HOSPICE INTAKE AND SCHEDULING FLOW CHART

Intake Process

This option works best for an organization who tracks leads or receives very little basic information at time of referral.

Add/Inquiry

New Inquiry

List/Inquiries

Inquiries List

New leads whose admission process has not been started will be found with all other leads. Select **Convert to Referral** to begin referral process.
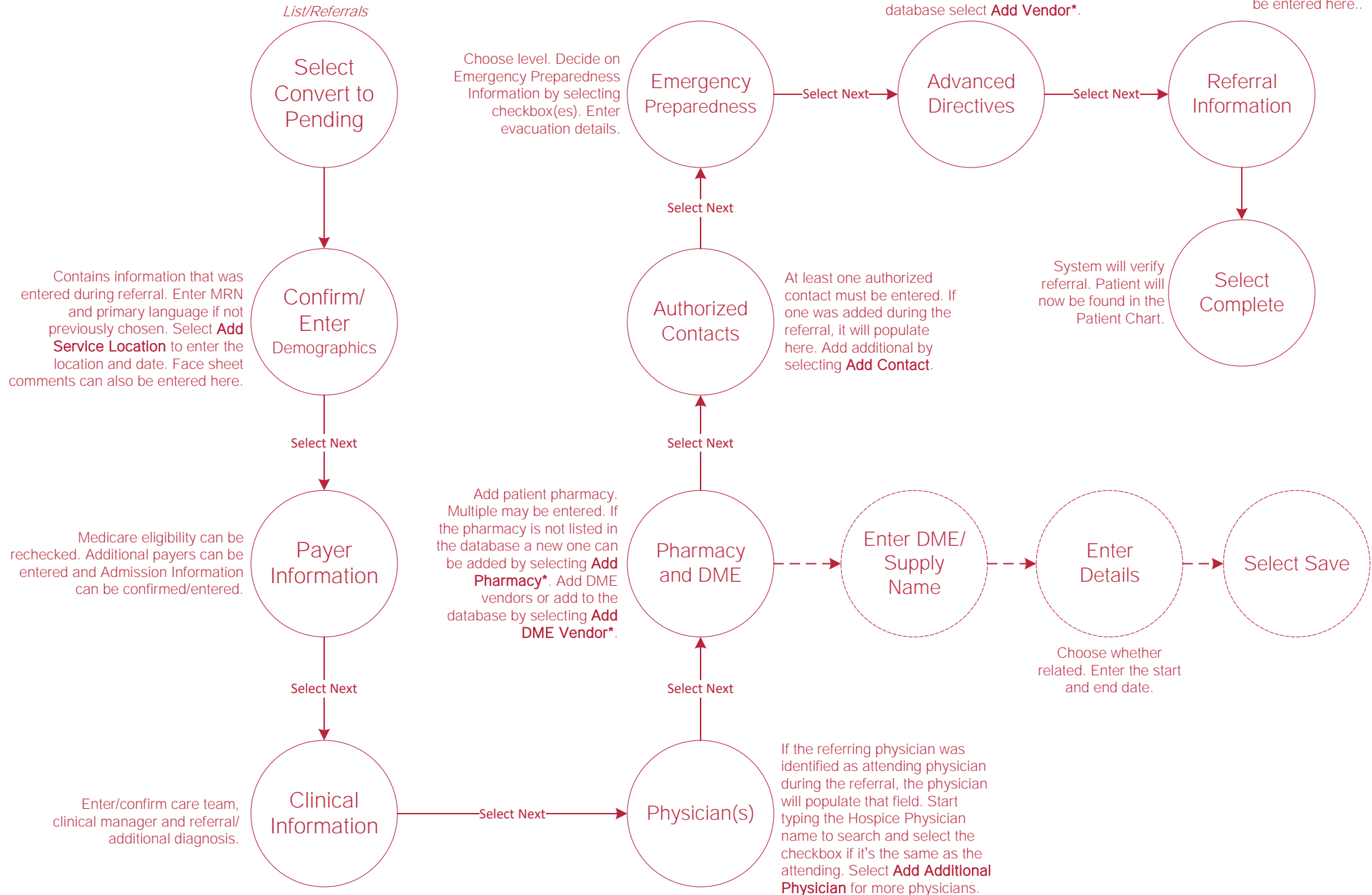
New Patient

Add/Referral

New Referral

List/Referral

Referral List

This option is most suitable when detailed patient information is provided at time of the referral.

