VETERANS HEALTH ADMINISTRATION

Assessing Circumstances and Offering Resources for Needs (ACORN) Initiative: Identifying and Addressing Social Determinant of Health Needs

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VA | U.S. Department of Veterans Affairs

PURPOSE

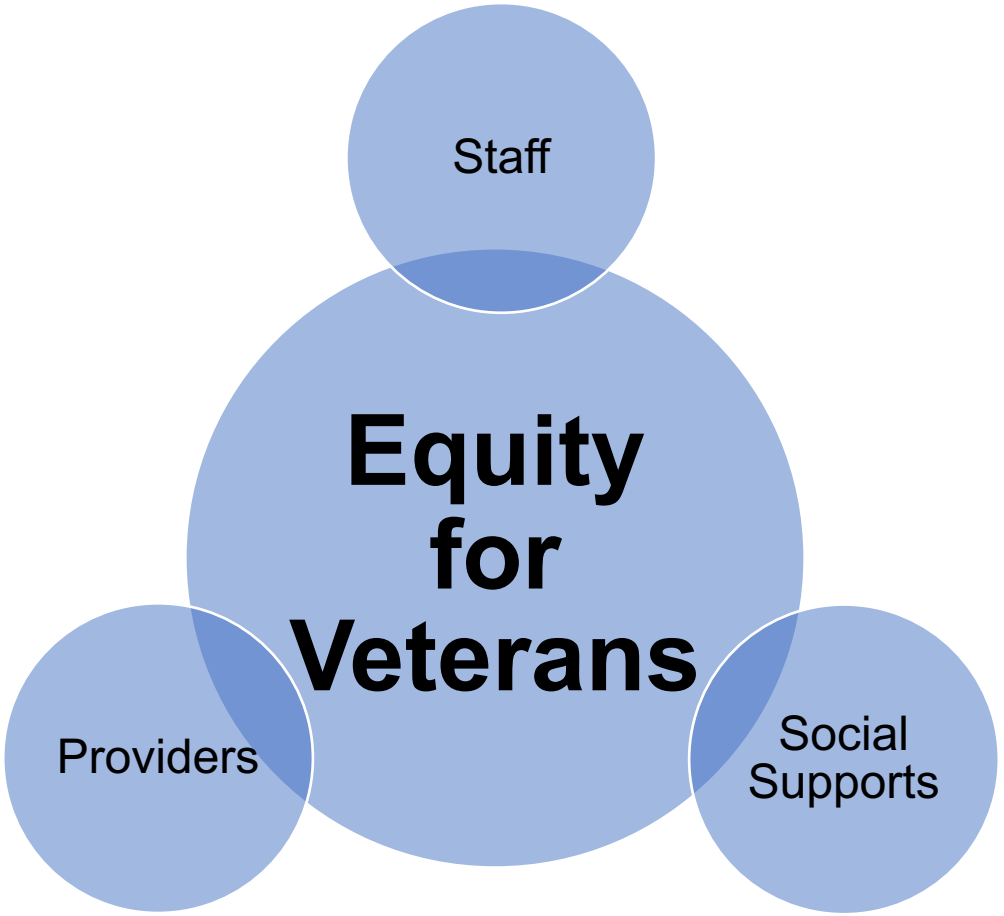
Systematically identifying, comprehensively assessing, and addressing social risks and needs in core social determinant of health (SDOH) domains is critical to advancing health equity among Veterans.

WHAT IS VA DOING TO PROMOTE EQUITY?

1. We work with Staff to ensure a diverse and inclusive environment

2. We work with Social Supports to address social needs

3. We work with Providers to reduce health inequities in health care



SOCIAL DETERMINANTS, RISK FACTORS AND NEEDS

Social determinants
The conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life.

