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The Department of Defense has challenged military medical management to deliver high quality health care and continued access to all beneficiaries, with an emphasis on cost containment. Each medical treatment facility was given the latitude to manage their facilities utilizing the most effective means for their particular facility. This project analyzes a portion of Winn Army Community Hospital's response to this challenge. It asks the question: Can a multi-disciplinary Process Action Team effectively transition the delivery of primary care from the hospital-based setting to stand-alone Soldier and Family Health Clinics? The Process Action Team is made up of the Deputy Commander for Administration, the Division Surgeon, Chief: Logistics, Chief: Family Practice, Chief: Coordinated Care Division, Chief Nurse: Ambulatory Care, the NCOICs of the Troop Clinics, and the Administrative Resident. The case study approach was utilized, documenting the events that led to the successful plan fort the transition. By observing and participating in the team planning meetings, this researcher was able to document the design plans for the new clinic, as well as the effectiveness of the Process Action Team.

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FAMILY PRACTICE IN THE TROOP MEDICAL CLINIC

A Graduate Management Project

Submitted in Partial Fulfillment of Requirements for

the U.S. Army-Baylor University Graduate Program

in Health Care Administration

CPT Michael P. Ryan

May 1993

Running Head: FAMILY PRACTICE

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This project could not have been completed without the excellent support and guidance received from the staff at Winn Army Community Hospital. A special thanks goes to all of the members of the Soldier and Family Health Clinic Process Action Team who demonstrated what a small group of dedicated and motivated people can accomplish when they "think outside the box."

I am indebted to my preceptor, Colonel Thomas Whitesell, who took the time and made the effort, to make the entire year a great learning experience, even as he came to the end of his illustrious career.

I would be remiss if I did not document a special word of thanks to my wife, Chris and son, Timmy, who supported me throughout the entire two year program. Their belief that I could accomplish the requirements of the program often surpassed the beliefs in myself. They also served as a continuous reminder of what is truly important in life.

ABSTRACT

The Department of Defense has challenged military medical management to deliver high quality health care and continued access to all beneficiaries, with an emphasis on cost containment. Each medical treatment facility was given the latitude to manage their facilities utilizing the most effective means for their particular facility. This project analyzes a portion of Winn Army Community Hospital's response to this challenge. It asks the question: Can a multi-disciplinary Process Action Team effectively transition the delivery of primary care from the hospital-based setting to stand-alone Soldier and Family Health Clinics? The Process Action Team is made up of the Deputy Commander for Administration, the Division Surgeon, Chief: Logistics, Chief: Family Practice, Chief: Coordinated Care Division, Chief Nurse: Ambulatory Care, the NCOICs of the Troop Medical Clinics,and the Administrative Resident.

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INTRODUCTION

The Department of Defense is looking at innovative and alternative ways to deliver health care to its beneficiaries in response to escalating health care costs. In an effort to increase access to health care for beneficiaries and increase the quality of care, while controlling costs, the Department of Defense has directed that managed care operations be initiated at its military treatment facilities. While some initiatives have come from centralized headquarters, the challenge has gone out to each military treatment facility to manage its resources as a business. This means delivering quality care to those beneficiaries served by the facility in the most efficient and effective manner.

There are a variety of alternatives to delivering health care under these challenges, however, the focal point to this delivery is the primary care physician who acts as the gatekeeper for entry into the health care delivery system. This challenge has led to this management study. The proposal at Winn Army Community Hospital is that primary care, based at the Troop Medical Clinics, is the most effective way to meet this challenge. This transition away from hospital-based primary care to outlying clinics is in response to the

Gateway to Care business challenge mandated by the Department of Defense.

As Winn Army Community Hospital (WACH) analyzed its strategic plan and the options available in response to the Gateway to Care challenge, it became obvious that primary care would be the focal point of the hospital's strategic plan. The hospital's strategic plan was generated by WACH staff, with guidance from higher headquarters. Health Services Command has challenged its constituents to find the most effective way to deliver primary care, insuring access to quality care, while containing resources. The Installation Commander, Fort Stewart has challenged Winn Army Community Hospital to deliver family health care in a Soldier and Family Health Clinic, with total family health care as the goal. The Executive Committee of Winn Army Community Hospital must take these goals from the strategic plans of their higher headquarters and answer the challenges from both.

It is the belief of the Hospital Command Group that primary care can be delivered more effectively through the Soldier and Family Health Clinics. This move would utilize existing facilities and personnel more effectively, but does require additional family practice physicians. Space currently utilized within

WACH for primary care may be used for more specialized care in the future, with the goal to bring more services to the Fort Stewart beneficiary population.

This study will document the transition requirements of moving to the outlying clinics from the hospital. The process of transition will be executed by a multi-disciplinary Process Action Team (PAT). The intent of this study is to develop a complete blueprint for the transition to a Soldier and Family Health Clinic for one of the three existing troop medical clinics.

PROBLEM STATEMENT

Winn Army Community Hospital is attempting to answer the Department of Defense's challenge with several initiatives. One initiative has led to this study which will ask the question: Can the multi-disciplinary Process Action Team effectively transition the delivery of primary care from the hospital-based setting to primary care delivered in a stand-alone Soldier and Family Health Clinic? This group will attempt to lay the ground work for the transition in one of the three Troop Medical Clinics on Fort Stewart, in order to develop the blueprint for the transition of the remaining clinics on the installation.

LITERATURE REVIEW

Management of military treatment facilities has taken on a new dimension with the challenge of coordinated care. As commanders are tasked to provide quality care while managing resources efficiently and insuring access to all beneficiaries, strategies must be implemented that are well thought out and staffed through all available subject area experts.

