(1)

CLASSIFICATION OF THIS PAGE

OCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

AD-A209 733

DTIC
JUN 05 1989

1b. RESTRICTIVE MARKINGS

3. DISTRIBUTION / AVAILABILITY OF REPORT

2b. DECLASSIFICATION / DOWNGRADING SCHEDULE
Unclassified

4. PERFORMING ORGANIZATION REPORT NUMBER(S)
130-88

5. MONITORING ORGANIZATION REPORT NUMBER(S)
Approved for public release;
Distribution unlimited

6a. NAME OF PERFORMING ORGANIZATION	6b. OFFICE SYMBOL (If applicable)	7a. NAME OF MONITORING ORGANIZATION
US Army-Baylor University Graduate Program in Health Care	Admin/HSHA-IHC	

6c. ADDRESS (City, State, and ZIP Code)	7b. ADDRESS (City, State, and ZIP Code)
Ft. Sam Houston, TX 78234-6100	

8a. NAME OF FUNDING / SPONSORING ORGANIZATION	8b. OFFICE SYMBOL (If applicable)	9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER

8c. ADDRESS (City, State, and ZIP Code)	10. SOURCE OF FUNDING NUMBERS			
	PROGRAM ELEMENT NO.	PROJECT NO.	TASK NO.	WORK UNIT ACCESSION NO.

11. TITLE (Include Security Classification)
A STUDY TO DETERMINE THE BEST ORGANIZATIONAL STRUCTURE, BOTH ADMINISTRATIVE AND PROFESSIONAL, BETWEEN REYNOLDS ARMY COMMUNITY HOSPITAL, FORT SILL, OKLAHOMA, AND ITS TROOP MEDICAL CLINICS

12. PERSONAL AUTHOR(S)
MAJ Leonard Mosesman

13a. TYPE OF REPORT	13b. TIME COVERED	14. DATE OF REPORT (Year, Month, Day)	15. PAGE COUNT
Study	FROM Jul 84 TO Jul 85	Aug 84	17

16. SUPPLEMENTARY NOTATION

17. COSATI CODES			18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)
FIELD	GROUP	SUB-GROUP	Health Care, Clinic Organizational Structure

19. ABSTRACT (Continue on reverse if necessary and identify by block number)

This study was conducted to determine the best organizational structure, both administrative and professional, between Reynolds Army Community Hospital and its Troop Medical Clinics. The current organizational system was ineffective. Surveys were sent to various large Army Medical Activities to assess the various organizational schemes in use and their viability. The author recommended movement of the Clinics to the control of the Chief of Family Practice Clinics in various any of four alternate organizational structures.

Keywords: Command guidance; military medicine; military organizations;

20. DISTRIBUTION / AVAILABILITY OF ABSTRACT	21. ABSTRACT SECURITY CLASSIFICATION
X ☐ UNCLASSIFIED/UNLIMITED ☐ SAME AS RPT. ☐ DTIC USERS	

22a. NAME OF RESPONSIBLE INDIVIDUAL	22b. TELEPHONE (Include Area Code)	22c. OFFICE SYMBOL
Lawrence M. Leahy, MAJ(P), MS	(512) 221-6345/2324	HSHA-IHC

DD Form 1473, JUN 86 — Previous editions are obsolete. — SECURITY CLASSIFICATION OF THIS PAGE

89 6 28 068

A STUDY TO DETERMINE THE BEST ORGANIZATIONAL STRUCTURE, BOTH ADMINISTRATIVE AND PROFESSIONAL, BETWEEN REYNOLDS ARMY COMMUNITY HOSPITAL, FORT SILL, OKLAHOMA, AND ITS TROOP MEDICAL CLINICS

A Graduate Research Project

Submitted to the Faculty of

Baylor University

In Partial Fulfillment of the

Requirements for the Degree

of

Master of Health Administration

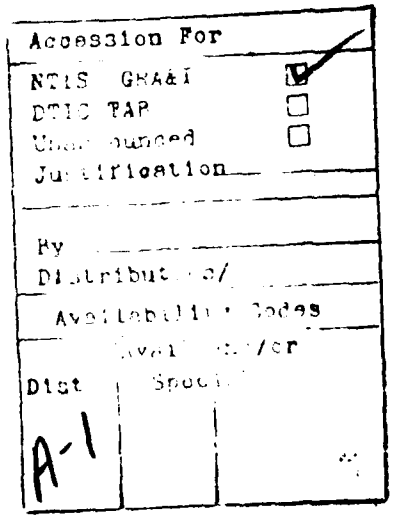
by

Major Leonard Mosesman, MSC

August 1984

ACKNOWLEDGEMENTS

The writer wishes to express his appreciation to all respondents, who took their time to answer the survey questions sent to all large Medical Department activities (MEDDACs), and to his fellow program students, who greatly assisted in distribution, follow-up, and return of the surveys. Special appreciation is extended to COL Michael J. Scotti, Jr., Commander of the Fort Polk MEDDAC, who dictated explanatory comments to numerous questions not requiring written explanation, and to MAJ Edward Matheke, Former Chief, Department of Primary Care and Community Medicine, whose conversations on and explanations of the Fort Sill MEDDAC and the family practice system paralled those of a learned college professor and formed the basis of the research question and many of the answers to the material presented in this study.



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CHAPTER I

INTRODUCTION

General Information

Mintzberg states that "every organized human activity--from the making of pots to the placing of a man on the moon--gives rise to two fundamental and opposing requirements: [1] the division of labor into various tasks to be performed, and [2] the coordination of these tasks to accomplish the activity."[1] Simply, then, an organization is the sum total of the ways in which it divides its labor into distinct tasks and achieves coordination among them.

How should that structure be designed? Is there one best way to design it? Drucker writes: "Organization is not an end in itself, but a means to the end. . . . performance and . . . results. Organization structure will seriously impair . . . performance and may even destroy it."[2]

The current Commander and the newly appointed Chief, Department of Primary Care and Community Medicine (DPC/CM), Reynolds Army Community Hospital (RACH), Fort Sill, Oklahoma, are concerned that the Medical Department Activity's (MEDDAC) current structure is not necessarily the best one for its purposes. To meet primary medical care delivery to the active duty soldier, which is seen as a major factor in maintenance of a viable readiness posture, is the primary mission of today's Army Medical Department.

Purpose of the Study

This study deals with the delivery of primary medical care to the active duty soldier by trying to determine the best organizational relationship, both administrative and professional, between Reynolds Army Community Hospital, Fort Sill, Oklahoma, and its troop medical clinics (TMCs).

Conditions Which Prompted the Study

An example of some of the problems in the current system which seem to highlight an inefficient organization and suggest a need for analysis is the overwhelming span of control confronted by the Chief, DPC/CM, who is currently the major department head in charge of TMCs. Besides five outlying TMCs, a separate building for physical examination, and one station training, there are three external health clinics off the Fort Sill installation, two in a neighboring state. Internal to the hospital is the Emergency Room (ER), the Acute Minor Illness Clinic (AMIC), and the Emergency Medical Services Unit. This is a span of control of thirteen activities; too many, too diverse in responsibilities and locations for one professional to administrate. There 's one Specialist 5 available in the Chief's office to provide continuity, but the rank and the experience of this individual limit him mainly to secretarial functions.

Further, the Chief, DPC/CM, does not hold a full-time administrative position; is considered a working professional; and, as such, is tasked with patient care in the AMIC and/or the ER, which account for 40-50 percent of his time. He is thus viewed somewhat as an outsider to

the system since he is removed from the daily professional and administrative management of the TMCs and the physician assistants (PAs) who man them. The lack of availability of the Chief, DPC/CM, has led to a divergence in the professional and the administrative organizational chains. There is a PA Coordinator position between the PAs in the TMCs and the Chief, DPC/CM, but that position is not officially recognized, is not in the rating scheme, and has no command responsibility.

The PA Coordinator is usually well respected, but, in reality, he is relegated to an information outlet for the Chief, DPC/CM, and is thus not a significant asset since he cannot set policy or procedure or give authoritative directives; no reward or punishment power resides in his position to solicit compliance, and he is thus viewed as a peer by his fellow workers. It is thought that the study of this and other existing systems might provide a better structure for the daily administrative and professional management of the TMCs and the PAs who work there.

Another administrative problem is the requirement for the physician supervisor to audit the medical records of the PA. Lack of medical record audits was a Fiscal Year 1983 Inspector General (IG) finding. Still, the proposed solution to the problem, a committee review of PA records, has not been implemented. Another solution to the problem--to allow two hours a month for review of the PA records by designated family practitioners--has since been suggested and will be implemented shortly. Since this system is untried, the results cannot be known yet, but this situation gives rise to a concern that the structured relationship between the TMCs and the hospital may profit from analysis.

These problems highlight the administrative difficulties in the

organization. However, there are professional ones too. The present structure does not facilitate delineated responsibilities within the organizational chain, making professional consultation and continuity of that consultation haphazard at best. For instance, the PAs interact with the hospital in a variety of ways. They can fill an appointment with a family practitioner for Family Practice-oriented problems; send a patient to the ER/AMIC if the case is urgent and cannot wait; and refer patients to a specialist in, for example, Obstetrics or Orthopedics or to another activity, such as Preventive Medicine for suspected venereal disease.

This basic structure has an advantage in that, if one avenue of care does not work, another is available. The disadvantages are that these options provide little continuity of consultation if the PA is free to contact any department and that no assurance is possible that a referred patient will be accepted in the system at the right point other than through the PA's personal commitment. An example that confirms the latter difficulty is that, invariably, the busiest admission route for acute respiratory disease patients for RACH is through the ER, when this sort of problem should be picked up by the PA at the TMC, the primary care entry point, and referred to a family practitioner for admission. The relationship between the hospital and the TMCs is obviously not working effectively.

Another key professional problem is the working relationship which exists between physicians and PAs in the TMCs. There is presently very little personal contact between physicians and PAs other than through telephonic consultation. This lack of personal contact creates a concern that the PAs might be referring patients whom they should not refer.

Telephonic consultation also does not appear to utilize the physician-PA working relationship in the delivery of patient care in the most effective way.

In accordance with Health Services Command (HSC) Regulation 40-5 and HSC Pamphlet 40-7-7, PAs are required to be under the supervision of a physician, who is responsible for the performance of the PAs. With the Chief, DPC/CM, spending almost half his time in actual delivery of patient care not associated with the TMCs, the remainder of his time can obviously not be spent just supervising the PAs, even though he is currently their rater. The lack of supervision resulted in another IG finding against the Fort Sill MEDDAC in Fiscal Year 1983. The action taken to correct this deficiency was to assign preceptors from Family Practice for supervision and consultation, the physicians to work with the PAs whenever possible either at the TMC or at their own clinic. This action has not, however, been fully implemented to date, and thus it is not known if the present method is an adequate solution to the PA supervision requirement or if other relationships might prove better.

As long as this restricted relationship is the only type of interface between the physician and the PA, the PA will continue to have little opportunity and probably little desire to participate in hospital continuing education programs for personal growth, since he will feel that he is an outsider. Continuing education was still another area which received a negative IG finding in Fiscal year 1983 and further highlights problems in the present structural relationship between the hospital and its TMCs.

Because of these problems and other concerns, the RACH Commander

has directed a review of the professional and the administrative organizational structure between the hospital and the TMCs in comparison with other MEDDACs to try to determine the best structure for the Fort Sill MEDDAC. It is hoped that analysis, comparison, and evaluation of many organizational systems will not only be valuable to RACH but also may prove useful, if the results are made available, to other MEDDACs during mission, structural, or personnel reorganization.

Statement of the Research Question

What is the best organizational relationship, both administrative and professional, between Reynolds Army Community Hospital, Fort Sill, Oklahoma, and its troop medical clinics?

Objectives

The objectives of this study are to:

1. Analyze and discuss the existing organizational relationship, both administrative and professional, between Reynolds Army Community Hospital and its TMCs.
2. Examine and discuss the existing organizational relationship, both administrative and professional, between other large MEDDACs and their TMCs.
3. Compare, discuss, and evaluate the advantages and disadvantages of the existing organizational relationship, both administrative and professional, between the present method at Reynolds Army Community Hospital and its TMCs and alternative methods from other large MEDDACs based upon established criteria.
4. Recommend the best organizational relationship, both administrative

and professional, between Reynolds Army Community Hospital and its TMCs.

5. If the recommended relationship differs from the current one, develop a plan for implementation of the recommended best organizational relationship, both administrative and professional, between Reynolds Army Community Hospital and its TMCs.

Criteria

The administrative and the professional organizational relationship must provide:

1. Congruence of these two chains.
2. Manageable supervisory span of control.
3. Delineated responsibility within the chains.
4. Availability of professional and administrative consultation.
5. Continuity of professional and administrative consultation.
6. Facilitation for professional growth of the PA.
7. Agreement with the functioning of the system by those who work within it.
8. Mechanism to conduct required medical audits.
9. Maximum effective utilization of and between the physician and the PA in their delivery of primary care at the TMC.
10. Adequate staffing within available resources.

See Appendix A for the Criterion Evaluation Measurement.

Assumptions

For the purposes of this study, it was assumed that:

1. The staff of other large MEDDACs would participate in answering the

survey questionnaire in a forthright manner.

2. The organizational relationships of medical centers and small MEDDACs would not prove as beneficial in comparison to the Fort Sill MEDDAC system as would those of other large MEDDACs.

Limitations

This research project was constrained by the following:

1. The inavailability of travel funds and time to visit every large MEDDAC personally to substantiate the information received from the survey.
2. The inherent limitations of a survey tool in gathering the information required.

Research Methodology

The research procedure for this study was comprised of the following steps:

1. Thorough review of the literature.
2. Preparation of two surveys with cover letters, one aimed at major department heads in the hospital and the other at physicians and PAs in the TMCs (see appendices B and C, respectively), to gather information concerning the organizational relationship, both administrative and professional, between a hospital and its TMCs.
3. Review of the surveys by the Health Services Command Consultant for Ambulatory Care and evaluation and incorporation of any recommended changes.
4. Pretesting of the surveys at RACH.
5. Evaluation of pretest results and revision of surveys as required.

6. Mailing of the revised surveys to the current U.S. Army-Baylor University Health Care Administration resident at every large MEDDAC, who was asked to conduct the survey in accordance with the instructions contained in Appendix D.
7. Follow-up with residents as required to obtain at least an 80 percent return rate of the MEDDACs surveyed.
8. On-site visit or telephonic substantiation by the researcher of the information received through the survey from the following MEDDACs: Fort Hood, Fort Leonard Wood, Fort Polk, and Fort Riley.
9. Comparison, discussion, and evaluation of the advantages and disadvantages of the systems at the different MEDDACs, as determined from the results of the survey, with the advantages and disadvantages of the RACH system based upon established criteria.
10. Recommendation of the best organizational relationship, both administrative and professional, between RACH and its TMCs.
11. Development of a plan for implementation of the recommended best organizational relationship, both administrative and professional, between RACH and its TMCs.

Footnotes

[1]Henry Mintzberg, Structure in Fives Designing Effective Organizations (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1983), p. 2.

[2]Peter F. Drucker, The Practice of Management (New York: Harper & Bros., 1954), p. 108.

CHAPTER II

REVIEW OF THE LITERATURE

Structure

The early literature on designing an effective organization focused on formal structure, the documented, official relationships among members of the organization. Two schools of thought dominated the literature until the 1950s, one preoccupied with direct supervision, the other with standardization.[1]

The "Principles of Management," fathered by Henri Fayol, were concerned primarily with specialization and organization as necessities for successful direct supervision in the organization.[2] The writers of this school of thought popularized such terms as unity of command (the notion that a "subordinate" should have only a single "superior"), scalar chain (the direct line of command from chief executive through successive superiors and subordinates to the worker), and span of control (the number of subordinates reporting to a single superior).[3]

The second school of thought promoted the standardization of work throughout the organization. In America, Frederick Taylor, the recognized father of the "Scientific Management" Movement, was mainly preoccupied with the programming of the contents of operational work. In Germany, Max Weber wrote of "bureaucratic" structures where activities had formalized rules, job descriptions, and training.[4]

For approximately the first half of this century, organizational structure meant a set of official, standardized work relationships with

a tight system of formal authority. With a series of experiments carried out on workers at the Western Electric Hawthorne Plant came the realization that other interactions were taking place in organizational structures, such as the formation of informal structure, i.e., unofficial relationships within the work group. This led to the third school of thought in the 1950s and the 1960s, called "Human Relations," which formulated such concepts as that direct supervision and standardization were at best misguided; at worst, dangerous to the psychological health of the worker, reported in the writings of Likert in 1961. More recent research has shifted away from such extreme positions and has demonstrated that formal and informal structures are intertwined and often indistinguishable.[5]

A group of researchers, using what was to become "Contingency Theory," opposed the notion of the one best structural form. Woodward announced in 1965 that the technical system of production determined a firm's structure. Lawrence and Lorsch, in 1967, found that environmental conditions impacting on an organization significantly affected its structure, and Pugh found, in 1969, that the size of an organization best explained its choice of structure.[6]

There is, then, a large and rapidly growing volume of literature, empirically based, much of it recent, to inform readers on the way in which organizations structure themselves. What it lacks, according to Mintzberg, is synthesis. "Most of the contemporary literature fails to relate the description of structure with that of the functioning of the organization."[7] Conrath concluded in 1973, after an extensive search of the literature, that "numerous concepts of organizational structure

can be found in the literature. . . . Unfortunately few of these can be . . . used directly to evidence properties of structure."[8]

Mintzberg favors another approach. The elements of structure should be selected to achieve an internal consistency or harmony as well as a basic consistency with the organization's situation--its goals, its size, its age, the kind of environment in which it functions, the technical systems it utilizes, the methods it uses to produce its products or services, and so on.[9]

For years, the literature of management suggested that a good structure was one of authority with spans of control no greater than six. Colonel Lydal Urwick unequivocally stated that "no supervisor can supervise directly the work of five or, at the most six subordinates."[10] Pfiffner and Sherwood note that "much blood has been let to reduce the executive's span [of control] with inconsequential results to administrative performance. . . . yet . . . span of control is so entrenched in the administrative culture that it must be accorded a prominent place in any book on organization."[11]

There are, however, significant ramifications regarding the number of people supervised by one person. If the span of control is too narrow, the supervisor will be managing too few people and be prone to oversupervise. If too wide, he may not be able to supervise those people effectively, either individually or in a group.[12]

There is no consensus on appropriate models for organization in hospitals and the reasons hospitals adopt specific organizational structures.[13] There is also no magic formula by which the optimum structure can be ascertained. Besides the factors presented previously, even

less well-defined factors related to a facility must be taken into account, including the philosophy of the organization, the skills of its management, and the views of management as to the problems facing the organization which are the greatest threat to its continued success.[14]

In designing a new structure, two considerations appear to be paramount. First, the reorganized structure should be as simple as possible, and, second, operational control over the entire structure must be maintained.[15] Kahn and Beam report that, although there very well may be one best structure for a given organization, it is doubtful that there is any sure way, or even any way, of finding it. Obviously, the structure should include all significant ongoing tasks to accomplish hospital goals. It should avoid excessive overlap, and, despite current unpopularity, hierarchical structure seems indispensable.[16]

Hospital structure can be depicted on an organizational chart to be used as a method of analyzing and evaluating existing organizational structures and personnel resources. This method offers a clear and concise way of visualizing the entire organization and serves as an excellent means of communication. However, limitations must be recognized: An organizational chart does not show how an organization actually functions and may be difficult to keep current. By its very nature, the organizational chart is limited in the amount of information it may contain and convey.

Process of Change

There is a growing literature on the process of large-scale change or reorganization in the form of organizational development which contains

some specific applications to health care settings. Change guidelines or behaviors are especially important in the planned change strategy. They include:

-planning for the introduction of change;
-providing direction for change efforts;
-using power to induce change;
-allowing participation in the change process; and
-mobilizing support for the total change effort.[17]

As the manager contemplates and initiates change in the organization, one theme is likely to emerge time and time again--that of resistance to the change process. The organization's members' responses to change will depend upon their own perceptions of the change and how they think it will effect their own needs and aspirations.[18]

This leads into another major area of concern in the literature--that of human factors. There are, of course, the classic theories of Maslow and Alderfer on drive reduction and Herzberg's intrinsic and extrinsic sources of work motivation and job enrichment. More current research, such as that of Morse and Lorsch (1970) and Deli (1975), has found that both motivation and performance are affected by organizational structure, technology, and goals.[19]

With the increased accountability required in health care organizations, there is greater demand for expertise and professionalism. This need is being met by a growing reliance on the corporate type of structure. Although it is not seen as a panacea, its advantages and disadvantages are being explored.[20]

Reorganization should be undertaken in a series of separate but interrelated steps that present an organized approach for implementation. The first step is to initiate a pilot study. The objectives of the pilot

study are to formulate objectives, identify problems, and project the impact of a reorganization. This helps the hospital to assess its operating environment.[21]

If a pilot study reveals no apparent barriers to reorganization, then a detailed study can begin. In this phase, those responsible will refine objectives, conduct interviews, analyze and research issues, develop and evaluate specific proposals, and conclude with specific restructuring proposals. If a new structure is approved, a work plan must be developed, setting forth a chain of "critical events" to insure that tasks are accomplished on schedule. Various individuals are assigned responsibility for specific tasks. Clearly, a reorganization cannot be accomplished overnight.[22]

Summary

A review of the literature reveals that considerable information on the theory of organizational structure is available but that a sufficient synthesis of these ideas in order to relate structure to the actual functioning of organizations has not been accomplished. There seems to be a growing acceptance in management philosophy that each organization is unique and that, therefore, the elements of structure must be carefully selected for each organization. Other information on the process of and the resistance to change and actual reorganization in the corporate community provided useful guidelines and ideas which were helpful to this study. There appear, however, to be no related research efforts either in the military health care arena or in the civilian equivalent toward determining the best relationship between a hospital and its TMCs.

Restructuring is really a means to an end and not the end itself. In most instances, restructuring is merely looking at different ways of doing the same thing. Sometimes, it is just looking at different techniques to achieve the same goal.

Footnotes

[1]Henry Mintzberg, Structure in Fives Designing Effective Organizations (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1983), p. 9.

[2]Fred Luthans, Organizational Behavior, 3rd ed. (New York: McGraw-Hill Book Co., 1981), p. 10.

[3]Mintzberg, Structure in Fives, p. 8.

[4]Ibid.

[5]Ibid.

[6]Luthans, p. 552.

[7]Henry Mintzberg, The Structuring of Organizations (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1979), p. 12.

[8]Ibid.

[9]Mintzberg, Structure in Fives, p. 3.

[10]Ibid., p. 65.

[11]J. M. Pfiffner and F. Sherwood, Administrative Organization (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1960), pp. 155-56.

[12]Alan D. Bauershemdt, "The Hospital as a Prototype Organization," Hospital Administration 15 (Spring 1970): 7.

[13]Frank A. Sloan, "The Internal Organization of Hospitals: A Descriptive Study," Health Services Research 15 (Fall 1980): 203.

[14]Richard A. Blacker, "Hospital Reorganization: Achieving Goals through Structure Design," Federation of American Hospitals Review 15 (July-August 1982): 53.

[15]Ibid., p. 51.

[16]Alfred Kahn and Robert D. Beam, The Logic of Organization (San Francisco: Jossey-Bass, Publishers, 1982), p. 271.

[17]John R. Schermerhorn, Jr., "Guidelines for Change in Health Care Organizations," Health Care Management Review 6 (Summer 1981): 9, 11.

[18]Robert A. Ullrich and George F. Wieland, Organization Theory and Design (Homewood, Ill.: Richard D. Irwin, Inc., 1980), p. 427.

[19]Ibid., pp. 222, 231.

