A STUDY TO DETERMINE METHODS OF IMPROVING PATIENT RELATIONS IN THE EMERGENCY DEPARTMENT AT RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI

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

Major Stephen W. Arnt, MSC

Waco, Texas

August 1976

APPROVED BY THE ACADEMY OF HEALTH SCIENCES, U.S. ARMY:

____
Director of the Program

APPROVED BY THE THESIS COMMITTEE:

____
Chairman

____

____

APPROVED BY THE GRADUATE COUNCIL:

____
Dean of the Graduate School

DATE: August 14, 1976

ABSTRACT

A STUDY TO DETERMINE METHODS OF IMPROVING PATIENT RELATIONS IN THE EMERGENCY DEPARTMENT AT RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI

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

Major Stephen W. Arnt, MSC

August 1976 93 pages

A copy of this document may be obtained from Xerox University Microfilms, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

The problem was to determine effective methods for improving patient relations in the emergency department at Research Medical Center in Kansas City, Missouri.

The research methods included a research of the literature, personal observation and flow chart analysis of emergency department operations, structured and unstructured personal interviews conducted with key hospital personnel, and the collection of statistical data relating to emergency department operations. The study resulted in the conclusion that several actions could be taken to improve public relations in the emergency department.

It was recommended that the triage nurse on the emergency department staff meet incoming patients and make the initial decision as to patient disposition. It was also recommended that specific actions be taken to make "waiting time" a more acceptable experience for the patient.

ACKNOWLEDGMENTS

My sincere appreciation and thanks are extended to Robert E. Adams, Executive Director of Research Medical Center and his staff for their courtesy, cooperation and assistance during the conduct of this study.

A special word of gratitude and appreciation is expressed to my wife Judy, for her secretarial skills and ever-cheerful support during the period of this study.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS ii

Chapter

I. INTRODUCTION 1
Hospital History and Setting 1
Conditions Which Prompted the Study 3
Statement of the Problem 3
Objectives 3
Criteria 4
Research Methodology 5
Review of the Literature 6
Footnotes 16

II. DISCUSSION 19
Emergency Department Organization and Philosophy 19
Emergency Department Publics 21
Emergency Department Patient Flow 21
Emergency Department Human Relations 27
Emergency Department Design 27
Emergency Department Patient Relations Program 30
Summary 31
Footnotes 33

III. CONCLUSIONS AND RECOMMENDATIONS 34
Conclusions 34
Recommendations 34

Appendix

A. PATIENT FLOW MODEL FOR A HOSPITAL EMERGENCY DEPARTMENT 37

B. U. S. ARMY HUMAN RELATIONS TRAINING MODEL . . 40

C. FUNCTIONAL CHART, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI 43

D. EMERGENCY SERVICE STATISTICS, FEBRUARY, 1975, RESEARCH MEDICAL CENTER, KANSAS CITY MISSOURI 45

E. EMERGENCY DEPARTMENT SHIFT STATISTICS, 1973, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI 47

F. SUMMARY OF EMERGENCY DEPARTMENT PATIENT POPULATION STATISTICS, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI 49

G. ORGANIZATIONAL CHART, AMBULATORY CARE DEPARTMENT, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI 51

H. T/O CHANGE REQUEST AND JUSTIFICATION FOR EMERGENCY SERVICES, 1975, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI 53

I. PATIENT FLOW CHART, EMERGENCY DEPARTMENT, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI 59

J. EMERGENCY DEPARTMENT MEDICAL STAFF QUESTIONNAIRE, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI 64

K. AMBULATORY SERVICE RECORD, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI 67

L. MAGAZINES IN THE EMERGENCY DEPARTMENT WAITING ROOM, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI 69

M. HUMAN RELATIONS DIAGNOSTIC CHECK LIST 71

N. PARKING LAYOUT, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI 73

O. EMERGENCY DEPARTMENT FLOOR PLAN, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI 75

P. PROJECTED EMERGENCY DEPARTMENT FLOOR PLAN, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI 77

Q. EMERGENCY DEPARTMENT PATIENT RELATIONS PROCEDURES, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI 79

R. EMERGENCY DEPARTMENT PUBLIC RELATIONS PROGRAM PLAN, 1975, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI 84

S. PUBLIC RELATIONS DEPARTMENT REORGANIZATION SUMMARY, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI 86

BIBLIOGRAPHY 89

CHAPTER I

INTRODUCTION

Hospital History and Setting

Research Medical Center, located in Kansas City, Missouri, began as a twelve-bed hospital in 1886. The original institution was located in a six-room house purchased by the German Hospital Association. The hospital was dedicated to "Suffering Humanity," a concern which is an integral part of the current hospital philosophy. Expansion at the original site became increasingly difficult and in 1965 the institution moved into a new facility at Meyer Boulevard and Prospect Avenue in Southwest Kansas City. The 517-bed facility was completed at a cost of $17 million. The hospital name has changed several times since its beginning, when it was known as German Hospital. The most recent change came in 1975 when Research Hospital and Medical Center was shortened to Research Medical Center (RMC).

Research Medical Center is incorporated in the State of Missouri as a nonprofit hospital and has no organizational affiliations. The institution is governed by a thirty-member Board of Trustees elected for a two-year term. The

President of the Board is the corporate head of the organization under state law and the hospital bylaws. The chief operations officer of the hospital is the executive director, who manages the institution through an assistant executive director, and five assistant directors. The executive director functions by the authority of the Board of Trustees and does not hold voting membership within that group.

The future of Research Medical Center is a bright one. A long-range plan has been developed to meet the ever-expanding needs of the southwest Kansas City community which the hospital serves. Stage I is expected to be completed in 1980 and Stage II in 1990. Stage I development will add 300 beds to the base hospital, provide 150 extended care beds, provide a 180-bed psychiatric hospital, expand the Doctors' Office Building to 200 suites, and increase staff apartments by 20 units. Stage II will double the bed capacity of the extended care unit and psychiatric hospital and provide for construction of a 250-bed OB-GYN hospital.

Over the years, Research Hospital's facilities for care have continually expanded and improved. Although large, this institution appears to have maintained a high quality of care and close attention to personal needs. The improvements currently underway will continue that tradition.

Conditions Which Prompted the Study

The executive director at Research Medical Center had recognized the emerging trend in health care delivery toward utilization of outpatient services. The public relations department of the hospital did not have a program oriented to the emergency department public, hence work had begun on developing such a program. At the request of the Assistant Director for General and Fiscal Services, A. Alan Transue, this study was undertaken to assist in identifying effective methods of improving patient relations within the emergency department.

Statement of the Problem

The problem was to determine effective methods for improving patient relations in the emergency department at Research Medical Center, Kansas City, Missouri.

Objectives

The objectives of this study were:

1. Describing the philosophy of the emergency department organization.

2. Identifying and describing the emergency department patients, staff and workload.

3. Identifying and describing the emergency department patient flow.

4. Describing and analyzing emergency department human relations program.

5. Describing and analyzing the emergency department architectural design.

6. Describing and analyzing the hospital patient relations program as it pertains to the emergency department.

7. Providing recommendations for improving patient relations within the emergency department at Research Medical Center, Kansas City, Missouri.

Criteria

The structure and operation of the existing emergency department, as it pertains to patient relations, will be evaluated against the following criteria:

1. Any recommended changes to the emergency department operations should be consistent with the goals and objectives of Research Medical Center.

2. The flow of patients through the emergency department should be in the most expeditious manner possible consistent with the practice of quality medicine.

3. The design of the emergency department should support patient flow; create a pleasant atmosphere; provide accommodations for nonpatient visitors; recognize the individuality of each patient; provide break areas for the staff; and be situated in such a manner as to facilitate patient movement to the reception area.

4. The public relations efforts of the emergency department should be an integral part of the overall hospital

public relations program, to include a program of continuing human relations training for all departmental employees and professional staff directly involved in patient reception or care; patient education; patient communications; and provision for continuing patient evaluation of the department.

Research Methodology

This study was conducted using the following primary methods:

1. A survey of the current literature was done in order to construct a model for patient relations within a hospital emergency department.

2. Institutional philosophy regarding emergency department utilization was determined through structured interviews of selected management personnel and observation of the department admitting procedures.

3. A patient profile was constructed by reviewing 345 emergency department patient records.

4. The emergency department staffing methodology was evaluated with respect to patient relations through unstructured interviews with selected department heads and assistant directors.

5. Patient flow through the emergency department was evaluated using a flow chart methodology and subsequently validated with the physician in charge of the department and the Director of Ambulatory Care.

6. The need for employee and staff human-relations training was evaluated through direct observation of department operations for a total of thirty-six hours during a two-week period using a predetermined checklist.

7. A current and proposed emergency department facility design was evaluated through interviews of selected department heads and the study of blueprints of existing and proposed facilities.

8. A review of the existing and proposed public-relations program documents for the hospital was conducted in order to evaluate their impact on the emergency department patient relations.

Review of the Literature

Cutlip and Center have stated in their book, Effective Public Relations, that ". . . people do not have to be sold on the hospital, they want more hospital care. They do not have to be sold on doctors; they only want more of them and more opportunity to use them."[1] This has become a particularly acute problem within most hospital emergency departments. The traditional role of the emergency department has been that of a trauma center. The literature indicates that this role is becoming subordinate to two additional roles: a substitute for unavailable private practitioners and primary care provider for the urban poor.[2] Community pressure for the hospital to assume these additional responsibilities appears to be the result of several

emerging trends. These include: an increasing public attitude of a right to medical care; a shortage of primary care physicians due to physician specialization;[3] and attempts by physicians to lead more ordered lives, thereby decreasing their availability to the public.[4] This increased patient use of the emergency department is causing much of the community perception of the hospital to be based on their experiences in the emergency department.

The basis for patient relations within the emergency department is the institutional philosophy regarding the department's function. If the institution applies the American Hospital Association warning that the emergency department should be used for emergencies only,[5] then as many as 60 per cent of the visitors will be turned away because their condition does not meet the definition of an emergency.[6] The Health Law Center has pointed out that this concept is rapidly becoming obsolete. Case law has developed in most states to a point where the establishment of an emergency department creates a duty for the hospital to provide treatment to those patients with urgent conditions. In an increasing number of instances, the court is applying this principle to include all those in need of aid, regardless of condition.[7] The patient relations problems presented by this philosophy involves those individuals not accepted as patients, rather than those that are. Spencer indicates that a more acceptable and realistic description of the department's function is published by the American College of Surgeons.

> The function of an emergency department is to give adequate appraisal and initial treatment or advice to any person who considers himself acutely ill or injured and presents himself at the emergency department door.[8]

It is within the framework of this description that a model for patient relations can be constructed from the literature.

The literature does not address patient relations within the emergency department patient experience, but it does address separate areas which influence the encounters the patient has with the facility and the staff. These encounters, taken as a whole, make up an emergency department experience for a patient. To assist in understanding the patient relations problems which take place in many of these encounters, it is necessary to describe the individuals who may be involved.

The patient is the individual who presents himself at the emergency department for treatment of a perceived physical problem. He is most often quite anxious about his condition and the prognosis. In actuality, his complaint may not be the result of a physical dysfunction, but rather a social problem requiring the expertise of a mental health professional. He expects to be seen promptly and courteously, receive better than average care for his ailment, and be charged a reasonable price for the service received. His primary concern is his own medical problem and it often takes precedence over all of the other patient conditions he may observe in the same emergency department.[9]

The previous discussion describes the general attitudes and prejudices of patients arriving at all emergency departments. The literature also emphasizes the importance of identifying attitudes and prejudices in specific patient populations. These are influenced by age, sex, ethnic background, annual income, and so forth. A patient profile constructed on an individual hospital basis will provide this information. The major impact will be on the efficient utilization of resources through the establishment of priorities during the implementation phase of a patient relations program.[10]

The behaviorists state that the relatives or friends who accompany a patient to the emergency department have many of the same feelings of anxiety that the patient feels. In addition, they may feel a personal responsibility for the injury and also a responsiblility for bringing the patient to this particular hospital in lieu of an alternative treatment facility. They often feel more contempt toward other emergency department patients than the patient they accompany would because they have only a heresay perception of the seriousness of both problems.[11]

The emergency department staff will normally consist of physicians, nurses, nurses' aides, orderlies, and receptionists. Of these people, the physician is paramount because it is his attitude in carrying out his duties which provides the leadership for all other staff members.[12] The

staffing methodology under which the physician works appears, in the literature, to be more the result of maximizing institutional resources than of fostering patient relations.

James G. Lifton indicates that of the six basic methods of staffing emergency departments in general use throughout the United States, a full-time, salaried plan results in the highest patient satisfaction.[13] The physicians' qualifications have an impact on the patient's perception of care, with members of the American College of Emergency Room Physicians portrayed as the optimum, followed by the general practitioner.[14] Other members of the staff are normally chosen for their ability to function efficiently under pressure and their personal desire to work in the department.[15] Ideally, all members of the staff within the emergency department have received formal training in patient communications and human relations.[16]

The flow of patients through the emergency department has, as its primary goal, quality patient care. The patient forms his impression of the institution during a series of encounters within the emergency room.. The sequencing of patient encounters influences not only the entire emergency department experience but prejudices specific encounters. The literature indicates that the key element in this series of encounters is time: the constraints of available time on the part of the individuals providing the service, and the

desire to be seen promptly on the part of those requiring the service.[17]

The optimum process begins with the arrival of a patient at the emergency department. At this point, a decision must be made by the staff as to the urgency of the patient's condition. A "yes, urgent" decision moves the patient directly to an encounter with the physician. A "not urgent" decision normally means the patient will be delayed in seeing a physician. A "no" decision also causes the patient to undergo the administrative process prior to treatment. On initial contact with the professional staff, an examination of the patient is made and a decision on the necessity for further diagnostic tests is reached. If further tests are required, the patient may be moved to other areas of the hospital for their accomplishment. On his return, the patient waits for the results to be seen by the physician before the treatment process begins.

If the emergency department physician is not qualified to render the treatment necessary, the patient again waits for the appropriate personnel to be called. Physician staffing methodology will normally govern the necessity for this step. After treatment has begun, the physician is required to determine if the patient needs to be admitted to the hospital. A "yes" decision starts the admitting process and a "no" decision means the patient will be sent back to

the administration area prior to discharge. Appendix A pictorially describes the previously mentioned process.[18]

The U. S. Army has conducted a study into the factors affecting the human relations interaction between patients and staff in an ambulatory care setting. The study's findings with regard to the patient have been presented in an earlier section of the literature review. The study recognized the human needs of hospital personnel with regard to the stresses of their jobs.[19] The study further stated that the department staff is a focus of potential human-relations problem and indicated that the following factors are most often responsible for conflicts with patients:

(1) Inattention to common courtesy.
(2) Preoccupation with the technical aspects of medical care, e.g., diagnosis, lab work, etc., and inattention to the social and emotional needs of the patient.
(3) Interprofessional staff conflicts and difficulties.
(4) Job dissatisfaction.
(5) Fatigue.
(6) Preoccupation with personal concerns.
(7) Treatment of patients as medical objects, not as people.
(8) Inability to interact effectively with people.
(9) Poor communication skills.
(10) Poor orientation to the purpose of their job as defined by the organization.
(11) A tendency to regard the patient's problem as routine and insignificant.[20]

Walk C. Jones and E. William Smock have said that a patient's arrival at the hospital creates his initial impression of the institution he is about to commit himself to for treatment. This initial impression will be built around the

ease in which he is able to find the emergency department entrance; the availability of a covered, unloading area during inclement weather; the availability of parking space; and the general appearance and cleanliness of the entrance.[21] George T. Harrel indicates that the individual charged with triage within the emergency department should be so located as to be able to observe all incoming patients. He also recommends that signs be placed so that the incoming patient knows where to go. Harrel further states that the area in which the actual triage takes place should provide for conversation that cannot be overheard by other patients or visitors within the emergency department. Although litters and wheelchairs are required near the entrance they should neither block traffic nor detract from the overall decor of the reception area.[22]

Patient administration procedures, by necessity, involve asking personal questions of the patient for both the patient treatment record and the financial accounts record. This area, for this function, should be capable of accommodating several patients in relative privacy at one time, with chairs and desks provided for filling out the necessary forms and answering staff questions. This has been accomplished in several institutions through the use of open-ended or partially enclosed booths.[23]

The waiting areas are of great importance to patient relations in the emergency department. Separate areas should

be provided for emotionally disturbed patients and their relatives. Litter patients should also be afforded a separate holding area which can be under the direct observation of professional or semiprofessional staff.[24] The waiting areas should be arranged in such a way that patients do not have to step over or around other patients to enter or leave. Reading materials should be plentiful, current, and varied.[25] The presence of a television can provide a time-consuming diversion for waiting patients as long as sound control and channel selection remain under the control of the staff. The lighting and interior decoration should convey a living room atmosphere as opposed to the "bus station" approach to waiting areas. Restrooms, drinking fountains, telephones, and vending machines should be within easy access to waiting patients. Cleanliness of all emergency room areas is essential to patient perception of the facility. Because of the large numbers of visitors to an emergency department, housekeeping personnel are scheduled into the area more often than for similar waiting areas in the hospital.[26]

The examining and treatment areas must provide the staff with functional surroundings and adequate storage for necessary diagnostic and treatment equipment and supplies. There should be more than one of these areas per physician in order to conserve physician time while patients enter and exit each area. The physicians must be afforded an office

in which to conduct patient consultations and complete patient charts. Physicians should also be provided with an area to sleep and clean up while assigned to extended duty responsibilities.[27] Other department staff will require a break area which is not visible from any of the patient areas, and provides for a restful atmosphere in which to recuperate from the sometimes fast-paced operation of the department. By enhancing the productivity of the staff through efficient design, an environment can be created which will lend itself to more positive patient relations within the department.[28]

Thought should also be given to locating the emergency department adjacent to the outpatient or family-practive clinics so that the triage staff can more effectively utilize institutional resources at minimum inconvenience to the patient and his family.[29]

The treatment of patients as individuals, rather than numbers passing through a process, will tend to make the patient more receptive to the communicative efforts of the staff and the institution as a whole. This, in turn, tends to influence in a very positive manner a patient's perception of the institution.[30]

An effective patient relations program should have as its goal the furtherance of positive patient relations. To do this, it must address the two components of patient relations: the patient and the environment. The environment in an emergency department includes the staff, institutional

procedures, and architectural design. To eliminate a problem area or potential problem area in patient relations will require a change in one or both of the components. A change can be effected through training, education, procedural modification, or architectural design modification. The implementation of procedural changes and human relations training will probably impact heavily upon available staff time. An outline of a human relations training program utilized by Health Services Command of the United States Army is contained in Appendix B. The American College of Surgeons state that the use of educational literature and closed-circuit educational television within the emergency department waiting area can effectively influence patient attitudes on emergency department procedures.[31] The positive impact that changes in procedures and architectural design would have on patient relations would require an individual hospital analysis.

