A STUDY TO DEVELOP RECOMMENDATIONS FOR IMPROVING THE SOCIAL SERVICE AT EARL K. LONG MEMORIAL HOSPITAL, BATON ROUGE, LOUISIANA

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CHAPTER I

INTRODUCTION

The State Hospital System

At the time this study was conducted, the Louisiana State Department of Hospitals was operating six, short term, general hospitals to provide health care for families and individuals classified as medical indigents (see Appendices A and B). In addition, the department had contractual arrangements with eighteen private hospitals for the provision of indigent medical care in areas not served by the state-owned charity hospital system. The director of the Department of Hospitals was an appointed official, reporting directly to the governor. Hospitals in the system were administered by appointed superintendents who reported to the department director.

It was significant to note that the state also owned two other general, charity hospitals which operated as independent agencies outside the Department of Hospitals. One of these, Confederate Memorial Hospital, a 730-bed facility at Shreveport, was examined in a brief comparative analysis to help illustrate the overall

problems of Earl K. Long Memorial Hospital, Baton Rouge, Louisiana, the location of this study. The other state-owned hospital operating outside the Department of Hospitals was Charity Hospital of Louisiana, a 2123-bed facility located in New Orleans.

The six hospitals delivering care in the state department of hospitals system were: Earl K. Long Memorial Hospital, a 215-bed facility at Baton Rouge; E. A. Conway Memorial Hospital, a 150-bed facility at Monroe; Huey P. Long Charity Hospital, a 212-bed facility at Pineville; Southwest Louisiana Charity Hospital, a 222-bed facility at Lafayette; Lallie Kemp Charity Hospital, a 132-bed facility at Independence; and Washington Saint Tammany Charity Hospital, a 70-bed facility at Bogalusa (see Appendix B). Including the two state-owned hospitals, which operated as independent agencies, there were 3854 general hospital beds and 392 bassinets in service to provide care for the indigent population of Louisiana.[1]

A Hospital in the System

Earl K. Long Memorial Hospital, a teaching hospital associated with Louisiana State University Medical School, was charged with providing care for an estimated 120,000 indigents residing in an eight parish area (see Appendix C). Since admission of its first patients in March 1968, the hospital's growth to a

design capacity of 250 beds had been hampered by a lack of state appropriated funds. However, it was anticipated that all 250 beds would be in service by June 1972.[2]

In 1969, the United States Public Health Service advocated six hospital beds per 1,000 of the population being served.[3] Based on this ratio and a service population of 120,000, Earl K. Long Memorial Hospital needed 720 beds. The hospital's service population was estimated from the known number of welfare recipients and family income statistics within the eight-parish service area. Hospital staff personnel derived the estimate for an official report required by the East Baton Rouge Grand Jury.[4]

Bed to service population ratios cannot be accepted as absolute measures of hospital need, however.[5] In addition to the size of the service population, socio-economic and environmental factors related to the composition of the population must be considered. A service population residing in an environment hostile to the maintenance of good health can be expected to produce a greater demand for hospital services than a population of equal size residing in a healthier area provided that all other factors are held equal. Population attitudes toward health care and demands for hospital services also differ because of

differences in culture and standards of living.[6]

Available data which considered population variables indicated the need for more than twice as many beds at the Earl K. Long Memorial Hospital. The research performed for the East Baton Rouge Grand Jury revealed that the indigent population served by Earl K. Long Memorial Hospital was similar in size, composition, and per capita income to the indigent population served by Confederate Memorial Hospital.[7] Because their service populations were comparable, workload experience at the larger hospital could be used as an indicator of the expansion needs of Earl K. Long Memorial Hospital. Bed and bassinet utilization statistics for the two hospitals are presented in the table below.

TABLE 1

BED DATA FOR FISCAL YEAR ENDING JUNE 30, 1970[8]

	Earl K. Long	Confederate Memorial
Accredited Beds	250	730
Accredited Bassinets	44	59
Beds in Service	177	730
Bassinets in Service	22	59
Avg. Daily Census, Beds	147	405.1
Avg. Daily Census, Bassinets	22	25.8

According to McGibony, bed occupancy beyond 80 to 85 per cent usually does not allow sufficient flexibility for emergencies and patient separation according to sex, diagnosis, and other factors in non-Federal

short-term general hospitals.[9] With an average daily census of 147 and only 177 beds in service, Earl K. Long Memorial Hospital experienced an 83 per cent bed occupancy rate for the fiscal year ending June 30, 1970. Using McGibony's criterion, this occupancy rate approached the upper limit of acceptability. This led the author to the conclusion that the Earl K. Long Memorial Hospital operated at near capacity patient loads for the 177 beds in service during the year.

Accepting the existence of a close similarity between the service populations of Earl K. Long Memorial Hospital and Confederate Memorial Hospital, it was also reasoned that patient workloads would be similar if sufficient beds were available at the smaller hospital. To provide care for an average daily census of 405 patients while maintaining an 83 per cent occupancy rate, Earl K. Long Memorial Hospital would have needed 488 beds in service.

The Social Service Department

In September 1970, a social service department was established at Earl K. Long Memorial Hospital as an additional professional element of the health care team. The new department was charged with the responsibility of helping health team members, patients, and the families of patients understand and appropriately respond to the social economic, and emotional factors

bearing on the patient's illness, treatment, and rehabilitation. Activity to meet this responsibility was to be based upon a specific body of social work knowledge regarding personality development, family dynamics, interpersonal relationships, general social problems, community organization, and community resources.[10]

Community involvement in the delivery of health care was identified as a special and important concern of the new department. To achieve greater community participation in providing health care, three departmental functions relating to the community, and community resources were defined. The department would coordinate with existing public and private community social work agencies to help families and patients resolve problems precipitated by illness. A major social service responsibility in regard to this function was to provide the Department of Public Welfare with medical information upon which to base the certification of patients for public assistance. The social service department would also play an active role in identifying community needs and promoting the development of community resources for improved health care. Finally, the department would seek methods of increasing the community's awareness of its responsibilities in the health care area. This was described as, "bringing the community into the hospital, thus sharing responsibility

for the delivery of health services."[11]

Factors Prompting the Study

The improper utilization of beds causes maximum adverse effects on health care delivery in hospitals which have too few beds to adequately care for their service populations. When patients who no longer require hospitalization continue to occupy hospital beds, for whatever reason, the effect is a reduction in the amount of needed inpatient care which can be provided to the service population. The shortage of beds at Earl K. Long Memorial Hospital discussed on pages four and five, made proper bed utilization a matter of great importance to the medical staff.[12]

Making the best possible use of beds was a particularly difficult and complex problem for the hospital because its normal inpatient census was composed entirely of people who were medical indigents as defined in Appendix A. Except for medical emergencies, only patients identified as indigents prior to admission were eligible for care. Indigent patients were often financially unable to provide for their health maintenance needs after discharge from the hospital. In such cases, they were frequently continued as inpatients until arrangements for assistance could be made with agencies outside the hospital.[13]

The discharge of certain patients without some

form of outside assistance can lead to early readmission for the same or a worse condition. Some conditions, once brought under control, can continue to be controlled with medications, self-administered, outside the hospital. Without maintenance medication, however, these same conditions can deteriorate rapidly and again require hospitalization for control.[14]

Frequently outpatients at Earl K. Long Memorial Hospital required assistance from outside agencies also. The needs of these patients were no less a concern to the hospital and the social service department than the needs of inpatients.[15] Complete health care for the community it served, a stated goal of the hospital, encompassed preventive as well as rehabilitative services. For many outpatients, complete health care meant some form of financial or other assistance to prevent almost certain future admission to hospital bed status.[16]

According to the social service director, the largest single outside provider of assistance to Earl K. Long Memorial Hospital patients was the Louisiana Department of Public Welfare. Through its state and parish offices, the department provided such benefits as maintenance medications, nursing home care, homemaker services, and general financial assistance. Patients awaiting certification of eligibility for new or additional public welfare benefits accounted for

most of those remaining in the hospital after discharge was medically indicated.[17]

Since only about 40,000 of the population being served by the hospital were currently on welfare rolls, many patients requested public assistance for the first time because of temporary or permanent disabilities connected with their illness.[18] More timely certification of the eligibility of patients for new or additional benefits would have permitted the hospital to reduce the length of hospitalization of some patients and prevent or forestall admission to bed status for others. Better bed utilization and inpatient hospital service for more patients would have resulted.[19]

Statement of the Problem

The purpose of this study was to develop recommendations for improving the social service at Earl K. Long Memorial Hospital with primary emphasis on achieving a more timely certification of eligibility for patients who needed Department of Public Welfare assistance.

Definitions

A definition of terms as they apply in this study may be found in Appendix D.

Factors Limiting Research

1. Information on social service activities at

Earl K. Long Memorial Hospital prior to September 1970 was limited since there was no formal program and files were not maintained.

2. Existing social service files were not adequate to determine which patients had to be retained in the hospital after discharge was medically indicated.

3. Records were not available on the number or specific types of requests for medical information received by the hospital records room from the Department of Public Welfare. Duplicates of the welfare form used for these requests were being returned and only patient authorizations for the release of information were being filed in individual medical records containing both inpatient and outpatient files. This restricted research in the problem area pertaining to certification of outpatients for public welfare benefits. There was no way to determine whether a particular request was for the purpose of initially establishing eligibility for a certain benefit or simply to determine if eligibility for some other benefit should be continued. It was not practical, in the absence of meaningful data, to estimate the magnitude of the problem under study in relation to outpatient care.

4. Recommendations resulting from this study had to be limited to actions which could be taken with existing financial and personnel resources at Earl K.

Long Memorial Hospital. State ownership of the hospital resulted in external control of the sources and uses of resources to a large degree. According to Ruth Lecher, hospital director of personnel, the need for additional social service staff had been recognized and two additional positions had been requested from state officials. Decisions on the number and skill level of positions to be filled were made outside the hospital.[20]

Research Methodology

There were no formal records made of social service activity prior to establishment of the department in September 1970. Responsibility for treating the social aspects of illness was assumed by physicians, nurses, and other hospital personnel on a more or less voluntary, individual basis when a need became recognized.[21] This made it necessary to rely heavily upon interviews with department heads and other hospital personnel involved in duties relating to the problem.

In some instances when formal records were available, they were found to be inadequate for use in a problem solving situation. Such was the case with records relating to the release of information to the Department of Welfare which was discussed earlier. Again, reliance had to be placed on interviews for information relating to the problem. All interviews were conducted during visits to the hospital February

15 - 19 and March 14 - 28, 1971. Interviews were used to gather historical data; to obtain estimates of the magnitude of the problem; to determine day-to-day procedures and priorities; and to identify problem causes and contributing factors.

Workload data at the hospital was drawn from a documentary source in each instance. Also, formal organizational structures, and policy and correspondence files were reviewed as sources of information and to gain familiarity with the hospital and its operation. The review of these files was beneficial in providing a proper framework for recommendations resulting from the study. As a practical matter, the author considered it important to know what formal and accepted lines of authority and what interdepartmental relationships would be affected by each recommendation considered for proposal.

