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A STUDY TO DETERMINE
THE MOST EFFECTIVE ORGANIZATIONAL
STRUCTURE FOR PROVIDING SUPERVISION
TO THE MEDICAL SUPPLY SPECIALISTS
(MOS 76J) ASSIGNED TO THE
DIRECTORATE OF MEDICAL
ACTIVITIES ADMINISTRATION,
WALTER REED ARMY MEDICAL CENTER

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Submitted to the Faculty of
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In Partial Fulfillment of the
Requirements for the Degree
of
Master of Healthcare Administration
by

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14 November 1988

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"Patients come to hospitals to see physicians, not [healthcare] administrators."

Major General Mologne, MC March 1988

"A [healthcare] administrator's role is to both educate and facilitate an understanding of the problem at hand to others."

Colonel Johnson, MS February 1988

"[Healthcare] administrators seek high-resolution to complex systems problems through a low-profile of continuous involvement and interaction."

Colonel Johnson, MS November 1987

"Never confuse micro-interest with micro-management."

Major White, MS March 1988

"When [healthcare] administrators see a problem they must wade into the middle and take charge according to the need."

Colonel Johnson, MS September 1987

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I. INTRODUCTION

Conditions Which Prompted The Study

This study is based upon a request from the Chief of Staff/Deputy Commander for Administration (DCA), Walter Reed Army Medical Center (WRAMC) and is predicated upon the following: the Chief of Staff/DCA is concerned that the current organizational structure for the supervision and support of the medical supply specialists (MOS 76J) assigned to the Directorate of Medical Activities Administration (DMAA) might be deficient in providing maximal service and support to patient care units within the hospital. This observation is reinforced by a number of factors which include a 1984 Directorate of Resources Management (DRM) study, historical documentation, and personal observations (DRM 50, Tab M).

Based on this background, the Chief of Staff/DCA is interested in facilitating and enhancing the organizational structure for supervising and supporting the 76Js assigned to the DMAA. The Chief of Staff/DCA wants to evaluate and, where necessary, improve the efficiency and effectiveness of the current organizational structure. This study has served to facilitate meeting the Chief of Staff/DCA's responsibilities as outlined under the Mission Statement and Functions from the Walter Reed Army Medical Center Regulation 10-1, Organization, Mission and Functions Manual, Chapter 6, and as indicated under the Management and Administrative Services (MA) standards (MA.1.4.2 and MA.1.4.4) from the Accreditation Manual for

Hospitals (AMH/88) published by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO AMH/88 91, 92).

Problem Statement

The problem statement for this study was to determine the most effective organizational structure for providing supervision to the medical supply specialists (MOS 76J) assigned to the Directorate of Medical Activities Administration (DMAA), Walter Reed Army Medical Center (WRAMC).

Objectives

The objectives of this study were:

1. To perform a literature review on the topic of personnel utilization and supervision in hospital material management organizational structures.
2. To evaluate the liaison relationship between the DMAA and Directorate of Logistics (DOL) in the following two areas: 1) the ability to assist in the coordination of daily medical material activities; and 2) the ability to provide the DMAA 76Js with a better understanding of their technical skills and responsibilities (Szilagyi and Wallace 216-217, 482-484).
3. To analyze the current Table of Distribution and Allowances (TDA) for 76J requirements, authorizations, utilization patterns, and supervision schemes within the DMAA.

4. To develop and administer a questionnaire to evaluate the DMAA unit healthcare administrator's, principle functional supervisor's, and 76J's top 15 job tasks; the DMAA scalar chain of command; and the DMAA for 76J job and supervisor ambiguity.
5. To develop recommendations concerning the most effective organizational structure for the supervision and support of the DMAA 76Js based on the outcomes derived from the four preceding objectives.

Criteria

The following criteria were applied to the accomplishment of this study:

1. Requirements and authorizations for the DMAA 76Js as currently documented by the most recent TDA served as the base-line manpower staffing document to assess manpower needs in terms of grade, MOS, and numbers.
2. The current liaison (boundary-spanning) activities between the DMAA and DOL were measured against the original WRAMC management concept of one logistics assistance officer (LAO) per floor, except for floors one through three which had only one LAO among them.
3. The daily job performance of the DMAA 76Js was evaluated by comparing the top 15 expected job tasks of unit healthcare administrators (first-line superisors) and principle 76J functional supervisors against the 76Js actual top 15 job tasks. A value of .79 (79%) or lower indicated the presence of role

ambiguity (lack of clarity with respect to duties, responsibilities, and activities associated with a 76J's job).

4. The scalar chain of command for the supervision and support of the DNAA 76Js was evaluated by comparing the documented chain of command against the supervisor identified by the 76J as his/her supervisor. A value of .94 (94%) or less indicated the presence of ambiguity in the present supervision structure.

5. The present organizational structure was evaluated by comparing the scalar chain of command against the matrix (functional) management concept to measure the number of individuals giving the DNAA 76Js tasks and directions to determine if supervision conflict existed. The presence of two or more individuals (including the unit healthcare administrator) giving tasks, making demands, and giving directions indicated the presence of supervisory conflict within the present organizational structure.

Assumption

In accomplishing this study it was assumed that the present organizational structure for the DNAA 76Js at WRANC would not change during the course of this research.

Limitation

This research involved only those 76J personnel assigned to the DNAA and was not applicable to other WRANC 76J personnel.

Review of the Literature

Beginning with the late 1960s, medical material management has come under increasing scrutiny by healthcare administrators. This is a result of their need to improve and refine the delivery of medical logistics within the institutional setting to achieve cost and manpower efficiency (Housley ix; Sanderson 1-8; Scheyer xi). For healthcare administrators, this type of "logistics management is the hospital-wide application of material management" (Henning 86). For many years, the healthcare industry, unlike other business sectors, has avoided using analytical techniques because it was felt that healthcare did not lend itself well to methodologies such as operations research (Johannides 58; Richardson, France and Erb 1-2; Tomlinson 83). This lack of managerial and statistical analysis applies to medical material management as well. With an increasing emphasis on the efficient delivery of health care service within the institutional setting, many questions about the organization and function of institutional medical material management are being addressed and studied (Heckathorn and Greisler 23; Pitts 64; Ryder 30; Wilcox 88).

One area of medical material management being studied concerns the centralization and consolidation of medical logistics functions. These functions have historically been decentralized under the various services within the health care institution (Perrin 56). To increase efficiency a major trend in medical material management in the last two decades has been

the move toward centralization and consolidation, to include personnel resources, under a single department or service organization within the healthcare institution (Henning 86; Koprowski 30; McKusick 81; Perrin 60, 62). This allows direct healthcare providers, such as nursing personnel, to spend more of their time on patient care by relieving them of the responsibility for medical material management (Koprowski 28; Pitts 74; Sanderson 167; Schanilec 6). However, any shifting of medical logistics tasks from services, such as nursing, to a more cohesive medical material management system would require changes in the organizational structure of the institution (Koprowski 34; Sandleback 68; Wilcox 88). Yet, even with this trend toward centralization, medical logistics is still being managed across a wide spectrum ranging from totally decentralized to highly centralized (Charlesworth 1; Housley 92; Reisman 25). When it comes to medical logistics, the single determining factor which controls the degree of centralization remains the individual healthcare institution (Pitts 71, 74; Perrin 62). Comparisons of individual health care institutions offer one way to study medical material management in assessing the current trends in medical logistics management (Henning 86).

Inherent in the issue of the centralization of medical material management functions under one department or service, supervision of medical logistical personnel plays a critical element in the centralization equation (Charlesworth 2; Koprowski 38-39). Supervision is a crucial component of the management and productivity of medical logistics personnel (Malone and

Rucci 13; Pitts 73; Seville 9; Spellman, Devin and Hughes 72-73). The improvement of centralized medical material management depends, to a substantial degree, on those key personnel that are assigned as supervisors of medical logistics personnel (Davidson 81; Henning 87; Tomlinson 85-86). Management and analytical studies of productivity measures resulting from the shift toward centralization of medical logistics personnel are useful tools to assess the impact of centralization on the different services. Before structural changes to these services, or the current medical material management operation occurs, a careful assessment of the present system is required (Buckles and Boissoneau 42; Schanilec 7). The concern with appropriate supervision of medical logistics personnel is a natural result of the current trend toward the centralization of medical material management and has a significant impact on the efficient management of any healthcare institution (Heckathorn and Greisler 26; Spellman, Devin and Hughes 74, 78).

Research Methodology

The research methodology for this study was accomplished in the following three phases.

1. The first phase consisted of a literature search, collection, and review of retrospective data. The literature search helped identify current trends in medical material personnel utilization and management, as well as presenting a review of how other organizations have attempted to resolve this

problem in their facilities. The collection of retrospective data included efforts to obtain SOPs, guidelines, and internal organizational structures concerning the medical material management personnel supervision issue at WRAMC. The sources for this information included:

- a. Army regulations and guidelines;
- b. JCAHO reports for the past two inspections;
- c. IG reports for the past two inspections; and
- d. WRAMC SOPs, organizational structure documents, manpower surveys, and all previous internal and external studies on the same or similar topic within the last 15 years.

2. Phase two was categorized as empirical research and consisted of concurrent data gathering and site visits.

Concurrent data gathering was performed via structured interviews and discussions with WRAMC personnel involved directly with the supervision of the DMAA 76Js. Specifically, interviews were conducted with floor associate healthcare administrators and unit healthcare administrators of inpatient wards and outpatient clinics and other appropriate personnel (e.g. Director, DMAA; Director, DOL; LOAs; 76Js; etc). Additionally, concurrent information was gleaned from participation in committee and/or review of pertinent committee minutes.

Data concerning the methods employed by the DMAA for the supervision of 76Js centered around an analysis of current internal organizational structures developed on the basis of functional and technical supervisory channels by the DMAA and the

five (5) associate healthcare administrators of the floor administrative units. Job ambiguity for the DMAA 76Js was evaluated by the use of a questionnaire which was used to develop a list of the top 15 daily 76J job tasks as were expected by the unit healthcare administrator (first-line supervisor), and the principle 76J functional supervisor and as were performed by the DMAA 76Js. Supervisor ambiguity was evaluated by determining the number and types of personnel providing tasks and directions to the DMAA 76Js [Data, to be generated on the top 15 76J skill related tasks was compiled for each floor administrative unit of the DMAA]. The staffing of the DMAA 76Js was also researched by utilizing the current IDA as the base-line reference document. This information served as a measure for the analytical comparison of the proposed organizational structures for the supervision of the DMAA 76Js.

Data was also collected during this time period, to develop a generic profile of those unit healthcare administrators who directly supervised the 76Js assigned to the DMAA. This data was used to evaluate the appropriateness of the current organizational structure for supervising 76Js assigned to the DMAA on the basis of the unit healthcare administrator's occupational category (military or civilian), civilian education, and experience as a unit healthcare administrator at WRAMC.

Site visits to other medical treatment facilities in the local area, were conducted to learn their methods and to determine their degree of success in the utilization and

supervision of medical material management personnel. Facilities visited included hospitals with active teaching programs (residency and fellowship programs) and those which represented various management and organizational philosophies (e.g. a for-profit hospital [Fairfax Hospital]; a university hospital [George Washington University Medical Center]; a military teaching hospital of similar size and function to WRAMC [Bethesda Naval Medical Center]; and a Veterans Administration hospital [Veterans Administration Medical Center, Washington, D.C.]).

3. Phase three consisted of the development and analytical comparison of proposed organizational structures. This comparison utilized the current organizational structure pattern (e.g. 76Js assigned to the DMAA) and a proposed organizational structure developed with guidance from current medical material management literature and observed medical material management organizational structures seen during site visits to other active healthcare institutions (See preceding paragraph) (e.g. 76Js assigned to DOL). The analytical comparison focused on a discussion of the advantages and disadvantages of the research findings of this study and their impact on the future organizational structure (e.g. either along the DMAA or DOL lines). It was planned that the recommendation would consist of that organizational structure which would offer WRAMC the best advantages in terms of current manpower staffing constraints, supervisory and support effectiveness, and efficiency in the utilization of the 76Js

authorized for the provision of medical material management to the patient care units within WRAMC [Note: An implementation plan was not planned as a product of this research].

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II. DISCUSSION

Historical Background and Perspective on the Directorate of Medical Activities Administration (DMAA)

The Directorate of Medical Activities Administration (DMAA) is one of ten directorate level activities currently reporting to the Deputy Commander for Administration/Chief of Staff/Deputy Post Commander for Walter Reed Army Medical Center (See TAB A - WRAMC Organizational Chart). The mission of the DMAA is "to provide direct [healthcare administrative] support to clinical activities within the Medical Treatment Facility (WRAMC Reg 10-1 6-29)." The DMAA accomplishes this mission by exercising "supervision over the management of [healthcare administrative] support services for the first, second, third, fourth, fifth, sixth, and seventh floors of the hospital (WRAMC Reg 10-1 6-29)." Before looking at the organizational structure of the DMAA in detail, it was first necessary to explore the historical background and perspective of the management philosophy and concept of operation behind this directorate.

In the middle 1970s transition plans were being developed to relocate from the old WRAMC medical treatment facilities opened in 1909 to a new, modern facility (See TAB B - WRAMC Installation Map). In line with this physical move was the concomitant development of a new administrative support and management philosophy for WRAMC (Southby and Rivera 5). This new administrative philosophy was called the Unit Administration (UA) Concept (Ferreira 1987). The UA concept implemented at WRAMC was taken from a

civilian model that recognized, especially for large medical centers, that these medical facilities had traditionally operated with "administrative aides," rather than with trained healthcare administrators (Oliver 1982, Southby and Rivera 1-10).

According to (then) Lieutenant Colonel Gerald C. Oliver, Medical Service Corps, United States Army, Director, DMAA from 1982 - 1984, there were three principle situations which lead to the adoption of the UA concept at WPAMC in the 1970s (1982). These situations included the following:

1. The enormous COMPLEXITY of a medical center;
2. The absolute necessity to be MOPE PRODUCTIVE. To keep nurses and physicians in patient care and NOT healthcare administration; and
3. The clinical staff was DEMANDING more SOPHISTICATED healthcare administrative services.

Additionally, within healthcare administration circles during the 1970s and at WPAMC there was a growing belief that the delivery of healthcare administrative services was much like the delivery of clinical services (Oliver 1982, Southby and Rivera 1-10). For example:

the real issue of QUALITY AND QUANTITY IS ALWAYS
PRESENT;
the DEMAND for administrative services is
INFINITE and there is never enough to go around; and

decisions as to TRADE-OFFS are OFTEN DIFFICULT.

The decision must often be made as to who will receive support. These decisions are made in conjunction with the clinical and nursing staffs.

The WRAMC UA concept was developed as a recognition of the real life issues mentioned previously and also because there was a demonstrated need throughout the entire Medical Center for trained healthcare administrators with technical proficiency in the following functional healthcare administrative areas:

1. Personnel management;
2. Budgeting; and
3. Facility, Equipment, and Maintenance.

Due to these circumstances, a decision was made to develop an organizational structure which would provide healthcare administrative management at all levels within the Medical Center. This structure was to address the need to improve the "quality and availability" of healthcare administrative services while at the same time increasing the "productivity" of the clinical staff by "relieving them of [healthcare] administrative tasks." The ultimate goal of the WRAMC UA organizational structure was "to provide better patient care (Oliver 1982)."

The concept of operation for the planned UA organizational structure provided for a healthcare administrative support structure with an "integrated structure parallel to the nursing

command group (Oliver 1982)." At the apex of the UA structure was the Assistant Chief of Staff for Medical Activities Administration (Director, DMAA). The Director, DMAA, was designed to provide a bridge that united the healthcare administrative and clinical missions at the command group level. To build this bridge the Director, DMAA, was to be provided his own directorate level activity within the WRAMC organizational structure and given direct (line) supervision over seven associate healthcare administrators within the Medical Center (Oliver 1982).

The seven associate healthcare administrators called for in the UA concept were to be roughly equivalent to clinical service chiefs within the Medical Center (Ferreira 1987). These seven associate healthcare administrators would include one associate administrator responsible for "clinical support services" (which consist of medical education, CPR clinic, medical library, tumor registry, and coordination with clinical department healthcare administrators), a second associate healthcare administrator who would be responsible for the "quality assurance program" (consisting of quality assurance, hospital committees, inpatient records, utilization review, JCAH (now JCAHO), recorder of the executive committee, risk management program, medical boards, and credentialing), and five associate healthcare administrators having responsibilities for a healthcare "administrative support division (Oliver 1982)."

The WRAMC UA concept called for these five associate healthcare administrators, as chiefs of a healthcare

administrative support division, to be assigned "geographical areas of responsibility" and assume the "full [healthcare] administrative management responsibility" for that locality. These geographic localities were to be an entire floor of the Medical Center, except in the case of one associate healthcare administrator who was to receive management responsibility for the first three floors of the Medical Center (Oliver 1982). These five associate healthcare administrators, as geographic managers, were designed in the UA organizational structure to exercise direct (line) supervision over the unit healthcare administrators that would be located on their floors (Ferreira 1987). The WRAMC UA concept called for a combination of both military and civilian unit healthcare administrators to be assigned and utilized at WRAMC (Southby and Rivera 1-10). These unit healthcare administrator positions were designed to "support a wide range of specialty clinics and inpatient units (Oliver 1982).

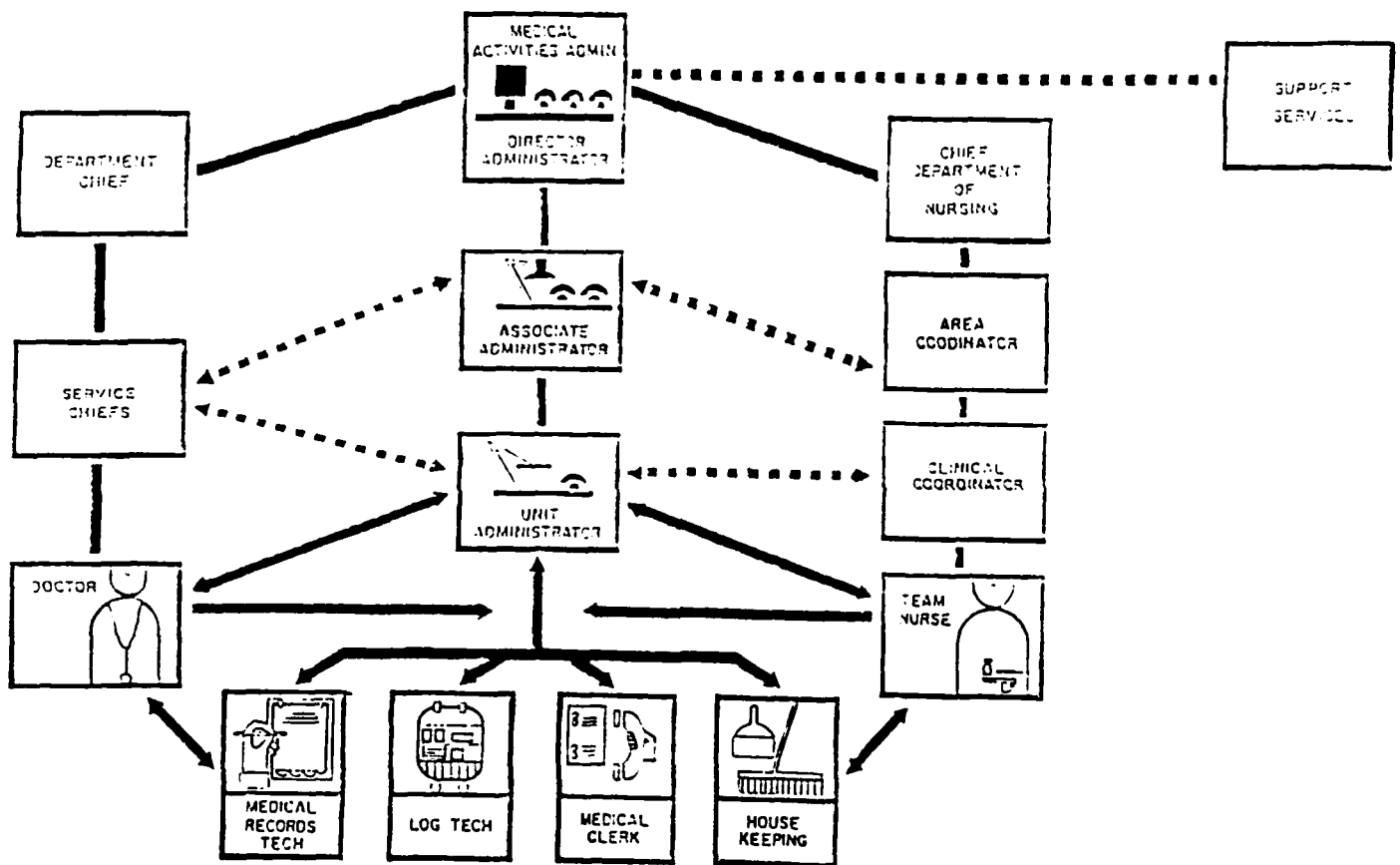
The base of the WRAMC UA healthcare administration structure was designed with the unit healthcare administrator as its fundamental component (Patterson 1987). Due to their position within the UA healthcare administration structure, unit healthcare administrators were given primary responsibility for accomplishing the following technical healthcare administration management functions at the nursing or clinic level (Ferreira 1987, Oliver 1982, Patterson 1987):

1. Logistics;
2. Medical records administration;
3. Receptionist duties; and
4. Housekeeping.

In addition to the above, the unit healthcare administrators were also "responsible for the broad functions of planning, organizing, directing, evaluating, and supervising their respective [healthcare administration] units (Oliver 1982)." Unit healthcare administrators were further held accountable for coordination between the medical and nursing staffs that were supported by their healthcare administration units (See Figure 1 - WRAMC UA Interaction Scheme). TAB C (WRAMC UA Functional Scheme) provides an expanded graphic illustration of the inherent responsibilities for the coordination envisioned for unit healthcare administrators under the original WRAMC UA functional scheme by including the support services structural chain (Ferreira 1987).

The WRAMC UA concept called for unit healthcare administrators to have responsibility for from two to four inpatient nursing units of 48 beds each and/or one or more clinics on floors four through seven. On the first three floors, the unit healthcare administrators were to have healthcare administration management responsibility for one or more outpatient clinics. The WRAMC UA structure called for the unit healthcare administrators to have the following healthcare personnel on their staffs to assist them in

Figure 1 WRAMC UA Interaction Scheme



Fulfilling their healthcare administration responsibilities (Ferreira 1987, Oliver 1982, Patterson 1987):

1. Medical records clerks;
2. Medical records specialists (MOS 71G);
3. Medical supply specialists (MOS 76J); and
4. Housekeepers.

The critical focal point of the original WRAMC UA organizational structure and concept was the planned nature of the unit healthcare administrator's dual responsibility for both ancillary healthcare personnel supervision and unit healthcare administration support. It was at this juncture in the UA structure that we found the unit healthcare administrator charged to function as both "a manager who must also be a first-line supervisor; [and as] a planner who must also do teaching of daily operational tasks (Oliver 1982)." It was this new healthcare administration management concept of operation that was to serve as the fulcrum for the future DMAA organizational structure within the new Medical Center.

The healthcare administration management philosophy behind WRAMC's UA concept was as equally as important as was the concept of operation that was developed for the new Medical Center healthcare administration structure (Southby and Rivera 1-10). The mission for this novel military healthcare administration structure at WRAMC was to "provide [healthcare] administrative support to the medical and nursing staff[s]." The major thrust behind the new structure was "to ensure that the philosophy of

[healthcare administrative] support [was] carried out and [was] exhibited by competent, professional behavior on the part of the [healthcare] administrative staff (Oliver 1982)."

The healthcare administration philosophy for the new WRAMC UA concept also stressed the fact that there was now a structural chain parallel to the clinical and nursing structural chains (Ferreira 1987, Oliver 1982, Patterson 1987). The purpose of this parallel chain was to allow for direct supervision and accountability from the unit healthcare administrators through the associate healthcare administrators and Chief, DMAA, to the Deputy Commander for Administration/Chief of Staff/Deputy Post Commander for the first time within a United States Army Medical Department (AMEDD) medical treatment facility (MTF). Thus, this parallel structural chain was designed to not only enable the healthcare administration structure to support both the clinical and nursing staffs, but also to be accountable to the Medical Center's command group as well. (See TAB C - WRAMC UA Functional Scheme).

It was envisioned from the initial conception and development of the WRAMC UA concept that the strength of this healthcare administrative structure should be manifested in its "ability to be flexible and when necessary, to manage shortages (Oliver 1982)." These shortages were specifically envisioned at the ancillary healthcare support personnel level [medical records clerks, medical records specialists (MOS 71G), medical supply specialists (MOS 76J), and housekeepers] where the medical and nursing staffs

were dependent for daily support (Ferreira 1987). An example of the planned flexibility in the WRAMC UA concept was illustrated by (then) LTC Oliver in a 1982 address to the Department of Health Services Administration at George Washington University through the following scenario:

"For example, the log tech [medical supply specialist] is accountable to his or her unit administrator. At the same time he must be responsive to the nurse on the ward or the physician in the clinic. As a practical matter, the log tech is there for only one reason.

SUPPORT! The unit administrator's responsibility is to ensure that the proper support is being provided."

From a historical background and perspective it then became clear that the healthcare administrative management philosophy behind the development of the WRAMC UA concept was two-fold. The first was to develop a healthcare administration structural chain parallel to the medical and nursing structural chains and accountable to the Medical Center command group. The second involved the development of a healthcare administrative structure to manage shortages and ensure the philosophy of healthcare administrative support through a competent, trained, and professional healthcare administration staff within the Medical Center. In conclusion, the WRAMC UA concept continues to remain, as of this date, the only healthcare administration structure of this type found in any AMEDD medical treatment facility (MTF). This can clearly be attributed to the passing vogue of this 1970s

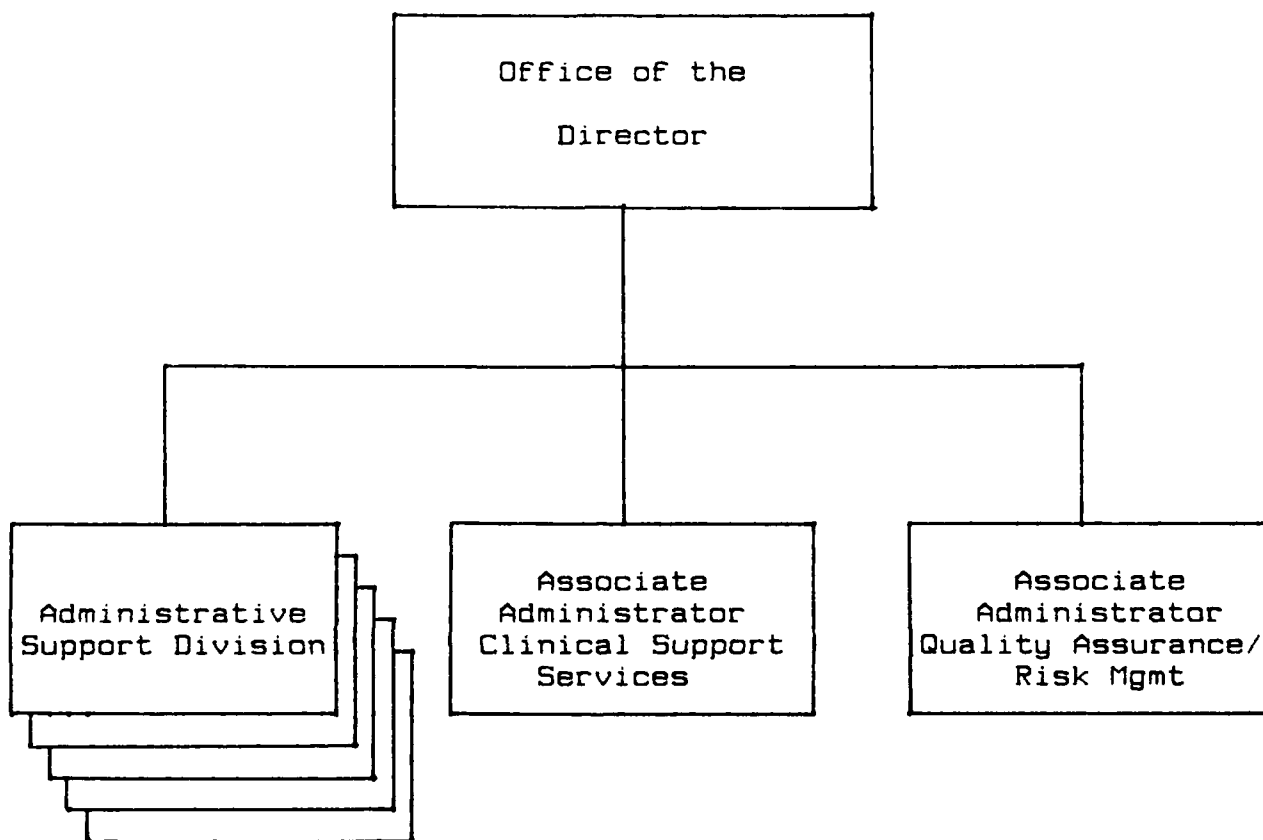
healthcare administration management concept, as well as the adherence by the AMEDD to a more traditional military healthcare administration structure within its MTFs (Southby and Rivera 1-10).

