Understanding Program Adoption Decision Making via the Veterans Health Administration Women's Health Transition Training Pilot: A Retrospective Qualitative Study

By

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DISSERTATION

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DEDICATION

To John David Sanders. You show up every single day and exemplify the meaning of a true partner. During this journey, you didn't keep score over the long nights and the missing weekend afternoons. Instead, you brought me dinner during class, made me tea to get me through dissertation revisions, and did the dishes every night without fail. You are a model of selfless love and without you, this would not have been possible. Being your life partner is and forever will be my greatest accomplishment. Thank you can only begin to express my eternal gratitude. I love you.

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LIST OF ABBREVIATIONS

ACWV	Advisory Committee on Women Veterans
BEC	Benefits Executive Committee
CEIR	Center for Evaluation and Implementation Resources
CWV	Center for Women Veterans
DACOWITS	Defense Advisory Committee on Women in the Services
DAV	Disabled American Veterans
DoD	Department of Defense
DVCO	DoD/VA Collaboration Office
ERIC	Expert Recommendations for Implementing Change
GAO	Government Accountability Office
HEC	Health Executive Committee
H.R.	House of Representatives
HSR&D	Health Services Research and Development Service
HVAC	House Committee on Veteran's Affairs
JEC	Joint Executive Committee
JIF	Joint Incentive Fund
MHS	Military Health System
MWC	Military Women's Coalition
MWR	Morale, Welfare, and Recreation
NCVAS	National Center for Veterans Analysis and Statistics
NDAA	National Defense Authorization Act
ORCA	Organizational Readiness to Change Assessment
ORID	Objective, Reflective, Interpretive, Decisional
PTSD	Post-traumatic Stress Disorder
QUERI	Quality Enhancement Research Initiative
ROI	Return on Investment
SSG	Senior Steering Group
SVAC	Senate Committee on Veterans' Affairs
SWAN	Service Women's Action Network
TAIWG	Transition Assistance Interagency Workgroup
TAP	Transition Assistance Program
Transition GPS	Transition Goals, Plans, Success
TVPO	Transition to Veterans Program Office
VA	Department of Veterans Affairs
VAMC	VA Medical Center
VBA	Veteran Benefits Administration
VFW	Veterans of Foreign Wars
VHA	Veterans Health Administration
VOW Act	VOW to Hire Heroes Act of 2011
VSO	Veteran Service Organization
WHWG	Health Executive Committee Women's Health Work Group

SUMMARY

This quality improvement study explored the decision-making processes and factors at all levels of the socio-ecological that led to the adoption of the Veterans Health Administration (VHA) Women's Health Transition Training pilot as a permanent program. The project also examined the implications for these findings for future VHA decision-making efforts.

This study was framed by recent calls for evidence-based public health and evidence-based decision making to more systematically make decisions about public health interventions. Evidence-based decision making is complex and "requires not only scientific evidence, but also considerations of values, resources, and context" (Brownson, Fielding, & Green, 2018, p. 30). Recent Government Accountability Office reports and Executive Orders have stressed the need to reduce fragmentation, overlap, and duplication in federal programs. As such, there is a significant amount of pressure for government agencies and programs to substantiate their programs' existence or the initiation of new programs with evidence.

This study retrospectively examined the complexity of decision making in a single case study. In 2017, VHA Women's Health Services, in collaboration with the Air Force Women's Initiative Team, was approved to conduct a pilot program for servicewomen transitioning from the military to the civilian sector. The transition period is noted as a vulnerable period, particularly for women Veterans. The pilot aimed to increase women Veterans' awareness and knowledge of VHA with the goal of increasing women Veterans' VHA enrollment and utilization. The pilot was approved as a permanent program on June 12, 2019, earlier than was expected. This study used three qualitative data collection and analysis processes to understand the decision-making processes and factors that facilitated the pilot being adopted as a permanent program: a document review to understand the chronology of decision-making and influencer activities; semi-

structured interviews to further understand the decision-making process and factors that influenced the decision to adopt the pilot as a permanent program; and a focus group to discuss the accuracy of and the implications of the findings for future efforts.

This study found that the decision-making process for this pilot was complex. The decision-making process was largely formal, hierarchical, and rational and engaged a number of successive interagency decision-making bodies. However, there was some degree of aberration from what is typically expected, largely because personal connections and networks were used to engage higher-level decision-making bodies earlier in the process than is typical. In addition to the formal decision-making process, a number of parallel influencer activities were noted as influencing the decision to adopt the pilot as a permanent program. These influencer activities included publicity and media attention, Veteran Service Organization involvement, and Congressional interest and draft bill text.

Twenty-four discreet factors were identified that influenced the pilot being adopted as a permanent program. Different factors played a role during different pilot phases (i.e., pilot exploration & approval, pilot implementation, pilot adoption decision) and factors were present at different levels of the socio-ecological model. Although factors were delineated as predominant factors and those with moderate and limited evidence, it was ultimately a combination of factors that interviewees cited as to why the pilot was adopted.

A focus group confirmed the validity of the study findings and served as a forum to discuss the implications of the findings. Using an ORID (Objective, Reflective, Interpretive, and Decisional) focus group guide, participants discussed the project findings and implications that served as the basis for Chapter V discussion and recommendations (e.g., the value of using implementation

science principles, engaging the community voice in policymaking, and the importance of a cohesive implementation team).

The findings from this study have implications for the Department of Veterans Affairs (VA), public health, and other public sector organizations. Decision making is the most downstream leadership activity that reflects the state of the organization and leaders in those organizations. The art of decision making involves understanding complexity and evaluating multiple factors simultaneously. Significant decisions are never straightforward and unlike a simple math equation, evidence-based decision making must balance science and art (Brownson, Chriqui, & Stamatakis, 2009). That said, six recommendations were generated based on the findings and conclusions drawn from this quality improvement study. These recommendations are rooted in the assumption that grassroots initiatives will continue to be encouraged and supported at VA in the future. Additionally, these recommendations are predicated on adaptive leaders navigating and embracing complex challenges.

- Define a process for initiating and sustaining interagency collaborations
- Consider the use of evidence-based implementation science protocols and train implementers and decision makers on their use
- Promote community participation in policymaking and consider how VA defines and operationalizes diversity and inclusion
- Create a culture where strategic thinking, acting, and learning are normalized, promoted, and rewarded
- Recognize the importance of change readiness and embrace change principles

- Involve key stakeholders in the program definition process, including defining desired outcomes

Decision making matters because public sector resources are scarce and there is an increased emphasis on reducing overlap and program duplication. This project demonstrated that there is room to better operationalize program implementation and decision-making processes; and in that, better designing programs with multilevel interventions and evaluations to make it so success can be more objectively identified and substantiated. There is an opportunity to make often implicit processes explicit to continue to increase the use of implementation science and evidence-based decision-making practices. Even though not all issues will be alike, organizations can benefit from frameworks to make more standardized high-stakes decisions. That said, a framework cannot replace the leadership artistry required of our 21st-century public health leaders. Rather than running from the challenges of this increasingly connected and complex world, we can train our public sector leaders to embrace and lead through complexity by understanding systems change.

I. BACKGROUND AND PROBLEM STATEMENT

A. Study Objectives

This single retrospective qualitative case study explored and described program adoption decision making in a pilot program addressing transitioning female Veteran health needs. The issues of women Veterans, the transition from the military to the civilian sector, and Veterans Health Administration (VHA) utilization are complicated and complex. VHA enrollment and utilization are lower for women than men and it is hypothesized that this disparity is due to a lack of knowledge about available gender-specific benefits (National Center for Veterans Analysis and Statistics (NCVAS) Profile of Women Veterans, 2016). The VHA Women's Health Transition Training pilot was designed to increase knowledge of VHA benefits for servicewomen transitioning from the military and is an example of a national public sector program aimed to address the complex health needs of a specific population. A decision was made in June 2019 to adopt this pilot as a permanent program, prior to the completion of the formal pilot period and the corresponding final outcome evaluation report. It's unclear how this decision was made and what factors influenced the adoption of the pilot prior to its completion. The study explored the complexities of program adoption decision making with many vested stakeholders in a highly political and sensitive area. This project may help to articulate the decision-making factors and processes involved in creating, implementing, and adopting government programs.

The three primary research aims were:

1. Understand and describe the program adoption decision-making process for the VHA Women's Health Transition Training pilot

2. Understand the decision-making factors that contributed to making the pilot a permanent program
3. Understand and describe the implications of the project findings for program adoption decision making within VA and among federal government agencies more broadly

B. Background and Context

The context of this pilot is important to understand. The pilot addresses servicewomen's health needs at a critical time of increasing numbers of servicewomen and women Veterans. To better understand the context in which this pilot occurred, literature reviews were conducted on three distinct areas related to the pilot context: women in the military/women Veterans, the military to civilian transition, and women Veterans and VHA utilization, including barriers and facilitators to enrollment. The key findings from these literature reviews are detailed in this section to articulate the context in which this pilot program exists: women Veterans who are transitioning from the military to civilian sector and the complexities surrounding their VHA enrollment and utilization decisions.

1. Women in the Military/ Veterans

Women have been a long-standing fixture in the U.S. military who have performed important core functions since the American Revolution. Women are the fastest-growing cohort in the military and subsequently, the Veteran population. Women Veteran demographics and experiences are different from their male Veteran and non-Veteran women counterparts in regards to the entire military life course — premilitary, military, and post-military. Additionally, women Veterans have unique physical and mental health needs as compared to their male Veteran and non-Veteran female peers. Since women Veterans will soon comprise more of the

Veteran population than ever before, it is more important than ever to understand this population's unique needs.

a) History of Women in the Military

Women have been serving in the U.S. military since the American Revolution, supporting combat soldiers as nurses, cooks, and laundresses (NCVAS Women Veterans Report, 2017). Centuries later, the Women's Armed Services Integration Act of 1948 opened up permanent military positions to women. The rescission of the 1994 Direct Ground Combat Definition and Assignment Rule for Women and the 2013 Combat Exclusion Policy opened up nearly all military roles to women, including previously prohibited leadership and combat positions (NCVAS Women Veterans Report, 2017). As of 2017, 16.5 percent of the U.S. military active duty component is comprised of women and women constitute 20 percent of new recruits (Disabled American Veterans (DAV), 2018). As of 2011, a slightly greater proportion of women are commissioned officers compared to men (17 percent vs. 15 percent, respectively; Morin, 2011). Women with combat exposure have increased 17 percent from those who served pre-1990 (7 percent) to those who served after 1990 (24 percent; Patten & Parker, 2011). As a result of this increase in military service, women are the fastest-growing cohort within the Veteran community (NCVAS Women Veterans Report, 2017). Women now comprise 10 percent of all Veterans, with an expected increase to 16.3 percent of the Veteran population within the next 25 years (NCVAS Women Veterans Report, 2017).

b) Demographics

The demographics of women Veterans are different than that of male Veterans and non-Veteran women. Women Veterans are more diverse than male Veterans, with 31 percent of post 9/11 servicewomen identifying as non-white and non-Hispanic (compared to 19 percent of men;

DAV, 2018). Sexual and gender minority women are more prevalent in the military than the civilian population and women make up 43 percent of the military's sexual minorities (Lehavot & Simpson, 2012). They are more likely to be divorced than their male Veteran counterparts and civilian women and are less likely to be married at all (NCVAS Women Veterans Report, 2017).

Socioeconomic outcomes for women Veterans are varied. On one hand, women Veterans have greater achievement of Bachelor's or advanced degrees (35 percent vs. 28 percent, respectively), are more likely to work in management, professional, or other related occupations (49 percent vs. 41 percent, respectively), and have higher median household incomes than non-Veteran women (NCVAS Profile of Women Veterans, 2016). Conversely, when women Veterans are compared to male Veterans, women Veterans have a lower median income (or no income at all), are more likely to live in poverty and use food assistance programs, and are younger (DAV, 2018). And although more male Veterans than female Veterans are homeless, female Veterans are at greater risk for homelessness than their male Veteran counterparts (Byrne, Montgomery, & Dichter, 2013).

c) Physical and Mental Health

Women Veterans have unique physical and mental health needs across the military and Veteran life courses. Researchers have found that many women enter the military with a history of adverse childhood experiences (Lang et al., 2008). While in the military, a woman's well-being is affected by a complex interaction of events in different dimensions, including her military career, family life, reproductive issues, and unexpected major life events (Segal & Lane, 2016). In addition, the seven distinct transition processes into, through, and out of military service bring about unique psychosocial stressors for women (Burkhart & Hogan, 2015). Women Veterans face greater physical health challenges post-military service compared to their male counterparts,

including greater incidence and prevalence of musculoskeletal issues, chronic pain, and obesity (Haskell et al., 2012; Breland et al. 2017). Compared to non-Veteran women, women Veterans are likelier to report chronic poor health, are more likely to engage in risky health behaviors, are less likely to participate in regular physical activity, and are more obese (Lehavot, Hoerster, Nelson, Jakupcak, & Simpson, 2012). And compared to male Veterans, women Veterans are more likely to experience anxiety and depression and comorbid mental and physical health conditions (e.g., military sexual trauma, post-traumatic stress, adjustment disorders; Strong, Crowe, & Lawson, 2018). Women are significantly more likely than men to be victims of intimate partner violence and female Veterans are more likely than civilian women to be victims of intimate partner violence (Dichter, Cerulli, & Bossarte, 2011).

2. Transition

The transition from military to civilian life is complex and challenging. It entails leaving a well-defined culture and community to myriad changes, including changes in career, family roles, support systems, social networks, community, culture, and life roles (Stein-McCormick, 2013; Castro, Kintzle, & Hassan, 2014). This transition has been recognized as a difficult time for service members in peer-reviewed journal articles and government documents. As a result, a number of transition resources and programs have been created, both in the public and private sectors, to help transitioning service members with career, benefits, and education guidance. Additionally, numerous studies have shown that the transition process is more difficult for women, highlighting the importance of considering additional transition resources for women Veterans. Among the most complicated changes is the move from an embedded workplace health system to a fragmented system of health care choices.

a) Transition Challenges

Military transition is the "period of reintegration into civilian life from the military and encapsulates the process of change that a service person necessarily undertakes when her military career comes to an end" (Forces in Mind Trust, 2013). The transition from military to civilian life is complex and challenging. The reintegration process involves many changes as an individual moves through a transition that involves changing structures, geographic location, career, family roles, support systems, social networks, community, culture, and life roles (Stein-McCormick, 2013; Castro, Kintzle, & Hassan, 2014). When service members transition from the military, they leave an institution of distinct rules that is culturally different from the civilian sector (Cooper, Caddick, Godier, Cooper, & Fossey, 2018). The transition is impacted by internal and external factors that influence the ability to cope and adapt (Anderson & Goodman, 2014). The success of the transition to civilian life is impacted by biological, psychological, and social factors at home and in the community (Strong, Crowe, & Lawson, 2018). Research has shown that women and men have different experiences during and after the transition from military to civilian life. A 2011 study found that male Veterans were more likely to report an easy adjustment to civilian life compared to female Veterans (Thompson et al., 2011). Factors that can impact a former servicewoman's reintegration into the civilian world include: availability of women's-specific VA policies and services; access to employment resources and higher education; access to mental health resources; and social stigmas related to being a female Veteran (Strong, Crowe, & Lawson, 2018).

b) Transition Resources

The military to civilian transition is situated in a complex environment that includes a network of often disparate benefits, services, and programs. These transition resources are contained within

individual service branches, supported by the interagency Transition Assistance Program (TAP), and supplemented by nonprofits, local government, and private industry resources (VA Military to Civilian Transition, 2018). The TAP program is mandated by Department of Defense (DoD) for all separating service members. The TAP curriculum, called Transition GPS (Goals, Plans, Success), provides transitioning service members counseling, employment assistance, financial guidance, and information on federal benefits for Veterans (DoD Transition GPS Curriculum, 2017). The required Transition GPS components include pre-separation counseling, a Department of Labor Employment Workshop, and VA benefits briefings (Cleymans & Conlon, 2014). In addition to the required courses, there are a number of optional courses available to service members to assist in the transition process (e.g., entrepreneurship, career and technical training, and accessing higher education). Most courses are available 12-14 months prior to transition and require multiple days to a full week to complete. Most service members complete the courses within six months of military separation. Although TAP services are offered in every military service branch and are legislatively mandated, the program has received criticism for not being focused on the full transition process and for being overly focused on initial job search activities (Anderson & Goodman, 2014; Business and Professional Women's Foundation, 2007).

c) Healthcare Changes

While on active duty, servicewomen access their healthcare through the DoD Military Health System (MHS), which provides preventive and medical services at 416 inpatient hospitals, medical centers, and ambulatory care clinics throughout the world (DoD MHS, n.d.). There are certain health check-up requirements for active-duty members, including an annual physical and annual immunizations. In this system, MHS takes care of a service member's every need to ensure he/she is deployable. When women transition from the military to civilian life, they leave

a workplace-embedded healthcare system and enter a system of many healthcare choices (Villagran, Ledford, & Canzona, 2015). The military is a system of mandated health compliance systems (e.g., fitness, weight management), while the civilian healthcare system is predicated on individual agency and advocacy (Villagran, Ledford, & Canzona, 2015). Navigating this fragmented healthcare structure is just one of the many challenges faced in the transition process.

3. VHA Utilization

VHA is the U.S.'s largest integrated health system. Numerous government reports since the 1980s have revealed opportunities for VHA to improve healthcare offerings for women Veterans. VHA has been making improvements to women's-specific service offerings, but a report as recent as 2015 revealed numerous barriers to care to VHA benefits for women, including not knowing or understanding the comprehensiveness of service offerings or eligibility requirements. Eligibility requirements are complicated and not every Veteran can receive services at VHA facilities. These factors (among others) have led to numerous appeals for increased VHA educational resources to inform women Veterans about available VHA benefits.

a) Evolution of VHA Provisions for Women

VHA is the U.S.'s largest integrated health system, providing care at 1,250 health care facilities, including inpatient hospitals and community-based outpatient clinics (VHA, n.d.). Due to the demographic makeup of the U.S. military, VHA has historically focused on treating men (Lehavot, O'Hara, Washington, Yano, & Simpson, 2015). The influx of women in the military is reshaping the Veteran population and subsequently, VHA's healthcare delivery priorities (Washington, Kleimann, Michelini, Kleimann, & Canning, 2007). A 1982 Government Accountability Office (GAO) report revealed four key findings related to women and VHA benefits: 1) women were not aware they could access VA benefits, 2) they did not think they

could receive full medical examinations, 3) VA medical facilities were not supplying gynecological services, and 4) women who had served were not informed enough of their benefits (NCVAS Women Veterans Report, 2017). As a result of these findings, the Advisory Committee on Women Veterans (ACWV) was created in 1983 under Public Law 98-160 to evaluate and report on women Veteran issues. Nearly a decade after the establishment of the ACWV, a 1992 follow-up GAO report shared that progress for VA women's health had been made, but more improvements were needed (GAO 92-93, 1992). Public Law 103-446, drafted in 1994, established the Center for Women Veterans (CWV), which advises the Secretary of VA on women Veteran legislation, policies, issues, and programs and initiatives (CWV, n.d.). GAO released another report in 2010 (10-287) that also showed that VA was making progress in increasing services for women Veterans, but that key policies needed to be revised and oversight processes improved (GAO 10-287, 2010).

b) VHA Barriers to Care for Women Veterans

In 2015, 35.9 percent of women Veterans were enrolled in the VHA healthcare system. However, not all women who enroll in VHA care ultimately become healthcare users (NCVAS Profile of Women Veterans, 2016). In 2015, 22.4 percent of all women Veterans used VA healthcare (compared to 13.1 percent in 2005; NCVAS Profile of Women Veterans, 2016). A 2007 study revealed that barriers to VHA use for both female VHA users and nonusers included a lack of information about eligibility and available services (Washington et al., 2007). The findings stressed the need to disseminate accurate information about VA eligibility and services and for VA to be responsive to women's perception of care (Washington et al., 2007).

Although much progress has been made, a 2015 report (in response to Public Law 111-163, sec. 201 requirement) revealed barriers to care for women Veterans to use VHA services (VA Study

of Barriers for Women Veterans, 2015). The "Study of Barriers for Women Veterans to VA Health Care" survey of VHA users and nonusers uncovered many of the same issues cited in Washington's 2007 study of women Veterans' perceptions about VHA care: only 51 percent of non-VA users felt that they knew enough about eligibility requirements and the scope of VHA services; more VHA users reported having received information on VHA women's health services than nonusers (67 percent vs. 21 percent, respectively); women were hesitant to seek care for mental health issues due to mental health stigma and hesitancies; and women had concerns about VA facility comfort and safety, particularly those who had experienced sexual harassment or assault (VA Study of Barriers for Women Veterans, 2015).

c) VHA Women's-Specific Services

VHA has made a concerted effort in recent years to enhance its women's-specific services based on their understanding of barriers. VHA policy updates (VHA Handbook 1330.01, May 2010) recommend that all women Veterans are able to receive women's health services and primary care services in a single visit in any VHA setting (Bergman, Frankel, Hamilton, & Yano, 2015). Women's-specific care and services are delivered in women's-only clinics or in integrated primary care settings. Every VHA facility now has an embedded Women Veterans Program Manager to advocate for women's health needs. Comprehensive primary care is provided for women Veterans at all sites and each Veteran is assigned a Women's Health Primary Care Physician to ensure ongoing needs are met (VHA Women's Health Services Transition Training Handbook, 2018).

d) VHA Eligibility and Utilization

With all of these advancements in VHA women's-specific services, eligibility remains a concern, as eligibility benefits differ based on a number of factors such as service-connected disability

rating, income, military awards, and time and geographic location of service (e.g., Veterans who served on active duty at Camp Lejeune for at least 30 days between 8/1/1953 and 12/31/1987). VA performs an assessment of many factors and assigns a priority group 1-8 accordingly. The priority group designation dictates the services a Veteran is entitled to receive at VHA. Priority group 1 means that a Veteran's healthcare services are 100% compensable by VHA with no required Veteran co-payment, while priority group 8 signifies a Veteran's gross income is above VA national income limits and the Veteran has to pay a co-payment for any care received in a VHA facility.

Due to this stratification and eligibility criteria, women Veterans who obtain care outside VHA tend to have higher incomes, do not know about VHA benefits and eligibility, have incorrect assumptions that VHA services are unavailable to women, and are more likely to have a negative perception of VHA care (Shen, Hendricks, Wang, Gardner, & Kazis, 2008; Vogt et al., 2006; Washington, Yano, Simon, & Sun, 2006). A 2015 study suggests that women with high posttraumatic stress and depressive symptoms and who are relatively younger are most likely to use VHA (Lehavot, O'Hara, Washington, Yano, & Simpson, 2015). This corroborates findings from many other studies that show that many factors, including poor health, low income, level of military service-connected disability, and racial/ethnic minority status are associated with increased VHA utilization among all Veterans, including women (Mooney, Zwanziger, Phibbs, & Schmitt, 2000; Ouimette, Wolfe, Daley, & Gima, 2003; Skinner & Furey, 1998; Washington, Villa, Brown, Damron-Rodriguez, & Harada, 2005; Friedman, et al., 2011).

4. Case Study Overview

As the background illustrated, the issues of women Veterans, the military to civilian transition, and VHA utilization are complicated and complex. The remainder of the background section

focuses on the case study overview. This section includes an overview of DoD and VA healthcare history and the evolution of VA women's health services over time, ultimately leading to the impetus of the VHA Women's Health Transition Training pilot. This context is important to understand the environment in which the pilot was inserted. The remainder of the section focuses on pilot details, including the pilot development process, training session components, and the program evaluation framework. This section further substantiates that this is a complex issue situated within and between the two largest U.S. federal government departments, a fitting backdrop for seeking to explore how program adoption decisions are made.

5. DoD and VA Healthcare History

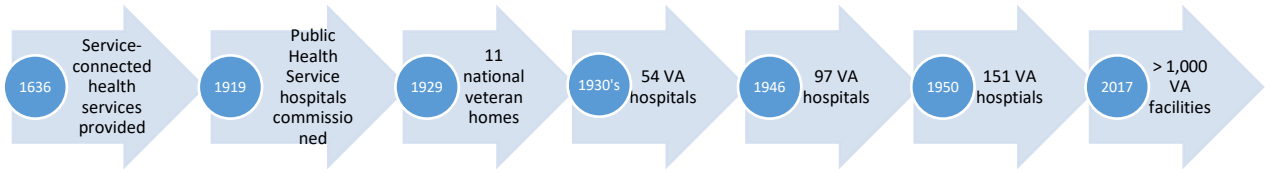
a) DoD Healthcare History

Military health care prior to World War I was locally administered and primitive. After World War II, DoD began to rethink medical service benefits and by 1997, DoD had a nationwide managed care program called TRICARE (GAO HEHS-95-142, 1995). The DoD MHS provides health care to active duty and retired U.S. military service members, their dependents, and some former spouses to maintain a deployable, medically-ready force. MHS care starts at the beginning of service, with military recruit medical testing and screening. MHS healthcare is administered throughout the military life cycle to maintain the physical standards of service members and provide emergency medical treatment for troops in theatre. The MHS sustains a $50 billion annual budget and serves approximately ten million beneficiaries. MHS facilities include 65 hospitals, 412 clinics, and 414 dental clinics in the U.S. and abroad, not including contingency and combat-theater operations worldwide (DoD MHS, n.d.).

b) VA Healthcare History

Veteran services in the U.S. can be traced to 1636 when the Pilgrims instituted laws to ensure the colonies supported disabled soldiers. During the first world war, the U.S. put into place a program of new Veteran services, including insurance and disability compensation and vocational rehabilitation for the disabled (Kizer, Demakis, & Feussner, 2000). The scope of Veteran healthcare provisions has increased substantially over the past few centuries, most notably from the 1900s-present. By 1919, legislation established medical care for Veterans in coordination with the Public Health Service and authorized new hospitals for patients with service-connected conditions (VA FY16 Annual Report, 2017). By 1929, a federal system of 11 national homes existed across the country that accepted Veterans of all American wars. Demand for healthcare grew dramatically in the 1930s, dominated largely by acute (i.e., tuberculosis) and neuropsychiatric conditions (VA History in Brief, 2006).

The VA healthcare system has grown from 54 hospitals in the 1930s to serving over eight million patients in over 1,000 medical facilities of varying size and capacity in 2017 (VA



History, n.d.). To accommodate the significant growth and changes in healthcare delivery and scope, VHA hospital operations were decentralized from VA Central Office in 1995 into 22 Veterans Integrated Service Networks. Over multiple decades, VHA shifted from inpatient facilities for Veterans with service-connected conditions to a system focused on comprehensive primary care and care in an outpatient setting. In 1997, the department altered eligibility criteria and started enrolling most Veterans in VHA healthcare, while concurrently opening more community-based outpatient clinics to increase points of access to healthcare (VA History in Brief, 2006). This growth over time has resulted in VHA becoming the largest integrated healthcare system in the U.S. (see progression in Figure 1).

Figure 1: VHA evolution

c) VA Women's Health Services

Women are becoming increasingly represented in the military and Veteran populations. Due to numerous public laws and GAO reports mentioned above, VHA has made a concerted effort to increase women's services. In 1988, VA created the Women Veterans Health Program to streamline services for women Veterans. The office has since evolved (and elevated) into VHA Women's Health Services under the Office of Patient Care Services. VHA Women's Health Services has a mission to provide comprehensive, private, safe, and gender-specific services to all female Veterans. The Program designs comprehensive primary care programs for women, provides women's health education, develops communication and partnerships with internal and external entities, and conducts women's health research (VA Women Veterans Healthcare, n.d.).

d) Pilot Development

Based on the premises that a primary barrier to post-service care for women Veterans is not understanding what women's health services are available and that women Veterans often have misperceptions regarding eligibility and overall VHA care, VHA Women's Health Services and the Air Force Women's Initiative Team partnered to increase understanding about what health services are available at VHA and how to enroll for VHA benefits (Women's Health Learning Session Overview, 2018). The Air Force Women's Initiative Team and VHA Women's Health Services committed to develop and pilot a women's health training focused on available VHA benefits. The ultimate goal of the pilot was to enroll servicewomen into the VHA health care system as quickly as possible after separation from the military to ensure the continuation of healthcare services and effective management of healthcare needs.

e) VHA Women's Health Transition Training Pilot Overview

The VHA Women's Health Transition Service Training pilot was hosted in 11 Air Force sites (TABLE I). As of June 12, 2019, the pilot was officially adopted as a permanent, nationwide program and began a phased, nationwide rollout in January 2020.

TABLE I: WOMEN'S HEALTH SERVICES TRANSITION TRAINING PILOT DETAILS

Women's Health Services Transition Training Pilot Details	
Host Agency	US Department of Veterans Affairs, Veterans Health Administration, Patient Care Services, Women's Health Services
Audience	Air Force Servicewomen (Typically transitioning within one year of pilot attendance)
Host	Air Force
Timeframe	October 2017 – July 2019
Where	Pilot Locations: • Pentagon (National Capital Region) • Hurlburt Field Air Force Base (Okaloosa, FL) • San Francisco, CA • Andrews Air Force Base (National Capital Region) • MacDill Air Force Base (Tampa, FL) • Scott Air Force Base (Belleville, IL) – Discontinued at this site due to poor attendance • Joint Base Lewis-McCord (Tacoma, WA) • Hill Air Force Base (Ogden, UT) – Discontinued at this site due to poor attendance • Travis Air Force Base (Fairfield, CA) – Added to the pilot • Wright-Patterson (Dayton, OH) – Added to the pilot • Joint Base San Antonio (San Antonio, TX) – Control

The Women's Health Transition Training pilot was a highly interactive, half-day workshop with a deep dive into VHA gender-specific services. The training was led by female Veterans that use VHA for their healthcare needs. The course consisted of five didactic training phases and a tour of a VA Medical Center (VAMC), if available. The five program phases, the components, and estimated time for each phase are shown in TABLE II.

TABLE II: VHA WOMEN'S HEALTH TRANSITION TRAINING PILOT COURSE CONTENTS

Phase	Components	Estimated Time
Phase 1	The Shift from Active Duty – MHS/VHA Crosswalk of Services	15 minutes
Phase 2	Understanding VHA • VHA Culture Transformation • VHA Organization • VHA Facilities • Designated Women's Roles and Models of Care • Quality of Care	20 minutes
Phase 3	Available Women's Health Services • Primary Care: Preventive Care and Wellness • General Medical and Specialty Care • Mental Health and Substance Use Disorders • Reproductive Health • Maternity and Family Care	2 hours
Phase 4	Enrolling in VHA • Eligibility, Disability, and Enrollment Process	20 minutes
Phase 5	Transition Assistance • Transition Support and Resources • Reintegration and Post-Deployment Support • Value of Enrollment	10 minutes

The pilot included a program evaluation framework consisting of three components: a pilot questionnaire pre-test, a pilot questionnaire post-test, and a women's health transition training pilot session feedback form. The pre-test was administered prior to the start of the session, while the post-test was distributed and completed immediately following completion of Phase 5. The pre-and post-tests included questions on knowledge, awareness, perceptions, and attitudes about VHA (e.g., How has today's Women's Health Transition Training changed your perception of VHA as a system to get quality health care?) and questions about likelihood to enroll (e.g., Do you believe you are prepared and have necessary information to start the enrollment process at

VHA?). Additionally, VHA enrollment data was collected and linked to pilot participants in the late-stage pilot implementation.

6. Program Adoption Decision Making

a) Importance of Evidence-Based, Systematic Decision Making

The decision to adopt a pilot as a permanent program is influenced by many factors. The decision to adopt the VHA Women's Health Transition Training pilot was made before the expected completion of the pilot and the corresponding pilot outcome evaluation report. For all intents and purposes, a decision was made to adopt this program before pilot evidence was fully collected and analyzed. This demonstrates the importance (and novelty) of using and building evidence when making decisions about public health interventions. Researchers from numerous disciplines have stressed the importance of decision making in implementing evidence-based public health interventions. Evidence-based public health is described as using the best evidence available at the time to make decisions about the most appropriate public health interventions (Brownson, Fielding, & Green, 2018). Brownson et al., in a meta-analysis of the literature, identified "that evidence-based decision making requires not only scientific evidence, but also considerations of values, resources, and context" (Brownson et al., 2018, p. 30). In a narrative on the importance of defining and determining the weight of evidence, Brownson et al. stated, "These observations highlight the need for clarity in the criteria for sufficient and appropriate evidence to catalyze action as well as capacity-building activities for both those sponsoring the intervention and the target organizations and populations" (Brownson et al., 2018, p. 30). The Brownson et al. excerpt highlights the importance of having enough of and the right information before making the decision to adopt new programs.

Decision-making complexity is articulated in an excerpt on government decision making, including the oft-wavering consideration of evidence in the process.

> *"Decision-making in government is a process in which evidence, both from systematic research and practical experience, mixes with a complex interaction of ideas, interests, ideologies, institutions, and individuals. These several factors are the determinants of decisions at the political and administrative levels. At different times and under different regimes, the decision-making process will be structured and managed in ways that seek to give more or less weight to evidence. No one process is necessarily or always more 'rational' than the others. It all depends on what questions need to be asked by decision-makers in the circumstances and context of the times in order to make the best possible decisions for their agendas and/or public expectations of good governance. As a consequence, the importance attached to the use of evidence in decision-making invariably waxes and wanes over time"* (Aucoin, 2005, para. 3).

The literature provides a call for evidence-based and systematic decision-making processes. Given the complexities of transitioning women Veterans' choice of healthcare, the literature emphasizes the importance of a new way of decision making that focuses on building evidence. Using evidence to show that effective programs are being implemented and sustained is vital to long-term success for VHA and DoD.

b) VHA Women's Health Transition Pilot Decision Making

In order to improve the likelihood to enroll in VHA benefits for servicewomen, VHA Women's Health Services created the Women's Health Services Transition Training pilot that was offered in 11 Air Force pilot locations. The pilot was officially approved as a permanent program on June 12, 2019, before the pilot implementation was intended to be complete. The pilot being adopted as a permanent program provided an opportunity to explore the decision-making processes and factors that were considered to make that decision. A complex interplay of stakeholders and decision makers were involved in this pilot that ultimately impacted the final decision to implement the program in all service branches. This dissertation project, set in this complex context, sought to understand how, and on what bases, the decision makers ultimately

decided to move forward with this pilot. This pilot turned program was used as a single retrospective case study to understand federal government program adoption decision making.

C. Problem Statement

Government decision making is a complex process "in which evidence, both from systematic research and practical experience mixes with a complex interaction of ideas, interests, ideologies, institutions, and individuals" (Aucoin, 2005). This complex interaction of numerous factors creates variation in the decision-making process and as a result, the importance of evidence waxes and wanes situationally. In 2018, the Air Force and VHA launched the Women's Health Transition Training pilot to address VHA enrollment and utilization for women Veterans. Although the VA has made a concerted effort in the past decade to increase and improve women's-specific health services, only 34 percent of eligible women use VHA for their health needs, compared to 43 percent of eligible men (USAF VA Pilot Initiative Joint Incentive Fund (JIF), 2017). This pilot program's mission was to improve the likelihood to enroll in VHA services for women Veterans. With public value at the forefront, it is important to understand the criteria and decision-making processes used to determine how programs are initiated, adopted, and scaled. This pilot presents an opportunity to retrospectively explore how the decision was made to make this pilot a permanent program and the factors that impacted the decision-making process.

D. Research Questions

TABLE III: RESEARCH QUESTIONS

Research Questions
a. Describing the process: How was the decision made to adopt this pilot program? a. What was the chronology of events related to bringing this pilot to fruition through the program adoption decision? b. What processes/protocols were used to make the decision? c. What were the key activities throughout this process? d. What were the turning points?
b. Decision-making factors: What decision-making factors impacted the program adoption decision? a. What individual-level factors impacted the decision to make this pilot a permanent program? b. What interpersonal-level factors impacted the decision to make this pilot a permanent program? c. What organizational-level factors impacted the decision to make this pilot a permanent program? i. What role did the pilot evidence play in the decision-making process? d. What societal/policy-level factors impacted the decision to make this pilot a permanent program?
c. Future state: What will happen next? a. What do these findings suggest about program adoption decision making within VA and among federal government agencies more broadly? b. How can this knowledge of decision-making processes inform future implementations?

E. Leadership Implications and Relevance

An Executive Order was signed in March 2017 to perform a "thorough examination of every executive department and agency" to find out "where money is being wasted [and] how services can be improved" (Fabian, 2017). The Executive Order is part of the current administration's aggressive push to reduce the size of the federal government. Similarly, the GAO releases a report annually that identifies opportunities for federal programs to eliminate duplication, fragmentation, and overlap and identify cost saving and revenue generating opportunities (GAO, 2018). As such, there is a significant amount of pressure for government agencies and programs

to substantiate their programs' existence with evidence of effectiveness. What determines if a program is effective? How are decisions made on whether to initiate, adopt, or scale a program?

As noted in the Aucoin excerpt, the decision to adopt a pilot program is influenced by many factors. Public sector leaders are entrusted with providing direction and oversight to their respective organizations. This responsibility inherently requires decisions on how to allocate resources, which are often scarce. Thus, decision making, particularly evidence-based decision making, is a key competency for strategic and effective leadership. And the research shows that using evidence to make decisions has great benefits. Research has found that using evidence-informed approaches for public health interventions "could potentially have numerous direct and indirect benefits, including access to more and higher-quality information on best practice, a higher likelihood of successful prevention programs and policies, greater workforce productivity, and more efficient use of public and private sector resources" (Lhachimi, Bala, & Vangas, 2016, p. 1). Making decisions on what programs to adopt and sustain is increasingly important in today's climate of rapid change and scarce resources.

The intent through this project is to shed light on VA program adoption decision making. These dissertation findings can encourage conversations around the use of systematic processes and evidence in program adoption decision making. Understanding the current state processes and opportunities for improvement are important for federal government leaders, especially in a large organization like VA. VA, as one of the largest and most complex departments in the federal government, is charged with making almost constant programmatic decisions at many levels of the organization, making it exceptionally challenging to make fully-informed programmatic decisions.

These findings will help VA leaders understand the factors that impacted program adoption decision making in this single case pilot adoption decision-making process. Figure 2 demonstrates the ideal short-term, intermediate, and long-term impacts of these findings.

Figure 2: Project impact

- **Short Term:** Change Knowledge: Illuminate the complexities of decision making via a focus group with pilot decision makers and stakeholders. Share preliminary research findings and start a dialogue about systematic and evidence-based decision making.
- **Intermediate:** Change Actions: VA decision makers will use the dissertation findings to make the case for a transition to more informed and systematic decision-making processes.
- **Long-Term:** Change Conditions: VA leaders will champion the charge to change conditions for policy and systems change to create a consistent and defendable system for program adoption decision making. VA decision makers will facilitate the creation of standardized and uniform program adoption decision-making processes and evidence requirements to improve objectivity and decrease process variability.

F. Chapter I Summary

As of 2017, 16.5 percent of the U.S. military active duty component is comprised of women and women constitute 20 percent of new recruits, a rate unsurpassed in history (DAV, 2018). Women's mental health and resilience needs across the military life course, including the transition and integration needs after the military, are complex. And compared to male Veterans, women Veterans are more likely to experience anxiety and depression and comorbid mental and physical health conditions (e.g., military sexual trauma, post-traumatic stress, adjustment disorders; Strong, Crowe, & Lawson, 2018). Suicide rates have increased by 45.2 percent for female Veterans between 2005 and 2015 (VA Women Veteran Facts, 2018). The success of the transition to civilian life is impacted by biological, psychological, and social factors at home and in the community (Strong, Crowe, & Lawson, 2018). Factors that can impact a former servicewoman's reintegration into the civilian world include: availability of women's-specific VA policies and services; access to employment resources and higher education; access to mental health resources; and social stigmas related to being a female Veteran (Strong, Crowe, & Lawson, 2018). Although VA has made a concerted effort in the past decade to increase and improve women's-specific health services, only 34 percent of eligible women use VHA for their health needs, compared to 43 percent of eligible men (USAF VA Pilot Initiative JIF, 2017).

In order to improve the likelihood to enroll in VHA services for servicewomen, VHA and DoD created the Women's Health Services Transition Training that was piloted in 11 Air Force locations. The decision was made in June 2019 to formally adopt the pilot as a permanent program. This pilot presented an opportunity in a single case to retrospectively examine the decision to adopt the pilot as a permanent program. With public value at the forefront, it is

important to understand the factors and decision-making processes used to determine how programs are initiated, implemented, and adopted.

The three project aims were to explore how program adoption decisions were made in relation to the VHA Women's Health Transition Training pilot, including:

1. Understand and describe the program adoption decision-making process for the VHA Women's Health Transition Training pilot
2. Understand the decision-making factors that contributed to making the pilot a permanent program
3. Understand and describe the implications of the research findings for program adoption decision making within VA and among federal government agencies more broadly

II. CONCEPTUAL AND ANALYTICAL FRAMEWORK

A. Literature Review

The peer-reviewed literature was used to inform chapter II and the associated conceptual framework and constructs. Numerous disciplines were searched and reviewed to better understand the science of decision-making factors and processes. Chapter II search terms included program adoption decision making, evidence-based decision making, capacity building, implementation science, program adoption readiness, change readiness, leadership, collaborative governance, interagency teams, dissemination research, and innovation diffusion. Program adoption, implementation science, evidence-based decision making, and change readiness emerged as the most relevant search terms; the associated concepts from these search results most widely informed the dissertation conceptual framework and associated constructs. A systematic cataloging process was employed to manage and prioritize peer-reviewed journal articles and an annotated bibliography was used to identify and extract key information from the most relevant research articles.

1. Chapter II Overview

Chapter II is organized by multiple sections, with traceability back to the research questions and conceptual framework. As noted above, chapter II is a synthesis of the literature across multiple disciplines. The chapter begins with justification for bounding this research as the adoption decision/preparation implementation process phase. This section is followed by the decision-making approach section, which draws on the literature on how innovation program decisions may be made. The final substantive literature review section is the rationalization for the use of the socio-ecological framework to understand decision-making factors at different levels of the model (and subsequently, the importance of the interactions of these factors). There are

individual sections and subsections devoted to the factors identified in the literature at each of the four levels of the socio-ecological framework: individual, interpersonal, organizational, and societal. Constructs and subcodes within these levels are defined in detail, with traceability back to the conceptual framework, measurement table, and codebook. Many constructs and subcodes were identified in the literature, particularly for decision-making factors. This thorough review informed selection of the most pertinent constructs and subcodes that were explored in interviews (Appendix A: Semi-Structured Interview Guide) and are reflected in the a priori codebook (Appendix B: A Priori Codebook). This chapter concludes with a synthesis of the literature and its culmination into the dissertation's conceptual framework.

2. Implementation Process Phase

One of the key findings in the initial implementation science search was the distinction between different implementation process phases. Aarons et al. noted that the actions of individuals and organizations exist within complex, multi-layered contexts (2011). Aarons et al., noting the work of their implementation colleagues in cataloging and understanding factors important for implementation, created a conceptual model of the most impactful implementation factors in public sector settings. The most unique aspect of the model is the emphasis that different factors may be more important and manifest differently during different implementation phases. As Aarons et al., stated, "Few implementation models explicitly recognize that different variables may play crucial roles at different points in the implementation process" (2011, p. 6).

The four implementation phases proposed by Aarons et al. include exploration, adoption decision/preparation, active implementation, and sustainment (2011). The exploration phase is the recognition that a problem exists or that there is a new way to address or approach an organizational challenge. The adoption decision/preparation phase is when organizations may

experiment with an innovation prior to broad implementation. The active implementation phase is when an intervention or innovation has been approved and is being actively implemented. The final phase, sustainment, is the continued use of an innovation in practice. In addition to differentiating the four implementation phases, Aarons et al. distinguished between inner and outer context factors. The inner context includes those factors that are contained within the organization, while the outer context refers to the environment beyond the organizational boundaries. Figure 3 shows the Aarons et al. conceptual model of implementation phases and factors affecting implementation in public service sectors. Based on the Aarons et al. distinctions, the dissertation project was bound to the adoption decision/preparation phase (with some discovery during the pilot exploration phase).

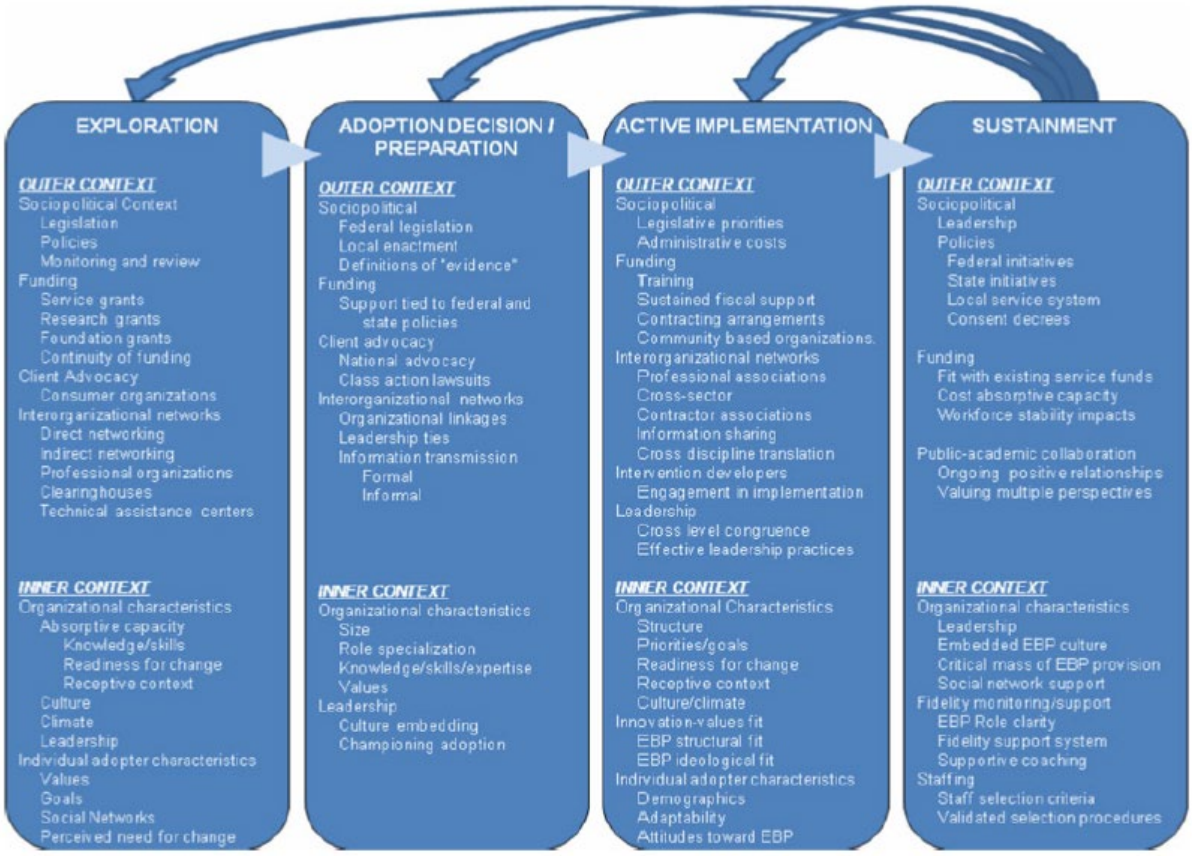


Figure 3: Aarons et al. implementation phases

3. Decision-Making Approach

a) Garbage Can Model of Decision Making

The garbage can model of decision making was originally considered as a theoretical framework to understand the decision-making process. This model emerged during the literature review and was also mentioned by numerous colleagues as a means of understanding public sector decision making. In researching the model, its components resonated. An excerpt from a seminal article on the garbage can model states, “To understand processes within organizations, one can view a

choice opportunity as a garbage can into which various kinds of problems and solutions are dumped by participants as they are generated. The mix of garbage in a single can depends on the mix of cans available, on the labels attached to the alternative cans, on what garbage is currently being produced, and on the speed with which the garbage is removed and collected from the scene" (Cohen, March, & Olsen, 1972, p. 2). It goes on to say that a decision is an "outcome or interpretation of several relatively independent streams within an organization" (Cohen, March, & Olsen, 1972, pp. 2-3). Although the model has merit and may apply to the pilot decision-making process, it assumes a certain level of irrationality and disconnect of many streams in a decision-making process. For this assumed irrationality and for potential perception issues with VA stakeholders (garbage can alone carries a negative connotation), this model was not selected as a theory for the a priori conceptual framework.

b) Decision-Making Processes

Question 1 is related to how the program adoption decision was made. In order to generate this understanding, the literature on the processes involved in the selection and prioritization of development/innovation projects was examined. Deciding on what projects to support has been described as a decision-making process that is "complex and dynamic, multi-staged, involving groups of decision makers, and presenting multiple and often conflicting objectives" (Gutierrez, Sandstrom, Janhager, & Ritzen, 2008, p. 1). For optimal decision making, the literature asserts that organizations should use methods and tools in a sequential decision-making process to ensure systematic decision making (Gutierrez et al., 2008).

McConnell (2016) noted that there should be five always-present elements of the implementation decision-making process:

- Gathering information

- Analyzing information and arranging it into alternatives
- Selecting a preferred alternative (i.e., deciding)
- Implementing the chosen alternative
- Following up on implementation

However, the literature has identified recurrent issues that arise in the program adoption decision-making process (Gutierrez et al., 2008). Some of the most common and frequently noted issues include:

- Ideas are implemented without first considering the impact on other projects in the portfolio. This issue is sometimes referred to as resource allocation syndrome (Gutierrez et al., 2008).
- Projects are difficult to stop. Once a project has been started, it takes on a life of its own. Gutierrez et al. asserted, "It is not easy to justify to an organization that an idea must wait or to stop another ongoing project, even though its implementation is no longer justified" (2008, p. 1).
- Projects can be promoted to a crisis point, forcing top management to give them a high priority. These projects may be arbitrarily selected as pet projects (Gutierrez et al., 2008).

McConnell asserted that it is possible to create guidelines to make many kinds of decisions through "rules, regulations, policies, and procedures" (2016, p. 89). However, it's not a copy and paste solution. "Good managerial decisions will remain a matter of arriving at a proper emphasis on all decision elements through judgment based on facts and figures, knowledge, experience, advice, intuition, and insight" (McConnell, 2016, p. 89).

To better understand how decisions are made, numerous resources in the literature were identified, most notably an article titled, "Innovation and Decision Making: Understanding Selection and Prioritization of Development Projects." The article identified four dimensions of choice for how decisions are made. Choice, as described in the article, was related to different approaches for making decisions and understanding innovation (Gutierrez et al., 2008). Due to the complexity of program adoption and decision making, there is no single approach for making decisions and different approaches are suitable for different situations. Organizations must make choices because there are different levels of acceptance for different decision-making approaches based on organizational, interpersonal, and individual norms. The four dimensions of choice noted in the Gutierrez et al. article are introduced below.

Understanding of Innovation

Understanding of innovation includes two dichotomous choices: static and dynamic. The static paradigm is effective when information about the program is unambiguous and certain. In a static situation, where an innovation can be forecasted or planned, decision makers feel safe. The dynamic approach can be utilized when innovation is unpredictable and changes are unavoidable. This more fluid paradigm "helps in preparing for change and reprioritizing in a less traumatic way" (Gutierrez et al., 2008, p. 3).

Rationality in Means

Rationality in means includes two dichotomous choices: rational and non-rational. Rational decision making uses analytical procedures to arrive at an optimal decision. In contrast, non-rational decision making is when intuition and "gut feelings" are used, resulting in subjective evaluations of the project. When subjectivity is introduced, there is an opportunity for particular interests to prevail (Gutierrez et al., 2008).

Formalization of Processes

Formalization of processes includes two dichotomous choices: formal and informal. Formal processes are more controlled regarding the initial decisions and follow-up decisions related to the innovation. Traceability is in place and makes it easier for stakeholders to understand who made the decision and what criteria were used. Informal approaches, however, are sometimes used in the early stages of an idea to gain the support of key stakeholders. Informal processes at any stage, however, make it difficult to communicate how the decision was made (Gutierrez et al., 2008).

Exercise of Power

Exercise of power includes two dichotomous choices: hierarchical and non-hierarchical. Involving higher levels in a hierarchy typically means that decision making ascends above individual party interests to ensure that decisions are made in line with organizational goals. Hierarchical decision making then, in theory, should resolve any conflict arising from different organizational programs and projects competing for resources. Non-hierarchical decisions are made when new ideas are considered promising and can be situated and decided upon at lower levels of the organization. Decisions made at lower levels of the hierarchy allow for more rapid development but may require sign off higher in the hierarchy if the program is intended to be further developed and expanded (Gutierrez et al., 2008).

A table was included in the Gutierrez et al. article that illustrated the contributions of the different approaches for making decisions, demonstrating that different approaches and different combinations of approaches may be a better fit in different situations (Gutierrez et al., 2008).

TABLE IV: CONTRIBUTIONS OF DIFFERENT APPROACHES FOR MAKING DECISIONS AND UNDERSTANDING INNOVATION

Contributions of the different approaches for making decisions and understanding innovation			
Managing and using strategies and plans	Static	Dynamic	Dealing with ambiguity and changes
Achieving optimal solutions	Rational	Non-rational	Facing uncertainty or ambiguity
Planning, control, and follow-up	Formal	Informal	Facing uncertainty or ambiguity
Solving political conflicts	Hierarchical	Non-hierarchical	Rapidly making decisions and supporting new ideas

Although it is presented as though these decision choices are bounded dichotomous options, these choices exist on a continuum where different processes may be employed for different stages. For example, there may be some components of a decision that are rational and systematic, while other components of the decision, particularly in early stages, rely more on subjective feelings. There may be a combination of informal and formal processes, where informal processes guide the early stages of decision making, while the later stages of decision making in taking a program to full-scale involve more formal, documented processes. Similarly, it's possible that non-hierarchical decisions are made in the earlier stages of program development, while hierarchical processes dictate the final decision-making processes related to program adoption. Additionally, there may be hybrid options within each component of decision making that allows for semi-rational decisions, if you will, in a singular instance.

Gutierrez et al. concluded that different approaches for making decisions and understanding innovation are needed (2008). However, an organization's acceptance of the approaches

ultimately determines the approach taken, regardless of appropriateness for the situation. “This puts decision makers in the conflictive situation of applying approaches that are sometimes appropriate but not accepted, and other times accepted but not appropriate” (Gutierrez, 2008, p. 7). This potential conflict of decision-making choice has implications for how an organization deals with complex problems, how it achieves collective understanding, interprets its environment, and prepares itself for change.

4. Socio-ecological Framework

Turner et al. in a 2017 systematic review on evidence use in innovation adoption decision making noted that “much of the existing literature on evidence in use of decision-making on innovation has focussed [sic] on processes at a particular level or not been explicit about the need to study processes at different levels” (p. 8). Turner et al., in turn, created a conceptual model demonstrating the interactions between evidence use and processes at different contextual levels, including professional, organizational, and local system’s levels (Figure 4). This conceptual model, although not perfectly aligned to this project’s research questions, is strikingly close and helped validate the use of a multi-level model to understand program adoption decision-making factors.

As noted in Turner et al.’s systematic review, there is a dearth of literature on using multi-level models to understand the use of evidence in decision making. There was only one health study identified in this literature review that used the socio-ecological model specifically to understand multi-level influences on decision making. Qiao et al. used the socio-ecological model to understand decision making involved in parental human immunodeficiency virus disclosure at multiple levels of influence (2015). The socio-ecological model facilitated the researchers’ understanding of the complexity of the decision-making process and the most influential factors

by level of the decision-making process. Even so, this study relied heavily on the individual and interpersonal level findings and only briefly touched on sociocultural influences to decision making.

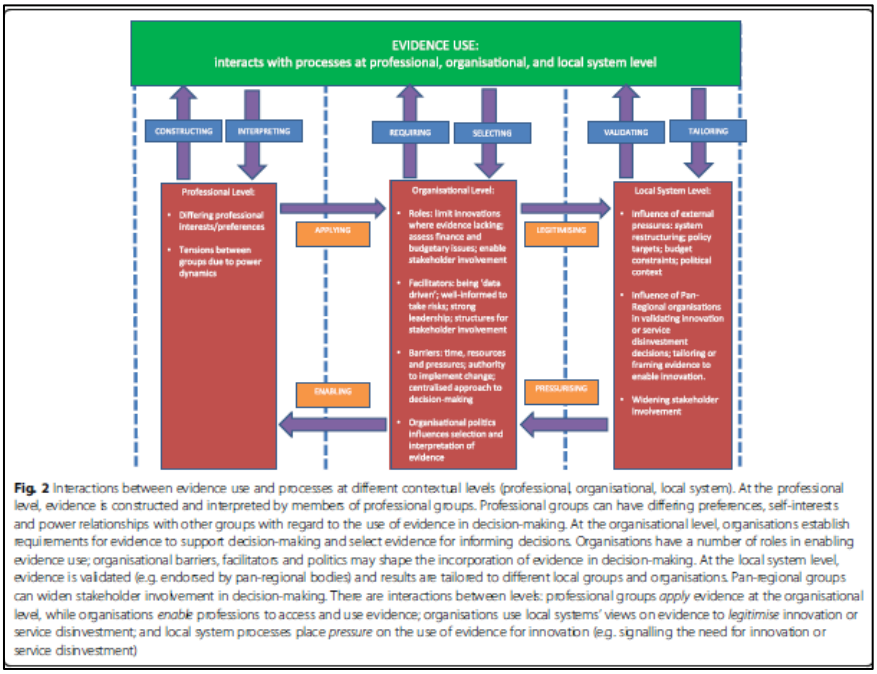


Fig. 2 Interactions between evidence use and processes at different contextual levels (professional, organisational, local system). At the professional level, evidence is constructed and interpreted by members of professional groups. Professional groups can have differing preferences, self-interests and power relationships with other groups with regard to the use of evidence in decision-making. At the organisational level, organisations establish requirements for evidence to support decision-making and select evidence for informing decisions. Organisations have a number of roles in enabling evidence use; organisational barriers, facilitators and politics may shape the incorporation of evidence in decision-making. At the local system level, evidence is validated (e.g. endorsed by pan-regional bodies) and results are tailored to different local groups and organisations. Pan-regional groups can widen stakeholder involvement in decision-making. There are interactions between levels: professional groups *apply* evidence at the organisational level, while organisations *enable* professions to access and use evidence; organisations use local systems' views on evidence to *legitimise* innovation or service disinvestment; and local system processes place *pressure* on the use of evidence for innovation (e.g. signalling the need for innovation or service disinvestment)

Figure 4: Turner et al. interactions between evidence use and processes at different contextual levels

Satterfield et al. created a transdisciplinary model of evidence-based practice that also informed the selection of the socio-ecological model to understand decision-making factors. Their revised evidence-based practice model is "grounded in an ecological framework and emphasizes shared decision making" (2009, p. 381). Satterfield et al. "used an ecological framework because

intervening solely with individuals often is insufficient to maximize long-term gains for the population as a whole" (2009, p. 381). This model demonstrates that decision making occurs at the intersection of three primary organizational factors – best available research evidence; resources, including practitioner's expertise; and client's/populations characteristics, state, needs, values, and preferences. These organizational factors are ultimately impacted by the environment and organizational context that envelop the organization (Figure 5).

