Ambulatory Care Network HEALTH SERVICES • LOS ANGELES COUNTY *Quality • Compassion • Responsibility*	Policy & Procedure Number	ACN CD-01.018
TITLE: Documentation – Comprehensive Health Assessment **DIVISION: Ambulatory Care Network** **SERVICE AREA/ UNIT: ACN Clinics**	**Origination Date:**	08/29/2019
	Revision Date:	
	Review Date:	
	Approved By:	ACN P&P

1.0 PURPOSE:

To establish the required elements to be obtained and documented during a comprehensive health assessment in the PCMH clinic.

2.0 POLICY:

Every Ambulatory Care Network (ACN) PCMH designated staff will obtain and document pertinent patient information in the ORCHID electronic health record as outlined.

3.0 DEFINITIONS:

3.1 **ORCHID**: The Los Angeles County Department of Health Services' electronic health record system.

3.2 **Intake:** The process of obtaining patient clinical data and social history.

4.0 PROCEDURE:

4.1 During patient intake in PCMH clinics, licensed and/or unlicensed (Certified Medical Assistant) non-provider team members will screen the patient and gather a minimum set of required elements to complete the Staying Healthy Assessment.. The "Staying Healthy Assessment" (SHA) form will be updated annually. The intake documentation will be updated and/or reviewed using the "Adult Ambulatory Care Intake and History" form or the "Pediatric Ambulatory Well Child Intake" form in ORCHID, annually during Initial Health Assessment or wellness visit, unless stated otherwise.

4.2 The following elements, including the social and behavioral determinants of health (SBDOH) will be obtained from the patient/family/caregiver during intake:

4.2.1 History of patient and family, including but not limited to:

- Medical history
- Mental health history
- Substance use history

4.2.2 History of patient:

- Procedure/Surgical history
- Medication history
- Immunization

4.3 Family, social and cultural characteristics (e.g. marital status, educational level).

4.4 Communication needs to identify any barriers to learning: physical (i.e. visual or auditory impairment), cognitive, or language comprehension. Results should be documented on "Interdisciplinary Patient/Family Record of Learning Needs" form.

4.5 Social functioning, to identify patient's ability of patients to maintain and perform social tasks and engagment (e.g., declining cognition, isolation, interpersonal relationships and activities of independent living. Results should be documented on the "Interdisciplinary Patient/Family Record of Learning Needs" form and the Social History tab in ORCHID. Licensed personnel will review the documentation and make referrals accordingly.

4.6 The "Staying Health Assessment" form will be handed to patients and/or caregivers to document behaviors affectinghealth (e.g., assessing risky and unhealthy behavior that go beyond physical activity, alcohol consumption and smoking status and may include nutrition, oral health, dental care, risky sexual behavior and second-hand smoke exposure). Providers/other licensed personnel will review the form and make referrals/intervene accordingly.

4.7 The "Ages and Stages Questionnaire" (ASQ) form will be handed to parent/family/caregiver at age-appropriate well-child visits at time of registration to be completed prior to being seen by provider. Providers/other licensed personnel will review the form and make referrals/intervene accordingly.

4.8 Advance care planning: Document preferences for the end of life care.

4.9 Behavioral Health Screenings: Utilize a standardized tool located in the Adult Ambulatory Care Intake and History" form and "Pediatric Ambulatory Well Child Intake" form unless stated otherwise. Providers/other licensed personnel will review the results of the screening and make referrals accordingly.

4.9.1 Depression (PHQ2 and/or PHQ9): Completed annually during wellness or Initial Health Assessment visit and/or as indicated by provider

4.9.2 Anxiety (GAD-2 and/or GAD-7): Completed upon request by the provider.

4.9.3 Alcohol and substance use screening (CAGE, NIDA and/or ASSIST) performed annually during wellness or Initial Health Assessment visit

4.9.4 Post-partum depression (PHQ2 and/or PHQ9): if applicable.

5.0 MONITORING:

5.1 ACN Nursing leadership or designee will routinely monitor the completeness of documentation.

6.0 SOURCES AND REFERENCE:

6.1 ACN Patient Centered Medical Home Manual (2019)

7.0 AUTHORITY:

7.1 National Committee for Quality Assurance, Patient-Centered Medical Home Standards & Guidelines

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Approvals:

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P&P History

Date	Department	Policy & Procedure #	Comments	Next Annual Review Due
8/29/2019	ACN		Draft prepared	
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