In the civilian hospital industry, the increase in the demand for outpatient services has forced hospitals to reorganize the delivery of services from the inpatient units to ambulatory settings (Saslaw, 1992). The proposed transition to the Soldier and Family Health Clinics represents an initiative that is answering some of the same challenges faced by our civilian counterparts, as well as the challenges presented by coordinated care. Saslaw also recognized that as capital resources shrink, hospitals must integrate their facility expansion and renovation programs with their strategic and financial plans. This has led to an increase in the importance of designing operationally efficient facilities.

Parker (1991) argues that healthcare administrators must recognize the importance of well-designed facilities in enhanced patient care,

marketing, cost-control and staff retention. Facility construction or alteration projects must take careful measure of the design to insure that these important aspects are recognized. This project is an attempt to utilize the facility resources available to their maximum capability, with minimum expansion or construction requirements.

As discussed by Munn and Saulsberry (1992), facility planning should be based on the strategic plan of the healthcare organization. As the organization is faced with changes in its mission, the workload volume, or population served, the strategic objectives may change. Munn and Saulsberry stressed the role that environmental forces, such as politics, technology, regulation, education, etc, can play. These forces must be analyzed against internal capabilities of an existing facility when management develops a strategic plan.

According to Hardy and Lammers (1986), changes in the environment or changes in internal capabilities are what should predicate change in the use of the facility. Changes in how and where health care is delivered should not be a capricious decision, but one made as a result of the strategic plan. Krause (1990) accepted the notion that most hospitals face the

challenge of using existing and often outdated facilities to deliver high quality and cost-effective care, but that does not excuse piecemeal planning. New services should not be added simply because space becomes available. New services should be added with the long range plan as a solid guide so that efficient use of site, structure, equipment, and staffing is guaranteed.

Once a decision has been made to alter the delivery of health care in response to the strategic plan, the process must be identified that will carry the project from start to finish. According to Womack (1992), planners must realize that the process is actually a system, where individual steps impact on other steps. This process system stresses the idea that no one step stands alone and that the process is constantly evolving. At the center of this system are customers and their needs.

To accurately identify and monitor steps in the process while keeping the customer in mind requires a committee made up of people with various subject-area expertise (Ronan, 1990). Womack stressed that each step of the process of a major repair or upgrade impacts the customer's needs and the use of the facility. To lose sight of the customer during

construction phases creates a dissatisfied customer and greater organizational turbulence.

Sipkoski and Kozakiewicz (1991) advocated the committee approach to facility project planning and construction as a cost-containment tool. They recommended the team approach, involving all parties associated in the construction project as early as the planning stage. Collaboration during the earliest project stages should have the greatest impact on cost and production schedules. Further, Becker (1980) emphasized the importance of staff involvement in gaining institutional commitment. The more the staff feels in control of change, the more they will commit to the project.

Smith (1992) echoed this sentiment in his documentation of the $127 million expansion at St. Jude Children's Research Hospital in Memphis, Tennessee. This facility made use of an expansion planning committee, made up of a diverse group of subject area experts. Of particular importance was the inclusion of the users of the expanded space from physicians to laboratory researchers. This supports the arguments made by many of the researchers in that support is gained from the eventual utilizer of the space, and, because the users have a part in the planning, the

space should conform to their needs more effectively, thus insuring a greater return on the capital investment.

PURPOSE

The purpose of this study is to examine the management process of the transition of primary care from the hospital setting into the stand-alone clinic setting. In this case study, the analysis will be centered on the effectiveness of the multi-disciplinary process action team and the results of this group's endeavors to lead the transition through to completion. By examining the transition of one Troop Medical Clinic to a Soldier and Family Health Clinic, serving both the assigned soldiers and their beneficiaries in a family practice setting, a blueprint will be developed for the transition of the two remaining Troop Medical Clinics.

METHODS AND PROCEDURES

The transition to primary care in the outpatient clinic from hospital-based primary care will not be executed simultaneously for the entire Fort Stewart community. Rather, it will begin with one Troop Medical Clinic and its supported soldiers and their dependents.

The project itself is being planned through a Process Action Team. The PAT is currently made up of the Deputy Commander for Administration, the Division Surgeon, Chief: Coordinated Care Division, Chief: Family Practice Clinic, Head Nurse: Department of Primary Care and Community Medicine, Chief: Logistics, and the Administrative Resident.

As the recorder for the PAT, this researcher had access to all the documentation that was utilized by the subject area experts on the team. Some of the key documentation that was utilized included the Winn Army Community Hospital Gateway to Care business plan. Included in this document were the population data for the Ft Stewart Community, which forces the personnel and equipment requirements for the project.

Archival records that proved useful were workload data from the current hospital-based family practice clinic as well as workload data from the existing Troop

Medical Clinics. This data was supplemented by information gained through interviewing personnel from these clinics. This allowed for facts and opinions to be expressed related to the current capabilities of the existing facilities as well as prognosis of capabilities for the proposed facilities.

Direct observation by the researcher, and, participant-observation by the researcher, was the most important tool for gathering evidence. Some facets of this project were within the expertise of the researcher. By participating in the process, a better understanding of the project was gained. Also, it is believed that this provided credibility to the researcher so that other PAT members were more inclined to cooperate with the research component of this project. It should be noted that all efforts were made to respect individuals rights to privacy. All members of the PAT knew that research was being conducted on the planning process and a conscious decision was made to use only position titles in identifying people.

The central concept to the stated means of data collection was to utilize a variety of means to accomplish this task. It is believed that this variety better insured the soundness of the study. The project analyzed the data uncovered during the planning process

so that documentation existed delineating how the project moved from a concept to some finished product. Also, by observing the process of the PAT, the soundness of executing a major portion of the hospital's strategic plan by a multi-disciplinary Process Action Team was evaluated.

