Title: Standardized Palliative Care Home Visit Form
Date Created: 10/21/2016
Date Modified:
Date Approved by Board of Directors: 11/8/2016
Clinical Guideline # CGC-CG-33

Purpose: Standardize the Palliative Care Agencies home visit across the 9 county PPS

Clinical Guideline: An electronic form will be in use to evaluate a member and status in their living situation by a Palliative Care Agency during their home visit. The form is used to provide the Palliative Care Representative a check list for completion and guidance that can also be utilized to communicate valuable status to the Primary Care Physician. Note: The form may be printed off and completed by hand if needed.

Definitions:

Procedure:

Home Visit Checklist

Patient Name: Click or tap here to enter text.
Patient ID #: Click or tap here to enter text.
Palliative Care Agency Name: Click or tap here to enter text.
Palliative Care Representative Name: Click or tap here to enter text.
Assessment Date: Click or tap to enter a date.
Setting (check): ☐Patient's Home ☐Office ☐Nursing Home
Assessment Type (check): ☐Initial ☐Status Change ☐Routine
Primary Insurance Type (check): ☐ Commercial ☐Medicaid ☐Medicare ☐Uninsured
Secondary Insurance Type (check): ☐ Commercial ☐Medicaid ☐Medicare ☐Uninsured

Please answer the following questions:

1. **Has an eMOLST been completed and on file prior to visit?** ☐**Yes** ☐**No**
    a. **If no eMOLST is on file, was one completed upon visit?**
    ☐**Yes** ☐**No**
2. **Is an IPOS on file with the primary care physician?** ☐**Yes** ☐**No**
    a. **If no IPOS is on file with PCP was one completed during this visit?**
    ☐**Yes** ☐**No**
3. **Has patient completed a Power of Attorney?** ☐**Yes** ☐**No**
    a. **If no power of attorney is completed, was an FAQ supplied?**
    ☐**Yes** ☐**No**

If yes: **Name and Contact of Attorney:** Click or tap here to enter text.

a. **Add copy of Power of Attorney available?**
☐Yes ☐No

4. **Has the patient been assigned a Health Care Proxy?** **☐Yes ☐No**
   a. **If no Health Care Proxy was previously assigned, was one assigned at this visit?**
   ☐Yes ☐No
   Health Care Proxy Assigned: Click or tap here to enter text.

5. **Does the patient have a personal care representative?** **☐Yes ☐No**
   (can be the same as the Health Care Proxy or different)
   Personal Care Representative: Click or tap here to enter text.

6. **Has the patient had a major change in circumstances?** **☐Yes ☐No**
   If yes, please check all that apply:
   i. **Weight change?**
   ☐ Yes ☐No
   ☐Weight Gain
   ☐Weight Loss
   Please describe: Click or tap here to enter text.

   ii. **Increased Symptoms?**
   ☐Yes ☐No
   Please describe: Click or tap here to enter text.

   iii. **Change in cognitive abilities?**
   ☐Yes ☐No
   Please describe: Click or tap here to enter text.

   iv. **Change in mental status?**
   ☐Yes ☐No
   Please describe: Click or tap here to enter text.

7. **Has the patient had a major change in circumstances since assessment ☐Yes ☐No with PCP or Palliative care agency?**
    a. **Please check all that apply:**

       ☐Hospitalization

       Description: Click or tap here to enter text.

       ☐Emergency Department Visit

       Description: Click or tap here to enter text.

       ☐New diagnosis that will alter care

       Description: Click or tap here to enter text.

       ☐Change in living situation

       Description: Click or tap here to enter text.

       ☐Other

       Description: Click or tap here to enter text.

8. **Has a personal health record been completed with the patient? ☐Yes ☐No**
9. **Have any social determinant been found that the patient will need assistance with? ☐Yes ☐No**

Please check all social determinants that apply:

Health Insurance and/or Financial Concerns

☐Lack of or no insurance coverage
☐Need financial assistance from Medicaid
☐Need for prescription assistance
☐Need for medical equipment or supplies
☐Need explanation of financial paperwork
☐Difficulty paying bills
☐Other: Click or tap here to enter text.

Transportation

☐Public transportation assistance needed
☐Private transportation assistance needed

☐**Medicaid taxi transportation needed**
☐**Volunteer transportation needed**
☐**Other:** Click or tap here to enter text.

Support Needs
☐**Child/Elder care**
☐**Housing**
☐**Food access**
☐**Clothing**
☐**Vocational support (i.e., job skill, employment skills)**
☐**Extended care needs (i.e., home care, hospice, long-term care)**
☐**Other:** Click or tap here to enter text.

Communication and/or Cultural Needs
☐**Primary language other than English**
☐**Inability to read/write**
☐**Poor health literacy**
☐**Cultural barriers (i.e., effect on lifestyle choices)**
☐**Other:** Click or tap here to enter text.

Documents
☐**Needs a living will**
☐**Needs help completing a living will**
☐**Needs a power of Attorney**
☐**Other:** Click or tap here to enter text.

Disease Management
Treatment Compliance Issues (i.e., missed appointments)
☐**Needs assistance with making appointment**
☐**Mental health services needed**
☐**Needs assistance understanding treatment plan or procedures**
☐**Needs further evaluation with provider (i.e., physician, nurse, therapist)**
☐**Requests more information about:** Click or tap here to enter text.

Other social determinants not previously mentioned: Click or tap here to enter text.

10. **If social determinants were identified, please list the agency the patient was referred to for assistance:**
    a. **Navigation Agency or Contact:** Click or tap here to enter text.
    b. **Referral Method (check all that apply):**
        ☐**Patient/Caregiver given contact information for Navigator**
        ☐**Warm handoff to Navigation services**
        ☐**Reported back to palliative care organization for Navigation services**
        ☐**Reported to PCP the need for Navigation services**

Additional Notes: Click or tap here to enter text.

When PPS clinical protocols and pathways are developed through the Clinical Governance Committee(s) of the PPS and approved by the CCN Board of Directors and are applicable to Partner Organization's delivery of health care services and project participation, such protocols and pathways shall not (1) override the professional judgment of Partner Organization and its licensed health care professionals in treating patients in individual cases or (2) interfere with the governing body/established operator of any licensed health care facility or its medical staff in overseeing the provision of clinical services to patients and the quality of care

Clinical Guideline Board Approval History:

Clinical Guideline Revisions:

Date	Revision Log	Updated By
10/21/2016	Creation	S.Woolever

This Clinical Guideline shall be reviewed periodically and updated consistent with the requirements established by the Board of Directors, Care Compass Network's senior management, Federal and State law(s) and regulations, and applicable accrediting and review organizations.