


ORIGINAL RESEARCH



Home Health Aides' Increased Role in Supporting Older Veterans and Primary Healthcare Teams During COVID-19: a Qualitative Analysis

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BACKGROUND: Home health aides are important but often overlooked members of care teams, providing functional and emotional support to patients. These services became increasingly important during the COVID-19 pandemic as older adults faced disruptions in in-person medical services and family caregiving. Understanding how aides supported healthcare teams is important for informing emergency planning and better integrating home health services with primary care.

OBJECTIVE: To describe aides' roles in supporting veterans and working with primary care teams during COVID-19 and identify COVID-related changes in tasks.

DESIGN: Semi-structured interviews.

PARTICIPANTS: Eight home health aides, 6 home health agency administrators, and 9 primary care team members (3 RNs, 3 social workers, 3 MDs) serving veterans at a large, urban, Veterans Affairs medical center.

APPROACH: Combined deductive and inductive analysis to identify a priori concepts (aide roles; changes in tasks and new tasks during COVID-19) and emergent ideas. Aide, administrator, and provider interviews were analyzed separately and compared and contrasted to highlight emergent themes and divergent perspectives.

KEY RESULTS: Participants reported an increase in the volume and intensity of tasks that aides performed during the pandemic, as well as the shifting of some tasks from the medical care team and family caregivers to the aide. Four main themes emerged around aides' roles in the care team during COVID-19: (1) aides as physically present "boots on the ground" during medical and caregiving disruptions, (2) aides as care coordination support, (3) aides as mental health support, and (4) intensification of aides' work.

CONCLUSIONS: Home health aides played a central role in coordinating care during the COVID-19 pandemic, providing hands-on functional, medical, and emotional

support. Integrating aides more formally into healthcare teams and expanding their scope of practice in times of crisis and beyond may improve care coordination for older veterans.

KEY WORDS: home health; home health aides; primary care; geriatrics; COVID-19.

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INTRODUCTION

Home health aides (HHAs) help older and disabled patients remain safely in their homes by assisting with daily functions like bathing, eating, and dressing, as well as providing companionship and emotional support.^{1,2} But, because this work is often codified as non-medical support, aides' contributions to patient care such as ensuring patient safety, helping to manage chronic conditions, and supporting patients' emotional health are undervalued and overlooked. As a result, aides are often disconnected from the rest of the healthcare team.^{1,3–5}

Aides' work became increasingly critical during the COVID-19 pandemic as older adults faced disruptions in medical services and family caregiving.⁶ Older patients with complex or co-morbid conditions generally experience disproportionately high rates of hospital and emergency department utilization.⁷ During the pandemic, they have also been at high risk of serious complications or death related to COVID-19, causing both medical providers and family caregivers to maintain physical distance to avoid exposing their patients or relatives to the virus.^{6,8,9} During this chaotic time, aides have provided stable support and necessary hands-on care when other medical and support resources were strained.¹⁰

Maintaining care for older veterans through the COVID-19 crisis has been an important focus for the Veterans Health Administration (VHA), which serves an aging population.

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VHA is the largest integrated health system in the USA, providing comprehensive, longitudinal primary care in the clinic and home to older veterans through interdisciplinary teams.^{11,12} VHA's patient-aligned care teams (PACT) include a primary care provider, nurse, and medical assistant, as well as other professionals such as a social worker or pharmacist depending on the patient population. Many older veterans enrolled in VHA experience multiple chronic conditions, have cognitive and functional limitations,¹³ and increasingly rely on home health aides to support their functional needs. As a result, VHA's home health aide benefit is the system's most frequently used home- and community-based service.¹⁴ However, like many other health systems, VHA purchases home health services through contracted, non-VHA home health agencies rather than including them directly in PACT teams, adding a layer of complexity to coordinating care between the home and clinic. Care coordination challenges may have been further exacerbated by pandemic-related service delivery changes as VHA limited in-person visits and rapidly increased virtual care. In just the first 6 weeks of the pandemic, VHA primary care video visits increased from 1000 per week to over 13,000 and telephone visits increased by 131% to nearly 900,000 in the last week of April 2020.^{15,16} While telehealth allowed primary care teams to maintain contact with many patients, it also presented access challenges due to technological limitations and older veterans' cognitive and sensory abilities.¹⁵ This potentially limited providers' ability to conduct thorough patient assessments and communicate with patients and family caregivers.

