

Patient-Centered Care for Warriors, Veterans, and Their Families: An Interprofessional Modular Curriculum

Carol A. Terregino, MD, Robert C. Like, MD, Ronald J. Steptoe, Evelyn Lewis, MD, Kevin Parks, MD, Joyce Afran, MD, Diana Glendinning, PhD, Anthony Tobia, MD, Mei Liu, PharmD, Brian Greenwald, MD, Mark A. Graham

Abstract

Most veterans receive health care in the civilian sector, where the complexities of delivering care to them require interprofessional teams that include other veterans. Recognizing this, the Rutgers Robert Wood Johnson Medical School committed to graduating health profession students who were familiar with, responsive to, and knowledgeable in addressing veteran health issues. Based upon the Warrior-Centric Healthcare Training program, interprofessional learning activities were developed addressing the significant need for health care for military and their families. The full-day curriculum, which is flexible enough for modularization, includes panel discussions, videos, poignant testimonials, debriefing exercises, interprofessional role-playing, and formulations of collaborative care plans for complex veteran issues. It is suitable for medical, pharmacy, nursing, physician assistant, physical therapy, social work, and applied psychology students. The program has been implemented for 3 years. It began as a mandatory activity for rising fourth-year medical students, pharmacy students in their third professional year, and other health professions students in the clinical portions of their training. The medical students requested the program earlier in their training so that they could apply the knowledge learned during clerkships. By fostering a safe learning environment, culturally sensitive communication skills, and willingness to learn from others, this active learning program creates a therapeutic alliance between veterans and health care learners that may lead to improved educational outcomes and future clinical impact.

Please see the end of the Educational Summary Report for author-supplied information and links to peer-reviewed digital content associated with this publication.

Introduction

Joining Forces, an initiative sponsored by the White House to serve military personnel and their families, received the help of the Association of American Medical Colleges when it joined in 2011 and the initiative received pledges from more than 100 medical schools to dedicate patient care, research, and educational resources to advance veteran health care.¹ Rutgers Robert Wood Johnson Medical School is among the participating medical schools and has sponsored this interprofessional educational program annually to train cohorts of health professions students to meet the needs of the military and their families. The planning faculty were committed to graduating students who were informed about the issues, prepared to access appropriate resources, and sensitive to building resilience

among veteran patients and their families. Health care professionals must understand that

in an age of sustained conflict, fitness requires continuous performance, resilience, and recovery of the whole person, not just the physical body. Injury from these conflicts is physical and mental, social, and spiritual. It impacts the service members, their families and communities, and the nation.²

As written in *Stars and Stripes* in 2012, “the goal is to ensure that young medical professionals are familiar with the signature wounds of war, and able to more effectively treat the millions of veterans who will struggle with those issues for decades to come.”³ More than half of Iraq and Afghanistan veterans receiving treatment for mental health issues rely not on the Military Health System or Department of Veterans Affairs but instead on private civilian medical practices.

Dr. John Prescott, Director of Academic Affairs for the Association of American Medical Colleges, said, “While

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many of the schools touch on military health topics, most don't have them as a core competency for graduates." The next generation of health care providers will care for the 15 million veterans who seek their care in the community rather than in the Veterans Administration System. In just the state of New Jersey, there are currently more than 400,000 veterans of whom 320,000 are considered war-time veterans. Military service has additionally impacted at least two of each veteran's family members, resulting in more than a million New Jersey citizens connected and impacted by military service.⁴

We decided to develop a program of interprofessional learning activities based on the Steptoe Group's Warrior-Centric Healthcare Training (WCHT) program, which addresses the significant need for health care and support services for military and families. The WCHT program was developed by Ronald Steptoe, a disabled veteran, and Dr. Evelyn Lewis, a family physician and decorated Navy veteran, and has been presented at a host of professional organizations, academic institutions, and military medical centers. The program is informed by research findings from the RAND Corporation,⁵ the Department of Defense,^{6,7} the US Army,⁸ and the Joint Commission.⁹

The Joining Forces Patient-Centered Care for Warriors, Veterans, and Their Families interprofessional education program has been integrated into the Rutgers Robert Wood Johnson Medical School's longitudinal 4-year patient-centered medicine curriculum and is also one of a growing number of interprofessional education activities at Rutgers Biomedical and Health Sciences. Patient-centered medicine is the foundational course where students learn how to integrate, collaborate, and apply the basic, clinical, and health care delivery sciences in providing patient-centered care to diverse populations and communities. The course focuses on providing culturally sensitive care to patients and families, improving communication, and contextualizing the patient experience. The course structure provided a matrix upon which this education program was developed to address biopsychosocial perspectives in an integrative way, add military cultural competency training to other diversity training, address disparities in health and health care experienced by veterans, and emphasize a strengths- and assets-based approach for community reintegration, recovery, and resilience.