A questionnaire (see Appendix E) was sent to each of the other state-owned, general, charity hospitals in Louisiana to determine if the stated problem, and possibly a solution for it, existed elsewhere in the state hospital system. It was expected that information obtained from other hospitals in the same system would provide a basis for solution to the stated problem at Earl K. Long Memorial Hospital. It was hypothesized that inadequate staffing was a major contributing

factor to this problem and the questionnaire sought information for comparison of the study hospital's social service staffing to that of other state-owned hospitals. Staffing to service population ratios could provide a basis for rejecting this belief, given the existence of three other conditions which would also have to be established. First, a close similarity between service populations would have to exist. Second, social services of the hospital being compared would have to be judged adequate. Third, the comparison hospital would have to have a staffing ratio equal to or less than that of Earl K. Long Memorial Hospital. If staffing was not rejected as a major factor, there would be stronger reason for its acceptance.

A selective review of the literature was undertaken to define current trends and philosophies in medical social work. An overview was needed to gain knowledge of the commonly accepted roles and general problems of social work in a medical setting. Innovative techniques developed to cope with these problems might also have direct application or suggest methods to help resolve the problem under study.

Literature Review

Emerging concepts of comprehensive health care have placed demands on hospitals for strengthening and expanding patient services and for better utilization

of available beds. Social service departments help hospitals realize these goals by contributing to the health care team their own special knowledge and understanding of the interrelationships of medical, social, emotional, and economic factors in illness.[22] Unlike the physician, who is trained to consider the patient in terms of his disease, the social worker sees the patient as a member of a family and social group and recognizes his anxieties about the effects of illness on his life style. Going beyond this, the social worker is concerned with the impact the patient's illness may have on his family group. Until the patient and family are understood and accepted in terms of social, economical, and emotional variables, the patient cannot be helped to cope with his medical situation.[23]

Social service departments, through their contacts with public and private social agencies outside the hospital, are effective in promoting community involvement in health care delivery. This aspect of social work greatly expands and strengthens the patient services offered by a hospital.[24] Improved bed utilization, attributed to social service departments, is often the result of an effective system of discharge planning. Discharge planning may be defined as planning for the movement of the patient from the hospital to an outside unit of the hospital, another health care program, or

to the patient's home. It encompasses the development of community resources to provide those services required by patients after discharge.[25]

Considering the benefits to be derived from the social service department, it would seem logical to assume that great emphasis would be placed on such departments within all hospitals able to support them. "A social service department functioning as an integral part of the medical care program provides a major advantage for a hospital of any size in its service to patients."[26] The fact is that the value of the trained social worker in a medical setting is not universally recognized. Physicians do not all understand exactly what a social service department can do for them and their patients.[27] A further obstacle to the effective utilization of social service departments is the failure of some physicians to recognize social workers as fellow professionals working toward a common goal. Social workers are placed in a "perpetually defensive position" by this lack of recognition and must continually strive to demonstrate their value to the medical profession and the hospital.[28]

Before medical social work became a profession in its own right, volunteers performed many of the social work functions that were not performed by physicians. Today, volunteer and social service programs are

separate, distinctly different, and complex hospital functions. However, volunteers still contribute greatly to the social service department, in many cases working directly with patients. They perform an infinite variety of tasks which must be identified by the volunteer coordinator and director of social services.[29] In performing these tasks under the supervision of the social worker, the volunteer extends the professional's area of usefulness and in some instances makes her own unique contribution. Volunteer services in certain situations are more appropriate than the services of the social worker.[30]

There are two essential elements to the successful collaboration of the volunteer and the professional medical social worker. The volunteer must derive satisfaction from the service she performs and the social worker must have confidence that this service is effectively performed in the best interest of the patient. Achievement of mutual satisfaction for the volunteer and the professional depends upon careful selection of volunteers; thorough orientation of volunteers and staff; matching volunteers with specific social service assignments; and the provision of ongoing supervision by the professional social worker. When volunteers are used to assist with social service functions, the department of social service must assume responsibility for

orientation and guidance. Volunteers, on the other hand, must be willing to accept their accountability to the department.[31]

Levels of performance will differ according to the skills which volunteers bring to the social service department. Volunteers usually provide supportive services such as becoming friendly visitors to elderly patients, giving attention to lonely or neglected children, or providing transportation. In some cases, however, the volunteer has the aptitude and experience to handle much more complex assignments. Inservice training for those capable of accomplishing more difficult and sensitive tasks becomes an additional social service responsibility.[32]

Benefits of Literature Review

The role, responsibilities, and problems of the medical social work profession were more clearly defined for the author from his review of the literature. From the literature, the role of the social worker was synthesized as the detection, diagnosis, treatment, and prevention of the sociological aspects of illness in patients, their families, and the community.

Responsibility of the profession was perceived as being divided and directed toward patients, families, the community, and the hospitals. In addition to individual responsibility to each of these groups, an overall

responsibility to society was conceptualized. The medical social work profession was seen as having the duty to promote hospital and community health care goal alignment toward a comprehensive delivery system which recognizes the right of all individuals to adequate health services. Knowledge of social needs, and hospital and community resources to meet those needs, was believed to uniquely equip the profession for this responsibility.

Discussions in the literature of two problem areas provided insights and possible partial solutions to the problem under study. These discussions concerned themselves with problems of social service acceptance and utilization by the hospital staff, and methods of expanding social service coverage through the use of volunteer workers. References to these discussions are found on pages fifteen and sixteen.

Footnotes

[1]Louisiana Department of Hospitals, Statistical Summary - Fiscal Year 1970 (Baton Rouge, La.: State Printing Office, 1970), p. xiii.

[2]Earl K. Long Memorial Hospital, General Information Fact Sheet, Baton Rouge, La.: n.d. (Mimeographed).

[3]Robert L. Allen, Earl K. Long Memorial Hospital Report to East Baton Rouge Grand Jury, July 22, 1970 (Baton Rouge, La.: Office of Hospital Superintendent, 1970), p. 24.

[4]William A. Colvin, III, interview with hospital superintendent during research visit to hospital, March, 1971.

[5]John R. McGibony, Principles of Hospital Administration, (2nd ed., New York: G. P. Putnam's Sons, 1969), p. 36.

[6]Ibid. pp. 29-32.

[7]Allen, Report to Grand Jury, p. 25.

[8]Ibid.

[9]McGibony, Principles, p. 181.

[10]Earl K. Long Memorial Hospital, "Department of Social Service Statement of Objectives," Baton Rouge, La.: n.d. (Typewritten).

[11]Ibid.

[12]G. Tipton McKnight, interview with medical director during research visit to hospital, March, 1971.

[13]Dorothy M. Tiedeman, interview with social service director during research visit to hospital, March, 1971.

[14]McKnight, interview, March, 1971.

[15]Tiedeman, interview, March, 1971.

[16]McKnight, interview, March, 1971.

[17]Ibid.

[18]Agnes Drehr, interview with Department of Public Welfare regional representative, Baton Rouge, La., February, 1971.

[19]McKnight, interview, March, 1971.

[20]Ruth Lecher, interview with director of personnel during research visit to hospital, March, 1971.

[21]McKnight, interview, March, 1971.

[22]American Hospital Association, Essentials of a Social Service Department in Hospitals and Related Institutions (Chicago: American Hospital Association, 1961), pp. 2-3.

[23]Harriet M. Bartlett, Social Work Practice in the Health Field (New York: National Association of Social Workers, 1961), pp. 79-88.

[24]Walter W. Walker, "Social Services: Annual Administrative Review," Hospitals, XXXVIII (April 1, 1964), 160.

[25]Alice M. Gonnerman, "After Hospitalization, What? Discharge Planning Offers Answers," Hospitals, XLIII (April 16, 1969), 81.

[26]American Hospital Association, Essentials of Social Service, p. 1.

[27]August H. Groeschel, "Medical Social Service," Hospital Progress, XLI (September, 1961), 81-82.

[28]Katherine M. and Marvin E. Olsen, "Role Expectations and Perceptions for Social Workers in Medical Settings," Social Work, XII (July, 1967), 70-71.

[29]Margaret Gaughan Brock, Social Work in the Hospital Organization (Canada: University of Toronto Press, 1969), p. 60.

[30]American Hospital Association, Guidelines for the Use of Volunteers in Departments of Social Work in Hospitals (Chicago: American Hospital Association, 1963), p. 1.

[31]Ibid., p. 2.

[32]American Hospital Association, Essentials of Social Work Programs in Hospitals (Chicago: American Hospital Association, 1971), p. 24.

CHAPTER II

DISCUSSION

General Information

Four hospital functions were selected for investigation in the problem solving effort. Three of these, the social service department, the medical records department, and the professional staff, were identified through interviews during the first hospital visit as having direct involvement in activities bearing on the problem.[1] The social service and medical records departments were responsible for providing information to the Department of Public Welfare for the purpose of determining patient eligibility for benefits. The professional staff identified and referred to the social service department those patients with needs for welfare department assistance. The fourth function selected for investigation, volunteer services, was identified in the literature as a means of expanding social service capability.[2]

Results of Questionnaire

In order to learn more about the nature and magnitude of the problem under study, a questionnaire

(see Appendix E) was sent to each of the other seven state-owned general hospitals in Louisiana. (Six answered.) Purpose of the questionnaire was twofold. First, it was desired to establish a basis for comparing the Earl K. Long Memorial Hospital Social Service Department to others in the state hospital system. The second purpose was to determine if bed utilization problems existed elsewhere in the state because of failures to obtain patient certification for public assistance on a timely basis. To achieve this purpose, the questionnaire asked when hospitalized patients were identified as needing new or additional public assistance. Identification of such patients after they became physically well enough for discharge was indicative of a utilization problem.

Initially, the first objective was only partially met. Responding hospitals described their service populations only in terms of the number of parishes served. An attempt by telephone to obtain an estimate of service populations from the hospitals was also fruitless and a request for the desired information was sent to the Statistical Section, Louisiana State Department of Hospitals. The Statistical Section provided the following estimate of service populations for the six general hospitals operating under the state department of hospitals.

TABLE 2

HOSPITAL SERVICE POPULATIONS[3]

Hospital	Population Served
Lallie Kemp Charity Hospital	28,650
Washington St. Tammany Charity Hospital	29,560
Huey P. Long Charity Hospital	86,268
E. A. Conway Memorial Hospital	90,116
Earl K. Long Memorial Hospital	125,312
Southwest Louisiana Charity Hospital	130,982

The sizes of service populations were not an adequate measure for social service staffing or staffing comparisons for the same reasons that population sizes were a poor measure of bed needs. Other variables within the populations had to be considered (see pages 3 and 4). The effects of some of these variables were eliminated, however, by the fact that the service populations listed above were all composed of individuals who could be described as medically indigent by an established and precise set of standards (see Appendix A). These populations were also drawn from adjoining geographical areas within the State of Louisiana.

