

PRIMARY CARE PROVIDERS SCREENING
FOR MILITARY SERVICE AND PTSD

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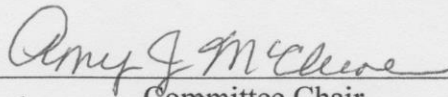
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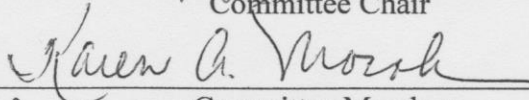
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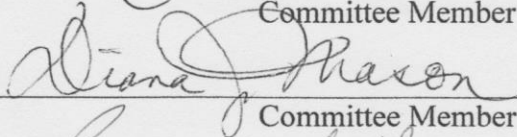
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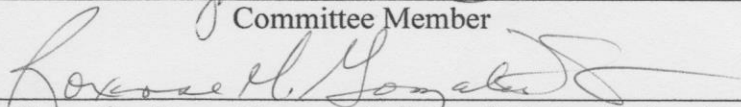
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Abstract

There are currently millions of veterans living in the United States. Veterans have the option to receive their health care within the veteran's administration (VA) or through primary care providers (PCPs) in the private sector. If PCPs who work in the private sector are not screening their patients for military service then veterans are less likely to be screened for post-traumatic stress disorder (PTSD). Even if the PCP does know that the patient is a veteran, providers might be less likely to screen for mental illness based on the provider's comfort level in treating the condition. Research was performed using a survey to determine if PCPs are screening for military service and subsequent PTSD. The theoretical basis of this research was Albert Bandura's social cognitive theory as it relates to self-efficacy.

The design of this study was a quantitative, cross-sectional, non-experimental study. The survey was distributed by the researchers to 250 primary care practice in central and western Pennsylvania through the United States Postal Service (USPS). An unknown amount of providers were reached by utilizing social media via Facebook and primary care providers who work within a local health care system through their work e-mail. The total eligible responses for data collection was 50 ($n=50$). Results revealed 4 (8%) of the respondents screen all of their patients for military status and 20 (40%) screen none of their patients. Most respondents (60%) screen none of their patients for PTSD and only 2 (4%) screen all of their patients. PCPs in the private sector should be educated on why every patient needs screened, how to properly screen, and the general health concerns for anyone who has served in the military.

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Chapter 1

Introduction

Veterans are often involved in traumatic experiences throughout their career in the military. When they finally return to civilian life, veterans are expected to be able to adapt to their new life without difficulty. Unfortunately, they can be left with disabilities that limit their ability to acclimate. Disabilities may result from physical injury incurred during service, as well as mental illness which may not be visible to family members or health care providers (National Council on Disability, 2009). Veterans have the option to receive their health care within the Veterans Affairs or obtain their care within the private sector. VA health care providers are educated to provide comprehensive care to veterans, assessing both physical and mental illness concerns. In the private sector, the provider may or may not know if the patient is a veteran. Consequently, PCPs may not be aware of all the health concerns associated with military service, especially those that are not visible during a physical assessment. Mental illness such as PTSD in veterans unidentified and consequently un-treated early increases the risk of suicide (National Council on Disability, 2009). There is limited research available which investigates whether or not PCPs who do not work in the VA are screening patients for military service and subsequent PTSD.

Background of the Problem

In 2014, the number of veterans in the United States was 21.8 million (United States Census Bureau, 2014). After serving in the military, veterans are often left with disabilities that affect their return to civilian life and may be at risk for long-term health problems. These disabilities are not limited to only physical and visible conditions, but also disorders including

PTSD, not easily assessed by civilian health care personnel (National Council on Disability, 2009).

According to The American Legion (2015), about 30 percent of veterans who have most recently served in the military live in rural areas. The VA has attempted to improve healthcare access for veterans in rural areas, by developing the VA Office of Rural Health (The American Legion, 2015). However, not all veterans choose to receive their healthcare through the VA system and therefore are not screened for PTSD related to military service. One of the recurring themes in helping those with PTSD is the importance of early intervention and treatment, including extensive rehabilitation (National Council on Disability, 2009).

The problem is occurring in primary care practices where health care providers such as physicians, physician's assistants, and nurse practitioners do not screen patients for military service and PTSD. Civilian PCPs are not educated to the same degree as their VA counterparts in dealing with mental illness associated with military trauma. It is largely unknown whether or not primary care practices outside of the VA system are currently assessing veterans for PTSD. In a national survey it was discovered only about 40% of PCPs and community-based mental health providers routinely ask patients if they or a family member have ever served in the military (Kilpatrick, Best, Smith, Kudler, & Cornelison-Grant, 2011). Spont et al. (2013) state that primary care practices frequently miss veteran PTSD diagnoses and therefore delay the implementation of mental illness treatment.

The American Academy of Nursing (n.d.) initiative "Have You Ever Served in the Military?" is attempting to raise awareness in primary care and provide information such as screening tools for healthcare providers to assess patients who are veterans for PTSD and other service-related conditions. The issue has also been addressed by Congress with the recent

passing of the Clay Hunt Suicide Prevention for American Veterans Act (Clay Hunt SAV Act). The Clay Hunt SAV Act specifically focuses on mental health care provided within the VA system and mandates evaluation of the care (Congressional Research Service, 2014). Even though the Act focuses on the VA's responsibilities to veterans, their mental illness, and suicide prevention, the involvement of Congress raises awareness to all health care providers.

Physicians, nurse practitioners, and physician assistants all need to know how important it is to screen every patient for military service and PTSD. PCPs should understand why screening their patients is imperative to prevent delays in treating conditions such as PTSD.

Albert Bandura's social cognitive theory applies to veterans who are suffering from mental illness following military service. Military men and women are under pressure and frequently encounter traumatic experiences during their years of service. According to Bandura (1989b) children in his study learned certain behaviors based on their environment. Benight and Bandura (2004) investigated specifically how the social cognitive theory applies to veteran's ability to adapt to civilian life and cope with PTSD based on self-efficacy. This will be discussed further in chapter two.

Statement of the Problem

Lack of screening of patients for military status and service-connected PTSD by PCPs in the private sector results in compromised care of veterans. If PTSD associated with military service are not diagnosed early and treated appropriately the patient can have a higher risk of suicide in addition to other health concerns.

Purpose of the Study

The purpose of this quantitative study is to determine if PCPs (physician's assistants, nurse practitioners, or physicians) are screening patients for military status and subsequent PTSD in primary care settings.

Research Questions

1. In primary care settings in the private sector, are providers (physicians, physician's assistants, or nurse practitioners) screening patients for military service and PTSD?

Definition of Terms

The following list includes conceptual definitions of important terms used in this study.

1. PCP is defined as “a healthcare practitioner who sees people that have common medical problems” (Vorvick, 2013, para. 1).
 - a. Physician is defined as “a person skilled in the art of healing and one educated, clinically experienced, and licensed to practice medicine as usually distinguished from surgery” (“Physician”, 2015, para. 1).
 - b. Physician’s assistant (PA) is defined as “a nationally certified and state-licensed medical professional. PAs practice medicine on health care teams with physicians and other providers” (American Academy of Physician’s Assistants, n.d., para. 1).
 - c. A nurse practitioner (NP) is a registered nurse who is prepared, through advanced education and clinical training, to provide a wide range of preventive and acute health care services to individuals of all ages (Buppert, 2015, p. 1, para. 2).
2. Private sector can be defined as “private health care can be provided through “for profit” hospitals and self-employed practitioners, and “not for profit” non-government providers,

including faith-based organizations (Basu, Andrews, Kishore, Panjabi, & Stuckler, 2012, p. 14).

3. Military service is defined as “active duty in a branch of the armed forces” (“Military service”, 2015, para. 2).
4. Mental illness is defined as “any of various disorders in which a person's thoughts, emotions, or behaviour are so abnormal as to cause suffering to himself, herself, or other people” (“Mental illness”, 2015, para. 2).
5. Veteran is defined as “a person who was once a member of the armed forces” (“Veteran”, 2015, para. 2).
6. PTSD is defined as “a mental health condition that's triggered by a terrifying event by either experiencing it or witnessing it. PTSD can include symptoms such as: flashbacks, nightmares and severe anxiety, and uncontrollable thoughts about the event” (Mayo Clinic Staff, 2015, para. 1).
7. Screening is defined as “...asking questions carefully designed to determine whether a more thorough evaluation for a particular problem or disorder is warranted” (Center for Substance Abuse Treatment, 2009, p. 58).
8. Stigma is defined as “a perceived negative attribute that causes someone to devalue or think less of the whole person” (Salters-Pedneault, 2014, para. 1).
9. Self-stigma is defined as occurring when “an individual buys into society’s misconceptions about mental health. By internalizing negative beliefs, individuals or groups may experience feelings of shame, anger, hopelessness, or despair that keep them from seeking social support, employment, or treatment for their mental health conditions” (California Mental Health Services Authority, n.d., What is self stigma section, para 1).

10. Public stigma in mental illness can be defined as “essentially a form of prejudice, comprised of cognitive, affective, and behavioral reactions” (Bathje & Pryor, 2011, p. 162).
11. Veterans Administration is defined as, “a U.S. cabinet department that provides patient care, veterans’ benefits, and other services to veterans of the U.S. armed forces and their families” (“Veteran’s Administration”, 2015, para. 1).

Need for the Study

September 11, 2001 was a tragic day that Americans will never forget. The act of terrorism on U.S. soil brought forth many brave men and women who chose to serve and protect their country. It has been estimated that 1.64 million military personnel were deployed to Afghanistan and Iraq in October 2001 (Tanielian & Jaycox, 2008). The wars in Afghanistan and Iraq are the most recent wars producing veterans. Advances in technology and health care enable soldiers to survive traumatic events that in previous wars would have resulted in death (Tanielian & Jaycox, 2008). There are many different health concerns that affect military service members and their family members. While there has been a growing interest and concern for the health care of veterans within the VA health system, policies improving care in the private sector have not been initiated. According to the National Council on Disability (2009), approximately 25% to 40% of veterans are affected by disabilities that are not easily recognized. This includes PTSD as a result of witnessing or being involved in a traumatic event, a traumatic brain injury, or sexual trauma. The risk of suicide in veterans not treated after experiencing such traumas is a serious health concern.

According to the study performed by Tanielian and Jaycox (2008), it was estimated that out of the 1.64 million soldiers deployed after October 2001, 300,000 veterans have either PTSD or major depression. When mental illness is not recognized and treated early, veterans can suffer

from “depression, generalized anxiety disorders, substance abuse, and interpersonal conflicts” (National Council on Disability, 2009, p. 9). If veterans are not diagnosed and treated for PTSD, they can suffer from a range of health impairments and functional difficulties. Activities such as maintaining healthy social relationships, focusing on their work, and functioning in environments that can trigger unpleasant memories from their war experience can become a daily struggle (National Council on Disability, 2009). PTSD in veterans is often related to combat and the life threatening situations that service members experience in their work environment. According to the National Council on Disability (2009), “between 10 to 30 percent of service members develop PTSD within a year of combat” (p. 19). Of the veterans deployed to Afghanistan and Iraq after October 2001, only about half of those diagnosed with PTSD made the decision to receive treatment (Tanielian & Jaycox, 2008). Suicide risk for veterans is a problem that has been escalating over the past 10 years. Zoroya (2013) notes that, among the veterans who have committed suicide, only 36 per 100,000 used the VA for their health care. In fact, Bryan, Theriault, and Bryan (2014) report that suicide is “the second leading cause of death” for those who have served in the military (p. 40).

