

Care Planning Guide for Veterans

Please note that this guide is to be used as a model that your organization can adapt and staff should not utilize if they do not feel prepared, are uncomfortable, or if there is a possibility that addressing below could cause trauma to surface for staff or volunteers. The assessment, interventions, and goals of care outlined below will need to be integrated into the patient's larger plan of care. For urgent situations, the Veterans/Military Crisis Line at 800-273-8255 is available 24/7/365 and VA enrollment is not necessary to use this resource.

Assess and Plan for Post Traumatic Stress
Interventions
<ul style="list-style-type: none"> • During hospice initial and comprehensive assessments (preferably performed by a nurse or SW), pay attention to comments that could indicate symptoms of traumatic stress and plan to follow up with interventions and/or referrals as appropriate after trust is established.
<ul style="list-style-type: none"> • Identify on hospice plan of care potential symptoms of traumatic stress (e.g., reports of intrusive thoughts/ memories or triggering events) that may need follow up and/or special consideration from team members.
<ul style="list-style-type: none"> • After sufficient trust is established, ask permission to discuss symptoms of traumatic stress and to identify factors that might be contributing to them (including previous military assignments).
<ul style="list-style-type: none"> • If continued assessment/discussion indicates that there are symptoms of traumatic distress that are troubling, ask if he/she wants to speak to someone about them. If the answer is “yes,” make a referral to someone skilled in trauma, loss, grief, and forgiveness. Refrain from attempts to minimize guilt or distress; avoid platitudes such as: “You were just following orders”, “You were just doing what you were trained to do,” etc. <ul style="list-style-type: none"> ○ <i>*See Addendum below for a three-step approach to addressing PTSD symptoms.</i>
<ul style="list-style-type: none"> • Validate the helplessness they may be feeling as they are becoming more ill, experiencing various physical symptoms, losing control and losing their independence (recognize that helplessness may be acting as a trigger for the original helplessness felt during traumatic experiences).
<ul style="list-style-type: none"> • Invite conversation about the difficulty of feeling helpless, losing control and independence, facing changing routines, having less privacy, experiencing physical symptoms that may trigger traumatic stress (i.e., shortness of breath, diarrhea). Help patient and caregivers understand that traumatic stress can re-emerge as people age, develop illness and lose independence.
<ul style="list-style-type: none"> • Utilize accepted approaches for stabilizing symptoms of traumatic stress (e.g., patient-specific body-awareness and grounding techniques, mindfulness, visualization) provided by a trained and competent clinician (after thorough assessment does not contraindicate them) that helps them learn how to allow peace and helplessness sit side by side together.
<ul style="list-style-type: none"> • If patient becomes agitated and/or has a paradoxical reaction to anti-anxiety medications, assess for traumatic stress and post-traumatic stress syndrome (in addition to terminal restlessness). Participate in creating helpful interventions with other team members and document on the hospice plan of care. Monitor their effectiveness.
<ul style="list-style-type: none"> • Other Patient Specific:
Goals
<ul style="list-style-type: none"> • Create emotionally safe environment by reducing avoidable triggers, and utilize accepted approaches for stabilizing symptoms of traumatic stress (e.g., patient-specific body-awareness and grounding techniques, mindfulness, visualization) provided by a trained and competent clinician (after thorough assessment does not contraindicate them) to help them learn how to make peace with unavoidable triggers (helplessness, death, loss of control, etc.).
<ul style="list-style-type: none"> • Shorten the length of traumatic stress response episodes by using symptom stabilizing strategies appropriate for traumatic stress (e.g., grounding, mindfulness, visualization). Where possible, teach these to patient and caregivers to foster a sense of independence and control over symptoms.
<ul style="list-style-type: none"> • Other Patient Specific:

Planning and Assessing Pain and Other Symptoms
Interventions (Note – as indicated by clinical assessment)
<ul style="list-style-type: none"> Assess for severity and frequency of pain or other symptoms. Use a comparative approach. For example, if you assess that patient seems more/less uncomfortable than the last visit, ask if pain or symptoms are greater or worse than the last time you were there. Consider under/over reporting of pain. Query caregivers who may know the history of the patient in self-reporting of pain or other symptoms. Monitor for unintended emotional side effects of medications; i.e., sedation which may trigger feelings of helplessness and lack of control. Other Patient Specific:
Goals
<ul style="list-style-type: none"> Pain and symptoms will be properly assessed and interventions developed to alleviate discomfort for the patient. Other Patient Specific:
Moral Injury
Interventions:
<ul style="list-style-type: none"> Traumatic stress is difficult on relationships - inquire if it has impacted patient's relationships. If so, ask if he/she is interested in speaking with someone about this and make appropriate referrals as needed. Listen without judgement and do not diminish the strength of their feelings regarding the issue. In collaboration with other team members, develop a plan to address symptoms of traumatic stress and document on the hospice plan of care. <ul style="list-style-type: none"> <i>*See Addendum below for the Seven C's of the Stress First Aid Model.</i> For further information regarding Soul Injury and forgiveness techniques, please go to https://www.wehonorveterans.org/soul-injury-and-opus-peace-tools-deborah-grassman Other Patient Specific:
Goals
<ul style="list-style-type: none"> Patient will identify and participate in interventions designed to mitigate his/her traumatic stress symptoms. Where possible, involve caregivers in interventions. Other Patient Specific:
Military Rituals
Interventions
<ul style="list-style-type: none"> Identify any desired salutations (Sir, Acknowledge Rank) or preferences that these be avoided (some who have experienced moral injury do not wish to have their service recognized or honored). Identify desire for military funeral or flag draping (or other rituals). Ask about their desire for a pinning ceremony. Other Patient Specific:
Goals
<ul style="list-style-type: none"> Military rituals will be honored as per patient request/desire. Other Patient Specific:

Additional resources:

**Further resources regarding PTSD, Suicide Prevention, and Moral Injury can be found at www.wehonorveterans.org*

PTSD: if further help is needed refer to VA PTSD Consultation Program for Providers which includes experiences senior psychologists, psychiatrists, pharmacists, and other health professionals who treat Veterans with PTSD and are available to consult on everything from touch cases to general questions. Call (866) 948-7880 or consider telemental health visit by a VA Psychologist.

VA offers telehealth services across the U.S. — including via VA Video Connect app. **Veterans will need to be enrolled** to receive VA telehealth services which can be initiated online at the link below or by calling **877-222-VETS (8387)**. <https://www.va.gov/healthbenefits/online/>. Telemental Health Hubs connect mental health specialists with Veterans at sites who require same-day or urgent access to mental health services. www.telehealth.va.gov.

3-step Approach to address PTSD Symptoms

A useful approach to address PTSD in Hospice Care is the Stepwise Psychosocial Staged Model for Treating PTSD at the End of Life – A Patient Centered Approach. There are three stages to this model and treatment only moves on to the next stage if symptoms are not resolved and the Veteran would like additional treatment.

Stage I: Palliate immediate discomfort and provide social supports

Stage II: Enhance coping skills

Stage III: Treat specific trauma issues

Case Part 1: A hospice nurse went to complete the initial intake with a Veteran referred for home hospice. Upon arriving his wife shared with the nurse that he has battled chronic PTSD since returning from Vietnam and has difficulty trusting other people.

Stage 1: Stage one of the model aims to palliate immediate discomfort, provide social support and psychoeducation. Stage one targets what can be done in terms of the environment, relational, and related interventions that facilitate comfort. For example, in terms of environment the hospice team would want to help facilitate a relaxed environment that could be done with thoughtful scheduling of providers, not having an influx of providers in a short period of time. Engaging in relational techniques such as “ask” instead of “tell,” explaining purpose of visit and procedures, and remaining accountable would all help to build trust. Incorporating interventions into the care plan that provide psychoeducation and avoid triggering of symptoms are other ways to address care needs.

Case Part 2: As the hospice care team worked with the Veteran, he began having significant difficulty with increased anxiety upon waking early in the morning and finding himself alone. He had previously completed trauma treatment. The LCSW was able to review the coping skills he had previously learned during treatment and found helpful. He successfully incorporated relaxation and breathing exercises into his routine. His family was alerted to increase frequency checks to provide additional reassurance and comfort if they found him awake.

Stage 2: Interventions to Enhance Coping Skills

- Relaxation and breathing re-training
- Sleep apps
- Thought-stopping skills
- Mindfulness-based/acceptance skills
- Problem-solving interventions
- Communication/social-skills training
- Psychoeducation regarding coping skills for PTSD symptoms with patient and family

Case Part 3: *As his health declines, his symptoms appear to be worsening. He would like to engage in psychotherapy and at this point in his disease progression he is able to participate in individual sessions but would prefer telehealth.*

While many symptoms are successfully managed using techniques from the first two stages, if the Veteran desires further intervention, this is the point in the model that a hospice agency would refer to another provider trained in evidence based treatments for PTSD if they do not have one on staff.

Stage 3: Referral to Treat Specific Trauma Concerns

- Apply traditional recommended exposure-based methods if appropriate given prognosis and energy level.
- Telehealth options
- Modified EMDR – “On-the-spot”
- “Life-review-based” exposure approach
- Spiritually oriented psychotherapy
- Complementary and Alternative approaches

Sorocco and Bratkovich (2018); Feldman.B., Sorocco, Bratkovich (2014); Based on Hyer & Woods (1998)

Moral Injury: The Stress First Aid Model

Stress first aid is a model that was developed in military settings to help service members have better self-care and provide peer support to each other. It has applicability in hospice and palliative care settings with Veterans because the actions of stress for state are simple and very much tailored towards military culture.

Stress First Aid is based on research literature that says that people tend to do better when they feel safe are able to calm themselves, feel connected to others, feel like they can get through what they're having to deal with, or have a sense of hope.

