PROGRAM PROFILE

Building Tailored Resource Guides to Address Social Risks and Advance Health Equity in the Veterans Health Administration

Lauren E. Russell, MPH, MPP[a*]; Kathleen M. Mitchell, MPH[b*]; Meaghan A. Kennedy, MD, MPH[b,c]; Steven Chrzas, MPH[d]; Lisa Soleymani Lehmann, PhD, MD, MSc[e,f]; Jennifer W. Silva, LCSW-S[g]; Ernest Moy, MD, MPH[a]; Alicia J. Cohen, MD, MSc[h,i,j]

Background: Health care organizations, including the Veterans Health Administration (VHA), are increasingly adopting programs to address social determinants of health. As part of a comprehensive social risk screening and referral model, tailored resource guides can support efforts to address unmet social needs. However, limited guidance is available on best practices for the development of resource guides in health care settings.

Observations: This article describes the development of geographically tailored resource guides for a national VHA quality improvement initiative, Assessing Circumstances and Offering Resources for Needs (ACORN), which aims to systematically screen for and address social needs among veterans. We outline the rationale for using resource guides as a social needs intervention and provide a pragmatic framework for resource guide development and maintenance. We offer guidance based on lessons learned from the development of ACORN resource guides, emphasizing a collaborative approach with VHA social workers and other frontline clinical staff, as well as with community-based organizations. Our how-to guide provides steps for identifying high-yield resources along with formatting considerations to maximize accessibility and usability among patients.

Conclusions: Resource guides can serve as a valuable cross-cutting component of health care organizations' efforts to address social needs. We provide a practical approach to resource guide development that may support successful implementation within the VHA and other clinical settings.

Author affiliations can be found at the end of this article.
*Contributed equally as co-first authors.
Correspondence: Kathleen Mitchell (kathleen.mitchell@va.gov)

Fed Pract. 2024;41(1). Published online January 15. doi:10.12788/fp.0446

Social risk factors and social needs have significant, often cumulative, impacts on health outcomes and are closely tied to health inequities. Defined as the individual-level adverse social conditions associated with poor health, social risk factors broadly include experiences such as food insecurity and housing instability; whereas the term social needs incorporates a person's perceptions of and priorities related to their health-related needs.[1] One recent study examining data from the Veterans Health Administration (VHA) found a 27% higher odds of mortality with each additional identified social risk, underscoring the critical link between social risks and veteran health outcomes.[2]

Assessing Circumstances and Offering Resources for Needs (ACORN), a collaborative quality improvement initiative conducted in partnership with the VHA Office of Health Equity and VHA National Social Work Program, Care Management and Social Work Services, is a social risk screening and referral program that aims to systematically identify and address unmet social needs among veterans to improve health and advance health equity.[3,4] ACORN consists of 2 components: (1) a veteran-tailored screener to identify social risks within 9 domains; and (2) provision of relevant VA and community resources and referrals to address identified needs.[3,5] Veterans who screen positive for ≥ 1 need receive referrals to a social worker or other relevant services, such as nutrition and food services or mental health, support navigating resources, and/or geographically tailored resource guides. This article describes the development and use of resource guides as a cross-cutting intervention component to address unmet social needs in diverse clinical settings and shares lessons learned from implementation in VHA outpatient clinics.

BACKGROUND

Unequal distribution of resources combined with historical discriminatory policies and practices, often linked to institutionalized racism, create inequities that lead to health disparities and hinder advancements in population health.[6,7] Although health care systems alone cannot eliminate all health inequities, they can implement programs to identify social risks and address individual-level needs as 1 component of the multilevel approach needed to achieve health equity.[8]

As a national health care system serving > 9 million veterans, the VHA is well

positioned to address social needs as an essential part of health. The VHA routinely screens for certain social risks, including housing instability, food insecurity, and intimate partner violence, and has a robust system of supports to address these and other needs among veterans, such as supportive housing services, vocational rehabilitation, assistance for justice-involved veterans, technology access support, and peer-support services.[9-11] However, the VHA lacks a systematic approach to broader screening for social risks.