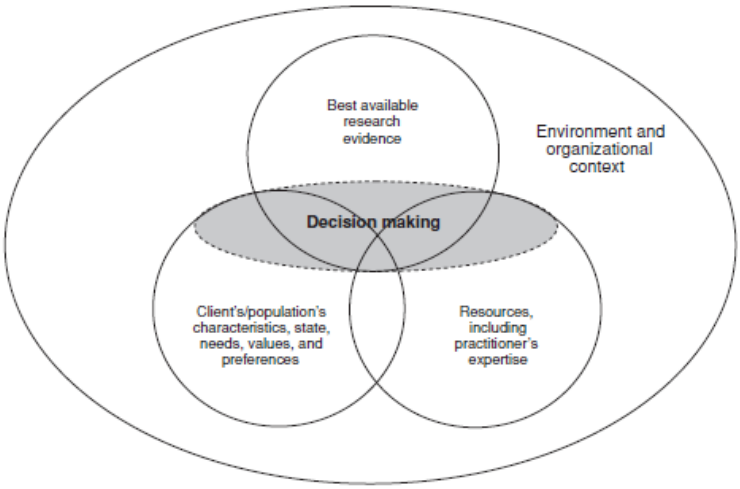


Figure 5: Satterfield et al.'s ecological model for evidence-based decision making

Although examining the role of evidence in decision making is just a component of this project, there is much that can be drawn from this model. Satterfield et al. purposively moved decision making to the center of this model, a deviation from previous evidence-based practice conceptual frameworks. Decision making was moved to the center for four primary reasons:

1. "Decision making is not a particular individual's inherent professional skill; rather, it is a systematic decisional process combining evidence with the client, resources, and context;
2. To demonstrate the great difficulties and complexities in reconciling the many variables needed to make evidence-based decisions;
3. The previous extensive reliance and centrality of a practitioner's expertise was not supported by evidence; and
4. To demonstrate the importance of shared decision making in evidence-based practice implementation" (2009, pp. 383-384).

The socio-ecological model examines factors at five levels (i.e., individual, interpersonal, organizational, community, and societal) and how they interact and overlap (Figure 6). However, there are variations of the socio-ecological model used by different organizations and entities. The socio-ecological model used in this research will look specifically at four levels – individual, interpersonal, organizational, and societal. The community level was specifically omitted due to the pilot's embedded nature within a public sector organization and relative invisibility to the broader community.

Different sources were used to identify decision-making factors at all levels of the socio-ecological model. The Aarons et al. framework served as the primary basis for inner (within the organization - organizational) and outer context (outside the organization - societal) factors. In addition to Aaron et al.'s model and associated factors, the literature search unveiled additional organizational and societal-level factors. A variety of peer-reviewed articles and textbooks served as the source for individual and interpersonal level factors. The socio-ecological framework helped layer the societal, organizational, interpersonal, and individual-level factors

together into a single model to examine decision-making factors at different levels that interact in and impact the decision-making process.

Figure 6: UNICEF socio-ecological model

5. Decision-Making Factors

Many factors were identified that may have impacted the decision to make this pilot a permanent program. The decision-making factor identification process required culling factors from numerous articles and disciplines in the literature. Decision-making factors were then differentiated by the nested levels of the socio-ecological framework. Factors that span multiple levels (e.g., sense of urgency, understanding of the problem, pilot evidence) of the socio-ecological model are noted in each respective level's section (e.g., individual, interpersonal). The

list of factors at all levels of the socio-ecological framework is likely limitless; this is not an exhaustive list, but a robust representation of the most relevant a priori decision-making factors.

a) Individual-Level Factors

The individual level of the socio-ecological model encompasses the characteristics of an individual that influence decision-making behaviors. Although these individual-level factors are not the primary focus of this research, it's important to make note of them explicitly and their role in program adoption decision making. Numerous individual decision factors were identified in the change readiness, decision making, and implementation science literature. Individual-level factors are categorized into four a priori constructs: biological factors, individual difference factors, individual structural factors, and affective components of change readiness.

(1) Biological Factors

Individual-level biological factors were identified in the decision-making literature. The majority of these factors were detailed in March's book, A Primer on Decision Making: How Decisions Happen. He detailed four primary factors that can serve as constraints on an individual's decision-making ability — attention, memory, comprehension, and communication (March, 1994). These four factors are considered barriers, or constraints, on human information processing. The aforementioned factors impact an individual's decision-making ability under the premise that attention is scarce, memory is faulty, humans have difficulty connecting different parts of information to create a coherent story, and individuals have limits to communicate and share information about complex information (March, 1994). These factors collectively impact an individual's ability to make fully informed decisions.

March's work was reinforced by Foss and Weber and their three dimensions of bounded rationality:

- Processing capacity – Constraints on memory, attention, and time limit the brain's ability to process all pertinent information in a situation.
- Cognitive economizing – Limits in cognition lead to short cuts to manage complex information.
- Cognitive biases – People tend to hear what they want to hear to confirm existing beliefs, often ignoring contradictory information (Foss & Webber, 2016).

(2) Individual Difference Factors

Individual psychological difference factors were identified in Holt & Vardaman's conceptual framework in the change readiness literature. Their conceptual framework, derived from factors identified in previous systematic reviews, recognizes the multidimensions and multilevels involved in change and specifically identified and defined individual difference factors (2013). Holt & Vardaman defined individual difference factors as those factors that, "reflect the extent to which members of the organization are cognitively inclined to accept, embrace, and implement a particular change" (2013, p. 11). Five primary individual difference factors were identified in the literature, including precontemplation and preparation, appropriateness, principal support, change efficacy, and valence. These factors are rooted in an individual's beliefs and include, "whether or not individuals: (1) have an inclination to take action in the immediate future (i.e., precontemplation and preparation), (2) feel a change is appropriate (i.e., appropriateness), (3) believe management support the change (i.e., principal support), (4) feel capable of making the change successful (i.e., change efficacy), and (5) believe the change is personally beneficial (i.e., valence)" (2013, p. 12). These factors are also referred to as the cognitive components of change

readiness, a term validated in Rafferty's multilevel framework for understanding change readiness (Rafferty, Jimmieson, & Armenakis, 2013). The individual difference factors/cognitive components of change readiness have been confirmed in numerous systematic reviews, articles, and change readiness frameworks.

(3) Individual Structural Factors

Individual structural factors were also identified in Holt & Vardman's conceptual framework in the change readiness literature. In addition to the individual difference factors, Holt & Vardaman identified individual structural factors as "factors that reflect the extent to which the circumstances under which the change is occurring enhance or inhibit the acceptance and implementation of change" (2013, p. 12). Holt & Vardaman's conceptual framework only identified one individual structural factor – knowledge, skills, and ability alignment. This factor reflects the extent of the alignment of skills, knowledge, and abilities with the change.

Using the definition of individual structural factors provided by Holt & Vardaman, pilot evidence was included as a factor in this category, a factor identified in discussions with pilot stakeholders and confirmed in the literature. Turner et al. identified "preferences for evidence" as a professional-level process influencing evidence use. Preferences for evidence can vary by individuals, groups, and sectors. As Turner et al. stated, "evidence can be given different meanings by different stakeholders resulting in uncertainty about whether evidence was lacking, was not of good quality, or was limited" (2017, p. 5). Similarly, Helfrich et al. created an Organizational Readiness to Change Assessment instrument (ORCA) and defined evidence as "the strength and nature of the evidence as perceived by multiple stakeholders" (2009, p. 4). Drawing from the implementation science literature, evidence was one of the scales used by Helfrich in the ORCA survey to assess organizational readiness for implementation; the other

scales included understanding of the context of the implementation and the way in which the implementation was facilitated (Helfrich, Li, Sharp, & Sales, 2009).

(4) Affective Components of Change Readiness

There is extant literature on individual difference factors (synonymous with cognitive components of change readiness; Rafferty et al., 2013). However, recent literature acknowledges the affective, or emotional, components of change readiness existent at the individual level that are often not differentiated from the cognitive component of change readiness. In the Rafferty review, affective reactions capture an individual's "emotions concerning a specific change event" (2013, p. 116). The affect or emotion can change based on feelings and what the individual may imagine happening, which can ultimately impact decision making. These emotions can then impact a sense of urgency, or the inclination to take action in the immediate future (Holt & Vardaman, 2013).

b) Interpersonal-Level Factors

The interpersonal level of the socio-ecological model includes the formal (and informal) social networks and peer support systems that can influence decision making, including family, friends, peers, co-workers, customs, or traditions (UNICEF, n.d.). Although these interpersonal-level factors are not the primary focus of this research, it is important to make note of them explicitly and the role they play in program adoption decision making. While there was a plethora of literature on individual-level decision-making factors, literature was scarce for interpersonal-level decision-making factors. However, some literature on groups/workgroups related to change readiness and decision making was used as a proxy for the interpersonal level. Whelan-Barry, when referring to change readiness, noted that "the organizational-level change process inherently involves the group and individual change processes" (2003, p. 116). Rafferty posited

that an organization's change readiness is derived from the individual cognitive and affective processes, which in turn impact social interaction processes, which then ultimately impact an organization's change readiness (2013). With that, the interpersonal-level factors include workgroup/group factors and factors that may cross multiple levels of the socio-ecological model. Interpersonal-level factors are categorized into three a priori constructs: cognitive beliefs, affective responses, and interests and identities.

(1) Cognitive Beliefs

Workgroups and interpersonal relationships are comprised of individuals. Individuals in groups are exposed to similar stimuli (e.g., leaders, organizational events, processes) that, over time, converge into a similar view of events (Rafferty et al., 2013). Rafferty posits that the "meaning of any change event is negotiated and ultimately determined by individual and group sensemaking efforts" (2013, p. 117). Individuals arrive at these shared beliefs by communicating and working together. Similar to the individual difference factors (cognitive components of change readiness) noted at the individual level of the socio-ecological model, workgroups may develop convergent beliefs that change is needed and that change will generate favorable outcomes. These shared beliefs improve the potential for successful change implementation (Rafferty et al., 2013). Relatedly, Qiao noted that the strength of the relationship was an important interpersonal level decision-making factor that facilitated open communication and disclosure (2015). However, Klein and Sorra noted that functional or hierarchical groups (e.g., senior managers, supervisors, technicians) will likely differ in their values and views from other employees based on their distinctive backgrounds and traits, roles in the organization, and their common interactions and experiences (1996).

Similarly, Greenhalgh et al. identified opinion leaders as an important component of innovation diffusion and influencing the opinions of others related to the change. Opinion leaders can be present in either an expert or peer opinion capacity and have the ability to exert influence either positively or negatively. Those considered experts influence through their status and level of authority, while peers may influence others through their relatability and credibility (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004). Similarly, champions, key individuals in one's social network, also play a role in promoting a program and influencing the likelihood a program will be adopted. Adoption is more likely to occur if champions support the innovation (Greenhalgh et al., 2004).

(2) Affective Responses

Similar to the individual-level affective components of change readiness, affective responses (emotions) are an important component in workgroup change readiness. Similar to how individuals' affective/emotional responses impact change readiness and decision making, researchers have suggested that collective emotional reactions, the culmination of individual group member's emotions, can develop in response to and impact change events. These emotions can then impact a sense of urgency, or the inclination to take action in the immediate future (Holt & Vardaman, 2013).

There were two primary shared affective responses identified in the literature – emotional comparison and contagion. Emotional comparison, as defined by Rafferty, is "when individuals in ambiguous and physiologically arousing situations – such as during periods of large-scale organizational change – seek out and use cues from similar others to label their aroused state" (2013, p. 117). These comparisons help an individual member gauge the intensity of their emotion. Emotional contagion then is the conscious or subconscious impact of a person or group

of people's emotions on a group (Rafferty, 2013). Emotional contagion, or collective emotions, does not just happen within any group. Rafferty et al.'s review referenced a number of antecedents identified by other researchers that need to be in place to induce collective emotions, including "task and social interdependence, the frequency and continuity of contact, mood regulation norms, identification with the workgroup, commitment to the group, and workgroup climate" (2013, p. 118).

(3) Interests and Identities

In March's book, A Primer on Decision Making: How Decisions Happen, he discusses the complexities and inconsistencies that can be present in multiple actor (teams and partners) decision-making processes. March referred to these multiple actor factors as interests and identities. He notes that in interpersonal decision making, beliefs are important "particularly beliefs about who wants what, who has power, and who will act" (March, 1994, p. 110). Trust and loyalty in decision making are noted as valuable and scarce. Comparable to the biological individual-level decision-making factors, attention is also important at the interpersonal level. Decisions depend on "who participates and to what degree" (March, 1994, p. 111). March noted, "Actors with "power" and "resources" may fail because they are distracted, and actors with few resources and little power may succeed because they are alert or persistent" (1994, p. 111).

c) Organizational-Level Factors

The organizational level of the socio-ecological model includes institutions and organizations with operational structures and practices that dictate the provision of services to groups and individuals (UNICEF, n.d.). Organizational-level impacts and influences are the primary focus of this research, including the complex interplay of these organizational-level decision-making factors with factors at other levels of the socio-ecological framework. In the Aarons et al.

framework, the inner context can be considered synonymous with the organizational-level factors. The organizational level is the culmination of individual and interpersonal decision-making factors, with additional factors and synergies at play. The organizational-level factors are organized into five a priori constructs: organizational characteristics, leadership, organizational readiness for change, politics or the political frame, and pilot characteristics.

(1) Organizational Characteristics

Aarons et al. identified organizational characteristics as important to the inner context of the adoption decision/preparation phase. There are many intra-organizational variables that can facilitate or inhibit program adoption, including organizational structure components. Organizational size was confirmed as an important factor in innovation in a dated meta-analysis by Damanpour (1991). Size, for example, can serve as a facilitator of innovation adoption, as more expansive organizations may have greater resources to commit to "evaluating and exploring the potential utility of different innovative practices" (Aarons et al., 2011, p. 11). Aarons et al. noted, however, that "organizational size is likely a proxy for structural variables, such as role specialization and the existence of knowledge and skills within an organization to support adoption of innovations" (2011, p. 11).

Organizational culture/climate is another key component of program adoption decision making. Organizations must consider the fit of a program with the roles, structure, values, and authority of an organization that may facilitate or inhibit program adoption and sustainment (Aarons et al., 2011). Considerations of fit within the existing structure and responsibilities of an organization ultimately contribute to whether or not a program is adopted. Weiner et al. and Aarons et al. discuss the innovation-values fit, which is the extent to which the program or innovation will fulfill the organization's values and align with the mission, values, and organizational tasks and

duties (Weiner, Lewis, & Linnan, 2009; Aarons et al., 2011). Similarly, Helfrich et al. identified organizational culture as one of the three context components that determine successful innovation implementation (2009). Organizational culture, according to Helfrich et al. refers to "the values, beliefs, and attitudes shared by members of the organization, and can emerge at the macro-organizational level, as well as among sub-units within the organization" (2009, p. 2). Over time, an organization develops distinctive beliefs, values, and customs (Bolman & Deal, 2017). This organizational culture ultimately impacts the extent to whether the organization is aware the problem exists and whether the organization values the issue as a problem (Castaneda et al., 2012).

In line with an organization's culture, risk preference impacts aggregate decision behavior and ultimately program adoption decision making. March identified three sets of risk-taking factors that impact organizational decision making, including risk estimation (how much risk is perceived in the decision), risk-taking propensity (the organization's tolerance for risk), and the structural factors within which risk-taking occurs (the context that impacts the organization's risk estimation and risk-taking propensity; 1994). These risk characteristics impact decision making at the organizational level of the socio-ecological model.

Bolman & Deal created a four-frame model to understand the multiple lenses and perspectives that organizations may use to create their own images of reality. The four-frame model — structural, human resources, political, and symbolic — stresses that each of the lenses is valid and that multiframe thinking and design helps to better understand situations and make decisions. Bolman & Deal demonstrated that "any event can be framed in different ways and serve multiple purposes" (2017, p. 300). For example, related specifically to decision making, each of the frames views decision making in different ways. The structural frame views decision making as

a rational process to arrive at a decision. The human resource frame views decision making as a collaborative process to produce commitment, whereas the political frame views decision making as an opportunity to gain or exercise power. Finally, the symbolic frame views decision making as a ritual to confirm values and bring people together. Numerous studies have shown that employing multiple decision-making frames simultaneously is associated with improved organizational effectiveness (Bolman & Deal, 2017).

Communication is an important organizational characteristic that facilitates decision making and readiness for change. High-quality change communication increases acceptance, openness, and commitment to change (Rafferty et al., 2013). According to Greenhalgh et al.'s systematic review, "effective communication across structural boundaries within the organization enhances the success of implementation and the change of routinization. A narrative approach (i.e., the purposeful construction of a shared and emergent organizational story of "what are we doing with this innovation") can serve as a powerful cue to action" (2004, pp. 611-12).

(2) Leadership

Aarons et al. identified leadership as a critical piece in the adoption decision/preparation inner context to instilling an organizational culture and a climate conducive to the adoption of necessary programs (2011). Numerous studies have shown that innovative practices are far less likely to move beyond the exploration and adoption phases into implementation without an internal organizational champion (Aarons et al., 2011). Leaders, according to an article by Stragalas, "have the most impact in generating change management success" (2010, p. 35). One source asserted that "one distinguishing difference between leaders that succeed at driving collaboration and innovation versus those that fail is their ability to grasp complexity. This skill set involves framing difficult concepts quickly, synthesizing data in a way that drives new

insight, and building teams that can generate future scenarios different from the world they see today" (Caldicott, 2014, para. 9). The leadership construct is so highly pervasive that it permeates down to the individual level in the concept of principal support. Principal support is the notion that leaders are committed to the change and that it will not be just another flavor of the week (Holt & Vardaman, 2013). The literature has also noted that leadership at all levels (e.g., senior executives, middle managers) combined with organizational support has the ability to create a positive adoption climate, attitudes, and readiness for program adoption (Aarons et al., 2011).

It is important to note that the definition of leadership has been evolving from individual-centric characteristics to a more complex view that encompasses a number of factors, including the individual, relationships, and context (Bolman & Deal, 2017). The five key principles that demonstrate this shift include: the view of leadership as an activity, not a position; that leadership is different from management (visioning, networking, and building relationships vs. planning, organizing, and controlling; Kotter, 1988); leaders empower others to lead regardless of formal position; leadership is distributed rather than concentrated at the top; and leadership is situated in the exchange between a leader and constituents (Bolman & Deal, 2017). This change in the definition and operationalization of leadership has also then changed how decisions are made.

There is extant literature on the importance of leadership in strategic activities and leading change. A decision on whether or not to adopt a pilot program (and the sense of urgency that is placed around this decision) is no exception. According to Bolman & Deal, "leadership helps groups develop a shared sense of direction and commitment" (2017, p. 176). Reminiscent of this concept is a Heifetz & Drath diagram that was shared in IPHS 501 on leadership levels (Figure

7). Similar to Maslow's hierarchy of needs and Bloom's taxonomy, the leadership level advances as the apex of the triangle is approached. Leadership Level I, Personal Dominance, is where a single person solves a problem or sets the direction. This approach is generally a fit for a

Figure 7: Levels of public health leadership and relevant problem type

technical or clear problem. Level II leadership is designated for non-technical/clear problems where the solution is partially known or unclear, with some adaptive learning necessary. A group is required to solve the issue and the leader must have interpersonal influence and political skill, and the ability to harness commitment, alignment, motivation, spirit, and teamwork from others. Level III is the most complex type of leadership reserved for adaptive circumstances in which

the solution to the problem is not obvious and decision making should be shared with all stakeholders with an interest in the issue. The activities or competencies required of this leadership level include promoting organizational learning, managing and resolving tension, fostering an environment for open dialogue, facilitating paradigm shifts, systematically framing issues, and proposing and leading innovation and change (Heifetz & Drath, n.d.). These complex activities require what Bolman & Deal refer to as leadership artistry, the counterbalance of the technical and rational aspects of leadership (2017). Similarly, leaders have the ability to set the tone for the importance of evidence in the decision-making process (Helfrich, 2011).

(3) Organizational Readiness for Change

Satterfield et al. noted change readiness as an important factor in their evidence-based practice decision-making model (2009). Change readiness is a robust and standalone field in and of itself, but it is also an important piece of organizational-level decision making. Change readiness, or perceived change readiness, is indubitably considered when deciding whether to adopt a program. Holt & Vardaman used the term collective commitment as the "shared belief and resolve to pursue courses of action that will lead to successful change implementation" (2013, p. 12). Collective commitment is further supported by Bouckneghee's concept of climate of change, which is the impact the organization's context has on the perception of the circumstances in which the change is occurring (2009). That climate of change then impacts the perception and reality of organizational readiness to change. Castaneda et al., when referring to commitment to change, stated that "believing that change is possible and being committed to an issue are essential to being ready to make change happen. In organizations, motivation for change is based on the belief that change is needed, or on external pressures. If the motivation

for change is not activated, organizational members are unlikely to initiate change behaviors, such as adopting innovative programs" (2012, p. 223).

Although the capacity to implement change could be considered a construct on its own, Castaneda et al. included capacity as a dimension of community readiness (2012). Capacity is the extent to which organizational characteristics impact the ability to identify and address health and social issues (Castenada et al., 2012). The capacity to implement change is not a static state; it can change based on capacity-building efforts that may be initiated as a result of interactions within and outside the organization.

Similar to the workgroup/interpersonal level, cognitive beliefs and affective responses impact organizational readiness for change (Rafferty et al., 2013). Similar to the individual and interpersonal factors, a sense of urgency impacts the organization's inclination to take action in the immediate future (Holt & Vardaman, 2013). As Greenhalgh et al. stated, "If staff believe that the current situation is intolerable, a potential innovation is more likely to be assimilated successfully" (2004, p. 27). Related to cognitive beliefs, Rafferty posited that a "number of top-down processes are likely to result in employees in an organization as a whole developing shared beliefs about change" (2013, p. 118). Many forces exist that result in organizations being comprised of individuals with similar characteristics and personalities, often resulting in developing convergent interpretations of organizational events. Similarly, Rafferty's review of the literature found that there are many factors that can impact the likelihood that organizational members will develop similar emotions when confronted with organizational change events, including the perceived impetus for the change event and shared pros and cons of the change events (2013). These affective responses, in addition to the imminent change, are also influenced

by organizational culture, as the organizational culture establishes what behaviors and emotions are acceptable and validated (Van Maanen & Kunda, 1989).

(4) Politics or Political Frame

Organizational politics influence the type of evidence accessed and how it is interpreted (Turner, 2017). Greenhalgh et al. noted that a political push during the early stages of program adoption can increase its chances of success, "perhaps most crucially by making available a dedicated funding stream" (2004, p. 610). In looking at organizational decision making, Cyert and March (1963) identified four relational concepts that organizations use in a political bargaining process to make decision making more digestible: reducing problem complexity by breaking an issue into pieces and distributing responsibilities to different entities; simplifying the issue to make it seem more predictable than it actually is; looking for convenient solutions close to the problem and jumping at the first reasonable solution; and changing what is important over time.

(5) Pilot Characteristics

Characteristics of the pilot study have the potential to impact decision making. The strength and nature of the pilot evidence as perceived by the organization can impact decision making (Helfrich et al., 2009). An innovation that is deemed a fit (innovation-system fit) with the existing "values, norms, strategies, goals, skill mix, supporting technologies, and ways of working, is more likely to be assimilated" (Greenhalgh et al., 2004, p. 608). If the program has a defined budget and identified resources for its sustainment, it is more likely to be adopted (Greenhalgh et al., 2004). Similarly, a program will more likely be adopted and maintained if it has monitoring and evaluation systems in place (Greenhalgh et al., 2004).

d) Societal/Policy-Level Factors

The societal/policy level of the socio-ecological framework includes the local, state, national, and global factors that impact decision making and may govern the allocation of resources (UNICEF, n.d.). In Aarons et al.'s model, these societal-level factors are considered the outer context, or the outer-level factors. Societal influences envelop the organizational, interpersonal, and individual levels of decision making. The societal-level factors are organized into four a priori constructs: sociopolitical/funding, client advocacy, interorganizational networks, and media messaging.

(1) Sociopolitical/Funding

Some adoption decisions can be partially explained by major legislative landmarks. Laws and policies can reflect heightened awareness and concern over an issue (e.g., sense of urgency). Similarly, laws and policies can reflect the extent to whether external entities (e.g., Congress, advocacy groups, broader societal members) are aware a problem exists and whether members value it as a problem (Castaneda et al., 2012). These adoption decisions can also be tied to federal and state policy funding for specific implementation models. Aarons et al. noted that programs adopted and locally enacted in response to new laws often have differing emphases on evidence-based practices – some adopted programs had a strong evidence base, while other programs had a weak evidence base (2011). However, there is a level of subjectivity related to evidence; Helfrich et al. defined evidence as the "strength and nature of evidence as perceived by multiple stakeholders" (2009, p. 4). Hence, there may be some discord over the validity and strength of evidence, but discussions of what is evidence-based can be complicated by funding appropriations. Turner et al. noted that "external pressures, including system restructuring, meeting policy targets, and budgetary constraint influenced how evidence was used in decisions

about innovation" (2017, p. 7). Relatedly, if an innovation has dedicated and ongoing funding (regardless of the evidence base), it is more likely to be implemented and sustained (Greenhalgh et al., 2004).

(2) Client Advocacy

Aarons et al. noted that client advocacy, and advocacy on behalf of clients plays a role in the decision to adopt new programs (2011). Advocacy organizations at the national level can be highly influential in shaping the sociopolitical context that can ultimately determine if programs are adopted. These advocacy organizations can help conceptualize issues and shape legislation to influence outcomes on behalf of their client (e.g., women Veterans). Local client advocacy may also occur but has not historically been as influential as national-level advocacy. Some locally-led class-action lawsuits have, however, led to changes in local policy and practice (Aarons et al., 2011).

(3) Interorganizational Networks

Aarons et al. noted that "interorganizational forces, which focus on how individual organizations relate to, partner with, and compete with one another also play a potentially powerful role in adoption decisions" (2011, p. 10). These interorganizational forces are impacted by interorganizational networks, including informal and formal connections, communication pathways used by the entities, and shared perceptions of risk. All of these factors combine to create a picture of the costs and benefits of initiating an innovation and have the potential to impact the perception of risk around adopting a program. These forces can generate pressure for organizations to adopt an innovation if comparable organizations have done so or plan to do so (Greenhalgh et al., 2004).

(4) Media Messaging

VA, particularly in the past five years, has faced an onslaught of negative media coverage. Headlines such as "Report: VA scandal may have killed more than 1,000 vets," "A fatal wait: Veterans languish and die on a VA hospital's secret list," and "Despite $10B 'Fix,' Veterans are Waiting Even Longer to See Doctors," have painted VA in a negative light. The news has not been favorable for VA's counterpart DoD, either. The New York Times released an extensive report in 2014 titled, "In Military Care, a Pattern of Errors but not Scrutiny," among others. It is not to say that these organizations do not respectively have their challenges, but the two largest healthcare systems serving our nation's service members and Veterans operate under a microscope. Consequently, media attention and messaging impact legislative and policy actions. The added pressure and immediacy of some issues can generate immediate, short-term solutions to the problem (Yanovitzky, 2002). This study by Yanovitzky also showed that once the amount of media attention on an issue was reduced, policy preferences shifted from short-term solutions to more sustainable, long-term solutions, implying that media attention can adversely impact sustainable policy and programmatic decisions (2002).

B. Conceptual Framework

A conceptual framework is a way of organizing and bounding research while aiding in the understanding of complex situations. The conceptual and analytical framework for this research is based on the aforementioned literature related to how decisions are made related to innovation programs and decision-making factors at all levels of the socio-ecological model (Figure 8).

Aarons et al. identified four implementation phases present in public sector programs: exploration, adoption decision/preparation, active implementation, and sustainment (2011). To properly frame this research within a feasible dissertation scope, the focus is on the adoption

decision/preparation phase of program adoption. Two primary questions drive the inquiry – how did VA make the decision to adopt the pilot program (RQ#1) and what factors influenced the program adoption decision (RQ #2). To better understand the factors that influenced the program adoption decision, the socio-ecological framework was used to understand the primary factors

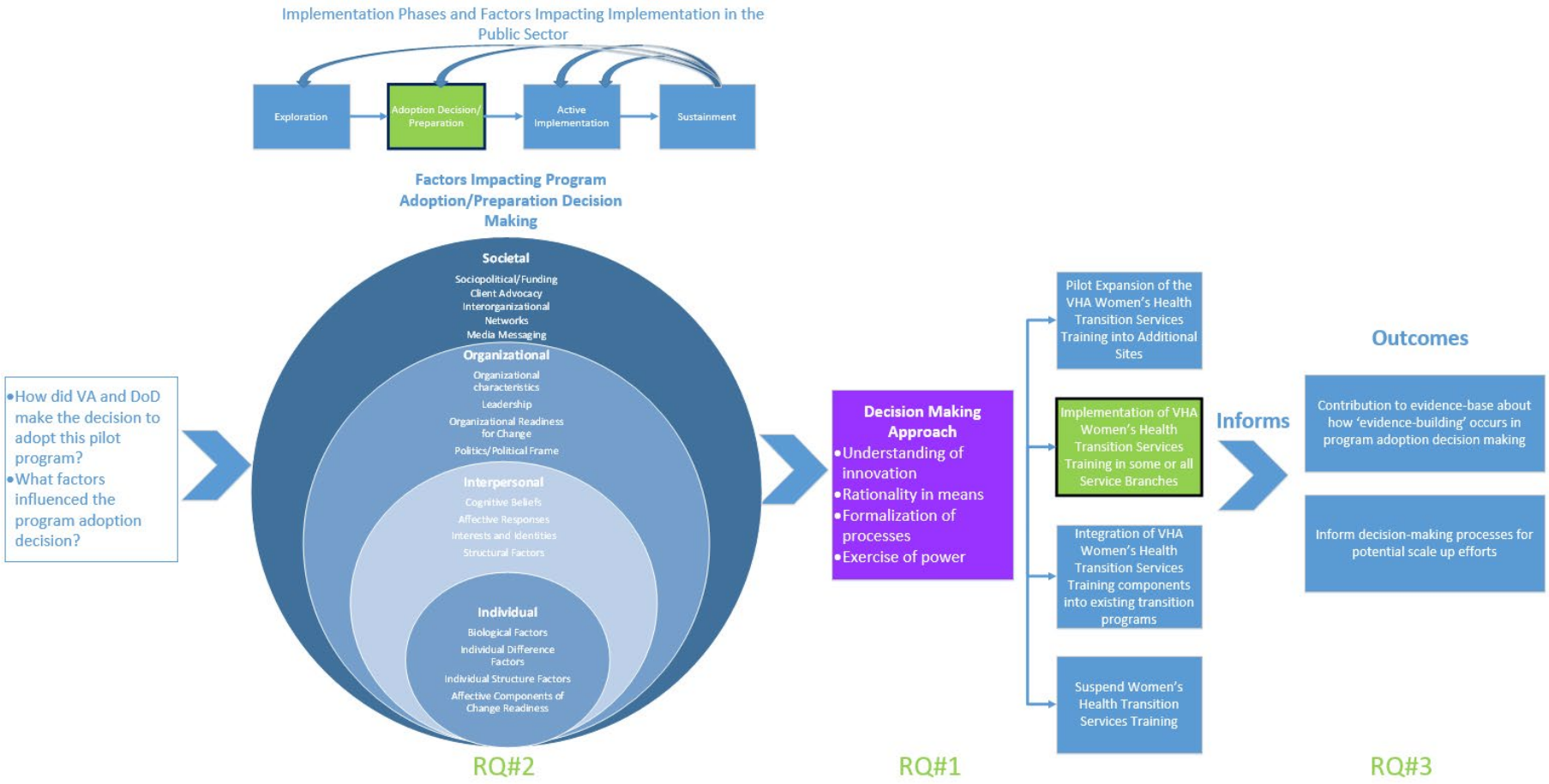


Figure 8: Program adoption decision making conceptual framework

that impacted program adoption/preparation decision making at all levels of the socio-ecological model – individual, interpersonal, organizational, and societal.

In addition to understanding the factors involved in the decision-making process, the decision-making approach will be examined as to how the decision was ultimately made. These decision-making factors and the decision-making approach ultimately resulted in implementation of the pilot in all service branches, but it is important to note this decision-making process could have resulted in one of four outcomes: pilot expansion, implementation of the pilot in some or all service branches, integration of pilot training components into existing transition programs (e.g., TAP), or suspension/cessation of the pilot. The final question and component of this study is to understand the broader implications and applications of this project. The findings on factors and how decisions are made will contribute to VA's knowledge base about how 'evidence-building' occurs in program adoption decision making and may inform subsequent decision-making processes for VA innovation programs.

C. Chapter II Summary

Chapter II provided an extant review of the literature on how innovation adoption decisions may be made and potential program adoption decision-making factors at all levels of the socio-ecological model. This chapter is a synthesis of concepts from multidisciplinary sources to understand the decision-making process and factors in a single case. It is recognized that not all constructs and subcodes are of equal importance, nor will they all be identified explored within the purview of a single dissertation; however, they are highlighted in chapter II for consideration and comprehensiveness.

The literature on how decisions are made was examined and presented, illustrating the complexity of decision making and the various choices that impact how a decision is made. Literature was identified and presented for potential decision-making factors and factors were organized using the socio-ecological model. A conceptual framework was created to guide the exploration of how the decision was made and the factors that contributed to the decision-making process for the VHA Women's Health Transition Training pilot.

III. STUDY DESIGN, DATA, AND METHODS

A. Study Selection and Program Partner Overview

The VHA Women's Health Transition Training pilot offered a unique opportunity to examine program adoption decision making retrospectively. The pilot was a candidate for a case study because according to Yin, a case study is an appropriate method when 'how' or 'why' questions are posed (2009). This case study was deemed a representative single case study because the lessons learned from this case, "are assumed to be informative about the experiences of the average person or institution" (Yin, 2009, p. 48). Access to this single case shed light on a broader organizational/systems issue of program adoption decision making, which is routinely conducted in the public sector to determine how best to allocate scarce resources.

VHA Women's Health Services and Air Force Women's Initiative Team program partners were involved and integral in the design and implementation of this dissertation project. The program partners participated in the initial study framing and conceptualization of the project via regularly scheduled meetings and numerous ad hoc meetings; provided documents included in the background and context (Chapter I) and the document review (Chapter IV); assisted with identification and recruitment of interview and focus group participants; and assisted in member checking throughout the data analysis process to verify the accuracy of project findings (particularly document review and deidentified interview findings). Member checking is when data, interpretations, and conclusions are tested within the group from which the information was obtained and is considered a means in which to establish the validity of study findings (Cohen & Crabtree, 2006). Additionally, the program partners helped shape this project as a quality improvement project for VHA to use the findings to assist with future program implementations. VHA's endorsement of the dissertation project as non-research for the purposes of quality

improvement ultimately led to a UIC Institutional Review Board designation of the project as non-research (Appendix M: UIC Non-Research Determination). It is of note that although this project was deemed non-research for the purpose of quality improvement, research best practices were followed to ensure the confidentiality of all participants.

B. Analytical Approach

This single exploratory qualitative case study examined program adoption decision making in a pilot program designed to address transitioning servicewomen health needs. Qualitative methods were used to answer the study questions, as the methods fit with the exploratory nature of this project and the centrality of context (e.g., women Veterans and healthcare access) to the inquiry and analysis. The quality improvement project used three phases to understand how the decision was made and the decision-making factors that impacted the decision to adopt this pilot as a permanent program (see Appendix C: Measurement Table for phase details). The remainder of Chapter III provides an overview of the three successive phases and methods employed, including details on the data sources, collection, management, and analyses used.

1. Phase I: Document Review

A document review was completed to partially answer question 1 – how was the decision made to adopt this pilot program? A total of 68 documents were reviewed to examine the chronology of events related to the impetus and permanent program adoption of the VHA Women's Health Transition Training pilot.

2. Phase II: Semi-Structured Interviews

Interviews were conducted with 15 VHA Women's Health Transition Training pilot stakeholders to answer questions 1 and 2. The interviews, facilitated with a semi-structured interview guide

(Appendix A: Semi-Structured Interview Guide), explored the individual's role in the decision-making process, their perceptions on how the decision was made (including the 'how' and 'why' of decision-making processes), and the factors that impacted the decision-making process.

3. Phase III: Focus Group

A focus group was conducted with four pilot stakeholders to answer question 3. The purpose of this phase was to primarily understand the leadership implications of the study findings and how these findings may inform future program implementations and decision-making efforts. Secondarily, the focus group assessed the accuracy and resonance of findings with pilot stakeholders (i.e., member checking).

C. Data Sources, Collection, and Management

Data was collected via three qualitative methods – a document review, semi-structured interviews, and a focus group. An Excel workbook was used to manage and analyze document review data, while MAXQDA was used to manage and analyze interview and focus group data. Descriptions of the data sources, collection, and management practices for each method are discussed in the following sections.

1. Phase I: Document Review

A document review was conducted to partially answer question 1. A total of 68 documents from the pre-pilot timeframe (pre-January 2017) to the decision to adopt the pilot as a permanent program (June 12, 2019) were reviewed. The majority of documents included in the review were provided by program partners; additional documents were also procured using the search term, "VHA Women's Health Transition pilot." TABLE V displays the breakdown of documents included in the review by document type.

TABLE V: DOCUMENT REVIEW OVERVIEW

Document Type	Number of Documents
Email/Personal Correspondence	2
Report	6
Meeting Minutes	7
Briefing (PowerPoint Presentation)	21
Information Paper	2
Legislative Bill	3
Letter	5
Memorandum	1
Online Article	17
Poster	1
Panel	2
Proposal	1
Written Response	1
Total Documents	**68**

The document review informed the development of a comprehensive timeline of events. The document review and assembly of the chronology of events in an Excel workbook helped develop more robust descriptions of the stakeholder groups involved, understand which stakeholders attended different meetings, and identify information disseminated at different time points. A component of question 1 was to understand if a standard program implementation decision-making process exists. It was identified that no such protocol exists; therefore, it was not possible to compare the pilot decision-making process to an established protocol. The document review process is described in greater detail in the analysis section.

2. Phase II: Semi-Structured Interviews

Interviews were conducted to answer the first two questions – how the decision was made to adopt the pilot as a permanent program and factors that impacted the decision-making process.

Semi-structured interviews allowed for an exploration of the how and why of the decision-making processes. Patton refers to this method as the "standardized open-ended interview" in which the wording of the questions is determined in advance and all questions are asked in the same basic order in an open-ended format (2015, p. 438).

a) Interview Recruitment Strategy

A sampling plan was created to elicit perspectives from the primary pilot stakeholder groups (Appendix D: A Priori Sampling Plan). Purposeful selection or (purposeful sampling) was employed to recruit participants due to the finite number of individuals involved in the pilot. "In this strategy, particular settings, persons, or activities are selected deliberately to provide information that is particularly relevant to your questions and goals, and that can't be gotten as well from other choices" (Maxwell, 2013, p. 97). Heterogeneity in pilot stakeholders was sought, with the possibility to then draw contrasts or comparisons of responses based on different vantage points and perspectives.

The program partners assisted with participant recruitment by providing names, contact information, and participant roles of recommended interviewees. The inclusion criteria for interviewees was that the individual must have been involved as part of the pilot implementation team, as a decision maker, or as a member of an identified influencer group. The total number of potential interviewees was further refined from the initial proposed sampling strategy, as the program partners conveyed that the number of proposed eligible interviewees (51) was not actually feasible. For example, for some groups, a designated official only was allowed to speak on behalf of the group, which reduced the number of potential interviewees in that stakeholder group to a single interviewee.

The proposed interview sample methodology was stratified by entity, level, and role. That level of specificity is not included here to preserve the confidentiality of individual interview participants. Consequently, interviewees were classified into three pilot stakeholder groups: implementer, influencer, and decision maker. The interview sample inclusion criteria of decision makers, implementers, and influencers allowed for visibility into different stakeholder perspectives on the decision-making process and factors that impacted the successful adoption of the pilot program. Descriptions of the pilot stakeholder groups are included below and further defined and delineated in Chapter IV.

(1) Decision Makers

Four primary interagency committees convene on a regularly scheduled basis to make decisions impacting DoD and VA. The four primary interagency decision-making entities involved in the pilot included: Joint Executive Committee (JEC), Health Executive Committee (HEC), including the HEC Women's Health Working Group (WHWG), Senior Steering Group (SSG), and Transition Assistance Program Interagency Workgroup (TAIWG).

(2) Implementers

VHA Women's Health Services was responsible for developing the pilot curriculum and the program evaluation for the VHA Women's Health Transition Training pilot. During the pilot phase, the Air Force furnished pilot sites, hosted pilot sessions, and presented jointly with VHA representatives on pilot progress. The implementation team included both federal government employees and contractor support staff.

(3) Influencers

Stakeholder groups external to VA and DoD were influential to the pilot implementation decision-making process. These groups include two Federal Advisory Committees (i.e., Defense Advisory Committee on Women in the Services and Advisory Committee on Women Veterans), Veteran service organizations (e.g., Service Women's Action Network), and Congressional entities (e.g., House and Senate Armed Services Committees and Committees on Veterans' Affairs).

A standardized email template was created and approved by the program partners during the interviewee recruitment process. Emails were sent in late-October 2019 by the principal investigator to 23 potential interviewees; program partners were copied on the email to improve credibility. The email included the study purpose and objectives, signed VHA letter of support (Appendix E: VHA Letter of Support), and a request for an interview (Appendix F: Interviewee Recruitment Letter). Individual interviews were scheduled using email correspondence to set dates and times for interviews. Confirmed interviewees were assigned a deidentified ID number and were sent an interview consent form (Appendix G: Interview Informed Consent Form) approximately one week prior to the scheduled interview date. All interviews were conducted in November-December 2019. Interview consent forms were signed by interviewees prior to the interview; once received, the principal investigator signed and returned the form to the interviewee for their records.

TABLE VI displays the distribution of interviewees by role: implementer, influencer, or decision maker. Of the 23 interviewees outreached, 15, or 65%, of potential interviewees participated. There were a variety of reasons reported for why individuals did not participate in an interview. Some of the outreached individuals never responded to the first or second email solicitation,

while others were not available to participate in the specified timeframe. Others did not participate due to their official role/position and the potentially sensitive nature of the interview.

TABLE VI: INTERVIEWEES BY ROLE

Role	Number of Interviewees
Decision Maker	4
Influencer	7
Implementer	4
Total	**15**

b) Semi-Structured Interviews

A semi-structured interview guide was created and used to conduct participant interviews (Appendix A: Semi-Structured Interview Guide). The interview guide was piloted in June 2019 and updated based on mock interviews with former VA officials that tested the wording and flow of questions. The interview guide included skip logic based on the interviewees' role and knowledge of the processes. For example, influencers were asked about their knowledge of the decision-making process; if they did not have visibility into the internal decision-making processes, the remainder of the questions pertaining to that topic was bypassed. Interviews ranged in length from 15 to 75 minutes, with a total of 840 minutes of interview time (an average of 56 minutes per interview). All interviews were conducted virtually using Google Hangouts audio functionality.

3. Phase III: Focus Group

a) Focus Group Recruitment and Participant Selection

The primary objective of the Phase III focus group was to answer question 3 – what do these findings suggest about program adoption decision making within VA and DoD and how can this knowledge inform future implementations? Secondarily, the focus group was used to assess the validity of study findings with pilot stakeholders and participants (member checking).

The principal investigator worked with the program partners to identify focus group participants. The inclusion criteria for focus group participants was that the individual must have been in one of the identified pilot stakeholder groups. The program partners recommended five focus group participants. Four of the five proposed participants ultimately participated (80%); the fifth potential participant was unable to attend due to another commitment at the scheduled time. All four participants were sent a focus group consent form one week prior to the scheduled focus group (Appendix H: Focus Group Participant Form). Focus group participants signed and returned consent forms prior to the focus group. The principal investigator then signed the forms and returned to the focus group participants for their records.

b) Focus Group Methods

Four pilot stakeholders participated in a 90-minute virtual focus group and member-checking session in late-December 2019. Google Hangouts audio was used to conduct the focus group to accommodate participants in different locations. The focus group included a 40-minute presentation of document review and interview findings, followed by a 50-minute facilitated discussion. The ORID method was used to guide a discussion around the participants' understanding of the findings, reflections on the findings, interpretation of the findings to uncover deeper meanings, and how the findings may impact future implementation and decision-

making processes. The guide (Appendix I: Focus Group Guide - ORID Framework) included questions like, “How do these findings reflect what happened? What did you find new or surprising about these findings? What particularly resonated with you? What did you learn from these findings? What would you change about the pilot process if you could go back? What recommendations can be made to improve decision making in the future? What skills or resources are needed to make these changes?”

4. Data Management

A private DropBox data collection repository was used to store and organize dissertation documents (e.g., document review data, deidentified interview transcripts) that were used to answer the study questions. Interview and focus group data were also imported into and managed within MAXQDA.

Although this project was deemed non-research for quality improvement purposes, research best practices were followed to maintain participant confidentiality. The data collection repository database was maintained and managed solely by the principal investigator. Deidentified transcripts and notes were maintained in a private DropBox site, while interviewee names and contact information were maintained in a separate private UIC box. The second coder did not have access to the data collection repository and was sent deidentified transcripts without any participant names or titles to ensure confidentiality. Additionally, only deidentified transcripts were maintained and uploaded into MAXQDA and as a further precaution, the study’s MAXQDA platform was not shared with anyone.

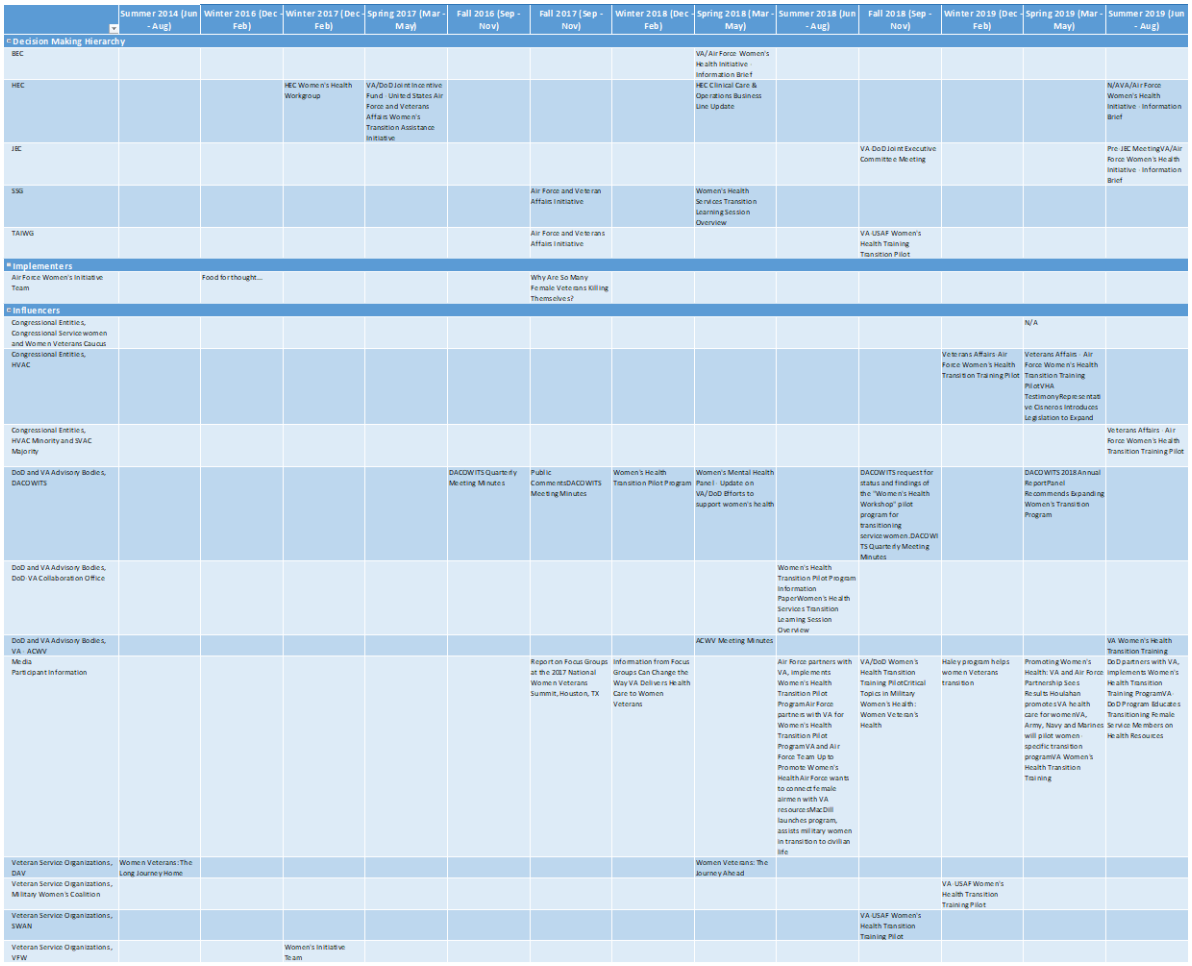
D. Analysis Plan

1. Phase I: Document Review Analysis

A document review was performed to partially answer question 1. Sixty-eight documents were reviewed and assembled into an event-listing matrix to understand decision-making processes, steps, and stakeholders for how the decision was made to adopt the pilot as a permanent program (Miles, Huberman, & Saldana, 2013). This matrix captured chronological decision-making processes and helped with high-level visualization of concurrent pathways of multiple variables (Figure 9).

A more detailed event-listing matrix was developed from the high-level event-listing matrix to include key details about each document reviewed, including the stakeholder category (i.e., influencer, decision maker, implementer), level (e.g., Veteran Service Organization (VSO), media), time period, date, title, purpose, location, authors, audience, format, and content (Figure 10). This more detailed view helped to consolidate document review findings and assisted in a more streamlined analysis process. Detailed event-listing matrix variables are included in Appendix J: Event-Listing Matrix Data Points.

Additionally, construction of the detailed event-listing matrix helped to identify three separate components related to decision making. There were activities before the pilot entered into the decision-making process, formal decision-making processes, and influencer activities that impacted the decision-making process. To reflect this distinction, the question 1 response in Chapter IV is divided into three sections: Pre-Pilot Reports and Correspondence; Formal Decision-Making Process; and Influencers and Media/External Visibility.



	Summer 2014 (Jun - Aug)	Winter 2016 (Dec - Feb)	Winter 2017 (Dec - Feb)	Spring 2017 (Mar - May)	Fall 2016 (Sep - Nov)	Fall 2017 (Sep - Nov)	Winter 2018 (Dec - Feb)	Spring 2018 (Mar - May)	Summer 2018 (Jun - Aug)	Fall 2018 (Sep - Nov)	Winter 2019 (Dec - Feb)	Spring 2019 (Mar - May)	Summer 2019 (Jun - Aug)
Decision Making Hierarchy													
BEC								VA/Air Force Women's Health Initiative Information Brief					
HEC			HEC Women's Health Workgroup	VA/DoD Joint Incentive Fund - United States Air Force and Veterans Affairs Women's Transition Assistance Initiative				HEC Clinical Care & Operations Business Line Update					N/AVA/Air Force Women's Health Initiative - Information Brief
JEC										VA DoD Joint Executive Committee Meeting			Pre-JEC MeetingVA/Air Force Women's Health Initiative - Information Brief
SSG						Air Force and Veteran Affairs Initiative		Women's Health Services Transition Learning Session Overview					
TAIWG						Air Force and Veterans Affairs Initiative				VA-USAF Women's Health Training Transition Pilot			
Implementers													
Air Force Women's Initiative Team		Food for thought...				Why Are So Many Female Veterans Killing Themselves?							
Influencers													
Congressional Entities, Congressional Servicewomen and Women Veterans Caucus												N/A	
Congressional Entities, HVAC											Veterans Affairs-Air Force Women's Health Transition Training Pilot	Veterans Affairs - Air Force Women's Health Transition Training PilotVHA Testimony/Representative Cisneros Introduces Legislation to Expand	
Congressional Entities, HVAC Minority and SVAC Majority													Veterans Affairs - Air Force Women's Health Transition Training Pilot
DoD and VA Advisory Bodies, DACOWITS					DACOWITS Quarterly Meeting Minutes	Public CommentsDACOWITS Meeting Minutes	Women's Health Transition Pilot Program	Women's Mental Health Panel - Update on VA/DoD Efforts to support women's health		DACOWITS request for status and findings of the "Women's Health Workshop" pilot program for transitioning service women .DACOWITS Quarterly Meeting Minutes		DACOWITS 2018 Annual ReportPanel Recommends Expanding Women's Transition Program	
DoD and VA Advisory Bodies, DoD-VA Collaboration Office									Women's Health Transition Pilot Program Information PaperWomen's Health Services Transition Learning Session Overview				
DoD and VA Advisory Bodies, VA - ACWV								ACWV Meeting Minutes					VA Women's Health Transition Training
Media Participant Information						Report on Focus Groups at the 2017 National Women Veterans Summit, Houston, TX	Information from Focus Groups Can Change the Way VA Delivers Health Care to Women Veterans		Air Force partners with VA, implements Women's Health Transition Pilot ProgramAir Force partners with VA for Women's Health Transition Pilot ProgramVA and Air Force Team Up to Promote Women's HealthAir Force wants to connect female airmen with VA resourcesMacDill launches program, assists military women in transition to civilian life	VA/DoD Women's Health Transition Training Pilot-Critical Topics in Military Women's Health-Women Veteran's Health	Haley program helps women Veterans transition	Promoting Women's Health: VA and Air Force Partnership Sees Results Houlahan promotes VA health care for women in VA, Army, Navy and Marines will pilot women specific transition programVA Women's Health Transition Training	DoD partners with VA, implements Women's Health Transition Training ProgramVA DoD Program Educates Transitioning Female Service Members on Health Resources
Veteran Service Organizations, DAV	Women Veterans: The Long Journey Home							Women Veterans: The Journey Ahead					
Veteran Service Organizations, Military Women's Coalition											VA-USAF Women's Health Transition Training Pilot		
Veteran Service Organizations, SWAN										VA-USAF Women's Health Transition Training Pilot			
Veteran Service Organizations, VFW			Women's Initiative Team										