[20]Emily Schulman Mendel, "Questions and Answers on Corporate Restructuring," Trustee 34 (November 1981): 40.

[21]Stephen Walker, "Corporate Restructuring: Walk before You Run," Trustee 35 (September 1982): 47.

[22]Ibid.

CHAPTER III

PRESENTATION OF SURVEY FINDINGS

The information by which to analyze and discuss the existing organizational relationship, both administrative and professional, between Reynolds Army Community Hospital and its troop medical clinics was gathered through questionnaire surveys (refer to appendices B and C) submitted to selected personnel at MEDDACs of a size similar to that of RACH. There were two types of survey employed: (1) one for command/department level officers (hereinafter referred to as department survey) and (2) one for physicians and physician assistants (hereinafter referred to as P/PA survey). Upon the return of these surveys to the researcher, the data were collated and analyzed to determine if the measurement standards for the surveys had been met by the responses to the questions. Such a step was not only appropriate but also necessary since any evaluation of and comparison with other MEDDACs to be accomplished in the course of the study were limited to the information gathered from the survey instruments. Thus, it was necessary to maintain a similarity in the types of information utilized.

Evaluations of the survey material are grouped by the ten major criteria (refer to Appendix A). This system is followed throughout the paper and lends a structure to the discussion which can be easily followed. A summary of all respondents' answers formatted by criterion, evaluation question, and measurement standard is presented in Appendix E.

Reynolds Army Community Hospital, Fort Sill, Oklahoma

The evaluation of the Fort Sill MEDDAC must begin with its mission. The mission of most large MEDDACs is the same--the provision of health services to authorized personnel within the MEDDAC's area. The actual delivery of that care, however, is certainly diverse, as this study will show. The delivery of care by RACH is probably a little more unique than most because of three factors:

1. The hospital has a large Department of Family Practice (DFP)--fifteen physicians.
2. It is located on a Training and Doctrine Command (TRADOC) post with no Forces Command (FORSCOM) physician and just two physician assistant assets available.
3. The number of general medical officers (GMOs) has been decreased by the necessity to "trade-off" for the larger number of family practitioners.

The three factors impacting together have created the framework within which RACH should be analyzed. Before the major criteria are evaluated for each MEDDAC, it may prove informative to review Appendix F for additional information gathered by the surveys.

Criterion 1: Congruence of chains

Twelve survey questions were used to evaluate this criterion. Question numbers in parentheses are from the department survey (Appendix B). Question numbers marked by a number symbol (#) denote queries for PAs only. Question numbers marked by an asterisk (*) denote physician questions only.

Questions 4(2) and 5(3). Queries concerning under what major department the TMCs fall for administrative responsibilities were answered almost 100 percent with the DPC/CM. However, concerning professional responsibilities, the answers varied. One hundred percent of the P/PA survey respondents replied that professional responsibilities are under the DPC/CM. The department survey respondents indicated that professional responsibilities are under the DPC/CM (57 percent), the DFP (29 percent), and the Department of Nursing (14 percent). Both surveys met the measurement standard, with 100 percent agreement by the P/PA survey and 74 percent agreement by the department survey. (Seventy percent agreement was necessary to meet the measurement standard established.) The discrepancy in the attribution of responsibility for the professional chain was explained somewhat by the sketches of the professional chain submitted (see Appendix G), which revealed that all department survey respondents showed the DFP in the professional structure.

Questions 6(4). For explication of this question, see Appendix G.

Questions 7(5). To the question, Do you feel that the administrative chain is correctly constructed? there were 100 percent agreement that it is in the P/PA survey and 50 percent agreement in the department survey. The surveys showed an average 80 percent agreement, meeting the measurement standard overall and, thus, the criterion.

Questions 9(7). To the question, Is the professional organizational chain correctly structured? the respondents to the P/PA survey indicated Yes, 50 percent, and No, 50 percent, while the department survey showed Yes, 20 percent, and No, 80 percent. Neither of these two questions satisfied the measurement standard, so the criterion was not met.

The PAs thought that there should be a GMO or a family practitioner between them and the Chief, DPC/CM, and the department survey respondents thought that the chain should go through the DFP before reaching the DPC/CM. One department survey respondent was in favor of a combined DPC/CM and DFP; another thought that the DFP should be decentralized to the TMC level to provide sick call for active duty patients, followed by dependent care.

Questions 11(9). These questions asked if there was a congruence between the administrative and the professional chain. The P/PA survey respondents replied Yes, 67 percent, and No, 33 percent, while the department survey respondents said Yes, 60 percent, and No, 40 percent, for an overall Yes rate of 64 percent. The measurement standard and the criterion were thus not met.

Summary. It was felt that the administrative chain is correctly constructed and that the professional chain is not. What is needed in the professional chain, according to the respondents, is either a GMO or a family practitioner to "supervise" or "precept" the PAs. Also, more actual similarities between the two chains are needed, meaning that either the DFP or the DPC/CM should have authority. It was felt that authority should not be split between the two departments, with one fulfilling administrative duties and one fulfilling mainly professional responsibilities. This group of questions evaluated failed overall to meet the criterion.

Criterion 2: Manageable span of control

Only questions 12(10) and 13(11) were used to evaluate Criterion 2.

The administrative chain appeared correct to 50 percent of the respondents; the professional chain appeared correct to only 40 percent. The difficulty seems to be that the chain is too broad, as 58 percent of the respondents so stated when queried as to the suitability of span of control. In the final analysis, this criterion was not met.

Criterion 3: Delineated responsibility

This criterion was evaluated with questions 14(12). Ninety-one percent of the respondents felt that they know who to contact for consultation in both the administrative and the professional chain. Delineated responsibility appears to be adequate, and thus this criterion was fully met.

Criterion 4: Availability of professional and administrative consultation

Questions 17(15) were used to evaluate this criterion. Concerning availability of professional consultation, 73 percent of the respondents said that it is readily available; 80 percent replied that administrative consultation is readily available. The measurement standard was satisfied; thus, the criterion can be considered to have been fully met.

Criterion 5: Continuity of professional and administrative consultation

Questions 16(14) and 18(16) were used to evaluate this criterion. There was 100 percent agreement on the desire to consult with the same individual for guidance on a recurring basis, but only 27 percent of the respondents reported that the individual to be contacted is always

the same person on the professional side while 73 percent replied that it is the same person on the administrative side, indicating that professional consultation continuity is an area needing improvement. Since questions 16(14) were weighted and the measurement standard was satisfied, the criterion is therefore considered to have been met for administrative consultation.

Criterion 6: Facilitation of PA growth

Seven questions were used to evaluate this criterion.

Questions #47(32). One hundred percent of the respondents at RACH indicated that contact between the PA and the physician covers less than two hours per day, not meeting the measurement standard of greater than or equal to two hours per day for this question.

Question #48. The PAs reported by 100 percent that contact with the physician is from telephone calls, once again not meeting the measurement standard for this question, which was an answer other than telephone calls or no major contact.

Questions #50 and #51(35). These questions concerned the way the PA spends his time after sick call compared to the way he feels it should be spent to best utilize his time. The answers indicated that the PA's time is usually spent working on records (55 percent) or working in the hospital (27 percent). When asked where he should spend his time after sick call, P/PA survey responses showed that PAs would prefer to spend time working on records (14 percent), attending training (24 percent), working in the hospital (38 percent), and performing other duties (24 percent), including on appointments and in the confinement facility.

What is of interest here is how the department survey respondents felt the PA should spend his time and how the PA actually spends his time. Specifically, 55 percent of the PA respondents said that they spend time after sick call working on records while only 14 percent of the department survey respondents thought that this was how the PAs' time should be spent. Twenty-seven percent of the PAs indicated that their time is spent in the hospital, while 38 percent said that this is where they should spend their time. Agreement with the measurement standard was 45 percent and 66 percent for the P/PA and the department survey, respectively; thus, the measurement standard was not met on these questions.

Question *54. See Question *54 under Criterion 9.

Summary. For Criterion 6, the majority of questions did not satisfy the measurement standard, so overall the criterion was not met. It appears that PA growth is limited because of the amount of contact with the physician, the type of contact when it occurs, and the way in which the PA spends his time after sick call is over.

Criterion 7: Agreement with system by those within it

Eleven survey questions were used to evaluate this criterion.

Questions 23 and 24(21). The researcher's intent with these questions was to determine whether or not the TMC is perceived as the place where the actual "primary" or principal care should be carried out and, if so, whether or not it was felt that more facilities than just a treatment room should be made available. However, on evaluation, it was felt that the term primary care was probably interpreted by the respondents to mean initial care and that, thus, the answers did not furnish the

researcher with the type of information the questions were designed to elicit. These questions were therefore eliminated from the evaluation.

Questions 27 and 29(24). In response to how long they thought the TMC should be open, 100 percent of the department survey respondents said All day, and 67 percent of the P/PA survey respondents agreed. This is in close agreement with what the actual hours are at RACH. The surveys showed an 82 percent agreement with the measurement standard, which met the criterion.

Questions 28 and 30(25). In response to a query on what the sick call hours of the TMC should be, 100 percent of the P/PA survey respondents said from 6:00 a.m. to 8:00 a.m., while 50 percent of the department survey respondents said the same thing, with the remaining 50 percent feeling that the TMC should be open from 7:00 a.m. to 4:00 p.m. That is, the P/PA survey respondents were in 100 percent agreement with the actual sick call hours, while only 50 percent of the department survey respondents were. Both surveys showed an overall agreement between questions of 80 percent; thus, the measurement standard was satisfied and the criterion met.

Questions 35(41) and 36(42). It was asked if the PA should screen patients at the algorithm-directed TMC (ADTMC). These responses were compared to what is actually done. There was 100 percent agreement by the PAs that they should not screen at the ADTMC and, in fact, they do not. Twenty-five percent of the department survey respondents felt that the PAs should screen at the ADTMC, but 100 percent knew that, in fact, the PAs do not, for an overall agreement rate for both surveys of 90 percent, which satisfied the measurement standard and met the criterion.

Questions 38(39). Finally, when it was asked if the referral system is correctly constructed, there was 100 percent agreement by the P/PA survey and 80 percent by the department survey respondents. This criterion was fully met.

Summary. All the measurement standards were satisfied, so overall the criterion was met.

Criterion 8: Mechanism to conduct medical audit

There were only two questions used to evaluate this criterion, questions 32(34). Audits of the PAs' medical records are required by HSC Regulation 40-5. The questions asked how the audit is being accomplished, if it is. Eighty percent of the P/PA survey respondents said that an audit is not being done. Sixty-seven percent of the department survey respondents said that it is being done on a rotating basis by a physician and 17 percent, by a committee; 17 percent said that it is infrequently done. A joint survey average of 55 percent of the respondents said that audits are being accomplished. The measurement standard was not satisfied, and subsequently the criterion was not met.

Criterion 9: Maximum effective utilization of and between physician and PA

Seventeen questions were used to evaluate this criterion.

Questions 25(22). To the question of whether or not PAs and physicians are being efficiently utilized, the P/PA survey respondents answered Yes, 80 percent, for the PAs and No, 83 percent, for the physicians. Similar results were obtained from the department survey respondents,

who answered Yes, 80 percent, for the PAs and No, 80 percent, for the physicians. The PA is apparently thought to be efficiently utilized. The PA portion of the question met the measurement standard, but not the physician portion. Comments from the P/PA survey indicated that the physician should spend more time in the TMC and that he should deal with the active duty troops more in depth. Several respondents said that physician supervisory presence is needed in the TMC; one tnought full time.

Questions 33(36) and 34(37). To the question of the setting in which the physician mainly comes in contact with the PA in comparison to the setting in which he should come in contact with the PA, 40 percent of the P/PA survey respondents answered that contact is usually in the hospital, with 20 percent saying in the clinic; 14 percent thought that contact should take place in the hospital and 86 percent, in the clinic, showing a marked difference between what actually happens and what it is thought should happen. Similarly 75 percent of the department survey repsondents indicated that contact occurs in the hospital and 25 percent, at the clinic, while 20 percent of the department survey respondents thought that contact should occur in the hospital and 80 percent, in the clinic. Agreement on the P/PA survey was 34 percent and on the department survey, 45 percent; however, it is a promising indication that, although contact is not occurring in the place both types of respondents desire, it is agreed that contact should be in a clinic setting such as a TMC or in an outpatient area. Since the measurement standard was not satisfied by these questions, the criterion was not met.

Questions #40 and #41(26). Thirty percent of the P/PA survey

respondents said that they come to the TMC to conduct sick call, training, and medical audits, while 60 percent responded that they should come to the TMC for sick call; 20 percent, for training; and 20 percent, for audits. The department survey indicated that 39 percent thought that the PAs should come to the TMC to conduct sick call and 31 percent thought that they should come to the TMC for training and audits. This is an agreement rate of 70 percent for the P/PA survey and 90 percent for the department survey. For both the surveys, there was an agreement rate of 86 percent, so the measurement standard was satisfied and the criterion met.

Questions #42 and #43(28). To the question of how long the PA usually remains in the TMC, 100 percent of the P/PA survey respondents said All day. In response to how long they should remain, 50 percent said All day and 50 percent said One-half day, in comparison to the department survey, where 100 percent said All day. Thus, the P/PA survey is in 50 percent agreement while the department survey is in 100 percent agreement. The joint survey rate is 75 percent, which satisfied the measurement standard. Thus, the criterion was met for these questions.

Questions #44 and #45(29). When asked where the PA goes when he leaves the TMC if he spends less than all day in the TMC, 50 percent of the P/PA survey respondents said To the hospital, while 50 percent said that they Don't leave. In comparison, they felt that they should leave to go To the hospital, 80 percent, and that they Should not leave, 20 percent. The department survey respondents answered To the hospital, 60 percent; To another TMC, 17 percent and Should not leave, 33 percent. The P/PA survey agreement rate was 70 percent and the department survey

agreement rate was 83 percent, for an overall rate of 77 percent, which satisfied the measurement standard. Thus, the criterion was met.

Questions #48 and (33). When asked how the majority of contact between physician and PA occurs, the P/PA survey respondents indicated that contact is mainly through telephone calls, 67 percent, and that it does not occur, 33 percent. The department survey respondents replied that contact should occur from telephone calls, 9 percent; at sick call, 27 percent; during audits, 18 percent; during training, 27 percent; and through direct observation, 18 percent. This was an agreement rate of 9 percent, the measurement standard and the criterion not being met because the majority of contact between physician and PA is through telephone calls.

Questions *54, *55, *56, *57(30), *58, and *59(31). Because responses to these questions, which were to be answered by physicians only on the P/PA survey, were not adequate (usually one respondent, no respondent, or unanswered), evaluations could not be properly made. Hence, these questions have been eliminated from the discussion. The answers to these questions are available for review in Appendix E.

Summary. It is important to remember that, overall, it was felt that the PA is utilized correctly and that the physician is not. This basic statement holds true when compared to the rest of the questions asked in evaluation of this criterion. For example, there was agreement between what the PA comes to the TMC to do and what he should come there to do. There was also agreement between how long he stays at the TMC and how long he should stay, and, further, there was agreement between where he actually does go to work if he stays in the clinic less than

all day and where he should go to work if he leaves. When questions concerning the physician's interplay with the PA were asked, the measurement standard failed. It failed when the PA was asked how the majority of contact with the physician occurs (telephone calls) and how it should occur (sick call and training). It failed when the PA was asked where the majority of the contact with the physician occurs (hospital and ER while seeing patients) and where it should occur (clinics). In the final analysis, since the questions for which the measurement standard was not satisfied were weighted questions, even though the answers to other questions did satisfy the measurement standard, overall, this criterion cannot be considered to have been met.

Criterion 10: Adequate staffing

Six questions evaluated this criterion.

Questions 19(17). These questions asked if the respondents thought that there was adequate staffing. The P/PA survey indicated 100 percent agreement that there is not adequate staffing, and the department survey showed that 80 percent thought that staffing is inadequate. Since the measurement standard was adequate staffing, this criterion was not met.

Questions 21(19) and 22(20). The final questions asked if there is a Medical Service Corps (MSC) officer in the administrative chain involving TMCs and if there should be one. The P/PA survey respondents agreed 100 percent that one is not needed and 100 percent that there is not one in the chain. The department survey indicated that one is needed, 60 percent, and that there is not one in the chain, 100 percent. The combined surveys reflected 73 percent agreement, which met the measurement standard and the criterion.

Summary. Althought one set of questions did meet the criterion, the set that did not contained weighted questions. Thus, overall, the criterion was not met. A recapitulation of all the RACH outcomes by criterion can be found in Appendix H.

Other MEDDACs

To examine and discuss the existing organizational relationship, both administrative and professional, between other large MEDDACs and their TMCs with as thorough a written analysis, with percentages met and failed, as was done for the Fort Sill MEDDAC will not be attempted here. Instead, the researcher will indicate whether or not the ten major criteria were met and expand on any areas which might prove beneficial to further comparison as to what caused a criterion to be met or to fail to be met.

Fort Belvoir MEDDAC

Criterion 1: Congruence of chains. Negative responses to the question of whether or not the administrative and the professional chain are correctly constructed were returned by two flight surgeons who wanted the airfield commander in both the professional and the administrative chain caused this measurement standard not to be met. The department surveys, however, indicated a correctly constructed administrative and professional chain. There was also unanimous agreement on congruence between the chains by both surveys' respondents. Overall, this criterion is considered to have been met.

Criterion 2: Manageable span of control. Measurement standard and criterion were fully met here.

Criterion 3: Delineated responsibility. Although there was 100 percent agreement on everyone being aware of whom to contact for consultation in the professional and the administrative chain, the method of dissemination was reported to be substantially by word of mouth: for the professional chain, 41 percent; for the administrative chain, 33 percent. Since this last question was weighted, overall, this criterion is not considered to have been met.

Criterion 4: Availability of professional and administrative consultation. Measurement standard and criterion were fully met.

Criterion 5: Continuity of professional and administrative consultation. Measurement standard and criterion were fully met.

Criterion 6: Facilitation of PA growth. This criterion was fully met because the one PA is in contact with the physician continuously throughout the workday.

Criterion 7: Agreement with system by those within it. Measurement standard and criterion were fully met.

Criterion 8: Mechanism to conduct medical audit. Measurement standard and criterion were fully met. Audits are conducted mainly by a designated physician and sometimes by a committee.

Criterion 9: Maximum effective utilization of and between physician and PA. Several questions could not be evaluated because of limited responses: however, the key to evaluation of this criterion is to remember that there is just one PA, who is working with the family practitioner in a clinic setting. Therefore, this criterion was met.

Criterion 10: Adequate staffing. There was marked disagreement over whether or not professional staffing is adequate. Respondents to

the P/PA survey reported that it is not; the department survey respondents replied that it is. Also, it was felt that an MSC officer is needed at the major administrative department level, yet there is not one, although professional-administrative support is coordinated by an MSC officer in the Clinical Support Division (CSD). Since professional staffing was not considered adequate and this question was a weighted one, overall, the criterion was not met. However, the administrative chain did meet the measurement standard and thus the criterion. A recapitulation of outcomes by criterion for the Fort Belvoir MEDDAC is presented in Appendix H.

Fort Benning MEDDAC

Criterion 1: Congruence of chains. It was felt that the administrative and the professional chain are correctly constructed but that they are not congruent. Looking at the sketches submitted, it was impossible to reach a decision on this question. There does appear to be a GMO preceptor who does not necessarily work at each TMC and a senior PA. Since the question on congruence was a weighted one, overall, the criterion is not considered to have been met.

Criterion 2: Manageable span of control. Measurement standard and criterion were fully met.

Criterion 3: Delineated responsibility. Measurement standard and criterion were fully met.

Criterion 4: Availability of professional and administrative consultation. Measurement standard and criterion were fully met.

Criterion 5: Continuity of professional and administrative consultation. Measurement standard and criterion can be considered to have

been fully met for the administrative chain since there was substantial agreement that the same individual is always contacted for consultation. The P/PA survey respondents felt that the professional chain shows continuity of consultation, but the department survey repsondents did not agree. Since this was a weighted question and the measurement standard was not satisfied for the professional chain, the criterion cannot be considered to have been met for the professional chain.

Criterion 6: Facilitation of PA growth. This measurement standard and thus the criterion were not met since the PA is usually in contact with the physician less than two hours per day, has the majority of contact with the physician by telephone, and spends the majority of his time after sick call on records.

Criterion 7: Agreement with system by those within it. There was substantial agreement on most of the measurement standard, so this criterion can be considered to have been met.

Criterion 8: Mechanism to conduct medical audit. Measurement standard and criterion were fully met.

Criterion 9: Maximum effective utilization of and between physician and PA. It was felt that the PAs are being efficiently utilized but not the physicians. The P/PA survey respondents' comments were that the physician should be working in the TMCs so the patient would get better care and the PA would learn more. Some P/PA survey respondents said that PAs should be in the DFP, and one department survey respondent said that physicians and PAs need to work together more as a team. One last comment was that, to maintain rapport and gain empathy with the PA, the physician should help with unusually high sick calls, so he should

be assigned to work with the PA for morning sick call, which would also eliminate some unnecessary referrals. The majority of the measurement standards involved here were not satisfied; thus, this criterion was not met.

Criterion 10: Adequate staffing. Although there was agreement on the need for an MSC officer in the administrative chain, staffing overall was not considered adequate. Since this last question was a weighted one, the criterion overall was not met. A recapitulation of outcomes by criterion for Fort Benning MEDDAC is contained in Appendix H.

Fort Bragg MEDDAC

Criterion 1: Congruence of chains. Measurement standards and criterion were met.

Criterion 2: Manageable span of control. The department survey respondents felt that the span of control is correct; the P/PA survey respondents did not. The measurement standards were not satisfied; thus, the criterion was not met.

Criterion 3: Delineated responsibility. There was agreement by the P/PA survey respondents that they are aware of whom to contact for consultation, but the department survey respondents did not agree. Individuals are made aware of whom to contact substantially by word of mouth. Thus, this measurement standard was not satisfied; overall, the criterion also was not met.

Criterion 4: Availability of professional and administrative consultation. There was agreement on the department survey that consultants are readily available in both the administrative and the professional

chain, but the P/PA survey respondents did not agree. Considering both surveys, the measurement standard was satisfied; thus, overall, the criterion was met.

Criterion 5: Continuity of professional and administrative consultation. All the respondents agreed completely on the desire to be able to contact the same individual for guidance on a recurring basis, but they greatly disagreed on the ability to always contact the same person. Since this last question was a weighted one and did not satisfy the measurement standard, overall, the criterion must be considered not to have been met.

Criterion 6: Facilitation of PA growth. Contact between physician and PA appears to be frequent and for a variety of reasons, although 50 percent of the P/PA survey respondents said that contact is through telephone calls. One P/PA survey respondent did say that the availability of phone consultant services is of significant value. There also appears to be a variety of duties besides working on records performed by the PA, and this was recognized by the department survey respondents. There was an even split in the questions meeting the measurement standard; thus, this criterion cannot be considered to have been met.

Criterion 7: Agreement with system by those within it. Although there was some disagreement among the department survey respondents, the P/PA survey respondents were in substantial agreement. Every question satisfied the measurement standard, and thus the criterion is considered to have been met.

Criterion 8: Mechanism to conduct medical audit. Measurement standard and criterion were fully met.

Criterion 9: Maximum effective utilization of and between physician and PA. The majority of the measurement standards involved here were satisfied; thus, this criterion is considered to have been met. It was felt that the PA and the physician are being effectively utilized but that they should not be moved around so much. The respondents felt that some degree of permanency is needed by the physician and the PA. Contact between physician and PA is mainly in the clinic during sick call and training; seeing the physician's patients was also mentioned. It is of interest to note that the time the physician spends in the TMC ranges from all day to one-half day to just for sick call.

