VA | U.S. Department of Veterans Affairs

Assessing Circumstances and Offering Resources for Needs (ACORN)

Implementation Toolkit

JUNE 2024

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Assessing Circumstances and Offering Resources for Needs (ACORN) Implementation Toolkit

ACORN is a standardized approach to addressing social risks and social needs among Veterans receiving care in the VHA. To enhance existing screening processes and interventions for social risk factors, ACORN consists of a standardized social risk screening tool and planned provision of resources and referrals to address identified needs.

ACORN is a national Veterans Health Administration (VHA) quality improvement initiative conducted in partnership with the VISN 1-based ACORN team, Office of Health Equity, and the National Social Work Program within Care Management and Social Work Services.

ACORN Implementation Efforts

In 2018, the ACORN Advisory Board, an interprofessional team of clinical leaders, staff physicians, social workers, mental health providers, informaticists, researchers, and other subject matter experts in the VA New England Healthcare System (VISN 1), developed the original ACORN screening tool and resource guides.[1] Partnerships with the Office of Health Equity began in 2019 and with the National Social Work Program in 2021. ACORN has since been implemented in a variety of clinical settings, including Primary Care, Women's Health, Patient-Aligned Care Teams (PACT), Mental Health, Geriatrics, Whole Health, and a range of specialty clinics, as well as in emergency departments and inpatient settings.[2]

For more information on the ACORN initiative and implementation standards, contact the ACORN Leadership Team at VHAACORN@va.gov.

Toolkit Overview

The ACORN Leadership Team created the **ACORN Implementation Toolkit** based on best practices, lessons learned, and staff feedback to serve as a resource to successfully integrate the ACORN model into diverse clinical settings.

Due to the varying resources and capacities of VA medical centers and clinical settings across VHA, the ACORN Leadership Team encourage sites to adapt this guidance as needed to create implementation plans best suited for the capacities, staff workloads, and resource availability within their clinical settings.

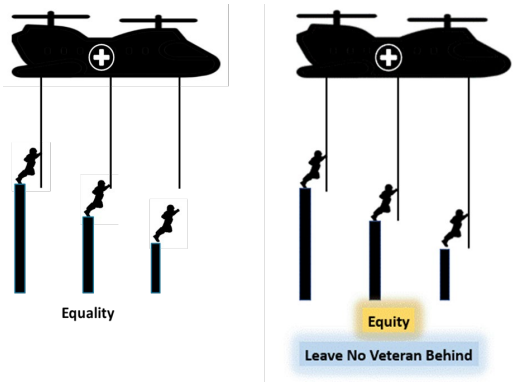
Note: *This toolkit has been adapted for an external audience. Links to internal VHA websites have been removed.*

KEY TERMINOLOGY

Before implementing an initiative like ACORN, it can be helpful to orient staff and partners to the terms often used when describing ACORN or similar social needs interventions.

Equality is when everyone receives the same number and types of resources, support, and treatment irrespective of unique differences between individuals.[3]

Equity considers individual differences to provide each person with the types of resources, support, and treatment they need so everyone has an opportunity to achieve optimal health.[3] *Equity places an emphasis on reaching out to those in need, so no one is left behind.*



Graphic credit: Ernest Moy, Office of Health Equity.[3]

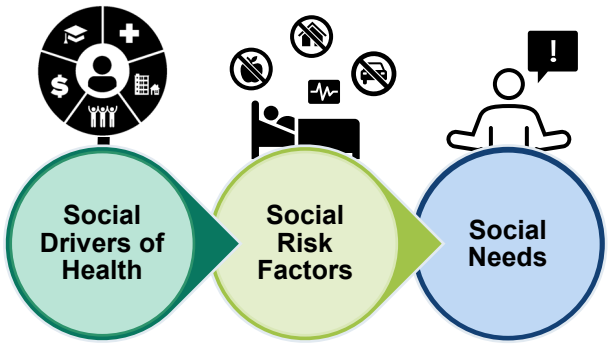
Health equity means getting people what they need to attain their highest level of health.[4]
To achieve health equity, everyone must be valued equally and societal efforts prioritized to address avoidable inequalities, historical and on-going practices and injustices, and the elimination of inequities in access to and the provision of healthcare.

Health disparities adversely impact groups or populations that systematically experience greater social and/or economic obstacles, which have made it difficult for them to access the resources and services associated with optimal health and well-being.[4]

Social drivers/determinants of health (SDOH) are the "conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life."[5] Adverse SDOH can lead to health inequities and hinder advancements in population health.[5,6,7]

The Importance of Language

VA embraces the use of "social drivers of health" in place of "social determinants of health." While the term *determinants* may imply a sense of finality about one's own health, the term *drivers* seeks to empower patients. This intentional reframing better conveys the message that people and communities have the agency to overcome or change the social factors influencing their health and well-being.[8,9,10]



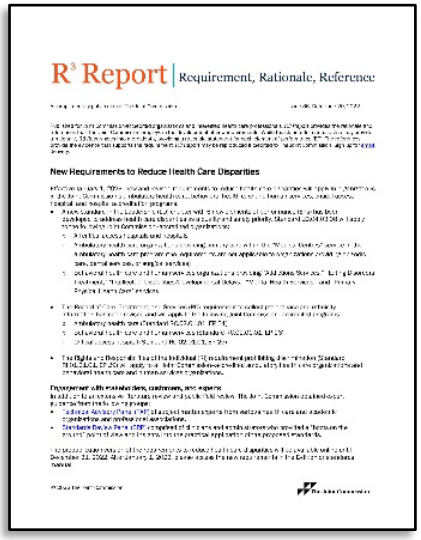
SDOH Circle Graphic Credit: Healthy People 2023.[12]

Social risk factors are defined as specific, individual-level adverse social conditions associated with poor health, such as food insecurity or housing instability.[7]

Social needs are a patient-centered concept that incorporates a person's perceptions of and priorities related to their own health-related needs.[7,11]

SOCIAL RISK SCREENING AS A STANDARD OF CARE

Health systems have increasingly recognized the critical importance of integrating social care into the provision of medical care. In 2023, The Joint Commission[13,14] and the Centers for Medicare and Medicaid Services[15,16] (CMS) established standards that task healthcare organizations with implementing activities to improve health equity, including collecting data on SDOH (or social risk factors) and addressing identified social needs.

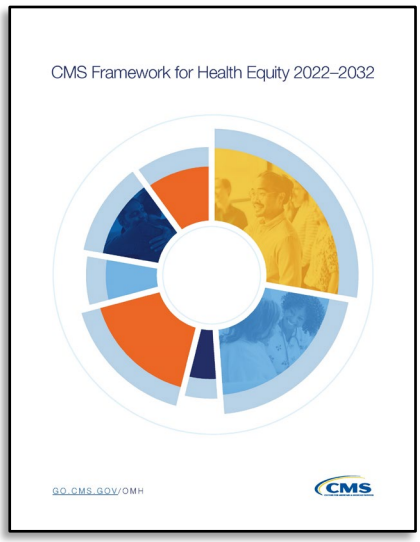

R³ Report | Requirement, Rationale, Reference

New Requirements to Reduce Health Care Disparities

The Joint Commission named the reduction of healthcare disparities and improvement of healthcare equity as quality and safety priorities in the form of *Leadership (LD) Standard LD.04.03.08* and *National Patient Safety Goal (NPSG) Standard NPSG.16.01.01*.[13,14]

Leadership Standard, Element of Performance 2:

The organization assesses the patients' health-related social needs and provides information about community resources and support services.[13,14]



CMS released the CMS Framework for Health Equity to reiterate a concentrated and on-going effort to "address avoidable inequalities and eliminate health and healthcare disparities" is a central tenet to ensure all people can attain their highest level of health.[15,16]

CMS Equity Standards:

Attest that your hospital engages in:

- Data collection of patient demographics and SDOH
- Training of staff in culturally sensitive data collection
- Inputs demographic and SDOH data into EHR[15,16]

For more information on the resources, tools, and services available in VHA to meet The Joint Commission standards: Addressing Veteran Health-Related Social Needs: How Joint Commission Standards Accelerated Integration and Expansion of Tools and Services in the Veterans Health Administration.

Assessing Circumstances and Offering Resources for Needs (ACORN)

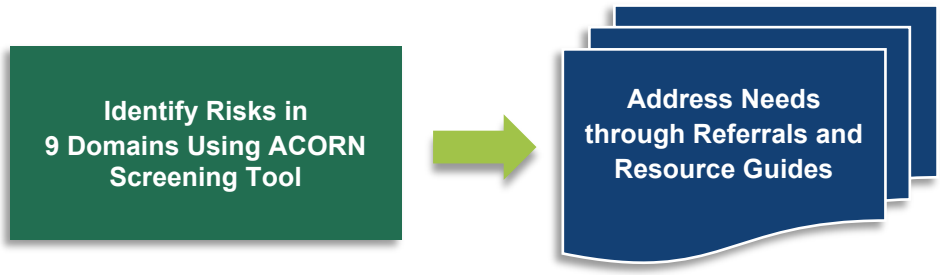
ACORN's mission is to systematically identify and address unmet social needs among all Veterans to improve health and advance health equity.

A long-time leader in the integration of medical care and social care,[17,18] VHA is well-positioned to identify and address social risks and social needs among Veterans. Over the past decade, VHA implemented screening for housing instability,[19] food insecurity,[20] and intimate partner violence[21] but lacked a systematic screening process to broadly identify social needs.

To address this gap in the service delivery system, ACORN aims to: 1) systematically screen Veterans for social needs in several social risk domains; 2) provide clinical teams real-time information about Veterans' unmet social needs; and 3) address identified social needs by offering resource guides, support navigating resources, and/or referrals to social work, mental health, or other relevant VHA and community services.

The ACORN Model

ACORN consists of two core components: a standardized screening tool to identify nine social risks at the point of care, and the provision of relevant resources and referrals to help address Veterans' identified social needs.



ACORN Screening Tool

The ACORN screening tool was informed by existing social needs screening tools used in other healthcare settings.[22-27] It includes Veteran-tailored items developed by the ACORN Leadership Team as well as VHA's existing clinical reminders for food insecurity and housing instability.

ACORN screens across nine social risk domains: food, housing, utilities, transportation, education, employment, legal, social isolation/ loneliness, and digital needs (device/internet access and digital health literacy).

There are currently two main mechanisms for delivering ACORN: staff-administered screening via the VA's electronic record system (Computerized Patient Record System (CPRS)) and paper screening.

ACORN Screening Tool Questions

The following shows the ACORN screening tool with responses highlighted in green to indicate which responses demonstrate a "positive" unmet need. For an ACORN screening tool overview, refer to Step 4. The ACORN National CPRS Template.

(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?[1]

a. Yes – Living in stable housing

- (1.1) 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?[1]

i. Yes – worried about housing near future

- (1.2) Where have you lived for MOST of the past two months?[1]

a. Apartment/House/Room (no government subsidy)
b. Apartment/House/Room (with government subsidy)
c. With Friend/Family
d. Motel/Hotel
e. Short-term Institution like Hospital, Rehab Center, Drug Treatment Center
f. Homeless Shelter
g. Anywhere outside (e.g. Street, Vehicle, Abandoned Building)
h. Other

ii. No – Not worried about housing near future

b. No – Not living in stable housing

- Collect answer for the question "Where have you lived for MOST of the past two months?" [1]

➢ If respondent endorses either "not living in stable housing" OR "worried about housing near future" for (1):
(1.3) Are you currently without a place to stay?

a. Yes b. No

(2) I'm going to read you two statements that people have made about their food situation. For each statement, please tell me whether the statement was often true, sometimes true, or never true for your household in the last 12 months.

