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PREPARING FOR THE DOWNSIZING AND CLOSURE OF
LETTERMAN ARMY MEDICAL CENTER: A CASE STUDY

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In Partial Fulfillment of the
Requirements for the Degree
of
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by
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ABSTRACT

Letterman Army Medical Center (LAMC) is scheduled for a phased downsizing beginning in July 1991 and leading to closure by 30 June 1994. With planned future reductions in Army personnel, the downsizing and closure of LAMC may be a harbinger of future downsizings and closures of military hospitals. An analysis of the information gathered during the downsizing and closure process at LAMC can serve as an invaluable resource for medical treatment facility managers faced with similar challenges in the future. By review and analysis of documentation and by surveys of key personnel, this case study extracted and interpreted pertinent information from historical records and from personnel involved in planning for the downsizing and closure of LAMC. The review and analysis was limited to documentation produced from the December 1988 publication of the study by the Commission on Base Realignment and Closure targeting LAMC for closure through 31 December 1990. The case study quantified contacts between LAMC and external entities and internal employee groups, and it also quantified each issue recorded in the documentation archived by the LAMC Base Realignment and Closure (BRAC) Committee. The study qualitatively evaluated the importance of each issue's impact on LAMC's patient care, fiscal resources, and personnel. Finally, by using a survey, the issues identified in the review of documentation were qualitatively evaluated by LAMC managers, from the commander down through section chiefs, and by a stratified random sample of other

LAMC employees. The information in this study provides managers of military hospitals that are downsizing or closing with a summary of issues for planning, compiled by their relative importance.

Effective communication with employees and with beneficiaries was the most important and time-consuming task facing LAMC managers.

Efforts to communicate and plan effectively were complicated by political machinations that created uncertainty about the future of LAMC.

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Chapter I. INTRODUCTION

Background

The Defense Secretary's Commission on Base Realignment and Closure was chartered on 3 May 1988 to recommend military installations within the United States and its possessions for realignment and closure. The Congress and the President subsequently endorsed this approach through Public Law 100-526, Base Closure and Realignment Act, 24 October 1988. Among the recommendations in the Commission's December 1988 report was the closure of the Presidio of San Francisco, including Letterman Army Medical Center (LAMC) ("Base Realignments," 1988).

The collapse of Communism in Eastern Europe and the ensuing perception of a reduced threat of armed conflict have given additional political impetus to reducing the size of United States military forces. In spite of tensions in the Middle East, fiscal realities also support reduced expenditures on national defense. Army force reductions are projected to exceed 25% in the next five years (Donnelly, 1990). The reunification of Germany and political pressure in the Philippines may hasten the withdrawal of forces from these countries. The downsizing and closure of LAMC may be a harbinger of future downsizings and closings of military hospitals throughout the world.

LAMC is located on the historic Presidio of San Francisco, a park-like post bordered by the Pacific Ocean, the San Francisco Bay, and some of the most affluent residential areas in North America.

In 1898, at the beginning of the Spanish-American War, construction began on the original hospital facility, with the mission of providing primary healthcare to soldiers en route to combat duty in the Philippines. The U.S. Army General Hospital, Presidio of San Francisco, was renamed for Major Jonathan Letterman in 1911.

Letterman General Hospital expanded to 2,200 beds in World War I, making it the largest military hospital in the world at that time.

The hospital further expanded to 3,500 beds in World War II.

Letterman remains the only medical center in the Army that can claim the distinction of serving casualties from the Pacific theater and also thousands of liberated prisoners of war (Meines, 1990).

In 1924, intern training began at Letterman. A general surgery residency was established in 1947, and seven additional residency programs soon followed. More than 3,400 Army physicians have graduated from intern, resident, and fellowship programs at Letterman. The present modern, ten-story hospital was occupied in 1969, and in 1973, Letterman General Hospital was redesignated Letterman Army Medical Center (Meines, 1990).

As of spring 1991, LAMC was a 340-bed tertiary care teaching hospital with regional referral responsibility for all of California and Nevada, and parts of the Far East and the Pacific Basin. In fiscal year (FY) 1990, the combined military and civilian staff of 1,825 personnel supported 373,000 outpatient visits and an average daily census of 244 patients with a \$47 million budget. Retirees and their dependents accounted for 59% of outpatient visits and

70.8% of inpatient clinic visits. The physician staff of 250 included 16 fellows, 93 residents in 16 training programs, and 32 physicians in their first year of graduate medical education (GME) ("Monthly Administrative," 1990).

The downsizing and closure of LAMC was planned to be accomplished in phases. Graduate medical education at LAMC is to cease on 1 July 1991, except for the psychiatry and ophthalmology residencies. The ophthalmology residency is to cease on 1 July 1992, and the psychiatry residency is to end on 1 July 1993. From 1 July 1991 through 30 September 1991, LAMC was to transition to a 100-bed Army Community Hospital. LAMC was to be redesignated Letterman U.S. Army Hospital, the Army Medical Department Activity (MEDDAC), Presidio of San Francisco, effective 1 October 1991. Letterman was to function as a MEDDAC through September 1993, with personnel reductions to 967 by October 1991, 743 by October 1992, and 469 by October 1993. The hospital was to become an Army health clinic on 1 October 1993 and was to function as such until closure on 30 June 1994.

After the Presidio and LAMC are vacated by the Army, the property will be ceded to the Golden Gate National Recreation Area (GGNRA). GGNRA is part of the National Park Service within the Department of the Interior.

The Department of the Army has attempted in the past to close LAMC, but political forces have prevented its closure. Although the Commission on Base Realignment and Closure had the support of public

law for its closure recommendations, California politicians and medical beneficiaries attempted to forestall closure (Schlepp, 1989). These attempts continued through 1991 to save the Presidio and LAMC from closure.

In April 1991, the closure plan for LAMC was changed to extend its tenure as a medical center at least through June 1992 as a 185-bed medical center without GME, except for ophthalmology and psychiatry as noted above. The data for this study were gathered prior to this change in the downsizing plan.

One year after the December 1988 publication of the Base Realignments and Closures Report, LAMC established a Base Realignment and Closure (BRAC) Committee to oversee the LAMC downsizing and closure activities. The committee maintained detailed historical records of actions related to the closure, including correspondence related to BRAC and minutes of BRAC Committee meetings in which recommendations were made regarding plans for downsizing and closure.

Managing a facility scheduled to close and planning for its downsizing or closure pose significant management challenges. The myriad tasks required for downsizing or closing a hospital necessitate systematic planning and proper sequential execution of these tasks with sufficient lead time to assure success. Since LAMC is the first Army hospital to close since the 1973 closing of Valley Forge hospital in Phoenixville, Pennsylvania, an analysis of the downsizing and closure experience can serve as an invaluable

resource for managers of medical facilities faced with similar challenges. While Army community hospitals have been downsized to health clinics in the past, e.g., Kirk U.S. Army Hospital at Aberdeen Proving Ground, Maryland, in 1977, LAMC is the only tertiary care, teaching Army medical center to be mandated to close.

Problem Statement

The anticipated future downsizing of the Army during the next five years by approximately 30% is planned to include downsizing of at least five Army hospitals. While Army hospitals have downsized or closed in the past, experience and historical data are not available on implementing this complex process or on its impact on employees, beneficiaries, and the local community.

Review of the Literature

The financial reason for closure of civilian hospitals relates only tangentially to the factors leading to the closure of LAMC. Virtually all of the 698 nonfederal hospitals that closed in the United States during the 1980s were financially troubled ("Total Hospital", 1990). The Commission on Base Realignment and Closure studied the "military value" and potential cost reduction when choosing military bases to close (Schlepp, 1989). Based on the Commission's recommendations, five military hospitals in addition to

IAMC are slated for closure by 1995. A 1991 Department of Defense proposal calls for the Army to close five more hospitals and two more health clinics by 1997 (Tice, 1991).

Hospital closings have far-reaching impact on the overall health care system, hospitals and communities directly involved, employees, patients, and healthcare providers (Petchers, Swanker, & Singer, 1988; Doherty, O'Donovan, & O'Donovan, 1986). Announcements of closure for hospitals in financial trouble may be only two to four weeks prior to actual closing (Clarke, 1989). The maintenance of quality care, acceptable performance, and productivity are particularly challenging between the announcement of a planned hospital closure and the actual closure (Petchers et al., 1988).

The myriad issues and groups involved in hospital closure should be dealt with through use of a deliberate strategy. The pending closure of a health care organization changes its relationships with local businesses, government agencies, community groups, volunteers, donors, vendors, and the media, as well as with employees, healthcare providers, and patients (Leahigh, 1989). Mullaney (1989) suggests that a highly visible steering committee responsible for developing and implementing the overall reduction plan is critical to downsizing efforts. The committee should be composed of senior management and should represent all major areas of operation.

The psychosocial process of organizational decline can be likened to the way in which people react to death. The stages of

the response, beginning with denial, lead through anger and depression, and end with forms of acceptance (Krantz, 1985; Marks, 1988). These stages can be limited and managed effectively, but they cannot be eliminated. It is important to understand loss as part of the human side of organizational upheaval (Marks, 1988).

No matter how carefully a reduction in force is implemented and no matter how effective communication between and among affected parties may be, layoffs are a traumatic occurrence for a hospital and its employees. For the hospital to accomplish its mission of delivering quality care to its patients, it needs positive employee morale and professional satisfaction. Downsizing undermines morale and creates fear and dissension. It is not possible for the downsizing process to be painless. A good planning process, effective communication, and a comprehensive plan that avoids a piece-meal response can attenuate the pain (Mullaney, 1989).

Individuals tend to go through four stages when their jobs are terminated: the stage of uncertainty, the post-announcement stage, the exiting stage, and the resolution stage (Davis, 1988). When the stage of uncertainty begins, two-way communication between line staff, supervisors, and administrators is critical. During post-announcement stage, employees experience intense reactions, such as a sense of betrayal, hurt, or anger. An objective person, such as a social worker, can help deal with the feelings and the need to be allowed to mourn (Davis, 1988; Krantz, 1985; Marks, 1989). Kindness, empathy, and honest human concern from both

administration and survivors are essential (Davis, 1988; Leahigh, 1989). Absenteeism can be expected to increase during the first two months following employee transfers, and this absenteeism may continue for about two months (Barnes, Harmon, & Kish, 1986).

The management of an organization which is downsizing, closing, or merging must maintain credible, candid communication with employees. Well-coordinated management of personnel issues, including an extensively planned outplacement program, bolster employee morale and reduce adverse community reaction and negative publicity (Newman, 1987). McManis and Leibman (1988) recommend a human relations committee comprised of staff from various organizational units to be responsible for ensuring open, straightforward communication about employee displacement.

Mishandling employee communication risks the loss of mission purpose and concern for quality patient care (Doherty et al., 1986). Petchers et al. (1988), in their study of employees of a hospital involved in a merger, found the lack of communication of believable information during the closing process to be the worst problem area. Employees felt that they were not given access to the information necessary to make informed decisions. Straightforward communication is the key to building employee loyalty during a time of downsizing ("Corporate Downsizing," 1988). Supervisors should also be kept informed because of their great influence on attitudes of employees who are displaced (Barnes et al., 1986). As for how much to disclose and when, experience suggests that maximum disclosure of

information is helpful (Hirschhorn & Gilmore, 1983). People will always want more information, but it should be provided in context (Kennedy, 1988).

Human issues should be integrated into planning to the extent possible through highly visible, communicative management. Without official word regarding what changes to anticipate, employees rely on rumors, media accounts, and past personal or vicarious experiences. These tend to produce worst case scenarios. While a variety of communication channels can be used (letters, videos, and newsletters), meetings should be conducted, both one-on-one with key managers and large group meetings. Efforts should be made to enhance upward communication, both to give employees an outlet for venting their emotions and to help senior management to understand employees' concerns (Marks, 1989).

Organizations in situations of great uncertainty are likely to develop political power groups outside of the organization's formal structure. Organizational politics arise during periods of high uncertainty; diverse goals; and a loose, decentralized structure (Daft, 1986). Coalitions may develop to resolve differences among organizational interest groups. These coalitions may not have adequate information about alternatives when attempting to resolve disagreements about goals (Daft, 1986). Communication can counter the atmosphere of uncertainty, reducing the illegitimate power of political groups.

Leaders often serve as the focus for hostility and aggression in organizational life. An increase in acrimony can be expected when serious and threatening decisions are made during organizational decline. Long-standing conflicts emerge, interest-based groups coalesce, and staff members become envious of people in higher positions who are thought to be more secure. All of this can add to the turmoil and undermine the manager's ability to lead (Krantz, 1985).

Managers are unlikely to have had previous experience closing a hospital. Two fundamental problems with closures are lack of belief in what is being done and lack of reward. During closure activities, managers should allow staff to participate fully in the plans for closure, motivate staff, provide necessary training, adopt a participative style of management, and provide a secure environment (Dulley, 1989).

Patient care issues must be addressed during the period leading to closure. Sinusas (1989) reported that the majority (65.3%) of patients surveyed upon learning that their family physician was ending his practice felt that they themselves were responsible for locating a new physician. Some believed that the physician and his staff were responsible. The medical staff must identify patients whose discharge is not appropriate before the date of closure and coordinate alternative care plans for these patients (Clarke, 1989).

Community perceptions can be shaped. The organization should stay ahead of and on top of every development and be the first to

disclose news rather than appearing to be swept along by events. Employees should be given information before it is released to the public or the media. Negative information related to downsizing and layoffs should be presented quickly and candidly with empathy. Preemptive information defuses rumors before they build and fester (Leahigh, 1989).

