

**Submission Id: 4749**

**Title**

*Engaging the EHR to Address Health Related Social Needs: 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 health-related social needs and connecting them with appropriate resources in an effective, efficient, and timely way can prove challenging. The EHR should serve as a tool that facilitates Primary care clinicians' (PCCs') identification of their patients' social needs and referral to community-based organizations (CBOs). Objective: To understand our health system PCCs use of the EHR to identify patients experiencing social needs, refer them to CBOs for help, and to document SDOH Z codes. 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, who agreed to participate in the LC. Instrument: A brief intranet survey was sent to members of the primary care LC. The survey included multiple-choice questions, with additional optional narrative responses. Outcomes Measured: Assess PCCs practice patterns for identifying and addressing social needs through utilization of the EHR tools, and to determine specific social needs that PCCs feel are most essential for the healthcare team to address. Results: 74 responses were received out of 193 surveys conducted. Only a small portion of PCCs found the EHR system useful or very useful in helping to identify and address patient's social needs (13%). Most PCCs did not use the Community Resource Referral Platform that is built into the EHR because they don't know how to use it (33%), didn't know it existed (31%), or didn't find it helpful (15%). Not surprisingly, only 4% of PCCs reported use of an SDOH Z code as a visit diagnosis. Of the social needs domains investigated in our survey, PCCs indicated that it is most important to address food insecurity (33%), interpersonal violence (21%), housing insecurity (19%), financial strain (15%), transportation (10%), and social connections (6%) at the time of the visit. Conclusion: While PCCs believe that it is important to screen and refer for identified social needs, they did not find the EHR helpful to accomplish these goals. Resources to build the EHR infrastructure and adequate care team education are necessary to facilitate comprehensive screening and referral workflows to address social needs.