This study will benefit veterans, their families, and PCPs. The long term goal of this study was to improve the quality of care that veterans receive in the private sector by first encouraging PCPs to screen patients for military service. The American Academy of Nursing (n.d.) initiative is currently encouraging providers to ask about military service, but is also asking veterans to speak up and inform providers of their military experience. It is common for veterans suffering from mental health illness to have strained relationships with family members and significant others. Family members benefit as a result of the comprehensive care that the veteran will receive, which might even save the veteran’s or family member’s life. PCPs will be

able to assess their current practice and make changes to improve care provided to veterans. A gap in literature exists because there have not been many studies performed to identify care provided to veterans in the private sector. Research in identifying and treating PTSD in veterans has been conducted primarily through the VA system.

Significance of the Study

PTSD affects 7.7 million American adults, who have been a part of or witnessed some sort of traumatic event (National Institutes of Health, 2009). However military service members are the highest number of citizens who suffer from PTSD (National Institutes of Health, 2009). PTSD statistics broken down by individual wars are as follows; 31% of Vietnam veterans, 10% of Gulf War veterans, 11% of veterans who served in Afghanistan, and 20% of Iraqi war veterans (National Institutes of Health, 2009). It is estimated that 1 in 3 adults have PTSD that is undetected (Primary Care Rural Health, 2010). These are alarming statistics, which represent a call for action.

From 2004 to 2008 suicide rates increased to 80% among active U.S. army soldiers (Bachynski, Canham-Chervak, Black, Millikan, & Jones, 2012). Out of the 225 soldiers who committed suicide, 17% of them had been previously diagnosed with a mental illness and only half had visited a healthcare professional for a mental health issue (Bachynski et al., 2012). According to Kemp and Bossarte (2012), only 36 per 100,000 of the veterans who have committed suicide actually used the VA for their health care. This is another indication that the majority of veterans are likely seeking their health care services outside of the VA. The U.S. Department of Veterans Affairs (2015) found the current rate of suicide among female veterans is 11.2 for every 100,000 and for male veterans it is 33.4 for every 100,000. Not only is suicide a risk for veterans, but research shows that those with PTSD are more likely to end up with heart

disease than those who do not have the mental illness (Sidney, 2013). Even though veterans are most affected by this mental illness, their loved ones who surround them can also suffer consequences. According to Bannerman (2014), more than 80% of veterans who are diagnosed with PTSD were involved in violence with their significant others in the past year, a staggering-14 times higher than the civilian population.

By evaluating whether or not PCPs are screening their patients, a need for increasing education and awareness on the issue may be identified. If providers are not screening their patients, the consequences could be life-threatening. The American Academy of Nursing (n.d.) provides the necessary resources such as intake questions, pocket cards, posters, and even customized starter kits. These informative resources not only assist the provider in screening patients but also encourage patients to let their healthcare providers know about their military service.

Assumptions

In this study it was assumed:

1. The PCPs will answer the self-reported survey questions honestly.
2. The survey questions used will be appropriate to identify if the providers are screening for military service in their patients.
3. All PCPs will have access to the internet to complete the online survey.
4. PCPs will be able to read English and understand the questions being asked.

Summary of the Problem

The number of U.S. veterans will increase every year. Veterans will explore their options for health care once they leave active duty. While the VA is making progress in improving the comprehensive care provided to veterans, changes have not been implemented in the private

sector. Delays in diagnosing and treating veterans for PTSD increases their risk of suicide and impacts their family members' well-being. The literature review will examine current practices of PCPs managing the care of veterans and potential tools that can assist providers in screening veterans for PTSD.

Chapter 2

Review of Related Literature

Caring for veterans in the private sector can be problematic when their service history and possible PTSD go undetected and untreated. Stigmas associated with the diagnosis of a mental illness create a barrier when veterans who suffer from self-stigma do not seek care. Practitioners who stigmatize mental illness are not screening, treating, or referring veterans appropriately due to lack of education or experience. Little research has been performed to identify appropriate screening procedures.

Chapter two is divided into five sections. The first section is a general overview of mental illness stigma. The second section explores co-managed care between VA and non-VA providers and the outcomes of those patients who receive co-managed care. The third section examines the co-morbidities that can accompany PTSD. The fourth section focuses on suicide related to PTSD. Lastly, the final section reviews Albert Bandura's social cognitive theory, which serves as the theoretical framework for this study.

Mental Health Stigma

Stigma associated with mental illness can be divided into two groups, public and self-stigma. Public stigma is when society views individuals with mental illness based on stereotypical beliefs (Bathje & Pryor, 2011). Specific stigmatizing characteristics of individuals with mental illness includes that they are dangerous, unkempt, crazy, and that they are personally responsible for having the illness (Bathje & Pryor, 2011). Self-stigma occurs when a person with mental illness internalizes the stereotypical beliefs about their illness, which results in a loss of self-esteem and self-efficacy (Bathje & Pryor, 2011). Self-stigma can cause individuals to

avoid seeking treatment because they do not want to society to view them differently based on a diagnosis or treatment for mental illness.

Mental illness is a serious public health concern which might not be addressed by providers in the primary care setting due to a lack of experience in treating mental health patients. The provider's stigma and attitude toward mental illness is directly linked to a barrier in accessible and quality care (Ungar, Knaak, & Szeto, 2014). People who experience mental illness often experience self-stigma, which results in social isolation, lack of self-worth, and discrimination (Ungar, Knaak, & Szeto, 2014). Veterans and active service members are often described as strong, heroic, and brave. These same words would not routinely be used to describe someone suffering from a mental illness, based on public stigma. Military personnel may avoid seeking treatment even when they know something is wrong or they are suffering from PTSD because they don't want people to think less of them.

PCPs in the private sector may have public stigma and avoid screening or offering mental health treatment because of their own discomfort with the subject. Options for providers to become more comfortable discussing mental illness with veterans would be to first identify their personal barriers and secondly seek out further education/training. Ungar, Knaak, and Szeto (2014) make the recommendation that providers utilize a trans-disciplinary approach which would include listening to patient stories and perspectives on the patient's mental illness. Improving "communication skills as well as health provider comfort and confidence, skill-based training may improve the quality of interpersonal contact between health providers and patients, leading to more positive attitudes, diminished social and clinical distance, improved client experiences, and better care" (Ungar, Knaak, & Szeto, 2014, p. 2). Providers participating in

this study might perform a self-evaluation of their perceptions caring for veterans suffering from PTSD or major depressive disorder.

Quartana et al. (2014) describe mental health stigma among soldiers, including the specific military culture in which soldiers are expected to be resilient and if they receive treatment for mental illness, it would impact their career negatively. Study results concluded that the utilization of mental illness services has increased during the time period from 2002 to 2011 (Quartana et al., 2014). Along with increases in use of services, there was an overall decrease in mental illness stigma, however, less than half of the soldiers reported that they felt they had PTSD sought treatment (Quartana et al., 2014). It is evident that stigma among soldiers and veterans impacts their decision to openly discuss mental illness concerns with providers. The only way for a provider to know if a veteran is struggling with PTSD or major depressive disorders is for the provider to overcome any apprehension on the topic and ask the patient. Currently, there are no mandatory requirements for providers in the private sector to screen patients for military service, let alone mental illness associated with military service.

Seal et al. (2008) investigated the requirement of VA providers to screen veterans from the Afghanistan and Iraq wars for PTSD, depression, and high-risk drinking. If the veteran screened positive for any of these conditions, the provider was responsible for referring the veteran to mental health services. The purpose of the study was to determine the impact of overcoming the “don’t ask; don’t tell” barrier to mental illness treatment for veterans. Of the 338 eligible veteran participants screened for the previously mentioned mental health disorders, 69% were positive for at least one of the mental illnesses and 171 were positive for PTSD (Seal et al., 2008). Within 90 days of screening, the study revealed 24% of the veterans who screened

positive for a mental illness attended their scheduled appointment (Seal et al., 2008). Overall, the study determined that screening veterans led to a higher rate of follow up and treatment.

Co-managed Care Between VA and Non-VA Providers

Veterans have the option to receive care from both VA and non-VA providers and the largest number of veterans who receive co-managed care are rural veterans due to lack of VA site availability (Schooley, Horan, Lee, & West, 2010). While distance to VA sites is the main barrier to receiving VA only care, research indicates that communication barriers may also steer patients to private care. While telephone is the main way of communicating with the provider in the VA system, other private providers have adopted internet communication, which younger patients utilize more often than the telephone (Schooley et al., 2010). Nayar, Apenteng, Yu, Woodbridge, and Fetrick (2013) agree that distance is the main barrier to receiving care at a VA facility, the researchers also discuss that many veterans have already established a relationship with a non-VA provider. Due to these barriers or personal patient preferences, many veterans receive dual care from both non-VA and VA providers, but minimal research has been conducted to understand how veteran's care is affected when both non-VA and VA providers are utilized.

Gaglioti et al. (2014) studied the perspectives of non-VA providers and VA providers co-managing veteran's health care. Minimal research has been conducted to understand how veteran's care is affected when both non-VA and VA providers are utilized. The largest number of veterans co-managed are rural veterans due to lack of VA site availability. The goal of Gaglioti et al. (2014) was to develop guidelines for best practice and provide PCPs with resource materials to improve communication between VA and non-VA providers (Gaglioti et al., 2014). The study utilized a questionnaire with a sample size of 67 completed surveys, in addition to 21 semi-structured telephone interviews. Data were analyzed and suggested that the current

communication between non-VA and VA providers is inadequate and that the veteran is the main source of sharing information between providers (Gaglioti et al., 2014). This is an ineffective way to ensure medical information is adequately transferred, which could result in duplicate testing, medication errors, and compromised care. Non-VA providers felt that they were unable to obtain direct contact with VA providers and 66% were dissatisfied with the current system of communication (Gaglioti et al., 2014).

