



VA



U.S. Department of Veterans Affairs

Veterans Health Administration
New Jersey Health Care System

Reaching Women Veterans:

Background Report &
Communications
Strategy



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Note:

This work is an academic exercise only. Quotes, figures, and data used in historical, contextual, statistical, or other representations of the US Department of Veterans Affairs or its Administrations are deliberative and unofficial unless otherwise expressly approved and authorized in writing and submitted as an addendum to this work. Any opinions stated herein are the authors only and may not accurately or completely reflect the positions of the Department or its Administrations. This work is not a record.

“To care for him who shall have borne the battle, and for his widow, and his orphan”

When the predecessor to the Veterans Administration, the National Home for Disabled Volunteer Soldiers, was first established, it had a single health-oriented mission. The mission was to house and care for the nation's war wounded after separation from the military. The standard for care at the time was not much more than to keep the public from peering too closely at the horrors of war, so regulations did little more than to define who would be granted access and for how long, and how far from public view these institutions would be placed. From the time right after the Civil War to directly after World War II, not much changed for veterans from a health care delivery perspective. It took the formal establishment of the Veterans Administration in 1946 to finally bring the need for complexity and an expansion of services to the forefront of the federal government. The first Administrator of the Veterans Administration, General Omar Bradley, was famously quoted in Congressional testimony in response to the nearly immediate backlog of claims for service and compensation as saying, *"It is about veterans, not procedures. Their problems, not ours."* His words are more influential today than ever before, as nearly 9.2 million veterans hope to decode and access their earned health benefits through the United States Department of Veterans Affairs (VA).



President Lincoln delivers his second inaugural address on the steps of the U.S. Capitol

[1] Department of Veterans Affairs, "Veterans Affairs," About VA, January 1, 2005, https://www.va.gov/ABOUT_VA/index.asp

[2] Department of Veterans Affairs, "About VHA," Veterans Health Administration, February 17, 2022, <https://www.va.gov/health/aboutvha.asp>

[3] Department of Veterans Affairs, "About NCA," National cemetery Administration, January 21, 2022, <https://www.cem.va.gov/about/index.asp>

[4] Department of Veterans Affairs, "VA Organization," Department of Veterans Affairs, December 28, 2021, https://www.va.gov/about_va/organizations.asp

"It's about veterans, not procedures. Their problems, not ours."

The stated mission of today's VA is to fulfill President Lincoln's promise, "To care for him who shall have borne the battle, and for his widow, and his orphan" by serving and honoring the men and women who are America's veterans.[1] VA carries out a range of primary functions directed through three administrations. The Veterans Health Administration (VHA) is the nation's only national healthcare system and serves approximately 9 million[2] veterans annually. The Veterans Benefits Administration (VBA) helps servicemembers transition out of military service and assists with education, home loans, life insurance, disability compensation, and pension. The National Cemetery Administration (NCA) provides dignified burial services for Veterans and eligible family members by maintaining more than 150 cemeteries[3]. VA's Central Office houses the functions of departmental-level executive leadership and 24 staff offices[4] not otherwise associated with an administration.



General Omar N. Bradley, First
Administrator of Veterans Affairs

[1] Department of Veterans Affairs, "Veterans Affairs," About VA, January 1, 2005, https://www.va.gov/ABOUT_VA/index.asp
[2] Department of Veterans Affairs, "About VHA," Veterans Health Administration, February 17, 2022, <https://www.va.gov/health/aboutvha.asp>
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Simplified Department Organization Focusing on VHA



VA Central Office

Veterans Benefits Administration

Veterans Health Administration

National Cemetery Administration

Veterans Integrated Service Network (VISN)

VA Medical Center

Community Based Outpatient Clinic

ORGANIZATION OVERVIEW



US Department of Veterans Affairs

VA New Jersey Health Care System

VA



U.S. Department of Veterans Affairs

Veterans Health Administration
New Jersey Health Care System

East Orange VA
Medical Center

Lyons Ambulatory
Care Center

Community
Based
Outpatient Clinic
(x9)

VA New Jersey Healthcare System (VANJHCS) is an entity of the Veterans Health Administration. VANJHCS provides comprehensive health care services at 11 locations in New Jersey. Facilities include medical centers in East Orange and Lyons and nine community-based outpatient clinics located throughout northern New Jersey. VANJHCS is one of nine healthcare systems in VHA's Veterans Integrated Service Network (VISN) Two, the New York/New Jersey VA Healthcare Network (VISN 2). **VANJHCS serves approximately 50,000 veterans each year, of which approximately 4,000 identify as women veterans.** The total medical care budget of VANJHCS is approximately \$625 million per year.[5]

VANJHCS serves veterans, their eligible dependents, and certain others under humanitarian assistance by completing approximately 100,000 clinical interactions each year. Nearly 10,000 benefit patients listed in their confidential health records as female or seeking gender-specific care for women[6] in these clinical interactions.



US Department of Veterans Affairs

Recognizing and understanding the weight of criticality placed on VANJHCS in redefining the standards it communicates with women veterans is a foundational aspect of this communications improvement plan. Without fully understanding the disconnect between female veterans and the VA system, we cannot arrive at a point where any attempt at improvement is meaningful and beneficial for all parties.

With this in mind, it is essential to understand how care is paid for through VHA. The current budgeting system will not be sufficient to address the needs of women veterans and an aging population, the ballooning costs of operating a national health care system, and delivering world-class care to millions of people in the coming years.

Having an adequate and ready workforce to care for women veterans at VA coincides with budgeting, because a well-functioning health care system should not allow provider staffing levels to lag behind patient census numbers. We know that the number of women joining the military is increasing, so it should be expected that the number of women who become veterans and seek services through VA will also increase.

Although women are projected to make up more of the veteran population each year, the total number of veterans in the US is declining. With fewer living veterans accessing services, the cost of services must go up, or the services must be ended. Neither is a palatable option for politicians, but the other alternatives are to put more money into the system or streamline and modernize the portfolio of VHA properties completely.



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Funding and staffing needs are two critical areas where, unless more women veterans use VA, we won't have the resources to treat them later. Communication now is critical.

Since the US Department of Veterans Affairs is a public entity, most of its funding is derived from the federal budget allocation process. Every budget cycle, the administration tallies the costs for providing care to our nation's veterans and others. It then uses a complex set of legal and fiscal rules to project future needs.

Two of the tools that VHA provides for measuring need and allocating costs are the Clinical Complexity Indexing Model (CCI)[1] and the Veterans Equitable Resource Allocation (VERA) Model[2]. Those not the exclusive drivers for crafting the penultimate cost of care at VHA, they are two of the most influential ones.

