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A STUDY OF THE APPOINTMENT SYSTEM IN THE OUTPATIENT DEPARTMENT OF MARTIN ARMY HOSPITAL, FORT BENNING, GEORGIA

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CHAPTER I

INTRODUCTION

General Information

Visits by patients to outpatient clinics have increased significantly. This growth has, however, created problems in the clinics for those providing the services and for the patient himself. The military clinic system has proved to be no different than that of its civilian counterpart. For 150 years, the Army and Navy provided minimal care for dependents, and this mainly in isolated areas. In the 1930's, the trend to the provision of more medical care for military dependents began.[1] If anything, the number of patients visiting outpatient clinics in the military is larger than that visiting civilian outpatient clinics because of the accessibility, acceptability, and availability of clinics within the military medical system.

Increased patient visits necessitate more physicians, examining and treatment rooms, clerical personnel for record keeping, patient waiting areas, and efficiency. Efficiency in the clinics has received a large measure of attention; for, although it cannot reduce patient visits, it can create better conditions for both physicians and patients. An appointment system has been instituted in many clinics to provide a smooth and orderly flow of patients into the clinics. As P.H. Tatham

has stated:

> With an appointment system, one can organize the arrival of return patients to suit oneself and the known hours of loading. An appointment system is of use, only if it is easy to run, convenient for patients and staff, and tending to increase efficiency.[2]

The Robert B. Green County Hospital Outpatient Clinic in San Antonio, Texas, had found its waiting rooms and halls overflowing with patients. It thus proceeded to implement an appointment system. The system significantly reduced the number of waiting patients, thereby clearing the congestion in the clinics and reducing the amount of average waiting time per patient.[3] This is one example of what is occurring in clinics in the United States and abroad that are using the appointment system; efficiency has been proved.

Each clinic, however, determines the type of appointment system that best meets its needs. Consideration must be given to the type of services provided, the availability of physicians, the type of population being supported, the administrative help available, the kind and amount of medical care to be provided, the physical plant, and the convenience to patient, physician, and clerical personnel.

The Hospital Setting and History

The first permanent hospital at Fort Benning, Georgia, was opened on May 20, 1925. The patient load was of such a number that in 1941 a cantonment hospital was built across from the permanent hospital. During the 1940's a dispensary for dependents was located on the post, and an outpatient service

was located in Columbus, Georgia for those dependents living off post. In 1943 a total of 319,295 outpatients for 462,180 treatments had been cared for as compared to 58,174 outpatients and 119,756 treatments in 1939. The demands on the professional service had been greatly increased by the large number of dependents living on the post. After the war outpatient visits scaled downward, but once again climbed with the onset of the Korean War. In the early 1950's the medical care of dependents was the largest medical activity on the post. The number of physicians on duty after normal duty hours was increased in order to cope with the heavy load and to compensate for the size of the staff. Inpatient loads during this period decreased because of the emphasis on outpatient medical care designed to eliminate hospitalization in as many cases as possible.

Construction of a new 500-bed hospital was completed in 1958. From 1958 to 1968, there was a 205 per cent increase in outpatient services. The large number of outpatients necessitated the renovation of the old hospital as a central outpatient clinic complex with most of the clinics being housed in this building. Duplication of personnel and equipment was inevitable, and military and civilian personnel shortages have only compounded the problem. During 1968, night clinics and Saturday morning clinics were added to accommodate the demand for medical services.[4]

Conditions Which Prompted the Study

The large population served by the outpatient clinics of Martin Army Hospital, the lack of proper facilities, and a shortage of professional and administrative personnel have created

a situation in which complaints are imminent. The population has complained of the service provided by the central appointment desk. It is a common complaint by outpatients that the telephone of the central appointment desk is continually busy and that it is difficult to obtain an open line to make an appointment. Also, there is the complaint that oftentimes once the desk is reached, an appointment cannot be made because there are no appointments available. The complaints and the apparent justification to many of them led to the decision by the command of the hospital to request a study of the present appointment system.

Statement of the problem

The problem is to determine the best procedures to improve the functioning of the components of the appointment system for the outpatient department of Martin Army Hospital, Fort Benning, Georgia.

Objectives

The objectives of the study are:

1. To define the present appointment system for the outpatient clinics and determine its subsystems.

2. To analyze the total appointment system presently in use and to study the interactions among its component subsystems.

3. To make recommendations for greater efficiency in the existing system.

Criteria

The criteria for the study are:

1. The appointment system should be flexible

and responsive to changes in the hospital's ability to handle its prospective patient load.

2. The appointment system should adequately provide for new patients, emergency medical situations, and follow-up visits at some distance in the future.

3. There should be greater speed and ease in making appointments.

4. There should be a minimum of clerical work in making appointments and preparing clinic schedules.

5. Appointments at a certain date and time must be scheduled for each clinic with a mutual understanding between the patient and institution.

Assumptions

The assumptions for the study are:

1. Funds will be available to implement administrative recommendations as described.

2. Individual clinic requirements for appointment procedures will not be markedly changed.

3. The outpatient population will remain fairly constant.

Definitions

To facilitate the understanding of certain terms used in the study, the following definitions are provided:

A walk-in is an outpatient who requests to see a physician in a clinic without a prior appointment.

A no-show is an outpatient who has not reported for his scheduled appointment.

An expedite is an outpatient who appears in a clinic on a referral for immediate care without an appointment.

A follow-up is a descriptive term for a patient returning to a clinic whose medical progress is being followed.

A block-type appointment system is an appointment system in which more than one outpatient is scheduled for an appointment with a physician or clinic at a specified time.

A "floating" physician is a clinic physician who is scheduled to care for walk-in patients, rather than patients with appointments.

Research Methodology

Personal observations and interviews were primarily used in gathering data for the study. Clinics being serviced by the central appointment system and those not being serviced were observed for effectiveness of their respective appointment systems. The central appointment office was observed for its efficiency as it affected the appointment system. Personal interviews with clinic heads and administrative personnel were conducted to determine individual clinic requirements as they related to an appointment system and how these requirements were being met. Data was obtained from the management service division of the hospital for the study of outpatient clinic population loads. A survey of telephone calls received by the central appointments office was conducted over a period of four

days to make a determination of the types of calls received by that office. A review of the applicable literature was utilized as a guide for observations and interviews and for evaluation of the collected data.

Review of the Literature

The outpatient department in a hospital had for years been thought of as a step-child of the hospital or as bargain basement medicine.[5] However, as medical care became centralized in the hospital, the outpatient department gained importance. It is considered to be the solution for providing medical care to a growing population demanding more such care. However, as the outpatient department assumes a more significant role in the delivery of health care, attention has been directed to its shortcomings. Consequently, methods of providing a more effective allocation of resources as well as provisions for better patient service have been considered.[6] The outpatient department, however, has not been studied as a complete system by system analysts. There is little data available in this area when compared to that published on the specific functions of other parts of the hospital. Research that has been accomplished has been on the basic problems of the department: traffic flow, paperwork, communications, and patient waiting time.[7]

The appointment system in the outpatient department has proved to be the most effective regulating device for patient traffic. An appointment system is predictive and regulating. It schedules future actions and events and matches demands and

services so that medical care can be accomplished.[8]

An appointment system might be further classified by its characteristics. Thus the making of appointments in a block or on an individual basis giving an exact time for each patient are characteristics which are used to classify appointment systems. An appointment system may then be termed a block system or an individual appointment system. However, the appointment-making process can be a centralized or decentralized function. These characteristics can also be used to classify an appointment system as a central or decentralized appointment system. The decentralized system allows individual clinics to make appointments, whereas a central system establishes a central office to accomplish this function for all clinics. For purposes of this paper, the appointment system will be classified as central or decentralized.

The block and the individual appointment systems have garnered most of the research, for the implementation of these systems directly affects patient and physician waiting times and proper resource allocation. Studies of clinic waiting times are numerous, for it is in this area that the greatest problems arise. Associated with these studies are those concerned with the no-show rate. The central and decentralized appointment systems have received little attention by comparison.

Henry P. Doble, Jr., and Charles A. Holston in describing the central appointment systems in their clinics, provided an example of what is common in most "central" appointment systems,

that few central appointment systems in actuality function as such.[9] Most central appointment systems are in reality not centralized, for there are usually some clinics which maintain their own appointment-making function. The appointment system, as viewed from a total system aspect, is then a modified central appointments system composed of two subsystems, the central appointment system and the decentralized appointment system. Studies that are concerned with the "central" appointment system limit their scope to the appointment process at the central desk.