The closure of a hospital has significant impact on the community, healthcare providers, employees, and patients. Managers face a difficult challenge of leading the organization and community through a complex and painful process. High quality patient care, productivity, coordination of alternate patient care, and community and media relations require a high level of commitment in the face of organizational dissolution. A key to success in this process is maintaining candid, credible, sensitive communication internally with employees and externally with physicians, patients, and the community.

Purpose

The purpose of this case study was to analyze the activities undertaken by LAMC in planning for downsizing and closure. The study quantified the constituents inside and outside the organization with whom the hospital interfaced and the issues recorded in the document repository maintained by the BRAC committee. The impact on the organization of each issue in terms of LAMC's mission of patient care, fiscal resources, and personnel

was also quantified. In addition, the study includes a time phased task schedule for managing a civilian reduction in force (RIF).

The perceptions of LAMC employees about closure issues was studied by using a survey. The survey was conducted in March 1991, prior to the change in the downsizing and closure timeline for LAMC. The survey identified employees' perceptions about the relative importance of closure issues, time requirements for managing closure issues, coordination requirements, learning requirements during the process of planning for closure, and the effectiveness of managing these issues. In addition, the survey results of senior leaders and middle managers were compared and contrasted with the results of other employees to ascertain differences in their perceptions of closure issues. Finally, the survey results about the importance of closure issues were compared and contrasted with the relative values of the issues derived from the quantitative analysis of the document repository.

Chapter II. METHODS AND PROCEDURES

This is a case study. The case study was conducted through review and analysis of documents maintained by the LAMC BRAC Committee and a survey of LAMC personnel. The review was confined to documents produced from 29 December 1988, the date of the Base Realignments and Closures report naming LAMC as a target for closure, through 31 December 1990. The closing date on the document review was required to allow time for analysis of the review, completion of the survey, and reporting of results. The case study focused primarily on plans for downsizing and closing LAMC, rather than activities implementing those plans, since the completion date of the study was prior to initial downsizing in July 1991. Evaluation of the downsizing and closure activities are beyond the scope of this study because of time constraints.

Document Review

The LAMC BRAC Committee's repository of all documentation associated with planning for the downsizing and closure of LAMC contained 438 documents dated through 31 December 1990. The documents were coded and entered into an electronic database to assist in classification and retrieval. Each document was coded with the document date, subject, originator, key words identifying issues addressed in the document, and other information not germane to this study. Each original document was reviewed to verify accuracy of information in the database. The documents included

correspondence between LAMC and Health Services Command (HSC) or Office of The Surgeon General (OTSG), minutes of meetings and teleconferences, tables of distributions and allowances (TDA), and other internal documents.

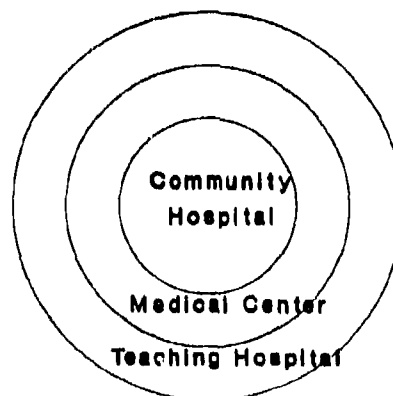
Identification of Issues

Each document was reviewed to ascertain the issues related to downsizing and closure addressed in the document. A code for each issue was assigned for each of three categories: mission, fiscal resources, and personnel.

The patient care and teaching missions of LAMC can be described as three major overlapping categories conceptualized as concentric circles. The center circle contains activities related to being a community hospital, specifically, primary and secondary patient care. The next larger circle contains the activities related to being a regional medical center, i.e., regional responsibility as a tertiary care facility and referral center, as well as a community hospital. The third and largest circle contains all the activities

Figure 1.

Mission of LAMC



related to being a teaching hospital, i.e., GME, as well as a community hospital and a regional medical center. The issues chronicled in the BRAC document repository were coded within this framework.

The mission category was coded 1 if primary or secondary care was affected, 1.5 if tertiary care was affected, and 2 if GME was affected. Because there are no clear dividing lines between primary and secondary care (Williams, 1984), these two categories were grouped together to represent the medical specialties typically found in an Army MEDDAC, based on the mission statement for the future Letterman Army Hospital. Tertiary care included all other medical specialties at LAMC. Medical specialties with GME programs were coded 2 regardless of their inclusion as primary, secondary, or tertiary care. See Appendix A for a listing of primary and secondary care medical specialties, tertiary care specialties, and GME programs.

The fiscal resources category was coded according to the number of medical care composite units (MOCUs) or supply dollars affected by each issue. Since several consumers of very large amounts of supply dollars do not generate MOCUs (pathology, pharmacy, radiology, the operating room, and central materiel supply), these areas were coded according to the supply dollars consumed. MOCUs and supply dollars equate to comparable fiscal resources since supply dollars are allocated based on workload measured in MOCUs. The MOCUs or supply dollars for identified patient care areas were

obtained from FY 1990 workload reports prepared by the LAMC Resource Management Division.

The personnel category was coded to indicate the total number of LAMC personnel, military and civilian combined, who were affected by each issue. This number was obtained from a roster of personnel assigned as of 30 September 1990. The fiscal resources and personnel categories were factored to be equally weighted, i.e., these codes became percentages of the total MCCUs for FY 1990 and total personnel assigned, respectively.

Using a roster of assigned personnel to determine the number of personnel affected by patient care issues may have overestimated this number since all hospital wards are not dedicated to single categories of patients. However, changes in patient population affect entire wards; therefore, a roster of assigned personnel represents the best method of counting employees impacted by closure issues. Attempting to determine the percentage of surgical versus medical patients on a mixed ward, for example, would have been unreliable and cumbersome due to fluctuations in patient mix and census. For patient care issues, this overestimation counteracts the underestimation of personnel caused by excluding administrative overhead, i.e., logistics, housekeeping, maintenance, patient administration, and other support personnel not directly involved in patient care.

For each issue identified, the total number of personnel and total resources affected was aggregated according to the patient

care areas involved. For example, surgical specialties were coded to include the personnel and fiscal resources in the specialty clinic and inpatient ward, operating room, anesthesiology service, central material supply, recovery room, and surgical intensive care unit. In addition, orthopedics included the cast room and brace shop. Medical specialties were coded to include personnel and fiscal resources in the specialty clinic and inpatient ward.

The reliability of the coding of values for the three categories (mission, fiscal resources, and personnel) was evaluated by correlating intra-rater and inter-rater reliability. The primary researcher coded the three categories for 25 randomly selected documents in the repository. Four weeks later, these documents were recoded. Additionally, two other officers familiar with LAMC coded the mission, fiscal resources, and personnel categories for the same 25 documents. Intra-rater and inter-rater correlation coefficients of 0.99 were obtained, indicating strong reliability of the coding procedure.

After each issue was identified and coded, a product of the three codes (mission, percent of fiscal resources, and percent of personnel) was obtained for each issue. Each issue was coded according to the specific area affected, then the products for the issue were totaled. For example, the two most frequently occurring issues in the document repository were GME ($n = 119$) and the 100-bed TDA ($n = 111$). The mission, fiscal resources, and personnel codes varied according to which hospital area was being addressed in the

document under review. A particular document may have addressed GME in the department of surgery or in the hematology/oncology service. The issue was GME, but the specific codes for each document were unique. Consequently, the summation of 21 products for GME and 35 products for the 100-bed TDA were used for ranking the issues identified during the document review. The same procedure was followed for all seven other issues having multiple codes.

The issues identified from the document repository were rank ordered according to the products obtained above. The issues were also rank ordered according to the frequency with which each issue was identified. See Appendix B for a listing of issues by each rank ordering. Rank order correlations were calculated for the top ten issues. The rank order correlation of the products to the frequencies was statistically significant ($r_s = .8667$, $n = 10$, $p < .001$). The rank order correlation of the frequencies to the products was also statistically significant ($r_s = .5512$, $n = 10$, $p < .05$). The correlations support the face validity of the coding procedure. They also suggest that a simple tabulation of the number of times each issue appeared in the documentation would be almost as valid an indicator of the impact of each issue on the organization as the elaborate coding procedure.

Internal and External Constituents

Using the document repository as a source, the constituents involved in each downsizing and closure issue were identified, both inside and outside LAMC, and the number of contacts with each constituent was tallied. The internal constituents were staff physicians, physicians in GME programs, other military personnel, and civilian personnel. Further disaggregation of internal constituents did not add useful information, since the case study focuses on issues related to closure rather than on employee groups.

External constituents were identified, and the number of contacts with each group was quantified. Included among the external constituents are LAMC beneficiaries. Although all patient care issues impacted beneficiaries, only those issues that directly involved communication with the beneficiary community were included, i.e., beneficiary counseling on alternative sources of care, correspondence with retiree organizations, and newsletters to beneficiaries. See Appendix C for a list of internal and external constituents and the number of contacts identified in the document review.

New Structures

All structures and dedicated personnel that emerged to support the downsizing and closure effort were identified and discussed in this study.

The above analysis of activities recorded by the BRAC Committee gave a surrogate indication of the activities that demanded the most time and had the greatest potential impact on the organization. However, a quantitative analysis alone could not adequately address the complexities of managing the downsizing and closure of LAMC. The judgments of the people involved in these activities provided critical input for capturing the qualitative aspects of the importance of the activities and the challenges encountered while planning for downsizing and closure.

Employee Survey

A survey was developed using the top ten issues from the document review rank ordered according to the product of the mission, fiscal resources, and personnel codes. The survey identified employees' perceptions about the importance of each issue to the organization and to them personally, time management requirements for each issue, and coordination requirements for managing each issue. The survey also asked employees to indicate their perceptions about the learning required to manage downsizing and closure issues, since LAMC personnel were not experienced at closing hospitals. Finally, employees' perceptions about the effectiveness of the management of each issue were ascertained. Because the survey was conducted in March 1991, the opinions gathered reflected a general belief that LAMC would downsize and close according to the timeline described previously.

The survey was pretested using a group of ten volunteers, including officer, enlisted, and civilian personnel. The average time for completing the survey by these volunteers was found to be ten minutes, and this information was included in the survey cover letter. The respondents were interviewed about the survey content to evaluate face validity of the survey, and they were in good agreement with the surveyor about the intent of the survey items. They also provided helpful comments about the layout of the survey instrument. See Appendix D for the survey instrument.

LAMC employees in key leadership positions and a cross-section of other hospital employees were surveyed. Seventy-one personnel in the top four echelons of management were specifically targeted, i.e., the hospital commander down to section chief level, to include all teaching chiefs of GME training programs. Two hundred other employees were randomly sampled. The random sample was stratified by rank or grade (all wage grades through GS-8, GS-9 through GS-14, E-1 through E-5, E-6 through E-9, W-1 through O-3, and O-4 through O-6) so that a representative sample was obtained. Civilian employees were divided between GS-8 and GS-9 because most positions considered professional in nature rather than administrative are graded GS-9 or above. For enlisted personnel, E-6 is arguably the entry level for senior enlisted positions, and officers were naturally divided between company grade and field grade. All 13 personnel who were assigned to the targeted management positions at the time of the closure announcement, but had since departed, were

surveyed by mail. The random sample was selected from a personnel roster of all LAMC employees arranged by pay grade. A random numbers table was used for selecting individuals from the roster. See Appendix E for a list of the positions of personnel surveyed.

The surveys were addressed to each selected individual by name and sent through internal mail. The cover letter for the survey was signed by the deputy commander for administration/chief of staff, and respondents were asked to return the survey within two weeks. The surveys were coded to indicate the addressee to allow complete demographic information to be collated with the survey results. Personnel in the targeted management positions were contacted to encourage maximum response. All survey responses were grouped for analysis, and the identity of each respondent remained confidential.

The survey instrument allowed respondents to add up to three issues of importance for each item. Ten respondents added comments to a total of 42 survey items. Providing respondents the opportunity to add comments to the survey strengthened its validity by assuring that issues were not omitted that respondents perceived as critical. Since fewer than 10% of the respondents added comments, the face validity of the survey instrument was strengthened.

The return rate for the survey was 94.8% for the targeted managers currently assigned to LAMC, 31% for the stratified random sample, and 53.8% for managers previously assigned to LAMC, for an overall return rate of 44.3%. For the stratified random sample, the

percentage of respondents by pay grade closely approximated the percentage of employees assigned by pay grade (see Table 1). This close approximation strongly suggests that the random sample was representative of all IAMC employees. The range of responses to survey items was at least 1 to 5 for all except four survey items. (A zero was entered for survey items with no response.) The variance for survey items for the stratified random sample ranged from .4868 to 2.5978. The variance of the survey responses suggests that the responses of the sample were representative of all IAMC

Table 1.
SURVEY RETURNS
Stratified Random Sample

Pay Grade	Assigned	Percent	Surveys		
			Sent	Returns	Percent
WG - GS8	624	35.6	71	22	35.5
GS9 - GS14	197	11.2	22	7	11.3
E-1 - E-5	406	23.2	47	11	17.7
E-6 - E-9	134	7.6	15	6	9.7
W-1 - O-3	271	15.6	32	7	11.3
O-4 - O-6	120	6.8	13	9	14.5
Total			200	62	31.0
Executives and Middle Managers			58	55	94.8
Previously Assigned			13	7	53.8
Overall			271	120	44.3

employees since responses tended not to be tightly clustered around particular ratings. See Appendix F for descriptive statistics of overall survey responses and the variance of responses from the stratified random sample.