Footnotes

[1]Scott M. Cutlip and Allen H. Center, Effective Public Relations (Englewood Cliffs, N. J.: Prentice-Hall Inc., 1971), p. 514.

[2]Harvey M. Golomb and Stuart R. Herrold, "An Alternative Staffing Proposal for Emergency Rooms, "Journal of the American Medical Association, CCXXVIII (April 15, 1974), 329.

[3]Ibid., p. 330.

[4]Ibid., p. 329.

[5]James H. Spencer, The Hospital Emergency Department (Springfield, Ill.: Charles C. Thomas, 1972), p. 4.

[6]Golomb and Herrold, p. 329.

[7]Health Law Center, Problems in Hospital Law (Rockville, Md.: Aspen Systems Corporation, 1974), pp. 60-61.

[8]Spencer, p. 3.

[9]Margaret Jane Bennett, "The Social Worker's Role," Hospitals, XLVII (May 16, 1973), 111.

[10]Cutlip and Center, pp. 133-53.

[11]Bennet, pp. 28-33.

[12]Spencer, pp. 133-35.

[13]James G. Lifton, "Eight Ways to Provide Physician Coverage of the Emergency Room and How to Tell Which is Best," Modern Hospital, CXXI (October, 1973), 79.

[14]R. R. Hannas, Jr., "Staffing the Emergency Department," Hospitals, XLVII (May 16, 1973), 84.

[15]Spencer, pp. 149-50.

[16]U. S. Army Health Services Command, "A Study Guide for Human Relations in Ambulatory Patient Care," Ambulatory Patient Care (APC) Program, July, 1974. (Mimeographed.)

[17]Walk C. Jones and E. William Smock, "Built-in Traffic Control -- Foundation of Good Design," Hospitals, XLI (February 1, 1967), 51-54.

[18]Interview with Robert B. Best, M.D., Director, Emergency Physicians Group, Research Medical Center, Kansas City Missouri, March, 1975.

[19]U. S. Army Health Services Command, p. 3.

[20]Ibid., p. 4.

[21]Jones and Smock, pp. 51-52.

[22]George T. Harrel, Planning Medical Center Facilities (University Park: Pennsylvania State University Press, 1974), p. 106.

[23]Warren R. Hanff, "Centralized Outpatient Care," Hospitals, XLVIII (February 1, 1974), 89.

[24]Harrel, p. 106.

[25]American College of Surgeons, A Model of a Hospital Emergency Department (Chicago: American College of Surgeons, 1967), p. 9.

[26]Kenneth E. Johnson and Laverne G. Holden, "How the Behavioral Sciences Influence the Design of Hospital Interiors," Hospital Progress, XLVIII (September, 1967), 48-58.

[27]Harrel, p. 106.

[28]Johnson and Holden, pp. 48-58.

[29]Roslyn Lindheim, "Ambulance or Ambulant?," Hospitals, LI (February 1, 1967), 49.

[30]Johnson and Holden, pp. 48-58.

[31]American College of Surgeons, p. 9.

CHAPTER II

DISCUSSION

Emergency Department Organization and Philosophy

Emergency services at Research Medical Center were organized directly under the Department of Ambulatory Care which was under the managerial control of the Assistant Director for Patient Services (Appendix C). It was the function of this service to provide initial treatment and progression to an appropriate disposition for all medical and psychiatric emergencies which present themselves for care. In an interview with LaVaughn Boldt, Assistant Executive Director,[1] he stated that an institutional interpretation of this functional description considers an emergency to be a patient's perception of his physical condition. Subsequent interviews with Carl J. Felling, Assistant Director of Patient Services,[2] and Gerald Winchell, Ambulatory Care Director,[3] indicated this philosophy had been disseminated throughout the management structure. Observation of the emergency services operation also indicated that no patients were turned away.

Emergency Department Publics

The department's workload was approximately sixty

patients per day and had been increasing at an 8 per cent annual rate (Appendix D). A review of 345 emergency department patient service records for ten days in March, 1975, indicated that 40 per cent of the patients were seen during the day shift, 7:00 A.M. to 3:00 P.M.; 46 per cent of the workload accrued during the evening shift, 3:00 P.M. to 11:00 P.M.; and 14 per cent of the patients were seen during the night shift, 11:00 P.M. to 7:00 A.M. These statistics are comparable to past data maintained by the hospital (Appendix E). A record review revealed that patients spent an average of one hour and twenty-five minutes in the department. A patient profile was also constructed during this record review (Appendix F).

The physician staffing methodology utilized by Research Medical Center was a full-time, salaried-type plan. One physician was on duty at all times, with four physicians under contract in order to provide continuous service. All physicians were general practitioners. The staffing methodology for registered nurses, licensed practical nurses, and nurses' aides is depicted in Appendix G. The registered nurse team leader was utilized only for the evening shift. This position was recently added to the department staff. The justification for this position relied heavily on the need for improved patient relations, which was expected with an individual functioning within the purview of the stated job description (Appendix H).

However, it was observed that this nurse seldom left the nurses' station or the treatment area to either triage incoming patients or reassure patients and relatives in the waiting area.

Emergency Department
Patient Flow

The patient flow through the emergency department was observed during the period of the study and was validated with the Director of the Ambulatory Care Department and the Director of Emergency Physicians (Appendix I). On entry into the department, a patient would present himself to the patient accounts clerk sitting at a desk near the entrance. The clerk would inquire as to the nature of the patient's condition and make a decision as to the urgency of his condition. If the clerk considered the patient urgent, he would gain the attention of the occupants of the nursing station by tapping on the glass wall between the areas and direct the patient into the treatment area. The triage nurse would determine the need for immediate treatment and whether the patient had a private physician. If the patient had a private physician on the hospital's staff, only that treatment necessary to stabilize his physical condition was accomplished and, at the same time, the named physician was contacted. The private physician was given the option of allowing the emergency service physician to continue treatment

or coming to the emergency department to provide treatment himself.

The hospital periodically queried all members of the medical staff to determine their desires for disposition of their patients who present themselves for treatment at the emergency department (Appendix J). The desires of the medical staff are consolidated on lists posted at the nurses' station and, in some instances, preclude the necessity of contacting a private physician. There appeared to be a slowly developing trend for physicians to have their patients treated by emergency department personnel. During this process, an ambulatory service record (Appendix K) is initiated for the patient, as time and his condition permits. If the private physician decided to treat the patient, then the patient was informed of the decision and asked to wait in either the waiting area or a treatment room, depending on his condition. In some instances, these patients were observed to be waiting in the hallway of the treatment area. In many cases, the private physician would request that diagnostic tests be performed prior to his arrival.

Although patient waiting time varied considerably, it exceeded the time the patient would have waited for emergency physician treatment in all observed instances. The patient was treated in the emergency department when the private physician arrived. If the private physician determined the patient required hospitalization, the admitting

process was started. If hospitalization was not required, the patient was sent back to the patient accounts clerk in the reception area to settle the account generated by the visit.

If the private physician indicated a desire for the emergency service physician to treat his patient by responding appropriately to the hospital's questionnaire or telephonically at the time of the patient encounter, the emergency room physician then brought the patient to the disposition decision. During the course of treatment, the emergency service physician was observed to encounter certain physical conditions which he believed he was not qualified to diagnose or treat. In these instances, an on-call consultant was contacted for advice or, as it happened in most of these situations, the consultant would come to the hospital and provide the necessary assistance.

The emergency room physicians had admitting privileges on the hospital staff, but declined to exercise this privilege because of the responsibilities involved in accepting an in-house patient. For this reason, when the emergency service physician determined a patient required hospitalization, an on-call medical staff member was contacted to accept responsibility for the patient while he was in the hospital.

When the patient accounts clerk determined that an entering patient had a nonurgent condition, the patient would

be asked to provide the information required on the ambulatory service record. After completing this document, the patient was asked to wait in the designated waiting area, located in the reception area. The patient accounts clerk passed the ambulatory service record through a slot in the wall to the nurses' station where the triage nurse verified the information on the record, substantiated whether the patient would be seen in the facility, and established whether he had a private physician. If the patient was to be seen, and no private physician was named, the patient was incorporated onto the waiting list kept by the triage nurse. If the patient could not be seen, as would be the case should a private physician want to see the patient in his office, he was then informed of the decision by the triage nurse, and left the hospital. If the patient indicated he had a private physician, the process previously described relative to private-physician patients was carried out. The patient's flow through the department then proceeded, with the emergency room physician treating. The exceptions to this flow were the previously described necessity for a physician consultant, or those instances in which the patient required admittance to the hospital.

This flow depicted the encounters and sequencing of encounters that consitituted a patient's experience with the emergency service at Research Medical Center. Several of these encounters had a higher potential for patient

dissatisfaction than others. The initial encounter a patient experienced was with the patient accounts clerk. This individual made a decision which directly influenced the time involved between patient arrival, evaluation, examination, and treatment by the professional or semiprofessional staff. It was doubtful that the credibility of this clerk, in making this decision went unnoticed by the patient. His apparent lack of expertise, coupled with the relatively unsophisticated method of informing the triage nurse of an urgent patient, appeared to give the newly arrived patient an impression of a lack of professionalism on the part of the hospital staff.

Another series of encounters which had a high potential for patient dissatisfaction involved the patient who indicated on the ambulatory service record, or during an interview with the triage nurse, that he had a private physician. This patient was often surprised to find himself waiting for the named physician to be consulted. It appeared that most of the patients arriving with a condition which they considered urgent or emergent, fully expected to be treated by the physician on duty in the emergency department. It also appeared that a patient, inconvenienced by the wait for a private physician, transferred his dissatisfaction to the institutional process rather than the physician for whom he was waiting. This dissatisfaction was not apparent in those patients awaiting the arrival of a consultant. It was

also observed that patients who were required to go to the laboratory or radiology service for diagnostic procedures often had to wait because the staff in these departments, qualified to perform the necessary procedures were on a coffee or meal break. All instances in which a patient was required to wait carried a high potential for patient dissatisfaction; hence, a negative patient relationship within the emergency department. In several instances, patients were placed in the treatment area hallway to await a physician or the results of a diagnostic test. These individuals were not offered any form of diversion, such as a magazine or other reading material during periods of up to an hour's duration. Twice a parent was observed to be waiting with a child who was seated in a wheelchair. The parent was not offered a chair nor were any available in the hallway. Patients waiting in this area were able to overhear most staff conversation and observe the staff actions and reactions which took place in this hallway. An interview with a nursing supervisor indicated that this area was used in order to assure observation of the patient from the nursing station. Within the primary waiting area, there were twelve magazine-type publications available for patients (Appendix L). All but two of these were considered outdated and all appeared to have been well utilized because their covers were nonexistent or tattered.

Emergency Department
Human Relations

The human relations expertise of the emergency service staff was evaluated against a predetermined checklist (Appendix M). The results of this informal survey varied considerably between members of the staff. No one group, such as nurses, physicians, and so forth, was identified as having more or less expertise than another. Interviews with selected staff members indicated an absence of any formal training within the human relations area.

Emergency Department Design

An evaluation of the design configuration of the emergency department began with the arrival of patients at Research Medical Center. The emergency entrance to the hospital grounds was found to be well marked. Patients arriving at the hospital were afforded a drive-through garage for off-loading directly in front of the emergency department door. Parking facilities for emergency patients were limited in the area adjacent to the entrance (Appendix N). Hospital employees were prohibited from parking in the designated patient parking area; however, no specific number of stalls were reserved for emergency department patients. Entry into the medical staff parking areas was controlled by a mechanical gate which opened with a magnetic card issued to the medical staff. The lack of a reserve parking area for emergency department patients and the limited access

medical staff parking areas did not appear to impact on available parking for emergency department patients.

The interior design of the emergency department had areas which appeared to inhibit positive patient relations within the department. The patient accounts desk and files were located to the left front of the entrance in the reception area (Appendix O). This location caused a traffic obstruction to entering patients and also to traffic between the waiting area, the rest rooms, and the water fountain.

Also located within this area were from four to six wheelchairs and a litter stanchion. These items obstructed traffic to the public telephone and generally created an atmosphere of disarray as they were often moved by patients trafficking the area. Immediately to the rear of the patient accounts clerk was a glass window separating this area from the nurses' station. This allowed patient and visitor observation of all occupants of the nurses' station. The patient accounts clerk was afforded no privacy in the conduct of his administrative duties. Conversation between this individual and patients was easily overheard by anyone in the immediate area. Seating in the waiting area was provided with solid plastic chairs around the wall.

The vinyl wall covering had a soiled appearance, and there were no pictures on any of the walls. All lighting within this area was provided by ceiling-mounted fixtures. The ceiling-mounted television provided a diversion for

waiting patients and visitors; however, it was mounted over the entrance to the waiting area, and individuals watching it were easily distracted by entering patients and the activity at the patient accounts desk.

A separate waiting area was not provided for emotionally disturbed patients or relatives. The treatment area did not provide for a physician's office where consultation could take place. Therefore, consultations with either patients or relatives took place in a treatment room or in the hallway. This appeared to be disconcerting to the patient, the family of the patient, and the staff. There was no lounge area provided for the staff, and the staff made use of a utility room for break periods.

The cleanliness and orderliness of the treatment areas were exceptional. They exemplified the efficiency and professionalism of the institution. It was the philosophy of the institution that signs or other direction-giving devices hanging from hallway ceilings, protruding from the walls, or painted on the floors detracted from the professional appearance of the hospital; therefore, patients referred to other sections of the hospital for diagnostic tests, treatment, or pharmaceuticals found it very difficult to locate the proper area. Junior volunteers were used as guides for individuals so referred, but it was observed that these volunteers were not always available for this duty, and often a patient would be required to find his own way,

On several occasions patients were observed returning to the emergency department in a frustrated state of mind to ask for more complete directions.

An emergency service area renovation was included in the Stage I construction plan scheduled for completion in 1980 (Appendix P). Most of the previously mentioned floor plan deficiencies which appeared to have an impact on patient relations would be eliminated by this plan. An exception to this design was the failure to provide a physician's office within the emergency department. It was also noted that the programed design allows for patients to be triaged into an adjacent outpatient area. This change would allow for better utilization of hospital resources.

Emergency Department Patient Relations Program

The emergency department patient relations program at Research Medical Center was a fragmented collection of procedural directives (Appendix Q). More recently a program plan for the Ambulatory Care Department has been published (Appendix R). As of the date of the study, three of the four program elements had not been formulated. The Public Relations Director stated in an interview that the program was based on past patient complaints. An inventory of these complaints was not available for the study. The Public Relations Director further stated that the standard for public relations within this department was the absence of complaints.[4]

A formal reorganization of the Public Relations Department to a Patient/Public Relations Department was being studied during the time of this inquiry (Appendix S). The stated objectives of this proposal and the proposed staffing necessary to implement these objectives could greatly enhance the emergency department effort in this area.

Summary

The organization and philosophy of the Research Medical Center Emergency Department fosters positive patient relations within the department. A review of the patients statistical data does not indicate unusual trends developing with the patient population. The physician staffing methodology utilized in the emergency department should provide the best possible environment for patient relations. Nurse staffing appeared more than adequate; however the team leader concept, recently introduced, was not accomplishing the patient relations objectives because of a failure on the part of the incumbent to interact with patients and relatives in the waiting area.

Patient flow in the department presented several negative patient relations situations. The patient accounts clerks' involvement in the triage process is open to criticism. The waiting time involved in contacting named private physicians was excessive and the resultant patient and family anxiety appeared as criticism of the institution.

