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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Opportunities Exist to Better Integrate Health-Related Social Needs and Social Determinants of Health into Discharge Assessment and Planning

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Executive Summary

The unique demands on individuals who serve in the military contribute to a variety of complex health conditions.[1] As a result, veterans are at greater risk for medical problems compared to the average US population.[2] Additionally, veterans experience increased exposure to social risk factors as those "who use VHA [Veterans Health Administration] services generally have worse health status . . . and are from more socially disadvantaged groups, than the general population."[3] VHA, the largest integrated healthcare system in the US, has the capacity—and responsibility—to assess and address social risk factors to improve patients' health both nationally and locally.[4]

These risk factors are formally referred to as social determinants of health (SDOH) and health-related social needs (HRSN). 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 [one's] daily life."[5] Research shows "only 20 percent of health outcomes depend on clinical medicine, and that 80 percent are due to SDOH."[6] HRSN are individual social and economic needs such as housing stability, access to food, employment, personal safety, transportation, and affordable utilities.[7]

Integrating SDOH/HRSN into discharge assessment and planning has been shown to improve health outcomes, as it enables care providers to assess whether aspects of the patient's physical

[1] Richard E. Adams et al., "Social and Psychological Risk and Protective Factors for Veteran Well-Being: The Role of Veteran Identity and Its Implications for Intervention," *Military Behavioral Health* 7, no. 3 (March 12, 2019): 304–14, https://doi.org/10.1080/21635781.2019.1580642.

[2] Jose A. Betancourt et al., "Exploring Health Outcomes for U.S. Veterans Compared to Non-Veterans from 2003 to 2019," *Healthcare* 9, no. 5 (May 18, 2021): 604, https://doi.org/10.3390/healthcare9050604.

[3] Karin Nelson et al., "The Association Between Neighborhood Environment and Mortality: Results from a National Study of Veterans," *Journal of General Internal Medicine* 32, no. 4 (November 4, 2016): 416–22, https://doi.org/10.1007/s11606-016-3905-x; Richard E. Adams et al., "Social and Psychological Risk and Protective Factors for Veteran Well-Being: The Role of Veteran Identity and Its Implications for Intervention."

[4] David J. Shulkin, "Why VA Health Care is Different," *Federal Practitioner*, (May 2016): 9–11.

[5] "Social Determinants of Health," World Health Organization, accessed July 11, 2022, https://www.who.int/health-topics/social-determinants-of-health; The VA Office of Health Equity define SDOH as, "the social, economic, and physical conditions in the environments where people live, work, and play." "Social Determinants of Health," VHA Office of Health Equity, accessed March 19, 2024, https://www.va.gov/HEALTHEQUITY/Social_Determinants_of_Health.asp.

[6] Edmondo J. Robinson et al., "About SDOH in Healthcare," Agency for Healthcare Research and Quality, accessed August 16, 2022, https://www.ahrq.gov/sdoh/about.html; "A Call for Action to Achieve Health Equity," *AHRQ Views* (blog), August 16, 2021, https://www.ahrq.gov/news/blog/ahrqviews/achieve-health-equity.html.

[7] A patient experiences an HRSN when they lack access to a particular resource, which requires the action of an individual to assist. A patient experiences the effects of SDOH when the community in which they live lacks resources, requiring larger, collective actions. Assistant Secretary for Planning and Evaluation, *Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts,* HP-2022-12, April 1, 2022.

and social environment may pose barriers to safety and well-being.[8] Patients are particularly vulnerable when discharged from hospital inpatient care, as the primary responsibility for care often shifts from hospital providers to individuals and caregivers. Clinical research indicates that "approximately 20% of patients experience adverse events in the first 3 weeks after discharge, with 61% of those events regarded as preventable."[9]

VA has recognized the value in addressing patients' social needs during discharge planning.[10] VHA policy outlines responsibilities for social workers to assist patients with discharge planning, care coordination, and social and financial issues.[11] Further, the VHA social work mission highlights the importance of a social worker's role in addressing SDOH, and VA has incorporated references to these concepts in its strategic plans.[12]

However, there are still apparent challenges in how SDOH/HRSN are managed locally. Previously, the VA Office of Inspector General (OIG) identified gaps in hospital discharge planning, which resulted in staff's failure to ensure a patient's continuity of care and safety at home. The OIG also determined social workers did not consistently complete thorough and detailed psychosocial assessments to address the patient's SDOH/HRSN.[13]

The OIG conducted a review to evaluate VHA and medical center leaders' awareness and incorporation of SDOH and HRSN into discharge assessments, planning, policies, and templates. The OIG disseminated a questionnaire on this topic to 120 VA medical center leaders responsible for these functions.[14] The OIG reviewed national resources and local policies and procedures and conducted interviews with VHA health equity and social work program leaders.

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[8] Tamika Hudson, "The Role of Social Determinates of Health in Discharge Practices," *Nursing Clinics of North America* 56, no. 3 (September 1, 2021): 369–378, https://doi.org/10.1016/j.cnur.2021.04.004.

[9] Katherine Liang and Eric Alper, "Patient Safety During Hospital Discharge," *AHRQ PSNet*, accessed October 12, 2023, https://psnet.ahrq.gov/perspective/patient-safety-during-hospital-discharge.

[10] VA Office of Care Management and Social Work Services, *Discharge Planning White Paper*, December 2017; "Department of Veterans Affairs National Social Work Program Office Discharge Planning During COVID-19: Tip Sheet for Social Workers," April 23, 2020, updated June 9, 2020; VA Office of Care Management and Social Work Services, *Guide to Discharge Planning*, June 2021.

[11] VHA Directive 1110.02, *Social Work Professional Practice*, July 26, 2019; VHA Directive 1110.04(1), *Integrated Case Management Standards of Practice*, September 6, 2019, amended May 18, 2020.

[12] "VHA Social Work Mission, Vision & Values," VA, accessed September 1, 2022, https://vaww.socialwork.va.gov/mission.asp. (This site is not publicly accessible.)

[13] VA OIG, *Discharge Planning Deficits for a Veteran at the Malcom Randall VA Medical Center in Gainesville, Florida*, Report No. 21-01695-38, November 30, 2021.

[14] The OIG disseminated the questionnaire to 120 leaders at VA medical centers with an inpatient medical and surgical unit during fiscal year 2021 (October 1, 2020–September 30, 2021). Medical center staff completing the questionnaire included chiefs, acting/interim chiefs, or executives of social work services; a social work supervisor; a social worker; and one chief of quality management. The OIG selected this time period to capture medical center practices in place after the onset of the COVID-19 pandemic, as the pandemic brought increased awareness to the relationship between SDOH, HRSN, and health outcomes.

Additionally, the OIG examined VHA efforts to identify and address SDOH/HRSN with health disparity tools and community resources and partnerships. The OIG aimed to understand how VHA recognizes and incorporates SDOH/HRSN into discharge assessment and planning, as addressing these patient needs is critical to improving health outcomes.

Review Results

Leaders surveyed reported that social workers were involved in the completion of discharge assessments at 115 of 120 medical centers (96 percent). However, the OIG found that medical center leaders did not consistently incorporate SDOH/HRSN into discharge assessment and planning. Additionally, the OIG found few medical center leaders reported using VHA Office of Health Equity-developed health disparity data tools, and almost half of the leaders surveyed did not participate in any formal partnership with community resources to address SDOH.

Incorporation of Social Determinants of Health and Health-Related Social Needs into Discharge Policies and Procedures

The OIG reviewed VHA guidance and determined there were no national policies or procedures incorporating SDOH/HRSN into discharge assessment and planning. The National Social Work Program Manager told the OIG that the VA Office of Care Management and Social Work Services had not developed policy, as this office was not the process owner for all layers of discharge planning at individual medical centers. The program manager noted that discharge planning varies based on "facility size, geographic location, [and] the way the facility sets up their discharge unit."

Lack of Awareness of National Discharge Assessment and Planning Reference Documents

Although VHA lacks national policy, the OIG learned the VA Office of Care Management and Social Work Services published three discharge assessment and planning reference documents from December 2017 through June 2021 outlining a social worker's role, best practices, and suggested procedures on how to incorporate SDOH/HRSN.[15] Despite the VA Office of Care Management and Social Work Services' efforts, the OIG learned through interviews and questionnaire responses that the reference documents were not considered formal guidance, were largely unknown to medical center leaders responsible for discharge assessment and planning on medical and surgical units, and did not widely contribute to the development of local discharge planning policy or processes.

[15] VA Office of Care Management and Social Work Services, *Discharge Planning White Paper,* December 2017; "Department of Veterans Affairs National Social Work Program Office Discharge Planning During COVID-19: Tip Sheet for Social Workers," April 23, 2020, updated June 9, 2020; VA Office of Care Management and Social Work Services, *Guide to Discharge Planning*, June 2021.

Due to limited local awareness of VA Office of Care Management and Social Work Services discharge assessment and planning reference documents, the OIG reviewed medical center discharge policies and procedures to examine how SDOH/HRSN were incorporated. The OIG found that in the absence of a national policy, most medical center staff had developed their own discharge policies and procedures that addressed SDOH/HRSN. Of the 120 leaders surveyed, 109 (91 percent) presented evidence of a local discharge policy or procedure. Ninety-six of these 109 facilities had policies or procedures that addressed SDOH/HRSN. The development of a national discharge planning and assessment policy would reduce variation among facilities and is a future opportunity to ensure SDOH/HRSN assessments are standardized and consistently implemented VHA wide.

Lack of National Social Work Discharge and Assessment Templates

An electronic health record (EHR) allows a healthcare system to screen, collect, and analyze demographics that affect patient health outcomes. As EHR screening templates standardize data collection, templates with SDOH/HRSN-based questions provide healthcare systems with an improved ability to predict health outcomes.[16] VHA's EHR can be used to identify, compare, and measure outcomes of SDOH/HRSN on a large scale over time.

The VA Office of Care Management and Social Work Services established EHR templates for primary care social workers that include assessment questions related to SDOH/HRSN. However, there was no template for discharge planning within medical and surgical units, where patients are known to be vulnerable. Although there is no national discharge assessment and planning template for medical and surgical units, over half of medical center leaders surveyed (61 of 120) reported existence of a local template. Establishing a nationally standardized SDOH/HRSN assessment across care settings offers an opportunity to avoid untoward events such as readmission and provide reliable feedback that would inform policy or resource distribution.[17]

While many medical center leaders responsible for discharge assessment and planning reported use of a local template, the OIG found VHA national leaders also recognized the impact of incorporating SDOH/HRSN into a screening tool and launched the Assessing Circumstances and Offering Resources for Needs (ACORN) initiative in 2018. The templated screening expands

[16] Min Chen, Xuan Tan, and Rema Padman, "Social Determinants of Health in Electronic Health Records and Their Impact on Analysis and Risk Prediction: A Systematic Review," *Journal of the American Medical Informatics Association* 27, no. 11 (2020): 1764–1773, https://doi.org/10.1093/jamia/ocaa143; American Health Information Management Association, "Electronic Documentation Templates Support ICD-10-CM/PCS Implementation (2015 Update)," updated June 2015, https://bok.ahima.org/doc?oid=107665#.ZAoGL2nMLIU. (This site is not publicly accessible.)

