A STUDY OF OUTPATIENT FLOW INTO METHODIST HOSPITAL OF DALLAS, TEXAS

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ABSTRACT

The writer attempts to reorganize the flow of outpatients into Methodist Hospital of Dallas, Texas. The problem was solved by recommending that a Central Outpatient Registration Office be established in the immediate vicinity of the Emergency Room. In reorganizing the outpatient flow three other hospitals were visited and their systems were used as alternatives of how Methodist Hospital could be organized. The study was made because the system in use was inadequate to handle the outpatient load that has increased at a rapid rate in recent years. It was pointed out that medicare requirements were another point of consideration because of the need for charging all outpatients the same fee for service received. Scheduling appointments at the Central Outpatient Registration was not a consideration of the paper. Complete administrative information, a higher rate of fee collection, and increased service to the patients are considered to be advantages of the Central Outpatient Registration Office.

The location of the office near the Emergency Room should be effective as an extension of the Admissions Office and perform many functions presently requiring extensive coordination.

ACKNOWLEDGEMENTS

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INTRODUCTION

Forty-two years have elapsed since Methodist Hospital of Dallas first began operation. In that time, the hospital has developed dramatically from a modest community institution of 85 beds into a modern hospital center of 412 beds annually serving more than 25,000 patients from Dallas and the surrounding regions.

Methodist Hospital currently offers a comprehensive program of inpatient care in the general services of medicine, surgery, obstetrics, and pediatrics. Additionally, psychiatric care is provided for an average of fifteen patients a day. These patients are treated in the regular medical and surgical units rather than in a separately established psychiatric unit. For the overall inpatient care programs, the hospital currently provides 412 beds, assigned as follows:

330 to medicine and surgery
43 to obstetrics
39 to pediatrics

Outpatient care is offered in the various diagnostic and treatment services such as Physical Medicine, X-Ray, Laboratory, Emergency Room, Inhalation Therapy, and through twelve individual organized outpatient clinics.

Methodist Hospital of Dallas provides broad diagnostic and treatment services to support and augment its basic patient care program. The program includes cobalt and isotope therapy, electro-

encephalography, the blood bank, intensive care, and postanesthesia recovery services.

The number of Outpatient Clinic visits and Emergency Room visits have increased steadily since 1960. Table I illustrates a year by year comparison of the Clinic outpatient visits and the Emergency Room visits since 1960.

TABLE I

VOLUME OF OUTPATIENT CLINIC VISITS
AND EMERGENCY ROOM VISITS
METHODIST HOSPITAL OF DALLAS

Year	Outpatient Clinic visits	Percent Increase OPC	Emergency Room visits	Percent Increase ER
1960	10,043		10,674	
1961	11,365	+11	11,820	+11
1962	12,640	+11	14,125	+23
1963	13,252	+ 8	15,850	+17
1964	12,782	- 3	15,744	- 1
1965	14,079	+11	15,032	- 7
1966	14,823	+ 8	18,257	+32

Conditions Which Prompted Study

Methodist Hospital is in an explosive growth situation. The population of the primary service area of the hospital has doubled in the last ten years (Appendix A). The future growth of the immediate and primary service area is anticipated to be 75% by the year 1985.

Projecting the estimated growth in relation to the total population growth expected in the Dallas Metropolital area, the estimate from 1965 through 1985 is shown in Table II.

TABLE II

PRIMARY SERVICE AREA GROWTH
METHODIST HOSPITAL OF DALLAS
1965-1985

Year	Population	Increase over Previous Period	
		Number	Percent
1965	293,000	------	------
1970	352,000	58,800	20.1
1975	418,000	66,000	18.8
1980	488,000	70,000	16.7
1985	563,000	75,000	15.4[1]

As evidenced in the two preceding tables, the utilization of the Outpatient Services of the hospital have increased at a rate of 3-1 over population growth. With the expanded use of Outpatient facilities and the expected population growth over the next twenty years, the use of these facilities should increase at the same rate, or greater, as in the past ten years.

Mr. Glenn Scott, an assistant administrator, pointed out that with the implementation of Medicare on 1 July 1966, it was realized a system must be established to clearly identify and document all outpatient charges.[2] Medicare would reimburse the hospital for outpatient charges to their patients on the same basis charges were made to all other outpatients.[3]

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[1]James A. Hamilton Associates, Program of Development, Methodist Hospital of Dallas, March, 1965.

[2]Medicare Bill, passed by 89th Congress, signed into Public Law, July 30, 1965.

[3]Interview with Mr. Glenn Scott, Dallas, Texas, May 4, 1967.

Work began at that time to establish charges for all procedures that were not previously covered. It was realized that the present system of processing outpatients was not adequate. Another method of handling outpatients was necessary to cover all aspects required for complete documentation. Minor adjustments were made to satisfy the needs of medicare. It was determined that a complete revision of the system should be implemented to fully realize all revenue from the outpatient program.

The increased outpatient workload has been superimposed on an outdated system of administratively processing outpatients. The present system has been in operation for many years with no major adjustments. The foremost consideration of the hospital is to give maximum patient care with minimum inconvenience to the patient.

Information acquired from outpatients for Business Office purposes must sometimes be acquired by non-business office personnel. The requirement often results in deficient information to fulfill Business Office needs.

At the present time, there is no effort made to collect payment for the services rendered prior to treatment. The patient is told to report to the Business Office for payment in another area of the building after treatment is received. According to the Hospital Controller, there is a write-off of approximately 60% of the patients' accounts who are supposed to pay their bill in the above manner. It is assumed that many patients never report to the Business Office

because of its location away from the area of treatment.

Under this decentralized system of rendering service to outpatients, the hospital is unable to accumulate adequate and accurate statistics on the number of patients treated. It is often difficult to incorporate necessary controls to insure accurate and complete information necessary for patient billing.

Statement of the Problem

Methodist Hospital does not have an adequate system to administratively process outpatients. There is a need to determine the best method by which outpatients can be administratively processed and controlled.

Factors Bearing on the Problem

An exact documentation of charges for outpatient care must be recorded due to Medicare requirements of paying the same charges as all other outpatients.

The outpatient workload of the Methodist Hospital of Dallas has increased by 60% since 1960.

The continuation of a well-rounded teaching program for interns and residents is dependent upon a large number of clinic outpatients.

Clinic patients are paying the same amount for treatment today they were paying ten years ago.

Additional income to the hospital could be generated by a small increase in payments for services received by each clinic patient.

Requests for service in the various departments are sometimes

completed by personnel who have no interest in business office functions of the hospital.

The Business Manager is unable to correlate outpatient visits and billing.

Departmental personnel could function more efficiently if they were relieved of Business Office administrative requirements.

The efficiency of the Business Office depends on the quality of information received on each patient.

Patients presently report to the Business Office for payment or arrangements for payment after treatment is received.

No effort is made to collect for the service prior to treatment.

All categories of outpatients are processed at three separate locations.

Automatic Data Processing Equipment will have the capability in December, 1967, to handle all outpatient accounting. At the present time Automatic Data Processing can handle only emergency and private referred patients.

Assumptions

Unsatisfactory documentation of outpatients will result in loss of medicare revenue.

The outpatient workload is expected to continue to increase over the next few years. There is a distinct possibility that the rate of growth may be accelerated by expansion of speciality capabilities of the hospital.

It is believed that a new system of outpatient management would be supported by all departments.

Hospital revenue will improve in all areas of outpatient care if a more defined system of management is established and patients are requested to pay for treatment before it is received.

It is expected the Business Manager can support a revision of the system with some personnel from his present staff.

Definition of Unusual Terms

1. Central Outpatient Registration - A desk or office where administrative procedures are completed, fees are paid by the patient, and general assistance is provided to the outpatient in assuring he receives the best possible care.

2. Emergency Room - An area where emergency care treatment is rendered and there is a physician on duty.

3. Private Referred Outpatient - A patient referred by a private physician for comprehensive diagnostic or treatment services.

4. Full-Pay Visit - A visit which the patient is charged in full by the Business Office for both professional and non-professional portions of the bill.

5. Part-Pay Visit - A visit involving a discount on the professional and non-professional parts of the bill.

6. Third-Party Payment - Previous arrangements made between the patient and a source of payment, the source of payment being the third party, for both or either of the professional and non-professional parts of the bill.

7. Financial Counselor - The person who evaluates the patient's financial position for billing classification.

Objectives

1. To consider that the hospital does not have a system to assure receipt of all revenue due from outpatient visits.
2. To develop a vehicle of operation that will be convenient to the patient as well as of value to the hospital.
3. To recognize the necessity of making as few changes as possible in long established procedures and still accomplish the desired goals.
4. To administratively admit each outpatient in a similar manner as inpatients.
5. To provide the best service possible.

Standards

1. To eliminate the necessity of patients reporting to another area of the hospital for payment of their bills or for making arrangements for future payments.
2. To consider that revenue gained by this change in operation will provide funds to offset any expense incurred.

Criteria

1. To recommend actions that will preclude deviation from the pattern once it is established.
2. To recognize the hospital desires to minimize the increase of staff for the operation of a centralized outpatient

reporting desk.

Limitations

1. To continue making appointments through the various clinics and departments treating outpatients.
2. To adapt the system to handling a large number of patients.
3. To make the system simple so it can easily be taught to staff personnel.

Literature Review

Historically, hospitals were planned and organized around the care of the inpatient. The bed dominated the facility. It was on the basis of the bed count, for instance, that space requirements were projected and that money for construction was allocated. A few hospitals did maintain outpatient departments, but they were relegated to the basements and were used primarily for the indigent population.

Since World War II, however, there has been an about face in the attitude of the hospital and its medical staff toward the outpatient, and vice versa. Today, a high percentage of X-ray, laboratory, and other diagnostic and therapeutic facilities are centered in the care of ambulant patients, and of these a large number have been referred by their private physicians.[4]

The comparatively new outlook of the hospital and the patient is a reflection of (1) medical progress made in prevention, early diagnosis, and treatment of disease; (2) new social and medical

attitudes; (3) increased demand for medical care on the part of large sections of the population who are becoming increasingly sophisticated about the potentials of early diagnosis and treatment; (4) the ability of even larger sections of the population to pay for medical care through various forms of private, federal, and state insurance and prepayment plans.[5]

The complete change in attitude towards ambulant care has placed outpatient facilities under the impact of many pressures. The impact is centered in three vital areas: the outpatient clinic, the Emergency Room, and the area of privately referred patients. The increased use of the ancilliary services of the hospital for diagnosis and treatment of ambulant privately referred patients has made these services an informal extension of the doctor's office.[6]

The changed usage of the hospital outpatient facilities has necessitated a complete reassessment of facilities, their locations, accomodations, and general effectiveness. Procedures in handling the patient have been realigned to assure a steady flow of patients as well as to assure the hospital of maximum collection of earned revenue. A clear documentation of policies related to the organization of the system is required to accomplish the specific objectives.

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[4]Roslyn Lindheim, "Ambulance or Ambulant? New Patterns of Outpatient Service Require New Design Approaches," Hospitals, XLI (February 1, 1967), 46.

[5]E.R. Weinerman, "Changing Patterns in Medical Care," Hospitals, XXXIX (December 16, 1965), 67.

[6]Lindheim, op. cit., p.47

Good management enables an enterprise to remain in business over the long run. This is as true for hospitals as for any other kind of business. The hospital must remain solvent; satisfy its patients, physicians, and employees; and plan for future needs.[7]

A basic assurance for a hospital to remain solvent is the collection of all revenue due from patients for services received. A new trend in hospitals is to collect the money before the service is rendered. The patient receives a definite appointment in the department indicated by the physician and is given laboratory and X-ray requisitions which must be completed before the patient's first appointment. The payments are made at the cashier's desk, and the patient is directed to the laboratory and X-ray service area.[8]

The entrance to the outpatient department must be clearly identified with an information and control station immediately inside the entrance. This facilitates control of the patient movement, and the sight of someone at the station ready to lend assistance can do much to calm a nervous individual.[9]

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[7]Richard Durbin, "A New Concept of the Organization and Management of the Outpatient Department," Hospital Management, XCV (February, 1963), 44.

[8]Ibid.

[9]Walk C. Jones and E. William Smock, "Built in Traffic Control; foundation of good design," Hospitals, XLI (February 1, 1967), 52.

Research Methodology

Data on workloads was obtained from annual reports of Methodist Hospital of Dallas.

Nonstructured interviews were conducted with the Hospital Administrator, Associate Administrator, Assistant Administrator in charge of Outpatient Services, Chief Nurse, Nurse Supervisor of Clinics, Nurse Supervisor of Emergency Room, Chief of each department providing service to the outpatient, Hospital Controller, Business Manager, members of the medical staff, and numerous other people filling positions that were considered to be related to outpatient functions.

Structured interviews were conducted with the Chief of Pharmacy, Chief of Personnel and Chief of Engineer Services. They were also conducted with personnel previously mentioned after the results of the nonstructured interviews were evaluated.

In addition to interviews with the staff of Methodist Hospital of Dallas, conferences were held with assistant administrators at the following hospitals: Santa Rosa Medical Center in San Antonio, Texas, and Baylor University Medical Center and St. Paul Hospital, both of Dallas.

Tours were made through each of the hospital's system of controlling outpatients. Detailed observations and comparisons were made on each system. In each of the systems special attention was given to where the patient reported, how he was charged, when the

fee was paid, and whether the hospital had a system of classification for clinic patients. Also observed were the billing of clinic patients, the number of clinic patients treated in 1966, and the amount of income derived from the operation of their clinic.