Patients sent to other hospital departments for diagnostic tests often had to wait for adequate staffing before the tests could be performed. Patients often experienced difficulty in finding other areas of the hospital, resulting in a certain amount of anxiety. The use of the hallway in the emergency department allowed patients to observe staff actions not necessarily involved with patient care. Diversions for waiting patients, such as magazines, were inadequate.

The absence of an inservice human relations training program within the department limited the development of better staff-patient relationships.

The internal design configuration of the reception and waiting areas inhibited patient flow. The interior decoration of these areas presented a cold and dingy appearance. The lack of a private waiting room for emotionally disturbed patients or relatives subjected those persons in the waiting area to undue stress. The lack of a break area for the staff allowed patient observation of these individuals during their rest periods. The proposed emergency department renovation plan did not provide for a physician's office and this oversight could inhibit the privacy necessary in some types of consultations.

The current emergency department patient relations program was not effective in that it was based on solving identified complaints rather than preventing future complaints.

Footnotes

[1]Interview with LaVaughn Boldt, Assistant Executive Director, Research Medical Center, Kansas, Missouri, March, 1975.

[2]Interview with Carl J. Felling, Assistant Director for Patient Services, Research Medical Center, Kansas, Missouri, March, 1975.

[3]Interview with Gerald Winchell, Ambulatory Care Director, Research Medical Center, Kansas, Missouri, March, 1975.

[4]Interview with Gordon C. Thomson, Public Relations Director, Research Medical Center, Kansas City, Missouri, March, 1975.

CHAPTER III

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Although the patient relations within the emergency department at Research Medical Center, as measured by the hospital's standards, were good during the period of the study, the potential for adverse relationships within certain areas cannot be discounted. Attention to these areas should not only lessen their negative patient relations potential, but raise the current level of patient satisfaction within the department. The more than twenty thousand annual patient visitors to this department could have a tremendous impact on how the community views Research Medical Center.

Recommendations

The following recommendations are submitted as effective methods of improving patient relations in the emergency department at Research Medical Center:

1. The triage nurse should meet incoming patients and make the initial decision as to patient disposition.

2. The emergency department staff should take more efforts to ensure waiting patients are informed of their status.

3. The hospital should actively solicit medical staff cooperation in allowing the emergency department physicians to treat those patients who present themselves for treatment in the department.

4. Patients should not be referred to ancillary services when those services do not have the necessary staff immediately available.

5. Patients should not be required to wait in the treatment area hallway. The observation room should be used for this purpose, and a staff member should be present.

6. A current periodical selection should be maintained within waiting areas.

7. The 1975 Program Plan for Patient Relations within the Ambulatory Care Department should be implemented.

8. A more pleasant atmosphere should be created within the reception and waiting areas by:

a. Cleaning or re-covering walls and woodwork.

b. Breaking up large expanses of wall with pictures or other decorative devices.

c. Repositioning the waiting area television.

d. Providing indirect lighting in the form of lamps in the waiting area.

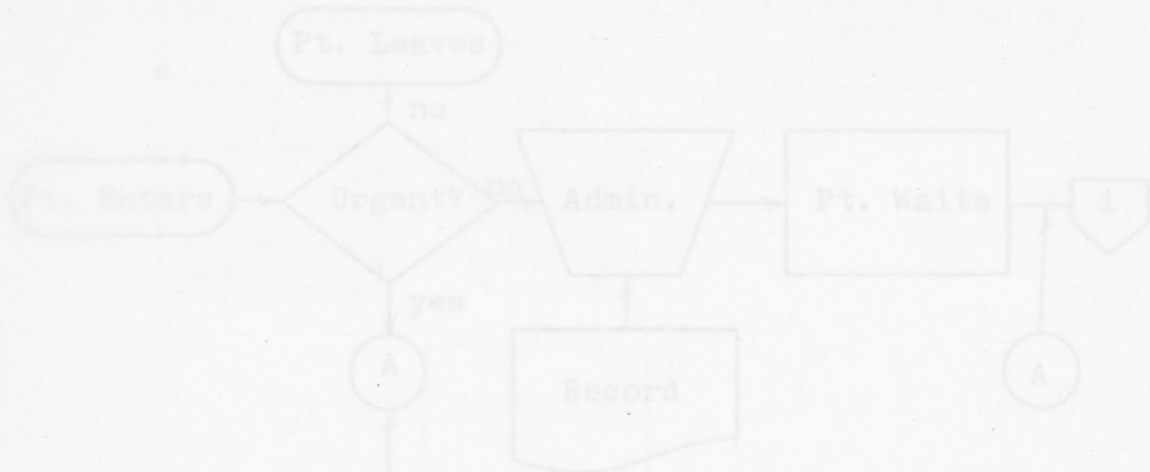
e. Removing the wheelchairs and litter stanchion from the reception area and placing them within the garage.

f. Moving the patient accounts clerk to a position adjacent to the nurses' station wall and screening off the interview area.

9. The proposed renovation plans should be implemented with a provision for a physicians office.

10. The patients should be given a simple floor plan diagram to assist them in locating other services in the hospital.

11. The proposed Public Relations Department reorganization should be implemented with the public relations training program having a primary impact on the emergency department of the hospital.

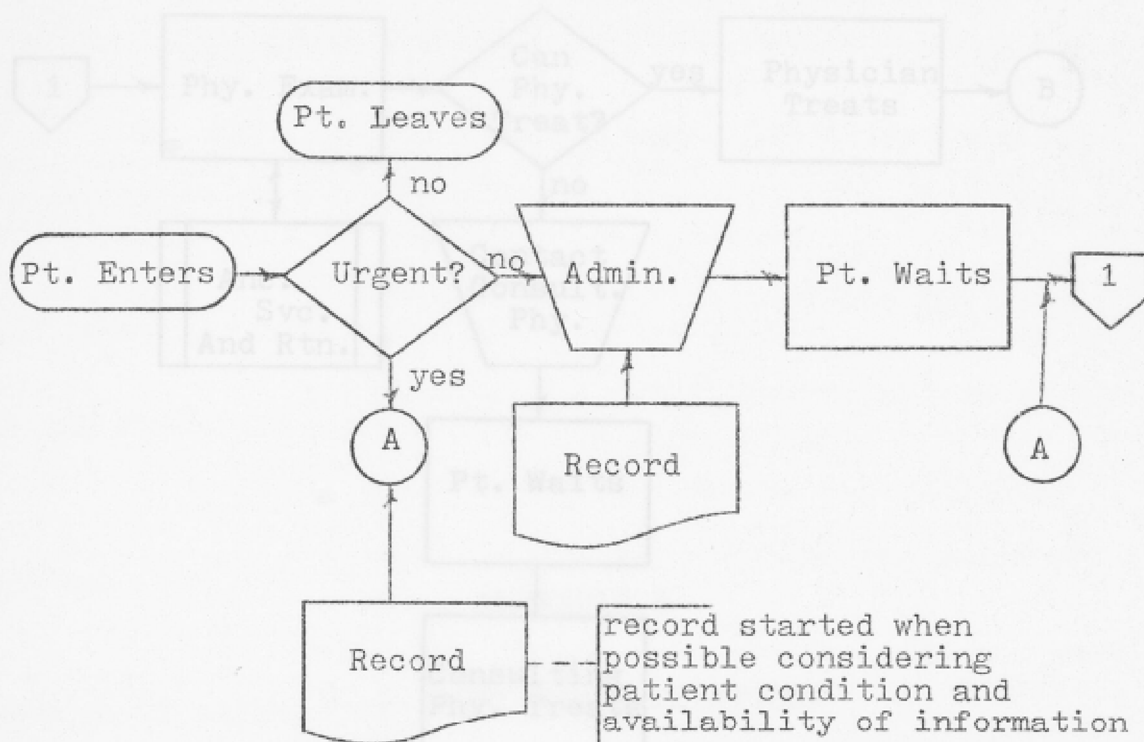


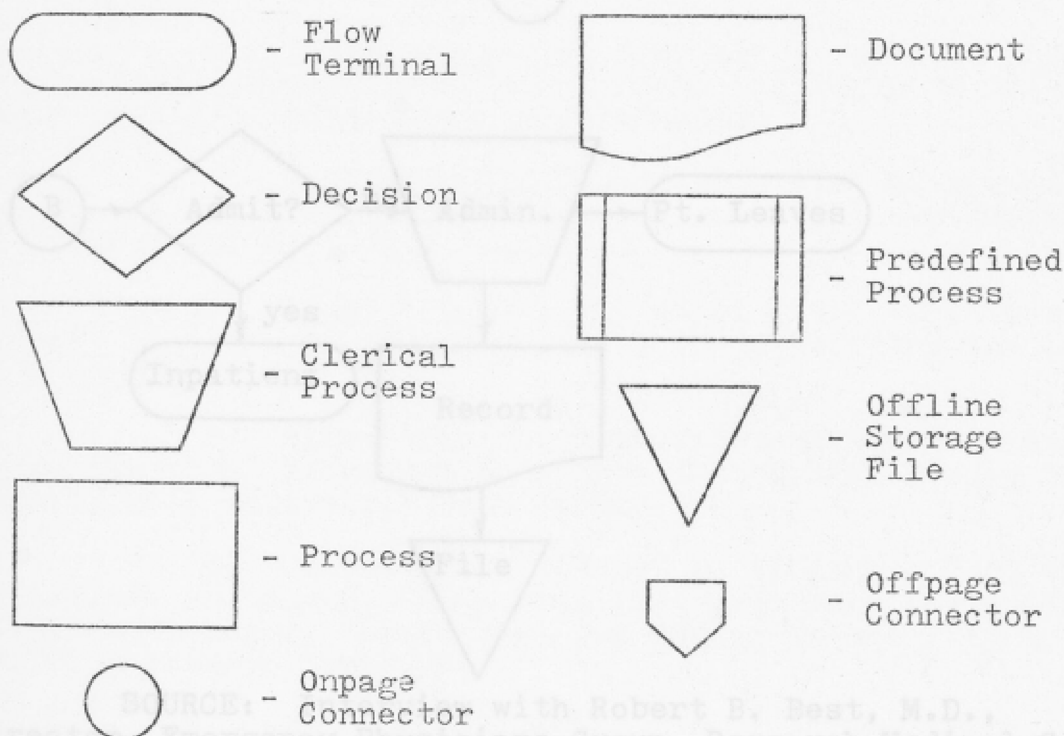
APPENDIX A

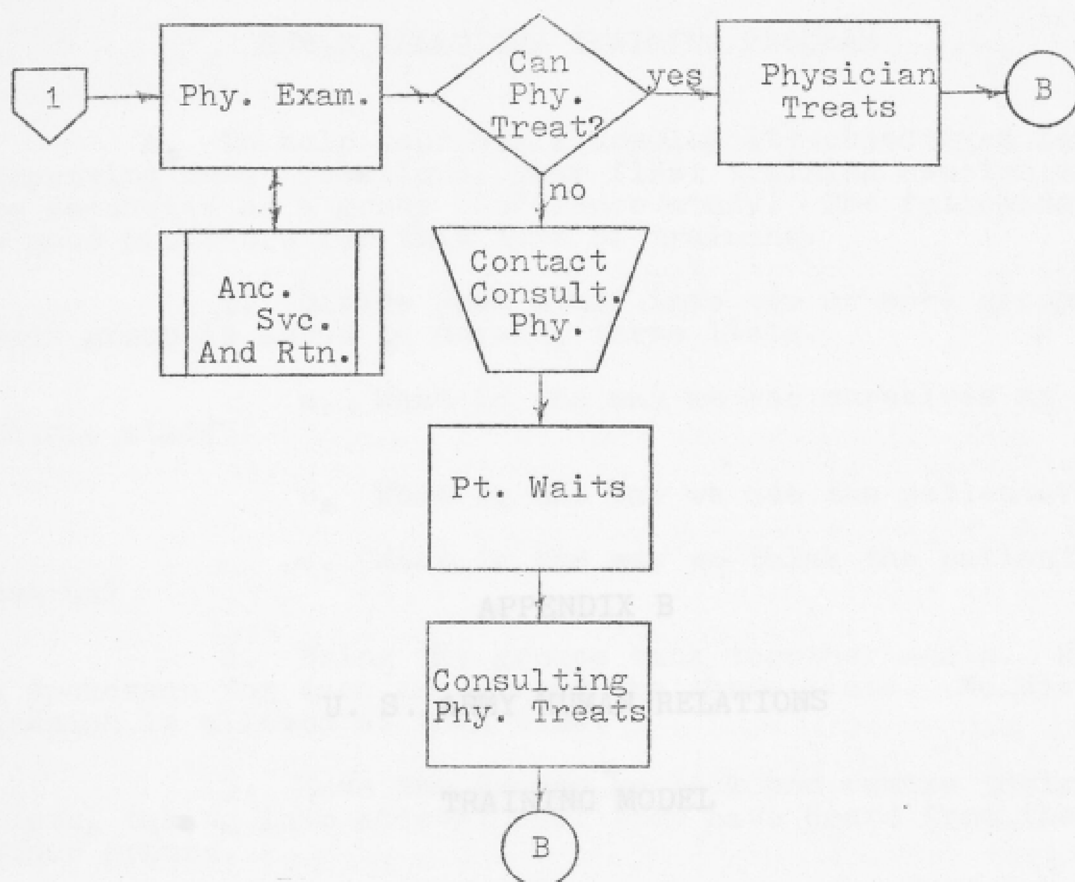
PATIENT FLOW MODEL FOR HOSPITAL EMERGENCY DEPARTMENTS

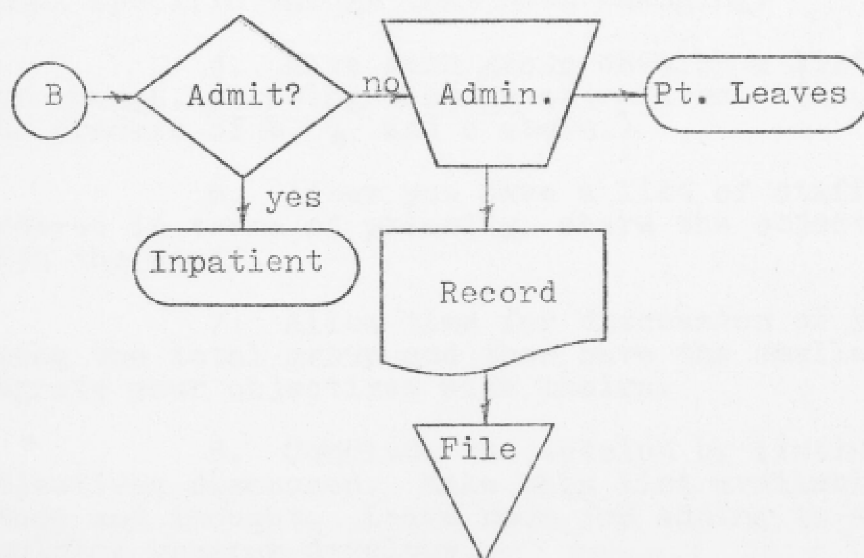
PATIENT FLOW

HOSPITAL EMERGENCY DEPARTMENT









SOURCE: Interview with Robert B. Best, M.D., Director, Emergency Physicians Group, Research Medical Center, Kansas City, Missouri, March, 1975.

APPENDIX B

U. S. ARMY HUMAN RELATIONS

TRAINING MODEL

HUMAN RELATIONS TRAINING PROGRAM

A. To help your staff develop its objectives for improving human relations, your first training session should be conducted as a group conference study. The following is a good procedure for this type of training:

1. Divide your staff into two or more groups. Each group is asked to develop three lists.

a. What is the way we see ourselves as a clinic staff?

b. What is the way we see the patients?

c. What is the way we think the patients see us?

2. Bring the groups back together again. Have a spokesman for each group read the three lists. No discussion is allowed at this time.

3. Have the groups go back and remake their lists, taking into account what they have heard from the other groups.

4. Bring the groups together to discuss their final lists. Suggest that each individual begin to think about specific things that need changing.

5. Have each group develop a list of priorities for change, phrasing them as objectives. (You can repeat the process of b, c, and d above.)

6. After you have a list of staff objectives ordered in terms of priority, share the objectives you have with the staff.

7. Allow time for discussion of your objectives among the total group and then have the smaller groups integrate your objectives with theirs.

8. Conclude the session by listing all of the objectives discussed. Make this list available for staff study and thought. Leave room for adding to the list as your training program develops.

B. Plan your future sessions around specific objectives. Begin with those which you and your staff feel have the highest priority and those that will produce immediate change.

1. Prepare discussion questions for each objective and if possible present them in advance to your staff.

2. Sessions can be augmented by films or by selected guest speakers who have information pertaining to the subject.

3. You should always allow time for the participants in the training to discuss the material. Keep the emphasis on direct application to your clinic's operation.

4. If you survey your patient population, the results of the survey can serve as the topic for an entire training session. Use this information as a tool to help your staff develop a diagnosis of themselves.

C. The advantages of this approach to training are numerous. Not only are you making needed information available to your staff, but you are also involving them in the training process. Making people aware of problems often creates an immediate change in behavior simply because people begin thinking about what they do. Another desirable side effect of this approach is improved communication between staff members. Problems are out in the open where they can be dealt with directly rather than covertly. In addition, you are in a better position to deal with your staff, as well as with other elements of the hospital, when you know what the problems are. The end product will be a better human relations climate in your clinic and reduced patient dissatisfaction.