Figure 9: Event-listing matrix

ID	Category	Level	Time Period	Date	Title	Purpose	Location	Authors	Audience	Format	Content
1	Influencers	Veteran	Summer 2014 (Jun - Aug)	7/6/2014	Women Veterans: The Long	Communicate	DAV website	DAV	DAV Members, Congressional	Report	The report "recommended
2	Implementers	Air Force Wome	Winter 2016 (Dec - Feb)	2/5/2016	Food for thought...	Communicate	Email	AF Women's Initiative,	AF Women's Initiative Team	Email	This email expressed alarm
3	Implementers	Air Force Wome	Spring 2016 (Mar - May)	4/7/2016	Women Veteran Issues	Request for data	Email	AF Women's Initiative	VA Office of Mental Health	Email	Looking at the feasibility of
4	Influencers	DoD and VA	Fall 2016 (Sep - Nov)	9/13/2016	DACOWITS Quarterly Meeting	Quarterly	Alexandria, VA	DACOWITS	DACOWITS Members and DoD	Meeting Minutes	Discussion on "The
5	Decision Making Hierarch	HEC	Winter 2017 (Dec - Feb)	1/18/2017	HEC Women's Health	Brief the HEC on	Crystal City, VA; DoD/VA Health	AF Women's Initiative,	HEC Members	PowerPoint Presentati	Joint Incentive Fund
6	Influencers	Veteran	Winter 2017 (Dec - Feb)	2/1/2017	Women's Initiative Team	Formal	Washington, DC	AF Women's Initiative	VFW Members	PowerPoint Presentati	Situation - VA Study (2015);
7	Decision Making Hierarch	HEC	Spring 2017 (Mar - May)	3/9/2017	VA/DoD Joint Incentive Fund -	JIF proposal with	N/A	AF Women's Initiative,	JIF leadership and JIF proposal	Proposal	Joint Incentive Fund
8	Influencers	DoD and VA	Fall 2017 (Sep - Nov)	9/12/2017	Public Comments	Public Comment	Arlington, VA	AF Women's Initiative,	DACOWITS Members	Information Paper	Appeal to DACOWITS to
9	Influencers	DoD and VA	Fall 2017 (Sep - Nov)	9/12/2017	DACOWITS Meeting Minutes	Public Comment	Arlington, VA	AF Women's Initiative,	DACOWITS Members	Meeting Minutes	Capt Nadeem began her
10	Decision Making Hierarch	TAIWG	Fall 2017 (Sep - Nov)	9/13/2017	Air Force and Veterans Affairs	Brief the TAIWG	Pentagon Conference Center -	AF Women's Initiative,	TAIWG Members	PowerPoint Presentati	Air Force Barrier Analysis
11	Influencers	Media	Fall 2017 (Sep - Nov)	10/1/2017	Report on Focus Groups at the	Present focus	Houston, TX	VHA WHS, Center for	Women Veteran Health	Report	Summary of the focus
12	Decision Making Hierarch	SSG	Fall 2017 (Sep - Nov)	10/5/2017	Air Force and Veteran Affairs	Ask for	Washington, DC	AF Women's Initiative,	SSG Members	PowerPoint Presentati	Appeal to SSG to support
13	Implementers	Air Force Wome	Fall 2017 (Sep - Nov)	10/16/2017	Why Are So Many Female	Bring female	Project on Government Oversight	Mark Thompson, Writer	Online readers, particularly	Online Article	Veteran suicide rates,
14	Influencers	DoD and VA	Winter 2018 (Dec - Feb)	12/12/2017	Women's Health Transition	A briefing from	Meeting of the DACOWITS Federal	DACOWITS	DACOWITS Members	Meeting Minutes	This presentation was
15	Influencers	Media	Winter 2018 (Dec - Feb)	12/21/2017	Information from Focus	Share findings	VAntage Point Blog - official blog of	Kayla Williams, Director	Internal and external VA blog	Online Article	20 women gathered at the
16	Influencers	DoD and VA	Spring 2018 (Mar - May)	3/1/2018	Women's Mental Health Panel	Describe the	Panel Briefing at the meeting of the	AF Women's Initiative,	DACOWITS Members	Panel	Dr. Haskell began her
17	Decision Making Hierarch	SSG	Spring 2018 (Mar - May)	4/5/2018	Women's Health Services	Share on pilot	Washington, DC	AF Women's Initiative,	SSG Members	PowerPoint Presentati	Purpose - overview of the
18	Decision Making Hierarch	HEC	Spring 2018 (Mar - May)	5/3/2018	HEC Clinical Care & Operations	Update	HEC Clinical Care & Operations	AF Women's Initiative,	HEC Leadership	Briefing	N/A - Did not receive this
19	Influencers	DoD and VA	Spring 2018 (Mar - May)	5/8/2018	ACWV Meeting Minutes	Quarterly	VACO Washington, DC	ACWV	ACWV Members	Meeting Minutes	Air Force (AF) and Veterans
20	Influencers	DoD and VA	Summer 2018 (Jun - Aug)	7/1/2018	Women's Health Transition	To provide	N/A	AF Women's Initiative,	DoD Veteran Collaboration	Information Paper	Background: Collaboration
21	Influencers	Veteran	Spring 2018 (Mar - May)	7/10/2018	Women Veterans: The	Communicate	DAV website	DAV	DAV Members, Congressional	Report	The DAV 2018 report,
22	Influencers	Media	Summer 2018 (Jun - Aug)	8/7/2018	Air Force partners with VA,	Information	AF.mil	Staff Sgt. Victoria H.	Potential AF participants	Online Article	Image with "Did you
23	Influencers	Media	Summer 2018 (Jun - Aug)	8/8/2018	Air Force wants to connect	Make people	Air Force Times	Charlsy Panzino	AF Times readers and potential	Online Article	Goal of the women's health
24	Influencers	Media	Summer 2018 (Jun - Aug)	8/13/2018	MacDill launches program,	Make people	Forever Wingman	Airman 1st Class Ashley	Forever Wingman readers and	Online Article	MacDill is one of five sites
25	Influencers	Media	Summer 2018 (Jun - Aug)	8/16/2018	Air Force partners with VA for	Make people	Standard Examiner	Staff Sgt. Victoria H.	Standard Examiner readers	Online Article	Overview of the pilot -
26	Influencers	DoD and VA	Summer 2018 (Jun - Aug)	8/23/2018	Women's Health Services	Brief Mr. Odle	Washington, DC	AF Women's Initiative,	DoD Veteran Collaboration	PowerPoint Presentati	Purpose: "The VHA
27	Influencers	Media	Summer 2018 (Jun - Aug)	8/27/2018	VA and Air Force Team Up to	Advertise the	Higher Echelon's website	Higher Echelon	Visitors to the HE website and	Online Article	VA and AF joined forces to
28	Influencers	DoD and VA	Fall 2018 (Sep - Nov)	9/1/2018	DACOWITS request for status	Provide a	Arlington, VA	AF Women's Initiative,	DACOWITS Members	Written Response	A) Status of
29	Influencers	DoD and VA	Fall 2018 (Sep - Nov)	9/12/2018	DACOWITS Quarterly Meeting	Summarize the	Arlington, VA	DACOWITS	DACOWITS Members and DoD	Meeting Minutes	Regarding this
30	Decision Making Hierarch	JEC	Fall 2018 (Sep - Nov)	9/21/2018	VA-DoD Joint Executive	Update the JEC	Washington, DC	AF Women's Initiative,	JEC Members	PowerPoint Presentati	Women's Health Transition
31	Decision Making Hierarch	JEC	Fall 2018 (Sep - Nov)	9/21/2018	VA-DoD Joint Executive	Memorandum	Pentagon Library	JEC Staff	JEC Members	Meeting Minutes	AF and VHA representatives
32	Decision Making Hierarch	TAIWG	Fall 2018 (Sep - Nov)	10/31/2018	VA-USAF Women's Health	Pilot overview	Washington, DC	AF Women's Initiative,	TAIWG members	PowerPoint Presentati	Women's Health Transition
33	Influencers	Media	Fall 2018 (Sep - Nov)	11/1/2018	VA/DoD Women's Health	Present findings	San Diego, CA	VHA WHS	APHA Conference Attendees	Poster	Introduction - overview of
34	Influencers	Media	Fall 2018 (Sep - Nov)	11/1/2018	Critical Topics in Military	Present on	Washington, DC	VHA WHS	AMSUS, The Society of Federal	PowerPoint Presentati	Only one slide of this
35	Influencers	Veteran	Fall 2018 (Sep - Nov)	12/5/2018	VA-USAF Women's Health	Present the pilot	Washington, DC	AF Women's Initiative,	SWAN Staff	PowerPoint Presentati	Women's Health Transition
36	Influencers	Media	Winter 2019 (Dec - Feb)	12/7/2018	Haley program helps women	Overview of the	Haley VA Website: Tampa, FL	Ed Drohan	Visitors to VA Haley website	Online Article	Pilot developed as a
37	Influencers	Veteran	Winter 2019 (Dec - Feb)	1/1/2019	VA-USAF Women's Health	Present the pilot	Washington, DC	AF Women's Initiative,	Women's Coalition Staff	PowerPoint Presentati	Women's Health Transition
38	Influencers	Congress	Winter 2019 (Dec - Feb)	2/1/2019	Veterans Affairs-Air Force	Put pressure on	Washington, DC	AF Women's Initiative,	HVAC Professional Staff	PowerPoint Presentati	Data collected - current
39	Influencers	Veteran	Winter 2019 (Dec - Feb)	2/22/2019	Letter to Chairman Smith,	Request for	Washington, DC	Military Women's	Chairman and Ranking Member	Letter	The Military Women's
40	Influencers	Veteran	Winter 2019 (Dec - Feb)	2/22/2019	Letter to Chairman Inhofe,	Request for	Washington, DC	Military Women's	Chairman and Ranking Member	Letter	The Military Women's
41	Influencers	DoD and VA	Spring 2019 (Mar - May)	3/8/2019	DACOWITS 2018 Annual	Provide nine	N/A	DACOWITS	DoD Senior Leaders	Report	The paper contains nine
42	Influencers	DoD and VA	Spring 2019 (Mar - May)	3/11/2019	Panel Recommends	Communication	Air Force Magazine	Rachel S. Cohen	Air Force Magazine Readers	Online Article	DACOWITS said on Monday
43	Influencers	Media	Spring 2019 (Mar - May)	3/14/2019	Promoting Women's Health:	Advertise the	Higher Echelon's website	Higher Echelon	Potential pilot participants,	Online Article	Higher Echelon has been
44	Influencers	Media	Spring 2019 (Mar - May)	3/14/2019	VA Women's Health Transition	Raise awareness	Women Veterans Alliance	Women Veterans Alliance	Women Veterans Alliance	Online Article	AF and DoD partnered to
45	Decision Making Hierarch	JEC	Spring 2019 (Mar - May)	3/18/2019	Department of Veterans	JSP's strategic	N/A	JEC Staff	VA and DoD Leadership	Report	The strategic framework for
46	Influencers	Congress	Spring 2019 (Mar - May)	3/21/2019	Veterans Affairs - Air Force	HVAC Hearing	Washington, DC	AF Women's Initiative,	HVAC Members	PowerPoint Presentati	Women Veteran Health
47	Influencers	Congress	Spring 2019 (Mar - May)	3/28/2019	Letter to Chairwoman	Request to	Washington, DC	Rep. Chrissy Houlahan	Chairwoman of the	Letter	Ask for robust funding for
48	Influencers	Congress	Spring 2019 (Mar - May)	4/3/2019	PLEASE SIGN	To get additional	N/A	Rep. Chrissy Houlahan's	Congressional Representatives	Word Document	Suicide rate for women vets
49	Influencers	Congress	Spring 2019 (Mar - May)	4/10/2019	Letter to the Secretaries of	To request that	Washington, DC	Rep. Chrissy Houlahan	Secretary Esper (Army) and	Letter	Appeal to the Secretaries of
50	Influencers	Media	Spring 2019 (Mar - May)	4/15/2019	Houlahan promotes VA health	Advertise Rep.	Reading Eagle	Reading Eagle	Reading, PA constituents	Online Article	Rep. Houlahan and 33 other
51	Decision Making Hierarch	BEC	Spring 2018 (Mar - May)	5/30/2019	VA/Air Force Women's Health	Brief to the	Washington, DC	AF Women's Initiative,	BEC Members	PowerPoint Presentati	Women's Health Pilot
52	Influencers	Congress	Spring 2019 (Mar - May)	5/2/2019	VHA Testimony	For the Chief	Washington, DC	Dr. Patricia Hayes	HVAC Members	Briefing	Dr. Hayes spoke about four
53	Influencers	Congress	Spring 2019 (Mar - May)	5/2/2019	HR 2500, 116th Congress, 1st	To authorize	N/A	Congress	Department of Defense	Legislative Bill	Sec. 723 - Encouragement of
54	Influencers	Media	Spring 2019 (Mar - May)	5/3/2019	VA, Army, Navy and Marines	Discuss the pilot	Connecting Vets.com website	Kaylah Jackson	Connectingvets.com Readers	Online Article	Women service members
55	Influencers	Congress	Spring 2019 (Mar - May)	5/10/2019	HR 2941, 116th Congress, 1st	To direct the	N/A	Ms. Houlahan	Congress - House of	Legislative Bill	This was a bill to direct the
56	Influencers	Congress	Spring 2019 (Mar - May)	5/17/2019	N/A	Issues Facing	Washington, DC	AF Women's Initiative	Congressional Servicewomen	Panel	WHAT: Representative
57	Influencers	Congress	Spring 2019 (Mar - May)	5/23/2019	HR 2942, 116th Congress, 1st	To direct the	N/A	Mr. Cisneros	Congress - House of	Legislative Bill	Act is cited as "Helping
58	Influencers	Congress	Spring 2019 (Mar - May)	5/23/2019	Representative Cisneros	Press Release	Representative Cisneros Website	Rep. Cisneros Website	Rep. Cisneros consituents and	Online Article	"Today, Congressman
59	Decision Making Hierarch	JEC	Summer 2019 (Jun - Aug)	6/4/2019	Pre-JEC Meeting	Brief the JEC on	Washington, DC	AF Women's Initiative,	JEC Members	Briefing	N/A - Did not receive this
60	Decision Making Hierarch	HEC	Summer 2019 (Jun - Aug)	6/11/2019	N/A	Briefed the HEC	Washington, DC	AF Women's Initiative,	HEC WHWG members	Briefing	N/A - Did not receive this
61	Influencers	Congress	Summer 2019 (Jun - Aug)	6/11/2019	Veterans Affairs - Air Force	HVAC Minority	Washington, DC	AF Women's Initiative,	HVAC Minority and SVAC	PowerPoint Presentati	N/A - Did not receive this
62	Decision Making Hierarch	JEC	Summer 2019 (Jun - Aug)	6/12/2019	VA/Air Force Women's Health	Pilot update and	Washington, DC	AF Women's Initiative,	JEC Members	PowerPoint Presentati	Women's Health Pilot
63	Decision Making Hierarch	JEC	Summer 2019 (Jun - Aug)	6/12/2019	VA-DoD Joint Executive	Memorandum	Washington, DC	JEC Staff	JEC Members	Meeting Minutes	AF and VHA representatives
64	Decision Making Hierarch	HEC	Summer 2019 (Jun - Aug)	6/13/2019	VA/Air Force Women's Health	Pilot update and	Washington, DC	AF Women's Initiative,	HEC Members	PowerPoint Presentati	(Same content as the JEC
65	Decision Making Hierarch	JEC	Summer 2019 (Jun - Aug)	6/17/2019	Joint Executive Committee	Provide	N/A	JEC Staff	HEC, BEC CoChairs	Memorandum	The VA-DoD Joint Strategic
66	Influencers	DoD and VA	Summer 2019 (Jun - Aug)	7/3/2019	VA Women's Health Transition	Information	VA Center for Women Veterans,	ACWV	Internal and external VA	Online Article	VA and DoD are hosting a
67	Influencers	Media	Summer 2019 (Jun - Aug)	7/17/2019	DoD partners with VA,	Advertise the	AF.mil	Staff Sgt. Victoria H.	Potential AF participants	Online Article	VA and DoD partnered to
68	Influencers	Media	Summer 2019 (Jun - Aug)	7/18/2019	VA-DoD Program Educates	Inform the	Air Force Magazine	Jennifer-Leigh Ophrihory	Air Force Magazine Readers	Online Article	VA and DoD are formalizing

Figure 10: Detailed event-listing matrix

Finally, a chronology matrix was assembled to further assist with visualization of a large amount of information and to more easily view document trends over time. The chronology matrix included the title and date of all documents with a variable matrix to visualize the components of each reviewed document (Figure 11). Chronology matrix variable definitions were created to further operationalize the assignment of document variables (Appendix K: Chronology Matrix Definitions).

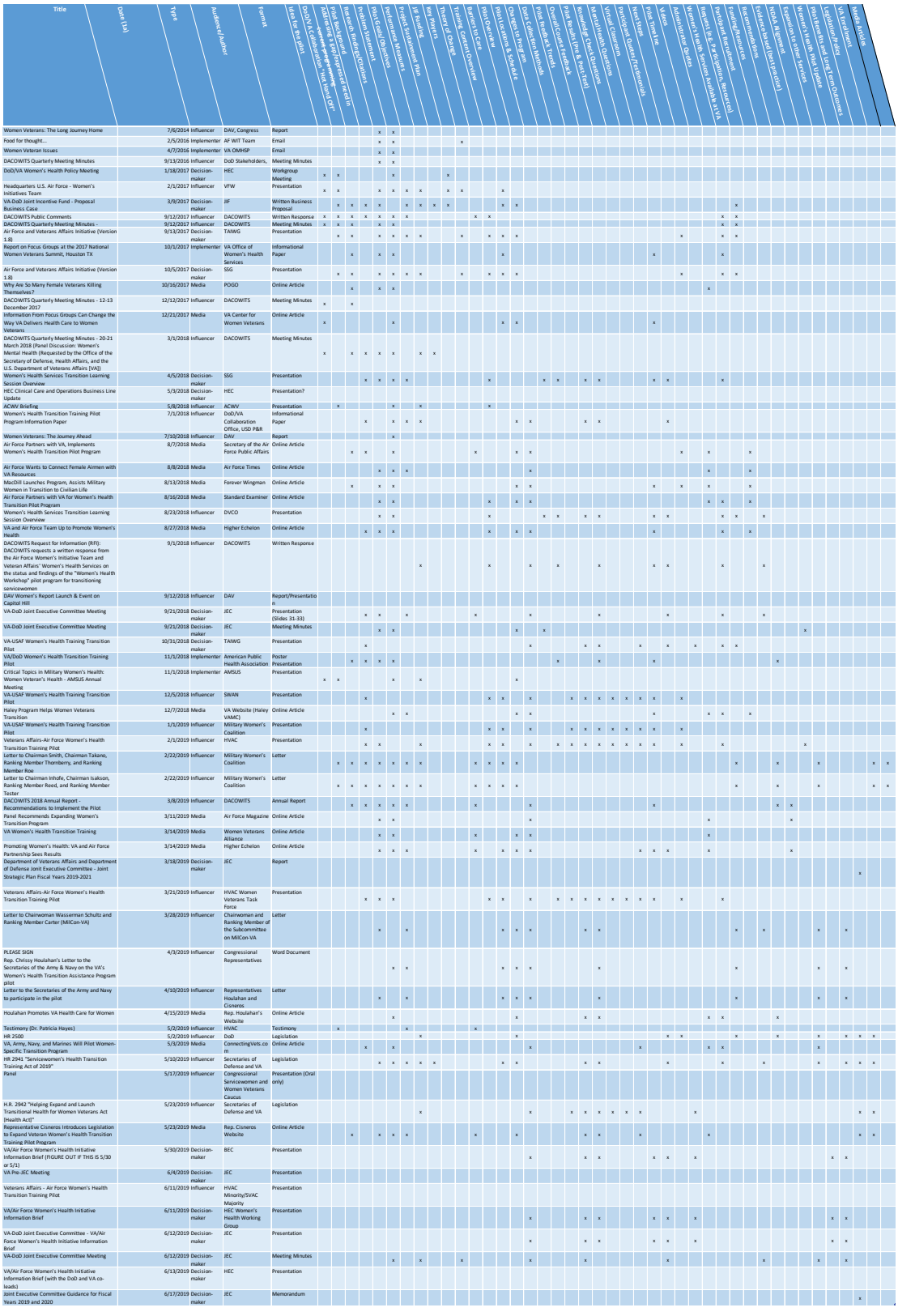


Figure 11: Chronology matrix

Content accuracy was verified at various points in the document review process. The event-listing matrix was shared and validated with the program partners in October 2019. No inconsistencies in dates or sequences of events were identified during the review process. However, a few additional dates and documents were added that were missing from the chronology. Additionally, during the interview phase, new documents were provided by interview participants and subsequently included in the document review and associated matrices.

2. Phase II: Interview Analysis

A systematic process was followed to record and transcribe interviews. Interviews were recorded using iPhone Voice Memo. Interviews were then uploaded as an m4a file into Otter, an online text transcription service. Each m4a interview file was automatically transcribed by Otter within 24 hours of interview completion. The principal investigator listened to each voice recording and read through the corresponding interview transcript to ensure content accuracy. Each interview took approximately 1.5 - 2 times the interview length to listen to the recording and correct any transcription errors. Once transcripts were deemed to be 100% accurate with the voice recording, they were exported to Microsoft Word.

Both hand coding and MAXQDA coding processes were employed to analyze interview data. Six interviews were initially coded in MAXQDA using the a priori codebook (Appendix B: A Priori Codebook). To further refine the codebook, all 15 interviews were hand coded in Microsoft Word. The new codes identified in the hand coding process were compiled into a revised Excel codebook. While defining and identifying examples for the codes, the codebook was further refined and some codes were collapsed into similar codes (e.g., “women in leadership positions” was collapsed into the “broader societal influences” code upon reflection

on the interview findings; women in leadership positions was then identified in the coding definition/instructions memo for "broader societal influences"; Appendix L: Revised Codebook).

A second coder was used to further refine the codebook and ensure a clear delineation and hierarchy of codes. The second coder, a senior scientist with extensive qualitative analysis experience, was assigned two interviews (13.3 percent of the total interviews) to code. The interview transcripts were deidentified prior to the assignment to the second coder. A 90-minute discussion session was held prior to coding to discuss the codebook and suggested coding style (e.g., code entire speaker turns and only code interviewer data when necessary for context). The principal investigator explained all of the codes to the second coder, including definitions, and examples of passages in which the codes would apply to alleviate any potential ambiguity during the coding process. Following the tutorial and receipt of the interview transcripts and codebook, the second coder hand coded the transcripts in Microsoft Word.

Two 60-minute meetings were held to discuss the results of the second coder's process. As this project was conceptualized for the purpose of quality improvement, these discussions served the primary purposes of establishing construct validity (do the codes make sense and fit the data?) and ensuring a clear delineation and hierarchy of codes. As a result of these meetings, eight codes not previously applied were applied to speaker passages, as mutually agreed upon by the principal investigator and second coder. No additional codes were added to the codebook as a result of the interrater reliability process, but some codebook definitions were updated to provide further code clarification.

All interview transcripts were coded in MAXQDA following the initial round of hand coding and the second coder process. All interviews were coded individually first. Following the coding

of all interviews, a number of MAXQDA visualization tools were used to understand the data across interviews from multiple perspectives, including code frequencies (by both coded segments and documents), code prevalence across interviewees, and code co-occurrences. Codes were also examined by stakeholder group (e.g., decision maker), pilot phase (e.g., pilot exploration & approval), and level of the socio-ecological model (e.g., organizational) to understand the potential variances in factors at different time points, with different stakeholders, and at different levels.

Code frequencies by both coded segments and number of interviewees cited (documents) were used to understand the prevalence of codes within and between interviews (note that code frequencies by document played an important role in stratifying factors in answering question 2 in Chapter IV; see Figure 12 for the MAXQDA code frequency output).

	Frequency	Percentage	Percentage (valid)
Understanding of the Need	15	100.0	100.0
Senior Leader Support	14	93.3	93.3
Pilot Data	14	93.3	93.3
Visibility	13	86.7	86.7
Organizational Characteristics	12	80.0	80.0
Collaboration	12	80.0	80.0
Readiness for Change	12	80.0	80.0
Coordinated Implementation...	11	73.3	73.3
Congressional Influence	11	73.3	73.3
Priority Alignment	10	66.7	66.7
Resources	9	60.0	60.0
Combination of Factors	9	60.0	60.0
Navigating Bureaucracy	9	60.0	60.0
Veteran Service Organization	9	60.0	60.0
Passion and Persistence	9	60.0	60.0
Sense of Urgency	9	60.0	60.0
Connections	8	53.3	53.3
VA-DoD Advisory Body	8	53.3	53.3
Perception	8	53.3	53.3
Champion	7	46.7	46.7
Trust	6	40.0	40.0
Empathy	6	40.0	40.0
Broader Societal Influences	6	40.0	40.0
Grassroots	5	33.3	33.3
Risk Perception	5	33.3	33.3
Politics	5	33.3	33.3
Affective Reaction	4	26.7	26.7
Recruitment and Retention	2	13.3	13.3
Buy In	2	13.3	13.3
DOCUMENTS with code(s)	15	100.0	100.0
DOCUMENTS without code(s)	0	0.0	
ANALYZED DOCUMENTS	15	100.0	

Figure 12: Code frequency by document

Additional MAXQDA visualization tools were used to understand findings across interviews. The code matrix browser was a helpful tool for visualizing the prevalence of factors within and between interviews (Figure 13).

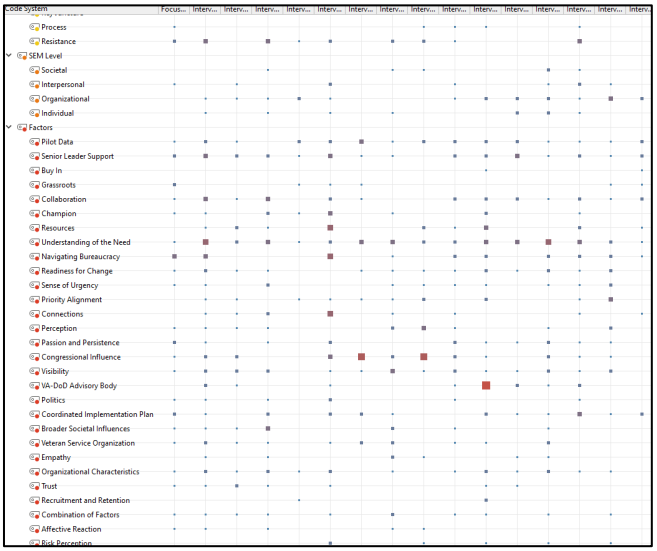


Figure 13: Code matrix browser output

The code relations browser was a helpful tool in understanding and visualizing the co-occurrence of codes and the relationship between multiple factor codes (Figure 14).

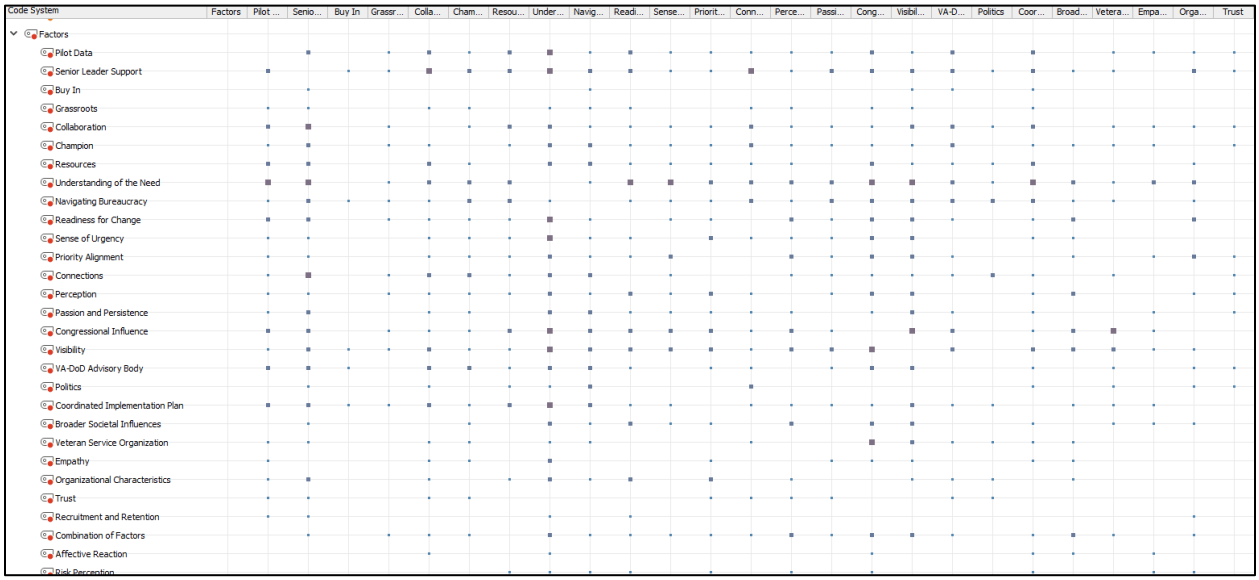


Figure 14: Code relations browser output

The process to stratify and understand the strength of evidence of each factor took many components into consideration. The aforementioned data views and dimensions, combined with the principal investigator's detailed knowledge of the interview data, served as the basis for understanding the strength of evidence for each factor. The stratification of factors as predominant, moderate, or limited evidence were primarily determined by code frequencies, secondarily by the number of phases in which a factor occurred, and then the context in which the factor was mentioned.

3. Data Integration

Document review and semi-structured interview findings were integrated to answer question 1 to understand how the decision was made to adopt the pilot as a permanent program. Document

review findings were first assembled in an event-listing matrix and chronology matrix to detail the content and order of events at different junctures in the pilot process (e.g., pilot exploration and approval and pilot implementation). A detailed narrative of the process was written based on the chronology assembled in the event-listing matrices.

In Phase II, interviewees were asked how the decision was made (using interview questions 5-7; Appendix A: Semi-Structured Interview Guide) to bolster the question 1 response. Interview text related to questions 5-7 was coded by pilot phase (i.e., pilot exploration & approval, pilot implementation, pilot adoption decision) and stakeholder group to establish chronology and stakeholder involvement. Data by pilot phase was analyzed, extracted, and integrated into the document review narrative when the interview statements supplemented the narrative. The interview findings enhanced the document review narrative, as interviewees were able to speak about the importance and gravity of some of the events, which could not be elicited from reviewing the documents alone. For example, two JEC meetings were identified in the document review, but interviewees also spoke about the importance of the JEC's involvement in the process. The relevant interview passages were then weaved into the JEC document review narrative to bolster the findings. Similarly, if interviewee passages were coded as influencer in the pilot implementation phase, the interview narrative may have been brought in to supplement the document review chronology of events. For example, interviewees noted that Service Women's Action Network (SWAN) involvement was a key juncture in the decision-making process. Pertinent interviewee quotes were then brought into the existing document review narrative to describe the importance of SWAN's involvement during the pilot implementation stage.

Findings for the how of decision making and the decision-making factors (questions 1 & 2, respectively) were initially analyzed separately. However, the findings came together because the factors, much like the decision-making process, were coded with the pilot phase. This allowed for the integration of the question 1 and 2 findings by examining the narratives by phase. In doing this, it became evident that different factors were important during different phases of the pilot process. For example, by coding factors with phases, it was determined that there were many factors that were important throughout the entire pilot process (e.g., understanding of the need, passion and persistence, sense of urgency). Using this same method, it was elicited that there were other factors that were important during one or two discreet phases of the pilot, such as the VA and DoD advisory body influence during the pilot implementation phase or the role of the perception factor during the pilot implementation adoption decision phases. This understanding of the multidimensions of the process only happened when the interview and document review findings were integrated. This synthesis of findings is presented in response to question 2 in Chapter IV.

4. Phase III: Focus Group Analysis

The focus group session was recorded and transcribed using the same method as the interviews. The focus group transcript, similar to the semi-structured interview process, was first hand coded in Microsoft Word. Upon completion of this initial coding process, the focus group transcript was imported and coded in MAXQDA using the revised codebook. No emergent codes were identified or added to the codebook as a result of the focus group. Key themes were summarized by the component part of the ORID framework in which they were discussed (e.g., objective, reflective).

E. Validity and Reliability Considerations

Four tests are typically used to determine study quality: internal validity, external validity, construct validity, and reliability (Yin, 2009).

1. Internal Validity

According to Yin, internal validity is largely applicable to explanatory case study research and is not of great consequence in exploratory studies (2009). From this perspective, the issue of decision making was explored and was not intended to draw specific conclusions or to determine a causal relationship. Furthermore, a single theory of decision making was not used from the literature in which to compare this research, providing further justification that this was an exploratory study and traditional internal validity methods like pattern matching or rival explanations were not used. Internal validity, in the context of this exploratory case study, was ensured in that the appropriate study design and methods were used and applied. Additionally, member checking was used throughout the process, particularly at the conclusion of the document review and during the phase III focus group to address the resonance and representativeness of the findings with pilot stakeholders.

2. External Validity

External validity is the concern of whether a study's findings are transferable beyond the bounds of a single case study. As this project was designed and executed for the express purpose of quality improvement, external validity is not of great consideration. However, there may be lessons learned about government decision making from this project that other entities may find valuable.

3. Construct Validity

Construct validity is "identifying the correct operational measures for the concepts being studied" (Yin, 2009, p. 40). Establishing construct validity means defining specific concepts and relating them back to the original purpose and objectives of the study and identifying operational measures that match the concepts (Yin, 2009). Yin cites three ways to improve construct validity: drawing from many sources to improve the available evidence base, keeping track of processes and procedures used to derive evidence, and using key informants to review work products (2009). The peer-reviewed literature was used heavily in the process of developing the study conceptual framework and associated constructs and subcodes. As discussed in Chapter II, constructs and subcodes for decision-making factors were culled from various disciplines (e.g., evidence-based decision making, capacity building, and implementation science). This project drew from many frameworks and models, although some frameworks were referenced more frequently than others (i.e., Aarons et al. for implementation factors and Gutierrez et al. for the 'how' of decision making). Per Yin, the diversity of sources helps increase construct validity (2009). Although a priori definitions were created for the constructs and subcodes, the codebook and associated operational definitions were updated during the project to reflect emergent codes and the vernacular of interviewees. In Phase III, a focus group (partially a member-checking session) was used to share preliminary findings and substantiate the findings, further contributing to construct validity.

4. Reliability

Reliability is the ability of subsequent researchers to follow the same case study protocol and uncover similar findings (Yin, 2009). Ensuring reliability means properly documenting processes and procedures, most commonly achieved by creating a case study protocol. The case study

protocol established in the dissertation proposal was created and followed to increase the likelihood of successful study replication. In addition to using memoing to document and analyze study findings, memoing was consistently employed throughout the research process to document changes in methods and justification for said changes to create a chain of evidence. For example, the sampling methodology was updated per the dissertation contacts' specified preferences. To maintain the confidentiality of interview participants, the sampling methodology and reporting of participant roles were relegated to identifying them as either an implementer, influencer, or decision maker.

A second coder coded 13.3 percent of interviews to improve the reliability of study findings. The primary purpose of the second coder was to test the codebook and ensure the codes and associated code hierarchy were applicable to the data. The coding discussions resulted in updates to the codebook descriptions and the application of eight additional codes between the two interview transcripts.

F. Institutional Review Board Determination

This project was designed and conducted for the express purpose of quality improvement. VHA endorsed the project as non-research for the express purpose of quality improvement (Appendix E: VHA Letter of Support). As such, the UIC Office for Protection of Research Subjects determined that this dissertation project does not meet the definition of research as defined in 45 CFR 46.102(1); Appendix M: UIC Non-Research Determination).

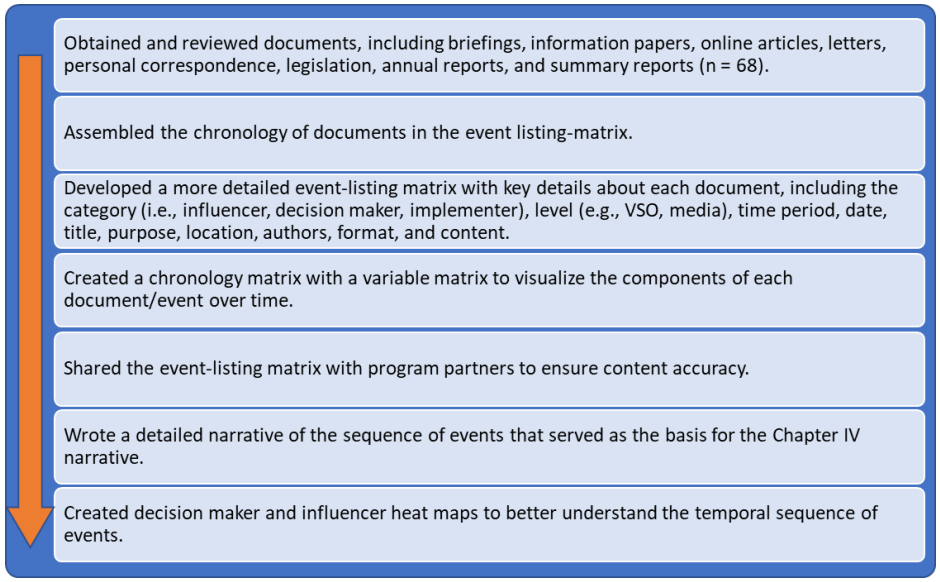
G. Chapter III Summary

Chapter III provided a summary of the case study, methods, sampling strategy, and analyses performed for this dissertation. The recent adoption of the VHA Women's Health Transition

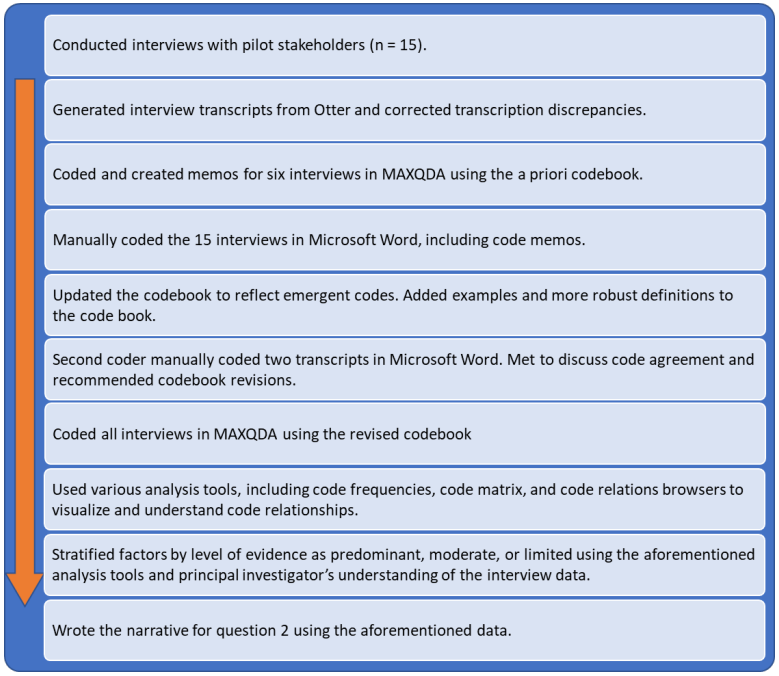
Training offered a unique opportunity to examine program adoption decision making retrospectively. This qualitative study used a document review, semi-structured interviews, and a focus group to address the three primary questions. TABLE VII provides a graphical summary of the data collection and analysis procedures used to produce the results presented in Chapter IV.

TABLE VII: ANALYSIS STEPS BY PHASE

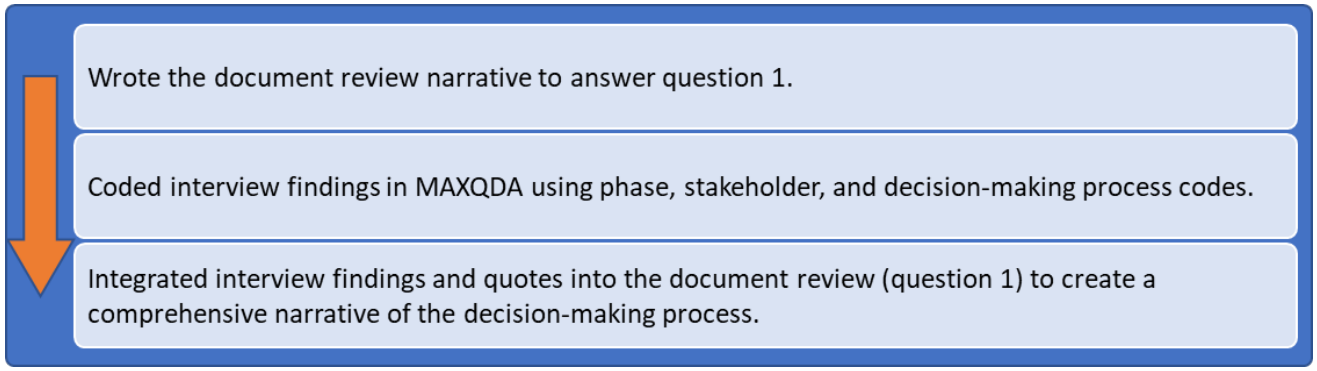
A. Phase I – Document Review Analysis Steps



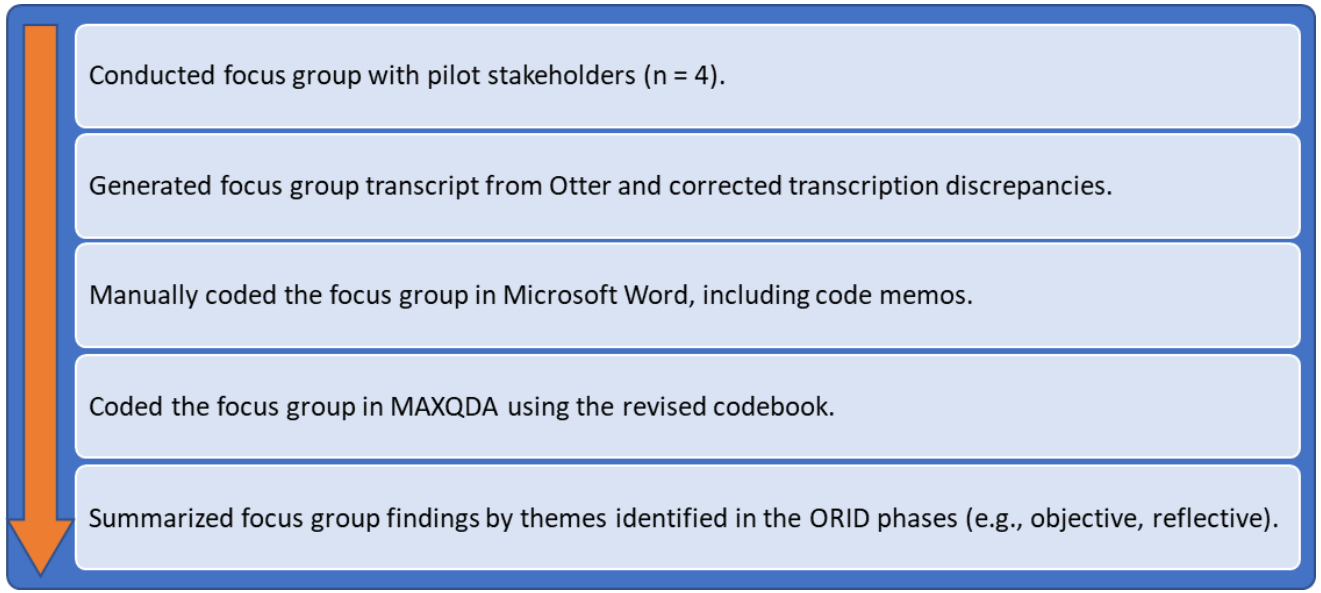
B. Phase II – Semi-Structured Interview Analysis Steps



C. Document Review and Interview Integration Steps



D. Phase III – Focus Group Analysis Steps



IV. RESULTS

A. Presentation of Results

Chapter IV is a presentation of results by study question. The three primary questions were:

1. Describing the process: How was the decision made to adopt this pilot program?
2. Decision-making factors: What decision-making factors affected the program adoption decision?
3. Future state: What will happen next?

Question 1 addresses how the decision was made to adopt the pilot program. For this question, the findings from both the document review and interviews are integrated to provide an overview of the formal decision-making process employed to adopt this pilot as a permanent program and the influencer activities that accompanied the formal process. Document review and interviewee characteristics are highlighted in TABLE VIII and TABLE IX, respectively.

TABLE VIII: DOCUMENT REVIEW OVERVIEW

Document Type	Number of Documents
Email/Personal Correspondence	2
Report	6
Meeting Minutes	7
Briefing (PowerPoint Presentation)	21
Information Paper	2
Legislative Bill	3
Letter	5
Memorandum	1
Online Article	17
Poster	1
Panel	2
Proposal	1
Written Response	1
Total Documents	**68**

TABLE IX: INTERVIEWEE OVERVIEW

Role	Number of Interviewees
Decision Maker	4
Influencer	7
Implementer	4
Total	**15**

The second question addresses the decision-making factors that affected the program adoption decision. This question was answered by using data obtained from the 15 interviewees in TABLE IX. The third question presents the focus group findings (n=4), including the implications of these findings for future implementation and decision-making efforts. Each question section is concluded with a summary of the most pertinent findings. The chapter then concludes with a summary of the methods and synthesis of the findings across questions.

B. Question #1 – Describing the process: How was the decision made to adopt this pilot program?

1. Document Review and Interview Overview

Responses for this question are derived from the document review and semi-structured interview data. As described in Chapter III, a number of data displays were created to visualize and analyze the decision-making process chronology and document components. An extensive narrative was first developed from the document review data, which was further summarized to generate the contents of this section. Knowledge gained from the document review was then used to probe interviewees in the second phase about the sequence and content of events. Relevant interview passages related to the decision-making process were identified during the analysis by pulling the coded data by phase (e.g., pilot implementation) and integrating text into the document review narrative. In addition to the integrated document review and interview narrative, visuals,

including descriptive tables and timelines, were created to summarize the extensiveness of the document and interview data.

Three separate components related to the decision-making process emerged during data analysis. There were activities before the pilot entered into the decision-making process, formal decision-making processes, and influencer activities that impacted the decision-making processes. To reflect this delineation, the question 1 response is divided into three sections: Pre-Pilot Reports and Correspondence to tell the story of how the pilot came to fruition; Formal Decision-Making Process details the processes followed to initially endorse and ultimately adopt the pilot as a permanent program; and Influencers and Media/External Visibility details the influencer activities that occurred in parallel with the formal decision-making process.

2. Pre-Pilot Reports and Correspondence

There were documents and correspondence as many as three years prior to the pilot endorsement and creation that laid the groundwork for this initiative. The sense of urgency for resources to address the transition for women Veterans was generated by internal conversations between VHA Women's Health Services and Air Force Women's Initiative Team colleagues, respectively, and by three external reports by DoD and VA federal advisory committees and a Veteran service organization. A timeline was created to depict the sequence of reports and correspondence during the Pre-Pilot Reports and Correspondence component (Figure 15). Details about each report and documented correspondence are detailed below.

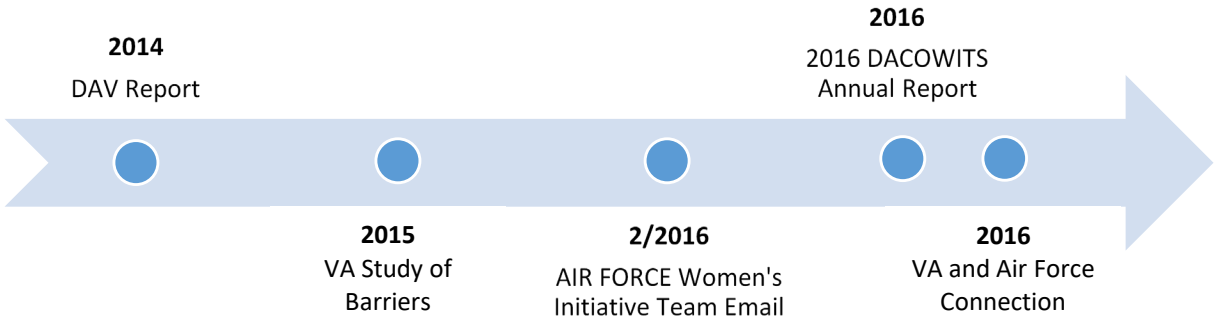


Figure 15: Sense of urgency timeline

Three years prior to the endorsement to launch the pilot, the 2014 Disabled American Veterans (DAV) report, "Women Veterans: The Long Journey Home," called for improvements to the transition assistance program to address women Veteran challenges. The 2014 report recommended that "TAP partners should conduct an assessment to determine needs of women veterans and incorporate specific breakout sessions during the employment workshop or add a specific track for women in the three-day session to address those needs" (DAV, 2014, p. 7).

The following year in 2015, VA conducted the "Study of Barriers to Care for Women Veterans." The study was mandated by Public Law 111- 163, Sec. 201-Women Veterans Health Care Matters to understand the needs of women Veterans when it comes to their healthcare needs, including assessing barriers to care at VHA facilities. An interview participant identified this report as a key impetus for taking action.

> *"I think in the early stages, that was some of the really critical, you know, the data we used to…present to the senior steering group and that kind of thing…I guess from the perspective of facts, that is really foundational… and how we were able to even really kind of show that current state."*

In February 2016, an email circulated among members of the Air Force Women's Initiative Team that contained a link to the article, "Alarming rate of female veteran suicides address in Brown bill" (Albrecht, 2016). The Air Force Women's Initiative Team email correspondence stressed the outrage at the suicide rates of women Veterans and the need to use their remaining time with supportive Air Force leaders to take action (A. Nadeem, personal communication, February 5, 2016).

In the same year, the 2016 Defense Advisory Committee on Women in the Services (DACOWITS) Annual Report cited transition services as a recommendation area based on the findings in the 2014 DAV, "Women Veterans: The Long Journey Home" report. DACOWITS recommended, "The Secretary of Defense should review and enhance the content of current transition assistance programs to better meet the unique needs of transitioning servicewomen" (DACOWITS 2016 Report, 2016, p. 46). The DACOWITS report provided reasoning for their recommendation, which included knowledge gaps about transition services and VA eligibility and unique transition circumstances for servicewomen, including economic challenges. The DACOWITS report went on further to say, "DACOWITS believes the SECDEF should augment TAP content to better meet the unique needs of transitioning servicewomen. In concert with its TAP partners, DoD should conduct a needs assessment of servicewomen and develop a TAP breakout session for female military members to address those needs" (DACOWITS 2016 Report, 2016, p. 47).

a) Convergence of VHA and Air Force

As revealed in interviews with multiple participants, both the Air Force Women's Initiative Team and VHA Women's Health Services were tracking and actively researching the issue of transitioning women Veterans for a while before their efforts converged in 2016. The Air Force

Women's Initiative Team had reviewed the aforementioned documents and were actively researching women Veteran statistics presented in VA studies, including demographics, socioeconomic factors (e.g., education, employment, insurance status), and VA usage, including VHA and Veterans Benefits Administration (VBA) statistics. Additionally, they collected statistics from external sources (e.g., news articles, external reports) on suicide, Military Sexual Trauma, PTSD, homelessness, and awareness of VA benefits. An interviewee described the process of all of these factors coming together to serve as the basis for the pilot concept.

> *"What I saw is everyone was doing really good work, but nobody was kind of owning the entire problem. And I said …where could you put all this data into and kind of synthesize it… And also the VA was struggling to reach out to women Veterans once they departed service, so they were having an issue of connecting with them… I just thought, well, what if we told them all this stuff? What if we…included all the research and explained these are some of the things you may face. You know, unfortunately, suicide is a risk for female Veterans, you're going to face all these different health issues. And I think that's kind of where it came together, of just bringing the whole of it together in one course."*

VHA Women's Health Services had also reviewed the aforementioned reports and was contemplating internally about how to approach this issue. In 2016, through a personal connection made through another women's program that was coordinated between VA and Air Force, the Air Force Women's Initiative Team was put in contact with VHA Women's Health Services to jointly collaborate on this issue. An interview participant aptly described this process of the Air Force and VHA Women's Health Services coming together first informally and then more formally during an interagency workgroup at the end of 2016.

> *"So this topic had been suggested multiple times by the Center for Women Veterans as a way to really improve…It was that, we need to do better on this transition from military to VA. And it was constantly kind of identified as a gap that we weren't addressing. That was a huge need that would improve care…women were not being informed of what the VA has to offer them. They did not feel included in the VA community. They did not know that we had women's health services, they were kind of uninformed. So a better kind of transition program was suggested multiple times…So we started to kind of brainstorm about this concept. So I was on this interagency workgroup and we had brought together*

> *a number of different branches of DoD and a number of different kind of programs in VA that worked on women's Veterans issues. So we had social work, we had us, we had nursing, we had a number of different programs and we would…be on conference calls and talk about ways to improve women's experiences, both in military and VA, and how to share data and what kind of projects to focus on."*

These documents and correspondence contributed to the need and sense of urgency around the transition process for women leaving the military. These actions ultimately led to the creation of a transition pilot specifically for women Veterans.

3. Formal Decision-Making Process

The formal decision-making process commenced following the convergence of the Air Force Women's Initiative Team and VHA Women's Health Services efforts in late 2016. As the focus of this dissertation is decision making, this section is limited to the formal decision-making processes employed to make decisions on the pilot's future; influencer entities and activities will be discussed in a separate section.

Five formal entities were involved in the decision-making process (listed in order of engagement in the process): Health Executive Committee (HEC), Transition Assistance Interagency Working Group (TAIWG), Senior Steering Group (SSG), Joint Executive Committee (JEC), and Benefits Executive Committee (BEC). TABLE X provides a high-level overview of each of the decision-making entities.

For the purpose of this dissertation, three main phases within the adoption decision/preparation time period (Aarons et al., 2011) were identified and defined: pilot exploration & approval (January – October 2017), pilot implementation (October 2017 – May 2019), and the pilot adoption decision (May – June 2019). These time periods and key decision-making activities are illustrated in Figure 16.

TABLE X: DECISION-MAKING ENTITIES OVERVIEW

Entity	Description and Role in Pilot Decision-Making
Health Executive Committee (HEC)	Interagency decision-making entity for health-related decisions between VA and DoD. The HEC Women's Health Working Group (WHWG), a HEC subcommittee, served as the initiative owner and was briefed quarterly on pilot progress.
Transition Assistance Interagency Working Group (TAIWG)	Interagency workgroup responsible for oversight of the Transition Assistance Program (TAP). Includes members from all branches of the military and includes VA representatives. TAIWG was briefed on the pilot to ensure there were no conflicts with the existing TAP program. Pilot implementers also briefed the TAIWG Curriculum Subcommittee to ensure agreement with the pilot curriculum and evaluation plan.
Senior Steering Group (SSG)	Interagency workgroup responsible for oversight of military to civilian transition activities. Includes senior leaders from VA, DoD, and Department of Labor. Gave formal approval for Air Force and VHA Women's Health Services to implement the pilot.
Joint Executive Committee (JEC)	Interagency decision-making entity responsible for oversight of the Health & Benefits Committees. Oversees creation and adoption of the VA/DoD Joint Strategic Plan. Formally made the decision to adopt the pilot as a permanent program on June 12, 2019.
Benefits Executive Committee (BEC)	Interagency decision-making entity for benefits-related decisions between VA and DoD. Briefed as a formality in May 2019 to inform committee members about the pilot.

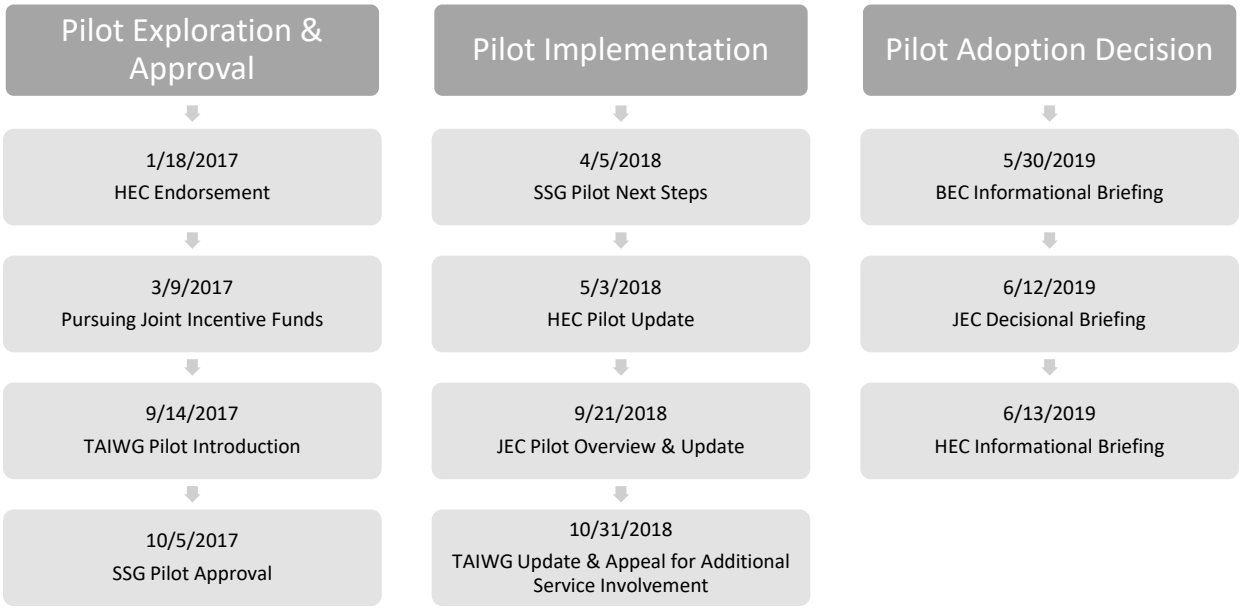


Figure 16: Formal decision-making chronology

a) Pilot Exploration & Approval

The pilot exploration & approval phase is being defined as the time period in which the concept of the pilot was being explored and further developed. During this timeframe, the idea of a women's transition pilot was formally endorsed by the HEC WHWG during the DoD/VA Women's Health Policy Meeting (HEC Endorsement – 1/18/2017), avenues of funding were explored (Pursuing Joint Incentive Funds – 3/9/2017), the pilot was introduced to transition stakeholders (TAIWG Pilot Introduction – 9/14/2017), and the pilot was ultimately approved for implementation by the interagency transition Senior Steering Group (SSG Pilot Approval – 10/5/2017).

(1) Pilot Exploration & Approval Timeline

(a) HEC Endorsement

All implementer interviewees agreed that the efforts and concerns of both the Air Force and VHA first formally culminated in a DoD/VA Women's Health HEC Policy Meeting on January 18, 2017. This first official decision-making process was noted as a key juncture by multiple interviewees. The joint meeting, hosted by VHA Women's Health Services and supported by the HEC WHWG, was a full-day session to share priorities, goals, and policies related to women's health at VA and DoD and to identify at least one joint project to develop and submit to receive Joint Incentive Funding (DoD/VA Women's Health Policy Meeting Agenda, 2017). The morning agenda included a discussion of the HEC Strategic Plan, an overview of VA women's services, and DoD health activities. The afternoon consisted of a discussion of overlaps in priorities, a session discussing transition issues for women Veterans, and breakout sessions to discuss potential joint projects. VHA Women's Health Services developed project ideas prior to the meeting that fit under an overarching theme of continuity/coordination of care for women transitioning from active duty military service to civilian life. The proposed project topic areas were cardiovascular health, musculoskeletal issues, and transition, including piloting a women's-specific transition program in the Air Force (HEC Breakout Session, 2017). The group collectively reviewed the topic areas and project ideas and voted during a 15-minute voting session to initiate the transition pilot as the first joint HEC WHWG project. An interviewee shared about the structure of the VA and DoD policy meeting and the role of the HEC WHWG in the pilot implementation.

> *"There were 50 participants across the services, VA, DoD. And we had an all-day session, and then breakout groups and then we voted. The breakout groups were supposed to come up with two projects each that we were going to pursue. And then we voted on them. And we chose the women's health transition training. That was the*

consensus of the group. And so this pilot was started under the auspices of the HEC Working Group. Now the HEC that we report to they, I mean, they were like, great, you know, they never said yes or no, or whatever they just said, yeah, that seems like a good thing to pursue. And we have to report up to them quarterly on our progress."

(b) Pursuing Joint Incentive Funds

Implementer interviewees shared that once the project was officially endorsed, the pilot implementation team started developing a Joint Incentive Fund (JIF) proposal. JIF are discretionary funds that both VA and DoD authorize to embark on joint projects. The pilot did not ultimately receive JIF funds (funds were not dispersed for any projects that year), but the proposal process served as a means in which to further develop and operationalize the pilot details. During this time, there was a great deal of interagency collaboration to further develop the pilot concept. One interviewee shared about the closeness in which VHA and Air Force worked together during the pilot creation.

"I mean, we were having meetings every Thursday morning, phone meetings, right, on status updates, and that kind of thing… I think the difference was it wasn't a group that got together once a quarter and the DoD comes and says alright VA, this is what we're doing and the VA comes over and says okay DoD, this is what we are doing. Alright, break, go. It was totally like we were in the same office."

(c) TAIWG Pilot Introduction

The Transition Assistance Interagency Working Group (TAIWG) was introduced to the pilot in September 2017. As shared by implementer interviewees, the TAIWG, although they did not have ultimate decision-making authority for the pilot, was the first necessary interagency group to brief since they are responsible for standardization of the transition process across military services. One participant shared more about the role of the TAIWG (which is primarily comprised of Transition to Veterans Program Office (TVPO) representatives).

"So then it went to TVPO…we had to go through them to sort of read through the curriculum, evaluate the course…they weren't necessarily decision makers of the pilot

happening. They were kind of, if you will, helping us along with…the curriculum. So we had to start working through them a bit for certain…aspects of the program. For standardization and stuff like that."

(d) SSG Pilot Approval

As noted in the document review event chronology, three weeks following the TAIWG informational meeting, the pilot implementation team met with the Senior Steering Group (SSG). The SSG is comprised of senior leaders that approve transition programs and activities between DoD, VA, and the Department of Labor. The SSG ultimately signed off on the further development and implementation of the pilot. The ease of the SSG approval process was described by an interviewee.

"I don't know if they take turns…who leads those meetings and who is kind of the de facto leader of the SSG, but I seem to recall it was the Department of Labor person that was running that meeting. And we presented why we wanted to do it and how we were going to do it. And he just said, yeah, go do it."

(e) Pilot Funding Procurement

Interviewees shared that also during this timeframe (fall 2017), VA funding was procured to implement the pilot, which included funding for a contractor to assist with curriculum development, content delivery, and program evaluation. The pilot was framed as a suicide prevention initiative because as VA's top clinical priority, there were funds earmarked specifically for these initiatives. One interviewee shared about the process of procuring the funds.

"…it was the end of that fiscal year that they were able to say, hey, we've got some leftover suicide prevention money…and just focus on the suicide prevention, use those funds to then fund the development of the curriculum and the training of the contractors and all that kind of thing. So it ended up being focused on suicide, which is, you know, definitely the biggest factor, but at the time, I had a different you know, I was looking at more of the bigger picture. But the way to get there was through suicide prevention money that the VA had."

(2) Pilot Exploration & Approval Overview

As identified while reviewing the documents in this phase, in the 10-month span from the approval of the concept to approval for implementation, the Women's Health Transition Training pilot evolved from an idea to a well-defined pilot concept with expressed needs. The HEC WHWG endorsed a very high-level pilot concept at the January 2017 VA/DoD Women's Health Policy meeting. By the time the Air Force Women's Initiative Team and VHA Women's Health Services applied for JIF funding in March 2017, the problem statement, gaps/challenges the pilot was addressing, and goals/objectives for the pilot were well-defined, but there were still multiple options/iterations of the pilot presented, including one-day and multi-day options. When the Air Force Women's Initiative Team and VHA Women's Health Services presented to the TAIWG and SSG in the fall of 2017, the format of the pilot was more developed, including the one-day structure and the proposed training curriculum. One interviewee described the role of TAIWG and SSG in approving sanctioned programs into the military transition portfolio and their role in the Women's Health Transition Training pilot process.

