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A STUDY TO DEVELOP AN IMPROVED ORGANIZATIONAL STRUCTURE
FOR THE PROVISION OF ADMINISTRATIVE SUPPORT FOR THE
DELIVERY OF HEALTH CARE AT FITZSIMONS ARMY MEDICAL CENTER

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CHAPTER I

INTRODUCTION

General Information

"The community general hospital is an organization that mobilizes the skills and efforts of a number of widely divergent groups of professional, semi-professional and nonprofessional personnel to provide a highly personalized service to individual patients...the chief objective of the hospital is, of course, to provide adequate care and treatment to its patients...A hospital may, of course, have additional objectives...but all these are subsidiary to the key objective of service to the patient which constitutes the basic organizing principle that underlies all activities in the community general hospital."¹

Although Georgopoulos' and Mann's article focuses on the essential characteristics and organizational problems encountered by a community general hospital, their remarks are appropriate to the military hospital as well.

While the primary objectives and goals of the civilian and the Army hospital are in consonance, their organizational structures differ. With some variations, the civilian hospital's three major elements are the governing board, the administrator and the medical staff. The military hospital has a different configuration. Treatment facilities have a physician as the Chief Executive. Subordinate to this position

is a Chief of Professional Services and a Chief of Administrative Services. The Chief of Administrative Services, usually a graduate of a program in Health Care/Hospital Administration, is not the hospital administrator in the same sense as his civilian counterpart. The civilian facility usually has a well-defined structure headed by a Chief Executive Officer or administrator who is held directly responsible by the governing body, "for implementation of established policy for providing liaison between the hospital board and the medical staff, and for making direct reports to the hospital board on the overall activities of the hospital."²

No formal separate administrative structure exists within Army hospitals. In 1974 the US Army Health Services Command, realizing that a major deficiency existed in the administrative management within its hospitals, published APC Model 18, "Clinical Support Division," an innovative aid to assist hospitals in improving their administrative support. This document was partially prompted by a survey conducted of administrative assistants at the eight major Army Medical Centers. The results of the survey indicated the need for establishment of an impersonal administrative organizational structure.³

Hospital Setting and History

Fitzsimons Army Medical Center, one of eight major Army Medical Centers, provides definitive health care services in practically every medical specialty. In addition, residency programs are offered in 16

medical specialties. The medical education program also includes specialty training for intensive care nurses, nurse anesthetists and pediatric nurse clinicians, as well as providing residencies in health care administration, hospital pharmacy and medical procurement.

Fitzsimons was originally a recuperation center situated on 600 acres of land given to the Government by the people of Denver in 1918. The present hospital was constructed in 1941 at a cost of 3.5 million dollars. Today, Fitzsimons Army Medical Center is not only a major health care facility, but also a complete military installation with 11 tenant organizations.

No distinct organizational structure exists at Fitzsimons Army Medical Center for the provision of administrative support to the professional departments. Each service or department has its own administrative resources, who function autonomously and independently from other professional activities. Within the professional services there are eight recognized manpower requirements for departmental administrators or administrative officers. There are also eight authorized positions for professional services noncommissioned officers or chief administrative clerks. To provide clerical and supplementary administrative support, there are 69 additional positions. Of this number, 22 clerical positions are provided to support both the Department of Radiology and the Tumor Registry within the Department of Surgery.

The support that is provided is done in an autonomous fashion

with each department chief exercising supervision over the administrative aspect of his operation. No coordination nor control is exercised by the hospital Executive Officer with the exception that he is in the evaluation scheme for those officers who function as administrative assistants.

Conditions Which Prompted the Study

The author, having completed the didactic phase of the US Army-Baylor University program in health care administration, observed a noticeable absence of any organizational structure within the professional services for the provision of administrative support. This observation was shared by the Center's Executive Officer. This deficiency was manifest in a frequent breakdown in communication from the top level of management down into the departmental/service organizations. No policy or directives existed which administrative assistants or officers could utilize in accomplishing their job. Very little coordination existed between administrative elements. In essence, each department operated as an independent agency, each concerned with its own problems and functions. Within such a system, utilization of resources, professional development of the administrative staffs, and the accomplishment of the Center's health care delivery mission are not optimal; rather, the organizational climate was status quo; i.e., "it is done this way because this is the way it has always been done." This situation, as observed by the author and the Center's Executive Officer needed improvement.

An attempt to accomplish this improvement was the impetus behind this study.

Statement of the Problem

The problem was to develop an improved organizational structure for the provision of administrative support for the delivery of health care at Fitzsimons Army Medical Center, Denver, Colorado.

Research Methodology

The methodology employed in research of the problem, in development of alternatives and in determination of the ultimate recommendation was based on qualitative measures.

Structured interviews were conducted with administrative officers and, in those activities where no officer is authorized, with the senior enlisted or civilian individual responsible for administration and supervision of nonprofessional resources. The purpose of these interviews was to determine perceptions and expectations to roles, functions, education and ideas as to whether an optimal organizational structure existed which could be applied to accomplish the Center's administrative support function. Similar structured interviews were conducted with department chiefs. Information obtained was concerned with their perceptions and expectations of their administrative staffs. The results of the interviews were analyzed to determine what organizational and educational attributes were deemed necessary as well as optimal from

both perspectives.

Additionally, the organizational structure of a civilian Medical Center was examined to determine if that system, or portions thereof, could be implemented at Fitzsimons Army Medical Center.

A review of the literature was conducted to determine present trends and current methods of providing administrative support to professional departments. Where the review revealed structural innovations, these were considered for incorporation into the design of the structure at Fitzsimons.

Objectives

The successful completion of pertinent interim objectives is necessary to the resolution of the problem statement. Establishment of these interim objectives was a necessary element in performing an analysis of the existing problem. The objectives of this study are:

1. Determine what administrative support is being provided to professional departments and how that support is being provided.
2. Determine the academic qualifications of the present administrative assistants/officers.
3. Ascertain the perceptions that present administrative officers have about their roles, and ascertain the perceptions of department chiefs regarding their administrative support.
4. Determine whether or not staffing to provide administrative/ clerical support functions is adequate.

5. Analyze organizational structures that have been developed to provide administrative support to professional services.

6. Determine current trends in the provision of administrative support functions.

7. Evoke alternatives to the existing system of providing administrative support to professional services.

8. Develop a recommendation which can be practically implemented within existing resources and facilities.

Criteria

The identification and evaluation of interim objectives requires that valid criteria be utilized. In reference to the academic qualifications of current administrative assistants, that data developed by the American Hospital Association, the American College of Hospital Administrators and/or the Federation of American Hospitals, was considered as a basis for measurement.

To ascertain whether interim objectives relating to the level and type of support being furnished were being fulfilled, measurable criteria established by a review of the literature was used. In addition, commentary provided in structured interviews with department chiefs and administrative assistants was used against which to evaluate the effectiveness of the present organizational structure.

Staffing criterion published by the Department of the Army and other health care organizations was used to measure the adequacy of current

staffing and was also considered when changes to staffing patterns were determined to be a requirement in resolution of the problems.

Assumptions

For the purpose of this study it was assumed that:

1. Fitzsimons Army Medical Center will continue in operation as one of eight Army Medical Centers.
2. Qualified administrative personnel will be available through military or civilian academic programs, thus no formal in-house training program will be required.

Limitations

The following limitation applied to this study:

Proposed alternatives must be capable of implementation within existing manpower constraints. While some additional staffing requirements may be required, alternatives would not result in major increases to staffing levels.

Literature Review

"Organization," "management" and "administration" are three of the most commonly used terms in the industrial perspective; be that industry production oriented or, as with the delivery of health care, service oriented. There is no lack for material on any one of the three subjects. Frequently, unfortunately, much is either a redefinition or a

"review" of what previous authors have written.

It is not the intent to provide a dissertation on the subjects. There are an abundance of volumes already in print. Note, for example, two rather well known contemporary scholars - Harold Koontz and Cyril O'Donnell. They have produced six editions of their basic management text; their latest work views the subject from a systems and a contingency perspective.⁴ Rather, what shall be attempted in this review is to look at some of the specifics with which this paper is concerned. An attempt will be made to show the complexities of the environment within which the modern day administrator must not only exist but also optimally function.

Basil S. Georgopoulos has edited an extensive and inclusive book whose underlying concern is with the creation and maintenance of effective organizations within health care institutions. One impressive chapter discusses the physician's role in institutional management. Written by Robert Guest, the chapter traces the historical perspective which then provides some understanding as to why the physician has found it so difficult to properly blend his professional focus with the institution's demand for complete patient care. He further discusses such current subjects as the medical staff's role in policy making and concludes with some speculative comments as to what the future holds for the physician's institutional relationship.⁵

Quoting Georgopoulos and Mann, Guest provides a good overview

of the complexity of the hospital.

"To do its work the hospital relies upon an extensive division of labor among its members, upon a complex organizational structure which encompasses different departments, staff officers and positions and upon an elaborate system of coordination of tasks, functions and social interaction.

Work in the hospital is greatly differentiated and specialized, and of a highly interactional character. It is carried out by a large number of cooperating people whose backgrounds, education, training, skills and functions are as diverse and heterogeneous as can be found in any of the most complex organizations in existence. And much of the work is not only specialized but also performed by highly trained professionals - the doctors - who require the collaboration, assistance and services of many other professional and nonprofessional personnel."⁶

He further gives some insight into the relationship between the administrative aspect of the hospital and the physician. Borrowing from R. W. Wilson's "The Physician's Changing Hospital Role," Guest indicates that traditional roles are no longer valid in the current hospital environment.

"As the hospital has become more complicated and more critical to all of medical practice, as its uses have multiplied and its patient load has extended rapidly, the administrator has enjoyed an accompanying growth in stature. Rational planning and control, from food management to finances to surgery, have become a hospital necessity. The rationalization of hospital life could not occur without the expansion of old roles, like those of personnel director or comptroller. Thus, the administrative staff, traditionally seen as the doctor's handmaiden and existing, like the nurse, for his sole convenience, has been transformed into something approaching - although not nearly reaching - the character of executive echelons in corporate or governmental hierarchies."⁷

The terms "administration" and "management" appear frequently throughout the paper. Prior to examining the current environment and attempting to improve upon it, the need exists to briefly differentiate between the two. In common usage they have frequently become as one - as have their derivatives, i.e., manager and administrator. Both are used interchangeably. It is important to make a distinction for they do have separate orientations. Any management text which purports to be an academic treatise will provide a comprehensive definition. Basically, as Dale states, "Management is a process of organizing and employing resources to accomplish predetermined objectives."⁸ While not directly expressed, the implication is that management is more directly concerned with people. Although the term administration is frequently used in lieu of management, the subtlety of the term would imply its concern with things - with processes. Webster, in a pure definition, indicates that the verb "to administer" is synonymous with the verb "to execute."⁹ Thus, the implication is that management is more than simply an execution - it is both a science and an art, which says it's more than systematized knowledge; rather, management also requires skills which are based on experience. Writing in 1971, John Price differentiated the two terms by suggesting that both management and administration are essential to the success of any organization. They are, he commented, dependent upon each other for ultimate achievement of each area's effectiveness.¹⁰

The literature strongly emphasizes the human element with reference to management. While manipulation of all resources is essential for effective management, the human element is by far the most important. Administration, on the other hand, provides a framework through which management can occur.¹¹ The manager is the organizational hub, he is..."the unifying force, and the leader in marshalling the resources of the complex hospital organization. He continually must seek more effective ways of accomplishing his hospital's mission."¹² The administrator's prime concern by the current definition are such things as procedural policies, functionalization of tasks and organizational structure.

