Social Determinants of Health

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Co-Chair, LVHN SDOH Steering Committee

Goals:

1. Alignment of all agencies interacting with patients
2. Use National SDoH screening tool built in Epic
3. Completed by patients to identify needs
4. Data is collected from the survey and resources provided

National Academy of Medicine:

- Alcohol Use
- Depression
- Financial Resource Strain
- Intimate Partner Violence
- Physical Activity
- Social Isolation
- Stress
- Tobacco Use

Added based on customer feedback:

- Food Insecurity
- Transportation Insecurity

Ambulatory Workflow

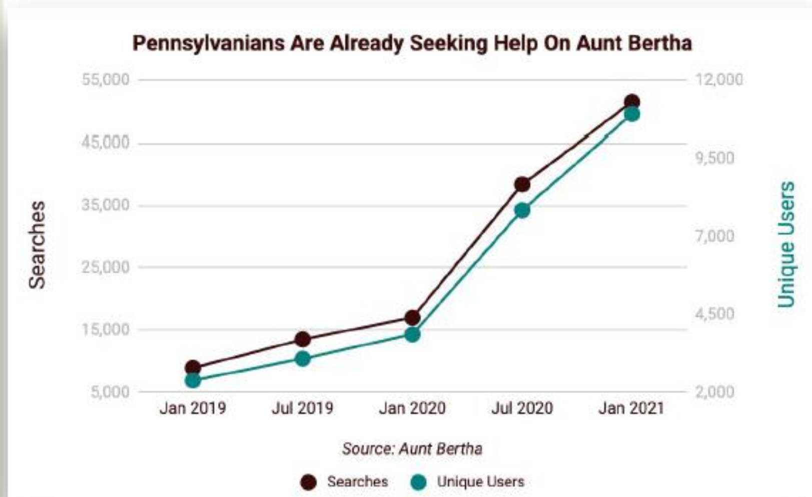
1. Patient provides SDOH information by completing Patient Entered Questionnaire.
   - Key Points:
     - Staff ensures every new patient has MyLVHN access when making new patient appointment (instant activation) and notifies patient that questionnaires will be available to complete prior to visit.
     - If not done prior to visit, clinical staff provides tablet at check in for patients to complete in waiting room.
     - Ambulatory Visit types: New Patient; Annual Wellness/Preventive (18 and Over)
2. Clinical Staff – intervention needed if PEQ is not completed
   - PEQ in exam room
   - Answer questions/provide guidance as needed
3. Providers:
   - Review SDOH data collected by patient (in rooming section)
   - If applicable:
     - Refers to CCT/Population Health (Care Management)
     - Adds ICD 10 code to Problem List/Visit diagnosis
     - Provides info on patient facing LVHN branded FindHelp website

FindHelp (Formerly Aunt Bertha)

Pennsylvania Network

Our social care network in **Pennsylvania**, by the numbers:

- **260,000+** users;
- **1.325 Million +** searches across the state
- **1,527** in-network CBO programs serving residents of Pennsylvania in need on our platform.
- **15,741** available programs



St Luke's
UNIVERSITY HEALTH NETWORK

Client Confidential

Access Limited to Authorized Personnel

L E H I G H   V A L L E Y   H E A L T H   N E T W O R K

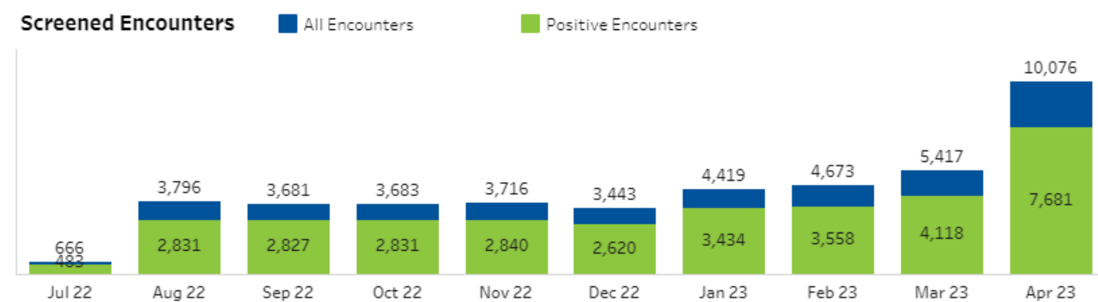
All New Patient, New Patient Video Visit, New Patient/Phys/Preventative encounters within Lehigh Valley Physician Group.
*It is advised to get Positive Risk Encounters, one should exclude Tobacco, Depression, and Risky Alcohol Use domains.