Health initiatives throughout the U.S. are trying to improve the continuity in care and outcomes for all patients. Veterans have the unique opportunity receive primary care services from both VA and non-VA providers, or they can choose one or the other. Kaboli, Shivapour, Henderson, Isdhani, and Charlton (2012) studied the quality of care among co-managed veterans based on patient outcomes. Specific health conditions including hypertension, hyperlipidemia, diabetes, and obesity were evaluated on quality of care through surveys and chart reviews (Kaboli et al., 2012). The convenience sample provided 191 patients in a VA center waiting to see their provider. Out of the 191 patients, 189 agreed to participate in a survey about their hypertension treatment. The survey allowed for the researchers to identify whether the patient was dual-managed or strictly a VA patient. The results revealed 36% or 67 veterans surveyed were dual-managed, but it was unclear what aspects of their health care they received from each provider. In this particular study, Kaboli et al. (2012) found that sampled patients utilized VA providers as opposed to non-VA providers to manage their hypertension. Results of the study did not find any significant difference in the overall quality of care when the veteran was co-managed. Kaboli et al. (2012) suggested that continuity of care may not be present in dual-managed patients. However, this study did not determine that quality of care was impacted. LDL cholesterol, hemoglobin A1C, and body mass index (BMI) levels were not significantly different

between dual-managed or VA only patients. With less than 50% of those surveyed co-managed, and a majority of them utilizing the VA for hypertension management, evidence indicates that further research is needed to evaluate veteran health outcomes in dual-managed care.

The research discussed to this point has suggested that communication between non-VA and VA providers is not satisfactory. The problem with providers not directly communicating or working together to care for the veteran is that the veteran is then responsible for transferring the important medical information between providers.

Wolinsky, An, Liu, Miller and Rosenthal (2007) investigated the mortality risk for older veterans who were co-managed by VA and non-VA providers through their Medicare benefits. The study concluded that there is an increase in the mortality risk when veterans are co-managed (Wolinsky et al., 2007). The study suggested two different explanations for why mortality is greater when a veteran is a dual user. The first explanation associated the increased risk to “uncoordinated and poorly managed care” and that this type of care plays an important role with veterans who have more than one chronic conditions (Wolinsky et al., 2007, p.9). As mentioned above, improvement is needed in the communication between Va and Non-VA providers. The second theory is that veterans who are dual users have health conditions which are more complex than the average patient (Wolinsky et al., 2007). When veterans are co-managed and the providers do not follow through on continuity of care, patients suffer the consequences. This is evident when patients have comorbidities and there is a lack of clarity between providers on who is responsible for which disease process.

Limited research exists as to whether or not non-VA providers are screening their patients for military service. The goal of this research is to encourage PCPs to ask their patients about military service. Literature reviewed in this section demonstrates that further guidelines

and improved communication need to take place once a patient is identified as a veteran, especially when comanaged.

PTSD and Comorbidities

A diagnosis of PTSD can be traumatizing, but another concern is other significant health problems that can accompany PTSD. The health problems that will be discussed in this section are substance abuse, depression, and heart failure. The discussion of comorbidities is important because if PTSD is appropriately detected and treated, the number of comorbidities occurring could be prevented.

Alcohol abuse. In September 2013, the National Defense University (NDU) conducted a study that reported alcohol abuse increases among service members following deployment (Arvanitis, 2013). The NDU then studied the alcohol use patterns of U.S. National Guard units upon return home from Afghanistan and Iraq and then again eight months later (Arvanitis, 2013). After returning home, 9% showed problem levels of alcohol consumption and eight months later, the number increased to 22% (Arvanitis, 2013). Veterans often use alcohol as a way to cope with high stress levels, loneliness, or boredom of being a service member. Overuse of alcohol as a coping mechanism can exacerbate the negative effects associated with alcohol abuse such as: impaired decision-making, judgment, problem-solving, learning and memory (Arvanitis, 2013). Not only is alcohol abuse a problem in itself, it becomes an even greater problem when paired with PTSD. According to Arvanitis (2013), 30% of individuals returning from combat have PTSD, and when left untreated those individuals turn to alcohol to “self-medicate”. This idea has been considered in several research projects.

Substance abuse. Unfortunately, there is little current information on veterans and substance abuse. Results from the National Comorbidity Survey found that in the population

with PTSD, lifetime prevalence of comorbid substance use disorders is 22% (Petrakis, Rosenheck, & Desai, 2011). Petrakis, Rosenheck, and Desai (2011) used regression analysis to identify the independent effects on the risk of substance abuse, PTSD, other psychiatric diagnoses and service era. The researchers used veterans treated in VA facilities during a one year interval, and who had served in the Vietnam era (VET) or later with a primary or secondary psychiatric diagnosis (major depression, bipolar disorder, schizophrenia, PTSD, dysthymia, or an anxiety disorder).

The sample included 1,001,996 VA patients with 213,442 being dually diagnosed with psychiatric and substance abuse and 788,554 with psychiatric diagnosis alone (Petrakis, Rosenheck, & Desai, 2011). Those with anxiety disorders, bipolar disorder, schizophrenia, and PTSD were all more likely to have substance abuse disorders than those without a mental illness. The rate of substance abuse in those with a mental illness ranged from 21%-35% with the post-VET era veterans having the highest rate of dual diagnosis (28%) (Petrakis, Rosenheck, & Desai, 2011). Those with substance abuse and PTSD have worse clinical prognosis than those with PTSD alone. Petrakis, Rosenheck, and Desai (2011) suggest that services need to be available to address serious mental illness and comorbid substance abuse.

Depression. According to Arvanitis (2013), depression increased from 6% to 31% in the eight months following deployment. Research suggests that depressive symptoms affect 30-50% of people diagnosed with PTSD (Campbell et al., 2006). With the increasing symptomatology, depressive-PTSD patients show more frequent suicidal ideation, worse physical health, higher alcohol consumption, lower social support, increased mental and physical health care utilization, and lower care satisfaction (Campbell et al., 2006).

Campbell et al. (2006) used a site-randomized evaluation that included 10 patients from VA primary care clinics in five states using a 50-minute baseline interview. The questions included demographic characteristics, depressive symptomatology, suicidal ideation, PTSD, anxiety/panic, probable bipolar disorder, alcohol consumption, general health, medical comorbidity, social support, self-reported care utilization, and care satisfaction. Of the 677 participants, 36% had probable concurrent PTSD. This confirmed the researcher's expectation that comorbid PTSD would be associated with worse depression and increased healthcare utilization (Campbell et al., 2006). Although there have been successful treatments for PTSD and depression alone, little is known about proper and effective treatment for PTSD with depression as a comorbidity.

Pittman, Goldsmith, Lemmer, Kilmer, and Baker (2011) conducted a study researching how PTSD and depression affect health-related quality of life (HRQoL). Current research suggests that PTSD and depression negatively affect HRQoL when diagnosed separately (Pittman et al., 2011). A clinical survey and self-report questionnaire were given to 220 Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) combat veterans. The data found by Pittman et al. (2011) supported previous research indicating PTSD and depression are negatively correlated with HRQoL. The research failed to take into consideration other factors that could lower HRQoL in patients with comorbid PTSD and depression, but still showed the effect that comorbid conditions have on HRQoL. PTSD combined with depression and substance abuse has a dramatic effect on quality of life, treatment options, and outcome of patients, but physical comorbidities combined with PTSD raise another set of questions.

Cardiac. Qureshi, Pyne, Magruder, Shulz, and Kunik (2009) found that cardiac problems were the most commonly linked illness to PTSD. There was an increased likelihood of hypertension and chronic heart disorders in those with PTSD than those without PTSD.

Roy, Foraker, Girton, and Mansfield (2015) considered why PTSD contributes to coronary heart disease (CHD). The contributing factors include autonomic system dysfunction, inflammation, hypercoagulability, cardiac hyperactivity, altered neurochemistry, and co-occurring metabolic syndrome. Research is limited but some data show a threefold increase in the odds of developing heart failure in those with PTSD (Roy et al., 2015). A study by Schnurr, Spiro, and Paris (as cited in Roy et al., 2015, p. 757) surveyed 605 male veterans of World War II and the Korean War found that CHD was more common among veterans with PTSD than those without. Veterans with PTSD were 50% more likely to develop heart failure than those without PTSD (Roy et al., 2015). The researchers were unable to find the link between PTSD and CHD, but suggest practitioners include mental illness and chronic disease detection and management in the care of veterans.

PTSD is a difficult disease to diagnose and treat alone, but can cause even more health problems when left undetected and untreated. PTSD and substance use have a strong correlation with one another. When PTSD and substance use are combined it can lead to lifetime abuse/dependence for many veterans as well as further health problems, suicide, and family/social problems. Not only do PTSD and substance abuse occur simultaneously, but research also shows a strong tie between PTSD and depression. It was found that depression can also cause further health problems, suicide, family/social difficulties as well as a lower HQRoL (Pittman et al., 2011). When PTSD is linked with mental illness, it often raises questions of how to treat the concurrent cardiac problems; however PTSD can also be tied to physical health

problems. Roy et al. (2015) found that over the period of their study, the risk for developing heart failure significantly increased in those veterans with PTSD versus those without PTSD. The research presented in this section provided support to further increase military status and PTSD screening in order detect PTSD sooner and decrease or prevent the comorbidities that can occur with PTSD.

Suicide Related to PTSD

In 2010, it was estimated that 22 veterans died by suicide every day (Finley et al., 2015). According to Finley et al. (2025), there are several risk factors for veteran suicide which included: previous diagnosis of psychiatric disorders such as PTSD, depression, substance abuse, bipolar disorder and schizophrenia. Focusing on PTSD alone, it was approximated that one fifth of OEF and OIF veterans cared for in the VA have been diagnosed with PTSD (Finley et al., 2015). Although we are focusing on veterans, research has suggested that PTSD is a predictor of suicide ideation in veterans as well as nonveterans.

Finley et al. (2015) used information from the VA OEF/OIF roster to identify patients who also received VA care as an inpatient or outpatient to determine the effects of PTSD on suicide related behavior. The researchers used the International Classification of Diseases, Ninth Revision Clinical Modification (ICD-9-CM) codes to determine suicide ideation and attempt. The ICD-9-CM information was further grouped into four categories: (1) neither ideation nor attempt, (2) ideation only, (3) attempt only, and (4) both ideation and attempt (Finley et al., 2015). The demographics included age, gender, race, and marital status which were all retrieved from the VA system. It was concluded that out of 211,652 veterans (OEF/OIF), 97.3% (205,899) had neither suicide ideation or attempt, 2.0% (4,310) ideation only, 0.4% (753) attempt only, and 0.3% (690) had both attempt and ideation (Finley et al., 2015).

It was concluded that veterans diagnosed with bipolar disorder, anxiety, substance abuse, schizophrenia, depression, or PTSD were more likely to be diagnosed with all three categories of suicide related behavior (Finley et al., 2015). When adding comorbid depression or substance abuse, it increased the risk for suicidal ideation and attempt in those already diagnosed with PTSD. A limitation of this study was that the researchers only used patients from the VA system and did not allow for comparison with veterans seeking care outside the VA system. According to Bossarte et al. (2012), in general, there has been a 66% increase in suicide risk among veterans receiving services from the VA system.