Select Convert to Pending

Patient Charts

The patient's electronic medical record. Status of the patient can also be changed to non-admitted from here once in pending status.

RN Initial Assessment

Both populate a POC after document is approved by QA

RN Comprehensive Assessment

Home/HIS Export Manager

HIS Export Manager

HIS document is created when the assessments are completed. Document is audited/approved and then **Marked as Exported**.

Pending Admission

Patients whose admission chart was Saved, but **Admit Patient** was not yet selected or status is not changed while entering information.

Non-Admissions

Existing referrals or pending admissions that did not qualify for admission are considered to be non-admissions.

New Referral

Add/Referral

Enter Referral Source

Choose the line of service, referral date, referral source and enter any other available referral information.

Enter Demographics

Enter the name, DOB, gender, phone, branch and address. Select the **Validate Patient Primary Address** button. Enter the patient's visit address if different from primary otherwise check box. Assign tags to patient.

Enter Payer*

Choose the payment source and enter Medicare/Medicaid numbers if applicable. All eligibility fields must be entered for a check. Add additional payers by selecting **Add Payer**. Payers can be added to database if user has permissions.

Enter Admission Info

Choose the type of admission, admission source and enter benefit period number.

Select Create Referral

To save or select **Convert to Pending** to move to the next step of the intake process.

Enter Contact(s)

Enter as much patient contact information as available. Select **Add Contact** for more contacts.

Enter Clinical Info

Enter the referring physician, choose the care team and enter referral diagnosis. Create a pre-admission evaluation. Select **Add Diagnosis** to enter additional diagnoses.

Documents

Attach any relevant documentation by selecting **Add Documents**.

Referral Readiness and Notes

Indicate whether consents completed, hospice order received, F2F visit obtained, verbal CTI received by selecting the checkbox(es). Preadmission notes can also be added here.

Enter Non-Required Info

The following options are not required to create the referral, but should be entered if information is available.

*Primary payer is not required to save a referral, but is required for converting a referral to pending status.

Admit Referral

List/Referrals

Select Convert to Pending

Contains information that was entered during referral. Enter MRN and primary language if not previously chosen. Select **Add Service Location** to enter the location and date. Face sheet comments can also be entered here.

Confirm/ Enter Demographics

Select Next

Medicare eligibility can be rechecked. Additional payers can be entered and Admission Information can be confirmed/entered.

Payer Information

Select Next

Enter/confirm care team, clinical manager and referral/ additional diagnosis.

Clinical Information

Choose level. Decide on Emergency Preparedness Information by selecting checkbox(es). Enter evacuation details.

Emergency Preparedness

Select Next

At least one authorized contact must be entered. If one was added during the referral, it will populate here. Add additional by selecting **Add Contact**.

Authorized Contacts

Select Next

Add patient pharmacy. Multiple may be entered. If the pharmacy is not listed in the database a new one can be added by selecting **Add Pharmacy***. Add DME vendors or add to the database by selecting **Add DME Vendor***.

Pharmacy and DME

Select Next

If the referring physician was identified as attending physician during the referral, the physician will populate that field. Start typing the Hospice Physician name to search and select the checkbox if it's the same as the attending. Select **Add Additional Physician** for more physicians.

Physician(s)

Select Next → **Clinical Information** → *Select Next* → **Physician(s)**

If the patient has an advanced care plan or surrogate decision maker and able to provide legal documentation select yes and enter details below. Enter Funeral Home and if not in the database select **Add Vendor***.

Advanced Directives

Select Next → **Emergency Preparedness** → *Select Next* → **Advanced Directives** → *Select Next* → **Referral Information**

Confirm referral date and referral source. Comments, pending reason and preadmission notes can also be entered here..

Referral Information

System will verify referral. Patient will now be found in the Patient Chart.

Select Complete

Enter DME/ Supply Name

Enter Details

Choose whether related. Enter the start and end date.

Select Save

*Permissions based.

