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Development of a Toolkit to Enhance Nursing Education of Veteran Health Concerns

Carlee Y.S. Balzaretti

University of San Francisco, cybalzaretti@usfca.edu

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Development of a Toolkit to Enhance Nursing Education of Veteran Health Concerns

Carlee Yetive Stewart Balzaretti  
University of San Francisco, cybalzaretti@usfca.edu

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Development of a Toolkit to Enhance Nursing Education of Veteran Health Concerns

Carlee Balzaretti, DNPC, MSN, FNP-BC, CNL

University of San Francisco

School of Nursing and Health Professionals

DNP Comprehensive Project

Juli Maxworthy DNP, MSN, MBA, RN, CNL, CPHQ, CPPS, CHSE

Committee Chairperson

Timothy Godfrey, SJ, DNP, RN, PHCNS-BC

Committee Member

Neftali Cabezudo PhD, RN

Committee Member
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Abstract

U.S. Veterans are a vulnerable patient population, more prone to health disparities as compared to the general population. There are 21.8 million Veterans currently in the United States, with the majority receiving their healthcare outside of the Veteran Health Administration. Veterans form a culture that is steeped in military tradition and it is essential that healthcare providers have knowledge regarding this vulnerable population to provide care that is culturally appropriate. In response to the Veteran healthcare crisis, the Department of Veteran Affairs initiated the Veteran Affairs Nursing Academy Partnership (VANAP), a joint venture between VHA medical centers and schools of nursing, with a focus on caring for Veteran patients. One outcome of these partnerships was the evidence-based development of ten competencies designed to provide nursing students with the minimal preparation necessary in caring for Veterans. Given the majority of Veterans seek healthcare outside of the VHA system, these competencies should not be limited to students in a VANAP program. The University of San Francisco, being part of the VANAP initiative, has a great opportunity to bring these competencies to all of its students. The focus of this project was to create an evidence-based toolkit for nurse educators, containing ten educational modules based on the ten competencies. The modules were evaluated by Veteran and education subject matter experts for appropriateness of content, being able to meet the metrics of knowledge acquisition, and ease of use. They will be available online to allow for easy accessibility.

Key Words: Veterans, healthcare, PTSD, homelessness, TBI, end of life, suicide, amputation, military, exposures, MST, substance use, disparities, toolkit, effectiveness, cultural competence, cultural sensitivity, cultural awareness, nursing students, nursing, VANAP.
Introduction

Background Knowledge

This practice improvement project was designed to enhance the nursing care of United States (US) Veterans. In response to the growing concerns of the healthcare Veterans are receiving, the Department of Veteran Affairs (VA) initiated the Veteran Affairs Nursing Academy Partnership (VANAP), a partnership with various nursing schools across the country, with a focus on caring for the Veteran patient. This practice improvement project took place at one of the VANAP sites at the University of San Francisco (USF) in Sacramento, California. The USF VANAP affiliate was the Northern California VA, located in Mather, California. VANAP programs are intended to provide nursing education on military and Veteran culture, the Veteran Health Administration (VHA), and the main morbidities that afflict many Veterans: Post Traumatic Stress Disorder (PTSD), amputation (that requires the use of assistive devices), environmental/chemical exposures, substance use disorders, military sexual trauma (MST), traumatic brain injury (TBI), suicide, homelessness, and serious illness, especially at the end of life.

Local Problem

The First Lady, Michelle Obama and the White House started Joining Forces, to rally around our services member and Veterans. Joining Forces works with both public and private sectors to ensure that service members, Veterans, and their families have the tools needed for success (Whitehouse.gov, 2016). Several nursing associations (including the American Nurses Association) are vowing to “join forces” and recommend that nurses educate themselves by enhancing awareness and knowledge regarding Veteran health concerns (American Nurses Association, 2016).
The VA Office of Academic Affiliations (OAA) funded the VANAP initiative, allowing for the mutually beneficial partnerships between local VA facilities and Schools of Nursing (U.S. Department of Veteran Affairs, 2016). VANAP students conduct the majority of their clinical rotations within the VHA system, as well as being exposed to a Veteran-centric curriculum that prepares them to provide culturally competent care to Veterans, regardless of where they work upon graduation. The VANAP programs are accountable to objectives and standards that are set by the OAA, such as education on the topics affecting many Veterans.

The VANAP program at USF did a wonderful job in developing elective courses on TBI, amputations, PTSD, and military culture however, as these electives were not required nor needed by many of the students, only a handful of VANAP students took advantage of these courses. A recommendation set forth by the OAA was to incorporate a required overview of all the specified topics, either at the start or at the end of the program, to provide a basic awareness of these issues. Within the scope of this project, the author created online training modules of each topic to be completed by the VANAP students as their instructors see fit. The online format will enable the author to continue this project by allowing the training modules to be utilized for those outside of the VANAP program.

**Intended Improvement/Purpose of Change**

The overall aim of this project was to enhance the care that Veteran patients are receiving by: (a) developing a toolkit for nurse educators, containing ten online training modules based on evidence-based, identified Veteran issues, (b) having the modules evaluated for appropriateness of content, meeting the metrics of knowledge acquisition and ease of use by subject matter experts (SMEs), (c) incorporating the SME’s feedback into the modules to maximize efficiency,
(d) having the majority of SMEs approve the modules to be presented to the VANAP students, and (e) to set up plans for a future research study of the teaching effectiveness of the modules.

**Review of the Evidence**

A review of the literature was done to validate and assess the following topics: Veteran health disparities, Veteran health topics, cultural competence and awareness, the culture of Veterans, and effectiveness of the use of toolkits. Utilizing the USF Gleeson Library’s Fusion database, search terms included Veterans, healthcare, PTSD, homelessness, TBI, end of life, suicide, amputation, military, exposures, MST, substance use, disparities, toolkit, effectiveness, cultural competence, cultural sensitivity, cultural awareness, nursing students, nursing, and VANAP. Initial search returned 190,000 to 250,000 results. To narrow this down, different combinations of key terms were used and limits were set to only include peer-reviewed journals published within the last 5 years. This narrowed the results to 200-500 results depending on the topic searched.

To critically appraise the articles, the Johns Hopkins Nursing Evidenced-Based Practice (JHNEBP) model (Dearholt, & Dang, 2012) was used (see Appendices A and B). Approval to use the tools was obtained (Appendix C). The relevant articles assisted the author in the evidence-based development of each of the training modules (see Appendix D for evidence table).

**Veteran’s health disparities.** Since 1789, when Congress first officially created the armed forces of the United States (Library of Congress, 2016), American men and women have fought for the rights and freedoms of its citizens. Given the vast number of U.S. military, those who have fought have had varying cultural and reintegration experiences, health exposures, and subsequent health concerns (Emanuel et al., 2012). Legally defined, eligible wartime eras (for

The U.S. Department of Veteran Affairs defines a Veteran as “a person who served in the active military service and who was discharged or released under conditions other than dishonorable” (U.S. Department of Veteran Affairs, 2016, p. 1). Regardless of war era, disparities of Veterans as compared to their civilian counterparts have been widely documented. In a self-reported study of health and health behavior differences of Veteran and civilian men, Veteran men were more likely to report poorer overall health than their civilian counterparts (Hoerster, Lehavot, Simpson, Reiber & Nelson, 2012). Specifically, Veterans were more likely to have cardiovascular disease, arthritis, and cancer diagnoses. Veterans were also more likely to perceive their overall health as poor and express limitations of functions relating to poor health.

While women in the military (and subsequently women Veterans) have always been a minority, their numbers are increasing. The number of women enlisted in the military has increased from 27,948 in 1970, to currently over 200,000 (Bureau of Labor Statistics, 2015). Although many of the studies conducted on Veterans’ health disparities focus mostly on men, female Veterans are not exempt on disparities. One study found that women Veterans were more likely than non-Veteran women to report high-risk sexual behaviors such as younger onset of intercourse and more lifetime partners (Lehavot, Simpson, McFall, Reiber, & Neslon, 2014). These behaviors correlated with higher lifetime rates of genital herpes, genital warts, and chlamydia, although the higher rates of chlamydia may be attributable to the military’s strict mandates on screening (Lehavot, et. al., 2014).
In addition to physical health disparities, both men and women Veterans have shown to be at higher risk for mental illness. For example, 7-8% of the general public will acquire PTSD after experiencing a traumatic event. This number more than triples for Veterans who served in the Vietnam War (as high as 30%), and is significantly higher in those who served in Operations Iraqi Freedom and Enduring Freedom (11-20%) and Desert Storm (12%). Ten percent of women experiencing a traumatic event will develop PTSD as compared to 4% of males (National Center For PTSD, 2016). This implies that women Veterans are possibly the most vulnerable group susceptible to PTSD. Perhaps due to this high rate of PTSD, Veterans commit suicide at double the rate of non-Veterans (Hargarten, Burnson, Campo, & Cook, 2014). Veterans, moreover, are more likely to report a history of depression and anxiety, tobacco use, higher intake of alcohol, and higher rates of homelessness (Hoerster, Lehavot, Simpson, Reiber, & Nelson, 2012; Fargo et al., 2012). These outcomes can lead to an increase in physical illness (De Hert et. al, 2011; American Psychological Association, 2010).

Currently, the VHA (2016) provides health benefits and care to 8.76 million Veterans per year. Given that there are 21.8 million Veterans currently in the United States, the majority of Veterans are receiving their healthcare outside of the VHA system (United States Census Bureau, 2012). Based on these population statistics, it is imperative that non-VA healthcare providers have sound knowledge of Veteran-centric conditions and be familiar with the resources to provide responsive care that is culturally appropriate.

**Veteran topics.** As a result of the VANAP partnerships, one of the major outcomes has been the development of 10 competencies (utilizing knowledge, skills, and attitudes) to be used by nursing schools in order to promote culturally appropriate practices for nurses caring for the Veteran population (Moss, Moore, & Selleck, 2015). These competencies were derived from
best practices found in the literature and VA policies, and were then reviewed by subject matter experts in the care of Veterans including VANAP faculty. The evidenced-based competencies are designed to provide nursing students with the minimal preparation necessary to address the needs of Veterans (Moss, Moore, & Selleck, 2015; see Appendix E for more details on the proposed competencies).

**Patient-centered care/cultural awareness.** Over the last two decades, the U.S. Department of Health and Human Services has been focusing on reducing health disparities. Three goals of its Healthy People 2020 initiative are to “achieve health equity, eliminate disparities, and improve the health of all groups” (U.S. Department of Health and Human Services, 2016, p. 1). A core competency identified by the National Academy of Medicine for healthcare providers of patient-centered care is to “identify, respect, and care about patients’ differences, values, preferences, and expressed needs” (National Academy of Medicine, 2003, p. 45). In order to fully meet this competency and the Healthy People goal, the American Association of Colleges of Nursing (2008) embraced the initiatives and endorsed the need for cultural competency/awareness in nursing education, including the development of competency in caring for minority sociocultural groups such as U.S. Veterans.