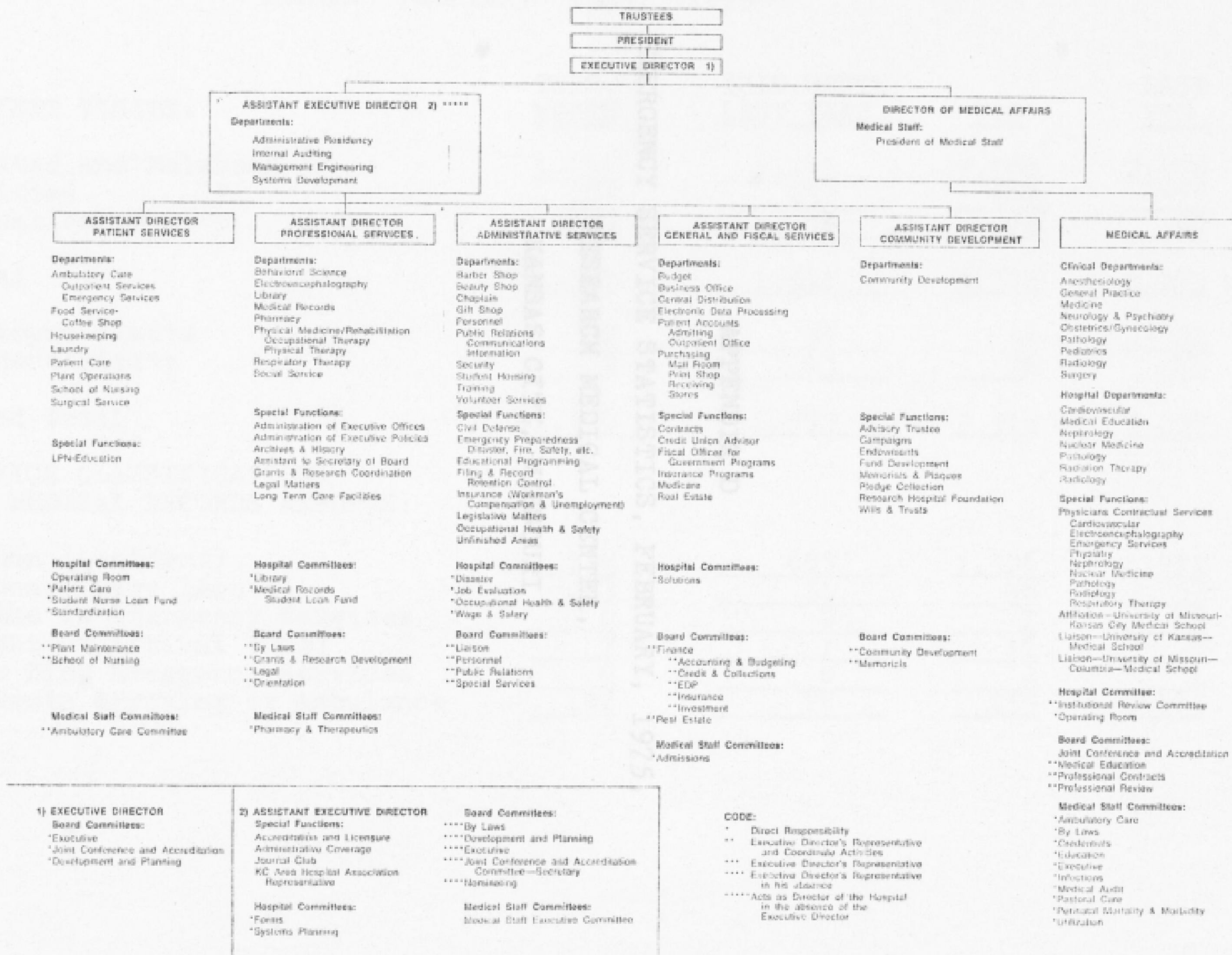
SOURCE: U. S. Army Health Services Command, "A Study Guide for Human Relations in Ambulatory Patient Care," Ambulatory Patient Care (APC) Program, July, 1974. (Mimeographed), pp. 13-14.

APPENDIX C

FUNCTIONAL CHART, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI

RESEARCH HOSPITAL AND MEDICAL CENTER

FUNCTIONAL CHART



APPENDIX D

EMERGENCY SERVICE STATISTICS, FEBRUARY, 1975,

RESEARCH MEDICAL CENTER,

KANSAS CITY, MISSOURI

RESEARCH MEDICAL CENTER
EMERGENCY SERVICES STATISTICS
MONTH: February YEAR: 1975

PATIENT VISITS:	THIS MONTH	THIS MONTH LAST YEAR	YTD	LAST YTD
Treated and Released	1,234	1,241	2,700	2,476
Admitted	285	232	602	517
In-patient Visits	38	38	76	80
Total	1,557	1,511	3,378	3,073
Employee Visits	22	37	56	82
Student Visits	29	45	76	83
Grand Total	1,608	1,593	3,510	3,238
SERVICE CLASSIFICATIONS FOR MEDICAL RECORDS REPORTS:				
Trauma (Accident)	784	685	1,506	1,411
Coronary Care (Acute)	23	31	48	57
Deaths in Emergency Services	0	0	1	2
Deaths on Arrival (DOA)	7	1	11	7
Code Blue Emergency Services	0	0	2	1
Patients Arriving by Ambulance	142	78	255	185

APPENDIX E

EMERGENCY DEPARTMENT SHIFT STATISTICS, 1973, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI

RESEARCH MEDICAL CENTER
KANSAS CITY, MISSOURI

Number of Patients Seen per Shift
per Month in the Emergency
Department in 1973

MONTH	DAYS	EVENINGS	NIGHTS	TOTAL
January	663	903	315	1,881
February	571	751	221	1,543
March	560	811	244	1,615
April	664	934	263	1,861
May	707	1,094	281	2,082
June	743	1,134	315	2,192
July	762	1,115	342	2,219
August	682	1,081	328	2,091
September	683	1,008	280	1,971
October	747	1,011	274	2,032
November	679	847	293	1,819
December	700	793	257	1,750
Total	8,161	11,482	3,413	23,056
	(35%)[a]	(50%)[a]	(15%)[a]	

[a]Per cent of the total.

SOURCE: Ambulatory Care Department Files, Research Medical Center, Kansas City, Missouri, March, 1975.

APPENDIX F

SUMMARY OF EMERGENCY DEPARTMENT PATIENT POPULATION STATISTICS, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI

SUMMARY OF EMERGENCY DEPARTMENT
PATIENT POPULATION STATISTICS

Patient Population 1975[a]	Number	Percentage
Patient Origin		
City[b]	255	73.9
State[c]	73	21.2
Out-of-State	17	4.9
Legal Status		
Adult	211	61.2
Children	134	38.8
Sex		
Male	182	52.8
Female	163	47.2
Method of Payment		
Self Pay	25	7.2
Third Party Pay[d]	320	92.8

[a]Survey of 345 ambulatory service records.

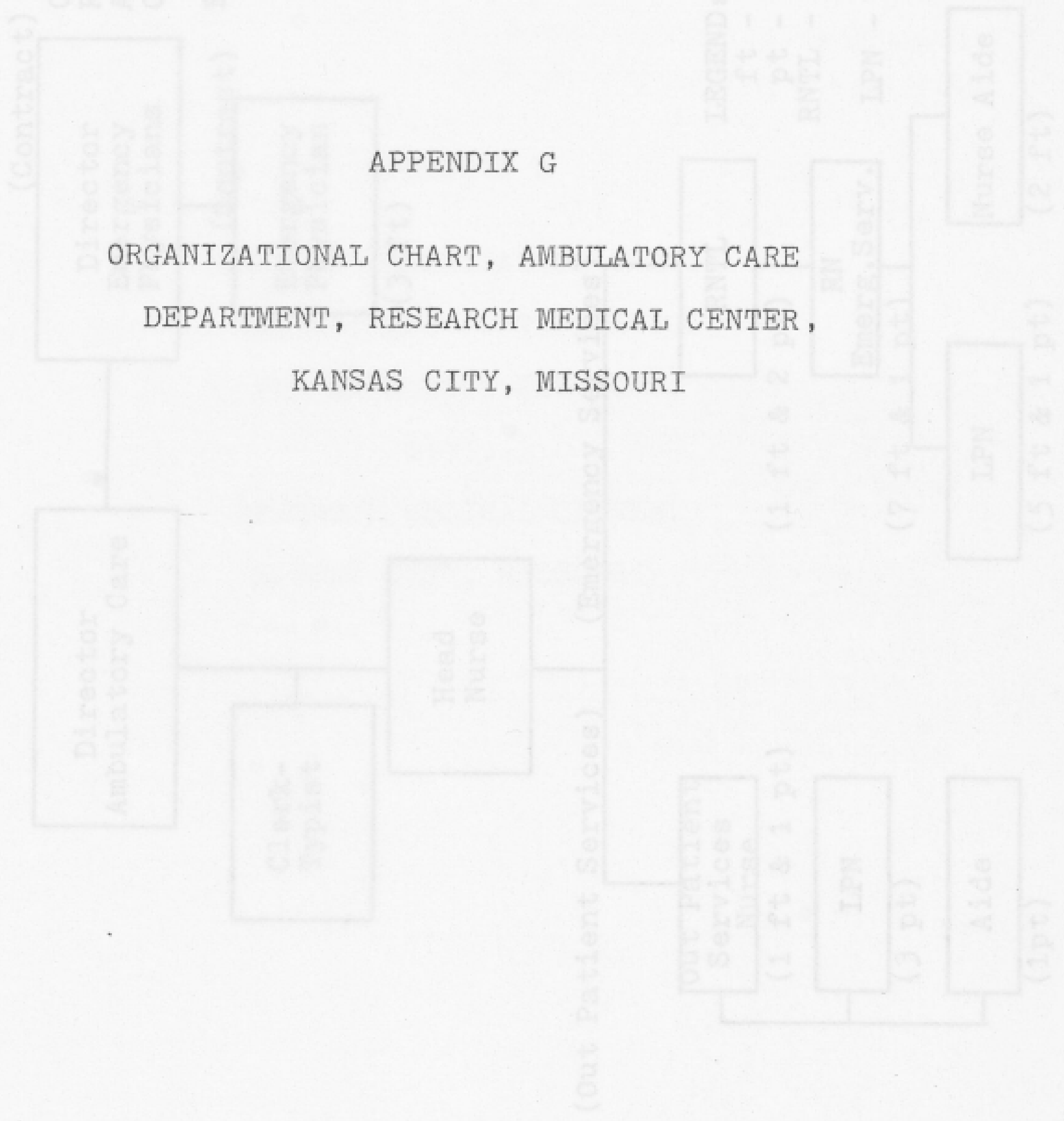
[b]Kansas City metropolitan statistical area.

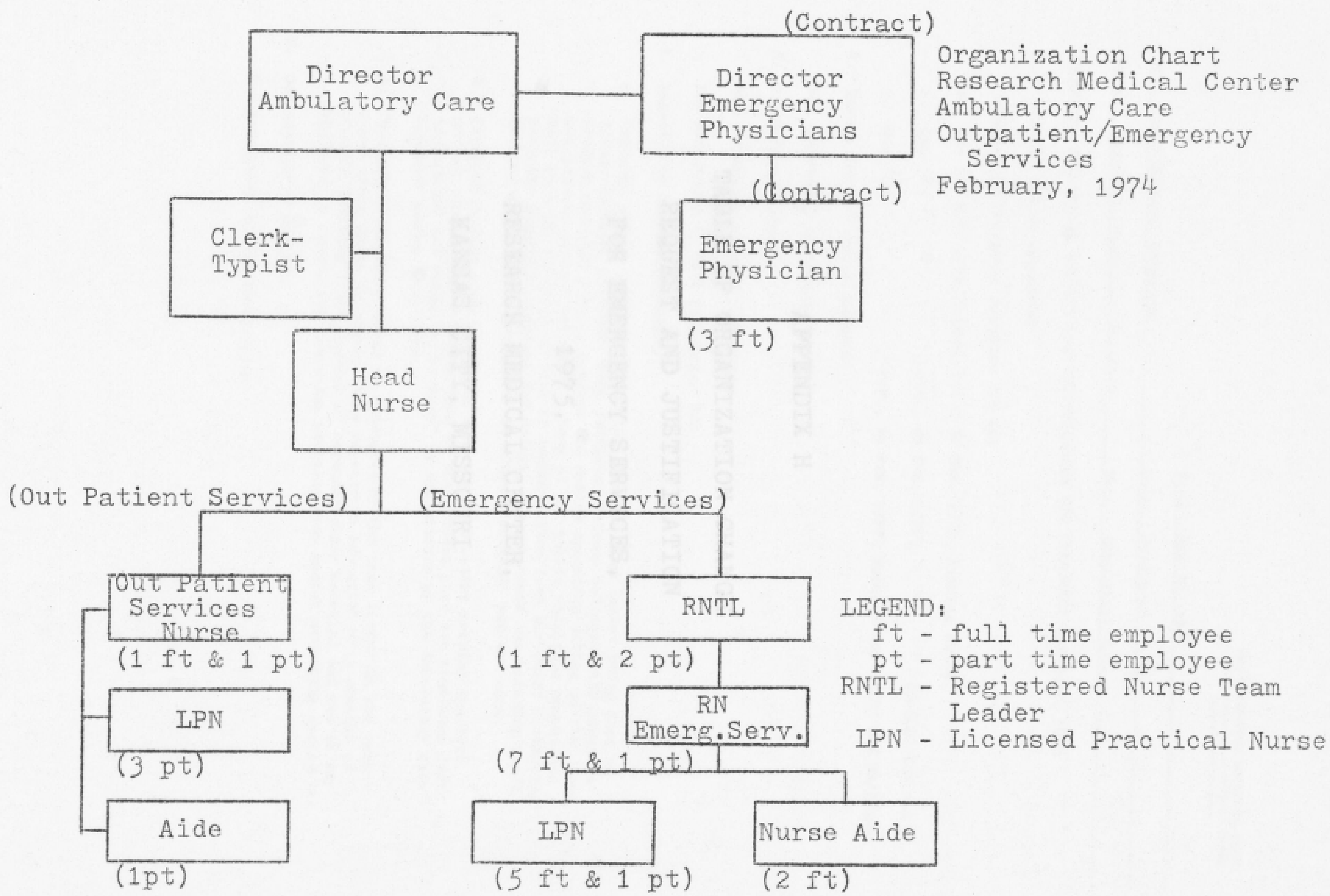
[c]Kansas and Missouri.

[d]Patients claimed third party coverage.

APPENDIX G

ORGANIZATIONAL CHART, AMBULATORY CARE DEPARTMENT, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI





Organization Chart
Research Medical Center
Ambulatory Care
Outpatient/Emergency
Services
February, 1974

LEGEND:
ft - full time employee
pt - part time employee
RNTL - Registered Nurse Team Leader
LPN - Licensed Practical Nurse

APPENDIX H

TABLE OF ORGANIZATION CHANGE
REQUEST AND JUSTIFICATION
FOR EMERGENCY SERVICES,
1975,
RESEARCH MEDICAL CENTER,
KANSAS CITY, MISSOURI

MEMORANDUM

RESEARCH HOSPITAL AND MEDICAL CENTER
MEYER BOULEVARD AT PROSPECT AVENUE
KANSAS CITY, MISSOURI

Date: May 15, 1974

TO: David Whitney, Director — Dept: Personnel

FROM: Gerald L. Winchell, Director — Dept: Ambulatory Care

SUBJECT: T/O CHANGE REQUEST AND JUSTIFICATION FOR EMERGENCY SERVICES, 1975

1. Specific change requested:

   Addition to Emergency Services T/O of:

   a. One (1) R.N. Team Leader, F.T., 80 Hrs. P/PP, Evening Shift

   b. One (1) " " " P.T., 40 Hrs. P/PP, " " (Relief for a.)

   c. One (1) " " " P.T., 40 Hrs. P/PP, Weekend Day Shift and Holidays

2. Reason for T/O Change Request:

   See Attachment A, Narrative.

3. Statistical Data:

   See Attachment B, 1973 Statistics

   See Attachment C, 1974 Statistics YTD

4. Benefits or savings expected:

   a. Improved public relations resulting from the team leader being free to triage incoming patients, keep patients/visitors informed with progress reports and also free to oversee the entire operation acting as the liaison between patient and staff. Many of our public relations complaints fall into the category of lack of communication from our staff concerning patients condition, reasons for delays, etc., because the existing staff is busy with patient care which is often "critical" patient care.

   b. Improved patient care resulting from the team leader keeping the work moving, checking on patients (who at the present time are sometimes left unattended) and being "straw boss" in the absence of the Ambulatory Care Director and/or Head Nurse.

   c. In-service education could be conducted by the team leader in the rare slack times which do occur. This in-service education will consist of showing training films, review of coronary class material and use of any appropriate in-service education training aids and/or materials available.