Scheduling Tasks*

Schedule Single Task

Schedule/Employee Schedule
Schedule/Patient Schedule

Select Add Task

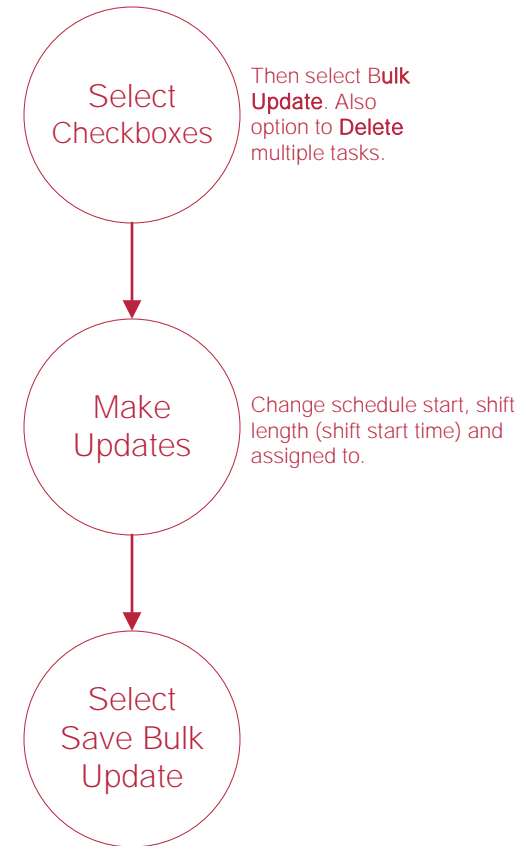Add repeat for scheduling multiple tasks.

Enter Details

Enter the task and search for the employee. Enter the date and whether the task has shift lengths. Select on-call visit check box if applicable.

Select Save Task

Or select **Save Task & Add Another** to add more visits.
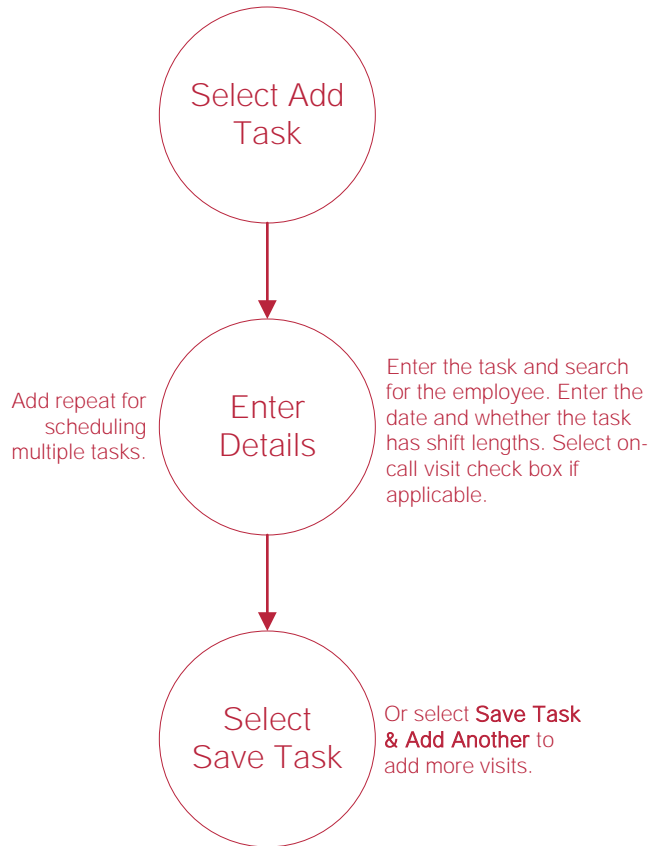
Reassign Single Task

Schedule/Employee Schedule/List
Schedule/Patient Schedule/List

Select Three Dot Button

Then select **Reassign**.

