

Commission Report



submitted by the

New Hampshire Legislative
Commission on Post-Traumatic Stress Disorder
(PTSD) and Traumatic Brain Injury (TBI)

Chapter 115-D, Law of 2014

February 2016

Commission on PTSD and TBI

Membership

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NH Legislative Commission on PTSD and TBI Report

Issue Overview

The single best way to honor the sacrifices of our Veterans and their families is to end the ongoing crisis that is quality healthcare accessibility. In this long era of war, our nation, our state, and our communities have expressed terrific resolve to embrace and receive those who have served.

Since the publishing of the Commission's Governor's Report in 2014 our small state of New Hampshire has moved from the 5th highest veteran population (per capita) in the United States to the 8th. The decline is the result of our WWII era and Korean War era Veterans passing away, as our Vietnam era Veterans continue to age (approximately 48% of NH Veterans are over the age of 65). Despite the progressive loss of previous generations of NH Veterans, our National Guard and Reservists continue to deploy to the Middle East and beyond.

NH is home to 1,175 NH Air National Guard members, 1,724 NH Army National Guard members, 950 Army Reservists, and 340 Navy/Marine Reservists (NH National Guard, 2015). Their needs, and the needs of their families, upon their return home and while they are away, continue to increase. The common challenges of reintegration after deployment will strain families, and the invisible wounds of war: Post-Traumatic Stress Disorder and Traumatic Brain Injury (PTSD and TBI) will surface for many of our brave men and women over the course of their reintegration and later stages of life.

The cycle will persist, for as this current era's men and women return home and begin their journey, our older Veterans are finding symptoms and memories rising to the surface in their later years. As tired bodies and minds enter the final stages of life, 60+ year old brain injuries speed cognitive decline; silent stories finally demand to be heard and forgotten feelings felt, all having been long buried by life's duties and youthful resilience. The needs of our Veterans for quality, accessible healthcare will not end. The requisites for care for our current era of Veterans will continue for the next 70 years or more, and who and what will follow only remains to unfold.

NH is working hard to be prepared. Since the release of the 2014 Governor's Report, the NH Commission on PTSD & TBI has generated powerful momentum with passion, initiative, and innovation that has proven a model for this country and abroad, but we didn't do it alone.

The deepest gratitude must be paid to those 1,170 NH Veterans who offered profoundly personal experiences with receiving health care in NH on the Survey Helping to Advance Recovery Efforts (SHARE) conducted by the NH Study Commission on PTSD & TBI in 2012. The honesty and bravery shown by those individuals, who shared their experiences with stigma, shame, embarrassment, and feeling generally misunderstood by the providers that they had met, came with no expectation of reward or repair for themselves, but only with hope for improved opportunities and care for those who come after them; a true testament to the selfless act of service.

The data collected on that survey, as well as the qualitative information gathered at 50+ meetings and conferences, including NH's Veteran Service Organizations (VSOs), provided the foundation for which all of the initiatives, accomplishments and long-term goals covered in this current report were built.

Upon that foundation, the fundamentals for State-wide change have been established: education, outreach, and collaboration. Based on the data collected, this Commission's previous report highlighted the priority need for education and improved accessibility to be hospitals, Community Mental Health Centers, and private providers. Education of community providers, and collaboration between the VA, Vet Centers and civilian organizations continue to be priorities moving forward.

The initiative for collaboration, and effective engagement and education of community providers also reflected the national VA initiative Veteran's Choice Program that began to gather momentum over the course of 2015. Now more than ever, NH Veterans can and will be treated in their communities. It is essential that our providers are prepared to receive them.

The social and emotional risks experienced by so many veterans and their family members seeking health care may be eased by providing more information to providers and communities. Easing the risk requires reducing the stigma associated with service and mental health challenges; stigma reduction requires effective education and accurate information. The challenge of stigma with regard to disorders of mental health and TBI are not unique to veterans, but the trauma of combat, war, and the experience of military culture is exclusive to a small fraction of the population. When the risk for misguided inference is twofold, as both a veteran and a person with a mental illness or TBI, it comes as no surprise that stigma was identified by SHARE as the number one barrier to treatment across all eras of service (eras of service represented in the 2012 SHARE data: 38% from Vietnam era, 35% from Post 9/11 era, 18% from Desert Storm era and 9% from other Veterans).

The Challenges of PTSD & TBI

Roughly two-thirds of all documented combat wounds, from the wars in Iraq and Afghanistan, are the result of blasts from improvised explosive devices (IED's). As a result, TBI has become the "signature injury" of these conflicts. A TBI is an injury that disrupts normal brain functioning, often resulting in physical, cognitive, behavioral and mental health challenges. TBI, while not a mental health condition, often occurs with symptoms of PTSD when sustained during a traumatic event. It is a substantial contributor to the development and struggle with depression and PTSD facing our Veterans. Often with no outward physical signs, and deeply intertwined symptom profiles, differentiating between TBI and PTSD is complicated and sometimes impossible. The challenge of diagnosis, the unique nature of the military experience, and the stigma of invisible wounds make for a difficult link to services for the veteran living in their civilian community.

PTSD is the unrelenting emotional arousal, and recurring periods of numbness and detachment that result from having experienced a traumatic event or series of events. PTSD is a mental health condition that differs from typical post-trauma stress, which will occur for the vast majority of us, after experiencing something horrific. While most symptoms of post-trauma stress will dissipate over time (hyper arousal, sleep difficulties, irritability, etc.), PTSD occurs when symptoms do not relent on their own, and begin to interfere with normal daily functioning. Painful, traumatic memories and feelings are re-experienced in flashbacks or nightmares, emotion regulation is strained, an individual may be easily startled or on edge, depression often occurs as the symptoms increasingly interfere with the individual's sense of safety, concentration, sleep and general coping with daily life.

Much like TBI, PTSD is the result of actual changes in the brain structure and/or function. In the vast majority of cases, these changes can and will respond to treatment; but overcoming the stigma of mental health challenges and the perception that PTSD is a sign of weakness, particularly in the military/veteran community,

as well as limited access to quality, local care, perpetuates the risk for mental health crises for the veteran and for his/her family.