**Veterans as a culture.** There are numerous definitions of culture. The classic definition is that culture is “everything that makes us who we are” (Ritter & Graham, 2017, p. 4). A contemporary definition is “the integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups” (Ritter & Graham, 2017, p. 4). This definition signifies that culture is not restricted to particular ethnicities or races. Although Veterans will undoubtedly fluctuate in their military identification after discharge, this unique military culture will generally be with
them throughout the rest of their lives. Demonstrating a basic awareness of military (and subsequently Veteran) culture, as well as competency in addressing the health issues inherent in each, can result in stronger provider relationships, a deeper understanding of the context of certain health conditions, and increased appreciation for the sacrifice made by those who served (VHA, 2016).

Conceptual Frameworks

**Culture care: diversity and universality theory.** This evidence-based practice project was based on Madeleine Leininger’s Diversity and Universality Theory (Leininger, 2014). Madeleine grew up on a farm in Nebraska in an area of mixed cultures. From an early age she was taught by her parents (an Irish mother and father of German decent) to interact with those of different cultures. After graduating nursing school, Madeleine first went to work as a child psychiatric nurse (a new field at the time). It was during this time she realized the effects that cultural differences had on illness and treatment. Since there was no formal cultural education in nursing schools, Madeleine identified a large gap in education. (Leininger, 2014).

After a “culture shock” experience in Guinea, Madeline Leininger took a job as Dean of the School of Nursing at the University of Washington and developed the Theory of Culture Care: Diversity and Universality. She coined such terms as cultural care (multiple aspects of peoples’ culture that guide their ability to improve their health), cultural care diversity (identifying the differences in meanings, values, or acceptable modes of care delivery distributed in the dissimilar groups of people), and cultural care accommodation or negotiation (creative nursing actions to help those in specific cultures to negotiate or adapt (Sitzman & Eichel, 2011). Her theory has evolved to become a specialty within the field of nursing.

Leininger’s theory of cultural awareness was the framework utilized for the development
of the toolkit. Although there may be many sub-cultures among Veterans depending on their personal backgrounds as well as war era and branch-served, the dominant culture of Veterans is unique. Presenting these patients with providers who are knowledgeable and experienced with their population will ensure that this vulnerable group is receiving therapeutic cultural care that is competent.

**Knowles adult learning theory.** In addition to the Diversity and Universality Theory, the development of the toolkit was also based on Malcolm Knowles’s Adult Learning Theory of Andragogy. The term andragogy recognizes the different needs of adult learners as compared to child learners. This project followed four of these principles. The first principle is that adults need an explanation as to why the particular topics are being taught. Each module started off with an explanation as to the importance of the topic (Knowles, 1984).

The second principal is that education should be focused on a task rather than memorization, allowing for learning activities to be in the context of common tasks to be performed. The activities embedded in the modules were formatted in a *hands on* approach. The third principle is that people come from different learning backgrounds, leading to various types of learning styles. Therefore, learning materials and activities should allow for these differences. Lastly, adults are more self-directed than children; education should therefore be structured to allow for self-discovery while providing guidance and help when mistakes are made. The modules were designed to allow the learners to utilize them as they deem appropriate, allowing for self-discovery (Knowles, 1984).

**Methods**

**Ethical Issues**

The project proposal of the development and implementation of this toolkit was submitted via the Statement of Determination to the faculty of the Doctorate of Nursing Practice
(DNP) Program at USF. After review, the project was deemed to be an evidence-based practice improvement project and not research, with approval on 2/5/2015 (Appendix F). With this approval, the author was not required to submit an application to the Institutional Review Board. The author however, received training on Human Subject Assurance from the National Institutes of Health to ensure awareness of human subject’s rights when conducting research. Following approval by the DNP department, it was determined approval was needed from both the VHA and USF Co-Program Directors. This approval was obtained 3/21/2015 (Appendices G & H). Subsequently, the author developed a project prospectus that was approved by the committee chairperson and additional committee members.

Ethics is defined as the study of conduct and character (Potter & Perry, 2013). Nurses and nursing students must be aware of health care ethics and their professional responsibility to follow the professional nursing code of ethics, which is a set of guiding principles for the profession. This project is based on several of these ethical principles. The first is *beneficence*, which refers to taking positive action to help others (Potter & Perry, 2013). Accepting the ethical principle of beneficence indicates that nurses will put the needs of their patient first above their own needs. By understanding the specific needs of Veterans and taking positive actions when providing care, the nurse is practicing this ethical principle of beneficence.

Another ethical principal of this project is that of *justice*. The term justice refers to fairness, and is most often used to discuss access to healthcare services (Potter & Perry, 2013). Veterans are a vulnerable population, more prone to health disparities than their non-Veteran counterparts. By enhancing awareness of these injustices through education and providing necessary skills to care for Veteran patients, the goal is to decrease these disparities in health among Veterans. Additionally, nurses have a responsibility for the nursing care that their client’s
receive. They have a responsibility to define, implement, and maintain standards of professional practice, and are responsible for their own competence. This includes being knowledgeable regarding specific patient populations. Lastly, nurses follow accountability. They are accountable for their practice: judgments, decision, and actions, including culture specifics (American Nurses Association Code of Ethics, 2015).

**Setting**

This project took place virtually within the VANAP program of USF. The VANAP program consists of two cohorts of twenty students who study year round and complete the program in two years. Small cohorts allow for close communication with each other as well as individualized instruction from faculty. The students are all transfer students and clinically ready, meaning they start their clinical rotations during their first semester. As transfer students, they have a diversity of ages and backgrounds with some of them being Veterans themselves. Their curriculum consists of USF’s BSN curriculum, with an emphasis on Veteran-centric nursing care and Veteran-based electives. All of the VANAP clinical rotations (with the exception of pediatrics and obstetrics) are done within the VHA system.

At the start of this project, there were ten VANAP faculty members, five were employees of USF and five were employees of the VA. All of the faculty were experienced RNs, had a minimum of a master’s degree, and were either enrolled in a doctoral program (DNP or EdD) or held a doctoral degree (PhD). One faculty member was a Veteran himself, and three had prior experience working in the VHA system. These characteristics made them SMEs in nursing, education, and care of the Veteran. With the small cohort size, faculty members taught several different classes that vary per semester. The majority of the faculty, however, was new to education and several had never worked at the VHA. Those with appropriate experience
taught the electives; however, enrollment in them was low from both cohorts. All professors were interested in having modules that could be integrated in the VANAP program. These modules would then be able to fill gaps in students’ awareness of these Veteran issues.

Planning the Intervention

The planning of this practice improvement project began with a SWOT analysis (Appendix I). One of the internal strengths identified was that the author was familiar with and known at the site. This allowed for easy promotion and communication of the project. Another strength was that both VANAP faculty and leadership saw the value in the project and were dedicated to its implementation. The project was strongly desired by both parties. An external opportunity that presented itself was that the project was determined to fulfill one of the requirements for the OAA grant and was strongly supported by their office officials. Additionally this project opens up opportunity for future research with nurses and nursing students.

An identified internal weakness of the project was that the modules in their entirety were time consuming, with an average completion time of ten hours. Due to this, there was a risk that not all faculty members would complete the modules in the set timeframe. Since this practice improvement project is not considered research, the focus was working with the faculty and not utilizing the student population in the development since they are considered a vulnerable population. Given the modules are targeted at them, this posed a possible weakness of the project. An external threat was the ability to provide the modules for access outside of USF. Determining a format that would allow for all of the educational materials to be presented for external use was a challenge to project implementation.

After completion of the SWOT analysis, the author determined that the strengths and
opportunities outweighed the weaknesses and threats. The main opportunity that was presented was to fill a gap in Veteran-centric education. The author then decided that developing educational modules based on the main issues facing Veterans as a toolkit for educators would help to fill this gap in education. All faculty members were in agreement that these modules would provide a basic overview and be a valuable tool for enhancing awareness of these issues for the VANAP students and nurses.

Subsequent to further discussion, it was decided that the issues would be split into 10 separate modules, each covering one of the identified topics. Each module would take approximately one hour to complete. To allow for future use by non-USF affiliates, the delivery platform was determined to be via a Prezi presentation (a cloud based presentation software) and Padlet (a virtual bulletin wall). After creation, evaluation, and pertinent changes were made, the faculty, as a whole determined how the modules would be assigned to the students. An informal discussion with some of the VANAP students (including some Veterans) as to their thoughts on the project, yielded positive responses confirming that awareness to many of these issues was lacking. In addition, after hearing of the project, the OAA was very interested; thus the stakeholders of faculty, select students and Veterans, and the OAA were on board and invested in the project.

With support from the stakeholders, a formal budget was created (Appendix J). In order to maintain the Padlet site for an extended period of time, the initial cost was $45. The main cost of the intervention was the participants’ salaries. The author estimated her salary as an hourly rate of $58 and projected a total of 220 hours to complete the project. This put the cost of the author’s salary at $12,760. Each subject matter expert (SME) had an estimated hourly rate of $60 and was anticipated to spend twenty hours each for a total of 200 hours, placing the SMEs’
total cost at $12,000. This put the total cost of the project implementation at $24,805.

Although this was the potential cost for the project, the cost was offset in several ways. First, as a student, the author’s hours were worked for free. Second, each SME that worked for the VANAP program completed the project during their normal working hours and thus did not accrue additional pay. Finally, non-VANAP SMEs completed the modules for continuing education and did so on their own time, free of charge. Therefore ultimately the only cost $45 for the project implementation was for the Padlet cite.

To ensure that the project was completed by the deadline, the author created a GANTT chart with milestones and dates (Appendix K). These included:

1. Literature and VHA policy and procedure review, completed by May 20, 2016.
2. Existing resource review, content and content delivery determined by June 30, 2016.
6. SME review of modules to be completed by July 30, 2016.
8. Incorporate feedback into modules by August 15, 2016.

All milestones were completed; however, milestones 6-9 were completed past their deadlines. This factor was a potential barrier that was identified by the SWOT analysis (Appendix L for work break down structure)

**Module Objectives.** Prior to the start of the literature review, the author determined the order of the modules and formed objectives for each. Each module contained 7-10 objectives
and were either based on knowledge (e.g. discuss how to conduct a military health history), or for attitudes to be displayed with patients (e.g. convey care, understanding, and respect for service members, Veterans, and their families). See Appendix M for full list of objectives.

**Communication matrix.**

Open communication between the author, committee members, and SMEs was conducted throughout the project implementation. Communication was done primarily through emails, in-person meetings, and phone calls. The author and chairperson conducted as needed phone calls and emails on project updates. Monthly project updates were communicated via email and in-person to both co-directors of the VANAP program. Additionally, the author and SMEs conducted as needed emails and occasional in-person meetings for updates and suggestions. (Appendix N).