A growing body of literature examines disruptions in medical services for older, medically complex adults^{6,17} as well as the challenges home health workers and home health agencies experienced during COVID-19, including a lack of state and federal support, staff shortages, lack of personal protective equipment (PPE), and COVID-19 exposure.^{10,18–20} However, less is known about the specific roles that aides played in maintaining care for their patients. As the healthcare workers delivering the majority of hands-on care, understanding how aides contributed to the work of healthcare teams is important not only for informing emergency planning, but also for improving the integration of home health services with primary care. Our objective was to examine the role of home health aides caring for veterans in New York City, the initial epicenter of the pandemic, through the multiple perspectives of VHA primary care team members, home health agency administrators, and home health aides.

METHODS

Design, Setting, and Participants

We conducted interviews with VHA primary care team members, agency administrators, and home health aides as part of a quality improvement project focused on improving coordination between home health providers and VHA primary care

teams at the James J. Peters Veterans Affairs Medical Center (VAMC) in the Bronx, New York. The VAMC is a tertiary care center that provides clinic and home-based primary care services to over 14,000 veterans annually. Half of these veterans are over the age of 65. The VAMC employs 20 full-time equivalent primary care providers. Approximately 600 veterans receive VHA-paid home health aide services from approximately 8–10 contracted community home health agencies through the VHA Homemaker/Home Health Aide (H/HHA) benefit each year.^{14,21}

Because our project examined coordination across the VHA and non-VHA caregiving team (aides, contracted home health agencies, and VHA primary care team members), we recruited interview participants from each of these groups. We included primary care team members in different roles (physicians, social workers, and nursing staff) as they may have different interactions with and knowledge of aides' roles. Interviews were conducted from September 2020 to December 2020.

Data Collection

We recruited interview subjects through purposeful and snowball sampling. For VHA primary care teams, two physicians (KSB, MA) and a social worker (NK) on our project team identified VAMC primary care team members who regularly worked with older patients receiving home health aide services. The project lead and project coordinator (EF and TR), both VAMC employees, then contacted these team members by phone and email inviting them to participate, aiming to recruit a balanced sample across roles (physician, nursing, social work). For contracted agencies and aides, we requested interviews with administrators at seven home health agencies serving the highest volume of VAMC patients. Participating administrators were then asked to refer 2–3 aides who provided care to veteran clients within the past year for interviews. Aides gave their agencies permission for our team to contact them and received a \$25 cash incentive.

We (EF and TR) conducted semi-structured phone interviews lasting 30 to 45 min. Interviews were recorded and transcribed verbatim. Two participants preferred not to be recorded; in these cases, the interviewer took detailed notes which were reviewed and verified by a second interviewer on the call. One aide interview was conducted in Spanish by a bilingual team member (VGA), translated into English by a professional transcriptionist, and reviewed for accuracy by the interviewer.

Questions were adapted for each group but focused broadly on (1) perceptions of aides' roles and tasks; (2) changes during COVID-19 (changes to existing tasks; addition of new tasks); (3) communication between aides, agencies, and VAMC primary care teams; and (4) recommendations for the future. We probed participants around challenges delivering and coordinating care during COVID-19. The project team developed the interview guide collaboratively based on the researchers' experience in geriatrics, primary care, and home health services and emerging research on home health and primary care

during COVID-19. We piloted the guide with two VAMC primary care team members outside of our project team and an outside expert in conducting qualitative interviews with agencies and aides.