Demographic data obtained with each survey included date assigned to IAMC; military status; and healthcare provider, physician, nurse, resident, and teaching staff or not. Survey

results were tabulated by group of participants, i.e., executives (commander, deputy commander for clinical services, deputy commander for administration, deputy commander for veterinary services, dental activity commander, and command sergeant major), middle managers (third and fourth echelons of management), physicians, nurses, civilian personnel, military personnel, teaching staff, clinical and non-clinical staff. Responses were not grouped by residents because of the small number of responses ($n = 2$). In addition, surveys were coded to indicate respondents assigned to IAMC at least since January 1989, when the future closure of IAMC was announced. Employees not assigned to IAMC since at least July 1990 were excluded from the survey.

A randomized blocks analysis of variance was calculated for the survey instrument to compute Cronbach's α as a reliability measure. Because of the large number of survey items ($n = 80$) and survey respondents ($n = 120$), the survey questions were paired for calculating the analysis of variance. The computed Cronbach's α values were as follows: questions 1 and 2 --.83, questions 3 and 4 --.85, questions 5 and 6 --.89, and questions 7 and 8 --.88. The computed Cronbach's α indicated strong reliability of the survey instrument.

The survey responses were grouped by sub-item, i.e., all first sub-items under each question, all second sub-items under each question, etc., for all eight questions. A randomized blocks analysis of variance was calculated for sub-items to compute

Cronbach's α as a measure of internal consistency. The computed Cronbach's α of .76 shows high internal consistency, a measure of validity. All sub-items showed significant positive item-to-item correlation and whole-part correlation, indicating strong content and construct validity. This shows that each survey sub-item was a significant contributor to the overall survey score, and none of the items was a negative contributor.

Means and standard deviations were calculated for all survey sub-items for all survey responses and for the following groups: executives, middle managers, all others, former managers, and present executives and middle managers combined (see Appendix F). A Student's t test was calculated for each sub-item comparing present managers' responses with former managers' responses. A multivariate correlation analysis was conducted to determine significant relationships among all sub-item responses according to the following groups: executives, middle managers, physicians, nurses, clinicians, military personnel, and employees assigned to LAMC prior to January 1989.

The results of the survey about the importance of the issues were compared and contrasted with the values of the issues derived from the document review. This comparison of survey results was grouped by executives, middle managers, and all other employees.

Time-Phased Task Schedule for Reduction in Force

A time-phased task schedule for managing civilian employees during a RIF was developed by reviewing with the chief of Manpower and Documents, Resource Management Division, LAMC, the tasks performed and planned for LAMC's RIF. See Appendix G for the time phased task schedule for managing a RIF. The Reduction in Force Information Pamphlet published by the Office of the Assistant Secretary of Defense for management and personnel provides information for employees who will be affected by a RIF.

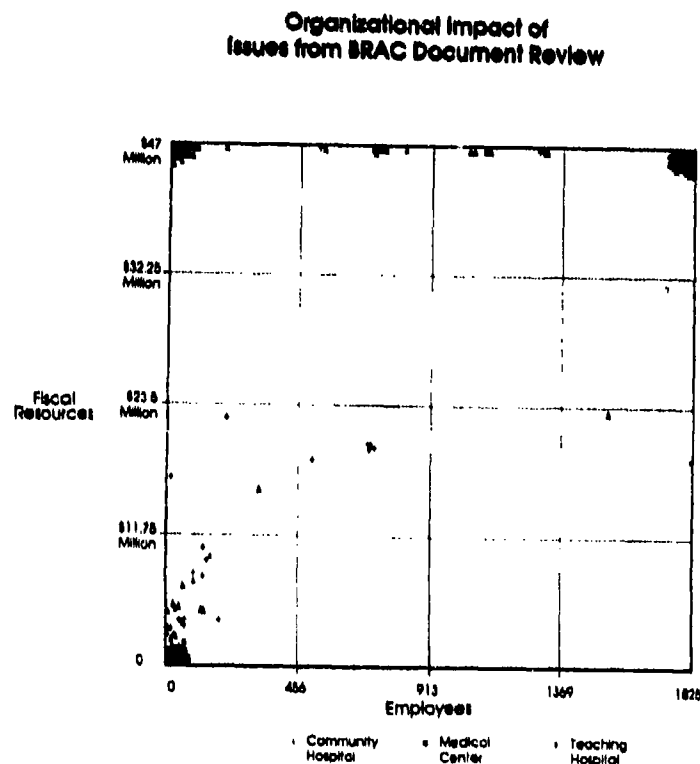
Chapter III. RESULTS

Document Review

Identification of Issues

The downsizing and closure issues identified during the document review are represented in Figure 2 according to their relative impact on LAMC in the areas of mission, fiscal resources, and personnel. Appendix B contains a listing of the issues rank ordered by the product of the mission, fiscal resources, and personnel factors and another listing rank ordered by the frequency with which each issue was identified in the document repository. These listings give an indication of the relative importance of each issue to LAMC and an approximation of the relative amounts of time required to manage each issue.

Figure 2.



Internal and External Constituents

A total of 823 contacts with various constituents was identified during review of the BRAC document repository. Of these, 569 (69.1%) involved internal constituents, and 254 (30.9%) involved external constituents. The number of contacts for internal constituents was civilian employees (n = 165, 30%), military employees (n = 161, 28.3%), physicians in GME (n = 134, 23.5%), and other physicians (n = 109, 19.2%). More than half of all contacts with external constituents were with HSC (n = 80, 31.6%), OTSG (n = 32, 12.6%), and LAMC beneficiaries (n = 26, 10.2%). Sixteen other external entities were identified with whom LAMC had contact during planning for downsizing and closure. See Appendix C for a listing of the internal and external constituents and the respective percentages of contacts.

New Structures

Several structures and dedicated positions arose to support the LAMC downsizing and closure activities. A BRAC committee was formed in January 1990 to oversee and coordinate all activities related to downsizing and closure. The full-time committee chair was a senior staff physician with extended tenure at LAMC, and the co-chair was the chief of the Department of Clinical Investigation. The committee reported directly to the LAMC commander. Members of the committee were the deputy commanders for administration and clinical services, department chiefs, assistant administrators, and the

public affairs officer. In addition, the former assistant chief nurse was dedicated to full-time duty with the BRAC committee.

A logistics officer was dedicated full-time to responsibilities associated with downsizing and closure. Redistribution of medical equipment after the cessation of GME programs, as well as movement and disposal of other property items required the full-time assistance of a senior enlisted logistics technician.

Drop boxes were placed in public areas throughout LAMC for employees to anonymously submit questions about the downsizing and closure. The public affairs office retrieved the questions and answered them in a regular column in the biweekly LAMC news publication.

The Resource Management Division coordinated several job fairs for civilian employees who anticipated displacement as a result of the downsizing. Representatives of the civilian personnel office from MAMC presented job opportunities for personnel whose jobs were integral with GME programs relocating to MAMC. Other job fairs included representatives from Oakland Naval Hospital, David Grant Medical Center, Travis Air Force Base, and the San Francisco Veterans Administration Medical Center. These job fairs resulted in accelerated attrition of LAMC employees.

The LAMC Social Work Service introduced an employee support group in April 1991 targeted toward civilian employees to assist in coping with the stress of the RIF. The group met weekly with representatives from Social Work Service, Psychiatry Service, and

the Chaplains' Office as facilitators. The support group met during normal (day shift) duty hours.

In September 1990, a reserve officer who was activated in support of Operation Desert Shield was tasked with establishing a beneficiary information initiative. This officer's background as a doctoral level research psychologist who headed his own marketing research firm ideally suited him for this project. The beneficiary information initiative developed information about alternative sources of care, the Civilian Health and Medical Plan for Uniformed Services (CHAMPUS), the CHAMPUS Reform Initiative (CRI), Medicare, and supplemental insurance plans for CHAMPUS and Medicare. A booklet with information about CHAMPUS, Medicare, supplemental insurance plans, and agencies that assist with alternative health plans was mailed to approximately 50,000 LAMC beneficiaries in March 1991. The mailing included a letter from the LAMC commander explaining the purpose of the booklet, the timeline for the downsizing of LAMC, and a contact telephone number for the Beneficiary Information Office. A return postcard in the mailing surveyed the recipients about their expected alternative sources of care and how they planned to finance their medical care.

The Beneficiary Information Office provided ongoing counseling for all interested beneficiaries about alternative sources of care, CHAMPUS, Medicare, and supplemental insurance. Personnel from this office also provided weekly briefings about these issues to all interested personnel. The briefings were by a CHAMPUS/CRI

representative and by a representative from the Health Insurance Counseling and Advocacy Program, a program funded by the California Department of Aging designed to assist seniors with health insurance.

The beneficiary information initiative developed a follow-up referral form for physicians to use when counseling patients about follow-up services that would not be available from LAMC. The LAMC overprint for Standard Form (SF) 600, Chronological Record of Medical Care (see Appendix H), was designed to facilitate physician/patient communication about future availability of services at LAMC and to protect LAMC from exposure to claims of patient abandonment.

Employee Survey

The overall means, standard deviations, and ranges of ratings for each survey item are in Appendix F. Table 2 shows the ten survey items for questions one and two (importance of each issue to LAMC and importance of each issue to the respondent individually) rank ordered according to mean scores by total survey respondents, executives, middle managers, and all others. The sequence of relative importance of these items derived from the document review (DR) is in the far right column.

Table 3 shows the ten survey items for questions three and four (individuals' time and lead time required for addressing each issue) rank ordered according to mean scores by total survey respondents,

executives, middle managers, and all others. Table 4 shows the ten survey items for questions five and six (internal coordination and external coordination required for managing each issue) rank ordered according to mean scores by total survey respondents, executives, middle managers, and all others.

Table 5 shows the ten survey items for question seven (amount of learning required to effectively manage each issue) rank ordered according to mean scores by total survey respondents, executives, middle managers, and all others. Table 6 shows the ten survey items for question eight (how effectively issues were managed) rank ordered according to mean scores by total survey respondents, executives, middle managers, and all others.

Possible differences in ratings for survey items were examined for former managers at LAMC and present managers (executives and middle managers). A Student's t test for mean differences for the 80 survey items indicated that a statistically significant difference existed between the former managers and present managers on 13 survey items. See Table 7 for the items with significant differences.

Table 2. RELATIVE IMPORTANCE
To LAMC

	Total	Execs	Mid Mgr	Other	DR
Communication with LAMC employees	1	1	1	1	9
Closure timeline and tasks	2	2	3	3	3
Civilian RIF	3	3	4	1	7
Communication with beneficiaries	4	3	1	5	8
Health record and X-ray disposition	5	6	5	4	6
100-bed TDA	6	5	6	6	4
GME	7	8	7	9	10
Space utilization	8	7	9	7	5
Equipment distribution	9	9	8	7	1
Future lease of LAMC building	10	10	10	10	2

To Individuals

	Total	Execs	Mid Mgr	Other	DR
Communication with LAMC employees	1	1	1	1	9
Closure timeline and tasks	2	3	2	3	3
Civilian RIF	3	6	4	2	7
100-bed TDA	4	2	3	4	4
Communication with beneficiaries	5	6	5	6	8
Space utilization	6	5	6	5	5
Equipment distribution	7	9	7	7	1
Health record and X-ray disposition	8	8	8	8	6
GME	9	3	9	9	10
Future lease of LAMC building	10	10	10	10	2

Table 3. TIME REQUIREMENTS
For Individuals

	Total	Execs	Mid Mgr	Other
Civilian RIF	1	3	2	1
Communication with LAMC employees	2	4	3	2
Closure timeline and tasks	3	1	4	4
100-bed TDA	4	2	1	5
Equipment distribution	5	9	8	2
Space utilization	5	5	5	5
GME	7	7	7	8
Communication with beneficiaries	8	6	6	7
Health record and X-ray disposition	9	8	9	8
Future lease of LAMC building	10	9	10	10

For Prior Planning

	Total	Execs	Mid Mgr	Other
Closure timeline and tasks	1	1	1	1
Civilian RIF	2	2	4	2
100-bed TDA	3	3	3	2
Communication with LAMC employees	4	5	2	4
Communication with beneficiaries	5	8	5	5
Equipment distribution	6	9	7	7
GME	7	3	6	10
Space utilization	8	6	9	6
Health record and X-ray disposition	9	7	8	9
Future lease of LAMC building	10	10	10	8

Table 4. COORDINATION REQUIREMENTS

Internal				
	Total	Execs	Mid Mgr	Other
Closure timeline and tasks	1	4	2	1
100-bed TDA	2	1	1	3
Communication with LAMC employees	3	6	3	2
Civilian RIF	4	3	3	3
Space utilization	5	1	3	6
Equipment distribution	6	7	7	5
Communication with beneficiaries	7	7	6	7
GME	8	5	8	9
Health record and X-ray dispositio	9	9	9	7
Future lease of LAMC building	10	10	10	10

External				
	Total	Execs	Mid Mgr	Other
Future lease of LAMC building	1	1	1	1
Communication with beneficiaries	2	7	1	2
Civilian RIF	3	4	3	4
GME	4	2	4	5
Equipment distribution	5	3	5	6
Health record and X-ray disposition	6	10	7	2
Closure timeline and tasks	7	4	6	7
100-bed TDA	8	6	8	8
Communication with LAMC employees	9	9	9	8
Space utilization	10	8	10	10

