

2008 Alliance Award for Outstanding CME Collaboration

In Recognition of Those Organizations Best Demonstrating Innovation or Uniqueness in Achieving Effective CME Collaboration

**Carl Patow, MD, Executive Director
HealthPartners Institute for Medical Education**

**Debra Curran, MA, Associate Director
Continuing Professional Development, HealthPartners Institute for Medical Education**

**Dan Johnson, MA, Associate Director
Program Development, HealthPartners Institute for Medical Education**

Joining Forces: Responding to the Health Care Needs of Our Returning Military

A Soldier's Experience

Company by company, members of Minnesota's Red Bull Brigade left to return to the United States—Iraq to Kuwait and then to Fort McCoy, 18 hours to go from desert brown and heat to the cool air and dark forest of Eastern Wisconsin. All that stood between them and home was the four days it would take to be processed out. This would include a health screening that would identify service-related health issues. On the fifth day, they would board a bus and finish the last 150 miles to the company's armory in Minnesota where they would be greeted with a heroes' welcome. One Guardsman recalls his thoughts and feelings during this earliest phase of reintegration into civilian life. "I couldn't stop thinking how green and beautiful it was and that in just a few days I'd see my little girl and my wife and my parents and my black lab. It was all I could think of. . . . It was euphoric! We'd made it. We were alive and going home. Nothing else mattered!"

Background

In the summer of 2007, Minnesota anticipated the return of over 3,000 veterans from Iraq and Afghanistan to their homes throughout the state, and 1,200 veterans had already returned. Of the entire Red Bull Brigade, only 21 were held for medical issues. The rest went home. In all the excitement surrounding their return, few recognized the signs of mild traumatic brain injury or posttraumatic stress disorder (PTSD), nor did they recognize the roots of depression, anxiety, or a vulnerability to substance abuse. If they did suspect one of these disorders, they knew that to say anything would mean a delay in the one thing they'd wanted since leaving—to go home. So home they went, and what a celebration awaited them!

In a month at most, less for some, it all was over. They went back to work, picked up their responsibilities as parents, spouses, employees, students. It was an amazingly complex world they returned to. All had to adjust to civilian life, and most would struggle to reestablish relationships and roles. Many would carry the residue of deep combat training that would require weaning themselves off the frequent adrenaline highs of life in war time. This adjustment was a challenge not only for those returning but for their spouses, children, parents, employers and communities.

Of the 4,200 recently returned service members, 75% (3,500) have direct combat experience, and 33% (1,400) have a service-related injury/illness. Of that 1,400, 25% (350) have mental illness or acute stress. Orthopedic injuries, traumatic brain injury (with symptoms often emerging after discharge), infectious disease and sexual trauma (13% of returning veterans are women) are the most frequently encountered conditions. Few may have yet recognized the signs and symptoms of the less visible conditions, such as mild traumatic brain injury, PTSD and depression, but those close to them will notice, and at some point these service members will seek help.

Minnesota has no regular military bases, and most of its physicians have no military experience. While physicians are aware of the return of deployed military personnel, there is a general sense that these soldiers are not among the patients they care for, that they receive their care through the Minneapolis Veterans Affairs Medical Center (VA). But the VA system in Minnesota will see only 28% of this population, leaving approximately 3,000 to be cared for by the nonmilitary health care providers in their own communities. When

they do eventually seek help, their own physician will be best positioned to respond to the hidden health issues confronting these soldiers, sailors and airmen. The challenge was how to get the civilian physician community ready to respond.

The entire state was mobilizing last summer. The Minnesota Department of Health, through its Office of Emergency Preparedness, was organizing to respond to the behavioral health challenges that would accompany such an influx of returning guardsman. The Minneapolis VA, with its PTSD and polytrauma units, was reaching new heights of responsiveness. What was needed was a CME provider who could take the message to the state's civilian physicians. In the fall of 2006, HealthPartners Institute for Medical Education invited the following organizations to collaborate in offering a one-day conference:

- Minneapolis VA. The VA provided the principal faculty for this event.
- Minnesota Department of Health (MDH). The MDH linked this event to its efforts at addressing statewide emergency preparedness for troop return, and brought its network of statewide services and expertise in working at a community level to the table.
- Minnesota Army National Guard. The National Guard brought their Senior Ranking Medical Officer as well as the chaplain in charge of reintegration. They contributed a first-hand awareness of the military experience and a readiness to share that with whoever would listen.