> *"Those are the groups that sort of govern over all things transition from an interagency perspective. So what they needed in the VHA world to kind of keep this pilot moving and get it fully integrated into interagency space was to have air time with that group, to make sure that it became a sanctioned part of the whole interagency portfolio of programs… And then pretty much at that point, they were sort of running their own initiative in collaboration with all of us. And then we just had regular touchpoints to get updates on… what the data was showing, and how they were proceeding with the pilot and so on."*

(3) Pilot Exploration & Approval Phase Themes

Three recurrent themes were identified in the pilot exploration & approval documents and interview data: DoD to VA "hot hand off," problem statement and pilot objectives, and resource requests and supportive champions.

(a) DoD to VA "Hot Hand Off"

All documents in this phase placed an emphasis on the proposed pilot as a collaboration between DoD and VA to establish a "hot hand off" between the two departments. The current hand off in the transition from active duty to civilian life was noted as a challenge and a gap/expressed need in current programming. A "hot hand off," which would be achieved through this pilot, would entail a direct transfer of healthcare from DoD to VA to ensure continuity of care. The documents recognized the strength of the proposed partnership and how it could very well help with the healthcare transition. "The Air Force has the highest percentage of females than any other Service and thus has an advantage of targeting females within the military to make them aware of VA healthcare services. The VA has the resources and wants to help, but has gaps in targeting that population once they become Veterans" (VA/DoD JIF Proposal Business Case, 2017, p. 6).

(b) Problem Statement and Pilot Objectives

The documents focused on the problem statement (health discrepancies in women Veterans) and the barriers to care that exist and explain the lower rates of women enrolling in VHA healthcare compared to their male Veteran counterparts. The problem statement, including research citations stressing the challenges faced by women Veterans, led into the pilot goals/objectives and desired pilot outcomes. The goal of the women's transition project, "is to ensure a successful transition for women separating or retiring from military service by providing a "hot hand off" to VA post military service. We will achieve this through an improved enrollment process for transitioning servicewomen to the VA healthcare system by educating them about VA health care services available to them, activating them to be proactive about their health and health care

and by directly connecting them to the VA health care system during the DoD's Transition Assistance Program (TAP)" (VA/DoD JIF Proposal Business Case, 2017, p. 5).

(c) Resource Requests and Supportive Champions

The TAIWG and SSG presentations, in addition to the aforementioned components, included specific resource requests (i.e., time, space, and funding) to progress the pilot from a concept to a viable implementation. The appeal from the Air Force was for space to conduct the sessions, resources to determine metrics to collect, to allow women to attend the pilot as a work-related appointment, and to help identify Air Force bases and joint Army bases to conduct the pilot. The ask from VA was for the ability to develop the curriculum, to procure health benefits briefers and tour guides for VAMC visits, to collect data/metrics on the pilot, and ultimately for funding to conduct the pilot. These presentations also included the names and titles/roles of key pilot stakeholders to communicate the already supportive champions (DoD/VA Initiative v1.8, 2017).

b) Pilot Implementation

The pilot implementation phase is being defined as the time period in which the pilot curriculum was developed and the pilot sessions were actively being implemented and evaluated in the selected pilot sites. The pilot implementation timeframe occurred from October 2017 – May 2019. Many of the approval decisions were made during the pilot exploration & approval phase; most of the briefings during the pilot implementation period updated decision-making entities on pilot progress and highlighted early wins.

During the pilot implementation timeframe, the SSG (the approver of the pilot) was updated on pilot progress (SSG Pilot Next Steps – 4/5/2018); the HEC, the sponsor and original endorser of the pilot, was briefed on pilot progress (HEC Pilot Update – 5/3/2018); the JEC, the ultimate decision-maker for the adoption of the pilot, was introduced to the pilot for the first time (JEC

Pilot Overview & Update – 9/21/2018); and the TAIWG was briefed on pilot progress and additional military service branches were requested for participation (TAIWG Update & Appeal for Additional Service Involvement – 10/31/2018).

(1) Pilot Implementation Timeline

(a) SSG Pilot Next Steps and HEC Pilot Update

Documents showed and interviews confirmed that the SSG briefing on April 5, 2018, was the first meeting with a decision-making entity during the pilot implementation period. The briefing provided an overview of the pilot, progress since the first meeting (including an overview of the human-centered design pilot curriculum development process and session content), and an overview of pilot next steps. The SSG brief occurred at a time when pilot implementers had only completed two pilot test sessions (i.e., Andrews Air Force Base and Pentagon) and VHA and their contractors were still making curriculum updates based on participant feedback. This meeting provided confirmation of the formal approval to proceed with pilot implementation. Similarly, the HEC was updated on pilot progress on May 3, 2018, with the same presentation.

(b) JEC Pilot Overview & Update

As shared by multiple interviewees, the pilot was made visible to DoD senior leaders through personal connections with Joint Executive Committee (JEC) contacts. As a result, the pilot implementation team was invited to brief the JEC on September 21, 2018. The JEC, an interagency committee that makes high-level decisions between VA and DoD, includes senior leaders from both departments. One interviewee shared the way in which the pilot first made it on the JEC agenda.

> *"The leaders of our DoD counterpart office came to us and said, this is something that's been proposed. We think it's a good idea. Let's look at it. So then we took it to the JEC*

co-chairs and the topic that we recommend be briefed and they said, yeah, that's great. Let's hear about it. So that that's how they got on the agenda to begin with."

In reviewing the JEC Memorandum for the Records and as shared by interviewees, the pilot implementation team was allotted 15 minutes of the two-hour JEC meeting to present an overview of the case for the pilot and preliminary pilot outcomes. There was some discussion among JEC members about the relevance of the pilot, but the briefing was primarily informational to increase visibility of the pilot with DoD and VA senior leaders. There were no noted action items from the meeting (JEC MFR, 2018) and as shared by multiple interviewees, there were no expectations initially for the pilot to be briefed to the JEC in a subsequent meeting. One interviewee spoke about the persistence of the pilot implementation team in keeping the pilot on the JEC's radar.

"We did not have any due outs from that briefing. So I think what happened there…we kind of thought this is sort of like, okay, it's been briefed. And they're going to go forward and do good things with this pilot. And maybe not necessarily come back to the JEC... And so really, just by sheer will, kept raising it and we kept having to kind of consider it and then we said, okay, fine, we'll, we'll bring it back. They wanted to come back and give an update on how the pilot was doing."

(c) TAIWG Update and Appeal for Additional Service Involvement

The final briefing with a decision-making entity during the pilot implementation phase was with the TAIWG on October 31, 2018. The briefing provided an update of the pilot, including preliminary pilot evaluation data (including pre vs. post-test scores and learning session feedback). The presentation included an appeal from the Air Force to the TAIWG to encourage other military services to participate in the pilot. The slide stated, "Given the positive data results and testimonials from servicewomen from the Women's Health Transition Training pilot, coupled with other military branches (e.g. Army) to pilot the course, VA would like to formally

request Navy participation to join pilot efforts. VA would like to use Norfolk as a pilot location due to its population size and multiple services stationed there, and deliver 3-5 trainings" (VA USAF Pilot, 2018, slide 10).

(2) Pilot Implementation Phase Themes

As revealed through the document review and confirmed by interviewees, the pilot implementation phase lasted for approximately 1.5 years, in which only four briefings were conducted with pilot decision makers. Presentations in the pilot implementation phase, similar to the pilot exploration & approval phase, still included the research findings that substantiated the development of the pilot, pilot background, and goals and objectives, but the primary emphasis shifted to pilot details. Pilot details included the pilot sites and session schedules, preliminary pilot results (including pre and post-test findings), and pilot next steps.

(a) Content Progression

As evidenced by reviewing the document review chronology matrix, presentation content evolved as the pilot progressed. The first presentation in the implementation phase to the SSG focused on the pilot curriculum development and processes. It highlighted the human-centered design process used to develop the pilot curriculum, including information gathering, material development, and material testing and updates (DoD/VA Session Overview, 2018). But as more pilot sessions were conducted, the presentation content focused less on curriculum development and creation processes and more on pilot evaluation data. The JEC presentation included preliminary evaluation data from 38 participants, while the TAIWG presentation further into the implementation phase included evaluation data from 94 participants. Both the JEC and TAIWG presentations stressed that participants to date had improved perceptions and knowledge of VHA benefits (VA/DoD JEC Meeting, 2018; VA USAF Pilot, 2018). To further highlight positive

participant reception, briefings also incorporated multimedia videos featuring participant testimonials.

c) Pilot Adoption Decision

The pilot adoption decision phase is being defined as the time period in which the pilot was officially adopted as a permanent program. For the purposes of decision making, this was the period from May 30, 2019 – June 13, 2019. During this timeframe, the Benefits Executive Committee was briefed on the pilot for the first time (BEC Informational Briefing – 5/30/2019), the JEC formally adopted the pilot as a permanent program (JEC Decisional Briefing – 6/12/2019), and the HEC was briefed on pilot progress (HEC Informational Briefing – 6/13/2019).

(1) Pilot Adoption Decision Timeline

(a) BEC Informational Briefing

The document review and interviews confirmed that the first presentation during the pilot adoption decision phase was to the Benefits Executive Committee (BEC) on May 30, 2019. The BEC was briefed at this juncture because the military to Veteran transition process fits into the BEC's committee purview. Additionally, the ownership of the Women's Health Transition Training program will be transferred from VHA to VBA in 2021, meaning the BEC will be responsible for making any ongoing VHA Women's Health Transition Training program implementation decisions.

(b) JEC Decisional Briefing

Prior to every JEC meeting, a pre-brief is held within each department to brief that respective departments' agenda items with senior leaders (VA and DoD, respectively). The importance of the JEC pre-brief meeting became apparent during participant interviews. VHA Women's Health

Services representatives attended the VA JEC pre-brief a week before the decision was made to adopt the pilot as a permanent program. One interviewee shared about the experience at the JEC pre-brief meeting and how there was a sense during that meeting that the pilot would be made permanent during the formal JEC meeting.

> *"So I just started talking about the pilot and why we're doing it, results we have so far… And the DepSec seemed to take an immediate liking to the program, thought it was needed, thought it was the right thing…I got the feeling that you know, at the JEC meeting he was going to go ahead and move to make it permanent."*

Another interviewee shared that decisions are typically made during the pre-brief meeting prior to the formal JEC meeting.

> *"The JEC is one of those meetings where all the decisions have already been made ahead of time. We just go to the JEC, everyone just formally says it out loud…but that's how."*

As noted during a few interviews, although the decision to move forward with the pilot was discussed during the pre-brief, the decision to adopt the pilot as a permanent program this early in the pilot implementation process was unexpected.

> *"We felt comfortable moving it forward to the JEC co-chairs, but we didn't expect there to be a decision in June. It just sort of got there."*

Documents and interviews corroborated that the quarterly JEC meeting on June 12, 2019, was when the formal decision to adopt the pilot was made. The JEC Memorandum for Record for the meeting provided detail about the final decision to adopt the pilot as a permanent program. The update began with the pilot implementation team thanking "VA for working with Air Force to start the pilot to address women's issues like suicide prevention and inform them of VA health care benefits" (JEC MFR, 2019, p. 4). They shared that the pilot has "congressional interest and several Veterans Service Organizations (VSO) have endorsed the initiative" (JEC MFR, 2019, p. 4). When asked about the long-term plans to make the pilot a permanent program, the

implementation team shared that, “88 percent of participants stated the program relieved perceived anxiety/fear of transition out of the military and 60 percent felt the classroom environment provided a safe space to share experiences. The team believes the program will increase enrollment, improve health outcomes, and increase women’s awareness of VA health care services” (JEC MFR, 2019, p. 5). The Director of the Office of Transition and Economic Development (VA) “added that this was a natural progression by providing something more granular for Service women. The next step will be to look at providing similarly focused information to men, Native Americans, and possibly other groups. She added that since the pilot has existed for a year the next step would be to gather some additional data as more Service members who participate in the program transition to Veteran status” (JEC MFR, 2019, p. 5). The VA Deputy Secretary, “stated that the pilot has been successful and encouraged moving forward with the roll out. He asked DoD members if there are any reasons from their perspective not to do so” (JEC MFR, 2019, p. 5). One member of the JEC expressed concern in the low numbers of participants, but otherwise, there was full agreement to move forward with full participation from all services and commitment from VA to fund the program. The minutes end with “Mr. Byrne noted that we were no longer in pilot mode and directed the working group to move out and get other Services to join” (JEC MFR, 2019, p. 5).

An interviewee also described how the interagency decision was made during the JEC meeting.

> *“So they're talking about the current situation for the pilot and where it was. And then Mr. Stewart, the US acting DP&R performing the duties of the DoD co-chair he said, he asked what the plan was to make the pilot a permanent program [redacted], said they're looking at the long-term data to determine the success of the program. There's more discussion about kind of longer-term things and then Mr. Byrne, who's our Deputy Secretary, chimed in and just said that the pilot has been so successful that we should just move forward with rollout. And then he said DoD, folks, if there are any reasons from their perspective not to do that. And there was some discussion with the services, but all very positive. And yeah, so he basically he said, it sounds like everybody's agreed. And*

let's get a brief back at the next JEC about the implementation and concept of operations plan."

(c) HEC Informational Briefing

Documents indicated and implementer interviewees shared that the HEC was briefed as a courtesy on June 13, 2019. This meeting was initially meant to update on pilot progress and to maintain buy-in, but the JEC meeting the day prior unexpectedly became the meeting that adopted the pilot as a permanent program. The pilot implementers briefed the HEC nonetheless and provided an update on pilot progress and pilot outcomes to date. The presenters stressed many of the pilot successes, including: the uniqueness of the collaboration between VHA and Air Force; receiving letters of support from Congress; VBA support; Army and Navy participation; Veteran Service Organization endorsement; and a favorable return on investment for the program (VA-DoD JEC Information Brief, 2019).

(2) Pilot Adoption Decision Phase Themes

Three high-level interagency executive committees were engaged in the final pilot adoption decision phase. Air Force Women's Health Initiative Team and VHA Women's Health Services representatives used the same presentation for all three committee briefings. The purpose of the briefings for each committee was slightly different, as the BEC and HEC presentations were informational, while the JEC briefing became decisional. Three primary themes were identified during the pilot adoption decision phase: pilot data, long-term outcomes, and pilot next steps.

(a) Pilot Data

All of the decision-making entities had been briefed during the pilot exploration and approval and pilot implementation stages, and as such, the presentations included key updates from the last time they were briefed. These informational/decisional briefings moved beyond the problem

statement and pilot background and focused primarily on pilot results. The presentations included quantitative data (pre and post-test and overall course feedback), qualitative quotes, and a video that included participant testimonials. One participant's course comment stated, "…we had servicewomen with ranks ranging from SrA to Major in the room, and all of us were, up to this point, clueless about VA benefits for servicewomen…so hopefully this acts as a testament for why this training program is necessary" (VA-DoD JEC Information Brief, 2019, slide 6).

(b) Long-Term Outcomes

Beyond the pilot data, the executive committee presentations discussed the expected pilot benefits and long-term outcomes for women Veterans. One slide, in particular, focused on three key components of the pilot: that the program is unique, proactive, and actually increased the number of women enrolling and utilizing VHA care. The slide touted that the "Women's Health Transition pilot is driving long term outcomes, providing key, early, intervention, and critical education" (VA-DoD JEC Information Brief, 2019, slide 5). This section recognized that the pilot was focused on assessing whether a transition assistance course would result in behavior change for servicewomen. It stated that the course was a proactive prevention strategy to reduce adverse health outcomes, improve health and wellness, and reduce the suicide rate. The potential benefits of increased numbers of women using VHA benefits, including helping to bolster VHA women's health programs and improving access for women to receive the care they need, was also highlighted as a desired long-term outcome (VA-DoD JEC Information Brief, 2019).

(c) Pilot Next Steps

Pilot next steps were included in each of the briefings during the pilot adoption phase. It is important to note that the fact that these next steps were included in the briefing signify that a decision was not initially expected, which was corroborated by an interviewee's statement.

"…we didn't expect there to be a decision in June. It just sort of got there."

The pilot next steps included in the briefings include the following:

- **Future of the pilot** – Pilot sessions will go through December 2019 and the pilot evaluation will continue through March 2020 to create an interim pilot outcome report to the TAP SSG.
- **Next Phase** – Ownership of the program will be transitioned from VHA Women's Health to VBA.
- **Collaboration with Army and Navy** – Continued effort will be put into collaborating with the other military branches and VSOs.
- **Tracking participant outcomes** – They will continue to collect participant outcomes and VHA enrollment to understand the longer-term impact of the program.
- **Virtual Module Implementation** – Virtual module sessions start in June 2019, including two test pilot sessions to test the functionality and impact of the delivery method.
- **Long-Term Funding** – Members of Congress made to a request to the MilCon – VA House Appropriations Committee for additional funding in FY20 to continue the pilot since funding ends in March 2020.

4. Influencers

There were numerous stakeholders involved in the pilot process, many of whom were influencers. Influencers are being defined as groups or entities that did not have formal decision-making authority to initiate or implement the pilot, but that may have influenced the successful adoption of the pilot as a permanent program. TABLE XI includes the three influencer groups identified during the document review and interviews and each of the entities included in the

overarching category. Influencer groups are discussed by entity category in the order of engagement in the pilot process.

A timeline of influencer activities was created to visually depict the timing of briefings/documents (Figure 17) for the three influencer entities: Veteran service organizations (orange), VA and DoD advisory bodies (blue), and Congressional entities (green). This timeline depicts that different entities and organizations were engaged at different stages in the pilot process. And the different entities and organizations served different purposes when engaged.

TABLE XI: INFLUENCER ENTITIES AND DESCRIPTIONS

Influencer Entity	**Organization**
Veteran Service Organizations	Veterans of Foreign Wars (VFW)
	Service Women's Action Network (SWAN)
	Military Women's Coalition (MWC)
VA and DoD Advisory Bodies	Advisory Committee on Women Veterans (ACWV) – Center for Women Veterans
	Defense Advisory Committee on Women in the Services (DACOWITS)
	DoD/VA Collaboration Office (DVCO)
Congressional Entities	House Committee on Veterans' Affairs (HVAC)
	House Committee on Veterans' Affairs – Women Veterans Task Force
	Senate Committee on Veterans' Affairs (SVAC)
	House Committee on Armed Services
	Senate Committee on Armed Services
	House Appropriations Committee – Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
	Congressional Servicewomen and Women Veterans Caucus

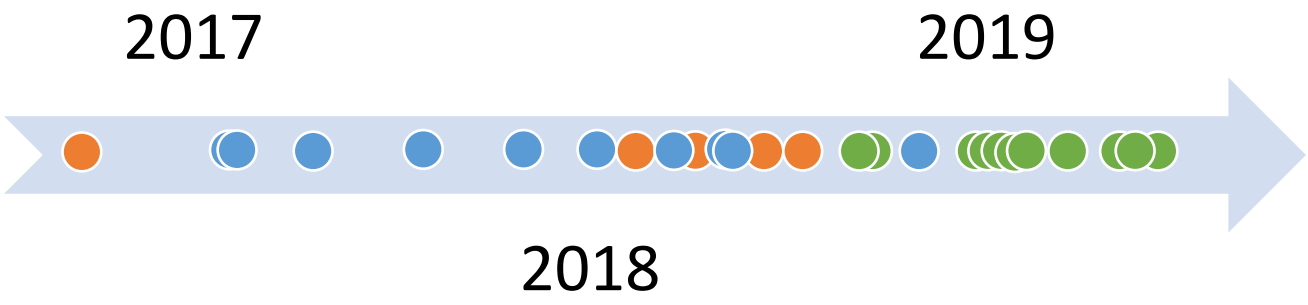


Figure 17: Influencer timeline

a) Veteran Service Organizations

Veteran service organizations (VSOs) are non-governmental organizations that work on behalf of Veterans in a number of different service areas. Two VSOs and one affiliated coalition were made aware of the pilot and briefed on pilot progress. TABLE XII provides a description of each Veteran service organization.

A timeline of Veteran service organization involvement was created to visually depict the timing of briefings/documents (Figure 18).

TABLE XII: VETERAN SERVICE ORGANIZATIONS

Influencer Entity	Organization	Description
Veteran Service Organizations	Veterans of Foreign Wars (VFW)	Veterans of Foreign Wars (VFW) is a nonprofit VSO that advocates on behalf of Veterans and service members (VFW, n.d.).
	Service Women's Action Network (SWAN)	The Service Women's Action Network (SWAN) is a network comprised of community advocates for servicewomen (SWAN, n.d.). SWAN was instrumental in advocating for the pilot and wrote a letter to Congress stressing the importance of this pilot for transitioning servicewomen.
	Military Women's Coalition (MWC)	The Military Women's Coalition (MWC) is a newly formed coalition of formal and informal organizations from across the country whose primary mission is to support military women. The MWC includes 18 organizations committed to engaging in collective action, sharing resources and knowledge, and promoting the activities of military women's organizations to better support servicewomen and women Veterans (SWAN Annual Report, 2019).

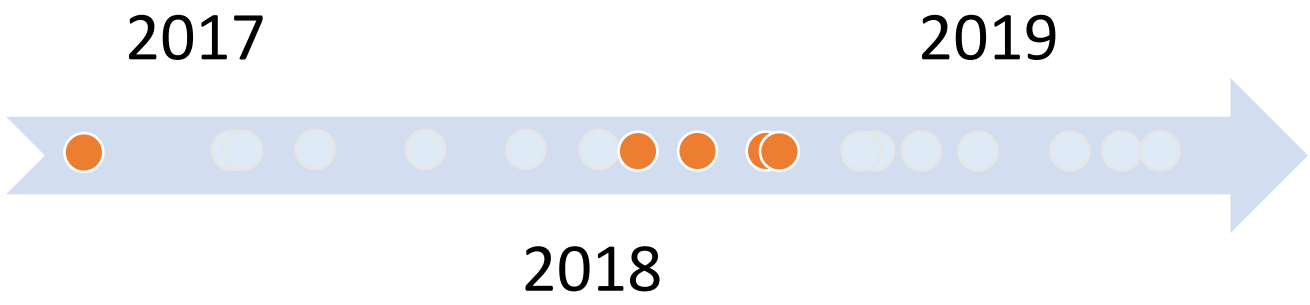


Figure 18: VSO timeline

(1) Veteran Service Organization Timeline

(a) Veterans of Foreign Wars Engagement

The document review and interviews verified that three VSOs were briefed on the pilot. One VSO, VFW, was engaged during the pilot exploration & approval phase, only weeks after the pilot was formally endorsed by the HEC (February 2017). Pilot implementers engaged VFW after listening to a VFW leader give testimony that cited the difficulties experienced in the military transition process. Although VFW did not formally endorse or engage in any pilot activities, they were involved in discussions about the pilot format and feasibility in the early conceptual stage.

(b) Service Women's Action Network and Military Women's Coalition Endorsement & Advocacy

Interviews and documents showed that SWAN and MWC were briefed during the pilot implementation phase (December 2018 and January 2019, respectively). SWAN, as a proponent of the pilot, scheduled a subsequent webinar with the MWC to discuss the pilot format and preliminary pilot results. Congressional Professional Staff Members were also invited to the webinar and subsequently asked for a separate meeting with Air Force and VHA Women's Health Services to include House and Senate Committees on Veterans' Affairs and House and Senate Committees on Armed Services representatives. Additionally, the MWC, which includes 18 organizations serving as advocates for female service members and Veterans, wrote two letters on February 22, 2019 – one to the House Committee on Veterans Affairs and House Armed Services Committee and another to the Senate Committee on Armed Services and Senate Committee on Veterans Affairs – asking for support of the program. Both letters stated the following, "We believe the Women's Health Transition Training Program addresses these

barriers and will profoundly impact the lives of service women through and beyond their transition. We earnestly ask for your support to continue and expand the program to all Services and in collection data on this program. This program creates a safe space for women to discuss gender- and military-specific challenges unlike any other. It is critical for service women to receive information about their future healthcare, challenge their beliefs about the VA health system, and build a community, all of which is vital to their success, health, and well-being, after serving" (MWC, 2019).

SWAN's involvement was noted by interviewees as a key juncture in the pilot progression. SWAN ultimately endorsed the pilot and collected MWC signatures to encourage Congressional support of the pilot. One interviewee stressed the importance of SWAN's involvement and their influence as an advocacy organization on Congressional buy-in.

> *"…a key Veteran service organization for us was SWAN…they have a very aggressive political agenda. And it's not in a bad way. But it's, they're just trying to make tangible changes through either legislation or law for women, whether that's, you know, ill-fitting equipment, whether that's getting infertility care. And so they really kind of helped us out because we can't just walk into Congress and say, we want something like this…But SWAN could do that, right? SWAN could say, hey, we really liked this program. And, you know, we think that Congress should endorse it, and Congress should look at it and so they went and did that…So when we went and briefed them, they turned around and they went to Congress and said, hey, this is the type of stuff we should be doing. And so that that's kind of what put us, that really moved the decision."*

(2) Veteran Service Organization Themes

Interviewees shared that each of the aforementioned organizations was engaged with the express purpose to collaborate and promote the pilot for women transitioning out of the military. Similar to all other entities briefed, the information presented to the VSOs progressed as the pilot progressed. The VFW presentation was during the pilot exploration & approval phase. Thus, the discussion was focused on the concept of the pilot as a DoD/VA collaboration to enhance the hot

hand off between the agencies to address known transition and women Veteran health challenges. The presentations to SWAN and the MWC provided a brief pilot background but focused heavily on the pilot findings to date (qualitative and quantitative data, including pilot feedback trends, overall course feedback and knowledge check, mental health questions, and pilot feedback trends).

b) VA and DoD Advisory Bodies

VA and DoD advisory bodies are both internal and external to the departments and influence organizational policy and decision making. Two of the three VA and DoD advisory bodies kept apprised of the pilot are federal advisory committees – the Advisory Committee on Women Veterans (ACWV) and the Defense Advisory Committee on Women in the Services (DACOWITS). The third organization in this influencer entity, the DoD/VA Collaboration Office (DVCO), is an internal DoD office that coordinates activities and responses between VA and DoD. Descriptions for each VA and DoD advisory body are included in TABLE XII.

A VA and DoD advisory body timeline was created to visually depict the timing of briefings/documents (Figure 19).

TABLE XIII: VA AND DOD ADVISORY BODIES

Influencer Entity	Organization	Description
VA and DoD Advisory Bodies	Defense Advisory Committee on Women in the Services (DACOWITS)	The Defense Advisory Committee on Women in the Services (DACOWITS) is a federal advisory committee that was established "in accordance with the Federal Advisory Committee Act of 1972 (5 U.S.C. App, as amended and 41 C.F.R. (102-3.50(d). DACOWITS is composed of civilian men and women appointed by the Secretary of Defense to provide advice and recommendations on matters and policies relating to the recruitment, retention, employment, integration, well-being and treatment of servicewomen in the Armed Forces" (DACOWITS, n.d.).
	Advisory Committee on Women Veterans (ACWV)	The Advisory Committee on Women Veterans (ACWV) is a federal advisory committee established and chartered by Public Law 98-160. ACWV "reviews VA's programs, activities, research projects, and other initiatives designed to meet the needs of women Veterans; and makes recommendations to the Secretary on ways to improve, modify, and affect change in programs and services for women Veterans and follow up on all those recommendations" (ACWV, n.d.).
	DoD/VA Collaboration Office (DVCO)	The Department of Defense/Veterans Affairs Collaboration Office is housed in the Department of Defense Office of the Under Secretary for Personnel and Readiness. DVCO "provides a central point of contact within DoD for the White House, Congress, the Department of Veterans Affairs (VA), and other Federal agencies and stakeholders regarding Service member and Veteran programs" (DVCO, n.d.).

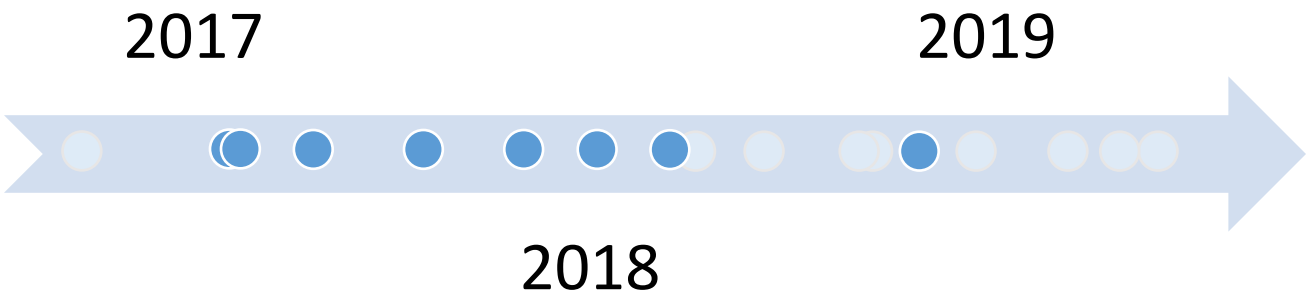


Figure 19: VA and DoD advisory body timeline

(1) VA and DoD Advisory Body Timeline

Documents and interviewees confirmed that three VA and DoD advisory bodies were kept apprised of pilot progress throughout the pilot exploration & approval and implementation phases: the Defense Advisory Committee on Women in the Services (DACOWITS), Advisory Committee on Women Veterans (ACWV), and the DoD/VA Collaboration Office (DVCO).

(a) Defense Advisory Committee on Women in the Services

DACOWITS was the first federal advisory committee engaged when pilot implementers attended and submitted a response during a 2017 DACOWITS public comment period. An interviewee described the DACOWITS public comment and subsequent recommendation generation process.

> *"We submit those requests for information, we get our responses, they come in, they brief the committee, the committee gathers that data, asks additional questions if they need to, you can ask follow up questions when necessary. And some of that information then is*

compiled and analyzed. And that is what helps with the research into that particular topic which may eventually lead to a recommendation for the Secretary of Defense."

Documents revealed and interviewees confirmed there were numerous touchpoints with DACOWITS that ultimately resulted in a recommendation in their 2018 Annual Report to adopt the Women's Health Transition Training across all military branches. The recommendation to the Secretary, which was discussed and agreed upon during a 2018 DACOWITS quarterly meeting, was, "The Secretary of Defense should direct all Military Services to improve their support to active duty women transitioning to the Reserve/Guard or civilian sector by offering programs similar to the Women's Health Transition Pilot Program, a best practice implemented by the Air Force in partnership with the Department of Veterans Air Affairs" (DACOWITS Quarterly Meeting Minutes, 2018, p. 48).

The 2018 DACOWITS Annual Report, in addition to the formal recommendation to the Secretary stated, "The Committee believes the expansion of the Air Force's Women's Health Transition Pilot Program or programs similar to it should be made available to all servicewomen" (DACOWITS Annual Report, 2019, p. 44). The section of the report titled, "Consideration of the Air Force's Women's Health Transition Pilot Program as a Best Practice," formally recognized the program as a best practice for transitioning servicewomen. "The Committee supports expanding a program similar to the Women's Health Transition Pilot Program across all the Military Services. Servicewomen face unique challenges when transitioning out of active duty military service, and a full range of resources should be available to them to address these challenges. Although there has been attention to these needs, more must be done to help ensure servicewomen are as successful in civilian, Reserve, or Guard life as they were on active duty" (DACOWITS Annual Report, 2019, p. 47).

DACOWITS's formal recommendation of the pilot in the 2018 Annual Report was noted by multiple interviewees as a key juncture in the pilot progression that also influenced proposed Congressional legislation. One interviewee shared about the high impact of a DACOWITS recommendation.

> *"I think what that means is that the Secretary of Defense cares about what the committee says and takes it very seriously. Now, it doesn't always happen immediately, you know, just puts it on the table. Sometimes they have to make multiple recommendations on the topic. And sometimes it takes years for that recommendation to actually come to life. But still a 98% implementation rate, I think, speaks volumes to the committee and to how seriously the Secretary of Defense takes their recommendations."*

(b) Advisory Committee on Women Veterans

Documents and interviewees confirmed the VA federal advisory committee, ACWV, was briefed on the pilot during the pilot implementation phase (May 8, 2018). In addition to this meeting, it was reported that the ACWV was routinely kept apprised of pilot progress. An interviewee shared that although ACWV did not formally endorse or recommend the pilot to the Secretary of VA, they would have provided a formal endorsement for the program if need be but that it did not seem necessary based on the pilot's trajectory and momentum.

> *"It could have gone in [the ACWV] report I suppose. But no…[ACWV] didn't do a formal endorsement. [ACWV] certainly would…But no, [ACWV] didn't put it in the 2018 report. And I guess because DACOWITS… their report comes out before [ACWV's]."*

(c) DoD/VA Collaboration Office

Interviewees shared and documents confirmed that DVCO, an entity within the Office of the Under Secretary for Personnel and Readiness, was informed twice about pilot progress during the pilot implementation phase. Air Force Women's Initiative Team and VHA Women's Services wrote the *Women's Health Transition Pilot Program Information Paper* in July 2018 to provide situational awareness to DVCO. The second interaction, a briefing on August 23, 2018, provided an additional overview of the Women's Health Transition Training pilot. DVCO was

noted by interviewees as an important stakeholder due to its direct link to the JEC. The DVCO website states that DVCO, "serves as DoD's Executive Secretariat for Joint Executive Committee (JEC), Benefits Executive Committee (BEC), and DoD/VA Secretaries' meetings as needed; and ensures the implementation of the JEC Joint Strategic Plan" (DVCO, n.d.)

(2) VA and DoD Advisory Body Themes

Similar to the document trends seen in the progression of information to the Veteran service organizations, as the pilot progressed, the information provided to advisory bodies also evolved. There was a heavy focus during the early DACOWITS documents (late 2017, early 2018) on the idea for the pilot based on the identified need/gaps in programming. VHA Women's Health Services and the Air Force Women's Initiative Team used women Veteran suicide data and VHA enrollment research findings and citations to formulate a problem statement and proposed solution. As the pilot was developed and implemented, the Air Force Women's Initiative Team and VHA Women's Health Services responded to the DACOWITS request for information and briefed DVCO with preliminary pilot findings (quantitative data and qualitative participant testimonials) that supported the assertion that participants had improved perceptions about VHA. The presentation to DVCO on August 23, 2018, included a section on how to solve women Veteran transition challenges and increase VHA enrollment long-term – that the program would need: a long-term funding plan; advocacy to take this from a VA-funded pilot to a DoD-wide effort; the ability to brief the JEC to align research, resources, and metrics across the military services and VA; and showcasing action to impact (Women's Health Learning Session Overview, 2018).

c) Congressional Entities

Congressional entities oversee federal government agencies, draft and review current legislation, and recommend bills or amendments related to different issues. There were four congressional committees, one subcommittee, one task force, and a Congressional caucus involved in the pilot process: House Committee on Veterans' Affairs (HVAC) (including the Women Veteran Task Force), Senate Committee on Veterans' Affairs (SVAC), House Committee on Armed Services, Senate Committee on Armed Services, and the House Appropriations Committee (Subcommittee on Military Construction, Veterans Affairs, and Related Agencies), and the Congressional Servicewomen and Women Veterans Caucus. Descriptions for each congressional entity are included in TABLE XIV.

A timeline of Congressional entity activity was created to visually depict the timing of briefings/documents (Figure 20).

TABLE XIV: CONGRESSIONAL ENTITIES

Influencer Entity	Entity	Description
Congressional Entities	House Committee on Veterans' Affairs (HVAC)	The House Committee on Veteran's Affairs oversees Veteran issues, including readjustment of service members to civilian life and oversight of Veterans' hospitals, medical care, and treatment of Veterans.
	House Committee on Veterans' Affairs – Women Veterans Task Force	The House Committee on Veteran's Affairs Women Veterans Task Force was established in 2019 to "advance equity in provision of access to resources, benefits, and healthcare for women veterans" (Women Veterans Task Force, n.d.).
	Senate Committee on Veterans' Affairs (SVAC)	The Senate Committee on Veterans' Affairs is dedicated to ensuring VA is serving the nation's Veterans as intended.
	House Committee on Armed Services	The House Committee on Armed Services oversees Department of Defense and military operations.
	Senate Committee on Armed Services	The Senate Committee on Armed Services, similar to its House of Representatives counterpart, is responsible for legislative oversight of the military and the Department of Defense.
	House Appropriations Committee – Subcommittee on Military Construction, Veterans Affairs, and Related Agencies	The House Committee on Appropriations Military Construction, Veterans Affairs, and Related Agencies subcommittee has jurisdiction over DoD, VA, and related agency appropriations.
	Congressional Servicewomen and Women Veterans Caucus	The Congressional Servicewomen and Women Veterans Caucus was established in May 2019 to focus on issues facing female service members and Veterans (Grisales, 2019).

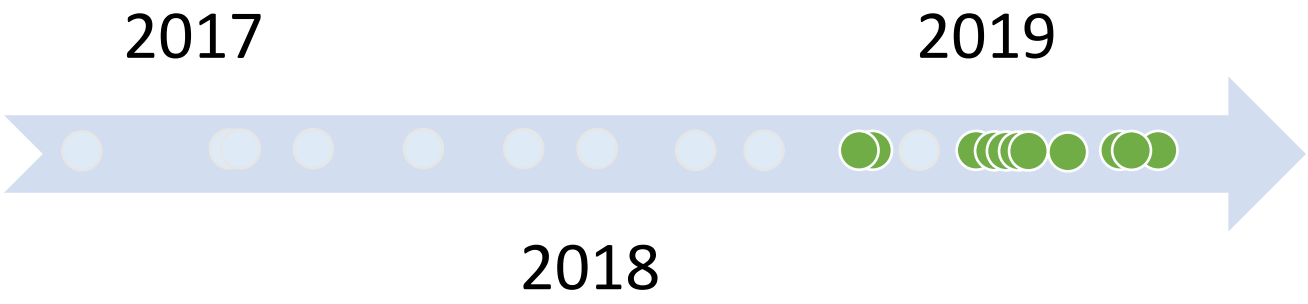


Figure 20: Congressional entities timeline

(1) Congressional Entities Timeline

Documents and interviews confirmed that four Congressional committees, one subcommittee, a task force, and a newly formed caucus were engaged on the VHA Women's Health Transition Training pilot during the pilot implementation phase. Professional Staff Members of the House Committee on Veterans' Affairs and the House Committee on Armed Services were informed of pilot progress during the MWC briefing in January 2019. Professional Staff Members of both the House Committees on Veterans Affairs and Armed Services then requested a subsequent briefing to discuss the pilot on February 1, 2019. An additional briefing was held on March 21, 2019, with the House Committee on Veterans' Affairs – Women Veterans Task Force to discuss pilot progress and preliminary pilot outcomes.

Interviews and documents confirmed that following these briefings, additional Congressional representatives and entities were engaged. In March and April 2019, two letters were written and signed by members of Congress – one to the House Appropriations Committee – Subcommittee on Military Construction, Veterans Affairs, and Related Agencies requesting funding to support

the pilot on an ongoing basis; and another to the Secretaries of the Army and Navy requesting their participation in the pilot. In addition to these letters requesting funding and Service participation, respectively, the pilot was written into the base text of the House of Representatives (H.R.) H.R.2500 and two separate bills released by the House of Representatives in May 2019 (H.R.2941 and H.R.2942). H.R.2500, also known as the National Defense Authorization Act of 2020, contains Sec. 723 – Encouragement of Participation in Women's Health Transition Training Pilot Program. H.R.2941, the Servicewomen's Health Transition Training Act of 2019, directed the Secretaries of the military departments and the Secretary of Defense to encourage separating servicewomen to participate in the Women's Health Transition Training pilot program. H.R.2942, HEALTH Act, directed the Secretary of Veterans Affairs to carry out the pilot through at least fiscal year 2020.

Interviewees shared that also in May 2019, members of the pilot implementation team participated in a panel hosted by the Congressional Servicewomen and Women Veterans Caucus. This panel discussed issues facing servicewomen and women Veterans. Additionally, the pilot was briefly mentioned during a May 2019 VHA testimony on women's health with House Committee on Veterans' Affairs Congressional representatives.

(2) Congressional Entities Themes

As validated in the document review chronology matrix, all Congressional involvement occurred during the pilot implementation phase. Presentations to Congressional entities focused heavily on qualitative and quantitative pilot evaluation data, including pre-test and post-test responses for current pilot results, mental health-related questions, and knowledge check questions; and overall course feedback and pilot feedback trends. The data overall showed a marked positive trend in the pre and post-test responses and very positive overall course feedback. In addition to the

heavy data focus, the Congressional entity presentations, unlike briefings to different stakeholder groups, stressed the alignment of the pilot with the John S. McCain National Defense Authorization Act (NDAA) for FY2019, which specifies the budget, expenditures, and policies of DoD for FY19.

Involvement of these Congressional entities ultimately led to a letter to the Secretaries of the Army and Navy to encourage their participation in the pilot, letters to the House Appropriations Committee to designate funding for the pilot, base text in the NDAA 2020 (H.R.2500), and two independent House bills (H.R.2941 and H.R.2942). A press release on May 23, 2019, on Representative Cisneros's (CA-39) website touched on the convergence of support that resulted in Congressional action, including the introduction of H.R.2942 (which to this date has only been introduced in the House and has not passed the Senate). Representative Houlahan (PA-6), another proponent of the pilot, was quoted in Representative Cisneros's press release. "A month ago, I wrote a letter that was signed by 33 of my colleagues from both sides of the aisle to the Secretary of the Army and the Secretary of the Navy urging both the Army and Navy to pursue full participation in the VA's Women's Health Transition Assistance pilot program. When I separated from the Air Force, I wasn't educated about any of the care that the VA offered for women veterans. Today, with a record number of women vets serving in Congress, it is time we stand up for the brave women who wear and wore the uniform. We lose too many veterans to suicide, and I believe it is my and my colleagues' duty to fight for those who have already given so much to our country. That is why I'm introducing this bill today. That is why I launched the first ever Servicewomen and Women Veterans Congressional Caucus. Our branches of the military owe these women every opportunity to become fully educated and aware of their options for receiving health care and life-saving treatments. In the Air Force, I promised to leave no one

behind, and with this bill, I am honoring that promise" (Cisneros, 2019, para. 4). Representative Julia Brownley, Chairwoman of the House Committee on Veterans' Affairs Women Veterans Task Force and the Subcommittee on Health said, "This legislation is a key step in better addressing the unique healthcare needs of women veterans and improving their health outcomes. This is one of the top priorities of the Women Veterans Task Force and I look forward to continuing to work with Rep. Cisneros to move this critical bill through the legislative process" (Cisneros, 2019, para. 3).

d) Media/External Visibility

Multiple media outlets wrote and posted articles about the Women's Health Transition Training pilot and presentations were delivered by implementers to various external audiences. These articles and presentations had two distinct purposes as identified during the document review analysis: advertising the pilot with the primary purpose of recruiting participants or informing a broader audience about the pilot (TABLE XV).

A timeline was created to visually depict the chronology of media/external visibility documents (Figure 21).

TABLE XV: MEDIA TYPES

	Type	Description
Media/External Visibility	Advertising the pilot for participants	Articles were written and posted by military bases and VA facilities with the intention of recruiting more pilot training participants (e.g., Haley VA website, Women Veterans Alliance, Air Force Times, Forever Wingman).
	Informing a broader audience	Articles and presentations were posted and delivered, respectively, to inform a broader audience (e.g., current and former military service members) about the pilot's progress. Outlets included the Higher Echelon website, Air Force Magazine, Military.com, Military Families, Association of Military Surgeons of the United States (AMSUS) Annual Meeting, and the American Public Health Association (APHA) Conference.

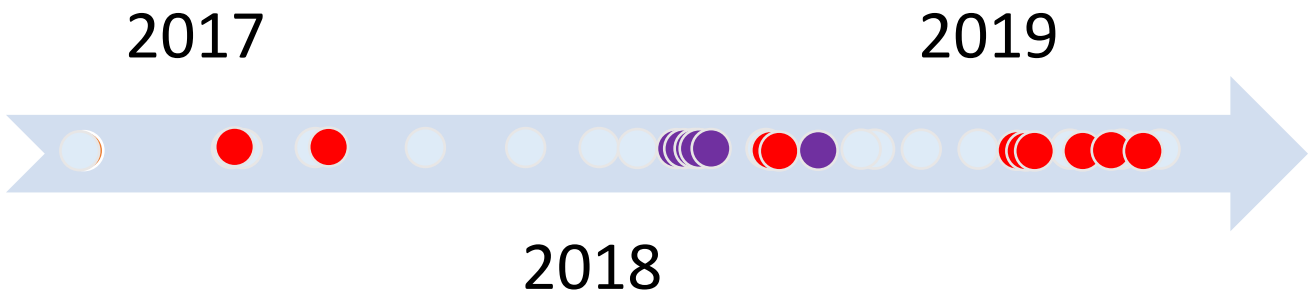


Figure 21: Media/external visibility timeline

(1) Media/External Visibility Timeline

Twenty documents were identified for the purpose of advertising the pilot for participants or informing a broader audience. All media activity advertising the pilot for the intent of recruiting

participants occurred during the pilot implementation phase, primarily in August 2018. Documents informing a broader audience were identified in both the pilot exploration & approval and implementation phases. The majority of media documents and presentations to inform a broader audience occurred in the later stages of the pilot implementation (Spring 2019), just prior to the pilot being adopted as a permanent program. Activities included in-person presentations at academic and trade conferences and online articles to introduce the pilot and share preliminary pilot evaluation data.

(2) Media/External Visibility Themes

Two articles released during the pilot exploration & approval phase highlighted the needs of transitioning servicewomen as disclosed during a women Veteran focus group and that a pilot was being developed to assist with the transition. One of those blog articles, written by the Director of VA's Center for Women Veterans, stated, "Listening to women Veterans' experiences was the first step toward designing and implementing tailored solutions. Using what we've learned in these focus groups, VHA is piloting an improved Transition Assistance Program for women in partnership with the Air Force at five bases in 2018. In this pilot program, women will receive a one-day session to discuss in detail the physical and mental health services available to them after they transition. The addition to the program is designed to take some confusion out of the process of enrolling in VA health care. If successful, it will be rolled out to other branches and sites as well" (Williams, 2017, para 4).

Articles intended for the purpose of recruiting pilot participants during the pilot implementation phase focused on the problem statement, pilot background, pilot locations and schedule, and information to recruit session participants. Quotes from pilot administrators were also used to highlight the purpose of the pilot; "The biggest obstacle that the VA faces is simply awareness

on what they provide to female Veterans. By providing relevant VHA health enrollment information, and describing the extent and depth of services offered at VHA, related to women's health, women veterans will learn how to access the health care services that they need and want at the VA in a timely manner" (Taylor, 2018, para 3).

Articles intended for a broader audience, although they were released in the latter stages of pilot implementation, focused largely on the problem statement and the gaps and barriers the pilot addressed. The articles were also infused with administrator quotes and expressly stated how the pilot was going to address women Veterans' health challenges. Some of these articles assembled an implicit theory of change underlying the pilot, which is that the pilot would aim to increase VHA enrollment and utilization for women Veterans, which would then address the unique health challenges of women Veterans and subsequently reduce women Veteran suicide rates. "VA has found that many women veterans do not see a place for themselves at VA and do not think of VA as a quality place to get women's health care, often leading to fewer women veterans enrolling in the system. Additionally, women veterans are not using VA services as much as their male counterparts. VA developed this training to focus on transitioning servicewomen's health needs, address misperceptions regarding eligibility for VA care, increase their awareness [sic] women's health services offered by VA, and encourage women Veterans to enroll in VA soon after leaving the military. We partnered with the Air Force to use this as an opportunity to help women think not only about their VA healthcare option, but also about their own health during their, often hectic, transition out of the military" (Strzalkowski, 2019, para 9).

5. Dimensions of Decision Making

The Gutierrez et al. framework (2008) was introduced in Chapter II as a means for understanding the dimensions of decision making and proposed as a way to understand the decision-making

processes explored in question 1. Four dimensions of decision making were introduced and discussed in Chapter II: understanding of innovation, rationality in means, formalization of processes, and exercise of power. Each dimension has what are seemingly dichotomous variables (e.g., hierarchical vs. non-hierarchical), but as hypothesized, the decision-making process related to this pilot was complex. To flesh out the complexity, the dimensions of decision making are delineated by the decision-making process and influencer activities. It is of note that the understanding of innovation dimension did not emerge in the interviews, largely because that construct pertains to how "innovation occurs or should be managed." This was not relevant for this particular exploration considering this project was less about how innovations are brought about and more about the decision-making processes to adopt innovations. This resulted in the inclusion of only three decision-making dimensions in this analysis – rationality in means, formalization of processes, and exercise of power.

a) Decision-Making Process

(1) Rationality in Means

Interviewee responses and document content indicated that this was a rational decision based on the understanding of the need and evidence of pilot effectiveness; yet perspectives differed as to the degree to which evidence underscored the rationality of the decision given how quickly the decision was made and concerns from decision makers about low pilot participation. Decision makers considered the data and the potential return on investment of the program. One interviewee summed up the leadership considerations in the decision-making process, including their encouragement to collect more data before a decision was made to support the pilot. Once the pilot implementation team had collected what was deemed "enough" data (including data on

VHA enrollment as a result of pilot session attendance), the decision was considered a "no brainer."

> *"…The governance body said, you know, we would really love to have a little bit more data so that we can make the case that from a longevity standpoint, this has really great return on investment [ROI]…And then once they had enough data to substantiate that, you know, women, servicewomen really love this program. We've got great data on healthcare utilization, we've got great data on sort of the qualitative commentary on how they liked the program. You know, once they had all that data, it was almost like a no brainer. That's really what you always hope for with an initiative like that is that you would test something out in a pilot phase and have real data to substantiate that it was, that it was meaningful enough and there's enough ROI to actually make it a permanent program and go forward from there."*

However, there were other opinions on the rationality of the process and that the decision was made more quickly, and perhaps more hastily than under other circumstances. One interviewee shared about how this pilot may have eventually been adopted as a permanent program, but it may have been approved years later, with much more data to support the decision and additional conversations about broader transition program implications.

> *"…This might have gotten done, but it would have been several years later, with data, showing that it had a positive outcome. And also maybe with some more discussion about… we need a wider health program for all members that goes through things...But it would have been data based. I expected that this thing would crunch along slowly and it would be data based…And I think it's going to show positive results, but we don't even know that right now. We have some early positive results. I think it's probably well accepted by servicewomen. But we certainly don't have that, as you know, as something we've documented that we would have for a normal decision process on something like this."*

(2) Formalization of Processes

Interviewee responses and document content indicated that a formal succession of decision-making authorities were involved in the decision to adopt the pilot as a permanent program; however, it was noted by interviewees that there was no set process to follow and they had to figure out the sequence and engagement of decision-making actors as they proceeded with the pilot. Additionally, there were some informal influences that impacted the decision (and the

timing of the decision), particularly the early engagement of the JEC. All entities involved in the decision-making process have governance structures that dictate what is discussed during meetings, how discussions are documented, and how decisions are made. And there were many stakeholders involved in this pilot given the multidimensional nature of the project – an interagency transition program related to women's health. One interviewee described the complexity of introducing new programs in the interagency transition space, with numerous stakeholders with different stakes and priorities.

> *"When you are creating something new that…goes into an interagency space that's bigger than just DoD and VA, because the interagency governance body for Transition Assistance Program is more than just those two agencies. There are multiple federal agencies in that governance body and the military services…it almost becomes its own little mini bureaucracy. And so there's a lot of sort of people to brief and people who will have questions and understand how it will affect their programs."*

It was noted by many interviewees that the pilot was made visible to the JEC much earlier than typical projects of this magnitude. The way in which the decision was reached on the day it was reached was also noted as atypical, as described by one participant.

> *"This is not typical…the JEC does not usually make decisions on the fly like that…there is usually a very clear build-up to those decision points and they're briefed as a decision brief. So this is an unusual situation where the co-chairs looked at it and said, this all makes sense. There's nothing bad, there are no risks involved in this that we feel are, you know, crucial enough to be concerned about. And this just makes sense. It's the right thing to do for Veterans. Let's cut the bureaucracy. Let's just do it."*

One interviewee discussed the complications and frustrations sometimes posed by complex and multi-layered bureaucratic and formal processes, but that the checks and balances serve an important purpose.

> *"In all the decision making at this level, like there is an interminable number of meetings that leads up to something like a vote…like that vote did not just happen. There were lots and lots of prep meetings and like lots of planning and lots of drafts of things exchanged by email…everything is so carefully documented to, I think, in part, preserve a record…to just confirm that things are on the up and up…the process is irritating, but I*

feel like, I had mixed feelings. Part of me was like…why does everything have to be this hard? And then another part of me is like, oh, to make sure that, you know, people aren't just throwing money at random bullshit that doesn't work or slipping like their cronies a big fat contract to do something ridiculous."

(3) Exercise of Power

Interviewees agreed the decision to make the pilot a permanent program followed a formal hierarchy of approvals; however, some interviewees noted that because higher levels of the hierarchy were engaged sooner than typical, the decision to make the pilot a permanent program was expedited. A formal hierarchy was followed in that subordinate committees were briefed prior to their associated superior committees. Such is the case in large government departments, committees at different levels possess different levels of authority. For example, the SSG gave the pilot implementation team permission to continue developing the pilot program, but the JEC as the highest-level committee made the decision to adopt the pilot as a permanent program. An interview participant shared about the system in place to ensure subordinate committees are briefed prior to elevating to the JEC, a very high-level committee; however it was also noted that even with this hierarchy in place, there was some surprise about the timing of the decision.

"This is also where it gets tricky with these interagency decisions because frequently people will bring things to the JEC. And the co-chairs are making some assumptions that things have been fully vetted within each department before it's presented in this joint forum. And so that's sort of partially our job is to really confirm that that's happened before it goes forward to the JEC co-chairs. So for this particular project, I know it had been briefed…So we felt comfortable moving it forward to the JEC co-chairs, but we didn't expect there to be a decision in June."

Similar to the passage about the JEC decision being unexpected, many interview participants commented on the short time this pilot took to progress from a concept to being instituted as a permanent program (less than two years). This was due in large part to the early involvement of the JEC to overcome resistance at some lower levels of the hierarchy. One participant shared

about the decision to engage the JEC early to gain support, rather than potentially stalling pilot progress with the lower-level decision-making entities.

> *"We definitely thought we were going to get slow-walked…And that we would just like do our pilot and produce a report recommending that it be made permanent and all services participate, but that report was going to the SSG and it could have just died there. We didn't know that they were necessarily ever going to report up to the JEC about it."*

b) Influencer Process

(1) Rationality in Means

Interviewees relayed that the factors that mattered in the decision-making process were also important to influencer groups (e.g., pilot data) that endorsed and promoted the program. And decisions to support the program by influencer groups were rational and logical based on the understanding of the need. Influencer groups that were engaged in the pilot all understand the issues facing women Veterans and saw this pilot as filling an expressed need. And the influencer groups used rational means and decision-making processes to come to support the pilot. One interviewee described the rigorous and rational process used by DACOWITS to generate recommendations for the Secretary of Defense.

> *"Once the committee receives information and conducts their own internal research…they draft up proposed recommendations…They take all their proposed recommendations and they put it before the committee for a full vote, and the vote has to pass by a majority. And so the individual who drafts that recommendation has to be able to answer questions and…justify the reason why they're putting that recommendation forward for voting. And so the committee votes at large. And then if it passes in September…the individual who proposed it has to write up the reasoning session…the justification that supports that recommendation before it goes into the actual report that goes forward to the Secretary of Defense."*

(2) Formalization of Processes

The document review and interviews revealed that a number of entities were engaged outside the formal decision-making hierarchy. External entities were engaged through both formal and informal means. Veteran service organizations were engaged more informally through direct

communication and subsequent meetings. Federal advisory committees were engaged via more formal means (e.g., through a public comment forum or through direct committee membership and participation). The groups that were engaged informally tended to have more informal decision-making processes related to their pilot support, while the federal advisory committees and Congress used standardized and formal means to make decisions and provide support. One interview participant shared about the formal process they employed to make an appeal to the Appropriations Committee on behalf of the Women's Health Transition Training pilot, which included the careful selection of signatories and circulation of a letter signed by many female Congressional representatives.

> *"The MilCon/VA Appropriations Subcommittee would be the committee responsible for appropriating funding for the VA and therefore, for the program...So we wrote this letter and we had a number of other women on House Armed Services and House Foreign Affairs sign that letter…part of the reason we had it in that closed group was to sort of show like this is women's health, here are a bunch of female members who care about this thing. So we submitted that to the Appropriations Committee via that online portal…And the reason there's this portal is because it lets members keep their appropriations requests private if they would like to, but then we also did press around that letter that we had other members sign. And it was a way to sort of elevate and communicate to people what this program was and why it was important."*

(3) Exercise of Power

The interviews revealed that there were differences in the influencer groups engaged in terms of their authority and power and what type of influence they could wield. Veteran service organizations can be strong advocates that may exert influence on Congress. The federal advisory committees make recommendations directly to the Secretaries of Defense and Veterans Affairs and those recommendations are often taken into account and further supported and pushed by Congress. Congress, which can be influenced by both Veteran service organizations and federal advisory committees, ultimately has legislative power, certainly a more authoritative

position in the hierarchy. The impact of these influencer entities will be discussed further in response to research question 2.

6. Question 1 Summary

Sixty-eight documents were reviewed that spanned the pre-pilot time period through the adoption of the pilot as a permanent program in June 2019. Document review findings were synthesized and analyzed using an event-listing matrix and a chronology matrix to identify trends across documents for different audiences and time periods. TABLE XVI summarizes the themes by component and phase that were discussed in the question 1 narrative. Additionally, document review findings were integrated with interview findings to create a rich picture of how the decision was made to adopt the pilot as a permanent program.

Many reports, dating back to 2014, expressed the need for a women's-specific transition program. These reports stimulated discussions between concerned stakeholders within the Air Force and VHA. These parallel Air Force Women's Initiative Team and VHA Women's Health Services efforts were eventually brought together through a personal connection at the end of 2016. Following these pre-pilot activities, the pilot progressed through three phases: pilot exploration & approval, pilot implementation, and the pilot adoption decision. In addition to the formal and hierarchical decision-making processes, a number of influencer activities occurred in parallel with the pilot implementation and decision-making processes that ultimately facilitated the pilot being adopted as a permanent program (Figure 22).