**Implementation**

Content delivery method varied and included Padlet (that works as a virtual wall for content posting), audio recorded PowerPoint slides, YouTube videos, and written materials. If the modules were only to be used by USF affiliates, each could have been easily loaded into Canvas (the University’s learning management system). Since the goal was to have the ability for the modules to be accessed outside of USF, a different method needed to be chosen. Initially, it was thought that Padlet would be the main format to allow for access outside of USF. After further exploration into the functionality of Padlet, it was determined that Padlet would not be the best format for the modules. The author then determined that Prezi (a 3D cloud based presentation program) would meet the project needs and be the main platform for content delivery. Each module was then loaded into Prezi, allowing anyone with the link to access the modules.
Prezi does not allow for PowerPoint slides to be embedded; however, the alternative for this was to provide a link within Prezi to Padlet where the PowerPoint was embedded. One of the PowerPoint presentations was too large of a file for Padlet. Their IT department was contacted and they were able to fix the issue to allow for the larger file. Despite several setbacks, all of the modules were completed within the specified timeframes.

After all of the modules were loaded into the Prezi presentation, an email with the link was sent out to all 10 faculty members (as well as all the project committee members) with instructions on use as well as the evaluation tool. Each faculty member was instructed to complete the modules at his or her own pace, to review for content accuracy and appropriateness, and to send back the evaluation form once completed. They were also instructed to email the author directly with any feedback they had that was not included in the evaluation tool. During the implementation phase, several faculty members left the VANAP program and did not complete the modules. In order to obtain the desired 10 SMEs for evaluation, the presentation link was then sent out to several additional experienced RNs for their feedback. Despite this, the goal of 10 participants was not met. Seven was the final number that completed the evaluation.

Planning the Study of the Intervention

The global aim of this project was to increase the awareness of VANAP nursing students of specific issues that affect Veteran patients by creating, evaluating, and implementing an educational toolkit, thus improving the delivery of healthcare. As this is difficult to measure, the author utilized evidence-based practice and created the modules to ensure that the participants had a basic understanding/awareness of these issues. The faculty members were to evaluate this, as well as their ease of use. The specific aims of this project were to ensure that:

- The listed objectives of each module were met.
Each module topic was adequately addressed at an introductory level

The order of module topics was appropriate.

The format of the modules was easy to follow.

The modules will help change the approach nursing students and RNs care for Veterans,

SMEs would recommend the modules will be recommended for nursing students and other healthcare professionals.

Additionally, the modules were also created with the intent to eventually be used for RNs outside of USF for continuing education units (CEUs). The modules in Prezi and Padlet allowed for this, instead of the preferred internal USF platform of Canvas. For this, there were two additional aims:

- Ten hours of CEUs should be given for completion of all the modules.
- Have SMEs determine if Prezi and Padlet vs. Canvas is the preferred delivery platform within USF.

Resource requirements were the guidance of the DNP committee chair and members, support of the VANAP program directors, and participation of VHA and USF subject matter experts. The author routinely reported to the committee chair on the progress of the project. In addition, technical support from Padlet was also utilized.

**Return on Investment**

Return on investment was difficult to determine, as many of the benefits of cultural awareness and competence are qualitative. There are, however, some ways that Veteran cultural awareness and competence can save money, one being patient satisfaction. Castro and Ruiz (2009) found that patient satisfaction was higher among patients who had healthcare providers
that were trained in cultural competency. Thirty-percent of Medicare’s decision to reimburse organizations is based off of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys (Sherman, 2012). In 2011, Medicare paid $182.7 billion for hospital stays (Torio & Andrews, 2011). If only 1% of Medicare’s reimbursement is not paid due to low patient satisfaction scores, the potential cost to organizations across the country is $1.827 billion. Providing culturally aware and competent care can ensure that this cost is not lost.

Given the age of the current wars’ Veterans and using a rough estimate of inflation, an estimated societal cost of a Veteran’s PTSD and comorbidities for 50 years is $1,250,000. Reduction of this lifetime cost can be achieved by early detection and treatment. The same is thought to be true of other Veteran injuries including traumatic brain injuries and amputations (Geiling, Rosen, & Edwards, 2012), all of which are included in the ten competencies. Additionally, nurse competence has been associated with less turnover rates (Takase, Teraoka, & Kousuke, 2015). The cost of losing one nurse has been estimated to cost twice the annual salary of the employee (Atencio, Cohen & Gorenberg, 2003). Therefore, the potential for cost saving with cultural competence is not only ample, but also practical.

Additionally, this project could assist with student retention in the program and within the VHA. One of the expectations of the OAA grant for the VANAP program is for 70% of the VANAP graduates to seek employment within the VHA system and 50% of those applying will secure employment. During the first two years of the VANAP program, five students from cohort two failed one semester, but repeated the course to remain in the program. Another student decided that she did not want to work with the Veteran population. From cohort one, one student failed a semester and chose not to return. When students fail to complete the program,
the loss of potential revenue can be substantial. Veteran health education may play a role in retaining students like these, ensuring grant funding and preventing loss of tuition revenue.

The approximate tuition of the program through USF is $13,000 per semester (for six semesters). If a student left the program after their first semester, there would be a loss in potential revenue for the remaining five semesters, approximately $65,000. Long-term maintenance of the modules would be once a year to review content material, for up to five hours. A VANAP faculty member could uphold the project. At $60 per hour, the total cost would be $300 per year. If the project retains just one student for one semester, the project more than pays for itself. Continuing the program will depend on students and tuition. After the grant expires, USF is committed to continuing the program with the VHA.

**Method of Evaluation**

The method of evaluation for this project was a 5 point Likert Scale that was reviewed by both VA Co-directors and the committee chairperson (Appendix O). The rating system scored as follows: 1 being strongly disagree, 2 mildly disagree, 3 neutral, 4 mildly agree, and 5 strongly agree. The statement for each item read:

1. Each module met the listed objectives.
2. Each of the ten modules were adequately addressed at an introductory level.
3. The order of the module topic was appropriate.
4. The format (layout) of the modules was easy to follow.
5. These modules will help change the approach nursing students and RNs care for Veterans.
6. I would recommend these modules (as is) for nursing students and other health professionals.
For each Likert Item, there was a comment section for the participants to discuss reasons for scoring any item 1-3. Two additional non Likert Scale statements were asked:

1. Ten hours of CEUs is appropriate for all the modules (yes or no)
2. The delivery format was designed for users outside of USF’s system to access. For those within USF the format should be: (as is or Canvas)

The Likert Scale and additional question items were compiled and sent out to the participants via Google Forms. This online platform enabled the responses to be anonymous. In Google Forms the responses can be viewed individually or in a summary with a color-coded graph. To assess for inter-rater reliability, Cronbach’s alpha was calculated at 0.63, indicating the Likert Scale had acceptable validity.

Analysis

A quantitative analysis of the Likert results was calculated to determine if project goals had been met. The initial goal of the project was to have an average score of four (somewhat agree) from the participants on each Likert item. If that goal was not met, the author was to incorporate the feedback preventing the scores from being 4, back into the modules. The modules would then be sent back to the SMEs for a re-review with a re-evaluation. The initial evaluation of the modules, however, demonstrated the average Likert score of each item was a four or above, indicating the project goals had been met.

After the evaluations were sent out, it was brought to the author’s attention that item five on the Likert Scale had two answers stating “strongly disagree” rather than one of them being “strongly agree.” All participants were notified, two of the participants indicated that their answers were “strongly agree” and not “strongly disagree.” The correction was made and then the responses were recalculated. Additionally qualitative analysis of SMEs’ feedback was
compared and utilized to enhance the efficacy of each module.

Section IV: Results

Program Evaluation/Outcomes

Quantitative results. Once all of the evaluations were collected, the results showed that 66.7% strongly agreed that each objective was met, with 33.3% mildly agreeing. Eighty three point three % strongly agreed that the modules were adequately addressed at a beginning level, with 16.7% mildly agreeing. The order of the module topics as appropriate was strongly agreed by 83.3% and mildly by 16.7%. 66.7% strongly agreed that the layout was easy to follow, with 16.7% mildly agreeing and 17.7 % remaining neutral. When asked if the modules would help change the approach nursing students and RNs will care for Veterans, 83.3% strongly agreed and 16.7% mildly agreed. 66.7% strongly agreed that they would recommend the modules, with 16.7% of the respondents saying they mildly agreed and were neutral. All participants agreed that ten hours of CEUs was the appropriate amount of time for completion, as evidenced by the amount of time spent on all modules. The response was split evenly regarding if the desired format was as is or Canvas (50% respectively [Appendix P]).

Qualitative analysis. The author informally discussed the modules with each of the participants. All of them were very impressed with the modules as a whole, and a few had suggestions for improvement. After feedback the following changes were made to the modules: font formatting was changed, a rerecording of a PowerPoint was done, and some typos in the PowerPoints were also corrected. The general consensus was that the modules would be very useful in the nursing curriculum. The majority of the SMEs felt that the most helpful components of the modules were the narrated PowerPoint slides and YouTube videos.

Discussion
Summary

There are many health issues a large majority of Veterans face. In addition, Veterans have a culture that is unique to their experience that only a Veteran can have. Madeleine Leininger’s Culture and Universality Theory informs healthcare providers that in order to provide the most effective healthcare for persons of different cultures, we must gain an understanding and eventual competence of these differences.

Cultural competence can take years to obtain and is hard to measure. One of the first steps in gaining this competence is through awareness. The creation of these evidence based educational modules provides viewers with a basic awareness of common issues affecting Veterans: PTSD, amputation and assistive devices, environmental/chemical exposures, substance use disorders, MST, TBI, suicide, and serious illness, especially at the end of life. While the goal of the modules is to reach as many nurses and nursing students at possible, if only one participant is able to recognize any of these ailments in a Veteran and initiate appropriate follow-up after completing the modules, it has the potential to positively affect the care the patient is given. The majority of the participants who viewed these modules agreed they would change the way not only nursing students, but RNs as well, provide care to Veterans.

Key Findings

Although the goals were met, there was some valuable feedback given for improvement. One recommendation was to review the audio of recorded PowerPoint slides, where a few contained background noise. Another recommendation was that the modules as a whole were too long to be done in one sitting. This feedback is important for the VANAP faculty to keep in mind when assigning the modules to students, and perhaps assigning them one at a time, rather than as a whole. Additionally, several members mentioned that module two on amputations was
particularly long and thus daunting to read. They preferred the YouTube videos and recorded PowerPoint slides due to being visual and auditory learners.

One respondent had attempted to complete the modules on an iPad and found that she was unable to view some of the PowerPoints and needed to switch to a computer, but appreciated the variety of media. A couple of participants indicated some of the information was old. Although the information given was still considered best practice, the author plans to go back to the literature to see if there is literature that is more recent. Finally, it was pointed out that not a lot of information on solutions to these problems was given. As the modules were intended to provide a basic awareness of issues, it was out of the initial scope to go in-depth into solutions. The author will, however, incorporate possible innovative or experimental treatment protocols into each of the modules.