(2.1) Within the past 12 months, you worried whether your food would run out before you got money to buy more.[2]

a. Often true b. Sometimes true c. Never true

(2.2) Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.[2]

a. Often true b. Sometimes true c. Never true

➢ If respondent endorses "often true" or "sometimes true" for either "food would run out" (2.1) OR "food didn't last" (2.2):
(2.3) Do you need help getting food for this week?

a. Yes b. No

(3) How often do you have trouble paying for your utilities (e.g., electric, gas, oil, water, or phone)?[3]

a. Often b. Sometimes c. Never d. Not applicable/I don't pay for utilities

➢ If respondent endorses "often"or "sometimes" for (3):
(3.1) Has the electric, gas, oil, water or phone company threatened to shut off services in your home?[4]

a. Yes b. No c. Already shut off d. Not applicable/I don't pay for utilities

(4) How often has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?[5]

a. Often b. Sometimes c. Never

(Continued)

➢ If respondent endorses “often”or “sometimes” for (4):
(4.1) Do you need assistance with transportation for an upcoming appointment?
a. Yes b. No

(5) Do you currently have any legal matters you need help with (e.g., child support or custody, divorce, debt or credit problems, or need for a discharge upgrade)?
a. Yes b. No

(6) How often do you feel lonely or isolated from those around you?[6]
a. Often b. Sometimes c. Never

(7) Do you want help finding or keeping work or a job?[7]
a. Yes, help finding work b. Yes, help keeping work c. No, I don’t want help finding or keeping work

(8) Do you want more information about educational benefits and resources for Veterans?
a. Yes b. No

(9) Do you have access to any of the following devices? (Please select all that apply.)
- ☐ Landline
- ☐ Simple cell phone (flip phone)
- ☐ Smartphone (a cell phone with a touchscreen and internet)
- ☐ Computer (laptop, desktop, or tablet such as an iPad)
- ☐ None

(10) Do you have access to affordable and reliable internet where you live?
a. Yes b. No c. Not applicable/I don’t want internet access

(11) Would you like help learning to use a smartphone, tablet, or computer to access VA healthcare online (e.g., video visits, medical record, secure messaging)?
a. Yes b. No c. Not applicable/I don’t have any of these devices

When derived from the Centers for Medicare and Medicaid Services (CMS) Accountable Health Communities (AHC) Screener, the original source is cited per AHC guidance. Questions without citations were developed by the VHA ACORN team and collaborators across multiple VHA offices and sites.

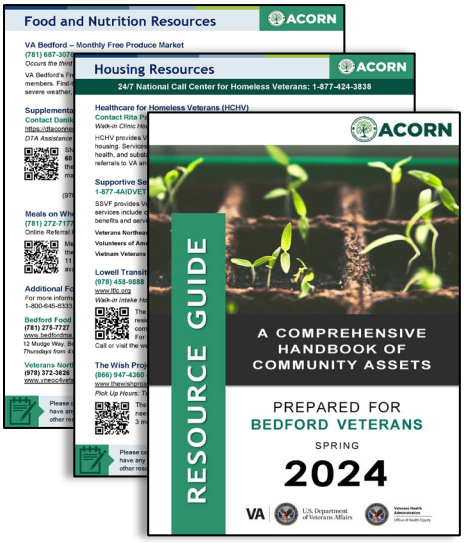
1. VA National Center on Homelessness Among Veterans. “Homeless Screener.” U.S. Department of Veterans Affairs, September 2020. https://www.va.gov/HOMELESS/nchav/resources/prevention/homeless-screener.asp
2. Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Cook, J. T., Ettinger de Cuba, S. E., Casey, P. H., Chilton, M., Cutts, D. B., Meyers A. F., Frank, D. A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics, 126(1), 26-32. doi:10.1542/ peds.2009-3146.
3. Adapted with permission from Page-Reeves J, Kaufman W, Bleecker M, Norris J, McCalmont K, Ianakieva V, Ianakieva D, Kaufman A. Addressing Social Determinants of Health in a Clinic Setting: The WellRx Pilot in Albuquerque, New Mexico. J Am Board Fam Med. 2016 May-Jun;29(3):414-8. doi: 10.3122/jabfm.2016.03.150272. PMID: 27170801.
4. Adapted with permission from Cook, J. T., Frank, D. A., Casey, P. H., Rose-Jacobs, R., Black, M. M., Chilton, M., . . . Cutts, D. B. (2008). A Brief Indicator of Household Energy Security: Associations with Food Security, Child Health, and Child Development in US Infants and Toddlers. Pediatrics, 122(4), 867-875. doi:10.1542/peds.2008-0286.
5. Adapted with permission from the national PRAPARE® social determinants of health protocol developed by the National Association of Community Health Centers, the Association of Asian Pacific Community Health Organizations, and the Oregon Primary Care Organization and their development partners. www.nachc.org/prapare. ©National Association of Community Health Centers. All Rights Reserved.
6. Adapted with permission from Anderson, G. Oscar and Colette E. Thayer. Loneliness and Social Connections: A National Survey of Adults 45 and Older. Washington, DC: AARP Research, September 2018. https://doi.org/10.26419/res.00246.001
7. Identifying and Recommending Screening Questions for the Accountable Health Communities Model (2016, July) Technical Expert Panel discussion conducted at the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Baltimore, MD.

Resources and Referrals

Veterans who express needs are offered: 1) referrals for further assessment and intervention to VHA services, including social work, nutrition/dietitian, and mental health among others; 2) support navigating VA and community resources; and/or 3) geographically tailored resource guides. The resources and referrals offered are tailored to Veteran's needs and preferences, with each site building local workflows to ensure that appropriate supports are provided to address endorsed social needs.

Resource Guides

ACORN resource guides are concise, high yield lists of resources for each social risk domain that can be offered to Veterans who screen positive for needs.

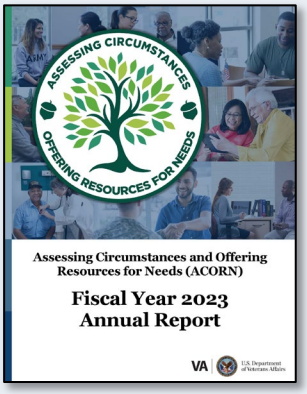


Resource guides can be used alone or provided in combination with other services, resources, and referrals. Veterans may benefit from care coordination or assistance from a social worker, Peer Specialists, or other care team member to navigate VA programs or community resources. This should be considered when determining when and how to use resource guides.

They can also serve as a stand-alone tool in cases where Veterans may not be interested in or comfortable accepting assistance at the time of screening or may prefer to research and navigate resources on their own.

For more information on guidance and expectations for creating ACORN resource guides, review the Building Resource Guides Manual.

ADDITIONAL ACORN RESOURCES



For a more detailed timeline on the history and initial piloting of ACORN:

- Assessing Circumstances and Offering Resources for Needs (ACORN) - Fiscal Year 2023 Annual Report
- Implementing a Social Needs Screening and Referral Program Among Veterans: Assessing Circumstances & Offering Resources for Needs (ACORN)
- Adaptation of a Social Risk Screening and Referral Initiative Across Clinical Populations, Settings, and Contexts in the Department of Veterans Affairs Health System

ACORN Community of Practice

The ACORN Community of Practice is a collaborative approach to support dissemination of ACORN throughout VHA sites and clinical settings.

Goals of this Community of Practice are to:

- Share knowledge and experiences across ACORN sites
- Engage new Partner Sites in ACORN implementation
- Support sustainment of ACORN implementation at existing sites over time
- Provide technical assistance as needed

What is a Community of Practice?

"A group of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise by interacting on an ongoing basis."[28]

Community of Practice Calls

The ACORN Community of Practice offers two primary monthly calls, one for all ACORN Partner Sites and one dedicated for new ACORN sites. Site Champions or designee(s) of new ACORN sites are strongly encouraged to attend both meetings, as they will focus on different aspects of ACORN implementation and sustainment.

Note: all ACORN Community of Practice calls are internal for VHA facilities.

ACORN Basics. An introductory overview of ACORN for interested sites that have not yet started pre-implementation planning.

New Sites Calls. Provides start-up support, assistance with workflow development and refinement, and technical assistance to successfully begin integrating ACORN into clinical settings. New Partner Sites attend these calls from pre-implementation through early implementation, typically around six months, to receive additional technical assistance and connect with other sites early in the implementation process.

All Sites Calls. Brings together both new and established ACORN sites to share national-level data and program updates, and features partner site spotlights to share lessons learned, challenges, and successes, as well as social risk domain-specific education with subject matter experts from the field and VA Program Offices.

Office Hours. A monthly drop-in call to provide sites with more individualized support for workflow development or technical assistance and troubleshooting.

Implementation Phases

The ACORN Leadership Team developed a set of implementation phases to provide specialized support and action steps for sites as they move through the process:

ACORN IMPLEMENTATION PHASES	
Partner Site Interest	▪ Information gathering stage for sites interested in implementing ACORN ▪ Sites will attend an ACORN Basics call and submit an ACORN Progressive Deployment LEAF request *[internal for VHA facilities]* ▪ Join the internal ACORN Community of Practice and can begin attending the New Sites and All Sites Calls *[internal for VHA facilities]*

Pre-Implementation	▪ Key Features of Pre-Implementation Planning:
	  ▪ Securing staff and Social Work Chief or Executive buy-in
	  ▪ ACORN workflow development
	  ▪ ACORN CPRS template installation and testing
	▪ Pre-Implementation sites will attend both New Sites and All Sites calls

Implementation	*Early Implementation* ▪ First six months of active ACORN implementation at a site ▪ Begin with one clinic or specific population to troubleshoot any initial challenges or barriers that may arise ▪ Early implementation sites continue to attend New Sites and All Sites Calls to receive ongoing implementation support *Implementation* ▪ Transition into this stage following six months of active screening ▪ Start considering expansion opportunities into additional clinical settings ▪ No longer expected to attend New Sites calls, but should continue to attend the All Sites Call indefinitely
Sustainment/ Maintenance	▪ Successful implementation of ACORN for at least one year ▪ Strategic expansion into additional clinical settings encouraged ▪ Sustainment sites continue to receive ongoing support and expansion guidance through All Sites calls, ACORN Office Hours, and site consultation meetings with the ACORN Leadership Team

Preparing for ACORN Implementation in your Clinical Setting

Pre-implementation planning lays the groundwork for smooth integration of ACORN into your clinical setting(s). The following chapters detail each action step of the pre-implementation process and site expectations necessary to create a strategic implementation plan:

- ☐ **Step 1.** Reviewing Site Readiness for Implementation
- ☐ **Step 2.** Engaging Key Partners and Securing ACORN Buy-in
- ☐ **Step 3.** Developing ACORN Workflows
- ☐ **Step 4.** Activating the ACORN National CPRS Template

For an overview of the ACORN pre-implementation process and site expectations, review the **ACORN Getting Started Checklist** in the Appendix.

STEP 1. CONDUCTING A SITE READINESS ASSESSMENT

New ACORN Partner Sites should begin the planning process by reviewing their site's readiness for implementation, including staff bandwidth and capacity, and site resources (e.g., technology resources, resource and referral availability for Veterans screening positive). Gathering this information can help inform identification of clinic priorities and long-term goals with ACORN implementation.