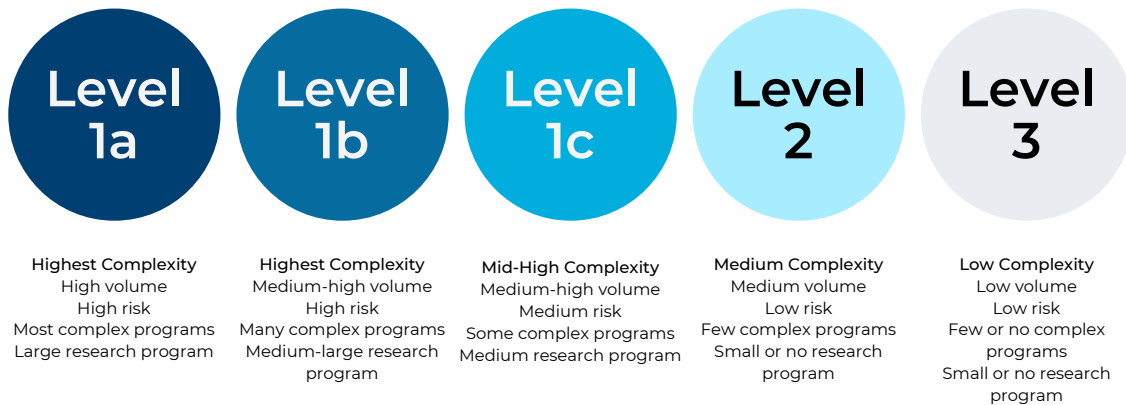
Veterans Equitable Resource Allocation (VERA) Model

VERA does not currently consider essential characteristics of health care cost budgeting. The model does not account for foundational demographic aspects such as age and gender. The rurality of a VA medical center or a veteran's home choosing to access that medical center or not adequately accounted for either. Because of this, women may not get the adequate services they are entitled to through VA if the current budgeting system remains unchanged in the coming years.

Clinical Complexity Indexing (CCI) Model

The existence of the Clinical Complexity Index model in its current form and its use at VHA to influence clinical staffing directly impact the ability of VAMCs to deliver the volume of care needed to sustain funding under the VERA model. This is a critical deficiency because the VERA model makes it difficult for all but the most complex and newest facilities, which serve Veterans with the most need, to receive adequate funding to sustain operations in increasingly costly facilities and with inadequate staffing.

Clinical Complexity Indexing (CCI) Model



PROBLEM STATEMENT

Access to health services at VA has become increasingly fractured and unequally accessible across the veteran population over the decades. We understand this to be accurate, as evidenced by the following premises. First, VA describes each VA Medical Center (VAMC) using a Clinical Complexity Indexing model⁷.

The Clinical Complexity Index classifies VA facilities into five levels, 1a, 1b, 1c, 2, and 3, with the most clinically complex facilities receiving a 1a designation. The model has a multifaceted use within the administration. Primarily, it provides peer grouping of facilities based on their clinical complexity. It is also a significant factor in the administration's Nursing Staffing Model^[1]. **Notably, the model strongly impacts yearly funding from the Network (regional groups of VAMCs) level to the VAMC level because patient flow through facilities is directly tied to clinical staffing.** Noting the budgetary inefficiencies experienced by VAMCs through this direct allocation model, VA sought to improve the equitability of resources across Networks and VAMCs.

Because of these reasons, The Clinical Complexity Index rating of a facility is a fair but not complete predictor of future budget allocations. We expect facilities with higher complexity ratings also to have more clinical staffing and, therefore, a theoretically higher patient flow. This supposition is not always accurate.

The CCI Model bottom line

- Strongly influences the Nursing Staffing Model
 - Impacts funding from the VISN
- More Staffing = More Patient Flow
 - Volume of clinical interactions is top criterion for CCI benchmarking
- Leads to inequitable allocation of resources



VERA is an add-on budgeting model to ensure budgetary allotments go to legally defined populations first.

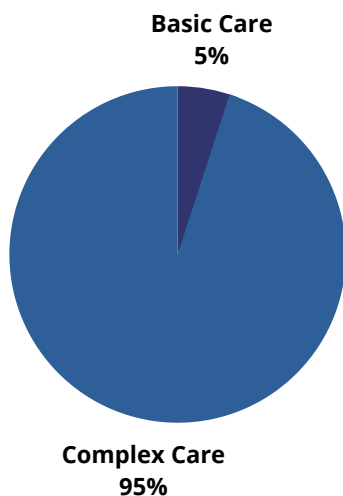
The Veterans Equitable Resource Allocation (VERA) model was implemented in 1997 to ensure VA Medical Centers are allocated the budgetary allotments needed to support the number of patients seen in the facility during the previous two-year VERA cycle. VERA is designed to ensure that regional and facility-level spending is allocated primarily to Veterans whose disabilities or conditions are connected to their service and those with exceptional health care needs. The primary reason for this is to ensure the Veterans Health Administration meets its legal mandate to provide cost-free and comprehensive health services to Veterans who sustained injuries or incurred illnesses while serving in the military.

The model does acknowledge the changing geographic locations of veterans over time. In this way, the dollars follow veterans. For example, suppose a veteran who receives care at a VAMC in New England for nine months out of the year decides to live in a sunny southern state in the winter and receives her care at a VAMC in the south. In that case, the VERA allocation for that veteran will be split 75/25 between those two facilities.

PROBLEM STATEMENT

VERA Case-Mix

Cost of Care

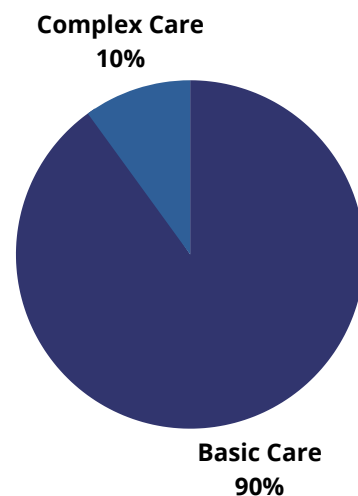


Vesting is an expression of a Veterans usage of a Medical Center during the previous VERA Cycle

Seeing Non-Vested Veterans draws from VERA Funding

Seeing Vested Veterans Sustains VERA funding

Type of Care



Veterans Equitable Resource Allocation (VERA) Model

The specific VERA allocations are decided based on the "case-mix" at a VAMC. A case-mix is a grouping of three VERA-defined sickness categories—Basic Care Vested, Basic Care Non-Vested, and Complex Care. Basic Care patients account for nearly 95% of patient flow through any given VAMC per VERA cycle, and their care is "worth" less than a veteran in need of Complex Care by a factor of nearly 10. Vesting for Basic Care patients expresses their usage of a medical center during a previous VERA cycle. Bluntly, seeing vested patients sustains VERA funding. Seeing non-vested or occasional-use patients is a drain on VERA funding.