Doble's and Holston's studies of the central appointment system at Walter Reed Army Medical Center and the U.S. Naval Hospital, National Naval Medical Center, Bethesda, Maryland, respectively, provide good descriptions of such a system, to include its advantages and disadvantages. Doble relates that more calls for appointments were coming in than could be answered, that the methods and procedures for these calls were too slow, and that the clerks were answering calls which from one-third to one-half of the time were not for appointments. He stresses the need for considering the forms, personnel, and equipment involved in the central appointment system.[10] These studies provide information on the equipment and forms and on their utilization in the system. Circular desks, files, and equipment forms are described in detail. Other writers describe the use of a central appointment board with pre-punched cards for all appointments.[11]

As computers gain acceptance in hospitals, their use is

being extended to the appointment-making process. Isabel Paulson describes a centralized system at Fitzsimons General Hospital in which a clerk punches cards from information provided by the appointment clerks. These cards then provide a listing of patients in alphabetical order to the records section and a listing by appointment times to the clinics.[12] Leonard W. Cronkhite, Jr. describes the use of a computer system in which appointment clerks through the use of cathode ray tube units instantaneously receive information on available appointments for any given day in a clinic. These clerks then feed information to the computer memory of the selected appointment so that the clinic schedules are continually being updated.[13]

In all studies the importance of the clinics scheduling their operating hours was emphasized, for the appointment-making process cannot be effected without schedule information. Thus the importance of cooperation between components of the appointment system is of prime importance. Everyone affected by the system must be informed about it. Poor use of the system by the patient population will decrease the potential benefits it was designed to provide. An appointment system can only help all individuals involved in accomplishing their goals; it is not a substitute for human initiative and intelligence.[14]

FOOTNOTES

[1]Frank T. Norris, "The Changing Pattern of Outpatient Care," Military Medicine, CXXIX (March, 1964), 253-255.

[2]P.H. Tatham, "Experience With an Appointment System in a Casualty Department," Lancet, I (May 28, 1966), 102.

[3]"Outpatient Service Revamped," Texas Hospitals, XXIV (January 12, 1969), 12.

[4]Archives, Martin Army Hospital, Fort Benning, Georgia, 1969.

[5]Paul B. Hofman and John F. Rockart, "Implications of the No-Show Rate for Scheduling OPD Appointments," Hospital Progress, L (August, 1969), 35.

[6]Ibid.

[7]"Systems Analysis and Design of Outpatient Department Appointment and Information Systems," United Hospital Fund of New York, 1967, p.3 (pamphlet).

[8]Ibid., p.9.

[9]Charles A. Holston, "Central Appointment System for Outpatient Clinics," Hospital Management, CIV (October, 1967), 65-70; Henry P. Doble, Jr., "Streamlining Walter Reed's Central Appointment System," Hospital Topics, XLII (October, 1964), 41-46.

[10]Holston, 65-70.

[11]G.L. Deschambeau, "Central Appointment Board System Saves Time and Effort," Modern Hospital, CV (October, 1965), 48.

[12]Isabel S. Paulson, "A Mechanized Appointment System for Outpatient Clinics," Hospitals, IV (September 16, 1966), 80-83.

[13]Leonard W. Cronkhite, Jr., "Computer Brings Order to Clinic Scheduling System" Hospitals, XLIII (April 16, 1969), 55-57.

[14]"Systems Analysis and Design of Outpatient Department Appointment and Information Systems," p.22.

CHAPTER II

DISCUSSION

During the present fiscal year, the average number of daily clinic visits has ranged from 2,058 to 2,606, while the patient population has ranged from 84,126 to 101,308 (see Appendix A). Yearly visits to the clinics since 1965 have been in excess of 380,000 (see Appendix B). The specialized clinics also support personnel on referral from Fort Rucker, Alabama; Fort Stewart, Georgia; Robins Air Force Base, Georgia; Fort McPherson, Georgia; Fort McClellan, Alabama; Redstone Arsenal, Alabama; Atlanta General Depot, Georgia; and Eglin Air Force Base, Florida. A comparison of individual clinic patient-load histories reveals minor fluctuations, except for the General Outpatient Clinic which increased from 23,575 visits in 1965 to 55,112 visits in 1969 (see Appendix C).

The Present Appointment System

The total system

The appointment system in the outpatient department of Martin Army Hospital is a modified appointment system. It is composed of two subsystems, the central appointment subsystem and the decentralized appointment subsystem. The decentralized subsystem is in itself formed by the ten appointment subsystems

of the various clinics maintaining independent systems. This modified system has the advantage of combining the strengths of both the centralized and decentralized systems.

Clinics under the central appointments subsystem and serviced by the central appointments desk include: dermatology, general outpatient, gastroenterology, orthopedic, pediatric, podiatry, proctology, surgical, allergy, urology, cast, eye refractions, and well baby. Clinics maintaining separate, independent subsystems composing the decentralized appointment subsystem include: medical speciality; cardiology; ear, nose, and throat; ophthalmology; mental hygiene; neurology; obstetrics-gynecology; physical therapy; diabetic; and tuberculosis.

Because of the large patient population and the size of the hospital, outpatient clinics are located in two separate facilities. The gastroenterology; orthopedic; podiatry; proctology; surgical; urology; cast; medical speciality; cardiology; ear, nose, and throat; neurology; obstetrics-gynecology; and physical therapy clinics are located in the hospital. The other clinics are housed in the hospital annex which is located 2.5 miles from the hospital. These clinics include dermatology, general outpatient, pediatric, eye refractions, well baby, mental hygiene, diabetic, and tuberculosis. The central appointments desk is located on the third floor in the hospital annex, next to the office of the administrative chief, hospital clinics. The outpatient records section is located in the basement of the hospital annex.

The central appointment subsystem

The central appointment system allows a patient to combine requests for various clinic appointments in one call. As a result there is a reduction of telephone traffic into the hospital, since one call to the central desk replaces a series of calls to various clinics. However, the greatest advantage is in the administrative area, for the administrative functions are reduced in those clinics using the central appointment desk. Also, a fewer number of clerks in combination can do the work that would require a greater number of personnel if the work were decentralized. Clinic administrative functions are minimized, and the clinic personnel can devote more time to rendering patient care.[1] Appointment clerks in such a centralized setting are highly skilled in their job performance because appointment-making is not merely one of several duties, but their main duty. Duties of the clerks in a centralized office can also be standardized.

The central appointment subsystem is dependent upon the central appointments desk for its operation since the desk makes the appointments for all clinics within the subsystem. The central appointments desk was originally located in the clinic waiting area at the hospital. In 1968 it was moved to the hospital annex. The move was necessitated by the difficult working conditions in the former location. When it was located in the hospital, the desk accepted telephonic, written, and personal requests for appointments. It was determined, however, that the

appointments clerks were also functioning in an information clerk capacity and that the noisiness of the area and the personal requests for appointments, which often developed into long conversations, were not conducive to the proper functioning of the desk.[2] The appointments office in the hospital annex is in an isolated area that is designated as off-limits to all personnel who do not work in the office. Only telephonic and written requests for appointments are accepted. The clerical staff is comprised of one supervisor, GS-5; three clerks, GS-4; and one military clerk, E-3. A recent post-wide reduction in force necessitated the movement of two clerks; one was replaced by a GS-4 and the other by an E-3 WAC. The supervisor has been an appointments desk staff member for twelve years and the two clerks with tenure have worked in that capacity for four and eleven years.

The four clerks are seated about a round table, which has a "lazy-susan" type book shelf in the center. The shelf is separated into sections for the various clinics, and alphabetically for doctors within the clinics having appointments for specific physicians. There is a telephone for each clerk with a device to permit the placing of a line on hold or the transferring of a call to another clerk. Although there is only one telephone number for the central appointments desk, the line will accept four calls; a caller will receive a busy signal when the four lines are in use.

The supervisor is located at a separate desk, with two

phones. One phone is for outside calls that may have to be placed, and the other is for special incoming calls. The telephone number for incoming calls is given only to the clinics and the dispensaries desiring appointments, so that the patients desiring appointments use only the publicized number for the centralized appointments desk.

An appointment system must control imput. "Systems Analysis and Design of Outpatient Department Appointment and Information System," a pamphlet published by the United Hospital Fund of New York states:

> If OPD appointments are to be handled on a consistent basis and organized to permit the proper operation of other parts of the system, there must be clear-cut policies regarding who will be accepted, at what rate they will be accepted, and what priorities will govern conflicts in desired scheduling arrangements. The policies and priority rules must obviously be related to the objectives and mission of the OPD as a whole, and they must be communicated to and understood by everyone involved in scheduling appointments: physicians, clerks. . .[3]

Each of the clinics serviced by the central appointments desk provides the desk with schedules of the projected activities of the clinic. All clinics have prepared their schedules to include the days and hours that the clinic will be functioning, the appointment interval time, the types of patients to be seen, and the number of patients to be seen. Clinics which request that patients be booked only for date and time notify the desk of any adjustments to be made in the schedules if the number of physicians available will modify patient loads. Each clinic advises the desk of the number of weeks that it may be booked in advance.