Current Organizational Structure of the Directorate of Medical Activities Administration (DMAA)

The current Directorate of Medical Activities Administration (DMAA) is organizationally very similar to the original WRAMC UA concept of the 1970s. The three major organizational components within the DMAA structure are still intact (See Figure 2 - Directorate of Medical Activities Administration Organization). These three major components still remain as the clinical support services, quality assurance/risk management, and the administrative support divisions, of which there are five (WRAMC Reg 10-1 6-28).

This research was limited to the administrative support divisions since the clinical support and quality assurance/risk management components do not have any medical supply NCOs or specialists (MOS 76J) required as organic components of their structures. Administrative support divisions are defined again as "geographic areas of [healthcare administrative] responsibility" that correspond to an entire floor of the Medical Center, except for floors one through three which comprise one administrative support division (Oliver 1982, WRAMC Reg 10-1 6-29 - 6-31).

Figure 2 DMAA Organization

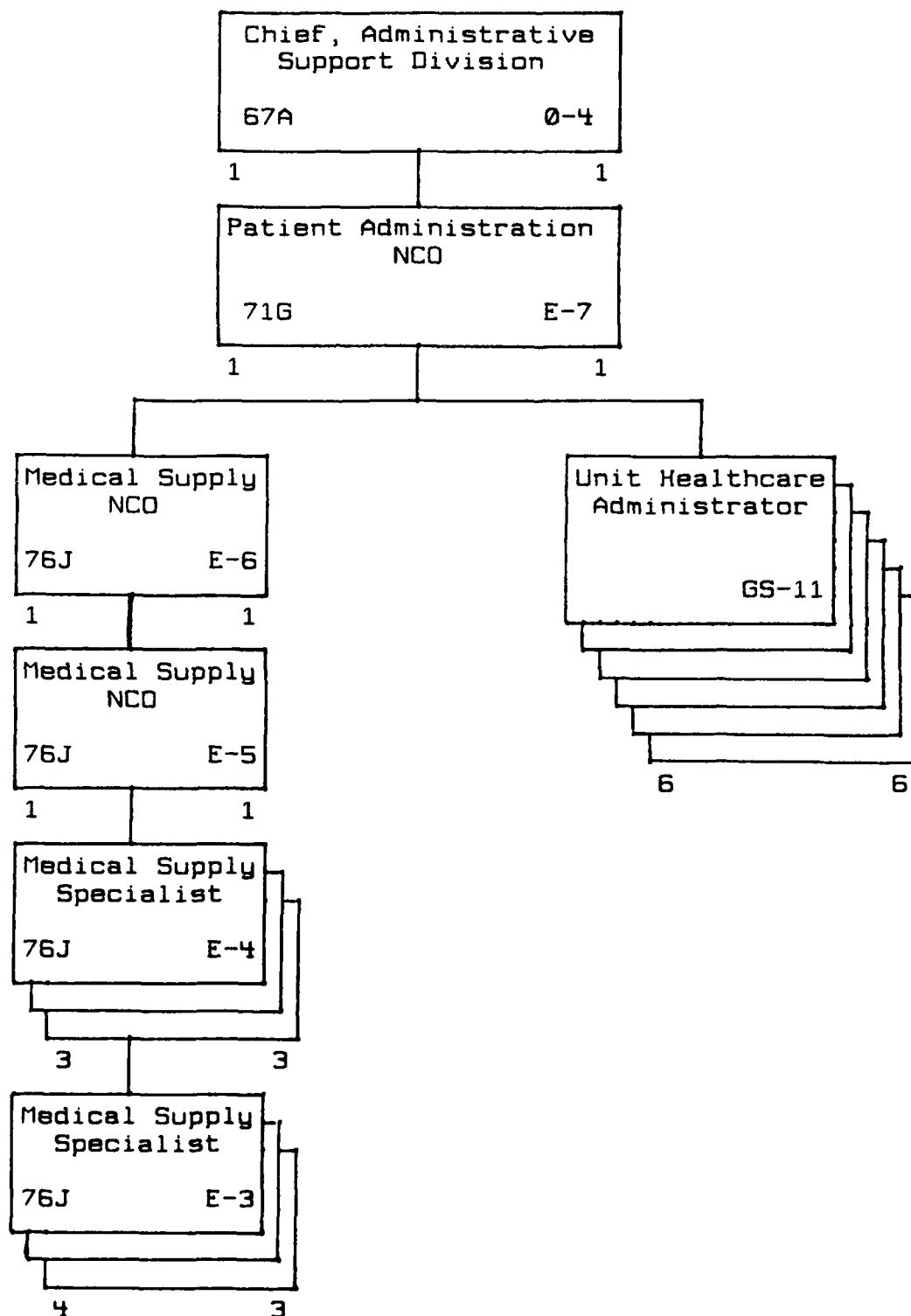


A detailed analysis of each of the five administrative support divisions was performed in this research for two purposes. First, an analysis was done to determine the present healthcare administrative organizational structure supporting each of the seven floors in the Medical Center. The second analysis was done to determine the actual supervisory structure for each of the five administrative support divisions. The Table of Distribution and Allowances (TDA) manpower and staffing document that governed this research was TDA HSW2DHAA (Walter Reed Army Medical Center), with an effective date of October 1987. The analysis of each of the five administrative support divisions was limited to the manpower and staffing that affected the organizational structure for supervision of 76Js assigned to the DMAA. TAB D (WRAMC TDA HSW2DHAA DMAA Excerpts) provides supporting documentation for the following discussion and the five DMAA administrative support divisions which follow.

Base-line templates for discussion within this research paper first had to be developed for the healthcare administration organizational structures of the five DMAA administrative support divisions to facilitate an understanding of the structures governing daily 76J performance and utilization within the Medical Center. For the purposes of this research, only structures affecting the supervision and utilization of 76Js within the DMAA were explored in detail.

The first DMAA administrative support division to be detailed is the one covering the first through third floors. Figure 3 (Administrative Support Division - Floors 1-3)

Figure 3 ASD - Floors 1-3

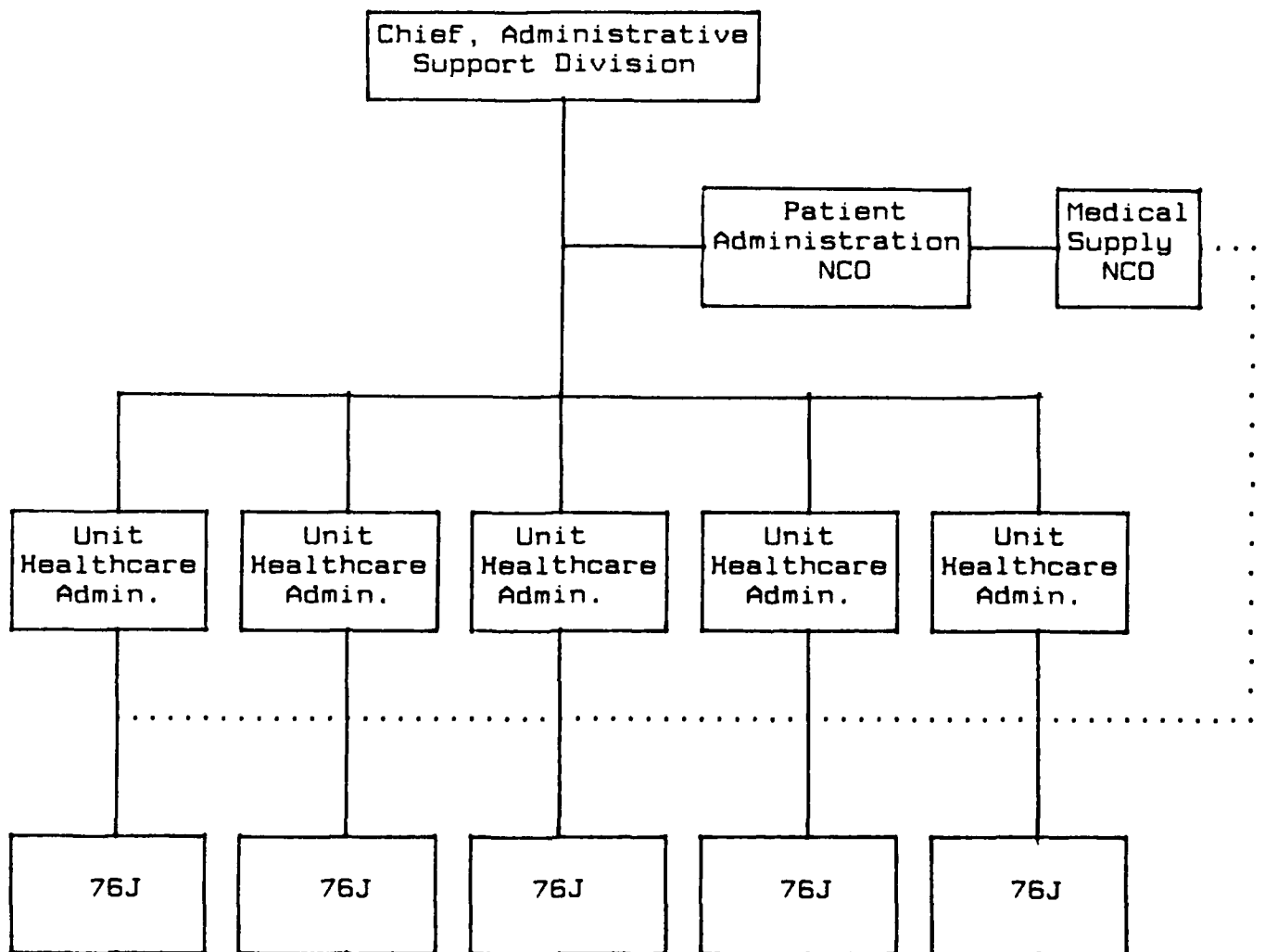


NOTE: Number under box to left is REQUIRED strength
 Number under box to right is AUTHORIZED strength

graphically illustrates the current organizational 76J manpower structure required and authorized for this geographic area. This administrative support division (ASD) has requirements for nine 76Js [one Staff Sergeant (E-6), one Sergeant (E-5), three Specialists (E-4), and four Privates (E-1 thru E-3)]. Currently this ASD is authorized only eight 76Js (all requirements are met, less one Private). Points of interest about this particular ASD include the facts that the authorized 76J Staff Sergeant is a new position within this ASD; that the Non-Commissioned Officer-in Charge (NCOIC) of this ASD is a Sergeant First Class (E-7), Patient Administration Specialist (MOS 716); and that all six unit healthcare administrators (referred to in the TDA as a Supervisor, Health System Specialists) are all documented civilian positions.

The actual supervision structure for the ASD, Floors 1-3, is fundamentally different from the organizational structure depicted in Figure 3 (Administrative Support Division - Floor 1-3). The current actual supervision structure for this ASD is depicted graphically in Figure 4 (ASD Floors 1-3 76J Supervision Scheme) (Costello 1987). In this ASD supervision schematic, the 76Js are directly supervised by their respective unit healthcare administrators. Technical supervision and guidance is provided as is needed or requested by the senior 76J Sergeant (E-5 thru E-6) assigned to the ASD, Floors 1-3. This supervisory structure is prototypical of what was intended under the original 1970s WRAMC UA concept with unit healthcare administrators functioning as first-line supervisors of 76Js (Ferreira 1987, Patterson 1987, TAB C).

Figure 4 ASD Floors 1-3 76J Supervision Scheme



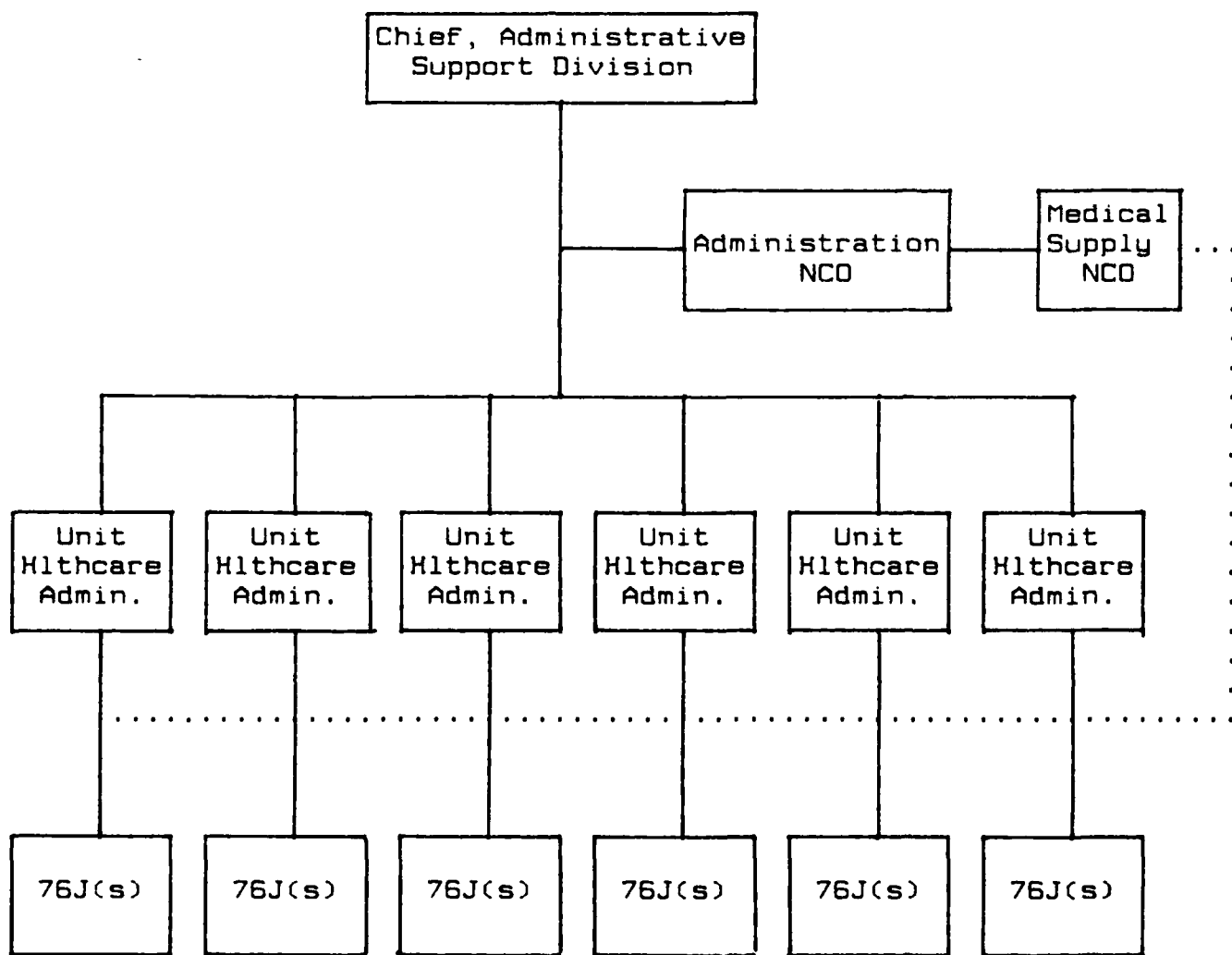
.....Technical Coordination/Support/Guidance

—————Direct Supervision/Chain of Command

The second DMAA ASD detailed covers the fourth floor of the Medical Center. Figure 5 (Administrative Support Division - Floor 4) graphically illustrates the current organizational 76J manpower staffing structure required and authorized for this particular geographic area. This ASD has requirements for 19 76Js [one Staff Sergeant (E-6), three Sergeants (E-5), seven Specialists, and eight Privates (E-1 thru E-3)]. At the current time, the ASD is authorized 18 76Js (all requirements are met, less one Private). Points of interest about this ASD include the fact that the authorized 76J Staff Sergeant position is not new; that the NCOIC for this ASD is a Staff Sergeant (E-6), Administration Specialist (MOS 71L); that only five of the six required unit healthcare administrator positions are authorized (two are military and three are civilian positions, the required but not authorized position is military); and that this ASD is generally accepted as the one supporting the most demanding geographic area (Stingle 1987).

The actual supervision structure for ASD, Floor 4, is, like the ASD, Floors 1-3, and is fundamentally different from the organizational structure depicted in Figure 5 (Administrative Support Division - Floor 4). The actual supervision structure for ASD Floor 4, is graphically depicted in Figure 6 (ASD Floor 4 76J Supervision Scheme) (Weiner 1987). In this particular ASD's supervisory schematic, the 76Js are, like ASD, Floors 1-3, being supervised directly by their respective unit healthcare administrators. Again, technical supervision and guidance is provided as is needed or requested by the senior 76J sergeant for

Figure 6 ASD Floor 4 76J Supervision Scheme



.....Technical Coordination/Support/Guidance

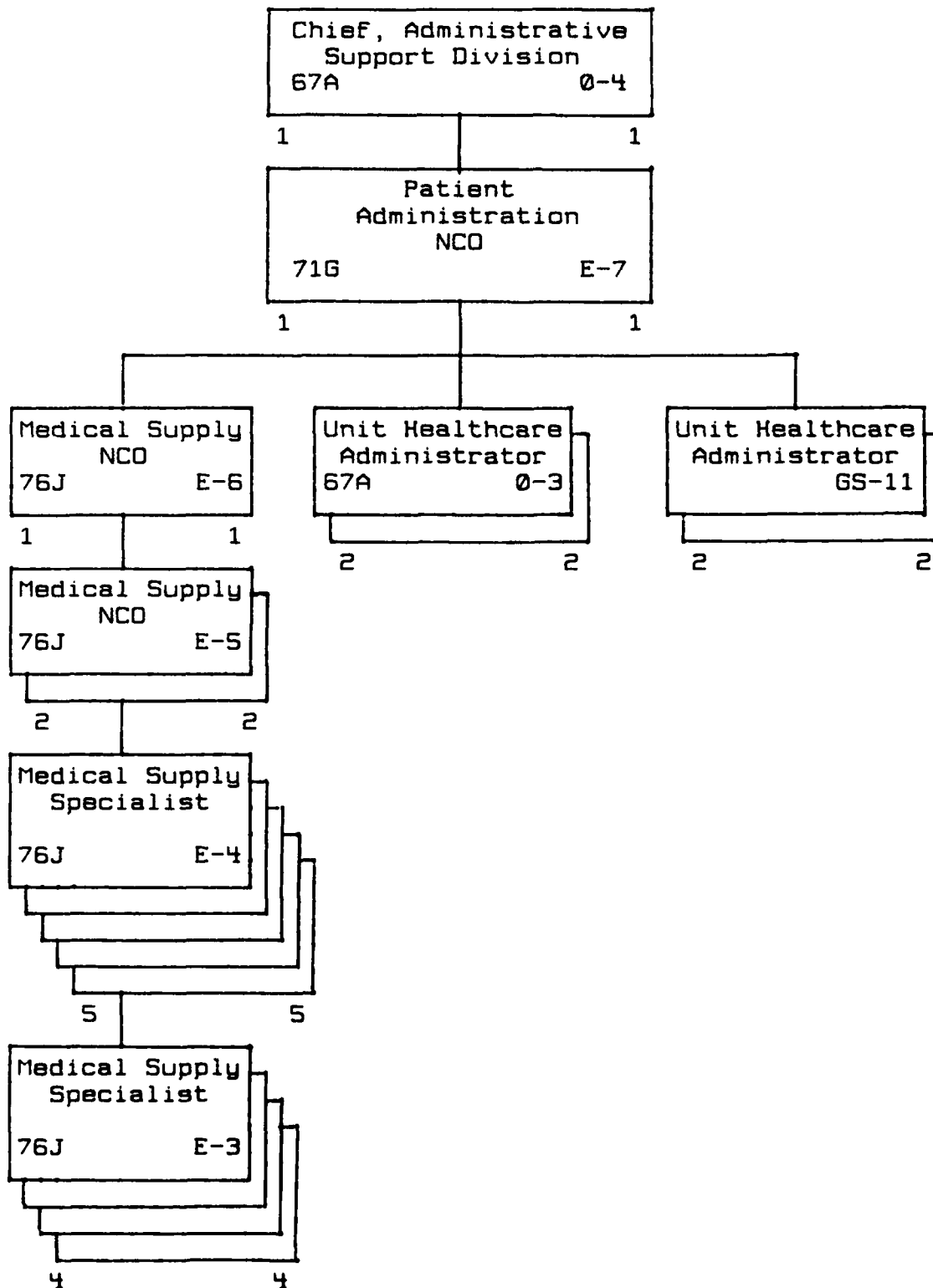
-----Direct Supervision/Chain of Command

the ASD, Floor 4. As with the ASD, Floors 1-3, this ASD has the prototypical supervision structure envisioned in the original WRAMC UA concept of the 1970s (Ferreira 1987, Patterson 1987, TAB C).

The third ASD detailed covers the fifth floor of the Medical Center. Figure 7 (Administrative Support Division - Floor 5) graphically illustrates the current organizational 76J manpower staffing structure required and authorized for this geographic area. The ASD, Floor 5, has requirements for 12 76Js [one Staff Sergeant (E-6), two Sergeant (E-5), five Specialists (E-4), and four Privates (E-1 thru E-3)]. Currently, the ASD, Floor 5, has all 12 requirements authorized. Points of interest about this ASD include the fact that the Staff Sergeant (E-6) is a new position; that (to be consistent) the NCOIC for this ASD is a Sergeant First Class (E-7), Patient Administration Specialist (MOS 71G); and that the four required and authorized unit healthcare administrator positions are split equally between military and civilian billets.

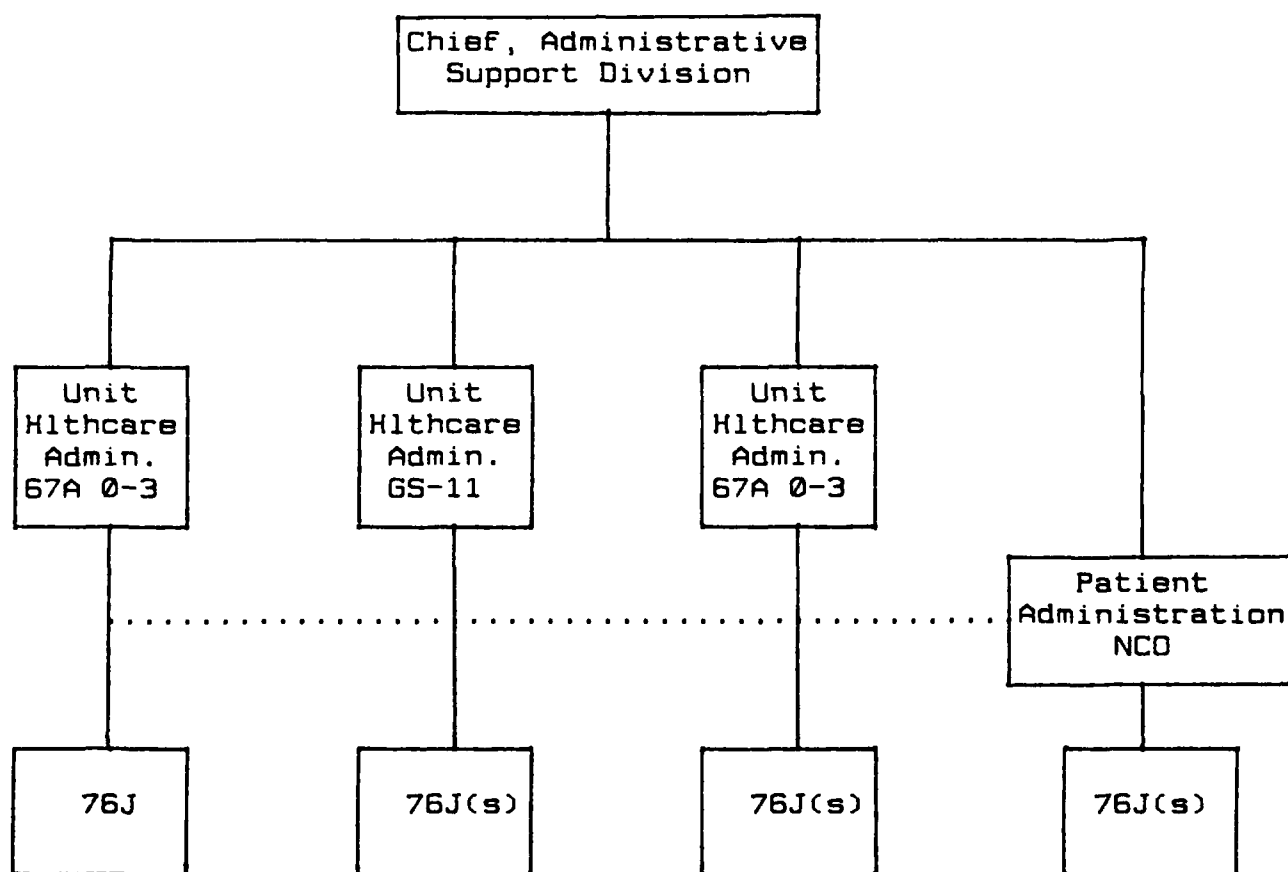
The actual supervision structure for the ASD, Floor 5, like the two preceding ASDs, is also different from the organization structure depicted in Figure 7 (Administrative Support Division - Floor 5). The current supervisory schematic is depicted in Figure 8 (ASD Floor 5 76J Supervision Scheme) (Weinschenk 1987). Like the two previous ASDs, the ASD, Floor 5, utilizes the prototypical supervision structure envisioned in the original 1970s WRAMC UA concept (Ferreira 1987, Patterson 1987, TAB C). And like the two previous ASDs, technical guidance is provided as is needed or requested by the senior 76J sergeant on the ASD, Floor 5.