**Relation to Other Evidence**

Toolkits in healthcare are becoming more common since they can provide general information for reference be tailored to meet the specific needs of an organization (Campbell, Townsend, Shaw, Karim, & Markowitz, 2015). Due to their increase in use, more research studies are being conducted to evaluate the effectiveness of toolkits. Nelson et al. (2007) set out to translate research on safe patient handling into nursing school curriculum. After identifying a problem with nursing students’ abilities to handle patients safely in order to prevent nurse injury, the authors sought best practices and translated this content into an educational module. The module included a narrated PowerPoint presentation, required readings, background materials, and a quiz (Nelson et al. 2007).

Using a quasi-experimental design, the authors implemented the module at twenty-six nursing schools with three nursing schools serving as the control group. The curriculum was
then given to nurse educators to review and use. All but one of the schools were baccalaureate programs. Despite a limited sample size, schools were chosen to reflect geographic diversity. With the use of questionnaires, data was collected pre and post intervention on the attitudes, knowledge, and beliefs about safe patient handling. The questionnaires similarly evaluated teaching methods, level of acceptance, and intention to continue with the new curriculum. Paired sample t-tests were used to test for pre/post test difference and an alpha level of 0.05 was used for the statistical test (Nelson et al. 2007).

The findings were positive, demonstrating the module resulted in statistically significant improvements in attitudes towards mechanical and manual lifting, knowledge and beliefs about safe patient handling, beliefs in abilities to exert behavioral control in using lifting devices, and intentions in using these devices. Additionally, 79% of the nurse educators indicated there was a “strong” likelihood that they would continue using the modules and 18% stating that they were “likely” to continue (Nelson et al. 2007).

Another study evaluated a toolkit that was created to assist with the implementation of the recommendation that 80% of the nursing workforce be prepared with a BSN degree (Tydings, 2014). By interviewing seven experts in the field of advancement of nursing education, Tydings developed the toolkit, which was designed to be given to nurse executives throughout several New York State hospitals. The toolkit consisted of a narrated 31-slide PowerPoint presentation, an educational video on BSN preparation of RNs, as well as a ready-to-print poster that illustrated the benefits of BSN education. Using a 17-question electronic survey and follow-up phone interview, the evaluation showed that overall the nurse executives found the toolkit beneficial and expressed plans to hire more BSN-prepared RNs. Additionally, they also expressed they would provide additional tuition reimbursement for RNs returning to
school for a BSN degree, demonstrating the toolkit’s effectiveness.

Campbell, Townsend, Shaw, Karim, & Markowitz (2015) created and implemented a forensic nurse practitioner evaluation toolkit designed to evaluate how the services of sexual assault nurse examiner (SANE) programs affected adult sexual assault prosecution rates in their community. The toolkit contained step-by-step instructions on evaluation as well as technical assistance including webinars, group consultation calls, individual phone and email consultation, and in-person site visits. Qualitative interviews post-toolkit usage indicated the toolkit was useful for program staff and all of the study sites completed the goal of evaluating prosecution rates by utilizing the toolkit (Campbell, et al.).

Lastly, Kantrowitz-Grodon et al. (2013) developed a video simulation-based nursing education toolkit to facilitate family presence during patient resuscitation. This toolkit included three video scenarios, instructor teaching guides, presentations, and student packets. The toolkit was developed collaboratively by PhD students and faculty at a college of nursing, was used to train experienced providers. The instrument was tested on a combination of undergraduate and graduate nursing students. After implementation, the author’s found that knowledge scores increased, as did student’s perception of the benefits and risk of family presence at resuscitation. Additionally students’ confidence related to family presence during resuscitation increased, demonstrating the efficacy of the toolkit (Kantrowitz-Grodon et al.).

**Barriers to Implementation/Limitations**

The author had planned on 10 SMEs to review the modules. It was the hope that by providing CEUs and with the support of the OAA, that all VANAP faculty members would complete them. Several faculty members left the program during the project implementation and thus were no longer invested in participating. Several attempts were made to engage the faculty
who had left by offering continuing education units. Responses were that they were not needed and therefore there was no incentive for them to participate. Another faculty member, being in a PhD program, subsequently did not have the time to participate. The author was in close communication with both VANAP directors in regards to the response rate. The directors attempted to engage the participants, but the final number remained at seven.

Another limitation was that since this was an evidence-based improvement project, the author had to be mindful in testing the toolkit on students. The author would have liked to include the nursing students in the project implementation, but due to their vulnerability as students, this was not feasible. In addition, the author would have liked to see if knowledge acquisition had been obtained with pre and post assessment of the presented material. Despite this limitation, the project was a success.

**Interpretation/Next Steps**

The evaluation of this project has indicated that the toolkit for enhancing nursing education of Veteran health concerns met the listed objectives, was adequately addressed at an introductory level, and was easy to follow. The participants affirmed the modules will help change the approach nursing students and RNs utilize to care for Veterans and they recommended the toolkit for distribution to nursing students and other health professionals.

After incorporating the SME’s feedback into the modules, the modules will be loaded into Canvas for access to USF students. The next step for the author is to obtain IRB approval from the University to conduct a study on the efficacy of the toolkit on VANAP students. This study will attempt to determine if the knowledge and attitude objectives of each module are met in students. The same inquiry will then focus on the outcomes for non-VANAP BSN nursing students.
If the two studies indicate that the toolkit is effective in increasing knowledge and skill acquisition, the next step is to provide a USF certification of completion for both nursing students and registered nurses who complete in their entirety as well as CEUs. The certification will then be promoted by the author with the eventual goal of being available to as many health care systems and providers that can be reached.

**Conclusion**

These modules will be a valuable tool in educating BSN students, not only on the specific culture of Veterans, but some of their main health issues. Following completion of the ten modules, nursing students will have an awareness of some of the main issues afflicting U.S. Veterans. This awareness will assist in empowering nurses to initiate care plans to provide each Veteran patient with culturally appropriate, patient-centered care. Given the younger ages and longer lifespans of 21st century Veterans, the need for healthcare providers to obtain Veteran cultural awareness will continue to grow. The work of the author’s project of curating and piloting these educational modules will assist in the process for nurses in obtaining this awareness.

**Section VI: Other Information**

**Funding**

The author funded this project. The author did, however, work in the VANAP program funded by the VA and this project met a metric of evaluation for the VANAP initiative.
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Appendices

Appendix A: John Hopkins Nursing Evidence-Based Practice Research Evidence Appraisal Tool

Evidence Level and Quality:

<table>
<thead>
<tr>
<th>Article Title</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author(s)</td>
<td>Publication Date</td>
</tr>
<tr>
<td>Journal</td>
<td></td>
</tr>
</tbody>
</table>

Setting: Sample (Composition & size):

Does this evidence address my EBP question? ☐ Yes ☐ No
Do not proceed with appraisal of this evidence

Level of Evidence (Study Design)

A. Is this a report of a single research study? If No, go to B.
1. Was there manipulation of an independent variable?
2. Was there a control group?
3. Were study participants randomly assigned to the intervention and control groups?

If Yes to all three, this is a Randomized ControlledTrial (RCT) or Experimental Study

If Yes to #1 and #2 and No to #3, OR Yes to #1 and No to #2 and No to #3, this is Quasi Experimental (some degree of investigator control, some manipulation of an independent variable, lacks random assignment to groups, may have a control group)

If No to #1, #2, and #3, this is Non-Experimental (no manipulation of independent variable, can be descriptive, comparative, or correlational, often uses secondary data) or Qualitative (exploratory in nature such as interviews or focus groups, a starting point for studies for which little research currently exists, has small sample sizes, may use results to design empirical studies)

NEXT, COMPLETE THE BOTTOM SECTION ON THE FOLLOWING PAGE, “STUDY FINDINGS THAT HELP YOU ANSWER THE EBP QUESTION”
B. Is this a summary of multiple research studies? **If No, go to Non-Research Evidence Appraisal Form.**

1. Does it employ a comprehensive search strategy and rigorous appraisal method (**Systematic Review**)? **If No, use Non-Research Evidence Appraisal Tool; If Yes:**
   a. Does it combine and analyze results from the studies to generate a new statistic (effect size)? (**Systematic review with meta-analysis**) **Yes** □ □ No
   b. Does it analyze and synthesize concepts from qualitative studies? (**Systematic review with meta-synthesis**) **Yes** □ □ No

**If Yes to either a or b, go to #2B below.**

2. For **Systematic Reviews** and **Systematic Reviews with meta-analysis or meta-synthesis:**
   a. Are all studies included RCTs?
   b. Are the studies a combination of RCTs and quasi-experimental or quasi-experimental only?
   c. Are the studies a combination of RCTs, quasi-experimental and non-experimental or non-experimental only?
   d. Are any or all of the included studies qualitative?

**COMPLETE THE NEXT SECTION, “STUDY FINDINGS THAT HELP YOU ANSWER THE EBP QUESTION”**

**STUDY FINDINGS THAT HELP YOU ANSWER THE EBP QUESTION:**

NOW COMPLETE THE FOLLOWING PAGE, "QUALITY APPRAISAL OF RESEARCH STUDIES", AND ASSIGN A QUALITY SCORE TO YOUR ARTICLE
## Quality Appraisal of Research Studies

- Does the researcher identify what is known and not known about the problem and how the study will address any gaps in knowledge?  □Yes □No
- Was the purpose of the study clearly presented?  □Yes □No
- Was the literature review current (most sources within last 5 years or classic)?  □Yes □No
- Was sample size sufficient based on study design and rationale?  □Yes □No
- If there is a control group:
  o Were the characteristics and/or demographics similar in both the control and intervention groups?  □Yes □No □NA
  o If multiple settings were used, were the settings similar?  □Yes □No □NA
  o Were all groups equally treated except for the intervention group(s)?  □Yes □No □NA
- Are data collection methods described clearly?  □Yes □No
- Were the instruments reliable (Cronbach’s α [alpha] ≥ 0.70)?  □Yes □No □NA
- Was instrument validity discussed?  □Yes □No □NA
- If surveys/questionnaires were used, was the response rate ≥ 25%?  □Yes □No □NA
- Were the results presented clearly?  □Yes □No □NA
- If tables were presented, was the narrative consistent with the table content?  □Yes □No □NA
- Were study limitations identified and addressed?  □Yes □No □NA
- Were conclusions based on results?  □Yes □No □NA

