Identifying and Serving Veterans in California's Civilian Healthcare System

A Policy Brief and Recommendations for Nursing Leaders and California Policymakers

American Nurses Association\California
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anacalifornia.org

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About the American Nurses Association\California

The American Nurses Association\California (ANA\California) is the state chapter of the American Nurses Association. ANA\California is a 501(c)6 lobbying organization, advocating for, and representing our members in the state of California, without regard to specialty or practice setting.

ANA\California's mission is to optimize nursing's contribution to the health and well-being of individuals, families, and communities. As nurses, this primary commitment to society guides and shapes our efforts to foster nursing practice standards, promote professional and leadership development, influence public policy, and enhance professional practice environments.

Joining ANA\California ensures that registered nurses have their voices heard in advocating for safe, competent, and quality health care for Californians. Learn more about ANA\California at www.anacalifornia.org.

For information about other campaigns and ways to get involved with ANA\California, visit www.anacalifornia.org/membership

About the ANA\California Veteran Health Campaign

The ANA\California Veteran Health Campaign examines how California's civilian healthcare system identifies and serves veterans and military-connected patients. The campaign brings nursing, informatics, policy, and frontline perspectives together to identify gaps in care and develop practical recommendations for improving veteran identification, care coordination, and continuity across healthcare settings.

The Veteran Health Advisory Council guides the campaign's direction, analysis, and recommendations. Council members contribute professional expertise and lived experience to interpret findings, identify priorities, and connect the work to the realities facing veterans, families, nurses, and healthcare organizations. The Council also helps ensure that the campaign remains focused on solutions that nursing leaders and California decision-makers can put into practice.

ANA\California Advocacy Institute Fellows support the campaign through research, listening sessions, survey development, analysis, and policy planning. Working with the Advisory Council, the Fellows help translate what participants shared into clear findings and recommendations.

This report is intended to help nursing leaders, health systems, educators, professional associations, and California decision-makers strengthen veteran-aware care and identify practical opportunities for coordinated action.

This report connects nursing policy and professional practice by bringing nurses together to examine how policies, organizational systems, and clinical workflows affect nursing practice and patient care. Each campaign combines frontline experience, research, and policy analysis to define a problem, develop practical recommendations, and identify actions for healthcare leaders and California decision-makers. The Veteran Health Campaign applies this approach to the care of veterans and military-connected patients in civilian healthcare settings. It connects nursing assessment and professional practice with broader policy priorities, including veteran identification, staff education, electronic health record workflows, care coordination, and access to follow-up services. By translating nurses' experiences into recommendations, the campaign supports changes that can be incorporated into professional education, organizational practice, and public policy.

Acknowledgements

We extend our deepest gratitude to the members of our ANA\California Veteran Health Advisory Council for their passion, leadership, and unwavering commitment to advancing veteran healthcare across California. Their dedication, clinical and policy insight, and commitment to shaping actionable solutions have been invaluable in guiding this work. Through their expertise and advocacy, this report reflects not only research and analysis but also the voices of nurses and leaders determined to create a more responsive and coordinated healthcare system for our veterans.

Furthermore, we'd like to thank our members, nursing and healthcare leaders, social workers, case managers, informaticists, and other professionals who participated in our survey, listening sessions, and conversations. Their collective experiences and insights were instrumental in helping ANA\California understand how veterans are identified and supported in civilian healthcare settings.

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A Note on Analytical Approach

This brief is the product of a qualitative inquiry into how California's civilian health system identifies and serves veteran and military-connected patients. Before the executive summary and findings we want to be transparent about how the analysis was conducted, the theoretical lens that shaped interpretation, and the way we have organized what we heard. The note that follows serves as both the conceptual orientation to the brief and a record of the analytical choices behind it.

Method

We treated the listening sessions, the statewide survey, and the direct conversations with health systems as three streams of qualitative data, triangulated rather than pooled, and the analytic approach is best described as rapid qualitative analysis with framework analysis influence (Ritchie & Spencer, 1994), executed within the reflexive thematic-analysis tradition (Braun & Clarke, 2006, 2019). Codes were developed inductively from participant language, organized into themes through iterative review across the Council, and refined against the survey scaffold and the system-conversation notes. The PICO question, in both its clinical and informatics framings, provided a deductive scaffold that helped focus the inductive coding without dictating its conclusions.

Theoretical lens

Interpretation is anchored in two compatible frames. The Donabedian (1966, 1988) structure-process-outcome quality framework provides the primary architecture, with identification practices and workflow ownership treated as process measures, Electronic Health Records (EHR) configuration and navigator roles and staff education and cross-agency partnerships treated as structures, and continuity outcomes (behavioral health linkage, housing stability at discharge, authorization timeliness, downstream clinical risk) treated as the consequences that those structures and processes produce. Structural competency (Metzl & Hansen, 2014) and structural vulnerability (Bourgois et al., 2017) inform the equity interpretation, particularly the recurring pattern in which institutional gaps are absorbed by patients and families themselves, and the way unhoused veterans and veterans with complex behavioral health needs are disproportionately exposed when continuity breaks down.

From findings to themes

An earlier version of this brief presented findings as seven content-area observations, but on reflection those observations are better understood as facets of four higher-order themes that have explanatory reach across the data. The themes are intended as analytical claims about what is happening in civilian veteran care rather than as a list of topics, and they are summarized as follows:

1. Identification without activation. Veteran status is collected as administrative ritual rather than as a clinical signal that triggers action.

2. Burden displacement to patients and families. The system functions in part because patients self-disclose, families advocate, and patients are asked to bridge their own records between EHRs.
3. Coordination without an owner. The post-identification work is being done, but no role consistently owns it, and partners across agencies often cannot reliably read the Department of Veterans Affairs (VA) coverage rules.
4. Continuity collapses where systems do not communicate. Behavioral health and housing carry most of the weight, with clinical risk following close behind, particularly for time-sensitive treatment and for veterans whose service-related exposures are invisible to the team.

The structural condition that makes these four themes consequential is civilian systems are in practice primary providers for many California veterans, is presented in the Problem section rather than as a peer theme, since it functions as the backdrop against which the themes operate rather than as a finding on the same logical plane.

Trustworthiness

We have aimed at the four criteria established by Lincoln and Guba (1985). Credibility is supported by methodological triangulation across the three data streams and by direct, attributed participant language throughout the Findings section; transferability is supported by explicit naming of the settings sampled and the geographic and facility-type limits of those settings; and dependability and confirmability are supported by documenting how themes were derived from codes, by retaining negative cases (Scripps and Kaiser Northern California are preserved in the text as in-state counter-examples to the variability story rather than being smoothed away), and by an audit trail held by the Council. Member checking with listening-session participants on the theme set is planned ahead of the February 2027 release.

Reflexivity

The authors are nursing leaders, informaticists, and ANA\California Advocacy Institute Fellows, several are veterans themselves, and all hold professional and personal commitments to the population at the center of this work. We treat that positioning as a strength of the analysis and as an explicit element of how the brief was produced, rather than as a confound to be hidden, and we recognize that it shapes which findings we treat as urgent and how we frame the recommendation language. Readers who want to interrogate that positioning will find the acknowledgments section identifies the contributors and their credentials.

How to read this brief

The sections proceed from this analytical framing, to a brief executive summary, to the introduction and expanded methodology, to the problem statement and the four themes, to implications, to seven prioritized recommendations (each mapped back to the themes it addresses), to an implementation roadmap, a call to action, a conclusion, and an appendix. Readers can begin with the executive summary,

the themes, or the recommendations depending on their role, but the four themes are the analytical heart of the document and the recommendations are derived from them and should be read against them.

