what they do."

–Representative of NCDMVA

Funding for Events

Veterans Benefits Live events are supported through a cost-sharing partnership model rather than a single funding stream. The VA contributes staff time and resources through its Veterans Benefits Administration and Veterans Health Administration. VA works most closely with traditional Veteran organizations like the American Legion, Veterans of Foreign Wars, Disabled American Veterans, Paralyzed Veterans of America, American Veterans (AMVETS), and Vietnam Veterans of America. Venue and logistical costs are typically absorbed by local partners such as county governments, community organizations, and Veterans organizations. This collaborative funding model keeps the events entirely free to attendees while leveraging federal, state, and community resources efficiently.

The Case for Continued Investment

The documented results of VBLs make a compelling case for continued investment and partnership. At a single three-day event in Mecklenburg County, more than 1,100 Veterans and their families were served. The VA paid out $606,739 in retroactive benefits during the three days after claims were processed on site, with a total of approximately $1 million expected after subsequent reviews.[41] At least 315 claims were filed related to the Promise to Address Comprehensive Toxics (PACT) Act, which expands VA health care and benefits for veterans exposed to burn pits and other toxic substances, and staff conducted 97 toxic exposure screenings on site.[41]

These events are particularly valuable because they address one of the most persistent challenges in Veterans' benefits delivery: the gap between eligibility and enrollment. Many Veterans are unaware of benefits to which they are entitled, lack the documentation or knowledge to navigate the claims process on their own, or face long delays when working through the system remotely. On-site claims processors can view Veterans' electronic folders simultaneously while speaking with them and can communicate directly with employees at the regional office to help expedite and authorize claims that are ready to rate on the spot. This is a level of responsiveness that is otherwise not available through standard mail or online channels.



RESOURCE AND **PARTNERSHIP** POSSIBILITIES

Veterans Benefits Administration

Veterans Health Administration

Local and regional Veteran organizations

Strategy 1.5: End predatory Veteran claims services

State regulators and the General Assembly should implement strong policies that protect Veterans from predatory claims services that charge high fees to submit claims for Veteran benefits. An initial step in this work can include a repeal or correction of Session Law 2025-72, Section 4, which created a framework for for-profit claims consulting companies to charge steep fees.

Desired Result

Strong state policies will protect Veterans from predatory, high-fee claims consulting services and ensure they can access the benefits claims assistance they are entitled to without exploitative costs.

Potential Measures of Success

- Repeal or correction of Session Law 2025-72, Section 4 (yes/no)
- Enactment of new state policy or legislation regulating Veteran claims consulting fees
- Number/percentage reduction in Veterans reporting fees charged for benefits claims assistance
- Number of for-profit claims consulting companies operating in North Carolina before vs. after policy change
- Increase in the number of Veterans using free or low-cost claims assistance (e.g., VSOs, accredited agents/attorneys) instead of for-profit services

How Predatory Benefits Agents Operate

Often referred to as "claim sharks," these unaccredited, for-profit businesses charge Veterans thousands of dollars for help filing VA benefits claims. However, these services are available for free through licensed organizations and Veterans Service Officers. Federal law is clear that only Department of Veterans Affairs (VA)-accredited attorneys, claims agents, and Veterans Service Organizations may assist Veterans with disability claims in exchange for compensation, and no Veteran can be charged when filing an initial claim.[42] The law requires that accreditation involves training, ethical compliance, continuing education, and fee oversight. However, in 2006, Congress repealed criminal penalties for unaccredited individuals who illegally charge Veterans for claims assistance, creating a regulatory gap that predatory companies have exploited.[43]

Claim sharks typically market themselves as expert navigators of the VA system and use aggressive online advertising that appeals to Veterans searching for claims help. Veterans can be charged upwards of $20,000 to handle a single claim and some companies take a percentage of a Veteran's future disability compensation.[43] The tactics have grown increasingly sophisticated. A 2025 NPR investigation of Florida-based Trajector Medical found that the company used auto-dialer software to access a VA benefits hotline meant for Veterans, dialing into the system to monitor benefit payments for thousands of clients, and then automatically billing Veterans when their payments increased.[44]

What Makes These Agents Predatory

Several features of the industry's practices are exploitative and predatory.

1. **The services they sell are legally available at no cost –** Accredited Veteran Service Officers and organizations like the American Legion, Veterans of Foreign Wars (VFW), and Disabled American Veterans provide free claims assistance to any Veteran.
2. **Claim sharks exploit complexity and vulnerability –** Veterans may not know that free assistance is available or may be misled about the nature of the relationship.
3. **These firms operate strategically to avoid accountability –** Unaccredited disability claim consultants are not subject to VA standards and strategically advertise their services to avoid regulatory oversight.

Harm to Vulnerable Populations

Older and aging Veterans can be particularly vulnerable targets of predatory claims practices, with exploitation centered on the VA's Aid and Attendance pension benefit. This is a supplemental payment program specifically designed to help Veterans and surviving spouses afford long-term care. Nationally, the VA paid $3.2 billion in total pension benefits to 232,000 Aid and Attendance recipients in fiscal year 2018.[45] The scale of that benefit pool has attracted predatory actors who have been termed "pension poachers" who target older Veterans to extract fees for assistance with claims. Task force members shared anecdotes about claim sharks giving presentations in long-term care facilities to gain clients and facility administrators pressuring families to apply for benefits.

North Carolina Session Law 2025-72

Session Law 2025-72[46], effective October 1, 2025, regulates people and businesses who charge Veterans money to help them with VA or state Veterans' benefits claims. In general, it bans charging any fee for help with an initial disability claim, bans paid referrals to claims-helpers, and bans promising or advertising a guaranteed benefit outcome or amount. If someone charges for **ongoing** help with a Veterans' benefits matter (not an initial claim), they can't aggressively solicit business, can't get access to someone's personal medical, financial, or government login credentials, and can't use a doctor they have an employment relationship with to conduct a secondary medical exam.

Before doing any paid work, anyone charging for help with an ongoing Veterans' benefits matter must put everything in a signed written agreement. Fees can only be charged if the claim succeeds, can't exceed five times the resulting one-month increase in benefits, and no upfront fee is allowed. That agreement must also include a disclosure—in at least 12-point font, explained out loud, and separately acknowledged and signed by the Veteran—stating that:

- The business isn't affiliated with the VA or state Veterans' agency,
- Free help may be available elsewhere, and
- The Veteran may qualify for other benefits too.

Breaking any of these rules counts as an unfair trade practice, which opens the violator up to legal consequences under state consumer protection law.

Advocates continue to be concerned that the allowance for fees can add up to a much larger sum than the Veteran may expect. In an op-ed, the Legislative Chairman for the Department of NC, Veterans of Foreign Wars stated:

> **"Among its many provisions, the law set rules for the for-profit companies that charge veterans to help file claims. It caps their fee at five times a veteran's first month of increased benefits. To the uninitiated that verbiage that sounds like a "limit." In practice, it has become a license. For a veteran without dependents who goes from a zero to a one-hundred-percent rating, that "capped" fee can exceed twenty thousand dollars, for a service an accredited officer in the same county would have provided for free."**
>
> **–Tanner Port, Legislative Chairman for the Department of NC, Veterans of Foreign Wars, Op-Ed: North Carolina Made a Promise to Veterans.**
> https://www.ncpoliticalnews.com/news/op-ed-tanner port-north-carolina-made-a-promise-to-veterans

Legal Actions Against Claims Services

- ***Texas v VA Claims Insider (2026):*** In January 2026, the Texas Attorney General secured more than $6.8 million in debt relief for disabled Veterans in a lawsuit against VA Claims Insider, alleging the company posed as legitimate Veteran assistance while deceptively charging disabled Veterans fees for navigating the VA claims process.[47]
- ***Ford v Veterans Guardian VA Claim Consulting, LLC (2023):*** US war Veterans filed a class action lawsuit against Veterans Guardian VA Claim Consulting, LLC, of Pinehurst, North Carolina, alleging that the company was a "claim shark" that charged fees beyond what is permitted by federal law and practiced law without a license.[48] On May 20, 2026, Judge Catherine Eagles of the US District Court, Middle District of North Carolina, issued an opinion finding that Veterans Guardian violated federal law by preparing and presenting Veterans' disability claims to the VA while charging fees and operating without VA accreditation.[49]

Other State Legislative and Regulatory Responses

In the absence of federal criminal penalties, a growing number of states are enacting protective legislation:

- **California:** California Governor Gavin Newsom signed Senate Bill 694, the Veteran Benefits Protection Act, in February 2026, prohibiting unaccredited private companies from billing Veterans for help with VA disability claims.[50]
- **New Jersey, New York, Maine, and Illinois:** Bipartisan legislation prohibiting or restricting fee-based claims assistance has been passed in these states, with the VFW's National Legislative Service leading a nationwide campaign to pass legal

protections in every state. Veterans Guardian sued to block New Jersey's law prohibiting fees for Veterans claim consulting, and a federal appeals court sided with the company. That ruling, however, reflects procedural and preemption arguments rather than an endorsement of the practice itself, and other states have proceeded with their own measures.[51]



RESOURCE AND **PARTNERSHIP** POSSIBILITIES

North Carolina General Assembly

North Carolina Attorney General

North Carolina Department of Military and Veterans Affairs

Meeting The Needs of Transitioning Service Members

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. Task force members underscored how this transition can lack support from 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, many describe the experience of TAP as a "firehose of information". Often those who attend the program are not focused on what their needs will be as a Veteran.

Challenges related to health care during transition can be exacerbated by a lack of Veteran cultural awareness among community clinicians, the possibility of gendered disparities in treatment at Department of Veterans Affairs (VA) medical centers, and the difficulty Veterans experience when trying to build community. Without knowing where else to ask for help, shared knowledge among Veterans is the primary way many Veterans learn about available resources and benefits.

> "In the 2025 [Military Family Lifestyle Survey], 58% of veteran respondents described their overall transition from military to civilian life as "difficult" or "very difficult." Additionally, 41% assessed that they were either "somewhat unprepared" or "very unprepared" to successfully navigate this transition. Among all veteran respondents, 48% felt the experience met their expectations, but 44% found it more difficult than expected."
>
> –2025 Military Family Lifestyle Survey Results. D'Aniello Institute for Veterans and Military Families at Syracuse University. 2025. https://ivmf.syracuse.edu/2025-military-family-lifestyle-survey-results/

Improving Information Access for Transitioning Service Members and Their Families

The North Carolina Department of Military and Veterans Affairs (NCDMVA) has developed a targeted outreach initiative to ensure that transitioning service members and their families are connected to state resources before and after they separate from the military. Approximately 20,000 Veterans complete military service in North Carolina annually, representing a significant population that the department is committed to supporting through the transition process.[52]

The initiative draws from a model already in use in Maryland. The Maryland Department of Veterans and Military Families operates its "Landing Zone Maryland" program, which serves as a comprehensive hub for transitioning service members and their families, connecting them to housing, employment, education, and benefits resources available in the state.[53] A key element of Maryland's approach involves identifying service members who indicate during the military separation process that they intend to relocate to Maryland—or who are open to relocating anywhere—and collecting their contact information to send them targeted outreach materials.

As of July 2026, NCDMVA has begun replicating this cost-effective model. The department developed a postcard that is mailed directly to transitioning service members who express an interest in settling in North Carolina. The postcard highlights key topic areas where the state can

provide assistance and includes a QR code linking to further resources. This postcard initiative complements that broader mission by extending the department's reach to individuals who may not yet be aware of the services available to them.

The approach is both simple and scalable. Rather than waiting for Veterans to seek out information on their own after they transition out of active duty, NCDMVA will proactively deliver a connection point to resources at a critical decision-making period in the service member's life.

Veterans Bridge Home and Onward Ops

In August 2026, Veterans Bridge Home began serving as the Onward Ops Community Integration Coordinator for the Expiration Term of Service Sponsorship Program (ETS-SP) in North Carolina. The ETS-SP "connect[s] new Veterans with trained sponsors from their destination community, focusing on the 12 months between leaving the military and reintegrating into civilian life."[54]

The ETS-SP helps to ensure that service members' care is safely transitioned and tailored to their unique needs before they leave active duty. The program focuses on:

- Wellness and resilience through employment, financial stability, and access to VA and community services.
- Addressing social determinants of health that can contribute to mental health challenges, including suicide risk.
- Linking Veterans to local sponsors who provide one on one mentorship and guidance.[55]

Sponsors are paired with transitioning service members to:

- Connect via email, text, or phone.
- Share information about the local area and available resources.
- Help the new Veteran identify goals and develop action plans to achieve them.[54]

> **"The Onward Ops program effectively bridges the gap for transitioning Veterans and their families by connecting them to the health care and benefits they earned in uniform and providing support through a trained community sponsor."**
>
> –Danielle Bracco, ETS-SP director of operations, https://www.va.gov/HEALTHPARTNERSHIPS/updates/impact/transition.asp

Veteran Family Needs and Challenges

From the beginning of the task force, members noted that the health needs of Veteran families are too often invisible to both the Department of Veterans Affairs (VA) and community health systems. A medical professional interviewed for the task force stressed that, as primary health care decision-makers in a Veteran's household, family members require the same levels of cultural competency and clear communication from providers that Veterans themselves need. A retired Veteran and Veteran advocate described the current state of recognition:

> **"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."**

She also noted a significant systemic gap regarding children of Veterans: without asking "Do you have a family member who has served in the military?" in schools and health settings, educators and providers "don't know what trauma they may be carrying forward," missing opportunities for early identification and support.

Caregiving for Veterans

The needs of Veterans' families and caregivers represent one of the least visible dimensions of Veteran health. A 2024 RAND Corporation study estimated that more than 14 million Americans are currently providing some form of care to a military Veteran or wounded service member, representing a caregiving community far larger than those enrolled in formal VA caregiving programs.[56] Nearly three-quarters of those caregivers are supporting someone older than 60, reflecting the aging of the Vietnam-era Veteran population.[56] Caregivers to those age 60 and under reported high levels of caregiver burden (52%), perceived stress (75%), depression (43%), and difficulty paying bills (70%).[56]

The economic footprint of this unpaid care is enormous. RAND researchers estimated the value of services provided by military and Veteran caregivers at between $119 billion and $485 billion annually, depending on the range of support counted.[56] Because of providing this care, more than a quarter of military and Veteran caregivers reported that caregiving had caused them to cut back their work hours, switch jobs, or stop working entirely.

> "Compared with non-caregivers, a greater proportion of caregivers to those 60 and under have probable depression and high rates of perceived stress, and 20 percent of military/veteran caregivers in this group have thought about taking their own lives."
>
> –America's Military and Veteran Caregivers. RAND Corporation. 2024. https://www.rand.org/pubs/research_reports/RRA3212-1.html

With the needs and challenges of Veteran family members and caregivers in mind, the task force makes the following recommendation.

RECOMMENDATION 2:

Increase Veteran family and caregiver awareness of available services and programs.

Strategy 2.1: Create a family transition navigator program

Strategy 2.2: Improve Veteran caregiver access to information and resources related to available benefits and services

Strategy 2.3: Increase research into Veteran caregiver needs

Strategy 2.1: Create a family transition navigator program

Responsible entities can improve Veteran family transition experience through the following actions:

A) Statewide Veterans service organizations and North Carolina Department of Military and Veterans Affairs (NCDMVA) should work together to identify a host organization and funding to support a Veteran family mentor support program, or "transition navigators", for family members of military service members who are transitioning to civilian life.

B) The identified host organization should pilot a Family Transition Navigator Program modeled on sponsor- and peer-transition programs, beginning 12–24 months before separation and continuing for 12 months post-transition. The program should serve spouses, caregivers, and dependent children and be promoted through a variety of mechanisms to reach the intended audience.

Desired Result

Provide military spouses, caregivers, and dependent children access to peer-based guidance and support to reduce isolation and improve family well-being during the transition from military to civilian life.

Potential Measures of Success

- Identification and designation of a host organization (yes/no)
- Launch of the pilot program (yes/no)
- Number of transition navigators recruited and trained
- Number of families (spouses, caregivers, dependent children) enrolled in the program; Number of referrals to additional resources or services made through navigators
- Family satisfaction and confidence ratings regarding the transition process
- Self-reported outcomes: reduced isolation, improved sense of preparedness, or stronger community connection

Comparison of Experience of the Transition Process for Families Based on Financial Situation

Assessment of Overall transition process as "Difficult"		Assessment of overall transition process as "Smooth"	
19%	"We are comfortable."	46%	"We are comfortable."
41%	"We are doing okay."	37%	"We are doing okay."
25%	"We are just getting by."	12%	"We are just getting by."
14%	"We're finding it difficult to get by."	5%	"We're finding it difficult to get by."

Source: Veteran Families in the 2025 MFLS: Community, Transition Needs, and Family Financial Situation. D'Aniello Institute for Veterans and Military Families at Syracuse University. 2025 https://bluestarfam.org/wp-content/uploads/2026/02/IVMF-Finding_FINAL_02202026.pdf

Resources for Transitioning Families

The military offers Transition Assistance Programs (TAPs) to help separating service members consider alternative careers, prepare financially, understand their benefits, prepare for interviews, and access Department of Veterans Affairs (VA) services available after transitioning. TAP workshops are typically mandatory for separating and retiring service members and the process typically begins at least 12 months ahead of a separation or retirement date. However, as mentioned earlier in this chapter, service members do not consistently attend the program as planned.

Most military installations encourage spouses to attend TAP programs, but it is largely optional and may be logistically out of reach. Other programs for transitioning families are:

- **MySTeP (Military Spouse Transition Program) –** A three-part program whose third component, "Stepping Beyond," focuses on preparing the family for transition by covering the separation process, DoD and VA benefits, finances, health care, and employment.[57]
- **USO Transition Program –** Connects separating service members and their spouses with a Transition Specialist who can help them develop an action plan and connect with resources for employment assistance, education, finances, and Veterans' benefits, all free of charge.[58]
- **VA Transition Assistance Program –** Available to family members and caregivers and covers health care, educational benefits, life insurance, home loans, disability compensation, and resources for social and emotional health.[57]
- **Transition Employment Assistance for Military Spouses (TEAMS) –** This program through the Department of Labor provides free employment training workshops.[59]

Specific Transition Challenges for Families

Despite available programs, the years after discharge represent a critical period during which Veterans and their families navigate shifts in identity, social connections, and employment.

One of the most persistent burdens on transitioning families is the employment challenge facing military spouses. The unemployment rate for active-duty military spouses was 8.8% in 2023, nearly four times higher than the civilian spouse rate of 2.5%.[60] This is driven in part by the fact that military families relocate 3.6 times more often than civilian families.[60] Barriers to spouse employment include constant relocations, lack of viable childcare options, and civilian employers' reluctance to hire someone with a transient lifestyle. These challenges do not automatically resolve upon separation.

For families with children, research indicates that Veteran mental health challenges create multifaceted and pervasive changes in family structure, roles, and routines. These changes produce negative mental health effects that ripple through the family system, with children in Veteran families facing distinct risks. One study found that children from Veteran families are more likely to experience clinically recognized externalizing mental health problems than children from non-Veteran families.[61]

The Case for Peer-Based Family Transition Support

Taken together, this evidence points to an opportunity for families to benefit from relational, peer-driven guidance from those who have lived the transition experience themselves. Reintegration into civilian life is influenced by factors at individual, family, community, and systemic levels. Providing early peer support with this adjustment could help mitigate long-term challenges. A dedicated mentor support program with experienced Veteran family members could provide the connective tissue between existing formal programs and the lived experience of families navigating an unfamiliar civilian world.



RESOURCE AND **PARTNERSHIP** POSSIBILITIES

- **Philanthropies supporting military-connected families**
- **North Carolina Department of Military and Veterans Affairs**
- **Veterans Bridge Home**
- **MySTeP (Military Spouse Transition Program)**
- **USO Transition Program**
- **VA Transition Assistance Program**
- **Transition Employment Assistance for Military Spouses (TEAMS)**

Strategy 2.2: Improve Veteran caregiver access to information and resources related to available benefits and services

Several responsible entities can improve Veteran caregiver access to information about available benefits and services through the following actions:

A) **Representatives of websites like Ask Me NC, NCServes, and the NC Caregiver Portal should ensure that there are resource lists for families and caregivers of Veterans, that they are easy to find and navigate, and that there is regular maintenance of resources on these sites.**

B) **The North Carolina Department of Military and Veterans Affairs (NCDMVA) should increase Veteran Service Officer (VSO) awareness of caregiver needs, available benefits and services, and VSO ability to refer to existing benefits and services.**

C) **NCDMVA, in coordination with stakeholder organizations such as the Elizabeth Dole Foundation, AARP NC, the North Carolina Department of Health and Human Services Division of Aging, the Department of Public Instruction, and health professional organizations, and with coordinated financial support, should host a virtual annual Veteran caregiver summit to help caregivers connect with each other, share resources, and learn about available support networks, benefits, and services.**

D) **Administrators of Veterans Directed Care programs should provide templates and tools for families to use to manage funds and administrative tasks for Veteran care through the program (e.g., budgeting and time sheet templates).**

Desired Result

Veteran caregivers will have easier access to accurate information, connection with support networks, and resources to manage the benefits and services available to them.

Potential Measures of Success

- Website traffic and click-through rates on caregiver resource pages
- Caregiver satisfaction survey results regarding ease of finding information
- Number of caregiver-specific referrals made by VSOs
- Caregiver satisfaction with VSO responsiveness to caregiver-specific questions
- Number of summits held (annual recurrence, yes/no)
- Number of caregivers registered and in attendance
- Number of connections, resources, or support networks caregivers report gaining from the summit
- Development and distribution of standardized templates (budgeting, time sheets, etc.) (yes/no)
- Caregiver-reported ease of managing funds and administrative tasks

Programs for Caregivers of Veterans

Several formal programs exist to support Veteran caregivers, though awareness of them among health care providers and VSOs can be limited.

VA Caregiver Support Program (CSP) – This is the primary federal caregiver program, operating through two distinct tracks:

1. **Program of General Caregiver Support Services (PGCSS) –** Available to caregivers of Veterans of any service era who are enrolled in VA health care. Provides education, skills training, peer support, and coaching.[62]
2. **Program of Comprehensive Assistance for Family Caregivers (PCAFC) –** Offers more intensive support that includes a monthly financial stipend, health care coverage through CHAMPVA, mental health counseling, and respite care. This program is for caregivers of Veterans with a service-connected disability rating of 70% or higher.[62]

> 74% of surveyed family members of Veterans said that they needed caregiver resources but didn't get them.
>
> –Veteran Families in the 2025 MFLS: Community, Transition Needs, and Family Financial Situation. D'Aniello Institute for Veterans and Military Families at Syracuse University. 2025 https://bluestarfam.org/wp-content/uploads/2026/02/IVMF-Finding_FINAL_02202026.pdf

Veteran Directed Care (VDC) – This program offers a distinct and flexible alternative for Veterans who need nursing home-level care but wish to remain in their homes and communities. Unlike the PCAFC, eligibility for VDC is based on care need rather than disability status. Through a partnership between the VA and local Aging and Disability Network Agencies – including Area Agencies on Aging in North Carolina – VDC provides enrolled Veterans with a flexible monthly budget they can use to hire the caregivers of their choosing, including family members, friends, and neighbors. Veterans work with person-centered counselors to develop and manage their care plan, with financial management services handling payment logistics.[63]

VSO Caregiver Resources

North Carolina's VSOs currently receive limited training on caregiver programs and resources. One-time courses may be coordinated by VSO regional managers and provided by the Veterans Health Administration (VHA). NCDMVA is currently planning for updates to the training curriculum for all VSOs in the state that would include caregiver resources, as well as methods to connect Veterans to additional supports such as Medicaid and Social Security Disability Income. Current practice is that VSOs provide clients with the VHA contact number for needs related to caregiver and other health care services, and some VSOs may provide additional information or submit caregiver service applications.

"I am a spouse to an Air Force Veteran. My husband served for 18 years and was in the process of medically retiring from his over 20 deployments when he had an accident here on our farm that rendered him quadriplegic. I am now his primary caregiver, and we also have two children, a 12-year-old and a 5-year old, so I'm the caregiver to them as well.

"I was a new military spouse. I didn't even have my military ID, and I was also 8 weeks pregnant with our second child. There were a lot of moving parts when his accident happened. I was working full time for a clinical research organization. I had to go on FMLA, which eventually led to me needing to resign from my position due to the amount of care I realized my husband would need.

"One of the things that I found most challenging in that moment in time was being provided with a lot of resources, but it was so overwhelming just being given a bunch of paper and not really understanding what all of the resources meant. There are so many amazing resources that are available through nonprofits, through the VA system, and through Tri-Care, but it is incredibly overwhelming and challenging to navigate. Especially when you are going through something traumatic, your brain cannot absorb all of the things.

"Having someone to help funnel down or walk you through some of those options is really important for people who are new to caregiving, who are new to the military and VA system."

–Wife and caregiver of an Air Force Veteran

RESOURCE AND **PARTNERSHIP** POSSIBILITIES

- VA Caregiver Support Programs
- Elizabeth Dole Foundation
- Ask Me NC
- NC Serves
- AARP NC
- North Carolina Division of Aging
- Department of Public Instruction
- State and regional philanthropies

Strategy 2.3: Increase research into Veteran caregiver needs

The Veteran Research Engagement Panel (VetREP) should encourage research into strategies to improve caregiver access and awareness of services and programs and experience navigating those services and programs.

Desired Result

Increased research into caregiver access and experience of programs for Veterans will identify strategies for improvement and reduce caregiver stress.

Potential Measures of Success

- Increase in the number of research studies initiated or funded focused on Veteran caregiver access, awareness, and navigation experiences
- Number of researchers or research institutions engaged through VetREP on caregiver-related topics
- Number of research findings published or disseminated (reports, journal articles, briefs)
- Number of policy or program recommendations generated from research findings
- Number of research findings translated into actionable changes (e.g., updated resources, new programs, policy proposals)

Experience of Caregivers with VA Medical Centers

The NCIOM Task Force on Veterans' Health included a Work Group on Veteran Family and Caregiver Needs. Work group members caregiving for Veterans included those with experience caring for adult children, spouses, and parents. These members live across North Carolina and therefore have experiences with different VA Medical Centers across the state. Caregivers in the Work Group shared a wide range of experiences with the VA Caregiver Support Program and other caregiver services. One caregiver has participated in very helpful and meaningful engagement with fellow caregivers through a peer-to-peer support group meeting once a month that is facilitated by one VA Medical Center. Other caregivers expressed struggles with navigating services, sometimes being the ones to educate the VA caregiving specialist about services. Many caregivers noted that it can be hard for caregivers to find out about the VA Caregiver Support Program and get connected to services unless it is recommended by another caregiver.

These experiences, as well as challenges related to re-evaluations of Veteran needs to remain enrolled in services, are also reflected in research findings.[64,65] These experiences highlight the value of continued attention and research into the needs of caregivers as well as potential strategies to improve connection to available services and evaluation of the experiences of caregivers receiving services for their Veterans.

VA Veteran Research Engagement Panel

The VA Veteran Research Engagement Panel (VetREP), which originated in Durham, has a mission to:

1. Promote patient-centered research, and
2. Translate VHA research into practice and community settings.[66]

VetRep is composed of Veterans and their caregivers who volunteer to lend their voices from representative Veterans, branches, and eras of service to researchers who request review of their work. The panel assists in setting research priorities and refining research questions as researchers design their studies and disseminate results. Through this work, the group is able to answer questions that researchers present to the panel, to encourage awarding of funding with letters of support from VetREP, and to influence the quality of research and the topics that researchers are investigating. This work is done through the VA's Durham Center for Innovation (COIN) to ADAPT (Accelerate Discovery and Practice Transformation) to improve Veteran care, health care efficiency, and equity.



RESOURCE AND **PARTNERSHIP** POSSIBILITIES

Caregiving Collaborative through the NC Serious Illness Coalition

Unique Needs of the Children of Veterans

There are currently 1.6 million military children in the United States.[67] While this number does not include the children of Veterans, it indicates the high population of children who are military-connected. Many military children have unique strengths, including:

- Rapid integration and adaptability gained through experiences of moving multiple times.
- Cross-cultural fluency gained through diverse global environments.
- High-stakes resilience gained through frequent geographic resets.[68]

However, there are also unique challenges for military-connected children, including:

- Separation from a loved one due to deployment or training.
- Frequent moves.
- Difficulties making friends and/or assimilating into new schools and environments.
- Challenges relating to their identity and belonging.
- Gaps in education due to frequent moves.[69]

Added challenges can arise for children of disabled Veterans. There are 2.3 million children in the United States under 18 who live with a disabled Veteran.[70]

Research has found that, although most military-connected children experience a stable home life and adult relationships, these children are more likely than civilian children to experience domestic violence, parental mental health issues, substance use, and suicidality, and struggles with family dysfunction.[71] Children who have experienced deployment of a parent are at higher risk for their own mental and behavioral health challenges than other military-connected or civilian children.[72,73]

With these unique needs and the opportunity for improved connections to services, the task force makes the following recommendation.



RECOMMENDATION 3:

Help the children of Veterans access the supportive services they may need.

Strategy 3.1: Enhance the capacity of schools to identify and meet the needs of the children of Veterans

Strategy 3.2: Develop Veteran child peer buddy program

Perspective of a Mental Health Clinician Who Services Military-Connected Families

"Children of Veterans can experience unique mental health challenges related to the lasting effects of military service on family life. When a Veteran struggles with conditions such as post-traumatic stress disorder (PTSD), depression, anxiety, or difficulties adjusting to civilian life, children may be exposed to increased stress within the home. They may witness mood changes, emotional withdrawal, irritability, or hypervigilance in a parent, which can lead to feelings of confusion, insecurity, fear, or responsibility for the parent's well-being. Research suggests that these experiences can increase a child's risk for anxiety, depression, behavioral concerns, and difficulties with emotional regulation.

In addition, many children of Veterans face challenges related to military culture and family transitions, including frequent moves, separations, deployments, and reintegration after a parent returns home. These disruptions can affect their sense of stability, peer relationships, and academic functioning. Some children may struggle with trust, social connection, or identity development, while others may take on caregiving roles within the family. Despite these risks, many children of Veterans demonstrate remarkable resilience when provided with supportive relationships, consistent routines, and access to mental health resources that address the unique needs of military and Veteran families."

Strategy 3.1: Enhance the capacity of schools to identify and meet the needs of the children of Veterans

Several responsible entities can improve awareness of possible mental health and social needs of the children of Veterans and available resources through the following actions:

C) **All local educational agencies should collect a Veteran Student Identifier for children in North Carolina public schools, similar to existing Military Student Identifier, by asking, "Is the student a dependent of a service member, Veteran, or retiree of the US Armed Forces (including National Guard or Reserve forces) of the Army, Navy, Air Force, Marine Corps, Space Force, or Coast Guard?"**

D) **Local educational agencies or individual schools should participate in the Purple Star Program to learn more about how to support military and veteran-connected children, or if already participating, should implement strategies to increase parent and family awareness of the program, its purpose, and activities.**

E) **Veteran student associations and student organizations related to school psychology, counseling, social work, school nursing, and teaching at North Carolina institutions of higher education should partner to provide educational opportunities for future professionals that will work with military- and Veteran-connected children to learn about their unique needs and available resources.**

Desired Result

Statewide adoption of a Veteran Student Identifier, expanded Purple Star Program participation, and increased preparation of educational professionals to better identify Veteran-connected children and proactively meet their mental health and social needs.

Potential Measures of Success

- Number/percentage of local educational agencies (LEAs) that adopt the Veteran Student Identifier question
- Number of students identified as Veteran-connected through the new identifier
- Use of identifier data to inform school-based support services or resource allocation
- Year-over-year growth in new Purple Star designations
- Number/percentage of LEAs or schools participating in the Purple Star Program
- Parent and family awareness levels of the program (survey-based)
- Number of partnerships formed between Veteran student associations and school psychology, counseling, social work, nursing, and teaching student organizations
- Pre/post assessment showing increased knowledge of military- and Veteran-connected children's needs among participants
- Number of Veteran-connected children identified and connected to school-based mental health or social support resources

Military Student Identifier

A military-connected student identifier is a designation used to recognize and track students who have a parent or guardian serving in, or who has served in, the United States Armed Forces, as well as their reserve and National Guard components. The Military Student Identifier (MSI) was established under the Every Student Succeeds Act (ESSA) of 2015, which requires states and districts to report on the academic performance of students with a parent in the military, making military-connected students a distinct subgroup for data and accountability purposes.

In North Carolina, each LEA has different ways of identifying military-connected children. Some may include the information in enrollment paperwork, however the primary method of collecting the military-connected status is through the Impact Aid verification form. This form is also unique to each district and optional for parents to complete. Identification of military-connected students on this form allows schools to qualify for federal Impact Aid and targeted Department of Defense (DoD) programs that are intended to offset the impacts of tax-exempt federal property and high student mobility in communities with large military-connected populations.

A Veteran-connected student identifier extends this concept to include children of those who have separated from military service, recognizing that the challenges associated with military family life do not necessarily end when a parent leaves active duty. This type of data can enable schools to disaggregate student demographic and performance information, evaluate program effectiveness, and ensure that appropriate tiered social, emotional, academic, behavioral, and mental health resources are available and systematically provided to this population. Collecting this information at enrollment would allow schools and districts to better recognize and respond to the unique needs of military- and Veteran-connected children, who may otherwise go unidentified and unsupported within the general student population.

