Whitney: Hello, everyone. This is Whitney \_\_\_\_\_ [00:00:11]. Welcome today's Focus On Health Equity & Action Series. Today's webinar is entitled Systematic Screening of Veterans for Health-Related Social Needs: An Ethical Imperative.

We'll be getting started as soon as I inform you of the following items. Cyberseminars are run in lecture mode which means attendees are muted. To change the display of your web presentation please move your cursor to the upper right-hand corner of the presentation and locate the white bubble for viewing display options; the side-by-side view is recommended.

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Today's webinar is being recorded and will be available in our archive catalog. You'll receive an email with a link to the archive of this session in a couple of days, please feel free to forward that email to any of your followers who might be interested.

After the top of the hour we'll go ahead and get things started. I would like to turn things over to Lauren Korshak. Lauren, may I turn things over to you?

Lauren Korshak: Yes, please. Hi. I’m Lauren Korshak. I work in the Office of Health Equity and I lead translation efforts, which means that I get to tell stories with all kinds of data that VA has about the health disparities we have--and don't have--within VA.

So, the Office of Health Equity was created in 2012 and we work to ensure that the Veterans Health Administration provides appropriate individualized healthcare to each veteran in a way that eliminates disparate health outcomes and assures health equity.  So, we have five goals around the topics of leadership, awareness, health outcome, workforce diversity, as well as data, research, and evaluation and we really try to target promoting health equity across all of these different avenues.

We also focus our efforts on veterans who experience greater obstacles to health-related to race and ethnicity, gender, age, geographic location, religion, socioeconomic status, sexual orientation, mental health conditions, the military era in which they served, cognitive sensory, or physical disabilities, justice-involvement, and the list grows.

So, this is my quick plug. Please go to our website; we are regularly updating it with new information and new resources. We also have a newsletter that you can sign up for through our website so that you can get monthly updates on what we're up to and new research going on in the field.

So, I’d like to introduce our presenters. And we first have Dr. Lisa Lehmann. She's a physician with the VA New England Health Care System and Associate Professor Of Medicine At Harvard Medical School and Associate Professor Of Health Policy and Management at the Harvard T.H. Chan School Of Public Health; I also have Lauren Russell, who's the Co-Access Lead, Chief Medical Office at the VA New England Health Care System; and Dr. Alicia Cohen is a research investigator at the Center of innovation in Long-Term Services & Support, is a physician at the Providence VA Medical Center, and Assistant Professor Of Family Medicine and Health Services, Policy, and Practice at Brown University; Adjunct Lecturer in the Department Of Family Medicine at the University Of Michigan.

And so, I would now like to let our presenters take the lead to share with us the work that they're doing.

Lisa Lehmann: Thank you, Lauren. So, as Lauren said, I’m Lisa Lehmann, and I’m a physician in VISN 1. And I want to first begin by just thanking Ryan Lilly, the VISN 1 Network Director, for his tremendous support of this effort; as well as to thank Dr. Ernest Moy, the Executive Director of the Office of Health Equity for his leadership and partnership in really advancing a program to systematically screen veterans for health-related social needs.

Just in terms of disclosures, none of the presenters today have any financial conflicts of interest to disclose and all the views expressed are those of our teams and don't represent VISN 1, the Department of Veterans Affairs or the US government.

By way of overview, just to give you a roadmap of where we're going, I’m going to share a little bit of information on social determinants of health as a background and context; we'll talk about some of the ethical questions that come up in screening patients in general, and veterans, in particular, for health-related social needs; and then we'll take a deep dive into the VA ACORN initiative and ACORN stands for Assessing Circumstances and Offering Resources for Needs, and this is an initiative that has been spearheaded in VISN 1 with the Office of Health Equity and really, really grateful to the partnership and our efforts to scale this throughout VA moving forward; and then we'll talk a little bit about what are some actionable solutions that will allow VA to ethically address veterans’ health-related social needs. We'll take questions at the end, so please feel free to jot them down or put them in chat, and at the end of the presentation we'll come back to them.

Just by way of background, I think it's really important to give you a sense of, currently in the US, how we are spending our health care resources and what's really driving social determinants of health. So, we spend about 95 percent of our health care resources on direct medical services; and yet, if you look at what is modifiable variation in health outcomes, the vast majority--so, 70 percent of them--are actually rooted in social and economic determinants, health behaviors, and our physical environment.

And so, as we think about really improving health outcomes for veterans, we need to draw our attention to responding to the unmet social needs, and it's this concern and this reality that so much of what drives health care outcomes are actually social and environmental factors that has led us to really focus on improving veterans’ health-related social needs.