Executive Summary

Approximately 1.6 million veterans live in California, the largest veteran population of any state, and the majority of them receive at least part of their health care outside the U.S. Department of Veterans Affairs (VA) system, which makes civilian hospitals, clinics, community health centers, and home health agencies frontline veteran healthcare providers in practice if not in name. Despite this, California's civilian system lacks a consistent way to know who its veteran and military-connected patients are, and an even less consistent way to act on that information once it has been collected.

This brief synthesizes findings from listening sessions with California nursing and informaticist leaders, a statewide survey instrument deployed by ANA\California, and direct conversations with health systems including Scripps, Sharp, Kaiser Northern California, Loma Linda, and UC San Diego. Across geographies and system types, the data converge on four analytical themes that organize the rest of the brief.

Four themes

- Identification without activation, in which veteran status is captured as administrative ritual rather than as a clinical signal that triggers a coordinated support pathway.
- Burden displacement to patients and families, in which the system continues to function because patients self-disclose, families advocate for transfer or for benefits, and patients are asked to bridge their own records between EHR systems.
- Coordination without an owner, in which the post-identification work is done by case managers and social workers but no role consistently owns the workflow, and cross-agency partners are often unfamiliar with VA coverage rules.
- Continuity of care breaks down for veterans most often where behavioral health and housing needs are not adequately addressed, and the downstream consequences show up in the clinic in two concrete ways: authorization delays that hold up time-sensitive treatments such as chemotherapy, and unrecorded service histories that leave the treating team unaware of PACT-eligible conditions and other health risks tied to toxic exposures during military service.

Seven prioritized recommendations

We propose seven actions for the 2026 to 2027 implementation window, sequenced so that earlier actions create the data and workflow conditions that later actions depend on, and each is mapped to the theme or themes it addresses:

1. Adopt the American Academy of Nursing (AAN) "Have You Ever Served?" framework as the universal veteran and military-connected identification standard at every civilian point of entry in California. (Themes 1, 2)

2. Embed identification in the EHR with structured fields, banner flags, and triggered downstream workflows. (Themes 1, 3)
3. Establish a veteran navigator or VA liaison role at every health system serving a meaningful veteran population. (Themes 2, 3)
4. Require veteran-specific staff education as a condition of nursing licensure renewal and as part of new-hire onboarding in licensed facilities. (Themes 1, 4)
5. Operationalize VA and civilian interoperability as a workflow rather than treating it as a purely technical problem. (Themes 2, 3)
6. Formalize partnerships for behavioral health, housing, and post-acute care so that identified veterans are routed to a defined follow-up services package. (Themes 2, 3, 4)
7. Develop a state-level data and accountability mechanism so progress can be measured, reported, and benchmarked across systems. (Theme 1, cross-cutting)

What we are asking decision-makers to do

We ask California health system leaders to commit to actions (1) and (2) within the next twelve months, since both are within the operational authority of system leadership and already have proof points inside the state; and we ask California state policymakers, including the Legislature, the Department of Health Care Access and Information (HCAI), the Board of Registered Nursing (BRN), and the California Department of Veterans Affairs (CalVet), to use existing licensure, reporting, and partnership levers to make actions (3) through (7) the operating standard rather than the exception.

Introduction

Purpose

This report is the first deliverable of a multi-phase initiative by ANA\California's Veteran Health Advisory Council and Advocacy Institute Fellows, and its purpose is twofold: Translate what California's nursing and informaticist leaders are telling us about the experience of veterans in civilian care into a clear, theoretically grounded statement of the problem, and to put forward a small number of actionable, owner-specific recommendations that nursing leaders and California policymakers can move on in the 2026 to 2027 window. A fuller report, with expanded recommendations, supplementary data, member-checked themes, and implementation playbook detail, is targeted for release in February 2027 in alignment with the project timeline.

Why this matters now

California is home to the country's largest veteran population, and decades of policy investment in the VA system can obscure a basic operational fact: most California veterans interact with the civilian health system at some point in their care, and many rely on it as their primary source of care, for reasons the listening sessions named clearly, including wait times, distance, scope of available services, family preference, and continuity with existing community-based providers.

Civilian systems were not designed around veteran-specific needs, nor were they designed to interoperate cleanly with the VA's records, benefits, or referral logic, nor were they designed to assume that some of their patients carry health risks (toxic exposures, traumatic brain injury [TBI], military sexual trauma [MST], combat-related musculoskeletal injury, post-traumatic stress disorder [PTSD]) that are tightly tied to a service history a civilian intake form may never ask about. The cumulative result is a population whose unique needs are systematically under-identified and inconsistently met by the very systems delivering most of their care.

Two developments make this moment particularly tractable. The federal Electronic Medical Records (EMR) transitions now in progress will reshape how civilian and VA systems can share data, which creates a once-in-a-generation opportunity to build veteran-aware workflows into the next version of the medical record rather than retrofit them later. At the same time, California's nursing leadership has already demonstrated, through programs like ANA\California, that statewide standards can be defined and adopted across the diversity of California health systems, so the window to align both technical and professional levers is open now.

Scope and audience

The brief speaks to two audiences simultaneously. For nursing leaders, in both service and academia, and executive health institution leaders in California health systems, it identifies operational levers, including intake workflows, EHR configuration, navigator roles, staff education, and post-discharge handoffs, that can be activated inside institutions; for California state policymakers and regulators, it identifies system-level levers, including licensure, reporting, funding, and partnership, that can make those operational changes the rule rather than the exception. The recommendations are deliberately limited to a prioritized set so that they can be acted on in sequence.

The brief does not attempt to assess the VA system itself, evaluate any specific commercial EHR product, or recommend any single screening instrument, since its focus is on what civilian systems and state policy can change.

Definitions and language

Throughout this report, the term veteran refers to any individual who has served or is currently serving in the U.S. military, including active duty members, veterans (separated or retired), National Guard members, and reservists, and the term military-connected refers to spouses, partners, children, and dependents of someone who has served or is currently serving. We use this broader framing intentionally, because both groups carry health considerations that civilian intake processes routinely miss, although where the listening sessions or survey instrument used narrower language we have preserved it in context.

Methodology and Inputs

The methodology summarized in the analytical framing above is described in fuller detail below. The findings draw on three streams of qualitative data, triangulated to surface patterns that appear consistently across them, and interpreted through the theoretical lens introduced in the framing section.

Approach

The study is a multi-method qualitative inquiry, and the analysis followed a rapid qualitative analysis approach with framework analysis influence (Ritchie & Spencer, 1994), within a reflexive thematic-analysis tradition (Braun & Clarke, 2006, 2019). Codes were derived inductively from participant transcripts and conversation notes, clustered into candidate sub-themes, and reviewed iteratively by the Council against the survey scaffold and the system-conversation memos, with four higher-order themes ultimately identified through that process. The PICO question, while not the primary driver of coding, served as a deductive scaffold that helped focus inductive analysis without constraining it.

Theoretical framework

Interpretation draws on two compatible frames. Donabedian's (1966, 1988) structure-process-outcome quality framework serves as the primary architecture, while structural competency (Metzl & Hansen, 2014) and structural vulnerability (Bourgois et al., 2017) inform the equity interpretation, particularly in Theme 2 (burden displacement) and Theme 4 (continuity collapse); Penchansky and Thomas's (1981) dimensions of access are used informally to characterize why civilian systems are absorbing veteran care in the first place.

