A STUDY OF THE ADMITTING AND DISMISSAL ACTIVITIES AT SAINT JOSEPH HOSPITAL, FORT WORTH, TEXAS

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CHAPTER I

INTRODUCTION

General Information

"I am Alpha and Omega, the beginning and the end, the first and the last" (Rev. 22:13). The preceding biblical statement is quite appropriate in its description of the admitting and dismissal activities in a hospital. Alpha applies to the admitting phase of hospital activities and Omega applies to the dismissal phase. These phases are extremely important because they are the ones which make initial and final impressions on the patient. If the patient is given a cordial reception upon admission to the hospital, it will set the tone for his hospital stay. If the opposite occurs, the patient's impression of the hospital will be transferred to the care that he receives. Despite the excellence of this care, criticism may develop.[1] Upon dismissal from the hospital, the patient will carry with him either a favorable or an unfavorable impression depending on the manner in which the financial transactions are carried out. One writer suggests that the most painful surgery in the hospital may be the operation performed at the business office in removing cash from the purse.[2]

An outstanding characteristic about hospital organization is that all hospitals are unique. Each hospital has its own set of circumstances which determines its pattern of organization. Hospital organizational

patterns which reflect the many different ways that admitting and dismissal are performed are tantamount to the variations that one sees when viewing a kaleidoscope. Seven thousand one hundred and seventy-two turns would show an equal number of different patterns.

In a relatively small hospital, one person may be responsible for all of the medico-administrative activities. In a large hospital, it is common to find these activities separated into functional groupings with layers of supervisory personnel. The composition of these groupings and the supervisory structure are normally determined by the hospital administrator and the governing board.

Numerous factors are considered during the grouping of hospital activities into divisions, departments, services, sections, and branches. Normally, the primary factors which determine the establishment of an admitting section are the number of patients admitted and the time required to interview them. Another significant factor is the number of different types of medical cases accepted. For example, hospitals primarily engaged in the care of short-term, acutely ill patients will have ten to eleven times as many admissions per bed as hospitals treating long-term patients, although the number of beds may be the same.[3] Dismissal activities are normally established as a cashier function within the collections and credit section of the business office. These activities include dismissal interviews and collections from patients; they are fairly standardized.

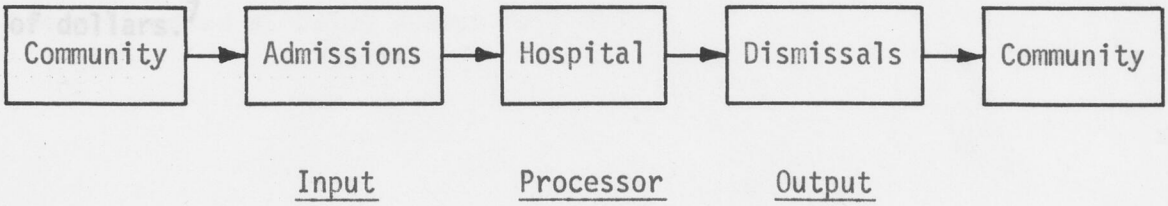
Since a good credit and collections program begins with the initial indoctrination of incoming patients in the admitting office, many large hospitals have placed this office under the control of the credit and

collections officer. However, under this type of organization there is the danger of overemphasizing the financial aspects of hospital care to a patient.[4] Within recent years a new organizational pattern has developed. According to it, the chief admitting officer reports to an assistant administrator who has been given responsibility for credits, collections, cashier duties, and all other financial matters that exist between the patient and the hospital. This type of organization is designed to minimize financial misunderstandings that might arise between the patient and the hospital.[5] At Saint Joseph Hospital, all financial activities are the primary responsibility of the comptroller who reports directly to the hospital administrator (Appendix A).

Viewed as a hospital public relations system, the admitting and dismissal activities represent the input and the output (Figure 1). Thus, the organization of any hospital should take into consideration the interrelationships of these important phases of the hospital's contact with the patient. The measure of effectiveness of this system is essentially qualitative in that effectiveness is determined by the presence or absence of complaints from the patients or their families.

Figure 1

Hospital Public Relations System



The Hospital Setting and History

Saint Joseph Hospital dates back to the late nineteenth century. The hospital site was first occupied by an infirmary established in 1885 by the Missouri Pacific Railroad Company for the care of its employees. The railroad company invited the Sisters of Charity of the Incarnate Word of San Antonio to supervise the nursing care of patients. This religious order had erected numerous medical service stations throughout the southwest to bring health and hope to suffering humanity without discrimination of race, creed, or color.[6]

On April 5, 1885, a fire completely destroyed the infirmary. The railroad company decided not to rebuild and sold the entire tract to the Sisters. The Sisters then constructed a two-story frame building and commenced to deliver health services to the Fort Worth community. From this modest structure with sixty beds, Saint Joseph Hospital has grown to a twelve-story, multiservice, fully accredited hospital of 480 beds. The mission of Saint Joseph Hospital as a charitable institution was clearly established when the first patient to enter the hospital in 1885 was a charity case. No sufferer is refused medical care because of lack of funds and every effort has been made to give first class service and consideration to both pay patients and charity patients. During its existence, Saint Joseph Hospital has given free service worth millions of dollars.[7]

Conditions Which Prompted the Study

Sister Mary James, the Hospital Administrator, is a staunch disciple of the philosophy of Saint Joseph Hospital which states that the dignity of man is inherent because he is made in the image of God and that he should be treated accordingly. She is not content merely with the construction of an outstanding medical treatment facility but is turning to the medico-administrative activities to seek ways to increase the amount of personal services and attention afforded the patient.

The administrator is primarily concerned about the lack of privacy afforded the patient upon dismissal in the discussion of matters related to the payment of hospital bills and about the lines that are formed when patients queue up at the cashier window in the main lobby to pay their bills. Additionally, she is concerned about the amount of time patients have to spend waiting to be admitted. The administrator feels that these problems exist because the personnel and facilities in the admitting and dismissal offices are not being used to their optimum capacity.

She is interested in a type of admitting-dismissal system in which private rooms or booths are used for conducting admitting and dismissal interviews and in which the same clerk admits and dismisses the patient. Several area hospitals have adopted this sort of system but it has not been attempted at Saint Joseph Hospital.

Statement of the Problem

The problem is to determine the best system for accomplishing admitting and dismissal activities within the business office at Saint Joseph Hospital, Fort Worth, Texas.

Definitions

Admissions refers to those patients admitted to the hospital for treatment and assigned to a bed.

Admitting refers to those activities which are related to the registration of patients on an inpatient or outpatient basis.

Courtesy Dismissals refer to those patients who are permitted to leave the hospital without obtaining clearance from the business office.

Dismissal refers to those activities which are related to the release of a patient from the hospital. This term is used synonymously with discharge and disposition.

Outpatient Admissions refer to those patients who are admitted to the hospital for treatment but who are not assigned to a bed.

Preadmission refers to those activities which are devoted to obtaining registration information on a patient prior to the arrival of the patient at the hospital for treatment.

Objectives

The objectives of this study are:

1. To evaluate the admitting and dismissal activities as they are performed under the present system.

2. To discuss two alternative systems.

3. To evaluate the advantages and disadvantages of the three systems.

Criteria

An effective admitting and dismissal system must be selected on the basis of several criteria. The system should:

1. Enhance the dignity and increase the privacy of patients.

2. Be compatible with the overall management philosophy of the hospital.

3. Increase the effectiveness and efficiency of the admitting and dismissal activities.

4. Provide for admitting and dismissing patients as quickly as possible in an environment which is conducive to a positive psychological state.

Factors Bearing on the Problem

The factors bearing on the problem are:

1. Admitting and dismissal activities are presently being performed under different supervisors within the business office.

2. The personnel who perform the admitting and dismissal activities share a considerable overlap in job knowledge and skill.

3. The private offices which are used for admitting patients are not being utilized fully during the day.

4. The liberal hospital policy on unlimited short notice reservations precludes an effective preadmission system. Reservations

made on short notice do not give the admitting office sufficient time to contact the patients prior to their arrival at the hospital for care.

5. Since 1966, the hospital has increased its bed capacity from 276 to 480 without a proportionate increase in business office personnel.

Assumptions

The following assumptions are made:

1. The present trend of increased admissions will continue.

2. An improved admitting and dismissal system will benefit the patient and the hospital.

3. An improved admitting and dismissal system will provide more efficient utilization of personnel and facilities in the business office complex.

Research Methodology

A review of the literature was made to obtain a base of knowledge pertaining to the admitting and dismissal phases of hospital administration. Special emphasis was placed upon those articles which discussed centralized and decentralized admitting and dismissal systems.

Unstructured interviews were conducted with the hospital administrator, the associate administrator, the assistant administrators, the comptroller, the business manager, the personnel officer, the business office supervisor, the admitting officer and the individuals who perform the admitting and dismissal activities. The purpose of these interviews was to gain information on the present system.

Visits were made to a number of hospitals in the San Antonio and Dallas/Fort Worth areas to observe different types of admitting and dismissal systems. These hospitals were comparable in their size and scope of operations to Saint Joseph Hospital. The visits provided a pool of knowledge and experience which helped this writer draw parallels between the different systems.

Operations research and quantitative techniques were used to evaluate the present and proposed systems. These results were compared with observations made by the author and with studies made by others in different hospitals.

Personal observations were made in all areas of activity within the business office complex. Particular attention was paid to the physical layout and the space requirements that were necessary for the accomplishment of these activities.

Review of the Literature

Articles which relate to admitting and dismissal systems are replete with references to the importance of these two phases of a patient's contact with the hospital. Many hospital administrators have adopted the philosophy that a hospital should strive to improve its service beyond the goal of providing adequate patient care. As a result, hospital administrators are attempting to ameliorate the hospital-patient relationship with various innovations.