Organizational structure is a significant element in any discussion which attempts to improve upon an existing situation. Drucker has commented, "above all, we have learned the danger of the wrong organization structure. The best structure will not guarantee results and performance. But the wrong structure is a guarantee of nonperformance."¹³

The hospital, indeed, is one of the most complex organizational types found in society. Many, in fact, have stated that "a hospital functions in spite of its organization -- not because of it."¹⁴

The development of American hospitals has been along the lines of traditional industrial models which historically were characterized by bureaucratization with charismatic or "traditional modes of operation."¹⁵

The result, according to Durbin and Springall has been the inefficient use of many manpower facilities and equipment.¹⁶

Research on hospital organization has resulted in some innovative thinking. Moseley and Grimes address one approach of a group of researchers, led by such scholars as Lawrence and Lorsch, which suggests that managers should adopt a contingency theory of organization. This approach is concerned with the systematic nature of an organization's characteristics.¹⁷

Specialization pertains to how the work within the organization is divided. Pugh indicates two specific aspects to specialization, role and functional. Role specialization is included within each functional area of specialization.¹⁸ Hospitals are labor intensive entities and to accomplish their objectives, they are dependent upon an extensive division of labor. To function properly, however, there must be a high degree of cooperation among persons whose functional areas are greatly differentiated and specialized.

Georgopoulos and Mann indicate the necessity for a high degree of interdependence within the hospital. Without a solidarity of cooperation, continuity within the organization could not be ensured. In this same perspective, they note that the hospital cannot afford to allow its coordination to function from mechanical standardization; but rather it must rely on the member's motivations, skills and attitudes to develop and maintain effective organizational coordination.¹⁹

Traditional, and in many instances, current hospital organization has been and is based on a departmental structure. The approach is an adjunct to the pyramidal form of organization, which, according to most theorists of the classical school, was necessary because, "as work decisions become more complicated, more comprehensive in scope and more significant to the organization, responsibility for that work should be shifted upward to a higher level personnel."²⁰ The matrix organization design has been offered by some as a viable alternative to the traditional hospital structure. This approach has demonstrated its success within industry. Developed to induce integration and cooperation in solving the crucial business problems of defense projects,²¹ the matrix organization presents almost an opposite orientation from the traditional pyramid structure. Decision making tends to be flattened out on a horizontal plane which is spread throughout the organization. Rather than require the chief executive to pass judgment on every issue, decision making is located at the middle management level. "...The intent is to push decision making as far down into the organization as possible to encourage group consensus."²²

This design innovation allows for decentralization, and enhances the "team approach." It allows for "constructive competition and collective motivation between groups while providing more and better feedback to all members of the team."²³

Matrix design allows the administrator more flexibility and

opportunity to place his personnel resources on the delivery of care and to decentralize the decision making process. "This team approach to problem solving allows for better interaction of paramedical personnel and provides a mechanism for physician participation in decisions affecting patient care."²⁴

Unique also to the hospital organization is the existence of status systems. The scalar status system is the more commonly acknowledged structure which has the usual authority patterns coming from the Board of Trustees to the administrator and then down through the organization. It is a familiar line and staff system. The medical staff is in a unique position responsible to the administrator for certain matters and, then also communicating with the board through a joint conference or liaison committee. The functional system operates with the physician at the top position; dependent not on the authority and jurisdiction as with the scalar system, but rather on the education, skills and training which only the physician has. The functional organization exists - because it must - within the direct patient care responsibility of the institution.²⁵ The question of who's in charge becomes important and can lead to a situation which can only lead to explosive results.

An informal status system also exists within the hospital. Based on individual's personalities or activities, this organizational system emerges as a result of personal relationships. While the informal organization per se is not visible, it has an important role

in the hospital's status structure. Administrators need to be aware of its existence and realize that it can have an important effect on the operation of the hospital.²⁶

The challenges for the administrator have never been more evident. As more research is done on hospitals and hospital organization, the implications for the administrator will even become more awesome. Moseley and Grimes' analysis of hospital effectiveness is just one example of this fact. Their work provides implications for practicing administrators:²⁷

a. The classical management approach is not universal and not applicable to all situations.

b. Adaptation to each situation is important. Success with management activity in one situation does not mean it will work in another situation.

c. Administrators must realize the existence of multi-employee levels within the hospital. Each level must be dealt with separately.

d. An administrator must critically examine his own performance by consideration of several aspects. Also, necessary to the successful administrator is a prioritization of personal goals and objectives.

e. A hospital's organizational structure is affected by a multiple goal orientation. Structural characteristics important to predicting patient care effectiveness are relatively unimportant in their impact on administrative effectiveness.

There is no one answer to an optimal administrative approach or

organizational structure. What is appropriate and effective for one institution may not be for another. The important aspect with which the administrator must deal, is that the organizational structure which is correct for his facility is that one which allows each activity to fully function and perform in pursuit of organizational goals.

Awareness of the research that is occurring in hospital organization will allow the administrative activity of the hospital to better plan and innovate. While an improved structure may enhance the effectiveness of administrative performance, there is no conclusive evidence that has shown there is an optimal structure which guarantees results and performance. Thus, change for change sake is inappropriate. However, at the same time, remaining with the status quo for the sake of tradition has no validity.

Footnotes

¹Basil S. Georgopoulos and Floyd C. Mann, "The Hospital as an Organization," Hospital and Health Service Administration 7 (Fall 1972): 50.

²John A. DiBiaggio and Raymond P. White, "Administrative Structure of an Accredited Hospital," Dental Clinics of North America 19 (October 1975): 581-2.

³US Department of the Army. Health Services Command. "Clinical Support Division," APC Model No. 18, Fort Sam Houston, Texas (July 1974): 2.

⁴Harold Koontz and Cyril O'Donnell, Management: A Systems and Contingency Analysis of Managerial Functions (New York: McGraw - Hill Book Co., 1976), ix.

⁵Basil S. Georgopoulos. "Introduction" in Organization Research on Health Institutions, ed: Basil S. Georgopoulos (Ann Arbor: The University of Michigan, 1972), 3.

⁶Robert H. Guest. "The Role of the Doctor in Institutional Management," in Organization Research on Health Institutions, ed: Basil S. Georgopoulos (Ann Arbor: The University of Michigan, 1972), 288.

⁷Ibid, p. 289.

⁸Ernest, Dale, Management: Theory and Practice (New York: McGraw - Hill Book Co., 1973), 4.

⁹Webster's Seventh New Collegiate Dictionary, rev. ed. (1970), S.V. "Administer."

¹⁰John B. Price. "There's a Difference Between Administration and Management," Office 74 (October 1971): 64.

¹¹Ibid.

¹²Walter Danco, "Hospital Managers Seek Ways to Cope with Change," Hospitals 51 (April 1977): 133.

¹³Peter F. Drucker, Management Tasks Responsibilities Practices (New York: Harper and Row, 1974), 519.

¹⁴David L. Brown and Michael F. Doody, "Up and Down the Organizational Ladder," Osteopathic Hospitals 20 (October 1976): 13-15.

¹⁵Richard L. Durbin and W. Herbert Springall, Organization and Administration of Health Care, 2d Ed., (St. Louis: The C.V. Mosby Co., 1974), 42.

¹⁶Ibid.

¹⁷S. Kelley Moseley and Richard M. Grimes, "The Organization of Effective Hospitals," Health Care Management Review 1 (Summer 1976): 14.

¹⁸Ibid, quoting Pugh's "Dimensions of Organization Structure," Administrative Science Quarterly 13 (June 1968).

¹⁹Georgopoulos and Mann, p. 53.

²⁰Terrance F. Moore and Bernard E. Lorimer, "The Matrix Organization in Business and Health Care Institutions: A Comparison," Hospital and Health Services Administration 21 (Fall 1976): 26.

²¹Ibid.

²²Ibid., p. 27.

²³Ibid., p. 31.

²⁴Ibid., p. 33.

²⁵Richard T. Viguess, "Whose on Top? Who Knows?" in Hospital Organization and Management, ed: Jonathan Rakich (St Louis: Catholic Hospital Association, 1972), 14.

²⁶Ibid., p. 18.

²⁷Moseley and Grimes, p. 21-22.

CHAPTER II

SYSTEMS AND ALTERNATIVES

Introduction

"....It is helpful to pause a bit to assess what is happening to our notions about how health services ought to be managed, organized and delivered.

Managers should routinely assess changes in their social, economic, political and technological environment. Then, an assessment of organizational resources and opportunities suggest leads as to how these can be matched to compete in the marketplace for services and ideas."¹

The Army is steeped in tradition. Change to an existing system is an extremely slow and laborious process. The organization of the Army hospital is an obvious example of a system whose structure has remained static for many years. While there are obvious distinctions between the small 50 bed hospital and the large medical center, both have the same basic structural framework. Rarely does the military system allow for reflection, examination or innovation. While studies have been conducted, and innovations designed and to some degree implemented, the basic organization as indicated in past and current regulations remains in effect.

With respect to providing administrative support to professional

departments, Fitzsimons Army Medical Center does not significantly differ from the seven other Army Medical Centers. In addition to an examination of Fitzsimons' current administrative structure, this section will discuss two other structural approaches; that employed at Colorado General Hospital and the Clinical Support Division, APC Model Number 18, which is, "a composite of tested, effective organizational concepts capable of providing improved service to the clinical staff."² Finally, an alternative structure will be offered. Basically a modification of the Clinical Support Division, the approach has potential for adoption at Fitzsimons Army Medical Center.

Current Status of Administrative Support to Professional Departments

Fitzsimons Army Medical Center is totally departmentalized. Installation functions are organized along traditional directorate lines, i.e., Directorate of Personnel and Community Activities, Directorate of Industrial Operations, Directorate of Plans and Training, Directorate of Resources Management, Directorate of Facilities Engineering, Directorate of Communications and Electronics and Directorate of Security. Within the hospital facility are found the professional departments. Five departments have recognized positions for commissioned administrative assistants or administrative officers. The Department of Primary Care and Community Medicine is the only department whose administrator position is delineated as a Health Care Administrator (SSI 67A).

