Boulder Community Health

Social determinants work flow and documentation:

Screening once per year (rolling – i.e., every 365 days per pt) via Seamless check in (iPad) – one initial screen in/out question – if "yes" then specific questions for different social determinants of health (childcare, financial, food, housing, literacy, safety, transportation, and utilities).

Clinical operations team will be training medical assistants and front desk staff on the screening process starting the week of 11/13/17. (See MA training document – Word)

- Roll out schedule – will start screening patients 60 years and older:
    1. DRFM, GFM, NWFM (week of 11/20/17)
    2. IMAF, SSIM, IMAL (week of 11/27/17)
    3. FIM, BRIM (week of 12/4/17)
    4. BCFM, IMAB, FMA (week of 12/11/17)
- No further age cohort yet – will allow this process to go for the rest of the year then reassess.
- Will eventually roll out to ages 18 and over at all clinics.

Any "yes" and would like to be contacted – weekly e-mail to CC-I for follow up and resource referral

Any "yes" and has immediate need – pt given 2-1-1 card for community resources

Other crisis – may be sent to RNCM for follow up if available in clinic; RNCM may expect some reach out if RNCM needs some support in determining appropriate resources for pts

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Standard follow-up and resource referral for CC-I:

Weekly e-mail of positive screens – outreach attempted in 7 business days (attempt one additional time if you do not reach the patient the first time)

Call pt and document in Greenway:

Open patient chart → documents → open social determinants screening document to determine area(s) of need

Create Note → Progress Note → Select Template (under Betsy Duckett) → Care Coordination SDA Template

HPI – template is already filled in (modify as necessary)

Results → In Office Results enter "social" and select:

1) **Social Determinants Assessment (BCH)** – *always* choose this for every note that there is attempted follow up