Listening sessions

Structured listening sessions were conducted with nursing leaders, social workers, case managers, oncology nurses, and informaticists across California and several comparison settings outside the state, using a guided discussion based on the project's PICO question: whether a structured, veteran-specific intake process (or, in informatics framing, a veteran-specific EHR intake system) yields better identification, documentation, and management of veterans' unique healthcare needs than the standard civilian intake. Participants spoke to current practices, perceived gaps, and ideas they would prioritize, and direct participant language is quoted, attributed by first name only, throughout the Findings section.

Statewide survey

ANA\California fielded a statewide survey of nursing and informaticist leaders, the ANA\California Veteran Health Survey (https://www.anacalifornia.org/veteran-health-survey), covering identification practices, EHR configuration, institutional partnerships, training, and demographics, and the survey instrument is included for reference in the Appendix. At the time of this draft approximately 200 responses had been received, concentrated in Los Angeles (76), Orange (22), San Diego (18), Santa Clara (10), Sacramento (9), Solano (9), Contra Costa (8), and Riverside (6) Counties, while roughly thirty

California counties returned no responses, which is itself a finding about geographic coverage gaps that the next survey wave should address.

Direct conversations with health systems

Members of the Advisory Council and Advocacy Institute Fellows held direct conversations with a set of California systems serving large veteran populations, including Scripps, Sharp HealthCare, Kaiser Permanente Northern California, Loma Linda University Health, and UC San Diego Health. These conversations were not formal interviews; they were leadership-to-leadership exchanges intended to surface what each system actually does at the intake and care-coordination level, and where leaders see the biggest gaps.

Trustworthiness

Credibility is supported by methodological triangulation across the three data streams and by direct, attributed participant language, while transferability is supported by explicit naming of the settings sampled and the geographic and facility-type limits of those settings (see Limits, below). Dependability and confirmability are supported in three ways: by documenting how themes were derived from codes, by retaining negative cases such as Scripps and Kaiser Northern California as in-state counter-examples to the variability story rather than smoothing them away, and by an audit trail held by the Council. Member checking with listening-session participants on the theme set is planned ahead of the February 2027 release.

Reflexivity

The authors are nursing leaders, informaticists, and Advocacy Institute Fellows, several of whom are veterans themselves, and all of whom hold professional and personal commitments to the population at the center of this work, and that positioning is treated as a strength and as an explicit element of how the brief was produced rather than as a confound to be hidden. It shapes which findings we treat as urgent, and the acknowledgments section names the contributors and their credentials so that readers can locate the analytic standpoint behind the writing.

Limits

The survey is a convenience sample, weighted toward Southern California and Bay Area metropolitan systems, so rural and Central Valley voices are under-represented and several counties returned no responses at all. The listening sessions intentionally over-sampled settings with significant veteran volume, which means the findings should be read as descriptive of what is happening in those settings rather than as a statistically representative portrait of every California facility, and the themes are presented as patterned and recurrent across the data rather than as exhaustive or universally applicable. The next phase of work will deliberately broaden geographic and facility-type coverage and will incorporate member checking on the theme set.

The Problem: What's Happening in Civilian Care

A structural condition shapes everything that follows in this brief: Civilian systems in California are not adjunct providers to VA care for veterans but, for many veterans much of the time, the primary providers. Participants described veterans seeking civilian care because the VA cannot meet a specific need in a specific time frame, with wait times, scope of services, geography, and family preference all surfacing as drivers, and the implication is that designing veteran-aware workflows in civilian systems is not optional or supplementary but a core piece of infrastructure that the state's health system has yet to build at scale.

> *"We accept VA patients because the VA doesn't offer them* [the service] OR t*he wait is too long." (Mary)*

Against that backdrop, perhaps the cleanest summary of the operational problem came from a participant who described veteran identification at intake as "a box we fill up for insurance," a line that captures with unusual precision where civilian systems are today: Veteran status is most often elicited because it has a billing implication rather than a clinical one, it lives on the insurance side of the intake conversation rather than the clinical side, and it is rarely linked to a downstream workflow that does anything meaningful with the answer.

Several patterns reinforce this picture.Nursing leaders, at all organizational levels, even at large California systems, frequently could not say with confidence whether their institutions formally identify veterans, and where identification does happen, consistency varies enormously across institutions in the same region: Scripps in San Diego has built strong, multidisciplinary practices for identifying and serving veterans, while Sharp HealthCare, serving a very similar population in the same county, continues to face challenges, and Kaiser Permanente Northern California captures a structured set of data elements (including status, branch, years served, service period, and disability or VA-related information) at a level of completeness that is not the norm elsewhere. A few institutions have used the Veterans Health Information Exchange (VHIE), but adoption remains inconsistent. The variability is striking in part because it is occurring against the backdrop of an existing and recently refreshed national standard, the American Academy of Nursing's "Have You Ever Served in the Military?" framework, launched in 2012 through the AAN Military and Veterans Health Initiative, supported by the federal Joining Forces effort, and most recently updated in the November 2025 AAN Military Health History Pocket Card, which combines the veteran and military-connected family questions into a single inclusive prompt, adds a dedicated PACT Act toxic exposure screening domain, and expands the blast and Traumatic Brain Injury (TBI) questions to include chronic low-level blast exposure. The framework exists, has been broadly endorsed by professional nursing organizations, and is implementable inside the EHR, yet adoption across California has been uneven. The in-state contrasts noted above are negative cases in our analysis, preserved here because they establish that the variability is not universal and that proof points for the recommendations in this brief already exist within California.

At the level of the bedside, the consequences of this inconsistency accumulate. Veterans with PACT Act-eligible conditions arrive in oncology, pulmonology, and primary care clinics without their service history being part of the clinical workup; patients with combat-related musculoskeletal injuries are managed without anyone asking what they did before they were a patient; veterans navigating chemotherapy face authorization lag and pharmacy-access friction that civilian patients on commercial coverage typically do not encounter; and unhoused veterans are discharged from civilian hospitals into post-acute and home health environments that are not familiar with VA coverage rules. Family members, participants emphasized repeatedly, frequently become the de facto navigators in this environment, asking on the patient's behalf whether VA transfer is possible, what benefits are in scope, and who pays for what.

> *"The best advocates that end up being the family members. I want my family member transferred to the VA hospital for financial reasons, for specialty reasons, for outreach reasons." (Peggy)*

None of this should be read as a story about absent intent, since every participant we spoke with cared, often deeply, about serving veterans well; rather, it is a story about the absence of consistent, owned, and system-supported workflows for doing so, and the four themes that follow describe the contours of that absence in more analytical detail.

Findings: Four Themes

Across the listening sessions, survey scaffold, and system conversations, four analytical themes emerge, each of which is presented below with its constituent subthemes, the supporting participant language, and the Donabedian and structural-competency interpretation that follows from it.

Theme 1. Identification without activation

The first theme is that veteran status is collected as administrative ritual rather than as a clinical signal that triggers action, with identification, where it happens, most often elicited because of a billing implication rather than because it sets in motion a clinically meaningful pathway. In Donabedian terms this is a process failure: the structure (a data field, sometimes a screening tool) exists, but the process that should follow it does not consistently exist alongside it.

Subtheme 1a. Insurance frame versus clinical frame

Veteran status lives on the insurance side of the intake conversation in most of the settings participants described, and Mary's "a box we fill up for insurance" captures the framing precisely: the question is typically asked, when asked at all, by registration staff working through the registration script rather than by the clinical team working through the nursing admission assessment, which routes the answer to billing systems instead of to clinical decision support.