Purple Star Schools Program

The Purple Star Schools Program is a national effort to serve military-connected children in schools. As of November 2025, 44 states had Purple Star School designation programs or approved legislation, and five states had proposed legislation.[74]

The North Carolina Department of Public Instruction's Purple Star designation is awarded to schools that demonstrate military-friendly practices and a commitment to military students and families.[75] As of 2026, 598 schools (around 22%) in the state have been awarded the designation.[76] One requirement of the program is to collect the Military Student Identifier discussed in the previous section.

> "Of the [military-connected] children in the K-12 age range, 80% attend public schools, meaning their school year is often interrupted during relocations. Frequent changes in school, childcare providers, and long stretches of time with a parent deployed can cause military children to face greater than average stress levels."
>
> The State of Military Families. Mission Roll Call. 2024.
> https://missionrollcall.org/veteran-voices/articles/the-state-of-military-families/

Research by the Military Child Education Coalition, which included the North Carolina program, found that the "Purple Star program's true value derives from its potential to:

- Centralize and make knowledge accessible.
- Develop stakeholder networks.
- Support schools in cultivating and communicating cultural competency in supporting military connected families."[77]

The study also found that, of surveyed school-level respondents:

- 66% said that the Purple Star program had a positive impact on their school.[78]
- 86% said that the process of applying was either "very easy," "easy," or "neither difficult nor easy."[77]
- 96% said that maintaining the designation once awarded has been "very easy," "easy," or "neither difficult nor easy."[77]

Parents and students also reported positive experiences with the program:

- 77% of parents were satisfied with their children's social-emotional experience, compared to just 54% of parents in non-Purple Star schools.[77]
- 72% of parents reported that the program was an important factor in their school selection.[78]
- 50% of students said their experience had been better than at non-Purple Star schools.[77]

Importantly, the research found that "schools and parents report[ed] that recognition of the Purple Star brand among families remain[ed] low.... Leveraging a Purple Star school's local parent networks will also be critical, as one of the sources of information cited most often by parents was local military-spouse clubs and parent groups."[77]

Engaging with Veterans in Schools

One Veteran task force member shared that they were asked by an elementary school principal to be interviewed by the school's History Club. Activities like this, while seemingly simple, can be a no-cost and local way to connect communities of different ages and backgrounds to Veterans, allows Veterans to be engaged with their communities, and can make military-connected children feel seen.

"Examples of practices that make schools eligible for the Purple Star award include having a military resource page on their website and a transition program for inbound and outbound families. Awarding-winning schools must have a staff member liaison for military families, and districts must also have a central office employee who serves as a point person for those liaisons. Finally, there must also be annual professional development addressing special considerations for military students and families."

Brown C. 598 NC schools awarded Purple Star designations for being 'military-friendly'. EdNC. April 27, 2026. https://www.ednc.org/04-27-2026-598-schools-awarded-purple-star-designations-for-being-military-friendly/



RESOURCE AND **PARTNERSHIP** POSSIBILITIES

- North Carolina Department of Public Instruction
- School District Military Liaison Counselors
- Military Child Education Coalition
- North Carolina Association of Coordinators of Veterans Affairs

Strategy 3.2: Develop Veteran child peer buddy program

Partners such as the North Carolina Department of Military and Veterans Affairs, North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities, and Substance Use Services, the Department of Public Instruction, and other groups connected to military and Veteran children should collaborate to identify an entity (e.g., NC Child) to develop and host a statewide Veteran child peer buddy program to provide mentorship and peer support.

Desired Result

A statewide Veteran child peer buddy program gives military- and Veteran-connected children access to mentorship and peer support that helps them navigate the unique challenges of military and Veteran family life.

Potential Measures of Success

- Identification and designation of a host entity (yes/no)
- Development and launch of the statewide peer buddy program (yes/no)
- Number of Veteran- and military-connected children enrolled in the program
- Number of peer buddies/mentors recruited and trained
- Self-reported outcomes among participating children (e.g., reduced isolation, increased sense of belonging, improved coping skills)

> **"Youth peer support programs and services use strategies such as providing hope through modeling well-being, strategically sharing personal stories to empower others, affirming the aspirations of their peers, normalizing and destigmatizing experiences, and building strong relationships to establish social connectedness. Youth peer support is not a replacement for clinical services; rather, it represents a unique and critical opportunity to extend a bridge of empathy, connection, and support to young people from those they often turn to the most– their peers[81]."**
>
> –Regis D, Resnick A, Sun E, et al. Trailblazing the Future of Youth Peer Support Acknowledgments. Accessed May 31, 2026. www.mhanational.org

Peer-to-Peer Mentorship: Evidence Across Youth Populations

A growing body of research supports peer-to-peer and cross-age peer mentoring as an effective strategy for improving outcomes among children facing a range of challenges. These programs rely on young people to support other youth, rather than adult-to-child relationships. This model

may be well-suited to a Veteran child peer buddy program, where shared experience of military and Veteran family life is a key feature.

Although not specific to the children of Veterans, one study compared outcomes of peer mentoring programs in which an older youth was paired with a younger peer to the outcomes of intergenerational (adult-to-youth) mentoring programs. The study found a medium effect on youth outcomes that was more than double the effect sizes observed in the intergenerational programs.[79]

An evaluation of a school-based peer mentoring program found that a primary driver of positive impact was simply having someone to talk to who understood their experience.[80] This relational dynamic could be especially relevant for children of Veterans, who often report feeling that peers and teachers do not understand the realities of military family life.

Research across multiple youth populations underscores that peer support programs grounded in shared lived experience offer distinct advantages over general support models. Among youth with chronic illness — another population characterized by experiences that peers often do not share or understand — peer-to-peer support has been shown to improve social connectedness, reduce isolation, and improve quality of life outcomes.[81] A peer support program for adolescents with chronic illness found that the shared nature of participants' experiences, rather than a shared diagnosis, created a meaningful sense of belonging for young people at risk of social isolation.[82]



RESOURCE AND **PARTNERSHIP** POSSIBILITIES

NC Child

Youth organizations, such as Scouting America and Girl Scouts of the USA

Local Education Agencies

Department of Public Instruction

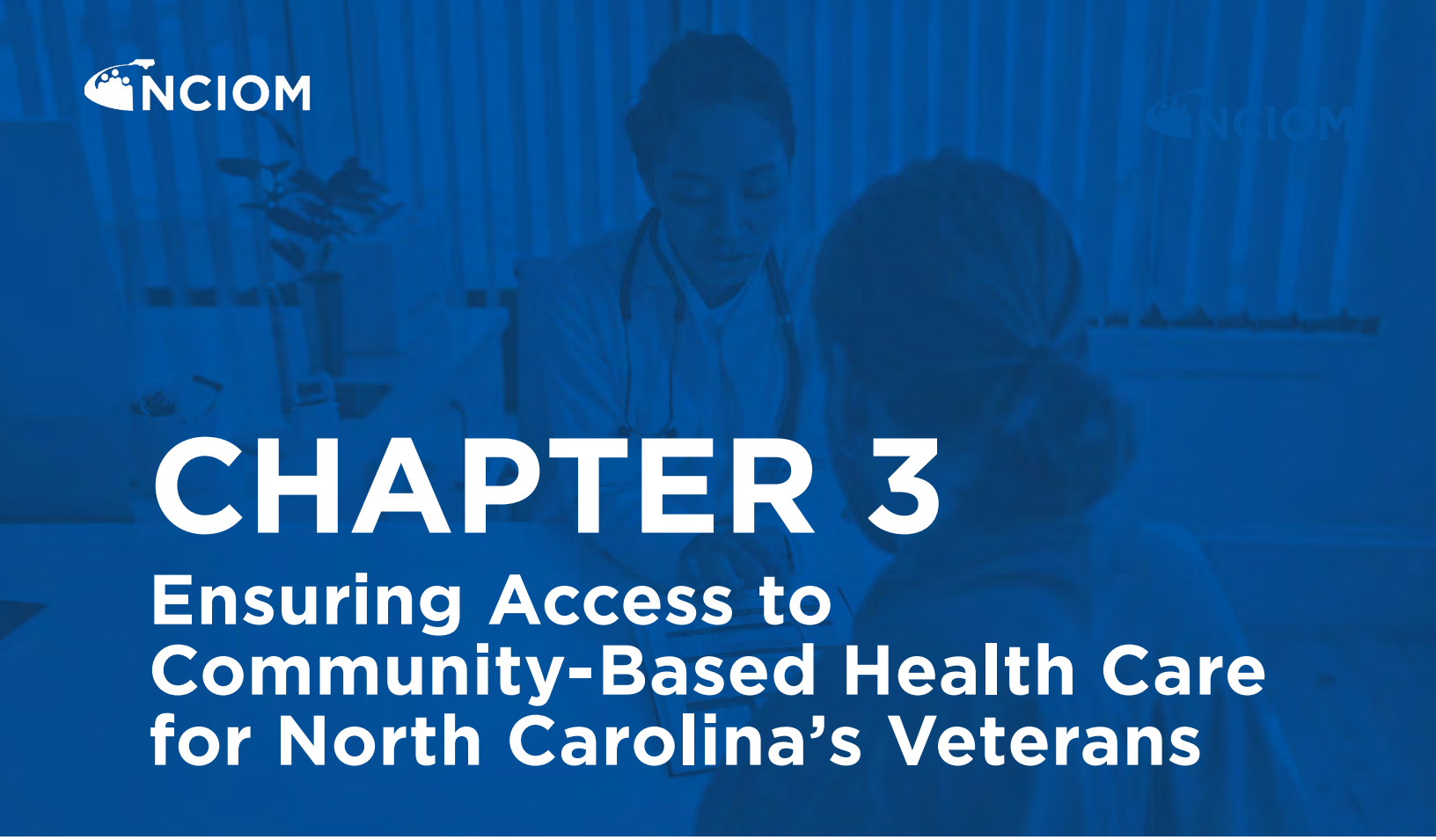
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CHAPTER 3

Ensuring Access to Community-Based Health Care for North Carolina's Veterans

This chapter's recommendations address the structural and geographic barriers that can stand between North Carolina's Veterans and access to health care services. They call for hosting an annual summit focused on connecting Veterans to health insurance, ensuring that justice-involved Veterans are not left behind as they reenter communities, expanding practice authority of certain health care providers, and strengthening the community-based provider network through gap analysis, practice support partnerships, and the Rural Health Transformation Program. Taken together, these strategies recognize that access to care is not a single problem with a single solution. Ensuring access requires attention to workforce, geography, and insurance coverage.

Contributors to Health Care Access

This chapter explores three key contributors to health care access for Veterans:

- **Health insurance –** Insurance status is the most basic component of access to care. The high cost of health care can often prevent those without insurance from establishing a consistent source of care.
- **Provider acceptance of common Veteran health insurance –** Veteran access to care is influenced by the availability of providers who accept their health insurance or payment source. This applies to Veterans who access care through the Department of Veterans Affairs (VA) and may be referred to community care providers, as well as Veterans who use TRICARE or Medicaid.
- **Health care workforce adequacy and distribution –** Access to care is also influenced by the presence, or lack thereof, of health care providers in a geographic area and by limitations on the type of services that certain types of clinicians can provide.

An indirect contributor to Veteran health care access is an individual's level of trust and comfort with the health care providers they may encounter. This topic is discussed in Chapter 4.

Veteran Health Insurance Status

Veterans are more likely than the general population to have access to health insurance or other payment options for care (e.g., VA benefits). This is largely due to access to Veterans' health benefits for those who have service-connected disabilities and/or low income. Figure 4 shows the likely distribution of health coverage for Veterans age 19-64 in states that have expanded Medicaid eligibility, like North Carolina. The largest difference from the general population is that nearly 21% of Veterans are covered by public insurance such as VA and TRICARE, whereas only 2% of the general public is covered by another public insurance other than Medicaid.[1]



A smaller proportion of Veterans are covered by Medicaid than the general population, however Medicaid still insures one in ten Veterans.[1] For Veterans enrolled in Medicaid as part of the expanded eligibility in North Carolina, there will be upcoming changes to continued eligibility related to reporting work activities or possible exclusion from that requirement. It will be important to consider ways to ensure these Veterans understand the new requirements to maintain their Medicaid enrollment.

Among those 1.6 million veterans with Medicaid coverage, most had additional forms of insurance. While some rely on Medicaid as their only source of coverage, it more often supplements other types of insurance by covering services that other payers may not, such as long-term care. For veterans who are also enrolled in Medicare, Medicaid can help cover both premiums and cost-sharing responsibilities, reducing out-of-pocket costs for services like doctor visits, hospital stays, and prescription drugs. Only 17% of veterans with Medicaid were covered by Medicaid alone. The remaining 83% had at least one other source of coverage. The most common combination was Medicaid and Medicare, which accounted for 60% of all veterans with Medicaid (some of whom were also enrolled in VA health care)… Smaller percentages of veterans were also enrolled in VA health care (17%), or another other form of insurance coverage, such as TRICARE or employer-sponsored insurance (6%).

–Cervantes S, et al. 5 Key Facts About Medicaid and Veterans. KFF.org. June 30, 2025. https://www.kff.org/medicaid/5-key-facts-about-medicaid-and-veterans/

Medicaid Eligibility Basics

In North Carolina, people with incomes at or below 138% of the Federal Poverty Guidelines (FPG) are eligible for Medicaid. For an individual, that is $22,025 per year, and for a family of four, that is $45,540 per year in 2026.[i]

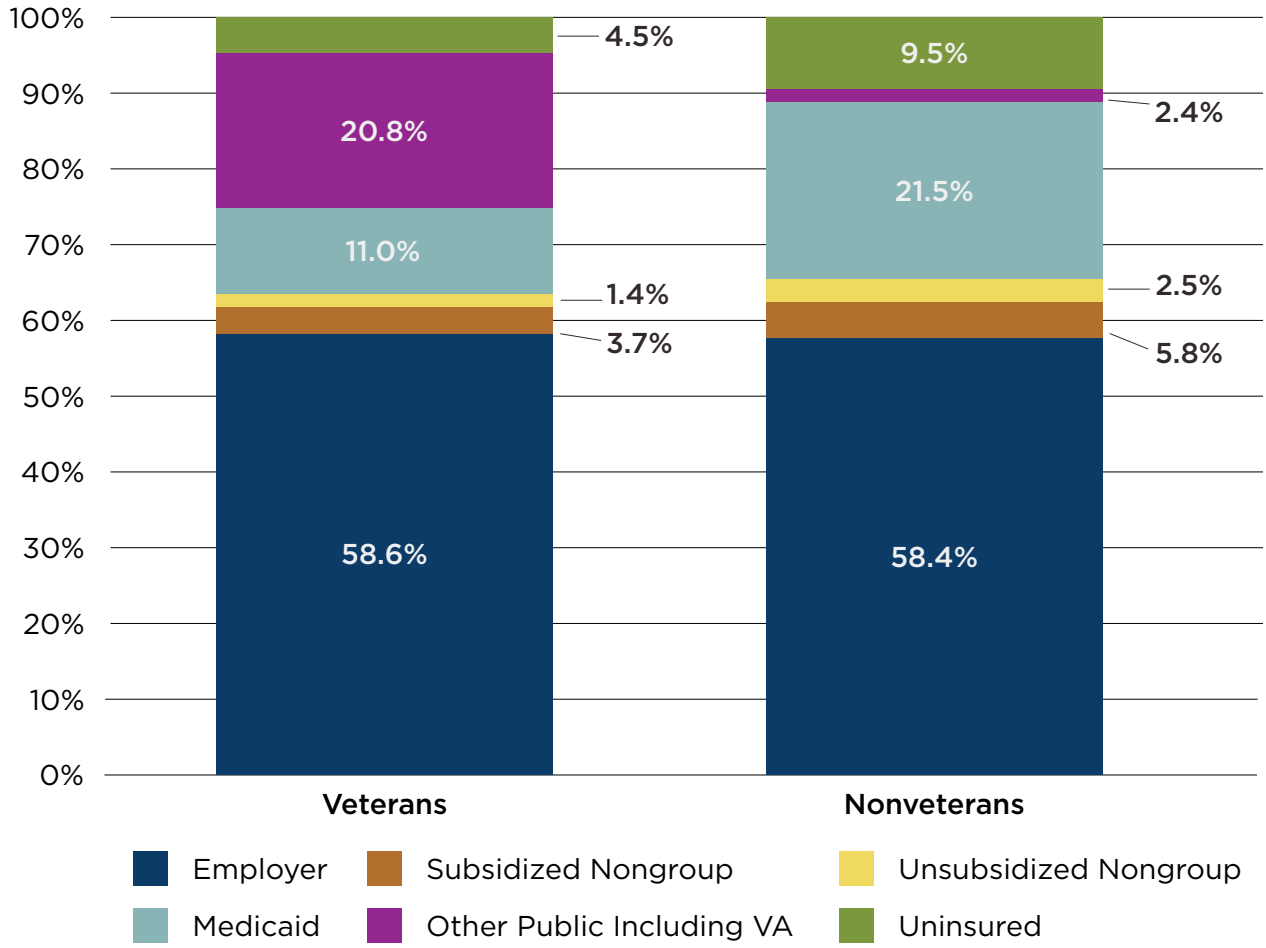
Individuals who are in both of the following categories will need to begin completing verification that they worked at least 80 hours per month or participated in other allowable activities:

Part of the Medicaid expansion population, which includes parents who make over 37% of the FPG and non-disabled adults without children,[ii] and

"Able-bodied" adults age 19-64 who are not pregnant, experiencing a serious medical condition, tribal members, or parents/caregivers of a dependent child that is age 13 or under or has a disability.[iii]

i U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. 2026 Poverty Guidelines: 48 Contiguous States. Accessed August 21, 2026. https://aspe.hhs.gov/sites/default/files/documents/b1bfa16b20ae9b89d525bc35de7c1643/detailed-guidelines-2026.pdf
ii University of North Carolina School of Government. Medicaid expansion workforce report. December 2024. https://ncimpact.sog.unc.edu/wp-content/uploads/sites/1111/2024/12/MEW_Report_2024-11-20-1.pdf
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Figure 4. Modeled Distribution of Health Coverage of Adult Veterans and Nonveterans (Ages 19-64) in Expansion States, 2024



Source: https://www.urban.org/sites/default/files/2023-11/Uninsured%20Veterans%20in%20the%20US.pdf

Veteran Use of Community-Based Care

As of 2025, 49% of the US Veteran population was enrolled in the VA Health Care System and around 43% of those enrolled accessed services through the VA that year.[2] This means that more than half of Veterans are not enrolled in the VA Health Care System and/or are not accessing care there.

For Veterans who access care through the VA, the portion of VA payments to community-based care has grown over recent years. The portion of Veterans Health Administration (VHA) medical spending on community care grew from about 12% in 2014 to 20% in 2021.[3] Under current VA rules, eligible Veterans may access community care when a service isn't offered by the VA, there are long wait times for appointments, or the VA provider is far from the Veteran.[4]

Outside of urban and suburban areas of North Carolina, access to community-based providers can be a limitation to care for anyone. With an already limited supply of providers, issues of network adequacy can be a factor when Veterans who use VA health care, TRICARE, or Medicaid are looking for health care providers near them.

Figure 5. Veteran Population in NC, 2020-2024

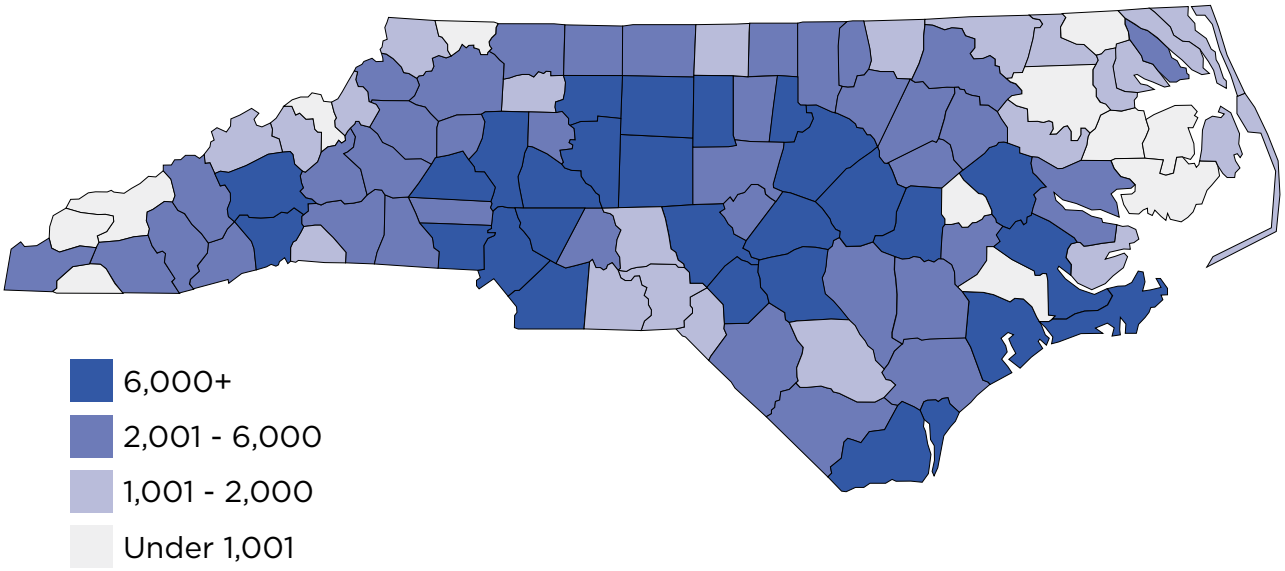


Figure 6. Primary Care Health Professional Shortage Areas in NC. 2025

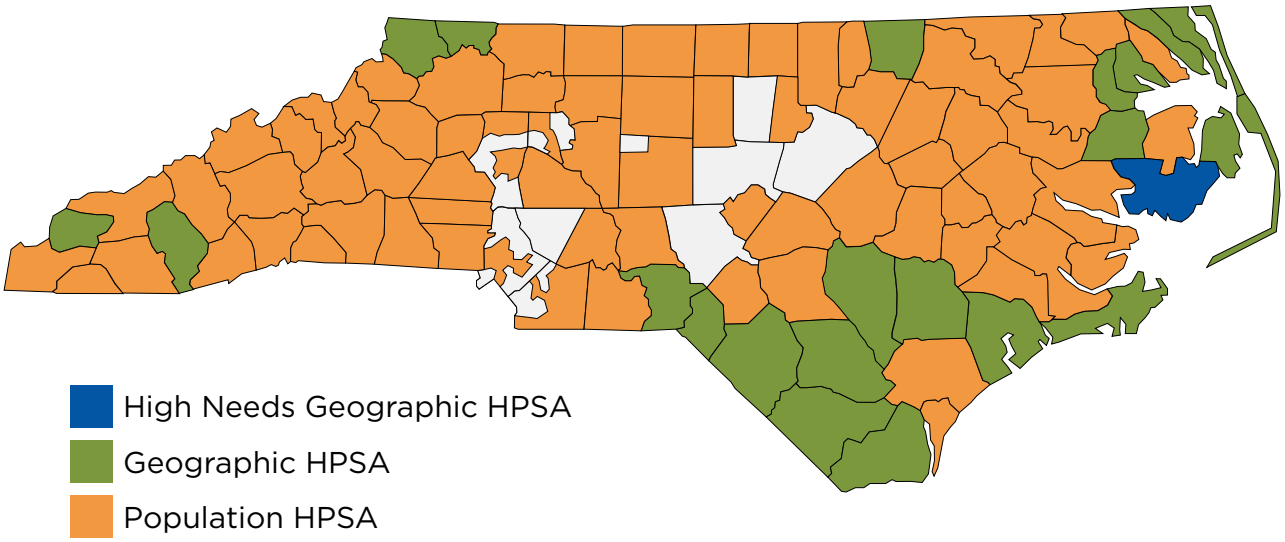
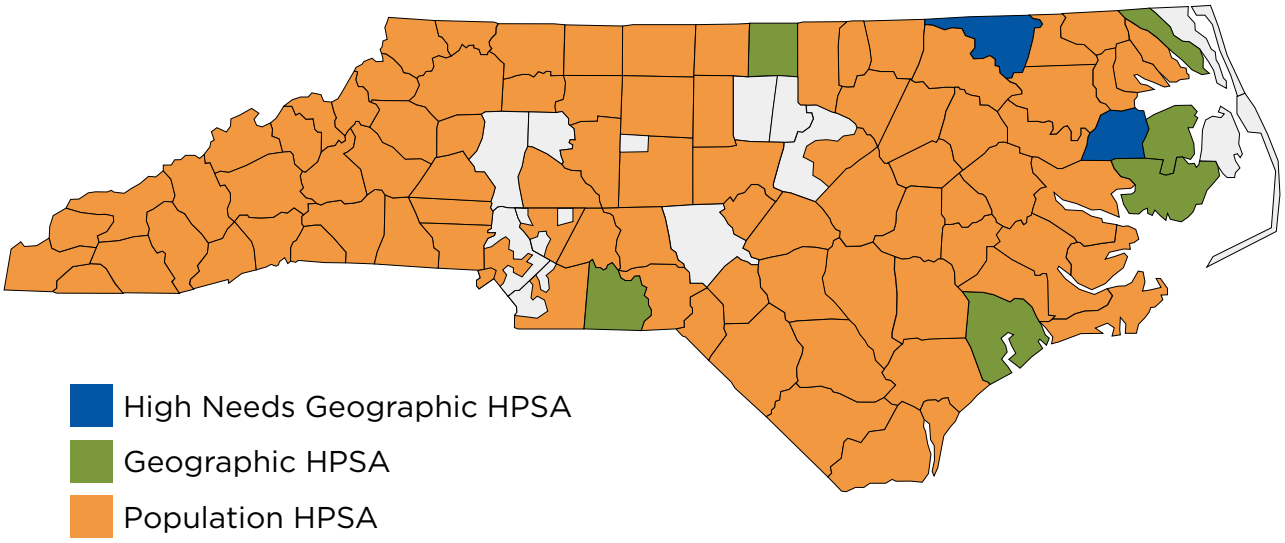


Figure 7. Mental Health Professional Shortage Areas in NC. 2025



High-needs geographic HPSAs are areas with moderate-to-high population-to-provider ratios paired with elevated community health needs or limited provider capacity.

Geographic HPSAs indicate shortages of health care providers for an entire population within a geographic region.

Population HPSAs indicate geographic areas within which specific groups of people face a shortage of health care providers.

With many Veterans accessing care in community-based settings, it is vital to consider what the strength of that access is and how to improve it. Access to care is even more important for Veterans facing mental health challenges like post-traumatic stress disorder (PTSD), as discussed in the next section.

Rural Veterans

"The rural Veteran population is older and medically complex. Rural and highly rural Veterans are more likely to be diagnosed with diabetes, obesity, high blood pressure, and heart conditions. Veterans serving in more recent military conflicts may also have multiple medical and combat-related health needs.

- Rural Veterans enroll for VHA care at a higher rate than their urban counterparts – **66% vs. 47%.**
- **65%** of enrolled rural and highly rural Veterans are age 55 or older.
- **2 million** enrolled rural Veterans have military service-connected health care needs.
- More than **370,000** rural Veterans (not service-connected or disabled) are eligible for care because they fall below VA's income limit."

Source: VHA Office of Rural Health. About Rural Veterans. https://www.ruralhealth.va.gov/aboutus/rural-veterans.asp. Accessed June 5, 2026.

PTSD: A Condition Long Overlooked

Post-traumatic stress disorder (PTSD) is a serious, often chronic mental health condition that develops after experiencing or witnessing traumatic events. Although it is now a well-defined medical diagnosis, the condition has been recognized in military personnel under many different names throughout history including "soldier's heart" during the Civil War, "shell shock" in World War I, and "combat fatigue" during World War II.[5] It was not until 1980 that the American Psychiatric Association formally recognized PTSD as a distinct clinical diagnosis, a delay that cost generations of Veterans appropriate treatment and benefits.[6]

PTSD can occur after any life-threatening or deeply distressing experience. For military Veterans, the most common triggers include witnessing severe injury or violent death in combat, exposure to sudden and unpredictable traumatic events, and both physical and sexual violence during service.[5] In the general population, roughly 8% of people will experience PTSD at some point in their lives, but among Veterans, that proportion is substantially higher.[5] According to the VA's National Center for PTSD, between 11% and 20% of Veterans who served in Iraq or Afghanistan have been diagnosed with PTSD.[5] Among Veterans who use VA health care, about 14% of men and 24% of women were diagnosed with PTSD in 2024.[7] One reason PTSD may be more common in women using VA care is military sexual trauma, which is reported by about 1 in 3 women Veterans and 1 in 50 male Veterans when screened by a VA provider.[7]

What PTSD Looks Like

PTSD is not simply difficulty adjusting to civilian life or lingering sadness after hardship. It is a medical condition with specific, measurable symptoms that can be profoundly disabling. These include:

- Flashbacks and nightmares that force Veterans to relive traumatic events involuntarily.
- Emotional numbness that prevents connection with loved ones.
- Persistent sleep problems.
- Sudden and uncontrollable anger.
- Social withdrawal.[8]

PTSD frequently co-occurs with depression, with depression nearly 3 to 5 times more likely in those with PTSD than those without.[8,9] Those with both conditions face worse prognosis, more medical issues, lower social support, and higher rates of suicidal ideation.[9] Substance use disorders (SUDs) are also deeply intertwined with PTSD, with between 55% to 75% of Iraq and Afghanistan Veterans with PTSD also affected by SUD.[9]

The consequences for Veterans' relationships and family life are equally serious. Partners of Veterans with PTSD report significantly higher caregiver burden compared to partners of Veterans seeking help for other behavioral health conditions.[10] Research has also begun to document that the effects of PTSD can ripple into the next generation by influencing parenting behaviors and children's developmental outcomes.[10]

Finally, the relationship between PTSD and suicide is one of the most urgent dimensions of this condition. Veterans are roughly 1.5 times more likely to die by suicide than their civilian peers, and the suicide rate for women Veterans is about 2.5 times higher than for women who have never served.[11] Critically, research has shown that worsening PTSD symptoms are associated with a 25% higher long-term suicide mortality rate,

while Veterans who achieve full symptomatic remission from PTSD show a substantial and sustained reduction in suicide risk.[12] In other words, effective treatment for PTSD is a life-saving intervention.

Identifying Patterns in Veteran Suicide

The **VESPER (Veteran Suicide Prevention Using Electronic Health Records)** study is a multi-site research project examining suicide risk among Veterans who receive care outside the VA health system. The study focuses on Veterans who are not enrolled in or using VA health care and is examining patterns in these Veterans through analysis of civilian electronic health records across five major health systems in North Carolina and Utah. The VESPER team is using the data to describe this population's characteristics, analyze suicide death records, and develop machine learning algorithms to predict suicide risk in non-VHA settings. Another aim involves interviewing experts to identify effective suicide-prevention strategies outside the VA. The study notes that most Veterans who die by suicide had no recent VA contact, underscoring the need for improved detection, coordination, and prevention across civilian health systems. This work is ongoing and aims to address this major knowledge gap.

Who Isn't Getting Help and Why

Despite the availability of effective treatments, barriers can stand in the way of accessing care.

- **Stigma –** Many service members are conditioned to suppress emotional pain, especially during active duty, and this stigma persists long after discharge, creating shame and fear around seeking help.
- **Access and provider shortages –** In North Carolina, nearly 4.3 million people live in a Mental Health Professional Shortage Area, mostly in rural communities.[13] Of the 4.4 million American Veterans who live in rural communities, many face staff shortages in rural health care facilities, hospital closings, travel and transportation issues, and limited broadband internet access for telehealth treatment.[14]
- **Eligibility and discharge status –** Veterans who received "other than honorable" discharges are at significantly elevated suicide risk but historically have had the most limited access to VA care. These Veterans include many individuals whose conduct was directly shaped by undiagnosed PTSD, traumatic brain injury, and/or substance use disorders.[15]
- **Underserved populations –** Reservists and National Guard members who need treatment for PTSD cannot access military treatment facilities and must instead navigate civilian insurance, TRICARE Reserve Select, or community resources. Older Veterans, including those who served in Vietnam, Korea, and World War II, may be carrying decades of unaddressed PTSD, sometimes exacerbated by the stresses of aging, retirement, and bereavement.

> **In analyzing VHA's fiscal year 2021 data, GAO found rural veterans used intensive mental health care programs at lower rates than their urban counterparts. For example, the rate at which rural veterans used outpatient care was approximately 21%, compared with a utilization rate of 79% for urban veterans.**
>
> –US Government Accountability Office. VA Mental Health: Additional Action Needed to Assess Rural Veterans' Access to Intensive Care. February 9, 2023. https://www.gao.gov/products/gao-23-105544

What Works: Evidence-Based Treatments

Effective treatments exist and have been rigorously tested. First-line treatment for PTSD centers on psychotherapy, with medications serving as a valuable complement or alternative.

The following psychotherapies are commonly used in PTSD treatment. Importantly, research suggests that treatments have differing impacts depending on symptoms, meaning treatment can and should be tailored to the individual Veteran's experience.

