	Citation	Access and Eligibility Issues	Outcomes for those who receive VA care versus those who don't	Common causes/issues
	Ahern, J., Worthen, M., Masters, J., Lippman, S.A., Ozer, E.J., & Moos., R. (2015). The challenges of afghanistan and iraq veterans' transition from military to civilian life and approaches to reconnection. PLOS ONE DOI: 10:(DO.10.1371/journal.pone.0128599): 1-13.			"Military as Family" = caretaker and structure; "Normal is Alien" = disconnection, unsupportive institutions, lack of civilian structure, and loss of purpose; "Searching for a new normal" = support from a navigator (peer), embracing an ambassador role, and ease with time.
	Doerries, B. (2015). The Theater of War: What Ancient Greek Tragedies Can Teach Us Today. New York, NY, Alfred A. Knopf.			Greek tragedy functioned by helping "those who'd been to war make meaning out of their fragmented memories AND (my emphasis) to evenly distribute the burden of what they brought back from battle upon the shoulders of ALL Athenians" (76).
	Damron-Rodriguez, J., White-Kazempiour, W., Washington, D., Villa, V.M., Dhanani, S. & Harada, N.D. (2004). Accesibility and acceptability of the department of veteran affairs health care: Diverse veterans' perspectives. *Military Medicine, 169, 243-250.*	Only 10% of veterans use VA health services - eligibility requirements, including military service-related disability and financial need, can limit access. Approx. 23% of eligible veterans choose the VA for health care. VA health care as a safety net option - higher use for veterans with low income or lack of medical insurance. Confusion surrounding eligibility vs. ineligibility may affect accessibility of VA services. Eligibilty status can also change over time.		Services must be available AND acceptable to the target population. Barriers may include: distance to VA centers, patient perception of discourteous and insensitive customer service, long waiting times for appointments and prescriptions, delays in getting follow-up specialty care appointments, paperwork, knowledge of available services/eligibility for services, fear of welfare stigma. Veterans' identity relates to their feelings about using VA services. Factors found to influence the use of VA health care services include: perception of attentiveness and respect from physicians and staff, war cohort, ethnicity/race, wartime military experience, belief in an entitlement to veterans services, and service-related disability.
	Davis, C.L., Kilbourne, A.M., Blow, F.C., Pierce, J.R., Winkel, B.M., Huycke, E., Langberg, R., Lyle, D., Phillips, Y., & Visnic, S. (2012). Reduced mortality among department of veterans affairs patients with schizophrenia or bipolar disorder lost to follow-up and engaged in active outreach to return for care. *American Journal of Public Health, 102, S1.*	When contacted by a social worker or other Point Of Contact, 72% of patients in the study returned to the VA for care. Among VA patients who did not accept a clinic appt following contact from a POC, reasons included: not having a perceived need for care, not satisfied with VA services, distance or transporation barriers. Patients who were ineligble for VA services were not included in the study participants.	The mortality rate of returning patients with schizophrenia or bipolar disorder was significantly lower than that for patients not returning to VA care, after at least 1 year of being lost to follow-up. The odds of dying were nearly 6 times higher for those who did not return for VA care than for those who did return.	Old Age, Medical Co-morbidities, and Longer length of time lost to follow-up, all correlated with higher odds of death. VA patients with schizophrenia or bipolar disorder who had long-term gaps in follow-up care were found to be at greater risk for experiencing poor health outcomes.

