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The Eleventh Hour: Navigating Posttraumatic Stress Disorder Within a Veterans' Community

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THE ELEVENTH HOUR: NAVIGATING POSTTRAUMATIC STRESS DISORDER WITHIN A VETERANS' COMMUNITY

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Scholarly Project Approval Form

This is to certify that **Christopher Ray Lee** has successfully presented his scholarly doctoral project entitled: **"The Eleventh Hour: Navigating Post Traumatic Stress within a Veteran Community"** and fulfilled the requirements of the Doctor of Nursing Practice degree.

Date of presentation: March 21, 2018

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Abstract

War-torn veterans have had limited support when combating symptoms of Post-Traumatic Stress Disorder (PTSD). Historically, PTSD was viewed as a weakness. Only recently has it gained attention as a health priority for veterans. This scholarly project provides an algorithmic resource to help providers discern and assess whether a veteran is suffering from PTSD. This paper will go on to define what PTSD symptoms are, and what care options there are for veterans suffering from PTSD. One specific option explored is animal therapy as a way for a veteran suffering from PTSD to better manage his or her symptoms.

Keywords: Doctorate of Nursing Practice-Family Nurse Practitioner, Advanced Practice Registered Nurse, Veteran, Veterans Association Healthcare System, Post-Traumatic Stress Disorder,

Chapter One: Introduction

Veterans, both men and women, have come home from war with unseen mental illness that torments their daily lives. Historically, these psychological wounds were described as the soldier's heart or shell shock and were merely overlooked by healthcare professionals as a cause of anguish for some veterans. These antiquated terms never fully described the turmoil these soldiers live and experience on a day- to- day basis. The more contemporary term - familiar to today's soldier is post-traumatic stress disorder (PTSD). PTSD is a disorder the National Alliance on Mental Illness (NAMI) PUT ON REF LIST)described as a traumatic event leading up to the body and mind sustaining long-lasting undesirable physical and psychological effects. Such traumatic events result in a person exhibiting debilitating psychological symptoms of reliving certain aspects of the traumatic event. Patients who suffer from PTSD can have their nervous system fundamentally hijacked during symptoms of PTSD, potentially leading to socially unacceptable behavior. Essentially, veterans suffering from PTSD feel like hostages of their disease and require help to manage their symptoms and behavior.

Problem Statement

Individuals diagnosed with PTSD may not know what resources are available to find the help they need. Healthcare providers within medical institutions may not have information on where or how to offer veterans with the PTSD the proper avenues to receive or access therapies such as animal therapy.

Purpose of the Scholarly Project

This scholarly project will provide a doctorate of nursing practice family nurse practitioner (DNP/FNP) information and resources for assessment services for a veteran patient suffering from PTSD. The information and resources will allow both a veteran and provider an opportunity to work with each other to find an appropriate course of treatment, including the possibility of animal therapy.

Clinical Question

Does the use of a screening or assessment tool help providers better recognize veterans with PTSD and subsequently provide veterans with resources and treatments for PTSD?

Objectives

The objective of this scholarly project is to develop and provide information and resources to practitioners for how to assess for PTSD and offer professional resources and services for care of veterans with PTSD.

I. Provide resources for assessing PTSD

II. Provide resources for potential rehabilitative services

III. Analyze and navigate the pathway of therapy the veteran should take using the algorithm whether it be traditional methods, animal therapy, or other services

Patient Population and Healthcare Setting for Implementation of Project

The population for this scholarly project will be veterans diagnosed with PTSD, as well as DNP/FNPs. If a veteran self-reports the need for animal therapy due to PTSD symptoms, the need to receive animal therapy will be addressed through a provider on

what qualifies a veteran for animal therapy and/or if the veteran qualifies for other types of services and resources. The healthcare setting will be within Veterans' Association Clinics and primary care clinics with ties to the community.

Chapter Two: Review of Literature

PTSD is a form of mental trauma that plagues veterans day and night with relentless relived memories. These memories are mental imprints of atrocities witnessed during times of excessive mental stress. These mental traumas are not entirely unfounded but are left to fester within the dark, untouched corners of a soldier's psyche, leading these soldiers to be tormented by thoughts of anxiety and despair over past events. These thoughts and anxieties can wreak havoc with a soldier's capacity to function within a socially acceptable norm. This literature review will focus on PTSD; symptoms portrayed by the disorder, treatment for the disease, and finally augmented therapies including animal therapy as a form of treatment.

What PTSD Is

According to the medical definition, PTSD is a mental disorder brought on by mental trauma where a person must experience, witness, or be confronted with an event that would or could involve death or serious injuries (United States Department of Veterans Affairs, n.d.). The person then must exhibit recurring symptoms of distress by reliving the event through images, thoughts, dreams, and acting out the event in a flashback. Encountering external cues may cause persons to react as though they were reliving the event. Hoge (2010) described the medical definition of PTSD as inept in comparison to the symptoms of what a person experiences during struggles with PTSD. Hoge elaborated that there is a lack of understanding of the person's perspective if that person has gone through combat. The definition does not capture the person's comprehensive reactions during the war experience and is in no way distinguishable from normal or abnormal behavior within the context of military behavior. Hoge expressed

medical professionals 'confusion on what PTSD actually is and how to recognize the disorder. Physicians use PTSD as an umbrella term to cover many aspects of a soldier's struggle with postwar behavior problems. Hoge asserted that all too often, the terms combat stress, PTSD, combat stress reaction, and acute stress reaction are used interchangeably and cause confusion over what the terms actually mean. Hoge argued that the use of terms other than PTSD lessens the severity of the disorder. He suggested that the other terms describe disorders related to combat stress, which is a breaking point where the soldier must shut down and reboot in a sense similar to that of a computer that has become overheated. PTSD, on the other hand, can be chronic and last indefinitely or be acute where symptoms last fewer than 3 months. Hoge stated that PTSD is not entirely a psychological problem but is also a physiological condition in which the entire body feels the effects from the disorder.

Diagnosing PTSD

PTSD can be diagnosed with various tools. According to Walker, McDonald, and Franke (2014), diagnosing the condition can be done through the PTSD checklist (PCL). The checklist identifies common phrases used to rate a person's feelings and stress when faced with symptoms of PTSD. The Department of Defense currently screens all veterans post deployment, and the checklist is used as a screening tool during certain clinical settings within the Veterans Association Hospitals. According to Duax, Bohnert, , Rauch, and Defever (2014), PTSD is also being measured through a primary care PTSD screening tool that is comprised of four items :(1) Have you had nightmares about it or thought about the incident when you did not want to? (2) Have you tried hard not to think about the incident or gone out of your way to avoid situations that remind you of the

incident? (3) Are you constantly on guard, watchful, or easily startled? (4) Have you felt numb or detached from others, activities, or your surroundings? This scale is used primarily by the Veterans' Administration currently and indicates a veteran with PTSD if he or she endorses three or more items within the scale.

Symptoms of PTSD

Symptoms of PTSD may overlap with symptoms of other diseases. All too often, the symptoms of PTSD are also accompanied by mild-traumatic brain injuries (mTBI), depression, and pain (Cifu et al., 2013). Cifu et al. (2013) stated that 6.7% of those who were diagnosed with mTBI were also diagnosed with PTSD. Knowing that mTBI and PTSD are sometimes coupled, Hannold et al. (2013) stated that PTSD veterans within the mTBI population also deal with a cognitive compromise as well as emotional dysregulation relating to the diagnosis of PTSD.