Subtheme 1b. Downstream silence

Even when identification does occur, the absence of a downstream trigger means it rarely changes the patient's experience of care, with participants describing data "collected but not actively used," no automatic referral to benefits navigation, no flag in the clinical record visible to the bedside team, and no triggered behavioral health or exposure screen. Ginger noted that the assessment in her setting does not go into "any, say, disabilities or anything they may have, but I know there's at least an identification of an active or former veteran," and that pattern of capture without consequence is the operative dynamic across most of the data.

Subtheme 1c. Education and awareness as upstream conditions

Staff education was, by some margin, the most consistently named lever for changing this dynamic, with participants emphasizing that asking about service history in a clinically useful way requires a baseline of awareness about why it matters, including familiarity with Post Traumatic Stress, military sexual trauma, traumatic brain injury, Agent Orange, and the PACT Act list of covered conditions; without that awareness, the question itself reverts to a transactional checkbox rather than serving as the opening of a clinical conversation.

> *"Education and training for the staff, awareness of PTSD, Agent Orange, and the list of PACT health conditions." (Ginger)*

Theme 2. Burden displacement to patients and families

The second theme is that the civilian system functions in part because patients and families absorb labor that institutional workflows have not absorbed, with veterans self-disclosing their status, families advocating for transfer to VA care, and patients being asked to consent to bridging their own records between EHR systems. In a structural-competency frame this is burden displacement, where a system gap is resolved by shifting effort, risk, and decision-making onto the people the system is meant to serve, and three subthemes give the pattern shape.

Subtheme 2a. Family as de facto navigator

Family members repeatedly emerged in the listening sessions as the most effective advocates for veterans in civilian care, with Peggy describing family members as the people who push for transfer to a VA hospital for financial, specialty, or outreach reasons. The pattern is visible across settings, and what it suggests is that the civilian system is, in many cases, relying on family members to do navigation work that a designated role inside the institution should be doing on the institution's behalf rather than on the family's.

Subtheme 2b. Patient-initiated interoperability

Records exchange between VA and civilian systems often hinges on the patient, because although Epic's Care Everywhere and the Veterans Health Information Exchange both exist, the bridge between them is most often initiated when the patient elects to connect their records, with the result that staff routinely

make care decisions on incomplete records for patients whose service history is, on its own, clinically significant.

> *"Unless the patient's willing to connect the two somehow, there's no good way to have access to both systems." (Sara)*

Subtheme 2c. Self-disclosure as the identification mechanism

In specialty settings particularly, identification often happens because the patient or family flags it themselves rather than because the institution asked, with Sara describing veteran identification in her cancer center setting as something "already identified by the patient before the patient's actually hitting our cancer center," likely built into the upstream referral process. That dependency on self-disclosure is a structural fragility, and it is disproportionately costly for patients who, for reasons of privacy, mistrust, or perceived irrelevance, choose not to disclose.

Theme 3. Coordination without an owner

The third theme is that the post-identification work happens, but no role consistently owns it, with case managers and social workers improvising the navigation work, navigator roles remaining aspirational, and cross-agency partners (including post-acute and home health agencies) routinely unfamiliar with VA coverage rules. In Donabedian terms (1966, 1988) this is a structure problem rather than a process or outcome problem: The role and partnership architecture necessary to convert identification into action does not yet exist as a system feature in most California settings, and three subthemes describe how the gap manifests.

Subtheme 3a. Case manager as improviser

Case managers are, in practice, doing the work of figuring out what benefits a veteran qualifies for, of contacting community-based services, and of coordinating with VA case management when it exists, and Mary's description of case managers doing "the bulk of the digging for services" is representative. The work is happening; what is missing is that it happens through individual effort rather than through a defined system process, which means the quality of the work varies with the experience and bandwidth of the particular person doing it on a particular shift.

Subtheme 3b. Navigator as aspiration

Participants consistently named a dedicated veteran navigator or VA liaison role as a high-leverage solution, while also describing it as rare in their own settings and inconsistently funded where it does exist, with the result that the role is, at best, partially present across California and not yet standardized in scope or accountability.

Subtheme 3c. Cross-agency illegibility of VA coverage

Discharge planning for veterans frequently stalls when post-acute, home health, and community providers cannot reliably interpret VA coverage rules, since authorization processes, benefit scope, and

referral pathways are illegible to many of the agencies a hospital is trying to discharge a veteran to, and the illegibility compounds the already-significant workload of the case manager carrying the navigation on the hospital side.

Theme 4. Where continuity collapses, behavioral health and housing carry the weight

The fourth theme is that when continuity of care fails for veterans in civilian settings, the failures cluster in predictable places: behavioral health is the most frequently cited gap, housing instability compounds it, authorization lag affects time-sensitive treatment, and the service history that would explain a veteran's clinical risk is often invisible to the team making decisions. In Donabedian terms (1966, 1988) these are outcomes, while in structural-vulnerability terms (Bourgois et al., 2017) the population most exposed to these failures is the population least equipped to absorb their consequences.

Subtheme 4a. Behavioral health as the dominant gap

Across the listening sessions, behavioral health emerged unprompted as the largest source of follow-up service gaps, with participants returning to it repeatedly when asked to name where continuity broke down, and the gap was largest for veterans with co-occurring substance use, PTSD, and complex psychosocial needs.

> *"The biggest gap is due to behavioral health." (Peggy)*

Subtheme 4b. Housing instability and discharge

Unhoused veterans face discharge planning challenges that no clinical workflow alone can solve, and participants in California and in comparison settings outside the state described the same underlying problem in different forms: hospitals are discharging unhoused veterans into systems (shelters, supportive housing, community programs) that are not designed to absorb them at the necessary pace, and this is where the equity weight of the brief is concentrated.

Subtheme 4c. Authorization lag in time-sensitive treatment

Oncology and infusion participants flagged that authorization lag for chemotherapy, and friction in medication fulfillment workflows, can push veterans into delays or into higher out-of-pocket retail pharmacy use, and for a veteran on a chemotherapy protocol a multi-day authorization delay can have meaningful clinical consequences. The pattern is not unique to oncology, although it is sharpest there because the clinical stakes are most immediate.

Subtheme 4d. Invisible service history with PACT and exposure implications

Veterans with PACT Act-eligible conditions and other service-connected exposures often arrive in civilian settings with their service history disconnected from the clinical workup, which means that without identification and structured capture the team treating a pulmonary or oncologic presentation does not necessarily know that the patient's service history belongs in the differential. The clinical risk is real and the data are recoverable, but only if the workflow asks for them in the first place.

Implications

For frontline nursing assessment

Nursing assessment is the first reliable point at which veteran status can become clinically meaningful rather than administratively recorded, which is where Themes 1 and 2 point most directly: Nursing intake and admission workflows are the natural site for converting identification into a triggered set of next steps, and converting them well requires an unambiguous identification question, a structured field that other parts of the team can act on, and a defined set of "if identified, then" actions tied to roles. Most California systems already have the EHR functionality and the nursing workforce needed to do this work, so what is missing in most settings is a shared standard rather than the underlying capability.

For health system operations

Theme 3, *Coordination without an owner,* reframes the operational problem as one of workflow ownership rather than technology, because the technical infrastructure that veteran-aware care depends on already exists in most California systems, with identification fields present in nearly all major EHRs, Epic's Care Everywhere broadly deployed, and the Veterans Health Information Exchange available to participating institutions; what does not yet exist in most settings is a named role responsible for what happens once a veteran is identified. A defined navigator role with explicit responsibility for VA liaison, benefits navigation, behavioral health linkage, housing referral, and post-acute coordination would resolve a large portion of the gaps participants described, without requiring new systems.