Based on the information provided, the desk supervisor prepares schedules for each clinic. These schedules are then placed in the appropriate notebook on the rotating shelf. As calls are received by the clerks, the proper appointment book is retrieved from the shelf, and an appointment is made.

The policy of the outpatient department, with a few exceptions, is that appointments to other than general outpatient, pediatric, dermatology, well baby, and eye refractions clinics may be made only by referrals. Experience has, however, demonstrated that many patients do not in fact know what clinic they need to go to. Calls must therefore be screened to eliminate wasted appointments caused by patients making an appointment for the wrong clinic or by patients requesting a referral clinic appointment without a physician's referral.

Such screening procedures preclude wrong appointments. As an example, a patient requesting an appointment with a pediatrician will be asked how old the child is. This question eliminates many appointments to this clinic, for it has been noted that the appointment request in many cases was for an adult who thought a pediatrician was the type of doctor he was to see for his particular problem. Further questioning will determine what clinic is to see the patient. An appointment for a child with the pediatric clinic may be made when, indeed, it is the optometry clinic that is needed. The examples of mistaken appointment requests are endless.

Also, since some of the clinics desire to see certain

types of patients at particular times, the nature of the caller's actual need must be determined. Clinics may, for example, desire to see follow-up or physical evaluation patients at a certain hour and in certain numbers. Appointments by sex or status, to include active duty, dependent, or age are often differentiated. Each clerk must therefore be familiar with the procedures performed in each clinic and with individual clinic practice as it determines the type of patients to be seen and the particular times for their appointments.

The supervisor receives calls from dispensaries requesting appointments to the referral clinics for some active duty personnel and from clinics requesting referral appointments for a particular patient. The policies as pre-established by the clinics determine in these instances also the appointments given.

After an appointment is agreed upon, necessary patient information is requested. This information includes the name of the patient; the patient status as to dependent, wife, son, or daughter; the sponsor's name and status; the number of the child, if applicable, as to first, second, or third child; the sponsor's social security number; and the telephone where the caller might be reached. This information is necessary for the record section, for advising a clinic of whom it is to see, and for notification of the patient by the appointments desk in case of a cancellation. Cancellations, though, are not common, for a cancellation usually affects only those patients who are to see a specific physician. In those clinics not having appointments by physician, a shortage of a physician results in a greater

patient load for the remaining physicians and in a potentially longer waiting period for incoming patients, but no cancellations are made. However, if a large number of physicians is unavailable, appointments must then be reduced through cancellations. Cancellation calls are made by the supervisor on her line for outgoing calls.

The schedules for the various clinics are withdrawn from the books on the afternoon two days prior to the appointment date for clinics located at the hospital, and one day prior for clinics located in the hospital annex. These schedules are then logged-in by the supervisor as to the number of appointments made by clinic and doctor, and they are taken to the outpatient records section.

In the records section, the schedules are used that night to retrieve the outpatient records of patients to be seen in the clinics. The schedules and the records are then forwarded to the respective clinics the following morning, where the schedule provides the clinic with information of the patients to be seen and of the times of appointments.

The desk although functioning independently under the department of hospital clinics, can function only with the rules, policies, and procedures as established by the clinics within the central appointment subsystem. The desk serves as a central device for accomplishing the appointment-making function as requested by the clinics. Each clinic should be reviewed for those characteristics, rules, policies, and procedures that provide the framework for the central appointment subsystem.

General outpatient clinic.--

The central appointments desk receives the schedule of physicians to be available during a week on the Wednesday preceding that week. This clinic has also established weekday night and Saturday morning clinic sessions in order to accommodate the demand for medical care. Patients are booked by physician during the regular clinic sessions and only by time for the night and Saturday morning clinics.

Since illness is an unforeseen circumstance, a person may become ill and desire to see a physician as soon as possible. The clinic has provided for this possibility through its appointment and non-appointment system. Since appointments for each daily clinic session are completely scheduled before the schedule is sent to the records section and thence to the clinic, a person calling the central appointments desk for an appointment could not receive an appointment that same day. He is advised, though, that he can make an appointment for that evening, or that he may obtain his record, walk in to the clinic during the day, and wait until he can be seen by a physician.

The clinic waiting room, therefore, has walk-ins in addition to the patients with appointments. Clinic policy is to have appointments scheduled until 11 A.M. and then to see the walk-ins who have entered the clinic by that hour and have gone to the records section and obtained their records. The patient is not advised of the hour in which he will be seen as a walk-in, for it is estimated that the clinic would then be swamped shortly before 11 A.M. in the efforts of walk-ins to see a physician

without waiting. Arrivals after 11 A.M. find a closed clinic and have to return at 1 P.M. During the afternoon clinic session, appointment patients are seen until 3:30 P.M., then walk-ins are seen. Walk-ins who are in obvious pain or discomfort will be seen as soon as possible.

It is thought that the walk-in will be discouraged from such future actions because of the waiting involved in obtaining records and seeing a physician and that he would in the future make an appointment. In the recent past, the clinic had "floating" doctors who were not scheduled with appointments for that day, and these doctors would see the walk-ins. This plan was brought to a halt when it was decided that the number of walk-ins increased because of the relative ease in seeing a physician without an appointment.[4]

Surprisingly, patients also walk in to the night clinic, notwithstanding the fact that appointments to that clinic can be made during that same day. As the clinic doors open at 6:30 P.M. for the evening session, there is a rush by the walk-ins to be logged-in by the nurse at the desk. The nurse informs walk-ins of the appointment system in an effort to reduce the walk-in load. Appointment patients are seen from 6:30 P.M. until 8:40 P.M.; at 8:40 P.M. walk-ins are seen. Those walk-ins with acute problems are usually fitted into the schedule as soon as possible. After the clinic closes, all walk-ins still untreated go to the hospital emergency room. At the emergency room, patients that can be treated at a later time are given an appointment for the

following morning in the outpatient clinic. Every morning a physician in the clinic who has been previously designated as the emergency room physician sees those patients referred from the emergency room.[5] The Saturday morning clinic is conducted in much the same manner as the other general outpatient clinic sessions.

During the morning and afternoon sessions, appointments with the physicians are for fifteen-minute periods. Evening and Saturday clinic appointments are for ten-minute periods. Walk-ins receive shorter intervals than appointment patients as a general rule in an effort to encourage the making of an appointment; the condition of the patient, however, is always the prime consideration.

Pediatric clinic.--

The pediatric clinic makes appointments by physician. It submits a list of its monthly schedule to the central appointments desk a month in advance. The desk may book patients upon receipt of the schedules. Pediatric clinic sessions are held every morning and afternoon, Monday through Friday. A pediatrician is present during the evening and Saturday morning clinic sessions; however, no appointments are made for these sessions, and all patients are treated as walk-ins. The children are treated by order of severeness of illness, then in order of arrival.

During what was considered a slack season, Spring, the daily load in the clinic averaged forty appointment patients and sixty walk-ins. The usual patient load approximates 180-240 patients a day. More pediatricians in the clinic are unscheduled

to accommodate the walk-ins than are scheduled for appointment patients. The chief of the clinic feels that children are more likely to become ill in a short period of time; this then dictates the policy of the clinic in scheduling appointments. It is held that appointments cannot be made in the near future for a sick child who should be seen as soon as possible. Walk-ins are therefore to be accepted and are tolerated more so in this clinic than in any other. Certain doctors see the walk-ins as they arrive with the acutely ill being seen first. Clinic policy is that no follow-up patient will be seen as a walk-in; an appointment is necessary for all follow-up patients unless the child is ill. This policy allows walk-ins that need priority treatment to be seen. Although most of the patients seen are on a walk-in basis, an appointment system is desired by the clinic in order to schedule the routine patients and to provide some continuity in the clinic sessions.[6] Also scheduled are physical evaluation appointments for school children entering kindergarten or the first grade for the first time in the Fort Benning schools and all children entering the county schools for the first time. This has necessitated appointments throughout the school year, and all examinations have not yet been completed.[7]

Allergy clinic.--

The allergy clinic is booked two months in advance by the central appointments office for Tuesday and Friday afternoons. This is strictly a referral clinic, and a referral is a necessity for an appointment. Since only one doctor is available for this clinic, there is no change in the clinic schedule unless it is

known that he will not be available for a clinic session. The appointment clerks must give instructions to the patients of actions that they must accomplish before their scheduled appointments so that the physician can perform treatment as required during the appointment period.

