PATH – Post Acute Transition Home

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Overview

- The PATH Tool was designed in collaboration with the MA Senior Care Steering Committee and Home Care Alliance of Massachusetts.

- PATH was designed to insure the “warm handoff” contains the highest quality of clinical information between the SNF and Home Care setting.

- It insures that receiving care givers are provided with the most comprehensive picture of the patient in real time.
Transitions Issues Impact Patient Care

- Home Care agencies are seeing rise in re-hospitalizations

- IMPACT Act – Penalties to SNF if Re-admitted within 30 days of Admission to SNF

- Home Care Agencies will be facing penalties in the near future for Avoidable Re-hospitalizations
PATH
Shared Expectations

• Standardized set of administrative and clinical practices for referring providers and accepting agencies

• Collectively recognize as independent and interdependent processes that can help define high-performance and reflect evolving models of integrated and accountable care
Reducing Readmissions

- Employ Targeted Discharge Planning
- Improve Patient Education
- Improve Coordination of Care post Discharge
- Reconcile Provider Medical Records
- Identify Patients with Readmission Risk Factors
  - Chronic Conditions prone to exacerbations
  - Multiple Chronic Conditions and Comorbidities
  - Patients with longer than average lengths of stay
  - Patients with excess Readmissions
  - Patients with Psychosocial Issues
Overview
More significant information on the PATH Tool

- Number of days of treatment supplies provided upon discharge
- When last treatment was done
- Medications missing from the patient’s supply upon transfer
- Whether a hard copy prescription was sent for controlled substances
- Whether goals of advanced care planning were discussed
- When last dosage of Pain Medication was given
- Whether patient needs an initial visit within the first 24 hours
- Identification of High Risk Issues
- If DME/IV/Medical Supplies have been ordered and will be in the home upon arrival
- Contact information of Supplier
- Current ADL Status
# PATH
## Post-Acute Transition Home

**SECTION A: Patient Information:**

<table>
<thead>
<tr>
<th>Name:________________________</th>
<th>Gender: M___ F ___</th>
<th>DOB: ___ / ___ / ______</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>mm dd year</td>
</tr>
<tr>
<td>Language: English Y N</td>
<td>Other______________</td>
<td></td>
</tr>
<tr>
<td>Tel. #: (1) (<em><strong>) _______ - _______ Tel#: (2) (</strong></em>) _______ - _______</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:___________________</td>
<td>Apt.: _____</td>
<td>City:________________</td>
</tr>
<tr>
<td>Emergency Contact:___________</td>
<td>Relationship to Patient:________________</td>
<td>Tel.: #(___) _______ - _______</td>
</tr>
<tr>
<td>Healthcare Proxy/Guardian (if different): _____________________________</td>
<td>Tel.# (___) _______ - _______</td>
<td></td>
</tr>
</tbody>
</table>

**SECTION B: Discharge Information**

| Discharging RN:_______________ | Tel.: # (___) _______ - _______ Unit: ____ | Ext.: ______ |
| Discharging Physician:_________ | Tel.#: (___) _______ - _______ | Date of Admission SNF:__________ |
| Home Health Agency:____________ | Tel.# (___) _______ - _______ |

**SECTION C: Advance Directives**

<table>
<thead>
<tr>
<th>Were goals of Advanced Care Planning discussed? Y N (specify)</th>
<th>Full Code DNR DNH DNI No Artificial Feeding Palliative Care Hospice MOLST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is patient capable of making decisions? Y N</td>
<td>Does patient have a HCP? Y N</td>
</tr>
</tbody>
</table>
### SECTION D: Patient Follow-Up Appointment

<table>
<thead>
<tr>
<th>Patient follow-up appointment date: <em><strong>/</strong></em>/______  PCP?: Y N  Specialist?: Y N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician assuming care: ____________________  Tel.#: # (____) <em><strong><strong>-</strong></strong></em>_____</td>
</tr>
<tr>
<td>Address: ______________________  City: __________________  State: ______  Zip: ______</td>
</tr>
<tr>
<td>Specialist: ______________________  Tel.#: # (____) <em><strong><strong>-</strong></strong></em>_____</td>
</tr>
<tr>
<td>Specialist: ______________________  Tel.#: # (____) <em><strong><strong>-</strong></strong></em>_____</td>
</tr>
</tbody>
</table>