TABLE XVI: THEMES BY COMPONENT AND PILOT PHASE

Component/Entity	**Themes by Phase**		
	Exploration	Implementation	Decision
Formal Decision-Making Process	• DoD to VA "Hot Hand Off" • Problem statement • Resource requests	• Pilot details • Preliminary pilot data • Pilot next steps • Multimedia • Content progression	• Pilot data • Long-term outcomes • Pilot next steps
Influencer - Veteran Service Organization	• Pilot concept • DoD to VA "Hot Hand Off"	• Pilot background • Pilot data	N/A
Influencer - VA-DoD Advisory Body	• Pilot concept • Problem statement • Proposed solution	• Pilot data • Long-term needs/requests (e.g., funding, advocacy, ability to brief the JEC) • DACOWITS Annual Report Recommendation	N/A
Influencer - Congressional Entities	N/A	• Pilot data • Alignment of the pilot to the NDAA FY2019 • Letters and advocacy • Legislation	N/A
Influencer - Media/External Visibility	• Needs of transitioning servicewomen • Pilot concept	• Participant recruitment • Pilot background • Quotes • Problem statement • Gaps/barriers addressed • Implicit theory of change	N/A

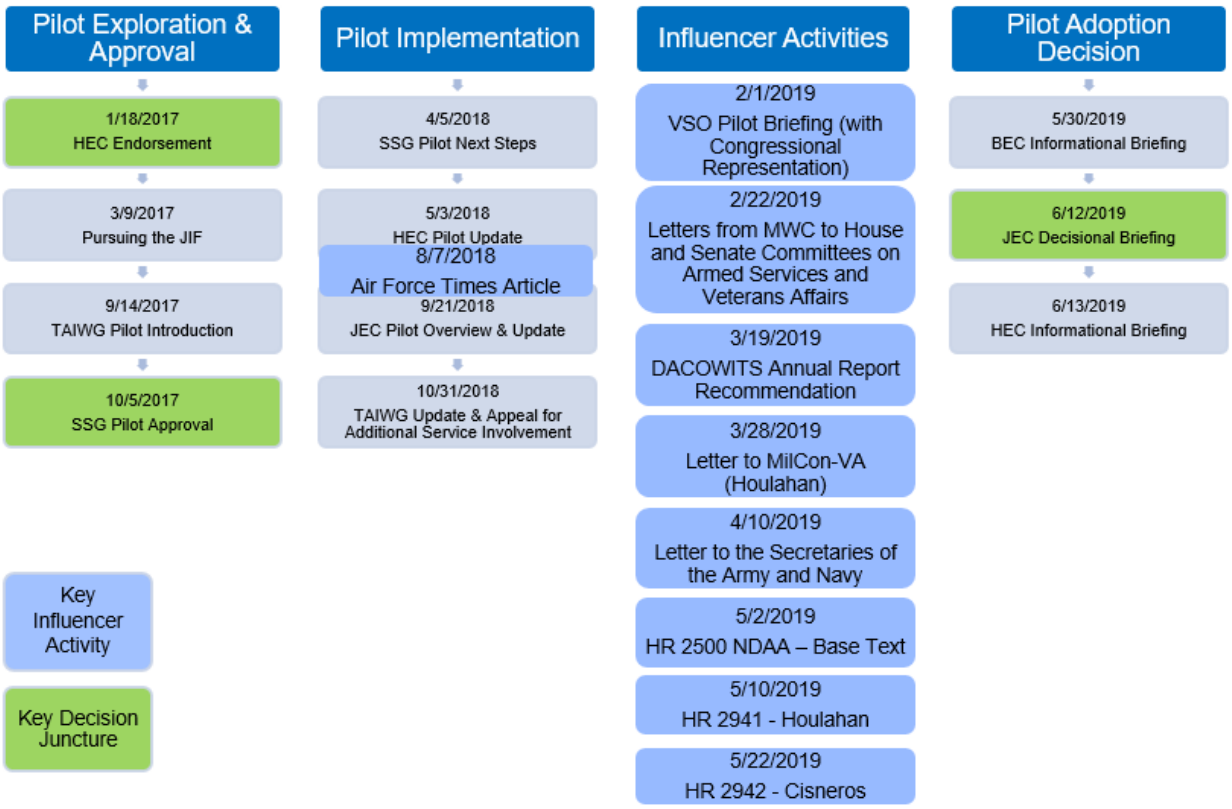


Figure 22: Decision-making process and key influencer activities

a) Key Decision-Making Activities

Three decision-making activities were noted by interviewees as key junctures in the pilot process (green boxes in Figure 22). The first was the HEC Endorsement on January 18, 2017, that officially granted permission to develop the pilot under the purview of the HEC WHWG. The SSG Pilot Approval on October 5, 2017, was a necessary endorsement in the interagency transition community to proceed with pilot development and implementation. And finally, the JEC Decisional Briefing on June 12, 2019, which ultimately made the decision to adopt the pilot as a permanent program across all military services.

The decision-making process as it was described by interviewees can be categorized as formal, hierarchical, and rational, but there was some degree of aberration from what is typically expected. When asked if there was a set process to follow when implementing a pilot program, implementer interviewees shared that they asked senior leaders for guidance on the process, but that they primarily figured out the process along the way. This is largely due to the fact that many programs are not developed organically like this pilot. A number of interviewees spoke to the uniqueness of this pilot decision-making process, largely because programs are normally derived from committee activities. One interviewee shared about how programs are typically borne out of governance bodies and contained within a single department and that one of the pilot's unique features was how it was created outside the committee structure and then assimilated into the portfolio of initiatives.

> *"A lot of times these initiatives don't start grassroots. They start more at the senior level and get sort of directed. So this one was kind of cool in that it was really grassroots…I think most of the ones that that I've been a part of have either been just part of the DoD or VA…interactions that happen as a natural part of the governance bodies that exist because there are multiples of those…They may be a little bit grassroots in that they come up from the working groups that support those committees. But this one kind of started outside of the working groups…And then we sort of brought them into the fold into the working groups and into the committees so it was a little bit different…once they made that connection, it was just kind of folded in and became a part of the process and became one of the initiatives in the portfolio."*

b) Key Influencer Activities

Nine influencer activities were noted by interviewees as key to having the pilot adopted as a permanent program (darker blue boxes in Figure 22). All of these activities occurred in the latter stages of pilot implementation (see Influencer Activities in Figure 22). An Air Force Times article released on August 7, 2018, led to additional media interest and follow-up interviews that resulted in additional pilot press and visibility. A number of interviewees discussed the impact of

the Air Force Times article and subsequent visibility on the pilot success, with one interviewee linking the media influence to VSO and Congressional interest.

> *"I think one key thing that happened was that we got an article in an Air Force publication about the training that generated a lot of interest not just from servicewomen, but you know, stakeholders, like Congress and advocacy groups."*

In early 2019, a VSO pilot briefing (webinar) was held. The briefing garnered both VSO and Congressional attention that ultimately led to letters being written to numerous Congressional entities. In addition to letters, the pilot was cited in the NDAA 2020 (H.R.2500) base text and was drafted into two independent House of Representatives bills (H.R.2941 and H.R.2942). In parallel with the Congressional interest, the DACOWITS 2018 Annual Report was released, which included a recommendation to the Secretary of Defense to encourage all military services to participate in the pilot (or a similar program). The impact of Congressional attention and action in relation to this pilot will be discussed in greater detail in question 2.

C. Question #2 – Decision-making factors: What decision-making factors affected the program adoption decision?

1. Qualitative Analysis Overview

Responses for this question are derived from the semi-structured interview analysis. As described in Chapter III, a number of MAXQDA data displays were examined and served as the basis for the qualitative analysis. Decision-making factors were analyzed by code frequency, phase of occurrence (i.e., pilot exploration & approval, pilot implementation, pilot adoption), level of the socio-ecological model, stakeholder group (e.g., decision maker), and co-occurrence of factor codes. These methods collectively helped delineate the most predominant factors and those that had moderate or limited evidence. For example, when using the code relations browser in MAXQDA to visualize code co-occurrences, understanding of the need was the most cited

factor and also had the highest co-occurrence with other factor codes. These visualization tools helped depict the relationship of understanding of the need with other factors such as senior leader support, readiness for change, sense of urgency around the issue, and influencer involvement and support during all phases. A combination of all of these methods, including understanding the nature of what was said in interviews and the context in which factors were discussed, was used to delineate and understand the importance of individual factors and factors in relation to one another. These methods also helped to decode patterns in factor identification by interviewee type (e.g., influencer).

Factors with the most evidence are presented first (predominant factors). The predominant factor section is followed by a discussion of the combination of factors discussed by interviewees that impacted the decision to adopt the pilot as a permanent program. Finally, factors with moderate or limited evidence are discussed, including commentary on the differences in factor importance as identified by the three pilot stakeholder groups. Data displays used to stratify factors are included in Appendix N: Qualitative Interview Data Summary. As this case is a retrospective example of a successful program adoption, all factors cited are facilitating factors. However, there were some other factors noted during interviews that were either neutral for consideration (e.g., resources) or barriers to program implementation (e.g., politics and resistance). These concepts are discussed if relevant to the facilitating factor in the respective narrative sections but were not included as factors for why the pilot was adopted as a permanent program. All codes and factors and associated definitions and examples are included in the updated codebook in Appendix L: Revised Codebook.

2. Analysis Results

Using the aforementioned methods, 24 factors were identified that facilitated the adoption of the pilot as a permanent program. TABLE XVII provides an overview of the identified factors; the percentage of interviewees that cited the factor by stakeholder type: influencer, implementer, or decision maker; the levels of the socio-ecological model in which the factor was present; and the phase in which the factor was present.

In the following section, factors are stratified into three categories – most predominant factors (12), factors with moderate evidence (5), and factors with limited evidence (7). For each factor, analyses are presented and supported by interviewee quotes. Additionally, the combination of factors construct is discussed immediately following the predominant factors section, as it demonstrates the importance of context in the decision-making process. Following the factor sections, there is a discussion of result patterns by stakeholder type. To preserve the anonymity of participants, roles are not typically assigned to interview passages, but rather are discussed more generally as interviewee responses.

TABLE XVII: ANALYSIS RESULTS OVERVIEW

Factor	**% of Interviewees Cited**			**Socio-ecological Model Level**				**Phase**		
	Influencer	*Implementer*	*Decision Maker*	Individual	Interpersonal	Organizational	Societal	Exploration	Implementation	Decision
Understanding of the Need	100%	100%	100%	X	X	X	X	X	X	X
Pilot Data	100%	75%	100%	X	X	X	X		X	X
Senior Leader Support	85.7%	100%	100%			X			X	X
Visibility	100%	100%	50%			X	X		X	
Collaboration	71%	75%	75%		X	X	X	X	X	X
Organizational Characteristics	71%	100%	75%			X		X	X	X
Readiness for Change	100%	100%	25%			X		X	X	X
Congressional Influence	86%	75%	50%				X		X	X
Coordinated Implementation Plan	71%	75%	75%		X	X		X	X	
Priority Alignment	71%	50%	75%			X	X		X	X
Passion and Persistence	43%	100%	50%		X			X	X	X
Sense of Urgency	57%	100%	25%	X	X	X	X	X	X	X
Navigating Bureaucracy	43%	75%	75%		X			X	X	
Veteran Service Organizations	71%	75%	25%				X		X	
Connections	29%	100%	50%		X			X	X	
Perception	57%	75%	25%	X		X	X		X	X
VA-DoD Advisory Body	57%	75%	25%				X		X	
Champion	29%	75%	50%		X			X	X	
Broader Societal Influences	43%	75%	0%				X		X	X
Empathy	57%	50%	0%	X				X	X	
Trust	43%	50%	25%		X			X	X	
Grassroots Initiative	14%	0%	100%		X	X	X	X	X	X
Risk Perception	43%	0%	50%			X			X	X
Recruitment and Retention	14%	0%	25%			X				X

a) Most Predominant Factors

The most predominant factors were determined by using a combination of analytical tools, including code frequencies, number of pilot phases in which the factor was present, levels of the socio-ecological model crossed, stakeholder type, and the nature of the factors as described in the interviewee discussions. These 12 factors consistently emerged using the aforementioned analytical methods and were therefore deemed the most predominant factors. Factors in this section are discussed in the order presented in TABLE XVIII.

TABLE XVIII: MOST PREDOMINANT FACTORS

Factor	# of Interviewees Cited	% of Total Interviewees	# Phases
Understanding of the Need	15	100.0%	3
Pilot Data	14	93.3%	2
Senior Leader Support	14	93.3%	2
Visibility	13	86.7%	1
Collaboration	12	80.0%	3
Organizational Characteristics	12	80.0%	3
Readiness for Change	12	80.0%	3
Congressional Influence	11	73.3%	2
Coordinated Implementation Plan	11	73.3%	2
Priority Alignment	10	66.7%	2
Passion and Persistence	9	60.0%	3
Sense of Urgency	9	60.0%	3

(1) Understanding of the Need

Understanding of the need was: the most cited factor across all phases, present at all levels of the socio-ecological model, and cited by all interviewees. This concept was explored in Chapter II as the extent to which members of an organization understand that a problem exists and

subsequently are cognitively inclined to promote and adopt change (Holt & Vardaman, 2013). Understanding of the need was important during all phases, but it was the primary antecedent for pilot development. Interviewees stated that the needs were well recognized and documented in various organizational reports and news outlets and served as the basis for pilot development. And it is not a single issue, but rather a complex web of issues including the transition process, women Veterans, suicide, homelessness, employment, and VHA utilization that served as the basis for pilot development. One interviewee summed up the complexity of the web of issues and the struggles both departments (VA and DoD) are having to adequately solve the issues the pilot addressed.

> *"Well, I think both departments are always struggling with how do we improve the transition process for service members? How do we really get people's attention at such a crucial time in their life and make sure that they get the resources they need and they're able to take advantage of those resources to set them up for success?...And then in the back of all of this, of course, is the VA's primary goal, primary objective is to reduce suicides…So all of these transition questions have that kind of goal in the background is what else can we do to try to reduce suicide? So I think when this came up it's focusing on one particular group of Veterans who have potentially been sort of underserved a little bit in as far as making sure that they're aware of all the benefits that are available to them."*

Interviewees shared that because the pilot program was framed as a solution to numerous complex issues, many different stakeholders were supportive based on their particular stake. For example, the interagency transition stakeholders were supportive because of their oversight in the transition space, the HEC WHWG was interested from a women's health perspective, while senior leaders were focused on the suicide prevention aspect addressed by the pilot. One leader shared about the focus of VA senior leaders on the suicide prevention aspect and how any effort to get women into VHA care to potentially reduce suicide risk is worth trying.

> *"I think the…need was finally recognized by the higher echelon in VA leadership…I think they're just like anything that they can do to intervene in that and you know, and there is*

data and research to suggest that if you can get women into VA mental health care that there is a protective effect against suicide. So anything that gets women into the VA at higher rates and this can get them into treatment if they need it. I think you know, why wouldn't you do it?"

As identified in the literature, understanding of the need is considered an important component of or precursor for readiness for change. Organizational readiness for change, as stated in Castaneda, "is reflected in organizational members' beliefs, attitudes, and intentions regarding the extent to which changes are needed and the organization's capacity to successfully make those changes" (2012, p. 220). Stakeholders recognized that a problem existed, but more importantly, believed and valued this as a problem that required action. There was an indisputable need, as shared by one interviewee, and that action was required.

"There was definitely the need. Everybody knew it. And it's been…reported many times about the barriers for women Veterans seeking VA care. So there was just no doubt that it was a needed program. And you know, given that transition is a very vulnerable period, especially, it seems for women. And so many bad things can happen when they try to reintegrate. And there was suicide or homelessness or gaps in care. And we also knew that women don't identify as Veterans…they don't think they're eligible, that you can't get women's health at the VA, it's bad quality. You know, all those things have been pointed out in the literature, you know, for years."

(2) Pilot Data

Pilot data was noted by 14 interviewees as one of the most important factors in the decision to adopt the pilot as a permanent program. Pilot data was cited as being important at all levels of the socio-ecological model (e.g., it was important to individuals, groups, DoD and VA, and to outside influencer organizations) during the pilot implementation and pilot adoption decision phases. As noted in Helfrich et al., evidence is not always objective; it is based on the perceived strength and nature of evidence by multiple stakeholders (2009). That said, the VHA Women's Health Transition Training pilot stakeholders viewed the pilot data as compelling and promising enough to endorse the pilot on these grounds. And pilot data came in many forms – personal

stories, quantitative and qualitative data presented through graphical displays, personal testimonial videos, and toward the end of the pilot period, actual VHA enrollment rates as a result of pilot attendance.

Many interviewees spoke about the influence of pilot data on their support of the pilot, with multiple interviewees citing it as the most important factor in the decision-making process.

- *"Well, what was most important was the data and the initiative owners were really good about not just testing this initiative, but making sure that they were collecting data both from a qualitative and a quantitative standpoint."*
- *"…And their evidence said, you know, it was very positive, even women that didn't think they needed a woman's specific program…So it was really the testimonials and the surveys that they did. And my own belief that this was necessary."*

One interviewee spoke about the evolution of personal stories into pilot data that helped to influence senior leader support. Personal stories were used in the pilot exploration & approval phase to demonstrate the need for the pilot. As the pilot was implemented and data was collected, the importance shifted from personal stories to pilot data.

> *"At first…when we first sold this…it was based on our stories…these are the stories that we're hearing…So I think that kind of got people's attention. But then I think when we gave…the preliminary data, I think that helped our senior leaders go, okay. Not only have we heard the stories, but now we see data to support it."*

It was not only qualitative and quantitative data on paper that made a difference. The implementation team leveraged participant testimonial videos to highlight the impact of the pilot. One participant shared about the impact of these testimonials, in coordination with the outcome data, on the decision-making process.

> *"I think a big part of that was how it was briefed initially, where…they did a video with interviews of actual women servicewomen who had gone through…this program. And said basically, if it hadn't been for this program, I would never have known that the VA was even an option for me…It's really showing how much of a need there is for women's-specific education about the VA that really set the expectation for leadership to say, yeah, this is something we really truly need. And then when they were able to document their outcomes and show these women talking about how this affected them and how now*

they're enrolled in care and that they have all these wonderful glowing things to say about it. I think that really, that really struck a chord with leadership saying, okay, well, this is something we can do that obviously makes a difference."

(3) Senior Leader Support

The support of senior leaders was cited by 14 interviewees as one of the most important factors at the organizational level of the socio-ecological model in the decision to adopt the pilot as a permanent program. This code was differentiated from the champion code (a factor with limited evidence) because senior leaders are individuals or group of individuals that have the power and authority to make programmatic and resource decisions, whereas champions do not always have that authority.

Simply put, interviewees stated that the pilot would not have progressed at all without senior leader support. Senior leaders were often the decision makers, making their support a necessary step in the pilot progression. But the timing in which senior leader support was gained and the positions and roles of the senior leaders facilitated this pilot being moved from a concept to a wide-scale implementation faster than most usual implementations. And the senior leader support helped overcome any resistance from other stakeholders. Interviewees spoke of the imperativeness of gaining and maintaining senior leader support in overcoming resistance, including getting the other military Services to participate in the pilot.

- *"And so we were just getting some resistance…but we knew we had support from leadership at the top level. So we had to make a decision that we needed to get this in front of senior leaders to formally say yes and in front of everybody, so that we could continue to move on…And you know, VA and DoD leadership were beyond supportive. You know we couldn't have asked for anything better."*
- *"…that really helped us was talking to senior leaders…instead of using the traditional hierarchy, the hierarchy model, I think just going to leadership and talking to them, really helped us and it expedited things, right. So that if we went and talked to a leader, and then the next week, we were in a meeting, we already had that built-in rapport with that leader."*

Interviewees shared that this senior leader buy-in was also obtained because pilot implementers listened to senior leaders and made changes to the pilot curriculum based on their feedback. One participant shared about the importance of briefing the right stakeholders and using an iterative process for gaining senior leader buy-in.

> *"One of the things that you also kind of need with a new initiative that's groundbreaking like this one was is you need senior leaders that are in your camp. And so I think that the initiative owners did a really great job of making sure that they were briefing all of the right people so that they could sort of test the waters, get feedback. There was, I think, a lot of fine tuning and tweaking that came from feedback that they got from various senior leaders. And I think that was just a best practice that they leveraged and I think that really helped them a lot."*

(a) Balancing Priorities

Interviewees relayed that senior leader support was an imperative prerequisite to the adoption of the pilot as a permanent program. But senior leader support for this pilot was not a given, considering senior leaders are subject to both internal and external pressures when making prioritization decisions. Sometimes the "loudest" issues, those that are in the media and in Congress's view, become those priorities. And the highly complex array of issues addressed by the pilot fit into that category of issues that are front and center and highly visible both internally and externally. One interviewee spoke about the many factors that influence senior leader support (and what ultimately led to senior leader buy-in of this program).

> *"…that senior leader support is influenced by multiple factors. Yes, it's influenced by the individual commitment and…if senior leaders can like, look at the data and care that, oh, yes, this is an actual issue, not just somebody's pet project…But also, they will be affected by these outside pressures…there's a public affairs issue to this or I'm getting letters from Congress, it makes it easier for them. When you have a bazillion competing challenges – when you're worried about electronic health records, and you're worried about suicide, and you're worried about the backlog of claims and you're worried about, you know, 16,000 things all at the same time and running an organization with 360,000 employees, balancing priorities is really difficult. And certainly the priorities that are, you know, making the news clips every day and that you're having to answer congressional letters about, it's a little easier to stay focused on those."*

(4) Visibility

Visibility was noted by 13 interviewees as a factor at the organizational and societal levels during the pilot implementation and adoption phases. The visibility construct is essentially two-pronged: the visibility of women Veteran and transition issues more broadly and the visibility specifically of the pilot in the media and the press.

(a) Visibility of Women Veteran Issues

Interviewees shared that the more general visibility of women Veteran issues contributed to the understanding of the need and the sense of urgency to act. This visibility was created by a number of factors, including Veteran service organizations, the media, and women Veterans being elected to Congress and advocating for other women Veterans.

> *"…there is definitely the fact that women Veterans started getting a lot of attention in the public eye had to play into it. I've been working on women Veterans issues for quite some time and in the past few years, it just, it's gotten a lot more attention than it used to. There have been a lot of headlines about women Veterans in terms of the suicide rate, women Veterans and homelessness, women Veterans and mental health challenges, sexual assault of women while they're in the military, the number of women Veterans running for Congress, number of Veterans actually getting elected to Congress. Just awareness of women, military women, and women Veterans has gone up significantly. And the level of interest being paid to these issues by members of Congress, by the press, by Veteran service organizations. I think all of that comes to play."*

(b) Pilot Visibility

Pilot publicity and visibility was also noted by multiple interviewees as a factor (and also noted as a key juncture in question 1). One Air Force Times article increased the visibility of the pilot and led to additional interviews and articles. The articles, in addition to advertising for pilot participants, gained the visibility of Congress, federal advisory committees, and Veteran service organizations. As shared by a few interviewees, the media articles also occurred in parallel with the public endorsements from a federal advisory committee and a Veteran service organization.

- *"Once we did the Air Force Public Affairs article…that's when we started getting more questions and then more interviews. And that's kind of what made it take off."*
- *"I think one key thing that happened was that we got an article in an Air Force publication about the training that generated a lot of interest not just from servicewomen, but you know, stakeholders, like Congress and advocacy groups. And then I know that around that time…we had presented this pilot to DACOWITS and they came out in support of it…and SWAN came out in support publicly."*

(5) Collaboration

Collaboration, specifically the interagency collaboration exhibited between Air Force and VHA, was noted by 12 interviewees as a key facilitator of the decision to adopt the pilot as a permanent program. Collaboration was a factor during all phases and was exhibited at the interpersonal and organizational levels of the socio-ecological model. The collaboration between VHA Women's Health Services and the Air Force Women's Initiative Team was noted by interviewees as unique. Interviewees shared that interagency efforts are rare, let alone efforts that are formed in the way the pilot was formed (this will be discussed further in the Uniqueness of Grassroots Initiative section).

Multiple interviewees spoke about the uniqueness of interagency collaboration efforts, particularly for women's health, and the impact that had on the decision-making process.

- *"Anytime you get cross-collaboration like that, people are going to kind of stop and go, okay, wait a minute. You have two institutions. So I think that that really helped."*
- *"I think it was the first of its kind for that kind of VA, DoD interaction around women's health issues…I don't know, maybe it's happened in other areas, but for women's health, I think we hadn't had those cross-agency discussions to that same extent. And we had never really, we had identified gaps in our own programs, but to really kind of build that bridge and say we're going to work on these programs together was something that I think was not done before."*

(6) Organizational Characteristics

Organizational characteristics is a construct that includes many embedded components, including, but not limited to, organizational culture, values, size, resources, and organizational

structure. Organizational characteristics were mentioned as facilitating factors by 12 interviewees at the organizational level of the socio-ecological model. These characteristics played a role in all phases of the pilot progression.

(a) Organizational Structure

Related to the organizational structure facet of this factor, many interviewees spoke about how both departments have permanent offices and structures in place to promote women's issues in the respective organizations. This organizational structure, as described by an interviewee, exemplifies the organizations' commitment to women and serves as recognition of the need for women's-specific considerations and services.

> *"…we finally have women's offices in these organizations…just this kind of creation of as more and more women have joined the military and our numbers have increased exponentially. And these offices have been set up. I think that they're finally you know, are actually doing things on behalf of servicewomen and women Veterans that are needed."*

Organizational structure, size, communication, and the siloes created by the size of the organizations, were noted as facilitating factors in the decision-making process. One interviewee spoke about how organizational siloes and non-existent communication channels allowed for navigation between entities without providing an opportunity to discuss the pilot.

> *"One of the things is that VBA and VA and VHA rarely talk to each other about anything. So someone was able to come in and in sort of cut through the lines and get various individuals involved or put various individuals on the spot because there isn't a consolidated program for anything, much less TAP or women Veterans. We have what's called a Women Veteran Program, but the governing board of that meets like every six months. And this did come up to that, but by the time it came up to that, it was fait accompli…there is no natural way for VBA and the TAP program to talk to anybody in VHA about anything."*

(b) Organizational Culture

Some interviewees mentioned organizational culture as a facilitating factor, while others cited how organizational culture created an environment of resistance to the pilot. Due to the influx of

women in the military, the culture has been changing. One interviewee discussed the changes in military culture that have occurred over the past few decades and how the inclusivity of women in service is a priority not just for optics, but as a matter of national military readiness.

> *"…I think that our senior leaders recognize the importance of having women in the service…It's not just about, you know, having women for the sake of having women. It's the readiness and security of the nation issue…I think they take very seriously the policies and the processes and how they impact the women that serve in the culture that women are serving in. And so that, not so much the case maybe when I first came in…it's a very male dominant organization, the military at large. And it still is, but I think that the culture is changing."*

And subsequently, the VA culture is also changing due to the number of women leaving military service and becoming Veterans.

> *"I think a big part of it is we've already seen a big growth in the number of women Veterans…So I think the known number of growth to the leadership was the demand signal for something like this. And also, yeah, there has to be a cultural transformation. You know…the VA health care system is no longer a place where you see grandpa from World War II…so I think that's driving this as well."*

As noted by interviewees quoted above, even with significant strides in recent decades, the military is still a male-dominated culture. This posture that service members are all the same is still present at some levels of leadership and has infiltrated throughout the organization. One interviewee shared that this cultural belief may be the source of cultural resistance to having women's-specific programs, on account of men feeling left out and women not wanting to be treated differently from their fellow service members.

> *"There will be guys that will say, hey, I want to know what they're getting. And then there will be women who say, I don't want to be treated differently. I want to be treated just like the men…So I think there might be some cultural resistance."*

(c) Resources

Nine interviewees spoke about resources related to the pilot. The pilot plan and concept were developed before the implementation team secured pilot funding. The implementation team

pursued JIF funds, but were unable to secure them through that channel. Due to the cross-sectoral and interagency nature of the program, there were multiple potential avenues for funding, which is not always the case in smaller or more resource-constrained organizations. These options proved to be an advantage for the pilot's progression. One interviewee shared that ultimately, the VHA Office of Patient Care Services was able to secure funding for the pilot based on direction from the HEC.

> *"So we laid out my plan…and they said, okay, we like your plan. But what do you need to make it happen? And I said, I need a million dollars to do a pilot. And they gave it to me."*

This example may make it seem as though procuring funding for the project was easy. But there were a number of factors that impacted the decision to fund the pilot implementation, including the understanding of the need and the sense of urgency felt by decision makers. One interviewee spoke about the leadership role of allocating scarce resources amidst competing priorities.

> *"Because we have limited resources, you have to decide where best to apply them. And so you have to look at where the needs are and kind of balance that out and what the priorities are and balance that out. And so if the resource is a priority and if we are losing women at alarming rates, then that is absolutely a need to address."*

(7) Readiness for Change

Readiness for change is a multi-faceted and complex construct cited by 12 interviewees. Readiness for change is differentiated from organizational characteristics in that readiness for change is more of a mindset, whereas organizational characteristics are largely related to the organizational infrastructure; however, they are both inextricably linked, as organizational readiness for change impacts organizational characteristics like the organizational structure, resource allocation, and values.

As discussed in Chapter II, there are many components of readiness for change, such as a collective commitment to action, motivation (that can be driven by a belief that change is needed

or on external pressures), the capacity to act (ability to address problems), and the climate of change (receptiveness to change) (Holt & Vardaman, 2013; Bouckneghee, 2009; Castaneda et al., 2012). As pieced together when analyzing the interview data, the implementation team and original champions and supporters of the pilot exhibited certain dimensions of readiness for change (e.g., collective commitment), but were operating in a broader political environment that had different concerns and considerations to take into account (e.g., climate of change). Thus, readiness for change was not uniformly distributed and motivations for change were different by individual and stakeholder groups. For example, some stakeholder groups, particularly senior leaders, were supportive of the change due to their understanding of the need and proximity to political pressure. Whereas other stakeholder groups, particularly groups whose programs were directly adjacent to the pilot, had different concerns about how the pilot would impact the implementation of their programs. These factors and vantage points impacted the willingness and readiness to embrace change. And ultimately, any resistance to change within the organization was usurped by leadership and decision-maker support by virtue of the pilot being adopted as a permanent program.

Readiness for change is impacted by both internal (organizational) and external (societal) forces. One interviewee spoke about the progressive military culture, driven primarily by internal forces, that has led the way societally for large social movements, including racial integration, equal pay, and inclusion of women. And that this innovative military culture, including the rotation of individuals into and through leadership positions, is a facilitator for an innovative new program to be adopted.

> *"The military historically has…led the way as it comes to inclusivity…When you look at the integration of blacks and whites in the military, it kind of happened here before it happened in society…Bringing in women and allowing women to hold positions men can*

hold….equal pay…the military…has kind of led the way. And so…I don't think it was driven by Congress, the shifts that are happening. I think it was internal. I think Congress may have helped in some areas, but I think it's more a desire to always be innovative and to recognize the changes necessary and that you need perspectives from everyone in order to be successful in the things that we have to do to keep the country safe…I think one of the benefits also is that…the military is always rotating right? You have new ones coming in, the older ones going out. And so as new ones come in, they are more open to new ideas …so over time, it will continue to get better."

Other interviewees spoke about the confluence of internal and external factors that may impact motivation and readiness for change. And how those factors were different between the different departments and entities represented. VA had a number of external perception issues to contend with that increased their appetite for this program. The Air Force, the military service with the most female members, had an appetite for serving this population and the pilot was aligned with the organization's diversity and inclusion priorities. DoD as a department, on the other hand, was more highly subject to political pressure by DACOWITS, the DoD federal advisory committee.

"I think for the VA it was a bigger issue politically and then within the media…anything the media highlights…VA was having to address that. So I felt like there was more of an appetite on the VA side…Air Force has a lot more females than the rest of the services. So [they] were probably a little bit more open-minded towards women's health. But I don't think the DoD had a huge appetite to do this. I think what really kind of influenced the DoD was DACOWITS coming forward and saying this, and then the Air Force kind of having this movement right now of…trying to address all kinds of things for females, for example, like ill-fitting equipment, certain policies that are outdated. And so it was just kind of, again, the right timing of hey, the Air Force said that they want to do all these things for diversity and inclusion, well here's all these things you could do today for diversity and inclusion for women."

(8) Congressional Influence

As noted in question 1, Congressional influence had an impact on the decision to adopt the pilot as a permanent program during the pilot implementation and adoption decision phases. Congressional influence was mentioned by 11 interviewees as an imperative factor at the societal level of the socio-ecological model. As identified in both the document review and interviews, Congress became involved in the pilot after attending a webinar on pilot progress and

participation in subsequent meetings and briefings. And they showed their support via base text in the NDAA 2020 (H.R.2500) and two separate bills – H.R.2941 and H.R.2942.

One interviewee spoke generally about Congressional influence on decision-making processes, including the relationship dynamics between the executive and legislative branches of government.

> *"…DoD is very, well, executive agencies broadly are pretty responsive to congressional, I don't want to say feedback, but we had, I think, 33 bipartisan numbers on the letter that we sent to the DoD and the DoD wants to make friends with members of Congress. You know, that'll make their lives easier. They want things in the NDAA, they better not, you know, make certain actors mad at them. So they want to maintain their relationships and goodwill. And I think, because Congress has oversight authority, a lot of executive agencies, they don't want to be the subject of not necessarily a, you know, an investigation, but they don't want to be subject to that microscope."*

Another interviewee spoke about women Veterans as an ever-increasing priority in Congress. The congressional infrastructure (e.g., task forces and caucuses) and current congressional representation are reflecting these priority shifts and the sense of urgency to act.

> *"But there are certainly lawmakers paying attention to it. And just this year, in fact, two new Veteran and servicewomen groups on the Hill have been formed. So there's the Women Veterans Task Force and then there's the Service Women and Women Veterans Caucus. So I think that…there are seven women Veterans now elected members of Congress. And at least on the congressional side, they seem to care about this and are working towards supporting servicewomen and women Veterans. So I think that…new lawmakers…along with what we see about Veterans in the community - concerns about high suicide rates, and especially high suicide rates, women Veterans coupled with sexual assault has, you know, created a degree of knowledge that people want to do something about."*

One participant spoke of the impact of Congressional involvement on the final decision to adopt the pilot as a permanent program. Even though the NDAA 2020 has still not yet been adopted into law, the language was essentially a call to action that forced VA's hand in making the pilot a permanent program.

> *"…what they did is they put it into the NDAA…what that did is, the VA got wind that, hey, Congress has given us a go do, you know. So VA made the decision then we went back to the JEC and informed them, hey, this is what Congress kind of wants to do. And they said, you know what, we're going to do this. We're going to get the services on board. We're going to do it. And that's what happened. So, you know, whether the NDAA passes or not, the VA's already said we're doing it."*

Other interviewees spoke of the impact of the bill text and Congressional letters on getting the other military services to participate in the program. The influence of Congress was described as energizing participation from the other Services and that there is a defined tension in the relationship between Congress and government departments that heavily influenced decision making.

- *"…the National Defense Authorization Act hasn't passed yet. But just it being in the base text of the bill…has energized and moved the services to participate even though it's not technically law yet.*
- *"So the fact that 33 bipartisan members from across the country signed this letter saying, hey, we see that Army and Navy are not participating in this pilot program, that is concerning to us. I don't think they were happy about receiving that. And I think that really expedited their action…it's certainly a relationship that has a defined tension and we use that to our advantage."*

(9) Coordinated Implementation Plan

A coordinated implementation plan was cited by 11 interviewees as a reason this pilot was supported, particularly in the pilot exploration & approval and pilot implementation phases. The pilot implementation team (interpersonal level of the socio-ecological model) had a coordinated plan that they executed. This coordinated implementation plan included facets of how the pilot was delivered (e.g., the pilot curriculum was delivered by women Veterans, not by men or women who had not served), the communication methods employed, and the stakeholders (internal and external) briefed on the pilot at different junctures.

(a) Curriculum and Program Evaluation

Numerous stakeholders noted the thoughtfulness of the program in meeting the need as a facilitating factor. In addition to meeting a need and being well coordinated, it was noted that the methodology and the built-in feedback loop (program evaluation) was a model for future VA and DoD programs.

- *"…it's a really well thought out program. It's really focused on the needs of a specific set of stakeholders and it really meets those needs very well. And I think just competency and like a good program that really is well thought out, I think that gets people's attention."*
- *"…it's great that it's focused on women's health and that's, I think a part of the reason why it's successful. That it's meeting an unmet need that people have definitely identified. But the methodology and the way in which that feedback loop is there is…what we want to see more of long term at DoD and VA."*

Interviewees shared that part of the appeal of the pilot was the thoughtful evaluation plan. One participant shared about the importance of the long-term evaluation metrics on their decision to support and endorse the program.

> *"…there weren't outcomes yet because the pilot was still ongoing. But I was really interested in the way that they were planning on measuring outcomes and that they were looking not just immediately post-transition, but up to 18 or 24 months…they were going about it in a scientific way and like had numbers and factors and utilization rates that they were going to use to measure. Which we haven't necessarily seen before in the transition space, which we would like to have more of to help guide our decision making."*

(b) Preparedness

Interviewees stated that an important component of the coordinated implementation plan was being steps ahead in order to seize opportunities when they arose. This included moving forward with planning the program before any seed money was secured to implement the pilot. Interviewees shared about the importance of this preparation and readiness and how in the right timing, being prepared with a "shovel ready" program was a facilitating factor. And ultimately being in "the right place, at the right time, with the right plan."

- *"There's not always a window to do certain programs. But when those windows do open, you've got to take advantage and be ready with not just an idea, but a whole program in mind. So I think the success of this was that we were very prepared at every step. And we had, even though we didn't have secured funding, we weren't relying on that to move forward…we came up with a plan and just found the funding when we needed it, rather than waiting for the funding and then come up with a plan…The reason we moved so fast is we just didn't wait. We did it. And then the money you know, you build it, they will come. And that's what happened."*
- *"We came up with a coordinated plan. We had all the stakeholder engagement. We were ready to go in, identified the bases, we had, you know, had started to develop an outline of the curriculum…they had money that they needed to spend. I told them I could spend it you know, in the next 12 months. I have a program that's shovel ready to go, that would address these huge gaps in this interagency transition that would focus on women Veterans, had all these metrics that we had built into it. So people were happy. They like shovel-ready products, you know, projects like this. And so we were at the right place, at the right time, with the right plan and we got the funding to do it."*

(c) Timing

Another interviewee shared about how quickly the program went from a pilot concept to being adopted as a permanent program. This, in their words, was attributed to a good program meeting an expressed need, a dedicated implementation team, and successful navigation of the decision-making process.

> *"I would say that sometimes within the Department of Defense and within the VA, things can sometimes move slowly, good idea sometimes take time to, you know, to marinate and make its way through the system. This one happened fairly quickly, which I'm somewhat amazed at, but I think it all comes down once again, when you have a good program and you have a good team that's working on it, and they use the process correctly to their benefit, then you're able to get things through. That ultimately are helping our service members."*

(10) Priority Alignment

Priority alignment was found to be an important factor at both the organizational and societal levels of the socio-ecological model during the pilot implementation and adoption decision phases. Priority alignment accounts for statements made by 10 interviewees about how the pilot aligned to organizational priorities and strategies, thereby impacting the decision to adopt the pilot as a permanent program. As voiced by one interviewee, the alignment with the NDAA and

the JEC Joint Strategic Plan, including the emphasis on transition and suicide prevention, was what ultimately earned pilot implementers a seat at the table for the initial JEC meeting in 2018.

> *"That seems like something that is in line with all of our priorities in the JEC. So I think it would be a good news story to have briefed related to all of our transition discussions and suicide prevention stuff…part of this was it's kind of tied into the requirement in NDAA, section 552 self-assessment with 13 factors to be considered…so I think part of what the selling point in getting this on the agenda to start with is because of that connection to the suicide prevention effort."*

Similarly, the pilot was described as an initiative that touched on many of the hot button topics and priorities that concern the JEC, which generated interest when the pilot was initially proposed as an agenda item.

> *"This kind of hit a lot of buttons on there…it really affects a lot of different things that the JEC cares about. And it also really scratched an itch as far as suicide prevention efforts and transition, which are all really key priorities and have been for years for both departments. So I think it just…addressed so many different priority issues that there was already just an interest in the topic as it came forward."*

Another selling point shared by an interviewee was that the pilot aligned with the VA initiative, Choose VA. Choose VA is an ongoing initiative to raise awareness about VA's service offerings and to get more Veterans to enroll for benefits (Choose VA, n.d.).

> *"…the Secretary's Choose VA. That's something we want to make sure that VA is the health care provider of choice for Veterans. I think this really, really supports that as well. Because for women who aren't even aware of the services, how can they choose VA until they understand what VA can do for them?"*

Priority alignment was also noted as a factor in the influencer interviews. The pilot was aligned with many organizations' priorities, including Veteran service organizations, Congress, and federal advisory committees. An interviewee from an influencer entity spoke about the organizational prioritization necessary when there are competing demands. Thus, when organizations receive requests for something that aligns with priorities, they are more likely to pay attention and potentially support the initiative.

"You know, I don't want to say [redacted] doesn't care about things. But there are things that [redacted] cares more about than other things and women's issues, and particularly, women Veterans and servicewomen's issues are one of those things. So if someone were to come to me with an issue, a problem, a policy fix on something relating to that population, I'm more likely to engage because it's something [redacted] I know will be interested in doing and she wants to be a leader in that space."

(11) Passion and Persistence

Although only mentioned by nine interviewees, of those that mentioned passion and persistence, a majority cited this interpersonal-level factor as one of the most important for why this pilot was adopted as a permanent program. Passion and persistence refers to the resolve and dedication of the pilot implementation team in seeing this pilot through from start to finish. Interviewees shared that the pilot was led by a group of individuals that believed in the program and did not give up on their vision, even in the midst of adversity. One interviewee shared about how they felt this resolve was the single most important factor in getting the pilot to the highest levels of decision making.

"I think top, top, first and foremost, it's the passion of the people who have developed this program and seen it through to this point. I mean, number one. It wouldn't even have hit our radar at the JEC if it hadn't been for…really pushing it, you know, just sort of getting it in front of people. I think that's first and foremost."

Additionally, this follow through, driven by passion and persistence, was noted by an interviewee as one of the top two factors for why this pilot was successfully adopted.

"…following through with, you know, the whole program. Some pilot programs kind of die on the vine. But this one, you know, started out strong and finished strong….everyone involved with it had, you know, passion and desire…and leadership making it work…Those factors are why we're here."

(12) Sense of Urgency

Due to personal connections to the issue and an understanding of the need, there was a sense of urgency among individual implementers, influencers, and decision makers that something needed to be done – and soon. A sense of urgency, cited by nine interviewees, was present

during all phases of the pilot, as well as at all levels of the socio-ecological model. Initially, the sense of urgency was largely at the individual, interpersonal, and organizational levels, but as outside entities were brought in during the pilot implementation phase, the sense of urgency was shared by societal influences. Multiple interviewees shared about the sense of urgency and imminence to act based on their understanding (and gravity) of the need.

- *"That was the initial…wake up everybody…we need to get this. This is going to be an issue if we don't do it now."*
- *"When you look at the stats for women Vets on suicide, or homelessness, or health issues and concerns, I think everyone takes that very seriously that the suicide rate for female Veterans is alarming…And so I think that if there's anything that could help to reduce that or help to make sure that Veterans at least know that resources are available if they find themselves in that dark place. Then it's something worth looking into and trying."*

b) Combination of Factors

As evidenced by many of the passages in the predominant factors section, most interviewees spoke about multiple factors occurring synergistically as the reason the pilot was adopted. In addition to the predominant factors already mentioned (and those to be discussed with moderate or limited evidence), nine interviewees described in detail the combination of factors that contributed to the decision to adopt the pilot as a permanent program. Passages were coded as a combination of factors when there were references to a perfect storm of multiple factors coming together that impacted the decision (e.g., pilot data, congressional attention, Veteran service organization involvement, broader societal forces). The fact that this code emerged supports the assertion that there was no single factor in isolation that ultimately made the decision; it was a confluence of complex factors at various levels of the socio-ecological model at different times that contributed to the context in which the decision was made.

Some examples of the combination of factors passages are included below, which include variations of factors that have already been discussed. The original content of the passages, albeit robust, has largely been preserved to maintain the voice and words of the interviewees.

- *"Just awareness of women, military women, and women Veterans has gone up significantly. And the level of interest being paid to these issues by members of Congress, by the press, by Veteran service organizations. I think all of that comes to play…when you have like, members of Congress writing letters, asking like, what are you doing about this about women Veterans? What are you doing about this issue or holding hearings or holding roundtable and you have, you know, stories showing up in news clips, and, you know, public affairs officers having to, like respond to questions from journalists. It all comes together to help push something forward."*
- *"Multiple groups, individual women who have been vocal and going out and talking about these issues. Veteran service organizations starting to pay more attention. DAV has been paying attention to women Veteran's issues for a long time. They've been really vocal about it. Then we also had a couple of years ago, several of, a couple, two or three in the same year, VSOs elected their first women as national commander that made the news. And there also have been women Veteran led organizations that have sprung up specifically to deal with issues related to women veterans like Service Women's Action Network. They've been very vocal and successful at getting a lot of media attention…Films like The Invisible War…it's a lot happening all at the same time. I was just talking to someone about this the other day, who was, she was asking like, I don't know what to do to try to, you know, make change. And I'm like it doesn't happen from one line of effort…it's when you have all these things going at the same time, when you have lawsuits being filed and films, documentary films coming out, and women going and meeting with members of Congress and it's like all of these things happening together that can make change happen synergistically in a way that, if you took like one or two of those prongs away, it would just fall over. It wouldn't have the stability to keep going."*
- *"My theory is that you had kind of a perfect storm and that you had a couple of women who really were dedicated and cared about this…who created and piloted a program at the same time that there was all these tremendous data, negative bad data points about women Veterans, especially suicide and homelessness. And so there was a sense we have to do something about this. And this was one of those things. Well, this might you know, work."*
- *"…there wasn't a lot being written about actually understanding women Veterans, and since then, there have been a number of different articles that have come out about that topic and a number of different things that have been happening both in the media as well as inside DoD and inside VSOs and other individuals in the Veteran space that have really started to make a difference. So you've got things like the Marine Corps has started to integrate women more into their commercials and their recruiting…And then you had the Marine United Scandal, which really brought to the forefront what was happening to women in the military. And that got Congress's attention, which really, of course, goes a long way to helping these kinds*

of things get activated. Then you have the fact that you had a female Secretary of the Air Force, which made a big difference when [redacted] pitched it to her. You also have, now, currently you've had a lot of legislation pertaining to women Veterans that's been coming out…you have a task force that's set up in both the House and the Senate to talk about women Veteran's issues. More and more women are starting to tell their stories. You've got books coming out… Ashley's War, Kate Germano's book, and MJ Hegar's books, you had a number of different things that were all happening at the same time that I think started to raise awareness of women Veterans…And so I think yeah, a lot of those factors all came together at the same time to really prompt the start of the program and then the actual implementation and then permanentizing the program."

c) Factors with Moderate or Limited Evidence

Factors with moderate or limited evidence are factors that were discussed in interviews but were assigned varying levels of importance among different stakeholder groups. This may be due in part to the different vantage points of the experience by the different stakeholder groups (this is discussed in the conclusion of this question response). Factors were assigned as having moderate or limited evidence in the same way predominant factors were determined – by using a combination of analytical methods and taking into account how the factors were discussed during interviews. That said, factors cited by 8-9 interviewees were generally delineated as factors with moderate evidence, while factors with limited evidence were cited by less than half of interviewees. TABLE XIX displays factors with moderate evidence (green) and with limited evidence (blue). For ease, factors with moderate or limited evidence are discussed in descending order by the number of interviewees cited.

TABLE XIX: FACTORS WITH MODERATE OR LIMITED EVIDENCE

Factor	# of Interviewees Cited	% of Total Interviewees	# Phases
Navigating Bureaucracy	9	60.0%	2
Veteran Service Organizations	9	60.0%	1
Connections	8	53.3%	2
Perception	8	53.3%	2
VA-DoD Advisory Bodies	8	53.3%	1
Champion	7	46.7%	2
Broader Societal Influences	6	40.0%	2
Empathy	6	40.0%	2
Trust	6	40.0%	2
Grassroots Initiative	5	33.3%	3
Risk Perception	5	33.3%	2
Recruitment and Retention	2	13.3%	1

d) Factors with Moderate Evidence

There were five factors designated as having moderate evidence: navigating bureaucracy, Veteran service organizations, connections, perception, and VA-DoD advisory bodies.

(1) Navigating Bureaucracy

Navigating bureaucracy was a factor mentioned by nine interviewees at the interpersonal level that was present in the pilot exploration & approval and pilot implementation phases. This factor, which was most frequently cited among decision makers and implementers, accounts for the use of practical knowledge of how multiple government departments work and using that savvy to push forward the pilot's agenda. During the pilot exploration & approval phase, it was figuring out who the stakeholders were that needed to be briefed about the pilot and in the pilot implementation stage, amassing more champions and senior leader support to get the pilot adopted as a permanent program.

Navigating bureaucracy accounts for the savvy to navigate processes within both VA and DoD. As shared by implementer interviewees, this oftentimes meant figuring out which organization to engage at any given juncture. One interviewee shared about the dynamic navigation process that was used to identify the path of least resistance at different times between VA and DoD to keep the pilot progressing as desired.

> *"So everybody, you know, has their own way of doing things, their own vision…sometimes it would be more advantageous to go through the VA on certain issues. Sometimes it would be more advantageous to go to the DoD or Air Force. So we always kind of had to figure out okay, where's our least resistance or our best possible path and we kind of would, you know, I think VA may be easier on this one. So we would go with the VA, right?"*

In addition to the navigation within VA and DoD, interviewees shared that savvy was used in leveraging Veteran service organization, federal advisory committee, and Congressional support (and subsequently applying pressure on the departments from the outside). One interviewee spoke of the uniqueness and ingenuity of engaging external entities to support and advocate for the pilot.

> *"…I don't think it would have ever occurred to me to go to an outside organization… to garner support for something I was trying to do inside the military."*

Interviewees shared that there are unspoken rules about how to proceed with program approvals. It was noted by interviewees that an unconventional approach to garnering support and navigating bureaucracy was used. One interview participant talked about differentiating between stakeholders by their authority and ability to make decisions and engaging them first, rather than progressing up a typical chain of command. This was also cited as a reason for why the pilot went from a concept to full-scale adoption so quickly. It was recognized by multiple stakeholders that if a normal hierarchy of engaging stakeholders had been used, the adoption of this program would have taken much longer.

> *"…one thing I understood really well is who owns the process….I understood policies. And I understood…if one person tells us no, do they actually have the authority to say no?… So a lot of my time was probably spent figuring out who is the decision maker…I started figuring out who owned what I was trying to change or do. And then instead of kind of working my way up, I would work my way down…If I spent the whole time running up the different chains, I'm never going to get this done. So it was an easier model…if a leader supported, that just made it 10 times easier…I went to the people that had the power and asked them versus doing it the other way, because when I was doing it the other way, we weren't getting anywhere."*

(2) Veteran Service Organization Influence

Nine interviewees, primarily the implementer and influencer stakeholders, spoke of the role of Veteran service organizations at the societal level in the progression of the pilot to a permanent program. As noted in the response to question 1, Veteran service organizations, particularly SWAN and the MWC, had an impact on the decision to adopt the pilot as a permanent program. These advocacy organizations formally endorsed and wrote letters to Congress to recommend their support of the pilot. In turn, engaging the Veteran service organizations was a necessary precursor to Congressional involvement that proved crucial. Numerous interviewees spoke about the role of Veteran service organizations, and one interviewee shared more generally about the role of Veteran service organizations in creating a platform for focusing on women Veteran and transition issues.

> *"I think they helped raise awareness on it for sure. And I think a lot of the conversations we've had with the Veteran service organizations and the testimony we've received from them and their work with VA and DoD…have sort of helped shape the ground or prepared the battlefield for something like this…they definitely sort of shaped the conversation as a whole and created the opportunity for something like this."*

Additionally, it is important to note that SWAN and the MWC are a network and a coalition, respectively. An interviewee stated that when these organizations advocate on behalf of a cause, it is not just receiving the endorsement of a single organization. And the weight of that endorsement is understood by Congress and within the government departments.

> *"…SWAN…they don't go alone at things…when they support something, they get all 36 women Veteran organizations in the United States to sign a document together. And that's powerful."*

(3) Connections

Personal connections and relationships at the interpersonal level were cited by eight interviewees (primarily implementers and decision makers) as being crucial during the pre-pilot and pilot exploration & approval phases. Personal connections and relationships are what led to the connection between VHA and Air Force entities to create this HEC-endorsed initiative. One interviewee spoke about the initial connection between the Air Force and VHA that put them in touch with very senior leaders that ultimately endorsed the pilot creation.

> *"We kind of told her about it and she said I think this is a great idea…I think you guys need to link up with the women's health services. And so she…invited us to the Health Executive Committee. And that's where we met the deputy. And we basically were able to kind of sell them on this."*

Interviewees shared that personal connections continued to be important during the pilot implementation phase in garnering senior leader support. One interviewee spoke about personal connections as a key facilitator in having the pilot adopted as a permanent program.

> *"I think those are the things that catapulted it forward. The relation with [high senior leader in VA] and others inside of VA, but mostly, I think also inside of DoD."*

(4) Perception

Perception, a multi-faceted construct, was noted by eight interviewees as a factor during the pilot implementation and adoption decision phases at the individual, organizational, and societal levels. This construct, mentioned predominantly by implementers and influencers, encapsulates multiple references to the pilot being a good news story for VA and DoD since both organizations have received negative press in recent years. In turn, the organizations want to be seen both publically and internally as innovative in solving complex issues and not as slow and

bureaucratic. Additionally, there were some individual-level components of this construct discussed in that individuals or groups wanted their names attached to the support of women Veterans for personal or political purposes.

(a) Organizational Perception

Interviewees shared about the role of perception on the decision to adopt this pilot, including it being a good news story focused on suicide prevention (a particular media interest).

- *"…both departments really are mission driven first, but also very reactive to what kind of oversight we get from the Hill and influence that we have in the media. So suicide prevention, in particular, has been getting a lot of attention…from all of those influencers around us. So I think that the leadership is very focused on anything that can improve that. That's a big piece."*

Numerous interviewees mentioned the pilot as a way to demonstrate to Congress that they are working effectively as government departments. And one interviewee indicated that if there are opportunities (such as this pilot) to move faster and be less bureaucratic, it is something the departments want to embrace.

- *"We are kind of always looking for ways that we can demonstrate progress and action. And sort of positive stories that we can report to the Hill rather than kind of getting beat up…This is one of those projects that it's a homegrown initiative that was developed by women's health experts within both departments that saw a need and developed a program to meet that need. It was not directed by the Hill to do it from the beginning…So those kinds of stories are always really positive on the Hill, because it just shows…we're not just this government organization that's just full of bureaucracy, like we're really, truly trying to do what's right for Veterans and trying to come up with new programs that will continue to benefit our constituents."*

(b) Individual Perception

Some interviewees shared about how there is interest in individuals supporting the pilot because being seen as supporting women Veterans is favorable and is the "hot commodity" right now.

"That women Veterans have become such a hot topic…women now in Congress… they're Veterans and they genuinely want things to improve for women Veterans.

> *Because they relate to them and they know the difficulties they may encounter, but also I think it's just, too, you know, political. That hot topic and everybody wants to be seen as supporting women Veterans…in the administration and Congress…it's hard not to be for it…It's the hot commodity right now."*

Additionally, one interviewee spoke about the use of standalone bills (like H.R.2941 and H.R.2942) in Congress as a means for representatives to get credit for supporting different issues and to demonstrate support, even if it is understood that the bills will not be instituted as law.

> *"The reason the standalone bills are introduced…so members can point to a bill and say, this is a bill that I introduced. You can see that I introduced it and I can take credit for the fact it's in the National Defense Authorization Act…in addition to being like a credit, a vehicle for credit, as also a vehicle to demonstrate support."*

(5) VA/DoD Advisory Body Influence

As noted in the response to question 1, VA/DoD Advisory Bodies impacted the decision to adopt the pilot as a permanent program at the societal level. Eight interviewees, primarily implementers and influencers, mentioned this as a factor. It was noted that this influence was particularly beneficial during the pilot implementation phase. Aarons et al. (2011) noted the impact that advocacy organizations can have in conceptualizing issues and influencing outcomes (in this case, the decision to adopt the pilot as a permanent program). As identified during the document review and confirmed by interviewees, for the three advisory bodies involved in the pilot, DACOWITS and ACWV have direct lines to the Secretaries of Defense and Veterans Affairs, respectively. They utilize formal processes to generate and make recommendations on behalf of servicewomen and Veterans. And DVCO has a direct line to the JEC, the highest interagency decision-making body serving both VA and DoD. One interviewee shared about the advisory body inclusion as part of a well-orchestrated and coordinated pilot implementation plan.

> *"I think there was a well-orchestrated, well-executed communications plan and campaign …to involve Congress, to involve some of the Veteran service organizations, to go to DACOWITS, to go to the Advisory Committee on Women Veterans."*

Additionally, many interviewees spoke specifically about the impact of the DACOWITS pilot endorsement, which not only influences the Secretary of Defense's programmatic decisions but subsequently can impact Congress's recommendations and even more downstream, impacts the departments' programmatic decision making.

- *"There's no higher approval…it's a big deal because you have a body, the most professional body of women in the DoD saying you should do this. So that really gave us a lot of street cred. You know, we were now able to say a DACOWITS-endorsed program and DACOWITS has put this in the report as a best practice, and something that all the DoD should be doing…so it's sort of, in some ways, forced decision making because people had to answer to that. And they would have to answer why they didn't support DACOWITS."*
- *"…they included that pilot program as a best practice and recommended that the Secretary of Defense consider expanding it throughout all the services. So what happens as it turns out, we know that Congress reads DACOWITS reports each year. We often see language pulled from the DACOWITS reports that show up in the NDAA, in congressional language. And so they actually picked up on that recommendation and included it in this year's NDAA…assisted in getting that program established as a full program throughout the Department."*
- *"I think it carries significant weight because…when they…advocate, then I think it catches the attention of Congress and the people in the HVAC and SVAC because I think they rely on them for those sort of, you know, way forwards…they trust their opinion about what should be pushed."*

Not only did VA/DoD Advisory Body support influence the decision to adopt the pilot as a permanent program, but it was also noted by interviewees to have accelerated the timeline between pilot implementation and the pilot adoption decision.

- *"…it's a great program in and of itself. And eventually, it may have gotten legs and you know, gotten some notice that would have taken time. I think the Air Force would have had this, you know, rolled it out completely. And then other services may have taken notice of it. But it would have taken much longer. I think that by bringing it to DACOWITS, DACOWITS was able to shine a light on it and accelerate the process to get it you know, in the view of senior leaders who are making the decisions."*
- *"So would it have come? Yes, maybe. Over time, down the road. But I think DACOWITS was just a vehicle that helped push it a little faster."*

e) Factors with Limited Evidence

There were seven factors designated as having limited evidence. Factors were assigned as having limited evidence in the same way predominant factors were determined – by using a combination of analytical methods and taking into account how the factors were discussed during interviews. That said, factors cited by 2-7 interviewees (a minority of interviewees) were delineated as factors with limited evidence.

(1) Champion

Seven interviewees, primarily implementers and some decision makers, spoke about the importance of champions in facilitating the pilot adoption decision. Interpersonally, there were champions who supported and encouraged the development and implementation of the pilot at different levels in both agencies. Champion is differentiated from senior leader support, as champions did not have higher levels of decision-making authority. Champion support was noted as the catalyst for getting the pilot off the ground and implemented in the first place.

Based on analysis of the interviewee statements, two types of champions were identified – individuals on the implementation team that led the pilot through widespread adoption (this was largely included and discussed in the Passion and Persistence factor section) and champions who were outside of the implementation team who supported and advocated for the pilot (this is partially covered in the discussion of the Senior Leader Support factor). Outside champions voiced their support for the program and helped the pilot implementers gain even more champions.

One interviewee described this snowballing of champions and the impact it had on the pilot trajectory.

"I'll also say the alpha critical piece…connecting to the VA and the initial champion saying go forward, and I trust what you're doing, and you don't need to ask at every little step…once we started to gain momentum and she was able to get us some really high powered champions when we started to get a little bit more resistance. And then, you know, at that point, it's like, you can't say no to something like that."

