



AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

# IRF Boot Camp

September 27, 2026

**Hit it Out of the Park with Referral Development**

Strategies for access, growth and defensible admissions

# Key Components for a Referral Management Process for IRF

## Core Clinical and Regulatory Compliance

- PAS
- IRF-Specific Criteria and Verification
- Fast Request for Information

## Technology and Workflow Integration

- EHR/EMR Interoperability
- Centralize Intake Pipeline Tracking
- Automated Status

## Performance Analytics and Relationship Management

- Conversion and Denial Tracking
- Referral Source Analytics

# Three major areas of consideration:

**Patient type** and  
clinical needs: TPN,  
Hemodialysis, stroke

**Referral  
Responsiveness:**  
Time from referral to  
decision and single  
point of contact

**Insurance  
Authorization** and  
connection with  
Preadmission screen  
(PAS)

## A Formal Referral System Protects Access and Growth

The strongest systems combine speed with clinical judgment and reliable follow-through

**7 days**

Consistent referral coverage

**2 hours**

Internal response target for  
complete referrals

**1 owner**

Clear accountability from  
referral to decision

### Operational Result

Fewer missed referrals, faster placement decisions and a documented reason for every non-admission.

## The 2026–2027 Referral Environment

Referral teams face more payer friction while hospitals expect faster, clearer decisions

- Medicare Advantage authorization remains a front-end access risk
- Payers begin major electronic prior-authorization API requirements January 1, 2027
- Competition is increasing



## Referral Operating Model

A single standard should govern every referral, regardless of source, payer or day of week

### 1 Capture

Time received, source,  
payer and clinical trigger

### 2 Triage

Clinical screen and  
missing-information  
request

### 3 Decide

Admit, decline or escalate  
with rationale

### 4 Close

Communicate disposition  
and document next step

**Required controls: shared queue, escalation standard, weekend handoff and closed-loop communication**

## What Referral Sources Value

FAST remains relevant, but each promise needs an operational definition

**F**

### **Fast**

A clear response time  
and escalation path

**A**

### **Accurate**

A decision supported  
by the available facts

**S**

### **Simple**

One contact and a  
predictable process

**T**

### **Transparent**

Status updates and a  
specific disposition

## The Effective IRF Liaison

The role blends clinical credibility with disciplined account management

### Clinical

Applies IRF criteria and identifies documentation gaps

### Service

Makes the process easier for referral partners

### Business

Uses data to focus time on the right accounts

### Hiring Test

Can this person explain why a patient qualifies, resolve the next barrier and preserve the referral relationship?

## Clinical Fluency for Referral Development

Training should build consistent judgment, not memorized talking points

- IRF coverage requirements and the intensity-of-service standard
- Common qualifying conditions and rehabilitation needs
- Medical necessity risks that commonly trigger payer denials
- Documentation language that connects impairment, intervention and expected benefit
- When to escalate to the rehabilitation physician or admissions leader



## Admission Criteria Conversation

The liaison translates clinical facts into the four questions the team must answer

### Need

Why does the patient require an IRF level of care?

### Intensity

Can the patient participate in and benefit from intensive rehabilitation?

### Complexity

Why does the patient need rehabilitation physician oversight and coordinated nursing?

### Plan

What measurable improvement and discharge destination are expected?

## Decision-ready PAS documentation

A strong preadmission screen tells a coherent clinical story before the patient arrives

- Baseline function and the event that caused decline
- Current functional deficits supported by specific observations
- Active medical issues and risk of complications
- Therapy needs, expected improvement and likely discharge setting
- Why a lower level of care cannot safely meet the patient's needs

### Quality check

**Could a reviewer  
understand the need  
for IRF care without  
searching the rest of  
the chart?**

# Summarize the clinical information into a cohesive paragraph



## Conditions That Caused Need for Rehabilitation:

This is a 66-year-old male referred to FACILITY for acute rehabilitation following: status epilepticus/stroke/acute encephalopathy. . This condition has impacted the patient in the following ways: decreased strength, decreased sensation, impaired balance, impaired coordination, decreased ROM, poor endurance, deconditioning, impaired proprioception, and increased spasticity. Prior to this admission this patient was: completely independent.

This patient requires 24-hour nursing and MD oversight for the following reasons: cardiac status monitoring, DVT monitoring and management, falls prevention strategies , fluid and nutrition intake, hemodynamic monitoring and treatment, HTN monitoring and management, Medication management, monitor and address labs and vitals , monitor and management bladder/voiding, monitor and management bowel program, monitor for stroke progression, safety education, and sepsis screening

Patient is at high risk for: adverse medication effects, aspiration pneumonia, constipation, dehydration, depression, DVTs, falls, pulmonary embolism, pulmonary infections, respiratory failure, seizures, skin integrity compromise, and urological complication

This patient also requires an intensive rehab program with a coordinated interdisciplinary team to include a rehab physician, PT, OT, and SLP. The patient's current functional status is as follows: mod to max A for ADLs & mod A for functional mobility w/ HHA. Functional needs include: adaptive equipment assessment and training, ADL training, balance training, breathing exercises, cognitive therapy, compensatory strategies, endurance training, energy conservation techniques, family/caregiver training, fine motor training, functional mobility training, home management, neuromuscular reeducation, safety training, strengthening, and swallowing strategies. There is a sufficient gap between the patient's current functional level and prior level of function to justify the need for acute rehab. An inpatient acute rehab program is needed to restore functional mobility and to decrease the burden of care for caregivers. The needs cannot be met in a lower level of care due to the amount of therapy needed, level of physician oversight required due to their comorbidities and high risk for complications.