Since the WCHT program was initially developed for those working in the military sector, we participated in

Educational Objectives

By the end of the full-day curriculum, learners should be able to:

1. Recognize, reflect upon, and discuss the importance of eliciting a military health history in order to identify selected health, mental health, and psychosocial challenges experienced by veterans transitioning from military to civilian life.
2. Describe best practices in the clinical assessment, treatment, and care of veterans with post-traumatic stress disorder and mild traumatic brain injury.
3. Use interviewing and communication skills during clinical encounters with warriors, veterans, and their families.
4. Conduct biopsychosocial assessments and work collaboratively with health and mental health professionals in developing treatment and care plans for veterans, military service members, and their families.
5. Describe stigma, ways to foster resilience, and resources to help veterans access needed health and behavioral health services and reintegrate more successfully into communities.

a full-day WCHT train-the-trainer program in March 2013 to identify areas for adaptation and modification for delivery to students of health care disciplines in the civilian sector. Takeaways included modeling the interprofessional approach to education, panel discussions that include both veterans and family members, developing small-group activities to engage interprofessional learners and challenge them to solve problems collaboratively, and tailoring the program to include the stories, experiences, and active participation of Rutgers student veterans. The train-the-trainer program can be augmented with recently published faculty development activities for veteran health educational programs.¹⁰

Methods

We selected an educational approach that could be implemented in a variety of educational settings employing active learning techniques. We also picked an approach that required preparation, reflection, and sharing of ideas among health professionals and veteran participants. We carefully identified the audience as busy health professions students addressing many different patient care populations. We then distilled their message of the importance of veteran health issue awareness, eliciting a military health history, addressing biopsychosocial aspects of care of

veterans and families, building resilience, learning from other team members, including veterans, and engaging the audience with poignant and thought-provoking stories and group activities.

The program is divided into five modules, which can be delivered in a 1-day program or interspersed throughout a sequential or longitudinal curriculum of veterans health issues. The curricular elements are delivered in large- and small-group settings.

The Curriculum Resource Form for Participants (Appendix A) should be made available on an electronic educational platform (such as Blackboard) for easy access by all learners. The learning objectives for the entire program and each of the five modules are included in the Curriculum Resource Form.

It is suggested that the program begin with introductions and acknowledgments; however, as stated earlier, modules can be presented in a stand-alone fashion. The Sample Introductory Comments (Appendix B) provide an example of introductory motivational words for the audience. The comments acknowledge and thank past and current members of the armed forces for their service and highlight the important impact of military service on virtually all members of the audience and their families. The formal program begins after the introductory comments.

The Mnemonics for Modules A and C (Appendix C) provide a simple handout with the three mnemonics used in modules A and C. The WARRIORS mnemonic from module A is a tool for eliciting information about a veteran's military service experiences and life-world perspective. It is an interviewing and assessment framework for providing culturally competent patient-centered care to veterans and military personnel. While it was developed for military members and their families, it can also be adapted for use with other groups such as emergency medical services, police/firefighters, survivors of natural and manmade disasters, and refugees and asylees who have experienced war and trauma. This mnemonic, with examples of questions that can be asked, should be distributed to all learners. Additionally, the BATHE and ETHNIC mnemonics from module C are included for distribution to all participants.

Module A serves to engage the audience in the issues of veterans and returning warriors, military culture partic-

ulars, and the power of stories told by veterans. It also serves as a tool to elicit a patient's experiences in service.

The Module A Slides (Appendix D) provide brief descriptive information about military culture, veteran population demographics (national and state), and key definitions and terminology used in the various military service branches. Learners are encouraged to learn more about the diversity of military culture and its values and traditions by visiting a website with a webinar presented by the Steptoe Group about these important subjects. The importance of asking patients about previous military service is emphasized. Critical questions for eliciting a culturally competent and focused military health history are shared.