Bossarte et al. (2012) conducted a study that used the Behavioral Risk Factor Surveillance System (BRFSS) and Veteran's Health Module (VHM) to create a questionnaire. The questionnaire included health related questions such as self-rated health; if the patient had a psychiatric diagnosis, a traumatic brain injury (TBI), or received psychological, or psychiatric counseling within the past 12 months; their availability of emotional and social support; and if they had any suicidal ideations and/or attempts during the last 12 months. Lastly, the survey included questions about history of active military service and service in combat war-zone. A total of 2602 veterans participated in the study. Results revealed 3.8% ($n=66$) reported suicide ideation and 0.4% ($n=8$) reported suicide attempt in the past 12 months (Bossarte et al., 2012). The statistics showed that those reporting suicide ideation were more likely to be in the age group between 60-79 years old, and majority reporting non-Hispanic ethnicity (Bossarte et al., 2012). Alarmingly, the prevalence of suicide ideation was among those who also reported a diagnosis of depression, anxiety, or PTSD (Bossarte et al., 2012).

Lastly, Herrell, Bliese, and Hoge (2013), created a questionnaire of four items which included "In the past year did you (1) often think a lot about death, (2) seriously think about

committing suicide, (3) make a plan for committing suicide, and (4) have you ever attempted suicide?" (p. e23). Researchers surveyed 1664 US soldiers and found that PTSD increased the odds for thoughts about death (odds ratio (OR) = 3.9), suicide (OR= 3.9), and suicide plan (OR= 10.0) (Herrell, Bliese, & Hoge, 2013).

Much research has been performed on suicide ideation and attempt, but little has been performed on suicide completion. According to Gradus et al. (2010), the incidence of suicide among U.S. Army members is currently higher than during any period on record. In a nationally conducted survey, PTSD was associated with suicidal ideation and attempt with odds ratios of 2.8 and 2.7 (Gradus et al., 2010). Researchers used Denmark's population of 5.4 million people and those that were ages 15-90 years old at time of suicide for a total of 9,612 completed suicides during the allotted time (Gradus et al., 2010). Researchers use data that was retrieved from Danish medical and administrative registries and the data was used in descriptive and stratified analysis. Out of 5.4 million people aged 15-90 years old 9,612 successfully complete suicide and thirty-eight percent of the suicide cases had been diagnosed with PTSD and those with a PTSD diagnosis had 5.3 times the rate of suicide compared to those without PTSD (Gradus et al., 2010). PTSD drastically increased the rate of suicide ideation, attempt, and completion and warrants more accessible and improved services.

Minimal research was found on the effect that appropriately screening and treating PTSD would have on suicide statistics. However, the Air Force Suicide Prevention Program (AFSPP) has achieved significant relative risk reductions of suicide rates (Knox et al., 2010). The AFSPP has 11 initiatives associated with this program:

1. Leadership involvement
2. Addressing suicide prevention through professional military education

3. Guidelines for commanders on use of mental health services
4. Community preventive services
5. Community education and training
6. Investigative interview policy
7. Trauma stress response
8. Integrated Delivery System (IDS) and Community Action Information Board (CAIB)
9. Limited Privilege Suicide Prevention Program
10. IDS Consultation Assessment Tool
11. Suicide Event Surveillance System

Knox et al. (2010) studied suicide rates from 1991-2008 within the Air Force. The estimated mean suicide rate per quarter during the intervention period was 2.387 per 100,000, compared with 3.033 per 100,000 for the pre-intervention mean, for a change of 0.646 ($p < .01$). Judging by the statistics over this period of time, the Air Force created an effective way to reduce suicide rates. The message researchers would like to convey is that for programs to be successful in reducing suicide, the interventions must be consistently supported, maintained, and monitored for compliance (Knox et al., 2010).

Unfortunately, most research conducted on PTSD and suicidality is conducted within the VA system or using the VA system's information. Little to no research has been performed on those who seek care outside of the VA system with PTSD and their risk for suicide. Although majority of the research above is performed within the VA system, it allows an inside look to the risk factors for suicide and the relationship PTSD has with suicide. Research has been shown few positive outcomes in suicide prevention programs other than that of the AFSPP. Although those are important themes to consider, the most important trend is the statistics showing the number

of veterans who have attempted or at least have ideations about attempting suicide. The goal for this research study was to encourage PCPs to screen for military service and subsequent PTSD in order to decrease those statistics.

Theoretical Framework

The theoretical framework for this study is Albert Bandura's social cognitive theory. Bandura's original theory was the social learning theory which explained that children often learned behaviors based on what they observed in their environment. Bandura updated his theory and renamed it because he determined cognition also impacts a person's behaviors (Bandura, 1989b). Triadic reciprocal determination, is the model for the social cognitive theory that focuses on how personal, behavioral, and environmental influences bi-directionally impact behaviors (Bandura, 1989b). It is significant to understand that personal and environmental influences are not always equal or occur at the same time, "it takes time for a causal factor to exert its influence and activate reciprocal influences" (Bandura, 1989b, p. 2). Bandura (1989a) goes into further detail about the human agent's cognitive impact and that self-efficacy beliefs can either be beneficial or negative when it comes to one's perception of control over the influences in their daily lives. The cognitive process that is related to self-efficacy shows that those who believe and visualize that they can succeed will be more likely to do so than those who see themselves failing or underperforming (Bandura, 1989a). Bandura's theory has contributed to the human psychology by determining that, "persons are neither autonomous agents nor simply mechanical conveyors of animating environmental influences" (Bandura, 1989a, p. 1175).

The social cognitive theoretical framework supports the importance of screening veterans for PTSD. Investigating how self-efficacy impacts a veteran's ability to adapt and cope with military trauma could impact potential treatment options for veterans diagnosed with PTSD. Benight and Bandura (2004) applied the social cognitive theory directly to posttraumatic recovery, focusing on the soldier's perceived self-efficacy. According to Benight and Bandura (2004), the trauma that military personnel face can negatively impact their self-efficacy and overall ability to cope. Self-efficacy is believed to be related to the veteran's coping abilities after enduring trauma (Benight & Bandura, 2004). It is interesting to understand that not everyone who experiences the same trauma will be impacted in the same way. This might be a result of prior traumatic experiences and the veteran's ability to cope and adapt after sustaining the trauma (Benight & Bandura, 2004). Bandura's social cognitive theory relates to this study by demonstrating why it is important to screen every veteran for PTSD and not only those who the provider assumes are suffering from PTSD. Self-efficacy in dealing with the trauma veterans have endured has the potential to change over time and therefore they should be screened for a period of time post-military service. Early treatment and intervention can impact self-efficacy positively and improve adaptation to civilian life, further demonstrating the importance of screening every veteran (Benight & Bandura, 2004).

Summary of the Review of Related Literature

Minimal research has been performed to determine effective screening procedures for military status and subsequent PTSD. Even further, research has not determined the positives and/or negatives of those receiving co-managed care between VA providers and private practice providers. However, plenty of research shows that the stigma associated with mental illness can lead to practitioners not screening or veterans not following up with their care. Without proper

screening or follow-up, patients are not receiving effective treatment and therefore putting themselves at further risk for comorbidities and even suicidal ideations and attempts. The basis of this study was Albert Bandura's social cognitive theory because of his idea that cognition impacts personal behavior. This theory drives this study by demonstrating the importance of screening veterans for PTSD by investigating how a veteran's cognition impacts their ability to adapt and cope with trauma, which each person does differently.

Chapter 3

Methodology

Primary care providers might be the first and only health care professional that a returning veteran visits. PCPs make the difference in the life of a veteran just by asking about the veterans experience in the service, but the provider must identify the patient as a veteran first. Mental illness stigma among providers and self-stigma in veterans create barriers to quality care, when neither wants to discuss PTSD. Un-treated PTSD, co-managed veterans, and comorbidities increase the morbidity and mortality in veterans, when the PCP does not know about the military history. This study evaluated whether or not PCPs in the private sector are screening their patients for military service. If the provider identified patients with military experience, the researchers examined whether the veterans are screened for PTSD.

Research Design

The design of this study was a quantitative, cross-sectional, non-experimental study. Data was collected from January 1, 2016 until March 1, 2016 to determine if PCPs in the private sector were screening for military status and subsequent PTSD in their patients using a survey.

Setting

The setting for the study was primary care offices within Western and Central Pennsylvania. These locations have been chosen due to the researchers' primary location. The survey was completed online at SurveyMonkey.com. Information (see Appendix A) about the study was mailed via the postal service, posted on Facebook, and sent through work email within a local health care system to providers. Respondents were able to complete the survey any time or place at their convenience.

Sample

This quantitative study used a convenience sample. Potential participants were identified using online search engines and professional connections. There are multiple provider directories linked with insurance companies and that provide the telephone numbers and mailing address for primary care practices. The researchers distributed 250 surveys (assuming there are at least two providers in each practice) to reach the goal sample size of 100. Social media was used via Facebook to distribute the information for the survey by posting the same information that was sent out in the mail. A local health care system also distributed the survey information to their affiliated PCPs via their email directory. This was done by the office manager so the PCPs know that the email is secure.

Ethical Considerations

The study was completed using human participants with no physical risk to the participants involved in the study. No identifiable data was collected about the participants. After receiving the information regarding the survey via mail, email or social media, participants were directed to the survey website. They again reviewed the informed consent and had the option to answer ‘yes’ (see Appendix B) prior to beginning the survey, which means that they voluntarily agree to complete the survey and participate in the study. Participants were able to also select “no” if they do not wish to participate in the survey. The researchers completed the CITI (Collaborative Institutional Training Institute) Research Ethics training (see Appendix C). The study was determined to be exempt by the Edinboro University Institutional Review Board before collecting data (see Appendix D for IRB review).

Instrumentation

A researcher designed survey consisting of 10 questions was used. The survey was made up of closed-ended questions including demographics that can be viewed in Appendix E. General demographic data to describe the participants include age, gender, educational background, and location of practice. There are two open ended questions allowing the participants to enter their age and location of practice. These included four yes/no items related to provider's previous military experience, friends or family who have served, if providers are aware of the AAN initiative, and if the provider has received specific education in providing health care to veterans. There are items using a 4 point Likert scale (all, most, few, none) asking how many patients that the provider currently screens for military service and out of the patients who are veterans how many does the provider screen for PTSD.

The researchers completed a pilot study with eight providers to ensure face and content validity. Respondents included physicians ($n=4$), physician's assistants ($n=3$), and nurse practitioners ($n=1$). Those who completed the survey felt that it was easy to read and the questions were presented clearly. All respondents were able to complete the survey in less than five minutes. There were no recommendations for changing questions on the survey. However, providers did ask the researchers if there would be additional information provided with the survey to educate on screening for military service PTSD. Content from the survey was shown to be valid, in that it measured what the researchers expected. The researchers adjusted the wording on Question 9 from how often to how many patients do the providers screen for military service, because of the response selection being all, most, few, or none. Question 10 was also rephrased to incorporate how many veterans are screened for PTSD, opposed to asking if they screen all veterans for PTSD with the Likert scale responses of all, most, few, or none.