*	Elnitsky, C. e. a. (2013). "Access to the US department of veterans affairs health system: self-reported barriers to care among returnees of Operations Enduring Freedom and Iraqi Freedom." BMC Health Services Research 13: 498-.	VA Polytrauma System of Care (5 Polytrauma Centers, 23 Polytrauma Network Sites, more than 130 support sites with Polytrauma Support Clinical Teams/Points of Contact). OEF-OIF registery of current or former service members who have applied to VA services. No significant difference in access barriers for veterans with polytrauma when compared to other veterans - barriers that effect exclusive VA use for healthcare may be uniform across the board.	Two-thirds of the study's participants (n=359) reported one or more barriers to receiving VA care. The absense of these reported barriers predicted exclusive use of VA healthcare services. Experiencing any barriers doubled the returnee's odds of not using VA, the distance to VA resulted in a 7-fold increases of the odds of not using VA, and long wait times double the odds of not using VA. Continuity of quality healthcare and reduced costs are both enhanced through exclusive use of VA care.	"Polytrauma" - multiple complex injuries to body systems - experiened by veterans of Afghanistan and Iraq. Barriers: cost of health care services, fear/embarrassment/stigma (influenced by cultural factors), being a burden to the system of taking "welfare", long wait times, long distances to treatment, concerns about staff/reputation for care, paperwork/hassle, lack of information about services, limited service hours, veteran had other insurance/monetary support/or private doctor, frear of military accessing health records, active duty status.
	Fried, D.A., Helmer, D., Halperin, W.E., Passannante, M., & Holland, B.K. (2015). Health and health care service utilization amoung U.S. veterans denied VA service-connected disability compensation: A review of the literature. *Military Medicine, 180, 10:1034.*	The VA disability compensation adjudication process can be onerous. Some individuals with SMI may be "denied" disability compensation because their psychiatric impairments are so severe that they are unable to give a full history of their military service or provide the necessary documentation. Denial of VA disability compensation signifies that a condition cannot be tied to military service, not that the condition is not severe or in need of supportive services. "Denied" applicants, when compared to "awarded" applicants, have lower socioeconomic status, more social isolation and unmet medical and psychiatric health care needs. This group of "denied" applicants may benefit from targeted outreach. "Denied" applicants who are poor, but who exceed the VA's income threshold for free care, may choose to forego health care or obtain alternative sources of care.	Compared to veterans "awarded" VA disability compensation, those "denied" have poorer health, use less VA health care, experience greater poverty and unemployment, and may experience social isolation. Veterans "denied" VA disabilty compensation leave the claims process with far fewer resources and a much thinner safety net. "Denied" subjects often report health limitations on their abiltiy to work.	Results from studies of other populations suggest that veterans "denied" VA disability compensation may be socially isolated and socioeconomically disadvantaged. Social isolation can effect health in multiple ways: homelessness, lower levels of encouragement, support and health-related feedback, reduced consumption of medical care and other health services, and reduced labor force participation. Strongly held beliefs or attitudes may influence veterans seeking health care (i.e. denial of a disability claim may discourage VA use.)
	Gabrielian, S., Yuan, A.H., Andersen, R.M., Rubenstein, L.V., & Gelberg, L. (2014). VA health service utilization for homeless and low-income veterans: A spotlight on the va supportive housing (vash) program in great los angeles. *Medical Care, 52, 5.*	Homeless veterans underuse health care relative to housed veterans - HUD VASH may address this disparity through housing and primary care referrals. Homeless veterans may benefit from increased access to VA PCMH e.g. walk-in and after hours appointments.	Study compared VA health service utilization among 4 groups: formerly homeless veterans housed through HUD-VASH, currently homeless veterans, housed low-income veterans not in HUD-VASH, and housed not low-income veterans. HUD-VASH and currently homeless veterans have the highest need. HUD-VASH may enable health care utilization and outpatient care for formerly homeless veterans and reverse disparities between currently homeless and housed veterans. Currently homeless veterans may be less VA-affiliated than HUD-VASH veterans and more like to use non-VA care.	HUD-VASH case management did not show an effect on preventable hospitalizations or use of acute care (emergency services and inpatient)

	Gordon, A.J., Haas, G.L., Luther, J.F., Hilton, M.T., Goldstein, G. (2010). Personal, medical, and healthcare utilization among homeless veterans served by metropolitan and nonmetropolitan veteran facilities. *Psychological Services, 7, 2, pp 65-74.*		Study of nonmetropolitan versus metropolitan based homeless veterans. Homeless veterans in metropolitan areas were 1.4 times more likely to have used a VA health facility in the 6 months prior to interview than homeless veterans in nonmetropolitan areas (might be attributable to access to transportation). The metropolitan group's lesser occurrence of employment, higher level of disability payments, and relatively high use of VA health facilities after one year of homelessness, may indicate relatively greater disabiltiy.	Vietnam veterans were more likely than pre-Vietnam, post-Vietnam or Persian Gulf veterans to use VA health facilities. Veterans in the metropolitan group who were homeless for more than 1 year were more likely to use VA services than were veterans who were homeless for less than 6 months. Veterans with a histroy of alcohol or drug dependece were more likely to use VA health facilities.