Table 5. AMOUNT OF LEARNING REQUIRED
For Effective Management

	Total	Execs	Mid Mgr	Other
Civilian RIF	1	4	1	2
Closure timeline and tasks	2	1	2	1
Communication with beneficiaries	3	4	3	4
Communication with LAMC employees	4	7	3	4
Future lease of LAMC building	5	1	7	3
Health record and X-ray disposition	6	4	5	7
100-bed TDA	7	8	7	6
GME	8	3	6	8
Equipment distribution	9	9	9	9
Space utilization	10	9	10	9

Table 6. EFFECTIVENESS OF MANAGEMENT

	Total	Execs	Mid Mgr	Other
Communication with LAMC employees	1	1	1	1
GME	2	2	2	2
Communication with beneficiaries	3	2	3	8
Closure timeline and tasks	4	4	5	5
Civilian RIF	5	6	6	3
Equipment distribution	6	8	4	7
100-bed TDA	7	7	7	4
Space utilization	8	5	8	6
Health record and X-ray disposition	9	9	9	9
Future lease of LAMC building	10	10	10	10

Table 7. SURVEY ITEMS DIFFERENT
For Present and Former Managers

Items Rated Higher by Former Managers Than Present Managers

- Importance to you personally of RIF
- Importance to you personally of communication with employees
- * Amount of time required to manage communication with employees
- * Lead time required to manage closure timeline and associated tasks
- * Coordination outside LAMC for medical equipment distribution

Items Rated Lower by Former Managers Than Present Managers

- * Importance to LAMC of the 100-bed TDA
- * Importance to LAMC of space utilization
- Lead time required to manage space utilization
- Lead time required to manage communication with beneficiaries
- Amount of internal coordination required to manage space utilization
- Effectiveness with which medical equipment distribution was managed
- Effectiveness with which the 100-bed TDA was managed
- * Effectiveness with which space utilization was managed

p < .05, * p < .01

Tables 8-15 show the results of a multivariate correlation analysis of the responses to survey items according to the following groups: executives, middle managers, physicians, nurses, all clinicians, military personnel, and employees assigned to LAMC prior to January 1989. Asterisks (*) indicate significant correlations under a 2-tailed test for significance (α .05, $n = 120$).

Table 8.

CORRELATION MATRIX
Relative Importance to LAMC

	AD	Clin	Nurse	MD	Pre-89	Exec	MMar
Equipment distribution	-.23*	-.14	.08	-.18*	.02	-.21*	-.04
Future lease of LAMC building	-.19*	.13	.10	.04	.02	-.15	-.13
Closure timeline and tasks	-.06	-.12	.09	-.14	-.04	.06	.06
100-bed TDA	-.10	.00	.20*	.02	-.07	-.01	.01
Space utilization	-.24*	.11	.11	.02	.04	.03	-.16
Health record/x-ray disposition	-.12	-.02	-.01	.01	.14	-.07	-.05
Civilian RIF	-.22*	-.03	.01	-.11	.14	-.01	-.03
Communication with beneficiaries	.21*	-.03	-.04	.07	.04	.00	.17
Communication with LAMC employees	.00	.00	.04	-.06	.11	.10	.04
GME	.05	.08	-.05	.11	.08	-.02	.09

critical value (two-tail, alpha .05) = +/- .17928 * p < .05

Table 9.

CORRELATION MATRIX
Relative Importance to Individuals

	AD	Clin	Nurse	MD	Pre-89	Exec	MMar
Equipment distribution	.03	.02	.04	-.03	-.03	-.12	-.02
Future lease of LAMC building	-.12	.01	.09	.01	.07	-.12	-.06
Closure timeline and tasks	-.07	-.11	.02	-.19	.05	-.02	.10
100-bed TDA	.01	.03	.15	-.11	.11	.05	.16
Space utilization	-.04	-.01	.11	-.05	-.01	.04	-.10
Health record/x-ray disposition	.02	.16	.02	.29*	.19	-.07	.01
Civilian RIF	-.38*	-.09	.07	-.24*	.23*	-.11	-.02
Communication with beneficiaries	.11	.23*	.09	.23*	.20*	-.03	.08
Communication with LAMC employees	-.14	-.04	.15	-.17	.27*	.05	.07
GME	.08	.25*	-.14	.46*	.14	.08	.03

critical value (two-tail, alpha .05) = +/- .17928 * p < .05

Table 10.

CORRELATION MATRIX
Time Requirements for Individuals

	AD	Clin	Nurse	MD	Pre-89	Exec	NMar
Equipment distribution	.15	-.07	-.05	-.08	-.04	-.12	-.01
Future lease of LAMC building	-.11	-.12	-.03	-.04	.04	.04	-.04
Closure timeline and tasks	.11	-.05	.02	-.11	.05	.17	.13
100-bed TDA	.27*	.02	.13	-.02	-.07	.06	.34*
Space utilization	.09	-.01	.05	-.03	.00	.03	.19
Health record/x-ray disposition	.15	.00	-.12	-.17	.11	.02	.01
Civilian RIF	-.02	.04	.03	-.10	.10	.00	.18*
Communication with beneficiaries	.10	.20*	-.03	.29*	.17	.04	.13
Communication with LAMC employees	.06	.04	.14	-.06	.03	.00	.19*
GME	.18	.27*	-.17	.55*	.18	.01	.18*

critical value (two-tail, alpha .05) = +/- .17928 * p < .05

Table 11.

CORRELATION MATRIX
Time Requirements for Prior Planning

	AD	Clin	Nurse	MD	Pre-89	Exec	NMar
Equipment distribution	.14	-.16	.15	-.13	-.14	-.03	.08
Future lease of LAMC building	-.07	-.06	.18*	-.12	-.10	.01	-.07
Closure timeline and tasks	.29*	.06	.02	.05	-.04	.16	-.01
100-bed TDA	.12	.09	.03	.04	.05	.11	.04
Space utilization	.01	.07	.12	-.06	-.02	.08	-.09
Health record/x-ray disposition	.16	.07	.00	.14	-.06	.06	.03
Civilian RIF	.02	.00	.03	-.15	.10	.13	.02
Communication with beneficiaries	.15	.10	.09	.07	-.05	-.03	.10
Communication with LAMC employees	.11	.13	.14	.00	.07	.05	.08
GME	.14	.10	.00	.20	.02	.14	.13

critical value (two-tail, alpha .05) = +/- .17928 * p < .05

Table 12.

CORRELATION MATRIX
Coordination Requirements: Internal

	AD	Clin	Nurse	MD	Pre-89	Exec	HMar
Equipment distribution	-.02	-.14	.12	-.23*	-.01	-.05	.03
Future lease of LAMC building	-.09	.20	.08	.01	.11	-.11	-.13
Closure timeline and tasks	.08	-.04	-.02	-.05	-.01	.03	-.03
100-bed TDA	.16	.22*	.07	.14	.09	.12	.13
Space utilization	.12	.09	.08	.01	-.06	.19*	.08
Health record/x-ray disposition	.00	.18	-.02	.09	.16	-.04	-.07
Civilian RIF	-.05	.09	.05	-.02	.05	.11	.02
Communication with beneficiaries	.12	.27*	.06	.13	.12	-.03	.08
Communication with LAMC employees	.09	.08	.10	-.07	.06	-.03	-.01
GME	.15	.17	-.10	.22*	.13	.10	.09

critical value (two-tail, alpha .05) = +/- .17928 * p < .05

Table 13.

CORRELATION MATRIX
Coordination Requirements: External

	AD	Clin	Nurse	MD	Pre-89	Exec	HMar
Equipment distribution	.05	-.01	.02	.05	.17	.10	.05
Future lease of LAMC building	.05	.21*	.17	.14	-.08	.08	-.09
Closure timeline and tasks	.06	.29*	.07	.17	.15	.13	.06
100-bed TDA	.07	.31*	.14	.18	.16	.13	.05
Space utilization	-.23*	.12	.05	.02	.02	.11	-.25*
Health record/x-ray disposition	-.14	.05	.09	-.10	.06	-.22*	-.09
Civilian RIF	.02	.09	.12	-.02	.02	.04	.04
Communication with beneficiaries	.05	.16	.17	-.01	.11	-.12	.08
Communication with LAMC employees	-.13	.11	.00	.06	.18*	-.05	.05
GME	.08	.12	.01	.18*	.05	.12	.07

critical value (two-tail, alpha .05) = +/- .17928 * p < .05

Table 14.

CORRELATION MATRIX
Learning Required for Effective Management

	AD	Clin	Nurse	MD	Pre-89	Exec	MMar
Equipment distribution	.04	.01	.14	-.01	.04	.04	.03
Future lease of LAMC building	.02	.19	.18	.07	-.01	.19*	-.08
Closure timeline and tasks	.02	.03	.06	.00	.02	.15	-.03
100-bed TDA	.02	.19	.05	.14	.15	.02	.01
Space utilization	-.04	.14	.14	-.01	.11	.07	-.07
Health record/x-ray disposition	.09	.20*	.24*	.10	.10	.11	.07
Civilian RIF	.01	.03	.13	-.06	.15	.02	.17
Communication with beneficiaries	.12	.10	.15	.04	.02	.07	.07
Communication with LAMC employees	-.03	.02	.07	-.05	.05	.04	.08
GME	.13	.17	.07	.21*	.16	.14	.08

critical value (two-tail, alpha .05) = +/- .17928 * p < .05

Table 15.

CORRELATION MATRIX
Effectiveness of Management

	AD	Clin	Nurse	MD	Pre-89	Exec	MMar
Equipment distribution	.03	-.15	-.06	-.05	-.08	-.05	.16
Future lease of LAMC building	-.01	.03	.14	-.07	-.10	-.12	-.01
Closure timeline and tasks	.06	-.06	-.01	-.01	-.18	.13	.05
100-bed TDA	.03	.02	.09	-.06	-.12	-.01	-.02
Space utilization	-.01	-.13	.04	-.07	-.20*	.08	.01
Health record/x-ray disposition	.12	-.06	.00	-.12	-.03	-.10	.08
Civilian RIF	.12	-.15	.02	-.13	-.18	-.01	.04
Communication with beneficiaries	.13	-.03	-.01	.05	-.17	.17	.14
Communication with LAMC employees	.16	-.12	-.09	.06	-.15	.15	.17
GME	.12	.08	.02	.16	-.05	.12	.17

critical value (two-tail, alpha .05) = +/- .17928 * p < .05

Ten survey respondents added a total of 42 comments on their surveys. The 73-bed TDA and transfer of administrative functions were added to all eight survey questions. The following additional items were added to question one, importance to LAMC: communication of ERAC issues, military reutilization and military RIF, staffing ERAC committee decisions, medical-legal liability of individuals and HSC, and health care for beneficiaries. Additional comments to question two (importance to individuals) were communication of ERAC issues, continuity of healthcare for dependents, military RIF, medical-legal liability of individuals and HSC, and health care for beneficiaries. Two additional comments for question three (amount of time required of you) were managing the reduction of medical supplies and making up for ERAC decision affecting my department. These issues were added to question four (amount of prior planning): healthcare for dependents after downsizing, future positions for active duty, consolidation of services/physician utilization, and reduction of medical supplies. Providing continued care for dependents and coordination for military transfers were additional issues requiring coordination with outside entities (question six). One respondent indicated that the ERAC committee needed to learn what staffing means, how clinics work, and how the civilian personnel office works (question seven). All of the issues added to the questions were rated high (four or five) by respondents, except

for the lone comment added to question eight (how well issues were managed). One responded rated as one (least well managed) how clearly service chiefs were made aware of their authority.

Five of the additional comments related to patient care issues. Five comments related to military transfers or reductions, four comments related to medical legal liability, and three comments related to communication. The other comments appeared to relate directly to the position of the person responding to the survey.

Chapter IV. DISCUSSION

Document Review

Identification of Issues

The issues identified in the document review pertained mostly to LAMC as an organization rather than to specific internal items. The BRAC committee focused on global issues more than on department or section issues early in the planning process. The level of detail in the documents increased as time passed and the focus of the planning process progressed from general to specific.

The coding system for rating the relative importance of the issues identified during the document review weighted issues affecting the entire organization highest. Therefore, some issues were rated higher than might have reflected their true impact on LAMC or the amount of time required to manage the issue. For example, the future lease of the LAMC building rated second highest, but the impact on the operation of LAMC was negligible. LAMC personnel had no authority to decide the future fate of the facilities since the property is to be ceded to the GGNRA. All survey respondents rated the future lease of the property the lowest in all categories except for coordination requirements with outside entities. Responses from the surveys helped clarify the true importance of the issues identified during the document review.

The document review revealed all the issues that LAMC faced while planning for downsizing and closure. Some of the issues were unique to LAMC, such as coordination with the San Francisco Medical

Command and Oakland Naval Hospital. Some of the issues were unique to teaching hospitals, such as discontinuing GME and the associated requirements for withdrawing training program certification and relocating staff and equipment. However, the identified issues can serve as a template for other military hospitals facing downsizing and closure. Included were personnel management items such as staff communication, stress management, the civilian employee RIF, and a freeze of movement by military personnel. Patient care issues included planning for disposition of health records and x-rays, communicating with beneficiaries about alternative sources of care, determining how the downsizing and closure would affect them, and financing the anticipated increase in civilian source prescriptions while operating with a reduced budget, and caring for patients with HIV disease. Internal management issues included planning for downsized TDAs, space utilization, managing BRAC dollars, outlining a detailed time-phased task list for all closure activities, and planning for equipment redistribution and property disposal. Coordination with the community required planning for emergency services, determining the impact of closure on city ambulance services, writing news releases, and coordinating media relations. Other more obscure issues identified were preserving historic items, planning for a homecoming celebration for the last graduating GME class and an appropriate ceremony marking the retirement of the IAMC colors, and relinquishing support responsibility for the local Military Entrance Processing Station.

