ADT 101 (ADT = Admission, Discharge Transfer)

ADT is a subset of a registration system. It is the backbone which ties information together in the healthcare system for a particular visit in an outpatient setting or a length of stay for an inpatient admission. At a minimum, it contains information specific to a particular person, a medical record number and a unique identifier such as an account or encounter number, dates associated with the visit or stay, and provider information. The unique identifier also drives charges (reimbursement) for the providers and the facility.

Not every facility will provide the same amount of information. What is common is that if the report is being delivered back to an Electronic Health Record (EHR), the unique identifier will drive where that report is filed electronically. In the rare instance that the facility isn’t using an EHR and/or is still using a paper copy, it can drive where the report delivers and can be as specific as a printer within a department. *This is why choosing the correct ADT information is critical*. If we don’t, reimbursement can be impacted and it becomes very difficult for the facility to locate the report for patient care.

Ultimately, it is the responsibility of the dictating provider to accurately enter and speak the pertinent information for the MLS to be able to search for and select the correct ADT information. However, it is the responsibility of the MLS to ***verify*** and ***choose*** or ***not choose*** the ADT information on the reports they receive. \*\**Exceptions*: Partial dictation WTs, WTs with “EPIC” in the name, or other WTs dictated directly from the EHR will always have the correct dictating provider name, patient information, ADT account/encounter #, dates, etc. Be careful not to make changes to this information as it will already be in place. Always reference the account instructions to aid you in the ADT selection process and for what to do if you are not certain which item to choose.

When performing searches, you must use critical thinking skills to search in multiple ways; patient name, MRN, and entered/dictated account # to find and select the correct ADT information. Remember that each report is needed for patient care, so we need to do our best to ensure the report is delivered on time AND to the right place at the facility.

**Basic Examples on choosing ADT**: (Use sample grid below)

* HP dictated on 9/20, provider dictates patient admitted on 9/20.
  + Correct choice is 1 which is an inpatient stay showing patient admitted 9/20 and is in hospital (no DOD).
* Clinic note dictated on 9/20
  + Correct choice is 2 which is an outpatient visit on 9/20 and there is only one outpatient visit on that date.
* Consultation dictated on 9/22/15. Provider dictates that patient was seen on 9/22.
  + Correct choice is 1 which shows the patient is currently an inpatient (no DOD).
* DS dictated on 9/24, provider gives date of admission as 9/1 and discharged 9/4.
  + Correct choice is 3. Provider doing an old dictation for a previous admission.
* Operative report dictated on 9/21. Provider gives date of procedure as 7/13.
  + Correct choice is NONE. There is not an ADT encounter associated with the date of 7/13. Follow instructions for bringing this to the attention of the facility.

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| Example #: | MRN | Acct # | Pt Name | Date of Admit | Date of Disch | Pt Type |
| 1. | 12345 | 2121212 | Smith, John | 9/20/15 |  | Inpt |
| 2. | 12345 | 1313131 | Smith, John | 9/20/15 | 9/20/15 | Outpt |
| 3. | 12345 | 1212121 | Smith, John | 9/1/15 | 9/4/15 | Inpt |
| 4. | 12345 | 1111222 | Smith, John | 7/17/15 | 7/17/15 | Outpt |
| 5. | 12345 | 1111111 | Smith, John | 6/30/15 | 7/4/15 | Inpt |