

# Doing Your Part for National Security: Providing Quality Care to Our Military and Veterans

Margaret Chamberlain Wilmoth

Civilian health professionals can play a significant role in our national security as it relates to medical readiness of the military. Members of the Reserve Component and many Veterans receive their health care in the civilian sector, thus all North Carolina health professionals need to understand the unique issues affecting this population. This issue highlights current challenges facing our military, their families, and our Veterans, and authors offer suggestions for providing quality care to this population.

## Introduction

North Carolina takes great pride in being welcoming to the military and to those who served in the past, whether in active duty, the National Guard, or in one of the Title 10 Reserve Components (RC). The state is home to eight active-duty installations and the active-duty Service Members and families assigned to them. The headquarters of the US Army Reserve is located at Fort Liberty (formerly Fort Bragg) in Fayetteville, North Carolina. Additionally, there are many North Carolina residents serving in one of the Reserve Components, including the approximately 11,000 members of the North Carolina National Guard (Army and Air) and the roughly 7,000 drilling Reservists who live across the state, often assigned to units in other states. Finally, there are approximately 700,000 Veterans who call North Carolina home (personal communication, Christopher Hastings, VISN 6 Strategic Planner, Veterans Administration).

Curricula in many, if not most, health care professions education programs do not include details on occupational health hazards arising from military service or common to different areas of military operations, nor do they explain differential diagnosis of these conditions, much less teach providers about military culture, customs, or courtesies. While many electronic health systems prompt the question, "Have you ever served in the military?" it is generally only a yes/no question, and the provider may not dive deeper [1]. Asking additional key questions about the person's military occupational specialty (MOS), when and where they served, and if they served in an area of operations could assist in achieving a more accurate diagnosis and treatment plan. This question is *not* asked to merely

prompt the provider to thank us for our service, which is a common misconception.

This issue of the *North Carolina Medical Journal* aims to equip the civilian provider with key information to help facilitate their delivery of quality care to those who are part of the 1% of Americans who have served in the military in the 50 years since the advent of the all-volunteer force.

## Overview of the Uniformed Services

While uniforms are often the same, there are numerous and critical differences between being an active-duty Service Member or one in the RC, and even more differences between being a Title 10, Title 14, or Title 32 Service Member. These titles refer to different sections of the US Code, which contains the general and permanent laws across 54 broad titles [2]. Collectively, there are eight Uniformed Services, five of them under the control of the Department of Defense. These five are referred to as the Armed Forces, since they are armed with weapons. They are the Army, Navy, Air Force, Marine Corps, and Space Force. The other three that round out the Uniformed Services are the Coast Guard, a component of the Department of Homeland Security; the US Public Health Service Commissioned Corps, under the Department of Health and Human Services; and the National Oceanic and Atmospheric Administration Commissioned Corps, a component of National Oceanic and Atmospheric Administration. The Armed Forces are further divided into components: the active component (AC) or "active duty" and the RC. The RC are further divided into the Title 10 Reserve forces and those under Title 32, better known as the National Guard. Title 10 Reserve elements are governed by their active component federal entity, while Title 32 National Guard elements report to their state's governor, who must provide the permission for them to be called to active duty in Title 10 status. The National Guard is further subdivided into Army and Air elements.

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Address correspondence to Margaret Wilmoth, Campus Box 7460, 140 Medical Dr, School of Nursing, UNC Chapel Hill, Chapel Hill, NC 27599-7460 or by email: wilmothp@email.unc.edu

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Just as with employment by any organization, there are benefits that come with employment in the military, and these benefits are tiered based on status. Eligible AC beneficiaries have full access and those in the RC have restricted access. There are several categories of benefits that differ from the civilian sector: in addition to health care, there are Department of Defense schools; morale, welfare, recreation, and family programs; commissary and exchange; and miscellaneous others [3]. The ability to obtain medical and dental care is one of the most sought-after benefits, yet it is a misconception to think that every Service Member obtains health care via military hospitals and providers, or that every Veteran is cared for by the Veterans Health Administration (VHA). The vast majority of those who serve on active duty will receive their health care through the Military Health System (MHS) on the active-duty installations across the state. However, due to Congressional mandates, their family members are increasingly being seen in civilian practices using TriCare insurance [4]. This has implications for health care providers and the health care systems in every community across the state.

