Post Combat Care

The Road Home

Demographics: OEF/OIF Veterans Using VA Health Care

- **Approximately 2.04 million individuals have been deployed since 2002**
- **1,094,502** OEF and OIF veterans who have left active duty and become eligible for VA health care FY 2002 through end FY 2009
  - **52% (573,404)** Former Active Duty troops
  - **48% (521,098)** Reserve and National Guard

VHA Office of Public Health and Environmental Hazards February 2010

What are the health concerns of OEF/OIF Veterans?

Iraq/Afghanistan Veterans seen in the VA

1,094,502 of the 2.04 million deployed, are separated and eligible for VA
46% (508,152) have been seen in VA between through 9/30/09

• **Musculoskeletal**	**52.2%**
• **Nervous system (hearing)**	**39.8%**
• **GI (dental)**	**33.9%**
• **Endocrine/Nutrition**	**26.6%**
• **Injury/Poisoning**	**25.6%**
• **Respiratory**	**22.9%**

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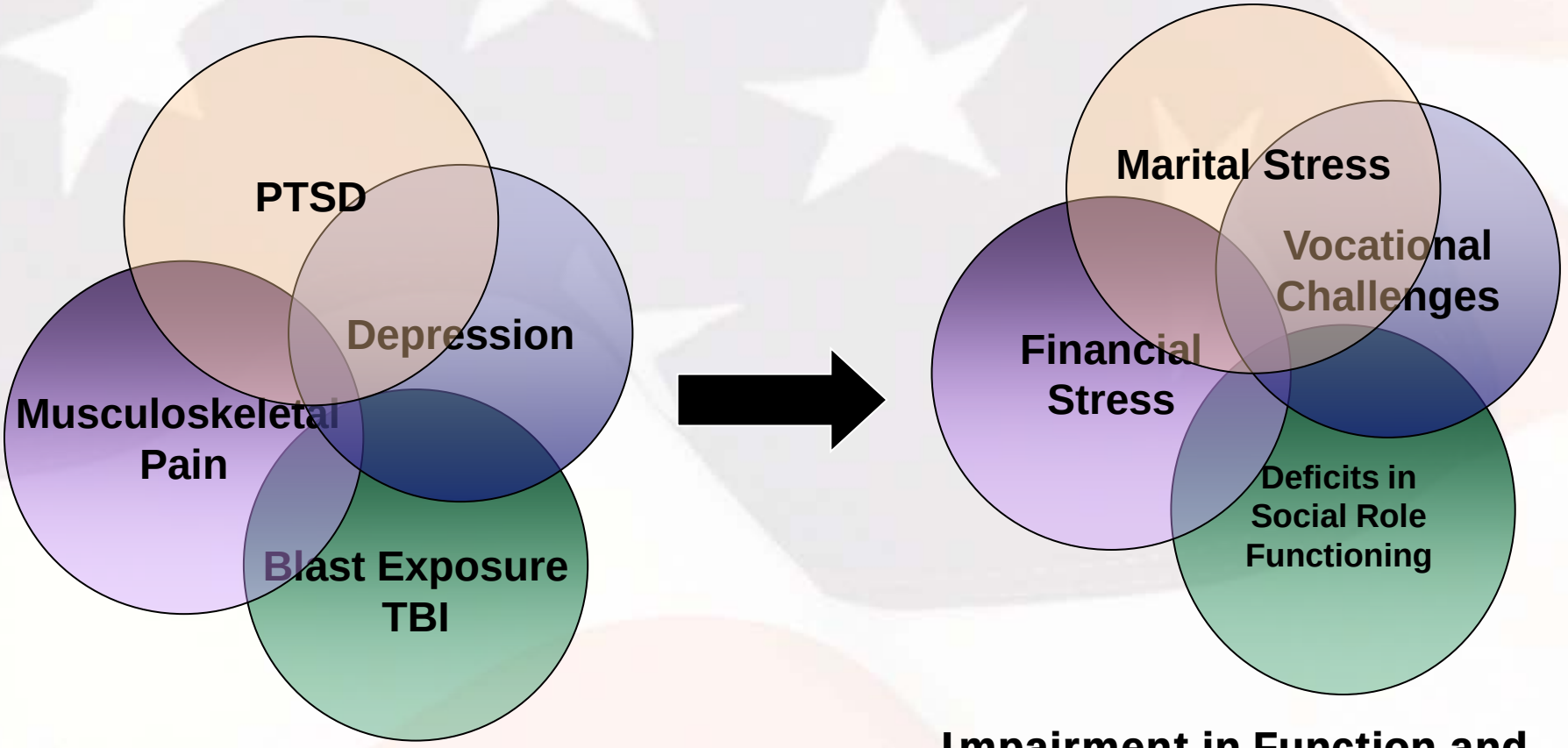
What do these veterans say they need?