The acute care hospital reports that this patient is very motivated and can fully participate in 3 hours per day of therapy at least 5 days/week.

## DIAGNOSIS INFORMATION:

Impairment Group Code: 0001.3 - Stroke: Bilateral Involvement

# Summarize the clinical information into a cohesive paragraph

This is a 67-year-old male referred to FACILITY for acute rehabilitation following: admitted with Gangrene of toe of right foot s/p chopart's amputation on 9/10/26 however pt's foot was unsalvageable and pt is now s/p R BKA on 9/15/26. Pt's course complicated by acute renal failure. This condition has impacted the patient in the following ways: decreased strength, decreased sensation, impaired balance, decreased ROM, deconditioning, and increased pain. Prior to this admission this patient was: Independent with ADLs and mobility without AD.

This patient requires 24-hour nursing and MD oversight for the following reasons: cardiac status monitoring, CKI monitoring and treatment, DVT monitoring and management, falls prevention strategies , fluid and nutrition intake, hemodynamic monitoring and treatment, HTN monitoring and management, manage incisions, Medication management, monitor and address labs and vitals , monitor and management bladder/voiding, pain management, safety education, sepsis screening, and skin/wound management.

Patient is at high risk for: adverse medication effects, anemia, atelectasis, bleeding at operative site, constipation, CRI, dehydration, DVTs, falls, post operative wound infections, pulmonary embolism, pulmonary infections, skin breakdown due to limited mobility, skin integrity compromise, and urological complication

This patient also requires an intensive rehab program with a coordinated interdisciplinary team to include a rehab physician, PT, OT, and dietician. The patient's current functional status is as follows: minimal assist for bed mobility, partial/moderate assist for LB dressing, partial/moderate assist for toileting, partial/moderate assist for sit to stand, partial/moderate assist for transfers and partial/moderate assist for ambulation using RW. Functional needs include: adaptive equipment assessment and training, ADL training, balance training, compensatory strategies, endurance training, energy conservation techniques, family/caregiver training, functional mobility training, home management, orthotic assessment & training, safety training, and strengthening. There is a sufficient gap between the patient's current functional level and prior level of function to justify the need for acute rehab. An inpatient acute rehab program is needed to restore functional mobility and to decrease the burden of care for caregivers. The needs cannot be met in a lower level of care due to the amount of therapy needed, level of physician oversight required due to their comorbidities and high risk for complications.

The acute care hospital reports that this patient is very motivated and can fully participate in 3 hours per day of therapy at least 5 days/week.

## **DIAGNOSIS INFORMATION:**

Impairment Group Code: 0005.4 - Amputation: Unilateral Lower Limb Below the Knee (BK)

## Denial Prevention Begins Before Authorization

The referral team should identify payer risk while the clinical story is still being assembled

**Incomplete facts**

Obtain missing therapy, nursing or physician evidence

**Vague benefit**

State the expected functional change and discharge goal

**Participation concern**

Explain barriers, accommodations and clinical management

**Lower level proposed**

Document why SNF, home health or outpatient care is insufficient

## The Two-Hour Response Workflow

Start the clock when the referral has enough information for meaningful clinical review

**0–15 min**

Acknowledge receipt  
and assign ownership

**15–45 min**

Screen criteria and list  
missing evidence

**45–90 min**

Resolve questions and  
escalate clinical  
uncertainty

**90–120 min**

Communicate decision,  
status or specific next  
step

**Measure both median and 90th-percentile response time. The average alone can hide delayed referrals.**

## **Closed-loop communication**

A referral partner should never have to chase the IRF for status

- Confirm receipt and name the liaison who owns the referral
- Set the next update time when a decision cannot be made immediately
- Explain missing documentation in specific, clinically useful terms
- Give a clear reason for non-admission and preserve the relationship
- Complete weekend and shift handoffs in the shared referral queue

## Referral Dashboard for 2026–2027

A small set of measures should show access, execution and avoidable loss

- |          |                                               |          |                                                 |
|----------|-----------------------------------------------|----------|-------------------------------------------------|
| <b>1</b> | Referral volume by source and payer           | <b>2</b> | Response time: median and 90th percentile       |
| <b>3</b> | Conversion rate with reason for non-admission | <b>4</b> | Authorization approval and appeal overturn rate |
| <b>5</b> | Lost referrals by controllable cause          | <b>6</b> | Liaison activity tied to account opportunity    |

## Liaison capacity math

Size coverage from actual demand and service expectations

$$\text{Required liaison hours} = \begin{array}{l} \text{Referral handling hours} \\ + \text{account development hours} \\ + \text{travel and administrative time} \end{array}$$

Then test coverage by day, shift, geography and seasonal volume. Do not use a single referral-to-liaison ratio as the only staffing standard.