Dermatology clinic.--

The dermatology clinic is presently staffed by one physician; however, once a week another physician provides help for wart removal. This clinic is booked six weeks to two months in advance. On Monday, Tuesday, and Friday afternoons, dependents are seen. Active duty military are seen every morning. Skin surgery is scheduled every Thursday afternoon, and appointments for wart removal may be made directly on Friday afternoons. This is a direct appointment clinic; no referral is necessary from the outpatient clinic.[8] Most of the appointments, by the clinic's request, are designated for follow-ups, with the remainder available for initial visit patients. Because of the great demand for this clinic's services, the large number of follow-ups, and the availability of only one physician, it is difficult to obtain an open appointment to this clinic for weeks in the future.

Eye refractions clinic.--

The eye refractions clinic is a direct appointment clinic; no referral is necessary. Appointments are available every morning for dependents and retired military; active duty military are seen in the afternoons. The clinic is scheduled and booked six weeks in advance. Another week of appointments

is opened every Monday; these available appointments are usually completely filled by Tuesday and often by Monday. Six optometrists are on the staff. Appointments are not by specific optometrist, but are block type appointments. Military appointments are made by the dispensaries which send a courier to the clinic with written requests. It is estimated that there is a 30 to 40 per cent no-show rate among military appointments.[9] Walk-ins are seen when an emergency situation exists; two spaces are unscheduled per day to accommodate such emergencies.

Surgery-suture removal, proctology, and gastroenterology clinics.--

The surgery clinic makes its initial appointments through the central appointments desk. All appointments are by referral only. Appointments to this clinic can be made up to two months in advance. Block-type appointments are used; six patients are scheduled every half hour. The central appointments desk is notified when a change in physician strength will necessitate adjustments to the schedule. Appointments are made for Mondays, Wednesdays, and Fridays. The clinic, however, makes follow-up appointments in the clinic after the physician has seen the patient. This is done because the chief of the clinic maintains that patients find it difficult to reach the appointment desk and are unable to obtain an open appointment from the desk on the day that the physician desires the follow-up visit.[10] The appointment schedule kept by the clinic reflects duplication of appointment times by the clinic and the appointments desk. The records of patients scheduled for a follow-up visit are kept in the clinic until the patient's return.

Suture removals are made through the central appointments desk for Mondays, Wednesdays, and Fridays at the rate of two patients every ten minutes. Walk-ins needing suture removals are treated.

One physician receives all proctology patients. These appointments are made only from referral by the surgery clinic; administrative personnel in the surgery clinic call the central desk supervisor for an appointment. Females are seen on Monday afternoons and males on Wednesday afternoons, at the rate of one patient every half hour.

The gastroenterology clinic has one physician. He sees patients during two weekly sessions on Tuesday and Thursday mornings; four to six patients are seen per clinic session. All appointments for this referral clinic are made through the central appointment office. The schedule is constant, unless the physician will be unavailable.

Urology clinic.--

The urology clinic is a referral clinic; appointments are made through the central appointments office for Monday, Tuesday, Thursday, and Friday afternoon sessions. Emergencies and expedites from other clinics and dispensaries are attended as soon as possible; appointments, however, have precedence over expedites. The clinic makes appointments for x-ray, cystoscopy, urethroscopy, cystometrogram, meatotomy, and retrograde pyelogram procedures. After being seen by a physician, the patient is given a sheet advising him of procedures to be accomplished. The above procedures are scheduled by the clinic because it is

believed that the clinic knows best when to more advantageously schedule the patient for a particular procedure.[11] If the patient's sheet indicates the need for a follow-up, the number of weeks in which this is to be done is circled, and he is advised to make an appointment through the central appointment desk asking for a follow-up appointment. The office in turn schedules profiles on Tuesday, and Friday mornings and follow-ups on Wednesday and Friday mornings. A request for an x-ray reading for a date in the future is obtained from the central office. The desk will accept appointments to this clinic up to two months in the future; however, an appointment can be obtained within two days. Walk-ins are not seen unless it appears that they should be seen by a physician that day; however, a minimum of four or five walk-ins are seen a day.

Podiatry clinic.--

The podiatry clinic schedules active duty personnel for Monday through Friday morning appointments; dependents and retired personnel are seen on Monday, Tuesday and Thursday afternoons. Appointments are through the central desk and may be made up to two months in advance. Two podiatrists staff the clinic; no change is made in the schedule provided the desk, unless both podiatrists would be unable to be present for a session.[12] Walk-ins are not treated in the clinic unless an emergency is sent from a dispensary or outpatient clinic.

Orthopedic and cast room clinics.--

The orthopedic clinic has sessions only in the afternoon because the staff has surgery every morning. Appointments to

this clinic are only by referral. Active duty personnel and dependents are scheduled on Monday and Tuesday afternoons, dependents under fourteen on Thursday afternoons, and dependent females on Friday afternoons. Appointments can be made at the central desk up to two months in advance. Appointments are of the block-type for the nine surgeons; however, two of the surgeons are retained as "floating" physicians, and they treat all emergency and expedite patients from the dispensaries, emergency room, and outpatient clinic. The staff secretary allows for five expedites a day from the dispensaries. Walk-in patients are not treated; they are referred to the emergency room if their condition necessitates this action.

The clinic maintains its own appointment schedules also, for if a physician desires that a patient return within two weeks, the patient calling the central desk will not be able to obtain an open appointment since all appointments, as scheduled by the orthopedic clinic itself, have been filled. The clinic, therefore, makes the appointment with the patient for all return visits. These patients upon their return visit must go to the hospital annex for their records and return to the orthopedic clinic in the hospital.

Outpatients are seen in the cast room every weekday afternoon, except for Wednesday. Appointments are made through the central desk. A "floating" physician from the orthopedic clinic is in charge of the clinic. Walk-ins are few, no more than three to five a day from the approximate thirty to forty patients that are seen daily. Patients are instructed to call the central

desk and to ask for an appointment on the day that the physician wants to see them again, but they are to return on the scheduled day even if unable to obtain an appointment.

Well baby clinic.--

The well baby clinic schedules visits for a six-week, three and a half-month and six-month check. The six-week check is held on Monday and Friday afternoons. The other clinic sessions are held on Thursday mornings. The central desk can book twenty-five babies for these checks.

The decentralized appointment subsystem

The decentralized appointment system allows for individual control of the appointment procedures in a clinic. This system, therefore, can be more readily flexible to physician changes and demands than the removed centralized office. At Martin Army Hospital, clinics which found it imperative to maintain control of their appointments retained the appointment-making function; all others were placed under the centralized system.

The clinics making their own appointments accept telephonic, written, and personal requests for appointments. Patients may stop at the appointment desk in the clinic and make appointments for their next visits. Appointment requests are screened in much the same manner as are the requests at the central desk. The same basic information is obtained from the patient, and the clinic schedules are forwarded to the records section for the records. These clerks are, however, not solely appointment clerks; they also function as receptionists and general clerks for the clinics.

Although the decentralized appointment subsystem is called a subsystem, it is not a system like the central appointment subsystem. "Subsystem" is used only as a term to collectively identify those appointment systems which function independently. There is no integration of the various systems, other than for those closely allied and adjacent clinics which share a common clerical staff. A study of the decentralized appointment subsystem is in actuality a study of the appointment systems of those clinics which make their own appointments: ear, nose, and throat and ophthalmology; speciality; cardiology; neurology; physical therapy; diabetic and tuberculosis; mental hygiene; and obstetrics-gynecology.

Ear, nose, and throat and ophthalmology clinics.--

The two clinics share an appointment system, waiting room, and administrative personnel. The ear, nose, and throat clinic is booked three weeks in advance, and the ophthalmology clinic one week in advance. Approximately thirty appointments are made for the two clinics daily. All patients must have an appointment unless they are expedite or emergency patients from the dispensaries or other clinics. Ear, nose, and throat patients are accepted on referrals; however, apparent ear, nose, and throat cases are booked directly. Both direct and referral are accepted in the ophthalmology clinic. Patients are treated in the ear, nose, and throat clinic every afternoon, except Wednesday, and all day Friday. The ophthalmology clinic schedules patients every day except for hours reserved for surgery on Tuesday and Friday.