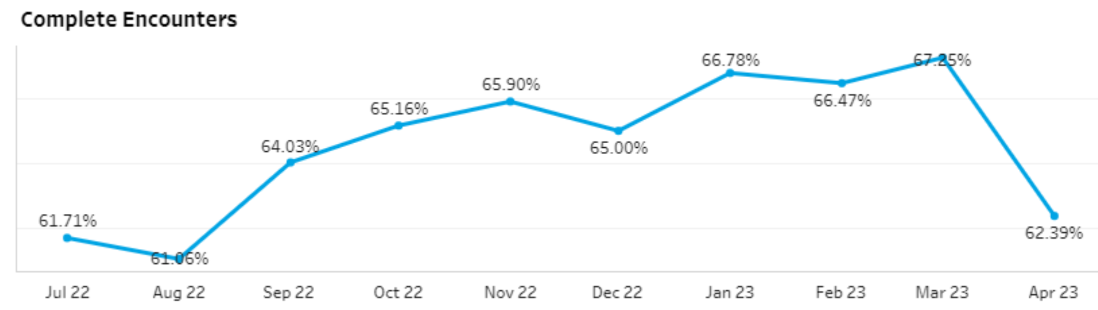
Data is updated daily

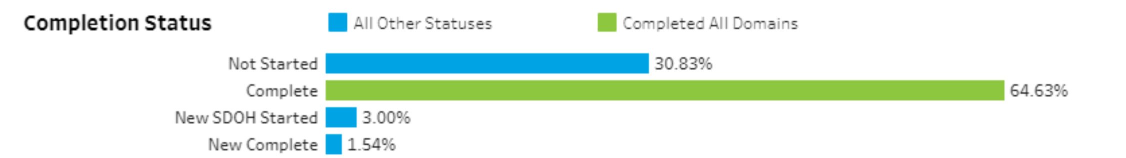
Fiscal Year	Contact Date	Visit Department	Age
2023	07/01/2022 – 04/29/2023	(All)	0 – 108

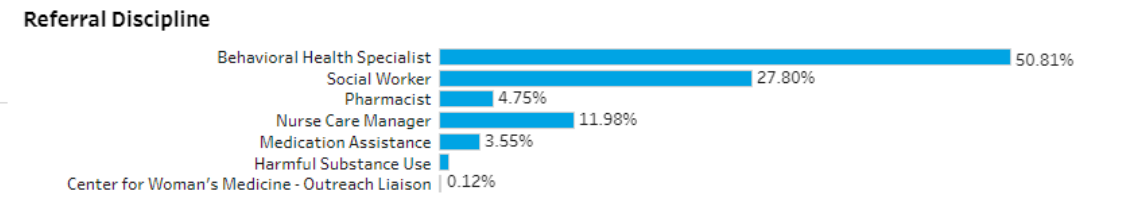
Complete Encounters	Eligible Encounters	Positive Risk Encounters	Positive Risk Referrals	Positive Risk Encounters with DX
64.63%	43,570	76.25%	5.31%	1.18%

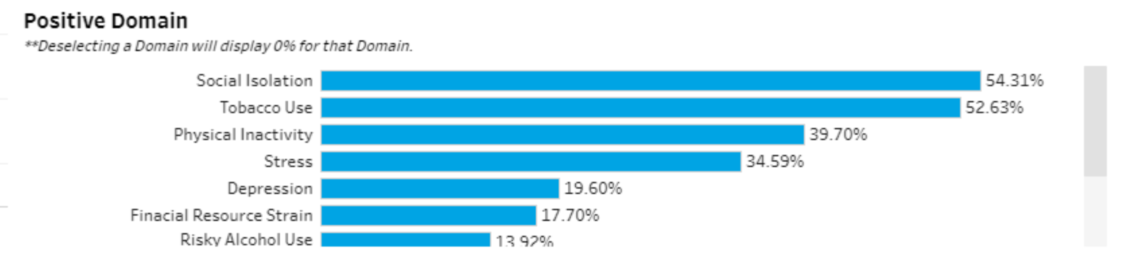
Gender	Value Based Registry	Ethnicity	Language	Race	Domain	Diagnosis	Chronic Condition
(All)	(All)	(All)	(All)	(All)	(All)	(All)	All











