Office of Health Equity

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OFFICE OF HEALTH EQUITY

Created in 2012

Vision: To ensure that VHA provides appropriate individualized health care to each Veteran in a way that-

- Eliminates disparate health outcomes and
- Assures health equity

OFFICE OF HEALTH EQUITY GOALS

1. **Leadership:** Strengthen VA leadership to address health inequalities and reduce health disparities.
2. **Awareness:** Increase awareness of health inequalities and disparities.
3. **Health Outcomes:** Improve outcomes for Veterans experiencing health disparities.
4. **Workforce Diversity:** Improve cultural and linguistic competency and diversity of the VHA workforce.
5. **Data, Research and Evaluation:** Improve data and diffusion of research to achieve health equity.

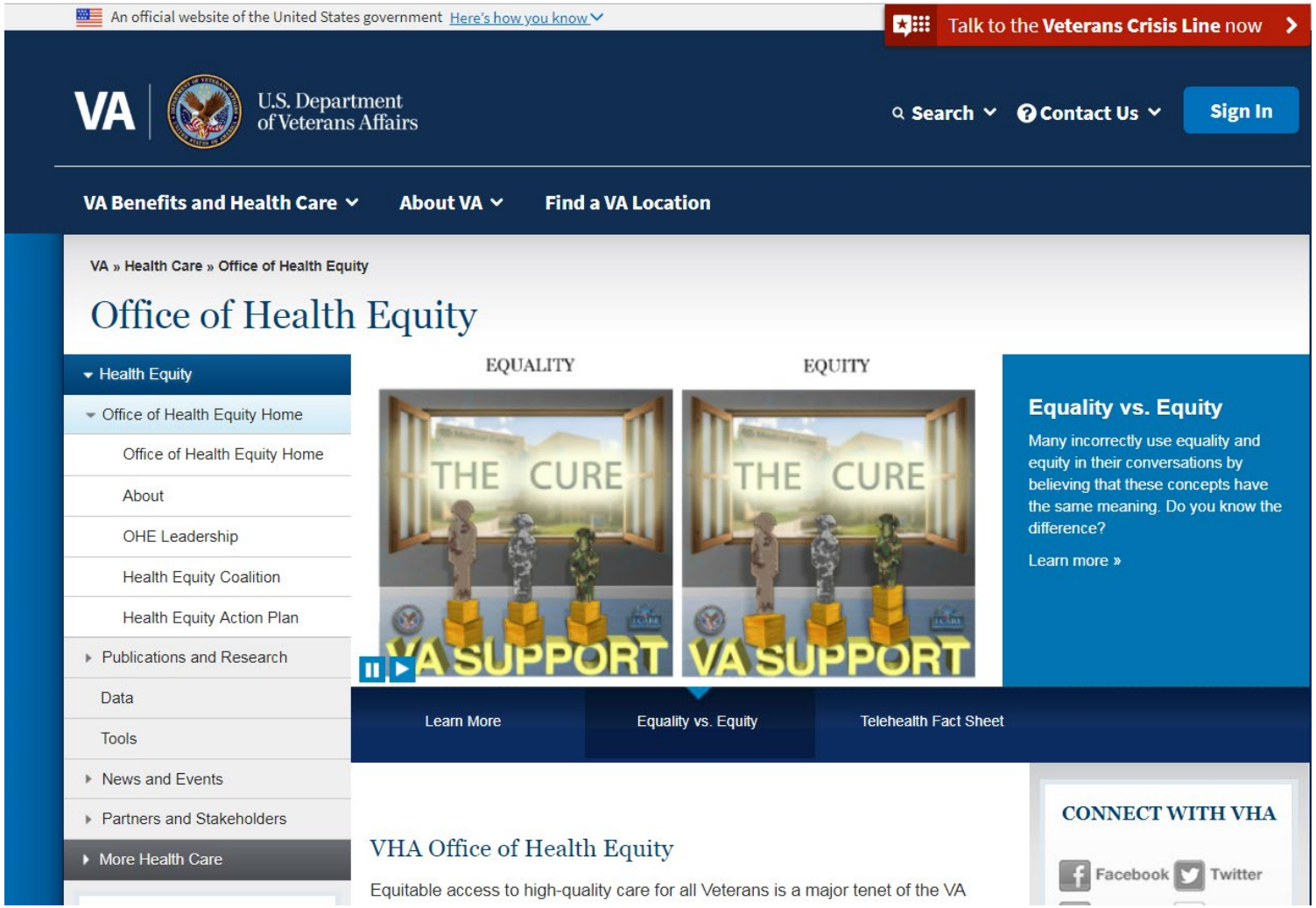
OFFICE OF HEALTH EQUITY POPULATIONS

Veterans who experience greater obstacles to health related to:

- Race or ethnicity
- Gender
- Age
- Geographic location
- Religion
- Socio-economic status
- Sexual orientation
- Mental health
- Military era
- Cognitive /sensory/ physical disability
- Justice-Involvement

OFFICE OF HEALTH EQUITY TEAM

https://www.va.gov/healthequity



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Systematic Screening of Veterans for Health-related Social Needs: An Ethical Imperative

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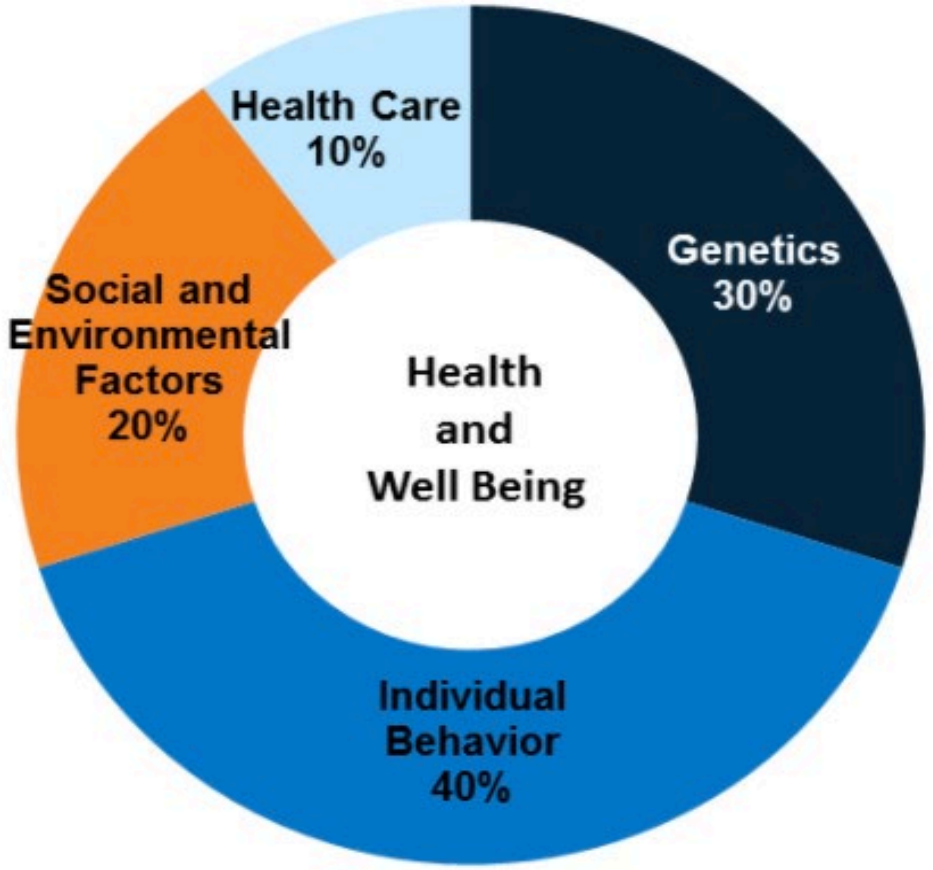
Disclosures

