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Addressing Veteran Health-Related Social Needs: How Joint Commission Standards Accelerated Integration and Expansion of Tools and Services in the Veterans Health Administration

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Background: The Joint Commission recently named reduction of health care disparities and improvement of health care equity as quality and safety priorities (Leadership [LD] Standard LD.04.03.08 and National Patient Safety Goal [NPSG] Standard NPSG.16.01.01). As the largest integrated health system, the Veterans Health Administration (VHA) sought to leverage these new accreditation standards to further integrate and expand existing tools and initiatives to reduce health care disparities and address health-related social needs (HRSNs).

Initiatives and Tools: A combination of existing data tools (for example, Primary Care Equity Dashboard), resource tools (for example, Assessing Circumstances and Offering Resources for Needs tool), and a care delivery approach (for example, Whole Health) are discussed as quality improvement opportunities to further integrate and expand how VHA addresses health care disparities and HRSNs. The authors detail the development timeline, building, limitations, and future plans for these tools and initiatives.

Coordination of Initiatives: Responding to new health care equity Joint Commission standards led to new implementation strategies and deeper partnerships across VHA that facilitated expanded dissemination, technical assistance activities, and additional resources for VHA facilities to meet new standards and improve health care equity for veterans. Health care systems may learn from VHA's experiences, which include building actionable data platforms, employing user-centered design for initiative development and iteration, designing wide-reaching dissemination strategies for tools, and recognizing the importance of providing technical assistance for stakeholders.

Future Directions: VHA continues to expand implementation of a diverse set of tools and resources to reduce health care disparities and identify and address unmet individual veteran HRSNs more widely and effectively.

The Joint Commission bolstered the role health care systems play in addressing social determinants of health (SDOH) by naming the reduction of health care disparities as a quality and safety priority (Leadership [LD] Standard LD.04.03.08).[1] Soon after, The Joint Commission moved and elevated the priority by establishing a new National Patient Safety Goal (NPSG) to improve health care equity (NPSG.16.01.01) containing six elements of performance (EPs).[2] The Veterans Health Administration (VHA), an integrated health care system providing medical and social services to more than nine million veterans at more than 1,300 health care facilities,[3] is uniquely positioned to demonstrate national leadership in addressing health-related social needs (HRSNs) and improving health care equity.

In this conceptual article, we share how strategies to address veteran HRSNs and health care disparities within VHA are being integrated to support NPSG.16.01.01. First, we describe VHA initiatives related to ameliorating unmet HRSNs and health care disparities that predated the new Joint Commission standards to improve health care equity. We then describe how we coordinated these initiatives in response to the new Joint Commission standards. We share limitations and future directions of these efforts in hopes that other health systems may learn from VHA's journey to eliminate health disparities and become a High Equity Reliability Organization.[4]

INITIATIVES ADDRESSING HEALTH CARE DISPARITIES AND SOCIAL DETERMINANTS OF HEALTH PRIOR TO 2023 JOINT COMMISSION STANDARDS TO IMPROVE HEALTH CARE EQUITY

VHA established the Office of Health Equity (OHE) in 2012 to champion the advancement of health equity and reduction of health disparities.[5] OHE's strategy is to identify

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Table 1. Organizational Matrix Description of Key Initiatives for Addressing Health-Related Social Needs and Health Care Disparities

Initiative	Partner(s)	VHA Sponsor(s)
Assessing Circumstances and Offering Resources for Needs (ACORN)	ACORN Leadership Team Office of Health Equity National Social Work Program Veterans Affairs Medical Centers Knowledge Based Systems Office of Connected Care Office of Patient Centered Care and Cultural Transformation	Office of Health Equity Care Management and Social Work Services Veterans Affairs Health Services Research and Development—Center of Innovation in Long-Term Services and Supports for Vulnerable Veterans New England Geriatric Research, Education, and Clinical Center
Primary Care Equity Dashboard	Office of Health Equity Veterans Affairs Health Services Research and Development—Center for Health Equity Research and Promotion Veterans Integrated Service Network 4 Office of Patient Centered Care and Cultural Transformation	Office of Health Equity Veterans Affairs Health Services Research and Development
Whole Health	Veterans Affairs Medical Centers	Office of Patient Centered Care and Cultural Transformation

VHA, Veterans Health Administration.