No articles were read that directly referred to a central outpatient registration for Business Office control purposes. Considerable information is written on "centralized appointment systems", with a small reference to collection.

A thorough observation was made of all facets of the present system of processing outpatients at Methodist Hospital. The results of the observations were compared with those from other hospitals. A study was made of the areas where improvement might make the operation function more economically.

CHAPTER II

PRESENTATION AND ANALYSIS OF DATA

General Information

Under the present system of outpatient flow into the Methodist Hospital of Dallas, patients report to three different points for treatment. There is a lack of complete information for billing purposes provided to the Business Office. All outpatient facilities, as well as the supporting ancilliary services, are basically located in the same area of the hospital. This provides an excellent justification for considering reorganization to improve the flow of patients as well as to improve the potential of the Business Office in carrying out functions related to the outpatient.

Present Procedures

At the time of this study, outpatients were flowing into the hospital by three separate routes. Clinic outpatients reported directly to the clinic where they were administratively processed. Emergency patients reported direct to the Emergency Room where they were processed. Private patients reported directly to the department where they were referred by their private physician and were registered at that location (Annex B).

Investigation of the various departments revealed personnel taking information for administrative purposes were getting inaccurate or incomplete information, or were recording the information illegibly. A twenty-three day survey in the Emergency

Room revealed there were 514 errors out of 804 cases processed (Appendix C). This is 63% error and reveals that one of several things could be happening.

1. The patient may not know the information.
2. There is a breakdown between the Business Office and Nursing Service on information required.
3. The clerk doesn't have time to complete all information.
4. Nursing Service personnel may not recognize the responsibility to acquire this type information.

A similar survey was conducted for five days on charge tickets received from the various departments providing outpatient services (Appendix D). Of 509 charge tickets processed, there were 539 errors. The implications are similar to that of the Emergency Room survey, with primary emphasis on breakdown between the Business Office and it's administrative requirements.

In one department it was discovered that a specialized technician, where there was a critical personnel shortage in her specialty, was found to be spending approximately one-third of her time doing administrative work because of a lack of clerical help and the administrative load generated by business office requirements.

Each department offering outpatient services was operating as an independent unit. Each registered the patient, prepared a chart or some other form of departmental record, gathered billing and insurance information, checked credit ratings, assisted the patient

in filling out medicare forms if required, and prepared charge tickets for service rendered.

The system of collecting fees for service rendered has been for the patient to report to the Business Office after treatment. An exception to this is for clinic patients, who pay a single fifty cent fee when they report to the clinic desk. According to the Hospital Controller, the record of collection, compared to the charges in the area of emergency and referred patients, is indicative that compliance with the system has been very poor. Investigation revealed there was no way to determine if the system was the cause of the poor collection. The assumption that the system was one of the primary causes was clearly supported by personal opinions of members of the staff concerned with this facet of hospital activity.

The location of the various departments in relation to the Business Office clearly substantiates that there would be temptation to not look for the place of payment. Under the present decentralized system of operation the hospital is unable to acquire adequate information for the purpose of statistics and patient billing.

The present system requires the clinic patient to pay a flat rate of fifty cents per visit. This is all inclusive, with no additional charges for ancilliary services other than Pharmacy where cash is paid upon receipt of the drugs at a rate of 10 percent above hospital cost. This system produces a poor rate of revenue in com-

parison with other hospitals of the city. The number of clinic visits made at each hospital visited and the amount of revenue produced are shown in Table III.

TABLE III

COMPARISON OF CLINIC VISITS WITH INCOME
THREE MAJOR DALLAS HOSPITALS
1966

Hospital	Number of Visits	Amount of Income
A	14,956	$28,600
B	17,850	34,914
Methodist	14,823	9,229

By comparing income to number of patient visits, it can easily be seen that Methodist Hospital is evidently not deriving the amount of income it might from clinic patients. Methodist's income includes approximately $1500 for central service sales. Except for a small margin of profit for handling these items are sold at cost to the patient and this is the total amount collected. The sales further reduces the amount of income from clinic patients and widens the ratio of income from clinic patients between Methodist and other hospitals. Hospital "A" derived $1.90 per visit, Hospital "B" derived $1.95 per visit, and Methodist derived $.68 per visit.

A similar study was accomplished by Mr. Glenn N. Scott in 1962, and the compared ratios were considerably closer than now. This implies other hospitals have raised their collection from Clinic patients while Methodist has remained the same.[10]

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[10] Glenn N. Scott, "A Suggested Revision of Outpatient Clinic Charges for Methodist Hospital of Dallas," Unpublished Report, April, 1962.

The Summary of the Financial Status of the Teaching Program of Methodist Hospital for 1966 indicated an actual cost for outpatient clinic services was $97,475 (Appendix E). This figure does not include clinic patients who reported to the Emergency Room rather than to the clinic during designated hours. There is presently no system of identifying the clinic patient in the Emergency Room. They are billed in the same manner as all emergency patients and are charged the same rate.

The clinic patient who reports to the Emergency Room and generates a sizable bill is a very poor risk because of his habit of receiving medical care in the clinic at the minimal fee of fifty cents per visit. There are no known circumstances of a patient being turned away from Methodist Hospital of Dallas for emergency care.

There are several admission functions presently being accomplished by the Emergency Room that are time consuming and tend to contribute to the heavy workload that normally exists. These functions are Emergency Room admissions, straight admissions, and transient surgery. Emergency admissions are generated by patients coming to the Emergency Room for treatment, and either the individual private physician or a member of the House Staff determines if he should be admitted as an inpatient. Straight admissions are non-ambulant patients and require assistance since they normally report to the emergency room area. Their names must be taken, room number acquired,

and assistance procured for those in a wheel chair. The transient surgery admissions are registered as an inpatient, but they are not assigned a room. All preliminary work is accomplished by the Emergency Room working with an admission clerk who must come from the up-stairs office. Upon completion of the minor surgery in the Operating Room the patient is released to go home. There are few patients of this type each year, but the function is time-consuming.

Evaluation of Alternatives

Three hospitals other than Methodist Hospital of Dallas were visited for comparison purposes. The hospitals were similar to the Methodist in that they were non-profit, private, church sponsored. Each of the hospitals were observed in the same manner as Methodist Hospital. This included physical layout, outpatient flow, point of reporting, and the manner they were processed.

Each of the hospitals will be discussed separately. By discussion in this manner, each method may be considered as an alternative in considering how Methodist Hospital could establish a method of controlling outpatient flow into the hospital.

The administrators of the other hospitals were questioned whether they believed their system was ideal and, if not, what system they considered to be ideal. They all gave the same answer in a similar manner. The best system would be a centralized business office function where all outpatients would be administratively processed as they come into the hospital. It is simple to say what the ideal

is, but quite difficult to accomplish since the primary problem to consider is physical layout of facilities.

Hospital A

The categories of patients were: private, emergency and clinic. All three of the categories were flowing into the hospital in a separate manner. The clinic patients were reporting to the clinic, the emergency patients to the Emergency Room, and the private referred patients were required to report to the admission office. Each one of these functions was located in a separate part of the building. The physical layout was such that it would be extremely difficult to handle the administrative processing in another manner.

In processing the clinic patients it was the duty of the intake social worker to procure all information on the background of the patient to determine their ability to pay and if they were eligible to receive treatment as a clinic patient. All money was collected from the clinic patient before he went to the ancilliary department for treatment. If the patient did not have the money to pay, the charges were manually transcribed to the patient's ledger. At this time the patient was informed of the balance on his account. He was encouraged to bring payment back with him when he returned for treatment. He was given a plain slip of paper, not a form, notifying the ancilliary department he had paid or made arrangements and was eligible for treatment. The departments were instructed to receive no clinic patients for treatment unless they had a notice of

eligibility from the Clinic Business Office.

Emergency patients are seen 24 hours per day. All administrative information on the patient was taken by the clerk at the Nurses Desk in the Emergency Room. The information was taken from a relative or from the patient if he was capable of talking. After treatment is given all charges are compiled, and the Emergency Room clerk makes an effort to collect the full amount of charges compiled against the patient.

If the clerk can only collect part of the bill, she does. The remainder of the bill is sent to the business office for their pursuit. The same thing applies when none of the bill is collected at the time service is rendered. The clerk at the Nurse's Desk serves as a representative of the Business Office although her assignment originates with Nursing Service.

All private referred patients sent to the hospital for treatment by their private physician must report to the admission office the same as all inpatients. At this point the patients are administratively processed so they may be billed for service received by the hospital business office. No effort is made to collect for service prior to time of treatment. The patient is given a slip by the admission desk showing they have been administratively processed. The ancilliary services are not to treat outpatients unless they have a slip showing the treatment is authorized.

This hospital is treating and processing the referred outpatient in the same manner as the inpatient. All collections or billing goes through the business office.

This system meets the needs of the hospital although it may not be considered to be the ideal system. Administrative processing is accomplished prior to the patient reporting to the ancilliary departments for treatment. An effort is made to collect prior to the patient receiving treatment, with the exception of the private referred patient. This type of patient is generally considered to be a good financial risk.

Hospital B

The categories of outpatients seen in this hospital are emergency, private referred, and contract services. The categories have previously been explained with the exception of contract services. The hospital has contracted with several laboratories and smaller hospitals to perform highly technical laboratory work. The work requires extremely expensive equipment procured by the hospital to handle a large volume of business.

Each emergency patient coming to the hospital is administratively processed by a clerk located in the Emergency Room who works for the Business Office. This clerk serves in a dual capacity. She processes the patient and collects for service rendered. This is a recent innovation in this hospital and has increased the amount of money collected from the Emergency Room service. The administrator

providing the information had no substantiating figures to support his statement. Previous to placing a business office clerk in the Emergency Room, business office functions were handled by nursing personnel.

The functions of the business office clerk are covered by only two shifts per day. The night shift from 11:00 PM - 7:00 AM is not covered by a business office clerk, and processing of patients reverts back to nursing service personnel. The business office clerk has the interest of the business office as her primary objective.

The private referred patients are channelized to a central outpatient desk in the admission office for the purpose of processing. The volume of business in this area has greatly increased in recent years due to the specialized services offered by the hospital and by it's centralized location in the city. The contractural services offered by the hospital are also processed at this desk. When a representative from a hospital or a laboratory having a contract with the hospital brings a speciman or a group of specimen for processing, they must be administratively processed through this desk.

When a private referred patient reports for treatment, there are two types of outpatient services rendered.

1. One-time visit - - the patient is referred to the hospital by a physician, receives the service requested, pays cash or is billed.
2. Multiple visits - - the patient is referred to the hospital

for outpatient services that require a series of treatments, which may extend over a period of weeks or months, such as in the Department of Irradiation Therapy, Physical Medicine, or Pulmonary Rehabilitation.

If the question of insurance arises on private outpatients, the patient is advised the hospital will provide them with a detailed statement so they may file their own insurance. The problem is handled in this manner because 90 percent of the private insurance firms do not handle outpatient payments. It eliminates an administrative burden on the hospital.

The patient is given a copy of the outpatient registration form to indicate he was processed at the registration desk. This indicates to the ancilliary service that the patient may be treated. The Central Outpatient desk remains open eight hours per day. Functions are handled by the admission office during the remaining hours.

The clinic patient reports directly to the outpatient clinic office for processing. The office concludes all problems related to the administrative processing of the clinic patient. This includes interviews by the social worker for classifying to determine his ability to pay, arrangements for appointments with physicians, preparation of charge tickets, collection of charges, and notification of future appointments.

Clinic patients are charged $1.00 for each ancilliary department procedure and Pharmacy cost plus 10 percent to cover handling charges.

Classification system for clinic patients:

1. Full pay of all clinic charges.
2. Half pay of clinic charges.
3. No pay.

The classification was determined by the social worker who did a background investigation based on information provided in the initial interview.

Inherent problems in this hospital are locations of the services offered in relation to the basic point of entry into the hospital by each category of patient.

Hospital C

The operation of this hospital's outpatient program is very similar to that of Hospital "A". The primary difference being in the processing of clinic outpatients. The categories of outpatients are the same. The potential for attaining the ideal at this hospital is greater that at the others.

An attempt was recently made in the operation of the Emergency Room to establish a functioning business office. The duties of this office were administrative processing, collections, and billing. According to the administrator, the office did not work because of the caliber of personnel selected to operate the office. It was belatedly recognized that the personnel selected should have come from the business office and not other areas of the hospital. Since the system did not work, the hospital reverted to a cash box collection

system with administrative processing being accomplished by an emergency room clerk.

Private referred patients are channeled into the hospital through the patient service office. This is comparable to the admission office in other hospitals. An attempt is made to collect from the patient after the service is performed by telling him to report to the cashier. All referred patient billing is handled through the business office. Ancilliary departments do not see patients unless they possess a statement of outpatient registration acquired at the patient service office.

The clinic is a separate department. It has complete business office facilities for controlling the clinic outpatient processing. The charges for service received by clinic patients are greater at this hospital than at others and subsequently produce greater revenue. The financial records indicate many long term accounts with a large balance, but the theory is that the patient is appreciative of the service received if he must pay. The charges to clinic patients are as follows: $1.00 annual registration fee, $.50 each visit, half price for any ancilliary service received and 40 percent above cost for pharmacy.

There are three classifications of clinic patients. The patients are classified by the social worker.