To address this gap, ACORN was developed in 2018 by an advisory board of subject matter experts, including clinical leaders, clinical psychologists, social workers, and health services researchers with content expertise in social risks and social needs.[3] This interprofessional team sought to develop a veteran-tailored screener and resource referral initiative that could be scaled efficiently across VHA clinical settings.

Although health care organizations are increasingly implementing screening and interventions for social risks within clinical care, best practices and evidence-based tools to support clinical staff in these efforts are limited.[12] Resource guides—curated lists of supportive services and organizations—may serve as a scalable "low-touch" intervention to help clinical staff address needs either alone or with more intensive interventions, such as social worker case management or patient navigation services.[13]

RESOURCE GUIDES—A CROSS-CUTTING TOOL

The VHA has a uniquely robust network of nearly 18,000 social workers with clinical expertise in identifying, comprehensively assessing, and addressing social risks and needs among veterans. Interprofessional patient aligned care teams (PACTs)—a patient-centered medical home initiative that includes embedding social workers into primary care teams—facilitate the VHA's capacity to address both medical and social needs.[14] Social workers in PACTs and other care settings provide in-depth assessment and case management services to veterans who have a range of complex social needs. However, despite these comprehensive social services, in the setting of universal screening with a tool such as ACORN, it may not be feasible or practical to refer all patients who screen positive to a social worker for immediate follow-up, particularly in settings with capacity or resource limitations. For example, rates of screening positive on ACORN for ≥ 1 social risk have ranged from 48% of veterans in primary care sites and 80% in social work sites to nearly 100% in a PACT clinic for veterans experiencing homelessness.[15]

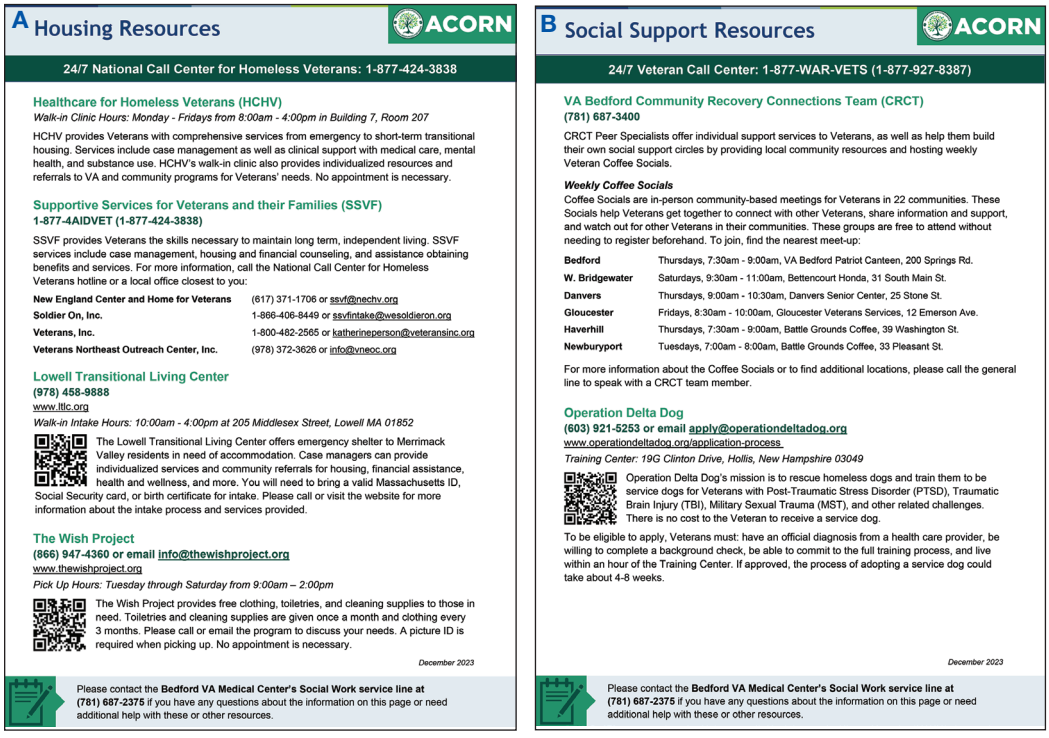
Additionally, a key challenge in the design of social needs interventions is determining how to optimize intervention intensity based on individual patient needs, acuity, and preferences. A substantial proportion of individuals who screen positive for social risks decline offered assistance, such as referrals.[16] Resource guides are a cross-cutting tool that can be offered to veterans across a variety of settings, including primary care, specialty clinics, or emergency departments, as either a standalone intervention or one provided in combination with other resources or services. For patients who may not be interested in or feel comfortable accepting assistance at the time of screening or for those who prefer to research and navigate resources on their own, tailored resource guides can serve as a lower touch intervention to ensure interprofessional clinical staff across a range of settings and specialties have accessible, reliable, and up-to-date information to give to patients at the point of clinical care.[17]