## Quality Appraisal of Systematic Review with or without Meta-Analysis or Meta-Synthesis

- Was the purpose of the systematic review clearly stated?  □Yes □No
- Were reports comprehensive, with reproducible search strategy?  □Yes □No
  o Key search terms stated  □Yes □No
  o Multiple databases searched and identified  □Yes □No
  o Inclusion and exclusion criteria stated  □Yes □No
- Was there a flow diagram showing the number of studies eliminated at each level of review?  □Yes □No
- Were details of included studies presented (design, sample, methods, results, outcomes, strengths and limitations)?  □Yes □No
- Were methods for appraising the strength of evidence (level and quality) described?  □Yes □No
- Were conclusions based on results?
  o Results were interpreted  □Yes □No
  o Conclusions flowed logically from the interpretation and systematic review question  □Yes □No
- Did the systematic review include both a section addressing limitations and how they were addressed?  □Yes □No

### QUALITY RATING BASED ON QUALITY APPRAISAL

A **High quality**: consistent, generalizable results; sufficient sample size for the study design; adequate control; definitive conclusions; consistent recommendations based on comprehensive literature review that includes thorough reference to scientific evidence

B **Good quality**: reasonably consistent results; sufficient sample size for the study design; some control, and fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence

C **Low quality or major flaws**: little evidence with inconsistent results, insufficient sample size for the study design; conclusions cannot be drawn
Appendix B: John Hopkins Nursing Evidence-Based Practice Non-Research Evidence Appraisal Tool

| Evidence Level & Quality: _____________________________ |

<table>
<thead>
<tr>
<th>Article Title:</th>
<th>Number:</th>
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<tbody>
<tr>
<td>Author(s):</td>
<td>Publication Date:</td>
</tr>
<tr>
<td>Journal:</td>
<td></td>
</tr>
</tbody>
</table>

**Does this evidence address the EBP question?**
☐ Yes ☐ No
Do not proceed with appraisal of this evidence

- **☐ Clinical Practice Guidelines:** Systematically developed recommendations from nationally recognized experts based on research evidence or expert consensus panel. **LEVEL IV**
- **☐ Consensus or Position Statement:** Systematically developed recommendations based on research and nationally recognized expert opinion that guides members of a professional organization in decision-making for an issue of concern. **LEVEL IV**

| Are the types of evidence included identified? | ☐ Yes ☐ No |
| Were appropriate stakeholders involved in the development of recommendations? | ☐ Yes ☐ No |
| Are groups to which recommendations apply and do not apply clearly stated? | ☐ Yes ☐ No |
| Have potential biases been eliminated? | ☐ Yes ☐ No |
| Were recommendations valid (reproducible search, expert consensus, independent review, current, and level of supporting evidence identified for each recommendation)? | ☐ Yes ☐ No |
| Were the recommendations supported by evidence? | ☐ Yes ☐ No |
| Are recommendations clear? | ☐ Yes ☐ No |

- **☐ Literature Review:** Summary of published literature without systematic appraisal of evidence quality or strength. **LEVEL V**

| Is subject matter to be reviewed clearly stated? | ☐ Yes ☐ No |
| Is relevant, up-to-date literature included in the review (most sources within last 5 years or classic)? | ☐ Yes ☐ No |
| Is there a meaningful analysis of the conclusions in the literature? | ☐ Yes ☐ No |
| Are gaps in the literature identified? | ☐ Yes ☐ No |
| Are recommendations made for future practice or study? | ☐ Yes ☐ No |

- **☐ Expert Opinion:** Opinion of one or more individuals based on clinical expertise. **LEVEL V**

| Has the individual published or presented on the topic? | ☐ Yes ☐ No |
| Is author’s opinion based on scientific evidence? | ☐ Yes ☐ No |
| Is the author’s opinion clearly stated? | ☐ Yes ☐ No |
| Are potential biases acknowledged? | ☐ Yes ☐ No |
Organizational Experience:

- **Quality Improvement**: Cyclical method to examine organization-specific processes at the local level. **LEVEL V**
- **Financial Evaluation**: Economic evaluation that applies analytic techniques to identify, measure, and compare the cost and outcomes of two or more alternative programs or interventions. **LEVEL V**
- **Program Evaluation**: Systematic assessment of the processes and/or outcomes of a program and can involve both quantitative and qualitative methods. **LEVEL V**

<table>
<thead>
<tr>
<th>Setting:</th>
<th>Sample (composition/size):</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Was the aim of the project clearly stated?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>• Was the method adequately described?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>• Were process or outcome measures identified?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>• Were results adequately described?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>• Was interpretation clear and appropriate?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>• Are components of cost/benefit analysis described?</td>
<td>□ Yes □ No □ N/A</td>
</tr>
</tbody>
</table>

- **Case Report**: In-depth look at a person, group, or other social unit. **LEVEL V**

| • Is the purpose of the case report clearly stated? | □ Yes □ No |
| • Is the case report clearly presented? | □ Yes □ No |
| • Are the findings of the case report supported by relevant theory or research? | □ Yes □ No |
| • Are the recommendations clearly stated and linked to the findings? | □ Yes □ No |

Community Standard, Clinician Experience, or Consumer Preference

- **Community Standard**: Current practice for comparable settings in the community **LEVEL V**
- **Clinician Experience**: Knowledge gained through practice experience **LEVEL V**
- **Consumer Preference**: Knowledge gained through life experience **LEVEL V**

<table>
<thead>
<tr>
<th>Information Source(s):</th>
<th>Number of Sources:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Source of information has credible experience.</td>
<td>□ Yes □ No □ N/A</td>
</tr>
<tr>
<td>• Opinions are clearly stated.</td>
<td>□ Yes □ No □ N/A</td>
</tr>
<tr>
<td>• Identified practices are consistent.</td>
<td>□ Yes □ No □ N/A</td>
</tr>
</tbody>
</table>

Findings that help you answer the EBP question:
### Quality Rating for Clinical Practice Guidelines, Consensus or Position Statements (Level IV)

**A High quality:** Material officially sponsored by a professional, public, private organization, or government agency; documentation of a systematic literature search strategy; consistent results with sufficient numbers of well-designed studies; criteria-based evaluation of overall scientific strength and quality of included studies and definitive conclusions; national expertise is clearly evident; developed or revised within the last 5 years.

**B Good quality:** Material officially sponsored by a professional, public, private organization, or government agency; reasonably thorough and appropriate systematic literature search strategy; reasonably consistent results, sufficient numbers of well-designed studies; evaluation of strengths and limitations of included studies with fairly definitive conclusions; national expertise is clearly evident; developed or revised within the last 5 years.

**C Low quality or major flaws:** Material not sponsored by an official organization or agency; undefined, poorly defined, or limited literature search strategy; no evaluation of strengths and limitations of included studies; insufficient evidence with inconsistent results, conclusions cannot be drawn; not revised within the last 5 years.

### Quality Rating for Organizational Experience (Level V)

**A High quality:** Clear aims and objectives; consistent results across multiple settings; formal quality improvement or financial evaluation methods used; definitive conclusions; consistent recommendations with thorough reference to scientific evidence.

**B Good quality:** Clear aims and objectives; formal quality improvement or financial evaluation methods used; consistent results in a single setting; reasonably consistent recommendations with some reference to scientific evidence.

**C Low quality or major flaws:** Unclear or missing aims and objectives; inconsistent results; poorly defined quality improvement/financial analysis method; recommendations cannot be made.

### Quality Rating for Literature Review, Expert Opinion, Community Standard, Clinician Experience, Consumer Preference (Level V)

**A High quality:** Expertise is clearly evident; draws definitive conclusions; provides scientific rationale; thought leader in the field.

**B Good quality:** Expertise appears to be credible; draws fairly definitive conclusions; provides logical argument for opinions.

**C Low quality or major flaws:** Expertise is not discernable or is dubious; conclusions cannot be drawn.
Appendix C: Permission of Use for John Hopkins’ Tools

Thank you for submitting the requested information. You now have permission to use the JHN EBP model and tools.

Click here to download the tools. Reminder: You may not modify the model or the tools. All reference to source forms should include “©The Johns Hopkins Hospital/The Johns Hopkins University.”
## Appendix D: Evidence Table

<table>
<thead>
<tr>
<th>Article</th>
<th>Background</th>
<th>Strength &amp; Quality of Evidence</th>
<th>Results</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hoerster KD, Lehavot K, Simpson T, Reiber G, Nelson K. Health and health behavior differences: U.S. military, veteran, and civilian men. AJPM. 2012; 43(5): 483-9.</td>
<td>To compare veteran, military, and civilian men on leading U.S. health indicators.</td>
<td>Data were obtained from the 2010 Behavioral Risk Factor Surveillance Survey, a U.S. population-based study. Strength of evidence: Non research, expert opinion. Level V B, Good quality.</td>
<td>Multivariate logistic regression results are presented despite better healthcare access, veterans reported poorer health functioning than civilians, National Guards/Reserve members on several indicators: diabetes, smoking, heavy alcohol consumption, and lack of exercise. Veterans have poorer health and health behaviors, indicating the increased vulnerability of these patients.</td>
<td></td>
</tr>
<tr>
<td>Lehavot, K.D., Simpson, T., McFall, M., Reiber, G., &amp; Nelson, K.M. (2012). Health and health behavior differences: U.S. military, veteran, and civilian men. American Journal of Preventative Medicine. 43(5): 483-9. doi: 10.1016/j.amepre.2012.07.029</td>
<td>Few studies have examined the sexual behaviors of women veterans compared to non veterans for the purpose of identifying potential sexual health disparities.</td>
<td>Data was used from the 1999-2010 National Health and Nutrition Examination Survey, a nationally representative U.S. survey to compare lifetime sexual history, sexual activity in last year, and STIs between women veterans and non veterans. Strength of Evidence: Non research, expert opinion. Level V A, High Quality</td>
<td>Women veterans reported higher rates of sexual activity, STIs, younger age at first experience with intercourse, greater number of sexual partners, and were more likely to have had genital herpes and warts that non-veteran counterparts. Women veterans report higher rates of sexual activity and STIs that non-veterans. More research is needed to assess high risk behavior factors. Additionally, providers ensure screening and interventions are provided for this at risk population.</td>
<td></td>
</tr>
</tbody>
</table>

Many veterans are afflicted with severe mental illness. This connection of mental illness and physical health, put veterans with severe mental illness at an even more increased risk than veterans without mental illness.
Homeless veterans are at higher risk for chronic disease; understanding the dynamics of homelessness among veterans can contribute to an understanding of their health needs.

Data was obtained on demographic characteristics and veteran status for 130,534 homeless people from jurisdictions that provide homelessness services, and for the population living in poverty and the general population from the American Community Survey for those same jurisdictions. Prevalence of veterans in the homeless, poverty, and general populations, and risk ratios (RR) for veteran status in these populations was calculated. Risk for homelessness was estimated by using multivariate regression models. 

Strength of evidence: Expert opinion, Level V A, High Quality

Veterans were overrepresented in the homeless population, compared with both the general and poverty populations, among both men (RR, 1.3 and 2.1, respectively) and women (RR, 2.1 and 3.0, respectively). Being a veteran and black, significantly increased the risk for homelessness for both men and women. Men in the 45- to 54-year-old age group and women in the 18- to 29-year-old age group were at higher risk compared with other ages.

