Welcome To HCHB Scenario-Based Training!

SUMMARY

Congratulations on completing your Online Learning Modules and successfully learning how to navigate HomeCare Homebase (HCHB). You will now be applying your new knowledge and skills to complete tasks related to your role in the PointCare or Back Office/R2 Training applications. 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 (field visit -MS01H) and Practice Subsequent visit (field visit - MS11H) 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 need further assistance, check out these resource manuals, quick reference guides, FAQs, and more:

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

If you cannot find your answer, you can unmute your microphone and ask the instructor 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 – MSW Evaluation Visit (MS01H)

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

This blue 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 and the Admissions Nurse has admitted the patient to hospice. An add-on Evaluation visit has been requested.

You perform MAINTENANCE on the Pointcare device and sync. You see the Evaluation visit (MS01H) has been added to your schedule today.

You speak with the Caregiver, confirm the visit for today and ACCEPT the visit. You sync your device again to let the Back Office know you have accepted the visit.

You review the Patient Information.

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. Prior to discharge, his medications will be reconciled, and he will take them orally.

Right now, the Palliative Care Physician in the ICU has consulted Seasons and a Clinical Liaison (CL) has case conferenced with Mr. Bear's medical team and is in the process of setting up an Initiation visit to sign consents. His prognosis is 6 months or less. Given that Mr. Bear's advanced directive indicated his deceased husband Lewis as his proxy, the CL speaks with the ICU social worker to set up a family care conference to discuss surrogacy as his daughter, Sarah, has been acting as the surrogate, however there are no legal papers for this prior to the info session/consents meeting.

The CL, daughter Sarah, son Dennis, and Palliative care physician have met in person. Son, Wyatt was able to ZOOM into the case conference for 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 feelings of resentment and issues related 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 the 4 hospice levels of care and other related topics. Mr. Bear is being discharged home this 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 Evaluation Documentation

When you arrive at the patient's home, the caregiver welcomes you in. → Tap 'START' on your device to begin your visit

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

You are welcomed into Mr. Bear's home and confirm patient's identity. You sit down to talk with Sarah about Mr. Bear and his hospice journey. Mr. Bear is alert and oriented to person and recognizes his family. Currently, Mr. Bear reports 4/10 pain though denies anxiety and nausea when asked. He is observed to be short of breath at times and you call and alert the hospice RN, Mary.

You learn that Mr. Bear was married in 1961 to Louisa and they had three children: Dennis (age 60), Sarah (age 58) and Wyatt (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.

Further discussion with Sarah reveals that 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 has 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 his condition worsened. Soon after, he required assistance with ADLS, became incontinent and became more dyspneic on exertion.

Sarah shared that 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 does have a DNR in place, and a copy has been entered into his chart by the CL. Sarah shared that they had a meeting with the CL in the hospital and Sarah will be the surrogate decision maker moving forward.

You continue to talk with Sarah and have learned more about Mr. Bear. 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 lately. 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.

You educate Sarah that both the Music Therapist and Chaplain will be calling to schedule a visit and Sarah stated she is looking forward to both. You discuss Mr. Bear's disease progression and needs he may have that might exceed what Sarah can provide. You discuss transferring to other locations and options including long term care facilities, private duty caregiving and involvement from family/friends/neighbors. You also brought up respite and the process that it involved and reviewed the 4 levels of care. Sarah decided she will engage Dennis and try to get his support despite their differences and his hesitancy with hospice for their father.

Through the initial Social Work evaluation, Mr. Bear became more alert and oriented as time went on. Mr. Bear expressed some pain and appeared to have a flat affect. 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. Sarah stepped away to make a phone call. While Sarah was away, you and Mr. Bear also discuss home living arrangements and support available. Mr. Bear feels well taken care of at home by his daughter Sarah and denied any feelings of fear or feeling as though things are being done against his will. Sarah returned to the room and you provide additional community resources.