VERA is a model administered and predicated on the notion that VA's Congressional budget allocation from year to year is a fixed sum. This fixed sum budgeting means that an increase in one region's funding through the model must, by design, decrease the funding allocation to a region with less apparent need.

The current VERA model does not consider some of the significant influences with which a facility struggles. First, we know that basic demographics, such as age and gender, independently affect patient care costs[1]. The Current VERA model does not differentiate allocations based on gender or age demographics. Next, we understand that Veterans who live in urban and suburban areas use more resources than those in rural areas. At the same time, costs are higher for those veterans who must travel long distances for care. VERA allocations make no distinction between the geographic location or the incurred costs of a patient. This distinction is significant since many Service-Connected Disabled Veterans are entitled to receive compensatory payment for their travel to and from VA medical appointments.

In addition to unaccounted-for patient-centered factors, most facilities must also contend with their physical infrastructure characteristics—including the age of their buildings, the historical significance of their sites, and the average physical condition of their structures. The budget of a VAMC includes both mandatory and discretionary spending, along with occasional monies for capital improvements. VERA allocations make no allowance for an aging facility requiring significant capital improvements year after year. As a VAMC draws more discretionary funding into capital improvements, less funding is left to supplement staffing or provide better clinical resources, not supporting veterans' better access to care.

Veterans Equitable Resource Allocation (VERA) Model

PROBLEM STATEMENT

Lastly, it is essential to note that every VAMC is a teaching facility. Every facility is linked to at least one clinical affiliate university in their geographic region. Training medical personnel impacts costs at facilities and thus patient flow through facilities in two ways. It has been shown[2] that a facility with a higher resident to physician ratio has a lower overall cost for care. Additionally, it has been shown⁸ that the intensity of research at a VAMC is directly and positively correlated with facility costs. Though thought to be positively correlated with costs, these two fundamental characteristics of every VA facility are not considered in the present VERA model. This means that facilities with large research offices or teaching rotations will generally have lower patient costs. That difference ultimately affects VAMCs, which cannot benefit from strong academic affiliations because of their geographic location, the needs of the institution, or any other mitigating factors.

Practical example: VERA

VA VISN 8 happens to cover Florida, Georgia, and the Caribbean. Their patient census is growing. New patients are vested by default. Next VERA cycle, they will see an increased budget to care for those new patients. VA uses fixed-sum budgeting though, so where did that money come from?

That money came from underperforming VISNs like VISN 2 and VISN 16, leaving them with less funding to treat their patients. VERA makes budget dollars follow Veterans. If a Veteran spends 9 months in New Jersey and 3 months in Florida each year, those two VISNs will split that Veteran's VERA allocation 75/25.

The only budgetary differences that are made are those in the current Case-Mix, Basic Care or Complex Care. This matters because VERA does not take basic patient health demographics into account and some patients will objectively cost more to treat than others.

VERA doesn't take gender-specific care into consideration

VERA doesn't take age-related into consideration

VERA doesn't take ethnicity into consideration

Additional contributory factors to budgeting



US Department of Veterans Affairs



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PROBLEM STATEMENT

VA Medical Centers are mandated to provide care to service-connected veterans who choose to access care through VA and cannot bill for those services[1]. This includes billing to third parties like private insurance, government-sponsored insurance like the Department of Defense TriCare program, or other government programs like Medicare or Medicaid.

It should be noted that VA sees many more patients than just service-connect disabled veterans. For one, the VA Disability Rating System allows for disabilities from 0% to 100%. In this way, a Veteran who is 20% disabled may only account for a 20% allocation of VERA funding since the allotments are designed to help VA reach its legally defined populations. That 20% service-connected veteran is allowed to access the full range of health services through VA, not only the services related to their condition.

VA is allowed to charge for non-service-connected care. The Veterans Health Administration uses various rates, including the Medicare and VHA billing models, when billing private insurance for care at a VA facility. VHA also charges co-pays to Veterans for billable services. These billing tools are in place to fill the gaps between VERA and the actual cost of caring for Veterans at VA.

It is little known that the Veterans Health Administration functions as the nation's emergency health care system in times of national crisis. This "Fourth Mission"[2] also helps to bolster budgets from time to time. For example, during the Coronavirus pandemic in 2020, VA facilities nationwide received the sickest civilian patients from overflowed hospitals. The funding to care for these patients came mainly through the CARES Act and the Federal Emergency Management Agency (FEMA)[3]. Though not consistent, this funding often relieves the pressure on VAMCs in underutilized locations to provide monies for staffing and other needed obligations, such as capital improvements.

Why this system matters for women



MilitaryTimes.com



US Department of Veterans Affairs

PROBLEM STATEMENT

Anecdotally, most VA medical campuses are many decades old at this point, and some are even on the National Register of Historic Places, which complicates their upkeep costs. At the same time these campuses were being built, the aim of healthcare in the US was institutionalization. Unfortunately for the government, the past 40 years have seen a nearly complete reversal of the medical model and the persistence of a new, decentralized, community-based wellness model.

The existence of the Clinical Complexity Index model in its current form and its use at VHA to influence clinical staffing directly impact the ability of VAMCs to deliver the volume of care needed to sustain funding under the VERA model. This is a critical deficiency because the VERA model makes it difficult for all but the most complex and newest facilities, which serve Veterans with the most need, to receive adequate funding to sustain operations in increasingly costly facilities and with inadequate staffing.

