"Advancing" Advance Care Planning to Veterans in the Veterans Health Administration

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ABSTRACT
Introduction: The completion rate of Advance Directive (ADs) in the Veterans Health Administration (VHA) is unknown. There is substantial literature on the need for effective Advance Care Planning (ACP) that leads to an AD to ensure that health care preferences for patients are known. Advance Directive are essential to consider since ACP, which explains and plans Advance Directive, does not reach all individuals. Health inequities, such as those experienced in rural areas, continue to exist. While ACP may disproportionately affect rural-residing veterans and their providers, a VHA program was specifically designed to increase ACP engagement with rural veterans and to address several systemic barriers to ACP.

Materials and Methods: This descriptive analysis seeks to identify patient, provider, and geographic characteristics associated with higher rates of ACP participation in VHA. An observational examination of the profile of veterans and the types of ACP (e.g., individual or in groups) using administrative data for all beneficiaries receiving VHA health care services in federal fiscal year (FY) 2020 was conducted as part of a national program evaluation. The measures include patient-level data on demographics (e.g., race, ethnicity, gender), unique patient identifiers (e.g., name, social security number), geographic characteristics of patient’s location (e.g., rurality defined as Rural–Urban Commuting Areas [RUCA]), VHA priority group; provider-level data (e.g., type of document definition, clinic stop codes, visit date used to verify Advance Care Planning via Group Visits [ACP-GV] attendance; data not shown), and electronic health record note titles that indicated the presence of ACP in VHA (e.g., “Advance Directive [AD] Discussion” note title, “ACP-GV CHAR 4 code”). Pearson’s chi-square statistics were used for between-group comparisons based on a two-sided test with a significance level of 0.05.

Results: The overall rate of AD discussions among unique VHA users in FY2020 was 5.2% (95% CI: 5.2%—5.2%) and for Advance Care Planning via Group Visits, which targets rural veterans using groups, it was 1.8% (95% CI: 1.8%—1.9%). Advance Directive discussions in VHA are more successful at reaching middle age (M = 64; SD = 16), African Americans, males, veterans living in urban areas, and veterans with a VA disability (Priority Group 1-4). Advance Care Planning delivered in groups is reaching slightly younger veterans under the age of 75 years (M = 62; SD = 15), African Americans, females, disabled veterans (e.g., Priority Group 1-4), and more veterans residing in rural communities compared to the national population of VHA users.

Conclusion: Advance Directives are delivered in groups is reaching slightly younger veterans under the age of 75 years (M = 64; SD = 16), African Americans, males, veterans living in urban areas, and veterans with a VA disability (Priority Group 1-4). Advance Care Planning delivered in groups is reaching slightly younger veterans under the age of 75 years (M = 62; SD = 15), African Americans, females, disabled veterans (e.g., Priority Group 1-4), and more veterans residing in rural communities compared to the national population of VHA users.

INTRODUCTION
Advance Care Planning (ACP) is an essential health care intervention that is defined as “...a process for identifying and communicating an individual’s values and preferences regarding future health care for use at a time when that person is no longer capable of making health care decisions. Advance Care Planning may, but does not necessarily, result in an Advance Directive (AD) document.”11 An AD is a written statement by a person who has decision-making capacity regarding preferences for the health care team to follow if
that individual becomes unable to make or communicate those decisions in the future.1

These early discussions are of paramount importance when an individual is unable to communicate or has diminished decision-making capabilities and another person (e.g., spouse, significant other, or a trusted agent) must be called upon to act on the individual’s behalf. An AD can help ensure that the patient’s preferences or wishes are respected and followed and has the added benefit of providing the other party with written guidance to inform decision-making. An AD can also mitigate future concerns the health care surrogate may have about having done the “right” thing, allaying any residual feelings of uncertainty, responsibility, or guilt for decisions made.

The completion rate of ADs in the Veterans Health Administration (VHA) is unknown. Based on previous literature, community estimates of AD completion rates are 26%.2 Using this as a guide, we estimate that 6.7 of the 9.3 million veterans enrolled in VHA care have not documented their preferences and, therefore, are at risk of painful or invasive procedures that will not prolong their quality of life or of being hospitalized without their health care preferences being known.