This is a project that is central to the delivery of health care to the Ft Stewart community under the Gateway to Care challenge. The project certainly is not the sole response of Winn Army Community Hospital to this challenge, however, it does represent a significant portion. Without an effective plan for the delivery of primary care, Gateway to Care will fail.

RESULTS

This project has resulted in two major benefits to the organization, one tangible and one intangible. The tangible benefit, which will be discussed in detail in this chapter, is that a multi-disciplinary Process Action Team has effectively delivered a blueprint for the expansion, alteration, and transition of the Troop Medical Clinic to a Soldier and Family Health Clinic. The intangible benefits, which will be delineated in the discussion chapter, are the feelings that the multi-disciplinary approach to this problem has validated the importance and effectiveness of teams of this nature and did serve as a catalyst in breaking down traditional barriers to communication.

At this time, the project is entering the contracting phase through the Directorate of Contracting (DOC) on post. The design phase has been completed by the multi-disciplinary PAT, delivering a completed blueprint, through the Directorate of Engineering and Housing (DEH), to the DOC. The term blueprint, as used here, however, refers to the entire planning process and requirements for a successful transition, not simply the architect's drawings.

The first requirement of this project was to complete a physical plant study to see if expansion and

alteration of the existing facilities were feasible. This was accomplished by Mr. John Travis, architect from the Health Services Command Facility Planning section. Mr. Travis examined the floor plans of the existing facilities and did a thorough walk through of all three Troop Medical Clinics. TMC 1 and TMC 2 have identical floor plans. (See Figure 1) TMC 3 is quite different and presented a much greater challenge, as it occupies space that was a company orderly room. He developed the initial drawings for the alteration and expansions of TMC 1 and TMC 2, after his visit to Fort Stewart and in consultation with the PAT, that provided twice the space for examination rooms. (See Figure 2) Of greater significance was the fact that the construction plans concentrated on the efficient use of space for examination rooms. While the usable space doubled, the number of exam rooms tripled from four to twelve. Further, his estimated costs for construction were below the $300,000 limit for minor construction projects. This provided the evidence needed by the command that the project was feasible.

One of the first significant results of the PAT's activities was the identification of the beneficiary population by sponsor's unit. This was an essential first step to formulate space, equipment, and personnel

requirements. Members of the team had access to the data submitted by the personnel from the office of the Deputy Chief of Staff, Resource Management Division, Health Services Command, however, there had always been some doubt as to the validity of their data. The PAT pulled together population data from the installation personnel staff, utilizing the Standard Installation/Division Personnel Systems(SIDPERS), that defined the Fort Stewart population by unit assignment. The goal was to measure number of dependents within each unit in order to determine the requirements for each Soldier and Family Health Clinic. This was determined by this process, however, the bonus result that was achieved was the evidence that the Fort Stewart beneficiary population was greater than what was determined by Health Services Command(HSC). In the age of capitated budgets, this information has proven quite beneficial.

The study of the population data led to the realization that not all of the dependents of the soldiers cared for at Troop Medical Clinics could be incorporated into the Soldier and Family Health Clinic. Space and personnel would be limiting factors in the support of this beneficiary population. (See Table 1) However, the original intent of creating Soldier and

Family Health Clinics for the major subordinate command supported at the Troop Medical Clinic could be accomplished. In other words, Troop Medical Clinics that supported the maneuver brigades would become known as "The First Brigade Soldier and Family Health Clinic" and "The Second Brigade Soldier and Family Health Clinic." The active duty population supported at these clinics will remain the same. However, the population data showed that approximately 3000 dependents would be added from the brigades. This number seems manageable from both a space and personnel perspective. As an example, the following table depicts the active duty (AD) and active duty dependent (DEP) enrollment eligible population data for the 1st and 2nd Brigade:

	#AD	#DEP
1st Brigade Total	4555	2801
2nd Brigade Total	5550	3345

It should be noted that the number of dependents within the brigades represent approximately half of the eligible dependent population whose sponsors are seen at the Troop Medical Clinic. It was felt that this was a significant reduction in the beneficiary workload seen in the outpatient areas of the main hospital. Health Services Command concurred as they provided the

funding required based upon the Primary Care Initiative submitted in the Gateway to Care Business Plan.

The CHAMPUS dollars allocated by HSC for the Primary Care Initiative in the Gateway to Care Business Plan total $460,000 for fiscal year 1993. More than $400,000 of that will be consumed by the facility modification for two TMCs. The estimate for the corresponding equipment required to convert the facilities to a Soldier and Family Health Clinic was funded at $260,000. (See Table 2) This money was funded in the fiscal year 1994 Gateway to Care Business Plan. The goal is to have the funds obligated for the construction contracts during fiscal year 1993 with a completion date of fiscal year 1994. The equipment money funded in fiscal year 1994 will be obligated at the beginning of the fiscal year, insuring that the equipment is available as construction is completed.

This project's success is contingent upon the Commanding General's commitment to utilize divisional medical assets currently at the Troop Medical Clinics to care for the enrolled dependents. It was noted that the existing TMCs are responsible for the direct patient care of approximately 5000 soldiers. The support to this population requires, on average, one-half day of patient care. This is based on direct

observation and the historical knowledge of the NCOICs of the clinics. It is also the direct observation of the Commanding General of the 24th Division, which was one of the compelling points he raised initially. His support for using Division medical assets in the Soldier and Family Health Clinics arose from the observation that his medical assets were under-utilized while the hospital was over-utilized.