Considering the population similarities mentioned in the paragraph above, the author concluded that the social service staff to service population ratio was improved as a measure for making comparisons. To further increase the validity of comparisons of the

Earl K. Long Memorial Hospital social service staffing to that of other hospitals in the same system, additional statistics considered relative to social service workloads were examined. The size of various social service staffs, obtained with the questionnaire, were considered in conjunction with the number of patients admitted to the respective hospitals and with the number of outpatient visits to the same hospitals.

Admission and outpatient statistics were obtained from the Louisiana State Department of Hospitals statistical report for Fiscal Year 1971 (See Appendix F). Based on the sample, the social service staff to annual admissions ratio was 1:2132. At Earl K. Long Memorial Hospital this ratio was 1:3842. To bring the study hospital social service staffing up to the staffing level of the sample would require the addition of two more people. Sample social service staffing to annual outpatient visit ratio was 1:20,910. This ratio at Earl K. Long Memorial Hospital was 1:66,816, indicating a requirement of one additional staff member to meet the sample staffing level.

Based on questionnaire information concerning social service staffing and service population estimates provided by the department of hospitals, the social service staff to service population ratio was approximately 1:23,000 for state-owned general hospitals

in Louisiana. The two-member social service staff at Earl K. Long Memorial Hospital would have to be increased by three members to achieve the same ratio.

None of the above ratios were thought to be absolute measures of social service staffing needs at the study hospital, but considered in aggregate as indicators, they influenced the author to conclude that additional staff was needed to achieve balance with other similar hospitals in the state. According to the literature, no exact formula exists for determining what size a social service staff should be.[4] By observation and from interview, it was found that the social service staff at Earl K. Long Memorial Hospital was too small to accomplish the hospital social service mission described in Chapter I. The social service chief stated that her department had to be limited almost entirely to the treatment of social crises because of insufficient staff to perform at a more comprehensive level.[5]

Of the six hospitals responding to the questionnaire, only two stated that their social service staffs were adequate. One of these was the only hospital which was identifying and referring to social service at the time of admission those patients who would need new or additional public assistance because of their illness. This hospital also indicated that referrals to social service were accepted from any source.

All three considerations, referrals upon admission, referrals from any source, and adequate staff, were perceived as being closely related to the stated problem. Referral upon admission allows the social service staff maximum time to determine and make arrangements for patient needs after discharge. For certain diagnoses physicians know that special patient needs will exist after discharge.[6] When patients with these conditions are referred upon admission, the result is shorter hospital stays with adequate provision for supportive care after discharge.[7]

By accepting referrals from any source, a social service staff increases the probability of earlier referrals. Patients manifest their problems in various ways and at various times. Any member of the health care team, or perhaps some family member or friend, may become the first to know that a problem is present.[8] Earlier referrals will allow earlier social service processing and consequently more time for Department of Welfare certification for public assistance on a timely basis.

Without an adequate staff to carry out social service responsibilities, the matter of when patients are referred loses some of its significance. As pointed out earlier, there is no formula for determining adequate size for a social service staff. However, "there

should be enough professional social workers, associates, technicians, and other staff members to meet the service needs of inpatients and outpatients, to serve on pertinent hospital committees, and to participate in education and community programs."[9]

Three of the six hospitals responding to the questionnaire indicated that patients requiring new or additional public assistance were frequently not being referred to social service until the time of discharge. From these responses, it was concluded that solutions to the stated problem would have value at locations other than Earl K. Long Memorial Hospital provided that their late referrals were arising from similar causes.

Social Service Department

Referral procedures

A single referral form, designed by the social service department (see Appendix G), served as a primary means for identifying both inpatients and outpatients requiring new or additional public assistance. The locally designed form, printed on five by eight inch cards, was used for several purposes other than identification. It provided a record of social service actions taken, and after case closure, became part of a permanent alphabetical file used for reference and statistical purposes. This file was viewed by the chief of the social service department as serving

several useful functions. It would provide a future means of analyzing workload data in terms of the social service staff and those community resources providing patient services and benefits. Since patients requiring social services were likely to require services again with any future admission, the file would serve as a timesaving reference source for the social worker.[10]

At the same time the referral form was proposed for adoption on September 18, 1970, the social service department issued a policy restricting referral privileges to physicians, nursing supervisors and head nurses. This action was taken to achieve the best possible utilization of limited hospital social service capability. The referral restriction policy was reiterated in November 1970,[11] and had not been formally changed at the time of the second research visit to the hospital.[12] The opinion of the director of social services was that unlimited referrals would so overload the small, newly organized department that less work would be done for patients.[13] The logic behind the restrictive policy was not questioned by the author, but as established earlier in this chapter, a limited referral system eliminates some sources of early referral to the social service department.

The loss of bed days

Unfortunately, some patients who could not

maintain themselves outside the hospital without new or additional public assistance were not being identified and referred to social service until discharge was medically indicated.[14] This created a "health care dilemma" for the hospital. Such patients could be retained in the hospital, as was frequently the case, until Department of Welfare certification for the needed assistance was obtained or they could be discharged without the means to care for themselves. Further complicating the matter was a continuing shortage of beds for patients who needed to be admitted to the hospital.[15]

Depending upon the particular benefit required, time spent by the Department of Public Welfare in certifying patients varied greatly. Certain temporary benefits were granted at the parish or first level of review. Applications for long term benefits, maintenance medications for example, were reviewed at the parish level but required further review and approval at the state level. Certification time varied according to the review procedure required and the level at which approval could be granted.[16]

The director of the study hospital's medical staff estimated that an average of sixty bed-days per month were being lost by the hospital because inpatients were being retained while awaiting certification for

public assistance.[17] While this estimate represented a loss of less than one per cent of the bed-days available, any preventable loss was significant because the size of the hospital was inadequate for the indigent population it was charged with serving. (See pages 3-5.) Annual admissions were divided into annual hospital days (See Appendix F.) to determine that the average length of hospitalizations at Earl K. Long Memorial Hospital was 7.8 days. By dividing the average length of hospitalizations into the estimated 720 days lost per year, it was further estimated that the hospital could provide inpatient care for an additional ninety-two patients per year by eliminating lost bed-days.

No estimate was made by the author of the number of admissions that could be avoided by more timely certification of outpatients for public assistance. Such an estimate was desirable to further define the magnitude of the problem but not enough information was available to make estimation practical (see Factors Limiting Research). It was logical to conclude, however, that some outpatients needing maintenance medications and some of those rendered unable to work by their illness were requiring preventable hospitalizations because of delays in obtaining public assistance. This assumption was supported by the literature.[18]

Many outpatients, needing new or additional public

assistance due to their medical conditions, were not referred to the social service department.[19] Some of these patients were applying directly to the Department of Public Welfare for benefits, and others, through lack of knowledge of what was available to them, were trying to meet their needs with their own inadequate resources. At best, outpatients not referred to social service were experiencing a built-in delay in obtaining certification. This was true because medical justification was still required by the Department of Public Welfare and had to be requested from the hospital through the mail.[20] It was concluded that the referral of outpatients to the social service department would reduce certification time for benefits which would in some instances prevent the need for hospitalization.

Department capabilities

A medical social worker and a secretary were the total staff of the Earl K. Long Memorial Hospital Social Service Department. Both staff members were sharing a single desk in an office which measured nine by eleven feet. In addition to being inefficient, this arrangement failed to provide the privacy desirable for social service counseling.[21]

Based on the observations of the author during two visits to the hospital, operation of the social service department was judged to be effective at existing

workload levels. A review of all referral forms on file in the department revealed little delay between patient referral and initial social service action. In most cases action was recorded for the date of referral. For the remaining cases, initial action was recorded on the next work day. Follow-up actions, through case closure, were recorded on each referral form.

Monthly statistical reports showed an increased case workload for each month since establishment of the department. During October, 1970, the first full month of operation, only seventy new cases were reported. By February, 1971, the workload had more than doubled and 152 new cases were reported.[22]

Based on my observations of the department in February and March, 1971, it was concluded that further increases in the case workload could not be effectively handled by the existing staff. Improved patient identification and referral techniques alone would create a bottleneck in the social service department and have little beneficial effect so far as the stated problem was concerned. It was thus determined that an expansion of social service capability was prerequisite to other recommendations designed to help secure more timely Welfare Department certification of patients for public assistance.

Volunteer Services Department

At Earl K. Long Memorial Hospital, the director of volunteer services worked under the supervision of the director of the social service department. Hospital volunteer workers, all graduates of an American Red Cross training program, were assigned to the hospital through a local office of that organization. Approximately ninety volunteers were working at the hospital in three, four-hour shifts per day. The volunteer workday began at 8:00 a.m.

Volunteers performed various services for the hospital in the admissions department, library, medical records department, and at the information desk. The number of volunteers available was not considered adequate to handle the jobs which had been identified for their performances; however, a recruiting program was underway.[23]

Personnel records on the volunteers were maintained by the Red Cross in a master file and were not readily available to the hospital. For this reason, no definitive study of volunteer education and work interest was made. However, it was learned through interview that the volunteer force at the hospital included a social worker, a registered nurse, a physical therapist, and at least one teacher. This source of accomplished volunteer personnel was not being utilized

by the social service department.[24]

Medical Records Department

Medical records department organization and operating procedures were considered important to the study because of the direct influence they had on the certification of outpatients for public welfare benefits. The department collected and released medical information required by the Welfare Department as justification for the awarding of public assistance to persons being treated in an outpatient status.

When a patient applied directly to the welfare office for assistance, a request for medical information, Department of Public Welfare Form 10-D (see Appendix H), was sent to the hospital along with the patient's written authorization for information release. According to the assistant director of the medical records department, approximately 100 requests for medical information were being received from the Public Welfare Department each week. Many of these requests sought information upon which to base reverification of eligibility. Some requests, however, were for information upon which to base the initial award of public assistance. All requests were answered by either the director of the department of her assistant.[25]

During the hospital visit in March 1971, it was found by inspection that only fifty-four public welfare

requests for medical information were awaiting answer. This backlog was relatively small compared to "much larger" backlogs which were said to exist previously. The improvement in responding to requests was attributed to simpler processing, made possible by the introducation of DPW Form 10-D in November 1970, and to special efforts being made within the medical records department. Welfare Department requests were admitted to have a low priority relative to other medical records work.[26] It was noted by the author that dates on the unanswered requests ranged from February 25 through March 12, 1971.