• Medical Care	49
• Assistance with C&P claim	21
• Financial	19
• Employment	19
• Dental	16
• Someone who understands	15
• Sleep	13
• Education	13
• Mental Health	13
• Counseling	12
• Marital	9
• Help with family/friends	8
• Housing	6
• Sexual functioning	6
• Legal	4
• ETOH treatment	2

85 OEF/OIF Veterans separating from Ft Lewis

How does combat affect health?



Clinical Diagnosis

(What the clinician sees)

Impairment in Function and Social Reintegration

(What the Veteran experiences)

Rationale for Implementation of OEF/OIF, Polytrauma and PDICI Programs

We recognized unique needs in returning combat Veterans:

- **High prevalence of physical injury, pain, TBI risk and mental health co-morbidities**
- **High rates of psychosocial impairments impacting marriages, families, financial and occupational domains**
- **High risk of functional decline in early months and years post-deployment; increased suicide risk**
- **Recognition that mainstream primary care not prepared to effectively meet the needs of this population**

Taking into account the unique needs of returning combat Veterans:

- **High prevalence of physical injury, pain, TBI risk and mental health co-morbidities**
  - **Need for integration of medical care, mental health care, polytrauma, SW and pain management support**
- **High rates of psychosocial impairments impacting marriages, families, financial and occupational domains**
  - **Need for SW involvement and benefits counseling as a standard of care**
- **High risk of functional decline in early months and years post-deployment; increased suicide risk**
  - **Need for more intensive SW case management/care management**
- **Recognition that mainstream primary care not prepared to effectively meet the needs of this population**
  - **Need for entire staff (clinicians and support staff) to be trained in post-combat health care needs**

Physical Health Outcomes

Medical literature supports:

- Elevated rate of new onset and recidivism of nicotine use
- Elevated rates of hypertension
- Elevated rates of eating disorders and weight changes in women
- Elevated rates of chronic pain and medically unexplained symptoms
- Elevated rates of Vitamin D deficiency

Mental Health Outcomes

Medical literature supports:

- Increased risk of excess alcohol use and alcohol related problems in combat veterans
- Higher rates of other substance abuse

Substance Use Disorder Prevalence

- 7.1 percent of veterans in past 12 months
- 3.8 percent of civilian population in past 12 months
- 12 percent misuse alcohol after return from Iraq
- Cigarette smoking in veterans in past month 18.8 percent
- Cigarette smoking in general population in past month 14.3 percent

Combat Related PTSD

- 11.8 % had symptoms of PTSD soon after deployment
- 16.7% had symptoms of PTSD 6 months after deployment
- Almost half remain symptomatic 3 years later
- PTSD Incidence is 3 times higher in combat exposed veterans

PTSD, DSM4 criteria

Traumatic event (perceived/actual threat to life)

3 of the following sxs for ≥ 1month

- **Re-experiences the event: intrusive recollections, nightmares, flashbacks**
- **Avoid reminders of the event and has generalized numbness of feeling**
- **Increased arousal: sleep, irritability, concentrating, vigilance, startle**