- The views expressed are our team's views and do not represent those of the Department of Veterans Affairs or the United States Government
- We have no financial conflicts to disclose

Overview

- Background
- The ethics of screening for health-related social needs
- VA ACORN initiative
  - Assessing Circumstances and Offering Resources for Needs (ACORN)
- Actionable solutions to allow VA to ethically address Veterans' health-related social needs

Background: Social Determinants of Health (SDOH)



Source: Kaiser Family Foundation; Schroeder, SA. (2007). We Can Do Better – Improving the Health of the American People. *NEJM.* 357: 1221-1228

Social Determinants of Health (SDOH) vs. Health-related Social Needs (HRSN)

- SDOH are “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” (WHO)
  - Examples: built environment (i.e., sidewalks, playgrounds); racism
- HRSN are the non-medical social needs impacting patients
  - Examples: food insecurity, housing instability, exposure to violence, utility concerns, and transportation needs

Covid-19 Exacerbated Existing SDOH

- SDOH contributing to increased exposure and transmission of Covid-19 are identified among those of lower socioeconomic status (SES) and who reside in densely populated areas or buildings
- Covid-19 has disproportionately affected individuals from economically and socially disadvantaged communities
  - Families experiencing homelessness are at higher risk of viral transmission and likely less access to Covid-19 screening and testing

Why Do SDOH Matter within Clinical Settings?

- Understanding the broader social, economic, and behavioral contexts impacting a person's quality of life and well-being can help promote patient-centered care
- Advancing the health of our population requires us to recognize the needs of the populations we serve
- Developing mechanisms for identifying and addressing population-level SDOH and individual-level health-related social needs in clinical settings can help us improve patients' clinical outcomes and promote health equity

Ethics of Screening for Health-Related Social Needs

- Can we address patients' needs?
  - If we can't address needs, should we screen?
- What is our obligation to ensure that needs are addressed?
  - Who has the obligation to follow up?
- How can we responsibly scale screening?
  - Are some topics too sensitive for electronic or remote screening?
  - E.g., Intimate Partner Violence or elder abuse

Potential Challenges of Screening for Personal Safety

- Remote/electronic screening may increase the potential for harm
- If abusers learn that their partner is disclosing incidents of abuse, they may control access to virtual devices to engage with healthcare providers
- Providers may need additional training to assess patient safety in the context of a telehealth visit

Ethics of Screening for Health-Related Social Needs

- Will patients feel stigmatized or too ashamed to participate in screening?
- How can we overcome the digital divide?
  - Lower SES populations may not have access to technology, internet, cellphone
  - Is it ethical to screen, if everyone won't have access?
- Given the impact on patients' health, can we ethically justify not screening for health-related social needs?

Evaluating ACORN:
A Health-Related Social Needs Screening and Referral Program Among Veterans

Background

- There is a need to improve identification and management of HRSN in clinical settings
- VA has instituted universal screening for food insecurity, housing instability, and intimate partner violence, but does not systematically screen for other HRSN
- In Oct 2019, the VA New England Healthcare System (VISN 1) piloted an HRSN screening and referral initiative: Assessing Circumstances and Offering Resources for Needs (ACORN)

Objectives

- Determine prevalence of identified HRSN and sociodemographic characteristics associated with screening positive for these needs
- Explore Veteran acceptability of ACORN and perceived effectiveness of providing geographically tailored resource guides in connecting Veterans with needed services

Screener Development

- VA-designed electronic screening platform
  - Veterans able to self-administer questions
  - Direct integration with VA EHR, data instantly available to care team
- Screening instrument developed by an interdisciplinary team that included a range of subject matter experts
- Validated questions used when available
- Questions piloted through cognitive interviews with Veterans

HRSN Domains

Food Insecurity
Housing Instability
Utility Needs
Transportation Needs
Legal Needs
Social Isolation
Employment Needs

Example Resource Guides

Food and Nutrition Resources

ACORN

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

Application Hotline: 1-800-249-2007 (Monday - Friday 8:45 AM - 5:00 PM)
www.dtaconnect.eohhs.mass.gov

SNAP benefits are provided by the federal government and administered by the Department of Transitional Assistance (DTA). Massachusetts residents who participate in SNAP are families with children, as well as elderly individuals and those with disabilities.