[17] Chen, Tan, and Padman, "Social Determinants of Health in Electronic Health Records and Their Impact on Analysis and Risk Prediction: A Systematic Review"; American Health Information Management Association, "Electronic Documentation Templates Support ICD-10-CM/PCS Implementation (2015 Update)."

VHA's capability to collect data, incorporates SDOH/HRSN questions, and captures results within the EHR.[18] However, VA medical center leaders determine which services and staff members use the tool and as of July 2023, only two medical centers use the tool within inpatient medical units.

Lack of Staffing and National Guidance on Incorporating SDOH/HRSN into Discharge Assessment and Planning

Several medical center leaders surveyed identified a lack of staffing and guidance from national leaders as barriers to incorporating SDOH/HRSN into discharge assessment and planning. The National Social Work Program Manager also recognized staffing as a barrier, as staffing limitations prohibit social workers from proactively addressing SDOH/HRSN for all patients.

The OIG found a disconnect exists regarding the need for guidance, as the National Director of Social Work reported, "it's not something that we're hearing from the social work community." However, national social work leaders have recognized challenges to discharge assessment and planning and are creating a national community of practice for inpatient social workers. Even though many medical centers have local discharge policies and templates, nationally standardized guidance could enhance SDOH/HRSN data collection and benefit patients.

Additionally, the OIG found limited use of pilot projects to address SDOH/HRSN in discharge assessment and planning within inpatient units. Only 5 of 120 medical center leaders surveyed (4 percent) reported pilot project participation. As these projects enable VHA staff to test ideas prior to wider implementation, VHA should consider their use to identify and address the barriers to assessing SDOH/HRSN at discharge.

VHA's Efforts to Identify and Address Social Determinants of Health

Office of Health Equity-developed resources are intended for VHA clinical staff and medical center leaders' use and include health mapping tools, which can be used to identify and address health disparities within their community.[19] Of the 120 medical center leaders surveyed, only 10 (8 percent) reported using tools to determine health disparities within catchment areas.[20] The OIG found that the use of Office of Health Equity tools is a future opportunity for VHA social workers to identify health disparities and develop interventions within their geographic areas.

[18] VHA Office of Health Equity, "The Assessing Circumstances & Offering Resources for Needs (ACORN) Initiative," updated September 2022.

[19] These tools include the Veterans Geography of Opportunity tool, displayed as a map that allows users to filter and review data such as quality of life, education, and diet and exercise; and the Primary Care Equity Dashboard, which provides quality measures by sex, race/ethnicity, urban/rural setting at the VISN and medical center levels, and allows users to identify individual patients who may experience adverse health outcomes.

[20] The OIG recognizes this may not account for other medical center leaders' use of health disparity tools.

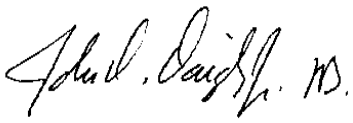
Additionally, community partnerships are a key objective in VHA's strategic plan to address SDOH. As 48 of the 120 (40 percent) leaders surveyed did not report formal partnerships within their communities, the OIG identified a future opportunity to create partnerships that will assist patients with SDOH/HRSN needs.

The OIG made five recommendations to the Under Secretary for Health related to the development of national policy on incorporation of SDOH/HRSN into discharge assessment and planning, implementation of a standardized EHR template such as the ACORN tool, evaluation of barriers to assessing SDOH/HRSN when discharging hospitalized patients, and use of health equity tools and community resource partnerships to address SDOH.

VA Comments and OIG Response

After reviewing the OIG draft report, VA provided the OIG with technical comments. The OIG reviewed and considered the comments. Based on the review, some changes were made to the report for clarification, but no changes were made to the OIG's findings.

The Under Secretary for Health concurred with recommendations 1, 3, 4, and 5 and provided acceptable action plans. The Under Secretary for Health concurred in principle with recommendation 2 (see appendix A). The OIG will follow up on the planned actions until they are completed.



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Contents

Abbreviations

ACORN	Assessing Circumstances and Offering Resources for Needs
EHR	electronic health record
HRSN	health-related social needs
OHE	Office of Health Equity
OIG	Office of Inspector General
SDOH	social determinants of health
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a review to assess Veterans Health Administration (VHA) and medical center leaders' awareness and incorporation of social determinants of health (SDOH) and health-related social needs (HRSN) into discharge assessments, planning, policies, and templates.[1] The OIG also examined VHA's efforts to identify and address SDOH/HRSN with (1) tools designed to recognize health disparities and (2) community resources and partnerships.[2] The OIG's review aims to identify how VHA recognizes and incorporates SDOH/HRSN into patients' discharge assessment and planning, as addressing these needs is critical to improving health outcomes.

Social Determinants of Health and Health-Related Social Needs

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 [one's] daily life."[3] The Agency for Healthcare Research and Quality states SDOH influence an individual's healthcare outcomes when the person experiences challenges from system or community-level conditions.[4] Additionally, understanding SDOH is "an integral part of delivering high-quality healthcare," with research showing "only 20 percent of health outcomes depend on clinical medicine, and that 80 percent are due to SDOH."[5]

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[1] VA and medical center leaders contacted were responsible for discharge assessment and planning.

[2] "Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by populations that have been disadvantaged by their social or economic status, geographic location, and environment." Examples of populations that experience health disparities include "some racial and ethnic minority groups, people with disabilities, women, people who are LGBTQI+ (lesbian, gay, bisexual, transgender, queer, intersex, or other)." What is Health Equity," Centers for Disease Control and Prevention, accessed June 7, 2023, https://www.cdc.gov/healthequity/whatis/index.html.

[3] "Social Determinants of Health," World Health Organization, accessed July 11, 2022, https://www.who.int/health-topics/social-determinants-of-health; The VA Office of Health Equity define SDOH as, "the social, economic, and physical conditions in the environments where people live, work, and play." "Social Determinants of Health," VHA Office of Health Equity, accessed March 19, 2024, https://www.va.gov/HEALTHEQUITY/Social_Determinants_of_Health.asp.

[4] "About SDOH in Healthcare," Agency for Healthcare Research and Quality, accessed August 16, 2022, https://www.ahrq.gov/sdoh/about.html. "The Agency for Healthcare Research and Quality's (AHRQ) mission is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable." "About AHRQ," AHRQ, accessed September 6, 2022, https://www.ahrq.gov/cpi/about/index.html.

[5] "About SDOH in Healthcare," AHRQ; Edmondo J. Robinson et al., "A Call for Action to Achieve Health Equity," *AHRQ Views* (blog), August 16, 2021, https://www.ahrq.gov/news/blog/ahrqviews/achieve-health-equity.html; Health outcomes include life expectancy, rates of early death, disability, psychological distress, level of joint pain, and life satisfaction. R. Gibson Parrish, "Measuring Population Health Outcomes," *Preventing Chronic Disease: Public Health Research, Practice, and Policy* 7, no. 4 (July 2010), https://www.cdc.gov/pcd/issues/2010/jul/pdf/10_0005.pdf.

HRSN are individual social and economic needs such as housing stability, access to food, employment, personal safety, transportation, and affordable utilities. HRSN may pose barriers to maintaining health and can occur due to SDOH.[6] A patient experiences an HRSN when they lack access to a particular resource, such as transportation to medical appointments, which requires the action of an individual to assist. A patient experiences the effects of SDOH when the community in which they live lacks multiple transportation resources, such as a public transit system and sidewalks, which requires larger, collective actions.[7]

VA addresses SDOH through homeless programs, education, and employment benefits; and VHA can target individual HRSN through programs delivered locally to patients that provide transportation assistance, extended clinic hours, and referrals to community resources.[8] The VHA social work mission highlights SDOH/HRSN concepts "to assist Veterans, their families and caregivers in resolving . . .challenges to health and well-being."[9] Medical social workers are trained to explore a patient's emotional and social issues and are skilled in accessing resources to address identified needs.[10]

Scope and Methodology

The OIG initiated the review on August 1, 2022, and conducted interviews from March 20 through April 3, 2023. Interviewees included the Executive Director of the VHA Office of Health Equity (OHE), the National Director of Social Work, a National Social Work Program Manager, the OHE Assessing Circumstances and Offering Resources for Needs (ACORN) Co-lead, and members of the National VA Social Work Professional Standards and Clinical Practice

[6] "Health-Related Social Needs vs The Social Determinants of Health," Oregon Health Authority, accessed February 14, 2023, https://www.oregon.gov/oha/HPA/dsi-pcpch/AdditionalResources/Health-related%20Social%20Needs%20vs%20the%20Social%20Determinants%20of%20Health.pdf. The OIG recognizes the distinction between the terms SDOH and HRSN. VA publications also use the term SDOH to refer to individual HRSN. Therefore, the OIG will use SDOH/HRSN when addressing individual patient social needs.

[7] Assistant Secretary for Planning and Evaluation, Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts, HP-2022-12, April 1, 2022.

[8] "Community Partnership Challenge series: How Veterans Hub and VHA's Office of Health Equity Address Social Determinants of Health," VA, National Center for Healthcare Advancement and Partnerships, July 9, 2020, https://www.va.gov/healthpartnerships/updates/CPC/07092020.asp; VHA OHE, "Identifying and Addressing Health-Related Social Needs Among Veterans Fact Sheet," accessed June 7, 2023, https://www.va.gov/HEALTHEQUITY/docs/Social_Determinants_Fact_Sheet_V2-0.pdf; David J. Shulkin, "Why VA Health Care is Different," *Federal Practitioner*, (May 2016): 9–11.

[9] "VHA Social Work Mission, Vision & Values," VA, accessed September 1, 2022, https://vaww.socialwork.va.gov/mission.asp. (This site is not publicly accessible.)

[10] Medical social workers "help patients understand their illness or condition and provide them with information about the resources available to them to cope with the emotional, financial, and social needs." "Medical Social Worker," Mayo Clinic, accessed July 13, 2023, https://college.mayo.edu/academics/explore-health-care-careers/careers-a-z/medical-social-worker/.

Committee.[11] The OIG also reviewed relevant VHA and VA medical center policies and procedures, VA strategic plans, SDOH/HRSN literature, and national and medical center electronic health record (EHR) templates.

The OIG disseminated a questionnaire related to the inclusion of SDOH/HRSN into discharge assessment and planning to 120 VA medical center leaders responsible for these functions.[12] Leaders at all VA medical centers with an inpatient medical and surgical unit during fiscal year 2021 received and responded to the questionnaire.[13] The OIG selected this time period to capture medical center practices in place after the onset of the COVID-19 pandemic, which brought increased awareness to the relationship between SDOH, HRSN, and health outcomes. All 18 Veterans Integrated Service Networks (VISNs) and all VHA complexity levels were represented within the 120 medical centers.[14]

The OIG reviewed the questionnaire responses and examined how VA medical center leaders incorporated SDOH/HRSN into patient discharge assessment and planning processes. The OIG recognized that exploring medical center leaders' experiences provided valuable context for understanding how staff incorporated SDOH/HRSN into discharge assessment and planning. The OIG analyzed responses and requested additional information from 29 medical center leaders.[15] The OIG did not independently verify VHA data for accuracy or completeness.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

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[11] VHA's OHE was created in 2012 to champion "the elimination of health disparities and achieving health equity for all Veterans." "Office of Health Equity," VHA OHE, accessed May 24, 2023, https://www.va.gov/healthequity/; The OIG interviewed the chairpersons of the 2016–2017 and 2020–2021 National VA Social Work Professional Standards and Clinical Practice Committee.

