

## Continuum of Care

1. Question:  
If you feel that post discharge services, i.e. DME, home care, etc., would benefit the patient and family, but are not sure the patient will qualify, what should you do?  
(CC.1)

Answer:  
Contact assigned Unit/Clinic Case Manager
2. Question:  
When should you begin to consider discharge planning?  
(CC.1)

Answer:  
On Admission.
3. Question:  
If a patient does not have benefits, i.e., Medicare, Medicaid or Insurance, may you request home care services?  
(CC.1)

Answer:  
Yes. Case Management staff will assess and make every attempt to help patients qualify for services by contacting the MAP office, referring patient's family to the Social Security Office, and Financial Counseling to file for free care status.
4. Question:  
Where is the criteria that determines what services are provided on a particular patient care unit?  
(CC.2, CC.2.1)

Answer:  
Each area has defined a scope of service, the patient population that is appropriate for admission and specific criteria for admission to the area.
5. Question:  
What document is evidence of compliance with the Patient Self-Determination Act and shows patient participation in making medical decisions?  
(CC.2, CC.2.1)

Answer:  
Advance Directives. Consent forms.
6. Question:  
What information is used to determine which service or care setting a patient is admitted to?  
(CC.2)

Answer:  
Patient Assessment.
7. Question:  
How is the family informed of the patient's condition and plan of care? Where is this documented?

Answer:  
Information to the family is provided by the physician, nursing staff and other disciplines. Family teaching is documented in the medical

(CC.3)

record: progress notes, nurses' notes, interdisciplinary education form, Outpatient Clinic Record, and informed consents.

8. Question:

How is it determined that a patient needs a different level of service?

(CC.4 and CC.5)

Answer:

Patient assessment. Referrals (consults) to different services. Case Management utilizes criteria sets to determine seriousness of illness, intensity of service, and readiness for discharge.

9. Question:

How does the hospital ensure continuity over time among the phases of service to a patient?

(CC.4)

Answer:

Communication between the different services are facilitated by medical record content: Progress notes, nurses' notes, consultation forms, i.e., shift-to-shift to unit to unit reports, Outpatient summary records, operative records, etc. Chart entries are made by physicians, nursing staff, and other Health Care Professionals, i.e. patient care conferences, grand rounds.

10. Question:

How are transfers both within and out of LSUHSC coordinated to ensure patients receive the appropriate level of service?

(CC.4 and CC.5)

Answer:

Intra and Inter facility transfer policies, and Case Management transfer policies. All appropriate information regarding the patient is reported/transferred to the receiving unit.

11. Question:

How does the continuum of care continue after a patient is discharged from the hospital?

(CC.5)

Answer:

Discharge instructions are given to the patient/family. Discharge summaries are sent to appropriate agencies. Follow-up clinic appointments are arranged for patients. Appointment dates/times are given to patients upon discharge.

12. Question:  
How are Ambulatory Care visits considered a phase of the continuum of care?  
(CC.4 and CC.5)

Answer:  
At each visit the patient is assessed and reassessed to evaluate the effectiveness of services. Treatment plans are modified when necessary to meet ongoing patient needs. Patient Recall and Missed Appointment Policies are followed for each area. Patient's medical records are obtained for each visit and entries are made on the Outpatient Visit form or other designated forms.

13. Question:  
What information does the hospital provide to the patient to inform them on how to seek assistance with discharge planning?  
(CC.3)

Answer:  
A patient handbook is given to each patient upon admission to LSUHSC-S. It provides information on how to contact a Case Manager or Social Worker for assistance with discharge planning.

14. Question:  
To whom do you refer a patient that has a question concerning their bill?  
(CC.3)

Answer:  
If the patient is still hospitalized refer to Financial Counseling Office located on 1st Floor K-Wing.

If patient has been discharged refer to Hospital Billing Office located at 1512 Kirby St.

If patient has a bill for outpatient services refer to Hospital Billing Office located at 1512 Kirby St.

15. Question:  
How does a patient apply for free care eligibility?  
(CC.3)

Answer:  
Patients should be referred to Financial Counseling Department between the hours of 8:00 am – 4:00 pm Monday through Friday. The Department is located on the 1st floor of K-Wing.

16. Question:  
When a patient's insurance company states the patient's admission is not medically necessary or should have been treated as an outpatient and therefore partial or all

Answer:  
If the insurance company has a contract with LSUHSC – Shreveport that states the patient cannot be billed, the hospital does not receive payment.

payment for the admission is denied, who is responsible for the hospital bill?

If the insurance contract does not have an exemption clause the patient may be billed. A patient does not automatically qualify for free care. If a patient desired to be considered for free care status, they must apply for it and be approved through the Financial Counseling Department of Hospital Billing.

17. Question:

When a patient is admitted to the hospital whose responsibility is it to notify the insurance company of admission?

Answer:

Notification of admission is the responsibility of Admitting/Patient Registration after 4:00pm M-F, Holiday and weekends. Financial Counseling notifies the insurance companies during routine office hours M-F. It is also the patient's responsibility to notify insurance co.

18. Question:

How do outside reviewers or Case Managers from insurance companies/workman's comp. obtain access to the medical records of an inpatient?

Answer:

The reviewer must go to the Utilization Review Department, show proper identification, provide patient authorization, sign in the review logbook and obtain a yellow visitor's badge prior to going to the inpatient must sign out in the Utilization Review Department and return the badge prior to leaving the building.