IMPACT OF VETERAN-CENTRIC PREPARED NURSES ON VETERAN OUTCOMES

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Abstract: Background: Developing and including Veteran-centric care in nursing curriculum is becoming important when taking into consideration that more than 85% of veteran patients receive health care outside the Veterans Affairs (VA) system (Nelson, Starkebaum, Reiber, 2007).

Method: Veteran Affairs Nursing Academic Partnership (VANAP) represents an innovative alternative to nursing education that practices collaboration between VA facilities and accredited academic Schools of Nursing.

Results: The curriculum exposes nursing students to concepts that will allow them to practice Veteran-centric nursing care.

Conclusion: Upon graduation, students have a firm understanding of (a) military basics, including knowledge of the different branches, associated terms, and core values; (b) military culture and the warrior ethos; (c) the challenges of deployment and reintegration on service member, their families, and communities; (d) the nursing implications and how to approach these patients.

Key words: veteran, nursing, military, veteran-centric, VANAP, VA Nursing Academy

Impact of veteran-centric prepared nurses on veteran outcomes

According to the National Center for Veterans Analysis and Statistics(Risen, 2014) there are about 22 million veteran nationwide; with a significant number of aging veterans from World War II, Korean War, Vietnam War, Desert Storm (Gulf War), Operation Iraqi Freedom (OIF), and Operation Enduring Freedom (OEF). Veterans present with many of the same health issues as the general population; however, a veteran patient might also present with various service-connected injuries and other health specific issues such as devastating wounds,

amputations, post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), behavioral health issues such as substance abuse and depression, as well as history of suicide attempts (Splaine et al., 2009).

The impact of educating tomorrow's nurses about unique health needs of veterans and their families, will improve quality of nursing attention at the point of care, in the community, in the Veterans Affairs (VA) medical centers, and across systems of health care.

Additionally, developing and including Veteran-centric care in the nursing curriculum is important when taking into consideration that the biggest volume of veteran patients receive health care outside the VA system. In a study that included 184,450 veterans, conducted by Nelson, Starkebaum and Reiber (2007), the results showed that 6.2% of the veterans reported receiving all of their health care at the VA, 6.9% reported receiving some of their health care at the VA, and 86.9% did not use VA health care at all.

Therefore, the Veteran Affairs Nursing Academic Partnership (VANAP) represents an innovative alternative to nursing education that practices collaboration between VA facilities and accredited academic Schools of Nursing (Morrison-Beedy, 2016).VANAP, originally known as the VA Nursing Academy, was conceived in 2005 by the Office of Academic Affiliations (OAA) and initially funded in 2007 by the U.S. Department of Veterans Affairs to address shortage of nurses with knowledge of the specific needs of veterans. Additionally, the VANAP program prepares baccalaureate nursing workforce with the commitment of ensuring quality Veteran care and promoting nurse leadership by developing clinical cooperation that is nurturing quality patient care, promoting evidence-based practice, enriching learning experience for nursing students, developing nurse leaders, and empowering skilled nurses to answer scientific questions at the bedside (Morrison-Beedy, 2016; Miltner et al., 2015). Through strengthened academic and clinical relationships and opportunities, VANAP seeks to address a growing population of Veterans with unique and complex care needs who are served within multiple, diverse care settings. Specifically, VANAP intends to promote the safe and effective care of Veterans within and across community healthcare settings by expanding the workforce of BSN-prepared nurses able to provide quality Veteran-centric care that improves patient outcomes and reduces cost of care.

The curriculum exposes nursing students to concepts that will allow them to practice veteran-centric nursing care. Upon graduation, the VANAP students will have a firm understanding of military basics and military culture (warrior ethos) and how these impact the individual. This knowledge is critical for all those who care for military Veterans.

Military basic: Key for the health care provider

The talk amongst Veterans is that nonmilitary providers do not understand them and their unique health care needs. How can they help me (Henry M. Jackson Foundation for the Advancement of Military Medicine, 2016)? For this reason many avoid treatment or care. How can providers be effective with this unique population? The military invest a tremendous amount of time and money to train and build successful branches, each with its own unique language and terminology. Crucial to being an effective provider includes learning and identifying the language and culture specific to veterans (Redmond et al., 2015). The Department of Defense (DOD) has a Dictionary of Military and Associated Terms (Joint Staff, 2016).It is a useful reference tool. The publication is 482 pages in length and includes terms from A-Z. The Center for Deployment and Psychology/Uniformed Services University of the Health Sciences has an abbreviated version of Common Military Acronyms and Terminology, which is two pages. It is crucial for students of nursing programs and RN's to become familiar with common terms and lingo to provide better care to Veterans and reduce cultural barriers (Olenick, Flowers, &

Diaz, 2015). Communication is vital to all cultures including the military to better plan appropriate care (Brim, 2015).