Figure 7 ASD - Floor 5



NOTE: Number under box to left is REQUIRED strength
Number under box to right is AUTHORIZED strength

Figure 8 ASD Floor 5 76J Supervision Scheme



.....Technical Coordination/Support/Guidance

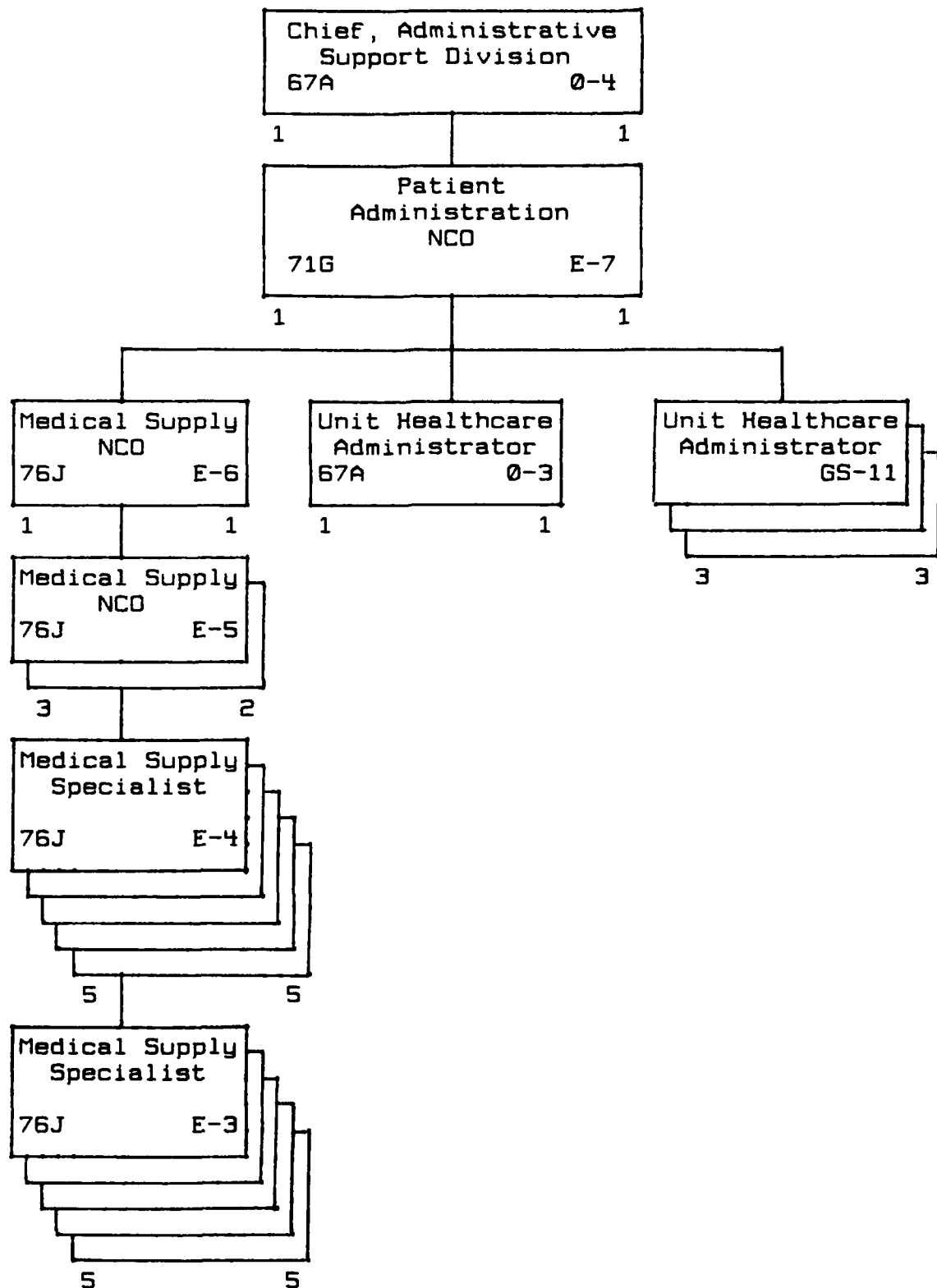
—————Direct Supervision/Chain of Command

However, in the case of the ASD, Floor 5, this assistance is provided by the senior 76J sergeant through the ASD's NCOIC supervision (Weinschenk 1987).

The fourth ASD detailed covers the sixth floor of the Medical Center. Figure 9 (Administrative Support Division - Floor 6) graphically illustrated the present organizational 76J manpower staffing structure required and authorized for this geographic area. This ASD has requirements for 14 76Js [one Staff Sergeant (E-6), three Sergeants (E-5), five Specialists (E-4), and five Privates (E-1 thru E-3)]. Currently, the ASD, Floor 6, has 13 76Js authorized (all requirements are met, less one Sergeant). Points of interest include the fact, like the ASDs, Floors 1-3 and 5, the 76J Staff Sergeant position is a new requirement and authorization; also, like the ASD, Floors 1-3, and the ASD, Floor 5, the NCOIC for this ASD is a Sergeant First Class (E-7), Patient Administration Specialist (MOS 71G); and that all four unit healthcare administrator positions are authorized (only one of the four positions is military).

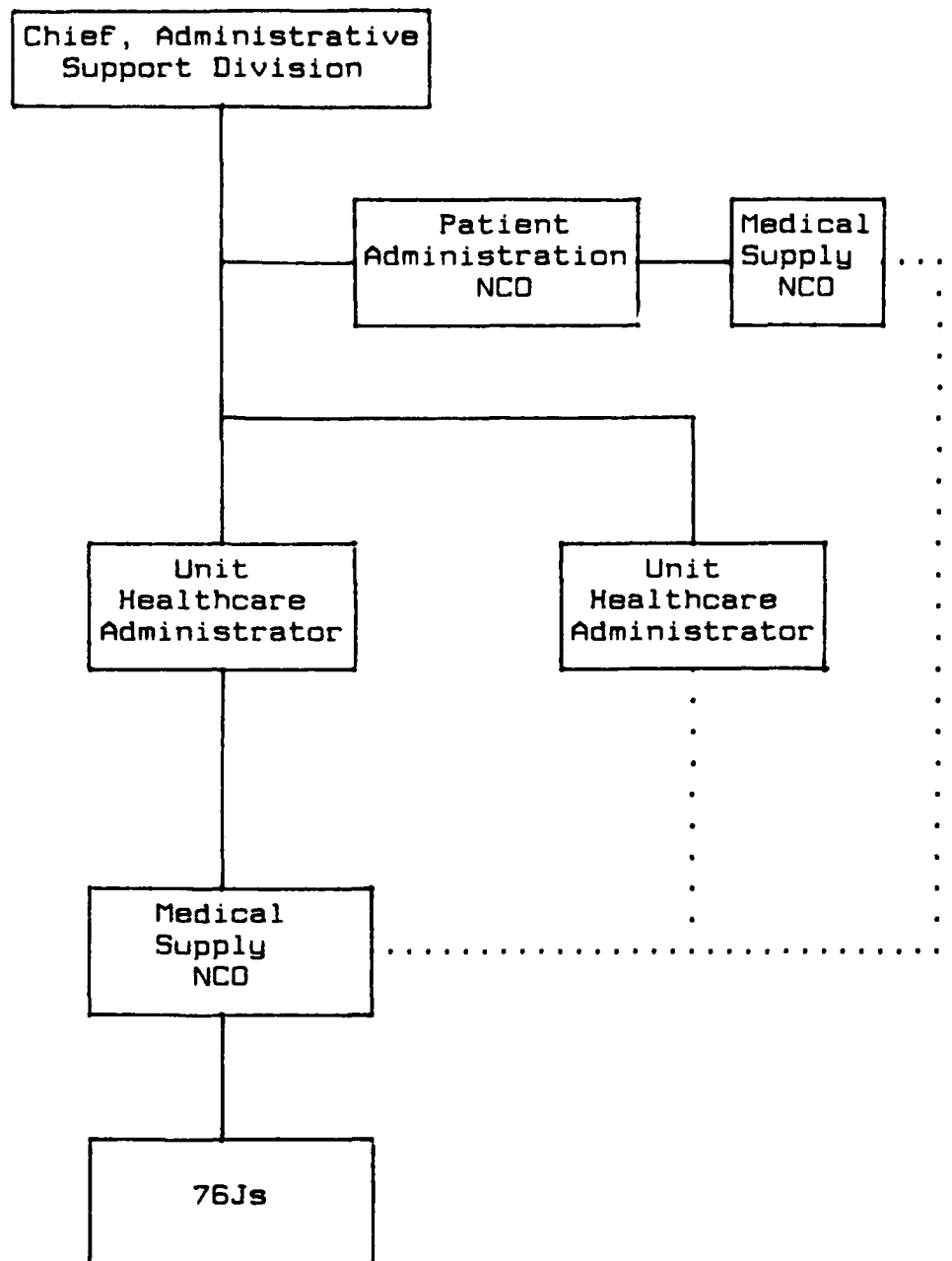
The actual supervisory structure for the ASD, Floor 6, is fundamentally different than the organizational structure depicted in Figure 9 (Administrative Support Division - Floor 6). The present supervision structure is depicted graphically in Figure 10 (ASD Floor 6 76J Supervision Scheme) (Stingle 1987). Unlike the previous three ASDs, this ASD's supervisory scheme does not follow the prototypical model envisioned in the WRAMC UA concept from the 1970s. Instead, in this ASD, 76Js are supervised on a daily basis by the senior 76J Sergeant for

Figure 9 ASD - Floor 6



NOTE: Number under box to left is REQUIRED strength
 Number under box to right is AUTHORIZED strength

Figure 10 ASD Floor 6 76J Supervision Scheme



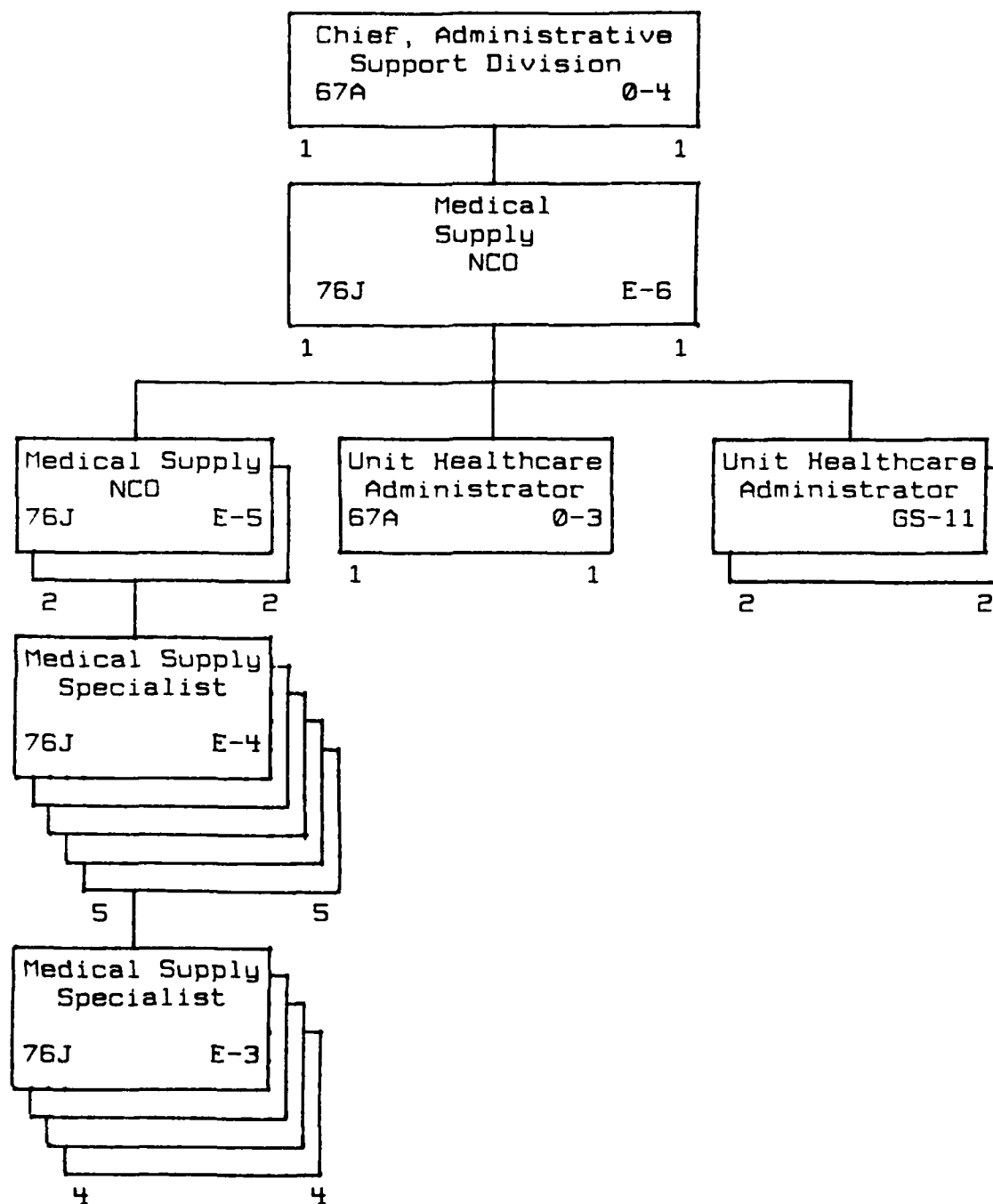
.....Coordination/Support/Guidance

—————Direct Supervision/Chain of Command

the ASD, and the senior 76J Sergeant (E-5 thru E-6) receives his/her necessary guidance and directions from one of the unit healthcare administrators designated as the ASD expert in healthcare material management. Other unit healthcare administrators for the ASD still provide guidance to the senior 76J Sergeant supervising the ASD 76Js as it affects their supported nursing units and clinics. This is a marked departure in supervision from the previous ASDs.

The fifth, and final, ASD detailed covers the seventh floor of the Medical Center. Figure 11 (Administrative Support Division - Floor 7) graphically illustrates the current organizational 76J manpower structure required and authorized for this final geographic area. This ASD has requirements for eleven 76Js [two Sergeants (E-5), five Specialists (E-4), and four Privates (E-1 thru E-3)]. Currently, this ASD has all its requirements authorized. Points of interest include the fact that this is the only ASD not authorized a 76J Staff Sergeant as the senior 76J NCO. Instead, this ASD is authorized a 76J (E-5) as its senior medical supply specialist. The reason for this is the fact that this ASD is the only ASD where the NCOIC for the ASD is a Staff Sergeant (E-6) rather than a Sergeant First Class (E-7), and a Medical Supply Specialist (MOS 76J) rather than a 71G (Floors 1-3, 5, and 6) or a 71L (Floor 4). However, on Floor 7, it was not intended for this ASD NCOIC to function in any other capacity except as the ASD NCOIC. Finally, this ASD is authorized all three required unit healthcare administrators (only one of the three positions is military).

Figure 11 ASD - Floor 7



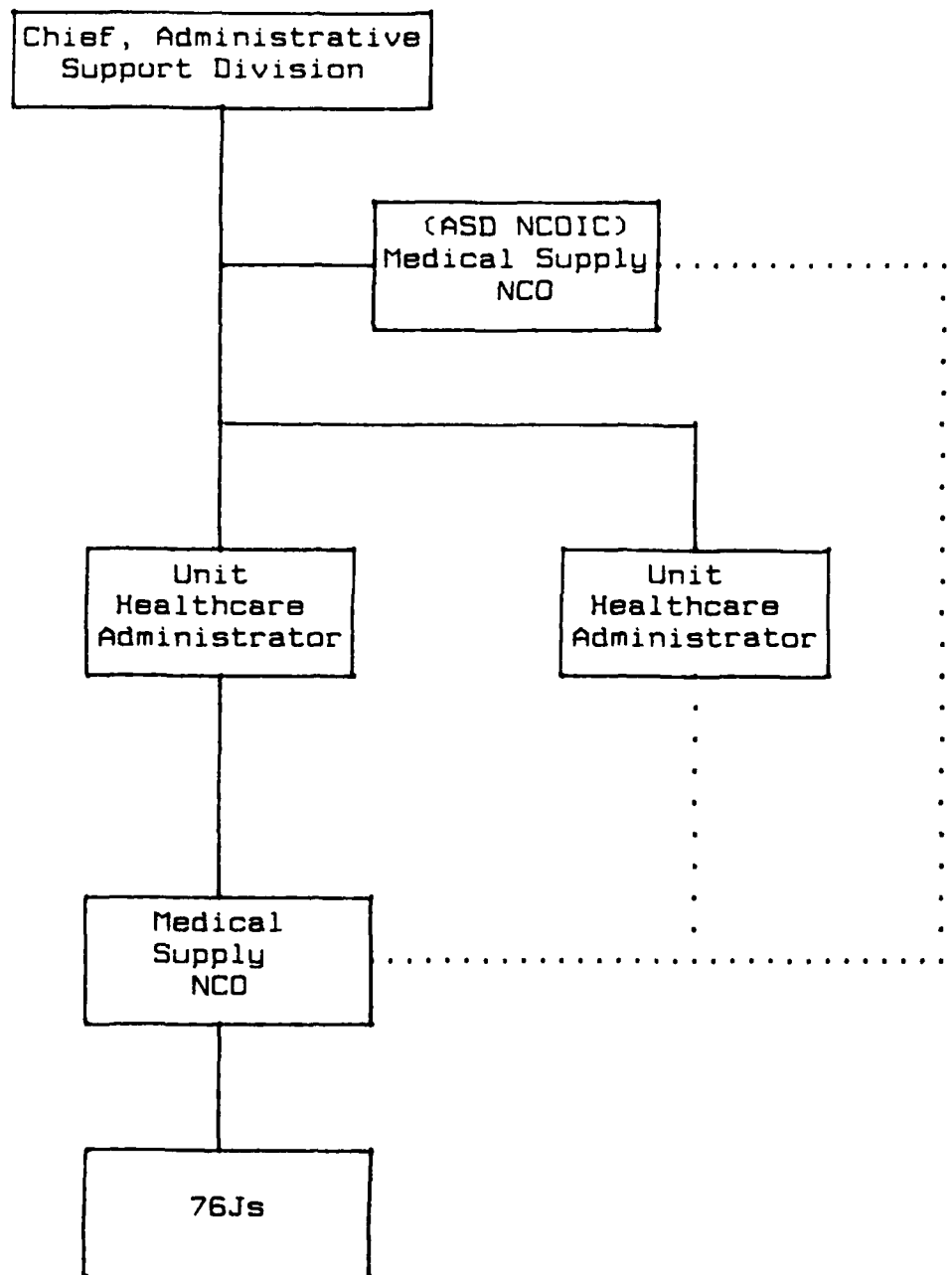
NOTE: Number under box to left is REQUIRED strength
 Number under box to right is AUTHORIZED strength

The actual supervision structure for the ASD, Floor 7, like all the previous ASDs, is different from the TDA organizational structure depicted (See Figure 11 Administrative Support Division - Floor 7). The actual supervisory structure is graphically depicted in Figure 12 (ASD - Floor 7 76J Supervision Scheme) (Murry 1987). Like the ASD, Floor 6, this ASD supervisory scheme differs remarkably from the intended 1970s WRAMC UA concept. The actual supervisory structure works in a fashion similar to the ASD, Floor 6, with a 76J Sergeant (E-5) providing daily supervision to the ASD 76Js and a designated unit healthcare administrator functioning as the ASD medical material management expert. Other ASD unit healthcare administrator(s) can provide guidance to the Floor 7 76J Sergeant as it affects their healthcare administration unit and supported nursing units and clinics.

A summary of information collected about the five DMAA ASDs is provided below and in Figure 13 (Summary of the Five DMAA Administrative Support Divisions) and shows their similarities and differences:

1. The ASDs, Floor 1-3, 5, & 6 have a Sergeant First Class (E-7), Patient Administration Specialist (MOS 71G) as the ASD NCOIC. The ASD, Floor 4, has a Staff Sergeant (E-6), Administration Specialist (MOS 71L) and the ASD, Floor 7, has a Staff Sergeant (E-6), Medical Supply Specialist as their ASD NCOIC.

Figure 12 ASD Floor 7 76J Supervision Scheme



.....Coordination/Support/Guidance

—————Direct Supervision/Chain of Command

2. All ASDs have a 76J Sergeant (E-5 or E-6) in their organizational structure that could be tasked to perform as both the ASD first-line supervisor of assigned 76Js and technical expert in medical material management.

3. Three of five ASDs are currently utilizing the 1970s WRAMC UA concept of the unit healthcare administrators as first-line supervisors for 76Js. Two ASDs are utilizing a modified supervision scheme with a 76J sergeant providing daily supervision of the ASD's 76J and a designated unit healthcare administrator supervising the 76J sergeant and also functioning as the ASD medical material management expert. Other ASD unit healthcare administrator provide guidance to the 76J sergeant supervising the ASD's 76Js as it effects their healthcare administration unit or support nursing units and clinics.

4. Two ASDs have their full complement of required 76Js authorized by WRAMC TDA (ASDs, Floor 5 & 7) and the other three ASDs are authorized only one less than their full requirements by TDA.

Figure 13 Summary of the Five DMAA Administrative Support Divisions

Summary of the Five DMAA Administrative Support Divisions					
ASD	NCOIC		76J Supervisor & Medical Material Management E-5/E-6	Prototypical of 1970s WRAMC UA Concept	Auth = Req'd
	GRADE	MOS			
1-3	E-7	71G	Y	Y	-1
4	E-6	71L	Y	Y	-1
5	E-7	71G	Y	Y	Y
6	E-7	71G	Y	N	-1
7	E-6	76J	Y	N	Y

As evidenced by the information collected and detailed in this section, three of five of the DMAA ASDs (the majority) are functionally structured to provide supervision of the DMAA's 76Js as originally envisioned in the 1970s WRAMC UA concept (TAB C). The effectiveness of the supervision structures utilized by the DMAA ASDs for 76Js are evaluated and detailed later in this research paper.

The Directorate of Logistic (DOL) Liaison Structure for
Supporting the Directorate of Medical Activities Administration
(DMAA)

The WRAMC UA concept developed in the 1970s recognized that the organizational structure envisioned for the Medical Center healthcare administration structure would assume full responsibility for managing medical material in all nursing units and clinics. However, the original organizational structure did not provide technical experts in medical material management as an organic component of the DMAA structure (Ferreira 1987, Patterson 1987). Medical material management experts were defined as any commissioned officer, enlisted soldier, or civilian within the DMAA organizational structure dedicated to providing personnel supervision, education, customer assistance, logistical planning, and technical consultation in the area of medical material management. Although some medical supply Non-Commissioned Officers (NCOs) were required and authorized under the original WRAMC UA concept, their grade was authorized only because of the need for them to manage a small receiving and issuing point on each of the five ASDs of the DMAA. Additionally, these NCOs were originally authorized only in the grade of Sergeant (E-5) (Ferreira 1987, Patterson 1987).

A method of providing the necessary technical supervision to allow the DMAA to manage its full range of medical material activities and responsibilities was crafted into the original

WRAMC UA concept by tasking the Directorate of Industrial Operations (DIO) (now called the Directorate of Logistics (DOL)) to "act as the primary logistical point of contact for supply and administrative personnel within the Medical Treatment Facility (MTF) (WRAMC Reg 10-1 6-37; Yates 1987)."

The original 1970s WRAMC UA concept called for the DMAA to be provided its medical material technical supervision through a liaison relationship between the DIO and DMAA (Ferreira 1987, Patterson 1987, Yates 1987). The present organization of the DOL is similar to the organizational structure of the DIO when the WRAMC UA concept was developed, except that the Purchasing and Contracting Division was made a separate directorate in 1988. (See Figure 14 DOL Organization) (Marley 1988). Under the original liaison relationship between the DIO and the DMAA, DIO provided one "logistic area manager (LAM)" to each of the DMAA five ASDs, for a total of five LAMs to support the DMAA (See Figure 15 Original DIO (DOL)/DMAA Liaison Structure) (Ferreira 1987, Patterson 1987; Romeo 1988, Smullen 1987, Yates 1987). LAM positions were a combination of commissioned Medical Service Corps (MS) logistics officer (67K) and civilian (GS-11) positions and were authorized on the DIO TDA (Ferreira 1987, Patterson 1987, Yates 1987). These five LAMs, under the control of a MS 67K who reported to the Director, DIO, worked in close association with their respective associate healthcare administrators to "monitor the performance of DIO activities within the [Medical Center]" and to provide "education, customer assistance, logistical planning and technical consultation" to the healthcare personnel of the ASD

Figure 14 DOL Organization

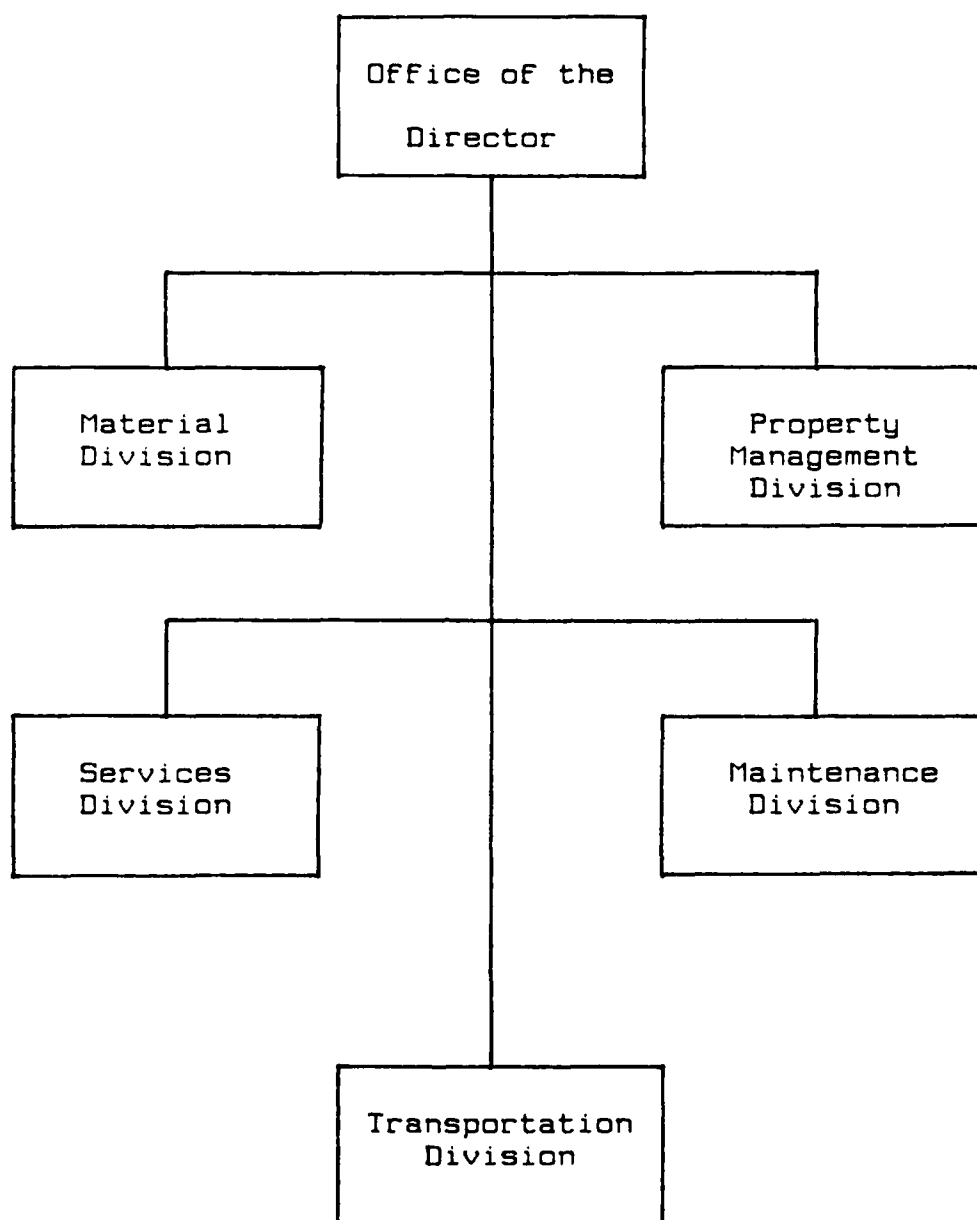
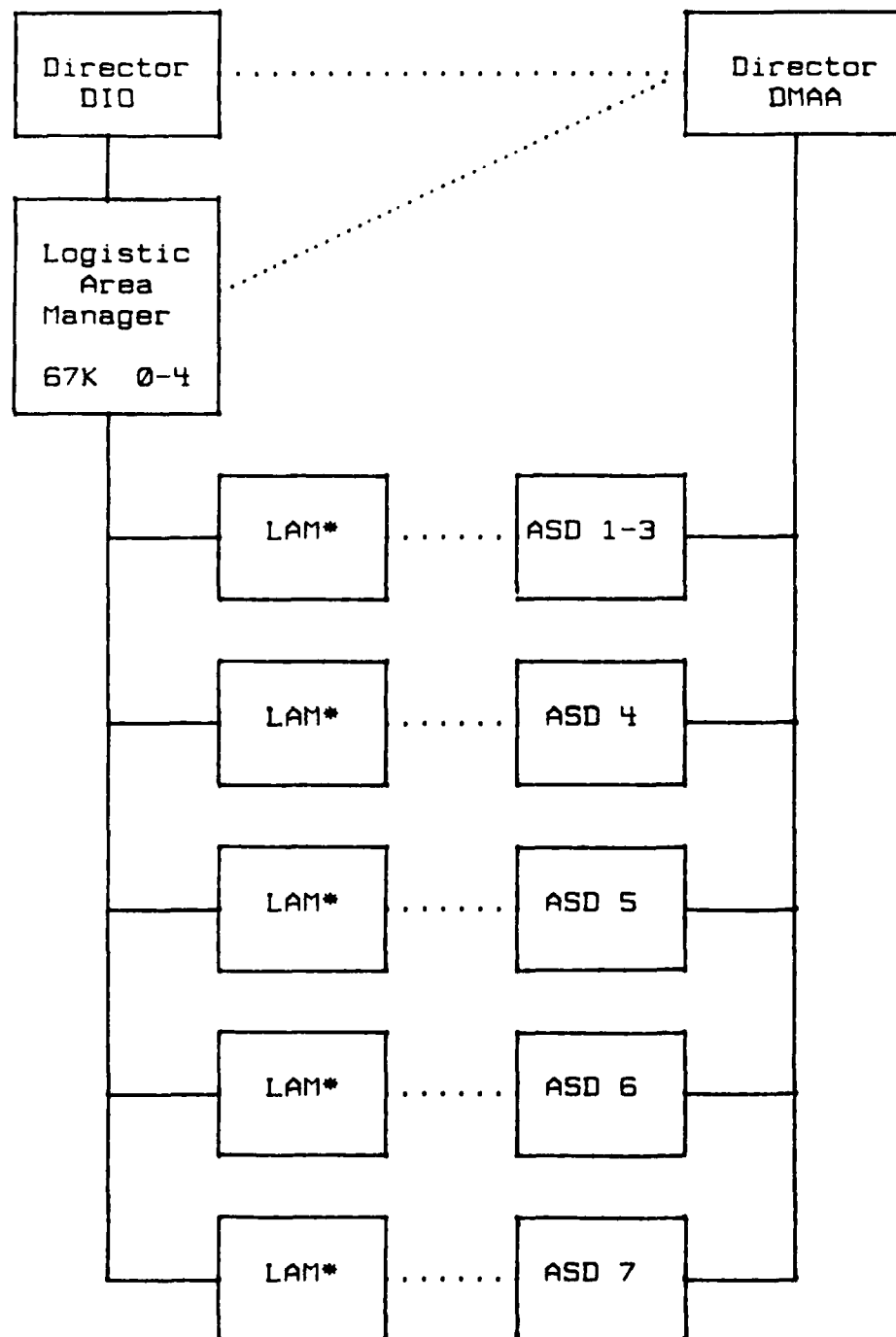