Resource guides also can be used with higher touch clinical social work interventions, such as crisis management, supportive counseling, and case management. For example, social workers can use resource guides to provide education on VHA or community resources during clinical encounters with veterans and/or provide the guides to veterans to reference for future needs. Resource guides can further be used as a tool to support community resource navigation provided by nonclinical staff, such as peer specialists or community health workers.

HOW TO BUILD RESOURCE GUIDES

Our team created resource guides (Figure) to provide veterans with concise, geographically tailored lists of VHA and other federal, state, and community services for the

FIGURE ACORN Resource Guide Examples with Resources for Veterans



A Housing Resources ACORN

24/7 National Call Center for Homeless Veterans: 1-877-424-3838

Healthcare for Homeless Veterans (HCHV)

Walk-in Clinic Hours: Monday - Fridays from 8:00am - 4:00pm in Building 7, Room 207

HCHV provides Veterans with comprehensive services from emergency to short-term transitional housing. Services include case management as well as clinical support with medical care, mental health, and substance use. HCHV's walk-in clinic also provides individualized resources and referrals to VA and community programs for Veterans' needs. No appointment is necessary.

Supportive Services for Veterans and their Families (SSVF)
1-877-4AIDVET (1-877-424-3838)

SSVF provides Veterans the skills necessary to maintain long term, independent living. SSVF services include case management, housing and financial counseling, and assistance obtaining benefits and services. For more information, call the National Call Center for Homeless Veterans hotline or a local office closest to you:

New England Center and Home for Veterans	(617) 371-1706 or ssvf@nechv.org
Soldier On, Inc.	1-866-406-8449 or ssvfintake@wesoldieron.org
Veterans, Inc.	1-800-482-2565 or katherineperson@veteransinc.org
Veterans Northeast Outreach Center, Inc.	(978) 372-3626 or info@vneoc.org

Lowell Transitional Living Center
(978) 458-9888
www.lttc.org

Walk-in Intake Hours: 10:00am - 4:00pm at 205 Middlesex Street, Lowell MA 01852

The Lowell Transitional Living Center offers emergency shelter to Merrimack Valley residents in need of accommodation. Case managers can provide individualized services and community referrals for housing, financial assistance, health and wellness, and more. You will need to bring a valid Massachusetts ID, Social Security card, or birth certificate for intake. Please call or visit the website for more information about the intake process and services provided.

The Wish Project
(866) 947-4360 or email info@thewishproject.org
www.thewishproject.org

Pick Up Hours: Tuesday through Saturday from 9:00am – 2:00pm

The Wish Project provides free clothing, toiletries, and cleaning supplies to those in need. Toiletries and cleaning supplies are given once a month and clothing every 3 months. Please call or email the program to discuss your needs. A picture ID is required when picking up. No appointment is necessary.