Each Troop Medical Clinic is staffed with one general medical officer and three physician assistants. According to the Health Service Command Management Engineering Activity (HCMEA), the standards for a family practice model are 1566 enrolled beneficiaries per physician. Physician assistants may enroll one-third of that number, based upon supervisory requirements. It was determined that the addition of one family practice physician from Winn Army Community Hospital to the brigade Troop Medical Clinic would provide the adequate resource to support the additional population served, as well as provide stability to the clinic during periods of deployments and training exercises.

DISCUSSION

To some, this project may seem to be a simple facilities upgrade under the direction of the hospital's logistics division. In actuality, the breadth of this project was extremely large. There seems to be no way that the results could be as effective without the use of a multi-disciplinary Process Action Team. As this project unfolded, there were many instances where input from subject area experts precluded costly errors.

The multi-disciplinary PAT is an effective means to accomplish a project of this magnitude. While actual construction of the facility has not begun as of this writing, the final plans are in the contracting phase. It is anticipated that construction for the first expanded clinic will begin in the August-September time frame. The PAT has contributed to the final product through all phases of design. Without input from all members of the team, the quality of the final product would be lacking.

The final blueprint for the Soldier and Family Health Clinic is not simply an architectural drawing of the physical plant. It is a complete design of the facility that includes construction drawings, personnel requirements, interior design considerations, and

equipment requirements, both medical and administrative.

To fully comprehend the results of this Process Action Team, a discussion of the events over the reported time frame must be discussed. To begin, the decision to form this PAT and execute a transition to stand-alone Soldier and Family Health Clinics was not a haphazard one. This decision was made in conjunction with the strategic plan of the 24th Infantry Division and the strategic plan of Winn Army Community Hospital.

The hospital has the tremendous task of delivering health care to its beneficiary population, satisfying the desires of the local community, the hospital command and staff, and the Health Services Command. The hospital's leadership must balance the requirements of providing access to care, maintaining fiscal responsibility, and insuring the highest quality of care.

While the idea to transition family practice from the hospital setting to the Soldier and Family Health Clinic was approved, much work was required to carry out the task. It was determined that a multi-disciplinary PAT would be the only way to successfully complete the myriad of requirements to move from idea to completion.

There were many diverse questions that had to be answered. First, the physical plant itself had to be evaluated to determine if the expansion was feasible. It was a given that the existing space was not sufficient to add family practice to the troop care given at the clinic. The space would have to be doubled in order for the project to be feasible. The expansion possibilities were addressed by personnel from Health Services Command's Facilities Planning section. While the physical characteristics of the new facility have been discussed, the importance of these drawings on the group dynamics must be understood.

This feasibility assessment provided the catalyst the team needed to begin work on the project. The basic drawings received from Health Services Command actually served several purposes. First, they provided the basic structure to plan the interior design. More importantly, however, they provided tangible proof to the PAT that this project was, in fact, beginning to materialize. There was a feeling between the members of the PAT that this project was more wishful thinking than something that merited actual planning. The drawings provided the impetus for the creative juices to begin to flow. The fact that a source from Health Services Command provided the drawings gave the

committee the feeling that higher headquarters actually felt this was a feasible plan. In actuality, Mr. Travis had no decision making authority for the Command, but that was not discussed with the PAT.

While the drawings infused the team with its initial energy, another, more philosophical change, insured the group would retain its vitality and proceed on with the burdensome tasks ahead. The initial bi-monthly meetings had lacked direction, with no set agenda or goals. Too much staff work and discussion consumed meeting times with little tangible accomplishments. For the group to remain a team, concrete goals and objectives had to be established, as well as milestones and taskings for following meetings.

The Deputy Commander for Administration (DCA) took over responsibility for the PAT. Previously, the PAT had been run by the Chief of Logistics, during a period of transition from one DCA to another. While his knowledge of facility planning was unsurpassed within the hospital, he lacked the experience to bring the diverse PAT together. Also, it was made clear that the new DCA would assume responsibility for the PAT. The DCA had participated in various PATs during his tenure as DCA in three separate facilities, and brought a wealth of knowledge on the use of Process Action Teams.

The DCA began by establishing, with everyone's input, the mission or purpose statement for the committee. The statement decided upon was: "To transition the existing troop medical clinics to Soldier and Family Health Clinics in order to establish family member care for active duty soldiers and their dependents." Also, objectives for the team were established including:

-Reduce costs (organizational concern)

-Increase access (#1 customer concern)

-Insure quality (Assumed by customers to exist)

-Transition first Troop Medical Clinic to Soldier and Family Health Clinic by 1 Sep 1993

-Develop marketing plan

-Generate a system for enrollment

-Produce a support plan (communications, automation, laboratory, pharmacy, etc)

-Acquire sufficient number of family practice physicians

-Obtain financial support (Gateway to Care Business Plan)

-Facility design, construction, build

This mission statement and the objectives that coincided began to give much needed direction to the PAT. Along with that, meetings began to have purposes,

with tasked personnel reporting back on progress. Members of the team were challenged to come to meetings with solutions, not problems. Coordination was done in between meetings, not at meetings. This insured progress was maintained and that meetings did not drag on indefinitely. In fact, it eventually got to the point that all attempts were made to keep meetings to one hour. The productivity of the Process Action Team increased, as well as the satisfaction of the members of the team.

The representatives of the medical community who were on the team have been discussed. To comprehend the success of the PAT, it should be noted what contributions were made by the members. While the DCA kept the team focused, as previously discussed, other members of the team brought much needed technical expertise.