1. Full pay of clinic rates (immediate on-the-spot payment)
2. Delayed pay (pay out on time)
3. No pay

The following are criteria for classification:

1. Size of family
2. Income
3. Sum total of outstanding debts

Each clinic patient has an account that is maintained in the clinic business office. Full charges are posted to the account for service received. The charge is discounted to zero balance by dividing the total in half and posting the two totals to the ledger. Aline is drawn and one-half of the discounted total is reposted to the ledger. It is discounted in this manner to comply with medicare requirements that all outpatients be charged the same for treatment. The recreated balance is the amount the clinic patient owes.

The clinic does not bill its patient. He is informed of his balance at the time he receives treatment. If he is not making an effort to pay his bill, it is discussed with him.

This hospital has been successful in their method of collection from clinic patients. The system may be more successful when the hospital acquires automatic data processing capability. The lack of an adequate system in the Emergency Room is recognized by the administration. There will be a business office established in that area. The private referred patient load is not sufficient to be considered a problem.

Proposed Procedures

The general policies regarding treatment of outpatients will not be changed. One of the basic objectives is to recognize the necessity

for as few changes as possible in established procedures and still accomplish the desired hospital goals. The proposed system is to establish a Central Outpatient Registration Office (hereafter written as C.O.R.), to which all outpatients will report prior to receiving treatment in the hospital.

Methodist Hospital of Dallas has the physical layout to clearly support a reorganization of operation requiring all categories of outpatients to report directly to C.O.R. All departments providing an outpatient service, with minor exceptions, are located in the same vicinity of the hospital. The most commonly used services - laboratory, X-ray, and physical medicine - are located nearest to the clinic and Emergency Room.

The basic elements that must be considered in proposing a new system of outpatient processing are: flow of patients, location of supporting departments, location of elevators or stairways, available space for the office, system of identifying clinic patients, revision of charge system to clinic patients, equipment for the office, personnel for staffing, advantages to the hospital.

Functions of Central Outpatient Registration

The C.O.R. is to function under direct control of the Business Manager. The functions are more inclusive than the name implies. The basic objectives for the office are to control the outpatient and to collect on-the-spot, for service rendered. When a person is confronted with a bill, they will sometimes pay without hesitation if

he has the money.

The functions are:

1. Remain open 24 hours per day and staffed by two persons each shift.

2. Receive all outpatients reporting to the hospital.

3. Administratively process all admissions coming through the emergency room.

4. Prepare an outpatient registration form on all clinic and referred patients.

5. Prepare emergency report form on all emergency room patients.

6. Prepare identification card for all clinic patients.

7. Collect charges for emergency service rendered.

8. Collect all fees paid by clinic patients, excluding Pharmacy.

9. Attempt to collect from private referred patients prior to rendering service.

10. Possess an up-to-date listing of hospital accounts receivable to assist the hospital in collections.

11. Emphasize cash payment to the patient.

12. Verify the name of guarantor.

13. Identify an individual by checking his drivers license or social security card.

14. Prepare Medicare forms.

15. Receive death cards from main business office for convenience of undertakers.

16.Account for numbered, controlled, outpatient registration forms and emergency report forms.

17. Process all inpatient admissions to the hospital after 4:00 PM daily.

Location

In determining the appropriate location for C.O.R., twelve possibilities were considered. Each of the locations were on the same floor as the Outpatient Clinic and Emergency Room. In eliminating the various locations from consideration, overall objectives were considered: the best service for the patient and control of the patient.

The following considerations were applied in selection of the location:

1. By design, the peak load of the clinic is from 8:00 - 4:00 (Appendix F). According to the Director of the Outpatient Department, the peak of the afternoon patient load is normally reached by 3:00.[11]

2. It is normal for the Emergency Room patient load to begin around 3:00 PM and to continue until approximately 10:00 PM. During the remaining hours of operation the frequency of patients is unpredictable.

(The purpose of contrasting the peak loads of the two departments is to indicate there should be minimal conflict in the use of C.O.R.)

3. By locating near the emergency room, the office can administratively process the inpatient admissions that are admitted through

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[11] Interview with the Director of the Outpatient Department, May 5, 1967.

the emergency room.

4. The C.O.R. office will be open 24 hours perday to perform all required functions. These functions normally revolve around the Emergency Room in the evening.

5. Public transportation and parking for vehicles provide a natural flow of outpatient traffic through the area recommended for C.O.R.

6. After the patient gets into the hospital elevators and stairways are convenient in relation to the proposed location of the office.

7. The primary points of consideration in the areas examined for location were present utilization of the area and cost of conversion to make it a usable area for C.O.R.

8. The office of the security personnel is conveniently located in relation to the flow of outpatients and the proposed location of C.O.R.

9. The pneumatic tube system is a primary means of communication and study revealed the Emergency Room tube outlet would be convenient for use by C.O.R.

Through the process of elimination the most central location was determined to be the three rooms near the Emergency Room that were originally built for observation rooms for emergency patients. They are presently used as sleeping rooms for various on-call personnel working the evening shift (Appendix M).

Two of the rooms are separated by a sheet rock wall that was placed there after the department was built. The other room is separated by a concrete wall and there would be no necessity to remove this wall since the room is needed for the addressograph machine and other supporting equipment for the operation of C.O.R.

According to the Plant Engineer, Methodist Hospital of Dallas, an inclusive cost (material and labor) for necessary modification to make the area usable would not exceed $250.00. The work involved would be as follows:

1. Cut one door, hang new door.
2. Remove temporary sheet rock wall.
3. Remove oxygen and vacuum outlets in the two rooms.

Outpatient Clinic Flow

A new patient entering the clinic for the first time reports to the desk and is immediately referred to the social worker. At this time the social worker questions the patient on aspects of his financial standing to determine if he is eligible for treatment. If he is eligible to be a clinic patient, the Social Service Admission History is filled out in triplicate to include information for the business office (Appendix G). This new one-half page form was determined to be appropriate because of the extremely personal nature of the information appearing on the complete social history form. The medical chart is also prepared at this time. The patient is advised on the charges for each visit and the fact that he is expected to pay cash

at the time of each visit. Paying cash precludes his receiving a bill from the hospital. An illustration for the flow of a new clinic patient is shown in (Appendix B).

The patient is now sent to C.O.R. He should possess the half-page form that provides the clerk with necessary information to give him an outpatient registration number and also to make him an outpatient clinic identification card (see section on clinic identification card). The outpatient registration number is taken from the outpatient registration form where all basic information is transcribed for business office purposes.

He will pay the cashier $1.00 for the card and be advised if the card is lost it will cost $1.00 for a replacement. The patient is further advised when he returns for a treatment or an appointment he must process through C.O.R. for the purpose of making payment prior to being treated.

He is given his identification card, a receipt for payment, the department copy of his Outpatient Registration Form, and is instructed to return to the clinic desk. The outpatient Registration Form will be filed in his official clinic record. It is for reference if the card is lost. The receipt for payment is his permit for treatment.

When the patient returns to the clinic he is eligible for treatment and is now seen by the physician. The physician may determine whether another appointment is necessary or he may prescribe tests in the ancilliary services. If tests are prescribed in another depart-

ment, they are written on the requisition for services (Appendix H). If central service supplies are used that are chargeable to the patient, they are also recorded on the requisition for services form. The clerk, using the patient identification card and the Daschew imprinting machine stamps the copies of service required if another appointment is made at this time.

Prior to reporting to the prescribed ancilliary service the patient must stop by C.O.R. and make payment for service or make arrangements for payment. A receipt must be obtained from C.O.R. which is his permit for treatment.

Return clinic appointment patients are required to report to C.O.R. and make payment of $1.00 prior to being seen in the clinic. The clerk will give the patient a receipt for payment. This will be his permit for treatment and will be presented to the clerk at the clinic desk. The flow of a return clinic appointment patient is shown in (Appendix B).

The physician in the clinic will determine the necessary services required for his patient and will indicate these by filling out the requisition for services form. If a return visit is required, he will so indicate. The clerk on the desk will stamp the requisition for service, with the patient's identification card, and make necessary reappointments. The patient is directed to go to C.O.R. prior to reporting to the prescribed department.

The patient pays or makes arrangement for payment at C.O.R.

prior to going to a department for service. The payment will be according to the number of requisitions for service he has in his possession. If, by chance, one of the requisitions is withheld from the clerk by the patient, a verification can be made when the charges come back to the Business Office from the department. The charges can be matched with the cash payment. Another check can be accomplished by the department when the clerk checks the receipt of payment for eligibility for treatment. The department where treatment is to be received should be listed on the receipt.

When the clinic patient with a department appointment enters the hospital, he reports direct to C.O.R. His appointment slip is shown to the clerk with the number of requisitions for service previously prepared by the clinic physician. The patient pays $1.00 for each procedure prescribed by the physician and is given a receipt for the amount paid. The receipt is the permit for treatment in the department where the service is to be received. There is no necessity for the patient to report to the clinic. The pattern of flow for a Clinic Patient with a Department appointment is indicated in (Appendix B).

The private referred patient reports directly to C.O.R. An outpatient registration form will be completed for each one-time visit (Appendix I). C.O.R. will request payment for treatment, if the amount of the fee can be determined. The clerk will complete all required business office information on the requisition for services form. Other information may be filled out on the form to

the maximum degree possible; excluded from this is the service required. Many times the patient will have a prescription from his physician. Even though the prescription may be readable, it should be the department's responsibility to interpret. The prescription will be attached to the form. An illustration of the flow for a Private Referred Outpatient is shown in (Appendix B).

In some cases the physician will have previously called the department, made the appointment, and given the service required. The patient will not know the treatment required; he only knows the department to which he is to report. The object of C.O.R. is to complete all information possible to fulfill the needs of the business office and to preclude the department's becoming back-logged with administrative work.

The other type visit a referred patient may make to the hospital is a series treatment. A series treatment is an outpatient seen in Radiology, Physical Medicine, or Inhalation Therapy at least once every thirty days, each visit in conjunction with the last.

If the patient knows he is a series patient, he will tell the C.O.R. clerk. At this time an outpatient registration form will be prepared on the patient. An "X" is placed in the block indicating this is a series treatment and charges are to be submitted to the business office after each treatment. At this time an addressograph card will be prepared for the patient. It will have the following information: name, address, outpatient registration number, and

name of guarantor. The C.O.R. clerk will prepare the requisition for services form as completely as possible.

If the patient is determined to be a series patient by the physician after he reports to the department for treatment, a call will be given to C.O.R. At this time, an addressograph card will be prepared for the patient and sent to the department through the pneumatic tube system.

When the series patient leaves C.O.R., he should have in his possession the department copy of the outpatient registration form, the requisition for service form, the addressograph card (if a known series) and, if possible, a receipt of payment. It is recognized that most patients of this nature are third-party payments, but immediate collection cannot be overemphasized.

There is no need for a series patient to report to C.O.R. on each successive treatment unless he is paying cash. Appointments are arranged by the department, and the department has the addressograph card indicating all pertinent information for the charge ticket submitted to the business office.

Emergency Room Patient

The number of patients reporting to the Emergency Room for treatment as actual emergencies are lessening every year in relation to the total number of treatments made. The concept in the usage is evolving as an extension of the doctor's office. For this reason, there is a necessity for the emergency room clerk to refrain from telling a patient who should be sent immediately

to a treatment room to sit in the waiting area.

When the patient enters the emergency room area, the clerk immediately refers the patient to the treatment room. The clerk gets the name of the patient. If there is a relative accompanying the patient, he will be directed to the C.O.R. desk which is located exactly thirty-two feet from the Emergency Room Nursing Desk. The C.O.R. clerk will request a driver's license or a social security card as positive identification. The C.O.R. clerk will fill out all required information on the Emergency Report Form (Appendix J). This form is presently in use with the exception of a one-half page that has been added to provide C.O.R. with information for business office purposes. When all information is recorded, the one-half page will be pulled, and the remaining forms will be given to the person providing the information with instructions to return them to the emergency room clerk.

If there are no relatives accompanying the patient and he is unable to go to C.O.R. himself, the emergency room clerk will have in her possession a copy of the numbered emergency report form. She or one of the nursing service personnel will acquire the information, if possible, from the patient. The intent is not to harass the patient, but to get maximum information to assist the hospital in collection of revenue from Emergency Room activity. An illustration for the flow of patients reporting to the Emergency Room is shown in (Appendix B).

As the patient is treated, certain charges will be generated: laboratory, X-ray, central service, etc. These charges will be processed exactly as in the present system. The emergency room clerk will fill out the requisition for service form and will attach the business office copy form to the emergency report form. After treatment is completed, the emergency room clerk gives the accounting copy and the insurance copy of the emergency report form to the patient or relative with instructions to report to C.O.R. for payment or arrangements for payment.

When these two copies are received by C.O.R., the clerk must compile the attached charge tickets. Other standard charges are listed in established emergency room charges and are easily identifiable by the clerk. The standard charges and charges for services rendered are added to make the total charge. The patient is asked to pay cash for treatment. If there is no insurance involved, and the patient can't pay cash, he is asked to pay a portion of the charges and to make arrangements for payment of the balance.

The clerk may discard the one-half page retained for the business office. Retention of this page was to provide information for billing those patients who depart without paying or making arrangements for payment. The accumulated slips serve as a reminder at the end of each shift for the C.O.R. clerk to check with the emergency room clerk to determine if there were patients who avoided C.O.R. prior to departing the hospital. This can be accomplished

by checking the emergency room copy on file against the C.O.R. one-half page copy. If the patient departed without paying or making arrangements, it will be known on the day of the incident. A bill can be compiled and sent to the patient who did not make arrangements or pay for the service.