- Enough information has been provided for you to now 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 a SW Subsequent Visit (MS11H) every week for the remainder of the cert period due to the fact that he is a RED patient. His RED status is due to the findings of his Suicide Risk Assessment. Add in a SW PRN Visit (MSPRN) on the first Saturday of the certification period. Also, since MT has been requested, add an add on evaluation visit. See Patient Experience Orders-Calendar for help.
- For more information on the Suspected Abuse/Neglect, refer to company policies on abuse and neglect.

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 Field SW Evaluation Visit!

CASE STUDY 2 – MSW Subsequent Visit (MS11H)

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

This blue 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 (MS11H) 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 Subsequent Visit Documentation

The following week, you go to see Mr. Bear and Sarah again. Mr. Bear is alert and oriented to person and place at this time and is reminiscing about his life in the Navy. At this time, Sarah shares funeral home information with you and you collaborate with Chaplain Pedro to relay the updated information. You offer a veteran pinning ceremony and Mr. Bear teared up as he has never been honored before. You set this up for the end of this week. You discuss more about his goals and wishes and Mr. Bear really just wants to go to church and play music. Mr. Bear shared how he has been very depressed because he hasn't been able to go out or see anyone from the VFW or from his church. You assess his mood further, complete a depression screen and find that patient is now a low-moderate risk as he has more coping mechanisms from the last visit and support from his daughter, Sarah. 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. She hopes Dennis' support will help her. You call Dennis and leave a voice message asking for a call back in order to set up a time to talk on the phone. You then alert the other Patient Experience team members about the need for a veteran pinning ceremony visit this week and request a Veteran volunteer to be present.

The next day the Chaplain and Music Therapist call together and are able to offer a joint visit for a pining ceremony. Sarah gladly welcomes the company as Mr. Bear was very engaged and eager when you were present. The Music Therapist brings the guitar and instantly Mr. Bear is excited for their visit. Mr. Bear reported minimal pain throughout the visit.

- Enough information has been provided for you to complete the Physical Assessment section of your visit, specifically: 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.
- Complete the '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, create a care plan update order to add a new pathway. It does not matter which new pathway you choose, you can add one based on what you feel is appropriate. See Patient Experience Orders POC Update for reference.
- 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.
- 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'.
- After completing your subsequent 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.
- 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'.
- To add the Funeral Home information, start at the Visit Actions screen. Then tap 'Medical Records', and then tap 'Demo-graphics'. 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'."
- For the Stanley Brown Safety Plan template, refer to Protocol 2111c. Click here if you need a refresher on the SHPC Suicide Protocol