Significant impairment in social, occupational, other areas of functioning

PTSD Checklist

- Repeated, disturbing *memories, thoughts, or images of a stressful experience from the past?*
- Repeated, disturbing *dreams of a stressful experience from the past?*
- Suddenly *acting or feeling as if a stressful experience were happening again (as if you were reliving it)?*

PTSD Checklist

- Feeling *very upset when something reminded you of a stressful experience from the past?*
- Having *physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?*
- Avoid *thinking about or talking about a stressful experience from the past or avoid having feelings related to it?*

PTSD Checklist

- Avoid *activities or situations because they remind you of a stressful experience from the past?*
- Trouble *remembering important parts of a stressful experience from the past?*
- Loss of *interest in things that you used to enjoy?*
- Feeling *distant or cut off from other people?*

PTSD Checklist

- Feeling *emotionally numb or being unable to have loving feelings for those close to you?*

- Feeling as if your *future will somehow be cut short?*
- Trouble *falling or staying asleep?*
- Feeling *irritable or having angry outbursts*
- Having *difficulty concentrating?*
- Being *“super alert” or watchful on guard?*
- Feeling *jumpy or easily startled?*

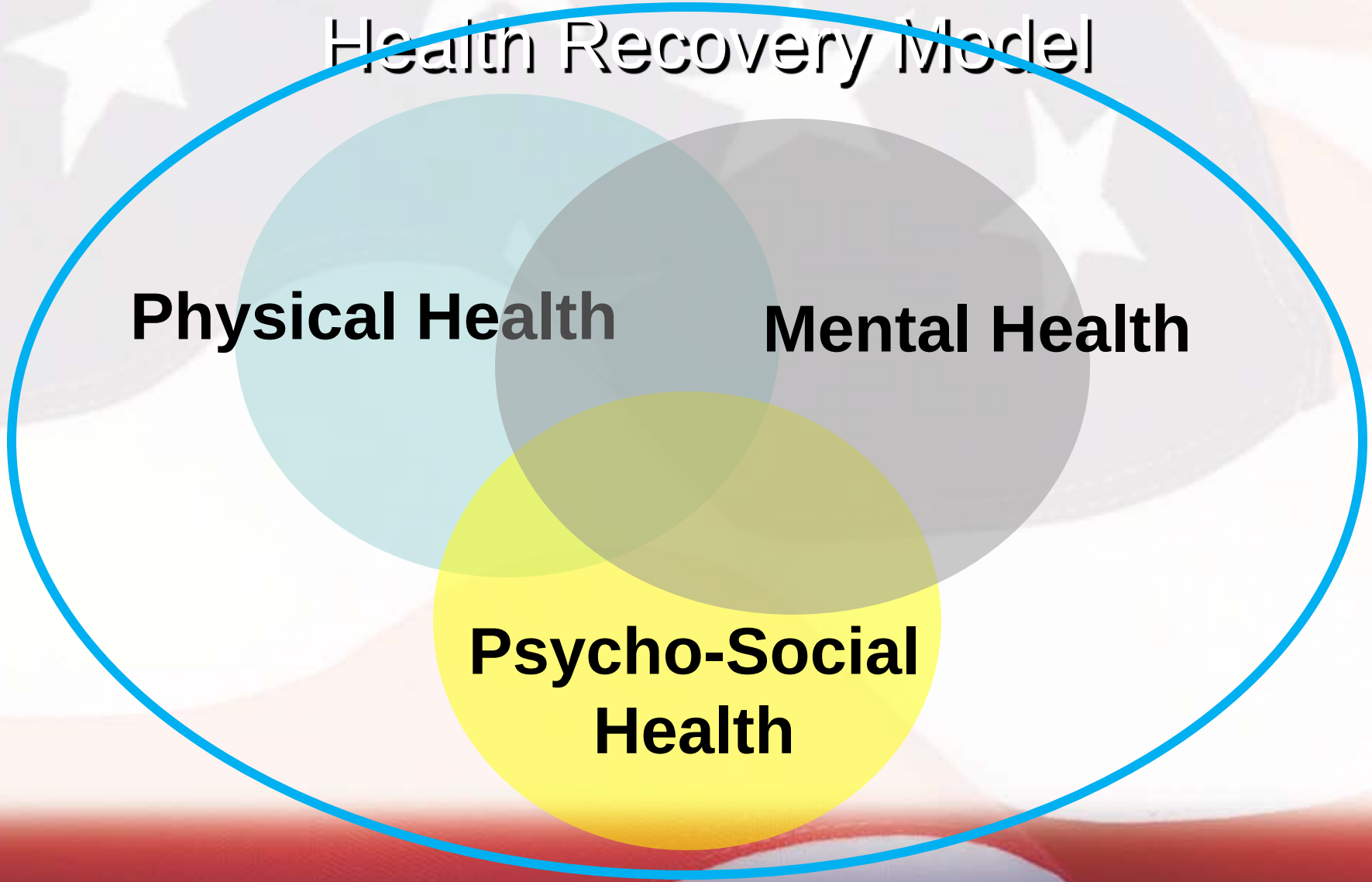
PTSD and Alcohol

- Worsens sleep disorders
- Increased emotional numbing, social isolation, anger, irritability, depression, hypervigilance
- Increase in Anxiety Disorders, Mood Disorders, Disruptive Behavior, Abuse of other substances, Chronic Physical Illness (Diabetes,Heart Disease or Liver Disease),Chronic Pain

Caffeine Withdrawal Symptoms

- Headache
- Fatigue
- Decreased attentiveness
- Irritability
- Depression
- Difficulty concentrating
- Nausea
- Muscle pain/Stiffness

Integrated Post Combat Care: Health Recovery Model



Musculoskeletal Pain

Stepped care multidisciplinary approach:

- Meds: nsaids, tca or neurontin for neuropathic pain, muscle relaxers for spasm, analgesic topicals
- Early referral for health psychology (biofeedback), chiropractor services, physical therapy, TENS