When the Emergency Room patient is admitted as an inpatient, all charges generated in the Emergency Room will be transferred to the inpatient account. For this reason, a conspicious space is required on the Emergency Report form for the inpatient registration number to serve as a cross reference for accounting purposes.

Clinic Patient Identification Card System

A basic requirement for clinic outpatients is a system of identifying the patient. They must be identified and an account established on the same basis as all other outpatients, and they must be charged the same fee. The fee will be discounted according to ability to pay, but the full charge will be shown on the patient's account.

The primary reason for the identical charge to all outpatients is to comply with Medicare, which indicates the government will pay a hospital the same amount for a Medicare outpatient treatment that is being made to other patients.

Each new clinic patient reporting for treatment will be interviewed by the Social Worker. The social worker will take a social history in triplicate with the third copy being the one-half

page for C.O.R. (Appendix G). C.O.R. will take all required information from the half sheet for the purpose of filling out an outpatient registration form (Appendix I).

The card will be used to record each service rendered to the patient and may be used in the following locations: clinic desk, Central Outpatient Registration, Emergency Room, and departments where service is rendered.

C.O.R. will prepare the addressograph identification card (Annex K). The following information is imprinted on the face of the card: outpatient registration number; full name, middle initial; address; expiration date; and classification.

All patients previously on the clinic role will be reinterviewed as they report to the clinic. A Central Outpatient Registration number will be established, and other information to be imprinted on the card will be verified. The date of expiration of the card will be one year from the date the card is issued.

The patient will be given the card to carry with him. If there is a loss of the card, the patient may get another one by notifying the clinic desk clerk who will refer him to C.O.R. where a new card will be prepared, and a fee of $1.00 will be charged for replacement.

Revised Charge System for all Clinic Patients

Charges made to clinic patients at Methodist Hospital of Dallas

have not changed for the last ten years.[12] During this time the vastness of service offered has increased immensely. The importance of the clinic patient to the teaching program cannot be over-emphasized. Comparisons made of other hospitals revealed an increase of income during the same period, primarily through the application of flat rate charges.

Charges made for services rendered by the other hospital clinics visited, have been fairly consistent. Each hospital has some system of classifying clinic patients into pay, part-pay, and no-pay categories. They generally follow the concept that a breakdown of classification should be used.

The necessity for the classification system must be specifically emphasized. The system provides the hospital with a method of charging clinic patients in accordance with their ability to pay as well as generating an income in an area that is traditionally supported by other aspects of the hospital operations. The income generated will not offset the expense incurred in operating the clinic activities but it will contribute greatly to the welfare of the patient because he will be held responsible only for what he can afford to pay. Table IV illustrates the difference in procedure.

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[12] William V. Mays, "Study of Outpatient Services, Methodist Hospital of Dallas," Unpublished Report, 1959.

TABLE IV

CHARGE SYSTEMS IN EFFECT AT KNOWN PRIVATE HOSPITAL CLINICS

	Classification System	Charge Schedule
Hospital A	Yes Class A - Full Clinic charges Class B - Part Pay Class C - Free	Per visit: $.50 Registration: $1.00 Drugs: 50% full charges Other Services: 50% full charges
Hospital B	Yes: Class A - Full Clinic charges Class B - Part Pay Class C - Free	Per visit: $1.00 Registration: $1.00 Drugs: 10% plus cost Other Services: $1.00 per procedure
Hospital C	Yes: Class A - Full Clinic charges Class B - Part Pay Class C - Free	Per visit: $.50 Registration: $1.00 Drugs: 50% full charge Other Services: 50% full charge
Methodist	No. All patients classified as part-pay. All pay the same.	Per visit: $.50 Registration: $.50 Drugs: Cost plus 10% Other Services: free

It is clear no charges are made at Methodist Hospital in some areas where other hospitals are making useful income. The clinic is expected to operate at a deficit. The paying patient is not expected to continue to bear as much of the load as he does in his hospital bill when he contributes to the care of indigents through his taxes and community charity gifts.

It is assumed there are some people who are destitute and really need care. These are the ones for whom free service should be provided. Inevitably, there is a certain percentage of borderline people who, through ignorance, or recognition of a "good thing", or their own bad management of family finances, will take advantage of the services offered by the clinic.[13] The approach to this problem should be liberal with the patient, but also consider the interest of the hospital. It should also be an unsophisticated approach.

It is for this reason that the proposed system of charges is based on a flat rate. If the patient can easily figure the amount of money he must bring with him when he reports for treatment, then it is more likely cash collections will be made for the services rendered. Table III indicates the amount of money collected through the clinic operations of two other hospitals compared to Methodist, and this clearly substantiates the fact an adjustment in charges is necessary.

With the implementation of Medicare, the necessity for detailed ledger accounting is absolute. It is required that all patients be accounted for in the same manner, be admitted as an outpatient on the same basis, and be charged an identical fee for the same services received. In other words, all outpatients will have the same fee schedule used as the charge for treatment received. This is the

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[13]Scott, op.cit., p.4.

only way Methodist Hospital can justify receipt of outpatient Medicare funds.

There are points of consideration in the proposed system that must be made by the social worker at the time of the interview with the patient. The situation will vary from time to time with individual patients. The simplicity of the flat rate system, the low charges for service rendered, and the classification system should provide flexibility to the social worker when dealing with individual cases. The proposed classification system is shown in Table V.

TABLE V

PROPOSED CHARGE SYSTEM
CLINIC PATIENTS
METHODIST HOSPITAL OF DALLAS

Classification System:	Charge Schedule:
Class A - Full clinic charges payable at time of service.	Annual registration: $1.00
Class B - Part-pay, arrangements for pay of full clinic charges.	Per visit: $1.00 Drugs: 10% plus costs
Class C - Free	Other services: $1.00 per procedure

The accounting procedures involved in the system will be simple once the hospital acquires the Automatic Data Processing capability to handle all clinic patients. Until this time, a manual system must be considered. The C.O.R. office is the most likely location for the manual accounting procedure since this is where all outpatients report and make payment for treatment received.

The posting may be accomplished by the night shift since the office will be accessible twenty-four hours per day.

Staffing Central Outpatient Registration

A significant point in considering the organization of an office such as C.O.R. is the cost of operation. The greatest portion of the expense involved will be salaries of personnel operating the office twenty-four hours per day.

It is proposed there be three eight-hour shifts per day. The shifts should parallel those of nursing service personnel. C.O.R. clerks should check with the Emergency Room Nursing desk at the end of each shift to determine if any emergency patients have failed to check out through C.O.R. It is recommended there be two clerks on duty each shift. The hours of the shifts are proposed as follows:

First shift - 7:00 AM - 3:00 PM
Second shift - 3:00 PM - 11:00 PM
Third shift - 11:00 PM - 7:00 AM

By simple computation, it is determined that on the basis of a forty-hour work week, it will require eight personnel to operate the office. This provides coverage of two people per shift for all but sixteen hours per week. The extra sixteen hours can be managed in two ways.

First, a part-time person could be hired to work sixteen hours per week. This would increase the expense of the operation, but would provide the desired two persons on duty at all times in the office. Second, the time of least activity in the office may be

determined and a reduction of the staffing to one person applied during this period. The office could be locked and a sign placed on the door during the period of absence, and two people would not be required during the sixteen hours determined to have the least activity.

Since there is a wide variety of functions in this office, the first alternative would be more feasible.

Equipment

The Business Manager was consulted on the proper equipment required to establish the proposed C.O.R.. The hospital has on hand in the Business Office an extra addressograph machine nullifying the necessity of purchasing this expensive piece of equipment. This machine can be moved to C.O.R. without expense or inconvenience to the hospital.

Table VI is a compilation of requirements, with an estimated cost for each item. The prices were procured from the hospital purchasing agent.

Great emphasis was placed on the equipment requirements from the viewpoint of available floor space. The proposed area limits the amount of equipment that can be placed in the reception room of C.O.R.. However, the recommended list of equipment requirements is considered adequate to accomplish the required objectives of C.O.R..

TABLE VI

C.O.R. EQUIPMENT REQUIREMENTS

Item Description	Quantity Required	Cost Each Item	Extended Cost
Addressograph Imprinter	1	$ 55.20	$ 55.20
Typewriters	2	450.00	900.00
Adding Machines(10 key)	2	238.05	476.10
Straight Chairs	4	37.60	150.40
Secretarial Chairs	2	54.00	108.00
Admitting Desk Consoles	2	255.35	510.70
Receipt Machines	2	25.00	50.00
Total Cost			$2,250.40

Forms

There are minimal changes in presently used forms required to establish the entire procedure involving C.O.R.. The purposes for having the forms and requiring their use, as stated throughout this paper, are for continuity of operation, control of the patient, accounting purposes, and ease of compliance with basic Medicare requirements.

EMERGENCY REPORT FORM (Appendix J).

There are two modifications required on this form. Neither will cause a major adjustment on the part of personnel making use of the form. The form is numbered and controlled. Accountability of the form is removed from the Emergency Room and given to C.O.R..

The first modification requires the admission number be removed from the bottom of the page and placed at the top of the page next to the control number so that it will be in a conspicuous location.

The transfer of the number to a more obvious location on the form will increase the importance of the number. It will influence the possibility of collecting revenue due for services rendered in the Emergency Room before the patient is admitted.

The second modification requires a one-half page be attached as the last page of the snapout form. The one-half page is retained by C.O.R. for final processing until the emergency report is returned after treatment. It serves as a reminder to the clerk of the number of Emergency Room patients who have registered but have not cleared C.O.R. and is the source of a double check to assure that all patients who depart without paying are pursued.

The one-half page will be a carbon copy of all information, on the front page of the report, down to the line where the nurse-in-charge signs the sheet.

ADMISSION INFORMATION CLINIC PATIENT (Appendix G).

An additional one-half page is required on this form. The one-half page is used by C.O.R. for the purpose of filling out an outpatient registration form and providing information for preparing the clinic identification card. The reason for the one-half page is that the information appearing on the remainder of the form is of a personal nature and of no concern to others. This form is destroyed after information is transferred to the outpatient registration form.

OUTPATIENT REGISTRATION FORM (Appendix I).

This is a preprinted, pre-numbered, controlled form. It is a new form that is used for the registration of a private referred

patient each time he comes to the hospital for a single treatment. For a series treatment, an addressograph card is prepared for the patient. It is used by the department rendering treatment on successive visits. If it is a series treatment, the clerk will check the block in the remarks section of the form. One copy of the form goes to the department with the patient, and the other is sent to the Business Office by C.O.R. where charge tickets will be matched with it for billing.

The form is also used for a clinic patient. The number on the form becomes his permanent outpatient registration number and is stamped on his identification card. All future visits to the clinic will require the patient to show his identification card, and it will be used in stamping his charge tickets for service. No additional formal registration is necessary.

One copy of the form goes to the business office for computer application so charges can be matched to it for billing. The other copy is returned to the clinic and placed in the permanent file of the patient.

The preprinted, pre-numbered form should be in two separate series, one for private referred patients and one for clinic patients.

There is no medical/legal need for a treatment permit to be placed on the outpatient registration form. A legal interpretation was made on this point by the law firm representing Methodist Hospital of Dallas (Appendix L).

PHYSICIAN REQUISITION FOR SERVICE (Appendix H).

This is a new form not presently in use by the hospital. It is a flexible form replacing twenty-three charge tickets presently in use by the departments.

The front page of the requisition is broken into three service-request forms. This page becomes a part of the patient's record. It clearly indicates the work that has been requested for the patient. The results of the work will eventually be returned to the physician and will be pasted into the blank spot on the front page of the form.

When the physician writes the order on the front page, it penetrates by means of carbon on three other pages. The separate orders are perforated. Each copy has a specific function: Copy 1 is the physician's copy and is returned to him with the results of the test. It has a gummed back and will be pasted into the original order to indicate the work has been accomplished. He will see the results when he observes the patient's records. Copy 2 is the Business Office copy, and will be forwarded there when the work has been completed. It will indicate the code number of the procedure for pricing purposes. Copy 3 is for departmental use.

The results of the service performed by the departments are placed in the blank area of the form by means of an imprint machine. The department will have an addressograph plate prepared with the results of each procedure they perform. By using this method only

one charge ticket is required for all departments.

Extra copies of the three-copy charge sheet will be available. They may be required for multiple tests performed as the result of one order by a physician.

When a private referred patient reports to C.O.R. with a physician's written order, the service requisition is completed to the extent of filling in the Business Office information. The physician's written order will be attached to the requisition and carried to the department where the service is performed.

The form is prepared by the physician. He fills out the request in the following manner, writing legibly, and using a ball point pen, if possible.

1. Checks the proper department where the service is performed.
2. Specifies diagnosis of a laboratory case.
3. Fills in physician's order and signs the slip.

The clinic will be certain to use the imprinting machine and patient identification card to record the information on the requisition. The Emergency Room will type the Business Office information.

Summary

Criteria for organizing the Central Outpatient Registration office at Methodist Hospital of Dallas are listed and explained. An annotation of the systems of outpatient flow into three other hospitals is given. The administrators of the other hospitals

indicated they were of the opinion the ideal system is Central Outpatient Registration; all Business Office functions could be completed at that location. The primary inhibitor to a centralized operation is physical layout in the other three hospitals. Methodist Hospital has the proper layout to support a Central Outpatient Registration. A detailed proposed system for the processing of all categories of outpatients is provided. The included flow charts should provide a clear picture of patient flow.

A comparison was made of the income from clinic outpatients of two other major Dallas, Texas hospitals. The results verify Methodist Hospital is not receiving income from services performed at the same rate as the other hospitals.