Enter Clinician

Select Save
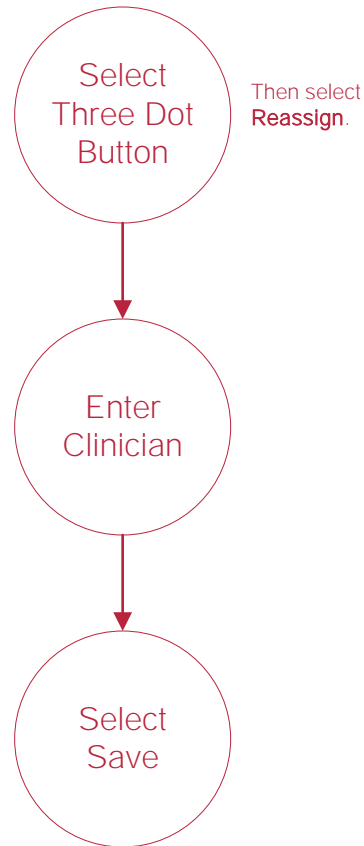
Reassign Multiple Tasks

Schedule/Employee Schedule/List
Schedule/Patient Schedule/List

Select Checkboxes

Then select B**ulk Update**. Also option to **Delete** multiple tasks.

Make Updates

Change schedule start, shift length (shift start time) and assigned to.

Select Save Bulk Update

Deleted Multiple Tasks

Schedule/Patient Schedule/List

Select Box(es)

Select Check/Uncheck All checkbox to select all.

Select Delete Selected

Choose one or multiple days on calendar.

Select Yes, Delete

Confirm.
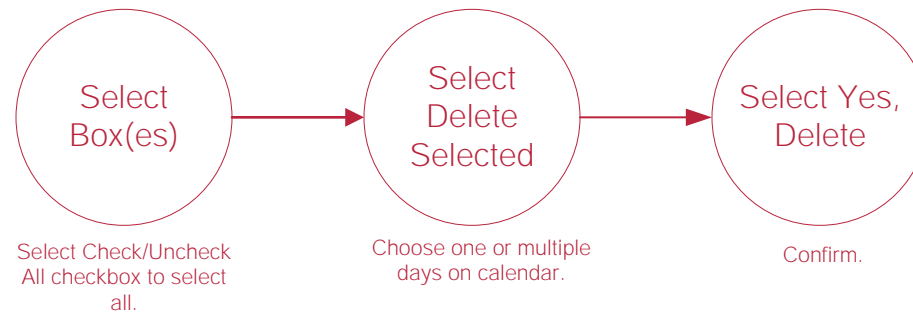
*Permissions based.

Non-Patient Activities

Schedule Non-Patient Activities

Select Add Activity

Enter Details*

Enter activity, agency branch (if more than one) and date.