Site readiness to implement ACORN to identify and address Veterans' social needs can be dependent on several factors, such as social work staffing, current clinic workloads, Veteran populations served, leadership and staff commitment, familiarity with existing social needs interventions, and logistical capacities.

Information gathered using the questions below in the ***Site Readiness Assessment Questions for Consideration*** can be used to help develop your implementation plan, including identifying clinic or program areas where screening may be most successful, determining target populations and how ACORN will be used to address health equity, or identify areas where screening is not currently recommended.

ACORN is designed to be used by a variety of clinical (e.g., social workers, nurses) and non-clinical staff (e.g., Peer Specialists, Whole Health partners and coaches, volunteers). As such, **review of your site should be an interprofessional activity;** clinicians, non-clinical and administrative staff, and other allied healthcare professionals interfacing with Veterans can all play a critical role in this site assessment.

Site Readiness Assessment Questions for Consideration

Examine why your team is interested in implementing ACORN at your site.

Clinic Priorities and Long-term Goals

- What are the clinic's goals and priorities with regard to addressing Veterans' social needs, and how can ACORN improve and align with them?
- Is there an identified gap in resource referrals and/or in meeting Veterans' social needs that comprehensive, standardized screening can help address?
- Are you looking to utilize ACORN's tools to identify social needs among specific populations or cohorts of Veterans, and enhance resource referral coordination for these groups?
- How will implementing ACORN at your site reduce health disparities and promote health equity?
- How would you define implementation success for your site?

Familiarity with Social Needs Interventions

- Does your site and/or clinic have prior experience with implementing social needs interventions?
- What were the successes of these prior interventions? Were there any challenges experienced during the implementation process that might be helpful to consider when working to implement ACORN?
- Are there points of contact from those programs who may be an asset to your team?

Veteran Population

- Why does your site want to screen Veterans for unmet social needs?
- What is an appropriate and feasible Veteran population (i.e., target population) to start with for initial implementation?

Clinic Staff Considerations

- Have you obtained support from social workers, including the Social Work Chief or Executive, impacted PACT social workers, and social workers in other clinical settings?
- Which clinical setting will be most appropriate to start with?
- Who are the key staff that will need to be brought in to help support ACORN implementation?
- Is there sufficient clinic bandwidth and capacity for staff to perform assigned ACORN activities?

Site Resources

- What is the resource landscape like for your service area?
- Do you have buy-in from the Social Work Chief or Executive?
- What other resources and programs available at your site may be beneficial to partner with?

Logistics and Flow

- What is your anticipated start date to begin screening Veterans? What support and/or resources are necessary to achieve this goal?
- What trainings are available to educate staff new to social needs interventions on SDOH, social risk factors, social needs, and health equity?

Reference: Kaiser Permanente Center for Health Research and OCHIN – Guide to Implementing Social Risk Screening and Referral-making

ACORN Pre-Implementation Timeline

Pre-implementation timelines are useful tools to document anticipated goals and objectives. Consider important milestones that can aid in successful integration and realistic expectations. For example, it is important to dedicate sufficient time to: 1) garner buy-in from site leadership and clinic staff; 2) develop ACORN workflows; 3) educate staff on the role of SDOH, social risks, and social needs; 4) train staff on the ACORN screening tool and following the site workflow; and

5) build resource guides (if applicable). Site timelines will look unique to each clinical setting based on local priorities and resource capacity (e.g., staff availability, technology constraints).

Thoughtful planning is highly encouraged; **total pre-implementation planning timelines generally last 3-6 months** to ensure sites are properly prepared, though timelines can vary substantially from site to site and based on time allocated for staff and local priorities.

The following timeline includes relevant tasks and timelines ACORN Partner Sites complete throughout the pre-implementation process. Based on aims, objectives, and workflows, some tasks on this timeline can be completed concurrently or may not apply to your clinical setting. This timeline is only offered as a guide and is not intended to be used as required timeframes for completion of each step or of overall pre-implementation.

Routine Pre-Implementation Timeline

ACTION ITEM	TIME DEDICATED
Review informational ACORN resources (ACORN Overview handout, Getting Started Checklist, etc.)	**1 week**
Meet with key partners, including leadership and clinical team members	**1-3 weeks**
Introduce ACORN to staff and educate on the role of SDOH, social risks, and social needs on health outcomes and health equity	**2-4 weeks**
Site Readiness Assessment	**2-4 weeks**
Site Champion attends ACORN Basics call *[internal for VHA facilities]*	**1-4 week**
Submit a "Participation in ACORN Deployment" request	**1-2 weeks**
Complete the ACORN Concurrence Memo *[internal for VHA facilities]*	**1-3 weeks**
Develop initial ACORN workflow	**2-4 weeks**
Submit ACORN Concurrence Memo and workflow	**1 week**
Revise workflow based on feedback from ACORN Leadership Team	**1-3 weeks**
Train staff on ACORN workflow	**2-4 weeks**
Build ACORN Resource Guides **timing can vary depending on whether your site is working off an existing resource lists*	**1-6 months***
Request activation of the ACORN national CPRS template *[internal for VHA facilities]*	**1 week**
Test ACORN national CPRS template with "zztest" patients and submit "zztest" patient to confirm data capture *[internal for VHA facilities]*	**1-2 weeks**
Communicate to leadership and clinic staff of approval to begin screening; provide start date for screening and how staff can share progress or barriers	**1 week**
Total Anticipated Timeline	***3-6 months***

STEP 2. ENGAGING KEY PARTNERS AND SECURING ACORN BUY-IN

An essential step in site preparations is gaining buy-in from site leadership and frontline staff who will help guide implementation efforts. This chapter details the preliminary steps necessary to secure program buy-in as well as guidance on identifying ACORN Site Champion(s).

Identify Key Partners

Given the collaborative nature of ACORN, it is imperative to engage early with healthcare system leadership, including your Social Work Chief or Executive, and frontline clinic and administrative staff who will be supporting implementation.

Take the time to identify partnerships best suited for your clinical setting and develop a plan to educate staff about ACORN. Communicating your goals and processes can help foster a cooperative environment that encourages leadership and staff buy-in, information dissemination, and proactive communication around addressing any barriers to ACORN adoption and sustainment.

The following describes some important individuals to engage during the planning stage:

Executive leadership	VISN leadership, Medical Center Director, Chief of Staff, Nurse Executive
Social Work leadership	Social Work Chief or Social Work Executive
Service-level leadership	Primary Care Chief, Mental Health Chief, Acute Care Chief, Geriatrics and Extended Care Chief **as relevant to your clinical setting*
Clinic leadership	Program coordinators, nurse managers, social work supervisors **those who are directly involved with staff in the clinical setting*
Clinical staff	Social workers, clinicians, nurses, pharmacists, etc.
Non-clinical and administrative staff	Peer Specialists, Whole Health partners and coaches, medical support assistants (MSAs), etc.

VHA staff can be involved in ACORN in a variety of ways, which may vary based on their scope and relationship to the chosen clinical setting for screening. Some partners, such as clinic and service-level leadership, should be actively engaged throughout the pre-implementation process. Others may act as consultants or program supports, such as through joining Community of Practice meetings or advocating on behalf of the clinic for further expansion efforts.

Social Work Chief or Executive Buy-in

New ACORN sites must start by connecting with their Social Work Chief or Executive to discuss feasibility of ACORN implementation and expansion to confirm sufficient social work staffing to provide screening follow-up.

To address identified social needs, site workflows should identify where Veterans who screen positive on ACORN are referred. Social Work Chiefs or Executives will have the knowledge on local bandwidth and whether social workers at your site are able to take on additional referrals that may come from ACORN screening. Social Work Chiefs or Executives also can provide expertise during workflow development to ensure Veterans will receive adequate follow up on identified needs.

➢ *ACORN IN LEAF: PRE-WORK*

- ***Note: Approval from the Social Work Chief or Executive is <u>required</u> prior to implementing ACORN.***

Frontline Clinic Staff Buy-in

<u>Engage with your care team early.</u> Work with your social work and nursing colleagues and other clinical and administrative staff who will be part of ACORN implementation. Implementation success happens when staff are aware of and passionate about screening for social risks and social needs that may impact Veterans' overall health and well-being.

> ***VA Social Workers.*** The mission of VA social work is to assist Veterans, their families, and caregivers, and survivors in resolving SDOH challenges to health and well-being. Social work is woven into the fabric of VA health care, providing clinical interventions, and services across the VA continuum of care. Social workers are crucial in ensuring Veterans with acute or complex needs can access and receive the immediate care and support needed to address them.
>
> ***Other Clinicians, Non-Clinicians, and Administrative Staff.*** While varying based on the setting where ACORN will be utilized, these partners can include other clinicians, nurses, Peer Specialists, Whole Health partners and coaches, and MSAs, among others.

Additionally, for sites planning to use resource guides as part of their workflows, identify a staff member or team who will take charge of building and maintaining the resource guides. To determine who may be best suited for this role, refer to the Step 3: Developing an ACORN Workflow chapter to review guidance and expectations for creating ACORN resource guides.

Identify ACORN Site Champion(s)

ACORN Site Champions are dedicated staff who will lead identification of clinic goals, support development of workflows, orient team members to ACORN, and provide feedback to key partners throughout the process. Site Champions can be staff from a variety of roles/disciplines,

including clinic and service-level leaders. Depending on the clinical setting, it may be helpful to identify more than one Site Champion. *A Social Work Co-Champion must be identified if the primary Site Champion is not a social worker.*

Characteristics and Roles of an ACORN Site Champion(s)

- Demonstrates strong enthusiasm in using ACORN to proactively identify areas of need to improve Veterans' health and well-being
- Has dedicated time to oversee all ACORN pre-implementation activities and implementation efforts
- Develops and adapts ACORN workflows throughout the implementation process
- Orients and trains staff on the ACORN screening tool and site's workflow
- Encourages staff throughout screening and referral efforts, and troubleshoots any potential barriers to implementation
- Attends the ACORN Community of Practice New Sites and All Sites Calls (Site Champions will attend the New Sites call for first six months of implementation and the All Sites call indefinitely)
- Oversees and/or provides implementation expertise on expansion efforts to other clinical settings within the site
- Reviews implementation progress toward program goals with key partners, including staff and clinic leadership, to show the impact of their work

Once identified, ACORN Site Champions will attend an ACORN Basics call to learn more about ACORN and discuss implementation logistics *[internal for VHA facilities].*

- Recommended attendees include: Social Work Chief or Executive, ACORN Site Champion(s), and core staff who will be involved in implementation (e.g., social workers, nurses, Peer Specialists, Whole Health partners and coaches).

➢ *ACORN IN LEAF: PART ONE [internal for VHA facilities]*

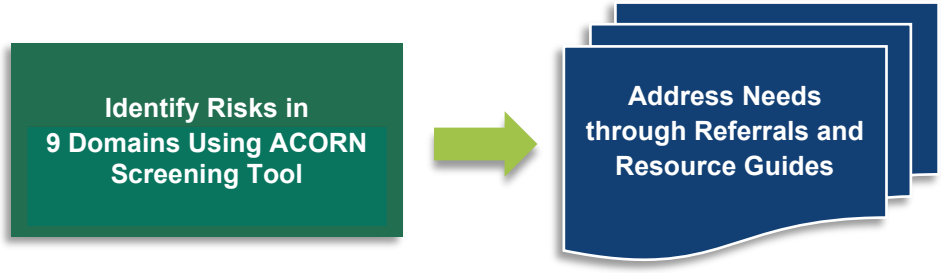
VHA sites interested in implementing ACORN will use the internal ACORN LEAF Site to submit requests and track all steps of their pre-implementation process.

