National Hospice and Palliative Care Organization

REFERRAL & ADMISSION MODELS RESOURCE

JUNE 2018

National Hospice and Palliative Care Organization

Referral and Admission Models
Explanation of Key Decision Points

This tool is designed to assist a hospice program in evaluating their referral and admission process for efficiency in operation and as a performance improvement opportunity. The quality considerations related to the referral and admission process include:

- Responsiveness to patient/family need
- Ease of patient/family transition hospice care
- Procurement of comprehensive patient/family information for optimal decision making

The tool consists of the Referrals and Admission Process Map, the Referral and Admission Process Map Text Guide and this Key Decision Points guide.

DECISION POINT #1: REFERRALS

A. Structure Options - Centralized or Decentralized

1. Centralized Structure

   Model characteristics

   - Higher efficiency
     - Allows standardization of processes
     - Facilitates consistency
     - Simpler to train staff and to script hospice policies
     - Ease of oversight – able to ensure that all tasks are accomplished
   - Streamlined for better customer service
   - Allows for multiple sites coverage including inpatient facility
   - Referrals accepted 24/7 (twenty four hours per day, seven days per week)

2. De-centralized Structure
   - Better for single provider number
   - Intake staff may have other responsibilities
   - Preference – tradition for hospice's culture; works well for staff
   - Referrals accepted during business hours

3. Hybrid Structure
   - Hospice service area includes a remote area with its own office
   - Referrals accepted either 24/7 or during business hours

B. Factors/Considerations for Choosing Structure

1. The size of the hospice
    - Consider total census and multiple locations under one Medicare provider number
2. Possession of multiple Medicare provider numbers
3. Wide geographic area
4. Technological limitations (i.e.: paper clinical records v. electronic clinical records)
5. Community and referral source expectations
6. Choosing staff which will be the most effective and cost efficient
7. Qualifications of staff
    a. Medical background – is it necessary or desirable?
        - LPNs/ LVNs – have medical knowledge and know what questions to ask
    b. Unlicensed (clerical; marketing; clinical team assistants) – require extensive training
    c. Choosing to utilize a liaison nurse for patients/family information visits
    d. Staff skills/competency necessary for intake staff to communicate with provider referral sources and patients/families

C. Suggestions for Service Excellence

1. Responses to referrals should be immediate
2. Use standardized intake procedure with all structure options
3. Include expectations of community and referral sources – choose a structure that promotes ease of use and timely response to maintain relationships
4. Keep the number of people that patient/family need to talk to consistent and to a minimum
5. Using unlicensed staff
    - The hospice should complete extensive training and have an RN as a ready resource for questions
6. The information asked for during the intake process should determine qualifications of intake staff
7. If medical information needs further investigation, non-licensed intake staff should elevate to an RN for completion (a pre-hospice evaluation by a physician may also be an option)

NOTE: Roles and titles used for intake staff may differ from hospice to hospice.

DECISION POINT #2: ADMISSIONS

1. **Structure Options**
    1. Dedicated admission team – admissions are all this team does; staff members are knowledgeable and competent related to admission compliance requirements and the hospice program's process
        - Single Step – only the registered nurse (RN) completes the admission
        - Two Step
            - RN and other interdisciplinary team (IDT) members complete the admission
            - RN and non-clinical staff completed the admission (non-clinical staff can complete informed consents, hospice elections statement and paperwork with patient/family)
    2. RN Case Managers – same RN completes admission and case manages patient beginning to end

> **NOTE:** The federal hospice Interpretive Guidelines §418.54(a) state:
> The purpose of the initial assessment is to gather the critical information necessary to treat the patient/family's immediate care needs. The assessment needs to take place in the location where hospice services are being delivered.

2. **Factors/Considerations**

The following lists prominent factors for consideration, but not all possible factors.

1. Volume
    - Average daily census (ADC) as well as patient turnover
    - Admissions volume
    - Percentage of short length of stay patients
2. Geography
    - Travel time for staff
    - Size of service area
3. Admission response (single step v. two-step)
4. Skills and training of admission staff
    - RN skills set and strength – admission v. case management
    - Skill set of liaison staff
    - Skill set of non-clinical staff

Positive factors

- Admission team
  - Dedicated admitting nurses develop familiarity with the admission form and will develop expertise in comprehensive completion of all required information
  - Social workers and spiritual care counselors have particular expertise in communication and can be utilized for information visits and patient/family paperwork review/signing
- RN case manager – promotes continuity of care from the start of care

Undesirable factors

- Non-clinical staff cannot answer all questions posed by patients/families
- Non-clinical staff need extensive training in communications and paperwork requirements
- Two-step structure may:
  - affect continuity of care
  - increase patient/family stress
  - increase burden of transition