[12] Medical center staff completing the questionnaire included chiefs, acting/interim chiefs, or executives of social work services; a social work supervisor; a social worker; and one chief of quality management.

[13] Fiscal years for federal agencies include an annual time period of "October 1 of one calendar year through September 30 of the next." "The federal budget process," USAGov, accessed January 27, 2023, https://www.usa.gov/federal-budget-process. The questionnaire included topics such as policy, training, resources, and staffing.

[14] "The U.S. is divided into 18 Veterans Integrated Service Networks, or VISNs—regional systems of care working together to better meet local health care needs and provides greater access to care." "Veterans Integrated Services Networks (VISNs)," VHA, accessed June 6, 2023, https://www.va.gov/HEALTH/visns.asp#; VHA's Facility Complexity Model is used to measure the complexity of services provided at each facility and for "peer grouping purposes, such as operational reporting [and] performance measurement. . . .The Facility Complexity Model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3 with level 1a being the most complex and level 3 being the least complex." "Additional OPES Resources: Patient-Level Risk Adjustment Models and the Facility Complexity Model," VHA Office of Productivity, Efficiency, and Staffing, accessed June 6, 2023, https://dvagov.sharepoint.com/sites/VHAOPES/SitePages/Facility-Complexity-Model-and-Patient-Level-Risk-Adjustment-Models.aspx. (This site is not publicly accessible.)

[15] The OIG requested additional information about pilot programs, discharge assessment templates, implementation plans for VA SDOH initiatives, and use of health mapping tools.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Review Results

The unique demands on individuals who serve in the military contribute to a variety of complex health conditions. Furthermore, VHA patients experience increased exposure to social risk factors as those "who use VHA services generally have worse health status . . . and are from more socially disadvantaged groups, than the general population."[16]

VHA patients' potential health and social challenges may become evident after transitioning out of the hospital. Patients in general are particularly vulnerable when discharged from hospital inpatient care, as the primary responsibility for care often shifts from hospital providers to individuals and caregivers. Clinical research indicates that "approximately 20% of patients experience adverse events in the first 3 weeks after discharge, with 61% of those events regarded as preventable."[17]

The incorporation of SDOH/HRSN into discharge assessment and planning has been shown to improve health outcomes, as it enables care providers to assess whether aspects of the patient's physical and social environment may pose barriers to safety and well-being.[18] As the largest integrated healthcare system in the US, VHA has the unique capacity to simultaneously assess and address SDOH/HRSN nationally and locally. Additionally, VHA's EHR can be used to identify, compare, and measure outcomes of SDOH/HRSN on a large scale over time, while the

[16] Social risk factors are "specific adverse social conditions that are associated with poor health, like social isolation or housing instability." Hugh Alderwick and Laura M. Gottlieb, "Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Care Systems," *The Milbank Quarterly* 97, no. 2 (May 8, 2019): 407–19, https://doi.org/10.1111/1468-0009.12390; Jose A. Betancourt et al., "Exploring Health Outcomes for U.S. Veterans Compared to Non-Veterans from 2003 to 2019," *Healthcare* 9, no. 5 (May 18, 2021): 604, https://doi.org/10.3390/healthcare9050604; Karin Nelson et al., "The Association Between Neighborhood Environment and Mortality: Results from a National Study of Veterans," *Journal of General Internal Medicine* 32, no. 4 (November 4, 2016): 416–22, https://doi.org/10.1007/s11606-016-3905-x; Richard E. Adams et al., "Social and Psychological Risk and Protective Factors for Veteran Well-Being: The Role of Veteran Identity and Its Implications for Intervention," *Military Behavioral Health* 7, no. 3 (March 12, 2019): 304–14, https://doi.org/10.1080/21635781.2019.1580642.

[17] Katherine Liang and Eric Alper, "Patient Safety During Hospital Discharge," *AHRQ PSNet*, accessed October 12, 2023, https://psnet.ahrq.gov/perspective/patient-safety-during-hospital-discharge.

[18] Tamika Hudson, "The Role of Social Determinates of Health in Discharge Practices," *Nursing Clinics of North America* 56, no. 3 (September 1, 2021): 369–378, https://doi.org/10.1016/j.cnur.2021.04.004.

National Veteran Health Equity Report offers detailed, quantitative evaluations of SDOH to guide support for HRSN.[19] Further, recent VA strategic plans contain the following direct references to SDOH/HRSN:[20]

- The 2018–2024 plan documents a strategy to "improve health outcomes by assisting Veterans with the social determinants of health to include education, vocational rehabilitation, employment, disability income, housing, life insurance, planning for memorial services, and access to legal services."[21]
- The 2022–2028 plan documents an objective to provide benefits and services that improve SDOH for veterans.[22]

Social workers play a critical role in assessing and managing SDOH/HRSN. According to the Acting Deputy Under Secretary for Health for Operations and Management, "social workers often have a direct impact on the re-admission of Veterans to inpatient facilities, as well as on the ability of Veterans to reach their highest level of independence and functioning."[23] VHA policy outlines responsibilities for social workers to

- assist patients with discharge planning and care coordination,
- assess for resource gaps,
- "identify psychosocial problems and stressors," and
- provide services to assist with social and financial vulnerabilities.[24]

Social workers may also provide case management services based on a patient's needs and the resources at hand and offer clinical interventions to address a patient's SDOH/HRSN prior to

[19] Shulkin, "Why VA Health Care is Different"; VHA OHE, *National Veteran Health Equity Report 2021*, September 2022. The National Veteran Health Equity Report provides information to compare veterans' health and the care they receive based on characteristics such as race, gender, age, residence in rural or urban areas, and income to increase "knowledge and awareness of the state of VHA health equity" and provide "a common foundation and evidence base for elucidating barriers, data needs, and recommended actions for improving health equity systemwide."

[20] VA strategic plans define VA's goals and the actions taken to achieve the goals.

[21] VA, *Department of Veterans Affairs FY [fiscal year] 2018–2024 Strategic Plan*, refreshed May 31, 2019.

[22] VA, *Department of Veterans Affairs Fiscal Years 2022–28 Strategic Plan*. In the fiscal year 2022–2028 plan, VA defines the five SDOH domains as "economic stability and consistent income; access and quality of education and schools; access to quality, comprehensive health care; safety and health of neighborhood and environment; [and] social and community support and interactions."

[23] Acting Deputy Under Secretary for Health for Operations and Management (10N), "VHA Social Work Clinical Note Templates," memorandum to [VISN] Network Directors (10N1-23), January 13, 2015.

[24] VHA Directive 1110.02, *Social Work Professional Practice*, July 26, 2019; VHA Directive 1110.04(1), *Integrated Case Management Standards of Practice*, September 6, 2019, amended May 18, 2020.

discharge.[25] The National Director of Social Work told the OIG that SDOH/HRSN were incorporated within the VHA social work mission to formally recognize that social workers "already do this work and we wanted to ensure that it was prevalent in our mission statement to really clarify that . . . we own a big piece of this work from a social work professional practice perspective."

A comprehensive assessment of a patient's social needs is consistent with federal law, which holds VA responsible for addressing both medical and non-medical needs of the veteran population.[26] A discharge assessment typically begins when a social worker meets with a hospitalized patient to gather information about the patient's "health, living situation, family and other support systems, military experience and the things the Veteran needs help with."[27] Then, discharge planning occurs when a multidisciplinary treatment team, in conjunction with the patient and the patient's support system, develops an individualized plan to manage the patient's health concerns, coordinates services for future health and social needs, and guides the transition to the next level of care.[28]

The OIG found leaders surveyed reported that social workers are involved in the completion of discharge assessments at 115 of 120 medical centers (96 percent).[29] However, despite VHA's description of the social work role and the demonstrated correlation of assessing a patient's SDOH/HRSN at discharge and improved health outcomes, the OIG found that medical center leaders did not consistently incorporate SDOH/HRSN into discharge assessment and planning. Additionally, the OIG found few medical center leaders responsible for discharge assessment and planning reported using OHE-developed health disparity data tools and almost half of the leaders surveyed did not participate in any formal partnership with community resources to address SDOH.

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[25] "VHA Social Work: What VA Social Workers Do," VA, accessed May 3, 2023, https://www.socialwork.va.gov/socialworkers.asp. The VA, with over 17,300 social workers on staff, is the largest employer of master's level social workers in the United States. "VHA Social Work," VA, accessed September 13, 2022, https://www.socialwork.va.gov/.

[26] VA, *Federal Benefits for Veterans, Dependents and Survivors*, Pamphlet 80-19-01, 2020.

[27] "VHA Social Work: What VA Social Workers Do." The OIG recognizes discharge planning is a combined effort across interdisciplinary fields; however, for the purposes of this report the OIG uses discharge assessment to refer to the social needs assessments completed prior to a patient's discharge.

[28] Daniela C. Gon?alves-Bradley et al., "Discharge Planning from Hospital (Review)," *Cochrane Database of Systematic Reviews* 2, no. CD000313 (February 24, 2022), https://doi.org/10.1002/14651858.CD000313.pub6; The Joint Commission, *Standards Manual*, E-dition, PC.04.01.03, February 2023. "The hospital discharges or transfers the patient based on the patient's assessed needs and the organization's ability to meet those needs." A treatment team is a group of healthcare professionals from different fields such as doctors, nurses, social workers, and physical and occupational therapists that work together with a patient to determine a treatment plan. The assessment of patient needs is a continuous process during the hospital stay.

[29] The OIG received information that there is no national template, and therefore, could not find a standardized data entry point to determine the percentage of patients nationally who receive discharge assessments.

1. Incorporation of Social Determinants of Health and Health-Related Social Needs into Discharge Policies and Procedures

The OIG reviewed VHA guidance and determined there were no national policies or procedures incorporating SDOH/HRSN into discharge assessment and planning. The OIG learned the VA Office of Care Management and Social Work Services published reference documents describing the importance of incorporating SDOH/HRSN into discharge assessment and planning and provided the documents to medical center social work chiefs and executives. However, the OIG found medical center leaders reported limited awareness of the published referenced documents, and few reported using the documents to develop local medical center policies.

Policies and procedures ensure staff have a clearly documented reference for performance expectations; consistent patient care; and laws, regulations, and accreditation requirements.[30] Discharge policies and procedures ensure facilitation of a patient's transition to the next level of care. Literature suggests medical centers should identify best practices and standardize discharge planning procedures. Since accounting for SDOH is a key step toward addressing health disparities and achieving greater health equity, "social determinants of health must be integrated into treatment and discharge planning to support positive health outcomes."[31]

Lack of Awareness of National Discharge Assessment and Planning Reference Documents

The OIG learned the VA Office of Care Management and Social Work Services published several reference documents for social workers about discharge planning from December 2017 through June 2021. These documents outlined a social worker's role within the discharge assessment and planning process, best practices, and suggested procedures on how to incorporate SDOH/HRSN. However, the documents did not provide formal guidance or mandate formal requirements.