A noncommissioned officer, E-6, and a receptionist make appointments to the clinics during work hours except the lunch hour. Their functions do not differ; both receive patients, prepare records for the physicians, provide information, and make appointments. Screening procedures must be accomplished with each appointment request to determine if the patient is calling the proper clinic. The ear, nose, and throat clinic is often thought to be an eye clinic and the ophthalmology clinic is thought by some to be the eye refractions clinic. Further screening is conducted to determine if the patient has a referral or if he should call the central desk for a general outpatient clinic appointment prior to a specialized clinic appointment. Different appointment intervals are in effect in the clinics for new and follow-up patients. Follow-up appointments may be made at the desk as the patient departs. The completed schedules are sent to the outpatient records section three days prior to a clinic session; they are returned with the records to the clinic. Patients are booked by physician in the ear, nose, and throat clinic; however, they are not advised of the physician with whom the appointment has been made. The two clinics have about sixty to seventy patient visits a day; approximately 65 per cent of the visits are for the ear, nose, and throat clinic. No-shows are not significant in the ophthalmology clinic, and although a patient is not booked by physician in this clinic, he usually sees the one who has treated him before. The no-show rate among the ear, nose, and throat patients is estimated to be from five to ten a day.

Specialty clinics.--

Thirteen clinic sessions a week, to include two each day Monday, Wednesday, Thursday, and Friday and five on Tuesday, are held for the various cases treated in the speciality clinics. Endocrine, rheumotoid, hypertension, and renal cases are among those seen in these clinics. Appointments are made through referral by the secretary of the clinic chief. Patients are booked to a particular physician according to the nature of the case and the physician's interest. Approximately twelve to fifteen appointments are made daily.

Cardiology and neurology clinics.--

Appointments to the cardiology and neurology clinics are made by secretaries in the respective clinics. All appointments must be through referrals. When a referral patient desires to make an initial appointment to the cardiology clinic, he is scheduled and is instructed to complete a cardiogram and an x-ray if these have not been previously accomplished. With these prerequisites the physician in the clinic will be able to make an evaluation. A patient is then rescheduled by the cardiologist; the secretary is advised of the time for his appointment and of any tests or consultations required. The secretary makes appointments for any patients that require scheduling with another clinic. Lists of appointments are sent to the records section for patient records.

The neurology clinic patients are seen by the neurologist who determines necessary procedures and future appointments; appointments are arranged through the secretary.

Physical therapy clinic.--

Every new patient to the physical therapy clinic is interviewed and examined by the chief of the clinic who, with the physician's request for therapy, determines the treatment to be accomplished. The chief then makes the therapy appointments for four sections within the clinic. Each section maintains an appointment chart on the wall, and patients are scheduled according to the treatments required so that the facilities, personnel, and equipment will not be overtaxed with waiting patients. Coordination is effected among the sections when treatments are required in more than one section.[13] The clinic maintains its own separate therapy records so outpatient records are not requested.

Diabetic and tuberculosis clinics.--

Diabetic and tuberculosis patients are monitored by the office of the health nurse. Patients are referred to the clinics by the outpatient clinic. Others who were recently assigned to the Fort Benning area were referred by the medical treatment facility at their previous military installation.

A secretary maintains a suspense file on the diabetic and tuberculosis patients. A letter is sent to these patients advising them of an appointment as established for them at the clinic. A tuberculosis clinic session is held monthly and a diabetic session twice monthly. The monitoring of tuberculosis patients in this manner allows for the continuous follow-up required for these patients.

Mental hygiene clinic.--

The mental hygiene clinic has the most flexible appointment system established by a clinic. The staff member dictates the schedule of his activities and of the patient's appointments. Appointments are based on the staff member's evaluation of the patient. Visits are made to the member's military unit, and arrangements for sessions at the unit level can be made. Schedules thus are not consistent and are arranged to accommodate the patient and staff member. Referrals are accepted from the units, dispensaries, chaplains, confinement officer, and clinics, or a patient may just walk in to the clinic and be seen. Specific referral to the psychiatrist rather than to social workers or their assistants may be made. A representative of the clinic is located in the pediatric clinic so that children may be seen in the environment of that clinic. The mental hygiene clinic maintains its own records, so no records are requested from the records section.

Obstetrics-gynecology clinic.--

The obstetrics-gynecology clinic makes its own appointments and is a direct appointment clinic. Patients are scheduled on a block appointment basis, but they may request a particular physician if he is in the clinic when the visit is made. Appointments are made by a clerk who functions as a receptionist, information clerk and appointment clerk. Observation during any hour of the day will demonstrate the all-encompassing tasks of the secretary. Appointments are made in this clinic for obstetric patients, family planning consultations, and gynecology patients.

There are two telephones on the clerk's desk which are continually ringing and often remain unanswered because the clerk is attending to other tasks. Callers request appointments and information. Calls must be screened to determine if an appointment is necessary when a patient calls with a problem. Many of the callers request information that was given to them at a previous clinic visit but was forgotten. Walk-ins are accepted in the clinic, but they must wait possibly until the end of the clinic session if the problem is not acute.

Issues

It can be said that the primary function of an appointment system is bringing the patient and the physician together at an agreed time, with a minimum of waiting and delay for either party. The very fact that appointment systems are commonplace in hospitals tends to obscure the differences among these systems.[14] A system may be adopted by a hospital and modified to meet its needs. The differences and complexities of an appointment system are limited only by human ingenuity. Each hospital outpatient department is an entity in itself. The personnel in the administrative and professional staffs, the patient population, the physical plant, and the objectives of the department create an outpatient department that is unique in its outlook, problems, and functioning. The outpatient department of Martin Army Hospital is no different from other departments in that it too is unique. It has taken the central appointment system concept and, based upon hospital needs, adapted it and made it a part of the total appointment system.

The entire appointment system is being reviewed because of problems in it affecting its primary function--bringing the patient and physician together at an agreed-upon time. The appointment system must be viewed in the total systems concept. One procedure, action, or change will not necessarily provide the panacea for a troubled system. The total appointment system must be thought of, then in terms of its component parts. These parts must be studied and each must then in turn bear scrutiny in terms of its functioning. Only after study, evaluation, and modification of the entire system can it be said, and then only hesitantly, that the appointment system as described in this paper is the best for the hospital.

An appointment system may be introduced because of the efficiency it can provide. As has been stated by the United Hospital Fund of New York, "Because it has the characteristics of a formal agreement, both parties--the patient and the hospital staff--expect the system to work."[15] The present system is a working system; however, it might not be the best functioning appointment system as evidenced by patient complaints. Problems areas exist in the centralized system as well as in a few of the independent systems.

Central appointment subsystem: processing of calls

The appointment-making process in the central appointments desk has created the most vociferous complaints from the patient population, because patients calling the desk have found that the line to the desk is continually busy. Serious though the

discomfort and complaints may be, these appear to be fairly common in outpatient departments that have centralized appointments as documented by Charles A. Holston in his description of the central appointment system at Bethesda Naval Hospital and by R.R.P. Jackson in his study of appointment systems.[16] This commonness though is of no comfort to patients when the desk cannot be reached. The most apparent solution would be that of adding more clerks to the desk, for this would allow more calls to be received at any one time. As an example, with four clerks, as is presently the case, four calls may be processed. One additional clerk would allow the processing of five calls at a time; six clerks could process six calls. However, with this approach, there would, in the economic sense, be a point of diminishing returns, for five or six clerks would be making the same number of appointments that four clerks are presently making, since all appointments scheduled are being filled. The only advantage would be that of faster service to the population.

The replacement of two experienced clerks at the desk by inexperienced personnel has served only to slow the processing of calls at the desk. The problem was further aggravated with one replacement being a WAC. A military clerk is subject to other requirements besides job performance, such as training and unit duties. This will necessitate absences from the desk leaving only three functioning clerks. The relative short assignment of military personnel also necessitates the constant training of replacements. A longer tenure is experienced with civilian clerks.

It was observed that mornings are the busiest hours in the office; the supplement of a military clerk to a permanent clerical staff of four individuals during the morning hours would do much to alleviate the heavy morning telephonic load.

Another alternative to faster appointment service would be that of decentralizing the appointment system so that each clinic would make its own appointments; this alternative would necessitate one clerk for each clinic presently being serviced by the central desk. This decentralization would thus require a minimum of eleven appointment clerks, and even this decentralization would not guarantee better service, as evidenced by the situation in the decentralized obstetrics-gynecology clinic where with one clerk and two phones, the phones are continually ringing and occasionally are unanswered.

The reduction of unnecessary calls to the central appointments desk would allow for other calls to be handled more expeditiously. Calls could be reduced by requiring all active duty personnel to make their appointments through their dispensaries, rather than having each individual referred to a specialty clinic by the dispensary making his own appointment. Each of the nine dispensaries could consolidate the required appointments and phone these in to the supervisor of the desk on her private line. Thus one call from a dispensary could eliminate any number of calls to the desk from military personnel. The desk, though, would not be permitted to directly accept appointments from active duty personnel in order to eliminate the possibility of making duplicate appointments. This procedure could also be

used as a monitoring device by the dispensaries so that they would know who in reality had scheduled appointments.