Please call the hotline or visit the website for more information on SNAP benefits and eligibility requirements.

DTA of Plymouth
61 Industrial Park Road
Plymouth, MA 02360
(508) 732-3100

NATHAN HALE VETERANS OUTREACH CENTER - FOOD PANTRY

(508) 224-0100 (Call to schedule curbside pick-up)
116 Long Pond Road, Plymouth, MA 02360

This program provides assistance to families and households by supplementing their weekly nutritional needs. Veterans must complete the Food Assistance Form as well as provide a physical copy of their picture ID, Veteran ID, VA medical card, proof of residence (ie: a bill with your name on it), and a phone number to qualify. Veterans who are homeless may use the address of a local service agency.

FOOD PROGRAMS AND MEAL SITES

Our community has a variety of food resources and pantries in several locations that can provide services as needed. To inquire about the food pantry nearest you, please contact:

CHRIST CHURCH
508-746-4959 (Call First)
149 Court Street, Plymouth
Tuesdays, Thursdays 4:00 PM - 5:30 PM
Saturdays 10:00 AM - 11:30 AM

DAMIEN'S PLACE
508-759-5245
65 Red Brook Road, E. Wareham
Tuesday, Thursday, Saturdays
10:00 AM - 12:00 PM
Bring ID, SSN# for all family members

SVDP/ST. PETER'S CHURCH
508-746-0663 (Call first)
10 Memorial Drive, Plymouth
In the Parish Hall
Every other Friday 4:00 PM - 5:00 PM

SALVATION ARMY
508-746-1559
8 Carver Street, Plymouth
Tuesday - Friday 9:00 AM - 2:00 PM

SECOND CHURCH OF PLYMOUTH
508-224-7220
518 State Road, Manomet
Monday, Wednesday, Thursday, Fridays
9:00 AM - 1:00 PM
Sundays 11:00 AM - 1:00 PM (Call first)

FIRST BAPTIST CHURCH
781-934-6095
2 Tremont Street, Duxbury
Saturdays 9:00 AM - 11:00 AM
Sundays 12:00 PM - 1:00 PM

QUICK NOTE

Please contact **Dexter Smart** at **(774) 826-1693** should you have any questions about the information on this page or need additional assistance with these or other resources.

Housing Resources
for use during COVID-19

ACORN

During COVID-19, non-essential evictions and terminations of federal and state rental vouchers have been suspended.

HOUSING AND URBAN DEVELOPMENT/VA SUPPORTIVE HOUSING PROGRAM

(857) 364-4947 or 1-877-4AID-VET (1-877-424-3838)

HUD/VASH provides permanent housing options for Veterans who are homeless or at risk of homelessness. The program also provides Veterans with clinical case management.

PLYMOUTH AREA COALITION - HOUSING SUPPORT

(781) 582-2010 or email info@plymouthareacoalition.org
www.plymouthareacoalition.org/how-we-help/

The Plymouth Area Coalition for the Homeless provides emergency assistance for families at the Pilgrim's Hope Shelter. Pilgrim's Hope Shelter provides these individuals with safe temporary housing for their families, as well as professional case management and support services focused on re-housing and housing stabilization.

PLYMOUTH HOUSING AUTHORITY (PHA)

(508) 746-2105
www.plymha.org

The Plymouth Housing Authority provides safe and sanitary housing conditions for low-income families and educates them on how to manage resources efficiently. PHA promotes personal, economic, and social upward mobility to provide families the opportunity to make the transition from subsidized to non-subsidized housing.

NOTE: During COVID-19, interested Veterans are still encouraged to submit applications to hold their spot in the waitlist.