So, what does this mean for veterans of different operations who have experienced combat? Kane, Saperstein, Bunt, and Stephens (2013) stated that the average veteran under reports feelings of depression, PTSD symptoms, and even addictive symptoms like alcoholism. The symptoms of PTSD, according to Angkaw et al. (2013), are similar to how Hoge (2010) described them. However, Angkaw et al reported that PTSD is often coupled with anger, aggression, depression, and addictive behaviors.

Treatment of PTSD

Successfully treating veterans with PTSD is complex. According to Waengelin and Tuerk (2014), treating PTSD begins by asking whether to treat the patient or to not treat the patient. They focused on PTSD being a public healthcare concern and that

PTSD rates are as high as 20% of contemporary veterans. Waengelin and Tuerk stated that because of PTSD is associated with co-morbidities of depression, addiction, and other medical mental health difficulties, there is high demand on successfully treating veterans with PTSD. They mentioned that early intervention with the PTSD symptoms is key to reducing signs of the disorder. According to Waengelin and Tuerk, traditional therapy for treating PTSD is through exposure therapy. Exposure therapy is a type of rehabilitation related to cognitive-behavioral therapy (CBT), where the veteran is reintroduced to the factor that is causing the PTSD symptoms. This type of therapy is the recommended type of rehabilitation when establishing care for the veteran already diagnosed with PTSD.

Preventative treatment has also been explored. The United States Army has initiated a preventative type of program called The Battlemind Program within the battlefield areas to help combat PTSD. According to Smith-Forbes, Najera, and &Hawkins (2014), the army has trained occupational therapists (OT) to help alleviate combat stress and avoid PTSD symptoms from taking over a soldier's life. Data from the Army's OT project showed that the project helped alleviate some symptoms, and it was a project that warranted extra time. The time used for the OT's work would help with an ever changing battlefield that the soldiers inherently need to adapt to. Sareen (2014) writes about treatment for PTSD in a non-military aspect and offers that veterans with PTSD benefit from use of non-pharmacological treatments, but often benefit from a pharmacological approach as well. The pharmacological interventions that Sareen speaks of are Selective Serotonin Reuptake Inhibitors (SSRI's). These medications are used as an adjunct to the non-pharmacological treatment and would not be enough for a patient

with PTSD alone. Sareen also discusses the need for treatment early on, and to establish rapport with the patient quickly. The rapport need is important because it offers an opportunity for the patient to discuss his or her symptoms openly, whereas the patient is usually very reluctant to discuss symptoms.

Laitman, Gajewski, Mann, Kubin, Morrison, and Ross (2014) explored ways to help veterans with PTSD sleep better. Laitman et al.'s study explored a way to offer rats alpha-1 adrenoceptor antagonist prazosin for sleep continuity to rats with a fear-condition. The study's goal was to show that the rats could experience restful sleep even with a condition that would normally awaken them and make it difficult to continue with sleep through the night. Laitman et al. suggested that rapid eye movement sleep (REMS) is very important in individuals with new fear conditions such as PTSD. When faced with PTSD, REM sleep is not wanted due to the chances of having unwanted recurring symptoms during the dreams state (Laitman et al., 2014). However, when using the norepinephrine alpha-1 antagonist with rats that have fear conditions, REM sleep is not entirely achieved, offering the rodent a restful night's sleep. Laitman et al. postulated that using the drug for veterans with PTSD that this treatment could potentially be beneficial. Norepinephrine was the focus of Olson et al.'s (2011) study, which suggests that mice with predispositions to violence or aggression also had higher levels of norepinephrine. The study showed that when using a noradrenergic inhibitor, the mice showed normalized aggression and more socially acceptable behavior.

Rothbaum et al.'s (2014) study offered a coupled treatments for veterans with PTSD. The treatments included the use of virtual reality exposure therapy (VRE) coupled with alprazolam or d-cycloserine as an effective form of treatment for PTSD.

VRE treatment puts the warrior back into realistic types of situations that may have caused the PTSD to occur. Alprazolam and d-cycloserine, according to Rothbaum et al., are medications used in conjunction with cognitive therapy. Alprazolam is an anxiolytic type of medication, where d – cycloserine is a medication that is usually used for treatment of tuberculosis but has been found to work well within the confines of exposure therapy. Rothbaum et al. noted that there was a response to VRE treatment with coupling of pharmacological support. The coupling of d-cycloserine and VRE treatment was cloudy on the results and offered little to no overall response of help. However, the VRE treatment coupled with alprazolam showed an apparent response to resolving symptoms of the disorder. The study did conclude that the use of benzodiazepines for treatment of PTSD may add to the addiction aspect of the disorder and that further studies needed to occur.

Sofuoglu, Rosenheck, and Petrakis (2014) focused on the addiction adjunct of PTSD, with the idea one cannot treat PTSD without treating the addiction side as well. This study showed promising outcomes for veterans with a substance use disorder (SUD) and PTSD combination, but efficacy of certain medications needed to be further studied due to the medications' addictive factors. Sofuoglu et al. described that norepinephrine reuptake inhibitors, as well as glutamate/GABA medications would be beneficial to veterans suffering from PTSD and SUD. The medications like ketamine described within the study are an addictive type of medication, and potentially confound the SUD symptoms within the veteran.

Information on treatments provided to other nationalities can be helpful. A Canadian soldier has just as much potential for ascribing symptoms of PTSD as does an

American soldier. Zamorski, Guest, Bailey, and Garber (2012) stated that because the transition home for Canadian soldiers can become toxic, they have developed a transitioning period for the soldiers to help mitigate mental disorders. Zamorski et al. studied two types of treatments to help combat mental disorder: Third-Location Decompression (TLD) and TBD, which the United States Army has also implemented with OTs within the battlefield to help combat PTSD. TLD is a program Zamoski et al. as being a 5-day program. The program starts day 1 with orientation, and individual free time. The second day spills over into day 3 where the soldiers go through educational sessions focused on coping, stress, anger, healthy relationships, post-deployment reintegration, and leadership after the action. The soldiers go through these classes to gain a better understanding on how to cope within a new world of post-deployment and be within civilian life again. Day 4 for the soldiers features free time, outings and chances to reflect on situations leading to PTSD symptoms. The results of the study indicated that there was a large dropout rate due to Canadian soldiers not liking the Americanized version of the TBP, as well as the length of the 5-day retreat. However, the numbers show that the two types of therapy helped alleviate some symptoms for the soldiers who did participate. Zomoski et al. stated that the two methods rely on non-pharmacological methods and shows promise for veterans of another country that has been a great ally to the United States.

In addition to studies that have focused primarily on pharmaceutical and non-pharmaceutical psychiatric care for veterans suffering from PTSD, some research has looked at spiritual treatment. Bromann, Liu, Thorp, and Lang's (2011) led spiritual well-being for veterans suffering from PTSD as a treatment for the disorder. Bromann et al.

studied having veterans use a personal phrase, mantra, or sacred word to help alleviate symptoms from PTSD. Bromann et al. explained that the use of a mantra type word actually redirects the attention of the veteran by initiating relaxing thoughts. The study showed that increasing the veterans' existential spiritual well-being reduced self-reported symptoms of PTSD using the PCL scale. The study mentioned that a veteran has to be able to emotionally process normal values of everyday life to be able to use the mantra type of care to increase spiritual well-being.

