ORGANIZATIONAL STRUCTURE OF AMBULATORY CARE SERVICES AT HERMANN HOSPITAL, HOUSTON, TEXAS

A Problem-Solving Thesis

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CHAPTER I

INTRODUCTION

General Information

The need for reorganization of outpatient services has been stressed in the past decade, but few practical suggestions for change or improvement have come about. General principles which should underlie the organization and delivery of high-quality medical care for ambulatory patients were delineated many years ago. The implementation of these principles, however, has been very slow as noted by writers such as Freilich, Lee, and Kresky and Rosenfeld.[1]

Patient dissatisfaction with current outpatient care is demonstrated in part in their choice of emergency room service on a large-scale basis. In an unprecedented fashion, utilization of emergency rooms had increased by 186 per cent between 1955 and 1962 in the United States.[2] Paying as well as nonpaying patients are participants in this shift. From 1960 to 1962 the use of outpatient services rose by 73 per cent, and admissions to hospitals by 38 per cent. Piore, Lewis, and Seeliger have stated in a recent study that the volume of outpatients' visits has tripled since 1953, and

that three-quarters of all outpatient visits are to the nearly 6,000 community hospitals.[3]

As medical care becomes complex, the need to avoid depersonalization becomes important. Today, with the rise of consumerism in all spheres, there is an increasing demand for medical care to be humanized and presented in a dignified manner.

All too often one sees the unhappy, sometimes tragic end results of uncoordinated piecemeal medical care. The failures are, as a rule, not failures of individual physicians or nurses or other personnel; but, rather, are failures of the system--a system lacking in adequate communication, follow-up, continuity, or the fixing of responsibility. When many are responsible for management of a case, often no one is responsible.

While there is rapidly expanding recognition of desirable attributes of good clinic care, the approach and methods for conversion of so vast and inadequate a system to one capable of achieving reasonable standards of availability, quality, and efficiency of ambulatory care are not entirely clear.

Hospital Setting and History

Hermann Hospital, Houston, Texas, was founded in 1925 through the generosity of George H. Hermann. During the past 40 years, the hospital has rendered medical care to over 580,000 private and charity inpatients in the community. Education programs include medical students, interns, and residents in twelve specialties. There are also schools for registered nurses, practical nurses, medical technologists, and X-ray technicians.

The Hermann Hospital Complex presently has 687 beds and 85 bassinets designed for patient care, teaching, and research. The Hospital cares for 26,000 inpatients, 4,000 newborns per year, and its 43 clinics and emergency department receive over 100,000 outpatient visits every year.

In 1970, the Hospital faced a decision--whether to continue operating in its present capacity or accept the challenge of becoming the primary teaching hospital for the University of Texas Medical School at Houston. The Hospital accepted the challenge and, along with it, the task of changing its orientation from a private, community-oriented hospital with emphasis on the low-income patient to that of a major teaching institution.

Expansion of existing facilities, updating of equipment and facilities, as well as more sophisticated administrative and personnel procedures, are felt to be needed by the board of trustees to augment the hospital's new direction. The building program includes, among other projects, a new major eight-story structure that will provide over 300 additional beds. Hermann Hospital today is an institution caught up in the throes of major reorganization and expansion.

Conditions Which Prompted the Study

The problem of determining the new organizational structure for Hermann Hospital Ambulatory Services is prompted by the new Hospital/Medical School affiliation agreement. In view of the fact that the hospital is now primarily concerned with education and research, it will be important for priorities to be established concerning medical education and primary patient care. Because the successful achievement of both institutions' objectives are interdependent, it is extremely important to create an organizational structure that will best serve the needs of the two institutions with patient care as the end product.

Statement of the Problem

The problem is to develop an organizational structure for the delivery of ambulatory care services, Hermann Hospital, Houston, Texas.

Objectives

The objectives of this study are to:

1. Identify current trends in ambulatory care organization.

2. Analyze the existing organizational structure for ambulatory services at Hermann Hospital.

3. Evaluate the proposed organizational structure for ambulatory services prepared by the Managerial Evaluation Department, Hermann Hospital.

4. Develop an organizational structure of ambulatory care for Hermann Hospital.

Criteria

The criteria of this study are to:

1. Provide an ambulatory care organizational structure which will afford quality patient care encompassing the basic principles of:

   a. Comprehensive personal care.

b. Continuity of care.

c. Follow-up care.

d. Coordination of outpatient and inpatient care.

e. Accessible and convenient care.

2. Provide an ambulatory care program which will meet the needs of the community.

Limitations

The limitations established for this study are as follows:

1. The study is limited to the actual organizational structure of the delivery of medical care in the ambulatory care center.

2. Only a small portion of the new medical staff who will be influential in forming the new organizational structure have arrived at the hospital. As a result, staff input is limited to those physicians actually present during the data-gathering period.

Assumptions

The assumptions are:

1. Improvement of ambulatory services can be made through reorganization of the existing program.

2. The affiliation between Hermann Hospital and the University of Texas Medical School will be finalized in the near future and both will agree on common goals.

3. The training of medical personnel will continue at the same or increased magnitude.

4. The outpatient population served by the hospital will remain stable or increase.

Factors Bearing on the Problem

Factors bearing on the problem are:

1. Hermann Hospital outpatient clinics care for 15,000 persons making 65,000 visits each year.

2. The hospital staff is dissatisfied with the existing organizational structure of the outpatient clinics.

3. The hospital staff has concluded that after reviewing the literature, no model outpatient system exists that can be used as a model for their setting.

4. The present hospital staff desires to have the "outpatient clinic" approach the environment of a "private doctor's office."

5. A study is currently underway to evaluate the "modular concept" which, at this time, is favored by the hospital staff.

6. Lines of authority and working relationships under the modular concept are not clearly delineated.

7. The hospital and medical school, because of their individual missions, will place different priorities on various aspects of the organization of ambulatory care which will have to be resolved.

Research Methodology

This study was conducted at Hermann Hospital, Houston, Texas, during the period February 26 through March 3, 1973. After an initial interview and discussion with the director of the hospital, his associate director, and the assistant directors, a tour of the hospital outpatient area was made. During the remainder of the time at the hospital, personal interviews were conducted with members of the outpatient planning committee, the outpatient communications committee, and the outpatient operating committee. The experience and opinions of the medical staff, students, and individual patients were also solicited.

Prior to, and during the study, a review of the available literature on ambulatory care was conducted.

Literature Review

"There are always two parties of the management of the disease--the physician and the patient."[4] Since early times, the patient has come to the physician for alleviation of his ills. After consulting with the physician, the patient would return to his own pursuits hopefully improved. This is the essence of ambulatory care. Today, it is still the most common form of patient-physician interaction. As medical technology advanced, the equipment and special skills became located in hospitals. Patients were brought to the resources for the purpose of better care, but also at times for the physician's convenience. Because of these factors, and the fact that many insurance policies pay for hospitalization but not for ambulatory care, many patients are unnecessarily hospitalized.

Numerous articles in the literature today have dealt with the economic impact of this situation, and the soaring costs of hospitalization have made it clear that ambulatory care should be substituted for inpatient care whenever possible. While the early outpatient clinics primarily treated the needy sick, the outpatient department of today is often concerned with other functions as well. It may serve as a

screening device for admission to the inpatient services and to follow-up the discharged patient. The Outpatient Department is used for the teaching of medical students, interns and residents, and it is also used for research in the outpatient population.

Basically, the outpatient department has been concerned primarily with episodic illness in individuals, and following this "fractionated philosophy" there has been increasing specialization by the continuous proliferation of separate specialty and subspecialty clinics. Some of our teaching hospitals boast over thirty separate specialty clinics. Others do not even have a general medical clinic.[5]

In recognizing these deficiencies of ambulatory care, some hospitals have established screening clinics where interns or residents screen patients for the specialty clinics. Patients with multiple disease conditions may be simultaneously followed in several clinics which may or may not meet on the same day. In this type of organizational structure it is impossible for any one physician to know the patient as a person and to integrate his total management. John E. Dertrick, M.D. at Cornell University Medical College, has severely criticized outpatient departments for this fractionalization of the

patient. He states that:

> . . . outpatient departments of teaching hospitals are generally second rate. . . . The clinics have been called the stepchildren of the hospitals; they serve in a subordinate position as screening services to provide the most interesting patients for the ward services.[6]

All too often the organizational structure seems to be designed primarily for the convenience of the hospital administration and separately organized supporting services. There is disregard for the convenience and comfort of the patient and disregard for the effective use of the doctor's time.

Much lip service is given to teaching and the needs of the student, but his needs frequently conflict with the day-to-day running of an overcrowded outpatient clinic, and are ignored. Today, our outpatient departments are extremely poor models of ambulatory medical care. The changing use of outpatient services (the volume of hospital outpatient visits has tripled since 1953)[7] further compounds the problem.

Many writers in the health care field have set down guidelines to improve ambulatory care service. While some are unrealistic, others such as the guide by Freilich are realistic and workable. Some of his points which seem common to most of the "guides" are the following:

1. There should be a well-qualified and interested chief of ambulatory care on a full-time basis.

2. Section chiefs should be responsible for each clinic.

3. The medical staff for ambulatory care should be integrated with the inpatient staff.

4. The number of specialty clinics should be limited.

5. Each patient should be assigned to one personal physician or team to ensure continuity of care.

6. The relationship of the outpatient service to the emergency service should be clearly defined and coordinated.

7. The system should permit easy accessibility and entry.[8]

During the past few years, not only have goals and guidelines been set down for improved ambulatory care, but there have also been some interesting and innovative experiments in the reorganization of ambulatory care delivery. The New Mount Sinai Hospital, Toronto, Canada, eliminated the traditional outpatient department-type facility and set up an ambulatory patient care system in their new hospital. Their concepts and facilities are described in an article by

Gordon Kerr.[9] Essentially, they eliminated the traditional outpatient department-type facility and set up an ambulatory patient care system incorporating their Family Practice Unit.

Leslie Sandlow, writing in Hospital Topics, discussed the reorganization of ambulatory services at Michael Reese Hospital, Chicago, Illinois.[10] Prior to their reorganization, the clinics were generally single-disease-entity related clinics, and patients could spend all week going from one clinic to another. Care was fragmented, impersonal, and no one physician was responsible for coordinating the care for the patient. An administrator for ambulatory care was appointed and directors of ambulatory care were appointed in each of the departments. Goals of care were defined: the program would be people-oriented rather than disease-oriented, and comprehensive care would be given to as many patients as possible. A new acute case area was developed with nurses performing triage, and medical residents spending part of their time in these clinics throughout their full residency period at the hospital.

Vorzimer and Katz have also described a program of comprehensive ambulatory patient care at Beth Israel Hospital, New York. Services organized in a team concept were provided

to 1,200 patients on a trial basis. As a result of professional and patient satisfaction with the reorganized service, the entire ambulatory care program is being reorganized into a series of comprehensive care units with concurrent elimination of "clinics." A comprehensive care unit is staffed by seven health personnel--two part-time internists, two public health nurses, one social worker, one aide, and one medical secretary. Patients are seen by their personal physician on an individual appointment basis--new and returns. With the implementation of four comprehensive care units, the traditional general medical clinics have been closed out. The units provide an improved method of early access and effective service.[11] These are some examples of how a few institutions are attempting to revamp ambulatory care for the patient's benefit.

Turning to education and research, it has been argued that the present pattern of outpatient service is necessary for research and teaching. Yerby believes that it is not only possible to conduct useful research, and to teach in a patient-centered program; but ultimately patient care will be taught only in patient-centered programs.[12] Robert Potter, Chairman of the Institute of Medicine, has said: "Medical

students traditionally have received poor ambulatory care experience in teaching hospitals . . . the training of medical students must include exposure to the realities of the community."[13]

The virtual confinement of medical training to hospitals may be partly responsible for the comparative lack of effectiveness of physicians in meeting the health care demands of our present society. The techniques employed in caring for hospitalized patients are not appropriate in the outpatient setting. A good educational experience in a comprehensive ambulatory care setting could alleviate some of these problems. The organization, delivery, economics, and teaching role of hospital-based outpatient services present major problems which need to be faced and solved in the near future.