Table 2. Assessing Circumstances and Offering Resources for Needs (ACORN) Health-Related Social Needs Domains

Health-Related Social Needs Domain	Years Included
Housing	2018–present
Food	2018–present
Utilities	2018–present
Transportation	2018–present
Legal	2018–present
Social isolation and loneliness	2018–present
Employment	2018–present
Education	2018–present
Digital access and literacy	2021–present
Interpersonal violence	2018–2022

and address social risks that underlie many inequities and to reduce disparities in clinical care directly. In addition, multiple offices support the initiatives we discuss that seek to advance health care equity (Table 1). We briefly describe three initiatives that began prior to the new Joint Commission standards: (1) Assessing Circumstances and Offering Resources for Needs (ACORN); (2) Primary Care Equity Dashboard (PCED); and (3) Whole Health.

ACORN

VHA routinely screens veterans for food insecurity,[6] housing instability,[7] and intimate partner violence[8] but has not historically conducted systematic screening for a broader set of social risks. An interprofessional group convened in 2018 to develop the ACORN quality improvement (QI) initiative to systematically identify and address veteran unmet HRSNs within nine domains (Table 2).[9–11]

The first iteration of ACORN was revised based on cognitive interviews with 18 veterans,[9] then piloted as a veteran-administered, tablet-based screener in a mental health clinic. Based on lessons learned from this pilot and feedback from our field-based partners and subject matter experts, we revised the screener (for example, adding questions to assess urgent food, housing, and utility needs that might require more intensive follow-up) before piloting it in a women's health clinic and primary care clinic in 2019–2020.[9] As a result of the COVID-19 pandemic, the ACORN team developed a staff-administered screener in the VHA electronic health record (EHR) and codeveloped digital access and digital literacy questions.[9,11] In 2021 the digital needs questions underwent cognitive testing and were revised based on veteran input prior to being piloted in a clinic.

Since July 2021 several strategies, including publications and conference presentations, VHA webinars, and support from VHA leadership, facilitated further use of ACORN. In conjunction with LD.04.03.08, the ACORN Community of Practice (CoP) was launched in January 2023 to support sites throughout ACORN preimplementation, implementation, and maintenance. Since then the number of Veterans Affairs Medical Centers (VAMCs) using ACORN has increased from roughly 10 to more than 25 of 140 VAMCs. Nearly 7,000 ACORN screens have been administered to date, 70% of which have been positive for one or more unmet HRSNs. Future plans include launching an ACORN dashboard for field-based partners to monitor site-specific patterns and trends in screenings and referrals and continuing collaboration with VHA program office leadership to accelerate the dissemination of ACORN.

Primary Care Equity Dashboard

Creation of the Primary Care Equity Dashboard (PCED) began in 2018 with the goal of engaging the VHA

workforce in identifying and addressing health care inequities in the context of primary care.[12–14] Developed following a user-centered design process[15] and leveraging data from VHA's EHR, the PCED comprises interactive data visualizations to support equity-focused QI activities in VAMCs. The PCED allows users to explore quality and equity in outpatient quality measures by racial/ethnic group, sex/gender, rural/urban residence, and neighborhood poverty level.[16] It also includes evidence-based, equity-focused resources on how to address disease- and population-specific health care disparities identified using the PCED.

The first version of the PCED contained facility-level reports designed to support QI at individual VAMCs. The design team closely followed PCED use in demonstration projects to inform further refinements and established a feedback mechanism to collect additional suggestions from the field. Use of the tool spread through multiple mechanisms including word of mouth, VHA webinars, e-mail updates to early adopters, and endorsement by VHA program office leaders. In 2022 OHE released its first call for equity-guided QI pilot project proposals to address known disparities, further increasing visibility and use of the PCED.

In 2022 the PCED team added a Veterans Integrated Services Networks (VISN)–level equity report that displays overall VISN (regional) and VAMC performance relative to a national score, plus a score of 1 to 4 conveying quality (above or below national) and equity (above or below demographic comparison group) for each of five racial/ethnic minority groups, women, rural veterans, and veterans living in high-poverty areas within each VISN and VAMC.