When we think about social determinants of health, it's a concept that has gained in popularity--and I think it's important to distinguish the idea of social determinants of health from health-related social needs. So, the social determinants of health are the conditions in which people are born grow, work, live, and age, and the wider set of forces and systems that shape the conditions of daily life, and this is a definition that was put forward by the World Health Organization, and some examples of that might just be what's the built-in environment that we happen to live in? Do we have sidewalks? Do we have playgrounds? Are we living in an environment that has structural racism? Those kinds of population health conditions that we are born into.

In contrast to that, when we speak about health-related social needs--and that will be abbreviated throughout this presentation as "HRSN"--we're referring to the non-medical social needs that actually impact our patients health and well-being; and some examples of that include food insecurity, housing instability, exposure to violence, concerns about utility or utilities and transportation needs. And we know that all of these things have a dramatic impact on patients' health and well-being and that we, as a health care system, therefore have an ethical responsibility to address them if we're really interested and committed to improving the health and well-being of our patients.

Our current global pandemic of COVID-19 has exacerbated existing social determinants of health at the population level. There's been a tremendous amount of work in this area both within VA as well as in the general population more broadly where it's very clear that social determinants of health are contributing to increased exposure and transmission of COVID-19, because as a result, lower-socioeconomic-status individuals who are living in densely-populated areas frequently in multi-generational housing have been subject to an increased risk of COVID-19 and have been disproportionately affected by COVID. And I think that that just drives home the importance here, of addressing things like homelessness, and housing, and these social needs which are putting certain populations at greater risk.

So, why do social determinants of health matter in a clinical setting? We hope that you'll come away from this with an understanding of how these broader social economic and behavioral factors actually impact a person's quality of life and well-being, and we believe that by addressing these things, we can actually help promote patient-centered care and the whole health system of care that has been so much a part of the VA's mission over the past several years. Advancing the health of our population actually requires us to serve the needs of the populations we serve and those needs are broader than the specific health things like addressing hypertension, and diabetes, and obesity, right? It's these social needs that are driving those factors and that allow our patients to ultimately address those specific health issues.

So, it's also critical to develop mechanisms to identify and address the population-level social determinants of health and individual health-related social needs and clinical settings because that's ultimately what's going to allow us to improve our patients' clinical outcomes and promote health equity. So, we've really felt that it's critical for the VA, as a health care system that is committed to improving the health and well-being of our patients, to focus on social determinants of health and health-related social needs.

Doing so raises a whole slew of ethical questions and I just want to call out some of these that we have struggled with and tried to help resolve as we've embarked on this effort to scale a systematic approach to screening veterans for health-related social needs.

So, the first question is well, can we address our patients' needs? Screening, in and of itself, is not the goal; and I would suggest, further, that if we screen and we don't address those needs, then we are failing in our ethical obligations. So, as we think about screening, we need to partner that screening with a program to actually address our patients' needs. That raises the further question is, well, what's the extent of our obligations here? Once we screen and even if we attempt to address those needs, do we have an obligation to ensure that those needs are actually addressed, that the resources that we provided to our veterans to address those needs that we've identified have actually been successful in addressing their needs. And that raises a lot of questions of, "Well, who has that obligation to follow up with veterans to ensure that the needs have been met and that we're being successful?"

And then I think a big question for an organization like the VA, as a national organization caring for millions of veterans, is how can we responsibly scale this screening? And that's always a challenge in our organization particularly when we're dealing with some topics that are very sensitive, and some might argue maybe too sensitive for electronic or remote screening such as screening for intimate partner violence or elder abuse. And is there a conflict there between scaling that using electronic modalities and the need to reach people in a large, integrated healthcare system?

Just let me focus a little bit more on some of the potential challenges of screening for personal safety. When we screen remotely or using electronic means, it may increase the potential for harm and I think it's important, as we go into this effort, that we do that with our eyes wide open and that we think about that potential harm in advance. And what I’m referring to here is that if people are screening remotely or using an electronic screening system not in a clinician's office, if an abuser of that patient learns that their partner is disclosing incidents of abuse, they may actually try to control access to virtual devices to engage with health care providers, and that may impact our patients, our veterans' ability to engage virtually with our providers.

Healthcare providers may also need additional training to assess patient safety in the context of a telehealth visit. And as I’m sure all of you know, COVID-19, the VA has been remarkably agile in moving towards and embracing telehealth even far beyond what we did before. So, making sure that we can do this screening through that virtual modality is really critical to our success in the future.

There are also some additional ethical questions, I think, that screening for health-related social needs raises, which is will our patients feel stigmatized or too ashamed to participate in screening? Our hope is actually, that as we broaden the conversation and make this the new normal, that we talk about these things and we try and address them, that patients won't feel stigmatized. So, the more broadly we can discuss health-related social needs and actually address it, and make it the norm that we're doing so, our hope is that any stigma associated with this will be diminished.