Footnotes

[1]Herbert Freilich, "A Guide to Improved Ambulatory Care Service," Hospital Management, CVII (March, 1969), 52; Sidney S. Lee, "A Fresh Look at Outpatient Department Problems," Hospitals, XXXII (March, 1958), 35; Beatrice Kresky and Leonard S. Rosenfeld, "Ambulatory Clinic Care in New York City," Hospital Topics, XLVII (April-May, 1969), 146.

[2]Medical Care Chart Book (Ann Arbor: Bureau of Public Health Economics, School of Public Health, University of Michigan, 1962), p. 162.

[3]Nora Piore, et al., A Statistical Profile of Hospital Outpatient Services in the United States: Present Scope and Potential Role (New York: Association for the Aid of Crippled Children, August, 1971).

[4]William B. Beam, Aphorisms from Latham (Iowa City: Prairie Press, 1962).

[5]Alonzo S. Yerby, "The Hospital Out-Patient Department as a Source of Medical Care," Medical Care, II (October-December, 1964), 226.

[6]John E. Deitrick, "Organization of Outpatient Departments," Journal of Medical Education, XLI (July, 1966) 710.

[7]Piore, et al.

[8]Herbert Freilich, "A Guide to Improve Ambulatory Care Service," Hospital Management, CVII (March, 1969), 52-55.

[9]Gordon M. Kerr, "A New Concept in Ambulatory Care," Canadian Hospital, XLIX (April, 1972), 54-61.

[10]Leslie J. Sandlow, "Changing from Specialty Clinics to Comprehensive Care Unit," Hospital Topics, XLIX (November, 1971), 55-56.

[11]Jefferson J. Vorzimer and Gerald Katz, "Toward Comprehensive Ambulatory Care: A Case History of Decisive Change," Medical Care, VIII (January-February, 1970), 76-81.

[12]Yerby, p. 226.

[13]"Closer Ties Between Medical Schools and Community Hospitals Urged by Panel," Hospitals, XLV (December, 1971), 126.

CHAPTER II

DISCUSSION

Introduction

The increasing importance of ambulatory services and the rising expectations of patients are creating demands for improved services. The usual list of areas in need of improvements includes staffing, financing, and physical facilities; but if continuous and personalized care is to be rendered, organizing must be added to the list. Organizational patterns which promote, rather than impede, coordination are necessary in any ambulatory service organization.

The hospital relies upon a complex organizational structure to accomplish its objectives. It also must rely on people with highly varied backgrounds to cooperate in a variety of tasks and functions, with a high level of intradependence. Normally, a typical business operation with an ultimate objective of maximizing its profit has a single source of authority. The hospital, however, has multiple sources such as the board of trustees, administrator, medical staff, nursing staff, and, in the case of Hermann Hospital, the affiliated Medical School. Problems caused by

such multiple lines of authority are as follows:

> The absence of a single line of authority in the hospital of course creates various administrative and operational problems as well as psychological problems having to do with the relative powers and influence on organizational functioning on the part of the doctors, trustees, administrators and others. For one thing it makes formal organization coordination rather difficult, for another it allows instances in which it is not clear where authority, responsibility, and accountability resides. Similarly, it allows for a situation where a large number of organizational members, particularly members of the nursing staff must be responsible to and take orders not only from the supervisor but also from doctors. . . . The absence of a single line of authority also makes for difficulties in the area of discipline, and difficulties in resolving problems that might be resolved through cooperative efforts on the part of both the lay-administrative and the medical-professional side.[1]

To summarize the above quote, multiple lines of authority impede coordination in the hospital. Most ambulatory services also manifest the above characteristics plus others which make coordination even more important. Ambulatory care areas are direct patient care areas and are subject to a high degree of physician influence. Nursing service frequently assumes the responsibility for continuity and also exercises strong influence. In addition, these services are major elements in any teaching program, and the Medical School frequently manifests influence here, too. Because of these multiple lines of authority, cooperative efforts are particularly important to ensure comprehensive care to the patient

utilizing these services. Coordination is not only essential among the various departments, but also within the various ambulatory service components themselves; for example, emergency services and outpatient department cooperation is necessary so that the emergency room is not flooded with nonurgent problems.

Against this background the current organizational structure of Hermann Hospital Outpatient Department will be examined. Next the "Modular" concept of reorganization as espoused by the Managerial Evaluation Department, Hermann Hospital, will be evaluated. Following this discussion, an alternative proposal for effective structural reorganization of ambulatory care at Hermann Hospital will be presented.

Current Organizational Structure

The formal organizational structure of Hermann Hospital is shown in Appendix A. The existing organizational structure of the outpatient department (Appendix B) is considered unmanageable. Both administrative and medical staff elements agree that the outpatient department is inadequate to provide quality care or provide instruction for medical students.[2] The current organizational structure is as follows: When a patient telephones or comes to the outpatient

department, he is initially referred to a central administrative section--unless he is in such obvious discomfort as to be apparent to any layman. In this case he is referred to the emergency service. The first administrative hurdle is central registration where the patient is registered and a comprehensive financial status is obtained (Appendix C, Registration Forms). The patient is then assigned a patient classification, based upon his ability to pay; and he is issued a clinic card. He is then "triaged" by central registration personnel who make the initial decision as to which specialty clinic the patient is to be referred.

If they are not sure, he is referred to the Maintenance and General Clinic; but before going to any clinic, the patient must first go to the central appointment desk for an appointment slip. Appointments are assigned in blocks, and there is often a two to three week wait. This appointment section has only three phone lines and two telephones to make appointments for forty-three clinics which currently have 6,000 outpatient visits per month.[3]

Experience gained in the Kaiser-Permanente Program indicates that one appointment clerk can handle appointments for five to seven physicians.[4] Hermann's outpatient appointment desk has two clerks for twenty to forty physicians. A

recent study by outpatient registration indicated that 20 to 25 per cent of all outpatient appointments are missed, and that 41 per cent of appointments made by telephone are missed.[5]

After the patient has obtained his appointment slip, he then returns to central registration to get the slip approved. Following this approval he is sent to the business office to pay $3 to see the doctor. Finally, he is referred to the clinic determined by the triage clerk in central registration. After the patient is seen by a doctor, if any special studies such as X-ray or laboratory work are ordered he must then retrace his steps to central registration for approval and report again to the business office and pay for the procedure before it is done. This policy encumbers the efficiency of the entire process of receiving care in the outpatient department. The patient must shuttle back and forth from the examination area to central registration, the cashier's cage, laboratory, and X-ray department, waiting in line at each area. More importantly, the fee-before-service requirement is a direct affront to patients. (See Appendix D for a patient's eye view of the current system as described by Jerald Tillman, Director of Outpatient Registration for

Hermann Hospital.)

The organizational lines of authority of the current structure are also fractionalized: The responsibility for eligibility and classification falls under the Fiscal and Administrative Services Division. Nursing personnel in the outpatient department are under the Operations Division, while the doctors in the various clinics are responsible to specialty chiefs. Currently, there are forty-three clinics held from Monday to Friday 8:00 A.M. to 4:30 P.M., plus five maintenance and general clinics per week, 3:00 P.M. to 6:00 P.M. or later. The entire outpatient department nursing staff to cover these clinics (Appendix E) consists of four registered nurses, five licensed vocational nurses, four nurse attendants and one ophthamology technician. This means that staffing is always a problem, and there is no allowance for vacation or sick leave. Other problems experienced by the nursing section are physicians reporting late to clinics, LVN's have to be paid time-and-a half for overtime, and ancillary services closing at 4:30 P.M. This means that patients seen after 4:00 P.M. are unable to get prescriptions or lab work.[6]

The Maintenance and General clinic is staffed by two

residents on a paid basis, plus one registered nurse and two student nurses. It serves as a maintenance clinic for patients with chronic conditions and directs difficult acute problems to the appropriate specialty clinic. Its function is monitored by the Chief, Department of Medicine. During the past three years, the volume of patients utilizing this clinic has increased to the point that in its current form it is rapidly becoming unmanageable (Table 1). The increase is due primarily to an increased number of referrals from the General Medicine Clinic and the emergency center.[7] There is currently no "walk-in" clinic for patients who just need to see a doctor. All patients seen in the Maintenance and General Clinic are referred as noted above or from the eligibility and classification section, and various other specialty clinics.

The specialty clinics are staffed by residents, house staff, and volunteer private physicians. Their line of authority is a vertical one to the specialty chiefs. Unfortunately, in such a situation many decisions concerning admission and type of treatment are made with restricted perspective without regard for nursing or administrative factors which may have a bearing on the quality of patient care rendered. There

TABLE 1

GENERAL MAINTENANCE AND SCREENING CLINIC

	No. of Patients			No. of Visits		
	1970	1971	1972	1970	1971	1972
January	117	200	234	136	246	261
February	150	202	246	169	232	256
March	142	229	347	174	285	372
April	171	187	301	210	219	330
May	140	155	332	178	188	361
June	162	194		198	230	383
July	165	139		193	155	316
August	151	160		176	192	302
September	138	175		147	210	254
October	193	154		228	203	267
November	188	184		217	222	292
December	124	174		150	188	297
Total	1,841	2,153	1,460	2,176	2,570	3,691

Source: Hermann Hospital Memorandum June 21, 1972.

is no provision made for horizontal communication among medical, nursing, and administrative elements.

This is in essence the current organizational structure of the outpatient department at Hermann Hospital. The

major disadvantages of the current system which have been enumerated are: difficulty of entry, depersonalized medicine, congestion in central reception delaying patient dispersal, no walk-in capability, and multiple line of authority. All of these problems culminated in a fragmented and depersonalized approach to care:

> The highly fragmented clinic structures of the outpatient departments of many hospitals, together with the all too frequent lack of assignment of the clinic outpatient to one physician for ongoing surveillance, tends to promote a fragmented and depersonalized approach to care which can be extremely frustrating to the patient.[8]

Fragmented clinic structures such as this reflect a high degree of specialization. Also the vertical organizational structure of the hospital's medical staff is difficult to change. In a comprehensive study conducted by the University of California's School of Public Health, hospitals surveyed indicated that the majority of patients came to the central outpatient departments for their basic primary health services; yet, the average number of separate clinics among these hospitals varied from 58 to 127.[9]

Proposed Modular Organizational Structure

Taking cognizance of the deficiencies in the current organizational structure, a planning committee composed of

medical and administrative personnel concluded that the outpatient system at Hermann should be redesigned so that patients are treated as they would be in a private physician's office.[10] To accomplish this objective, a complete decentralization of appointment scheduling, and payment of fees, would be necessary--along with dispersal of patients from the central waiting room to smaller clinic modules, more in keeping with a private physician's office. With this basic concept in mind, the Managerial Evaluation Department was charged with the responsibility for developing and coordinating a detailed study. On April 21, 1972, a formal written report was submitted through channels to the Administrative Council where implementation was halted, primarily due to a lack of detail relative to implementation of the study. This process is now currently being completed. The following description of the proposed modular organizational restructuring of the outpatient department was abstracted from the written report submitted by the Managerial Evaluation Department.[11]

The realignment of outpatient clinics, as presented, is a basic operational approach called the "modular concept." This concept has been adapted to provide outpatients with services similar to those observed in a private doctor's

office. The basic aim is to provide "one stop" handling and simplified work flow. To maximize the effectiveness of clerical and medical processing of the outpatients, the appointment and payment functions are to be decentralized. With this decentralization, the outpatient clinics will approach the environment of a "private doctor's office," and the requirements of the medical and teaching staff will be better met with less clerical delays. In fact, the clerical aspects should facilitate the medical aspects rather than the other way around, as noted in the current organizational structure. The patient will arrive at the Clinic Module at an appointed time, be able to make payment, and arrange subsequent visits--all on a "local" basis in the Clinic Module. The current appointment desk and cashier station will be eliminated. Four clinic module groupings are proposed in the reorganization:

Clinic Module A (Eleven Clinics)

Allergy
Dermatology
Gastrointestinal
Head and Neck Surgery
Heart
Hemotology
Medical/Chest
Medicine
Metabolic and Diabetic

Proctology
Screening and Maintenance

Clinic Module B (Twelve Clinics)

Back
Cardiovascular
Fracture
General Surgery
Hand
Hip
Minor Surgery
Muscle Disease
Orthopedics
Pediatrics
Plastic Surgery
Thoracic Surgery

Clinic Module C (Six Clinics)

Ear, Nose and Throat
Oral Surgery
Pediatric Heart
Pediatric Hospital Return
Pediatric Specialty
Well Baby

Clinic Module D (Ten Clinics)

Chemotherapy
Cystocopy
Genitourinary
Gynecology
Medical Hospital Return
Neurology
Neurosurgery
Obstetrics
Reproductive Disorders
Tumor Followup

Later, a fifth module containing eye and psychiatry clinics will be added. The five groupings total forty-one clinics.