The study site's Institutional Review Board determined this to be a non-research quality improvement project. Nonetheless, we were consistent with ethical standards of research, including obtaining verbal consent from participants for interviews and recording, and maintaining participant confidentiality.

Data Analysis

We conducted a qualitative thematic analysis using a combined inductive and deductive approach.²² First, three coders (EF, NK, and TR) independently reviewed three interviews (one each from the aide, agency, and primary care team groups). We made notes on a priori topic areas (e.g., aide roles, changes during COVID), as well as emerging concepts (e.g., scope of practice, managing gaps in care) and developed an initial codebook. The coders applied the codebook to these interviews, comparing, discussing, and refining it with additional team members (KJ and EG) until no new codes emerged. We then coded the remaining interviews independently. Through regular team meetings, we reviewed each other's coded transcripts, maintaining rigor by reviewing the accuracy of code definitions and their appropriate application against our analytic memos, and recoding segments as necessary.²³ Primary care team, aide, and agency administrator interviews were first analyzed separately and then compared and contrasted to highlight emergent themes and divergent perspectives.²⁴ We recruited subjects until thematic saturation was reached.²⁵ Data were analyzed using NVivo 12.²⁶

RESULTS

Participant Characteristics

Nine VHA primary care team members (three physicians, three RNs, and three social workers), six agency administrators, and eight aides from three agencies agreed to be interviewed (see Table 1). Agencies served between six and 300 veterans, with most agencies contracting with multiple local VAMCs. The aides were highly experienced and had worked as home health aides for between 4 and 32 years (median 10.5 years).

Table 1 Interview Participants

Role	N
VA primary care team members	
Physicians	3
RNs	3
Social workers	3
HHA administrators	6
Home health aides	8
Total participants	23

Aides' Roles During COVID-19

Participants reported an increase in the volume and intensity of tasks that aides performed during the COVID-19 pandemic, as well as the shifting of some tasks from the medical care team and family caregivers to the aide. Four main themes emerged around changes in aides' roles: (1) aides as "boots on the ground"; (2) aides as care coordination support; (3) aides as mental health support; and (4) intensification of aides' work (see Table 2).

Boots on the Ground: Aides as the Eyes, Ears, and Hands of the Medical Team. In the early months of the pandemic (March–May 2020), aides were often veterans' only in-person contacts as family caregivers and medical providers maintained distance to reduce infection risk. As one administrator explained, "aides are still doing personal care, hands-on care, whereas all of our supervisors have become telehealth." (Administrator 4). As a result, both agency staff and VHA

Table 2 Key Themes and Examples

Theme	Examples
<i>Boots on the ground: aides as the eyes, ears and hands of the medical team</i>	"Let's say the blood pressure is high, and we ask the patient or the aides to continue to monitor on a daily basis, keep a log, and if the log continues to be high, we report to the nurse practitioner; she'll make changes on the medication." (RN 2) "We offered video visits or video conferences with the patients, and if the aides were willing, they would help them get on the video conference with us and pharmacy management." (RN 3)
<i>Managing gaps in care: aides as care coordination support</i>	"Families... couldn't come in as much as they used to. The aide would be the one that would help the patients, assist in making appointments, keep up to date on their appointments." (RN 1) "The aide is the one who, when [one pill box] is depleted, gives him the other one because, if not, he will probably start taking medication from all the boxes." (MD 2)
<i>Managing social isolation, loneliness, and anxiety: aides as mental health support</i>	"[The veteran] used to be an artist—we do artwork passing the day, I show him my work, he shows me his little ideas.... We try to keep busy." (Aide 1) "[Aides are important] in terms of companion, in terms of, just someone familiar. It's enough that the patients have to be dealing with this isolation... It's very stressful for them. It's stressful for us." (RN 1)
<i>Increased intensity and volume of aides' work</i>	"[Veterans] don't go out themselves a lot. So, they use the aides' time to run to the laundry, to run to the store to pick up a lot of things." (Administrator 1) "The most difficult thing is the—the sanitation of the sites. I have been following the requirements that they requested, the gloves, all that... keeping them as disinfected as possible." (Aide 5)

primary care team members, particularly RN care coordinators, depended on aides to perform tasks they were physically unable to do. One nurse asserted they were “basically relying on the aides for everything” (RN 3).