CHAPTER III

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

An efficient Central Outpatient Registration system can be established in Methodist Hospital of Dallas by the following means:

1. Establishing a C.O.R. office near the Emergency Room.
2. Registering all outpatients and giving them a control number in the same manner as inpatients.
3. Adapting the newly recommended forms and making the stated modifications to the old forms.
4. Requiring all departments to deny treatment to an outpatient who has not checked in at C.O.R. prior to coming to the department. The exceptions to this are series treatments, after the initial visit; and emergency incapacitated, unaccompanied cases.
5. Installation of a communication system between C.O.R. and the Business Office for rapid inter-office communication.
6. Maximum utilization of the pneumatic tube located in the Emergency Room.
7. Staffing C.O.R. with two clerks per shift and maintaining a twenty-four hours per day operation.
8. Transferring four admission clerks from the admission office to C.O.R. to become the basic core of personnel for staffing the office.

9. Requiring an emphasis on the importance of cash collection prior to service being rendered, if possible, or ascertaining the method of remittance if cash payment is not made.
10. Implementing and maintaining a mechanical system of accounting in C.O.R. for clinic patients prior to acquisition of Automatic Data Processing capability. Emergency Room patients and private referred patients can be handled with present ADP capabilities.
11. Channeling all outpatient flow, in and out of the hospital, through the C.O.R. area; thus reducing traffic in other parts of the hospital.
12. Combining various admission functions presently handled by the Emergency Room, as well as making all inpatient admissions to the hospital after 4:00 PM daily.
13. Adapting the identification card system for clinic patients.
14. Revising the charge system to the clinic patient. It will provide an increased level of revenue to the hospital and bring the fees in line with other hospitals of the community.
15. Equipping the C.O.R. office according to the recommended equipment list.

Recommendation for Implementation

It is recommended that:

1. A Central Outpatient Registration system be instituted in Methodist Hospital of Dallas with the least possible delay.
2. The location of the area be in the three rooms of the Emergency Department originally built for the purpose of patient observation, and that only one door be cut into the two rooms from the outside hallway. (The door would be directly in front of the 21 x 44 inch pillar that divides the two rooms. This increases the usable area of the two rooms.)
3. All outpatients - clinic, private referred, and emergency - process through C.O.R..
4. No outpatient will be seen by a department unless he has processed through C.O.R.. Exceptions to this are a series patient who registered on his first visit, and incapacitated emergencies.
5. The C.O.R. office be open twenty-four hours per day.
6. Staffing of the office be on the basis of two persons per shift, and shifts be concurrent with nursing service.
7. C.O.R. be an extension of the Business Office and under operational control of the Business Manager.
8. A system of direct oral communication be established between the Business Office and C.O.R..

9. The system of charges to clinic patients be modified, as recommended, to be in line with the rate charges being made at other Dallas hospitals.
10. The clinic patient identification card system be established.

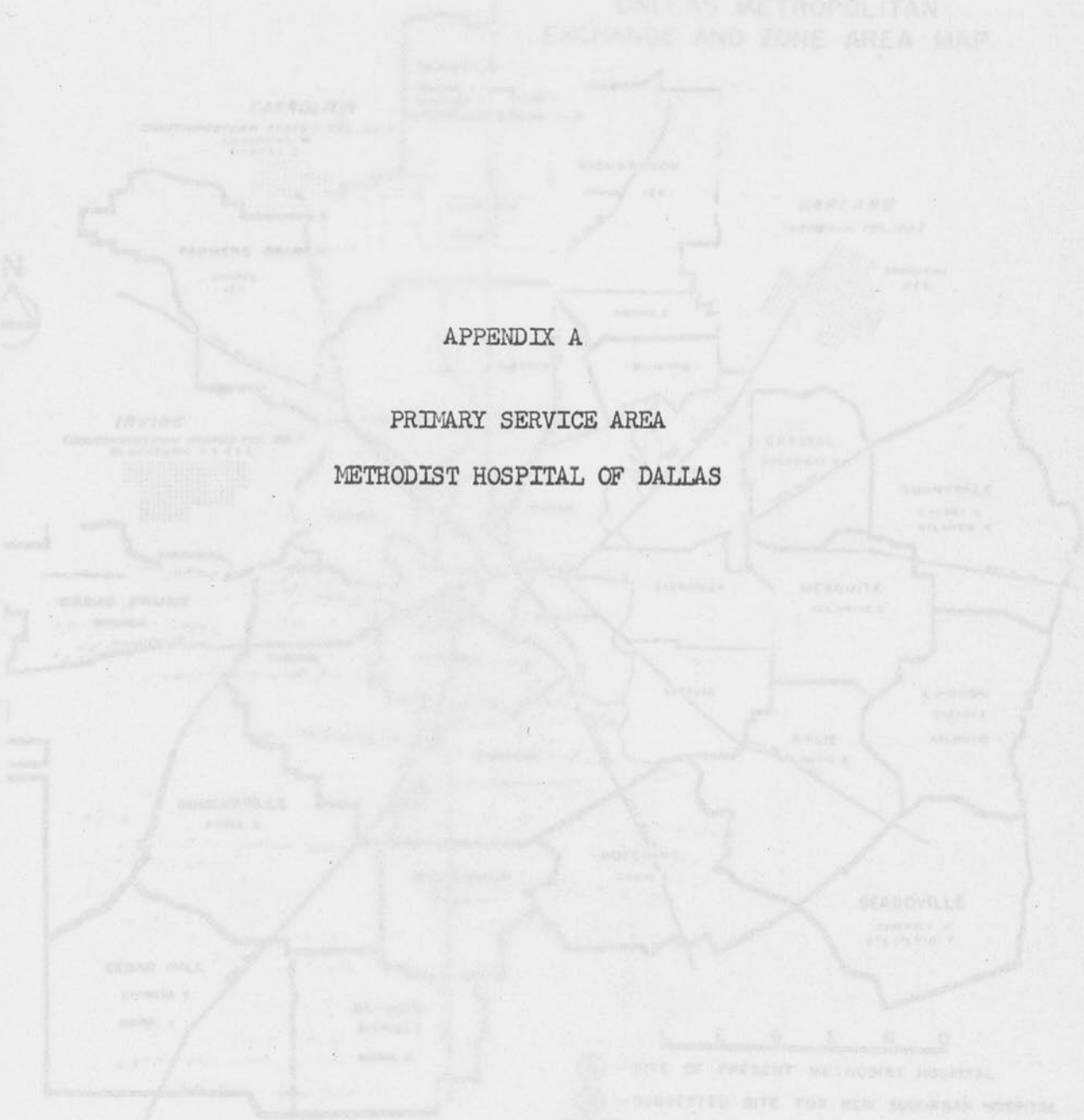
Recommendation for Further Study

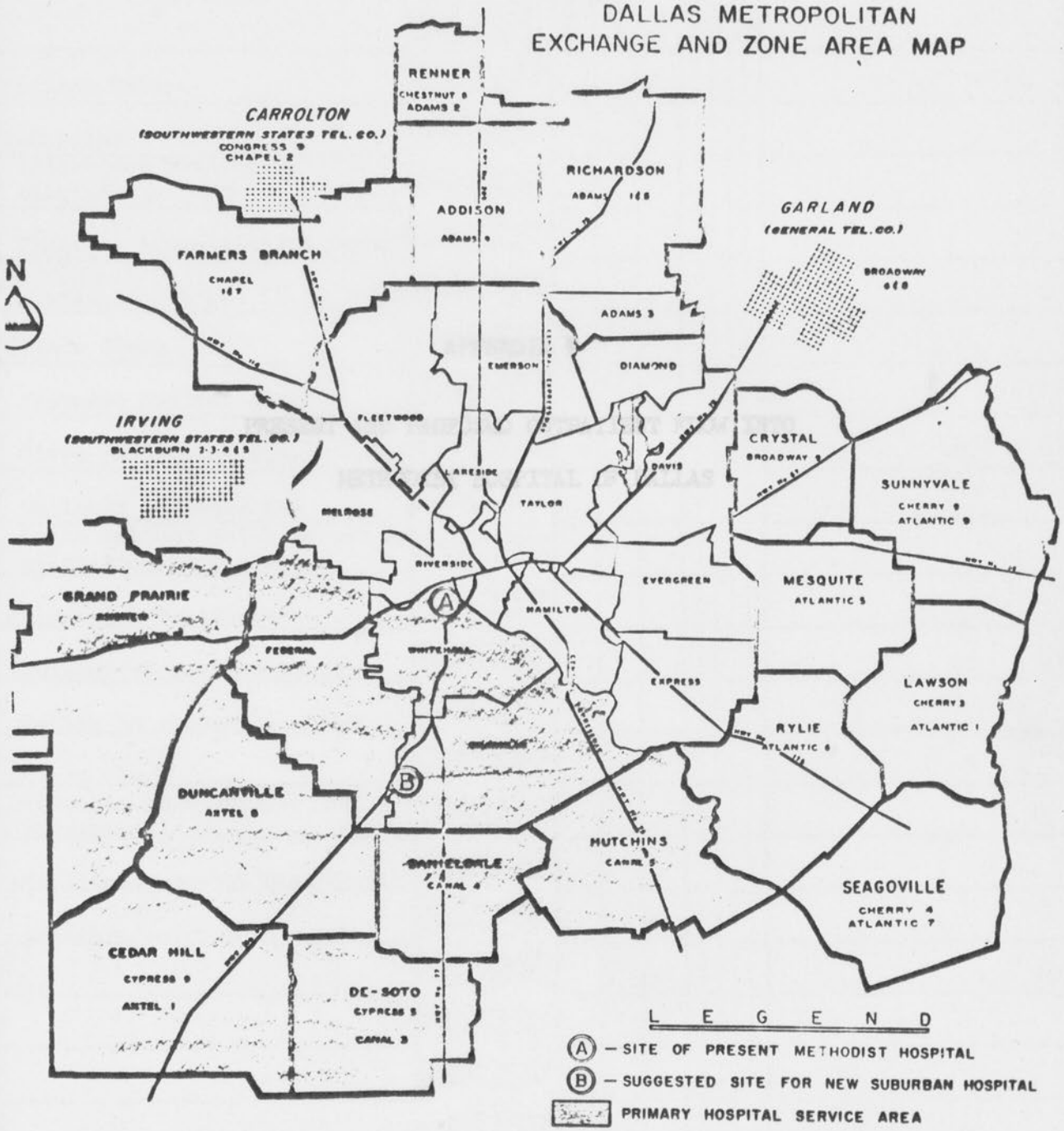
With the annual increase in the number of outpatients being treated in the Methodist Hospital it is recommended a study be made on the feasibility of establishing a central appointment system to provide better patient service for the outpatient.

APPENDIX A

PRIMARY SERVICE AREA

METHODIST HOSPITAL OF DALLAS




DALLAS METROPOLITAN
EXCHANGE AND ZONE AREA MAP
RENNER
CHESTNUT 8
ADAMS 2
CARROLTON
(SOUTHWESTERN STATES TEL. CO.)
CONGRESS 9
CHAPEL 2
RICHARDSON
ADAMS 1&5
ADDISON
ADAMS 4
GARLAND
(GENERAL TEL. CO.)
BROADWAY
6&8
FARMERS BRANCH
CHAPEL
1&7
ADAMS 3
EMERSON
DIAMOND
IRVING
(SOUTHWESTERN STATES TEL. CO.)
BLACKBURN 2-3-4&5
FLEETWOOD
LAKESIDE
DAVIS
CRYSTAL
BROADWAY 9
SUNNYVALE
CHERRY 9
ATLANTIC 9
MELROSE
TAYLOR
RIVERSIDE
EVERGREEN
MESQUITE
ATLANTIC 5
GRAND PRAIRIE
HAMILTON
FEDERAL
WHITEHORN
EXPRESS
LAWSON
CHERRY 3
ATLANTIC 1
RYLIE
ATLANTIC 6
DUNCANVILLE
ARTEL 8
HUTCHINS
CANAL 5
SEAGOVILLE
CHERRY 4
ATLANTIC 7
CEDAR HILL
CYPRESS 9
ARTEL 1
DE-SOTO
CYPRESS 5
CANAL 3
LEGEND
(A) — SITE OF PRESENT METHODIST HOSPITAL
(B) — SUGGESTED SITE FOR NEW SUBURBAN HOSPITAL
PRIMARY HOSPITAL SERVICE AREA

APPENDIX B

PRESENT AND PROPOSED OUTPATIENT FLOW INTO METHODIST HOSPITAL OF DALLAS

FLOW PROCESS CHART
(DA Pamphlet 20-300)

NUMBER | PAGE NO. | NO. OF PAGES

PROCESS: New Patient (Clinic)

[X] MAN OR [ ] MATERIAL

CHART BEGINS: Patient Enters

CHART ENDS: Departs, Home

CHARTED BY | DATE

ORGANIZATION: Methodist Hospital, Dallas, Texas

SUMMARY

ACTIONS	PRESENT NO.	PRESENT TIME	PROPOSED NO.	PROPOSED TIME	DIFFERENCE NO.	DIFFERENCE TIME
○ OPERATIONS						
⇨ TRANSPORTATIONS						
□ INSPECTIONS						
D DELAYS						
▽ STORAGES						
DISTANCE TRAVELLED *(Feet)*						

DETAILS OF [X] PRESENT [ ] PROPOSED METHOD

	OPERATION / TRANSPORTATION / INSPECTION / DELAY / STORAGE	DISTANCE IN FEET	QUANTITY	TIME	ANALYSIS: WHY? WHAT?	WHERE?	WHEN?	WHO?	HOW?	NOTES	ANALYSIS: ELIMINATE	COMBINE	CHNGE: SEQUENCE	PLACE	PERSON	IMPROVE
1 Patient Enters	○⇨□D▽															
2 Counselor	○⇨□D▽															
3 Interviews patient on eligibility	⊗⇨□D▽															
4 Prepares Administative papers	⊗⇨□D▽															
5 Discusses charges ($.50 @visit)	⊗⇨□D▽															
6 Clinic Clerk	○⇨□D▽															
7 Prepares Medical chart	⊗⇨□D▽															
8 Gives patient an appointment	⊗⇨□D▽															
9 Collects patients fee	⊗⇨□D▽															
10 Seats patient until he can see allocation physician	⊗⇨□D▽															
11 Allocation Physician	○⇨□D▽															
12 Determines service required	⊗⇨□D▽															
13 Refers to specialty clinic	⊗⇨□D▽															
14 Clinic Clerk	○⇨□D▽															
15 Prepares work request for physician	○⇨□D▽															
16 Ancilliary Service Department	○⇨□D▽															
17 Receives service	⊗⇨□D▽															
18 Home	○⇨□D▽															
19	○⇨□D▽															
20	○⇨□D▽															
21	○⇨□D▽															

DA FORM 1 MAY 51 684 *(Formerly DA AGO)* REPLACES OCS FORM 391, 1 FEB 1951, WHICH MAY BE USED.