Each module will have a clerical staff and a nursing staff. The clerical staff will consist of a clerical coordinator and clerical assistant. They will be responsible for all functions currently carried out in central registration except for initial determination of eligibility and classification. The modular clerical staff will perform the pricing function, collect payments, and schedule appointments, as well as perform the basic clerical tasks now accomplished by the nursing personnel in the clinics. It is anticipated by the Director of Outpatient Registration that the appointment and collection functions will be augmented by on-line computer support.[12] Social work and welfare functions will remain centralized. Whenever a patient needs these services, he will be sent to the appropriate office. The nursing staff for each module will consist of a registered nurse, a licensed vocational nurse, and a nursing attendant.

Line authority relationships in the modular system will remain unchanged. Administrative personnel will report to the Director of Outpatient Registration, and nursing personnel will report to the Director of Outpatient Nursing. These directors, in turn, report to the Director, Fiscal and Administration Department, and Director of the Operations

Division, respectively. The physicians also continue to report to the chiefs of the specialty clinics. Within the medical environment, nursing personnel would have work direction control over the functions taking place within the module. The medical staff would not be engaged in "supervision"; they would be the focal point for the overall treatment of the patient--both medically and personally. The ranking physician would be responsible for matters related to medical treatment. Differences which cannot be resolved within the module are referred up the various lines of authority. See Appendix F for an organizational chart of the modular concept.

Advantages of this concept are to be noted in the increased effectiveness of outpatient processing, due to decentralization of administrative functions and increased personalized treatment. Employees will be able to be more sensitive to the requirements of both patients and medical staff. They should also gain more familiarity with their jobs, due to the breakdown of clinics into smaller groups. In addition, responsibility and accountability should be easier to pinpoint in a more decentralized organization. Employees and staff will also come to know their repeat

patients a little better which will further "personalize" their treatment. The decentralized pricing and payment for services rendered will eliminate the trek to central registration and cashier station that each patient must now make. Much patient "running around" will be eliminated. Patients will only have to be seen at the central administrative offices for initial classification, or if credit arrangements are required.

The major disadvantage of the Modular concept is that it does not address the basic problem of unified organizational structure. Separate vertical chains of command exist for medical, administrative, and nursing functions. James Cooney, writing on the contemporary status of ambulatory services in large, urban public hospitals, refers to this structure as "professional organization"[13] where services are organized along occupational and professional lines. The chain of command for each vertical structure extends from the hospital department down into ambulatory services. No provision is made structurally to coordinate efforts of the various functional elements working at ambulatory services level. Multiple lines of authority are formalized by this method of organization, and there is little potential for

coordination. Another major disadvantage of the modular system as presented is general lack of coordination, in terms of formal organizational structure, between the various modules and the emergency center.

The problem of the "walk-in" patient also is not adequately dealt with in the Managerial Evaluation Study. This was also a major disadvantage noted in the current organizational structure of the outpatient department.

An Alternative Modified-Modular Structure

The following alternative organizational structure is proposed in order to alleviate the disadvantages observed in the current system and the proposed modular system. This alternative structure is essentially a modified-modular system incorporating aspects of the "Comprehensive Care Unit" concept as espoused by Vorzimer and Katz.[14] This alternative modified-modular structure is organized to specifically deal with the problems of nonunified organizational structure; lack of coordination between other hospital elements, such as the emergency center; depersonalized care; and lack of a "walk-in" facility. See Appendix G for an organizational chart of the modified-modular system.

In contrast to the "professional organization" with

separate vertical authority lines for medical, administrative, and nursing activities, the modified-modular concept would employ "functional organization." Under this arrangement there would be a Director of Ambulatory Services who would have responsibility for all ambulatory service components, consisting of medical, nursing, and administrative activities. This is in contradistinction to the traditional idea of the outpatient department being viewed as an extension of inpatient services where service chiefs are responsible for clinics in their respective specialty areas. A Chief of Ambulatory Services and a Chief of the Emergency Center would be directly responsible to the Administrative Director of Ambulatory Services. This would enhance communication between these two areas. The Chief of Ambulatory Services would be further assisted by an outpatient administrative director, and an out-patient nursing director. The outpatient administrative director would supervise the activities of clerical personnel in the clinic modules. Staffing would remain the same for clerical personnel as in the proposed modular structure. The outpatient nursing director would supervise the activities of the nursing personnel in the modules. The nursing staff would also remain unchanged from

the proposed modular concept except for staffing of the general care module which will be described later.

Initially, three categories of services (general, specialized, and consultative) as described by Vorzimer and Katz is suggested. Specific clinic groupings within these three categories is beyond the scope of this study; however, the general category would include medicine and pediatrics. This module would be responsible for ongoing care with services organized on a team basis which will be described later. Specialized services would be composed of specialty clinics which provide self-contained services to patients for a specific period of time. For example, obstetrics, eye, and psychiatry, would be placed in this category. Patients could be referred to clinics in this category without clearance through medicine. Consultative services would make arrangements to have specialists see referred patients in the general module at specific times. It has been found that a large number of outpatients require surgical, podiatry, gynecologic, and psychiatric services, so specialists from these areas would be available to see patients in the general module.[15] This alleviates the need for patients to attend multiple clinics with fractionalized care. It also allows

the consultant and referring physician to communicate on a face-to-face basis.

The general module will be organized into two comprehensive care units. Each comprehensive care unit will be staffed by seven health personnel organized on a team basis. Unit members include two part-time internists, two public health nurses, one social worker, one nurse's aide, and one medical secretary. Medical students would rotate through the comprehensive care units as part of their learning experience. The module would operate Monday through Friday. For off-duty coverage and easy access to continuous service, a card file from the comprehensive care module--containing patients' names, diagnoses, and drugs prescribed--could be left by the primary physician from the comprehensive care unit in the emergency center (see page 46). In this way, patients have the security of knowing where to call at all times. In the comprehensive care unit, patients would be seen by their "primary physician." Appointments would also be scheduled for patients if specialty consultation is required. Drop-ins will be seen by the public health nurse, social worker, and, if necessary, by the physician. These general or comprehensive care units could take full

responsibility for all adult patients seeking general medical services, and the general medical clinics now existing could be closed out.

Vorzimer and Katz, from their experience at Beth Israel Hospital, New York, felt that the comprehensive care unit organization offered the following advantages: easy accessibility to unit personnel and personalized care.[16] In this structure it is possible for patients to "drop-in" and see the social worker or health nurse without visiting the physician. This service was widely used at Beth Israel Hospital where ten to fifteen patients were seen weekly on an unscheduled basis by the public health nurse alone. Beth Israel also experienced a significant reduction of patients in medical specialty clinics who were referred to the comprehensive care units for ongoing care. The cardiac clinic alone experienced over a 30 per cent reduction.

Another advantage of this pattern of care is that it gives greater assurance of continuity and reduces duplication of effort. Administrators of such programs also feel there is less confusion and fewer complaints among patients.[17] The dangerous situation of the patient receiving conflicting instructions from several specialized clinics is also avoided.

One disadvantage of this arrangement, however, is the requirement for a high level of motivation and discipline among the medical staff.[18]

Leaving the comprehensive-care module and focusing attention on the whole modified modular concept, a major disadvantage which is of concern to the Chief of Medicine, Hermann Hospital, is that the smooth flow of patients from the ambulatory clinics to the wards might be interrupted.[19] At best, it is an artificial arrangement and, under ideal circumstances, the person seeing the patient in the clinic should follow him onto the wards. In reality, this practice is seldom carried out except with private patients. This will remain a problem; however, staff members of the comprehensive care units and assigned medical students could visit patients during their hospitalization, and participate in discharge planning and follow-up care.

Summing up the major advantages of the modified-modular system, there would be a unified organizational structure with one line of authority, lines of communication between the modules and emergency center would be established, care would be personalized, and patients would have easy access to a "walk-in" facility. Staff relationships would

exist between the clinics in the modules and the various specialty chiefs, but line authority would be vested in the Director of Ambulatory Services.

Summary

Hermann Hospital is organized as a private, community-oriented hospital and has recently affiliated with the University of Texas Medical School at Houston. As a result of this teaching affiliation and the major expansion, it is felt that the current organizational structure for ambulatory care is inadequate.

Three organizational models for the delivery of ambulatory care services have been discussed. The first model was the current organizational structure. The major advantage of the current organizational structure is that it is in existence and is functional. The primary disadvantages are its multiple lines of authority and centralized administrative functions which culminate in fractionated, depersonalized care.

The second alternative was the proposed modular organizational structure. The primary advantage is decentralization of administrative functions and increased personalized care. The main disadvantages are the absence of a unified

organizational structure and lack of coordination between the modules and the emergency center.

The third alternative was the modified-modular organizational structure. The major advantages are a unified organizational structure, established lines of communication between the modules and the emergency center, personalized care, and easy accessibility to a "walk-in" facility. The primary disadvantages are the requirement for a high level of motivation and discipline among the medical staff, and that smooth patient flow from the ambulatory service to the inpatient wards would be interrupted by a change of medical staff.

Footnotes

[1]Basil S. Georgopolus and Floyd C. Mann, The Community General Hospital (New York: Macmillan Co., 1962), p. 12.

[2]"Report No. 1 of the Outpatient Operating Committee," Hermann Hospital, Houston, Texas, May, 1972.

[3]Unstructured interview with Jerald Tillman, Director of Outpatient Registration, Hermann Hospital, Houston, Texas, February, 1973.

[4]Leonard S. Rosenfeld, Ambulatory Care: Planning (New York: Health and Hospital Planning Council of Southern New York, February, 1971), Chapter 8, p. 74.

[5]"Report No. 2 of the Outpatient Operating Committee," Hermann Hospital, Houston, Texas, May, 1972.

[6]Unstructured interview with Mrs. Harriet Connolly, RN, Director Outpatient Nursing, Hermann Hospital, Houston, Texas, February, 1973.

[7]Hermann Hospital Memorandum, June 21, 1972.

[8]Rosenfeld, p. xxxii.

[9]Ibid., p. xxxix.

[10]"Proposal for Reorganization of Hermann Hospital Ambulatory Services," Hermann Hospital, Houston, Texas, August 23, 1972.

[11]"Report on Certain Organizational Aspects of the Outpatient Clinic Department" (an unpublished study by the Managerial Evaluation Department, Hermann Hospital, Houston, Texas, April 21, 1972).

[12]Unstructured interview with Tim Lawrence, Management Information Officer, Hermann Hospital, Houston, Texas, February, 1973.

[13]Cited in Hospital Research and Educational Trust, The Contemporary Status of Large Urban Public Hospitals--Ambulatory Services (Chicago: Hospital Research and Educational Trust, 1972), p. 21.

[14]Vorzimer and Katz, p. 76.

[15]Ibid., p. 78.

[16]Ibid., pp. 77-80.

[17]Rosenfeld, pp. ii-66.

[18]Ibid., pp. ii-66.

[19]Correspondence with Walter M. Kirkendall, MD, Professor and Director of the Program in Internal Medicine, the University of Texas Medical School, Houston, Texas, March 4, 1973.

CHAPTER III

CONCLUSION AND RECOMMENDATIONS

Conclusion

The modified-modular structure is an organizational alternative for the delivery of health care services, Hermann Hospital, Houston, Texas.