Confirm previous research associating veteran status with higher risk for homelessness and imply that there will be specific health needs among the aging homeless population.

Review of Toolkit Effectiveness:


Facilitated family presence at resuscitation is endorse by multiple nursing and specialty practice organizations, but implementation of this practice is not universal. A strategy to promote this practice is to use a nursing student toolkit.

Using questionnaires, the study tested the effectiveness of the toolkit. Strength of Evidence: quasi experimental design, Level II A, High Quality.

Implementation of the toolkit significantly increased nursing student’s knowledge, perceptions, and confidence in facilitating family presence at resuscitation.

The use of a toolkit was effective.


Toolkits are becoming an increasingly common strategy for educational resources. Currently not many studies exist that, this toolkit was designed to evaluate if a sexual assault nurse practitioners’ services were increasing the amount of criminal convictions in their area.

After implementation, data collection was taken to assess how the programs were using the toolkit to conduct their evaluations as well as see how the sites were using their findings to create programmatic changes. Strength of evidence: quasi experimental, Level II A, High quality.

Sites’ perception of the toolkit was that it was helpful and beneficial for program evaluation. Additionally, all the sites completed their.

The use of the toolkit was effective.
| Tydings, D.M. (2014). Evaluation of a toolkit to assist with implementation of the “80/20” recommendation. Journal of Nursing Administration, 44(12), 647-652. | Although the literature substantiates the link between BSN preparation for RNs and enhanced patient outcomes, there are few resources to assist in the increasing the proportion of BSN prepared RNs. | Nurse executive evaluated the efficacy of the toolkit by the use of interviews. Strength of Evidence: quasi experimental, Level II A, High Quality. | Nurse executives found the toolkit effective and shared it inside and outside of their organizations. | Use of the toolkit was effective. |
| Nelson, A.L., Waters, T.T., Menzel, N.N., Hughes, N., Hagan, P.C., Powell-Cope, G., & Thompson, V. (2007). Effectiveness of an evidenced-based curriculum module in nursing schools targeting safe patient handling and movement. International Journal of Nursing Education Scholarship, 4(1). | Historically, nursing schools have focused on manual patient lifting techniques, despite the documented dangers to healthcare providers. There is a need for safe patient handling to be incorporated into nursing curriculum. A toolkit was created to deliver this information | Quasi experimental design using pre and post intervention evaluation of outcomes from an intervention group. Strength of evidence: quasi experimental; Level II A, High Quality. | Data was collected using questionnaires and demonstrated that the toolkit was effective in changing the knowledge, attitudes, and beliefs of nurse educators who taught safe patient handling. | The use of the toolkit was effective. |
Table 2. Veteran Competencies for Undergraduate Nursing Education

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skills</th>
<th>Attitudes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Competency Topic: Military and Veteran Culture</strong></td>
<td>1. Demonstrate the ability to conduct a military health history.</td>
<td>1. Convey care, understanding, and respect for service members, Veterans, and their families.</td>
</tr>
<tr>
<td>1. Describe military organizational structure, terms used to describe aspects of military service, and the demographic characteristics of those who serve in the military.</td>
<td>2. Utilize knowledge of military culture to make informed assessments of Veteran patients and their families.</td>
<td>2. Express thanks to Veterans and their families for their service.</td>
</tr>
<tr>
<td>2. Discuss stressors related to military service for those serving and their families.</td>
<td>3. Apply knowledge of military culture to provide informed treatment, support, and referrals for Veterans and their families.</td>
<td>3. Honor the service of the Veteran.</td>
</tr>
<tr>
<td>3. Summarize differences and similarities between Active and Reserve Component military service.</td>
<td>4. Recognize unique needs of military families including children.</td>
<td></td>
</tr>
<tr>
<td>4. Understand the importance and components of a military health history.</td>
<td>5. Demonstrate the ability to refer the Veteran to the state Veterans Service Office to determine eligibility for health care services.</td>
<td></td>
</tr>
<tr>
<td>5. Describe the most common health concerns of Veterans from different wars.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Describe the mission of the Department of Veterans Affairs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Differentiate between the Veterans Health Administration, the Military Health System, Tricare, and other health care Reimbursement systems.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Competency Topic: Post Traumatic Stress Disorder (PTSD)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Describe the signs and symptoms of PTSD.</td>
<td>1. Demonstrate the ability to conduct and interpret a PTSD screen (Primary Care PTSD screen—4 items).</td>
<td>1. Express support for the Veteran impacted by PTSD.</td>
</tr>
<tr>
<td>2. Summarize the prevalence, consequences, and longitudinal course of PTSD in civilian and Veteran populations.</td>
<td>2. Assess PTSD triggers and implement appropriate interventions to minimize risk and enhance patient safety.</td>
<td>2. Convey empathy to the family impacted by PTSD.</td>
</tr>
<tr>
<td>4. Discuss the treatment modalities for Veterans with PTSD.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Understand the impact of PTSD on children and families.</td>
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</tbody>
</table>

(continues)
Table 2. Veteran Competencies for Undergraduate Nursing Education (Continued)

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skills</th>
<th>Attitudes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Competency Topic: Environmental/Chemical Exposures</strong>&lt;br&gt;1. Describe the various environmental exposures related to different wars (Vietnam, Gulf War, OEF/OIF/OOND).&lt;br&gt;2. Understand the possible health sequelae related to various environmental exposures.&lt;br&gt;3. Know that environmental health registries for Veterans are maintained by the VA.&lt;br&gt;4. Understand the need to refer qualified Veterans for registry evaluations.</td>
<td>1. Ask all Veterans about exposures using Environmental Exposure Pocket Card.&lt;br&gt;2. Refer Veterans with environmental exposures to their local Environmental Health Coordinator.&lt;br&gt;3. Implement interventions appropriate to mitigate the current symptomology and long-term effects of exposure.</td>
<td>1. Convey support for the Veteran who has sequelae related to environmental exposures.</td>
</tr>
</tbody>
</table>
Table 2. Veteran Competencies for Undergraduate Nursing Education (Continued)

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skills</th>
<th>Attitudes</th>
</tr>
</thead>
</table>
| **Competency Topic: Substance Use Disorder (SUD)**
1. Discuss the prevalence and risk factors for substance use disorders among Veterans and service members.
2. Differentiate between low-risk use, risky use, and problem drinking in men and women.
3. Describe the SBIRT (Screening, Brief Intervention, and Referral to Treatment) approach to early intervention.
4. Understand the importance of family members in the long-term treatment of substance use disorders.
| 1. Screen for unhealthy alcohol use using the AUDIT-C (Alcohol Use Disorders Identification Test).
2. Provide brief intervention for those identified as risky or problem drinkers.
3. Refer to specialty care for those requiring further substance use treatment.
4. Recognize signs and symptoms of withdrawal and delirium tremens.
5. Implement appropriate interventions and a safety plan for someone in acute withdrawal. | 1. Accept that addiction recovery is long-term and may include relapse.
2. Convey a non-judgmental, non-shaming stance with an authentic and empathetic attitude. |
| **Competency Topic: Military Sexual Trauma (MST)**
1. Define the terms used to describe sexual harassment and assault in the military.
2. Report estimates of the frequencies of sexual harassment and assault in the military.
3. Describe the mental health impact of sexual trauma and implications for care.
4. Discuss resources available including DoD Safe Helpline (active duty), MST Coordinator, OEF/OIF Coordinator, or Women’s Veteran’s Program Manager at local VA Medical Center. | 1. Establish a comfortable climate for disclosure.
2. Screen all Veterans for MST using the Trauma Questionnaire.
3. Evaluate for signs and symptoms associated with MST.
4. Identify appropriate referrals for Veterans suffering from MST.
5. Assess and evaluate coping mechanisms.
6. Seek to understand the patient’s perceptions (“How has the MST experience affected your life and health?”) | 1. Convey a non-judgmental, non-shaming stance.
2. Express an authentic and empathetic attitude. |

(continued)
Table 2. Veteran Competencies for Undergraduate Nursing Education (Continued)

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skills</th>
<th>Attitudes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Competency Topic: Traumatic Brain Injury (TBI)</strong></td>
<td>1. Demonstrate the ability to identify those with mild TBI through use of the 3 Question DVBI C TBI Screening Tool.</td>
<td>1. Convey empathy of the impact of a TBI on the Veteran and their family.</td>
</tr>
<tr>
<td>1. Define TBI, the causes, and who is at risk.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Discuss the physical, cognitive, behavioral, and emotional signs and symptoms of TBI.</td>
<td></td>
<td></td>
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<tr>
<td>3. Understand the concomitant nature of TBI and PTSD.</td>
<td></td>
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<tr>
<td>4. Explain the evidence-based treatments for TBI.</td>
<td></td>
<td></td>
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<tr>
<td>5. Recognize the importance of ongoing caregiving in those with moderate-to-severe TBI.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Know about programs and services available to Veterans with TBI.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Competency Topic: Suicide</strong></td>
<td>1. Demonstrate the ability to screen for depression using the Patient Health Questionnaire (PHQ-9) and interpret findings.</td>
<td>1. Provide care in a supportive and nonjudgmental manner.</td>
</tr>
<tr>
<td>1. Describe risk factors for suicide in Veterans and service members.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Identify suicidal behaviors and warning signs and differentiate those that require immediate intervention.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Know the 24-h Veterans Crisis Line number (800-273-TALK).</td>
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<tr>
<td>4. Understand how to identify the nearest Veterans Health Administration Suicide Prevention Coordinator.</td>
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<tr>
<td>5. Recognize the role that families can play in preventing suicide.</td>
<td></td>
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</tbody>
</table>

(continues)
Table 2. Veteran Competencies for Undergraduate Nursing Education (Continued)

