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Cultural Competence for Serving Veterans: an Overview and Practical Considerations for Optometrists

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Abstract

As the demographics of the veteran population shift over time, it is our responsibility as optometrists to adapt to the different needs of our patients through trauma-informed care and cultural competence. We highlight aspects of caring for this specific population along with considerations and actions to take in an optometric setting to optimize outcomes and improve trust in us as healthcare providers.

Key Words: *veterans, cultural competency, cultural competence, trauma-informed care, optometric care, military culture*

Background

In 1976, the Veterans Health Administration (VHA) integrated optometry into its healthcare system to provide important eyecare services to veterans alongside ophthalmology. Since then, the VHA Optometry service has grown significantly and now provides most of the primary eye care and low vision rehabilitation services for the nation's 22.6 million veterans.[1-2] More than 950 staff optometrists, 1,300 optometry students and 215 residents work and learn at more than 350 VHA facilities throughout the country.[1] Almost 70% of graduates from the accredited optometry schools in the United States have completed a rotation at a VHA medical facility.[2] Optometrists in the private sector may also deliver care to this population, as approximately 58% of veterans do not use VHA healthcare services.[3] These veterans may opt to receive eye care outside the VA system and pay for their care using private health insurance, Medicare, Medicaid, the military healthcare program (TRICARE), the VHA Community Care program, or other means.[3-4]

Over the past 20 years, the demographics of the veteran population have dramatically shifted. Historically, the average veteran patient was older than 58, Caucasian and male.[5] However, as with trends in the U.S. population overall, the demographic profile of veterans has changed and is expected to continue changing over the next 20 years.[6] Projections indicate that the veteran population will be younger and more racially and ethnically diverse, with an increase in the number of female veterans from 6% (in 2001)[5] to 18% in 2046.[7-10] While data is limited, 6.1% of the current military population is estimated to be LGBTQ (lesbian, gay, bisexual, transgender, and queer).[11-12]

With this shift in demographics comes an expanding scope of medical and socio-political concerns that healthcare providers should be aware of and equipped to address. Among these concerns are those more unique to the veteran population, including being mentally and physically affected by trauma and increased comorbidities. Providing culturally competent care means being cognizant of the many issues relevant to veterans including, but not limited to, race, gender identity and sexual orientation. In addition,

healthcare disparities in both access and quality of care have been shown to vary by sex, race, sexual orientation, age, socioeconomic status and other factors.[13-18] As optometrists, we ought to be prepared to recognize these challenges, consider contextual information from a patient's background, and improve our ability to care through awareness, understanding and inclusion.

Considerations in the Care of the Veteran Patient

Trauma-informed care

Trauma affects the lives and health of many veterans before, during and after military service. Be aware of how to approach veterans with mental health conditions, including post-traumatic stress disorder (PTSD) and military sexual trauma (MST). Veterans have higher rates of mental health conditions including anxiety, depression and frequent mental distress compared with their civilian counterparts.[19-24] These rates are even greater among veteran women than among veteran men.[19,21,23-24] These mental challenges may also be exacerbated by MST; approximately 1 in 3 veteran women and 1 in 50 men have experienced MST.[23-24] Veterans affected by trauma may be overwhelmed by negative feelings and be prone to irritability and anxiousness.[19-24] Therefore, clinicians should proactively adopt a trauma-informed approach with all patients:

- Avoid possible triggers and escalating negative behaviors. Each veteran may have personal PTSD triggers that may cause disturbing thoughts, intense emotions or flashbacks.[19-24] Common triggers include certain conversation topics, confrontation, crowded areas, loud noises or unexpected physical touching.[19-24]
- Prioritize consent and avoid any physical contact without permission. Explain an action, such as holding eyelids during tonometry and binocular indirect ophthalmoscopy, before performing it.
- Evaluate the clinic from the patient's perspective. Enter the office and go through the motions of an exam from the viewpoint of a patient. How are patients greeted? What do they see or hear in the waiting or exam room?