December 2023

Please contact the **Bedford VA Medical Center's Social Work service line at (781) 687-2375** if you have any questions about the information on this page or need additional help with these or other resources.

B Social Support Resources ACORN

24/7 Veteran Call Center: 1-877-WAR-VETS (1-877-927-8387)

VA Bedford Community Recovery Connections Team (CRCT)
(781) 687-3400

CRCT Peer Specialists offer individual support services to Veterans, as well as help them build their own social support circles by providing local community resources and hosting weekly Veteran Coffee Socials.

Weekly Coffee Socials

Coffee Socials are in-person community-based meetings for Veterans in 22 communities. These Socials help Veterans get together to connect with other Veterans, share information and support, and watch out for other Veterans in their communities. These groups are free to attend without needing to register beforehand. To join, find the nearest meet-up:

Bedford	Thursdays, 7:30am - 9:00am, VA Bedford Patriot Canteen, 200 Springs Rd.
W. Bridgewater	Saturdays, 9:30am - 11:00am, Bettencourt Honda, 31 South Main St.
Danvers	Thursdays, 9:00am - 10:30am, Danvers Senior Center, 25 Stone St.
Gloucester	Fridays, 8:30am - 10:00am, Gloucester Veterans Services, 12 Emerson Ave.
Haverhill	Thursdays, 7:30am - 9:00am, Battle Grounds Coffee, 39 Washington St.
Newburyport	Tuesdays, 7:00am - 8:00am, Battle Grounds Coffee, 33 Pleasant St.

For more information about the Coffee Socials or to find additional locations, please call the general line to speak with a CRCT team member.

Operation Delta Dog
(603) 921-5253 or email apply@operationdeltadog.org
www.operationdeltadog.org/application-process

Training Center: 19G Clinton Drive, Hollis, New Hampshire 03049

Operation Delta Dog's mission is to rescue homeless dogs and train them to be service dogs for Veterans with Post-Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), Military Sexual Trauma (MST), and other related challenges. There is no cost to the Veteran to receive a service dog.

To be eligible to apply, Veterans must: have an official diagnosis from a health care provider, be willing to complete a background check, be able to commit to the full training process, and live within an hour of the Training Center. If approved, the process of adopting a service dog could take about 4-8 weeks.

December 2023

Please contact the **Bedford VA Medical Center's Social Work service line at (781) 687-2375** if you have any questions about the information on this page or need additional help with these or other resources.

Abbreviation: ACORN, Assessing Circumstances and Offering Resources for Needs.

social risk domains included on the ACORN screener. To inform and develop a framework for building and maintaining ACORN guides, we first reviewed existing models that use this approach, including Boston Medical Center's WE CARE (Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education) and Thrive programs. We provide an overview of our process, which can be applied to clinical settings both within and outside the VHA.[18,19]

Partnerships

Active collaboration with frontline clinical social workers and local social work leadership is a critical part of identifying and prioritizing quality resources. Equipped with the knowledge of the local resource landscape, social workers can provide recommendations pertaining to national or federal, state, and local programs that have a history of being responsive to patients' expressed needs.[20] VHA social workers have robust knowledge of the veteran-specific resources available at VHA medical centers and nationally, and their clinical training equips them with the expertise to provide guidance about which resources to prioritize for inclusion in the guides.[20]

After receiving initial guidance from clinical social workers, our team began outreach to compile detailed program information, gauge program serviceability, and build relationships with both VHA and community-based services. Aligning with programs that share a similar mission in addressing social needs has proved crucial when developing the resource guides. Beyond ensuring the accuracy of program information, regular contact provides an opportunity to address capacity and workflow concerns that may arise from increased referrals. Additionally, open lines of communication with various supportive services facilitate connections with additional organizations and resources within the area.

