GIP Level of Care Social Worker

WELCOME TO HCHB SCENARIO-BASED TRAINING!

SUMMARY

Congratulations on completing your Online Learning Modules and your HCHB Patient Experience Orientation Classes. Now you know how to navigate the HCHB Pointcare System. You will now be applying your new knowledge and skills to complete tasks related to your role in the PointCare Training application. This Scenario-based training guide provides you with some background information on HCHB, the resources you will need to achieve your objectives, and a case study or task list to guide you through this exercise. Let's get started!

GOALS & OBJECTIVES

- Using the Practice patients within your tablet (explained in class), please complete the Practice Evaluation visit (GIP visit - IPMS01H) and Practice Subsequent visit (GIP visit - IPMS09H) in the Pointcare Training application including:
  - Development of appropriate Plan of Care for patient
  - Accurate documentation of patient-related information and communication
- Familiarize yourself with HCHB support resources

TIPS & HELPFUL INFORMATION

If you get stuck, check out these resources for manuals, quick reference guides, FAQs and more:

- HCHB Resource Hub
- HCHB FAQs
- HCHB Glossary of Terms

- If you cannot find your answer, email NatLDInstructor@seasons.org your question.
- Utilize this patient scenario to document your practice patients visit as accurately as possible; however, if some specific information is not provided, you may use your imagination to fill in the blanks!

DIRECTIONS

1. Open up the HCHB Resource Hub on your computer or tablet to be able to access help during this assignment
2. Locate the "Practice Eval" and "Practice Sub" patients with in the Pointcare Training application (Note that these might be located in your Overdue section). These are the two visits that you will be using in this training.
3. Use the patient scenario and the instruction guide to complete your practice patients assigned to you in the Pointcare Training application.
4. After completing your visits make sure to sync your tablet to send the visits to the back office for review by the instructor.

CASE STUDY 1 – GIP LEVEL OF CARE MSW EVALUATION VISIT (IPMS01H)

LEGEND

Action(s) that occurred prior to your action item are described in this color box.

This green box signifies a required action in the PointCare application by you.

Tips and resources are found in this red text. If the text is bold and underlined, it's a clickable link to a relevant resource. For example, click to check out the **HCHB Resource Hub**!

Starting your Day and Gathering Information

A referral has been received; the RN has admitted the patient to GIP Level of Care at the IPC and scheduled an add on Evaluation visit.

You perform MAINTENANCE on the Pointcare device and sync. You see the Evaluation visit (IPMS01H) has been added to your schedule today.

You ACCEPT the visit and sync your device again to let the Back Office know you have accepted the visit.

You review the Patient Information and then speak to the Admissions Coordinator.

Johnathan Bear is an 80-year-old man who presented to the hospital with exacerbation of Congestive Heart Failure (CHF) and associated pneumonia. He has a history of pneumonia with a permanent PEG tube as he failed previous swallow studies. His past medical history includes cardiac disease, Post-traumatic Stress Disorder (PTSD) and unspecified dementia. Currently, he does not have capacity to make decisions and he has been in the ICU for 3 days. He is currently on 2 IV antibiotics for bacterial pneumonia which contributed to the exacerbation of his CHF and need for pain medication.

While reading the Share The Story, you learn that Mr. Bear was married in 1961 to Louisa and they had three children: Dennis Bear (age 60), Sarah Bear (age 58) and Wyatt Bear (age 56). In 1979 Mr. Bear and his wife divorced and he came out as a gay man. In 2011, Mr. Bear remarried a man named Lewis, who died 5 months ago from cardiac disease. Mr. Bear and Lewis met during a Navy Veterans event in 2003 and shared a lot of common interests. They entered into a relationship soon after.

Prior to this current hospitalization, Mr. Bear was in the hospital for dehydration, a hip surgery secondary to a fall and mental status changes secondary to untreated UTI and urosepsis. Mr. Bear's current advanced directive lists Lewis as his healthcare proxy and his living will has not been updated since the 1970s. Mr. Bear does have a DNR in place and a copy has been entered into his chart by the Clinical Liaison (CL). His prognosis is 6 months or less.