SDOH Dashboard

L E H I G H   V A L L E Y   H E A L T H   N E T W O R K

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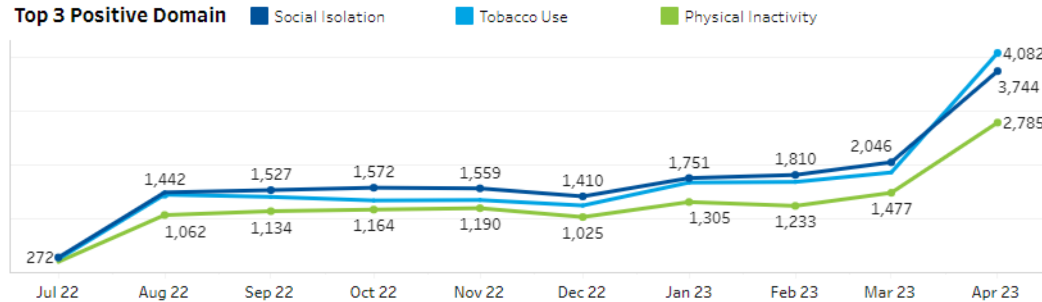
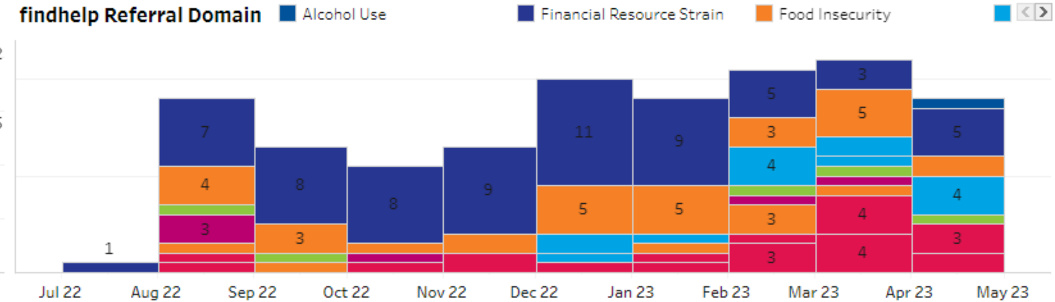
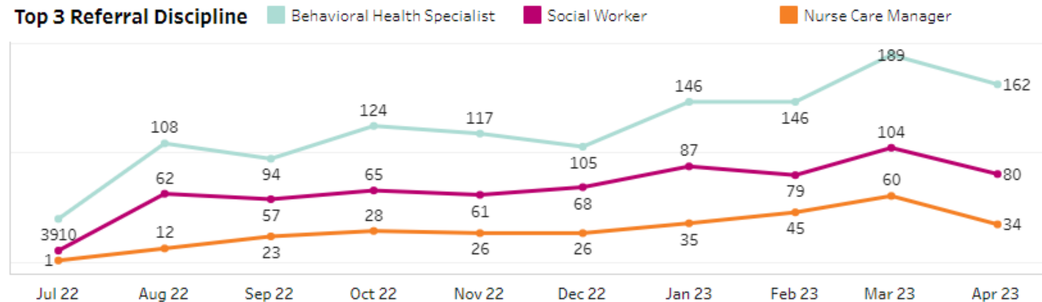
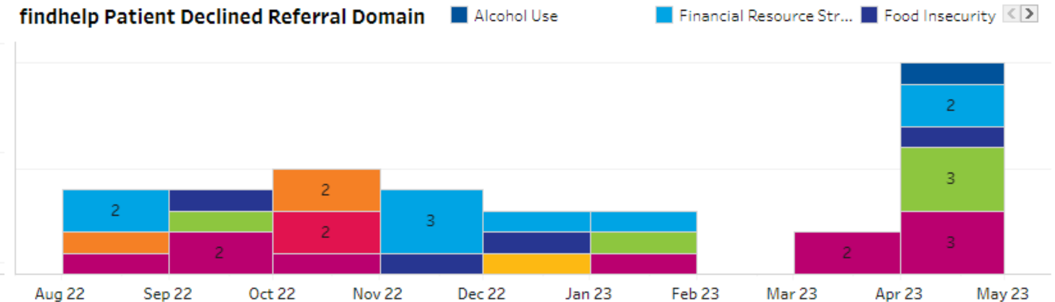
Eligible Encounters
43,570

Gender	Value Based Registry	Ethnicity	Language	Race	Domain	Diagnosis	Chronic Condition
(All)	(All)	(All)	(All)	(All)	(All)	(All)	All









SDOH Dashboard

Filter between All Eligible Patients, Complete Encounter Patients and Positive Encounter Patients.