Our Task

It is our responsibility, as a grateful nation and state, to make accessible the professional care and resources our Veterans, service members and their families need to meet the challenges of PTSD and TBI. Not only do these services need to be accessible, but the environment in which these services are delivered must be free from stigma, shame, judgment, and misinformation. Our state is strengthened by our Veterans of all eras, let us honor them by serving their needs, as they have served us.

Commission on PTSD and TBI – Fact Sheet

RSA 115-D, Law of 2014 was instituted to **permanently** establish the Commission on Post-traumatic Stress Disorder and Traumatic Brain Injury.

Mission

The mission of the Commission on PTSD and TBI is to improve access to care and quality of care for veterans and service members who experience post-traumatic stress disorder and traumatic brain injury.

Purpose

The purpose of the Commission on PTSD and TBI is to develop, coordinate and oversee the recommendations identified in the Study Report (submitted by the *Study* Commission on PTSD and TBI in January of 2014) on the effects of post-traumatic stress disorder and traumatic brain injury experienced by members of the armed forces and veterans.

Legislated Activities

- Maintaining sub-committees to further the charge of the Commission;
- Producing and submitting progress reports;
- Recommending, recognizing and introducing program changes, initiatives, funding opportunities, and new priorities to stakeholders; and
- Evaluating implementation of the recommendations of the Study Report.

Subcommittee Leadership

The Commission Subcommittees meet monthly or every other month. If you would like to join a subcommittee or have any questions on their work, please contact the below subcommittee co-chairs:

- Stigma Reduction: Nicholas Tolentino – Nicholas.tolentino@gmail.com; Jennifer Schirmer – Jennifer.Schirmer@dhhs.state.nh.us
- Military Education & Awareness: Nicole L Sawyer – Dr.Sawyerpsyd@gmail.com; Catrina Watson – Catrina.watson@nhms.org
- Integrated Care : Tony Paradiso – tparadiso@tds.net; Donna Primera – donna.primera@va.gov
- Legislative Action Subcommittee : Mary Morin - mary.morin@va.gov ; Peggy LaBrecque- peggy.labrecque@nhvh.nh.gov

Overall Subcommittee Focus

- Develop goals and objectives based on the Study Report;
- Identify program areas where improved military and civilian coordination is needed; and
- Improve access to care and quality of care for veterans, service members and those who have served.

Meetings

The Commission meets the third Thursday of each month, 2:30 – 4:30pm in Concord – at the Legislative Office Building or Walker Building in Concord. . All meetings are open to the public. For more information on committee meetings, please contact the Commission’s Secretary Major Stacey Carroll -

Stacey.Carroll@snhhs.org

For More Information

To review the Study Report or the full text for RSA 115-D, Law of 2014, please see the NH DHHS, Bureau of Community Based Military Programs webpage at: <http://www.dhhs.nh.gov/veterans/index.htm>

For more information on Commission work, please contact Commission Chair Jo Moncher at jamoncher@dhhs.state.nh.us

Tackling the Issue

Improving Quality & Access to Care for NH's Military & Veteran Community

Leveraged Funding Opportunities

The Commission initiated partnerships with the NH Military Leadership Team, DHHS Leadership and other military-civilian stakeholders, including the Administration for Community Living, Centers for Medicare & Medicaid Services, the Veterans Administration, and the NH CarePath System of Access and its Partners. These partnerships helped leverage funds to support eight contracts focused on improving access to and quality of care for NH Veterans, service members and their families. The deliverables of these contracts were developed to build upon the fundamentals for State-wide change established by the Study Commission's SHARE survey of 2012: education, outreach, and collaboration.

The contracts include:

- ServiceLink, ProForce Training, Military Culture Training & Care Coordination
Managed by Easter Seals NH
- Justice Involved Veterans Conference – 285 Attendees
Managed by NH Justice Involved Veterans Task Force, partially funded by LTC Partners
- “Ask the Question” Campaign
Managed by Easter Seals
- Military Culture Training – Goal: 50 Trainings Across NH
Managed by Dare Mighty Things
- Statewide Resource Guide
Managed by Dare Mighty Things
- Community Mental Health Center – Military Liaison Initiative
Managed by Community Mental Health Centers
- Military & Veterans Family Initiative
Managed by NAMI New Hampshire
- Sustainability System of Improvements
Managed by Easter Seals NH

Providing Military Culture Education for NH Health Care Providers

Through the SHARE survey of 2012, NH Veterans identified “not feeling understood by the providers they have met” as a primary barrier to accessing quality healthcare. NH Veterans described feeling misunderstood, over-pathologized, and disconnected from the civilian health-care providers they had encountered. Similarly, civilian health-care providers described feeling unsure that they were properly educated or informed in the nuances of military service to provide appropriate or competent care to veterans and/or their families (2013 survey conducted by the New Hampshire Psychological Association, NHPA). This clear and shared experience of disconnect between veterans/service members and providers informed the Commission's efforts to address the fundamentals of State-wide change: education, outreach, and collaboration by providing military culture trainings to providers across the state, including a focus on hospitals, Community Mental Health Centers, and private providers.

By partnering with DHHS, Easter Seals, Dare Mighty Things and other agencies across the State, the Commission's efforts have yielded the following conferences and trainings:

- “Serving Those Who Served” Statewide Conference (3 Free CE/CMEs), facilitated by Easter Seals, reaching over 150 providers from NH-based Community Mental Health Centers, hospitals and private practitioners. This conference was aimed at providing an introductory education on Military Culture and the impact military service and its culture may have on treatment, engagement, and provider-patient rapport. The planning and delivery of this event also included training modules and courses available online.
- Provided in-person military culture trainings to 9 hospitals and medical centers across the State, reaching an additional 150 providers. This course was created as a spin-off of the “Serving Those Who Served” Statewide Conference due to its overwhelming success and resulting provider-demand for further education opportunities.
- Dare Mighty Things “Military Culture Education” contract aims to provide 50 Military Culture trainings across the State. The Commission serves as advisor on this contract.

