



IDENTIFYING AND ADDRESSING HEALTH-RELATED SOCIAL NEEDS AMONG VETERANS FACT SHEET

Lauren Russell, MPP, VA New England Healthcare System (VISN 1), Alicia Cohen, MD, MSc, Providence VA, Steven Chrzas, MPH, VA New England Healthcare System (VISN 1), Lauren Korshak, DHealth(c), MS, RCEP, Office of Health Equity, Michelle Wong, PhD, VA Greater Los Angeles Healthcare System

INTRODUCTION

The Veterans Health Administration (VHA) serves a Veteran population that is increasingly racially and ethnically diverse and rapidly aging. Equitable access to high-quality care for all Veterans is a major tenet of the VA healthcare mission. The Office of Health Equity (OHE) champions the elimination of health disparities and achieving health equity for all Veterans.

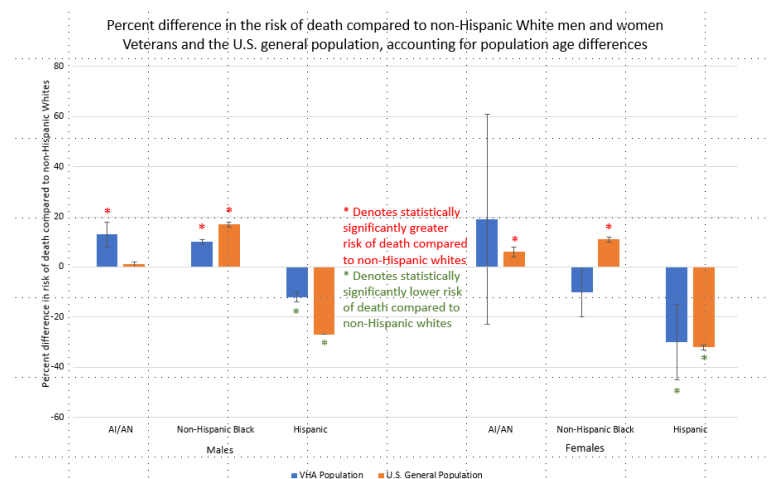
HEALTH-RELATED SOCIAL NEEDS

Health care access is not the only determinant of health outcomes. Often minority populations face barriers like food insecurity, housing instability, transportation challenges and a lack of employment opportunities. These health-related social needs can result in poor health outcomes.

VHA is an equal-access health care system that is unique in that it does not require users to pay insurance premiums to access care. VHA also works to address health-related social needs of the Veterans it serves by providing transportation assistance, extended clinic hours and other services and referrals to address health-related social needs.

ADDRESSING HEALTH DISPARITIES IN HEALTH CARE DECISION MAKING

The efforts VHA are making to address health-related social needs appear to be helping to reduce health disparities when mortality rates of Veterans are compared to non-Veterans. While there are still racial/ethnic disparities amongst VHA-users, many differences are smaller than those in the U.S. general populations. In this comparison, Veterans were receiving VHA care—which might indicate that they have a higher risk for adverse health outcomes—while the U.S. general population included everyone, both those with and without insurance.



Notes: Graph show the percent difference in the risk of dying for each racial/ethnic group compared to non-Hispanic Whites. Percentages > 0 indicate a higher risk of death compared to non-Hispanic whites, while percentages < 0 indicate a lower risk of death. Differences in age composition between the VHA and U.S. general populations are accounted for through the direct standardization methods, where mortality proportions have been standardized using weights based on the FY 2009 non-Hispanic White men or female VHA-user population. Data for the U.S. general population came from the National Center for Health Statistics's detailed mortality file and the U.S. Census

REDUCING DISPARITIES AND IMPROVING ACCESS TO CARE

The Office of Health Equity supports national and local efforts by the VA to reduce health disparities among vulnerable populations, including the VA New England Healthcare System's (VISN 1) health-related social needs (HRSN) and resource referral program. This program screens Veterans for health-related social needs and provides local resource referrals at the point of care by.

Veterans are asked to complete a 12-question health-related social needs assessment that encompasses nine domains: education; employment; exposure to abuse and violence; food insecurity; housing instability; legal needs; social isolation; transportation needs; and utility needs. Upon completion of the assessment, Veterans are provided with resource guides based on their identified need(s) and location.

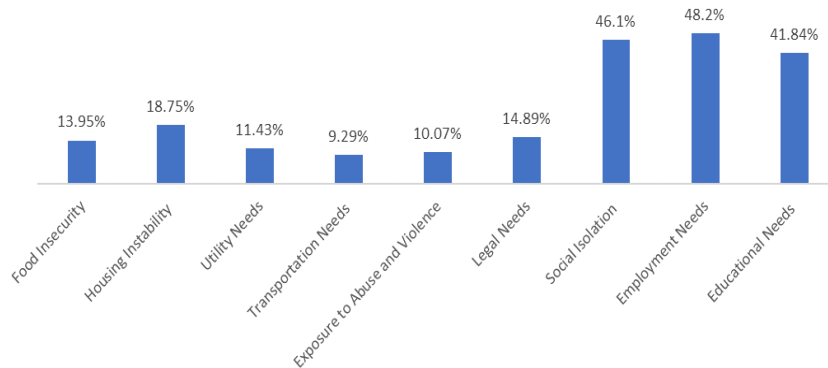
Screening results become a part of a Veteran's electronic health record (EHR) and are available immediately by the Veteran's clinical care team. This ensures that Veterans are screened for risk factors like homelessness and food insecurity at future medical appointments.

BEDFORD VA MENTAL HEALTH EVALUATION CENTER PILOT

In October 2018, the health-related social needs assessment and resource referral program was

piloted at the Edith Nourse Rogers Memorial Veterans Hospital in Bedford, Massachusetts. Among the 141 Veterans screened so far, 82% of Veterans reported at least one unmet health-related social need, and 29% of Veterans reported three or more.

Health-related Social Needs Among Veterans in the Bedford HRSN and Resource Referral Program Pilot



This pilot is expanding to two additional sites in the VA Boston Healthcare System. The expanded pilot will be evaluated to determine: 1) the feasibility of integrating eScreening across multiple VA sites; 2) the prevalence of health-related social needs and sociodemographic characteristics associated with screening positive for these needs; and 3) the major barriers to addressing identified needs. Results will be used to determine the most effective ways to screen for and address Veterans' health-related social needs across VHA.

For more information about the Office of Health Equity visit: <https://www.va.gov/healthequity/>

References

Wong, M., et al. (2019) "Racial/Ethnic Disparities in Mortality Across the Veterans Health Administration." *Health Equity*. 3.1:99-108.