Appointments for physical examinations for school children have necessitated calls to the desk. If these appointments were eliminated, the result would be fewer calls to the desk and better access to the desk line for other callers. This year, appointments for physicals were required for all children requiring such an examination. Previously, these physical examinations were given in a mass series, wherein for a few days all dependent school children were seen without appointments. Those not seen were scheduled later by appointment, and this number was usually not significant. This period of mass examinations did not create a large number of calls for appointment requests throughout the year. A limitation to the mass examinations procedure would be the assembly line process which such a method would require.

Reducing the average time required for each call at the desk would result in a larger number of callers being accommodated at a faster rate. Much time is wasted by patients who do not know what clinic they need, do not explain who the appointment is for, and do not know the information required by the clerk. Callers too many times do not know their sponsor's social security number; they are not aware of what is meant by "the number of the child." A four-day study of calls made in the office revealed that out of 1,285 calls, 18.6 percent were calls to the wrong place and 34 per cent created delays in the procedure because of a lack of the proper information and/or explanations being given

the caller (see Appendix D). A massive education program, utilizing the media of the post newspaper, personal visits to clubs and organizations, and information sheets should be implemented. A thirteen page booklet with clinic information is available to all individuals being serviced; there is, however, no information pertaining to procedures that should be used in making an appointment. There should be an example of the proper method of requesting an appointment, along with a listing of the information which the patient should have with him before placing the call. A separate "flyer" with this information would be of greater value than a page in a pamphlet since the information would not then be lost in a large amount of extraneous material.

In order to facilitate the availability of the line for more calls to the desk, a patient education program for more expeditious making appointment making procedures should be initiated and an additional clerk should be added to the clerical staff. Attempts should be made for reducing the number of calls to the desk by requiring all active duty personnel to make an appointment through their dispensaries and by eliminating appointments for pre-school physicals.

Central appointment subsystem: coordination

The central appointments subsystem is not functioning to its fullest capacity because of a lack of information, coordination, and understanding. The surgery and orthopedic clinics make appointments for follow-up patients although they are being serviced by the central appointments desk. The desk and the orthopedic clinic were found to be making duplicate appointments

for follow-up patients. These clinics make the appointments because they claim that patients can not obtain an open appointment from the desk for any period earlier than two weeks. Although the schedules as composed by the clinics themselves are filled by appointments booked by the desk, the clinics still manage to see those patients that they have booked as follow-ups. True, the central appointments system is not as flexible as one that is only a few steps removed from the physician's office, yet a lack of understanding inhibits greater flexibility. The system could be modified to incorporate changes in the scheduling of appointments, or it could continue in its present condition. However, from a total system viewpoint, it would be more advantageous to improve the present system so that strong points could be emphasized rather than weakened; in this case double work is actually being performed. Communication between the clinics and tha appointment desk could establish a new schedule in which a certain number of appointments are added to the schedule, but these would be labeled as follow-up appointments, and only follow-up patients could be booked into these appointments as requested by a physician. If the follow-up appointments were made through the desk, a patient's records could be forwarded to the clinic by the records section rather than having the patient retrieve his records as orthopedic follow-ups must do or having the records stored in the clinic as is being done in the surgery clinic.

Clinic chiefs serviced by the central appointments desk know that there is a system, but they know little of its actual

functioning. In many instances the physicians appear to know only that information about the system provided by the patients. The system can continue to function as it has with the desk providing a service to the clinics and with the professional staff not knowing how the system operates. Another alternative is that chiefs of the clinics be introduced to the central appointments desk for observation and an explanation of the flexibility that can be incorporated into the system. The latter alternative could in all probability increase the efficiency of the system because it would provide an education and understanding for those involved in the system. The physician aware of the problems, facts, and advantages of the system could do much to educate the patient population when the topic of the appointment-making process arose in conversation.

Central appointment subsystem: resource-capacity

One of the most important procedures in the appointment process is that of being advised in advance of the number of patients that can be serviced in a period of time; this is known as resource-capacity.[17] Without this information, appointments cannot be made. This is the present circumstance with appointments for the general outpatient clinic. The schedule of physicians and appointments to be booked during a week is not available to the desk until the Tuesday or Wednesday of the preceding week. This situation, in turn, dictates that for the first two or three days in any given week, appointments can be made only until the week's end. If these days are already filled, as happens in

too many cases, a call to the desk is wasted because no appointments for the following week can be made without the new schedule. The caller then has to phone again another day, hoping that the appointment schedule has been received.

The general outpatient clinic should submit the following week's schedule every Monday morning, thereby allowing enough lead-time for appointments to be made. This will necessitate more prior planning and coordination, and the schedule could be subject to emergency changes necessitating cancellation.[18] The system could continue as it has been functioning, but this will continue to result in wasted efforts by the caller and the clerks. An education program could be incorporated into the overall patient information program, informing patients not to call for outpatient clinic appointments for the following week until Thursday of the preceding week; however, much effort would be required in the re-education process and confusion with other clinic appointment-making procedures could possibly result. It would thus be best for the entire system if the outpatient clinic would submit its projected schedule two or three days earlier.

Dermatology appointment subsystem: policy

Dermatology is one of the clinics whose appointments are always filled well into the future. Policy has been that appointments can be made directly with the clinic. Most of the appointments are for follow-up patients as requested by the clinic; few new patients are provided an appointment. If the clinic accepted only referrals from the outpatient clinic, then those

appointments for new patients could be given to those who definitely need the service. A disadvantage to this change would be that the outpatient clinic would be increasing its patient load. The system could continue on a direct appointment basis; however, greater efficiency would result from accepting referral patients only.

Outpatient and pediatrics appointment subsystems: walk-ins

The walk-in numbers to the outpatient and pediatric clinics have been increasing. The pediatric clinic sees more walk-ins than appointment patients. The outpatient clinic sees almost the same number of walk-ins as it does appointment patients (see Appendix E). The walk-in patient creates problems for himself, the clinic, and the records section. He has to wait at the records section to obtain his record, and this could very well be at a building different from that of the clinic; he then must wait in the clinic until he can be seen. The number of appointments available has been steadily declining in the outpatient and pediatric clinics. Concurrently, the number of walk-ins has been increasing. Apparently every patient is being treated, so that in actuality more patients could be treated by appointment. A reduction of walk-ins could in all probability be effected if on the day prior to an appointment date, a certain number of appointments were scheduled for those who would otherwise be a walk-in the following day. This would require extensive education of the population. Advantages to the patient and to the clinics resulting from such a change would have to be explained. The change would eliminate waiting by the patients at the records

section and at the clinic, and it would ease the pressure on the records section which must locate the records of every walk-in. Another alternative is that of providing a "floating" physician. This has been attempted in the outpatient clinic, and the results were greater numbers of walk-ins; the pediatric clinic already provides "floating" physicians. The system can continue in its present form; this, however, does nothing to alleviate the present walk-in problem. All patients reporting to the various clinics must be seen; therefore, an alternative cannot be that of turning them away. Patients should not be referred to the emergency room, since this practice only encourages the misuse of that facility. An alternative must be selected that would be best for all concerned.

Decentralized appointment subsystem: processing of calls

The individual clinics as a rule have fewer problems in their appointment-making procedures than the centralized system because the comparable volume of calls in all but obstetrics-gynecology is rather small. Also the special procedures in some of these clinics circumvent the need for an appointment apparatus. Physical therapy and mental hygiene medical personnel, for example, schedule patients rather than having a desk in the clinic perform this function. It was noted, however, that the problem of a lack of information by callers was plaguing all clinics; it should be resolved.

Obstetrics-gynecology and ear, nose, and throat appointment subsystems: staffing

Administrative areas for improvement were observed in

some areas in these clinics. An imbalance of clerical personnel was found to exist in the obstetrics-gynecology and the ear, nose, and throat and ophthalmology clinics. In the obstetrics-gynecology clinic there is entirely too much work for one appointment clerk who also functions as a receptionist and information clerk. In the ear, nose, and throat clinic, however, there are two personnel--a noncommissioned officer and a civilian clerk--functioning in the same capacity and a paucity of work by comparison. The obstetrics-gynecology clerk could have her appointment-making duties removed and transferred to the central desk, which would have the civilian ear, nose, and throat clerk added to its staff to accommodate the increased number of calls. Or perhaps the ear, nose, and throat clerk could be transferred to the obstetrics-gynecology clinic where she could function as an appointment clerk; the present clerk could function as a receptionist and information clerk. The latter alternative would be the more beneficial to the system, since the obstetrics-gynecology clinic, because of the special nature of the cases and problems, necessitates a clerk intimately familiar with the clinic's functioning; the present obstetrics-gynecology clerk is a former nurse, and her knowledge enables her to properly screen the large volume of problems and questions that are presented. It would be best to retain the appointment-making function in the obstetrics-gynecology clinic because the desk would have to refer any patient complaining of complications to the clinic.