There's also an important question about how we can overcome the digital divide, right? We know that lower socioeconomic populations may not have access to technology, to the internet, or to cell phones, smartphones, and it's important to raise the question about whether or not it's ethical to screen if everybody won't have access to that screening into the resources that we're trying to provide. I will note here that VA has done a remarkable job in trying to address this digital divide, and especially in light of COVID, recently, there's been efforts to really ensure that veterans who don't have a tablet and can't engage in telehealth or don't have a smartphone or a cell phone will be provided with one through the VA. The VA is also working to address those populations especially in rural areas that don't have access to the internet, and so there are mechanisms to ensure that our patients without access to technology can obtain it.

And then lastly, I’ll just raise the question here, of whether, given the impact on our patients' health of health-related social needs, can we really ethically justify not screening for health-related social needs? And this is where that ethical imperative, I think, comes in and where we, as a healthcare system, really need to step up and address these social needs that impact the health of the millions of veterans that we treat.

I’m going to turn it over now to Lauren Russell who is going to talk about our ACORN Initiative.

Lauren Russell: Hi, everyone. Thanks so much, Dr. Lehmann. Today, Alicia Cohen and I would be talking about health-related social needs screening and referral program among veterans, or ACORN, as Dr. Lehmann mentioned earlier. So, I’m actually going to pass it over to Dr. Cohen to present our first half of slides and then I will talk with you all about the results.

Alicia Cohen: Thank you so much, Laruen. And thank you all. So, thank you, Dr. Lehmann, thank you Lauren. I will be talking with you a bit more of a deeper dive into our ACORN Initiative, the Health-Related Social Needs Screening and Referral program.

So, just to give a bit of background, given the increased recognition of the adverse impacts of social needs on health as Dr. Lehmann has been speaking about, there's really a critical need to improve the ways in which we identify and address health-related social needs in clinical settings; and this need is even more pressing during COVID-19, again recognizing the ways in which COVID has really both exacerbated existing disparities and also plunged many more newly into hardship.

So, currently, the VA has instituted universal screening for food insecurity, housing instability, and most recently, for intimate partner violence; but VA does not currently systematically screening for other health-related social needs more broadly. And to address this gap, in 2019 as we discussed, the VA New England Health Care System, or VISN 1, developed and piloted a health-related social needs screening and referral initiative which, as we've discussed, is called ACORN, Assessing Circumstances and Offering Resources for Needs.

So, in our evaluation of this pilot, our primary objectives or aims have been, first, to determine the prevalence of identified health-related social needs and the socio-demographic characteristics associated with screening positive for these needs; and then also to really understand explore veteran acceptability of the ACORN initiative as well as a perceived effectiveness of providing geographically-tailored resource guides that are connecting veterans with needed services.

So, when we were first developing the screener, the instrument itself runs on a VA-developed electronic screening platform which connects directly to the EHR, the electronic health record through VA-secured wi-fi and veterans are able to self-administer the screening questions on an electronic tablet which is provided to them in clinic, and then their response is--because the tablet syncs directly with the EHR, there's immediate integration of their responses into the medical record; and then the data is available for review by the care team.

So, our screening instruments and the subsequently-developed resource guides were developed by an interdisciplinary care team that included primary care physicians, social workers, and clinical psychologists as well as a number of additional subject matter experts; and our team incorporated the VA's existing screening questions for food insecurity and housing instability into our screening instrument, and then we also utilized these validated instruments for the other domains when such validated questions were available.

We then piloted the questions with veterans through cognitive interviews who made some additional modifications based on their feedback prior to then implementing the survey in the field. So, when we were deciding which domains to include on our screener, we started with a sort of master list that we compiled of social needs domains that were recommended by a number of expert bodies including recommendations from the National Academy of Medicine Leading Health Indicators for Healthy People 2020, and then kind of with our interdisciplinary panel and group of experts.

We then narrowed down the domains to those that could be reasonably addressed within the VA or through local community support services; and the reasons for this are, as Dr. Lehmann spoke to, we really wanted to make sure that if there were needs that we were screening for, they were ones that we could reasonably address if veterans screened positive. And I will also just note that although the needs displayed-- the seven needs--are the ones that are presented in our current analyses today, the full screener does include screening for two additional domains also--for personal safety and for education.

So, our team also built geographically-tailored resource guides to correspond with each domain included on the screening tool; and each resource guide is one page in length and provides information about both relevant VA and community-based resources. And above, you'll see--so, the guides are provided to veterans at the point of clinical care; and so there's two examples here. The first is on the left is a sample of a food and nutrition resource guide--and then that particular example was actually developed prior to COVID--and then the guide on the right is a housing resource guide that has been used since the start of a pandemic. And the main difference is just that our team modified all of our resource guides at the start of the pandemic to ensure that we were only including information about support services that could still offer programming and assistance to veterans given new safety and social distancing protocols, and also to make sure that we updated the resource guides to include any new resources that might be available.