Dr. Malcolm MacEachern states that the admitting department holds one of the most strategic positions in the hospital. Additionally, he states that apart from the actual work performed in admitting and

discharging patients, the importance of the admitting office lies chiefly in the field of public relations. It is here that the patient forms his first and lasting impressions of the hospital and it is here that the patient's relatives and friends begin to evaluate the service of the institution.[8] Another writer considers admitting and discharge as the Achilles heel of public relations.[9]

In describing admitting systems many authors discuss the pre-admission system as a prelude. They consider preadmissions as the key to an effective admitting system. A certain amount of information can be obtained from patients prior to their arrival at the hospital. Six methods for obtaining this information are described:

1. Obtaining information from the doctor at the time of reservation.
2. Having the doctor give out pre-admittance forms and urge the rapid completion and transmittal of the forms to the hospital.
3. Calling all incoming patients to gather the necessary information for all forms.
4. Having the doctor urge the incoming patient to call the admitting office.
5. Sending out preadmission forms as soon as the reservation is made.
6. Having the doctor's secretary fill out preadmission forms and mail them to the admitting office.[10]

Unique innovations in admitting systems which have appeared on the horizon within recent years are the use of preadmission nurses and the

direct admission system. Both of these systems are still in the developmental stage and only a few hospitals have been bold enough to experiment with them. Supporters of the preadmission nurse system emphasize the saving of time upon admission and the increased rapport between the admitting office and the nursing service.[11] Under this system a nurse, assigned to the admitting office, contacts each physician who has requested a room reservation to obtain preadmission information and to ascertain whether the patient will require special services upon admission. Special requests are then coordinated with the ward nurse. The direct admission system -- go to bed first, get admitted later -- reportedly gets patients in their rooms ten minutes after arrival.[12]

Numerous authors have extolled the virtues of combined admitting-dismissal systems. In an article describing the innovation of a combined system at the Methodist Hospital in Memphis, Tennessee, the author sums up its advantages by stating that in an office equipped to handle admissions and discharges, more patients can be served during peak periods in a shorter period of time, better utilization of employees is obtained, and better management controls are provided.[13] Another author suggests that if hospitals would abandon the stereotype of separate offices for admitting and dismissing patients and would concentrate instead on close integration under one office, the duties of both offices would be carried out more efficiently.[14]

Many different partnerships have been suggested for the activities which relate to financial matters that exist between the hospital and the patient. Since admitting policies are closely related to both credit and collection, the admitting officer often shares these responsibilities.

The following titles, revealing divided work, are fairly commonplace: (1) Admitting Officer-Bookkeeper; (2) Admitting Officer-Credit Manager; (3) Admitting Officer-Office Manager.[15]

Most articles suggest that even the smallest hospital should provide private rooms or booths for the admitting interviews; however, little emphasis has been placed on the dismissal interviews. In the face of increasing complexities in the interpretation of insurance matters, hospital administrators are beginning to pay more attention to the dismissal phase of the patient's contact with the hospital.

Operations research techniques are being applied to the health care industry on an increasing scale. Many hospitals have hired industrial engineers and management analysts to enhance the quality of the decision-making process. Recent management studies emphasize the use of operations research techniques in determining workload projections, equipment requirements, staffing levels, and waiting times. The use of queuing theory models, the program evaluation and review technique (PERT), linear programming, and transportation models are among the techniques which are being widely used.

With the increasing use of computers in the health care industry, numerous hospitals are announcing grandiose schemes for computers to take over much of the paperwork. Primarily, the systems involve an on-line computer linked to cathode ray display tubes. Instead of an admission form, the admitting clerk types the patient information directly onto the screen with an input keyboard. This information is the initial input into the patient accounting system and the computer stores it for use in all necessary hospital-patient transactions.[16] With daily printouts of

updated patient accounts, some hospitals have reported that dismissal time can be reduced to ninety seconds.[17] The use of the computer has also seen a marked reduction in the number of late charges. Many hospitals which have not installed computer systems are employing computer utility service bureaus. In this type of program, the hospital produces the punched cards which are run on the service bureau's computer. The punched cards are picked up prior to midnight and the computer printouts are returned to the hospital by 6:00 A.M. the following day.[18]

Footnotes

[1]Richard Gallagher, "The Non-Existent Perfect Admission Form," Hospital Accounting, XVIII (April, 1963), 4.

[2]Sister Mary Bertrand, "Front Office Practices," Hospital Accounting, XVI (October, 1962), 20.

[3]American Hospital Association, Manual of Admitting Practices (Chicago: American Hospital Association, 1952), p. 15.

[4]Ibid., p. 16.

[5]Ibid., p. 17.

[6]"Great Yesterdays...," Saint Joseph Hospital Newsartery (January-February, 1967) p. 15.

[7]Ibid.

[8]Malcolm T. MacEachern, Hospital Organization and Management, (3rd ed; Chicago: Physicians' Record Company, 1951), pp. 125-126.

[9]Charles U. Letourneau, "Admissions and Discharges -- The Achilles Heel of Public Relations," Part I, Hospital Management, XLII (September, 1961), 36.

[10]Stephen Sandler, et al., Admitting Office Design (Ann Arbor: University Microfilms, Inc., 1965), pp. 6-8.

[11]Ruth Schowalter and Carol Zeedek, "Admissions: An R.N. Soothes the Way," Registered Nurse, XXX (August, 1968), 50-51.

[12]Irwin Staller, "Go to Bed First, Get 'Admitted' Later," Modern Hospital, XXXI (April, 1969), 68.

[13]Robert J. Pratt, "Combined Admittance-Discharge Procedure," Hospital Progress, XCII (June, 1961), 58.

[14]Robert M. Sloane, "The Admitting Department -- Nerve Center of the Hospital," Hospital Management, XLVII (March, 1964), 62.

[15]American Hospital Association, Manual of Admitting Practices and Procedures (Chicago: American Hospital Association, 1952), p. 14.

[16]Robert Smith, "Better Patient Care -- Through Electronics," Management Services, (May-June, 1968), 52-57.

[17]"Computer Cuts Discharge Time to 90 Seconds," Hospitals, XLI (December 16, 1967), 113.

[18]Charles Atha, Comptroller, Interview at Saint Joseph Hospital, Fort Worth, Texas, May 6, 1969.

CHAPTER II

DISCUSSION

General Information

The basic methods for accomplishing admitting and dismissal activities in hospitals are through centralized and decentralized systems. In a completely centralized system these activities are combined and the personnel who perform them have the same supervisor, duties, and facilities. In a completely decentralized system these activities are performed separately under different supervisors and normally in different locations. However, there are myriad modifications of these two systems. This study focuses on a search for the type of system or modification which will eliminate the inconveniences that a patient faces upon being admitted to or dismissed from Saint Joseph Hospital.

The Present System

The present admitting and dismissal activities are decentralized within the business office. The business office manager is assigned to the comptroller who reports directly to the hospital administrator (Appendix A). Admitting activities are supervised by the admitting officer and dismissal activities are supervised by the chief supervisor of the business office (Appendix B). The physical layout provides spaces for five private admitting offices. Three of the offices are used

primarily for admitting purposes. One is used as an office for the admitting officer and the other is used by the room reservation clerk. The cashiers perform the dismissal activities over a counter in the business office (Appendix C).

The admitting procedures begin with a request for a room reservation from the physician or the physician's representative, usually his nurse. The request is normally made over the telephone. However, some physicians report to the room reservation office and make the request in person, especially if special considerations will be required for the patient whom the physician is seeking to admit.

A telephone interview preadmission system is used primarily to obtain information on patients prior to their arrival at the hospital. In some cases, enough information to constitute a preadmission can be obtained from information cards on previous patient visits which are filed in the admitting office complex. A three-week study of the preadmission activities revealed that they were approximately 28 per cent effective. The liberal policy of the administration toward short-notice admissions by the medical staff appeared to hamper the effectiveness of the preadmission system since members of the medical staff were allowed to admit patients without restrictions on the number of patients or the time of admissions. The impact of this liberal admission policy was also shown in the study referred to above where it was revealed that approximately 62 per cent of the patients were admitted to the hospital within twenty-four hours after the physician made the reservation.

Other observations of the preadmission activities revealed that it took approximately five minutes to conduct a telephone interview with a

prospective patient. Preadmission calls were normally made between 7:00 P.M. and 9:00 P.M. On some nights, especially Monday and Tuesday, the admitting clerks were too busy performing office tasks to place any calls.

An analysis of the admitting activities for a three-week period revealed that the peak workload for admitting activities occurred on Monday and Tuesday between the hours of 1:00 P.M. and 4:00 P.M. During the peak admitting periods, the average time required to admit a pre-admission patient was nine minutes, whereas it took an average of fourteen minutes to admit a regular patient. These statistics bear a close relationship to the statistical results of a time and motion study on admitting activities conducted at Saint Joseph Hospital by an industrial engineer from Harris Methodist Hospital in Fort Worth.[1] It is necessary to point out that admitting time is a function of many variables. Three important variables that this writer observed are the number of insurance policies that a patient may have, the number of consent forms that must be signed, and the capacity of the patient to understand the admitting procedures. Also, it appeared that the lack of a patient information booklet caused an increase in the number of questions that patients asked upon admission.

Dismissal activities are initiated when the patient or his representative presents himself at the cashier window for the discharge process. In rare cases, a cashier will be required to go to the ward to dismiss the patient. An analysis of the dismissal activities for a three-week period revealed that the peak workload occurred on Friday and Saturday between the hours of 9:00 A.M. and 1:00 P.M. The average time

required to dismiss a patient during the peak dismissal period was 5.5 minutes plus an average waiting time of 2.1 minutes.

The analysis of the admitting and dismissal activities for the three-week period reflected the same basic patterns as those found in the majority of hospitals.[2] The days of heaviest admitting workload were the lightest for dismissals and vice versa with the exception of midweek when the input and output of patients were nearly equal. Distributions of the daily and weekly admitting and dismissal workloads are shown in Tables 1 and 2, respectively.