Treatment also acknowledges emotional failures of veterans with PTSD. Baker, Gale, Abbey, and Thomas (2013) studied emotional processing therapy within a group of PTSD patients that revealed even just attempting to face symptoms may result in emotional failure. Emotional failure is failure to emotionally process a trigger of PTSD and not having the ability to push through the symptoms that cause problems for the veteran. Baker et al. described that disruption of the symptoms of PTSD must start with emotional processing where the patient is able to absorb the disturbances of PTSD. Essentially, the patient is exposed to the trigger criteria that would normally cause an exacerbation. Baker et al. stated that men and women who are not emotionally able to process must resolve key dilemmas that the mind is fighting. Baker et al. explained that a person may never be able to let go of feelings for a certain trigger because of lack of closure.

Ideally, the treatment for patients suffering from the diagnosis of PTSD should be tailored to the individual. Tailoring treatments for the veteran is the way that Crocker, Powell-Cope, Brown, and Besterman-Dehan (2014) suggested as a veteran-centric approach for reintegration. Crocker et al. defined reintegration as a veteran who has post

deployment difficulties in fitting into a society even after being integrated into society. Crocker et al. explained that post-deployment health is a critical step for development and dissemination of mental health for the patient. Ultimately, Crocker et al. reported that veteran -centered care postdeployment is a tailored program leading to opportunities for early detection of mental health issues that may lead to PTSD. Larson and Norman (2014) concurred with early detection of mental health problems in the veteran community, but also attributed functional difficulties as being a strong point for assessment with PTSD. Veterans recently released from active duty come home post-deployment and have classic symptoms of PTSD according to Larson and Norman. These veterans, however, have not been adequately set up for success post-deployment, and with symptoms of PTSD, other parts of life can falter. Larson and Norman described that the functionality within a normal society is key for veterans who want to be successful with integration into the civilian community. Larson and Norman stated that veterans who have difficulty containing PTSD symptoms will have functional difficulties as well. The difficulties described include unlawful behavior, financial problems, and work-related problems. Larson and Norman's study on the functional difficulties of veterans concluded that PTSD symptoms did predict functional outcomes except unlawful behavior. They added that an individual with greater combat exposure was at higher predictive risks for functional difficulties than his or her counterparts with less exposure.

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Animal Therapy

Pharmaceutical, non-pharmaceutical, spiritual well-being programs and even functional reintegration have been shown to be promising treatments for veterans with These treatments have shown promise with coupling of other treatments, but one treatment that may be underutilized is animal assisted therapy (AAT) or animal assisted intervention. Historically, animals have had a utilitarian purpose within a family's home or farmstead. However, ultimately, animals have been beneficial to the human race in many capacities. Parenti, Foreman, Meade, and Wirth (2013) have revised the taxonomy of animals considered assistive. Parenti et al. suggested that the term assistive, therapeutic, and emotional-support have labeled the animal assistance practice with uncontrolled and uncoordinated growth. The taxonomy report indicated that the overgrowth of animals within the service group causes confusion on what AAT actually is. Parenti et al. identified multiple assistive dog jobs: service dog, mobility assistance dog, working dog, therapy dog, visitation dog, emotional support dog, sport dog, and show dog, to name a few. The taxonomy report delineated what an assistance animal is and how the animal is used within the confines of its purpose. The report focuses on the vocabulary of what an assistance animal is and uses the vocabulary to describe confusion on what the animal should be trained for. Parenti et al. described that service animals and therapy animals are assistive animals involved in the service of a person in need due to a perceived disability. The disability does not need to be visual nor does it need to be apparent to others to be a disability fit for dog assistance. According to the report, the animal is there to aid the patient in the way the animal was trained to be used. The difference within the capacity of a service animal and a working dog is in the job they are

trained to perform (Parenti et al., 2013). The service dog's role is intended to perform tasks related to a disability or to perform support during emotional distress. A working dog's role is to perform tasks related to utilitarian needs such as hunting and retrieving.

The training of dogs for service is extensive. Rosetti and King (2010) stated that training and requirements for service dogs are stringent and require the highest importance for safety for dog and handler. Dogs must meet requirements through one of three national organizations to acquire the role of a service animal. The organizations all have the same stringent tests that focus on temperament, obedience, and AAT training. During the AAT training, the dog or animal will learn to behave appropriately within facilities. This training will include exposure to loud noises, new smells, and rides on elevators, walker, or wheelchairs. ATT training for the animal must include exposure to many new things, and the animal must react accordingly and not show fear or aggression. Once the AAT training is complete, the animal can then be placed with a person in need of a therapy animal, according to Rosetti and King.

Several studies reported benefits of therapy dogs. Polheber and Matchock (2014) indicated that having a dog present during times of stress decreased a patient's heart rate and cortisol levels when compared to a friend or loved one being present. In a similar study of dogs as a complimentary treatment for psychological symptoms, Nordgren and Engstrom (2014) found that dog-assisted interventions helped lessen behavioral symptoms versus having a friend present.

Actually walking a dog showed promise as a therapy according to Cangelosi and Sorrell (2010). These authors suggested that merely having a dog to care for and walk help a person who otherwise would be more sedentary get more exercise. Although some

facilities and businesses are reluctant to adopt AAT, the reluctance is present because of the fear of an animal causing harm to a client. A study by Zilcha-Mano, Mikulincer, and Shaver (2011) suggested that any sort of animal therapy would work dependent on the level of attachment of the patient in need and to the animal being used as the therapy animal. The study used the approach of attachment theory and focused on understanding the patients' needs within the confines of unmet attachment needs, attachment in security, coping, and responsiveness to therapy. The study found that regardless of animal type, the patient who had the most attachment or the best relationship with the animal was found to have the overall best outcome for therapy. Heathcote (2010) suggested allowing any type of animal within care facilities. Heathcote provided two case studies where the recipients of care could choose between multiple animals within a care facility or a dachshund for therapy. The animals involved had surpassed requirements for therapy purposes. The dachshund was used within the case study to help a client break from a non-communicative posture to being able to hold a conversation with the handler moments after having the animal placed in her lap. The same study indicated that 65% of the care facilities discussed did not have a formal rule for animals within the facility. The only suggestion as to why an animal was not being used was due to fear of an animal hurting a client, which was unfounded. Heathcote summarized that the benefits to having animals available for clients outweighs any possible risks.

Horses have also found their way into animal therapy. Lanning and Krenek (2013) discussed equine therapy for the combat veteran to help with quality of life. They mentioned that a veteran's post-deployment can have anger issues, and the veteran may outwardly react with anger toward family members. They stated that the veteran has to

show the horse respect and actually earn the horse's trust. The veteran also learns quickly that the horse is a large strong animal and to show the animal any sign of anger will extinguish any trust that may have been built between them. Thus, the veteran builds upon trust with the animal, decreasing outbursts of anger to family life. O'Haire, Guerin, and Kirkham (2015) discussed similarities of equine and dog therapy as being an important part of a coupled therapy for a person needing help with PTSD. The study speaks of veterans with PTSD and other comorbidities that include addiction, and depression. O'Haire et al. reiterated the use of animals within a therapeutic realm going back as early as the 18th century. The study focused largely on veterans with PTSD and their ability to function within a social norm. The study indicated reduction of symptoms of PTSD when using dogs as therapy animals, but it did offer some barriers that the veterans faced when having a service dog. The veterans who had been allowed an animal felt at risk for denial of entry to buildings, events, and other activities due to establishments not having education on the use of service animals and their use in AAT. No pets allowed are signs often seen when entering an establishment or business. Barriers like these are something that every handler and animal will face. Fine's (2010) textbook describes what an individual should or can do if he or she ever wants to have a service dog or start a service/therapy dog program. Barriers are met every day with the use of service animals. Fine stated that the only way to alleviate business owners from not allowing service animals into buildings is through education. In the end it is the person with the need for the service animal who will suffer.

