SDOH Screening at St. Luke's Physician Group

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Saint Luke's Physician Group

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Issue

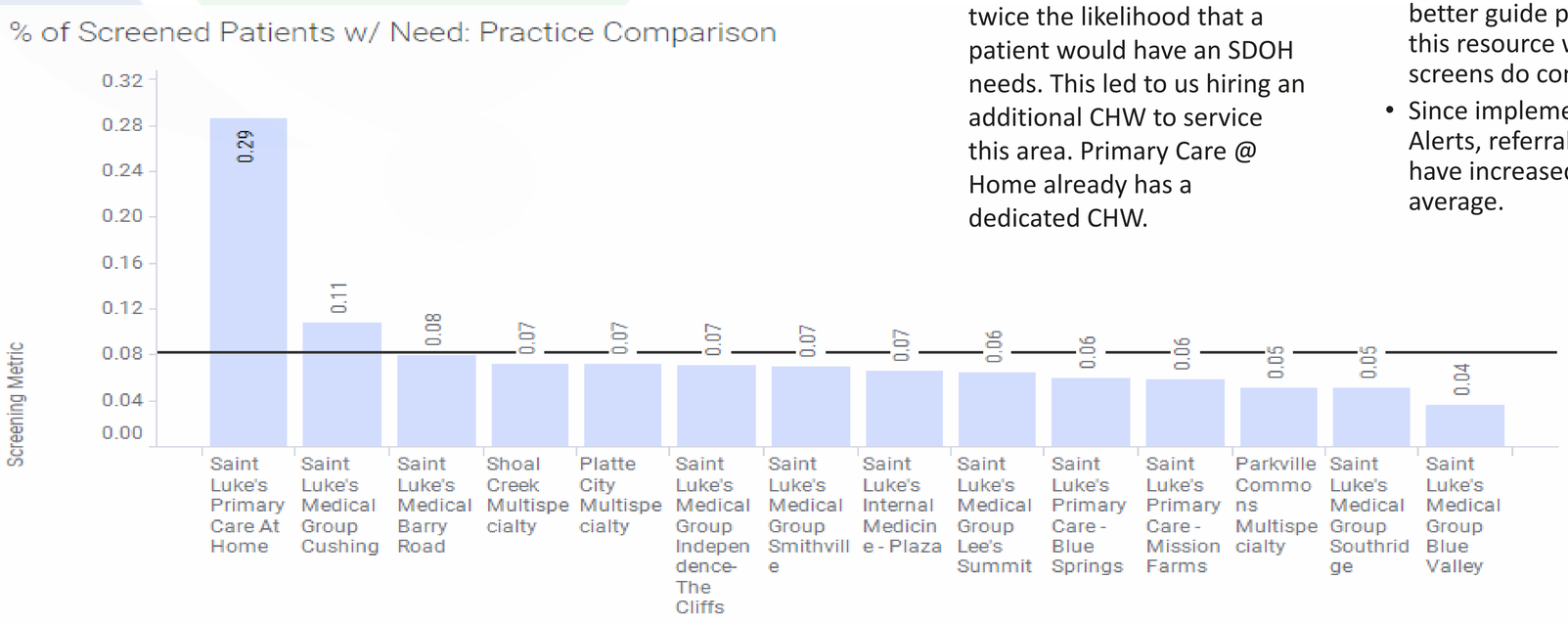
In order to achieve health equity for our patients, we must first ask the questions of what needs the patients have.

Project

In January 2022, Saint Luke's Physician Group began screening all patients for social determinants of health needs in the community of which they live in once per calendar year.

Results

- Since January 1st 2022, over 6,200 patients have screened positive for an SDOH need, which is 6.1% of our patient population
- Using the data stratified by Primary Care clinic location we were able to identify that our Cushing clinic had nearly twice the likelihood that a patient would have an SDOH needs. This led to us hiring an additional CHW to service this area. Primary Care @ Home already has a dedicated CHW.
- For patients with Food, Housing and Transportation needs – they are receiving follow up from Social Work 33% of the time.
- Our goal is to get that follow up percent to 50%, which led to us implementing a Best Practice Alert in Epic to better guide providers to this resource when positive screens do come through.
- Since implementing the Alerts, referrals have increased 8% on average.



Lessons Learned

Stratifying this data by clinic helped us identify that our Cushing clinic was having an 11% positivity rate and has led to us hiring an additional community health worker for that area to better support the social needs. See graph below.

Organization Information

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