The initial guidance, VHA Handbook 1004.023, mandates personalized ACP, that may result in ADs, to comply with the Patient Self-Determination Act of 1990 and the guidelines of The Joint Commission.4 Veterans Health Administration also expects providers to give veterans a chance to update their written AD annually (i.e., via the yearly requirement to ask about ACP during a visit for all veterans regardless of whether they already have a written AD). However, documentation of these conversations in VHA varies due to barriers including patient lack of awareness and provider lack of perceived clinical priority.5 In addition, both providers and patients may avoid these conversations for reasons that include discomfort with the topic, actual or perceived lack of time for adequate discussion,6 or mistaken beliefs that ACP is only needed at the end-of-life. In addition, veterans may not have an opportunity to engage in ACP due to access issues or other systemic barriers, such as provider and social work shortages in rural areas.7 Ultimately, the absence of documented ACP conversations, whatever the reason, increases the risk that veterans will receive care differently than they prefer and may experience undesired interventions leading to increased suffering and higher health care costs.8

National Data for ACP among VHA Users

To address barriers to documentation of ACP and to facilitate counting and locating ADs, the Department of Veterans Affairs (VA) National Center for Ethics in Health Care published a revision, VHA Directive 1004.06, in October 2018.9 This directive mandates the standardization of ACP-related note titles to be used within the electronic health record. Records were searched for ACP or AD documentation in accordance with this policy, and if not present, the patient was presumed to not have relevant documentation within the past year. Standardization of naming conventions system-wide now allows VHA to ensure that streamlined and consistent documentation practices align with the goal to become a high-reliability organization. As such, national-level VHA administrative data now provide an unprecedented opportunity to estimate the national rates of ACP among VHA users. To our knowledge, this article provides the first view of data using standardized note titles from VHA.

Best Practices: ACP-GV as an Office of Rural Health Enterprise-Wide Initiative

Advance Care Planning may occur in or outside of health care settings and may or may not involve health care professionals directly. There are two types of ACP: (1) individual ACP involving a provider and an individual patient discussing the patient’s care preferences, and (2) Advance Care Planning via Group Visits (ACP-GV), in which a trained clinician facilitates ACP discussions in a group of six to eight individuals. The primary goal of ACP-GV is to increase participation in ACP among veterans who reside in rural areas and are considered underserved by ACP. Both types address the key concepts of ACP and discuss the components of an executable AD.

Veterans Health Administration’s Office of Rural Health (ORH) funded an Enterprise-Wide Initiative Rural Access Solution grant in federal fiscal year (FY) 2017 (October 1, 2017—September 30, 2018) to integrate ACP-GV into VHA’s rural medical centers and Community-Based Outpatient Clinics (CBOCs) and to increase ACP engagement with rural veterans. The program was designed to address several systemic barriers to ACP that disproportionately affect rural-residing veterans and their providers, including: (1) a lack of understanding among veterans about the purpose and importance of ACP for themselves and its benefit to their families, (2) the dearth of health professionals trained in ACP in rural CBOCs, and (3) lack of quality ACP engagement in rural areas. This program offered 3 years of ORH seed funding to selected rural VHA facilities and CBOCs for staffing and resources that must be targeted primarily to veterans residing in rural areas. Seed funding, however, is limited to only 3 years for each site and requires an approved application.

In the remainder of this article, we describe the patient, provider, and structural characteristics associated with ACP participation in VHA, with a focus on the role of ACP-GV.

METHODS

We extracted patient- and provider-level data from the VA Corporate Data Warehouse, which houses administrative health care records for VHA service users in all 50 states, territories, and the District of Columbia. Program evaluation analyses focused on ACP that occurred in FY 2020 (October 1, 2019—September 30, 2020), the first full year of evaluation data collected and analyzed from the ACP-GV National Program. Since inception, ACP-GV has been implemented in over a third (75/171) of the VA Medical Centers across the nation.
Medical Record Documentation of ACP

Per VHA Handbook 1004.02, all health care providers are required to document all instances of ACP in the veteran’s electronic health record using one of three note titles. These note titles are: (1) “Advance Directive Discussion,” for any engagement with veterans about ACP, individually or in a group visit; (2) “Advance Directive,” for documenting completion of an AD; and (3) “Rescinded Advance Directive,” for documenting the removal of an AD from use. A clinical reminder dialogue (CRD) is used by a clinical provider to document participation in group ACP. The clinician who facilitates the ACP-GV group enters the type of participation in the “Advance Directive Discussion” note. Adding the CRD at the local level for ACP-GV documentation started in October 2018 with the launch of the ORH-funded ACP-GV National Program to disseminate and to evaluate the use of ACP best practices in rural areas.