(2) Broader Societal Influences

Although the broader societal influences factor is considered as having limited evidence primarily because of the number of interviewees cited, there were many external factors mentioned by the six influencer and implementer interviewees. Participants discussed multiple societal influences that further reinforced the understanding of the need and the sense of urgency around issues pertaining to women Veterans. These broader influences at the societal level particularly played a role during the pilot implementation and pilot adoption decision phases. Some of the broader societal influences cited by interviewees included large movements (e.g., Me Too, Know Your Value), military scandals (e.g. Marine United Scandal, firing of Kate Germano), documentaries, articles, books, and more women in positions of power or influence, including in Congress, the media, Veteran service organizations, and within VA and DoD. These broader societal influences emphasize the importance of timing when adopting programs and that this pilot occurred during the right time in history. Multiple interviewees discussed these broader societal influences that provided a compelling context for an affirmative decision to be made.

- *"I think timing too is really important because we are in the Me Too movement…And I think there's a lot of people trying to kind of fight for women right now in all, in all aspects. And so I think the time, even though this wasn't necessarily like a Me Too movement, it was…we're doing something for women and health, which has been overlooked for so long…it was just the right timing."*
- *"The Disabled American Veterans had their first female commander of their organization, American Legion had its first female commander. So you started to see women in the Veteran community coming into leadership positions, as well, which started really shaping the narrative…you had a lot of churning in the publicity space and in Congress to focus on this area that had previously not really been focused on."*

As a result of many of these broader societal movements, an interviewee shared that women's issues are more visible than they have been previously that and women are generally more empowered now to speak out about issues publicly.

> *"And then I think having a couple of key very loud women's voices in this space also helped get it going and really resonated for women. I think as a whole, women in this society are starting to really voice their concerns on issues that are impacting them and are not being willing to sit down and shut up and color anymore to use a military phrase. And I think that really, that helped as well….So I think that it is a topic that resonated with women, even if they weren't in the military. And I think the fact that there were a number of other things like the Me Too movement going through the civilian women in community at the same time, it really lent itself to this project."*

Yet another interviewee spoke about the potential organizational ramifications that may have been faced if the pilot had not been supported in the midst of this societal context.

> *"…the Kate Germano thing was happening at the same time. All of this, I mean, again, not directly, but we benefited from all of these things that were happening on that stage. The LeanIn movements, the Know Your Value with Mika Brzezinski. All of this was happening, that I think it was going to be harder to put up roadblocks for us, because then it would show…that this is really an example of why we have LeanIn happening and why we have Know Your Value happening and all of these kinds of things because it would just be a bad news story, for somebody to try to do that at that time, because we had all the statistics behind us."*

When referring to the time in which this pilot was introduced, two interviewees responded that even if this pilot had come out a year or two earlier, it likely would not have gained traction because it would not have been situated in the appropriate context. It was a confluence of factors at the right time that made this an obvious choice.

- *"Yeah, I don't think it would have happened…there's a tendency in defense to not want to focus on women as separate entities with different needs. And so I don't think that would have made it. I think the combination of the Marines United Scandal, the Me Too movement, all of the focus on women during that time period, as well as the suicide prevention numbers, were really instrumental in all of that coming together to be able to turn to the decision makers and be like, really, you don't want to support women Veterans right now? Really?"*
- *"And then of course, the same time you had VA's Office of Suicide Prevention release their updated report around the same time as well, that really showed the numbers*

around women Veteran suicide, which really galvanized a lot of action. And then the Marines United scandal just threw a whole spotlight on the way that the military as a whole was treating women Veterans and women service members. And I think all of that together really helped bolster [redacted] arguments. And so when they came forward with proposing it, I think it was top of people's minds as to yes, this is something we need to look at. Whereas I don't think had it been even a year or two earlier they would have gotten the same traction."

(3) Empathy and Affective Response

The empathy and affective response factor, discussed by six, primarily influencer, interviewees, was at the individual level of the socio-ecological model and was most important during the pilot exploration & approval stage. Interviewees and documents confirmed that the understanding of the need was known and understood cognitively and supported by data and reports. But it was also known through personal experience, whether it was lived experience or a personal connection to someone who served in the military. Many stakeholders involved in the pilot revealed a personal experience or connection to the need. They had perhaps been a woman in the military, had transitioned out of the military, are researchers in this space, and/or understood the unique health challenges that women face. It became clear through the interviews that this was personal to many people and stakeholders connected with the idea and the need it was addressing. One interviewee shared about their personal connection to the need and how it influenced their support of the pilot.

"I have a very personal connection to believing that women need a specific type or level of care that was not being provided."

Interviewees shared that personal stories of a troubled transition and of life after the military were shared during the pilot's infancy that contributed to empathy. One interviewee shared about the impact of stories on garnering support for the pilot and that it is easier to deny a program than it is to deny or overlook an individual's experiences.

> *"I think what helped, from an individual basis, is we had real stories. I think, for example, when I would go speak, I didn't just talk about this program. I talked about my experiences as a Veteran, you know, about my experience transitioning…then as a team, we used other people's stories that we had interviewed…It's one thing to talk about a program. You can talk about a program all day, but when you start talking about individual experiences and folks' stories, it becomes real…it sort of plays on your heart, right, because you can see it. And so I think we started telling stories. And so I think that was the first connection that people couldn't doubt…we had so many stories, people couldn't dismiss it. It's easy to dismiss a program, but it's harder to dismiss an individual's experiences."*

Akin to the impact of personal stories, this empathy and connection to the need created affective, or emotional responses in stakeholders that impacted the decision to support the program. One interviewee shared about their reaction of shock experienced during one of the pilot sessions and how it impacted their understanding of the need and subsequent support of the pilot.

> *"And she…asked her question in the middle of a presentation and said, are you saying that I can get access to maternity care at the VA? And that…was shocking to me, and I think demonstrates how this is relevant and important. There are women who just don't know."*

(4) Trust

Personal connections within both departments provided support to the pilot implementers because of trust. Trust was noted as a factor by six interviewees, primarily implementers and influencers. It was noted particularly in the pilot exploration & approval phase that trust between certain groups of individuals made it so this pilot was initially endorsed. Interviewees shared that many proposals are brought to senior leaders; trust in an individual's reputation helps senior leaders wade through competing resource requests. One interviewee spoke about the credibility of the implementation team in their decision to support the pilot from the beginning.

> *"I've worked with [redacted] on this other thing and she is a rational actor and she is somebody who can be trusted and somebody that you can work with. Sometimes it goes beyond like the formal level; the informal like backing somebody's legitimacy and integrity can also help move things along."*

Beyond the implementation team, trust was also noted by interviewees as a factor when respected leaders supported the pilot, which then impacted other individuals' or entities' support of the pilot. During the implementation phase, one interviewee noted the importance of a respected senior leader's endorsement that ultimately impacted their perception and support of the pilot.

> *"And [redacted] has such incredible credibility with us. You know, that's probably why we didn't ask her for any more metrics than that…because she would have told us if it was not as glowing of an outcome as she told us. You know, she's very, very frank with us on everything."*

(5) Uniqueness of Grassroots Initiative

Related to the uniqueness of the interagency collaboration, the uniqueness of this as a grassroots initiative was cited by five interviewees (all decision makers and an influencer) as a facilitating factor in the program being adopted as a permanent program. The uniqueness of the grassroots initiative, which was in the very fiber of the pilot, was a facilitating factor to program implementation during all phases at the organizational level. It was noted by interviewees that typically, programs like the VHA Women's Transition Training pilot are generated and pushed from the top down. This effort was unique in that it was grassroots and formed out of a collaboration between two entities within the two largest government departments.

Interviewees spoke about the way in which programs are typically conceived and executed in DoD and VA as top-down programs, including the statement below.

> *"All the programs we've been looking at were very, you know, top-down driven programs whereas this was a bottom-up one."*

Relatedly, another interviewee elaborated upon the uniqueness of the program compared to how programs are typically drafted and directed by senior leaders and how this was a facilitating factor in the pilot progression.

"I think it was different for me personally, in that it, you know, it came specifically from VHA and Air Force working together kind of at the grassroots, which was really kind of cool. A lot of times these initiatives don't start grassroots. They start more at the senior level and get sort of directed…I'm trying to imagine other initiatives in that same space that were similar and I think most of the ones that I've been a part of have either been just part of the DoD, VA you know, interactions that happen as a natural part of the governance bodies that exist because there are multiples of those. So they may be a little bit grassroots in that they come up from the working groups that support those committees. But this one kind of started outside of the working groups, which was kind of cool. And then we sort of brought them into the fold into the working groups and into the committees so it was a little bit different, but…once they made that connection, it was just kind of folded in and became a part of the process and became one of the initiatives in the portfolio."

(6) Risk Perception

Risk perception, an organizational-level construct, was cited as a factor by five interviewees (decision makers and influencers) during all pilot phases. Risk perception, although most prominent in making the decision to adopt the program, was also considered in the pilot exploration & approval stages. Interviewees shared that the pilot was the first HEC WHWG-backed program and they wanted to make sure they initiated a low-risk project for their entry into interagency women's health programming. An interviewee spoke about this consideration of risk in their decision to endorse the project and that this pilot was appealing because it did not assign blame to any one entity for the issue.

"This was an easy sell, because it didn't get into blaming anybody…We want to get more data and look at, you know, things that might implicate the shoes or the body armor, things that Army had actually identified in some women's reports…things that DACOWITS had identified. But getting people to risk being, you know, the champion of these topics on the DoD side…"

Interviewees mentioned how the perceived risk in adopting the pilot was low. Part of this was a function of the pilot itself and the preliminary pilot outcomes presented, but was also a function of the organization's risk-taking climate. Part of the perception of low risk was due to the fact

that many stakeholders viewed the pilot as an extension of an existing program and that it would not be as resource intensive as establishing a new program in a novel area.

> *"There was the thought that…it would not be that taxing on the resources as far as having someone to present the information because the TAP program is already established. You're just adding a couple hours to it so you're not standing up a whole program in and of itself. So the thought was it would be minimal additional resources required to support the program."*

An interviewee also discussed the role of risk perception in the final adoption decision.

> *"So this is an unusual situation where the co-chairs looked at it and said, this all makes sense. There's nothing bad, there are no risks involved in this that we feel are, you know, crucial enough to be concerned about. And this just makes sense. It's the right thing to do for Veterans. Let's cut the bureaucracy. Let's just do it."*

(7) Recruitment and Retention

Recruitment and retention, although only cited by two interviewees (a decision maker and an influencer), was unique enough to warrant separate mention. These interviewees mentioned the appeal of the pilot as a recruitment and retention tool for servicewomen and women Veterans. It was noted that although women comprise over 50 percent of the general population, only a fraction of the eligible female population is serving or has served in the military. This need to recruit and retain women was framed as a matter of military readiness by better utilizing the eligible population and improving retention of women in the military (including having more women in positions of influence in the military).

- *"…that it will positively impact things like retention and recruiting, which is at the end of the day, women are the most underrepresented demographic in the Department of Defense…50.2 percent of the American public and less than 20 percent across the DoD. So to the extent that we're able to recruit women, obviously we want to retain women. Them knowing what their benefits are as they're making those decisions helps them to make smarter decisions."*
- *"…there's a particular need to make sure that we take care of our women because we find that we lose women at a higher rate than we do men in the military services. So anytime we can find a program that's going to enhance how we take care of our women and potentially increase our retention of women, which will eventually lead to*

increased accessions of women…And so this is, I think, a good program that will work. And it will help our, not only our service members that are currently serving, but our Veterans as well. And so it makes sense. Um, why not embrace this type of program?"

3. Response Trends by Stakeholder Type

It is also of note that different factors were cited by different stakeholder groups. And different facets of factors were discussed by different stakeholders. There may have been differences in what was said based on roles and position and also when the individual/entity was engaged in the process. The predominant factors were largely universally cited across stakeholder groups, but there were other factors that were cited more frequently in some groups than others. Additionally, it was found that level of involvement with the pilot had an inverse relationship with the decision-making authority – many high-level entities had limited interaction with the pilot (e.g., JEC), but had the ultimate decision-making authority to adopt the program; whereas individuals implementing the pilot were responsible for delivering the curriculum and evaluating the program, but had no decision-making authority (but had a closer overall proximity to the pilot process). These factors account for the different vantage points and stakes represented by different stakeholder interviewees.

All or most decision makers cited the pilot data, senior leader support, the uniqueness of the grassroots movement, priority alignment, and risk perception as reasons why the pilot was adopted as a permanent program. Their vantage point was more from an organizational perspective of how effective the pilot is and where it fits into their organizational portfolio based on existing programs and the proposed pilot characteristics. And the decision-maker vantage point only represented the pilot implementation and pilot adoption decision phases of the process, which also accounts for a different emphasis on facilitating factors.

Influencers, on the other hand, based on their position outside the departments and their involvement in the pilot implementation phase, were more likely to cite broader influences, such as the visibility of the issue and the role of influencer organizations (e.g., Congressional, VSO, or VA/DoD advisory bodies) in the decision-making process. The influencer groups, albeit influential, were not involved with the daily implementation of the pilot, nor were they involved in the formal decision-making process. Consequently, they imparted a broader perspective of the context in which this decision was made.

The implementation team, with the closest proximity to the process, was more likely to note process-oriented factors that impacted the decision, such as garnering senior leader support (often achieved through personal connections), navigating bureaucracy, the role of the coordinated implementation plan in the initiation and implementation process, and the importance of interagency collaboration. Additionally, the implementation team was the only group of stakeholders that provided a full perspective of the pilot from pilot conception to the adoption decision.

In a pilot like this with many stakeholders, it's important to understand the common (or predominant factors) that were more universally recognized across all stakeholder groups and those factors that played a more unique role in the decision-making process. It was found in this study that the stakeholder interviewee type influenced the factors discussed, largely because of the level of involvement and vantage point of the interviewee. Whether a factor was predominant, moderate, or of limited evidence is not as important as understanding that all the factors worked in coordination, at different levels of the socio-ecological model, at different times, to influence the pilot being adopted as a permanent program. Examining factors by

stakeholder type was essential to achieving this level of understanding and is important for consideration for other research projects examining facilitating factors and barriers.

4. Question 2 Summary

In summary, the participant interviews confirmed that a confluence of factors impacted the decision to adopt the pilot as a permanent program. There were 24 unique facilitating factors identified during the analysis phase. The vast majority of the identified factors were discussed in the Chapter II literature review, but there were some emergent codes and some a priori codes that were renamed to reflect the words of the interviewees (e.g., understanding of the problem was renamed understanding of the need).

Different factors played a role during different pilot phases and factors were present at different levels of the socio-ecological model. Figure 23 models the factors by four different facets – delineation of evidence (i.e., predominant, moderate, limited); number of interviewees that cited the factor (orange box in top left corner); number of phases in which the factor was present (blue box in the bottom left corner); and the levels of the socio-ecological model the factor spanned (in the bottom right corner with the level of socio-ecological model shaded blue when present). This figure demonstrates the convergence and interaction of many factors during different phases of the pilot and at different levels of the socio-ecological model that ultimately facilitated the pilot becoming a permanent program.

When looking at factors by level of the socio-ecological model, the majority of the predominant factors were at the organizational and societal levels (or multiple levels) of the framework. The factors with moderate to limited evidence were more likely than the predominant factors to be clustered at the individual and interpersonal levels of the framework. Additionally, the predominant factors tend to be present in at least 2 phases, while most of the moderate and

limited evidence factors were present in only one or two phases (and are more likely to be those that were present in the pilot exploration & approval phase). The implications of these findings will be further discussed in Chapter V.

Figure 23: Factor summary

D. Question #3 – Future state: What will happen next?

1. Focus Group

This question was answered using focus group data. Four individuals participated in the focus group. For the purpose of maintaining participant confidentiality, focus group participant roles are not reported.

The principal investigator facilitated the focus group using an ORID focus group guide (Appendix I: Focus Group Guide - ORID Framework). The focus group served dual purposes – to confirm the validity of the findings (member checking) and understand the implications of the findings. The virtual focus group lasted 90 minutes; the principal investigator discussed preliminary project findings for 40 minutes (validity and member checking) and the focus group participants discussed the implications of the findings for 50 minutes. The focus group transcript was coded and analyzed in MAXQDA using the revised codebook developed during the semi-structured interviews (Appendix L: Revised Codebook).

2. Focus Group Findings

Key themes were identified in the focus group transcript, some of which corroborated interview findings and others that were novel. Thematic findings are presented by the ORID phase in which they were discussed – Objective, Reflective, Interpretive, Decisional.

a) Objective

The objective questions referred to the facts about the experience. This section of the session served as a member-checking mechanism to confirm the accuracy of decision-making events and factors. This section of the discussion was abbreviated, as there were no objections to the findings.

- *"I think that what you outlined is very accurate in my recollection of how things transpired."*
- *"So great job…putting the history together….I think it's very accurate and especially how we went about it."*

b) Reflective

The reflective questions were designed to elicit any emotions and feelings derived from the discussion of the pilot findings. Three primary thematic elements arose during the reflective discussion section – the sense of urgency around this issue, the importance of a coordinated implementation plan, and the influence of outside forces on the decision-making process.

(1) Sense of Urgency

Focus group participants reiterated the importance of the sense of urgency to the pilot process. And it was not just a sense of urgency to solve the problem. It was also a sense that if individuals close to the issue did not create the pilot the way they thought would most effective, the program would have eventually been designed and pushed down on them at another time in a way that was likely to be less effective.

> *"…if we don't do it now and have it ready, then at some point when the need is realized, it's going to be given to us in a form we might not like. So part of it is also just getting ahead of it and doing, building it how we wanted it to look, how it was going to be most appropriate versus waiting for someone else to agree that it needs to happen and come down eventually in a different form that's not going to be as effective."*

(2) Coordinated Implementation Plan

Focus group participants spoke about the role of the pilot characteristics in the decision to adopt the pilot as a permanent program. One participant reflected on the importance of the emphasis on a robust evaluation plan in their initial pilot concept. This focus group participant, along with another focus group participant, did not necessarily think the pilot data would be as influential in the decision-making process as it ended up being.

"One thing that I am kind of reflecting over and so glad we were rigorous with the evaluation plan…is how important it seems to be in this process. And we did work really hard on that evaluation plan, and we knew we needed that objective data. So I'm interested that it really played a big role in influencing people to support the program."

There was some emotion evoked over the fact that the coordinated implementation plan may not have been the primary reason the pilot was adopted. The fact that there were forces outside of it just being a good program was challenging for a few participants. And that they thought that the coordinated implementation plan should not be undervalued in the decision to make the pilot a permanent program.

- *"I think the program was incredible. And there was data and there was support. It really had an influence, like it had an impactful meaning for a lot of women Veterans. And it may be insignificant why they supported the program, but the fact that they supported it just to do something good…"*
- *"I agree it's a perfect storm. But I think what is being undervalued is that we…had something very tangible to offer at the right time…we had a very well developed program that met the needs, direct needs that were identified in that 2015 report, and that were reiterated year after year. So it was kind of a no brainer at the same time, because it was, just it was the right solution for the right problem at the right time."*

(3) Influence of Outside Forces

The document review and interviews confirmed that the coordinated implementation plan was supplemented and supported by the influence of outside forces. There was some consternation among the focus group participants that this was deemed by some interviewees as a political decision-making process. But ultimately, there was recognition among the group of the role of Congress and Veteran service organizations in the decision to adopt the pilot as a permanent program. One interviewee spoke about the success of involving outside entities in the pilot, but about how this was a lesson learned for future implementations.

"…we kind of forced their hand… there was a time where we felt that nobody was listening to us, besides outside sources. And once we talked to sort of outside sources, they really believed in it. And so I guess I do, we knew that what kind of changed the game is when SWAN got involved and when Congress got involved. But it's interesting

that it's confirmed….But now it's a lesson learned for if I have to do something like this again, how to do it."

Similarly, another participant shared about the impact of the combination of factors and forces that impacted the decision-making process, including more women in Congress and the perception factor that they want to be seen doing something for fellow women Veterans.

"…it was a perfect storm of lots of things coming together and certainly, that there were so many women Veterans elected to Congress in the last, you know, 2018, and I think they all wanted to be seen doing…things for women Veterans, and so it really was kind of a perfect storm."

c) Interpretive

The interpretive questions were designed to have participants make connections based on the facts and the previous reflections. Two primary thematic elements arose during this reflective discussion section – revelations about navigating bureaucracy; and implementation science principles, including the retrospective examination of the implementation science framework used for implementation, the strength of the implementation team, and the limitations of not having a dedicated resource for pilot implementation.

(1) Navigating Bureaucracy

When asked about what participants would do differently if given the chance, there was some discussion about the perceived slow speed of the process. This initiated a conversation on the choice to bypass the traditional hierarchy by going straight to senior leaders and involving outside entities instead of spending time at successive levels of the organization trying to gain approval.

"I think I would have started sooner at the top…we spent a lot of time sort of at the…mid-level…in lower levels, trying to convince people…And I think if we could have convinced people sooner…it just would have saved so much because…our top leadership really believed in it. So I think if I could do it over again, I would have just went to the top to begin with and worked our way down and if I was, you know, politically savvy

enough, you know early on to understand the, the sources of power of having…those outside influences. I just would have started there. And I think that's kind of what I'm learning now…"

Another participant agreed with this but also put into perspective that this program, particularly for a government program, was implemented quickly. And that this was largely because of the passion and persistence of the implementation team to see this pilot through to meet an expressed need.

"I just want to put this in perspective. I mean we got a program from basically a concept, an idea to full implementation across a whole branch of government, in what, 24 months, which is pretty amazing. So in some ways, I mean, maybe we could have tweaked little things to save some time or save some headache. But in the end, I think we were pretty efficient. And this team, in particular, was very focused and passionate…And I think the momentum we created, we just never let that drop. And there were different people who had to step out of the project at different times for various reasons, but we still cooperatively as a team never let the ball drop. I think that was a huge win."

Related to navigation of bureaucracy, the focus group participants talked about barriers they faced in bringing the pilot to fruition. And how they used different stakeholders and avenues to overcome some of these barriers and actually used roadblocks to their advantage to gain even more support.

- *"And I think that it was a real balance as to when we had to kind of push up to different people that were influencers…I think we had just a good balance of how we used, you know, the people at the higher levels or the people that were just kind of cross-functional."*
- *"We actually used some of the roadblocks to our advantage. I remember there were a few times where we were…put on the spot…to kind of prove our worthiness. And we used those to gain more support from leadership and used it to our advantage. So it kind of, you know, every time somebody tried to throw a roadblock, we made lemonade out of lemons."*

(2) Implementation Science Principles

An emergent construct discussed by focus group participants was that the pilot was not created with an explicit implementation science framework, but it could be retrospectively traced back to implementation science principles. One participant mentioned how the pilot was essentially

framed in the Expert Recommendations for Implementing Change (ERIC) principles, but that it was not explicitly prospectively applied.

> *"There's this ERIC compilation of effective implementation strategy research. The ERIC strategies, which it basically maps out and defines implementation strategies. And I think we never really mapped it, this is not a prospective implementation project. But I think if you mapped out what we did along each step, you know, we had key stakeholder engagement, we had development of a blueprint curriculum, we did a lot of those implementation steps that are necessary at all levels to ensure an effective implementation. I don't think we mapped it out prospectively that we were doing it, but we really ticked many of those boxes along the way."*

Also related to the implementation of the program, participants noted how the implementation process may have been easier (and potentially faster) if there had been a full-time dedicated resource to the project. The implementation of the pilot was noted as a side responsibility for all involved.

> *"In retrospect, it…would have been nice to have maybe one person focused on it full time. Maybe it could have gone faster."*

Despite the fact that this was an additional responsibility on everyone's already full plates, the pilot implementation was successful. Focus group participants attributed this to the cohesiveness, trust, and unwavering dedication of the implementation team.

> *"I have to say everybody contributed their part and…ran with the ball and did what they needed to do… I never really felt like anybody was dropping the ball at any step…we knew we can lean on each other and rely on each other and everybody was going to carry their weight in a very nice way."*

Finally, it was noted by a participant that this pilot implementation could be used as an example of effective leadership and a successful public health intervention.

> *"It is pretty amazing. I mean, it really is. And I've said this before like I actually sometimes haven't used this as an example of effective, you know public health intervention or leadership, but we really should. This was more amazing than many of the other things where I could have named you 100 different roadblocks that were not surmountable."*

d) Decisional

The decisional portion of the focus group considered the implications, decisions, actions, and choices as a result of this experience. Five thematic elements arose during this decisional discussion section – discussion around a roadmap for program implementation, including establishing a process for change implementations; encouraging the community voice in program development; increasing interagency collaborations; the importance of program evaluation; and the importance of a balanced and strong implementation team.

(1) Program Implementation Roadmap and Change Process

Participants discussed that it would be helpful to have a roadmap for embarking on and implementing joint VA-DoD projects. There were some roadblocks and resistance encountered when certain channels were not followed. This was noted by participants as largely because there was no explicit and written roadmap for who to engage when and how. And this is partially because grassroots initiatives are not the typical means in which programs are initiated and implemented in these departments. A roadmap would also be helpful because it was noted by an interviewee that the organizational cultures and structures are different enough between the two departments that it makes navigation challenging. However, it was mentioned that having a roadmap could come at the expense of having an overly bureaucratic process.

> *"…VA and DoD working together in a joint project…there's not really a roadmap… maybe just a roadmap of how you would get a project implemented from go to whoa, but then I would hate for it to become too bureaucratic because that could happen, too. But we…definitely kind of felt our way along."*

Similarly, participants spoke about some of the challenges encountered during the implementation process due to resistance to change. And that in the future, it may be beneficial to have a change management process to successfully navigate innovation adoption.

"I think a combination to that is just resistance to change. So I think that that's a cultural piece too that added some difficulty to the process…maybe a recommendation or something in the future is a process to go through some change because that's where some of our roadblocks really were highlighted."

(2) Community Voice in Policymaking

Related to the theme about the uniqueness of this being a grassroots initiative, it was discussed among focus group participants that the community voice is necessary for identifying issues and designing programs. As it stands now, most programmatic decisions are made and directed by senior leaders who are removed from the ground-level issues. It was expressed by focus group participants that policymaking needs to start with the need, which is best conveyed by the individuals on the ground and adjacent to the issues at hand.

- *"I think one of the things is just encouraging innovative ideas at the tactical level or at the lowest level…There's not really folks that are like kind of in the fight at the table…So I think just being open-minded to hearing what's happening at the tactical level. Or I wish there was like a way that they could bring in…women and ask them what they want, or whatever community it is…So if there was a mechanism to kind of get unfiltered comments between DoD and VA, that would be awesome."*
- *"I think that community voice is a piece that is often missing in policymaking, especially at VA and DoD. They have these high-level bureaucrats whether they served or they didn't serve…making decisions without always fully listening to what the needs are. And I think that policymaking should start with the needs."*

(3) Interagency Engagements

This engagement was noted by focus group participants as a successful interagency effort between DoD and VA. One participant spoke about how more interagency collaborations, particularly grassroots initiatives, should be encouraged, as they have the potential to make a great impact.

"…there's similar partnership potential…throughout any of the departments. You know, if it's DoD, and Interior or something like that or VA and…Human Services…it's probably a lot of things that could be impacted, you know, at that grassroots level between multiple departments."

(4) Program Evaluation

Having a robust program evaluation plan was noted by focus group participants as a best practice and as an important consideration for inclusion in any future program implementations. Additionally, it was discussed that for any implementation, program evaluation should be included in the program design rather than something that is a secondary consideration once the program is developed and implemented.

> *"…you need to have a rigorous evaluation plan, you need to have that from the beginning. It should be very tied to your objectives. And you got to really think through what's achievable and gettable. There are a lot of things you could think of to evaluate a program, but actually getting that data is a whole different story…we thought about that from the very beginning and developed a very rigorous evaluation protocol and really thought hard about…what we're trying to show and answer and you know how we're going to get that information."*

(5) Implementation Team

Focus group participants spoke about the importance of having a strong implementation team. And that having people on the team that bring different strengths is essential to balance and function. Participants shared that this is not often considered when programs are implemented, but it is an important ingredient for increasing the likelihood of successful implementations.

> *"Maybe that is, you know, a good practice is to really think about your team and what they bring to the table. I mean, we all have our different strengths. And that was key, you know. Some people are better at other things or in a position to do different things than the other team members are so a balanced, functioning team I think is super important."*

Participants agreed that part of this team dynamic was that they were not easily shaken by roadblocks and did not fear bureaucracy.

> *"And I think one of the skills that might need to be highlighted is that this group, in particular, does not fear bureaucracy…there are some people when they try to start a new program and do a new initiative, if they're thrown…a bureaucratic challenge to something, it's easier to back down than to keep going. But this group was kind of fearless. I mean, it was like, all right, what's the next bureaucratic challenge, we'll take that on and we would keep moving, right? Like it was not a deterrent. Some people take bureaucracy and they just get lost in it and end up not making any change."*

Another team aspect noted by focus group participants was that no one sought personal glory. The passion and persistence exhibited by the team was due to a commitment to a cause and an understood need. This ultimately helped the team work better together.

> *"…there's also not a lot of…need for glory…we were all kind of partners in crime on this with a collective need to really get this across the finish line and do a good job with it. Like we were all committed to the cause, which I just, I've worked on other teams where there is a need for somebody to take the glory and the shine. And I think the fact that nobody was like that in this team did add to…our ability to work so well together."*

3. Question 3 Summary

In summary, the focus group session confirmed the accuracy of the document review and interview findings and provided a forum for discussion of the implications of the findings. Different themes emerged during the different phases of the ORID discussion. TABLE XX provides a summary of the thematic elements by component of the framework. These findings, as many of them are implications and considerations for the future, are further discussed in Chapter V.

TABLE XX: ORID FRAMEWORK THEMES

Objective	**Reflective**	**Interpretive**	**Decisional**
N/A - member checking	• Sense of urgency • Coordinated implementation plan • Influence of outside forces	• Navigating bureaucracy • Implementation science principles	• Program implementation roadmap and change process • Community voice in policymaking • Interagency engagements • Program evaluation • Implementation team

E. Chapter IV Summary

Chapter IV presented results by study question. In summary, this project supported the theory that government decision making is complex and impacted by many factors. The study revealed a complex process of a formal decision-making hierarchy that was impacted by outside influences. The complexity of this process was further supported by semi-structured interview data that revealed 24 distinct factors that served as facilitators of a decision to adopt the pilot as a permanent program. Focus group data offered implications of the study findings and served as a basis for generating recommendations for future implementation efforts. This study can offer important insight into often opaque decision-making processes that are regularly performed in government agencies.

V. DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

A. Discussion of the Findings

1. Overview

Public sector program adoption decision making is complex. As described by an implementation scientist, decision making is a process, "in which evidence, both from systematic research and practical experiences mixes with a complex interaction of ideas, interest, ideologies, and individuals" (Aucoin, 2005, para. 3). This project demonstrated that the decision to adopt a program is impacted by a number of factors co-occurring at different levels of the socio-ecological model. Program adoption decision making is important because there is increasing pressure to demonstrate public value and substantiate programs' existence with evidence of effectiveness. As a result, the allocation of scarce resources in resource-constrained organizations is an important leadership competency.

The VHA Women's Health Transition Training pilot was an interagency effort initiated and implemented by VHA Women's Health Services and the Air Force Women's Initiative Team. The aim of this project was to retrospectively explore, in the context of a single case, the process and factors that influenced the VHA Women's Health Transition Training pilot being adopted as a permanent program. The decision-making process, factors that impacted the decision to adopt the program, and implications of the study findings were explored using qualitative methods, including an extensive document review, semi-structured interviews, and a focus group.

The study found that the process to progress the pilot concept to full program adoption included many formal, hierarchical, and rational decision-making processes at successive levels of interagency decision-making bodies. Meanwhile, a number of influencer activities (e.g., federal advisory committee endorsements and Congressional bill text) occurred in parallel with the

formal decision-making process structure that ultimately impacted and expedited the decision to adopt the pilot as a permanent program. Similar to the complexity of the process itself, 24 factors at all levels of the socio-ecological model were identified by interviewees as impacting the decision to adopt the pilot as a permanent program. Facilitating factors varied in importance according to the perceived strength of the factor and different stakeholder perspectives, but ultimately, it was a combination of factors working synergistically that impacted the decision. In the final phase, focus group participants verified the study findings and discussed the implications of these findings on future program implementation efforts.

The remainder of this chapter will further unpack and interpret the quality improvement project findings, including interpretations and discussion of findings by study question; implications of the findings for VA, public health, and other public sector organizations; a revised conceptual framework to reflect the actual project findings; strengths and limitations of the study; conclusions derived from the findings; and recommendations for VA's consideration.

a) Question 1

The first question sought to describe the process in which the decision to adopt the pilot as a permanent program was made. The findings, derived from integrating the document review and interview data, revealed that there was a multiple-year buildup to when the pilot concept was first endorsed. Many entities had formally documented the need for a female-specific transition program that served as the impetus for the pilot idea. Once the pilot concept was endorsed by the HEC WHWG, there were a number of formal interagency decision-making entities engaged at successive levels of the hierarchy with progressive levels of authority over pilot decision-making. In addition to the formal and hierarchical decision-making process, a number of influencer activities occurred in parallel that ultimately facilitated the pilot being adopted as a

permanent program. Influencer activities were noted as not only impacting the decision to adopt the pilot as a permanent program but also accelerating the speed in which the pilot was approved for full-scale implementation. The remainder of the question 1 discussion compares and contrasts the actual decision-making process to what was discussed and hypothesized in Chapters I and II.

(1) Alignment to the Gutierrez et al. (2008) Model

Using the Gutierrez et al. (2008) decision-making choice model as a frame, most interviewees confirmed that the process to adopt this pilot as a permanent program was largely formal, hierarchical, and rational. However, alongside and even inside the formal decision-making process, there were divergent elements. Personal connections allowed pilot implementers to engage higher levels of the decision-making hierarchy (i.e., JEC) earlier in the process than is typical, which expedited the final decision. Additionally, influencer organizations were engaged both formally and informally, who applied pressure on VA to make a decision. Veteran service organizations were engaged through more informal means (e.g., personal communication), which eventually led to Congressional involvement and support; meanwhile other influencer organizations, like federal advisory committees, were engaged more formally through their established mechanisms for engagement (e.g., public comment periods).

(2) Role of Influencers

The role of external influencers, including the extensive involvement and influence of Congress, led some interviewees to classify this a political or influential decision-making model or that it was forced decision making (and therefore was not really a decision at all). This assertion contradicts the Gutierrez et al. model of choice, as it is focused on organizational-level processes and does not account for external forces that may impact the decision-making process (2008). However, more recent models recognize external factors. As referenced in Chapter II, Turner et

al. (2017) recognized the impact of external forces (referred to as the local system level) on decision-making, which in turn applies pressure on the organizational level. Anderson et al. (2018) also discussed and explored the role of external factors on public sector program adoption decisions. In their study of organizational innovations and the impact of external factors, Anderson et al. went as far as to say, "Our results consistently show that public managers react to top-down political pressure rather than to conformity pressure from institutionalized models or performance information when deciding on innovation adoption and abandonment" (Anderson & Jakobsen, 2018, p. 3).

(3) Decision-Making Processes and Considerations

Interviewees confirmed that there was not a set process followed to move this pilot from a concept to being adopted as a permanent program. This was largely due to the fact that grassroots initiatives developed outside of the executive committee structure are rare, if not entirely non-existent, in the interagency space. In turn, pilot implementers had to figure out the process and layers of approval as they proceeded, seeking guidance from senior leaders along the way. Although each committee has formal processes and hierarchical functions embedded in their respective structures, there is no standardized protocol for how interagency programs are implemented, evaluated, and formally adopted. Decision-making tools have their merit, but they are not a panacea. McConnell (2016) asserted that there is no magic formula for decision making. There can be guidelines, checklists, rules, policies, regulations, and procedures. But there are ever-present biological constraints to contend with, such as limitations to what individuals and groups can pay attention to and consider (March, 1994). In effect, good decisions, with or without procedures in place, will rely on judgment based on, "facts and figures, knowledge, experience, advice, intuition, and insight" (McConnell, 2016, p. 89).

(4) Analysis of Alternatives and the Role of Decision Makers

Another point of consideration in program adoption decision making is the presentation and analysis of alternatives. McConnell (2016) asserted that there should always be five components of implementation decision-making, three of which are related to the analysis of alternatives. The three analysis of alternative steps include developing alternatives, selecting a preferred alternative, and implementing the chosen alternative. As was shared by interviewees, the pilot implementation team created the pilot independently, outside the formal decision-making hierarchy. By the time the pilot was integrated into the decision-making process, alternatives (e.g., a 3-day or full-week program) had been examined and eliminated. Subsequently, decision-makers were presented with the pilot in its near-final format. Since the informal "analysis of alternatives" was completed by implementers, the "alternatives" presented to decision-makers were essentially the adoption of the pilot in its current form or retain the status quo (i.e., no women's-specific transition program). Decision-makers then were only included in one of the McConnell decision-making steps – deciding (and not even among alternatives). This then begs the question – in complex decision-making processes involving many stakeholders, who should be involved in the conversations about alternatives? And since the implementation team had developed the program prior to it entering the formal decision-making hierarchy, as Gutierrez et al. noted, it is hard to stop projects once they are started, as they often take on a life of their own (2008). And this approach to developing the program may also have led to resource allocation syndrome, where ideas are approved and started without considering other projects in an organization's portfolio (Gutierrez et al., 2008).

b) Question 2

The second question explored the factors that impacted the decision to adopt the pilot as a permanent program. The findings, as revealed in the semi-structured interviews, indicated that there were 24 unique factors of varying importance that impacted the decision-making process. Factors were identified at all levels of the socio-ecological model (i.e., individual, interpersonal, organizational, societal) and factors were noted as being important during different phases of the pilot (i.e., pilot exploration & approval, pilot implementation, and pilot adoption decision). Although there were a number of factors that were deemed predominant factors based on a number of measurements (e.g., code frequency, number of phases impacted, and the nature of the discussion in which the factor was mentioned), it was clear that a combination of factors acting in coordination with each other ultimately impacted the decision to adopt the pilot as a permanent program. The remainder of the question 2 portion discusses and interprets the findings compared and contrasted to the hypotheses and factors in Chapters I and II.

(1) Understanding of the Need

Understanding of the need was identified as the most predominant factor for why the pilot was adopted as a permanent program. Understanding of the need, which was present at all levels of the socio-ecological model, is the extent to which a problem is known to exist and the entities value it as a problem (Castaneda et al., 2012). There was a fairly consistent understanding and appreciation of the need by all stakeholders. And the pilot appeared to be an innovation-values fit, in that the program aligned with the VA organizational mission, values, and structure (Weiner, Lewis, & Linnan, 2009; Aarons et al., 2011). What was not evident as a pilot stakeholder consideration was that the central premise of the program was focused on individual-level change. The pilot's theory of change was to increase the awareness and knowledge of

women Veterans to increase the likelihood of enrollment in VA benefits. Increased enrollment may then lead to increased VHA utilization and more long-term, the reduction of female Veteran suicides.

The VHA Women's Health Transition Training pilot was grounded in the individual level of the socio-ecological model, as it focused on changing knowledge and awareness of VHA benefits to ultimately impact health behavior. Public health interventions are becoming increasingly more grounded in the socio-ecological framework, as there is an understanding that most health outcomes are impacted by a complex interplay of factors, which should then be addressed by interventions at different levels. This comprehensive approach is believed to increase the sustainability of public health efforts more than individual interventions or programs (CDC, n.d). VHA indubitably has women's health and transition interventions at various levels of the socio-ecological model. But what if all women's health and transition programs/interventions had been mapped to the socio-ecological model to assess the entire portfolio and identify gaps before adding a new program? As sometimes is the case with change and change readiness, this pilot may have been a symbolic gateway to demonstrate that VA and DoD are taking action on a highly pressing issue. This would be in line with incremental change, which Rafferty et al. acknowledged as more successful generally than transformational change (2012). Researchers have indicated that the smaller the scale of change, the more likely individuals are to have a positive response to change (Rafferty et al., 2012). As indicated by some interviewees, this pilot perhaps, rather than being the perfect solution, may be a smoke signal to demonstrate support for a need and response.

(2) Pilot Data

Pilot data were noted by interviewees as one of the top factors for why the program was adopted as a permanent program. As discussed in Chapter II, the strength and nature of pilot evidence as perceived by the organization can impact decision making (Helfrich et al., 2009). Turner et al. (2017) also noted that "evidence can be given different meanings by different stakeholders resulting in uncertainty about whether evidence was lacking, was not of good quality, or was limited" (p. 5). Based on pilot data being a predominant factor and the fact that the pilot was adopted as a permanent program signifies that the pilot data was necessary for making a decision. But as Brownson et al. noted in their review of the evidence-based public health literature, scientific evidence in and of itself is not sufficient to make a decision; values, resources, and context must also be considered (2018). Brownson et al. (2018) also asserted that evidence-based decision making means using the best evidence available at the time to make decisions about appropriate public health interventions. In turn, they acknowledge the importance of having enough of and the right information before making the decision to make a decision to adopt new programs (Brownson et al., 2018).

These assertions raise questions about evidence and evidence-based decision making – what constitutes as best-available evidence and how much is enough? And what weight does data or evidence convey in relation to the other decision-making considerations (i.e., values, resources, and context)? Brownson et al. aptly sum up this conundrum, "An ongoing challenge for public health practitioners involves determining when scientific evidence is sufficient for action, and when it is appropriate for some settings or problems or populations, whether it is sufficient for the ones at hand" (2018, p. 30).

(3) Interpersonal Factors

Navigating bureaucracy, political savvy, personal connections, trust, and passion and persistence all connected into a conglomeration of interpersonal-level facilitating factors. The emergence of these factors, in coordination with factors such as understanding of the need and empathy, highlights the importance of networks and assembling a strong implementation team that understands the bureaucratic process. March (1994), in his discussion of multiple-actor factors, noted that decisions can often be made based on who is paying attention, who is participating, and who is alert and persistent. Rhodes (1997) referred to similar concepts as a network. Networks have characteristics and rules predicated on an exchange between interacting organizations. These networks, as was the case with this pilot, occur and work in parallel with hierarchical processes (Rhodes, 1997). And as Greenhalgh et al. (2004) noted, these network forces can generate pressure for organizations to adopt an innovation.

(4) Timing and Context

The perception, visibility, and broader societal influence factors that emerged all signal that timing and context mattered in this decision. The issues facing women Veterans are very public, as evidenced by the number of articles, books, documentaries, and public scandals on the topic. Some interviewees noted that it would have been a very poor decision if VHA had not supported the pilot based on the ongoing women's movements (both inside and outside DoD and VA). As discussed in Chapter II, Yanovitzky (2002) demonstrated that public attention to an issue can impact legislative and policy actions. The pressure and immediacy of some issues can lead to the generation of immediate, short-term solutions to a problem; but Yanovitzky (2002) found that once media attention subsides, more long-term solutions are typically implemented.

(5) Political Pressure

The study findings very clearly indicated that leaders' decisions are impacted by external forces, including timing and context. Anderson & Jakobsen (2018) generated a political pressure hypothesis that "the more pressure from political principals for adoption of an organizational innovation, the more likely an organization is to adopt the innovation" (p. 13). But amidst the inevitable (and persistent) pressure, how can leaders focus on making evidence-based decisions that will be sustainable over time? And how can organizations recognize and acknowledge the role of political pressure and still make sound organizational decisions? Especially in the case of this pilot, Congress got involved and as noted in Chapter IV, there is a clear tension between the legislative and executive branches because of the resource dependency. Braun & Gilardi (2006) spoke of the political pressure from a resource-dependency perspective, "…this can give rise to coercive pressure because the wishes of the political principals are directly or indirectly linked to the organization's dependency on financial, legislative, or hierarchical resources from the political principals. Based on such dependencies, political principals can make it very costly (or very beneficial) to not adopt (or adopt) a specific organizational innovation" (p. 310).

(6) Combination of Factors

And finally, the combination of factors involved in making this decision cannot be overlooked. Chapter II included a literature review of a multitude of a priori decision-making factors at all levels of the socio-ecological model. A mapping of a priori factors to those that actually emerged Appendix O: A Priori to Emergent Code Mapping revealed that many of the a priori constructs and subconstructs emerged in the study. And although some factors were cited by interviewees more than others, it truly was the convergence of all the factors simultaneously that facilitated the decision. In viewing this through a philosophical lens, there were some factors or conditions

that were necessary for the pilot to come to fruition (i.e., pilot data). But no single factor alone was sufficient to produce the outcome (e.g., understanding of the need). Instead, this complex array of factors converged to generate the sufficiency to adopt the program. Even factors with moderate or limited evidence played a role.

c) Question 3

The third question sought to understand the implications and resonance of the study findings with pilot stakeholders. The findings, generated from the participant focus group, revealed pilot implementation lessons learned and suggested practices. Many of the focus group findings reflected key thematic elements discussed during interviews, while the decisional portion of the ORID discussion unveiled recommendations for future implementations.

(1) Implementation Science Principles

Focus group participants voiced that although a prospective implementation science framework was not built into the pilot structure, the implementation strategy aligned with many of the Expert Recommendations for Implementing Change (ERIC) central tenets. How important then is the alignment of a program to an evidence-based implementation strategy (e.g., ERIC) to the evidence-based decision-making process? The ERIC compilation is not a prescriptive implementation strategy, but rather a compilation of strategies that can be used to build, "a tailored multicomponent strategy for implementation" (Powell et al., 2015, p. 7). A 2015 systematic review found that tailored implementation strategies are more effective than no strategy or a strategy that is not tailored (Baker et al., 2015). And because implementation science best-practices factor in organizational readiness for change, it stands to reason that implementing evidence-based implementation science principles will increase the likelihood of success of an intervention (Moir, 2018). Although the pilot was successfully adopted as a

permanent program without following explicit implementation science best practices, there are still opportunities to institute implementation science principles and best practices as the program is scaled up and instituted in all military service branches.

(2) Interagency Engagements

It was noted by focus group participants that there was no interagency project roadmap for initiating and executing a grassroots initiative between two federal government departments. This is due to the fact that interagency collaborations, especially grassroots initiatives, are rare. With the concern of duplication, overlap, and fragmentation (noted in Chapter I), interagency collaborations are more recently being recognized as a mechanism in which to combine forces and work across sectors. As a result of this notion, the Government Performance Results Act (GPRA) Modernization Act of 2010 was established to encourage a more integrated approach across agencies to address complex issues (GAO-12-1022, 2012). Although an interagency collaboration framework was not followed for this pilot, GAO has identified eight key practices that should be in place when initiating an interagency collaboration (e.g., "define and articulate a common outcome, establish mutually reinforcing or joint strategies"; GAO-12-1022, p. 3). It is unclear if and how this framework is being disseminated and applied.

(3) Program Implementation Roadmap and Change Process

Focus group participants noted that an explicit change management process was not used and may have helped to usher this pilot along and to overcome any resistance to change. As noted in Chapter IV, there were varying levels of readiness and subsequently resistance to change in pockets throughout the departments. Ultimately, all resistance was overcome by senior leader support, but the fact that this was strong-armed may have implications on the buy-in and long-term sustainability of the program. Rafferty et al. (2013) asserted that change readiness is

attributed to many factors, but maybe none more so than individuals' attitudes toward change. This change readiness is tied into the understanding of the need in which someone believes there is a problem, believes there should be change to meet the problem, and that the organization has the capacity to achieve change (Rafferty, 2013). An individual and an organization's readiness for change are impacted by many factors and will impact the likelihood of an initiative being successfully adopted. Thus, readiness for change should be considered prior to initiating change implementations. This was succinctly summarized by Rafferty (2013), "…Assessing readiness and then subsequently increasing efforts to create individual, group, and organizational change readiness may be the necessary ingredient to increase the likelihood of successful organizational change" (p. 130). Program leaders and implementers will need to continue to consider readiness to change as they continue to implement the program, as readiness is a dynamic state that fluctuates and is impacted by individual, interpersonal, organizational, and societal forces (Jansen, 2000).

(4) Implementation Team

The strength of the implementation team was noted by focus group participants as a facilitating factor for the successful adoption of the pilot. Participants also noted that the consideration of team dynamics is something that should be intentional and purposeful, as the pilot implementation team possessed different skills and backgrounds that were leveraged at different points in the implementation process. Recent literature has stressed the value of teams in an ever-collaborative world. Important team components are attitude, skill, and knowledge (Lacerenza, Marlow, Tannenbaum, & Salas, 2018). Lacarenza et al. (2018) asserted that teams then should be assembled intentionally, using systematic activities aimed to improve the competencies, processes, and overall effectiveness of teams. The pilot implementation team was fortunate

enough to come together organically and work well together around a shared vision, but establishing mechanisms to pick the right team to implement promising interventions may be useful in the future. Moir (2018) stressed the importance of the team as a design consideration in all interventions, but that putting together an ideal team can be difficult in real-world settings.

(5) Community Voice

Focus group participants also talked about the need for the community voice in policymaking, to leverage the people closest to the issues to bring the issues to the table and propose solutions. This program implementation was successful because it addressed organizational diversity and inclusion initiatives. But this practice of including and valuing the community voice needs to continue to be upheld to inform future public health and equity initiatives (Cain, Orionzi, O'Brien, & Trahan, 2017). And as discussed by focus group participants, this would require systems change to accommodate this paradigm shift. Community-based participatory research, which does not necessarily have to apply to research, may be a way for VA to involve community members in a collaborative approach to achieving change (Faridi, Grunbaum, Gray, Franks, & Simoes, 2007).

B. Implications

There are decision-making implications that can be drawn from the project findings for VA, public health practice, and public sector organizations more broadly. Each section below discusses the implications for each sector; however, implications should be considered within the context of this as a quality improvement project.

a) VA Implications

As a quality improvement project for VA, this project has implications for the department, particularly the consideration of standardized decision-making processes that embrace and do not reduce complexity.

This project revealed that the decision-making process related to this VA pilot was complex. And it was noted that the decision to adopt this pilot as a permanent program was accelerated compared to other implementations due to many factors, including the early engagement and endorsement of senior leaders and many broader societal factors. The reality of the complexity is consistent with researchers' assertions of public sector decision making (Aarons et al., 2011; Gutierrez et al., 2008; Aucoin, 2005). Decision making, arguably one of the most important roles assumed by leaders, is not an inherent skill; it is a systematic process that must be practiced and requires artistry to combine and evaluate a number of important elements at different times (Satterfield et al., 2009). Decision making, as described by Aucoin (2005), is impacted by many factors and varies in rationality depending on administrative and political factors. Based on this noted complexity and the successful implementation being described as a "perfect storm," it's unlikely that this exact process and outcome in a different time would be replicable. But there are many relevant lessons learned for VA to consider for future program implementations.

This project demonstrated that political pressure can play a significant role in decision making. Decision making is complex enough as it is and particularly challenging in large bureaucratic organizations. Organizational characteristics make it so there is not always transparency or cross-collaboration to understand the activities of other workstreams. Add in political pressure and it is highly possible that decisions may be made that are not in line with an overall organizational strategy. Or that there is significant overlap or duplication in program offerings.

With this complexity in mind, it would benefit VA to make some of these often implicit forces explicit. This dissertation project, in the short-term, aimed to change knowledge by starting a dialogue about project implementation and decision-making processes. This project demonstrated that there is room for improvement in operationalizing many of these variable processes. A first step to changing actions may be developing more informed and systematic decision-making processes. In the long term, this change in actions could precipitate a change in conditions, perhaps changes to policies and systems, to create a consistent and defendable system for program adoption decision making. This with the ultimate goal of improving objectivity and decreasing process variability, which can occur when political and external forces are overwhelming. Decision making, as stated by McConnell (2016), can never be simplified into a checklist, but there should be mechanisms to safeguard against some of the problems that can occur in decision making: reducing complexity to make decision making more palatable; reducing problem complexity by breaking an issue into its component parts; simplifying the issue to make it more predictable than it really is; and jumping at the first reasonable conclusion (Cyert & March, 1963).

With the number of factors identified that impacted the decision, the complexity of the decision-making process, and the calls by focus group participants for more standardized processes, VA can benefit from establishing systematic decision-making processes to reduce variability and subjectivity. This will require the adoption of and training in evidence-based decision making, which will likely require multiple upstream system changes. The implications of decision making are far-reaching and expensive. VA may not be subject to the same budget reductions experienced by other federal government departments, but VA's performance is more visible and under more scrutiny as a result. They have been most intensely scrutinized as of late for the

rising Veteran suicide rate. Thus, decision making sends a message about what is important and reflects organizational culture and values.

This project also proved that a coordinated implementation plan (and corresponding pilot data) was necessary, but not sufficient. Without the external influences, would this data have been enough? This process demonstrated that evidence does not stand on its own. Which means that, without evidence-based decision-making processes in play, programs that address a need, but may not be the best solution may become adopted. Conversely, evidence-based programs in the wrong time may not be implemented. Timing is an important factor for consideration in implementation, if not the most important factor. And the proper use of timing is a sign of a learning organization. Albert (1995) stated, "A reason for acting at a given time…is a product of learning; that is, it depends on past context, and by definition refers to some aspect of the continually unfolding context that defines the plot into which actions will be inserted" (p. 7).

b) Public Health Implications

These project findings have public health implications, including using terminology appropriately, evidence-based decision making, determining how to allocate scarce resources, considering interventions that address multiple levels of the socio-ecological model, and the importance of timing.

(1) Importance of Terms

This project brought to light questions about defining and fidelity to evidence-based practice and decision making. It was noted in Chapter IV that this pilot was externally recognized as a best practice program. This brings up questions about how best practices are defined and what and who determines if something is a best practice. Best practices are typically generally accepted practices that have been identified as being the most effective or correct. How then did the

classification of this project as a best practice impact decision making? This illustrates the importance of defining and maintaining fidelity to the use of the terms best practice and evidence-based, as it has implications on what programs are adopted and approved.

(2) Evidence-Based Decision Making

Evidence-based public health is a universally recognized approach to influencing public health outcomes (Baker, 2009). However, there is some question about how to apply evidence-based decision making in practice. Brownson et al. (2018) noted that evidence-based decision-making is using the best evidence available at the time. What does that mean in the context of decision-making? How much and what type of evidence is sufficient? As public health interventions are highly complex and are most effective at different levels of the socio-ecological model, evidence-based decision making in public health is heavily reliant on context (Brownson, Fielding, & Maylahn, 2009). And this makes the process exceedingly difficult, as noted by Brownson et al., "Although the concept of [evidence-based public health] EPBH is likely to resonate with most public health professionals, the dissemination and implementation (D&I) of effective intervention strategies remains a significant challenge" (2009, p.186). Despite the complexity, public health leaders should recognize the importance of evidence in decision making (Brownson et al., 2009). Moreover, public health leaders should then be trained on EBPH and evidence-based decision making and should be equipped to navigate these highly complex situations.

(3) Public Value

Public health, as a public enterprise, is concerned with public value. That is, using taxpayer money wisely to generate and implement effective interventions (Moore, 1998). There are many considerations for public value, including issues of risk and ethics of prioritizing and potentially

marginalizing some groups. A key facet to ensuring public value is determining how to allocate scarce resources. Similar to what happened in this pilot, the literature identified that public health resource allocation has to respond to risks. And the greater the risk of not doing something, the more likely an intervention is to be allocated resources (Daniels, 2016). Tools for guiding resource allocation are limited particularly because of their limits to consider the complexity of decision making (Daniels, 2016). Thus, this is another training opportunity for public health leaders to navigate complex resource allocation decisions to increase the likelihood of generating public value.

(4) Multilevel Intervention Considerations

The public health approach to solving complex problems is largely predicated on the socio-ecological framework – that interventions are needed at multiple levels of an ecological model to have the greatest impact. The pilot project was firmly rooted in the individual-level of the socio-ecological framework, addressing women Veterans' knowledge and awareness of VA programs. A mapping of interventions at different levels of the framework may have been useful to understand the levels of intervention for transitioning servicewomen. But in addition to understanding interventions at different levels, it is also important to consider the impact of introducing new programs/interventions into an established portfolio. And to consider if the sequence of the introduction of interventions matter (e.g., should individual-level interventions be introduced prior to or in coordination with societal efforts?). There is ample literature on using the socio-ecological model to frame interventions, but a dearth of literature on how to best sequence interventions at the levels (or to even incorporate new and existing interventions). Public health leaders then should consider the socio-ecological levels of influence of innovative

interventions, in light of the fact that incremental change is more likely to be effective (Rafferty et al., 2012).

(5) Timing and Context

The adoption of this pilot as a permanent implementation stresses the importance of timing and context to decision making. This pilot occurred during an important time in history for women, both societally and within VA and DoD. The Marines United Scandal thrust DoD's treatment of servicewomen into the spotlight in March 2017. This scandal was centered around the distribution of naked pictures of servicewomen without their consent to 30,000 male servicemembers in a closed Facebook group. Outside the DoD, the Me Too movement was in full swing when the pilot was initiated, bringing attention and justice to women survivors of sexual assault and harassment. Know Your Value, a program designed to stymy pay inequality and help women grow professionally, was cited as another manifestation of society reacting to injustices against women. Additionally, there were many books and documentaries cited that shone a light on women in the military. "The Invisible War" was a harrowing documentary about sexual assault and rape in the military. Three books that share true stories of women in service were noted as impactful for a broader audience, including Ashley's War: The Untold Story of a Team of Women Soldiers on the Special Ops Battlefield, Fight Like a Girl: The Truth Behind How Female Marines Are Trained, and Shoot Like a Girl: One Woman's Dramatic Fight in Afghanistan. Additionally, it was noted that there are record numbers of women Veterans in Congress and in positions of leadership within DoD and VA and in VSOs, bringing a voice to a previously underrepresented demographic. The importance of this historical context cannot be ignored when considering the implementation of this program.

These broader societal forces, in coordination with organizational forces, generated pressure to act. As discussed above, the pilot was an individual-level intervention designed to change awareness and knowledge. Was this the right diagnosis or the right need? And if that is indeed the proper diagnosis, was the pilot the proper solution? Despite external pressure, public health interventions should be carefully considered. And perhaps the Heifetz et al. framework would benefit our adaptive public health leaders (2009). Public health leaders should first determine if the issue is a technical or adaptive challenge. If the issue is deemed to be an adaptive challenge, then the first step is to get on the balcony to assess how the organization is currently addressing the issue (Heifetz, Grashow, & Linsky, 2009). Rather than jumping to solutions, it will be an essential part of training public health leaders to take a step back and diagnosis a situation before jumping to solutions that may not meet the need (if the need is even truly understood).