PTSD is an ongoing struggle to diagnose for healthcare providers and a struggle for those that are diagnosed with the disorder. PTSD, a major health concern for

veterans, is considered a public health issue. Historically, the treatments for PTSD was to treat with medications. The more contemporary approach for treatment is using medications to treat the depression side of PTSD, coupled the treatment with a cognitive reexposure therapy. The treatments do offer promise to veterans diagnosed with PTSD, but the studies indicate that there is more that can be done. The use of contemporary treatments such as AAT may be a more preferred route for healthcare professionals as well as for veterans. Healthcare providers need to be able to adequately diagnose veterans with PTSD with an assessment tool and ultimately treat the PTSD accordingly using the tool. Veterans who suffer from PTSD need resources and help and would benefit from early treatment of the disorder. Veterans gave up so much for their country, it is time that healthcare providers focus on improving detection of PTSD and resources for treatment of PTSD.

Chapter Three: Theoretical and Conceptual Framework

Military men and women are asked to sacrifice time with family, work , and sometimes give the ultimate sacrifice of losing one's life during a time of conflict or war. In combat, tumultuous events can cause extraneous stress on a soldier's mental status. Once a soldier has returned home, the soldier may realize he or she may have brought a part of the war home. The part of the war that follows a soldier home is emotional unrest called PTSD, a disorder largely left untreated or undiagnosed for many veterans. PTSD is a psychological disorder brought on by mental trauma where a person must experience, witness or be confronted with an event that would or could involve death or serious injuries (United States Department of Veterans Affairs, n.d.). The person then must exhibit recurring symptoms of distress by reliving of the event through images, thoughts, dreams, acting out the event in a flashback, and sometimes even encountering external cues that may cause persons to react as though they were reliving the event. All too often the disorder is left untreated or misdiagnosed and is left within the soldier to fester and to possibly cause psychological problems later for the veteran. However, the misdiagnosis can change with a change that needs to happen within the primary care provider's office with a veteran's initial visit and completion of a questionnaire to establish a symptomatic history. The Eleventh Hour (TEH) project is an example of an algorithm tool that helps providers identify veterans in need who have a history of PTSD.

The premise behind The Eleventh Houris to empower practitioners by identifying patients with PTSD and providing a resource for the provider to guide a veteran toward modalities of treatment. Because the population of patients will be strictly veterans, the tool will first establish whether the patient is a veteran. Once the patient has been identified as a veteran, the patient will be asked to take an inventory

using three different tools to establish the extent of the PTSD. The Primary Care PTSD Screen tool uses four items to elicit traumatic memories. The tool is designed to be used within a primary care setting and positively identifies a veteran who answers yes to any three items on the screening tool. The Beck Anxiety Inventory – Primary Care (BAI-PC) is another tool that will be used to screen for depression, anxiety, and PTSD (SOURCE). The BAI-PC is a screening tool used to determine whether the patient has underlying depression or anxiety that can be highly comorbid with PTSD. The screening tool follows a 4 -point scale ranging from 0 = not at all to 3 = severely. The patient who self-reports a score of five is suggestive of anxiety, depression, or PTSD. The last tool used is the Depression Anxiety Stress Scales (DASS). This tool is a 42 item, self-reported inventory that measures the three related emotional states of depression, anxiety, and stress. The patient who identifies with having PTSD will then need to have a formal referral done with a mental health provider. The patient will then have to follow up with his or her primary care provider to ensure treatment is going as planned and to investigate alternative modalities of care for the PTSD.

Madeline Leininger, a nursing theorist, has brought culture care, universality, and diversity to the forefront of nursing, bringing nursing into a culturally congruent practice (McFarland & Wehbe-Alamah, 2015). The Sunrise Enabler is a visual tool Leininger developed to help individuals make the journey through cultures at the bedside, and through other endeavors involving different cultures (SOURCE). The Sunrise Enabler is a multifactorial cultural guide that provides information about cultural care expressions and their meanings. The Sunrise Enabler serves as a cognitive map as well as a visual diagram for the person using it to explore a culture comprehensively. Cultures

throughout the world can be investigated as well as the multifaceted culture of the military. The military, much like many cultures has its ethos, and the visual aspects of the Sunrise Enabler would be beneficial for any healthcare provider to traverse the many avenues within it.

A veteran is versed in the culture of his or her branch of the military and must follow those traditions accordingly. The Sunrise Enabler, a broad overview to identify factors that potentially could occur within a culture, is the theoretical framework for THE and will help the primary care provider explore a person's culture whether personal or military based.

The roadmap to the underpinning of TEH is the Sunrise Enabler, but the primary care provider cannot merely follow a map within a culture without using Leininger's theory, The Theory of Culture Care, Diversity, and Universality (TCCDU). The importance of using TCCDU is to help the provider circumvent the Sunrise Enabler by finding the needs of the person, their family, within groups or institutions, or within the culturally diverse military community (McFarland & Wehbe-Alamah, 2015). McFarland and Wehbe-Alamah (2015) discussed Leininger's four tenets that help conceptualize TCCDU theory. The four tenets form a travel guide that the provider should use to help him or her through the diverse world of the veteran using the Sunrise Enabler. The first tenet speaks of cultures having many commonalities, some of which are universal, as well as having individualized expressions, meanings, patterns, and practices. This tenet allows for the veterans from all branches of the military to provide truths behind each of their military, cultural nuances, and help the provider better understand the diversity of what each veteran is presenting with symptoms of PTSD. The second tenet focuses on

the specific social factors, ethnohistory, a language used, and generic, professional, and critical influencers within the military. This tenet will help the provider with many of the different military type languages that veterans may use that a civilian healthcare provider may not understand. This principle will also assist the provider understand the social structures that stand within the military and understand that there are hierarchies veterans separated from the military for some time may still follow. The third tenet speaks to the professional or folk health factors that influence health and what may affect the person with the illness. The military has a strong history of following instructions and listening to direct orders so the veteran can have a strong influence from his or her time from the military. However, many times the military member is seen as weak for going to seek medical care and may see themselves that way postdeployment. This view of weakness is something the provider should be aware of and follow the Sunrise Enabler accordingly. The final tenet speaks of a sense of congruency within the culture and the care provider. The previous three tenets help frame the final tenet with the idea that there should be preservation or accommodation of the patient's culture, as well as the restructuring of culture care to accommodate the many cultures found within the military. Leininger's theories fit well within the culture of the military because it is universal and allows for different tracks when negotiating the Sunrise Enabler. The healthcare provider should be aware of many cultures that are within the military as well as the military's culture. The provider that acknowledges the two cultures will more than likely make a connection with the veteran, and be more successful with finding a treatment.