The CL, daughter Sarah, son Dennis, and Palliative care team met in person. Son Wyatt was able to ZOOM into the Initiation Visit their father. The team discussed the prognosis with Mr. Bear's children and the surrogacy topic. Sarah and Wyatt are

understanding of the disease progression and on board with hospice however Dennis is hesitant and in shock of the news and now accuses his siblings of keeping information from him. Dennis expressed a lot of feelings of resentment and issues relating to closure. Despite Dennis' position on the situation, the family moves forward with hospice as they all agree that Sarah will serve as the surrogate decision maker. A surrogacy designation form has been signed by Wyatt and Dennis to indicate that they are in agreement with Sarah being the lead surrogate.

Sarah and the CL signed consents that same morning and reviewed GIP level of care and other topics related to hospice. Mr. Bear was transferred to Seasons IPC in the afternoon.

- Having trouble locating this? Try reviewing the Share The Story. To access this from your rolling calendar, tap the three-dot menu button in the upper right-hand corner. Tap 'Medical Records' and then tap your patient's name. Then tap any visit underneath your patient's name. Under the History section, tap 'Visit History' to see a list of previous visits for this patient. Review the Admission SOC Visit and the Initiation Visit.

Social Work GIP Evaluation Visit Documentation

You arrive at the patient's room and are welcomed in. → Tap 'START' on your device to begin your visit

Remember! Don't tap START until you are welcomed into the patient's room.

You confirm the patient's identity by asking him his name. His daughter Sarah confirms this information. Mr. Bear is alert and oriented to person and recognizes his family.

You talk with Sarah and learned more about Mr. Bear and his family. Mr. Bear currently reports pain at 5/10. He denies nausea and anxiety. He also reports shortness of breath and you notify his nurse Mary. When asked, both Sarah and Mr. Bear deny current suicidal ideation.

He is a Christian and enjoys classic rock music. He used to play the guitar when his children were younger, and Wyatt became interested in music on a professional level. Mr. Bear and Lewis would attend church together but since Lewis' death he has not been attending. Sarah tries to play sermons for him on YouTube, but he has seemed less interested. Since her father has been ill, it has been hard to get him out of the house to attend church even though he wants to.

Dennis, though he lives close to his father, did not handle his father's coming out well and still holds on to feelings of anger and guilt surrounding this and other unresolved family issues. He was unaware that his father is ill and as a result had not been involved with caring for his father nor being present for Lewis' funeral. Wyatt has been out of the country for the last 2 years. Sarah has been supportive of her father and has been the primary caregiver as she is close by. Since Lewis died, she has been the main source of support for her father. Sarah moved in to live with her father a few months ago after her father's condition worsened. Soon after, he required assistance with ADL's, became incontinent and became more dyspneic on exertion.

You educate Sarah that both the Music Therapist and Chaplain will be stopping by and Sarah stated she is looking forward to both. You discuss discharge and GIP level of care again. SW learned that Sarah is comfortable with Mr. Bear coming home but worried about the amount of help she may need considering his needs are complex now. SW discussed discharge locations and options including long term care facilities, private duty caregiving and involvement from family/friends/

neighbors. Sarah decided she will engage Dennis and try to get his support despite their differences and his hesitancy with hospice care for their father.

You support Sarah as she explained to her father what was happening and looked to get her father's permission despite being the designated surrogate. After a few conversations between Mr. Bear and Sarah, Sarah feels more at peace with the families' decision to begin hospice and accepting the services available to help her father transition. Sarah reports that she is still working on funeral home arrangements and will update the SW when she finalizes plans. In order to coordinate care, you contact Chaplain Pedro to relay this information.

You check in with Mr. Bear as he is now awake while Sarah steps out to take a phone call. You discuss home living arrangements and support available in the home. Mr. Bear feels well taken care of at home by his daughter Sarah and he denied any feelings of fear or feeling as though things are being done against his will. You call Dennis and leave a voice message to call back to set up a time to talk on the phone regarding plan of care.