Unfortunately, some veterans have had negative provider interactions, which may influence subsequent healthcare experiences. Build trust by being dependable, caring and genuine. To facilitate a better exam experience:

- Acknowledge patient complaints and concerns. Answer all questions that may be asked without seeming dismissive or rushing the exam.
- Be transparent and flexible with regard to treatment options to help the patient make informed decisions. Incorporate the patient's view of the diagnosed condition, and tailor management plans to be realistic to the patient's lifestyle. For example, if a patient has erratic bedtimes, consider prescribing latanoprost to be used in the morning alongside other medications.
- Avoid confrontational language and tone when discussing non-compliance to avoid seeming accusatory or condescending. Instead of "You are going to go blind if you always miss your drops," say "I understand it's difficult for you to consistently use your drops because [you're really busy or you have other health concerns]. Let's try to figure out a game plan to get you back on track because it is really important for you to take them."
- If a patient becomes agitated or distressed, carefully try to determine what is causing this state. Respond in a calm manner: "Let's slow down and focus on helping you to feel safe. What can I do to help?"

Traumatic brain injuries

Traumatic brain injuries (TBIs) are unfortunately not uncommon in the veteran population. Exposure to blasts is one of the most frequent injuries suffered by those who served in Iraq and Afghanistan during

Operation Enduring Freedom (OEF; 2001-2014) and Operation Iraqi Freedom (OIF; 2003-2010).[25-28] From 2000 to 2021, the Department of Defense reported that more than 453,919 cases of TBI were diagnosed among U.S. forces.[25] It is estimated that 22% of all casualties from the OEF/OIF conflicts resulted from brain injuries. In contrast, 12% of Vietnam War-related casualties resulted from brain injuries.[25,28-29] Other common causes of TBIs in the military include motor vehicle accidents, gunshot wounds and head injuries during training exercises.[25-29]

Issues resulting from TBIs can include headaches, photosensitivity, eyestrain, sleep and mood disorders, memory problems and slower thinking.[25,27-28,30-31] These conditions can lead to long-term physical and mental health problems. To address eye-related concerns:

- Perform a comprehensive eye examination, including assessing visual acuity, pupillary response, intraocular pressure, and confrontation visual fields as well as examining the anterior and posterior segments.
- Assess for any possible oculomotor dysfunctions or visual discomfort for veterans who may have a history of TBI. This includes a more in-depth assessment of versional eye movements, vergence eye movements, accommodation, cover testing and photosensitivity. Patients may benefit from prisms, additional correction for near work, tinted lens coating and/or vision therapy to alleviate headaches and eyestrain.
- For veterans who are sensitive to bright and flashing lights, maximize visual comfort by using dimmer lighting when possible.
- Consider dilation with a lower-concentration mydriatic drop such as 0.5% tropicamide (or excluding 2.5% phenylephrine if using 1.0% tropicamide) when possible to lessen patient discomfort and improve tolerability. Be sure to educate the patient as to why dilation is important and on the possible side effects such as temporary blurry vision, photosensitivity, etc.

Comorbidities among veterans

Veterans have been shown to have a higher rate of comorbidities than the general population.[32-33] This results in complex medical histories, which may involve physical, psychological and substance abuse that requires sensitivity. Consider:

- Being aware of the language used. An illness does not define a patient. Referring to a patient as “someone with diabetes” instead of “a diabetic” can go a long way.
- Being cognizant of the medical conditions associated with period of service in which the patient has served, as certain environmental exposures can lead to a higher risk for certain diagnoses. For example, veterans deployed to Vietnam between 1962 and 1975 and near the Korean Demilitarized Zone from 1967 to 1971 were potentially exposed to the toxic herbicide Agent Orange, which has been shown to cause cancers, diabetes, ischemic heart disease, Parkinson’s Disease and other illnesses.[32-34] Veterans involved in the Gulf War (1991) and OEF/OIF have higher rates of photosensitivity and dry eye syndrome from the desert environment.[27-28,31,35]
- Having an interdisciplinary approach with other specialties and referring veterans who also need to be seen by neurology, endocrinology, therapists and psychiatrists, audiologists, physical medicine and rehabilitation, etc.