Chapter Four: Methodology and Evaluation

When individuals walk into a clinician's office with complaints, it is the general practitioner's job to use objective data and subjective data to ensure a proper diagnosis. Many patients are asked an extensive number of questions while a physical examination occurs. The practitioner then decides from his or her findings what is wrong with the person at that moment. However, a patient may not reveal all to a practitioner if the patient is not asked appropriate questions. These important questions that need to be asked are about unseen maladies and may require some investigation by the practitioner. Consequently, the goals of this project are to bring awareness of and much needed help to veterans who suffer from PTSD related to their experiences while in the military. TEH: Navigating Posttraumatic Stress Disorder among a Veteran Community is a way to bring awareness to a general practitioner who may not screen all veterans for symptoms of PTSD. The indication for this project is that there is a high suicide rate amongst veterans, especially those who have experienced combat (Wilk et al., 2013). The process of evaluation for this project requires all practitioners within an outpatient setting to screen patients at every visit for veteran status, and follow an algorithm tool (see Appendix A) to help veterans get help from the Veterans Affairs Offices and receive benefits that the veteran has earned.

Less than 1% of the population are veterans, and the percentage of veterans entering a practitioner's office is even less than that (Wilk et al., 2013). Wilk et al. (2013) described that men and women seeking medical are may exhibit multiple and varying degrees of chief complaints. However, the one thing that most veterans do not

talk about or are ever asked about by their general practitioner is PTSD or the confounding comorbid disabilities that come with PTSD like depression and anxiety.

The knowledge of what PTSD is and who it affects is growing every day (Duax et al., 2014). However, the need for recognizing the problem is even more severe than ever. The price for under recognition of the disorder is being paid by veterans' lives. According to Kang et al.' (2015) study, the average number for veterans committing suicide daily is similar to that of the general population. However, Kang et al. stated that due to the numbers of individuals in the military versus the actual number of the general population, the number surpasses the national suicide rate substantially.

TEH is a way to provide information to providers about PTSD as well as an algorithm (see Appendix A) to assist with veterans' needs and the Veteran's Affairs Office when it comes to caring for a veteran with PTSD. The setting for this program will be eventually any general practice clinic that sees patients. However, at this moment, Allina Health Care has been gracious enough to allow implementation of TEH within its general practice clinic later this winter. The population who will be validating TEH will be medical doctors, nurse practitioners, and physician's assistants throughout this clinic.

The goal is to reach every person who enters the clinic that matches criteria to be assessed. The criteria needed to be considered includes any man or woman over the age 18 who presents to the clinic for any chief complaint. The provider will then offer all people that matched criteria a questionnaire that asks whether they are a veteran or not, and if the person answers yes, the next step will be to address the person about his or her time while in the military. The questions that will need to be asked will be deployment

history, combat history, and if the person has sought help concerning any depression or anxietyor if the veteran has experienced PTSD symptoms.

The practitioner will also offer the veteran three-anxiety/depression/PTSD assessment tools (see Appendices B, C, D) to see if there are any hidden symptoms that may come up. A veteran who exemplifies the need for help will then be given options from the medical practitioner on what route to take using the algorithm tool (see Appendix A). The need for the veteran with PTSD to be recognized far outweighs the time this may take within a visit.

The follow up for THE will be representative of the clinicians' views on how many people they felt they were able to recognize as a veteran, and whether the veteran needed help or not and if the help was warranted. This will be accomplished through an online survey that the clinicians will fill out at their leisure and will ask questions regarding the numbers of patients seen in the time frame given, how many patients were veterans, how many patients had undiagnosed symptoms, and how many patients sought help. The clinicians will then be asked to summarize the experience reflecting on whether they felt this was a hindrance or a helpful tool to add to their practice.

Chapter Five: Significance and Implications

For veterans being assessed within any primary care, the integration of THE algorithm tool will increase patients being recognized as veterans as well their mental health disparities being addressed. TEH seeks to recognize those patients who are veterans as well as help them navigate through the Veterans Administration's health system.

TEH has many significant implications for the recognition of and management of military veterans with their mental health needs within a primary care facility. The eight WRITE OUT essential guidelines are the directorial force that integrates a holistic approach as well as uses evidence-based practice to enhance the care to this marginalized group of individuals (SOURCE). Coupling these two strengths along with TEH's algorithm on how to navigate the Veterans Administration, veterans will finally be recognized as a marginalized group of individuals, as well as having their mental health assessed during their visits to their primary care providers. Ultimately, this project will support bringing veterans to the situation their own mental health well-being -and allow them to have their voices heard through the DNP-FNP role.

Implications for Advanced Practice Nursing

THE project involved an algorithmic tool that guides the practice of the DNP-FNP while caring for a veteran with a new mental health diagnosis. It will guide the practitioner to recognize the Veteran first and foremost as well as address the possible undiagnosed mental health issues. The algorithm will also guide the DNP-FNP, as well as the veteran in establishing a caseworker through the Disabled American Veteran Association.The addition of the caseworker will ensure the veteran is recognized through

the Veterans Administration's healthcare system. Once recognized, the veteran and DNP-FNP will establish care for the veteran, as well as provide compensation for the veteran through the Veterans Administration's Healthcare system.

TEH project provides a DNP-FNP a process through the Veterans Administration's healthcare system as well as the veteran's unique medical needs. TEH integrates its model of care based on Leiningers Theory of Culture Care. The Sunrise Enabler is Leininger's visual tool that helps the DNP-FNP navigate differing cultures with an empathic understanding and willingness to help those with a holistic approach. THE is a model that asks a DNP-FNP to identify the veteran with mental health needs and walk with the person through the journey of achieving mental health intelligibility and understanding.

Implications for Patient Care

The hope for TEH scholarly project will be to make the view of mental health disorders more of an expressed subject matter within all cultures and communities. The success of this project is achievable by talking with every veteran patient first and foremost to establish what the patient's mental health baseline is at each visit. The secondary benefit THE possesses is to have the veteran who identifies with a mental health disorder rbe assisted through gaining access to resources. The collaboration of the patient and DNP-FNP is then needed to keep open lines of communication so if there is a change from the patient's baseline, it is quickly recognized, and the symptoms are appropriately cared for.

Ultimately, TEH seeks to achieve by taking a patient- centered approach to identifying whether a veteran patient has mental health disparities. With the use of the

Sunrise Enabler, TEH's algorithm, and the help of a DNP-FNP, veteran patients with mental health problems will be recognized and helped and have access to appropriate resources. This will encourage the subject of mental health to be openly discussed with each visit, and the patients may perceive their mental health needs to be as routine as a yearly evaluation or a normal office visit.

Disease Management

Standards of care, evidence- based practice, and best practices based on disease processes will route the disease management of a veteran patient with mental health disorders. It is important to differentiate the role of the as a tool that helps a DNP-FNP recognize the person as a veteran with mental health needs and not as an algorithm tool of decision making to treat the patient through disease processes. The tool will take the patient from being recognized with a mental health disorder, such as PTSD, depression, and anxiety, and help both the DNP-FNP and patient get through the Veterans Administration healthcare system to hopefully be recognized as a veteran with a service connected disability.

Essentials of Doctoral Education for Advanced Practice Nursing

The Essentials of Doctoral Education for Advanced Practice Nursing (AACN, 2006) is a road map of moral and scientific directions that have been laid out within in a curricular element from the Collegiate Nursing Education for schools that seek accreditation for DNP programs. The essentials are an outline of competencies that are considered the foundational core of an advanced practice registered nurse (see Appendix E). This essential document covers all of an advanced practice registered nurse's roles;

including nurse practitioners, clinical nurse specialists, nurse anesthetists, and nurse midwives. the was conceived to offer a marginalized population of veterans a chance to be recognized and to get assistance for their mental health needs. The marriage of the AACN's (2006) Essential's of Doctoral Education and the will help honor those veterans who have unseen mental health comorbidities that have yet to be discovered and treated.