Criterion 10: Adequate staffing. There was substantial agreement that staffing is not adequate for either the professional or the administrative structure; thus, the measurement standard was not satisfied. Since this was a weighted question, the overall criterion was not met either. There was agreement on the need for an MSC officer in the administrative chain. A recapitulation of outcomes by criterion for Fort Bragg MEDDAC is presented in Appendix H.

Fort Campbell MEDDAC

Criterion 1: Congruence of chains. There was almost no agreement between the P/PA survey and the department survey respondents in this area. One reason for this appeared to be the P/PA survey repsondents' desire to have more Division Surgeon representation in the administrative chain and the department survey respondents' desire to have less. There was generally a feeling that the Division Surgeon and the DPC/CM are sometimes at cross-missions. One respondent stated that it is inappropriate for a field artillery officer to be in the rating chain of a physician.

This criterion was not met.

Criterion 2: Manageable span of control. The P/PA survey showed agreement on both a correct administrative and a correct professional span of control; the department survey respondents felt just the opposite. The criterion was met overall for the professional span of control but not for the administrative span of control.

Criterion 3: Delineated responsibility. Once again, the P/PA and the department survey had very different answers. The P/PA survey respondents felt that they are aware of what individual to consult; the department survey respondents felt that the PAs are not. The P/PA survey respondents said that they are made aware of whom to consult in the traditional ways, mainly through means other than word of mouth, while the department survey respondents felt that word of mouth is the dominant method of knowing whom to see for both professional and administrative consultation. This last question was a weighted one, and, thus, because its measurement standard was not satisfied, overall, the criterion was not met.

Criterion 4: Availability of professional and administrative consultation. There was unanimous agreement that the individual to be contacted is not readily available if needed in both the administrative and the professional chain. Measurement standard and criterion were, therefore, not met.

Criterion 5: Continuity of professional and administrative consultation. Everyone agreed to the desire to be able to consult with the same individual, but only the P/PA survey respondents thought that continuity actually occurs, though only in the administrative chain.

Thus, the measurement standard and the criterion were met for the administrative chain but not for the professional chain.

Criterion 6: Facilitation of PA growth. Contact between PA and physician appears to happen frequently and for a variety of reasons, although telephone calls comprise a large portion of the contact. Also, there was no agreement on what the PA should spend his time doing after sick call. These questions were evenly split in satisfying the measurement standards, and, thus, the criterion cannot be considered to have been met overall.

Criterion 7: Agreement with system by those within it. The majority of the measurement standards involved here were satisfied; thus, overall, this criterion is considered to have been met. Still, questions about the referral system brought responses such as the "ADTMCs are a waste of time" and "Throw out the algorithm."

Criterion 8: Mechanism to conduct medical audit. The measurement standard and the criterion were fully met.

Criterion 9: Maximum effective utilization of and between physician and PA. The P/PA survey respondents strongly felt that they are correctly utilized; they were evenly split on the use of the physician, as were the department survey responses. One respondent said that the TMC should have a physician assigned the majority of the time, although another said that, for the majority of TMC problems, the PA is well suited and well trained to cope and does not require the presence of a physician. Still another comment was that the best utilization would be to have PAs see troops only in the morning and dependents of troops in the afternoon at a centralized TMC, which Fort Campbell MEDDAC has. One last

comment was that field requirements often strain the remaining resources and interfere with the patient care mission. Since several measurement standards were not satisfied, including one for a weighted question, this criterion was not met overall.

Criterion 10: Adequate staffing. Staffing was not considered adequate except in the administrative area by the P/PA survey respondents; thus, this measurement standard was not satisfied, and, since it was a weighted question, overall, the criterion must be considered not to have been met even though there was agreement on the need for an MSC officer in the administrative chain and there is, in fact, one in the administrative chain. A recapitulation of outcomes by criterion for the Fort Campbell MEDDAC may be found in Appendix H.

Fort Carson MEDDAC

The survey results from the Fort Carson MEDDAC were not returned in time for incorporation into this study.

Fort Hood MEDDAC

Criterion 1: Congruence of chains. It was strongly agreed that the administrative and the professional chain are correctly constructed and that a congruence exists in the chains although a mixture of dual responsibilities was reported between the Division Surgeon and the DPC/CM. All questions satisfied the measurement standards; thus, the criterion can be considered to have been met.

Criterion 2: Manageable span of control. None of the questions satisfied the measurement standard, so this criterion was not met.

Criterion 3: Delineated responsibility. There was unanimous

agreement on the desire to contact the same individual in the chain for consultation, but word of mouth was reported to be the prominent means of notification. This last question was weighted, and, since it did not satisfy the measurement standard, the overall criterion is not considered to have been met.

Criterion 4: Availability of professional and administrative consultation. The measurement standards involved here are considered to have been satisfied, as was the criterion, but one respondent felt that there is "no one reasonably available to get a hold of to talk to at the hospital."

Criterion 5: Continuity of professional and administrative consultation. Measurement standard and criterion were met.

Criterion 6: Facilitation of PA growth. This criterion was not met since there was not sufficient contact between physician and PA (only one TMC has a physician--for one-half day in the morning). Also, although there is a variety of contacts by the physician other than phone calls, audits are the next major contact, and together these two areas determine 57 percent of the overall PA to physician contact.

Criterion 7: Agreement with system by those within it. The measurement standard was satisfied for only half the questions asked, so, overall, this criterion was not met.

Criterion 8: Mechanism to conduct medical audit. Measurement standards and criterion were fully met.

Criterion 9: Maximum effective utilization of and between physician and PA. Both surveys considered the PA to be efficiently utilized, but only the department survey respondents thought that the physician

is efficiently utilized. Although there was complete agreement on the setting for PA and physician to make contact (clinics) and overall agreeemnt on why the PA should come to the TMC (to conduct sick call), there was no agreement on three other measurement standards, one of which was that the majority of PA-physician contact is from telephone calls. Numerous comments from P/PA survey respondents mentioned that the physician should be in each TMC at least one-half day and that the physician apparently feels that he is available for consultation only. Overall, this criterion cannot be considered to have been met.

Criterion 10: Adequate staffing. There was complete agreement that the administrative chain has sufficient resources to accomplish its responsibilities but not the professional chain. There was limited agreement on the need for an MSC officer in the administrative chain, even though there is one. Since the previous question on adequacy was a weighted question and since that measurement standard was satisfied only by the administrative chain, the criterion can be considered to have been met only by that chain. A recapitulation of outcomes by criterion for the Fort Hood MEDDAC is presented in Appendix H.

Fort Knox MEDDAC

Criterion 1: Congruence of chains. There was unanimous agreement on every question by type of survey that the chains are congruent; thus, the measurement standards and the criterion were fully met.

Criterion 2: Manageable span of control. Once again, the answers corresponding to these measurement standards were almost unanimous. One respondent to the P/PA survey stated that, although the span of control is correct for the professional chain, it is "often bypassed for

referrals and dialogue with all specialty areas." This criterion is considered to have been met.

Criterion 3: Delineated responsibility. There was unanimous agreement on the awareness of whom to contact for consultation, but the P/PA survey respondents felt that word of mouth is the most common way of finding out whom to consult. However, because the second question was a weighted one and it did not satisfy the measurement standard, the criterion cannot be considered to have been met overall.

Criterion 4: Availability of professional and administrative consultation, Measurement standard and criterion were fully met.

Criterion 5: Continuity of professional and administrative consultation. Measurement standard and criterion were met.

Criterion 6: Facilitation of PA growth. The measurement standards involved here were not satisfied on any of these questions; thus, the criterion was not met. Contact between physician and PA is infrequent and mostly through telephone calls or through the PA Coordinator, who naturally has more contact with the physician. Additionally, the majority of the PA's time after sick call is over is spent on records, while the PAs felt that they should be seeing scheduled appointments.

Criterion 7: Agreement with system by those within it. There were mixed comments on how long the TMCs should be open. In reality, some are open all day, several close at midday, and one closes after sick call. There also was no complete agreement on what sick call hours should be. Because these questions did not satisfy the measurement standards, the criterion cannot be considered to have been met.

Criterion 8: Mechanism to conduct medical audit. Measurement

standard and criterion were fully met.

Criterion 9: Maximum effective utilization of and between physician and PA. The PA was considered to be effectively utilized by respondents to both surveys. Physician utilization could not be evaluated because of the number of replies. Overall, there was agreement that the PA and the physician should have the majority of their contact in the clinics, which is where the PAs want to spend their time, mainly at sick call duties. There were two measurement standards which were not met: One, the PAs did not prefer to leave the TMC to be best utilized yet the department survey respondents thought that they should go to the hospital, and, two, the majority of contact with a physician occurs in a variety of ways yet it was thought by the department survey respondents that direct observation and training should rank high when, in reality, it does not. This last question was a weighted one and did not meet the measurement standard, although another weighted question did. Overall, it must be considered that this criterion was not met. One of the comments from the P/PA survey noted that "the only TMC that utilizes a physician and PA is the aviation clinic; there should be a physician in each TMC to help the PA and allow him to do something more besides triage/refer, which an LPN [licensed practical nurse]/91B can do."

Criterion 10: Adequate staffing. Administrative staffing, it was agreed, is adequate; the department survey respondents thought that professional staffing is adequate also, although, overall, the professional chain did not satisfy the measurement standard. This was a weighted question, and only the administrative chain responses satisfied the measurement standard and the criterion. On the questions concerning having

an MSC officer in the administrative chain, there was agreement on the need for an MSC officer, and one is so employed. Nevertheless, this criterion overall cannot be considered to have been met. A recapitulation of outcomes by criterion for the Fort Knox MEDDAC can be found in Appendix H.

Fort Leonard Wood MEDDAC

Criterion 1: Congruence of chains. There was complete agreement that the administrative and the professional chain are correctly constructed and there was general agreement with their congruence. The only disagreement was that the major department head for the administrative chain was listed as the DPC/CM by some and as the CSD by others. A look at the respondents' wire diagrams shows the DPC/CM as the major activity head. The majority of measurement standards were satisfied, and, thus, the criterion is considered to have been met.

Criterion 2: Manageable span of control. Measurement standard and criterion were fully met.

Criterion 3: Delineated responsibility. There was unanimous agreement on the awareness of the individual to contact for consultation if needed; however, the P/PA survey respondents thought that word of mouth is substantially the method of making people aware of whom to contact in the chain. Concerning the administrative chain, however, it was agreed by all that awareness of whom to consult is substantially by methods other than word of mouth. Thus, the measurement standard and the criterion were met.

Criterion 4: Availability of professional and administrative consultation. Measurement standard and criterion were fully met.

Criterion 5: Continuity of professional and administrative consultation. Measurement standard and criterion were fully met.

Criterion 6: Facilitation of PA growth. Contact between physician and PA does not occur frequently, and what contact there is often comes about through telephone calls. Although there was substantial agreement by all respondents on where the PA should spend his time after sick call (hospital) and where he does spend his time overall, the majority of measurement standards were not satisfied and, thus, the criterion was not met.

Criterion 7: Agreement with system by those within it. There was substantial agreement with the way the system is organized by those within it, so all measurement standards were satisfied and the criterion was met.

Criterion 8: Mechanism to conduct medical audit. Measurement standard and criterion were fully met.

Criterion 9: Maximum effective utilization of and between physician and PA. The majority of department survey respondents thought that the PA and the physician are efficiently utilized, although the P/PA survey respondents had mixed reactions about this. However, the measurement standard for the P/PA responses is considered to have been met. There was unanimous agreement on the setting in which the PA should come in contact with the physician (the clinic) and on the reason the PA should come to the TMC (to conduct sick call). There was close agreement on how long the PA should remain in the TMC, mainly one-half day, and on how the majority of contacts with a physician are made. In these responses, although telephone calls were significant, a great deal of contact

was said to occur in other areas, such as training and direct observation. Finally, there was the recognition by the department survey respondents that the best place for the PA, if he stays less than all day in the TMC, is at the hospital. Most of the measurement standards involved here were satisfied, so overall the criterion was met. Comments from the department survey respondents indicated that the physician is a supervisor and not a "hands-on" provider in the TMC; he comes for evaluation, audit, training, and consultation, and, as a supervisor, he travels to several TMCs and then back to the hospital. The P/PA survey respondents, however, noted that a physician is desired in the TMC to improve the patient care system. Two respondents to the P/PA survey commented that a consolidated TMC would better provide patient care and better utilize the PA.

Criterion 10: Adequate staffing. There was substantial agreement on the need for an MSC officer in the administrative chain, and one is assigned. There was also agreement that the professional staffing is adequate; there was not sufficient agreement, however, that the administrative chain is adequately staffed. Since this last question was a weighted one and the measurement standard was not completely satisfied for the administrative chain, the criterion is considered to have been met only for the professional chain. A recapitulation of outcomes by criterion for the Fort Leonard Wood MEDDAC can be viewed in Appendix H.

Fort Ord MEDDAC

The measurement standards for the surveys sent to the Fort Ord MEDDAC were evaluated using only the P/PA survey, of which no respondents were physicians. There were no department surveys returned.

Criterion 1: Congruence of chains. It was felt that both the administrative and the professional chain are correctly constructed but that congruence is lacking in these chains. This was substantiated by a comment that the administrative chain falls under the Division Surgeon and by other comments that it is under the DPC/CM. Since not all the measurement standards were satisfied, the criterion cannot be considered to have been met.

Criterion 2: Manageable span of control. There was unanimous agreement that the span of control for the professional chain is correct, but there was an even split on the administrative side. The measurement standard was thus satisfied for the professional chain but not for the administrative chain. The criterion can therefore be considered to have been met only for the professional chain.

Criterion 3: Delineated responsibility. There was unanimous agreement that everyone is aware of whom to contact for consultation, but the way in which they are made aware of whom to consult is mainly through word of mouth. This last question was weighted, and, because it did not satisfy the measurement standard, the overall criterion cannot be considered to have been met.

Criterion 4: Availability of professional and administrative consultation. Measurement standard and criterion were fully met.

Criterion 5: Continuity of professional and administrative consultation. There was total agreement on the desire to consult with the same individual on a recurring basis; it was felt, however, that this is likely to occur only on the administrative side. Thus, the measurement standard and the criterion were satisfied for the administrative but

not for the professional chain.

Criterion 6: Facilitation of PA growth. Responses on contact between PA and physician met the measurement standard of greater than or equal to two hours per day; however, a good majority of contact is from telephone calls. There was substantial agreement between what the PA thought he should be doing after sick call and what he actually does. There was no physician response, so this perspective on contact between physician and PA could not be evaluated. The majority of the measurement standards were satisfied, so the criterion is considered to have been met.

Criterion 7: Agreement with system by those within it. There was complete agreement on the length of time the TMC should stay open and the construction of the referral system, with partial agreement on whether or not the PA should screen at the ADTMC. The only measurement standard not satisfied was the one concerning the hours which sick call should comprise. Substantial satisfaction of the mesurement standards resulted in the criterion being met. Several comments from the P/PA survey respondents indicated a need to abolish the algorithm.

Criterion 8: Mechanism to conduct medical audit. The measurement standard was not satisfied since the indication was that the medical audit is primarily not done or is done by the PA. This criterion is not considered to have been met.

Criterion 9: Maximum effective utilization of and between physician and PA. The P/PA survey respondents felt that both physician and PA are utilized efficiently, but there was no agreement on the setting in which the PA should come in contact with the physician (a weighted question) or on the reasons the PA should come to the TMC. There was agreement

on how long the PA should stay at the TMC (one-half day) and where he should go when he leaves (to the battalion aide station [BAS]). Overall, since several measurement standards were not satisfied, including one for a weighted question, the criterion cannot be considered to have been met.

Criterion 10: Adequate staffing. The P/PA survey respondents thought that there is not adequate staffing on the administrative side but that there is on the professional side. Since this was a weighted question, the measurement standard and the criterion are considered to have been met for the professional side but not for the administrative side. A majority said that an MSC officer is not needed but were uncertain as to whether or not one is currently utilized, so this measurement standard was not met. The recapitulation of outcomes by criterion for the Fort Ord MEDDAC is presented in Appendix H.

Fort Polk MEDDAC

Criterion 1: Congruence of chains. The responses to these questions showed complete agreement and thus the measurement standards and the criterion were fully met. Of interest in this structure was the fact that a separate chief, DPC/CM, was eliminated when the MEDDAC went to an all family practice system and now the Deputy Commander for Clinical Services (DCCS) also serves as the Chief, DPC/CM.

Criterion 2: Manageable span of control. Measurement standard and criterion were fully met.

Criterion 3: Delineated responsibility. There was some uncertainty on the part of the department survey respondents as to the amount

of awareness of whom to contact for consultation in both the administrative and the professional chain. The P/PA survey respondents felt that they are aware of whom to contact. The method, however, of making people aware of whom to contact is substantially by word of mouth. This was a weighted question, and, thus, because the measurement standard was not satisfied, the criterion overall is not considered to have been met.

Criterion 4: Availability of professional and administrative consultation. Measurement standard and criterion were fully met.

Criterion 5: Continuity of professional and administrative consultation. There was total agreement on the desire to be able to consult with the same individual for guidance on a recurring basis, but actually the individual is not always the same one. This last question was weighted, and the measurement standard was not satisfied. Not satisfying this measurement standard meant that the overall criterion was not met.

Criterion 6: Facilitation of PA growth. There appears to be substantial contact between the physician and the PA in the form of direct observation. There was some hint of disagreement on how the PA should spend his time after sick call is over and how he actually does spend it. The P/PA survey respondents thought that the PA spends time working on records, undergoing training, and working at the BAS after sick call, while the department survey respondents thought that the PA spends time mainly in the BAS. The results were very close to satisfying the measurement standard. Overall, the majority of measurement standards were satisfied, and thus the criterion can be considered to have been met.

Criterion 7: Agreement with system by those within it. There was agreement on these responses except for what hours sick call should

comprise. Since the majority of the measurement standards were satisfied, the criterion can be considered to have been met.

Criterion 8: Mechanism to conduct medical audit. Measurement standards and criterion were fully met.

Criterion 9: Maximum effective utilization of and between physician and PA. There was significant agreement that, under the current system, the PA and the physician are efficiently utilized. It was thought that contact between PA and physician should happen at the TMC, and that is where the majority of contact does occur. There was some disagreement on whether or not the PA should stay in the TMC all day, but, if he leaves, it was agreed that his efforts should be utilized at the BAS. The majority of the measurement standards were satisfied, and, thus, this criterion is considered to have been met overall. One comment by a department survey respondent is of interest. His thought was that the PA should report to the TMC only after stopping at the BAS; then, if patients could not be handled at that level, they could be referred to the TMC, where the PA has better equipment for treatment.

Criterion 10: Adequate staffing. There was agreement that the professional staff is adequate to accomplish its responsibilities. There was a close consensus on the administrative side that staffing is less than adequate, so this measurement standard was not met. There was overall agreement on the need for an MSC officer in the administrative chain, and one is so employed. Because the adequacy of staffing was a weighted question and the responses on the administrative chain did not satisfy the measurement standard, only the responses on the professional chain can be considered as meeting the criterion. A recapitulation of outcomes

by criterion for the Fort Polk MEDDAC is presented in Appendix H.

Fort Riley MEDDAC

Criterion 1: Congruence of chains. It was felt that the administrative and the professional chain are correctly constructed; however, there was a lack of agreement as to whether or not the chains are actually congruent. Studying the wire diagrams, it appears that they are not similar. Since this question was a weighted one, failing to satisfy the measurement standard meant that the overall criterion was not met. Comments by both P/PA and department survey respondents indicated that a combination of division and MEDDAC chain sometimes leads to confusion.

Criterion 2: Manageable span of control. The administrative chain was considered correct but not the professional one. Thus, the administrative chain met the measurement standards and criterion, but the professional chain did not.

Criterion 3: Delineated responsibility. There was significant agreement on the awareness of whom the individual to be contacted for consultation is, but the manner of making people aware of this individual is substantially by word of mouth. Since the last question was weighted and the measurement standard was not satisfied, the overall criterion is not considered to have been met.

Criterion 4: Availability of professional and administrative consultation. It was felt that administrative consultation is readily available but not professional consultation. Thus, the administrative chain satisfied the measurement standard and met the criterion; the professional chain did not.

Criterion 5: Continuity of professional and administrative consultation. There was significant agreement on the desire to contact the same individual in case guidance is needed; however, it was felt that in neither the professional nor the administrative chain does this occur. Since the last question was weighted and failed to satisfy the measurement standard, overall, the criterion is not considered to have been met.

Criterion 6: Facilitation of PA growth. Although there are two physicians in the Fort Riley TMCs, PAs are not in contact with them for a significant number of hours. Of what contact there is, a substantial portion is by telephone. Most measurement standards for these questions were not satisfied; thus, overall, the criterion was not met.

Criterion 7: Agreement with system by those within it. There was partial agreement on when the TMC should be open and on what the sick call hours should be. There was significant agreement on whether or not the PA should screen at the ADTMCs (No) and on the referral system. The majority of the measurement standards involved here were satisfied, so, overall, this criterion is considered to have been met.

Criterion 8: Mechanism to conduct medical audit. Measurement standards and criterion were fully met.

Criterion 9: Maximum effective utilization of and between physician and PA. It was felt that PA and physician are efficiently utilized, and it was agreed that contact between physician and PA should be in the clinic setting. The PA comes to the TMC to conduct sick call mainly, and this was in agreement with what the survey respondents thought the PA should do. The PA appears to remain in the TMC only one-half day,

and, again, this was in agreement with what the department survey respondents felt would best utilize the PA. There was not, however, agreement as to where the PA should go after sick call. Usually, the PA goes to the hospital or the physical exam center, but the P/PA survey respondents thought that the majority of the PA's time should be spent at the hospital, which was in agreement with the department survey responses. A majority of contact with the physician is by telephone, although direct observation is also prominent. The department survey respondents thought that direct observation is most important. Overall, the majority of the measurement standards were satisfied, so the criterion was met. Two department survey respondents said that, since there are more TMCs than GMOs, it might be best to utilize a consolidated TMC after sick call. A respondent to the P/PA survey said that going from TMC to TMC needs to be stabilized so that there can be better follow-up.

Criterion 10: Adequate staffing. It was felt that there is adequate administrative staff but not adequate professional staff. It was also felt that, overall, an MSC officer is needed in the administrative chain involving TMCs, and one is currently so employed. Since the first question was a weighted one and only the administrative chain satisfied the measurement standard, only the administrative chain can be considered as meeting the criterion. A recapitulation of outcomes by criterion for the Fort Riley MEDDAC is located in Appendix H.

CHAPTER IV

ANALYSIS OF SURVEY FINDINGS

The method chosen to compare, discuss, and evaluate the existing organizational relationship, both administrative and professional, between RACH and its TMCs with alternative methods from other large MEDDACs will be, first, to look at the ten major criteria to ascertain which ones were not met by the Fort Sill MEDDAC. Then, using the same criteria which Fort Sill MEDDAC did not meet, it will be determined if a better system, idea, or comment can be found by looking at the systems of the MEDDACs that did meet the criteria. The initial information can be easily found by looking at the recapitulation of outcomes by criterion for all MEDDACs contained in Appendix H.

Criterion 1: Congruence of Chains

Criterion 1 was not met by RACH. The main reason for this was the belief that the professional chain is not correctly constructed and an obvious dissimilarity between the administrative and the professional chain (refer to Appendix G). This noncongruence leads to a division of responsibility that may perhaps cause a breakdown of interface and communication among all involved parties and, thus, inefficiencies in performing the mission. In looking at other MEDDACs that did meet this criterion, Fort Belvoir, Fort Bragg, Fort Hood, Fort Knox, Fort Leonard Wood, and Fort Polk, all, except Fort Knox and Fort Leonard Wood, have exactly the same administrative and professional responsibility chains.