Problems, Needs, Gaps

The return of veterans is a relevant issue for the civilian health care community. Yet professionals lacked some of the essential experience, awareness, knowledge and skill needed to recognize and effectively respond to the health care needs of the returning veterans and their families. Specific barriers to effective care included the absence of systems that identify patients as having a military background, the lack of an adequately developed awareness of the veteran's war experience, an underdeveloped empathy for the returning veteran and his/her family, and a lack of familiarity with both the commonly presented injuries and illnesses and the behavioral health dimension of the returning veteran. Also lacking was a familiarity with those resources available through the VA care system.

Target Audience

Civilian providers most likely to address the health care issues of this population in Minnesota are principally primary care physicians, nurse practitioners, nurse specialists, physician assistants, registered nurses and behavioral health professionals. These clinicians work in outpatient settings and emergency rooms across the state, and in the border regions of the four adjacent states.

Conference Objectives

Our objectives were to have participants:

1. Alter their initial patient assessment to include an inquiry into their patient's past military experience
2. Identify the most likely manifestations of combat-related injury or illness and the required changes in standard care necessary to realize a positive outcome of care
3. Describe the various aspects of the veteran's military experience and the related re-entry to civilian life that has significant bearing on their patient's health
4. Describe opportunities in their communities to support returning military and their families.

Event Design

The conference was offered in the spring of 2007. It began with registration under a tent supplied by the National Guard. It included an introduction to the experience of combat and life in Iraq, including a mission briefing typically experienced by a convoy security detail. Clinical topics included: polytrauma, mild traumatic brain injury, infectious disease, overuse syndrome and other musculoskeletal complaints, and behavioral health challenges (PTSD and depression).

The day also included consideration of marriage and family dynamics and challenged physicians, as leaders, to support local efforts at reintegration of veterans into their communities. Woven throughout the day were informal micro-simulations that helped the learners gain insight into the war experiences of their patients.

These included the opportunity to wear body armor, helmet and full pack, and the challenge of climbing into a cramped army vehicle. Uniformed members of the military were present and participated throughout the day.

Following the event, a website of useful links and resources (www.joiningforcesonline.org) was sent to attendees as a means of reinforcing the learning that occurred and supporting an ongoing effort to address these issues.

Outcomes

A follow-up survey was electronically distributed via email two months postevent (self-reported, 36/86 response rate) targeting the central question, *Do you routinely ask your patients, "Have you served in the military overseas?"* Preconference responses indicated that 34% of the participants routinely asked this question. Two months postconference, 65% indicated that they routinely asked this question. Comments suggested that even more may have improved their performance but had not achieved what they considered a routine level.

Course Evaluation

Two methods were used to evaluate this experience.

1. An opportunity was provided for participants to share new insights and impressions from the day's activities throughout the day, by writing those thoughts on Post-It™ notes and placing them at the entrance of the auditorium. The notes served as a secondary method for sharing with one another, and as an indication of whether course objectives had been addressed. The comments affirmed that the conference was effectively focused and that new insights were gained by participants.
2. A postevent survey, collected at the end of the day, focused on the quality and effectiveness of the event. The conference was very highly rated in all dimensions, with comments that expressed an overwhelming appreciation for the insights gained into the military experience and the challenges being faced by our returning military. This survey also indicated that the collaborative nature of the activity and the presence of the military throughout the event were the major contributing factors to the event's success.

On Collaboration

This activity called for a collaborative approach, because neither the understanding of the challenge being faced nor the resources needed to respond resided with the CME provider alone. The multi-organizational approach gave the event both credibility and authority. The right organizational representatives brought capacity to mobilize. Sharing of networks supported dissemination of related information. Best of all, the relationships forged led to a second initiative. In the fall of 2007, four 30-minute programs capturing core elements of the spring course were filmed and broadcast throughout Minnesota, via Twin Cities Public Television. In the spring of 2008, funded by a grant from the VFW National Foundation, approximately 2,500 DVDs will be distributed as an enduring material offering CME credit to providers across the state. An additional 5,000 DVDs are planned for distribution through the American Hospital Association—to every member institution in the country. Ah, the power of collaboration!



Used by permission, HealthPartners Institute for Medical Education

Going to war certainly affects the soldiers, but it also affects their spouses, children, parents, friends, employers and communities.



Used by permission, HealthPartners Institute for Medical Education

The conference drew considerable attention from local media outlets.



Used by permission, HealthPartners Institute for Medical Education

Each participant was given this dog tag as a reminder of the central targeted outcome.