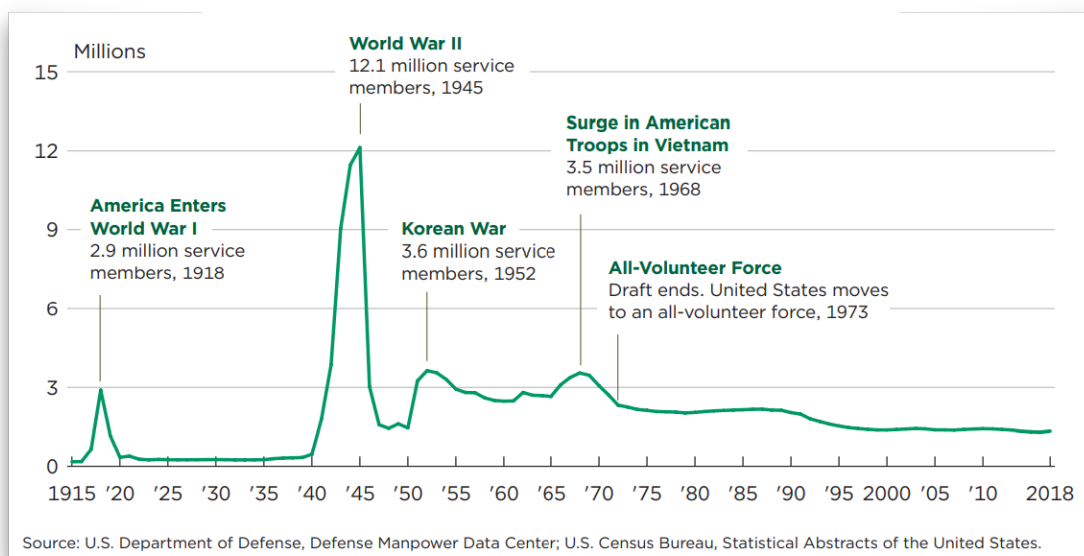
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Declining Patient Census

The Veterans Health Administration is more than 75 years old, and some of its flagship facilities predate the Administration itself. The need for a robust and standardized system of healthcare facilities to house and treat America's war veterans has existed since the Civil War, though the formal establishment of the Veterans Administration, now known as the Veterans Health Administration, would not take place until after World War II.

Conscription to military service through the US Selective Service System was formalized in 1917[1], as the US entered World War I. It remained that way until 1973, when the United States moved to an all-volunteer military. The US entered four periods of war between 1917 and 1973, and more than 22 million[2] men were drafted during that time. A large number of servicemembers and the increasingly efficient practice of battlefield medicine meant that many more people were coming home from war in need of ongoing healthcare than before. A decades-long surge in infrastructure development to accommodate this need created the VHA system we know today.

PROBLEM STATEMENT



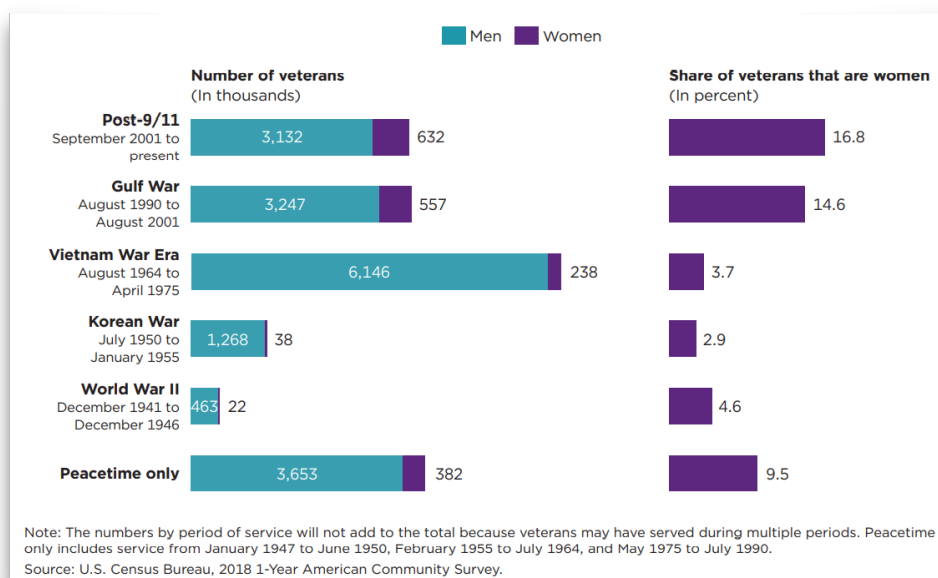
A Century of Serving

Size of the U.S. Armed Forces Since 1915

Declining Patient Census

Since 1973, the number of people serving in the military has slowly declined (Figure 1). There are many reasons for this, including the increasing pace of technology which precludes direct human involvement on the battlefield, and the broad scale of physical conflict being much smaller in recent decades than previously fought. This is becoming an increasingly complex concern for VHA because it remains the most extensive integrated health care system in the United States². It provides care at 1,293 health care facilities, including 171 VA Medical Centers and 1,112 outpatient sites of care of varying complexity (VHA outpatient clinics). With a budget of approximately \$68 billion annually, a workforce of more than 367,200 people, 120,000 health professions trainees, 16,000 affiliated medical faculty, and 46,000 active volunteers, the slow decline in patient volume through VHA facilities is worrisome for the future of the publicly funded system.

PROBLEM STATEMENT



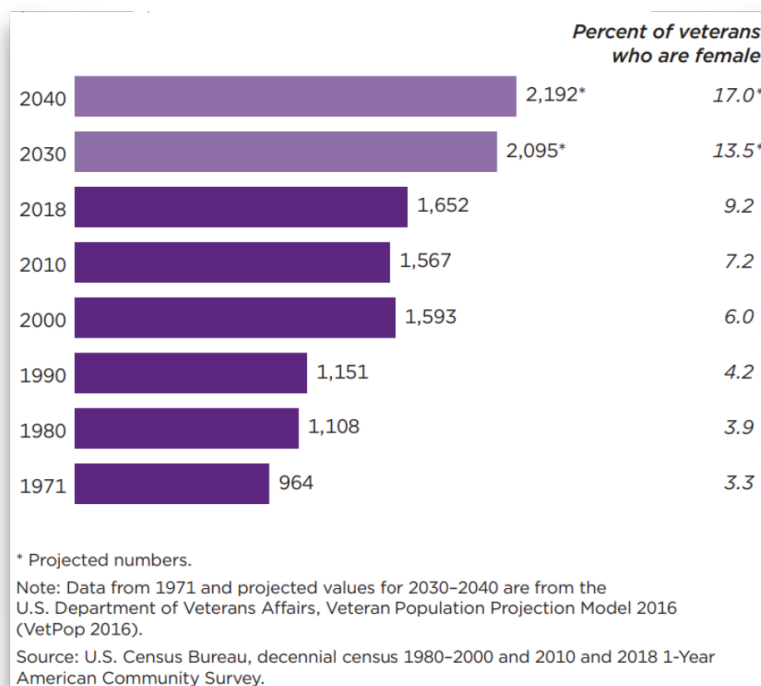
Those Who Served
Percentage of Female Veterans in 2018 by Period of Service

Declining Patient Census

PROBLEM STATEMENT

Women formally became a part of the military in 1901 when the Army Nurse Corps was created. Although they could not be drafted into service, approximately 298,000 women volunteered to serve between 1941 and 19758. Those brave women comprised nearly 3.6% of the total US Armed Forces during the first 34 years while the Veterans Administration was established in earnest. That percentage slowly increases each year (Figures 2 & 3.). It would be decades before women veterans would be afforded the same opportunities as their brothers-in-arms had been beginning during the civil war period. Some still struggle to receive adequate healthcare services from the Department of Veterans Affairs. Even today, the services for women veterans are not complete, and worry-free access to primary gender-specific care is fragmented in many places. The Veterans Health Administration has made many strides in recent years to better integrate care for women into the complete offerings throughout VHA facilities which include establishing a Women Veterans Health Program in every VA Medical Center, ensuring basic dignity with proactive anti-harassment campaigns, and emboldening women to seek care for services related to Military Sexual Trauma and Intimate Partner Violence.