Select Save Activity

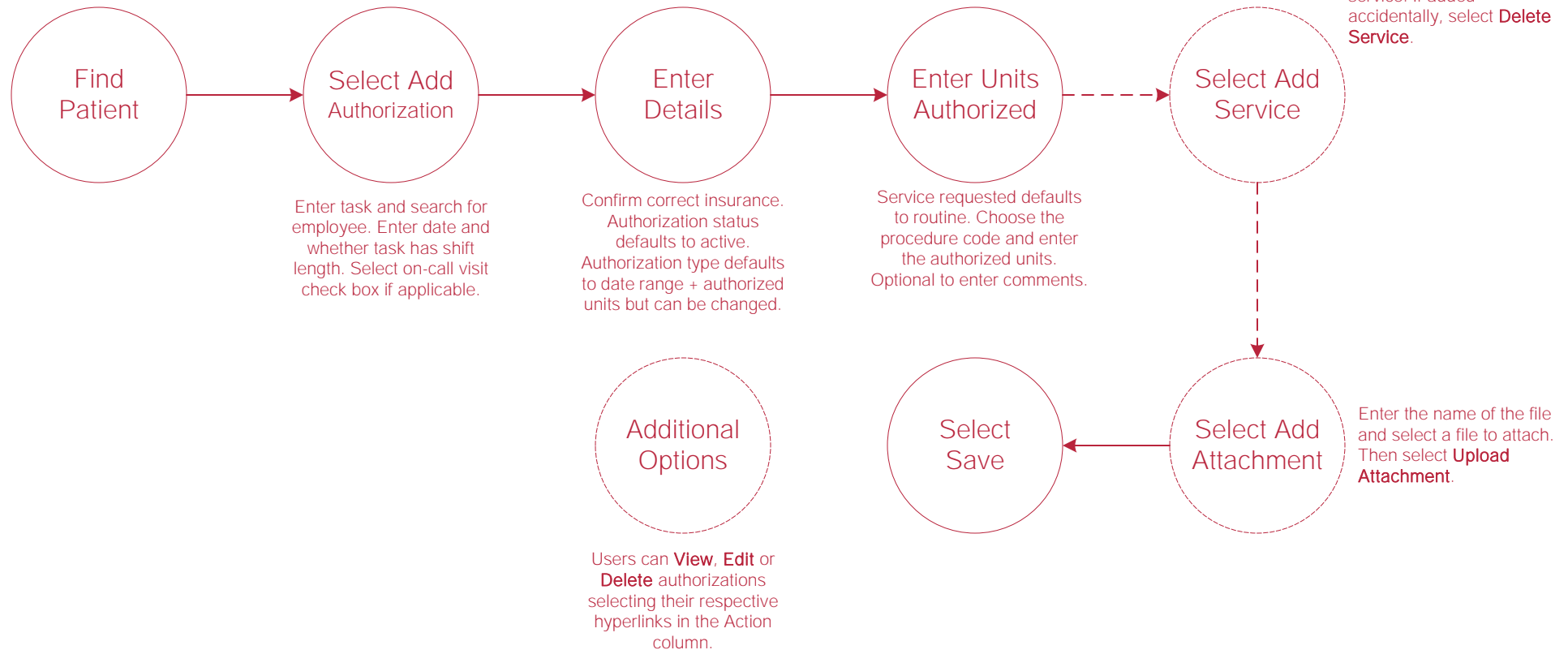Or select **Save Activity & Add Another** for more activities.
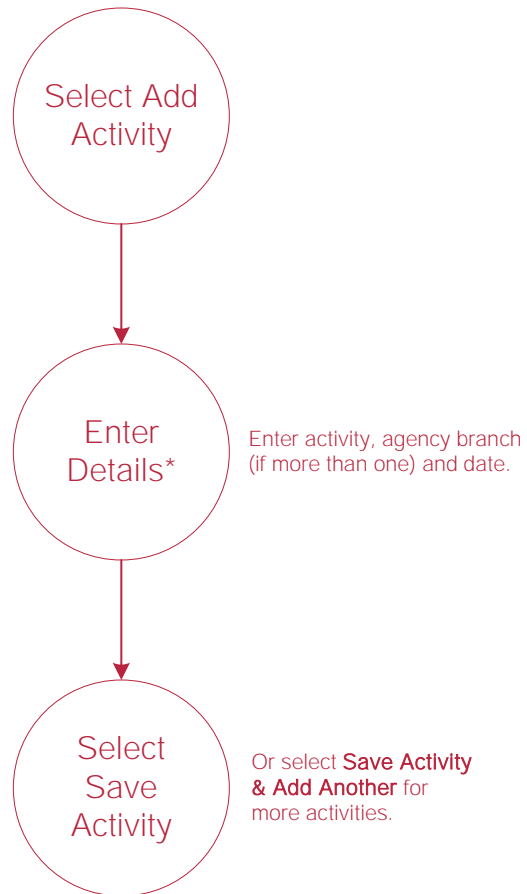
*If the activity will be repeated, select the appropriate frequency. By default, activities will not repeat. If the activity is a shift, select a shift length and enter a shift start time.
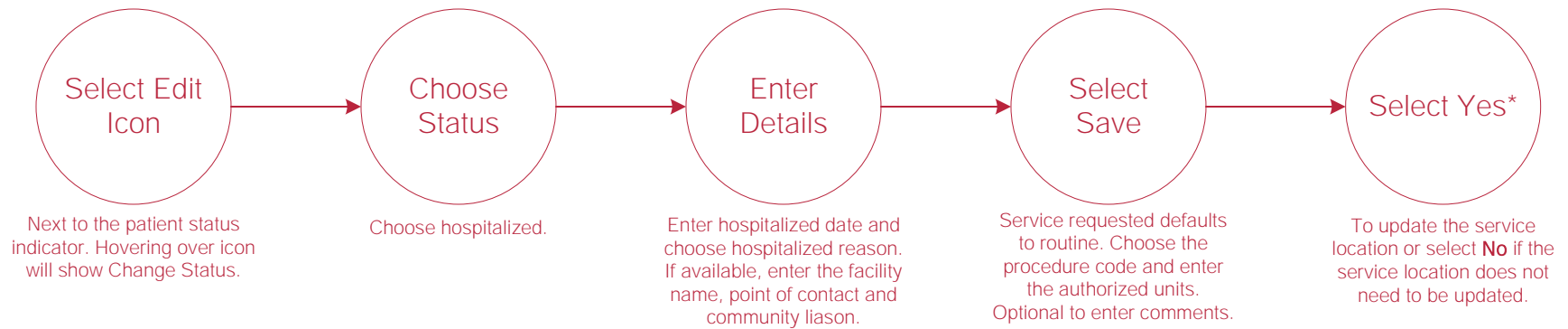
Authorizations*