HEIDREA FOR HEROES (H4H)

Eric Robinson: (774) 573-9580 or email e.robinson@heidrea4heroes.org
Application: www.heidrea4heroes.org/application-for-services

H4H offers services to Veterans and military widows, including one-time assistance to assist with costs of utility bills. H4H serves the following areas: Plymouth, Norfolk, Bristol, and Barnstable counties.

To find out if you are eligible to receive services from H4H, please submit an application online, or call Eric Robinson for more information.

NEIGHBORWORKS HOUSING SOLUTIONS

(781) 422-4200, ext. 6
www.housingsolutionssema.org

A regional non-profit that provides housing services and promotes affordable housing across Plymouth and Bristol counties, as well as Randolph, Weymouth, Holbrook, and Cohasset in Norfolk County. NeighborWorks Housing Solutions helps low- and moderate-income families secure affordable housing by providing many programs, including housing for homeless families and homeless prevention efforts.

QUICK NOTE

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Mixed Methods, Multi-site Pilot

- QI initiative at two VA outpatient primary clinics in VISN 1 between Oct 2019 - May 2020
  - Veterans asked to complete e-tablet based assessment for HRSN
  - Veterans screening positive provided geographically tailored resource guides based on identified need(s)
  - Two-week follow-up interviews with purposive sample of 15 Veterans
- Analyses: multivariable ordered logistic regression (quant); directed content analysis (qual)

Adaptations due to COVID-19

- In March 2020, COVID-19 and the transition to increased virtual care impacted screening efforts
  - Screening halted at urban women's health clinic due to COVID-related staffing changes

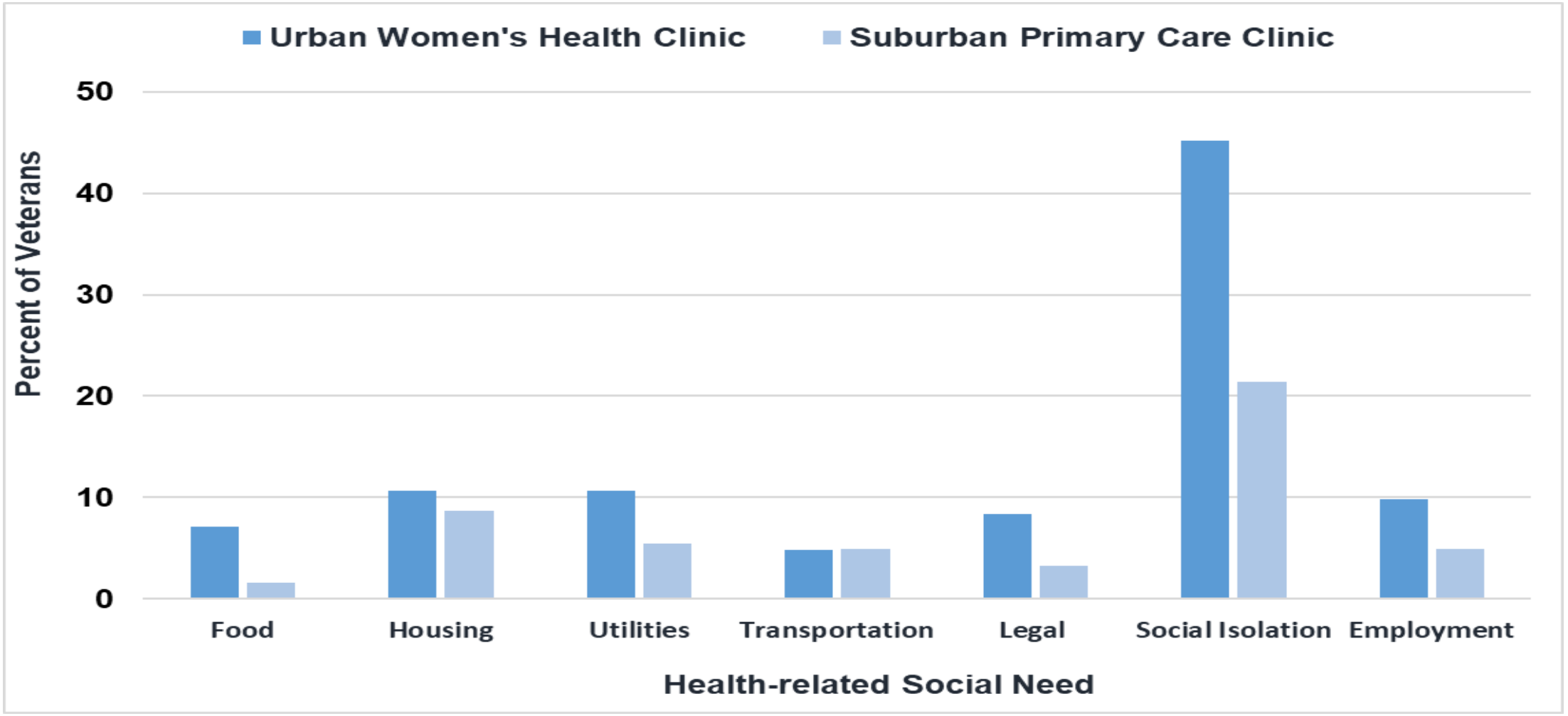
Rapid adaptations:

- Updated resource guides
- Built PDF versions of resources guides to enable electronic or mail distribution
- Developed local template to allow for staff-administered screener during virtual visits
  - Includes existing VHA Clinical Reminders for food and housing
  - Created Health Factors for all questions

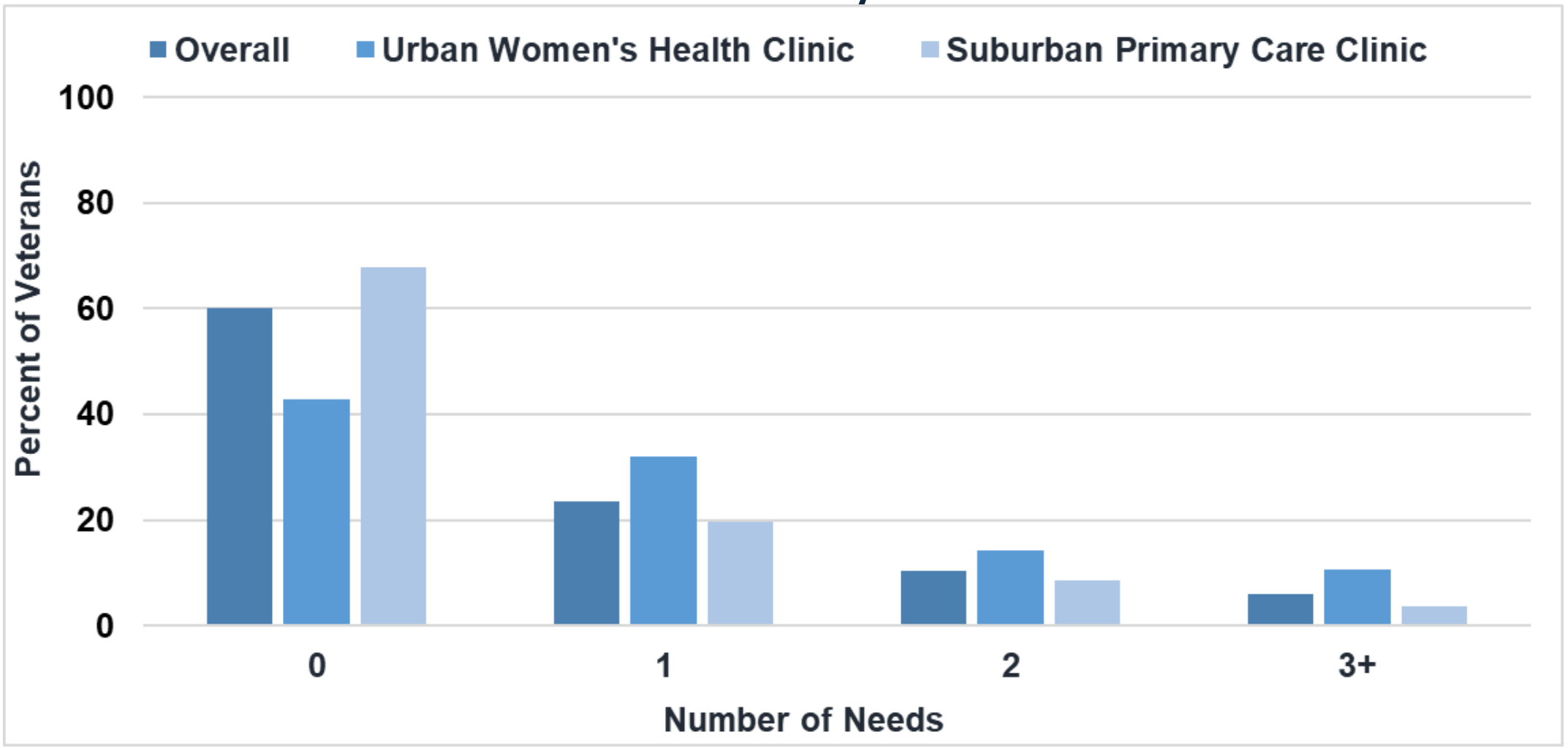
Sociodemographic Characteristics of Veterans Screened