Table 1

Admitting Workload March 23 - April 12, 1969

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Total
1st Week	48	75	59	43	45	32	26	328
2nd Week	44	56	63	46	44	44	19	316
3rd Week	44	61	48	49	55	36	14	307
Total	136	192	170	138	144	112	59	
Average	45	64	57	46	48	27	20	

NOTE: These figures do not include the registration of outpatients on their initial visit.

Referred outpatients are processed through the admitting office upon their initial visit to the hospital but the numbers are not reflected in the workload distribution in Table 1. Hospital statistics did not show an adequate breakdown of the workload imposed upon the admitting office

Table 2

Dismissal Workload March 23 - April 12, 1969

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Total
1st Week	32	29	37	44	50	61	70	323
2nd Week	28	32	41	50	46	63	52	312
3rd Week	26	29	42	52	49	50	59	307
Total	86	90	120	146	145	174	181	
Average	28	30	40	48	48	58	60	

NOTE: These figures do not include outpatient transactions.

by outpatients. From 3:00 P.M. to 11:00 P.M., patients who come to the emergency room are processed by an emergency room admitting clerk. At all other times, emergency room patients are processed by personnel from the admitting office.

Nineteen full-time and three part-time personnel are authorized to operate the present admitting and dismissal system. A breakdown by job position and man-hours appears in Table 3.

The formal training given to admitting clerks and cashiers is relatively brief. Upon employment, the admitting officer gives the admitting clerks a briefing on hospital policies and admitting procedures, an overview of the admitting documents, and approximately one week of on-the-job training under supervision. The training for cashiers consists primarily of approximately two weeks of on-the-job training.

A major advantage of the present decentralized system is the zero turnover rate among the cashiers for the past one and one-half years.

Table 3

Personnel Summary for the Decentralized System

Position	Full Time	Part Time	Total Manhours per Week
Admitting Officer*	1		40
Evening Supervisor	1		40
Reservation Clerks	3		120
Admitting Clerks	6	2	280
Head Cashier	1		40
Cashiers	4	1	176
Addressograph Operators	3	—	120
Total	19	3	816

*A Catholic Sister assists the Admitting Officer on a limited part time basis.
Source: Personnel Office records.

This rate contrasts markedly with the turnover rate for admitting clerks (Table 4). A partial explanation for the zero turnover rate is the favorable working hours enjoyed by the cashiers. Generally, the cashiers work from 8:00 A.M. to 4:30 P.M. and the brunt of the weekend work is borne by part-time help. Admitting clerks, on the other hand, work on shifts that are quite irregular. In many cases, they are hired for one shift and then moved to another and they may work as many as ten days straight before they can get a day off.[3]

A major disadvantage of the present decentralized system is the lack of privacy for patients when they report to the cashier's window to settle their accounts. Patients are sensitive about having to discuss their personal financial matters in the presence of others. Additionally, the queues impede traffic in the main lobby.

Table 4

Personnel Turnover Figures*

Position	1969 to Date	1968
Business Office	10.0	53.8
Cashiers (Part Time-Full Time)	0.0	0.0
Admitting Office	30.8	61.5
Admitting Clerks (Full Time)	33.3	50.0
Admitting Clerks (Part Time)	100.0	100.0

*Figures expressed in percentages.
Source: Personnel Office records.

Closely aligned to the preceding disadvantage is the fact that the private rooms used for admitting interviews are not utilized fully during the morning hours. Admitting clerks perform miscellaneous admitting-related activities until a patient arrives to be processed as an inpatient or as an outpatient. In this respect, the hospital does not appear to be making maximum utilization of the private rooms.

Centralized System

Under a centralized system the admitting and dismissal activities would be placed under one supervisor. Since the admitting officer is required to know both activities, she would be a logical choice for the title of admitting-dismissal officer. Separate admitting clerks and cashiers would be replaced by admitting-dismissal clerks who would be able to perform both functions. Other specific job titles would include room reservation clerk, addressograph operator, patient coordinator, and cashier. The room reservation clerk would take the reservations, make

room assignments, handle transfers of patients, and perform admitting-related duties. Addressograph operators would be used on two shifts to stamp the required plates and forms. The patient coordinator would greet the patients and visitors, direct them to the proper party, and coordinate the flow of patients in and out of the admitting-dismissal offices. The cashier would be responsible for taking money collected by admitting-dismissal clerks from patients. The proposed reorganization is shown in Appendix D.

The private admitting offices shown in Appendix C would serve both for admitting and dismissal interviews. To determine if conflicts would arise from the use of the private admitting offices for both purposes, a study was made of the hourly workload patterns of these activities by the day and by the week (Appendix E). The study revealed that the peak workload periods for admissions and dismissals did not overlap greatly. Despite a small amount of overlap of admissions in the morning and dismissals in the afternoon it appeared that the same offices could accommodate both activities. Conflicts, if they did arise, could be resolved by the patient coordinator.

As mentioned in the discussion of the present system, three of the five private admitting offices were available for full-time use and one for part-time use. To determine the net effect of operating five offices on a full-time basis, the simulation method of solving queuing problems was used. Prior to the use of the simulation method, a study was conducted to determine the average amount of waiting and service time for patients being admitted during the peak period of the heaviest day of

the week for admissions. Since the admitting activities would consume the greatest amount of time, only the peak admitting workload periods were considered in determining the number of offices required to handle the workload. The study revealed that the average waiting time was fourteen minutes and the average service time was thirteen minutes. The application of the simulation method revealed that if five offices had been operated full-time on that date, the average waiting time would have been reduced to eighteen seconds or one patient would have waited six minutes. The service time, of course, was assumed to remain the same. The raw data for this study is shown in Appendix F.

The full-time use of the existing five admitting offices could be obtained by relocating the offices of the admitting officer and the room reservation clerk to those presently occupied by the business office manager and the business office supervisor. The proposed relocations of the admitting officer and the reservation clerk would place both of their offices in juxtaposition to the admitting offices. The proposed relocation of the business office manager and the business office supervisor would still provide a sound functional arrangement for the business office complex. The two rooms that they would occupy are being used as temporary storage locations for data processing equipment and an x-ray machine. By eliminating the cashier windows in the business office, storage space could be made available for computer printouts which are presently being stacked in the office of the business office supervisor. The relocations described above are shown in Appendix G.

As a part of their job requirements, admitting clerks are expected to know the procedures for dismissing a patient as well as admitting one (Appendix H). Cashiers, on the other hand, are expected only to know the dismissal procedures (Appendix I). To portray the amount of overlap in the knowledge and skills of both admitting clerks and cashiers, knowledge and skill matrices were constructed (Appendixes J and K). The purpose of constructing the matrices was to determine the additional knowledge and skills that would be required for cashiers to perform as admitting clerks. The matrices revealed that cashiers would be required to learn admitting procedures, medical terminology, admitting diagnoses, and the rules and regulations that apply to the members of the medical staff. Additionally, cashiers would be required to develop skills in typing and in the operation of the addressograph equipment (Appendixes J and K).

The personnel that would be required to operate this system are shown in Table 5. It shows that personnel would be needed to work 936 man-hours per week. This represents 120 man-hours over the number authorized for the present system. Initially, it may appear paradoxical to design a system which requires more personnel to operate it when one of the goals of this study is to obtain optimum utilization of the present personnel. However, the authorized man-hours per week for the admitting office have not changed significantly during the past three years despite almost a twofold increase in the number of beds. Since 1966, the hospital has added 204 beds. However, only thirty-two man-hours per week have been added to the admitting office authorization. During the same period the authorization for cashiers was increased by only eight man-hours per week.

Table 5

Proposed Personnel Summary

Position	Day Shift		Evening Shift		Night Shift		Total
	FT	PT	FT	PT	FT	PT	
Admitting Officer	1						40
Evening Supervisor			1[a]				40
Reservation Clerks	1				1	1	96
Admitting-Dismissal Clerks	5	5	3	3	1	1	504
Emergency Room Admitting Clerk			1				40
Cashier	1	1					56
Addressograph Operators	1		1				80
Patient Coordinators	2	—	—	—	—	—	80
Total	11	6	6	3	2	2	
Man-hours	440	96[b]	240	48[b]	80	32[b]	936

[a] Functions as reservation clerk.

[b] Any combination of full-time or part-time workers can be used to account for this number of man-hours. Part-time hours are provided to staff the positions seven days a week.

Additionally, two other events which occurred in 1967 increased the workload of the admitting office. First, the implementation of an automatic data processing program (software) for patient accounting has not reduced the workload of the admitting office as originally anticipated by the administration. Admitting office personnel are required to code the financial information sheet, to add self-check numbers to the patient's folder, and to go to the wards for sequence numbers on emergency patients who were assigned beds without going through the admitting office. On the other hand, it has reduced the workload of the cashiers considerably.

With a daily printout of updated patient accounts, cashiers have less calculations to make when the patient's bill is totaled. The biggest impact has been on the workload of the head cashier. She is required to code the information sheet which serves as input into the data processing office (keypunch operation). Second, the installation of a Sequential Multiple Analyzer in the laboratory has made a substantial contribution to the increased workload of the admitting office. Since laboratory tests can be run much faster on this machine than by conventional methods, numerous physicians have referred their patients to Saint Joseph for laboratory tests. As mentioned previously, outpatients are registered in the admitting office on their initial visit to the hospital.