For equity

Themes 2 and 4 carry most of the equity weight in this analysis, because burden displacement falls hardest on patients and families with the least capacity to navigate the system on their own behalf, and continuity collapses most visibly for veterans with co-occurring behavioral health needs and for unhoused veterans, both of whom are routinely discharged into community settings that are not resourced to absorb them at the necessary pace. Any package of recommendations that does not name behavioral health and housing as central will under-serve precisely the veterans most in need of attention.

For California's role

California has the regulatory, licensure, and reporting infrastructure necessary to make veteran-aware care the operating standard rather than a system-by-system project, with the largest veteran population in the country and a nursing workforce of more than 400,000 licensed RNs to work with, and the available leverage points include nursing continuing education requirements, hospital licensure and reporting through HCAI, CalVet's partnership infrastructure, and the existing Veterans Health Information Exchange. None of these levers require new statutory authority; what they require is coordinated use of authority that the state already has.

Prioritized Recommendations

Seven recommendations follow, prioritized by feasibility, impact, and sequencing, and each is mapped to the theme or themes it addresses so that readers can trace the evidence-to-action path. They are organized so that earlier actions create the data and workflow conditions that later actions depend on, and a full owner-organized summary appears in the Appendix.

Recommendation 1. Adopt the AAN "Have You Ever Served?" framework as the universal veteran and military-connected identification standard at every civilian point of entry

Themes addressed. Theme 1 (identification without activation) and Theme 2 (burden displacement, since a universally asked question reduces reliance on patient self-disclosure).

Owner. Health systems and employers, supported by the California Department of Health Care Access and Information (HCAI) through licensure reporting expectations.

What to do. Require every licensed California hospital, FQHC, ambulatory clinic, and home health agency to adopt the American Academy of Nursing's "Have You Ever Served in the Military?" framework, which was launched in 2012 through the AAN Military and Veterans Health Initiative, supported by the federal Joining Forces effort, and most recently refreshed in the November 2025 Military Health History Pocket Card, as the standard identification approach at every patient point of entry. The framework anchors on the updated combined primary question "Have you or has someone close to you ever served in the military?", which identifies both veterans and military-connected family members in a single inclusive prompt, and is operationalized through the AAN Pocket Card, which provides a structured set of follow-up questions covering era and dates of service, branch, component (Active Duty, Reserve, or National Guard), primary role, deployments and combat or hostile-area assignment, enemy fire and witnessed casualties, wounds and hospitalizations, participation in experimental projects or tests, environmental and chemical exposures (burn pits, Agent Orange, contaminated water, radiation, warfare agents, infectious disease exposures), prior toxic exposure screening and PACT Act status, blast and traumatic brain injury including newly added low-level blast exposure (firing heavy weapons, breaching exercises, working with explosive ordnance), post-traumatic stress, military sexual trauma, suicide risk, substance use, and current VA enrollment and benefits status together with social determinants such as stable housing, food security, and need for caregiving support. The primary question should appear in standard intake forms, registration scripts, and EHR prompts so that the path of asking it is consistent regardless of who is conducting the registration, and the Pocket Card follow-up questions should be available to the clinical team on a positive response.

Why it matters. The field already has an established, evidence-based standard for veteran identification in civilian settings, which means California systems do not need to invent their own question set; what they need is consistent adoption of the framework that already exists. Anchoring on the AAN framework

also creates interoperability with national clinician resources (the AAN Pocket Card, the VA Community Provider Toolkit, the VA Military Health History Pocket Card for Trainees, and Joining Forces materials), reduces variability across institutions, and gives staff a well-supported set of follow-up questions to use when a patient discloses service. The November 2025 refresh is particularly relevant for California because it operationalizes PACT Act toxic exposure screening, expands the blast and TBI domain to include chronic low-level blast exposure (an area of active research and clinical concern), and consolidates the previously separate veteran and military-connected questions into a single inclusive prompt that reduces the cognitive load on registration staff. The current state, in which identification depends on patient self-disclosure, family advocacy, or the memory of an individual staff member, leaves California systems with neither the consistency nor the clinical depth that the AAN framework was designed to provide.

What good looks like. The updated AAN combined primary question is asked of every patient at registration and on the nursing admission assessment rather than only on insurance forms; identification rates are tracked at the facility level; the November 2025 Pocket Card follow-up questions are available to the clinical team on a positive response, including the new toxic exposure screening and low-level blast domains; and identification is paired explicitly with a documented next step (a referral, an offer of navigator outreach, a PACT Act toxic exposure screening referral, or a benefits screen) so that being captured is reliably linked to being supported.

Recommendation 2. Embed identification in the EHR with structured fields, banner flags, and triggered workflows

Themes addressed. Theme 1 (converting capture into activation) and Theme 3 (creating the structural conditions for an owned workflow to operate against).

Owner. Health system informatics leadership, in partnership with EHR vendors (Epic, Oracle Health / Cerner, MEDITECH).

What to do. Configure the EHR so that the updated AAN "Have You Ever Served?" combined primary question (Recommendation 1) appears as a required prompt at registration and at the nursing admission assessment, and so that a positive response (a) opens the November 2025 AAN Military Health History Pocket Card follow-up domains as structured discrete fields, including era and dates of service, branch, component, primary role, deployments and hostile-area assignment, enemy fire and witnessed casualties, wounds and hospitalizations, environmental and chemical exposures, prior toxic exposure screening and PACT Act status, blast and TBI (with the newly added low-level blast exposure domain), post-traumatic stress, military sexual trauma, suicide risk, substance use, VA enrollment, and service-connected disability status, together with the social-determinant prompts on housing stability, food security, and caregiving needs; (b) displays a visible patient banner indicator for identified veterans and military-connected patients; and (c) triggers a defined set of downstream workflows including a behavioral health screen, a benefits-navigator referral, a PACT Act toxic exposure screening referral

where indicated, a Care Everywhere or VHIE prompt for record connection, and a flagged review at discharge.

Why it matters. The structured-data deficit is what makes everything downstream (care coordination, reporting, clinical decision support, alerting on PACT-eligible conditions) harder than it needs to be, and Kaiser Northern California's existing structured-data model serves as a useful in-state proof point that this configuration is achievable inside the major EHRs already deployed in California; triggered workflows are what convert a data field into a clinical action.

What good looks like. A veteran patient arriving at any California hospital is visibly identified on the patient banner, has the relevant structured data populated and queryable for reporting, and automatically routes to a documented set of veteran-specific care-coordination steps, with the same patient at a different California system experiencing a comparable workflow; pending EMR transitions are used as an opportunity to build these elements in by default rather than as custom builds.

Recommendation 3. Establish a veteran navigator or VA liaison role at every health system serving a meaningful veteran population

Themes addressed. Theme 2 (relieves the burden displacement onto patients and families) and Theme 3 (names an explicit owner for the post-identification workflow).

Owner. Health systems and employers, supported by CalVet partnership infrastructure and County Veterans Service Offices.

What to do. Designate a named individual or small team responsible for what happens after a veteran is identified, with the role owning VA liaison, benefits navigation, behavioral health linkage, housing referral, post-acute coordination, and authorization escalation; the role may be filled by social work leadership, by nursing case management, or by a dedicated navigator depending on system scale, but the responsibility must be named, resourced, and visible to the bedside team.

Why it matters. The most consistent operational gap surfaced in the listening sessions was the absence of an owner for the post-identification workflow, with case managers doing the work ad hoc and with high variation across patients and shifts, and naming the role is what transforms a heroic individual effort into a system process.