After attending the ACORN Basics call, ACORN Site Champions should complete, in order, the following LEAF steps to formally declare interest in becoming an ACORN Partner Site.

- **Submit a "Participation in ACORN Deployment" request on the ACORN LEAF Site**. This form should identify your ACORN Site Champion(s), target clinical settings, and anticipated implementation timelines.
  - **Title of LEAF request:** "VISN Number Station Number ACORN Request" (e.g., VISN 00 Station 000 ACORN Request)
- **Complete the ACORN Concurrence Memo** with your Social Work Chief or Executive as initiator. Signatures for the memo include the Social Work Chief or Executive, Medical Center Director, and VISN Director. All signatures are required ***before*** submission to the ACORN Leadership Team.
  - Once signatures have been obtained, the ACORN Leadership Team will return the completed memo to your Site Champion(s) and Social Work Chief or Executive.
  - Sites are required to upload the fully signed ACORN Concurrence Memo, including signatures from National Social Work Program and Office of Health Equity leadership, in part two of the LEAF process (workflow submission).
- **Join the ACORN Community of Practice Teams Channel** as a New ACORN Partner Site.

STEP 3. DEVELOPING AN ACORN WORKFLOW

Once your site has secured site leadership and staff buy-in, your team will create strategic plans, or workflows, to implement ACORN into your clinical setting(s). Workflows should detail the process steps for both screening and addressing identified needs, as well as identify who is responsible for each step.



This chapter will take you through the key steps to developing an ACORN workflow. This includes guidance on building out a practicable screening and referrals process, tips on designing a visual workflow, and how to introduce ACORN to your colleagues and engage staff in discussions about the initiative's utilization within your VA medical center. All teams should have a collaborative discussion to create workflows that meet the unique needs of your team and clinical setting(s).

What is a Workflow?

A workflow is a set of processes that standardizes and streamlines the delivery of care or a clinical outcome. For ACORN, the workflow represents the process of social risk screening and the provision of resources and referrals for Veterans in your clinical setting. By building your ACORN workflow, your team is creating the roadmap for social risk screening and referral at your site.

Workflows provide an important visual representation of your process to ensure that everyone involved is aligned in the systematic approach.

Workflows are also a discussion and refinement tool that should be revisited when onboarding new team members, expanding to new roles, or feel that the process may need to be updated throughout the implementation process.

Think of the workflow as a living document that should be updated and refined as your team encounters challenges or changes during ACORN implementation.

Pre-Work: Assembling a Workflow Group

Similar to the Site Readiness Assessment, your team should develop workflows collaboratively with all staff who will be involved in or impacted by ACORN implementation to support engagement and ensure alignment with existing clinical workflows.

You may also choose to include other clinic staff or subject matter experts to support the process:

> ***Leadership (e.g., program coordinators, nurse managers, social work supervisors)*** who have direct involvement with staff in the clinical setting should be included to review

finalized workflows or in a consultative manner, if there are questions related to staff duties or roles. Involving leadership can ensure that screening is a priority and help team members feel supported in this endeavor.

ACORN Site Champion(s) can also be crucial members in supporting the team through workflow development. ACORN Site Champion(s) can have an active role in developing the granular details of the workflow or may serve as a guide/mentor.

The depth of their role may vary based on the team members' experience and comfort level with developing workflows or the ACORN Site Champion's relationship to the clinical care setting where screening will be administered.

Developing your ACORN Workflow

Time spent developing your workflow and focusing on the details for decision points will support implementation by providing visibility of screening, follow-up, and staff roles.

Referring to your Site Readiness Assessment can also help in developing your workflow.

Key Workflow Steps

Choosing your screening population. After identifying the clinical setting(s) where screening will occur and forming your workflow group, you will identify which Veterans will be screened.

Many sites find it helpful to start small with a single population to identify, assess, and resolve any initial challenges or barriers associated with implementation (e.g., number of referrals to other clinical services, staffing bandwidth and capacity, resource guide/list development).

Introducing SDOH Concepts to Staff

For some staff, the role of SDOH and social needs interventions to address social risks may be a new concept.

As you assemble your workflow group, be sure to introduce ACORN to staff and educate on the role of SDOH, social risks, and social needs on health outcomes and health equity.

The Key Terminology handout on page 8 can be a helpful starting point.

Additional Trainings

The Office of Patient Centered Care and Cultural Transformation offers a number of trainings related to both Whole Health and SDOH on the Whole Health webpage.

Determining who will be screened may be based upon various factors and there is no "right" or "wrong" choice. You may choose a population-based approach, identifying a subset of Veterans who may be more high-risk for particular conditions. Or you may decide to screen new admissions to an inpatient setting, outpatient clinic, or program.

Consider as a team the ability and ease at which this group will be identified for screening. For example, if choosing to screen Veterans with a specific risk factor, how simple is it to gather this information to identify which Veteran should be screened? In thinking through this part of the process, it may be helpful to make a list with direct links depicting where this information will be found and who will be responsible for this task. A list could include appointment lists, dashboards, or other tools. Even if you feel that current staff know where to find this information, detailing this

information in the workflow will support sustainment in the process.

Frequency of screening. Screening criteria should also include the frequency with which Veterans will be screened. The ACORN Leadership Team recommends screening at least annually or more often, as clinically appropriate. Screening frequency may vary by population and clinical setting; local sites can use their discretion to decide what frequency makes the most sense for their patient population(s).

Keep in mind, the more complex and complicated it becomes to identify which Veterans will be screened and frequency, the more likely it is to experience barriers.

Specifying how screening will be completed. A key component of effective implementation is ensuring that staff members involved know their role and the roles of others.[29] When using ACORN, your workflow should determine who will administer the screening tool (i.e., staff-administered vs. Veteran self-administered) and who will review and follow up on positive screens.

Positive vs. Negative Screens

A **positive** screen means a Veteran has identified one or more unmet social need on the ACORN screening tool.

A **negative** screen means a Veteran does not report any unmet social needs.

Determining staff roles may be discussed in combination with the method in which screening will occur. Will a staff member ask the Veteran screening questions during the visit? Will paper screens be provided to the Veteran for self-screening? Your decision may be a combination of both, depending on your chosen population or clinical setting.

Regardless of whether the screen will be administered by staff or completed by the Veteran independently, identification of specific staff involved in this part of the process is crucial to supporting team members.

If the ACORN screening tool will be Veteran self-administered, you will want to identify:

- Which staff member will provide the Veteran with the screening tool and when?
- What will the Veteran do with a completed screening tool and how will it get to the staff member for review and follow-up?
- Which staff member is responsible for reviewing the responses and entering the completed screening tool into CPRS (including when responses will be reviewed and entered into CPRS)?

Reviewing screening responses and completing an assessment with the Veteran related to the needs identified guides appropriate follow-up. This is a vital part of addressing social needs. For Veterans who screen negative, the responses can be entered into CPRS with no necessary follow-up. Veterans who screen positive for one or more unmet social needs should have an assessment and be provided referrals or resources to help address their needs.

Addressing positive screens. Workflows should clearly indicate which staff members will

address identified needs when a Veteran screens positive on the ACORN screening tool, as well as the timeframe for follow-up (based on local policies or guidelines).

Identification of this staff member may be dependent upon who performs the screen, existing workflows in your clinical setting for addressing social needs, availability of staff, or other factors. Positive screens can be addressed by the staff administering ACORN or can be a different staff member. When identifying the staff who will follow up on positive screens, also consider how this staff member will be alerted (e.g., in-person warm hand-off, referral or consult, scheduled appointment, Teams message, email).

Note: Veterans may screen positive for urgent needs in ACORN. Veterans identifying urgent needs can be provided a warm hand-off to a social worker for same day assessment and assistance.

The following are the three responses on the ACORN screening tool that constitute an urgent need:

- Are you currently without a place to stay?
  - ☐ Yes
  - ☐ No
- Do you need help getting food for this week?
  - ☐ Yes
  - ☐ No
- Has the electric, gas, oil, water, or phone company threatened to shut off services in your home?
  - ☐ Yes
  - ☐ No
  - ☐ Already shut off
  - ☐ Not applicable/I don't pay for utilities

Social workers play a key role in addressing social risks and social needs on a routine basis. **Veterans may be referred to a social worker for assessment of positive needs,** especially if they screen positive in several domains, receive VA and/or community resources but still report having unmet needs, have complex needs, or express concerns about difficulty navigating resources independently.

There are a variety of ways to address identified needs, which may include referrals to VA programs or services, care coordination, or linkage with community resources. Assessment is a key component of this process to help identify the Veteran's current resources, strengths, and needs in order to individualize the intervention plan that will work best for them. Understanding the full picture reduces the risk of providing resources that are not accessible, not relevant to the

Veteran's interest, or not meeting the Veteran's needs.

Veterans who screen positive on the ACORN screening tool may also decline assistance. When planning your workflow, ensure there is an avenue for Veterans to reach out should they later decide they would like assistance or their situation changes. Veterans should be provided with contact information for a VA staff member or clinic to contact in the future. Veterans who decline assistance can also be provided resource guides so they have information should they be interested in resources in the future.

BUILDING ACORN RESOURCE GUIDES


REFERENCE MANUAL:
Building ACORN Resource Guides
BACKGROUND
The ACORN Initiative
ACORN RESOURCE GUIDES

Resource guides can serve as an effective tool to support Veterans in identifying, connecting with, and receiving assistance from VA and community services. Developing and maintaining high-quality resource guides requires both an up-front and long-term investment from your ACORN implementation team and partners.

The following highlights the core components and considerations for resource guide development. For more comprehensive guidance on building resource guides and formatting recommendations, review the Building ACORN Resource Guides Manual.

Developing an Action Plan

Teams using resource guides as part of their ACORN workflow should begin by developing a plan of action that includes consideration of the site catchment area, staff capacity, and whether existing resource materials are already available at your site.

Building Partnerships

Active collaboration with VHA clinical social workers, non-clinical staff, and community program contacts is important to create effective guides.

Compiling Quality Resources

Resource guides are intended to be applicable to a broad range of Veterans expressing one or more social needs.

Maintenance of Guides

Resource guides should be updated approximately every **six months** to reflect any changes in program and service information, such as points of contact, hours, location, virtual services, and eligibility requirements.

Formatting Considerations

There are key elements that should be included on each guide and in the program descriptions (e.g., point of contact, phone number). Additionally, visual consistency across ACORN resource guides is a key feature to maximize space and enhance usability.

Additionally, the **ACORN Social Risk Domains Resource List** (in Appendix) provides an overview of national-level resources available to most VAMCs for each social risk domain included on the ACORN screening tool. While not exhaustive, this list can serve as a starting point to identify relevant resources and referrals for Veterans with identified needs, both in VA and the community or nationally.

Follow-Up to Referrals and Resources Provided. Determine if the Veteran will receive additional follow-up from VA staff after a referral or resource is provided. Veterans with referrals to internal VHA programs should receive an outreach from that service or program area to schedule an appointment or discuss their needs.

Also consider whether there is the ability or desire to follow-up with Veterans who are provided resources or referrals to identify if they were able to access resources or referrals and if it addressed their identified need(s). This is also an opportunity to identify any barriers the Veteran may have had in receiving requested services and provide support in navigating referrals.

