Social History Documentation and Review for Providers and Clinical Staff

Cerner PowerChart Ambulatory **EDUCATION**

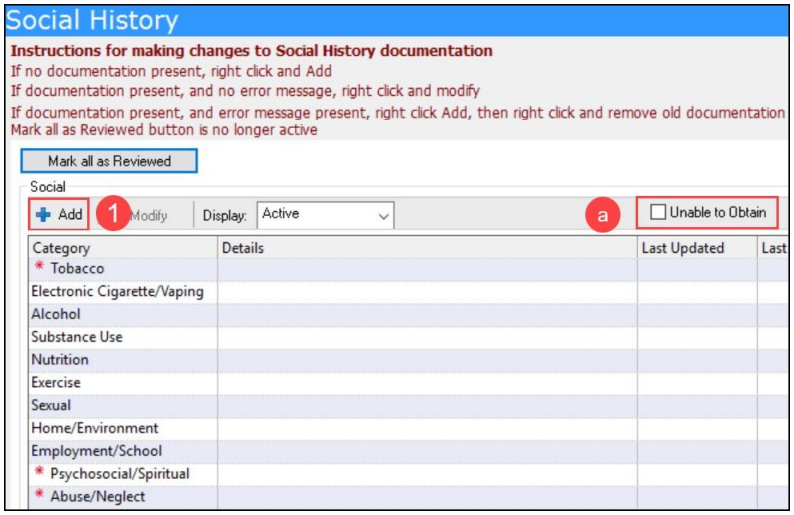
Social History is required to be reviewed at every patient visit. This includes documenting at a minimum, tobacco status for meaningful use and Home/Environment information for rural health clinics. Follow practice guidelines for additional social history documentation.

Social History Documentation and Review

Access Social History from the Histories workflow page component, Histories on the left side menu, or from an Intake PowerForm.

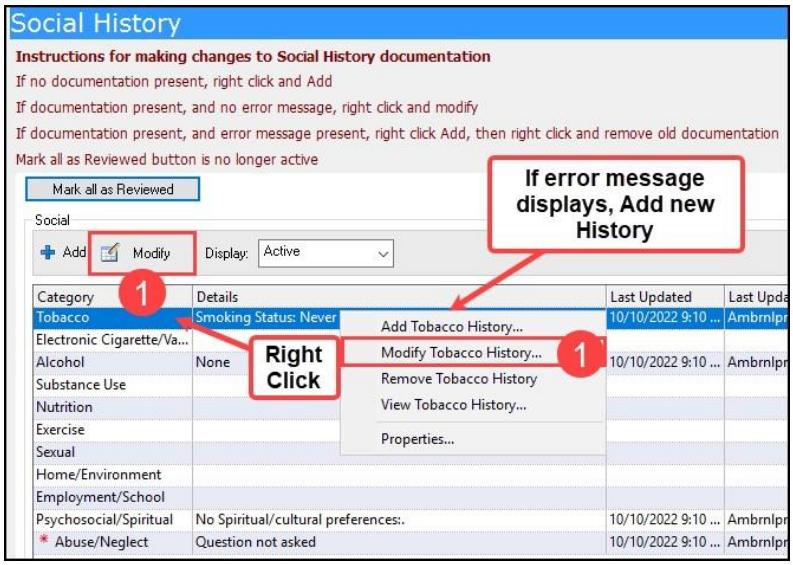
Documenting new Social History:

1. Click **+ Add**.
    a. Note: If a patient or family is unable to provide social history information, select Unable to Obtain.
2. The Add History dialog box is displayed with a list of questions specific to each category.
3. Complete the required categories and any additional categories as directed by your practice. Use the scroll bar to access additional categories and questions.



Reviewing Previously Documented Social History:

1. Highlight the desired Social History Category and click the Modify button or right-click on the Category and select Modify.
    a. If an error message displays, right click on the Category and select Add History. Then right click on the outdated documentation and select Remove History.



2. Click **OK**.

Documenting the Sexual Orientation and Gender Identity Information

The following questions are now required fields for each patient 18 years and older. *(Recommendations pending for those under 18.)*

- In the inpatient setting, the CMS requirement is that this data be collected once during the admission process.
- In the ambulatory setting, the CMS requirement is one time per 365 days period.

1. Enter the patient's self-described sexual orientation.
2. Select the patient's self-described gender identity. Please note that this is a multi-select field. If "Addl gender category…" is selected, a comment field will open. Enter the patient's comment using their words.

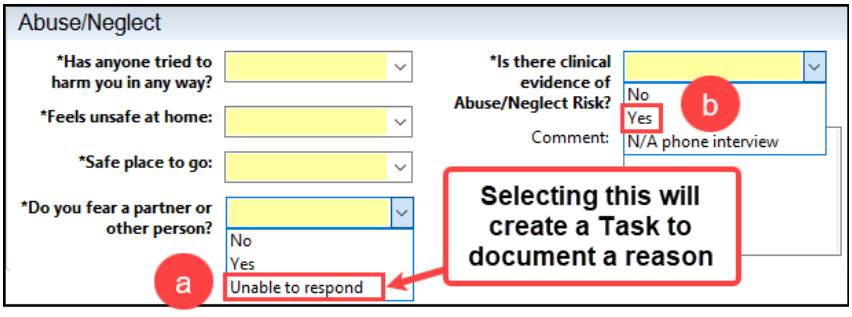
Note: Sexual History can be edited within the Providers Workflow Histories component.

Click on the following link to view the complete education document: Department Educator Resources Diversity Equity and Inclusion (mhc.net)

Abuse/Neglect Screening

The Abuse/Neglect category of Social History contains 5 mandatory fields for patients 18 and older and 1 mandatory field for pediatric patients. Documentation to meet regulatory guidelines is required once every 365 days for all patients.

1. Screen the patient and document the patient's response to each question.
    a. Selecting **Unable to respond** for **ANY** Abuse/Neglect question will create a Task that must be documented on by clinical staff.
        i. See the steps below on documenting the Task.



    b. Document whether clinical evidence of Abuse/Neglect Risk is present. **Pediatric screenings will contain this question only.**

2. When abuse or neglect is reported, notify the provider, and provide resources to the patient.

- Options for resources may include: ○ Referral to care management ○ Referral to behavioral health ○ Domestic violence resources ○ Shelter resources ○ Referral to Adult Protective Services (APS)/Child Protective Services (CPS), Phone 855-444-3911.

3. If Unable to Respond was selected as an answer for **ANY** Abuse/Neglect question, the Abuse/Neglect Screening Task should be completed.

   a. Navigate to the patient Task List from the dark blue PowerChart Menu.

Open the task documentation by double clicking on the task, or right clicking and selecting Chart Details.