- **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) –** addresses distorted thoughts and beliefs that emerge from trauma.
- **Eye Movement Desensitization and Reprocessing (EMDR) –** uses guided eye movements alongside trauma recall to help patients process and reframe traumatic memories.
- **Cognitive Processing Therapy (CPT) –** a 12-week structured approach, is also widely used and specifically validated for combat-related PTSD.[16]
- **Prolonged Exposure (PE) –** employs a progressive approach to trauma-related memories, feelings, and situations which patients have been avoiding since their traumatic experience.[17]

For pharmaceutical treatment, the largest body of evidence supports the use of SSRIs (selective serotonin reuptake inhibitors), a class of antidepressants.[16] These medications are most helpful for hyperarousal and mood symptoms, though less effective for the emotional numbing and avoidance that many Veterans find most disabling.

New Developments in PTSD Treatment

Research into psychedelic-assisted therapy is a rapidly evolving frontier in PTSD treatment, particularly for Veterans who have not responded adequately to conventional approaches. Two compounds have received the most scientific attention: MDMA and psilocybin.

MDMA is believed to work by reducing activity in the brain's fear center (the amygdala) while increasing activity in the prefrontal cortex, which helps patients process traumatic memories without becoming overwhelmed.[i] Two Phase 3 randomized controlled trials of MDMA-assisted psychotherapy produced positive outcomes compared to those receiving therapy with a placebo.[i]

Psilocybin, the active compound in hallucinogenic mushrooms, has shown strong results for depression and anxiety, conditions that frequently co-occur with PTSD, and is actively being explored for PTSD treatment directly.[ii]

Despite these promising findings, significant regulatory and scientific hurdles remain. In August 2024, the FDA declined to approve MDMA-assisted psychotherapy for PTSD, citing the difficulty of masking participants in trials who could easily identify whether they had received the active drug, questions about data integrity at some trial sites, and the generalizability of findings from highly controlled clinical settings to real-world practice.[i] Researchers and advocates view the FDA decision as a delay rather than a rejection and expect that improved study designs will produce the evidence needed for approval. Nonetheless, it would be premature to conclude that future research findings will confirm that this treatment is both safe and effective.

FDA review of psilocybin is underway, though several states have already legalized its use in supervised medical settings.[ii]

The Veterans Health Administration is actively funding research on psychedelic medications and President Donald Trump signed an executive order in April 2026 intended to accelerate research and approval for these medications. Three bills related to psychedelic research have been introduced in the North Carolina General Assembly: SB 1018, The HEAL Act (2025-26 Session)[iii]; SB 568 F– The Innovative Treatments for Mental Health Act (2025-26 Session)[iv], and HB 727, The Breakthrough Therapies Research/ Advisory Act (2023-24 Session)[iii]. Although SB 568 was initially introduced independently, its primary request was contained in SB 1018.[iv]

Members of the **NCIOM Task Force on Veterans' Health** participated in discussions about psychedelic uses for PTSD treatment. Due to the research and regulatory constraints described here, task force members declined to recommend any state action related to these medications at this time.

i Woolley J. Update on Novel Psychedelic Treatments for PTSD. Published online 2024. doi:10.1016/j.eclinm.2020.100538
ii Psychedelic-Assisted Therapy for PTSD - PTSD: National Center for PTSD. Accessed April 28, 2026. https://www.ptsd.va.gov/professional/treat/txessentials/psychedelics_assisted_therapy.asp
iii NC Health News. Psychedelic-assisted therapy research gains traction with NC lawmakers, academics. July 16, 2026. https://www.northcarolinahealthnews.org/2026/07/16/psychedelic-assisted-therapy-research-funding-nc-general-assembly
iv Senate Bill 568, Innovative Treatments for Mental Health Act. https://www.ncleg.gov/Sessions/2025/Bills/Senate/PDF/S568v1.pdf

Traumatic Brain Injury: The Signature Wound of Post-9/11 Conflicts

Traumatic brain injury (TBI) is a serious and widespread health issue among Veterans, particularly those who have served in post-9/11 conflict zones. According to the Defense and Veterans Brain Injury Center, nearly 414,000 TBIs were recorded among US service members between 2000 and late 2019. More than 185,000 Veterans receiving VA health care have been diagnosed with at least one TBI.[18] Around one quarter of Veterans screen positive for a probable TBI.[19] These injuries are particularly common among those who served in Iraq and Afghanistan, where the widespread use of improvised explosive devices (IEDs) exposed troops to powerful blast waves. Blast-related injuries account for roughly 60% of all military TBIs.[20] Thanks to improvements in body armor, helmet design, and battlefield medical care, more service members are surviving these injuries than in past conflicts, however this means more Veterans returned home with lasting physical and neurological effects that require ongoing care and support.[20]

The consequences of TBI extend far beyond the initial injury and can affect nearly every aspect of a Veteran's health and daily life. TBI often occurs alongside a cluster of other physical and mental health conditions that compound to make recovery more challenging. There are strong associations between TBI and the following conditions:



Musculoskeletal injuries



Headaches



Vision problems



Sleep problems



PTSD



Depression



Aggression/violence[21]

Treatments for TBI can help to address the physical, psychological, and social needs that Veterans can experience. A comprehensive study of treatments for TBI found that:

> **Evidence supports cognitive rehabilitation for cognitive outcomes, psychotherapy for psychological outcomes, behavioral interventions for social outcomes, occupational rehabilitation for occupational outcomes, and psychotherapy and behavioral interventions for [post-concussion syndrome]. Even so, most TBI research is conducted among the general adult population and often includes non-TBI neurological diagnoses that may result in imprecise or inaccurate efficacy of interventions to support veterans with TBI specifically. Innovations and traditional treatments for TBI show promise, but additional high-quality research in veteran populations is essential to understanding the most-effective interventions for improving outcomes after TBI.[22]**

Through the VA, Veterans with moderate to severe TBIs, can receive care at five Polytrauma Rehabilitation Centers[1] that provide comprehensive inpatient care using advanced technologies to help address challenges with mobility, communication, thinking skills, strength, and emotional well-being.[23] Veterans with milder injuries, or who have completed inpatient rehabilitation, can access care through a network of more than 100 outpatient clinics and specialized teams across the country.[23] These outpatient programs focus on practical goals: managing symptoms like pain, headaches, and sleep difficulties; building strategies for everyday tasks; and supporting Veterans in returning to their communities.[23] Treatment is coordinated across a range of services, including primary care, mental health, vocational counseling, and assistive technology.

1 The five Polytrauma Rehabilitation Centers are located in Richmond, VA, Tampa, FL, Minneapolis, MN, Palo Alto, CA, and San Antonio, TX. https://www.polytrauma.va.gov/POLYTRAUMA/system-of-care/care-facilities/polytrauma-rehabilitation-centers.asp

Case Study: The Transforming Health and Resilience in Veterans (THRIVE) Program

Since 2022, the THRIVE Program, through their three-day, multidisciplinary evaluation, served more than 500 participants, from first responders to active duty service members, recently transitioning Veterans, and Veterans who have been out of active service for years but continue to struggle with mild to moderate traumatic brain injuries (TBI) or post-traumatic stress disorder (PTSD).

The program offers a unique approach, combining clinical care with a variety of behavioral health services.

For people experiencing the lasting effects of TBI and PTSD, finding the right combination of care can be challenging. Treatment may involve multiple providers, appointments, and types of therapy, often requiring patients to navigate a complicated health care system while already managing the effects of their injuries.

The THRIVE program aims to make that process easier by offering a comprehensive slate of services under one roof, at no out-of-pocket cost to participants.

"One strength is the fact that we have so many providers working together," said Master Sergeant (Retired) Samuel Rodriguez, the THRIVE program's Veteran outreach and program coordinator. "There are other factors that influence someone with TBI. If my assessment shows that I'm OK cognitively, but I'm still showing other symptoms, we can work as a team to find, for example, if equine or art therapy will help."

THRIVE participants begin with a three-day, interdisciplinary evaluation that covers an array of clinical, physical and behavioral health factors. After the initial evaluation, eligible participants can choose to participate in a three-week intensive outpatient program, which includes multiple types of therapy, including equine and art therapy, acupuncture, moral injury discussions, reading groups, and yoga and mindfulness sessions.

On the clinical side, the program also offers diagnostic tools and treatments that aren't available in other, less specialized, settings. For example, participants experiencing dizziness may have access to specialized assessment and treatment aimed at addressing their underlying vestibular issues, rather than simply having medication to dampen their symptoms.

"THRIVE is a uniquely impactful program in our state that serves Veterans, first responders, and active duty service members to mange complex injuries in a way that traditional health care settings would find difficult," said Dr. Jason P. Mihalik, Director of the Matthew Gfeller Center and Chief Executive Officer of the THRIVE Program.

TBI Assessment Resource

"The Online Brain Injury Screening and Support System (OBISSS) is a free online tool for youth and adults ages 10 and older that helps identify a person's lifetime history of brain injury and better understand the challenges that may be affecting daily life. Results can help individuals and providers connect to resources, improve communication, and plan for appropriate supports.

OBISSS can help you:

- Identify a history of brain injury
- Better understand brain injury-related challenges
- Receive personalized strategies and resources
- Improve communication between individuals and providers
- Identify resource information"

OBISSS is available at https://www.online.nashia.org/surveys/?s=ELNECFTK9EKW7ALK

State Login: North Carolina

Subscriber Code: 704

Source: North Carolina Department of Health and Human Services. Traumatic Brain Injury - Introducing the Online Brain Injury Services and Support System (OBISSS). Accessed August 26, 2026. https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-use-services/traumatic-brain-injury

With the variety of non-VA health insurance and health care resources that are available to Veterans and the importance of connecting Veterans to care, the task force makes the following recommendation:

RECOMMENDATION 4:

Improve Veteran access to health care providers, services, and programs to meet their mental and physical health needs and eligibility status.

Strategy 4.1: Host an annual Veteran health information summit

Strategy 4.2: Increase Veteran access to health services, particularly in rural areas

Strategy 4.3: Assist justice-involved Veterans in accessing available health-related services

Strategy 4.1: Host an annual Veteran health information summit

The North Carolina Department of Military and Veterans Affairs, with dedicated financial support, should increase knowledge and connections between Veteran health stakeholders, such as Veterans Integrated Service Network (VISN) 2, County veteran service officers, Affordable Care Act Marketplace Navigators, State Health Insurance Information Programs, and others, by hosting a virtual annual Veteran health information summit.

Desired Result

Strengthen knowledge-sharing and collaboration among Veteran health stakeholders to improve collective ability to connect Veterans with the health coverage and services available to them.

Potential Measures of Success

- Number of summits held (annual recurrence, yes/no)
- Amount/source of dedicated financial support secured
- Number of Veteran health stakeholders registered and in attendance
- Number of stakeholders reporting increased knowledge of available Veteran health resources (pre/post survey)

A Veterans' Health Summit would help to increase knowledge and connection about topics such as:

Increasing Veteran Service Officer (VSO) knowledge about additional health insurance options for Veterans ineligible for Department of Veterans Affairs (VA) services, including Medicare, Medicaid, and the Affordable Care Act Marketplace, and where to refer Veterans for more information and assistance.

Educating NC Navigators, State Health Insurance Assistance Programs (SHIPs), and others involved in health insurance counseling for Veterans who may also be eligible for VA services.

Helping Veterans enrolled in Medicaid and/or SNAP understand network reporting requirements.

Ensuring Veterans who access at least some of their care through the VA have information about Veteran Power of Attorney and Advance Directive forms (e.g., specific forms for VA, community-based provider access to forms).

Insurance Status and Access to Care for Veterans

> **"We estimate that 1 in 4 uninsured veterans (25.1 percent) would be eligible for Medicaid coverage but [are] not enrolled. Another 22.4% would be eligible for Marketplace [Premium Tax Credits (PTCs)]. These uninsured veterans mostly have incomes between 100% of [Federal Poverty Level (FPL)] and 400% of FPL—an income range in which significant PTCs to purchase Marketplace coverage are common—and have no access to an affordable employer offer of coverage. Those with incomes less than 250% of FPL would also be eligible for cost-sharing reductions that raise the generosity of the plan benefits (share not shown). Thus, nearly half of uninsured veterans (47.5%) in 2024 are projected to be eligible for Medicaid or subsidized Marketplace coverage but not enrolled."**
>
> – Banthin J, Haley JM, Simpson M. Uninsured Veterans in the US Greater Expansion and Take-Up of Medicaid and Marketplace Coverage Has the Potential for Coverage Gains. Published online 2023.

A specific area of need for Veteran access to care involves health insurance coverage for Veterans who are not enrolled in—or not fully served by—VA health care. An estimated 1 in 4 uninsured Veterans would be eligible for Medicaid coverage but are not enrolled.[24] In addition, Veterans can apply for Medicaid coverage for uninsured family members which would comprise a significant

benefit to the Veteran's well-being. VSOs can be a Veteran's first point of contact for benefits navigation, yet they may not have sufficient knowledge of non-VA coverage options like Medicare, Medicaid, and the Affordable Care Act Marketplace to refer Veterans appropriately.

In North Carolina, programs such as NC Navigators Consortium and the North Carolina Seniors' Health Insurance Information Program (SHIIP) offer free, unbiased counseling on health insurance options. SHIIP counselors help individuals understand Medicare benefits, compare and choose coverage options, and identify programs that reduce out-of-pocket costs.[25] These counselors could be another access-point for connecting Veterans with the best health insurance that meets their needs.

Veterans enrolled in Medicaid and/or SNAP (the Supplemental Nutrition Assistance Program) also face important policy changes that require proactive outreach. The 2025 Congressional reconciliation law (Public Law No: 119-21) requires states to implement Medicaid work reporting requirements beginning January 1, 2027. Limited experiences with similar requirements in other states has highlighted the potential for administrative challenges that contribute to loss of coverage. The Congressional Budget Office estimates that work reporting requirements will increase the number of uninsured nationally by 5.3 million over the next decade and reduce monthly SNAP participation by roughly 2.4 million people over the same period.[26] Veterans are no longer automatically exempt from SNAP work reporting requirements under the new law, though Veterans with a total disability rating remain exempt from Medicaid work requirements.[26] Many Veterans enrolled in these programs may be unaware of new reporting obligations or of exemptions for which they may qualify.

Other Health-Related Topics

There are many other health-related topics that could be discussed at an annual Veteran health summit, such as long-term care planning and related legal documentation. Providers in community-based settings may lack access to or knowledge of VA-specific legal documents that govern Veterans' health care preferences. VA Form 10-0137, the VA Advance Directive: Durable Power of Attorney for Health Care and Living Will, allows Veterans to designate a trusted decision-maker and document their wishes for medical, mental health, and long-term care.[27] It is important that these documents meet state law requirements when a Veteran needs care outside of a VA medical facility and that there be a method to make community providers aware of a Veterans' documented wishes in a crisis. Power of Attorney documents that are different from VA Form 10-0137 cannot be used in VA facilities.

Taken together, the landscape of Veterans' health in North Carolina reflects both tremendous need and significant opportunity. An annual Veterans Health Summit would serve as the connective infrastructure to bridge gaps in knowledge, build relationships across sectors, and ensure that the state's Veterans are not left behind as policies, programs, and systems continue to evolve.



RESOURCE AND **PARTNERSHIP** POSSIBILITIES

- State and regional philanthropy
- VISN 2
- County veteran service officers
- ACA Marketplace navigators
- State Health Insurance Assistance Programs

Strategy 4.2: Increase Veteran access to health services, particularly in rural areas

The NCIOM Task Force on Veterans' Health endorses the following actions to increase access to health care services by addressing certain limitations on the health care workforce:

A) The North Carolina General Assembly should consider granting full practice authority for Advanced Practice Registered Nurses.

B) The North Carolina Medical Board, health systems, rural practices, community clinics, and VA Community Care network participants should collaborate to develop clear implementation guidance and workforce policies that enable qualified Physician Assistants to register and practice in team-based settings.

C) Implementation of Strategy 21 from the NCIOM Task Force on Oral Health to expand scope of practice for dental hygienists and dental assistants.

Desired Result

Expanding practice authority for Advanced Practice Registered Nurses, Physician Assistants, and dental hygienists/assistants strengthens North Carolina's health care workforce capacity, increasing timely access to medical, oral, and rural health care services for Veterans and all North Carolinians.

Potential Measures of Success

- Passage of legislation granting full practice authority for APRNs (yes/no)
- Change in the number of APRN-provided primary care visits statewide
- Increase in APRN presence in rural or underserved counties
- Development and publication of clear implementation guidance/workforce policies (yes/no)
- Increase in PA-provided care visits, particularly in rural or VA Community Care settings
- Implementation status of Strategy 21 from the NCIOM Task Force on Oral Health (yes/no, timeline)
- Increase in access to oral health services, particularly in rural/underserved areas

Advanced Practice Registered Nurse Scope of Practice and Access to Care

Scope of practice laws for advanced practice registered nurses (APRNs) vary significantly across the US and determine the degree to which APRNs can evaluate, diagnose, treat, and prescribe without physician oversight. State laws governing APRN practice generally fall into one of three categories:

- **Full practice authority –** APRNs can practice independently under a state board of nursing license without a collaborative agreement with a physician.
- **Reduced practice authority –** Limits at least one element of practice and requires a collaborative agreement for certain tasks.
- **Restricted practice authority –** Requires career-long physician supervision.

Potential Benefits of Expanded APRN Practice Authority

- Expanded access to primary care in rural areas of the state.
- Expanded access to VA Compensation and Pension (C&P) examiners.
- Increased career opportunities in North Carolina for Veterans and their family who are nurses.

Currently, 27 states and Washington, D.C., grant APRNs full practice authority, while 12 states limit at least one aspect of practice and 11 states require career-long supervision.[28] Research indicates that full practice authority can help states to increase the APRN workforce, improve access to care in rural and low-income areas, and lower costs for some services.[29,30]

North Carolina is currently a restricted practice authority state for APRNs, except for certified nurse midwives. Nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists are required to practice under a collaborative practice agreement (CPA) with a supervising physician.

Reform of APRN practice authority has been the subject of sustained legislative discussion in the North Carolina General Assembly. The Safety and Access to Value and Excellence Act—which would eliminate the mandatory CPA for all APRNs—has been introduced repeatedly in the General Assembly. Proponents argue the bill would address geographic gaps in care and remove outdated rules, while opponents contend that physician supervision remains an important patient safety requirement. The legislation has bipartisan support but has not yet been passed into law. During emergency waivers granted for the COVID-19 pandemic and Hurricane Helene, the North Carolina Board of Nursing reported no increase in complaints under relaxed standards.[31]

Physician Assistant Practice and Access to Care

Under the traditional model of practice for physician Assistants (PAs, also called physician associates), a PA in North Carolina is licensed by the North Carolina Medical Board and practices under a supervisory arrangement. This includes delegated scope, prescribing instructions, and quality-improvement processes. PAs may prescribe and order medications, tests, and treatments, but the statute historically treats those acts as authorized by and assigns responsibility to the supervising physician.[32,33]

The 2025 Team-Based Practice Act (Session Law 2025-37 (HB 67)) created a new pathway that can reduce a principal rural-access barrier for experienced PAs by removing the requirement to maintain a designated supervising physician. The law became operational on June 30, 2026.[32]

The key change from this legislation is that a qualifying PA may practice without a primary supervising physician or an Intent to Practice filing, provided the PA:

- Has more than **4,000 clinical hours** as a licensed PA;
- Has more than **1,000 clinical hours** in the relevant specialty with a physician in that specialty;
- Registers with the NC Medical Board; and
- Works in a qualifying team-based setting.[32]

This model requires the PA to work alongside physicians in a setting with meaningful physician participation and to consult, collaborate, and refer as determined by the clinical team. Qualifying settings can include hospitals, clinics, nursing homes, and other health facilities.[32] This contributes to improved access to care through operational flexibility in community-based care. In qualifying clinics and facilities, experienced PAs can continue providing care when recruiting, retaining, or designating a specific supervising physician is difficult, a barrier that can be especially consequential in rural communities.

As a new law, the potential of this model can only be fully realized through collaborative efforts to spread awareness and develop implementation guidance and workforce policies. A review of how this model has been implemented in other states—including Delaware, Iowa, Maine, Montana, New Hampshire, North Dakota, South Dakota, Utah, Virginia, and Wyoming—may be beneficial to this work.[34]

Dental Assistant Scope of Practice and Access to Care

As with APRNs and PAs, the scope of practice for dental assistants is influenced by state regulations and educational pathways. Dental assistants primarily assist dentists during procedures, handle equipment sterilization, and may perform basic oral health tasks like applying sealants or fluoride, depending on the state. Scope of practice policies for dental assistants can be used to address oral health care access and efficiency. Expanded functions for dental assistants can allow them to perform more complex tasks, like applying sealants, fluoride treatments, and, in some states, restorative functions. States allowing expanded functions for dental assistants include Florida, Illinois, Maryland, and Wyoming, among others.[35]

Current strains on the oral health workforce have led to clinical challenges within dental practices.

Allowing dental assistants to perform more procedures and perform some designated procedures independently may provide patients with more convenient and timely services. This shift facilitates quicker access to essential treatments and preventive care, potentially reducing waiting times and enhancing overall patient satisfaction.

For these reasons, the NCIOM Task Force on Oral Health[2] recommended expanding scope of practice for dental hygienists and dental assistants to increase clinical impact, effectiveness, and efficiency. The Task Force on Oral Health's specific recommendation and strategy to accomplish this is as follows:

2 North Carolina Institute of Medicine. Transforming Oral Health Care in North Carolina. Chapel Hill, NC: North Carolina Institute of Medicine; 2024. https://nciom.org/wp-content/uploads/2024/05/Oral-Health-Report-5-8-Online.pdf

From NCIOM Task Force on Oral Health

Recommendation 8: Expand scope of practice for dental hygienists and dental assistants to increase clinical impact, effectiveness, and efficiency.

Strategy 21: The North Carolina Dental Society, North Carolina Oral Health Collaborative, the North Carolina Dental Hygienists' Association, the North Carolina Dental Assistant Educators' Association, and the North Carolina Dental Assisting Association should partner to convene a group to examine scope of practice for dental hygienists and assistants by:

A) Engaging dental hygienists and assistants to better understand professional needs and motivations.

B) Conducting research to analyze regulation, supervision, and scope of practice for dental hygienists and assistants by state.

C) Ensuring expanded dental hygienist and assistant representation on the North Carolina Dental Society Council for Prevention in Oral Health.

Source: North Carolina Institute of Medicine. Transforming Oral Health Care in North Carolina. Chapel Hill, NC: North Carolina Institute of Medicine; 2024. https://nciom.org/wp-content/uploads/2024/05/Oral-Health-Report-5-8-Online.pdf.



Veteran Access to Dental Care

*"There are over 9 million Veterans enrolled in VA health [nationally]. At the end of 2023 there were approximately 1.8 million enrolled Veterans eligible for comprehensive dental care (**22.5% of all enrolled Veterans**). During 2023, VA dental services managed the care of 582,000 Veterans eligible for comprehensive dental care. An additional 102,000 were eligible and provided dental care due to medical necessity, totaling 690,000 Veterans."*[i]

Access to dental services is limited among the Veteran population, with 80% of Veterans enrolled in VA care not eligible for dental services and only one-third of those eligible using services.[i] To be eligible for dental benefits through the VA, Veterans must fit into one of the following groups:

- Have a service-connected disability rating of 100%.
- Have a service-connected dental condition.
- Be a former prisoner of war.
- Be unhoused.[ii]

Veterans who are enrolled in the VA for health care who do not qualify under one of these categories, may be eligible to purchase insurance through the VA Dental Insurance Program.[ii]

A survey of Veterans that asked about their oral health and dental access found that:

- "**45%** of surveyed veterans reported having permanent teeth removed due to pain or infection after separation from the military."
- "Veterans ranked cost as the **number one reason** for not seeing a dentist in the past year followed by a lack of dental coverage."
- "On average, veterans pay **65%** more in out-of-pocket dental costs compared to nonveterans."
- "Roughly one-quarter of veteran respondents said they had no dental coverage at all." [iii]

Consequences of poor oral health include:

- Serious impacts on health for those with chronic conditions.
- Effects on the ability to work.
- Decrease in overall wellbeing. [vi]

[i]US Department of Veterans Affairs. FY 2025 Budget Submission. Volume 2 of 5. March 2024. https://www.va.gov/opa/docs/remediation-required/management/fy2025-va-budget-volume-ii.pdf
[ii]Military Officers Association of America. Are You Eligible for VA Dental Insurance?May 27, 2025. https://www.moaa.org/content/publications-and-media/news-articles/2025-news-articles/advocacy/are-you-eligible-for-va-dental-insurance/
[iii] The American Institute of Dental Public Health and CareQuest Institute for Oral Health. Inadequate Dental Care for Veterans Is Painful and Costly. Boston, MA: March 2023. Copyright © 2023 The American Institute of Dental Public Health and CareQuest Institute for Oral Health, Inc. https://aidph.org/wp-content/uploads/2024/04/Inadequate-Dental-Care-for-Veterans.pdf
[iv]The American Institute of Dental Public Health and CareQuest Institute for Oral Health. Oral Health Is Essential to Veteran Productivity and Well-Being. Boston, MA: February 2024. https://carequest.org/wp-content/uploads/2025/10/CareQuest_Institute_AIDPH_Oral-Health-Is-Essential-to-Veteran-Work-Productivity_3.11.24.pdf



RESOURCE AND **PARTNERSHIP** POSSIBILITIES

- NC General Assembly
- NC Nurses Association
- North Carolina Medical Board
- North Carolina health systems
- Rural health care practices
- Community clinics
- VA Community Care network participants
- NC Oral Health Collaborative
- North Carolina Dental Society
- North Carolina Dental Hygienists' Association
- North Carolina Dental Assistant Educators' Association
- North Carolina Dental Assisting Association

Strategy 4.3: Assist justice-involved Veterans in accessing available health-related services

Several responsible entities can improve access to information and resources for justice-involved Veterans through the following actions:

A) Veteran groups should engage with justice-involved Veterans in jails and prisons to create community and help to inform them of services available post-release.

B) North Carolina Department of Military and Veteran Affairs regional managers should meet on a quarterly basis with local reentry councils within their region of responsibility to provide updates on resources available to Veterans they may encounter.

C) The North Carolina Administrative Office of the Courts should improve identification of Veterans by phrasing questions about Veteran status to ask if individuals have ever served in the military.

D) The North Carolina Judicial Branch, North Carolina Administrative Office of the Courts (NCAOC), and North Carolina Department of Military and Veteran Affairs (NCDMVA) should collaborate to track aggregate data on the distribution of justice-involved Veterans in North Carolina to understand where increased access to Veteran Treatment Courts may be needed.

E) Veteran service officers (VSOs) who serve geographic areas supported by Veteran treatment courts should collaborate with program directors to assist with coordination of services for program participants and with NCServes staff to ensure Veterans are connected to resources to meet their health-related social needs.

Desired Result

Ensure justice-involved Veterans are identified, connected to community support, and linked to the health-related services available to them post-release.

Potential Measures of Success

- Number of Veteran groups actively engaging with justice-involved Veterans in correctional facilities
- Number of regions with active, ongoing engagement; Number of justice-involved Veterans reached or engaged
- Revision of court intake questions to ask about any history of military service (yes/no)
- Increase in the number of Veterans identified through court intake processes
- Establishment of an aggregate data-sharing/tracking system between North Carolina Judicial Branch, NCAOC, and NCDMVA (yes/no)
- Use of data to inform Veteran treatment court expansion decisions
- Number of Veteran treatment court participants receiving VSO-coordinated services
- Increase in the number of justice-involved Veterans connected to health-related services post-release

Veterans in the Justice System

Veterans are overrepresented in the US criminal justice system relative to their share of the general population. One in three of the nation's approximately 19 million Veterans reports having been arrested at least once in their lifetime, compared to roughly one in five among the general public.[36,37] An estimated 107,400 Veterans are currently incarcerated in state or federal facilities, representing nearly 8% of the state prison population and almost 6% of the federal prison population.[38]

Unique Risk Factors Driving Justice Involvement

Combat Exposure and Behavioral Health Consequences

Military service exposes many Veterans to traumatic combat experiences that can produce lasting psychological harm. Veterans with post-traumatic stress disorder (PTSD) are 61% more likely to have criminal justice involvement than Veterans without PTSD, and those with a traumatic brain injury (TBI) are 59% more likely to experience such involvement.[39] Symptoms associated with these conditions—including hypervigilance, impulsivity, aggression, and misappraisal of threat—can directly contribute to behaviors that lead to arrest.[40]

Substance Use Disorders

As many as two-thirds of justice-involved Veterans are estimated to have alcohol or substance use disorders, a rate far exceeding that of Veterans in the general population.[41] Veterans may use alcohol and drugs to self-medicate PTSD, depression, chronic pain, and TBI-related symptoms.

Discharge Status and Loss of Benefits

Discharge characterization significantly affects Veterans' access to care and increases vulnerability to justice involvement. Among Veterans incarcerated in state prisons, 6% received a dishonorable or bad conduct discharge and 10% received an "other than honorable" discharge.[39] Veterans with other-than-honorable discharges are often ineligible for VA health care, educational benefits, and housing assistance—the very services that might prevent a downward trajectory. The behavioral health conditions that contribute to discharge status can be the same conditions that drive criminal behavior, creating a compounding cycle of exclusion and risk.

Challenges Upon Release from Incarceration

Veterans leaving incarceration face acute, overlapping barriers to successful reentry that increase the risk of recidivism and deteriorating health outcomes. These challenges are not unique to Veterans but are often compounded by service-related conditions and complications with benefit eligibility.

Reentry represents a major break in continuity of health care. Lack of health insurance, competing economic needs, residential instability, and unaddressed mental health and substance use needs are significant barriers to accessing health and social services after release.[42] Because of those barriers, health needs are deprioritized in favor of immediate survival concerns, increasing the risk of relapse and rearrest.

To begin to improve Veteran knowledge about benefits they may be eligible for post-incarceration, representatives from the North Carolina Department of Adult Correction and the NCDMVA have collaborated to include information about Veteran services in the pre-release information that inmates receive.[43] This and other efforts are ongoing as part of Reentry 2030 which seeks to "dramatically improve reentry success for people exiting prison & for those under community supervision".[44] Specifically, Objective 18 states: "By 2030, provide 100% of self-identified incarcerated veterans within state facilities with services to gain healthcare upon release."[45] Another strategy that this initiative is planning is the creation of a Veteran-specific reentry peer support program.[45]

Veterans Justice Outreach Program

The Department of Veterans Affairs' (VA) Veterans Justice Outreach (VJO) Program "identif[ies] justice-involved Veterans and contact[s] them, in order to facilitate access to VA services at the earliest possible point. Veterans Justice Programs accomplish this by building and maintaining partnerships between VA and key elements of the criminal justice system".[46] VJO specialists work for VA Medical Centers and help link Veterans who are eligible with mental-health and substance-abuse treatment services.[46] Research has found that the VJO Program is highly successful at identifying Veterans in need of mental health and substance use services and connecting them to care:

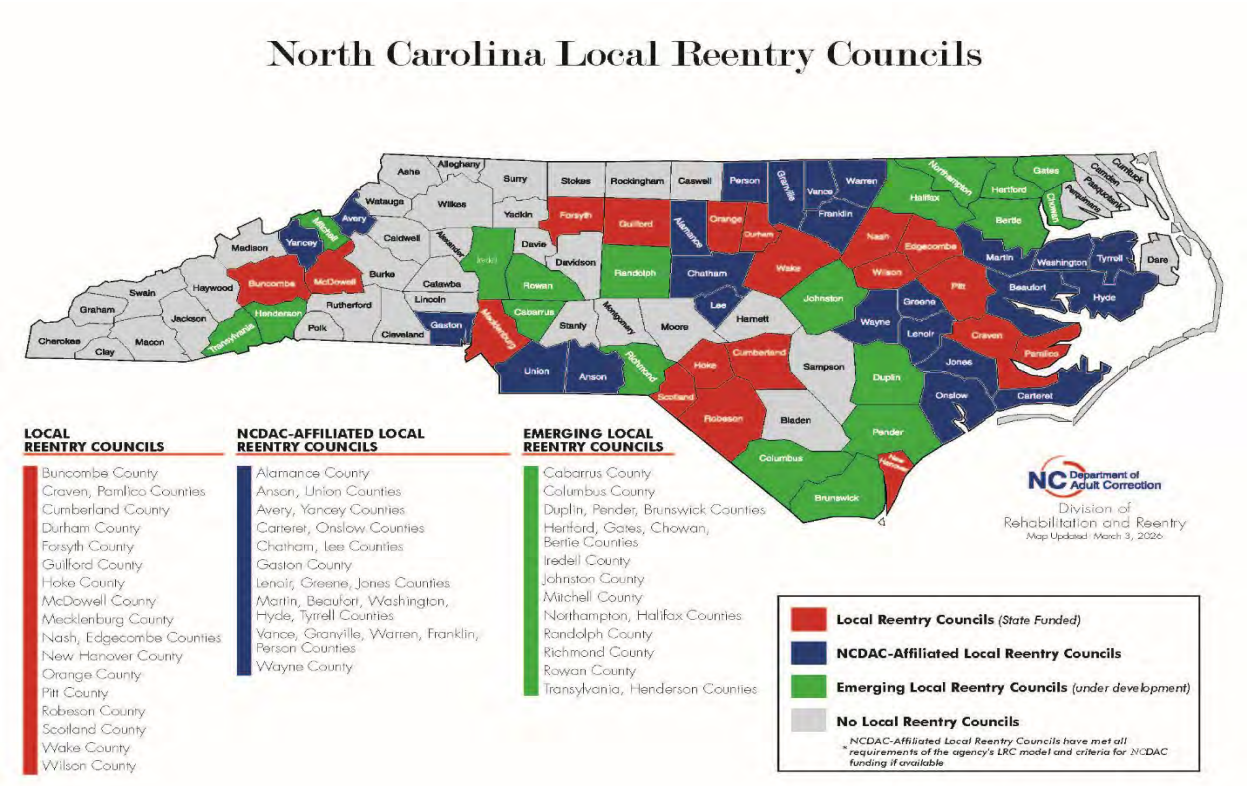
> **"Although not a jail diversion program, the VJO program coordinates with legal system staff around diversion activities to connect eligible veterans with health care and benefits. Almost all veterans (97%) who entered VHA care after contact with a VJO Specialist and were subsequently diagnosed with a mental health disorder received some mental health treatment. These results suggest that these veterans who see a VJO Specialist are doing far better than the general VHA patient population at connecting to care."**
>
> –Finlay AK, et. al. U.S. Department of Veterans Affairs Veterans Justice Outreach Program: Connecting Justice-Involved Veterans with Mental Health and Substance Use Disorder Treatment. Crim Justice Policy Rev. 2016;27(2):10.1177/0887403414562601. doi: 10.1177/0887403414562601.