5. Description of Duties:

   See Attachment D, Job Description

MEMORANDUM

RESEARCH HOSPITAL AND MEDICAL CENTER
MEYER BOULEVARD AT PROSPECT AVENUE
KANSAS CITY, MISSOURI

Date: May 15, 1974

TO: David Whitney, Director — Dept: Personnel

FROM: Gerald L. Winchell, Director — Dept: Ambulatory Care

SUBJECT: T/O CHANGE REQUEST AND JUSTIFICATION FOR EMERGENCY SERVICES, 1975 (continued)

6. Effect of the Additional Position on the Duties of Existing Positions:

   Improved employee morale, patient care and production.

7. Estimated Cost of the Change for 1975:

	J/C	Job Description	Work Status	No./Emp.	Hrs./PP	Approx. Annual Cost
1.	281	R.N. Team Leader	P.T.	1	80	$10,371
2.	281	" "	P.T. (Relief for #1)	1	40	$ 5,185
3.	281	" " "	P.T. (Coverage weekend, day shift and holidays)	1	40	$ 5,185
					TOTAL	$20,741

Cost based on pay grade 11.2, Step C, including shift differential where applicable but not including fringe benefits.

Gerald L. Winchell, Director
Ambulatory Care

GLW: mc

cc: Assistant Director, Patient Services
file

ATTACHMENT D

RESEARCH HOSPITAL AND MEDICAL CENTER

Kansas City, Missouri

Job Description

TITLE: Team Leader Emergency Services

REPORTS TO: Head Nurse, Ambulatory Care

SUMMARY:

Responsible for direct supervision of professional and non-professional personnel assigned to Emergency Services to insure quality of services rendered to patients. Serves as triage officer assuring that patients are handled in order of medical priority. Serves as a liaison between patients, nurses, doctors and family assuring a good line of communication between nursing service and patient/family. Reads and reviews appropriate technical and educational literature. Assists in the organization and conduction of an ongoing inservice education program. Assists in the orientation of new employees. Assumes responsibility for Ambulatory Care Department in Head Nurse's absence.

DUTIES AND RESPONSIBILITIES:

1. Assists in organizing and administering the Department of Ambulatory Care; assumes responsibilities delegated by Head Nurse, Ambulatory Care, including responsibility for direction of Department in Head Nurse and Director's absence.

2. Conducts conferences and discussions with personnel to encourage participation in formulating Departmental policies, promote initiative, solve problems and present new policies and procedures.

3. Analyzes nursing services to improve quality of patient care and to obtain maximum utilization of staff time and abilities. Co-ordinates activities of the nursing service in Emergency Services to achieve and maintain harmonious relationships among personnel supervised, medical staff, patients and others. Assists in establishing lines of authority and responsibility and defining the duties of nursing service personnel consistent with good administrative techniques to assure that Department objectives are accomplished.

4. Qualifications are:

   a. Ability to recognize the individual patient's signs and symptoms promptly.

   b. Astute nursing judgment in determining the acuteness of the patient's medical problems.

   c. Broad nursing knowledge of all aspects of patient care.

   d. Ability to relate to the patient regardless of age and level of intelligence.

   e. Ability to speak and write concisely and accurately.

   f. Ability to establish and maintain good public relations.

g. Ability to function effectively in stress situations.

h. Skill in listening.

i. Ability to work well with and through others.

j. Conduct that is socially acceptable.

k. Use of understanding, patience, tact, and discretion at all times in dealing with patients and visitors, community and law-enforcement agencies, ambulance drivers, hospital staff, and volunteer workers.

l. Ability to enforce visitor regulations in the Emergency suite with tact and discretion. The functions for which the team leader is responsible for are:

1.) Receives the eight-hour report of pertinent events from the preceding tour of duty. This report, by the triage nurse on each shift, includes information on the total number of patients seen; patients with significant problems such as traumatic injuries or drug overdose, the battered child syndrome, or cardiac arrest, and their condition and disposition; patients who have been in the Emergency suite for more than four hours - their diagnosis and probable disposition; any problems regarding unidentified patients, notification of next-of-kin, release of information to news media, reporting of cases to law-enforcement agencies, or patients being sent from other hospitals or cities.

2.) Sees each patient to assess his medical problem and refer him to the appropriate area in the suite.

3.) Gives emergency care to patients at the triage area, when indicated. Examples: applies pressure bandages or arm splints, delivers babies.

4.) Maintains good public relations with patient, family, and visitors.

5.) Obtains information via the intercom system concerning patients in the treatment areas and keeps relatives and visitors in the waiting room informed.

6.) Directs visitors and patients to other hospital departments, to the pay phone, and other facilities as needed.

7.) Assists the registration clerks in locating families of patients in the emergency suite.

8.) Is responsible for reporting any unusual circumstances to the supervisor.

9.) Notifies law-enforcement agencies of any patient admitted to the Emergency suite with a history of trauma, poisoning, overdose, or a similar situation.

10.) Receives emergency phone calls from police and fire departments concerning patients being sent to the hospital and notifies the clinical area to which the patient will be referred.

11.) Helps control visitors in accordance with hospital policy; issues visitor passes to the Emergency suite.

12.) Assists in the orientation of new employees.

13.) Maintains a safe, comfortable, and orderly environment.

5. Assists in cost control by being aware of budget restrictions and remaining within these restrictions in requesting supplies, etc. Communicates cost awareness to subordinates.

6. Assists in the orientation and inservice training programs for both professional and non-professional personnel. Insures proper and economical use of equipment, supplies, and facilities for maintaining patient care.

EXPERIENCE:

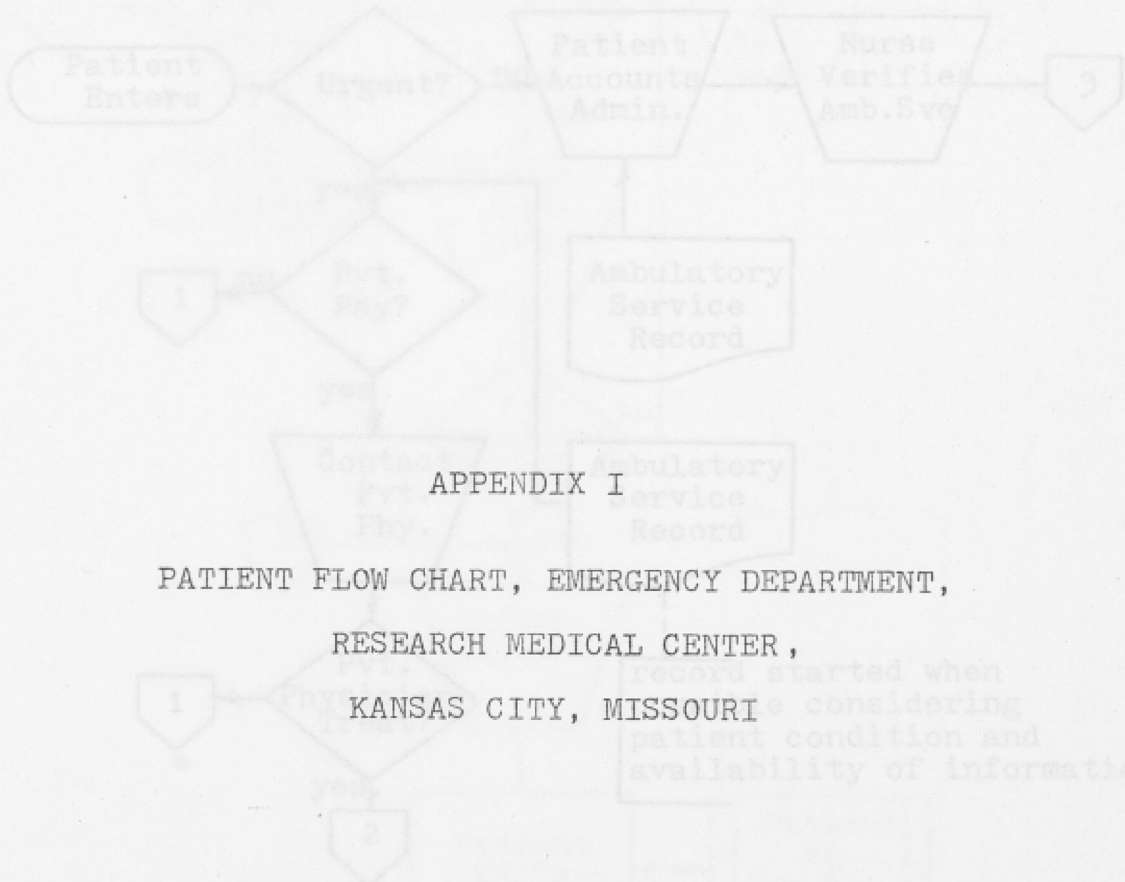
Experience in a supervisory capacity in which administrative, supervisory, and teaching abilities have been demonstrated. Previous Emergency Services experience desirable.

EDUCATION:

Graduation from an accredited school of nursing, current licensure by Missouri State Board of Nursing. Advanced education desirable.

Approved:

Date Department Head

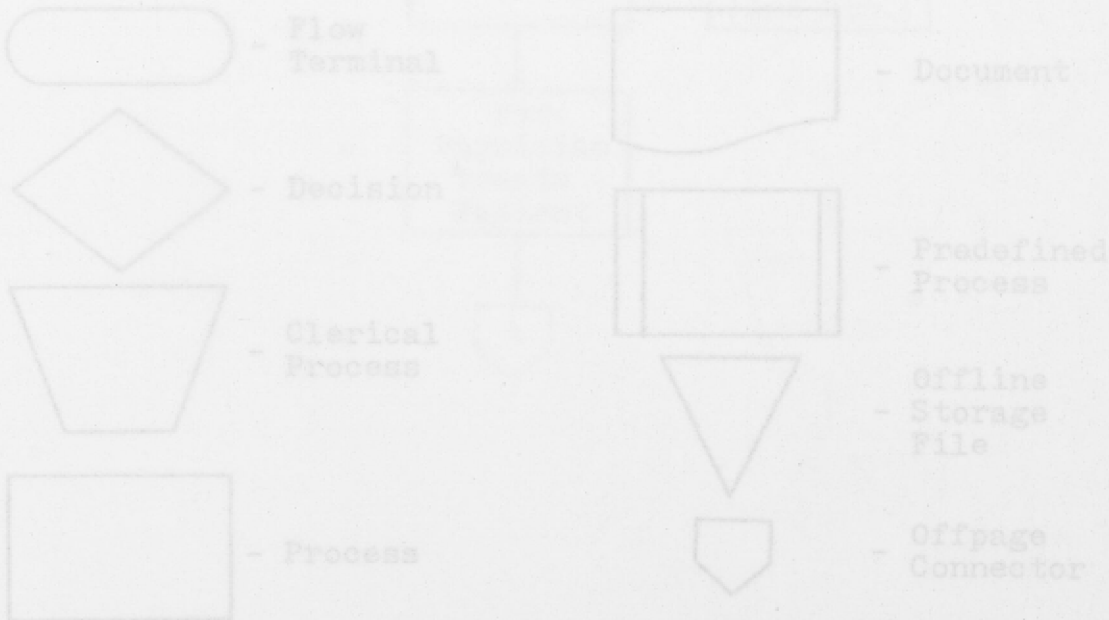


APPENDIX I

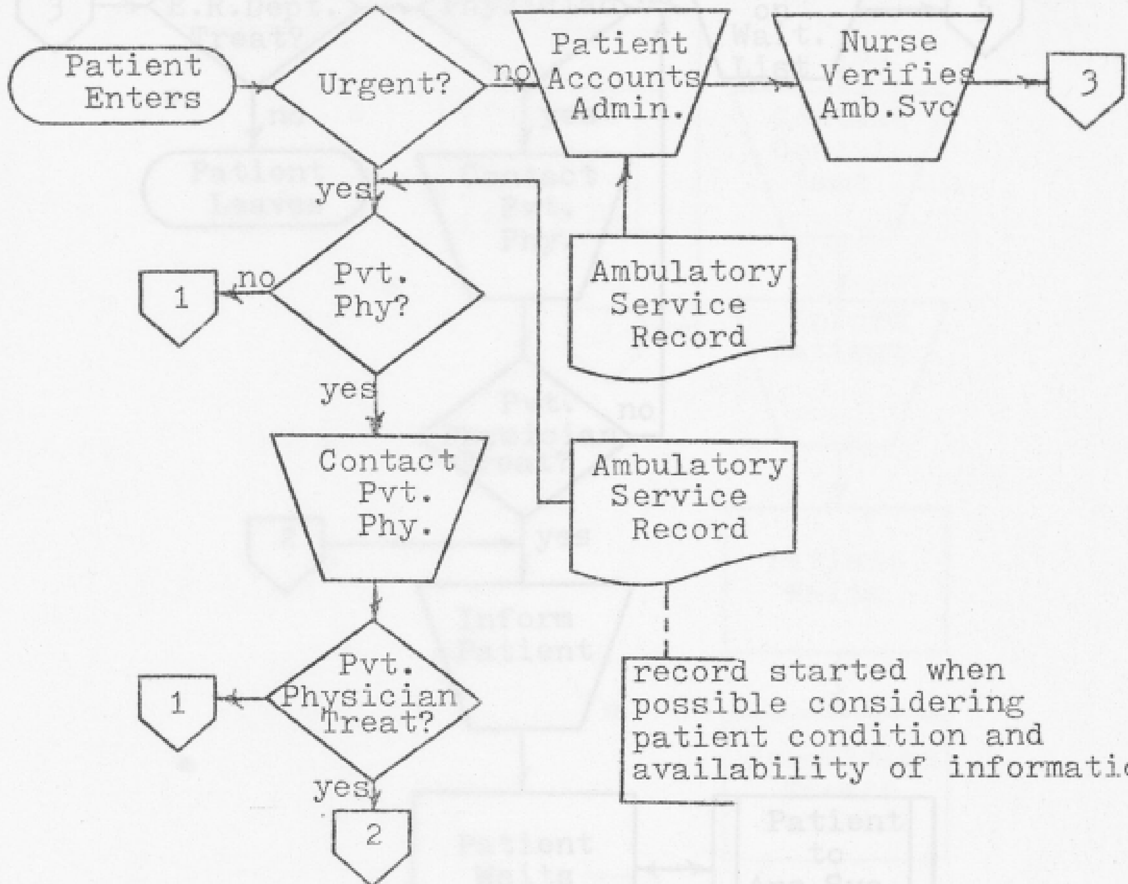
PATIENT FLOW CHART, EMERGENCY DEPARTMENT,