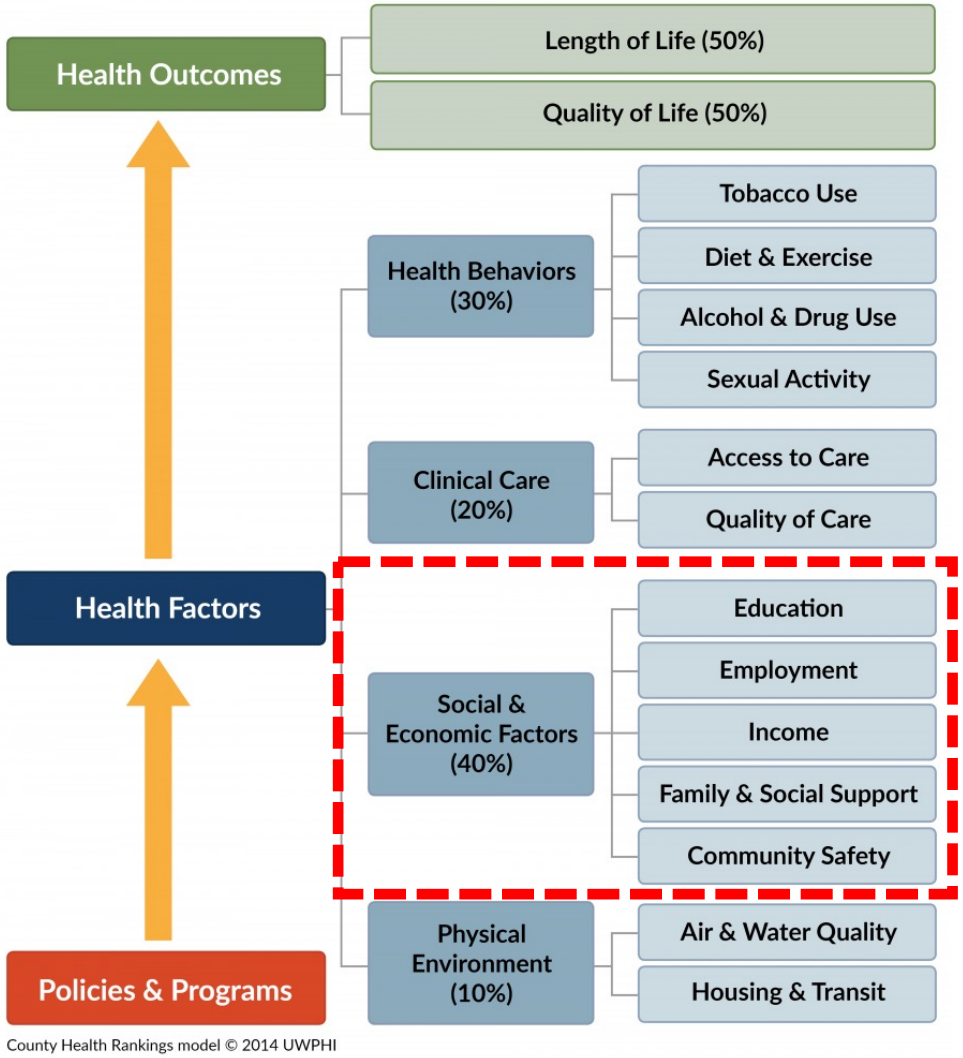
Social risk factors
Specific adverse social conditions associated with poor health, such as food insecurity and housing instability.

Social needs
A patient-centered concept that incorporates a person's perception of their own health-related needs.

- Alderwick H, Gottlieb LM. Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Care Systems. *Milbank Q*. 2019 Jun;97(2):407-419.
- Green K, Zook M. "When Talking About Social Determinants, Precision Matters, " *Health Affairs Blog*, October 29, 2019.
- National Academies of Sciences, Engineering, and Medicine. 2019. Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health. Washington, DC: The National Academies Press.
- WHO (World Health Organization). 2010. About social determinants of health. https://www.who.int/social_determinants/sdh_definition/en.