Scientific Underpinnings for Practice

This essential explains the complexity of nursing within an advanced practice role as well the heritage within the foundation of nursing. This essential is met through a lengthy literature meta-analysis from which the idea for TEH stemmed. The process of the literature review showed that there was a lack of recognition within the medical community to recognize patients as veterans with potential mental health comorbidities. The unearthing of this gap within the medical community opens the doors for patients and DNPs-FNPs to offer a better understanding and detection rates of those in need.

Organizational and Systems Leadership for Quality Improvement and Systems Thinking

This essential document focuses on improving healthcare outcomes and improving patient outcomes. The doctoral trained nurse uses skill and knowledge to reach health care goals, eliminate health disparities, and promote safety within the practice. TEH meets this essential by providing leadership with a new way to screen and recognize veterans in need. This also challenges those within the healthcare field for improving the task at hand, which is addressing mental health for every person who enters the facility and allowing for healthcare equity for all those seeking much needed help.

Clinical Scholarship and Analytical Methods for Evidence-Based Practice

Like many other professional doctorate programs, this essential hallmarks the role of research and scholarship. TEH demonstrates scholarship and fulfills this essential largely through its conception and implementation. THE allows for the use of the algorithm tool to identify those with mental health comorbidities, whether they are veterans or not. The tool allows for research in regard to the numbers of men and women who have been identified as veterans, as well as those who have been treated for mental health needs while using the algorithm for guidance.

Information and Patient Care Technology for the Transformation of Healthcare

Informatics and technology is a mainstay within most if not all healthcare facilities today. The doctorate trained advanced practice registered nurse is an essential component within the realm of using technology to improve the patient care experience. This essential is met through the need of evaluating each patient with a new algorithm that can be easily placed within the electronic medical record. This will also help transform healthcare in regard to reaching every single patient and establishing that person's mental health needs as well as recognizing a veteran. The tool itself will offer insight into a realm of patients that should have been on healthcare's radar for some time now.

Healthcare Policy for Advocacy in Healthcare

DNPs engaged in policy, whether at the governmental or organizational level creates the framework for healthcare facilities to address healthcare needs. They engage their practice within healthcare policy to create a system that meets all patients' needs.

Advocacy for all patients is important, but the role of TEH is advocacy for the veteran population that normally would go unseen with mental health needs. The ultimate goal for TEH is to become a standard healthcare policy, and advocate for veterans world to have healthy minds.

Inter-Professional Collaboration for Improving Population Health Outcomes

The healthcare system has become increasingly complex with multiple professions. The collaboration of these professions is an inevitable and dynamic part of healthcare, and with today's patients' complex needs, inter-professional collaboration is essential. TEH calls upon collaboration with all aspects of healthcare, including teaming up with other facilities like the Veterans Administration's healthcare system and the Doctor of Nursing Practice, and patient. The engagement and use of these collaborative, caring veteran specific companies will help improve the population by advancing mental health outcomes one patient at a time.

Clinical Prevention and Population Health for Improving the Nation's Health

The term clinical prevention is representative to health promotion as well as to risk reduction. The population health is an umbrella term to represent all aspects of community, culture, environment, and anything that is aggregate to a population. This essential was addressed by bringing everyone to the table and opening the conversation of mental health awareness. The conversation then takes the biases, and stereotypes of mental health comorbidities and will hopefully dissolve them, making the overall mental health of patients a preventable disease. The use of TEH will take the mass of patients who come to the DNP-FNP and utilize this new algorithm to improve not only veterans'

mental health but will address those who have no voice as well by examining their mental health needs during every visit to the provider.

Advanced Practice Nursing

This essentialcommunicates the broad need for all DNP graduates to be prepared within their desired skillset, indicating that the DNP cannot be master of all advanced practice registered nurses roles but shall be practice competent within the discipline chosen. This is prevalent within the complex healthcare system where the advanced practice registered nurses are needed to have advanced knowledge and expertise within their specialty. TEH meets this essential by providing the DNP-FNP with a tool that will reshape the patient and care provider dynamic by introducing questions of mental health awareness. This also invites a group of otherwise marginalized individuals to be involved in their own health and well-being by asking those hard to ask questions about mental health and allows the DNP-FNP, healthcare providers, and systems a chance to change old ways of knowing.

The Eleventh Hour was well perceived in its initial presentation to a group of medical doctors, administrative persons, and psychiatrists. The idea of TEHwas recognized and given an opportunity to move forward with further investigation in utilizing a tool within the family practice model. The algorithm and the ideas surrounding the implementation of the program were supported and approved at subsequent presentations, composed of respected leaders within a large medical facility. Those present were two family practice doctors, one of whom is a veteran of the current conflict in the Middle East. Also present during these meetings were a nurse administrator involved with subtle nuances with new projects dealing with patient care as

well as a few administrators involved in implementing projects within the family practice areas.

However, TEH fell short of impressing the financial administrator. The feedback from the finance administrator was that, unfortunately, there is not adequate funding to involve a program that has no proven benefit for the industry. The financial administrator commented that the premise is honorable and worth looking at with future endeavors, but at this moment would not be able to be implemented on a larger scale. The same administrator stated that a smaller start of the pilot would be beneficial in hopes that this would show the importance of representing the group of veterans with mental health disparities.

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Appendix A

Primary Care PTSD Screen (PC-PTSD)

Description

The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the V A. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the PC -PTSD should be considered "positive" if a patient answers "yes" to any 3 items. Those screening positive should then be assessed with a structured interview for PTSD. The screen does not include a list of potentially traumatic events.

Scale

Instructions:

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?

   YES / NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

   YES / NO

3. Were constantly on guard, watchful, or easily startled?

   YES / NO

4. Felt numb or detached from others, activities, or your surroundings?

   YES / NO

Current research suggests that the results of the PC- PTSD should be considered "positive" if a patient answers "yes" to any three items.

Prins, Ouimette, & Kimerling, 2003

Primary Care PTSD Screening Tool, PC-PTSD

Appendix B

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 (14 August 2013) National Center for PTSD Page 1 of 1

Post traumatic stress disorder checklist, PCL-5

Appendix C

Beck Anxiety Inventory (BAI)

About: This scale is a self-report measure of anxiety.

Items: 21

Reliability:
Internal consistency for the BAI = (Cronbach's α=0.92)
Test-retest reliability (1 week) for the BAI = 0.75 (Beck, Epstein, Brown, & Steer, 1988).

Validity:
The BAI was moderately correlated with the revised Hamilton Anxiety Rating Scale (.51), and mildly correlated with the Hamilton Depression Rating Scale (.25) (Beck et al., 1988)

Scoring:

	Not At All	Mildly but it didn't bother me much	Moderately - it wasn't pleasant at times	Severely – it bothered me a lot
All questions	0	1	2	3

The total score is calculated by finding the sum of the 21 items.
Score of 0 – 21 = low anxiety
Score of 22 – 35 = moderate anxiety
Score of 36 and above = potentially concerning levels of anxiety

References:

Beck, A. T., Epstein, N., Brown, G., Steer, R. A. (1988). An inventory for measuring clinical anxiety: Psychometric properties. *Journal of Consulting and Clinical Psychology, 56,* 893-897.