The hospital closure literature has a recurrent theme of the importance of candid, credible communication with employees during a time of organizational upheaval. LAMC invested time and energy into communicating with employees, as identified in the document review and according to the survey ratings. This same level of communication is also imperative for hospital beneficiaries and the local community. The document review indicated that LAMC also committed tremendous resources to educating the beneficiary community about the status of the downsizing and closure as well as alternative sources of medical care and cost reimbursement.

Identification of Constituents

The impact of the issues identified in the document review was relatively similar for the four groups of internal constituents: civilian employees (30%), military employees (28.3%), physicians in GME programs (23.5%), and other physicians (19.2%).

For entities outside of LAMC, contacts were made most frequently with LAMC's higher headquarters (HSC--31.6% and OTSG--12.6%). The next most frequent outside entity was the beneficiary community. Coordination requirements were also high for Madigan Army Medical Center (MAMC), since regional responsibilities and several graduate medical education programs with their staff and equipment were to be relinquished to MAMC. Correspondence with residency review committees was required for voluntary withdrawal of GME program certifications. Coordination for continuing beneficiary

care accounted for more than 13% of contacts with outside entities, which included the Oakland Naval Hospital, Foundation Health Corporation (the CRI contractor), and San Francisco Medical Command. The future owner of the Presidio of San Francisco and the LAMC facility, the GGNRA, accounted for the next largest number of external contacts. Other outside communication was with government agencies, members of Congress, and Army agencies.

The communication with outside entities consisted of coordination with higher headquarters, the future owners of LAMC's missions of GME and patient care, and the future owner of LAMC real estate. The other communications were ad hoc and defy categorization.

New Structures

The formation of a ERAC committee to oversee and coordinate the activities related to downsizing and closure was consonant with good management practice (Mullaney, 1989). The full-time assignment of the chair of the ERAC committee gave the committee an identity and a focal point for all coordination and questions. His accountability directly to the LAMC commander facilitated critical communication with and access to the ultimate decision authority.

The leadership of LAMC recognized early in the planning process that some of the downsizing and closure tasks were too time-consuming to be absorbed into the regular duties of hospital personnel. Several dedicated positions emerged to meet these

challenges. A logistics officer and non-commissioned officer were committed to ERAC duties only. Equipment movement coordination for GME equipment was the first project. Later projects will include movement and accountability for property as space within the LAMC facility is vacated and consolidated. Finally, disposal of all property will be a gargantuan undertaking for these personnel. The phased downsizing would make property accountability, movement, and disposal more manageable. However, the revised downsizing plan calls for LAMC to function as a 185-bed MEDDAC through FY 1992, then abruptly downsize to 73 or fewer beds. While the plans for the future of LAMC are unclear, a precipitous downsizing or closure will be more challenging to manage than a gradual phase-down.

In addition to the logistics officers, a senior nurse administrator was assigned to ERAC duties full-time. This officer's projects have included determining space utilization, preserving historical items, and coordinating the time-phased task list of closure-related items.

The outplacement services offered via the job fairs at LAMC were designed to meet the needs of individual employees. The leadership of LAMC understood the risk of encouraging other agencies to offer jobs to employees who were still needed at LAMC before commencement of downsizing. Several employees accepted offers and resigned from LAMC before their positions were eliminated. The change in future plans for LAMC as of April 1991 further complicated the challenge of maintaining a viable workforce in an organization

with an uncertain future. In spite of these risks, the leadership of IAMC undertook to provide every means possible to assist employees with their transition out of IAMC.

The assistance to employees included establishing an employee drop box for questions about the future downsizing and closure and an employee support group for stress management. The IAMC commander also used civilian awards ceremonies as a forum for communicating information to civilian employees and encouraging interchange of information. Although few questions and comments were forthcoming in this public setting, the anonymity afforded by the drop box was successful in eliciting questions and revealing the level of understanding of the plans and issues related to the downsizing effort. The employee support group began about the time that the change in future plans for IAMC became known, i.e., a 185-bed hospital for one more fiscal year. This change eliminated the planned RIF for July 1991, so the need for the support group was significantly reduced.

The beneficiary information initiative filled a unique role for IAMC. In general in the civilian community, patients seek initial medical care in a physician's office, from which referrals are made and admission to a hospital occurs, as needed. The closure of a hospital may affect access to emergency medical care, but physician office-based care continues unabated, with the physician admitting patients to alternative hospitals. For beneficiaries of the military medical system, the military hospital is usually the

physician's office, e.g., the point of entry into the healthcare system. This dichotomy with the civilian healthcare system influenced LAMC's approach to communication with beneficiaries. Many beneficiaries who visited the Beneficiary Information Office had no experience with Medicare, although they were eligible. Most had no experience with supplemental insurance plans. The specific information made available to the beneficiaries both in print and verbally was much more detailed than would be expected of a civilian hospital facing closure.

Because LAMC has provided almost all the healthcare needs of its beneficiaries for many years, curtailment of services could expose the government to charges of patient abandonment. Special attention was given to providing beneficiaries detailed information about their options for continued care. Fortunately, the CHAMPUS Reform Initiative (CRI) in California provided an excellent means for patients to enroll in a plan designed to reduce their expenses while giving access to a network of healthcare providers.

Employee Survey

Surveyed Importance Ratings Versus Document Review

The ratings of the top ten issues from the document review and the importance ratings from survey responses differed substantially. Although equipment distribution and the future lease of the LAMC facility were referred to the most in the document review, these two items were rated lowest by all survey respondents, both aggregated

and grouped by executives and middle managers (Table 2). Employee communication was rated highest in importance to the organization and to individuals in the aggregate and grouped categories, which revealed a good appreciation of the need for effective communication. The closure timeline and associated tasks and the civilian RIF were rated second or third in importance to individuals and to the organization by respondents aggregated and grouped. The agreement among groups on the issues of greatest importance indicated effective communication among management and employees.

The differences between the importance ratings of issues identified in the document review and the opinions of IAMC employees supports the need for incorporating the experiences of people who were involved in planning for downsizing and closure. While a document repository can provide excellent historical information and guidance for other hospitals downsizing or closing, the experience of the people who were there should be integral in any chronicle of the downsizing experience.

Ratings by Employee Group

The three employee groups whose mean ratings were used for rank ordering the ten survey sub-items were very different demographically. The executives were all active duty personnel in the ranks of colonel or brigadier general. Except for three personnel, the middle managers were also active duty. Twenty-nine of sixty-two of the other respondents were civilians. This accounts

for the civilian RIF being rated higher in importance to individuals among the non-executive or middle-manager group.

The same items were rated in the top four for individual time requirements for executives, middle managers, and others. Prior planning requirements were likewise similar for the top four items, with executives placing more emphasis on GME than the other groups. Executives saw communication with employees requiring less internal coordination than the other groups, but otherwise the internal coordination requirements were viewed similarly for the surveyed items. Executives saw communicating with beneficiaries to require less external coordination than other employee groups. Otherwise, the external coordination requirements were viewed similarly for all employee groups.

Executives perceived that managing the future lease of the LAMC facility required the most learning. Few employees other than those at the executive level were involved in any of the issues regarding the future of the facility. This explains the lower rating among all groups except for executives. Executives also perceived less learning to be required for effectively communicating with employees. Clearly, excellent communication skills should be a characteristic of executive level managers, and they recognized this quality in themselves.

The effectiveness of management in dealing with the ten surveyed items was rated similarly among groups except that the executives and middle managers rated their effectiveness in managing

the 100-bed TDA lower than others rated it. This could be because the executives and middle managers were immersed in the process of producing the 100-bed TDA, and many of the other employees were oblivious to the difficulties inherent in creating this document.

With the exceptions described above, the rank order of the ten surveyed items by mean ratings were similar for each group of LAMC personnel. These similarities indicate the effectiveness of leaders in communicating the vision of the organization to all levels of employees, and in garnering employee commitment to this vision.

Differences Between Present and Former Managers

The Student's t test for mean differences showed five survey items out of 80 to be rated significantly higher by former managers than those presently assigned to LAMC. The personal importance of the RIF and of communication with employees may indicate only individual differences. The higher ratings for time required to manage communication with employees, the higher ratings for lead time to manage the closure timeline and associated tasks, and the higher ratings for coordination outside LAMC for medical equipment distribution may have arisen from the experience level of managers presently assigned to LAMC. The perception of time required for managing these issues could have been greater because the downsizing was further in the future.

The Student's t test for mean differences showed eight survey items out of 80 to be rated significantly lower by former managers

than those presently assigned to IAMC. The items related to the 100-bed TDA, space utilization, equipment distribution, and communication with beneficiaries. Again, the differences can be explained by the perspective of being more than 18 months from the first phase of the downsizing for the former managers versus being immersed in the details of effecting the management of these issues.

The low number of statistically significant differences among former and present managers (13 of 80) suggests that the information gathered from the surveys can be valuable for others required to plan for downsizing or closing a hospital. The validity of the information provided by respondents may be reduced slightly with increased time between involvement in planning for downsizing and the date of implementing the downsizing. However, the survey information appeared to be valid and not time-bound.

Correlations Among Employee Groups and Survey Results

The multivariate correlation analysis for the relative importance of survey items to IAMC (Table 8) showed significant positive correlations between being a civilian employee and the RIF, equipment distribution, the future lease of the IAMC facility, and space utilization. Since many civilian employees have lengthy tenure at IAMC, their stakes in space utilization and future use of the facility were higher. Their interest in the RIF is self-evident, but the correlation to equipment distribution defies explanation. There was a significant positive correlation between

being active duty and the importance of communicating with beneficiaries. This could be because active duty employees are also beneficiaries of IAMC, as are their dependents. There was a significant positive correlation to being a nurse and the importance of the 100-bed TDA. This could be due to the immediate impact of staffing levels on nurses. There was a negative correlation between the importance of equipment distribution and being a physician or executive. Equipment distribution was rated overall second to lowest, and physicians and executives probably perceived equipment is a micromanagement issue, not a major organizational issue.

The multivariate correlation analysis for relative importance of survey items to individuals (Table 9) showed a strong positive correlation between being a civilian employee and the RIF, for obvious reasons. Being a clinician or a physician was positively correlated to the importance of beneficiary communication and GME. Being a physician was also positively correlated with health record and x-ray disposition. These relationships can best be explained by the patient care and teaching orientation of the medical staff. Being a physician was negatively correlated with the personal importance of the RIF. Only one of the physician respondents was a civilian; all others were active duty personnel. Being assigned to IAMC prior to the January 1989 announcement of plans to close IAMC was positively correlated with the individual's perception of the importance of the RIF, communication with beneficiaries, and communication with employees. The lengthy tenure of many civilians

explains the importance of the RIF. Longevity may relate to the felt need to be kept informed and a sense of compassion for the beneficiaries with whom relationships have been established.

The correlation analysis for time requirements for individuals (Table 10) showed a significant positive correlation between being active duty or a middle manager and managing the 100-bed TDA. This could be because most of the middle managers (55 of 58) were active duty, and the middle managers were tasked with coordinating the downsized TDAs. There was a very strong positive correlation between time required for managing GME and communicating with beneficiaries and being a clinician or physician. Since these two categories overlap, the similarity and the interest in these two areas by physicians and other healthcare providers becomes clear. Being a middle manager was positively correlated with the time required to manage the RIF, communication with employees, and GME. All department chiefs and teaching chiefs of GME programs were included as middle managers, and middle managers have a significant responsibility to communicate with employees, which explains the correlations.

The correlation analysis showed a positive relationship between being active duty and the prior planning requirements for the closure timeline and between being a nurse and the future lease of the LAMC facility. These relationships were statistically

significant, but they are not readily explained nor considered especially enlightening in studying the downsizing and closure effort.

The significant correlations for internal coordination requirements (Table 12) were between being a clinician and the 100-bed TDA and communication with beneficiaries, being a physician and GME and equipment distribution (negatively correlated), and being an executive and space utilization. These relationships arose from the interest area of each employee group and the responsibilities of each.

The multivariate correlation analysis for the external coordination requirements (Table 13) showed a negative correlation between active duty and middle manager respondents and space utilization, and between executives and health record and x-ray disposition. Positive correlations were shown between physicians and GME; employees assigned to IAMC prior to 1989 and communication with beneficiaries; and clinicians and the future lease, closure timeline, and the 100-bed TDA. These correlations reflected areas of interest and responsibility.

Positive correlations for survey respondents groups and the learning required for effectively managing issues (Table 14) were shown for clinicians and nurses and health record and x-ray disposition, between physicians and GME, and between executives and the future lease of the IAMC facility. The concern of clinicians and nurses for appropriate disposition of health records and the

continuity of care for beneficiaries is probably reflected in their responses. Physicians had the greatest personal involvement in GME, and executives found themselves in unfamiliar territory when dealing with inter-agency agreements and political maneuverings at the cabinet secretary level about the future fate of the LAMC facility.