What good looks like. Every California health system with meaningful veteran volume has a named navigator role, a documented escalation pathway, and a working relationship with the regional VA medical center and the County Veterans Service Office, with the navigator reachable by the bedside team within one shift.

Recommendation 4. Require veteran-specific staff education as a condition of nursing licensure renewal and as part of new-hire onboarding

Themes addressed. Theme 1 (raises the baseline awareness that makes identification clinically meaningful) and Theme 4 (equips staff to recognize PACT-eligible conditions, behavioral health risks, and exposure histories).

Owner. California Board of Registered Nursing (BRN), in partnership with ANA\California, accredited continuing nursing education providers, and academic nursing programs.

What to do. Establish a one-time mandatory veteran-health continuing education requirement for nursing licensure renewal in California, modeled on existing mandatory CE topics (such as implicit bias, suicide prevention, and child abuse and neglect reporting), and the required content should cover the AAN "Have You Ever Served?" framework and the November 2025 AAN Military Health History Pocket Card as the standard identification and follow-up tool, together with veteran-specific health risks (PTSD, military sexual trauma, traumatic brain injury including chronic low-level blast exposure, PACT Act covered conditions, Agent Orange, contaminated water exposure, and Gulf War-related illness), PACT Act toxic exposure screening, VA benefits basics, and how to ask about service history in a respectful and privacy-aware way.

Why it matters. Staff education was the most frequently named lever in the listening sessions and is among the easiest to scale, with a single CE requirement reaching more than 400,000 California RNs over a renewal cycle, and it addresses the awareness gap upstream of the workflow changes recommended elsewhere in this brief.

What good looks like. California is the first state with a veteran-health CE requirement for nurses, the required module is co-developed with veteran-serving organizations and updated as the PACT Act list and other federal updates evolve, and health systems supplement the CE with role-specific onboarding for intake, case management, social work, and behavioral health teams.

Recommendation 5. Operationalize VA and civilian interoperability as a workflow, not just as a technology problem

Themes addressed. Theme 2 (removes patients as the bridge between systems) and Theme 3 (assigns workflow ownership for the records-connection step).

Owner. Health system informatics and operations leadership, with state-level coordination by HCAI and CalVet.

What to do. Define the operational steps that make VA-to-civilian record sharing actually happen for an identified veteran, including who initiates the records-connection request, at what point in the visit the request happens, with what consent language, who reviews the returned records, and where the results are documented; existing tools (Care Everywhere, the Veterans Health Information Exchange, and the federal EMR transition's emerging exchange capabilities) should be wired into a standard connect-records step in the veteran intake workflow rather than left as optional capabilities.

Why it matters. The current state places the burden of inter-system data flow on the patient, which is both an equity issue (the patients least able to navigate the connection are most affected) and a clinical safety issue (decisions are being made on incomplete records), and a workflow standard is what converts existing technical capability into routine practice.

What good looks like. Every identified veteran is offered records connection at intake using standardized scripting, consent is documented in the EHR, returned records are routed to a clinician for review, and the bedside team has visibility into VA medications, service-connected conditions, and recent VA encounters by the time they round on the patient.

Recommendation 6. Formalize partnerships for behavioral health, housing, and post-acute care so identified veterans are routed to a defined follow-up services package

Themes addressed. Theme 2 (removes families as default navigators), Theme 3 (creates the cross-agency owners), and Theme 4 (directly addresses behavioral health and housing as the dominant continuity gaps).

Owner. Health systems and county-level partners, with state-level partnership infrastructure from CalVet, the California Department of Health Care Services (DHCS), and the California Department of Housing and Community Development (HCD).

What to do. For every health system, define a documented veteran follow-up services package that an identified veteran is routed to at discharge, with the package prioritizing (a) behavioral health linkage, including warm handoffs to VA behavioral health, community mental health, and veteran peer-support programs; (b) housing resources, including coordinated entry into county Continuums of Care and VA Supportive Housing (HUD-VASH) where appropriate; (c) post-acute and home health providers familiar with VA coverage; and (d) a benefits-navigation touch point with the County Veterans Service Office.

Why it matters. Behavioral health and housing were named by participants as the largest sources of continuity-of-care failure for veterans, and authorization lag and post-acute unfamiliarity with VA coverage were named as recurring operational failures, and a defined services package is what converts each of these from a per-case scramble into a routable pathway.

What good looks like. A veteran discharged from a California hospital has documented, named follow-up arrangements for behavioral health and housing where indicated, with a primary point of contact and a defined timeline for first contact, and the hospital's case management team has a working relationship with the regional VA medical center and the County Veterans Service Office that pre-dates any individual discharge event.

Recommendation 7. Develop a state-level data and accountability mechanism so progress can be measured, reported, and benchmarked

Themes addressed. Theme 1 (makes identification visible as a quality measure) and cross-cutting (creates the feedback loop that the other recommendations need in order to mature).

Owner. California Department of Health Care Access and Information (HCAI), in coordination with CalVet, the BRN, and ANA\California.

What to do. Add a small set of veteran-care indicators to existing California hospital and clinic reporting, with indicators that include (1) the share of registered patients with a documented veteran or military-connected status, (2) the share of identified veterans with a documented downstream action (referral, navigator outreach, or records connection), (3) the share of identified veterans with a documented follow-up plan at discharge, and (4) the share of inpatient nursing staff with current veteran-health CE on record; publish results at the system level on an annual basis.

Why it matters. What gets measured tends to change, and the variability between similarly situated California systems (such as Scripps and Sharp serving the same San Diego population) is partly a function of the absence of any comparable, system-level measurement of veteran-aware care, so a small, sharp indicator set creates the feedback loop that the prior six recommendations need in order to mature into durable practice.

What good looks like. California publishes an annual snapshot of veteran-aware care across reporting facilities, with year-over-year improvement targets, and the dataset is usable by health systems for internal benchmarking and by policymakers for funding and partnership decisions.

Implementation Roadmap

The seven recommendations are intentionally sequenced, and the roadmap below summarizes the order in which they should be activated, the primary owners, and the time horizon for each:

- Months 0 to 12. Recommendation 1 (universal identification standard) and Recommendation 2 (EHR fields, banner flags, triggered workflows), owned by health systems, informatics leadership, and HCAI; these form the foundation for Themes 1 and 3.
- Months 6 to 18. Recommendation 3 (veteran navigator or VA liaison role), owned by health systems, CalVet, and County Veterans Service Offices, and dependent on Recommendation 1 being in place; addresses Themes 2 and 3.
- Months 6 to 24. Recommendation 4 (veteran-health CE for nursing licensure renewal), owned by the BRN, ANA\California, and accredited CE providers, moving on an independent regulatory track and addressing Themes 1 and 4.
- Months 12 to 24. Recommendation 5 (VA and civilian interoperability as workflow), owned by informatics leadership, HCAI, and CalVet, and dependent on Recommendations 1 and 2; addresses Themes 2 and 3.

- Months 12 to 24. Recommendation 6 (behavioral health, housing, and post-acute partnerships), owned by health systems, CalVet, DHCS, and HCD, and dependent on Recommendation 3; addresses Themes 2, 3, and 4.
- Months 18 to 36. Recommendation 7 (state-level data and accountability mechanism), owned by HCAI, CalVet, the BRN, and ANA\California, and dependent on Recommendations 1, 2, and 4 being in place to generate the underlying data; cross-cutting across the four themes.

The first two recommendations are foundational because without them the others lack the data and workflow scaffolding they require, while the CE requirement (Recommendation 4) can move on an independent regulatory track in parallel; Recommendations 5 and 6 then build on the identification and navigator infrastructure, and the data and accountability mechanism (Recommendation 7) becomes meaningful once Recommendations 1, 2, and 4 are in place to generate the underlying data.