“Ask the Question” Campaign (ATQ): making connections and improving care

“Have you or a family member ever served in the military?” is the simple question behind a State-wide campaign managed by Easter Seals and advised by the Commission. The goal of NH’s Ask the Question Campaign is to improve access to and quality of care by encouraging medical and service providers to identify veterans, service members and their families in the intake process and provide appropriate service planning and referrals when needed.

- All 10 NH Community Mental Health Centers are now asking “the Question”.
- In Coos County a ServiceLink coordinator asked “the Question” of an elderly woman (age 92) and discovered that she is a Veteran. As a result, she was referred to the Veterans Independence Program – supported by the White River Junction VA Medical Center – which helped to address her in-home care needs.
- Shortly after an ATQ briefing at the Seacoast Fire Chief’s Association meeting, a home burned down in one of their communities. A provider responding to the fire noticed the resident’s veterans’ license plate, asked “the Question”, and called the local Vet-to-Vet Rep who went to the home immediately. He supported the Veteran (who had also lost his service dog in the fire), drove him to the Manchester VA Medical Center to get his medications refilled, and connected him to Easter Seals Military & Veteran Services for additional support. The recovery team took extra care and was able to salvage all the Veteran’s service medals, ribbons and military uniforms.

In addition to greater access to services and benefits, this Question - in conjunction with increased education and understanding of military culture - provides improved opportunities for rapport building that will result in more successful service planning and outcomes, improved patient experience, and stigma reduction. The Ask the Question Website is: www.AsktheQuestionNH.com .

Reducing Stigma

NH Veterans identified stigma as the #1 barrier in accessing care in the 2012 survey. For veterans struggling with symptoms of mental illness or TBI, the experience of stigma can generally be categorized in two ways, internal stigma and external stigma.

Internal stigma is the experience of shame or the self-assessment that one is weak or damaged due to mental health challenges or brain injury. Military culture in general reinforces such internal stigma with its necessary emphasis on building “strength” and eliminating “weakness.” Suppression of personal needs as a means to support the greater mission is a cornerstone of the military perspective and imperative for operational success. Acknowledging that one has struggles for which he or she needs help, assistance, or is in some way impaired can create a tremendous conflict within the individual and within their family, often creating a significant barrier to engaging in treatment.

External stigma is the bias, misunderstanding, discrimination and demoralization that comes from perceptions of the public, providers, the media, and the like, with regard to military service, being a veteran, or having mental health challenges or traumatic brain injury. External stigma is fed by the over-glorification of war and service, misperceptions of pathology in normal post-deployment adjustment experiences, exaggerated media portrayals of mentally unstable veterans or military personnel, over-dramatized portrayals of PTSD/TBI, etc. External stigma creates a pressure to remain silent and minimize one’s needs in order to avoid the risk of bringing negative perceptions onto oneself or their family.

Internal Stigma: beginning a war against the battle within

Impacting the Campus Experience for Veterans

NH’s institutions of higher learning play a critical role in serving our military and veterans. Men and women of this current era are often returning home from war and service and enrolling in college to begin the next phase of their life. This transition from service to civilian is a vital time to combat internal stigma before it takes hold. Integrating into a campus environment is a challenge for many veterans who may feel disconnected or unable to relate to their non-veteran peers. This is also a time when symptoms of PTSD or TBI can begin to impact the student’s ability to engage in common classroom experiences, resulting in perceived weakness or failure.

To begin the war against internal stigma, the Commission buoyed an initiative to reach student-veterans at NH colleges and universities. This initiative included:

- Securing funds from LTC Partners to offer the Military or Veterans Impacting New Generations (MOVING) grant.
- Developing a Request for Proposal (RFP) and program guidelines that focused on: stigma reduction, military-civilian integrated care, and military education.
- Awarding two grants to the university or colleges that exemplified the aim of the initiative to better serve and support their student-veterans.
 - Recipients of the MOVING Award were the University of New Hampshire (UNH) and New England College (NEC).
 - UNH initiated an orientation for new students called VET Connect, a veteran-specific orientation experience that assisted veterans and service members entering the education system with increased knowledge and support. After meeting several veterans during orientation, one veteran said, “I have PTSD and TBI, so it is difficult for me to sit in a large classroom with so many people. I sometimes get panic attacks. But now, when I walk into a classroom, I sometimes see someone who I know is a veteran because I met them during orientation. Knowing that one of my brothers or sisters is in the classroom with me reduces my stress and increases my comfort level. I know that my brother or sister ‘has my back’.”
 - NEC created a Veteran’s Resource Center to help support their students who have served. The dedicated space allows student-veterans to get to know one another, provide support

and guidance for each other, and allows a quiet and comfortable environment managed by and designed by veterans, for veterans. Additionally, New England College's commitment to military and veteran students include advanced preregistration preference and a wellness counselor and academic tutor who specialize in assisting students living with TBI and PTSD.

Both of the above awards have helped to significantly increase peer support among the student-veterans at these colleges, and thus reduced the experience of internal stigma that comes with having served and/or having educational or personal challenges as a result of their service.

External Stigma: increasing provider confidence & competency with education and information

The Stigma Reduction Fact Sheet for providers

NH's providers treat veterans and their family members every day for life's common ailments, as well as service-connected injuries. Of the 113,390 veterans residing in NH (Manchester VA, 2015), only 30,301 of them receive their health care at the VA (Manchester VA, 2015).

The VA's Veteran's Choice Program has increased the number of veterans seeking services in their communities. As was noted previously, there is a shared experience of disconnect between veterans and providers (2013, NHPA provider survey), feeling misunderstood or ill equipped to make the important healthcare connection between civilian-provider and veteran. External stigma or the fear of stigma can paralyze both veteran and provider, making the connection difficult.

In response, the Commission developed a Stigma Reduction Fact Sheet for providers. The fact sheet identifies stigma as a barrier for veterans, service members and their families and provides concrete do's and don'ts with regard to making a connection and starting a service-related conversation. This Fact Sheet complements the Ask the Question campaign by providing tangible, interpersonal action for the provider when the answer to The Question is yes.

