Social History Documentation and Review for Clinical Staff

Oracle Health PowerChart **EDUCATION**

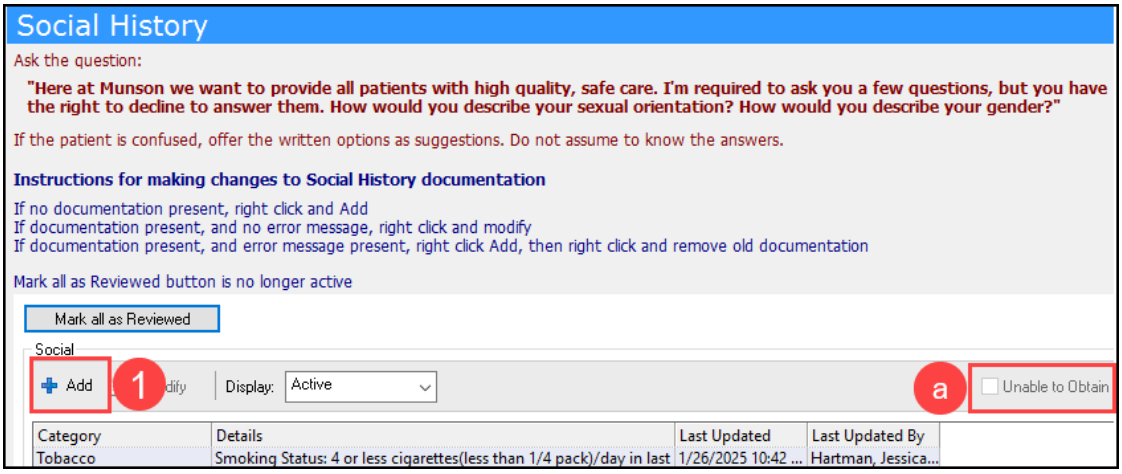
Social History is required to be reviewed at every patient visit. This includes documenting at a minimum, tobacco status for meaningful use and Home/Environment information for rural health clinics. Follow practice guidelines for additional Social History documentation.

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:

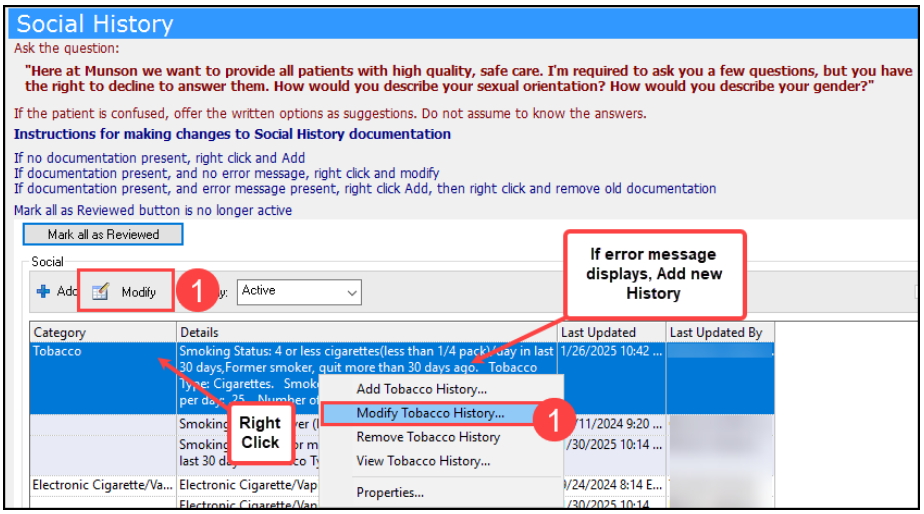
1. Click **+ Add**.
    a. If a patient or family is unable to provide social history information, select **Unable to Obtain**.
2. The Add History dialog box is displayed with a list of questions specific to each category.
3. Complete the required categories and any additional categories as directed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



Note: The red script in the Social History section serves as a guide to support effective questioning and encourage patient responses to Sexual Orientation and Gender Identity (SOGI) 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 is displayed, right -click on the Category and select Add History. Then right-click on the outdated documentation and select Remove History.