Influences of military culture

Many aspects of military culture can impact a veteran’s beliefs, values, traditions and behaviors. The military ethos emphasizes the importance of group over self and respect of the hierarchical “chain of command” organizational structure.[36-38] These values are carried throughout the rest of a veteran’s life. As a result, some patients:

- May have a seemingly low priority on self-care.
- May have mixed feelings about receiving health care.
- May have concerns about perceptions and consequences from seeking care, especially mental health care (e.g., harming a career or being viewed as “weak” by peers).
- May feel that their symptoms and conditions are not as critical and may feel guilt (i.e., “someone else may need these resources more than I do”).[36-38]

Be mindful of these factors when examining a veteran patient and:

- Be considerate of any stigma as a barrier to truthful reporting of symptoms.
- Avoid making assumptions about experiences.
- Listen to the patient and avoid being condescending. Convey genuine concern and empathy through eye contact and body language. For example, avoid typing on the computer if the patient is discussing symptoms and concerns.

Diversity competence

Be cognizant of different racial and ethnic values among veterans that may impact how they approach suggestions for decision-making and treatment plans from healthcare providers. There is a history of racism in medicine towards people of color.[13] Black and indigenous people in particular tend to receive lower-quality healthcare. This leads to worse medical outcomes and increased morbidity and mortality compared to that of their White counterparts.[13-17] Cultural competence is crucial to closing the gap in the quality of health care.[39-41] Make sure your patients feel listened to and confirm that you have met their needs during the exam by:

- Using inclusive language when speaking and on health intake forms.[39] Note a patient’s pronouns in the chart, so you do not have to ask repeatedly over multiple visits.
- Being mindful of how you refer to a patient’s race and ethnicity. Do not make assumptions about the patient’s race and ethnicity, sexual orientation, gender identity, beliefs or concerns based on physical characteristics such as appearance, clothing, tone of voice or perceived masculinity or femininity.
- Asking open questions such as “How may I help you today?” (instead of including sir, ma’am”) and “What pronouns do you use?” Always use general wording such as “partner” rather than “husband” or “wife,” or “parents/guardians” rather than “mother” and “father.”[39]
- Asking patients how they feel about their diagnoses and treatment recommendations. Some patients may have difficulty establishing trust toward their medical provider. If patients express resistance or an alternative solution against your recommendations, don’t immediately correct them. Instead, acknowledge their perspectives: “I understand you are concerned about your health. I want to make sure that we take the route that will be the most effective and convenient for you, and I hope that you will be open to considering these options with me.”[42]

As a general rule, if there is any doubt or uncertainty as to a patient’s preferences, ask for guidance in a respectful manner. If it does not jeopardize the eye health plan, try to integrate one or more of the patient’s alternative solutions. The goal is to create a safe atmosphere for our patients, and these actions can be a small but meaningful step in establishing trust and improving their experience during an eye exam.

The importance of cultural humility

Cultural competence is essential to building diversity awareness and preventing errors due to lack of cultural understanding. With the ever-evolving complexities of multiculturalism, healthcare providers must view it as a dynamic process, one that begins with an awareness of their own culture and beliefs.

Tervalon and Murray-Garcia introduced the term cultural humility, which encourages personal reflection and growth around culture in addition to being culturally competent.[43]

To effectively connect with those from other cultures, we must mitigate our implicit biases ? unconscious stereotypes and perceptions towards certain ideas or groups that can influence our behaviors and actions.[44-45] To create a non-judgmental environment for patients:

- Do not let personal beliefs and prejudices affect your care; this includes racial, religious and cultural stereotypes.
- Recognize any implicit biases you may have, reflect on the social interactions that you have had, and learn from others who are socially dissimilar.[42,44-46]
- Use local and online resources to gain personal and organization perspective on cultural competence and help you to find personal ways to improve.[42] The U.S. Department of Health & Human Services Office of Minority Health offers a self-directed practical guide for culturally competent care for physicians.[46] For those who practice institutional optometry, your institution may offer training in cultural competence. For those who work or rotate through a VHA clinic, the VHA Talent Management System offers several courses on cultural competence.