The miniature lecture sets the stage for seeing a brief, impactful documentary trailer (Appendix E) that serves as an icebreaker that helps to personalize and locally situate a host of issues relating to veterans' health, wellness, and community reintegration. The documentary follows Rutgers community members, and while the impact may be greatest for Rutgers students, the veteran student messages are universal and relevant for all. Following this is a moderated interactive panel discussion with veterans and family members. During the panel discussion, the moderators (a faculty member and a medical student veteran) can project the WARRIORS mnemonic on the screen and ask questions of the panelists, who should represent men and women from different military service branches, returning veterans from recent conflicts, veterans from previous wars, and family members. Five to six panelists are an optimal number. Panelists should be comfortable speaking in front of a large group. Information should be shared ahead of time about the goals and objectives of the overall program so that panelists are prepared and have an appropriate educational context.

Module B is titled Neurobiology, Epidemiology, Diagnosis, and Treatment of Posttraumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) in Veterans. The Module B Slides (Appendix F) are divided into distinct sections, each delivered by different faculty members of the interdisciplinary team. The slides cover epidemiology of PTSD, neurobiology of PTSD, pharmacological treatment of PTSD, and psychopharmacological treatment of PTSD and TBI in veterans. The slide deck can be used altogether, or sections can be broken down into miniature lectures, converted into podcasts, or embedded within neuroscience, behavioral science, pharmacology, psychiatry, physical medicine, and rehabilitation curricula.

Module C begins the small-group exercises. Each small group is facilitated by a lead facilitator, a participant of the train-the-trainer program, and at least one other health professions faculty from another discipline. Facilitators can include faculty from all health professions schools, as well as other individuals who work with veterans such as pastoral care providers.

The Module C Facilitator Guide (Appendix G) is distributed to all faculty facilitators prior to the program. It provides guidelines for creating a positive group dynamic and improving communication during clinical encounters with veterans and their families. Module C describes how each small-group session will need to begin with exercises that reinforce the group dynamic and emphasize the key message for the exercise, that the small group is a safe place for everyone to have a positive and meaningful learning experience. The facilitator's guide outlines group instructions and provides learner materials, talking points, clarifying questions, and answers to the small-group work.

The Module C Role Plays for Learners (Appendix H) supply the patient and provider roles for each of the four role-plays on separate pieces of paper so that they can be easily duplicated and distributed to the group members. Additionally, the BATHE and ETHNIC mnemonics are included for distribution to all participants.

The Module D small-group exercise begins with distributing the Module D Facilitator Guide (Appendix I) to all faculty facilitators prior to the program. The guide provides the guidelines for creating a positive group dynamic. If Module D follows Module C in 1-day programming, there is no need to repeat the reinforcing positive group dynamic exercises; however, if this is presented as a stand-alone exercise, the exercises should precede the assessment and collaborative care planning exercises.

Module D divides the learners into teams based upon their respective disciplines. Ideally, multiple disciplines should be represented in each small group to enhance interprofessional learning. Student learners can come from schools of medicine, nursing, physician assistants, pharmacy, psychology, social work, physical therapy, occupational therapy, residency programs, and hospital and health care institutions. Veterans can also participate actively in the small groups and provide critically important perspectives based on their military service, community reintegration, and other personal and family experiences. Faculty cofacilitators

provide real-world care perspectives and help role-model the clinical best practices of their respective disciplines.

Module D for Learners (Appendix J) includes the highly complex two-page clinical case and a collaborative care plan grid.

If unable to schedule a live speaker for the program, Module E (Appendix K) provides a recommended video that emphasizes the importance of confronting stigma regarding mental illness and suicide, fostering resilience, and mobilizing community resources. If using video rather than a live speaker, Module E can be completed in the small-group setting, rather than in a large group.

Session Lengths

This curriculum can be modified to be a full day, half day, or individual session curriculum. Additionally, there is flexibility in the ordering of the modules. If at all possible, leave enough time for debriefing and reflection.

Module A: large-group setting.

- Introduction, miniature lecture, and video: 15 minutes.
- Panel discussion: 45 minutes.

Module B: large-group setting.

- Presentations from neuroscience, psychiatry, pharmacy, physical medicine, and rehabilitation: 50 minutes.
- Questions and comments: 10 minutes.

Module C: small-group setting.

- Forming the small group, reflections on learning experiences: 45 minutes.
- Role-play and debriefing of the four-act plan: 45 minutes.

Module D: small-group setting.

- Read the case and independently complete worksheet: 20 minutes.
- Small groups of four to five participate in a simulated group meeting: 20 minutes.
- Cofacilitators debrief all of the small groups: 20 minutes.

Module E: large-group setting.

- Live speaker: 45 to 60 minutes, with time allotted for breaks and pre-post evaluations.