Figure 15 Original DIO (DOL)/DMAA Liaison Structure



* either military (67K 0-3) or civilian (GS-11)

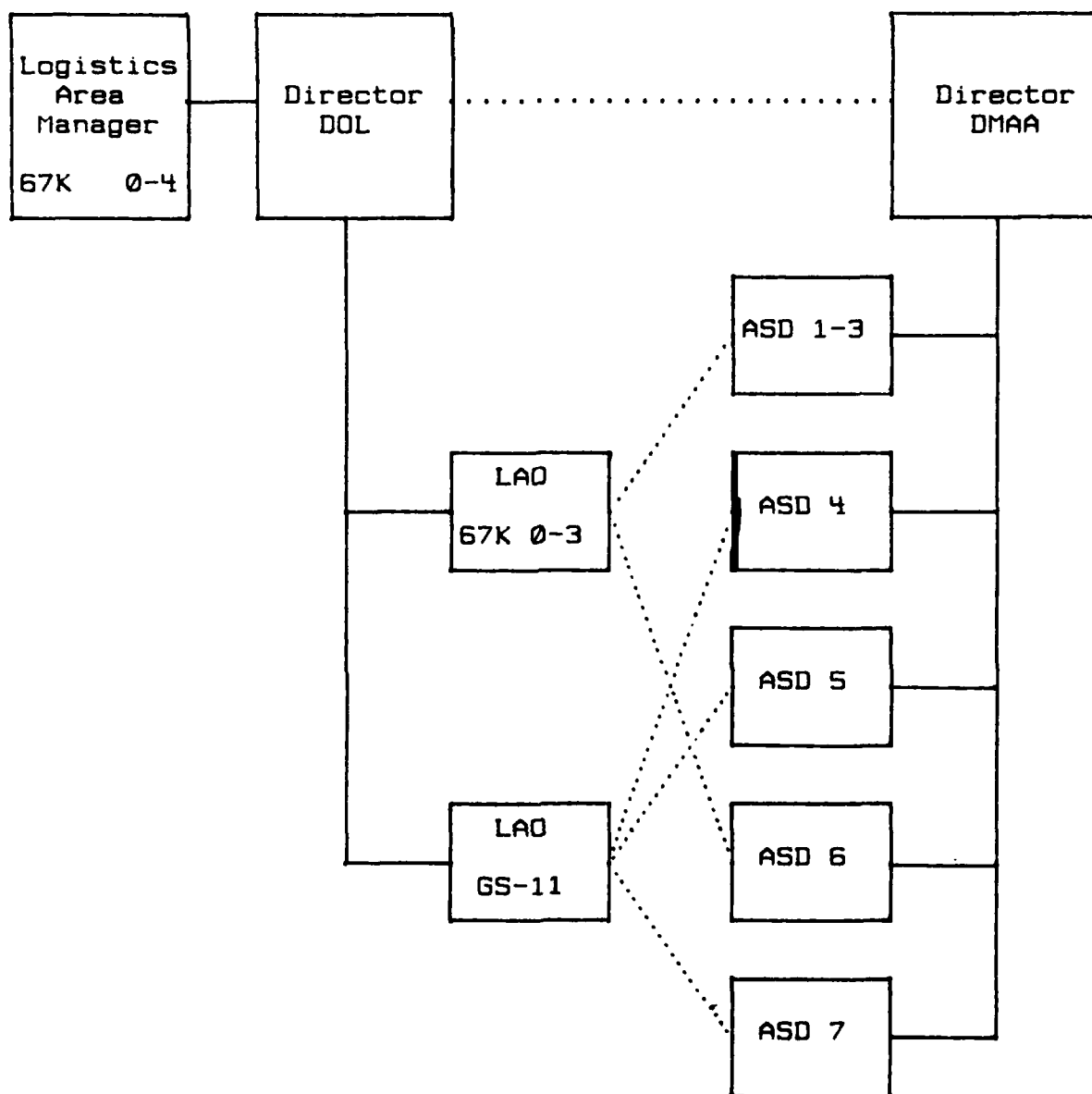
.....medical material management technical liaison and assistance channel

to which they provided liaison services. These LAMs did not fall under the direct supervision of the DMAA, but were supervised by the Director, DIO, through a logistic area manager (MS 67K Major 0-4) for support of the Medical Center (Ferreira 1987, Patterson 1987, Smullen 1987, Yates 1987).

In looking at the current liaison relationship between the DOL and the DMAA, the specific liaison responsibilities envisioned under the original 1970s WRAMC UA concept still remain valid (Smullen 1987, Yates 1987). The single most noticeable difference between the original and current liaison relationship between the DOL and DMAA is that there is no longer an authorized DOL liaison position for each of the five DMAA ASDs (See Figure 16 Current DOL/DMAA Liaison Structure). Additionally, the LAMs are now referred to as "logistic assistance officers (Yates 1987)." It is evident that a reduction has occurred, through many progressive WRAMC TDAs, in the number of authorizations, but not in requirements, for LAOs on the DOL TDA (See TAB E WRAMC TDA HSW2DHAA DOL Excerpts, Smullen 1987, Yates 1987). Currently, there are only two LAOs (one military and one civilian) assigned to the liaison mission between the DOL and DMAA. The third position of logistics area manager (MS 67K 0-4) is being utilized for other duties within the DOL (Smullen 1987). Of the two LAOs, one (military) is assigned as liaison for the ASDs, Floors 1-3 & 6, while the other LAO (civilian) is assigned as liaison for the ASDs, Floors 4, 5, & 7 (Smullen 1987, Yates 1987).

The effect of a 60% reduction (three of five) in total numbers of authorized LAOs from the original 1970s WRAMC UA

Figure 16 Current DOL/DMAA Liaison Structure



LAO = Logistic Assistance Officer

.....medical material management technical liaison and assistance channel

concept has caused a definite degradation in the DOL/DMAA liaison structure and in its ability to perform its full range of medical material management responsibilities. In the original DOL/DMAA liaison structure, each ASD had its own LAO to provide the full range of liaison functions previously mentioned (Yates 1987). Because the ASDs did not have an authorized position on the TDA for an individual with extensive medical material management experience, their reliance on the LAOs for technical assistance in medical material management was critical. The current WRAMC TDA authorizes each of the DMAA ASDs a 76J (medical supply specialist) position in the grade of Staff Sergeant (E-6). However, the exact function of this position has yet to be defined by the DMAA, although its use as a medical material management supervisor by the individual ASDs is anticipated.

Compared to the original DIO/DMAA liaison structure of one LAM per ASD, the current DOL/DMAA liaison relationship provides the DMAA ASDs with a reduced capability. The ability of the two LAOs to assist the 76Js in developing a better understanding of their technical skills and responsibilities is compromised. Since the probability of gaining an increase in the number of authorized LAOs in the future is unlikely, especially considering the Congressional desire to reduce the military budget, other methods of strengthening the DMAA ASD medical material management technical assistance/liaison structure will have to be developed for the future.

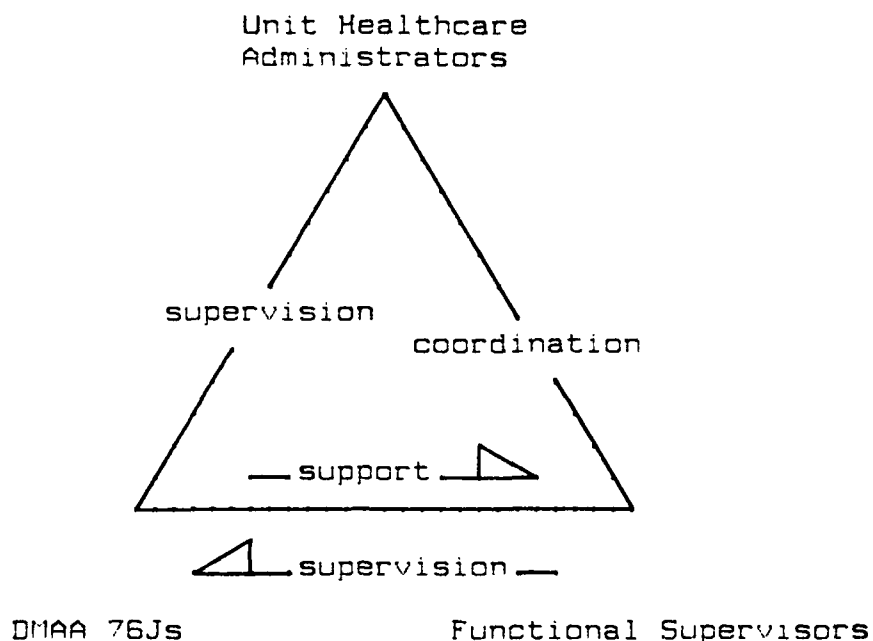
Research Findings

Questionnaire Usage

Data developed for evaluating the current DMAA organizational structure was derived through the use of purposive sampling (Renick 1988). The author developed all questionnaires needed for this research utilizing current literature as a guide for its design and application (Boissoneau 17-20; USAOECS RB 26-14). The questionnaires used were of three (3) types depending on the predominant group to be surveyed. The three groups surveyed were 1) the DMAA unit healthcare administrators; 2) the DMAA 76Js; and 3) the predominate functional supervisor, in the case of this research, the Department of Nursing (DON) wardmasters (See Table 5). A wardmaster for the purpose of this research was defined as the senior Non-Commissioned Officer (NCO) of a nursing ward or an outpatient clinic within the Medical Center.

It is important to understand why three groups were sampled. The three groups named above comprise a "productivity triangle" (Ryder 30 -36). Figure 17 illustrates this productivity triangle. At the apex are the unit healthcare administrators that function as the DMAA 76Js direct supervisors and also as points of contact for the functional supervisors supported by the DMAA 76Js. These functional supervisors are found at one corner of the triangle base. The predominate functional supervisors for the DMAA 76Js have been demonstrated to be the DON wardmasters who supervise and coordinate the daily tasks of the DMAA 76Js that directly support them and their wards and clinics.

Figure 17 Productivity Triangle



Finally, at the other corner of the triangle base are the DMAA 76Js, whose daily performance is a function of the supervision they receive from this productivity triangle.

The questionnaires distributed to the three groups had the same generic characteristics as is outlined below:

1. Each questionnaire had a cover sheet which identified the group being surveyed and outlined instructions for completing the questionnaire.
2. Each questionnaire consisted of a list of 56 76J tasks. the 56 tasks came from the Soldier's Manual and Trainer's Guide MOS 76J Medical Supply Specialist (STP 8-76J15-SM-TG 6 Feb 1985). The 56 tasks were all inclusive of the total realm of skill level one and two tasks for 76Js.

3. Each respondent was asked to identify 15 tasks on the questionnaire. These 15 tasks comprised 26.8% (15/56) of the total skill level one and two tasks.

4. In addition to the 56 tasks listed on the questionnaire, up to four other tasks not associated with the Soldier's Manual and Trainer's Guide could be written in by the individual being surveyed. This brought the total number of potential tasks listed to 60.

5. The 15 tasks to be identified on the questionnaire then comprised 25.0% (15/60) of the total tasks that completed the list of tasks on the questionnaire.

6. The questionnaire had a section that asked the participant to prioritize his/her selected 15 tasks. The tasks were to be prioritized from the most important task to the least important task.

7. The questionnaires were pilot-tested on a small sample from each of the three groups [DMAA unit healthcare administrators (2/21 = 10%); DMAA 76Js (5/47 = 11%); DON wardmasters (4/40 = 10%)]. Minor administrative changes to the questionnaires were made as a result of the pilot-test.

8. All three questionnaires utilized were approved by the Chief of Staff and the appropriate directorate/department chiefs (e.g. Director, DMAA; Chief, DON).

Questionnaires for the DMAA unit healthcare administrators were distributed in February 1988. Distribution was accomplished by hand-delivering the questionnaires to each floor associate healthcare administrators who in turn distributed the

questionnaires to his/her unit healthcare administrators. Upon completion of the questionnaires by the unit healthcare administrators they were turned in to the floor associate healthcare administrators who in turn forwarded the completed questionnaires to the author. A total of 21 questionnaires were distributed via floor associate healthcare administrators and 16 were returned for a response rate of 76% (16/21). A breakdown by floor and the DMAA is indicated in Table 1. The questionnaire distributed to the DMAA unit healthcare administrators is enclosed as TAB F - DMAA Questionnaire for Unit Administrators.

Questionnaires for the DMAA 76Js were distributed in February 1988. Distribution was accomplished by hand-delivering the questionnaires to the DMAA senior NCO who in turn distributed the questionnaire to the five ASD NCOICs. The ASD NCOICs distributed the questionnaires to their assigned 76Js in the grades of Sergeant (E-5) and below. Enlisted grades of Sergeant (E-5) and below are equivalent to skill levels one and two in terms of training. In fact, skill level one equals the grades of Private (E-1) through Specialist (E-4) and skill level two equates directly to Sergeant (E-5) (Soldier's Manual and Trainer's Guide 1-1). Upon completion of the questionnaires by the DMAA 76Js they were returned to the appropriate ASD NCOIC who in turn forwarded the completed questionnaires to the DMAA NCOIC. The DMAA NCOIC returned the completed questionnaires to the author. A total of 47 questionnaires were distributed via the DMAA NCOIC and 41 were returned. Of the 41 returned questionnaires, only 37 were completed in a manner sufficient to be utilized. The response

TABLE 1 DMAA Unit Healthcare Administrator Questionnaire Response

DMAA Unit Healthcare Administrator Questionnaire Response			
Floor/ASD	# Responding	# Not Responding	Total
1-3	5/ 63%	3/37%	8/100%
4	4/ 67%	2/33%	6/100%
5	3/100%	0/ 0%	3/100%
6	2/100%	0/ 0%	2/100%
7	2/100%	0/ 0%	2/100%
DMAA	16/ 76%	5/24%	21/100%

TABLE 2 DMAA 76J Questionnaire Response

DMAA 76J Questionnaire Response			
Floor/ASD	# Responding	# Not Responding	Total
1-3	6/ 86%	1/14%	7/100%
4	10/ 67%	5/33%	15/100%
5	8/100%	0/ 0%	8/100%
6	7/ 78%	2/22%	9/100%
7	6/ 75%	2/25%	8/100%
DMAA	37/ 79%	10/21%	47/100%

rate for the DMAA 76Js was 79% (37/47). A breakdown by floor and the DMAA is indicated in Table 2. The questionnaire distributed to the DMAA 76Js is enclosed as TAB G - DMAA Questionnaire for 76Js.

Questionnaires for the DON wardmasters were distributed in March 1988. Distribution was accomplished by hand-delivering the questionnaires to the DON Sergeant Major (SGM) who in turn distributed the questionnaires to the DON equivalents of the DMAA ASD NCOICs, the nursing floor NCOIC. The nursing floor NCOIC distributed the questionnaires to the wardmasters. Upon completion of the questionnaires by the wardmaster the above sequence of events was reversed. A total of 40 questionnaires were distributed and 34 were returned for a response rate of 85% (34/40). A breakdown by floor and the DON is indicated in Table 3. The questionnaire distributed to the DON wardmasters is enclosed as TAB H - DMAA Questionnaire for Wardmasters and Clinic NCOICs.

Role Ambiguity

The data collected from the completed questionnaires allowed an assessment of the presence of role ambiguity (lack of clarity with respect to duties, responsibilities, and activities) in the daily work environment of the DMAA 76Js due to the present organizational structure of the DMAA (Szilagyi and Wallace 191). This was accomplished by comparing the top 15 tasks identified by the DMAA unit healthcare administrators, the DMAA 76Js, and the DON wardmasters to establish a commonality of

TABLE 3 DON Wardmaster Questionnaire Response

DON Wardmaster Questionnaire Response			
Floor/ASD	# Responding	# Not Responding	Total
1-3	6/ 75%	2/25%	8/100%
4	8/ 67%	4/33%	12/100%
5	8/100%	0/ 0%	8/100%
6	6/100%	0/ 0%	6/100%
7	6/100%	0/ 0%	6/100%
DON	34/ 85%	6/15%	40/100%

tasks between the three groups. The standard used to evaluate the commonality of tasks was set by the author at 12 of 15 tasks (80%) in common between the three groups. If the groups had less than 12 tasks in common among their top 15 tasks, it was felt by the author that there was a lack of clarity with respect to duties, responsibilities and activities for the DMAA 76Js.

In the case of these three groups, the DMAA 76Js represented the actual individual being supervised. The DMAA 76J is traditionally supervised by the DMAA unit healthcare administrator, except in the cases of the sixth and seventh ASDs where the DMAA 76J is supervised by the senior DMAA 76J sergeant. However, in all cases, the direct (line) chain of command is exercised through the DMAA. The DON wardmaster is the most common functional supervisor (outside the direct chain of command) that

provides supervision and direction to the DMAA 76Js (the issue of the scalar chain of command will be discussed in detail later in this research). Suffice it to say that the DMAA 76Js operate in an environment of multiple functional supervisors and a single line supervisor. Because the DON wardmaster is the most common functional supervisor in the DMAA 76Js productivity triangle, they provided a base for comparing the commonality of the DMAA unit healthcare administrators and 76Js job tasks against a supported management structure, in this case the DON through its wardmasters.

Table 4 gives a synopsis of the degree to which all three groups agreed on the same 15 tasks for a given floor unit. As can be seen from the data, no floor unit within the Medical Center met the minimum standard of naming 12 of 15 job tasks in common. This data clearly indicated that not only the supervised personnel (the DMAA 76Js), but both the direct (line) supervisor (the DMAA unit healthcare administrator) and the functional supervisor (the DON wardmaster) had a significant problem in clarifying the job tasks, responsibilities, and activities for the DMAA 76Js on a daily basis. This inability to agree on common tasks necessary to be performed on a daily basis was expected to be manifested in a feeling of lack of support by functional supervisors and frustration by the DMAA 76Js because they cannot meet supervisor (direct and functional) expectations. The direct supervisors' inability to provide adequate support

TABLE 4 Commonality of Top 15 DMAA 76J Job Tasks

Commonality of Top 15 DMAA 76J Job Tasks			
Floor	Groups	# Job Tasks Agree*	% Job Tasks Agree*
1-3	All	8	53%
	UA/76J	10	67%
	UA/DON	10	67%
	DON/76J	11	73%
4	All	8	53%
	UA/76J	10	67%
	UA/DON	10	67%
	DON/76J	10	67%
5	All	9	60%
	UA/76J	11	73%
	UA/DON	10	67%
	DON/76J	10	67%
6	All	8	53%
	UA/76J	11	73%
	UA/DON	11	73%
	DON/76J	10	67%
7	All	4	27%
	UA/76J	7	47%
	UA/DON	8	53%
	DON/76J	8	53%

*Standard = 12 Job Tasks Should Agree/80% Job Tasks Should Agree

to either the DMAA 76J or the supported functional supervisors, in this case the DON wardmasters, also became apparent (Szilagyi and Wallace 499 - 502).

The current WRAMC management philosophy of separate management structures for the DMAA, the DON, and professional (clinical) services creates an environment where the premium is on communication between separate, but complementary management hierarchies. The results indicated in Table 4 illustrate the need for substantially better communications between supervisory personnel of these structures, especially the DMAA and DON. If the supporting management structure (the DMAA) cannot communicate with the supported structure (the DON), then a consensus about common job tasks to be accomplished on a daily basis by the DMAA 76Js can not be reached. This is currently the case as is documented in Table 4. Clearly, the presence of role ambiguity for the DMAA 76Js is a current factor in their present work environment that must be addressed in the present DMAA organizational structure if improvements in its ability to supervise and support the assigned 76Js are to occur.

Scalar Chain of Command / Supervisor Ambiguity and Conflict

A clear chain of command, often called the scalar principle because authority flows distinctly from superior to subordinate, shows "who reports to whom, who is responsible for the actions of an individual, [and] who has authority over the worker (Liebler, Levine, and Dervitz 73)." Superior and subordinate working relationships within the DMAA (e.g. unit healthcare administrators

and 76Js) tend to be less structured in terms of a clear daily hierarchical superior to subordinate reporting environment than other WRAMC hierarchical management structures (e.g. DOL). In the case of the DMAA 76Js daily work environment, the issue of organizational unity of command (the uninterrupted line of authority from superior to subordinate) presented another area of concern.

The unique aspect of the management structure of WRAMC provides for the complementary use of three distinct and separate management structures for professional (clinical) services, nursing, and administration, which places the DMAA 76Js in a matrix-like organizational structure during their daily work environment. While the DMAA 76Js have their traditional "line", or hierarchical, organizational structure (See TAB C - WRAMC UA Functional Scheme), they work under the "functional" daily supervision of the DMAA, DON, and professional services management structures. Table 5 shows the most common functional supervisors in the DMAA 76Js daily work environment as identified by the 76Js in their questionnaire responses.

Table 5 shows that the DMAA 76Js clearly see themselves as responsible to multiple management (functional) structures in addition to their own management (line) structure. Multiple supervision structures are "a predominant characteristic of the matrix organization and stand in distinct contrast to the unity of command in the traditional organizational structure" (Liebler, Levine, and Dervitz 83). This clash of traditional "line" versus "functional" supervision is a great source of frustration

TABLE 5 Most Common Daily Functional DMAA 76J Supervisors

Most Common Daily Functional DMAA 76J Supervisors			
Supervisory Position	% of Total DMAA 76Js Identifying	# of DMAA 76Js Selecting/ Responding	Rank
Wardmaster/ Clinic NCOIC (DON)	84%	31/37	1
ASD NCOIC (DMAA)	65%	24/37	2
Nurse/ Clinic Coordinator (DON)	51%	19/37	3
Physician (Clinical)	24%	9/37	4

and conflict for those supervisors, both military and civilian, who were trained to supervise and manage in other traditional military hierarchical organization structures with follow clear chain of command and unity of command principles. Nowhere is this more apparent than in the DON management structure, where wardmasters have traditionally had at other AMEDD MTFs the direct (line) supervision of all ward personnel, to include the 76Js. "Functional" supervision with its inherent responsibility to train and manage someone else's personnel without "traditional" hierarchical supervisory authority is a high hurdle that must be overcome at WRAMC. To accomplish this, the education of functional supervisory personnel (within and outside of the DMAA)

occurs on the intricacies of matrix organizations and the proper utilization of the current daily supervision structure for the DMAA 76Js. The critical roles that "line" and "functional" supervisors perform in the daily work environment of the DMAA 76Js must be understood by the other management structures within the Medical Center. It is the responsibility of the DMAA to educate the other management structures about these roles. This responsibility is a function of the DMAA that can not be abrogated.

The presence of supervisory ambiguity (the inability to identify one's correct first-line supervisor) and conflict (two or more supervisors giving tasks, making demands, and giving directions and guidance) in the DMAA organizational structure is a problem for the DMAA 76Js that warrants management attention. Supervisor ambiguity and conflict should be expected due to the unique nature of the multiple supervision structures in the daily work environment of the DMAA 76Js and because of the inherent clash between the "traditional" military hierarchical and matrix supervision structures. Table 6 shows a breakdown by floor and the DMAA of the DMAA 76Js ability to correctly identify their first-line supervisors. The actual first-line (direct) supervisors were obtained from documentation supplied by the DMAA associate floor healthcare administrators for the appropriate ASD. The standard for evaluating the presence of supervisory ambiguity was set at 95% (95/100) by the author [NOTE: The author was unable to find a suitable standard in the literature]. It was felt that an

TABLE 6 DMAA Supervisor Ambiguity

DMAA Supervisor Ambiguity		
Floor/ASD	# / % of DMAA 76Js Indicating Correct First-Line Supervisor	# / % of DMAA 76Js Indicating Incorrect First-Line Supervisor
1-3	4 / 67%	2 / 33%
4	9 / 90%	1 / 10%
5	7 / 88%	1 / 12%
6	6 / 86%	1 / 14%
7	6 / 100%	0 / 0%
DMAA	32 / 86%	5 / 14%

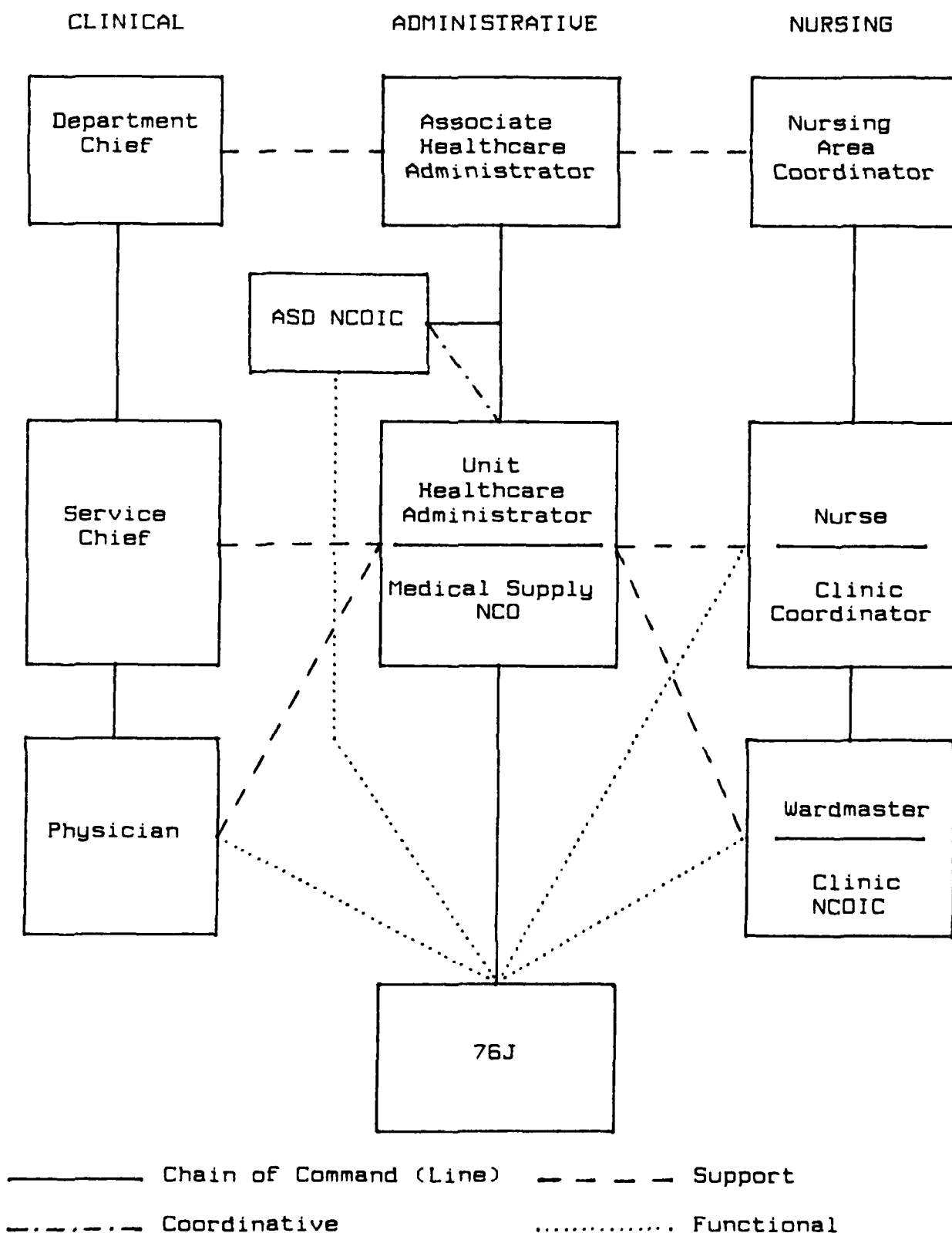
organization was correctly managing supervisory ambiguity in a matrix supervisory structure when 95% of personnel could correctly identify their documented supervisors.

