

Social Determinants of Health (SDoH) are conditions in the environment where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Northern Light Health is committed to promoting healthy practices that include addressing the negative impact SDoH have on one's health. The SDoH PowerForm captures Food Insecurity, Housing, Transportation & Utility needs, Family, and Community Support. The SDoH PowerForm is used to assess patients receiving care in the ED, WIC, inpatient locations, and ambulatory practices.

## Social Determinants of Health (Prapare) Form Overview

The new PowerForm will satisfy the requirements of the SDoH in one location. Each section highlighted in yellow must be answered **Once Annually** for **Ambulatory**, **ED**, and **WIC** settings and upon **every Inpatient Admission**. If a patient would like help with any barriers identified, a **yes** documented on the form triggers a task to Care Management to follow up with the patient.

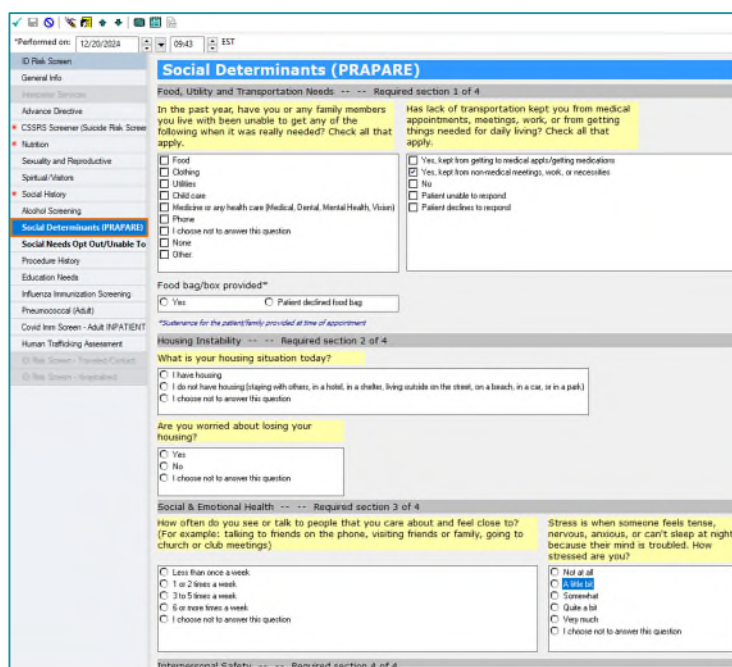
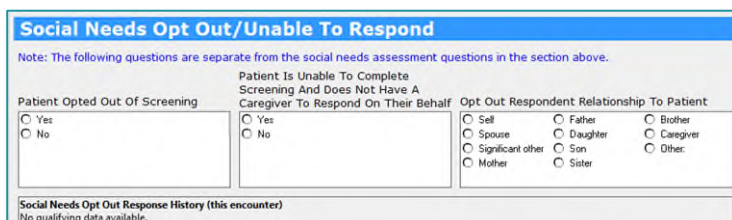
### ➤ Required Fields:

- Food, Utility, and Transport Needs
  - This includes two sections of multi-select boxes.
- Housing Instability
  - This includes two single-select sections.
- Social and Emotional Help
  - This includes two single-select sections.
- Interpersonal Safety
  - This includes four single-select sections.

➤ The remaining fields are not required and should be answered based on the patient situation.

### ➤ Social Needs Opt Out/Unable to Respond

- This form is for those patients who are not able to respond or unable to complete the questions, do not have a responsible caregiver to respond on their behalf, or adamantly refuse to complete the questions.

The MPage component shows the history of SDOH documentation completed by date and questions answered. This gives staff a quick view of the patient's SDOH history and informs the ambulatory staff if the entire form was completed for the current year.

- More information is pulled into the SDOH component to gather all social information in one location to reduce time spend looking through the chart for information. To see the crosswalk for other information click [here](#).

**NOTE:** If the SDOH component is not viewable, click the three line elipsis in the right corner, click components, select SDOH so it has a checkmark beside it to be viewable. Make sure to use the Exit door when leaving PowerChart to save the change.

## Provider Auto Text

Providers have the ability to add SDOH information into the social history portion of the Dyn Doc note or within a PowerNote by using an auto text, /sdoh\_prapare. The auto text will include the last charted value documented within the SDOH form across encounters for the past 12 months.

