

# VETERANS HEALTH ADMINISTRATION

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

June 13, 2023



Choose **VA**

**VA**



U.S. Department  
of Veterans Affairs

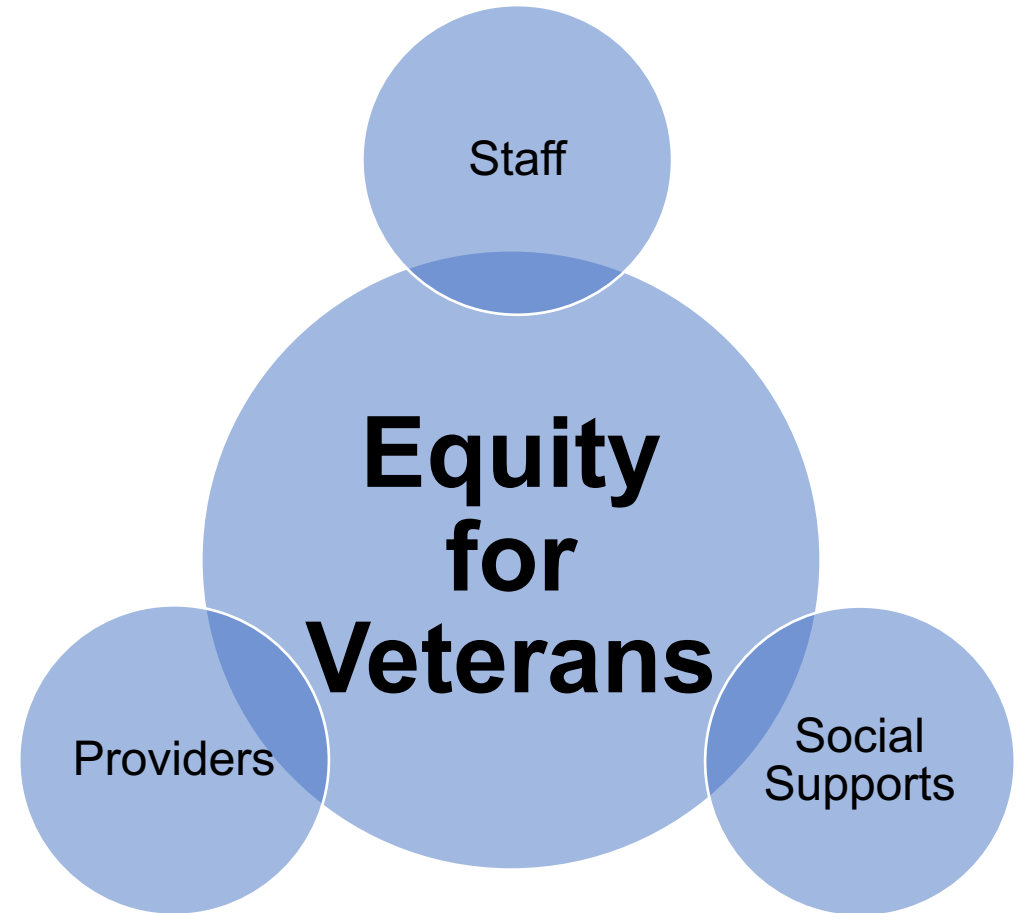
# PURPOSE

**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

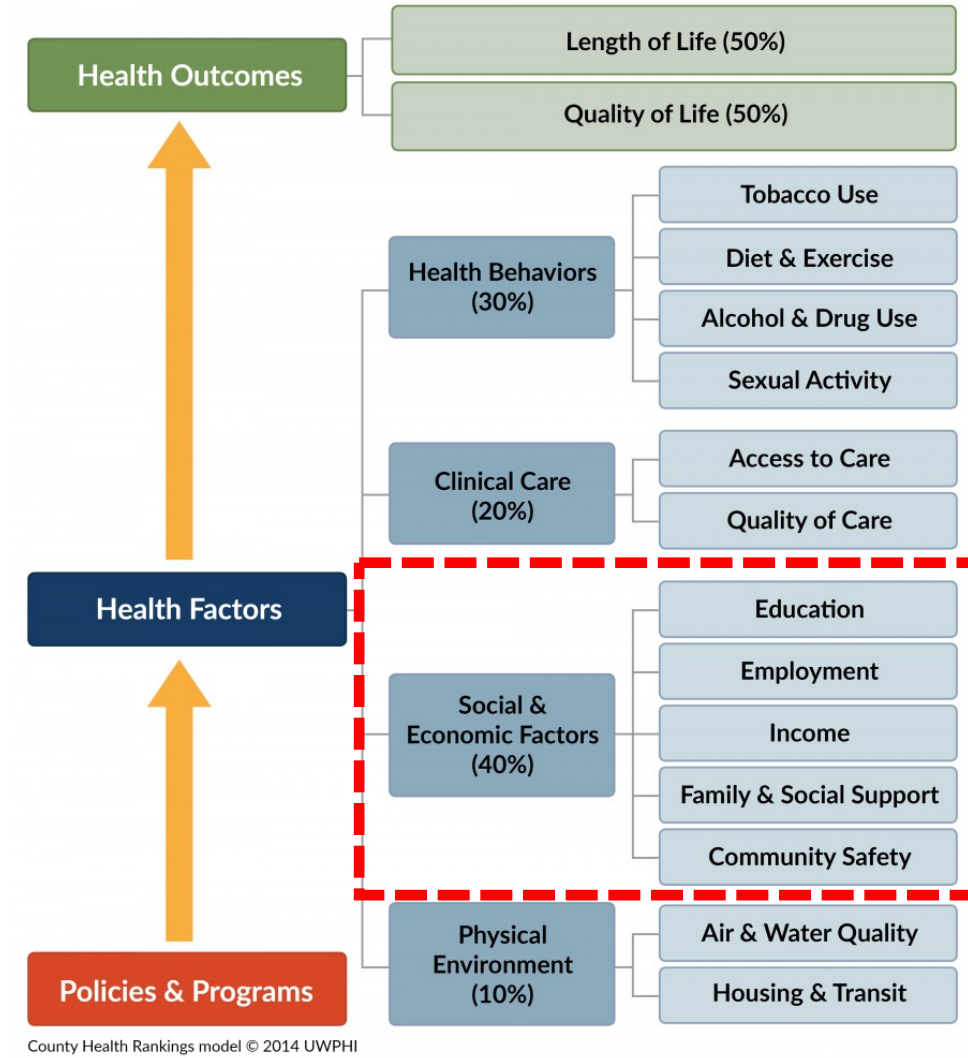