Veterans Health Administration emphasizes delivery of care that is personalized, proactive, and patient-driven, much like ACP-GV, thus requiring tracking of both the implementation and the effectiveness of these new patient-driven services. These new services are tracked separately from conventional therapies due to the differences in required training and/or the focus of the interventions. This necessitates tracking beyond procedure-based codes to include documentation of locations where new services are being provided, the person providing them, required resources, and outcomes. Four-character (i.e., CHAR 4) codes that specifically identify these new services have been added to VHA documentation practices. “Advance Directive Discussion” notes accompanied by four-character code (a.k.a. a CHAR 4 code) can be used to identify veterans receiving ACP in group setting (ACP-GV) and notes without a CHAR 4 code can be used to identify veterans receiving ACP individually. ACP-GV provider workload is also documented by the provider using the CHAR 4 code entry for each veteran attending a group visit.

Measures

The measures used in this analysis include: patient-level data on demographics (e.g., race, ethnicity, gender), unique patient identifiers (e.g., name, social security number), geographic characteristics of patient’s location (e.g., rurality defined as Rural–Urban Commuting Areas [RUCA]), VHA priority group, defined as an indicator of each person’s medical needs along with the potential cost of VHA care provision (e.g., nonveteran means an individual that has not served in the U.S. uniformed services). However, the individual may still be eligible to receive VHA health care due to special categorizations/circumstances such as type of insurance (e.g., The Civilian Health and Medical Program of the Department of Veterans Affairs [CHAMPVA] or beneficiary); Priority 1-4 is those veterans who have a VA disability; Priority 5-6 is those veterans who have a 0% VA disability, VA pension, or annual income lower than VA adjusted income levels, or select military service before 1988; Priority 7-8 is those veterans whose income is above and below the VA income limits and geographically adjusted income limits for where they live, and agree to copayments; provider-level data (e.g., type of documentation, clinic stop codes, visit date used to verify ACP-GV attendance; data not shown), and electronic health record note titles that indicated the presence of ACP in VHA (e.g., “Advance Directive [AD] Discussion” note title, “ACP-GV CHAR 4 code”).

Data Analysis

Pearson’s chi-square statistics were used for between-group comparisons. Data were analyzed using SAS version 9.4 (SAS Institute Inc.) based on a two-sided test with significance level of 0.05.

RESULTS

A total of 6,767,313 unique VHA patients were identified who used VHA services in FY 2020 and whose electronic health records included documentation of those with and without ACP, and either via an AD discussion note title (hereafter called AD discussion) or ACP-GV code. Frequencies and percentages were used to summarize key demographic characteristics for four groups: the subgroups of the national VHA-user population in FY 2020 that (1) did (n = 351,353) and (2) did not (n = 6,415,960) have any documented AD discussion (individual or group), and the subgroups that (3) did (n = 6,425) and (4) did not (n = 6,760,888) have documentation of group visits using the ACP-GV CHAR 4 code. The overall rate of any documented AD discussion among VHA users in FY 2020 was 5.19% (95% CI: 5.18%–5.21%), and among all AD discussions in FY 2020, the rate of ACP-GV, which targets rural areas using groups, was 1.83% (95% CI: 1.78%–1.87%).

As shown in the Table I, the group with no AD discussions in FY 2020 differed significantly from the group with any AD discussion on most key demographic characteristics. Specifically, the AD discussion group was slightly older on average (64 [SD = 16] vs. 62 [SD = 17]; P < .0001) and included a higher percentage of African American (26.7% vs. 18.3%; P < .0001) veterans. The two groups included similar percentages of Hispanic or Latino (7.2% vs. 7.6%) veterans. Higher proportions of those with no AD discussions were rural residents (33.9% vs. 29.8%; P < .0001) and women (12.0% vs. 10.2%; P < .0001) veterans compared to those with any documented AD discussion. The overall test and pairwise comparisons for priority categories were highly significant across the two groups. Fewer veterans in the AD discussion group were categorized as “nonveteran” and “Priority 7-8” compared to the national veteran VHA users group.