Administrators and providers reported increased, sometimes daily, contact with aides during the pandemic. Agencies required aides to report on changes in patient status and emergencies, as well as monitor themselves, patients, and families for COVID-19 symptoms. On the provider side, VHA RNs said aides were particularly helpful in managing video visits, which were often a learning experience for both patient and provider. “I try to make sure the aide is present to assist the patient in getting onto the device,” explained one RN, noting that if the patient did not have a family member present, “it’s the aide that we have to rely on.” (RN 1).

In some cases, VHA nurses used video visits to walk aides through tasks they would normally perform, such as monitoring blood pressure or managing medications under the provider and patient’s direction. “We didn’t have nurses going in [to administer medications],” noted an RN. “So we do it at the video conference with either the pharmacist or nursing staff to assist [the veteran] with separating their medications, and the aides would help them with that.” Another nurse found aides helpful in identifying emergent issues like pressure ulcers, explaining that “say, a wound that just showed up and we haven’t seen it or any swelling, so [the aide] shows us with the video, and we were able to help out.” (RN 2).

Some providers and administrators described tension around aides taking on medical tasks beyond the written plan of care when other medical providers were not available. While home health aides are certified to perform some health-related tasks (e.g., measuring blood pressure), medical tasks such as medication administration and wound care fall outside their scope of practice under New York state regulations. However, some participants noted aides at times had stepped in to change a patient’s dressing or assist with mobility exercises when wound care nurses or physical therapists could not visit in person. Although participants acknowledged this might happen in practice when there was no other option, agencies expressed concern over potential liability.

Managing Gaps in Care: Aides as Care Coordination Support. Participants in all groups reported aides’ involvement in care coordination activities increased during COVID-19. Pre-pandemic, communication between aides and the primary care team was sporadic and often unplanned, usually occurring when an aide accompanied a patient to an appointment, answered the veteran’s phone, or was working during a home visit. Physicians reported they received little information about what aides were doing in the home, or about their patients’ condition between appointments. As one physician explained, “I have like, a visit every six months with a patient, so if something happens in between, I have no idea.” (MD 2). Nurses did report communicating with aides pre-

pandemic, with one commenting that “we have to incorporate the aides...[the aide is] the number one point of communication” for issues like appointment or medication reminders. (RN 3). However, both nurses and social workers also noted this communication became more frequent during the early months of the pandemic as they performed more frequent outreach and “wellness checks” on patients.

Aides were frequently responsible for scheduling and facilitating medical appointments; ensuring veterans had sufficient food, medicine, and medical supplies; and coordinating virtual and in-person visits with family. Since aides’ ability to help with some tasks was limited by scope of practice, they also coordinated with family or neighbors. One aide explained that for a blind patient, “I had his son in law come every morning before I come, he give him his medication....and me, when I went, I always make sure if he gave it to him.” (Aide 5). In some cases, VAMC physicians stepped in to make medication regimens easier, for instance, “trying to minimize the pill burden, if the medication can be stretched from b.i.d. (twice daily) to a single dose.” (MD 2). However, aides did face barriers in actively assisting with care coordination. Agency policies required the agency rather than the VHA team to be aides’ first point of contact, and some agencies actively discouraged aides from communicating directly with providers citing patient privacy and liability concerns. Some agency administrators and primary care team members also stated that health privacy laws prevented them from sharing patient information with aides, although home health aides are considered covered health care providers under HIPAA.²⁷

VHA provides an average of 10 h of paid aide services per week, leaving gaps in personal care that were exacerbated during the pandemic. As one nurse explained, the veteran “might just have two days of service...but those are the two days that the aide has to get as much [done] as they possibly can, especially things that a family member maybe used to do.” (RN 1). Aides focused on doing all they could for the veteran during those shifts: “I do all the laundry, I make sure that...he has clean clothes before he takes a shower...I make sure he eats, make sure he takes his pills while I’m there.” They also prepared for their absence, for instance, by making several days of meals or laying out extra clothing or supplies.