A patient-centered concept that incorporates a person's perception of their own health-related needs.

- 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](https://www.who.int/social_determinants/sdh_definition/en).

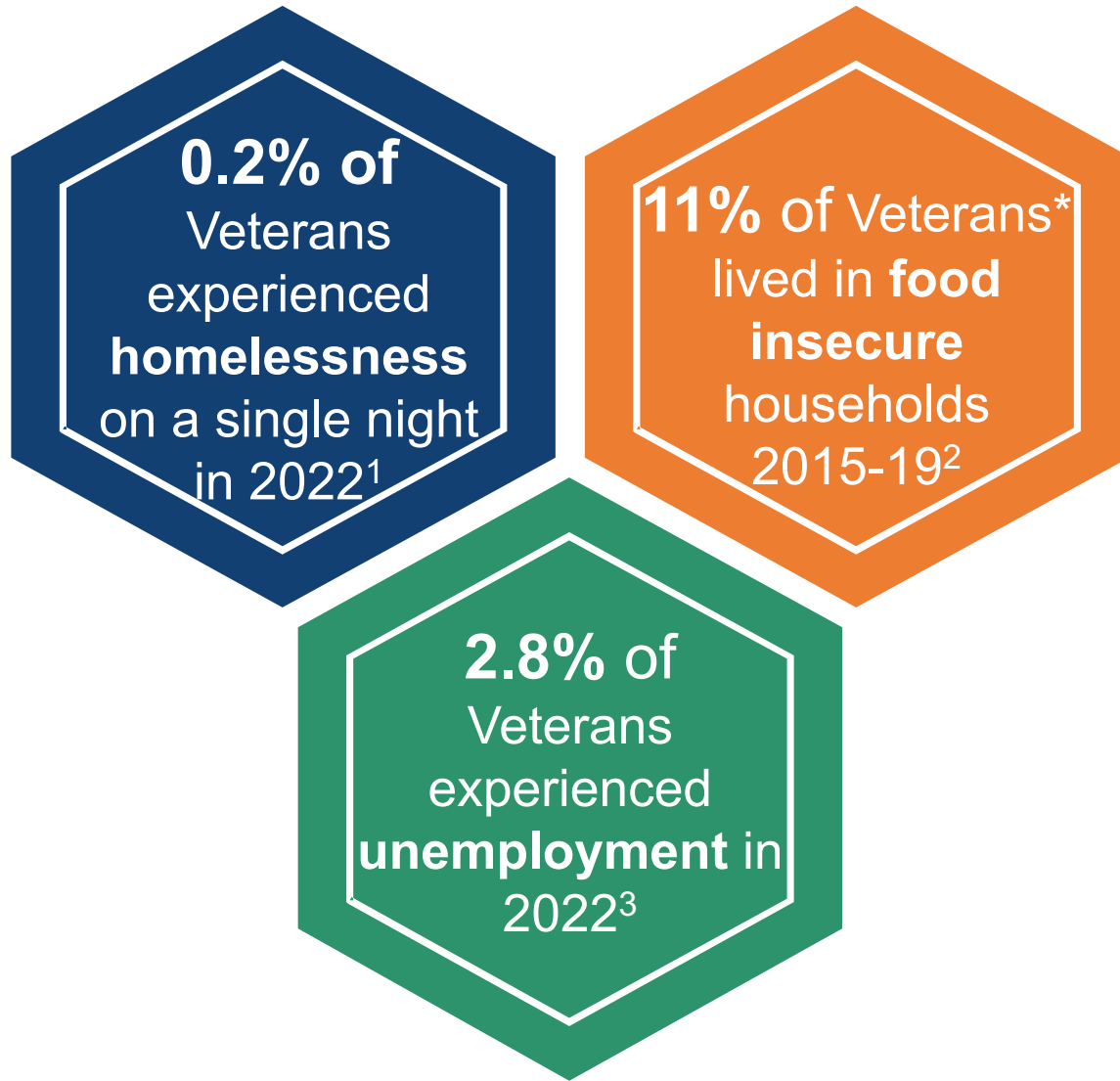
# IMPACTS OF SOCIAL DETERMINANTS OF HEALTH

