Assessing Circumstances and Offering Resources for Needs (ACORN): A Veterans Health Administration Initiative to Screen for, Assess, and Address Social Risks and Social Needs

Office of Health Equity Focus on Health Equity and Action Cyberseminar Series

January 10, 2024

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Cyberseminar Presenters

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Co-lead, VHA Assessing Circumstances and Offering Resources for Needs (ACORN) Initiative

Conflict of Interest Disclosure

We have no actual or potential conflicts of interest in relation to this program or presentation to disclose.

Office of Health Equity

Created in 2012

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

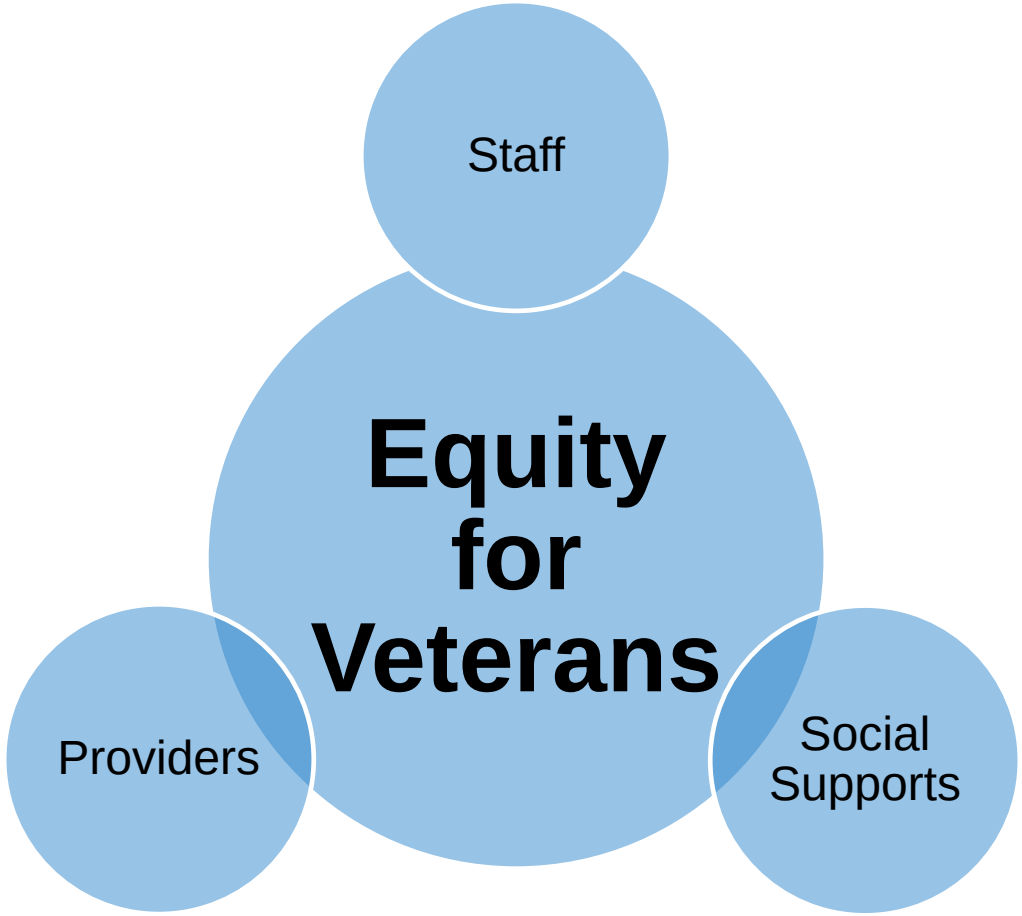
- Eliminates disparities in health outcomes
- Promotes health equity

What is VA doing to promote equity?

1. We work with the Office of Resolution Management, Diversity and Inclusion and other partners to ensure Staff work in 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.



Veteran Populations

Veterans who experience greater obstacles to health related to:

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

Office of Health Equity Website

https://www.va.gov/healthequity

Objectives

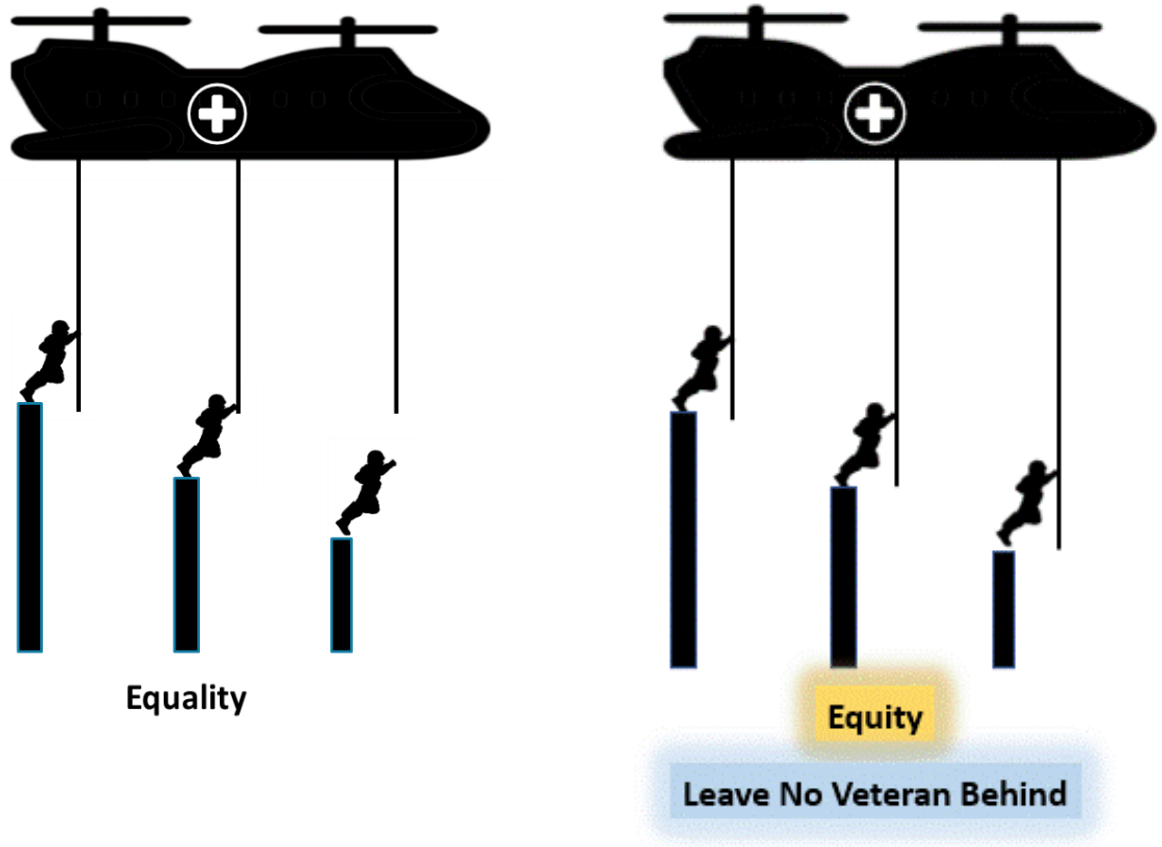
1. Introduce relevant concepts and definitions including equity, social determinants of health, social risk factors, and social needs
2. Review the importance of addressing social determinants of health in healthcare settings
3. Provide an overview of the ACORN initiative and recently released ACORN Dashboard
4. Discuss opportunities for integrating ACORN into clinical settings to improve identification of social needs and access to relevant resources among Veterans

Systematically identifying, comprehensively assessing, and addressing social risks and needs is critical to advancing health equity among Veterans.

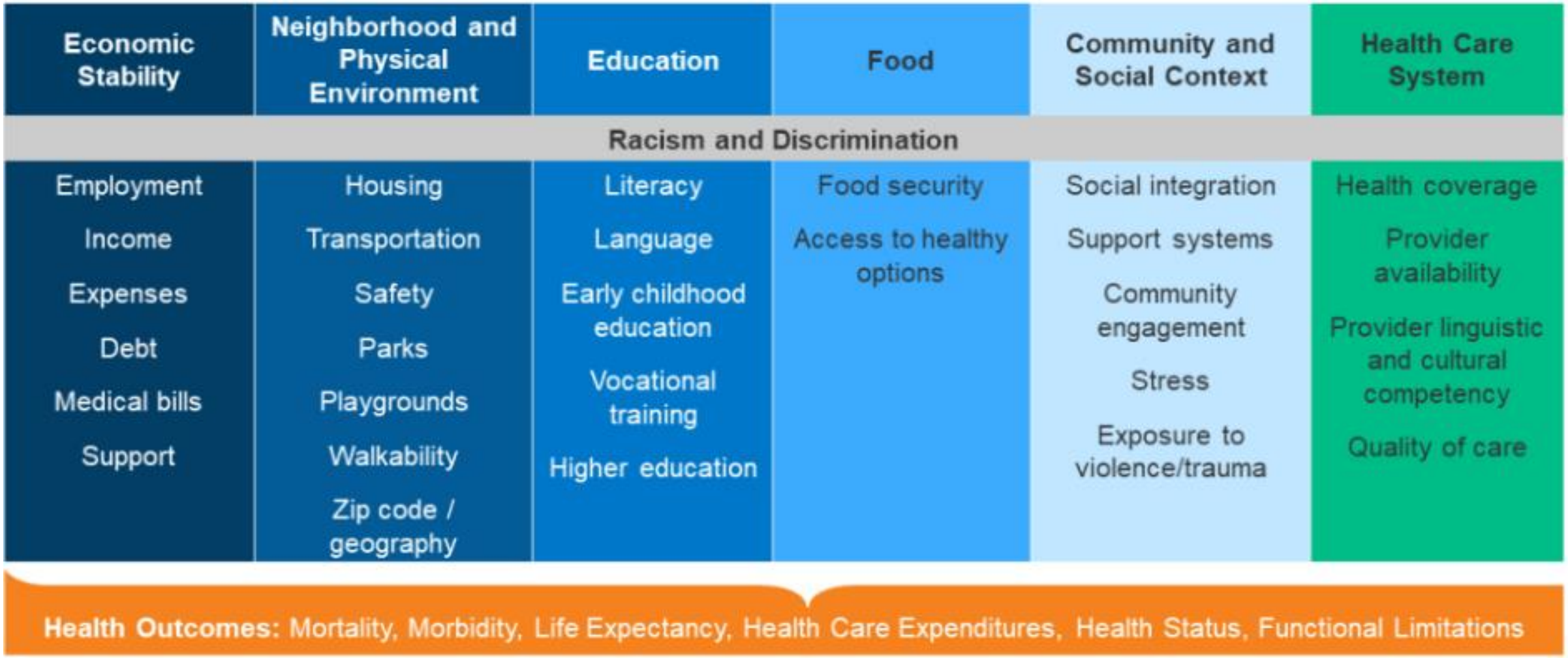
Equality vs. Equity

Equality means providing the same resources to everyone.

Equity means getting people what they need, so no one is left behind.

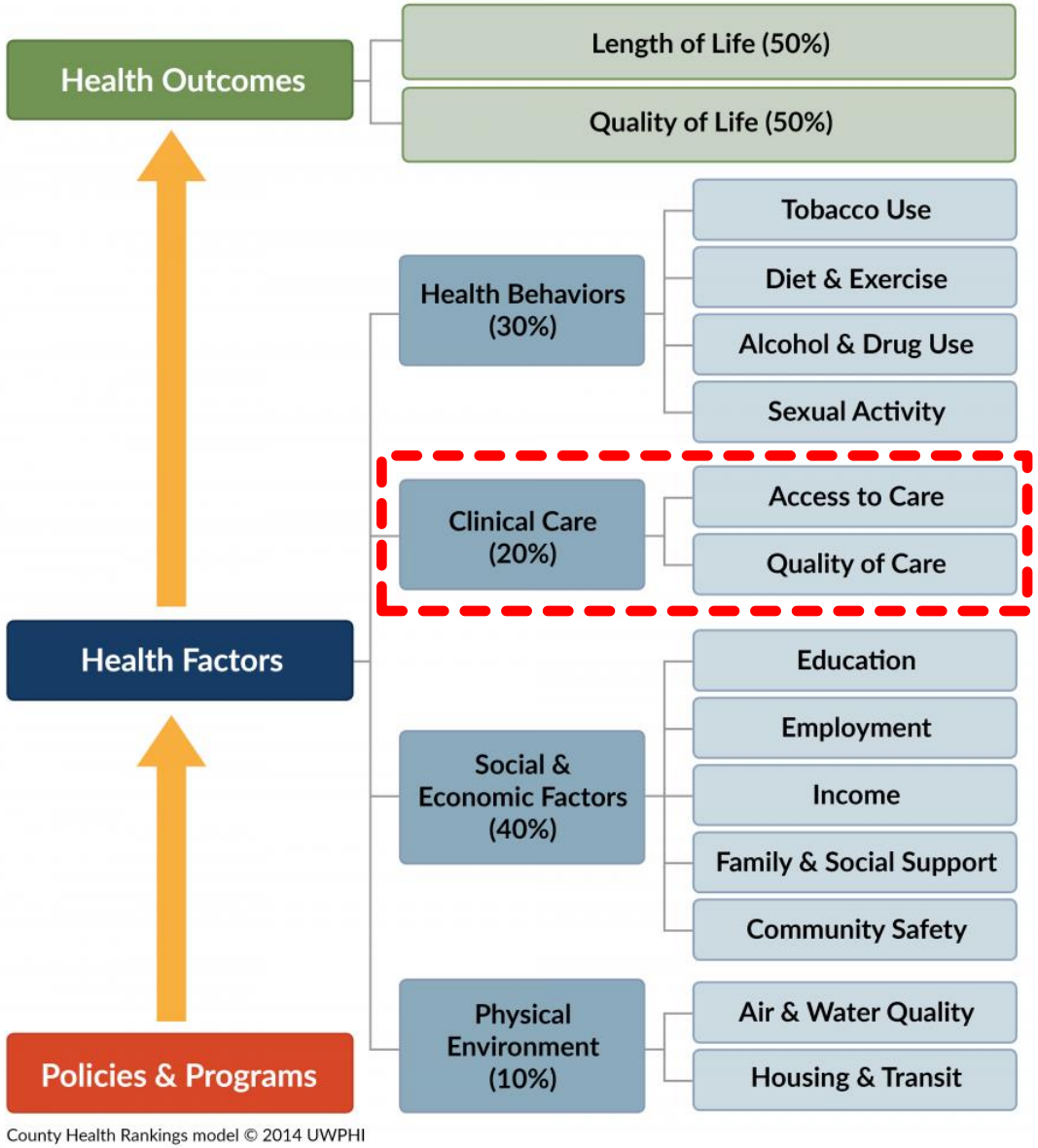


Social Determinants of Health (SDOH)



Artiga, S. *Health Disparities Are a Symptom of Broader Social and Economic Inequities.* Kaiser Family Foundation. 2020.

Social determinants have a greater impact on health outcomes than clinical care.



Remington PL, Catlin BB, Gennuso KP. *Popul Health Metr*. 2015 Apr 17;13:11.

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

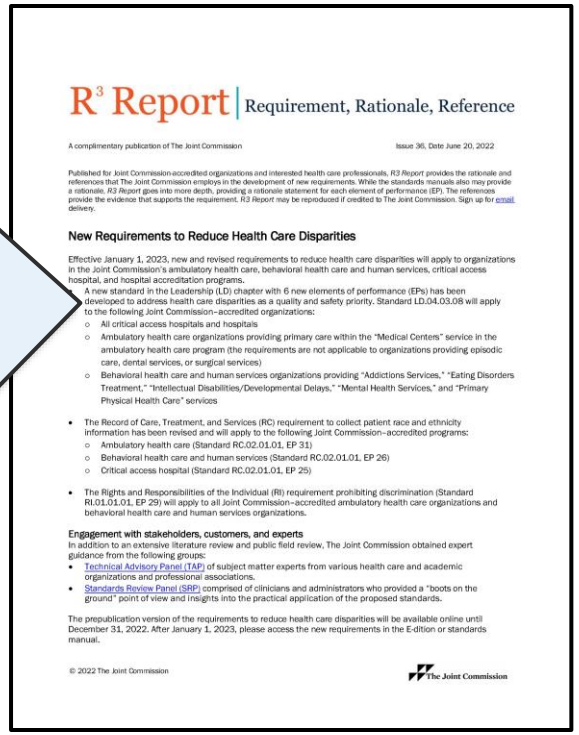
A patient-centered concept that incorporates a person's perception of their own health-related needs.

Alderwick H, Gottlieb LM. *Milbank Q*. 2019 Jun;97(2):407-419.
Green K, Zook M. *Health Affairs Blog*, October 29, 2019.
National Academies of Sciences, Engineering, and Medicine. Integrating Social Care into the Delivery of Health Care, 2019
World Health Organization. 2010. www.who.int/social_determinants/sdh_definition/en.

ACORN can help meet Joint Commission and CMS Equity Standards

Joint Commission Leadership Standard

Element of Performance 2:
The organization assesses the patients' health-related social needs and provides information about community resources and support services.



R³ Report | Requirement, Rationale, Reference

A complimentary publication of The Joint Commission — Issue 36, Date June 20, 2022

Published for Joint Commission–accredited organizations and interested health care professionals, *R3 Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, *R3 Report* goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. *R3 Report* may be reproduced if credited to The Joint Commission. Sign up for email delivery.

New Requirements to Reduce Health Care Disparities

Effective January 1, 2023, new and revised requirements to reduce health care disparities will apply to organizations in the Joint Commission's ambulatory health care, behavioral health care and human services, critical access hospital, and hospital accreditation programs.