## Revenue contribution model

Connect liaison activity to appropriate admissions and contribution margin

$$\begin{array}{ccccc} \text{Appropriate} & & \text{Average contribution} & & \text{Fully loaded} \\ \text{incremental admissions} & \times & \text{margin} & - & \text{liaison cost} \end{array}$$

Use hospital-specific assumptions. Separate true incremental growth from admissions that would have occurred without liaison activity.

## 2027 Readiness Priorities

Referral development should prepare now for faster, more transparent authorization workflows

- Map payer-specific workflows and deadlines before January 2027
- Confirm the EHR and referral platform can exchange structured clinical information
- Standardize documentation packets for common IRF diagnoses and denial risks
- Track payer decision timeliness and specific denial reasons
- Create a downtime process for API or portal failures
- Train liaisons to distinguish clinical eligibility from payer authorization



# Five disciplines sustain appropriate occupancy



The strongest IRFs manage access and quality as one system

1

**Focused market strategy**

2

**Clinically credible liaisons**

3

**Reliable admissions coverage**

4

**A shared metric dictionary**

5

**Staffing matched to workload**

**Final question**

**Which single  
operating change  
would improve your  
next appropriate  
admission?**

**Thank you**

# Referral management tool kit:

## Referral Development Checklist AMRPA IRF Boot Camp Edition 2025

| Checklist for Referral Development Program                   | Never | Rarely | Frequent | Always |
|--------------------------------------------------------------|-------|--------|----------|--------|
|                                                              | 0     | 1      | 2        | 3      |
| Comprehensive Training on IRF Rules on Hire                  |       |        |          |        |
| Training on Admission Criteria that fits your IRF on Hire    |       |        |          |        |
| Training on Documentation Standards on Hire                  |       |        |          |        |
| Pre-Auth Training (Physician Training Included)              |       |        |          |        |
| Sufficient Numbers of Liaisons for Demand                    |       |        |          |        |
| Two Hour Time Frame in Place                                 |       |        |          |        |
| Established Expectations for Communication with Ref Sources  |       |        |          |        |
| Tasks to do when Referrals Are Low                           |       |        |          |        |
| Annual Training for Liaisons                                 |       |        |          |        |
| Back Up Personnel for Liaisons to Maintain 2 Hour Time Frame |       |        |          |        |
| Established Ratio of Beds to Liaisons                        |       |        |          |        |
| Incentive Bonus for Liaisons                                 |       |        |          |        |
| Service Recovery Routines in Place (i.e. website complaints) |       |        |          |        |
| Collateral Materials on Rehab Program                        |       |        |          |        |
| Web Site Built for Defined Audience                          |       |        |          |        |
| Retention Program for Liaisons                               |       |        |          |        |
| Weekend Coverage System for 7 Days a Week                    |       |        |          |        |
| Succession Program for Liaisons                              |       |        |          |        |
| Sufficient Tools for Liaisons to Perform Job Efficiently     |       |        |          |        |
| Critical Analysis of Patients That Fail Rehab                |       |        |          |        |
| Evaluation of Non-Admissions                                 |       |        |          |        |
| Ready Supply of New Activities Happening at IRF              |       |        |          |        |
| Data Captured on Patients Lost to Competition                |       |        |          |        |
| Liaisons Involved with Patient Satisfaction Analysis         |       |        |          |        |

# Role of Liaisons at the Bedside

Clinical liaisons don't want to sound like 'marketers.'



# The Clinical Liaison at the Bedside



A clinician who bridges direct patient care, evidence and the wider care team

-  **Direct patient engagement**  
Assess, counsel and advocate for patient needs at the bedside.
-  **Clinical translation**  
Turn complex data, evidence and guidelines into practical, patient-centered actions.
-  **Team coordination**  
Work with nursing, physicians, allied health and administration to keep care safe and efficient.
-  **Education and mentorship**  
Teach at the bedside and guide less experienced clinicians toward continuous learning.
-  **Advocacy and equity**  
Ensure decisions reflect patient values, health equity and real-world context.

# The 5-Part Bedside Influence Model



Build trust, create contrast, anchor outcomes and close ethically



## **Introduce our role**

Inform and educate patients and families about inpatient rehabilitation options.



## **Establish trust first**

Earn permission in the first two minutes before explaining anything.



## **Create contrast**

Describe what makes “YOUR FACILITY” different without criticizing other providers.



## **Anchor on outcomes**

Translate data into what it means for the patient's recovery and return home.



## **Close without pressure**

Invite the decision, respect the timeline and stay present until admission.

# Part 1: Our Role Is to Inform and Educate



— We are a clinical resource for patients and families, not a sales call



## **Inform about options**

Explain inpatient rehabilitation and distinguish the value of a rehab hospital from a skilled nursing facility.