Call to Action

To California health system leaders

We ask system leadership to commit, within twelve months, to Recommendations 1 and 2, since both are within the operational authority of system and informatics leadership, both have proof points already inside California, and both create the conditions under which everything else in this brief becomes feasible; ANA\California stands ready to convene cross-system informatics, nursing, and operations leaders to share implementation playbooks across the systems that move first.

To the California Board of Registered Nursing

We ask the BRN to move Recommendation 4, a one-time veteran-health CE requirement for nursing licensure renewal, through the established mandatory-CE pathway in California, with the required content co-developed by veteran-serving organizations and the Advisory Council; this single regulatory action would reach the full California nursing workforce within one renewal cycle.

To the California Legislature, HCAI, CalVet, DHCS, and HCD

We ask the Legislature and the state agencies named here to coordinate existing authority to advance Recommendations 5, 6, and 7, none of which require new statutory authority, since what they require is a shared decision to use licensure reporting, partnership infrastructure, and existing exchange platforms in a coordinated way. We invite a state-level convening, hosted with ANA\California, to align on indicators, timelines, and partnership commitments.

Conclusion

California's civilian health system is, in practice, a primary provider of veteran care, and the veterans inside it carry health histories that civilian systems were not designed to ask about together with care coordination needs that civilian systems were not designed to meet. The four themes developed in this

brief describe the contours of that gap with more analytical precision than a list of findings can: identification operates as administrative ritual rather than as a clinical signal that triggers support; the burden of bridging institutional gaps falls onto patients and families rather than on the institutions themselves; the post-identification workflow happens without a named owner; and continuity collapses where systems do not communicate well across organizational boundaries, with behavioral health and housing carrying most of the weight and clinical risk following close behind.

The recommendations that follow from these themes are deliberately limited to seven actions, sequenced by feasibility and impact, mapped explicitly to the themes they address, and assigned to owners with the authority and infrastructure to act on them, and they use mechanisms California has already proven it can operate at scale, including licensure CE requirements, HCAI reporting, EHR configuration standards, CalVet partnership infrastructure, and the convening capacity of ANA\California itself.

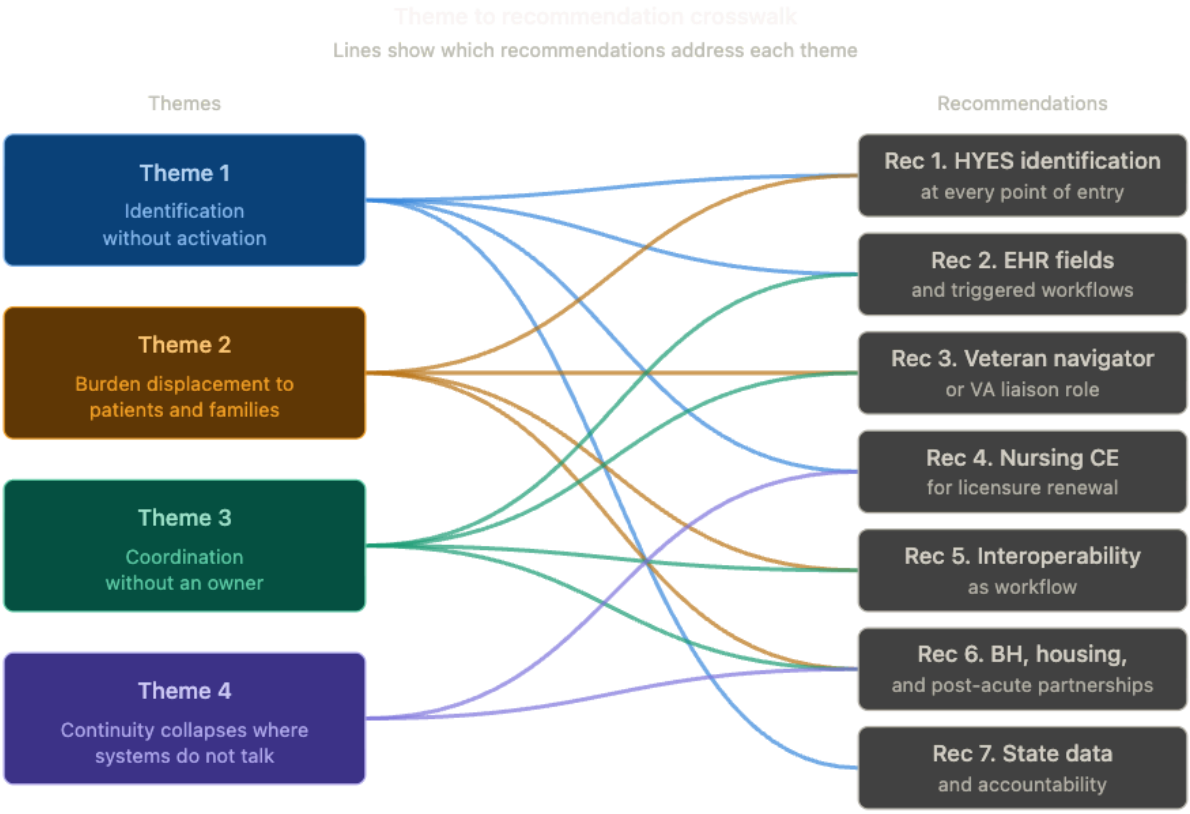
California has the largest veteran population in the country together with one of the most consequential nursing workforces in the country, which together make veteran-aware care by design a reachable goal rather than an aspirational one, and the ANA\California and Veteran Health Advisory Council invite system leaders, regulators, legislators, and partner organizations to commit to the seven actions in this brief and to the implementation horizon they describe.

Appendix

A. Theme to recommendation crosswalk

The seven recommendations map back to the four themes as follows, with the crosswalk intended as a credibility tool so that each recommendation can be traced to the analytical claim that supports it:

- Theme 1 (identification without activation) is addressed by Recommendations 1, 2, 4, and 7.
- Theme 2 (burden displacement to patients and families) is addressed by Recommendations 1, 3, 5, and 6.
- Theme 3 (coordination without an owner) is addressed by Recommendations 2, 3, 5, and 6.
- Theme 4 (continuity collapses where systems do not talk) is addressed by Recommendations 4 and 6.



B. Owner-organized recommendation summary

A condensed view of the seven recommendations by primary owner:

Health systems and employers. Adopt the AAN "Have You Ever Served?" identification framework at every point of entry (Recommendation 1); configure EHR fields, banner flags, and triggered workflows aligned with the AAN Military Health History Pocket Card (Recommendation 2); name a veteran navigator or VA liaison role (Recommendation 3); define the interoperability workflow (Recommendation 5); and build behavioral health, housing, and post-acute partnerships (Recommendation 6).

Educators and training programs. Co-develop veteran-health CE content (Recommendation 4); integrate veteran-specific competencies into nursing pre-licensure curricula; and provide role-specific onboarding modules in partnership with health systems.