The VISN equity report was released in January 2023, in conjunction with LD.04.03.08. In the first eight months, the VISN equity report was accessed 5,875 times by 1,636 unique users across all VISNs, indicating rapid uptake and national reach. Future plans include using the PCED as a

Table 3. Mapping of Joint Commission National Patient Safety Goal (NPSG) 16: Improve Health Care Equity (NPSG.16.01.01) EPs onto Existing Tools and Processes Within the Veterans Health Administration

	Relevant VHA Tool or Approach
EP 1: The [organization] designates an individual(s) to lead activities to improve health care equity for the [organization's] patients.	Each accredited VHA facility selects individuals (for example, creates a health equity committee) to assess, identify, and support activities. National program offices offer examples of staff roles (for example, clinical, administrative) for committee composition.
EP 2: The [organization] assesses the patient's health-related social needs (HRSNs) and provides information about community resources and support services.	The ACORN initiative is a social risk screening and referral program that aims to systematically identify and address unmet health-related social needs among veterans to improve health and promote health equity. The ACORN screener is provided to VAMCs as a template within the VHA electronic health record, which allows clinical care teams to view social needs data at the point of care.
EP 3: The [organization] identifies health care disparities in its patient population by stratifying quality and safety data using the sociodemographic characteristics of the [organization's] patients.	The PCED contains interactive reports and data visualizations that allow for the stratification of select outpatient quality measures by racial/ethnic group, sex/gender, rural/urban residence, and neighborhood poverty level as defined by the Area Deprivation Index. The PCED includes data for the entire VHA health care system and can be accessed by any member of the VHA health care workforce. Reports summarize quality and equity at regional (that is, VISN), facility, and division levels and contain patient-level data to facilitate targeted outreach and tailored interventions.
EP 4: The [organization] develops a written action plan that describes how it will improve health care equity by addressing at least one of the health care disparities identified in its patient population.	Accredited facilities can plan to use tools, such as the PCED and ACORN, in their action plans to reduce health disparities. The PCED contains a curated library of evidence-based equity-focused resources and guidance on how to address disease- and population-specific health care inequities, including action planning templates. Facility action plans can also draw upon national program office strategic plans, such as the annual OHE Health Equity Action Plan. Facility clinical teams can apply for OHE pilot funding for equity-guided quality improvement projects and join OHE learning collaboratives.
EP 5: The [organization] acts when it does not achieve or sustain the goal(s) in its action plan to improve health care equity.	Accredited VHA facilities use continuous process improvement principles to recalibrate efforts to reduce disparities. National program offices offer tools (for example, the PCED, ACORN) and education (for example, electronic libraries, direct facility advisement, training) to facilities in support of goal attainment.
EP 6: At least annually, the [organization] informs key stakeholders, including leaders, licensed practitioners, and staff, about its progress to improve health care equity.	Accredited VHA facility leadership informs staff and VISN leadership on progress made addressing health disparities. National program offices, such as OHE, host trainings, regular seminars (for example, Health Equity Community of Practice), and create information materials that identify areas of success, best practices, and areas for improvement on the reduction of health disparities.

EP, element of performance; VHA, Veterans Health Administration; ACORN, Assessing Circumstances and Offering Resources for Needs; VAMC, Veterans Affairs Medical Center; PCED, Primary Care Equity Dashboard; VISN, Veterans Integrated Services Network; OHE, Office of Health Equity.