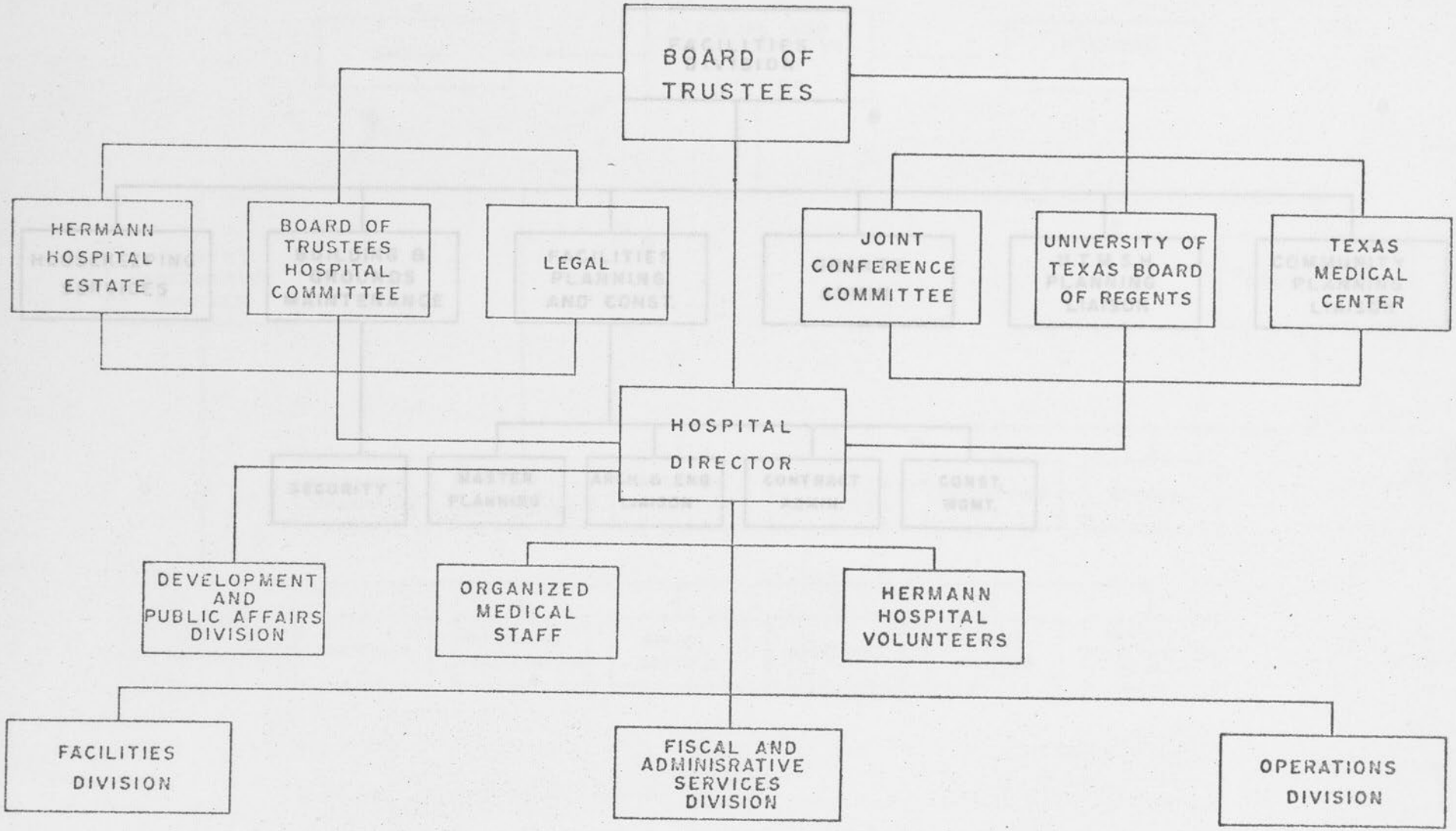
Recommendations

Recommendations of this paper are that a further study should be made: (1) with the objective of establishing optimum patient flow between the ambulatory service and the inpatient wards; and (2) with the objective of establishing the optimum arrangement of clinic groupings within the modular structures.

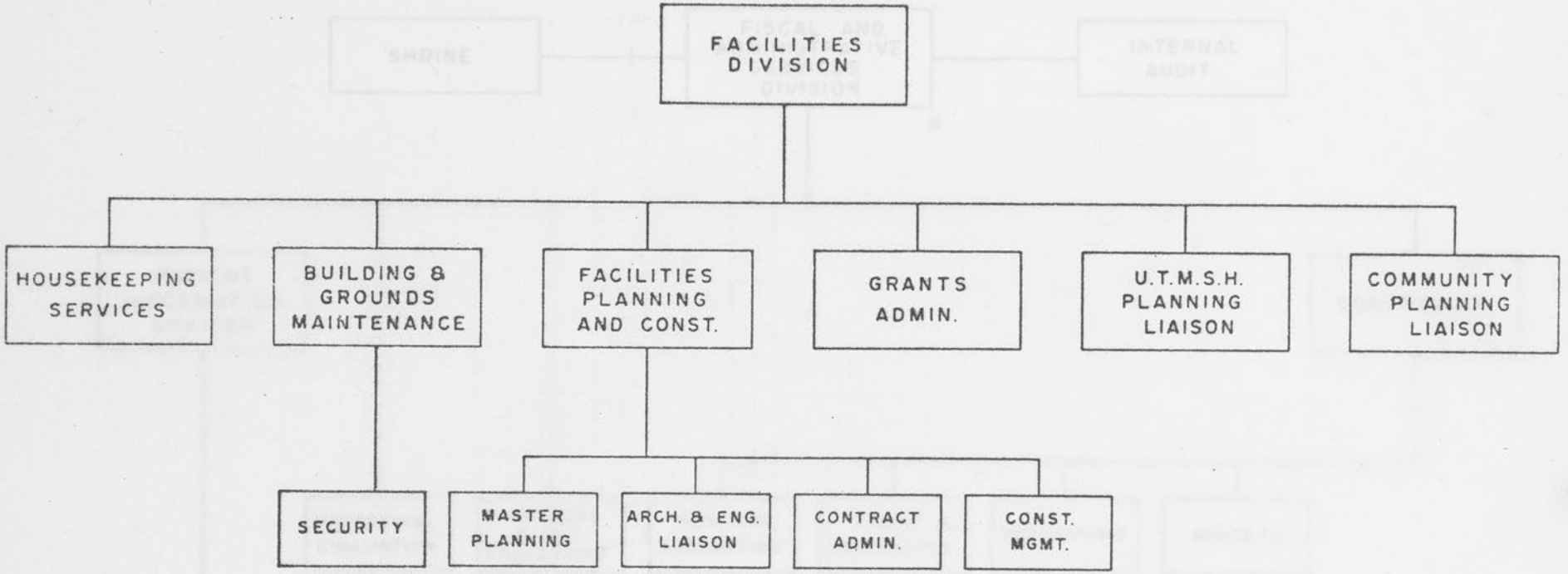
APPENDIX A

ORGANIZATIONAL CHART, HERMANN HOSPITAL, HOUSTON, TEXAS

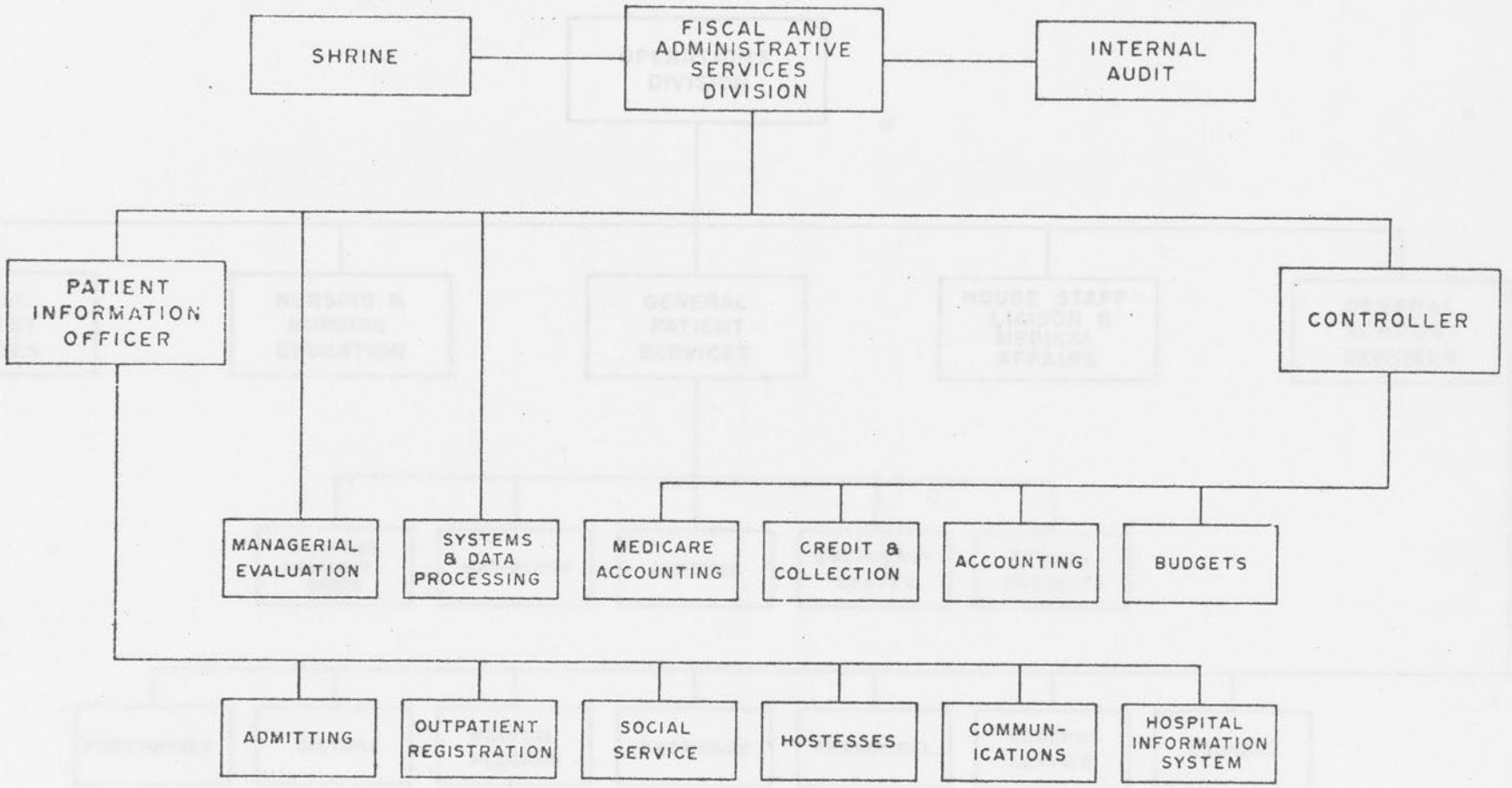
ORGANIZATIONAL CHART
HERMANN HOSPITAL, HOUSTON, TEXAS