(6) Multisector and Multipartner Engagement

And finally, this interagency collaboration was unique. As mentioned in the VA implications, the federal government is increasingly recognizing the importance of interagency collaboration to streamlining interventions and better using resources. Multisector, multiagency approaches have also been identified as a priority in public health. One of the central tenets of Public Health 3.0 is to engage multiple sectors and community partners to generate collective impact (DeSalvo, Wang, Harris, Auerbach, Koo, & O'Carroll, 2017). Public health is increasingly recognizing the importance of having many and different partners with seats at the table. And this is due in large part to the shift in focus to social determinants of health, including housing, employment, education, and access to care. As was stated in an article on the importance of public health partnerships, "Partnership is an essential ingredient of public health for tackling the key determinants of health; as a shared responsibility, to avoid overlap and duplication…The

multisectoral approach requiring action by all agencies and individuals which have an impact in health strengthens approaches to address health problems and inequalities" (Adetunji, 2013, p. 94). Forming these partnerships requires public health leaders to be innovative and creative in thinking about systems solutions to complex adaptive public health challenges.

c) Other Public Sector Government Agencies Implications

Many of the VA implications also apply to other public sector government agencies. Other government agencies are also subject to political pressures converging with organizational factors. Decision making does not occur in a vacuum and regardless of the evidence for a program (however that is subjectively defined within the organization), the evidence does not stand alone. Similar to VA, it would benefit other public sector government agencies to establish procedures or systems to support evidence-based public health and decision-making processes. These systems should include, but are not limited to, policies and protocols for decision making, frameworks for assessing evaluation data, and training leaders in the central tenets of these practices. As Gutierrez et al. (2008) posited, the more formal, rational, and hierarchical the decision-making process, typically the better to assist with objectivity and traceability of the process.

C. Revised Conceptual Model

The study began with a conceptual framework predicated on a number of factors at different levels of the socio-ecological model that would impact how the decision was made to adopt this pilot program. The conceptual model components, including the factors and decision-making processes, were heavily steeped in the literature.

A revised conceptual framework, derived from the document review, interview, and focus group findings, reflects that various factors at different levels of the socio-ecological model did indeed

impact the decision-making process, which was largely hierarchical, rational, and formal. It was also noted that the process was complex and different factors mattered during different pilot phases (i.e., pilot exploration & approval, pilot implementation, and pilot adoption decision). The primary updates to the conceptual model are included below. It is of note that the entirety of the complexity of this process could not be captured in a one-page graphic. Ideally, this graphic would have contained the factors that were present during each phase at all levels of the socio-ecological model, including each factor's level of evidence (e.g., predominant, moderate). Figure 23 in Chapter IV summarizes this level of complexity in a single graphic.

- The Aarons et al. (2011) implementation framework originally at the top of the framework was replaced with the actual phases of the pilot that occurred, including pilot exploration & approval, pilot implementation, and pilot adoption decision. These phase delineations were constructed by the principal investigator; the dissertation phases fit within the Aarons et al. framework exploration and adoption preparation/decision phases. Although not originally going to be included in the study, there were components of the pilot exploration process, including corresponding decision-making processes that set the tone and were important for the ultimate decision to adopt the pilot as a permanent program.
- The Gutierrez et al. (2008) four dimensions of choice related to the decision-making process were replaced with the three Gutierrez process constructs that actually emerged - the rational, hierarchical, and formal dimensions (purple box labeled *Decision-Making Approach*). In addition, the new conceptual framework also accounts for the role of influencers on the decision-making process during the pilot implementation and pilot adoption decision phases (as indicated by the green *Influencers* box).

- Due to space constraints, the concentric circle representation of the socio-ecological model was replaced with a rectangular graphic to accommodate the increase in the number of factors. The updated conceptual framework includes the factors that emerged at all levels of the socio-ecological model – individual, interpersonal, organizational, and societal. Factors that appeared at multiple levels are denoted at each level in which they appeared. The original conceptual framework used the Chapter II constructs, or larger buckets, that were used to organize the various subconstructs. The factors represented in the updated conceptual model are the equivalent of subconstructs. They were not organized by construct in Chapter IV or in the conceptual framework, but rather by predominant, moderate, or limited evidence factors. In addition to the factors that emerged at all levels, a ring encircles the socio-ecological model labeled *Combination of Factors*. This accounts for interviewee assertions that it was a combination of a number of factors of varying importance that impacted the decision to adopt the pilot as a permanent program. Additionally, the orange arrows circling the graphic denote that the factors impact each other within and between levels of the socio-ecological model.
- The initial conceptual framework represented the various final decision-making options (e.g., pilot expansion of the training into additional sites). These four options have been replaced with the actual single outcome – implementation of the VHA Women's Health Transition Training in all Service branches. Similar to the original conceptual framework, the pilot being adopted as a permanent program informs the implications of the decision and the findings for VA. As this was framed as a quality improvement effort, the desired outcomes were updated to reflect the contribution of this project to VA's program

adoption decision-making process knowledge base and will hopefully inform implementation and decision-making for future implementations.

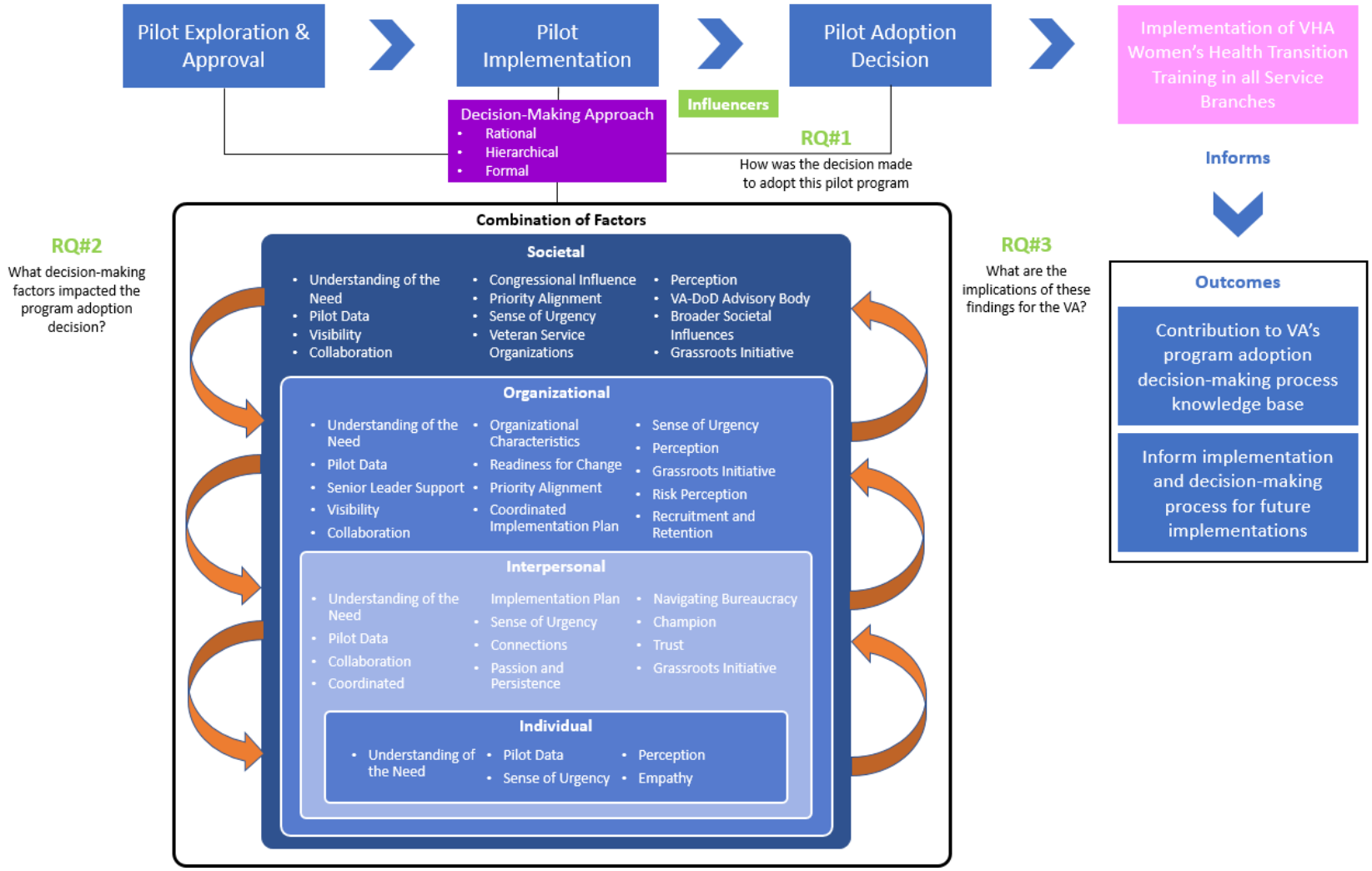


Figure 24: Revised conceptual framework

D. Strengths and Limitations

1. Strengths

This project exhibited a number of strengths. It offered a unique opportunity to retrospectively examine decision-making processes in the successful adoption of a pilot program. As identified in Chapter II, there have been few to almost no studies that have examined decision-making or program implementation in the socio-ecological frame (Turner et al., 2017). Additionally, this project provided a unique opportunity to explore decision-making in an interagency collaboration. Interagency programs themselves are rare, let alone being able to explore decision-making processes and associated facilitating factors. Due to these unique properties, the findings are revelatory for VA and may have value for other federal government organizations due to the representativeness of the single case.

Another strength of this project was that it was performed in close coordination with program partners. Program partners were heavily involved in the scoping, data collection facilitation, and analysis processes. Their participation not only increased the reliability of the findings but also aided in the recruitment of interviewees and focus group participants. Because of the program partner buy-in and credibility, the study was able to achieve interviewee diversity, including implementers, decision-makers, and influencers. These unique perspectives contributed to a holistic view of the process and factors from different vantage points.

2. Limitations

Although the project had many strengths, there were also limitations. First, this was a single case study. Although single case studies can provide an in-depth exploration, there are some limitations due to putting "all your eggs in one basket" (Yin, 2009, p. 61). Additionally, since this project was purposively designed as a quality improvement project for VA, generalizability

is limited. These findings may have relevance and value to other organizations, but the study type and focus must be taken into consideration when thinking about the broader application of the findings.

There were a few limitations related to the interviews and focus groups. The majority (63 percent) of eligible interviewees participated, but that amounted to 15 interviewees. Additionally, some stakeholders were excluded from the original denominator because they were advised not to participate in this project based on their program's adjacent position to the pilot and somewhat political nature of the process. However, as mentioned in the strengths, despite this, the group of participants that ultimately participated was representative of the three different stakeholder groups involved in the pilot, which adds to the study's strength and diversity of perspectives. Similarly, the sample size of the focus group was small (four participants); however, this number accounted for 80% of the participants suggested by the program partners.

Recall bias and participants' roles may have impacted interviewee responses. There were some interviewees that were removed from the pilot process for over a year, which led to a reliance on their memories (and they did not have access to documents that may have assisted with recall). However, due to the study design and diversity in participant perspectives, their testimonies and recall of the process were supplemented by other interviewees' perspectives and recall of events. The level of openness by interviewees varied by role and individual. Some individuals, based on their formal position and their role in the project, had to be more reserved, in a sense, in terms of what they shared and how freely. This may be partially explained by their vantage point related to the pilot, as they may not have been aware of some of the more political processes. Whereas other individuals (e.g., influencers and implementers) spoke more freely about the process and factors that impacted the decision.

There was potential for researcher bias as to the rationality of the decision-making process. To ward against this, the initial conceptual framework for this project did not assume a level of irrationality around the decision-making process (e.g., the garbage can theory of decision-making); rather, a more neutral position was taken for how the decision was made (i.e., factors at different levels of the socio-ecological model). In addition to the conceptual framework itself being framed to reduce researcher bias, the study data was the sole means of generating project findings. Subsequently, the dissertation narratives and analyses were shaped around the data, not preconceived notions of the process. This resulted in abandoning and significantly revising a priori constructs and concepts.

Reliance on program partners for documents and scheduling interviews and focus groups was initially identified as a limitation. However, the document review, in total, included 68 documents that were provided by practice partners, an online search, and interviewees. The connection to the program partners ultimately lent credibility to scheduling participant interviews that would not have been possible with the principal investigator's notoriety alone.

As noted in Chapter IV, there were 24 unique factors across all levels of the socio-ecological model identified as having impacted the decision-making process. This number of distinct factors made it difficult to assemble a coherent story of how the factors worked together to make the decision. In order to delve more deeply into the factors and to understand interactions and relationships, future research could benefit from taking a narrower focus on a subset (e.g., implementation team) or level (e.g., organizational level of the socio-ecological model) of factors.

E. Conclusions

The findings from this study support the following conclusions:

1. Decision making is complex, particularly decision making within this interagency transition context. This was demonstrated by the number of stakeholders involved with different stakes and interests and the presence of facilitating factors at all levels of the socio-ecological model.
2. Context and timing matter. The decision to adopt this pilot as a permanent program demonstrates that implementations are impacted by the broader environment and societal influences. It is not sufficient to have a well-coordinated program. There has to be a match of the need, with a viable solution, at the right time.
3. There is the opportunity for variability, subjectivity, and political pressure to prevail when there are no set processes in place or there is an aberration from the normal program process (e.g., grassroots initiatives brought into committee processes).
4. Implementation team dynamics matter. A diverse skill set, the ability to navigate bureaucracy, and persistence through complicated processes served as necessary skills to having this pilot adopted as a permanent program.

F. Recommendations

Six recommendations were generated based on reflection on the dissertation findings, including practice partner feedback and interview and focus group findings; in particular, the majority of the recommendations are derived from the decisional portion of the focus group discussion. These recommendations are rooted in the assumption that grassroots initiatives will continue to be encouraged and supported in the future. Additionally, these recommendations are predicated on complex, adaptive leaders navigating and embracing the complexity of adaptive challenges.

1. Define a Process for Initiating and Sustaining Interagency Collaborations

Focus group participants shared the need for and potential benefits of a defined process for initiating and sustaining interagency collaborations. This study found that there was no explicit process for initiating or implementing interagency initiatives. This created a certain level of ambiguity in the process and informal communication channels and personal relationships were used to navigate and expedite the process. This was due in large part to the program originating at the grassroots level, which is an aberration from typical program development. If grassroots initiatives continue to be encouraged, it would behoove VA and DoD to develop a framework for these types of initiatives in the future. A conceptual framework for interagency collaboration, like that developed by Ward et al. (2018) can be used to understand the context and antecedents of the collaboration, the design of the collaboration, the rules and processes in place to govern the partnership, and finally, outcomes and evaluation to understand what was accomplished. This more defined process would also consider necessary stakeholders and their desired level of involvement. Following and defining a process for collaboration can ensure traceability and set a precedent for future interagency collaborations.

One potential process change includes further normalizing the use of pilot interventions before implementing widespread interagency changes. Piloting interventions provides a means to test the feasibility and appropriateness of interventions at a smaller scale first before more widespread implementation. Researchers posited about the value of piloting interventions to evidence-based decision making, "…they allow intervention mapping (feasibility, components, contextual factors, fit for real conditions), which is needed for the knowledge transfer process. These two conditions for evidence-based decision-making and pilot studies could thus facilitate

evidence-based decisions in public health policy" (Thabane et al., 2019, p. 6). VA and DoD, in addition to further operationalizing interagency collaboration standards, should consider further normalizing the procedures to initiate, implement, and evaluate interagency pilot studies.

To further encourage interagency collaboration ideas, VHA's innovative Shark Tank model could be leveraged. And this could further operationalize the pilot approach. VHA's Shark Tank Competition is used to elevate promising clinical and operating practices that have been successful in at least one facility and align with VHA's priorities (VHA Innovation, n.d.). The competition uses standardized practices to submit, evaluate, pitch, and approve innovations. This model may have some utility in the interagency space, as long as there are traceable and defendable systems for how decisions are made about what is chosen, what is deemed evidence, and the decision-making process for selecting and potentially expanding programs.

2. Consider the Use of Evidence-Based Implementation Science Protocols and Train Implementers and Decision-Makers on Their Use

Focus group participants discussed that an explicit evidence-based implementation science framework was not used for this implementation, although the program aligned with many of the ERIC criteria. It is recommended that future VA implementations explicitly consider evidence-based implementation science practices during all project phases. Explicitly using an implementation science framework can help ensure program fidelity (Moir, 2018). Although an implementation science-based framework is not a panacea, it can provide a systematic means to think through complex systems before embarking on a new program intervention. Adhering to an implementation science framework also means building evaluation into the implementation design, which can further assist in evidence-based decision making.

Scalability is an implementation concern related to this pilot, considering its expansion from 11 Air Forces sites to all military Service facilities worldwide (~800 military bases) by January 2020. Additionally, interviewees mentioned the need to consider women who transitioned from the military prior to the institution of this program. It is suggested that VA identifies and uses a scale-up framework to guide these efforts. Some of the recommended scaling mechanisms identified include leadership, communication, social networks, a culture of urgency, and persistence (Barker, Reid, & Schall, 2016). These program adoption facilitators must co-exist with support systems like learning and data systems; infrastructure, human capacity, and capability for scale-up; and sustainability (Barker et al., 2016).

To properly use implementation science principles and design scale-up efforts, VA can leverage already existing resources. VA has demonstrated its commitment to implementation science through the establishment of the VA Health Services Research and Development Service (HSR&D) Quality Enhancement Research Initiative (QUERI) Center for Evaluation and Implementation Resources (CEIR). CEIR provides advisory and consultative services to VA leaders on implementation and evaluation methods to enable scale-up and spread of priority-aligned policies and clinical practices (QUERI CEIR, n.d.). Although CEIR is more focused on clinical implementations, they are a resource for all departmental implementations. CEIR can help identify optimal and tailored implementation strategies aligned with evidence-based practices, develop sustainable implementation strategies for long-term changes, and provide a network of experts for support. Using this resource would have been valuable to this project and should be considered in any future program implementations to train implementation teams and leaders to more thoughtfully consider implementation science principles in creating tailored approaches to real-world problems.

3. Promote Community Participation in Policymaking and Consider How VA Defines and Operationalizes Diversity and Inclusion

The first two recommendations are predicated on innovative strategies originating from the community (i.e., grassroots). Similarly, there was a recommendation by focus group participants to promote the community voice in policymaking and consider more inclusive forms of decision making. Perhaps the decision-making process remains hierarchical, but the way in which solutions are generated could be altered to be more open and involve the constituents closest to the issues. This would require many structural and cultural changes, but this paradigm shift would more closely align VA to similar community-focused movements, such as community-based participatory research. Community-based participatory research has become a way in which to engage communities in social change, empowering communities to advocate for and promote their own health (Hicks et al., 2012). VA can follow this lead to ensure all voices are represented, that they are represented equitably, and that assumptions and "elephants in the room" are exposed and discussed.

Interviewees shared that some stakeholders were concerned that the pilot exclusively targeted women. This concern caused some stakeholders to not support the pilot. Through a series of events, any resistance was overcome and the pilot was adopted as a permanent program. However, questions still remain about next steps for transition programs tailored to other VA underrepresented populations (e.g., LGBTQ and Native American communities). VA must now consider if and how they will target other populations since a precedent has been set for singling out segments of the military population and tailoring transition programs. This will be a challenge for VA to figure out, as it traverses into the territory of how people identify and categorize themselves. This raises important questions for VA to consider, including, "What

does it mean for VA to truly promote diversity and inclusion in program implementation? And what are the costs and benefits of initiating and maintaining numerous population-specific programs on organizational culture and resources?"

4. Create a Culture Where Strategic Thinking, Acting, and Learning Are Normalized, Promoted, and Rewarded

This recommendation is based on the principal investigator's interpretation of how the lack of strategic planning and lack of defined processes for expanding programs facilitated this pilot being adopted as a permanent program. This study demonstrated that more often than not, programs are added to an already existing portfolio of projects and programs. Adjacent and sometimes overlapping programs and initiatives are created to meet slightly different needs without consideration for existing programs. And without looking at the entire system. Rather than just continually adding programs, it would behoove VA to promote a culture of strategic thinking, action, and learning, the antecedents to strategic planning (Bryson, 2011). Strategic planning has been recognized as a means of improving decision making. "Strategic planning…accepts and build on the nature of political decision making. Raising and resolving important issues is the heart of political decision making, and the heart of strategic planning. Strategic planning seeks to improve on raw political decision making, however, by helping to ensure that issues are raised and resolved in ways that benefit the organization, its key stakeholders, and society" (Bryson, 2011, p. 40). Especially in such a large department, VA would benefit from creating a culture that promotes and normalizes strategic thinking, acting, and learning. Strategic planning is not just a plug and play activity; it is a mindset. Tools and templates can be provided, but cannot replace the time and space to think systematically about

complex issues. Additionally, strategic planning can help to preserve and embrace the complexity in decision making.

5. Recognize the Importance of Change Readiness and Embrace Change Principles

Focus group participants discussed the need for having change management structures in place to increase buy-in and decrease resistance to new initiatives. Change is constant at VA. Every new administration and leader brings with them newly branded change initiatives and the same underlying message of transformational change. Researchers have shown that frequent communication during the change and employee involvement, "increases acceptance, openness, and commitment to change" (Rafferty et al, 2013, p.122). This contributes to change readiness. Conversely, if a change is poorly socialized, it can result in cynicism and exaggerated negative perceptions of the change (Rafferty et al., 2013). The ability to successfully navigate change is contingent on thoughtful leadership and the ability to turn wicked problems into opportunities. There are many frameworks available for leading successful change, such as Kotter's eight-stage change process. This process for leading change stresses, "establishing a sense of urgency; creating a guiding coalition to lead the change; developing a vision and strategy; communicating the change vision; empowering broad-based action; generating short-term wins; consolidating gains and producing more change; and anchoring new approaches in the culture" (Kotter, 2012, p. 23). Similar to all other recommendations, a framework is a technical solution. Successful and lasting change is predicated on adaptive leadership, the antecedent to any successful change effort.

6. Involve Key Stakeholders in the Program Definition Process, Including Defining Desired Outcomes

This recommendation is based on the principal investigator's interpretation of how the way in which the pilot was created and assimilated into the committee structure led to ambiguity in the program adoption decision, including knowing how much data/evidence was enough to move forward with the program. A program evaluation was created in the pilot design phase and data was collected for each pilot session. As evidenced in this pilot, having a program evaluation and associated pilot data is necessary, but not sufficient for decision making. Even with an evaluation in place, there was still a question about what constituted as enough evidence. For future implementations, VA could benefit from engaging decision-makers in the program evaluation design process to ensure all stakeholders understand what is being measured (and that what is being measured is meaningful to decision making). For example, decision-maker interviewees mentioned the importance of return on investment data to making decisions. If decision-makers were involved in the program design and evaluation phases, they could ensure important metrics are defined and included in the evaluation. This engagement with leaders/decision-makers will help to reduce ambiguity about when the right amount of evidence is reached to make expansion or sustainment decisions.

G. Conclusion

This project explored the decision-making processes and factors that impacted the adoption of the VHA Women's Health Transition Training as a permanent program. The project found that decision making is complex. And it was particularly complex in this interagency, grassroots initiative targeting an underserved population that has received a great deal of attention organizationally and societally. Decision making matters because public sector resources are

scarce and there is an increased emphasis on reducing overlap and program duplication. The study conclusions and recommendations have relevance to VA in particular but may also have value to public health and other public sector organizations.

This project demonstrated that there is room to better operationalize program implementation and decision-making processes; and in that, better designing programs with multilevel interventions and evaluations to make it so success can be more objectively identified and substantiated. There is an opportunity to make often implicit processes explicit to continue to increase the use of implementation science and evidence-based decision-making practices.

Decision making is the most downstream leadership activity that reflects the state of organizations and leaders in those organizations. The art of decision making involves understanding complexity and evaluating multiple factors simultaneously. Significant decisions are never straightforward and unlike a simple math equation, evidence-based decision making must balance science and art (Brownson, Chriqui, & Stamatakis, 2009). Even though not all issues will be alike, organizations can benefit from frameworks to make more standardized high-stakes decisions. That said, a framework cannot replace the leadership artistry required of our 21st-century public health leaders. Rather than running from the challenges of this increasingly connected and complex world, we can train our public sector leaders to embrace and lead through complexity by understanding systems change.

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APPENDICES

Appendix A: Semi-Structured Interview Guide

VA-DoD VHA Transition Women's Pilot Stakeholder/Decision Maker

Date of Interview: _____/_____/_____ MM DD YYYY		
Role of interviewee:		
Type of interview: ☐ **Decision Maker** ☐ **Pilot Stakeholder**	**Interviewee's Name Agency, City, and State:**	
Time of Interview:	Start |__|__:__|__|	End |__|__:__|__|

Introduction

Thank you for participating in this study about decision making for the VHA Women's Transition Pilot. You were selected for this interview based on your experience with **[name the entity the stakeholder group they belong to].** As you may know, the pilot was recently adopted as a permanent program. I am interested in your input on how the decision was made to adopt the pilot and what factors impacted this decision.

I would like to record the interview if it's OK with you. Your name will not be used in any reporting and none of your responses during this interview will be released in a form that identifies you. Your participation is voluntary; we can stop this interview at any time. I am so grateful for you taking time out of your busy schedule and I anticipate the interview will take an hour. Do you have any questions before we begin?

Background Questions [5-10 minutes]: I would like to start by asking a few background questions about your role and involvement with the VHA Women's Health Transition Training pilot.

1) What is your current position/job title?
    a. How long have you been in this role?
    b. How are you connected to the military to civilian transition process in your current role?
2) What is your role related to the VHA Women's Health Transition Training pilot?
    a. How did you find out about the pilot?
    b. How did you become involved?
3) What need was this pilot trying to address?
    a. What was the purpose of the pilot program, in your opinion?
    b. What were your expectations for the pilot?
4) What would it look like if this program is successful in 3, 5, or 10 years?
    a. What outcomes would you expect?

How of Decision Making [25-30 minutes]: I would like to know more about the processes involved in making the decision to make this pilot a permanent program.

5) Walk me through your experience and involvement with this pilot program.
    a. What kind of decisional meetings did you attend related to the pilot?
        i. Can you walk me through one of the meetings?
            1. Who was at the meetings?
            2. How frequent were the meetings?
            3. What was discussed at the meetings?
    b. What were some key junctures in the pilot process?
        i. What information was presented at those key junctures?
    c. What kind of information was typically shared about the pilot?
        i. How was evaluation data related to pilot outcomes shared?
        ii. At what points in the process was evaluation data shared?
6) What was your role in the decision making process?
    a. If they were involved: Can you tell me about your role and responsibilities?
    b. If they weren't: Ask them question 7 and the probes to see if they know anything about the decision making process or have any ideas for how they think it happened.
7) How was the decision made to adopt this program?
    a. What processes were followed to make the decision to start this pilot and eventually adopt it as a permanent program?
        i. What types of decisions were made at different time points?
        ii. What aspects of the process were formal? What processes were informal?
    b. Who would you say were the decision makers for how this pilot progressed?
        i. Who led the decision making process?
            1. How do you think that entity's role influenced the progression process from pilot to program?
        ii. What other entities were involved in the decision-making process?
            1. How do you think [name of entity] influenced the decision making process?

Decision-Making Factors (25-30 minutes)

8) What factors do you think influenced the decision to make this pilot a permanent program?
    a. Tell me about what factors influenced your support of the pilot.
        i. Why was that important to you?
        ii. Was there anything that inhibited your ability to support the program?
    b. Tell me about what factors were at play between groups of pilot stakeholders that may have impacted the decision to make this pilot a permanent program.
        i. How did group dynamics/beliefs impact decision making?
            1. Groups within VHA?
            2. Groups within DoD?
        ii. What beliefs or emotions between colleagues and groups were present related to this pilot?

1. How do you think this impacted the decision to make this pilot a permanent program?

c. Tell me about the characteristics of VA and DoD as organizations that may have impacted the decision to make this pilot a permanent program. This may include the size of the organizations, resources (including staff and funding), organizational structure, organizational cultures, and values.
    i. How did VA/DoD organizational culture influence the decision? This may include values, beliefs, or attitudes.
    ii. Any thoughts on the impact of how this pilot was communicated about that may have impacted the decision?
d. What is your impression on how the organizations' readiness for this change impacted the decision to make the pilot a permanent program? This may include the commitment to pursue a course of action, the motivation for action, and the capacity to address the issue.
    i. What impact did this have on the decision?
e. Talk to me about how you think leadership impacted the decision to make this pilot a permanent program.
    i. What leaders were involved in this decision?
        1. What leaders in VA had an impact on this decision?
            a. Why?
        2. What leaders in DoD had an impact on this decision?
            b. Why?
    ii. How did VA and DoD leadership align on this decision-making process?
    iii. What committees do you think were involved in this decision?
        1. What did the committees do?
        2. How effective were they in general?
f. Tell me about how organizational politics impacted the decision to make this a permanent program.
    i. Who are all the organizational political actors you thought were important in this process?
    ii. What did they do?
    iii. What organizational politics were at play?
g. Tell me about how characteristics of the pilot itself impacted the decision to adopt it as a permanent program.
    i. What do you constitute as evidence for this program?
    ii. How did pilot evidence impact the decision to adopt this program?
h. Tell me about factors outside of VA and DoD that may have impacted the decision to make this pilot a permanent program
    i. What role do you think did external politics have in this decision making process?
        1. What role did Veteran advocacy groups play in this process?
            a. What Veteran advocacy groups were involved?
            b. What did they do?
        2. What role did Congress play in this process?
        3. What role did the general public's perception of this issue play in the decision making process?

ii. What legislation or policy may have impacted the decision to make this pilot a permanent program?
iii. If/how did federal or state funding support impact the decision to make this pilot a permanent program?

Wrap Up (5 minutes)

9) You said that success would look like **[repeat back their answer to question 4**]. Do you think the pilot is on track to do that?
    a. Why?
    b. What recommendations do you have, if any, for changes you think need to be made between the pilot and when this becomes a full program?
10) Have you ever been part of a committee making a decision on a pilot?
    a. If so, how did this experience compare?
11) In closing, what two factors would you say were most important in making the decision to adopt this pilot as a permanent program?
12) Is there anything else you want me to know?
13) Do you have anyone else you recommend I speak to about this?

Appendix B: A Priori Codebook

TABLE XXI: A PRIORI CODEBOOK

Construct	Sub Code	Level	Description	Key Words	Notes
Biological Factors: Decision makers face serious limitations in attention, memory, comprehension and communication. March considers these to be biological constraints on human information processing that manifest in decision making (March, 1994).	Processing capacity	Individual	Reference to limits of time, memory, attention, comprehension, and computing speed mean that the brain can only process a fraction of the information in a given situation. Communication can also impact the ability to share and process complex information.	• Memory • Time • Attention • Too much going on • Communication Comprehension	Combined the attention, memory, comprehension, and processing capacity subcodes to make this single subcode.
	Cognitive economizing	Individual	Reference to simplifying and breaking down a complex situation to make it more manageable.	• Just needed to make a decision • Simplify • Pressure to act • Broke it down	This may not come out explicitly, but may be inferred from responses. Need to make note of this in memo if so.
	Cognitive biases	Individual	Reference to confirming what I already believe, expect, and value at the potential cost of evidence.	• Confirming what I know • Confirming what I believe • Mind made up	
Individual Difference Factors: Factors that "reflect the extent to which members of the organization are cognitively inclined to accept, embrace, and implement a particular change" (Holt & Vardaman, 2013, p. 11).	Change readiness	Individual	Reference to beliefs, attitudes, and intentions regarding the extent to which changes are needed and the organization's capacity to successfully undertake those changes. This can include their inclination to take action in the immediate future, belief that a change is appropriate for the situation, belief that leaders are	• Readiness • Change is needed, • Capacity to change • Appropriate • Action • Commitment • Beneficial • Success • Urgency	Combined the individual difference factors to make one subcode: change readiness. This includes precontemplation and preparation, appropriateness,

Construct	Sub Code	Level	Description	Key Words	Notes
			committed to the success of the change, belief that the change is beneficial to them, and that there is capability to make the change successful.		principal support, change efficacy, and valence.
	Understanding of the problem	Individual Interpersonal Organization Societal	Reference that refers to the extent to which the individual/group/organization is aware the problem exists and values it as a problem. Understanding of the problem is impacted by an individual/group/organizational knowledge, attitudes, and beliefs.	• This is a problem • I think it is a problem • Understand it is a problem	
Structural Factors: Factors that "reflect the extent to which the circumstances under which the change is occurring enhance or inhibit the acceptance and implementation of change" (Holt & Vardaman, 2013, p. 12).	Pilot evidence	Individual Interpersonal Organization	Reference to the strength of the pilot evidence. Delineate whether the respondent is referring to how this impacts decision making at the individual, interpersonal, and organizational levels.	• Pilot works • Good outcomes • Data to prove • Pilot impact	This also includes the converse of these responses (e.g., not sure the pilot works or has an impact)
Affective Components of Change Readiness: Affective reactions capture an individual's "emotions concerning a specific change event" (Rafferty et al., 2013, p.116).	Affective reaction	Individual Interpersonal Organization	Reference to their individual/peer/organizational emotions concerning women Veterans issues and the pilot specifically. At the interpersonal level, reference to gauging emotions about the change against others. Also consider the impact of others' emotions on the groups' collective emotions about the change.	• I feel… • This is personal to me • Importance of women Veterans • My experience • How other people are reacting • How other people are feeling • The impact of how	Combined emotional comparison and emotional contagion in the interpersonal construct.

Construct	Sub Code	Level	Description	Key Words	Notes
				other people are feeling • How other people are reacting	
	Sense of urgency	Individual Interpersonal Organization Societal	Reference to the need to do something about this soon.	• Sense of urgency • Do something about it soon	
Cognitive Beliefs: Individual and group sensemaking process taking place in a social context that is a product of constant and ongoing human production and interaction in organizational settings" (Rafferty et al., 2013) Based on George & Jones, 2001: 421	Group sense-making	Interpersonal Organization	Reference to how the meaning of any change event was created by a negotiation with other members of the group that converged into a collective belief. This may happen when group members have close relationships with others in the group	• This change means to us… • We think • We negotiated • We thought • We have decided • We believe • Shared thoughts • Shared beliefs about the change • Convergence of beliefs • Single-minded	
	Champion	Interpersonal Organization	Reference to key individuals in a social network or organization that played a role in decision making and influenced the likelihood of a program being adopted.	• Champion • Support • Advocate • Opinion leader • Peer leader • Advocate for • Make change • Push decisions	Combined opinion leader and champion. Combined with champion from the leadership construct – organizational level.
Interests and Identities: March notes the political aspects of multiple actor decision making, including	Beliefs	Interpersonal	Reference to beliefs specifically related to interpersonal decision making, particularly beliefs about who wants what, who has power,	• Group interests • Power to decide • Step up	This is different than collective beliefs, the convergence of

Construct	Sub Code	Level	Description	Key Words	Notes
implications of interpersonal inconsistency between different members of the group (March, 1994, p. 110).			and who will act.		beliefs after a group works together for a period of time. This is related specifically to beliefs about who the players are and what they will do to push and advocate for their beliefs.
	Trust and Loyalty	Interpersonal	Reference to trust and loyalty at the interpersonal level of decision making.	• Trust • Honesty • Loyalty • Relationship	
Organizational Characteristics: Sufficient tangible (e.g. funding, reward and incentive systems) and an encouraging intangible environment (i.e. culture and climate) to support implementation (Holt & Vardaman, 2013). Additional organizational factors include size, role specialization, knowledge/skills/expertise, and values. (Aarons et al, 2011).	Organizational size	Organization	Reference to size and resources as a facilitator of innovation adoption, as more expansive organizations may have greater resources to commit.	• Size • Resources • Staff • Funding • Biggest Departments in the federal government	
	Organizational structure	Organization	Reference to the fit of the program with the roles, structure, values, and authority of the organization.	• Organizational roles • Structure • Authority • Hierarchy	
	Organizational culture	Organization	Reference to the values, beliefs, and attitudes shared by members of the organization.	• Values • Beliefs • Attitudes • Culture	
	Risk preference	Organization	Reference to the organization's perception of the risk involved in	• Risk • Uncertainty	This may include the estimate of the

Construct	Sub Code	Level	Description	Key Words	Notes
			adopting the program.	• Trial • Test • Pilot	risk of the decision, the organization's tolerance for risk, and the context in which the risk is taking place.
	Communication	Organization	Reference to the use and impact of communication on the decision-making process.	• Communication • Openness • Information	
Leadership: Leadership is a crucial variable in both creating the organizational culture and climate conducive to adoption of service innovations and in taking ownership of the process of advancing a specific innovative practice (Aarons et al, 2011).	Direction and commitment	Organization	Reference to the role of leadership in conducting strategic activities and leading change. Reference to leadership in generating a shared sense of direction and commitment.	• Shared commitment • Shared direction • Leading change • Strategy	
	Artistry	Organization	Reference to the finesse required of leadership to navigate this complex decision making process. Reference to the balance of many factors involved.	• Leading change • Leading innovation • Dealing with paradigm shifts • Framing issues • Creating dialogue • Understanding context • Managing conflict • Managing tension • Creating meaning • Facilitating organizational	
Organizational readiness for change: Readiness for change refers to organizational members' resolve to implement a	Collective commitment	Organization	Reference to the shared belief and resolve to pursue courses of action that will lead to the decision to adopt the pilot.	• Shared belief • Shared resolve • Commitment • Organizational commitment	Included commitment to change in this subcode.

Construct	Sub Code	Level	Description	Key Words	Notes
change and shared belief in their collective capability to do so (Weiner, 2009).	Motivation	Organization	Reference to the motivation for the change based on the belief that change is needed or that the change is motivated by external pressures.	• Motivation • Belief that change is needed • Change is forced • Outside pressure to change	
	Capacity	Organization	Reference to the capacity of the organization to identify, mobilize, and address the issue.	• Capacity • Means to address the problem • Resources • Ability	
	Climate of change	Organization	Reference to perceptions of which organizational change initiatives are expected, supported, and rewarded.	• Organizational culture • Organizational climate • Expectations • Supported behaviors • Rewarded behaviors	
Politics or political frame: Organizations have to "recognize major constituencies, develop ties to their leadership, and manage conflict as productively as possible" (Bolman & Deal, 2017)	Politics	Organization	Reference to politics, competing for scarce resources, and dealing with a range of people and interests groups with their own agendas.	• Politics • Interest groups • Agenda	
Sociopolitical/Funding: The state and federal sociopolitical and funding contexts influence the program adoption decision (Aarons et al., 2011)	Legislative landmarks	Societal	Reference to laws, policies, or mandates that may impact the decision-making process.	• Legislation • Law • Mandate • Policy	
	Federal and state policy funding	Societal	Reference to federal and state funding to support programs.	• Federal funding • State funding	

Construct	Sub Code	Level	Description	Key Words	Notes
Client Advocacy: Client advocacy, and advocacy on behalf of clients, plays a role in the ultimate decision to adopt innovative service models (Aarons et al., 2011).	National and local-level advocacy	Societal	Reference to advocacy organizations at the national or local levels that can be highly influential in shaping the sociopolitical context that can ultimately determine if models are adopted.	• National organizations • Local organizations • External Advocacy • Lobbying • Women Veterans	
Interorganizational Networks: The extent to which and the impact of information and innovations being transmitted from one organization to another through interorganizational communication pathways (Aarons et al., 2011).	Interorganizational connections	Societal	Reference to interorganizational connections, both private and public sector, including how the organizations relate to, partner with and compete with each other, and how leaders are linked together.	• Links to other organizations • Ties to other organizations • Competition with other organizations • Leader connections • Communication with other organizations	
Understanding of innovation: Approach to explaining how innovation occurs or should be managed (Gutierrez et al., 2008).	Static	Decision-making process	Reference to decision making when information about the program is unambiguous and certain.	• No question about the program • Planning and controlling at the same time • Unambiguous • Certain	Noted in the literature that this is the "ideal of working." The dynamic paradigm "serves as an accepted explanation to mitigate anxiety and frustration when plans cannot be fulfilled."
	Dynamic	Decision-making process	Reference to decision making when the innovation is unpredictable and changes are unavoidable.	• Unpredictable • Change is unavoidable • Reprioritization • Changing plans	Not considered an ideal means for decision making. The dynamic paradigm "serves as an accepted

Construct	Sub Code	Level	Description	Key Words	Notes
					explanation to mitigate anxiety and frustration when plans cannot be fulfilled."
Rationality in means: Choice when making a decision that can either be done using rational analytical procedures or non-rational means (Gutierrez et al., 2008).	Rational	Decision-making process	Reference to rational means of decision making using analytical procedures to arrive at an optimal decision.	• Evidence-informed • Systematic • Rational • Analytical • Objective	Rational means and behaviors were advocated by interviewees as the right way to make decisions.
	Non-Rational	Decision-making process	Reference to non-rational means of decision making when intuition and "gut feelings" are used.	• Intuition • Gut Feelings • Subjective • Non-rational • Partiality • Preliminary development	Non-rational means are sometimes used to reach a certain level of development.
Formalization of Processes: A choice between formal and informal processes for decision making (Gutierrez et al., 2008).	Formal	Decision-making process	Reference to formal decision-making processes with established protocols and rules.	• Formal processes • Traceability • Meeting minutes • Agendas • Presentations • Appointed decision makers • Protocol	
	Informal	Decision-making process	Reference to informal decision-making processes that may be made through unestablished channels and means.	• Informal processes • Not easily traced • Lack of documentation • Early stage of process	Rarely do decisions stay completely informal. Decisions eventually progress to a point where they need to

Construct	Sub Code	Level	Description	Key Words	Notes
					undergo a formal process.
Exercise of power: The organizational hierarchies that participate in the decision making process and the extent to which they influence it. These were categorized as hierarchical or non-hierarchical (Gutierrez et al., 2008).	Hierarchical	Decision-making process	Reference to hierarchical decision making when decisions are made a higher-levels of the hierarchy.	• Hierarchical decision making • Authority • Higher-level of organization • Later development	It is accepted that higher levels of hierarchies should make strategically more important decisions.
	Non-Hierarchical	Decision-making process	Reference to when non-hierarchical means are used to make decisions, where decisions may be made at lower levels of the organization.	• Non-hierarchical decision making • New ideas • Lower-level of organization • Early development	Non-hierarchical decision-making may be made at earlier stages of the process.

Appendix C: Measurement Table

TABLE XXII: MEASUREMENT TABLE

Measurement Table				
Question #1: Describing the process: How was the decision made to adopt this pilot program?				
Key Questions for Analysis and Examination a. What was the chronology of events related to bringing this pilot to fruition through the program adoption decision? b. What processes/protocols were used to make this decision? c. What were the key activities throughout this process? d. What were the turning points?				
Question Alignment	**Constructs**	**Possible Sub Codes**	**Data Collection Approach**	**Analysis**

1
1a
1b
1c
1d
	Chronology and decision making process	• Date (Month, Day, Year)
		• Organization
		• Presentation title
		• Document title
		• Meeting title
		• Participants
		• Agenda
		• Meeting minutes
			• Phase I: Document review
			• Phase II: Interviews (Interview Questions 3-7, including all sub-questions and probes)
				Document Review Analysis
				• Descriptive process of the decision making chronology and processes using an event-listing matrix
				• Document with a priori code categories (e.g., date, organization, presentation title, document title, meeting title)
				Interview Analysis
				• Deductive and inductive thematic analysis with MAXQDA using a priori and emergent codes
				  • Coded text
				  • Code counts (to understand the prevalence of codes to facilitate an understanding of the relationships between constructs)
				  • Summaries by construct
				• Within interview analysis; between interview analysis using MAXQDA visualization tools (i.e., code matrix and code relations browser)
				• Second coder – 10 percent of interview transcripts with multiple rounds until 80 percent agreement is reached

Measurement Table				
				• Organization of findings by research question **Triangulation** • Assess the document review matrix and interview data to examine the similarities and differences discovered using both methods by construct • Synthesize findings and organize under the pertinent constructs and subcodes for research question #1

1
1b
1c
1d
	Understanding of Innovation
	Approach to explaining how innovation occurs or should be managed (Gutierrez et al., 2008).
		• Static (Gutierrez, et al., 2008)
		• Dynamic (Gutierrez, et al., 2008)
			• Phase II: Interviews (Interview Question 7, including all sub-questions and probes)	• Deductive and inductive thematic analysis with MAXQDA using a priori and emergent codes
				  • Coded text
				  • Code counts (to understand the prevalence of codes to facilitate an understanding of the relationships between constructs)
				  • Summaries by construct
				• Within interview analysis; between interview analysis using MAXQDA visualization tools (i.e., code matrix and code relations browser)
				• Second coder – 10 percent of interview transcripts with multiple rounds until 80 percent agreement is reached
				• Organization of findings by research question

1
1b
1c
1d
	Rationality in Means
	Choice when making a decision that can either be done using rational analytical procedures or
		• Rational (Gutierrez, et al., 2008)
		• Non-Rational (Gutierrez, et al., 2008)
			• Phase II: Interviews (Interview Question 7, including all sub-questions and probes)	• Deductive and inductive thematic analysis with MAXQDA using a priori and emergent codes
				  • Coded text
				  • Code counts (to understand the prevalence of codes to facilitate an understanding of the relationships between constructs)
				  • Summaries by construct
				• Within interview analysis; between interview analysis using MAXQDA visualization tools (i.e., code matrix and code relations

Measurement Table				
	non-rational means (Gutierrez et al., 2008).			browser) • Second coder – 10 percent of interview transcripts with multiple rounds until 80 percent agreement is reached • Organization of findings by research question

1
1b
1c
1d
	Formalization of Processes
	A choice between formal and informal processes for decision making (Gutierrez et al., 2008).
		• Formal (Gutierrez, et al., 2008)
		• Informal (Gutierrez, et al., 2008)
			• Phase II: Interviews (Interview Question 7, including all sub-questions and probes)	• Deductive and inductive thematic analysis with MAXQDA using a priori and emergent codes
				  • Coded text
				  • Code counts (to understand the prevalence of codes to facilitate an understanding of the relationships between constructs)
				  • Summaries by construct
				• Within interview analysis; between interview analysis using MAXQDA visualization tools (i.e., code matrix and code relations browser)
				• Second coder – 10 percent of interview transcripts with multiple rounds until 80 percent agreement is reached
				• Organization of findings by research question

1
1b
1c
1d
	Exercise of Power
	The organizational hierarchies that participate in the decision making process and the extent to which they influence it. These were categorized as hierarchical or
		• Hierarchical (Gutierrez, et al., 2008)
		• Non-Hierarchical (Gutierrez, et al., 2008)
			• Phase II: Interviews (Interview Question 7, including all sub-questions and probes)	• Deductive and inductive thematic analysis with MAXQDA using a priori and emergent codes
				  • Coded text
				  • Code counts (to understand the prevalence of codes to facilitate an understanding of the relationships between constructs)
				  • Summaries by construct
				• Within interview analysis; between interview analysis using MAXQDA visualization tools (i.e., code matrix and code relations browser)
				• Second coder – 10 percent of interview transcripts with multiple rounds until 80 percent agreement is reached

Measurement Table				
	non-hierarchical (Gutierrez et al., 2008).			• Organization of findings by research question
Question #2: Decision-making factors: What decision-making factors affected the program adoption decision?				
Key Questions for Analysis and Examination a. What individual-level factors impacted the decision to make this pilot a permanent program? b. What interpersonal-level factors impacted the decision to make this pilot a permanent program? c. What organizational-level factors impacted the decision to make this pilot a permanent program? a. What role did the pilot evidence play in the decision-making process? d. What societal/policy-level factors impacted the decision to make this pilot a permanent program?				
RQ	**Study domains and areas of inquiry**	**Constructs and Possible Sub Codes**	**Data Collection Approach**	**Analysis**
2a	**Individual Level** Characteristics of an individual (intrinsic and extrinsic) that will ultimately impact their decision-making behaviors (UNICEF, n.d.)	• Biological Factors (March, 1994) • Processing capacity (Foss & Webber, 2016) • Cognitive economizing (Foss & Webber, 2016) • Cognitive biases (Foss & Webber, 2016) • Individual Difference Factors • Change readiness (Rafferty et al., 2013) • Understanding of the problem (Castaneda et al., 2012) • Structural Factors • Pilot evidence (Turner et al., 2017) • Knowledge, skills, and ability alignment (Holt &	• Phase II: Interviews (Interview Questions 8a and 10-11, including probes)	• Deductive and inductive thematic analysis with MAXQDA using a priori and emergent codes • Coded text • Code counts (to understand the prevalence of codes to facilitate an understanding of the relationships between constructs) • Summaries by construct • Within interview analysis; between interview analysis using MAXQDA visualization tools (i.e., code matrix and code relations browser) • Second coder – 10 percent of interview transcripts with multiple rounds until 80 percent agreement is reached • Organization of findings by research question

Measurement Table				

		Vardaman, 2013)
		• Affective Components of Change Readiness
		  • Affective reaction (Rafferty et al., 2013)
		  • Sense of urgency (Holt & Vardaman, 2013)		

2b	**Interpersonal Level**
	Includes the formal (and informal) social networks and peer support systems that can influence decision making, including family, friends, peers, co-workers, customs, or traditions (UNICEF, n.d.)
		• Cognitive Beliefs (Rafferty et al., 2013)
		  • Group sense-making (Rafferty et al., 2013)
		  • Champion (Greenhalgh, 2004)
		  • Understanding of the problem (Castaneda et al., 2012)
		• Affective Responses (Rafferty, 2013)
		  • Affective reaction (Rafferty et al., 2013)
		  • Sense of urgency (Holt & Vardaman, 2013)
		• Interests and Identities (March, 1994)
		  • Beliefs (March, 1994)
		  • Trust and loyalty (March, 1994)
			• Phase II: Interviews (Interview Questions 8b and 10-11, including probes)	• Deductive and inductive thematic analysis with MAXQDA using a priori and emergent codes
				  • Coded text
				  • Code counts (to understand the prevalence of codes to facilitate an understanding of the relationships between constructs)
				  • Summaries by construct
				• Within interview analysis; between interview analysis using MAXQDA visualization tools (i.e., code matrix and code relations browser)
				• Second coder – 10 percent of interview transcripts with multiple rounds until 80 percent agreement is reached
				• Organization of findings by research question

2c	**Organizational Level**
	Organizations or institutions with rules and regulations for operations that
		• Organizational Characteristics (Aarons et al, 2011)
		  • Size (Aarons et al., 2011)
		  • Organizational structure (Aarons et al., 2011)
		  • Organizational culture (Weiner, 2009)
			• Phase II: Interviews (Interview Questions 8c-g and 10-11, including all sub-questions	• Deductive and inductive thematic analysis with MAXQDA using a priori and emergent codes
				  • Coded text
				  • Code counts (to understand the prevalence of codes to facilitate an understanding of the relationships between constructs)
				  • Summaries by construct

Measurement Table				
	affect how or how well services are provided to an individual or group (UNICEF, n.d.).	• Risk Preference (March, 1994) • Communication (Greenhalgh, 2004) • Leadership (Aarons et al, 2011) • Champion (Aarons et al., 2011) • Direction and Commitment (Bolman & Deal, 2017) • Artistry (Bolman & Deal, 2017) • Organizational Readiness for Change • Collective Commitment (Holt & Vardaman, 2013) • Motivation (Castaneda et al., 2012) • Capacity (Castaneda et al., 2012) • Cognitive beliefs (Rafferty, 2013) • Affective responses (Rafferty, 2013) • Climate of change (Bouckenooghe, 2009) • Politics or Political Frame (Bolman & Deal, 2017) • Politics (Bolman & Deal, 2017)	and probes)	• Within interview analysis; between interview analysis using MAXQDA visualization tools (i.e., code matrix and code relations browser) • Second coder – 10 percent of interview transcripts with multiple rounds until 80 percent agreement is reached • Organization of findings by research question
2d	**Societal Level** Local, state, national, and global factors	• Sociopolitical/Funding (Aarons et al., 2011) • Legislative landmarks (Aarons et al., 2011)	• Phase II: Interviews (Interview Questions 8h	• Deductive and inductive thematic analysis with MAXQDA using a priori and emergent codes • Coded text • Code counts (to understand the prevalence

Measurement Table				

	that impact decision making (UNICEF, n.d.)	• Federal and state policy funding (Aarons et al., 2011)
		• Client Advocacy (Aarons et al., 2011)
		  • National and local-level advocacy (Aarons et al., 2011)
		• Interorganizational Networks (Aarons et al., 2011)
		  • Interorganizational connections (Aarons et al., 2011)
			and 10-11, including probes)	of codes to facilitate an understanding of the relationships between constructs)
				  • Summaries by construct
				• Within interview analysis; between interview analysis using MAXQDA visualization tools (i.e., code matrix and code relations browser)
				• Second coder – 10 percent of interview transcripts with multiple rounds until 80 percent agreement is reached
				• Organization of findings by research question

Research Question #3: Future state: What will happen next?				
Key Questions for Analysis and Examination a. What do these findings suggest about program adoption decision making within VA and among federal government agencies more broadly? b. How can this knowledge of decision-making processes inform future implementations?				
RQ Alignment	**Study domains and areas of inquiry**	**Possible Sub Codes**	**Data Collection Approach**	**Analysis**

3
3a
3b
	Use constructs and sub codes from RQs #1 & 2
	Document emergent codes and define in codebook
			• Phase III: Focus group session using ORID framework with pilot stakeholders and decision makers	• Deductive and inductive thematic analysis with MAXQDA using a priori and emergent codes
				  • Coded text
				  • Summaries by construct
				• Organization of findings by research question

Appendix D: A Priori Sampling Plan

TABLE XXIII: A PRIORI SAMPLING PLAN

Level	Entity	Interviewee Roles	Min	Max
Interagency	TAIWG	DoD and VA leadership (SES-level)	2	3
	SSG	DoD, VA, and DoL leadership (SES-level)	2	3
	JEC	DoD and VA leadership (Political appointees)	0	2
	HEC WHWG	DoD and VA leadership (Political appointees)	0	2
Department/ Administration	DoD - TVPO	GS-employees (13-15)	2	4
	VHA – Office of Women's Health Services	GS-employees (13-15)	3	7
	Veterans Business Administration	GS-employees (13-15)	1	2
Service	DoD - US Air Force Women's Initiative Team	GS-employees (11-15)	3	5
	Service-level TAP, including non-pilot participants (i.e., Army, Navy, Marines)	GS-employees (13-15)	2	4
	Military Secretary Offices – Military Readiness & Reserves	DoD and VA leadership (SES-level)	2	4
Base/Local Level	DoD – MWR	GS-employees (11-13)	1	2
External Entities	Congressional Caucus for Women's Issues	House of Representatives members	1	2
	House Committee on Veteran's Affairs	Congressional representatives	1	2
	DACOWITS	Civilian members (various ranks)	2	3
	VA – ACWV	Civilian members (various ranks)	2	3
	Service Women's Action Network (SWAN)	Member-driven community network	2	3
Potential interview range			26	51

Appendix E: VHA Letter of Support

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
810 Vermont Avenue, NW
Washington DC 20420

In Reply Refer To: 10P4W

September 10, 2019

Office for the Protection of Research Subjects
Office of the Vice Chancellor for Research
University of Illinois at Chicago
1737 West Polk Street, Suite 310
Chicago, IL 60612

To Whom It May Concern,

As Chief Consultant for Women's Health Services in the Office of Patient Care Services for the Department of Veterans Affairs, I am writing to express my support for the dissertation project being conducted by Kelly Sanders, a University of Illinois at Chicago School of Public Health (UIC SPH) Doctor of Public Health student.

Ms. Sanders's dissertation project titled, "Understanding Program Adoption Decision Making via the VHA Women's Health Transition Pilot: A Retrospective Qualitative Study," will examine the decision-making processes and factors involved in the progression of the Veterans Health Administration (VHA) Women's Health Transition Pilot to a permanent program. Her three primary project aims are to:

- Understand and describe the program adoption decision-making process related to the VHA Women's Health Services Transition Training pilot becoming a permanent program
- Understand the decision-making factors that contributed to the pilot becoming a permanent program
- Understand and describe the implications of the research findings for future program adoption decision making within VA

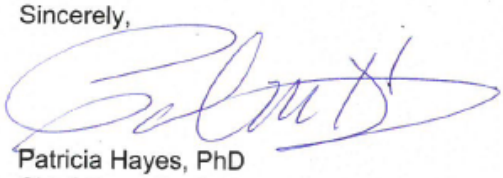
This project will help the U.S. Departments of Veterans Affairs and Defense understand and make explicit the decision-making processes and factors that were employed to successfully implement this pilot as a permanent program. The research findings will help the U.S. Departments of Veterans Affairs and Defense replicate successful methods for future program implementations.

It is our understanding that Ms. Sanders will be conducting a document review to understand the chronology of decision-making events related to the VHA Women's Health Transition pilot process. She will also conduct interviews and a focus group with decision makers and pilot implementers to understand the decision-making processes

and factors that influenced this pilot becoming a permanent program. We understand that Ms. Sanders has been trained in these methods and that she successfully defended her dissertation proposal on July 19, 2019.

Dr. Nancy Maher, Project Manager of the Women's Health Transition Pilot, will have a limited role in connecting Ms. Sanders with potential interviewees and providing her with pertinent documents for the document review. According to VA's research designation protocol, the proposed dissertation is considered non-research for the purposes of quality improvement; however, I am assured that Ms. Sanders will conduct this project in a manner consistent with the ethical standards of human subjects research (e.g., interview data will be kept separate from participant contact information and all interview and focus group participants will be made aware that their participation is voluntary). This letter serves as documentation of my support for Kelly Sanders to conduct this dissertation project.

Sincerely,



Patricia Hayes, PhD
Chief Consultant
Department of Veterans Affairs, Office of Patient Care Services, Women's Health Services
810 Vermont Ave. NW
Washington, DC 20420

Appendix F: Interviewee Recruitment Letter

Dear [*insert name*],

My name is Kelly Sanders and I am a student from the Doctor of Public Health program at the University of Illinois-Chicago. I am writing to invite you to participate in my research study about how the decision was made to adopt the VHA Women's Health Transition Training pilot as a permanent program. You're eligible to be in this study because you [*insert description*]. I obtained your contact information from [*describe source*].

If you decide to participate in this study, you will be asked to participate in a one-hour interview. I would like to audio record your interview and then I'll use the information to complete my dissertation research. No statements will be directly attributed to you and all of your responses will be deidentified.

Your participation is completely voluntary. You can choose to be in the study or not. If you'd like to participate or have any questions about the study, please email or contact me at ksande27@uic.edu.

Thank you very much.

Sincerely,

Kelly Sanders

Appendix G: Interview Informed Consent Form

Consent for Participation in Interview

I volunteer to participate in a dissertation project conducted by Ms. Kelly Sanders, a doctoral student from the University of Illinois at Chicago. I understand that the project is gathering information from VHA Women's Health Transition Training pilot stakeholders and decision makers to understand how the decision was made and what factors impacted the decision to adopt the pilot as a permanent program. It's anticipated that 15-20 participants total will be interviewed for this project.

1. My participation in this project is voluntary. I am not being compensated for my participation. No one in my organization will be told whether I participate in this interview.
2. I may choose how much or how little I want to say. I may choose to stop the interview at any time without any repercussions. If I feel uncomfortable at any time during the interview, I have the right to decline to answer any question or to end the interview.
3. Participation includes being interviewed by Ms. Kelly Sanders. The interview will last 60 minutes and will be audio recorded in order to accurately capture my responses. I may request the recording be paused at any time. Audio recordings and subsequent typed transcripts will only be viewed and heard by the primary researcher and will be stored on a password protected computer.
4. All responses will be aggregated to protect participants' confidentiality. I understand that in the dissertation report, my identity will remain anonymous and details of the interview that may reveal my identity will be excluded. However, disguised extracts from my interview may be included in the dissertation report.
5. There are no anticipated risks for participating in this project. However, there is always the possibility of a breach of privacy. The Principal Investigator is following protocol to minimize risk by keeping files password protected and keeping interviewee contact information in a separate database from deidentified interview transcripts.
6. This research has been reviewed and deemed non-research by the University of Illinois at Chicago Institutional Review Board. However, best practices of Studies Involving Human Subjects will be upheld.
7. I have been given a copy of this consent form.

