# Addressing Veterans' Sociocultural Determinants of Health

Second hi everyone, I want to welcome you all and thank you for joining. My name is Lauren Korshak and I lead translation activities for the VA's office of HealthEquity. Ohe, the office of HealthEquity was established in 2012 and it champions. Advancement of HealthEquity and the reduction of health disparities and veterans. My job means that I get to tell stories about the data that we have about veterans and their health today on the HealthEquity and Veterans Podcast series will be discussing how VA is addressing social determinants of health and their impact on health outcomes. Through interventions to advance HealthEquity of our veterans. But first, I'm really excited to introduce today's speakers. Doctor Alicia Cohen is a research investigator at the VA Providence Health Care System Center of Innovation. In long term services and supports, and a primary care physician at the VA Providence homeless clinic and Women's Health Clinic, she is also an assistant professor. Family medicine at the Alpert Medical School of Brown University and an assistant professor of Health Sciences policy and practice at the Brown University School of Public Health. Lauren Russell is the access Kha lid in the chief medical office for the VA, New England health care system and is a former presidential management fellow. Dr Joanne Eliason is a core investigator. And research health scientist with the Center for Health Information and Communication at the Rudebusch VA Medical Center. She is also a research scientist at the Regent Stripe Institute and at the Indiana Alzheimer's Disease Research Center. So to get started, we've learned that the conditions in which individuals live and work can significantly impact their access to social and economic opportunities and resources and ultimately impact their health outcomes. Could you all share some examples of these social determinants of health and and YV is working to address them? Yeah, so I think first it's really helpful to just start out with, you know, the definition of social determinants of health. So the World Health Organization defines social determinants of health as the conditions in which people are born grow work, live in age and the wider set of forces and systems shaping the conditions of daily life. Some examples of these forces and systems are the social and physical environment, social policies as well as political and economic. Systems I think that's a really great framing Lauren kind of thinking. Overarchingly about what we mean about social determinants and then trying to ground. Kind of what that means in terms of the the veterans were seeing in front of us. You know, I, I say a lot that you can't tell from looking at somebody if they're struggling to put food on the table or to pay their rent. Or you know, even necessarily if they're you know, feeling really isolated from their community. These are the types of things that, in less were asking questions were going to be missing. People who are in need. And so you know, I know a lot of the work that many of us have been doing both within VA and outside of VA is to kind of think about ways that we can really kind of systematically or routinely screen for social determinants or health related social needs. And to you know, really kind of normalize that as a standard part of care. As an as an integral part of health care, and that these are not only appropriate questions to be asking in the context of a health care visit, but really important questions to be asking because. These are needs that are impacting all of our lives are impacting veterans health, and so these are things that we want to be proactively asking about a veterans when we see them for health care, and I think that this need for kind of this systematic screening has become even more acute during COVID since we've seen the ways in which COVID has both exacerbated existing disparities and also plunged many more who previously were doing OK into new financial hardship. And again, you know, I think also clearly. You know many people have been struggling with social isolation when that may or may not have been the case before, but you know whether it's because of kind of personal changes to their own health status or the health status of people they are close to, you know, and also recognizing the many ways in which people's income sources have been impacted during the pandemic. This is just a really critical time to be proactively