- A new standard in the Leadership (LD) chapter with 6 new elements of performance (EPs) has been developed to address health care disparities as a quality and safety priority. Standard LD.04.03.08 will apply to the following Joint Commission–accredited organizations:
  - All critical access hospitals and hospitals
  - Ambulatory health care organizations providing primary care within the "Medical Centers" service in the ambulatory health care program (the requirements are not applicable to organizations providing episodic care, dental services, or surgical services)
  - Behavioral health care and human services organizations providing "Addictions Services," "Eating Disorders Treatment," "Intellectual Disabilities/Developmental Delays," "Mental Health Services," and "Primary Physical Health Care" services
- The Record of Care, Treatment, and Services (RC) requirement to collect patient race and ethnicity information has been revised and will apply to the following Joint Commission–accredited programs:
  - Ambulatory health care (Standard RC.02.01.01, EP 31)
  - Behavioral health care and human services (Standard RC.02.01.01, EP 26)
  - Critical access hospital (Standard RC.02.01.01, EP 25)
- The Rights and Responsibilities of the Individual (RI) requirement prohibiting discrimination (Standard RI.01.01.01, EP 29) will apply to all Joint Commission–accredited ambulatory health care organizations and behavioral health care and human services organizations.

Engagement with stakeholders, customers, and experts

In addition to an extensive literature review and public field review, The Joint Commission obtained expert guidance from the following groups:

- Technical Advisory Panel (TAP) of subject matter experts from various health care and academic organizations and professional associations.
- Standards Review Panel (SRP) comprised of clinicians and administrators who provided a "boots on the ground" point of view and insights into the practical application of the proposed standards.

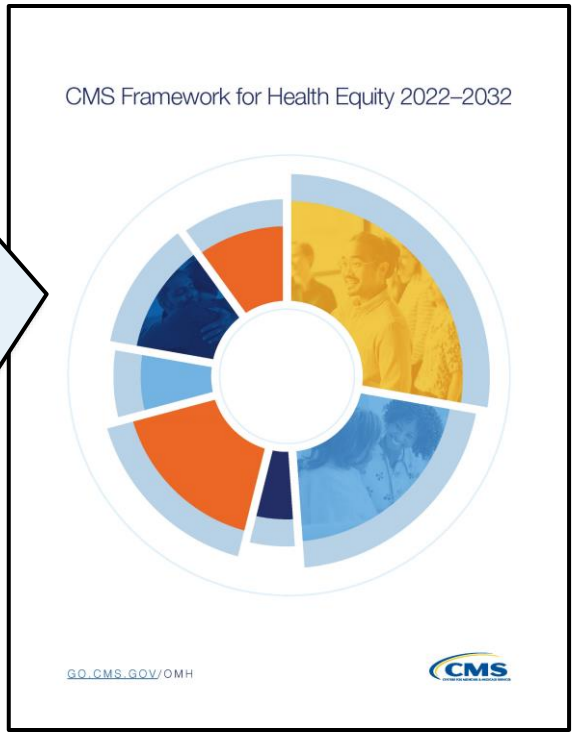
The prepublication version of the requirements to reduce health care disparities will be available online until December 31, 2022. After January 1, 2023, please access the new requirements in the E-dition or standards manual.

The Joint Commission

Centers for Medicare and Medicaid (CMS) Equity Standards

Attest that your hospital engages in:

- Data collection of patient demographics and social determinants of health (SDOH)
- Training of staff in culturally sensitive data collection
- Inputs demographic and SDOH data into EHR



CMS Framework for Health Equity 2022–2032

GO.CMS.GOV/OMH

CMS

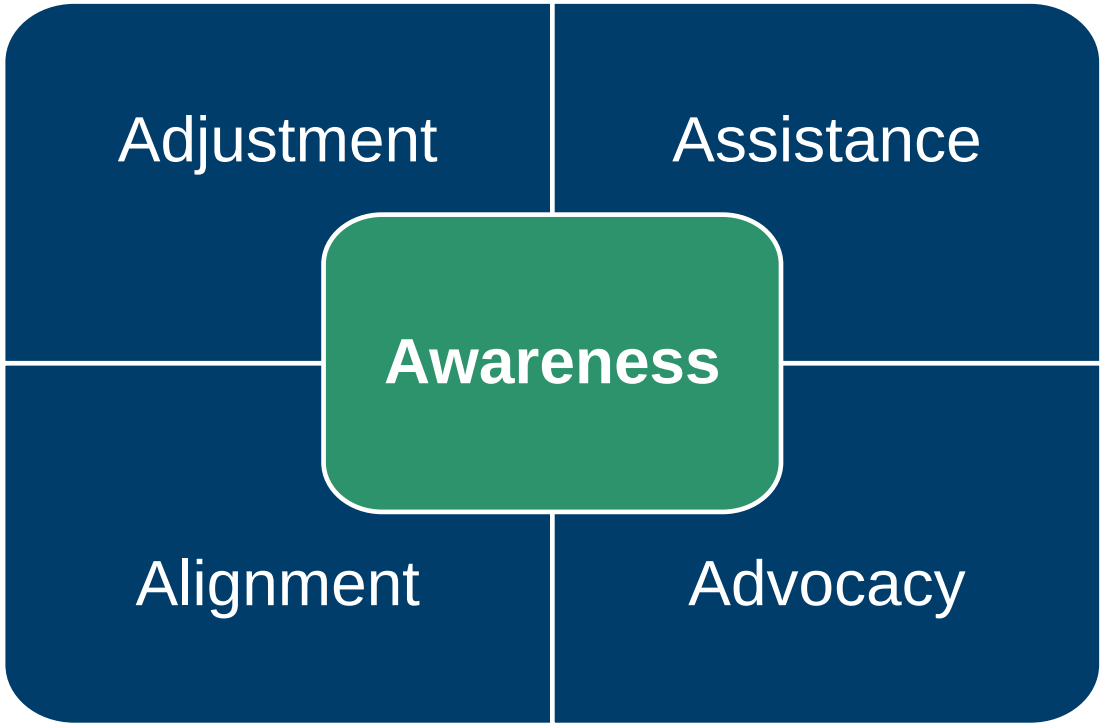
The Joint Commission R3 Report: New Requirements to Reduce Health Care Disparities

CMS Framework for Health Equity 2022–2032; CMS MLN Connect Newsletter: Special Edition

Healthcare organizations can address social risks and needs in multiple ways.

Activities focused on individuals

Activities focused on communities



Integrating Social Care into the Delivery of Health Care, National Academies of Sciences, Engineering, and Medicine2019.

VHA screens for certain risks and offers well-established interventions for needs.

VA Social Risk Screening

- Food security
- 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

VHA does not have a systematic screening program for identifying social needs more broadly.

How can we better identify social risks and needs systematically, and connect Veterans with existing VA and community resources?

ACORN

(Assessing Circumstances & Offering Resources for Needs)

ACORN aims to systematically identify and address unmet social needs among all Veterans to improve health and advance health equity.

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

*VHA has safety screening processes (e.g., intimate partner violence, suicide risk, elder mistreatment) independent of ACORN

Link to ACORN National CPRS Template Materials

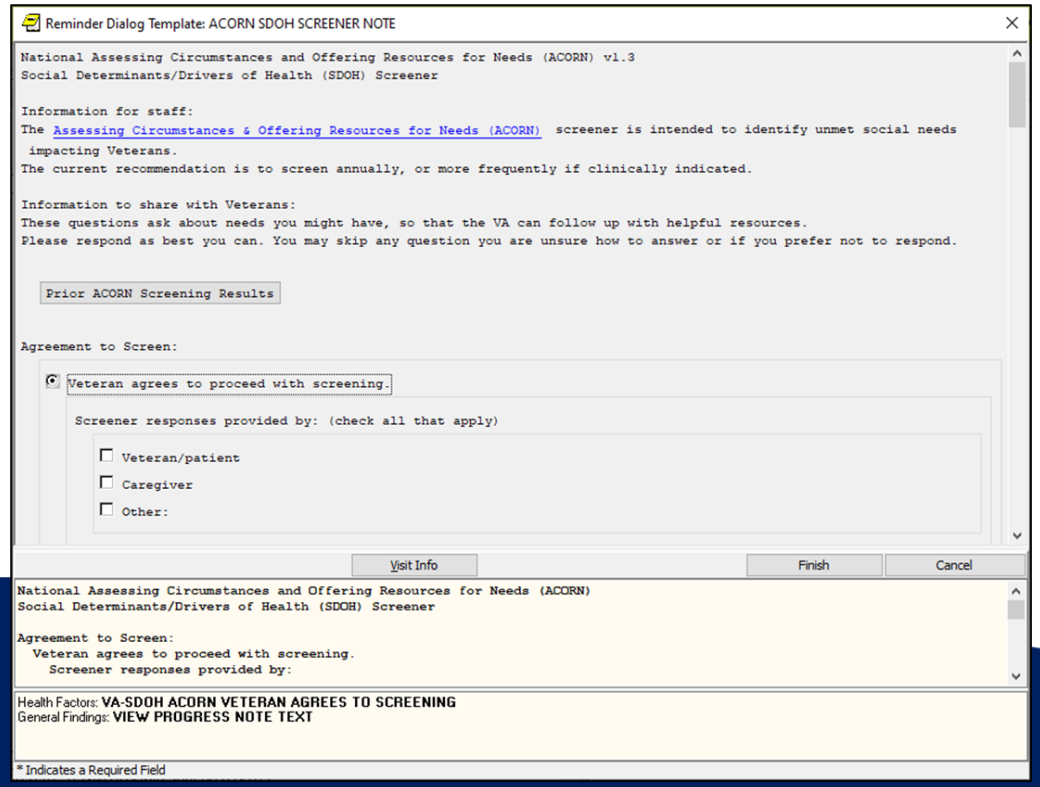
ACORN Assessing Circumstances & Offering Resources for Needs (ACORN) Screening Tool

Last Name:_____ Last 4 SSN:_____ Date:_____

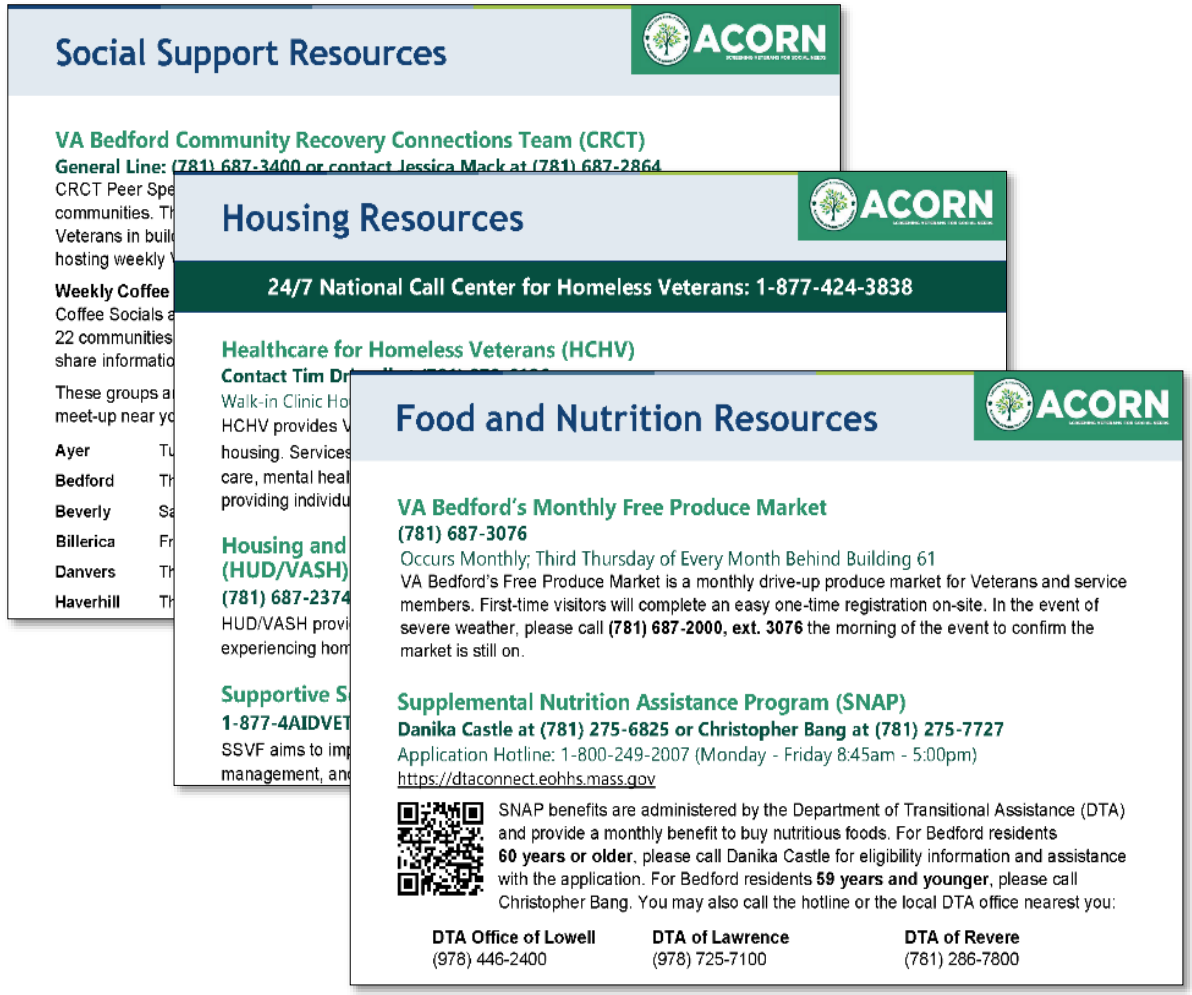
These questions ask about needs you might have, so that the VA can follow up with helpful resources. Please respond as best as you can.

1)	**In the past two months, have you been living in stable housing that you own, rent, or stay in as part of a household?**	☐ Yes	☐ No
2)	**Are you worried or concerned that in the next two months you may NOT have stable housing that you own, rent, or stay in as part of a household?**	☐ Yes	☐ No
3)	**Where have you lived for MOST of the past two months? (Please check only one.)**	☐ Apartment/House/Room (no government subsidy) ☐ With Friend/Family ☐ Motel/Hotel ☐ Anywhere outside (e.g., Street, Vehicle, Abandoned Building)	☐ Apartment/House/Room (with government subsidy) ☐ Short-term Institution like Hospital, Rehab Center, Drug Treatment Center ☐ Homeless Shelter ☐ Other
4)	**Are you currently without a place to stay?**	☐ Yes	☐ No
5)	**Please answer how often the following statement was true for you. Within the past 12 months, you worried whether your food would run out before you got money to buy more.**	☐ Often True ☐ Sometimes True	☐ Never True
6)	**Please answer how often the following statement was true for you. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.**	☐ Often True ☐ Sometimes True	☐ Never True
7)	**Do you need help getting food for this week?**	☐ Yes	☐ No
8)	**Currently, you don't have enough money to get food OR you are worried that your food will run out before you get money to buy more.**	☐ Yes	☐ No
9)	**How often do you have trouble paying for your utilities (i.e., electric, gas, oil, water, or phone)?**	☐ Often ☐ Sometimes	☐ Never ☐ Not applicable/I don't pay for utilities

Page 1 of 2



ACORN Model: Resources and Referrals



Social Support Resources

ACORN

VA Bedford Community Recovery Connections Team (CRCT)

General Line: (781) 687-3400 or contact Jessica Mack at (781) 687-2864

CRCT Peer Spe
communities. Th
Veterans in buil
hosting weekly

Weekly Coffee
Coffee Socials a
22 communities
share informatio

These groups a
meet-up near yo

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

Housing Resources

ACORN

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

Healthcare for Homeless Veterans (HCHV)

Contact Tim D

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

ACORN

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:

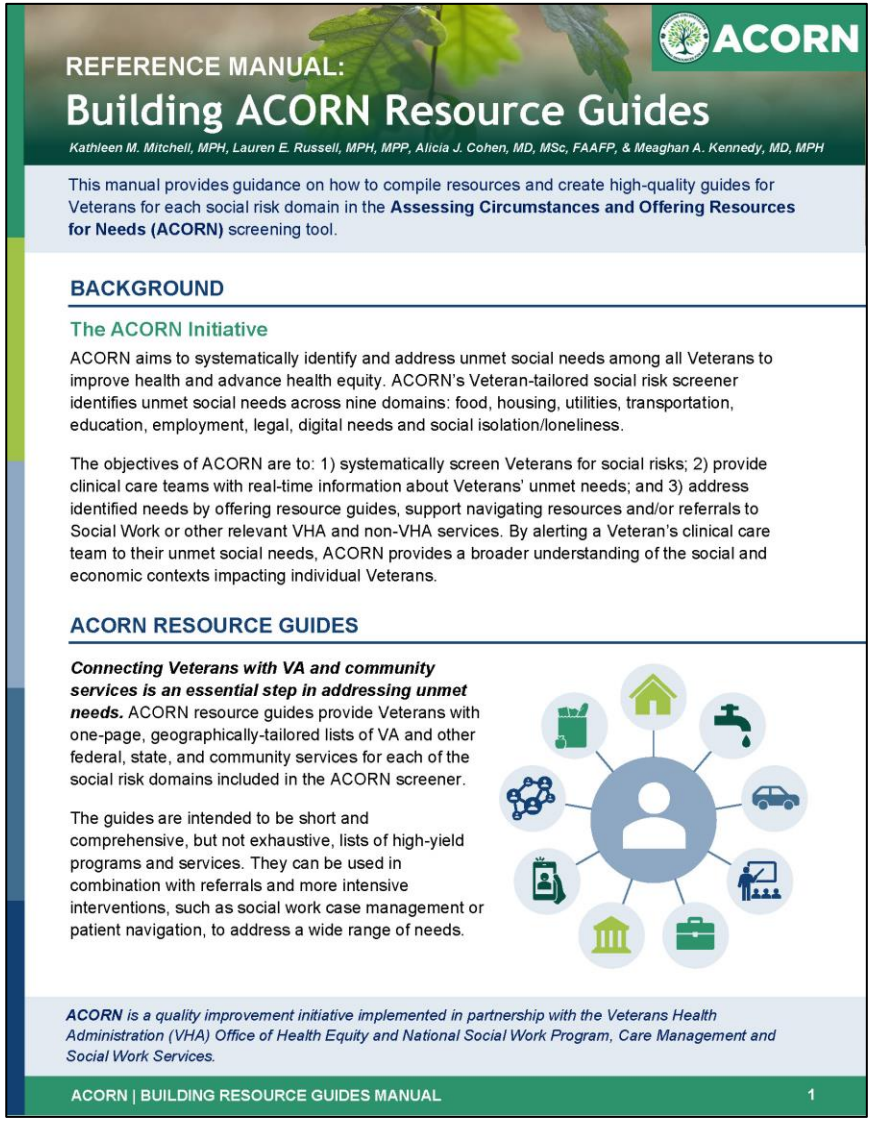
DTA Office of Lowell	DTA of Lawrence	DTA of Revere
(978) 446-2400	(978) 725-7100	(781) 286-7800

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

ACORN Resource Guides

Overview:

- Clinic staff can provide resource guides as a supplement to other supports such as social work and case management
- ACORN resource guides are one-page, geographically tailored lists of VA and other federal, state, and community services
- Guides are short and comprehensive, with a focus on highest-yield over quantity



REFERENCE MANUAL:

Building ACORN Resource Guides

Kathleen M. Mitchell, MPH, Lauren E. Russell, MPH, MPP, Alicia J. Cohen, MD, MSc, FAAFP, & Meaghan A. Kennedy, MD, MPH

This manual provides guidance on how to compile resources and create high-quality guides for Veterans for each social risk domain in the **Assessing Circumstances and Offering Resources for Needs (ACORN)** screening tool.

