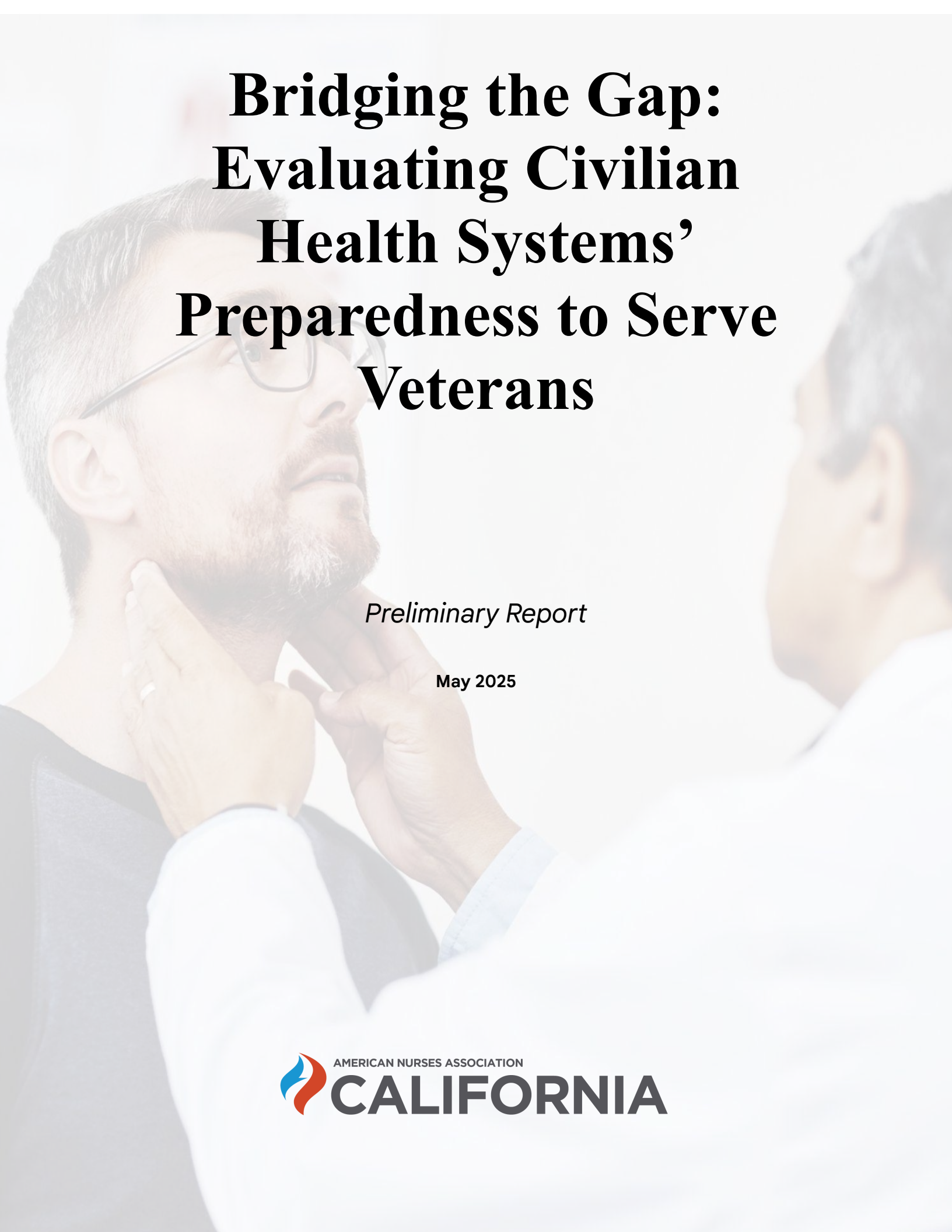

Bridging the Gap: Evaluating Civilian Health Systems' Preparedness to Serve Veterans

Preliminary Report

May 2025

AMERICAN NURSES ASSOCIATION
CALIFORNIA

Introduction

California is home to the largest veteran population in the nation—approximately 1.5 million veterans. While research from Rand (2019) shows the overall number of veterans across the United States has been steadily decreasing, the number of veterans actively receiving care from the Department of Veterans Affairs (VA) has increased. This uptick reflects not only the influx of a new era of veterans, but also the complex and serious service-connected health problems they carry with them.

While the VA is responsible for delivering comprehensive care, access is limited—and not guaranteed. Eligibility depends on factors like length of service, discharge status, service-connected disabilities, income level, and exposure to environmental hazards.