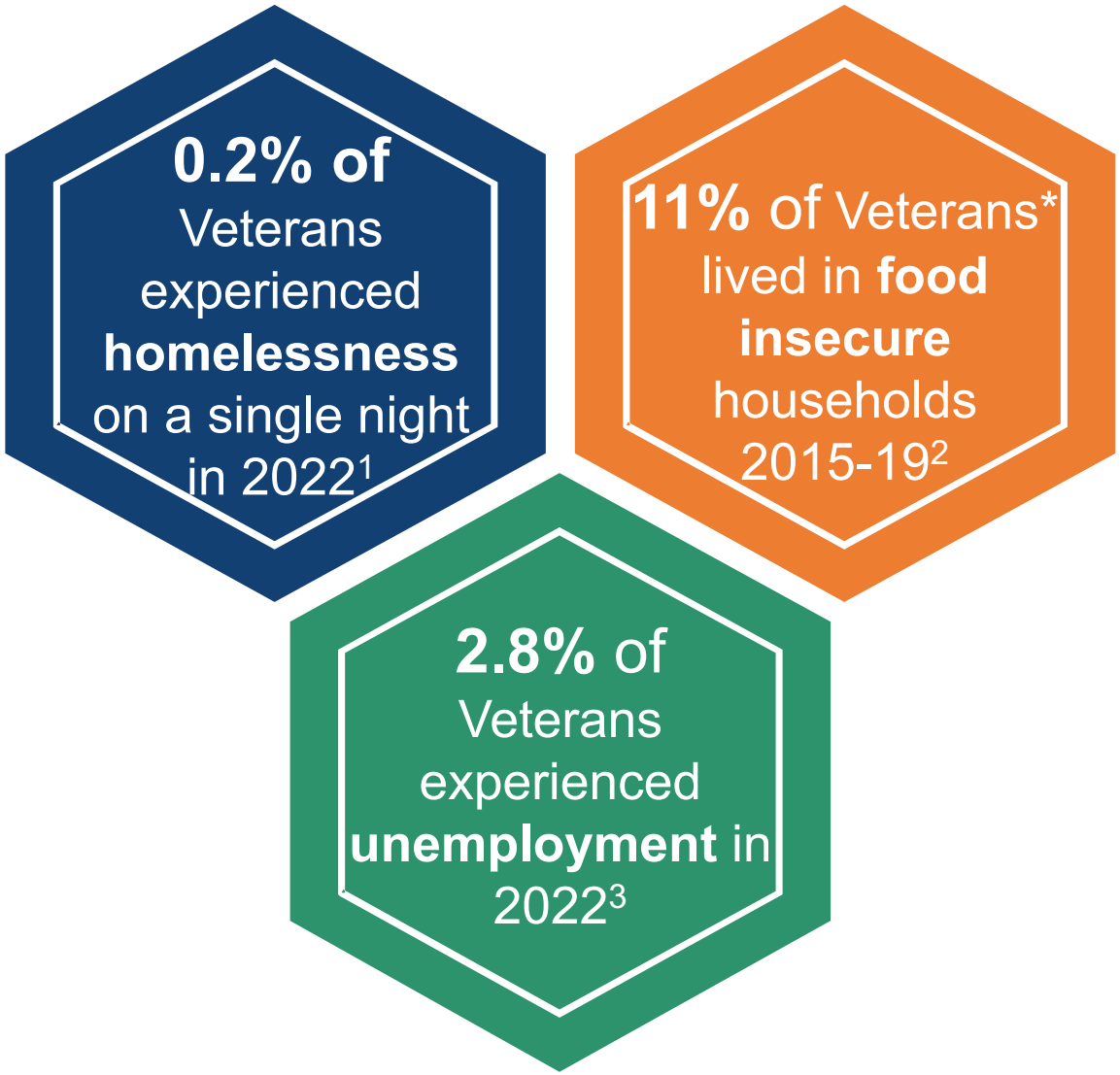
IMPACTS OF SOCIAL DETERMINANTS OF HEALTH

- Have a greater impact on health outcomes than clinical care
- Contribute to health disparities and inequities



Remington et al. *Popul Health Metr.* 2015;13:11.