BACKGROUND

The ACORN Initiative

ACORN aims to systematically identify and address unmet social needs among all Veterans to improve health and advance health equity. ACORN's Veteran-tailored social risk screener identifies unmet social needs across nine domains: food, housing, utilities, transportation, education, employment, legal, digital needs and social isolation/loneliness.

The objectives of ACORN are to: 1) systematically screen Veterans for social risks; 2) provide clinical care teams with real-time information about Veterans' unmet needs; and 3) address identified needs by offering resource guides, support navigating resources and/or referrals to Social Work or other relevant VHA and non-VHA services. By alerting a Veteran's clinical care team to their unmet social needs, ACORN provides a broader understanding of the social and economic contexts impacting individual Veterans.

ACORN RESOURCE GUIDES

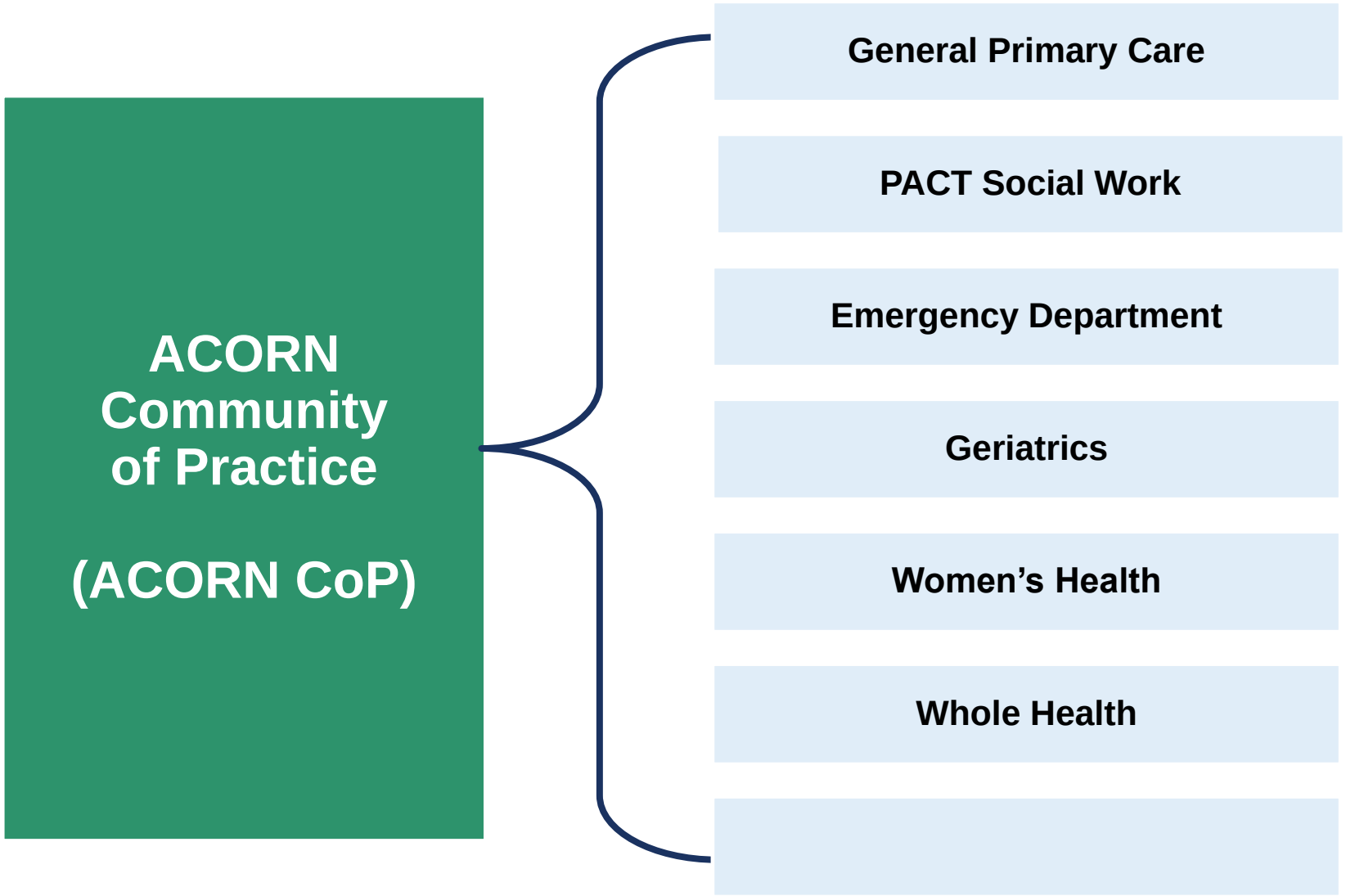
Connecting Veterans with VA and community services is an essential step in addressing unmet needs. ACORN resource guides provide Veterans with one-page, geographically-tailored lists of VA and other federal, state, and community services for each of the social risk domains included in the ACORN screener.

The guides are intended to be short and comprehensive, but not exhaustive, lists of high-yield programs and services. They can be used in combination with referrals and more intensive interventions, such as social work case management or patient navigation, to address a wide range of needs.

ACORN is a quality improvement initiative implemented in partnership with the Veterans Health Administration (VHA) Office of Health Equity and National Social Work Program, Care Management and Social Work Services.

ACORN | BUILDING RESOURCE GUIDES MANUAL 1

Select ACORN Implementation Sites



ACORN Community of Practice (CoP)

All Sites CoP
(monthly 2nd Tues)

- Knowledge sharing across all participating ACORN sites
- National level ACORN data and updates
- "Site Spotlight" to share lessons learned, challenges, and successes

New Sites CoP
(monthly 4th Tues)

- Start up support as New Sites plan and implement ACORN
- Workflow development and refinement

Office Hours
(monthly 1st Thurs)

- Individualized start up support and workflow refinement
- Technical assistance to troubleshoot barriers

ACORN Basics
(monthly 3rd Thurs)

- Introduction to ACORN
- Discuss next steps for sites interested in implementing ACORN

Data: ACORN Screens

Newly Launched: ACORN Dashboard

12,066
ACORN screens completed*

68%
Positive in ≥ 1 domain

37% Digital Needs

29% Social Isolation/Loneliness

18% Food Needs

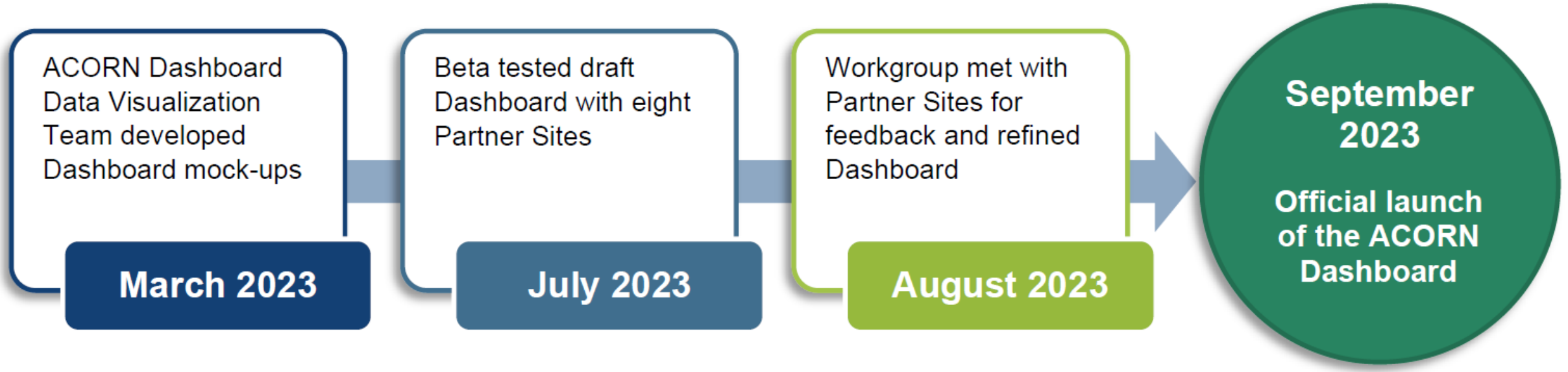
15% Transportation

13% Housing

13% Utilities, 8% Education, 6% Legal, 6% Employment

**Data collected between July 1, 2021 – January 8, 2024*

Developing the ACORN Dashboard



The ACORN Dashboard

Welcome to the ACORN Dashboard

The Assessing Circumstances and Offering Resources for Needs (ACORN) Dashboard was created in 2023 to increase access to data collected through the ACORN screening tool. This Dashboard will help VHA clinical teams and programs: (1) understand the social risks and social needs impacting Veterans; (2) track the types of resources and referrals provided to Veterans who screen positive on ACORN; and (3) observe how screening rates and resources and referrals vary by demographic factors and over time.

Please use the **Pages pane** on the left side to navigate the dashboard.

The **Overview Data** page displays total counts and percentages for all screens, positive screens and any resource or referral. It also provides trend lines depicting all screens and positive screens over time along with a figure displaying the positive social need domains.

The **Demographics** page contains an overview of several demographic characteristics: age, birth sex, sexual orientation and gender identity (currently hidden due to a large number of missing data), married/partnered status, priority group, race, ethnicity, and rurality.

The **Domain Trends** page contains trend lines for positive screens over time for all nine social need domains.

The **Resources and Referrals** page provides information on the various resources and referrals provided to Veterans screening positive on ACORN. The total counts and percentages of those already receiving assistance and those who declined are also displayed.

The **Co-Occurring Needs by Domain** page displays data broken down by each ACORN social risk domain. The table and figure show a few different data points, including positive screens by domain and the co-occurrence of the selected social risk domain with other unmet social needs.

The **Resources and Referrals by Domain** page displays data broken down by each ACORN social risk domain. The table and figure show data about the resources and referrals provided to Veterans who endorsed a particular unmet need (either alone or in combination with other unmet needs).

For additional information, review the **ACORN User Guide and FAQ**.

Note: When there are fewer than 13 Veterans in any given category, values are hidden to protect privacy. This dashboard only includes data from the clinics/programs at sites that are using the ACORN screener. Thus, data may differ from other dashboards and is not representative of VHA-enrolled Veterans.

Please visit the **ACORN SharePoint** to access other resources, such as the **ACORN Screener**, **Partner Site Interest Form**, **CPRS template PowerPoint**, and **Resource Guide Manual**. If you have any questions or comments please contact **VHAACORNDASHBOARD@va.gov**.

+ The ACORN Dashboard Developed by: Lauren Russell, Sarah Leder, Chris Halladay, and Jaime Boris in collaboration with Michelle Wilcox, Chava Sonnier, Ernest Moy, Kathleen Mitchell, Meaghan Kennedy, Kenneth Jones, Alicia Cohen, and Andrea Berkheimer.

VA | U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Health Equity

The ACORN Dashboard: Overview Data

ACORN DASHBOARD

Assessing Circumstances and Offering Resources for Needs (ACORN) aims to systematically identify and address social needs among Veterans receiving care in the VHA. ACORN screens for nine social risk domains: food, housing, utilities, transportation, education, employment, legal needs, social isolation/loneliness, and digital needs. Veterans who screen positive are offered resources and referrals to address identified needs.

VISN, Facility, and Station: All

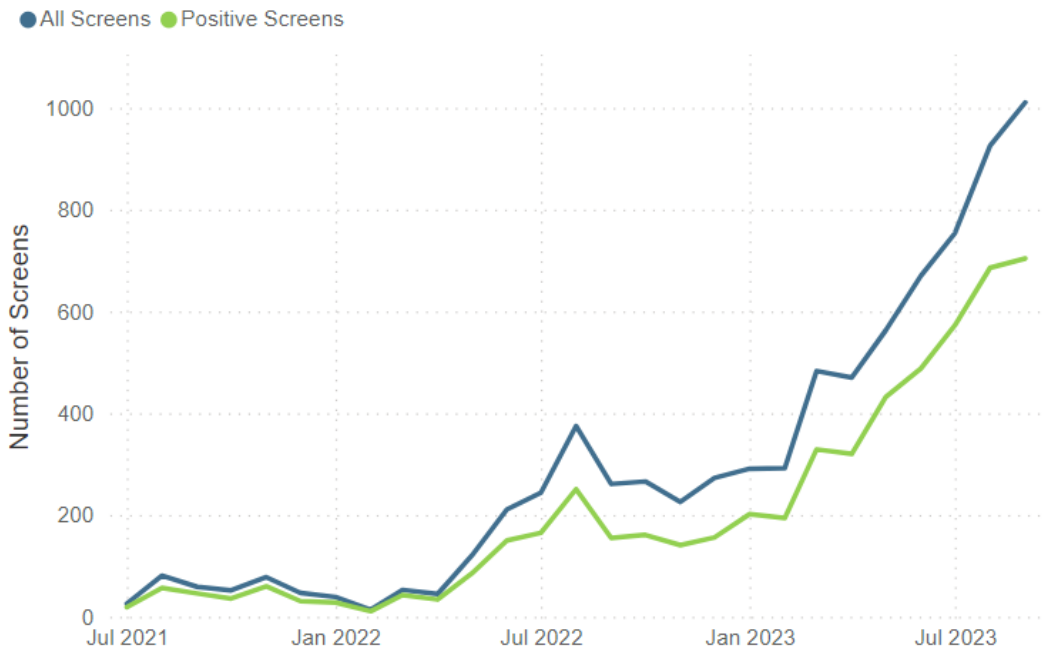
Fiscal Year, Quarter: Multiple selections

1/1/2024
Data Updated

Clinic Names/Stop Codes: All

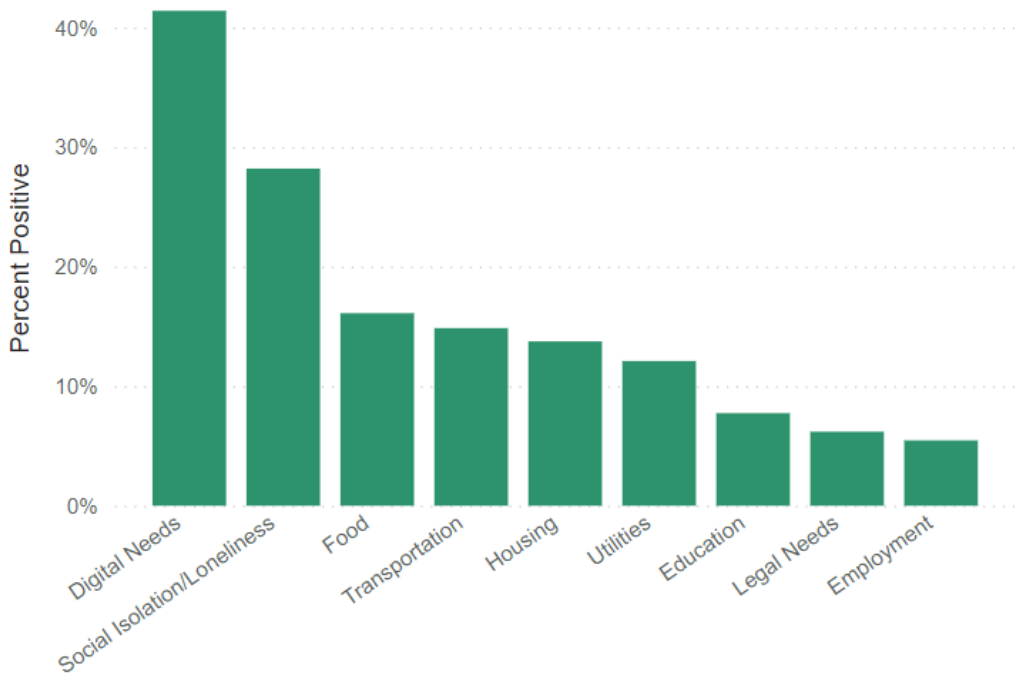
ACORN Screens (N)	Positive ACORN Screens* (N (%))	Any Resource or Referral* (N (%))	ACORN Screens Not Done
7930	5557 (70.1%)	3402 (61.2%)	963

ACORN Screens by Month



Breakdown of Responses for Multi-Question Domains

Veterans' Reported Social Needs



*NOTE: Denominator for % Positive ACORN Screens is the total number of ACORN screens completed. Denominator for % Any Resource or Referral is the number of positive screens.