In addition to the position in the Department of Primary Care and Community Medicine, there are only three other positional requirements for Health Care Administrators; the Center Executive Officer, the Chief, Administrative Support Branch, Medical Activities and Medical Education, and the Clinic Administrator, United States Army Health Clinic, Dugway Proving Grounds, Utah. Four departments - Surgery, Medicine, Psychiatry and Nursing - have requirements for Captains with a Specialty Skill Identifier of 67B (Field Medical Assistant). Both the Department of Radiology and Department of Obstetrics and Gynecology have an approved manpower requirement for a civilian administrative officer. The Department of Pediatrics has a requirement for a senior noncommissioned officer with a Specialty Skill Identifier of 71G40 (Professional Services NCO). The Department of Pathology and Area Laboratory Services and the Clinical Investigation Service do not have validated administrative positions per se. Rather, the Department of Pathology has, located within the office of the Chief, both a clinical laboratory officer, a chief medical laboratory NCO (NCOIC) and a supervisory clerk-stenographer. In the Clinical Investigation Service, as with the Department of Pathology, there are requirements for a clinical laboratory officer and a medical laboratory NCO within the office of the chief. Neither of the two officers assigned to these two activities function in their duty SSI. AR 611-101 states that a clinical laboratory officer "conducts and directs the performance of laboratory procedures used in the detection, diagnosis, treatment and prevention of disease."³ No mention is made of administrative skills required as a specific qualification. In addition to the officer position,

the Department of Psychiatry has a validated requirement for a chief administrative NCO (SSI 71L40). Physical Medicine Service has a recognized position only for a physical therapy NCO in addition to secretarial support. With the exception of the Department of Primary Care and Community Medicine, no administrative assistant positions are recognized below departmental level. Several services, however, utilize the senior enlisted person in the traditional clinic/service NCOIC role.

Current written guidance does not differentiate between commissioned officer, noncommissioned officer or civilian administrators. "Administrative assistants to the chiefs of professional departments or services will be assigned in such numbers and grades as the workload may require."⁴ Table 1⁵ shows the current manpower staffing for administrative assistants, administrative officers, professional services non-commissioned officers and administrative noncommissioned officers. Excluded are secretarial/clerical/supply positions which function in an administrative capacity within subordinate services. Included, however, are officers who function in an administrative capacity within Pathology and Clinical Investigation Service.

With the exception of the Department of Pathology and Clinical Investigation Service, structured interviews were conducted with each individual filling an administrative office/professional services NCO position.⁶ The results of these interviews indicated some common weaknesses with the method in which administrative support is currently provided. While all individuals indicated that they had discussed their

TABLE 1

Staffing Requirements, Authorizations and Assignments
For Administrative Positions Within Professional Departments

<u>Dept</u>	<u>Position</u>	<u>Recognized</u>	<u>Authorized</u>	<u>Assigned</u>
Medicine	Admin Off	X	X	X
	PSNCO	X	X	X
	Admin NCO	-	-	X
Surgery	Admin Off	X	X	X
	PSNCO	X	X	X
Pediatrics	Ch, PSNCO	X	X	X
OB-GYN	Admin Off (C)	X	X	X
Radiology	Admin Off (C)	X	X	X
	X-Ray NCO	X	X	X
Pathology	Clin Lab Off (a)	X	X	X
	Ch Med Lab NCO	X	X	X
Psychiatry	Admin Off	X	-	X
	Ch Admin Clk	X	X	X
DPCCM	Hlth Care Admin	X	X	X
	Clinic Admin (b)	X	X	X
	Admin Off	X	-	-
	Admin Off (C)(c)	X	X	X
	Ch Clinic NCO	X	X	X
	Medical NCO (b)	X	X	-
Nursing	Admin Officer	X	X	-
CIS	Clin Lab Off (a)	X	X	X
	Med Lab NCO	X	X	X
Physical Medicine	Phys Therapy NCO	X	X	X

NOTES: C - Civilian

(a) - Functions predominately as admin officer/assistant

(b) - USAHC, Dugway Proving Grounds, Utah

(c) - USACEHC, Tooele Army Depot, Utah

jobs with their department chief upon assignment to the position, only two were able to affirm that they were given specific responsibilities and functions. Although the Center's regulation concerning administrative assistants provides a functional list of responsibilities, and at least one individual has a job description which lists functional responsibilities, historically, a lack of precise definition of job responsibilities has been given during initial interviews and orientations. In only two cases was there any overlap between departing and currently assigned personnel. In fact, in three departments the incumbent was the first person to occupy the position.

While an informal channel of communication exists between the administrative assistants in the Departments of Surgery and Medicine, this relationship exists only as a result of a friendship between the incumbents. There is no formal mechanism which allows for effective communication or coordination between the professional departments. A periodic meeting is held with the Chief, Administrative Support Branch, Medical Activities and Medical Education. However, the primary purpose is to disseminate information. Consequently, no forum exists which allows for maximizing cooperation, discussion and potential solution of common problems.

Finally, only one of the departmental administrative officers has had specific training in health care administration. Two of the three other assigned commissioned administrative officers have baccalaureate

degrees; one in Botany and the other in Public Administration. The fourth administrative officer has a Master's degree in Eastern European area studies. The experiential basis of the military members has been highly oriented to field activities. Both civilians' backgrounds have been in the secretarial/clerical field. Table 2 provides a summary of the qualifications of departmental administrative officers.

TABLE 2

Qualifications/Assigned Departmental Administrators

	<u>Medicine</u>	<u>Surgery</u>	<u>Pediatrics</u>
Length of Service	2.5 yr	4.5 yr	21.5 yr
Tenure in Position	7 mos	3 mos	19 mos
Auth/Actual Grade	CPT/1LT	CPT/CPT	SFC/MSG
DSSI/PSSI/GS Series	67B/67B	67B/67F	71G40/71G50
Educational Level	Baccalaureate Degree	Master's Degree	HS Grad
	<u>DPCCM</u>	<u>Psychiatry</u>	<u>*OB-GYN</u>
Length of Service	12 yr	3.5 yr	28 yr
Tenure in Position	19 mos	4 mos	13 mos
Auth/Actual Grade	MAJ/MAJ	CPT/1LT	GS-7/GS-7
DSSI/PSSI/GS Series	67A/67J	67B/67B	314/314
Educational Level	Master's Degree	Baccalaureate Degree	HS Grad
	<u>Radiology</u>	<u>Pathology</u>	<u>CIS</u>
Length of Service	22.5 yr	17 yr	9.5 yr
Tenure in Position	10 yr	7 mos	4 yr, 7 mos
Auth/Actual Grade	GS-7/GS-7	CPT/LIC	CPT/CPT
DSSI/PSSI/GS Series	314/314	68F/68F	68F/68F
Educational Level	HS Grad	Baccalaureate Degree	Baccalaureate Degree

*NOTE: Although assigned to her current position for only 13 months, the occupant has served within the Department of OB-GYN for 22 years.

All incumbents, except the administrative officer in the Department of Radiology have some decision making authority in regard to fiscal matters. The latter individual has no involvement or decision authority with any fiscal matters. The extent of this authority ranges from one officer whose authority is nearly complete for expenditure and transfer of funds, to an officer whose fiscal responsibility is limited to routine expendable supply purchases. Excluding Radiology, all individuals are responsible for making a monthly analysis of departmental expenditures. Only the administrator within the Department of Primary Care and Community Medicine actually establishes fiscal policy within the department.

Again, with the exception of the Department of Radiology and the Department of Primary Care and Community Medicine, administrative officers have limited supply responsibility. Other than monitoring the expenditure of funds for supplies, and coordinating or approving routine requests, little materials management is practiced. In the larger departments, routine expendable supplies are ordered by service or clinic NCOIC's. Some restraint is maintained in the manipulation of supply funds. Usually, at departmental level there is an enlisted specialist or an NCO whose principle duty is to coordinate routine supply activities. With the exception of the Department of Primary Care and Community Medicine, supply policy is generally established by the chief of the department. Some programs have been initiated in supply economy and inventory control; however, those have been limited to the Department of Primary Care and Community Medicine and to a slight extent, the Department of Pediatrics.

All administrative officers coordinate development of the departmental MEDCASE program. Final prioritizing of items and approval lies with the department chief.

The administrator of the Department of Primary Care and Community Medicine is extensively involved with personnel management functions concerning both civilian and military personnel. Within the other activities, there is little involvement by the administrator in personnel management functions. What involvement exists is concerned with coordinating civilian employee recruitment and termination actions, which are normally initiated by affected service chiefs. With minor exceptions, supervisory responsibility is restricted to those clerical and administrative personnel who are assigned directly within the office of the department chief. There appears to be very little activity within any, but the Department of Primary Care and Community Medicine, to develop any program for employee professional growth or development.

While much of the reason for the apparent lack of managerial involvement can be explained by the newness of assigned personnel, nonetheless, there appears to be a lack of understanding as to the role of a department administrator. Interestingly, only the officer assigned to the Department of Primary Care and Community Medicine felt that his position required an advanced degree, specifically within the field of health care administration.⁷ All others had no strong feelings as to what, if any, were the minimum educational or academic requirements. None felt that their position

responsibility required an advanced degree. There was unanimity, however, that a course for administrative officers should be developed aside from the AMEDD Officer Basic Course. The focus of such training should be with resource management.

None of the administrators, except in the Department of Primary Care and Community Medicine, indicated they had policy making authority. Additionally, there was little evidence that any of the administrators engaged in any significant planning activities. Little noticeable involvement was observed with staffing or organizing activities.

The general observation is that each administrative officer, except in the Department of Primary Care and Community Medicine, functions in a reactive mode; responding to daily situations which arise and concern nonprofessional matters. With only a vague perception as to what their position entails, crisis management is the vehicle by which administrative support is provided.

Two positions bear further discussion because of the uniqueness of their involvement with administrative support functions.

US Army Health Clinic, Dugway Proving Grounds, Utah.

The clinic administrator at the US Army Health Clinic, Dugway Proving Grounds, Utah, occupies an unusual position. He is the responsible official, the "boss" of a military patient care facility. Located approximately 85 miles west of Salt Lake City, Dugway Proving Grounds is a DARCOM installation primarily involved with munitions testing. The

clinic, previously a MEDDAC with inpatient responsibilities, provides ambulatory care, dental and optometric services to assigned military personnel and dependents and civilian employees and their dependents. The clinic has an authorized strength of 40 personnel which includes two military physicians, both general medical officers. The physicians function almost totally as health care providers. What small involvement they have with administrative activity is limited to the senior physician functioning as the installation's Director of Health Services. The responsibilities of the clinic administrator include most routine "command" functions. He also has decision making authority for most fiscal, equipment, logistical and personnel matters. Although as with any other military organization, the administrator has a chain of command to which he is responsible, it is the intent of the Department of Primary Care and Community Medicine that the clinic administrator operate in the functional role of an administrator.

The clinic operates smoothly within the environment. The physicians appear to have completely accepted their roles as providers and, except for a lack of contact with academic medicine, are satisfied with the organizational structure and delineation of administrative responsibilities. The installation commander positively accepts and supports the manner in which the clinic is organized and operated.⁸

Administrative Support Branch, Medical Activities and Medical Education.

Subordinate directly to the Director of Medical Activities and Medical Education is the Administrative Support Branch.

Conceptually, this office was established to function as an advisory body to the Deputy Commander on the general spectrum of administration. Additionally, it was envisioned that the office would exercise staff supervision and control over all administrative elements that supported the professional departments.⁹

The office does not, in fact, function as a focal point for existing administrative elements. While the chief holds periodic meetings with departmental administrators, he has no supervisory responsibility over their activities.