Additionally, each branch of the US Military has its unique mission and core values. The Army is the oldest and largest branch (Brim, 2010). The Army's mission is to engage and destroy enemy land forces. The mission is always first and they never accept defeat, quit or leave a fallen comrade. The Army's core values are loyalty, duty, respect, selflessness, honor, integrity, and personal courage. The Navy's mission is to maintain, train, and be equipped for combat. They are always ready for combat. The Naval forces are capable of winning wars, deterring aggression and maintaining freedom of the seas. The Navy's core values are honor, courage and commitment. The Navy is the second largest branch. The US Marine Corps is the smallest branch. The Marine Corps' mission is to conduct amphibious operations and develop amphibious doctrine. They protect naval shore facilities and government property, such as the American Embassy. The Marine Corps' core values are honor, courage, and commitment.

The Air Force is the youngest branch. The Air Force's mission is to defend the country from air, space and cyber space threats. They are the aerial warfare branch. The Air Force core values are integrity first, service before self, and excellence in all we do. The Coast Guard's mission is to protect the public, the environment, and the United States economic and security interests in any maritime region in which those interests may be at risk, including international waters and America's coasts, ports, and inland waterways. The Coast Guard core values are honor, respect, and devotion to duty.

Army, Navy and Air Force Reserves are used by the DOD in emergencies, while State Governors have control over State Army National and Air Guard Units. The President can also order the Reserves and National Guard to support active duty forces (Brim, 2010). Within each service of military there is what is called Life Chapters. Life Chapters include but are not limited to boot camp/training, first assignment, tour of duty or deployment, military career continuation, separation from military service and veteran status (Brim, 2010). Individuals joining any branch of the military sign a contract of Military Service Obligation. This contract usually extends for a period of at least eight years, four as active duty and another four as reserve. Service members can enlist or accept a commission as an officer. Officers typically have a minimum of a Bachelor's degree. The military socializes new recruits through a training called basic training or boot camp. It is a rigorous process which includes harsh and humbling activities both physically and emotionally (Redmond et al., 2015).

Exposure to military culture such as language and codes are introduced. At the completion of boot camp recruits show a new identity and commitment to the military. Once boot camp is complete an assignment is given which can include their tour of duty or deployment. A tour of duty is a period of time usually spent in combat or operational duties specific for the service branch. The tour can range from 6 months to four years. Once the tour is complete, the service member then decides whether they will continue military service or separate from military service. After the military service, the individual who has served in any military service branch for any length of time is considered a Veteran.

Military culture: Understanding warrior ethos

In addition to understanding the military lingo of a service member, a health care provider in the civilian world needs to assess the depth of the effect of military culture to the individual behavior towards their engagement in their care. Military ethos or warrior ethos is a core Military culture that can be challenging in understanding veterans' response to health care.

The Warrior Ethos is stated succinctly in the four lines of the soldiers' creed: "I will always place the mission first. I will never accept defeat. I will never quit. I will never leave a fallen comrade." These ethoses have served the military person well while in service (LaMotte, 2004). Whether in the front line or in peacekeeping, it emphasizes teamwork, moral focus, and a deep and enduring sense of loyalty and commitment to fellow service members. The Military and/or war ethos are values adapted through experience with the military. Each military branch of service have unique ethos that is shared among military personnel, with common threads that include honor, courage and commitment. These same values can also negatively impact access to care if not assessed well when they are injured and in recovery. This was best described by a retired Major in the US Airforce, stating the unspoken code that military men value providing service more than receiving service. The retired marine officer added "we are used in serving and ready to die to defend our country and fellow men and it is very difficult at times to now ask to be served even though we need the health care" (S. Phillips, personal communication, August 15, 2016).