Obstetrics-gynecology appointment subsystem: general

The obstetrics-gynecology clinic appointment desk should have only one line. It is an impossibility for one clerk to be on two lines at one time. At present, one finds the clerk either speaking on one phone while the other rings or talking to a patient in the clinic with both phones ringing. Often, calls simply do not get answered. If another clerk were added, then two lines might very well be utilized, but at present one phone should be eliminated from the desk.

The large volume of calls for birth control pill information could be reduced if the patients remembered instructions issued to them when the pills were issued; unfortunately, patients forget the instructions and call the clinic for information on further issuance of pills. "Flyers" of common clinic procedures should be printed and distributed to the patients at the time of pill issuance; patients, would thus know when an examination was required and how the pills might be resupplied, and the volume of calls would be considerably lessened.

Total appointment system: record retrieval

Although the outpatient records section is under supervision of the registrar and is not an integral part of the appointment system, it is due attention in those aspects of its functioning affected by the appointment-making procedures of the outpatient department appointment system. As part of their appointment-making function, the appointment clerks complete schedules which are forwarded to the outpatient records section

for record retrieval. It was observed, though, that every clinic had different schedule formats. Some used pre-printed forms; others used ruled paper. The central desk uses different forms for each of its clinics. Observation of the record retrieval process from the clinic appointment schedules showed that the process was as good as could be expected, with the only difficulties encountered being those of reading different handwritings. In the very near future, however, records will be filed by the terminal digit system and retrieved by using the social security account number given by the caller. A review of the forms used showed that all forms had the last name of the patient in the first column, and this is satisfactory for present needs. The social security account number was found in different positions on the schedules. A standardized form should have this number in one location, and in the best position for faster retrieval of the record when the new filing system is implemented (see Appendix F). The present method will allow the records section to find the necessary records using the terminal digit system, but more effort will be required since the necessary digits are usually crammed together. The proposed form, although not aiding the appointment clerks in any manner, would aid the outpatient department as a whole through the assistance provided the records section clerks.

Summary

The appointment system in the outpatient department of Martin Army Hospital is a modified appointment system composed of two subsystems, the central appointment subsystem and the

decentralized appointment subsystem. The central appointment subsystem consists of the consolidated appointment-making function accomplished by a central desk for thirteen clinics. The decentralized appointment subsystem is composed of the ten independent clinic appointment systems. The total appointment system combines the strengths of both the centralized and decentralized systems.

The centralized appointment subsystem reduces the administrative functions in those clinics it supports. The clerical staff at the appointment desk, located in an isolated area of the hospital annex, makes telephonic appointments based upon the schedules of the serviced clinics. After screening the calls and determining to what clinics the patients are to be scheduled, clerks make the appointments. The completed appointment schedules are sent to the outpatient records section before the appointed day where the records are retrieved and forwarded to the proper clinics. The framework of the central appointment subsystem is dependent upon the characteristics, rules, policies, and procedures of the various clinics for which the appointment-making function is accomplished.

The decentralized appointment subsystem allows for individual control of the appointment-making process in the clinics. This subsystem is therefore more flexible since it adjusts more readily to the clinic changes and demands. Those clinics determined to need immediate control of their appointments retrained the appointment-making function. Appointments are made by clinic personnel who also function as receptionists and general clerks. Each clinic appointment system is unique, in that it is independent and functions in accordance with its own established procedures.

The outpatient department of Martin Army Hospital has been subjected to an increased patient load and fewer physicians. Under these circumstances an appointment system may reflect problems in any one of the many elements which in toto constitute the system.

There is no one change which would automatically create a perfect system; problem areas are located in various component parts. The most common complaint of the appointment system made by the patient population is the difficulty in placing a call to the central appointments desk. Observation of the desk has shown that a majority of the calls create a delay because of a lack of patient information. It was also noted that some clinics being serviced by the central desk are not utilizing the desk to its fullest capabilities; double work is being accomplished by some clinics which persist in making their own follow-up appointments. Evidence of a lack of information on the functioning of the central desk was apparent in most clinics serviced by the desk. The need for additional cooperation was noted in the general outpatient clinic which habitually submits a late weekly appointment schedule. The need for studies of the direct appointment procedures in the dermatology clinic and of the walk-in situation in the outpatient and pediatric clinics is indicated. The appointment-making procedures in the decentralized clinics were found to be functioning well; however, an overabundance of work for one clerk in the obstetrics-gynecology clinic and a comparative scarcity of it for two clerks in the ear, nose, and throat clinic was noted. It was observed that appointment schedules sent to the records section

for record retrieval differed in format for all clinics, but that the needs of this section were being met in spite of this difference.

FOOTNOTES

[1]Charles A. Holston, "Central Appointment System for Outpatient Clinics," Hospital Management, CIV (October, 1967), 70.

[2]LTC Tom H. Sadler, Administrative Chief, Department of Clinics, Martin Army Hospital, Fort Benning, Georgia, interview held during April, 1970.

[3]"Systems Analysis and Design of Outpatient Department Appointment and Information Systems" (New York: United Hospital Fund of New York, 1967), p.35 (pamphlet).

[4]MAJ Jerry R. Stewart, Chief, Department of Clinics, Martin Army Hospital, Fort Benning, Georgia, interview held during April, 1970.

[5]Although outpatients are still seen in the emergency room, the addition of the night and Saturday morning clinic sessions has significantly affected the number of patients seen in the emergency room. As shown in Appendix C, the number of emergency room patients dropped from 108,754 in 1968 to 83,984 in 1969.

[6]LTC Patrick D. Tisdale, Chief, Pediatric Clinic, Martin Army Hospital, Fort Benning, Georgia, interview held during April, 1970.

[7]Physicals for school children also affect the general outpatient clinic for females over fourteen years and males of fourteen and fifteen must have an appointment made in this clinic. Males over sixteen years are seen in the physical evaluation facility.

[8]CPT Jeffrey A. Carmel, Chief, Dermatology Clinic, Martin Army Hospital, Fort Benning, Georgia, interview held during April, 1970.

[9]MAJ Charles L. Crowley, Chief, Eye Refractions Clinic, Martin Army Hospital, Fort Benning, Georgia, interview held during April, 1970.

[10]CPT John R. Clarke, Chief, Surgery Clinic, Martin Army Hospital, Fort Benning, Georgia, interview held during April, 1970.

[11]LTC Fernando Dias-Ball, Chief, Urology Clinic, Martin Army Hospital, Fort Benning, Georgia, interview held during April, 1970.

[12]MAJ James F. Newton, Chief, Podiatry Clinic, Martin Army Hospital, Fort Benning, Georgia, interview held during April, 1970.

[13]LTC Martha J. Eason, Chief, Physical Therapy Clinic, Martin Army Hospital, Fort Benning, Georgia, interview held during April, 1970.

[14]"Systems Analysis and Design of Outpatient Department Appointment and Information Systems," pp.9, 11.

[15]Ibid., p.12.

[16]Ibid., p.70; R.R.P. Jackson, "Design of an Appointments System," Operations Research Quarterly, XV, No. 3 (May-June, 1967), 221.

[17]"Systems Analysis and Design of Outpatient Department Appointment and Information Systems," p.20.

[18]In observing the appointments desk for the general outpatient clinic at Brooke General Hospital, Fort Sam Houston, Texas, it was noted that the clinic books patients two months in advance. This necessitates much prior planning. Leaves are therefore requested at least two months in advance so that schedules can be prepared. As emergencies requiring schedule changes arise, the clerks adjust schedules and make cancellations. The system appears to function well; however, other hospitals need not adopt a two-month advance schedule.

CHAPTER III

CONCLUSION

Conclusions

The best procedures to improve the functioning of the components of the appointment system for the outpatient department of Martin Army Hospital, Fort Benning, Georgia, are those of implementing the changes as recommended in the existing modified centralized appointment system.

Recommendations

Recommendations are that:

1. Appointments for military personnel should be made through the dispensaries and not directly to the clinics.

2. One clerk should be added to the central appointments desk.

3. Clerks in the central appointments desk should be full-time civilian personnel.

4. Physicals for school children should be handled en masse, and no appointments should be made for these physicals throughout the year except for new students and those who missed the physical examination when scheduled. Such a process would eliminate unnecessary calls to the central appointments desk.

5. An extensive education program should be implemented for the patient population consisting of new information booklets with appointment-making information and talks to groups in order to reduce the time involved in the appointment-making process.

6. All clinic chiefs should be introduced to and briefed on the central appointments system.

7. The surgery and orthopedic clinics should co-ordinate with the central appointment desk so that appointments for follow-ups may be made through the central appointments desk.