The branch is comprised of an officer and a civilian clerk-stenographer. Major activities supervised include the Medical Library, the Medical Illustration Section and the Central Appointments Section. Other major responsibilities include developing the graduate medical education and continuing medical education programs. Additionally, the office coordinates, consolidates and finalizes for the Deputy Commander, budgetary matters pertaining to temporary duty, consultants' visits and supplemental care.

On a day-to-day basis, the office, because of its size can only react to requirements and projects imposed by the Deputy Commander, or in response to requests from other agencies. Coordination with other de-

partmental administrative elements is practically non-existent. Management of subordinate functional areas is accomplished almost solely by exception.

While it might appear that the Administrative Support Branch is inefficient because of its inability to accomplish those functions originally conceived in development of the office, that is not the case. With present staffing, little more than what is presently being done can be accomplished.

There is no formal relationship between the Chief, Administrative Support Branch, Medical Activities and Medical Education and the Center's Deputy for Administrative Support Services (Executive Officer). The organizational chain is directly to the Deputy Commander and the Commander. Yet, the incumbent receives a performance evaluation from the Executive Officer. Without the existence of a close professional relationship between the Deputy Commander and the Executive Officer, this dual chain of responsibility could place the Chief, Administrative Support Branch in an untenable position.

The independent position of the Administrative Support Branch serves to reinforce the autonomy of the professional departments. Its current operation provides added impetus for the need to develop a more formal arrangement to insure optimal administration is being provided the professional elements of the Medical Center.

The Perspectives of Department Chiefs.

In order to gain as complete a composite as possible of how the professional departments are provided administrative support, interviews were conducted with the chiefs of the Departments of Medicine, Surgery,

Obstetrics and Gynecology, Pediatrics, Psychiatry, Primary Care and Community Medicine and Radiology.¹⁰ A discussion was also held with the Assistant Chief, Department of Nursing, who provided some personal insight and perceptions pertaining to utilization of an administrative assistant within the Department of Nursing. Also, during the author's rotation through the Department of Pathology and Area Laboratory Services, a discussion was held with the chief, specifically with reference to administration and management of clinical pathology services.

It is interesting to note that none of the current department chiefs have had any training or experience in the field of management or administration. Nor have any previously held positions as department chiefs at similar size institutions. Interestingly, both the chief of Medicine and of Surgery graduated from the United States Military Academy. Therefore, during their early service careers, they were exposed to some military management responsibilities.

When asked their perceptions of the role of the administrative officer, all but one chief expressed positive comments. The indication of six of the seven department heads was that the administrative officer's primary responsibility is to handle the day-to-day administrative functions within the department. Additionally, the administrative officer was projected as being responsible for coordinating the development of the departmental budget and MEDCASE program, and for making minor routine administrative decisions. While each chief indicated he could absorb the functions currently

accomplished by his administrative officer, there was a unanimous qualification that if such were to happen, both the clinical and training roles would suffer. Generally, the administrative officer was perceived to be both productive and satisfied with the job. One department head expressed complete disgust with his administrative officer, who was considered ineffectual and incompetent.¹¹ Conversely, at the other end of the spectrum, one department chief confessed that his administrative officer, in effect, "ran the department."¹²

While all but one chief spoke positively of the responsibility with which the administrative officer is charged, six of the seven physicians indicated that they personally retained decision making authority for all but routine administrative matters. Additionally, while administrative officers may, in some instances, propose and coordinate departmental policy, the chiefs have kept approval or disapproval authority over those policy decisions.

Chiefs of departments with residency programs unanimously perceived themselves with three major roles; clinician, educator and administrator. Each would prefer to reduce, to the maximum extent possible, the amount of time spent in administration which ranges from 15 to 50 percent.

While each department chief has his own perception of what administrative support is required by the department, the specific role of the administrative assistant could not, except in one case, be well de-

fined. In response to a request to define and differentiate between the terms "administration" and "management," none could provide any good distinction. Responses varied from a vague comment that, "management is concerned with financial matters and administration, utilization of manpower,"¹³ to, "that set of procedures that a person responsible for the overall functioning of a service area adopts to expedite the overall job of those under his supervision and the overall functioning of his area (management)," and "administration and management are pretty synonymous to me,"¹⁴ to "management is bringing your total resources into the operation in the most effective way to accomplish the mission," and "administration has to do with the clerical functions, and the dotting of the 'i's', opening the boxes, procurement, the paperwork and so forth, and management is the think part of it."¹⁵

Although all but one of the chiefs indicated that a baccalaureate degree was the minimum educational requirement for the administrative position, none felt that the functional and positional responsibilities required an advanced degree. Additionally, prior military experience within an administrative spectrum was valued more highly than academic credentials. Only one chief thought that the responsibilities of an administrative officer were of sufficient magnitude to require an advanced degree.¹⁶ That department was the only one that received journals in the field of health care management or administration. All chiefs positively supported the idea that their administrative officer should attend courses or seminars to improve their skills, however, only one of the assigned

administrative officers has attended any training sessions.

In discussion with the chief of the Department of Pathology, his perception was quite evident: a physician should be in charge of a clinical pathology service. The reasoning provided was that such responsibility is necessary to allow the doctor to gain valuable administrative experience. The MSC Officer, trained in scientific endeavors, is more closely associated with the role of a medical technologist.¹⁷

No administrative officer is currently assigned to the Department of Nursing. The previous occupant attempted to function as a departmental administrator, rather than simply as an office manager. He met with severe resistance and was only able to partially succeed in his perceived role. When asked to differentiate between an associate administrator and administrative assistant, the assistant chief nurse responded that it was really only a semantical distinction. When presented with the author's perceptions of the role of an associate administrator, the Assistant Chief Nurse indicated that if that were the case, there would be no valid need for the Assistant Chief Nurse position.¹⁸

It becomes obvious that department chiefs do not have a clear definition as to the specific role of their administrative officers. While all expressed a desire to be involved as little as possible with administrative functions, none were willing to give carte blanche authority to administrative officers to be a departmental administrator. Never having been exposed to any other system, department chiefs felt trapped

by the "system." No chief could provide any suggestion or innovative idea as to how to improve the organizational structure to better relieve them of the administrative burden that they so vocally abhorred but which they were so reluctant to give up.

Colorado General Hospital

Colorado General Hospital is a major teaching facility licensed to operate 393 beds and 41 bassinets. The hospital is one of the entities comprising the University of Colorado Medical Center. The Medical Center, in turn, is one of four major organizations within the University of Colorado system (the other three elements: The University of Colorado campuses at Boulder, Denver and Colorado Springs). The Medical Center is comprised of the Colorado Psychiatric Hospital, the Wardenburg Student Health Center, Colorado General Hospital and the Schools of Medicine, Nursing and Dentistry. Overseeing the Medical Center is a Chancellor who reports to the University President. The President, in turn, reports to the Board of Regents, an autonomous elected body.

The Executive Director of Hospitals is responsible to the Chancellor for administration of the three health care facilities. Interestingly, the Colorado Psychiatric Hospital has no inpatient facilities. In 1974, because of the poor condition of the building, it failed to be accredited by the Joint Commission on the Accreditation of Hospitals. The legislature did not favorably consider building a new structure. Instead, they voted to incorporate the psychiatric beds within those at the Colorado General Hospital. At the

same time the number of beds was reduced from 67 to 40. Presently, part of the eighth floor of the hospital houses the two psychiatric (adult and child) units. By statute, however, the institution is a distinct entity, having an independent administrative system.¹⁹

The role of the Executive Director of Hospitals appears to be one of an intermediary with the external environment. The incumbent establishes policy which affects all three facilities, and effects liaison between the three hospitals and the Medical Center. Additionally, the position requires extensive involvement with state health agencies and legislative committees who are involved with the state health care system.²⁰

Within Colorado General Hospital itself there is an administrator, two associate administrators and two assistant administrators. The administrator and both associates are graduates of Health Care Administration programs. One assistant administrator has a graduate degree in public administration. The other, who also functions as the Director of Nursing Service, has a Master's degree in Nursing Administration. Not included within the organizational chart is an administrative assistant to the hospital administrator. The incumbent's responsibilities are vague and he can best be described as a "special projects officer." He has a Master's degree in Health Care Administration. Table 3²¹ shows the qualifications of the administrative staff at Colorado General Hospital.

TABLE 3

QUALIFICATIONS OF HOSPITAL ADMINISTRATORS - COLORADO GENERAL HOSPITAL

	<u>Administrator</u>	<u>Assoc. Admin.</u>	<u>Assoc. Admin.</u>
Tenure in Professional Field	12 yr	6 yr	6 yr
Tenure in Hospital	5 yr	4 mos	1.5 yr
Educational Level	MBA	MHA	MHA
	<u>Assist. Admin</u>	<u>*Assist. Admin.</u>	<u>Admin. Asst.</u>
Tenure in Professional Field	8 yr	14 yr	3 yr
Tenure in Hospital	4 yr	3 yr	1 yr
Educational Level	MPA	MNA	MHA

*NOTE: Although the incumbent has been the Director of Nursing for three years, she has held the dual role of Assistant Administrator for only ten months.

The relationship between the two associate and two assistant administrators is not well defined. One associate administrator, who has been with the facility the shortest amount of time perceives that his role should be that of the "second in command." His concept is that there is too much duplication between the role of the Executive Director of Hospitals and the Hospital Administrator. His further perception is that there is a valid requirement for only one associate administrator, himself, who is responsible for the internal operation of the hospital. The other three administrative personnel would then be responsible for the administration of functional areas within the hospital.²² This perception is not similarly

held by the other administrators.

The two associate administrators view their role somewhat differently. One considers the primary responsibility of the position as that of coordination between the medical staff and the hospital. The other associate administrator views the role as that of a policy maker and a resource advocate.