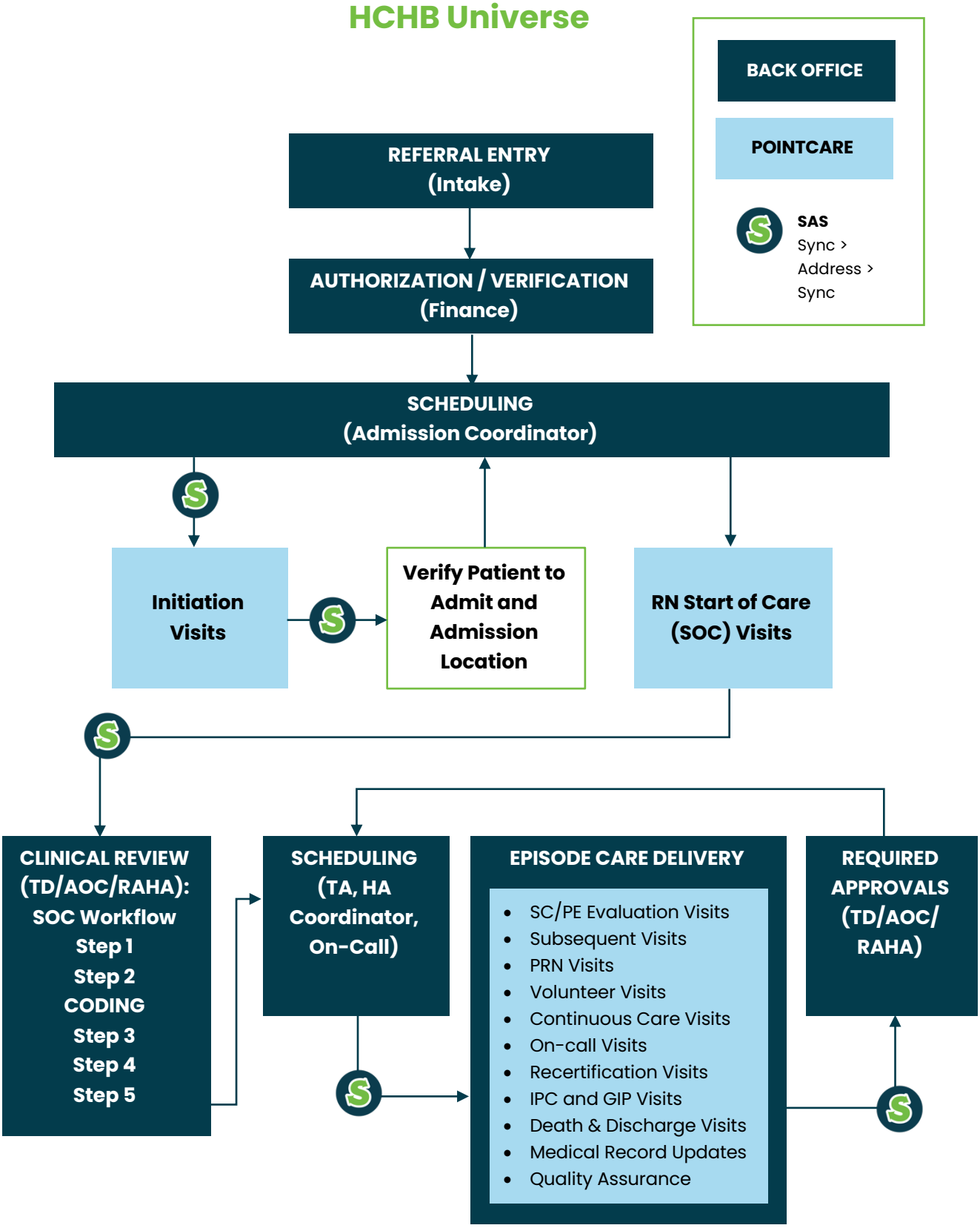
Completing Your Visit and Signing Out

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!

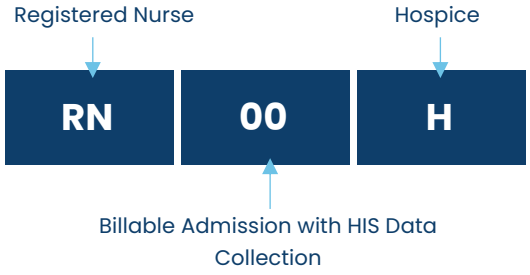
Congratulations on completing the scenario-based training for the MSW Subsequent Visit!

HCHB Universe



UNDERSTANDING SERVICE CODES (VISIT CODES)

Before we get started, let's look at 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:



= RN00H - RN Hospice Start of Care (SOC) Admission Visit

Common Discipline and Visit Codes

Discipline Codes		Discipline Codes	
AT	Art Therapy	**IH**	Hospice Initiation Visit
BC	Bereavement Coordinator	**00H**	Hospice Billable Admission Visit with HIS Data Collection
CH	Chaplain	**01H**	Evaluation Visit
HCC	Hospice Care Consultant	**11H**	Subsequent (Routine) Visit
HS	Hospice Aide	**11H**	MT/CH/AT Phone Call visit
MS	Medical Social Worker	**09H**	Subsequent GIP SW Visit
MU	Music Therapy	**NODA**	No One Dies Alone Visit
PHY	Physician	**72H**	Bereavement Visits
RN	Registered Nurse	**PRN**	As Needed (PRN) Visit
SN	Skilled Nurse	**IP**	Inpatient (included in all IPC visits)
VOL	Volunteer	**HP**	Social Worker Phone Calls and Bereavement Phone Calls
VC	Volunteer Coordinator		

**For full Service Code list, click here; for Patient Experience-specific codes, click here*