VA is aware that the trend of women veterans comprising a significant percentage of the overall veteran population each year will not slow for many years to come. There are many ways to approach the oncoming change, including modernization and improvements to nearly every aspect of women's experience when choosing VA for healthcare.



Rise of Female Veterans

*Historical and Projected Trends of Female veterans
(In thousands)*

Poor record of communication with women

Since at least 2017, various community-led initiatives have highlighted a perceived inadequacy of services for women veterans through VA New Jersey Health Care System. Though the services provided at and through VANJHCS for women veterans meet current VHA guidelines, various grassroots organizations have pressured healthcare system leadership to provide a broader range of services to meet the population's needs. The issue has gained the attention of the VA Central Office and various Congressional offices. [On both sides, the efforts to meet the needs of women veterans are slow to produce much change without increasing the number of women veterans who use the services of VANJHCS.](#)

Women veterans describe gender-specific services as inadequate.

Both US Senators and five Congressional Representatives from districts in NJ have made formal inquiries into the lack of gender-specific care at VANJHCS facilities after complaints levied by constituents reached their offices. Women veterans consistently voice their concerns about not having mammogram services in-house, not being able to see a female provider when requested, not being afforded the same flexibility to get care throughout the system as their male peers, and about continued harassment by patients and staff in VA medical centers and clinics.

Many of the specialties and modalities of women-specific care are outsourced through VA Community Care, a cumbersome process in which veterans can receive care in the community and have VA pay the provider directly. Women consistently complain that VA Community Care is inadequate and inflexible and that they are billed for services when public law expressly prohibits that from happening.

Women Veterans repeatedly ask for more consistency and clarity in communication with VANJHCS.

I serve as Community Outreach Program Coordinator at VANJHCS and have frequent contact with key stakeholders in the women veterans' space in northern New Jersey. In the past four years, I have completed nearly 700 events in the community, approximately 140 of them focused in part or whole on women veterans. Until recently, I have rarely heard a woman veteran who accesses care at VANJHCS say something positive about the experience.

Poor record of communication with women

One of the consistent and widely-held complaints I hear is that the process to access care is too complex and ambiguous or that they were given wrong information about the same. Frequently, I hear these complaints as they are levied at me during a public event of some kind. Some of the most impactful statements made to me by women who chose to access VA care through VANJHCS have been:

— “

“I’d rather [expletive] die than go back to that place.”

Veteran JC, in reference to East Orange VA Medical Center

“I got the bill. I was told not to pay it. You didn’t either and it ruined my credit.”

Veteran KB, in reference to her experience with VA Community Care for mammography services

“Every time I go, I get catcalled walking to my appointment. Then I have to explain that I am the veteran, and I am not there with my husband.”

Veteran LU, in reference to East Orange VA Medical Center

“Why would I schedule another appointment there? It’s just going to be canceled anyway, right?”

Veteran ET, in reference to the Jersey City Community Based Outpatient Clinic

— ” —

There is no single formal communication strategy in place at VANJHCS for the consistent distribution of information to patients. Multiple official and unofficial sources exist, but patients cannot rely on them as the single source for all current information originating from VANJHCS. Products like My HealtheVet, VA’s online patient portal, are capable of this, but inadequate staffing and administration-level policy restrictions prevent the platform from being used in this way. The VANJHCS internet site (www.va.gov/new-jersey-health-care) is the official platform for information from the health care system, but staffing levels do not make consistently updating it feasible. The health care system has more than 20 individual services and multiple programs, offices, and other functions that would need near-constant work to keep a whole architecture of pages to date. Social media is used for some information streams, but not everything is appropriate for the fleeting nature of interactions through that modality.

Poor record of communication with women

Women veterans have described actions not taken by VANJHCS as untrustworthy.

In mid-2018, a group of local advocates lobbied for a meeting with the Executive Medical Center Director (MCD) at the time, and the request was granted. During that meeting, the MCD made three promises to the group.

VANJHCS would pursue the establishment of a Women Veterans Clinic in Secaucus.

VANJHCS would ensure the establishment of a women-only entrance at the East Orange VA Medical Center and the Lyons Campus.

VANJHCS would purchase a mammography machine and provide the appropriate staffing.

PROBLEM STATEMENT

Although the MCD is a member of the Senior Executive Service of the Federal Government, he does not have unilateral authority to enter into contracts for new facilities without involving the appropriate federal contracting entities and allowing due process for the same, and making appropriate requests through VISN 2 and VHA leadership. Although he has complete control over the administration of the facilities under his authority, there are various reasons why an entrance specifically for women is not feasible, including the local fire code, compliance with the Americans with Disabilities Act, and the look of preferential treatment of one group over another. Although he has control over his capital expenditures, he cannot provide for the purchase of equipment without also providing staffing for it. In addition, the location of the mammography machine would likely have been controversial as it would have been placed in the East Orange Medical Center, causing women veterans from the furthest areas of the VANJHCS catchment area to have to travel more than 40 miles for an appointment.

The Executive Medical Director could not deliver on any of the three promises he made during that meeting and subsequently declined any further meeting with the group, including the key women veterans advocates who remain bitter about the interaction.

Scope of this project

In order to leverage the consistent and meaningful input from our women veterans, and to assure them that they are heard at VANJHCS, I have developed the following Communications Improvement Plan. This plan provides a framework from which the community and key members of the Health Care System can remain accountable, build lasting partnerships and improve the communications with women veterans in general.

The Communications Improvement Plan for reaching Women Veterans at VA New Jersey Healthcare System creates a two-phased, novel plan to strengthen women veterans' connection with VANJHCS. It ultimately seeks to increase usage of resources, improve public sentiment towards VA programs and services, and help to expand the available array of services to women veterans based on increased usage.

The broad aspects of the plan are to:

Establish and maintain an open, two-way communication path between women veterans and VANJHCS.

Identify key community leaders and organizations to lead the community communications efforts with VANJHCS participation.