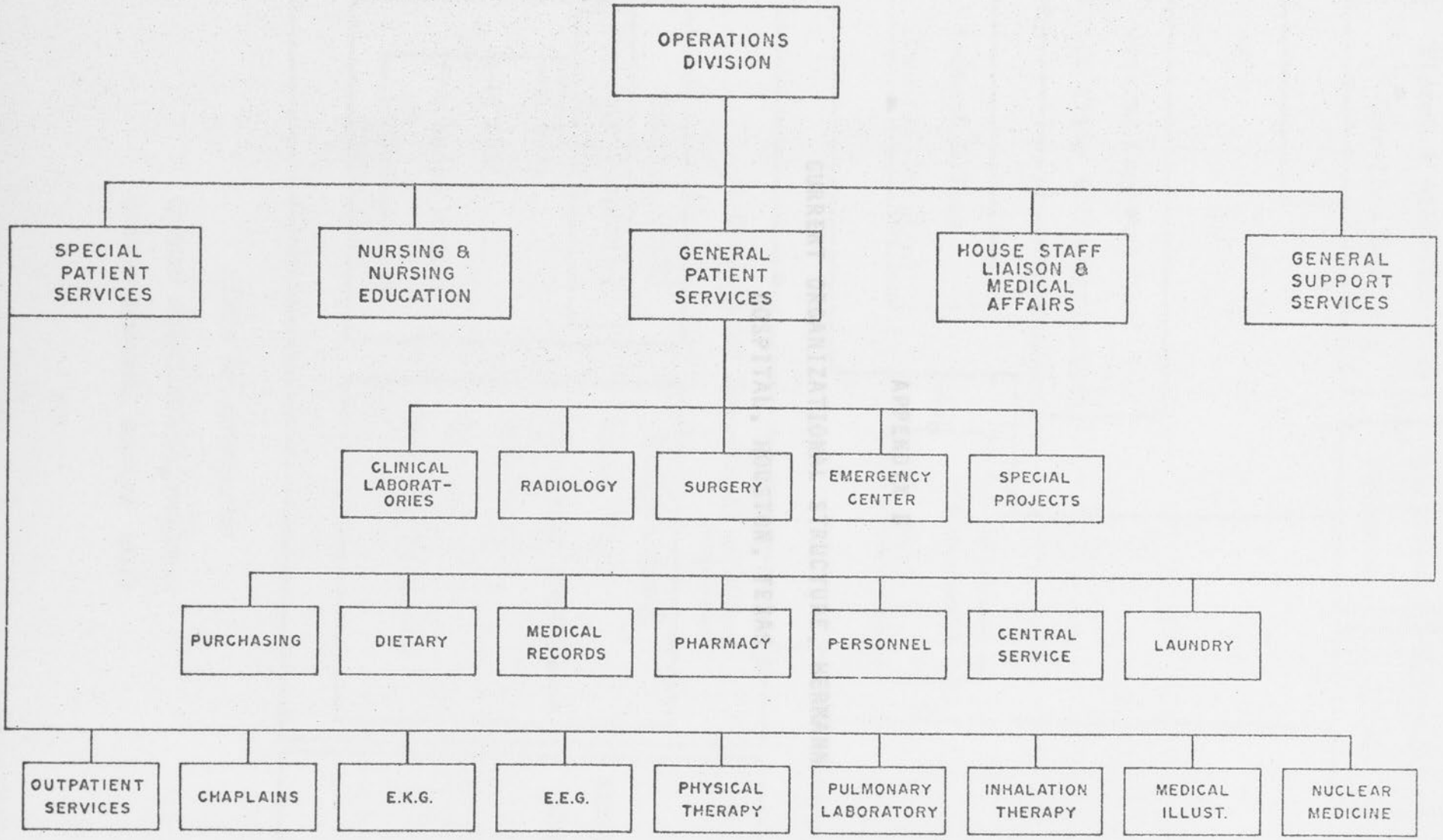
ORGANIZATIONAL CHART
FACILITIES DIVISION



ORGANIZATIONAL CHART
FISCAL AND ADMINISTRATIVE DIVISION

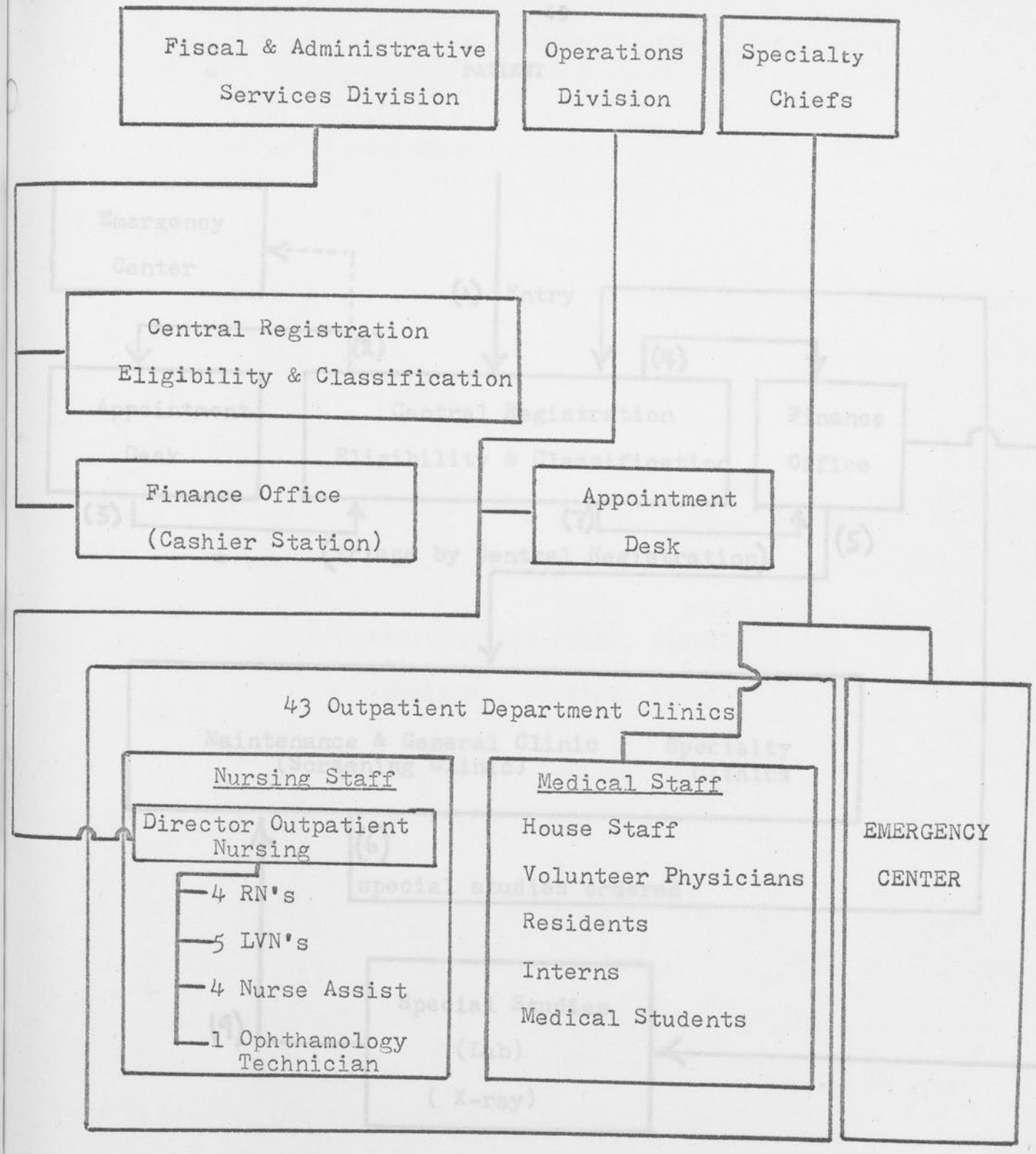


ORGANIZATIONAL CHART
OPERATIONS DIVISION



APPENDIX B

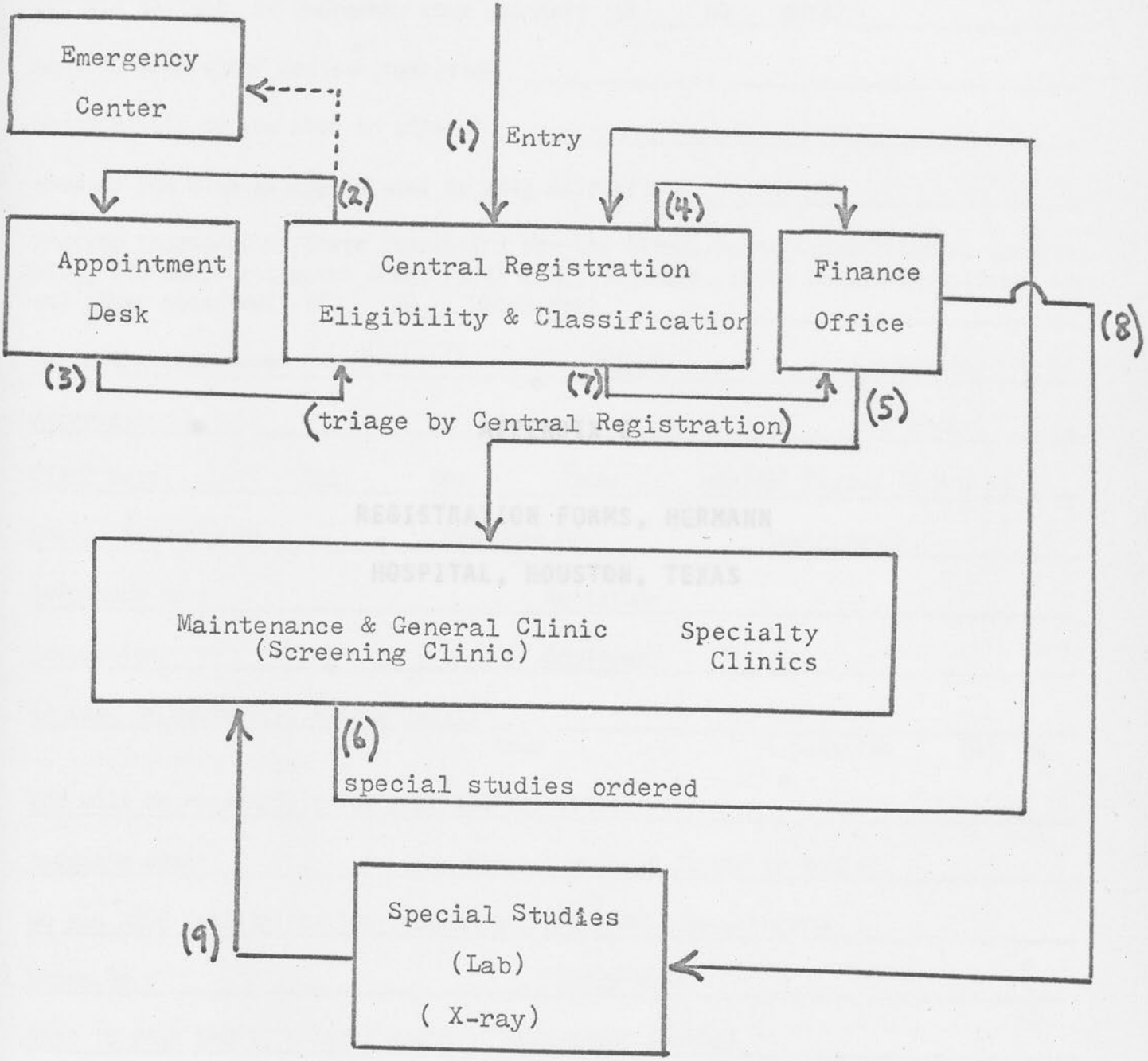
CURRENT ORGANIZATIONAL STRUCTURE, HERMANN HOSPITAL, HOUSTON, TEXAS



LINES OF AUTHORITY

CURRENT ORGANIZATIONAL STRUCTURE
HERMANN HOSPITAL, HOUSTON, TEXAS

PATIENT



AMBULATORY PATIENT FLOW

HERMANN HOSPITAL, HOUSTON, TEXAS

APPENDIX C

REGISTRATION FORMS, HERMANN HOSPITAL, HOUSTON, TEXAS

Date_____

HERMANN HOSPITAL OUTPATIENT CLINIC SERVICES
Application for New and Re-registering Patients
(Please Print)

Have you (the patient) ever been to Hermann Hospital as a clinic patient, private patient, or emergency room patient? YES___ NO___ WHEN?_____

What is your chief medical complaint? _____

Which clinic do you wish to attend? _____

When do you wish an appointment in this clinic? _____

Are you sponsored by State Commission for the Blind, Texas Rehabilitation Commission, Florence Crittenton Home, Faith Home, Medicare, State or County Welfare, or any other agencies? YES___ NO___ Which one? _____

Patient's Last Name: First: Middle:

Address: Zip code:

Birth Date: Age: Sex: Race: Marital Status (S M D W)

Social Security No.: Medicare No.: Medicaid No.:

Telephone No.: Religion:

Occupation: Employer:

In case of emergency, please call:
Name Relation Tel. No.