- After completing your evaluation visit documentation and synching this back to the back office, go into the medical record for the patient and complete the Phone Call note for your voicemail to Dennis. For help on how to do this, refer to the **Patient Experience Phone Call Documentation**.
- Enough information has been provided for you to complete the Physical Assessment section of your visit. As you document notice how each section (other than pathways, goals/interventions and new orders section) can be done in any order to facilitate natural conversation instead of mechanical. Pathways, goals/intervention and new orders should be done in the specified order and after the rest of your documentation to paint the full picture.
- Complete a Bereavement Risk Assessment on Sarah. If you need help on how to do this, refer to number 3 on the HCHB **Patient Experience Evaluation Visit Instructions.** Ensure that the correct individual is checked to receive the CAHPS survey and that all appropriate individuals are checked for Bereavement Services.
- Complete the 'Pathways' and 'Interventions/Goals' section based on your assessment of the above patient and family. If you need additional help on how to do this, refer to **this document.**
- In the 'New Orders' section, add an GIP SW Subsequent Visit (IPMS09H) once a week for the entire cert period. Add in a SW PRN Visit (MSPRN) on the first Saturday of the certification period. Also, since MT and CH have been requested, add an add-on evaluation visit for both. See **Patient Experience Orders-Calendar** for help.
- IPC Social Workers work on each of their IPC patients daily. Whether that is an in-person visit with the patient and/or care giver or a phone call pertaining to the case or discharge planning. These interactions must be documented into HCHB.
- For more information on the Suspected Abuse/Neglect, reference **Policy 225**.

Completing Your Visit and Signing Out

It is now time to complete your visit and sign out.

See pages 126-130 of the Pointcare User Manual for detailed steps for completing these tasks!

Congratulations on completing the scenario-based training for the GIP MSW Evaluation Visit!

CASE STUDY 2 – GIP MSW SUBSEQUENT VISIT (IPMS09H)

LEGEND

Action(s) that occurred prior to your action item are described in this color box.

This green box signifies a required action in the PointCare application by you.

Tips and resources are found in this red text. If the text is bold and underlined, it's a clickable link to a relevant resource. For example, click to check out the **HCHB Resource Hub**!

Starting your Day

You have arranged a Subsequent Visit with the Bear family for today.

You perform MAINTENANCE on the Pointcare device and sync. You see the Subsequent visit (IPMS11H) is on your schedule.

You ACCEPT the visit and sync your device again to let the Back Office know you have accepted the visit.

You review the Patient Information.

Social Work GIP Subsequent Visit Documentation

You arrive at the patient's room and are welcomed in.

Tap 'START' on your device to begin your visit

Remember! Don't tap START until you are welcomed into the patient's room.

On day 3, you check in again with Sarah and find that Mr. Bear's infection has improved, and his pain is more managed. He currently rates his pain at a 2/10 and denies all other SNAP symptoms. He is more alert and oriented to person but not to time or place. At this time, Sarah shares funeral home information with you and you collaborate with Chaplain Pedro to relay the updated information. The team discussed that Mr. Bear will be ready for discharge and Sarah states that she is going to call Dennis again today to discuss his involvement in caring for Mr. Bear.

An hour later, Sarah comes to the nurses' station to update you on her conversation with Dennis. They go to a private area and Sarah shared with relief that Dennis is willing to help. Sarah became tearful as she has been the only caregiver and has limited support herself. She expressed feeling very depressed as Mr. Bear is also her main source of support. Sarah expressed that sometimes she wished everything would just end. You complete another bereavement risk assessment and found that she is now high risk for bereavement and she has had suicidal thoughts. You then complete a depression screen/suicide risk assessment (found in the subsequent documentation) and found that Sarah is high risk for depression. You then

attach a note and complete the Columbia Suicide Risk Assessment. From this assessment, you find that Sarah is a moderate suicide risk and complete the Stanley Brown Safety Plan template. Sarah began crying and you offer verbal counseling. You discuss discharge with the IPC team to ensure patient will be safe at home with Sarah as his primary caregiver and to ensure that Sarah has adequate support.