FLOW PROCESS CHART
(DA Pamphlet 20-300)

NUMBER | PAGE NO. | NO. OF PAGES

PROCESS: Patient with Department Appointment (Clinic)

[X] MAN OR [ ] MATERIAL

CHART BEGINS: Patient Enters

CHART ENDS: Departs, Home

CHARTED BY | DATE

ORGANIZATION: Methodist Hospital, Dallas, Texas

SUMMARY

ACTIONS	PRESENT NO.	PRESENT TIME	PROPOSED NO.	PROPOSED TIME	DIFFERENCE NO.	DIFFERENCE TIME
○ OPERATIONS						
⇨ TRANSPORTATIONS						
□ INSPECTIONS						
D DELAYS						
▽ STORAGES						
DISTANCE TRAVELLED *(Feet)*						

DETAILS OF [X] PRESENT [ ] PROPOSED METHOD

	OPERATION / TRANSPORTATION / INSPECTION / DELAY / STORAGE	DISTANCE IN FEET	QUANTITY	TIME	ANALYSIS: WHY? WHAT?	WHERE?	WHEN?	WHO?	HOW?	NOTES	ANALYSIS: ELIMINATE	COMBINE	CHNGE: SEQUENCE	PLACE	PERSON	IMPROVE
1 Patient Enters	○⇨□D▽															
2 Ancilliary Service Department	○⇨□D▽															
3 Receives service	⊗⇨□D▽															
4 Home	○⇨□D▽															
5	○⇨□D▽									* Patient should ~~have service req.~~ prev. filled out ~~by clinic clerk.~~						
6	○⇨□D▽															
7	○⇨□D▽															
8	○⇨□D▽															
9	○⇨□D▽															
10	○⇨□D▽															
11	○⇨□D▽															
12	○⇨□D▽															
13	○⇨□D▽															
14	○⇨□D▽															
15	○⇨□D▽															
16	○⇨□D▽															
17	○⇨□D▽															
18	○⇨□D▽															
19	○⇨□D▽															
20	○⇨□D▽															
21	○⇨□D▽															

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FLOW PROCESS CHART
(DA Pamphlet 20-300)

NUMBER | PAGE NO. | NO. OF PAGES

PROCESS: Return Clinic Patient For Appointment

☒ MAN OR ☐ MATERIAL

CHART BEGINS: Patient Enters | CHART ENDS: Departs, Home

CHARTED BY | DATE

ORGANIZATION: Methodist Hospital, Dallas, Texas

SUMMARY

ACTIONS	PRESENT NO.	PRESENT TIME	PROPOSED NO.	PROPOSED TIME	DIFFERENCE NO.	DIFFERENCE TIME
○ OPERATIONS						
⇨ TRANSPORTATIONS						
□ INSPECTIONS						
D DELAYS						
▽ STORAGES						
DISTANCE TRAVELLED *(Feet)*						

DETAILS OF ☒ PRESENT ☐ PROPOSED METHOD	OPERATION / TRANSPORTATION / INSPECTION / DELAY / STORAGE	DISTANCE IN FEET	QUANTITY	TIME	ANALYSIS: WHY? WHAT?	WHERE?	WHEN?	WHO?	HOW?	NOTES	ANALYSIS: ELIMINATE	COMBINE	CHNGE: SEQUENCE	PLACE	PERSON	IMPROVE
1 Patient Enters	○⇨□D▽															
2 Clinic Clerk	○⇨□D▽															
3 Pulls chart	○⇨□D▽															
4 Collects $.50 fee	○⇨□D▽															
5 Physician	○⇨□D▽															
6 Prescribes Services required	○⇨□D▽															
7 Determines if new appointment	○⇨□D▽									required						
8 Clinic Clerk	○⇨□D▽															
9 Prepares service request	○⇨□D▽															
10 Makes new appointment slip, if required	○⇨□D▽															
11 Ancilliary Service Department	○⇨□D▽															
12 Receives service	○⇨□D▽															
13 Home	○⇨□D▽															
14	○⇨□D▽															
15	○⇨□D▽															
16	○⇨□D▽															
17	○⇨□D▽															
18	○⇨□D▽															
19	○⇨□D▽															
20	○⇨□D▽															
21	○⇨□D▽															

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FLOW PROCESS CHART
(DA Pamphlet 20-300)

NUMBER | PAGE NO. | NO. OF PAGES

PROCESS: Private Referred Outpatient

☒ MAN OR ☐ MATERIAL

CHART BEGINS: Patient Enters

CHART ENDS: Departs, Home

CHARTED BY | DATE

ORGANIZATION: Methodist Hospital, Dallas, Texas

SUMMARY

ACTIONS	PRESENT NO.	PRESENT TIME	PROPOSED NO.	PROPOSED TIME	DIFFERENCE NO.	DIFFERENCE TIME
○ OPERATIONS						
⇨ TRANSPORTATIONS						
□ INSPECTIONS						
D DELAYS						
▽ STORAGES						
DISTANCE TRAVELLED *(Feet)*						

DETAILS OF ☒ PRESENT ☐ PROPOSED METHOD	OPERATION / TRANSPORTATION / INSPECTION / DELAY / STORAGE	DISTANCE IN FEET	QUANTITY	TIME	ANALYSIS: WHY? WHAT?	WHERE?	WHEN?	WHO?	HOW?	NOTES	ANALYSIS: ELIMINATE	COMBINE	CHNGE: SEQUENCE	PLACE	PERSON	IMPROVE
1 Patient Enters	○⇨□D▽															
2 Ancilliary Service Depart.	○⇨□D▽															
3 Receives Service	○⇨□D▽															
4 Home	○⇨□D▽															
5	○⇨□D▽									*All administrative processing completed in Depts. No cash collections						
6	○⇨□D▽															
7	○⇨□D▽									are made with exception Pharmacy						
8	○⇨□D▽									Patients are referred to Business						
9	○⇨□D▽									Office for payment.						
10	○⇨□D▽															
11	○⇨□D▽															
12	○⇨□D▽															
13	○⇨□D▽															
14	○⇨□D▽															
15	○⇨□D▽															
16	○⇨□D▽															
17	○⇨□D▽															
18	○⇨□D▽															
19	○⇨□D▽															
20	○⇨□D▽															
21	○⇨□D▽															

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FLOW PROCESS CHART
(DA Pamphlet 20-300)

NUMBER | PAGE NO. | NO. OF PAGES

PROCESS: Emergency Room Patient

[X] MAN OR [ ] MATERIAL

CHART BEGINS: Patient Enters

CHART ENDS: Completion Business

CHARTED BY | DATE

ORGANIZATION: Methodist Hospital, Dallas, Texas

SUMMARY

ACTIONS	PRESENT NO.	PRESENT TIME	PROPOSED NO.	PROPOSED TIME	DIFFERENCE NO.	DIFFERENCE TIME
○ OPERATIONS						
⇨ TRANSPORTATIONS						
□ INSPECTIONS						
D DELAYS						
▽ STORAGES						
DISTANCE TRAVELLED *(Feet)*						

DETAILS OF [X] PRESENT [ ] PROPOSED METHOD	OPERATION / TRANSPORTATION / INSPECTION / DELAY / STORAGE	DISTANCE IN FEET	QUANTITY	TIME	ANALYSIS: WHY? WHAT?	WHERE?	WHEN?	WHO?	HOW?	NOTES	ANALYSIS: ELIMINATE	COMBINE	CHNGE: SEQUENCE	PLACE	PERSON	IMPROVE
1 Patient Enters	○⇨□D▽															
2 Emergency Room Clerk	○⇨□D▽															
3 Directs patient to	⊗⇨□D▽									treatment room						
4 Procures all information	⊗⇨□D▽									for administrative processing						
5 Physician	○⇨□D▽															
6 Prescribes services	⊗⇨□D▽															
7 Emergency Room Clerk	○⇨□D▽															
8 Attaches all charges to	⊗⇨□D▽									accounting copy						
9 Requests patient or relative	⊗⇨□D▽									to report to Business Office						
10 Business Office	○⇨□D▽															
11 Compiles additional charges	⊗⇨□D▽															
12 Bills patient if no pay	⊗⇨□D▽															
13	○⇨□D▽															
14	○⇨□D▽															
15	○⇨□D▽															
16	○⇨□D▽															
17	○⇨□D▽															
18	○⇨□D▽															
19	○⇨□D▽															
20	○⇨□D▽															
21	○⇨□D▽															

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FLOW PROCESS CHART
(DA Pamphlet 20-300)

NUMBER	PAGE NO.	NO. OF PAGES

PROCESS: Private Referred Outpatient

☒ MAN OR ☐ MATERIAL

CHART BEGINS: Patient Enters

CHART ENDS: Departs, Home

CHARTED BY:

DATE:

ORGANIZATION: Methodist Hospital, Dallas, Texas

SUMMARY

ACTIONS	PRESENT NO.	PRESENT TIME	PROPOSED NO.	PROPOSED TIME	DIFFERENCE NO.	DIFFERENCE TIME
○ OPERATIONS						
⇨ TRANSPORTATIONS						
□ INSPECTIONS						
D DELAYS						
▽ STORAGES						
DISTANCE TRAVELLED *(Feet)*						

DETAILS OF ☐ PRESENT ☒ PROPOSED METHOD	OPERATION / TRANSPORTATION / INSPECTION / DELAY / STORAGE	DISTANCE IN FEET	QUANTITY	TIME	ANALYSIS: WHY? WHAT?	WHERE?	WHEN?	WHO?	HOW?	NOTES	ANALYSIS: ELIMINATE	COMBINE	CHNGE: SEQUENCE	PLACE	PERSON	IMPROVE
1 Patient Enters	○⇨□DV															
2 Central Outpatient Registra.	○⇨□DV															
3 Administrative processing	○⇨□DV															
4 Collects fee or	○⇨□DV															
5 Makes arrangement	○⇨□DV									for payment						
6 Ancilliary Service Dept.	○⇨□DV															
7 Home	○⇨□DV															
8	○⇨□DV															
9	○⇨□DV															
10	○⇨□DV															
11	○⇨□DV															
12	○⇨□DV															
13	○⇨□DV															
14	○⇨□DV															
15	○⇨□DV															
16	○⇨□DV															
17	○⇨□DV															
18	○⇨□DV															
19	○⇨□DV															
20	○⇨□DV															
21	○⇨□DV															

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FLOW PROCESS CHART
(DA Pamphlet 20-300)

NUMBER	PAGE NO.	NO. OF PAGES

PROCESS: Clinic Patient, Department Appointment

☒ MAN OR ☐ MATERIAL

CHART BEGINS: Patient Enters

CHART ENDS: Departs, Home

CHARTED BY:

DATE:

ORGANIZATION: Methodist Hospital, Dallas, Texas

SUMMARY

ACTIONS	PRESENT NO.	PRESENT TIME	PROPOSED NO.	PROPOSED TIME	DIFFERENCE NO.	DIFFERENCE TIME
○ OPERATIONS						
⇨ TRANSPORTATIONS						
□ INSPECTIONS						
D DELAYS						
▽ STORAGES						
DISTANCE TRAVELLED *(Feet)*						

	DETAILS OF ☐ PRESENT ☒ PROPOSED METHOD	OPERATION ○ TRANSPORTATION ⇨ INSPECTION □ DELAY D STORAGE ▽	DISTANCE IN FEET	QUANTITY	TIME	ANALYSIS WHY? WHAT?	WHERE?	WHEN?	WHO?	HOW?	NOTES	ANALYSIS ELIMINATE	COMBINE	CHNGE SEQUENCE	PLACE	PERSON	IMPROVE
1	Patient Enters Hospital	○⇨□D▽															
2	Central Outpatient Registra.	○⇨□D▽															
3	Collects for Service or	○⇨□D▽															
4	Makes arrangements	○⇨□D▽									for payment						
5	Ancilliary Service Dept.	○⇨□D▽															
6	Home	○⇨□D▽															
7		○⇨□D▽															
8		○⇨□D▽															
9		○⇨□D▽															
10		○⇨□D▽															
11		○⇨□D▽															
12		○⇨□D▽															
13		○⇨□D▽															
14		○⇨□D▽															
15		○⇨□D▽															
16		○⇨□D▽															
17		○⇨□D▽															
18		○⇨□D▽															
19		○⇨□D▽															
20		○⇨□D▽															
21		○⇨□D▽															