And the other thing I’ll just note is that, in addition to providing both VA and community resources, the resource guides also at the bottom where it says that quick note, all have additional information for a social worker within VA as a point of contact in case veterans had additional questions or needed additional assistance.

So, in order to evaluate this pilot, we have been conducting a mixed methods of multi-site evaluation. This is a QI initiative at two VA clinics in VISN 1, an urban women's health clinic, and also a suburban primary care clinic. Beginning in October, 2019 veterans presenting for care at the two clinics were asked to complete an e-tablet-based assessment for health-related social needs upon check-in. The results from the screening were then synced with the VA health record, as we mentioned, and available for immediate review by the care team.

And then following screening, an RN reviews the responses with the veteran and provides them with relevant geographically-tailored resource guides based on any needs that have been identified. And then our team has also been conducting two-week follow-up interviews with a purposive sample of veterans to better understand the acceptability of the screening tool and effectiveness of the resource guides in connecting veterans with needed support services.

And our analyses for this, for our quantitative analyses, we've been using multivariable order logistic regression models to estimate systemic characteristics associated with healthcare and social needs and then we've also been using directed content analysis to analyze our interviews.

So, one last note that I’ll make just before turning things over to Lauren, is just to make note that then March 2020, COVID happened--well, COVID happened to March 2020, but in March 2020 kind of our world got turned upside down for a number of reasons. And among those for this particular project, the transition to virtual care that occurred as a result of COVID significantly impacted our existing screening and referral processes. And one notable impact for the evaluation itself and for the initiative itself was that as a result of COVID-19 related staffing changes at the Urban Women's Health Clinic, our screening efforts actually needed to be halted at the Urban Women's Health Clinic entirely starting in March 2020.

And then just also to note additionally, our team made some pretty rapid adaptations in response to changes related to virtual care and otherwise, in response to COVID. So, the first thing that we did was, as I mentioned, we updated the resource guides to make sure that we were reflecting the most up-to-date resources that were available; we also developed PDF versions of resource guides initially because the veterans were--the screening was all happening on site, the resource guides were provided to veterans on site at the point of clinical care; now, because there's screening that's also happening within the context of virtual visits, we now have these PDF versions of all the resource guides that we can send to veterans in whatever method they prefer: we can send it via mail, we can send it to them via secure email, or we can send it to them via secure messaging in the patient portal.

And then finally, we developed a local template within the electronic health record to allow for staff-administered screening. So, initially, veterans were filling out the screener on an e-tablet in the waiting room; obviously, that's not possible during virtual visits. So, now we also have an option where the template is literally embedded directly in the EHR so staff can administer the screening during virtual visits in a very similar way to the ways in which they do the food and housing clinical reminders and sort of some of the other clinical screening that occurs in the context of it--that routinely occurs in the context of clinical care.

Also, within this template, we've actually included the existing VA clinical reminders for food insecurity and for housing instability; we had those questions already in the screener, but by formally incorporating a clinical reminder, that means that when this screener is completed, those clinical reminders are actually satisfied, are kind of checked off as being done in the electronic health record which means that that work then doesn't need to be duplicated at another time.

And the other thing that we did is we created something called health factors for all of the other questions. And so, health factors are essentially the ways in which data for food and housing, and any of the other clinical reminders within VA, are both kind of stored within the EHR and also within the corporate data warehouse which is in a VA administrative database. So, because we were able to map these questions to the health factors, it means that when we're doing data analysis on the back end, it allows us to, in a very streamlined way, be able to access and extract that data from the EHR.

So, with that I will turn things over to Lauren to tell you a bit about what we found so far.

Lauren Russell: Hi. Thanks so much, Alicia. So, I’m going to talk with you all a little bit more about our preliminary results, conclusions, limitations and just kind of next steps and implications.

So, to date, we've screened 268 veterans between the two clinics; with 84 of those having been screened in the Urban Women's Health Clinic and 184 having been screened in our suburban primary care clinic. Of note is that the median household income for the population served by our urban women's health clinic is about $8,000 below the national median household income and about $30,000 below the median household income for the population served by our suburban primary care clinic.

Of those screened overall, 64 percent were male; however, the breakdown between male and female across the two clinics looks quite different. The suburban primary care clinic was about 94 percent male, while our urban women's health clinic was 100 percent female. The mean age of those screens was about 56 years old and 81.7 percent identified as non-Hispanic white; 6 percent identified as non-Hispanic black; 4.1 percent identified as Hispanic; and 8.2 percent identified as other.