	Health and homelessness among veterans: A literature review. National Health Care for the Homeless Council, May 2012.	Veterans with compensation benefits are higher priority in the VA system, while those with pension benefits wait longer before receiving the most basic services. Veterans receiving compensation benefits were more likely to be female and married, while those receiving pension benefits were more likely to be older, have no income, and experience homelessness for one year or more. Female veterans have been found to underutilize the VA system in comparison to their male counterparts.		Veterans make up approximately 16% of the adult homeless population. Likelihood of VA health services utilization is increased by: higher income, receipt of VA benefits, placement in residential treatment programs, older age, higher educational attainment, service in Vietnam or a war zone, dual diagnosis, diagnosis of PTDS, high score on the health problems index, service-connected disabilties, non-service connected pensions, living in a city with VA medical centers/hospitals, and living in a metropolitan area. Factors that decrease VA services utilization include: lengthier duration of homelessness, literal homelessness, substance abuse, schizophrenia, military history of bad conduct or dishonorable discharge, and living in a nonmetropolitan area. Consistently homeless veterans were more likely to have a VA psychiatric hospitalization that their consistently housed counterparts (19% versus 9%), more likely to use VA emergency departments services (61% versus 41%).
	Hoge, C. W. e. a. (2004). "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care." The New England Journal of Medicine 351(1): 13-22.	Study of four combat infantry units and effects of combat on mental health. Combat experience, especially repeated incidents of firefights correlates with “significant risk of mental health problems.” In addition, subjects “reported significant barriers to receiving mental health services, particularly the perception of stigma among those most in need of such care.”		
	McCarthy, J.F., Bossarte, R.M., Katz, I.R., Thompson, C., Kemp, J., Hanneman, C.M., Nielson, C. & Schoenbaum, M. (2015). Predictive modeling and concentration of the risk of suicide: Implications for preventive interventions in the us departments of veterans affairs. *American Journal of Public Health, 105, 9.*		VHA testing a predictive model that uses clinical and administrative data from electronic medical record to identify patients with increased risk for suicide. VHA could introduce enhanced clinical care, evidence-based suicide interventions and target those at highest risk.	Suicide decedents were more likely than nonsuicide partients to be young, male, and unmaarried, to live in a rural area, to have a hsitory of or be at reisk for homeslessness, to have no service-connected disabilities, to have diagnosed mental health conditions, pain , sleep disorders, and traumatic brain injury, to have used VHA mental health services, to have had psychiatric hospitalizations, to have received mental health residential care and emergency department or urgent care, to have used psychotropic medication, and the previously attempted suicide.

	Montgomery, A.E., Byrne, T.H. (2014). Services utilization among recently homeless veterans: A gender-based comparison	Veterans who do not use VA homeless assistance services are generally less engaged with preventative VA heath and behavioral health care	Veterans who seek mainstream homeless services use fewer VA outpatient services, but more VA emergency department services.	The female Veteran population is anticipated to grow by 17% over the next two decades (in 2011, women were 7.2% of the Veterans population but 9.8% of the population of Veterans experiencing homelessness). Among newly homeless veterans, men used more substance abuse outpatient treatment and emergency services, and women used more outpatient medical treatment.