8. The outpatient clinic should submit its appointment schedule for the week not later than the Monday of the preceding week.

9. The civilian clerk in the ear, nose, and throat clinic should be transferred to the obstetrics-gynecology clinic where assistance is direly needed.

10. The obstetrics-gynecology clinic should have "flyers" printed with instructions about family planning procedures in order to reduce the number of calls for information.

11. The central appointments desk should book only referral patients for the dermatology clinic.

12. A new standard form to aid the records section in retrieval of outpatient records using the terminal digit process should be initiated throughout the outpatient department clinics.

Area for Further Study

The problem of the increasing numbers of walk-ins to

the outpatient and pediatric clinics should be studied. Patients should be interviewed on their thoughts and suggestions on this subject. Methods of reducing the number of walk-ins should be determined and evaluated.

APPENDIX A

AVERAGE PATIENT POPULATION AND CLINIC VISITS

AVERAGE PATIENT POPULATION AND CLINIC VISITS

JULY 1969 - MARCH 1970

MARTIN ARMY HOSPITAL, FORT BENNING, GEORGIA

	Jul 69	Aug 69	Sep 69	Oct 69	Nov 69	Dec 69	Jan 70	Feb 70	Mar 70
Military Trainees	7,279	7,965	9,231	7,754	6,137	2,369	1,123	1,202	1,187
Military (All Other)	40,805	40,082	41,080	41,596	39,415	36,348	37,876	35,397	32,807
Dependents (Active Duty)	38,451	39,494	39,567	40,443	41,002	40,816	40,430	40,494	39,365
Retired and Dependents	11,307	11,367	11,430	11,505	11,517	11,565	11,592	11,649	10,767
Total - (Patient Population)	97,842	98,908	101,308	101,298	98,071	91,098	91,021	88,742	84,126
Specialized Clinics Avg. No. Visits	1,031	1,039	1,075	1,169	1,018	902	1,048	1,152	1,178
General O.P. Clinic Avg. No. Visits	1,285	1,303	1,355	1,437	1,346	1,156	1,247	1,361	1,145
Avg. Clinic Visits	2,316	2,342	2,430	2,606	2,364	2,058	2,295	2,513	2,323

APPENDIX B

OUTPATIENT DEPARTMENT CLINIC VISITS

OUTPATIENT DEPARTMENT CLINIC VISITS

CALENDAR YEARS 1965-1970

MARTIN ARMY HOSPITAL

FORT BENNING, GEORGIA

	1965	1966	1967	1968	1969	1970**
Total Clinic Visits*	409,530	383,042	475,241	426,369	445,241	120,504

*Excludes emergency room and dispensary figures.

**1970 figures include only three months, thru March 1970.

APPENDIX C

OUTPATIENT DEPARTMENT INDIVIDUAL CLINIC VISITS

OUTPATIENT DEPARTMENT INDIVIDUAL CLINIC VISITS

FISCAL YEARS 1965-1970

MARTIN ARMY HOSPITAL

FORT BENNING, GEORGIA

Clinic	1965	1966	1967	1968	1969	1970*
General Outpatient	-	23,575	35,355	32,280	55,112	54,634
Surgical	12,289	10,568	11,994	11,148	10,842	8,353
Orthopedics	31,282	22,464	39,748	44,457	42,990	31,958
ENT	10,738	11,330	13,305	11,048	12,672	8,934
Eye Refractions	23,316	29,587	41,319	44,046	46,888	33,091
Obstetrics	39,112	20,591	30,304	28,595	30,652	23,992
Gynecology	35,712	28,212	42,177	41,421	29,900	20,352
Pediatrics	75,425	61,385	67,774	51,740	54,146	51,718
Physical Therapy	32,967	34,856	69,663	75,386	56,137	36,070
Urology	11,002	12,653	10,594	8,722	9,336	9,446
Dermatology	26,135	14,213	17,379	16,772	17,676	12,493
Cardiology	23,045	25,315	21,366	18,715	18,211	13,148
Gastroenterology	-	-	716	650	346	429
Neuropsychiatric	42,096	13,711	24,402	27,311	27,427	16,812
Medical Specialty	2,338	5,497	6,836	4,994	2,354	5,357
Emergency Room	-	85,883	93,981	108,754	83,984	56,529

*1970 figures include only three quarters of the fiscal year, thru March 1970.

APPENDIX D

CALLS TO CENTRAL APPOINTMENTS DESK

FOUR-DAY SURVEY - APRIL 13, 16, 17, 20, 1970

CALLS TO CENTRAL APPOINTMENTS DESK

FOUR DAY SURVEY - APRIL 15, 16, 17, 20, 1970

MARTIN ARMY HOSPITAL

FORT BENNING, GEORGIA

	Apr 15 Wed	Apr 16 Thurs	Apr 17 Fri	Apr 20 Mon*	Total
Total Calls	333	348	322	282	1,285
Called Right Place	268	279	257	241	1,045
Called Wrong Place**	65	69	65	41	240
% Wrong Calls of Total	19.4	19.8	20.1	14.5	18.6
Caller Created a Delay***	115	104	115	112	446
% Delaying Calls of Total	34.5	29.8	35.7	39.7	34.0

*Number of calls was affected by one clerk being absent during the afternoon hours.

**Callers called appointments desk for appointments to clinics not serviced by desk, for information, etc.

***Appointment clerks were delayed in the appointment-making process by having to explain information to caller, by caller not having needed information readily available, by caller not knowing what he really wanted, etc.

APPENDIX E

GENERAL OUTPATIENT CLINIC APPOINTMENTS - VISITS, 1969

GENERAL OUTPATIENT CLINIC APPOINTMENTS - VISITS 1969

MARTIN ARMY HOSPITAL

FORT BENNING, GEORGIA

	Appointments Made	Clinic Visits	Difference*
January	4,013	7,128	3,115
February	3,629	5,795	2,166
March	4,241	6,754	2,513
April	3,953	6,137	2,184
May	3,681	5,882	2,201
June	3,364	5,657	2,293
July	2,771	5,059	2,288
August	2,049	5,182	3,133
September	2,542	6,384	3,842
October	3,550	7,250	3,700
November	2,774	5,708	2,934
December	2,473	5,806	3,333
Total	39,020	72,722	33,702

*The difference between the clinic visits and appointments made is the number of walk-ins to the general outpatient clinic.

GENERAL OUTPATIENT CLINIC APPOINTMENTS - VISITS 1969

MARTIN ARMY HOSPITAL

FORT BENNING, GEORGIA

	Appointments Made	Clinic Visits	Difference*
January	4,013	7,128	3,115
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March	4,241	6,754	2,513
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September	2,542	6,384	3,842
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November	2,774	5,708	2,934
December	2,473	5,806	3,333
Total	39,020	72,722	33,702

*The difference between the clinic visits and appointments made is the number of walk-ins to the general outpatient clinic.

APPENDIX F

SUGGESTED APPOINTMENT SCHEDULE FORM

CLINIC_____ PHYSICIAN_____ DATE_____

DAY_____

TIME	NAME (Last, First)	STATUS	SPONSOR	PHONE	SSAN		

This devised form could be utilized by all clinics making appointment schedules for record retrieval. The vacant time column allows all interval times or block appointment times. The form would be of aid to the record section clerks in obtaining records, for the SSAN column would always be in the same position. This column is divided into three columns; the last two columns providing the basic digits of the filing system allow for greater speed in finding records.

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ABSTRACT

A STUDY OF THE APPOINTMENT SYSTEM IN THE OUTPATIENT DEPARTMENT OF MARTIN ARMY HOSPITAL, FORT BENNING, GEORGIA

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
Captain Raymundo Elizondo, MSC

August, 1971 73 Pages

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

The problem was to determine the best procedures to improve the functioning of the appointment system for the outpatient department of Martin Army Hospital, Fort Benning, Georgia. Methods of research employed in studying the problem included observation of the clinic administrative personnel in their functioning roles, interviews with professional and administrative personnel, and a review of the applicable literature. In studying the outpatient department appointment system, the total system was studied, observed, and evaluated in terms of the components; thus the central appointments system was studied as a subsystem as were the appointment systems of all of the independent clinics. It was found that the need for a study had resulted from patient complaints of not being able to obtain an open line to the central appointments desk in order to make an appointment. Interviews and observation indicated that there was a lack of information about the central appointments system on the part of the patient population and the professional and administrative staffs. It was concluded that the appointment system at Martin Army Hospital was a working system, but that some improvements could be made in its functioning components in the individual appointment-making clinics as well as in the central appointments desk. Recommendations included methods of lowering the number of calls and reducing the time of the calls to the appointment-making facilities, staffing the appointment desks, and coordinating among the clinics utilizing the central appointments desk.