The Fact Sheet has been distributed at conferences, trainings, summits and meetings involving providers, community leaders, and military-civilian community members and it is available on the Ask the Question website. (www.AsktheQuestionNH.com)

The Road Ahead

"A journey of a thousand miles begins with a single step."

- Laozi (Chinese philosopher, c 604 BC - c 531 BC the Tao Te Ching, chapter 64)

Our destination is clear: to end the ongoing crisis that is quality healthcare accessibility for NH Veterans and their families living with PTSD and TBI. NH has taken our journey's first step.

Next Steps and Goals

- Target Community Mental Health Centers, hospitals, private health care providers and other civilian health service providers for continued outreach, training and coordination.
- Promote "Ask the Question" Campaign and Website throughout multiple provider sectors.
- Identify new opportunities for greater coordination with VA and other military providers.
- Target employers, educational institutions and the general public for awareness and stigma reduction regarding military service and service-connected injury/disability.
- Promote TBI services and supports with service and health care providers, while strengthening the partnership between the Commission and TBI service providers.

- Promote awareness of alcohol and drug related services for military members and their families by aligning with the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment, and Recovery.
- Develop and organize a follow up survey of NH Veterans (to follow the SHARE of 2012) to help identify ongoing or unaddressed barriers that impact access of care, transfer of care, and quality of care for veterans and service members.
- Strengthen peer supports for veterans and service members through the identification of gaps, needs and opportunities of peer support agencies and groups throughout the State.
- Influence national best practices for military-civilian partnerships through coordination with NH's Congressional Delegates, media publicity, and national leadership relations.

Dedication

The Ask the Question Campaign is dedicated to Lt. Col. Stephanie Riley, a former nurse with the NH National Guard and a strong advocate and leader for Ask the Question. Lt. Col. Riley died of lung cancer on December 29, 2014, but her message and spirit continue to create positive change within our State.

In recognition of Lt. Col. Riley's leadership and service to the Commission on PTSD and TBI, a name placard with Lt. Col Riley's name is placed at a seat during every Commission meeting.

"The NH Commission on PTSD and TBI demonstrates the power of alignment, described as — the more closely each organizational component (of the COPT) aligns with others and with the overall strategy, the more effective will be the overall performance."

*Nursing Administration Quarterly
Summer 2015*

Related Activities

Legislation

Senate Bill 397 proposes to increase membership of the Commission by adding representation from a TBI Provider, Easter Seals Military & Veteran Services and the Care Coordination Program NH.

Training & Consultation

NH Department of Health and Human Services (DHHS) provided consultation on possible connections and conflicts between the role/responsibilities of COPT, DHHS and Contract Partners. Specific support was provided by the DHHS Commissioner, Chief Legal Counsel, and Legislative Director.

Contract Partners

Easter Seals NH manages the Ask the Question initiative in partnership with NHCarePath, NH's ServiceLink Network, The Gorham Family Resource Center, and Catchfire Creative. Ask the Question is an initiative of DHHS with ongoing review from the COPT, and with ongoing collaboration and consultation with the VA Medical Centers in Manchester NH and White River Junction VT.

Dare Mighty Things manages the Military Culture Training and Resource Guide in partnership with NHCarePath. The Military Culture Training Campaign is an initiative of DHHS with ongoing review from the COPT.

Community Mental Health Centers (CMHC) manage the Military Liaison Initiative (MLI) in partnership with NHCarePath. The CMHC MLI is an initiative of DHHS and is supported by COPT.

Supports

Administration for Community Living, Centers for Medicare and Medicaid Services and the VA Administration served as national partners to DHHS and COPT contract work.

NHCare Path served as the statewide partner to DHHS and COPT contract work.

LTC Partners provided financial sponsorship to support Military or Veterans Impacting New Generations (MOVING), a grant to enhance and support the educational and campus experience of veterans. Grant recipients included University of New Hampshire and New England College.

Veterans of Foreign Wars provided financial sponsorship to help support the efforts of the Commission.

The State Veterans Advisory Committee (SVAC) received updates on COPT activities at the majority of their monthly meetings, providing an opportunity to share support and feedback.

The NH Charitable Foundation provided funds, staffing, and resources in spearheading the facilitation of a Commission Retreat.

The NH Military Leadership Team supported the work of the COPT through guidance and feedback.

Commission on PTSD and TBI Attachments

Attachment 1

Stigma Fact Sheet

Attachment 2

Aligning for Heroes: Partnership for Veteran Care in NH

Stigma

noun stig·ma \ 'stig-mə

A degrading and debasing attitude held by society that discredits a person or group because of an attribute (such as an illness, gender, gender identity, color, sexual orientation, nationality, religion, socioeconomic status, etc.). The resulting coping behavior of the affected person results in internalized stigma. Self or internalized stigma is equally destructive, whether or not actual discrimination occurs. Stigma often negatively affects a person's dignity; marginalizes affected individuals; violates basic human rights; markedly diminishes the chances of a stigmatized person achieving their greatest potential; and impedes pursuit of happiness and contentment.

What does stigma have to do with military veterans, service members and their families?

Stigma was identified by NH Veterans as the #1 barrier to accessing healthcare. More specifically, NH Veterans identified feeling embarrassed or ashamed of their needs (internalized stigma) and feeling as though their providers did not understand them.

The perception that healthcare providers do not understand veterans stems from: 1) the fact that the vast majority of NH health care professionals have no military background and/or zero to minimal exposure to military culture 2) the veteran/service member's fear/belief that a lack of understanding will result in stereotypes, pathologized interactions, misunderstandings, and over-glorification or negative judgments about their identity and experiences.

What does understanding military culture have to do with stigma?

When health care professionals and systems are responsive to their patients' cultural backgrounds, patients are more likely to receive appropriate care, show up to appointments, follow through with treatment plans, disclose necessary treatment information, and pay their bills. It's a win, win.

Fighting stigma in your practice:

Considerations for interacting with veterans, service members, or their family members...

