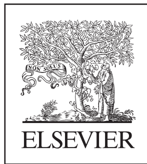

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Nurs Outlook 63 (2015) 512–520

Nursing Outlook

www.nursingoutlook.org

Military and veteran's health integration across missions: How a college of nursing "joined forces"

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ARTICLE INFO

Article history:
Received 14 January 2015
Revised 27 April 2015
Accepted 12 May 2015
Available online 29 May 2015

Keywords:
Joining forces
Military
Veterans

ABSTRACT

Background: To address the unique needs of our returning military and veterans, the White House initiated the Joining Forces campaign and has encouraged colleges of nursing throughout the nation to support this mission.

Methods: At the University of South Florida College of Nursing, we have implemented a multifaceted approach that addresses education, research, and employment. These military-related programs have been unified under our RESTORE LIVES (Research and Education to Rehabilitate and Restore the Lives of Veterans, Services Members and their Families) initiative.

Results: To accomplish this mission, we enhanced our curriculum to include veteran health care issues, developed research that addresses veteran wellness, launched an accelerated program to enable veterans and military personnel with medical experience to obtain their baccalaureate in nursing, and encouraged a culture within the college that is supportive of military-based health care and employment needs.

Conclusions: We have shared our experiences through webinars and presentations and by hosting a national conference.

Cite this article: Morrison-Beedy, D., Passmore, D., & D'Aoust, R. (2015, AUGUST). Military and veteran's health integration across missions: How a college of nursing "joined forces". Nursing Outlook, 63(4), 512-520. http://dx.doi.org/10.1016/j.outlook.2015.05.004.

In response to First Lady Michelle Obama and Dr. Jill Biden's Joining Forces initiative, the University of South Florida (USF) College of Nursing is among the 660 nursing education institutions throughout the United States (Cacchione, 2012) that have committed resources and effort to improving the health care of service members, veterans, and their families. In 2012, the college's dean was one of 25 nursing leaders invited to a national nursing summit on veteran health care at the University of Pennsylvania. At this summit, the USF College of Nursing was recognized by Mrs. Obama for efforts in military and veteran health care research. Since that time, the college has continued building on the strength of its military-based research and education foundations.

Background

As health care providers, educators, and scientists, nurses have the ability and the duty to make a significant difference in the care of our veterans, active military personnel, and their families. Throughout U.S. history, each military action has inflicted unique physical and psychological injuries on

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http://dx.doi.org/10.1016/j.outlook.2015.05.004

Table 1 – Unique Health Risks for Era of Military Service

Era	Risks	
World War II and Korea	• Cold injury (including frostbite) • Chemical warfare agent experiments • Nuclear weapons testing or cleanup	
Cold War	• Chemical warfare agent experiments • Nuclear weapons testing or cleanup	
Vietnam	• Agent Orange exposure • Hepatitis C	
Gulf War	• Animal bites/rabies • Blunt trauma • Burn injuries • Chemical or biological agents • Chemical munitions demolition • Combined penetrating injuries • Depleted uranium • Dermatologic issues • Embedded fragments (shrapnel)	• Mental health issues • Multi–drug-resistant Acinetobacter • Oil well fires • Reproductive health issues • Spinal cord injury • Traumatic amputation • Traumatic brain injury • Vision loss
Operation Iraqi Freedom Operation Enduring Freedom Operation New Dawn	• Animal bites/rabies • Blunt trauma • Burn injuries (blast injuries) • Chemical or biological agents • Chemical munitions demolition • Combined penetrating injuries • Depleted uranium • Dermatologic issues • Embedded fragments (shrapnel) • Malaria prevention: mefloquine (Lariam, Hoffmann–La Roche, Switzerland)	• Mental health issues • Multi–drug-resistant Acinetobacter • Oil well fires • Reproductive health issues • Spinal cord injury • Traumatic amputation • Traumatic brain injury • Vision loss
All Eras	• Asbestos • Burn pit smoke • Cold injury • Contaminated water (benzene, trichloroethylene) • Endemic diseases • Heat stroke/exhaustion • Hexavalent chromium • Ionizing and nonionizing radiation	• Mustard gas • Nerve agents • Pesticides • Radiation (ionizing and nonionizing) • Sand, dust, smoke, and particulates • Tetrachlorodibenzo-p-dioxin and other dioxins

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our troops (Table 1). The war on terrorism, which officially began in 2001, has been no exception, and over 700,000 troops have returned with physical or emotional disabilities unseen in previous combat experiences (Watson Institute for International Studies, 2013).

Some of these differences are because of service member deployment, which currently tends to be longer and more frequent than in previous conflicts, increasing the risk of potential physical and mental health concerns (Coll, Weiss, & Yarvis, 2011). Physical injuries are compounded by the proliferation of improvised explosive devices resulting in frequent polytrauma injuries, including traumatic brain injuries (TBIs) and amputations, which differ significantly from the types of injuries sustained in previous military actions (MacLennan et al., 2008). One of the most pressing challenges facing those returning from combat service is the issue of post-traumatic stress disorder (PTSD). Currently, over 100,000 military personnel and veterans have been diagnosed with PTSD (Fischer, 2014). Despite the number of combat veterans returning from service with PTSD symptoms, relatively few seek care because of concerns regarding self-stigma or perceived stigma from military and nonmilitary sources such as family and health care providers (Blais & Renshaw, 2013).

After initial treatment and stabilization, patients treated in veteran facilities are frequently transferred to hospitals closer to their homes (MacLennan et al., 2008). These patients are often mistrustful of nonmilitary personnel, requiring health care practitioners to develop an understanding of military culture in order to establish trust (Coll et al., 2011; Hall, 2011). Additionally, returning military veterans may not seek health care from veteran administration (VA)-related institutions because of accessibility or eligibility, and reservists frequently live apart from military communities limiting access to VA health care (Murphy & Fairbank, 2013). Although there are an estimated 23 million

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