

BH Module

ADA update to Health History



Selected Language fields on the **Health History** Assessment have been updated to enhance identifying patients that need ADA resources as well as ensuring they are offered the correct accessibility services. Verbiage has been updated to align with current ADA recommendations.

Health History Assessment

Language services type:

1 ☐ Interpretation via phone Select mode(s) of services needed.

2 ☐ Interpretation via video

3 ☐ Onsite interpretation Document use of language services in Language Assistant.

4 ☒ Other

Preferred language: ENG ENGLISH

Accessibility needs: Blind/low vision

Language services: Patient/rep accepts

Language services type: Other

Additional language services detail:

Free Text

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Language service type field responses have been updated. 'Other' has been added as an available response.

Note: If Other is selected, then *Additional language services detail* becomes a **required*** Free Text field in order to provide any additional details about language services needs or preferences.

Health History Assessment

Vocalization: [or free text]

1 ☐ Appropriate 7 ☐ None 13 ☐ Slurred

2 ☐ Aphasic expressive 8 ☐ Non-verbal 14 ☒ Speechless

3 ☐ Aphasic receptive 9 ☐ Phonation strong 15 ☐ Word salad

4 ☐ Cri du chat 10 ☐ Phonation weak

5 ☐ Incomprehensible sounds 11 ☐ Repetitive

6 ☐ Intubated 12 ☐ Shrill Cry

1 Blind/low vision:

2 Deaf/hard-of-hearing:

3 Vocalization:

4 Cognitive disability:

Auxiliary aids/services:

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The following verbiage has been updated per ADA recommendations:

- 1 - Vision impairment has been updated to **Blind/low vision**
- 2 - Hearing impairment has been updated to **Deaf/hard-of-hearing**
- 3 - Under Vocalization, the field response 'Mute' has been updated to **'Speechless'**
- 4 - Cognitive impairment has been updated to **Cognitive disability**

Health History Assessment

Auxiliary aids/services: [or free text]

1 ☐ Assistive listening dev
 2 ☐ Braille
 3 ☐ Captioning services
 4 ☐ Cochlear implant
 5 ☐ Communication board
 6 ☐ Or<F9> For More Options

Document any auxiliary aids/services the patient is currently using, regardless of whether they were provided by the patient or the hospital.

Blind/low vision:>
 Deaf/hard-of-hearing:>
 Vocalization:>
 Cognitive disability:>
 Auxiliary aids/services

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Auxiliary aids/services: Lookup

Select ☐

Options

1 Contacts
 2 Corrective lens
 3 Cueing
 4 Hearing aid
 5 Magnifier
 6 Notetaker
 7 Prosthetic eye
 8 Qualified reader
 9 Read lips
 10 Real-time transcription
 11 SAP Auditory prng
 12 Telecommunications device
 13 Texting device
 14 TTY phone
 15 White board
 16 Written material

<End of list>

Auxiliary aids/services is a new multi-select field with the following responses:

- Assistive listening dev
- Braille
- Captioning services
- Cochlear implant
- Communication board
- Contacts
- Corrective lens
- Cueing
- Hearing aid
- Magnifier
- Notetaker
- Prosthetic eye
- Qualified reader
- Read lips
- Real-time transcription
- SAP Auditory programming
- Telecommunications device
- Texting device
- TTY phone
- White board
- Written Material
- Or 'Free-Text comment'

The **Yellow informational** box provides additional guidance:

Document any auxiliary aids/ services the patient is currently using regardless of whether they were provided by the patient or the hospital.

This update affects the following interventions:

Nursing	Emergency Department	Surgery
Admission/Shift Assessment +	Detailed Assessment	SURG: Assessment PAC +
Admission Health History +	Paramedic Intake	SURG: Admission Assessment +
BH: Level of Care Assessment +	Non-Urgent General Focus	SURG: Admission Assessment Int +
BH: Outpatient Initial Nurse Assessment+	Rapid Initial Assessment	SURG: Admission Health History +
BH: Psychosocial Assessment (PSA) +	First Point of Contact - Onc	SURG: Neurological Assessment Pre +
BH: Health History Assessment +	Recept MOA 1st POC	SURG: Neurological Assessment Int +
Neuro Checks +		SURG: Neurological Assessment PAC +
Neonatal Intervention +		

Intake Supplement/Additive Documentation



There is currently no way to document the specific nutritional supplement or additive within intake. The nurse can capture the amount of an oral nutritional supplement or "other" intake but there is no free text box or additional fields to identify what was administered or provided.