A good start:

- Make eye contact
- You can never go wrong with *"Thank you for your service"*
- Or a hand shake
- She serves too
- No matter how old or young the veteran is, say *"Welcome Home"*
- Show you care by asking *"How has it been going for you since you've been home?"*
- Do ask, *"Do you get any of your healthcare through the VA?"*
- Remember that most NH Veterans do NOT get health care through the VA, and that's ok.
- Accept their level of identification with their service, no matter how high or low
- Believe the stories. War is hell.
- Transitions are hard, whether the transition is from a deployment to home or from military service to civilian life.

Validate, Support, Accept, Refer

Just don't:

- Never insert politics into any conversation about someone's service
- As well-meaning as you may be, don't say "I'm glad you made it home [safe/okay/unharmful, etc.]" or "Good thing you didn't have to go over there!"
- "How many people did you kill?" Nope, NEVER. Just Do Not Ask.
- Don't assume that one's military service has involved a deployment or that a military deployment has involved combat. Listen and Ask.
- Don't assume that one's service is a factor in their presenting problem. Don't assume that it isn't. Listen and Ask.

Remember: The first step to fighting stigma is in knowing who you're talking to. **Ask the Question.** Ask every patient you see, *"Have you, or has anyone in your family ever served in the military?"*

Aligning for Heroes

Partnership for Veteran Care in New Hampshire

Dijon R. Fasoli, PhD, RN

A growing number of veterans and service members (“veterans” refers to both veterans and eligible service members) are returning home and may be living with mental health conditions related to their military service. For a variety of reasons, the majority of US veterans receive their health care outside the Veterans Administration or the military health system. Nurse leaders and citizen-soldiers were among a number of concerned government officials, health care professionals, service providers, and military leaders in New Hampshire (NH) who joined forces to explore NH veterans’ mental health needs and manage provider service capacity. This article describes the formation and efforts of a permanent legislative commission, the NH Commission on PTSD and TBI (COPT), composed of interdisciplinary, multiorganizational, and cross-governmental leaders aligned to address the issues of stigma, military cultural awareness, and integration of care. Commission participants were asked to share their perspectives on the gaps and challenges to veterans’ care, opportunities for collaboration, and measurable outcomes. Key challenges included inter-agency communication and care integration issues, veteran and provider knowledge gaps about needs and system problems. Favorable timing, available funding, and the collaborative environment of the commission were identified as potential opportunities. While still a work in progress, the COPT has begun making an impact. We identify early outcomes and lessons learned. The COPT is a model for leveraging interdisciplinary professional collaboration to improve access to care for veterans. **Key words:** *care coordination for veterans, mental health, nurse leader emerging roles, organizational leadership and alignment, veteran health care access and treatment*

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The author is grateful to Jo Moncher, Chair of the NH State Commission on PTSD and TBI (COPT), for her consultation, in-depth account of the history and formation of the COPT, regular updates on COPT progress, and constructive reviews and editing; Donna Primera, RN, MSN, CRNP, Mental Health Service Line Manager at the Manchester VAMC, for her assistance with surveys; and the leaders and members of the COPT and the COPT Subcommittees for their participation in interviews and surveys.

This article is dedicated to all NH veterans, service members, and their families, and, especially, Lt Col Stepbante Riley, State Occupational Health Nurse, NH Office of the State Surgeon, NH Air National Guard. A nurse leader, citizen-soldier, Lt Col Riley was part of the original Study Commission on PTSD and TBI; she is credited with bringing the “Ask the Question” Initiative to the

THROUGHOUT HISTORY, NURSES have been journeying to the battlefield to serve the needs of civilians and soldiers in time of war.¹ Continuing the legacy, a group of nurse leaders in New Hampshire joined forces with other caring professionals to address the unmet health needs of returning veterans. These nurse leaders include decorated combat veterans, citizen-soldiers from the New Hampshire (NH) Air National Guard and the US Army Reserve, as well as administrators from the Veterans Administration (VA) and a community mental health center. The dual

forefront in New Hampshire. Lt Col Riley passed away on December 29, 2014.

The author declares no conflict of interest.

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role that many of these leaders play in the military and in their civilian communities has been a powerful tool in the effort to communicate across the table with a group of diverse leaders for the benefit of NH veterans. This "journey" begins with our heroes: the veterans.

Combat or non-combat? Foreign wars, overseas, or domestic duty? Discharge status? Military branch, National Guard? Active duty or reserve? Retired? Service-connected disability? Time served? Length and frequency of deployments?

There is pervasive confusion about who is a "veteran" or a "service member" and who is entitled to veterans' benefits and access to care in the VA or military health systems. The ambiguity exists among VA, military, and civilian providers, and even veterans and service members and their families.

According to the VA, a "veteran" is one who has served in the active military service and who was not dishonorably discharged.² This "may" also include members of the Reserves or National Guard who were called to active duty. National Guard members are not considered veterans and are not eligible for VA benefits unless they were deployed longer than 179 days or were injured in the line of combat duty (LTC R. Oberman, Oral Communication, 2014). The VA encourages all service members to apply to the VA to determine enrollment eligibility because there are "minimum duty requirements" and "enhanced eligibility status" for certain veterans. "Service members" are those who are on active duty, but they may also be eligible for VA health care benefits up to 5 years after discharge for conditions related to their service in the Iraq/Afghanistan theater.³ Once enrolled in the system, veterans are assigned a priority group, which determines the extent of their eligibility benefits. Not surprisingly, confusion reigns.

There may also be misperceptions about where veterans seek health care services. Only 5.6 million (25%) veterans of 22.3 million living veterans received health care through the VA in financial year 2012.⁴ The remainder seek care, if at all, in the community.

