

Admissions Huddle Patient Face Sheet

Date: Name of patient:

Person completing intake:

Walk in or Scheduled Appointment:

Age:

Diagnosis (Priority Diagnosis/ Not Priority Diagnosis) See checklist for priority diagnoses.

Priority Population: post hospital referral (must be seen within 7 days), pregnant or parenting female with substance use disorder/ IV drug user/overdose survivor (must be seen same day if possible or next day appointment), veteran (assign to select provider), child (refer to child/adolescent team); opiate dependent (follow opiate “clinical care pathway”—to be developed and assign to opiate team)

Primary Care Team/LOC:

Group/Group Facilitator/Date of First Group (must be within 7 days):

Individual Clinician or Physician/Date of First Appointment (must be within 7 days):

Tx plan scheduled 45 days:

Current PCP name:

If no PCP or has not seen PCP in over one year:

( ) MA referred to community based PCP Name: \_\_\_\_\_

( ) Referred to onsite PCP Date of Appointment: \_\_\_\_\_

( ) Refused

Chronic Health Condition or Risk Factor: Must be documented in Health Assessment.

( ) Smoking ( ) Obesity (BMI>25) ( ) Diabetes

( ) Heart Disease ( ) COPD ( ) High Blood Pressure

( ) Other: \_\_\_\_\_

External Referral made: Must be documented in a Care Coordination Note

( ) Higher level of care \_\_\_\_\_

( ) Specialty or other community based care provider \_\_\_\_\_

( ) Other

Case Management: All patients must be assigned to some level of case management. Notification to CCC for Case Management.

- Routine administrative case management
- Targeted case management
- Blended case management

Meets criteria for Peer Support:  Yes  No Referral Completed:

Warm hand off to case management and/or peer support services. Must be documented by CM and/or Peer Support Specialist.

Findings upon screening:

- PHQ9 Score 9 or above
  - Follow up plan documented
  - Annual follow up date inputted into patient schedule (one year minus 30 days)
- CSSRS with risk factors
  - Follow up plan documented
  - Crisis plan created
- Audit-C positive (3 or more for a female; 4 or more for a male)
  - Patient enrolled in substance abuse services or
  - Active engagement effort documented
  
- Social Determinants Score \_\_\_\_\_
  
- High Risk Screening Completed
  
- Preliminary Treatment Plan completed

## Summary of Daily Admissions

Number of walk-ins for the day:

\_\_\_\_\_ First time patients

\_\_\_\_\_ Re-engagements

Number completing same day Clinical Evaluation:

Number unable to complete same day Clinical Evaluation:

\_\_\_\_\_ Patient unable to stay

\_\_\_\_\_ 48 hour verification required

Number of patients unable to be seen same day/referred for follow up appointment (Schedule next day unless supervisor approval):

Number of referrals to walk in expected but did not arrive within 5 days (follow up required):

Number of scheduled appointments for the day:

Number of scheduled appointments completing Clinical Evaluation:

Number of patients not completing admission process:

## Incomplete Admissions Patient Face Sheet

Date:

Patient name:

Reason admission was not complete:

Follow Up Plan:

- Patient in hospital in past 7 days – refer to CM for engagement
- Routine – Clinical Care Coordinator to attempt engagement
- CM needs—refer to CM
- Peer Support needs—refer to Peer Support Specialist

Target date (10 days post screening):

Status at target date:

- Admission has now been completed
- Patient admission still incomplete

If still incomplete, case manager will pick up case for routine reengagement and evaluate whether targeted or blended case management needs exist

Case manager assigned: \_\_\_\_\_