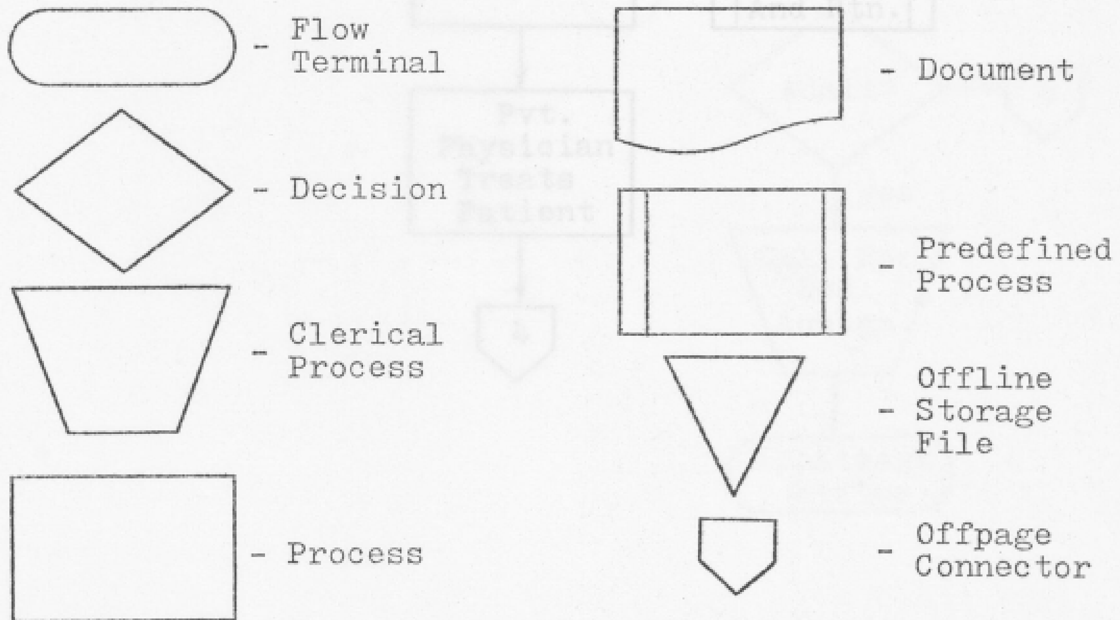
RESEARCH MEDICAL CENTER,

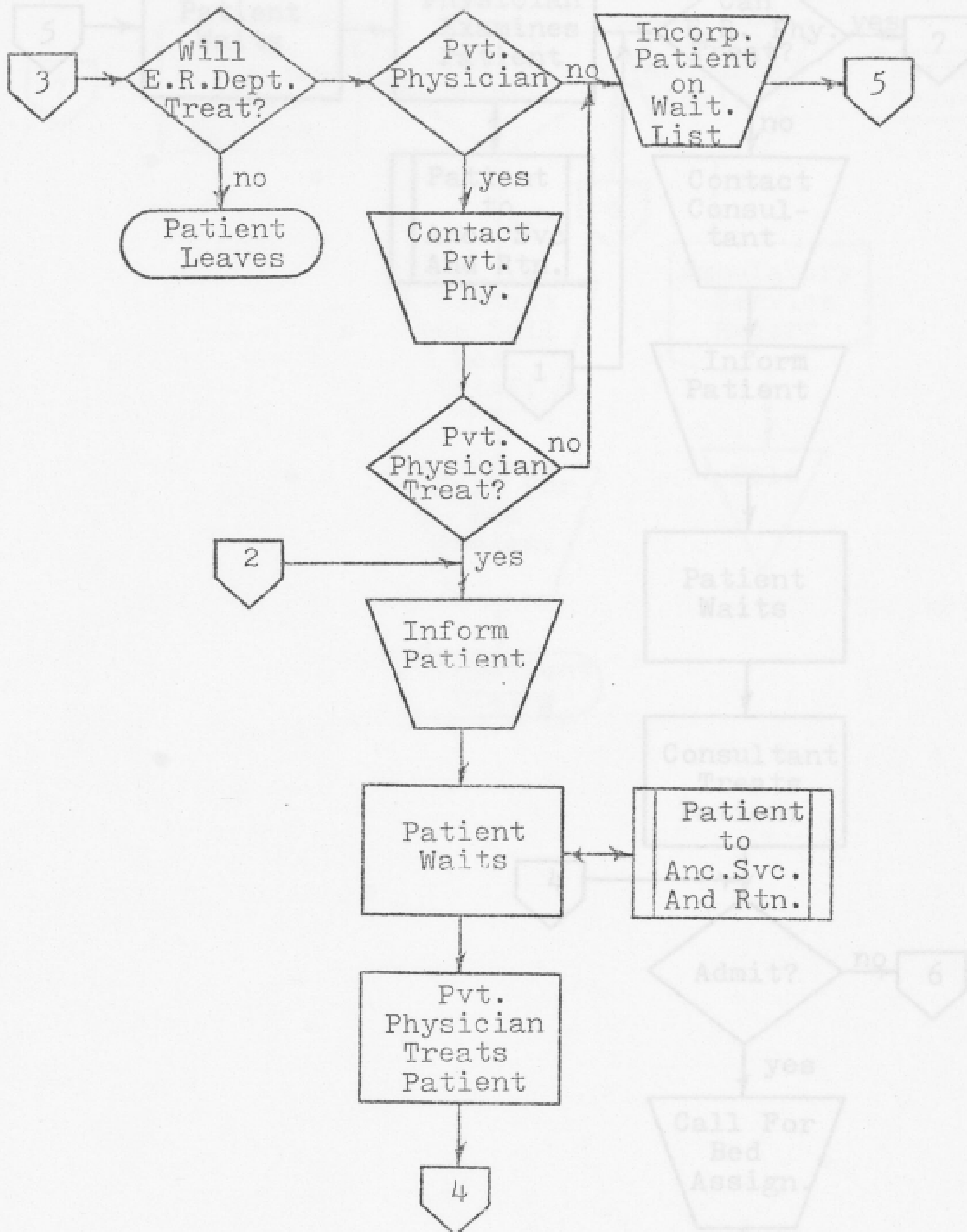
KANSAS CITY, MISSOURI

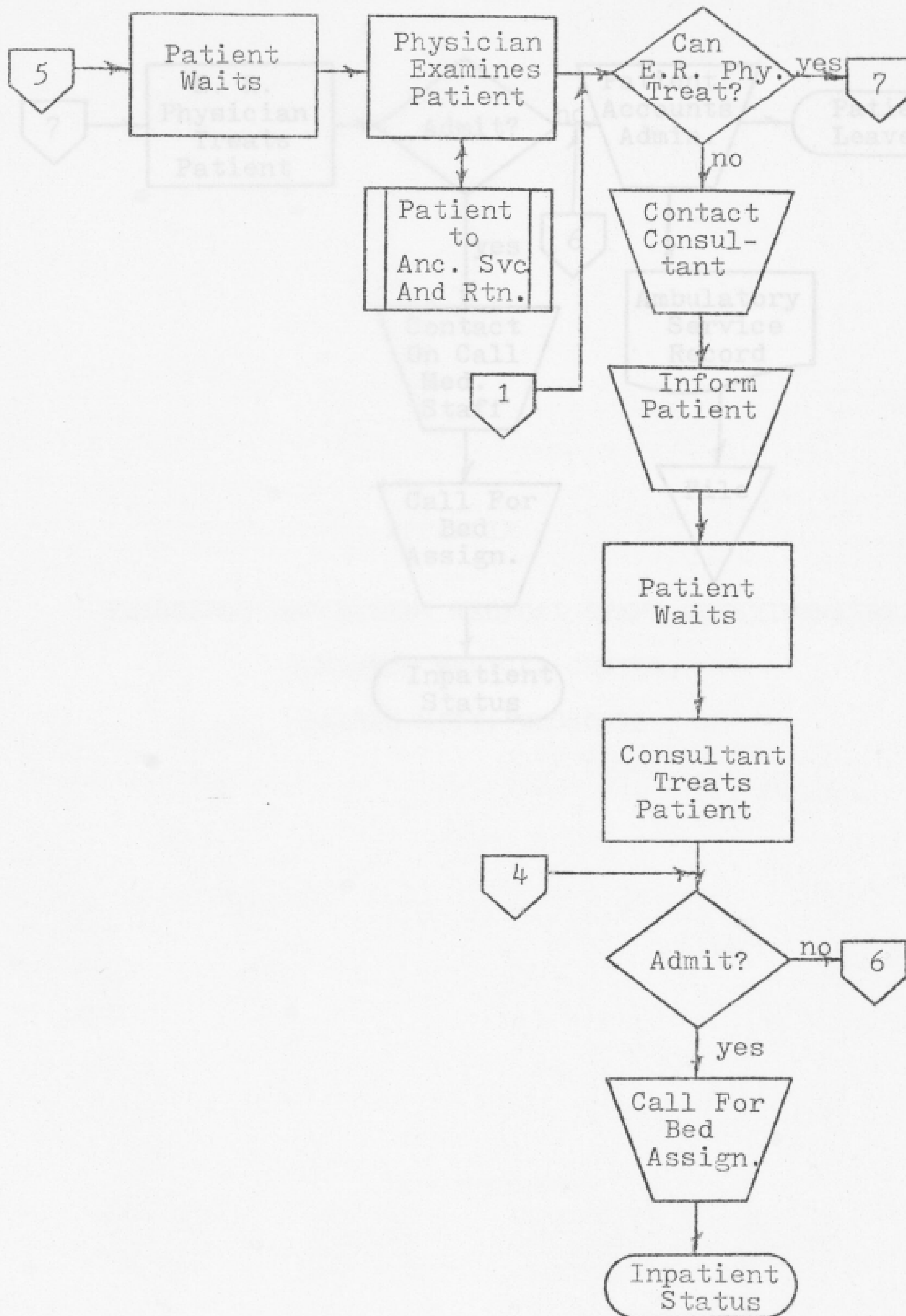


PATIENT FLOW CHART
EMERGENCY DEPARTMENT
RESEARCH MEDICAL CENTER
MARCH, 1975

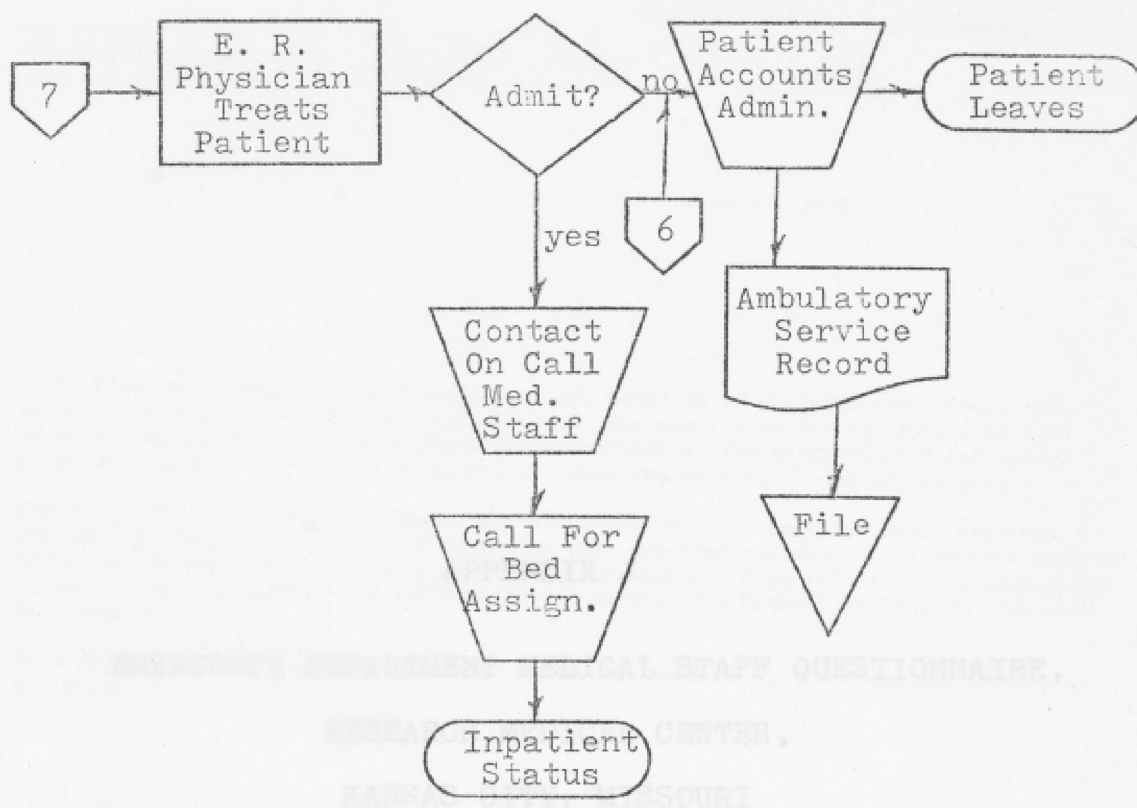


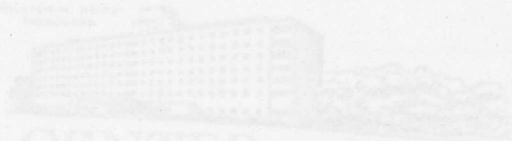



3
Will
E.R.Dept.
Treat?
no
Patient
Leaves
Pvt.
Physician
no
yes
Contact
Pvt.
Phy.
Pvt.
Physician
Treat?
no
yes
2
Inform
Patient
Patient
Waits
Patient
to
Anc.Svc.
And Rtn.
Pvt.
Physician
Treats
Patient
4
Incorp.
Patient
on
Wait.
List
5



5
Patient Waits
Physician Examines Patient
Can E.R. Phy. Treat?
yes
7
no
Patient to Anc. Svc And Rtn.
1
Contact Consul-tant
Inform Patient
Patient Waits
Consultant Treats Patient
4
Admit?
no
6
yes
Call For Bed Assign.
Inpatient Status


7
E. R.
Physician
Treats
Patient
Admit?
no
yes
6
Patient
Accounts
Admin.
Patient
Leaves
Contact
On Call
Med.
Staff
Ambulatory
Service
Record
Call For
Bed
Assign.
File
Inpatient
Status



APPENDIX J

EMERGENCY DEPARTMENT MEDICAL STAFF QUESTIONNAIRE,

RESEARCH MEDICAL CENTER,

KANSAS CITY, MISSOURI

JOHN D. CROUCH, PRESIDENT — JOHN W. BELGER, SR., VICE PRESIDENT — HENRY NOTTBERG, JR., SECRETARY — WILLIAM H. REICH, TREASURER

RESEARCH MEDICAL CENTER

2316 East Meyer Boulevard • Kansas City, Missouri 64132 • 816/276-4000

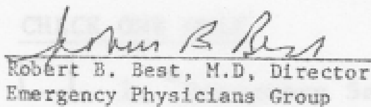
ROBERT E. ADAMS
EXECUTIVE DIRECTOR

March 11, 1975

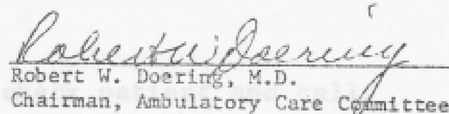
It is time to re-establish your preference for handling of patients who present themselves at Research Hospital and Medical Center Emergency Services and give your name as attending physician. Please check only one block on the enclosed card and return it to us promptly. If your card is not returned you will be placed in Category 3.

The categories are only guidelines. Not every patient will meet the exact criteria. Any patient seen by the Emergency Physician that requires admission will require notification of the patient's attending or personal physician. When referral to a specialist is left to the prerogative of the Emergency Physician the Medical Staff Call List will be utilized.

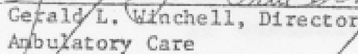
If a life or limb threatening situation exists the patient will be seen and treated immediately.



Robert B. Best, M.D, Director
Emergency Physicians Group



Robert W. Doering, M.D.
Chairman, Ambulatory Care Committee



Gerald L. Winchell, Director
Ambulatory Care

GLW: mc

cc: file

BOARD OF TRUSTEES

Peter C. Barnes
John W. Belger, Sr.
Arthur Brand
Paul H. Byers
William E. Clarkson
John D. Crouch
Roy K. Dietrich
Jerry T. Duggan
Henry J. Hodes
Robert D. Hovey
James F. Hughes
Len T. Jones, Jr.
Paul A. Jordan
Robert A. Kroenert
William V. Longmoor
Wallace G. McDowell
James P. Metzler
Henry Nottberg, Jr.
J. Doyle Patterson
Roland V. Petering
Richard J. Powell
Jud W. Putsch
William H. Reich
Harry J. Reitz
C. C. Richardson
Paul A. Rings
Raymond L. Voskamp, Jr.
Willard E. Winters

FIRST CLASS
PERMIT NO. 8383
Sec. 34.9, P.L. & R.
KANSAS CITY, MO.

BUSINESS REPLY MAIL
No Postage Necessary if Mailed in the United States

POSTAGE WILL BE PAID BY

RESEARCH MEDICAL CENTER

2316 East Meyer Boulevard
Kansas City, Missouri 64132

ATTN: AMBULATORY CARE DIRECTOR

CHECK ONE ONLY

☐ 1. Emergency Service Nurse check patient and call.

☐ 2. Emergency Physician check patient and call.

☐ 3. Emergency Physician check and treat patient. Call only if admission or referral indicated.

(Sign below and return card.)

Signature ________________________________

APPENDIX K

AMBULATORY SERVICE RECORD,

RESEARCH MEDICAL CENTER

KANSAS CITY, MISSOURI

RESPONSIBILITY:

I, the undersigned will be responsible for any unpaid balance on this account.

SIGNED: ____________________

CONSENT FOR TREATMENT:

This is to certify that I (we) the undersigned consent to the administration of whatever Anesthetics and the performing of whatever procedures may be decided to be necessary or advisable in the opinion of the attending physician.