## **Educate on “Facility”**

Help prospective patients and family caregivers understand the benefits of Burke Rehabilitation.



## **Establish differentiation**

Build brand understanding and preference through clarity, not comparison.



## **Assist with admission**

Support the admissions process and deliver a seamless hand-off.



## **Equip the family**

Give the patient what they need to share with other family members and key decision makers.

## Part 2: Establish Trust in the First Two Minutes



— Patients decide emotionally before they decide logically

### Sit down

Sitting at eye level signals calm, presence and nonverbal authority.

### Slow your pace

A slower speech pace lowers anxiety and makes complex information easier to absorb.

### Ask before explaining

Open with one question: “What matters most to you right now?” Then listen.

### Mirror concerns

Reflect back what you heard so the patient knows the plan starts with their priorities.

## Part 3: Create Contrast Without Criticizing



Confidence beats comparison — describe Burke, never diminish others

### Language to avoid

“We’re better than...” and “They don’t have...” put families in the middle of a competition.

### Language to use

“What makes Burke different is...” keeps the focus on what the patient will experience here.

### Focus and accreditation

“Some facilities offer rehab within a larger hospital. We focus exclusively on rehabilitation.” Not every rehab hospital pursues CARF accreditation — we choose to.

### Tools that speak for us

US News & World Report recognition, the virtual hospital tour, patient stories and our awards and accreditations.

## Part 4: Anchor on Outcomes, Then Translate Them



— Don't just state the numbers — say what they mean for this patient

### Discharge to home

Instead of “our discharge-to-home rate is higher,” say:  
“More of our patients are able to safely return home rather than transfer to another facility.”

### Public quality data

Instead of “our CMS scores are higher,” say: “You can look up our outcomes publicly on Care Compare. We consistently perform above many regional programs.”

### Show, don't tell

Pull the data up on your phone or iPad at the bedside so the family sees the source themselves.

### Name the sources

Centers for Medicare & Medicaid Services, the Commission on Accreditation of Rehabilitation Facilities and Burke Rehabilitation.

## Part 5: Close Without Pressure — the Ethical Close



— Invite the decision, respect the timeline and stay present until admission

### Closes to avoid

“So can I put you down for Burke?” and “We need a decision” turn a clinical conversation into a transaction.

### The honored close

“If inpatient rehab is recommended, we would be honored to be part of your recovery.”

### The comfort check

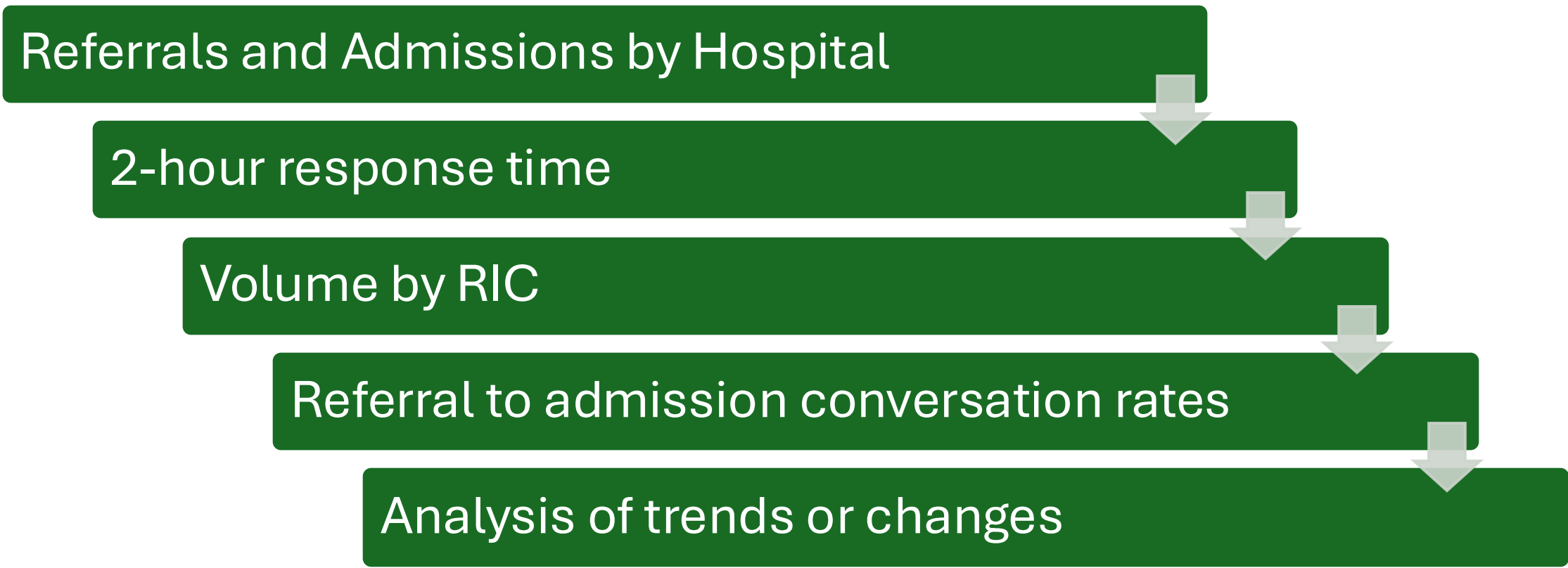
“Would you feel comfortable choosing Burke if everything lines up medically and with insurance?”