Those who serve in the National Guard or in one of the RC (Army, Navy, Marine Corps, Air Force, or Coast Guard Reserve) typically receive all of their health care, including preventive services, dental care, and gynecological care, through their civilian health care provider. They will use their civilian employer-provided health insurance or TriCare Reserve Select, should they choose to purchase that insurance. The only time they receive care from the MHS is when they are on federal active duty for more than 30 days and for up to six months following the end of that period [5]. Reservists do obtain an annual health assessment from the military, but this is merely an assessment of their health status and does not include care for any identified conditions [6].

## Our Veterans

North Carolina is home to the eighth-largest number of Veterans in the country [7]. While the numbers fluctuate, there are currently approximately 505,011 Veterans eligible to receive care through the VHA (personal communication, June 22, 2023, Christopher Hastings, VISN 6 Strategic Planner, Veterans Administration). Approximately 345,632 of these Veterans receive some, but not all, of their health care through the VHA. Since nearly 50% receive some, *if not all*, of our health care from civilian providers, it is important that providers outside of the MHS and VHA be knowledgeable about military occupational and operational health hazards and factor this information into their practices. For example, there have been well-documented negative health impacts from tainted water at Camp Lejeune in Jacksonville, North Carolina, and the Air Force Global Strike Command recently reported that banned chemical compounds used in building and electrical materials were detected at a nuclear missile base in Montana, leading to possible toxic exposure

among those serving in such facilities [8, 9]. A health provider should be aware of this type of potential risk factor and alter cancer surveillance recommendations for someone who has served at such locations.

## Overview of Issue

Health care professionals across the state—dentists, nurses, nurse practitioners, physicians, physician assistants, social workers, and more—must be attuned to the fact that there is a high probability that they are providing care to someone who has served or is serving in the Armed Forces, and who may have been exposed to military-centric occupational health hazards along with their family members. In this issue of the *NCMJ*, subject matter experts from across North Carolina and across the country highlight current issues facing our military, their families, and our Veterans, and provide suggestions for providing quality care to this population.

Health insurance can be quite confusing, and the federal health care program TriCare is no different [10]. Drs. Susan Lee and Pamela Willson from the University of Texas MD Anderson Cancer Center provide some clarity about the types of TriCare, eligible beneficiaries, and the benefits and weaknesses of this insurance program [11].

While the members of the RC who live, work, and pay taxes in North Carolina comprise a relatively small percentage of the population, they play an outsized role during state and federal crises. They must be medically and dentally ready to deploy on short notice. In fact, having poor dental health is a key reason for soldiers to be deemed “non-deployable” [12]. Being “medically ready” includes having all required immunizations as well as having one’s oral health at a Dental Classification of 1 or 2, meaning normal condition or not likely to need treatment within 12 months. Retired Major General, US Army Dr. T. Rob Tempel, Jr., former chief of the US Army Dental Corps and current Associate Dean for Extramural Clinical Practices at the ECU School of Dental Medicine, and LTC Joel Bachman, Dental Corps officer in the North Carolina Army National Guard, provide details about dental readiness and suggest ways that civilian dentists can assist their patients in achieving this annual requirement [13].

Behavioral health issues and rising suicide rates continue to confront Americans in every community, and the military is not insulated from this health crisis. Dr. Matthew Kleiman from the US Public Health Service and colleagues from the Center for Deployment Psychology highlight the fact that those in the RC are seen by local mental health/behavioral health providers [14]. They provide some culturally appropriate suggestions for ways to engage with these Service Members that may lead to improved outcomes.

A new effort through the Gillings School of Public Health at UNC-Chapel Hill, in partnership with the Durham Veterans Health Administration, is targeting suicide prevention among community-dwelling Veterans across the state,

particularly those who receive care outside of the VHA [15]. The project has performed extensive peer-reviewed and gray literature reviews on the community-level factors affecting Veteran mental health and leveraged geographic information system (GIS) mapping software to identify existing community assets and areas for improvement.