The value of these relationships was evident at the onset of the COVID-19 pandemic, when the ACORN resource guides in use by our clinical site partners required frequent modifications to reflect rapid changes in services (eg, closures, transition to fully virtual programs, social distancing and masking requirements). Having

established connections with community organizations was essential to navigating the evolving landscape of available programs and supports.

Curating Quality Resources

ACORN currently screens for social risks in 9 domains: food, housing, utilities, transportation, education, employment, legal, social isolation/loneliness, and digital needs. Each resource guide pertains to a specific social risk domain and associated question(s) in the screener, allowing staff to quickly identify which guides a veteran may benefit from based on their screening responses. The guides are meant to be short and comprehensive but not exhaustive lists of programs and services. We limit the length of the guides to one single-sided page to provide high-yield, geographically tailored resources in an easy-to-use format. The guides should reflect the geographic area served by the VHA medical center or the community-based outpatient clinic (CBOC) where a veteran receives clinical care, but they also may include national- and state-level resources that provide services and programs to veterans.

Although there is local variation in the availability and accessibility of services across social risk domains, some domains have an abundance of resources and organizations at federal or national, state, and/or community levels. To narrow the list of resources to the highest yield programs, we developed a series of questions that serve as selection criteria to inform resource inclusion (Table).

Because the resource guides are intended to be broadly applicable to a large number of veterans, we prioritize generalizable resources over those with narrow eligibility criteria and/or services. When more intensive support is needed, social workers and other VHA clinical and nonclinical staff can supplement the resources on the guides with additional, more tailored resources that are based on individual factors, such as physical residence, income, transportation access, or household composition (eg, veteran families with children or older adults).

Formatting Resource Guides

Along with relevant information, such as the program name, location, and a specific point of contact, brief program descriptions provide information about services offered, eligibility criteria, application requirements, alternate contacts and locations, and website links. At the bottom of each guide, a section is included with the name and direct contact information for a social worker (often the individual assigned to the clinic where the veteran completed the ACORN screener) or another VHA staff member who can be reached for further assistance. These staff members are familiar with the content included on the guides and provide veterans with additional information or higher touch support as necessary. This contact information is useful for veterans who initially decline assistance or referrals but later want to follow up with staff for support or questions.

Visual consistency is a key feature of the ACORN resource guides, and layout and design elements are used to maximize space and enhance usability. Corresponding font colors for all program titles, contact information, and website links assist in visually separating and drawing attention to pertinent contact information. QR codes linked to program websites also are incorporated

TABLE Selection Criteria for ACORN Resource Guides

1. How comprehensive are the state and community services compared with the US Department of Veterans Affairs or other federal programs offering similar services? Does the program specifically cater to veterans?
2. How easy will it be for a veteran to contact the service provider to apply, enroll, and receive services? What are their hours of operation and options for modes of contact? Did your team experience multiple failed attempts in connecting with a supportive service via phone or email?
3. Are the services offered for free or at a reduced cost based on military history (veteran status), income level, etc?
4. Does the service provider have a specific point-of-contact who may be willing to directly triage calls from veterans?
5. If it is a local community service, is it easily accessible by veterans in the area? If service provision is in-person, can veterans reasonably access the service through public transit and/or rideshares?

Abbreviation: ACORN, Assessing Circumstances and Offering Resources for Needs.

for veterans to easily access resource information from their smartphone or other electronic device.

Maintaining Resource Guides

To ensure continued accuracy, resource guides are updated about every 6 months to reflect changes in closures, transitions to virtual/in-person services, changes in location, new points of contact, and modifications to services or eligibility requirements. Notations also are made if any changes to services or eligibility are temporary or permanent. Recording these temporary adjustments was critical early in the COVID-19 pandemic as service offerings, eligibility requirements, and application processes changed often.

Updating the guides also facilitates continuous relationship building and connections with VHA and community-based services. Resource guides are living documents: they maintain lines of communication with designated contacts, allow for opportunities to improve the presentation of evolving program information in the guides, and offer the chance to learn about additional programs in the area that may meet veterans' needs.