KEY ACORN WORKFLOW STEPS	

Which Veterans will be screened?	**Recommendation:** Many sites find it helpful to start small with a single clinic and population for screening to work through any initial challenges or barriers that may arise in the screening and/or referral process.
	▪ Identify a Veteran population to screen. Some considerations:
	  ▪ Newly accessing VA care? Already established with VA care?
	  ▪ With specific risk factors?
	  ▪ Attending certain groups?
	  ▪ Annual visit?
	▪ How will staff identify Veterans to be screened (e.g., referrals to social work, Primary Care Equity Dashboard (PCED), team huddles, chart review, visit check-in)?

When will they be screened?	**Recommendation:** Frequency of screening should be at least annually or more often as clinically appropriate.
	▪ When will screening work best given current clinic workflows? Some possibilities include:
	  ▪ During intake?
	  ▪ Before visits or during visits?
	  ▪ As part of follow-up visits or follow-up phone calls?

Who will conduct the screening?	**Recommendation:** Screening can be conducted by staff, or Veterans can self-administer the screen.
	▪ If staff-administered, who will ask the questions?
	  ▪ Providers and/or other clinical staff?
	  ▪ Non-clinical staff (e.g., MSA, Peer Specialist, Whole Health Partner or Coach, volunteer)?
	▪ If self-administered by Veterans, who will give them the screening tool and instructions to complete it?

- If completed on paper, when and by whom will paper screens be entered into CPRS? Who will review the screen to determine appropriate follow-up?

How will they be screened?

All completed screens must be entered into CPRS.

Recommendation: Screening can be conducted on ACORN paper screens or directly in the CPRS template. Paper ACORN screens should be entered into CPRS per local documentation policy timelines.

- During what types of visits will screening occur?
  - In-person, phone, telehealth/VVC?
- Will screens be completed on paper, directly in CPRS, or both?
  - If completed on paper, when and by whom will paper screens be entered into CPRS? Who will review the screen to determine appropriate follow-up?

How will positive screens be addressed?

Recommendation: Urgent needs (currently without housing, not enough food for the week, utilities currently shut off) should be given a warm hand-off to social work for day-of assistance.

- Who (e.g., LPN, RN, SW, Peer, Physician/Provider) will review positive screens?
- When needs are identified, how will they be addressed?
  - Is there someone on the clinic team (such as a social worker) who can address needs at the time they are identified? If not, how will needs be communicated?
  - Will referrals, consult orders, warm hand-offs, and/or Teams be used?
  - Will ACORN resource guides be created and offered to Veterans?
- Consider the local and national consults and resources you have available at your site.
- Identify a dedicated staff person/role who will build and maintain ACORN resource guides, if using at your site.
  - Where will the resource guides be housed (e.g., printed hand-out, linked to the medical center's intranet, Teams channel)?
- Consider any additional follow-up procedures after providing initial referrals/resources, as clinically appropriate.

References: Kaiser Permanente Center for Health Research and OCHIN – Guide to Implementing Social Risk Screening and Referral-making and PRAPARE – Implementation and Action Toolkit

Additional Tips and Recommendations for Workflow Development

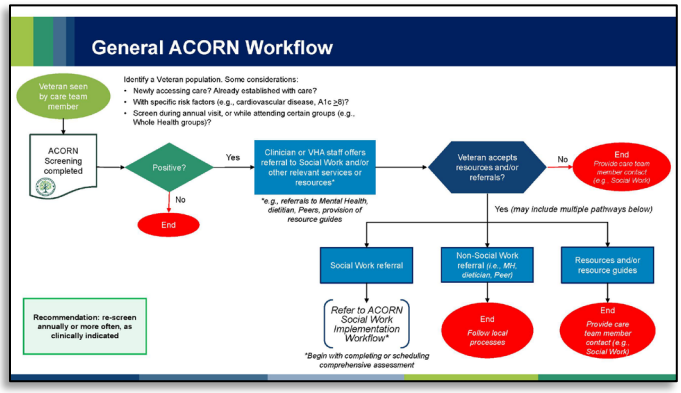
- **Use the optional planning tool.** This tool can assist ACORN Partner Sites in planning the process for both screening and addressing identified needs in an ACORN workflow. The **ACORN Workflow Planning Tool** is available in the Appendix.
- **Get outside feedback.** Once you've developed your ACORN workflow, consider having a staff member outside your clinic area review it. Are the steps clearly outlined? Is the workflow easy to follow? This feedback can provide beneficial insight to make sure all staff understand their role and responsibilities in the process.
- **Make it visual.** Staff may find it helpful to have a visual representation of your ACORN workflow. Visual workflows can be created in PowerPoint, Word, or Visio.

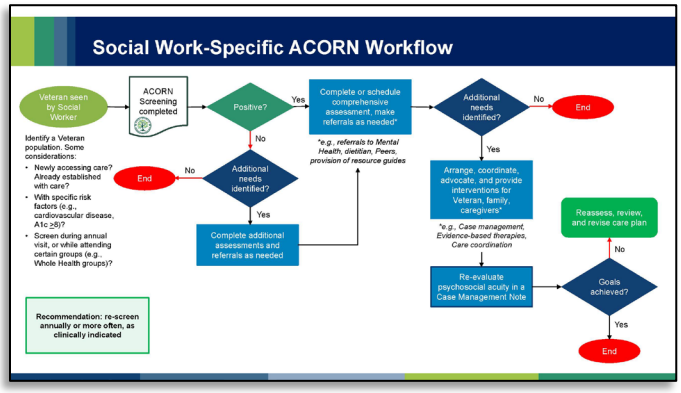
Workflow Models

Model ACORN workflows are available for sites to use as a starting point.

These workflow models include all the process steps to consider with your team during workflow development. While there may be additional processes or steps you want to add based on your patient population(s) and clinical setting(s), the generalized workflows can serve as the baseline to adapt as needed.

Sites can utilize one of the two workflows available: a social work-specific workflow that details expectations if your team intends to refer Veterans with positive screens primarily to social work, and a more general one with more flexibility for the roles/disciplines managing referrals that can be adapted to the chosen clinical setting for implementation.





Some teams may only use one of the two workflow models provided while others may opt to use both. VHA facilities interested in using the paper ACORN screening tool as part of their workflow can contact the ACORN Leadership Team for downloading instructions.

➢ *ACORN IN LEAF: PART TWO [internal for VHA facilities]*

ACORN Site Champions should complete, in order, the following LEAF steps to submit your workflow for review by the ACORN Leadership Team. The fully signed ACORN Concurrence Memo will also be uploaded in this step.

- **Upload finalized workflows and signed ACORN Concurrence Memo to the ACORN LEAF Site by selecting your original submission request (highlighted in yellow).**
  - Suggested feedback will be provided by the ACORN Leadership Team for the team to incorporate into the workflow for approval.
  - **Reminder:** Signatures for the memo include the Social Work Chief or Executive, Medical Center Director, and VISN Director. All signatures are required *before* submission to the ACORN Leadership Team.
- **Following workflow approval, request activation of the ACORN national CPRS template.** Site Champions will receive an email to share with your Clinical Applications Coordinator (CAC) and/or Health Informatics Specialist (HIS) requesting completion of the post-installation instructions.

Next Steps: Train Staff on your ACORN Workflow

Staff should be trained on each step of the workflow to understand their role in implementation. Providing training through workshops and educational materials will help staff feel more comfortable and confident in interacting with Veterans about their social needs, and in answering any questions a Veteran may have about the screening tool and/or interventions provided.[30,31] Before screening Veterans, clinic staff should be trained on the specific delivery mode for their setting (i.e., CPRS template, paper screening, or a combination) and how to communicate the purpose of ACORN to Veterans, based on their role in the process.

Following workflow approval by the ACORN Leadership Team in LEAF, disseminate the finalized workflow to all staff who will be part of the ACORN process. Additionally, to ensure staff feel comfortable with this process, make sure they know how to locate and use the ACORN CPRS template and follow up on positive screening results.

Note: Staff administering ACORN should ask the questions exactly as they appear on the screening tool to maintain fidelity and properly document the identified needs and actions taken during the encounter. Recognizing ACORN can be administered during appointments as part of a conversational flow, sites may find it helpful to print out a paper copy of the ACORN screening tool to have on hand for reference as they ask the questions. For more information on paper screening tools, refer to the Step 4. The ACORN National CPRS Template chapter.

Once implementation begins at your site, meet with your team regularly to seek feedback and adjust workflows as needed. Document the rationale for any implementation changes and consider sharing ACORN data with your team to show the impact of their work.

Applying your Workflow: Socializing ACORN

Staff may feel nervous or uncomfortable asking Veterans about social risks and social needs given the sensitive nature of these topics. However, based on information published by University of California – San Francisco's Social Interventions Research and Evaluation Network (SIREN), patients have rarely reported being upset or uncomfortable by social risks or social needs screening, and they often appreciate being asked about their needs.[32] Further, during initial piloting of ACORN in VISN 1, the ACORN Team found that the subset of Veterans interviewed after completing ACORN reported feeling comfortable with VA screening for social risks and social needs and that VA should continue screening given the impact these risks and needs can have on Veterans.[1]

To promote increased comfort among staff and Veterans, it can be helpful to encourage staff to administer ACORN in a private setting (e.g., in a patient's room) or to allow Veterans to self-administer with a paper screening tool.

Beginning the Conversation

Veterans may feel comforted knowing VA is routinely asking about their social risks and social needs. Explaining why these questions are being asked can help ensure the Veteran understands that clinical care team members hope to use this information to provide enhanced care and support. To enhance comfortability for both staff and Veterans during screening, staff can use the following script with Veterans prior to administering ACORN.

> ***"***ACORN stands for 'Assessing Circumstances and Offering Resources for Needs.'
> It is a VA initiative that helps identify and address needs that Veterans might be experiencing. This includes things like housing, food, transportation, utilities, access to telehealth, and social support.
>
> As part of this initiative, VA staff ask Veterans about their needs in different areas of their life and offer resources in the VA and in the community.
> We ask about these needs as part of your care because we know that they are important for your overall health and well-being.
>
> The questions included in the ACORN screening tool ask about needs you might have, so that the VA can follow up with helpful resources. Please respond as best you can. You may skip any questions you are unsure how to answer or if you prefer not to respond.***"***

Staff Experience

Asking Veterans about their social risks or social needs can often open the door for more in-depth discussions about non-medical needs that impact their health or well-being. In these conversations, Veterans may identify difficult situations that contribute to or are impacted by their social risks. Depending on the nature of these discussions, conversations may lead to the Veteran disclosing information regarding mental health, substance use, intimate partner violence, suicide risk, or other traumatic experiences. Staff should be aware of how to proceed when a Veteran identifies these needs through their local policies and procedures.

This information may also have an impact on the staff member working with the Veteran, as they may find shared experiences or have a reaction to the information being shared. When this occurs, it is important for staff to feel comfortable completing the conversation with the Veteran, finding a course of action, and seeking support for themselves. This may include reaching out to a colleague, mentor, or supervisor to discuss the situation and receive guidance or preparation for how to handle situations in the future. In some cases, staff may benefit from the Employee Assistance Program.[33,34] Acknowledgment that this can occur and providing avenues for staff to receive support is important.