Dr. Evelyn Lewis and her colleagues from Warrior Centric Health, Inc., provide an overview of the legislation passed in 2018 that created and broadened many VHA programs, commonly referred to as the MISSION Act [16]. Among other initiatives, this legislation replaced the Veterans Choice Program with the Veterans Administration (VA) Community Care program aimed at allowing enrolled Veterans to obtain some health care from facilities in their communities rather than having to travel long distances to a VHA facility. Dr. Michael Zychowicz, former Army Reservist and currently a professor who leads the Veterans' Health Care Specialty at Duke University School of Medicine, provides an overview of the PACT Act, recent legislation that expands VHA coverage for those exposed to toxic substances [17].

Dr. Suzanne Boyd of the UNC-Charlotte School of Social Work shares new data highlighting an increasing incidence of multiple sclerosis (MS) in Veterans [18]. If diagnosed while in the service or within seven years of discharge, it may be possible to obtain a service-connected disability rating [19]. This window of time for obtaining a service-connected disability for MS highlights another reason for civilian health professionals to have knowledge of military service, as failure to file for a claim within this window may deprive a Veteran of their rightfully earned and much-needed benefits given the chronic nature of this disease. Civilian providers can play an important role in Service Members' overall health and well-being by encouraging their patients to register their service with the VA. Drs. Mona Pearl Treyball, Susan Letvak, and Penny Kaye Jensen write to educate providers about screening their patient populations for toxic exposures [20]. Dr. Letvak also writes in a separate paper about the Veteran-to-nurse pipeline, particularly UNC-Greensboro School of Nursing's Veterans Access Program for Nurses, which is designed to assist military Veterans in becoming bachelor's prepared Registered Nurses [21].

Daniel Johnson shares his research and experience regarding the impact of traumatic brain injury on this population from his perspective as an Army Veteran and current PhD student in communication and media at the University of North Carolina at Chapel Hill [22].

The families of those who volunteer to wear the uniform of our country, whether it be on active duty or in the Reserves, also serve and sacrifice [23]. Pediatricians, educators in our schools, and school nurses and counselors also have a role to play in providing support for military-connected children. This extends far beyond the school districts surrounding active-duty installations. Wilmoth, Phyoniam, and Bian from UNC-Chapel Hill address the large, yet often invisible, population of RC-connected children in North Carolina's schools

[24]. Their article points out what little is known about how parental deployment affects these children and the state of programs and support systems in North Carolina schools that target their needs. Areas for policy improvements are highlighted. Dr. Alicia Rossiter, a retired Air Force officer and former school nurse now on faculty at the University of South Florida, and Dr. Catherine Ling, a military spouse who is on faculty at Johns Hopkins University, provide more detail on the invisible populations within the military and discuss in detail two pocket cards that are companions to the 'Have You Ever Served in the Military?' pocket card already in use by many clinicians [25].

## Conclusion

This issue of the *NCMJ* focusing on the health care needs of North Carolina citizens who volunteer or who formerly served in the Armed Forces comes eight years after a previous issue addressing North Carolina's Veteran population [26] and 12 years following the report from the North Carolina Institute of Medicine Task Force on Behavioral Health Services for the Military and Their Families [27]. Veterans' needs of their civilian care providers highlighted in these previous publications remain, namely: knowledgeable, quality care. However, much has changed in the intervening years, including new federal legislation that affects service-connected disability, the increased population of younger Veterans, and the growing numbers of women who are Veterans. Civilian health professionals need some awareness of these changes, as well as the unique medical and dental needs of RC Service Members and their families and children. It is hoped that the information provided in this issue of the *North Carolina Medical Journal* will enhance the quality of care provided to these populations residing across our state. *NCMJ*

**Margaret Chamberlain Wilmoth, PhD, MSS, RN, FAAN Major General, US Army (ret)** Professor, School of Nursing, and Associate Dean for Academic Affairs, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina; Adjunct Professor, Uniformed Services University of the United States, Bethesda, Maryland.

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