This heroic ethos may delay military personnel from seeking help. In addition, some returning soldiers from deployment may question their worthiness of surviving when their troop suffered casualties, and may question the need to seek care. Sadly, cases have been observed that the state of mental health may blur the line of being a patient and being a warrior, and see suicide as a better option. Suicide rate among veterans is roughly 50% higher than the rate among the civilians (Zarembo, 2015). As providers of health care, how do we effectively assess the warrior ethos as a factor that can spell recovery or demise if not properly addressed? Awareness and understanding of warrior roles helps the health provider more effectively inquire about and validate the range of experiences many military service members and veterans have had. Per the OAA's Military Health History Pocket Card (Veterans Health Administration Office of Academic Affiliations, 2015), history taking should include:

The combat roles or support roles, mission of deployment, combat versus humanitarian assistance and current era of complex counterinsurgency warfare where service member continuously balance the protection of life against the winning of armed conflicts. Any conflict between the values and known military ethos and what the person is expected to do to survive, can affect the trust they might have with their provider and their capacity to function. The health care provider must assess their own attitudes or possible biases about the military since this can impact the provision of care to this population. Respect for their experiences as well as their personal viewpoint needs to be clearly perceived by the patient. Transgression of deeply held values or warrior ethos may also inflict moral injury that has deleterious long-term effect emotionally, psychologically, behaviorally, spiritually and socially (Maguen & Litz, 2016). For healthcare providers, assessment of the extent of the effect of these in military person (including veterans) is critical for the coping, recovery and rehabilitation (Maguen & Litz, 2016). Pressfield (2011) highlighted how the warrior culture is not necessarily shared by the society, and can be a barrier in civilian health care provided care, where at times values can be opposites. As cited, where civilian society rewards wealth and celebrity; military culture praises honor. In warrior culture aggression is valued but not in civilian life. A warrior trains for adversity, while civilian world aims for luxury and ease. Selflessness is a virtue in warrior culture not necessarily in civilian life.

Deployment and reintegration

Deployment and reintegration can bring about many challenges that not only impact the service member but their families and communities as well. The DOD accounts that approximately forty-four percent of deployed service

members are parents. That equates to nearly one million service members (DOD, 2010). In addition to this, the DOD (2010) cites that of those that were deployed, 48% of them were deployed multiple times; as high as three to four times in the OEF/OIF theater. As a result, unique needs such as employability, family reintegration, work-place reintegration and unique healthcare needs must be understood to better meet the needs of the service members.

The reintegration of the service members post-deployment into the family, work, and community milieu can be challenging. Pre-deployment service members are trained in such a way that they are combat-ready and survivability skills are heightened; however they do not receive training for reintegration into civilian life. Military experience may be transferable to civilian employment thus providing a continuum of financial support. However, employability is not solely dependent on availability of jobs but also of the physical and mental health of the service member; albeit not all military experience is readily transferable to the civilian workforce and additional training and education is at times warranted further impacting the financial sustainability of the service members. Family reintegration post-deployment may be challenging. Just as the service member mitigates transition from pre-deployment to post-deployment, so too does the family. Resiliency is built by family members as a result of shared meaning and collaboration. Often it is found that both the service member and families have changed to certain extent. Poor reintegration may lead to decline in relationship dynamics both of the spouse and that of the children. Further, a building of trust between family members and the service member is often needed (Doyle & Peterson, 2005).

Family roles may be changed upon the return of the deployed service member; the spouse that was left behind learns how to run the household alone and in their specific manner; reintegration of household logistics and the spouse's role may also prove to be challenging (Verburg, 2010). Many military couples confirm added stressors post deployment such as low sex drive, abusive behavior, and overall dissatisfaction in the marriage due to feelings of hopelessness from the spouse (Military Times, 2013).

Children also go through reintegration dynamics with the returning parent. Often children feel a stronger connection to the remaining parent and ultimately may cause feeling of rejection of the returning parent. Babies may have no connection with the service member whereas 3-5 years old may have fear of the returning parents. The adolescent population may display indifference of their returning parent. However, all ages fear losing their parent again to deployment (Shaffer, 2008). Olenick, Flowers and Diaz (2015) have identified substance use disorder, PTSD, depression risk for suicide, TBI, chronic pain, amputations, hazardous exposures, homelessness and rehabilitative care as unique needs of the veteran. Along with these processes, one surging care need is that of moral injury. Moral injury is described as ethical and moral discord of the veteran secondary to deployment actions.