The need for additional personnel is also revealed by comparing the number of man-hours budgeted and the number filled in the admitting office. Business office records indicate that in 1968 a total of 24,000 man-hours were budgeted and a total of 26,856.25 man-hours were filled. The excess is equivalent to one full-time employee working forty hours a week and one part-time employee working approximately sixteen hours a week. As of April 20, 1969, a total of 8,640 man-hours were budgeted and 9,692 were filled. The percentage of excess is approximately the same as for 1968.[4]

Efforts to correlate the number of personnel required to operate centralized and decentralized admitting and dismissal systems were essentially fruitless. Interviews with the supervisors of admitting and dismissal activities in seven hospitals in San Antonio, Dallas, and Fort Worth revealed that there is no universal set of duties performed by admitting

clerks and cashiers under each system. For example, in a number of hospitals which utilized a decentralized system, admitting clerks were not required to operate the addressograph equipment. In others, they were required not only to operate the addressograph equipment but also to call preadmissions, to verify insurance, and to perform numerous other miscellaneous tasks as well. Cashiers, on the other hand, only made collections from patients in some hospitals. In others, they were required to do posting, filing, insurance verification, and other tasks assigned by the business office supervisor. The duties of the admitting-dismissal clerks in hospitals which utilized the centralized system were equally as variable.

A major advantage of this system is that dismissal interviews would be conducted in private rooms and the unpleasant practice of standing at the cashier's window would be eliminated.

A second advantage of the centralized approach is that one person would be familiar with all of the aspects of the patient's financial relationship with the hospital. A hospital-patient relationship which fosters mutual understanding and cooperation could be promoted if the hospital would strive to have all of the patient's financial transactions handled by one person. In this respect, special efforts would be required to insure that the clerk who admitted the patient was the same one who dismissed him. It is in this endeavor that the important role of the patient coordinator would be manifested. However, it would be incumbent upon the hospital to devise a system for determining projected dismissals as early as possible. This system would greatly facilitate the establishment of a one-to-one arrangement between the patient and the business

office. The ramifications involved in establishing a system of this type are not being included in the scope of this study.

Another advantage lies in the personnel flexibility that a centralized system could provide. Since the peak workloads for admissions and dismissals occur at different times, one office is overwhelmed with work while the other is relatively free except for the performance of miscellaneous tasks. With a larger manpower pool capable of performing both activities, a higher degree of flexibility would be provided in adjusting to the demands of peak periods for either admissions or dismissals.

The primary disadvantages of this system would be the additional personnel required to operate it, the reorganization of personnel within the business office, and the costs involved in relocating the offices.

The retraining that would be required for cashiers to perform the admitting activities can also be considered as a disadvantage. None of the presently employed cashiers can type and this writer detected a slightly negative attitude on their part toward the thought of having to develop typing skills. As pointed out in the discussion of the present system, there has been an extremely low turnover rate among the cashiers during the previous one and one-half years whereas the turnover rate for admitting clerks has been quite high. The cashiers indicated that they would not like to change their regular shifts for the irregular shifts that are common for admitting clerks. The cashiers gave the impression that they would prefer to seek employment where they could work on regular shifts, preferably from 8:00 A.M. to 4:00 P.M.[5]

Modified Decentralized System

A modified decentralized system would require three changes in the present system. First, the cashiers would use the private admitting offices for conducting dismissal interviews. Second, the physical rearrangement of offices recommended for the centralized system would be implemented (Appendix G). Third, the position of patient coordinator would be established.

Since the peak workload periods for admissions and dismissals do not overlap greatly as shown in Appendix E, both activities could be performed in the same admitting-dismissal offices if five offices could be made available for full-time use. To provide the required number, four offices within the business office complex would have to be relocated. The present and proposed locations of these offices are shown in Appendixes C and G respectively.

The same rationale for increasing the man-hour authorization for the centralized system would serve as a basis for increasing the number of man-hours authorized for this system. With an increase in the number of authorized man-hours for the admitting office, the position of patient coordinator could be established and additional admitting clerks could be hired on a full- or part-time basis. Additional personnel in the admitting office might create more time for the admitting officer to devote to supervision and training. Observations of the present system revealed that the admitting officer spent a large amount of her time as an admitting clerk. Also, through effective scheduling, additional man-hours could be devoted to calling preadmissions.

The key to the modified decentralized system would be the addition of a patient coordinator to the admitting office staff who would regulate the traffic in and out of the private offices. The patient coordinator would determine the order in which patients would be registered by the admitting-dismissal clerks. It appears that two patient coordinators would be needed to perform these duties effectively. Since the bulk of the admitting and dismissal workload occurs between 9:00 A.M. and 5:00 P.M., one patient coordinator should work from 8:00 A.M. to 4:30 P.M., the other from 9:00 A.M. to 5:30 P.M. Patient coordinators could also be used to perform patient escort duties and admitting-related activities. A proposed job description is shown in Appendix L.

Courtesy dismissals have been innovated in some hospitals.[6] In these hospitals, patients are given a credit rating which can normally be determined within the first few days of a patient's stay at the hospital. Patients who receive favorable credit ratings can be granted "courtesy dismissals." This means that when a doctor discharges a patient, he can be dismissed without being required to clear through the business office. It would appear that the granting of courtesy dismissals would reduce the dismissal workload and enhance public relations greatly. However, the requirements for implementation of courtesy dismissals involve more business office personnel than those involved in admitting and dismissing patients and will not be covered in this study.

A great amount of workload flexibility is provided in the modified decentralized approach. For example, if the admitting offices are tied up with admitting activities in the morning, the patient coordinator can direct the dismissals to the cashier windows. Instead of having the

patients wait in line, they can be ushered to seats in the waiting room. As one patient completed his transaction at the cashier window, another would be ushered to the vacant cashier window. Even in this situation, the patient would not be required to stand in line while waiting to undergo the dismissal process. The same arrangements could be made in the afternoon if the admitting offices were tied up.

Other advantages of this modified decentralized approach would include increased privacy by using the private rooms for admitting and dismissal interviews, the elimination of queues in the main lobby, and the attainment of a maximum utilization of facilities. Additionally, no organizational changes would be necessary and no retraining would be required for the cashiers.

The major disadvantages of this system would be the high degree of coordination that would be required in the use of the same offices for both admitting and dismissal activities and the cost involved in relocating the offices.

Summary

The present system and two alternative systems for accomplishing admitting and dismissal activities have been discussed. The present system is decentralized and its shortcomings have formed the basis for this study. The decentralized system as it is presently operated does not provide privacy for patients during the dismissal process and requires them to line up at the cashier windows in the main lobby.

Under the proposed centralized system, all personnel who perform activities related directly to admissions and dismissals would be assigned

to the admitting-dismissal officer. The advantages of this system are: (1) admitting and dismissal interviews would be conducted in private rooms; (2) the unpleasant practice of standing at the cashier's window would be eliminated; (3) the same clerk could admit and dismiss the patient; (4) increased personnel flexibility would be provided. The disadvantages are: (1) additional personnel would be required to operate the system; (2) the business office would have to be reorganized; (3) costs would be incurred in relocating the offices; (4) cashiers would require retraining in the duties of admitting clerks.

The modified decentralized system would require that private rooms presently used exclusively for admitting purposes also be used by cashiers when dismissing patients. The advantages of this system are: (1) increased workload flexibility would be provided; (2) admitting and dismissal interviews would be conducted in private rooms; (3) queues in the main lobby would be eliminated; (4) maximum utilization of business office facilities would be attained; (5) no organization changes would be necessary; (6) no major changes in the duties of personnel presently employed would be required for implementation. The disadvantages are the high degree of coordination required to use the rooms for dual purposes and the cost involved in relocating the offices.

Footnotes

[1]W. G. Rivers, Industrial Engineer, Interview at Saint Joseph Hospital, Fort Worth, Texas, February 27, 1969.

[2]Robert J. Pratt, "Combined Admittance-Discharge Procedure," Hospital Progress, XCII (June, 1961), 58.

[3]Lindley Pickard, Personnel Officer, Interview at Saint Joseph Hospital, Fort Worth, Texas, May 7, 1969.

[4]Charles Koldin, Business Office Manager, Interview at Saint Joseph Hospital, Fort Worth, Texas, April 30, 1969.

[5]Edna Hicks, Business Office Supervisor, Interview at Saint Joseph Hospital, Fort Worth, Texas, April 28, 1969.

[6]Gary Silvers, "Helping the Patient Through the Business Office Jungle," Hospital Accounting, XXI (January, 1967), 16.

CHAPTER III

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

At this time, the best system for accomplishing admitting and dismissal activities within the business office at Saint Joseph Hospital, Fort Worth, Texas, is the modified decentralized system. The implementation of this system could serve as a prelude to a centralized system if the hospital wished to realize the added benefits of centralization.

Recommendations

To implement the modified decentralized system, the following recommendations are made:

1. The offices within the business office complex should be relocated as specified in Appendix G.

2. The position of patient coordinator should be established and a patient coordinator booth should be constructed in the main lobby as indicated in Appendix G.

3. The admitting office should be authorized an additional 120 man-hours per week to permit the hiring of two full-time patient coordinators and one admitting clerk.

To implement the centralized system, the following two-step procedure is recommended:

1. Implementing the modified decentralized system as recommended.

2. Evaluating the modified decentralized system after a six-month period and making the necessary personnel adjustments.

To improve the overall admitting and dismissal activities, a patient information booklet should be published and distributed to all physicians who admit patients to the hospital. The physicians should be encouraged to give the booklets to patients for whom room reservations have been made at the hospital.