### Stay with them

For patients awaiting authorization or not yet ready, keep visiting to reinforce that they made a good choice.

# Referral Metrics

Referrals and Admissions by Hospital



```
graph TD; A[Referrals and Admissions by Hospital] --> B[2-hour response time]; B --> C[Volume by RIC]; C --> D[Referral to admission conversation rates]; D --> E[Analysis of trends or changes];
```

2-hour response time

Volume by RIC

Referral to admission conversation rates

Analysis of trends or changes

# Referral Metrics

Facility Rehabilitation Growth Metrics and Targets- 2026

|                                          |                  | Goal | Jan   | Feb   | Mar   | Q1 2026 | Apr   | May   | Jun   | Q2 2026 | Jul   | Aug    | Sep | Q3 2026 | Oct | Nov | Dec | Q4 2026 | 2026 Annual |
|------------------------------------------|------------------|------|-------|-------|-------|---------|-------|-------|-------|---------|-------|--------|-----|---------|-----|-----|-----|---------|-------------|
| Admission from Key Referring Hospital    | Hospital A       | 50   | ✗ 47  | ✗ 47  | ✓ 60  | 154     | ✗ 48  | ✓ 55  | ✓ 54  | 157     | ✓ 56  | ✓ 52   |     |         |     |     |     |         | 419         |
|                                          | Hospital B       | 40   | ✓ 67  | ✓ 42  | ✓ 54  | 163     | ✓ 53  | ✓ 50  | ✓ 56  | 159     | ✓ 51  | ✗ 35.0 |     |         |     |     |     |         | 408         |
|                                          | Hospital C       | 15   | ✓ 19  | ✓ 17  | ✓ 20  | 56      | ✗ 14  | ✓ 21  | ✓ 20  | 55      | ✓ 15  | ✓ 22.0 |     |         |     |     |     |         | 148         |
|                                          | Hospital D       | 6    | ✓ 18  | ✓ 11  | ✓ 6   | 35      | ✓ 8   | ✗ 5   | ✓ 6   | 19      | ✓ 7   | ✗ 4.0  |     |         |     |     |     |         | 65          |
|                                          | Hospital E       | 10   | ✗ 8   | ✗ 5   | ✗ 5   | 18      | ✗ 7   | ✗ 9   | ✗ 7   | 23      | ✗ 8   | ✗ 8.0  |     |         |     |     |     |         | 57          |
|                                          | Hospital F (new) | 4    | ✗ 1   | ✗ 0   | ✗ 1   | 2       | ✓ 4   | ✓ 4   | ✗ 3   | 11      | ✗ 3   | ✓ 4.0  |     |         |     |     |     |         | 20          |
| Decision Time (<2hrs)                    | All Hospitals    | 70%  | ✗ 62% | ✗ 60% | ✗ 62% | 62%     | ✗ 66% | ✗ 67% | ✗ 64% | 66%     | ✗ 67% | ✗ 68%  |     |         |     |     |     |         |             |
| Discharges                               | Actual           | 2178 | ✓ 280 | ✗ 263 | ✗ 273 | 816     | ✓ 282 | ✗ 267 | ✗ 270 | 819     | ✓ 281 | ✗ 262  |     |         |     |     |     |         | 2178        |
|                                          | Goal             | 3360 | 280   | 280   | 280   | 280     | 280   | 280   | 280   | 280     | 280   | 280    | 280 | 840     | 285 | 280 | 295 | 860     | 3380        |
| Non-Traumatic Brain Injury Volume*       | FACILITY         | 18   | ✓ 21  | ✓ 25  | ✓ 26  | 72      | ✓ 23  | ✓ 20  | ✓ 14  | 57      | ✓ 14  | ✓ 16   |     |         |     |     |     |         | 159         |
| Traumatic Brain Volume                   | FACILITY         | 10   | ✓ 14  | ✗ 9   | ✗ 9   | 32      | ✗ 7   | ✓ 10  | ✓ 10  | 27      | ✗ 8   | ✓ 16   |     |         |     |     |     |         | 83          |
| Non-Traumatic Spinal Cord Injury Volume* | FACILITY         | 16   | ✓ 17  | ✗ 13  | ✓ 21  | 51      | ✓ 26  | ✗ 15  | ✓ 24  | 65      | ✓ 21  | ✓ 24.0 |     |         |     |     |     |         | 161         |
| Traumatic Spinal Cord Injury Volume      | FACILITY         | 5    | ✗ 3   | ✗ 4   | ✗ 3   | 10      | ✗ 3   | ✗ 3   | ✗ 3   | 9       | ✗ 2   | ✓ 6    |     |         |     |     |     |         | 27          |
| Stroke Volume                            | FACILITY         | 74   | ✗ 70  | ✗ 66  | ✗ 68  | 204     | ✓ 77  | ✓ 77  | ✓ 81  | 235     | ✓ 87  | ✗ 60   |     |         |     |     |     |         | 586         |
| Neurological Conditions Volume*          | FACILITY         | 26   | ✗ 19  | ✓ 30  | ✓ 26  | 75      | ✗ 24  | ✗ 24  | ✓ 27  | 75      | ✓ 28  | ✗ 22   |     |         |     |     |     |         | 200         |
| Hemodialysis                             | FACILITY         | 8    | ✓ 10  | ✓ 9   | ✓ 9   | 28      | ✓ 10  | ✗ 7   | ✗ 5   | 22      | ✓ 8   | ✗ 6    |     |         |     |     |     |         | 64          |