Who will be responsible for your medical bills?

Spouse's name: First Name's of Father or Mother:

Do you have hospitalization insurance? YES NO Insurance Co.:

Group No.: Policy No.:

What is your family's total monthly "take-home" income?

How many people in your family depend on this income?

WOMEN ONLY: How many times have you been married?

Full name of your present husband:_____
Employer _____
Full names of former husbands:_____
Your maiden name:_____

HERMANN HOSPITAL
OUTPATIENT CLINIC SERVICES
(Registration Form)

I.P.E. ☐

Clinic _____ Date _____ 19__

PATIENT IDENTIFICATION

Last Name	First	Middle	Maiden			
Acct. #		Adm. Date		Pat. Type		
Hosp. Serv.	Adm. Dr.	Fin. Class	# Ins.	Pat. Address		Clin.Cl.
Birth Date	Sex	Marital Status	Religion		Race	
Social Security #	Medicare #	Guar. Phone		Unit No.	Att. Dr.	
Medicaid #	Clinic No.	Age	Birthplace		Texas Driver's License	
Contact in Case of Emergency		Telephone				

EMPLOYMENT INFORMATION

Patient Occupation	Address
Husband - Occupation (Father if Minor)	Address
Wife - Occupation (Mother if Minor)	Address
Husband/Father Employer - Address	Wife/Mother Employer - Address

FINANCIAL INFORMATION

Guarantor: Self ☐ Spouse ☐ Parents ☐ Other ☐ _____

Guarantor Name _____ Address _____

Employer _____ Texas Driver's License # _____

Medicare No. _____ Medicaid No. _____

Social Security No. _____ Bank Reference _____

HOSPITALIZATION INSURANCE: Yes ____ No ____ Insurance Co. _____

Insurance Co Address _____ Group No. _____ Policy No. _____

Rent _____ Buying _____ Payment _____ Credit Card Account # _____

Car Payments: Yes ____ No ____ Car Payments Made to: _____ Amount _____

Patient's Income /Month	Spouse's Income /Month	Other Income	Total Monthly Income	Total # Dependents	Clerk

REMARKS: _____

APPENDIX D

PATIENT'S EYE VIEW OF CURRENT ORGANIZATIONAL STRUCTURE: A VISIT TO HERMANN CLINIC, HOUSTON, TEXAS

A VISIT TO HERMANN CLINIC

Several weeks ago I began experiencing intermittent pains in my chest. A few days passed and the pains became worse. I decided to see a doctor. Not having a personal doctor or an overabundant income, I consulted a friend. He suggested that I call Hermann Clinic. I took his advice. I found "Herman Hospital" in the Houston Telephone Directory and found the subtitle "Outpatient Clinic." I wanted to find out when I could see a doctor about my chest pains. Though I did not see an "Information" number, I did see the listing "Appointment Desk," so I called that number. The Hermann Clinic must be a very busy place because it took two hours to get my call through. Nevertheless, I finally got through to the Appointment Desk. I told the lady about my chest pains and asked when I could see a doctor. The lady, who was most courteous, asked me if I had a clinic card. I replied no. The lady told me that I would have to obtain a clinic card before I could make an appointment to see the doctor. I asked if this could be done today since I wanted to get my problem attended to as soon as possible. She told me that I could get the clinic card and make the appointment

today, but the first opening to see the doctor was November 13 (three weeks away). I told the lady that my chest pains were becoming severe and I should see a doctor soon. She suggested that I report to the Emergency Center immediately. She said the Emergency Center physician would see me and refer me to the clinic for follow-up. She informed me, however, that there was a $10 minimum fee to visit the Emergency Center. I proceeded to the Emergency Center.

I never knew an Emergency Center facility could be so beautiful. The Center's ultra-modern concept and comfortable seating arrangements helped my two-hour waiting period. But I did see a doctor and he was most helpful. He gave me a prescription and referred me to the Screening Clinic. The bill was $20 plus my prescription. The referral slip that was given me by the Emergency Center said to "call 527-4170 for Appointment." At the bottom of the slip under "Comments or orders of Physician:" the slip read "As soon as possible."

The following morning, on my coffee break, I called the Appointment Desk. The line was busy. I called again on my lunch hour, in fact three times, but the line was busy. Finally on my afternoon coffee break I got through. I told the lady I had been in the Emergency Center, seen by the

doctor, and referred to the Screening Clinic. She asked me if I had obtained a clinic card. I replied no. She asked me to read her the number in the upper left hand corner of the referral slip and the "Comments or orders of Physician." I did. She said that I have an appointment to the Screening Clinic on November 13, 1972, at 3 P.M. and to report to Central Registration one hour before the appointment to obtain a clinic card.

Three weeks passed and on November 13, at 2:00 P.M. I reported to the Hermann Hospital Outpatient Service. When I entered the parking lot I stopped at the "Attendant's Shack" as the sign instructed. An attendant approached me. He asked me if I had a clinic card. I replied "no, that's why I'm here." He told me I would have to pay $.25 to park until I obtained a clinic card, then I could park free of charge. I paid the $.25, parked my car, and approached the clinic building. I must say I experienced a strange feeling. Here was an old rustic-appearing building with iron bars and gates and a security officer with a gun on his hip sitting at the front door. I felt that I was reporting to either a prison unit or maybe a closed psychiatric unit. I entered the building and saw a sign that read "All Patients" with an

arrow pointing to the right. I took a right turn and saw a counter and a line of people. There was a sign over the counter that read "Central Registration" so I figured I was at the right place. Again, I felt strange. Outside the building I felt that I was approaching a prison unit. But now that I am inside I don't feel that way at all. I feel like I'm in an antique train station. I wonder if this place was ever a train station? I waited in the line for about ten minutes. I presented my "referral slip" to the lady at the counter and told her I needed a clinic card. She wrote my name on a list and asked me to be seated. A few minutes later another lady called my name and escorted me into an office. The lady was very courteous but she asked some very personal questions. She wanted to know the exact amount of my income, rent, car payment, dependents, where I bank, and credit references. After I gave the lady my information she left the office for a minute and returned with a plastic card. My gosh, this must be my clinic card. I'll surely want to safeguard it. The lady told me that I must report to the Appointment Desk to obtain my appointment slip. After ten minutes in that line, I received my appointment slip. The lady at the Appointment Desk instructed me to go to Central

Registration to get the slip "OK'd." After another ten minutes in the "initial" line the lady at the counter placed a white object on my clinic card, gave me a white slip that she had imprinted with my invaluable clinic card, made a mark on a pad behind the counter, and instructed me to proceed to the Business Office to pay. After standing in that line for ten minutes I paid the lady behind the bars $3 to see the doctor. The lady took my white slip, stamped my pink slip, and told me to proceed to the Screening Clinic.

I reported to the Screening Clinic where a nurse took my clinic card and pink slip and asked me to be seated on the hard bench in the train station lobby. Within a few minutes a nurse called my name and four others. She escorted us into the clinic, lined us up against the wall, and placed a thermometer in our mouths. Meanwhile, each of us were weighed and our blood pressures taken. When this was completed, we were instructed to return to our benches. About one hour passed and I noticed the doctors reporting to clinic. I wonder why I had to be there at 3 o'clock when the doctors don't get there until 4 o'clock? Anyhow, another hour passed and I finally was called in by the nurse. The nurse escorted me into the doctor's office. The doctor was very polite and

very helpful. He asked that I get a chest X-ray and a blood test three days before my next visit and return in one week. I asked if I could do this now so I could prevent taking off from work. He said that he was sorry but the lab closes at 2:30 P.M. and the X-ray Department closes at 4:30 P.M.

Three days before my appointment I returned to the clinic building. Needing an X-ray, I reported to the X-ray Department. I presented my clinic card and the X-ray form the nurse had given me. The lady said that I needed to pay at the Business Office before I could receive the X-ray. After standing in that line for ten minutes, the lady told me I had to get the form approved by Central Registration before I could pay for it. I returned to Central Registration and stood in that line for ten minutes. The lady at the counter then stapled a pink slip to the X-ray form. She said that I could now proceed to the Business Office. I stood in the Business Office line again, paid for my X-ray, and proceeded to the X-ray Department. I then received my X-ray.

Now I am ready for my lab tests. Or am I? I reported to the lab. I should have known better, but I just did not know <u>where</u> to start. The rerouting process was identical to

that experienced with my X-ray.

Three days later I returned to see the doctor. This visit was similar to the first one except the doctor told me that the tests results were favorable and I did not need to make a return visit unless I became worse. After I got home, I sat down to figure what my illness had cost me in hours and dollars. I was surprised at the results:

Item	Dollars	Hours
Emergency Center	$ 20.00	3
Prescription	4.52	
First Clinic Visit	3.00	
Parking	.25	
Time-off from Work	10.40	4
X-ray, lab tests	18.07	
Time-off from Work	10.40	4
Return Visit	3.00	
Time off from Work	5.20	2
	$ 74.84	13 hours

Next time I become sick, I think I shall seek another route to recovery. Can you blame me?

Source: Narrative description derived from patient interviews and observation by Director of Outpatient Registration, Hermann Hospital, February, 1973.

APPENDIX E

OUTPATIENT SERVICES DEPARTMENT SCHEDULE, HERMANN HOSPITAL, HOUSTON, TEXAS

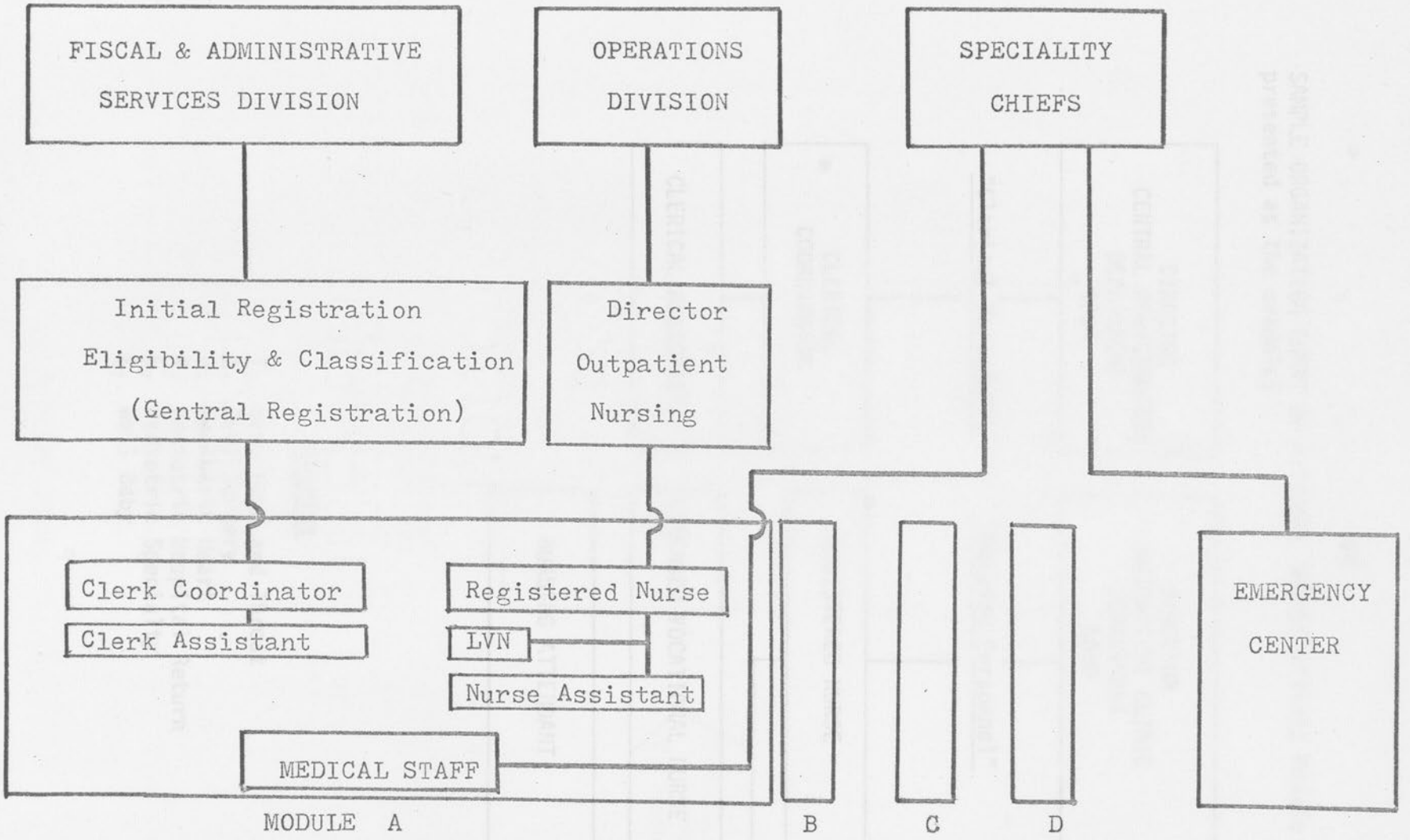
43 CLINICS

APPOINTMENT DESK EXT. 4170 — OUTPATIENT SERVICES DEPARTMENT SCHEDULE — (Revised Jan. 1973)