Patients/Authorizations

Add Authorization

Find Patient

Select Add Authorization

Enter task and search for employee. Enter date and whether task has shift length. Select on-call visit check box if applicable.

Enter Details

Confirm correct insurance. Authorization status defaults to active. Authorization type defaults to date range + authorized units but can be changed.

Enter Units Authorized

Service requested defaults to routine. Choose the procedure code and enter the authorized units. Optional to enter comments.

Select Add Service

If more than one service is authorized or requested. Enter the details for each service. If added accidentally, select **Delete Service**.

Select Add Attachment

Enter the name of the file and select a file to attach. Then select **Upload Attachment**.

Select Save

Additional Options

Users can **View**, **Edit** or **Delete** authorizations selecting their respective hyperlinks in the Action column.

*Permissions based.

Hospitalization

Patients/Patient Charts

Flag as Hospitalized

Select Edit Icon

Next to the patient status indicator. Hovering over icon will show Change Status.

Choose Status

Choose hospitalized.

Enter Details

Enter hospitalized date and choose hospitalized reason. If available, enter the facility name, point of contact and community liason.

Select Save

Service requested defaults to routine. Choose the procedure code and enter the authorized units. Optional to enter comments.

Select Yes*

To update the service location or select **No** if the service location does not need to be updated.

*The Hospitalized flag will appear at the top of the patient's chart. To remove the flag, follow the same actions to update the patient status to active. The date selected as the active date will be the date that the system uses as the hospitalization end date for reporting.

Room and Board*

Assign to Facility**

Add/Vendor

Enter Facility Details → **Select SNF or NF*** → **Next Tab** → **Select Add RUG Rate** → **Enter Details**

On the **Vendor Details** tab, select Skilled Nursing Facility (SNF) or Long-Term Nursing Facility (NF) from the vendor type.

Navigate to the **Room and Board** tab.

Enter the RUG level, rate and effective date.

Select Save ← **Select Save**

Select Save button.