3. **Suggestions for Service Excellence**
   1. If >10 admissions/week or frequent evening admissions, consider implementing staggered schedules for admission staff (i.e. 11:00 am – 8:00 pm).
   2. Consider supportive service availability outside of business hours
      - I.e. social work, spiritual care counseling services, etc…
   3. With multi-staff structure, if patient eligibility is questionable, then send RN to evaluate clinical completion (a pre-hospice evaluation by a physician may also be an option).
   4. Evaluate the threshold for utilizing admitting nurses
      - i.e. Use the team approach with 20 admissions/month
   5. Evaluate your threshold for appropriate nursing volumes
      - i.e. Limit of two admissions per nurse per day (depends on model)
   6. Ensure capability of admission process to accommodate language needs/preferences

7. Reasonable response time to first contact
    - Evaluate and establish an appropriate timeframe for first contact with patient/family
        - Consider how to respond to an immediate need (i.e. 8:00 pm ref**er**ral)
    - Evaluate and establish an admission timeframe in policies/procedures
        - Assessment at time election

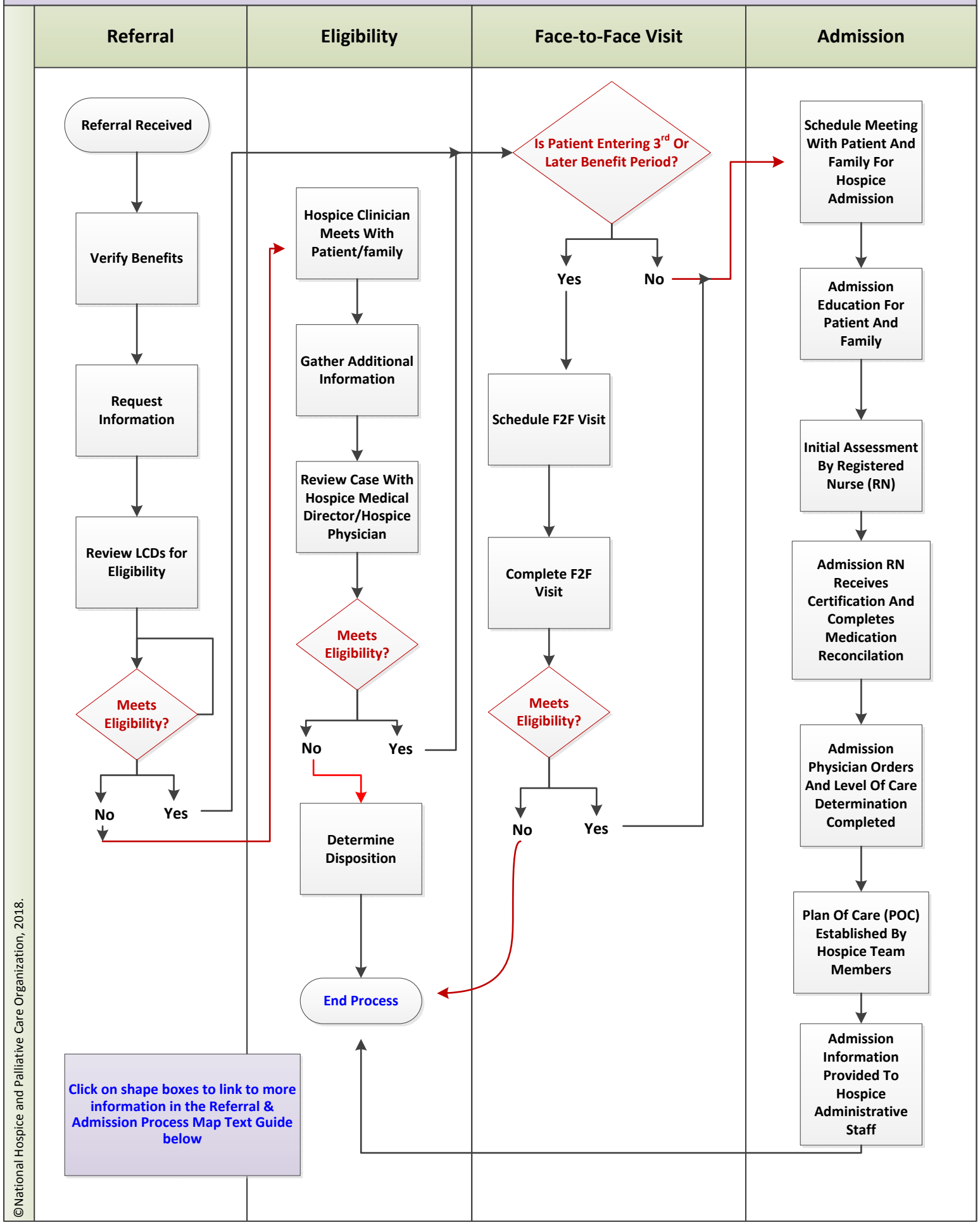
NOTE: The federal hospice Interpretive Guidelines at §418.54(a) require an RN to complete an initial assessment within 48 hours after the election of hospice care.