The VA Office of Care Management and Social Work Services distributed the documents through a national email group, requesting that group members disseminate the information to local social work staff.[32] The documents included the

- *Discharge Planning White Paper*,

[30] "Jessica J. Ayd et al., "Effective Health Care Policies Mitigate Litigation Risks," American Society for Health Care Risk Management Forum, June 9, 2021, https://forum.ashrm.org/2021/06/23/effective-health-care-policies-mitigate-ligation-risks/.

[31] Tamika Hudson, "The Role of Social Determinates of Health in Discharge Practices."

[32] The OIG learned of the distribution of documents during an interview and through document review. The email group included social work VISN leads and medical center social work chiefs and executives.

- "Department of Veterans Affairs National Social Work Program Office Discharge Planning During COVID-19: Tip Sheet for Social Workers," and
- *Guide to Discharge Planning*.

Discharge Planning White Paper

The VA Office of Care Management and Social Work Services participated in a National Acute Care Integrated Clinical Practice Team that examined "integrated care on inpatient units" and "recognized the need to identify existing social work practice standards for discharge planning and establish standards where needed."[33] The clinical practice team identified variations in practices between medical centers and recommended the development of a national process to standardize discharge planning.[34] The team's recommendation prompted a national social work leadership committee to develop the *Discharge Planning White Paper* in 2017 to

> assist social workers in defining their role in the inter-professional process of discharge planning; set practice standards according to accrediting bodies and professional organizations; and establish a standardized process. The hope is this information will be helpful in addressing transition goals for Veterans to prevent readmission, and to meet the educational needs of social workers in the field.[35]

The OIG reviewed the December 2017 *Discharge Planning White Paper* and found the national social work leadership committee identified SDOH/HRSN best practices when a social worker performs discharge assessment and planning tasks such as

- a comprehensive assessment of "access to care, economics, housing, social supports, and functional and psychological status" to ensure comprehensive discharge planning "including early referrals to community or VA resources;"
- coordination of handoff or referrals for ongoing services to support psychosocial needs beyond discharge as "services initiated from the inpatient setting reduce the likelihood of outpatient crisis or future hospitalizations;" and
- confirmation that the patient "has access to resources to carry out the plan."[36]

The committee chair told the OIG the committee's purpose was to "explore the resources that guide discharge planning" and submit findings to the National Social Work Leadership Council,

[33] VA Office of Care Management and Social Work Services, *Discharge Planning White Paper*, December 2017. The National Acute Care Integrated Clinical Practice Team was formed in 2016.

[34] VA Office of Care Management and Social Work Services, *Discharge Planning White Paper*.

[35] VA Office of Care Management and Social Work Services, *Discharge Planning White Paper*. In this document, VA specifies that "there are eight National Social Work Committees, whose function is to report to the Social Work Leadership Council (SWLC). The SWLC serves as an advisory council to the National Social Work Program Care Management and Social Work in VA Central Office."

[36] VA Office of Care Management and Social Work Services, *Discharge Planning White Paper*.

and that "a white paper is intended to inform leadership decisions." When asked, the National Social Work Program Manager reported distribution of the white paper to all VA social workers, stating, "Any social worker could take it, could use it, it's widely available. The information if you want to use it, you're able to utilize it." Further, the National Social Work Program Manager reported it was a "summary document of what a social worker needs to know in VA and what the current state was for VA with discharge planning" with suggestions but not requirements for "best practices or options for care."

The OIG found 59 of 120 (49 percent) of leaders surveyed reported awareness of the white paper and 26 of the leaders surveyed reported use of the white paper to develop local practices related to discharge assessment and planning.

The OIG determined that, despite the National Acute Care Integrated Clinical Practice Team's recommendation and the VA Office of Care Management and Social Work Services' distribution of the *Discharge Planning White Paper*, it was largely unknown to medical center leaders responsible for discharge assessment and planning on inpatient units and did not contribute to widespread national changes to local discharge planning policy or processes.

Discharge Planning During COVID-19: Tip Sheet for Social Workers

The COVID-19 pandemic increased attention on the impact of SDOH/HRSN and how health disparities disproportionately affect rates of illness and death.[37] "Many social determinants of health—including poverty, physical environment (e.g., smoke exposure, homelessness), and race or ethnicity" were found to have substantial impact on COVID-19 outcomes and demonstrated the need to include SDOH/HRSN into public health priorities and policy implementation.[38] According to the VA Assistant Under Secretary for Health, Discovery, Education and Affiliate Networks,

> The COVID-19 pandemic not only amplified the extent and nature of healthcare disparities, but dramatically underscored their impact on healthcare overall.

[37] Elissa M. Abrams and Stanley J. Szefler, "COVID-19 and the Impact of Social Determinants of Health," *Lancet Respiratory Medicine* 8, no. 7 (July 2020): 659–61, https://doi.org/10.1016/s2213-2600(20)30234-4; A pandemic is "an outbreak of a disease that occurs over a wide geographic area (such as multiple countries or continents) and typically affects a significant proportion of the population." *Merriam-Webster.com Dictionary*, "pandemic," accessed December 6, 2022, https://www.merriam-webster.com/dictionary/pandemic; The World Health Organization declared a world-wide pandemic on March 11, 2020, citing "alarming levels of spread and severity" of COVID-19. "WHO Director-General's opening remarks at the media briefing on COVID-19 - 11 March 2020," World Health Organization, accessed December 6, 2022, https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

[38] Abrams and Szefler, "COVID-19 and the Impact of Social Determinants of Health."

> Closing these gaps in care means recognizing the population groups most acutely affected as well as the drivers behind the inequities they face.[39]

The National Director of Social Work told the OIG the VA Office of Care Management and Social Work Services' COVID-19 Tiger Team developed the April 2020 "Department of Veterans Affairs National Social Work Program Office Discharge Planning During COVID-19: Tip Sheet for Social Workers," as "the social work community was asking can you please provide some reference points for us on how we can navigate discharge planning in this COVID environment, especially because resources were . . .limited."[40]

The tip sheet aimed "to serve as a general overview of discharge planning during the COVID-19 pandemic."[41] The National Social Work Program Manager stated the tip sheet also addressed inpatient unit staff training needs as social workers who did not have prior experience with discharge planning could reference the tip sheet and get "information quickly . . .while people were in the crisis, and planning for the future with a guide made more sense."[42]

The OIG reviewed the tip sheet's recommendations for "SDOH assessment and intervention within 24 hours of admission" to "improve outcomes for patients" and resources for "Patient Post-Discharge Supportive Services" based on the complexity of a patient's SDOH/HRSN.[43]

The OIG found 59 of 120 (49 percent) of leaders surveyed reported awareness of the tip sheet and 13 of the leaders surveyed reported use of the tip sheet to develop local practices related to discharge assessment and planning.

The OIG determined that, despite the VA Office of Care Management and Social Work Services' efforts to provide an overview of discharge planning during the COVID-19 pandemic, the tip sheet (1) was largely unknown to medical center leaders responsible for discharge

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[39] VA, *National Veteran Health Equity Report 2021*, September 2022. The Assistant Under Secretary for Health for Discovery, Education and Affiliate Networks has been in the position since 2018.

[40] "Department of Veterans Affairs National Social Work Program Office Discharge Planning During COVID-19: Tip Sheet for Social Workers," April 23, 2020, updated June 9, 2020. A Tiger Team is a group of people with different expertise "pulled together for a period of time to address a critical issue." "Tech at GSA: Running Tiger Teams," General Services Administration, accessed April 12, 2023, https://tech.gsa.gov/guides/tiger_teams/. The National Director of Social Work reported activating the National Social Work COVID-19 Tiger Team, separate from the National Social Work Leadership Council, to develop COVID-19 pandemic national response resources.

[41] "Department of Veterans Affairs National Social Work Program Office Discharge Planning During COVID-19: Tip Sheet for Social Workers."

[42] Hospitals experienced staffing shortages from COVID-19 due to healthcare staff becoming sick or caring for sick family members. Hospital leaders were assigning staff to cover areas where they may not typically be assigned and needed to ensure orientation and training to accommodate new staffing assignments. "Strategies to Mitigate Healthcare Personnel Staffing Shortages," Centers for Disease Control and Prevention (CDC), accessed May 3, 2023, https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html.

[43] "Department of Veterans Affairs National Social Work Program Office Discharge Planning During COVID-19: Tip Sheet for Social Workers."

assessment and planning on medical and surgical units and (2) did not contribute to widespread local discharge planning policy or processes.

Discharge Planning Guide

The OIG learned the VA Office of Care Management and Social Work Services' Social Work Professional Standards and Clinical Practice Committee and the COVID-19 Tiger Team published a 2021 *Guide to Discharge Planning*, which provides discharge planning information to social workers and expands on the information in the 2017 *Discharge Planning White Paper*.[44] The guide states comprehensive discharge planning begins "after [the] assessment of the social determinants of health (SDOH) experienced by the Veteran" and includes health conditions, housing, access to care, economics, support services, safety, mental health or substance use, and functional status.[45]

The National Director of Social Work reported the guide was distributed as an updated resource for the VHA social work community to provide "more about VA's approach to how social work should engage with the healthcare team and discharge planning from all areas of the organization" and also to examine "discharge planning areas of focus that we really need to be mindful of in terms of social determinants of health, so ensuring that there are resources provided." The OIG surveyed medical center leaders and asked, "What VHA policies, memorandum or guidance does your facility use to develop local practices related to discharge assessment and planning?" Only 1 medical center leader of 120 mentioned the 2021 discharge planning guide.[46]

The VA Office of Care Management and Social Work Services invested resources to develop reference documents and recommendations related to social work's role and the incorporation of SDOH/HRSN into the discharge assessment and planning process. The National Director of Social Work told the OIG the reference documents were created in response to topics of interest identified as important by VA social workers. However, national social work leaders told the OIG the reference documents were not intended as formal guidance, and the documents were developed to support social workers as, "something that we endorse, but it's not something we are mandating."

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[44] VA Office of Care Management and Social Work Services, *Guide to Discharge Planning*, June 2021. The National Social Work Program Manager told the OIG that the 2021 guide transitioned the 2017 white paper and 2020 tip sheet into one document, combining the expertise of the National Social Work Leadership Council and the National Social Work COVID-19 Tiger Team. The National Social Work Leadership Council serves as a consultative council to the National Social Work Program, Care Management and Social Work Services in VA Central Office. VHA Directive 1110.02.

[45] VA Office of Care Management and Social Work Services, *Guide to Discharge Planning*.

[46] The OIG learned of the guide after distribution of the medical center questionnaire; therefore, the OIG did not assess medical center leaders' awareness of the reference document and subsequent policy and practice changes.