Select Save hyperlink.
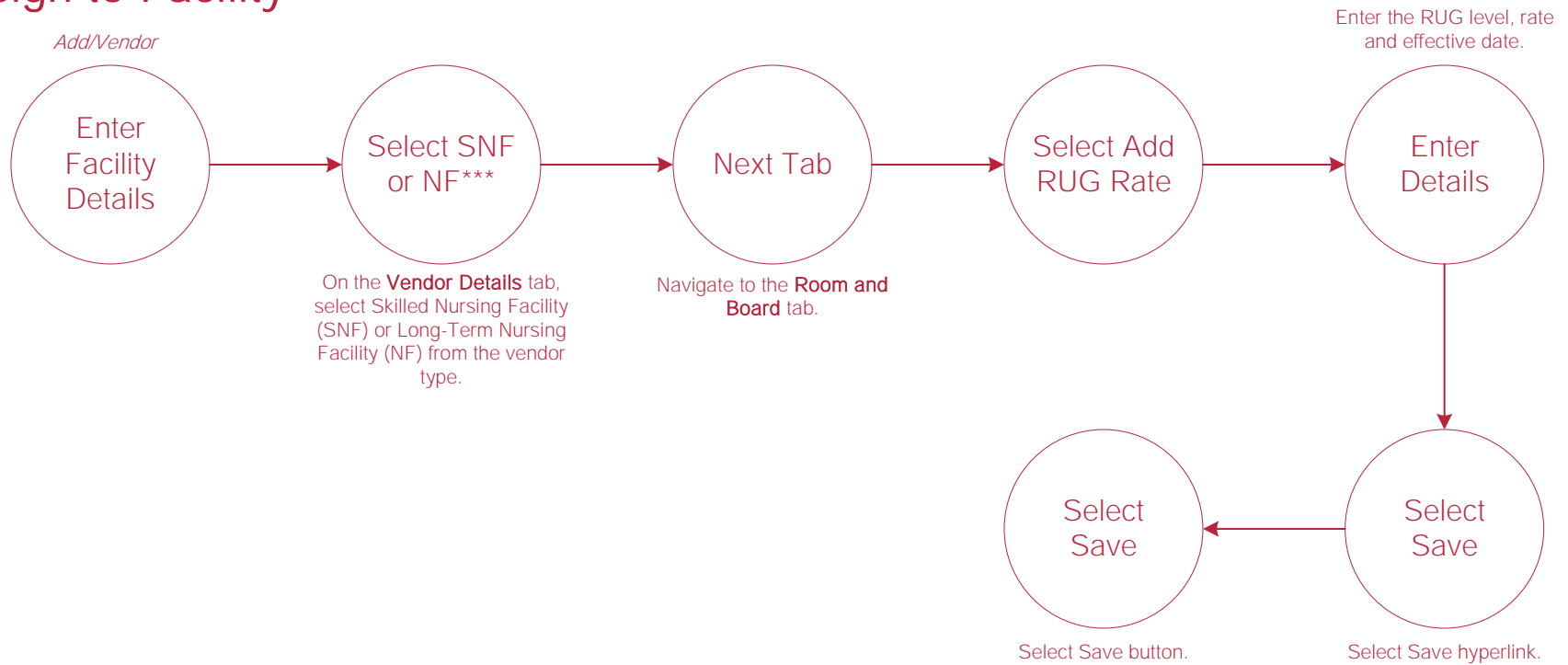
Assign to Patient

Patients/Patient Charts/Edit Profile/ Payer Information

Select Add Payer → **Enter Details** → **Select Save****** → **Select Add RUG Level** → **Enter Details** → **Select Save**

Add the payer, effective date and select room and board from the payer type.

Enter the facility, RUG level and effective date.
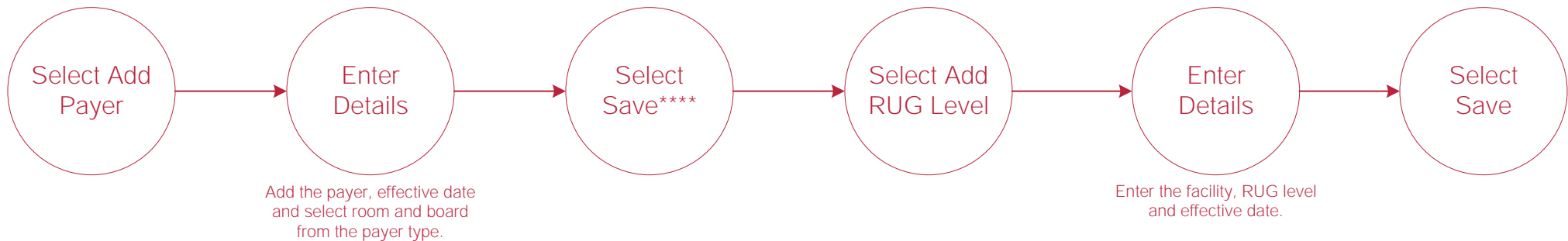
*Permissions based. **This can also be done from *Lists/Vendors* for previously entered facilities. ***If SNF or NF are not selected as the vendor type, RUG rates will not be available on the subsequent tab. ****Once payer is assigned to the patient, a new Room and Board section will appear under Payer Information.

Help Center Process

Help Center
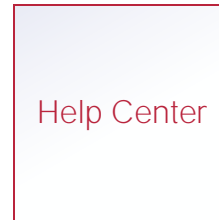
This center will provide
step-by-step instruction
on areas of the software,
as well as instructional
videos.