Local Reentry Councils

Local reentry councils (LRCs) across the state engage community organizations to coordinate resources and referral to services for justice involved individuals. These services can include education, training, employment support, treatment for substance use disorder, and help coordinating housing and transportation.[47-49] LRCs serve a variety of justice involved individuals, including those who are up to six months from release to those who have been in the community for several years post release.[47-49]

> **There are currently 20 state-funded local reentry councils serving 26 counties. As many as 31 LRCs were at work in 2025, but lack of funding caused some councils to cease operations, while others reduced or redirected services. NC [Department of Adult Corrections] continues to seek funding to support local reentry councils and their critical work in connecting people with resources during and after release from prison.**
>
> - Local Reentry Councils. NC DAC. Accessed July 20, 2026. https://www.dac.nc.gov/divisions-and-sections/rehabilitation-and-reentry/local-reentry-councils

Figure 8. Map of Local Reentry Councils in North Carolina



Source: North Carolina Department of Adult Corrections. Accessed July 21, 2026. https://www.dac.nc.gov/media/13893

Veteran Treatment Courts

Veteran treatment courts (VTCs) are a type of problem-solving court that diverts justice-involved Veterans away from traditional prosecution and incarceration into judicially supervised treatment. Grounded in the therapeutic jurisprudence model developed by drug treatment courts, VTCs address the substance use, mental health, and trauma-related conditions that often underlie a Veteran's contact with the justice system, and the model has expanded rapidly to more than 600 Veteran-focused courts and dockets across the country.[50,51] A VTC coordinates a multidisciplinary

team—typically a judge, prosecutor, defense counsel, probation officer, treatment providers, a VJO specialist, and a county Veterans Service Officer—to connect participants with care and monitor their progress.[51,52]

Participants advance through a structured, multi-phase treatment program, regular drug screening, frequent court appearances, and peer mentorship by fellow Veterans. Those who complete the program may have their charges reduced or dismissed.[53] Research indicates that VTC participation, particularly program completion, is associated with reduced recidivism and improved connection to health care and benefits, though rigorous evaluation remains limited and outcomes vary across programs.[54]

In North Carolina, VTCs operate as one category of recovery court within the state's judicial branch. The North Carolina General Assembly established the state's treatment court program in 1995 under the North Carolina Drug Treatment Court Act, housed in the NCAOC. These courts were later renamed recovery courts as they expanded to serve Veterans and others with mental health and co-occurring conditions. Where they exist, North Carolina's VTCs demonstrate the strengths of the model. A VTC launched in New Hanover County in early 2023 overlays Veteran culture—service flags, challenge coins, and phased promotions modeled after military rank advancement—onto an evidence-based recovery court structure. It connects participants to VA primary care, substance use treatment, and behavioral health services through an on-team VJO specialist and county VSO. The Buncombe County VTC, an 18-month program serving high-risk, high-need Veterans, similarly links participants to a broad network of clinical care and social supports, from dental and primary care to equine- and canine-assisted therapy, and helps dismiss and expunge charges upon successful completion.

Despite these successes, access to VTCs is uneven across the state. Programs are established and operated locally, and their viability depends heavily on county resources, clinical infrastructure, and committed local leadership. North Carolina provided recurring state appropriations for treatment courts until 2011, when funding was reduced during the national financial downturn, and programs now rely on a shifting patchwork of county, state, and federal grant dollars.[55] The state does provide some centralized guidance – the Judicially Managed Accountability and Recovery Court (JMARC) Advisory Committee recommends program guidelines to the Administrative Office of the Courts and monitors local courts – but this structure spans all recovery court types.[55] There is not a body solely dedicated to coordinating VTCs statewide. As of 2025, North Carolina operated roughly 83 recovery courts, 15 of which are VTCs that operate in the following counties:[55,56]

- Buncombe
- Catawba
- Cumberland
- Forsyth
- Gaston
- Harnett
- Iredell
- Moore
- New Hanover
- Onslow
- Pitt
- Randolph
- Rockingham
- Rowan
- Union

Maryland Veteran Treatment Court Coordination

Other states offer models for more centralized coordination of VTCs. Maryland administers its Veteran Treatment Courts through the Maryland Judiciary's Office of Problem-Solving Courts, a statewide body that sets and enforces programmatic guidelines, maintains a statewide

management information system, superintends financial support, and provides training and technical assistance to local specialty dockets.[57] Maryland has increasingly organized VTCs on a regional, multi-county basis. The Central Maryland Regional Veterans Treatment Court, for example, coordinates services across five jurisdictions—Baltimore City and Baltimore, Carroll, Harford, and Howard counties—under a single program structure.[58]



RESOURCE AND **PARTNERSHIP** POSSIBILITIES

- Local reentry councils
- Veteran Treatment Courts
- North Carolina General Assembly
- Veteran interest and advocacy groups
- North Carolina Department of Military and Veterans Affairs
- North Carolina Department of Adult Corrections
- North Carolina Judicial Branch
- North Carolina Administrative Office of the Courts
- NCServes
- Veteran Justice Outreach Program Specialists
- Reentry 2030
- North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities, and Substance Use Services

VA Community Care Network

Many Veterans see the Department of Veterans Affairs (VA) as their best source for integrated health care and benefits, as well as a hub of providers who have experience working with Veterans. However, many Veterans access at least some of their VA care in community-based, non-VA settings due to either waiting times at the VA or geographic access issues.

The VA's Community Care Network (CCN) contractors—Optum Serve is the contractor that manages the region that includes North Carolina—are responsible for building and maintaining provider networks within their assigned regions. To do so, they use strategies such as recruiting providers already credentialed through other non-VA contracts and applying Veteran utilization data alongside geospatial tools to target markets where additional recruitment is needed.[59] The VA has two main mechanisms to help fill gaps in the networks that contractors have developed: rate waivers, which allow contractors to reimburse individual providers or practices above standard rates, and Veteran Care Agreements (VCAs), which let individual VA facilities contract directly with outside providers to fill network gaps.[59] VCAs are generally intended to last up to three years or until the provider either joins the CCN or is no longer needed.[59]

The VA's primary method for assessing whether a network is adequate is a review of contractor-submitted performance reports that calculate the percentage of paid claims meeting the VA's drive-time and appointment-availability standards.[59] When contractors identify deficiencies, they must submit corrective action plans to the VA within 10 days.[59] VA, contractors, and facility officials hold regular meetings to discuss network adequacy and resolve identified issues. However, a federal Government Accountability Office (GAO) review found that a limitation of this approach is that the VA's calculation methodology excludes claims involving "deviations" (cases where two or fewer providers offer a given service in an area) or Veteran preferences (such as a Veteran's choice of a specific provider or appointment time) whenever those claims fail to meet the drive-time or appointment-availability standard, while including such claims when they do meet the standard.[59]

This asymmetric assessment method can make network performance look better than it actually is. GAO's analysis of mental health claims found that roughly 6% of claims were excluded from drive-time calculations and about 19% from appointment-availability calculations on this basis.[59] In addition, the VA does not systematically require facility staff to document the specific reasons when an appointment cannot be scheduled or is delayed. As a result, the VA lacks comprehensive insight into how much scheduling difficulty is actually attributable to network adequacy problems versus other factors.

Together, these findings indicate that while the VA has established a recurring, multi-layered process for monitoring and supplementing its community care networks, the underlying metrics used to judge adequacy may not fully reflect Veterans' real-world access to care.

TRICARE Insurance Network

> **The TRICARE program, managed by the Defense Health Agency for the Department of Defense, provides more than a dozen different health and dental plans for active-duty personnel, retirees, National Guard and Reserve personnel, and their family dependents and survivors around the world. However, it is essentially a health insurance program that provides access to care at either Military Treatment Facilities, a catchall term for military hospitals and clinics, or civilian hospitals and medical offices, depending on the specific plan chosen. And importantly, non-retired veterans are generally not eligible to receive TRICARE benefits.**
>
> Military Benefit Association. TRICARE for Veterans: Eligibility and VA Benefits Comparison. Accessed July 2026. https://www.militarybenefit.org/get-educated/tricare-health-insurance-veterans/

Nearly half a million people were enrolled in TRICARE in North Carolina in FY 2024.[60] Like VA Community Care, TRICARE is a payer for community-based care (except when members receive care at Military Treatment Facilities). In that sense, it has a similar reliance on health care providers that accept payment from the program.

Very little information is available publicly about network adequacy for TRICARE enrollees. A GAO evaluation of the program is due out at the end of 2026.[61] Anecdotally, some task force members and others interviewed about their experience have expressed concerns about the adequacy of the TRICARE network, with some suggesting that providers may be part of the network but not accepting patients. In addition, task force members shared anecdotes about provider dissatisfaction with TRICARE payment levels and administrative challenges working with this payer.

With the current gaps in understanding of network adequacy for Veterans to receive care in community-based settings and the opportunity to increase access to care and Veteran-informed care in rural settings, the task force makes the following recommendation:



RECOMMENDATION 5:

Enhance the network of health care providers in community-based health care settings that are available to Veterans.

Strategy 5.1: Analyze the network of community – based providers available to Veterans

Strategy 5.2: Improve the capacity of smaller health care practices to serve Veterans

Strategy 5.3: Engage the Rural Health Transformation grant to improve access to care for Veterans

Strategy 5.1: Analyze the network of community-based providers available to Veterans

The University of North Carolina at Chapel Hill Gillings School of Global Public Health should convene relevant partners to develop a plan and organizational roles for conducting regularly updated gap analyses of where Veterans are able to receive care in community-based settings. This work should inform efforts to improve network adequacy. Analyses should consider:

- Provider networks for common Veteran payers (i.e., VA Community Care and TRICARE),
- Health professional shortage areas in the state,
- Veteran population in the state, and
- Interaction with upstream factors of Veteran health and well-being.

This work should inform future efforts to improve network adequacy.

Desired Result

Equip the state with the data needed to identify care access gaps and target future efforts to improve network adequacy for Veterans.

Potential Measures of Success

- Completion of the gap analysis (yes/no)
- Number of follow-on recommendations or initiatives developed based on the analysis
- Use of findings to inform provider network expansion, funding decisions, or policy changes
- Increase in Veteran access to community-based care in previously identified shortage areas (long-term outcome measure)

Network adequacy is foundational to whether someone with health insurance can use the benefits they are entitled to. Inadequacy of health care provider networks has direct, tangible consequences: patients who cannot find an in-network provider face greater out-of-pocket costs, longer travel times, delayed care, or foregone treatment. The American Medical Association has emphasized that provider networks must contain enough contracted physicians and other providers in each specialty and geographic region to enable timely access to care.[62] For federal programs such as Department of Veterans Affairs (VA) Community Care and TRICARE—which together serve millions of Veterans, active-duty service members, and their families—these principles are especially urgent because beneficiaries may have limited or no alternative coverage outside the program network. The consequences extend beyond inconvenience as the number of Veterans receiving care through VA Community Care providers grew from roughly 1.1 million in 2014 to approximately 2.8 million in 2023, placing increasing pressure on community networks to absorb demand that VA facilities cannot meet.[63]

Geography magnifies the consequences of network gaps: rural Veterans are already more likely to live in areas with provider shortages. A 2018 study found that areas farthest from VA facilities also often have the fewest non-VA providers, meaning that community care referrals alone may not resolve access problems when underlying provider supply is low.[64] Research on Veterans eligible for care under the Veterans Choice Act found that:

- Approximately **70%** lived in mental health care shortage areas.
- Around **75%** of rural Veterans eligible for community care lived in counties classified as mental health shortage areas.
- Roughly **73%** of those same rural Veterans lived in counties with no psychiatrists at all.[64]

These supply constraints affect both VA Community Care networks and TRICARE networks since both programs rely on the same underlying civilian provider workforce. Conducting a geospatial analysis of network adequacy—mapping where VA Community Care and TRICARE providers are located relative to where Veterans and beneficiaries live—would allow policymakers and program administrators to identify specific counties or service areas where provider supply is critically low to serve the needs of Veterans, and to distinguish between gaps in primary care, behavioral health, and specialty care that may require different recruitment and policy responses. Other factors to consider in this analysis include whether providers in these networks are taking new patients with those payer types and time to next available appointment.

Provider Types Requiring Special Attention

Certain provider types warrant particular attention in the proposed network adequacy evaluation for Veterans.

Mental health providers, including psychiatrists, psychologists, licensed clinical social workers, and psychiatric nurse practitioners represent one of the most persistently under-networked categories. The demand for mental health care within VA has grown considerably in recent years, with the number of Veterans receiving community mental health care increasing substantially since the Veterans Community Care Program launched in 2019.[65]

Substance use disorder treatment providers, pain management specialists, and providers with experience treating PTSD and military sexual trauma represent additional gaps in Veteran-specific mental health access.

Women's health specialists are another specific area of need. Women Veterans face a distinct layer of access challenges related to gender-specific care. VA facilities, particularly smaller community-based outpatient clinics, can lack on-site women's health specialists, so women Veterans rely heavily on community care referrals for services such as gynecology, obstetric care, labor and delivery, and mammography. Yet, past analysis has found that community care networks in some areas have insufficient obstetricians and gynecologists.[66]

The most commonly cited barriers to access to care for women Veterans is limited availability of providers trained in women's health and gender-specific care, as well as inefficient referral and coordination with community providers.[67] A study assessing obstetric network adequacy for

VA community care found that when obstetric care, classified by VA as a specialty, is measured against specialty-care drive-time thresholds rather than primary-care thresholds, the proportion of women Veterans facing inadequate geographic access increases substantially, suggesting that how VA classifies these services affects whether network gaps are even visible in standard adequacy reporting.[68]



RESOURCE AND **PARTNERSHIP** POSSIBILITIES

- VISN 2
- Optum
- TRICARE
- Cecil G. Sheps Center for Health Services Research
- North Carolina General Assembly
- State and regional health-related philanthropies

Strategy 5.2: Improve the capacity of smaller health care practices to serve Veterans

North Carolina Area Health Education Center's Practice Support Program, with increased financial resources from the North Carolina General Assembly and/or additional grant funding, and in partnership with Veterans Integrated Service Networks (VISN) 2, should help smaller practices serve Veterans by:

A) Providing information and assistance to providers interested in being part of the Department of Veterans Affairs (VA) Community Care and/or TRICARE networks.

B) Supporting health care providers with connection to the VA's External Provider Scheduling system.

C) Integrating questions about Veteran status and clinical guidelines for additional questions about possible toxic exposures, mental health status, and other military-connected conditions.

D) Assisting community primary care practices with implementation and standardization of clinical and administrative workflows and optimization of health information technology and billing/coding in support of care delivery to Veterans.

Desired Result

Increase Veteran access to care through, and capacity of, smaller health care practices to deliver high-quality, Veteran-informed care.

Potential Measures of Success

- Increase in financial resources allocated to AHEC's Practice Support Program (dollar amount)
- Number of practices successfully enrolled in VA Community Care and/or TRICARE networks; Number of practices successfully integrated into the scheduling system
- Number/percentage of participating practices that integrate Veteran status questions into intake
- Practice-reported efficiency gains in care delivery to Veterans
- Increase in the number of community-based providers available to Veterans statewide

Strategy 5.3: Engage the Rural Health Transformation grant to improve access to care for Veterans

Rural Health Transformation grant Rural Organizations Orchestrating Transformation for Sustainability (ROOTS) Hubs should help to improve access to care for Veterans by:

A) Ensuring there is Veteran representation on advisory councils guiding grant activities and Veteran support networks (e.g., NCServes and Veterans Bridge Home) are included in service integration efforts.

B) Using grant funds to allow federally qualified health centers (FQHCs) to participate in Veteran cultural awareness trainings and integrate clinical guidelines for questions about possible toxic exposures, mental health status, and other military-connected conditions.

C) Using grant funds to provide technical assistance to rural community-based practices that want to enroll in the Department of Veterans Affairs (VA) Community Care Network and the External Provider Scheduling system.

Desired Result

Strengthen rural health care providers' capacity to identify, understand, and serve Veterans and improve Veteran access to quality, culturally competent care in rural communities.

Potential Measures of Success

- Number/percentage of ROOTS hub advisory councils with designated Veteran representation
- Number of joint initiatives or referral pathways developed between ROOTS hubs and Veteran support networks
- Amount of grant funding allocated to FQHC Veteran cultural awareness trainings
- Number of FQHCs and providers completing Veteran cultural awareness training
- Number of practices successfully enrolled in the VA Community Care Network and the External Provider Scheduling system
- Increase in the number of rural, Veteran-informed care access points statewide

Practice Support Program

The North Carolina Area Health Education Centers (NC AHEC) Practice Support Program provides free resources, training, and support to primary care settings in the areas of:

1. Quality improvement
2. Advanced Medical Home
3. Collaborative Care Model
4. Health information technology
5. American Board of Medical Specialties Continuing Certification

Program coaches have worked with over 1,300 practices, primarily independent practices, FQHCs, rural health clinics, and health departments.[69]

This program provides an opportunity to increase access to care for Veterans, particularly in rural areas, by helping smaller practices enter into contracts with VA Community Care and/or TRICARE and enhancing administrative and care practices specific to Veteran care, such as those discussed in the following sections.

Because the program is free to participating practices, it relies on grant funding to operate. Additional funding from the North Carolina General Assembly and/or philanthropic sources would be needed to add specialized services that target Veteran access to care.

VA External Provider Scheduling

The VA External Provider Scheduling (EPS) system is a technology platform designed to reduce the time it takes to connect Veterans who have a referral for community care with a community care provider. While the VA has an internal goal of scheduling community care appointments within seven days of eligibility determination, the national average is around 26 days (higher in North Carolina).[70] The lengthy time it takes to schedule a community care appointment is due to the extensive back-and-forth of phone calls, faxes, and emails needed between VA staff, community providers, and Veterans to schedule appointments.

> "The External Provider Scheduling system gives VA employees instant access to the scheduling systems of all community care providers who participate in this program. With that information, VA can immediately book appointments for Veterans that fit their schedules.
>
> Without EPS, VA employees often make multiple calls to multiple community care providers and relay that information back to Veterans before a single appointment can be booked. Under this traditional method, a single VA employee can only book a handful of community care appointments per day, and it can take days or even weeks to book a single appointment."
>
> **Source:** VA News. VA moves to speed up community care appointment scheduling. March 9, 2026. https://news.va.gov/press-room/va-moves-to-speed-up-community-care-appointment-scheduling/

EPS addresses this by directly integrating with community providers' electronic health records, giving VA scheduling staff real-time visibility into provider availability, specialties, and constraints. As of this report, the platform:

- Has facilitated over **175,000** appointments, reduced community provider no-shows by more than **15%,** and reduced average booking time to under seven minutes.[70,71]
- Supports **74** specialties and over **61,000** provider locations.[71]

In North Carolina, EPS providers are already active, though they represent only a small share of the nearly 383,000 annual referrals sent to community partners in the state.[71]

Clinical Guidelines

As discussed in various other sections of this report, non-VA providers can begin to better serve Veterans by first asking all patients if they have served in the military or have a family member who has. And while this collection of patient Veteran status is important, it is the actions taken by clinicians based on that information that can have the greatest impact on the care Veterans receive. Assessing Veteran patients for toxic exposures, military-connected injuries, stressors, and traumatic experiences can guide clinicians to additional health screenings and preventive care that may be needed. As more community-based providers become connected to Veteran payers and build awareness of the Veterans they may already be serving, they can improve their care for these patients by implementing care processes described in the clinical resources listed in the box on the following page.

In addition, Veterans are significantly more likely to die by suicide than their non-Veteran peers and suicide rates are higher among Veterans in community health care settings than among those in VA care.[72] One factor in this may be that, while VA clinical and non-clinical staff are required to repeat suicide prevention training annually, such training is not uniformly available in community settings.[73] Dissemination of VA suicide prevention clinical guidelines would equip community-based clinicians with evidence-based assessment and management tools as well as opportunities to cross walk Veterans at significant risk for suicide to specialized VA suicide prevention programs.



Clinical Resources

VA/DOD Clinical Practice Guidelines: Assessment and Management of Patients at Risk for Suicide – "The guideline describes the critical decision points in the management of Suicidal Risk Behavior (SRB) for suicidal self-directed violent behavior and provides clear and comprehensive evidence-based recommendations incorporating current information and practices for practitioners throughout the DOD and VA Health Care systems. The guideline is intended to improve patient outcomes and local management of patients with SRB."

Engaging Service Members, Veterans, And Families: A Toolkit for Certified Community Behavioral Health Clinics – "This toolkit is designed to provide an overview of key components of working with those who are serving or have served in any branch of the military—service members, Veterans, and families. This toolkit provides topic overviews, fact sheets, strategies, action steps, and insights from experts for everyone establishing, working for, and leading a Certified Community Behavioral Health Clinic."

Have You Ever Served in the Military?™ - This effort by the American Academy of Nursing seeks "to improve the care provided to Service Members, Veterans, and their families. This pocket card lists the most common health concerns linked to military service, as well as questions nurses and clinicians should ask the Veteran or the Veteran's family to obtain a more complete medical history".

APA Guidelines for Psychological Practice with Military Service Members, Veterans, and Their Families – "[T]hese professional practice guidelines were developed to provide recommendations for psychologists who provide services to SMVF, recognizing that there are varying degrees to which psychologists have received training, including when and what type of training, as well as amount of practical opportunity to reach competency for different types of work."

Health Centers Serving Veterans: A Toolkit for the Veteran Community Care Program (VCCP) Administered by the U.S. Veterans Health Administration – "This toolkit is intended to provide information about Veterans, Veteran healthcare, and how health centers can provide care to Veterans through VA's Veterans Community Care Program (VCCP)."

Rural Health Transformation Program

On December 29, 2025, the Centers for Medicare and Medicaid Services (CMS) awarded North Carolina over $213 million in federal funding through the Rural Health Transformation Program (RHTP). North Carolina applied for the funds to improve healthcare for rural North Carolinians and their communities.

The comprehensive initiative focuses on six interconnected strategies:

Community-Rooted Care Networks: *Establishing locally governed "NC ROOTS" Hubs that connect medical, behavioral health, and social services, making it easier for rural residents to access comprehensive care close to home*

Prevention and Chronic Disease Management: *Expanding programs for diabetes and hypertension control, cancer screening, maternal health services, and nutrition support, including "food as medicine" initiatives*

Behavioral Health Expansion: *Growing mental health and substance use disorder services through new clinics, mobile crisis teams, school-based programs, and integration with primary care*

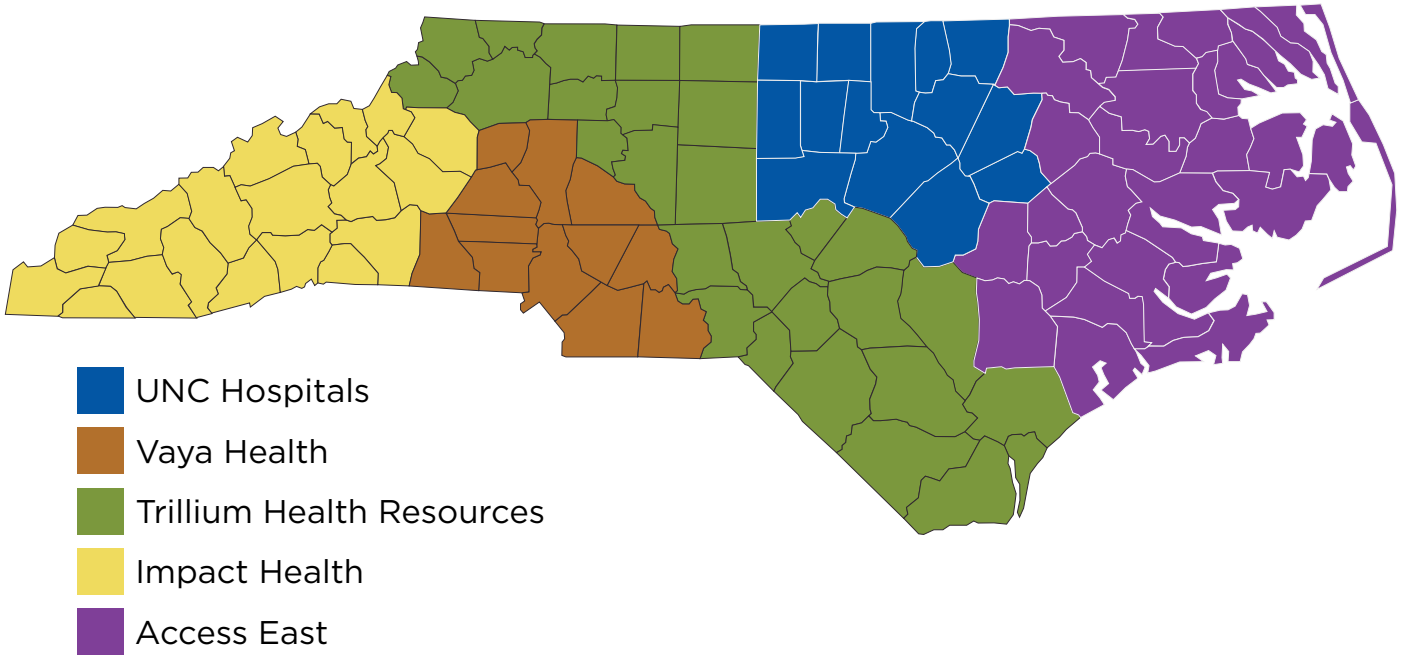
Workforce Development: *Training and retaining healthcare professionals through rural residency programs, incentives and innovative career pathways—creating jobs while addressing provider shortages*

Financial Sustainability: *Helping rural practices and hospitals transition to value-based payment models that reward keeping people healthy, not just treating illness*

Technology and Innovation: *Deploying cutting-edge artificial intelligence to support rural providers, improving health information sharing, and ensuring digital literacy for all residents*[74]

The North Carolina Department of Health and Human Services (NCDHHS) has selected lead organizations across six regions to serve as ROOTS Hubs to coordinate services and implement the RHTP funds. Lead organizations for the ROOTS Hubs are shown on the map in **Figure 9**

Figure 9: ROOTS Hub Network Leads



ROOTS Hubs will complete a regional needs assessment and then "establish local networks of partner organizations focused on strengthening the rural health care infrastructure."[75] This statewide effort is an opportunity to ensure Veteran partners and voices are included in efforts to improve health care resources and access in rural areas.

Innovative Uses of RHTP Funds for Veteran Care

RHTP funds can be used for a wide range of purposes to improve access to care in rural areas. One unique strategy that Nebraska is implementing is to use RHTP funds to support the onboarding of rural health care providers, including hospitals, ambulatory clinics, and federally qualified health centers into the VA EPS system discussed above. Facilities can receive funds to assist with:

- Technology interface development and connection fees.
- Legal and compliance review for VA connectivity.
- Development of provider scheduling grids within EPS.
- Staff time required for onboarding and workflow integration.
- Local outreach efforts to Veterans and community partners.[76]



RESOURCE AND **PARTNERSHIP** POSSIBILITIES

- VISN 2
- North Carolina General Assembly
- State, regional, and local health-related philanthropy
- NC Community Health Center Association
- NC Association of Free and Charitable Clinics
- NC Office of Rural Health
- NCServes
- Veterans Bridge Home

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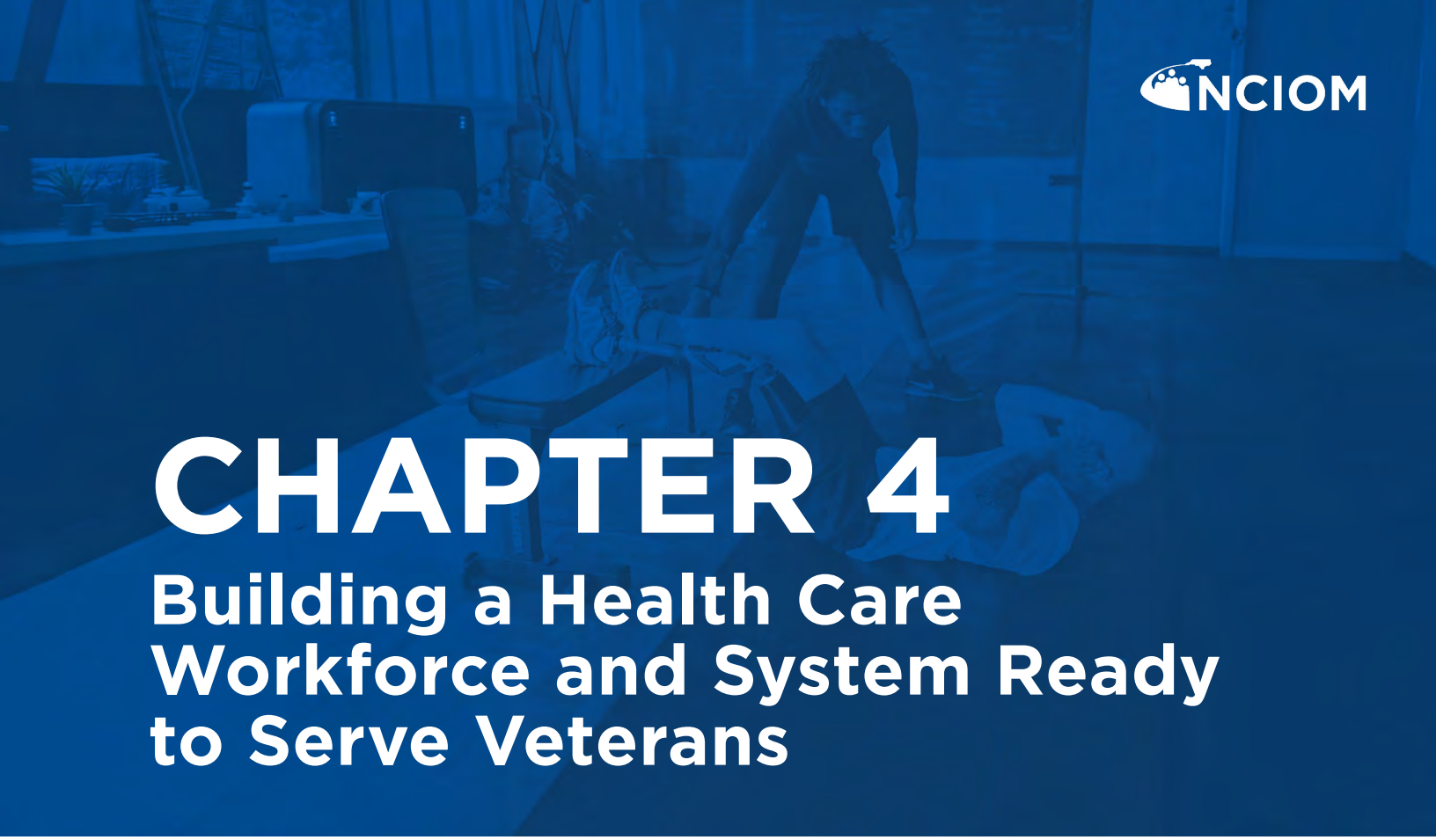
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CHAPTER 4

Building a Health Care Workforce and System Ready to Serve Veterans

Access to care means little if the providers delivering it are not equipped to understand the people they serve. This chapter's recommendations focus on strengthening both the pipeline and the preparation of North Carolina's health care workforce to better meet Veterans' health care needs. The recommendations call for expanding accelerated training pathways that recognize the medical experience some Veterans bring from their service, deepening partnerships across educational institutions and workforce agencies to recruit more Veterans into health professions, and equipping community-based providers with the cultural awareness and clinical knowledge needed to care for Veterans. Beyond individual providers, these strategies also call for systemic change within health care organizations: routinely asking patients about military service, improving the exchange of health records between the Department of Veterans Affairs (VA) and community systems, and building internal infrastructure that keeps Veteran care quality at the center of institutional planning and accountability. Together, they reflect a vision of a health care system in which every Veteran encounters a provider who is informed, prepared, and connected to the right resources.