These actions may contribute to a discord of their previously held values, beliefs and humanity (Park, 2010).It has been concluded that the higher the moral injury the bigger the impact on overall mental health of the veteran (Holland et al., 2013).According to Maguen and Litz (2014)examples that might induce moral trauma are killing or harming others, witnessing death, failing to prevent immoral acts of others or receiving or giving orders from authority that conflict with internal values.

Moral injury manifestation may be categorized into emotional or behavioral categories. Emotional manifestations include inappropriate guilt and shame, anxiety, anger, emotional numbing and feeling conflicted which ultimately leads to self-loathing and forgiveness problems. Behavioral manifestation include drug or alcohol abuse, suicidal

ideations, social instability, lack of trust in others, avoidance, sleep disturbance and re-experiencing the event (Worthington & Langberg, 2012). Further, in concordance with moral injury veterans tend to justify PTSD and other mental health ailments by withdrawing from therapeutic treatments or distance themselves from supportive personnel including family members (Maguen & Litz, 2014).In addition, the veteran's spirituality may be questioned and lack of faith in their higher power diminishes (Exline, 2013).

Nursing implication: Asking the right questions

Veteran-centric nursing education focuses on culturally competent care and behaviors (Redmond, 2015). These behaviors demonstrate thoughtfulness and respect towards military culture while recognizing and accepting patient's unique experiences and background. Student nurses learn that the length of time in service and quality of experience while serving may have a significant influence on their patient's level of stress, appraisal of stressors and resources, and response to stressors inherent in military life. Having a general understanding of the broad range of potential stressors, reactions, and resources that each patient might bring; allows veteran-centric educated nurses to provide the best quality care.

Nurses taking care of veterans always start by asking permission to ask questions (Veterans Health Administration Office of Academic Affiliations, 2015) "Would it be ok if I talked with you about your military experience?", "Would it be ok if I asked about some things you may have been exposed to during your service?", "Would it be okay to talk about stress(Veterans Health Administration Office of Academic Affiliations, 2015)?"This not only allows the veteran to feel in control, but it helps establish rapport and a therapeutic relationship. Consequently it opens the door for veterans to discuss issues later, if the experience may be too difficult to discuss at the moment. Due to the broad range of patients' reaction related to military training, nurses must ask about a patient's key functions and roles in military organizations, tour of duty or deployment, and/or military career continuation decisions. These elements eliminate comments or assumptions about the veteran's experience, values, or goals and factor into the patient's self-identification.

Furthermore, healthcare providers need to be mindful that military training encourages service members to be proud of their ability to overcome any challenge. Veteran-centric nursing emphasizes understanding a veteran's interpretation of "recovery" and "resilience," (especially when it comes to mental health) as these might interfere with help-seeking and treatment success. For instance, your patient may have interpreted that "resilient" means that no matter what, being a "good soldier" means overcoming your problems on your own and returning to duty. Although resilience permits some veterans to persevere despite physical and/or mental handicaps, it hinders other veterans' transition to civilian healthcare due to its focus on the patient's problems, rather than their strengths. Hence, nurses that take care of veterans need to help their patient's create an adaptive definition of resilience, such as, redefining resilience as the ability to identify when something is wrong and actively addressing it by seeking support or healthcare.

In the end, it is the nurse's responsibility to help link patients with the right team of healthcare professionals to solve complex problems. Knowledge and familiarity with military culture and language is integral in identifying problems that need treatment, as well as effectively learning ways to bolster resilience-training components and determining how to use those components towards treatment success.

References

Brim, W.K. (2015). Military culture: Core competencies for healthcare professionals military organization and roles. Retrieved from https://www.train.org/DesktopModules/eLearning/CourseDetails/CourseDetailsForm.aspx?CourseID=1 056278

Department of Defense. (2010). Report on the impact of deployment of members of the armed forces on their dependent children. Washington, DC: Department of Defense.

Doyle, M.E., Peterson, K.A. (2005). Re-entry and reintegration: Returning home after combat. Psychiatry Quarterly, 76(4), 361-70.

Exline, J.J. (2013). Religious and spiritual struggles.APA handbook of psychology, religion, and spirituality (Volume 1: Context, theory, and research; pp. 459-475). Washington, DC: American Psychological Association.