SIGNED: ____________________

WITNESS:

ACCOUNT NBR	E/O	DATE	MEANS OF ARRIVAL	BY WHOM TRANSPORTED	TIME IN	LOG TIME	TIME OUT

PATIENT NAME	TELEPHONE	EMERGENCY CONTACT	TELEPHONE

PATIENT ADDRESS	ADDRESS

SOCIAL SECURITY NBR	BIRTH DATE	AGE	SEX	M.S.	P/F	RELATIONSHIP	DOCTOR

RESPONSIBLE PARTY	TELEPHONE	INSURANCE COMPANY OR CARRIER	CITY & STATE

ADDRESS	TYPE	GROUP	CERTIFICATE	PRE-EXIST	POLICY HDR

EMPLOYER	TELEPHONE	INSURANCE COMPANY OR CARRIER	CITY & STATE

EMPLOYER ADDRESS	TYPE	GROUP	CERTIFICATE	PRE-EXIST	POLICY HDR

CHIEF COMPLAINT (IF ACCIDENT, HOW — WHEN — WHERE)

DOCTOR'S ORDERS:

PERTINENT HISTORY AND FINDINGS:

NURSES RECORD

VITAL SIGNS:

ALLERGIES:

DIAGNOSIS:

CONDITION ON DISCHARGE	GOOD	FAIR	SERIOUS	CRITICAL	OTHER
DISPOSITION	HOME	HOSP.	OTHER		

DOCTORS SIGNATURE:

NURSES SIGNATURE

INSTRUCTIONS TO PATIENT:

AMBULATORY CARE SERVICE RECORD

SERVICE DEPARTMENT COPY

RESEARCH HOSPITAL and MEDICAL CENTER
Meyer Boulevard at Prospect Avenue
Kansas City, Missouri 64132

FORM R 18-2 25M 8-74

APPENDIX L

MAGAZINES IN THE EMERGENCY DEPARTMENT WAITING

ROOM, RESEARCH MEDICAL CENTER,

KANSAS CITY, MISSOURI

MAGAZINES IN THE EMERGENCY
DEPARTMENT WAITING ROOM
ON MARCH 8, 1975

New Ingenue	March, 1975
Travel and Leisure	February, 1975
People	January, 1975
Newsweek	January, 1975
Time	January, 1975
C Q	Winter, 1974
Time	December, 1974
Newsweek	December, 1974
Time	November, 1974
Time	November, 1974
Newsweek	July, 1974
House and Garden	December, 1973

APPENDIX M

HUMAN RELATIONS DIAGNOSTIC

CHECK LIST

HUMAN RELATIONS DIAGNOSTIC CHECK LIST

1. Do they look at patients when they are talking with them?

2. Do they smile?

3. Do they show interest in what the patient is saying by their posture and gestures?

4. Do they explain things to the patients and then check to be sure the patient "really" understands?

5. Do they perform other activities (answer telephones, file records, type, etc.) while interacting with patients?

6. Are questions from patients answered in a courteous and pleasant voice?

7. Do they speak with patients in such a way that they can not be easily overheard by other people in the area?

8. Do patients who appear well dressed and groomed receive better treatment?

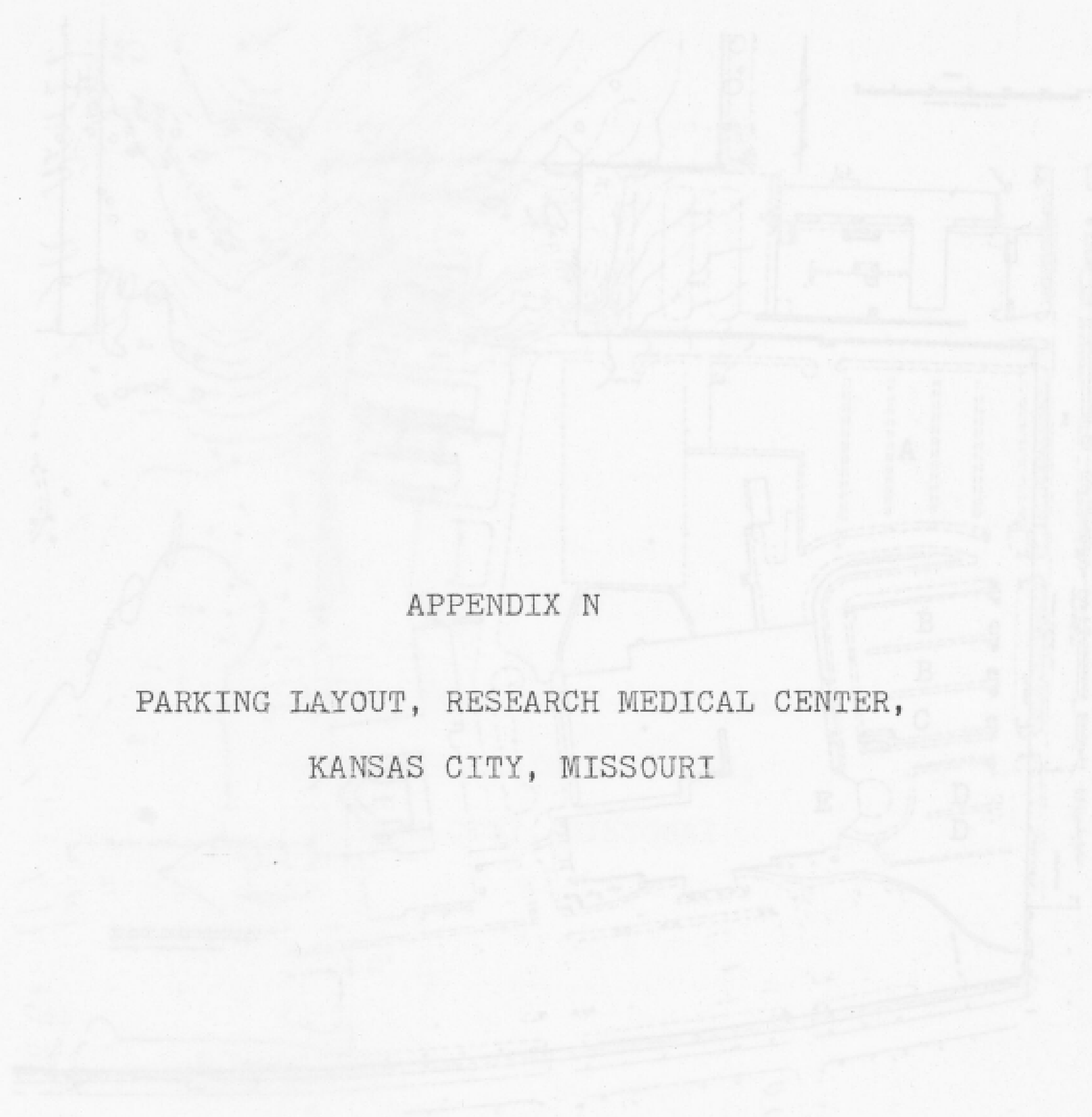
9. Do patients of different races receive different treatment?

10. Do patients who are less articulate or speak a foreign language receive different treatment?

11. Does the staff explain to patients the reasons for an extended waiting time or why specific patients are seen out of turn?

12. Does the staff pay prompt attention to patients who are in obvious distress and pain?

SOURCE: U. S. Army Health Services Command, "A Study Guide for Human Relations in Ambulatory Patient Care," Ambulatory Patient Care (APC) Program, July, 1974. (Mimeographed), pp. A1-A2.



APPENDIX N

PARKING LAYOUT, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI

PARKING LAYOUT
RESEARCH MEDICAL CENTER

A. Employee parking.
B. Patient parking.
C. Medical staff parking, 5:00 A.M. to 10:00 A.M.
D. Medical staff parking.
E. Emergency department entrance.

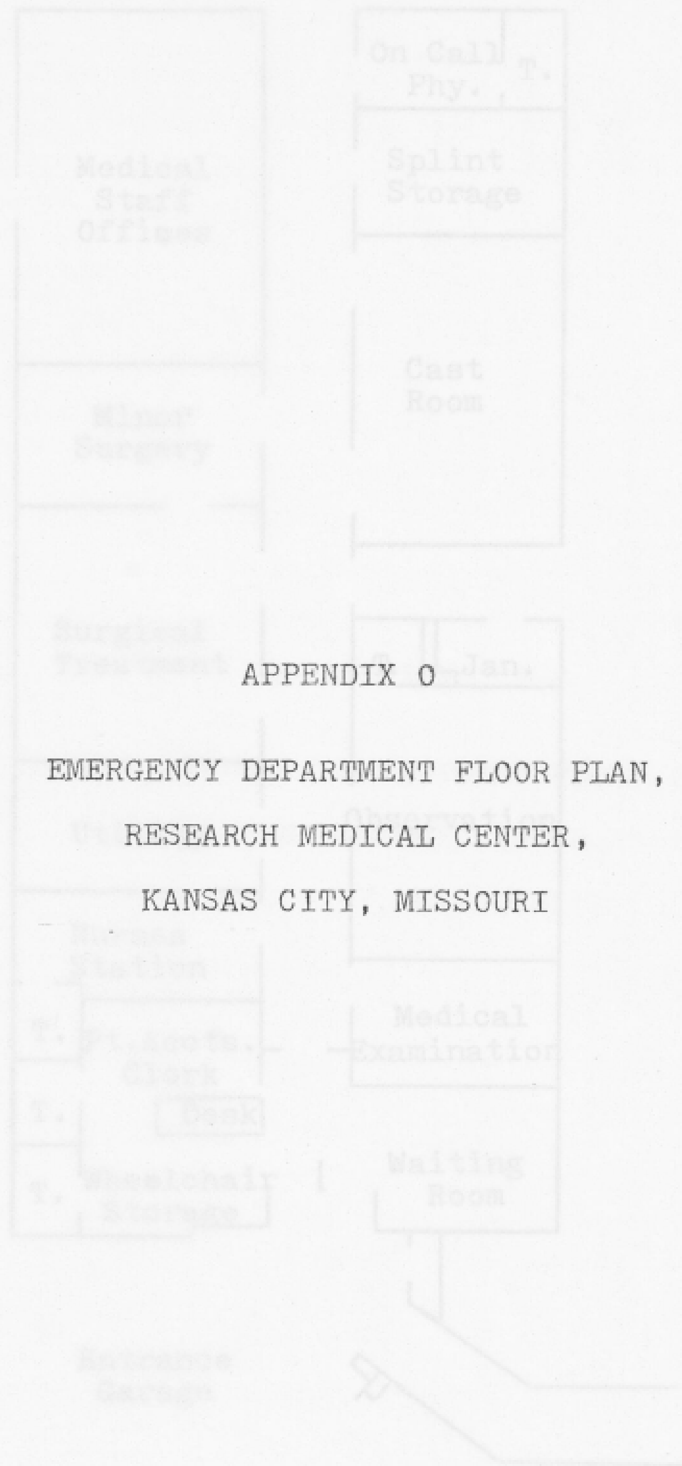
SOURCE: Research Medical Center Drawings, March, 1975.

APPENDIX O

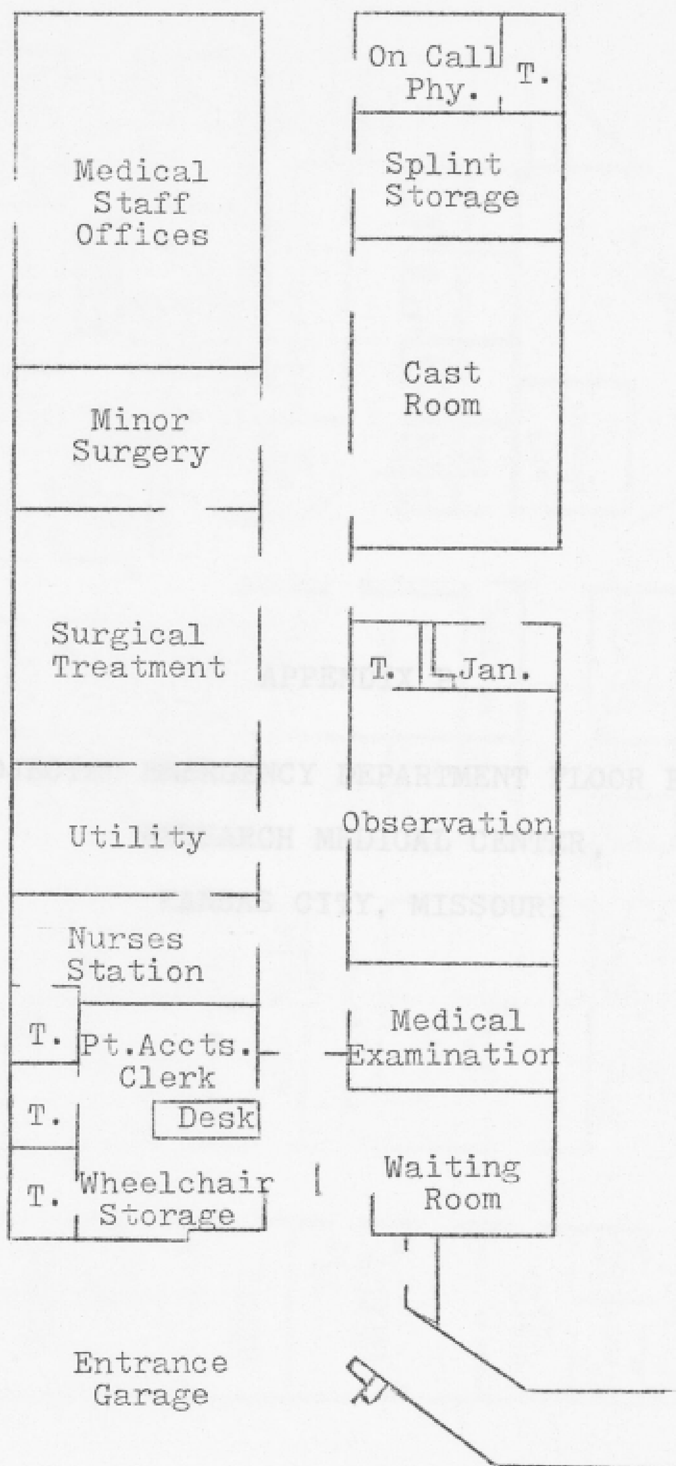
EMERGENCY DEPARTMENT FLOOR PLAN,

RESEARCH MEDICAL CENTER,

KANSAS CITY, MISSOURI



RESEARCH MEDICAL CENTER EMERGENCY
DEPARTMENT FLOOR PLAN, 1975

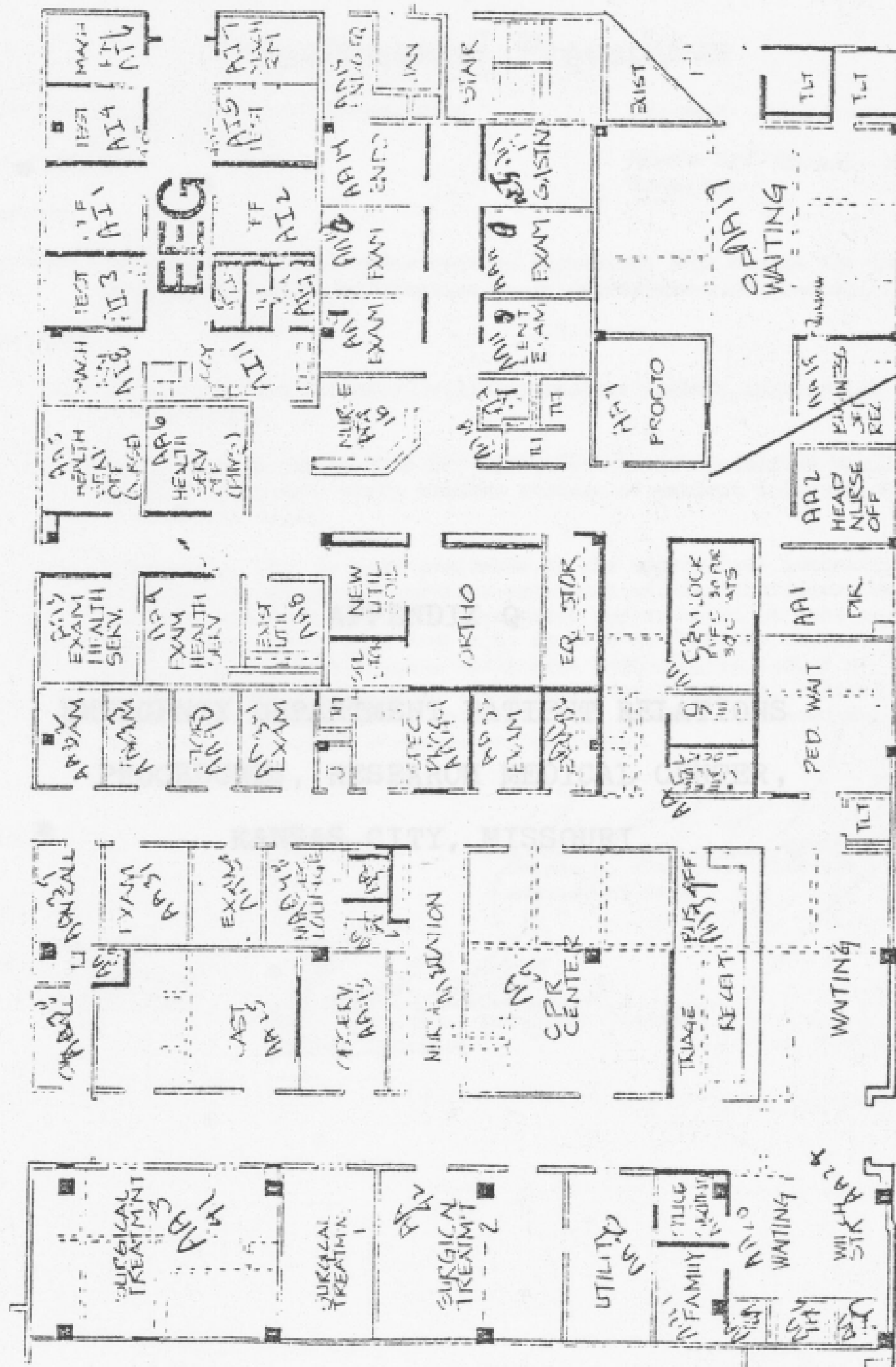


SOURCE: Research Medical Center Drawings, 1975.

APPENDIX P

PROJECTED EMERGENCY DEPARTMENT FLOOR PLAN, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI

PROJECTED EMERGENCY DEPARTMENT FLOOR PLAN



SOURCE: Research Medical Center Drawings, 1975.

APPENDIX Q

EMERGENCY DEPARTMENT PATIENT RELATIONS PROCEDURES, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI

RESEARCH HOSPITAL & MEDICAL CENTER
Kansas City, Missouri

Departmental Procedures

SUBJECT: RELEASE OF PATIENT INFORMATION TO NEWS SERVICES

Department: Ambulatory Care

SUPERSEDES:

Effective Date: February 10, 1972

Revised Date:

AMENDS:

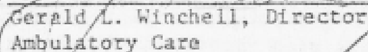
PURPOSE: To provide the news media with an authorized RHMC source for the release of patient information on an around-the-clock basis.