Social History /sdoh_prapare		
Social Determinants (PRAPARE)		
Event Name	Event Result	Date/Time
# of People, Including Self, Living w/You	3	11/26/24
Afraid of Ex/Partner in the Past Year	Yes	11/26/24
Are You a Refugee	No	11/26/24
CM Preferred Spoken Language	English	11/26/24
Discharged From US Armed Forces	No	11/26/24
Gone Without Household Needs Past Year	Food, Clothing, Utilities, Medicine or any health care (Medical, Dental, Mental Health, Vision), None	11/26/24
Housing Situation Today	I have housing	11/26/24
Live in Physical and Emotional Safety	No	11/26/24
More than 2 Consecutive Jail INightPastYr	No	11/26/24

## Recommendation – SDOH (Ambulatory Only)

- Social Determinants of Health now fires to the Recommendations component yearly.
- Complete all required questions highlighted in yellow.

**NOTE:** The field shows last charted value to assist users to identify when a complete SDOH screening was last performed.

Recommendation	Next Due	Recurrence	Orders
Influenza Vaccine	Overdue (3 months)	Seasonal	
Adult Wellness	Today	Every 1 YR	Orders
Latent TB Screen (If Risk)	Today	One-time only	Orders
Lipid Screening	Today	Every 5 YR	Orders
Social Determinants of Health	Today	Every 1 YR	

- The SDOH completed today section, at the bottom of the PowerForm, needs to be answered: Yes. This field is what satisfies the recommendation.

All REQUIRED SDOH questions were answered

☒ Yes

## Care Management/Social Worker Tasking

### ➤ Acute Case Management Worklist

- During the SDoH assessment, if a patient states they would like assistance, then a task fires to the Acute Case Management Worklist for Care Management or Social Work to review and meet with the patient.
  - Once the task has been completed, select **Done** to remove from the task list.
- A new **Assessment** column is available on the Acute Case Management worklist, to give Care Managers a quick reference to the SDoH form answers by the patient for the current encounter.

### ➤ Social Determinants Workflow MPage

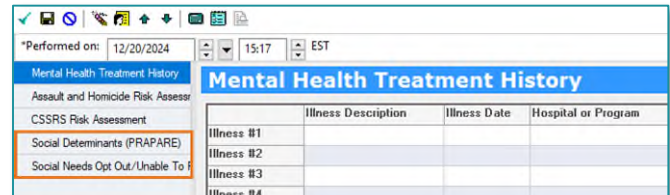
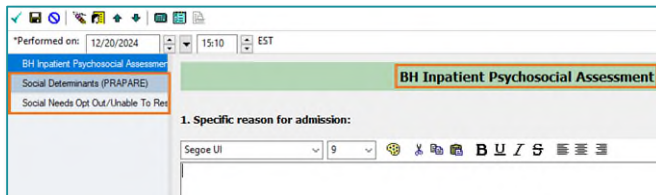
- Care Managers have the option to add the Social Determinants of Health worklist MPage to their view if they choose. The MPage view shows SDoH form completion dates and information if any changes have occurred throughout the year. The dropdown arrow will take you directly to the form for the current encounter.

## AMB Care Management Documentation

- Interactive View** and **I&O** will continue to be the location for the **AMB Care Managers** to document SDoH. They also have the SDoH component within the **Active Case MPage**.
- During the SDoH assessment, if a patient states they would like assistance, then a task fires to an **Insight Report** for the **AMB Care Managers** to pull and contact the patient directly to assist them. The process is applicable to Family Practice, Peds, Specialty clinics, and the WIC.

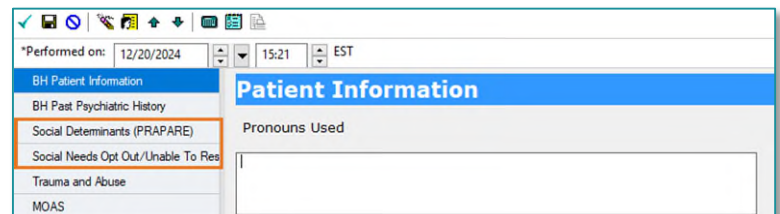
## Acadia Inpatient and Amb Workflow

- The SDoH forms have been added to the **BH Inpatient Psychosocial Assessment** and the **BH Provider Initial/Ongoing Assessment** to assist the Clinicians with ease of locating and documenting in one area during initial assessment.



- The SDoH has been added and moved to the top portion of the **BH Outpatient Intake Assessment Form**.

**NOTE:** The form will not fire to any case workers.



- Acadia Inpatient Clinical Associates will follow the [Care Management/Social Work](#) workflow for tasks as shown above.