Appendix D

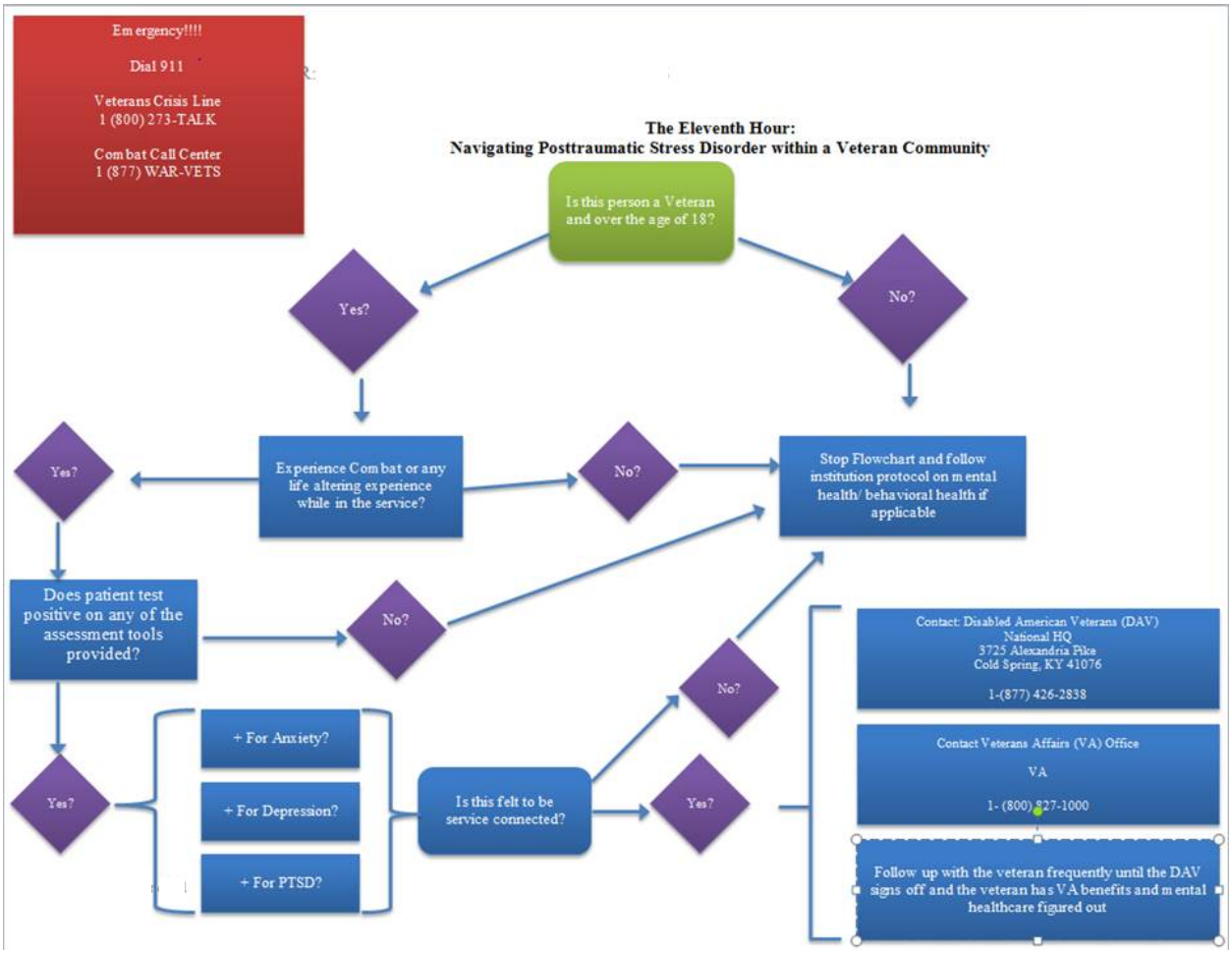
Beck Anxiety Inventory (BAI)

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not At All	Mildly but it didn't bother me much	Moderately - it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	☐	☐	☐	☐
Feeling hot	☐	☐	☐	☐
Wobbliness in legs	☐	☐	☐	☐
Unable to relax	☐	☐	☐	☐
Fear of worst happening	☐	☐	☐	☐
Dizzy or lightheaded	☐	☐	☐	☐
Heart pounding/racing	☐	☐	☐	☐
Unsteady	☐	☐	☐	☐
Terrified or afraid	☐	☐	☐	☐
Nervous	☐	☐	☐	☐
Feeling of choking	☐	☐	☐	☐
Hands trembling	☐	☐	☐	☐
Shaky / unsteady	☐	☐	☐	☐
Fear of losing control	☐	☐	☐	☐
Difficulty in breathing	☐	☐	☐	☐
Fear of dying	☐	☐	☐	☐
Scared	☐	☐	☐	☐
Indigestion	☐	☐	☐	☐
Faint / lightheaded	☐	☐	☐	☐
Face flushed	☐	☐	☐	☐
Hot/cold sweats	☐	☐	☐	☐