Stress First Aid maps onto these five elements, and adds two more, check and coordinate because it is a long-term model that starts with assessing ourselves and others (check) and may require coordinating with others in order to access other resources and ensure progress or recovery:

- Check should be continuous, and it involves observing, paying attention, and checking in on people on a regular basis.
- Coordinate should also be continuous, and it involves always being aware of additional resources that you may need to refer to, if your SFA actions aren't sufficient to make a difference in alleviating stress reactions.
- Cover maps onto helping a person feel safer.
- Calm involves calming the person down or staying calm through an extended difficult experience.
- Connect involves helping a person feel a greater sense of connection to others, which may be peers, mentors, or family members. This is important because when people are stressed or responding to moral injury or PTSD, they often isolate themselves from others, and remove the possibility of social support, which of been shown to be very helpful in recovery from many types of stress.
- Competence involves helping a person feel more capable in a number of different ways, including feeling more capable to handle their own stress reactions, or feeling better able to function and recover from stressful situations.
- The last element is Confidence, which maps onto helping people have more hope or Confidence in themselves, life, or their spiritual beliefs or values. It can also sometimes involve helping reduce their sense of guilt or shame, or philosophical questions that arise as a result of the stressors in their life.
- This diagram makes it seem like these actions are sequential, but in actuality, Check and Coordinate are continuous, and the others are only used as needed.
- The goal of SFA is to move people towards wellness.

STRESS FIRST AID: Stages 1 and 2 in Stepped Care Model



Trauma Reactions and Symptoms

<p>Immediate Emotional Reactions</p> <ul style="list-style-type: none"> Numbness and detachment Anxiety or severe fear Guilt (including survivor guilt) Exhilaration as a result of surviving Anger Sadness Helplessness Feeling unreal; depersonalization (e.g., feeling as if you are watching yourself) Disorientation Feeling out of control Denial Constriction of feelings Feeling overwhelmed 	<p>Delayed Emotional Reactions</p> <ul style="list-style-type: none"> Irritability and/or hostility Depression Mood swings, instability Anxiety (e.g., phobia, generalized anxiety) Fear of trauma recurrence Grief reactions Shame Feelings of fragility and/or vulnerability Emotional detachment from anything that requires emotional reactions (e.g., significant and/or family relationships, conversations about self, discussion of traumatic events or reactions to them)
<p>Immediate Physical Reactions</p> <ul style="list-style-type: none"> Nausea and/or gastrointestinal distress Sweating or shivering Faintness Muscle tremors or uncontrollable shaking Elevated heartbeat, respiration, and blood pressure Extreme fatigue or exhaustion Greater startle responses Depersonalization 	<p>Delayed Physical Reactions</p> <ul style="list-style-type: none"> Sleep disturbances, nightmares Somatization (e.g., increased focus on and worry about body aches and pains) Appetite and digestive changes Lowered resistance to colds and infection Persistent fatigue Elevated cortisol levels Hyperarousal Long-term health effects including heart, liver, autoimmune, and chronic obstructive pulmonary disease
<p>Immediate Cognitive Reactions</p> <ul style="list-style-type: none"> Difficulty concentrating Rumination or racing thoughts (e.g., replaying the traumatic event over and over again) Distortion of time and space (e.g., traumatic event may be perceived as if it was happening in slow motion, or a few seconds can be perceived as minutes) Memory problems (e.g., not being able to recall important aspects of the trauma) Strong identification with victims 	<p>Delayed Cognitive Reactions</p> <ul style="list-style-type: none"> Intrusive memories or flashbacks Reactivation of previous traumatic events Self-blame Preoccupation with event Difficulty making decisions Magical thinking: belief that certain behaviors, including avoidant behavior, will protect against future trauma Belief that feelings or memories are dangerous Generalization of triggers (e.g., a person who

	<p>experiences a home invasion during the daytime may avoid being alone during the day) Suicidal thinking</p>
<p>Immediate Behavioral Reactions Startled reaction Restlessness Sleep and appetite disturbances Difficulty expressing oneself Argumentative behavior Increased use of alcohol, drugs, and tobacco Withdrawal and apathy Avoidant behaviors</p>	<p>Delayed Behavioral Reactions Avoidance of event reminders Social relationship disturbances Decreased activity level Engagement in high-risk behaviors Increased use of alcohol and drugs Withdrawal</p>
<p>Immediate Existential Reactions Intense use of prayer Restoration of faith in the goodness of others (e.g., receiving help from others) Loss of self-efficacy Despair about humanity, particularly if the event was intentional Immediate disruption of life assumptions (e.g., fairness, safety, goodness, predictability of life)</p>	<p>Delayed Existential Reactions Questioning (e.g., “Why me?”) Increased cynicism, disillusionment Increased self-confidence (e.g., “If I can survive this, I can survive anything”) Loss of purpose Renewed faith Hopelessness Reestablishing priorities Redefining meaning and importance of life Reworking life’s assumptions to accommodate the trauma (e.g., taking a self-defense class to reestablish a sense of safety)</p>
<p>Sources: Briere & Scott, 2006b; Foa, Stein, & McFarlane, 2006; Pietrzak, Goldstein, Southwick, & Grant, 2011.</p>	

Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS PublicationNo. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.