The ACORN Dashboard: Overview Data

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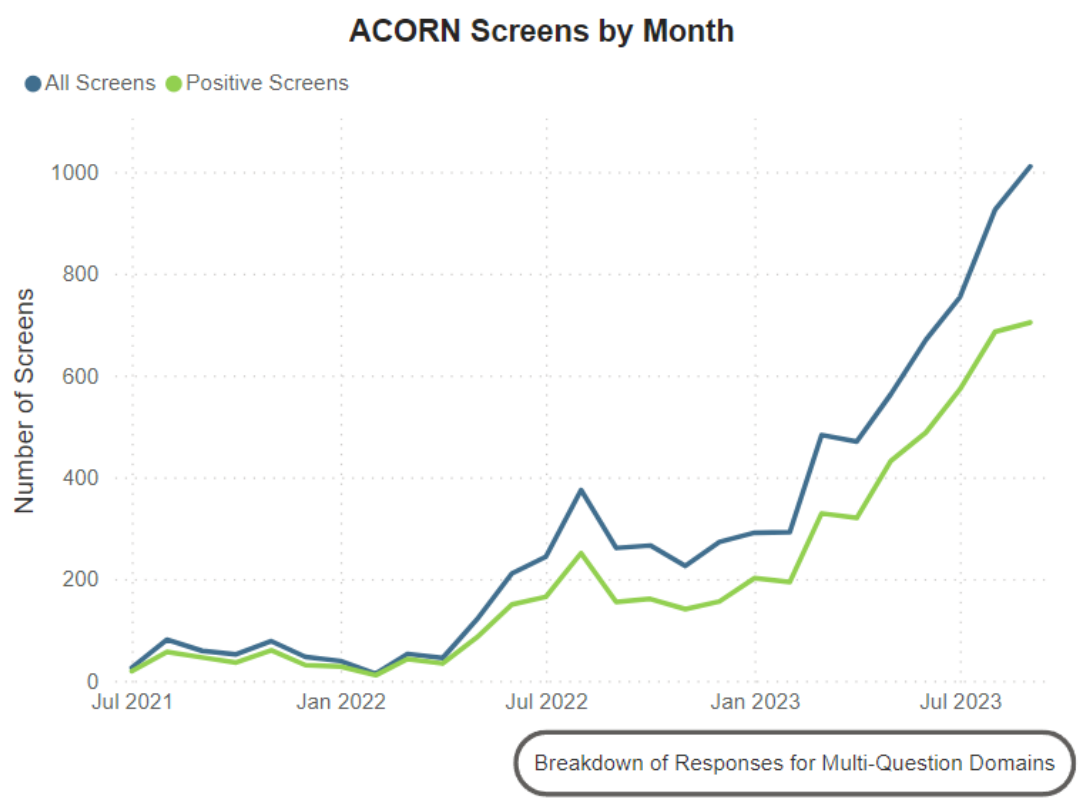
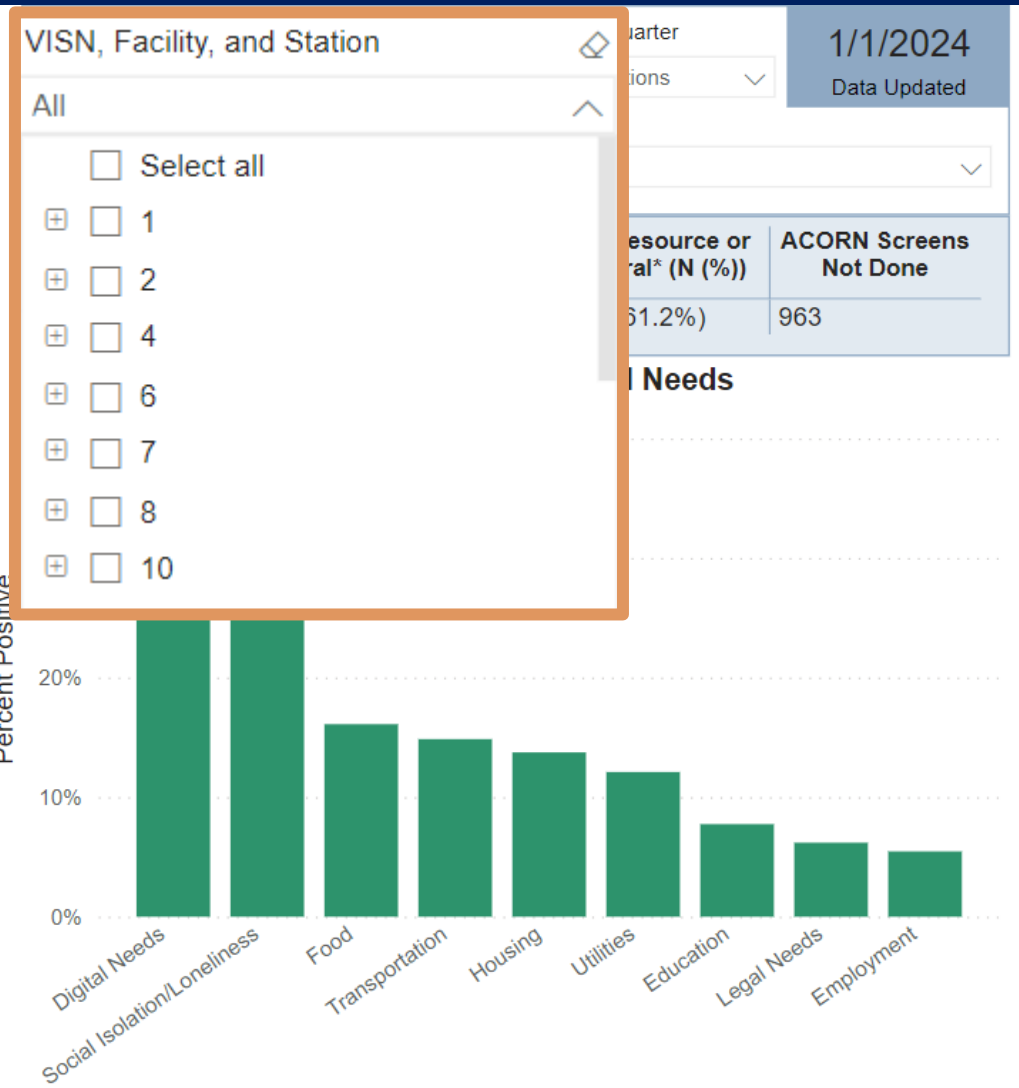


Breakdown of Responses for Multi-Question Domains



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The ACORN Dashboard: Overview Data

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VISN, Facility, and Station

All

Clinic Names/Stop Codes

All

Fiscal Year, Quarter

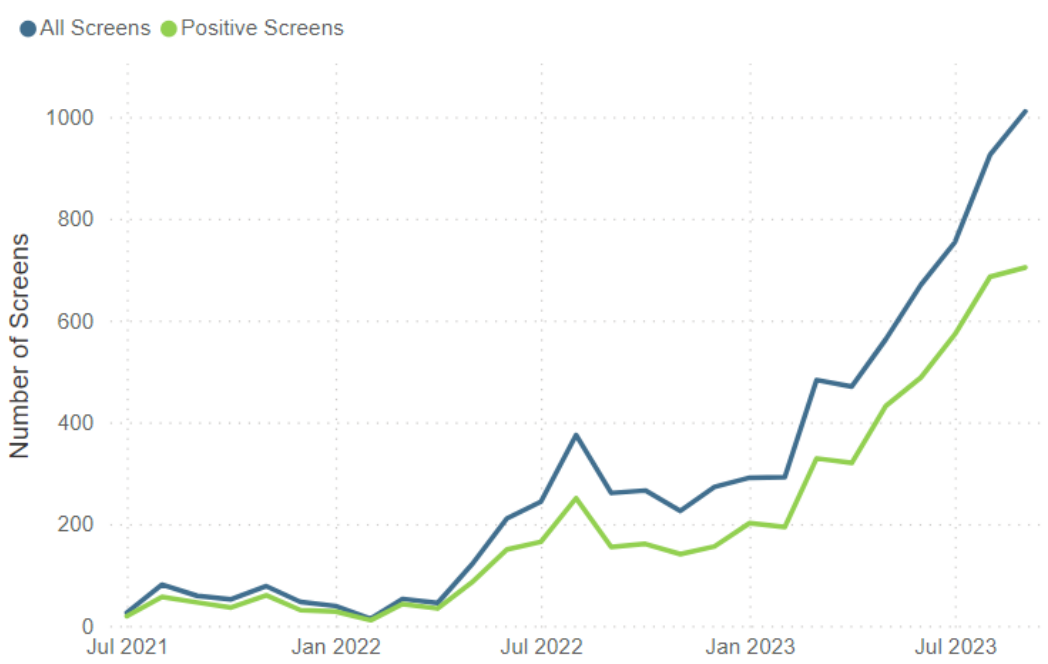
Multiple selections

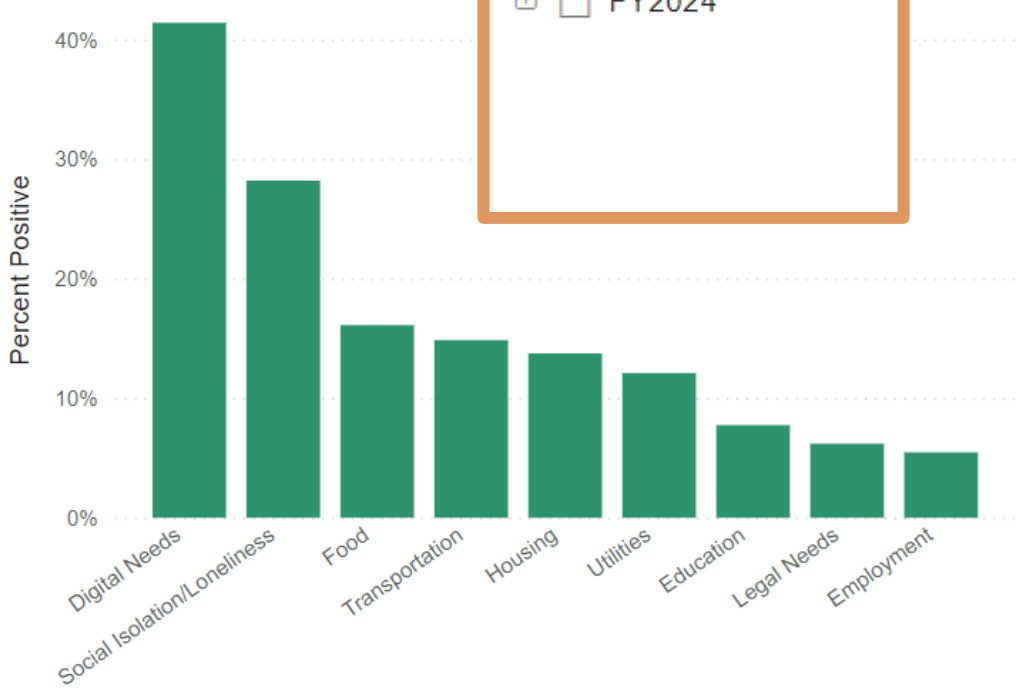
- Select all
- FY2021
- FY2022
- FY2023
- FY2024

2024

Updated

ACORN Screens (N)	Positive ACO Screens* (N	creens one
7930	5557 (70.1%)	





Breakdown of Responses for Multi-Question Domains

*NOTE: Denominator for % Positive ACORN Screens is the total number of ACORN screens completed. Denominator for % Any Resource or Referral is the number of positive screens.

The ACORN Dashboard: Overview Data

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VISN, Facility, and Station

All

Clinic Names/Stop Codes

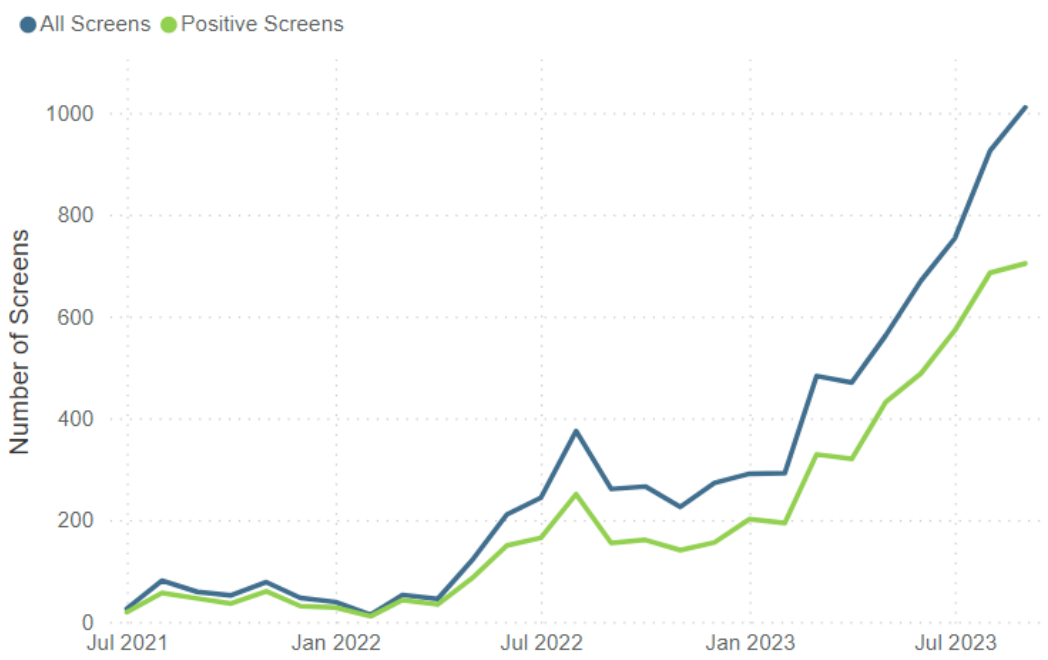
All

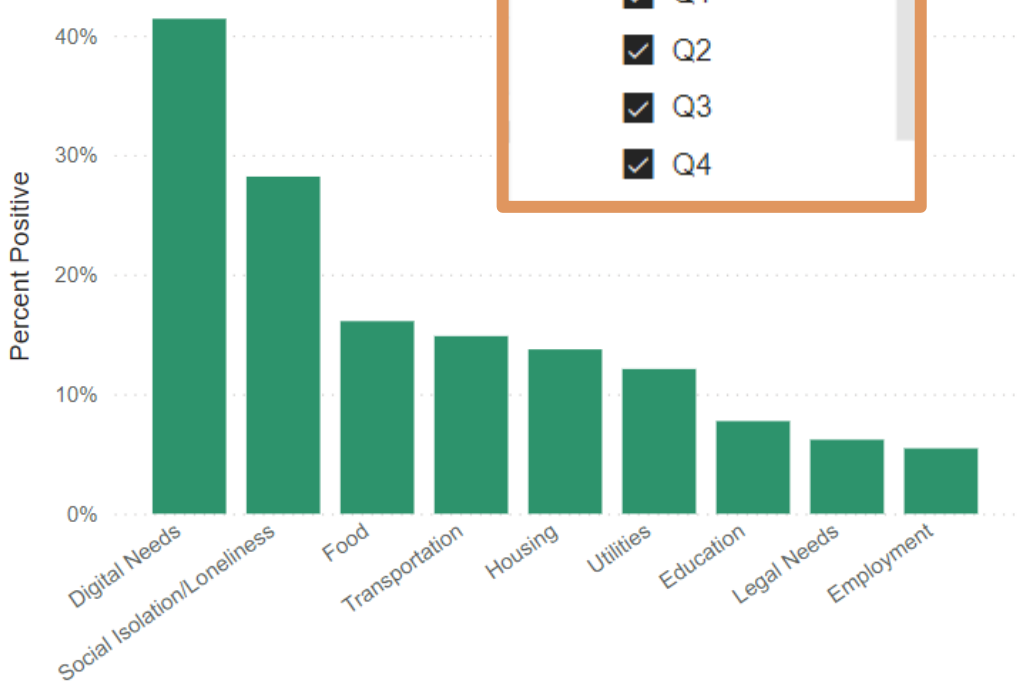
Fiscal Year, Quarter

Multiple selections

- Select all
- FY2021
- FY2022
- FY2023
  - Q1
  - Q2
  - Q3
  - Q4

ACORN Screens (N)	Positive ACOR Screens* (N (%
7930	5557 (70.1%)





Breakdown of Responses for Multi-Question Domains

*NOTE: Denominator for % Positive ACORN Screens is the total number of ACORN screens completed. Denominator for % Any Resource or Referral is the number of positive screens.

The ACORN Dashboard: Overview Data

ACORN DASHBOARD

Assessing Circumstances and Offering Resources for Needs (ACORN) aims to systematic
identify and address social needs among Veterans receiving care in the VHA. ACORN scr
nine social risk domains: food, housing, utilities, transportation, education, employment, le
needs, social isolation/loneliness, and digital needs. Veterans who screen positive are offe
resources and referrals to address identified needs.

VISN, Facility, and Station: All

Fiscal Year, Quarter: Multiple selections

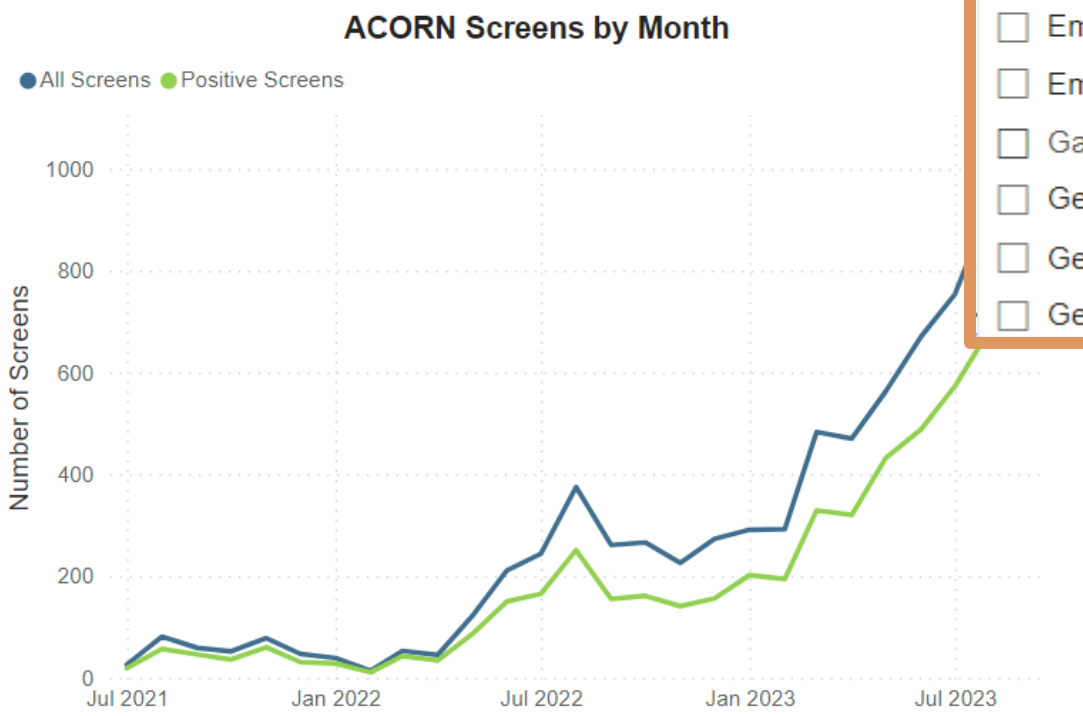
1/1/2024
Data Updated

Clinic Names/Stop Codes

All

Search

- Emergency (130) | Social Work (125)
- Emergency (131) | None (None)
- Emergency (131) | Social Work (125)
- Gastroenterology (337) | None (None)
- General Medicine (301) | None (None)
- General Medicine (301) | Social Work (125)
- General Surgery (432) | None (None)



Breakdown of Responses for Multi-Question Domains

*NOTE: Denominator for % Positive ACORN Screens is the total number of ACORN screens completed. Denominator for % Any Resource or Referral is the number of positive screens.