Recommendations for Further Study

Studies should be made:

1. Of the hospital admission policy and its impact on the preadmission system.

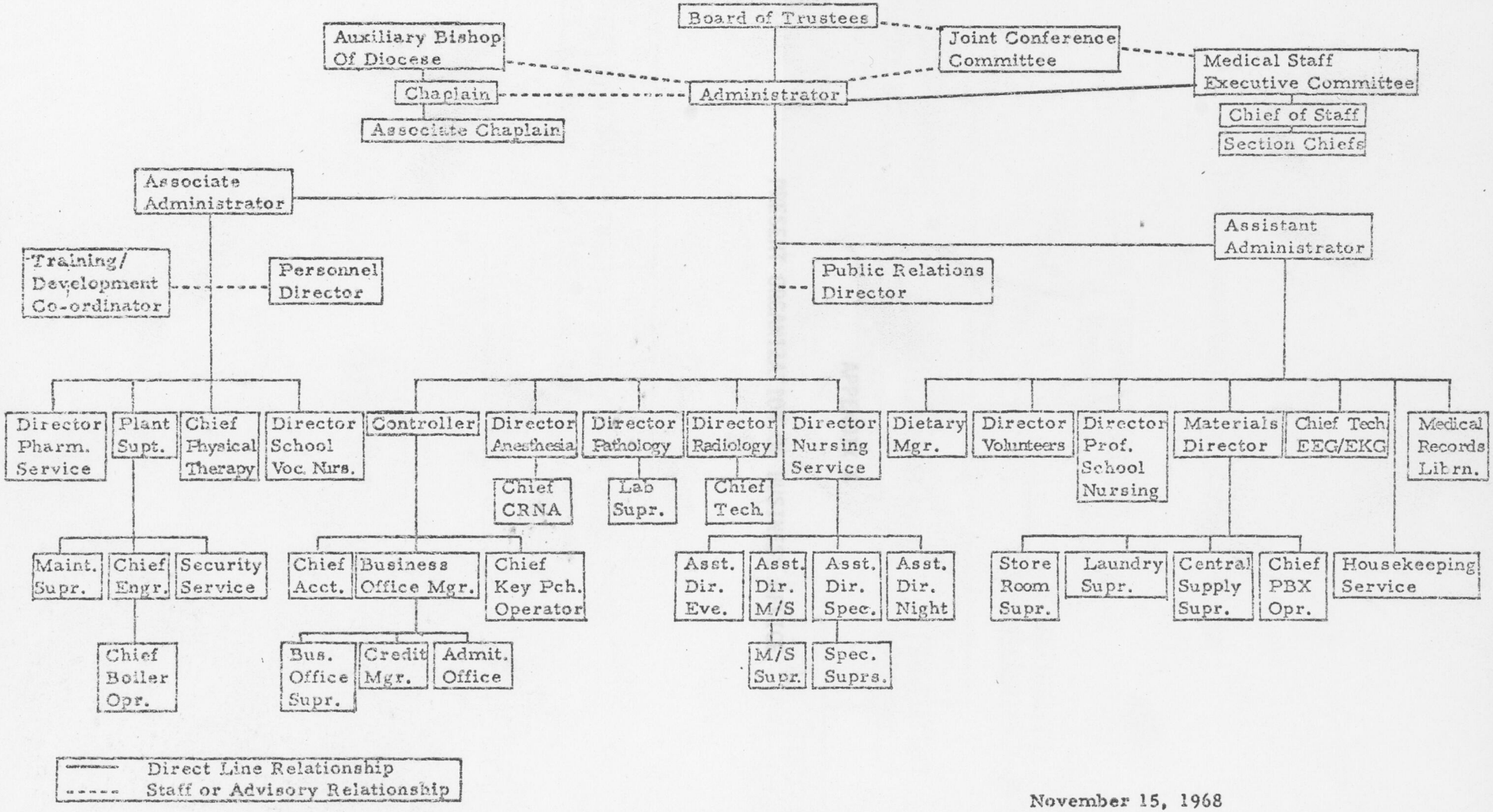
2. Of the feasibility of granting courtesy dismissals to selected patients. Courtesy dismissals would reduce the dismissal workload markedly and enhance public relations immeasurably.

APPENDIX A

HOSPITAL ORGANIZATION CHART

ORGANIZATIONAL CHART

SAINT JOSEPH HOSPITAL
Fort Worth, Texas



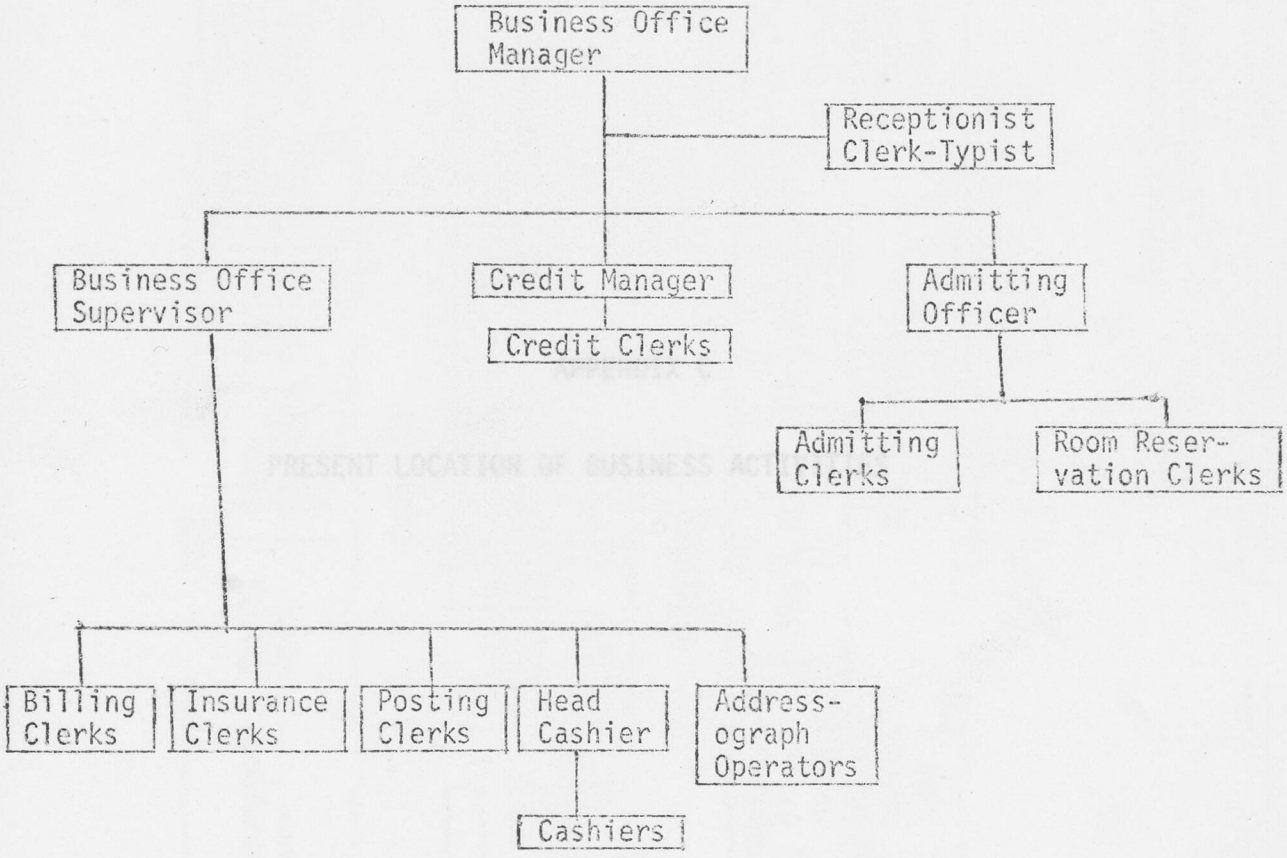
Direct Line Relationship
----- Staff or Advisory Relationship