STEP 4. THE ACORN NATIONAL CPRS TEMPLATE

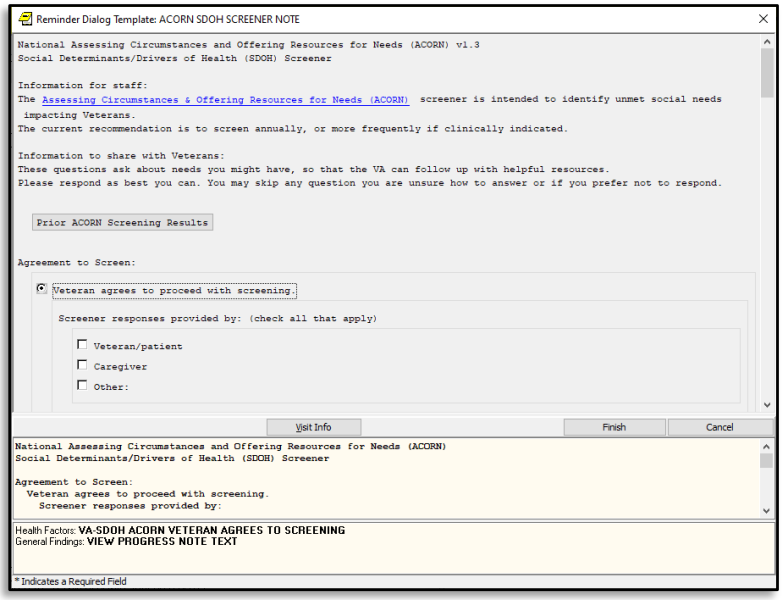
To successfully provide resources and referrals to Veterans who endorse unmet social needs, the ACORN screening tool at its core is intended to be flexible and adaptable. There are currently two main mechanisms for delivering ACORN: staff-administered screening via CPRS and paper screening (typically Veteran self-administered, though can also be staff-administered).

When choosing your mode of administration, determine whether your site will primarily enter Veteran responses directly into CPRS, administer ACORN on paper for Veterans to complete and return to staff, or a combination of the two. Consider which method will be achievable based on your clinic resources, as well as feasibility and acceptability among staff and Veterans.

Key Features of the ACORN National CPRS Template

The ACORN screening tool is available to VHA facilities as a national template in CPRS for use during routine visits with Veterans. All ACORN screens, including those initially conducted on paper, must be entered into the national ACORN CPRS template. Using the ACORN v1.3 SDOH Screener CPRS Template, staff can administer ACORN in person or during telehealth (e.g., Veteran Video Connect (VVC) and phone appointments).

Prior ACORN Screening Results. Displays previous dates on which the ACORN screening tool was administered, any positive screening results, and resources and referrals provided.



Clinical Reminders. VHA screens for housing instability and food insecurity through national clinical reminders, both of which are integrated into the ACORN screening tool. When completed as part of ACORN, these responses will satisfy the required clinical reminders.

Linked Health Factors. Veterans' responses and the documented resources and referrals provided have associated health factors that link ACORN screening data to relevant sociodemographic, clinical, and administrative data in the VHA Corporate Data Warehouse (CDW) for data evaluation purposes. These health factors are used to populate the data that sites can view in the ACORN Dashboard.

Disposition Fields / Action Steps. A list of standard disposition fields or "action steps" are included at the end of the CPRS template. Staff will use this field to denote which resources and referrals, if any, were provided to the Veteran the day of screening to address needs identified.

These fields are designed to be applicable to a variety of staff administering ACORN, and appropriate action responses will vary depending on staff roles, site workflows, and resources available.

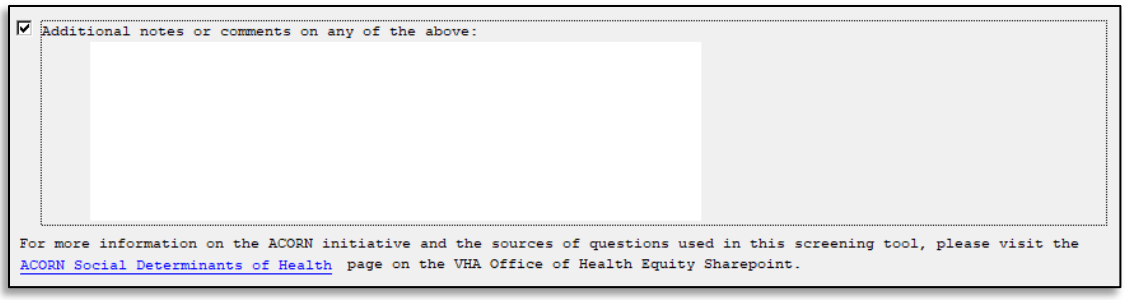
Disposition Field / Action Steps in the ACORN CPRS Template

The action step options are included below in the order they appear in the template. The staff member completing the CPRS template can select more than one option.

ACTION STEP	WHEN TO CHOOSE THIS ACTION STEP
No resources or referrals given	If Veteran screens negative for all needs on the screener, declines assistance, or reports they are already receiving services or assistance
Resources provided	If you provided VA or non-VA resources or information to the Veteran (e.g., provided information or assisted Veteran with contacting a community organization) Also choose this option if you provided structured resource guides/lists
(For social workers only) Social Work intervention provided today	If you are a social worker and provided an intervention today
Social Work Connection	If you provided a warm hand-off or entered a consult order to Social Work
Primary Care Behavioral Health (PCBH) or Primary Care Mental Health Integration (PCMHI) Connection	If you provided a warm hand-off or entered a consult order to Primary Care Behavioral Health (PCBH) or Primary Care Mental Health Integration (PCMHI)
Mental Health Connection	If you provided a warm hand-off or entered a consult order to Mental Health
Dietitian Connection	If you provided a warm hand-off or entered a consult order to Nutrition/a Dietitian
Digital Divide Program Connection	If you provided a warm hand-off or entered a consult order to the Digital Divide program
Follow up planned	If you have arranged to see the Veteran for a follow up visit or phone call
Communication with other care team member	If you relayed information to another member of the Veteran's care team (e.g., Primary Care Provider, Mental Health Provider, Case Manager, Peer)
Other	Choose this option for any other actions taken today as a result of the ACORN screen that don't fit into the categories above (you can use the associated free text box at the end of the template to write in any additional actions)

Recommendations for Using the Disposition Field / Action Steps

- **If no actions are taken day of screening,** select "No resources or referrals given" and choose one of the following options:
  - "Screened negative for all needs" (if the Veteran screens negative for all needs)
  - "Veteran declines assistance at this time" (if the Veteran screens positive for one or more needs but declines assistance today)
  - "Veteran already receiving services or assistance" (if the Veteran screens positive for one or more needs, but reports that they do not need assistance today because they are already connected with resources or programs to address all the needs identified)
- If selecting "Social Work Connection", "PCBH/PCMHI Connection", "Mental Health Connection", "Dietitian Connection", or "Digital Divide Program Connection", use the checkboxes that appear to indicate whether a warm hand-off was made or a consult order entered.
- Free text boxes are optional unless there is an asterisk (*), which indicates that a response is required. Free text boxes can be used to document additional relevant information as needed.
- The "Other" option may be used to document any actions taken that don't fit into the other categories.
- A free-text field at the bottom of the template (shown below) is provided for staff to document other relevant clinical information and actions taken related to the encounter.



SDOH International Classification of Disease (ICD)-10 Z Codes *(Health Professionals Only).* SDOH ICD-10 Z codes can be used by health professionals to easily document and code for reported social needs on the encounter form associated with the visit in which the ACORN screening tool is administered. The ICD-10 Z codes selected in the template will automatically populate in the encounter form. Staff should review utilization guidelines with their supervisor.

Health professionals can select one or more ICD-10 codes for the encounter from the following options:

- Homelessness, unspecified – Z59.00
- Housing instability, housed, with risk of homelessness – Z59.811
- Food insecurity – Z59.41

- Material hardship due to limited financial resources (including inability to obtain adequate utilities due to limited financial resources) – Z59.87
- Inadequate housing utilities – Z59.12
- Transportation insecurity – Z59.82
- Problems related to other legal circumstances – Z65.3
- Other specified problems related to psychosocial circumstances (including risk for feeling loneliness) – Z65.8

Paper Screening Tool

ACORN can also be administered on paper, either by the Veteran themselves (e.g., in the waiting room while waiting for an appointment) or the screening questions can be directly asked by staff using the paper screening tool and subsequently entered into the CPRS template.

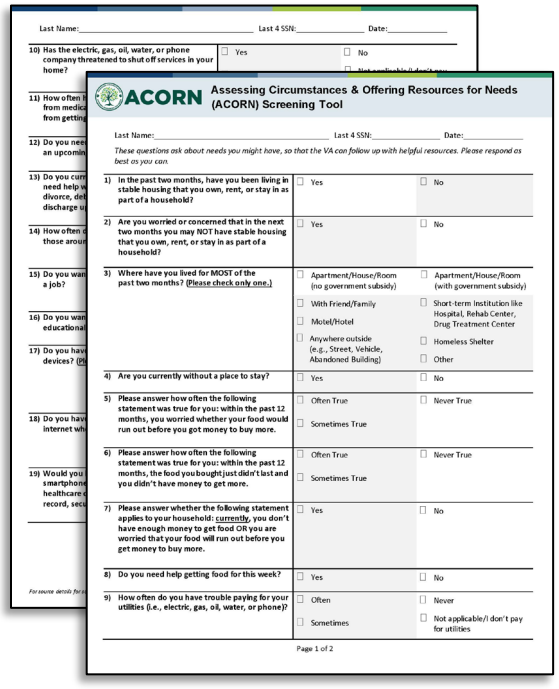
The ACORN paper screening tool follows the ACORN CPRS template and associated branching logic. Notably, the paper screening tool also includes the 3-month follow-up question for the national food insecurity clinical reminder to ensure responses will satisfy the clinical reminder requirements.

To decide whether paper screens will be a beneficial tool in your clinical setting, consider the following:

- What will be the process for giving out and collecting the completed screens from Veterans presenting for care?

  It is critical to assign a staff role/discipline (or specific team member(s)) for the distribution and collection of paper screens, as well as clarity around which team member(s) will be expected to review and enter the completed responses into CPRS.

  Paper ACORN screening tools should be entered into CPRS per local documentation policy timelines. *All ACORN screens must be entered into CPRS for documentation and tracking purposes.*


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)
☐ Apartment/House/Room (with government subsidy)
☐ With Friend/Family
☐ Short-term Institution like Hospital, Rehab Center, Drug Treatment Center
☐ Motel/Hotel
☐ Homeless Shelter
☐ Anywhere outside (e.g., Street, Vehicle, Abandoned Building)
☐ 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) Please answer whether the following statement applies to your household: 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

8) Do you need help getting food for this week? ☐ 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

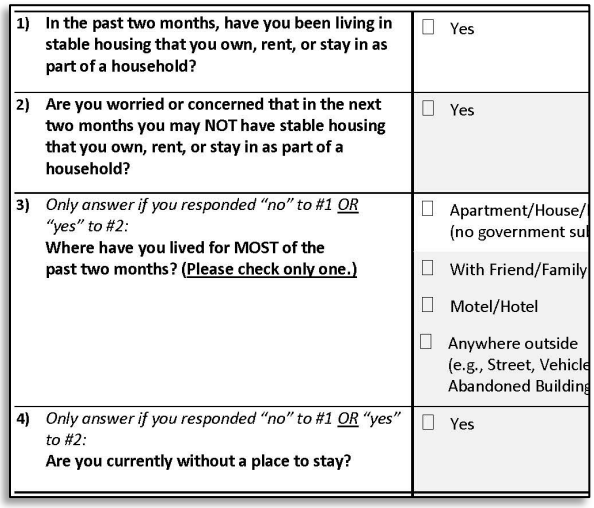
- Can the Veterans served in your clinical setting complete the paper screen on their own? Or do they need assistance from a staff member to complete it?
- Does your clinical setting have the time and capacity for using paper screening tools, including any potential printing costs, availability of secure storage, and/or proper

destruction of completed screening tools once entered into CPRS (i.e., shredding, secured recycling)?