- To date, 268 Veterans screened overall
  - Urban women's health clinic (n=84) and suburban primary care clinic (n=184)
  - Median household income for population served by urban women's health clinic $55,140 vs $85,654 for population served by suburban primary care clinic (median $63,179 for households nationally, U.S. Census Bureau, 2018)
- 64% male overall
- Mean age of 55.9 (SD 18.6)
- 81.7% non-Hispanic white; 6.0% non-Hispanic Black; 4.1% Hispanic
- 50.4% non-married/partnered
- 12.7% low income

HRSN Among Veterans Screened, by Site



Need Burden Among Veterans Screened, Overall and by Site



Sociodemographic Characteristics Associated with Higher Number of HRSN

Characteristics	aOR	95% CI
Gender		
Female	2.25*	1.24 - 4.07
Age		
18 – 34	Ref	Ref
35 – 49	1.47	0.66 - 3.26
50 – 64	2.30*	1.01 - 5.25
65 – 79	2.01	0.87 - 4.61
≥80	2.63	0.84 - 8.16
Race/ethnicity		
Non-Hispanic White	Ref	Ref
Non-Hispanic Black/Hispanic/Other	1.68	0.86 - 3.28
Marital Status		
Non-married/partnered	2.02*	1.17 - 3.49
Enrollment Priority		
Groups 1 – 4	Ref	Ref
Group 5	1.20	0.56 - 2.58
Group 6 – 8	0.67	0.35 - 1.31

Multivariable ordered logistic regression (0, 1-2, ≥3 needs), *p<0.05

Perceived Acceptability Among Veterans Screened

- Overall Veterans find screening for HRSN both acceptable and appropriate, and feel VA should continue such screenings
- While some Veterans found the resource guides helpful, others did not use the guides
  - Reasons ranged from already receiving assistance from VA to discomfort initiating contact with non-VA organizations

Limitations

- Two sites with low patient volume (3rd site initially included in pilot but excluded from analyses due to data integrity concerns)
- COVID-19-related disruptions in screening due to lack of in-person visits and staffing shortages
- Likely underpowered to detect correlates of HRSN due to unexpectedly low sample size
- Multiple challenges with data collection and integrating new technology into existing clinical workflow

Conclusions

- Veterans feel an HRSN screening and referral program is acceptable and important to continue
- Use of the resource guides was limited
- 40% of Veterans reported at least 1 HRSN (57% in urban clinic)
- Almost 1/3 reported social isolation; 1 in 5 reported at least one form of material hardship
- Women and non-married/partnered Veterans are at increased risk for reporting multiple unmet HRSN