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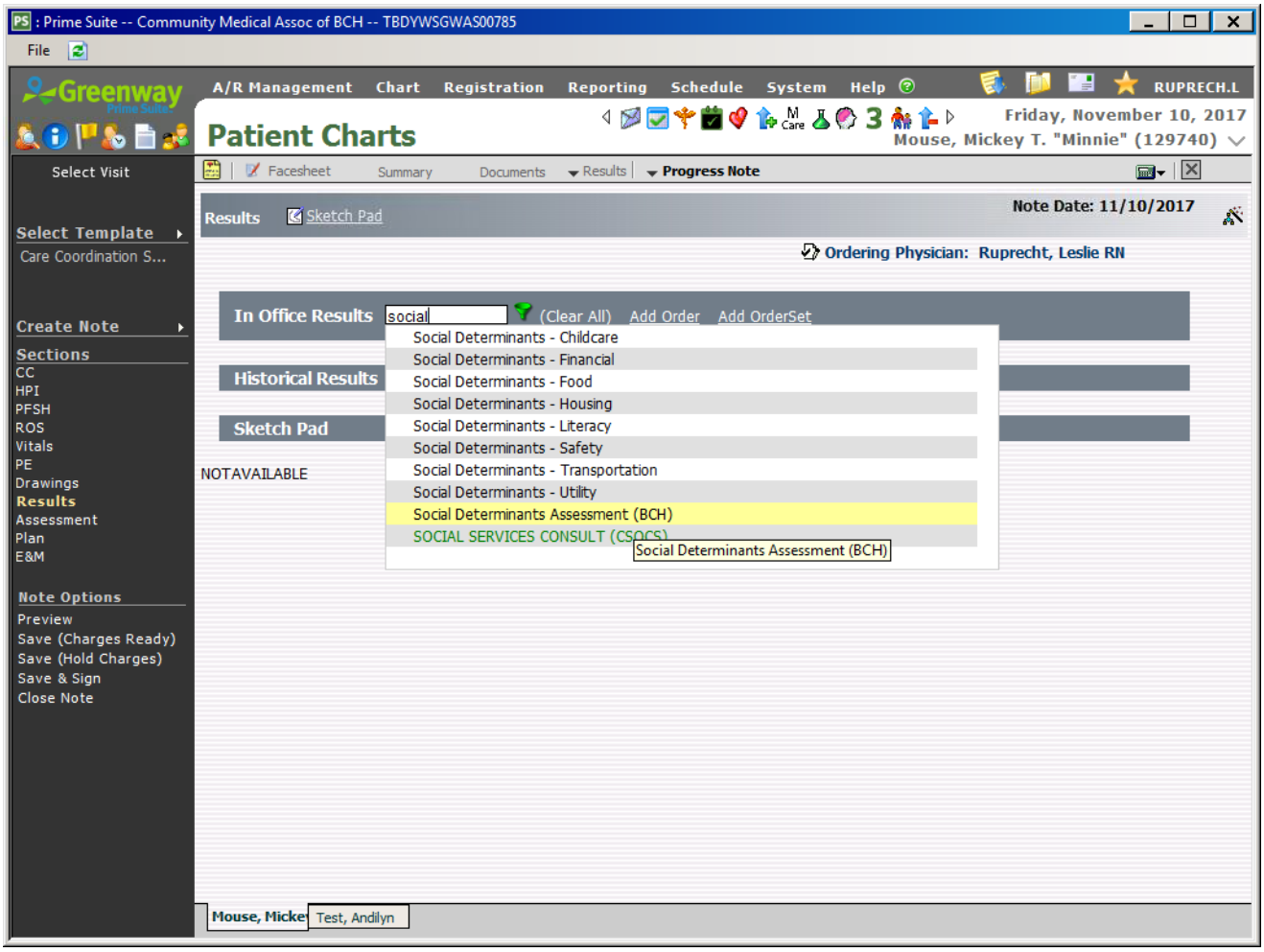
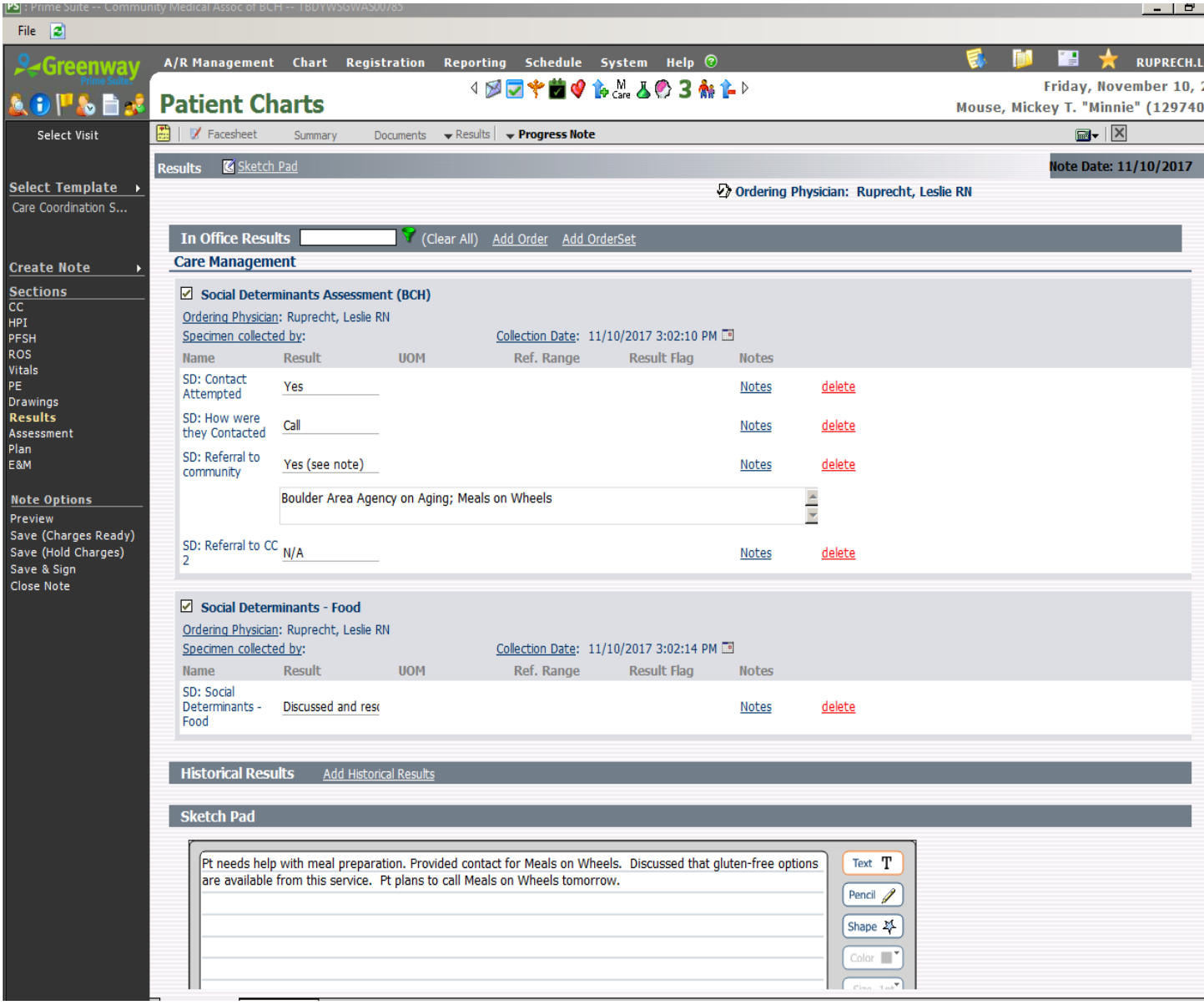
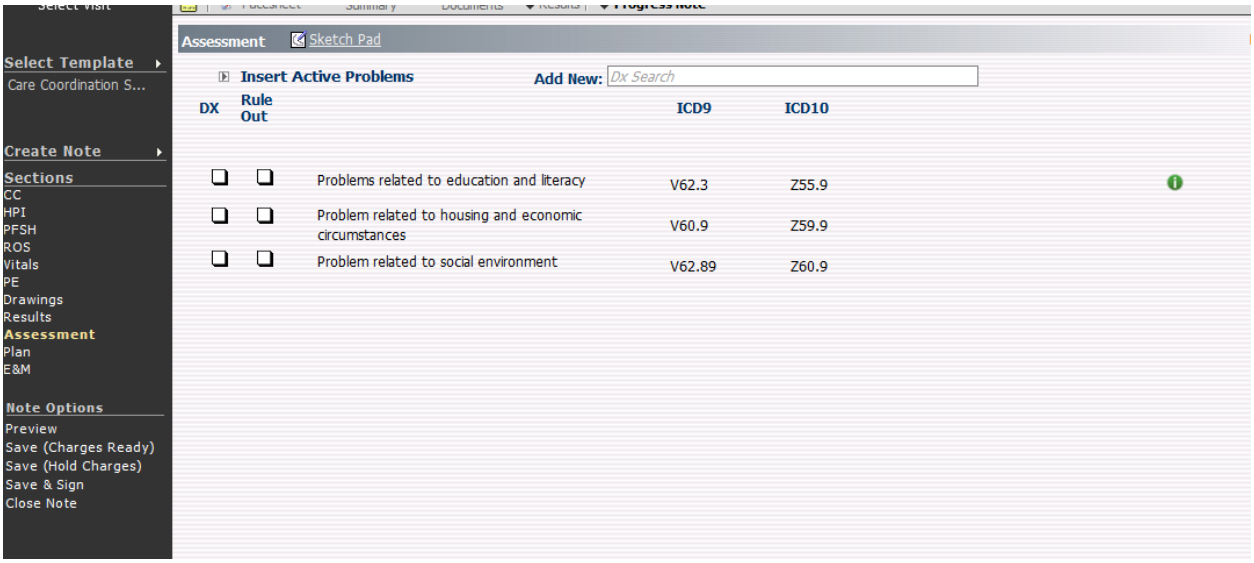


2) For each specific social determinant screen positive (“yes” answer) – enter “social” in <In Office Results> and select applicable measure – choose only the categories of need as determined by the screener:
    a. Childcare
    b. Financial
    c. Food
    d. Housing
    e. Literacy
    f. Safety
    g. Transportation
    h. Utility
3) Fill in the drop down for each category in results
    a. Add notes as needed
    b. Add sketch pad notes for narrative



Assessment section – choose one to entitle the progress note – click box under Dx – select diagnosis that applies; this appears as the title of the progress note in the documents list:



Optional: under Note Options – select Preview to review note before signing

Save and sign note.

- For active care management and care coordination patients – notify RNCM - ok for CC-I to do initial resource referral; if needs continued follow up, then RNCM should continue with care coordination or care management
- Only document initial social determinant follow up on this progress note
- Attempted and did not reach – then write progress note to capture attempt in results section; if pt calls back later then document in misc. note that resource was given; title the note CC: Social Determinants Referral(s)