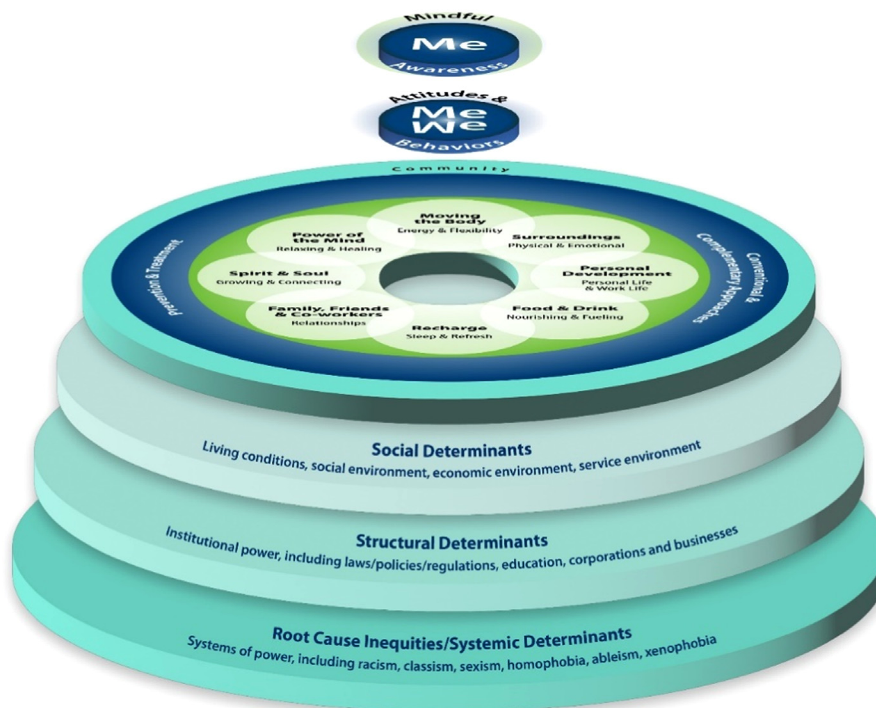

Figure 1: This figure illustrates Whole Health, which includes the interaction between the Circle of Health—exemplifying connections between health and other community and life aspects—and the social and structural determinants of health.

model to incorporate equity-based data stratification into other quality and monitoring processes across VHA and to work in partnership with national program offices on initiatives to scale best practices emerging from equity-guided QI projects funded through OHE.

Whole Health

Whole Health refers to a holistic health care approach that seeks to empower and equip people to take charge of their health and well-being by centering their care around what matters most to them.[17] The Whole Health System being implemented across VHA integrates health coaching, peer-to-peer support and engagement, evidence-based complementary and integrative health approaches such as acupuncture and meditation, and increased emphasis on self-management and self-care skills into clinical care and support of well-being. Within VHA, care teams exemplify Whole Health through their efforts to better understand what experiences and factors in a veteran's community and personal life might be affecting their journey to happy and healthy living, including SDOH, social risk factors, and HRSNs (Figure 1). During 2023 roughly 25% of active VHA users participated in Whole Health services in some way, and the Whole Health System is now deployed across the entire VHA as a standard part of the approach to care.

The integration of health equity and SDOH into the Whole Health Program for Whole Health Coach and Whole Health Partner staff was facilitated through cross-program collaboration on the development of a four-part curriculum titled *Whole Health for All: Social and Structural Determinants of Health*. Both ACORN and the PCED were featured in this training as clinical tools to support staff in identifying whether veteran subgroups are experiencing social or structural barriers to achieving optimal health as defined by inequities in chronic disease management quality measures and to identify and understand social factors in a veteran's community and life that might be affecting their health, respectively. Forty Field Implementation Team consultants actively engage with VAMCs on SDOH screening and related programming, and future plans include continued expansion of the Whole Health workforce.

COORDINATION OF INITIATIVES COINCIDING WITH 2023 JOINT COMMISSION STANDARDS TO IMPROVE HEALTH CARE EQUITY

Although there was growing awareness of the ACORN and PCED initiatives, given the size and scope of VHA, additional strategies were created to identify and disseminate resources to VHA facilities when the new Joint Commission health care equity standards were announced. In response to LD.04.03.08 and in anticipation of NPSG.16.01.01, the VHA Office of Quality Management (OQM) set up a diverse stakeholder committee to coalesce an inventory of activities, tools, and emerging best practices to satisfy the new Joint Commission requirements. This committee built an online resource library available to all VHA facilities, including tools such as ACORN and the PCED, to aid sites

Table 4. Examples of Technical Assistance for Initiatives Addressing Health-Related Social Needs and Health Care Disparities