Data Collection

Information was mailed through the postal service to the provider's practice site about the research project and web address to access the survey (see Appendix A). The information included the title of the study, investigators, purpose of the study with a description, confidentiality, risks and benefits, and contact information for any questions or concerns about the study. SurveyMonkey, an online survey generator, was used to distribute the surveys. By using the online survey, providers were able to have it available to them until the specified time frame ended.

Data Analysis

Data analysis began after data collection. Analysis of demographics and both research questions is presented.

Demographic analysis. During data analysis the researchers evaluated the respondent's age, gender, educational background, and military experience, as well as his or her current screening practices. All of the demographic questions were measured on the nominal level, other than the age of the provider which was measured on the ratio level. Age was analyzed using measures of central tendency. All other demographic data was analyzed using frequencies and percentages.

Research question: In primary care settings in the private sector, are providers (physicians, physician's assistants, or nurse practitioners) screening patients for military service and PTSD? This is a descriptive question which was analyzed by examining the responses to each item on the survey.

Summary of Methodology

The study was a quantitative, cross-sectional, non-experimental study. The study took place in Central and Western Pennsylvania. PCPs in the private sector were surveyed on their current practice on screening patients for military service and PTSD. Prior to submission to the IRB the survey was tested with eight PCPs in order to determine the instrument's face and content validity. Adjustments to the questionnaire were made based on the respondent's feedback. Using SurveyMonkey for PCPs to complete the survey, the researchers will collect and analyze the data. This is a descriptive study and data was analyzed using frequencies and percentages. Demographic data was measured by frequency and central tendency, in order to describe the population completing the questionnaire.

Chapter 4

Results and Discussion

Chapter 4 describes the results from the survey conducted to explore primary care providers' (PCP) military screening practices in central and western Pennsylvania (PA). Information includes the total responses, demographic data, and how often PCPs are screening their patients for military service and PTSD. The researchers also discuss how the results apply to the theoretical framework and the limitations to the study.

Results

The study information was distributed to 250 primary care practice in central and western Pennsylvania through the United States Postal Service (USPS). The surveys were also distributed to primary care providers by email through a local health care system as well as through social media using Facebook. The survey was open on Survey Monkey from January 1, 2016 until March 1, 2016. A total of 58 individuals agreed to participate in the survey, eight of those participants did not answer any of the survey questions and those surveys were excluded. There were five responses that listed U.S. as their county of practice which was likely due to misreading the question. The consent for the survey specifically stated that they survey was for primary care providers in central and western Pennsylvania and therefore the researchers did not feel it was necessary to exclude those responses. The total of eligible responses for data analysis was 50 ($n=50$). The researchers were unable to calculate an exact response rate because of unknown survey distribution through social media and an unknown number of PCPs who received information through the local healthcare system email.

Demographic Results

Demographic data were collected in order to differentiate between providers (MD, DO, PA, and NP), age, and gender. The demographic data for this also included questions to evaluate the provider's personal military experience, whether or not the provider has friends or family who have served in the military, if the provider has received any additional training in providing healthcare to veterans, and if the provider has ever heard of the American Academy of Nursing's initiative "Have You Ever Served in the Military?". There were two participants who did not list their age and another two who did not list their professional role.

Location was listed as a demographic question in order to limit the research to the specific area of central and western PA. Participants were asked to list their location of practice in an open-ended question and the greatest response was from at Butler county, PA (62%, $n = 31$). There were providers who listed United States (US) 8% ($n = 4$), as mentioned above the responders who listed the US were not excluded. From the PCPs who participated the majority were physician's assistants at 37.5% ($n = 18$) and there were two participants that did not complete this question ($n = 48$). Please refer to Table 4.1 for a full description of the sample.

Table 4.1

Provider's Professional Role

Provider type	<i>n</i>	Percent
MD	12	25.00%
DO	7	14.58%
Physician's Assistant	18	37.50%
Nurse Practitioner	11	22.92%
Total	50	100%

Of the providers who completed the survey the gender was evenly split between males 48% ($n=24$) and females 52% ($n=26$). There were two participants who chose not to disclose their age therefore $n=48$. The age range was from 25-65 years old with a mean age of 42 years (see Table 4.2 for age distribution).

Table 4.2

Age of PCP

Age	<i>n</i>	Percent
25-35	19	39.56%
36-45	10	20.83%
46-55	10	20.83%
56-65	9	18.75%
Total	48	99.97%

Military associated demographic data is listed in Table 4.2. The majority (96%) of the participants have never served in the military in any capacity and only 4% ($n=2$) have served in the military. The majority of participants have close friends or family that have served in the military (see Table 4.3 for full list of results). Only 8% ($n=4$) of the providers were familiar with the AAN initiative “Have You Ever Served in the Military?”. Please refer to Table 4.4 for providers who have had previous training in providing health care for patients who have served in the military. Out of the 11 nurse practitioners that completed the survey only one was familiar with the AAN initiative.

Table 4.3

Friends or Family That Have Served in the Military

Response	<i>n</i>	Percent
Yes	39	78.00%
No	11	22.00%
Total	50	100%

Table 4.4

Previous Education Specifically for Providing Healthcare to Veterans

Response	<i>n</i>	Percent
Yes	6	12.00%
No	44	88.00%
Total	50	100%

Screening Results

The participants were asked how many patients they screen for military service. Only 8% ($n=4$) answered that they screen all of their patients for military status while 40% ($n=20$) screen none. See full distribution in *Figure 1*.

■ All ■ Most ■ Few ■ None

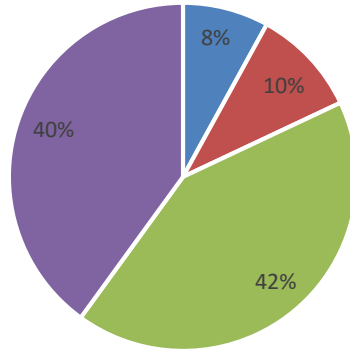


Figure 1. Patients screened for military service

The final question asked providers, out of their patients who have served in the military how many are screened for PTSD? Sixty percent ($n = 30$) of those surveyed screen none of their patients for PTSD and only 4% ($n=2$) screen all of their patients. A full distribution of these results are shown in *Figure 2*.

■ All ■ Most ■ Few ■ None

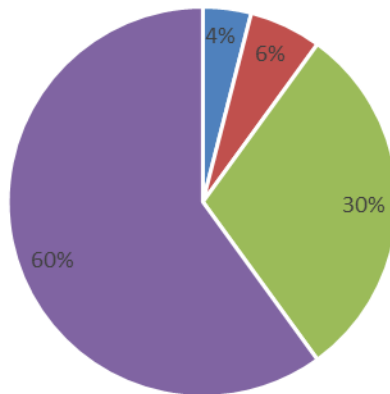


Figure 2. Those who have served in the military screened for PTSD.

Research Question

The research question for this study was “In primary care settings in the private sector, are providers (physicians, physician's assistants, or nurse practitioners) screening patients for military service and PTSD?” Data were obtained using Likert style questions. After reviewing the results, it was determined by this study that majority of PCP’s surveyed are not screening for military service or PTSD.

Discussion of Results

It has been estimated that 1.64 million military personnel were deployed to Afghanistan and Iraq in October 2001 and of those deployed, it was estimated that 300,000 veterans either have PTSD or major depression (Tanielian & Jaycox, 2008). When PTSD remains undiagnosed it can lead to other conditions including mental illnesses, drug and alcohol dependency, physical health decline, and ultimately suicide attempts or completions. In 2010, it was estimated that 22 veterans died by suicide every day (Finley et al., 2015).

There has been increased visibility of veterans dealing with PTSD, with the Clay Hunt Act, the *American Sniper* feature film, and social media utilizing hashtags including #ThePowerOf1 and #Mission22. The question remains, are health care providers identifying their patients as veterans. The primary goal of this research was to evaluate if primary care providers in central and western Pennsylvania were screening their patients for military service and PTSD. The secondary goal was to increase the likelihood that PCPs in Western PA will screen patients for prior military service and PTSD by raising awareness of the the AAN initiative’s “Have You Ever Served in the Military?” and provide the participants with the initiative's web address so that they can obtain further information and resources.

Veterans have the option to receive their health care services through the VA, the private sector, or they can be co-managed by both. Nayar et al. (2013) discussed that one of the main reasons that veterans seek their care through the non-VA providers or are co-managed is due to their location and accessibility to a VA facility. Issues from co-managed care include that the VA uses a computerized health system that non-VA providers do not have access to. This restricts the fluidity in transitional care when the private sector does not get the patient's past or current health care information including: assessments, diagnoses, medication lists, progress notes, or test results. According Gaglioti et al. (2014), 66% of the PCPs in the private sector are not satisfied with the communication with VA providers. The providers felt that it was difficult to obtain records from the VA which can result in duplicate or insufficient testing, non-VA providers felt it was also very difficult to talk with VA providers directly, which results in delay in care (Gaglioti et al., 2014). If the veteran only receives their care in the private sector and the veteran is not screened for military service, as evidenced by the lack of screening from the survey's respondents the provider might be missing or misdiagnosing major health conditions. Further research could be completed to evaluate how the veterans health has been directly impacted from providers that do not screen for military service.

In a national survey it was discovered only about 40% of PCPs and community-based mental health providers routinely ask patients if they or a family member have ever served in the military (Kilpatrick et al., 2011). The study also found that 40% ($n=20$) of respondents did not screen any of their patients for military status, supporting the findings by Kilpatrick et al. (2011).

Unfortunately, there has been limited prior research to indicate whether or not PTSD screening is being performed on veterans by primary care providers in the private sector. Out of the providers who participated in this study, 60% do not screen their veterans for PTSD.

Application of Theoretical Framework

The framework for this research was Albert Bandura's social cognitive theory. The theory highlights the importance of screening for military status and PTSD because not every veteran will be affected the same way upon returning to civilian life (Benight & Bandura, 2004). According to Bandura (1989b) it is significant to understand that personal and environmental influences are not always equal or occur at the same time. That being said each veteran will likely present differently, therefore if they are not exhibiting the signs and symptoms associated with PTSD, this does not preclude the provider from appropriate screening.

According to Benight and Bandura (2004), the trauma that military personnel face can negatively impact their self-efficacy and overall ability to cope. Early treatment and intervention can impact self-efficacy positively and improve adaptation to civilian life, further demonstrating the importance of screening every veteran (Benight & Bandura, 2004). Therefore, if providers are screening appropriately the veteran has a greater chance of improved self-efficacy when adapting to civilian life and coping with the diagnosis of PTSD. The majority of survey respondents are not screening for military status or PTSD, therefore not providing early treatment or intervention to aid veterans in the return to civilian life.

Limitations

The limitations for this study included:

1. Limiting participants to rural central and western PA
2. Utilizing a convenience sample.
3. Utilizing social media does not allow restrictions on who can access the survey.
4. No way to validate or confirm that those who participated in the study are PCPs.

5. Researchers were unable to determine the response rate because it is unknown how many people the survey reached on social media and it was an office manager that distributed the survey through the local health system.