Practical Implementation Advice

The size and comprehensiveness of Rutgers made the identification of health professions students and faculty less challenging than in an institution without the diversity of multiple schools. Our experience, however, demonstrated that local practitioners in nursing, occupational therapy, physical therapy, prosthetics, psychology, pastoral care, and social work learned of the program by word of mouth and were very interested in participating and facilitating sessions. It was very helpful to identify leaders in each of the health professions as contacts for student recruitment, faculty cofacilitator recruitment, distribution of learning resources, and potential fund-raising for costs such as printing, facilities (small-group rooms), and refreshments. Participating health professions can include pharmacy, physician assistant, nursing, nurse practitioner, physical therapy, occupational therapy, social work, psychology, medicine, dentistry, podiatry, and pastoral care.

The identification of student veterans was invaluable as they were instrumental in shaping the program. The students participated in the first train-the-trainer session, which was designed to prepare faculty to facilitate the small-group sessions. The more-recent iterations of the program have been improved by their feedback. A student veteran who was a former Army medic was also selected to moderate the panel discussion.

The Rutgers University Office of Veteran and Military Programs and Services and the Rutgers University Behavioral Health Care's NJ Vet2Vet program were both wonderful resources for identifying local veterans willing to participate in the interprofessional education activities. The veterans served as teachers in the large-group panel discussion and small-group sessions and were critical to their success. Another important resource was the Rutgers University Behavioral Health Care's national Vets4Warriors program, a confidential resource for service members, veterans, and their families.

Faculty Development

After 3 years of implementation, we have an established group of lead facilitators. We conducted several on-site and phone conference exercises to orient the facilitators to the learning objectives of the sessions. Because interprofessional collaboration was a goal of the exercise, we had comoderators in each small group, using as many faculty participants as available to model interprofessional and interdisciplinary teaching and collaboration.

It is critical that all participants engage in reflection and debriefing in order to share feelings and lessons learned, strengthen take-home messages, and model active participatory adult learning. Examples of questions worth exploring include the following:

- What were the most surprising things that you learned today?
- Discuss how the interactions with other health professionals will impact the way that you practice.
- Were the small-group scenarios realistic? Why or why not?
- How comfortable will you be the next time you interact with a veteran?
- Veterans, health professionals, and learners, what did we miss? What do you want the take-home messages to be for the participants and directors of the program and other key stakeholders and constituencies?

This may take place in a large- or a small-group setting. Techniques such as audience response or pair-and-share can be used to get all participants involved in the reflective process. Time constraints always make the time for reflection and debriefing too short.

The cofacilitation model was useful as residents in the specialties of physical medicine and rehabilitation, psychiatry, emergency medicine, and family medicine made positive contributions to small-group activities. Depending on the number of participants and the selection of modules, both lecture halls and seminar/small-group teaching rooms will need to be identified. The lecture hall will need to have wireless access and LCD projection capabilities. Up to 20 small-group rooms with a capacity of up to 25 students each may be needed.

Results

The program has been implemented for 3 years. The program began as a mandatory activity for rising fourth-year medical students, pharmacy students in their third professional year, and other health professions students in the clinical portions of their training. The medical students requested the program earlier in their training so that they could apply the knowledge learned during clerkships. This was accomplished in 2015 by placing the program in the third year of the curriculum. Additionally, we modified the patient-centered medicine guide to the history and physical examination used by students beginning year one of their medical school training to include questions on veteran

status and military health history as well as the WAR-RIORS, BATHE, and ETHNIC mnemonics. In the first year of the curriculum, during a patient-centered medicine session focused on disabilities, students now have the opportunity to meet and learn from veterans with PTSD or TBI. Numbers of other health professions students and faculty have increased in both the disciplines represented and the number of participants in both years. In fact, in 2015, the large-group portion of the program had to be moved to a building away from the small-group teaching space, thus leading to more than 500 attendees (approximately 400 students and 100 faculty) traveling between two buildings. In the future, we will need to better balance the different professions and be more mindful of enrollment numbers and space limitations.

Veteran participation is critical. Veterans serve as facilitators, provide expertise, and share real-life experiences. Optimally, there should be two to three veterans per small-group room. Recruitment of 50 to 75 veterans can be challenging.