For the effectiveness of management, only the group of respondents assigned to LAMC prior to 1989 showed a significant correlation (Table 15). The effectiveness of managing space utilization was negatively correlated with the pre-89 respondent group. These employees with longer tenure may have developed a sense of ownership about their space, and they may have had difficulty accepting the changes inherent with the downsizing. This indicated a need for sensitivity to the needs of all employees, especially those with longer tenure, when making changes in space allocations.

Comments

The additional comments added to the surveys by ten respondents related to patient care, military personnel, medical-legal issues, and communication. Although several of the respondents who added comments considered their area of responsibility important enough to be added, most of the comments related to issues affecting the organization as a whole. The concern for patient care, personnel,

and communication revealed an understanding of the mission of LAMC and the crucial issues (people and communication) that must be carefully managed during a downsizing operation.

CHAPTER V. CONCLUSIONS AND RECOMMENDATIONS

LAMC is the first of at least five military hospitals slated for closure in the next five years. Additionally, the MEDDAC in Panama must close by the end of 1999 in accordance with treaty provisions. Already, LAMC has hosted leaders from an Army hospital mandated for closure so these leaders could learn from the LAMC experience. This study can be a source of invaluable information for leaders of military hospitals facing downsizing and closure. However, no amount of information can adequately prepare military hospital leaders for the vagaries of political machinations that disrupt the planning process and emotional equilibrium of the organization.

Most military hospital closures can be expected to be known months, if not years, in advance, and they will probably be accomplished in phases. Advance identification of critical issues, rather than discovery of them when they emerge as problems, can facilitate effective management of these issues. As a management tool, more information is needed when there is greater uncertainty. Since closing hospitals is a relatively unknown operation for military managers, additional information, especially information gained from actual experience, can be advantageous. The document review provides a comprehensive listing of the issues LAMC faced while planning for downsizing and closure. The rank order of the

issues (Appendix B) provides an indication of the time required to manage them and the potential impact on the organization during the downsizing process.

The survey responses of LAMC employees further refined the information gleaned from reviewing the document repository. The agreement among groups of respondents about what was important evidenced successful communication of the organizational vision and goals. The survey agreement showed an organizational culture lacking in parochialism and exhibiting a unified vision of concern for patients, quality patient care, and excellent graduate medical education.

The approach to managing the downsizing and closure at LAMC emphasized credible communication with employees, empathy and support for employees, and continuity of care for beneficiaries. A 94% fill rate for civilian positions two months prior to a scheduled RIF was testimony to the success of a management strategy of candid communication, fostering loyalty to the organization, and empathetically seeking to meet the needs of employees. The outplacement services offered through job fairs, the multiple communication modes employed for disseminating information to employees, and the employee support groups were crucial for maintaining morale and commitment to the organization's core mission of high quality patient care. The beneficiary information initiative provided LAMC beneficiaries with a compassionate means of obtaining information about alternative sources of care and options

for underwriting healthcare. Employees and patients alike were treated with sincere compassion and empathy.

This study was limited to evaluating downsizing and closure activities from December 1988 through December 1990 and employee perceptions about the downsizing in March 1991. Implementation of the downsizing and closure process lies ahead, and further study of the LAMC experience should be undertaken to comprehensively address the vicissitudes of managing the closure of a military hospital.

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Appendix A

PRIMARY, SECONDARY, AND TERTIARY CARE SPECIALITIES

<u>Primary and Secondary Care</u>	<u>Tertiary Care</u>
Allergy	Cardiology
Adult Psychiatry	Child/Adolescent Psychiatry
Anesthesiology	Clinical Psychology
Audiology	Endocrinology
General Surgery	Gastroenterology
Gynecology/Obstetrics	Health Physics
Internal Medicine	Hematology/Oncology
Occupational Medicine	Immunology
Occupational Therapy	Infectious Disease
Ophthalmology	Nephrology
Orthopedic Surgery	Neurology
Otolaryngology	Nuclear Medicine
Pathology	Physical Medicine
Pediatrics	Plastic Surgery
Physical Therapy	Pulmonology
Radiology	Radiation Therapy
Social Work	Rheumatology
Urology	Speech Pathology
	Total Joint Prosthetics
	Thoracic and Cardiovascular Surgery
	Vascular Surgery

Graduate Medical Education Programs

Anesthesiology

Cardiology

Child and Adolescent Psychiatry

Clinical Psychiatry

Diagnostic Radiology

General Surgery

Hematology

Internal Medicine

Neurology

Nuclear Medicine

Ophthalmology

Oncology

Orthopedics

Radiation Oncology

Thoracic and Cardiovascular Surgery

Urology

Transitional Internship

Appendix B

ISSUES IDENTIFIED FROM DOCUMENT REVIEW

Rank Ordered by Weighting Factor

<u>Issue</u>	<u>Frequency</u>	<u>Weighted</u>
Medical equipment	41	82
Lease-back of IAMC building	38	76
Detailed closure plan and timeline	32	64
100-bed TDA	111	39
Space utilization	15	30
Disposition of health records and x-rays	44	28
Civilian positions/RIF	65	26
Beneficiary communication	23	23
Communication with IAMC employees	10	20
Graduate medical education	119	19
Staff migration to other assignments	21	12
BRAC account (dedicated dollars)	5	10
Case mix of IAMC patients	4	8
Mission of downsized hospital	11	8
Freeze of movement for active duty	13	7
73-bed TDA	11	6
CHAMPUS	4	6
Catchment area impact	3	6
Enlisted phase II training	8	5
BRAC 91	2	4

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Visit by HSC BRAC team	2	4
Minor construction	4	4
Coordination with Naval Hospital, Oakland	4	4
Resource sharing	4	4
LAMC homecoming celebration	3	3
Discharge diagnoses of LAMC patients	1	2
Environmental impact study	1	2
Coordination with San Francisco Med Cnd	2	2
LAMC strategic plan	1	2
50-bed TDA	5	2
Base operation support	1	1
Medical evacuation system	1	1
Mobilization mission	1	1
Physical security	1	1
Logistics stock fund	1	1
Stress management for employees	1	1
Presidio Civilian Personnel Office	2	.8
US Army Reserves Capstone	1	.5
Outpatient staff	1	.4
Prepositioned war reserve stocks	8	.4
Veterinary lab	5	.2
Professional officer filler system (PROFIS)	1	.1
Medical board's	3	.1
Nuclear medicine	4	.08
Historical items	15	.05

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Civilian prescriptions	3	.03
Media relations	11	.02
Logistics officer dedicated to BRAC	15	.01
Emergency services	6	.01
Blood bank	1	.005
Administrative officer dedicated to BRAC	4	.005
Medical library	1	.001
Military Entrance Processing Station (MEPS)	1	.001
HIV mission	5	.0003
Outlying clinic support	1	.0002

ISSUES IDENTIFIED FROM DOCUMENT REVIEW

Rank Ordered by Frequency

<u>Issue</u>	<u>Frequency</u>	<u>Weighted</u>
Graduate medical education	119	19
100-bed TDA	111	39
Civilian positions/RIF	65	26
Disposition of health records and x-rays	44	28
Medical equipment	41	82
Lease-back of LAMC building	38	76
Detailed closure plan and timeline	32	64
Beneficiary communication	23	23
Staff migration to other assignments	21	12
Space utilization	15	30
Historical items	15	.05
Logistics officer dedicated to ERAC	15	.01
Freeze of movement for active duty	13	7
Mission of downsized hospital	11	8
73-bed TDA	11	6
Media relations	11	.02
Communication with LAMC employees	10	20
Enlisted phase II training	8	5
Prepositioned war reserve stocks	8	.4
Emergency services	6	.01
ERAC account (dedicated dollars)	5	10
50-bed TDA	5	2

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Veterinary lab	5	.2
HIV mission	5	.0003
Case mix of LAMC patients	4	8
CHAMPUS	4	6
Minor construction	4	4
Coordination with Naval Hospital, Oakland	4	4
Resource sharing	4	4
Nuclear medicine	4	.08
Administrative officer dedicated to ERAC	4	.005
Catchment area impact	3	6
LAMC homecoming celebration	3	3
Medical boards	3	.1
Civilian prescriptions	3	.03
ERAC 91	2	4
Visit by HSC ERAC team	2	4
Coordination with San Francisco Med Cnd	2	2
Presidio Civilian Personnel Office	2	.8
Discharge diagnoses of LAMC patients	1	2
Environmental impact study	1	2
LAMC strategic plan	1	2
Base operation support	1	1
Medical evacuation system	1	1
Mobilization mission	1	1
Physical security	1	1
Logistics stock fund	1	1

Downsizing and Closure
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Stress management for employees	1	1
US Army Reserves Capstone	1	.5
Outpatient staff	1	.4
Professional officer filler system (PROFIS)	1	.1
Blood bank	1	.005
Medical library	1	.001
Military Entrance Processing Station (MEPS)	1	.001
Outlying clinic support	1	.0002

Appendix C
CONSTITUENTS

<u>Internal</u>		<u>Percent</u>
Civilian Employees	165	30.0
Military Employees	161	28.3
Physicians in GME	134	23.5
Physicians	109	19.2
TOTAL	569	
<u>External</u>		
Health Service Command	80	31.6
Office of the Surgeon General	32	12.6
Beneficiaries	26	10.2
Civilian Community	19	7.5
Naval Hospital Oakland	19	7.5
Madigan Army Medical Center	17	6.7
GCNRA/ Department of Interior	14	5.5
Residency Review Committees	12	4.7
Foundation Health Corporation	8	3.2
San Francisco Medical Command	7	2.7
Civilian Personnel Division (Presidio)	5	1.8
Veterans Administration Medical		
Center, San Francisco	4	1.5
Members of Congress	3	1.2

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Silas B. Hays Army Hospital	3	1.2
Sacramento Office, Corps of Engineers	2	.8
Fitzsimons Army Medical Center	2	.8
Academy of Health Sciences	1	.4
Office of Management and Budget	1	.4
Office of Economic Adjustment	1	.4
TOTAL	254	

Appendix D

DOWNSIZING AND CLOSURE SURVEY

Cover Letter For Surveys Sent to Current LAMC Employees

S: 15 Mar 91

HSHH-DCA-AR

1 March 1991

SUBJECT: Letterman Army Medical Center Downsizing and Closure Survey

1. The enclosed survey is being conducted as part of a research project by LAMC's healthcare administration resident. You are being asked to complete the survey so that the Army can learn from LAMC's experience of downsizing and closing a hospital. The average time to complete this survey is ten minutes.
2. Your responses will be kept anonymous and will be combined with the responses of others for inclusion in the research project. However, your survey is identified merely to assist the researcher in acknowledging your response. Identifying information will not remain with your completed survey.
3. The survey asks about your opinions on several issues. Some questions may appear more pertinent to your situation than others. Please answer each question even if you are not totally familiar with all aspects of the question.
4. Please return your completed survey, simply by folding the survey so that the return address located on the reverse of the last page of the survey is on the outside, and send through distribution to the Administrative Resident not later than 15 March.
5. If you have any questions please contact MAJ Bales at 5991, and thank you for your participation.

Encl
as

ROBERT B. AASEN
Colonel, MS
Deputy Commander for Administration/
Chief of Staff

IAMC Downsizing and Closure Survey

Please rate the following issues as they relate to the downsizing and closure from 1 to 5 (least to most) as each question asks by circling the number. Spaces are provided for you to add and rate up to three issues besides those already listed. If you add any, please rate all the issues—those already listed and those you added.