- 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**.<sup>4</sup>

\*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. Blossnich 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





# 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

## Social Support Resources

**VA Bedford Community Recovery Connections Team (CRCT)**  
**General Line: (781) 687-3400 or contact Jessica Mack at (781) 687-2864**

CRCT Peer Support groups provide support and resources to Veterans in build communities. The communities. The Veterans in build hosting weekly

**Weekly Coffee Socials**  
 Coffee Socials are held in 22 communities share information

These groups are meet-up near you

Ayer	Tu
Bedford	Th
Beverly	Sa
Billerica	Fr
Danvers	Th
Haverhill	Th

## Housing Resources

**24/7 National Call Center for Homeless Veterans: 1-877-424-3838**

**Healthcare for Homeless Veterans (HCHV)**  
**Contact Tim Dr...**  
 Walk-in Clinic Ho  
 HCHV provides V  
 housing. Services  
 care, mental heal  
 providing individu


**Housing and (HUD/VASH)**  
**(781) 687-2374**  
 HUD/VASH provi  
 experiencing hom

**Supportive S...**  
**1-877-4AIDVET**  
 SSVF aims to imp  
 management, and

## Food and Nutrition Resources

**VA Bedford's Monthly Free Produce Market**  
**(781) 687-3076**  
 Occurs Monthly; Third Thursday of Every Month Behind Building 61  
 VA Bedford's Free Produce Market is a monthly drive-up produce market for Veterans and service members. First-time visitors will complete an easy one-time registration on-site. In the event of severe weather, please call **(781) 687-2000, ext. 3076** the morning of the event to confirm the market is still on.

**Supplemental Nutrition Assistance Program (SNAP)**  
**Danika Castle at (781) 275-6825 or Christopher Bang at (781) 275-7727**  
 Application Hotline: 1-800-249-2007 (Monday - Friday 8:45am - 5:00pm)  
<https://dtaconnect.eohhs.mass.gov>

  
 SNAP benefits are administered by the Department of Transitional Assistance (DTA) and provide a monthly benefit to buy nutritious foods. For Bedford residents **60 years or older**, please call Danika Castle for eligibility information and assistance with the application. For Bedford residents **59 years and younger**, please call Christopher Bang. You may also call the hotline or the local DTA office nearest you:

**DTA Office of Lowell**  
 (978) 446-2400

**DTA of Lawrence**  
 (978) 725-7100

**DTA of Revere**  
 (781) 286-7800

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  $\geq 1$   
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?