The top screenshot shows the 'Meals Consumed Intake' form with the 'Nutritional supplement given:' section. A red box highlights the '1 Yes' selection. Below this, there are fields for 'Meal:', 'Amount taken:', 'AM snack:', 'PM snack:', and 'HS snack:'. A red box also highlights the 'Nutritional supplement given:' checkbox.

The bottom screenshot shows the 'Meals Consumed Intake' form with the 'Nutritional supplement 1 ml:' section. A red box highlights the '100' value entered in the 'Nutritional supplement 1 ml:' field. Below this, there are fields for 'Nutritional supplement 1 type:', 'Nutritional supplement 2 ml:', 'Nutritional supplement 2 type:', 'Nutritional supplement 3 ml:', 'Nutritional supplement 3 type:', 'Nutritional supplement 4 ml:', 'Nutritional supplement 4 type:', 'Nutritional supplement 5 ml:', and 'Nutritional supplement 5 type:'. A red box also highlights the 'Nutritional supplement 1 ml:' field.

The **Intake** documentation fields have been updated to allow for additional supplements given.

This update has been added to the following **Intake** selections:

- Infant Nutrition
- Nutrition
- Meals

If 'Yes' is answered for *Nutritional supplement given*, additional **Intake** documentation becomes available.

Users will have the ability to document up to 5 supplements given at one time.

Note: If an *mL amount* is entered for a supplement, the corresponding supplement number field becomes a **required*** 'free-text' comment field.

This update affects the following interventions:

Nursing	Emergency Department	Surgery
Critical Care Flow Record +	Intake & Output	SURG: Intake and Output Intra-Op +
Intake and Output +	Disposition-DC/TX/ADM/LPT	SURG: Intake and Output PACU +
	Newborn Stabilization	SURG: Intake and Output Pre-Op +

Nursing & Ancillary Module

Clinical Nutrition - Nutrition Related Diagnosis Update



Conflicting definitions of 'Underweight' identified in the **Nutrition Assessment** has been resolved.

Nutrition Assessment

☒ **Nutrition related diagnosis:**

- 1 Mild malnutrition
- 2 Moderate malnutrition
- 3 Severe malnutrition
- 4 Morbid obesity
- 5 Obese
- 6 Overweight
- 7 **Underweight**

Nutrition monitoring:>

Nutrition related diagnosis: Underweigh

Nutrition diagnosis details: BMI less than 18.5

Nutrition prescription:>

In the **Nutrition Assessment**, the *Nutrition diagnosis details* for an 'Underweight' has been updated to **BMI less than 18.5**.

Previously listed as *BMI less than 19.9*, this update resolves the conflict between the *Nutrition diagnosis details* and the *BMI evaluation* fields in the **Nutrition Assessment** intervention.

Nutrition Assessment

☒ **BMI evaluation**

- 1 Normal
- 2 Obese class I
- 3 Obese class II
- 4 Obese class III
- 5 Overweight
- 6 Pediatric obese
- 7 **Underweight**

Adults 20 and older:

Normal (18.5-24.9)

Overweight (25.0-29.9)

Obesity, class I (30.0-34.9)

Obesity, class II (35.0-39.9)

Obesity, class III (Greater than 40.0)

Underweight (Less than 18.5)

This update affects the following interventions:

Nursing
Nutrition Assessment +

BH Assessments: Update Type of Abuse Questions



Per clinical request, the Type of Abuse Questions on Behavioral Health assessments have been updated to address the additional information necessary to meet TJC requirements.