It is evident from Table 6 that supervisory ambiguity is present within the DMAA. All ASDs, except ASD 6, showed some confusion by assigned 76Js as to exactly who is their first-line supervisor. In all cases in which a DMAA 76J named an incorrect first-line supervisor, they named a functional supervisor as their first-line (direct) supervisor. Again this addresses the need for the DMAA to educate not only line and functional supervisors about matrix organizations, but more importantly, the individuals that work within this structure.

Figure 18 (DMAA Matrix Supervision Scheme) provides the best illustration of the complex and multiple supervision structures that the DMAA 76Js currently function under on a daily basis. One can easily visualize how supervisor conflict between line and functional supervisor supervisors can and does occur because of this situation. It can be seen that the DMAA 76J is, to some degree, supervised on a daily basis by not only the line (direct) supervisor, but also by functional supervisors from all three predominant management structures within the Medical Center. This type of matrix supervision scheme is unique to WRAMC.

Until the Medical Center recognizes the uniqueness of its own matrix management structure and learns how to maximize it, WRAMC will fail to recognize the need to educate those personnel trained and developed along management and supervisory tracts in other AMEDD organizations and MTFs. This training and education should serve to modulate, but not entirely eliminate, the degree of conflict between line and functional supervisors of the DMAA 76Js and improve the 76J daily work environment. To the casual observer, the uniqueness of the DMAA 76J matrix supervision structure, with its inherent potential supervisor conflict and ambiguity, could make it appear to be a major liability to WRAMC. However, when properly understood, applied, and managed, the three separate management structures within the Medical Center, through the use of the DMAA 76J matrix supervision structure and philosophy, could free nurses, physicians, and other direct patient care professionals from some of the rigidity of the

Figure 18 DMAA 76J Supervision Matrix Scheme



"traditional" hierarchical organizations (Liebler, Levine, and Dervitz 84). The maximum contributions of this unique matrix supervision structure for the DMAA 76Js will only be realized when the DMAA assumes the role of lead facilitator and educator for the rest of WRAMC and seeks the committed and willing cooperation of the other two Medical Center management structures in ensuring that the WRAMC UA concept works.

DMAA Unit Healthcare Administrators

The test of how well the DMAA 76J matrix supervisory scheme functions as a major component of the WRAMC UA concept depends on a complete understanding of the involvement of key players from the various supervision structures. Liebler, Levine, and Dervitz identified three principle roles necessary for the matrix supervision structure to function as a viable management concept (83). This matrix of organizational relationships involves, as a minimum, the following three essential interactive supervisor patterns: 1) technical (functional); 2) managerial (line); and 3) coordinator/final authority (line) (Liebler, Levine, and Dervitz 83). Szilagyi and Wallace assigned managerial behaviors to the three supervisor patterns identified by Liebler, Levine, and Dervitz (501). Szilagyi and Wallace however would call the three patterns identified by Liebler, Levine, and Dervitz by a different description, although the meaning is synonymous. Table 7 provides a synoptic description of matrix supervisor patterns and their associated behavior patterns according to the above references.

TABLE 7 Supervisor Behavior in a Matrix Structure

Supervisor Behavior in a Matrix Structure		
Supervisor Description	Supervisor Description	Key Behaviors
Liebler, Levine, and Dervitz	Szilagyi and Wallace	
Technical	Functional	Learn to share power Work with loss of status Concern with complex human resource management - Employee needs - Training requirements - Job assignments - Manpower planning - Balance workloads - Handling of staff
Managerial	Project	Learn to share power Develop basic lines of coordination and communication Learn to manage differences Rely on personal qualities and persuasion Be innovative in approaches to problems Develop a balanced, generalist orientation
Coordinator/ Final Authority	Two-Boss Manager	Learn to control anxiety and stress Develop a total organization perspective Learn to resolve conflict quickly Learn how to control differences Develop general manager orientation

The key position in this matrix supervision structure is the individual functioning as the managerial or project ("line" / first-line) supervisor (Liebler, Levine, and Dervitz 83). In the case of the DMAA 76J supervision matrix scheme, this individual is the unit healthcare administrator, a role envisioned for them from the original WRAMC UA concept. It is important to take a critical look at the current generic characteristics and qualifications of the unit healthcare administrators in the DMAA 76J supervisory matrix structure. Data generated about the unit healthcare administrators will assist WRAMC top management in making informed decisions about the ability to improve the qualifications of these individuals and subsequently, the DMAA supervisory matrix structure.

The DMAA unit healthcare administrators were interviewed by the author using a prepared list of questions (See TAB I), in September 1987, to acquire information in the following three areas: 1) occupational category (military or civilian); 2) civilian education (highest level obtained/preparation in healthcare administration); and 3) actual experience as a unit healthcare administrator at WRAMC. Of 21 DMAA unit healthcare administrators currently performing in some capacity as either a first-line (direct) or a line (managerial) supervisor of the DMAA 76Js, 20 were interviewed. This was a interview rate of 95% (20/21). Where possible, data obtained was compared with similar data documented in research done in February 1982 by Dr. Richard F. Southby, Ph.D., Chairman and Professor of Health Services

Administration and of Health Care Sciences and Ms. Linda Rivera, Graduate Student in Health Services Administration; both from The George Washington University.

The first area explored for the DMAA unit healthcare administrators involved their occupational category. Occupational category was defined as whether the unit healthcare administrator was currently military or civilian. The WRAMC TDA currently authorizes two types of unit healthcare administrator: 1) military O-3 (Captain) 67A (healthcare administrators); or 2) civilian GS-11 Health Systems Specialist (See TAB D - WRAMC TDA HSW2DHAA DMAA Excerpts). In September 1987, WRAMC was authorized 22 unit healthcare administrators, of which 6 were military and 16 were civilian authorizations. Table 8 provides a breakdown of the occupational categories for the DMAA unit healthcare administrators. Table 8 also illustrates that approximately three-quarters of the DMAA unit healthcare administrator authorizations (73% - 16/22) and currently filled positions (76% - 16/21) are civilian. One should expect a reasonably stable DMAA unit healthcare administrator staff based on a predominately civilian work force.

Another characteristic of the DMAA unit healthcare administrators addressed was the experience level of these individuals in terms of actual experience as a unit healthcare administrator within the Medical Center. [Note: Previous experience in other healthcare institutions, both military and civilian was discounted due to the unique nature of the WRAMC UA concept]. Hands-on experience within the Medical Center as

TABLE 8 Occupational Category of DMAA Unit Healthcare Administrators

Occupational Category of DMAA Unit Healthcare Administrators			
	Authorized Positions	Filled Positions	Percentage of Authorizations
Military	6	5	27% (6/22)
Civilian	16	16	73% (16/22)
DMAA	22	21	100% (22/22)

unit healthcare administrator was viewed as a vicarious measure of both technical expertise in medical material management and as the ability to function successfully in a matrix supervision structure. An increasing experience level was associated with an increased expertise in medical material management and the DMAA 76J supervisory scheme. Table 9 shows that the actual experience level of the DMAA unit healthcare administrators increased by eight months from 1982 to 1987 (2 years, 6 months to 3 years, 2 months) and that the number of the DMAA unit healthcare administrators with over one year experience increased by 10% (14 of 20 in 1987 versus 12 of 20 in 1982). Table 10 shows the breakdown by ASD (floor) for the DMAA unit healthcare administrators. With the exceptions of ASDs 4 and 6, all other ASDs indicated a relatively experienced unit healthcare administrator work force. However, it is important to point out

that ASD 4, considered the most demanding ASD in terms of healthcare administration, has the lowest overall experience level. In general, it can be stated that the DMAA unit care administrators, as a whole, demonstrated a high degree of experience functioning in both medical material management and the DMAA 76J matrix supervisory scheme as it relates to WRAMC.

The lower work experience level of ASD 4 is an interesting phenomenon of the current manpower staffing model for the DMAA unit healthcare administrators. All currently authorized civilian unit healthcare positions on the WRAMC TDA are classified as GS-11s, predominately due to the implied civilian education requirements of these positions [e.g. masters degree level (healthcare administration)] (Ferreira 1987, TAB D - WRAMC TDA HSW2DHAA DMAA Excerpts). Because all currently authorized civilian unit healthcare administrator positions in the DMAA are GS-11s, there is no current mechanism for demanding career professional development or educational growth. Without career progression, the DMAA civilian unit healthcare administrators are not motivated to seek the most demanding job vacancies or positions, such as on ASD 4. This is an area that the DMAA, as well as top management at WRAMC, should pursue as a way to fine-tune one aspect of the WRAMC UA concept. The creation of a career pattern demanding professional growth, documented education in healthcare administration, and a systematic mechanism for progression from less to more demanding unit healthcare administrator positions is warranted in today's volatile military healthcare sector. A wider range

TABLE 9 DMAA Unit Healthcare Administration Experience Level

DMAA Unit Healthcare Administration Experience Level	
1982	2 years, 6 months average experience
1987	3 years, 2 months average experience
1982	12 of 20 (60%) One year of experience or more
1987	14 of 20 (70%) One Year of experience or more

TABLE 10 DMAA Unit Healthcare Administration Experience Level
(by Floor / ASD)

DMAA Unit Healthcare Administration Experience Level (by Floor / ASD)				
Floor/ASD	# of Years, Months	# / % Responding	No Response	Total
1-3	3,3	7 / 88%	1	8
4	1,1	6 / 100%	0	6
5	3,5	3 / 100%	0	3
6	1,6	2 / 100%	0	2
7	10,6	2 / 100%	0	2
DMAA	3,2	20 / 95%	1	21

of GS ratings (e.g. 9 through 12), with concomitantly expanded salary bands and required civilian education in healthcare administration (e.g. baccalaureate and masters degrees) tied to specific GS ratings (e.g. GS 9 and 10 to baccalaureate degrees; GS 11 and 12 to masters degrees) would serve to reinforce a return to the original WRAMC UA philosophy of a competent and trained professional healthcare administration staff by top management at WRAMC.

In line with the previous comments about educational (civilian) requirements for the DMAA unit healthcare administrators, a detailed look at current qualifications is warranted. Table 11 gives a comprehensive breakdown on the education status of the DMAA unit healthcare administrators in terms of the highest education level completed. For 1987 a breakdown is provided for both military and civilian unit healthcare administrators. A comparison of education levels from 1982 is provided as a source of reference (Southby and Rivera 17). Of 21 DMAA unit healthcare administrators, 20 were interviewed in 1987 for a rate of 95% (20/21). In 1982, the rate was 91% (20/22) (Southby and Rivera 17).

An interview was conducted with Mr. Ferreira, who was the first individual hired as a unit healthcare administrator at WRAMC (August 1978). He assisted in the research and development of the original WRAMC UA concept and pointed out quite clearly that the DMAA unit healthcare administrators were rated GS-11s because of the original WRAMC management intention that they have a masters-level education [with a strong preference to hospital

TABLE 11.

Education Level of the DMAA Unit Healthcare Administrators (Highest Level Completed)					
	Completed HS	Completed AA/AS	Completed BA/BS	Completed MA/MS/MHA MPH/MBA	Total
1987					
Military			2	3	5
Civilian	3	1	4	7	15
Total	3	1	6	10	20
1982					
Total	2		5	13	20

Abbreviations: HS = High School; AA = Associate of Arts; AS = Associate of Science; BA = Baccalaureate of Arts; BS = Baccalaureate of Science; MA = Masters of Arts; MS = Masters of Science; MHA = Masters of Hospital [Healthcare] Administration; MPH = Masters of Public Health; MBA = Masters of Business Administration

(healthcare) administration degrees, or at least a concentration in hospital (healthcare) administration] as a prerequisite for employment (1987). Table 11 shows that between 1982 and 1987 the percentage of masters level trained unit healthcare administrators dropped by 15% [13/20 (1982) to 10/20 (1987)].

Clearly, there has been movement away from the original WRAMC UA philosophy of a trained, professional healthcare administration staff at the unit healthcare administration level. The shift toward a less prepared unit healthcare administration staff is the product of many variables of which supply and demand could play the most significant role within the Washington, D.C. area.

More revealing than the raw breakdown of educational qualifications in terms of overall highest degree completed were the numbers of unit healthcare administrators with a degree, or concentration, in healthcare administration. Table 12 provides a breakdown of the total number of unit healthcare administrators with a degree or a degree with a concentration in healthcare administration. No data from 1982 were available as a reference point. Only 45% (9/20) of all DMAA unit healthcare administrators have a degree or a degree with a concentration in healthcare administration. More important is the fact that only 40% (6/15) of the DMAA civilian unit healthcare administrators have a degree or a degree with a concentration in healthcare administration.

The documented fact that both the DMAA and Medical Center rely so heavily on an unit healthcare administrator structure that is largely civilian, with their expected longevity, makes this issue of education in healthcare administration a critical component in assessing the DMAA 76J supervisory matrix scheme. The original WRAMC UA philosophy called for a trained, professional healthcare administration staff. This is not the present situation.

TABLE 12 Education in Healthcare Administration

Education in Healthcare Administration			
	Completed Baccalaureate in Healthcare Administration	Completed Masters in Healthcare Administration*	Total
Military		3	3
Civilian	1	5	6
Total	1	8	9

* or degree with a concentration in healthcare administration

Unit healthcare administrators, which are the linchpin in the current DMAA 76J supervisory matrix scheme, may lack the necessary civilian education qualifications to function in a maximal manner within a large and complicated environment. The presently assigned unit healthcare administrators are functioning adequately with their current education credentials. However, if they were all masters level prepared, WRAMC top management could expect them to function at a more optimal level. Further research outside of this study is indicated to determine the appropriate civilian education level for the DMAA unit healthcare administrators.

Summary of Findings

Many different research findings have been presented and addressed in the preceding pages. To provide a succinct review of the many findings concerning the supervisory structure of the DMAA 76Js, the major findings are outlined and briefly discussed below:

1. The DMAA is one of three separate and complete management structures within the Medical Center. This concept of a separate healthcare administration structure was researched and developed in the 1970s and is unique to WRAMC.

2. The healthcare administrative structure developed for the Medical Center had two fundamental philosophies and goals as its cornerstone. The first was to provide a healthcare administrative structural chain parallel to the medical and nursing structural chains and accountable to the Medical Center Command Group. The second was to provide a healthcare administrative structure to manage shortages and ensure quality healthcare administrative support through a competent, trained, and professional healthcare administrative staff.

3. The original DOL/DMAA liaison structure for medical material management technical support and assistance has slowly eroded through progressive WRAMC TDAs. The number of authorized LAOs has been reduced by 60% (from five to three). Therefore, the current DOL/DMAA liaison structure has a reduced capability to assist the DMAA ASDs and their assigned 76Js.

Furthermore, needed daily medical material activities and the ability to educate the DMAA 76Js on their technical skills and responsibilities has been reduced.

4. Role ambiguity (lack of clarity with respect to duties, responsibilities, and activities) is a major problem in the daily work environment of the DMAA 76Js. A lack of consensus between and among the first-line and key functional supervisors, to include the DMAA 76Js as well, has resulted in an environment where the DMAA 76Js feel frustrated by a lack of support from supervisors (direct and functional) and supervisors feel a lack of support from the DMAA 76Js.

5. There is a definite clash between the classical military, or scalar chain of command principle (i.e. each subordinate has only one supervisor) and the DMAA 76J supervisory matrix design (Szilagyi and Wallace 499).

6. Civilian and military supervisors, both first-line and functional, are not trained to deal with the following: 1) how to balance or share power over the DMAA 76J manpower resources; 2) the need to make joint decisions; or 3) that since conflict is inevitable, how to make open and frequent use of confrontation as a resolution mechanism (Szilagyi and Wallace 497 - 502).

7. As a natural consequence of the clash between the classical scalar chain of command and the matrix design the DMAA 76Js show a clear indication of supervisor ambiguity (the

inability to distinguish between direct and functional supervisors when two or more supervisors are giving directions, making demands, and giving tasks).

8. The current matrix supervisory scheme utilized by the DMAA places the unit healthcare administrator in two of the three roles necessary for a matrix design to function (Liebler, Levine, and Dervitz 83; Szilagyi and Wallace 501). At present, the unit healthcare administrator functions to varying degrees as both a functional (technical) supervisor and a two-boss manager (coordinator/final authority) for the DMAA 76Js.

9. Southby and Rivera pointed out in their 1982 study of the WRAMC unit administration system the clear need for "NCOIC support" of the DMAA unit healthcare administrators (27). What they were referring to was the development of a functional supervisor position in the DMAA 76J supervision matrix scheme that would allow the DMAA unit healthcare administrators to assume the role of a two-boss manager, the more appropriate role for them in a matrix design. The DMAA role for the newly authorized senior 76J Sergeant positions on each ASD has yet to be defined as that of a functional supervisor for 76Js within the DMAA supervision matrix scheme, although it appears headed in that direction. Therefore, the current DMAA supervision matrix scheme lacks a clear delineation of the supervisor roles and responsibilities expected from the unit healthcare administrators and senior 76J Sergeants.

10. The civilian education levels (i.e. masters level prepared) of the DMAA unit healthcare administrators are not in line with the original WRAMC UA goal of a trained and professional healthcare administration staff. Statistically, 45% (9/20) of all the DMAA unit healthcare administrators have a degree or a degree with a concentration in healthcare administration and only 40% (6/15) of the DMAA civilian unit healthcare administrators are educated in this manner.

11. The question of educational credentials also plays a role in whether to realign the DMAA 76J supervisory matrix scheme by concentrating the focus of unit healthcare administrators in the two-boss manager role. The demands expected to be placed on the DMAA unit healthcare administrators will justify greater reliance on higher-level education in healthcare administration by WRAMC if they assume this new management role in the DMAA 76J supervisory matrix scheme.

12. Civilian authorizations carry with them the strength of stability and longevity for the DMAA and Medical Center. The issue of sufficient education and preparation within the field of healthcare administration is also a critical issue when realizing that 73% (16/22) of the DMAA unit healthcare administrators are civilian (GS-11) authorized positions. Given the numbers of healthcare administration programs in the Washington, D.C. area, WRAMC has the ability to utilize these sources for employment and development of a trained, professional healthcare administration staff.

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III. ORGANIZATION STRUCTURE PROPOSALS

Medical Material Management Organizational Structures

Medical material management organizational structures are as unique as the individual healthcare organizations they support (Pitts 71, 74; Perrin 62; Sanderson 7 - 12, Scheyer 379 - 384; Housley 163 - 168). Even though individual healthcare institutions have designed and implemented unique medical material organizational structures that are geared to meet the needs and demands of their particular healthcare setting, a common thread is readily apparent among these separate healthcare institutions. This common ground is an accelerating trend toward the development of centralized internal and external medical material management organizational structures within healthcare institutions (Scheyer 382).

The Walter Reed Army Medical Center (WRAMC) utilizes the Directorate of Logistics (DOL) to provide external material management, to include medical items, for all institutions and activities on the WRAMC installation (Smullen 1987; WRAMC Reg 10-1 Chapter 6). Within the Medical Center there is presently no single centralized or internal organizational structure to direct and coordinate medical material management functions (Smullen 1987, Dawson 1988). The functions of linen management, medical material distribution, and medical logistics assistance are controlled by the external DOL organizational structure for internal Medical Center requirements. The Directorate of Medical Activities

Administration (DMAA) is responsible for controlling and directing the functions of internal medical material management on the wards, clinics, and floors of the Medical Center (Stingle 1987). Clearly, there is a dichotomy in the internal management of medical material for the Medical Center. Currently, the DOL is planning to implement in the Fall of 1988 a centralized medical material management structure for its internal elements (Dawson 1988). However, there are no present to incorporate the DMAA medical material management responsibilities into the DOL centralized structure to create a consolidated medical material management department solely responsive to internal Medical Center requirements.

A comparison of individual healthcare institutions offers one way to study medical material management (Henning 86). A number of healthcare institutions, with missions similar to WRAMC, were studied to offer a comparison of medical material organizational designs. The healthcare institutions selected were all tertiary medical facilities with a medical teaching mission located in the Washington, D.C. area. The healthcare institutions selected for comparison were 1) Bethesda Naval Medical Center (BNMC); 2) The George Washington University Medical Center (GWUMC); 3) Fairfax Hospital; and 4) the Veterans Administration Medical Center, Washington, D.C. The comparison between WRAMC and the other facilities was based on the use of either a centralized, de-centralized, or no controlling medical management department activity within the healthcare institution. Additionally, the use of a centralized material

management department, to include medical items, to perform logistics functions external to the healthcare institution was noted for comparison. The results of this comparison are displayed in Table 13.

TABLE 13 Comparison of WRAMC and Other Healthcare Institutions

Comparison of WRAMC and Other Healthcare Institutions		
Institution	Type of Medical Material Management Structure within the Healthcare Facility	Type of External Medical Material Structure
Bethesda Naval Medical Center	CENTRALIZED	CENTRALIZED
George Washington University Medical Center	CENTRALIZED	CENTRALIZED
Fairfax Hospital	CENTRALIZED	CENTRALIZED
Veterans Administration Medical Center Washington, DC	CENTRALIZED	CENTRALIZED
WRAMC	NONE	CENTRALIZED

The comparison between WRAMC and the other healthcare institutions indicated quite clearly that WRAMC is unique in being the only tertiary healthcare facility within the surveyed group

that does not currently have a centralized and internal medical material management department located within its Medical Center. Based on this comparison and the accelerating trend toward centralized medical material management departments within healthcare institutions, a centralized and internal medical material management department for the Medical Center will be discussed as one proposal for consideration.

Proposed Medical Material Management Organizational Structure
for the Medical Center

The Medical Center currently has various elements of DOL in support of its patient care mission. These elements include the Material Distribution Branch (MDB), the Linen Management Branch (LMB), and the Logistics Assistance Officers (LAOs). The Linen Management Branch falls under the control of the DOL Services Division (Morton 1988), while the Material Distribution Branch is controlled by the DOL Material Division (Dawson 1987), and the LAOs are under the control of the Chief, DOL (Yates 1987). Figure 13, DOL Organization, illustrates the DOL structure. It is important to note that these three DOL elements are each controlled by a separate organization within the DOL.

Besides the medical material management activities performed by these three elements of the DOL, one other important medical material management function not controlled by the DOL is performed within the Medical Center. The function of controlling the medical supply specialists (MOS 76J) that support the wards, clinics, and floors of the Medical Center is assigned to

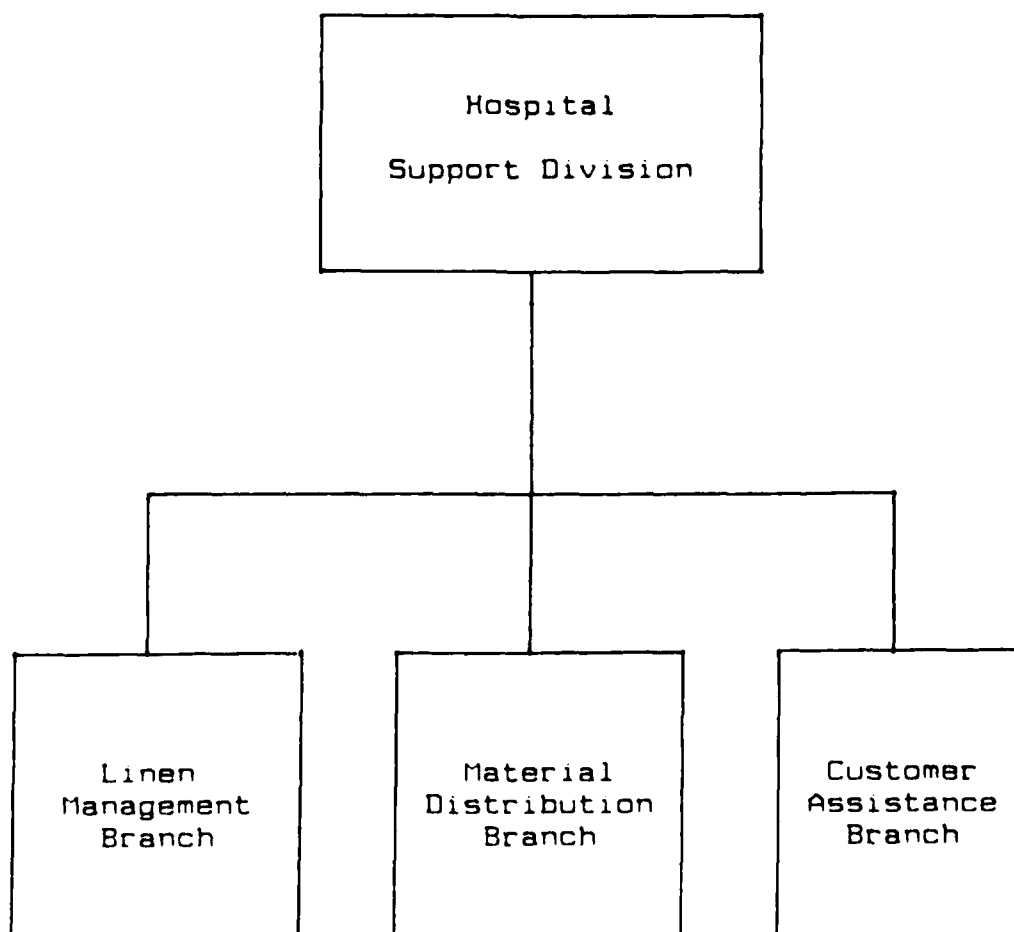
the DMAA. These medical supply specialists requisition, issue, maintain, and stock medical material items received from both the Material Distribution and Linen Management Branches as well as coordinating and receiving guidance from the DOL LAOs for the wards, clinics, and floors they support.

It is evident that a dichotomy of control for medical material management functions exists within the Medical Center. The DOL is concerned with not only the acquisition and storage of medical material for the Medical Center, but also the distribution of these medical items up to the point of issue to the wards, clinics, and floors. The DMAA steps in at this point and controls receipt, issue, storage, and maintenance of medical material items for the wards, clinics, and floors within the Medical Center through its 76J personnel. It is these separate DOL and DMAA organizational structures that control internal medical material management and the medical supply specialists (MOS 76J) within the Medical Center. That these organizational structures could be consolidated and centralized under a single medical material management structure internal to the Medical Center is one proposal for developing a more effective organizational structure for providing supervision to the 76Js assigned to the DMAA.