I have read the consent form and understand that the interview will be recorded. I agree to participate in this project.

Appendix H: Focus Group Participant Form

Consent for Participation in a Focus Group

Purpose

You have been invited to participate in a focus group as part of Ms. Kelly Sanders's dissertation project, a doctoral student from the University of Illinois at Chicago. You have been selected based on your role in the VHA Women's Health Transition Training pilot. The purpose of the focus group is to primarily understand the leadership implications of the study findings and how these findings may inform future decision-making efforts. The secondary purpose is to assess how well the findings of the project resonate with pilot stakeholders (member checking).

Procedure

You will be in a group of 4-5 participants during this 90 minute focus group. Ms. Sanders, the principal investigator, will commence the focus group with a presentation of key study findings and the latter part of the focus group will be facilitated using the ORID (Objective, Reflective, Interpretative, and Decisional) method. The ORID method will help guide a discussion around the participants' understanding of the findings, reflections on the findings, interpretation of the findings to uncover deeper meanings, and how these findings may impact future decision-making processes.

This dissertation project has been reviewed and deemed non-research by the University of Illinois at Chicago Institutional Review Board. However, best practices of Studies Involving Human Subjects will be upheld.

Participation in this group is voluntary. You may stop at any time during the course of the discussion. The focus group will be audio-recorded in order to accurately capture what is said. You may request that the recording is paused at any time. Audio recordings and subsequent typed transcripts will only be viewed and heard by the primary researcher and will be stored on a password protected computer. Your responses will remain confidential, and no names will be included in the final report.

You may choose how much or how little you speak during the group. There are no right or wrong answers. Your viewpoint is important and your honesty is encouraged, even when your responses may be different from other participants.

Benefits and Risks

Participating in this study may not benefit you directly, but it will help Ms. Sanders learn about decision-making processes related to this pilot. You will not be compensated for your participation. There are no anticipated risks for participating in this project. However, there is always the possibility of a breach of privacy, particularly since the principal investigator cannot control what is discussed by participants outside of the focus group forum. The principal investigator is following protocol to minimize risk by keeping files password protected and keeping interviewee contact information in a separate database from deidentified interview transcripts.

Confidentiality

The principal investigator and the other participants in the focus group are the only people that will know about your participation. Should you choose to participate, you will be asked to respect the privacy of other focus group members by not disclosing any content discussed during the discussion. The principal investigator will be the only one to view and analyze the data. In the dissertation report, your identity will

remain anonymous and details of the interview that may reveal your identity will be excluded. However, disguised extracts from your interview may be included in the dissertation report.

I have read the consent form and understand that the focus group will be recorded. I agree to participate in this project.

Appendix I: Focus Group Guide - ORID Framework

Introduction

Thank you for participating in this focus group about decision making for the VHA Women's Transition Pilot. I am interested in your input on the impact of these findings and what this means for both VA and DoD.

I would like to record the focus group if it's OK with you. Your name will not be used in any reporting and none of your responses during this focus group will be released in a form that identifies you. Your participation is voluntary; we can stop this focus group at any time. I anticipate this focus group will take 1.5-2 hours. Do you have any questions before we begin?

[Presentation of key findings – 30-40 minutes]

Objective: Facts and Reality

- How do these findings reflect what happened?

Reflective: Draw Connections

- What did you find new or surprising about these findings?
- What is positive from the findings?
- What feels challenging about the findings?
- What resonated with you?
- How representative was this situation of a decision-making process compared to other decisions you've made?

Interpretative: Uncover Deeper Meanings

- What did you learn from these findings?
    - What insights have we unearthed?
- What more would be useful to know?
- What would you change about the pilot if you could go back?

Decisional: Lead to Actions

- What recommendations can be made to improve decision making in the future?
- What skills or resources are needed to make these changes?

Appendix J: Event-Listing Matrix Data Points

TABLE XXIV: EVENT-LISTING MATRIX DATA POINTS

Data Point	Definition	Example
Date	Date of the document	12/06/2018
Title	Title of the document	VA-USAIR FORCE Women's Health Transition Training Pilot
Purpose	Purpose of the document	Update the TAIWG on pilot progress
Location	Location of the document/presentation, if applicable	Washington, DC – In-person meeting
Authors	Creator(s) of the content	Air Force Women's Initiative Team, VA Women's Health Services
Audience	Intended audience of the document	TAIWG Members
Format	Document format	PowerPoint presentation
Content	Key contents of the document	-Women's Health Transition Training Pilot Background (What do we know from the research? What is the root of the problem? How can we address this problem? -Training content overview (Phase 1- Phase 5) -Current pilot locations & workshop schedule -Current pilot results (pre-test vs. post-test scores) -Women's Health Transition Learning Session Feedback -Women's Health Training Virtual Classroom -Participant testimonials - why would you recommend this course to others? (Think this was a video)

Appendix K: Chronology Matrix Definitions

TABLE XXV: CHRONOLOGY MATRIX DEFINITIONS

Document Review Content	Definition
Title	Document title (verbatim as specified on the document reviewed)
Date	Document date (In some cases, no document date was provided in the actual document, but it was indicated in the title of the presentation or confirmed in an email with Major Alea Nadeem or Dr. Nancy Maher)
Type	Document audience type (Four drop-down options: Decision-maker, Implementer, Influencer, or Media)
Audience	Name of the audience of the document (e.g., HVAC, SVAC, VFW) or in some cases, the author of the document if it was not the VA/DoD implementers (e.g., DACOWITS, DAV)
Format	Type of document reviewed (e.g., presentation, meeting minutes, online article, written business proposal)
Idea for Pilot	References to a potential pilot, but as a more abstract concept and prior to actual pilot development and implementation
DoD/VA Collaboration "Hot Hand Off"	References to the collaboration between VA and DoD. Sometimes specific language that refers to the "hot hand off" between DoD and VA.
Addressing a gap/expressed need in programming	References to how current programming does not meet the unique needs of women Veterans
Pilot background	References to how the pilot came to be. This is in many presentations the "Women's Health Transition Learning Session Background" and may include "what do we know from the research? What is the root of the problem? How can we address this problem?"
Research findings/citations	References to studies conducted internal to VA or published in peer-reviewed journal articles that substantiate the problem statement and current gaps in programming
Problem statement	References to the health challenges that women Veterans face that served as the impetus for the pilot (e.g., rising suicide rates, mental health challenges, musculoskeletal issues). This does not include barriers to care.
Pilot goals/objectives	References to what the pilot is trying to accomplish. Sometimes explicitly noted as goals and objectives.
Performance measures	References to desired outcomes for the pilot
Project sustainment plan	References to how the project will be sustained beyond the pilot period
JIF funding	References to JIF as a funding source for the pilot
Key players	References to the key players and champions involved in the pilot

Document Review Content	Definition
	development
Theory of change	References to how the pilot will impact enrollment in VHA benefits and subsequently improve women's health (and potentially decrease suicide rates). These are references that associate a cause and effect relationship between these variables.
Training content overview	References to the content of the pilot training. This is often explicitly listed on slides as "Training Content Overview."
Barriers to care	References to barriers to care for women Veterans. This is differentiated from the problem statement in that these are external barriers to care and are typically explicitly called out as barriers to care.
Pilot overview	References to structure of the pilot session, including references to the morning and afternoon sessions.
Pilot locations & schedule	References to pilot locations (current, former, or future) and schedule with upcoming or past dates.
Changes to program	References to changes in the program that were made as a result of participant feedback in the formation phase of the pilot (human-centered design process).
Data collection methods	References to how the pilot data was collected (methodology). Often will include references to the pre and post-tests and the pilot questionnaire.
Pilot feedback trends	References to how the pilot feedback has trended over time. This is often explicitly listed on slides as "Pilot Feedback Trends."
Overall course feedback	References to overall course feedback that is not directly tied to the pre and post tests. This will often include data derived from the questionnaire.
Pilot results (pre and post)	References to the pre- and post-test results of the pilot evaluation.
Knowledge check questions	References to the responses received on the knowledge check questions of the pilot evaluation.
Mental health questions	References to the responses received on the mental health questions of the pilot evaluation.
Virtual classroom	References to the development of the virtual classroom to conduct future sessions. This is often explicitly listed on slides as "Virtual Classroom."
Participant quotes/testimonial	References to participant quotes and experiences with the pilot.
Next steps	References to future activities or events related to the pilot.
Pilot timeline	References to the pilot timeline, both past and present. This is often explicitly listed on slides as "Pilot Timeline."
Videos	Placeholders for videos that were shared with meeting participants. This is only applicable to PowerPoint presentations.

Document Review Content	Definition
Administrator quotes	References to quotes from pilot administrators (e.g., US Air Force Women's Initiative Team, VHA Women's Health, Women's Health Program Managers). These are typically included in media outlets.
Women's health services available at VHA	References to the women's health services available at VHA. This is often explicitly listed on slides as "Women's Health Services Available at VHA."
Request (e.g., participation, resources)	References to a request being made of the audience. This may include an appeal to the other military services to participate or a request for additional resources to support the pilot.
Participant recruitment	References to site locations and contact information that is provided for the intent of recruiting session participants.
Funding	References to funding or money related to the pilot, whether it is inquires about sustained funding or requests for funding from the pilot implementers.
Recommendations	References to recommendations for the future of the pilot. Recommendations may have been made by pilot implementers or on behalf of the pilot (e.g., DACOWITS).
Evidence-based (best practice)	References to the pilot being evidence-based or a best practice.
NDAA alignment	References to the alignment of the pilot to the 2019 NDAA.
Expansion to other services	References to the pilot being expanded beyond the Air Force into other military service branches.
Women's Health Pilot Update	References to women's health pilot updates since a prior briefing. In many presentations, this is referred to specifically as "Women's Health Pilot Update."
Pilot benefits and long-term outcomes	References to the projected pilot benefits and long-term outcomes. This is differentiated from the pilot goals/objectives because this is specifically focused on longer-term outcomes.
Legislation	References to legislation released in support of the pilot.
VA enrollment	References to the pilot's impact on women Veterans' VHA enrollment.

Appendix L: Revised Codebook

TABLE XXVI: REVISED CODEBOOK

Code	Memo	Examples
Stakeholder Group		
Stakeholder Group\Influencer	Code this in direct response to the question, "What is your current position/job title?" Code when an individual was part of a Veteran Service Organization, VA/DoD Advisory Body, or Congress. This may include SWAN, VFW, Congress, DACOWITS, or ACWV.	
Stakeholder Group\Implementer	Code this in direct response to the question, "What is your current position/job title?" Code when an interviewee was part of the team that helped start and implement the pilot.	
Stakeholder Group\Decision Maker	Code this in direct response to the question, "What is your current position/job title?" Code when an interviewee had a role in one of the decision-making bodies. This would include the TAIWG, SSG, HEC, or JEC.	
Background		
Background\Job Title	Code this in direct response to the question, "What is your current position/job title?" Code when there is a reference to an individual's job role, title, or position. Code with a stakeholder group (i.e., influencer, implementer, decision maker)	
Background\Connection to Transition	Code this in direct response to the question, "How are you connected to the military to civilian transition process in that role?"	
Background\Pilot Involvement	Code this in direct response to the question, "What is your role related to the VA Women's Health Transition Training Program?"	

Code	Memo	Examples
Background\Pilot Development	Code this when an interviewee is talking about how the pilot came about and processes that were involved to get it off the ground.	
Background\Pilot Need	Code this in direct response to the question, "What need was this pilot trying to address?"	
Background\Comparison to other Implementation Efforts	Code this in direct response to the question, "Have you ever been part of a committee making a decision on a pilot? If so, how did this experience compare?" Code this when an interviewee discusses how this pilot implementation and decision making process was either similar to our different from previous implementation experiences.	
Background\Pilot Expectations	Code this in direct response to the question, "What would it look like if this program is successful in 3, 5, or 10 years?" Reference to what they hope or expect from the pilot as either short-term or long-term outcomes.	
Background\Context	Code when there is helpful background context that better explain the organization/entity/committee structure.	"So the committee, like I said, is a Federal Advisory Committee. It works for the pleasure of the Secretary of Defense. The mission of the committee is to review policies and procedures that impact women serving in the areas of recruitment and retention, employment and integration, wellbeing and treatment. And so each year the committee's given specific topics to kind of do a deep dive into for the SecDef, and they review the policies, they talk to service members, they talk to senior leaders throughout the Department of Defense to review those policies and get some perspective. And they make

Code	Memo	Examples
		recommendations to the Secretary of Defense on areas that could be improved to enhance the service of women."
Phase		
Phase\Pilot Exploration & Approval	Reference to dates and events that occurred prior to January 2017. Code with the other decision-making codes (e.g., formalization of processes, hierarchical processes, rationality in means), when applicable. Also code with stakeholder group (i.e., decision maker, implementer, or influencer).	
Phase\Pilot Implementation	Reference to dates and events that occurred on those dates for the period from January 2017 - approximately May 2019. Code with the other decision-making codes (e.g., formalization of processes, hierarchical processes, rationality in means), when applicable. Also code with stakeholder group (i.e., decision maker, implementer, or influencer).	
Phase\Pilot Adoption Decision	Reference to dates and events that occurred on those dates during the May 2019 - June 2019 period. Code with the other decision-making codes (e.g., formalization of processes, hierarchical processes, rationality in means), when applicable. Also code with stakeholder group (i.e., decision maker, implementer, or influencer).	
Decision Making		
Decision Making\Formalization of Processes	Code this when references are made to the level of formality related to the process. This may include formal decision making, which would include references to formal decision-making processes with established protocols and rules. Conversely, this may include informal decision making processes that may include	"Well, the JEC was the one that formally approved it as a permanent program in June of 19. But my understanding was it was the SSG, which is the senior steering group with DoD."

Code	Memo	Examples
	references to informal decision-making processes that may be made through unestablished channels and means. Also code as Stakeholder Group\Implementer, Decision Maker, or Influencer to delineate what type of process was applied within those groups.	
Decision Making\Hierarchical Processes	Code this when references are made to different decisions being made my different committees and decision making bodies. This may include hierarchical decision making, which would include references to when decisions are made at higher-levels of the hierarchy (or progress up the different levels of the hierarchy). Conversely, this may include non-hierarchical means to make decisions, the hierarchy is not heeded or bypassed in the decision making process.	"Rather than me make the final decision, why don't we bring it to, first I think people wanted to bring it to JEC. The JEC said, no, we're not ready to hear this. Why don't you just decide this at the SSG level? And so she said, let's bring it to the SSG because she didn't think it was going to move forward. She thought that was going to be the, they were going to decide not to move it forward. And so we did, and to her surprise, but I think we expected it. We got support to start developing the pilot."

Code	Memo	Examples
Decision Making\Rationality in Means	Code this when references are made to how the decision was made and what bases the decisions were made. This may include references to rational means of decision making using analytical procedures to arrive at an optimal decision. Conversely, this may include references to non-rational means of decision making when intuition and “gut feelings” are used.	"So I was on this interagency workgroup and we had brought together a number of different branches of DoD and a number of different kind of programs in VA that worked on women’s veteran issues. So we had social work, we had us, we had nursing, we had a number of different programs and we would sit around and we would, sit around, we would be on conference calls and talk about ways to improve women's experiences, both in military and VA, and how to share data and what kind of projects to focus on. And this kind of inter agency work group took the reports from the Center for Women Veterans, to help us kind of identify what gaps should be focused on. We had a pretty large inter agency, collaborative session, months before the pilot."
Decision Making\Key Juncture	Code in direct response to the question, "What were some key junctures in the pilot process?" Reference to a significant event that was key to the decision-making process.	"I think one key thing that happened was that we got an article in an Air Force publication about the training that generated a lot of interest not just from servicewomen, but you know, stakeholders, like Congress and advocacy groups. And then I know that around that time. Oh, we had presented this pilot to DACOWITS and they came out in support of it."
Decision Making\Process	Code when decision-making processes are referenced and they don't fit into the types of decision buckets.	
Decision Making\Resistance	Code when resistance or opposition was faced. If the resistance is aligned to a particular factor, code with the	"Yeah, they were not fully supportive. For a long time, I mean, basically till I left mostly

Code	Memo	Examples
	factor.	because they, the position that they took was like the TAP program is universal for all military personnel. And they don't want to create separate TAP programs for you know, if they do this for women, do they have to do it for African Americans and for transgender and for MSM? Or, like do they need to do special TAP programs for every demographic?"
SEM Level		
Individual	Code when referring to factors at the individual, or personal level that may have influenced support of the pilot. This should be coded in addition to the factor if the SEM level is evident from the passage (e.g., individual, affective reaction).	
Interpersonal	Code when referring to factors at the interpersonal, or small group level that may have influenced support of the pilot. This may include smaller entities within the larger organizations. This should be coded in addition to the factor if the SEM level is evident from the passage (e.g., interpersonal, trust and loyalty).	
Organizational	Code when referring to factors at the organizational level that may have influenced support of the pilot. This will include references to VA and DoD. This should be coded in addition to the factor if the SEM level is evident from the passage (e.g., organizational, organizational characteristics).	
Societal	Code when referring to factors outside of the organizations that may have influenced support of the pilot. This would include Veteran Service Organizations, Congress, and broader societal movements. This should	

Code	Memo	Examples
	be coded in addition to the factor if the SEM level is evident from the passage (e.g., societal, women in positions of influence)	
Factors		
Factors\Pilot Data	Code when referring to early signs of success or pilot data as factors for why this pilot was adopted as a permanent program. Reference to the strength of the pilot evidence. Code with SEM level if it's evident from the passage. Code with the timeline phase, as well, if evident (e.g., timeline\pre-pilot).	"Well, what was most important was the data and the initiative owners were really good about not just testing this initiative, but making sure that they were collecting data both from a qualitative and a quantitative standpoint."
Factors\Senior Leader Support	Code when someone makes reference to a senior leader specifically, by name, or refers to senior leaders more generally. Code with SEM level if it's evident from the passage; this will likely be coded with the organizational SEM level.	"And so, but we knew we had support from leadership at the top level. So we had to make a decision that we needed to get this in front of senior leaders to formally say yes and in front of everybody, so that we could continue to move on. So we made the decision to go ahead and pursue that. And so we pursued that."
Factors\Buy In	Code when references are made to this being an iterative process and that incorporating different stakeholder feedback was important to achieving stakeholder buy in. Code with SEM level if it's evident from the passage; this will likely be interpersonal or organizational. Code with the timeline phase, as well, if evident (e.g., timeline\pre-pilot).	

Code	Memo	Examples
Factors\Grassroots	Code when references are made to this being a grassroots effort or being a unique initiative in that it was not a top-down dictated program.	"I think it was different for me personally, in that it, you know, it came specifically from VHA and Air Force working together kind of at the grassroots, which was really kind of cool. A lot of times these initiatives don't start grassroots, they start more at the senior level and get sort of directed. So this one was kind of cool in that it was really grassroots."
Factors\Collaboration	Code when there are references to the effectiveness of collaboration. This may be intraagency (e.g., between VHA and VBA) or interagency (e.g., between VA and Air Force). Code with SEM level if it's evident from the passage; this will likely be organizational. Code with the timeline phase, as well, if evident (e.g., timeline\pre-pilot).	"You know, we've partnered with a different agency. You know, and that that was powerful in itself, the fact that two agencies came together and said, there's a need for this. So we sort of used that as our advantage. Not only do we have personal stories, we have two powerful agencies coming together and saying that there's a need for this. "
Factors\Champion	Code when there are references to a champion or someone who supported and encouraged the development and implementation of this pilot. This may include references to mid-level or senior leaders. Code with SEM level if it's evident from the passage; this will likely be interpersonal or organizational. Code with the timeline phase, as well, if evident (e.g., timeline\pre-pilot).	"Hey, I'm thinking about, you know, doing something sort of in this space with transition for women and she was very, very supportive. And basically, gave me the green light she kind of said, you know, dream as big as you want, until people start telling you no, you know, keep going."

Code	Memo	Examples
Factors\Resources	Code when there are references to staff or funding related to the pilot. Code with SEM level if it's evident from the passage; this will likely be organizational or societal. Code with the timeline phase, as well, if evident (e.g., timeline\pre-pilot).	"We pursued joint incentive funds, VA DoD joint incentive funds, but they were unable to disperse any money that year. So women's health services came up with the money near the end of the fiscal year in 2017, and we were able to get a contract through to develop the curriculum, and the contractor that won was the Small Business contractor higher echelon, they subcontracted to Deloitte. And we started in earnest."
Factors\Understanding of the Need	Reference to the extent to which the individual/group/organization is aware the issue exists and values it as a problem. This may include references to challenges faced in the transition process, women Veterans, suicide, homelessness, employment, and VA utilization (including barriers to care). Code with SEM level if it's evident from the passage; this may be individual, interpersonal, organizational, or societal. Code with the timeline phase, as well, if evident (e.g., timeline\pre-pilot).	"So as I mentioned, we know that women have specific challenges sometimes when leaving the services We know that women tend to acknowledge their veteran status less than men, and they tend to take less advantage of the benefits is what we're finding. And so this pilot, I think, is intended to capture women while they're still serving and make them aware of what benefits are available to them specifically to meet some of their needs, especially as it pertains to health. So there are some unique challenges that we find that women experience while serving, and then that transition period."
Factors\Navigating Bureaucracy	Reference to using practical knowledge of how multiple organizations work and savvy to push forward an agenda. This should also include the time-speed of implementation that was noted about the pilot. Code with SEM level if it's evident from the passage; this will likely be organizational. Code with the timeline phase, as well, if evident (e.g., timeline\pre-pilot).	"And so it, sometimes it would be more advantageous to go through the VA on certain issues. Sometimes it would be more advantageous to go to the DoD or Air Force, you know, so we always kind of had to figure out okay, where's our least resistance or our best possible path and we kind of

Code	Memo	Examples
		would, you know I think VA may be easier on this one. So we would go with the VA, right?"
Factors\Readiness for Change	References to organizational members' resolve to implement a change and shared belief in their collective capability to do so. Include the subfactors of collective commitment (shared belief and resolve to do something), motivation (belief that change is needed or external pressure), capacity, and climate of change. Code with SEM level if it's evident from the passage; this will likely be interpersonal, organizational, or societal. Code with the timeline phase, as well, if evident (e.g., timeline\pre-pilot).	"I mean, again, when you're an active duty, all we're considering, or we're looking at is, what is my role right now in this organization? I think the DOD has a huge challenge right now to say, and this is all veterans and issues that veterans have, as a population, is until the DoD starts all of their actions from the perspective of when I gain them into the military, I also need to make sure that they are aware that they will be a veteran someday, that does not happen. You know, when we're having commander's calls, do we look at all the things that we're doing the deployments that we're doing whatever it is, with the mindset of, yes, this is the primary mission and focus right now. But at some point, everybody standing in front of me is going to be a veteran. We're not looking at it from that perspective at all."
Factors\Sense of Urgency	Reference to the need to do something about the issue soon. Code with SEM level if it's evident from the passage; this may be individual, interpersonal, organizational, or societal. Code with the timeline phase, as well, if evident (e.g., timeline\pre-pilot).	"You know why we needed to do this. That was the initial like, you know, wake up everybody kind of thing we need to get this, this is going to be an issue if we don't do it now. I remember afterwards the National Guard Bureau guy, he hadn't heard of any of this. And he's like, we want to, you know, he came to me, he's like, we want to be part of it, too."

Code	Memo	Examples
Factors\Priority Alignment	Code when there is reference to organizational priority alignment or alignment with strategy. Also code when there are references to limited time, attention, and focus and that priorities have to be established. Code with SEM level if it's evident from the passage; this will likely be organizational or societal. Code with the timeline phase, as well, if evident (e.g., timeline\pre-pilot).	"I mean, I think it was essentially an email from Mike from my boss's counterpart saying, I've been approached by this major, who wants to get this on the agenda. That seems like something that is in line with all of our priorities in the JEC. So I think it would be a good news story to have briefed related to all of our transition discussions and suicide prevention stuff, because I think they had tied it into that NDAA connection because that's another thing that we tracked in the JEC."
Factors\Connections	Code when there is reference to a personal connection, relationship, network, or contact that may have facilitated pilot development, implementation, and subsequent adoption as a permanent program.	"So we started to look into that via some of these connections that I had with [redacted], and she was at that time the director of [redacted] and she connected us to some, so let me see so we got a researcher for women veteran homelessness statistics."
Factors\Perception	Code when there is reference to the pilot being a good news story, DoD and VA getting beat up by the media, and in general the internal and external (e.g., women Veterans, the public, Congress) perceptions of VA and DoD. This may include references to wanting to be seen as innovative and not being viewed as slow and bureaucratic. Also code when people wanted their names attached to doing something for women Veterans for some type of personal or political gain.	"But we are kind of always looking for ways that we can demonstrate progress and action. And sort of positive stories that we can report to the Hill rather than kind of getting beat up, if that makes sense. This is one of those projects that it's a homegrown initiative that was developed by women's health experts within both departments that saw a need and developed a program to meet that need."
Factors\Passion and Persistence	Code when there are references to the passion, persistence, and perseverance related to the pilot implementation team. Code with SEM level if it's	"For one, I think top, top, first and foremost, it's the passion of the people who have developed this program and seen it through

Code	Memo	Examples
	evident from the passage; this will likely be individual or interpersonal. Code with the timeline phase, as well, if evident (e.g., timeline\pre-pilot).	to this point. I mean, number one."
Factors\Congressional Influence	Code when there are references to Congressional influence. Code when there are references to Congress, House, Senate, appropriations committee, NDAA, or House Resolutions. Code with SEM level if it's evident from the passage; this will likely be societal. Code with the timeline phase, as well, if evident (e.g., timeline\pre-pilot).	"I'm sure that congressional interest helped when we asked for briefings on it. And then we also talked with DoD, and the other agencies about working to tailor the Transition Assistance Program to be more individual and to move it towards using big data to identify service members at risk. And using that to drive the program that service members have to go through before they're signed off on. I'm sure that sort of helped shape it."
Factors\Visibility	Code when there are references to the media, press, or publicity around this pilot. Also code when there are references to the visibility of women Veteran issues.	"So we went through like our Air Force public affairs and just said, Hey, we want to write an article about this. We want to get this out, but we knew that it would get picked up by other news sources and it did. So once we did the Air Force public affairs article, it was picked up by, you know, Military Times, I can't even remember all the different ones that it was picked up by. So then it started, that's when we started getting more questions, and then more interviews. And that's kind of what made it take off."
Factors\VA-DoD Advisory Body	Code when there are references to VA-DoD Advisory Body influence, which would include DACOWITS and ACWV. Code with SEM level if it's evident from the passage; this will likely be societal. Code with the timeline phase, as well, if evident (e.g., timeline\pre-	"But I do think that DACOWITS did a lot to shine a light on it. Can't take credit for the program itself, but the support this committee was willing to give and I credit [redacted] for bringing it to the committee, I

Code	Memo	Examples
	pilot).	think was essential because this got into the sight of the Department of Defense at large, not just the Air Force, but took it to the higher level to SecDef who has oversight for all the services, right, and without his support, the other services may not have adopted this program, it would have just been an Air Force program. So I think that those things are key.
Factors\Politics	Code when there are references to politics, competing for scarce resources, and dealing with a range of people and interests groups with their own agendas.	"...I know there was politics on that side, as well. There was one woman in particular who was not a huge supporter. But [redacted] had the backing of senior leadership at Air Force to make it happen. And I think that was absolutely one of those relationships that definitely helped move it forward."

Code	Memo	Examples
Factors\Coordinated Implementation Plan	Code when there are references to the pilot implementation team having a coordinated and organized implementation plan. Also include facets of how the pilot was delivered (e.g., the pilot program was delivered by women Veterans, not by men or women who had not served; communication methods employed).	"Yeah. I'm making it sound simpler than it was. But basically, we came up with a coordinated plan. We had all the stakeholder engagement. We were ready to go in, identified the bases, we had, you know, had started to develop an outline of the curriculum. All we needed was the funding, and we must have approached them at the right time, when they had some spare money, I think it was towards the end of the year. They had money that they needed to spend. I told them I could spend it you know, in the next 12 months. I have a program that's shovel ready to go, that would address these huge gaps in this interagency transition that would focus on women veterans, had all these metrics that we had built into it. So people were happy. They like shovel ready products, you know, projects like this. And so we were at the right place at the right time with the right plan, and we got the funding to do it."

Code	Memo	Examples
Factors\Broader Societal Influences	Code when broader societal influences are discussed as factors, including large movements (e.g., MeToo), military scandals, documentaries, articles, books. Also code when it's discussed that there are more women in positions of power or influence now, including in Congress, media, VSOs, and leadership in VA and DoD.	"And that's kind of what made it take off. And so we knew, we knew there was an appetite for this, for women, and you also, I think timing too is really important is because we are in the Me Too movement, right. And I think there's a lot of people trying to kind of fight for women right now in all, in all aspects right? And so I think the time, even though this wasn't necessarily like a Me Too movement, it was sort of part of like, Hey, we're doing something for women and health, which has been overlooked for so long. And it just kind of put it, it was just the right timing."
Factors\Veteran Service Organization	Code when there are references to Veteran Service Organization influence, which would include VFW, DAV, and SWAN.	"And so they said, you know, as an outside nonprofit, we can do things that insiders can't do. We can press in ways that they can't. And I think we mentioned the idea of petitioning members of congress to support this. I don't remember exactly how that idea came about, but [redacted] was all excited about that idea. And eventually she drafted a letter for us to send to the VA committees. The Yeah, the VA. Forget whether we I don't know exactly. I think I still have the letter. There were a couple of letters that we sent to some of the Hill committees introducing this program talking about its potential benefits."

Code	Memo	Examples
Factors\Empathy	Code when there is a reference to a personal connection and understanding of the need. Many times this is through lived experience (i.e., women Veterans that have transitioned out of the services), but other times it is just a desire and empathy to know where they came from.	"And it was this sense that women haven't done these things. They don't deserve it the same kind of care. So from a very personal level. And then so what I did, because I had all these women in my research, I got a couple of retreat programs to tailor programs specifically for women who have been in combat care. And I got them into these programs in a different couple different places. I've even attended the programs with some of them since. So, yeah, I have a very personal connection to believing that women need a specific type or level of care that was not being provided. "
Factors\Organizational Characteristics	Code when there are references to organizational characteristics, including culture, values, size, structure, and risk tolerance.	"A lot of this was also happening at the same time. So that was kind of within the you know, in those in that women military leadership kind of circle kind of conversation you know, anyway, being a bitch, whatever, and there's a, you know, a guy can kind of say things and get away with it. But so anyways, as [redacted], had, I think some of the that perspective that I made it through the Air Force Academy as one of the first females. I didn't need anything different than a guy. And I don't think that there should be anything different for women or anything more for women because that's going to set us back.

Code	Memo	Examples
Factors\Trust	Code when there is a reference to trust and trusting someone's reputation as a reason to support the implementation of the pilot.	"And [redacted] has such incredible credibility with us. You know, that's probably why we didn't ask her for any more metrics then that, her telling us that because she would have told us if it was not as glowing of an outcome as she, as she told us. You know, she's very, very frank with us on everything."
Factors\Recruitment and Retention	Code when there are references to this pilot (now program) being a way to recruit and retain women in the military.	"And so it was the feedback, and it was, feedback we had from past pilot programs that are indicative at this point that it will positively impact things like retention and recruiting, which is at the end of the day, women are the most underrepresented demographic in the Department of Defense, you know 50.2% of the American public, and less than 20% across the DoD. So to the extent that we're able to recruit women, obviously we want to retain women. Then knowing what their benefits are as, as they're making those decisions, helps them to make smarter decisions and so that was all presented in 2018 as the pilot program."
Factors\Combination of Factors	Code when there is reference to a perfect storm, a number of/multiple factors coming together that impacted this decision.	"And the level of interest being paid to these issues by members of Congress, by the press, by veteran service organizations. I think all of that comes to play."
Factors\Affective Reaction	Code when there are affective or emotional reactions to the needs of women Veterans and the pilot. At the interpersonal level, reference to gauging emotions about the change against others. Also consider the impact of	"And she, within the first 20 minutes, raised her hands and interrupted, not in a not a rude way, but you know, asked her question in the middle of a presentation and said, Are you

Code	Memo	Examples
	others' emotions on the groups' collective emotions about the change.	saying that I can get access to maternity care at the VA? And that was really, that was, that was shocking to me, and I think demonstrates how this is relevant and important. There are women who just don't know. I don't think my boss, the member I work for, I don't think that she, I think she would agree, I don't think she really understood that she qualified for VA benefits."
Factors\Risk Perception	Reference to the organization's perception of the risk involved in adopting the program.	"There's nothing bad there are no risks involved in this that we feel are, you know, crucial enough to be concerned about."
Future		
Future\Future Program Considerations	Code this in direct response to the question, "What recommendations do you have, if any, for changes you think need to be made between the pilot and when this becomes a full program?" This can also be coded when there are comments about how things could have been done differently during pilot implementation. Also include references to equity, diversity and inclusion, and parity that may also be included in the resistance code.	"I mean, this this particular initiative makes so much sense for this population, but they're also begs the question of what are we going to do for other specific populations? Are going to have a male specific TAP class or are we going to have you know, any other particular interest groups that have specific needs like Native American veterans. Are we going to look at explaining their different healthcare options, because they have other options besides VA, DoD, they have, you know, the tribal stuff. So, you know, so there's some discussions happening as far as like, how do we make sure that there's parity for this?"

Code	Memo	Examples
Chapter V Discussion	Code when there are facets that will be important to the discussion section of my dissertation (e.g., the concepts of diversity and inclusion and parity, the discussion of the importance of evidence-based programs).	"Yeah, so I think it was trying to address all the different researchers that were out there. So I'll give you an example. You know, suicide had done research on women veterans committing suicide, but that was like one research. Then there was also research on women having different effects of PTSD on women. That was one research. Then there was research on homelessness for female veterans and then you know, it goes on and on. Like, you know, then you have your heart health, and then you have military sexual trauma, mental health. So everybody was doing this independent research, right? You know, if you will, like, it's a stove pipe, right? Everybody had the research, but nobody as a collective whole was sitting down and saying, hey, do you know that like, you know, homelessness leads to suicide? And then you know, nobody was kind of sitting down and putting all those things together."

Code	Memo	Examples
Quotable	Code as quotable when there is text that is particularly insightful and should be used in the dissertation narrative to highlight a thematic area.	We want to get this out, but we knew that it would get picked up by other news sources and it did. So once we did the Air Force public affairs article, it was picked up by, you know, Military Times, I can't even remember all the different ones that it was picked up by. So then it started, that's when we started getting more questions, and then more interviews. And that's kind of what made it take off. "And so we knew, we knew there was an appetite for this, for women, and you also, I think timing too is really important is because we are in the Me Too movement, right. And I think there's a lot of people trying to kind of fight for women right now in all, in all aspects right? And so I think the time, even though this wasn't necessarily like a Me Too movement, it was sort of part of like, Hey, we're doing something for women and health, which has been overlooked for so long. And it just kind of put it, it was just the right timing. And so that's sort of what we did with the, with the public affairs, is we would do official public affairs, we would do interviews, and then that kind of just kept turning into more business, if you will."

Appendix M: UIC Non-Research Determination

Notice of Determination
Activity Does Not Represent Research

October 22, 2019

20191157-127709-1

Kelly Sanders
Doctor of Public Health in Leadership

RE: **Protocol # 2019-1157**
"Understanding Program Adoption Decision Making via the VHA Women's Health Transition Pilot: A Retrospective Qualitative Study"

Sponsor/Funding Source: None

Dear Kelly Sanders:

The UIC Office for the Protection of Research Subjects received your application, and has determined that this activity DOES NOT meet the definition of research as defined in 45 CFR 46.102(l).

Specifically, the proposed project is a single qualitative case study to explore how the decision was made to adopt the Veterans Health Administration (VHA) Women's Health Transition Service Training pilot as a permanent program. As this is a VHA sponsored and funded program, a letter of support from VHA is included in this package. VHA has determined this project to be non-research for the express purpose of quality improvement. VHA will provide you with applicable documents for the document review and connect you to pilot stakeholders for their inclusion in semi-structured interviews. There is no intent to produce or contribute to generalizable knowledge.

You may conduct your activity without further submission to the IRB.

Please note:

- If this activity is used in conjunction with any other research involving human subjects, prospective IRB approval or a Claim of Exemption is required.
- If this activity is altered in such a manner that may result in the activity representing human subject research, a NEW Determination application must be submitted.
- The results of activities conducted as non-research related QA/QI projects may NOT be published, presented or otherwise disseminated as being "research" as defined under 45 CFR 46.102(l). Such publications/presentations must clearly be identified as being QA/QI projects.

cc: Patrick Lenihan
Elizabeth Jarpe-Ratner

UNIVERSITY OF ILLINOIS AT CHICAGO
Office for the Protection of Research Subjects
201 AOB (MC 672)
1737 West Polk Street
Chicago, Illinois 60612
Phone (312) 996-1711

Appendix N: Qualitative Interview Data Summary

TABLE XXVII: CODE FREQUENCY BY INTERVIEWEE

Factor	# of Interviewees Cited	% of Total Interviewees
Understanding of the Need	15	100.0%
Pilot Data	14	93.3%
Senior Leader Support	14	93.3%
Visibility	13	86.7%
Collaboration	12	80.0%
Organizational Characteristics	12	80.0%
Readiness for Change	12	80.0%
Congressional Influence	11	73.3%
Coordinated Implementation Plan	11	73.3%
Priority Alignment	10	66.7%
Passion and Persistence	9	60.0%
Sense of Urgency	9	60.0%
Navigating Bureaucracy	9	60.0%
Veteran Service Organizations	9	60.0%
Connections	8	53.3%
Perception	8	53.3%
VA-DoD Advisory Body	8	53.3%
Champion	7	46.7%
Broader Societal Influences	6	40.0%
Empathy	6	40.0%
Trust	6	40.0%
Risk Perception	5	33.3%
Grassroots Initiative	5	33.3%
Recruitment and Retention	2	13.3%

TABLE XXVIII: CONSTRUCT APPEARANCE BY PILOT PHASE

Factor	Exploration & Approval	Implementation	Adoption	Total Phases
Collaboration	x	x	x	3
Grassroots Initiative	x	x	x	3
Organizational Characteristics	x	x	x	3
Passion and Persistence	x	x	x	3
Readiness for Change	x	x	x	3
Sense of Urgency	x	x	x	3
Understanding of the Need	x	x	x	3
Champion	x	x		2
Connections	x	x		2
Coordinated Implementation Plan	x	x		2
Empathy	x	x		2
Navigating Bureaucracy	x	x		2
Trust	x	x		2
Broader Societal Influences		x	x	2
Congressional Influence		x	x	2
Perception		x	x	2
Pilot Data		x	x	2
Priority Alignment		x	x	2
Risk Perception		x	x	2
Senior Leader Support		x	x	2
VA-DoD Advisory Body		x		1
Veteran Service Organizations		x		1
Visibility		x		1
Recruitment and Retention			x	1

TABLE XXIX: CONSTRUCT CITATIONS BY STAKEHOLDER ROLE

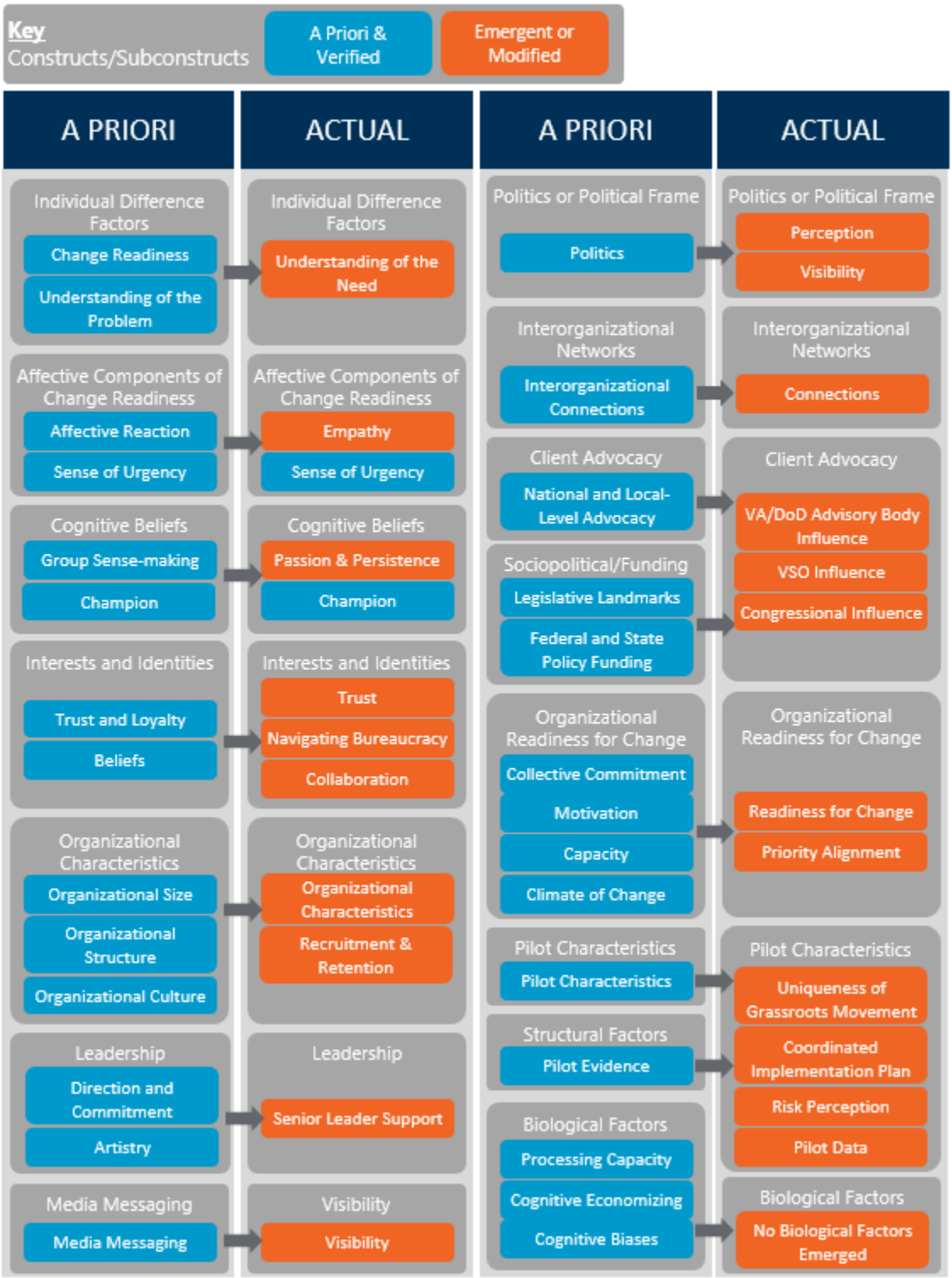
Understanding of the Need			
N = 15	**Role**	**# Cited**	**% of Role**
	Decision Maker	4	100%
	Influencer	7	100%
	Implementer	4	100%
	Total	**15**	**100%**
Pilot Data			
N = 14	**Role**	**# Cited**	**% of Role**
	Decision Maker	4	100.0%
	Influencer	7	100.0%
	Implementer	3	75.0%
	Total	**14**	**93.3%**
Senior Leader Support			
N = 14	**Role**	**# Cited**	**% of Role**
	Decision Maker	4	100.0%
	Influencer	6	85.7%
	Implementer	4	100.0%
	Total	**14**	**93.3%**
Visibility			
N = 13	**Role**	**# Cited**	**% of Role**
	Decision Maker	2	50%
	Influencer	7	100%
	Implementer	4	100%
	Total	**13**	**86.7%**
Collaboration			
N = 12	**Role**	**# Cited**	**% of Role**
	Decision Maker	3	75.0%
	Influencer	5	71.4%
	Implementer	4	100.0%
	Total	**12**	**80.0%**
Organizational Characteristics			
N = 12	**Role**	**# Cited**	**% of Role**
	Decision Maker	3	75.0%
	Influencer	5	71.4%
	Implementer	4	100.0%
	Total	**12**	**80.0%**
Readiness for Change			
N = 12	**Role**	**# Cited**	**% of Role**
	Decision Maker	1	25.0%
	Influencer	7	100.0%
	Implementer	4	100.0%
	Total	**12**	**80.0%**

Congressional Influence			
N = 11	**Role**	**# Cited**	**% of Role**
	Decision Maker	2	50.0%
	Influencer	6	85.7%
	Implementer	3	75.0%
	Total	**11**	**73.3%**
Coordinated Implementation Plan			
N = 11	**Role**	**# Cited**	**% of Role**
	Decision Maker	3	75.0%
	Influencer	5	71.4%
	Implementer	3	75.0%
	Total	**11**	**73.3%**
Priority Alignment			
N = 10	**Role**	**# Cited**	**% of Role**
	Decision Maker	3	75.0%
	Influencer	5	71.4%
	Implementer	2	50.0%
	Total	**10**	**66.7%**
Passion and Persistence			
N = 9	**Role**	**# Cited**	**% of Role**
	Decision Maker	2	50.0%
	Influencer	3	42.9%
	Implementer	4	100%
	Total	**9**	**60.0%**
Sense of Urgency			
N = 9	**Role**	**# Cited**	**% of Role**
	Decision Maker	1	25.0%
	Influencer	4	57.1%
	Implementer	4	100.0%
	Total	**9**	**60.0%**
Navigating Bureaucracy			
N = 9	**Role**	**# Cited**	**% of Role**
	Decision Maker	3	75.0%
	Influencer	3	42.9%
	Implementer	3	75.0%
	Total	**9**	**60.0%**
Veteran Service Organization Influence			
N = 9	**Role**	**# Cited**	**% of Role**
	Decision Maker	1	25.0%
	Influencer	5	71.4%
	Implementer	3	75.0%
	Total	**9**	**60.0%**
Connections			
	Role	**# Cited**	**% of Role**
	Decision Maker	2	50.0%

N = 8	Influencer	2	28.6%
	Implementer	4	100.0%
	Total	**8**	**53.3%**
Perception			
N = 8	**Role**	**# Cited**	**% of Role**
	Decision Maker	1	25.0%
	Influencer	4	57.1%
	Implementer	3	75.0%
	Total	**8**	**53.3%**
VA/DoD Advisory Body Influence			
N = 8	**Role**	**# Cited**	**% of Role**
	Decision Maker	1	25.0%
	Influencer	4	57.1%
	Implementer	3	75.0%
	Total	**8**	**53.3%**
Champion			
N = 7	**Role**	**# Cited**	**% of Role**
	Decision Maker	2	50.0%
	Influencer	2	28.6%
	Implementer	3	75.0%
	Total	**7**	**46.7%**
Broader Societal Influences			
N = 6	**Role**	**# Cited**	**% of Role**
	Decision Maker	0	0.0%
	Influencer	3	42.9%
	Implementer	3	75.0%
	Total	**6**	**40.0%**
Empathy and Affective Response			
N = 6	**Role**	**# Cited**	**% of Role**
	Decision Maker	0	0.0%
	Influencer	4	57.1%
	Implementer	2	50.0%
	Total	**6**	**40.0%**
Trust			
N = 6	**Role**	**# Cited**	**% of Role**
	Decision Maker	1	25.0%
	Influencer	3	42.9%
	Implementer	2	50.0%
	Total	**6**	**40.0%**
Uniqueness of Grassroots Initiative			
N = 5	**Role**	**# Cited**	**% of Role**
	Decision Maker	4	100.0%
	Influencer	1	14.3%
	Implementer	0	0.0%
	Total	**5**	**33.3%**

Risk Perception			
N = 5	**Role**	**# Cited**	**% of Role**
	Decision Maker	2	50.0%
	Influencer	3	42.9%
	Implementer	0	0.0%
	Total	**5**	**33.3%**
Recruitment and Retention			
N = 2	**Role**	**# Cited**	**% of Role**
	Decision Maker	1	25.0%
	Influencer	1	14.3%
	Implementer	0	0.0%
	Total	**2**	**13.3%**

Appendix O: A Priori to Emergent Code Mapping



VITA

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EDUCATION

Dr.P.H. (candidate), Leadership in Public Health. Expected May 2020.
University of Illinois Chicago, Chicago, IL

M.P.H., Epidemiology, August 2008
University of Toledo College of Medicine, Toledo, Ohio

B.S., Movement Science, December 2007
University of Michigan School of Kinesiology, Ann Arbor, MI

PROFESSIONAL EXPERIENCE

Sigma Health Consulting, LLC
Senior Manager 05/2016 – Present

Project manager and public health subject-matter expert for the U.S. Department of Veterans Affairs (VA) Office of Mental Health and Suicide Prevention's Suicide Prevention Program

- As project manager of the Research and Program Evaluation work lane, responsible for leading and directing a team of 10 direct reports with an annual budget of $4.5 million.
- Directing all research and program evaluation activities, including literature synthesis and integration and development of public health communication materials, executive leadership talking points and presentations, and a performance measurement framework aligned with VA's National Strategy for Veteran Suicide Prevention.
- Spearheading the VA *From Science to Practice* and *Together We Can* educational series, literature reviews that translate evidence-based research on suicide risk and protective factors into actionable recommendations for VA clinicians and Veterans, their families, and their caregivers.
- Providing strategic advisory and direction to Suicide Prevention Program to transition from a medical model to a public health approach to suicide prevention by developing infographics, conceptual models, and other communication materials.

Senior analyst for VA Office of Identity, Credential, and Access Management (OICAM) Continuous Process Improvement project

- Completed a gap analysis to assess the current state of OICAM in comparison to the established Federal Identity, Credential, and Access Management roadmap and playbooks. Built a current state operational viewpoint graphical artifact depicting the current operations, resource/data flows, and organizational interactions within VA and outside VA for OICAM. Developed final recommendations based on gap analysis findings.
- Developed a series of future state strategic documents, including strategic goals, objectives, and associated tasks; a concept of operations for a proposed future state; an OICAM strategic plan that further operationalized the strategic objectives; and a stability blueprint, a framework for control and predictability for five years beyond the span of the OICAM strategic plan.

Program manager/subject-matter expert for VA Human Resources (HR) Modernization project

- Designed and facilitated HR shared vision workshops to develop and validate a HR future state operating model with numerous stakeholders across the VA enterprise (including national, regional, and local level leaders).
- Conducted 15 unique, highly visible special studies for the VA deputy secretary. Used qualitative and quantitative data collection and analysis methods to generate presentations to inform organizational next steps and decision-making.

Project manager for Veterans Health Administration (VHA) Office of Quality, Safety, and Value Product Effectiveness Benefits Realization contract

- Managed the study design and execution of three large studies: VA clinical pharmacy baseline engagement, a qualitative and quantitative assessment of the role of clinical pharmacists in VA patient-aligned care teams; VistA scheduling baseline engagement, a qualitative and quantitative assessment of the VistA scheduling package and proposed system and process enhancements; and the pharmacy automation assessment engagement, a qualitative measurement of pharmacy automation tools and systems across the VHA enterprise.

Altarum Institute
Senior Consultant 06/2008 – 4/2016

Project manager for U.S. Department of Defense (DoD) Enhanced Multi Service Market (eMSM) Business Plan and Business Performance Plan support

- Performed all project management duties, including overseeing four full-time equivalents; conducting strategy and progress meetings with DoD leadership; and managing the contract budget of $750,000 for a one-year period of performance. Served as a healthcare subject-matter expert and consulted with eMSM leaders to draft business performance plans.

Project manager for Military Health System (MHS) Studies & Biostatistical Analysis Support Contract, DoD Defense Health Agency (DHA)

- Performed all project management duties, including overseeing five full-time equivalents; conducted strategy and progress meetings with the DHA chief, trust fund, and revenue cycle management; and managed the contract budget in excess of $2.5 million for a five-year period of performance.

- Oversaw and provided subject-matter expertise to the Data Quality Management Control program, MHS external coding audit, Federal Health Care Center Reconciliation project, eMSM studies, and other ad hoc biostatistical analyses.

Program manager for the DHA Uniform Business Office (UBO)

- Led the Billing and Collections workstream. Oversaw staffing and work products for U.S. Coast Guard and VA prospective payments, patient administration tables, third-party collection goals and metrics, and VA-DoD and MHS cosmetic surgery calculators.
- Served in advisory capacities as the MHS Cosmetic Surgery Program manager and subject-matter expert for VA-DoD resource-sharing agreements.
- Responsible for UBO strategic communications efforts, including website and newsletter content, training and education initiatives, and client communication strategies.

Subject-matter expert for the U.S. Department of State (DoS) Bureau for Education and Cultural Affairs (ECA) Accident and Sickness Program for Exchanges Assessment

- Conducted university site visits and interviews with DoS leadership and program officers to identify current state health coverage challenges. Using qualitative and quantitative findings, conducted a full health insurance and industry needs assessment and provided comprehensive health benefit recommendations for exchange program participants.
- Briefed DoS leadership on final recommendations, including the assistant secretary of state for ECA, principal deputy assistant secretary at ECA, and deputy assistant secretaries of state.

Subject-matter expert for Outpatient Coding Improvement Analysis, VHA Consolidated Patient Account Center Chief Business Office

- Conducted site visits and semi-structured interviews with health information management professionals, physicians, and revenue cycle staff to explore current operations and discuss outpatient coding challenges. Synthesized qualitative and quantitative data to provide actionable process improvement recommendations for VHA revenue cycle functions.

Qualitative analyst for the Environmental Scan of Community-Based Wellness and Prevention Programs, Centers for Medicare and Medicaid Services

- Conducted a comprehensive environmental scan of community wellness and prevention programs using primary and secondary research methods to identify best practice and evidence-based community wellness and prevention programs.

Qualitative analyst for Centers for Disease Control and Prevention project

- Conducted focus groups to understand physician laboratory test ordering practices and laboratory test interpretation. Performed qualitative analysis using software to elucidate key findings.

Qualitative analyst for Altarum Culture of Health Strategic Research Initiative

- Contributed to four large internal research projects, including Case Studies from Community Intervention Programs; An Ecological Perspective to Systems Change: Definitions and Implications for Assessment and Evaluation in Community Health Interventions; Improving Readiness for Successful Community Interventions; and The Effect of Geographic Mobility on Community Interventions.
- Performed tasks related to the research projects: conducted a literature review on addressing community health improvement methods; conducted key informant interviews with collaborative and partnership leaders; managed editor of two manuscripts; and contributed sections to the case study manuscript.

Primary researcher for Shelter-in-Place vs. Evacuation Internal Research and Development project

- Performed an extensive literature review (over 200 articles prioritized based on relevance) and conducted expert interviews with emergency responders from various facilities (e.g., hospitals, nursing homes, public health departments) to understand their facility's decision-making process for shelter-in-place vs. evacuation.
- Synthesized literature review and interview findings, and had our findings published in the peer-reviewed journal *Risk, Hazards & Crisis in Public Policy* under the title: "Shelter-in-place versus evacuation decision making: A systematic approach for healthcare facilities." Presented findings at two public health conferences.

Manager/subject-matter expert for the U.S. Department of Health and Human Services Assistant Secretary for Preparedness and Response–Funded Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) project

- Conducted environmental scans with states and territories to assess volunteer health professional registry development progress. Using environmental scan findings, provided states and territories with technical assistance services and developed implementation and operations plans to help states effectively and efficiently plan, implement, and operate ESAR-VHP-compliant volunteer registries. Managed communication and relationships with Federal Emergency Management Agency regions III, IV, VII, VIII, IX, and X states.

Project manager of the Boys & Girls Clubs (B&GC) of Southeast Michigan Youth Powered Health Academy

- Conducted an extensive literature review to understand the evidence-base for successful after-school programs while simultaneously reviewing the existing B&GC curricula. Led the design of focus group and interview guides, conducted needs assessments, and led focus groups at six southeast Michigan B&GC sites to understand the perception of physical activity and nutrition offerings from different stakeholder groups. Synthesized the data into a comprehensive report that included the study methodology, needs assessment and site visit findings, opportunities, and a summary and future directions. Based on the findings, developed a model after-school program.

University of Toledo College of Medicine
Graduate Assistant 01/2007 – 04/2008

- Conducted the Survey of Cultural Issues in a Medical Education Environment. Assisted in survey instrument design, constructed and implemented data collection processes, analyzed the quantitative data using SPSS, and summarized the findings. Presented findings at the Annual Meeting of the American College of Graduate Medical Education and at the Ohio State University College of Medicine.

PUBLICATIONS AND REPORTS

DePena, K., & **Sanders, K. A.** (2016, March 22). Bumps along the rural road: Using telemedicine to treat chronic disease in rural communities. *Healthcare IT News*. https://www.healthcareitnews.com/blog/bumps-along-rural-road-using-telemedicine-treat-chronic-disease-rural-communities

Zaenger, D., Efrat, N., Riccio, R., & **Sanders, K. A.** (2010). Shelter-in-place versus evacuation decision making: A systematic approach for healthcare facilities. *Risk, Hazards & Crisis in Public Policy*, *1*(3), 19–33. https://doi.org/10.2202/1944-4079.1028

PRESENTATIONS

- **Sanders, K.A.** & Workman, G. (2019, August). *Measuring suicide prevention impact*. 2019 VA/DoD Suicide Prevention Conference, Nashville, TN.
- **Sanders, K.A.** & Strickland, S. (2019, August). *Operationalizing the public health approach to suicide prevention*. 2019 VA/DoD Suicide Prevention Conference, Nashville, TN.
- Efrat, N., Riccio, R., **Sanders, K.A.,** & Zaenger, D. (2010). *Shelter-in-place vs. evacuation decision-making: A systematic approach for healthcare*. National Evacuation Conference, New Orleans, LA.
- Efrat, N., Riccio, R., **Sanders, K.A.,** & Zaenger, D. (2009). *Shelter-in-place vs. evacuation decision-making*. Integrated Medical, Public Health, Preparedness and Response Training Summit, Dallas, TX.
- Bork, C., **Bowes (Sanders), K.A.,** Khuder, S., Kleshinski, J., Milz, S., & Smith, MK. (2008). *Assessment of cultural issues in a medical education environment*. Association of American Medical Colleges Central Group on Educational Affairs and the Ohio State University College of Medicine, Columbus, OH.
- Bork, C., **Bowes (Sanders), K.A.,** Khuder, S., Kleshinski, J., Milz, S., & Smith, MK. (2008). *Assessment of cultural issues in a medical education environment.* American College of Graduate Medical Education, Dallas, TX.

PROFESSIONAL TRAINING

- Project Management Professional, Project Management Institute (2014)
- Lean Six Sigma Yellow Belt (2014)
- Building Competency Models Certification, Workitect (2013)
- Cultural Competency Training, Mid Atlantic Regional Public Health Training Center, Johns

Hopkins Bloomberg School of Public Health (2011)
- FEMA National Incident Management System Training (2009)
- FEMA IS-100 C: Introduction to the Incident Command System, ICS 100 (2009)

PROFESSIONAL AND ACADEMIC HONORS AND AWARDS

- Altarum AltE award nominee, 2012
- Public Health Student Award, University of Toledo College of Medicine, 2008
- Full tuition and room and board scholarship, University of Toledo, 2007-2008
- Williams J. Branstrom Freshman Prize, University of Michigan, 2004
- Dean's List, University of Michigan, 2003-2006