Fort Knox and Fort Leonard Wood are almost identical except for the addition of a PA coordinator in the professional chain between the PAs and the major department head. Certainly these chains are significantly simpler and more congruent than the ones at RACH.

A hidden blessing of the Fort Sill MEDDAC may be its not being on a FORSCOM post and having a Division Surgeon; this is pointed out by the several activities that did not meet this criterion, e.g., Fort Campbell MEDDAC respondents felt that the Division Surgeon and the DPC/CM are often at cross-missions. This situation is also present at the Fort Ord and the Fort Riley MEDDAC, and they did not meet this criterion either. Fort Bragg and Fort Hood MEDDAC have Division Surgeons but met the criterion, as did the Fort Polk MEDDAC, which has an interesting system. First of all, the Fort Polk MEDDAC eliminated the separate Chief, DPC/CM, slot when the MEDDAC went to an all family practice system and now the DCCS serves as Chief, DPC/CM, with Physical Exam (PE) and Emergency Medical Services (EMS) reporting to him. There are no outlying clinics. The Division Surgeon is also the Chief of TMCs in order to fulfill the obligation of the Director of Health Services for post, which keeps him from being left out of the responsibility of troop care and enhances his control over brigade surgeons and division PAs. It is also of interest to note that, in all MEDDACs that met this criterion, they either have a PA/GMO coordinator or the PAs actually work with the physicians in the TMCs. RACH has this position, too, and it appears to be one which should be maintained.

Criterion 2: Manageable Span of Control

Criterion 2 was not met by the Fort Sill MEDDAC. The MEDDACs that met the criterion in its entirety were those at forts Belvoir, Benning, Knox, Leonard Wood, and Polk. The two MEDDACs that did not meet this criterion at all, those at Fort Bragg and Fort Hood, happen to have the largest number of TMCs. RACH ranks with those having the lowest number of TMCs. This criterion will not be discussed at any great length since, as the literature review suggested, perhaps too much emphasis has been given to the subject already.

What certainly needs to be realized is that span of control needs to be considered in conjunction with staffing and responsibility. In the case of RACH, there is a Chief, DPC/CM, who is currently a major department head in charge of TMCs. Besides five outlying TMCs, a separate building for physical examinations, and one station training, there are three external health clinics off the Fort Sill installation, two in a neighboring state. The Chief, DPC/CM, also has control over the ER, the AMIC, and the EMS Unit. This is a span of control of thirteen activities, with diverse responsibilities and locations, which one professional administrates. There is a Specialist 5 in the office to help provide some continuity, but the rank and the experience of this individual limit his functions. Further, the Chief, DPC/CM, is considered to be a working professional and, thus, is not even a full-time administrator.

Criterion 3: Delineated Responsibility

This criterion was fully met by the Fort Sill MEDDAC, so no comment is necessary.

Criterion 4: Availability of Professional and Administrative Consultation

This criterion was fully met by the Fort Sill MEDDAC, so no comment is necessary.

Criterion 5: Continuity of Professional and Administrative Consultation

For the Fort Sill MEDDAC, the respondents reported continuity of consultation on the administrative side but not on the professional side, as was the case with three other MEDDACs. There was complete positive agreement by all MEDDACs on the question of whether or not they desired to consult with the same individual for guidance on a recurring basis in both the professional and the administrative area.

No additional information was gathered to enable the researcher to determine why there is continuity in some MEDDACs and not in others, but one comment from the Fort Knox MEDDAC, which met the criterion, might prove informative. The respondent said that the professional chain is often bypassed, as the PA has referral and dialogue privileges with all specialty areas. This situation is known to exist at the Fort Sill MEDDAC, where the PAs interact with the hospital in a variety of ways. This basic structure has an advantage in that, if one avenue of entry into the system does not work or is not available, another can be tried. The disadvantage is that continuity in the chain is interrupted.

A PA at the Fort Ord MEDDAC commented that he seeks out "the experts in the area and not someone just because they are filling a slot." This attitude might very well indicate why the respondents at seven out of eleven MEDDACs felt that professional continuity is not present at their MEDDAC.

Criterion 6: Facilitation of PA Growth

Criterion 6 was not met by the Fort Sill MEDDAC. Two very important reasons for this are the limited amount of contact between PA and physician and the fact that what contact does exist is mainly telephonic. Further, the PA usually spends his time on records after sick call is over. It is interesting to note that both P/PA and department survey respondents at the Fort Sill MEDDAC agreed that the PA should not be spending the majority of his time on records after sick call.

Three MEDDACs met this criterion, those at Fort Belvoir, Fort Ord, and Fort Polk. The advantage to all these MEDDACs is significant PA-physician interface in the clinic setting. The Fort Belvoir MEDDAC has its one PA at a satellite clinic with two family practitioners; the Fort Ord MEDDAC has a PA with a GMO or a flight surgeon in four of its five TMCs; and the Fort Polk MEDDAC couples its PAs with a brigade surgeon, a MEDDAC GMO, or a flight surgeon. It should again be noted that these are the three MEDDACs with the least number of TMCs and that Fort Sill MEDDAC is the same size as two of these. Having a PA with a physician in the clinic setting obviously facilitates PA growth by direct contact through observation by; indepth, immediate consultation with; and training from the physician.

Criterion 7: Agreement with System by Those within It

Almost every MEDDAC, including RACH, met this criterion; therefore, no comment is necessary.

Criterion 8: Mechanism to Conduct Medical Audit

For the Fort Sill MEDDAC, the department survey respondents thought that medical audits were being performed, but the P/PA survey respondents did not. The overall result was that 55 percent said that audits are accomplished; thus, the Fort Sill MEDDAC failed to meet this criterion. Every other MEDDAC but that of Fort Ord met this criterion.

The consensus on the way in which medical audits are performed is presented in Table 1. The designated physician was usually the Chief,

TABLE 1

SUMMARY CONSENSUS ON MECHANISM TO PERFORM MEDICAL AUDITS

Mechanism	Consensus Percentage
Designated physician	75
Committee	10
Other	6
PA	4
Rotated among physicians	4
Not done	1
TOTAL	100

DPC/CM, followed by the Division Surgeon, the GMO supervisor, and the TMC officer-in-charge. Most of these mechanisms have the capability of working. Designated physician, committee, and rotation among physicians pinpoint responsibility to get the medical audit accomplished. The PA is obviously not the individual to audit his or his cohorts' records,

so this means should be excluded from the possible mechanisms for medical audit.

Criterion 9: Maximum Effective Utilization of and between Physician and PA

The Fort Sill MEDDAC did not meet this criterion, nor did five other MEDDACs. The reason for failure appears to be not the utilization of the PA but rather the utilization of the physician with the PA. The present method at RACH brings the PA to the TMC to conduct sick call, where he usually remains all day. If the PA does get a chance to leave, he goes to work at the hospital. This routine is in agreement with what the PA desires to do and what the department survey respondents felt should happen. Physician interface with PAs is minimal, however; the majority of contact is by telephone, although some occurs in the ER during additional duties for the PA.

The Fort Belvoir MEDDAC met this criterion because its one PA works with the family practitioner in the satellite clinic. The Fort Bragg MEDDAC met the criterion even though the time a physician spends in the TMC ranges from all day to one-half day to just for sick call. The Fort Knox MEDDAC did not meet the criterion, but a P/PA survey respondent in the Fort Knox MEDDAC had an interesting perspective on the utilization of the PA. His comment was that a physician should be in the TMC to help the PA, to allow him to do "something besides triage/referral, which an LPN/91B could do." One department survey respondent at the Fort Leonard Wood MEDDAC, which met the criterion, stated that the "physician is a supervisor and not a 'hands-on' provider [at the TMC level] but should come for evaluation, audit, training, and consultation.

He is a supervisor of several TMCs and goes to each before returning to the hospital." This type of system is certainly different from the current one at RACH and implies a very different interface between physician and PA.

A department survey respondent from Fort Riley MEDDAC noted that, if there are more TMCs than GMOs, then perhaps the TMC function should be consolidated, at least after 12:00 noon. The Fort Sill MEDDAC does have a shortage of GMOs, so this suggestion might help to correct the difficulty of physician and PA not being able to work together.

A respondent from the Fort Polk MEDDAC, which also met the criterion, commented that the best utilization of the PA is for him to report to the TMC only after stopping at the BAS, where the ADTMCs have indicated which patients the PA should see. Patients not able to be handled by the PA at that level should then be referred to the TMC, where the PA has better equipment to handle patients. This suggestion could very well decrease sick call numbers enough to free the PA at mid-morning for other, more worthwhile activities, such as training, working with a physician in the hospital, etc.

Criterion 10: Adequate Staffing

Part of this criterion was purely a subjective evaluation for the respondents to see if they thought that staffing was adequate in the professional and the administrative area. Forty-five percent of the respondents indicated that there is adequate staffing in both chains; an additional 18 percent said that there is adequate staffing in either the administrative or the professional area, but not both. Respondents at four MEDDACs, including those at Fort Sill, thought that there is

not adequate staffing in either area. It is interesting that, of these facilities, two are TRADOC--Fort Benning and Fort Sill--and two are FORSCOM--Fort Bragg and Fort Campbell. It might have been assumed that staffing problems would occur more often on a TRADOC post because of unavailability of additional assets from FORSCOM units.

CHAPTER V

CONCLUSIONS, RECOMMENDATIONS, AND PROPOSED IMPLEMENTATION PLAN

Conclusions

As a result of this study, the following conclusions have been reached:

1. The present organizational relationship, both administrative and professional, between Reynolds Army Community Hospital and its troop medical clinics is an ineffective system because the two chains of responsibility lack congruence, the span of control is incorrectly structured, the continuity of professional consultation is absent, the growth of physician assistants is not facilitated, no mechanism is established to audit PA records, the maximum effective utilization of and between physician and PA at the TMC is not provided, and the staffing is not adequate.
2. The information received from surveys for examination, discussion, and comparison of the existing organizational relationship, both administrative and professional, between other large MEDDACs and their TMCs provided data which can be used in the formulation of recommendations to restructure the organizational relationship, both administrative and professional, between RACH and its TMCs to provide the best organizational relationship possible.

Recommendations

Recommendations on the best relationship, both administrative and professional, between Reynolds Army Community Hospital and its TMCs are listed below. Each recommendation listed is expected to satisfy certain measurement standards of a criterion not met in the survey. This relationship is also indicated below. The recommendations, evolved through examination and analysis of the survey data and subsequent pertinent comparisons, are as follows:

1. Fort Sill is considered to be a "family practice installation"; thus, troop care should be family practice oriented. Each TMC now under the DPC/CM should be placed under administrative and professional supervision of a DFP clinic. This restructuring would provide congruence to the chains (Criterion 1). However, the reorganization could be accomplished by four different approaches. In all four methods, the DFP clinics would be reorganized so as to support the dependents of the units with which the TMCs are now aligned.
   a. Removing the TMCs from the DPC/CM would take a substantial responsibility from the Chief, DPC/CM, so this position should be abolished. The remaining sections, i.e., ER, AMIC, PE, One Station Training (OST), and off-post health and troop medical clinics, would report to the DCCS. (The Fort Polk MEDDAC has a chain similar to this.) This reorganization would make available a senior GMO for assignment to the ER or elsewhere and free the administrative noncommissioned officer, who should go to the Chief, DFP, to help coordinate these new clinics. See Figure 1 for a diagram of this new structure.

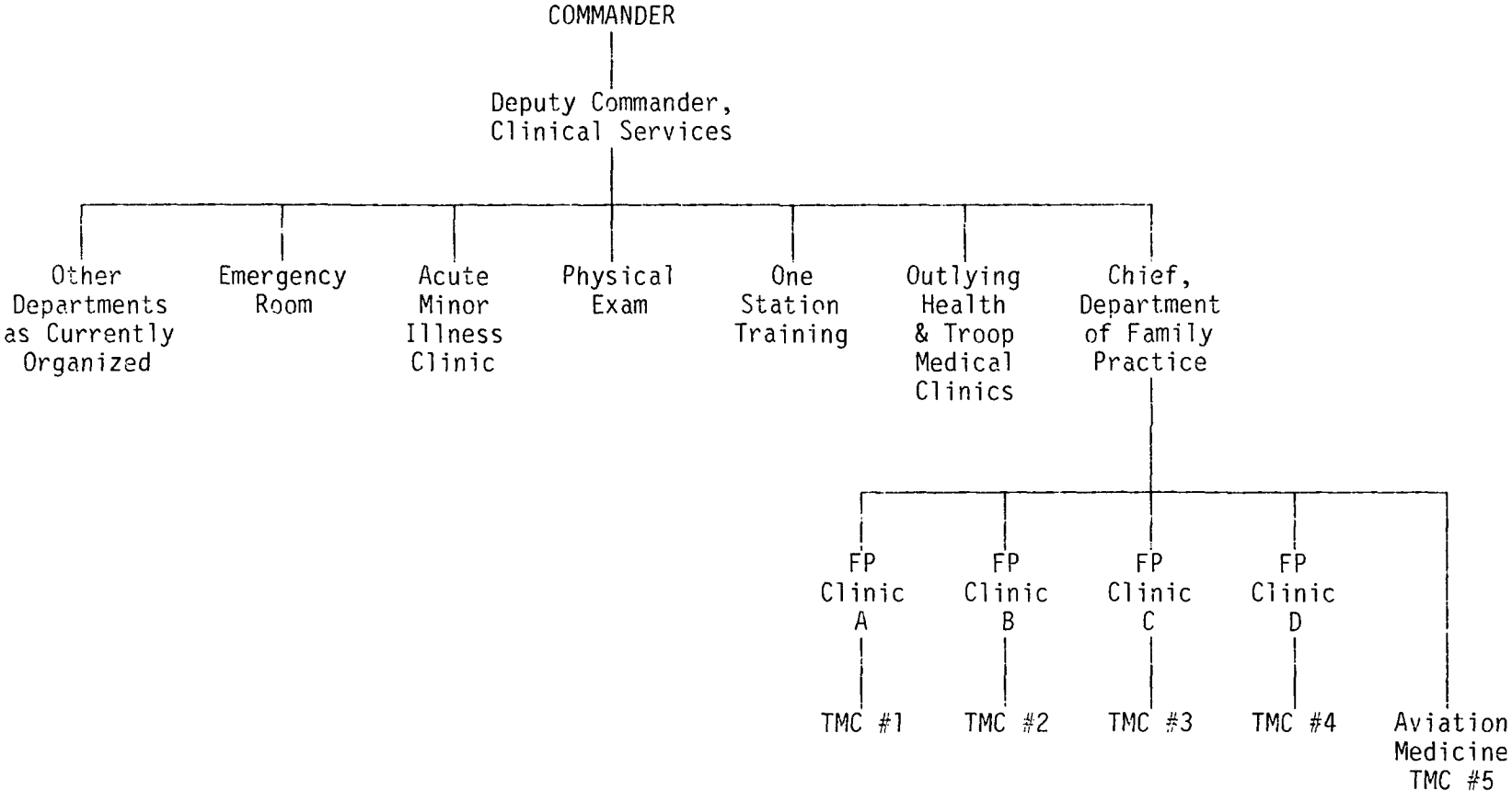


Fig. 1. Reorganization of Department of Family Practice and Troop Medical Clinics According to Recommendation 1a

b. The restructuring involved here would be essentially the same as in Recommendation 1a, except that the Chief, DPC/CM, would be retained and given responsibility for ER, AMIC, PE, OST, and off-post health and troop medical clinics. See Figure 2 for a diagram of this new structure.

c. This reorganization would duplicate Recommendation 1b, except that the Chief, DFP, would report to the Chief, DPC/CM. See Figure 3 for a diagram of this new structure.

d. This recommendation is the same as Recommendation 1a, except that ER, AMIC, PE, OST, and off-post health and troop medical clinics would report to the Chief, DPC/CM/FP. This is in reality the same span of control as under the present system with the DPC/CM except that the Family Practice clinics would be inserted between the TMCs and the Chief; however, the Chief would now have a family practitioner through whom to work in supervising the TMCs both administratively and professionally. See Figure 4 for a diagram of this new structure.

Under all these reorganizations, it is suggested that a PA or a GMO coordinator be placed between the TMCs and the Family Practice clinics. This reorganization would improve span of control (Criterion 2) by dividing the responsibility of the overworked and understaffed DPC/CM and giving part or all of it to the Chief, DFP, who has family practitioners in each clinic whom he could assign as coordinators for the newly assigned TMCs, working through them to supervise the TMCs. This reorganization would further delineate responsibility (Criterion 3) so that measurement for Criterion 3 would continue to be met and

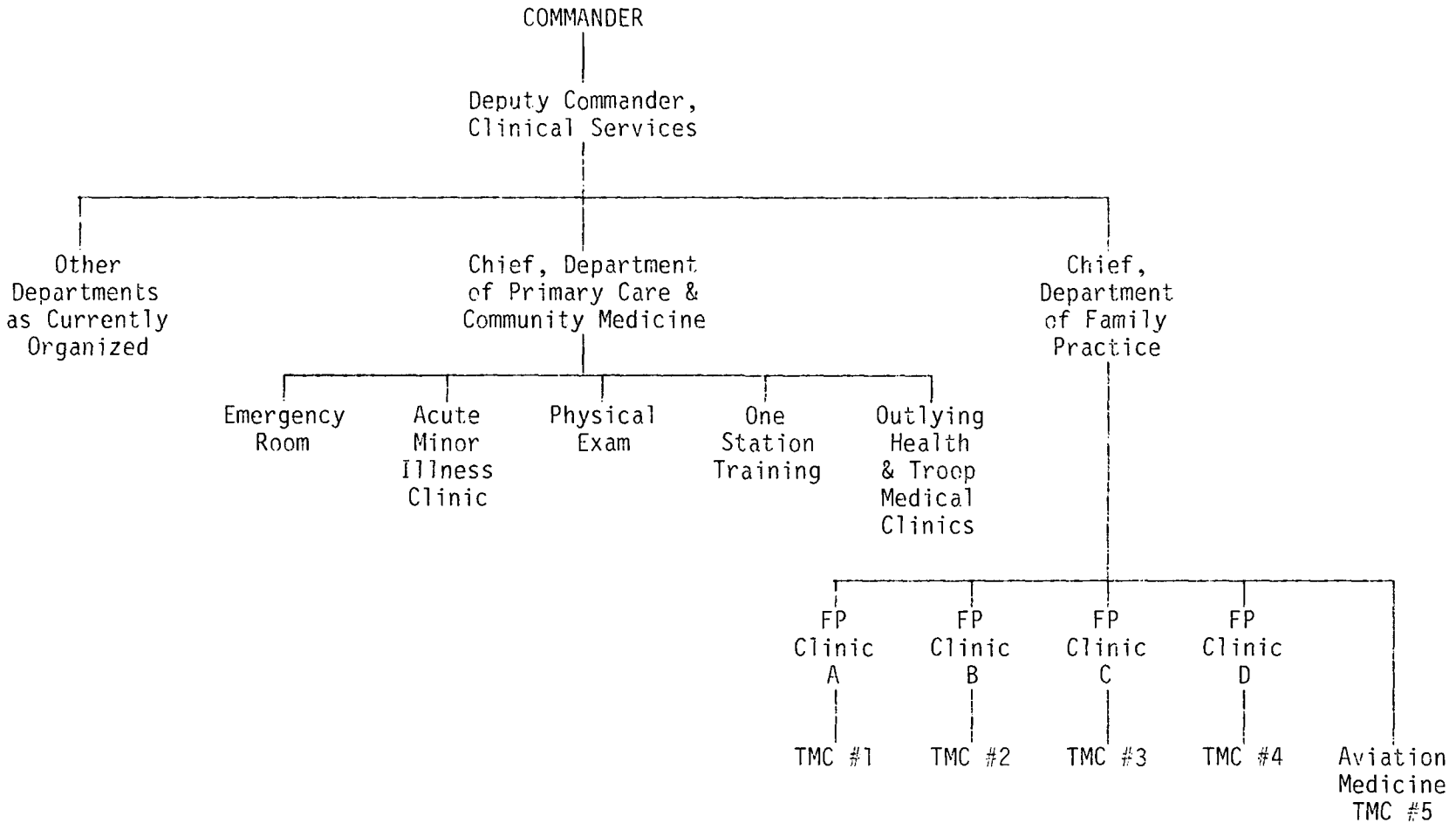


Fig. 2. Reorganization of Department of Family Practice and Troop Medical Clinics According to Recommendation 1b

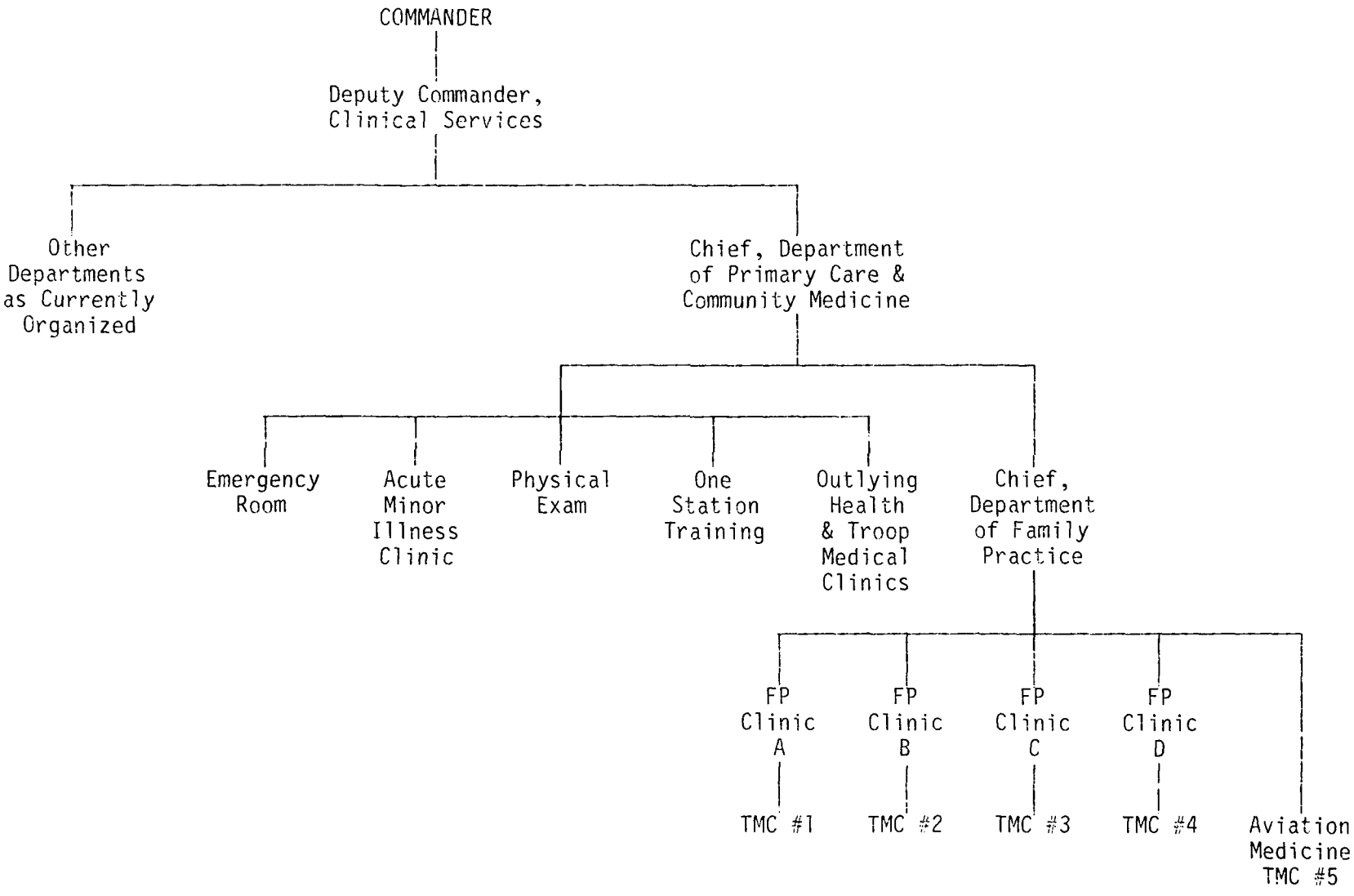


Fig. 3. Reorganization of Department of Family Practice and Troop Medical Clinics According to Recommendation 1c