Figure 19 illustrates a proposed organizational structure for centralized control and management of medical material and associated DMAA 76J personnel. The chief of this new division would be a Medical Service Corps officer at the grade of Lieutenant Colonel (O-5) from the medical logistics field (AOC 67K). For purposes of discussion, this division would be called the Hospital

Support Division (HSD). Under this division would be located three branches; the Linen Management Branch (LMB), Material Distribution Branch (MDB), and the Customer Assistance Branch (CAB). The organizational structure and functions now performed by the LMB and MDB under the DOL would not change. The Customer Assistance Branch would be a new organizational structure composed of the DOL LAOs and the DMAA medical supply NCOs and specialists (MOS 76Js).

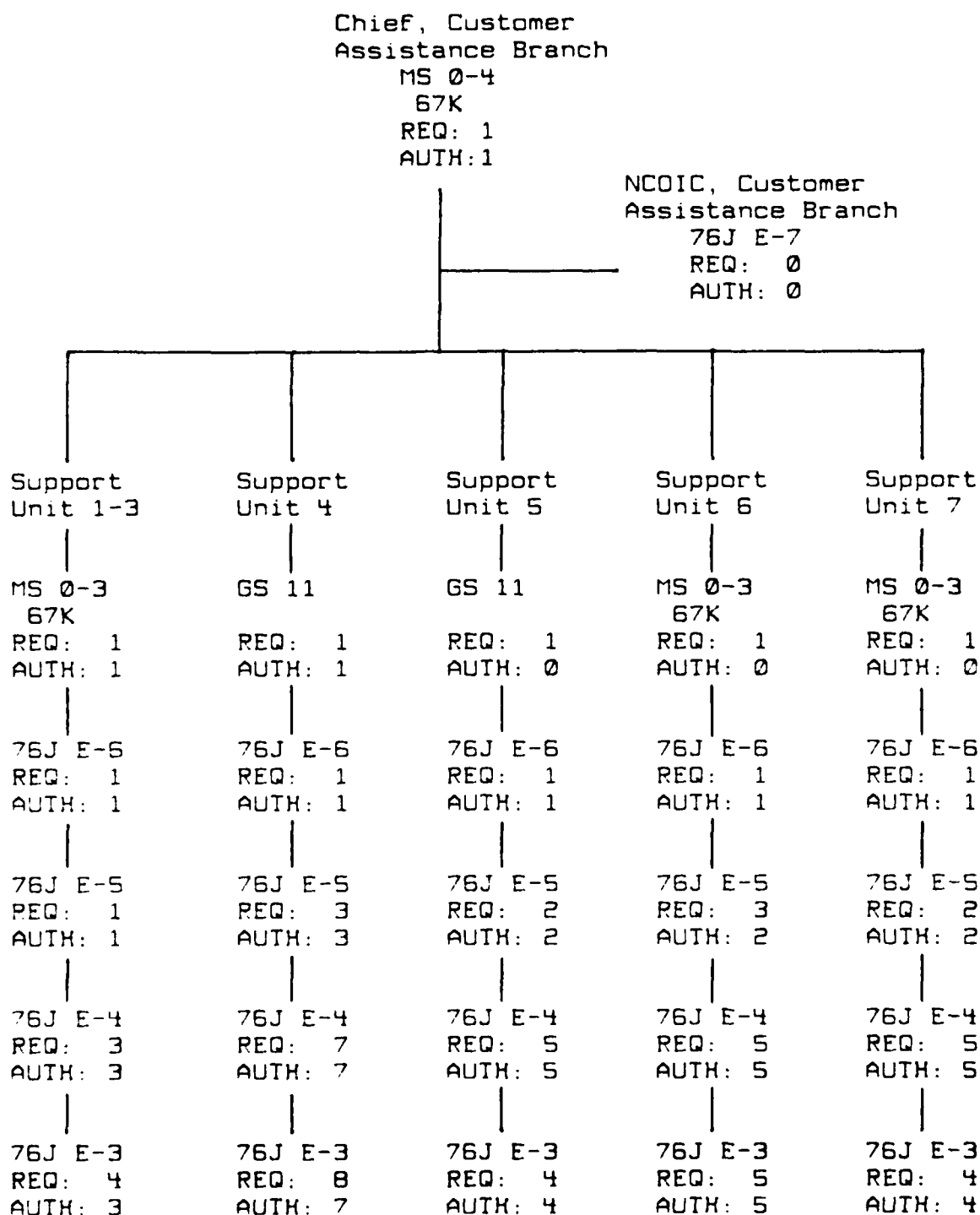
FIGURE 19 Proposed Medical Center Logistics Services Division



The new Customer Assistance Branch is illustrated in Figure 20. This branch would be organized to provide medical material personnel (MOS 76J) support to the Medical Center by floor. A total of five units would comprise this branch. The branch chief could be the current Logistics Area Manager from the DOL TDA. His responsibilities would include the control of the five units supporting the Medical Center. These support units would be organized from the DMAA TDA requirements and authorizations for medical supply NCOs and specialists as well as the DOL TDA requirements and authorizations for LAOs. A support unit would be structured to support each floor of the Medical center, except for floors one through three which would be supported by one support unit. Each support unit would be headed by what is now a DOL LAO. The requirements for five LAOs would have to be fully authorized as currently only two of five LAO positions are authorized on the WRAMC TDA. The 76J NCO and enlisted medical supply positions would remain the same as is currently documented under the DMAA TDA.

In summary, only three new requirements and six new authorizations would be needed to develop the new Hospital Support Division for the Medical Center. The three new requirements would be the 1) Chief, Hospital Support Division (MS 0-5 67K); NCOIC, Hospital Support Division (E-7 76J); and NCOIC, Customer Assistance Branch (E-6 76J). The six new authorizations would include the three new requirements and the three current LAO positions on the DOL TDA that are required positions but which are not authorized for staffing.

FIGURE 20 Customer Assistance Branch*



* Required (REQ) and authorized (AUTH) positions are from WRAMC TDA, HSW2DHAA, dated 2 October 1987.

The only remaining question in the development of this structure concerns which major directorate level organization it should report to for control and guidance. One line of thought would suggest that this new division should report to the DOL to continue to centralize medical material management functions (Housley 245; Scheyer 245; Sanderson 9). Another line of thought would be that the broad guidance for medical material management must come from the healthcare administrative channel since it controls the direction that all healthcare management will follow (Murry 1987, Stingle 1987, Weiner 1987, Weinschenk 1987). Thus, this line of logic would place the new division under the DMAA since it controls and directs internal healthcare administrative management for the Medical Center. The final answer to this question will have to be addressed and answered by the top-level management at WRAMC.

The DMAA Organizational Structure for Assigned 76Js

Howard and Beatrice Rowland state in the Hospital Administration Handbook that "[O]rganizing is the process of grouping the necessary responsibilities and activities into workable units, determining the lines of authority and communication, and developing patterns of coordination (101)." One goal of any organization must be to allocate limited resources in a manner that represents the most efficient and effective methodology (Liebler, Levine, and Wallace 72; Szilagyi and Wallace 248). As discussed earlier in this research, the Unit Administration (UA) concept developed for WRAMC in the 1970s was intended to manage limited resources, especially ancillary healthcare support

personnel, through units designed with the authority to control coordinate, and communicate effectively with the other organizational structures they support. Therefore, it is a natural course that leads to a discussion which centers on modifications to the current DMAA 76J supervision structure as a second proposal.

Reorganizing a structure may become necessary when management has reason to believe that the existing structure is too far from an "ideal" structure to allow it to continue functioning effectively (Haimann 135). The depth to which restructuring an organization must occur should be the minimum necessary to allow the structure to return to effective functioning (Szilagyi and Wallace 559 - 561). Additionally, the less the amount of organizational change required, the less traumatic are the effects on the entire organization (Haimann 135 - 137). Utilizing the existing DMAA organizational structure for the supervision of assigned 76J as a vehicle for implementing organization change should minimize the negative effects of reorganization. Thus, this should serve to maximize the development of a more effective supervisory structure for the DMAA 76Js while providing the least disruption to the entire Medical Center.

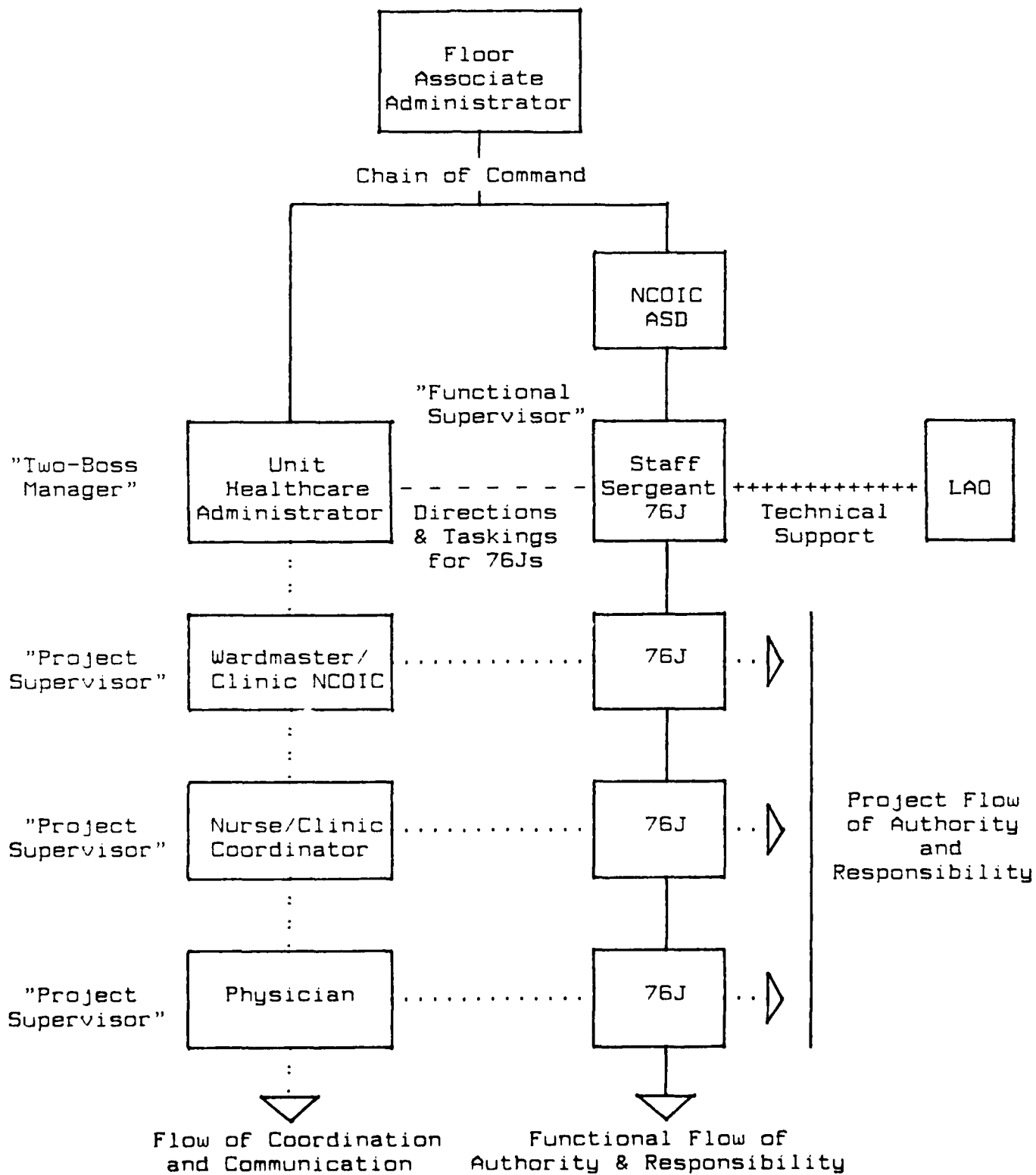
As early as 1982, Southby and Rivera identified the need for NCOIC support of unit healthcare administrators as a way to increase the effective supervision of ancillary healthcare support personnel under their control (27). Until the recent WPAMC IDA became effective in October 1987, there were no 76J

NCOs in the grade of Staff Sergeant (E-6) required or authorized for any floor, except the fourth floor, to support the DMAA unit healthcare administrators. Effective for the first time in October 1987, all Administrative Support Divisions (ASDs) of the DMAA had both requirements and authorizations for Staff Sergeant (E-6) 76Js documented on the IDA (See TAB D - WRAMC IDA HSW2DHAA DMAA Excerpts). The knowledge, skills, and abilities that Staff Sergeant (E-6) 76Js bring to the ASDs offers a clear way to modify and enhance the supervisory structure that currently exists between unit healthcare administrators and the DMAA 76Js in the grades of E-4 (Specialist) through E-1 (Private) under their control.

Figure 21 illustrates a proposed supervisory matrix schematic for providing more effective supervision of the DMAA 76Js assigned to the ASDs. This matrix structure would allow the unit healthcare administrator to assume the more appropriate supervisor behavior pattern of a "two-boss manager", while the Staff Sergeant (E-6) 76J would become the "functional" supervisor and non-DMAA personnel become "project" supervisors (Szilagyi and Wallace 501). Additionally, the DOL LAOs would be integrated into this structure through the Staff Sergeant 76Js for the continued provision of medical material management technical assistance and guidance to the DMAA ASDs.

As the "two-boss manager" in this supervisory matrix schematic for the DMAA 76Js on the ASDs, the unit healthcare administrator would be responsible for coordinating, communicating, and in the case of the Staff Sergeant 76J for the ASD, he/she would be responsible

Figure 21 DMAA ASD Supervision Matrix Schematic Utilizing the Staff Sergeant (E-6) 76J



for providing daily, weekly, and monthly tasks to be accomplished in support of "project supervisors" and their wards and clinics. The unit healthcare administrator in this proposed supervision matrix schematic would be placed into a situation to better utilize the knowledge, skills, experience, and abilities that this mid-level management position would call for, that of a masters-level prepared healthcare administrator (Ferreira 1987). It is this masters-level education in healthcare administration that should have prepared the unit healthcare administrator for a general manager orientation, the ability to have developed a total organization perspective, how to control differences, and resolve organization conflict that are the necessary behavior traits for the "two-boss manager" (Szilagyi and Wallace 501).

The second critical role in this proposed supervisory matrix schematic is that of "functional supervisor." The knowledge, skills, and abilities of the Staff Sergeant 76J would make him the logical individual to place in this position. As a NCO, he has been generally prepared to meet soldier needs, training requirements, manpower planning, job assignments, balancing workloads, and the handling of staff personnel that are the hallmarks of the "functional supervisor" (Szilagyi and Wallace 501). Additionally, as 76Js themselves, they are already technically prepared to handle the needs of their subordinates or to seek assistance and guidance from the DOL LAOs that are assigned to support their ASDs.

The final critical role in this proposed supervisory matrix schematic is the "project supervisor." Project supervisors are those non-DMAA personnel that are supported in their wards and clinics by the DMAA ASD 76Js. These personnel, generally wardmasters/clinic NCOICs, nurses/clinic coordinators, and physicians would also be responsible for the training and supervision of the DMAA ASD 76Js as it would relate to proper support of their wards and clinics. These individuals must be educated by the unit healthcare administrator in their role as "two-boss manager" on the inherent responsibilities of "project managers" to learn to share power, develop basic lines of communication and coordination, learn to manage differences, be innovative, and develop a balanced, generalist orientation as it affects the Medical Center organizational structure (Szilagyi and Wallace 501). The ability of unit healthcare administrators to successfully perform this responsibility will rest heavily on their educational preparation and background.

This proposed supervision matrix schematic calls for all of the 76Js on an ASD to be placed under the functional authority (chain of command) of the Staff Sergeant 76J. The Staff Sergeant therefore would assume the day-to-day supervision, training, and control now vested in most unit healthcare administrators of the DMAA. Commensurate with their responsibilities as a manager of "functional" and "project" supervisors, unit healthcare administrators would no longer be held responsible as a direct first-line supervisor of the DMAA ASD 76Js. This responsibility would fall directly to the Staff Sergeant 76J as the

"functional" supervisor. The unit healthcare administrator would become responsible for the planning, coordination, and direction of medical material management for his/her supported wards and clinics while the Staff Sergeant 76J would become the day-to-day operator and implementor of policy and tasking. The successful implementation of a supervisory matrix structure similar to this proposal is currently being demonstrated by the ASD, Floors 6 and 7, and was previously discussed in this research.

In addressing the need to create more new positions to support this supervisory matrix schematic, none are required. All the unit healthcare administrators, Staff Sergeant 76Js, and 76J positions that would be needed are currently authorized on the October 1987 WRAMC IDA. In terms of the DOL technical assistance structure necessary to support the DMAA, the number of LAOs should be expanded from the current two to the full complement of five, one LAO for each ASD. The ability to implement this supervisory matrix structure would amount to only a matter of clearly defining the job descriptions of the key individuals involved in this structure, educating and training those individuals and the other management structures of the Medical Center (e.g. Clinical and Nursing), and finally, incorporating the use of this supervision matrix structure throughout all the DMAA ASDs.

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IV. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Colonel Thomas Munley, MS, Chief of Staff, Health Services Command, U.S. Army, stated in 1987 that the first and most important question that must be asked in doing research was: "Is the problem BEHAVIORAL or STRUCTURAL?" In addressing this research the attempt was made to approach the problem of the most effective organizational structure for providing supervision to the medical supply specialists assigned to the DMAA at WRAMC from that perspective.

The unit administration concept found at WRAMC is unique only to this AMEDD healthcare institution. No other AMEDD healthcare facility is organized nor functions in this manner. The uniqueness of the unit administration system often makes it an easy target for criticism. This criticism is seldom supported by documented research. The most common rationale for condemning any aspect of the WRAMC unit administration system is that it is unlike any other healthcare administration system found in the AMEDD. This failure to accept the uniqueness of the WRAMC unit administration system can be symptomatic of a BEHAVIORAL failure by individuals to adopt to a new, and potentially, more challenging healthcare administration situation.

With this BEHAVIORAL issue aside, the data arrived at in this research clearly indicated that the WRAMC unit administration system is in need of some structural modifications. What may appear as BEHAVIORAL shortcomings in the DMAA supervisory

structure for assigned 76Js are in fact indications of structural shortcomings that were identified as early as 1982 by Southby and Rivera in their examination of the unit administration system at WRAMC. Previous research, as well as this current research, have factually documented the clear indications of structural deficiencies in the WRAMC unit administration system for the Medical Center. The predominant structural shortcomings are synopsized below:

1. The DMAA lacks a clear supervision structure resulting in supervisory ambiguity and conflict.
2. Role ambiguity for the DMAA 76Js results from a failure to clearly identify daily tasks expected by those personnel involved in the daily supervision of the DMAA 76Js.
3. DMAA unit healthcare administrators are functioning in an inappropriate supervisory role in the current matrix supervision structure.
4. There is a current shortage of medical material management experts in not only the DMAA organizational structure, but also the DOL liaison structure.
5. The ability of WRAMC to train personnel assigned to the three separate management structures of the Medical Center on unique aspects of their job role and function as it pertains to healthcare administration is impeded by a lack of education models.

Recommendations

To produce the most effective organizational structure for providing supervision to the medical supply specialists (MOS 76J) assigned to the Directorate of Medical Activities Administration (DMAA), the implementation of the following actions is recommended:

1. WRAMC should adopt the structural proposal that modifies the current DMAA matrix supervision structure by placing the unit healthcare administrator into the role of the "two-boss manager"; the Staff Sergeant 76J into the role of "functional" supervisor; and other personnel that supervise the DMAA 76Js on a daily basis into the role of "project" supervisors.

2. The Chief of Staff/DCA through the Chief, Military Personnel Office should monitor assignment policies to guarantee that all the DMAA Staff Sergeant (E-6) [NOTE: Sergeant (E-5) for ASD 7J 76J positions are immediately filled by available personnel.

3. The Chief of Staff/DCA through the Directors of Resources Management (DRM) and Logistics (DOL) should begin actions to bring authorizations up to full documented TDA requirements for the DOL logistics assistance officers (LAOs).

4. The DMAA should be tasked to immediately begin development of education models to train personnel in their new roles as demanded by this modified matrix supervision structure. Additionally, task the DMAA to develop an education model to

bring unit healthcare administrators up to the necessary level of civilian education called for in the original unit administration concept (e.g. masters-level education in healthcare administration).

5. Task the DMAA to ensure that personnel involved in the daily supervision of the DMAA 76Js develop a documented description of the daily job tasks expected of the 76Js. This action must be coordinated by the unit healthcare administrator through the "functional" and "project" supervisors.

6. The Chief of Staff/DCA should evaluate the effectiveness of this modified matrix supervision structure one (1) year after implementation throughout the DMAA. If improvements in the supervision of the DMAA 76Js are not realized, consider the proposal to centralize all medical material management functions under one (1) organizational structure within the Medical Center.

Considered Initiative:

The Chief of Staff/DCA should consider a study to determine the appropriate level of civilian education for each DMAA unit healthcare administrator position as a matter for further research.

List of Abbreviations Used

AA.....Associate of Arts Degree
AOC.....Area of Concentration
AS.....Associate of Science Degree
AMEDD...Army Medical Department
AMH.....Accreditation Manual for Hospitals
ASD.....Administrative Support Division
BA.....Baccalaureate of Arts Degree
BNMC....Bethesda Naval Medical Center
BS.....Baccalaureate of Science Degree
CAB.....Customer Assistance Branch
DCA.....Deputy Commander for Administration
DIO.....Directorate of Industrial Operations
DMAA....Directorate of Medical Activities Administration
DOL.....Directorate of Logistics
DON.....Department of Nursing
DRM.....Directorate of Resources Management
GS.....General Pay Scale
GWUMC...George Washington University Medical Center
HCA.....Healthcare Corporation of America
HS.....High School Graduate
HSD.....Hospital Support Division
JCAHO...Joint Commission on Accreditation of Healthcare
 Organizations
LAM.....Logistic Area Manager
LAO.....Logistics Assistance Officer
LMB.....Linen Management Branch
MA.....Management and Administrative Services
MA.....Masters of Arts Degree
MBA.....Masters of Business Administration Degree
MDB.....Material Distribution Branch
MHA.....Masters of Hospital [Healthcare] Administration
MOS.....Military Occupational Skill
MPH.....Masters of Public Health Degree
MS.....Masters of Science Degree
MS.....Medical Service Corps
MTF.....Medical Treatment Facility
NCO.....Non-Commissioned Officer
NCOIC...Non-Commissioned Officer-in-Charge
Ph.D....Doctor of Philosophy Degree
SGM.....Sergeant Major
SOP.....Standard Operating Procedure
TDA.....Table of Distribution and Allowances
UA.....Unit Administration
WRAMC...Walter Reed Army Medical Center

O-3.....Captain, US Army
O-4.....Major, US Army
O-5.....Lieutenant Colonel, US Army

List of Abbreviations Used

E-1.....Private, US Army
 E-2.....Private, US Army
 E-3.....Private First Class, US Army
 E-4.....Specialist
 E-5.....Sergeant, US Army
 E-6.....Staff Sergeant, US Army
 E-7.....Sergeant First Class, US Army

 67A.....Healthcare Administration Officer
 67K.....Medical Logistics Officer
 71G.....Patient Administration Specialist
 71L.....Administration Specialist
 76J.....Medical Supply Specialist

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Adm. Serv. Contracts Div.	4-020
Contracting Div.	4-030
Procurement Div.	4-040
Inspection Div.	4-050
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CLIN. UNIT	152115
Adult Clinic	152115
Psychiatric Outpatient	152115
Psychiatric Inpatient	152115
Psychiatric Medicine	152115
Psychiatric Surgery	152115
Psychiatric Pharmacy	152115
Psychiatric Radiology	152115
Psychiatric Pathology	152115
Psychiatric Laboratory	152115
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Psychiatric Nursing	152115
Psychiatric Dietetics	152115
Psychiatric Occupational Therapy	152115
Psychiatric Music Therapy	152115
Psychiatric Art Therapy	152115
Psychiatric Recreation Therapy	152115
Psychiatric Case Management	152115
Psychiatric Peer Support	152115
Psychiatric Crisis Intervention	152115
Psychiatric Forensic Services	152115
Psychiatric Geriatrics	152115
Psychiatric Pediatrics	152115
Psychiatric Women's Health	152115
Psychiatric Transgender Health	152115
Psychiatric Substance Use	152115
Psychiatric Addictive Disorders	152115
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Psychiatric Sleep Medicine	152115
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Psychiatric Smart Devices	152115
Psychiatric Connected Devices	152115
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ALLERGY IMMUNOLOGY SERVICE BLDG 2 LTC CAMPBELL/PAUL WALLACE	HOKA A Am Lab 185/187	1849 1811 1849/1818 2566/2717 277/278 272/273 1849
Sppl. Allergist Clinical Immunology Lab Allergic Clin Immunol Cn NEDS Clinic Allergist Phil L La NEDS Lab NEDS Allergy Center Linn Allergy		

MS-100	DEPT OF PASTORAL CARE	1,300
MS-101	BLDG 2	1,300
MS-102	CH CCLL - BULK/MS/SC ACTIVE	1,300
MS-103	Administrative Office	1,300
MS-104	Medical Clinician	1,300
MS-105	Chc Past 1-6 Seps	1,300
MS-106	Translating Document	1,300
MS-107	International Chapter	1,300
MS-108	MS/SC	1,300