The National Director of Social Work also told the OIG of encouraging social work chiefs and executives to ensure that

- "veterans, especially those veterans that are at high risk, are being assessed and it's being documented and there's follow-up," and
- "discharge planning assessments are being conducted by social workers within consultation with the health care team . . . social workers work with the entire health care team on the inpatient units to identify those needs and then address them accordingly."

The National Social Work Program Manager stated the VA Office of Care Management and Social Work Services had not developed policy, as this office was not the process owner for all layers of discharge planning at individual medical centers. The program manager noted that discharge planning varies based on "facility size, geographic location, [and] the way the facility sets up their discharge unit."

The OIG concluded although social workers are involved in discharge assessment and planning at most medical centers, there are no national policies incorporating SDOH/HRSN into discharge assessment and planning. While the VA Office of Care Management and Social Work Services reference documents include best practices for SDOH/HRSN incorporation, the OIG found that leaders surveyed had limited awareness of these documents and few changes were made to incorporate the recommendations.[47]

Discharge policies and procedures are a crucial tool to ensure social workers understand how to consistently incorporate SDOH/HRSN when assessing a patient for discharge. Although the OIG acknowledges the unique qualities of each medical center and that the VA Office of Care Management and Social Work is not the process owner for all aspects of discharge planning, some standardization at the program office level ensures the quality of care. The development of a national requirement for SDOH/HRSN incorporation into discharge assessment and planning is a future opportunity for social work intervention, which may ultimately lead to improved health outcomes and reduced readmissions.

Local Discharge Assessment and Planning Policies

The OIG reviewed medical center discharge policies and procedures to examine how SDOH/HRSN are incorporated due to limited local awareness of VA Office of Care Management and Social Work Services discharge assessment and planning reference documents. The OIG found 109 of 120 (91 percent) of leaders surveyed were able to provide a local discharge policy or procedure to the OIG for review. The OIG also found that 96 of 109 facility

[47] The OIG did not ask leaders who reported awareness of the reference documents why the information was not incorporated into medical center policy.

policies or procedures (88 percent) addressed SDOH/HRSN. The OIG determined that despite a lack of national policy, most medical centers had local discharge policies or procedures.

The OIG acknowledges local leaders' efforts to develop local policies in the absence of a national policy and recognizes that some variability in policy may be necessary to meet the unique needs of each medical center. However, not all medical center policies incorporated SDOH/HRSN as recommended in the VA Office of Care Management and Social Work Services reference documents. The development of a national discharge planning and assessment policy will reduce variation among facilities and is a future opportunity to ensure SDOH/HRSN assessments are standardized and consistently implemented VHA wide.

Lack of National Social Work Discharge and Assessment Templates

The OIG found that although there is no national discharge assessment and planning template for medical and surgical units, over half of medical center leaders surveyed reported existence of a local template.

An EHR allows a healthcare system to screen, collect, and analyze unique patient demographics that affect patient health outcomes.[48] As EHR screening templates standardize data collection, templates with SDOH/HRSN-based questions provide healthcare systems with an improved ability to predict "healthcare utilization and health outcomes," including risk of hospital readmissions.[49] Research also shows SDOH/HRSN data collection varies significantly across VA medical centers and SDOH/HRSN risk factors are not well documented.[50] This affects the ability of VHA leaders to "better allocate funding and resources to address such issues."[51]

In April 2011, the VA Office of Care Management and Social Work Services released three national EHR social work screening templates to track VA social work case management

[48] "Frequently Asked Questions: What is an electronic health record (EHR)," Office of the National Coordinator for Health Information Technology, accessed March 8, 2023, https://www.healthit.gov/faq/what-electronic-health-record-ehr; Min Chen, Xuan Tan, and Rema Padman, "Social Determinants of Health in Electronic Health Records and Their Impact on Analysis and Risk Prediction: A Systematic Review," *Journal of the American Medical Informatics Association* 27, no. 11 (2020): 1764–1773, https://doi.org/10.1093/jamia/ocaa143.

[49] Chen, Tan, and Padman, "Social Determinants of Health in Electronic Health Records and Their Impact on Analysis and Risk Prediction: A Systematic Review." "Templates add an advantage by reminding providers to ask patients specific questions" and ensure patient information is collected, presented, and organized the same way for all patients so that data analysis can produce reliable insight about relationships in data points and patient outcomes. American Health Information Management Association, "Electronic Documentation Templates Support ICD-10-CM/PCS Implementation (2015 Update)," updated June 2015, https://bok.ahima.org/doc?oid=107665#.ZAoGL2nMLIU. (This site is not publicly accessible.)

[50] Charlie M. Wray et al., "Examining the Interfacility Variation of Social Determinants of Health in the Veterans Health Administration," *Federal Practitioner* 38, no. 1 (January 2021): 15–19, https://doi.org/10.12788%2Ffp.0080.

[51] Wray et al., "Examining the Interfacility Variation of Social Determinants of Health in the Veterans Health Administration."

outcomes, improve social work interventions, and identify the social needs of patients by collecting health factor data (see table 1).[52]

Table 1. Summary of National Social Work Screening Templates

Template Title	Description of Template
Social Work Triage Assessment	Identifies the patient's and patient's family or caregiver's SDOH/HRSN to determine the need for further social work services.
Social Work Comprehensive Assessment	An "in-depth assessment of issues identified in the triage assessment" that addresses SDOH/HRSN topics including access to care, economics, housing, psychological status, social support, and functional status. The assessment prompts the social worker to assign a level to rate the severity of need for the presenting issues and identify a level of social work case management.
Social Work Case Management Note	Documents ongoing social work services and whether SDOH/HRSN have been resolved.

Source: OIG review of VA Office of Care Management and Social Work Services documents.

The OIG found that while the VA Office of Care Management and Social Work Services has established social work screening templates for primary care, there is no template for discharge planning within inpatient medical and surgical units, where patients are known to be vulnerable. The National Director of Social Work told the OIG that medical center social workers can "use these notes in other areas of care as appropriate" if no changes are made in the content compromising data collection.[53]

Although there is no national discharge assessment and planning template for medical and surgical units, the OIG learned 61 of 120 leaders (51 percent) surveyed reported existence of a local template. The OIG reviewed local discharge assessment templates and found 60 of 61 local templates (98 percent) included SDOH/HRSN-related assessment questions.[54] Of the local

[52] Health factors are data extracted from VHA EHR templates about patient psychological and social needs based on answers to assessment questions such as family history of alcohol use or smoking status. Acting Deputy Under Secretary for Health for Operations and Management (10N), "VHA Social Work Clinical Note Templates," memorandum.

[53] VHA also provided guidance in 2015 that encouraged VISN Network Directors to require primary care social workers to use the templates as well as "other social work programs where case management services are provided." Acting Deputy Under Secretary for Health for Operations and Management (10N), "VHA Social Work Clinical Note Templates," memorandum. The National Social Work Program Manager told the OIG the data collected is used to identify trends to inform leadership decisions such as staffing, programming, and training within primary care, and template answers trigger specific data collection. The removal of these fields from the template would change the consistency of information available for data analysis.

[54] The OIG reviewed literature to identify SDOH and HRSN topics listed within screening tools. The four screening tools reviewed included Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE), Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool, HealthBegins Upstream Risks Screening Tool, and the Health Leads Screening Tool; Chen, Tan, and Padman, "Social Determinants of Health in Electronic Health Records and Their Impact on Analysis and Risk Prediction: A Systematic Review."

templates that included SDOH/HRSN-related assessment questions, 34 contained specific questions that addressed patient SDOH/HRSN beyond discharge. Figure 1 provides examples of questions identifying patient SDOH and HRSN needs beyond discharge.

Figure 1. *Examples of questions identifying patient SDOH and HRSN beyond discharge.*
Source: OIG analysis of VHA submitted discharge note templates.

Literature demonstrates that medical centers benefit from SDOH/HRSN data collection via a template as it allows for standardized assessment and identification of barriers that contribute to poor health outcomes, such as readmissions.[55] Additionally, data standardization ensures patients receive needed social work services while providing national and medical centers leaders with reliable information to facilitate policy revision and implementation and resource distribution. The National Director of Social Work stated that "with the new focus on social determinants of health in VHA," the national social work program plans to explore opportunities to develop strategies to better ensure social assessments are "happening consistently across the organization."

The OIG concluded the VA Office of Care Management and Social Work Services developed and established the use of national screening templates within primary care settings; however, no national discharge planning assessment templates exist for inpatient medical and surgical units.[56] Although 61 of 120 (51 percent) of the medical centers surveyed had a local template, approximately half of medical centers did not include identification of SDOH/HRSN that would affect a patient's future healthcare outcome. This offers an opportunity to ensure nationally standardized assessments of patients' SDOH/HRSN across care settings to avoid untoward events such as readmission and to provide reliable feedback that would inform policy or resource distribution updates.

Assessing Circumstances and Offering Resources for Needs Initiative

While many medical center leaders responsible for discharge assessment and planning reported use of a local template, the OIG found VHA recognized the value of incorporating SDOH/HRSN into a screening tool and launched the Assessing Circumstances and Offering Resources for Needs (ACORN) initiative in 2018. The templated screening expands VHA's capability to collect data, incorporates SDOH/HRSN questions, and captures results within the EHR. However as of July 2023, only two medical centers use the tool within inpatient medical units.

OHE, in partnership with the VA Office of Care Management and Social Work Services, deployed the ACORN screening initiative to "systematically identify and address social needs

[55] Chen, Tan, and Padman, "Social Determinants of Health in Electronic Health Records and Their Impact on Analysis and Risk Prediction: A Systematic Review;" American Health Information Management Association, "Electronic Documentation Templates Support ICD-10-CM/PCS Implementation (2015 Update)," updated June 2015, https://bok.ahima.org/doc?oid=107665#.ZAoGL2nMLIU. (This site is not publicly accessible.)

[56] Acting Deputy Under Secretary for Health for Operations and Management (10N), "VHA Social Work Clinical Note Templates," memorandum.

among all Veterans to improve health outcomes and promote health equity."[57] The ACORN screening is suitable for any healthcare setting, but according to the OHE's Executive Director, VA medical center leaders determine which services and staff members use the tool.[58] The templated screening incorporates questions within SDOH and HRSN domains (see figure 2).

Figure 2. *The SDOH and HRSN domains included in the ACORN screening tool.*
Source: VHA ACORN Screening Tool, September 2022.

The ACORN screening results are captured within a patient's EHR to ensure the treatment team has information to address social risk factors during future appointments.[59] If the screening tool

[57] Alicia J. Cohen et al., "Adaptation of a Social Risk Screening and Referral Initiative Across Clinical Populations, Settings, and Contexts in the Department of Veterans Affairs Health System," *Frontiers in Health Services* 2 (January 30, 2023): 1–10, https://doi.org/10.3389/frhs.2022.958969. A multidisciplinary team from the VA New England Healthcare System first developed and piloted the ACORN screening tool in 2018. The tool was designed based on social risk screening models and existing VHA screening processes. The ACORN screening tool has since been adapted over time based on feedback from patients, frontline staff, and VA leaders and subject matter experts.