The results for comparisons of the FY 2020 subgroups with and without documented ACP-GV are in the Table I. Similar to analyses comparing the national veteran population of VHA users to the AD discussion population, all between-group comparisons were statistically significant. While the overall
TABLE I. Comparison of Characteristics of Veterans Health Administration (VHA) Users Who Had and Did Not Have an Advanced Directive (AD) Discussion or Advanced Care Planning via Group Visit (ACP-GV) in Federal Fiscal Year 2020 (N = 6,767, 313)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>FY2020 VHA users with no AD discussion</th>
<th>FY2020 VHA users with AD discussion</th>
<th>P-values</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-34</td>
<td>n = 6,415,960 (95%)</td>
<td>n = 351,353 (5.0%)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>35-54</td>
<td>M(SD) 62(17)</td>
<td>M(SD) 64(16)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>55-64</td>
<td>&lt;0.0001a</td>
<td>&lt;0.0001b</td>
<td>&lt;0.0001a</td>
</tr>
<tr>
<td>65-74</td>
<td>&lt;0.0001a</td>
<td>&lt;0.0001b</td>
<td>&lt;0.0001a</td>
</tr>
<tr>
<td>75+</td>
<td>&lt;0.0001a</td>
<td>&lt;0.0001b</td>
<td>&lt;0.0001a</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race*</th>
<th>FY2020 VHA users with no ACP-GV</th>
<th>FY2020 VHA users with ACP-GV</th>
<th>P-values</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>n = 6,760,888 (99.9%)</td>
<td>n = 6,425 (0.1%)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Caucasian</td>
<td>M(SD) 63(17)</td>
<td>M(SD) 62(15)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Other</td>
<td>&lt;0.0001a</td>
<td>&lt;0.0001b</td>
<td>&lt;0.0001a</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity*</th>
<th>FY2020 VHA users with no ACP-GV</th>
<th>FY2020 VHA users with ACP-GV</th>
<th>P-values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic or Latino</td>
<td>n = 442,833 (7.2%)</td>
<td>283 (5.6%)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>M(SD) 5,707,911 (93%)</td>
<td>5,890 (95%)</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rural, Urban</th>
<th>FY2020 VHA users with no ACP-GV</th>
<th>FY2020 VHA users with ACP-GV</th>
<th>P-values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>n = 427,394 (66%)</td>
<td>&lt;0.0001</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Urban</td>
<td>2,280,460 (34%)</td>
<td>2,362 (37%)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Gender</td>
<td>Male 5,648,251 (88%)</td>
<td>5,583 (87%)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Female</td>
<td>802,486 (12%)</td>
<td>842 (13%)</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority</th>
<th>FY2020 VHA users with no ACP-GV</th>
<th>FY2020 VHA users with ACP-GV</th>
<th>P-values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Veteran</td>
<td>n = 350,986 (5.2%)</td>
<td>16 (0.2%)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Priority 1-4</td>
<td>3,590,747 (59%)</td>
<td>4,567 (71%)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Priority 5-6</td>
<td>1,959,259 (29%)</td>
<td>1,647 (26%)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Priority 7-8</td>
<td>463,169 (6.9%)</td>
<td>195 (3.0%)</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

*Denote variable contain missing observations;
bDenote p-value from overall test;
Denote p-value from pairwise test.
Non-veteran means an individual that has not served in the U.S. uniformed services. However, the individual may still be eligible to receive VHA health care due to special categorizations/circumstances(e.g., CHAMPVA or beneficiary); Priority 1-4 is those veterans who have a VA disability; Priority 5-6 is those veterans who have a 0% VA disability, VA pension, or annual income lower than VA adjusted income levels, select military service before 1988; Priority 7-8 is those veterans whose income is above and below the VA income limits and geographically adjusted income limits for where they live, and agree to copayments. For more detail, see: https://www.va.gov/health-care/eligibility/priority-groups/.

discussion

test statistic for age was significant, the largest pairwise comparison differences occurred in the 75+ age cohort with ACP-GV having a much smaller percentage compared to the national population of VHA users in FY 2020 (16.6% vs. 24.3%; p<0.0001). The ACP-GV group was slightly younger on average (62 [SD = 15] vs. 63 [SD = 17]; P <.0001), included a higher percentage of African American veterans (31.8% vs. 18.7%; P <.0001), more women veterans (13.1% vs 11.9%; P = .0022) and more rural residents (36.8% vs. 33.7%; P <.0001) than the group with no documented ACP-GV. Finally, the ACP-GV group had a higher percentage of veterans classified as “Priority 5-6” or “7-8.”