Beck Anxiety Inventory, BAI

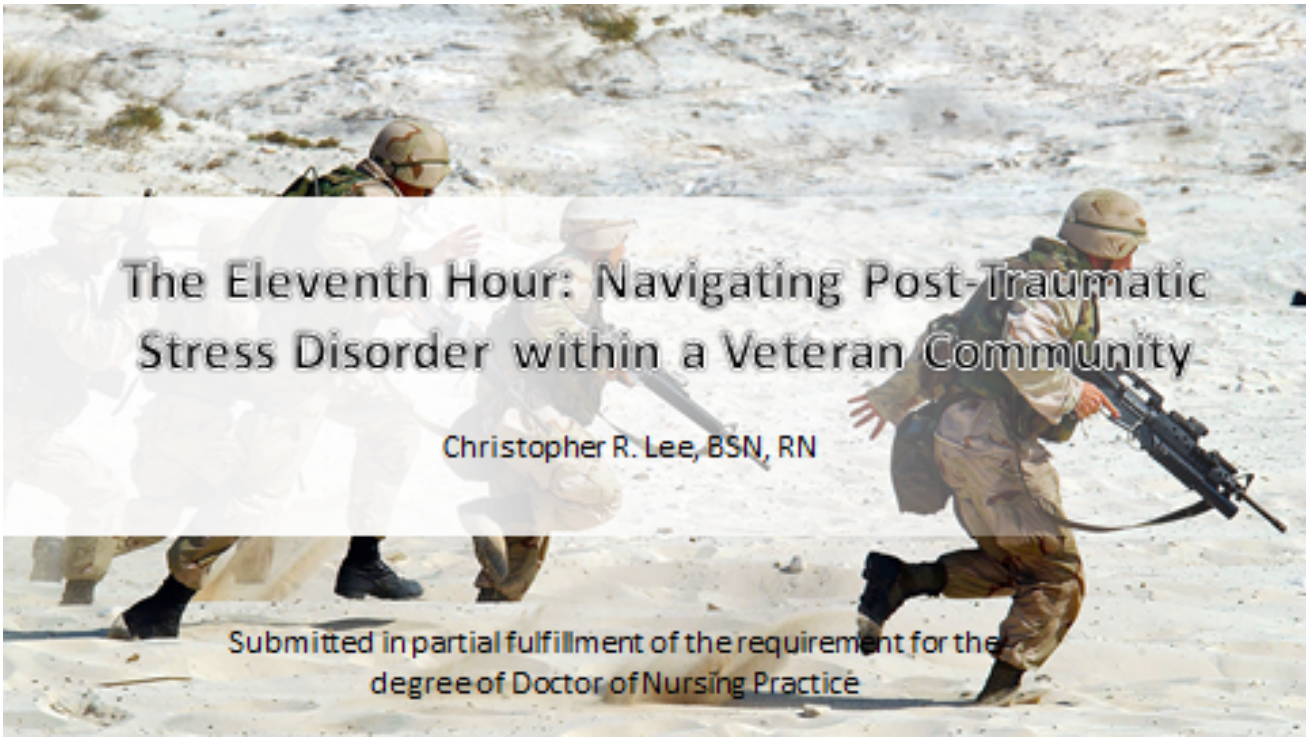
Appendix E


Emergency!!!!
Dial 911
Veterans Crisis Line
1 (800) 273-TALK
Combat Call Center
1 (877) WAR-VETS
The Eleventh Hour:
Navigating Posttraumatic Stress Disorder within a Veteran Community
Is this person a Veteran and over the age of 18?
Yes?
No?
Experience Combat or any life altering experience while in the service?
Yes?
No?
Stop Flowchart and follow institution protocol on mental health/ behavioral health if applicable
Does patient test positive on any of the assessment tools provided?
No?
Yes?
+ For Anxiety?
+ For Depression?
+ For PTSD?
Is this felt to be service connected?
No?
Yes?
Contact: Disabled American Veterans (DAV)
National HQ
3725 Alexandria Pike
Cold Spring, KY 41076
1-(877) 426-2838
Contact Veterans Affairs (VA) Office
VA
1- (800) 827-1000
Follow up with the veteran frequently until the DAV signs off and the veteran has VA benefits and mental healthcare figured out

Appendix F

The Essentials of Doctoral Education for Advanced Nursing Practice

I. Scientific Underpinnings for Practice
II. Organizational and Systems Leadership for Quality Improvement and Systems Thinking
III. Clinical Scholarship and Analytical Methods for Evidence-Based Practice
IV. Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care
V. Health Care policy for Advocacy in Health Care
VI. Interprofessional Collaboration for Improving Patient and Population Health Outcomes
VII. Clinical Prevention and Population Health for Improving the nation's Health
VIII. Advanced Nursing Practice. (AACN, 2006, p. or para.).



Who am I?

- Long line of military service in my family
- I joined the Navy after an initial try at college in July in 1998
- September 11, 2001 occurred
- We all were sent somewhere that was not home
- Sent home around Christmas 2005, finished my 8 years as a reservist
- Went to college again as an adult learner
- Spent the past 10 plus years in CV Surgery ICU
- Four years ago started this journey

Clinical Question

Does the use of a screening or assessment tool help providers better recognize veterans with PTSD, and provide the veteran with resources and treatments for PTSD?

Objectives

1. Provide resources for assessing PTSD with veterans
2. Provide resources for potential rehabilitative services for veterans
3. Analyze and navigate the pathway of therapy the veteran should take using the algorithm whether it be traditional methods or animal therapy, or other services
4. Develop an algorithm to assist veterans in navigating traditional medical methods, animal services and other services

Aaron Burke, Iraq Deployment

Population: How many Veterans are there?

321 million people in the US

- Veterans make up 1% of that population

– 3.21 million people are veterans ranging from WWII and to today's contemporary military

Population: Who are Veterans?

- Older than you might think
- Broad variety of life experiences
- Hard-charging
- Independent
- Physically fit
- Largely drug-free
- Usually talkative
- Self-deprecating
- Good humored
- Proud to have served

Paul Bohling, Operation Iraqi Freedom

What is PTSD? Why does it Matter?

- 1 in 6 Army and Marine Veterans of Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF) meet criteria for PTSD, depression or anxiety following the return home from combat.
- Active troops have a PTSD prevalence of up to 30% following deployment
- Combat exposure has a positive correlations with developing PTSD

Aaron Burke, Iraq Deployment

Methods: How to assess if PTSD is a factor?

- Assess your patient
- Beck Anxiety Inventory
- Primary Care PTSD Screen
- PCL-5

Paul Bohling, USS Peleliu LHA-5 Dry Dock

How to assess if PTSD is a Factor?

Conceptual Framework: What is the Eleventh Hour? Madeline Leiningers Culture of Care: Diversity, and Universality Theory

Billy Pinkstock, MACE in Face

Conceptual and Theoretical Framework: Leininger Tenents: A moral compass for those in need

1. Care diversities (differences) and universalities (commonalities) existed among cultures in the world which needed to be discovered the world which needed to be discovered, and analyzed for their meaning and uses to establish a body of transcultural nursing knowledge.
2. Care is the essence of nursing and a distinct, dominant, central, and unifying focus. Some would say that caring is not unique to nursing.
3. Care is essential for well being, health, growth, survival, and to face handicaps or death.
4. Culturally based care is the broadest means to know, explain, interpret, and predict nursing care phenomena to guide nursing care decisions and actions.

Michael Denoyer, SPEC-OPS

What is the Veteran culture like?

- Unique set of value systems
- Own set of rules and norms, very rigid
- Not ONE culture, but many cultures
- Own language/Alphabet
- Organized hierarchy/rank structure (caste system)
- Very close-knit community, everyone knows each other's business/history
- Culture evolves, sometimes rapidly i.e. Navy Reserves in Afghanistan
- NEVER assume you know; ASK

Billy Pinkstock, Grenade Launcher

Methodology and Evaluation?

- Who is the subject matter?
  Really anyone can be evaluated
- In the end The Eleventh Hour hopes to reach other potential victims of PTSD
- Veterans are angry!

Joseph Childers, BAS MED Station

Setting:Where would this take place?

Family Practice
Psychiatric visits
Hospital stays
Veteran Forums
Internal Medicine

Really anyplace that allows for the question, "Are you a Veteran? Do you have mental health needs?"

Billy Pinkstock, Iraq Deployment

Implications for Practice

- The Eleventh Hour Algorithm spells it out
  - Ask if they are a Veteran
  - If yes further investigate if:
    - Combat Zone Experience
- Use the PTSD, Depression, Anxiety assessment tools
- Refer to Disabled American Veterans for resources

Joseph Childers, Training Exercise

Significance and Implications

- The VA is asking the questions now why aren't civilian facilities?
- The 1% sacrificed a lot to be where they are, and are warranted be recognized
- These Veterans are a marginalized group
- It will help shape the role of the general practitioner and patient relationship by asking the right questions

Billy Pinkstock, Iraq Deployment

Disease Management

- The management of PTSD, Depression, and Anxiety is not dependent upon the direction of the Eleventh Hour.
- The Eleventh Hour is merely a tool that helps the practitioner and veteran achieve a common goal.
- All of the patients that are identified by using the Eleventh Hour algorithm should follow evidence based practices, and work closely with their medical provider to manage PTSD, Depression, and anxiety.

Joseph Childers, Bridge Port, CA

Doctorate of Nursing Essentials

- Scientific Underpinnings for Practice
- Organizational and Systems Leadership for Quality Improvement and Systems Thinking
- Clinical Scholarship and Analytical Methods for Evidence-Based Practice
- Information and Patient Care Technology for the Transformation of Healthcare
- Healthcare Policy for Advocacy in Healthcare
- Interprofessional Collaboration for Improving Population Health Outcomes
- Clinical Prevention and Population Health for Improving the Nation's Health
- Advanced Practice Nursing

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