[58] Medical centers have implemented the ACORN screening tool in settings including primary care, geriatrics, whole health groups, and emergency departments. Staff performing the screening include but are not limited to social workers, nurses, and peer specialists.

[59] VHA OHE, "Identifying and Addressing Health-Related Social Needs Among Veterans Fact Sheet."

indicates unmet SDOH/HRSN, the patient receives a locally-developed resource guide and social work support.[60] The ACORN screening tool also expands VHA's capability to collect data on SDOH/HRSN and is "a critical step towards connecting patients with services, identifying gaps in service delivery, and informing future resource allocation."[61]

As of April 2023, the ACORN initiative was active at 27 medical centers.[62] The OIG found 2 of the 27 medical centers, the VA Hudson Valley Healthcare System in New York and the Marion VA Medical Center in Illinois, implemented the ACORN tool with patients on inpatient medical units. Staff from these medical centers reported social workers use the ACORN screening tool to assess patients on inpatient units, begin to address SDOH/HRSN during admission, and facilitate handoff to outpatient social workers for continued case management after discharge.

The OIG learned the national ACORN team recognizes the opportunity to screen hospitalized patients who "have not otherwise presented for outpatient care" and "may also be at particularly high risk for experiencing unmet social needs, making it crucial to screen this patient population to equitably expand ACORN's reach."[63] When asked about plans to widely implement use of the ACORN screening tool, the National Director of Social Work stated

> it would be wonderful that a veteran would walk into any point of care in VHA . . . complete the screening, the ACORN screening, while they are either in their appointment or waiting for their appointment, which would then provide them direct access to a social worker to do that proactive intervention, right because, honestly, that's what we're trying to do. We want to identify the veteran's needs as early as possible before it becomes a crisis, so that we can keep them moving forward in their journey to wellness.[64]

The OHE ACORN co-lead told the OIG of plans for continued ACORN expansion across VHA by the end of fiscal year 2023 to include additional sites and implementation of a national data

[60] "Initial funding for ACORN was provided by the VHA Innovators Network Spark-Seed-Spread Innovation Investment Program in 2018. The [OHE] has funded the continued implementation and evaluation of ACORN since 2019." VHA OHE, "The Assessing Circumstances & Offering Resources for Needs (ACORN) Initiative," updated September 2022.

[61] Cohen et al., "Adaptation of a Social Risk Screening and Referral Initiative Across Clinical Populations, Settings, and Contexts in the Department of Veterans Affairs Health System;" Lauren E. Russell et al., "Implementing a Social Needs Screening and Referral Program Among Veterans: Assessing Circumstances & Offering Resources for Needs (ACORN)," *Journal of General Internal Medicine* (May 10, 2023), https://doi.org/10.1007/s11606-023-08181-9.

[62] The OHE ACORN co-lead reported sites are in different phases of implementation.

[63] Cohen et al., "Adaptation of a Social Risk Screening and Referral Initiative Across Clinical Populations, Settings, and Contexts in the Department of Veterans Affairs Health System."

[64] Point of care in VHA refers to all medical center settings including the emergency room, outpatient clinics, and inpatient units.

dashboard.[65] The fiscal year 2023 health equity operational plan also included an action item to address SDOH through expanding use of the ACORN screening tool across "VHA clinical sites."[66] However, OHE leaders described barriers to ACORN's further implementation nationally, such as

- expansion is time intensive and requires individualized implementation support for new sites,
- current staffing levels do not support the ability to manage increased social work referrals generated by the screening tool,
- patient self-screening processes are not available to lessen staff burden, and
- staff inconsistently screen patients for SDOH/HRSN.

The OHE ACORN co-lead and the National Social Work Program Manager told the OIG that as more data about the prevalence of SDOH/HRSN among VHA patients becomes available, resources such as increased staffing may be allocated to support SDOH/HRSN. OHE's Executive Director further explained training was being developed to address implementation barriers.

The OHE ACORN co-lead and National Social Work Program Manager also reported their intentions to replace the Social Work Triage Assessment template with the ACORN screening tool, thus making a national version of the ACORN EHR template available to all VHA facilities. However, since national social work leaders reported only primary care social work is required to use the National Social Work Triage Assessment Note, there remains a need to promote ACORN screening on inpatient medical and surgical units.

The OIG determined that VHA has recognized and encouraged the identification of SDOH/HRSN through the ACORN initiative optional templated screening tool. However, as of July 2023, staff at only two medical centers reported implementing the tool within inpatient medical units. The OIG concluded the efficacy of the tool should be evaluated to support OHE and social work leaders in addressing barriers to ACORN implementation nationally. As standardized assessments allow VHA staff to collect and analyze patient SDOH/HRSN data to inform national policy, implementation of the ACORN screening tool on inpatient units can provide greater insight into resource needs.

[65] Health care organizations use dashboards to capture, analyze, and display data with a goal for "users to quickly visualize actionable data to inform and optimize clinical and organizational performance." Danielle Helminski et al., "Dashboards in Health Care Settings: Protocol for a Scoping Review," *Journal of Medical Internet Research* 11, no. 3 (March 2, 2022): e34894, https://doi.org/10.2196/34894.

[66] VHA OHE, *VHA Health Equity Action Plan FY23 Operational Plan*, November 10, 2022; The Health Equity Action Plan is "a living strategic document to achieve health equity for U.S. Veterans," and an annual Health Equity Action Plan Operational Plan "identifies functions, activities, and objectives for the current fiscal year." "Health Equity Action Plan," VHA OHE, accessed May 4, 2023, https://www.va.gov/HEALTHEQUITY/Health_Equity_Action_Plan.asp.

Furthermore, expansion and implementation of the ACORN screening tool on inpatient units ensures vulnerable patients are identified prior to discharge and provided appropriate services to reduce poor health outcomes.

Barriers to Incorporating Social Determinants of Health and Health-Related Discharge Needs into Discharge Assessment and Planning

The OIG found several medical center leaders surveyed identified the lack of national guidance as a barrier to incorporating SDOH/HRSN into discharge assessment and planning, while the National Director of Social Work denied awareness that additional guidance is needed. The OIG found in the absence of guidance from national leaders, medical center leaders created local discharge policies and templates; however, in doing so, not all local policies and templates address SDOH/HRSN.

Screening patients for SDOH/HRSN has the potential to improve health outcomes, but literature identifies implementation barriers such as not enough time during patient appointments and a lack of knowledge or resources to adequately address SDOH/HRSN.[67] To understand the potential VHA-specific challenges, the OIG asked medical center leaders to identify barriers for incorporation of SDOH/HRSN into discharge assessment and planning. The leaders' most frequently cited barriers were lack of (1) staffing and (2) guidance from national leaders.

The National Social Work Program Manager recognized the lack of staffing as a barrier during an interview with the OIG, stating that "[social workers] want to do case management, they want to do supportive counseling, they want to spend the time but many of them just don't have the capacity to do it." The manager further explained that staffing limitations prohibit social workers from proactively assessing and providing case management services to address SDOH/HRSN for all patients, and subsequently they focus on the most acute patient needs.

Although medical center leaders reported the lack of guidance as a substantial barrier, the National Director of Social Work stated, "It's not something that we're hearing from the social work community that is needed." The OIG found that although a disconnect exists regarding guidance, national social work leaders reported being in the process of creating a national community of practice for inpatient social workers. The community of practice will offer quarterly conference calls, an email distribution group, and a platform for members to share messages, tools, and files.[68] VA social work leaders reported "planning is in process and [the] date of implementation is to be determined."

[67] Emilia H. De Marchis et al., *State of the Science on Social Screening in Healthcare Settings Summer 2022*, Social Interventions Research & Evaluation Network, University of California, San Francisco, Summer 2022.

[68] VA Office of Care Management and Social Work Services leaders are implementing the inpatient social work community of practice in response to a request received from medical center social workers.

The VA Office of Care Management and Social Work Services' plan to establish a social work community of practice for inpatient social workers is an opportunity to address barriers to incorporating SDOH/HRSN discharge needs into discharge assessment and planning. The OIG found several medical center leaders surveyed identified lack of guidance from national leaders as a barrier to incorporating SDOH/HRSN into discharge assessment and planning, while the National Director of Social Work denied awareness that additional guidance is needed. The OIG found in the absence of guidance from national leaders, medical center leaders created local discharge policies and templates; however, in doing so, not all local policies and templates address SDOH/HRSN. The OIG concluded that medical center leaders would benefit from national guidance to coordinate discharge assessment and planning efforts and enhance SDOH/HRSN data collection.

Pilot Projects to Address Social Determinants of Health and Health-Related Social Needs

The OIG found that although VHA promotes the use of pilot projects, only 5 of 120 medical centers (4 percent) used pilot projects to address SDOH/HRSN into discharge assessment and planning within inpatient units.

A pilot project is a method for VHA employees "to reduce the risk of failure across the entire organization by testing the idea in a small, controlled setting" prior to large-scale dissemination.[69] "As Department of Veterans Affairs (VA) employees provide care to Veterans, they often discover ways to do their jobs even more effectively and without wasting precious resources."[70]

Of the medical center leaders surveyed, 5 of 120 reported pilot projects focused on the incorporation of SDOH/HRSN into discharge assessment and planning within inpatient units.

- VA Eastern Colorado Health Care System and the West Palm Beach VA Medical Center implemented pilot projects that provide transportation assistance to patients discharging from inpatient units.
- Richard L. Roudebush VA Medical Center's pilot project screens inpatients who are not enrolled in primary care for SDOH/HRSN barriers in an effort to connect them to post-discharge follow-up care.
- Martinsburg VA Medical Center's pilot project aims to screen admitted patients for SDOH/HRSN within 24 hours.

[69] Ron Ashkenas and Nadim Matta, "How to Scale a Successful Pilot Project," *Harvard Business Review*, January 8, 2021, https://hbr.org/2021/01/how-to-scale-a-successful-pilot-project.

[70] VA TAMMCS (Vision, Analysis, Team, Aim, Map, Measure, Change, Sustain, Spread), *Improvement Framework Guidebook*, Version 2, May 2011.

- South Texas Veterans Health Care System's pilot project assesses patients to determine transportation needs, safety in the home environment, and status of functioning utilities.

As pilot projects enable VHA staff to test ideas prior to wider implementation and help to avoid failure, VHA should consider use of pilot programs to identify and address the barriers to assessing SDOH/HRSN at discharge. Given previously cited evidence that 80 percent of patient health outcomes are due to SDOH/HRSN, increased emphasis, standardization, and identification of SDOH/HRSN prior to discharge will help patients avoid poor health outcomes, and help VA better allocate resources to avoid readmissions.[71]

2. Efforts to Identify and Address Social Determinants of Health

The OIG found few medical center leaders responsible for discharge assessment and planning reported using OHE-developed tools.

In the 2021 National Veteran Health Equity Report, OHE acknowledges veterans experience healthcare disparities for many significant health outcomes and discusses how VHA is committed to eliminating these disparities to achieve health equity for veterans.[72] Additionally, VA has committed to SDOH research by examining

- data-driven methods to identify SDOH,
- modifiable factors affecting patients at risk due to SDOH within primary care,
- SDOH among rural veterans,
- SDOH screening and referrals, and
- services to address patients' SDOH and how it reduces suicide risk.[73]

[71] Edmondo J. Robinson et al., "A Call for Action to Achieve Health Equity," *AHRQ Views* (blog), August 16, 2021, https://www.ahrq.gov/news/blog/ahrqviews/achieve-health-equity.html.