Regulators and policymakers. BRN: adopt veteran-health CE as a mandatory renewal topic (Recommendation 4). HCAI: add veteran-care indicators to hospital and clinic reporting (Recommendation 7). CalVet: coordinate state-level partnership infrastructure. DHCS and HCD: align

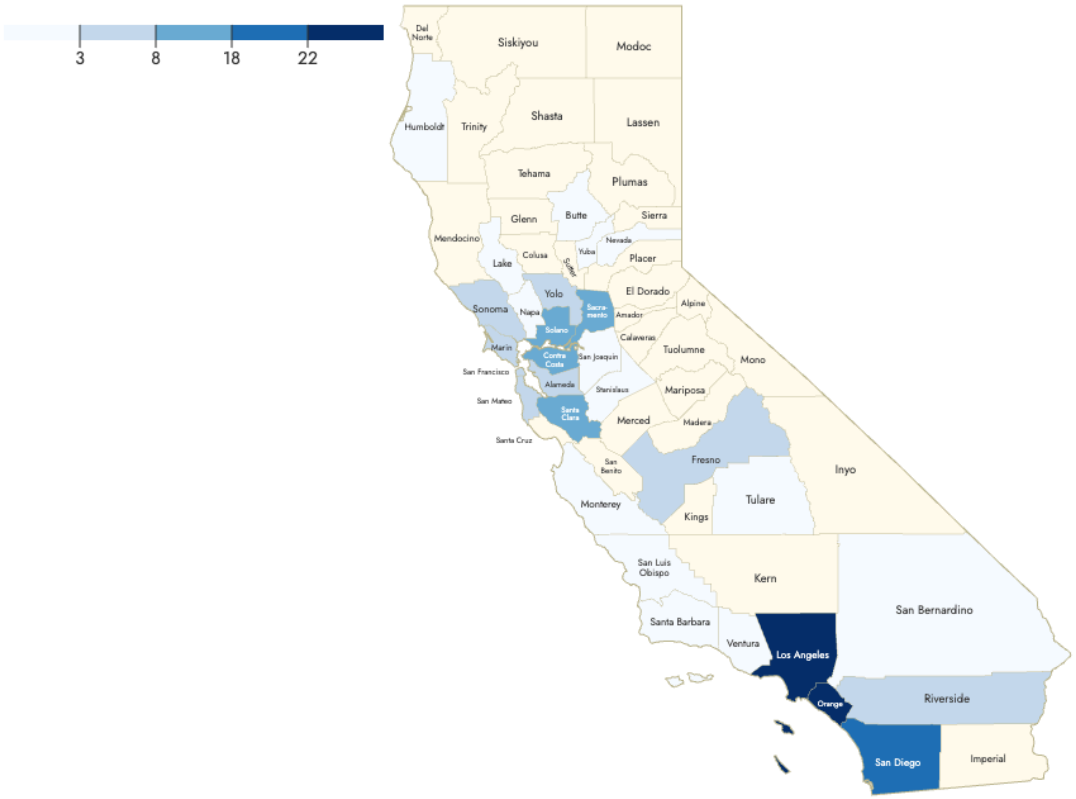
behavioral health and housing pathways with veteran-specific needs. Legislature: support statewide convening and reporting infrastructure.

Professional associations and partners. ANA\California: convene cross-system informatics, nursing, and operations leaders; co-develop CE content; host an annual statewide convening on veteran-aware care; and partner with the VA, County Veterans Service Offices, and veteran-serving community organizations on referral pathways.

Recommendation	Health Systems & Employers	Educators & Training Programs	Regulators & Policymakers	Professional Associations & Partners
Rec 1. HYES identification standard *Adopt the AAN framework at every point of entry.*	●	·	·	·
Rec 2. EHR triggered workflows *Configure structured fields and triggered actions.*	●	·	·	·
Rec 3. Veteran navigator role *Name a single owner for post-identification work.*	●	·	·	·
Rec 4. Mandatory licensure CE *Veteran-health CE for nursing license renewal.*	·	●	●	●
Rec 5. Interoperability workflow *A defined records-connection step at intake.*	●	·	·	·
Rec 6. BH, housing, post-acute partnerships *Route veterans to a defined follow-up package.*	●	·	·	●
Rec 7. State data and accountability *Add veteran-care indicators to HCAI reporting.*	·	·	●	●

C. Survey geographic coverage (partial responses)

Survey responses (approximately 200 total at the time of this draft) are concentrated in metropolitan Southern California and the Bay Area, with substantial gaps in the Central Valley, North Coast, and Sierra counties, and the next survey wave should specifically address these gaps:



This graphic was designed using ultimaps

D. PICO question (reference)

Clinical framing. In veterans receiving care in the civilian healthcare system (P), does the use of a structured, veteran-specific intake process (I), compared to standard civilian healthcare intake (C), result in better identification of veterans' unique healthcare and resource needs (O)?

Informatics framing. In veterans receiving care in the civilian healthcare system (P), does the use of a veteran-specific EHR intake system (I), compared to standard EHR intake systems (C), lead to improved identification, documentation, and management of veterans' unique healthcare needs (O)?

E. References

References are formatted to American Psychological Association (APA) 7th edition style. Page ranges use hyphens in place of en dashes for consistency with the rest of the document.

Identification framework and clinician resources

American Academy of Nursing. (2025, November). *Military health history pocket card for clinicians: Have you ever served in the military?* AAN Military and Veterans Health Initiative. https://cdn.ymaws.com/aannet.org/resource/resmgr/policydocuments/HYES_Pocket_Card_Nov_2025.pdf

American Academy of Nursing. (n.d.). *Have you ever served in the military? Campaign.* AAN Military and Veterans Health Initiative. https://www.haveyoueverserved.com

Carlson, J., Andrews, J., Ortiz, M., Jackson, M., Frazier, R., Gomez, S., Jarvis, T., & Williams, M. (2013). "Have you ever served in the military?" Campaign in partnership with the Joining Forces initiative. *Nursing Outlook, 61*(5), 375-376.

U.S. Department of Veterans Affairs. (n.d.). *Community provider toolkit.* VA Office of Mental Health and Suicide Prevention. https://www.mentalhealth.va.gov/communityproviders/

U.S. Department of Veterans Affairs. (n.d.). *Military health history pocket card for health professions trainees and clinicians.* Office of Academic Affiliations. https://www.va.gov/oaa/docs/mhpcmobile.pdf

U.S. Department of Veterans Affairs. (n.d.). *The PACT Act and your VA benefits.* https://www.va.gov/PACT

U.S. Department of Veterans Affairs, Office of Public Health. (n.d.). *Military environmental exposures assessment pocket card for healthcare professionals.* https://www.publichealth.va.gov/PUBLICHEALTH/docs/exposures/MEE-Assessment-Pocket-Card.pdf

Methodological references

Bourgois, P., Holmes, S. M., Sue, K., & Quesada, J. (2017). Structural vulnerability: Operationalizing the concept to address health disparities in clinical care. *Academic Medicine, 92*(3), 299-307.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11*(4), 589-597.

Donabedian, A. (1966). Evaluating the quality of medical care. *The Milbank Memorial Fund Quarterly, 44*(3), 166-206.

Donabedian, A. (1988). The quality of care: How can it be assessed? *JAMA, 260*(12), 1743-1748.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Sage.

Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine, 103*, 126-133.

Penchansky, R., & Thomas, J. W. (1981). The concept of access: Definition and relationship to consumer satisfaction. *Medical Care, 19*(2), 127-140.

Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R. G. Burgess (Eds.), *Analyzing qualitative data* (pp. 173-194). Routledge.

F. Acknowledgments

This brief was prepared by the ANA\California Veteran Health Advisory Council with contributions from the Advocacy Institute Fellows.

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Survey instrument: https://www.anacalifornia.org/veteran-health-survey



This figure was developed using generative artificial intelligence as a design-support tool. AI-assisted methods were used to explore visual layouts, graphic structure, and illustration concepts. All substantive content, interpretation, recommendations, and final design decisions were created, reviewed, and approved by the authors.