It was concluded that the low priority given to Welfare Department requests worked to the detriment of outpatients awaiting initial certification for benefits such as maintenance medications. This was true because there was no way to provide these benefits temporarily while awaiting medical justification and approval of a more permanent nature.[27]

No estimate was made of the percentage of requests seeking justification for initial certification because records of past requests, other than patient release authorizations, were not maintained. The requests on hand were considered by the author to be biased sample and not adequate for estimation using scientific techniques. To avoid bias a requirement existed for each

observation within the population to have a "precisely equal chance" of appearing in the sample selected for analysis.[28] The population of interest was all of the Welfare Department requests which had been received by the hospital. An estimate of the number of requests for initial certification would have been useful for determining the potential number of admissions that could result from excessively delayed awards of public assistance. Requests for recertification were not considered in this regard because they related to a benefit already being received and could be programmed sufficiently in advance by the Welfare Department to allow for delays in processing.[29]

The Professional Staff

Because of the hospital's teaching role, professional medical staffing was handled by the Louisiana State University School of Medicine. Clinical department heads in the hospital were also faculty members and medical students, interns, and residents rotated through the various clinical services as a part of their training. In addition, some eighty local physicians in private practice also held faculty appointments and served the hospital in a consultant capacity.[30]

The rotation of students, interns, and residents through the medical departments and their lack of permanence on the hospital staff were seen as complicating

factors for the problem under study. It was concluded that the lack of stability in this element of the staff created a need for continuing education and coordination in the problem area if lasting solutions were to be found.

The full time medical staff at Earl K. Long Memorial Hospital numbered forty-seven, including eighteen residents and twelve interns. For the geographic area in which the hospital was located, the physician to population ratio was 114:100,000.[31] Thus, considering that the hospital had responsibility for both inpatient and outpatient care for 125,000 medical indigents, it was found that proportionately the general public in the area had more than twice as many physicians available to them than did the medically indigent service population. This disparity in the number of available physicians could be lessened in effect so far as inpatients were concerned by finding solutions to the problem. More timely certification of patients for public assistance would shorten hospital stays and enable physicians to care for a greater number of inpatients in a given period (see discussion pages 30-31).

Maximum utilization of the social service department to help provide care for more patients became a need apparent to the author. Yet, a study of opinions conducted among fourteen interns at the hospital in 1970 revealed that they considered the medical social worker's

proper role in health care delivery as somewhat limited in scope.[32] On the other hand, these same interns thought that the training of social workers should be both comprehensive and highly specialized. A conclusion of the study was that the interns did not understand and appreciate medical social work.[33]

The above study was conducted before establishment of the social service department. Subsequent to establishment, interns at the hospital were being brought into direct contact with the social service department and it was an impression of this author that a better understanding of medical social work existed. Still, it was found by interview that the director of social services was not a scheduled participant in the orientation of newly assigned personnel. At the time of the interview, plans were being made for the abolishment of the existing orientation program in favor of one which would be video taped and used on closed circuit television.[34]

Discussion Summary

To what extent the interrelationships of the social service department with other departments influenced the late referral of patients to social service could not be precisely measured. However, the fact that some inpatients were not referred until the time of discharge and many outpatients were not referred at all

made it worthwhile to seek ways to improve interdepartmental communication and understanding. An impression of the author, supported by general observation, was that departments were sometimes so involved in their own internal affairs that the sight of organizational objectives and the roles of other departments in achieving those objectives was lost. This was considered as a partial cause of late referrals by the professional staff; the low priority given to welfare department requests by the records department; and of the failure by the social service department to seek expanded capability through the use of volunteers.

Major conclusions and findings expressed in the chapter are:

1. The social service staff was too small to accomplish the hospital's social service objectives (see page 27).

2. Three considerations closely related to the problem were referrals upon admission, referrals from any source, and adequate staff (see page 28).

3. Solutions to the study problem would have value for other hospitals provided their late referrals for social service were arising from the same causes (see pages 28 and 29).

4. Some inpatients who were medically ready for discharge were being retained in the hospital to await certification for welfare benefits (see page 31).

5. Any preventable loss of bed-days was significant considering the size of the hospital against the size of its service population (see page 32).

6. Some outpatients were requiring preventable hospitalizations because of delays in obtaining public assistance (see page 32).

7. Expansion of social service capability was prerequisite to other recommendations to help secure more timely certification of patients for welfare benefits (see page 33).

8. Volunteers were not being used in the social service department and there was no system for identifying volunteers suited to that type of work (see pages 34 and 35).

9. Welfare Department requests for information were given low priority by the medical records department and this worked to the detriment of patients awaiting initial certification for welfare benefits (see page 36).

10. Because of the transiency of students, interns, and residents continuing education and coordination were required for lasting solutions to the problem (see pages 37 and 38).

11. Solution to the problem would help the hospital's relatively small professional staff care for a larger number of inpatients (see page 38).

12. The social service director was not a participant in the orientation of newly assigned staff members (see page 39).

Footnotes

[1]Tiedeman, interview, February, 1971.

[2]American Hospital Association, Guidelines for Use of Volunteers, p. 1.

[3]Letter from Statistical Section, Louisiana Department of Hospitals, Nov. 8, 1971.

[4]American Hospital Association, Essentials of Social Work, p. 19.

[5]Tiedeman, interview, March, 1971.

[6]Charlotte L. Rosenberg, "Where Discharge-Planning Starts on Admission Day," Medical Economics, Oct. 12, 1970, p. 272.

[7]Ibid.

[8]Frances Upham, A Dynamic Approach to Illness (New York: Family Service Association of America, 1949), p. 36.

[9]American Hospital Association, Essentials of Social Work, p. 19.

[10]Tiedeman, interview, March, 1971.

[11]Policy memorandums from director of social service to director of nursing, September 18 and November 13, 1970. Found in social service correspondence file.

[12]Tiedeman, interview, March 1971.

[13]Ibid.

[14]McKnight, interview, March 1971.

[15]Ibid.

[16]Drehr, interview, February 1971.

[17]McKnight, interview, March 1971.

[18]Les J. H. Johnson, "Social Service: A Vital Link in Total Care," Canadian Hospital, XXXVII (September 1961), 36-37.

[19]Drehr, interview, February 1971.

[20]Ibid.

[21]Mary E. Davis, "The Practice of Social Work in Hospitals," Hospital Progress, LII (January 1971), 64.

[22]Statistical Report, Social Service Department, Earl K. Long Memorial Hospital, months of October 1970 through February 1971. Filed in Social Service Department.

[23]Jean Holmes, interview with volunteer coordinator, Earl K. Long Memorial Hospital, March 1971.

[24]Ibid.

[25]Helen Goldsmith, interview with assistant director, medical records department, Earl K. Long Memorial Hospital, March 1971.

[26]Ibid.

[27]Drehr, interview, February 1971.

[28]A. Bradford Hill, Principles of Medical Statistics (7th ed. New York: Oxford University Press, 1961), p. 15.

[29]Drehr, interview, February 1971.

[30]Jane Lambremont, "Description of the Institutional Programs Served by the Library," Earl K. Long Memorial Hospital, Baton Rouge, La., 1969. (Mimeographed).

[31]Article, American Medical News, March 1, 1971, p. 6.

[32]Laura J. Milne, "A Study of Interns' Perceptions of the Social Workers Role in a Medical Setting" (unpublished M.A. thesis, Louisiana State University, 1970), p. 43.

[33]Ibid.

[34]McKnight, interview, March 1971.

CHAPTER III

RECOMMENDATIONS

For an orderly presentation of recommendations to help secure more timely certification of patients for public welfare benefits, this chapter is divided into five sections. Four of these sections correspond to the hospital departments discussed in Chapter II. The fifth includes those recommendations which either cut across departmental lines or do not relate to one of the departments.

Social Service Department Recommendations

1. To expedite processing of requests for certification of eligibility for public assistance, it is recommended that the social service department be expanded. Selected members of the hospital's volunteer services organization may be assigned duties with the social service department. Volunteer workers can free the full-time social service staff of many nonprofessional duties and allow them more time for patient problems of a sensitive nature. Also, with orientation and inservice training, some volunteers can be assigned social work.[1] Some of the volunteers serving the

hospitals are known to have capabilities for more complex assignments (see pages 34 and 35).

In implementing the recommendation to use volunteers in social service, advanced planning and close coordination between the two services is essential to success.[2] Social Service tasks must be matched against the skills and desires of available volunteers. Since volunteer services comes under the social service department in the hospital's organizational structure, the necessary planning and coordination should be accomplished without undue difficulty.

2. To open all possible avenues for the earlier identification of patients with needs for public assistance, it is suggested that all social service referral restrictions be lifted. Home or family problems of an emotional or economic nature may preclude adequate care following hospital discharge and lead to readmission. In situations where the social problem is indirectly related to the patient's illness, a physician or nurse may not be the first to know of its existence.[3]

Volunteer Service Recommendations

To derive maximum hospital benefits from the services of volunteers, it is recommended that a personnel file on these workers be established at the hospital. This file, as a minimum should contain information on the age, sex, phone number, address, edu-

cational achievement, work preference, and hours of availability of each volunteer working at the hospital. The selection of a file format and system is not important so long as the needed information is provided and is readily available for volunteer assignment actions. Initial inputs for the file may be obtained from the local American Red Cross. For new volunteers, information can be obtained at the time of initial hospital interview. Such a file would be beneficial in planning volunteer assignments to expand social service capability.

Medical Records Department Recommendations

1. Instead of placing a low priority on answering Department of Welfare requests, it is recommended that a suspense system be established to insure timely responses. By filing requests according to date received and responding to them in the same order, it would become easy to maintain surveillance on the number and age of unanswered requests. A suspense period, or greatest amount of time any request would remain unanswered, should be established and used to control the timeliness of responses to requests for certification information.

2. To shorten response time, it is recommended that the policy of having all responses to the Welfare Department prepared by either the medical records

librarian or her assistant be discontinued. Response time can be reduced by letting record clerks prepare simple requests for signature.

3. To further shorten response time, it is suggested that a copy of the information supplied to the Department of Public Welfare be placed in the patient's medical record along with the authorization for its release. This will preclude time consuming research in responding to second requests for the same information and in preparing follow-up reports for reverification of a patient's eligibility for benefits.

Professional Staff Recommendations

1. As a first step in promoting an understanding and appreciation of social service functions and capabilities among physicians and other hospital staff members, it is recommended that an active role be given to the social service department in the orientation of newly assigned personnel. Physicians and nurses practicing at Earl K. Long Memorial Hospital cannot be expected to place emphasis on the proper utilization of the social service department when the hospital does not indicate its importance by giving it maximum visibility in organizational functions such as orientations and professional meetings. The size of the social service staff precludes an individualized orientation and education program for each professional member of

the hospital team. More official exposure and recognition of the social service department by the hospital organization is needed. This will provide a means of efficiently educating staff members to the importance of referring patients at the earliest possible date and foster professional recognition and rapport between the social service department and other professional elements of the hospital.

Heads of the clinical departments within the hospital have a unique opportunity for enhancing the effective use of the social service department, particularly in regard to educating residents and interns under their professional control. In addition to the influence of their personal emphasis, these department chiefs can invite the medical social worker to attend departmental meetings to present the social aspects of selected cases that are of general interest within the department.