	O'Toole, T.P., Bourgault, C., Johnson, E.E., Redihan, S.G., Borgia, M., Aiello, R., & Kane, V. (2013). New to care: Demands on a health system when homeless veterans are enrolled in a medical home model. *American Journal of Public Health, 103, S2.*	Medical care for homeless individuals is often provided in the emergency department, however this does not encompass chronic care management or preventative services. For this reason, many medical and mental health diagnoses are deferred, delayed or not-yet-diagnosed in this population.	26% of study participants in the homeless cohort stopped going to the emergency department after 3 months of primary care enrollment. In the first 6 months of enrollment in primary care, almost all homeless study participants had at least 1 newly diagnosed condition (avg. 4.1 diagnoses per person): two thirds were diagnosed with a new chronic medical condition, 45.7% had a new mental health diagnosis, and 28.3% had a new substance abuse diagnosis. Homeless individuals who had more than 5 primary care visits were almost 1.5 times more likely to have no emergency department use in the latter 3 months of the study and those with more than 5 specialty clinic visists in combination with primary care were more than 10 times more likely to have no emergency department use.	Homeless veterans are approximately 10 years older than nonveteran homeless individuals and tend to be sicker and use more acute services.
	Philips, B.R., Shahoumian, T.A., & Backus, L.I. (2015). Surveyed enrollees in veterans affairs health care: How they differ from eligible veterans surveyed by brfss. *Military Medicine, 180, 11:1161.*	Use of Veterans Health Adminstration care depends on veterans' demographic and socioeconomic characteristics, health status and medical condition, distance to a VHA facility, availability of other health care coverage and satisfaction with VHA care. Veterans Access, Choice, and Accountability Act (VACAA) increased veterans access to both VHA and nonVA health care - coordination of care is essential avoid the rish of fragmentation.	VHA serves as a safety net provider for veterans who are older, poorer and sicker than the total population of veterans eligible for services.	VHA is required to prioritize veterans with certain military experiences (e.g. combat-related injury, prisoner of war status) and veterans with low income. Veterans who are in poor health are also likely to be older.
	Phillips, D. (March 30, 2016). Report finds sharp increase in veterans denied VA benefits. New York Times. New York.	The Department of Veterans Affairs does not technically consider persons with "other than honorable" discharge as veterans - consequently, they can be denied permanenet health care, disability pay and job training. Former memebers of the military are being refused benefits at the highest rate since the system's inception after WWII. Veterans who served after 2001 were nearly twice as likely as those who served during Vietnam to be barred from benefits, and 4x as likely as thos who served during WWII.	More than 125,000 Iraq and Afghanistan veterans have discharge statuses that preclude them from receiving care. Research has shown that veterans with bad paper discharges may be more likely to commit suicide. Those with untreated post-traumatic stress disorder are at higher risk of drug abuse and incarceration.	"We separate people for misconduct that is actually a symptom of the very reason they need health care." About 6.5% of all Iraq and Afghanistan troops have bad paper discharges, one in 10 Marines is ineligible for benefits. Military increasingly relies on other-than-honorable discharges to dismiss troubled troops who might otherwise quality for time-consuming and expensive medical discharges.

	Sloane, L.B and Friedman, M.J. (2008). After the War Zone a Practical Guide for Returning Troops and Their Families.	Organizations such as Tricare, Military OneSource, Dept of Veteran Affairs, VA medical centers, Vet Centers, chaplains, and family programs offer free advice, counseling and therapy for 6 months-5 years following a deployment.		American and military cultures can make it difficult to admit psychological pain and seek mental health treatment. Barriers to care include: Fear and stigma, physical distance to available services, transporation issues, work schedule restraints, long wait times, availability of certain services, privacy of health information, childcare issues, affordability, daunting process of dealing with benefits/insurance, reluctance to revisit traumatic events, information about available services and how to access them.