1. Rate the following issues according to their importance to IAMC as an organization, with 1 being not very important and 5 being very important.

	not very important			very important	
	1	2	3	4	5
Equipment distribution	1	2	3	4	5
Future lease of IAMC building	1	2	3	4	5
Closure timeline and detailed task lists	1	2	3	4	5
100-bed TDA	1	2	3	4	5
Space utilization	1	2	3	4	5
Disposition of health records and X-rays	1	2	3	4	5
Civilian reduction-in-force and future civilian positions	1	2	3	4	5
Communication with beneficiaries	1	2	3	4	5
Communication with IAMC employees	1	2	3	4	5
Graduate Medical Education	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5

2. Rate the following issues according to their importance to you personally, with 1 being not very important and 5 being very important.

	not very important			very important	
	1	2	3	4	5
Equipment distribution	1	2	3	4	5
Future lease of IAMC building	1	2	3	4	5
Closure timeline and detailed task lists	1	2	3	4	5
100-bed TDA	1	2	3	4	5
Space utilization	1	2	3	4	5
Disposition of health records and X-rays	1	2	3	4	5
Civilian reduction-in-force and future civilian positions	1	2	3	4	5
Communication with beneficiaries	1	2	3	4	5
Communication with IAMC employees	1	2	3	4	5
Graduate Medical Education	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5

3. Rate the following issues according to the amount of time which each required of you. Please give issues which you feel were not very time consuming a 1, and the issues which were very time consuming a 5. Your perception of the time you spent is more important than your trying to reconstruct actual time.

	not very time consuming			very time consuming	
Equipment distribution	1	2	3	4	5
Future lease of IAMC building	1	2	3	4	5
Closure timeline and detailed task lists	1	2	3	4	5
100-bed TDA	1	2	3	4	5
Space utilization	1	2	3	4	5
Disposition of health records and X-rays	1	2	3	4	5
Civilian reduction-in-force and future civilian positions	1	2	3	4	5
Communication with beneficiaries	1	2	3	4	5
Communication with IAMC employees	1	2	3	4	5
Graduate Medical Education	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5

4. Rate the following issues according to the lead time (prior planning) you feel was required to manage them effectively, with a 1 being very little lead time and a 5 being very much lead time. Even if you did not participate, please give your perception.

	very little			very much	
Equipment distribution	1	2	3	4	5
Future lease of IAMC building	1	2	3	4	5
Closure timeline and detailed task lists	1	2	3	4	5
100-bed TDA	1	2	3	4	5
Space utilization	1	2	3	4	5
Disposition of health records and X-rays	1	2	3	4	5
Civilian reduction-in-force and future civilian positions	1	2	3	4	5
Communication with beneficiaries	1	2	3	4	5
Communication with IAMC employees	1	2	3	4	5
Graduate Medical Education	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5

5. Rate the issues according to the internal coordination which you feel is required to manage them effectively, with a 1 being very little internal coordination and a 5 being very much internal coordination.

	very little			very much	
Equipment distribution	1	2	3	4	5
Future lease of LAMC building	1	2	3	4	5
Closure timeline and detailed task lists	1	2	3	4	5
100-bed TDA	1	2	3	4	5
Space utilization	1	2	3	4	5
Disposition of health records and X-rays	1	2	3	4	5
Civilian reduction-in-force and future civilian positions	1	2	3	4	5
Communication with beneficiaries	1	2	3	4	5
Communication with LAMC employees	1	2	3	4	5
Graduate Medical Education	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5

6. Rate the issues according to the coordination with entities outside the hospital required to manage them effectively, with a 1 being very little outside coordination and a 5 being very much outside coordination.

	very little			very much	
Equipment distribution	1	2	3	4	5
Future lease of LAMC building	1	2	3	4	5
Closure timeline and detailed task lists	1	2	3	4	5
100-bed TDA	1	2	3	4	5
Space utilization	1	2	3	4	5
Disposition of health records and X-rays	1	2	3	4	5
Civilian reduction-in-force and future civilian positions	1	2	3	4	5
Communication with beneficiaries	1	2	3	4	5
Communication with LAMC employees	1	2	3	4	5
Graduate Medical Education	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5

7. Since no one at IAMC has ever closed a hospital before, some activities required to plan for downsizing and closure were new, and some were familiar. Please rate the issues according to the amount of learning which you feel was required to manage them effectively, with a 1 being very little learning and a 5 being very much learning.

	very little			very much	
Equipment distribution	1	2	3	4	5
Future lease of IAMC building	1	2	3	4	5
Closure timeline and detailed task lists	1	2	3	4	5
100-bed TDA	1	2	3	4	5
Space utilization	1	2	3	4	5
Disposition of health records and X-rays	1	2	3	4	5
Civilian reduction-in-force and future civilian positions	1	2	3	4	5
Communication with beneficiaries	1	2	3	4	5
Communication with IAMC employees	1	2	3	4	5
Graduate Medical Education	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5

8. Because this was a learning experience, you may perceive that some issues were managed better than others. Please rate the issues according to how you feel they were managed, with a 1 being least effectively and a 5 being most effectively.

	least			most	
Equipment distribution	1	2	3	4	5
Future lease of IAMC building	1	2	3	4	5
Closure timeline and detailed task lists	1	2	3	4	5
100-bed TDA	1	2	3	4	5
Space utilization	1	2	3	4	5
Disposition of health records and X-rays	1	2	3	4	5
Civilian reduction-in-force and future civilian positions	1	2	3	4	5
Communication with beneficiaries	1	2	3	4	5
Communication with IAMC employees	1	2	3	4	5
Graduate Medical Education	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5

REMOVE THE BLANK BACK PAGE OF THIS SURVEY. FOLD OVER AND STAPLE CLOSED WITH RETURN ADDRESS LABEL SHOWING. PLACE IN DISTRIBUTION. THANK YOU!

Appendix E

PERSONNEL SURVEYED

- * indicates personnel formerly in each position who were surveyed by mail in addition to incumbent

Executives

- * Commander

Commander, Dental Activity

Command Sergeant Major

- * Deputy Commander for Clinical Services

- * Deputy Commander for Administration

Deputy Commander for Veterinary Services

Middle Managers

Chair, ERAC Committee

Co-Chair, ERAC Committee

ERAC Committee members not otherwise listed

- * Chief, Department of Nursing

Assistant Chief, Department of Nursing

- * Chief, Department of Surgery

Assistant Chief, Department of Surgery

Chief, Department of Medicine

Assistant Chief, Department of Medicine

Teaching chiefs, each residency training program
and fellowship

* Executive Officer

Chief, Patient Administration

Assistant Chief, Patient Administration

Chief, Resource Management Division

Chief, Program and Budget

Chief, Manpower and Documents

Chief, Management Analysis Branch

* Chief, Logistics

Chief, Materiel Branch

* Chief, Biomedical Maintenance

Chief, Property Management

Chief, Services Branch

Chief, Plans, Training, Mobilization & Security

* Chief, Clinical Support Division

Chief, Medical/Surgical Nursing

Chief, Critical Care Plus Nursing

Chief, Ambulatory Care Nursing

Chief, Department of Psychiatry

Chief, Pharmacy Service

Chief, Preventive Medicine & Primary Care

Chief, Social Work Service

Chief, Pathology

Chief, Physical Medicine and Rehabilitation

* Chief, Information Management Division

Chief, Military Personnel and Troop Commander

* Chief, Nutrition Care

Chief, Ministry and Pastoral Care

* Assistant Administrator, Department of Surgery

* Assistant Administrator, Department of Medicine

Assistant Administrator, Department of Psychiatry

Chief, Pediatrics

Chief, Psychiatry

Chief, Radiology

Other Employees

Stratified Random Sample

Appendix F

DESCRIPTIVE STATISTICS OF SURVEY RESPONSES

Survey Item	ACTIVE DTY		CLINICIANS		NURSES		PHYSICIANS		PRE-89		EXECUTIVES		MID-MGRS	
	Mean	Std Dev	Mean	Std Dev	Mean	Std Dev	Mean	Std Dev	Mean	Std Dev	Mean	Std Dev	Mean	Std Dev
1A	3.55	1.21	3.55	1.26	4.00	1.04	3.34	1.33	3.74	1.35	2.75	1.17	3.66	1.25
1B	2.78	1.48	3.15	1.48	3.36	1.45	3.06	1.52	2.98	1.58	2.13	.99	2.74	1.53
1C	4.44	.69	4.39	.69	4.64	.50	4.31	.74	4.44	.72	4.73	.52	4.51	.70
1D	4.10	.94	4.16	.94	4.64	.50	4.19	.86	4.10	.96	4.13	.83	4.17	.98
1E	3.59	1.06	3.85	1.01	4.07	1.14	3.78	.98	3.79	1.17	3.88	.83	3.55	1.10
1F	4.17	.91	4.22	1.00	4.21	.80	4.25	.84	4.38	.99	4.00	1.07	4.19	.96
1G	4.30	.91	4.39	.95	4.43	1.34	4.25	.84	4.52	.72	4.38	.74	4.38	.92
1H	4.48	.68	4.35	.83	4.29	.73	4.47	.67	4.41	.88	4.38	.74	4.53	.67
1I	4.50	.63	4.50	.67	4.57	.65	4.44	.67	4.57	.67	4.75	.46	4.53	.64
1J	3.88	1.26	3.94	1.34	3.64	1.50	4.06	1.22	3.93	1.25	3.75	1.28	3.96	1.26
2A	3.14	1.60	3.15	1.52	3.29	1.73	3.03	1.51	3.07	1.61	2.38	1.51	3.08	1.62
2B	2.32	1.45	2.44	1.49	2.79	1.63	2.44	1.50	2.52	1.61	1.75	1.04	2.32	1.49
2C	3.80	1.29	3.71	1.40	3.93	1.21	3.44	1.61	3.92	1.23	3.75	1.49	4.00	1.22
2D	3.74	1.28	3.77	1.25	4.29	.73	3.50	1.44	3.87	1.20	4.00	1.20	3.96	1.33
2E	3.24	1.31	3.26	1.35	3.71	1.49	3.16	1.35	3.26	1.47	3.50	1.20	3.11	1.44
2F	3.02	1.47	3.24	1.40	3.07	1.38	3.72	1.25	3.29	1.53	2.63	1.19	3.02	1.49
2G	3.48	1.36	3.66	1.32	4.07	1.21	3.25	1.30	4.08	1.13	3.25	1.49	3.75	1.31
2H	3.52	1.36	3.74	1.20	3.79	1.19	3.97	1.09	3.70	1.25	3.25	1.28	3.57	1.38
2I	4.09	1.13	4.15	1.13	4.64	.63	3.88	1.26	4.48	.91	4.38	.74	4.26	1.00
2J	2.99	1.62	3.29	1.62	2.29	1.38	4.13	1.34	3.13	1.59	3.38	2.00	2.96	1.56
3A	2.76	1.49	2.53	1.31	2.43	1.50	2.44	1.22	2.57	1.37	2.00	1.41	2.60	1.43
3B	1.74	1.19	1.68	1.16	1.71	1.27	1.75	1.16	1.87	1.34	2.00	1.51	1.77	1.23
3C	3.07	1.48	2.90	1.41	3.07	1.44	2.72	1.40	3.05	1.41	3.88	.99	3.19	1.35
3D	3.16	1.47	2.95	1.54	3.43	1.70	2.88	1.48	2.82	1.51	3.25	1.39	3.49	1.35
3E	2.69	1.24	2.61	1.21	2.79	1.67	2.56	1.05	2.62	1.25	2.75	1.04	2.89	1.34
3F	2.27	1.32	2.15	1.20	1.71	1.27	2.53	1.16	2.30	1.46	2.25	1.04	2.17	1.31
3G	3.09	1.41	3.16	1.37	3.21	1.63	2.88	1.29	3.25	1.31	3.13	1.46	3.40	1.21
3H	2.64	1.36	2.82	1.37	2.43	1.22	3.22	1.36	2.79	1.44	2.63	1.51	2.75	1.31
3I	3.03	1.28	3.03	1.32	3.50	1.56	2.84	1.08	3.02	1.31	3.00	1.31	3.26	1.26
3J	2.58	1.58	2.82	1.67	1.71	.91	3.81	1.47	2.69	1.64	2.50	1.85	2.74	1.61
4A	3.75	1.13	3.47	1.17	4.14	1.29	3.41	1.07	3.49	1.15	3.50	1.07	3.75	1.14
4B	3.26	1.52	3.24	1.58	4.07	1.14	3.03	1.66	3.18	1.53	3.38	1.69	3.21	1.55
4C	4.28	.92	4.15	1.05	4.14	1.29	4.19	1.00	4.03	1.18	4.75	.46	4.08	1.00
4D	4.00	1.06	4.02	1.00	4.00	1.11	4.00	1.02	3.97	1.06	4.38	.74	3.96	1.04
4E	3.56	1.04	3.63	1.10	3.93	1.14	3.44	1.13	3.52	1.16	3.88	.64	3.43	1.07
4F	3.06	1.18	3.56	1.29	3.50	1.29	3.78	.98	3.41	1.32	3.75	.71	3.53	1.22
4G	3.93	1.16	3.91	1.11	4.00	1.30	3.63	1.04	4.03	1.14	4.50	.93	3.94	1.13
4H	3.88	1.20	3.89	1.24	4.07	1.38	3.91	1.17	3.70	1.19	3.63	1.51	3.91	1.15
4I	3.98	1.10	4.05	1.11	4.36	1.15	3.91	1.20	3.98	1.16	4.13	1.36	4.00	1.06
4J	3.70	1.47	3.73	1.47	3.57	1.65	4.06	1.22	3.61	1.52	4.38	1.19	3.79	1.34
5A	3.82	1.16	3.68	1.21	4.21	1.05	3.41	1.21	3.82	1.16	3.63	1.41	3.79	1.18
5B	2.84	1.36	3.17	1.35	3.21	1.12	2.94	1.44	3.07	1.30	2.38	1.30	2.72	1.29
5C	4.31	.90	4.23	.91	4.21	1.12	4.19	.86	4.25	.81	4.38	.52	4.23	.93
5D	4.27	.93	4.39	.82	4.36	.93	4.41	.80	4.27	.89	4.63	.52	4.32	.96
5E	4.08	.85	4.10	.84	4.21	.80	4.03	.90	3.97	.91	4.63	.52	4.09	.86
5F	3.57	1.22	3.79	1.22	3.50	1.34	3.75	1.11	3.77	1.28	3.38	1.19	3.47	1.20
5G	4.03	1.10	4.16	.89	4.21	.80	4.03	.97	4.11	.98	4.50	1.07	4.09	1.11
5H	3.83	1.17	4.05	1.00	3.93	.83	4.00	1.05	3.89	1.02	3.63	1.07	3.85	1.18
5I	4.16	.88	4.18	.92	4.36	.63	4.00	.98	4.16	.86	4.00	1.07	4.09	.90
5J	3.76	1.32	3.85	1.25	3.29	1.54	4.13	1.01	3.80	1.33	4.13	1.25	3.77	1.32