The Chief of Logistics was essential to the process as he understood the inner workings of the Directorate of Engineering and Housing and the Directorate of Contracting. He understood the timetable that the team had to work around. He also had served as a project officer in the construction of a new MEDDAC within Health Services Command. His tasks included monitoring the design phase, through direct

coordination with Mr. Travis, and questioning other team members as to their requirements. For example, the nursing representative had many concerns over introducing children and female dependents into a male dominated treatment facility. She was counted on to provide the structural information that would make the clinic suitable for these added beneficiaries. She could tell the Chief of Logistics that the design needed ceiling mounted privacy curtains in each examination and treatment room. The Chief of Logistics, knowing that he did not have all the knowledge of these type requirements sat down with other team members, one on one, and, explained to them what the plans showed. Members were then able to add things they felt were necessary. At the monthly meetings, the Chief of Logistics would present the compilation of the recommendations so all team members had an understanding of what was being put into the clinic. This also served as a quality control check to better insure the identification of all requirements.

The Division Surgeon was essential in the planning process. He served as the liaison to the Commanding General, who insisted on progress reports. Also, the Division Surgeon's specialty was Family Practice. In essence, he served, not only the Division, but his

physician counterparts, and was extremely useful in all aspects. The Division Surgeon essentially represented two extremely important and concerned groups. It was essential to the hospital to keep the Commanding General pleased with the progress. This project represented part of the Commanding General's plan to take care of his soldiers and their families. However, the team did not want to be pushed into a timetable that was not achievable. The Division Surgeon had first-hand knowledge of the entire planning process and kept the General up to date. In fact, the Commanding General contributed to the success of the project by sending a letter through his channels to Health Services Command, asking for support for this plan.

The Division Surgeon also brought credibility to the team in the eyes of the physicians, particularly the family physicians. The Family Practice Clinic had many concerns over this concept. The primary concern seemed to be moving away from the hospital. The General Medical Officers belonging to the Division are rarely seen in the hospital, and, are often viewed as second class citizens. The Division Surgeon's discussions with the hospital's Family Physicians persuaded them that this concept would work. As he explained the expansions and alterations, it became

evident to them that some thought had gone into the plans. In fact, the plans represented a more efficient use of space than the existing clinics within the hospital. His credibility was such, that, after several meetings, he began to represent the clinic as well as the Division. This allowed the Chief of Family Practice to keep his appointment schedule, precluding disruption to patient care.

The importance of physician involvement cannot be overstated, however, the selection must be carefully scrutinized. The Division Surgeon represented someone with a vested interest, a key stakeholder, both from his association with the Division and his professional association with the Family Physicians. His contribution cannot be overstated.

Whenever a diverse group of people are put together to solve a problem, conflict is bound to arise. If that conflict causes discussion of the issues, even heated discussion, some benefits should arise. It is safe to say that the nursing representative from Ambulatory Care caused discussion. Without this representative, however, it is safe to say that issues that were obvious from a nursing perspective would have been forgotten. Nurses can take responsibility for much of the patient-centered

alterations in the new clinic. The bathroom areas have been expanded, allowing access for the handicapped. Space was set aside for medics to take vitals, height and weight, and other information, in a private setting, not required in the existing clinic. It was the nurse who served as the constant reminder of the potential medical-legal liability faced from dependents that does not occur when treating soldiers. It was the nurse who asked where the clean linen would be stored, where the dirty linen would be kept, and, how the infectious waste would be handled. None of these issues were extremely hard to solve. The point is that they would not have been issues without the voice from nursing.

It was the members of the PAT who realized that an addition to the team was required. The non-commissioned officers in charge (NCOICs) from each of the three existing clinics were to become key members. While the PAT had an excellent representation from many areas of expertise, the NCOICs represented the clinical staff workers who would have to live with the decisions of the team. They served as a vital link to the physicians and physicians' assistants who practiced medicine in the clinics. They had a keen understanding of what equipment and materials were currently

available within the clinics. They also served as the "worker bees" to collect information on equipment requirements from their physicians, the nursing staff, and, the Logistics Division.

In the current environment which all hospitals in HSC operate, the Business Plan serves as the focal point to obtain needed funds to expand services to dependents. The Chief of Coordinated Care was responsible for taking the dollar requirements of the project and incorporating these ideas into the Business Plan. The financial results have already been discussed. However, it is worth noting that the only hope for any project requiring construction is to keep the project under the $300,000 limit of Minor Construction. Projects over that amount require approval through Congressional appropriations, and, with the current major construction projects already ongoing, there is no chance of this occurring in the near term.

The Chief of Coordinated Care was extremely well-versed in the administrative requirements of a project of this sort. Through his diligence and salesmanship, the project was funded at the levels already discussed. This role cannot be down played. The technical experts were extremely pleased with the product they were

developing, however, the desire to contribute time and effort to projects of this nature will be lost if the perceived "bean-counters" turn down proposals.

As a side note, proving the worth of primary care projects is extremely difficult. Attention is paid to high dollar areas such as surgery or psychiatry. HSC is not paying large dollars to outside sources for primary care as they are in the these other services. However, in order to make Gateway to Care successful, access to primary care must be insured. The plan had to be sold in terms, not of money saved in the near term, but in terms of the increased dependent population with a primary care physician. It is accepted by HSC that this will save funds in the long term, similar to civilian Health Maintenance Organizations. Only the Chief of Coordinated Care, who attends many conferences with the HSC personnel and understands the administrative system could put the project in acceptable terms, gaining the funding required.

As the diversity of issues increased during the planning sessions, the team often brought in subject area experts whose input was required for specific issues, but not necessary for the entire project. It was recognized by the team that other services could

provide vital information, but were not essential for the entire planning process. This would keep the numbers in the team manageable, but still allow for as much pertinent information as possible to be collected.