EXT.	CLINIC		MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
4260	Allergy	001			11:30-4:30		8-10
4260	Arthritis	002	8-11 Medical Referral only				
4276	Back	044				Call Apt.desk	
4122	Cardiovascular	003	1-4:30				
3926	Chemotherapy	004					1-4:30
4031	Cystoscopy	006	12:30-4:30 GU referred only		/GU referred only		8-4:30
4260	Dermatology	007	12:30-4:30				12:30-4:30
4213	Ear,Nose & Throat	008	(Check Dr. Harris' memo)				
3660	Eye	009	8-4:30	8-4:30	8-4:30	8-4:30	8-4:30
4276	Family Planning	047		5-8P.M.			
4276	Fracture	011					1PM Call Apt.dk
4260	Gastrointestinal	012					8-11
4029	Genitoruinary	014		Male 12-4:30		Female 12-4:30	
4122	General Surgery	015		2-4:30		2-4:30	
4029	Gynecology	016	12-4:30		12-4:30		12-4:30
4276	Hand	017					1PM Call apt.dk
4260	Head & Neck Surgery	018				1-3	
4260	Heart	019		8-12			
4260	Hematology	020			10-12		
4276	Hip	043				1-4:30	
4261	Hypertension	021				Call Apt. desk 8-12	
4261	Medical	022	8-4:30	8-4:30	8-4:30	8-4:30	8-4:30
3926	Med.Hosp.Return	023		1-4:30			
3926	Medical Chest	024				1-4:30	
4260	Metabolic & Diabetic	025				8-12	
4122	Minor Surgery	046					2-4:30
3926	Neurology	026			1-4:30		
3926	Neurosurgery	027	1-4:30				
4029	Obstetrics	028	8-12	8-12 P.P.	8-12	8-12	8-12
4213	Oral Surgery	029		8-11		8-11	
4122	Orthopedics	030			1-4:30		
4122	Pediatrics	031	8-12	8-12	8-12	8-12	8-12
4172	Pedi Heart	032				12-4:30	
4122	Pedi Hosp. Return	033	12-4:30				
4172	Pedi Specialty	034		1-4:30			
4122	Plastic Surgery	035					12:30-2
4260	Proctology	036		12:30-4:30			
4172	Psychiatry	037			1-4:30		
3926	Reproductive Disorders	010				12-4:30	
4260	Screen. & General	038	3:30-6		3:30-6	3:30-6	3:30-6
4122	Thoracic Surgery	039	1-4:30				
3926	Tumor Follow-up	040					1-4:30
4172	Well Baby	041	8-12	8-12	8-12	8-12	

APPENDIX F

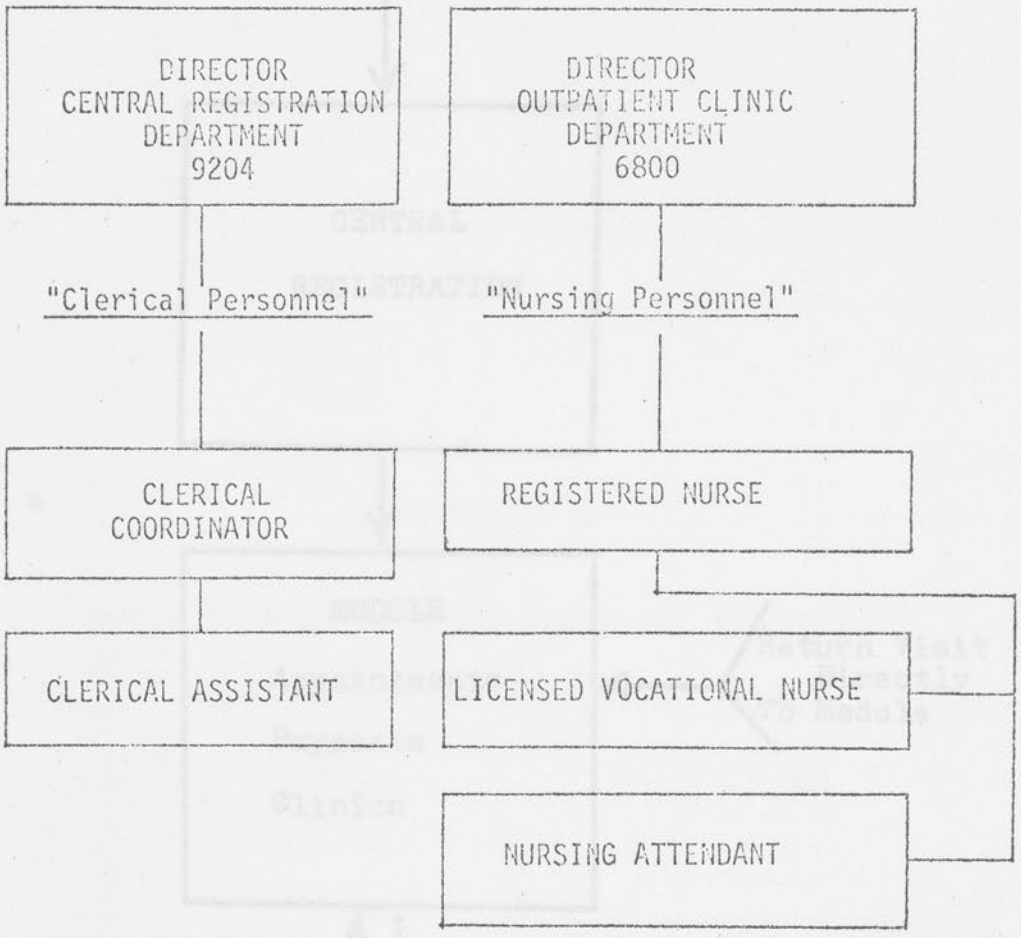
PROPOSED MODULAR ORGANIZATIONAL STRUCTURE, HERMANN HOSPITAL, HOUSTON, TEXAS



LINES OF AUTHORITY

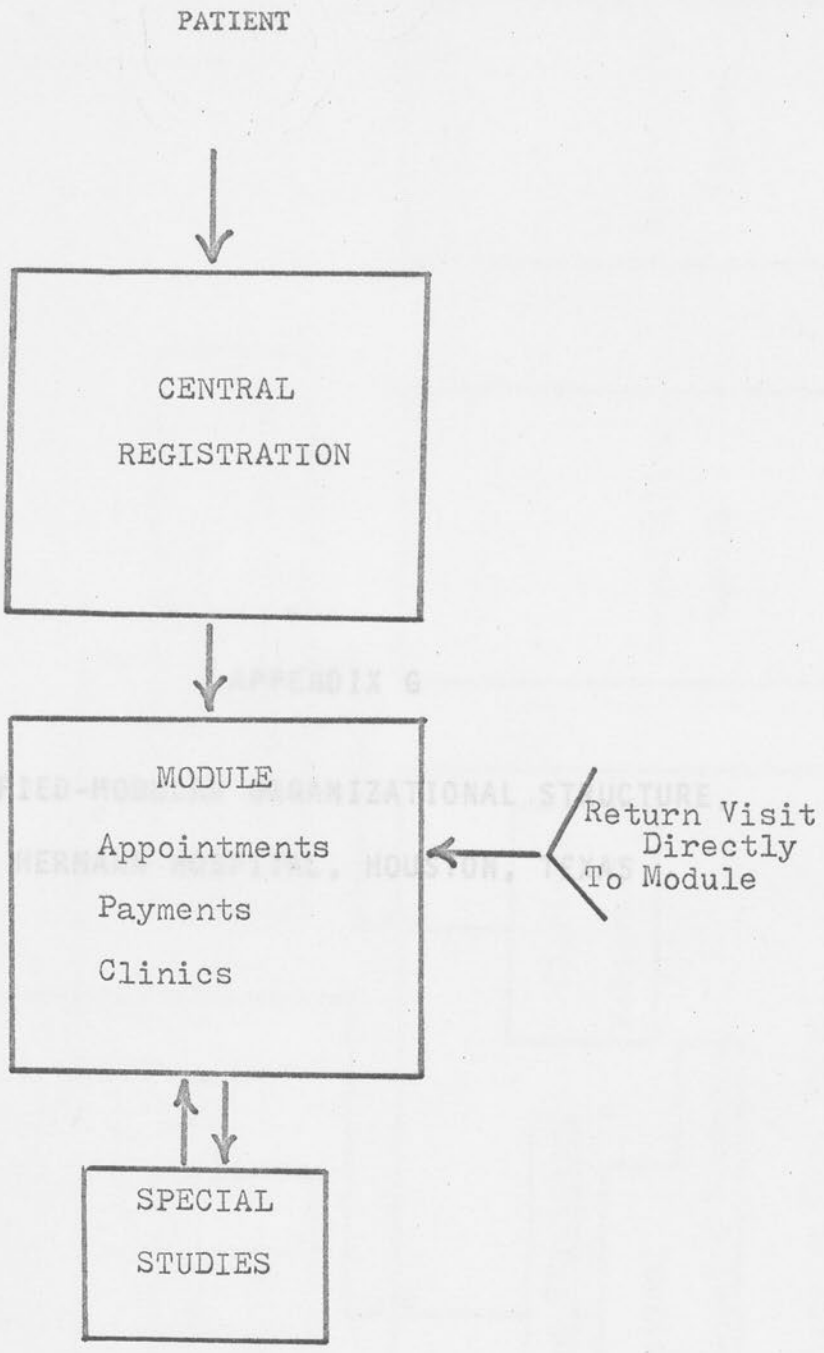
PROPOSED MODULAR ORGANIZATIONAL STRUCTURE

SAMPLE ORGANIZATION CHART OF A CLINIC MODULE (Clinic Module C is presented as the example)



Clinics

1. Ear, Nose and Throat
2. Oral Surgery
3. Pediatric Heart
4. Pediatric Hospital Return
5. Pediatric Specialty
6. Well Baby