## 2025 vs 2026 Where are the volume changes?

Through August, total discharges declined 4.3% year over year, primarily due to lower Orthopedic volume, partially offset by growth in Brain Injury, General Rehab, Pulmonary, and Spinal Cord. Compared to budget we are 142 patients below budget.

| Diagnostic Cat.     | 2025         | 2026         | Change      | % Change    |
|---------------------|--------------|--------------|-------------|-------------|
| <b>Total</b>        | <b>2,270</b> | <b>2,173</b> | <b>-97</b>  | <b>-4%</b>  |
| General Rehab       | 106          | 135          | 29          | 27%         |
| Pulmonary           | 85           | 107          | 22          | 26%         |
| Spinal Cord         | 172          | 191          | 19          | 11%         |
| Brain Injury        | 242          | 268          | 26          | 11%         |
| Cardiac             | 137          | 145          | 8           | 6%          |
| <b>Stroke</b>       | <b>614</b>   | <b>586</b>   | <b>-28</b>  | <b>-5%</b>  |
| <b>Neurological</b> | <b>223</b>   | <b>210</b>   | <b>-13</b>  | <b>-6%</b>  |
| <b>Orthopedic</b>   | <b>691</b>   | <b>531</b>   | <b>-160</b> | <b>-23%</b> |