Veterans may choose not to access their care through the VA or military treatment facilities because they have health coverage from other sources, they do not perceive the need, or they perceive or experience barriers accessing VA care (including fear of impact on career or delays in returning home).⁵

For veterans experiencing symptoms of posttraumatic stress disorder (PTSD) or traumatic brain injury (TBI), access to quality treatment may be even more challenging. Approximately one third of the returning Operations Iraqi Freedom and Enduring Freedom veterans have a mental health condition or have experienced a TBI, but only about half seek care, and only about half of those receive minimally adequate care, in terms of duration and treatment type.^{5,6} Stigma, defined here as negative attitudes about and behavior toward veterans with mental illness, plays a role in treatment seeking.⁷ Finally, coordination of care issues between VA, Department of Defense, and non-VA providers increases the potential for duplication of efforts, conflicts, and missed care in the treatment of TBI.⁵

Access to care for veterans has become a high priority for the state of New Hampshire where, in 2012, veterans comprised nearly 11% of the total population.^{2,8} Of the approximately 115 000 NH veterans, only about 25% received VA services. Although New Hampshire has Air and Army National Guard members as well as Reservists, there is no active duty installation in the state. Furthermore, New Hampshire has no military treatment facilities or full-service VA hospital, so veterans seeking VA care must travel to neighboring states.⁸ Confounding the problem, the northern half of New Hampshire is largely rural, so access to health care, generally, can be difficult.⁹

In 2011, in response to concerns that the health care needs of NH veterans were not being met, the NH Study Commission on PTSD and TBI was legislatively established to study the effects of service-connected PTSD and TBI suffered in the line of duty by members of the armed forces and veterans.⁸ Nurse leaders and citizen-soldiers from the military, VA,

mental health centers, and hospitals were among the professionals instrumental in forming the commission and later requested to participate in the commission. They exemplify the emerging role of nurses sharing their unique expertise and experience practiced over the continuum of care in the realm of public affairs¹⁰ and population health.¹¹

The study commission evolved into a permanent legislative commission, the NH Commission on PTSD and TBI (COPT), bringing together the leadership of military, VA, state government, and civilian organizations. Using an organizational care coordination framework, the commission and subcommittee (SC) members were surveyed and interviewed about (1) the gaps and challenges to veterans' care, (2) opportunities for collaboration, and (3) measurable outcomes.

ORGANIZING FRAMEWORK FOR COORDINATING CARE

The COPT is a group of organizations connecting to share professional values to produce better outcomes than working independently. The COPT demonstrates the power of alignment, described as "the more closely each organizational component aligns with others and with the overall strategy, the more effective will be the overall performance."¹²

A summary of the relationship of concepts modeling alignment and organizational coordination is referred to as the Organizing Framework for Coordinating Care (OFCC),¹³ which can be used as a useful tool for evaluating the COPT and its processes. The OFCC is a composite of organizational coordination frameworks, evolved from the fields of behavioral science, organizational design, management sciences, and health care, and provides a systems approach to examining the multidisciplinary efforts needed to address veteran health care in New Hampshire. The model informed the evaluation of (1) the current situation (ie, a baseline assessment of the most pressing needs and resources members "bring to the table"); (2) the strategy

and processes needed to fulfill the mission (options for interventions/action steps); and (3) outcomes.

METHODS

COPT leaders and members were interviewed and/or surveyed, using open-ended questions related to commission formation, gaps and challenges, resources, action steps, team processes, and outcomes. Emerging themes were identified using content analysis.

About the commission

The first problem the study commission encountered was a lack of veteran-specific data for New Hampshire. In partnership with the University of New Hampshire Survey Center, local veteran service agencies, the American Red Cross, and the NH Psychological Association, the commission surveyed 1170 NH veterans, 80 military and civilian providers and members of the NH Psychological Association.⁸ The 2 major reasons veterans gave for not seeking care were embarrassment or shame (30%), and not feeling understood by providers (16%). Other reasons included confusion about where to get help, feeling no one wants to or can help them, wanting to speak only to another veteran, and issues with accessing care at VA Medical Centers. Community providers expressed willingness to care for veterans, but lacked understanding of military culture and veterans' unique needs.⁸

As a result of the study commission's findings, the COPT was created, with a mission to develop, coordinate, and oversee recommendations identified in the report.⁸ The COPT is composed of top leaders from organizations representing government, VA, military, and civilian communities. This was the first time in the history of New Hampshire that VA, military, and community leadership partnered in a significant effort to focus on improving access to health care (J. Moncher, oral communication, 2014). Directors from VA facilities in

New Hampshire and Vermont, which are both federal facilities, recognized the need and responded to state legislation. Today, mental health leadership from both facilities serves as active members of the COPT.

The COPT is an oversight body that meets monthly. Work is being done in SCs established to focus on the 3 main priorities identified in the surveys: stigma reduction, military cultural education, and integration of care. SC membership is composed of COPT members and external participants. SC chairs draw on their extensive networks to invite leaders with a complementary skill mix and desire to work on the particular SC focus. As one cochair stated, "... we reached out to our networks to create a critical mass with an objective to have larger numbers in order to get the necessary work done" (T. Paradiso, oral communication, 2014).

The COPT held its first meeting as a full, permanent commission on August 21, 2014. At the time of writing, SC membership continues to grow. Decision making is done by consensus with much of the work occurring at monthly SC meetings and being communicated to and voted on at the COPT meetings.

Assessment of gaps and challenges

Interviewees echoed the concerns of study survey respondents, and further reported systematic problems at the provider, organizational, and policy levels. The assessment spanned the OFCC concepts, including the need for coordination, predisposing characteristics, enabling resources, structures of care, and information requirements. Challenges to providing care to veterans were categorized into 3 main themes.

Communication/integration of care issues

Communication and care integration refers to the issues associated with getting veterans to the appropriate provider with the capacity and expertise to provide safe, high-quality care in a timely, caring fashion. Participants identified gaps and challenges in 3 areas: in-

teragency cooperation, access and referrals, and integration of care.

Interagency cooperation

The integration of military, VA, and civilian services and programs is difficult because of the lack of communication that has historically existed between these entities. There is a need to cross barriers of multiple bureaucratic systems. This makes communication time-consuming and complicates care integration.

Access and referrals

Veterans with PTSD and TBI need timely access to the appropriate level of care, whether it is a VA, military, or civilian provider. There is no central resource for contact information about services or providers in New Hampshire that can be accessed by veterans and their families or providers. Because stigma plays a major role in whether or not a veteran with mental health issues seeks or continues with mental health care, providers and referring agencies need to be sensitive and competent in providing care consistent with the special needs of veterans.