Creating a Manual for ACORN Resource Guide Development

To facilitate dissemination of ACORN across VHA clinical settings and locations, our team developed a Resource Guide Manual to aid ACORN clinical sites in developing resource guides.[21] The manual provides step-by-step guidance from recommendations for identifying resources to formatting and layout considerations. Supplemental materials include a checklist to ensure each program description includes the necessary information for veterans to successfully access the resource, as well as page templates and style suggestions to maximize usability. These templates standardize formatting across the social risk domain guides and include options for electronic and paper distribution.

RESOURCE GUIDE LIMITATIONS

The labor involved in building and maintaining multiple guides is considerable and requires a time investment both upfront and long term, which may not be feasible for clinical sites with limited staff. However, many VHA social workers maintain lists of resource and referral services for veterans as part of their routine clinical case management. These lists can serve as a valuable and timesaving starting point in curating high-yield resources for formal resource guides. To further reduce the time needed to develop guides, sites can use ACORN resource guide templates rather than designing and formatting guides from scratch. In addition to informing veterans of relevant services and programs, resource guides also can be provided to new staff, such as social workers or peer specialists, during onboarding to help familiarize them with available services to address veterans' unmet needs.

Resources included on the guides also are geographically tailored, based on the physical location of the VHA medical center or CBOC. Some community-based services listed may not be as relevant, accessible, available, or convenient to veterans who live far from the clinic, which is relevant for nearly 25% of veterans who live in rural communities.[22] This is a circumstance in which the expertise of VHA social workers should be used to recommend more appropriately tailored resources to a veteran. Use of free, publicly available electronic resource databases (eg, 211 Helpline Center) also can provide social workers and patients with an overview of all available resources within their community. There are paid referral platform services that health systems can contract with as well.[23] However, the potential drawbacks to these alternative platforms include high startup costs or costly user-license fees for medical centers or clinics, inconsistent updates to resource information, and lack of compatibility with some electronic health record systems.[23]

Resource guides are not intended to take the place of a clinical social worker or other health professional but rather to serve in a supplemental capacity to clinical services. Certain circumstances necessitate a more comprehensive clinical assessment and/or a warm handoff to a social worker, including assistance with urgent food or housing needs, and ACORN workflows are created with urgent needs pathways in mind. Determining how to optimize intervention intensity based on individual patients' expressed needs, preferences, and acuity remains a

challenge for health care organizations conducting social risk screening.[12] While distribution of geographically tailored resource guides can be a useful low touch intervention for some veterans, others will require more intensive case management to address or meet their needs. Some veterans also may fall in the middle of this spectrum, where a resource guide is not enough but intensive case management services facilitated by social workers are not needed or wanted by the patient. Integration of peer specialists, patient navigators, or community health workers who can work with veterans to support them in identifying, connecting with, and receiving support from relevant programs may help fill this gap. Given their knowledge and lived experience, these professionals also can promote patient-centered care as part of the health care team.

CONCLUSIONS

Whether used as a low-touch, standalone intervention or in combination with higher touch services (eg, case management or resource navigation), resource guides are a valuable tool for health care organizations working to address social needs as a component of efforts to advance health equity, reduce health disparities, and promote population health. We provide a pragmatic framework for developing and maintaining resource guides used in the ACORN initiative. However, additional work is needed to optimize the design, content, and format of resource guides for both usability and effectiveness as a social risk intervention across health care settings.