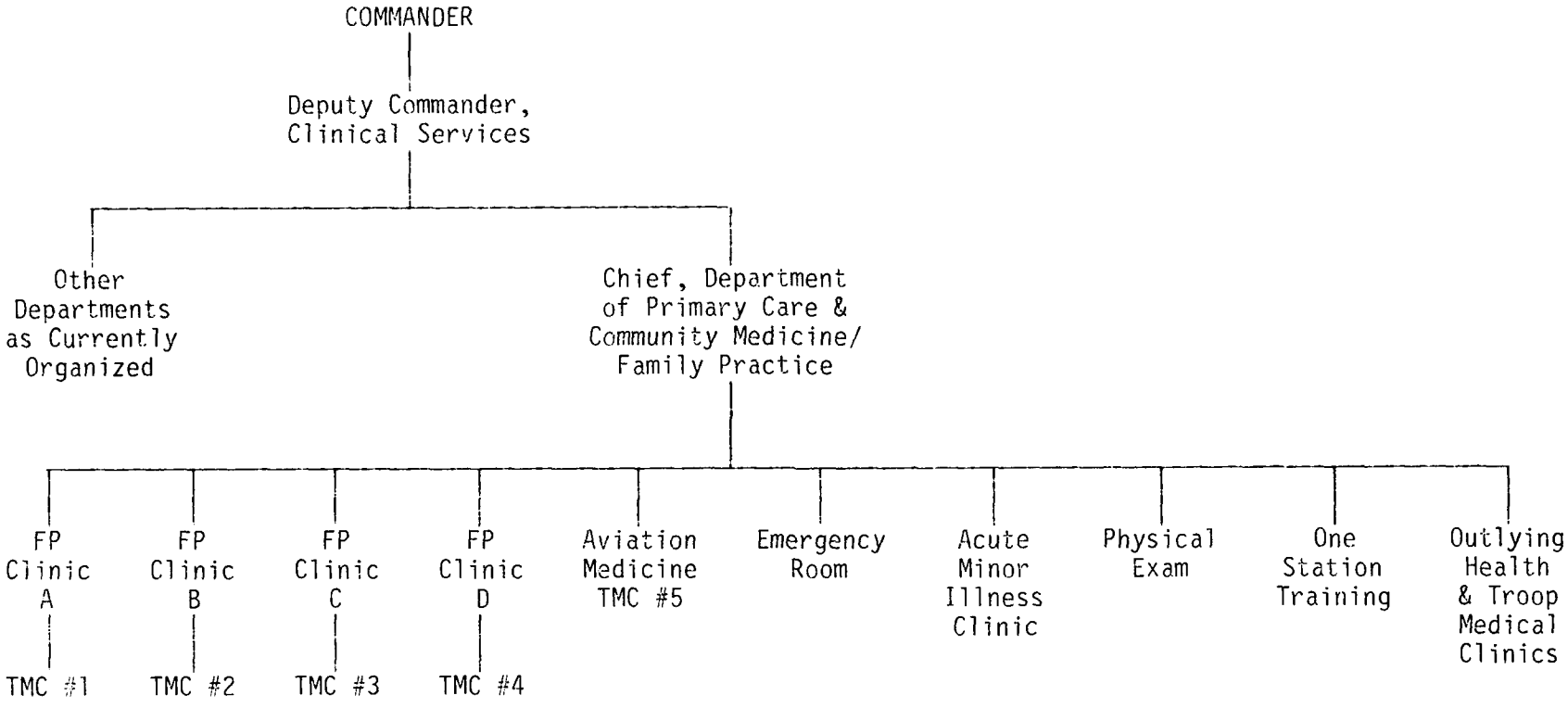


Fig. 4. Reorganization of Department of Family Practice and Troop Medical Clinics According to Recommendation 1d

improved. With the TMCs directly under a specific DFP clinic, availability of an individual for consultation (Criterion 4) would be assured. Also, this arrangement would certainly increase agreement with the system by the PA (although it might decrease it for the physician), thus satisfying Criterion 7 more fully.

2. The DFP should be reorganized so that clinic panels coincide with the units now supported by the TMCs so that administrative and professional responsibility is appropriately assigned. With more streamlined channels of responsibility, the likelihood of dealing with the same individual (Criterion 5) would be increased, improving professional as well as administrative continuity until the overall criterion was met.

3. Family practitioners should be required to work with the PAs during sick call hours at the TMC (Criteria 6 and 9). This was a major area of concern for respondents to both surveys. One suggestion is to have a different family practitioner rotate assignment through the TMC every month, giving each family practitioner a chance to know the active duty members of the dependents he has been treating. There is sufficient room in each TMC to accommodate a physician during the sick call hours. No new equipment would be needed, and additional supplies, if any, required should be minimal. This approach would speed up sick call or, at the very least, turn it into more of a teaching vehicle for the PAs and the screeners. If sick call were accomplished more quickly, this would allow the PA to spend more time at the hospital working in a specialty area or with "his" DFP clinic, attending more training, or just getting his paperwork done.

This system might ultimately allow appointing patients with the physicians for follow-up at the hospital. It would definitely reduce referrals to the hospital and most certainly provide better treatment for the active duty patients (which would mean, at a minimum, less transportation time). It is realized that there is the potential for loss of workload in taking family practitioners from their clinics and letting them supervise PAs and treat active duty personnel at the TMCs. Stringent controls on documenting patients seen in the TMC referred from the screener or the PA would be a must to help offset this potential.

4. An individual should be designated for continuity of consultation (Criteria 5 and 9). Following up on the suggestion in Recommendation 3, having one physician rotate through the TMC each month would provide that one source (the same individual) for professional consultation on site. Specialty consultation could then be the family practitioner's decision.

5. An individual should be designated for medical records audit (Criteria 8 and 9). The reorganization would indicate that the most logical person to conduct an audit of the PA's records would be the physician working with the PA in the TMC. Once again, having one physician rotate through the TMC each month would pinpoint that one source (a "designated physician," the most prevalent means of auditing records) to be responsible for medical record audits for that month.

6. The request for closure of ADTMCs should be re-initiated. Numerous comments from survey respondents indicated that the ADTMCs should be abolished. Research in this area has already been done by another

student, and closure has been recommended, with the unit medics to be offered work in the TMC to conduct screening and fulfill other medical duties. Perhaps this would be a more attractive offer to the units now if they knew that a physician would be providing professional supervision during sick call hours. These additional assets would have the potential of further improving the sick call process (Criterion 10).

7. If Recommendation 1a or 1b is accepted, an MSC officer should be assigned to the Clinical Support Division to help the DCCS in the administration of these new structures. If Recommendation 1c or 1d is accepted, an MSC officer should be assigned to the Chief, DPC/CM (Criterion 10). The majority of survey respondents felt that there should be an MSC officer at the major department head level in the administrative chain involving TMCs. It is uncertain whether the respondents meant to designate the department level itself or the CSD or a similar office level, but the responses indicated that the respondents felt that there is a need for such an officer devoted to TMC level administration. This individual would initially need to be an officer already in the organization.
8. A study should be initiated to determine the feasibility of consolidating the TMCs after sick call (criteria 6, 9, and 10). Closing one or two clinics and rotating coverage may free assets for other duties or let those clinics which are closed catch up on administrative duties.

Proposed Implementation Plan

The requirements to implement these recommendations could be accomplished completely through administrative procedures, i.e., there would be no physical movement, no equipment to purchase, etc., involved in their implementation. There would be eight major areas to be addressed:

1. Realignment of the TMCs from under the DPC/CM to under the DFP.
2. Reorganization of the Family Practice clinics so that their panels coincide with the units supported by the TMCs.
3. Assignment of family practitioners to begin working in the TMCs during sick call.
4. Designation of an individual(s) for continuity of consultation.
5. Designation of an individual(s) for medical record audit.
6. Re-initiation of the request for closure of the ADTMCs.
7. Assignment of an MSC officer to help in administrating the TMCs.
8. Initiation of a study to determine the feasibility of consolidating the TMCs after sick call.

First and most important in any change plan is the support of all affected activities and their participation in planning, coordination, and implementation of recommendations. The major activities to be involved would appear to be DPC/CM with PA representative, DFP, DCCS, Department of Nursing, CSD, and Patient Administration Division (PAD).

Implementation of Recommendation 1 (reassignment of TMCs from DPC/CM to DFP) would include the following steps:

1. The Commander would make a decision as to which, if any, approach under this recommendation to accept.
2. A request would be sent to HSC for approval (if required) of the reorganization.

3. A simple organizational chart would be prepared and distributed throughout the hospital to inform the staff of the change.
4. The date for the change would be published.
5. The change would be accomplished.
6. A more detailed chart and more encompassing information would be sent to various activities to inform them of the change--e.g., post for printing of organizational chart.
7. The rating scheme would be updated/changed.
8. Standard operating procedures would be updated to indicate changes of responsibilities.

The steps to accomplish Recommendation 2 (reorganization of DFP clinics) would involve the following:

1. A study would be made to determine how many family practitioners it would take to support the basic strength of troop units assigned to each TMC. (A procedure is already being accomplished in the DFP that will pinpoint the size of each unit by active duty strength and then divide those units as evenly as possible between family practitioners to distribute expected "panels" or patient populations supported, so this requirement would not be new or any more demanding.) The end result may very well present a "lopsided" clinic, e.g., seven in DFP Clinic A to support TMC #4, five in DFP Clinic B to support TMC #3, and one each in DFP clinics C and D and Aviation Medicine Clinic to support TMCs 1, 2, and 5.
2. The public would be informed of the reorganization, the reasons for it, the date for the change, and the significance of the change for them through media releases.

3. The DFP clinics would be aligned according to the study results. It is assumed that no physical relocation of family practitioners would be required to support the new reorganization, i.e., all newly formed clinics would still fit within the physical boundaries of their current hospital locations. At any rate, an attempt would be made to retain current family practitioners in the units they now serve.
4. A chief for clinics A, B, C, and D would be designated.
5. Pertinent information on the change would be published and distributed to the necessary parties, e.g., TMCs, DFP clinics, PAD, CSD, etc.

The steps to accomplish Recommendation 3 (assignment of family practitioners in the TMCs) would include the following:

1. Policies would be developed at department level to specify family practitioner interface with the TMC and the PA during sick call, e.g., times, referral procedure, work count compilation, medical record entries, patient flow, additional equipment required, if any, etc.
2. A reasonable implementation date for the program would be established.
3. A trial run of the new procedure at one DFP clinic would be carried out for one month. If the results of the trial run were satisfactory, the program would then be implemented.
4. Family Practice hours would be blocked during morning sick call so that no patients would be appointed.

The steps to accomplish Recommendation 4 (designation of an individual as a consultant) would consist of the following:

1. Policies would be developed at department level to facilitate continuity of consultation to meet standards.

2. These policies would be implemented.
3. Policy implementation would be evaluated and adjusted in thirty days.

The steps to accomplish Recommendation 5 (designation of an individual for medical record auditing activity) would involve the following:

1. Policies to meet standards by designation of an individual for medical record audit would be developed at department level.
2. Said policies would be implemented.
3. Policy implementation would be evaluated and adjusted in thirty days.

The steps to accomplish Recommendation 6 (request for ADTMC closure) would include the following:

1. The previous study on ADTMC closure would be updated.
2. An outline of the proposal for closure of the ADTMCs, the reasons for closure, the effects of closure, the proposed use of unit medics after closure, etc., would be prepared.
3. The proposal would be submitted in an informal talk with the III Corps Commander.
4. If the above approach proved unsuccessful, the proposal would be formalized and submitted for staffing at post level to the Commanding General.

To accomplish Recommendation 7 (assignment of an MSC officer), the Deputy Commander for Administration should make a recommendation to the Commander for the individual to be placed in that position.

To accomplish Recommendation 8 (study for TMC consolidation), this project should be assigned to the incoming Health Care Administration Course resident for review, analysis, and recommendations as his/her quarterly management project.

APPENDIX A

CRITERION EVALUATION MEASUREMENT

CRITERION EVALUATION MEASUREMENT

Criterion	Evaluation Question[a]	Measurement Standard
1. Congruence of chains	4(2)	Agreement with Question 5(3)
	6(4)	Agreement between sketches of professional & administrative organizational chains
	7(5)	Yeses
	9(7)	Yeses
	11(9)	Yeses (weighted--2x)
2. Manageable span of control	12(10)	Answer "b"
	13(11)	Answer "b"
3. Delineated repsonsibility	14(12)	Yeses
	15(13)	Other than "c"--word of mouth (weighted--2x)
4. Availability of professional & administrative consultation	17(15)	Yeses
5. Continuity of professional & administrative consultation	16(14)	Yeses (weighted--2x)
	18(16)	Yeses
6. Facilitation of PA growth	#47(32)	Greater than or equal to 2 hours a day
	#48	Other than "a" or "f"
	#50	Agreement with Question #51 (35)
	*54	Other than "e"--Do not come to TMC
7. Agreement with system by those within it	24(21)	Answer "a"--then answer to Question 23 should be "b" Answer "b"--then answer to Question 23 should be some combination of "a", "b", "c", and "d" but not "b" alone
	29(24)	Agreement with Question 27
	30(25)	Agreement with Question 28
	36(42)	Agreement with Question 35(41)
	38(39)	Yeses
8. Mechanism to conduct medical audit	32(34)	Other than "a" or "e"

CRITERION EVALUATION MEASUREMENT--Continued

Criterion	Evaluation Question[a]	Measurement Standard
9. Maximum effective utilization of & between physician & PA	25(22)	Yeses
	33(36)	Agreement with Question 34 (37) (weighted--2x)
	#40	Agreement with Question #41 (26)
	#42	Agreement with Question #43 (28)
	#44	Agreement with Question #45 (29)
	#48	Agreement with Question (33) (weighted--2x)
	*54	Agreement with Question *55 (27)
	*56	Agreement with Question *57 (30)
	*58	Agreement with Question *59 (31)
10 Adequate, capable staffing	19(17)	Yeses (weighted--2x)
	21(19)	Agreement with Question 22 (20)

[a]Question numbers in parentheses are from the command/department level officers' survey, Appendix B.

NOTE: # = PA questions only.
* = Physician questions only.

APPENDIX B

COVER LETTER AND SURVEY OF COMMAND/DEPARTMENT LEVEL OFFICERS ON ADMINISTRATIVE AND PROFESSIONAL ORGANIZATIONAL RELATIONSHIP BETWEEN THE HOSPITAL AND ITS TROOP MEDICAL CLINICS

Medical Department Activity Commander
Deputy Commander for Clinical Services
Department Head
Chief, Ambulatory Nursing Service

The attached questionnaire is concerned with highlighting the organizational relationship, both administrative and professional, between your hospital and its troop medical clinics (TMCs). Primary medical care delivery to the active duty soldier is a major factor in the maintenance of a viable readiness posture, the primary mission of today's Army. Presently, physician supervision of troop care in the TMC is frequently absent and troop care in general is of low priority to most medical treatment facility (MTF) commanders, according to Colonel Robert Todd, Health Services Command Consultant for Ambulatory Care.

To help redirect emphasis to this area, it is felt that the first action to be undertaken is to determine and implement at each MTF the best organizational relationship, both administrative and professional, between the hospital and its TMCs. The results of this survey will be used with those from other large Medical Department activities (MEDDACs) to try to determine the best administrative and professional organizational structure for the Ft. Sill MEDDAC. It is hoped, however, that analysis, comparison, and evaluation of many organizational systems will not only be valuable to the Ft. Sill MEDDAC but also may prove useful, when the results are made available, to your and other MEDDACs during mission, structural, or personnel reorganization.

I am particularly desirous of obtaining your responses. They will contribute significantly toward establishing criteria in this important area of organizational structure. The inclosed questionnaire has been tested with a sampling of physicians and has been revised in order to make it possible to obtain all necessary data while requiring a minimum of your time. The average time required was fourteen minutes.

It will be greatly appreciated if you will complete the questionnaire within one week and return it to the individual from whom you received it. Other phases of the research cannot be carried out until analysis of the questionnaire data is completed. I would welcome any comments which you might have concerning any aspect of organizational structure not covered in the questionnaire. I will be pleased to send you a summary of the questionnaire results if you so desire.

Thank you for your cooperation.

Leonard Mosesman
MAJ MSC

1 Incl.: Questionnaire

SURVEY OF COMMAND/DEPARTMENT LEVEL OFFICERS OF ADMINISTRATIVE AND PROFESSIONAL ORGANIZATIONAL RELATIONSHIP BETWEEN THE HOSPITAL AND ITS TROOP MEDICAL CLINICS

1. Your duty title is _____.

TO ANSWER MANY OF THE FOLLOWING QUESTIONS, THESE DEFINITIONS APPLY:

ADMINISTRATIVE RESPONSIBILITY--Officer Efficiency Reports, leaves, command, and control

PROFESSIONAL RESPONSIBILITY--professional technical guidance, consultation, and training

2. The troop medical clinics (TMCs) fall under what major department within the Medical Department activity (MEDDAC) for administrative responsibilities? (Check one)

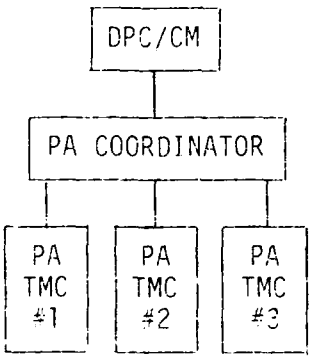
____ Department of Primary Care and Community Medicine (DPC/CM)
____ Department of Family Practice (FP)
____ Emergency Medical Services (EMS)
____ Other (Please specify) _____

3. The TMCs fall under what major department within the MEDDAC for professional responsibilities? (Check one)

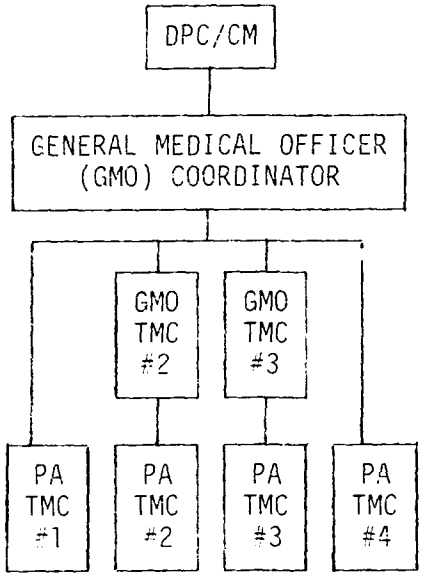
____ DPC/CM
____ FP
____ EMS
____ Other (Please specify) _____

4. What intermediary levels of responsibility/coordination exist between the physician assistant (PA) in the TMC and his/her major department head within the MEDDAC? (Please sketch these structures below)

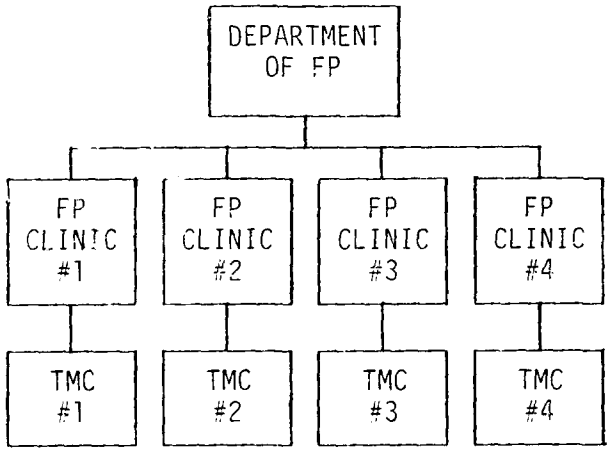
EXAMPLES:



Sketch the administrative responsibility chain from the major department head to the TMC, including intermediary levels, in the space below:



Sketch the professional responsibility chain from the major department head to the TMC, including intermediary levels, in the space below: (This may or may not be the same as the administrative chain sketched above.)



5. Do you feel that the administrative organizational chain is correctly constructed? (Check one)

____ Yes
____ No

6. If not, please sketch how you think the administrative chain should be constructed (similarly to what you did in No. 4 above):

7. Do you feel that the professional organizational chain is correctly constructed? (Check one)

____ Yes
____ No

8. If not, please sketch how you think the professional chain should be constructed (similarly to what you did in No. 4 above):

9. Do you feel that there is a congruence (similarity) between the administrative organizational chain and the professional organizational structure? (Check one)

____ Yes
____ No

10. Do you feel that the span of control for the immediate supervisor of the PA in the administrative organizational chain is: (Check one)

____ Too broad
____ Correct
____ Not broad enough

11. Do you feel that the span of control for the immediate consultant of the PA in the professional organizational chain is: (Check one)

____ Too broad
____ Correct
____ Not broad enough

12. Do you feel that most people in your organization are aware of what individual in the professional and the administrative chain is supposed to be contacted for consultation, if needed? (Check one response for each section)

a. Professional ____ Yes ____ No
b. Administrative ____ Yes ____ No

13. How are people aware of what individual in the chain is supposed to be contacted for consultation?

	Professional	Administrative
Wire diagram	_____	_____
Policy letter	_____	_____
Word of mouth	_____	_____
Other (Please specify):_____	_____	_____

14. Is the individual to be contacted always the same one? (Check one response for each section)

a. Professional ____ Yes ____ No
b. Administrative ____ Yes ____ No

15. Do you feel that this individual is readily available if needed? (Check one response for each section)

a. Professional ____ Yes ____ No
b. Administrative ____ Yes ____ No

16. Do you feel that the PA should be able to consult with the same individual for guidance on a recurring basis? (Check one response for each section)

a. Professional ____ Yes ____ No
b. Administrative ____ Yes ____ No

17. Do you feel that there is adequate staffing within available resources to accomplish administrative and professional responsibilities? (Check one response for each section)

a. Professional ____ Yes ____ No
b. Administrative ____ Yes ____ No

18. If not, at what level is staff not adequate? (Check one or more responses for each section)

	Professional	Administrative
TMC	_____	_____
Intermediate level	_____	_____
Department level	_____	_____
Staff adequate	_____	_____

19. Is there a Medical Service Corps (MSC) officer at the major department head level in the administrative chain involving TMCs? (Check one)

____ Yes
____ No

20. Do you think that there should be an MSC officer at the major department head level in the administrative chain involving TMCs? (Check one)

____ Yes
____ No

21. Do you feel that the TMC should be a: (Check one)

____ Triage/referral center
____ Primary care treatment center
____ Other (Please specify):_____

22. Do you feel that, under the current patient care system employed by the TMC, the following individuals are efficiently utilized? (Check one response for each section)

a. Physicians ____ Yes ____ No
b. Physician assistants ____ Yes ____ No

23. If not, how could they be better utilized? Please elaborate below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

24. Do you feel that the TMC should: (Check one)

____ Remain open all day
____ Close at midday
____ Close after sick call

25. What should sick call hours be?

From _____ hours to _____ hours
(Fill in time) (Fill in time)

26. Do you feel that the PAs would best be utilized if they came to the TMC to conduct: (Check one or more responses)

		CIRCLE ONE:			
____	Sick call	Daily	Weekly	Monthly	Other
____	Training	Daily	Weekly	Monthly	Other
____	Medical audits	Daily	Weekly	Monthly	Other
____	Other (Please specify)	Daily	Weekly	Monthly	Other

_____

_____

27. Maximum effective utilization of and between the physician and the PA would be accomplished if the physician had contact with the PA to conduct: (Check one or more responses)

		CIRCLE ONE:			
____	Sick call	Daily	Weekly	Monthly	Other
____	Training	Daily	Weekly	Monthly	Other
____	Medical audits	Daily	Weekly	Monthly	Other
____	While physician sees patients	Daily	Weekly	Monthly	Other
____	Contact not needed	Daily	Weekly	Monthly	Other
____	Other (Please specify)	Daily	Weekly	Monthly	Other

_____

_____

28. If the PA comes to the TMC for sick call, for best utilization, he/she should usually remain: (Check one)

____ All day
____ One-half day
____ For sick call only
____ Doesn't come for sick call

29. If the PA stays less than all day in the TMC, for best utilization, he/she usually should leave to go to work at: (Check one)

____ Hospital
____ Another TMC
____ Other (Please specify):_____
____ Doesn't stay less than all day

30. If the physician comes to the TMC for sick call, for best utilization, he/she should usually remain: (Check one)

____ All day
____ One-half day
____ For sick call only
____ Doesn't come for sick call

31. If the physician stays less than all day in the TMC, for best utilization, he/she usually should leave to go to work at: (Check one)

____ Hospital
____ Another TMC
____ Other (Please specify):_____
____ Doesn't stay less than all day

32. The PA in a TMC is usually in direct contact with/supervision from a physician _____ hours a (day week month).
(Fill in number) CIRCLE ONE

DO NOT INCLUDE TELEPHONE CONTACT.