Conclusion

The face of the VHA patient population will continue to change, and this increasingly diverse community of people all have different experiences, preferences, beliefs and values. We bear the responsibility to improve our own cultural competence to meet the needs of our patients. Patients' overall identity is a culmination of many factors ? gender identity, race, ethnicity, religion, socioeconomic status, sexual orientation ? which shape their perceptions of health care and potential barriers to care. Improving our cultural competence leads to better patient communication, increases compliance with treatment and follow-up care, and improves patient trust in healthcare providers. Ultimately, this will maximize health outcomes. Optometry, just as other healthcare professions, needs to shift its focus and priorities as our patient populations continue to evolve. Recognizing these challenges and adapting to each patient's needs may mean the difference between average and excellent care. This aligns with the VHA's core values of integrity, commitment, advocacy, respect and excellence.

References

1. VA Optometric Service [Internet]. Washington, DC: U.S. Department of Veterans Affairs; 2019 Sep [cited 2021 Aug 29]. Available from: https://www.va.gov/optometry/docs/Optometry_Service_Brochure_9-2019.doc.
2. VA Health Care Optometry: Education and Training [Internet]. Washington, DC: U.S. Department of Veterans Affairs; 2021 Jul [cited 2021 Aug 29]. Available from: https://www.va.gov/optometry/education_and_Training.asp.
3. The Number of Veterans that Use VA Health Care Services: a Fact Sheet [Internet]. Washington, DC: Congressional Research Service; 2014 Jun [cited 2021 Aug 14]. Available from: https://sgp.fas.org/crs/misc/R43579.pdf.
4. VA Health Care: Community Care [Internet]. Washington, DC: U.S. Department of Veterans Affairs; 2021 Jan [cited 2021 Aug 29]. Available from: https://www.va.gov/COMMUNITYCARE/programs/Veterans/General_Care.asp.
5. 2001 National Survey of Veterans [Internet]. Washington, DC: U.S. Department of Veterans Affairs; 2002 Aug [cited 2021 Aug 29]. Available from: https://www.va.gov/VETDATA/docs/SurveysAndStudies/NSV_Methodology_Report.pdf.
6. Demographic Turning Points for the United States: Population Projections for 2020 to 2060 [Internet]. Washington, DC: U.S. Census Bureau; Feb 2020 [cited 2021 Aug 29]. Available from: https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1144.pdf.