50 percent or so were non-married and non-partnered and 12.7 percent were considered low-income based on their VA enrollment priority group status.

Here, you can see reported health-related social needs by site. On the X-axis, you're going to see the health-related social needs, so those are our seven categories; and on the Y-axis, you'll see the percent of veterans.

The darker-blue bar--since I know these are a little hard to differentiate here with the colors--so the darker-blue bar which is on the left side for each need, represents the urban women's health clinic and then the lighter-blue bar which is on the right side represents the suburban primary care clinic.

Across both clinics, the most commonly-reported needs were social isolation followed by housing and utilities, as you can see here, and although these needs were pretty consistently reported across both clinics, the rates were substantially higher among the veterans screened at our urban women's health clinic; which, as I mentioned, on the previous slide serves a lower socio-economic status population.

Here, you can see the need burden among veterans screened, overall and broken down by site. So, on the X-axis here, you have the number of health-related social needs broken into four categories: 0 needs, 1 need, 2 needs, and then 3 or more. And on the Y-axis, you have the percent of veterans.

The first bar--since, once again, I realized that we need to improve our blues of how clear these are to see--so the first bar is overall, the second bar represents the urban women's health clinic, and then the third bar represents the suburban primary care clinic. And so, overall, about 40 percent of veterans expressed one or more health-related social needs; and as you can see in the figure, the need burden was overall higher in our urban women's health clinic where nearly a third expressed one health-related social need and about 10 percent expressed three or more needs. And then of the veterans screened at the suburban primary care clinic, about 20 percent expressed one health-related social need, and about four percent express three or more needs.

So, here, we kind of broke down socio-demographic characteristics associated with a higher number of health-related social needs; and as you can see, based on the font that's shown here in red, veterans who were female aged 50 to 64 and non-married or non-partnered had higher odds of reporting a greater number of health-related social needs; in addition, veterans of color also trended towards higher odds of a greater number of health-related social needs, but as you can see here, this did not reach significance.

And then we conducted site-stratified analyses as well, and the findings overall were pretty similar to what you're seeing on this slide with the exception that marital status in the urban women's health clinic was not correlated with reporting a greater number of health-related social needs.

So, as Alicia mentioned, we conducted veteran interviews to try to better understand perceived accessibility; and through these interviews with a sample of our veterans, we learned that, overall, veterans find screenings both acceptable and appropriate and so the VA should continue to conduct such screenings within clinical settings.

We also found that while some veterans thought the resource guides were helpful, others didn't use the guides citing reasons ranging from having already received assistance from the VA; so maybe they received a referral while they were in the clinic or are you receiving other supportive services, to others feeling discomfort with initiating contact with organizations outside of the VA.

So, as with any pilot, there are definitely some limitations here and also just some lessons learned. So, first, it's important to just note that the two sides had relatively low patient volume which became lower with the onset of COVID. So, unfortunately, it did make it a little difficult to detect correlates of health-related social needs onto the unexpectedly-low sample size. In addition, there were some issues that we encountered in terms of collecting data and incorporating new technology into the existing clinical workflow and a lot of this just revolved around our veteran-administered screeners, required use of an iPad, we're just trying to make sure that our clinical staff were trained in terms of how to access the e-screening platform, helping make sure veterans knew how to log into the platform, sort of figuring out when to administer the screening with the iPad and in which part of the patient's appointment itself. And those are just some examples of the kind of challenges we experienced, areas where we're kind of seeking to find ways to tailor the process to meet the needs of individual clinical sites based on site-specific clinical flow and operations.

So, in conclusion, though the use of resource guides was limited, veterans do feel that screening for health-related social needs is important and that we should continue to do this work. And through this initiative, we've been able to develop a much greater understanding of the knees impacting veterans in our two clinics within the Greater Boston area.

So, overall, 40 percent veterans screened reported at least one health-related social need; and when we broke this down by clinic, 32 percent of those screened at our suburban primary care clinic expressed at least one health-related social need in comparison to 57 percent of those in our urban women's health clinic who reported at least one need.

For both clinics, social isolation was definitely the greatest unmet need and overall, about a third of veterans reported this concern. One in five veterans reported at least one form of material hardship and overall rates of positive screens for these issues range from 3 percent for food insecurity, to 5 percent for transportation, to 7 percent for utilities, to 9 percent for housing. Based on our sample, it does appear that women and non-married, non-partnered veterans are at an increased risk for reporting multiple unmet social needs.

So, kind of where do we go from here? As was mentioned both by Dr. Lehmann and Dr. Cohen, there's an increasing recognition around the impact of unmet social needs on an individual's health and well-being, and our team certainly believes that incorporating a health-related social needs screening and resource referral program into clinical settings is a critical step in terms of being able to connect veterans with needed and relevant supportive services. By screening veterans for these needs, we can also identify existing gaps in our service delivery model and better inform future resource allocation within the VA.