November 15, 1968

APPENDIX B

PRESENT ORGANIZATION OF BUSINESS OFFICE

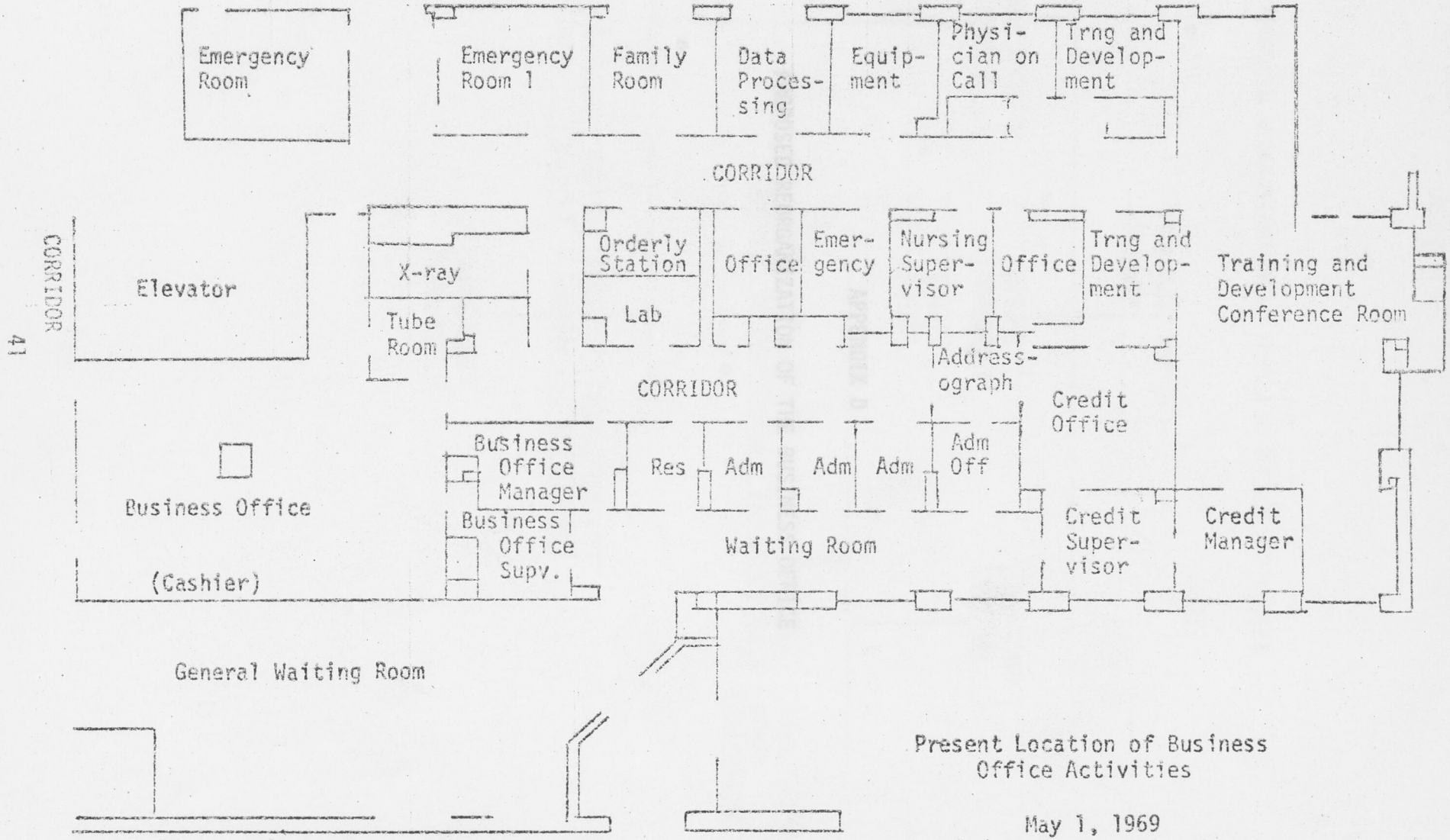
PRESENT ORGANIZATION OF BUSINESS OFFICE



May 1, 1969

APPENDIX C

PRESENT LOCATION OF BUSINESS ACTIVITIES



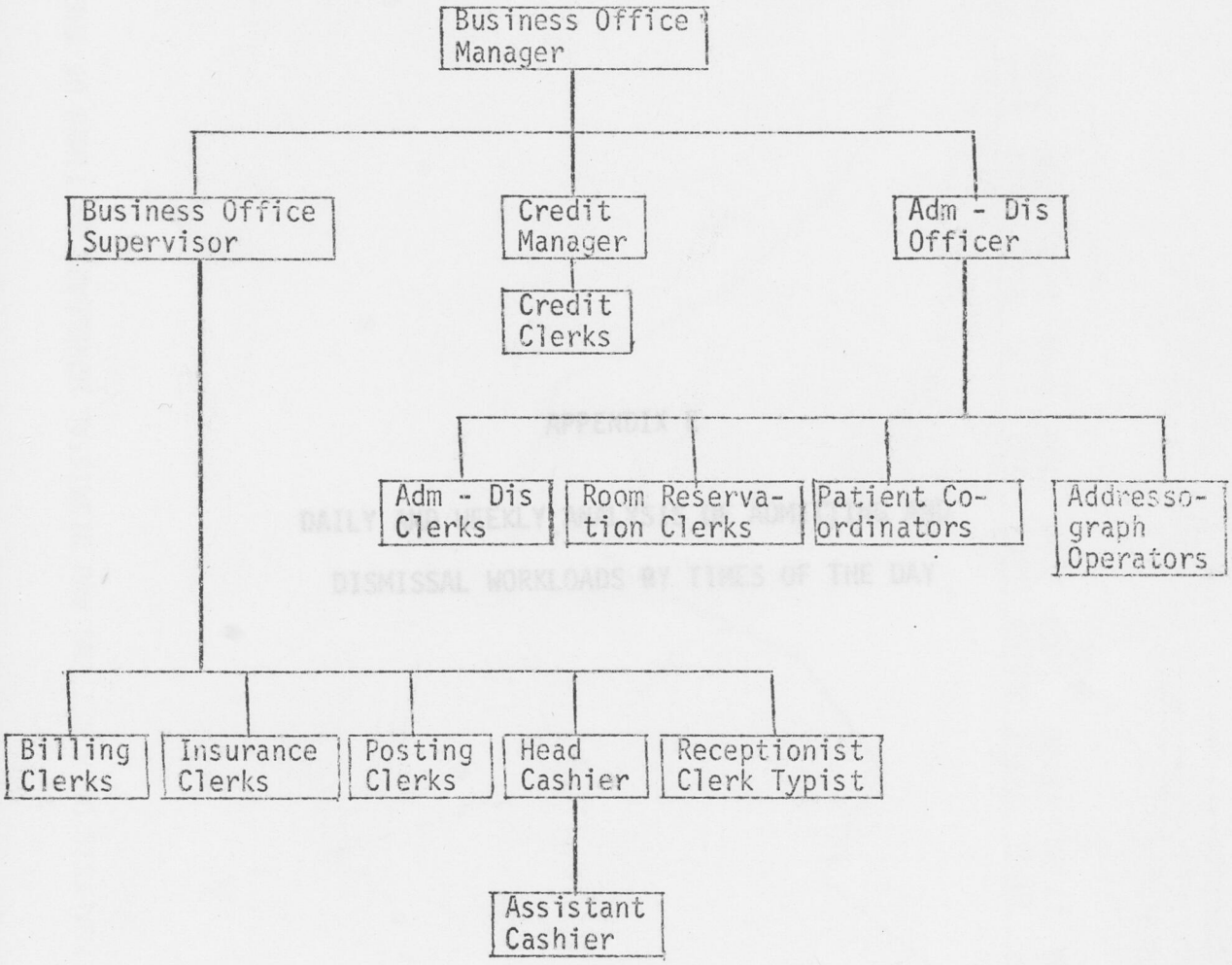
Present Location of Business Office Activities

May 1, 1969

APPENDIX D

PROPOSED REORGANIZATION OF THE BUSINESS OFFICE

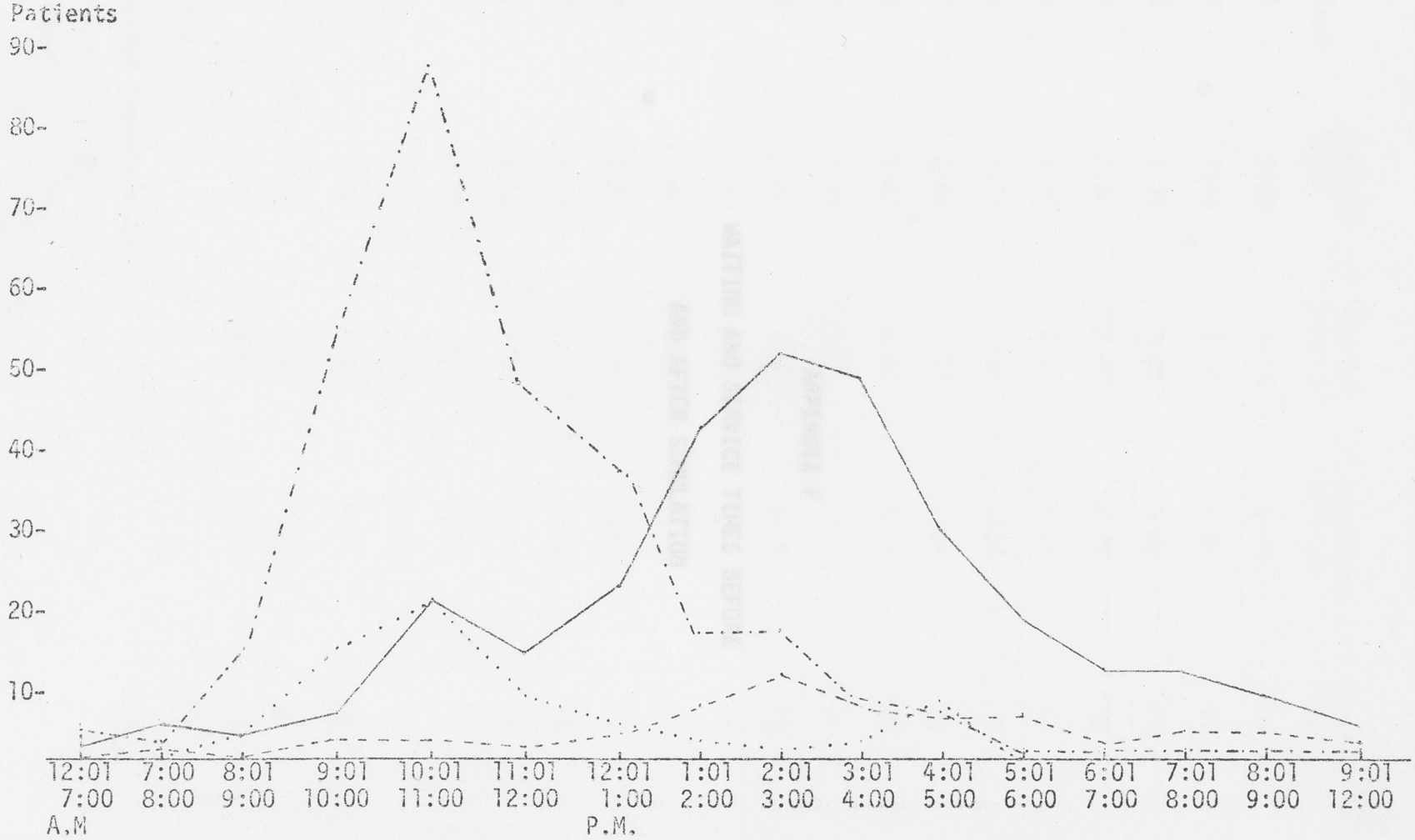
PROPOSED REORGANIZATION OF BUSINESS OFFICE ACTIVITIES



APPENDIX E

DAILY AND WEEKLY ANALYSIS OF ADMITTING AND DISMISSAL WORKLOADS BY TIMES OF THE DAY

DAILY AND WEEKLY ANALYSIS OF ADMITTING AND DISMISSAL WORKLOADS BY TIMES OF THE DAY



Legend: Weekly Admitting Workload_____
Daily Admitting Workload----------
Weekly Dismissal Workload- - - - - - - -
Daily Dismissal Workload.....