### SECTION E: Clinical Information

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Primary Discharge Diagnosis: ____________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Diagnoses: ________</td>
<td></td>
</tr>
<tr>
<td>Mental Health Diagnoses: ____________________________</td>
<td></td>
</tr>
<tr>
<td>Height</td>
<td>_______Ft _______Inches</td>
</tr>
<tr>
<td>Weight</td>
<td>_______________ Pounds</td>
</tr>
<tr>
<td>Pain</td>
<td>Y N  Pain Site: ___________________ Pain Rating: ____________________</td>
</tr>
<tr>
<td>Pain Medication: Y N  Name(s): ____________________</td>
<td></td>
</tr>
<tr>
<td>Last dose given: ___________AM/PM</td>
<td></td>
</tr>
<tr>
<td>Mental Status: Alert  Disoriented, cannot follow commands  Disoriented, can follow commands  Not Alert</td>
<td></td>
</tr>
</tbody>
</table>
SECTION F: High Risk Information

Does patient need an initial visit within 24 hours (i.e. same day admit/IVs)? Y N  (specify)____________________________
Has Home Care Provider been contacted if initial visit within 24 hours is needed? Y N
Check all that apply:
Fall Risk  Delirium  Agitation  Aggression  Aspiration Precautions  Sun Downing Precautions____________________________
(Specify other Precautions) ____________________________

SECTION G: Medication Information & Allergies

Medication list attached: Y N  Allergies: Y N  Type:____________________________
Patient Teaching: Y N  Nurse Initials: __________
Hard copy prescription Controlled Substances: Y N
Number of Days of medication supplied to patient at discharge __________
Are all Medications being provided upon discharge? Y N
If Patient is missing Medications upon Discharge, please clarify which Medications: ________________________________

SECTION H: Treatments & Therapeutic Devices

Has all DME/IV/Medical Supplies been ordered and will it be in the patient’s home upon discharge? Y N  If No, specify:
________________________________________________________________________________________________________
Please provide contact information of Supplier: Name: ___________________________ Tel. #: #: (____) _____-__________
PICC  IV  PluerX  Wound Vac  G or J Tube  JP Drain  Catheter
Skin Breakdown: Y N
Pressure Ulcers > Stage 2 (require detailed location & measurements)  Treatment list attached?: Y N
Last Treatment: ________________________________
Number of days treatment supplies being supplied at discharge __________
Is the Patient aware of Discharge Teaching: Y N  Nurse Initials: __________
### SECTION I: Nursing Care

<table>
<thead>
<tr>
<th>Activity</th>
<th>Independent</th>
<th>Assistance</th>
<th>Unable</th>
<th>Independent</th>
<th>Assistance</th>
<th>Unable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed-Chair Transfer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bath Self</td>
<td>Independent</td>
<td>Assistance</td>
<td>Unable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feed Self</td>
<td>Independent</td>
<td>Assistance</td>
<td>Unable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobility</td>
<td>Independent</td>
<td>Assistance</td>
<td>Unable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grooming</td>
<td>Independent</td>
<td>Assistance</td>
<td>Unable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td>Independent</td>
<td>Assistance</td>
<td>Unable</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Bowel & Bladder Program**: Y N
- **Incontinence**: (please circle) – Bowel Bladder Catheter ?: Y N
- **Type**: ____________________________  Last Changed: ____________________________

- **Impairments**: Speech  Hearing  Vision  Other: ____________________________
- **Disabilities**: Amputations  Paralysis  Contractures  Decubitus
- **Communication**: Can Write  Talks  Non-Verbal
- **Behavior**: Alert  Forgetful  Confused  Withdrawn  Wanders

- Requires “S” if Sent: “N” if needed
- Colostomy Care [ ]  Dentures [ ]  Cane [ ]  Crutches [ ]  Walker [ ]  Wheelchair [ ]
- Eye Glasses [ ]  Hearing Aid [ ]  Prosthesis [ ]  Bedpan [ ]  Urinal [ ]  Commode [ ]

**Therapies (please attach assessments/recommendations)**
- PT  OT  Speech  Respiratory  Dialysis

### SECTION J: Additional Information

_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
Review

• PATH is more comprehensive report of the patient in real time

• Path does not replace the Page 2

• Decreases the likelihood of Readmissions
PATH Pilot

- Volunteers
- Facilities & Home Care Agencies
  - Strengthen Relationship
  - Decrease Readmission Rates
- Please contact lcasale@maseniorcare.org
Questions