2. It is recommended that a modified referral procedure be adopted to accomplish referral upon admission where this is possible. The proposed procedure is one in which the physician simply notes on his admission order that referral is desired rather than completing the referral form and sending it to the social service department. The physician's note would alert the admissions clerk who would complete the referral

form and forward it to social service. Using this method would simplify this type of highly desirable referral[4] and save valuable professional time.

3. To eliminate those delays in obtaining certification that are inherent in the process whereby patients apply directly to the Department of Public Welfare (see page 33), it is recommended that the referral of outpatients be encouraged.

General Recommendations

1. Ultimate responsibility for the effectiveness of the total social service activity of the hospital should rest with the social service department.[5] To help the social service department adequately meet this responsibility, it is recommended that a system be devised to keep the department aware of the number and age of Department of Public Welfare requests for information awaiting answer in the records department. Because responses to these requests have a direct bearing on the timeliness of certification for welfare benefits, it is suggested that the records department submit periodic written status reports to social service. The interval between these reports would depend upon the length of the response suspense period covered in an earlier recommendation.

According to Urwick, this type of system would create a specialized or functional relationship in which

an individual would have authority for a specific activity within the functional area of another equal. In the model described by Urwick, the social service director would exercise her special or functional authority through the director of the medical records department. Such systems are ideally a collaborative effort, and the intervention of higher level management is necessary only when there is a breakdown of human relations between the department heads.[6]

2. It is believed by the author that further benefits can be derived from a study of the problem within the Department of Public Welfare. The possibility of streamlining review and approval procedures is thought to exist from impressions gained through interview with a department representative.[7] It is recommended that the hospital seek ways to undertake such a study.

Footnotes

[1]American Hospital Association, Essentials of Social Work, p. 24.

[2]Brock, Social Work in the Hospital Organization, p. 60.

[3]Upham, A Dynamic Approach to Illness, p. 36.

[4]Ibid.

[5]Evelyn M. McNamara, "Hospital Social Service," Hospitals, XLII (November 16, 1968), 42.

[6]Urwick, Lyndall F., "The Nature of Line and Staff," in Management: A Book of Readings, by Harold Koontz and Cyril O'Donnel, (New York: McGraw-Hill Book Company, 1964), pp. 212-214.

[7]Drehr, interview, February, 1971.

APPENDIX A

ELIGIBILITY FOR CHARITY SERVICES IN GENERAL HOSPITALS UNDER THE ADMINISTRATION OF THE STATE DEPARTMENT OF HOSPITALS

ELIGIBILITY FOR CHARITY SERVICES IN GENERAL HOSPITALS UNDER THE ADMINISTRATION OF THE STATE DEPARTMENT OF HOSPITALS AND HOSPITALS HAVING CHARITY BED CONTRACTS WITH THE DEPARTMENT

(Adopted by the State Hospital Board, February 1, 1961)
(Revised July 27, 1961, and August 27, 1970)

The following rules shall govern the admissibility or rejection of patients seeking admission to the general hospitals under the administration of the State Department of Hospitals and to hospitals having charity bed contracts with the Department.

Definitions

"Hospital" as used herein means a general hospital under the administration of the State Department of Hospitals or a private or non-profit hospital having charity bed contracts with the Department.

"Legally responsible relatives" as used herein means the father, mother, or children, including adopted children, of a person seeking admission to a hospital. By adopting this definition relating to admissions the Board does not waive or relinquish any legal right the Department may have to collect from other legally responsible relatives.

"Income" as used herein means the income of an applicant or his legally responsible relatives derived from salary, rent, royalty, commission, interest, self-employment or any other type of income after deduction of income and Social Security taxes.

Eligibility

1. Persons who are bona fide residents of the State of Louisiana and have maintained their residency in this State for at least twelve months preceding application for admission to a hospital and are found by the medical staff of the hospital to be in need of medical services shall be admitted if otherwise eligible.

2. Subject to Par. 4 hereof, any person whose net worth (including the combined net worth of legally responsible relatives) does not exceed $5,000.00, exclusive of home in which the applicant or his legally responsible relative resides, shall be eligible for admission to a hospital.

3. Any recipient of public assistance shall be presumed to have a net worth which does not exceed $5,000.00 and shall also be presumed to have an income which does not exceed the amounts stipulated in Par. 4 hereof. Such a person shall be admitted to a hospital upon presenting evidence that he is receiving public assistance.

4. Any person whose monthly income does not exceed the following scale, and who qualifies under Par. 1 and 2 shall be admitted to a hospital for ward or clinical treatment:

Single Person	$200.00
Wife and Husband	225.00
Wife, Husband and 1 Dependent	250.00
Wife, Husband and 2 Dependents	275.00
Wife, Husband and 3 Dependents	300.00
Wife, Husband and 4 Dependents	325.00
Wife, Husband and 5 Dependents	350.00
Wife, Husband and 6 Dependents	375.00

Wife, Husband and 7 Dependents	$400.00
Wife, Husband and 8 Dependents	425.00
Wife, Husband and 9 Dependents	450.00
Wife, Husband and 10 Dependents	475.00

5. When diagnosis and treatment are obviously beyond the person's ability to pay or he has spent during the preceding twelve months 20% or more of his income for medical care he may be admitted for charity services if the Superintendent of the hospital is convinced from evidence submitted to him that such person is unable to pay hospital and other medical expenses in a private hospital.

6. Persons suffering disabilities requiring emergency treatment shall be admitted without delay, provided such persons who do not meet the eligibility requirements herein stipulated shall be charged for services rendered them.

7. Persons not adequately covered by hospitalization, Workmen's Compensation or health and accident insurance shall be admitted if they would otherwise be indigent, provided they assign benefits payable to them under their policy or policies to the hospital.

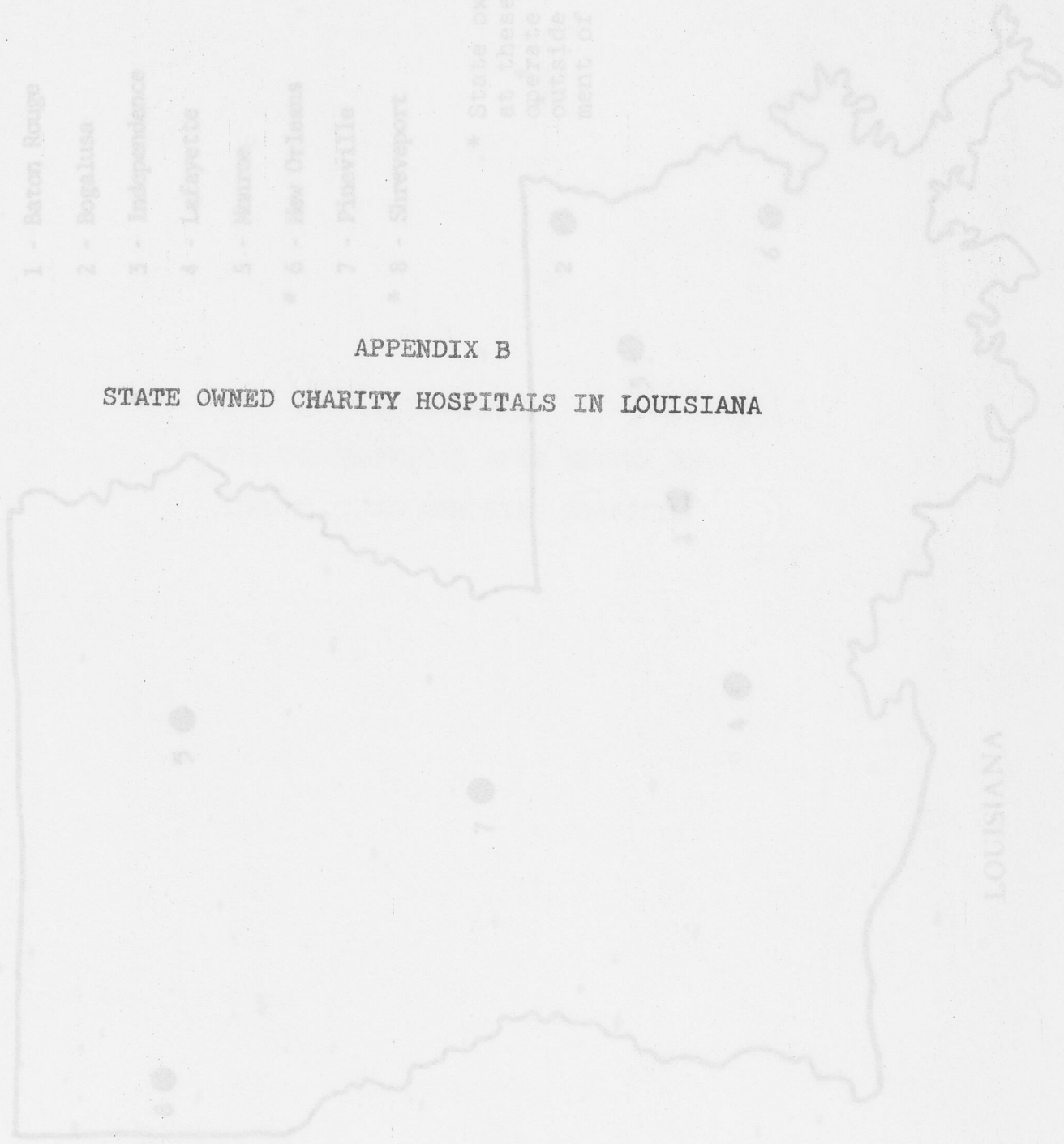
8. All persons who are admitted before their eligibility is correctly determined, such as those who are admitted for emergency treatment or through fraud or misrepresentation, or are admitted without a final decision having been made as to their eligibility, shall be charged for services rendered them if it later develops after investigation that they were not indigent at the time of admission.