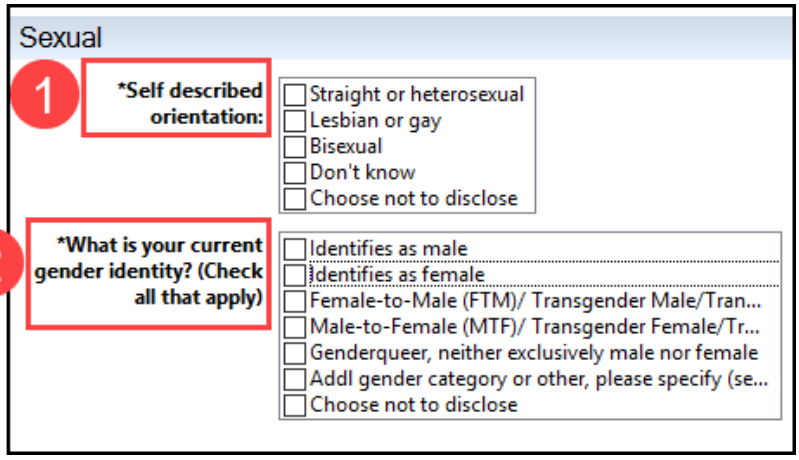


2. Click **OK**.

Documenting 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.)*

1. Select the patient's Self-described sexual orientation.
2. Select the patient's self-identified gender identity. This is a multi-select field. If "Addl gender category…" is chosen, a comment field will appear, allowing entry of the patient's specific description.
   - Within the **Inpatient** setting CMS requires that this data be collected once during the admission process.
   - Within the **Ambulatory** setting CMS requires this data be collected one time per 365-day period.



Note: Sexual History can be reviewed and edited within the Provider Workflow Histories component.

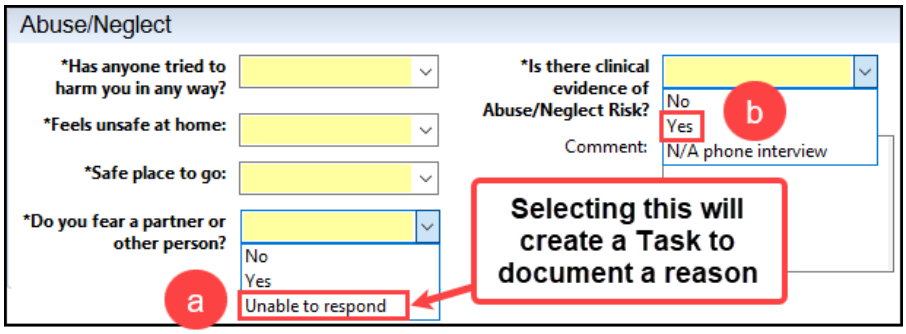
Abuse/Neglect Screening

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.

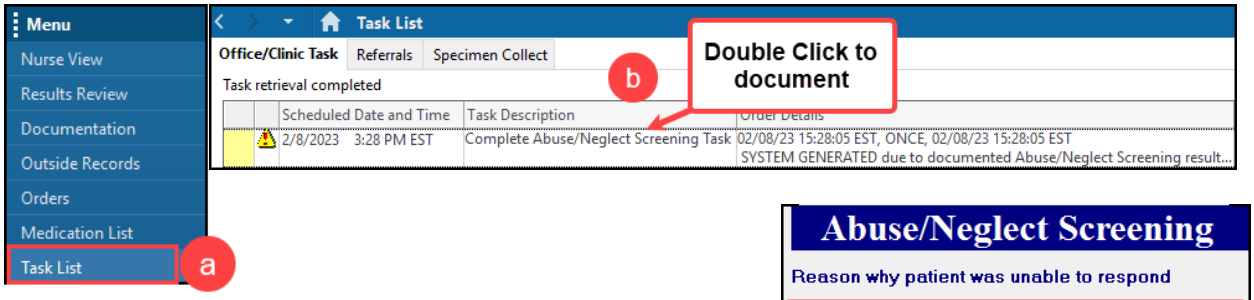
   a. Selecting **Unable to respond** for **ANY** Abuse/Neglect question will create a Task that must be documented on by clinical staff.
      i. See the steps below on documenting the Task.

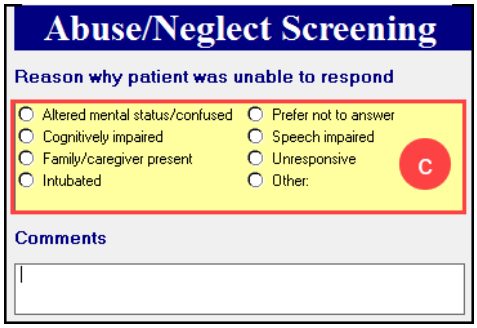
   b. Document whether clinical evidence of Abuse/Neglect Risk is present. **Pediatric screenings will contain this question only.**



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 PowerChart Menu.
    b. To open the task documentation, double click the task or right-click and choose Chart Details.





    c. Select the Reason why patient was unable to respond. Select Other to free text a reason.
    d. Click the green check mark ☑ to complete and sign the PowerForm.

Note: If the task does not display on either Task List, personal settings may need to be corrected. See the Clinical Personalization document on the Clinical EHR Education website for instructions.