The pharmacist and laboratory manager, for example, provided the necessary information from their perspective on capabilities of their services within the Soldier and Family Health Clinics. They discussed with the Family Physicians, nurses, and NCOICs what they believed they needed. In the final analysis, a relatively simple formulary requiring only one pharmacy technician was deemed suitable. The Laboratory Manager had similar discussions with much of the same conclusions. One laboratory technician to do simple laboratory procedures would suffice. The important thing was that these experts provided needed input, but were not required to spend time at all of the meetings on subjects that did not concern them.

Personnel from the Information Management Division were tasked to evaluate the automation and communication needs for the expanded clinics. They coordinated directly with the NCOICs of the clinics. They were able to look at the existing Family Practice Clinic and condense the requirements for the clinics. They also served as the experts in working with the

Directorate of Information Management on the installation. This facilitated the paperwork required for the additional phone lines and computer terminals. Services were needed that would facilitate the patient appointment process. The requirements for terminals and wiring were identified before construction to alleviate the need to alter the facility at a later date. It is impossible to predict all the automated needs as evidenced by the number of holes in existing structures due to new technology, however, the goal was for the clinics to identify these type needs before the construction began.

CONCLUSIONS

While it is true that the transition to Family Practice in the stand-alone Soldier and Health Clinics is still some time away, the goal of this project was to analyze and document a Process Action Team's success in planning for a significant change in the delivery of primary care. How can that success be accurately measured?

First, the Executive Committee of Winn Army Community Hospital were kept informed of the progress and approved of the plans. Second, the plans met the approval of the Commanding General of Fort Stewart. Third, funding was secured, in a time of constrained resources, from the Health Services Command Facilities Program Budget Advisory Council. These are all strong indications that the plans are sound.

While the importance of the soundness of the plans cannot be down played, it is more important to this study to reach some conclusions as to the effectiveness of this approach to problem solving. This project has lent credence to the multi-disciplinary Process Action Team approach to delivering solutions to complex challenges. It is believed that this process will become increasingly more important as budgetary constraints cause greater challenges in the future.

While the plan itself speaks well for the team's efforts and abilities, one fact that provides evidence for the validity of this method to problem solving is the simple fact that the team stayed intact throughout the process. The members of this team are busy and responsible individuals throughout the post. Attendance was never a problem, and, the enthusiasm remained constant. This can be compared to many of the required committee meetings that enjoy little support or gain little enthusiasm from the staff. Success stories, such as these, must be marketed within the facility to prove that this approach is an effective and efficient means for developing quality solutions to complicated problems. In fact, the required committees in the hospital could learn from this example. Goals and objectives are extremely important to keep people on track and interested. Perhaps, if committee chairmen analyzed the goals and objectives of their committees periodically, the committees would become more effective.

Additionally, this study has shown that it is feasible to deliver primary care in the stand-alone clinic away from the hospital. While it is true that the project is still in the contracting phase, many of the doubters of stand-alone clinics have been convinced

that this methodology will work. The fact that the Soldier and Family Health Clinics have been designed with efficiency in mind has swayed many doubters.

Some problems will undoubtedly ensue, however, the plan to enroll small numbers within the Brigade, over time, should allow for lessons to be learned. This will also aid in the marketing of the clinic. Beneficiaries want access. The clinic will gain its support from the Brigades if access is delivered. The PAT has stressed the necessity of pilot enrollment initially. Units will enroll over an extended time period so beneficiaries will not have negative experiences at the outset.

This study has supported the Gateway to Care mission and has incurred the support of the community and the hospital as an effective alternative delivery system. The Commanding General of the Fort Stewart Installation and the Commander, Winn Army Community Hospital are committed to this alternative for the delivery of health care. This project will have significant near-term ramifications for the delivery of health care at Ft. Stewart and will serve as a building block in the Gateway to Care business plan mandated by HSC.