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skills</th>
<th>Attitudes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competency Topic: Homelessness</td>
<td>1. Identify those who are homeless and those at risk for homelessness</td>
<td>1. Provide care in a supportive and nonjudgmental manner.</td>
</tr>
<tr>
<td>1. Describe the current statistics related to Veterans and homelessness.</td>
<td>(hidden homeless) in the inpatient and outpatient settings.</td>
<td></td>
</tr>
<tr>
<td>2. Discuss risk factors and causes of homelessness among Veterans.</td>
<td>2. Assess social supports available to the Veteran.</td>
<td></td>
</tr>
<tr>
<td>3. Discuss VA’s Commitment to End Veteran Homelessness Initiative.</td>
<td>3. Initiate a referral for appropriate local resources for the Veteran</td>
<td></td>
</tr>
<tr>
<td>4. Know the 24th number for the National Call Center for Homeless Veterans (877-AID-VET).</td>
<td>who is at-risk or currently homeless.</td>
<td></td>
</tr>
<tr>
<td>Competency Topic: Serious Illness Especially at End of Life</td>
<td>1. Demonstrate knowledge of advance directive documentation in the</td>
<td>1. Appreciate the importance of advance care planning for all Veterans</td>
</tr>
<tr>
<td>1. Describe the process of advance care planning and identification of</td>
<td>electronic medical record and legal aspects of document completion.</td>
<td>early in the illness trajectory.</td>
</tr>
<tr>
<td>proxy to support decision-making in serious illness.</td>
<td>2. Apply knowledge from the military health history and cultural</td>
<td>2. Display comfort and experience with difficult communications around</td>
</tr>
<tr>
<td>2. Explain the importance of identifying the military health history that</td>
<td>assessment to provide informed end-of-life symptom management and/or</td>
<td>serious illness.</td>
</tr>
<tr>
<td>could impact Veteran’s end-of-life.</td>
<td>support.</td>
<td>3. Convey respect for military experiences that can influence the</td>
</tr>
<tr>
<td>3. Define specific barriers and resources in VA facilities that could</td>
<td>3. Demonstrate the ability to consult VA-specific pain and palliative</td>
<td>Veterans’ and their family’s end-of-life experiences.</td>
</tr>
<tr>
<td>impact excellent pain and symptom management.</td>
<td>care resources to achieve appropriate pain and symptom management for</td>
<td></td>
</tr>
<tr>
<td>4. Recognize the importance of military culture and era of service on</td>
<td>Veterans with serious illness and at end-of-life.</td>
<td></td>
</tr>
<tr>
<td>Veteran’s end-of-life experiences.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Identify the availability of comfort care orders and other resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>to enhance the Veterans’ and their family’s end-of-life experience.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Abbreviation: VA, Veterans Affairs.
Appendix F: Statement of Determination

DNP Project Approval Form: Statement of Determination

Student Name: Carlee Stewart

<table>
<thead>
<tr>
<th>Title of Project:</th>
<th>Enhancing the knowledge of healthcare providers of the cultural and health considerations of war era Veterans.</th>
</tr>
</thead>
</table>

Brief Description of Project:

A) Aim Statement: By September 1, 2016, develop, implement and evaluate a toolkit on the special healthcare needs of Veterans who served during the Korean, Vietnam, Gulf, and Iraq/Afghanistan wars, with the goal of improving healthcare delivery.

B) Description of Intervention: Development of online educational modules containing cultural and healthcare considerations specific to various war era Veterans will be created to educate pre-licensure and graduate level RNs.

C) How will this intervention change practice? Cultural competence in healthcare has been effective in reducing health disparities among patients. There are millions of Veterans in the United States and their specific healthcare needs are often different based on the era of war in which they fought. Currently there is an opportunity for education of students on this subject at the University of San Francisco's School of Nursing. By providing these training modules, the aim of this project is to enhance the culturally competent care that is provided to each unique war era Veteran.

D) Outcome measurements:
Increase the knowledge of pre-licensure and graduate nursing students of the specific issues affecting Veterans by 10% from their baseline assessment.

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used: (http://answers.hhs.gov/ohrp/categories/1569)

This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments:

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

Instructions: Answer YES or NO to each of the following statements:

<table>
<thead>
<tr>
<th>Project Title:</th>
<th>Enhancing knowledge of cultural considerations in war era Veterans for healthcare providers.</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>The aim of the project is to improve the process or delivery of care with established/accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>The specific aim is to improve performance on a specific service or program and is a part of usual care. ALL participants will receive standard of care.</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The project is NOT designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does NOT follow a protocol that overrides clinical decision-making.</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does NOT develop paradigms or untested methods or new untested standards.</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does NOT seek to test an intervention that is beyond current science and experience.</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The project has NO funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., not a personal research project that is dependent upon the voluntary participation of colleagues, students and/or patients.</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: “This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board.”</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ANSWER KEY:** If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to **ANY** of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.*
Appendix G: VA Letter of Support

March 21, 2016

To Whom It May Concern:

As a fellow faculty member in the VANAP (Veterans Affairs Nursing Academic Partnership) program with Carlee Balzaretti for the past 19 months, I have had the distinct opportunity and pleasure to witness her commitment and genuine concern for Veteran-centric education and care. Her dedication towards providing quality instruction for our nursing students taking care of Veterans is evident in her compassionate approach and diligent supervision. In her role, Carlee has always taken the time to listen to Veterans’ concerns and incorporate them into her teaching with students. In the classroom, she addresses Veteran issues such as PTSD and substance abuse into her presentation content so that students have a clearer understanding. In the clinical setting, she encourages students to talk with Veterans about their military experiences and health issues so that they can be more informed and responsive to their patients’ needs.

As a retired Navy & Air Force officer and a recipient of medical care through the VA, I am delighted to hear that Carlee has taken a keen interest in addressing these Veteran issues. The care we currently provide in the VA is becoming increasingly complex as we deal with significant war-related injuries that are more prevalent such as TBI and Limb Amputations. The focus of Carlee’s DNP project on Veteran competencies is very timely and encouraging in our efforts as an organization to provide the most comprehensive care to our Veterans and, concurrently, shape how we educate our future nurses in delivering this care to them.

Thank you for your time and consideration of this candidate’s DNP proposal.

Warmest regards,

Neftali Cabezudo, Ph.D., RN
VA Program Director & Faculty, VANAP USF
Nursing Education & Professional Development
VA Northern California Health Care System
(916) 903-8511
March 15, 2016

To Whom It May Concern:

I have had the great pleasure to work with Carlee Balzaretti for the past 14 months. Carlee is an excellent educator and supporter of the Veteran focused BSN program in Sacramento. Given that, she has found a Capstone project that has far reaching impact. Carlee is planning the creation of several online modules on the care of the Veteran. As you may know, the Veteran population has grown significantly in the last decade and the difference between each conflict has challenged health care providers in their care. For example, taking care of a Veteran with both PTSD and Post Partum depression simply was not on the forefront until recently. Due to all of these factors, our health care system is brimming with Veterans with unique health care needs and a health care provider population that is not prepared to provide the specialty care they need.

In Sacramento, one of our primary charges is to educate nurses to care for Veterans. We do this through educating our students but strive for a much larger reach. We have a vision that eventually, we can educate health care professionals across the country on the care of the Veteran. Carlee’s project has the potential to aid in this very important mission as we strive to educate health care providers in the core competencies of Veteran care. Given this, Carlee has my full support for this project. The Chief Nurse at the VA in Sacramento is highly vested in this project and is looking forward to sharing it with her nurses. Additionally, the Office of Academic Affairs would love the opportunity to share Carlee’s work nationally through their network of schools.

This project is important, has far reach, and the ability to improve care for our nations Veterans. Please contact me if you have any further questions.

Thank you very much,

Laureen Turner

Laureen Turner RN, MA, MSN
Assistant Professor
Sacramento BSN Assistant Director
University of San Francisco
School of Nursing and Health Professions
Appendix I: SWOT Analysis

<table>
<thead>
<tr>
<th>SWOT ANALYSIS</th>
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<tbody>
<tr>
<td><strong>INTERNAL</strong></td>
</tr>
<tr>
<td><strong>STRENGTHS</strong></td>
</tr>
<tr>
<td>• Author familiar with project site</td>
</tr>
<tr>
<td>• Easy promotion and communication for author</td>
</tr>
<tr>
<td>• Easy promotion and communication for author</td>
</tr>
<tr>
<td>• Dedicated faculty members</td>
</tr>
<tr>
<td>• Dedicated management</td>
</tr>
<tr>
<td>• VANAP program allows for an easy audience. It can quickly go to VAs nationwide</td>
</tr>
<tr>
<td>• Project is desired</td>
</tr>
<tr>
<td><strong>WEAKNESSES</strong></td>
</tr>
<tr>
<td>• Modules are lengthy and may take a while to complete</td>
</tr>
<tr>
<td>• All participants may not complete modules in allotted timeframe</td>
</tr>
<tr>
<td>• Unable to utilize nursing students</td>
</tr>
<tr>
<td><strong>EXTERNAL</strong></td>
</tr>
<tr>
<td><strong>OPPORTUNITIES</strong></td>
</tr>
<tr>
<td>• Fulfills some requirements of OAA grant</td>
</tr>
<tr>
<td>• Future research possibilities</td>
</tr>
<tr>
<td>• Supported by OAA</td>
</tr>
<tr>
<td>• There is a national need to nursing education of Veterans. This project fills that need</td>
</tr>
<tr>
<td><strong>THREATS</strong></td>
</tr>
<tr>
<td>• Creating modules for use outside of USF will be difficult</td>
</tr>
<tr>
<td>• Delivery format may be difficult to complete</td>
</tr>
</tbody>
</table>
Appendix J: Budget

### Expense Summary

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Hourly Rate</th>
<th>Expected Hours</th>
<th>Estimated Expenses</th>
<th>Actual Expenses</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$58</td>
<td>220</td>
<td>$12,760</td>
<td>$0</td>
<td>$12,760</td>
</tr>
<tr>
<td>SME</td>
<td>$60</td>
<td>200</td>
<td>$12,000</td>
<td>$0</td>
<td>$12,000</td>
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<tr>
<td>Materials</td>
<td>$45</td>
<td></td>
<td>$45</td>
<td>$40</td>
<td>$5</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td></td>
<td></td>
<td><strong>$24,805</strong></td>
<td><strong>$40</strong></td>
<td><strong>$24,765</strong></td>
</tr>
</tbody>
</table>

### Project Budget Overview

<table>
<thead>
<tr>
<th>Budget Totals</th>
<th>Estimated</th>
<th>Actual</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Expenses</td>
<td>$24,805</td>
<td>$40</td>
<td>$24,765</td>
</tr>
<tr>
<td><strong>Difference</strong></td>
<td>-$24,805</td>
<td>-$40</td>
<td>-$24,765</td>
</tr>
</tbody>
</table>
### Carlee Balzaretti, DNP Project GANTT Chart

<table>
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<tr>
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## Appendix L: Work Breakdown Structure

