

The SDOH Program at Berks Community Health Center

Nicole Belote
SDOH Coordinator

Screening

- ▶ Text Message/Email
 - 3 days prior to patient's appointments, they will be sent a text message and an email to complete the PRAPARE form
- ▶ Tablets
 - Complete the form on the Tablet when the patient comes to their appointment
- ▶ Paper Forms
 - When tablets are not working, paper PRAPARE forms are completed

Next Steps

- ▶ Meet with the patient
 - Confirm information on the form
 - Provide any community resources
 - Complete any applications with the patient
 - SNAP, Medicaid, LIHEAP, Etc.

Next Steps Continued

- ▶ Input everything into the patient's chart
 - Any SDOH's found will be included on the problems list

Update - FEMALE TEST -- Append at BCHC on 4/3/2023 4:13:44 PM by Nicole Belote [Doc ID: 2975]

The screenshot displays a patient chart interface with a summary of SDOH (Social Determinants of Health) data. The patient's name is PRAPARE, with a DOB of 01/01/1950 and a patient age of 73 years old. The interface is divided into several sections: Sociodemographic/Socioeconomic, Money and Resources, and Psychosocial Assets. The Sociodemographic/Socioeconomic section includes fields for Race (State Prohibited), Ethnicity (State Prohibited), and Preferred Language (English). It also contains a question about seasonal or migrant work in the last 2 years, with a 'Yes' response, and a 'Veteran Status' field set to 'Yes'. The Family and Home section includes an address (645 PENN STREET, READING, PA 19602), household size (4), monthly family income (50), housing situation (do not have housing), and a concern about losing housing (No). A button labeled 'Add Homelessness (Z59.0) to Problem List' is visible. The interface also shows a sidebar with 'Forms' and 'Attachments' sections, and a 'Favorites' section with a 'Blank image' option. The bottom of the screen displays version information (v1.07 - version date: 10/18/2016) and the organization name (Alliance of Chicago Community Health Services, L3C).

Next Steps Continued

- ▶ Input all community resources referred into the patient's chart

Update Orders - FEMALE TEST 73 Years Old Female, (DOB: 01/01/1950)

Orders: This update Open All Primary Coverage:

!	Date	Description	Status	Diagnoses
	04/03/2023	Berks Coalition to End Homelessn	Unsigned	HOMELESSNESS (ICD-V60.0) (ICD10
	04/03/2023	New Journey - Food Pantry	Unsigned	LACK OF ADEQUATE FOOD (ICD-V6I
	04/03/2023	Helping Harvest - Food	Unsigned	LACK OF ADEQUATE FOOD (ICD-V6I

Remove Reorder Clear Diagnoses

Potential Diagnoses:

- * Homelessness
- Family planning
- Neurologic Disorder
- * Lack of adequate
- Underachievement in School
- Neuropathy-peripheral
- Liver Transplant
- Kidney Disease
- Hypothyroidism
- Hepatitis B
- * GSD

Custom List Categories Search Order Details

Clinical Information

Description: Helping Harvest - Food

Code: CPT-99999 Diagnoses...

NDC: Add Modifiers...

Authorized By: Kelleher MD, Mary

Modifiers:

Instructions:

Disposition: Admin Hold

Previous Order Next Order

Referral Administration

Start Date: 04/03/2023 End Date:

Duration: 0 Days Weeks Months

Max Visits: 0 Create Transition of Care Document

Reason:

Referring To: External Internal provider

Insurance Notes:

Change Coverage... Ref. Coordination...

Sign Orders OK Cancel

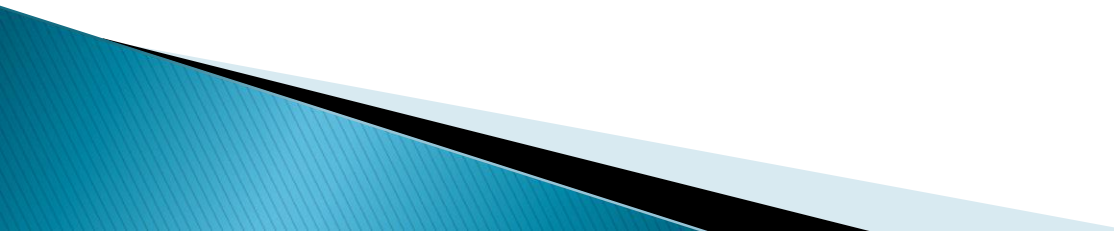
Final Steps

- ▶ Follow up with the patient in 2 weeks
 - Call the patient to see if they were able to get the resources that were needed
 - Provide any additional resources
- ▶ Close all open referrals

Using the Data

- ▶ All problems are added to the patient's chart and sent to MCO
- ▶ Able to track:
 - How many patients complete the form
 - Problems patients are facing
 - Community Resources most utilized
 - When a patient is due to have another form sent to them (completed once a year)

Limitations

- ▶ Patients Completing the form before appointment
 - ▶ Tablets
 - ▶ Staffing
 - ▶ Reaching Patients
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Thank you

Any Questions?