Recognize and confirm the community-supported messaging formats used primarily during this scope of work.

Evaluate the results of the communication efforts and make changes accordingly as time progresses.

Improve trust in VANJHCS, increase enrollment of women veterans at VANJHCS, and encourage usage of services through VA.



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Evaluation through direct feedback

Constant Communication Model.

This communications model was designed through a collaborative effort between the VANJHCS Women Veterans Program Manager, Public Affairs staff, Associate Director and Women's Executive Champion, and key women veteran members of the community. It is comprised of three main aspects and is designed to be perpetual. Every three months, a complete cycle of the model takes place, which consists of three focus groups for VANJHCS patients and a town hall open to the public at large. A debriefing session is held with vital VANJHCS staff between each focus group to discuss new issues, progress on outstanding issues, and development of trends. A confidential and anonymous digital issue tracker is used to record progress between focus groups and grade the urgency, scope, and resolution of the issue in real-time.



This communications model was designed through a collaborative effort between the VANJHCS Women Veterans Program Manager, Public Affairs staff, Associate Director and Women's Executive Champion, and key women veteran members of the community. It is comprised of three main aspects and is designed to be perpetual. Every three months, a complete cycle of the model takes place (Figure 4.), which consists of three focus groups for VANJHCS patients and a town hall open to the public at large. A debriefing session is held with vital VANJHCS staff between each focus group to discuss new issues, progress on outstanding issues, and development of trends. A confidential and anonymous digital issue tracker is used to record progress between focus groups and grade the urgency, scope, and resolution of the issue in real-time.

Evaluation through direct feedback

Women's Health Focus Groups.

Each month, all women veterans who get their care through VANJHCS are invited to participate in a structured focus group conducted by the Women Veterans Program Manager and a licensed mental health provider. The attendance at the focus group is confidential, and no responses are associated with an individual veteran. These focus groups are mandated through VHA quarterly, though VANJHCS has piloted the monthly offerings as a gesture of good faith in better communication. The focus groups are virtual and meet for one hour. They have been offered during and after working hours to accommodate most patients. The prompting questions are inconsistent between groups, though three main themes are always present.

First, a question regarding access to care is posed to the group. Questions like, *"In the past 30 days have you been able to schedule and keep all of your women's health appointments at VANJHCS?"* or *"In the past 30 days have you had any trouble accessing care at a VANJHCS facility?"* are usually asked.

Next, a question regarding billing or VA Community Care is asked. Questions like, *"In the past 30 days have you received a bill from VA or because of VA Community Care that you were not expecting?"* or *"In the past 30 days have you needed to contact our billing or Community Care offices about something to do with Women's Health at VANJHCS?"* are asked to the group

Finally, a mandatory question about harassment in VA facilities is asked by the facilitator. It is always the same. *"Have you ever witnessed or been physically, verbally, or sexually harassed by a patient, an employee, or anyone else, at a VANJHCS facility?"* This question is explicitly asked to satisfy a VHA mandate and understand any longevity in harassment at VANJHCS facilities.

As of April 2022, VANJHCS has held six monthly Women's Health Focus Groups, and 12 women have participated, some multiple times. Thirteen issues have been tracked through the Women Veteran Program Issue Tracker. Five were labeled with Critical Priority (solution needed now) and two with High Priority (solution needed within 30 days). There are long-term solutions for eight of the issues, four have temporary holds in place, and one is awaiting more information to proceed—the average time for an issue to solve is six days.

Evaluation through direct feedback

Quarterly Women Veteran Town Halls.

VANJHCS has held one quarterly Women Veteran Town Hall to date. It was a virtual event attended live by 16 people, not including employees. Since the event was recorded, it was edited for confidentiality and shared on social media. It has generated 257 views on Facebook since March 22, 2022. Seventy-nine of the views lasted longer than 3 minutes, indicating that the viewer showed genuine interest in the content.

The final 15 minutes of the town hall were devoted to reporting on progress from the anonymized issues to the public and then taking questions from the attendees directly. A total of 3 questions were asked by attendees, all of which needed to be edited out of the recording because the attendee shared graphic personal information. Health Care System leadership responded empathetically and honestly to each question and then offered to follow up with the attendee directly after the event. The next business day, they all did so, and the concerns were resolved.



Evaluation through direct feedback

Women Veteran Program Issue Tracker.

The need for a collaborative platform to track issues being worked on through Women's Health has been longstanding. Considering this, I developed a light touch workflow to log quickly, grade, and track an issue to a resolution for a small team using available digital resources.

The Issue Tracker uses a Microsoft Forms form to collect responses from the Women Veteran Program Manager. Microsoft PowerAutomate then runs a flow to get the response details from the form and post them to a secure Microsoft SharePoint List site submission of the form and, if the item is logged with critical priority, uses Microsoft Outlook to send an email to the Associate Director and Women's Health Executive Champion, the Women's Health Director, and the Community Outreach Coordinator with an urgent tag and a link to view the item on the SharePoint List.

The list collects items so they can be collaborated on by tagging any VANJHCS employee in the Comments section of the item, which sends an email alert to the employee. This workflow increases cooperation and expedites the resolution of the issue. In addition, the list can be exported to Microsoft Excel for data trending.

Issue	Issue description	Priority	Status	Responsible Entity	Date reported	Running Notes	Issue Category
Issue #1		Critical: Now	Long-Term Solution Needed	Chief of Urology	3/16/2022	Notes	
Issue #2		Critical: Now	Resolved	Chief of Neurology Nurse Manager	2/17/2022	Notes	
Issue #3		High: Within...	More Information Needed	ACOS primary care	1/20/2022	Notes	
Issue #4		Normal: ASAP	Long-Term Solution Needed	WVPM PAO	1/20/2022	Notes	
Issue #5		Critical: Now	Long-Term Solution Needed	MAS Chief	1/20/2022	Notes	
Issue #6		Normal: ASAP	Long-Term Solution Needed	MAS	12/16/2021	Notes	
Issue #7		Normal: ASAP	Long-Term Solution Needed	Chief of Community Care /Business Office Facility Leadership	12/16/2021	Notes	
Issue #8		Normal: ASAP	Resolved	PM&RS supervisor EO	11/30/2021	Notes	

The Community Messaging Structure

The idea that the community should co-lead a series of efforts to strengthen trust and understanding of VA programs and services is a critical component to the success of this communications plan. Anecdotally, public sentiment surrounding women's health at VANJHCS is not favorable. Some of the stakeholders' stated rationale for the distrust is poor communication with the community from VANJHCS. One community member recently shared the following frustration via email to health care system leadership:

— “ —

“...This is ridiculous. How many times are you going to lie to us? First, it was a separate entrance, then the mammography services, now a clinic. Enough is enough. Stop telling us that you're going to do something and then not do it. People avoid this place like the plague. You know that, right? Why do you think that is? It's because we get treated like second-class citizens! You should be [expletive] ashamed of yourselves!”