33. Maximum effective utilization of and between the physician and the PA would be accomplished if the majority of contact by the PA with a physician was from the following: (Check one or more responses)

____ Telephone calls
____ Sick call
____ Audits
____ Training
____ Direct observation
____ No major contact
____ Other (Please specify):_____

34. Medical audits of the PA's records are accomplished by: (Check one)

____ PA
____ Designated physician(s)
____ Rotating basis among physicians
____ Committee
____ Not done
____ Other (Please specify):_____

35. The PA would be best utilized if his/her time after sick call was spent: (Check one)

____ On records
____ Attending training
____ Working in the hospital
____ Other (Please specify):_____

36. The physician primarily comes in contact with the PA in what setting? (Check one)

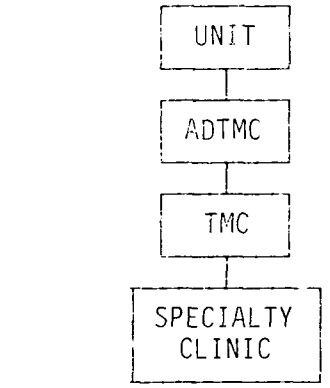
____ Hospital
____ Clinics such as TMC or Outpatient
____ No contact
____ Other (Please specify):_____

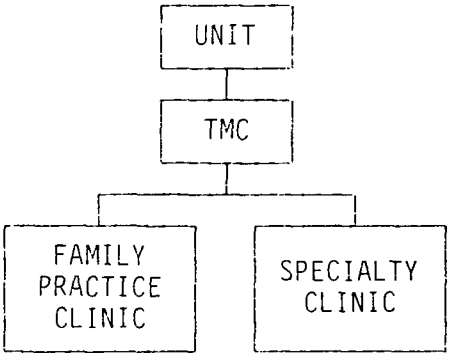
37. For maximum effective utilization of and between the physician and the PA, the physician should primarily come in contact with the PA in what setting? (Check one)

____ Hospital
____ Clinics such as TMC or Outpatient
____ No contact necessary
____ Other (Please specify):_____

38. What is the referral system for troop medical care? Please sketch this structure below.

EXAMPLES:





Sketch the referral system for troop medical care from the lowest level (algorithm-directed TMC [ADTMC] if it exists in your system) to the hospital in the space below:

39. Do you feel that the referral system is correctly constructed? (Check one)

____ Yes
____ No

40. If not, please sketch how you think the referral system should be constructed below:

41. If there are ADTMCs on post, does the PA screen patients there? (Check one)

____ Yes
____ No
____ There are no ADTMCs on post

42. Do you feel that the PA should screen patients at the ADTMC? (Check one)

____ Yes
____ No
____ There are no ADTMCs on post

43. On what type of post is your MEDDAC located? (Check one)

____ FORSCOM
____ TRADOC

44. If physician or PA assets are available from other medical units on post and are utilized, these assets are used to support what activity? (Check one response for each section)

	Physician	Physician Assistant
Hospital	_____	_____
TMC	_____	_____
Not available or used	_____	_____

45. If assets are available and used, from what type of unit do they come? (Check one or more responses)

____ Corps
____ Division
____ Medical battalion
____ Combat support hospital
____ Field hospital
____ Other (Please specify):_____

APPENDIX C

COVER LETTER AND SURVEY OF PHYSICIANS AND PHYSICIAN ASSISTANTS ON ADMINISTRATIVE AND PROFESSIONAL ORGANIZATIONAL RELATIONSHIP BETWEEN THE HOSPITAL AND ITS TROOP MEDICAL CLINICS

Physician
Physician Assistant

The attached questionnaire is concerned with highlighting the organizational relationship, both administrative and professional, between your hospital and its troop medical clinics (TMCs). Primary medical care delivery to the active duty soldier is a major factor in the maintenance of a viable readiness posture, the primary mission of today's Army. Presently, physician supervision of troop care in the TMC is frequently absent and troop care in general is of low priority to most medical treatment facility (MTF) commanders, according to Colonel Robert Todd, Health Services Command Consultant for Ambulatory Care.

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I am particularly desirous of obtaining your responses. They will contribute significantly toward establishing criteria in this important area of organizational structure. The inclosed questionnaire has been tested with a sampling of physicians and physician assistants and has been revised in order to make it possible to obtain all necessary data while requiring a minimum of your time. The average time required was fourteen minutes.

It will be greatly appreciated if you will complete the questionnaire within one week and return it to the individual from whom you received it. Other phases of the research cannot be carried out until analysis of the questionnaire data is completed. I would welcome any comments which you might have concerning any aspect of organizational structure not covered in the questionnaire. I will be pleased to send you a summary of the questionnaire results if you so desire.

Thank you for your cooperation.

Leonard Mosesman
MAJ MSC

1 Incl.: Questionnaire

SURVEY OF PHYSICIANS AND PHYSICIAN ASSISTANTS ON ADMINISTRATIVE AND PROFESSIONAL ORGANIZATIONAL RELATIONSHIP BETWEEN THE HOSPITAL AND ITS TROOP MEDICAL CLINICS

1. Your troop medical clinic (TMC) number is _____ (Number).

2. How many total patient visits per day does your TMC average? _____ (Number).

3. How many TMCs are there at your Medical Department activity (MEDDAC)?

_____ (Number)

They are categorized as:

_____ (Number) Troop medical clinics

_____ (Number) Aviation health clinics

TO ANSWER MANY OF THE FOLLOWING QUESTIONS, THESE DEFINITIONS APPLY:

ADMINISTRATIVE RESPONSIBILITY--Officer Efficiency Reports, leaves, command, and control

PROFESSIONAL RESPONSIBILITY--professional technical guidance, consultation, and training

4. The TMCs fall under what major department within the MEDDAC for administrative responsibilities? (Check one)

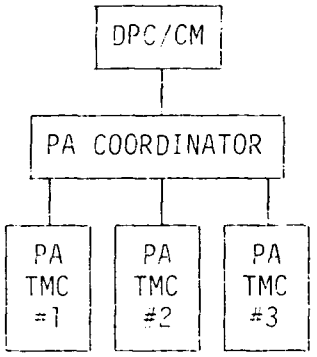
____ Department of Primary Care and Community Medicine (DPC/CM)
____ Department of Family Practice (FP)
____ Emergency Medical Services (EMS)
____ Other (Please specify) _____

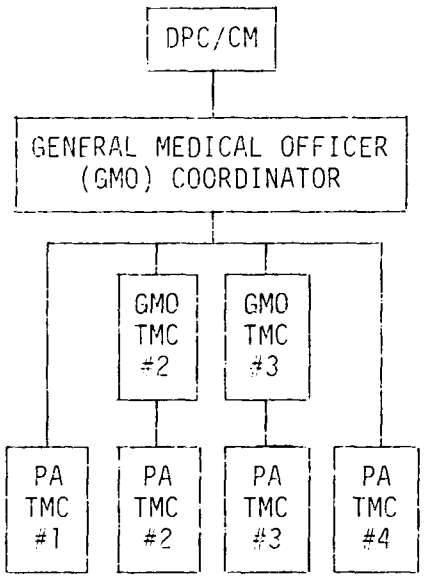
5. The TMCs fall under what major department within the MEDDAC for professional responsibilities? (Check one)

____ DPC/CM
____ FP
____ EMS
____ Other (Please specify) _____

6. What intermediary levels of responsibility/coordination exist between the physician assistant (PA) in the TMC and his/her major department head within the MEDDAC? Please sketch these structures below.

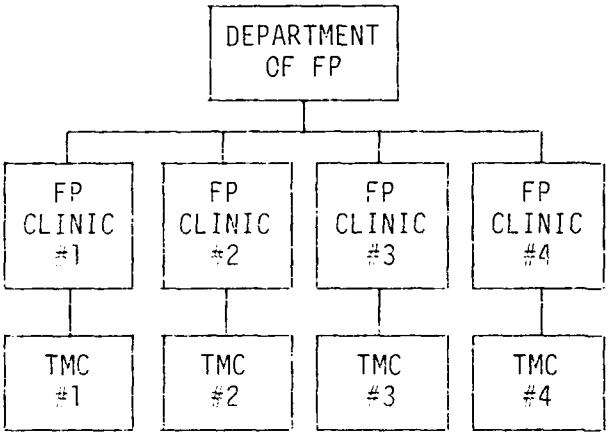
EXAMPLES:





Sketch the administrative responsibility chain from the major department head to the TMC, including intermediary levels, in the space below:

Sketch the professional responsibility chain from the major department head to the TMC, including intermediatry levels, in the space below: (This may or may not be the same as the administrative chain drawn above.)



7. Do you feel that the administrative organizational chain is correctly constructed? (Check one)

   ____ Yes
   ____ No

8. If not, please sketch how you think the administrative chain should be constructed (similarly to what you did in No. 6 above):

9. Do you feel that the professional organizational chain is correctly constructed? (Check one)

____ Yes
____ No

10. If not, please sketch how you think the professional chain should be constructed (similarly to what you did in No. 6 above):

11. Do you feel that there is a congruence (similarity) between the administrative organizational chain and the professional organizational structure? (Check one)

____ Yes
____ No

12. Do you feel that the span of control for the immediate supervisor of the PA in the administrative organizational chain is: (Check one)

____ Too broad
____ Correct
____ Not broad enough

13. Do you feel that the span of control for the immediate consultant of the PA in the professional organizational chain is: (Check one)

____ Too broad
____ Correct
____ Not broad enough

14. Are you aware of what individual in the professional and the administrative chain is supposed to be contacted for consultation, if needed? (Check one response for each section)

a. Professional	____ Yes	____ No
b. Administrative	____ Yes	____ No

15. How are you aware of what individual in the chain is supposed to be contacted for consultation? (Check one response for each section)

	Professional	Administrative
Wire diagram	_____	_____
Policy letter	_____	_____
Word of mouth	_____	_____
Other (Please specify):_____	_____	_____

16. Is the individual to be contacted always the same one? (Check one response for each section)

a. Professional	____ Yes	____ No
b. Administrative	____ Yes	____ No

17. Do you feel that this individual is readily available if needed? (Check one response for each section)

a. Professional	____ Yes	____ No
b. Administrative	____ Yes	____ No

18. Do you desire to be able to consult with the same individual for guidance on a recurring basis? (Check one response for each section)

a. Professional	____ Yes	____ No
b. Administrative	____ Yes	____ No

19. Do you feel that there is adequate staffing within available resources to accomplish administrative and professional responsibilities? (Check one response for each section)

a. Professional	____ Yes	____ No
b. Administrative	____ Yes	____ No

20. If not, at what level is staff not adequate? (Check one or more responses for each section)

	Professional	Administrative
TMC	_____	_____
Intermediate level	_____	_____
Department level	_____	_____
Staff adequate	_____	_____

21. Is there a Medical Service Corps (MSC) officer at the major department head level in the administrative chain involving TMCs? (Check one)

____ Yes
____ No

22. Do you think that there should be an MSC officer at the major department head level in the administrative chain involving TMCs? (Check one)

____ Yes
____ No

23. Does your TMC have any of the following facilities? (Check one or more responses)

____ Pharmacy
____ Treatment room
____ Laboratory
____ X-ray

24. Do you feel that the TMC should be a: (Check one)

____ Triage/referral center
____ Primary care treatment center
____ Other (Please specify):_____

25. Do you feel that, under the current patient care system employed by the TMC, the following individuals are efficiently utilized? (Check one response for each section)

a. Physicians ____ Yes ____ No
b. Physician assistants ____ Yes ____ No

26. If not, how could they be better utilized? Please elaborate below.

_____

_____

_____

_____

_____

_____

_____

_____

27. Your TMC is open from _____ hours to _____ hours.
(Fill in time) (Fill in time)

28. Sick call hours for your TMC are officially from _____ hours to _____ hours.
(Fill in time) (Fill in time)

29. Do you feel that the TMC should: (Check one)

____ Remain open all day
____ Close at midday
____ Close after sick call

30. What should sick call hours be?

_____ hours to _____ hours
(Fill in time) (Fill in time)

31. For all practical purposes, the TMC is through seeing the majority of its patients by _____ hours.
(Fill in time)

32. Medical audits of the PA's records are accomplished by: (Check one)

____ PA
____ Designated physician(s)
____ Rotating basis among physicians
____ Committee
____ Not done
____ Other (Please specify):_____

33. The physician primarily comes in contact with the PA in what setting? (Check one)

____ Hospital
____ Clinics such as TMC or Outpatient
____ No contact
____ Other (Please specify):_____

34. For maximum effective utilization of and between the physician and the PA, the physician should primarily come in contact with the PA in what setting? (Check one)

____ Hospital
____ Clinics such as TMC or Outpatient
____ No contact necessary
____ Other (Please specify):_____

35. If there are algorithm-directed TMCs (ADTMCs) on post, does the PA screen patients there? (Check one)

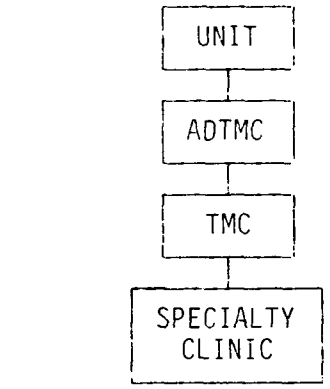
____ Yes
____ No
____ There are no ADTMCs on post

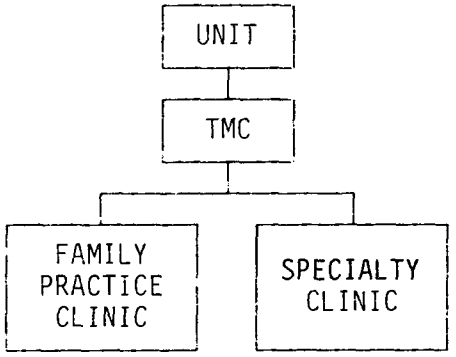
36. Do you feel that the PA should screen patients at the ADTMC? (Check one)

____ Yes
____ No
____ There are no ADTMCs on post

37. What is the referral system for troop medical care? Please sketch this structure below.

EXAMPLES:





Sketch the referral system for troop medical care from the lowest level (ADTMC if it exists in your system) to the hospital in the space below:

38. Do you feel that the referral system is correctly constructed? (Check one)

____ Yes
____ No

39. If not, please sketch how you think the referral system should be constructed below.

IF YOU ARE A PHYSICIAN ANSWERING THIS QUESTIONNAIRE, PLEASE SKIP TO QUESTION NO. 52 AND CONTINUE.

IF YOU ARE A PHYSICIAN ASSISTANT ANSWERING THIS QUESTIONNAIRE, PLEASE CONTINUE ON WITH THE NEXT QUESTION, FINISHING WITH QUESTION NO. 51.

40. You come to the TMC to conduct: (Check one or more responses)

	CIRCLE ONE:			
____ Sick call	Daily	Weekly	Monthly	Other
____ Training	Daily	Weekly	Monthly	Other
____ Medical audits	Daily	Weekly	Monthly	Other
____ Other (Please specify)	Daily	Weekly	Monthly	Other

_____

_____

41. Place a star by the activity above in Question No. 40 in which you feel you would be best utilized by coming to the TMC to conduct the activity.

42. If you come to the TMC, you usually remain: (Check one)

____ All day
____ One-half day
____ For sick call only
____ Don't come to the TMC

43. You would be best utilized if you stayed in the TMC: (Check one)

____ All day
____ One-half day
____ For sick call only
____ Not at all

44. If you stay less than all day in the TMC, you usually leave to go to work at: (Check one)

____ Hospital
____ Another TMC
____ Other (Please specify):_____
____ Don't stay less than all day

45. If you prefer to stay in the TMC less than all day but do not, for best utilization, you would like to leave and go to work at: (Check one)

____ Hospital
____ Another TMC
____ Other (Please specify):_____
____ Don't prefer to stay less than all day

46. The total number of PAs who come to work in the TMC is _____.
(Number)

47. You are usually in direct contact with/supervision from a physician _____ hours a (day week month).
(Fill in number) CIRCLE ONE

DO NOT INCLUDE TELEPHONE CONTACT.

48. Your majority of contact with a physician is from the following: (Check one or more responses)

____ Telephone calls
____ Sick call
____ Audits
____ Training
____ Direct observation
____ No major contact
____ Other (Please specify):_____

49. You would be best utilized if you had a physician with you for guidance/supervision during which of the following? (Check one or more responses)

____ Not at all
____ During sick call
____ For audits
____ For scheduled training
____ Anytime the PA is in the TMC
____ Other (Please specify):_____

50. You usually spend your time after sick call is over: (Check one)

____ On records
____ Attending training
____ Working in the hospital
____ Other (Please specify):_____

51. You would be best utilized if you spent your time after sick call is over: (Check one)

____ On records
____ Attending training
____ Working in the hospital
____ Other (Please specify):_____

THE REMAINING QUESTIONS ARE TO BE ANSWERED BY PHYSICIANS ONLY.

52. Indicate whether you are a: (Check one)

____ General medical officer (GMO)
____ Family practitioner
____ Other (Please specify):_____

53. The total number of physicians who come to work in your TMC is _____.
(Number)

By specialty:

a. GMOs _____ (Number)

b. Family practitioners _____ (Number)

c. Other (Please specify):_____ (Specialty) _____ (Number)

_____ (Specialty) _____ (Number)

54. You have contact with the PA to conduct: (Check one or more responses)

	CIRCLE ONE:			
____ Sick call	Daily	Weekly	Monthly	Other
____ Training	Daily	Weekly	Monthly	Other
____ Medical audits	Daily	Weekly	Monthly	Other
____ While seeing your patients	Daily	Weekly	Monthly	Other
____ Don't have contact	Daily	Weekly	Monthly	Other
____ Other (Please specify)	Daily	Weekly	Monthly	Other

_____

_____

55. Place a star by the activity above in Question No. 54 in which you feel maximum effective utilization of and between yourself and the PA would be accomplished if you came in contact with the PA to conduct the activity.

56. If you come to the TMC, you usually remain: (Check one)

____ All day
____ One-half day
____ For sick call only
____ Don't come to the TMC

57. You would be best utilized if you stayed in the TMC: (Check one)

____ All day
____ One-half day
____ For sick call only
____ Not at all

58. If you stay less than all day in the TMC, you usually leave to go to work at: (Check one)

____ Hospital
____ Another TMC
____ Other (Please specify):_____
____ Don't stay less than all day

59. If you prefer to stay in the TMC less than all day but don't, for best utilization, you would like to leave and go to work at: (Check one)

____ Hospital
____ Another TMC
____ Other (Please specify):_____
____ Don't prefer to stay less than all day

APPENDIX D

COVER LETTER TO HEALTH CARE ADMINISTRATION

RESIDENT WITH INSTRUCTIONS

SAMPLE

Major John Doe
Care Less Army Community Hospital
Fort Worthless, Texas 75xxx

Dear Fellow Resident:

I refer you to our telephone contact earlier this month regarding my survey on the administrative and the professional organizational structure of troop medical clinics (TMCs). The instructions included herein will just help to elaborate on that conversation.

You will notice that there are two different surveys inclosed, one with a cover letter addressed to the concerned command/department level officers and another addressed to physicians and physician assistants (PAs). Please hand out set one personally to the following individuals (if you are so organized at your facility): Medical Department Activity (MEDDAC) Commander; Chief, Professional Services; Chief, Primary Care and Community Medicine; Chief, Emergency Medical Services; Chief, Family Practice; Chief, Ambulatory Nursing Service; and any other major department head involved in supervision of, functioning of, and/or major interrelationships with the TMCs. I have asked for a return of the survey within one week; if a longer period were allowed, the surveys would probably be ignored, lost, or thrown away. Please put a reminder on your calendar as to the return date.

The second set of surveys needs to be passed out to every physician and PA who works more than ten hours a week in a TMC or an aviation health clinic. If at all possible, have a group meeting to pass out the survey. The cover letter and survey should be self-explanatory. Again, please ask for a return of this survey within one week.

If all the surveys are not returned within the requested time frame, please follow up to the maximum extent possible. I will leave that to your judgment, but please tell the involved personnel that their nonparticipation will help to statistically negate the responses from their colleagues and that the average time to take the survey is only fourteen minutes. Please encourage all participants to complete the survey.

Please do not hold up the majority of the returned surveys waiting for a few late ones after reasonable follow-up attempts have been made. If you receive completed surveys later, they can always be forwarded. Send the surveys in a government envelope to:

Major Leonard Mosesman
7020 S.W. Chaucer
Lawton, Oklahoma 73505

In summary:

1. Pass out survey set one to: MEDDAC Commander; Chief, Professional Services; Chief, Primary Care and Community Medicine; Chief, Emergency Medical Services; Chief, Family Practice; Chief, Ambulatory Nursing Service; and any other major department head involved in supervision of, functioning of, and/or major interrelationships with the TMCs.

2. Pass out survey set two to every physician and PA that works more than ten hours a week in a TMC or an aviation health clinic.

3. Follow up to the maximum extent possible after the one-week response date.

4. Do not hold up the majority of the returned surveys waiting for a few late ones after reasonable follow-up attempts have been made.

5. Forward any late surveys when received.

I greatly appreciate your assistance and eagerly look forward to being able to return it in kind.

Yours truly,

Leonard Mosesman
MAJ MSC

2 Incls.: 1. Command/department level officer survey with cover letter
2. Physician/PA survey with cover letter

APPENDIX E

CRITERION, EVALUATION QUESTION, AND MEASUREMENT STANDARD RELATIONSHIP AND ANSWERS

ABBREVIATIONS AND ACRONYMS USED

ACC	Ambulatory Care Clinic
ADM/Admin	Administrative
ADTMC	Algorithm-directed troop medical clinic
AVN	Aviation Medicine Clinic
BAS	Battalion Aide Station
BN Resp	Battalion responsibilities
BNA	Battalion activities
Brig Resp	Brigade responsibilities
C/D	Command/department
CE	Cannot evaluate
Cns	Consolidated
Cnslt	Consults
Cntrl	Control
CRT	Criterion
CSD	Clinical Support Division
DCCS	Deputy Commander for Clinical Services
DivS	Division Surgeon
DON	Department of Nursing
DPC/CM	Department of Primary Care and Community Medicine
EMS	Emergency Medical Services
ER	Emergency Room
FP	Family Practice
GMO	General medical officer
Hosp	Hospital
Inf	Infrequent
MEDDAC	Medical Department Activity
MS	Measurement standard
MSC	Medical Service Corps officer
Mtg	Meeting
N/A	Not answered, Not applicable
OH	Occupational Health
PA	Physician assistant
PE	Physical Exam
PM	Preventive Medicine
P/PA	Physician/physician assistant
Prof	Professional
Rsp	Respondents
SpecC	Specialty clinic
Supv	Supervisor
TMC	Troop medical clinic
Unk	Unknown
Uns	Unsure
WTC	Weight Control Clinic

CRITERION 1: CONGRUENCE OF CHAINS

EVALUATION QUESTION: 4(2). The TMCs fall under what major department within the MEDDAC for administrative responsibilities: (a) DPC/CM, (b) FP, (c) EMS, (d) Other (specify)?