Integration of care for veterans and their families or caregivers

Family members and caregivers are often the first to recognize the need for care, yet are just as bewildered as the veteran as to where to access care and how to determine eligibility for benefits. Unfortunately, family members who may be in need of support are usually unable to be seen by the same provider agencies, because they are not eligible for the same benefits as their veteran (S. Griffin, oral communication, 2014). Agency providers are frustrated because, without the knowledge to coordinate between governmental and civilian agencies, they are often unable to provide a "warm handoff" in interagency transfers (M. D. LaBrecque, oral communication, 2014).

Veteran and provider knowledge gap and needs

There is much unawareness, misunderstanding, and confusion among both veterans and providers about benefits, eligibility, and health care services available to veterans. This situation is made even more perplexing by the medical community's unfamiliarity with military culture.

Understanding of benefits and eligibility for services

Veterans and their family members are frequently unaware of their eligibility for services in the VA and in the community. Providers express concerns at not knowing where to send veterans for follow-up and continuing care after emergency services have been provided. Insurance coverage, payment, and reimbursement issues are a major concern for all, with veterans not aware that they may also be eligible for Medicaid and Medicare (K. Capuchino, oral communication, 2014).

Military culture

Military culture plays an enormous role in whether or not a veteran will seek mental health care. Concerns about impact on career, possible discharge, self-perception of "weakness" versus "warrior," and fear of other penalties associated with seeking mental health care create an atmosphere of stigma and distrust. Nonmilitary providers recognize the need to be sensitive to these concerns, but lack explicit education in military culture (K. Norton, oral communication, 2014).

Combat-related PTSD and TBI

Interviewees cited the need for focused training for providers, especially emergency department staff, about combat-related PTSD and TBI and other associated mental health diagnoses, such as substance abuse and anxiety. There may be more stigma associated with TBI, so veterans may be unwilling to share that they have been exposed to TBI, leading to potential misdiagnosis (R. Snow, oral commu-

nication, 2014). All interviewees agreed that providers across the state need to ask every patient if they have ever served in the military, with an understanding that "service" includes many different branches of the uniformed services.

System issues

The final set of challenges interviewees identified crossed organizations and requires policy changes, including reimbursement and payments for providers related to military insurance, the need to share scarce resources to increase capacity, and the lack of other social services that can impede access to mental health care.

Reimbursement

Beyond the benefit eligibility confusion, interviewees reported that many providers are not accepting military (Tricare) insurance contracts because of insufficient reimbursement rates or heavy administrative burden (S. Griffin, oral communication, 2014; P. Evers, oral communication, 2014; S. Brown, oral communication, 2014). There was a general lack of understanding of how to qualify to be a community provider for VA or other government insurers.

Sharing scarce resources

Both the VA and community organizations cited a need for more mental health providers to keep up with current and projected demand from returning veterans. Some noted the difficulties of working with a large federal bureaucracy. They expressed a perception that they were in competition for limited funding and that there is a reluctance to share information. Although working across organizations is challenging, all agreed that a VA-community partnership is necessary to manage the needs of veterans wherever they choose to receive their care.

Additional social services needed

A number of social services were listed as enabling resources for veterans to access and continue receiving mental health care. Coordination with other organizations and governmental agencies is necessary to provide housing for homeless veterans, employment opportunities, transportation services, care for family members, and caregivers who are also impacted by the veteran's trauma, support for veterans interacting with the legal system because of their behavioral health, and substance abuse services.

ASSESSMENT OF RESOURCES

Interviewees identified resources that could be activated immediately, through existing organizations and partnerships, and opportunities that could be pursued through the COPT. The 3 main resources included right timing, funding opportunities, and the COPT's potential as a change agent.

Right time

New Hampshire may be in the midst of a "perfect storm" in the environment of care for veterans. A national interest in veterans and their families is evident. The Joining Forces Campaign,¹⁴ the "Have you ever served in the military?" Initiative,¹⁵ the Balancing Incentive Program (BIP) No Wrong Door Initiative (to increase access to and use of long-term care services provided in community settings),¹⁶ and The Veterans Access, Choice and Accountability Act of 2014 (H.R. 3230)¹⁷ are initiatives that are designed to have a positive impact on veterans and health care access. The timing is right (S. Griffin, oral communication, 2014) for change because veteran health care is a "burning platform" that is sitting "higher on the political totem pole" (P. Evers, oral communication, 2014). Finally, there is increasing public awareness about TBI with the dissemination of educational messages about the risks associated with concussions and brain injuries in the National Foot-

ball League and other professional sports (R. Snow, oral communication, 2014).

Available funding

The COPT is not funded to implement or subsidize projects. However, the NH Department of Health and Human Services (NH DHHS) is a recipient of a BIP grant. As a result of the study commission's findings and the COPT's focus on the need to ask the question, "Have you served?,"¹⁸ the NH DHHS identified BIP funding to support initiatives addressing the 3 COPT priorities: stigma reduction, military culture education, and integrated care.

Potential influence of the COPT

Among interviewees, the COPT is unanimously viewed as the most promising effort in New Hampshire to bring together critical decision makers. Members are leaders in their organizations, and representation brings commitment, enthusiasm, diversity, and a unique perspective to the commission. Interviewees were asked why this commission will work when other efforts have not. Responses included the impact of legislation mandating participation, the specialized and germane expertise of willing participants, and the ability of a small state to reach out to providers and veterans where other states may struggle under the magnitude of the problem.

OPTIONS FOR INTERVENTIONS/ACTION STEPS

The OFCC suggests that coordinating mechanisms be examined when designing or evaluating an intervention. Interviewees were asked about their experiences and what should be changed or focused on. Responses fell primarily into 2 categories: (1) commission processes and structure and (2) taking advantage of existing resources and opportunities.