Summary

In this chapter, data obtained from the survey were analyzed to determine what extent primary care providers screen patients for military status and PTSD. It was found that majority of primary care providers are not screening their patients for military status or PTSD. The findings of whether or not primary care providers screen their patients for military status were comparable with the reviewed literature. There was no literature reviewed to compare if PCPs screen for PTSD. In the following chapter, a summary of findings, implications for nursing, and recommendations for future research will be discussed.

Chapter 5

Summary, Conclusions, and Recommendations

Summary of Findings

There is insufficient research to determine if PCPs in the private sector are indeed screening their patients adequately. Because of the significance of veteran status and PTSD on a patient's well-being and the veteran's quality of life, it is imperative that they are being appropriately screened. The purpose of this study was to determine if primary care providers in the private sector are screening their patients for military status and PTSD.

The demographic data showed the majority of participants in the survey practice in Butler County Pennsylvania. There were slightly more females and physician's assistants who completed the survey. The majority ($n=48$) of PCPs have never served in the military however 78% have had friends or family members who have served in the military. There were 47 (92%) of participants who have never heard of the AAN's initiative, nor have 44 (88%) of them received any specific training in regards to providing care to those in the military. Lastly, most of the participants screen none of their patients for military service 20 (40%) or PTSD 30 (60%).

Implications for Nursing and Healthcare Professionals

Findings from this study show that the majority of the PCPs who were surveyed do not screen their patients for military status or subsequent PTSD. If patients with PTSD go undiagnosed it can lead to mental and physical illness. When there is a delay in diagnosing and treating PTSD it can lead to an increased risk of suicide attempts or completion. PCPs are on the front line for early identification and treatment of health concerns for veterans, both physical and mental. It is the provider's responsibility to take action and improve screening practices.

There are a many ways that nurses and healthcare professionals can increase the number of patients being screened. The first route is to educate the PCPs in the private sector. Education should include why every patient needs screened, how to properly screen, the general health concerns for anyone who has served in the military, and the AAN's initiative. The AAN's initiative website provides resources providers can use to aid in their screening process. These include: information on signs and symptoms, the questions to be asked, and hard copies of the questions and posters.

Advanced practice nurses (APN) have a reputation of providing holistic care to their patients. Holistic care encompasses all aspects of the patient's life that might influence their well-being or overall health outcomes, including the patient's professional background. Assessing professional background is something that APN's should be doing on a routine basis the data shows that they are not screening their patients for military service as often as they should be. Due to the amount of veterans who receive care in the private sector APN's would benefit from receiving veteran specific health care education while in school. This would allow the APN to be adequately prepared to care specifically for veterans upon graduation.

Nurses and support staff act as advocates for their patients. Educating all office staff could potentially increase the number of patients screened by providers. Staff members need to be educated on the importance of screening so that they can assist in the screening process when necessary. It is within a nurse's scope of practice to participate in screening patients for military service and potential PTSD. Office staff can help assist in supplying veterans with available resources, making arrangements for follow up care, and referrals if necessary.

The main setting for this study was primary care but screening can take place in urgent care centers, emergency departments, and hospital inpatient setting. It is possible that a veteran

does not have a primary care provider and utilizes such facilities for acute illnesses only. Due to the complex health concerns for veterans it is ideal that screening takes place in all health care facilities. As previously mentioned education is key and should become a part of yearly mandatory education for all staff members within health care facilities who take part in patient care. By training the staff associated with patient care, they can assist providers (physicians, physician assistants, nurse practitioners) in their screening practices.

Recommendations for Further Research

It was discovered during the literature review that there is ultimately limited research available investigating screening patients for military service and PTSD in any capacity. This study was limited to central and western PA which means the results cannot be generalized among all primary care providers within the United States. The same general research should be completed including a broader sample in order to generalize the results. By completing a larger scale study, recommendations for evidence based practice will be more generalizable.

Replication of the survey in the same general population at least once over the next year if not more would provide information to evaluate whether or not providers have increased their screening practices just by participating in this study. It would also show how many providers took the time to learn about the AAN's initiative, which could ultimately influence how often they screen their patients.

Lastly, further research is recommended to assess why the majority of providers do not screen any of their patients for military status or PTSD. Is it because they are not familiar with what questions to ask once they identify the patient as a veteran? Do they not know what tools to use when screening for PTSD in veterans? Do they not feel comfortable discussing mental illness with patients and avoid it unless the patient discusses it first? These are all questions that

need to be answered to provide evidence based practices for PCPs or any health care professionals.

References

- American Academy of Nursing. (n.d.). *About have you ever served in the military?* Retrieved from <http://www.haveyoueverserved.com/about.html>
- American Academy of Physician Assistants. (n.d.). *What is a PA?* Retrieved from <https://www.aapa.org/landingquestion.aspx?id=290>
- Arvanitis, H. (2013). Combating alcohol abuse: The military's uphill battle. *The Exceptional Parent (Online)*, 43(11), 54-58. Retrieved from http://go.galegroup.com/ps/i.do?id=GALE%7CA351950367&v=2.1&u=lom_lansingcc&it=r&p=ITOF&sw=w&asid=38dbb37098fa6b459028f0a703a19324#
- Bachynski, K., Canham-Chervak, M., Black, S., Dada, E., Millikan, A.M., & Jones, B.H. (2012). Mental health risk factors for suicides in the US army, *Injury Prevention*, 18(6), 405-412. doi:10.1136/injuryprev-2011-040112
- Bandura, A. (1989a). Human agency in social cognitive theory. *American Psychologist*, 44(9), 1175-1184. doi:10.1037/0003-066X.44.9.1175
- Bandura, A. (1989b). Social cognitive theory. *Annals of Child Development*, 6, 1-60. Retrieved from <http://www.uky.edu/~eushe2/Bandura/Bandura1989ACD.pdf>
- Bannerman, S. (2014, April 7). *High risk of military violence on the home front*. Retrieved from <http://www.uky.edu/~eushe2/Bandura/Bandura1989AP.pdf>
- Basu, S., Andrews, J., Kishore, S., Panjabi, R., & Stuckler, D. (2012). Comparative performance of private and public healthcare systems in low- and middle-income countries: A systematic review. *PLoS Medicine*, 9(6), 1-14. doi: 10.1371/journal.pmed.1001244.g001
- Bathje, G. J., & Pryor, J. B. (2011). The relationships of public and self-stigma to seeking mental health services. *Journal of Mental Health Counseling*, 33(2), 161-176. Retrieved

from <http://connection.ebscohost.com/c/articles/59783187/relationships-public-self-stigma-seeking-mental-health-services>

- Benight, C. C., & Bandura, A. (2004). Social cognitive theory of posttraumatic recovery: The role of perceived self-efficacy. *Behavior Research and Therapy*, 42(10), 1129-1148. doi:[10.1016/j.brat.2003.08.008](https://doi.org/10.1016/j.brat.2003.08.008)
- Bossarte, R. M., Knox, K. L., Piegari, R., Altieri, J., Kemp, J., & Katz, I.R. (2012). Prevalence and characteristics of suicide ideation and attempts among active military and veteran participants in a national health survey. *American Journal of Public Health*, 102(S1), S38-S40. doi:[10.2105/AJPH.2011.300487](https://doi.org/10.2105/AJPH.2011.300487)
- Bryan, A. O., Theriault, J. L., & Bryan, C. J. (2014). Self-forgiveness, posttraumatic stress, and suicide attempts among military personnel and veterans. *Traumatology*, 21(1), 40-46. doi:[10.1037/trm0000017](https://doi.org/10.1037/trm0000017)
- Buppert, C. (2015). *Nurse practitioner's business practice and legal guide* (5th ed.). Burlington, MD: Jones & Bartlett Learning.
- California Mental Health Services Authority. (n.d.). *Definitions of stigma and discrimination*. Retrieved from <http://www.disabilityrightsca.org/pubs/CM0401.html>
- Campbell, D. G., Felker, B. L., Liu, C., Yano, E. M., Kirchner, J. E., Chan, D., ... Chaney, E. F. (2007). Prevalence of depression-PTSD comorbidity: Implications for clinical practice guidelines and primary care-based interventions. *Journal of General Internal Medicine*, 22(6), 711-8. doi:[10.1007/s11606-006-0101-4](https://doi.org/10.1007/s11606-006-0101-4)
- Center for Substance Abuse Treatment. (2009). *Substance abuse treatment: Addressing the specific needs of women*. Retrieved from <http://www.ncbi.nlm.nih.gov/books/NBK83252/pdf/TOC.pdf>

Congressional Research Service. (2014, December 9). *H.R.5059 - Clay Hunt SAV act*.

Retrieved from <https://www.congress.gov/bill/113th-congress/house-bill/5059>

Davidson, J. R. T., Hughes, D. C., Blazer, D. G., & George, L. K. (1996). Post-traumatic stress disorder in the community: An epidemiological study. *Psychological Medicine*, 21(3), 713-721. doi:10.1017/S0033291700022352

Finley, E. P., Bollinger, M., Noël, P. H., Amuan, M. E., Copeland, L. A., Pugh, J. A., ... Pugh, M. J. V. (2015). A national cohort study of the association between the polytrauma clinical triad and suicide-related behavior among US veterans who served in Iraq and Afghanistan. *American Journal of Public Health*, 105(2), 380-387. doi:10.2105/AJPH.2014.301957

Gaglioti, A., Cozad, A., Wittrock, S., Stewart, K., Lampman, M., Ono, S., ... Charlton, M. E. (2014). Non-VA primary care providers' perspectives on comanagement for rural veterans. *Military Medicine*, 179(11), 1236-1243. doi:10.7205/MILMED-D-13-00342

Gradus, J.L., Qin, P., Lincoln, A.K., Miller, M., Lawler, E., Sorensen, H.T., & Lash, T.L. (2010). Posttraumatic stress disorder and completed suicide. *American Journal of Epidemiology*, 171(6), 721-727. doi: 10.1093/aje/kwp456

Herrell, R. K., Bliese, P. D., & Hoge, C. W. (2013). PTSD, depression, anxiety, and suicidality in a sample of US soldiers. *Comprehensive Psychiatry*, 54(8), e23. doi:10.1016/j.comppsy.2013.07.026

Kaboli, P. J., Shivapour, D. M., Henderson, M. S., Ishani, A., & Charlton, M. E. (2012). The impact of primary care dual-management on quality of care. *Journal of Primary Care & Community Health*, 3(1), 11-16. doi:10.1177/2150131911411194