[72] VHA OHE, National Veteran Health Equity Report 2021, September 2022.

[73] "IIR 19-335-HSR&D Study," VA, Health Services Research and Development, accessed September 1, 2022, https://www.hsrd.research.va.gov/research/abstracts.cfm?Project_ID=2141707767; "IIR 19-013 – HSR&D Study," VA, Health Services Research and Development, accessed September 1, 2022, https://www.hsrd.research.va.gov/research/abstracts.cfm?Project_ID=2141707379; "SDR 21-001 – HSR&D Study," VA, Health Services Research and Development, accessed September 1, 2022, https://www.hsrd.research.va.gov/research/abstracts.cfm?Project_ID=2141709342; "SDR 21-133 – HSR&D Study," VA, Health Services Research and Development, accessed September 1, 2022, https://www.hsrd.research.va.gov/research/abstracts.cfm?Project_ID=2141709300; "SDR 20-368 – HSR&D Study," VA, Health Services Research and Development, accessed September 1, 2022, https://www.hsrd.research.va.gov/research/abstracts.cfm?Project_ID=2141709163.

The OIG further learned VHA aims to advance efforts to identify and address patient SDOH/HRSN through the creation of tools to recognize health disparities and expansion of community resources and partnerships.

Creation of Tools to Recognize Health Disparities

The OIG found that the OHE-developed health disparity data tools for VHA clinical staff and medical center leaders' use, but only 10 of 120 medical center leaders (8 percent) surveyed reported the use of tools to determine health disparities within their catchment area.[74]

Geographic representations of a community's specific population characteristics such as race, gender, medical diagnoses, education level, and income are powerful tools to inform resource allocation and help VHA staff identify which patients are potentially experiencing unaddressed social needs and are at risk of poor health outcomes.[75] Created in 2012, VHA's OHE promotes "health equity through policies, education/communication" and identifies "strategies for capturing data for vulnerable populations and social determinants of health and promote data collection, evaluation, and reporting for such populations."[76]

The OIG learned OHE developed health mapping tools to assist VHA staff with identifying and addressing health disparities within their communities.[77] OHE's Executive Director told the OIG the tools "help people in the field understand the disparities in the care that is being delivered in their particular local facility, help them identify disparities to work on." Additionally, OHE training material states that "without tools that track equity, it often gets omitted from quality monitoring and improvement processes."[78]

According to OHE staff, the Veterans Geography of Opportunity Tool was developed in 2018 and provides "information . . .about variations and the levels of health for different geographic regions" and explores different factors "that influence health in communities where Veterans live, work, and play."[79] OHE's Executive Director told the OIG the tool can be used to

[74] The OIG recognizes this may not account for other medical center leaders' use of health disparity tools.

[75] Elham Hatef et al., "The Impact of Social Determinants of Health on Hospitalization in the Veterans Health Administration," *American Journal of Preventive Medicine* 56, no. 6 (June 1, 2019): 811–818, https://doi.org/10.1016/j.amepre.2018.12.012.

[76] VA, *National Veteran Health Equity Report 2021*, September 2022; VHA OHE, *VHA Health Equity Action Plan FY23 Operational Plan*; "Patient Care Services 2022 Accomplishments," VHA, accessed October 5, 2023, https://www.patientcare.va.gov/accomplishments-2022.asp.

[77] While the Primary Care Equity Dashboard is primarily used in an outpatient setting, the OIG found this type of dashboard could have potential use across inpatient settings.

[78] "Primary Care Equity Dashboard," VHA OHE, accessed May 24, 2023, https://app.powerbigov.us/groups/me/apps/f4f65d69-99f6-4852-a649-7aad7040e048/reports/34c38372-25fa-483b-b059-3814616b6ed7/ReportSectione0f6781e503c0c079c11?ctid=e95f1b23-abaf-45ee-821d-b7ab251ab3bf. (This website is not publicly accessible.)

[79] The OIG did not independently verify data sources included in the Veterans Geography of Opportunity Tool.

"understand more about the populations that are served" and develop resources, engagement, and outreach activities. The Executive Director further advised the tool is available on the OHE website, and that OHE encourages VHA leaders and staff to use it to understand the local environment. The tool, displayed as a map, compiles data and allows users to select filters such as quality of life, education, diet and exercise, and community safety (see figure 3).[80]

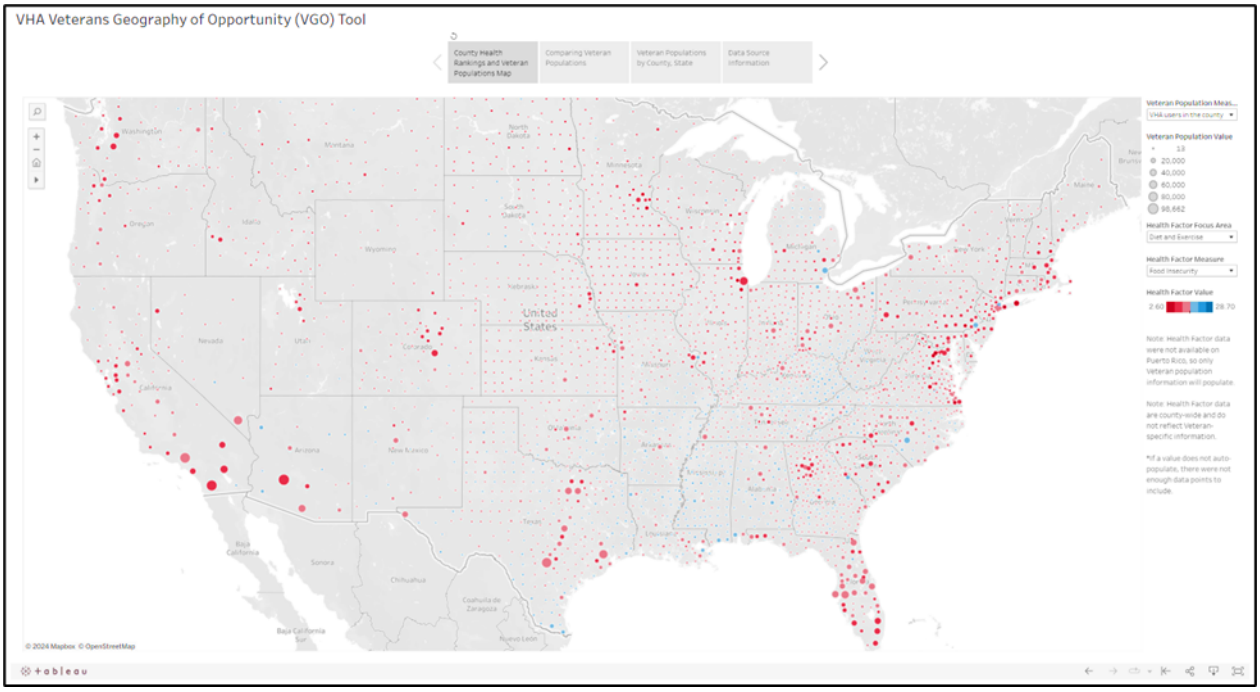

Figure 3. *The Veterans Geography of Opportunity Tool with the selected health factor focus area of "Diet and Exercise" and the selected healthcare measure "Food Insecurity."*
Source: "Office of Health Equity: Data," VHA OHE, https://www.va.gov/HEALTHEQUITY/Data.asp#vgo, accessed January 10, 2024.
Note: The size of the circle represents the number of veterans residing in that county. The darker red represents a lower percentage of veterans experiencing food insecurity within that county, the darker blue represents a higher percentage of veterans experiencing food insecurity within that county. When the tool user hovers over a county, further information is displayed.

OHE's Executive Director reported that the Primary Care Equity Dashboard was launched in 2020 "to engage the VA healthcare workforce in the process of identifying and addressing inequities in their local patient populations."[81] This dashboard examines quality measures by sex, race/ethnicity, urban/rural setting, and area deprivation index at the VISN and medical center

[80] At the time of this report, no data definitions were available for individual health factor focus areas and healthcare measures. "Office of Health Equity: Data," VHA OHE, accessed May 23, 2023, https://www.va.gov/HEALTHEQUITY/Data.asp#vgo. The Veterans Geography of Opportunity Tool uses VHA population data, the American Community Survey, and data from the County Health Rankings & Roadmap, a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

[81] "Primary Care Equity Dashboard," VHA OHE.

levels and allows users to identify individual patients who may experience adverse health outcomes (see figure 4).

Measure and Facility	Worse than National Overall	Black	Hispanic/ Latino	Asian	AI/AN/ Indigenous	NH/PI	Female
⊞ HbA1c less than 8 in patients with diabetes (dmg13h_ec)		2	2	2	2	2	1
⊞ Poor control of HbA1c in patients with diabetes (dmg23h_ec)		4	2	2	2	2	2
⊞ Blood pressure less than 140/90 in patients with diabetes (dmg27h_ec*)		4	2	1	2	2	1
⊞ Statin therapy for patients with diabetes (statn7_ec*)		1	2	1	1	1	4
⊞ Statin adherence for patients with diabetes (statn8_ec)	✓	4	4	4	1	4	4
⊞ Statin therapy for patients with cardiovascular disease (statn1_ec*)		1	1	4	1	1	4
⊞ Statin adherence for patients with cardiovascular disease (statn4_ec)	✓	4	4	4	2	1	4
⊞ Controlling high blood pressure in patients with hypertension (ihd53h_ec*)		4	2	2	4	2	2
⊞ Non-recommended PSA screening in men 70 years and older (psa1_ec)	✓	4	4	4	4	4	–

Figure 4. *The Primary Care Equity Dashboard "VISN Opportunity Matrix" shows fiscal year quarterly results for a de-identified VISN. The dashboard calculates scores for "at-risk populations" compared to national data and specific groups (for example, female/male, Black/White). 1 (green) represents better than national & comparator; 2 (no color) represents better than national, worse than comparator; 3 (no color) represents worse than national, better than comparator; 4 (pink) represents worse than national & comparator; - (gray) represents less than or equal to the minimum average number of patients per month.*

Source: VHA OHE, "Primary Care Equity Dashboard."

Medical center staff can use the dashboard to view patient-level information to address health disparities or potentially screen the patient for SDOH/HRSN.[82] Medical center leaders and VHA leaders can also use the tool to develop strategies to improve care delivery for patients by

- targeting efforts and determining why patients are not receiving medications or treatments,
- standardizing data collection,
- highlighting population trends influencing larger scale actions, and
- pursuing policy development, targeted outreach, and distribution of resources.

Although OHE developed health disparity data tools for VHA clinical staff and medical center leaders' use, the OIG found 10 of 120 medical center leaders surveyed (8 percent) reported the use of tools to determine health disparities within their catchment areas.[83] The National Social Work Program Manager told the OIG that the VA Office of Care Management and Social Work Services is familiar with OHE tools, but was unable to provide specific examples of use.