The ACORN Dashboard: Overview Data

ACORN DASHBOARD

Assessing Circumstances and Offering Resources for Needs (ACORN) aims to systematically identify and address social needs among Veterans receiving care in the VHA. ACORN screens for nine social risk domains: food, housing, utilities, transportation, education, employment, legal needs, social isolation/loneliness, and digital needs. Veterans who screen positive are offered resources and referrals to address identified needs.

VISN, Facility, and Station: All

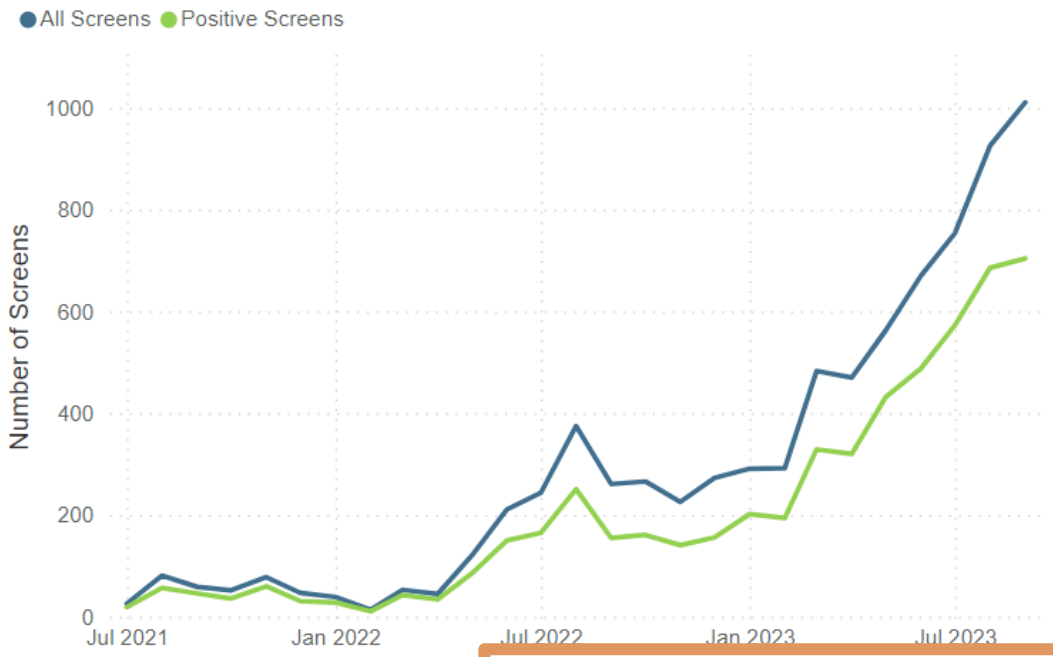
Fiscal Year, Quarter: Multiple selections

1/1/2024
Data Updated

Clinic Names/Stop Codes: All

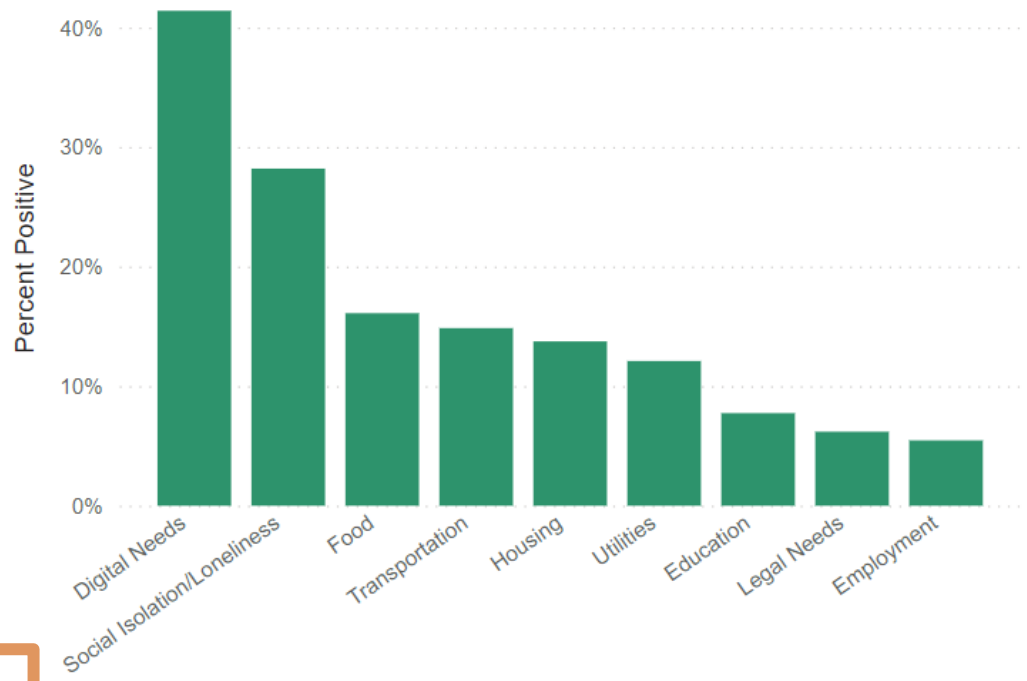
ACORN Screens (N)	Positive ACORN Screens* (N (%))	Any Resource or Referral* (N (%))	ACORN Screens Not Done
7930	5557 (70.1%)	3402 (61.2%)	963

ACORN Screens by Month



Breakdown of Responses for Multi-Question Domains

Veterans' Reported Social Needs



*NOTE: Denominator for % Positive ACORN Screens is the total number of ACORN screens completed. Denominator for % Any Resource or Referral is the number of positive screens.

The ACORN Dashboard: Overview Data

ACORN DASHBOARD

Assessing Circumstances and Offering Resources for Needs (ACORN) aims to systematically identify and address social needs among Veterans receiving care in the VHA. ACORN screens for nine social risk domains: food, housing, utilities, transportation, education, employment, legal needs, social isolation/loneliness, and digital. Veterans who screen positive are offered resources and referrals to address identified needs.

VISN, Facility, and Station: All

Fiscal Year, Quarter: Multiple selections

1/1/2024
Data Updated

Clinic Names/Stop Codes: All

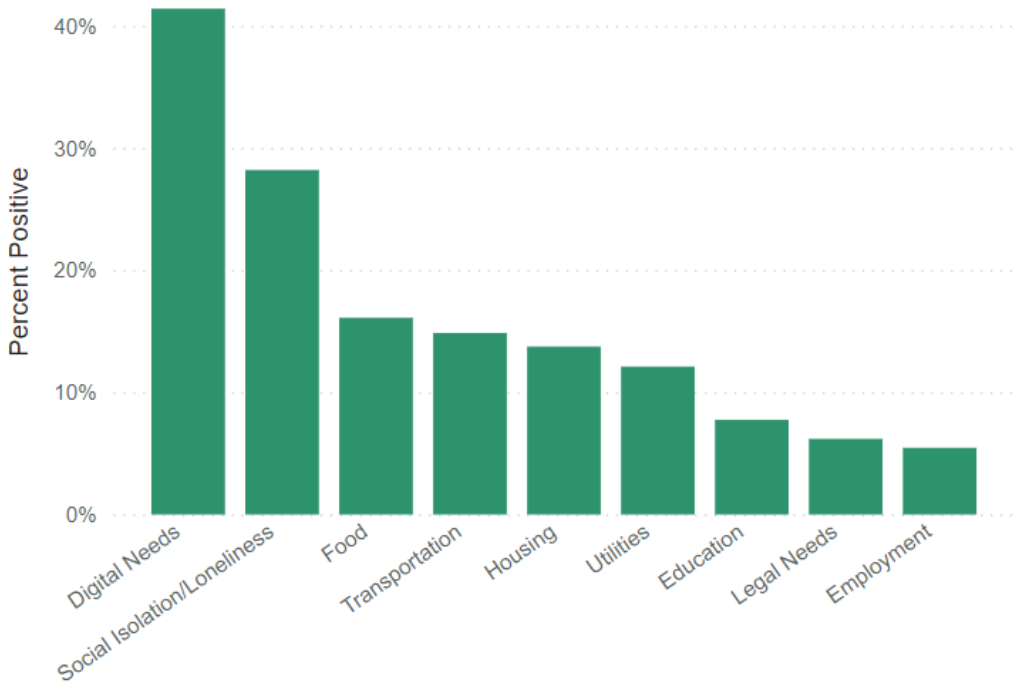
ACORN Screens (N)	Positive ACORN Screens* (N (%))	Any Resource or Referral* (N (%))	ACORN Screens Not Done
7930	5557 (70.1%)	3402 (61.2%)	963

Breakdown of Responses for Multi-Question Domains

Domain	Number of Positive Screens
Digital Needs	
Need Help Learning to Use a Telehealth Device	432
Need Help Setting Up a Video Visit	959
No Access to a Phone or Computer/Tablet	291
No Access to a Video-Capable Device	1284
No Access to Reliable and Affordable Internet	1774
Often/Sometimes Ran Out of Phone Minutes and/or Data	287
Food	
Need Help Getting Food this Week	324
Often/Sometimes Ran Out of Food	864
Often/Sometimes Worried about Food	972
Housing	
No Current Place to Stay	189
Unstable Housing	600
Worried about Housing	488
Transportation	
Need Transportation for Upcoming Appointment	425
Often/Sometimes Lack Transportation	1178
Utilities	
Often/Sometimes Have Trouble Paying for Utilities	960
Threatened to Shut Off/Already Shut Off	267

ACORN Screens by Month

Veterans' Reported Social Needs



*NOTE: Denominator for % Positive ACORN Screens is the total number of ACORN screens completed. Denominator for % Any Resource or Referral is the number of positive screens.

The ACORN Dashboard: Demographics

ACORN by Demographic Characteristics

Age Groups are provided in five age buckets/categories. These data are based on the age information recorded in the Veteran's medical record.

VISN, Facility, and Station: All

Fiscal Year, Quarter: Multiple selections

1/1/2024
Data Updated

Clinic Names/Stop Codes: All

ACORN DASHBOARD

- Age
- Birth Sex & Gender Identity
- Enrollment Priority Group
- Marital/Partnered Status
- Race & Ethnicity
- Rurality
- Sexual Orientation

Age Group	ACORN Screens (N)	Positive ACORN Screens* (N (%))	Any Resource or Referral* (N (%))	Already Receiving Assistance* (N (%))	Declined Assistance* (N (%))
18-34	430	321 (74.7%)	225 (70.1%)	25 (7.8%)	< 13
35-49	686	521 (75.9%)	376 (72.2%)	57 (10.9%)	23 (4.4%)
50-64	1588	1186 (74.7%)	789 (66.5%)	97 (8.2%)	69 (5.8%)
65-79	3836	2580 (67.3%)	1491 (57.8%)	123 (4.8%)	124 (4.8%)
80+	1390	949 (68.3%)	521 (54.9%)	44 (4.6%)	65 (6.8%)
Total	**7930**	**5557 (70.1%)**	**3402 (61.2%)**	**346 (6.2%)**	**292 (5.3%)**

*NOTE: Denominator for % Positive Screens is the total number of screens completed. Denominator for % Any Resource or Referral, % Already Receiving Assistance, and % Declined Assistance is the number of positive screens within the demographic subgroup.

The ACORN Dashboard: Demographics

ACORN by Demographic Characteristics

Age Groups are provided in five age buckets/categories. These data are based on the age information recorded in the Veteran's medical record.

VISN, Facility, and Station: All

Fiscal Year, Quarter: Multiple selections

1/1/2024
Data Updated

Clinic Names/Stop Codes: All

ACORN DASHBOARD

- Age
- Birth Sex & Gender Identity
- Enrollment Priority Group
- Marital/Partnered Status
- Race & Ethnicity
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The ACORN Dashboard: Domain Trends

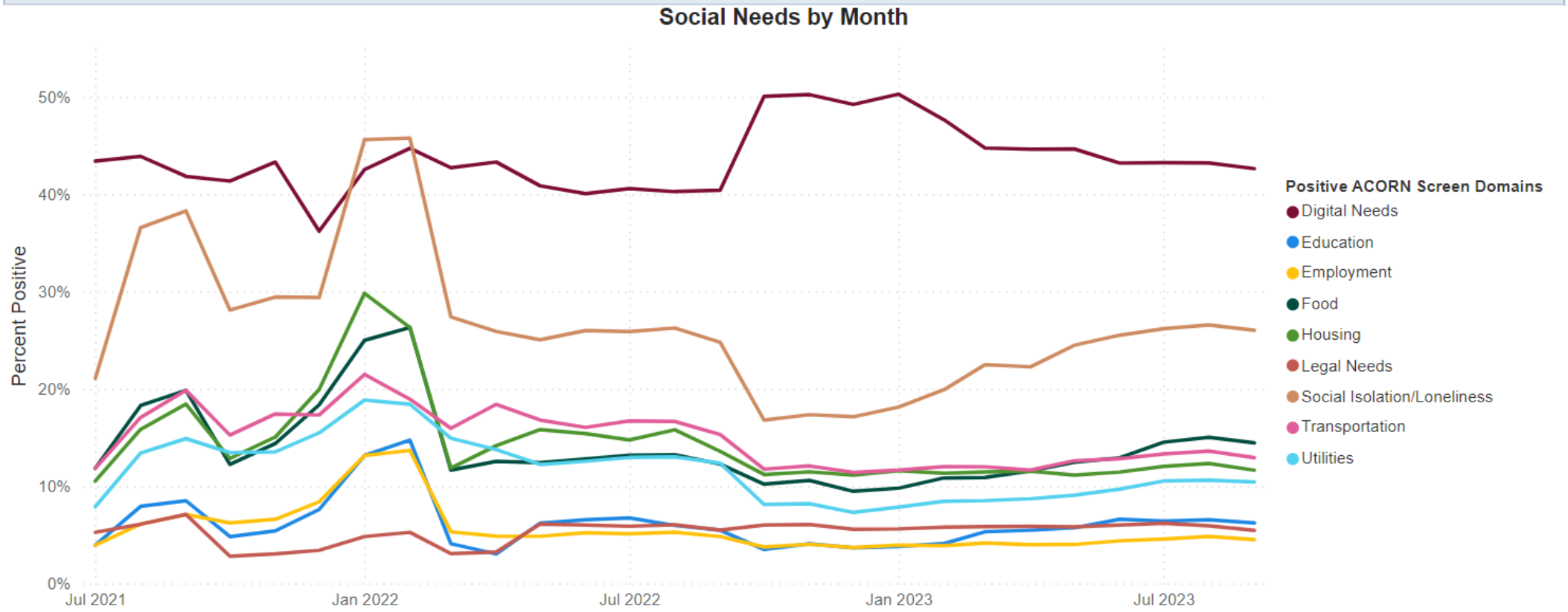
Domain Trends

ACORN DASHBOARD

This page displays trend lines for positive screens for all nine social need domains.
There is also a filter embedded to change which domains are displayed in the trend lines.

VISN, Facility, and Station	Fiscal Year, Quarter	
All	Multiple selections	1/1/2024 Data Updated
Clinic Names/Stop Codes	**Positive ACORN Screen Domains**	
All	All	

ACORN Screens	Positive Digital Screens	Positive Education Screens	Positive Employment Screens	Positive Food Screens	Positive Housing Screens	Positive Legal Screens	Positive Loneliness Screens	Positive Transportation Screens	Positive Utilities Screens
7930	3283 (41.4%)	614 (7.7%)	433 (5.5%)	1277 (16.1%)	1090 (13.7%)	491 (6.2%)	2236 (28.2%)	1178 (14.9%)	960 (12.1%)



The ACORN Dashboard: Domain Trends

Domain Trends

ACORN DASHBOARD

This page displays trend lines for positive screens for all nine social need domains.
There is also a filter embedded to change which domains are displayed in the trend lines.