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Figure 1

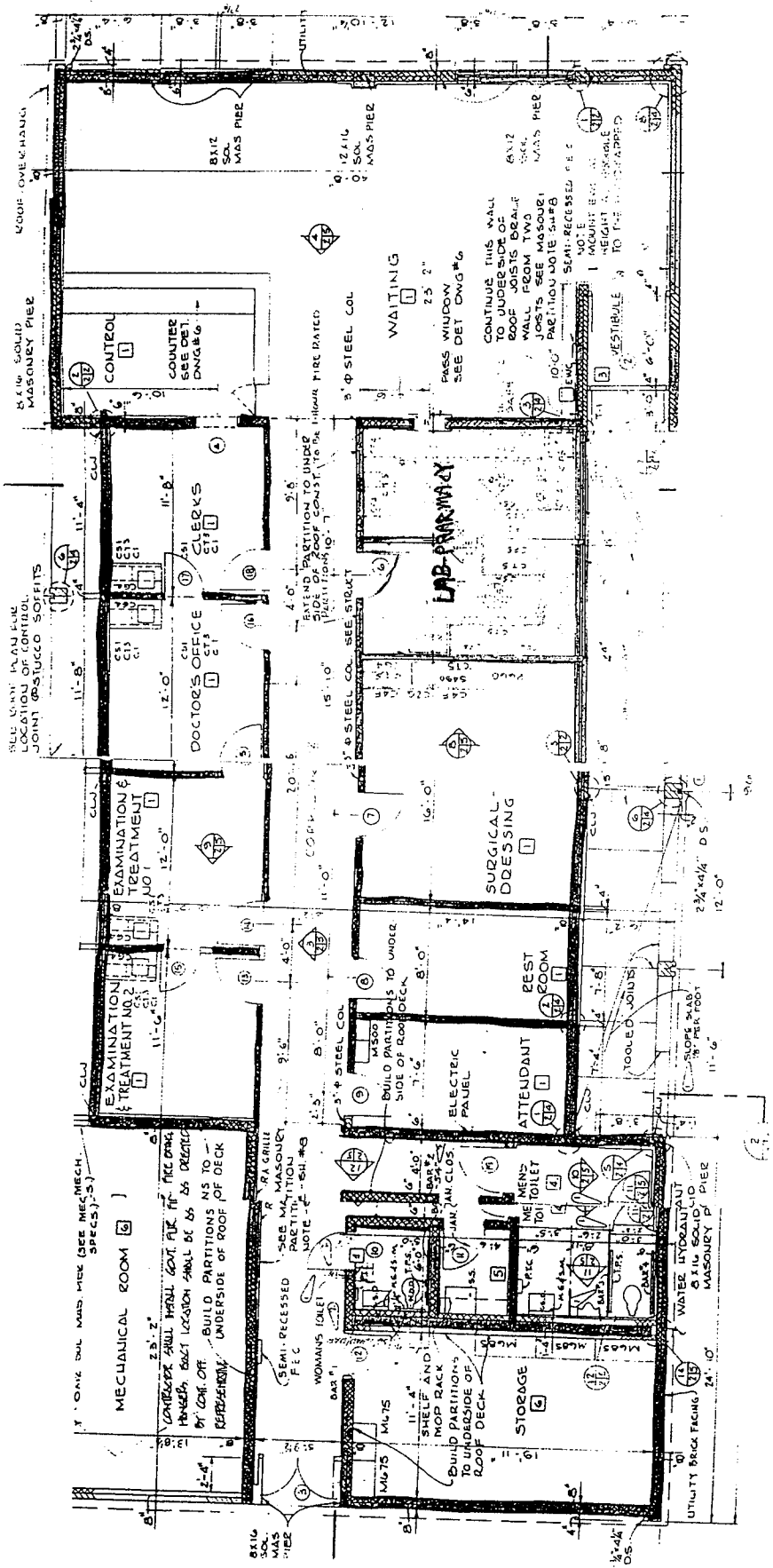
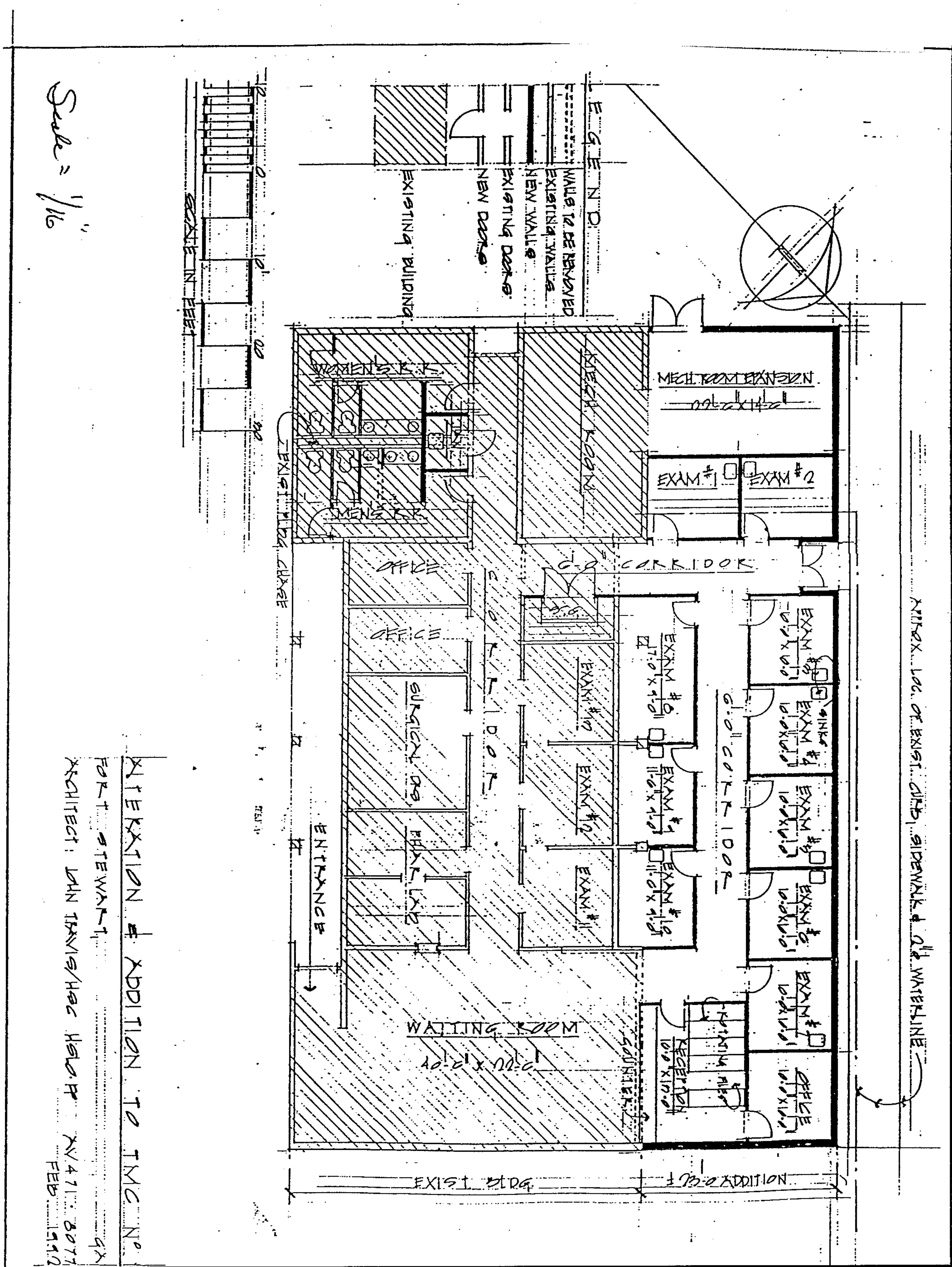