Technical Assistance Resource Example	Components	Additional Description
ACORN CoP	Direct technical assistance for VAMCs Biweekly to monthly calls for VAMCs using ACORN Monthly office hours ACORN resource distribution through intranet platforms and e-mail Additional ad hoc support as needed	CoP model is intended to support sites in preimplementation, implementation, and maintenance/sustainment.
PCED technical team	Widely accessible online training Individual consultations with VAMC QI teams Dissemination of PCED updates through e-mail and videos	
Whole Health training program	Training of Whole Health Coaches and Whole Health Partners on NPSG.16.01.01	
Quality management training	Training of VHA patient safety professionals, accreditation specialists, and quality managers on NPSG.16.01.01	Training is a partnership between VHA National Patient Safety Center, and Office of External Accreditation Services. Approximately 400 staff trained during initial wave.

ACORN, Assessing Circumstances and Offering Resources for Needs; CoP, Community of Practice; VAMC, Veterans Affairs Medical Center; PCED, Primary Care Equity Dashboard; QI, quality improvement; NPSG, National Patient Safety Goal; VHA, Veterans Health Administration.

Table 5. Example of a List of Planned Next Steps to Support Improving Health Care Disparities and Addressing Veteran Health-Related Social Needs

Programmatic Item	Description	Next Steps
Equity-guided QI curriculum	Online curriculum available for all staff providing education on the following: 1. Tools available for identifying and addressing social needs and clinical health care disparities by demographic characteristics 2. Strategies for launching equity-guided QI activities	Finalize and generate awareness of curriculum through multiple channels.
Expand PCED capabilities	Increase number of quality measures available for stratification by race/ethnicity, sex/gender, geography, and neighborhood-level poverty status in the PCED.	Release expanded measure list in the PCED in fall 2023 and generate awareness of additional measures available for equity-guided QI activities.
ACORN EHR screening note template	Nationally available screening template to promote consistent HRSN screening	Finalize changes based on feedback from subject matter experts, field-based partners, and veterans.
ACORN Dashboard	Dashboard for VAMCs using ACORN to view key metrics pertaining to HRSNs screening, provision of resources and referrals, and sociodemographic variables	Finalize changes based on feedback from beta testers and release to VHA staff in fall 2023. Generate awareness of dashboard through ACORN CoP, word of mouth, and VHA webinars.
Technical assistance	Continue expanding technical assistance on tools to support activities addressing NPSG.16.01.01 EPs.	Ongoing presentations to the following: • Quality-related and clinical-related workgroups • Executive leadership at national, regional, and facility levels • Clinical and administrative staff providing direct patient care

QI, quality improvement; PCED, Primary Care Equity Dashboard; ACORN, Assessing Circumstances and Offering Resources for Needs; EHR, electronic health record; HRSN, health-related social needs; VAMC, Veterans Affairs Medical Center; CoP, Community of Practice; VHA, Veterans Health Administration; NPSG, National Patient Safety Goal; EP, element of performance.

in their plans to address EPs. Table 3 provides examples of how these existing, scalable programs align with the EPs for NPSG.16.01.01. In addition, national program offices provide technical support for implementation of these tools and resources (Table 4).

The announcement of LD.04.03.08 resulted in the creation of new health equity committees at many VHA facilities. Offices such as OHE and OQM continue to advise on strategies to make such committees effective and representative of staff and veterans. Teams often include nurse and physician leaders (both inpatient and outpatient), social work, and quality managers, among others. Some of these committees discovered ACORN and the PCED through the process of seeking outreach for their nascent committees. ACORN and the PCED have been actively disseminated to VHA, VISN, and VAMC leadership through multiple communication channels. In addition, although it has not been possible to measure their impact given how recently the EPs were launched, educational opportunities such as grand rounds and town hall formats at individual VAMCs provide captive audiences for raising awareness of these tools for addressing disparities and HRSNs.

Limitations

Bundling and expanding existing initiatives as part of implementing the new Joint Commission health care equity standards has been accompanied with limitations. These include potentially missed opportunities for, and difficulties in, capturing process metric data on the number of people educated specifically on EPs' requirements and tools to address them (for example, number of attendees at presentations and their staff roles). In addition, we may have incomplete information on the number of people who have accessed each tool. Given the recent release of the new Joint Commission standards, we are temporarily limited in assessing the systemwide progress made to date on addressing EPs because implementation itself is handled at local and regional levels.

