Standard Work

Process Name	Social Determinants of Health Assessment (SDOH)	Location:	WellSpan Health	Department:	Case Management
Document Owner:	CM SDM P&Q	Date Created:	01/20/2019	Revision Date (s):	2/24/21
Trigger:	Positive Social Insecurities Screening, Case Management Referral, and/or Case Management Assessment		Related Policies:		

Process Steps	Role Performing Task	Key Point	Pictures, Diagrams, Workflows, etc.
1. CM prepares to meet with patient to complete Initial Assessment. - Reviews Nursing Assessment- History, Social Insecurities Assessment, Psychosocial Assessment - Prior SDoH Assessment	CMRN, CMSW	Review Nursing Assessment of Social Insecurities (SI) and Psychosocial history for current encounter. Review any previously filed information in SI, SDOH, and Psychosocial history. SDOH is addressed and documented on in the Inpatient and Ambulatory environments.	Refer to CM *'Chart Review'* and *'Review of Chart'* Guides
2. Meet with patient - Address identified Social Insecurities for clarification - Complete Social Determinants of Health Assessment as appropriate - Assess Disability Status - Identify Post-Discharge Needs based upon assessments	CMRN, CMSW	Reassessment needed to identify the Social insecurity concerns to determine the interventions and resources needed. *If NO NEED is identified skip to #4. Document SDOH note with smart text stating **"completed assessment and no needs identified at this time"**	Refer to *'CM Navigator Placement and Plan'* Standard Refer to *Social Determinants of Health (SDOH)* Guide
3. Discuss Resources, barriers to resources and potential options, with the patient	CMRN, CMSW	Resources vary per County of residence and level of need identified.	
4. Provide resource material and/or make referrals to community resources	CMRN, CMSW	Communication to community agencies.	Refer to CM *'Discharge Placement'* Guide, *'CM Epic Documentation'* Standard, *and 'Epic Ensocare'* Standard

5. Complete documentation - SDOH (Note that housing must be documented individually from Storyboard or SDOH Wheel) - Discharge Planning, identifying any resources provided and/or referrals made - Document on Care Plan - Document Education - Add Resource information for the AVS including Follow-Up Appointments, Agency Referrals, and/or Patient Instructions	CMRN, CMSW	SDOH Smart Text allows CM to document information allowing for appropriate Z-Code to be identified. Documentation requirements for problem, goals, and interventions. Identification of appointments and resources provided on AVS. Note: Federal Poverty Level (FPL) information can be found on Healthcare.gov. The measure of income defining the FPL is issued every year by the Department of Health and Human Services (HHS).	Refer to CM *'Care Plans'* Guides Refer to *'CM Navigator Placement and Plan'* Standard Refer to *SDOH Smart Text* Guide