DEPT OF MARINE	BLDG #	NO. OF PERSONNEL	NO. OF PERSONNEL
4th Fleet	14	14	14
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UNITED STATES DEPT. OF COMMERCE BUREAU OF ECONOMIC RESEARCH DIVISION OF INFORMATION MANAGEMENT	ADP No. : A-1111 A-1112 A-1113 A-1114 A-1115 A-1116 A-1117 A-1118 A-1119 A-1120 A-1121 A-1122 A-1123 A-1124 A-1125 A-1126 A-1127 A-1128 A-1129 A-1130 A-1131 A-1132 A-1133 A-1134 A-1135 A-1136 A-1137 A-1138 A-1139 A-1140 A-1141 A-1142 A-1143 A-1144 A-1145 A-1146 A-1147 A-1148 A-1149 A-1150 A-1151 A-1152 A-1153 A-1154 A-1155 A-1156 A-1157 A-1158 A-1159 A-1160 A-1161 A-1162 A-1163 A-1164 A-1165 A-1166 A-1167 A-1168 A-1169 A-1170 A-1171 A-1172 A-1173 A-1174 A-1175 A-1176 A-1177 A-1178 A-1179 A-1180 A-1181 A-1182 A-1183 A-1184 A-1185 A-1186 A-1187 A-1188 A-1189 A-1190 A-1191 A-1192 A-1193 A-1194 A-1195 A-1196 A-1197 A-1198 A-1199 A-1200 A-1201 A-1202 A-1203 A-1204 A-1205 A-1206 A-1207 A-1208 A-1209 A-1210 A-1211 A-1212 A-1213 A-1214 A-1215 A-1216 A-1217 A-1218 A-1219 A-1220 A-1221 A-1222 A-1223 A-1224 A-1225 A-1226 A-1227 A-1228 A-1229 A-1230 A-1231 A-1232 A-1233 A-1234 A-1235 A-1236 A-1237 A-1238 A-1239 A-1240 A-1241 A-1242 A-1243 A-1244 A-1245 A-1246 A-1247 A-1248 A-1249 A-1250 A-1251 A-1252 A-1253 A-1254 A-1255 A-1256 A-1257 A-1258 A-1259 A-1260 A-1261 A-1262 A-1263 A-1264 A-1265 A-1266 A-1267 A-1268 A-1269 A-1270 A-1271 A-1272 A-1273 A-1274 A-1275 A-1276 A-1277 A-1278 A-1279 A-1280 A-1281 A-1282 A-1283 A-1284 A-1285 A-1286 A-1287 A-1288 A-1289 A-1290 A-1291 A-1292 A-1293 A-1294 A-1295 A-1296 A-1297 A-1298 A-1299 A-1300 A-1301 A-1302 A-1303 A-1304 A-1305 A-1306 A-1307 A-1308 A-1309 A-1310 A-1311 A-1312 A-1313 A-1314 A-1315 A-1316 A-1317 A-1318 A-1319 A-1320 A-1321 A-1322 A-1323 A-1324 A-1325 A-1326 A-1327 A-1328 A-1329 A-1330 A-1331 A-1332 A-1333 A-1334 A-1335 A-1336 A-1337 A-1338 A-1339 A-1340 A-1341 A-1342 A-1343 A-1344 A-1345 A-1346 A-1347 A-1348 A-1349 A-1350 A-1351 A-1352 A-1353 A-1354 A-1355 A-1356 A-1357 A-1358 A-1359 A-1360 A-1361 A-1362 A-1363 A-1364 A-1365 A-1366 A-1367 A-1368 A-1369 A-1370 A-1371 A-1372 A-1373 A-1374 A-1375 A-1376 A-1377 A-1378 A-1379 A-1380 A-1381 A-1382 A-1383 A-1384 A-1385 A-1386 A-1387 A-1388 A-1389 A-1390 A-1391 A-1392 A-1393 A-1394 A-1395 A-1396 A-1397 A-1398 A-1399 A-1400 A-1401 A-1402 A-1403 A-1404 A-1405 A-1406 A-1407 A-1408 A-1409 A-1410 A-1411 A-1412 A-1413 A-1414 A-1415 A-1416 A-1417 A-1418 A-1419 A-1420 A-1421 A-1422 A-1423 A-1424 A-1425 A-1426 A-1427 A-1428 A-1429 A-1430 A-1431 A-1432 A-1433 A-1434 A-1435 A-1436 A-1437 A-1438 A-1439 A-1440 A-1441 A-1442 A-1443 A-1444 A-1445 A-1446 A-1447 A-1448 A-1449 A-1450 A-1451 A-1452 A-1453 A-1454 A-1455 A-1456 A-1457 A-1458 A-1459 A-1460 A-1461 A-1462 A-1463 A-1464 A-1465 A-1466 A-1467 A-1468 A-1469 A-1470 A-1471 A-1472 A-1473 A-1474 A-1475 A-1476 A-1477 A-1478 A-1479 A-1480 A-1481 A-1482 A-1483 A-1484 A-1485 A-1486 A-1487 A-1488 A-1489 A-1490 A-1491 A-1492 A-1493 A-1494 A-1495 A-1496 A-1497 A-1498 A-1499 A-1500 A-1501 A-1502 A-1503 A-1504 A-1505 A-1506 A-1507 A-1508 A-1509 A-1510 A-1511 A-1512 A-1513 A-1514 A-1515 A-1516 A-1517 A-1518 A-1519 A-1520 A-1521 A-1522 A-1523 A-1524 A-1525 A-1526 A-1527 A-1528 A-1529 A-1530 A-1531 A-1532 A-1533 A-1534 A-1535 A-1536 A-1537 A-1538 A-1539 A-1540 A-1541 A-1542 A-1543 A-1544 A-1545 A-1546 A-1547 A-1548 A-1549 A-1550 A-1551 A-1552 A-1553 A-1554 A-1555 A-1556 A-1557 A-1558 A-1559 A-1560 A-1561 A-1562 A-1563 A-1564 A-1565 A-1566 A-1567 A-1568 A-1569 A-1570 A-1571 A-1572 A-1573 A-1574 A-1575 A-1576 A-1577 A-1578 A-1579 A-1580 A-1581 A-1582 A-1583 A-1584 A-1585 A-1586 A-1587 A-1588 A-1589 A-1590 A-1591 A-1592 A-1593 A-1594 A-1595 A-1596 A-1597 A-1598 A-1599 A-1600 A-1601 A-1602 A-1603 A-1604 A-1605 A-1606 A-1607 A-1608 A-1609 A-1610 A-1611 A-1612 A-1613 A-1614 A-1615 A
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US ARMY DIGITAL ACTIVITY CENTER FORD DR Bldg 2, Ford Dr Bldg	37
COMMADDER	37
COL WHEELER	37
EXECUTIVE OFFICE/COMPANY CDR	37
MAJ WALKER	37
SERJANT MAJOR	37
Sgtm WELSH	37

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PRESCRIPTION SERVICE BLDG. 7 11700 WINGWALKER HALLWAY	Pharmacy Agreement Paper RXCLIP Sample & Report Order Total Insurance Coverage Statement Insurance Policy Statement New Paper Pharmacy Old Paper Pharmacy New Paper Pharmacy Old Paper Pharmacy Outpatient Pharmacy Drug and Cancer
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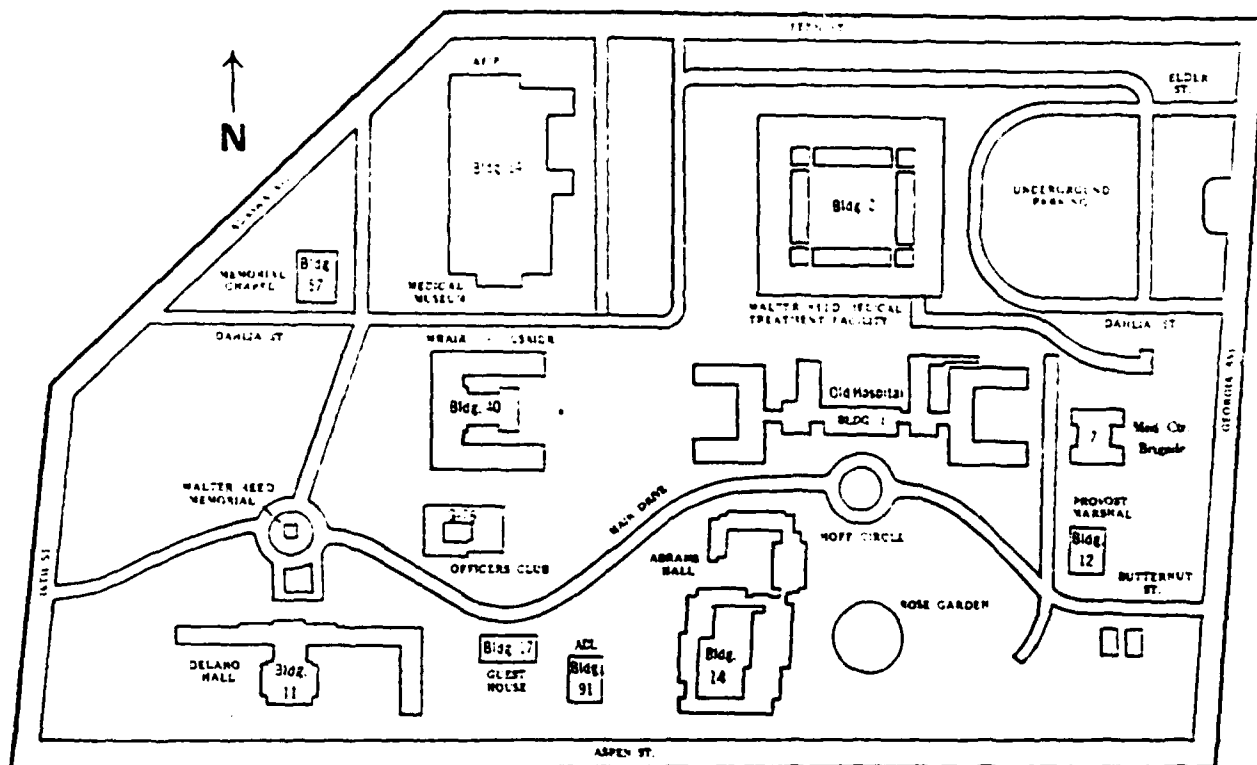
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1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044	2045	2046	2047	2048	2049	2050	2051	2052	2053	2054	2055	2056	2057	2058	2059	2060	2061	2062	2063	2064	2065	2066	2067	2068	2069	2070	2071	2072	2073	2074	2075	2076	2077	2078	2079	2080	2081	2082	2083	2084	2085	2086	2087	2088	2089	2090	2091	2092	2093	2094	2095	2096	2097	2098	2099	2100	

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International Bank		47
Commercial Bank		47
Industrial Bank		47
Mutual Bank		47

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WALTER REED ARMY MEDICAL CENTER



Building 11 (Delano Hall)

- MILPO/Customer Service
- Disbursing Section
- Education Center
- Finance and Accounting
- ID Card/DEERS Office
- Personnel (Military and Civilian)
- SATO (Schedule Airline Traffic Office)
- Transportation/Travel

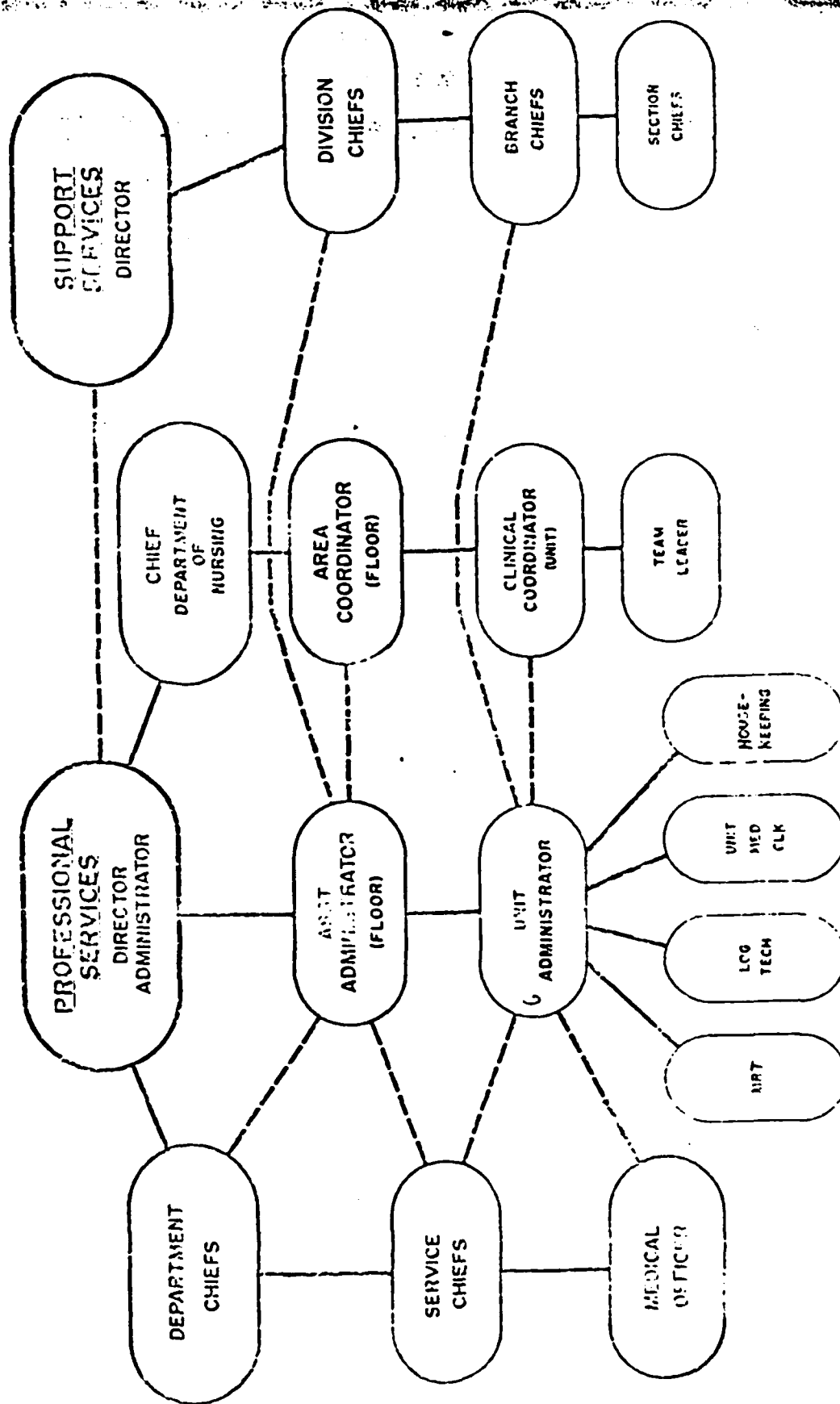
Building 1 (Old Hospital)

- ACS/AER Office
- Bank
- Center Judge Advocate
- Credit Union
- EEO Office
- Family Support Div.
- Housing Referral Office
- Inspector General
- Med. Hold Co.
- Medical Equipment
- Home Loan Section
- Parking Office
- U.S. Post Office

Building 7

- Medical Center Brigade
- Administration
- Personnel Admin Center
- Supply
- Clinical Pastoral Education (CPE)
- CPR Clinic

FUNCTIONAL SCHEME



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INPUT ANALYSIS REPORT TDA TYPE B
PART 1 INPUT TRANSACTION AND ERROR LISTING
WALTER REED ARMY MEDICAL CENTER

PROJECTED
TDA HSW2DHAA
CCNUM HSO288

TYPE PROCESSING: ESTABLISHED
FILE: MASTERFILE

UNITS AFFECTED
UIC UNIT DESIGNATION

W2DHAA WALTER REED ARMY MEDICAL CENTER

SUPERSESSION DOCUMENT EDATE ASGMT
HSW2DHAA 0387 871002 HS HW M

SECTION II PERSONNEL ALLOWANCE

PARA	LINE	DESCRIPTION	ITAADS CODE	HW	GR	MUS	ASI/LIC	BR	ID	AMS	PARENT UNIT		PARENT UNIT		ACTION		
											LINE TOTAL	REQ	NET CHANGE	REQ	AUTH	RMKS	PP
101	00	SW2DH23 COMMANDER															
101	01	COMMANDER/DHS HTA			MG	00800	6Y		GO K	84771141BBA	1	1				SA	
101	02	DEPUTY CDR HTA			BG	00800	6Y		GO K	84771141BBA	1	0					
101	02A	DEPUTY CDR HTA			U6	60A00	6Y		MC K	84771141BBA	0	1				SA	
101	03	DCA/CS/DPC HTA			U6	67A00	6Y		MS K	84771141BBA	1	1				SA	
101	03A	NUR ADMIN HTA			U3	66A00	9E		AN K	84771141BBA	1	1				TB	
101	03B	EXEC OFF HTA			U5	67F00			MS K	84771141BBA	1	1					
101	04	AIDE-DE-CAMP HTA			U3	01A00			MS K	84771141BBA	1	1				SA	
101	05	COMD SGT MAJ HTA			E9	00250			NC I	84771141BBA	1	1				SB	
101	05A	ADMIN SUPV HTA			E7	71L40			NC I	84771141BBA	1	1					
101	06	ENL AIDE HTA			E7	91B40	25		NC I	84771141BBA	1	1				SB	

SECTION II PERSONNEL ALLOWANCE

PARA LINE	DESCRIPTION	HTA	ITAADS CODE	GR	MUS	ASI/LIC	UR ID	AMS	PARENT UNIT LINE REQ	PARENT UNIT TOTAL AUTH	PARENT UNIT NET CHANGE REQ	ACTION RMKS PP DA CDE
101 07	SECY(STENO)	HTA		09	00318		GS C	84771141BBA	1	1		SB
101 08	SECY(STENO)	HTA		08	00318		GS C	84771141BBA	2	2		SB
101 08A	SECY STENO	HTA		07	00318		GS C	84771141BBA	1	1		
101 09	PROTOCOL ASST	HTA		07	00301		GS C	84771141BBA	1	1		SB
PARAGRAPH TOTALS												
101A 00	\$W2DHO1 DIR MED ACT								14	14		
101A 01	DMAA/ACS	HTA		06	67A00		MS K	84771141BBA	1	1		SAZR
101A 02	HLTH CARE ADM	HTA		04	67A00		MS K	84771141BBA	1	1		SB99
101A 03	C. ADMIN NCO	HTA		E7	71L40		NC I	84771141BBA	1	1		SBNB
101A 04	HLTH SYS ADM	HTA		12	00670		GS C	84771141BBA	1	1		
101A 06	PNT ASST REP	HTA		08	00303		GS C	84771141BBA	2	2		
101A 07	SECY (T)	HTA		07	00318		GS C	84771141BBA	1	1		SB
101A 08	HSLH SYS SP	HTA		12	00671		GS C	84771141BBA	1	0		
101A 09	CLK TYP	HTA		03	00322		GS C	84771141BBA	1	1		
PARAGRAPH TOTALS									9	8		

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SECTION II PERSONNEL ALLOWANCE

PARA LINE	DESCRIPTION	HTB	HTB	GR	MUS	ASI/LIC	BR ID	AMS	PARENT UNIT LINE TOTAL REQ AUTH	PARENT UNIT NET CHANGE REQ AUTH	ACTION RMKS PP DA CDE
102J 22	CLERK TYPIST	HVD		O4	00322		GS C	84771141HVD	1	1	
									21	21	
102K 00	SAFETY OFC										
102K 01	SAFE HLTH MGR	CPG		12	00018		GS C	84771141CHG	1	1	SB
102K 02	SAFE HLTH SC	CPG		11	00018		GS C	84771141CHG	3	3	SB
102K 04	SAFE CLK(T)	CPG		06	00303		GS C	84771141CHG	1	1	
									5	5	
102L 00	QASRM OFC										
102L 01	HLTH SYS SP	HTB		12	00671		GS C	84771141BBB	1	1	SB
102L 02	HLTH SYS SP	HTB		11	00671		GS C	84771145CHG	1	1	SB
102L 03	PROG MGT TECH	HTB		07	00303		GS C	84771145CHG	1	1	
102L 04	MRT	HTB		05	00075		GS C	84771145BBB	1	1	
102L 05	PNT ADMIN SP	HTB		E4	71G10		I	84771141BBB	1	0	
									5	4	
102M 00	INT AUD OFC										
102M 01	SUPR,AUDITOR	CNA		13	00511		GM C	84771141CGA	1	1	SB

PARAGRAPH TOTALS

PARAGRAPH TOTALS

PARAGRAPH TOTALS

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SECTION II PERSONNEL ALLOWANCE

PARA LINE	DESCRIPTION	ITAADS CODE	GR	MOS	ASI/LIC	BR ID	AMS	PARENT UNIT LINE TOTAL		PARENT UNIT NET CHANGE		ACTION
								REQ	AUTH	REQ	AUTH	
1100 00	MED ED OFC											
1100 01	EDUC TECH TAY		08	01702		GS C	8467611KUAY	1	1			ZR
1100 02	EDUC ASST (T) TAY		07	01702		GS C	8467611NUAY	1	1			SB
1100 03	CRED CLK(T) TAY		06	00303		GS C	8467611NUAY	1	1			SB
1100 04	CLK TYP TAY		03	00322		GS C	8467611NUAY	1	1			
								4	4			
PARAGRAPH TOTALS												
110E 00	\$W2DHO1 ADMIN SPT FL3	HW										
110E 01	C.ADM SPT FL3 HTC		04	67A00		MS K	84771144ARA	1	1			SB
110E 02	HLIII CARE ADM HTC		03	67A00		MS K	84771144ARA	1	0			
110E 03	PNT ADMIN NCO HTC		E7	71G40		NC I	84771144ARA	1	1			
110E 03A	MED SUP SGT HTC		E6	76J30		NC I	84771144ARA	1	1			
110E 04	SR PNT ADM SP HTC		E5	71G20		NC I	84771144ARA	2	2			
110E 05	MED SUP SGT HTC		E5	76J20		NC I	84771144ARA	1	1			
110E 06	PNT ADMIN SP HTC		E4	71G10		I	84771144ARA	2	2			
110E 07	MED SUP SP HTC		E4	76J10		I	84771144ARA	3	3			
110E 08	PNT ADMIN SP HTC		E3	71G10		I	84771144ARA	2	2			

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SECTION II PERSONNEL ALLOWANCE

PARA LINE	DESCRIPTION	HTC	IIAADS CODE	GR	MOS	ASI/LIC	BR ID	AMS	PARENT UNIT LINE TOTAL REQ	PARENT UNIT NET CHANGE REQ	ACTION
110E 09	MED SUP SP	HTC		E3	76J10		I	84771144ARA	4	3	
110E 10	S. HLTH SYS SP	HTC		11	00371		GS C	84771144ARA	6	6	
110E 11	SECY(STEND)	HTC		06	00318		GS C	84771144ARA	1	1	
110E 12	MRT	HTC		05	00675		GS C	84771144ARA	13	13	
110E 13	SUP CLK	HTC		05	02005		GS C	84771144ARA	1	0	
110E 14	MED CLK (TYP)	HTC		04	00679		GS C	84771144ARA	11	8	
110E 15	CLX TYP	HTC		03	00322		GS C	84771144ARA	1	0	
PARAGRAPH TOTALS									51	44	
110F 00	\$W2DHQ1 SUP SVC BR		11W								
110F 01	C SPT SVCS BR LEY			03	67A00		MS K	84771144NNY	1	1	SB
110F 02	PNT ADMIN NCO LEY			E7	71G40		NC I	84771144NNY	1	1	
PARAGRAPH TOTALS									2	2	
110G 00	\$W2DHQ1 ADMIN SPT FL4		HW								
110G 01	C. ADM SPT FL4 HEBBP			04	67A00		MS K	84771143ARA	1	1	SB
110G 02	HLTH CARE ADM HEBBP			03	67A00		MS K	84771143ARA	3	2	
110G 03	HS MAT OFF	HTC		02	67K00		MS K	84771143ARA	1	0	

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SECTION II PERSONNEL ALLOWANCE

PARA	LINE	DESCRIPTION	STATUS CODE	GR	MOS	ASI/LIC	BR ID	AMS	PARENT UNIT		PARENT UNIT		ACTION	
									LINE REQ	TOTAL AUTH	NET CHANGE REQ	UNIT AUTH	RMKS	PP
110G	04	C. ADMIN NCU	HEBBP	E6	71L30		NC I	84771143ARA	1	1				
110G	04A	MED SUP SGT	HEBBP	E6	76J30		NC I	84771143ARA	1	1				
110G	05	MED SUP SGT	HTC	E5	76J20		NC I	84771143ARA	3	3				
110G	06	ADMIN SP	HTC	E5	71L20		NC I	84771141ARA	2	1				
110G	07	MED SUP SP	HEBBP	E4	76J10		I	84771143ARA	7	7				
110G	08	MED SUP SP	HEBBP	E3	76J10		I	84771143ARA	8	7				
110G	09	S. HLTH SYS SP	HEBBP	11	00671		GS C	84771143ARA	3	3				
110G	10	S. M DATA TEC	(THEBBP	07	00699		GS C	84771141ARA	1	1				
110G	10A	S. MRT	HEBBP	07	00675		GS C	84771143ARA	3	1				
110G	11	SECY (T)	HEBBP	06	00318		GS C	84771143ARA	1	1				
110G	12	SUP TECH	HEBBP	06	02005		GS C	84771143ARA	1	1				
110G	13	M DATA TECH(T	HEBBP	05	00699		GS C	84771143ARA	10	5				
110G	14	MRT	HEBBP	05	00675		GS C	84771143ARA	40	32				
110G	15	SUP CLK	HEBBP	05	02005		GS C	84771143ARA	3	2				
110G	17	CLK TYP	HEBBP	03	00322		GS C	84771143ARA	2	2				
PARAGRAPH TOTALS									91	71				

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SECTION II PERSONNEL ALLOWANCE

PARA LINE	DESCRIPTION	ITAADS CODE	GR	MUS	ASI/LIC	DR ID	AMS	PARENT UNIT LINE REQ	TOTAL AUTH	PARENT UNIT NET CHANGE REQ	ACTION RMKS PP DA CDE
110H 00	\$W2DHO1 ADMIN SPT FL5	HW									
110H 01	C.ADM SPT FL5 HEBBP		04	67A00		MS K	84771143ARA	1	1		SB
110H 02	HLTH CARE ADM HEBBP		03	67A00		MS K	84771143ARA	2	2		
110H 03	PNT ADMIN NCO HEBBP		E7	71G40		NC I	84771143ARA	1	1		
110H 03A	MED SUP SGT HEBBP		E6	76J30		NC I	84771143ARA	1	1		
110H 04	MED SUP SGT HEBBP		E5	76J20		NC I	84771143ARA	2	2		
110H 04A	SP PNT ADM SP HEBBP		E5	71G20		NC I	84771143ARA	1	1		
110H 05	PNT ADMIN SP HEBBP		E4	71G10		I	84771143ARA	2	2		
110H 06	MED SUP SP HEBBP		E4	76J10		I	84771143ARA	5	5		
110H 07	PNT ADMIN SP HEBBP		E3	71G10		I	84771143ARA	1	1		
110H 08	MED SUP SP HEBBP		E3	76J10		I	84771143ARA	4	4		
110H 09	S.HLTH SYS SP HEBBP		11	00671		GS C	84771143ARA	2	2		
110H 10	SECY (T) HEBBP		06	00318		GS C	84771143ARA	1	1		
110H 10A	S.MRT(T) HEBBP		07	00675		GS C	84771143ARA	1	1		
110H 11	S.MRT HTC		07	00675		GS C	84771141ARA	1	1		
110H 12	MRT HEBBP		05	00675		GS C	84771143ARA	29	22		

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SECTION II PERSONNEL ALLOWANCE

PARA LINE	DESCRIPTION	IIAADS CODE	GR	MOS	ASI/LIC	BR ID	AMS	PARENT UNIT LINE REQ	PARENT UNIT TOTAL AUTH	PARENT UNIT NET CHANGE REQ	ACTION
110H 12A	MRT	HIC	05	00675		GS C	84771143ARA	1	0		UB
110H 13	MRT(1)	HEBBP	05	00675		GS C	84771143ARA	10	7		
PARAGRAPH TOTALS											
110J 00	\$W2UHO1 ADMIN SPT FL6	HW						65	54		
110J 01	C.ADM SPT FL6	HEBBP	04	67A00		MS K	84771143HVD	1	1		SB
110J 02	HLTH CARE ADM	HEBBP	03	67A00		MS K	84771143HVD	1	1		
110J 03	PNT ADMIN NCU	HEBBP	E7	71G40		NC I	84771143HVD	1	1		
110J 04	MED SUP SGT	HEBBP	E6	76J30		NC I	84771143HVD	1	1		
110J 05	SR PNT ADM SP	HEBBP	E5	71G20		NC I	84771143HVD	3	3		
110J 06	MED SUP SGT	HEBBP	E5	76J20		NC I	84771143HVD	3	2		
110J 07	PNT ADMIN SP	HEBBP	E4	71G10		I	84771143HVD	4	4		
110J 08	MED SUP SP	HEBBP	E4	76J10		I	84771143HVD	5	5		
110J 09	PNT ADMIN SP	HEBBP	E3	71G10		I	84771143HVD	3	3		
110J 10	MED SUP SP	HEBBP	E3	76J10		I	84771143HVD	5	5		
110J 11	S.HLTH SYS SP	HEBBP	11	00671		GS C	84771143HVD	3	3		
110J 12	S.MRT(1)	HEBBP	07	00675		GS C	84771143HVD	1	1		

SECTION II PERSONNEL ALLOWANCE

PARA LINE	DESCRIPTION	LIAADS CODE	GR	MUS	ASI/LFC	UR ID	AMS	PARENT UNIT		PARENT UNIT		ACTION	
								REQ	AUTH	LINE TOTAL	NET CHARGE	REQ	AUTH RMKS PP DA CDE
110J 13	S.MRT	HEBBP	07	00675		GS C	84771143HVD	2	1				
110J 14	SECY (T)	HEBBP	06	00318		GS C	84771143HVD	1	1				
110J 15	M DATA TECH(T) HEBBP		05	00699		GS C	84771141HVD	9	7				
110J 16	MED RCD TECH HEBBP		05	00675		GS C	84771143HVD	10	9				
110J 17	SUPPLY CLERK HEBBP		05	02005		GS C	84771143HVD	2	1				
110J 18	CLERK TYP HTC		04	00322		GS C	84771141ARA	2	1				
110J 19	CLERK TYP HTC		03	00322		GS C	84771143ARA	1	1				
PARAGRAPH TOTALS								58	51				
110K 00	\$W201001 ADMIN SPI FL7	HW											
110K 01	C.ADM SPI FL7 HEBBP		04	67A00		MS K	84771143ARA	1	1				30
110K 02	HLTH CARE ADM HTC		03	67A00		MS K	84771141ARA	1	1				
110K 03	MED SUP SGT HTC		E6	76J30		NC I	84771141ARA	1	1				
110K 04	SR PNT ADM SP HTC		E5	71G20		NC I	84771141ARA	3	3				
110K 05	MED SUP SGT HTC		E5	76J20		NC I	84771141ARA	2	2				
110K 06	PNT ADMIN SP HTC		E4	71G10		I	84771141ARA	5	5				
110K 07	MED SUP SP HTC		E4	76J10		I	84771141ARA	5	5				

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SECTION II PERSONNEL ALLOWANCE

PARA LINE	DESCRIPTION	ITAADS CODE	GR	MOS	ASI/LIC	BR ID	AMS	PARENT UNIT LINE TOTAL REQ AUTH	PARENT UNIT NET CHANGE REQ AUTH	ACTION RMKS PP DA CDE
710 00	\$W2DH23 DIR IND OPS	HW								
710A 00	\$W2DH23 OFC OF DIR	HW								
710A 01	DIR INDUS OP YLO		06	67K00		MS K	84779689YAS	1	1	SA
710A 02	DEPUTY DIR YLO		05	67K00		MS K	84779689YAS	1	1	SA
710A 03	MED LOG SGT YLO		E9	76J50		NC I	84779689YAS	1	1	SB
710A 04	ADMIN SP YLO		E5	71L20		NC I	84779689YAS	1	1	SB
710A 05	SECY(T) YLO		07	00318		GS C	84779689YAS	1	1	SB
	PARAGRAPH TOTALS							5	5	
710C 00	\$W2DH23 DIO PROG/MGT	HW								
710C 01	C.DIO PROG MT YLO		04	67K00		MS K	84779689YAS	1	1	
710C 02	MED SUP SGT YLO		E7	76J40 M6		NC I	84779689YAS	1	1	
710C 03	BUD ANAL YLO		11	00560		GS C	84779689YAS	1	1	SB
710C 04	SUP TECH YLO		09	02005		GS C	84779689YAS	1	0	
710C 05	SECY (T) YLO		05	00318		GS C	84779689YAS	1	1	
710C 06	SUP CLK CEEP YLO		04	02005		GS C	84779689YAS	1	0	
	PARAGRAPH TOTALS							6	4	

PREPARED ON 870617 1113 HRS
PCN ANI-601
PAGE 131

INPUT ANALYSIS REPORT 1DA-TYPE B
PART I INPUT TRANSACTION AND ERROR LISTING
WALTER REED ARMY MEDICAL CENTER

PROJECTED
TDA HSW2DHAA
CCNUM HSO288

SECTION II PERSONNEL ALLOWANCE

PARA LINE	DESCRIPTION	ITAADS CODE	GR	MOS	ASI/LIC	BR ID	AMS	PARENT UNIT LINE REQ	PARENT UNIT TOTAL AUTH	PARENT UNIT NET CHANGE REQ	ACTION RMKS PP DA CDE
7100 00	\$W2DH23 LOG AREA MGR	14W									
7100 01	LOG AREA MGR YLO		04	67K00		MS K	847796B9YAS	1	1		99
7100 01A	HS MAT OFF YLO		03	67K00		MS K	84771151YAS	3	1		
7100 02	INV MGR SP YLO		11	02003		GS C	847796B9YAS	2	1		SB
PARAGRAPH TOTALS											
711 00	MAINT DIV							6	3		
711A 00	C MAINT DIV										
711A 01	C.MAINT DIV LDA		13	01601		GM C	84771151LDA	1	1		SB
711A 02	ADMIN OFF LDA		09	00341		GS C	847796CLLDA	1	1		SB
711A 03	BUDG ASST LDA		07	00561		GS C	847796CLLDA	1	1		
711A 04	SECY(STENO) LDA		06	00318		GS C	847796CLLDA	1	1		
711A 05	CLERK TYPIST LDA		04	00322		GS C	847796CLLDA	1	0		SB
PARAGRAPH TOTALS											
711F 00	\$W2DH23 C&E REP BR	HW						5	4		
711F 01	C.COM ELEC BR LDFNA		12	00856		GS C	847796CILRH	1	0		SB
711F 02	COMM SYS SUPV LDFNA		E7	31Y40		NC I	847796CILRH	1	1		SB

DEPARTMENT OF MEDICAL ACTIVITIES ADMINISTRATION
(DMAA) QUESTIONNAIRE FOR UNIT ADMINISTRATORS

INSTRUCTIONS

This questionnaire is designed to gather information on the fifteen (15) most important job tasks that you, as a unit administrator, expect your 76J(s) (medical supply specialists) to accomplish during a normal duty day.

