

## Implementing a social needs screening and community health worker referral program for obstetric patients

Kavita Vani<sup>1</sup>, Samantha Levano<sup>2,3</sup>, Jessica Haughton<sup>2,3</sup>, Kevin Fiori<sup>2,3</sup>

<sup>1</sup>Department of Obstetrics & Gynecology and Women's Health, Albert Einstein College of Medicine, <sup>2</sup>Department of Pediatrics, Albert Einstein College of Medicine, <sup>3</sup>Department of Family & Social Medicine, Albert Einstein College of Medicine

kvani@montefiore.org

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**Background:** Health systems have expanded their focus on health equity in recent years to address the health and social needs of pregnant and postpartum patients.

**Objective:** To describe the implementation of a novel program, which included standardized screening of health-related social needs (HRSNs) and referral to community health workers (CHWs).

**Methods:** This was a retrospective cohort study of patients who had: 1) prenatal care, 2) delivered at our institution, and 3) completed a standardized HRSN screener between June 2022 and March 2024. Patients who were screened and self-reported at least one HRSN were eligible to be referred to a CHW by their clinician during routine clinical encounters. We used descriptive statistics to summarize the reach and effectiveness of the HRSN screening and CHW referral program.

**Results:** There were 3,275 obstetric patients screened for HRSNs during the specified timeframe. Of those screened, 489 (14.9%) reported at least one HRSN with the most prevalent HRSNs identified as food security (n=204, 6.2%), housing security (n=160, 4.9%), child or adult care (n=150, 4.6%), housing quality (n=120, 3.66%), and healthcare transportation (n=120, 3.7%). There were 382 (78.1%) patients referred to a CHW, with 303 (89.1%) consenting to HRSN navigation. Overall, 197 patients were connected to at least one social service (65.0%). Of those connected to a social service, 189 (95.9%) reported that their HRSN was improved or fully resolved.

**Conclusion:** This novel standardized screening and referral program was effective in connecting pregnant and postpartum patients to social services. Future research should evaluate the gap between patients who self-reported HRSNs and those who were successfully connected to a CHW to improve the program's reach. In addition, the impact of HRSN resolution on key obstetric outcomes should be explored.