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FLOW PROCESS CHART
(DA Pamphlet 20-300)

NUMBER	PAGE NO.	NO. OF PAGES

PROCESS: Outpatient Clinic, New Patient

[x] MAN OR [ ] MATERIAL

CHART BEGINS: Patient Enters

CHART ENDS: Departs, Home

CHARTED BY:

DATE:

ORGANIZATION: Methodist Hospital, Dallas, Texas

SUMMARY

ACTIONS	PRESENT NO.	PRESENT TIME	PROPOSED NO.	PROPOSED TIME	DIFFERENCE NO.	DIFFERENCE TIME
○ OPERATIONS						
⇨ TRANSPORTATIONS						
□ INSPECTIONS						
D DELAYS						
▽ STORAGES						
DISTANCE TRAVELLED *(Feet)*						

DETAILS OF [x] PRESENT [ ] PROPOSED METHOD	OPERATION / TRANSPORTATION / INSPECTION / DELAY / STORAGE	DISTANCE IN FEET	QUANTITY	TIME	ANALYSIS: WHY? WHAT?	WHERE?	WHEN?	WHO?	HOW?	NOTES	ANALYSIS: ELIMINATE	COMBINE	CHNGE SEQUENCE	PLACE	PERSON	IMPROVE
1 Patient Enters	○⇨□D▽															
2 Counselor	○⇨□D▽															
3 Interviews patient	○⇨□D▽									on eligibility						
4 Prepares paperwork	○⇨□D▽															
5 Counsels on charges	○⇨□D▽															
6 Prepares Medical chart	○⇨□D▽															
7 Central Outpatient Registra.	○⇨□D▽															
8 Registers patient	○⇨□D▽															
9 Prepares I.D. card	○⇨□D▽															
10 Collects initial fee	○⇨□D▽															
11 Allocation Physician	○⇨□D▽															
12 Examines patient	○⇨□D▽															
13 Prepares service request	○⇨□D▽															
14 Special Clinic Appointment	○⇨□D▽															
15 Central Outpatient Registra.	○⇨□D▽															
16 Collects for service or	○⇨□D▽															
17 Discuss arrangements	○⇨□D▽									for payment						
18 Provides patient receipt	○⇨□D▽									admits him for svc.						
19 Ancilliary Service	○⇨□D▽															
20 Home	○⇨□D▽															
21	○⇨□D▽															

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FLOW PROCESS CHART
(DA Pamphlet 20-300)

NUMBER	PAGE NO.	NO. OF PAGES

PROCESS: Return Clinic Appointment Patient

[x] MAN OR [ ] MATERIAL

CHART BEGINS: Patient Enters

CHART ENDS: Departs, Home

CHARTED BY:

DATE:

ORGANIZATION: Methodist Hospital, Dallas, Texas

SUMMARY

ACTIONS	PRESENT NO.	PRESENT TIME	PROPOSED NO.	PROPOSED TIME	DIFFERENCE NO.	DIFFERENCE TIME
○ OPERATIONS						
⇨ TRANSPORTATIONS						
□ INSPECTIONS						
D DELAYS						
▽ STORAGES						
DISTANCE TRAVELLED *(Feet)*						

	DETAILS OF [ ] PRESENT [x] PROPOSED METHOD	OPERATION / TRANSPORTATION / INSPECTION / DELAY / STORAGE	DISTANCE IN FEET	QUANTITY	TIME	ANALYSIS: WHY? WHAT?	WHERE?	WHEN?	WHO?	HOW?	NOTES	ANALYSIS: ELIMINATE	COMBINE	CHNGE: SEQUENCE	PLACE	PERSON	IMPROVE
1	Patient Enters	○⇨□D▽															
2	Central Outpatient Registra.	○⇨□D▽															
3	Receives payment	⊗⇨□D▽									provides receipt						
4	Clinic Area	○⇨□D▽															
5	Physician	○⇨□D▽															
6	Prescribes required svc.	⊗⇨□D▽															
7	Makes new appointment	⊗⇨□D▽															
8	Central Outpatient Registra.	○⇨□D▽															
9	Collects for service or	⊗⇨□D▽															
10	Discuss arrangements	⊗⇨□D▽									for payment						
11	Provides patient a receipt	⊗⇨□D▽															
12	Ancilliary Service Dept.	○⇨□D▽															
13	Home	○⇨□D▽															
14		○⇨□D▽															
15		○⇨□D▽															
16		○⇨□D▽															
17		○⇨□D▽															
18		○⇨□D▽															
19		○⇨□D▽															
20		○⇨□D▽															
21		○⇨□D▽															

DA FORM 1 MAY 51 684 *(Formerly DA AGO)*

REPLACES OCS FORM 391, 1 FEB 1951, WHICH MAY BE USED.

FLOW PROCESS CHART
(DA Pamphlet 20-300)

NUMBER | PAGE NO. | NO. OF PAGES

PROCESS: Emergency Room Patient
☒ MAN OR ☐ MATERIAL

CHART BEGINS: Patient Enters
CHART ENDS: Departs, Home
CHARTED BY | DATE
ORGANIZATION: Methodist Hospital, Dallas, Texas

SUMMARY

ACTIONS	PRESENT NO.	PRESENT TIME	PROPOSED NO.	PROPOSED TIME	DIFFERENCE NO.	DIFFERENCE TIME
○ OPERATIONS						
⇨ TRANSPORTATIONS						
□ INSPECTIONS						
D DELAYS						
▽ STORAGES						
DISTANCE TRAVELLED (Feet)						

	DETAILS OF ☐ PRESENT ☒ PROPOSED METHOD	OPERATION / TRANSPORTATION / INSPECTION / DELAY / STORAGE	DISTANCE IN FEET	QUANTITY	TIME	ANALYSIS: WHY? WHAT?	WHERE?	WHEN?	WHO?	HOW?	NOTES	ANALYSIS: CHANGE: ELIMINATE	COMBINE	SEQUENCE	PLACE	PERSON	IMPROVE
1	Emergency Room Clerk	○⊗⇨□D▽															
2	Directs patient to E.R.	⊗⇨□D▽															
3	Directs relative to C.O.R.	⊗⇨□D▽															
4	E.R. Clerk acquires information	⊗⇨□D▽									if no relative						
5	Central Outpatient Registra.	○⇨□D▽															
6	Administratively process	⊗⇨□D▽															
7	Patient treatment	○⇨□D▽															
8	Central Services	⊗⇨□D▽															
9	Ancilliary Services	⊗⇨□D▽															
10	Emergency Room Clerk	○⇨□D▽															
11	Attaches all charges to	⊗⇨□D▽									E.R. report						
12	Gives patient or relative a copy	⊗⇨□D▽									tells report to C.O.R.						
13	Central Outpatient Registra.	○⇨□D▽															
14	Ascertains complete charges	⊗⇨□D▽															
15	Collects for service or	⊗⇨□D▽															
16	Makes arrangements	⊗⇨□D▽									for payment						
17	Home	○⇨□D▽															
18		○⇨□D▽															
19		○⇨□D▽															
20		○⇨□D▽															
21		○⇨□D▽															

DA FORM 1 MAY 51 684 *(Formerly DA AGO)* REPLACES OCS FORM 391, 1 FEB 1951, WHICH MAY BE USED.

APPENDIX C

EMERGENCY ROOM SURVEY

SUBJECT: Emergency Room Survey

Date	# of Emergency visits	No Number Assignment	Not Enough Insurance Information
Jan.			
24	27	7	12
25	35	12	11
26	15	1	5
27	26	6	13
28,29, 30	130	12	70
31	15	3	7
Feb.			
1	39	8	12
2	37	9	12
3	34	7	6
4,5,6	133	26	65
7	67	13	25
8	21	3	9
9	19	8	5
10-14	170	27	92
15	36	2	26
	804	144	370

APPENDIX D

FIVE DAY SURVEY CHARGE TICKETS

SUBJECT: Five day Survey Department Charge Tickets

Date	# Tickets Surveyed	No Number Assigned	# Incorrect Charge Tickets
May			
3	136	126	18
4	56	46	15
5	93	83	20
8	109	99	15
9	115	105	12

APPENDIX E

SUMMARY OF FINANCIAL STATUS OF TEACHING PROGRAM, 1966

METHODIST HOSPITAL OF DALLAS

SUMMARY OF FINANCIAL STATUS OF TEACHING PROGRAM

DATE 12-31-66

	This Month			Year to Date		
	Budget	Actual	Over (Under) Budget	Budget	Actual	Over (Under) Budget
General Surgery	$ 9,952.72	$ 6,220.50	($ 3,732.22)	$ 76,000.00	$ 72,267.78	($ 3,732.22)
Urology	930.90	177.20	(753.70)	9,000.00	8,246.30	(753.70)
Orthopedic	(128.20)	2,287.35	2,415.55	6,000.00	8,415.55	2,415.55
E.N.T.	3,122.90	— 0 —	(3,122.90)	5,000.00	1,877.10	(3,122.90)
Medicine	8,155.76	5,013.95	(3,141.31)	90,000.00	86,858.69	(3,141.31)
OB	2,008.85	5,679.50	3,670.65	48,000.00	51,670.65	3,670.65
Gyn	13,913.56	2,406.73	(11,006.83)	42,000.00	30,993.17	(11 006.83)
Radiology	54.50	— 0 —	(54.50)	4,500.00	4,445.50	(54.50)
Pediatrics	752.61	2,451.80	1,699.19	7,000.00	8,699.19	1,699.19
Newborn	(1,577.15)	1,586.75	3,108.90	8,000.00	11,108.90	3,108.90
O.P.	(5,437.15)	8,043.75	13,475.90	84,000.00	97,475.90	13,475.90
TOTALS	$ 31,308.80	$ 33,817.53	$ 2,508.73	$ 379,500.00	$ 382,008.73	$ 2,508.73

Distribution of Copies

1 Director of Medical Education
2 Administrator
3 Associate Administrator
4 Director of Chief Resident
5 Business Office
6 Finance Office
7 Social Service Worker

A-134(10/64)

APPENDIX F

OUTPATIENT CLINIC SCHEDULE

OUTPATIENT DEPARTMENT

CLINIC SCHEDULE

JULY 1966

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	8:00 - 9:00 Dental Allocation 8:30 ENT 9:00 - 12:00 General Medicine Pedi	8:00 - 9:00 Allocation 9:00 - 12:00 General Medicine Pedi	8:00 - 9:00 Allocation 9:00 -12:00 General Medicine Pedi	8:00 - 9:00 Allocation 9:00 - 12:00 General Medicine Well-Child clinic	8:00 - 9:00 Allocation 9:00 - 12:00 General Medicine Pedi
PM	12:00 - 4:00 New OB Post Partal 1:00 - 4:00 Urology	12:00 - 1:30 Eye 1:00 - 4:00 Orthopedic	1:00 - 4:00 Gen. Surg. Proctology	12:00 - 4:00 Old OB	1:30 - 4:00 Gen. Surg Proctology

APPENDIX G

ADMISSION INFORMATION, CLINIC PATIENT

Methodist HOSPITAL of DALLAS

(IMPORTANT: Aplicant Must Fill in Each of the Spaces Below or Write "None.")

I hereby make application for medical service for_____
(Member)

and in so doing, I authorize the hospital to obtain and retain in its files any information concerning the statements made in this application or any other information it may require.

Name_____ Age_____ Sex_____ Race_____ Marital status_____
(S. M. W. D. Sep.)

Home Address_____ Tel. No._____
(Street) (City) (State)

Previous hospitalization_____ Where_____ Date_____
(Hospital)

Church_____ Referred by_____

Hospitalization and/or Sickness benefits_____
(Company) (Policy No.)

Employed by_____ Kind of business_____ Tel. No._____

Address of business_____ My duties are_____

APPENDIX H

PHYSICIAN'S REQUISITION FOR SERVICE FORM

PHYSICIANS SERVICE ORDER, METHODIST HOSPITAL OF DALLAS

Please check proper service area

Laboratory Phys. Med.
Radiology EKG
Other_____
If Lab.
Specify
Diag. _____

Patients
Name_____ In pat.
Patient
Number_____ Outpat.
Patient
Address_____ Clinic
Dr.
Name _____ Emerg

Physicians
Order _____

_____

_____

By_____ MD

Do not write in this area.
Results of tests wil be
pasted here.