Please look at the following list of 76J tasks and place a "X" by the fifteen (15) tasks you consider the most important to be completed during a normal duty day by your 76J(s). (A total of 56 tasks are listed on the questionnaire).

Example: 43. X Edit a Request for Issue (4-4).

The numbers in the brackets at the end of a task (e.g. (4-4)) are a reference to the task number in the Soldier's Manual and Trainer's Guide (STP 8-76J15 SM) and have no affect on your answer.

If you do not see a task listed, please list and describe the task in the space(s) marked "OTHER" (Example: Obtain lab results).

Example: 57. X OTHER. Describe Task Obtain Lab Results

DO NOT mark more than fifteen (15) tasks.

This questionnaire is a total of six (6) pages in length.

Please return this questionnaire to your floor administrator.
Thank you for your assistance and help.

DEPARTMENT OF MEDICAL ACTIVITIES ADMINISTRATION
(DMAA) QUESTIONNAIRE FOR UNIT ADMINISTRATORS

GENERAL INFORMATION

Please complete the following information. DO NOT place your name on this questionnaire.

FLOOR ASSIGNED TO: _____ (example: 1,2,3,4,5,6,7)

Please list the job title of your 76J's immediate supervisor (to include yourself) (examples: unit administrator, nurse, wardmaster, clinic NCOIC, floor NCOIC, etc).

JOB TITLE: _____

Please list the job title(s) of other individuals that give your 76J(s) daily job tasks to complete (examples: unit administrator, nurse, wardmaster, clinic NCOIC, floor NCOIC, etc).

JOB TITLE(S): 1. _____
2. _____
3. _____
4. _____

DEPARTMENT OF MEDICAL ACTIVITIES ADMINISTRATION
(DMAA) QUESTIONNAIRE FOR UNIT ADMINISTRATORS

Place a "X" by the Fifteen (15) tasks you consider most important for your 76Js to accomplish on a daily basis.

76J JOB TASKS

1. _____ Post Transactions to the Manual Property Book (9-5).
2. _____ Read and Interpret the Army Master Data File (AMDF) (1-1).
3. _____ Process Customer Issues and Issue Supplies to Customer Units (6-4).
4. _____ Receive Supplies and Equipment (7-6).
5. _____ Prepare a DA Form 3318 (Record of Demands-Title Insert) for the First Demand of a Nonstocked (Fringe) Medical Repair Part (2-1).
6. _____ Conduct and/or Assist in Inventorying Supplies and Equipment (9-6).
7. _____ Request Supply Status for High-Priority Requests (Issue Priority Designators 01 through 08) (7-4).
8. _____ Post Partial Issue of Medical Item (Pre-Post Method) (4-1).
9. _____ Suspend Medical Material from Issue/Use (8-5).
10. _____ Store Medical Material Requiring Special Handling (5-1).
11. _____ Compute Authorized Levels for Initial and Continuing Stockage of Medical Items (EOQ Method) (3-1).
12. _____ Apply Procedures for Cancellation Requests on Requisitions (4-5).
13. _____ Process Incoming Medical Supplies (6-1).
14. _____ Request Extension of Expiration Dates on Medical Supplies (8-7).
15. _____ Prepare Emergency Request for Medical Material (03 Priority) (7-1).
16. _____ Post Quality Control Messages (SGMMA-LDT-Q) to Quality Control Register (8-1).
17. _____ Issue Supplies and Equipment to Hand Receipt Holders (9-1).

DEPARTMENT OF MEDICAL ACTIVITIES ADMINISTRATION
(DMAA) QUESTIONNAIRE FOR UNIT ADMINISTRATORS

76J JOB TASKS

18. _____ Prepare and Post Due Out Record for Medical Items (4-2).
19. _____ Receive Carrier for Unloading (6-5).
20. _____ Load/Unload a Flatbed Trailer (12-Ton S&P) (6-2).
21. _____ Report Medical Material Complaints (8-6).
22. _____ Determine Method of Obtaining Relief from Responsibility for Lost, Damaged, and Destroyed Property (9-7).
23. _____ Inventory Medical Linen (7-2).
24. _____ Maintain Quality Control and Surveillance Record for TOE Medical Assemblages (8-2).
25. _____ Request Cancellation of Supplies (7-5).
26. _____ Prepare and Maintain Hand/Sub-Hand Receipt Files (9-2)
27. _____ Record Medical Supply Transactions on Voucher Register (4-3).
28. _____ Select, Withdraw, and Prepare Supplies and Material for Issue or Shipment (6-3).
29. _____ Order Supplies and Equipment (7-3).
30. _____ Prepare and Maintain Supplemental Records for Expiration Dated Items (8-3).
31. _____ Direct the Unloading of Supplies (6-6).
32. _____ Transfer Supplies and Equipment (9-3).
33. _____ Use a Julian Date Calendar (1-2).
34. _____ Add a Medical Repair Part to the Demand Supported Prescribed Load List (PLL) (2-2).
35. _____ Prepare and Process Report of Survey (9-8).
36. _____ Interpret Priority Designator Codes (1-4).
37. _____ Select Appropriate Method of Disposal for Medical Material (8-9).
38. _____ Transport Palletized Supplies with a Forklift Truck (Rough Terrain or Conventional) to Designated Area (5-3).

DEPARTMENT OF MEDICAL ACTIVITIES ADMINISTRATION
(DMAA) QUESTIONNAIRE FOR UNIT ADMINISTRATORS

76J JOB TASKS

- 39. _____ Re-Mark Expiration Dates on Medical Supplies (8-4).
- 40. _____ Update Signature Cards (Notice of Delegation of Authority--
Receipt for Supplies) (2-4).
- 41. _____ Turn In Supplies and Equipment (7-8).
- 42. _____ Report Excess Stockage of Medical Material (3-3).
- 43. _____ Edit a Request for Issue (4-4).
- 44. _____ Prepare a Location Placard or Loose Issue Label (5-5)
- 45. _____ Research Material Release Denials (6-8).
- 46. _____ Store Controlled Items (5-2).
- 47. _____ Prepare a Property Book (9-4).
- 48. _____ Interpret Document Identifier Code (1-3).
- 49. _____ Store Supplies (5-4).
- 50. _____ Compute Authorized Stockage Levels for Medical Supplies
Using the Days of Supply (DOS) Computation (3-2).
- 51. _____ Prepare an Inventory Adjustment Report (4-7).
- 52. _____ Check the Processing of Incoming Supplies (6-7).
- 53. _____ Prepare and Maintain a Document Register (2-3).
- 54. _____ Prepare Destruction Document for Medical Material (DA Form
3161 - Request for Issue or Turn-In) (8-8).
- 55. _____ Apply Procedures for Follow-Up Requests on Requisitions
(4-6).
- 56. _____ Maintain Due-In Status File for Requested Items (7-7).
- 57. _____ OTHER. Describe Task _____
- 58. _____ OTHER. Describe Task _____
- 59. _____ OTHER. Describe Task _____
- 60. _____ OTHER. Describe Task _____

DEPARTMENT OF MEDICAL ACTIVITIES ADMINISTRATION
(DMAA) QUESTIONNAIRE FOR UNIT ADMINISTRATORS

Now that you have marked your top fifteen (15) daily tasks with a "X", please list these tasks (by question number) in order of importance for your 76J(s) to complete on a daily basis. (MOST important = 1 / LEAST important = 15).

EXAMPLE: 1 56
2 7
3 43
4 19
5 31
6 57
7 2
8 55
9 5
10 44
11 50
12 26
13 36
14 13
15 58

YOUR ANSWERS: 1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
10 _____
11 _____
12 _____
13 _____
14 _____
15 _____

DEPARTMENT OF MEDICAL ACTIVITIES ADMINISTRATION
(DMAA) QUESTIONNAIRE FOR 76Js (Medical Supply Specialists)

INSTRUCTIONS

This questionnaire is designed to gather information on the fifteen (15) job tasks most frequently, or most often, performed during a normal duty day by the Department of Medical Activities Administration's (DMAA) 76Js (Medical Supply Specialists).

Please look at the following list of 76J tasks and place a "X" by the fifteen (15) tasks you perform most frequently during a normal duty day (A total of 56 tasks are listed on the questionnaire).

Example: 43. X Edit a Request for Issue (4-4).

The numbers in the brackets at the end of a task (e.g. (4-4)) are a reference to the task number in the Soldier's Manual and Trainer's Guide (STP 8-76J15 SM) and have no affect on your answer.

If you do not see a task listed, please list and describe the task in the space(s) marked "OTHER".

Example: 57. X OTHER. Describe Task Obtain Lab results

DO NOT mark more than fifteen (15) tasks.

This questionnaire is a total of six (6) pages in length.

Please return this questionnaire to your floor NCO. Thank you for your assistance and help.

DEPARTMENT OF MEDICAL ACTIVITIES ADMINISTRATION
(DMAA) QUESTIONNAIRE FOR 76Js (Medical Supply Specialists)

GENERAL INFORMATION

Please complete the following information. DO NOT place your name on this questionnaire.

RANK: _____ (example: PFC, SP4)

FLOOR ASSIGNED TO: _____ (example: 1,2,3,4,5,6,7)

Please list the job title of your immediate supervisor (examples: unit administrator, nurse, wardmaster, clinic ncoic, floor ncoic, etc).

JOB TITLE: _____

Please list the job title(s) of other individuals that give(s) you your daily job tasks to complete (examples: unit administrator, nurse, wardmaster, clinic NCOIC, floor NCOIC, etc).

JOB TITLE(S): 1. _____
2. _____
3. _____
4. _____

DEPARTMENT OF MEDICAL ACTIVITIES ADMINISTRATION
(DMAA) QUESTIONNAIRE FOR 76Js (Medical Supply Specialists)

Place an "X" by the fifteen (15) tasks you perform most often during a normal duty day.

76J JOB TASKS

1. _____ Post Transactions to the Manual Property Book (9-5).
2. _____ Read and Interpret the Army Master Data File (AMDF) (1-1).
3. _____ Process Customer Issues and Issue Supplies to Customer Units (6-4).
4. _____ Receive Supplies and Equipment (7-6).
5. _____ Prepare a DA Form 3318 (Record of Demands-Title Insert) for the First Demand of a Nonstocked (Fringe) Medical Repair Part (2-1).
6. _____ Conduct and/or Assist in Inventorying Supplies and Equipment (9-6).
7. _____ Request Supply Status for High-Priority Requests (Issue Priority Designators 01 through 08) (7-4).
8. _____ Post Partial Issue of Medical Item (Pre-Post Method) (4-1).
9. _____ Suspend Medical Material from Issue/Use (8-5).
10. _____ Store Medical Material Requiring Special Handling (5-1).
11. _____ Compute Authorized Levels for Initial and Continuing Stockage of Medical Items (EOQ Method) (3-1).
12. _____ Apply Procedures for Cancellation Requests on Requisitions (4-5).
13. _____ Process Incoming Medical Supplies (6-1).
14. _____ Request Extension of Expiration Dates on Medical Supplies (8-7).
15. _____ Prepare Emergency Request for Medical Material (03 Priority) (7-1).
16. _____ Post Quality Control Messages (SGMMA-LDT-Q) to Quality Control Register (8-1).
17. _____ Issue Supplies and Equipment to Hand Receipt Holders (9-1).

DEPARTMENT OF MEDICAL ACTIVITIES ADMINISTRATION
(DMAA) QUESTIONNAIRE FOR 76Js (Medical Supply Specialists)

76J JOE TASKS

18. _____ Prepare and Post Due Out Record for Medical Items (4-2).
19. _____ Receive Carrier for Unloading (6-5).
20. _____ Load/Unload a Flatbed Trailer (12-Ton S2P) (6-2).
21. _____ Report Medical Material Complaints (8-6).
22. _____ Determine Method of Obtaining Relief from Responsibility for
Lost, Damaged, and Destroyed Property (9-7).
23. _____ Inventory Medical Linen (7-2).
24. _____ Maintain Quality Control and Surveillance Record for TOE
Medical Assemblages (8-2).
25. _____ Request Cancellation of Supplies (7-5).
26. _____ Prepare and Maintain Hand/Sub-Hand Receipt Files (9-2)
27. _____ Record Medical Supply Transactions on Voucher Register (4-3).
28. _____ Select, Withdraw, and Prepare Supplies and Material for
Issue or Shipment (6-3).
29. _____ Order Supplies and Equipment (7-3).
30. _____ Prepare and Maintain Supplemental Records for Expiration
Dated Items (8-3).
31. _____ Direct the Unloading of Supplies (6-6).
32. _____ Transfer Supplies and Equipment (9-3).
33. _____ Use a Julian Date Calendar (1-2).
34. _____ Add a Medical Repair Part to the Demand Supported
Prescribed Load List (PLL) (2-2).
35. _____ Prepare and Process Report of Survey (9-8).
36. _____ Interpret Priority Designator Codes (1-4).
37. _____ Select Appropriate Method of Disposal for Medical Material
(8-9).
38. _____ Transport Palletized Supplies with a Forklift Truck
(Rough Terrain or Conventional) to Designated Area (5-3).

DEPARTMENT OF MEDICAL ACTIVITIES ADMINISTRATION
(DMAA) QUESTIONNAIRE FOR 76Js (Medical Supply Specialists)

76J JOB TASKS

- 39. _____ Re-Mark Expiration Dates on Medical Supplies (8-4).
- 40. _____ Update Signature Cards (Notice of Delegation of Authority--
Receipt for Supplies) (2-4).
- 41. _____ Turn In Supplies and Equipment (7-8).
- 42. _____ Report Excess Stockage of Medical Material (3-3).
- 43. _____ Edit a Request for Issue (4-4).
- 44. _____ Prepare a Location Placard or Loose Issue Label (5-5).
- 45. _____ Research Material Release Denials (6-8).
- 46. _____ Store Controlled Items (5-2).
- 47. _____ Prepare a Property Book (9-4).
- 48. _____ Interpret Document Identifier Code (1-3).
- 49. _____ Store Supplies (5-4).
- 50. _____ Compute Authorized Stockage Levels for Medical Supplies
Using the Days of Supply (DOS) Computation (3-2).
- 51. _____ Prepare an Inventory Adjustment Report (4-7).
- 52. _____ Check the Processing of Incoming Supplies (6-7).
- 53. _____ Prepare and Maintain a Document Register (2-3).
- 54. _____ Prepare Destruction Document for Medical Material (DA Form
3161 - Request for Issue or Turn-In) (8-8).
- 55. _____ Apply Procedures for Follow-Up Requests on Requisitions
(4-6).
- 56. _____ Maintain Due-In Status File for Requested Items (7-7).
- 57. _____ OTHER. Describe Task _____
- 58. _____ OTHER. Describe Task _____
- 59. _____ OTHER. Describe Task _____
- 60. _____ OTHER. Describe Task _____

DEPARTMENT OF MEDICAL ACTIVITIES ADMINISTRATION
(DMAA) QUESTIONNAIRE FOR 76Js (Medical Supply Specialists)

Now that you have marked the top fifteen (15) daily tasks with a "X", please list these tasks (by question number) in order of importance for you to complete on a daily basis.
(MOST important = 1 / LEAST important = 15).

EXAMPLE: 1 56
2 7
3 43
4 19
5 31
6 57
7 2
8 55
9 5
10 44
11 50
12 26
13 36
14 13
15 58

YOUR ANSWERS: 1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
10 _____
11 _____
12 _____
13 _____
14 _____
15 _____

DEPARTMENT OF MEDICAL ACTIVITIES ADMINISTRATION
(DMAA) QUESTIONNAIRE FOR WARDMASTERS AND CLINIC NCOICs

INSTRUCTIONS

This questionnaire is designed to gather information on the Fifteen (15) most important job tasks that you, as a wardmaster or clinic NCOIC, expect the 76J(s) (medical supply specialists) supporting your ward or clinic to accomplish during a normal duty day.

Please look at the following list of 76J tasks and place a "X" by the fifteen (15) tasks you consider the most important to be completed during a normal duty day by the DMAA's 76J(s). (A total of 56 tasks are listed on the questionnaire).

Example: 43. X Edit a Request for Issue (4-4).

The numbers in the brackets at the end of a task (e.g. (4-4)) are a reference to the task number in the Soldier's Manual and Trainer's Guide (STP 8-76J15 SM) and have no affect on your answer.

If you do not see a task listed, please list and describe the task in the space(s) marked "OTHER" (Example: Obtain lab results).

Example: 57. X OTHER. Describe Task Obtain Lab Results

DO NOT mark more than fifteen (15) tasks.

This questionnaire is a total of six (6) pages in length.

Please return this questionnaire to your floor wardmaster.
Thank you for your assistance and help.

DEPARTMENT OF MEDICAL ACTIVITIES ADMINISTRATION
(DMAA) QUESTIONNAIRE FOR WARDMASTERS AND CLINIC NCOICs

GENERAL INFORMATION

Please complete the following information. DO NOT place your name on this questionnaire.

FLOOR ASSIGNED TO: _____ (example: 1,2,3,4,5,6,7)

Please list your job title _____

DEPARTMENT OF MEDICAL ACTIVITIES ADMINISTRATION
(DMAA) QUESTIONNAIRE FOR WARDMASTERS AND CLINIC NCOICs

Place a "X" by the Fifteen (15) tasks you consider most important for the DMAA's 76Js to accomplish on a daily basis in support of your ward or clinic.

76J JOB TASKS

1. _____ Post Transactions to the Manual Property Book (9-5).
2. _____ Read and Interpret the Army Master Data File (AMDF) (1-1).
3. _____ Process Customer Issues and Issue Supplies to Customer Units (6-4).
4. _____ Receive Supplies and Equipment (7-6).
5. _____ Prepare a DA Form 3318 (Record of Demands-Title Insert) for the First Demand of a Nonstocked (Fringe) Medical Repair Part (2-1).
6. _____ Conduct and/or Assist in Inventorying Supplies and Equipment (9-6).
7. _____ Request Supply Status for High-Priority Requests (Issue Priority Designators 01 through 08) (7-4).
8. _____ Post Partial Issue of Medical Item (Pre-Post Method) (4-1).
9. _____ Suspend Medical Material from Issue/Use (8-5).
10. _____ Store Medical Material Requiring Special Handling (5-1).
11. _____ Compute Authorized Levels for Initial and Continuing Stockage of Medical Items (EOQ Method) (3-1).
12. _____ Apply Procedures for Cancellation Requests on Requisitions (4-5).
13. _____ Process Incoming Medical Supplies (6-1).
14. _____ Request Extension of Expiration Dates on Medical Supplies (8-7).
15. _____ Prepare Emergency Request for Medical Material (03 Priority) (7-1).
16. _____ Post Quality Control Messages (SGMMA-LDT-Q) to Quality Control Register (8-1).
17. _____ Issue Supplies and Equipment to Hand Receipt Holders (9-1).

DEPARTMENT OF MEDICAL ACTIVITIES ADMINISTRATION
(DMAA) QUESTIONNAIRE FOR WARDMASTERS AND CLINIC NCOICs

76J JOB TASKS

- 18.____ Prepare and Post Due Out Record for Medical Items (4-2).
- 19.____ Receive Carrier for Unloading (6-5).
- 20.____ Load/Unload a Flatbed Trailer (12-Ton S&P) (6-2).
- 21.____ Report Medical Material Complaints (8-6).
- 22.____ Determine Method of Obtaining Relief from Responsibility for
Lost, Damaged, and Destroyed Property (9-7).
- 23.____ Inventory Medical Linen (7-2).
- 24.____ Maintain Quality Control and Surveillance Record for IDE
Medical Assemblages (8-2).
- 25.____ Request Cancellation of Supplies (7-5).
- 26.____ Prepare and Maintain Hand/Sub-Hand Receipt Files (9-2)
- 27.____ Record Medical Supply Transactions on Voucher Register (4-3).
- 28.____ Select, Withdraw, and Prepare Supplies and Material for
Issue or Shipment (6-3).
- 29.____ Order Supplies and Equipment (7-3).
- 30.____ Prepare and Maintain Supplemental Records for Expiration
Dated Items (8-3).
- 31.____ Direct the Unloading of Supplies (6-6).
- 32.____ Transfer Supplies and Equipment (9-3).
- 33.____ Use a Julian Date Calendar (1-2).
- 34.____ Add a Medical Repair Part to the Demand Supported
Prescribed Load List (PLL) (2-2).
- 35.____ Prepare and Process Report of Survey (9-8).
- 36.____ Interpret Priority Designator Codes (1-4).
- 37.____ Select Appropriate Method of Disposal for Medical Material
(8-9).
- 38.____ Transport Palletized Supplies with a Forklift Truck
(Rough Terrain or Conventional) to Designated Area (5-3).

DEPARTMENT OF MEDICAL ACTIVITIES ADMINISTRATION
(DMAA) QUESTIONNAIRE FOR WARDMASTERS AND CLINIC NCOICs

76J JOB TASKS

- 39._____Re-Mark Expiration Dates on Medical Supplies (8-4).
- 40._____Update Signature Cards (Notice of Delegation of Authority--
Receipt for Supplies) (2-4).
- 41._____Turn In Supplies and Equipment (7-8).
- 42._____Report Excess Stockage of Medical Material (3-3).
- 43._____Edit a Request for Issue (4-4).
- 44._____Prepare a Location Placard or Loose Issue Label (5-5).
- 45._____Research Material Release Denials (6-8).
- 46._____Store Controlled Items (5-2).
- 47._____Prepare a Property Book (9-4).
- 48._____Interpret Document Identifier Code (1-3).
- 49._____Store Supplies (5-4).
- 50._____Compute Authorized Stockage Levels for Medical Supplies
Using the Days of Supply (DOS) Computation (3-2).
- 51._____Prepare an Inventory Adjustment Report (4-7).
- 52._____Check the Processing of Incoming Supplies (6-7).
- 53._____Prepare and Maintain a Document Register (2-3).
- 54._____Prepare Destruction Document for Medical Material (DA Form
3161 - Request for Issue or Turn-In) (8-8).
- 55._____Apply Procedures for Follow-Up Requests on Requisitions
(4-6).
- 56._____Maintain Due-In Status File for Requested Items (7-7).
- 57._____OTHER. Describe Task _____
- 58._____OTHER. Describe Task _____
- 59._____OTHER. Describe Task _____
- 60._____OTHER. Describe Task _____

DEPARTMENT OF MEDICAL ACTIVITIES ADMINISTRATION
(DMAA) QUESTIONNAIRE FOR WARDMASTERS AND CLINIC NCOICs

Now that you have marked your top fifteen (15) daily tasks with a "X", please list these tasks (by question number) in order of importance for the DMAA's 76J(s) to complete on a daily basis. (MOST important = 1 / LEAST important = 15).

EXAMPLE: 1 56

2 7

3 43

4 19

5 31

6 57

7 2

8 55

9 5

10 41

11 50

12 26

13 36

14 13

15 58

YOUR ANSWERS: 1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

8 _____

9 _____

10 _____

11 _____

12 _____

13 _____

14 _____

15 _____

Interview Questions

1. WHAT IS YOUR HIGHEST LEVEL OF CIVILIAN EDUCATION COMPLETED?

- a. If the highest level completed is not specified as an area of healthcare administration, did the individual concentrate his/her studies in healthcare administration?

Have individual specify degree.

e.g. High School Degree, Associate of Arts/Science Degree, Baccalaureate of Arts/Science Degree, Masters of Arts/Science, etc.

- b. Do not count work experience for equivalent education as the Civilian Personnel Office does in its consideration of job applications.

2. HOW LONG HAVE YOU BEEN AN UNIT HEALTHCARE ADMINISTRATOR AT WALTER REED ARMY MEDICAL CENTER?

- a. Ask for month and year that individual began employment.
- b. Discount experience from other healthcare administration jobs except that of unit healthcare administrator at Walter Reed.

3. WHAT IS YOUR CURRENT OCCUPATIONAL CATEGORY?

Is the individual military or civilian?

4. HOW MANY MEDICAL SUPPLY SPECIALISTS (MOS 76J) DO YOU DIRECTLY SUPERVISE?

Be precise, have individual identify exact number.