Henry M. Jackson Foundation for the Advancement of Military Medicine. (2016). Center for Deployment Psychology/Why know about Military Culture. Retrieved from http://deploymentpsych.org/military culture

Holland, J.M., Futterman, A., Thompson, L.W., Moran, C., Gallagher-Thompson, D. (2013). Difficulties accepting the loss of a spouse: A precursor for intensified grieving among widowed older adults. Death Studies, 37(2), 126–144.

Joint Staff.(2016). Department of Defense Dictionary of Military and Associated Terms. Retrieved from http://www.dtic.mil/doctrine/new_pubs/jp1_02.pdf.

LaMotte, J.J. (2004). The Warrior Ethos and basic combat training. Retrieved from http://www.quartermaster.army.mil/oqmg/professional_bulletin/2004/spring04/The_warrior_Eth os_and_Basic_Com bat_Training.htm

Maguen, S. &Litz, B. (2014).Moral injury in the context of war as defined by the VA. Retrieved from http://acircleofwarriors.org/moral-injury-in-the-context-of-war-as-defined-by-the-va/

Maguen, S. & Litz, B. (2016). Moral injury in the context of war. Retrieved fromhttp://www.ptsd.va.gov/professional/cooccurring/moral_injury_at_war.asp

Military Times.(2013). DoD studies intimacy issues among combat vets. Retrieved from http://www.militarytimes.com/story/military/archives/2013/03/29/dod-studies-intimacy-issues-among-combatvets/78535718/

Miltner, R.S., Selleck, C.S., Froelich, K.D., Bakitas, M.A., Cleveland, C.D., Harper, D.C. (2015).Caring for America's Veterans: The power of academic-practice partnership. Nursing Administration Quarterly, 39(3), 263-271.

Morrison-Beedy, D. (2016). Finding a path forward: A focus on military and veterans health. Nursing Outlook, 64(5), 403-405.

Nelson, K.M., Starkebaum, G.A., Reiber, G.E. (2007). Veterans using and uninsured veterans not using Veterans Affairs (VA) health care. Public Health Reports, 122(1), 93-100.

Olenick, M., Flowers, M., Diaz, V.J. (2015). US veterans and their unique issues: Enhancing health care professional awareness. Advances in Medical Education and Practice, 2015(6), 635-639.

Park, C.L. (2010). Making sense of the meaning literature: An integrative review of meaning making and its effects on adjustment to stressful life events. Psychology Bulletin, 126(2), 257-301.

Pressfield, S. (2011).The Warrior Ethos. Brooklyn: NY. Black Irish Entertainment.

Redmond, S.C., Wilcox, S.L., Campbell, S., Kim, A., Finney, K., Barr, K. & Hassan, A.M. (2015).A brief introduction to the military workplace culture. Work, 50(1), 9-20.

Risen, T. (2014).Veterans day data boot camp: The top statistics about veterans' health, jobs, backgrounds and outlook. The U.S.

News and World Report. Retrieved from   http://www.usnews.com/news/blogs/data-mine/2014/11/10/veterans-day-data-boot-camp

Shaffer, I. (2008). The family reunited: Helping special needs kids cope with reintegration. EP Magazine,38(10), 84-86.

Splaine, M.E., OgrincG., Gilman, S.C., Aron, D.C., Estrada, C.A., Rosenthal, G.E. . . . Batalden, P.B. (2009). The Department of Veterans Affairs National Quality Scholars Fellowship Program: Experience from 10 years of training quality scholars. Academic Medicine, 84(12), 1741-1748.

Verburg, S. (2010).For soldiers returning home, more challenges await. Retrieved from

http://host.madison.com/wsj/news/local/for-soldiers-returning-home-more-challenges-await/article_a38c0f72-fd6b11de-94c8-001cc4c002e0.html

Veterans Health Administration Office of Academic Affiliations. (2015). Military health history: Pocket card for health professions trainees and clinicians. Retrieved from http://www.va.gov/oaa/archive/Military-Health-History-Card-forprint.pdf

Worthington, E.L. & Langberg, D. (2012).Religious considerations and self-forgiveness in treating complex trauma and moral injury in present and former soldiers. Journal of Psychology and Theology, 40(4), 274-288. Zarembo, A. (2015). Detailed study confirms high suicide rate among recent veterans. Retrieved from   http://www.latimes.com/nation/la-na-veteran-suicide-20150115-story.html