Commission processes and structure

Within 3 months of inception, all the "right people" were at the commission table. The

group's energy turned to ensuring attendance and encouraging participation at meetings, building relationships among the members, and ensuring that all voices were heard. Decision making was democratic and inclusive to encourage buy-in (D. Primera, oral communication, 2014). The agenda was driven by the leadership team, composed of commission and SC chairs and cochairs, with chairpersons serving as conduits between the SCs and the COPT. Concerns were raised that agreement was needed on outcomes and that it was time to develop stricter committee processes that would promote shared information, cross-training among commission members, and respect for everyone's time.

Although COPT and SC membership was complete from a statutory perspective, the need was cited to continually assess the membership. There were suggestions that others still needed to be invited to the table, including the following: VA and non-VA medical providers to provide a holistic perspective; VA and Medicare program representatives to provide perspectives on payment and reimbursement issues; and other Department of Defense representatives not presently on the COPT. It was recognized that "we may not even know about" other organizations that should be represented on the COPT. However, it was also noted that the addition of members must be balanced by the need to manage ideal group size and group processes.

The SCs represent the COPT's current priorities and are where the more defined tasks are being implemented. As more priorities are defined, new SCs will be created. Interviewees recognized that SCs will only be effective if measurable outcomes for each SC are determined.

Existing opportunities

Interviewees overwhelmingly cited the BIP as the most promising opportunity to achieve the COPT's mission of building on existing resources in the state to reduce stigma, educate providers about military culture, and integrate care for NH veterans. The vision of funders is for all individuals accessing services any-

where in the system to experience the same process and receive the same information about long-term care services and supports. Aligned with COPT priorities, the initiative focuses on infrastructure, training, and public awareness.¹⁹

OUTCOMES

Consistent with the OFCC, outcomes to be assessed were identified at the patient, provider, and organizational levels. The COPT mission statement and the Study Commission Report provided the group's umbrella goals and objectives. Interviewees suggested more long-term goals for the COPT, such as "no territories" between providers (T. Paradiso, oral communication, 2014); increased awareness of veterans, providers, employers, and legislature; New Hampshire receiving federal approval for a full-service VA hospital; and caring for "one veteran at a time" (M. Morin, oral communication, 2014).

It was generally agreed that measurable work and specific outcomes related to the 3 priorities should be determined at the SC level. Participants proposed outcomes, including the following: measuring the number of providers with an "Ask the Question" brochure in the waiting area or using an intake form with a check box for "Have you served?"; the number of providers, veterans, and provider sites trained in military culture; and the presence and utilization of a resource book or Web site by families, veterans, and providers. Outcomes were to be further defined by applicants as a requirement of the BIP grant initiative.

Although more work is needed to link measurable outcomes to specific COPT activities, the COPT is already having an impact on the community. The COPT's focus on "Ask the Question" has resulted in emergency department staff at a local hospital beginning to ask "Have you served?" on every triage assessment (MAJ S. Carroll, personal communication with J. Moncher, 2014). Cross-training was conducted by members about the advantages and challenges presented by the Veterans Choice Card, which enables eligible

veterans to seek care outside the VA and Safe Messaging related to suicide prevention.^{20,21} The MOVING (Military or Veterans Impacting New Generations) Experience Grant Award Program, a joint effort of the COPT/LTC Partners to award institutions of higher learning for innovative and inclusive programs that enhance and support the educational and campus experience of veterans, was also introduced as part of the training.²² As a result of the Commission's Report, the DHHS has contracted with Easter Seals to coordinate training for hospitals, private practitioners, and community mental health centers. This has provided \$100 000 in direct provider reimbursements to allow staff (including nurses) to attend military culture training and webinars.²³

PROGRESS SO FAR—LESSONS LEARNED

The COPT started as a small core of members responsible for planning and implementing the study, writing the report, and garnering legislative support. The full commission transitioned into an advisory body with the ground work done in the SCs. An unintended consequence of the transition with its necessary increase in formal processes was that the group had to seek ways to continue the energy, robust discussions, and personal engagement that came with building the foundation of the commission and the addition of new members.

The focus on funding, although necessary to the group's mission, raised some concerns that participant organizations and the COPT would be focusing on dollars, instead of overall efforts, and that the COPT would lose momentum after the grant is implemented. However, the participants' perceptions of COPT leadership and processes were positive, citing the passion of the membership, the progress of the group toward its goals, and the abilities and reputation of the COPT and SC leaders. To help address the issues that come with change, a team-building retreat was being planned for the COPT in the coming months.

Along with the progress noted above, the COPT has been actively developing, promoting, and educating the public about the BIP grant. To avoid conflict of interest, a subgroup composed of individuals not intending to apply for funding was tasked with development of the request for proposals. The bidding process was disseminated and implemented by the NH DHHS. The request for proposals encouraged statewide partnerships to provide sustainable outreach, education, and training activities related to (1) an "Ask the Question" outreach and educational campaign, (2) military culture, training, and education, and (3) strengthening military resources. Applicants were encouraged to use evidence-based or promising practices to identify or develop the resources and outreach campaigns that would work in New Hampshire for NH veterans.^{15,24} Applications are under review, as of this writing.

CONCLUSIONS

New Hampshire is a small state that has leveraged professional collaboration to make a difference for veteran health care. The COPT is an alignment of the right professionals and stakeholder organizations with a common purpose. Nurse leaders and citizen-soldiers are playing a vital role in this borderless health care/social services/patient/community partnership.²⁵ Although a work in progress, the path is leading toward reducing stigma and barriers to care through implementation of campaigns such as "Ask the Question," and to education of providers in military culture while increasing provider, veteran, and family member awareness of available services. Ongoing efforts need to address the nationwide shortage of mental health providers required to deal with the surge of veterans expected to need mental health services, both in the VA and the community.^{17,26}

To the question, "Can the COPT be successful where others have not?", one participant said, "Yes, I am sure we will make a difference. This is a diverse group that brings the many perspectives that are needed. Our

communities have a variety of resources that can help veterans and their families that also want to do a better job. With a little tweaking, alignment occurs. Then follows the tipping point to make the dominoes

fall in the right order to fill the gaps” (D. Krider, oral communication, 2014). Perhaps a little state can, to quote Gladwell, “make a big difference,”²⁷ when new partners work together for the good of a population.

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