**DISCUSSION**

We aimed to describe the VHA population using ACP and identify patient, provider, and geographic characteristics associated with higher and lower rates of ACP participation in VHA. In addition, we sought to initiate a more in-depth understanding of how VHA currently engages veterans in ACP. Compared to those who had no AD documentation, veterans in the VHA AD discussion cohort were middle aged (54 to 74 years), African Americans, males, lived in urban areas, and had an established VA disability rating (i.e., “Priority Group 1-4”). The findings related to priority groups, which is an indicator of medical need, and cost of care suggest that veterans with greater needs may have more engagement in VHA care, and resulting, more access to ACP. Compared to those who had no group AD documentation, the ACP-GV cohort included a higher proportion of veterans who were under the age of 75, African Americans, females, had an established VA disability rating, and lived in a rural area.

Overall, study findings indicate that we are reaching veterans who are considered underserved owing to residing in rural areas. This is reflected in the finding that rural veterans were
overrepresented among those receiving ACP-GV, although the reverse was true for those having any AD discussion. For ORH seed funded ACP-GV sites in rural areas, the initial infusion of dedicated resources and attention to ACP is adding value and specialized services to rural VHA facilities and CBOCs. Seed funding, however, is limited to only 3 years. Therefore, the authors used the number of unique patients with AD discussions as an indicator to begin a conversation with ACP-GV National Program leadership about the potential impact that the distribution of resources for ACP to nontraditional settings, such as rural community clinics, would likely have on other largely underrepresented veteran subpopulations if scale up and spread to all veterans in the VHA population was achieved.

Limitations
This evaluation contains limitations. First, it is important to consider the impact of clustering on interpretation of individual-level findings, especially because the clustering cannot be controlled in the characteristic-specific bivariate comparisons. In addition, because of the large sample size, nearly all between-group differences achieve statistical significance; careful attention must be paid to whether they are also meaningful differences. Thirdly, with regard to respondent and selection bias, proposals for ORH seed funding to specifically promote ACP-GV was introduced via an annual application to solicit large VA facilities that serve nearby rural communities. While all VA facilities that serve rural populations can apply for funding, not all have. Thus, it is possible that patient characteristics may not be what is driving participation. Rather, the significant difference may be in the characteristics of sites that delivered ACP-GV and those that did not. Nonetheless, individual-level data on unique veteran users are critical in estimating the reach of the ACP mandate across VHA. Overall, information on who is reached, and where, is essential in planning for the future spread of ACP individually or via group visits. Next, documentation variation due to an AD being a scanned image stored in electronic medical records is an ongoing issue and the ease of locating completed or previous versions of ADs should not be a barrier to ACP discussions taking place. Finally, using the same AD discussion note title is challenging for evaluation as this documentation practice does not allow for the data to be differentiated by type, group, or individual. To compensate for this, we use both note titles and CHAR 4 codes in our analyses that provides a first look of the data using four different groups for comparison with a large national sample.

Policy Implications and Call to Action
A national program targeting rural areas has improved veteran access to ACP. A recent controversy in the field suggests that ACP has not been translated into a well-defined or well-funded national priority and that “a call to action to improve the processes that prevent ACP from being successful” is needed. Yet, given the likelihood that every individual may experience unexpected illness(es) or injury(ies), will face needs for end-of-life care, and may have specific wishes (including religious and/or cultural preferences) about how those needs are met, ACP is invaluable in patient-centered health care. It is imperative that health care workers commit to having ACP conversations surrounding care preferences and ensure that these wishes are documented in an AD and stored in an easily accessible location. These steps make certain the health care team has supported their patients in preparing for an unexpected health care crisis. In addition to patient-centered care delivery, system-wide strategies such as identifying national partners, garnering top leadership support, and securing resources to enable scale up and spread of this field-based innovation focused on reaching targeted subpopulations of veterans, are planned. ACP is needed now more than ever to ensure all veterans, young and old, healthy and acutely or chronically ill, have their wishes respected and followed.

CONCLUSION
It is timely, given the urgency of Coronavirus (COVID-19) pandemic, to have more balanced, data-driven discussions regarding the challenges posed in promoting ACP amid the difficult task of setting health care priorities. It is imperative to disseminate the message that ACP and ADs are needed for everyone across the life course who might suddenly experience an emergent condition that limits their ability to communicate their preferences. By expanding ACP through discussions held in a group setting, the authors hope to broaden the dimensions for the creation of a well-informed clinical priority and best practice that would engage the entire veteran population in ACP and support the completion of ADs. As an ORH “Rural Promising Practice” model for the delivery of ACP to veterans in a group format, ACP-GV has great potential to increase quality and access to ACP beyond rural facilities to all VHA facilities and their CBOCs and in any nonveteran health care setting.

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CONFLICT OF INTEREST STATEMENT

None declared.

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