VISN, Facility, and Station: All

Fiscal Year, Quarter: Multiple selections

Clinic Names/Stop Codes: All

1/1/2024
Data Updated

ACORN Screens	Positive Digital Screens	Positive Education Screens	Positive Employment Screens	Positive Food Screens	Positive Housing Screens	Positive Legal Screens	Positive Loneliness Screens	Pos
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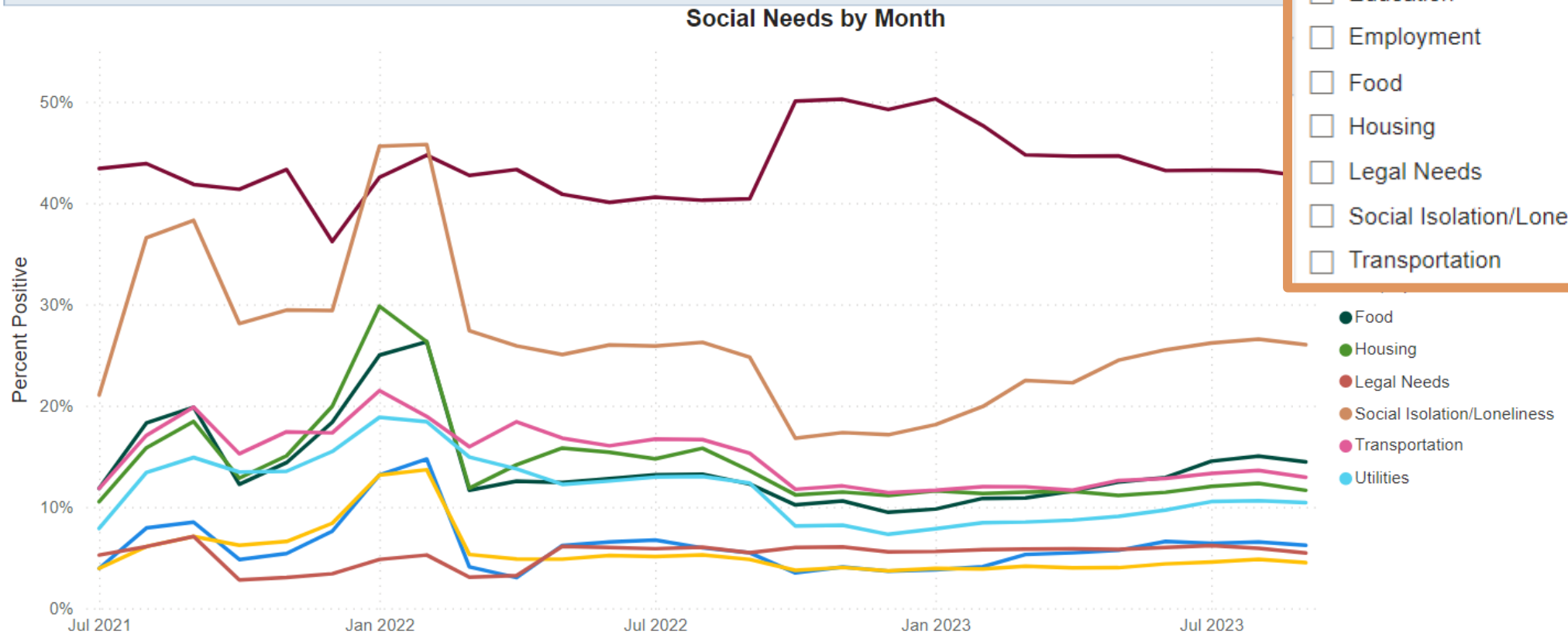
Positive ACORN Screen Domains

All

- [ ] Digital Needs
- [ ] Education
- [ ] Employment
- [ ] Food
- [ ] Housing
- [ ] Legal Needs
- [ ] Social Isolation/Loneliness
- [ ] Transportation



The ACORN Dashboard: Resources and Referrals

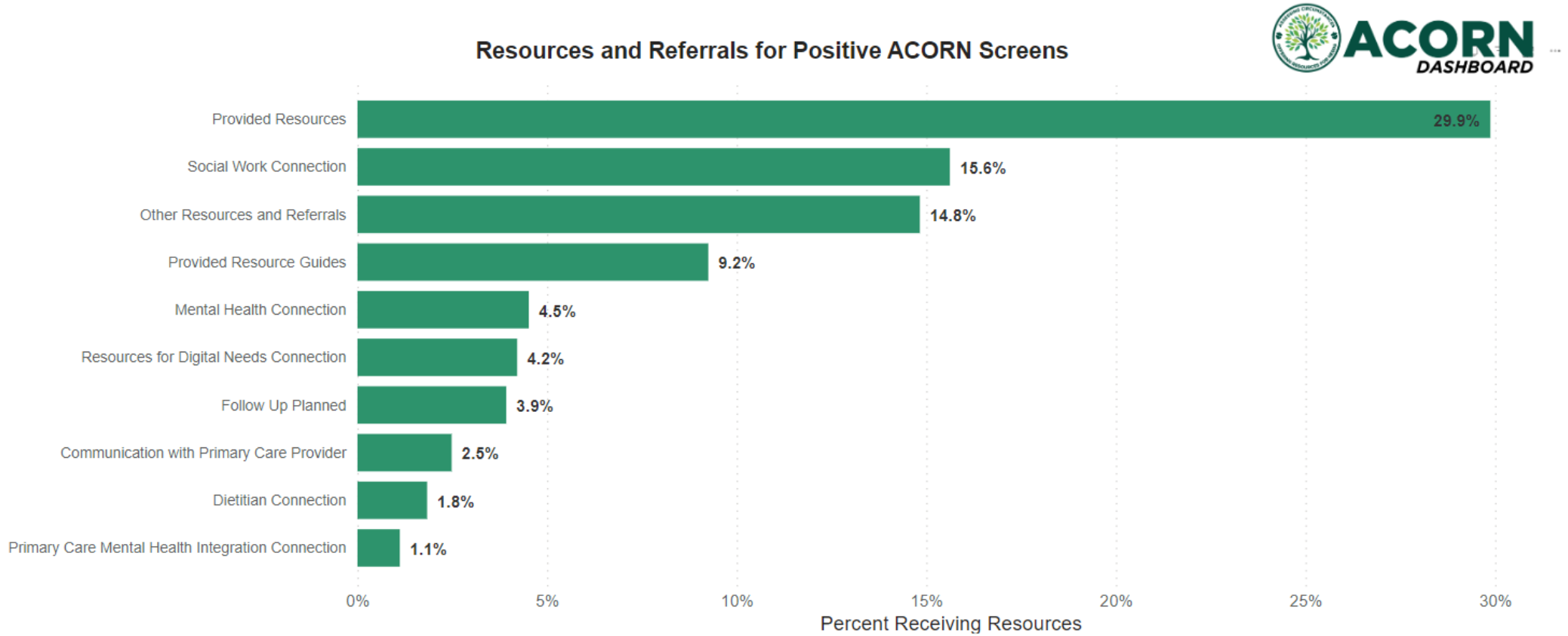
ACORN Screens (N)	Positive ACORN Screens* (N (%))	Any Resource or Referral* (N (%))	Already Receiving Assistance* (N (%))	Declined Assistance* (N (%))
7930	5557 (70.1%)	3402 (61.2%)	346 (6.2%)	292 (5.3%)

VISN, Facility, and Station: All

Fiscal Year, Quarter: Multiple selections

1/1/2024
Data Updated

Clinic Names/Stop Codes: All



*NOTE: Denominator for % Positive ACORN Screens is the total number of ACORN screens completed. Denominator for % Any Resource or Referral, % Already Receiving Assistance, and % Declined Assistance is the number of positive ACORN screens.

The ACORN Dashboard: Co-Occurring Social Needs

Co-Occurring Needs by Domain

This page provides information broken down by each social need domain. In the table, the domain specific positive screens count is based on the number of screens where the Veteran endorsed Digital Needs either alone or in combination with other unmet needs. The figure shows the overlap between Digital Needs and the other individual domains. Of note, Digital Needs includes positive screens for digital access and digital literacy.

Positive Digital Screens* (N (%))	Any Resource or Referral* (N (%))	Already Receiving Assistance* (N (%))	Declined Assistance* (N (%))
3283 (41.4%)	1778 (54.2%)	138 (4.2%)	149 (4.5%)

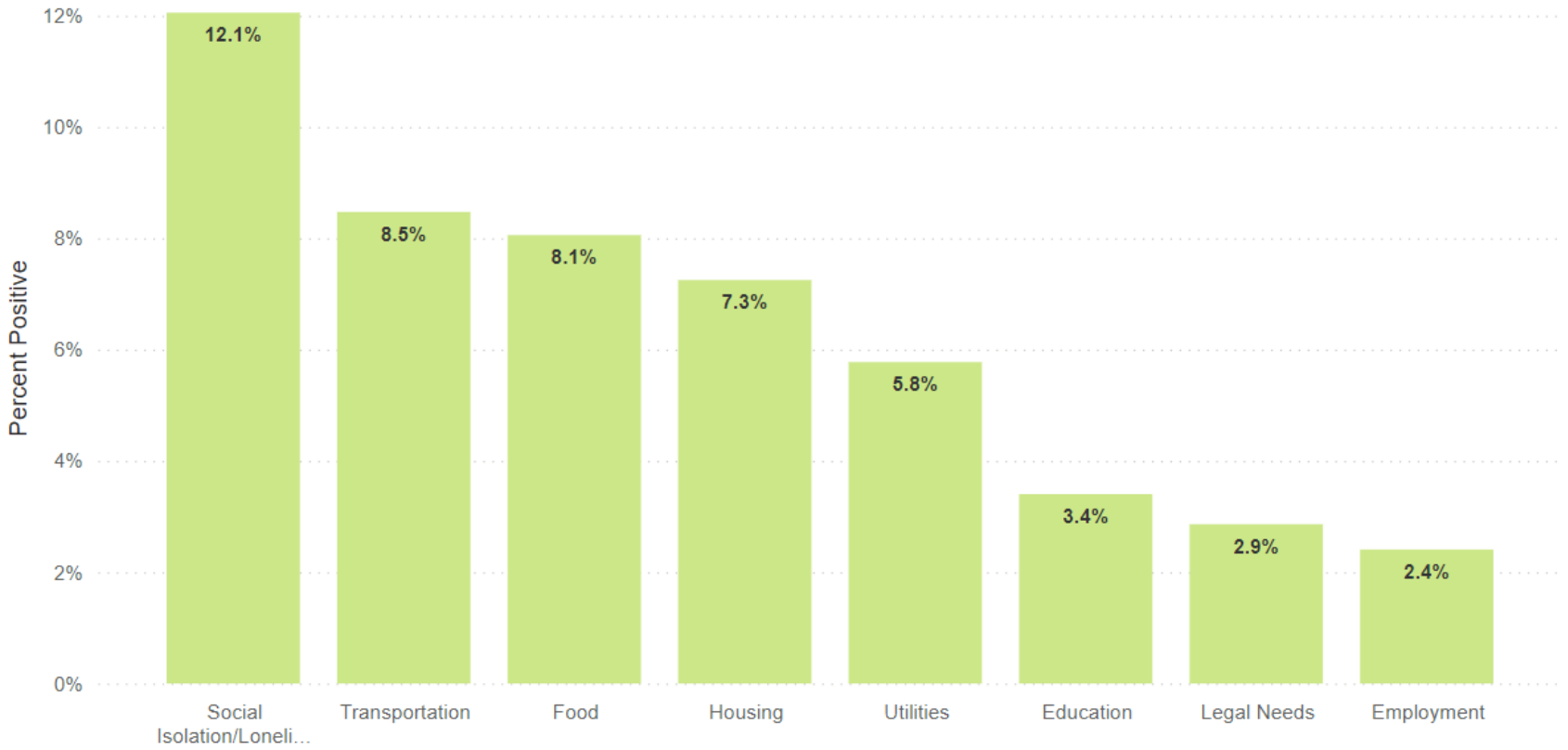
Fiscal Year, Quarter

Multiple selections

1/1/2024

Data Updated

Co-Occurring Social Needs for Veterans with Digital Needs



ACORN DASHBOARD

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

*Note: Digital Positive Screens is the number of screens where Veterans endorsed Digital as an unmet need (either alone or in combination with other unmet needs). The denominator for % Any Resource or Referral, % Already Receiving Assistance, and % Declined Assistance is the number of digital positive screens.

The ACORN Dashboard: Co-Occurring Social Needs

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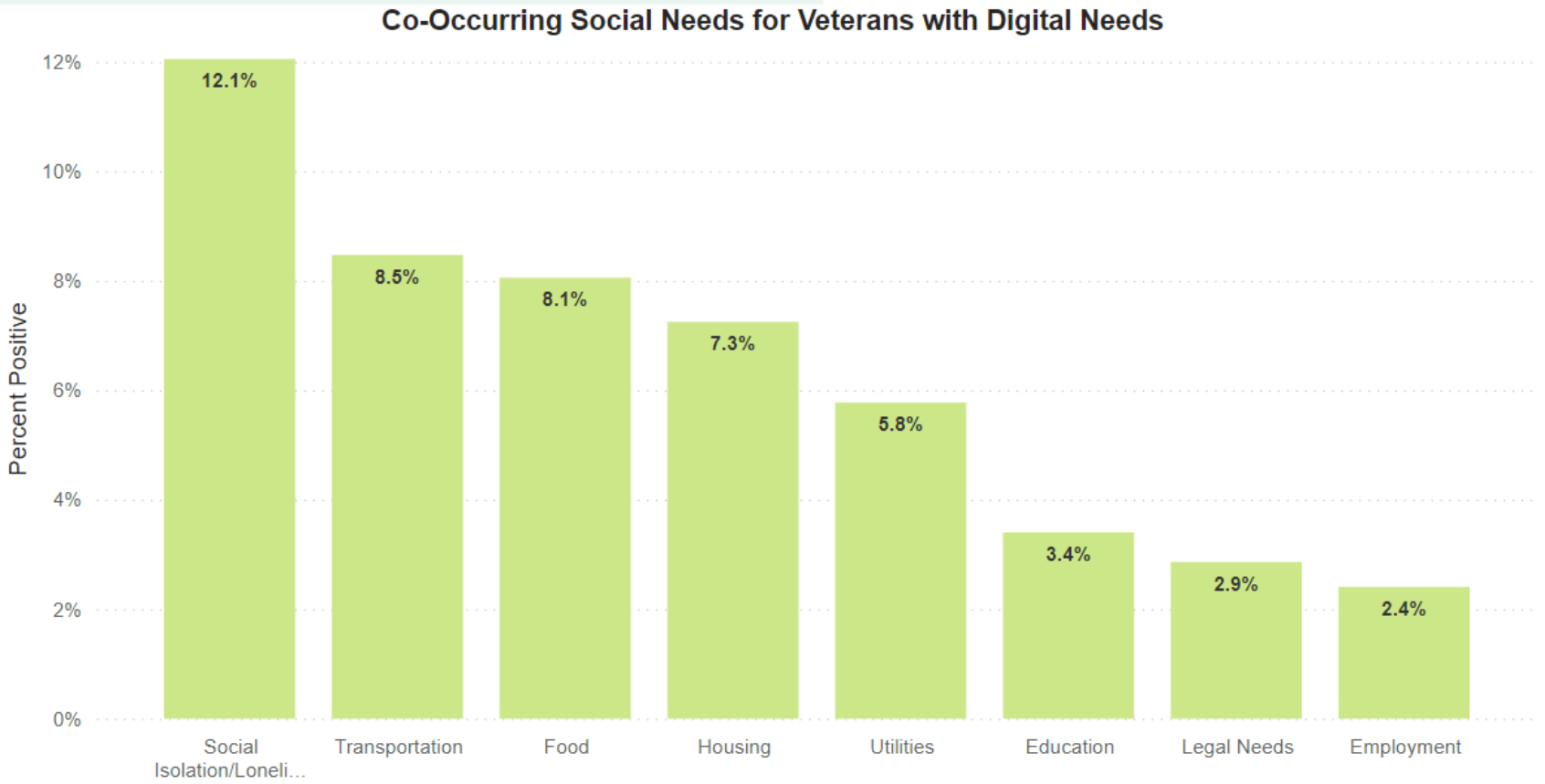
Positive Digital Screens* (N (%))	Any Resource or Referral* (N (%))	Already Receiving Assistance* (N (%))	Declined Assistance* (N (%))
3283 (41.4%)	1778 (54.2%)	138 (4.2%)	149 (4.5%)

Fiscal Year, Quarter

Multiple selections

1/1/2024

Data Updated



ACORN DASHBOARD

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

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The ACORN Dashboard: Resources and Referrals by Domain

Resources and Referrals by Domain

This page provides information broken down by each social need domain. In the table, the domain specific positive screens count is based on the number of screens where the Veteran endorsed Digital Needs either alone or in combination with other unmet needs. The figure shows the resources and referrals provided to these Veterans. The resources and referrals shown in the figure were provided to either address the Veteran's reported Digital needs or another unmet need. Of note, Digital needs includes positive screens for digital access and digital literacy.