# Referral Performance — Key Declines & Top Improvers

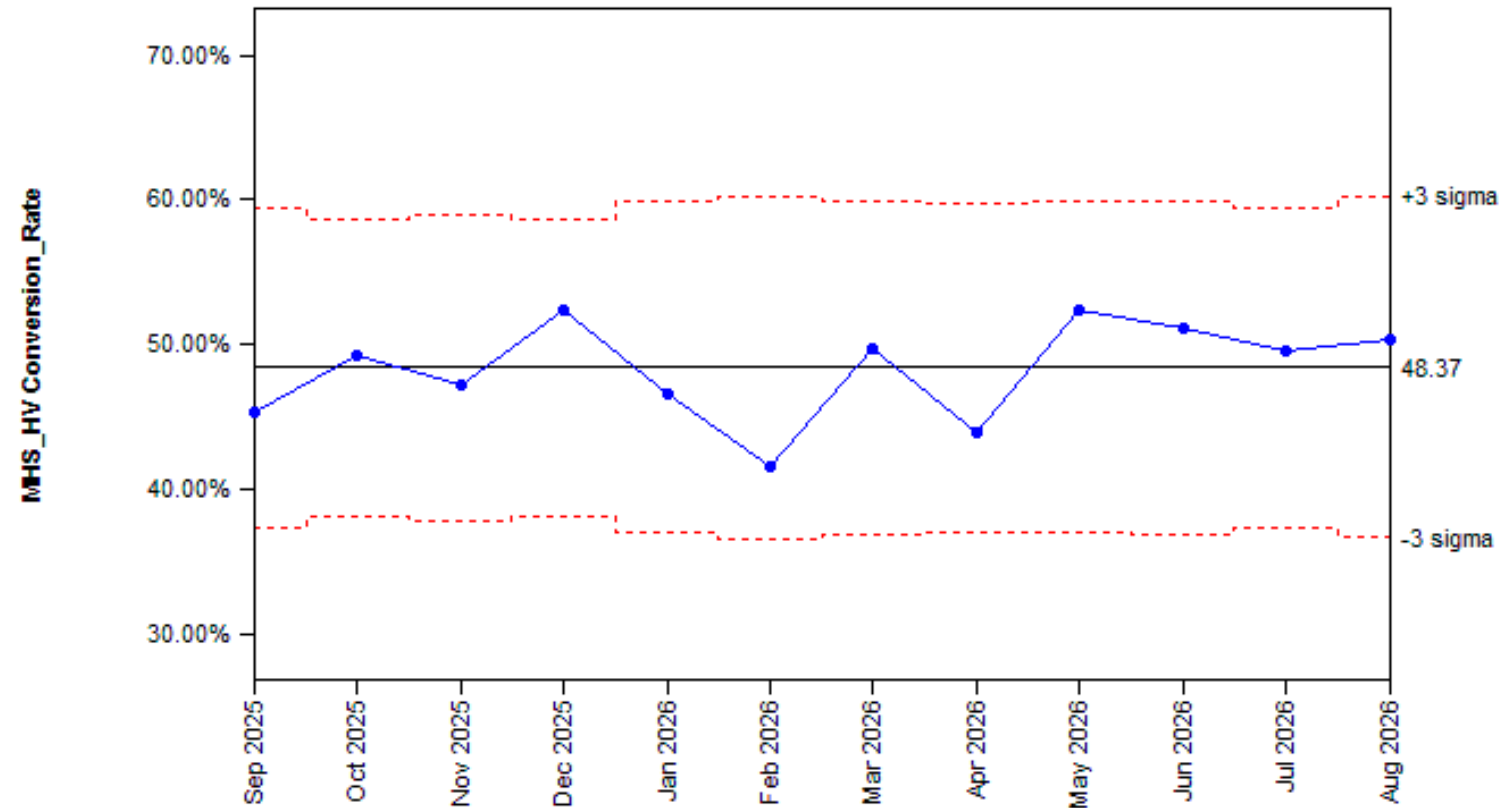
Jan–Aug 2026 vs. Jan–Aug 2025

| Referral Source  | Total Change | Diagnosis        | 2025 | 2026 | Diag. Change | Key Message                             |
|------------------|--------------|------------------|------|------|--------------|-----------------------------------------|
| Acute Hospital A | -187         | Orthopedic       | 196  | 77   | -119         | Largest loss- TEAMS Medicare – New True |
|                  |              | Stroke           | 161  | 131  | -30          |                                         |
|                  |              | Neuro – Other    | 63   | 36   | -27          |                                         |
|                  |              | General Rehab    | 36   | 26   | -10          |                                         |
|                  |              | SCI              | 35   | 27   | -8           |                                         |
|                  |              | Cardiac          | 30   | 27   | -3           |                                         |
| Acute Hospital B | -48          | Stroke           | 44   | 28   | -16          | Stroke leads decline                    |
|                  |              | Neuro – Other    | 16   | 4    | -12          |                                         |
|                  |              | Orthopedic       | 73   | 62   | -11          |                                         |
| Acute Hospital C | -38          | Stroke           | 28   | 7    | -21          | Stroke leads decline                    |
|                  |              | Orthopedic       | 28   | 13   | -15          |                                         |
|                  |              | Neuro – Other    | 7    | 4    | -3           |                                         |
| Acute Hospital D | +94          | Total Discharges | 299  | 393  | +94          | Top absolute improver                   |
| Acute Hospital C | +28          | Total Discharges | 35   | 63   | +28          | Top % improver (+80%)                   |