PROCEDURE:

A. Ambulatory Care personnel will not release patient information to the media.

B. The procedure dated March 10, 1970, from Public Relations shall apply in all cases which require release of patient information to the news media.

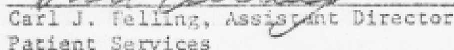
C. Information will be made available to the appropriate administrative personnel by Emergency Services personnel within 15 minutes, using the news media report. The news media report shall be sent to Patient Care (B-8) from 7:00 A.M. to 8:30 A.M. Monday through Friday, to Public Relations (B-7) from 8:30 A.M. to 5:00 P.M. Monday through Friday, and to the Assistant Directors, Patient Care Office, 5 west (B-3) from 5:00 P.M. to 7:00 A.M. each day and around the clock weekends and holidays.



Gerald L. Winchell, Director
Ambulatory Care

Approved:

2-17-72
Date



Carl J. Felling, Assistant Director
Patient Services

Form 11-40—2M-

NEWS MEDIA REPORT

DATE OF ACCIDENT________________

TIME OF ACCIDENT________________

NAME________________________________ ADDRESS________________________________

AGE___ MARITAL STATUS___ SEX___ OCCUPATION________________________________

NAME OF NEAREST RELATIVE________________ ADDRESS________________________________

DESCRIPTION OF ACCIDENT (WHEN, WHERE, HOW ACCIDENT ALLEGEDLY OCCURRED)

DESCRIPTION OF POSSIBLE INJURIES:

BURNS (Part of body involved and degree of burns)

FRACTURES (Location - If not confirmed by X-Ray, say "Possible Fx")

GENERAL CONDITION (Good___) (Fair___) (Serious___) (Critical___)

ADMITTED ( ) IF SO, ROOM______

TREATED AND RELEASED ( )

SIGNATURE OF PERSON RELEASING INFORMATION

____

RESEARCH HOSPITAL & MEDICAL CENTER
Kansas City, Missouri

Departmental Procedures

SUBJECT: PUBLIC RELATIONS

Department: Ambulatory Care

SUPERSEDES:

Effective Date: July 1, 1974

Revised Date:

AMENDS:

PURPOSE: To insure that the Research Hospital and Medical Center standards concerning public relations are maintained at all times in Ambulatory Care.

PROCEDURE:

A. All Ambulatory Care personnel will make a continuous effort to establish and maintain friendly and courteous face to face communications that convey to the patient, his family and friends a favorable public relations image of Research Hospital and Medical Center.

B. Emergency Services personnel must exert a special effort in carrying out this procedure so that they provide for the patient both a safe as well as pleasant atmosphere in that they see patients for but a brief time and very often under the worst possible conditions. The patient, family, or both are usually under emotional stress and say and do things which may irritate all concerned; and, this is the very moment when public relations contact is made or broken by the way you, the employee, respond.

C. If, in spite of your best efforts, you feel that a patient or a member of a patient's family has left Ambulatory Care dissatisfied in any way with our service, an incident report is to be completed giving the details of the patient's complaint and your version of the incident. The incident report is to be forwarded to your immediate supervisor for review. The immediate supervisor will make any appropriate comments, sign the incident form and forward it to the Director of Ambulatory Care for review and signature. The Director of Ambulatory Care will then forward the incident report to the Public Relations Director for review.

D. All Ambulatory Care personnel will assist the Public Relations Department in their investigation of any complaint concerning Ambulatory Care. The mutual goal is to attempt to answer the complaint and help the Public Relations Department bring a complaint to a satisfactory conclusion which will result in a happy, satisfied patient which is the ultimate mutual goal of everyone at Research Hospital and Medical Center.

Gerald L. Winchell, Director
Ambulatory Care

Form 11-40—2M-

M E M O R A N D U M

RESEARCH HOSPITAL AND MEDICAL CENTER
MEYER BOULEVARD AT PROSPECT AVENUE
KANSAS CITY, MISSOURI

Date: February 19, 1975

TO: See Distribution Dept.:

FROM: Robert E. Adams, Executive Director Dept.: Executive Offices

SUBJECT: Processing Patient Complaints - Emergency Room

1. When a complaint concerning an Emergency Physician is received a preliminary response (written or verbal) should be given promptly (within 24 hours) by Public Relations. This response should acknowledge receipt of the complaint and give an assurance that it will be investigated and answered.

2. Subsequently the records pertinent to the incident should be pulled and reviewed by the physician involved, the Director of Emergency Physicians and the Director of Public Relations and/or the Director of Medical Affairs.

3. Following this a response to the complaint should be drafted, subject to approval by the Director of Emergency Physicians, and forwarded to the complaining individual.

4. A record consisting of the complaint, preliminary and final response, dates of such should be prepared and filed by Public Relations.

5. In the event that a dispute arises between the Director of Medical Affairs and/or the Director of Public Relations and the Director of Emergency Physicians as to the context of the final response the Chairman of the Ambulatory Care Committee should be involved as an arbiter.

REA

Robert E. Adams
Executive Director

REA:ke

Distribution: Assistant Executive Director
Director of Medical Affairs
President, Medical Staff
Chairman, Ambulatory Care Committee
Assistant Director, Patient Services
Assistant Director, Administrative Services
Director, Public Relations
Director, Ambulatory Care
Director, Department of Emergency Care

APPENDIX R

EMERGENCY DEPARTMENT PUBLIC RELATIONS PROGRAM PLAN, 1975, RESEARCH MEDICAL CENTER, KANSAS CITY, MISSOURI

1975

PROGRAM PLAN

PROGRAM PLAN FOR: Ambulatory Care

Operating Goal: Improve public relations in Ambulatory Care

Reason for the Program

To insure that Ambulatory Care public relations standards are consistent with RHMC Public Relations standards and are maintained within standard as nearly as possible 100% of the time.

The Program

1. Develope a check list of standards involving public relations. Establish minimum acceptable variations from these standards. Audit Ambulatory Care public opinion polls monthly for variances from standards.

2. Include training in public relations for all Ambulatory Care employees as a part of the on going in-service education program.

3. Improve physical facilities, particularly in Emergency Services in the waiting area for patients and their families:

   a. Paint
   b. Better furniture
   c. Improved patient accounts work area
   d. One-way glass in nurse station

4. Obtain supervisor/triage nurse to maintain liaison with patients, family and staff (see 1975 T/O Change Request) on the second shift, weekends and holidays in the absence of the Director of Ambulatory Care and/or Head Nurse.

Method of Measuring Program Progress

In concert with the Public Relations Department, implement and maintain, on a regular basis, a separate public opinion poll for Ambulatory Care to be tallied and computed by the Public Relations Department.

Method of Measuring Results

A decrease in the incidence of patient complaints to, at or near zero, and the absence of a pattern or type of complaint would indicate the success of the system.

APPENDIX S

PUBLIC RELATIONS DEPARTMENT REORGANIZATION

SUMMARY, RESEARCH MEDICAL CENTER,

KANSAS CITY, MISSOURI

M E M O R A N D U M

RESEARCH HOSPITAL AND MEDICAL CENTER
MEYER BOULEVARD AT PROSPECT AVENUE
KANSAS CITY, MISSOURI

Date: March 5, 1975

TO: Robert E. Adams, Executive Director Dept.: Executive Offices

FROM: C. Dean Gibson, Asst. Director Dept.: Executive Offices

SUBJECT: Reorganization of Public Relations to Patient/Public Relations

1. The Public Relations Director has completed a study recommending the addition of certain positions to the Public Relations Table of Organization.

2. The addition of the requested positions will enable the Public Relations Department to meet the following objectives:

   a. Improvement of relations with patients, families and visitors.

   b. Improvement of public relations efforts by employees.

   c. Improvement of relations with news media and augmented media coverage of Medical Center activities.

   d. Improvement of total communications to the Medical Center's various publics.

3. The staffing recommended to meet these objectives is as follows:

		Current	Proposed	1975 Cost*	1976 Cost
a.	Patient Representative	0	1 FT 80 hrs/pp	$6,629	$9,947
b.	Public Relations Training Instructor	0	1 FT 80 hrs/pp	6,629	9,947
c.	Publications Clerk	0	1 FT 80 hrs/pp	4,946	7,380
d.	Public Relations Secretary	0	1 FT 80 hrs/pp	4,946	7,380
	Total			$23,150	$34,654

It is recommended that endowment funds be allocated to cover salary costs for the above recommended positions for a three year period.

		Current	Proposed	1975 Cost*	1976 Cost
e.	Publication/Publicity Specialist (reclassification to Pay Grade 12 from Pay Grade 10)	1 80 hrs/pp	1 FT 80 hrs/pp	$737*	$1,125

*Based on May 1, 1975 implementation.

4. Capital Expense

Total capital equipment expenditures necessary to support the additional positions equal $1,752. All equipment would be purchased in fiscal year 1975.

5. Physical Requirements

In order to accommodate the augmented staffing, it will be necessary to relocate the current Publications Specialist and the porposed Publications Clerk to another area. It is recommended that the Graphic Arts room located on B-Level be remodeled to provide space for Public Relations Staff. Total cost of the construction is estimated at $965.

a. The Public Relations Training Instructor will share the office of the Audio-Visual Technician in the Training Department.

b. It is recognized the Patient Representative will not need an office in the usual sense, however, this person will have space for record retention in the central clerical area provided in the remodeled area of the Reactivation of the Community Development Division. Volunteers compiling Patient Opinion Poll statistics in the Public Relations' secretary's office will move to this area also.

6. The functional charts to support the duty assignments of the Patient/ Public Relations positions are attached.

C Dean Gibson

C. Dean Gibson
Assistant Director
Administrative Services

CDG:ke

CC: Assistant Executive Director

BIBLIOGRAPHY

BIBLIOGRAPHY

Books

American College of Surgeons. *A Model of a Hospital Emergency Department.* Chicago: American College of Surgeons, 1967.

Cutlip, Scott M., and Center, Allen H. *Effective Public Relations.* Englewood Cliffs, N.J.: Prentice-Hall Inc., 1971.

Department of Health Administration, Duke University. *The Citizenry and The Hospital, A Report of: The 1973 National Forum on the Citizenry and The Hospital.* Durham, N.C.: Department of Health Administration, Duke University, 1974.

Harrel, George T. *Planning Medical Center Facilities.* University Park: Pennsylvania State University Press, 1974.

Health Law Center. *Problems in Hospital Law.* Rockville, Md.: Aspen Systems Corporation, 1974.

Joint Commission on Accreditation of Hospitals. *Accreditation Manuel for Hospitals.* Chicago: Joint Commission on Accreditation of Hospitals, 1971.

Noble, John H.; Wechster, Henry; LaMontagne, Margaret E.; and Noble, Mary Anne. *Emergency Medical Services: Behavioral and Planning Perspectives.* New York: Behavioral Publications, 1973.

Spencer, James H. *The Hospital Emergency Department.* Springfield, Ill.: Charles C. Thomas, 1972

Periodicals

Bennett, Margaret Jane. "The Social Worker's Role." *Hospitals*, XLVII (May 16, 1973), 111-18.

Bloch, Joseph L., and Hankin, Bernard. "Hospital Responds to Community Protest." *Hospitals*, XLVIII (September 1, 1974), 53-56.

Cavalier, Richard. "Ombudsman is Middle Man Between Clinic Patients and Hospital." Modern Hospital, CXIV (January, 1970), 92-96.

"Crisis Care for Body and Spirit." Hospitals, XLVIII (January 1, 1974), 28-33.

Doktorsky, A. I. "Better Staffing -- Hospital Emergency Departments." Emergency Medicine Today, I (July, 1972), 1-4.

Gersonde, James R. "Two Approaches to Providing Physician Coverage in E. R." Hospital Topics, XLIX (February, 1971), 50-54.

Gibson, Geoffrey. "EMS: A Facet of Ambulatory Care." Hospitals, XLVII (May 16, 1973), 59-66.

Golomb, Harvey M., and Herrold, Stuart R. "An Alternative Staffing Proposal for Emergency Rooms." Journal of the American Medical Association, CCXXVIII (April 15, 1974), 329-31.

Hanff, Warren R. "Centralized Outpatient Care." Hospitals, XLVIII (February 1, 1974), 87-90.

Hannas, R. R., Jr. "Staffing the Emergency Department." Hospitals, XLVII (May 16, 1973), 83-86.

Johnson, Keith E. "Consumer Involvement in Community Planning." Hospitals, XLVII (February 1, 1973), 59+.

Johnson, Kenneth E., and Holden, Laverne G. "How the Behavioral Sciences Influence the Design of Hospital Interiors." Hospital Progress, XLVIII (September, 1967), 48-58.

Jones, Walk C. III, and Smock, E. William. "Built-in Traffic Control--Foundation of Good Design." Hospitals, XLI (February 1, 1967), 51-54.

Krembs, Gerhard A.; Moyer, Jason K.; and Williams, William J. "Contracting with a Physicians' Group for ER Coverage." Hospital Progress, LI (January, 1970), 51-53.

Lifton, James G. "Eight Ways to Provide Physician Coverage of the Emergency Room and How to Tell Which is Best." Modern Hospital, CXXI (October, 1973), 79-82.

Lindheim, Roslyn. "Ambulance or Ambulant?" Hospitals, XLI (February 1, 1967), 46-50.

Mangold, Karl G. "The Financial Realities of EMS." Hospitals, XLVII (May 16, 1973), 89-96.

Moseley, S. Kelley. "Survey of Physician Staffing in E. R. Shows Group Practice Favored." Hospital Topics, L (June, 1972), 61-68.

"Prizewinning Clinic Stresses Comfort for Patients, Efficiency for Staff." Hospitals, XLI (February 1, 1967), 97-100.

"The Potentials and Limitations of Emergency Medical Services." Hospitals, XLVII (May 16, 1973), 57-58.

"Report Labels Emergency Medical Services Weak Link in Health Care Delivery System." Hospitals, XLVI (October 16, 1972), 168-69.

Romano, Teri. "Trauma Nursing in Illinois." Hospitals, XLVII (May 16, 1973), 67+.

Skeer, John D. "Volunteers in Emergency Department Assist Staff and Patients." Volunteer Leader, XI (January, 1970), 7-10.

"State Ruling May Void Doctors' Contracts With Hospitals." Modern Hospital, CXVII (October, 1971), 48+.

Tuck, Jay N. "A Shot in the Arm for Emergency Services." Modern Healthcare, June, 1974, pp. 25-30.

"Which E. R. Coverage Arrangement is Best?" Medical Economics, XLIX (November 6, 1972), 112-16.

Yedvab, Jay O. "Consumer's Role in Defining Goals, Structures, and Services." Hospital Progress, LV (April, 1974), 56-60.

Zielinski, William T., and Mosher, Carl L. "Updating, Expanding, Outpatient Facilities." Hospitals, XLVII (February 1, 1973), 91-96.

Government Publications

U. S. Army Health Services Command. "A Study Guide for Human Relations in Ambulatory Patient Care." Ambulatory Patient Care (APC) Program, July, 1974. (Mineographed).

U. S. Department of Health, Education, and Welfare. Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities. Washington D.C.: Government Printing Office, 1974.

Other Sources

Best, Robert B., Director, Emergency Physicians' Group, Research Medical Center, Kansas City, Missouri. Interview March, 1975.

Best, Robert B., Director Emergency Physicians' Group, "A Study of the Emergency Physicians' Role as Related to the Emergency Department." Kansas City, Mo.: Research Hospital and Medical Center, n.d.

Boldt, LaVaughn A., Assistant Executive Director, Research Medical Center, Kansas City, Missouri. Interview March, 1975.

Felling, Carl J., Assistant Director, Patient Services, Research Medical Center, Kansas City, Missouri. Interview March, 1975.

Middleton, R. Lawrence, Patient Accounts Director, Research Medical Center, Kansas City, Missouri. Interview March, 1975.

Thomson, Gordon C., Public Relations Director, Research Medical Center, Kansas City, Missouri. Interview March, 1975.

Winchell, Gerald, Ambulatory Care Director, Research Medical Center, Kansas City, Missouri. Interview March, 1975.

BIOGRAPHICAL SKETCH

Major Stephen W. Arnt was born on ,
. He attended public schools in Payette, Idaho, graduating in 1960. He attended the University of Idaho and received his B.S. in Education in 1965 after a one year teaching assignment in Payette, Idaho.

Major Arnt accepted a commission in the Regular Army Medical Service Corps in August of 1965, and completed the eight week Medical Service Corps Officer Basic Course in November of that year. He remained at the Officer Student Battalion, Medical Field Service School until his entry into Rotary Wing Officers Flight Course at Fort Wolters, Texas in February, 1966. Upon graduation in September of 1966, Major Arnt was assigned to an air ambulance unit at Fort Bragg. He accompanied that unit to Vietnam in July, 1967 and flew helicopter evacuations for a one-year tour. Subsequent assignments included operations Officer of an air ambulance unit in Japan, the AMEDD Officer Advanced Course, and commander of three air ambulance units in Vietnam and Hawaii.

Major Arnt

. Upon completion of the formal course of instruction, Major Arnt was assigned as an administrative resident at Fitzsimons Army Medical Center, Denver, Colorado.