BH Level of Care Assessment

Experienced emotional abuse:

- 1 Yes
- 2 No
- 3 Refuses to answer
- 4 Unable to assess

Evidence, suspicion of physical and/or psychological abuse: No

Experienced emotional abuse: Yes

Experienced exploitation: No

Experienced neglect: Refuses to answer

Experienced physical abuse: Unable to assess

Experienced sexual abuse: Yes

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The following updates have been made to improve response clarity on **BH: Assessments**.

The following New fields are **Required***:

- Experienced emotional abuse
- Experienced exploitation
- Experienced neglect
- Experienced physical abuse
- Experienced sexual abuse,

and have these responses:

- Yes
- No
- Refuses to answer
- Unable to assess

Note: If 'Yes' is selected for any newly added field responses, the clinician will be directed to the detail screen for additional documentation.

BH Level of Care Assessment

Timeframe of emotional abuse:

- 1 ☒ Current
- 2 ☐ Past six months
- 3 ☒ Lifetime
- 4 ☐ None currently
- 5 ☐ None in past six months
- 6 ☐ None in lifetime

Select all that apply.

Timeframe of emotional abuse: Current

Timeframe of emotional abuse: Lifetime

Describe current emotional abuse:

Describe emotional abuse over past 6 months:

Describe emotional abuse over lifetime:

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Since 'Yes' was selected for *Experienced emotional abuse*, then *Timeframe of emotional abuse* becomes available and will be **required***.

Selecting any of the responses:

- Current
- Past six months
- Lifetime

will make the associated documentation for that timeframe **required***.

Note: Previously documented responses will recall/default in with future documentation episodes.

This update affects the following interventions:

Nursing		
BH: Nurse Assessment (INA)	BH: OP Nurse Assessment	BH Level of Care Assessment
BH: Level of Care Assessment	BH: Psychosocial Assessment	

Consult Case Management – SDOH Order Alert



In the 2024.1 MEDITECH 5.6 EHR Release, **Social Determinants of Health (SDOH)** was added to the **Health History Assessment**. A Case Management Consult order will reflex when Food, Living Situation, Safety, Transportation and/or Utility are identified as unmet. A new pop-up alert will now remind nursing what the order is for and provide instructions on how to order the consult.

The screenshot shows the 'Health History Assessment' form with the 'Patient has instability or unmet needs related to:' section. The 'Food' checkbox is checked, and the 'Living situation' checkbox is also checked. A yellow box highlights the text: 'Select all that apply if the patient is experiencing instability in any of the five social conditions which may impact their health or well-being. Case Management will be consulted to perform additional screening and potentially identify referrals or other needed services.' A red box highlights the 'Living situation' checkbox. A red arrow points from the 'Living situation' checkbox to the 'Social Determinants of Health (SDOH) Alert' pop-up window.

Social Determinants of Health (SDOH) Alert

*** Social Determinants of Health (SDOH) Alert ***

Patient meets the following SDOH criteria and requires a Case Management SDOH consult:

- Safety
- Transportation
- Living situation
- Food
- Utility

Please submit the automated Consult Case Management - SDOH order that will appear upon filing this intervention.

*When placing order enter:
Admitting Provider (TEST.DR) & Order Source (Z) 'Department/Process'.

<End of text>

<Return>/<Esc>/<Exit> when done

Upon filing the **Health History Assessment**, the **Social Determinants of Health (SDOH) Alert** will serve as a reminder to the clinician to submit a **Consult Case Management – SDOH** order when one or more of the SDOH needs are identified as unmet:

- Food
- Living Situation
- Safety
- Transportation
- Utility

Note: The alert will include guidance when placing the order to:

- Enter the Admitting Provider as the ordering provider
- Use Order Source (Z) 'Department/Process'

The clinician will be taken directly into **Order Management** where they will then add the:

- **Admitting Provider** as the ordering provider **AND**
- Use **Order Source: 'Z'** (Department/Process) to ensure the consult is properly routed.

The screenshot shows the 'Order Management' form with the 'Ordering Provider' field highlighted by a red box. The 'Order Source' field is set to 'Z'. A red arrow points from the 'Order Source' field to the 'Z' value. The 'OK' and 'Cancel' buttons are visible at the bottom.