WAITING
CONTROL
CLERKS
DOCTORS OFFICE
LAB-PHARMACY
EXAMINATION & TREATMENT
SURGICAL-DRESSING
REST ROOM
ATTENDANT
MECHANICAL ROOM
STORAGE
MENS TOILET
WOMENS TOILET
ELECTRIC PANEL
TOOLED JOINTS
WATER HYDRANT
UTILITY BRICK FACING

FIGURE 2



LEGEND
WALLS TO BE REMOVED
EXISTING WALLS
NEW WALLS
EXISTING DOORS
NEW DOORS
EXISTING BUILDING
SCALE IN FEET
MECH ROOM EXPANSION
EXAM #1
EXAM #2
WOMENS R.R.
MENS R.R.
OFFICE
OFFICE
CORRIDOR
SURGICAL OB
ENTRANCE
WAITING ROOM
RECEPTION
EXIST. BLDG
ADDITION
ALTERATION & ADDITION TO TMC No.
FORT STEWART

Table 1:Population Data

UNIT	ACTIVE DUTY ASSIGNED	DEPENDENTS
	TMC #1	
HHC 1st Brigade	96	143
3-7 INF	831	959
3-69 AR	586	781
2-7 INF	835	918
HHB DIVARTY	185	301
G TAB 33 FA	79	114
38 ORD DET	12	24
3-41 FA	659	861
13th FA	162	177
1-41 FA	737	914
1-2 ADA	373	567
TMC #1 Total:	4555	5759
	TMC #2	
HHC 2nd Brigade	107	161
4-64 AR	589	720
3-15 INF	853	942
2-4 CAV	563	743
1-64 AR	575	779
USAISC Fort Stewart	35	50
HHC 24th IN DIV	395	759
NCO Academy	59	156
B CO HQ CMD MP	139	139
A CO HQ CMD	329	729
92 ENGR	596	611
632 MAINT	278	365
50 PA	5	4
30th MP DET CID	12	46
293 MP CO	93	105
24 REP	44	106
24 PSC AG	133	154
24 MP	157	166
24 IN DIV Band	32	57
24 FSU Area Sup	76	108
225 MED	17	14
153 DET	7	9
124 MI	456	535
TMC #2 Total:	5550	7458

Source: 24th Infantry Division/Fort Stewart Standard Installation/Division Personnel Systems

Table 2:Equipment Breakout

ITEM	UNIT COST	REQUIRED NO	TOTAL
Table, Surgical Inst.	$160.36	12	$1924.32
Thermometer, Electric	$270.00	16	$4320.00
Monitor, B/P Station	$2671.76	5	$13358.80
Pediatric Scale	$1840.50	1	$1840.50
Gurney, 4 Wheel	$703.64	6	$4221.84
Defib & Cardioscope	$3174.54	3	$9523.62
Electrocardiograph	$10582.50	3	$31747.50
Electrosurgical Appar.	$3471.57	3	$10414.71
Cabinet, Surg Instrument	$870.50	3	$2611.50
Cabinet, Narcotic Meds.	$1290.02	3	$3870.06
Suction Unit w/ Charger	$436.45	3	$1309.35
Scale, Person 300 lbs	$92.91	3	$278.73
Examination Table	$2047.91	9	$18431.19
Desk	$634.00	20	$12680.00
Light, Exam Floor Model	$696.28	5	$3481.40
Light, Exam Fiber-Optic	$585.10	36	$21063.60
Cabinet, Surg Inst & Dressing	$956.53	28	$26782.84
Otoscope/Ophthal. Wall Mount	$289.64	7	$2027.48
Illuminator, X-Ray Film	$1736.90	7	$12158.30
Bookcase 3 Shelf	$176.00	38	$6688.00
Wall-Mounted B/P Cuff	$225.00	7	$1575.00
Chair, Desk	$250.00	20	$5000.00
Stool, Roller	$155.00	32	$4960.00
Television, 20 in.	$500.00	3	$1500.00
VCR	$400.00	3	$1200.00
Chair	$120.00	150	$18000.00
Magazine Rack	$326.00	3	$978.00
Computer System	$4500.00	7	$31500.00
Typewriter	$597.00	6	$3582.00
Wall Unit	$250.00	15	$3750.00
Wide Filing Cabinet	$915.00	25	$22875.00
Viewer, Microfiche	$183.24	3	$549.72
Microwave	$175.00	3	$525.00
Refrigerator	$363.40	3	$1090.20
Table	$100.00	3	$300.00
Chair	$112.00	15	$1680.00
Small Refrigerator	$200.00	3	$600.00
Pager, Tone & Voice	$270.00	15	$4050.00
Suture Set	$500.00	30	$15000.00
I & D Set	$500.00	30	$15000.00
Basin Small	$30.00	30	$900.00
Basin Medium	$35.00	15	$525.00
Basin Large	$40.00	15	$600.00
Crash Cart w/ Ped Pad	$1300.00	3	$3900.00
Pediatric Board	$100.00	3	$300.00
FAX	$989.00	3	$2967.00
Anal Scope, Adult	$3500.00	3	$10500.00
Anal Scope, Peds	$3500.00	3	$10500.00
Sigmoidscope, Rigid	$500.00	3	$1500.00
Wall Mounted Meds Cab	$600.00	27	$16200.00
Fiberoptic Speculums	$250.00	50	$12500.00
		Total:	$256028.74

Source: Winn Army Community Hospital Gateway to Care Business Plan: Primary Care Initiative