- Kilpatrick, D. G., Best, C. L., Smith, D. W., Kudler, H., & Cornelison-Grant, V. (2011). *Serving those who have served: Educational needs of health care providers working with military members, veterans, and their families*. Charleston, SC: Medical University of South Carolina Department of Psychiatry, National Crime Victims Research & Treatment Center.
- Kemp, J. & Bossarte, R. (2012). *Suicide data report, 2012* [PDF Document]. Retrieved from <http://www.va.gov/opa/docs/Suicide-Data-Report-2012-final.pdf>
- Knox, K. L., Pflanz, S., Talcott, G. W., Campise, R. L., Lavigne, J. E., Bajorska, A., ...Caine, E.D. (2010). The US Air Force suicide prevention program: Implications for public health policy. *American Journal of Public Health, 100*(12), 2457-2463.
doi:10.2105/AJPH.2009.159871
- Mayo Clinic Staff. (2015). *Post-traumatic stress disorder-PTSD*. Retrieved from <http://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/basics/definition/con-20022540>
- Mental-illness. (n.d.). In Collins English Dictionary online- Complete & Unabridged [*mental illness*] (10th ed.). Retrieved October 22, 2015, from Dictionary.com website: <http://dictionary.reference.com/browse/mental-illness>
- Military service. (2015). In Merriam-Webster online dictionary [*military service*]. Retrieved from <http://www.merriam-webster.com/dictionary/military%20service>
- National Council on Disability. (2009, March 4). *Invisible wounds: Serving service members and veterans with PTSD and TBI*. Retrieved from <http://www.ncd.gov/publications/2009/March042009/>

- National Institute of Health. (2009). *PTSD: A growing epidemic*. Retrieved from <http://www.nlm.nih.gov/medlineplus/magazine/issues/winter09/articles/winter09pg10-14.html>
- Nayar, P., Apenteng, B., Yu, F., Woodbridge, P., & Fetrick, A. (2013). Rural veterans' perspectives of dual care. *Journal of Community Health, 38*(1), 70-77. doi:10.1007/s10900-012-9583-7
- Petrakis, I.L., Rosenheck, R., & Desai, R. (2011). Substance use comorbidity among veterans with posttraumatic stress disorder and other psychiatric illness. *The American Journal of Addictions, 20*, 185-189. doi: 10.1111/j.1521-0391.2011.00126.
- Physician. (2015). In Merriam-Webster online dictionary [*physician*]. Retrieved from <http://www.merriam-webster.com/dictionary/physician>
- Pittman, J. O. E., Goldsmith, A. A., Lemmer, J. A., Kilmer, M. T., & Baker, D. G. (2012). Post-traumatic stress disorder, depression, and health-related quality of life in OEF/OIF veterans. *Quality of Life Research, 21*(1), 99-103. doi:10.1007/s11136-011-9918-3
- Primary Rural Care Health. (2010, June 15). *Post traumatic stress disorder (PTSD) in primary care* [Word Document]. Retrieved from http://solutions.allencorp.com/RHIShare/RHI_PTSD/resources/PTSD_in_Primary_Care_Mobile_Accessible_mobile_2_6_2013.doc
- Quartana, P. J., Wilk, J. E., Thomas, J. L., Bray, R. M., Rae Olmsted, K. L., Brown, J. M., ... Hoge, C. W. (2014). Trend in mental health services utilization and stigma in US soldiers from 2002 to 2011. *American Journal of Public Health, 104*(9), 1671-1979. doi:10.2105/AJPH.2014.301971

- Qureshi, S. U., Pyne, J. M., Magruder, K. M., Schulz, P. E., & Kunik, M. E. (2009). The link between post-traumatic stress disorder and physical comorbidities: A systematic review. *Psychiatric Quarterly*, 80(2), 87-97. doi:10.1007/s11126-009-9096-4
- Roy, S. S., Foraker, R. E., Girton, R. A., & Mansfield, A. J. (2015). Posttraumatic stress disorder and incident heart failure among a community-based sample of US veterans. *American Journal of Public Health*, 105(4), 757-763. doi:10.2105/AJPH.2014.302342
- Salteras-Pedneault, K. (2014). *Stigma-A definition of stigma*. Retrieved from <http://bpd.about.com/od/glossary/g/stigma.htm>
- Schooley, B., Horan, T., Lee, P., & West, P. (2010). Rural veteran access to healthcare services: Investigating the role of information and communication technologies in overcoming spatial barriers. *Perspectives In Health Information Management*, 7(2), 1-16. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2889372/pdf/phim0007-0001f.pdf>
- Seal, K. H., Bertenthal, D., Maguen, S., Gima, K., Chu, A., & Marmar, C. R. (2008). Getting beyond “don’t ask; don’t tell”: An evaluation of US veterans administration postdeployment mental health screening of veterans returning from Iraq and Afghanistan. *American Journal of Public Health*, 98(4), 714–720. doi:10.2105/AJPH.2007.115519
- Sidney, S. (2013). Post-traumatic stress disorder and coronary heart disease. *Journal of the American College of Cardiology*, 62(11), 979-980. doi:10.1016/j.jacc.2013.06.005
- Spoont, M., Arbisi, P., Fu, S., Greer, N., Kehle-Forbes, S., Meis, L., ... Wilt, T. J. (2013). *Screening for post-traumatic stress disorder (PTSD) in primary care: A systematic review* (VA-ESP Project #09-009). Retrieved from <http://www.ncbi.nlm.nih.gov/books/NBK126691/pdf/TOC.pdf>

- Tanielian, T. L., & Jaycox, L. (2008). *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery*. Santa Monica, CA: RAND Corporation.
- The American Legion. (2015). *Rural health*. Retrieved from <http://www.legion.org/veteranshealthcare/ruralhealth>
- Ungar, T., Knaak, S., & Szeto, A. C. (2015). Theoretical and practical considerations for combating mental illness stigma in health care. *Community Mental Health Journal*, 52(3), 262-271. doi:10.1007/s10597-015-9910-4
- United States Census Bureau. (2014, October 28). *How do we know? A snapshot of our nation's veterans*. Retrieved from <http://www.census.gov/library/infographics/veterans.html>
- U.S. Department of Veterans Affairs. (2015). *Suicide risk and risk of death among recent veterans*. Retrieved from <http://www.publichealth.va.gov/epidemiology/studies/suicide-risk-death-risk-recent-veterans.asp>
- Veteran. (2015). In Cambridge Dictionaries Online [*veteran*]. Retrieved from <http://dictionary.cambridge.org/us/dictionary/american-english/veteran>
- Veteran's Administration. (2015). In Investopedia online [*Veteran's Administration*]. Retrieved from <http://www.investopedia.com/terms/v/veterans-administration.asp>
- Vorvick, L.J. (2013, August 11). *Choosing a primary care provider*. Retrieved from <http://www.nlm.nih.gov/medlineplus/ency/article/001939.htm>
- Wolinsky, F. D., An, H., Liu, L., Miller, T. R., & Rosenthal, G. E. (2007). Exploring the association of dual use of the VHA and Medicare with mortality: Separating the contributions of inpatient and outpatient services. *BMC Health Services Research*, 7, 1-10. doi:10.1186/1472-6963-7-70

Zoroya, G. (2013, February 1). *VA study: 22 vets commit suicide every day*. Retrieved from <http://www.usatoday.com/story/news/nation/2013/02/01/veterans-suicide/1883329/>

Appendix A

Survey Information for Providers

Title of Study: PRIMARY CARE PROVIDERS SCREENING FOR MILITARY SERVICE AND PTSD

PRINCIPAL INVESTIGATOR:

Amy McClune, PhD, RN. amcclune@edinboro.edu

CO-INVESTIGATORS:

Kristin Mohler RN, BSN. K.M.Mohler@eagle.clarion.edu

Cydnee Sankey RN, BSN. C.A.Sankey@eagle.clarion.edu

PURPOSE OF THIS STUDY: There are over approximately 21 million veterans living in the United States. Veterans and their family members often have unique health care needs that require comprehensive care. The purpose of this quantitative study is to determine if primary care providers (PCPs) (physician's assistants, nurse practitioners, or physicians) are screening patients for military status and subsequent PTSD in primary care settings.

DESCRIPTION: This study is researching the military screening practice among primary care providers in Central and Western Pennsylvania, in the private sector. You have been asked to participate in this 10 question, online survey based on professional qualifications and your practice location. Completion of the online survey is at no cost to respondents and can be completed in less than 5 minutes.

This is a research project that is being conducted by Kristin Mohler and Cydnee Sankey, with the supervision of Dr. McClune, through Clarion/Edinboro Universities. The researchers are currently graduate students pursuing their MSN as Family Nurse Practitioners. It has come to the researcher's attention that suicide among veterans is an issue that needs attention in the private sector.

RISKS AND BENEFITS: There are no foreseeable financial or physical risks involved in participating in this study. As with any online related activity the risk of a breach of confidentiality is always possible. As a participant in this research you will not receive any direct benefits from completing the survey. By taking the time to participate the researchers will be able to collect data that will help them learn more about the current screening practices of private sector PCPs. This is valuable information that can be used to evaluate the need for further education for primary care providers in screening for military service and PTSD. Participating in this study also will allow providers to reflect on their current screening practices which could potentially increase the number of veterans screened in the future.

TO COMPLETE THE SURVEY: You can access this survey at any time by going to <https://www.surveymonkey.com/r/R2KYRYM>. Please share this with all of the providers in the practice. Thank you for your time and completion of this survey.

Military Service and PTSD Screening

Welcome to My Survey

Consent to Participate in a Research Survey
Clarion/Edinboro Universities of Pennsylvania

Title of Study: PRIMARY CARE PROVIDERS SCREENING FOR MILITARY SERVICE AND PTSD

PRINCIPAL INVESTIGATOR:

Amy McClune, PhD. amcclune@edinboro.edu

CO-INVESTIGATORS:

Kristin Mohler RN, BSN. K.M.Mohler@eagle.clarion.edu

Cydnee Sankey RN, BSN. C.A.Sankey@eagle.clarion.edu

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CONFIDENTIALITY: The survey will be completed through the link provided for SurveyMokey.com. The data will be kept in an electronic format that will be password protected. The researchers will not be asking for any information that would be able to identify respondents. No one will know if you have participated in the study or not. This means there is a chance that you might receive another link to complete the survey if there have not been enough responses.

RISKS AND BENEFITS: There are no foreseeable financial or physical risks involved in participating in this study. As with any online related activity the risk of a breach of confidentiality is always possible. As a participant in this research you will not receive any direct benefits from completing the survey. By taking the time to participate the researchers will be able to collect data that will help them learn more about the current screening practices of private sector PCPs. This is valuable information that can be used to evaluate the need for further education for primary care providers in screening for military service and PTSD. Participating in this study also will allow providers to reflect on their current screening practices which could potentially increase the number of veterans screened in the future.

PARTICIPATION: Participating in this survey is voluntary and you may refuse to participate and complete the survey without penalty. You are free to refuse to answer any of the questions in the survey and may exit the survey at any time.

QUESTIONS AND CONCERNS: If you have questions about this project or if you have a research-related problem, you may contact the principal investigator Amy McClune (contact information above). If you feel that you have encountered any concerns regarding your rights as a research subject you may contact Edinboro University Institutional Review Board at (814) 732-1052. You may also contact the IRB any questions, concerns, or complaints that you wish to address to someone other than the investigator

CONSENT: I have read the above information, and have received answers to any questions I asked. I voluntarily consent to take part in the study.