FUTURE DIRECTIONS

A suite of ongoing activities and next steps (Table 5) informs the future direction of work aligned with NPSG.16.01.01. VHA strives to go beyond a compliance mindset to one of exceptionalism in improving health equity by weaving together compliance, systematic programming, and actionable data to produce the most meaningful improvements. As a government-financed organization, VHA is unique within the American health care landscape with its ability to plan longer-term social and medical care delivery strategies. Non-VHA health care systems might require different approaches to addressing health care disparities and HRSNs, but programmatic elements from VHA initiatives may inform similar efforts in these systems.

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REFERENCES

1. The Joint Commission. New Requirements to Reduce Health Care Disparities, Jun 20, 2022. R^3 Report, Issue 36Accessed Oct 12, 2023 https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_disparities_july2022-6-20-2022.pdf.
2. The Joint Commission. National Patient Safety Goal to Improve Health Care Equity, Dec 20,

2022. R[3] Report, Issue 38 Accessed Oct 12, 2023 https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3-report_npsg_16.pdf.
3. US Department of Veterans Affairs. Veterans Health Administration, Sep 7, 2023. Updated:Accessed Oct 12, 2023 https://www.va.gov/health/aboutVHA.asp.
4. Moy E, Hausmann LRM, Clancy CM. From HRO to HERO: making health equity a core system capability. Am J Med Qual. 2022;37:81–83.
5. US Department of Veterans Affairs. Office of Health Equity: About, Jan 22, 2020. Updated:Accessed Oct 12, 2023 https://www.va.gov/HEALTHEQUITY/Facts_About_OHE.asp.
6. Cohen AJ, et al. Food insecurity among veterans: resources to screen and intervene. Fed Pract. 2020;37:16–23.
7. Montgomery AE, et al. Universal screening for homelessness and risk for homelessness in the Veterans Health Administration. Am J Public Health. 2013;103(Suppl 2):S210–S211.
8. Iverson KM, et al. Intimate partner violence screening programs in the Veterans Health Administration: informing scale-up of successful practices. J Gen Intern Med. 2019;34:2435–2442.
9. Russell LE, et al. Implementing a social needs screening and referral program among veterans: assessing circumstances & offering resources for needs (ACORN). J Gen Intern Med. Epub. 2023 May 10.
10. Cohen AJ, et al.US Department of Veterans Affairs The Assessing Circumstances & Offering Resources for Needs (ACORN) Initiative, Sep 2022. Updated:Accessed Oct 12, 2023 https://www.va.gov/HEALTHEQUITY/docs/ACORN_Screening_Tool.pdf.
11. Cohen AJ, et al. Adaptation of a social risk screening and referral initiative across clinical populations, settings, and contexts in the Department of Veterans Affairs Health System. Front Health Serv. 2023 Jan 30;2:958969.
12. Hausmann LRM, Lamorte C, Estock JL. Understanding the context for incorporating equity into quality improvement throughout a national health care system. Health Equity. 2023 May 26;7:312–320.
13. Burkitt KH, et al. Evaluation of a collaborative VA network initiative to reduce racial disparities in blood pressure control among veterans with severe hypertension. Healthc (Amst). 2021;8(Suppl 1):100485.
14. Chin MH, et al. A roadmap and best practices for organizations to reduce racial and ethnic disparities in health care. J Gen Intern Med. 2012;27:992–1000.
15. International Organization for Standardization. ISO 9241-210:2019: Ergonomics of human-system interaction—Part 210: Human-centered design for interactive systems. 2nd ed, Jul 2019. Accessed Oct 12, 2023 https://www.iso.org/standard/77520.html.
16. Hannan EL, et al. The Neighborhood Atlas Area Deprivation Index for measuring socioeconomic status: an overemphasis on home value. Health Aff (Millwood). 2023;42:702–709.
17. US Department of Veterans Affairs. Whole Health: What Is Whole Health?, Sep 28, 2023. Updated:Accessed Oct 12, 2013 https://www.va.gov/wholehealth/.