There is little coordination or communication between the four subordinate administrators. Although staff meetings between the associate/assistant administrators and the hospital administrator are regularly scheduled, they rarely occur.²³

Fiscal, personnel and purchasing decisions are restricted as a result of the state affiliation of the Medical Center. The hospital has no dedicated comptroller, materials manager, housekeeping staff or personnel director. These functions are responsibilities of the Medical Center staff, specifically within the realm of operations of the Vice Chancellor for Administration. To complicate matters even further, the decision of, for example, the purchasing agent, can be overturned by the state purchasing agent who has little if any understanding or appreciation for medical material management.²⁴

Each clinical area has an "on the ground" employee responsible for daily operation and management of the particular area. Subordinate to the assistant administrator and Director of Nursing are four patient service managers; three for the inpatient nursing units and one for the

operating room. The three inpatient patient managers are each responsible for two nursing floors. Their main area of concern is supervision of the patient service clerks (ward clerks) and resolution of supply problems that may appear. Restocking of those expendable supplies stocked within the Center's (not the hospital's) general stores is the responsibility of one individual. Nonstocked items are purchased in accordance with Center established procedures. Additional responsibilities include coordination with Dietary Services, Environmental Services and the Central Supply Service. This coordination is affected to insure that adequate support is being provided to the units.²⁵

Within the operating room, the patient service manager's responsibility is restricted to budgeting for supplies and coordinating with the Environmental Services, Maintenance and the Biomedical Engineering Section to insure an acceptable level of service and support is provided the unit.²⁶

The outpatient patient service managers are directly responsible to an associate administrator for supervising daily clerical and receptionist support being provided the multi-specialty clinics. They are also involved with scheduling of rooms for the use of the various medical departments. They act as troubleshooters with regard to problems which arise in staffing, supply or scheduling.²⁷

Some department managers have a dual reporting chain. For example, the Administrator of the Department of Radiology is a hospital employee directly subordinate to an associate administrator. However, the incumbent works on

a daily basis with the head of the Department of Radiology, an employee of the School of Medicine who, in fact, provides his performance evaluation.²⁸ Such an organizational arrangement can be disastrous unless the physician and the administrator are effectively communicating, and have subjugated their personal goals to those of the hospital. This marriage is extremely difficult. Peter Drucker in fact states, "Physicians generally see a hospital much differently than from the viewpoint of an administrator."²⁹

This relationship however is not consistent throughout the hospital. For example, within the Department of Physical Medicine there is both a department head who is a physician, and a physical therapist whose function is to provide administrative support and supervision to the department. The therapist's performance appraisal is not rendered by the physician, but rather it is done by the associate administrator.³⁰

The organizational structure at Colorado General Hospital is more definitive in provision of administrative support. Clinical departments have, for the most part, "on the ground" managers with limited authority who are responsible for the routine daily operation. Those managers, in turn, report to an assistant or associate administrator who becomes involved with intradepartmental coordination and interaction with the professional staff to insure that the delivery of care is accomplished in a timely, efficient and effective manner.

The organizational relationships between the administrators and with the Hospital Administrator are vague and unclear. However, there is

a structure--staffed by trained personnel which allows for the provision of administrative support. Responsibilities and roles appear to be fairly well defined. While the present organization needs refinement, it appears to satisfy current requirements and demands generated by the Center as well as the state.

Clinical Support Division

Concern with the manner in which to provide administrative support to professional departments and services is not a recent problem. "The US Army Medical Department from its earliest time utilized men who were not physicians as part of the medical team to assist in....the management of hospitals....and certain aspects of command and administration."³¹ During the war years, specifically in 1942 and 1943, there were several commissions and boards established by the War Department with the expressed purpose of investigating Medical Department administration and personnel problems. Emphasis, even in those days, was placed on the continuing shortages of physicians. The conclusions drawn and recommendations made by these groups were predictable, in light of the austerity of physician resources. "Medical Corps officers must be relieved of all administrative duties."³² One board's specific recommendation was, "that Medical Administrative Corps officers relieve Medical Officers, whenever possible, of duties that are not essentially pertinent to the medical profession."³³

More recently, the need for a clarification and definition of the role of departmental administrators was requested by the majority of officers

in attendance at the 1969 Hospital Commanders' Conference.³⁴

Addressing the subject of "Staff and Command Assignments of Health Professionals," a Secretary of Defense Memorandum in 1973 stated, "We must also find other innovative ways to make maximum use of our physicians and dentists."³⁵ The implication was clear. New innovative programs had to be developed so that physicians (and dentists) could devote their full attention to the clinical practice of medicine (and dentistry).

The Army Medical Department had already initiated a project to reorganize, to a degree, the practice of medical administration. In the summer of 1972 selected officers were assigned to three different sized hospitals; Silas B. Hayes Army Hospital at Fort Ord, California; Raymond Bliss Army Hospital at Fort Huachuca, Arizona; and Munson Army Hospital at Fort Leavenworth, Kansas. Assigned to function as administrators to both the Chief of Professional Services and the Chief of Ambulatory Care, these officers were tasked with additional responsibilities. Specifically, they were asked to assess the need for the administrator positions as well as develop a detailed and comprehensive task list for them. By early 1974 it was felt that sufficient experience had been gained. In January a working group composed of the officers involved at the three hospitals and members of the Health Services Command and Academy of Health Sciences staffs met to determine whether adequate data and information had been gathered to propose specific courses of action, or whether further study was required. Within the same time frame, an Ad Hoc committee formed by

members of the Academy of Health Sciences staff had completed a study entitled "Utilization of MSC Officers in Administrative Roles Within the MEDDAC." The conclusions arrived at by the Ad Hoc committee were very similar to the real world experiences related by the project hospitals. In essence, the trial reorganization and utilization of trained individuals who were graduates of health care administration programs resulted in a significant improvement in the delivery of health care.³⁶ Thus, the Clinical Support Division was developed. Because it is an innovative technique, the concept was published as part of the US Army Health Services Command Ambulatory Patient Care Program. Known as Model 18, the concept has undergone some revision from the initial model published in July 1974. The current APC Model (October 1977) is written with a better experiential basis than with the original program, and gives the user more latitude in establishing an organizational structure.

The basic objective of the Clinical Support Division is to provide an administrative structure that will allow the physician expanded time to see patients. The concept is based on two broad assumptions. First, through centralization of administrative support, both the patient's and the physician's needs will be better met. Secondly, by providing administrative support the physician, relieved of the vast amount of his administrative function, will be better able to increase his productivity, obviously, because he has more time to devote to direct patient care.³⁷

Fitzsimons does not presently have, nor ever has implemented

the Clinical Support Division concept. For comparative purposes as an alternative course of action, a brief overview of the model is presented.

In addition to the previously mentioned basic objective, establishment of a Clinical Support Division potentially has other benefits:

- "a. Identify and group like functions within the organization.
- b. Improve management supervision of the administrative support provided to professional care elements.
- c. Insure maximum use of the education and experience of assigned administrative personnel.
- d. Enhance the job satisfaction and career development of the junior hospital manager.
- e. Delineate a progressive career pattern leading to SSI 67A.
- d. Ultimately produce more clinically oriented senior hospital managers."³⁸

The Clinical Support Division organization centralizes functional authority and administrative support elements under a single administrator. Although the chief can be organizationally placed subordinate to either the Chief, Professional Service/Deputy Commander or the Executive Officer, experience has indicated that total management has been more effective when the division is organizationally placed under the Executive Officer.³⁹

The model identifies two basic subordinate elements within the division; the Ambulatory Care Support Branch and the Inpatient and Ancillary Care Support Branch. These two entities as depicted in the model will suffice adequately for the hospital in the 50-175 bed range. However, in

larger facilities, an accepted alternative structure has been developed. In this modification, the integrity of specialty services has been recognized, thus, all appropriate services (both inpatient and outpatient) are put under one specialty chief. To allow for this situation, it has been proposed that there be three subordinate elements within the division: a Specialty Care Support Branch; a Primary Medical Services Support Branch and an Ancillary Services Support Branch.⁴⁰ This structure reduces extensively the scope of outpatient services under the conceptual Ambulatory Care area. The focus within the Primary Medical Services Support Branch is towards general outpatient services, Emergency Medical Service, Troop Medical Clinics and Physical Examination Services.

At Appendix A is the organization of the Clinical Support Division as depicted by the APC Model. Appendix B provides the functional responsibilities for the Chief of the Clinical Support Division and both the assistant administrator and administrative officer for the Ambulatory Services area for Inpatient and Ancillary Care Services.

While the Clinical Support Division is not construed to be a panacea, it is a viable alternative that has proven effective in some hospitals. As the APC program clearly indicates, the models are aids for innovation to assist facilities in improving primarily the delivery of Ambulatory Health Care Services.

While the model is not meant to be static, it does provide sufficient detail for a well defined organizational structure.

Utilization of the model or some modification thereto, can provide for more responsive administrative service and support being provided to the professional services in general and department chiefs specifically.

An Alternative Model

APC Model 18 provides an excellent framework upon which to build a viable administrative support system. Through further delineation of functional responsibilities, and expansion of the model to embrace all the professional departments, it is suggested that improved administrative service could be rendered. This refined or expanded model would provide a distinct administrative entity which would encompass the entire clinical realm. Included within the structure would be a supervisory element--the office of the chief--and four subordinate administrative elements.

Officer staffing would include, in addition to a division chief and four assistant administrators, requirements for two administrative assistants and a clinical laboratory officer.

Each professional department would retain, at a minimum, its professional services NCO and departmental secretary. Separate service secretaries would also continue to be assigned as they are presently; however, positions specifically delineated with receptionist and general clerical responsibilities would be transferred to the appropriate support branch, as would ward secretaries.

The proposed reorganization would change the role of the Chief, Administrative Support Branch, Medical Activities and Medical Education, to Associate Administrator responsible for delivery of administrative support to all professional departments. In addition to the three branches mentioned in the model; a Specialty Care Support Branch, Primary Medical Care Support Branch and an Ancillary Services Support Branch, would be added a Nursing Services Support Branch.

The chief of the division would retain responsibility within his immediate office for graduate medical education, the central appointment system and the professional library. In addition, his office would assume the responsibility for coordinating compliance with the requirements of the Joint Commission on Accreditation of Hospitals. Also, the Center's Patient Assistance Office would be included within the responsibilities of the division chief's office. Such placement would put the Patient Assistance Office in closer proximity to the Center's professional activities and would permit improved coordination in problem resolution, answering of complaints and removal of perceived or real irritants.

The chief, as perceived, would also provide guidance and managerial supervision to subordinate branches. In conjunction with the Center Executive Officer and/or with the Deputy Commander and, where necessary, the Commander, he would establish broad administrative policy.

To free the chief from the inevitable routine daily requirements and "crises," an administrative assistant would be assigned to effect accomplishment of daily activities.

The Specialty Care Support Branch, as its title implies, would be dedicated to providing administrative support to those departments providing direct inpatient/outpatient services, i.e., Medicine, Surgery, Obstetrics and Gynecology, Pediatrics and Psychiatry. While the magnitude of consolidating these departments is awesome, it is determined that general administrative support and assistance can be provided. The daily administrative operation of the departments, however, would become the responsibility of assigned PSNCO's, permitting the Support Branch to provide expertise in resolving problem areas and in developing innovative methods to assist the departmental administrative staff improve its daily operation.

It is envisioned that an administrative assistant would also be located within this branch to coordinate supervision of clerical receptionists and provide assistance to the departments routine administrative problems. Such a delineation of duties would allow the branch chief to meet with the department chiefs, effect necessary liaison both between departments and among the other administrative branches, and stimulate improvement of departmental administrative operations.

The Primary Medical Services Support Branch would function similarly to the present Department of Primary Care and Community Medicine. However, with the exception of one dedicated clerk-receptionist, other administrative resources would remain within the department. The realm of responsibility of this branch would include Outpatient Services, Emergency Medical Services, Physical Examination Services and supervision

of the off-post clinics.

The Ancillary Services Support Branch would be responsible to provide an acceptable level of support to the Departments of Radiology, and Pathology, Pharmacy Service and Physical Medicine Service. Additionally, the Clinical Investigation Service would fall within the responsibility of this branch. A clinical laboratory officer would be assigned to function as an administrative assistant. His area of responsibility would generally be associated with the clinical administrative aspects, particularly in Pathology, Radiology and Clinical Investigation Service.