SAME AS ABOVE
TOP TWO BLOCKS

SAME AS ABOVE
SECOND TWO BLOCKS

SAME AS ABOVE
TOP TWO BLOCKS

SAME AS ABOVE
SECOND TWO BLOCKS

APPENDIX I

OUTPATIENT REGISTRATION FORM

UARCO BUSINESS FORMS
PARIS, TEXAS

BAYLOR UNIVERSITY MEDICAL CENTER

OUTPATIENT REGISTRATION

No. 362896

PATIENT

- PATIENT NAME (LAST) | FIRST | MIDDLE | DATE | TIME
- PATIENT'S HOME ADDRESS | CITY | STATE | ZIP CODE | HOME PHONE
- PATIENT'S DALLAS ADDRESS | CITY | STATE | ZIP CODE | DALLAS (LOCAL) PHONE
- AGE | SEX | MAR. STAT. | PREVIOUS PATIENT AT BAYLOR | INPATIENT DATES | ADMITTED UNDER WHAT NAME (IF DIFFERENT)
- OUTPATIENT'S SERVICES REQUESTED (DEPT.)
- PHYSICIAN NAME(S) | ID PLATE YES, NO
- IF SERVICE REQUESTED IS A RESULT OF AN ACCIDENT, INDICATE DATE OCCURRED AND CIRCUMSTANCES

X | PAID $ | PVT 0 | EMP 5 | PHYS/MIN 6 | CLINIC 7 | INS 1 | WORK COMP 4 | STATE 5 | ACCID. 6 | DAA MED 7

RESP. PARTY

- NAME RESPONSIBLE PARTY | RELATION TO PATIENT | PHONE
- ADDRESS | CITY | STATE | ZIP CODE | OCCUPATION OR POSITION
- EMPLOYER NAME ADDRESS

INSURANCE

- HAS PATIENT BEEN HOSPITALIZED IN LAST 60 DAYS? WHERE DATES | SERVICES RECEIVED | MEDICARE NO. IF ANY
- INSURANCE CO. - CITY & STATE - POLICY NO. - NAME OF INSURED - GROUP NAME & ADDRESS - CERT. OR EMP. NO.

REMARKS:

☐ **Series treatment, charges are to be submitted to the Business Office after each treatment.**

FORM NO. CP 437 U

DATA PROCESSING-BUSINESS OFFICE

APPENDIX J

EMERGENCY REPORT FORM

INSTRUCTIONS FOR USE

1. PLEASE WRITE LEGIBLY
2. BEAR DOWN YOU ARE WRITING FOUR COPIES
3. FILL IN ALL UNSHADED AREAS
4. FILL IN SHADED AREAS IF INFORMATION IS AVAILABLE
5. MAKE SURE ALL RELEASES AND ASSIGNMENT OF BENEFITS ARE SIGNED BY PERSONS INDICATED

UARCO BUSINESS FORMS PARIS, TEXAS

Methodist
HOSPITAL of DALLAS, P.O. BOX 5999, DALLAS, TEXAS 75222

ADMIT NUMBER

No. E

LAST NAME	FIRST NAME	MIDDLE NAME	DATE / /	TIME AM PM		HOME PHONE
STREET ADDRESS	CITY	STATE	AGE	SEX	RACE	MARITAL STATUS M S W D SEP
EMPLOYER (NAME & ADDRESS)			BUSINESS PHONE			OCCUPATION (NATURE OF WORK)
EMERGENCY NOTIFICATION (RELATIVE OR FRIEND, PARENT OR GUARDIAN IF MINOR)			RELATIONSHIP			PHONE
RESPONSIBLE PARTY & ADDRESS			RELATIONSHIP			PHONE
RESPONSIBLE PARTY'S EMPLOYER			OCCUPATION (RESP. PTY.)			BUS. PHONE
INSURANCE CO.	NAME OF POLICY HOLDER		CERT. OR POLICY NO.			GROUP NO.

ACCIDENT ☐ ON JOB ☐ OTHER ☐ | DATE OCCURRED / / | WHERE HAPPENED | HOW HAPPENED

ILLNESS ☐ | DATE SYMPTOMS BEGAN / / | CHIEF COMPLAINT

FAMILY DOCTOR | NOTIFIED YES ☐ NO ☐ | BROUGHT BY: RELATIVE ☐ OTHER ☐ SELF ☐ POLICE ☐ AMBUL ☐ _____ | VERIFIED IDENTITY DR. LISC. ☐ OTHER ☐ | NURSE IN CHARGE (SIGN) RN

I (or we) hereby authorize such medical procedures as they deem necessary to be performed on the above named patient by, or at the direction of, the Medical Staff of Methodist Hospital of Dallas.

SIGNED _____

WITNESS _____

I CERTIFY THAT I AM REMOVING THE ABOVE NAMED PATIENT FROM METHODIST HOSPITAL AGAINST THE ADVICE OF THE HOSPITAL PERSONNEL AND MY ATTENDING PHYSICIAN DR. _____. IN DOING SO I RELEASE METHODIST HOSPITAL AND THE AFOREMENTIONED ATTENDING PHYSICIAN OF ALL RESPONSIBILITY AND LIABILITY.

SIGNED _____ WITNESS _____

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE THE _____ COMPANY TO PAY DIRECTLY TO METHODIST HOSPITAL ALL BENEFITS DUE ME, IF ANY, BY REASON OF SERVICES DESCRIBED IN THE STATEMENTS RENDERED, AND AS PROVIDED FOR IN THE ABOVE POLICY CONTRACT WITH AFOREMENTIONED INSURANCE CO. I WILL PAY AT DALLAS, TEXAS FOR ALL SUCH CHARGES INCURRED OR FOR ALL CHARGES IN EXCESS OF WHATEVER SUMS MAY BE PAID BY THE INSURANCE CO. ABOVE MENTIONED. I HEREBY AUTHORIZE ANY PHYSICIAN OR HOSPITAL WHO HAS TREATED OR ATTENDED ME TO FURNISH THE INSURANCE CO. OR ITS REPRESENTATIVE, ANY INFORMATION REQUESTED.

I DIRECT THAT MEDICAL AND/OR SURGICAL BENEFITS (IF ANY) BE PAID TO: _____ (PHYSICIAN) / / DATE

SIGNATURE OF PATIENT (OR PARENT IF PATIENT IS MINOR) X _____ SIGNATURE OF POLICYHOLDER X _____

PHYSICIANS REPORT

HISTORY AND PHYSICAL: TEMP. P. R. B.P.

DIAGNOSIS:

LAB WORK

TREATMENT AND MEDICATION: TETANUS TOXOID cc

SERVICE	CHARGES
EMERG. CHARGE 10500	
PHARMACY	
X RAY	
LAB	
TOTAL	

DISPOSITION: TIME / / AM PM | REFERRED TO DR. | ADMITTED ☐ | ~~DOA~~

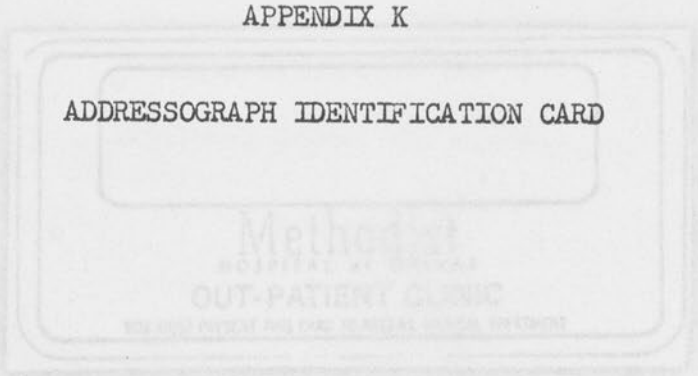
RELATIVES NOTIFIED ☐ SENT HOME ☐ | POLICE NOTIFIED ☐ OTHER | IDENTIBAND APPLIED ☐ | SIGNED: HOUSE OFFICER OR ATTENDING PHYSICIAN MD

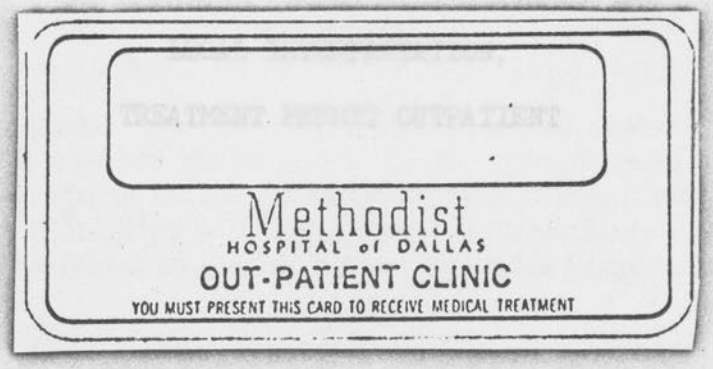
FORM NO. ER 100 (9/64)

EMERGENCY REPORT
EMERGENCY RECORD

APPENDIX K

ADDRESSOGRAPH IDENTIFICATION CARD




Methodist
HOSPITAL of DALLAS
OUT-PATIENT CLINIC
YOU MUST PRESENT THIS CARD TO RECEIVE MEDICAL TREATMENT

APPENDIX L

LEGAL INTERPRETATION,

TREATMENT PERMIT OUTPATIENT

THOMPSON, KNIGHT, SIMMONS & BULLION
ATTORNEYS AND COUNSELORS
REPUBLIC NATIONAL BANK BUILDING
DALLAS, TEXAS 75201

TELEPHONE
AREA CODE 214
RIVERSIDE 1-4721

CABLE TOMTEX

May 11, 1967

Administrator
Methodist Hospital of Dallas
301 West Colorado Boulevard
Dallas, Texas

Dear Sir:

In our telephone conversation, you requested that our office give you and opinion on whether there is any medical/legal need for a treatment permit form to be placed on the outpatient registration form that will be a part of the administrative processing for all outpatients presenting themselves for treatment in the Methodist Hospital Outpatient Department.

It is our opinion that a person presenting himself for treatment in your Outpatient Department follows the same principle as a patient presenting himself in a doctor's office. The individual's presence is permission for treatment.

We do not feel any real medical/legal need for any time-consuming treatment permit forms in your Outpatient Department.

Yours very truly,

Timothy E Kelley

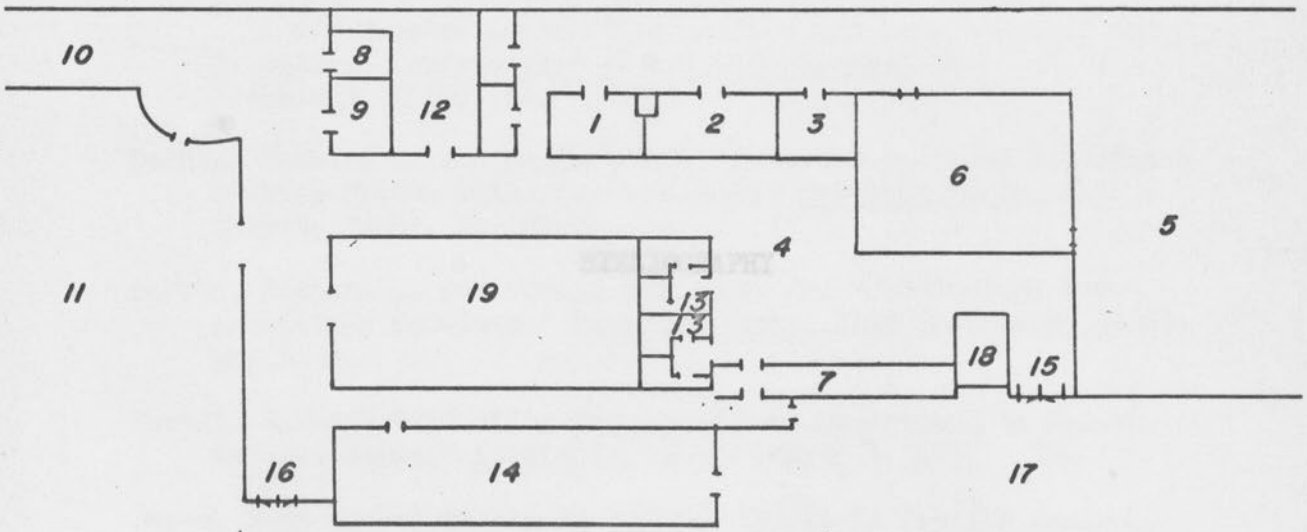
TEK:em

APPENDIX M

NON-SCALED SKETCH OF CENTRAL OUTPATIENT

REGISTRATION LOCATION

PROPOSED CENTRAL OUTPATIENT REGISTRATION AREA



1. CENTRAL OUTPATIENT REGISTRATION.
2. " " " " "
3. " " " " "
4. WAITING AREA
5. EMERGENCY ROOM
6. EMERGENCY ROOM DESK
7. STAIRWAY
8. ELEVATOR
9. " "
10. HALLWAY
11. PHYSICAL MEDICINE
12. TELEPHONE SWITCHBOARD
13. RESTROOMS
14. FAMILY ROOM OF DECEASED
15. ENTRANCE (OUTSIDE)
16. ENTRANCE (OUTSIDE)
17. AMBULANCE LOADING.
18. POLICE-PRESS ROOM
19. ENGINE ROOM

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BIBLIOGRAPHY

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_____. Personal interview with L.B. Trigg, Hospital Engineer, Methodist Hospital of Dallas, Dallas, Texas. May, 1967.

_____. Personal interview with Mary Mansfield, Director of Outpatient Department, Methodist Hospital of Dallas, Dallas, Texas. May, 1967.

BIOGRAPHICAL SKETCH

The writer [redacted]. He received his B.S. degree in Physical Education from the University of Arkansas in June, 1955. He then entered the Graduate School of the University of Arkansas, receiving a Master's Degree in Education Administration in June, 1956.

He entered the Army in June 1956. He was graduated from the Basic Officer's Course in September, 1956, and was assigned to Headquarters, Brooke Army Medical Center where he remained until January, 1958. He was then assigned to the Medical Field Service School where he attended the Company Grade Officer's Course. From January, 1959, until June, 1962, he was assigned to the 98th General Hospital in Germany. He returned to the Medical Field Service School to attend the Career Course, prior to being assigned to the 47th Medical Battalion at Ft. Hood, Texas, from June, 1963, until February 1965. In March, 1965, he went to Vietnam as Senior Medical Advisor to the Vietnamese III Area Logistical Command. He returned to the United States to attend the U.S. Army-Baylor University program in Hospital Administration in September, 1966.