Our pilot work is ongoing and we are hoping to expand our initiative to other primary care clinics and specialty care clinics, and geographic regions outside of New England. As Dr. Cohen mentioned, we developed a local electronic health record template and health factors that can actually be shared across the VA and pretty seamlessly implemented into facilities across the country. So, we're hoping that that will also make increasing our efforts and being able to screen more veterans a bit more accessible.

And in our future work, we're really hoping to kind of better understand which veterans may benefit most from low-touch interventions like resource guides and which veterans may need additional support like care coordination, because we do realize that addressing health-related social needs is a pretty complex issue and there isn't really a one-size-fits-all solution for how to address these needs for our veterans.

So, with all that shared, I would like to just give one more thank you to all the individuals throughout the VA who've supported our efforts over the past couple of years and made this work possible. So, I appreciate your time today and I’m going to hand it back over to Dr. Lehmann.

Lisa Lehmann: Thank you, Lauren. I really appreciate that. So, I want to take a few moments just and speak a little bit about how we can, as an organization, meet our ethical obligation to systematically screen and address health-related social needs. And I’ll just remind people to feel free to use the chat if you have questions; we're going to try and leave at least ten minutes to respond to any questions that people have.

So, I hope that you've gotten a good picture of, first of all, the importance of screening for health-related social needs, and what we've done in VISN 1, and where some of the opportunities are to scale this really throughout the country.

In order to really do this ethically, I think we need to we need the ability to screen and refer or link to resources. There's clearly some challenges to doing that in terms of scaling it and the reliance on electronic screening, it can't all happen in the context of a clinic; and I think the other piece of this is really that linkage to resources that is critical that needs to be further developed.

As Lauren mentioned--and as Alicia mentioned--we've done some work to really be able to seamlessly connect this information with CPRS with the VA EHR, and we hope that those of you who are listening around the country will really take advantage of the note template that we've created as well as the health factors; you can work with your clinical application coordinators, your CACs, to actually have those be usable at your clinics; and if you need any more information about that in the code for the CACs, please feel free to reach out to... I’ll say Lauren is probably the best person to reach out to as the point of contact for that. But connecting the screening data to the EHR is critical so that it can be followed up, so that it can be tracked, and that we can really ensure that we're meeting our veterans' needs.

There's also an important role here for more staff training to screen and respond to patients. Many of us working in a clinical environment, this is not our particular area of expertise and it's something that we're learning and further developing; so, I think that we, as a system, need to think about how can we really get all of our staff up to speed so that they're comfortable screening veterans for health-related social needs and have the ability and know where all the resources are to respond to patients.

We also know that our clinics are short staffed, not all CAC teams are actually staffed in the way that they ideally should be according to our models, and that time is always a challenge given the complexity of our veterans' healthcare needs. So, we need to figure out how to ensure that we have time to actually address social needs, to be able to respond to the screening, and to think about how to efficiently screen maybe outside of the clinic and then use that clinic time to really be able to address it.

We also need to develop an infrastructure to address the identified unmet needs--and I’ll talk a little bit more about how we can do that--because really, it's critical that we have the resources that infrastructure is not just an infrastructure to screen, but it's an infrastructure to figure out how we going to respond; and then I think we also need to be mindful of and attend to some of the setbacks in social needs that have been created by COVID-19.

So, what can we do, practically speaking, on a large scale within our organization? We know that screening is a critical step in terms of connecting veterans to needed services and resources, but that's just the first step. And we also know that as an organization, we're strapped for resources, right? We don't have enough social workers in our organization, we don't have enough staff to really do intensive case management.

So, we've mapped out here, three different approaches; and as you saw from the work that we've done with ACORN, we started really with the resource guides as a way to respond to veteran’s needs. It's very time-intensive to generate these resource guides, the resources are tailored to the particular location of veterans, and we've also realized that there's some challenges and that the resource guides are not being used as widely as we would have anticipated; and it may be that their--and from the data that Lauren and Alicia shared, we also know that there's some veterans that have multiple health-related social needs.

And so, I think what we need to be able to do here is really figure out how we can make the resource guides more valuable and actionable in terms for veterans, and then which veterans are going to actually benefit maybe from a peer navigator or from more intensive case management? And maybe it's stratifying veterans based on some of the data that we know in terms of what's putting people at risk whether it's non-married individuals, non-married women, people who are in more urban areas and really figuring out how to tailor our resources in a way that is going to be most effective at actually improving outcomes and addressing these needs.

There's also an important role here for us to address our veterans’ self-efficacy and empower them to connect with supportive services. We've been somewhat surprised by veterans' response to resource guides and the reasons or the lack of willingness to really seek out and connect to some of the resources that we've shared with them. So, we need to figure out how to overcome this and how to have more empowerment of our veterans.

