

**Submission Id: 2651**

**Title**

*Use of the EHR to Address the Social Determinants of Health - Primary Care Learning Experiences in a Health System*

**Priority 1 (Research Category)**

Social determinants and vulnerable populations

**Presenters**

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**Abstract**

Context: Identifying patients with needs related to Social Determinants of Health (SDOH) and connecting them with appropriate resources in an effective, efficient, and timely way can prove challenging. Primary care clinicians (PCC's) interact with the EHR thousands of times daily; this engagement can be leveraged to better address the SDOH. Objective: To understand our health system PCC's use of the EHR to identify adult patients who are experiencing adverse SDOH. Study Design: Descriptive study conducted by a learning collaborative (LC). Setting: A large health system including urban and rural regions in Minnesota, Wisconsin, Iowa, Florida, and Arizona. Population studied: Community-based physicians, nurse practitioners, and physician assistants practicing in family medicine, general internal medicine, or pediatrics. Instrument: A brief intranet survey was sent to members of the system's primary care learning collaborative. The survey included multiple-choice questions, with additional space provided for optional narrative responses. Outcome Measures: Assess PCC's practice patterns for addressing the SDOH through utilization of the EHR tools. Results: 87 responses were received out of 192 surveys issued (45%). Most PCC's see patients who are negatively impacted by SDOH either daily (85%) or weekly (92%). Fifty-six percent review the patient specific SDOH information in the EHR at the time of the clinical encounter, while 29% do not review the information at all. Of those who review the SDOH in the EHR, 63% refer the patient to someone else to manage the identified needs; 78% use social workers, 44% use nursing staff, and 24% use case managers. Only 11% rated the EHR as very useful in identifying SDOH, 55% find it somewhat useful and 32% do not find it helpful at all. Most (78%) were unaware of how to use the EHR to refer a patient to a community-based organization. Forty-four percent of PCC's were interested in learning, in written or webinar form, more about using the EHR to screen and intervene on the SDOH. Conclusion: PCC's frequently see patients with needs related to the SDOH. While the EHR is a tool to screen patients for barriers to optimal health, it is not currently being well utilized by PCCs to intervene on these barriers. PCCs tend to engage ancillary team members to address the complex care needs of their patients. There is interest in learning ways to use the EHR to identify and intervene when adverse SDOH are identified.