Why Awareness of Veteran Status and Health Conditions Matters for Community-Based Care

With the majority of Veterans in the United States receiving at least some of their health care outside of the Veterans Health Administration (VHA), community-based providers, including those in primary care, emergency medicine, behavioral health, home health, and long-term care, are likely to be a point of contact for a Veteran seeking care. Whether these encounters result in care that is safe, effective, and responsive to a Veteran's history of military service depends on whether the provider recognizes that service in the first place and understands what it may mean for that patient's health.

Veterans are not simply patients who happen to have served in the military; as a population, they can carry a distinct set of physical and mental health conditions tied directly to their service. These issues have been detailed in other chapters of this report but can include:

- **Physical Health –** Elevated rates of toxic exposure-related illness, exposure to other environmental and occupational hazards, and heightened risk for certain cancers as a result of that exposure. Many Veterans also carry musculoskeletal injuries, hearing loss, and traumatic brain injury (TBI) associated with combat or training.[1-4]
- **Mental Health –** Veterans experience posttraumatic stress disorder, military sexual trauma, and suicide at rates that exceed those of the general population, and these conditions often present alongside, or are masked by, physical symptoms such as fatigue, insomnia, or chronic pain.[5-7]

Despite this complexity, community-based providers frequently lack the training, experience, and even the basic awareness needed to identify and respond to these needs.[8] Research has consistently found that community providers may not have experience caring for Veterans and, in many cases, may not even realize that a given patient has served in the military at all.[8-10] This is not a peripheral gap: evidence suggests that fewer than half of primary care and mental health providers routinely screen patients for military service, meaning most Veterans in community settings are never asked the questions that would surface a service-connected condition.[9] Veterans themselves frequently do not volunteer this information, whether from a sense that it is not relevant, discomfort discussing their service, or simple assumption that providers will ask if it matters.

The consequences of this gap are concrete rather than theoretical. Providers who do not know a patient is a Veteran cannot help connect them to VA benefits they may be eligible for, cannot factor exposure history into a differential diagnosis, and may misattribute symptoms of PTSD, TBI, or military sexual trauma to unrelated causes, delaying appropriate treatment or referral.

> **"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."**
>
> –Senior home health executive on how knowledge of Veteran culture directly enhances care quality

The American Academy of Nursing points to a clear remedy: equip community providers with basic military-culture knowledge and simple screening practices. Their "Have You Ever Served in the Military?" initiative encourages providers to ask a single screening question at intake and provides resources to continue the conversation with Veterans.[11] In one community emergency department that embedded a mandatory military-service question into its electronic medical record, staff identified 415 previously unrecognized Veterans over just 80 days—patients who could then be connected to VA benefits and resources they would not otherwise have received.[12] In another example, a care-coordination model embedded staff trained in Veteran needs within community health centers and improved both the identification of Veterans and the management of their unmet medical and social needs.[13] These examples demonstrate that closing the knowledge gap does not require community providers to become experts in military medicine; it requires only that they know enough to ask the right questions, recognize the conditions that are more common in this population, and know when and how to connect Veterans to the specialized resources, including VA benefits and services, for which they may be eligible.

This chapter examines what community-based providers currently know, and do not know, about the health needs of the Veterans they serve, and what can be done to close that gap. It considers the barriers that keep common military-connected physical and mental health conditions from being recognized in community settings and the practical steps, from routine screening for military service to targeted training in military culture and service-connected conditions, that can help ensure Veterans receive care that reflects the full picture of their health and their service.

With the need for increased awareness among community-based health care providers and improved systems to identify Veterans and address their care needs, the task force makes the following recommendations:

RECOMMENDATION 6:

Improve community-based health care provider knowledge about Veteran culture and military-connected conditions.

Strategy 6.1: Increase the number of Veterans in the health care workforce

Strategy 6.2: Educate community-based health care providers about the unique mental and physical health needs of Veterans

Strategy 6.3: Create a database of Veteran-ready health care professionals

Strategy 6.4: Incentivize health care providers to increase their knowledge of the unique mental and physical health needs of Veterans

Strategy 6.5: Engage health care professional students in learning about the unique mental and physical health needs of Veterans

Strategy 6.1: Increase the number of Veterans in the health care workforce

Responsible entities can increase the number of Veterans who pursue careers in health care through the following actions:

A) North Carolina health professional training programs for mental health, social work, nursing, physician associate/assistant, and similar roles should develop competency-based, accelerated health professional training programs that recognize prior medic/corpsman and military mental health experience to encourage more Veterans to join the health care workforce. Programs should use the University of North Carolina (UNC) Military Equivalency System to identify coursework equivalencies in all areas of study.

B) The UNC and North Carolina Community Colleges Systems should encourage Veterans to enter health care professions and increase awareness of training opportunities through partnerships with educational institutions that have training programs catered to Veterans and military instillations in the state.

Desired Result

Increase the number of Veterans entering and succeeding in health care careers to grow the Veteran-experienced health care workforce in North Carolina.

Potential Measures of Success

- Number of North Carolina health professional training programs that develop accelerated, competency-based pathways for Veterans
- Number of programs utilizing the UNC Military Equivalency System to identify coursework equivalencies

- Number of Veterans reached through outreach efforts; Increase in Veteran enrollment in health care training programs system-wide
- Increase in the number of Veterans employed in the North Carolina health care workforce

One natural way to increase the military- and Veteran-cultural awareness of the health care workforce is to increase the presence of Veterans in that workforce. This would not only increase patient contact with Veteran health care providers, but also increase contact between health care colleagues, thus helping to improve awareness and broaden the perspectives of non-Veteran health care workers.

A Model for Veteran-Specific Health Care Training in North Carolina

Since 2013, the UNC Greensboro School of Nursing's Veteran Access Program (VAP) has prepared Veterans and active-duty military with medical training to be nurses. These new nurses have predominately stayed in North Carolina for employment after graduation. The program provides an accelerated pathway by granting students credit for comparable training completed during military service. Developed with support from a Health Resources and Services Administration (HRSA) grant, the program has graduated over 225 nurses to date.

North Carolina's **UNC Military Equivalency System** (MES) went live February 2025 and is now helping UNC System schools identify coursework equivalencies in all areas of study. With a mandate from the North Carolina General Assembly to increase the number of nurses educated in the state, representatives from the UNC System have collaborated with UNC System nursing programs to create uniform guidance for applying military training and certifications to nursing curriculum. Application of the MES can help the state's nursing programs appeal to the nearly 500 service members that have served in medical occupations who leave the military in North Carolina each year.



According to VAP administrators:

- Military medical experience and responsibilities have given these students unique preparation for nursing school and health care careers.
- There is a more equal gender balance in the VAP than in traditional nursing programs, which has resulted in training more men to be nurses.
- VAP and programs like it offer an opportunity to use and build on medical training for lifelong careers.

Challenges Veterans May Face Translating their Military Experience to the Civilian World

"Transferring credits from other military training programs is more complicated. Military branches other than the Air Force rely on the American Council on Education (ACE) to assess and recommend credit for training and education provided to service members. Although ACE recommendations are based on rigorous review by educational experts, many colleges are unaware of this review process and the value inherent in the coursework listed on the ACE-generated Joint Services Transcript (JST). Every veteran from the Army, Navy, Marines, and Coast Guard receives an individual JST upon request. The JST does not include a letter grade or grade point average (GPA), but lists training modules where a minimum performance level has been met (usually equivalent to B- or above). A college admissions official who does not know this may find it challenging to establish the GPA for a veteran and decide whether the module meets the transfer and prerequisite requirements. Even colleges that are aware of the ACE process may not accept credits because the military training programs do not reside in regionally accredited educational institutions."

Additionally, "Medics and corpsmen receive training in the military that may qualify them as basic EMTs or licensed practical nurses/licensed vocational nurses (LPNs/LVNs). These credentials may not reflect the additional high-level training (e.g., Special Forces Medic or Independent Duty Corpsman) and functioning or scope of practice that these veterans experienced during a deployment. Without a clear mechanism to translate this high-level field training and experience, veterans who seek to qualify for a higher level credential, such as a paramedic or registered nurse, may need to undertake education and training that is redundant to their military experience."

The UNC Military Equivalency System helps to address these challenges Veterans can face in translating military experience to the educational setting.

Source: Snyder CR, Wick KH, Skillman SM, Frogner, BK. Pathways for Military veterans to Enter Healthcare Careers. Center for Health Workforce Studies at the University of Washington. May 2016. https://depts.washington.edu/fammed/chws/wp-content/uploads/sites/5/2016/05/Pathways_for_Military_Veterans_FR_2016_May_Snyder.pdf

Helping to Address Workforce Shortages

One benefit that bringing more Veterans into the health care workforce could bring is helping to address the shortages in some areas of health care. For example, North Carolina has been and expects to continue to experience a nursing workforce shortage. The Cecil G. Sheps Center for Health Services Research Program on Health Workforce Research and Policy projects that "by 2033, North Carolina faces an estimated shortage of 12,459 [Registered Nurses] RNs (or 11% of the projected RN workforce) across all settings," and "a shortage of 5,044 [Licensed Practical Nurses] LPNs, which represents a 26.8% shortfall in future LPN supply relative to demand".[14] Other areas of health care that experience shortages, particularly in the distribution of providers, include mental health—with 97 of the state's counties having a geographic or population Health Professional

Shortage Area for Mental Health and dental health—with 93 the state's counties having a geographic or population Health Professional Shortage Area.[15]

Increasing Gender Diversity in the Health Care Workforce

Increasing the number of Veterans entering the civilian health care workforce also improves the gender diversity within a variety of health care roles.[16] Below are some examples of increased gender diversity among Veteran health care workers compared to non-Veterans, particularly in roles that tend to be majority female in non-Veteran populations.

- **Dental hygienists –** non-Veterans: **2.4%** male; Veterans: **13.6%** male
- **Licensed practical nurses –** non-Veterans: **7%** male; Veterans: **49%** male
- **Registered nurses –** non-Veterans: **8%** male; Veterans: **42%** male
- **Social workers –** non-Veterans: **17%** male; Veterans: **65%** male
- **Counselors –** non-Veterans: **26%** male; Veterans: **77%** male
- **Physician Associates/Assistants –** non-Veterans: **27%** male; Veterans: **77%** male
- **Psychologists –** non-Veterans: **26%** male; Veterans: **85%** male[16]

RESOURCE AND **PARTNERSHIP** POSSIBILITIES

- North Carolina Department of Military and Veterans Affairs
- NC AHEC
- NC Health Talent Alliance
- NCWorks
- Department of Defense/War transition programs
- North Carolina Military Installations

Strategy 6.2: Educate community-based health care providers about the unique mental and physical health needs of Veterans and the social factors that can affect their health

Responsible entities can increase the number of health care providers, including physicians, nurses, and social workers, who are trained in Veteran culture and military-connected conditions through the following actions:

A) **North Carolina Area Health Education Centers (NC AHEC), the Governor's Institute, and Ask Me NC should partner to publicize, host, and/or disseminate existing continuing education trainings, webinars, Veterans Administration/Department of Defense Clinical Practice guidelines, and pocket guides for community-based health care providers to learn best practices in care for Veterans.**

B) **The North Carolina Department of Military and Veterans Affairs should facilitate collaboration between key Veteran organizations and North Carolina health care trade and professional associations to bring awareness about the unique health-related needs of Veterans and encourage participation in available trainings.**

Desired Result

Increase the number of community-based providers trained in Veteran culture, military-connected health conditions, and the social factors affecting Veteran health.

Potential Measures of Success

- Number of Continuing Education trainings, webinars, clinical practice guidelines, and pocket guides publicized or disseminated
- Number of providers reached through association-based outreach
- Total number of community-based providers (physicians, nurses, social workers) trained in Veteran culture and military-connected conditions
- Veteran-reported satisfaction with the cultural competence of care received from community-based providers

Strategy 6.3: Create and maintain a database of Veteran-ready health care professionals

NC AHEC, the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities, and Substance Use Services, the Governor's Institute, and Ask Me NC should partner to develop and identify a host for an online database of health care professionals that have met criteria to be considered trained on Veteran culture and physical and mental health needs. The database could begin by concentrating on specialties in mental health, behavioral health, and primary care.

Desired Result

Help Veterans and referral sources identify and connect with health care providers equipped to meet their unique cultural, physical, and mental health needs

Potential Measures of Success

- Launch of the database (yes/no)
- Number of health care professionals meeting criteria and listed in the database at launch
- Geographic distribution/coverage of listed providers across North Carolina
- User satisfaction ratings (Veterans, VSOs, providers) with database usability and usefulness

Importance of Provider Training

> **Military specific exposures should be considered as important military health history during assessment and, if possible, addressed in care plans. These exposures may include receipt of vaccinations, use of or exposure to chemical and biological weapons, radiation-related diseases, toxic embedded fragments from shrapnel injuries, amputations, traumatic brain injuries, and chronic pain. Specific war era morbidities are also important to recognize and assess for. These are often specific to combat theater regions or due to specific weapons or operational approaches used. For example, veterans deployed in support of named operations across Southwest Asia and Afghanistan may contract Gulf War Syndrome or chronic fatigue/fibromyalgia. They may be exposed to infectious diseases such as malaria, brucellosis, shigella, West Nile Virus; and may have exposure to oil well fires, depleted uranium, and sand and dust particles leading to respiratory complications.**
>
> –Borah E, et al. Evaluation of a Military Informed Care Training with Private Sector Healthcare Providers. Mil Behav Health. 2022;10(3):249-260. doi:10.1080/21635781.2021.2000904

Veterans are a distinct group whose health is shaped by military culture and the specific hazards of service. Physically, many carry health conditions tied directly to their service: toxic exposures from burn pits or Agent Orange, traumatic brain injuries from blast events, Gulf War Illness, chronic pain, respiratory disease, and infectious diseases contracted during overseas deployment. Mentally, Veterans experience significantly higher rates of PTSD, depression, anxiety, and substance use disorders than the general population and face a disproportionately higher risk of suicide.

Military culture itself affects how Veterans engage with health care. Values like self-reliance and stoicism that are strengths in service can become barriers to seeking help in civilian life. Veterans may minimize symptoms, distrust civilian providers, or describe their experiences in ways that don't align with standard clinical questions. For clinicians to build trust and ask the right questions they need cultural knowledge that most don't have without specialized training.

> **"The failure to view veterans as a unique population with military service-connected determinants of health, both physical and psychological, creates the potential for negative health outcomes."**
>
> –Wilmoth MC, et al. Civilian Health Care Systems Must Recognize and Study Military Service as a Social Determinant of Health. NAM Perspectives. 2025;1. doi:10.31478/202501B

When providers are not trained in Veterans' health, Veterans may receive diagnoses that miss service-related conditions, mental health care that is not evidence-based or culturally appropriate or miss out on guidance to access VA benefits they have earned. For Veterans already at elevated risk of suicide and chronic illness, these missed opportunities have serious consequences.

Currently, few clinicians are exposed to topics related to military or Veteran health.

Training & Exposure		Competence & Practice	
1 in 5 medical schools include any military culture content in their curriculum[17]	**2%** of VA community behavioral health providers completed even one of 8 core VA trainings[19]	**8%** of non-VA civilian providers demonstrate military cultural competence[17]	**<50%** of civilian providers routinely screen patients for Veteran status[17,18]
6% of mental health providers report that they served in the military[20]	**33%** of mental health providers have experience in a military or VA setting[20]	**1 in 5** mental health providers have "high military cultural competency"[20]	**<1 in 3** community providers feel equipped to refer Veterans to VA care[18]

Despite these statistics, 80% of surveyed providers say they *want* more information about Veterans' health needs.[18] **The barrier is not motivation; it is awareness of and access to clear, practical training.**

Improving care for Veterans requires training more providers, especially those in primary care and community settings, in **military-informed care:** the practice of using knowledge of a patient's military background to guide assessment, care planning, and referrals.[21] This means routinely asking patients about military service, taking a military health history, screening for service-related conditions, and knowing how to connect Veterans to specialized resources.

Existing Trainings for Health Care Providers

North Carolina

- **Veteran Support Specialist (VSS) –** Hosted by the Governor's Institute, this training is intended to build military cultural competency, improve understanding of behavioral health (mental health, substance use), and improve engagement skills. A mini course is also offered to provide quick, accessible cultural competency and practical tools (e.g., identifying Veterans, connecting to resources).
- **Cultural Competency & Clinical Trainings –** Hosted by the Military & Government Counseling Association of the North Carolina Counseling Association this training helps providers improve clinical skills and increase cultural competency to care for Veterans, service members, and first responders.
- **Military Women's Health Symposium –** Hosted by Southern Regional AHEC annually, the goals of the symposium are to Improve care for military women by providing information and resources on topics such as trauma-informed care, post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), substance use, and treatment for insomnia.
- **Empowering Military Children and Families Program -** Hosted by Southern Regional AHEC, this training helps learners gain a deeper understanding of how military life stressors impact mental health and behavior of children.
- **Hospice-Veteran Partnership –** The Association for Home & Hospice Care of North Carolina hosts a Hospice-Veteran Partnership. Hospice-veteran partnerships help participants gain knowledge about local resources and build awareness of the unique needs of Veterans and ways to improve their clinical work. The partnership is also part of a broader a community engagement opportunity from the National Alliance for Care at Home, offering a public Caring for Veterans initiative and a members-only We Honor Veterans program.

National

- **VHA TRAIN** – Offers a variety of training and education resources for community providers.
- **Consortium for Defense Psychology** – Provides a variety of online trainings.
- **Substance Abuse and Mental Health Services Administrations Service Members, Veterans, and their Families Technical Assistance Center** – Webinars on a variety of topics are available through their YouTube channel.
- **Counseling on Access to Lethal Means (CALM)** – Hosted by the CALM organization, this training provides a practical intervention to increase the time and distance between individuals at risk of suicide and the most common and lethal methods of suicide, particularly firearms.

Being a part of the We Honor Veterans program included covering knowledge gaps, educational offerings for staff, helping staff to understand Veterans unique needs, helping with resources and education for Veterans and their families, and even establishing processes in an organization to figure out, 'how do you even know if someone's a Veteran? How do you even ask? What are the appropriate ways to set up steps in your organization to learn about how many Veterans you are serving?'

We worked on projects. We engaged our volunteer base. We had a committee that began to meet routinely because one of the things that we learned and continue to learn is that it takes a team. Everyone has their own unique experiences and skill sets. They can be critical members of that team, and coming together helps us identify goals and ways that the organization could improve and advance through different levels of the (We Honor Veterans) program, and more importantly, to continue to advance in our ability to better care for Veterans and their families.

–Senior hospice and home health executive on her organization's participation in the We Honor Veterans program

Opportunity for Registry of Veteran-Ready Providers

A registry of clinicians who have completed defined and verifiable training on Veteran-culture and service-connected conditions would help Veterans who would value such knowledge to identify health care providers who are more likely to understand their background. This directly targets a dynamic clinician and researchers have described, where an initial bad experience prevents Veterans from returning for further care.[20]

A well-designed registry also creates a market incentive for clinicians to pursue this training, since inclusion becomes a visible identifier that can attract military-connected clients and referrals from other professionals (e.g., physicians, chaplains, care coordinators). This is consistent with the design and stated purpose of the existing and previous examples of similar efforts:

- **Star Behavioral Health Providers (SBHP) –** Developed in 2011 and the largest existing model of this kind, SBHP trains civilian behavioral health clinicians in sequential tiers—from an introduction to military culture and deployment through more specialized topics like moral injury and traumatic brain injury. Once a clinician completes the initial tier, they are listed in a public, searchable online directory that Veterans, families, and referral sources can use to find a trained provider in their area.[22,23]

- **Citizen Soldier Support Program –** In North Carolina, there was a previous collaboration between regional AHECs, the Odum Institute, and the Citizen Soldier Project that involved large-scale training of mental health providers-including outside North Carolina-and development of a website that listed trained providers. The website also included geospatial mapping that helped identify where trained providers were located.

These examples show there is both precedent and previous infrastructure in the state that a renewed or expanded registry could build on, rather than starting from scratch.

Case Study in Previous Provider Training Efforts – Citizen Soldier Support Program

- Approximately **4,000** providers participated in day-long trainings.
- Approximately **25,000** providers completed nearly 50,000 online trainings.
- Providers from all **50** states and more than one-third of US counties were trained.
- Trainings covered PTSD, TBI, women returning from combat, issues affecting families during deployment, approaches to treating Veterans in primary care, recognizing mild TBI during eye exams, among other issues.

Source: CSSP – Training Behavioral Health Professionals ; https://citizensoldiersupport.org/training

Limitations of a Provider Registry

A registry of this kind answers one narrow but important question: has this clinician completed a defined training on Veteran culture and Veteran-specific health issues? It cannot and should not be represented as a certification of clinical skill, competence, or quality of care more broadly. A clinician can complete cultural awareness training and still vary widely in overall clinical ability, just as a clinician who has not completed such training may still be an excellent, Veteran-attuned provider through other experience (e.g., being a Veteran or military family member themselves). Public communications about any potential registry should be explicit that listing indicates completion of a specific training pathway only, not an endorsement of the provider's general quality or an outcome guarantee.



RESOURCE AND **PARTNERSHIP** POSSIBILITIES

- NC AHEC
- Veterans Integrated Service Network (VISN) Public Affairs Officer and Mental Illness Research, Education, and Clinical Center (MIRECC)
- Rural Health Transformation Program ROOTS Hubs
- NCServes
- Veterans Bridge Home
- Veterans Services of the Carolinas
- North Carolina Governor's Institute
- NCCare360
- Foundation for Health Leadership and Innovation
- Veterans of Foreign Wars
- American Legion
- North Carolina health care professional organizations

Women Veterans: Military Service Challenges and Their Impact on Veteran Health Care

Women are the fastest-growing group within the US Veteran population, projected to make up roughly 18% of all Veterans by 2040.[i] Despite this growth, women's experiences of military service and its aftermath remain distinct from those of male Veterans—and can go unrecognized by the civilian and VA health care providers who care for them once they leave service.[i]

"Consistent themes in the research on women's access to and satisfaction with VA care have been that the gender-specific care they need is not available through VA and that there are barriers to accessing care when it is available. Studies indicate that a lack of VA providers trained in women's health and insufficient coordination with community providers are two significant factors that limit veteran women's access to VA care."[ii]

Military Sexual Trauma and Harassment – Military sexual trauma (MST)—sexual assault or repeated, threatening sexual harassment during service—is reported by roughly one in three women seen in VA care, compared with about one in fifty men.[iii] Population-based surveys suggest true prevalence may be even higher for both genders, with some studies estimating between 40-50% of Veteran women screening positive depending on the definitions used.[iv] MST is associated with post-traumatic stress disorder, depression, anxiety, substance use disorders, and elevated risk of suicide.[iii]

Discrimination – Some women Veterans who have used VA care describe gender-based harassment from fellow Veterans in VA waiting rooms and facilities, along with biased or dismissive treatment from providers and staff based on gender, appearance, sexual orientation, or body size.[v]

Unique Occupational and Reproductive Health Exposures – Deployment-related environmental exposures—burn pit and airborne particulate emissions, heavy metals, industrial solvents, contaminated water, pesticides, and extreme heat—may disrupt hormonal regulation and have been linked to risks for infertility, miscarriage, preterm birth, and congenital anomalies, though gaps in research still remain.[vi, vii]

Why This Matters for Health Care Providers – Because MST, harassment, and toxic exposures are underreported, underdiagnosed, and inconsistently documented, providers who are unaware of these issues risk missing key drivers of a woman Veteran's physical and mental health presentation—attributing depression, chronic pain, gastrointestinal symptoms, or reproductive complaints to unrelated causes rather than screening for an underlying service-connected cause.

Providers can improve care by using trauma-informed, universal MST screening; asking specifically about deployment-related environmental exposures and reproductive/gynecologic history; ensuring access to women's health-trained providers and same-sex provider options when requested; creating physically safe, private clinical spaces; and approaching each Veteran's presentation with awareness that military service may carry gendered risks that can be overlooked.

[i] Villanueva R, et al. Invisible Ranks: The Untold Battle for Women Veterans' Mental Health. Psychiatric Times. November 11, 2025. https://www.psychiatrictimes.com/view/invisible-ranks-the-untold-battle-for-women-veterans-mental-health
[ii] Schultz D, et al. Improving Support for Veteran Women. RAND. September 15, 2022. https://www.rand.org/pubs/perspectives/PEA1363-3.html
[iii] US Department of Veterans Affairs. PTSD: National Center for PTSD. Accessed July 8, 2026. https://www.ptsd.va.gov/understand/types/sexual_trauma_military.asp
[iv] Wilson LC. The Prevalence of Military Sexual Trauma: A Meta-Analysis. Trauma Violence Abuse. 2018 Dec;19(5):584-597. doi: 10.1177/1524838016683459. Epub 2016 Dec 16. PMID: 30415636.
[v] Katon JG, et al. Experiences of Discrimination Among Women and Gender Diverse Veterans Using Veterans Health Administration Health Care. Health Equity. 2024 Sep 30;8(1):692-700. doi: 10.1089/heq.2024.0085.
[vi] US Department of Veterans Affairs. War Related Illness and Injury Study Center. Accessed July 8, 2026. https://www.warrelatedillness.va.gov/WARRELATEDILLNESS/WRIISC-WOMEN/ww-repro.asp
[vii] Clark KL. Environmental and occupational risks to reproductive health in women service members and veterans. Front. Public Health. 2025. doi: 10.3389/fpubh.2025.1628858

Strategy 6.4: Incentivize health care providers to increase their knowledge of the unique mental and physical health needs of Veterans

North Carolina health insurance carriers and NC Medicaid should implement a recognition program for providers who engage in defined training(s) on Veteran culture and service-connected health care needs.

Desired Result

Expand the pool of health care providers equipped to deliver culturally competent care to Veterans.

Measures of Success

- Development and launch of a formal recognition program (yes/no)
- Number of health insurance carriers participating in a recognition program
- Establishment of defined training criteria/requirements for recognition (yes/no)
- Number of providers completing defined Veteran culture and health care trainings

Incentivizing Provider Behavior

Health insurers have well-established tools for shaping provider behavior, the most common of which is pay-for-performance (or value-based payment), in which a portion of a provider's compensation is tied to meeting defined quality or outcome targets rather than to the volume of services delivered.[24] Insurers also operate provider recognition and designation programs—such as those built around the National Committee for Quality Assurance's Patient-Centered Medical Home standards—that reward practices meeting defined criteria with enhanced payments, public recognition, or preferential placement in provider directories.[25] The evidence on these approaches is mixed but instructive: incentive programs are most likely to change clinical practice when the targeted activities are evidence-based, clinically meaningful, understood by clinicians, and paired with adequate support. These programs are least effective when incentives are small, narrowly focused on productivity, or disconnected from the work clinicians value.[26]

Case Study: Red White and Blue NC

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) launched an initiative called **"Red White and Blue NC"** in 2014. The program offered free online training to North Carolina health-care professionals on topics including:

- Taking a military history
- Traumatic brain injury
- VA 101
- Assisting Veterans in crisis
- Military-family issues and other Veteran-related concerns

This was not simply an educational outreach effort. Blue Cross NC offered to reward community-based primary-care practices for completing the courses through its value-based incentive program called the Blue Quality Physicians Program. The training also counted toward continuing education credits for clinicians.

Source: Blue Cross Blue Shield NC. BCBSNC's Red White and Blue NC Program Highlights Veterans Issues and Resources. November 11, 2014. Accessed August 18, 2026. https://mediacenter.bcbsnc.com/news/bcbsncs-red-white-and-blue-nc-program-highlights-veterans-issues-and-resources

There is also direct precedent for tying provider incentives to the completion of defined trainings. Several state Medicaid programs require or reward participating providers for completing cultural competency training; New York, for example, has previously required Medicaid managed care providers to certify annual completion of a state-approved cultural competency curriculum.[27]

Research on cultural competency training has found that it can measurably increase providers' cultural competence and is associated with improved patient satisfaction, supporting the premise that structured, topic-specific training can enhance clinical practice.[28] A Veteran-focused reward program could build on this experience, applying an established incentive infrastructure to the specific knowledge gaps community providers face in serving Veterans.

Importance of a Required or Defined Curriculum

To be effective and credible, any reward program should define a specific set of trainings or competencies a provider must complete to qualify, rather than crediting Veteran-related education in general. A defined curriculum ensures that participating providers gain a consistent, meaningful baseline of knowledge and allows the program to be evaluated over time. At minimum, qualifying content should address the topics most relevant to community-based Veteran care, including:

- Military culture and communication
- Toxic exposure screening and the conditions addressed under the Sergeant First Class Health Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act
- Suicide prevention and lethal means safety
- Awareness of military sexual trauma
- Caregiver and family awareness
- Basics of referral to and navigation of Department of Veterans Affairs (VA) health services and community care.

Each of these topics reflects a distinct dimension of Veteran health that is often unfamiliar to civilian providers. For example, the PACT Act now requires the VA to screen every enrolled Veteran for toxic exposures and has expanded eligibility for burn pit, Agent Orange, and other exposure-related conditions, yet community providers who see these same Veterans may not recognize what qualified them for expanded care.[29,30]

As detailed in Strategies 6.2-6.3, several Veteran culture- and service-connected health care trainings are already available to North Carolina providers at no cost, so a reward program can draw on existing curricula rather than requiring new ones to be developed.[31]

Incentive Options

Ultimately, program design will shape whether a reward approach succeeds. Rewards can take several forms – direct payments or bonuses, continuing education or maintenance-of-certification credit, reduced administrative requirements, or a "Veteran-ready" designation displayed in provider directories to help Veterans and their families identify knowledgeable providers. A directory designation carries the added benefit of easing a navigation barrier raised repeatedly during task force discussions: the difficulty Veterans face in finding community providers who understand military and Veteran culture. In turn, this can help providers who may be seeking to increase their patient panel through Veterans seeking their care.

RESOURCE AND **PARTNERSHIP** POSSIBILITIES

North Carolina Association of Health Plans

North Carolina Department of Health and Human Services

North Carolina Department of Military and Veteran Affairs

Veteran interest and advocacy groups

Strategy 6.5: Engage health care professional students in learning about the unique mental and physical health needs of Veterans

Responsible entities can increase the awareness and knowledge of students in health care professional training programs through the following actions:

A) Veteran student associations and health care professional student organizations at North Carolina institutions of higher education should partner to provide educational opportunities for health professional students to learn about the unique physical and mental health needs of Veterans.

B) A University of North Carolina System nursing, or other health professional, program should develop a pilot Veteran-centric curriculum or certificate for non-Veteran students interested in this area of concentration. Based on lessons learned from the pilot, the program could expand to a statewide model, such as a fellows program, and expand to other health professions.

Desired Result

Build early awareness and specialized knowledge among future health care professionals and grow the pipeline of providers prepared to meet Veterans' unique health needs.

Potential Measures of Success

- Number of institutions of higher education participating
- Number of health professional students reached/participating
- Student-reported knowledge gain regarding Veteran physical and mental health needs (pre/post survey)
- Development and launch of a pilot curriculum or certificate program (yes/no)
- Number of students enrolled in the pilot program
- Development of a statewide model (e.g., fellows program) based on pilot outcomes (yes/no)

Health Professional Training and Population-Specific Needs

Health professional training is where clinicians first develop the competencies and habits that shape a career of practice, making it an efficient point at which to build awareness of populations with distinct needs. Embedding population-specific content into health professional education is a well-established strategy, and several structured resources already exist for teaching students about Veteran health specifically. The American Association of Colleges of Nursing's Enhancing Veterans' Care faculty toolkit offers curriculum elements and examples for integrating Veteran and military health content into nursing education, and the National League for Nursing's Advancing Care Excellence for Veterans project provides simulation-based cases—such as a young combat Veteran managing post-traumatic stress disorder during pregnancy—that let students practice Veteran-centered care in a controlled setting.[32,33] Engaging students through their own professional organizations and Veteran student associations extends this learning beyond the classroom and builds early peer networks around the topic.

Star Behavioral Health Training

One existing model of provider-focused education is the Star Behavioral Health Providers (SBHP) program. Launched in 2011 as a collaboration among the Center for Deployment Psychology at the Uniformed Services University, the Military Family Research Institute at Purdue University, and the National Guard, SBHP is a free, tiered continuing-education program that prepares civilian behavioral health providers to serve service members, Veterans, and their families, and maintains a searchable directory so military-connected individuals can find trained providers.[34] Its introductory tier covers military culture and the deployment cycle and is open to any professional or community member, while advanced tiers address clinical topics such as PTSD, sleep problems, and suicide risk. As of fiscal year 2025, SBHP had expanded to all 50 states, making it available to providers and students in North Carolina.[35]

Veteran-Centered Curriculum for Non-Veterans

A number of Veteran-centric curricula for students have also been developed at US institutions, largely under the Joining Forces initiative launched in 2011, which asked schools of nursing to pledge to incorporate military and Veteran health content into their curricula; several hundred nursing programs made the pledge with support from the Department of Veterans Affairs (VA), the American Nurses Association, and other organizations.[36] Implementation, however, has been uneven. Studies have found wide variation in how, and how deeply, programs integrated the content. Limited instructional time and already-full curricula were cited as the most common barriers.[36] This variability is precisely why a deliberately designed, evaluated pilot—rather than an unstructured pledge—offers value: it can establish what a rigorous Veteran-centric course of study looks like in North Carolina before the model is scaled to a nationwide program and extended to other health professions.

Existing Educational Tools

These efforts can draw on educational tools that are already available or in development at no cost to the learner or educational institution.