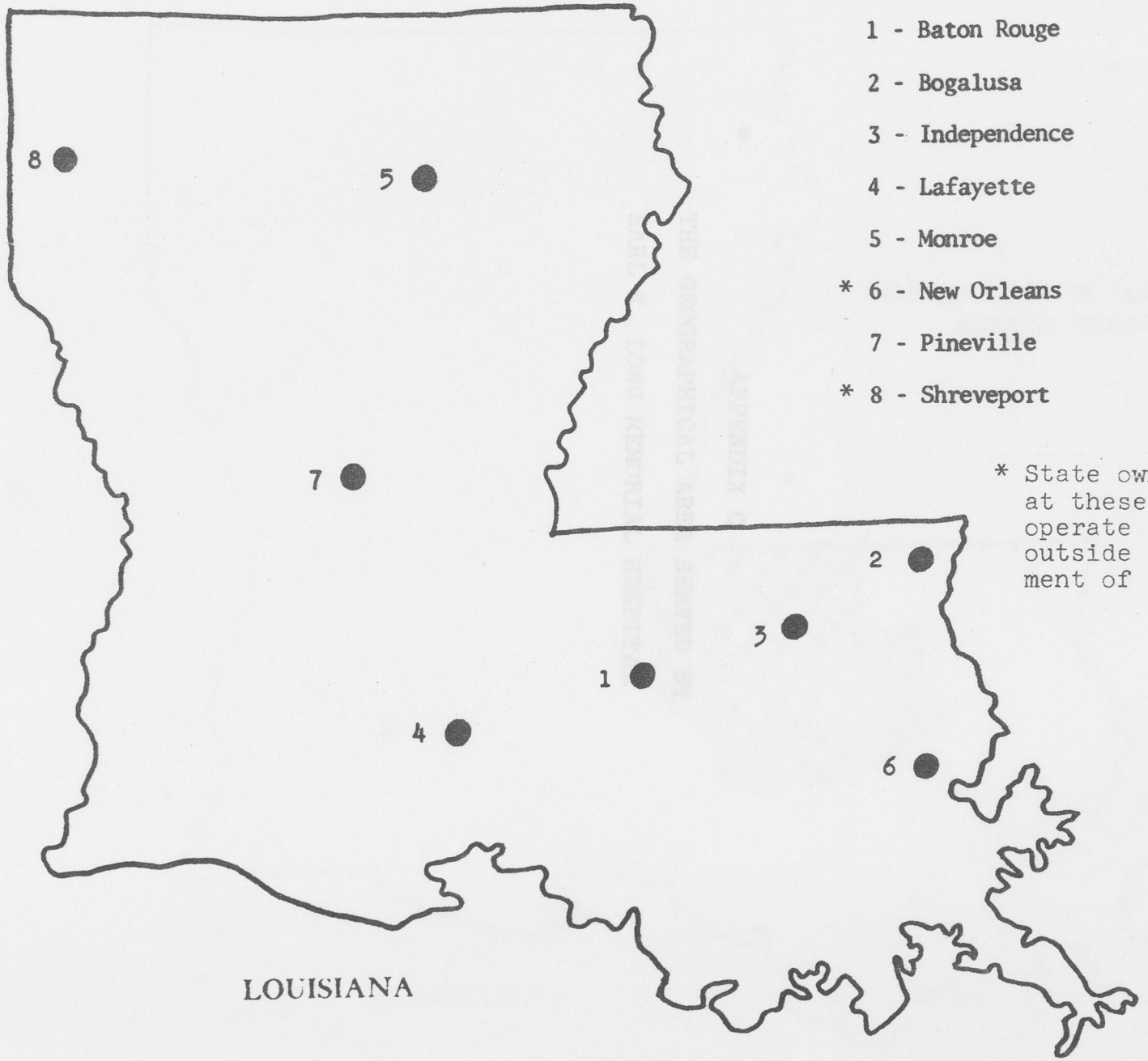
9. Notwithstanding any provisions of these standards to the contrary, all aged persons who are eligible to receive medical assistance

benefits from any agency administering the Federal Medical Assistance Program shall, if admitted to a State hospital or a private hospital having a charity bed contract with the Department, be charged fees for their hospitalization and drugs rendered them at rates to be established by agreement between the hospital and the agency administering the Federal Medical Assistance Program; provided the proper agency has agreed to make appropriate reimbursement for such services to the hospital

APPENDIX B

STATE OWNED CHARITY HOSPITALS IN LOUISIANA





1 - Baton Rouge

2 - Bogalusa

3 - Independence

4 - Lafayette

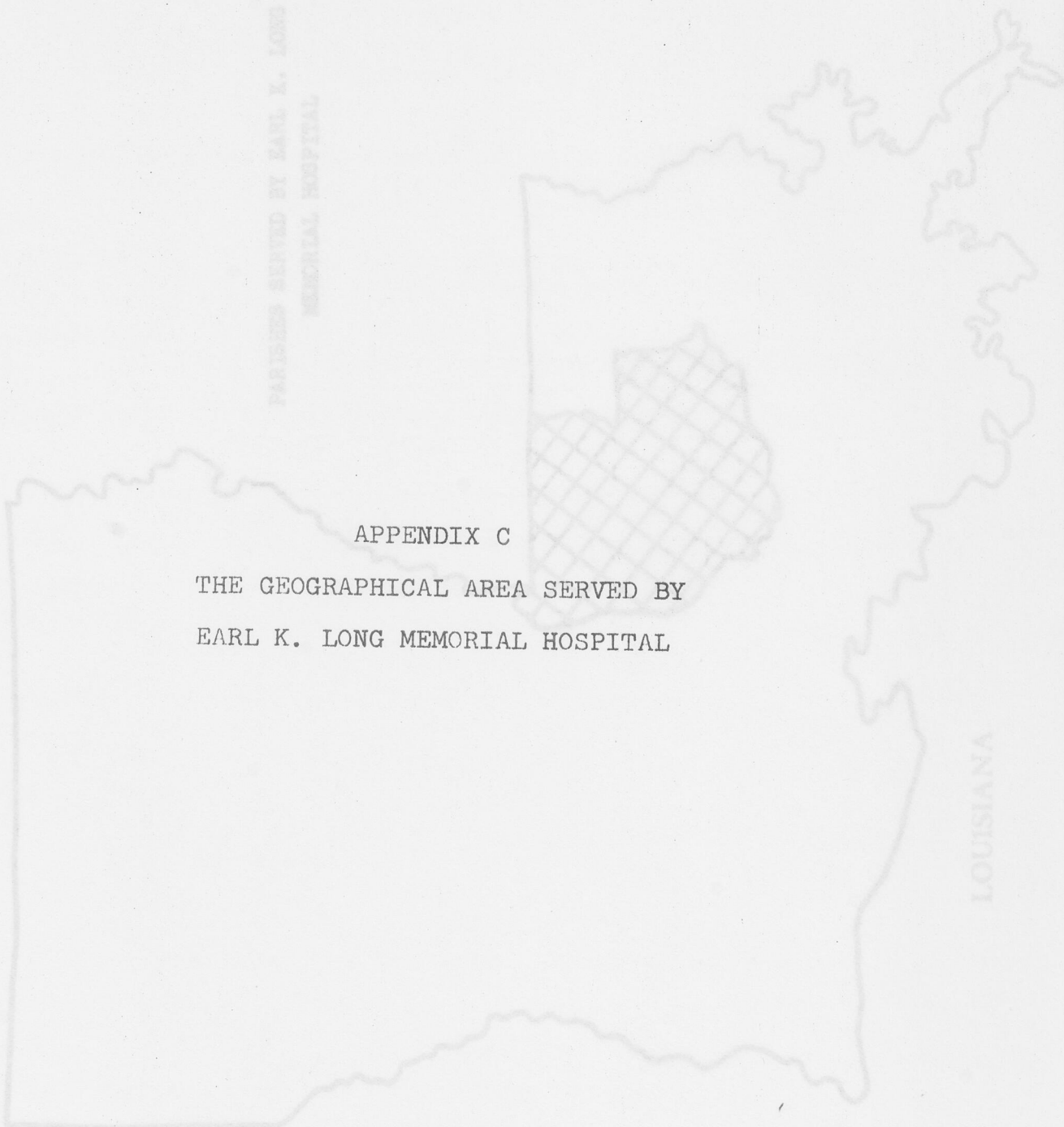
5 - Monroe

* 6 - New Orleans

7 - Pineville

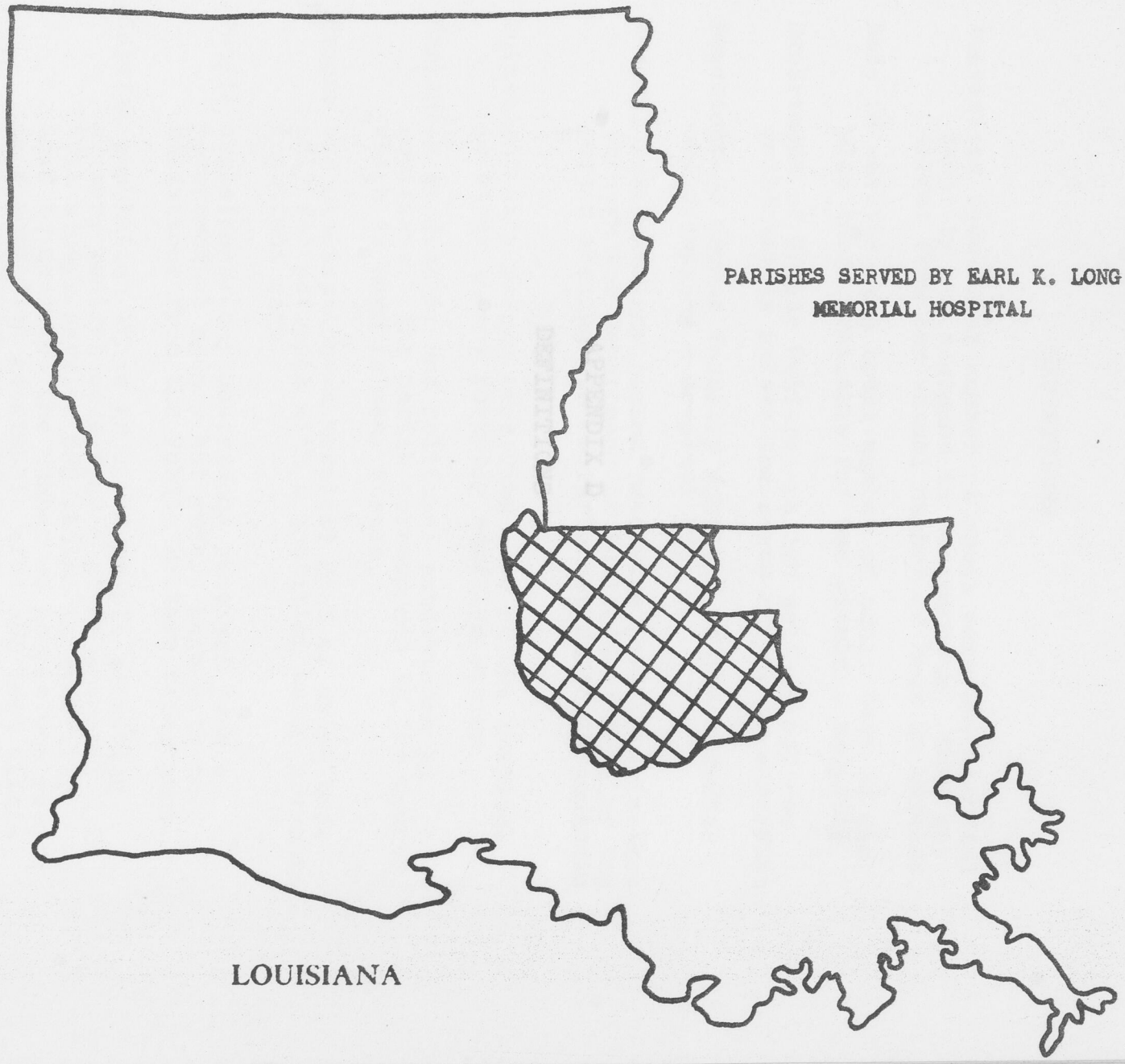
* 8 - Shreveport

* State owned hospitals at these locations operate independently outside the Department of Hospitals.