I wanted to share with you just briefly, an initiative that was started at New York-Presbyterian Hospital, in collaboration with NYU, where they actually launched community health workers into their multidisciplinary response to COVID-19. This was actually recently published in the New England Journal, and community health workers had a significant impact on addressing social determinants of health amongst those disproportionately affected by COVID. And this is just some of the data to show you what they did, that the community health workers actually engaged in 9600 wellness phone checks where they are able to do medication refills, address housing and security, and those individuals who are unable to pay their rent as a result of COVID and being unemployed. They provided bereavement support, they enrolled patients into their patient portal so that the people could have more access to healthcare and their healthcare providers, and they helped with virtual health coaching sessions.

So, there's a tremendous opportunity here that this model of community health work workers presents in terms of enhancing the opportunity to address health-related social needs.

So, as we think about moving forward, I think that we really need to deploy a system-wide electronic screening for health-related social needs--and some of the work that we've already done that was mentioned in terms of the CPRS template and the health factors should make it easy for you in other VISNs to actually deploy these resources. We need to develop an infrastructure that allows us to easily connect veterans to resources in real-time and identify which veterans are in most need of the intensive staff case management approach versus the resources or peer support; and then this information needs to be connected to our EHR so the healthcare providers can act on it and follow up on it; we need to encourage more patient empowerment.

And importantly, we need to build partnerships with community-based organizations to help meet veterans' needs. We know that this is not something that the VA can do alone, that we work in communities and that our communities are an important part of meeting our mission and achieving our goal of improving the health and well-being of our patients.

And I think launching a VA campaign or marketing around social needs to reduce the stigma associated with it, similar to what the VA has done successfully around homelessness and suicide, is another important part of our path forward.

I’ll stop there. I see that there's a lot of questions in the chat and I don't know if--I’ll turn it back to Whitney, our host, and see if we take questions live from the audience or we just do it from the chat.

Whitney: Alright. Thank you, Dr. Lehmann. I’ll be reading the questions. So, our first question is, "Who coined the term 'health-related social needs'?"

Lisa Lehmann: That's a great question. I don't know if any of the other others on the call have an answer to that. I am not entirely sure who coined that, I know that there are multiple groups around the country that are working on addressing health-related social needs, and--but I’ll ask Lauren and Alicia if they know specifically who coined it. I assume maybe we could search the internet and find that out.

Alicia Cohen: This is Alicia. I’ll just add that I am actually not sure either who coined it. I will say that it's a term that I think has been gaining increasing use and traction over the past couple of years, sort of in recognition of the distinction between social determinants of health which kind of encompasses some of those larger social factors as opposed to kind of some of the more downstream unmet social needs. It's a term that's been adopted by the Centers for Medicare & Medicaid Services and their accountable health communities and for these projects, and it's in pretty wide use right now. But it's a great question that we can look up and try to get back to the group about, but I don't know who initially coined it.

Whitney: Great. Thank you. "Can you walk through the initial point of screening to where a social worker would be involved?"

Lauren Russell: So, in terms of the screening for when we kind of hope to get social worker involved or for more of the emergent needs such as if someone is already without food or housing, or if a utility company has threatened to cut off their utilities, those would kind of prompt referrals to social work and hopefully more of a warm handoff with social work so that the veteran can have that need addressed as soon as possible if it's more urgent.

And then additionally, if a veteran screens positive for personal safety or social isolation, those veterans are typically also connected with social work if they're not already receiving that support. So, hopefully, that kind of answers your question. I don't know if either Dr. Lehmann or Dr. Cohen want to chime in with anything.

Lisa Lehmann: Thanks, Lauren. I don't have anything else to add to that.

Alicia Cohen: I agree.

Whitney: Next question, "It seems like social isolation was the most common need you identified. What were they asked on the screener and what resources were provided if positive?"

Lisa Lehmann: Great question. Lauren, do you want to take that one?

Lauren Russell: Yes, sure. So, they were asked about their feelings of social support and then using a Likert scale , that's how we kind of based our responses for whether or not they were in need of social support. And as you can imagine--so, I’m happy to follow up with you if you'd like the exact wording; I know we did not include an example of our screening tool in the slides as we've kind of expanded the screen till it's gotten a little too robust to include on the slides and give you a clear visual of it. And then in terms of screening positive, so obviously, that's shifted a little bit with COVID. Pre-COVID, there were a lot more in-person veteran support groups. One of the veteran service organizations actually near the suburban primary care clinic owns a farm where they help teach veterans how to farm and grow plants and that's one of their social activities, there are also a lot of coffee socials.