APPENDIX F

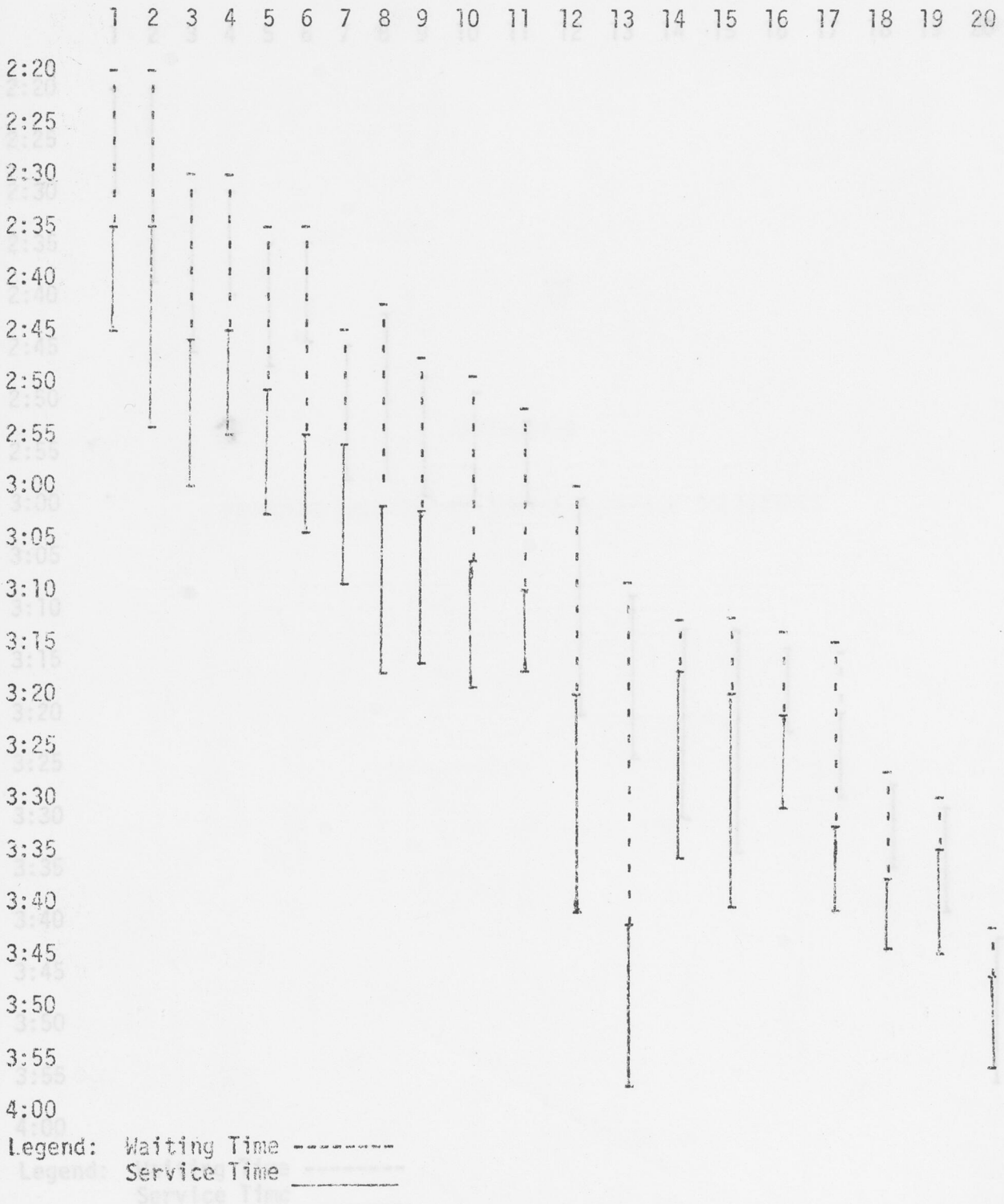
WAITING AND SERVICE TIMES BEFORE AND AFTER SIMULATION

Waiting and Service Times Before Simulation (Raw Data)

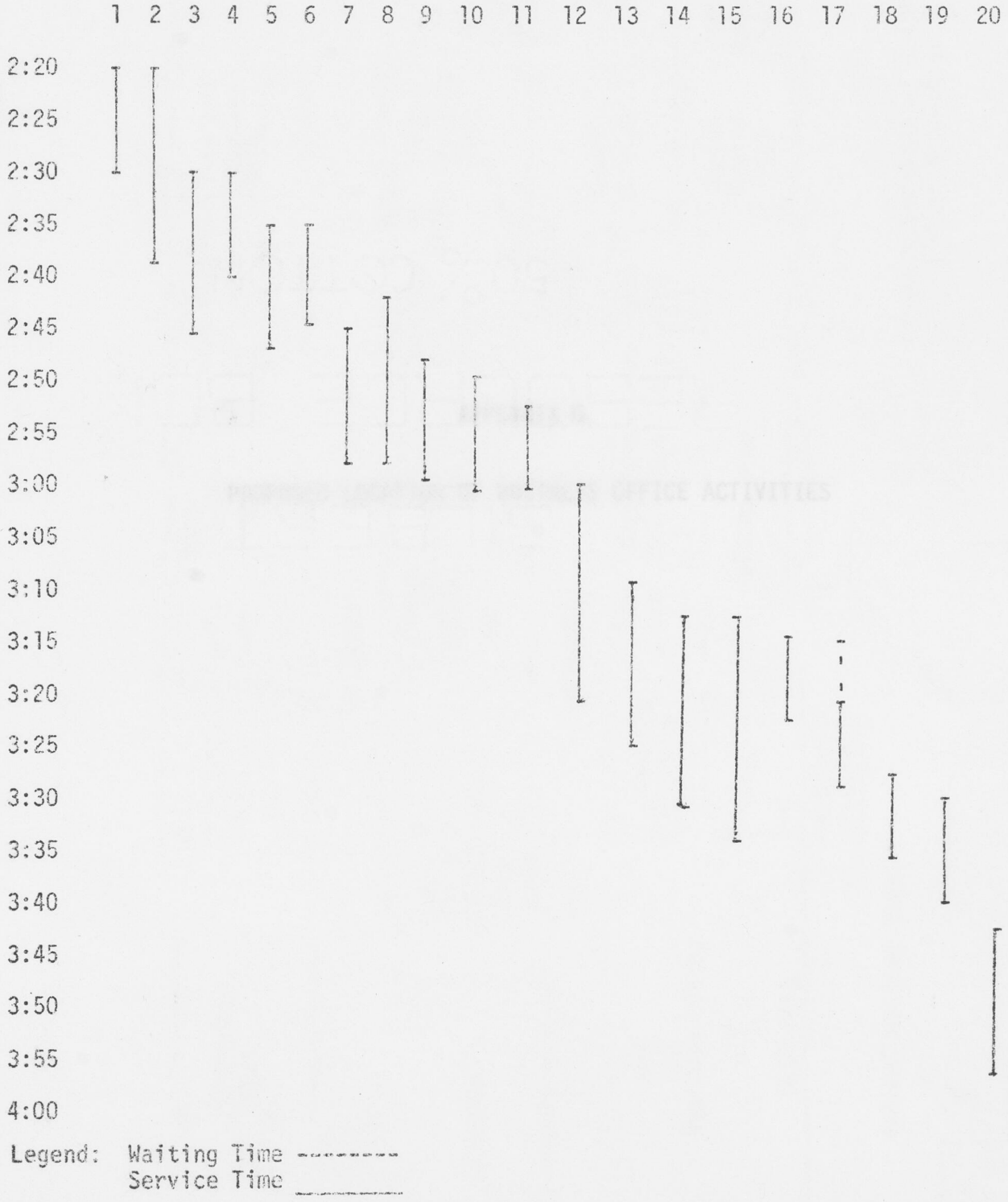
Patient	Arrival Time	Started Service	Completed Service	Service Time*	Waiting Time*
1	2:20	2:35	2:45	10	15
2	2:20	2:35	2:54	19	15
3	2:30	2:46	3:00	14	16
4	2:30	2:45	2:55	10	15
5	2:35	2:51	3:03	12	16
6	2:35	2:55	3:04	9	20
7	2:45	2:56	3:09	13	11
8	2:42	3:02	3:18	16	20
9	2:48	3:03	3:17	14	15
10	2:49	3:07	3:19	12	18
11	2:53	3:10	3:18	8	17
12	3:00	3:20	3:41	21	20
13	3:09	3:42	3:58	16	33
14	3:13	3:18	3:36	18	5
15	3:13	3:20	3:41	21	7
16	3:14	3:22	3:31	9	8
17	3:15	3:33	3:41	8	18
18	3:28	3:36	3:44	8	8
19	3:30	3:35	3:45	10	5
20	3:43	3:47	3:56	9	4
Total				257	286
Average (approximate)				13	14