talking with veterans and and kind of assessing both what their current situation is, what their current needs are and the ways in which we can try to. Best help help them address those needs and so I think that you know a lot of the work that you know where, where each working on and I'm going to talk a little bit about today. Kind of really seeks to get at that piece of how do we best find out what needs veterans have, what social needs better and have what social determinants veterans may be struggling with and and how we can best address them. Adding to what Elisha just shared. I also wanted to emphasize why it is important for all of us to be engaged in this work and why the VA is investing in addressing social determinants of health. And somebody may ask, well, why does this have to do with health issues like diabetes, that veteran may experience or mental health condition? It's really important to understand that these social determinants of health are not only associated with poor physical and mental health, but in many cases they are the underlying mechanisms leading to wise of poor health. So to really do a good job at getting veterans healthy or healthier, we need to address not just the symptoms. Of health conditions that they may have, but we only have to address the underlying mechanisms which can be linked back to social determinants of health. You all are engaged in work to help connect veterans with the things they need to address these social determinants that may be impacting their health. Could you all take some time to share what you're currently working on? Yeah, so in this in one which is the VA New England health care system? Several years ago we convened a group of primary care physicians and mental health providers. Social workers. And you know some informatics is to help us really build out a way in which we could better screen veterans for these needs more broadly. So to provide a little bit of background there. Prior to that, you know VA has really emphasized broadly screening for you know food and housing needs as well as intimate partner violence. But we really wanted to, you know, expand upon those screening efforts to look more broadly at other needs that might be impacting better. And, you know, for all the reasons that Joanne and we should, just, you know, outlined as to why this is important to do. Within clinical settings and how these needs can really impact of veterans, you know quality of life and overall well being along with their clinical outcomes and so through this work you know we we built a screening tool referred to as a corn, so the addressing circumstances and offering resources for needs, screening tool and and with that you know we're able to screen for nine different needs, including food and housing, legal needs and in several others within the clinic where veterans could, you know, express any of these needs they might have and we were able to within the time of their appointment, provide. Resources that were geographically tailored to the clinic where they were being served to try to connect them with both VA and Community resources, so the hope of this was really to not only be able to identify veterans needs, but to also be able to then follow up and address them. We didn't want to simply screen for the sake of screening or for data collection, but rather to actually hopefully help veterans get connected with services that they could utilize to better help them. You know, address these needs and hopefully sort of alleviate them in the future. And so with that you know we've piloted this work in several different clinics in a mental health setting. Primary care, Women's Health, as well as a homeless clinic and really working to figure out how we can continue to more systematically screened for these needs throughout VA. And can you know and continue developing partnerships with community based organizations so that for any needs for which the VA maybe isn't able to best meet the veterans needs, you know we can connect them with those that are in there. You know, local neighborhood or community. And I think through that you know, really hoping to be able to use that overall to be able to better inform the VA of needs that are impacting veterans and continue to better understand. Maybe any needs for which were not already screening. I think in addition, everything Lauren has been sharing about the ACORN initiative

and you know, again, kind of wanting to make sure that the the work that we're doing is both meaningful kind of on the ground for individual veterans and end that were able to hopefully meet the needs of of the veterans that we serve. You know, based on what work identifying? Screening that also kind of thinking. Bigger picture at how we can also use some of that information to inform either local or via wide initiatives to hopefully be able to better meet some of the needs that we may not be able to you know. Otherwise, meet right now, or if there's areas where we potentially should be investing additional resources because it seems like there there's a lot of need that we may not have been aware of previously and you know another thing that we work on, a lot is really thinking about both not only the resources that we have to address veteran needs. Within VA, but really being aware of other resources that are available in the Community and how we can work with our community partners and really kind of try to facilitate and strengthen those partnerships so that collectively we can best address veterans needs. And one other piece that has kind of been a bit newer with our screening initiative is that both given the I think increase in in digital needs for all kinds of reasons during the pandemic weather. It's having an appointment with your having a video appointment with your medical provider or trying to order groceries online or trying to sign up for for COVID testing or for a vaccine there. There's so many ways, and during the pandemic that wall, I think in the digital age, well, Internet access has served a number of purposes. The need for Internet access and reliable Internet access has become more acute during the pandemic, and VA has really been. A leader nationally, both in terms of the availability and access of providing Tele health services. And you know allowing for video visits. But in addition to that, VA has for awhile. How to program where. If veterans were in need of either a device and or broadband in order to be able to access clinical virtual care with their providers that there's a program in which VA will provide. An iPad that has a data plan or has broadband so that veterans can can indeed have those those needed clinical appointments virtually, and that could be whether they're living a really rural area, you know, and Cowboys can't get in to see their provider. Or clearly during kovid we saw this huge increase in virtual care provision, and the VA is taking it a step further and now actually has something called a digital divide console where it's made it much easier to identify those veterans who are in need of. Assistance can bridging this whole called digital divide of being able to reliably access a device and Internet access so that they can connect with their provider and in other ways use the Internet and so now there is a specific console that you can place to be able to assess veterans digital divide needs, and so as we've kind of been adapting and expanding our acorn pilot, one of the pieces that we've been doing is also formally incorporating screening about digital divide needs into the screeners so that we can better identify. Those veterans who may benefit from my digital divide console and you know ultimately get connected with a device that has Internet access. If that would be appropriate. So that's just kind of. I think that there's been a lot of adaptations for everybody during the pandemic, and the way in which care is delivered, and I think the same is true for, you know, social terminates or social needs screening, and that's just one of the recent adaptations we've made around the types of needs that that we're seeing emerging, and that were specifically screening for things. Alicia, I'll jump in to give. Another example of how we are not only assessing but also addressing social determinants of health in the VA. So here at the Indianapolis VA we have. We are piloting period patient navigation program called partner image in this program is directed to support racial and ethnic minority veterans who are receiving mental health services in outpatient mental health clinics and our approach to assessing and addressing social determinants of health is really grounded in the understanding that. For some veterans, they can't really focus on improving their mental well being until they address some basic social needs, like having a safe place to stay, having food, having basic transportation's to get to