Veteran HW, regarding the services for women at VANJHCS.

— ” —

Noting this negative sentiment, VANJHCS works proactively with key stakeholder organizations to join their initiatives to rally women veterans, hear their concerns, and communicate progress towards resolution of the same openly. The sample Community Messaging Structure will propose multiple channels for ideal VANJHCS participation. Each messaging campaign or event will need to be coordinated closely with the community key stakeholders' group for maximum benefit. It is imperative that the community co-lead these efforts and that VANJHCS staff are supportive, honest, and straightforward throughout the scope of this work. Some of the proposed community-led messaging will include:

Coordinated media & social media campaigns

COMMUNITY MESSAGING STRUCTURE

Through ongoing consultation with the community, it is agreed that VANJHCS has the most comprehensive platform and farthest reach for writing press releases and feature stories. The healthcare system has 46,000 subscribers via its GovDelivery e-newsletter service. VANJHCS has an internal secure messaging platform called My HealthVet, available to all 50,000 currently enrolled veterans, though usage rates are somewhat lower. The healthcare system maintains working relationships with each Congressional Office, State Assembly Office, State Senate Office, and critical federal, state, and county-level departments and organizations within its area of responsibility. In addition, VANJHCS is well known to local, regional, and national Veterans Service Organizations (VSOs). These invaluable connections are leveraged to amplify messaging.

VANJHCS maintains an indexed and searchable public-facing website within the VA.gov architecture (va.gov/new-jersey-health-care) and uses the platform to promote events, publish feature stories, and post press releases for public consumption. Real-time Google Analytics data assists with determining which types of interactions do well. Stakeholders are actively encouraged to interact with releases and stories once published.

Including the community in official VANJHCS messaging efforts is a critical component of this communications plan. Reporting from internal surveying tools (V-Signals and Survey of Healthcare Experience of Patients) consistently identify trust and clear communication as areas of concern in the community. VANJHCS staff work with community stakeholders to jointly prepare statements of support for various VA initiatives highlighting historically women veteran-centric issues. With community support, VANJHCS seeks to undertake: Intimate Partner Violence awareness and education campaigns; Military Sexual Assault awareness and education campaigns; Anti-Harassment awareness and education campaigns; Awareness of gender-specific illnesses; Awareness of LGBTQ+ issues and resources; and other campaigns as applicable and time allows.

Coordinated media & social media campaigns

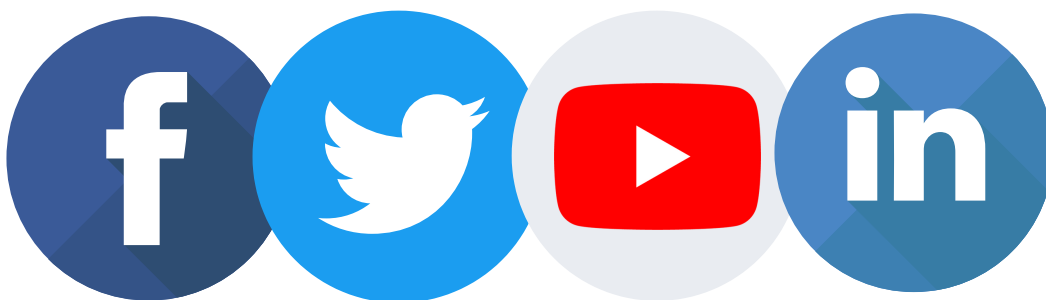
Social Media: Facebook, Twitter, LinkedIn, and YouTube.

In addition, the healthcare system maintains an official Facebook page and Twitter feed (@vanjhcs) with low follower counts. Approximately 3500 people follow each page through the number of impressions and interactions on Facebook and Twitter has grown steadily in the past year with increased presence.

Facebook content reflects current programming at VANJHCS. Staff consistently post significant initiatives that have historically involved a large audience of women veterans using posts, events, and tags. Twitter content will be short-form and identical primarily to Facebook content for consistency. Staff consistently post significant initiatives that have historically involved many women veterans using tweets, re-tweets, mentions, and hashtags.

LinkedIn content is personalized and professionally focused. There is no organizational LinkedIn account for VANJHCS, so key staff from VANJHCS post and share curated content. Most content includes a link to va.gov, nationally identified VA hashtags and direct mentions of community stakeholders. All posts on LinkedIn are reflective of a successful collaboration with the community. The goal is to support the professional identities of the community in their support of VANJHCS women veteran initiatives.

Posting YouTube content is aspirational only. VA Central Office restricts YouTube accounts for medical center-level public affairs in favor of higher-level administration and departmental-focused content. Any community event in which VANJHCS is participating can be recorded and posted to community curated YouTube accounts without further approval from VA. VANJHCS will support this with offers to edit and caption raw recordings appropriately.



Collaborative event programming

Community-led discussions with VANJHCS staff.

During March, VANJHCS staff partnered with Rutgers University's Office of Military and Veterans Programs and Services to host a round table discussion with their military-affiliated female students. VANJHCS Executive Leadership and attended the discussion. The discussion focused on common concerns surrounding access to care at VA and a deeper discussion about the future of VA Healthcare for women veterans.

During June, VANJHCS will partner with the New Jersey Department of Military and Veterans Affairs, the YWCA, Cornerstone Family Programs: Operation Sisterhood, the Pink Berets, Claymore Vets, and various VSOs to conduct a guided panel discussion on women veteran-specific concerns at VANJHCS. A member of the community will moderate the event.

Community-led Congressional site visits and panel discussions.

The Congressional delegation in northern New Jersey supports expanding health services for women veterans. Their constituents know this and use it to add pressure to health care system leadership. The relationship between VANJHCS and most Congressional delegation members has been contentious in recent years. An opportunity to realign with key delegation members, and their constituents, has presented itself with the recent changes to the executive leadership team.

An open invitation to all delegation members is always available. VANJHCS is proactively seeking to meet with three key representatives and one senator. These specific delegates are most influential with the community because VANJHCS Medical Centers are in their districts. One representative is a woman veteran. The senator's office has always been vocal about women's issues.

In March, a member of the Congressional delegation in northern New Jersey was invited to the Lyons Campus to discuss services for women veterans at VA, access concerns, and the availability of resources. She was given a facility tour and met with women veterans who receive their care at VANJHCS. Another site visit is planned for April with a second delegation member.