Coauthor Kevin Parks, who published a Wing of Zock article entitled “Improving Care for Our Veterans and Military Service Members by Asking the ‘Unasked Question,’”¹¹ conducted an internal review board–approved pretest and posttest survey in year one of the program on three critical statements (5-point Likert scale, 5 = strongly agree). The following mean (*SD*) changes for unmatched responses (pretest $N = 151$, posttest $N = 205$) in learning outcomes were noted: “I feel uncomfortable screening/eliciting a history from a veteran of the Armed Forces” decreased from 2.2 (0.8) to 1.9 (0.8); “When I gather veterans’ histories I ask (I will ask) about veteran status” increased from 2.1 (1.1) to 4.2 (0.7); and “I am aware of resources available to veterans to help them meet their healthcare needs” increased from 2.5 (0.9) to 3.7 (0.8). Each of these changes was statistically significant ($p = .001$).

Twenty interprofessional faculty members who participated in the program for continuing education credit also completed the evaluation survey. Ratings (5-point Likert scale, 5 = strongly agree) ranged from 4.55 to 4.95 on being better able after completing the activity to recognize the importance of eliciting a military health history in order to identify selected health, mental health, and psychological challenges; describe best practices in assessment and treatment of veterans with PTSD and mild TBI; conduct biopsychosocial assessments and work collaboratively

with health and mental health professionals; and address stigma, foster resilience, and mobilize resources to help veterans reintegrate. The practice impact for the participants was as follows: implement a change in practice/workplace and seek additional information (55%), seek additional information on the topic (25%), and implement in practice/workplace (15%).

Discussion

In addition to the few quantitative indicators referenced above, there are a number of soft indicators suggesting that the program has impacted our learners. Incoming medical students who have heard about the program from upperclassmen are asking to participate. Veteran applicants to medical school have heard about the program and ask to represent the veteran population in our small groups. The participating health professions schools now call us to confirm the date of the program.

The event is a signature program of the Rutgers Biomedical and Health Sciences interprofessional group. The program will be used to enhance the training of faculty, residents, and staff at our academic family medicine ambulatory practice site that will be receiving veterans in its practice. We also hope to offer the educational program to interested hospitals, outpatient clinics, and other health care facilities. The real impact of programs such as these will be a measurable change in the health care and health outcomes of our veterans; the definitive study is likely a long way off, but the following brief anecdote provides encouragement to us. We interviewed veterans on their experiences as we prepared our cases for the small-group sessions. Carol Terregino ran into one of these veteran students, whose spine-chilling story leading to his PTSD impacted all of us and who told her how our program had helped him. He now sought care regularly and was learning to advocate for himself. He thanked us for caring about veterans and developing a tool to help him and others.

We have learned many lessons in the 3 years of the program. The most important lesson is to identify enough veterans through school, health care, or community organizations because the more veterans in small groups interacting with students, the better the educational program. It is also important to insure that there are representatives from various military service branches as well as generational diversity from different wars and military conflicts. This will help demonstrate both similarities and differences in the life-world experiences of veterans.

Challenges specific to women in the military and women family members need to be included as well as more diversity-related issues (e.g., sexual orientation, gender expression, disability, religion/spirituality). We have also found that more life-cycle (childhood, adolescence, adult, older adult), family systems, and community issues need to be covered. There is a critical need to foster trust and a therapeutic alliance between veterans and civilian health care providers. This is not always easy to do and requires creating a safe environment, employing effective communication skills, and demonstrating cultural humility and a willingness to learn about their experiences. It is very important to avoid pathologizing veterans. Emphasize instead strengths, assets, and resilience in order to counter negative stereotypes and overgeneralizations that often occur in the media.

We have also identified the need to balance the health professions participants in the small groups. The greater variety of health professions participants, the better. Team collaborative care planning discussions are enhanced by having multiple health professions in the small groups. It is important to try not to have an excessive number of medical students with each provider. In future iterations of the program, it will be important to include even more on nursing, social work, and caseworkers as individual patient and population care coordinators. Involving faculty champions from these and other disciplines in the planning of educational activities will be essential. Having multiple cofacilitators of different professions and a trained lead facilitator has proven to be the best strategy for generating positive group activities and lively, engaged discussions. Our program champions an integrated biopsychosocial approach that has successfully brought together the medical, health professions, behavioral health, and social services fields, effecting a new educational paradigm.

Our learners have provided us with valuable feedback. As noted above for medical students, the earlier in the clinical years, the better. A longitudinal program addressing veteran and military health issues in the curriculum should also be encouraged to reinforce what is being taught. We learned to review other curricular material to ensure consistency; we needed to revise our guide on eliciting a history to include questions about veterans and their military health history.