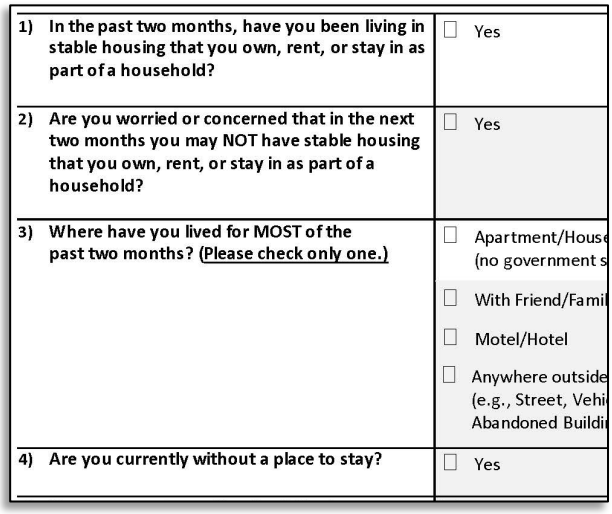
Note: Even if your clinical setting elects not to use paper copies of the ACORN screening tool, consider whether staff could benefit from having hard copies on hand. Veterans may find a paper copy beneficial as a reference tool to follow along while staff asks the questions and enters responses in CPRS. Staff may also find it easier to fill out Veteran responses on paper during administration so as to not interrupt the encounter, with the ability to later enter the responses into CPRS.

Using the Paper Screening Tool *[internal for VHA facilities]*

The paper ACORN screening tool is a 2-page handout that includes shaded boxes around all positive responses that would constitute an unmet social need. These boxes assist staff in quickly identifying the areas of need to provide appropriate resources and referrals. Two versions of the paper screening tool are available: one with question prompts and one without.



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
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
3) *Only answer if you responded "no" to #1 OR "yes" to #2:* **Where have you lived for MOST of the past two months? (Please check only one.)**	☐ Apartment/House/ (no government sul ☐ With Friend/Family ☐ Motel/Hotel ☐ Anywhere outside (e.g., Street, Vehicle Abandoned Building
4) *Only answer if you responded "no" to #1 OR "yes" to #2:* **Are you currently without a place to stay?**	☐ Yes



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
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
3) **Where have you lived for MOST of the past two months? (Please check only one.)**	☐ Apartment/House (no government s ☐ With Friend/Famil ☐ Motel/Hotel ☐ Anywhere outside (e.g., Street, Vehi Abandoned Buildi
4) **Are you currently without a place to stay?**	☐ Yes

VHA facilities interested in using the paper ACORN screening tool as part of their workflow can contact the ACORN Leadership Team for downloading instructions. The version with prompts includes question skip logic for the person completing the screening tool, similar to the branching logic on the CPRS template. The version without prompts includes all questions without use of skip logic.

➢ *ACORN IN LEAF: PART THREE AND FOUR [internal for VHA facilities]*

ACORN Site Champions should complete, in order, the following LEAF steps to submit your zztest patients for review by the ACORN Leadership Team. *Sites must test the note template with test patients prior to implementation to ensure health factor data is correctly captured in the VHA Corporate Data Warehouse (CDW) and template activation was done correctly.*

- **Following workflow approval, request activation of the ACORN national CPRS template.** Site Champions will receive an email via LEAF to share with your CAC/HIS requesting completion of the post-installation instructions.
  - **Reminder:** The core ACORN screening, which includes all components of the template other than the disposition field, should **NOT** be modified.
  - The national ACORN template should be used in a free-standing note and not embedded in other note templates.
  - The standardized note title for the national ACORN template is: "ACORN SDOH Screener Note".
- **Test the CPRS template with 2-3 zztest patients.** Upload your zztest patients' full names and full Social Security numbers to the ACORN LEAF Site. Please do **not** submit PHI in your LEAF request.

- **Completion.** Once the test patients are submitted, the ACORN Leadership Team will review the health factor data for accuracy. If health factor data is captured successfully, the requestor will receive an email titled ***"Congratulations, ACORN pre-implementation is Complete"*** to notify the site when implementation can begin.

PLANNING FOR SUSTAINMENT

When implementing a new clinical process such as ACORN, it is important to continuously monitor, reassess, and refine the process as challenges are encountered or changes occur in the clinical context. Identifying and addressing challenges and adapting workflows to accommodate changes will help support sustainment of ACORN in your clinical setting.

Meet with your team regularly. Schedule regular check-in meetings including the ACORN Site Champion(s), frontline staff, and involved leadership to review barriers encountered and lessons learned, and revise your site implementation workflow as needed. Document the rationale for any implementation changes. Frequency of team meetings may vary over time; a more frequent cadence (weekly or every other week) may be needed in pre-implementation and early implementation phases, whereas monthly or even quarterly meetings may be appropriate in later implementation and sustainment phases.

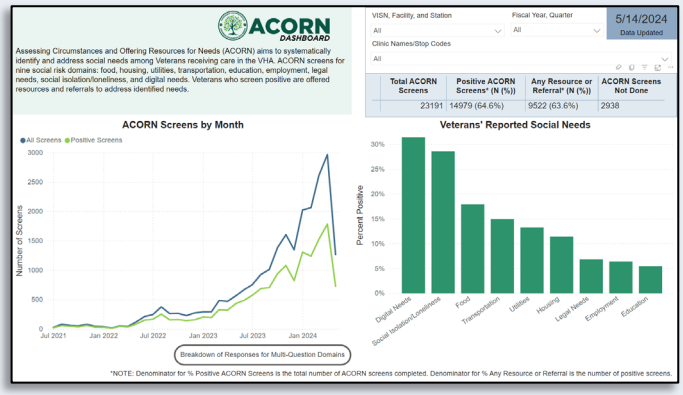
Use the ACORN Dashboard *[internal for VHA facilities].* ACORN Site Champion(s) should become familiar with the ACORN Dashboard as a tool to track screening progress and resources and referrals provided for positive screens. Data can be shared with frontline staff and leadership to provide updates on progress towards goals and identify gaps or areas for improvement.

This information can also be used to understand the prevalence of certain social needs among Veterans in your facility and different clinical settings, and highlight the need for resources and programs to better address them.

ACORN DASHBOARD

The ACORN Dashboard supports VHA clinical teams and programs to:

- Understand the social risks and social needs impacting Veterans
- Track the types of resources and referrals provided to Veterans who screen positive on ACORN
- Observe how screening rates and resources and referrals vary by demographic factors and over time



The use of health factors facilitates evaluation of screening results and the interventions provided to address identified needs at the national, VISN, facility, site, and clinic level.

For troubleshooting support or questions, contact VHAACORNDASHBOARD@va.gov.

***Note:** The ACORN Dashboard only includes data from the clinics/programs at sites using ACORN. Data in the ACORN Dashboard may differ from other VHA dashboards and is not considered representative of the full VHA-enrolled Veteran population.*

ACORN Expansion

Team meetings can also serve as an opportunity to discuss expansion of ACORN screening to additional patient populations or new clinical settings at your facility once implementation has been established in your original setting (typically after 3-6 months).

When your site has identified new populations or settings for ACORN expansion, you can enter an expansion request and upload your new workflow specific to those clinical setting(s) in LEAF for review by the ACORN Leadership Team. Prior to entering the expansion request, seek confirmation of adequate social work staffing from your facility Social Work Chief or Executive.

Expansion to other populations or settings should occur in consultation with the ACORN Leadership Team.

➢ *ACORN IN LEAF: EXPANSION REQUESTS [internal for VHA facilities]*

ACORN Site Champions should complete, in order, the following LEAF steps to submit your expansion request and new workflow(s) for review by the ACORN Leadership Team.

- **Submit a "Expansion Workflow Submission" request on the ACORN LEAF Site**. This form should identify the anticipated clinical setting(s) for expansion and the new Veteran population that will be screened in these settings.
  - **Title of LEAF request:** "VISN Number Station Number ACORN Request" (e.g., VISN 00 Station 000 ACORN Request)
  - You will also submit new workflows tailored to these new clinical setting(s) for review by the ACORN Leadership Team. Suggested feedback will be provided for the team to incorporate into the workflow for approval.

The ACORN Leadership Team is available to discuss questions or ideas for expansion via email at VHAACORN@va.gov, ACORN Office Hours calls, or site consultation meetings (coordinated by request).

APPENDIX

ACORN Getting Started Checklist

ACORN Workflow Planning Tool

ACORN Social Risk Domains Resource List

GETTING STARTED: BECOMING AN ACORN PARTNER SITE

Pre-implementation planning lays the groundwork for smooth integration of **Assessing Circumstances and Offering Resources for Needs (ACORN)** into your clinical setting(s). Below are the responsibilities associated with each step in the process. New ACORN sites are expected to complete, in order, the following activities to ensure successful implementation.

The ACORN Implementation Toolkit is available to assist sites with planning and implementing ACORN across pre-implementation to sustainment.

Essential action items are marked with a ➢.

Note: *This checklist has been adapted for an external audience. Links to internal VHA websites have been removed.*

☐ Phase 1. Gathering Resources and Obtaining Support

- **Explore the ACORN SharePoint** for program information and review the resources available.
- **Secure Leadership support.** Approval from the Social Work Chief or Executive and Facility Executive Leadership Team is required prior to implementation and joining the ACORN Community of Practice.
    - Leadership support recommendations: share how identifying and addressing social needs can impact Veteran's health; consider facility resources when identifying goals and convey leadership support to staff.
    - *This work is done in preparation for the ACORN Concurrence Memo action item in Phase 3.*
- **Engage with your clinical care team early.** Work with your social work colleagues and other clinical and administrative staff to review site readiness for implementation.

➢ **Attend an ACORN Basics call** to learn more about ACORN and discuss implementation logistics.

- Recommended attendees: Social Work Chief or Executive, ACORN Site Champion(s), core staff who will be involved in implementation.

☐ Phase 2. Onboarding

- **Identify ACORN Site Champion(s)** who will lead identification of clinic goals, support development of workflows, orient team members to ACORN, and provide feedback to key partners throughout the process. A Social Work Co-Champion must be identified if the Site Champion is not a social worker.
- **Join the ACORN Community of Practice Teams Channel** as a New ACORN Partner Site.

Submit a "Participation in ACORN Deployment" request on the ACORN LEAF Site. This form identifies your ACORN Site Champion(s), target clinical settings, and anticipated implementation timelines.