According to the VA Enrollee Data Report (2021), 80% of VA enrollees reported having some type of public or private health insurance. The remaining 20%—a significant and vulnerable minority—were uninsured.

The VA is also facing persistent workforce shortages. As of FY 2024, 82% of VA facilities reported nursing as a severe staffing shortage, and four of the five most critically understaffed roles—psychology, practical nurse, psychiatry, and medical technologist—have been repeatedly identified as areas of concern since FY 2018. These staffing shortages have serious consequences: veterans may wait for primary and specialty care due to inconsistent scheduling, inadequate oversight, and unresolved consult backlogs, according to US Government Accountability Office Report.

As of May 2025, the VA is proceeding with plans to cut approximately 83,000 positions, aiming to return to its 2019 staffing levels of around 400,000 employees. However, there is bipartisan concern that support positions—critical for scheduling, logistics, and patient coordination—may be affected. These reductions could strain the VA's capacity, potentially increasing reliance on civilian healthcare providers who may not be fully equipped to address veterans' unique needs.

Challenges are compounded through ongoing struggles in addressing veterans' unique health needs:

1. **Service-Related Health Conditions**
    a. **Post-Traumatic Stress Disorder:** PTSD is slightly more common among Veterans (7%) than civilians (6%). However, women veterans are at a significantly higher risk of developing PTSD (13%).
    b. **Military Sexual Trauma:** While about 1 in 50 men report experiencing MST at some point during their military service, about 1 in 3 women report they have survived MST.
    c. **Traumatic Brain Injury:** Nearly 1-in-4 US veterans screen positive for probable TBI.

d. **Chronic Musculoskeletal Pain:** 81.5% of veterans have a high prevalence of chronic musculoskeletal pain.
e. **Toxic Exposure:** Over 374,000 veterans reported possible toxic exposure during military service, with nearly 40% reporting potential exposure to airborne hazards like burn pits.

2. **Transition and Reintegration Challenges**
   a. **VA Care vs. Non-VA Care (Civilian Care):** Studies comparing VA care to non-VA care showed mixed results for access and cost, while patient experience tended to favor VA care or found it comparable.
   b. **Help-Seeking Stigma:** Approximately 50% of recent veterans with significant mental health symptoms have not sought services, despite the availability of care.
   c. **Unemployment:** The unemployment rate for veterans (post-9/11 and Gulf War-era II) held steady at 3.2% in 2024.
   d. **Organizational and Societal Barriers:** A thematic analysis of focus groups revealed two key barriers to veteran reintegration: organizational and societal barriers—like limited transition programs, discharge status, negative support service experiences, and perceived discrimination—and personal barriers, including lack of planning and difficulty adjusting to civilian workplaces.
3. **Social Determinants of Health**
   a. **Homelessness:** California has the highest percentage of homeless veterans who are unsheltered than any other state in the nation—69% of the state's 9,310 homeless veterans lack shelter.
   b. **Food Insecurity:** Approximately 20% of California veterans and their families are experiencing food insecurity.
   c. **Opioid Overdose Deaths:** Of the 334 Californian veteran opioid overdose deaths, 278 of them were attributed to fentanyl.
   d. **Suicides:** The average number of suicides reported in California across 2020 - 2023 is approximately 552. The suicide rate among women veterans jumped 24.1% between 2020 and 2021—nearly four times higher than the 6.3% increase among male veterans and vastly higher than the 2.6% increase among nonveteran women. Transgender veterans and active-duty service members have higher odds of suicidality than their cisgender counterparts. About 60% of self-identified transgender veterans report lifetime incidents of suicidal ideation.
   e. **Transportation:** Nearly 80 percent of veterans who live more than 40 miles from VA medical facilities also live within 40 miles of a non-VA primary care provider, yet this percentage drops markedly for other specialties.
4. **Barriers to Continuity of Health Records**
   a. **Interoperability:** Civilian providers cited poor coordination with the VA—such as lack of access to VA records and unclear care responsibilities—as a major barrier to continuity.
   b. **Civilian Primary Care Identification of Veterans:** Civilian primary care providers reported three main barriers in a qualitative study exploring their experiences with identifying and caring for veteran patients:

i. **Difficulties in recognizing patients as veterans** due to inconsistent self-identification and lack of standardized screening;
ii. **The absence of effective tools to systematically identify and assess** veteran status and related health risks; and
iii. **Challenges in integrating veteran-specific care practices**—such as screening for service-related conditions—into routine clinical workflows.

Note: This is not an exhaustive list and reflects only the most commonly reported barriers identified in the literature and provider interviews.