- **Veterans Health Administration's Training Real-time Affiliated Integrated Network (VHA TRAIN) –** Courses such as *Military Culture: Core Competencies for Health Care Professionals* are available to community providers nationwide.
- **PsychArmor –** This national nonprofit, offers a library of more than 200 free online courses on military culture, suicide prevention, caregiver support, and related topics for clinicians, students, and the broader public.[37,38] Existing resources like these mean that new curricula and student programs can build on vetted material rather than starting from scratch.
- **Veteran Support Specialist Training –** Hosted by the Governor's Institute, this training is intended to build military cultural competency, improve understanding of behavioral health (mental health and substance use), and improve engagement skills. A mini course is also offered to provide quick, accessible cultural competency and practical tools (e.g., identifying Veterans, connecting to resources).[39]

North Carolina's Health Care Workforce Training: Primed for Opportunity

North Carolina is well positioned to act. Several of the state's largest nursing programs—including those at East Carolina University, The University of North Carolina (UNC) at Chapel Hill, and UNC Greensboro—already operate Veteran-focused programs. However, these have generally centered on supporting Veteran students' own progress through school rather than teaching non-Veteran students to care for Veteran patients. Task force members active in nursing education described a national movement toward recognizing military and Veteran nursing as a specialty with certification and toward preparing all providers in "military-informed care." These task force members suggested that entities such as the North Carolina Area Health Education Centers could help deliver such programming. One nursing leader also cautioned that Veteran-focused education should avoid implying that everyone who served carries post-traumatic stress disorder (PTSD) or a mental health condition—a reminder that this content should be framed around understanding and cultural competence, not assumption.



RESOURCE AND **PARTNERSHIP** POSSIBILITIES

- University of North Carolina System
- North Carolina Community Colleges System
- Private universities with health professional training programs
- North Carolina Area Health Education Centers
- North Carolina Nurses Association
- Veterans interest and advocacy organizations
- North Carolina Department of Health and Human Services
- North Carolina Department of Military and Veterans Affairs
- Governor's Institute
- North Carolina Governors Challenge
- Veterans Bridge Home
- Veterans Services of the Carolinas
- VA Mid-Atlantic Mental Illness Research, Education & Clinical Center on Post Deployment Mental Health

RECOMMENDATION 7:

Consistently identify Veterans, their families, and caregivers within health care systems to improve the care Veterans receive.

Strategy 7.1: Ask patients about their military connections

Strategy 7.2: Establish Veteran care improvement mechanisms

Strategy 7.3: Improve community-based provider access to Veteran health information

Strategy 7.1: Ask patients about their military connections

All mental and physical health care providers should:

A) Implement a process to document the military-connected status of all patients by asking if they have served in the military or are family or a caregiver of someone who has, and

B) Establish supports and resources for health care professionals to use for patients who are identified as military-connected to inquire about potential military-connected health-related conditions.

Desired Result

Health care providers are identifying military-connected patients and proactively addressing the unique health conditions associated with their service or as a family member or caregiver.

Potential Measures of Success

- Number/percentage of health care practices implementing a standardized military-connected status question
- Number/percentage of patients identified as military-connected through screening
- Number/percentage of military-connected patients receiving follow-up inquiry about service-related health conditions
- Veteran and family/caregiver satisfaction with care that acknowledges their military connection

Identification of Veteran and Military-Connected Status in Community-Based Health Care Settings

Despite its clinical value established earlier in this chapter, the routine identification of Veteran and military-connected status in community health care settings remains uncommon. Research consistently characterizes military service as "the unasked question" in civilian health care.[40] A regional study of primary care providers found that the majority (56%) reported that they never or rarely asked patients about their military service, with only 19% saying they often or always

asked.[40] Notably, 71% of those same providers agreed or strongly agreed that knowing whether a patient was a Veteran was important information for their care, suggesting that the gap between perceived importance and actual practice is substantial.[40]

Barriers to asking include provider unfamiliarity with military stressors and Veteran health conditions, limited time, and uncertainty about what to do with the information once collected.[40] The same study found that providers identified post-traumatic stress disorder (PTSD), depression, and anxiety as common concerns among Veterans, but very few flagged substance use disorders or traumatic brain injury (TBI)—two of the most prevalent conditions in this population—as top clinical concerns.

Standardized screening can change this. Research documenting the implementation of a structured Veteran status screening question in a Federally Qualified Health Center's electronic health record system found that the intervention significantly increased the number of Veteran patients identified, enabling the health center to better understand and respond to their specific needs.[41]

The framing of the question matters as well: evidence indicates that phrasing such as, "Have you ever served in the military?" yields more accurate identification than more narrowly worded questions that may inadvertently exclude National Guard members, reservists, and women Veterans, who are among those most likely to go unrecognized.

The Ask Me NC campaign recommends phrasing the question as, "Have you or a family member ever served in the military?"[42] This is a more inclusive question that can identify people who may not self-identify as Veterans, as well as family and caregivers who may have health-related challenges related to their military-connected status.

How Identification of Veteran Status Can Impact Care of Veterans

Identifying Veteran status opens a clinical conversation that can meaningfully change the quality of care. A Veteran psychiatric practitioner interviewed during the learning period for the task force described how often Veterans' health histories go unrecognized in community settings:

> **"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 [...] their exposures aren't understood." He continued, capturing the reflexive self-minimization that frequently prevents Veterans from volunteering information about their service: "Most Veterans won't even sign up for the VA [...] '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.**

When a provider asks and then acts on the answer, the impact can be substantial. It informs screening decisions for service-connected conditions, from hearing loss and musculoskeletal injuries to burn pit-related respiratory illnesses and the range of mental health conditions described elsewhere in this report. It supports appropriate referrals, both to Department of Veterans Affairs (VA)-based care and to community-based Veteran services, and it builds the foundation of trust that effective care for this population requires. As one senior home health executive reflected: "If they don't trust you, you're not getting anywhere."

Case Study: Camp Lejeune Water Contamination

Military-connected toxic exposures are not limited to oversees deployments. One prominent example is Camp Lejeune, a US Marine Corps base in North Carolina. The base experienced groundwater contamination when industrial solvents seeped into the drinking water from roughly the early 1950s through 1987. The most contaminated wells were closed by 1987 and the US Environmental Protection Agency (EPA) placed Camp Lejeune on the National Priorities List, also known as Superfund, in 1989. It is estimated that between 500,000 and 1 million people may have used the contaminated water. Several of the contaminants are classified as human carcinogens, and studies have linked exposure to some with elevated risks of several cancers, congenital anomalies, miscarriages, and neurological diseases such as Parkinson's disease. [i]

In response, Congress passed the Camp Lejeune Families Act of 2012, which lets qualifying Veterans who served at least 30 days on base between 1953 and 1987 receive VA health care for related conditions, and the Camp Lejeune Justice Act of 2022 (part of the PACT Act), which for the first time allowed Veterans, family members, and civilian workers to file administrative claims or lawsuits against the federal government for compensation.[i] As of mid-2026, Camp Lejeune Justice Act settlement offers have exceeded $968 million, with paid settlements surpassing $801 million. More than 408,000 claims have been filed with the Navy and progress remains slow, with the vast majority still lacking sufficient documentation to advance to settlement.[ii]

i. Committee on the Review of Clinical Guidance for the Care of Health Conditions Identified by the Camp Lejeune Legislation; Board on the Health of Select Populations; Institute of Medicine. Review of VA Clinical Guidance for the Health Conditions Identified by the Camp Lejeune Legislation. Washington (DC): National Academies Press (US); 2015 Mar 26. Summary. Available from: https://www.ncbi.nlm.nih.gov/books/NBK284970/
ii.Mass Tort Info. Camp Lejeune Water Contamination Lawsuit — Eligibility, Deadline, and Settlement Updates. Accessed August 18, 2026. https://masstortinfo.com/camp-lejeune-lawsuit/

One Veteran interviewed during the learning period described an experience that illustrated both the promise and the current failure of identification efforts in practice:

> **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.**

Asking the question, in other words, is only meaningful when the system behind it is prepared to respond.

Identification through VA data

Through interoperability with VA health care data systems (described in greater detail in Strategy 7.3), non-VA health care systems can identify patients who also receive care through the VA. This can allow health systems and providers to proceed to additional screening questions or other care processes for these military-connected patients.



RESOURCE AND **PARTNERSHIP** POSSIBILITIES

- Ask Me NC
- Health professional associations
- Health care provider trade associations
- North Carolina Area Health Education Centers
- North Carolina Department of Health and Human Services
- North Carolina Department of Military and Veteran Affairs
- Veterans interest and advocacy organizations

Screening and Follow-Up Questions Recommended by the American Academy of Nursing

Have you or has someone close to you ever served in the military?

- When did you serve?
- Which branch?
- Were you Active Duty, Reserve, or National Guard?
- What was your primary role while you were in the military?
- Were you assigned to a hostile or combative area?
- Did you experience enemy fire or see combat?
- Did you witness casualties?
- Were you wounded, injured, or hospitalized?
- Did you participate in any experimental projects or tests?
- Were you exposed to chemicals, gases, demolition of munitions, pesticides, burn pits, or other hazardous substances?
- Have you ever received a toxic exposure screening?
- When was your last screening?
- Would you like more information about toxic exposure screenings?

Where do you receive your medical care now?

- Have you ever used the VA for health care?
  - When was your last visit to the VA?
  - Is there a waiver or permission needed to access these records?
- Do you have a service-connected disability or presumptive condition?
  - Do you have a claim pending?
  - If so, what is the nature of the claim?
- Would you like more information about establishing care at the VA?

Do you have a place to go when you leave today?

- Is your living situation stable?
- Do you feel safe where you live?
- Do you have a stable source of food?
- Do you need assistance in caring for yourself or members of your household?
- Would you like help with this?

Source: Have You Ever Served in the Military?™. American Academy of Nursing. Accessed July 8, 2026. https://aannet.org/page/HaveYouEverServed

Strategy 7.2: Establish Veteran care improvement mechanisms within hospitals and health systems

The North Carolina Healthcare Foundation, with appropriate funding secured, should serve in an advisory capacity to connect health care systems with information and resources on how to improve their ability to identify and serve Veteran patients, families, and caregivers. This could include establishing internal committees to continuously improve Veteran care, incorporate Veteran care quality into strategic planning and evaluation metrics, and promote awareness campaigns for their employees to understand available supports and services for Veterans and their families

Desired Result

Hospitals and health systems will establish internal structures that continuously improve their capacity to identify and serve Veteran patients, families, and caregivers.

Potential Measures of Success

- Establishment of advisory role/capacity to support health systems on Veteran care (yes/no)
- Number of health systems/hospitals engaging with Veteran care resources and guidance
- Employee-reported knowledge of available Veteran supports and services (pre/post survey)
- Veteran and family/caregiver satisfaction with care received at participating hospitals and health systems

Health System Advisory Groups

Hospitals and health systems routinely use internal advisory and quality-improvement structures to focus organizational attention on a specific population or care problem. The most widely adopted patient-facing example is the Patient and Family Advisory Council (PFAC), a standing group of patients and family members who partner with a health system on staff education, quality improvement, and patient safety. PFACs are endorsed by national quality bodies such as the Agency for Healthcare Research and Quality and are embedded in the standards for Patient-Centered Medical Home recognition and Accountable Care Organizations.[43,44] Roughly half of US hospitals operate a PFAC, with adoption more common among larger, system-affiliated hospitals that have the resources to sustain them.[45]

The evidence base for these structures is still maturing. Systematic reviews have found that rigorous data on their effect on clinical outcomes remain limited, though individual programs have reported gains in patient satisfaction, screening rates, and reductions in length of stay and complaints.[46] The literature is consistent that impact depends on genuine organizational commitment, diverse membership, deliberate operational planning, and systematic measurement of the council's work.[47]

Dedicated Veteran-focused versions of these mechanisms are rare outside the Department of Veterans Affairs (VA). Within the Veterans Health Administration (VHA), Veteran experience and

advisory functions focus explicitly on the Veteran population. Civilian health systems seldom maintain committees, metrics, or care manager roles dedicated to Veterans, even though most Veterans receive at least some of their care outside the VA.[29]

The North Carolina Healthcare Association and Foundation

The North Carolina Healthcare Association (NCHA) is well positioned to advise members on building these mechanisms. Founded in 1918 and known until its centennial as the North Carolina Hospital Association, NCHA describes itself as the "united voice" of the state's health care community.[48,49] It represents more than 130 hospitals, health systems, physician groups, and other health care organizations, and works with members through advocacy, education, data and insights, and convening.[49]

NCHA has an established track record of serving in exactly this kind of advisory and convening capacity on defined care-quality priorities. Its health equity work is illustrative: NCHA developed a statewide clinical care equity resolution that a large majority of member hospitals signed, launched an Equity of Clinical Care Dashboard to track progress across the state, and—through the NCHA Foundation and in partnership with the American Hospital Association's Institute for Diversity and Health Equity—has convened quality-improvement and patient-safety programming for members.[50] NCHA also curates peer-learning resources and toolkits and spotlights member programs so that effective practices can spread from one system to another.[51] The same infrastructure could be applied to Veteran care: assembling and disseminating practical guidance, helping members stand up Veteran-focused committees or a Veteran care manager function, and incorporating Veteran-care measures into the shared dashboards and improvement work NCHA already leads.

The North Carolina Healthcare Foundation is the "charitable non-profit, innovative, and programmatic arm of the North Carolina Healthcare Association," and has a mission to "foster and accelerate the collective impact of hospitals, health systems, and community partners to improve the health of North Carolinians."[52] The foundation is engaged in projects across a variety of topics with activities including convenings, webinars, learning collaboratives, reporting and evaluation support, and implementation tools and resources. Funding partners for these projects have included Wells Fargo, The Duke Endowment, and The Leon Levine Foundation, while project partners have included the North Carolina Department of Health and Human Services and Population Health Improvement Partners, among others.[53]

Multi-Layered Strategy to Improving Veteran Care

As described in Strategy 7.1, identification of Veteran status is a meaningful gap. One survey found that a majority of community-based primary care and mental health professionals did not routinely ask patients whether they had served.[54] Task force discussions reinforced the need for hospital-level structures to improve care for Veteran patients. For example, health systems and hospitals can implement clear protocols for clinical interviews of Veteran patients and designate a Veteran advocate who understands how to connect patients with VA benefits and services they may be entitled to. Embedding these functions and a broader focus on Veteran care in hospital operations would help ensure that Veterans and their families are recognized and appropriately served wherever they seek care.



RESOURCE AND **PARTNERSHIP** POSSIBILITIES

North Carolina Department of Health and Human Services

North Carolina Department of Military and Veteran Affairs

Strategy 7.3: Improve community-based provider access to Veteran health information

The NCIOM Task Force on Veterans' Health endorses a bidirectional exchange of Veteran health records with consent of the Veteran, pending full consideration of ethical and legal concerns. This could include VA medical centers becoming full participants in the NC Health Information Exchange.

Desired Result

Health care providers in community-based settings will have a more complete picture of a Veteran's health history to improve care coordination and clinical decision-making.

Potential Measures of Success

- Department of Veterans Affairs (VA) medical centers' enrollment status as participants in the NC Health Information Exchange (number/percentage of VA medical centers participating
- Provider-reported improvement in access to comprehensive Veteran health history
- Provider satisfaction with the completeness and usability of exchanged health information
- Veteran satisfaction with coordination between VA and community-based providers

Even though many Veterans receive their health care at least partially, if not entirely, outside the VA system, the electronic health data systems used by VA and by community providers still do not reliably share patient health data. Although VA has made some progress connecting with larger hospital systems, far fewer physician practices, clinics, and other community providers exchange data with VA. A 2025 VA Office of Inspector General report found that community care medical records are frequently missing or incomplete in veterans' VA electronic health records because of weak controls over how those records are requested, received, and imported.[55]

> "Currently 27 health systems enable the API in production and verified over 1.5 million confirmed Veteran status. Participating health system and hospitals are able to identify Veterans in their care, opening the door to care and benefits for potentially millions of Veterans. Health systems are encouraged to evaluate the API and determine the most effective fit within their existing EHR workflows and operational priorities."
>
> –Veterans Health Administration. Veterans Interoperability Pledge. Accessed July 13, 2026. https://department.va.gov/vha/veteran-interoperability-pledge/

Veteran Interoperability Pledge

The Veteran Interoperability Pledge (VIP) is VA initiative allowing non-VA health systems to securely exchange health data with the VA. Participation in the VIP enables community providers to instantly identify Veteran patients, securely coordinate shared care, and connect them with earned benefits and reduced out-of-pocket costs. In North Carolina, Atrium Health has been the primary founding health care system piloting the VIP.[56]

A community of practice was developed and "brings together healthcare organizations committed to the Veteran Interoperability Pledge and works collaboratively to improve Veteran health care through seamless data exchange and system integration."[56] The VIP Community of Practice has three core objectives:

1. **"Accurately identify Veterans –** Help community providers reliably confirm Veteran status using standards-based workflows and the VA Title 38 API [Application Programming Interface]."
2. **"Connect Veterans with resources –** Ensure Veterans access VA benefits and programs, including PACT Act and COMPACT Act support."
3. **"Coordinate care reliably –** Improve bidirectional data exchange between VA and community providers for shared Veteran patients."[57]

Findings from the VA Office of the Inspector General

The VA Office of the Inspector General (OIG) conducted a review "to determine whether VHA staff took appropriate action to retrieve and document the medical records from community providers and import the records into the veterans' electronic health records (EHR)". The 2025 OIG report found that:

"[VA] staff did not always import records in a timely manner into the EHR after receipt. VHA policy requires that all internal and external documents be imported or scanned into the EHR within five business days of receipt. VHA policy suggests community care staff have two business days to review medical records, and [Health Information Management] or community care staff have three business days to import the records into the EHR.

"Barriers to importing records into the EHR in a timely manner included technology limitations….At the time of the review, the largest number of records came back via electronic fax, which is inefficient because of issues with fax systems not working for periods of time. During interviews with the team, staff at five facilities cited issues with electronic faxes in processing community care medical records. The VHA portal available for community providers to return records to VHA was generally not used because of the complexity for the individual providers. Facilities that used tools to improve processing shortened the time it took to import records into the EHR….

"Any medical records not imported into the EHR within five business days become part of the backlog of records. Backlogs increased the risk of duplicate requests because staff could not determine which records were in the backlog and would therefore request the same record multiple times. When community care records are not imported within five business days, it increases the risk that clinicians will not have records to review when needed or that VHA clinicians will implement contingencies to request the record, which often add to clinical staff's workload."

These findings are consistent with challenges in record sharing between VA facilities and community providers that were described by task force members.

Source: US Department of Veteran Affairs Office of the Inspector General. Facilities Faced Challenges Retrieving Medical Records from Community Providers and Importing Them into Veterans' Electronic Health Records. August 7, 2025. https://www.vaoig.gov/sites/default/files/reports/2025-08/vaoig-24-02154-154_final.pdf

VA Exchange

Separate from the VIP, the VA Exchange "enables bi-directional sharing of VA health information between VA and participating non-VA partners and providers. The information is exchanged over a secure network and includes medical history, allergies, medications, immunizations and more."

Changes to the VA Exchange were implemented in 2020 after the 2018 VA MISSION Act removed restrictions on sharing of electronic health records that had meant patients previously needed to elect to share their information in the Exchange.[58] Now, all VA patients are included in the Exchange unless they opt out.

VA health care staff can access electronic health information through VA Exchange from the following North Carolina providers:

- Atrium Health CareConnect
- Ballad Health
- Charlotte EENT Associates
- CommonWell Health Alliance
- CVS MinuteClinic
- Duke Health
- FirstHealth Carolinas
- Mission Health (NC)
- Novant Health
- OCHIN
- U.S. Renal Care
- UNC Health Care
- ECU Health[59]

Notably, connection to the VA Exchange requires individual non-VA providers to take action, which can be a challenge for smaller or lower-resourced providers.

NC Health Information Exchange

In North Carolina, any healthcare provider that receives funds from the state for patient care must be connected to NC Health Connex, "a secure electronic network that facilitates conversations between health care providers, allowing them to access and share health-related information across the state."[60] NC Health Connex is the health information exchange (HIE) for the state designated by law and managed by the NC Health Information Exchange Authority in the North Carolina Department of Information Technology.[60] While VA Medical Centers in the state are able to access data for patients from non-VA providers, as partial participants in NC Health Connex, non-VA providers are not able to access the same level of data from the VA.[61]

HIEs like NC Health Connex help link providers who may have different types of electronic health record (EHR) systems, allowing those providers to share data that is necessary for patient care. Other states with HIEs have had similar challenges with connecting VA providers to their exchanges. An official from Michigan's exchange spoke with the US House of Representatives Subcommittee on Technology Modernization of the Committee on Veterans' Affairs. While the status of Michigan's HIE connection with that state's VA providers is not the same as North Carolina's, his words are helpful to consider broadly in relation to the importance of connecting data systems:

> **Today, however, in Michigan, the VA and DOD are a blind spot to a veteran's overall healthcare. The VA does not only not submit data through the network but cannot access its patients' records from encounters outside of the VA.... Today, the VA does not comprehensively see interactions outside of its facilities, and... Community Care facilities cannot see veterans' interactions with the VA hospital either. There is no such thing as a lifetime record of a veteran's healthcare residing in one EHR system. It simply does not exist. There is also no such thing as a national exchange with a handful of EHRs that can replace the infrastructure we have spent the last 14 years perfecting. We can and we must do better to provide higher quality care to our veterans in Michigan. There is always potential for improvement, and I believe we can achieve it with the right strategies, support, and collaboration.**
>
> –Congress.gov Closing the Data Gap: Improving Interoperability Between VA and Community Providers. Library of Congress. Accessed July 12, 2026. https://www.congress.gov/event/119th-congress/house-event/118027/text

Veteran Choice

While data interoperability is vital to patient care, Veterans must have trust in their data privacy and an ability to opt out of data sharing. Currently, the VA provides the following option to Veterans who would prefer to opt out of data sharing: "If you would prefer that VA not share your health information electronically, you must complete and submit VA Form 10-10164 to your facility's Release of Information Office (ROI). You can also update your sharing preferences by signing into My HealtheVet on VA.gov Medical Records and scrolling down to find Manage your electronic sharing settings."[62]

RESOURCE AND PARTNERSHIP POSSIBILITIES

- Veterans Integrated Service Network (VISN) 2
- North Carolina VA Medical Centers
- NC Health Information Exchange Authority
- North Carolina Healthcare Association

Capturing Veteran Status in Community Care: A Gateway to Research and Analytics

The gap in data on Veteran status of patients in non-VA health care settings has consequences that extend well beyond individual encounters by foreclosing entire lines of research and analytics that depend on being able to identify who is a Veteran in patient populations.

Why the Missing Field Matters

Research from the United Kingdom's National Health Service illustrates this problem. Investigators developing the Military Service Identification Tool found a similar gap in their health records, noting that it "prohibits an evaluation of the healthcare needs of those who have served in the Armed Forces".[63] A related feasibility study involved painstakingly mining free-text clinical notes with keyword searches just to identify a probable Veteran cohort, verifying only 693 of 1,600 flagged records after manual review—a resource-intensive workaround that a structured data field would make unnecessary.[64] This dynamic means that Veterans who rely partly or fully on community providers are effectively invisible to researchers interested in investigating care quality and outcomes for this population that carries elevated risks of post-traumatic stress disorder (PTSD), traumatic brain injury, substance use disorders, and toxic-exposure-related illness, among other conditions.

Research and Analytics Opportunities that Data on Veteran Status Would Unlock

If community providers reliably captured Veteran status, several categories of work become possible that are largely closed off today:

- **Population health surveillance:** Aggregated, de-identified data would let researchers estimate the true size and health profile of the Veteran population in community-based health care settings, most of whom fall outside VA administrative data today.
- **Comparative outcomes research:** Identifiable Veteran records in community-based systems make it possible to compare Veterans against non-Veterans, and Veterans in VHA care against Veterans in community care, on shared clinical measures — the kind of comparison the UK researchers noted would let investigators study differences in "demographic characteristics, physical and mental health outcomes, and healthcare utilization" between those with and without military service.[63]
- **Risk stratification and predictive analytics:** The VA has already used its own EHR data with machine learning to flag Veterans at elevated suicide risk with the REACH VET early-identification program.[65] Extending structured Veteran-status data into community EHRs would allow similar risk models to reach Veterans who do not receive their health care through the VA.
- **Exposure and condition-specific registries:** Toxic-exposure screening under the PACT Act has already identified potential exposures in about 42% of Veterans screened within VA. Collection of Veteran status in community-based settings would support similar registries and follow-up research for Veterans.[66]

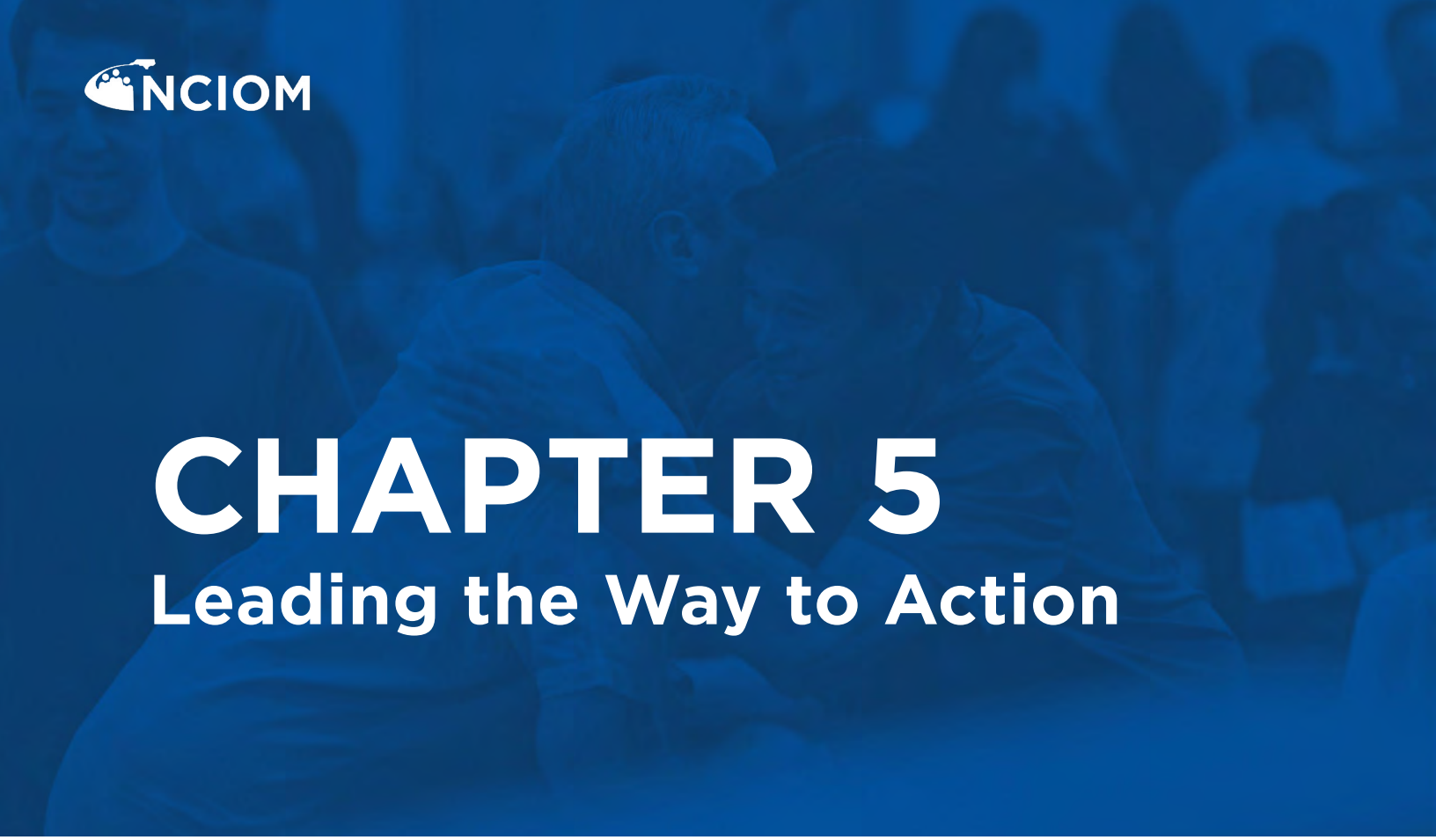
- **Cohort recruitment and generalizability checks:** Structured identifiers make it far easier to recruit Veterans into studies and to check whether findings from VA-based research—which reflects only Veterans who chose to enroll in VA care—generalize to the broader Veteran population, an open methodological concern that VA researchers themselves have flagged.
- **Encouragement for provider training:** As health care providers become more familiar with the number of Veterans they are serving, they may become more likely to seek out training on Veteran culture and service-connected health issues.

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CHAPTER 5
Leading the Way to Action

The recommended actions discussed in the preceding chapters will require steady, ongoing attention from people with authority to act long after the momentum of a single report has faded. That is the challenge addressed in this final chapter. Attention from the right organizations and people, sustained over time, is what can turn a set of findings into lasting improvement. The recommendations in this chapter are therefore less about specifying what to do than about ensuring there is accountability among those responsible for taking action. The recommendations call for activities and structures that keep these issues in front of decision-makers on an ongoing basis, so that the work of improving community-based care for Veterans remains a priority.

Veteran Representation in State-Level Policy

North Carolina General Assembly House Committee on Homeland Security and Military and Veterans Affairs

This is a House Standing Committee that has no specific charter, but reviews legislation that relates to military and Veteran issues in North Carolina. As of Summer 2026, there are three chairs of the committee (Representatives Edward C. Goodwin, Donnie Loftis, and Joseph Pike), a Vice Chair (Rep. Allen Chesser), and 17 additional members.[1] The bills discussed during committee meetings in 2025-26 are as follows (in chronological order of committee discussion) and include bills that may or may not have been passed:

- HB 28 – Gun Violence Prevention Act[2]
- HB 35 – Establish Military Appreciation Month[2]
- HB 69 – Veterans Educational Promise Act[2]
- HB 91 – Define Armed Forces/Conforming Changes[2]
- HB 118 – Disabled Veterans Tax Relief Bill[3]
- HB 94 – Disabled Veteran Homestead Exclusion Prequalification[3]
- HB 213 – Post NC Veterans' Benefits[3]
- HB 110 – National Guard Student Loan Repayment Program[4,5]
- HB 254 – Adopt Tuskegee Airmen Day[4]
- HB 266 – Adopt Women Veterans Day[4]
- HB 300 – Vet Care for Retired First Responder Dogs[4]
- HB 133 – NC Farmland and Military Protection Act[6]
- HB 384 – NCNG Tax Deduction for Federal Pay[6]
- HB 373 – UNC Tuition Discounts for Certain Students[6]
- HB 572 – Veterans/eTMS Pilot Program[6]
- HB 741 – Veterans Registration Plate Modifications[7]
- HB 114 – Employment Preference for Military Personnel[7]
- HB 615 – Enrollment Stability for Military Students[7]
- HB 703 – Memorials in Veterans Cemeteries[7]
- HB 57 – Adopt State Veterans Museum[5]
- HB 146 – Remote License Renewal/Active Duty Military[5]
- SB 394 – Prohibit Foreign Ownership of NC Land[8]

The North Carolina Senate does not have a committee dedicated to discussing issues and legislation related to military or Veteran affairs.

Other State Government Entities Responsible for Veterans

North Carolina Department of Military and Veteran Affairs (NCDMVA)

As discussed in Chapter 2, the NCDMVA is a state agency designed to build and maintain the relationship between North Carolina and its military and Veteran families and military installations. NCDMVA is charged with a large range of tasks related to military, transitions, and Veteran services, yet has the smallest budget and smallest staff of all cabinet-level agencies.

North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS)

DMH/DD/SUS is responsive to North Carolina's Veteran needs through funding and partnership support for a variety of Veteran services, including the Governor's Institute, NCServes, and MilVet Academy and has one Veterans Services Coordinator on staff. The Division also provided substantial funding to support the work of the NCIOM Task Force on Veterans' Health due to their strong interest in the mental health needs of North Carolina's Veterans.

Several of the recommendations from the task force align with the DMH/DD/SUS strategic plan for 2024-2029, including the following:

- **Goal 1.1 – Increase Treatment Initiation and Retention.** Make it easier for children, adolescents, and adults of all ages to access evidence-based services in a timely manner and stay in services for the recommended duration of treatment.
- **Goal 3.2 – Increase Access to Evidence Based Substance Use Disorder (SUD) Treatment.** Increase timely access to SUD services, especially for geographies and populations with low penetration rates.
- **Goal 4.3 – Increase Licensed Providers.** Increase the number of licensed providers entering the public workforce.
- **Goal 5.1 – Connect to Crisis Care.** Connect individuals to appropriate crisis services and facilitate seamless handoffs.
- **Goal 6.1 – Increase Engagement in Deflection and Diversion Programs.** Increase linkages for people with mental health needs, SUD, intellection and developmental disorders, or TBI to evidence-based care and services to provide an alternative to incarceration.
- **Goal 6.2 – Increase Successful Community Re-engagement.** Ensure successful community re-entry of justice-involved individuals with a broad range of needs.[9]

Previous NCIOM Report

The North Carolina Institute of Medicine published a report from the Task Force on Behavioral Health Services for the Military and Their Families in January 2011. The report reflected similar themes as were produced by the Task Force on Veterans' Health, including the need to train clinicians and community members in military and Veteran culture and military-connected conditions and the need to identify and serve the needs of military-connected children.[10] While some of the recommendations were implemented, there has not been long-lasting sustainability. For example, the Citizen Soldier Project successfully trained thousands of health care providers across the country, but funding for North Carolina's program was discontinued and there is no longer any unified effort for this type of training in the state. Lack of sustainability may be related to changes in leadership within the organizations and entities responsible for implementation of the 2011 task force recommendations. Also, no single entity was tasked with ongoing monitoring and advocacy for the 2011 recommendations.