2 days later, Mr. Bear's symptoms are well managed, and he is ready for discharge and the are made aware from Sarah that she is in a better place and has started scheduling time for herself as Dennis is able to assist. Sarah will continue to be seen by the field Social Worker once at home and be continually monitored. The Inpatient SW makes contact with the field SW to provide a full handoff on the patient and family dynamics. You then alert the other field team members about the desire for a veteran pinning ceremony once Mr. Bear returns home and you request a Veteran volunteer to be present.

- Enough information has been provided for you to complete the Physical Assessment section of your subsequent visit, including: SNAP, Depression/Suicide Risk Basic Screening, Environment, Bereavement and DAROP. For help on how to do this, refer to the **Patient Experience Subsequent Visit Workflow.**
- In the 'New Orders' section, create a care plan update order to add a new pathway. See **Patient Experience Orders POC Update** for reference.
- To attach the Columbia Suicide Risk Assessment, tap back in your visit until you get to the Visit Action Page. From there, tap Notes and then tap 'Add'. The note type is 'Comprehensive'.
- For the Stanley Brown Safety Plan template, refer to **Protocol 2111c.** Click **here** if you need a refresher on the SHPC Suicide Protocol.
- To add the Funeral Home information, start at the Visit Actions screen. Then tap 'Medical Records', and then tap 'Demographics'. Then tap 'Facilities' to see a list of facilities associated with the patient's care. To add a facility, tap 'Edit' and then tap 'Add'.
- To complete a Volunteer request, tap back in your visit until you get to the Visit Action Page. From there, tap Notes and then tap 'Add'. The note type is 'Volunteer Referral Form'.

Completing Your Visit and Signing Out

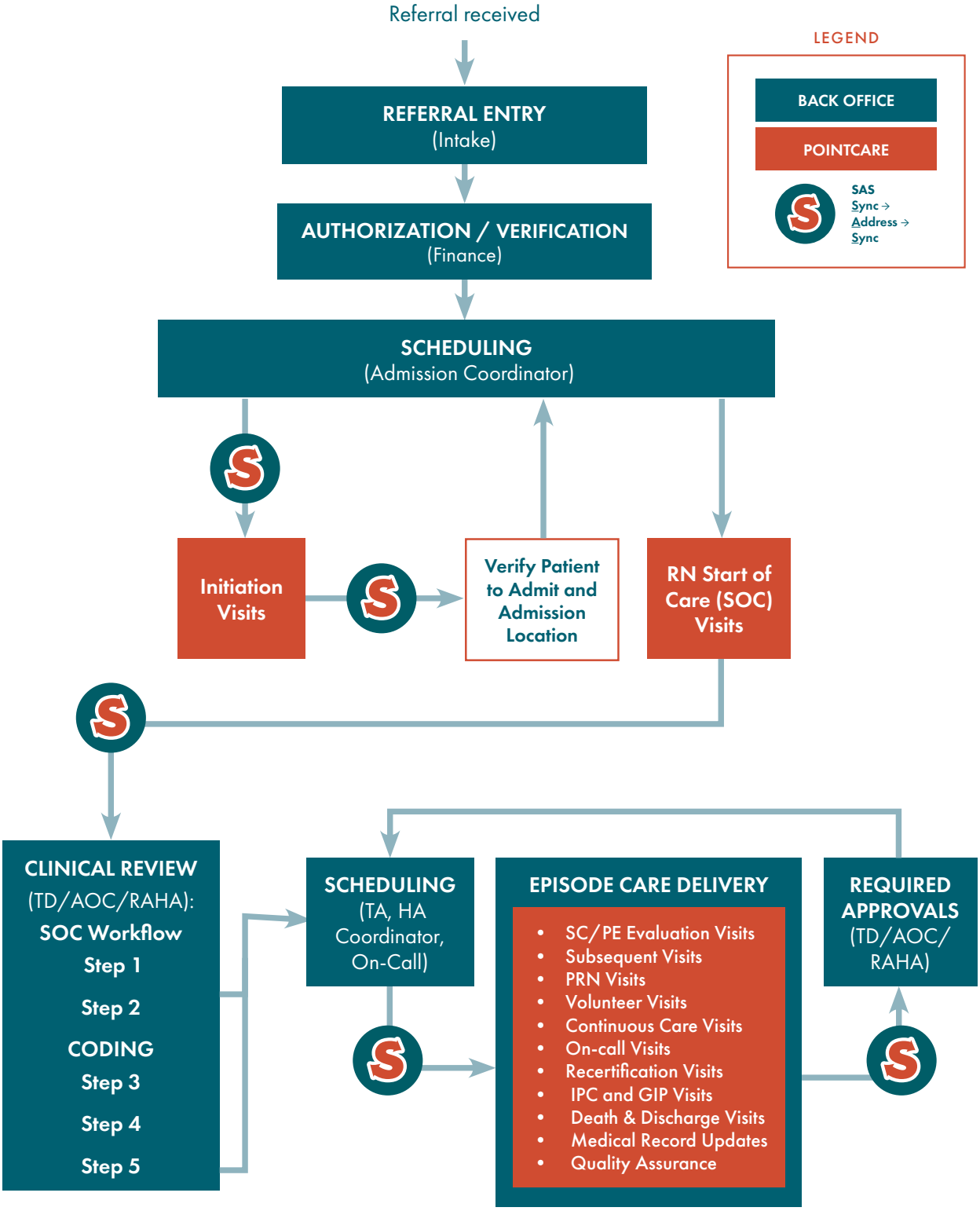
It is now time to complete your visit and sign out.