- Title of LEAF request: "VISN Number Station Number ACORN Request" (e.g., VISN 00 Station 000 ACORN Request)

☐ Phase 3. Pre-Implementation

- **Attend the ACORN Community of Practice calls.** Site Champion(s) or designee should attend the following meetings:
  - **New Sites Call: every 4th Tuesday at 11:00 – 11:45am ET.** Provides start-up support, workflow development and refinement, and technical assistance. New sites should plan to attend these calls through the Early Implementation phase (Phase 4).
  - **All Sites Call: every 2nd Tuesday at 11:00 – 11:45am ET.** Brings together new and established ACORN sites to share national-level data and program updates. Features site spotlights to share lessons learned, challenges, and successes, as well as social risk domain-specific education with subject matter experts from the field and VA Program Offices.

Complete the ACORN Concurrence Memo with your Social Work Chief or Executive as the initiator. Once all signatures have been obtained, the ACORN Leadership Team will return the completed memo to your Site Champion(s) and Social Work Chief or Executive.

- Sites are required to upload the fully signed ACORN Concurrence Memo in part two of the LEAF process (workflow submission).

- **Develop your ACORN workflow.** Workflows should detail the process steps for both screening and addressing identified needs in your clinical setting(s), as well as identify who is responsible for each step.
  - The ACORN Workflow Planning Tool can assist your team in planning the step-by-step process for both screening and addressing identified needs in an ACORN workflow.
  - Staff may find it helpful to have a visual representation of your ACORN workflow. Visual workflows can be created in PowerPoint, Word, or Visio.
  - Looking for examples to get started? Example ACORN workflows are available on the ACORN SharePoint.
  - For additional guidance on workflow development, ACORN Office Hours are offered for participating VHA facilities.
- **Build ACORN Resource Guides *[Optional].*** For sites interested in developing resource guides, visit the SharePoint for the Building ACORN Resource Guides Manual.

Key ACORN Workflow Steps: Overview	
Which Veterans will be screened?	▪ Veterans newly accessing care? Already established with care?
When will they be screened?	▪ Before visits, during visits? ▪ In-person, phone, telehealth/VVC?
Who will conduct the screening?	▪ Veterans to complete on their own? Staff asking the questions? ▪ Who (i.e., LPN, RN, SW, Peer) will enter the responses into CPRS?
How will they be screened?	▪ On paper? In CPRS? ▪ If on paper, who will enter the responses into CPRS?
How will positive screens be addressed?	▪ Referral and follow-up processes (i.e., Social Work, etc.) ▪ Process for urgent needs ▪ ACORN resource guides, if using

For a more comprehensive breakdown with recommendations of the key workflow steps, review the Developing an ACORN Workflow chapter in the ACORN Implementation Toolkit.

➢ **Upload finalized workflows and signed ACORN Concurrence Memo to the ACORN LEAF Site by selecting your original submission request (highlighted in yellow).**

- **Request activation of the national ACORN CPRS template** following workflow approval. Site Champion(s) will receive an email via LEAF to share with your CAC/HIS requesting completion of the post-installation instructions.
  - The core ACORN screening tool, which includes all components of the template other than the disposition field, should ***NOT*** be modified.
  - The national ACORN template should be used in a free-standing note and not embedded in other note templates. The standardized note title is: "ACORN SDOH Screener Note".
  - Test the CPRS template with 2-3 zztest patients. Upload your zztest patients' full names and full Social Security numbers to the ACORN LEAF Site. Do ***not*** submit PHI in your LEAF request.
- **Train clinic staff** on the ACORN screening tool and site workflow. Staff should be trained on the specific delivery mode for their clinical setting (e.g., staff-administered screening) and how to communicate the ACORN tool with Veterans, based on their role in the process.

➢ **All steps met.** Site Champion(s) will receive an email via LEAF titled ***"Congratulations, ACORN pre-implementation is Complete"*** to notify that site implementation can begin.

☐ Phase 4. Early Implementation

- **Begin implementing ACORN.** Start small with a single team, clinic, or population to work through any initial challenges or barriers that may arise in the screening and/or referral process.
- **Site Champion(s) should continue attending All Sites and New Sites ACORN Community of Practice Calls**. New Partner Sites will attend the New Sites call for the first 6 months of implementation and the All Sites call indefinitely.
- **Meet with your team regularly** to seek feedback and adjust workflows as needed. Document the rationale for any implementation changes and consider sharing ACORN data with your team to show the impact of their work.
- **Use the ACORN Dashboard.** The ACORN Dashboard supports VHA clinical teams and programs to: 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.
    - The use of health factors facilitates evaluation of screening results and the interventions provided to address identified needs at the national, VISN, facility, site, and clinic level.

The ACORN Team is available for implementation support at VHAACORN@va.gov.

Additional support is available in the ACORN Community of Practice Teams Channel, ACORN Office Hours calls, and site consultation meetings (coordinated by request).

OPTIONAL PLANNING TOOL: DEVELOPING AN ACORN WORKFLOW

This is an **optional** tool to assist ACORN Partner Sites in planning the process for both screening and addressing identified needs in an ACORN workflow.

For a more comprehensive guidance on workflow development, review the ACORN Implementation Toolkit. Additional guidance and feedback from the ACORN Leadership Team is offered in ACORN Office Hours *[internal for VHA facilities].*

Site/Facility:

Clinical Setting:

Site Champion(s)/Team Members:

Social Work Chief:

Anticipated Start Date:

Last Revised:

Which Veterans will be screened?

Who are you anticipating for your target population? *For example, all patients coming in for care, new patients only, patients referred to social work, adults 65+ years of age, etc.*

How will staff identify Veterans to be screened (e.g., referrals to social work, Primary Care Equity Dashboard (PCED), team huddles, chart review, visit check-in)?

When will Veterans be screened?

When will your staff conduct the ACORN screening? *For example, in-person during intake, via telephone or video before or during VVC visits, or as part of follow-up visits over the phone.*

Determine frequency of screening (e.g., annually, every 6 months). The general recommendation is that all Veterans (including those with negative screens) be screened annually or more often if clinically indicated:

Who will conduct the screening?

If staff administered, who will ask the questions? Please indicate the role(s)/staff discipline(s) of those who will be conducting the assessment.

If self-administered by Veterans, who will give them the screening tool and instructions to complete it?

If completed on paper, when and by whom will paper screens be entered into CPRS? Who will review the screen to determine appropriate follow-up?

How will Veterans be screened?

What mechanism will you use to administer the ACORN assessment? Will screens be completed on paper, directly in CPRS, or both?

During what types of visits will screening occur? *For example, in-person, over the phone, telehealth/VVC?*

How will positive screens be addressed?

For Veterans who screen positive for a social need(s), determine when warm hand-offs will be facilitated (for urgent needs) and if/when referrals or consults will be placed for non-urgent needs.

Who (e.g., LPN, RN, SW, Peer, Physician/Provider) will review positive screens?

When needs are identified, how will they be addressed?

Urgent Needs:

Non-urgent Needs:

Is there someone on the clinic team (such as a social worker) who can address needs at the time they are identified? If not, how will needs be communicated?

Will referrals, consult orders, warm hand-offs, and/or Teams be used?

Will ACORN resource guides be created and offered to Veterans?

ACORN SOCIAL RISK DOMAINS RESOURCE LIST

This resource list is designed to provide an overview of national-level resources available to most VAMCs. This list is not exhaustive. ACORN teams should verify availability, contact information, and types of services available through each of these and other state/local resources in their area before providing the contact information to Veterans.

Overarching VA Clinical Services:

- Social Work service
- Mental Health (e.g., Veteran Community Partnerships (VCPs))
- Nutrition
- Homeless Program
- Nursing

HOUSING

- *VA Resources:*
  - 24/7 National Call Center for Homeless Veterans at 1-877-4AID VET (1-877-424-3838)
  - HUD-VASH Program
  - Healthcare for Homeless Veterans (HCHV), as available at facilities
  - Supportive Services for Veterans and their Families (SSVF) – SSVF Provider Directory
  - Veterans Justice Outreach Program (VJO)
  - Homeless Veterans Community Employment Services
- *National Resources:*
  - Local Public Housing Agencies directory

Note: the Homeless Program Office Fact Sheet includes a comprehensive list of VHA housing programs.

FOOD

- *VA Resources:*
  - VHA Food Security Office - Nutrition and Food Services
  - Healthy Teaching Kitchen Program
- *National Resources:*
  - Supplemental Nutrition Assistance Program (SNAP)
  - Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
  - Call the USDA National Hunger Hotline at 1-866-3-HUNGRY (1-866-348-6479) or 1-877-8-HAMBRE (1-877-842-6273)
  - The EveryONE Project
  - Feeding America
  - Meals on Wheels America

UTILITIES

- *VA Resources:*
  - Digital Divide Consult
  - Supportive Services for Veterans and their Families (SSVF) – SSVF Provider Directory
- *National Resources:*
  - Low Income Home Energy Assistance Program (LIHEAP)
  - Low Income Household Water Assistance Program (LIHWAP)

Note: for additional digital needs/technology access resources, refer to the Digital Divide section at the end of this list.

TRANSPORTATION

- *VA Resources:*
  - Veterans Transportation Service (VTS), as available at facilities
- *National Resources:*
  - Disabled American Veterans

LEGAL

- *VA Resources:*
  - Legal Services for Veterans Program (LSV)
  - VA Medical Legal Partnerships/Legal Clinics directory
- *National Resources:*
  - Stateside Legal
  - American Bar Association (ABA) - Free Legal Answers
  - Military Pro Bono Project
  - VetLex

SOCIAL ISOLATION

- *VA Resources:*
  - Whole Health
  - Compassionate Contact Corps, as available at facilities
  - Community Recovery Connections Team (CRCT), as available at facilities
  - National Buddy Check Week
  - Coaching Into Care
- *National Resources:*
  - United Service Organizations (USO)
  - Team Red, White & Blue
  - Veteran Service Organizations (VSOs) (e.g., Lifeline for Vets), as available at facilities
  - America's VetDogs
  - US Men's Shed Association
  - Institute of Aging's Friendship Line

EDUCATION

- *VA Resources:*
  - Veteran Readiness & Employment (VR&E - Chapter 31)
  - Vocational Rehabilitation Services: Compensated Work Therapy (VRS / CWT)
  - Veterans Employment Through Technology (VET TEC)
  - Veteran Integration to Academic Leadership (VITAL), as available at facilities
  - VA education and training benefits webpage, including GI Bill benefits:
    - Choosing an Education Pathway guide
    - Furthering Your Career guide
    - Understanding GI Bill benefits guide

- *National Resources:*
  - CareerOneStop

EMPLOYMENT

- *VA Resources:*
  - Veteran Readiness & Employment (VR&E - Chapter 31)
  - Vocational Rehabilitation Services: Compensated Work Therapy (VRS / CWT)
  - Veterans Employment Through Technology (VET TEC)
  - Homeless Veterans Community Employment Services

- *National Resources:*
  - CareerOneStop
  - Disabled American Veterans – Employment & Entrepreneurship

DIGITAL DIVIDE

- *VA Resources:*
  - Digital Divide Consult
  - Virtual Health Resource Center (VHRC), as available at facilities
  - 24/7 Connected Care Help Desk (866-651-3180)
  - For help with VVC visits, contact the local Telehealth Tech to do a test call, as available
  - For MyHealtheVet assistance:
    - Facility MHV Coordinator
    - MyHealtheVet Help Desk
    - Health Resource Center (877-470-5947)

- *National Resources:*
  - Lifeline
  - EveryoneOn, as available

MISCELLANEOUS RESOURCES

- VA Welcome Kit
- List of state Departments of Veterans Affairs offices for additional state/local resources
- Vet Center National Directory for additional state/local resources and services
- National Veterans Financial Resource Center (FinVET)

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