ADT/CCD Follow Up Guide

ER Visits and Hospital Admissions

- Supports Coordinators are expected to check their ADT and CCD notices daily and follow up with the participant within one (1) business day of notification of an Emergency Room Visit, Hospital Admission, or Nursing Facility Admission.

- Follow-up, including the reason for the participant's visit or admission, must be documented in the participant's case file.

- Below is a sample script to complete follow-up with the participant. The questions below do not need to be asked verbatim and can be asked differently based on the participant, keeping in mind the information that needs to be gathered. Document the participant's answers to these follow-up questions within the monitoring note in narrative form.

Notification of Emergency Room visit without Admission:

- What happened that caused you to seek emergency medical treatment?

- Did you receive any new diagnosis(es)?

- What treatment(s) did you receive?

- Did you have any changes to your medications?

- Did you receive any discharge instructions?

    - The Supports Coordinator should review the discharge instructions with the participant, if available. Ask if they have any questions or concerns about any of the information.

- Do you have a follow-up visit scheduled with your primary physician?

Notification of Hospital Admission/Inpatient Status:

- Was this a planned or unplanned admission?

- What happened that caused you to be admitted to the hospital?

- What date were you admitted? (confirm date from ADT)

- What date were you discharged? (confirm date from ADT, if applicable)

- Did you receive any new diagnosis, prognosis, treatments, etc?

- Did you receive any discharge instructions?

    - The Supports Coordinator should review the discharge instructions with the participant, if available. Ask if they have any questions or concerns about any of the information.

- Do you have any changes to your medications?

- Did you receive any orders for new durable medical equipment?

- Are you receiving any skilled care such as PT, OT, ST, or nursing?

- Are you in need of any changes to your current MI Choice Waiver Services?

    - The Supports Coordinator should offer any appropriate MI Choice Services that might mitigate the risk of a readmission to the hospital based on the participant's needs or situation.

    - If the ER visit or hospitalization results in a significant change of condition or need for additional services, the Supports Coordinator must schedule a full reassessment and PCSP review.

Additional Follow Up:

- If the participant reports medication changes, make sure to update the participant's medication list in COMPASS

- Refer to Care Transitions Policy for direction regarding requirements and processes specific to the care setting – i.e. Hospital, Nursing Facility, etc.

- The Supports Coordinator may need to contact the admitting hospital or nursing facility to get a copy of any important documentation, admission or discharge paperwork (if the CCD/ADT information is not available).

- Based on the details of the ER visit or Hospitalization, the Supports Coordinator may be able to provide resources to the participant to mitigate the risk of re-admission.

    - This may include referrals to UPCAP Health & Wellness programs like Matter of Balance, Personal Action Towards Health (PATH), Walk with Ease, etc.
    - This may include pamphlets or brochures on specific health conditions or diagnosis
    - Any resources or referrals provided to the participant should be documented.

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