APPENDIX C

THE GEOGRAPHICAL AREA SERVED BY EARL K. LONG MEMORIAL HOSPITAL


PARISHES SERVED BY EARL K. LONG
MEMORIAL HOSPITAL
LOUISIANA

APPENDIX D

DEFINITIONS

DEFINITIONS

Accredited beds--that number of adult beds the hospital facility was designed to accommodate. This may differ from the actual number of beds in service.

Beds in service--the total number of adult beds in use plus those available for use within a hospital.

Department of Public Welfare--parish welfare offices collectively unless the state office is specified.

Inpatient--a person formally admitted to the hospital and occupying a hospital bed.

Medical indigent--any person receiving public assistance through the Department of Public Welfare plus any person meeting the criteria set forth in Appendix B.

Outpatient--any person receiving care at the hospital in other than a formally admitted status.

Parish--a geographic and political subdivision in Louisiana. The parish corresponds to the county which is used in many states.

Proper bed utilization--a hospital goal of using beds only for patients with a condition which warrants inpatient care.

Public assistance--any assistance received from a governmental agency but refers here only to assistance from the Public Welfare Department.

Service population--that group of people receiving primary medical care from a given hospital. In this study, service population is generally used to describe the number of people who reside in a specified geographic area and meet eligibility requirements set forth in Appendix A.

Study hospital--refers to Earl K. Long Memorial Hospital, Baton Rouge, Louisiana.

APPENDIX E

QUESTIONNAIRE

QUESTIONNAIRE

1. How many beds is your hospital currently operating?

2. Is any expansion underway or scheduled to start within one year? If so, how much?

3. What is the size of the indigent population you serve?

4. Do you feel that your inpatient facilities are adequate for this population? Briefly explain negative answers.

5. If you have a social service department, how many members are on its staff? Please break this down according to professional qualification--number of medical social workers, assistants, etc. Do you feel that the size of your social service staff is adequate?

6. At what point in hospitalization are patients who will need new or additional public assistance after discharge identified? How are they identified?

7. What department is responsible for providing required medical documentation (DPW Form 10-D) to the Department of Public Welfare?

APPENDIX F

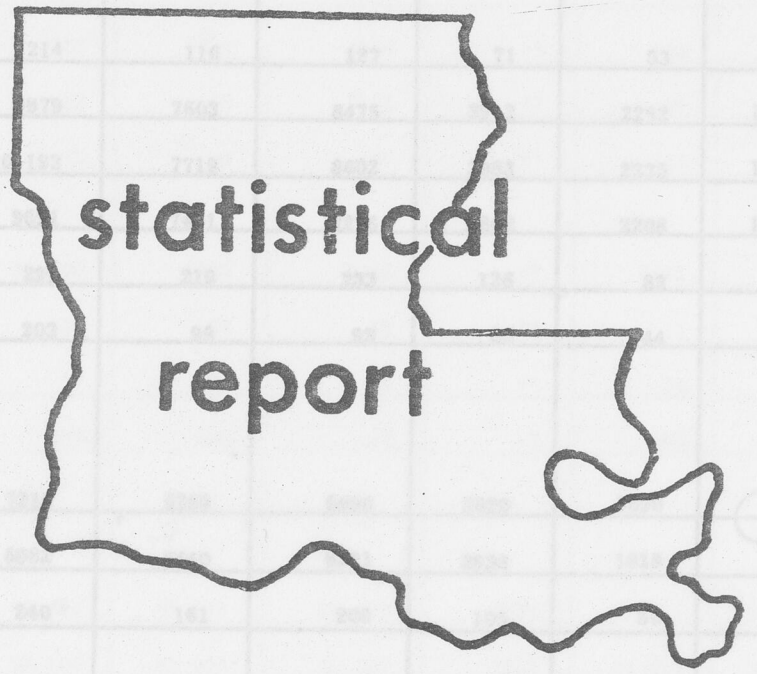
STATE DEPARTMENT OF HOSPITALS

STATISTICAL REPORT

FISCAL YEAR 1971

LOUISIANA STATE DEPARTMENT OF HOSPITALS

FISCAL 1971



prepared by the Statistical Section

GENERAL HOSPITALS

Fiscal, 1971

	Southwest	Huey P. Long	E. A. Conway	Lallie Kemp	Wash.-St. Tamm.	Earl K. Long	Total	Fiscal, 1970 Total
MOVEMENT OF POPULATION								
CENSUS, July 1, 1970	214	116	127	71	53	143	724	692
ADMITTED DURING MONTH	9979	7603	8475	3912	2282	10,475	42,726	42,810
TOTAL CARED FOR	10,193	7719	8602	3983	2335	10,618	43,450	43,502
DISCHARGED ALIVE	9691	7401	8276	3802	2208	10,186	41,564	41,573
DIED	299	219	233	126	83	258	1218	1205
CENSUS, July 30, 1971	203	99	93	55	44	174	668	724
INPATIENT-HOSPITAL								
ADMITTED	7213	5788	6498	3030	1890	7684	32,103	32,100
DISCHARGED ALIVE	6982	5640	6321	2938	1818	7441	31,140	31,035
DIED	240	161	208	105	80	222	1016	1006
UTILIZATION								
HOSPITAL DAYS	53,712	41,147	43,134	23,108	14,226	59,992	235,319	240,106
AVERAGE DAILY CENSUS	147	113	118	63	39	164	644	665
NUMBER OF BEDS	222	212	150	132	70	195	981	1107
PERCENT OCCUPANCY	66%	53%	79%	48%	56%	84%	66%	60%

*Temporary transfers from TB Annex are not counted in general hospital patient movement. See Tuberculosis Hospital Section.

GENERAL HOSPITALS-CONTINUED

Fiscal, 1971

	South-west	Huey P. Long	E. A. Conway	Lake Charles	Lallie Kemp	Wash.-St. Tamm.	Earl K. Long	Total	Fiscal, 1970 Total
NURSERY-INPATIENT									
ADMISSIONS	2766	1815	1977	**	882	392	2791	10,623	10,710
DISCHARGES	2709	1761	1955	**	864	390	2745	10,424	10,532
DEATHS	59	58	25	**	21	3	36	202	199
STILLBIRTHS	72	49	37	**	17	12	59	246	259
UTILIZATION									
NURSERY DAYS	12,608	7493	6445	**	4017	1352	9741	41,656	42,578
AVERAGE DAILY CENSUS	35	21	18	**	11	4	27	116	118
NUMBER OF BASSINETS	77	34	44	**	24	10	35	224	248
OCCUPANCY IN PERCENT	45%	62%	41%	**	46%	40%	77%	52%	48%
OUT-PATIENT CLINIC									
NEW VISITS	44,135	42,747	27,422	5254	30,311	16,739	22,415	189,023	172,720
RECURRENT	50,142	42,078	55,797	7316	50,699	22,397	79,413	307,842	292,739
ACCIDENT ROOM *	2091	3188	2683	17,122	1109	276	31,804	58,273	35,933
TREATED & LEFT	1912	2873	2397	17,122	1109	276	29,517	55,206	33,363
TREATED & RETAINED	179	315	286	-	-	-	2287	3067	2570
TOTAL VISITS	96,368	88,013	85,902	29,692	82,119	39,412	133,632	555,138	501,392
AVERAGE DAILY VISITS	264	241	235	81	225	108	366	1520	1396

*Accident patients are included in this figure.
**Lake Charles now serves as a specialized outpatient clinic.

GENERAL HOSPITAL COST

OPERATING COST

Fiscal, 1971

	Maintenance Cost	Units of Cost*	Average Cost per Unit
SOUTHWEST	$ 4,702,084.07	84,502 **	$55.64
HUEY P. LONG	$ 3,078,254.53	59,563	$51.68
E. A. CONWAY	$ 3,413,031.53	60,674	$56.25
LAKE CHARLES	$ 685,366.12	29,692	$23.06
LALLIE KEMP	$ 2,201,589.79	38,804	$56.74
WASHINGTON-ST. TAMMANY	$ 1,080,916.41	21,471	$50.34
EARL K. LONG	$ 5,637,547.45	87,135	$64.70
TOTAL	$20,798,789.90	381,841	$54.47

*For accounting purposes, units of cost include hospital patient days, one-half nursery days, and one-sixth clinic visits.
**Includes 8425 patient days from the T.B. Annex.

TUBERCULOSIS HOSPITALS

Fiscal, 1971

MOVEMENT OF POPULATION	Greenwell Springs	Lafayette TB Annex	Total	Fiscal, 1970 Total
IN RESIDENCE, July 1, 1970	113	36	149	168
ON TEMPORARY TRANSFER TO CHARITY HOSPITAL	-	-	-	1
ON RECORD, July 1, 1970	113	36	149	169
ADMITTED DURING MONTH	261	151	412	446
RETURNED FROM TEMPORARY TRANSFER	-	1	1	3
PLACED ON TEMPORARY TRANSFER	-	7	7	10
DIED WHILE IN CHARITY HOSPITAL	-	1	1	2
DIED WHILE IN TB HOSPITAL	20	5	25	27
DISCHARGED WHILE IN CHARITY HOSPITAL	-	4	4	4
DISCHARGED WHILE IN TB HOSPITAL	258	158	416	430
IN RESIDENCE, June 30, 1971	96	18	114	149
ON TEMPORARY TRANSFER, June 30, 1971	-	1	1	-
ON RECORD, June 30, 1971	96	19	115	149

TUBERCULOSIS HOSPITALS-CONTINUED

Fiscal, 1971

	Greenwell Springs	Lafayette TB Annex	Total	Fiscal, 1970 Total
UTILIZATION				
PATIENT DAYS	32,135	8425	40,560	51,080
AVERAGE DAILY POPULATION	88	23	111	149
NUMBER OF BEDS	306	77	383	442
PERCENT OCCUPANCY	29%	30%	29%	34%
OPERATING COST				
MAINTENANCE COST	$1,836,308.83	*		
AVERAGE COST PER PATIENT DAY	$ 57.14	*		
AVERAGE COST PER PATIENT PER MONTH	$ 1,738.20	*		

*Maintenance cost for Lafayette TB-Annex is reported with Southwest Charity Hospital in the General Hospital section of this report.