Managing Social Isolation, Loneliness, and Anxiety: Aides as Mental Health Support. In addition to physical care, aides helped veterans cope with the emotional impacts of the pandemic by alleviating loneliness, social isolation, and anxiety. One RN recalled speaking with an aide whose shift had ended but was keeping her patient company. “His family have not been coming around either because of COVID,” she explained. “There’s been so much isolation...[aides] might be the only familiar ones that they have seen over the past few months.” (RN 1). An administrator also noted that aides’ companionship was important in avoiding “pandemic fatigue” as the crisis wore on. “Patients really needed that emotional support, and that [aide] really bringing that ray of

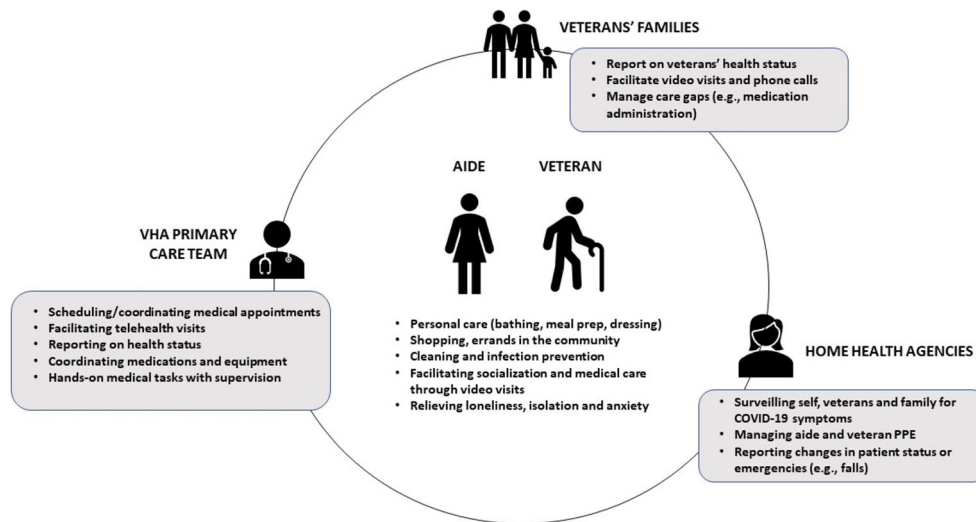


Fig. 1 Home health aides' role in the healthcare team during COVID-19

sunshine into them...[helped] keep them in the house and safe.” (Administrator 5).

Aides described mental health support, or keeping veterans “at ease,” as one of the most significant parts of their role, and employed strategies like music and art, facilitating social connections, and limiting stressors. Aides read to patients, listened to favorite songs, asked about special memories or their military service, and simply provided social support by talking and listening to fears and concerns. Most aides expressed concern that constant news coverage of the pandemic was particularly stressful for veterans who were already isolated and confined to the home, and described efforts to distract veterans from the 24-h news cycle by suggesting more calming programs or movies, or engaging in other activities away from the television or internet. Aides also updated family members on veterans' well-being, managed video visits, and assisted with social media. “I’ve had aides report, ‘we never thought Mr. Jones would be FaceTiming with his children and grandchildren’, but now they’re [asking the aide] ‘how do I use that?’” shared an administrator (6).

Increased Intensity and Volume of Aides' Work. Social distancing and limited contact resulted in HHAs broadening their roles to help with tasks usually performed by other members of their patient's care network. The intensity and volume of work increased as aides took on a larger share of grocery shopping, pharmacy pickups, pet care, or laundry. “The aide has to do a little bit more. Maybe the family that used to do the grocery shopping, they’re staying away,” explained one RN (1). Aides also took on tasks veterans had previously done by themselves since “you don’t want the person to be exposed going out unnecessarily” (Administrator 5).