MEASUREMENT STANDARD: Agreement with Question 5(3): The TMCs fall under what major department within the MEDDAC for professional responsibilities: (a) DPC/CM, (b) FP, (c) EMS, (d) Other (specify)?

MEDDAC	Met CRT	P/PA Survey			C/D Survey		
		Admin	Prof	Met MS	Admin	Prof	Met MS
Ft. Sill	x	6--a	6--a	x	5--a, 1--d (DON)	4--a, 2--b, 1--d (DON)	x
Ft. Belvoir	x	5--b	5--b	x	1--a, 4--b	1--a, 4--b	x
Ft. Benning	x	3--a, 2--d (DON)	5--a		3--a, 1--(d) (DON, CSD)	4--a, 1--b, 1--d (DON)	x
Ft. Bragg	x	6--a	4--a	x	2--a	2--a	x
Ft. Campbell		11--a, 1--d (DON)	7--a, 2--b, 3--d (DON)		3--a	3--b	
Ft. Hood	x	2--a, 5--d (4 DivS, 1 DCCS)	4--a, 4--d (2 DivS, 2 DCCS)		1--c	1--c, 1--d (DivS, DCCS)	
Ft. Knox	x	4--a	3--a, 1--d (DCCS)	x	3--a, 1--d (CSD)	4--a	x
Ft. L. Wood		6--a, 1--d (CSD)	7--a	x	2--a, 3--d (CSD)	5--a	
Ft. Ord		2--a, 2--d (DivS)	3--a, 1--d (SpecC)		NONE RETURNED		
Ft. Polk	x	4--a, 3--d (DivS, CSD)	3--a, 2--b, 2--d (DivS, CSD)	x	4--a, 3--d (DivS)	5--a, 1--d (DivS)	x
Ft. Riley	x	7--a, 2--d (CSD)	6--a, 2--d (Uns)	x	4--a, 1--d (DivS)	3--a, 2--d (1 DivS, 1 Unk)	x

CRITERION 1: CONGRUENCE OF CHAINS--Continued

EVALUATION QUESTION: 6(4). What intermediary levels of responsibility/coordination exist between the PA in the TMC and his/her major department head within the MEDDAC? Please sketch these structures below.

MEASUREMENT STANDARD: Agreement between sketches of professional and administrative organizational chains.

SEE APPENDIX G.

MEDDAC	Met CRT	P/PA Survey			C/D Survey		
		Admin	Prof	Met MS	Admin	Prof	Met MS
Ft. Sill							
Ft. Belvoir							
Ft. Benning							
Ft. Bragg							
Ft. Campbell							
Ft. Hood							
Ft. Knox							
Ft. L. Wood							
Ft. Ord							
Ft. Polk							
Ft. Riley							

CRITERION 1: CONGRUENCE OF CHAINS--Continued

Evaluation Question: 7(5). Do you feel that the administrative organizational chain is correctly constructed?

MEASUREMENT STANDARD: Yeses

MEDDAC	Met CRT	P/PA Survey			C/D Survey		
		Yes	No	Met MS	Yes	No	Met MS
Ft. Sill	x	6		x	2	2	
Ft. Belvoir		3	2		3	1	x
Ft. Benning	x	5	1	x	3	1	x
Ft. Bragg	x	6		x	1		x
Ft. Campbell		6	5		1	2	
Ft. Hood	x	4	2		2		x
Ft. Knox	x	4		x	4		x
Ft. L. Wood	x	6		x	4	1	x
Ft. Ord	x	4		x	NONE RETURNED		
Ft. Polk	x	5	2	x	6		x
Ft. Riley	x	6	1	x	4	1	x

CRITERION 1: CONGRUENCE OF CHAINS--Continued

EVALUATION QUESTION: 9(7). Do you feel that the professional organizational chain is correctly constructed?

MEASUREMENT STANDARD: Yeses

MEDDAC	Met CRT	P/PA Survey			C/D Survey		
		Yes	No	Met MS	Yes	No	Met MS
Ft. Sill		3	3		1	4	
Ft. Belvoir		3	2		3	1	x
Ft. Benning	x	4	1	x	3	1	x
Ft. Bragg	x	6		x	1		x
Ft. Campbell		7	3	x	2	1	
Ft. Hood	x	6	1	x	2		x
Ft. Knox	x	4		x	4		x
Ft. L. Wood	x	7		x	5		x
Ft. Ord	x	3		x	NONE RETURNED		
Ft. Polk	x	5	1	x	6		x
Ft. Riley	x	8	1	x	3	2	

CRITERION 1: CONGRUENCE OF CHAINS--Continued

EVALUATION QUESTION: 11(9). Do you feel that there is a congruence (similarity) between the administrative organizational chain and the professional organizational structure?

MEASUREMENT STANDARD: Yeses (Weighted--2x)

MEDDAC	Met CRT	P/PA Survey			C/D Survey		
		Yes	No	Met MS	Yes	No	Met MS
Ft. Sill		4	2		3	2	
Ft. Belvoir	x	5		x	4		x
Ft. Benning		2	3		4		x
Ft. Bragg	x	6		x	1	1	
Ft. Campbell		7	3	x	2	1	
Ft. Hood	x	6	1	x	2		x
Ft. Knox	x	3	1 Not Sure	x	4		x
Ft. L. Wood	x	5	2	x	4	1	x
Ft. Ord		1	3		NONE RETURNED		
Ft. Polk	x	6	1	x	6		x
Ft. Riley		5	4		2	3	

CRITERION 2: MANAGEABLE SPAN OF CONTROL

EVALUATION QUESTION: 12(10). Do you feel that the span of control for the immediate supervisor of the PA in the administrative organizational chain is (a) too broad, (b) correct, or (c) not broad enough?

MEASUREMENT STANDARD: Answer b--Correct

MEDDAC	Met CRT	P/PA Survey					C/D Survey				
		a	b	c	Other	Met MS	a	b	c	Other	Met MS
Ft. Sill		2	4				1	2	3		
Ft. Belvoir	x		3		2 N/A	x		4			x
Ft. Benning	x		3		2 N/A	x	1	3			x
Ft. Bragg		1	3	2				2			x
Ft. Campbell		2	7	1		x	1	1			
Ft. Hood		3	4					2			x
Ft. Knox	x		3	1		x		3			x
Ft. L. Wood	x	1	6			x		5			x
Ft. Ord		2	2				NONE RETURNED				
Ft. Polk	x	2	5			x		5		1 N/A	x
Ft. Riley	x	2	6	1			1	4			x

CRITERION 2: MANAGEABLE SPAN OF CONTROL--Continued

EVALUATION QUESTION: 13(11). Do you feel that the span of control for the immediate consultant of the PA in the professional organizational chain is (a) too broad, (b) correct, or (c) not broad enough?

MEASUREMENT STANDARD: Answer b--Correct

MEDDAC	Met CRT	P/PA Survey					C/D Survey				
		a	b	c	Other	Met MS	a	b	c	Other	Met MS
Ft. Sill		2	2	1			2	2	1		
Ft. Belvoir	x		3		2 N/A	x		4			x
Ft. Benning	x	1	2	1	2 N/A	x	1	3			x
Ft. Bragg		1	3	2				2			x
Ft. Campbell	x		10	1		x	2		1		
Ft. Hood		6	1					2			
Ft. Knox	x	2	2					3			x
Ft. L. Wood	x		6	1		x		5			x
Ft. Ord	x		4			x	NONE RETURNED				
Ft. Polk	x	1	6			x		6			x
Ft. Riley			6	3				3	2		

CRITERION 3: DELINEATED RESPONSIBILITY

EVALUATION QUESTION: 14(12). Are you aware of what individual in the professional and the administrative chain is supposed to be contacted for consultation, if needed?
a. Professional
b. Administrative

MEASUREMENT STANDARD: Yeses

MEDDAC	Met CRT	P/PA Survey						C/D Survey					
		Prof			Admin			Prof			Admin		
		Yes	No	Met MS	Yes	No	Met MS	Yes	No	Met MS	Yes	No	Met MS
Ft. Sill	x	5	1	x	6		x	4	1	x	5		x
Ft. Belvoir	x	5		x	5		x	4		x	4		x
Ft. Benning	x	5		x	5		x	4		x	3	1	x
Ft. Bragg	x	6		x	6		x	1	1		1	1	
Ft. Campbell	x	11		x	11		x	2	1		1	2	
Ft. Hood	x	7		x	7		x	2		x	2		x
Ft. Knox	x	4		x	4		x	4		x	4		x
Ft. L. Wood	x	6	1	x	7		x	5		x	4	1	x
Ft. Ord	x	4		x	4		x	NONE RETURNED					
Ft. Polk	x	6	1	x	6	1	x	4	2		4	2	
Ft. Riley	x	9		x	7	1	x	4	1	x	5		x

CRITERION 3: DELINEATED RESPONSIBILITY--Continued

EVALUATION QUESTION: 15(13). How are you aware of what individual in the chain is supposed to be contacted for consultation: (a) wire diagram, (b) policy letter, (c) word of mouth, (d) other (specify)?

MEASUREMENT STANDARD: Other than c--Word of mouth (Weighted--2x)

MEDDAC	Met CRT	P/PA Survey										C/D Survey									
		Prof					Admin					Prof					Admin				
		a	b	c	d	Met MS	a	b	c	d	Met MS	a	b	c	d	Met MS	a	b	c	d	Met MS
Ft. Sill		QUESTION NOT IN FT. SILL SURVEY																			
Ft. Belvoir		2	1	5			1		2			4	1	2	2	x	4	2	2	1	x
Ft. Benning	x	1	5		1	x	2	3	1	1	x		3		1	x		3		1	x
Ft. Bragg			2	3	1			1	4	1		2	1	2			2	2	1		x
Ft. Campbell			5	3	3	x		4	4	4			2	2			1	1	2		
Ft. Hood				5	1		2	2	3				2	2				2	2		
Ft. Knox			1	3				1	3			2	2	1	1	x	2	1	1	1	x
Ft. L. Wood	x ADM	1	1	3	1		2	2	1	1	x	3	4	3		x	2	4	2		x
Ft. Ord		1	1	3			1	1	3			NONE RETURNED									
Ft. Polk			1	4	1			1	4	1		2	4	5	1		2	3	5	1	
Ft. Riley			2	6				4	5			2	2	1		x	2	2	1		x

CRITERION 4: AVAILABILITY OF PROFESSIONAL AND ADMINISTRATIVE CONSULTATION

EVALUATION QUESTION: 17(15). Do you feel that this individual is readily available if needed?
a. Professional
b. Administrative

MEASUREMENT STANDARD: Yeses

MEDDAC	Met CRT	P/PA Survey						C/D Survey					
		Prof			Admin			Prof			Admin		
		Yes	No	Met MS	Yes	No	Met MS	Yes	No	Met MS	Yes	No	Met MS
Ft. Sill	x	4	2	x	4	2	x	4	1	x	4		x
Ft. Belvoir	x	5		x	5		x	4		x	4		x
Ft. Benning	x	4	1	x	5		x	4		x	4		x
Ft. Bragg	x	3	2		3	2		2		x	2		x
Ft. Campbell		3	7		2	8		1	2		1	2	
Ft. Hood	x	2	4		6	1	x	2		x	2		x
Ft. Knox	x	3	1	x	3	1	x	4		x	4		x
Ft. L. Wood	x	5	2	x	5	2	x	5		x	5		x
Ft. Ord	x	3		x	3		x	NONE RETURNED					
Ft. Polk	x	6	1	x	5	2	x	6		x	6		x
Ft. Riley	x ADM	5	4		8	1	x	4	1	x	5		x

CRITERION 5: CONTINUITY OF PROFESSIONAL AND ADMINISTRATIVE CONSULTATION

EVALUATION QUESTION: 16(14). Is the individual to be contacted always the same one?
a. Professional
b. Administrative

MEASUREMENT STANDARD: Yeses (Weighted--2x)

MEDDAC	Met CRT	P/PA Survey						C/D Survey					
		Prof			Admin			Prof			Admin		
		Yes	No	Met MS	Yes	No	Met MS	Yes	No	Met MS	Yes	No	Met MS
Ft. Sill	x ADM	2	4		5	1	x	1	4		3	2	
Ft. Belvoir	x	5		x	5		x	4		x	4		x
Ft. Benning	x ADM	4	1	x	4	1	x	1	3		3	1	x
Ft. Bragg		2	3		3	4		1	1		1	1	
Ft. Campbell	x ADM	7	4		9	2	x		3		1	2	
Ft. Hood	x	4	3		7		x	2		x	2		x
Ft. Knox	x	2	2		4		x	4		x	4		x
Ft. L. Wood	x	5	2	x	6	1	x	5		x	5		x
Ft. Ord	x ADM	1	3		3	1	..	DCNT RETURNED					
Ft. Polk		3	4		3	4		4	2		4	2	
Ft. Riley		5	4		6	3		1	4		3	1	x

CRITERION 5: CONTINUITY OF PROFESSIONAL AND ADMINISTRATIVE CONSULTATION--Continued

EVALUATION QUESTION: 18(16). Do you desire to be able to consult with the same individual for guidance on a recurring basis?
a. Professional
b. Administrative

MEASUREMENT STANDARD: Yeses

MEDDAC	Met CRT	P/PA Survey						C/D Survey					
		Prof			Admin			Prof			Admin		
		Yes	No	Met MS	Yes	No	Met MS	Yes	No	Met MS	Yes	No	Met MS
Ft. Sill	x	6 Yeses					x	5 Yeses					x
Ft. Belvoir	x	5		x	5		x	4		x	4		x
Ft. Benning	x	5		x	4	1	x	4		x	4		x
Ft. Bragg	x	5	1	x	5	1	x	2		x	2		x
Ft. Campbell	x	9	2	x	10	1	x	3		x	2		x
Ft. Hood	x	6		x	5	1	x	2		x	2		x
Ft. Knox	x	2	2		3	1	x	4		x	4		x
Ft. L. Wood	x	6	1	x	7		x	5		x	5		x
Ft. Ord	x	4		x	4		x	NONE RETURNED					
Ft. Polk	x	7		x	7		x	6		x	6		x
Ft. Riley	x	6	3		9		x	5		x	5		x

CRITERION 6: FACILITATION OF PA GROWTH

EVALUATION QUESTION: #47(32). You are usually in direct contact with/supervision from a physician _____ hours a (day, week, or month).

MEASUREMENT STANDARD: Greater than or equal to two hours a day.

MEDDAC	Met CRT	P/PA Survey			C/D Survey		
		No. Rsp	Time	Met MS	No. Rsp	Time	Met MS
Ft. Sill		2 2 2	1 hour per day 1 hour per week ø hour per day		1 2 1	1 hour per month 1 hour per week Not often	
Ft. Belvoir	x	1	8 hours per day	x	4	8 hours per day	x
Ft. Benning		4	ø hour per day		1 2 1	4 hours per day 1 hour per day 0 hours per day	
Ft. Bragg	x	1 1 1	6 hours per day 4 hours per week 28 hours per week	x	2	4 hours per day	x
Ft. Campbell	x	3 3 2	5 hours per ? 4 hours per day 4 hours per month		1 1 1	0-8 hours per day 8 hours per day Depends on TMC	
Ft. Hood		3 1 1	2 hours per week 40 hours per month ø hours per day		2	4 hours per day	
Ft. Knox		1 1	12 hours per week 1 hour per day		1 1 1 1	1 hour per day 4 hours per day 4 hours per month 10 hours per month	
Ft. L. Wood		3 2	2 hours per week 4 hours per week		2 1 1	1 hours per week 4 hours per month 3 hours per week	
Ft. Ord	x	3 1	5 hours per day 2 hours per month		NONE RETURNED		
Ft. Polk	x	3 2	6 hours per day 8 hours per week		3 2 1	4 hours per day 6 hours per day 10 hours per day	x

CRITERION 6: FACILITATION OF PA GROWTH--Continued

EVALUATION QUESTION: #47(32). You are usually in direct contact with/supervision from a physician _____ hours a (day, week, or month).

MEASUREMENT STANDARD: Greater than or equal to two hours a day.

MEDDAC	Met CRT	P/PA Survey			C/D Survey		
		No. Rsp	Time	Met MS	No. Rsp	Time	Met MS
Ft. Riley		1	ø hours per day		3	2 hours per day	
		3	4 hours per week		1	1 hour per week	
		3	4 hours per day		1	4 hours per week	
		1	8 hours per week				

CRITERION 6: FACILITATION OF PA GROWTH--Continued

EVALUATION QUESTION: #48. Your majority of contact with a physician is from (a) telephone calls, (b) sick call, (c) audits, (d) training, (3) direct observation, (f) no major contact, or (g) other.

MEASUREMENT STANDARD: Answers other than a or f.

QUESTION DID NOT APPEAR ON COMMAND/DEPARTMENT LEVEL SURVEY.

MEDDAC	Met CRT	P/PA Survey						
		a	b	c	d	e	f	g
Ft. Sill		4					2	
Ft. Belvoir	x		1					
Ft. Benning		3						2
Ft. Bragg		2	1			1		
Ft. Campbell		5	6	2		3		
Ft. Hood	x	4	2	4	3	1		
Ft. Knox		1	1	1			1	1
Ft. L. Wood		4	1	3		1		2
Ft. Ord		4	3			2	1	
Ft. Polk	x	3	1	2	1	3		
Ft. Riley		4	2	1	1	3		

CRITERION 6: FACILITATION OF PA GROWTH--Continued

EVALUATION QUESTION: #50. You usually spend your time after sick call is over (a) on records, (b) attending training, (c) working in the hospital, (d) other (specify).

MEASUREMENT STANDARD: Agreement with Question #51(35): You would be best utilized if you spent your time after sick call is over (a) on records, (b) attending training, (c) working the hospital, (d) other (specify).

MEDDAC	Met CRT	P/PA Survey								C/D Survey			
		Usually Spend Time				Should Spend Time				Should Spend Time			
		a	b	c	d	a	b	c	d	a	b	c	d
Ft. Sill		6	1	3	1		2	4	1	3	3	4	4
Ft. Belvoir		1					1					1	3
Ft. Benning		3	1	1	2		1	3	1	3	3	2	2
Ft. Bragg		1	1	2			1	1	1			1	1
Ft. Campbell		5	2	1	4		3	6					3
Ft. Hood		2	1	1	4		1	1	6		2		
Ft. Knox		2			2	1	1		3		2	4	
Ft. L. Wood	x	2		4	1	1	1	3	2	1	1	4	2
Ft. Ord	x	1	1		4	1	2		3	NONE RETURNED			
Ft. Polk		3			4	3	3		3		1	1	3
Ft. Riley	x	1	2	5	2		7	5		1	1	3	

CRITERION 6: FACILITATION OF PA GROWTH--Continued

EVALUATION QUESTION: *54. You [the physician] have contact with the PA to conduct: (a) sick call, (b) training, (c) medical audits, (d) while seeing your patients, (e) don't have contact, (f) other (specify).

MEASUREMENT STANDARD: Other than e--Don't have contact.

QUESTION NOT ON COMMAND/DEPARTMENT LEVEL SURVEY.

QUESTION ELIMINATED FROM EVALUATION.

MEDDAC	Met CRT	P/PA Survey						
		a	b	c	d	e	f	Specify
Ft. Sill	x						1	ER daily
Ft. Belvoir	CE						4	2 No PA 2 N/A
Ft. Benning	CE					1		
Ft. Bragg	x	3	2	3	2			
Ft. Campbell	x	3	3	3	3			
Ft. Hood	CE		1	1	1			
Ft. Knox	CE	1	1	1	1			
Ft. L. Wood	CE	NOT ANSWERED						
Ft. Ord		NO RESPONDENTS						
Ft. Polk	x	2	2	2	2			
Ft. Riley	CE	1	1	1	1			

CRITERION 7: AGREEMENT WITH SYSTEM BY THOSE WITHIN IT

EVALUATION QUESTION: 24(21). Do you feel that the TMC should be a (a) triage/referralcenter, (b) primary care center, or (c) other (specify)?

MEASUREMENT STANDARD: Match to Question 23: Does your TMC have a/an (a) pharmacy, (b) treatment room, (c) laboratory, or (d) X-ray?

If the answer to Question 24(21) is "a", then the answer to Question 23 should be "b". If the answer to Question 24(21) is "b", then the answer to Question 23 should be some combination of "a", "b", "c", and "d" but not "b" alone.

QUESTION ELIMINATED FROM EVALUATION.

MEDDAC	Met MS	P/PA Survey		C/D Survey
		TMC Should Have	TMC Has	TMC Should Have
Ft. Sill		6--b	1--b; 4--a, b; 1--a, b, c	4--b
Ft. Belvoir		5--b	5--b	4--b
Ft. Benning		4--b	3--a; 5--b; 1--d	2--a; 4--b
Ft. Bragg		3--a, b	2--a; 6--b; 3--c	2--a, 1--b
Ft. Campbell		1--a; 10--b	11--a, b, c; 4--d	3--b
Ft. Hood		1--a; 7--b	6--a, b, c; 2--d	2--b
Ft. Knox		1--a; 3--b	2--a; 3--b; 2--c	1--a; 4--b
Ft. L. Wood		7--b	5--a; 5--b; 2--N/A, No TMC	1--a; 2--b; 1--c, both
Ft. Ord		2--a; 4--b	3--a; 4--b	NONE RETURNED
Ft. Polk		7--b	7--a, b, c	1--a; 5--b
Ft. Riley		2--a; 7--b	7--a; 9--b; 8--c; 4--d	5--b

CRITERION 7: AGREEMENT WITH THE SYSTEM BY THOSE WITHIN IT--Continued

EVALUATION QUESTION: 29(24). Do you feel that the TMC should (a) remain open all day, (b) close at midday, or (c) close after sick call?

MEASUREMENT STANDARD: Agreement with Question 27: Your TMC is open from _____ hours to _____ hours.

MEDDAC	Met CRT	P/PA Survey					C/D Survey			
		Should Be Open				Is Open	Should Be Open			
		a	b	c	Met MS		a	b	c	Met MS
Ft. Sill	x	4	2			6--0600-1530	5			x
Ft. Belvoir	x	5			x	5--0700-1500	4			x
Ft. Benning	x	4			x	4--0630-1500 1--0730-1630	3		1	x
Ft. Bragg	x	5	1		x	6--0800-1600	1	1		
Ft. Campbell	x	11			x	11--0700-1530/1600	3			x
Ft. Hood	x	6	1		x	7--0630-1630	2			x
Ft. Knox		4	1	1		4--0630-1600	2	1	1	
Ft. L. Wood	x	7			x	5--0630-1530; 1--N/A	4		1	x
Ft. Ord	x	4				4--0700-1600	NONE RETURNED			
Ft. Polk	x	7			x	7--0700-1500	5	1		x
Ft. Riley		6	3		x	8--0730-1630 1--till 1130 in hosp	2	2	1	

CRITERION 7: AGREEMENT WITH SYSTEM BY THOSE WITHIN IT--Continued

EVALUATION QUESTION: 30(25). What should sick call hours be?