the clinics or digital access to health services we all using our assessment for social determinants of health. Also as a tool for engagement in really to make the care that we provide. Individualized to each veteran's unique needs so we have peer support specialists who are veterans thems elves who are in recovery and they're using their lived experiences as well as training that they have received in the VA to support other veterans. So they conduct those social needs assessment. They talked to veterans about various in different types of needs that they may have, ranging from housing needs to food insecurity, to social isolation. And the goal of it is to capture veterans who may need additional support before they reach a point of crisis. So as I come to the clinic to receive mental health services, we are conducting those assessments and the peers are able to navigate veterans to different resources both within the VA and we know that the VA has a vast array of different type of social support and resources. But we're also going beyond the VA to each other community organizations to point veterans. Louise horses that may be able to assist them and this has been a great opportunity to get a better understanding of veterans social context at the different needs that they have. And of course the impact of COVID-19 are we started this program right at the beginning of the pandemic and we got an understanding of how the pandemic has affected really every aspects of veterans lives and appears that we are working with have been fantastic. They have been what some of the veterans. Called a lifeline for them by being there to support them and really talk to them about one that it's OK to ask for help to open up and share with providers that they do have needs and how these needs might be related to their health and to their mental health. And also get the support that they need. So this is just one example of different programs at the VA is currently supporting to not only add access but also address the various social needs that veterans may have in an effort to better support. Their mental well being. Thank you so much so these initiatives are so incredibly important. I am wondering though, are there things that veterans and their family members can do themselves to get help addressing social determinants that may be impacting their health? They of course the different things that veterans can do and one of the things that we encourage veterans doing partner image is to speak up is to open up to their providers their cognitions to have better communication to talk to the clinicians. About what is going on in their lives, what are their needs so that the clinicians can know and be able to support them, help them, or point them to the right direction so we do encourage veterans to communicate their needs and be vocal about it, but also to be informed about how social determinants of health can affect their well being and how they can better be active in their care and maintain a healthy lifestyle and also gets support not just to intervene. When they need mental health or health interventions but also to maintain and promote good quality of life. So these are some examples and I'm sure that Allison Lauren can add to that. I totally agree with everything you were saying and I would say that in addition to you know, really looking to your health care provider and you're in your local VA as very much a source of support and information and whether that be your primary care provider or your mental health team. Or you know getting connected with the social worker or any of the other. Number of resources available at the VA to certainly veterans and their families. Certainly you know can and should feel comfortable availing themselves of those resources because they're there to help. And you know, I would also say that there's a number of resources available in the Community, so United Way 211 is a phone number that people can always call. There's also you can go to 211.org, which is a website, and they can often provide information on specific resources in the area. Veteran service organizations can. Also be a wonderful source of both specific resources and support and information about what may be available in the community and finding your State Office of Veterans Affairs. They may also have both veterans specific resources and also more general resources that that can be a benefit to veterans and can help you try to connect with

some of those resources so you know I would say depending on you know some people really like talking to somebody by phone. Some people would prefer to meet in person, some people would prefer to, you know, be able to just kind of find the information. On their own in the Internet. So I think the good news is that regardless of the ways in which you would like to engage and get this information, there is typically a lot of information and resources available both at the Community level and and through your local VA. Yeah, I think both of you outlined a lot of different ways in which veterans can get, you know, connected to resources both within the VA and the Community, and I think just in terms of, you know, going to joann's point about, you know hopefully better understanding the impacts that you know social determinants of our social needs can have on. You know your health. It's it's really helpful to both. You know, understand that you know. Hopefully, this podcast is shed some light on it, but additionally, you know, I think that the office of HealthEquity is trying to increase awareness about social determinants of health through resources that they are including on. You know their website that are accessible to veterans and their family members. So the general public has access to those and I think as we increase our partnerships, hopefully with various Community resources across the VA, you know we'll be able to. Hopefully, you know. Better connect veterans. Sort of warm handoffs from the VA to those community partners and then just one additional resource that I just wanted to mention that's specifically for veterans and their family members. That's still certainly, you know, continuing to add resources to it, but might be complementary. Or, you know, a nice addition to the resources that Joanne and Alicia mentioned is also the National resource directory, since that's specifically for veterans and service members and their families, and on there you can search. You know where you live and different resources that might meet various needs that you might be experiencing or have. And so that's an additional resource that could be useful. I want to especially thank our speakers for joining us today and sharing all of these resources and the important work that they're doing to help empower veterans to be the healthiest versions of themselves. I want to thank our audience for joining us, and I hope that you all will join our next episode. Thanks so much.