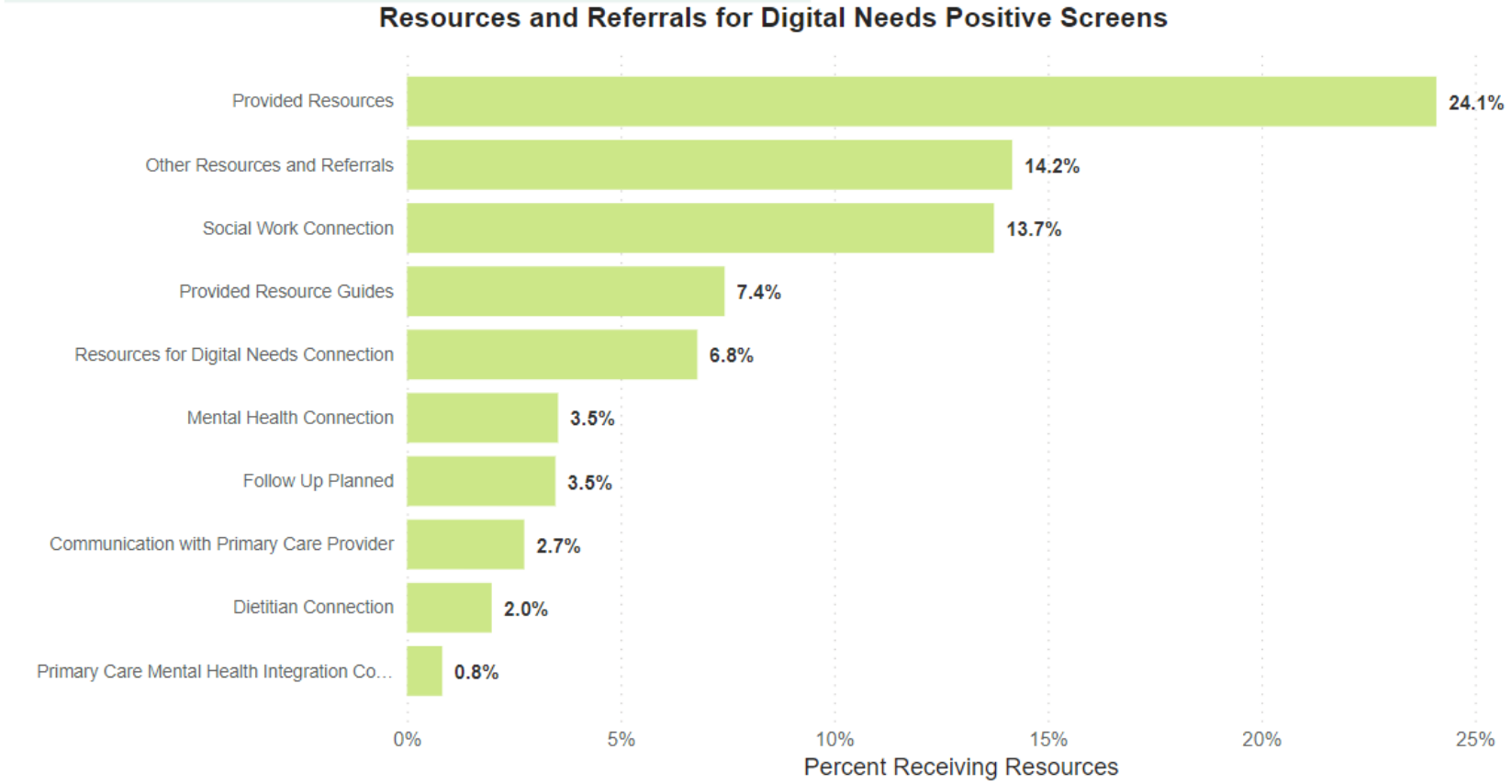
Digital Positive Screens* (N (%))	Any Resource or Referral* (N (%))	Already Receiving Assistance* (N (%))	Declined Assistance* (N (%))
3283 (41.4%)	1778 (54.2%)	138 (4.2%)	149 (4.5%)

Fiscal Year, Quarter

Multiple selections

1/1/2024

Data Updated



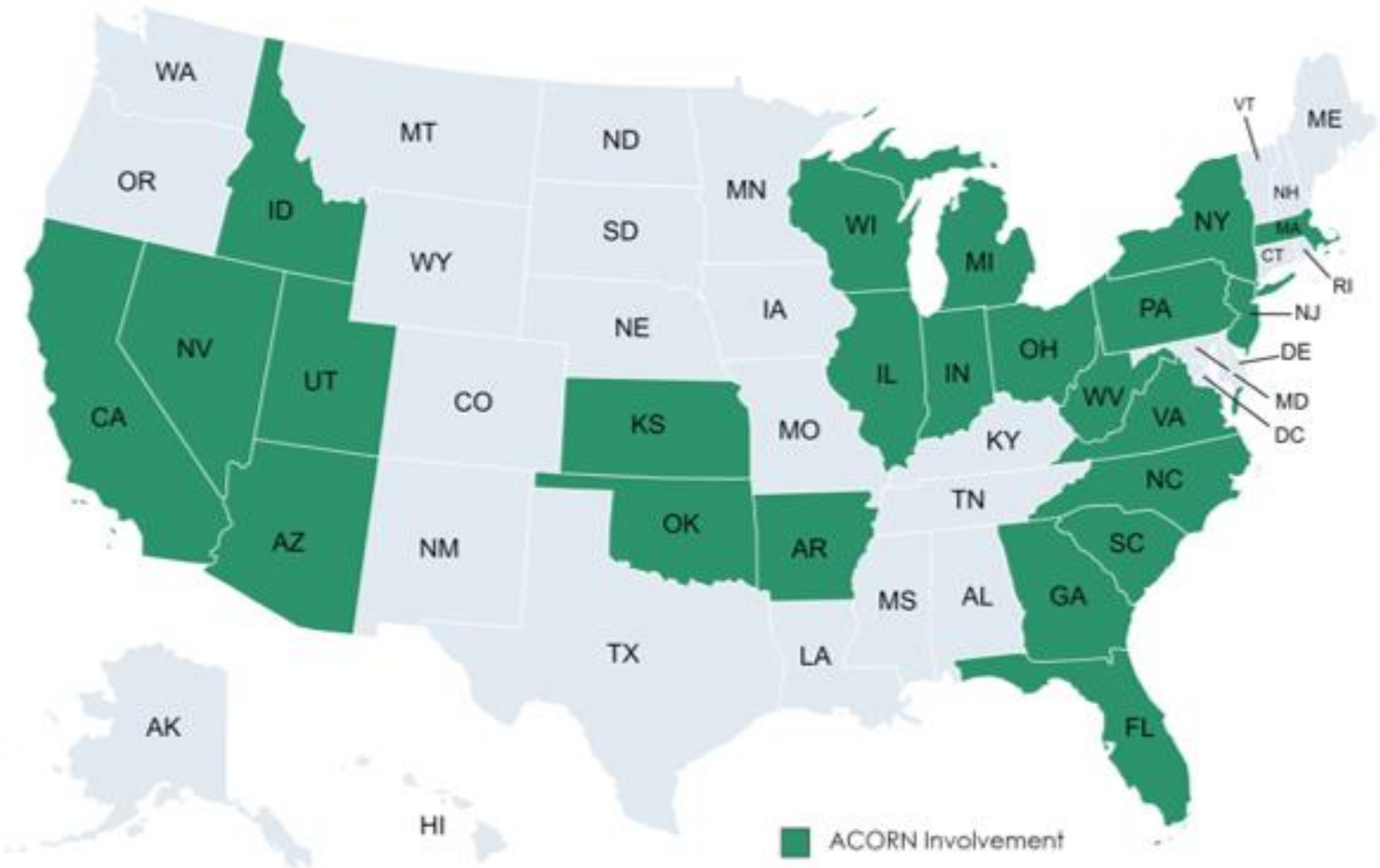
ACORN DASHBOARD

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

*Note: Digital Positive Screens is the number of screens where Veterans endorsed Digital as an unmet need (either alone or in combination with other unmet needs). The denominator for % Any Resource or Referral, % Already Receiving Assistance, and % Declined Assistance is the number of digital positive screens.

- 9 sites in Pre-Implementation
- 19 sites in Implementation
- 8 sites in Sustainment/Maintenance

Geographic Distribution of ACORN Partner Sites



Demographic Characteristics of Veterans Screened (N=12,066)

	Total Screens n (%)
Age (years)	
18-34	704 (5.8%)
35-49	1172 (9.7%)
50-64	2647 (21.9%)
65-79	5565 (46.1%)
≥80	1978 (16.4%)
Sex Assigned at Birth	
Female	1352 (11.2%)
Male	10714 (88.8%)
Race/Ethnicity	
American Indian or Alaska Native	119 (1.0%)
Asian	37 (0.3%)
Black or African American	3507 (29.1%)
Hispanic or Latino	375 (3.1%)
More than one race	109 (0.9%)
Native Hawaiian or Other Pacific Islander	61 (0.5%)
White, non-Hispanic	7212 (59.8%)
Unknown/Missing	646 (5.5%)

**Data collected July 1, 2021 – January 8, 2024*

Demographic Characteristics of Veterans Screened (N= 12,066)

	Total Screens n (%)
Marital Status	
Married/Partnered	5252 (43.5%)
Non-married/Non-Partnered	6336 (52.5%)
Unknown/Missing	478 (4.0%)
Rurality	
Rural/Highly Rural	4338 (36.0%)
Urban	6579 (54.5%)
Unknown/Missing	1149 (9.5%)
Sexual Orientation	
Straight/Heterosexual	8842 (73.3%)
LGBQ+	233 (1.9%)
Choose not to disclose	669 (5.5%)
Missing	2322 (19.2%)
Enrollment Priority Group	
1-4	7320 (60.7%)
5	2927 (24.3%)
6-8	1780 (14.8%)
Unknown/Missing	39 (0.3%)

**Data collected July 1, 2021 – January 8, 2024*

Prevalence of Positive Screens, by Demographics (N=12,066)

	Positive Screens n (%)
Age (years)	
18-34	505 (71.7%)
35-49	865 (73.0%)
50-64	1933 (73.0%)
65-79	3608 (64.8%)
≥80	1301 (65.8%)
Sex Assigned at Birth	
Female	973 (72.0%)
Male	7230 (67.5%)
Race/Ethnicity	
American Indian or Alaska Native	90 (75.6%)
Asian	29 (78.4%)
Black or African American	2612 (74.5%)
Hispanic or Latino	283 (75.5%)
More than one race	76 (69.7%)
Native Hawaiian or Other Pacific Islander	47 (77.0%)
White, non-Hispanic	4640 (64.3%)
Unknown/Missing	425 (66.0%)

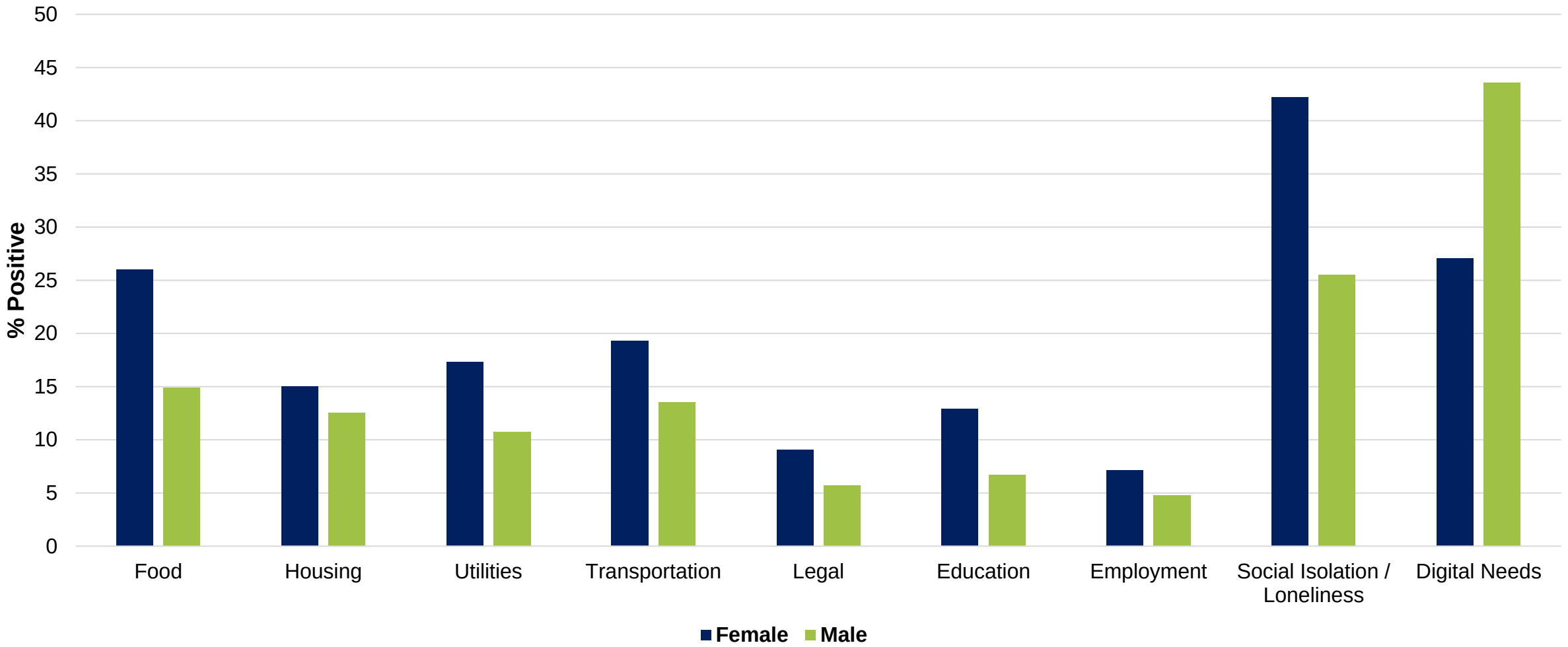
**Data collected July 1, 2021 – January 8, 2024*

Prevalence of Positive Screens, by Demographics (N= 12,066)

	Positive Screens n (%)
Marital Status	
Married/Partnered	3129 (59.6%)
Non-married/Non-Partnered	4740 (74.8%)
Unknown/Missing	334 (69.9%)
Rurality	
Rural/Highly Rural	2844 (65.6%)
Urban	4630 (70.4%)
Unknown/Missing	729 (63.4%)
Sexual Orientation	
Straight/Heterosexual	6014 (68.0%)
LGBQ+	185 (79.4%)
Choose not to disclose	450 (67.3%)
Missing	1554 (66.9%)
Enrollment Priority Group	
1-4	4843 (66.2%)
5	2264 (77.3%)
6-8	1073 (60.3%)
Unknown/Missing	23 (59.0%)

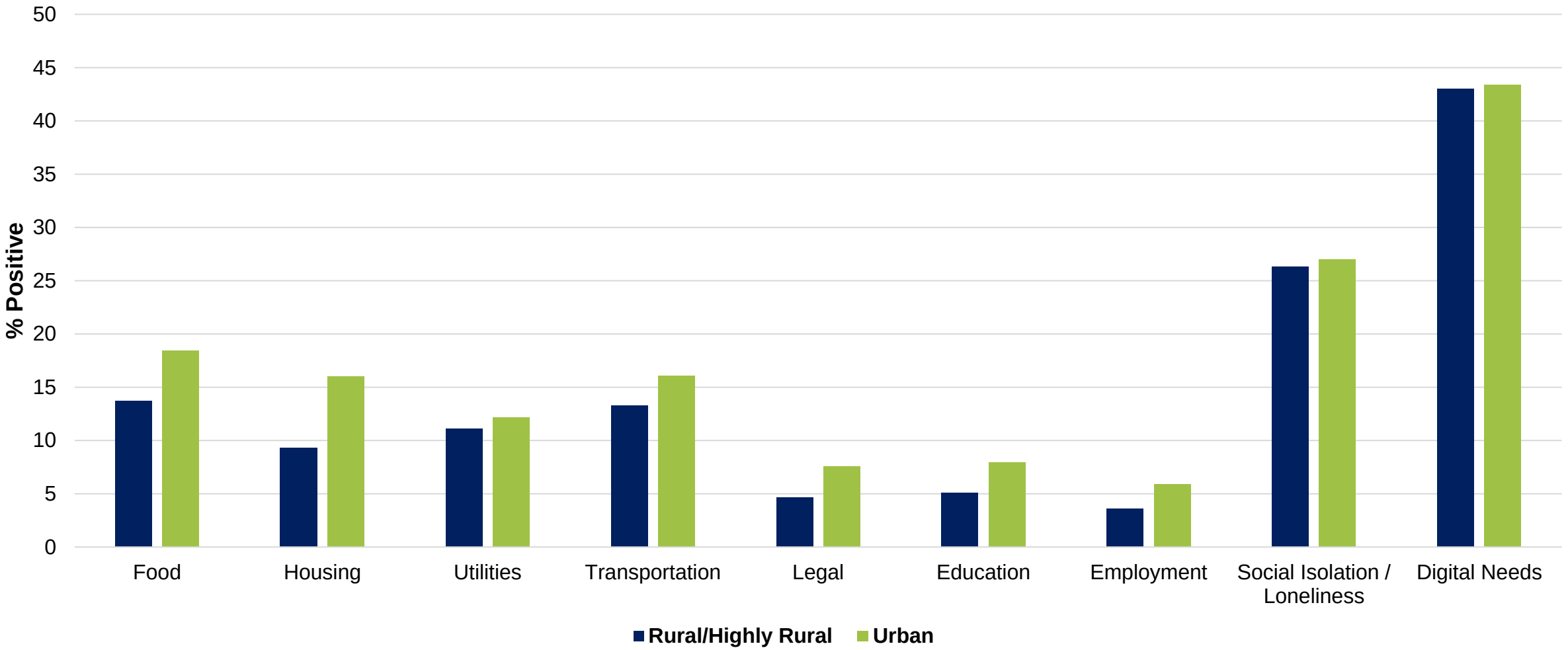
**Data collected July 1, 2021 – January 8, 2024*

Positive Screens, by Birth Sex*



*Currently unable to report gender identity due to a large number of missing data. Gender identity will be added as the number of missing responses decreases.