Taken together, these findings underscore a fragmented system—one where both the VA and civilian health systems face structural, logistical, and cultural barriers to delivering consistent, veteran-centered care. To address these challenges, we must first understand the current landscape of civilian system preparedness and outline clear, evidence-based recommendations for reform.

Objective

This preliminary report begins to evaluate the readiness of civilian health systems to identify and care for veterans and military-connected individuals. Through a structured literature review and expert consultation, we explore barriers to access, current efforts, and necessary reforms. Our goal: to integrate evidence and insights into actionable policy recommendations that strengthen care for veterans across all systems.

Research Terms and Framework

Using the PICO framework, we focused our inquiry on:

- **Patient/Population (P):** Veterans receiving care in civilian health systems
- **Intervention (I):** Structured protocols for veteran identification, care integration, and follow-up
- **Comparison (C):** Civilian healthcare practices without veteran-specific protocols
- **Outcome (O):** Improved veteran identification, care continuity, and access to services

Key terms included *veterans, barriers, care-seeking, healthcare access, intake, admissions, eligibility, health services, and non-VA care*. Additional phrases reflected our focus on *veteran identification, care integration, service-connected conditions, continuity of care, and civilian provider preparedness.* These terms helped surface relevant literature examining gaps and opportunities across systems of care.

Findings

Current evidence reveals significant limitations in civilian health systems' ability to consistently identify and care for veteran patients—challenges that directly affect care continuity and access. Although most non-VA providers agree that knowing a patient's military status would improve care, more than half report rarely or never asking about veteran status, despite having the time to do so. This gap is compounded by limited military cultural competency and stereotypes that prevent providers from connecting symptoms with service history. Providers have expressed a clear need for better training and tools to support veteran-specific care.

From a systems perspective, studies consistently show that VA care is comparable or superior to non-VA care across quality and safety metrics. However, findings on access and efficiency are mixed, with some studies indicating civilian care may perform better in certain domains. Importantly, no study identified community care as outperforming the VA in patient experience.

Federal initiatives like the Veterans Choice Act (2014) and the MISSION Act (2018) were intended to expand access by allowing veterans to seek care outside the VA. However, both rely heavily on civilian providers' ability to identify veterans. Without standardized screening or protocols, these policies fall short of their potential, particularly for veterans who do not self-identify.

Together, these findings suggest that while the infrastructure exists to support expanded access through civilian systems, its success hinges on improving veteran identification, provider training, and cross-system coordination—critical gaps that remain unresolved.

Conclusion & Next Steps

This preliminary report highlights the complexity of navigating veteran healthcare across fragmented systems. California's large and diverse veteran population faces intersecting challenges—from service-related conditions and social determinants of health to systemic gaps in access and continuity. While the VA remains a critical provider of care, workforce shortages, eligibility limitations, and upcoming staffing cuts are driving increased reliance on civilian systems. Yet these systems are not fully equipped to meet veterans' unique needs.

Despite isolated efforts and promising pockets of practice, health professionals lack a comprehensive understanding of how ready civilian health systems are to serve veterans. No

system-wide assessment has measured whether veterans receive timely, appropriate care across sectors, or how breakdowns in identification, coordination, and follow-up affect outcomes. These knowledge gaps pose real risks to veteran health and demand urgent attention.

ANA\California's Advocacy Institute Fellow 2025, Lance Rounkles, and the ANA\California Veteran Health Advisory Council are leading a statewide initiative to evaluate civilian system readiness. We are gathering insight into current practices, barriers, and emerging solutions through direct engagement with subject matter experts—including informaticists, nurses, and healthcare leaders—to better understand how veterans and military-connected individuals are identified and supported.

In parallel, ANA\California has launched the *Evaluating Civilian Health Systems' Preparedness to Serve Veterans Survey* for nurses to assess whether community care providers, hospitals, and health systems are recognizing military affiliation—and if so, how they are addressing the unique health needs of those who have served.

This is not the conclusion. It's the beginning of a better path forward.

ANA\California Veteran Health Advisory Council

Members
Dr. Ali R. Tayyeb, PhD, RN, NPD-BC, PHN, FAAN
Michelle French, MSN, RN, CNS, CEN, CNE
Dr. Sheree Scott, PhD, RN, AGCNS-BC, CMSRN, CNL
Kim Brown Sims MBA, BSN, RN, PHN, FACHE, NEA-BC, LBBH, RNC-NIC(E)

Advocacy Institute Fellow
Lance Rounkles MSN, RN, PMH-BC, CNML, NE-BC

Contributors
Dr. Marketa Houskova, DNP, MAIA, BA, RN
Jared Fesler