Without delineating specific responsibilities, it is envisioned that this activity would function similar to the other two branches. A major responsibility would be to provide an informal program to train departmental NCO's, the majority of whom have a primary area of expertise within a technical field rather than in administrative or managerial skills. Also, by being separated from the daily administrative routine, this branch could give more time to assisting in resolution of more significant administrative problems.

Due to the complexity involved in the delivery of nursing care and the size of the Department of Nursing, a separate Nursing Care Support Branch is considered a necessary part of a total administrative support organization.

It is envisioned that the only resources who initially would fall within the supervision of this branch would be the ward clerks. The branch

would also be responsible for personnel management and logistical matters, in addition to equipment planning, resolution of staffing problems, maintenance, space utilization, and provision of academic support to educational activities. It is further perceived that this branch would effect improved liaison, both with the other administrative branches within the division, and other elements of the administrative staff. Dedicated to the Department of Nursing as a whole and not responsible for the daily routine within the chief nurse's office, the administrator of this branch could potentially be of valuable assistance in development of innovative administration systems to enhance the provision of optimum nursing care.

Because each of these entities is concerned more with major administrative support situations than with the day-to-day operation of a department, the possibility for improving administration within the professional department is increased. Proactive rather than reactive in its approach, each branch could dedicate itself to management improvement actions, to innovations, to insuring that, from an administrative perspective, Fitzsimons is providing optimum level health care services!

Footnotes

¹Montague, Brown, "New Leadership Needed for Future Management Systems Concept," Review: The Federation of American Hospitals 9 (October 1976): 21.

²US Department of the Army, Health Services Command, "Clinical Support Division," APC Model 18, Fort Sam Houston, Texas, October 1977, p. 2.

³US Department of the Army, "Commissioned Officer Specialty Classification System," Army Regulation 611-101, Change 3, Washington, D. C., 19 April 1977, p. 4-56.

⁴US Department of the Army, Fitzsimons Army Medical Center, "Organization and Functions: Administrative Assistants to Chiefs of Professional Departments and Services," FAMC Regulation No. 10-6, Denver, Colorado, 7 March 1975, p. 1.

⁵Data pertaining to manpower requirements and authorizations was obtained from the Fitzsimons Army Medical Center "Table of Distribution and Allowances," No. HSWOQZAA, Section II, Personnel Allowances, dated 15 March 1978.

⁶Information pertaining to administrative operations within professional departments was obtained from interviews with the following personnel: Major Stephen W. Arnt, MSC, Chief, Administrative Support Branch, Department of Primary Care and Community Medicine, 6 March 1978; Master Sergeant W. Benjamin Fields, Chief, Professional Services, Noncommissioned Officer, Department of Pediatrics, 6 March 1978; Mrs. Esther Hanson, Administrative Officer, Department of Obstetrics and Gynecology, 13 February 1978; Captain Richard C. House, MSC, Administrative Officer, Department of Surgery, 20 February 1978; First Lieutenant Leif G. Johnson, MSC, Administrative Officer, Department of Medicine, 21 February 1978; First Lieutenant Ronald G. Staus, MSC, Administrative Officer, Department of Psychiatry, 15 March 1978; and Mrs. Betty Surber, Administrative Officer, Department of Radiology, 30 January 1978.

⁷Interview with Major Stephen W. Arnt, MSC, Chief, Administrative Support Branch, Department of Primary Care and Community Medicine, Fitzsimons Army Medical Center, Denver, Colorado, 6 March 1978.

⁸Information pertaining to the organization and functions of the United States Army Health Clinic, Dugway Proving Grounds, Utah, was obtained during an on-site visit by the author, 11 January 1978.

⁹US Department of the Army, Fitzsimons Army Medical Center, "Organization, Mission, Functions Manual," FAMC Regulation 10-1, 1 December 1976, p. 2-2.

¹⁰Perceptions and opinions concerning administrative support were obtained during interviews with the following department chiefs: Colonel (Dr.) Nicholas C. Bethlenfalvay, MC, Department of Primary Care and Community Medicine, 6 March 1978; Colonel (Dr.) Julius T. Coggin, MC, Department of Pathology and Area Laboratory Services, 3 February 1978;

Colonel (Dr.) Keith F. Deubler, MC, Department of Obstetrics and Gynecology, 14 February 1978; Lieutenant Colonel (Dr.) Nassar Ghaed, MC, Department of Radiology, 31 January 1978; Colonel (Dr.) Larry E. Isom, MC, Department of Psychiatry, 16 March 1978; Colonel (Dr.) Lewis A. Mologne, MC, Department of Surgery, 3 March 1978; Colonel (Dr.) James E. Shira, MC, Department of Pediatrics, 6 March 1978; and Colonel (Dr.) George W. Ward, MC, Department of Medicine, 27 March 1978.

¹¹Interview with Colonel (Dr.) Nassar Ghaed, MC, Chief, Department of Radiology, Fitzsimons Army Medical Center, Denver, Colorado, 31 January 1978.

¹²Interview with Colonel (Dr.) Nicholas C. Bethlenfalvay, MC, Chief, Department of Primary Care and Community Medicine, Fitzsimons Army Medical Center, Denver, Colorado, 6 March 1978.

¹³Interview with Colonel Ghaed.

¹⁴Interview with Colonel (Dr.) Larry E. Isom, MC, Chief, Department of Psychiatry, Fitzsimons Army Medical Center, Denver, Colorado, 16 March 1978.

¹⁵Interview with Colonel (Dr.) Lewis A. Mologne, MC, Chief, Department of Surgery, Fitzsimons Army Medical Center, Denver, Colorado, 3 March 1978.

¹⁶Interview with Colonel Bethlenfalvay.

¹⁷Interview with Colonel (Dr.) Julius Coggin, MC, Chief, Department of Pathology and Area Laboratory Services, Fitzsimons Army Medical Center, Denver, Colorado, 3 February 1978.

¹⁸Interview with Colonel Dorothy A. Simon, ANC, Assistant Chief, Department of Nursing, Fitzsimons Army Medical Center, Denver, Colorado, 16 December 1977.

¹⁹Interview with Mr. Jack Armstrong, Assistant Administrator, Colorado General Hospital, Denver, Colorado, 22 February 1978.

²⁰Ibid.

²¹Ibid.

²²Interview with Mr. Tony Padilla, Associate Administrator, Colorado General Hospital, Denver, Colorado, 22 February 1978.

²³Ibid.

²⁴Interview with Ms. Peggy Miller, Associate Administrator, Colorado General Hospital, Denver, Colorado, 22 February 1978.

²⁵Interview with Mr. Max Bible, Patient Services Manager, Colorado General Hospital, Denver, Colorado, 22 February 1978.

²⁶Ibid.

²⁷Interview with Ms. Miller.

²⁸Interview with Mr. Gene Kamrass, Administrator, Department of Radiology, Colorado General Hospital, Denver, Colorado, 22 February 1978.

²⁹Peter F. Drucker: "The Dynamics of Health Care Administration," Review: The Federation of American Hospitals 11 (February 1978); 16.

³⁰Interview with Ms. Miller.

³¹Edward J. Costello, LTC, MSC, "Evolution of the Medical Service Corps, US Army," (Typewritten; Washington, D. C.: The Office of the Surgeon General, 1967-8): p. 1.

³²Ibid., p. 14.

³³Ibid.

³⁴Gerald D. Allgood, LTC, MSC, "Administrative Support to Professional Departments," Fact Sheet (Typewritten, Washington, D. C., Office of the Surgeon General, undated).

³⁵Ibid.

³⁶Ibid.

³⁷Clinical Support Division, p. 2.

³⁸Ibid., p. 2.

³⁹Ibid., p. 3.

⁴⁰Ibid.

CHAPTER III

DISCUSSION

The number of potential structural entities that could be developed within the context of this study are almost endless. While organizational design itself is important, it cannot nor should not take precedence in resolving present structural deficiencies. The number and configuration of organizational elements is important, but not the paramount matter which must be addressed.

Regardless of what structure is presented, barriers to providing improved administrative support can be traced to two primary areas of concern. Individuals currently charged to function as administrative officers are not fully cognizant of specifically what it is they are expected to do. Secondly, without any training and experience, most of the incumbents lack the skills and knowledge required to function as administrators. Additionally, the fact that none of the department chiefs have any significant expertise or training in administration or management, coupled with the lack of any central direction and guidance, reinforces the observation that the current organizational structure--or lack thereof--proliferates positions which are reactive in their approach. Within this context, acceptance of the administrative role is predicated on personalities and the physician's perception as

to what will keep the paperwork down to a minimum.

The present system's strength is that department chiefs do, for the most part, feel very comfortable with the administrative structure within their departments. Perceptions, for the most part, are that administrative officers are productive and supportive of departmental clinical and educational objectives. Fortunately, sufficient resources exist at each departmental office level to insure expeditious discharge of routine administrative functions. With such resource affluence, the administrative officer, theoretically, should be able to become divorced from the daily operation and become involved with more substantial matters. Within the present structure the autonomous position of the departments and to some extent subordinate services is supported. The work gets done at the expense, however, of the department chief's time. If left unchanged, the current system will continue to place administrative demands upon department chiefs, demands which the system will not allow the administrative officer to handle.

There is nothing explicitly derogatory with the present organization, except, that, in reality, an organization doesn't exist. Administrative functions are accomplished, correspondence is completed; reports are prepared and suspense dates are met, etc. However, little if any effective planning is done - formal goal setting is non-existent, viable coordination between departments to improve the delivery system

is absent. No central management exists to assist both in major administrative situations, and in developing management improvement programs. The present system is totally reactive. It fulfills a necessary minimum requirement; but that is all. It provides little, if any, framework for innovation, change or improvement.

Adoption of the administrative structure employed at Colorado General Hospital, while possible, is not feasible. The organization of the military hospital is unlike other health care institutions. Physicians are considered "employees" as much as are clerk-typists. Additionally, many of the departmental entities at Colorado General Hospital, e.g., electrocardiography, electroencephalography and respiratory therapy are not separate activities within the military hospital. Rather, they are integral activities of major departments. Also, many of the functional areas for which assistant and associate administrators are responsible are separate organizational entities within the military hospital, whose chief is a major administrative staff member. The most obvious example is the Medical Records Service. This function, a separate entity within the civilian facility, is just one section within an AMEDD Patient Administration Division.

Perhaps the most obvious reason that the civilian model would not be feasible for implementation within the military environment is the position and perceptions of physicians. Daily operation of the civilian hospital is the responsibility of the Administrator. While

major policy is made and approved by the board, the administrator is responsible for developing operational policy as it affects the institution's daily management. Within the military hospital the Commander, always a physician, frequently absorbs the routine administrative functions associated with the administrator of the civilian facility.

Colorado General Hospital does, however, provide some positive benefits for analysis. Perhaps the most significant advantage is that those persons responsible for the administrative operation are trained for their role! While a degree, per se, does not determine the efficiency or the efficacy of an administrator, it does provide some understanding of the complexities of the health care delivery system. It also provides exposure to both management theory and management skills. It helps to solidify a management philosophy and provides an improved basis to perform in an administrative role. Comparatively speaking, department managers and patient service managers at Colorado General Hospital function in a similar perspective to the department administrative officers at Fitzsimons Army Medical Center.