While several state-level entities do important work to serve the needs of Veterans, they are currently either overburdened or not the appropriate fit for ongoing oversight of implementation of the task force recommendations. Having a strong organizational interest in monitoring the

recommendations may go a long way in their implementation and maintenance of those efforts. To begin that effort, it would be useful to bring broader public attention and interest to the needs of Veterans receiving care in community-based settings. For these reasons, the task force makes the following recommendation:

RECOMMENDATION 8:

Activate new and ongoing attention to the health needs of Veterans

Strategy 8.1: Generate attention to Veterans' health

Strategy 8.2: Identify and sustain a lead organization to facilitate ongoing action

Strategy 8.1: Generate attention to Veterans' health

The North Carolina Governor should sign a Proclamation or Executive Order calling attention to the mental and physical health needs of North Carolina Veterans, their families, and caregivers, noting specific actions that can be taken beginning at the state level.

Desired Result

Elevate statewide attention to the mental and physical health needs of North Carolina Veterans, their families, and caregivers.

Potential Measures of Success

- Issuance of a Proclamation or Executive Order by the Governor (yes/no)
- Level of media coverage generated by the Proclamation/Executive Order
- Public awareness of Veteran health needs following the announcement (survey-based)
- Number of legislative or agency initiatives introduced or accelerated as a result of the Proclamation/Executive Order

Executive Action to Elevate Veterans' Health

Governors possess two complementary tools for directing public attention toward pressing issues: executive orders, which carry the force of directive authority over state agencies and can compel concrete action, and proclamations, which are largely symbolic declarations—such as designating a day, week, or month—intended to raise public awareness and signal that the state attaches importance to a cause. Nearly every state, including North Carolina, uses proclamations for this latter purpose, and they are generally reserved for issues of statewide significance affecting a broad population.

Research on the effectiveness of these symbolic actions has found that strategies such as health awareness days, weeks, and months can increase online activity.[11] Related work using internet search data has similarly shown that awareness months for conditions such as autism, breast cancer, and colorectal and prostate cancer produced significant, measurable increases in public search interest.[12–14] Awareness alone is typically only the first step in a longer change process, but it offers a low-cost mechanism for elevating public and institutional attention, generating media coverage, and signaling a state-level priority, laying groundwork that can be reinforced by the more substantive recommendations in this report.

Ask Me NC Campaign Proclamation

Governor Josh Stein has taken several official actions to promote Veteran and military issues. On November 5, 2025, Governor Stein made a proclamation to bring awareness to the start of the Ask Me NC campaign (see more details about Ask Me NC in Chapter 2). The proclamation noted the size of North Carolina's Veteran, active-duty, National Guard, and Reserve populations, the large number of military installations in the state, the prevalence of Veteran suicide, and the opportunity that Ask Ne NC provided to be "a call to action and a vital step toward saving lives, strengthening communities, and honoring the service of our military-connected residents."[15]

"Do Your Part" Initiative

On August 6, 2025, Governor Stein signed on to the Blue Star Families' "Do Your Part" Initiative. The initiative intends to help states "identify, prioritize, and implement the most effective policies and programs to support military families".[16] The national initiative has produced a state toolkit that provides resources to:

- "Understand your state's current policy landscape at a glance.
- Identify high-impact opportunities that are feasible to implement.
- Use real data and examples to inform discussions with governors, legislators, and partners."[17]

North Carolina Executive Order 38: Strengthening North Carolina Military Communities

On May 27, 2026, Governor Stein signed an Executive Order that called for the following actions related to communities around North Carolina's military installations:

1. **Designating Military Affairs Coordinators –** mandated that the Secretaries of each Cabinet agency, and requested that the Head of each Council of State agency, designate a Military Affairs Coordinator
2. **Improving Services for Military Communities –** called on the North Carolina Department of Military and Veterans Affairs (NCDMVA) to convene the designated Military Affairs Coordinators to develop strategies to support military communities
3. **Bolstering Coordination with Military Communities –** called on Cabinet agencies to coordinate with NCDMVA to coordinate communication with military communities about activities that may impact them
4. **Updating Reporting –** called on Cabinet agencies to collaborate with NCDMVA and others to produce an updated report on Military Economic Impact on North Carolina[18]

Strategy 8.2: Identify lead organization to facilitate ongoing action

The organization that is identified to sustain the University of North Carolina Healthy Vets Community Project's work should lead ongoing coordination and track progress of the NCIOM Task Force on Veterans' Health recommendations.

Desired Result

Ensure sustained, accountable follow-through on efforts to improve the health and well-being of North Carolina Veterans, their families, and caregivers.

Potential Measures of Success

- Identification and designation of a lead organization(s) (yes/no)
- Development of a system or process for tracking progress on task force recommendations
- Number/percentage of recommendations showing documented progress or completion over time
- Overall rate of implementation across all task force strategies as tracked by the lead organization

Arizona's Be Connected

> **"We work with people, helpers, organizations, communities and systems to foster collaboration and align Arizona's military and veteran-supportive community across important initiatives designed to ensure that service members, veterans and their families receive the support they need to thrive."**
>
> *–Be Connected. About. Accessed July 15, 2026. https://connectveterans.org/about/*

Coordinated by Arizona Coalition for Military Families, Be Connected provides organizational leadership in Arizona to "cultivate and engage an ever-expanding community of people and organizations to strengthen how [they] collectively care for, serve, support, employ, educate, and assist service members, veterans, and their families." Their programming includes:

- An Annual Statewide Symposium that "brings together the military, government, and community to strengthen services and support for Arizona's **500,000+** service members, veterans, and their families."
- A free support line to identify resources to meet a variety of needs.
- Webinars, panel discussions, and free trainings that include topics of suicide intervention, military culture, and mental health first aid.
- A faith-based community network that provides members with resources and training.

- A community-based helper network that offers training and volunteer opportunities.
- Summits with focuses such as mental health and faith.[19]

Be Connected also conducts a biennial survey of Arizona's Veteran population to "gain insight into the needs of Arizona's military and veteran population to continue to assess interventions and improve the care and resources available."[20] The survey assesses Veteran demographics, basic needs, employment, family and social supports, finances and benefits, higher education, housing and homelessness, legal issues, mental health, substance use, physical health, spirituality, and community helpers.

Be Connected was inspired and informed in part by work that was happening in North Carolina at the time of its development. Many of the activities the network engages in are activities that North Carolina organizations are already engaging in, however there is not one coordinating agency for North Carolina. It is worth noting that Be Connected operates with a degree of independence that can insulate it from shifts in Arizona's political leadership. A report on the work of Be Connected made the following recommendations to other states:

"The Be Connected program in Arizona is unlike any other suicide prevention effort among the military and veteran community in the country. The novel approach of an upstream intervention model is intriguing to many and there is much interest in scaling up this approach to be implemented in other states. Initial results are promising and have identified several factors that may be key to successful implementation of a statewide collaborative effort and replication. However, continuing evaluation of the Be Connected program is needed to draw conclusions about what makes Be Connected a success. Additionally, the complexities of each state and their individual populations must be considered. Some key recommendations have 18 been developed to initiate the implementation of suicide prevention programs similar to Be Connected in other states.

1. Create or identify an organization for state military and veteran communities
2. Invite all stakeholders to the table.
3. Provide interventions that address all social determinants of health.
4. Begin data collection efforts early."[21]

Sustaining Attention to Task Force Recommendations

As discussed in Chapter 2, the Healthy Vets Community Project, based at the University of North Carolina (UNC) at Chapel Hill Gillings School of Global Public Health, is a statewide initiative dedicated to engaging communities to improve the conditions that shape Veteran wellness. The project's approach extends beyond individual health care encounters to address the social, economic, and institutional conditions that either support or undermine Veterans' ability to thrive where they live, work, and age.[12]

As of the publication of this report, UNC Healthy Vets Community Project leadership is in discussion with stakeholders in Veterans' well-being, services, and supports to identify an organizational lead to sustain project activities. Sustainability will require ongoing engagement of partners across a variety of sectors, similar to those called on in the task force recommendations contained in this report. With that in mind, the selected organizational home for the UNC Health Vets Community Project could also serve as a natural lead entity to monitor recommendation implementation and to spark renewed attention when needed.

Federal Actions Needed for Improved Veteran, Family, and Caregiver Health

While the preceding chapters of this report focus on opportunities to advance Veteran health that are within the purview of state-level authority or stakeholder action, several of the barriers identified by the task force sit outside that authority entirely. Veterans' health care is anchored in the federal system managed by the Department of Veterans Affairs (VA) eligibility rules, community care authorizations, reimbursement methodology, graduate medical education funding, transition-of-care policy between the Department of Defense and VA, caregiver program design, and the regulations governing care for incarcerated Veterans are all established, funded, and administered at the federal level under Title 38 and related statutes. No amount of state investment or policy innovation can address system-level challenges that are under the authority of the VA or Congress. The task force therefore also identified a set of federal actions that it believes would help to more fully address the gaps Veterans and their families and caregivers face. The task force encourages the North Carolina Congressional delegation and other state leaders to advocate for consideration of these issues and opportunities for policy change at the federal level.

1. **Expand Veteran access to dental care and include dental services in the VA's extended authorizations for community care.** Veteran eligibility for dental care through the VA is defined entirely by federal statute and VA regulation. Only about 21% of Veterans enrolled in VA health care are eligible for dental services.[22] VA has solicited a new national contract intended to standardize and expand general, specialty, and preventive dental services delivered through community providers, but this addresses only how care is delivered, not who qualifies.[23] Expanding the number of Veterans who are eligible for dental benefits would require congressional action, such as the proposed Dental Care for Veterans Act, which envisions a four-year phased rollout.[24] An additional policy change that could streamline Veteran access to dental care is the addition of dental services to the list of 30 types of care that were authorized for a full year of treatment beginning in 2025.[25] See Page 97 - 98 in Chapter 3 for additional context.

2. **Allow for higher reimbursement of providers who participate in VA Community Care in areas with a health professional shortage or other access gap.** VA's community care reimbursement structure is governed by federal rulemaking. VA applies reimbursement based on a methodology built from VA claims data, Medicare and Medicaid fee schedules, TRICARE rates, and national benchmarking data, without a built-in adjustment for provider shortage areas.[26] Such an adjustment could act as an incentive to providers in areas where access to VA Community Care could be improved with a wider network of enrolled providers. See Page 107 - 111 in Chapter 3 for additional context.

3. **Continue to improve processes related to VA community care.**
   If reliance on VA community care continues to grow as it has in recent years, improvements in administrative processes could encourage more community-based providers to participate and enhance coordination of care. Administrative challenges can sometimes discourage community providers from contracting with VA community care and can impact Veteran experiences of care. Government Accountability Office (GAO) reviews have identified improvements implemented by the VA based on previous recommendations and continued areas of need.[27] Implementation of GAO recommendations related to provider network, scheduling systems, care coordination, and provider training on caring for military-connected patients would improve Veteran access to care. See Page 113 - 114 in Chapter 3 for additional context.

4. **Create a formal system for seamless continuation of medical and caregiver services during the transition from military to civilian status.**
   The transition from active duty to Veteran status is governed almost entirely by Department of Defense (DoD) and VA policy, not by any state health system. Federal oversight has found real gaps: service members separating due to injury or disability may need a "warm handoff" directly to VA for continuing care, but many who should receive one do not, and DoD does not reliably verify that these warm handoffs even occur or assess whether they are helpful.[28] Where the two departments have built true continuity, the results are notable. At the jointly operated Lovell Federal Health Care Center in Chicago, there is a shared electronic health record that allows information generated under DoD care to flow immediately to VA clinicians.[29] This has reduced duplication and delays, which matters especially for conditions like traumatic brain injury that can present with delayed symptoms.[29] In addition, programs such as the Onward Ops Expiration Term of Service Sponsorship Program (ETS-SP) are helping to ensure that service members' care is safely transitioned and tailored to their unique needs before they leave active duty. See Page 29-30, 55-56, and 59-60 in Chapter 2 for additional context.

5. **Enhance support for families and caregivers of Veterans through catastrophic injury transitions.**
   Support for families and caregivers of catastrophically injured Veterans is delivered through a federal caregiver benefit whose eligibility rules, stipend levels, and scope are set by federal statute. The Program of Comprehensive Assistance for Family Caregivers (PCAFC) was created by the Caregivers and Veterans Omnibus Health Services Act of 2010, and the VA MISSION Act of 2018 later expanded eligibility in phases to caregivers of Veterans injured before September 11, 2001, while adding new benefits such as financial planning services.[30] Advocates and lawmakers continue to push federal fixes for gaps in the program. For example, the proposed RESPECT Act would revise PCAFC's evaluation process for Veterans with mental health conditions or brain injuries, including a longer records look-back period and a duty for VA to help gather supporting documentation.[31] See Page 61-63 in Chapter 2 for additional context.

6. **Remove regulatory barriers preventing VA care for incarcerated Veterans.**
   Incarcerated Veterans do not lose their underlying eligibility for VA health care, but a federal regulation implemented in 1999

bars the VA from providing hospital and outpatient care to a Veteran held in another government agency's institution when that agency already carries a duty to provide the care.[32] The case for changing this policy rests on several grounds. First, VA offers clinical expertise that general correctional health systems typically lack, particularly in combat-related mental health conditions, military sexual trauma, and other service-specific concerns. Advocates have testified to Congress that access to VA mental health care can be lifesaving for justice-involved Veterans.[33] Second, research on formerly incarcerated Veterans has found that losing continuity with VA and being forced to rebuild a treatment relationship and health history from scratch actively discourages Veterans from engaging in care at all.[34] Finally, this is an active area of federal policy attention, with members of Congress and Veteran legal advocates recently pushing for legislative fixes, including proposals to allow incarcerated veterans access to VA behavioral health care via telehealth, alongside continued federal investment in Veterans treatment courts.[33] See Page 101-106 in Chapter 3 for additional context.

7. **Enhance VA caregiver supports to provide ongoing navigator services that can help monitor individual needs and counsel on available supports.**
The VA's Caregiver Support Program uses a primary point of contact at each VA medical center called a Caregiver Support Coordinator who helps a caregiver enroll and points them toward available services. However, the success of ongoing case management depends on federal staffing levels and program design. VA's Office of the Inspector General (OIG) has found that coordinators' caseloads and workloads vary widely by facility.[35] The OIG also found that Veteran health status was not consistently documented or monitored for changes between required reassessments.[35] Recommendations for improvement included building a well-defined process for tracking those changes so that shifts in a Veteran's needs are caught and acted on rather than surfacing only at the next scheduled review. See Page 61-63 in Chapter 2 for additional context.

Conclusion

North Carolina's more than 615,000 Veterans have *earned* a system of care that meets them where they live, understands what their service has asked of them, and helps them navigate a path to well-being that is too often complex and disjointed. As community-based care has grown from a supplement to a substantial share of how Veterans receive treatment, so too has the responsibility of the state, health systems, and community providers to ensure that this care is accessible, culturally informed, and consistently high-quality for every Veteran. The stakes of getting this right are made clear by the disproportionate rates of suicide, toxic exposure, and untreated mental and physical health conditions that Veterans carry, and by the families and caregivers who share in these burdens. The recommendations from the NCIOM Task Force on Veterans' Health that were presented in this report offer a practical and evidence-informed roadmap for this work, but a roadmap alone cannot close these gaps. Sustained commitment from state leaders, health care organizations, and communities across North Carolina is needed to ensure that those who have served receive the coordinated, competent, and compassionate care they deserve.

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Appendix A: All Recommendations

Recommendation 1: Enhance access to available services and support through more robust engagement with Veterans, their families, and caregivers

Strategy 1.1: Increase funding to support Veterans' access to the services they are eligible for

The North Carolina General Assembly should support Veterans' health by increasing funding to the following cabinet agencies for these specific purposes:

A) The North Carolina Department of Military and Veteran Affairs (NCDMVA) to hire additional Veteran Service Officers (VSOs), enhance training opportunities for all VSOs, and support engagement activities with transitioning service members, Veterans, and their families.

B) The North Carolina Department of Administration (NCDOA) to establish a permanent Tribal Veterans Services funding allocation for federally recognized tribes. Funding should support transportation assistance, disability claims clinics, outreach events, Veteran engagement initiatives, cultural programming, digital access, and other services designed to overcome the geographic and systemic barriers faced by Tribal and rural Veterans.

C) The North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS) to market the Ask Me NC campaign, increase public awareness about where Veterans can connect to mental health services, and reduce mental health stigma among Veterans with the support of NCDMVA, NCServes, Veterans Bridge Home, and Veteran Services of the Carolinas.

Strategy 1.2: Increase community identification of Veterans

County and local elected officials and local leaders should integrate the Ask Me NC campaign into common points for community member interaction and display information about where Veterans, their families, and caregivers can access resources.

Strategy 1.3: Develop community-based engagement strategies to connect with Veterans

The organization that is identified to sustain the University of North Carolina Healthy Vets Community Project's work should create a Veteran-healthy community and organization designation, and partner with the Department of Military and Veteran Affairs, the North Carolina Association of County Commissioners, AARP NC, the Division of Mental Health, Developmental Disabilities, and Substance Use Services, and non-profit Veteran-serving organizations and advocacy groups to:

A) Publicize and distribute the UNC Healthy Vets Project community guide and other tools,

B) Identify strategies for communities to allocate or access financial, human, and in-kind resources to implement Veteran-healthy community development activities, and

C) Distribute available information and resources for trainings and strategies that address lethal means safety to reduce Veteran suicide.

Strategy 1.4: Maintain Veterans Benefit Live events

State Veteran service organizations and federal VA partners should ensure that Veteran Benefits Live events continue to occur across the state with VA disability and compensation raters in attendance.

Strategy 1.5: End predatory Veteran claims services

State regulators and the General Assembly should implement strong policies that protect Veterans from predatory claims services that charge high fees to submit claims for Veteran benefits. An initial step in this work can include a repeal or correction of Session Law 2025-72, Section 4, which created a framework for for-profit claims consulting companies to charge steep fees.

Recommendation 2: Increase Veteran family and caregiver awareness of available services and programs

Strategy 2.1: Create a family transition navigator program

Responsible entities can improve Veteran family transition experience through the following actions:

A) Statewide Veterans service organizations and North Carolina Department of Military and Veterans Affairs (NCDMVA) should work together to identify a host organization and funding to support a Veteran family mentor support program, or "transition navigators", for family members of military service members who are transitioning to civilian life.

B) The identified host organization should pilot a Family Transition Navigator Program modeled on sponsor- and peer-transition programs, beginning 12–24 months before separation and continuing for 12 months post-transition. The program should serve spouses, caregivers, and dependent children and be promoted through a variety of mechanisms to reach the intended audience.

Strategy 2.2: Improve Veteran caregiver access to information and resources related to available benefits and services

Several responsible entities can improve Veteran caregiver access to information about available benefits and services through the following actions:

A) Representatives of websites like Ask Me NC, NCServes, and the NC Caregiver Portal should ensure that there are resource lists for families and caregivers of Veterans, that they are easy to find and navigate, and that there is regular maintenance of resources on these sites.

B) The North Carolina Department of Military and Veterans Affairs (NCDMVA) should increase Veteran Service Officer (VSO) awareness of caregiver needs, available benefits and services, and VSO ability to refer to existing benefits and services.

C) NCDMVA, in coordination with stakeholder organizations such as the Elizabeth Dole Foundation, AARP NC, and the Division of Aging, the Department of Public Instruction, and health professional organizations, and with coordinated financial support, should host a virtual

annual Veteran caregiver summit to help caregivers connect with each other, share resources, and learn about available support networks, benefits, and services.

D) Administrators of Veterans Directed Care programs should provide templates and tools for families to use to manage funds and administrative tasks for Veteran care through the program (e.g., budgeting and time sheet templates).

Strategy 2.3: Increase research into Veteran caregiver needs

The Veteran Research Engagement Panel (VetREP) should encourage research into strategies to improve caregiver access and awareness of services and programs and experience navigating those services and programs.

Recommendation 3: Help the children of Veterans access the supportive services they may need

Strategy 3.1: Enhance the capacity of schools to identify and meet the needs of the children of Veterans

Several responsible entities can improve awareness of possible mental health and social needs of the children of Veterans and available resources through the following actions:

A) All local educational agencies should collect a Veteran Student Identifier for children in North Carolina public schools, similar to existing Military Student Identifier, by asking, "Is the student a dependent of a service member, Veteran, or retiree of the US Armed Forces (including National Guard or Reserve forces) of the Army, Navy, Air Force, Marine Corps, Space Force, or Coast Guard?"

B) Local educational agencies or individual schools should participate in the Purple Star Program to learn more about how to support military and veteran-connected children, or if already participating, should implement strategies to increase parent and family awareness of the program, its purpose, and activities.

C) Veteran student associations and student organizations related to school psychology, counseling, social work, school nursing, and teaching at North Carolina institutions of higher education should partner to provide educational opportunities for future professionals that will work with military- and Veteran-connected children to learn about their unique needs and available resources.

Strategy 3.2: Develop Veteran child peer buddy program

Partners such as the North Carolina Department of Military and Veterans Affairs, the North Carolina Department of Health and Human Services (NCDHHS) Division of Mental Health, Developmental Disabilities, and Substance Use Services, the Department of Public Instruction, and other groups connected to military and Veteran children should collaborate to identify an entity (e.g., NC Child) to develop and host a statewide Veteran child peer buddy program to provide mentorship and peer support.

Recommendation 4: Improve Veteran access to health care providers, services, and programs to meet their mental and physical health needs and eligibility status

Strategy 4.1: Host an annual Veteran health information summit

The North Carolina Department of Military and Veterans Affairs, with dedicated financial support, should increase knowledge and connections between Veteran health stakeholders, such as Veterans Integrated Service Network (VISN) 2, County veteran service officers, Affordable Care Act Marketplace Navigators, State Health Insurance Information Programs, and others, by hosting a virtual annual Veteran health information summit.

Strategy 4.2: Increase Veteran access to health services, particularly in rural areas

The NCIOM Task Force on Veterans' Health endorses the following actions to increase access to health care services by addressing certain limitations on the health care workforce:

A) The North Carolina General Assembly should consider granting full practice authority for Advanced Practice Registered Nurses.

B) The North Carolina Medical Board, health systems, rural practices, community clinics, and VA Community Care network participants should collaborate to develop clear implementation guidance and workforce policies that enable qualified Physician Assistants to register and practice in team-based settings.

C) Implementation of Strategy 21 from the NCIOM Task Force on Oral Health to expand scope of practice for dental hygienists and dental assistants.

(Further context – NCIOM Task Force on Oral Health Strategy 21 text that will be listed in written context for this recommendation:

Recommendation 8: Expand scope of practice for dental hygienists and dental assistants to increase clinical impact, effectiveness, and efficiency.

Strategy 21: The North Carolina Dental Society, North Carolina Oral Health Collaborative, the North Carolina Dental Hygienists' Association, the North Carolina Dental Assistant Educators' Association, and the North Carolina Dental Assisting Association should partner to convene a group to examine scope of practice for dental hygienists and assistants by:

a. Engaging dental hygienists and assistants to better understand professional needs and motivations.

b. Conducting research to analyze regulation, supervision, and scope of practice for dental hygienists and assistants by state.

c. Ensuring expanded dental hygienist and assistant representation on the North Carolina Dental Society Council for Prevention in Oral Health.)

Strategy 4.3: Assist justice-involved Veterans in accessing available health-related services

Several responsible entities can improve access to information and resources for justice-involved Veterans through the following actions:

A) Veteran groups should engage with justice-involved Veterans in jails and prisons to create community and help to inform them of services available post-release.

B) North Carolina Department of Military and Veteran Affairs (NC DMVA) regional managers should meet on a quarterly basis with local reentry councils within their region of responsibility to provide updates on resources available to Veterans they may encounter.

C) The North Carolina Administrative Office of the Courts (NCAOC) should improve identification of Veterans by phrasing questions about Veteran status to ask if individuals have ever served in the military.

D) The North Carolina Judicial Branch, NCAOC, and NCDMVA should collaborate to track aggregate data on the distribution of justice-involved Veterans in North Carolina to understand where increased access to Veteran Treatment Courts may be needed.

E) Veteran service officers (VSOs) who serve geographic areas supported by Veteran treatment courts should collaborate with program directors to assist with coordination of services for program participants and with NCServes staff to ensure Veterans are connected to resources to meet their health-related social needs.

Recommendation 5: Enhance the network of health care providers in community-based health care settings that are available to Veterans

Strategy 5.1: Analyze the network of community-based providers available to Veterans

The University of North Carolina at Chapel Hill Gillings School of Global Public Health should convene relevant partners to develop a plan and organizational roles for conducting regularly updated gap analyses of where Veterans are able to receive care in community-based settings. This work should inform efforts to improve network adequacy. Analyses should consider:

- Provider networks for common Veteran payers (i.e., VA Community Care and TRICARE),
- Health professional shortage areas in the state,
- Veteran population in the state, and
- Interaction with upstream factors of Veteran health and well-being.

Strategy 5.2: Improve the capacity of smaller health care practices to serve Veterans

North Carolina Area Health Education Center's Practice Support Program, with increased financial resources from the North Carolina General Assembly and/or additional grant funding, and in partnership with Veterans Integrated Service Networks (VISN) 2, should help smaller practices serve Veterans by:

A) Providing information and assistance to providers interested in being part of the Department of Veterans Affairs (VA) Community Care and/or TRICARE networks.

B) Supporting health care providers with connection to the VA's External Provider Scheduling system.

C) Integrating questions about Veteran status and clinical guidelines for additional questions about possible toxic exposures, mental health status, and other military-connected conditions.

D) Assisting community primary care practices with implementation and standardization of clinical and administrative workflows and optimization of health information technology and billing/coding in support of care delivery to Veterans.

Strategy 5.3: Engage the Rural Health Transformation grant to improve access to care for Veterans

Rural Health Transformation grant Rural Organizations Orchestrating Transformation for Sustainability (ROOTS) Hubs should help to improve access to care for Veterans by:

A) Ensuring there is Veteran representation on advisory councils guiding grant activities and Veteran support networks (e.g., NCServes and Veterans Bridge Home) are included in service integration efforts.

B) Using grant funds to allow federally qualified health centers (FQHCs) to participate in Veteran cultural awareness trainings and integrate clinical guidelines for questions about possible toxic exposures, mental health status, and other military-connected conditions.

C) Using grant funds to provide technical assistance to rural community-based practices that want to enroll in the Department of Veterans Affairs (VA) Community Care Network and the External Provider Scheduling system.

Recommendation 6: Improve community-based health care provider knowledge about Veteran culture and military-connected conditions

Strategy 6.1: Increase the number of Veterans in the health care workforce

Responsible entities can increase the number of Veterans who pursue careers in health care through the following actions:

A) North Carolina health professional training programs for mental health, social work, nursing, physician associate/assistant, and similar roles should develop competency-based, accelerated health professional training programs that recognize prior medic/corpsman and military mental health experience to encourage more Veterans to join the health care workforce. Programs should use the University of North Carolina (UNC) Military Equivalency System to identify coursework equivalencies in all areas of study.

B) The UNC and North Carolina Community Colleges Systems should encourage Veterans to enter health care professions and increase awareness of training opportunities through partnerships with educational institutions that have training programs catered to Veterans and military instillations in the state.

Strategy 6.2: Educate community-based health care providers about the unique mental and physical health needs of Veterans and the social factors that can affect their health

Responsible entities can increase the number of health care providers, including physicians, nurses, and social workers, who are trained in Veteran culture and military-connected conditions through the following actions:

A) North Carolina Area Health Education Centers (NC AHEC), the Governor's Institute, and Ask Me NC should partner to publicize, host, and/or disseminate existing continuing education trainings, webinars, Veterans Administration/Department of Defense Clinical Practice guidelines, and pocket guides for community-based health care providers to learn best practices in care for Veterans.

B) NC DMVA should facilitate collaboration between key Veteran organizations and North Carolina health care trade and professional associations to bring awareness about the unique health-related needs of Veterans and encourage participation in available trainings.

Strategy 6.3: Create and maintain a database of Veteran-ready health care professionals

Southern Regional and South East AHEC, with additional funding to support capacity, should facilitate a discussion with NC AHEC, the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities, and Substance Use Services, the Governor's Institute, and Ask Me NC to develop and identify a host for an online database of health care professionals that have met criteria to be considered trained on Veteran culture and physical and mental health needs. The database could begin by concentrating on specialties in mental health, behavioral health, and primary care.

Strategy 6.4: Incentivize health care providers to increase their knowledge of the unique mental and physical health needs of Veterans

North Carolina health insurance carriers and NC Medicaid should implement a recognition program for providers who engage in defined training(s) on Veteran culture and health care needs.

Strategy 6.5: Engage health care professional students in learning about the unique mental and physical health needs of Veterans

Responsible entities can increase the awareness and knowledge of students in health care professional training programs through the following actions:

A) Veteran student associations and health care professional student organizations at North Carolina institutions of higher education should partner to provide educational opportunities for health professional students to learn about the unique physical and mental health needs of Veterans.

B) A UNC system nursing, or other health professional, program should develop a pilot Veteran-centric curriculum or certificate for non-Veteran nursing students interested in this area of concentration. Based on lessons learned from the pilot, expand to a statewide model, such as a fellows program, and expand to other health professions.

Recommendation 7: Consistently identify Veterans, their families, and caregivers within health care systems to improve the care Veterans receive

Strategy 7.1: Ask patients about their military connections

All mental and physical health care providers should:

A) Implement a process to document the military-connected status of all patients by asking if they have served in the military or are family or a caregiver of someone who has, and

B) Establish supports and resources for health care professionals to use for patients who are identified as military-connected to inquire about potential military-connected health-related conditions. Practice guidelines, document in medical record.

Strategy 7.2: Establish Veteran care improvement mechanisms within hospitals and health systems

The North Carolina Healthcare Foundation, with appropriate funding secured, should serve in an advisory capacity to connect health care systems with information and resources on how to improve their ability to identify and serve Veteran patients, families, and caregivers. This could include establishing internal committees to continuously improve Veteran care, incorporate Veteran care quality into strategic planning and evaluation metrics, and promote awareness campaigns for their employees to understand available supports and services for Veterans and their families.

Strategy 7.3: Improve community-based provider access to Veteran health information

The NCIOM Task Force on Veterans' Health endorses a bidirectional exchange of Veteran health records with consent of the Veteran, pending full consideration of ethical and legal concerns. This could include VA medical centers becoming full participants in the NC Health Information Exchange.

Recommendation 8: Activate new and ongoing attention to the health needs of Veterans

Strategy 8.1: Generate attention to Veterans' health

The North Carolina Governor should sign a Proclamation or Executive Order calling attention to the mental and physical health needs of North Carolina Veterans, their families, and caregivers, noting specific actions that can be taken beginning at the state level.

Strategy 8.2: Identify and sustain a lead organization to facilitate ongoing action

The organization that is identified to sustain the University of North Carolina Healthy Vets Community Project's work should lead ongoing coordination and track progress of the NCIOM Task Force on Veterans' Health recommendations.

Appendix B: Resources

General Resources for Veterans, Families, and Caregivers

Veteran Service Officers – These specialists are equipped to assist Veterans with the full range of benefit claims and service connections.

- https://www.ncacvso.com/vso-office/

AskMeNC – This website connects Veterans to resources and functions as a digital hub and single point of entry for a wide range of services available to Veterans and their families across the state. The website also offers guidance tailored to different professional contexts like health care providers, educators, first responders, and housing workers and describes how identifying Veteran or military family status can change the support available to an individual in each setting.

- https://askmenc.org/

NCServes – A referral platform with a coordinated network of public, private, and nonprofit organizations that offer services ranging from housing and employment to mental health and legal aid for Veterans, service members, and their families.

- https://www.ncserves.org/

Veterans Bridge Home – Coordinates supports related to employment, housing, health, and recreation, among others, to help Veterans successfully reintegrate into civilian life and build a strong foundation for the future.

- https://veteransbridgehome.org/

Clinical Resources for Veteran Care

VA/DOD Clinical Practice Guidelines: Assessment and Management of Patients at Risk for Suicide – "The guideline describes the critical decision points in the management of Suicidal Risk Behavior (SRB) for suicidal self-directed violent behavior and provides clear and comprehensive evidence-based recommendations incorporating current information and practices for practitioners throughout the DOD and VA Health Care systems. The guideline is intended to improve patient outcomes and local management of patients with SRB."

- https://library.samhsa.gov/product/engaging-service-members-veterans-families-toolkit-certified-community-behavioral/pep26-01-007

Engaging Service Members, Veterans, And Families: A Toolkit for Certified Community Behavioral Health Clinics – "This toolkit is designed to provide an overview of key components of working with those who are serving or have served in any branch of the military—service members, Veterans, and families. This toolkit provides topic overviews, fact sheets, strategies, action steps, and insights from experts for everyone establishing, working for, and leading a Certified Community Behavioral Health Clinic."