See pages 126-130 of the Pointcare User Manual for detailed steps for completing these tasks!

Congratulations on completing the scenario-based training for the GIP SW Subsequent Visit!

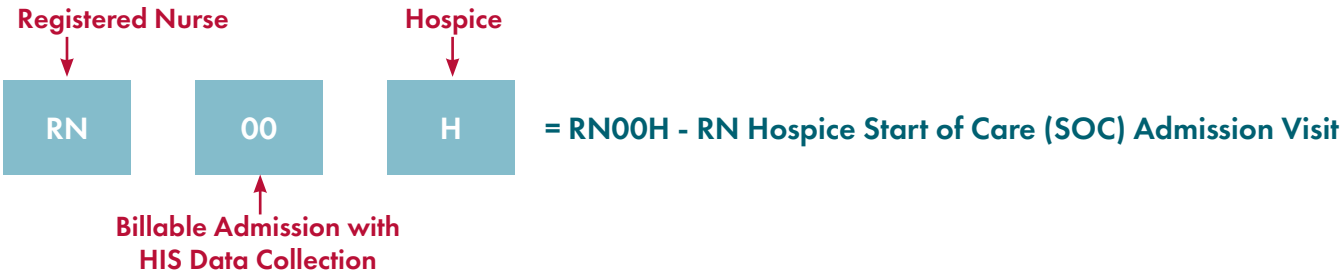
GIP Level of Care Social Worker

HCHB UNIVERSE



UNDERSTANDING SERVICE CODES (VISIT CODES)

Below is a reminder of how you can identify visits by the Service Codes (also referred to as Visit Codes) in HCHB. The service codes begin with letters, which represent the discipline. They are followed by numbers or letters that identify the type of visit, followed by the letter H for Hospice. For example:



Common Discipline and Visit Codes

DISCIPLINE CODES	
AT	Art Therapy
BC	Bereavement Coordinator
CH	Chaplain
HCC	Hospice Care Consultant
HS	Hospice Aide
MS	Medical Social Worker
MU	Music Therapy
PHY	Physician
RN	Registered Nurse
SN	Skilled Nurse (RN or LPN)
VOL	Volunteer
VC	Volunteer Coordinator

COMMON VISIT CODES	
IH	Hospice Initiation Visit
00H	Hospice Billable Admission Visit with HIS Data Collection
01H	Evaluation Visit
11H	Subsequent (Routine) Visit
11H	MT/CH/AT Phone Call visit
09H	Subsequent GIP SW Visit
NODA	No One Dies Alone Visit
72H	Bereavement Visits
PRN	As Needed (PRN) Visit
IP	Inpatient (included in all IPC visits)
HP	Social Worker Phone Calls and Bereavement Phone Calls

For full for Patient Experience-specific code list, click **here*