Efficacy of a Social Needs Screening and Home Visiting Program

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Background

- Social needs include employment, food, housing, childcare, and home aide

- Addressing the social needs of patients as part of healthcare delivery can improve health outcomes[1]

- There has been a growing movement to incorporate social needs screening into clinical practice[2]

Objectives

- Evaluate the efficacy of our social needs screening and home visiting program

Materials & Methods

- Patients admitted to UPMC-Presbyterian who met the following criteria were included in the program:

- 1) moderate to high risk for readmission using a UPMC validated readmission risk score based on the HOSPITAL score[3]

- 2) residence in two targeted low-income zip codes

- 3) admission to the general medicine teaching or hospitalist service

- Patients were excluded if they had a terminal diagnosis or hospice enrollment, or if they resided in a long-term group home or skilled nursing facility.

Materials and Methods

- Eligible patients were screened using a questionnaire which covered many categories of social needs, including education and health literacy, employment and income, financial hardship, safety, and social support.

- Screening was administered by face-to-face interviews

- Patients who screened positive for one or more social needs were referred to a community-based peer supporter or trained college student volunteer, who called patients upon discharge to assist with identified social needs.

- Home visits were conducted for those who needed help beyond the initial phone call after discharge. Home visitors assisted patients with tasks such as completing applications and calling social service agencies, as well as making appointments with their PCPs and delivering groceries to patients with food insecurity.

Results

- Over a one-year period, 187 patients were engaged in the program.

- 30 patients who had been engaged for at least 3 months with phone calls and home visits accepted the invitation to participate in the survey. 25 of the 30 patients were successfully contacted.

Results

- Demographic data available for 24 of 25 patients contacted (**Table 1**)

Table 1. Respondent characteristics

	N (%)
Total	24
Age	
- 25-49	6 (25)
- 50-64	8 (33)
- >65	10 (42)
Gender	
- Male	10 (42)
- Female	14 (58)
Race	
- African-American	20 (83)
- Non-Hispanic White	4 (17)
Marital status	
- Single	16 (67)
- Other (married, divorced, or widowed)	8 (33)

Table 2. Impact of the program

	N (%)
Total	25
Connected to at least one resource	13 (52)
Connected to multiple resources	11 (44)
Received home visit	19 (76)

- The most common connected resources were food aid (8), primary care provider (8), home aid (7), and health insurance (7).

Conclusions

- In both inpatient and outpatient settings, social needs screening and intervention programs are particularly beneficial for underserved patient populations.

- Our study shows that home visits could be a very effective intervention method to help patients gain access to needed resources and services.

- This could potentially reduce hospital readmissions in high-risk patients, though future studies will be needed to examine the effect of home visiting programs on hospital readmissions.

- Considering both the proven and potential benefits of screening and intervention, we must continue to expand the capacity for healthcare systems to provide this important service to patients.

References

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