Limitations

The limitations of this work will undoubtedly include cost, timing, confidentiality, and sustainability. However, it is still too early to elaborate on how these constructs will manifest throughout the full project.

LIMITATIONS & RECOMMENDATIONS

01

Cost

Costs associated with implementing community events and creating any proposed marketing materials have been prohibitive in reaching a wider audience. In short, there is no allocated budget through VANJHCS or the community to promote collaborative efforts. VANJHCS is prohibited from using budgeted funding for paid advertisements without a multi-level approval process. Since most of the advocates in the community are not associated with a formal group, they also do not have funding to advertise.

02

Timing

The timing of events has been kept at a sustainable pace throughout the implementation phase of this plan by limiting the number of involved community partners. Since one of the plan's goals is for this work to be perpetual, if a sustained increase in community participation is seen, the pace at which collaboration opportunities are created may outpace the availability of VANJHCS staff to participate. At this time, VANJHCS has no full-time support for staffing women-centric events, and the likelihood of that changing is improbable.

03

Confidentiality & Privacy

All of the events being pursued by the community, and most being pursued by VANJHCS, are open to the public, and that has raised concerns over healthcare confidentiality and the privacy of contributors at events. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) precludes the voluntary disclosure of confidential health information without the consent of the individual concerned. Beyond that, VA imposes strict standards for adherence to the statute, VA and VHA policies, and local medical center directives regarding maintaining privacy and protecting confidential information.

04

Funding

As the availability of public funding for services and equipment ebbs and flows, staffing needs change with competing priorities, and operational planning is updated, the possibility of waning public sentiment about VANJHCS efforts to support women veterans is possible. Without support from influential stakeholders in the community to back the communications initiatives of VANJHCS, the community at large will likely see a decrease in the frequency and completeness of interactions through VANJHCS. This reaction may further the information divide between the community and the health care system.

05

Conclusion of work

Though this project will conclude in late April, the model implemented herein is purposefully designed to be perpetual. The Constant Communication Model builds on itself by increasing trust in VANJHCS after every successful three-month cycle of communications events. With no projected end and an everchanging landscape of competing priorities, crises, budgetary concerns, staffing levels, and desires, the sustainability of efforts from VANJHCS may be unrealistic in the future. At this time, no defined method to conclude this work exists, and an abrupt change in communication frequency may weaken the trust built in the community to that point.

Recommendations for VANJHCS

Recommendations attempt to overcome future limitations and address trends or major concerns raised through focus groups and town halls.

01

Clear Communication

The community has stated that it desires clear, consistent, and frequent communications regarding VANJHCS, which highlight changes in services for women and in general. I strongly recommend the creation of a standard communications timeline parallel with the focus group and town hall schedule for the routine dissemination of updates coming from VANJHCS. This may include creating a product like a newsletter that can be emailed to enrollees steadily.

02

Political Influence

The political influence of crucial community members is known to VANJHCS. I recommend that the health care system maintain cordial and proactive interaction with all delegates in the VANJHCS area of operation. This approach will likely result in better coordination of efforts and less undue pressure.

03

Establish Advisory Board

There is no Women Veterans Advisory Board currently at VANJHCS. I recommend that the facility seeks to appropriately charter and fill a board of both VANJHCS enrollees and influential community members who match the wide range of age, orientation, race, and disability status that the health care system serves. The board should meet no less than quarterly with the Executive Medical Center Director or their executive designee to discuss concerns and needs related to the care for women veterans at VANJHCS.

04

Establish a marketing budget

There is currently no marketing budget for outreach and recruitment initiatives. I recommend to increase this to a modest \$2,500 per year to sustain a community involvement program where VANJHCS can participate on equal ground with their community partners.

Recommendations for Women Veteran Community

Recommendations attempt to sustain cordial and constant efforts to engage in positive communications regarding the services for women throughout the state.

01

Clear Communication

The women veterans community recognizes a need for two-way communications with VANJHCS leadership surrounding its most important issues. With that, I recommend that the community pursues an organizing effort to make sure their efforts to engage with VANJHCS and lobby for improvements remain in line with what most women want and what is feasible through the health care system.

02

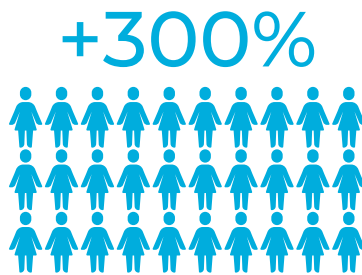
Statewide efforts

New Jersey is home to two VA VISNs (VISN 2 and VISN 4), three health care systems (New Jersey, Philadelphia, and Wilmington), and approximately 30 VA facilities. I recommend that the women veterans community makes a concerted effort to create at least one event per year which involves all VA entities serving women in New Jersey to ensure the widest dissemination of information.



Critical concerns resolved immediately

We defined critical concerns as those which immediately effect patient safety, reference ongoing harassment, or are otherwise marked as such by the Women Veterans Program Manager or Executive Leadership. There were four critical concerns communicated via focus groups which were developed, addressed, and long-term solutions in place [within 24-hours](#).



Opportunities for direct feedback

Historically, a major concern for women in the community has been the ability to [engage in direct, two-way communication](#) with VANJHCS leadership about their concerns. The Health Care System is required to conduct 4 focus groups annually and we increased the frequency to 12 annually. We added 4 public town halls annually

46%



Non-critical concerns resolved in 30 days or less.

Prior to the implementation of the Women Veteran Issue Tracker there was no longitudinal effort to resolve concerns and log results. Since initial rollout [the average time to put a long-term solution in place is less than 30 days](#) for a tracked concern.

Conclusion

VA is in a position now to champion more than ad hoc programming and ala carte services for women across its Veterans Health Administration, but doing so will mean needing to redefine local communications. If change is to happen, leaders of a care system borne of the needs of men must be able to listen empathetically, think creatively, and act with the same sense of duty and respect that our women veterans have served with since the birth of this nation.



Respect

- Listen non-judgmentally
- Follow through on actions
- Be good stewards of public trust

Integrity

- Champion change at the local level
- Provide clear communication
- Never overpromise



Empathy

- Hear what women are asking
- Act with care and humanity
- Support them where they are

We can make the future brighter for women veterans who choose to seek care at VA through reliance on a few well-structured and meaningful tools and a bit of humility.

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The strong women veteran advocates of New Jersey

My patient and loving wife, Erica

I thank you for your support in my efforts to contribute to the collective good.



VA



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New Jersey Health Care System

Reaching Women Veterans: Background Report & Communications Strategy