MENTAL HOSPITALS

Fiscal, 1971

	Central Louisiana (Pineville)	East Louisiana (Jackson)	Southeast Louisiana (Mandeville)	Total	Fiscal, 1970 Total
MOVEMENT OF POPULATION					
IN INSTITUTION, July 1, 1970	1565	2500	379	4444	4676
ON CONVALESCENT STATUS, July 1, 1970	2484	871	604	3959	4940
ON RECORD, July 1, 1970	4049	3371	983	8403	9616
ADMITTED DURING MONTH	2167	2746	2052	6965	7246
RETURNED FROM CONVALESCENT STATUS	715	388	205	1308	1374
PLACED ON CONVALESCENT STATUS	2427	930	884	4241	4402
DIED WHILE ON CONVALESCENT STATUS	84	22	6	112	120
DIED WHILE IN HOSPITAL	66	133	4	203	228
DISCHARGED WHILE ON CONVALESCENT STATUS	1527	651	611	2789	4009
DISCHARGED WHILE IN HOSPITAL	553	2199	1287	4039	4450
IN INSTITUTION, June 30, 1971	1401	2372	461	4234	4444
ON CONVALESCENT STATUS, June 30, 1971	2585	740	666	3991	3959
ON RECORD, June 30, 1971	3986	3112	1127	8225	8403
PATIENT DAYS	537,247	875,908	149,403	1,562,558	1,667,524
AVERAGE DAILY POPULATION	1472	2400	409	4281	4569
OPERATING COST					
MAINTENANCE COST	$8,143,592.25	$11,096,331.14	$3,793,988.94	$23,033,912.33	$19,389,098.03
AVERAGE COST PER PATIENT DAY	$ 15.16	$ 12.67	$ 25.39	$ 14.74	$ 11.63
AVERAGE COST PER PATIENT PER MONTH	$ 461.17	$ 385.42	$ 772.36	$ 448.39	$ 353.55

ALCOHOLISM TREATMENT UNIT*

Fiscal, 1971

	Central		East	Southeast	Total
	Alcoholism Treatment Unit	Vocational Rehabilitation			
ON ALCOHOLIC SERVICES 1st OF PERIOD	2	16	47	37	102
ADMISSIONS TO SERVICE DURING PERIOD	61	49	943	285	1338
FIRST ADMISSIONS	46	46	578	282	952
READMISSIONS	15	3	365	3	386
TRANSFERALS FROM OTHER SERVICES	39	54	10	100	203
DISCHARGES	77	94	882	363	1416
TRANSFERALS TO OTHER SERVICES	17	6	49	23	95
ELOPEMENTS (not returned during period)	-	-	17	-	17
DEATHS	-	-	-	-	-
RETURNS TO SERVICE FROM ELOPEMENT	-	-	-	-	-
ON ALCOHOL SERVICE, END OF PERIOD	8	19	52	36	115
PATIENT DAYS	1923	7046	18,212	12,173	39,354
TOTAL DAYS STAY					
FOR DIRECT DISCHARGE & TRANSFER	1923	6815	14,737	12,496	35,971
ELOPEMENTS	-	-	116	-	116
DEATHS	-	-	-	-	-
ALL EXITS	1923	6815	14,853	12,496	36,087
AVERAGE DAYS STAY					
FOR DIRECT DISCHARGE & TRANSFER	20.46	68.15	15.83	32.37	23.81
ELOPEMENTS	-	-	6.82	-	6.82
DEATHS	-	-	-	-	-
ALL EXITS	20.46	68.15	15.67	32.37	23.62

*THE ALCOHOLISM SERVICE OF MENTAL HOSPITALS

SCHOOLS FOR THE MENTALLY RETARDED

Fiscal, 1971

MOVEMENT OF POPULATION	Pinecrest State School	Ruston State School	Leesville State School	Hammond State School	Belle Chasse State School	Total	Fiscal, 1970 Total
IN INSTITUTION, July 1, 1970	1951	84	28	701	195	2959	2789
ON TEMPORATY ABSENCE, July 1, 1970	96	77	92	82	-	347	342
ON WORK PLACEMENT, July 1, 1970	5	-	-	5	-	10	9
ON EXTENDED ABSENCE, July 1, 1970	29	-	-	13	-	42	35
TOTAL ON RECORD, July 1, 1970	2081	161	120	801	195	3358	3175
ADMITTED	79	22	48	80	20	249	417
PLACED ON TEMPORARY ABSENCE	1870	1065	617	3848	2	7402	7452
PLACED ON WORK PLACEMENT	9	-	-	17	-	26	21
PLACED ON EXTENDED ABSENCE	3	-	-	48	-	51	47
RETURNED FROM TEMPORARY ABSENCE	1856	1035	566	3860	-	7317	7340
RETURNED FROM WORK PLACEMENT	8	-	-	13	-	21	15
RETURNED FROM EXTENDED ABSENCE	4	-	-	20	-	24	12
DISCHARGED ON TEMPORARY ABSENCE	20	9	47	14	1	91	98
DISCHARGED ON WORK PLACEMENT	-	-	-	5	-	5	5
DISCHARGED ON EXTENDED ABSENCE	2	-	-	22	-	24	24
DIRECT DISCHARGE	3	-	1	2	15	21	54
DIED	41	-	-	20	-	61	53
IN INSTITUTION, June 30, 1971	1976	76	24	745	198	3019	2960
ON TEMPORARY ABSENCE, June 30, 1971	86	98	96	51	1	332	347
ON WORK PLACEMENT, June 30, 1971	6	-	-	4	-	10	10
ON EXTENDED ABSENCE, June 30, 1971	26	-	-	18	-	44	42
TOTAL ON RECORD, June 30, 1971	2094	174	120	818	199	3405	3359

SCHOOLS FOR THE MENTALLY RETARDED - CONTINUED

Fiscal, 1971

	Pinecrest State School	Ruston State School	Leesville State School	Hammond State School	Belle Chasse State School	Total	Fiscal, 1970 Total
UTILIZATION							
PATIENT DAYS	760,626	59,920	43,662	293,400	71,435	1,229,043	1,192,881
AVERAGE DAILY CENSUS	2084	164	120	804	196	3368	3269
OPERATING COST							
MAINTENANCE COST	$7,963,177.45	$992,276.51	$508,731.20	$4,388,685.08	$1,393,020.37	$15,245,890.61	$12,706,849.76
AVERAGE COST PER PATIENT DAY	$ 10.47	$ 16.56	$ 11.65	$ 14.96	$ 19.50	$ 12.40	$ 10.65
AVERAGE COST PER PATIENT PER MONTH	$ 318.50	$ 503.76	$ 354.39	$ 455.08	$ 595.19	$ 377.21	$ 324.40

GERIATRIC HOSPITALS

Fiscal, 1971

	Villa Feliciana	Fiscal, 1970 Total
MOVEMENT OF POPULATION		
IN INSTITUTION, July 1, 1970	751	737
ON TEMPORARY TRANSFER, July 1, 1970	6	1
ON PASS, July 1, 1970	-	1
ON RECORD, July 1, 1970	757	739
ADMISSIONS DURING MONTH	155	201
RETURNS FROM TEMPORARY TRANSFER	45	56
RETURNS FROM PASS	23	36
DEATHS WHILE IN HOSPITAL	106	115
DISCHARGES WHILE IN HOSPITAL	16	21
PLACED ON TEMPORARY TRANSFER	83	105
PLACED ON PASS	24	38
DEATHS WHILE ON TEMPORARY TRANSFER	7	14
DEATHS WHILE ON PASS	-	1
DISCHARGES WHILE ON TEMPORARY TRANSFER	36	30
DISCHARGES WHILE ON PASS	1	2
IN INSTITUTION, June 30, 1971	745	751
ON TEMPORARY TRANSFER, June 30, 1971	1	6
ON PASS, June 30, 1971	-	-
ON RECORD, June 30, 1971	746	757
UTILIZATION		
PATIENT DAYS	273,554	272,016
AVERAGE DAILY POPULATION	749	745
OPERATING COST		
MAINTENANCE COST	$3,100,332.94	$2,389,928.89
AVERAGE COST PER PATIENT DAY	$ 11.33	$ 8.79
AVERAGE COST PER PATIENT PER MONTH	$ 344.66	$ 267.39

APPENDIX G

SOCIAL SERVICE REFERRAL FORM

SOCIAL SERVICE REFERRAL

Patient's Name_____ Race____ Ward, Rm_____ Referring Source_____

Address_____ Phone_____ Notify_____Date___

Admitting Date_____ Date of Birth_____ Record #_____ DPW#_____

DIAGNOSIS:

PROBLEM OR REQUEST:

SOCIAL SERVICE USE ONLY

Date Received:_____ Social Worker:_____

DISPOSITION:

APPENDIX H

DEPARTMENT OF PUBLIC WELFARE FORM 10-D

DPW Form 10-D
Issued 11/70

REQUEST TO STATE CHARITY HOSPITAL FOR MEDICAL DATA

TO: MEDICAL RECORD DEPARTMENT

_____

_____

FROM: _____ (Worker's Name) _____ (date), _____ (Parish) DPW

RE: _____ (Surname) (Given Name) (M.N.) Race ___ Sex ___ Birthdate _____

ID # _____ Hospital No. _____

Authorization of medical information / / attached / / previously submitted

STATUS OF CASE IN PARISH: / / Pending / / Redetermination / / Other

We need the following information: (circled items only)

1. Is client followed regularly at hospital? Yes ___ No ___
   If Yes, how frequently? _____ Date of next appointment _____
2. Medications prescribed: _____
   _____
3. Special diet prescribed - specify: _____
4. Appliances prescribed: _____
   _____
5. Hospital discharge summary with diagnosis: _____
   _____
6. Clinic data with diagnosis: _____
   _____
7. Has treating physician made recommendations regarding return to work?
   Yes? ___ No ___. If yes, when is client expected to return to work?
   _____
8. Other (specify)

_____ Date

_____ Hospital Worker's Signature

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ABSTRACT

A STUDY TO DEVELOP RECOMMENDATIONS FOR IMPROVING THE SOCIAL SERVICE AT EARL K. LONG MEMORIAL HOSPITAL, BATON ROUGE, LOUISIANA

A Problem Solving Thesis Submitted to the Faculty of Baylor University in Partial Fulfillment of the Requirements for the Degree of Master of Hospital Administration

by

Captain George E. Fleming, MSC

August 1972 84 Pages

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This study was conducted at Earl K. Long Memorial Hospital, Baton Rouge, Louisiana. Its purpose was to develop recommendations for improving the social service offered by the hospital with particular emphasis on achieving a more timely certification of eligibility for patients who needed Department of Public Welfare assistance. Primary research tools were the unstructured interview, a questionnaire, the review of existing records, and a review of selected, pertinent literature. The study centered around the policies and procedures of four basic components of the hospital which had, or could have had, a direct bearing on the study problem. These were the Social Service Department, Volunteer Services Department, Medical Records Department, and professional staff. A major finding of the study was that the capabilities of the Social Service Department had to be increased as a prerequisite to any improvements which might be suggested. To achieve this end, a program for volunteers in social service was recommended. Other conclusions and recommendations of the study involved policies, procedures, or both, in each of the four areas examined.