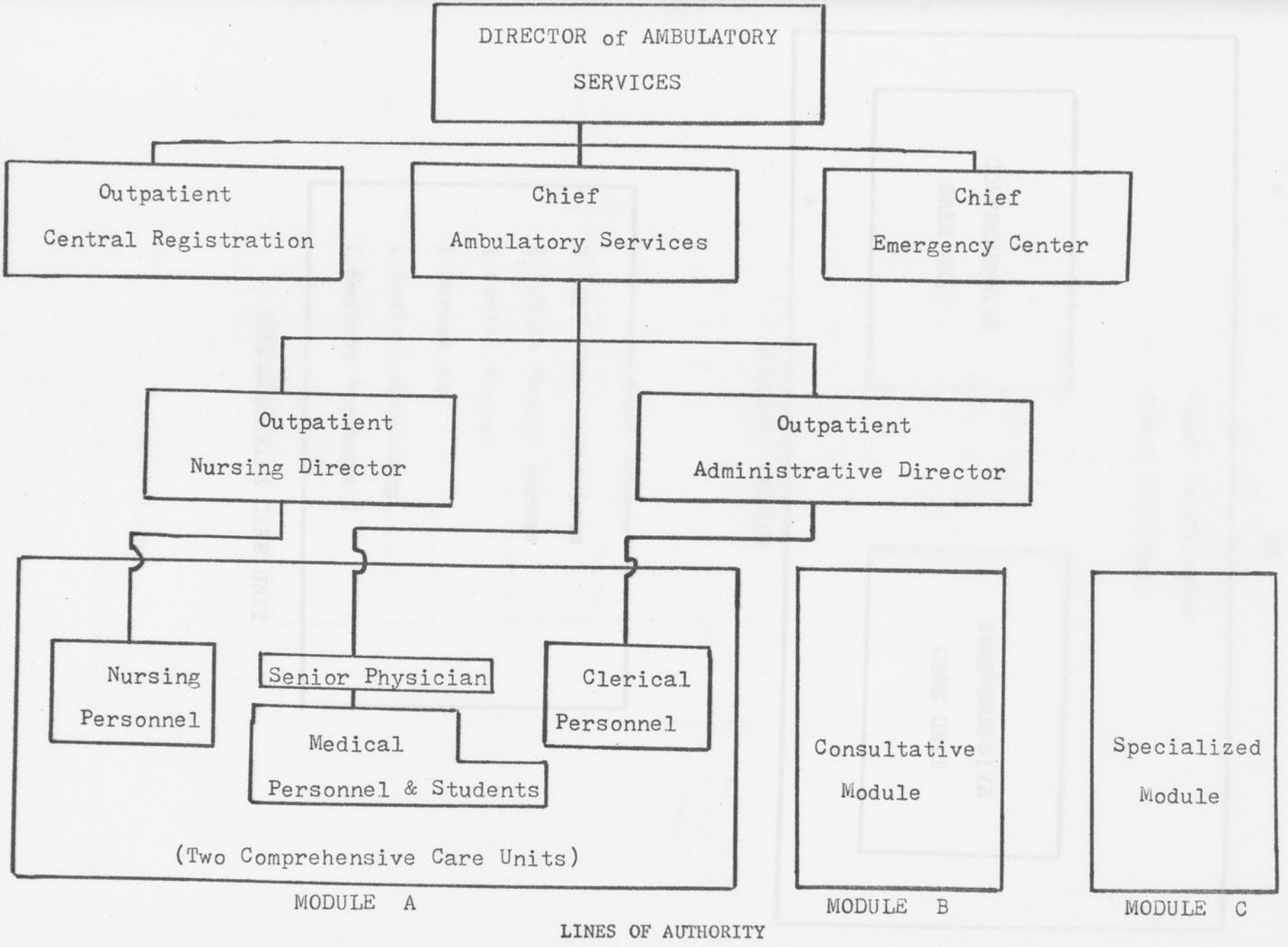


PATIENT FLOW

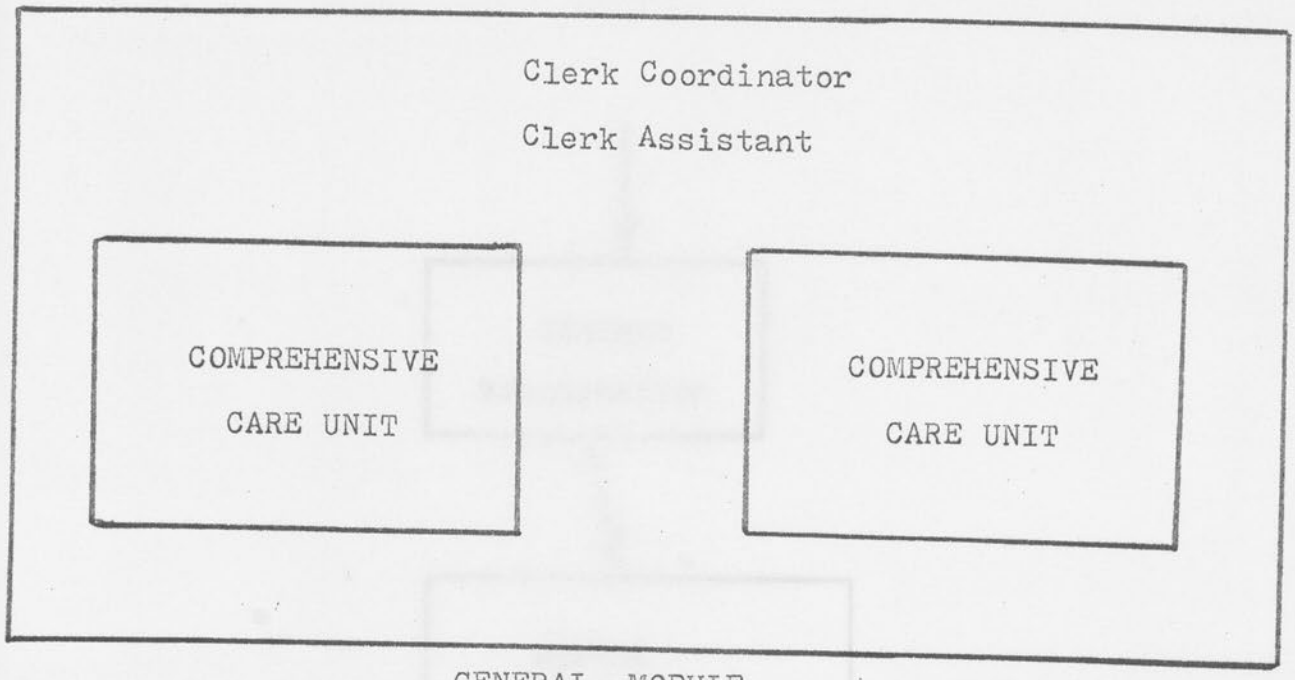
PROPOSED MODULAR ORGANIZATIONAL STRUCTURE

APPENDIX G

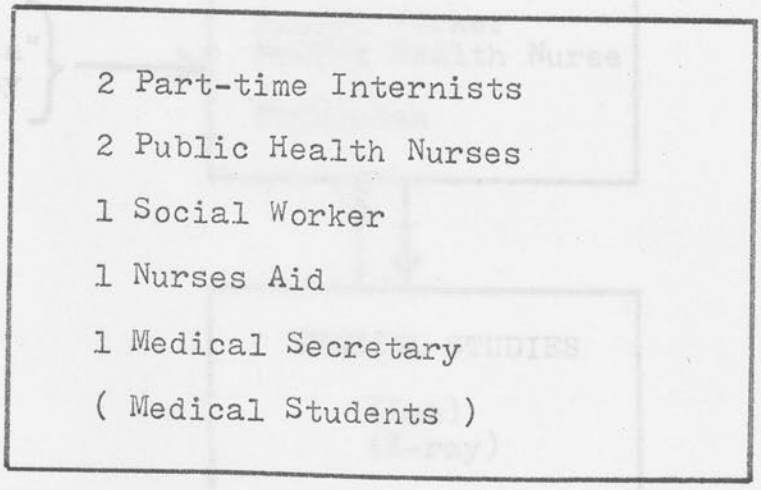
MODIFIED-MODULAR ORGANIZATIONAL STRUCTURE, HERMANN HOSPITAL, HOUSTON, TEXAS



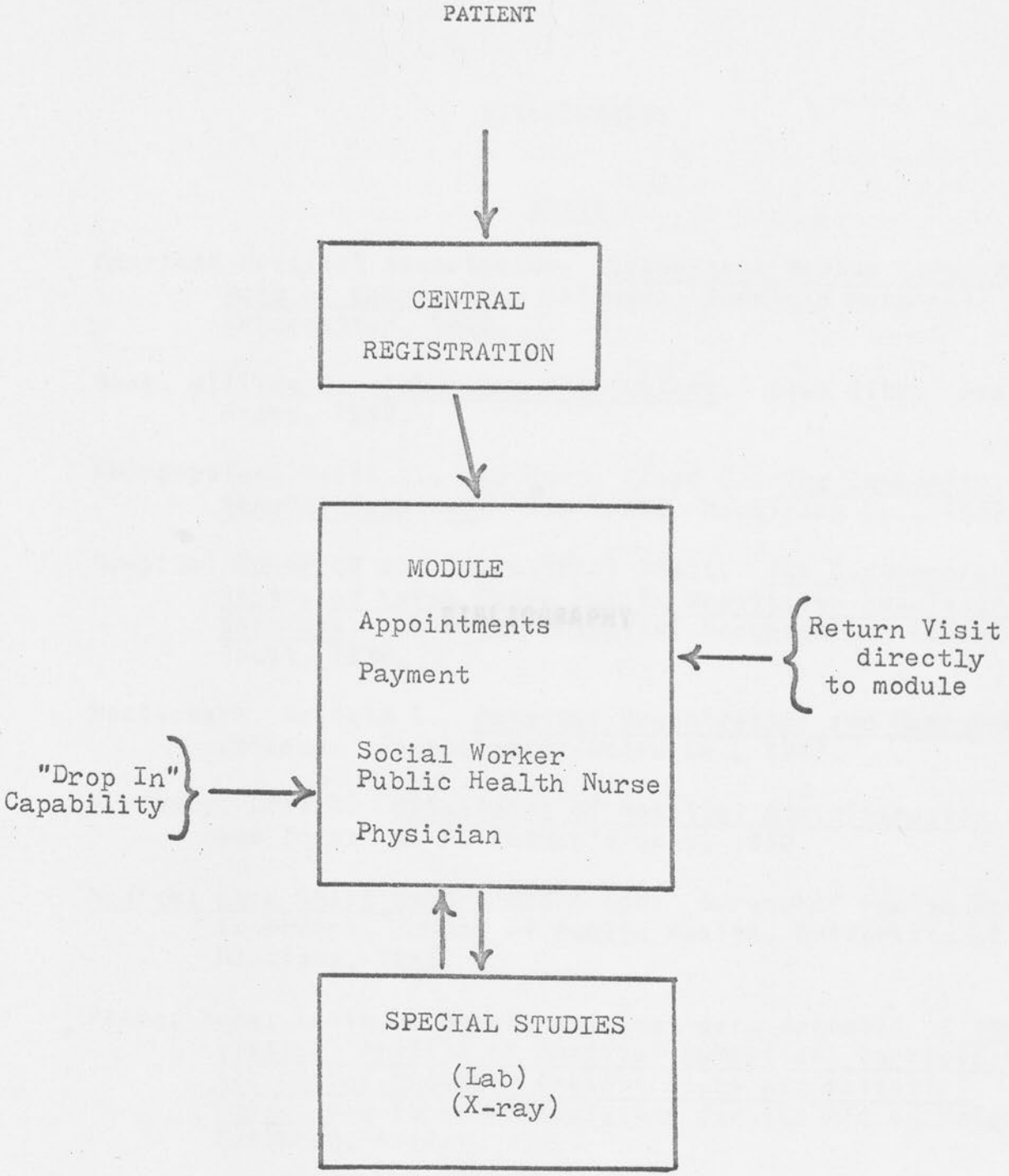
MODIFIED - MODULAR ORGANIZATIONAL STRUCTURE



GENERAL MODULE



COMPREHENSIVE CARE UNIT



PATIENT FLOW

MODIFIED - MODULAR ORGANIZATIONAL STRUCTURE

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ABSTRACT

ORGANIZATIONAL STRUCTURE OF AMBULATORY CARE SERVICES
AT HERMANN HOSPITAL, HOUSTON, TEXAS

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

by
Lieutenant Colonel Richard D. Cameron, MC

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The problem was to develop an organizational structure for the delivery of ambulatory care services at Hermann Hospital, Houston, Texas.

Data for this paper was obtained from personal observation of the operation of the outpatient clinics at Hermann Hospital, unstructured interviews with staff members, a review of the literature, and a review of hospital correspondence on file pertaining to the operation of the outpatient clinics.

In addition to the study conclusion, recommendations for further consideration included the following: (1) a study to examine optimum patient flow between the ambulatory service and the inpatient wards, and (2) a study to establish the optimum arrangement of clinic groupings within the modular structures.