# Referral to Admission Conversion Rates

P Chart 3-Sigma

**Hospital A Conversion Rate**  
Referring Location = ALL

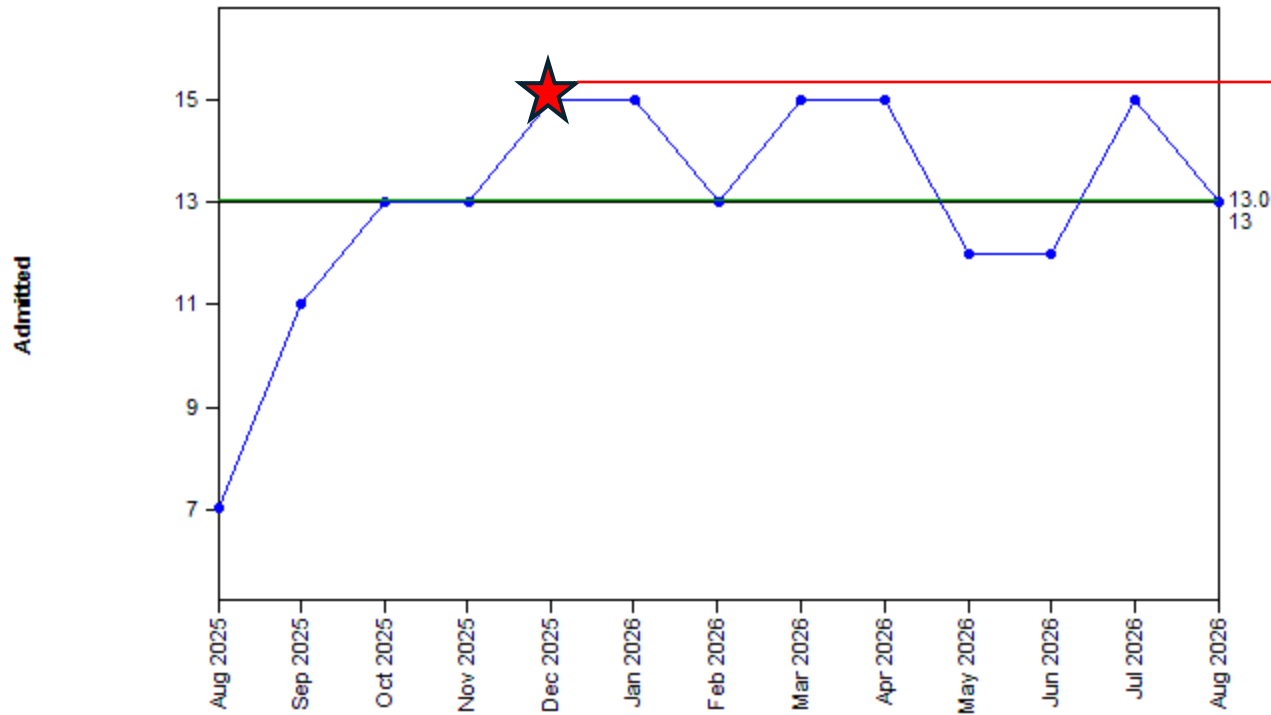


Sep 18, 2026 13:52:50

# Establish Referring Facility benchmarks

**BRH-SV-XLC-M-Admission by Hospital A**  
Payer = ALL

Run Chart

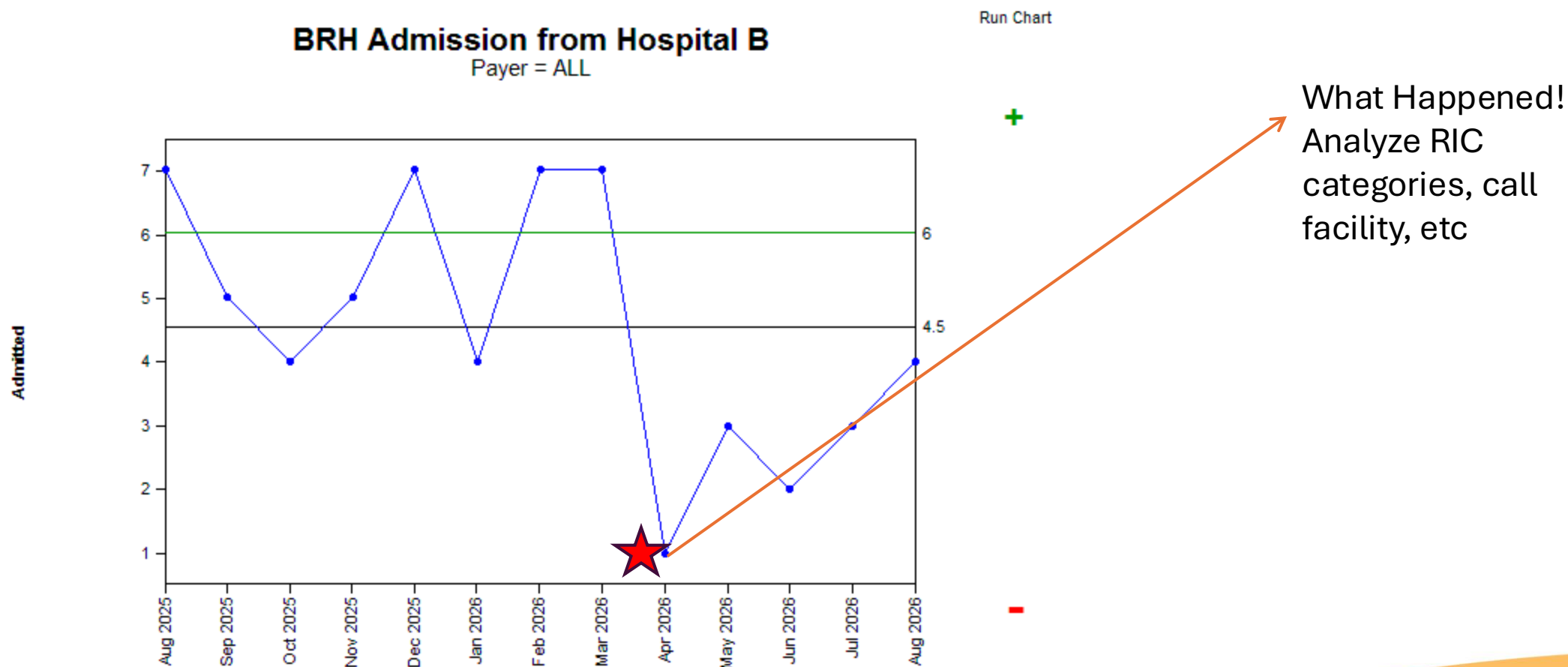


Added an Onsite Clinical Liaison

Sep 18, 2026 13:56:14

# WHAT HAPPENED!

Analyze trends and determine reason and action plans:



## In Summary:

- An effective IRF referral management process blends **clinical eligibility criteria, administrative verification, interdisciplinary coordination, and quality oversight**. This ensures referrals are timely, medically necessary, and aligned with both patient needs and regulatory requirements

## Referral Development

Fast decisions. Defensible admissions. Trusted relationships.

**Questions**