1. Do you agree to the above terms? By clicking Yes, you consent that you are willing to answer the questions in this survey

- Yes
- No

Appendix C

CITI Certificates (Mohler, Sankey)

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM) COURSEWORK REQUIREMENTS REPORT*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Kristin Mohler (ID: 4602102)
- **Email:** k.m.mohler@eagle.clarion.edu
- **Institution Affiliation:** Edinboro University of Pennsylvania (ID: 2228)
- **Institution Unit:** Nursing

- **Curriculum Group:** Human Subject Research
- **Course Learner Group:** Student researchers
- **Stage:** Stage 1 - Student researchers

- **Report ID:** 15012235
- **Completion Date:** 03/01/2015
- **Expiration Date:** 02/28/2018
- **Minimum Passing:** 80
- **Reported Score*:** 94

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
Belmont Report and CITI Course Introduction	03/01/15	3/3 (100%)
Students in Research	03/01/15	10/10 (100%)
History and Ethical Principles - SBE	03/01/15	4/5 (80%)
Defining Research with Human Subjects - SBE	03/01/15	4/5 (80%)
Privacy and Confidentiality - SBE	03/01/15	5/5 (100%)
Informed Consent - SBE	03/01/15	5/5 (100%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

CITI Program
Email: citisupport@miami.edu
Phone: 305-243-7970
Web: <https://www.citiprogram.org>

Collaborative Institutional
Training Initiative
at the University of Miami

**COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)
COURSEWORK TRANSCRIPT REPORT****

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

- **Name:** Kristin Mohler (ID: 4602102)
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- **Report ID:** 15012235
- **Report Date:** 03/01/2015
- **Current Score**:** 94

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT	SCORE
Students in Research	03/01/15	10/10 (100%)
History and Ethical Principles - SBE	03/01/15	4/5 (80%)
Defining Research with Human Subjects - SBE	03/01/15	4/5 (80%)
Belmont Report and CITI Course Introduction	03/01/15	3/3 (100%)
Informed Consent - SBE	03/01/15	5/5 (100%)
Privacy and Confidentiality - SBE	03/01/15	5/5 (100%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

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- **Email:** k.m.mohler@eagle.clarion.edu
- **Institution Affiliation:** Edinboro University of Pennsylvania (ID: 2228)
- **Institution Unit:** Nursing

- **Curriculum Group:** RCR Course
- **Course Learner Group:** RCR FOR SOCIAL & BEHAVIORAL for Students
- **Stage:** Stage 1 - SB for Students

- **Report ID:** 15012236
- **Report Date:** 03/01/2015
- **Current Score**:** 90

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT	SCORE
Responsible Conduct of Research (RCR) Course Introduction	03/01/15	No Quiz
Using Animal Subjects in Research (RCR-Basic)	03/01/15	5/5 (100%)
Research Involving Human Subjects (RCR-Basic)	03/01/15	4/5 (80%)
Plagiarism (RCR-Basic)	03/01/15	5/5 (100%)
Authorship (RCR-Basic)	03/01/15	4/5 (80%)
Collaborative Research (RCR-Basic)	03/01/15	5/5 (100%)
Conflicts of Interest (RCR-Basic)	03/01/15	5/5 (100%)
Data Management (RCR-Basic)	03/01/15	4/5 (80%)
Mentoring (RCR-Basic)	03/01/15	5/5 (100%)
Peer Review (RCR-Basic)	03/01/15	4/5 (80%)
Research Misconduct (RCR-Basic)	03/01/15	4/5 (80%)
Responsible Conduct of Research (RCR) Course Conclusion	03/01/15	No Quiz

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

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**COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)
COURSEWORK REQUIREMENTS REPORT***

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

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- **Report ID:** 15012236
- **Completion Date:** 03/01/2015
- **Expiration Date:** N/A
- **Minimum Passing:** 80
- **Reported Score*:** 90

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
Plagiarism (RCR-Basic)	03/01/15	5/5 (100%)
Responsible Conduct of Research (RCR) Course Introduction	03/01/15	No Quiz
Research Misconduct (RCR-Basic)	03/01/15	4/5 (80%)
Data Management (RCR-Basic)	03/01/15	4/5 (80%)
Authorship (RCR-Basic)	03/01/15	4/5 (80%)
Peer Review (RCR-Basic)	03/01/15	4/5 (80%)
Mentoring (RCR-Basic)	03/01/15	5/5 (100%)
Using Animal Subjects in Research (RCR-Basic)	03/01/15	5/5 (100%)
Conflicts of Interest (RCR-Basic)	03/01/15	5/5 (100%)
Collaborative Research (RCR-Basic)	03/01/15	5/5 (100%)
Research Involving Human Subjects (RCR-Basic)	03/01/15	4/5 (80%)
Responsible Conduct of Research (RCR) Course Conclusion	03/01/15	No Quiz

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

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**COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)
COURSEWORK REQUIREMENTS REPORT***

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- Name: Cydnee Sankey-Deemer (ID: 4800157)
- Email: cs142792@scots.edinboro.edu
- Institution Affiliation: Edinboro University of Pennsylvania (ID: 2228)
- Institution Unit: Nursing

- Curriculum Group: Human Subject Research
- Course Learner Group: Student researchers
- Stage: Stage 1 - Student researchers

- Report ID: 15870703
- Completion Date: 04/24/2015
- Expiration Date: 04/23/2018
- Minimum Passing: 60
- Reported Score*: 91

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
Belmont Report and CITI Course Introduction (ID:1127)	04/24/15	3/3 (100%)
Students in Research (ID:1321)	04/24/15	9/10 (90%)
History and Ethical Principles - SBE (ID:490)	04/24/15	5/5 (100%)
Defining Research with Human Subjects - SBE (ID:491)	04/24/15	5/5 (100%)
Privacy and Confidentiality - SBE (ID:505)	04/24/15	5/5 (100%)
Informed Consent - SBE (ID:504)	04/24/15	3/5 (60%)

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**COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)
COURSEWORK TRANSCRIPT REPORT****

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

- **Name:** Cydnee Sankey-Deemer (ID: 4800157)
- **Email:** cs142792@scots.edinboro.edu
- **Institution Affiliation:** Edinboro University of Pennsylvania (ID: 2228)
- **Institution Unit:** Nursing

- **Curriculum Group:** Human Subject Research
- **Course Learner Group:** Student researchers
- **Stage:** Stage 1 - Student researchers

- **Report ID:** 15870703
- **Report Date:** 04/24/2015
- **Current Score**:** 97

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT	SCORE
Students in Research (ID:1321)	04/24/15	9/10 (90%)
History and Ethical Principles - SBE (ID:490)	04/24/15	5/5 (100%)
Defining Research with Human Subjects - SBE (ID:431)	04/24/15	5/5 (100%)
Belmont Report and CITI Course Introduction (ID:1127)	04/24/15	3/3 (100%)
Informed Consent - SBE (ID:504)	04/24/15	5/5 (100%)
Privacy and Confidentiality - SBE (ID:505)	04/24/15	5/5 (100%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing Institution identified above or have been a paid Independent Learner.

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NOTE: The My Reports section now provides access to course completion data for both your current active affiliations and for past affiliations that are no longer active.

Edinboro University of Pennsylvania Reports

Human Subject Research

Student researchers

Stage	Completion Report #	Passing Score	Your Score	Start Date	Completion Date	Expiration Date	Completed Modules	Completion Report
Student researchers	15870703	80%	91%	04/24/2015	04/24/2015	04/23/2018	View	View

RCR Course

RCR FOR SOCIAL & BEHAVIORAL for Students

Stage	Completion Report #	Passing Score	Your Score	Start Date	Completion Date	Expiration Date	Completed Modules	Completion Report
SB for Students	15870704	80%	100%	04/24/2015	N/A	N/A	View	N/A

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Main Menu > Course RCR FOR SOCIAL & BEHAVIORAL for Students

RCR FOR SOCIAL & BEHAVIORAL for Students - SB for Students

To pass this course you must:

- Complete all 12 required modules
- Achieve an average score of at least 80% on all quizzes for the above

Your Current Score **100%**

You have unfinished required or elective modules remaining

Required Modules

	Date Completed	Score
Plagiarism (RCR-Basic) (ID: 15156)	04/24/15	5/5 (100%)
Responsible Conduct of Research (RCR) Course Introduction (ID: 1522)	Incomplete	0/0 (0%)
Research Misconduct (RCR-Basic) (ID: 16604)	Incomplete	0/0 (0%)

Appendix D

IRB Review

This memo provides the notification concerning EUP's Institutional Review Board (IRB) determination of the human subjects protocol:

To: Dr. Amy McClune

From: Dr. Colleen Barrett, EUP Nursing IRB Exempt Screening Committee Chair

Protocol # NURS2015-009

Date Approved 12/18/15

Title: Primary Care Providers Screening for Military Service and PTSD

The EU IRB Chair has designated this committee as reviewer of the application listed above for exempt status. It has been determined that your protocol is categorized as **Exempt** under federal regulations 45 CFR 46.101(b), since the research design involves one or more of the following criteria:

Research conducted in established or commonly accepted educational settings, involving normal educational practices.

Research using educational tests, surveys or interviews where respondents are not identified or are public officials.

Research involving observation of public behavior.

Research involving collection, study, and use of existing data where subjects are not identified.

Exempt protocol means that as long as you continue your research as described in your protocol application, the research does not require any further review or oversight by the IRB. Should you change any procedure within your research, you are required to resubmit the protocol to the IRB for reconsideration and determination before you implement any change. All data must be retained and accessible for three (3) years after the completion of the project.

Designation as exempt signifies only that the proposal adequately qualifies under 45 CFR 46.101(b) for such status. It does not imply, directly or indirectly, any institutional support or permission to conduct the study.

Should you have any questions or concerns, please feel free to contact me at 814-732-1643

Dr. Colleen Barrett, DNP, CRNP, FNP-BC

Cc: Dr. Lisa Joyce, Chair EUP IRB

Military Service and PTSD Screening

1. What is your age?

2. What is your gender?

- Female
- Male

3. What is your professional role?

- MD
- DO
- Physician's Assistant
- Nurse Practitioner

4. In what county do you practice?

5. Have you ever served in the military in the capacities of active duty personnel, reservist, or civilian personnel?

- Yes
- No

6. Do you have any close friends or family who currently or previously served in the military?

- Yes
- No

7. Have you heard of the American Academy of Nursing's initiative "Have you Ever Served in the Military?"

- Yes
- No

8. Have you received any specific education/training in providing health care for patients who have served in the military?

- Yes
- No

9. How many of your patients do you currently screen for military service?

- All
- Most
- Few
- None

10. Out of your patients who have served in the military, how many do you screen for PTSD?

- All
- Most
- Few

None

Thank you for participating in our study. If you would like more information about screening patients for military service and PTSD please go to the American Academy of Nursing website "Have You Ever Served in the Military?" <http://www.haveyoueverserved.com/>