Aides' infection prevention tasks also intensified as they took on more rigorous cleaning and sanitizing and maintained cleaning supplies and PPE for themselves and the veteran, as well as reporting on veterans' and their own symptoms to the

agency. However, aides noted that the intimate nature of their work made it impossible to maintain physical distance, and this was a source of constant “worrying”: “I take precautions. I wear my mask. I keep sanitizer on me. I wash my hands constantly but I still give them the attention they need, you know, it’s very hands-on” (Aide 7). Although most administrators reported having sufficient supplies of PPE, some aides described shortages or difficulties obtaining it. As one aide noted, her agency “is giving me like, five masks, and that’s it. So, I don’t even think about it, just bring my own bag, I bring my own gloves, my mask, everything.” (Aide 5). In some cases, VHA could fill these gaps by supplying products directly to the veteran through the VA prosthetics department. For example, one aide who “missed out” on PPE because she could not get to her agency’s office was able to use gloves her patient had received through the VAMC.

Finally, aides recognized patients' anxieties over potential infection and took proactive steps on their own to make them feel safer. One aide agreed to wear extra PPE and two masks, while another described undergoing private COVID-19 testing every 2 weeks even though it was not required so she could reassure her client that she was not carrying the disease. “I show [the veteran] the paperwork and say, look, I just want you to feel a little at ease that, you know, I’m negative [so] they don’t have that stress,” she explained (Aide 8).

DISCUSSION

Our findings demonstrate that in the context of COVID-19, some home health aides expanded and adapted their roles to take on tasks ordinarily performed by medical staff and family members. While news and journal articles have highlighted the increased intensity of work by medical and nursing staff performed during the COVID-19 pandemic in healthcare settings such as hospitals and nursing homes, less has been written about the increased intensity of work performed by aides in the home. At a time when medical providers,

agencies, and family caregivers were largely providing care from a distance, aides were physically present in the home, often facilitating virtual visits and serving as a crucial source of physical and emotional support for veterans (see Fig. 1). Because it encompasses the low-status, stigmatized care tasks characterized by care scholars as “dirty work,”^{28,29} aides’ labor is often considered outside the scope of medical care³⁰ and has historically been marginalized and undervalued.³¹ Our findings show that counter to this perception, aides are essential health care providers and valuable members of health care teams.

As providers and agencies proactively worked to maintain care for older veterans, our participants reported an increase in their interaction with and appreciation for home health aides. Providers, in particular nurse care coordinators, often relied on aides to perform an increased array of medical tasks and care coordination activities. Aides’ successful integration under these circumstances highlights a potential opportunity to involve them more directly in primary health care teams in the future. Aides frequently report minimal contact with supervisors or the health care team, resulting in unnecessary 911 calls or emergency department visits for issues that might be more easily resolved through direct access to or regular communication with a provider.^{1,32,33} In addition, we found that both agencies and VHA providers had misconceptions about what patient information could be shared with aides, likely related to the perception and definition of aides as non-medical workers (Medicare, for example, only pays for aide care when it supports nursing or therapy services). Efforts to include aides in care coordination can start simply with physicians and nurses asking patients about their paid care at home, acknowledging aides during visits, and including paid care in patient assessments and medical records. Primary care teams might also look to successful care coordination models that bridge medical and community care as a basis for integrating aides into patient needs assessments and setting goals and action steps for care, such as those developed for individuals with dementia.^{34,35} More proactive efforts might include developing and testing direct lines of contact such as nursing hotlines or interdisciplinary team models that permit aides to be supervised directly by a VHA nurse or employed directly by VHA, and advocating to explicitly categorize home health aides as medical workers.