Survey Item	ACTIVE DTY		CLINICIANS		NURSES		PHYSICIANS		PRE-89		EXECUTIVES		MID-MGRS	
	Mean	Std Dev	Mean	Std Dev	Mean	Std Dev	Mean	Std Dev	Mean	Std Dev	Mean	Std Dev	Mean	Std Dev
6A	3.68	1.28	3.63	1.24	3.71	1.44	3.75	1.14	3.85	1.08	4.13	1.13	3.72	1.28
6B	4.13	1.38	4.35	1.10	4.71	.61	4.41	1.01	3.98	1.35	4.50	.76	3.94	1.54
6C	3.45	1.19	3.76	1.07	3.64	1.39	3.75	.88	3.59	1.12	4.00	.93	3.49	1.23
6D	3.15	1.38	3.52	1.28	3.64	1.60	3.50	1.11	3.31	1.36	3.75	1.04	3.17	1.46
6E	2.47	1.10	2.77	1.19	2.79	1.25	2.66	1.07	2.66	1.22	3.13	1.25	2.30	1.03
6F	3.44	1.29	3.61	1.23	3.86	1.03	3.34	1.26	3.62	1.28	2.50	1.31	3.42	1.31
6G	3.84	1.21	3.94	1.16	4.21	.98	3.78	1.16	3.85	1.24	4.00	1.31	3.89	1.28
6H	3.88	1.32	4.03	1.13	4.43	.94	3.81	1.31	3.97	1.17	3.25	1.39	3.94	1.34
6I	2.88	1.35	3.13	1.31	3.00	1.52	3.13	1.29	3.23	1.31	2.75	1.58	3.06	1.34
6J	3.81	1.40	3.90	1.26	3.79	1.53	4.16	.92	3.80	1.31	4.38	.92	3.85	1.42
7A	2.97	1.18	2.95	1.29	3.43	1.28	2.91	1.17	2.98	1.37	3.13	.99	2.98	1.31
7B	3.44	1.49	3.71	1.38	4.21	1.12	3.59	1.54	3.40	1.56	4.50	.76	3.28	1.69
7C	3.80	1.19	3.82	1.21	4.00	1.04	3.78	1.31	3.80	1.31	4.50	1.07	3.74	1.20
7D	3.28	1.19	3.50	1.29	3.43	1.16	3.56	1.32	3.46	1.32	3.38	1.41	3.28	1.25
7E	2.80	1.16	2.98	1.21	3.29	1.20	2.81	1.26	2.95	1.23	3.13	1.55	2.74	1.16
7F	3.42	1.28	3.61	1.30	4.21	1.05	3.56	1.27	3.48	1.40	3.88	.99	3.45	1.35
7G	3.81	1.05	3.84	1.15	4.21	.98	3.69	1.12	3.97	1.15	3.88	.83	4.02	1.13
7H	3.63	1.29	3.66	1.32	4.07	1.14	3.63	1.36	3.56	1.32	3.88	1.36	3.64	1.32
7I	3.90	1.27	3.55	1.35	3.79	1.25	3.41	1.39	3.59	1.32	3.75	1.39	3.64	1.26
7J	3.34	1.41	3.47	1.47	3.50	1.56	3.72	1.25	3.46	1.48	4.00	1.20	3.36	1.48
8A	3.25	1.17	3.05	1.22	3.00	1.11	3.13	1.31	3.13	1.35	3.00	1.60	3.43	1.08
8B	2.44	1.28	2.48	1.25	2.93	1.00	2.31	1.40	2.33	1.30	1.88	1.81	2.43	1.23
8C	3.35	1.05	3.24	1.04	3.29	1.00	3.28	.89	3.11	1.17	3.88	.64	3.38	1.08
8D	3.22	1.25	3.21	1.20	3.50	1.02	3.06	1.19	3.05	1.33	3.13	1.64	3.17	1.25
8E	3.14	1.16	3.00	1.15	3.29	.91	3.00	1.19	2.92	1.20	3.50	1.60	3.15	1.10
8F	3.08	1.22	2.90	1.28	3.00	.96	2.72	1.30	2.95	1.47	2.50	1.69	3.09	1.23
8G	3.38	1.27	3.10	1.39	3.36	1.39	3.00	1.37	3.05	1.41	3.25	1.67	3.34	1.29
8H	3.43	1.24	3.29	1.29	3.29	1.38	3.44	1.16	3.11	1.37	4.13	1.13	3.53	1.32
8I	3.75	1.01	3.52	1.16	3.36	1.22	3.75	.88	3.48	1.27	4.25	1.04	3.85	1.01
8J	3.66	1.27	3.66	1.32	3.64	1.34	1.12	1.00	3.51	1.51	4.13	.64	3.81	1.32

Overall

<u>Survey Item</u>	Overall	Standard	Stratified Random	Overall Range	
	<u>Mean</u>	<u>Deviation</u>	<u>Sample Variance</u>	<u>Min</u>	<u>Max</u>
1A	3.7167	1.2379	1.4033	1	5
1B	2.9583	1.4917	2.0976	0	5
1C	4.4667	.6852	.4868	2	5
1D	4.1583	.8981	.7177	1	5
1E	3.7417	1.0651	1.0929	1	5
1F	4.2417	.9701	.9462	0	5
1G	4.4083	.8350	.9462	0	5
1H	4.3750	.7998	.6645	2	5
1I	4.5000	.6737	.5266	3	5
1J	3.8330	1.2856	1.7527	1	5
2A	3.1083	1.2856	2.5978	0	5
2B	2.4250	1.5100	2.4488	0	5
2C	3.8500	1.2811	1.7183	1	5
2D	3.7333	1.3140	1.6680	0	5
2E	3.7250	1.3840	1.8628	0	5
2F	3.0083	1.5091	2.4973	0	5
2G	3.7833	1.3359	1.7960	0	5
2H	3.4333	1.4126	2.1589	1	5
2I	4.1883	1.0922	1.4582	1	5
2J	2.9083	1.5877	2.4751	1	5
3A	2.6250	1.4498	2.1665	1	5
3B	1.8250	1.2746	1.6823	1	5
3C	2.9750	1.4463	2.2969	1	5
3D	2.9167	1.4927	2.0607	0	5
3E	2.6250	1.2573	1.3758	0	5
3F	2.1500	1.3325	1.9684	0	5
3G	3.1083	1.4248	2.4418	0	5
3H	2.5500	1.4014	2.2197	1	5
3I	2.9833	1.3472	1.9596	1	5
3J	2.4167	1.5480	2.0029	1	5
4A	3.6500	1.1714	1.4897	1	5
4B	3.3250	1.4791	1.9725	1	5
4C	4.0833	1.1492	1.7241	0	5
4D	3.9167	1.1345	1.5681	0	5
4E	3.5500	1.1291	1.5178	1	5
4F	3.4833	1.2568	1.8316	0	5
4G	3.9167	1.1923	1.6026	0	5
4H	3.7667	1.1923	1.5728	1	5
4I	3.9000	1.1624	1.5196	1	5
4J	3.5833	1.4871	2.5535	0	5
5A	3.8333	1.1252	1.0930	1	5
5B	2.9167	1.3694	2.0053	1	5
5C	4.2583	.9028	.8562	1	5
5D	4.1750	.9929	1.0859	1	5
5E	4.0167	.8791	.8088	2	5
5F	3.5667	1.2618	1.7738	0	5
5G	4.0667	1.0590	1.0169	0	5
5H	3.7500	1.1394	1.1256	1	5
5I	4.1083	.9330	.9123	1	5
5J	3.6417	1.3144	1.7008	0	5

6A	3.6417	1.3571	1.6680	0	5
6B	4.0833	1.3571	1.5453	0	5
6C	3.4083	1.2333	1.5722	0	5
6D	3.1000	1.3805	1.7732	0	5
6E	2.6333	1.2018	1.6365	0	5
6F	3.5500	1.2692	1.3267	0	5
6G	3.8250	1.2344	1.4343	0	5
6H	3.8333	1.2921	1.5336	0	5
6I	2.9833	1.3719	1.9456	0	5
6J	3.7417	1.3689	1.8369	0	5
7A	2.9333	1.2816	1.7054	0	5
7B	3.4250	1.5321	2.0041	0	5
7C	3.7833	1.2846	1.8907	0	5
7D	3.2667	1.2816	1.7358	0	5
7E	2.8520	1.1929	1.3931	0	5
7F	3.3500	1.3325	1.8095	0	5
7G	3.8000	1.1711	1.4868	0	5
7H	3.5333	1.3089	1.6902	0	5
7I	3.5250	1.3091	1.8282	0	5
7J	3.2250	1.4579	2.0689	0	5
8A	3.2250	1.1985	1.5126	0	5
8B	2.4500	1.2425	1.3559	0	5
8C	3.3083	1.1287	1.4535	0	5
8D	3.1917	1.2251	1.3472	0	5
8E	3.1417	1.1689	1.3892	0	5
8F	2.9833	1.3092	1.7732	0	5
8G	3.2833	1.3105	1.7013	0	5
8H	3.3333	1.2856	1.4629	0	5
8I	3.6417	1.1137	1.3413	0	5
8J	3.5667	1.3012	1.6838	0	5

Appendix G

TIME-PHASED TASK LIST

For Managing A Civilian Reduction In Force

<u>Point of Contact</u>	<u>Action To Be Taken</u>	<u>Completion Date</u>
Civilian Personnel Office (CPO)	Finalize Standard Operating Procedure (SOP) on establishment and maintenance of competitive levels	- 10 months
CPO and LAMC	Identify ground rules/discretion for minimizing reassignment and recruitment within competitive levels	- 10 months
	* maximize temporary promotions	ongoing
	* avoid and correct misassignments	ongoing
	* document details	ongoing
	Focus/prioritize/freeze selected critical classification actions; keep actions to a minimum	ongoing
CPO	Reconcile LAMC records with those of CPO	- 10 months
CPO	Prepare civilian staffing plan for remainder of open period	- 9 months
CPO	Review all competitive area definitions to insure completeness	- 9 months
HSC	Canvass employees for interest in relocating to other HSC activities	- 9 months

CFO	Obtain SF 52s from LAMC of abolish actions	- 8 months
CFO and LAMC	Freeze recruit actions	- 7 months
CFO and LAMC	Competitive level review	- 7 months
CFO and LAMC	Identify affected positions	- 7 months
CFO	Establish avenue with HSC to identify vacancies in other areas where employees may wish to be considered for positions	- 6 months
CFO	Input CFO data into Army Civilian Personnel Reporting System (ACPERS)	- 6 months
CFO	Input recruitment and placement data into ACPERS	- 6 months
CFO and LAMC	Update above pertinent listings	ongoing
CFO and LAMC	Submit SF 52s/input SF 52s into ACPERS	- 6 months
CFO and LAMC	Run a mock RIF	- 6 months
CFO	Inform service population of civilian personnel aspects of base closure; conduct mini-workshops for employees to review personnel files	ongoing
LAMC	Identify retraining needs	- 5 months
CFO	Advise other Federal activities in local area of employees who require special placement consideration.	- 6 months (ongoing)

Hold a job fair for excess employees and those agencies.

CPO	Enlist Office of Personnel Management (OPM) and Federal Executive Board (FEB) assistance for interagency placement	- 6 months
CPO	Contact other Federal agencies	- 4 months
CPO	Contact non-government employment prospects	- 4 months
CPO	Activate outplacement center	- 4 months
CPO and LAMC	Have employees review Report on Individual Person (RIP)	- 4 months
CPO	Input performance appraisal data into ACPERS; cutoff for accepting performance appraisals	- 3 months
CPO	Generate RIF letters	- 3 months
CPO	Inform state and local governments Department of Army and Department of Labor officials of upcoming actions	- 3 months
CPO	Review SF 52s with organization for abolishment to ensure accuracy	- 4 months
CPO	Conduct pre-RIF notification training for supervisors	- 3 months
CPO	Freeze recruitment within the competitive area for 45 days	- 3 months

CFO	Provide notice of termination for all temporary employees	- 3 months
CFO	Process SF 52s	- 3 weeks
CFO	Make appointments for RIF letter delivery; cancel leaves during RIF letter delivery period	- 2 months
CFO	Issue RIF special notices	- 2 months
CFO	Schedule individual sessions with personnel affected by RIF	- 2 months
CFO	Provide retirement session for eligible/interested employees	as needed

Appendix H

LAMC FOLLOW-UP REFERRAL FORM

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

FOLLOW-UP REFERRAL

Patient: _____ has been treated at
 Letterman Army Medical Center (LAMC) for

I recommend that he/she be seen in 1 2 3 6 9 12 _____ months by
 a _____ . I can be reached at the

(Type of Physician)

Clinic at LAMC,

(Day of Week)

from _____ AM/PM to _____ AM/PM. Phone: (415) 561- _____

Date _____ Signature _____

Printed Name

Dr. _____ has advised me of my medical needs for
 follow-up care. I understand my needs for follow-up care. I also understand
 that the LAMC staff will attempt to help me find health care if I request
 assistance.

All services at LAMC, including inpatient, outpatient, x-ray, laboratory, and
 pharmacy, will be severely reduced after 1 July 1991. The LAMC mission will
 change and hospital services will be reduced to support the active duty and
 their dependents. Others may receive care on a space available basis.

Date _____ Signature _____

Printed Name

PATIENT'S IDENTIFICATION (Use this space for Mechanical
 Imprint)

RECORDS
 MAINTAINED
 AT: 

PATIENT'S NAME (Last, First, Middle initial)

SEX

RELATIONSHIP TO SPONSOR

STATUS

RANK/GRADE

SPONSOR'S NAME

ORGANIZATION

DEPART./SERVICE

SSN/IDENTIFICATION NO.

DATE OF BIRTH