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<thead>
<tr>
<th>Level 1</th>
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<tbody>
<tr>
<td>1 Completed &amp; Validated Veteran Competency Educational Modules</td>
<td>1.1 First round modules completed</td>
<td>1.1.1 Review of the literature for best practices to include for each competency</td>
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<td>1.1.2 Search for available educational tools</td>
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<tr>
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<td>1.1.3 Connect with VANAP developers of competencies for educational module recommendations</td>
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<tr>
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<td>1.1.4 Develop PowerPoints, Prezis, &amp; learning response activities</td>
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<td>1.1.5 Finalize all materials to Padlet site</td>
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<tr>
<td>1.2 First round review &amp; Likert items completed</td>
<td>1.2.1 Create Likert item questions and ratings</td>
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<td>1.2.3 Inform subject matter experts that modules are ready to complete</td>
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<tr>
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<td></td>
<td>1.2.3 Collect and analyze Likert items</td>
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<td>1.3 Final version of modules completed with feedback incorporated</td>
<td>1.3.1 Review feedback from subject matter experts regarding what did not work</td>
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<tr>
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<td>1.3.2 Additional literature review as needed</td>
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<td>1.3.3 Modify educational modules based off of feedback and literature review</td>
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<tr>
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<td>1.3.4 Finalize to Padlet site</td>
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<tr>
<td>1.4 Final review and Likert completed</td>
<td>1.4.1 Inform subject matter experts that revision of educational modules is complete</td>
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<td>1.4.2 Collect final Likert items</td>
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<tr>
<td>1.5 Evaluation &amp; write-up</td>
<td>1.5.1 Review of final Likert items to determine efficacy of project</td>
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</tr>
<tr>
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<td></td>
<td>1.5.2 Begin final write-up of project</td>
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</table>
Appendix M: Module Objectives

Module 1: Military and Veteran Culture

Knowledge Objectives:

• Describe military organizational structure, terms used to describe aspects of military service, and the demographic characteristics of those who serve in the military
• Discuss stressors related to military service for those serving and their families
• Understand the importance and components of a military health history
• Describe the most common health concerns of Veterans from different wars
• Describe the mission of the Department of Veteran Affairs
• Discuss how to conduct a military health history
• Understand how to refer the Veteran to the state Veteran Service Office to determine eligibility for health care services

Attitudes to convey after module:

• Convey care, understanding, and respect for service members, Veterans, and their families
• Express thanks to Veterans and their families for their service
• Honor the service of the Veteran

Module 2: Amputation and Assistive Devices

Knowledge Objectives:

• Describe the prevalence of traumatic amputation among service members and Veterans
• Recognize common problems associated with traumatic amputations
• Identify methods of rehabilitation associated with amputee patients
• Discuss clinical issues related to the use of prosthetic devices
• Know about programs and services available to Veterans with amputations
• Discuss the importance of providing emotional support for patients with traumatic amputations
• Discuss clinical assessments, interventions, and outcomes of care for amputation sites
• Identify potential complications related to the use of prosthetic devices

Attitudes to convey after module:

• Show sensitivity to the Veteran regarding self-care, self-image, and independence
• Approach disability from a strength-based perspective

Module 3: Environmental/Chemical Exposures

Knowledge Objectives:
• Describe the various environmental exposures related to different wars
• Understand the possible health sequelae related to various environmental exposures
• Know that environmental health registries for Veterans are maintained by the VA
• Understand the need to refer qualified Veterans for registry evaluations
• Identify appropriate referral for Veterans with environmental exposures to their local Environmental Health Coordinator

Attitudes to convey after module:
• Convey support for the Veteran who has sequelae related to environmental exposures

Module 4: Traumatic Brain Injury

Knowledge Objectives:
• Define TBI, the causes and who is at risk
• Discuss the physical, cognitive, behavioral, and emotional signs and symptoms of TBI
• Understand the concomitant nature of TBI and PTSD
• Explain the treatments for TBI
• Recognize the importance of ongoing caregiving in those with moderate to severe TBI
• Know what programs and services are available to Veterans with TBI
• Discuss the 3 Question DVIBC TBI screening tool

Attitudes to convey after module:
• Empathy of the impact of a TBI on the Veteran and their family

Module 5: Military Sexual Trauma

Knowledge Objectives:
• Define the terms used to describe sexual harassment and assault in the military
• Discuss the frequency of sexual harassment and assault in the military
• Describe the mental health impact of sexual trauma and indications for care
• Discuss resources available including DoD Safe Helpline (active duty), MST Coordinator, OIF/OEF Coordinator, or Women’s Veteran’s Program Manager at local VA Medical Center
• Identify the need for a comfortable climate for disclosure
• Describe the Trauma questionnaire and signs and symptoms of MST
• Discuss referral options for Veterans suffering from MST

Attitudes to convey after module:
• Convey a non judgmental, non-shaming stance
• Express and authentic and empathetic attitude

Module 6: Post Traumatic Stress Disorder
Knowledge Objectives:
- Describe the signs and symptoms of PTSD
- Summarize the prevalence, consequences, and longitudinal course of PTSD in civilian and Veteran populations
- Report the risk factors for PTSD
- Discuss the treatment modalities for Veterans with PTSD
- Understand the impact of PTSD on children and families
- Discuss the Primary Care PTSD screen
- Discuss PTSD triggers
- Identify resources of Veterans experiencing PTSD and their families

Attitudes to convey after module:
- Express support for the Veteran impacted by PTSD
- Convey empathy to the family impacted by PTSD

Module 7: Substance Use Disorder

Knowledge Objectives:
- Discuss the prevalence and risk factors for substance use disorders among Veterans and service members
- Describe the SBIRT (Screening, Brief Intervention and Referral to Treatment) approach to early intervention
- Understand the importance of family members in the long-term treatment of substance use disorders
- Describe the AUDIT-C test for unhealthy alcohol use
- Identify referrals for specialty care for those requiring substance use treatment
- Recognize signs and symptoms of withdrawal and delirium tremens
- Identify appropriate interventions for acute withdrawal

Attitudes to convey after module:
- Accept that addiction recovery is long-term and may include relapse
- Convey a nonjudgmental, non-shaming stance with an authentic and empathetic attitude

Module 8: Suicide

Knowledge Objectives:
- Describe risk factors for suicide in Veterans and Service members
- Identify suicidal behaviors and warning signs and differentiate those that require immediate intervention
- Know the 24-h Veterans Crisis Line number (800-273-TALK)
- Understand how to identify the nearest Veterans Health Administration Suicide Prevention Coordinator
- Recognize the role that families can play in preventing suicide
- Discuss the VA Suicide Risk Assessment Guide
At attitudes to convey after module:
• Provide care in a supportive and nonjudgmental manner

Module 9: Homelessness

Knowledge Objectives:
• Describe the current statistics related to Veterans and homelessness
• Discuss risk factors and causes of homelessness among Veterans
• Discuss the VA’s commitment to end homelessness initiative
• Know the 24-h number for the National Call Center for Homeless Veterans (877-4AID-VET)
• Identify resources for the Veteran who is at risk or currently homeless

Attitudes to convey after module:
• Provide care in a supportive nonjudgmental manner

Module 10: Serious Illness at the End of Life

Knowledge Objectives:
• Describe the process of advances care planning
• Explain the importance of identifying the military health history that could impact a Veteran’s end of life
• Recognize the importance of military culture and was era of service on a Veteran’s end of life experiences
• Identify the availability of comfort care orders and other resources to enhance the Veteran's and their family's end of life experience

Attitudes to convey after module:
• Appreciate the importance of advance care planning for all Veterans early in the illness trajectory
• Display comfort and experience with difficult communications around serious illness
• Convey respect for military experiences that can influence the Veterans’ and their family’s end of life experiences
### Appendix N: Communication Matrix

<table>
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<th>Audience</th>
<th>Category</th>
<th>Information</th>
<th>Method</th>
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<tr>
<td>Chairperson</td>
<td>Project execution/Status</td>
<td>Updates on project status and occasional questions regarding project implementation</td>
<td>Email</td>
<td>As needed</td>
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<td>VANAP Co-directors</td>
<td>Project execution and Status</td>
<td>Updates on project status and check in regarding subject matter</td>
<td>Email, In-person meetings</td>
<td>Monthly and as needed</td>
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<td>SMEs</td>
<td>Project execution</td>
<td>Questions regarding the subject matter and assessment of the modules</td>
<td>Email, In-person meetings</td>
<td>As needed, throughout project implementation</td>
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Appendix O: Likert Scale

**Veteran Modules Effectiveness Evaluation**

Thank you so much for your participation!!!

Each module met the listed objectives.

- 1. Strongly Disagree
- 2. Mildly Disagree
- 3. Neutral
- 4. Mildly Agree
- 5. Strongly Agree

If your answer to the above question was 1-3, please provide a short explanation.

Long answer text
Each of the 10 competencies were adequately addressed at an introductory level.

〇 1. Strongly Disagree
〇 2. Mildly Disagree
〇 3. Neutral
〇 4. Mildly Agree
〇 5. Strongly Agree

If your answer to the question above was 1-3, please provide an explanation.

Long answer text

The order of the module topics was appropriate.

〇 1. Strongly Disagree
〇 2. Mildly Disagree
〇 3. Neutral
〇 4. Mildly Agree
〇 5. Strongly Agree

If your answer to the question above was 1-3, please provide a short explanation.

Long answer text
The format (layout) of the modules was easy to follow.

- [ ] Strongly Disagree
- [ ] Mildly Disagree
- [ ] Neutral
- [ ] Mildly Agree
- [ ] Strongly Agree

If your answer was 1-3 for the question above, please give a short explanation.

Long answer text

These modules will help change the approach nursing students and RNs care for Veterans

- [ ] Strongly Disagree
- [ ] Mildly Disagree
- [ ] Neutral
- [ ] Mildly Agree
- [ ] Strongly Agree

If your answer was 1-3 to the question above, please provide a short explanation

Long answer text
I would recommend these modules (as is) for nursing students and other healthcare professionals.

- [ ] Strongly Disagree
- [ ] Mildly Disagree
- [ ] Neutral
- [ ] Mildly Agree
- [ ] Strongly Agree

If your answer was 1-3 to the question above, please provide a short explanation.

Long answer text

---

Is ten hours of CEUs appropriate for all the modules?

- [ ] Yes
- [ ] No

If you answered no to the question above, please indicate how much time you feel is appropriate.

Long answer text

---

The delivery format was designed for users outside of USF’s system to access. For those within USF the format should be:

- [ ] As is
- [ ] Canvas
Appendix P: Results

Each module met the listed objectives

- Strongly Agree: 66.70%
- Mildly Agree: 33.30%
- Neutral: 0%
- Mildly Disagree: 0%
- Strongly Disagree: 0%

Each of the 10 modules were adequately addressed at an introductory level

- Strongly Agree: 83.30%
- Mildly Agree: 16.70%
- Neutral: 0%
- Mildly Disagree: 0%
- Strongly Disagree: 0%
The order of the module topics was appropriate

- Strongly Agree: 83.30%
- Mildly Agree: 16.70%
- Neutral: 16.70%

The format (layout) of the modules was easy to follow

- Strongly Agree: 66.70%
- Mildly Agree: 16.70%
- Neutral: 16.70%
- Mildly Disagree: 16.70%
- Strongly Disagree: 16.70%
These modules will help change the approach nursing students and RNs care for Veterans

I would recommend the modules (as is) for nursing students and other healthcare professionals
Is 10 CEUs appropriate for all the modules?

- Yes: 100%
- No: 0%

The delivery format was designed for users outside of USF's system to access. For those within USF, the format should be:

- As is: 50%
- Canvas: 50%