7. National Center for Veterans Analysis and Statistics: Veteran Population. Washington, DC: U.S. Department of Veterans Affairs; 2021 Apr [cited 2021 Aug 29]. Available from: https://www.va.gov/vetdata/Veteran_population.asp.
8. Those Who Served: America's Veterans from World War II to the War on Terror: American Community Survey Report [Internet]. Washington, DC: U.S. Census Bureau; 2020 Jun [cited 2021 Aug 29]. Available from: https://www.census.gov/content/dam/Census/library/publications/2020/demo/acs-43.pdf.
9. Shaeffer K. The Changing Face of America's Veteran Population [Internet]. Washington, DC: Pew Research Center; 2021 Apr 5 [cited 2021 Aug 29]. Available from: https://www.pewresearch.org/fact-tank/2021/04/05/the-changing-face-of-americas-Veteran-population/.
10. Racial and Ethnic Minority Veterans [Internet]. Washington, DC: U.S. Department of Veterans Affairs; 2020 Jul [cited 2021 Aug 23]. Available from: https://www.va.gov/HEALTHEQUITY/Race_Ethnicity.asp.
11. Meadows SO, Engel CC, Collins RL, et al. 2015 Department of Defense Health Related Behaviors Survey [Internet]. Santa Monica, CA: RAND Corporation; 2018 [cited 2021 Aug 29]. Available from: https://www.rand.org/pubs/research_reports/RR1695.html.
12. Better Data Needed to Assess the Health Outcomes of Lesbian, Gay, Bisexual, and Transgender Veterans [Internet]. Washington, DC: United States Government Accountability Office. 2020 Oct [cited 2021 Aug 21]. Available from: https://www.gao.gov/assets/gao-21-69.pdf.
13. Egede LE. Race, ethnicity, culture, and disparities in health care. J Gen Intern Med. 2006;21(6):667-9.
14. Anderson KO, Green CR, Payne R. Racial and ethnic disparities in pain: causes and consequences of unequal care. J Pain. 2009 Dec;10(12):1187-204.
15. Fiscella K, Sanders MR. Racial and ethnic disparities in the quality of health care. Annu Rev Public Health. 2016:37(1):375-94.
16. Paradies Y, Truong M, Priest N. A systematic review of the extent and measurement of healthcare provider racism. J Gen Intern Med. 2014;29(2):364-87.
17. Carter A, Borrero S, Wessel C, Washington DL, Bean-Mayberry B, Corbelli J; VA Women's Health Disparities Research Workgroup. Racial and ethnic health care disparities among women in the Veterans Affairs Healthcare System: a systematic review. Womens Health Issues. 2016 Jul-Aug;26(4):401-9.
18. Yamada T, Chen CC, Murata C, et al. Access disparity and health inequality of the elderly: unmet needs and delayed healthcare. Int J Environ Res Public Health. 2015;12(2):1745-72.
19. Health of Those Who Have Served [Internet]. Minneapolis, MN: United Health Foundation; 2016 [cited 2021 Aug 23]. Available from: https://assets.americashealthrankings.org/app/uploads/htwhs_report_r3.pdf.
20. Owens GP, Baker DG, Kasckow J, Ciesla JA, Mohamed S. Review of assessment and treatment of PTSD among elderly American armed forces veterans. Int J Geriatr Psychiatry. 2005 Dec;20(12):1118-30.
21. Oster C, Morello A, Venning A, Redpath P, Lawn S. The health and wellbeing needs of veterans: a rapid review. BMC Psychiatry. 2017 Dec 29;17(1):414.
22. Goldberg SB, Simpson TL, Lehavot K, et al. Mental health treatment delay: a comparison among civilians and veterans of different service eras. Psychiatr Serv. 2019 May 1;70(5):358-366.
23. Military Sexual Trauma [Internet]. Washington, DC: U.S. Department of Veterans Affairs; 2021 May [cited 2021 Aug 29]. Available from: https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf.
24. Cichowski SB, Rogers RG, Clark EA, Murata E, Murata A, Murata G. Military sexual trauma in female veterans is associated with chronic pain conditions. Mil Med. 2017 Sep;182(9):1895-9.
25. DoD TBI Worldwide Numbers [Internet]. Falls Church, VA: Military Health System; 2021 [cited 2022 July 6]. Available from:

https://health.mil/Military-Health-Topics/Centers-of-Excellence/Traumatic-Brain-Injury-Center-of-Excellence/DOD-TBI-Worldwide-Numbers.
26. VA/DoD Clinical Practice Guidelines: Management and Rehabilitation of Post-Acute Mild Traumatic Brain Injury [Internet]. Washington, DC: U.S. Department of Veterans Affairs; 2021 [cited 2021 Aug 23]. Available from: https://www.healthquality.va.gov/guidelines/Rehab/mtbi/.
27. Phipps H, Mondello S, Wilson A, et al. Characteristics and impact of U.S. military blast-related mild traumatic brain injury: a systematic review. Front Neurol. 2020 Nov 2;11:559318.
28. Cifu DX, Taylor BC, Carne WF, et al. Traumatic brain injury, posttraumatic stress disorder, and pain diagnoses in OIF/OEF/OND Veterans. J Rehabil Res Dev. 2013;50(9):1169-76.
29. Raymont V, Salazar AM, Krueger F, Grafman J. "Studying injured minds" – the Vietnam head injury study and 40?years of brain injury research. Front Neurol. 2011 Mar 28;2:15.
30. Alvarez TL, Kim EH, Vicci VR, Dhar SK, Biswal BB, Barrett AM. Concurrent vision dysfunctions in convergence insufficiency with traumatic brain injury. Optom Vis Sci. 2012 Dec;89(12):1740-51.
31. Callahan ML, Lim MM. Sensory sensitivity in TBI: implications for chronic disability. Curr Neurol Neurosci Rep. 2018 Jul 14;18(9):56.
32. Olenick M. US Veterans and their unique issues: enhancing health care professional awareness. Adv Med Educ Pract. 2015;6:635-9.
33. Richardson LM, Hill JN, Smith BM, et al. Patient prioritization of comorbid chronic conditions in the Veteran population: Implications for patient-centered care. SAGE Open Med. 2016 Nov 29;4:2050312116680945.
34. Agent Orange Exposure and VA Disability Compensation [Internet]. Washington, DC: U.S. Department of Veterans Affairs; 2021 [cited 2021 Aug 23]. Available from: https://www.va.gov/disability/eligibility/hazardous-materials-exposure/agent-orange.
35. Modi YS, Qurban Q, Zlotcavitch L, et al. Ocular surface symptoms in veterans returning from operation Iraqi freedom and operation enduring freedom. Invest Ophthalmol Vis Sci. 2014;55(2):650-3.
36. Understanding the Context of Military Culture in Treating the Veteran with PTSD [Internet]. Washington, DC: National Center for PTSD, U.S. Department of Veterans Affairs. Available from: https://www.ptsd.va.gov/professional/continuing_ed/military_culture.asp.
37. Ross PT, Ravindranath D, Clay M, Lypson ML. A greater mission: understanding military culture as a tool for serving those who have served. J Grad Med Educ. 2015 Dec;7(4):519-22.
38. Lee J, Sanders KM, Cox M. Honoring those who have served: how can health professionals provide optimal care for members of the military, veterans, and their families? Acad Med. 2014 Sep;89(9):1198-200.
39. How to Use Inclusive Language in Healthcare [Internet]. Lanham, MD: 2U Inc.; 2021 Apr [cited 2021 Aug 21] Available from: https://nursinglicensemap.com/blog/how-to-use-inclusive-language-in-healthcare/.
40. Nair L, Adetayo OA. Cultural competence and ethnic diversity in healthcare. Plast Reconstr Surg Glob Open. 2019 May 16;7(5):e2219.
41. Albieri G, Hue J, Gleason S. Cognitive strategies to improve patient care in cross-cultural settings. Optometric Education. 2017 Fall;43(1).
42. Kaufman L, Iwach AG, Varma R, Baskett LH. Improve Cultural Competence in Your Practice [Internet]. San Francisco, CA: EyeNet Magazine, American Academy of Ophthalmology; 2012 Nov [cited Aug 31]. Available from: https://www.aao.org/eyenet/article/improve-cultural-competence-in-your-practice?november-2012.
43. Tervalon M, Murray-Garcia J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. J Health Care Poor Underserved. 1998 May;9:117-125.
44. Hall WJ, Chapman MV, Lee KM, et al. Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: a systematic review. Am J Public Health. 2015 Dec;105(12):e60-76.

45. FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. BMC Med Ethics. 2017;18(1):19.
46. Think Cultural Health: a Physician's Practical Guide to Culturally Competent Care [Internet]. Rockville, MD: Office of Minority Health, U.S. Department of Health and Human Services; [cited 2021 August 31]. Available from: https://cccm.thinkculturalhealth.hhs.gov/.

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