Implications & Next Steps

- Screening for HRSN is a critical step towards connecting Veterans with needed services
- Pilot is ongoing, and there are plans to expand ACORN to primary care and specialty care clinics in other geographic regions
- Future work is needed to better understand which Veterans may benefit most from “low-touch” vs. “high-touch” interventions

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Moving Forward:
Meeting our Ethical Obligation to Systematically Screen and Address Health-Related Social Needs

Ethically Addressing HRSN in Clinical Settings

- Ability to screen and refer or link to resources
  - Electronic self-screening will enhance ability to scale screening
- Connection of screening data to EHR
- Adequate staff training to screen and respond to patients
- Time to address social needs
- Infrastructure to address identified unmet needs
- Attend to the HRSNs setbacks from Covid-19

What Can VA Do To Address SDOH on a Larger Scale?

- Screening for HRSN is a critical step towards connecting Veterans with needed services
- Risk stratification Veterans to different levels of support
  - (1) resource guides
  - (2) peer navigators
  - (3) intensive case management
- Encourage patient self-efficacy to empower them to connect with support services

Recent Initiative at New York–Presbyterian Hospital

- New York–Presbyterian Hospital and the NYU incorporated community health workers (CHWs) into their multidisciplinary response to Covid-19
- CHWs addressed social determinants of health that disproportionately affect low-income, minority populations and that are magnified during times of crisis (Covid-19)

The Impact of Community Health Workers (CHWs)

CHWs:

- 9600 wellness phone checks
  - Med Refill
  - Housing insecurity/ Unable to pay rent
  - Bereavement support
- 3400 enrolled into patient portals
- 600 virtual health coaching sessions

Examples of Ways in Which CHWs Have Addressed Intermediary Social Determinants during the Pandemic in New York City.*

Social Determinant of Health	CHW Strategies and Approaches	Example
Food availability	Connect patients to pantries and food-distribution sites; enroll them in SNAP benefits. Organize food tables and food drives in partnership with community- and faith-based organizations.	The undocumented-immigrant parent of a child with special needs successfully obtained access to a hospital's mobile food pantry. An immigrant community member expressed shame and fear of stigma associated with food assistance; after a supportive discussion, a CHW arranged for delivery directly to the patient's home.
Employment	Support patients and connect them to vocational training. Educate community members on unemployment resources and help them navigate complex filing systems.	A patient couldn't obtain access to the state's unemployment website; a CHW coached her through the application-submission process. An immigrant community member working as a taxi driver couldn't obtain access to unemployment benefits because of having independent-contractor status; a CHW connected the community member to a local worker center that helped clarify eligibility for benefits.
Housing	Connect patients to rent assistance and help with the transition out of shelters and other congregate settings.	A community member was desperate to leave the shelter system; a CHW successfully advocated for permanent placement by repeatedly calling the case manager during the peak of the pandemic.
Access to health care	Facilitate prescription refills; connect patients to primary care providers and mental health resources. Help patients navigate health systems by advocating for interpreter services, accompanying patients during in-person or televisits, or facilitating enrollment in health insurance.	A patient was nearly out of medication and was unable to obtain access to telehealth services; a CHW connected her to her provider to obtain refills and worked with a local pharmacy to have medication delivered to her home. CHWs created a linguistically tailored guide on televisits and virtual health education sessions for community members with limited English proficiency.
Immigration and documentation status	Navigate resources for undocumented immigrants.	A patient was concerned about obtaining access to unemployment benefits because of her immigration status; a CHW connected her to a local community-based immigration resource to safely explore options.

* CHW denotes community health worker, and SNAP Supplemental Nutrition Assistance Program.

PJ Peretz, et al., NEJM 9/23/2020

A Path Forward

- Deploy system wide electronic screening for health-related social needs
- Develop an infrastructure to connect Veterans to resources in real time
- Connect data to EHR so healthcare providers can act on it
- Encourage patient empowerment
- Build partnerships with community-based organizations to help meet Veterans' needs
- Launch VA campaign/marketing around social needs to reduce stigmatization (similar to efforts around homelessness and suicide)

Questions?

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