Analysis of the organizational structure at Colorado General Hospital, while it does not provide an alternative which can be implemented at Fitzsimons Army Medical Center, does provide some innovative approaches which could be further refined and potentially adopted.

The Clinical Support Division, as presented in APC Model 18 is not sufficiently developed to be a viable organizational structure.

First, too much emphasis is placed on the separation of ambulatory care services from inpatient services. At Fitzsimons, it would be extremely difficult, if not altogether impossible, to separate departmental responsibility for the delivery of inpatient and outpatient care. It is, in fact, questionable as to whether such a separation would be an effective measure in light of the Center's teaching responsibility.

The second shortcoming of the concept is that it is insufficiently developed to incorporate the teaching mission. A considerable administrative effort is expended at all levels of the organization to insure that each teaching program is in consonance with the objectives and parameters established by particular specialty boards.

The suggested modification to the Clinical Support Division model for large MEDDAC's has potential for implementation. However, it, too, does not consider the autonomy which exists at Fitzsimons. To be effective, it would need to incorporate the entire professional spectrum. That precisely is what the proposed alternative structure accomplishes. By providing a framework from the Commander down through and including separate services, innovative and improved administrative methods can be developed and implemented. By removing the department administrator from beneath the aegis of the department chief, the individual can be responsive to the organization rather than one person. Many administrative requirements could be transferred from the department chief to the administrator. Daily administrative operations could adequately be accomplished by a

trained senior NCO. Implementation would also allow for improved career development for both administrative officers and health care administrators.

While the proposed administrative support system would require refinement and adjustment, once implemented and operational, it would conceptually allow for a viable structure through which improved administrative support would be provided to the professional departments of Fitzsimons Army Medical Center. Removing the administrator from day-to-day involvement with departmental activities would allow for a proactive rather than a reactive approach to providing administrative support. Proper classification from Medical Field Assistants to Health Care Administrators for the four branch chiefs would provide an obviously increased educational basis from which innovation could be developed. If allowed to develop, the alternative model will provide for improved administrative support being accomplished through an acceptable organizational structure.

CHAPTER IV

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Fitzsimons Army Medical Center does not have a viable or effective organizational structure for the provision of administrative support to the Center's professional departments. This study clearly indicates that assigned departmental administrative staffs are primarily responsible for daily office operations with some limited fiscal and supply functions. Administrative interaction with subordinate services is limited usually to dissemination of information and monitoring supply and maintenance activities.

While most administrative officers appear motivated to do a professional job, their abilities are restricted due to a lack of knowledge on the part of both the administrator and his chief.

If the current system of providing administrative support is to remain in operation, there is no valid educational requirement for any administrative officer to possess a graduate degree in health care administration. Necessary training to function effectively in the present environment would require only a short course in military resource management. Additionally, some formal training would be required for department chiefs to improve their skills and allow them to function as medical ad-

ministrators.

Personnel resources, other than the administrative officer, are more than adequate to support the department's administrative role. A critical analysis of workload could well, in fact, possibly result in a reduction of staffing.

The job to be done is ill-defined and functional responsibilities are poorly delineated. Within the context of this environment, the professional departments are being administratively supported. The support, however, translates to the simple fact that the paperwork is being done. Acceptance by department and service chiefs is based, for the most part, on the fact that they are unfamiliar with what could or should be done. Additionally, they do not appear overly concerned or convinced that improvement or change is necessary.

Alternative organizational structures do exist, as evidenced by Colorado General Hospital. While utilization of associate and assistant administrators with advanced training is no guarantee of improved administrative support, it certainly is a positive attribute. Additionally, utilization of patient service representatives and departmental managers insures daily administrative functions are accomplished, allowing the responsible administrator to become involved with more significant managerial activities.

If a viable organizational structure is desired by the Commander, then the model indicated as a proposed alternative, is the best organiza-

tional structure for administrative support of clinical services. Establishment of such a Clinical Support Division, under the direction of an associate administrator, may assist in correcting deficient areas, improving the overall administrative climate and relieving professional personnel from performing unnecessary and burdensome administrative tasks.

Recommendations

Based on the above conclusions, the following are recommended:

1. An administrative organization be developed, based on the graphic depiction described in Chapter II and Appendix C, for implementation at Fitzsimons Army Medical Center.
2. Implementation of the administrative support system be a phased program. Appendix D indicates proposed implementation phases.
3. The Clinical Support Division be placed organizationally under the Executive Officer. To insure the vested interest of the professional staff is considered, the Deputy Commander should be the indorser on the division chief's performance evaluation.

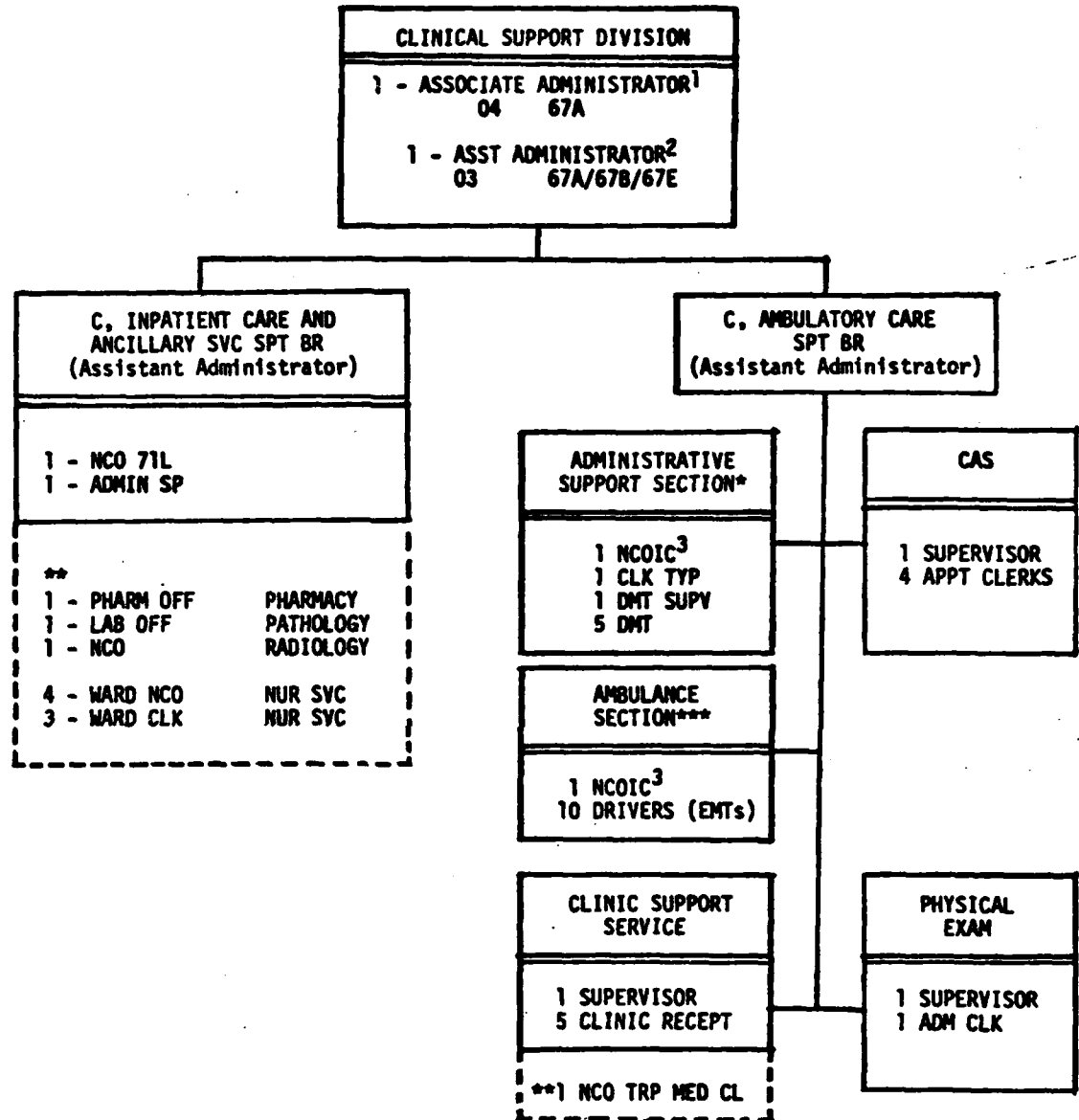
Organizational change, however, will not be effective unless it is permitted to develop and adjust to environmental stresses. Acceptance by the physician is paramount to successful implementation of this or any other model. It is human nature to strongly resist giving up something over which you have control. The physician's reluctance to lose control over a primary administrative resource is natural. A major task

~~then~~ in insuring a smooth transition to an improved organizational structure is to demonstrate to the physician that the change is to help him, not to reduce his power bases. Acceptance will result only if the physician staff is totally convinced that loyalty and dedication to the professional department's goals are not subjugated, but rather recharged.

APPENDIX A

PROPOSED CLINICAL SUPPORT DIVISION
FOR A 75-125 BED HOSPITAL
(APC MODEL 18)

Proposed Clinical Support Division
for a 75-125 Bed Hospital



¹Additional duty as Chief, Inpatient Care and Ancillary Svc Spt Branch.

²Additional duty as Chief, Ambulatory Care Support Branch.

³Additional duty as NCOIC of the Ambulance Section.

*Includes a typing pool to provide centralized typing support to ambulatory care activities

**Are points of contact for administrative coordination. Service to speciality continues as before.

***For "Ambulances" only, not patient transport vehicles. OPCON under C, EMS.

APPENDIX B

CLINICAL SUPPORT DIVISION
DUTIES AND FUNCTIONS GUIDE
(ANNEX C TO APC MODEL 18)

ANNEX C

CLINICAL SUPPORT DIVISION

DUTIES AND FUNCTIONS GUIDE

1. Chief, Clinical Support Division (Associate Administrator). The Associate Administrator should be a Medical Service Corps (MSC) officer who will be responsible to the Executive Officer (XO) or Chief of Professional Services (CPS) for the planning, organizing, directing, staffing, budgeting, and evaluating the administration of clinical service operations. He should insure that optimal efficiency, effectiveness and economy of operations are maintained at all times. Major tasks include:
 - a. Advising and consulting with the XO and CPS on matters relative to specific areas of responsibility.
 - b. Providing managerial support to all professional activities.
 - c. Directing and coordinating operations of assigned management activities; discussing, reviewing, and evaluating operational matters, policies, and procedures with Assistant Administrators.
 - d. Interpreting and communicating objectives, policies and directives to Assistant Administrators of Division.
 - e. Coordinating matters pertaining to the Joint Commission on Accreditation of Hospitals (JCAH).
2. Assistant Administrator for Inpatient Care and Ancillary Services. The Assistant Administrator for Inpatient Care and Ancillary Services should be an MSC officer who may be responsible for the following functions:
 - a. Managing administrative support for inpatient activities of the hospital.
 - b. Developing the budget for inpatient activities in coordination with clinical chiefs and exercising some degree of supervisory control over the expenditures generated for inpatient care.
 - c. Assisting the CPS in planning and coordinating medical continuing education programs.
 - d. Developing appropriate mobilization and emergency operating procedures in conjunction with the overall hospital plan.

e. Monitoring the timely completion of inpatient medical records, medical board actions, and TDRL evaluation, (assisting the Patient Administration Division (PAD)).

f. Assisting the CPS in establishing effective controls to insure timely disposition of hospitalized patients.

g. Developing an effective interpersonal relations program to further promote the concept of "concerned care."

h. Coordinating logistical support and the practice of supply economy for inpatient activities.

i. Providing stenographic and typing support to the hospital inpatient activities (other than PAD responsibilities).

j. Operating the hospital information desk.

k. Maintaining liaison with ambulatory care services to insure proper coordination of follow-up care for inpatients.

l. Supervising procedures and coordination of patient transfers to and from the hospital (assisting the PAD).

m. Maintaining liaison with local civilian hospitals (as appropriate).

n. Supervising personnel not engaged in the direct provision of patient care.

o. Supervising Manpower Management Program for inpatient care activities.