In addition to sharing patient information, our findings indicate there may also be an opportunity to expand aides’ roles. Aides consistently report a desire for more responsibility in patient care, provided it is accompanied by career advancement.^{36–38} “Upskilling” aides to take on advanced roles in care coordination or chronic care management, as well as expanding nurse delegation legislation to allow aides to take on tasks such as medication administration and wound care, may help retain qualified workers in the field and improve the functioning of healthcare teams.^{39–41} Importantly, upskilling must be accompanied by pay increases commensurate with these added responsibilities. This is of particular importance as

the US faces a critical and growing shortage of home health care workers due to low pay, poor job quality, and a physically and emotionally demanding workload^{41,42} that has likely been exacerbated by the stresses of COVID-19.⁴³

Importantly, we also found that aides served as informal mental health support, helping to combat veterans’ psychological response to the COVID-19 crisis by fulfilling a need among older veterans who were socially isolated and lonely. Social isolation and loneliness are associated with a host of negative outcomes for older, community-dwelling adults, including depression, dementia, nursing home placement, and increased mortality.^{44,45} Examining aides’ roles in supporting their clients’ mental health and the impact on health outcomes is an understudied but important research focus. It also suggests an opportunity to develop and test programs that train aides to identify and address mental health issues. The VHA’s “whole health” approach, for example, could provide aides with tools to guide improvements for veterans’ physical, emotional, and social well-being.⁴⁶ While VHA, like most payers, only provides aide services for clinical needs and not companion care, there is evidence that supportive relationships are an important factor in combating depression and improving treatment initiation and adherence.^{47,48} VHA’s focus on team-based care makes it an ideal venue to test models that expand aides’ roles in mental health and social support. Similar initiatives could potentially be replicated in the private sector through other comprehensive care models, such as the Program of All-Inclusive Care for the Elderly (PACE), Medicaid-managed long-term care organizations, or Medicare Advantage plans.^{49,50}

From a crisis planning perspective, our findings also highlight opportunities for health systems to coordinate with and support home health agencies. The home health industry is decentralized and fragmented, making disaster response challenging. In addition, institutional bias within the healthcare industry also means agencies are often excluded from large-scale disaster planning efforts.⁵¹ Agencies frequently do not have the resources or infrastructure to source supplies on their own, and agencies across the country struggled to access PPE and disinfectants, train staff, and keep up with rapidly changing infection prevention guidance during COVID-19.^{19,52} As a large, integrated health system, VHA was able to provide some support. Several aides in our project were able to access PPE and other supplies through their veteran clients, although this was on an ad hoc basis. More formally, under the CARES COVID-19 relief legislation, VHA was able to increase payments to home health providers to cover PPE costs.⁵³ Given the critical contributions of home health providers during crises like COVID-19, VHA and other large systems might further lend their strong crisis planning infrastructure to assist more directly with training, guidance, and resources to help agencies meet standards of infection control and outbreak mitigation, consistent with VHA’s “fourth mission” to help local communities during times of crisis.⁵⁴

Our project had limitations. Although we included the perspectives of the interdisciplinary primary care team as well as agency administrators and aides, we did not include patients or family caregivers. Since the VAMC was a client, agency administrators may have been hesitant to share negative information; similarly, aides referred by their employers may have been guarded in their responses or may have been selected because they were more successful in negotiating pandemic challenges than others. However, our findings suggest that administrators and aides were open about both positive and negative experiences. Our study also only examined the experience of one urban VAMC, and smaller or rural institutions may have had different experiences. However, our goal was not to generalize, but to develop an in-depth understanding of aides' roles and tasks.

CONCLUSION

Home health aides were the anchors of healthcare teams during the COVID-19 pandemic, providing hands-on functional, medical, and emotional support during pandemic-related care disruptions. Valuing aides' important contributions to patient care by integrating aides more formally into primary care teams and expanding their scope of practice in times of crisis and beyond, as well as supporting agency partners, could improve care coordination for medically complex older patients and the capacity of their primary health care teams.

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Declarations:

Conflict of Interest: The authors are employed by the US Department of Veterans Affairs.

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