Acknowledgments

We express our gratitude for the Veterans Health Administration (VHA) Office of Health Equity and the VHA National Social Work Program, Care Management and Social Work Services for their support of the Assessing Circumstances and Offering Resources for Needs (ACORN) initiative. We also express our appreciation for those who supported the initial screener development as part of the ACORN Advisory Board, including Stacey Curran, BA; Charles Drebing, PhD; J. Stewart Evans, MD, MSc; Edward Federman, PhD; Maneesha Gulati, LICSW, ACSW; Nancy Kressin, PhD; Kenneth Link, LICSW; Monica Sharma, MD; and Jacqueline Spencer, MD, MPH. We also express our appreciation for those who supported the initial ACORN resource guide development, including Chuck Drebing, PhD, Ed Federman, PhD, and Ken Link, LICSW, and for the clinical care team members, especially the social workers and nurses, at our ACORN partner sites as well as the community-based partners who have helped us develop comprehensive resource guides for veterans. This work was supported by funding from the VHA Office of Health Equity and by resources and use of facilities at the VA Bedford Healthcare System, VA New England Healthcare System, and VA Providence Healthcare System. Alicia J. Cohen was additionally supported by a VA HSR&D Career Development Award (CDA 20-037).

Author affiliations

[a]Office of Health Equity, Veterans Health Administration, Department of Veterans Affairs, Washington, DC
[b]Geriatric Research, Education, and Clinical Center, VA Bedford Healthcare System, Massachusetts
[c]Boston University Chobanian & Avedisian School of Medicine, Massachusetts
[d]VA Connecticut Healthcare System, West Haven, Connecticut
[e]Harvard Medical School, Boston, Massachusetts
[f]Harvard T.H. Chan School of Public Health, Boston, Massachusetts
[g]National Social Work Program Office, Care Management and Social Work, Patient Care Services, Department of Veterans Affairs, Washington, DC
[h]VA Health Services Research & Development Center of Innovation in Long Term Services and Supports, VA Providence Healthcare System, Providence, Rhode Island
[i]Warren Alpert Medical School of Brown University, Providence, Rhode Island
[j]Brown University School of Public Health, Providence, Rhode Island

Author disclosures

The authors report no actual or potential conflicts of interest or outside sources of funding with regard to this article.

Disclaimer

The opinions expressed herein are those of the authors and do not necessarily reflect those of *Federal Practitioner*, Frontline Medical Communications Inc., the US Government, or any of its agencies.

Ethics and consent

This article does not involve patient care or data and does not require patient consent.

References

1. Alderwick H, Gottlieb LM. Meanings and misunderstandings: a social determinants of health lexicon for health care systems. *Milbank Q*. 2019;97(2):407-419. doi:10.1111/1468-0009.12390
2. Blosnich JM, Montgomery AE, Taylor LD, Dichter ME. Adverse social factors and all-cause mortality among male and female patients receiving care in the Veterans Health Administration. *Prev Med*. 2020;141:106272. doi:10.1016/j.ypmed.2020.106272
3. Russell LE, Cohen AJ, Chrzas S, et al. Implementing a social needs screening and referral program among veterans: Assessing Circumstances & Offering Resources for Needs (ACORN). *J Gen Intern Med*. 2023;38(13):2906-2913. doi:10.1007/s11606-023-08181-9
4. Cohen AJ, Russell LE, Elwy AR, 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. *Front Health Serv*. 2023;2. doi:10.3389/frhs.2022.958969
5. Cohen AJ, Kennedy MA, Mitchell KM, Russell LE. The Assessing Circumstances & Offering Resources for Needs (ACORN) initiative. Updated September 2022. Accessed December 4, 2023. https://www.va.gov/HEALTHEQUITY/docs/ACORN_Screening_Tool.pdf
6. Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *Am J Public Health*. 2000;90(8):1212-1215. doi:10.2105/ajph.90.8.1212
7. American Public Health Association. Creating the healthiest nation: advancing health equity. Accessed November 28, 2023. https://www.apha.org/-/media/files/pdf/factsheets/advancing_health_equity.ashx?la=en&hash=9144021FDA33B4E7E02447CB28CA3F9D4BE5EF18