IMPACTS OF SOCIAL RISK FACTORS ON VETERANS



In a recent study of Veterans in VHA, each additional adverse social factor resulted in a **27%** increased odds of **mortality**.[4]

*Working-age Veterans ages 18-64

1. U.S. Dept of Housing and Urban Development. 2022. The 2022 Annual Homelessness Assessment Report (AHAR) to Congress. https://www.huduser.gov/portal/sites/default/files/pdf/2022-AHAR-Part-1.pdf
2. Rabbitt MP, Smith MD. Food Insecurity Among Working-Age Veterans. U.S. Dept of Agriculture, ERS. 2021. https://www.ers.usda.gov/webdocs/publications/101269/err-829.pdf?v=2737.5
3. U.S. Dept of Labor. 2023. Employment Situation of Veterans – 2022. https://www.bls.gov/news.release/pdf/vet.pdf
4. Blosnich JR et al. Adverse social factors and all-cause mortality among male and female patients receiving care in the Veterans Health Administration. *Prev Med*. 2020 Dec;141:106272.

SOCIAL RISK SCREENING AND INTERVENTIONS: CURRENT STATE

VA Social Risk Screening

- Food
- Housing stability
- Intimate partner violence

VA Social Needs Interventions *(just a few of the many!)*

- Robust integrated Social Work
- Novel housing and vocational programs
- Food programs
- Social groups
- Peer Support

WHAT IS ACORN?

- Assessing Circumstances and Offering Resources for Needs (ACORN) aims to systematically identify and address unmet social needs among all Veterans to improve health and advance health equity

- Quality improvement initiative implemented in partnership with the Veterans Health Administration (VHA) National Social Work Program and VHA Office of Health Equity

- Currently used by 17 VA Medical Centers, piloting in specific clinics

ASSESSING CIRCUMSTANCES OFFERING RESOURCES FOR NEEDS

ACORN

SCREENING TO ADDRESS SOCIAL RISKS

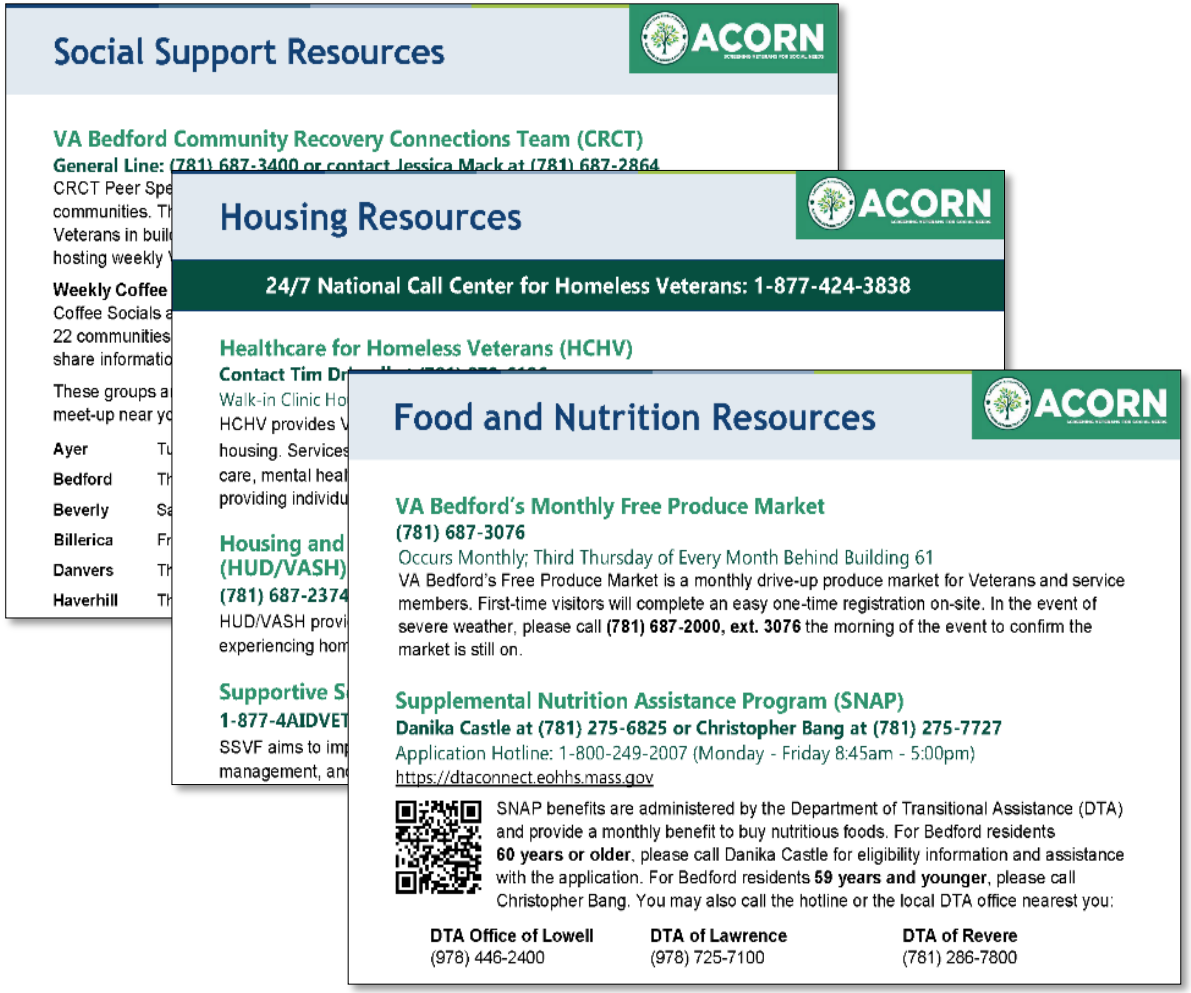
Identify Risks in 9 Domains Using ACORN Screening Tool