Positive Screens, by Rurality



Examples of ACORN in practice

Robert J. Dole VA Medical Center – Wichita, KS

- Setting: Women's health primary care clinic
- ACORN Target Population**:** Women Veterans across the age spectrum
- Workflow: RN Clinical Navigators administer ACORN as part of routine preventive screening discussions; maternity care coordinators administer ACORN with pregnant Veterans

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Central Virginia Veterans Healthcare System – Richmond, VA

- Setting: Emergency Department
- ACORN Target Population: All Veterans presenting to the ED
- Workflow: ED social workers administer ACORN

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Central Virginia Veterans Healthcare System – Richmond, VA

- Setting: Emergency Department
- ACORN Target Population: All Veterans presenting to the ED
- Workflow: ED social workers administer ACORN

Joseph M. Cleland VA Medical Center – Atlanta, GA

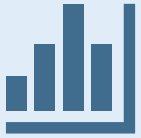
- Setting: Primary Care
- ACORN Target Population: Veterans with A1c ≥8 living in high poverty areas
- Workflow: Eligible Veterans identified using VA Primary Care Equity Dashboard; social workers outreach to administer ACORN

Key Fiscal Year 2023 ACORN Accomplishments

Developed Community of Practice (CoP) model for implementation and sustainment phase sites

Developing and refining tools to support dissemination, including the ACORN Dashboard, ACORN National CPRS Template, Implementation Toolkit, SharePoint site, and processes for electronic self-administered screening

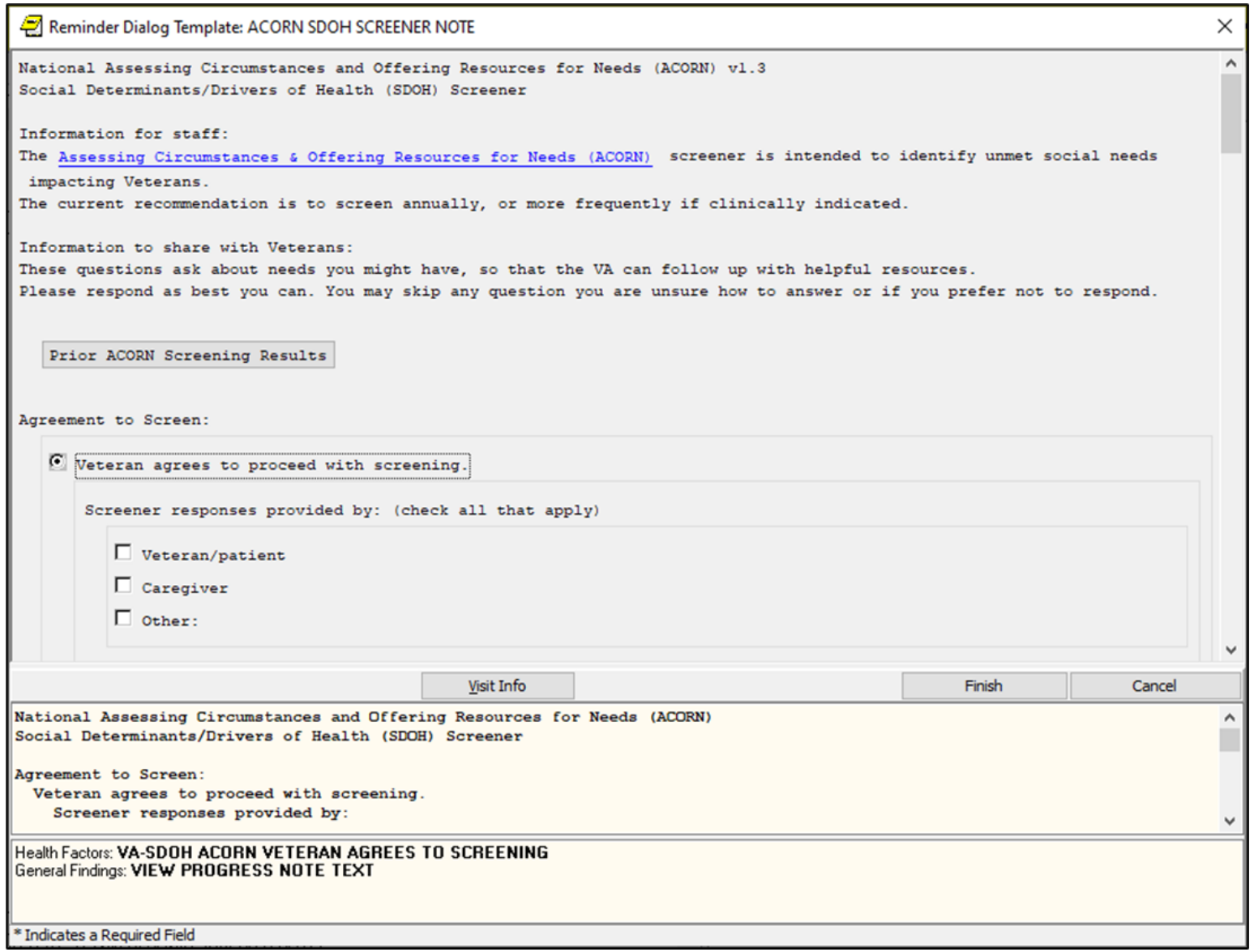
Convened ACORN Partner Engagement Group (APEG) comprised of representatives from programs and offices across VA to guide ongoing dissemination



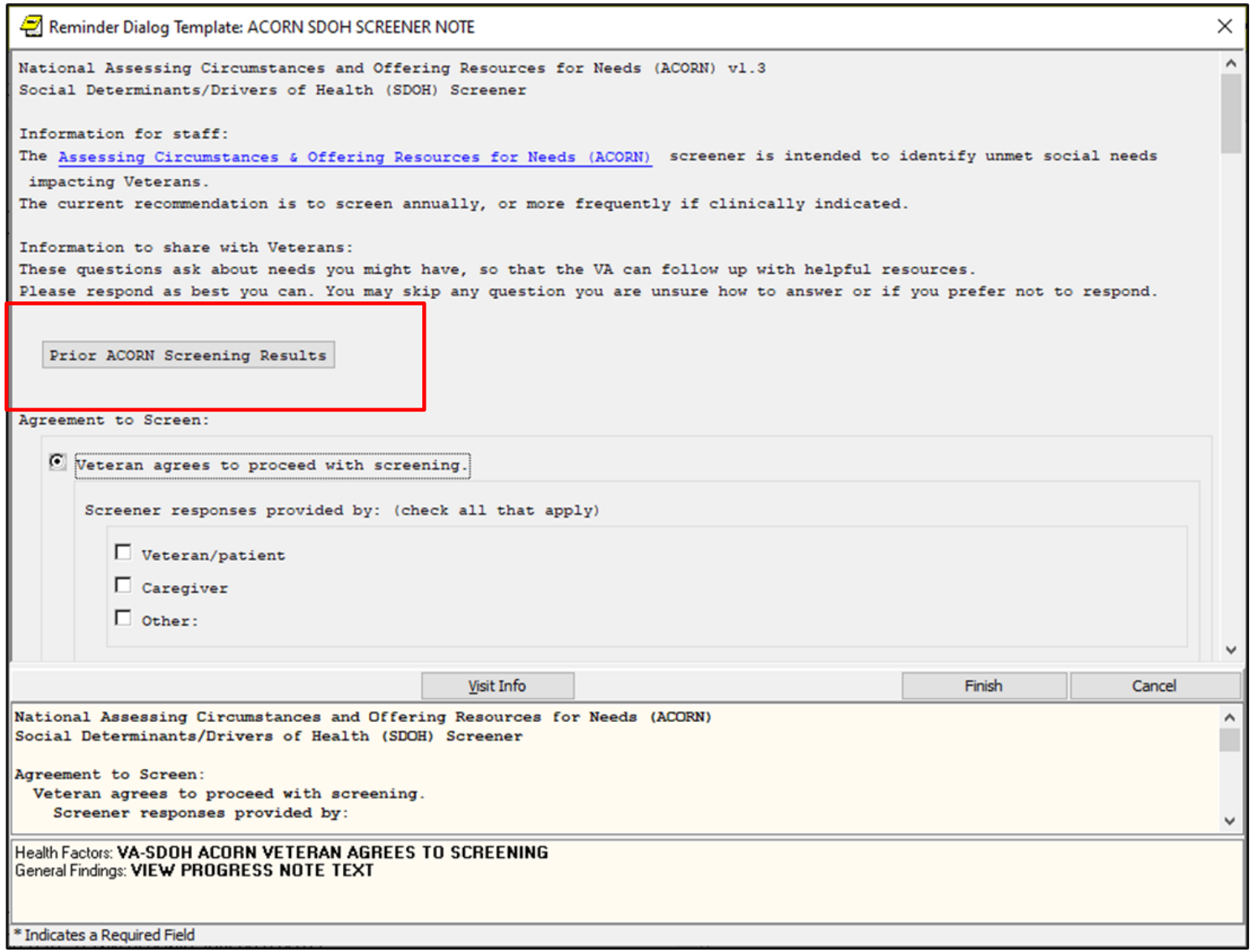
Continuing work with VA and external partners to ensure alignment of ACORN with national data capture and interoperability standards

Centralized ongoing evaluation across sites to determine barriers, facilitators, and optimal strategies for implementation

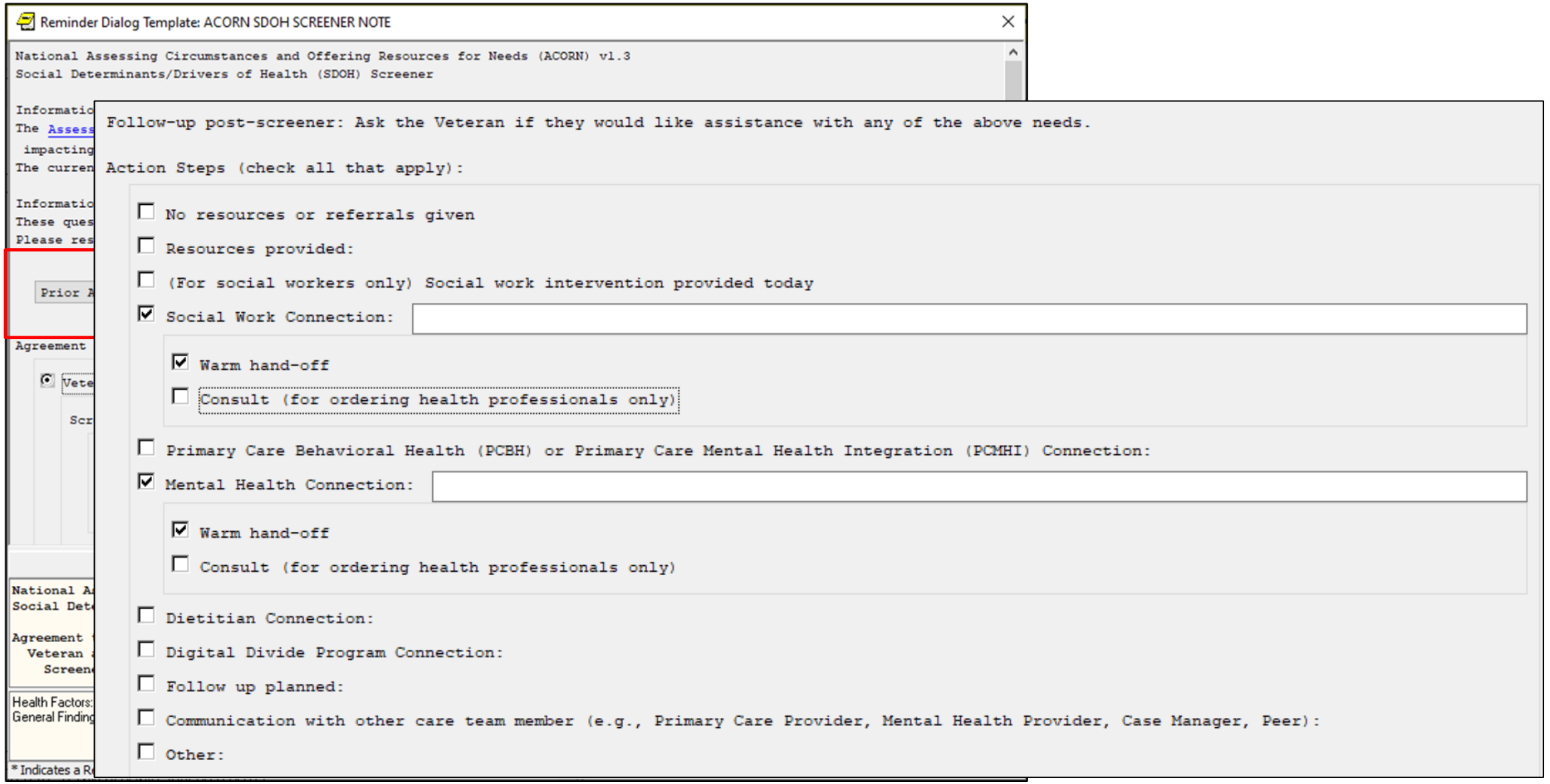
ACORN National Template



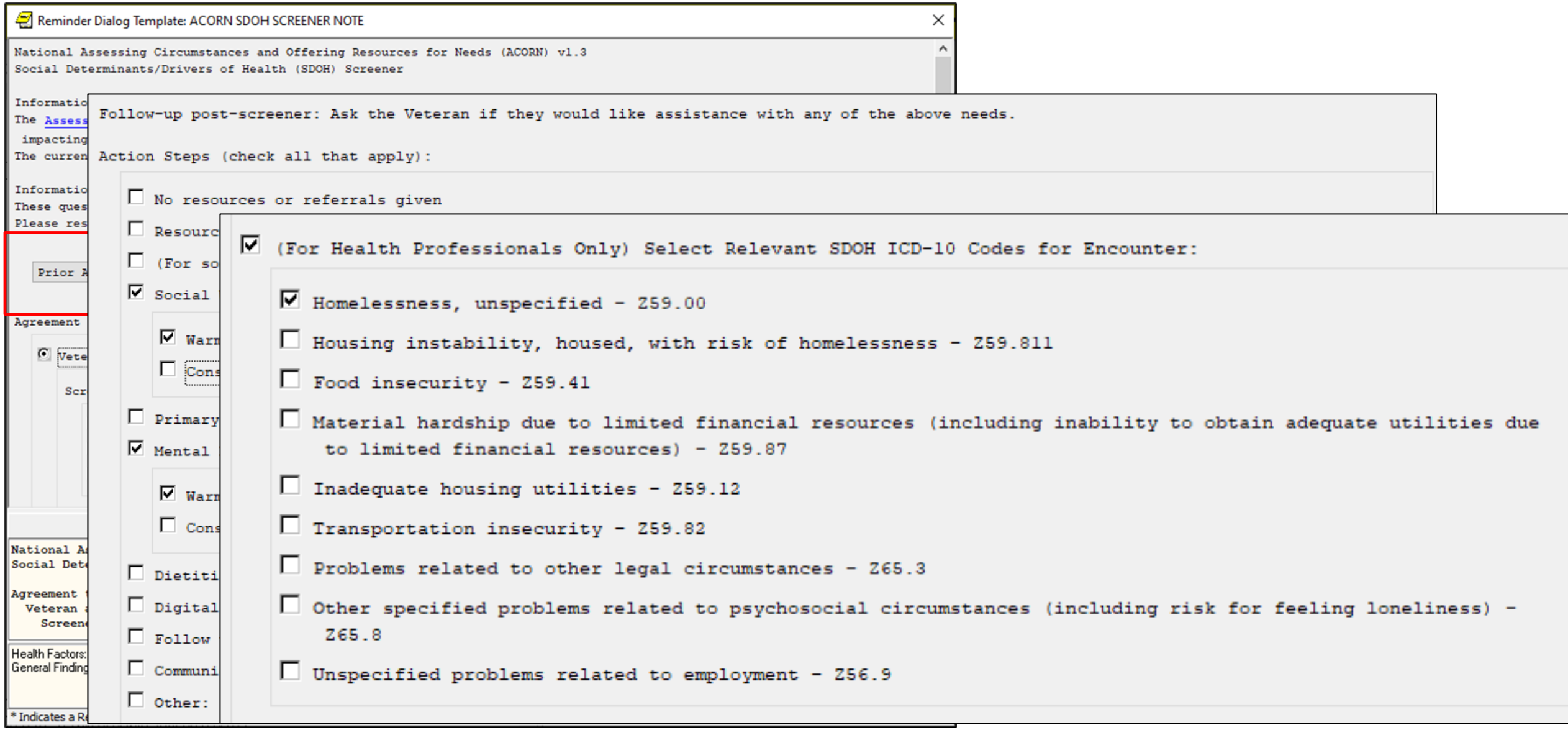
ACORN National Template



ACORN National Template



ACORN National Template



Future Directions

- Moving from proximal process- and social-risk related outcomes to more distal outcomes including connection with services, if needs are addressed, and health and utilization outcomes.
- Continuing to develop and refine standardized clinical workflows across a range of settings, specialties, and populations that maintain core ACORN elements while allowing for fidelity-consistent tailoring and adaptation
- Developing a multi-site, pragmatic hybrid implementation-effectiveness trial of ACORN
- Building out process for Veteran self-administered electronic screening
- Collaborating with field-based partners to develop communications and training materials to support clinical care team members in feeling comfortable screening for, assessing, and addressing social risks and social needs

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- How to best leverage current funding and reimbursement opportunities to ensure sustainability?
- How can we leverage technology to sustain screening, referral, and navigation efforts?

ACORN SharePoint

ACORN SharePoint

Assessing Circumstances & Offering Resources for Needs (ACORN) Initiative

Getting Started | ACORN Community of Practice | ACORN Resources

ACORN aims to systematically identify and address social needs among all Veterans to improve health outcomes and promote health equity.

ACORN works in partnership with the VHA Office of Health Equity and VHA National Social Work Program to develop and implement a systematic approach to identifying social risks and addressing social needs among Veterans.

By providing our clinical care teams with a broader understanding of the social, environmental and economic contexts impacting individual Veterans, we can develop tailored treatment plans and promote patient-centered care.

For VHA clinics and programs interested in implementing ACORN, please contact the ACORN Team at VHAACORN@va.gov.

ACORN Community of Practice

Questions: VHAACORN@va.gov

ACORN SharePoint: tinyurl.com/ACORN-Initiative

Becoming an ACORN Partner Site

Obtain Social Work Chief buy-in and engage with your team

Including social work colleagues and other VHA staff who will support ACORN implementation

Complete an ACORN Partner Site Interest Form and return to the ACORN Team at VHAACORN@va.gov

Attend the ACORN Basics call *(every 3rd Thursday at 2:00pm ET)* to discuss ACORN implementation logistics at your site

Join the **ACORN Community of Practice Teams Channel**

Addressing individuals' social needs is just one piece of the puzzle in achieving health equity.

Castrucci B, Auerback J. "Meeting Individual Social Needs Falls Short Of Addressing Social Determinants Of Health, " Health Affairs Blog, January 16, 2019. DOI: 10.1377/hblog20190115.234942

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- VHA National Social Work Program ACORN Team Leadership: Jennifer Silva, LCSW-S; Brittany Trabaris, LCSW (National Social Work Program Coordinator (ACORN)); Amy Donaldson, LCSW and Lisa Wootton, LCSW (ACORN Implementation Co-Leads)
- ACORN Dashboard, Data, and Evaluation Specialists: Chris Halladay, ScM and Sarah Leder, MSW
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ADDITIONAL RESOURCES AVAILABLE ON SHAREPOINT

https://dvagov.sharepoint.com/sites/VACOVHAOHE/SitePages/Test.aspx

ACORN

- **Email: VHAACORN@va.gov**
- ACORN Screening Tool
- ACORN SharePoint
- VHA Office of Health Equity
- VHA Social Work
- Annual Report

- PCED SharePoint
- Introductory Tutorial (CE credit available)
- Guide for Facilitating Implementation of PCED
- Webinars, case examples, and links to other equity resources in VA

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