8. Gathering additional information
    - If access to a coding specialist is available, have them review the patient's history/physical (H/P) for diagnoses and comorbid conditions before hospice physician reviews all of the patient's available clinical information. This review may provide additional information for the hospice physician's consideration
    - Consider utilizing a medical coder for complex cases (presents a different perspective)

References

Electronic Code of Federal Regulations (updated daily)
Hospice Regulations

Referral and Admissions Process Map



Referral & Admission Process Map Text Guide

This text guide pairs with the Referrals & Admission Process Map. Each section of this document correlates with the specific swim lane in the process map document.

Referral	
Referral Received	• Intake can be centralized or decentralized • Referral usually consists of a patient name and additional identifying information, and the physician order for hospice • Enough information must be gathered to verify benefits and support the admission process o If additional medical information needs further investigation, non-licensed intake staff should elevate to an RN for completion (a pre-hospice evaluation by a physician may also be an option)
Verify Benefits	• Medicare – through Common Working File • Medicaid – through state-specific verification portal • Commercial – call carrier
Request Information	• Additional demographics and contact information if needed • Medical history and physical/medical record information to support diagnosis/prognosis • Should include any hospitalizations or emergency room visits in the previous 12 months • Physician order for hospice care (if not already obtained)
Review LCDs for Eligibility	• Compare patient information (history and physical, medical record information and evaluation) to Local Coverage Determinations (LCDs) of hospice's Medicare Administrative Contractor (MAC)
Meets Eligibility?	• Based on initial review, determine if the patient qualifies for admission to hospice

Referral & Admission Process Map Text Guide

Eligibility (if patient does not meet eligibility criteria)	
Hospice Clinician Meets with Patient/ Family	• Gather additional medical record information and patient "story" • Obtain signed release of information to gather additional medical record information (if needed) • Evaluate clinical findings for primary diagnosis and other diagnoses that contribute to the terminal prognosis
Gather Additional Information	• Obtain documentation of additional information discovered during meeting with family (hospital records, primary care physician records, specialist medical records, etc…)
Review Case with Medical Director/Hospice Physician	• Review entire case with hospice medical director/ hospice physician to determine eligibility for admission to hospice services ★ (Refer to NHPCO's 'Determination of Relatedness to the Terminal Prognosis Process Flow' resource for additional assistance in determining relatedness
Meets Eligibility?	• Final determination of eligibility
Determine Disposition	• Based on hospice medical director/ hospice physician recommendation, communicate with family and referral source about additional care and services needs • Offer referral to another healthcare providers as appropriate

Referral & Admission Process Map Text Guide

Face-To-Face (F2F) Visit	
Entering 3rd Benefit Period?	This step is for patients entering their 3rd or subsequent benefit period, which requires a face-to-face visit to evaluate continued eligibility for hospice services.
Schedule Face-to-Face	• Must occur prior to or on the date of patient admission
Complete Face-to-Face	• The F2F visit must be done by a hospice physician (MD) or hospice nurse practitioner (NP) • A clinical note should include an explanation of why the clinical findings of the F2F support a life expectancy of 6 months or less • Physician or NP conducting the F2F must attest in writing that they completed a face-to-face visit with the patient, including the date of the visit • The attestation statement text for the NP or non-certifying physician shall state that the clinical findings of the visit were provided to the certifying physician for use in determining continued eligibility for hospice care
Meets Eligibility?	• Determined by the hospice medical director/ hospice physician in consultation with attending physician (if any)

Referral & Admission Process Map Text Guide

Admissions	
Schedule Meeting with Patient/ Family for Hospice Admission	
Complete Admission Paperwork	• Election statement includes patient choice of attending physician • Hospice reviews all admission paperwork including the notice of rights in a language and manner that the patient/family understands • The patient/representative signs a form indicating that patient rights notice was received and understood
Initial Assessment Completion	• A registered nurse (RN) completes an initial assessment of the patient/family within 48 hours of effective date of the election to hospice care ★ **Note:** In a nurse case manager model, the nurse may complete the initial or comprehensive assessment at the first visit (the comprehensive assessment must be completed within 5 calendar days of the effective of the election to hospice care)
Admission Nurse Receives Certification, Performs Medication Review	• Medication review and reconciliation by the RN is a component of the comprehensive assessment and must be completed within 5 calendar days of the effective date of the election to hospice care
Admission Orders Obtained, Level of Care Determined	• Admission orders obtained from attending and/or hospice medical director/hospice physician and level of care if determined
POC Established with Hospice Team Members	• At the completion of the initial assessment and the initiation of the Plan of Care, but before the provision of hospice care
Admission Information Provided to Hospice Administrative Staff	• Notice of Election (NOE) submitted within 5 calendar days of the hospice election