Address Risks through Resource Guides and Referrals

Social Risk Domains covered in the ACORN Screener:

- Food Security
- Housing
- Utilities
- Transportation
- Legal
- Education
- Employment
- Social Isolation & Loneliness
- Digital Needs

ACORN MODEL: RESOURCES AND REFERRALS



Veterans who express needs receive geographically-tailored resource guides, support with navigating resources, and/or social work assistance.

UTILITY ACROSS SETTINGS

- Screening can be self-administered or staff administered
- Administered in diverse clinical settings:
  - Emergency Department
  - Primary Care (Patient Aligned Care Teams)
  - Women's Health Clinics
  - Group Visits
  - Specialty Care Clinics
- Allows for identification of unmet social needs in clinic settings where this is not typically incorporated in the visit
- Often administered during triage assessment and used to inform comprehensive assessment completed by social workers

IMPLEMENTATION WITHIN PATIENT ALIGNED CARE TEAMS (PACT)

Butler VA Health Care System:

- VA PACT Social Workers began using the ACORN in July 2021
- Expanded implementation to Peer Support Specialists

Factors Contributing to Success:

- Strong social work service leadership support
- A clear workflow and communication plan for follow-up of positive screens
- VA PACT Social Workers are staffed at the ratio recommended in the VA PACT handbook

BUTLER VA HEALTH CARE SYSTEM OUTCOMES

- Completed 911 ACORN screens between July 2021 and April 2023
  - 65% positive for at least one social risk factor
- Provided available resources and connected with a VA PACT Social Worker for additional follow-up as needed
  - 27% were connected with a social worker within 30 days following a positive screen
- Improved ability to identify and address unmet needs impacting Veteran's health outcomes
- Positive feedback from Veterans
  - "*Thank you for taking the time to make sure I am okay*"

CURRENT OVERALL OUTCOMES

Total ACORN screens completed*: 4,102

68% positive in ≥1 domain

41% Digital Divide

25% Social Isolation

14% Transportation

14% Housing

13% Food Needs

8% Education, **6%** Employment & **5%** Utilities

*Data collected between July 2021 - Apr 2023

FUTURE CONSIDERATIONS

- Impact of resource availability to meet needs in rural or highly rural communities
- Expand use of ACORN to other settings
- Continued adaptation based on feedback from frontline staff and Veterans
- Enhanced support for health care facilities to identify and address barriers
- Large scale implementation as a standardized screening tool for social risk factors and social needs


Questions?