8. Castrucci B, Auerbach J. Meeting individual social needs falls short of addressing social determinants of health. *Health Aff*. Published January 16, 2019. doi:10.1377/hblog20190115.234942
9. Montgomery AE, Fargo JD, Byrne TH, Kane VR, Culhane DP. Universal screening for homelessness and risk for homelessness in the Veterans Health Administration. *Am J Public Health*. 2013;103(suppl 2):S210-211. doi:10.2105/AJPH.2013.301398
10. Cohen AJ, Rudolph JL, Thomas KS, et al. Food insecurity among veterans: resources to screen and intervene. *Fed Pract*. 2020;37(1):16-23.
11. Iverson KM, Adjognon O, Grillo AR, et al. Intimate partner violence screening programs in the Veterans Health Administration: informing scale-up of successful practices. *J Gen Intern Med*. 2019;34(11):2435-2442. doi:10.1007/s11606-019-05240-y
12. National Academies of Sciences, Engineering, and Medicine. *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health*. The National Academies Press; 2019. Accessed November 28, 2023. https://nap.nationalacademies.org/catalog/25467/integrating-social-care-into-the-delivery-of-health-care-moving
13. Gottlieb LM, Adler NE, Wing H, et al. Effects of in-person assistance vs personalized written resources about social services on household social risks and child and caregiver health: a randomized clinical trial. *JAMA Netw Open*. 2020;3(3):e200701. doi:10.1001/jamanetworkopen.2020.0701
14. Cornell PY, Halladay CW, Ader J, et al. Embedding social workers in Veterans Health Administration primary care teams reduces emergency department visits. *Health Aff (Millwood)*. 2020;39(4):603-612. doi:10.1377/hlthaff.2019.01589
15. Cohen AJ, Bruton M, Hooshyar D. US Department of Veterans Affairs, Office of Health Services Research and Development. The WHO's greatest ICD-10 hits for fiscal year 2022: social determinants of health. Published March 9, 2022. Updated November 6, 2023. Accessed December 4, 2023. https://www.hsrd.research.va.gov/for_researchers/cyber_seminars/archives/video_archive.cfm?SessionID=4125
16. De Marchis EH, Alderwick H, Gottlieb LM. Do patients want help addressing social risks? *J Am Board Fam Med*. 2020;33(2):170-175. doi:10.3122/jabfm.2020.02.190309
17. Cohen AJ, Isaacson N, Torby M, Smith A, Zhang G, Patel MR. Motivators, barriers, and preferences to engagement with offered social care assistance among people with diabetes: a mixed methods study. *Am J Prev Med*. 2022;63(3, suppl 2):S152-S163. doi:10.1016/j.amepre.2022.02.022
18. Buitron de la Vega P, Losi S, Sprague Martinez L, et al. Implementing an EHR-based screening and referral system to address social determinants of health in primary care. *Med Care*. 2019;57(suppl 6, suppl 2):S133-S139. doi:10.1097/MLR.0000000000001029
19. Boston Medical Center. The WE CARE Model. Accessed November 28, 2023. https://www.bmc.org/pediatrics-primary-care/we-care/we-care-model
20. US Department of Veterans Affairs, Office of Rural Health. VA social work. Updated July 11, 2023. Accessed December 4, 2023. https://www.socialwork.va.gov
21. Mitchell KM, Russell LE, Cohen AJ, Kennedy MA. Building ACORN resource guides for veterans. Accessed November 28, 2023. https://www.va.gov/HEALTHEQUITY/docs/ACORN_Resource_Guide_Manual.pdf
22. US Department of Veterans Affairs, Veterans Health Administration, Office of Rural Health. Rural Veterans. Accessed November 28, 2023. https://www.ruralhealth.va.gov/aboutus/ruralvets.asp
23. Cartier Y, Fichtenberg C, Gottlieb L. Community resource referral platforms: a guide for health care organizations. Published 2019. Accessed December 4, 2023. https://sirenetwork.ucsf.edu/tools-resources/resources/community-resource-referral-platforms-guide-health-care-organizations