3. Administrative Officer - Inpatient Care and Ancillary Service.

Administrative Officer(s) assigned to Inpatient Care and Ancillary Services should be MSC officer (s) who may be responsible for the following functions:

a. Conducting necessary orientations for newly assigned personnel.

b. Arranging the conduct of inservice education.

c. Providing administrative support for the clinical departments' budgetary processes.

d. Maintaining ward occupancy data and effecting necessary coordination with PAD for the processing of incoming and outgoing patients.

- e. Supervising the ordering of supplies, publications and materials as appropriate.
- f. Establishing procedures in support of overall hospital disaster plans.
- g. Providing necessary assistance to the professional staff in the timely completion of inpatient medical records.
- h. Monitoring control procedures for narcotics and other sensitive materials.
- i. Compiling statistical data for the preparation of required reports.
- j. Arranging for necessary support to next of kin and other personnel requiring specialized assistance.
- k. Collecting and consolidating data in support of the manpower management program.

1. Managing property and maintaining property accountability.

4. Assistant Administrator for Ambulatory Services. The Assistant Administrator for Ambulatory Services should be a MSC officer who may be responsible for the following functions:

- a. Managing clinics within and subordinate to the hospital. In this connection, he should also establish controls for expenditures and coordinate the submission of budgetary requirements. (Responsibility for professional management of patients is vested in the CPS).
- b. Utilizing personnel, facilities, and supplies in support of optimum patient care through coordination with other departments and services.
- c. Operating a Central Appointment Service for hospital clinics.
- d. Monitoring educational programs applicable to clinic support personnel in cooperation with other departments and services.
- e. Operating an interpersonal relations program in the care and management of ambulatory patients. In this connection, he is responsible for the publication and distribution of appropriate guidance/information to clinic patients.
- f. Monitoring the timely preparation and administration of out-patient medical records.
- g. Preparing and submitting reports and maintaining records as required.

- h. Reviewing clinic work methods and operational procedures.
- i. Providing logistical and administrative support to specialty clinics.
- j. Supervising the Manpower Management Program for ambulatory care activities.

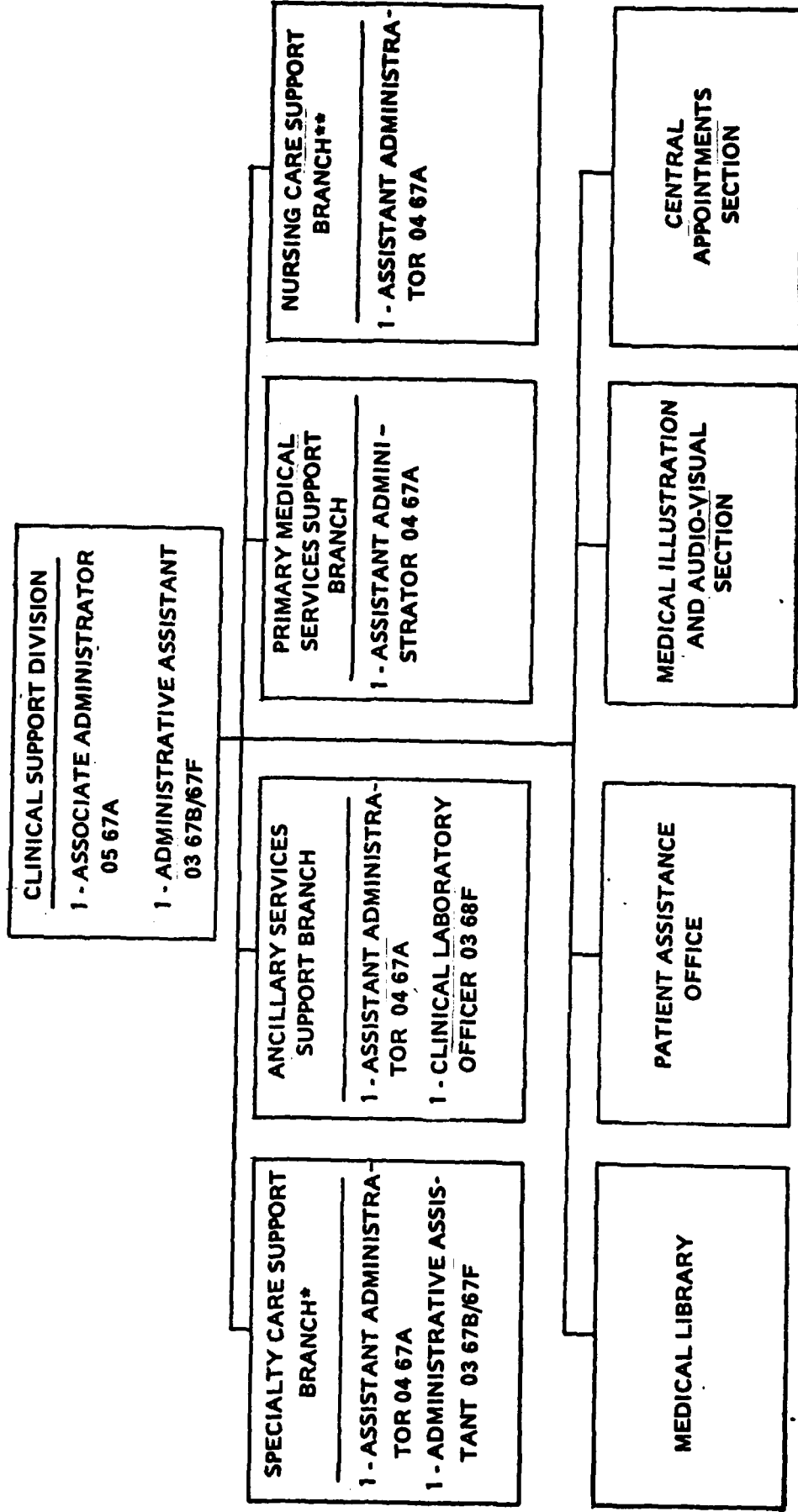
5. Administrative Officer - Ambulatory Care. The Administrative Officer(s) for hospital-based and satellite clinics should be a MSC officer who may be responsible for the following functions:

- a. Exercising administrative control over the operation of clinics providing sick call, emergency medical treatment, occupational health services, and/or preventive medicine services. (Responsibility for professional management of patients is vested in the CPS).
- b. Insuring timeliness and administrative completeness of outpatient medical records.
- c. Preparing and submitting reports, and maintaining records as required.
- d. Determining if patients seeking medical care or services are eligible beneficiaries.
- e. Managing the physical examination facility.
- f. Insuring proper scheduling of sick call, physical examinations, physical profiling, immunizations and medical processing (coordinating such activities with commander of supported units).
- g. Providing emergency ambulance service and coordinating administrative movement of patients, to include the evacuation and transfer of patients.
- h. Maintaining and collecting data in support of the Manpower Management Program.

APPENDIX C

PROPOSED ALTERNATIVE CLINICAL
SUPPORT DIVISION FOR
FITZSIMONS ARMY MEDICAL CENTER

PROPOSED CLINICAL SUPPORT DIVISION
FOR FITZSIMONS ARMY MEDICAL CENTER



*Clerks/Receptionists/Ward Secretaries are assigned to this Branch

**Ward Clerks are assigned to this Branch

APPENDIX D
IMPLEMENTATION PLAN

IMPLEMENTATION PLAN

To be a viable entity, the Clinical Support Division model must have the acceptance of all professional and administrative chiefs, at all levels of the organization. To allow for development of a formal entity, staffed from existing resources by individuals who have authority commensurate with their responsibility, a three phased program is recommended.

During the initial phase, the Chief, Administrative Support Branch, Medical Activities and Medical Education, will develop specific task lists for the assistant administrators of the four suggested support branches. Functions would be delineated based on input provided by department chiefs, administrative directorate chiefs and the Center Commander, Deputy Commander and Executive Officer. Additionally, a second officer would be assigned to the Administrative Support Branch to insure day-to-day requirements are met. Once developed, task lists would be staffed for approval.

This initial phase will concentrate on shaping the proposed structure to meet the unforeseen needs of the professional staff. Present organizational relationships will not change. As the roles of each branch are finalized, the current Administrative Support Branch, Department of Primary Care and Community Medicine will organizationally be transferred

to the supervision of the Chief, Administrative Support Office, Medical Activities and Medical Education.

In the intermediate phase, modification to the organization will be affected by the addition of an Ancillary Services Support Branch. Initiation of the Ancillary Services Support Branch will require detachment of resources from existing organizational entities and reassignment to this element. An officer resource will have to be acquired to function as branch chief. With resource austerity a real problem, the health care administrative resident would be a possible candidate. At the same time assignment of a clinical laboratory officer will be accomplished.

Dependent upon the manner of performance of these two newly created branches, development of the Specialty Care Support Branch will either be initiated or delayed. Once the "bugs" with the two developed branches have been identified, and action has been taken to eliminate them, a decision will be required to implement this third branch. Presumably, the two administrators assigned to the Specialty Care Support Branch will come from existing resources within departments supported.

Administrative liaison with the Department of Nursing will begin during this phase. A distinct support branch will not be formed.

Out of necessity a considerable amount of close coordination between the associate administrator and the two newly created branches will be required.

In the final phase, the Nursing Care Support Branch will be initiated. All four branches will be brought together into a formal

organization which for lack of a better title will be called the Clinical Support Division.

During implementation, statistical workload data will be required to be maintained for development of accurate staffing requirements. It is recommended that the division chief be a Medical Service Corps officer in the grade of Lieutenant Colonel. Branch chiefs should be Majors or senior Captains. Optimumly, all five of the administrators would possess the Health Care Administration Specialty Skill Identifier (SSI) 67A. The minimum requirement would be a senior Captain with at least five years experience in an active treatment facility.

This implementation plan is general in nature. It must be, for unknown situations must be considered, and sufficient flexibility provided for alterations and refinements as the organization develops.

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