- Understand that co-morbid mental health conditions (anxiety, sleep disturbances, and ptsd/depression) will lower pain threshold and augment pain experiences; effective treatment strategies must address both

Chronic Pain and Opiates

- Patients on opiates must be re evaluated for appropriateness of use
- Education about opiate effects and negative aspects of self medication of ptsd symptoms with opiates
- Non opiate therapy for pain is used whenever possible
- Pain addressed as a complex medical problem with a comprehensive approach and emphasis on improved function

Troops' pain meds raise concerns

- By 2005, two years into the war, narcotic painkillers were the most abused drug in the military, according to a survey that year of 16,146 service members.
- Among soldiers, 4% surveyed in 2005 admitted abusing prescription narcotics in the previous 30 days, and 10% did so in the previous 12 months.

Sleep

- Addressing sleep concerns is a often a good first step towards more comprehensive mental health treatment
- Decent data to support Prazosin (titrate to 10mg qhs) as a first line in treating combat related sleep disturbances
- Consider behavioral health/health psychology referral for sleep hygiene

PTSD Treatment

- Specialized counseling: PTSD clinic
  - Exposure therapy (confront painful memories/feeling)
  - Cognitive Processing therapy
  - Anxiety management, biofeedback
  - Interpersonal therapy
  - Group therapy

Smoking Cessation and PTSD

- Integrated treatment including counseling and pharmacologic treatment with nicotine replacement or Varenicline while undergoing treatment for PTSD
  - Patients 5 times more likely to quite smoking than patients patients receiving separate treatment for smoking cessation during a 9 month period of follow-up

PTSD/SUD Symptom Overlap

- Fatigue
- Insomnia
- Headaches
- Startle Response
- Hyperarousal or Hypervigilance
- Anxiety
- Fear
- Nightmares
- Shutting Down
- Increased Substance Abuse

Post Combat Care

- Integrates Primary Care, Mental Health, Chronic Pain Care, Social Work, and Treatment for TBI
- Understands the interaction between multiple post deployment problems
- Effective at treating the “whole” person and reintegrating veterans back into their families and the community