A major challenge for this educational program has been the intensive resources needed to plan, organize, and

deliver the multiple modules. We personally provided all of the resources to enlist and schedule faculty facilitators, veterans, and students. Other staff volunteered their time to assist with registration, developing signage, assisting attendees, finding rooms, and other logistical issues. Identifying a dedicated program coordinator to help manage these activities and troubleshoot problems is important. Class size also needs to be managed so as not to exceed available room space and audiovisual technology capabilities. Thanks to some modest donations from several of the program's institutional sponsors, externally interested organizations, and, in the 2015 academic year, a small continuing medical education grant from a commercial organization, funds were available to pay for food and printing costs.

The logistical problems associated with conducting an interprofessional training program at mutually convenient times for all the health professions students and faculty were complex and included major date and time constraints and scheduling challenges. In the half-day delivery, the modules seemed rushed at times. More time for icebreaker activities, experiential exercises, debriefing, and forming trust in the group would have helped to create a stronger learning community and enhanced the impact of the educational activities.

The preferences of interprofessional learners for patient-centered learning, panel presentations, and interactive small-group activities (and less use of lectures and slides) were some of the feedback received. We have reflected on the didactic presentation of the epidemiology, neurobiology, diagnosis, and treatment of PTSD and TBI. In the 2015-2016 academic year, we anticipate introducing the content by inviting real patients to come to the session and share their stories. The interprofessional faculty can then make their teaching points in relation to these patients and their experiences. There needs to be a thoughtful, careful, and sensitive balance struck between presenting the biopsychosocial traumas experienced by some veterans and presenting the resilience and adaptability of most returning armed forces members. Some participants noted that more emphasis should be placed upon the veteran without re-entry issues to dispel the stigmas and myths that returning veterans will be a risk to their families, their workplace, and their communities.

The interprofessional learning approach affords the opportunity to collaborate around physical, psychological, and

social issues in veterans and their families. We believe the curriculum would be enhanced by developing modules on medical conditions such as musculoskeletal trauma, stress-related medical conditions, substance abuse, neuropathies related to vibration injuries, hearing loss, chemical exposures, inhalation injury, and accelerated cardiovascular disease, as well as sexual trauma and potentially traumatic events experienced by the families at home. We are engaging faculty experts to address these medical conditions. Finally, we also need to be mindful of the effect of hearing these powerful veterans' stories and experiences on ourselves, as both faculty and learners. Engaging in individual and collective reflection about the implications for our ongoing professional work as educators, clinicians, researchers, and administrators, as well as our personal lives, is highly recommended.

Keywords

Veterans Health, Post-Traumatic Stress Disorder (PTSD), Stress Disorders, Post-Traumatic, Traumatic Brain Injury (TBI), Brain Injuries, Suicide, Interpersonal and Communication Skills, Cultural Competence, Behavioral Health, Interprofessional Teams, Collaborative Care, Systems-Based Practice

Appendices

- A. Curriculum Resource Form for Participants.pdf
- B. Sample Introductory Comments.pdf
- C. Mnemonics for Modules A and C.pdf
- D. Module A Slides.ppt
- E. The War After Trailer.mp4
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- K. Module E A Legacy of Hope.pdf

All appendices are considered an integral part of the peer-reviewed MedEdPORTAL publication. Please visit www.mededportal.org/publication/10389 to download these files.

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Dr. Carol A. Terregino is a professor of medicine at Rutgers Robert Wood Johnson Medical School.

Dr. Robert C. Like is a professor of family medicine and community health at Rutgers Robert Wood Johnson Medical School.

Mr. Ronald J. Steptoe is an adjunct instructor of family medicine and community health at Rutgers Robert Wood Johnson Medical School.

Dr. Evelyn Lewis is an adjunct associate professor of family medicine and community health at Rutgers Robert Wood Johnson Medical School.

Dr. Kevin Parks is a resident in medicine at Pennsylvania State University College of Medicine.

Dr. Joyce Afran is an assistant professor of family medicine and community health at Rutgers Robert Wood Johnson Medical School.

Dr. Diana Glendinning is an associate professor of neuroscience and cell biology at Rutgers Robert Wood Johnson Medical School.

Dr. Anthony Tobia is an associate professor of psychiatry at Rutgers Robert Wood Johnson Medical School.

Dr. Mei Liu is a clinical assistant professor at Rutgers Ernest Mario School of Pharmacy.

Dr. Brian Greenwald is a clinical associate professor of physical medicine and rehabilitation at Rutgers Robert Wood Johnson Medical School.

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