* Minutes

Waiting and Service Times Before Simulation

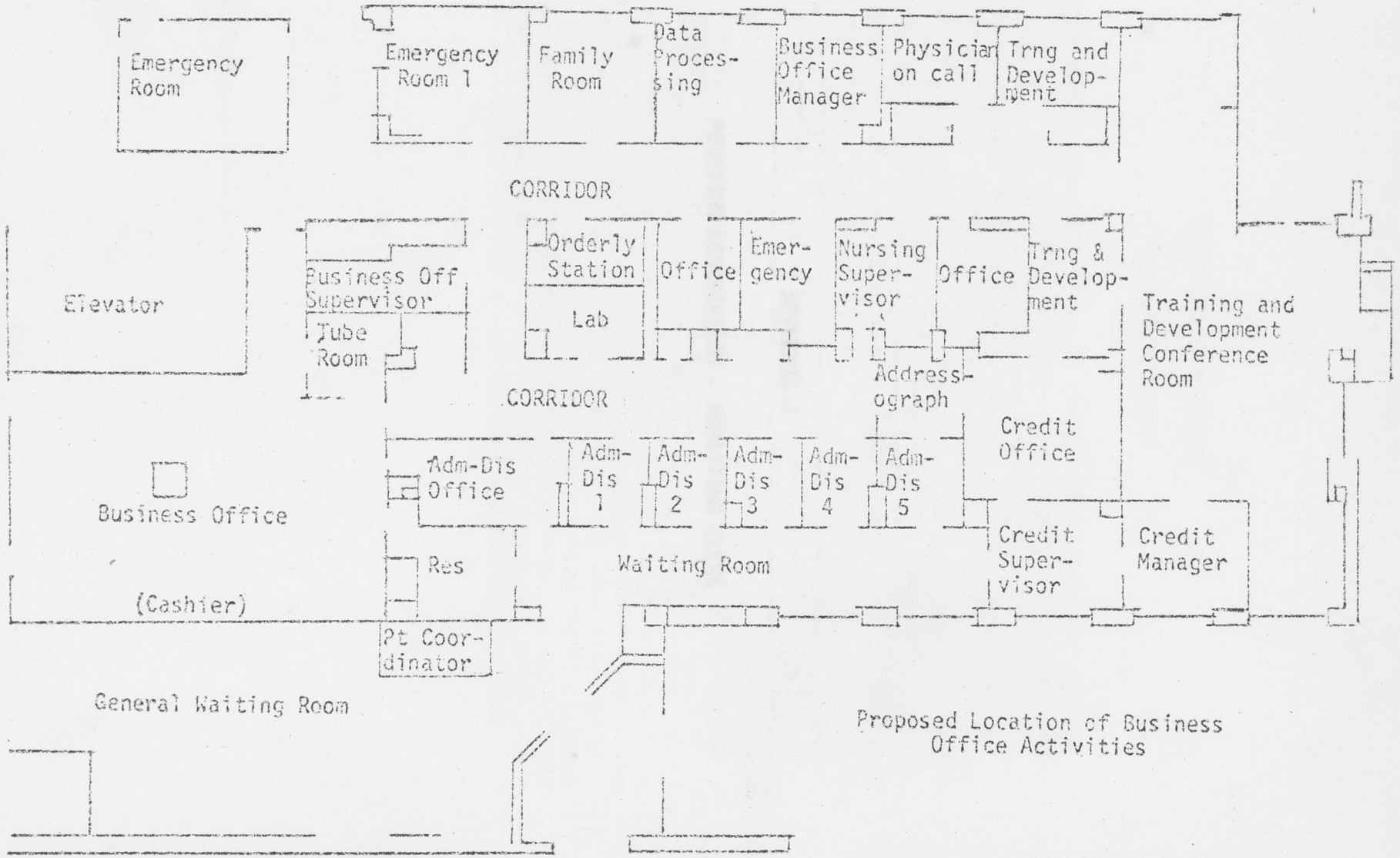


Waiting and Service Times After Simulation



APPENDIX G

PROPOSED LOCATION OF BUSINESS OFFICE ACTIVITIES


Emergency Room
Emergency Room 1
Family Room
Data Processing
Business Office Manager
Physician on call
Trng and Development
CORRIDOR
Elevator
Business Off Supervisor
Tube Room
Orderly Station
Lab
Office
Emergency
Nursing Supervisor
Office
Trng & Development
Training and Development Conference Room
CORRIDOR
Addressograph
Credit Office
Business Office
Adm-Dis Office
Adm-Dis 1
Adm-Dis 2
Adm-Dis 3
Adm-Dis 4
Adm-Dis 5
Credit Supervisor
Credit Manager
Res
Waiting Room
(Cashier)
Pt Coordinator
General Waiting Room
Proposed Location of Business Office Activities
CORRIDOR

APPENDIX H

POSITION DESCRIPTION - ADMITTING CLERK

POSITION DESCRIPTION

ADMITTING CLERK

Works under the direct supervision of the Admitting Officer. Admits patients promptly and courteously, determines insurance coverage and takes appropriate action for referral to the Credit Manager without causing embarrassment to the patient; goes to the room to obtain admitting information; escorts patients to their rooms; takes charts and addressograph plates to nursing stations and obtains necessary sequence numbers; performs relief duties for the Reservation Room Clerk while she goes to lunch and during unscheduled absences; performs Business Office functions which are delegated to the Admitting Office during the 24 hour period when the Business Office is closed; collects money, writes receipts and balances monies received; receives all overcalls by telephone from Reservation Desk taking reservations, inquiries; calls and accurately types pre-admissions to speed admitting procedure; preparation of Hospital Charts and Folders with extreme accuracy in adding the data number to each; answers inquiries from visitors both by phone and in person concerning location of patients; takes routine chest X-Ray of employee, and pre-employee; performs on-the-job training in this position; maintains the dismissal file; sees that the appearance of the Admitting Room and Lobby is clean and orderly; performs addressograph work in the absence of the addressograph operator; maintains the Desk File; occasionally will be required to relieve the Emergency Room Clerk; performs other tasks as may be assigned by the Admitting Officer; to participate with a democratic and cooperative spirit in fulfilling the primary objective of St. Joseph Hospital in maintaining and restoring health.

(Source: Personnel Office)

APPENDIX I

POSITION DESCRIPTION - CASHIER

POSITION DESCRIPTION

CASHIER

Under the moderately close supervision of the HEAD CASHIER and receives change fund from HEAD CASHIER and arranges change drawer; dismisses patients; receives payments from patients; explains charges and insurance and coverage at Cashiers' window and by telephone, to patients and public; pulls control ledgers for payments received by mail; files all control ledgers in alphabetical order in the Ledger Tub file; pulls control ledgers for refunds, change of status, and for collection agency payments; researches accounts; receives and delivers patients valuables; makes change for Departmental personnel, patients and visitors; removes monies from cash drawer, prepares tapes on receipts received, and balances receipt board with cash; makes Veri-Fax copies of bills for patients and prepares charge tickets for same; performs other tasks as directed by the SUPERVISOR.

Does this so that all revenue for Hospital services will be accurately accounted for, that payments may be posted to the proper accounts and that patients may have a clear understanding of their bills, promoting a cordial feeling in patient hospital relationship.

(Source: Personnel Office)

APPENDIX J

KNOWLEDGE MATRIX

Knowledge Matrix

Knowledge	Position							
	Adm Off	Evening Adm Supv	Night Sr Adm Clerk	Adm Clks	Res Clks	Emer Room Clk	Head Cash-ier	Cash-ier
Admitting procedures	x	x	x	x	x	x		
Dismissal procedures	x	x	x	x	x	x	x	x
Interdepartmental relationships	x	x	x	x	x	x	x	x
Capacity & convenience of rooms	x	x	x	x	x	x	x	x
Room prices	x	x	x	x	x	x	x	x
Medical terminology	x	x	x	x	x	x		
Admitting diagnoses	x	x	x	x	x	x		
Rules & regulations of medical staff	x	x	x	x	x	x		
Insurance coverage	x	x	x	x	x	x	x	x
Medicare information	x	x	x	x	x	x	x	x
Medicaid information	x	x	x	x	x	x	x	x

x indicates presence of knowledge

APPENDIX K

SKILL MATRIX

Skill Matrix

Skills	Position							
	Adm Off	Evening Adm Supv	Night Sr Adm Clerk	Adm Clks	Res Clks	Emer Room Clk	Head Cash-ier	Cash-ier
Interviewing	x	x	x	x	x	x	x	x
Typing	x	x	x	x	x	x		
Addressograph-graphotype operator	x	x	x	x	x	x		
Addressograph printer operator	x	x	x	x	x	x		
Adding machine operator	x	x	x	x	x	x	x	x
Verifax machine operator	x	x	x	x	x	x	x	x
Desk-fax (tele-graph) operator	x	x	x	x		x	x	x

x indicates presence of skill

APPENDIX L

PROPOSED POSITION DESCRIPTION

PATIENT COORDINATOR

PROPOSED POSITION DESCRIPTION

PATIENT COORDINATOR

Under the direct supervision of the admitting officer, the patient coordinator performs as a hostess for the hospital in greeting patients and visitors, directing each to the proper place, and acting as a coordinator for the flow of traffic in and out of the admitting-dismissal offices; maintains the patient coordinator booth and serves as a source of information for inquiries concerning patients; programs the use of the admitting and dismissal offices, resolves conflicts in the use of these offices, and refers to the admitting officer those conflicts not resolved; communicates with all departments of the hospital on information matters concerning patients; escorts patients to their rooms when hospital volunteers or orderlies are not available to perform this task; performs other tasks as assigned by the admitting officer.

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ABSTRACT

A STUDY OF THE ADMITTING AND DISMISSAL ACTIVITIES AS SAINT JOSEPH HOSPITAL, FORT WORTH, TEXAS.

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

By Major Charles Edwin Delane, MSC

August 1970 65 Pages

A copy of this document may be obtained on loan from the United States Army Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston, Texas.

A study was made to determine the best system for accomplishing admitting and dismissal activities within the business office at Saint Joseph Hospital in Fort Worth, Texas. Research methods included a review of the literature, unstructured interviews, quantitative techniques and personal observations. The present decentralized system and two alternative systems, centralized and modified decentralized, were discussed and the advantages and disadvantages of each were evaluated. The two alternative systems require private rooms for admitting and dismissal interviews. Since the peak admitting and dismissal workloads did not overlap greatly, it was determined that five private admitting-dismissal offices could accommodate both of these activities.

It was concluded that the modified decentralized system was best for Saint Joseph Hospital at the time of the study. The implementation of this system could serve as a prelude to a centralized system if the hospital wished to realize the added benefits of centralization. To implement the modified decentralized system, it was recommended that: (1) the business office complex be rearranged to provide five private offices for conducting admitting and dismissal interviews; (2) the position of patient coordinator be established; (3) two patient coordinators and one admitting clerk be added to the admitting office staff.