Data is updated daily

Fiscal Year	Contact Date	Visit Department	Age
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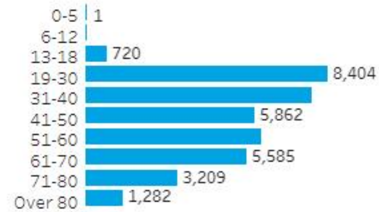
Complete Encounters	Positive Risk Encounters	Eligible Encounters
64.63%	76.25%	43,570

Gender	Value Based Registry	Ethnicity	Language	Race	Domain	Diagnosis	Chronic Condition	Cohort Filter
(All)	(All)	(All)	(All)	(All)	(All)	(All)	All	All Eligible Patients

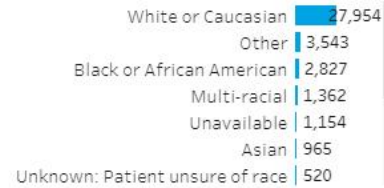
All Eligible Patients Age



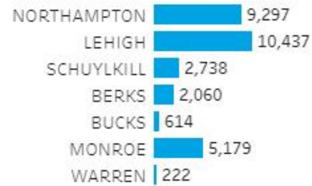
All Eligible Patients Ethnicity

All Eligible Patients Language

All Eligible Patients Race

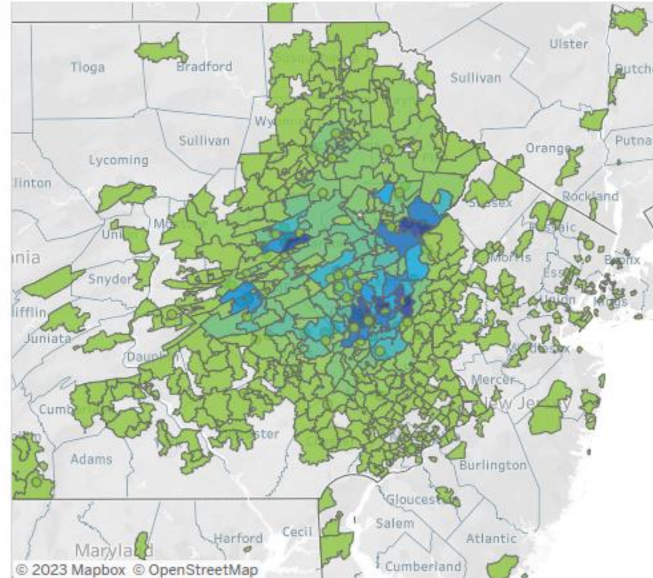


All Eligible Patients County

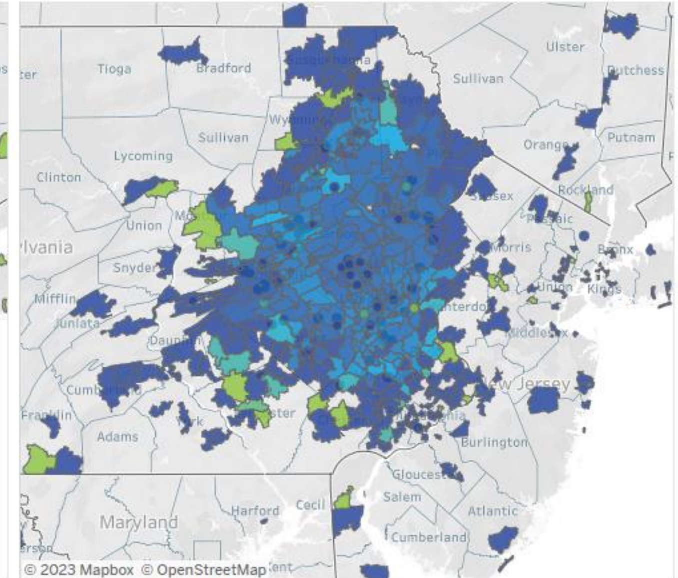


All Eligible Patients Gender

All Eligible Patients by Zip



% Positive of Completed Encounters by Zip



SDOH Dashboard

Looking Ahead

- Scale to additional visit types and other access points across the network
- Pediatric Screening
- BPA/Coding Optimization
- FindHelp Optimization
- Benchmarking-What Does Success Look Like?

Questions?

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