Unfortunately, with COVID, obviously, a lot of those aren't currently happening or just happening with less frequency. So, a lot more of the resources we're providing now are either online or phone social support resources; some that are specific to veterans and some that are just more broad social networks that we're hoping veterans can connect with. Obviously, the hope would be to sort of go back to more of those in-person resources once that's deemed safe.

Alicia Cohen: And another thing I’ll just add is that social isolation--for anyone on the call who's a social isolation or a social support researcher expert, there are validated instruments or measures available for social isolation, there's a number of them--and this was one of those instances where we were kind of trying to balance having a relatively brief screen that could be implemented rapidly in a clinical setting versus something that potentially could be lengthier in other contexts.

And so, this was where we really worked with our interdisciplinary team and experts and sort of going back and forth with veterans to try find the balance between sort of having an instrument that was brief enough to be practical, but also was able to adequately pick up on the needs. So, the social isolation--or really kind of assessing social support question is one that we took and has been used in multiple other screeners; and again we're happy to share that question after the fact, that this is,in fact, not sort of one of the more detailed multi-item-validated metrics that are available. So, I mean in other cases we were able to use validated measures; in this case we opted, for a number of reasons, for a more concise single-item screener instead.

Whitney: Thank you. "Was there consideration of using warm handoffs to existing providers of services identified during the screening, like United Way or Mental Health Association?"

Lisa Lehmann: Great question. We did have a lot of conversations internally about partnering with United Way. So, there's two different issues here: one is who we connect people to with resources? And then when you talk about a warm handoff I think about that sort of really within internal within our organization; and there's always that opportunity that's really at the clinician's discretion and which is why it's so critical that the screening be seamlessly integrated into the EHR, so that clinicians, at the point of care, can see what those needs are and see if there's something that needs to be really urgently shared with a social worker within our healthcare system.

And then there's the separate question about sort of partnering with other national groups. I’m going to turn it over to Lauren to just talk a little bit more about that because we did spend quite a bit of time exploring that and with national groups that provide resources to address health-related social needs. Lauren, do you want to say a little bit more about our work in that area?

Lauren Russell: Sure. So, as Dr. Lehmann said, we did explore several different options.  I think kind of the challenge here which she alluded to is just really figuring out a way to more seamlessly integrate this into our existing system. I think part of the challenge here, particularly with or that can pose challenges is with the VA's EHR, which since it was internally VA-developed and with the transition to Cerner, it's a little bit challenging to kind of build in new platforms right now to some of these which are existing EHR. So, I think that's one challenge.

And then I think the other is just figuring out how to still best coordinate those referrals. So, even if we partner with United Way nationally, kind of how do we ensure that the veteran gets connected with that service is still challenging. So, is that that we do a warm handoff to social work and then social work then connects the veteran? Is that once again just putting that information on the resource guides, which is kind of something we're already doing? But as you heard, that doesn't work for all veterans.

So, I think the challenge still is trying to figure out how to make sure that connection actually happens; and then once a connection does happen, how do we ensure that the veteran is actually having their needs met. So, I think there's still interest in partnering with those larger groups, I think a lot of it is still just kind of a process flow for how do we make sure people actually get the help that they need and that that does meet their needs.

Lisa Lehmann: Great. And I know we're almost out of time here, but I think that what Lauren's pointing to and what we're concerned about is that when we think about doing this work from an ethics perspective, it's critical that we do close that loop and we have to figure out ways where those kinds of partners can send back information that gets back into our electronic health record, so that we have confidence that we're actually meeting that responsibility to ensure that the needs are being met.

Whitney, I'll turn it back to you.

Whitney: Great. Thank you. Unfortunately, we are out of time and just to be respectful of everyone's time... just if you guys have any closing comments for the audience. We definitely apologize for not getting to all your questions, but the presenter's information is provided on your slide; if you do want to pursue those questions, Dr. Lehmann, Dr. Cohen, and... Lauren, do you have any closing comments?

Lisa Lehmann: I just want to say thank you to everybody for listening. We hope that you'll take this information and spread it throughout your own facilities; we're eager to help make sure that that happens, so anything that we can do to advance that, please feel free to be in touch with us.

Alicia Cohen: Thank you all so much, I appreciate it. And please feel free to follow via email and I’m happy to answer your questions. Sorry that we were unable to get to so many that are still in the Q&A.

Lauren Russell: Absolutely. Please send us the questions and we're happy to try to address them offline.

Whitney: Great. Thank you. Attendees, when I close out the meeting momentarily, you will be prompted with a feedback form. Please take a few moments to complete the form; we really do appreciate and count on your feedback to continue to deliver high-quality cyberseminars.

Thank you, everyone, for joining us for today's HSR&D cyberseminar and we look forward to seeing you at a future session.

Have a great day, everyone.