- https://library.samhsa.gov/product/engaging-service-members-veterans-families-toolkit-certified-community-behavioral/pep26-01-007

Have You Ever Served in the Military?™ – This effort by the American Academy of Nursing seeks "to improve the care provided to Service Members, Veterans, and their families. This pocket card lists the most common health concerns linked to military service, as well as questions nurses and clinicians should ask the Veteran or the Veteran's family to obtain a more complete medical history".

- https://aannet.org/page/HaveYouEverServed

APA Guidelines for Psychological Practice with Military Service Members, Veterans, and Their Families – "[T]hese professional practice guidelines were developed to provide recommendations for psychologists who provide services to SMVF, recognizing that there are varying degrees to which psychologists have received training, including when and what type of training, as well as amount of practical opportunity to reach competency for different types of work."

- https://www.apa.org/about/policy/guidelines-military-service-members-veterans-families.pdf

Health Centers Serving Veterans: A Toolkit for the Veteran Community Care Program (VCCP) Administered by the U.S. Veterans Health Administration – "This toolkit is intended to provide information about Veterans, Veteran healthcare, and how health centers can provide care to Veterans through VA's Veterans Community Care Program (VCCP)."

- https://www.nachc.org/wp-content/uploads/2023/08/Toolkit.pdf

Online Brain Injury Services and Support System (OBISSS) – "A free online tool for youth and adults ages 10 and older that helps identify a person's lifetime history of brain injury and better understand the challenges that may be affecting daily life. Results can help individuals and providers connect to resources, improve communication, and plan for appropriate supports."

- https://www.online.nashia.org/surveys/?s=ELNECFTK9EKW7ALK
- State Login: North Carolina; Subscriber Code: 704

Trainings for Health Care Providers

North Carolina

Veteran Support Specialist – Hosted by the Governor's Institute, this training is intended to build military cultural competency, improve understanding of behavioral health (mental health, substance use), and improve engagement skills. A mini course is also offered to provide quick, accessible cultural competency and practical tools (e.g., identifying Veterans, connecting to resources).

- https://milvetacademy.org/mva-vss/

Cultural Competency & Clinical Trainings – Hosted by the Military & Government Counseling Association of the North Carolina Counseling Association this training helps providers improve clinical skills and increase cultural competency to care for Veterans, service members, and first responders.

- https://n2ca.memberclicks.net/mgcanc---military-and-government-counseling-association-of-north-carolina

Military Women's Health Symposium – Hosted by Southern Regional AHEC annually, the goals of the symposium are to Improve care for military women by providing information and resources on topics such as trauma-informed care, PTSD, TBI, substance use, and treatment for insomnia.

Empowering Military Children and Families Program – Hosted by Southern Regional AHEC, this training helps learners gain a deeper understanding of how military life stressors impact mental health and behavior of children.

- https://www.southernregionalahec.org/courses-and-events

We Honor Veterans Program – Hosted by the Association for Home & Hospice Care of North Carolina the training helps trainees feel knowledgeable about local resources and builds awareness of the unique needs of Veterans and ways to improve their clinical work.

- https://www.wehonorveterans.org/

National

VHA TRAIN – Offers a variety of training and education resources for community providers.

- https://department.va.gov/vha/community-care/training-and-resources/

Consortium for Defense Psychology – Provides a variety of online trainings.

- https://cdp.usuhs.edu/online-training-courses

Substance Abuse and Mental Health Services Administrations Service Members, Veterans, and their Families Technical Assistance Center – Webinars on a variety of topics are available through their YouTube channel.

- https://youtube.com/playlist?list=PLrW7xf0Csz5yYaFusrKbs2oaF83D1ivgJ&si=W_pGP0K4YXFh2UCl

Counseling on Access to Lethal Means (CALM) – Hosted by the CALM organization, this training provides a practical intervention to increase the time and distance between individuals at risk of suicide and the most common and lethal methods of suicide, particularly firearms.

- https://www.calmamerica.org/

Lethal Means Safety

CALM America – A nationally recognized organization that trains clinicians to hold collaborative conversations about safe firearm storage with at-risk individuals and their families. They also offer gatekeeper training for community members, firearms literacy training for clinicians, and community organizing to bridge the suicide prevention and firearms communities.

- https://www.calmamerica.org/

NC SAFE – This initiative provides free gun locks and safe firearm storage education materials statewide and has partnered with the NC National Guard to distribute these materials at Yellow Ribbon events.

- https://www.ncsafe.org/

Lock. Call. Live. – This Wake County media initiative, supported by Stop Soldier Suicide and local partners, directly promotes firearm safety messaging to veterans and their families.

- https://www.wake.gov/departments-government/veterans-services/lock-call-live

Centerstone virtual LM workshops – This is a mental health provider that specializes in care for military-connected individuals offers online training for mental health clinicians and collaborates with Strong Star on "Face the Fight" LMS trainings held regularly throughout the year.

UNC Suicide Prevention Institute – The Institute is implementing CALM training across clinical and non-clinical staff throughout the UNC hospital system statewide.

Fayetteville VA Medical Center – The Fayetteville VA has developed a comprehensive local model, including firearms safety teams, CALM trainings, gun cleaning mats printed with LMS information, gun lock distribution, storytelling events to build shared resilience, and a new Safeguard pilot program in Cumberland County.

The National Guard – Requires a Suicide Intervention Officer for every 50 soldiers and mandates yearly suicide prevention training with lethal means safety as a core topic.

Caregivers

VA Caregiver Support Program – This is the primary federal caregiver program, operating through two distinct tracks:

1) **Program of General Caregiver Support Services –** Available to caregivers of Veterans of any service era who are enrolled in VA health care. Provides education, skills training, peer support, and coaching.
   - https://www.caregiver.va.gov/care_caregivers.asp

2) **Program of Comprehensive Assistance for Family Caregivers –** Offers more intensive support that includes a monthly financial stipend, health care coverage through CHAMPVA, mental health counseling, and respite care. This program is for caregivers of Veterans with a service-connected disability rating of 70% or higher.
   - https://www.va.gov/family-and-caregiver-benefits/health-and-disability/comprehensive-assistance-for-family-caregivers/

Veteran Directed Care (VDC) – This program offers a distinct and flexible alternative for Veterans who need nursing home-level care but wish to remain in their homes and communities. Through a partnership between the VA and local Aging and Disability Network Agencies VDC provides enrolled Veterans with a flexible monthly budget they can use to hire the caregivers of their choosing, including family members, friends, and neighbors. Veterans work with person-centered counselors to develop and manage their care plan, with financial management services handling payment logistics.

- https://www.va.gov/geriatrics/pages/Veteran-Directed_Care.asp

Home Modification

Specially Adapted Housing (SAH) grant – offers up to $126,526 for Veterans with significant disabilities

Special Housing Adaptation (SHA) – offers up to $25,350

Temporary Residence Adaptation – for those temporarily residing in a home owned by a family member; up to $50,961 for SAH, $9,100 for SHA

- https://www.va.gov/housing-assistance/disability-housing-grants/

Veteran Readiness and Employment Independent Living – grants for those unable to work due to service-connected disabilities

- https://www.va.gov/careers-employment/vocational-rehabilitation/programs/independent-living/

Home Improvements and Structural Alterations program – between $2,000 and $6,800 for more modest home modifications

- https://www.va.gov/fayetteville-coastal-health-care/programs/home-improvementsstructural-alterations-hisa/

AARP Veterans and Military Families Home Modification Benefits Guide

- https://www.aarp.org/content/dam/aarp/home-and-family/voices/veterans/2024/vmf-homefit-benefits-guide.pdf

Appendix C: Potential Measures of Success

Evaluation measures help clarify the intended impact of a policy or practice change and how that impact will be tracked. The measures below are suggestions for assessing the strategies in this report, however this list is not exhaustive. Selection of evaluation measures should consider data availability, collection methods, intended use of the information, cost, and other factors beyond the scope of this report.

Strategy 1.1: Increase funding to support Veterans' access to the services they are eligible for

Funding for NCDMVA – Veteran Service Officers

- Number of new Veteran service officers (VSOs) hired and onboarded
- Reduction in average wait time for VSO appointments
- Number of VSOs completing enhanced training programs
- Number/dollar value of successful benefits claims filed with VSO assistance
- Number of transitioning service members and families reached through engagement activities
- Veteran satisfaction ratings with VSO services

Funding for Tribal Veterans Services

- Establishment of a permanent, recurring funding line (yes/no, and dollar amount year-over-year)
- Number of disability claims clinics held and claims filed/approved
- Number of outreach and cultural programming events held
- Growth in Tribal Veteran engagement/participation rates over time

Funding for Ask Me NC / Mental Health Outreach

- Increase in public awareness of the Ask Me NC campaign (e.g., survey-based awareness metrics, website traffic, social media reach)
- Number of Veterans connected to mental health services through the campaign
- Number of partner-organization referrals (NCServes, Veterans Bridge Home, Veterans Services of the Carolinas)
- Pre/post survey data showing reduced mental health stigma among Veterans
- Number of outreach materials distributed or events held
- Increase in mental health service utilization rates among Veterans

Strategy 1.2: Increase community identification of Veterans

- Number of county and local government offices displaying Ask Me NC materials
- Number of community touchpoints (libraries, North Carolina Division of Motor Vehicles (DMV) offices, senior centers, faith organizations, schools, health care facilities, etc.) integrating the campaign into their work
- Number of counties/municipalities formally adopting or endorsing the Ask Me NC campaign

- Number of referrals or connections made to VSOs or Veteran services as a result of community identification
- Survey data showing increased community awareness of how to identify and support Veterans
- Number of local partnerships formed with Veteran-serving organizations
- Geographic reach/coverage of the campaign across urban, rural, and Tribal communities
- Year-over-year increase in the number of geographic areas participating in the initiative

Strategy 1.3: Develop community-based engagement strategies to connect with Veterans

- Establishment of a formal Veteran-healthy community/organization designation (yes/no)
- Number of communities and organizations achieving the designation
- Year-over-year growth in the number of designations awarded
- Veteran and community satisfaction with designation program and resources
- Number of communities/organizations that receive or download the community guide
- Number of trainings or presentations conducted to publicize the guide
- Website traffic or engagement metrics related to guide materials
- Survey data on community awareness of the guide and its tools
- Number of communities that identify or secure new funding sources for Veteran-healthy activities
- Dollar amount of financial, human, or in-kind resources allocated or leveraged
- Number of communities implementing Veteran-healthy development activities
- Case studies or documented examples of successful resource strategies replicated across communities
- Number of lethal means safety trainings conducted
- Number of individuals (Veterans, family members, health care providers, community members) trained
- Number of communities distributing lethal means safety information/resources
- Reduction in Veteran suicide rates involving lethal means (long-term outcome measure)
- Increase in community awareness of lethal means safety practices (survey-based)

Strategy 1.4: Maintain Veterans Benefit Live events

- Number of Veterans Benefits Live events held annually
- Geographic distribution of events across the state (urban, rural, Tribal communities)
- Number/percentage of events with Department of Veterans Affairs (VA) disability and compensation raters in attendance
- Number of Veterans attending each event
- Number of claims filed or processed on-site during events
- Number/percentage of claims resulting in a rating decision or expedited processing
- Number of state Veteran service organizations and federal VA partners actively participating
- Veteran satisfaction ratings with event experience and outcomes
- Year-over-year consistency or growth in the number of events held
- Number of Veterans who report learning about eligible benefits for the first time at an event
- Number of partner organizations co-hosting or supporting events

Strategy 1.5: End predatory Veteran claims services

- Repeal or correction of North Carolina Session Law 2025-72, Section 4 (yes/no)
- Enactment of new state policy or legislation regulating Veteran claims consulting fees
- Number/percentage reduction in Veterans reporting fees charged for benefits claims assistance
- Number of for-profit claims consulting companies operating in North Carolina before vs. after policy change
- Dollar amount of fees Veterans are protected from or saved as a result of policy changes
- Number of complaints filed against predatory claims services (tracked over time to show reduction)
- Number of enforcement actions taken against companies violating fee protections
- Level of public/legislative awareness of predatory claims service risks (survey-based)
- Veteran satisfaction/trust ratings regarding the claims assistance process

Strategy 2.1: Create a family transition navigator program

Host Organization & Funding

- Identification and designation of a host organization (yes/no)
- Amount of funding secured to support the program

Pilot Program Implementation

- Launch of the pilot program (yes/no)
- Number of transition navigators recruited and trained
- Number of families (spouses, caregivers, dependent children) enrolled in the program
- Number of families engaged 12–24 months before separation vs. post-transition
- Number of promotional/outreach mechanisms used and their reach (e.g., installations, family readiness groups, social media)
- Number of referrals to additional resources or services made through navigators
- Family satisfaction and confidence ratings regarding the transition process
- Self-reported outcomes: reduced isolation, improved sense of preparedness, stronger community connection
- Retention rate of families in the program through completion
- Geographic reach of the pilot (number of installations or regions served)
- Qualitative feedback/testimonials from participating families
- Recommendations or model refinements generated for potential statewide expansion

Strategy 2.2: Improve Veteran caregiver access to information and resources related to available benefits and services

Website Resource Accessibility

- User experience/navigability ratings for caregiver resource sections on Ask Me NC, NCServes, and NC Caregiver portal
- Frequency of content review and updates

- Website traffic and click-through rates on caregiver resource pages
- Caregiver satisfaction survey results regarding ease of finding information

VSO Awareness & Referral Capacity

- Number of caregiver-specific referrals made by VSOs
- Pre/post training assessment showing increased VSO knowledge of caregiver resources
- Caregiver satisfaction with VSO responsiveness to caregiver-specific questions

Virtual Annual Caregiver Summit

- Number of summits held (annual recurrence, yes/no)
- Number of caregivers registered and in attendance
- Number of partner organizations participating
- Amount/sources of coordinated financial support secured
- Caregiver satisfaction and engagement ratings from summit evaluations
- Number of connections, resources, or support networks caregivers report gaining from the summit
- Year-over-year maintenance or growth in attendance and participation

Veterans Directed Care Program Tools

- Development and distribution of standardized templates (budgeting, time sheets, etc.) (yes/no)
- Number of families using provided templates and tools
- Reduction in administrative errors or compliance issues within the program
- Caregiver satisfaction with program administration support

Strategy 2.3: Increase research into Veteran caregiver needs

- Number of research studies initiated or funded focused on Veteran caregiver access, awareness, and navigation experiences
- Number of researchers or research institutions engaged through VetREP on caregiver-related topics
- Amount of funding secured or allocated for caregiver research
- Number of research findings published or disseminated (reports, journal articles, briefs)
- Number of policy or program recommendations generated from research findings
- Number of research findings translated into actionable changes (e.g., updated resources, new programs, policy proposals)
- Identification of research gaps addressed over time
- Year-over-year increase in VetREP-supported caregiver research activity

Strategy 3.1: Enhance the capacity of schools to identify and meet the needs of the children of Veterans

Veteran Student Identifier

- Number/percentage of local educational agencies (LEAs) that adopt the Veteran Student Identifier question
- Number of students identified as Veteran-connected through the new identifier
- Use of identifier data to inform school-based support services or resource allocation

Purple Star Program Participation

- Number/percentage of LEAs or schools participating in the Purple Star Program
- Year-over-year growth in new Purple Star designations
- Number of schools implementing strategies to increase parent/family awareness of the program
- Parent and family awareness levels of the program (survey-based)
- Number of program activities or events held at participating schools
- Family satisfaction or engagement ratings with Purple Star Program offerings

Higher Education Training Partnerships

- Number of partnerships formed between Veteran student associations and school psychology, counseling, social work, nursing, and teaching student organizations
- Number of educational opportunities/trainings developed and delivered
- Number of future professionals (students) participating in these trainings
- Pre/post assessment showing increased knowledge of military- and Veteran-connected children's needs among participants

Cross-cutting/Overall

- Number of Veteran-connected children identified and connected to school-based mental health or social support resources
- Reduction in unmet mental health/social needs among Veteran-connected children (survey or data-based)
- Statewide geographic coverage of identifier adoption, Purple Star Program participation, and training partnerships

Strategy 3.2: Develop Veteran child peer buddy program

- Identification and designation of a host entity (yes/no)
- Number of partner organizations actively collaborating on program development
- Development and launch of the statewide peer buddy program (yes/no)
- Number of Veteran- and military-connected children enrolled in the program
- Number of peer buddies/mentors recruited and trained
- Geographic reach of the program across North Carolina school districts or regions
- Number of mentorship matches or peer support sessions/activities conducted

- Child and family satisfaction ratings with the program
- Self-reported outcomes among participating children (e.g., reduced isolation, increased sense of belonging, improved coping skills)
- Number of referrals to additional mental health or support services generated through the program
- Year-over-year growth in program enrollment and geographic expansion
- Retention rate of children and peer buddies in the program
- Qualitative feedback/testimonials from children, families, and mentors

Strategy 4.1: Host an annual Veteran health information summit

- Veteran health information summit planned and held (annual recurrence, yes/no)
- Amount/source of dedicated financial support secured
- Number of Veteran health stakeholders registered and in attendance
- Diversity/breadth of stakeholder organizations represented
- Number of topics/sessions covering key Veteran health information and resources
- Stakeholder satisfaction and engagement ratings from summit evaluations
- Number of stakeholders reporting increased knowledge of available Veteran health resources (pre/post survey)
- Number of referral pathways or collaborative initiatives developed following the summit
- Year-over-year maintenance or growth in attendance and stakeholder participation
- Geographic and organizational reach of participants (statewide representation)
- Documented examples of improved Veteran health outcomes or connections resulting from stakeholder collaboration

Strategy 4.2: Increase Veteran access to health services, particularly in rural areas

Full Practice Authority for APRNs

- Passage of legislation granting full practice authority for advanced practice registered nurses (APRNs) (yes/no)
- Number of APRNs practicing pre-/post- enactment
- Change in the number of APRN-provided primary care visits statewide
- Increase in APRN presence in rural or underserved counties
- Reduction in patient wait times for primary care appointments in APRN-served areas
- Number of new APRN-led practices established, particularly in rural/underserved areas

Physician Assistant Team-Based Practice

- Development and publication of clear implementation guidance/workforce policies (yes/no)
- Number of health systems, rural practices, community clinics, and VA Community Care participants adopting the guidance
- Number of physician assistants (PAs) registered and practicing in team-based settings under new guidance
- Increase in PA-provided care visits, particularly in rural or VA Community Care settings

- Reduction in care access barriers or wait times in areas utilizing expanded PA practice
- Stakeholder (North Carolina Medical Board, health systems, clinics) satisfaction with clarity and usability of guidance

Dental Hygienist/Assistant Scope of Practice

- Implementation status of Strategy 21 from the NCIOM Task Force on Oral Health
- Number of dental hygienists/assistants practicing under expanded scope
- Increase in access to oral health services, particularly in rural/underserved areas
- Number of new or expanded dental care sites utilizing expanded scope of practice
- Reduction in wait times or unmet oral health needs among Veterans and general population

Cross-cutting/Overall

- Increase in Veterans reporting timely access to medical, oral, and primary care services
- Reduction in overall health care workforce shortages in rural and underserved North Carolina counties

Strategy 4.3: Assist justice-involved Veterans in accessing available health-related services

Veteran Group Engagement in Jails/Prisons

- Number of Veteran groups actively engaging with justice-involved Veterans in correctional facilities
- Number of jails/prisons where engagement activities occur
- Number of justice-involved Veterans reached or engaged
- Number of Veterans informed about post-release services prior to release
- Veteran-reported awareness of available post-release resources (survey-based)

NCDMVA Regional Manager & Reentry Council Coordination

- Number of quarterly meetings held between regional managers and local reentry councils (tracking consistency/frequency)
- Number of regions with active, ongoing engagement
- Number of Veterans connected to resources as a result of reentry council coordination

Court-Based Veteran Identification

- Revision of court intake questions to ask about any history of military service (yes/no)
- Number/percentage of courts adopting the revised question
- Increase in the number of Veterans identified through court intake processes
- Consistency of identification practices across judicial districts

Data Tracking on Justice-Involved Veterans

- Establishment of an aggregate data-sharing/tracking system between North Carolina Judicial Branch, Administrative Office of the Courts, and North Carolina Department of Military and Veterans Affairs (NCDMVA) (yes/no)

- Completeness and consistency of data collected on justice-involved Veterans
- Number of reports or analyses produced on the geographic distribution of justice-involved Veterans
- Identification of underserved areas needing expanded Veteran treatment court access
- Use of data to inform Veteran treatment court expansion decisions (documented examples)

Veteran Service Officer Collaboration with Veteran Treatment Courts

- Number of VSOs actively collaborating with Veteran treatment court program directors
- Number of Veteran treatment court participants receiving VSO-coordinated services
- Number/types of services coordinated (e.g., benefits claims, mental health, housing)
- Program completion rates for Veterans receiving VSO support compared to those without
- Participant satisfaction with service coordination

Cross-cutting/Overall

- Increase in the number of justice-involved Veterans connected to health-related services post-release
- Reduction in recidivism rates among Veterans engaged through these initiatives
- Expansion in the number/geographic reach of Veteran treatment courts based on data-driven need
- Statewide consistency in identifying and supporting justice-involved Veterans across the reentry continuum

Strategy 5.1: Analyze the network of community-based providers available to Veterans

- Completion of the gap analysis (yes/no)
- Analysis produced covering all three key data areas: provider networks (VA Community Care, TRICARE), health professional shortage areas, and Veteran population distribution
- Publication and dissemination of gap analysis findings (report, briefing, presentation to North Carolina General Assembly or agencies)
- Number of stakeholders or policymakers briefed on findings
- Number of follow-on recommendations or initiatives developed based on the analysis
- Use of findings to inform provider network expansion, funding decisions, or policy changes (documented examples)
- Year-over-year tracking of network adequacy improvements in identified gap areas
- Increase in Veteran access to community-based care in previously identified shortage areas (long-term outcome measure)

Strategy 5.2: Improve the capacity of smaller health care practices to serve Veterans

VA Community Care / TRICARE Network Enrollment Support

- Increase in financial resources allocated to North Carolina Area Health Education Centers' (AHEC's) Practice Support Program (dollar amount)
- Number of smaller practices receiving information/assistance on joining VA Community Care and/or TRICARE networks
- Number of practices successfully enrolled in VA Community Care and/or TRICARE networks

VA External Provider Scheduling System Connection

- Number of practices assisted with connecting to the VA's External Provider Scheduling system
- Reduction in scheduling barriers or delays for Veteran patients at participating practices

Veteran Status & Clinical Screening Integration

- Number/percentage of participating practices that integrate Veteran status questions into intake
- Number of practices adopting clinical guidelines for toxic exposure, mental health, and military-connected condition screening
- Number of Veterans identified and screened for military-connected conditions as a result

Workflow & HIT/Billing Optimization

- Number of practices assisted with clinical and administrative workflow standardization
- Practice-reported efficiency gains in care delivery to Veterans

Cross-cutting/Overall

- Total number of smaller practices engaged through the Practice Support Program
- Geographic distribution of participating practices (rural/underserved area reach)
- Increase in the number of community-based providers available to Veterans statewide
- Veteran satisfaction with access to and quality of care at participating practices
- Year-over-year growth in program reach and practice participation

Strategy 5.3: Engage the Rural Health Transformation grant to improve access to care for Veterans

Veteran Representation & Service Integration

- Number/percentage of ROOTS Hub advisory councils with designated Veteran representation
- Number of Veteran support networks formally included in service integration efforts
- Number of joint initiatives or referral pathways developed between ROOTS Hubs and Veteran support networks
- Veteran advisory member satisfaction and engagement ratings

FQHC Cultural Awareness Training & Clinical Guidelines

- Amount of grant funding allocated to Federally Qualified Health Center (FQHC) Veteran cultural awareness trainings
- Number of FQHCs and providers completing Veteran cultural awareness training
- Number/percentage of FQHCs integrating clinical guidelines for toxic exposure, mental health, and military-connected condition screening
- Number of Veterans screened for military-connected conditions at participating FQHCs
- Provider-reported confidence in addressing Veteran-specific health needs (pre/post training survey)

Technical Assistance for VA Network Enrollment

- Amount of grant funding allocated to technical assistance efforts
- Number of rural community-based practices receiving technical assistance
- Number of practices successfully enrolled in the VA Community Care Network
- Number of practices successfully connected to the External Provider Scheduling system

Cross-cutting/Overall

- Increase in the number of rural, Veteran-informed care access points statewide
- Year-over-year growth in FQHC and practice participation in Veteran-focused training and enrollment support

Strategy 6.1: Increase the number of Veterans in the health care workforce

Competency-Based, Accelerated Training Programs

- Number of North Carolina health professional training programs that develop accelerated, competency-based pathways for Veterans
- Number of programs utilizing the UNC Military Equivalency System to identify coursework equivalencies
- Number of Veterans enrolled in accelerated pathways
- Number of course/credit equivalencies recognized through the UNC Military Equivalency System
- Employer or program feedback on preparedness of Veteran graduates

UNC and NC Community Colleges Outreach and Partnerships

- Number of outreach activities or campaigns conducted to raise awareness of health care training opportunities among Veterans
- Number of Veterans reached through outreach efforts
- Increase in Veteran enrollment in health care training programs system-wide
- Veteran awareness levels of available training opportunities (survey-based)

Cross-cutting/Overall

- Year-over-year increase in the number of Veterans entering and completing health care training programs in North Carolina

- Increase in the number of Veterans employed in the North Carolina health care workforce
- Geographic distribution of Veteran health care graduates (including rural placement)
- Retention rates of Veteran health care professionals in the field
- Veteran satisfaction with training program support and career transition into health care roles

Strategy 6.2: Educate community-based health care providers about the unique mental and physical health needs of Veterans and the social factors that can affect their health

Publicizing & Disseminating Continuing Education Trainings and Resources

- Number of continuing education (CE) trainings, webinars, and resources publicized or disseminated
- Number of community-based providers accessing or completing trainings
- Number of times materials (guides, webinars) are downloaded, viewed, or distributed
- Provider satisfaction and knowledge gain from trainings (pre/post assessment)
- Geographic reach of dissemination efforts across North Carolina providers

NCDMVA-Facilitated Collaboration

- Number of collaborations/partnerships formed between Veteran organizations and North Carolina health care trade/professional associations
- Number of joint awareness campaigns or initiatives launched
- Number of health care trade/professional associations actively promoting Veteran health trainings to members
- Number of providers reached through association-based outreach
- Increase in provider participation/registration in available Veteran health trainings

Cross-cutting/Overall

- Total number of community-based clinicians (physicians, nurses, social workers) trained in Veteran culture and military-connected conditions
- Provider-reported confidence and competence in caring for Veteran patients (survey-based)
- Increase in identification and appropriate referral of Veteran-specific health needs in community-based settings
- Veteran-reported satisfaction with the cultural competence of care received from community-based providers

Strategy 6.3: Create and maintain a database of Veteran-ready health care professionals

- Identification of a host organization for the database (yes/no)
- Establishment of formal criteria for "Veteran-ready" provider designation (yes/no)
- Launch of the database (yes/no)
- Number of health care professionals meeting criteria and listed in the database at launch
- Number of providers added over time, by specialty

- Geographic distribution/coverage of listed providers across North Carolina
- Number of database users/searches conducted (Veterans, VSOs, referral sources)
- Number of successful provider connections or referrals made through the database
- User satisfaction ratings (Veterans, VSOs, providers) with database usability and usefulness
- Frequency of database maintenance/updates to ensure accuracy
- Year-over-year maintenance or growth in the number of listed providers and specialties covered
- Awareness levels of the database among Veterans, caregivers, and referral sources (survey-based)

Strategy 6.4: Incentivize health care providers to increase their knowledge of the unique mental and physical health needs of Veterans

- Development and launch of a formal recognition program (yes/no)
- Number of health insurance carriers participating in a recognition program
- Establishment of defined training criteria/requirements for recognition (yes/no)
- Number of providers completing defined Veteran culture and health care trainings
- Number/percentage of providers earning recognition status
- Year-over-year maintenance or growth in the number of recognized providers
- Provider awareness of the recognition program (survey-based)
- Provider-reported motivation/incentive value of the recognition program
- Geographic distribution of recognized providers across North Carolina (including rural/underserved areas)
- Number of Veterans utilizing or seeking out recognized providers (if publicly listed/searchable)
- Veteran satisfaction with care received from recognized providers
- Integration of recognition status into provider directories or referral systems (yes/no)

Strategy 6.5: Engage health care professional students in learning about the unique mental and physical health needs of Veterans

Student Organization Partnerships

- Number of partnerships formed between Veteran student associations and health care professional student organizations
- Number of institutions of higher education participating
- Number of educational events, panels, or activities held
- Number of health professional students reached/participating
- Student-reported knowledge gain regarding Veteran physical and mental health needs (pre/post survey)
- Student satisfaction with educational opportunities provided

Pilot Veteran-Centric Curriculum/Certificate

- Development and launch of a pilot curriculum or certificate program (yes/no)
- Number of students enrolled in the pilot program
- Completion rate of students in the pilot curriculum/certificate
- Student-reported competence and interest in Veteran-focused care following completion

- Documented lessons learned and program refinements from the pilot
- Faculty/institutional satisfaction with pilot implementation

Statewide Expansion

- Development of a statewide model based on pilot outcomes (yes/no)
- Number of institutions adopting the expanded model
- Number of students participating in the statewide program
- Year-over-year maintenance or growth in program reach and institutional adoption

Cross-cutting/Overall

- Geographic distribution of participating institutions across North Carolina
- Long-term tracking of program graduates' career paths into Veteran-serving health care roles

Strategy 7.1: Ask patients about their military connections

Military-Connected Status Screening

- Number/percentage of health care practices implementing a standardized military-connected status question
- Number/percentage of patients screened for military-connected status
- Number/percentage of patients identified as military-connected through screening
- Integration of the screening question into electronic health record intake workflows (yes/no)

Supports, Resources, and Follow-Up Practice Guidelines

- Development and distribution of practice guidelines for follow-up inquiry on military-connected health conditions (yes/no)
- Number/percentage of providers trained on using the guidelines and supports
- Number/percentage of military-connected patients receiving follow-up inquiry about service-related health conditions
- Number of military-connected patients identified with previously undocumented service-related health conditions
- Provider-reported confidence and ease of use regarding available supports and resources
- Number of referrals made to appropriate services as a result of follow-up inquiry

Cross-cutting/Overall

- Statewide adoption rate of military-connected status documentation across health systems
- Increase in early identification of military-connected health conditions (e.g., toxic exposure, mental health, traumatic brain injury)
- Provider satisfaction and perceived value of the screening and follow-up process
- Veteran and family/caregiver satisfaction with care that acknowledges their military connection
- Year-over-year growth in the number of practices and providers implementing this process

Strategy 7.2: Establish Veteran care improvement mechanisms within hospitals and health systems

- Establishment of advisory role/capacity to support health systems on Veteran care (yes/no)
- Number of health systems/hospitals engaging with Veteran care resources and guidance
- Number of health systems establishing internal Veteran care improvement committees
- Number of health systems incorporating Veteran care quality into strategic planning and evaluation metrics
- Number of Veteran-specific quality metrics adopted and tracked by health systems
- Number of employee awareness campaigns launched regarding Veteran supports and services
- Number/percentage of employees reached through awareness campaigns
- Employee-reported knowledge of available Veteran supports and services (pre/post survey)
- Number of resources or best-practice guides disseminated to health systems
- Health system satisfaction with advisory support and resources
- Documented improvements in Veteran patient identification and care outcomes at participating health systems
- Veteran and family/caregiver satisfaction with care received at participating hospitals and health systems

Strategy 7.3: Improve community-based provider access to Veteran health information

- VA medical centers' enrollment status as participants in the North Carolina Health Information Exchange (number/percentage of VA medical centers participating)
- Number of community-based providers with access to shared Veteran health records
- Volume of health records exchanged bidirectionally (VA to community providers and vice versa)
- Provider-reported improvement in access to comprehensive Veteran health history
- Provider satisfaction with the completeness and usability of exchanged health information
- Veteran satisfaction with coordination between VA and community-based providers

Strategy 8.1: Generate attention to Veterans' health

- Issuance of a Proclamation or Executive Order by the Governor (yes/no)
- Level of media coverage generated by the Proclamation/Executive Order
- Public awareness of Veteran health needs following the announcement (survey-based)
- Number of legislative or agency initiatives introduced or accelerated as a result of the Proclamation/Executive Order
- Number of partner organizations or stakeholders publicly referencing or supporting the Proclamation/Executive Order
- Year-over-year renewal or reaffirmation of the Proclamation (if applicable)
- Documented policy or funding changes attributable to the increased attention generated

Strategy 8.2: Identify and sustain a lead organization to facilitate ongoing action

- Identification and designation of a lead organization(s) (yes/no)
- Development of a system or process for tracking progress on task force recommendations
- Frequency of progress reviews conducted (e.g., quarterly, annually)
- Number/percentage of recommendations showing documented progress or completion over time
- Number of stakeholders or partner organizations engaged in ongoing coordination efforts
- Level of stakeholder satisfaction with the lead organization's coordination and communication
- Sustainability of the coordination function over time (e.g., continued funding, staffing, leadership)
- Number of course corrections or strategy adjustments made based on progress reviews
- Overall rate of implementation across all task force strategies as tracked by the lead organization



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