When asked about sharing OHE-developed tools with the VA community, the OHE Executive Director told the OIG of an equity quality improvement community of practice. The OIG also discovered that OHE offers regularly scheduled webinars that include topics such as clinical staff using health equity tools and reducing disparities.

[82] "Primary Care Equity Dashboard," VHA OHE.

[83] The OIG recognizes this may not account for other medical center leaders' use of health disparity data tools.

Although OHE developed tools for VHA clinical staff and medical center leaders' use to (1) examine health disparity data, (2) determine where resources are needed, and (3) take meaningful action, the OIG found few medical center leaders responsible for discharge assessment and planning used these tools. The use of OHE tools is a future opportunity for VHA social workers, at large, to identify health disparities within their geographical areas and develop interventions, improve health outcomes, and ensure greater health equity.

Expansion of Community Resources and Partnerships

The OIG found 48 of 120 medical center leaders (40 percent) surveyed did not report partnerships with community resources.

VA's 2022–2028 strategic plan "describes how VA will expand partnerships and use them as a force multiplier to enhance our capabilities and capacity to deliver quality benefits, care and services that improve the lives of veterans, their families, caregivers, survivors and Service members" using SDOH.[84] Research shows hospital partnerships with (1) health insurance providers and local community support organizations resulted in decreased healthcare costs and (2) other healthcare providers, health insurance providers, organizations that offer legal assistance, and law enforcement resulted in decreased utilization of hospital services.[85]

OHE's fiscal year 2022 Operational Plan includes a goal to develop strong internal and external strategic partnerships.[86] According to OHE's Executive Director, "many of the resources that are available for veterans to address the social determinants of health exist in the community, and we are supportive of making those connections."

The OIG learned in an interview with the National Director of Social Work that the VA Office of Care Management and Social Work Services has plans to address SDOH in "areas where we have health disparities and resource disparities for populations," through staff education on "opportunities to create additional partnerships and resources to be able to bridge those gaps." The National Director of Social Work further clarified,

> in terms of actually going to facilities and identifying resources for them, that is not something that we do, but we certainly encourage our social work leaders to do that locally, and we give them the reference points and the tools to be able to work through those.

A VA Office of Care Management and Social Work Services representative reported engaging with the VHA National Center for Healthcare Advancement and Partnerships to ensure "SDOH

[84] VA, *Department of Veterans Affairs Fiscal Years 2022–28 Strategic Plan*.

[85] Hanadi Y. Hamadi et al., "Improving Health and Addressing Social Determinants of Health Through Hospital Partnerships," *Population Health Management* 26, no. 2 (April 14, 2023): 121–27, https://doi.org/10.1089/pop.2023.0002.

[86] VHA OHE, *VHA Health Equity Action Plan: FY2022 Operational Plan*, October 18, 2021.

related topics are considered" and encouraged "medical centers to establish partnerships with local community-based resources to address the SDOH needs of the Veteran community."[87]

The OIG found 72 of 120 (60 percent) of VHA leaders surveyed reported partnerships with community resources that address SDOH/HRSN. Community partnerships are a key objective in VHA's strategic plan to address SDOH.[88] The OIG identified a future opportunity for medical center leaders to develop formal partnerships within their communities to enhance patient access to resources and assist them with SDOH/HRSN needs.

Conclusion

As the largest integrated healthcare system in the US, VHA cares for patients who, when compared to the rest of the nation, experience increased exposure to social risk factors and are at greater risk for health problems. Addressing patients' SDOH/HRSN is a key step toward reducing health disparities, and VA is unique in its capacity to assess and address the SDOH/HRSN of veterans through multiple programs encompassing healthcare, financial, housing, transportation, and other resources.

VHA leaders recognize the importance of a social worker's role in addressing SDOH/HRSN, and the VA Office of Care Management and Social Work Services has disseminated information on best practices to integrate SDOH/HRSN into social work discharge assessment and planning. Furthermore, OHE has developed tools to support medical center leaders' (1) understanding of SDOH needs and (2) identification of targeted resources to address HRSN. The OIG acknowledges these VHA program offices' efforts to eliminate health disparities and achieve health equity for veterans.

The OIG recognizes local leaders' efforts to develop local policies in the absence of a national policy but notes variability in medical center discharge planning policies and procedures and the use of EHR templates to facilitate meaningful SDOH/HRSN screening. Only two medical centers have social workers on inpatient units using the ACORN screening tool with patients prior to discharge. Medical center leaders surveyed reported limited awareness of VA Office of Care Management and Social Work Services reference documents. Among the leaders who were aware, few reported the use of these reference documents to guide local policy and practice.

Several leaders surveyed cited the lack of national guidance as a barrier to incorporating SDOH/HRSN into discharge assessment and planning and only a small number reported using pilot projects to address SDOH/HRSN when discharging hospital inpatients. Only 8 percent of leaders surveyed reported using OHE tools to determine health disparities within their catchment

[87] The VA Office of Care Management and Social Work Services representative is a Health System Specialist with the Office of the Assistant Under Secretary for Health for Patient Care Services.

[88] VA, *Department of Veterans Affairs Fiscal Years 2022–28 Strategic Plan*.

areas and 40 percent of medical center leaders surveyed did not report partnerships with community resources. The OIG concludes that VHA can do more to integrate SDOH and HRSN during discharge planning and assessment.

Recommendations 1–5

1. The Under Secretary for Health considers the need for a national policy establishing the inclusion of social determinants of health/health-related social needs into discharge assessment and planning.

2. The Under Secretary for Health considers the implementation of a standardized electronic health record template, such as the Assessing Circumstances and Offering Resources for Needs tool, that includes the assessment of social determinants of health/health-related social needs of hospitalized patients.

3. The Under Secretary for Health evaluates barriers to assessing social determinants of health/health-related social needs when patients are discharged from VA medical centers.

4. The Under Secretary for Health promotes the use of health equity tools across VA medical centers.

5. The Under Secretary for Health promotes the establishment of partnerships of VA medical centers with community resources to address social determinants of health/health-related social needs.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: March 15, 2024

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Opportunities Exist to Better Integrate Health-Related Social Needs and Social Determinants of Health into Discharge Assessment and Planning (VIEWS 11431977)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report on opportunities to better integrate health-related social needs into discharge assessment and planning. The Veterans Health Administration (VHA) concurs with recommendations 1, 3, 4 and 5 and concurs in principle with recommendation 2. VHA provides action plans for the recommendations in the attachment.

2. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Shereef Elnahal M.D., MBA

Attachment

Office of the Under Secretary for Health Response

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan
OIG Draft Report, Opportunities Exist to Better Integrate Health-Related Social Needs and Social Determinants of Health into Discharge Assessment and Planning

Recommendation 1. The Under Secretary for Health considers the need for a national policy establishing the inclusion of social determinants of health/health-related social needs into discharge assessment and planning.

VHA Comments: Concur

The National Social Work Program, Care Management, and Social Work Services will establish a Social Drivers of Health (SDOH) coalition, including membership from various program offices engaged in SDOH activities. The SDOH coalition will explore the need for national policy establishing the inclusion of social drivers of health/health-related social needs into discharge assessment and planning and provide a recommendation for Veterans Health Administration (VHA) Senior Leadership consideration.

Status: In progress Target Completion Date: February 2025

Recommendation 2. The Under Secretary for Health considers the implementation of a standardized electronic health record template, such as the Assessing Circumstances and Offering Resources for Needs tool, that includes the assessment of social determinants of health/health-related social needs of hospitalized patients.

VHA Comments: Concur in principle

The Under Secretary for Health considered and supports the implementation of the Assessing Circumstances and Offering Resources for Needs (ACORN) initiative, which includes a screening tool to identify and address social risk factors and the social needs of Veterans. The screening tool is one aspect of the initiative that will indicate if a more comprehensive assessment is required for hospitalized patients. On January 16, 2024, the Computerized Patient Record System (CPRS) ACORN screening note template became widely available. The ACORN screening tool has been implemented in multiple VA clinical settings, including primary care clinics (Patient Aligned Care Team), emergency departments, and a variety of specialty clinics. As of February 2024, there are VHA medical facilities implementing ACORN to identify and address social risk factors and the social needs of hospitalized Veterans.

Status: Complete Completion Date: January 2024

OIG Comment:

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 3. The Under Secretary for Health evaluates barriers to assessing social determinants of health/health-related social needs when patients are discharged from VA medical centers.

VHA Comments: Concur

VHA acknowledges the importance of screening for social determinants of health during the discharge process for Veterans admitted to inpatient areas in VA medical centers, as well as the importance of a deeper assessment of these domains when screenings indicate it is needed. The Office of Care Management and Social Work Services will closely collaborate with inpatient program offices in Clinical Services, and other VHA offices as needed to develop an environmental scan that identifies barriers to screening for and assessing social determinants of health/health related social needs in the discharge process at VA medical centers (VAMC). Any barriers identified will be summarized and routed through a VHA governing structure as applicable based on the findings.

Status: In progress Target Completion Date: December 2024

Recommendation 4. The Under Secretary for Health promotes the use of health equity tools across VA medical centers.

VHA Comments: Concur

The Under Secretary for Health (USH) promotes awareness and adoption of available health equity tools through the sharing of equity safety stories at Governance Board. The Office of Health Equity supports the implementation of this recommendation by generating awareness of health equity tools across VA medical centers. Health equity tools may augment opportunities to better integrate health-related social needs and social determinants of health into discharge planning and assessment and speak to efforts to embed health equity into all applicable processes. Tools include the Veterans Geography of Opportunity Tool and the Primary Care Equity Dashboard. These tools address social needs, provide stratified data to examine health care disparities, educate the workforce on health equity issues, and provide clinical teams with support to perform equity-guided quality improvement activities and achieve more equitable delivery of health care services.

Status: In progress Target Completion Date: September 2024

Recommendation 5. The Under Secretary for Health promotes the establishment of partnerships of VA medical centers with community resources to address social determinants of health/health-related social needs.

VHA Comments: Concur

VHA National Center for Healthcare Advancement and Partnerships (HAP), in collaboration with the VA Office of Partnerships, will continue to support the establishment of partnerships at VAMCs with community resources to address social determinants of health (SDOH)/health-related social needs. VHA program offices across clinical and non-clinical services, VAMCs, and local organizations are best positioned to understand the specific SDOH needs of Veterans in their communities. HAP will provide resources, including information and training, to VHA staff to facilitate identifying, developing, and implementing partnerships at the local, regional, and national levels.

HAP will continue to support and expand the Veteran Community Partnership initiative at VAMCs, co-led by VAMC staff and community organizations, to deliver resources and services across SDOH through formal and informal partnerships.

HAP will continue to lead the VHA National Community Partnership Challenge on behalf of the USH, which recognizes partnerships that advance the health and well-being of Veterans and their communities. Through this initiative, partnership best practices and opportunities are shared across VHA. HAP is committed to promoting the development of partnerships at VAMCs by supporting VA staff and showcasing community partnership opportunities to address SDOH and health-related social needs.

Status: In progress Target Completion Date: September 2024

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