MEASUREMENT STANDARD: Agreement with Question 28: Sick call hours for your TMC are officially from _____ hours to _____ hours.

MEDDAC	Met CRT	P/PA Survey			C/D Survey	
		Should Be Open	Met MS	Is Open	Should Be Open	Met MS
Ft. Sill	x	6--0600-0800	x	6--0600-0830	2--0600-0800 2--0700-1600	
Ft. Belvoir	x	6--0630-0830		6--0630-0830	2--0630-0830 2--0630-1000	
Ft. Benning		5--0630-0900 1--0630-1500		5--0630-1500 2--0630-0900	2--0630-0930 1--0630-1500	x
Ft. Bragg	x	6--0800-0900	x	5--0800-0900 1--0800-1200	1--0630-0900 1--0700-1000	
Ft. Campbell	x	9--0700-0930 1--0700-1530	x	9--0700-0930 1--0700-1100 1--0700-1530	2--0600-1100 1--0630-1530	
Ft. Hood		6--0630-0930 1--0700-0800	x	6--0630-0930 1--0700-1130	2--0630-1030	
Ft. Knox		4--0630-0830 1--0630-1000 2--0630-1500	x	3--0700-1000 3--0700-1500	1--0630-0900 1--0630-1200 2--0630-1500	
Ft. L. Wood	x	6--0630-0830	x	6--0630-0830 1--N/A	2--0630-0830 1--0630-1130 1--0630-1530	
Ft. Ord		1--0600-0800 2--0700-0930 1--0700-1130		3--0700-1100 1--0700-1000	NONE RETURNED	
Ft. Polk		4--0700-0830 3--0700-0730		4--0700-0830 3--0630-0700	3--0700-1000 1--0600-1200 1--0600-1630 1--0730-1500	

CRITERION 7: AGREEMENT WITH SYSTEM BY THOSE WITHIN IT--Continued

EVALUATION QUESTION: 30(25). What should sick call hours be?

MEASUREMENT STANDARD: Agreement with Question 28: Sick call hours for your TMC are officially from _____ hours to _____ hours.

MEDDAC	Met CRT	P/PA Survey			C/D Survey	
		Should Be Open	Met MS	Is Open	Should Be Open	Met MS
Ft. Riley	x	4--0730-1100 4--0730-0930	x	7--0730-0930 2--0730-1130	2--0730-1000 1--0600-1000 1--0630-1130	

CRITERION 7: AGREEMENT WITH SYSTEM BY THOSE WITHIN IT--Continued

EVALUATION QUESTION: 36(42). Do you feel that the PA should screen patients at the ADIMC?

MEASUREMENT STANDARD: Agreement with Question 35(41): If there are ADIMCs on post, does the PA screen patients there?

MEDDAC	Met CRT	P/PA Survey							C/D Survey						
		Should Screen				Does Screen			Should Screen				Does Screen		
		Yes	No	Other	Met MS	Yes	No	Other	Yes	No	Other	Met MS	Yes	No	Other
Ft. Sill	x		6		x		6		1	3		x		5	
Ft. Belvoir	x	2		2 N/A 1 No ADIMC	x	2		2 N/A 1 No ADIMC	4			x	4		
Ft. Benning	x		1	3 No ADIMC	x	1	1	2 No ADIMC	1	1	1 No ADIMC				3 No ADIMC
Ft. Bragg	x	4	1	1 No ADIMC	x	5		1 No ADIMC		1			1		
Ft. Campbell		1	8	2 No ADIMC		8	1	2 No ADIMC	1	2			1		2 No ADIMC
Ft Hood		3	1	2 No ADIMC	x	5		2 No ADIMC		2				2	

CRITERION 7: AGREEMENT WITH SYSTEM BY THOSE WITHIN IT--Continued

EVALUATION QUESTION: 36(42). Do you feel that the PA should screen patients at the ADIMC?

MEASUREMENT STANDARD: Agreement with Question 35(41): If there are ADIMCs on past, does the PA screen patients there?

MEDDAC	Met CRT	P/PA Survey							C/D Survey						
		Should Screen				Does Screen			Should Screen				Does Screen		
		Yes	No	Other	Met MS	Yes	No	Other	Yes	No	Other	Met MS	Yes	No	Other
Ft. Knox	x	2	2			2		1 No ADIMC	4			x	4		
Ft. L. Wood	x	5	1	1 No ADIMC	x	6		1 No ADIMC	1		3 No ADIMC	x	1		3 No ADIMC
Ft. Ord	x	3	1		x	3	1		NONE RETURNED						
Ft. Polk	x	4	2	1 No ADIMC	x	2	3	1 No ADIMC	4	2			4	2	
Ft. Riley	x	2	6		x	4	5		3		1 No ADIMC 1 Unk	x	4		1 Unk

CRITERION 7: AGREEMENT WITH SYSTEM BY THOSE WITHIN IT--Continued

EVALUATION QUESTION: 38(39). Do you feel that the referral system is correctly constructed?

MEASUREMENT STANDARD: Yeses

MEDDAC	Met CRT	P/PA Survey			C/D Survey		
		Yes	No	Met MS	Yes	No	Met MS
Ft. Sill	x	6		x	4	1	x
Ft. Belvoir	x	5		x	3		x
Ft. Benning	x	4	1	x	4		x
Ft. Bragg	x	6		x	2		x
Ft. Campbell	x	9	2	x	2	1	
Ft. Hood	x	7		x	1		x
Ft. Knox	x	2	2		4		x
Ft. L. Wood	x	7		x	4	1	x
Ft. Ord	x	3		x	NONE RETURNED		
Ft. Polk	x	6	1	x	6		x
Ft. Riley	x	9		x	5		x

CRITERION 8: MECHANISM TO CONDUCT MEDICAL AUDIT

EVALUATION QUESTION: 32(34). Medical audits of the PA's records are accomplished by (a) PA, (b) designated physician, (c) on rotating basis among physicians, (d) committee, (e) not done, (f) other (specify).

MEASUREMENT STANDARD: Other than a (PA) or e (not done).

MEDDAC	Met CRT	P/PA Survey			C/D Survey		
		Audit Done by	Comment	Met MS	Audit done by	Comment	Met MS
Ft. Sill		1--b; 4--e			4--c; 1--d; 1--f	Inf	x
Ft. Belvoir	x	1--b	4--N/A	x	4--b; 3--d		x
Ft. Benning	x	1--a; 4--b; 1--f	No PAs	x	4--b		x
Ft. Bragg	x	6--b; 1--d		x	2--b		x
Ft. Campbell	x	10--b; 1--c; 1--e		x	3--b		x
Ft. Hood	x	7--b		x	2--b		x
Ft. Knox	x	1--a; 3--b		x	4--b; 1--c, d		x
Ft. L. Wood	x	6--b; 1--d; 1--f	GMO Supv	x	5--b; 1--d		x
Ft. Ord		2--a; 1--b, d, e			NONE RETURNED		
Ft. Polk	x	7--b; 1--a, d	CSD	x	5--b; 2--d		x
Ft. Riley	x	7--b; 2--c		x	4--b; 1--c		x

CRITERION 9: MAXIMUM EFFECTIVE UTILIZATION OF AND BETWEEN PHYSICIAN AND PA

EVALUATION QUESTION: 25(22). Do you feel that, under the current patient care system employed by the TMC, physicians and PAs are efficiently utilized?
a. Physicians
b. Physician assistants

MEASUREMENT STANDARD: Yeses

MEDDAC	Met CRT	P/PA Survey						C/D Survey					
		PA			Physician			PA			Physician		
		Yes	No	Met MS	Yes	No	Met MS	Yes	No	Met MS	Yes	No	Met MS
Ft. Sill	x PA	4	1	x	1	5		4	1	x	1	4	
Ft. Belvoir	x	3		x	5		x	4		x	4		x
Ft. Benning	x PA	4	1	x	1	3		3	1	x	3	1	x
Ft. Bragg	x	4	1	x	3	2		2		x	2		x
Ft. Campbell	x PA	9	2	x	6	4		2	1		1	2	
Ft. Hood	x PA	5	2	x	2	5		2		x	2		x
Ft. Knox	x PA	3	1	x	1	1 2 CE		3	1	x	1	2 CE	
Ft. L. Wood	x PA	4	3 1 CE		2	3 1 CE		5		x	4		x
Ft. Ord	x	4		x	4		x	NONE RETURNED					
Ft. Polk	x	7		x	6	1	x	6		x	5	1	x
Ft. Riley	x	6	3		6	3		5		x	4	1	x

CRITERION 9: MAXIMUM EFFECTIVE UTILIZATION OF AND BETWEEN PHYSICIAN AND PA--Continued

EVALUATION QUESTION: 33(36). The physician primarily comes in contract with the PA in what setting: (a) hospital, (b) clinics such as outpatient or TMC, (c) no contact, (d) other (specify).

MEASUREMENT STANDARD: Agreement with question 34(37): For maximum effective utilization of and between the physician and the PA, the physician should primarily come in contact with the PA in what setting: (a) hospital, (b) clinics such as TMC or outpatient, (c) no contact necessary, (d) other (specify). (Weighted--2x)

MEDDAC	Met CRT	P/PA Survey									C/D Survey								
		Has Contact In				Should Have Contact In					Has Contact In				Should Have Contact In				
		a	b	c	Other	a	b	c	Other	Met MS	a	b	c	Other	a	b	c	Other	Met MS
Ft. Sill		2	1		2 ER	1	6				3	1			1	4			
Ft. Belvoir	x		1		4 N/A		1		4 N/A	x	1	4				4			x
Ft. Benning	x	1	2	1		1	3		1 N/A	x	3	3			2	4			x
Ft. Bragg	x		6				6			x		2			1	1			
Ft. Campbell	x		10	1		1	10			x		3				3			x
Ft. Hood	x	4	4			2	7			x		2				2			x
Ft. Knox	x	2	1		1 Mtg	1	3				3	3			2	4			x
Ft. L. Wood	x	2	5			2	5			x	2	4			2	4			x
Ft. Ord		1	4	1	1 BAS		4							NONE RETURNED					
Ft. Polk	x	1	7			1	6			x		6				6			x
Ft. Riley	x	4	6			3	7			x	1	3		1	1	4			x

CRITERION 9: MAXIMUM EFFECTIVE UTILIZATION OF AND BETWEEN PHYSICIAN AND PA--Continued

EVALUATION QUESTION: #40. You come to the TMC to conduct (a) sick call, (b) training, (c) medical audits, and/or (d) other (specify).

MEASUREMENT STANDARD: Agreement with Question #41(26): Place a star by the activity above in Questions 40 which you feel you should come to the TMC to conduct.

MEDDAC	Met CRT	P/PA Survey									C/D Survey				
		Do Conduct				Should Conduct					Should Conduct				
		a	b	c	Other	a	b	c	Other	Met MS	a	b	c	Other	Met MS
Ft. Sill	x	6	6	6	2	3	1	1		x	5	4	4		x
Ft. Belvoir	CE	1	1		1	1					4	4	4		
Ft. Benning	x	4	4	4		4	1				4	4	4	1	x
Ft. Bragg	x	3	2	2		3					2	2	1		x
Ft. Campbell	x	9	7	7	5 PE	5	1		2		3	3			
Ft. Hood	x	5	5	3	1 WTC	5	1	1			2	2	2		
Ft. Knox	x	3	2			3	1			x	3	3	3		
Ft. L. Wood	x	4	3	2	1 N/A 2 ADM Cntrl	4	1	1	2 TMC	x	5	4	5		x
Ft. Ord		4	2	3	2 WTC	4					NONE RETURNED				
Ft. Polk	x	5	4	3	2 WTC	3	3	1		x	5	6	5	1 PE	x
Ft. Riley	x	8	4			6	2			x	5	5	5		

CRITERION 9: MAXIMUM EFFECTIVE UTILIZATION OF AND BETWEEN PHYSICIAN AND PA--Continued

EVALUATION QUESTION: #42. If you come to the TMC, you usually remain (a) all day, (b) one-half day, (c) for sick call only, or (d) don't come to the TMC.

MEASUREMENT STANDARD: Agreement with Question #43(28): You would be best utilized if you stayed in the TMC (a) all day, (b) one-half day, (c) for sick call only, or (d) don't come at all.

MEDDAC	Met CRT	P/PA Survey									C/D Survey				
		Usually Remain				Should Remain					Should Remain				
		a	b	c	d	a	b	c	d	Met MS	a	b	c	d	Met MS
Ft. Sill	x	6				3	3				6				x
Ft. Belvoir	CE	1				1				x	4				x
Ft. Benning		4				1	2				3		1		x
Ft. Bragg	x	1	2			1	2			x	1	1			
Ft. Campbell		7	2			2	2	4			1	2			
Ft. Hood		5				2	3				2				
Ft. Knox	x	2	1			2	1			x	1	1	2		
Ft. L. Wood	x		4	1	1		5	1		x	1	4			
Ft. Ord	x	3	3			1	2	1			NONE RETURNED				
Ft. Polk		5				2	3				4	2			
Ft. Riley	x		8	1		1	5	1		x		5			x

CRITERION 9: MAXIMUM EFFECTIVE UTILIZATION OF AND BETWEEN PHYSICIAN AND PA--Continued

EVALUATION QUESTION: #44. If you stay less than all day in the TMC, you usually leave to go to work at (a) hospital, (b) another TMC, (c) other (specify), or (d) don't stay less than all day.

MEASUREMENT STANDARD: Agreement with Question #45(29). If you prefer to stay in the TMC less than all day but do not, for best utilization you would like to leave to go to work at (a) hospital, (b) another TMC, (c) other (specify), or (d) don't prefer to stay less than all day.

MEDDAC	Met CRT	P/PA Survey									C/D Survey				
		Leave to Go to				Should Leave to Go to					Should Leave to Go to				
		a	b	c	d	a	b	c	d	Met MS	a	b	c	d	Met MS
Ft. Sill	x	3			3	4			1	x	3	1		2	x
Ft. Belvoir	CE				1				1	x	2			2	
Ft. Benning				1 ER	3	1		1 ER			1	2		1	
Ft. Bragg		2		1 Unit 1 PE				1 Unit	1		1				
Ft. Campbell	x	5		5 BAS	1	5		4 BAS	1	x		1	1 Cns TMC 1 Unit		
Ft. Hood		1			1	1		4 BAS					2 BN Resp		
Ft. Knox		1	2	1 Duty DPC/CM	1				2		4				
Ft. L. Wood	x	5		1 ACC		1		1 ACC 1 SpecC	1		5				x
Ft. Ord	x			4 BAS	1			3 BAS	1		NONE RETURNED				
Ft. Polk	x			1 AVN 1 BAS	1			1 AVN 3 BAS	1	x	2		1 BNA	3	
Ft. Riley		6	2	6 PE		4		1 SpecC			3	1	2 Brig Resp		

CRITERION 9: MAXIMUM EFFECTIVE UTILIZATION OF AND BETWEEN PHYSICIAN AND PA--Continued

EVALUATION QUESTION: #48. Your majority of contact with a physician is from the following: (a) telephone calls, (b) sick call, (c) audits, (d) training, (e) direct observation, (f) no major contact, (g) other (specify).

MEASUREMENT STANDARD: Agreement with Question (33): Maximum effective utilization of and between physician and PA would be accomplished if the majority of contact by the PA with a physician was from the following: (a) telephone calls, (b) sick call, (c) audits, (d) training, (e) direct observation, (f) no major contact, (g) other (specify). Weighted--2x.

MEDDAC	Met CRT	P/PA Survey							C/D Survey						
		Contact Is From							Contact Should Be From						
		a	b	c	d	e	f	g	a	b	c	d	e	f	g
Ft. Sill		4					2		1	3	2	3	2		
Ft. Belvoir	CE		1							1	1	1	4		
Ft. Benning		3						1 ER 1 Cnslt	2	1	2	3	3		
Ft. Bragg	x	2	1	1					2	2	2	1	1		
Ft. Campbell		5	6	2		3			1	1	1	2			
Ft. Hood		4	2		4	3	1			2		2			
Ft. Knox		1	1	1			1	1 Duty DPC/CM	3	2	3	3	2		
Ft. L. Wood	x	4	1	3		1		1 TMC 1 ACC	5	2	4	4	3		
Ft. Ord	CE	4	3	2		1			NONE RETURNED						
Ft. Polk		3	1	2	1	3			1	2	4	5	5		
Ft. Riley	x	4	2	1	1	3			3	2	3	3	5		

CRITERION 9: MAXIMUM EFFECTIVE UTILIZATION OF AND BETWEEN PHYSICIAN AND PA--Continued

EVALUATION QUESTION: *54. You have contact with the PA to conduct (a) sick call, (b) training, (c) medical audits, (d) while seeing your patients, (e) don't have contact, (f) other (specify).

MEASUREMENT STANDARD: Agreement with Question *55(27): Place a star by the activity above in Question 54 which you feel would effect maximum effective utilization of and between yourself and the PA if you came incontact with the PA to conduct the activity.

QUESTION ELIMINATED FROM EVALUATION.

MEDDAC	Met CRT	P/PA Survey												C/D Survey					
		Has Contact						Should Have Contact						Should Have Contact					
		a	b	c	d	e	f	a	b	c	d	e	f	a	b	c	d	e	f
Ft. Sill							1 ER	1	1	1	1			4	3	3			
Ft. Belvoir							4 N/A						4 N/A	4	4	4			
Ft. Benning						1		NOT ANSWERED						3	3	4			
Ft. Bragg	x	3	2	3	2			2		1				2	2	2			
Ft. Campbell		3	3	3	3			1	2					3	3	2			
Ft. Hood			1	1	1						1			2	2	2			
Ft. Knox		1	1	1	1						1			3	4	4			
Ft. L. Wood		NOT ANSWERED												2	4	5			1 Hosp
Ft. Ord		NO REPSONDENTS												NONE RETURNED					
Ft. Polk		2	2	2	2				1		1			4	6	5	3		
Ft. Riley		1	1	1	1			NOT ANSWERED						4	4	4	3		

CRITERION 9: MAXIMUM EFFECTIVE UTILIZATION OF AND BETWEEN PHYSICIAN AND PA--Continued

EVALUATION QUESTION: *56. If you come to the TMC, you usually remain (a) all day, (b) one-half day, (c) for sick call only, or (d) don't come to the TMC.

MEASUREMENT STANDARD: Agreement with Question *57(30): You would be best utilized if you stayed in the TMC (a) all day, (b) one-half day, (c) for sick call only, or (d) not at all.

QUESTION ELIMINATED FROM EVALUATION.

MEDDAC	Met CRT	P/PA Survey									C/D Survey				
		Usually Remain				Should Remain					Should Remain				
		a	b	c	d	a	b	c	d	Met MS	a	b	c	d	Met MS
Ft. Sill					1	NOT ANSWERED					4	1	1		
Ft. Belvoir	x	4				4				x	4				x
Ft. Benning	CE	1				1						1	2		
Ft. Bragg	x	1	1	1		1		2			1	1			
Ft. Campbell		2	1				2	1			1	1	1		
Ft. Hood			1				1					2			
Ft. Knox		1					1						1	3	
Ft. L. Wood		NOT ANSWERED										2		3	
Ft. Ord		NO REPSONDENTS									NONE RETURNED				
Ft. Polk		2				2					3	2	1		
Ft. Riley		1				1						3	2		

CRITERION 9: MAXIMUM EFFECTIVE UTILIZATION OF AND BETWEEN PHYSICIAN AND PA--Continued

EVALUATION QUESTION: *58. If you stay less than all day in the TMC, you usually leave to go to work at (a) hospital, (b) another TMC, (c) other (specify), or (d) don't prefer to stay less than all day.

MEASUREMENT STANDARD: Agreement with Question *59(31): If the physician stays less than all day in the TMC, for best utilization he/she usually should leave to go to work at (a) hospital, (b) another TMC, (c) other (specify), or (d) doesn't stay less than all day.

QUESTION ELIMINATED FROM EVALUATION.

MEDDAC	Met CRT	P/PA Survey									C/D Survey				
		Leave to Go to				Should Leave to Go to					Should Leave to Go to				
		a	b	c	d	a	b	c	d	Met MS	a	b	c	d	Met MS
Ft. Sill				1 PM 1 OH 1 ER		NOT ANSWERED					2			2	
Ft. Belvoir		2		2 AVN		2			2		2			2	
Ft. Benning				1 N/A				1 N/A			2	1		1	
Ft. Bragg		1		1 PE		1					1				
Ft. Campbell		1	1	2 AVN		2		1 SpecC			2		1 Cns TMC		
Ft. Hood				1 DivS		NOT ANSWERED					2				
Ft. Knox		NOT ANSWERED						1 SpecC			1		2 N/A		
Ft. L. Wood		NOT ANSWERED									4			1	
Ft. Ord		NO RESPONDENTS									NONE RETURNED				
Ft. Polk		NOT ANSWERED				1					2	1	1 N/A 1 ?	1	
Ft. Riley		1				1					4		2 Brig Resp		

CRITERION 10: ADEQUATE STAFFING

EVALUATION QUESTION: 19(17). Do you feel that there is adequate staffing within available resources to accomplish administrative and professional responsibilities?
a. Professional
b. Administrative

MEASUREMENT STANDARD: Yeses (Weighted--2x)

MEDDAC	Met CRT	P/PA Survey						C/D Survey					
		Prof			Admin			Prof			Admin		
		Yes	No	Met MS	Yes	No	Met MS	Yes	No	Met MS	Yes	No	Met MS
Ft. Sill		6 Nos						1 Yes; 4 Nos					
Ft. Belvoir	ADM		5		3	2		4		x	4		x
Ft. Benning		3	2		3	2		2	2		1	3	
Ft. Bragg		4	2		4	2		1	1		1	1	
Ft. Campbell		3	8		8	3	x		3		1	2	
Ft. Hood	ADM	1	6		7		x	2			2		x
Ft. Knox	ADM	2	2		3	1	x	3	1	x	4		x
Ft. L. Wood	PROF	6	1	x	5	2	x	4	1	x	3	2	
Ft. Ord	PROF	3	1	x	2	2		NONE RETURNED					
Ft. Polk	PROF	5	2	x	4	3		5	1	x	5	1	x
Ft. Riley	ADM	5	4		8	1	x	4	1	x	4	1	x

CRITERION 10: ADEQUATE STAFFING--Continued

EVALUATION QUESTION: 21(19). Is there an MSC officer at the major department head level in the administrative chain involving TMCs?

MEASUREMENT STANDARD: Agreement with Question 22(20): Do you think that there should be an MSC officer at the major department head level in the administrative chain involving TMCs?

MEDDAC	Met CRT	P/PA Survey						C/D Survey					
		Have MSC			Should Have MSC			Have MSC			Should Have MSC		
		Yes	No	Met MS	Yes	No	Met MS	Yes	No	Met MS	Yes	No	Met MS
Ft. Sill	x		6			6	x		5		3	2	
Ft. Belvoir		5			5		x	1	3		4		
Ft. Benning	x	3	2		4	1	x	3	1	x	4		
Ft. Bragg	x	5	1		5	1	x	2			2		x
Ft. Campbell	x	8	3	x	8	3	x	3		x	3		x
Ft. Hood	x	4	3		4	3		2			2		
Ft. Knox	x	3	1	x	4		x	3	1	x	2	1	
Ft. L. Wood	x	0	1	x	6	1	x	5		x	5		x
Ft. Ord		2	2		1	3		NONE RETURNED					
Ft. Polk	x	6	1	x	5	2	x	4	1	x	6		x
Ft. Riley	x	5	3		6	3		4	1	x	5		x

APPENDIX F

ADDITIONAL SURVEY INFORMATION

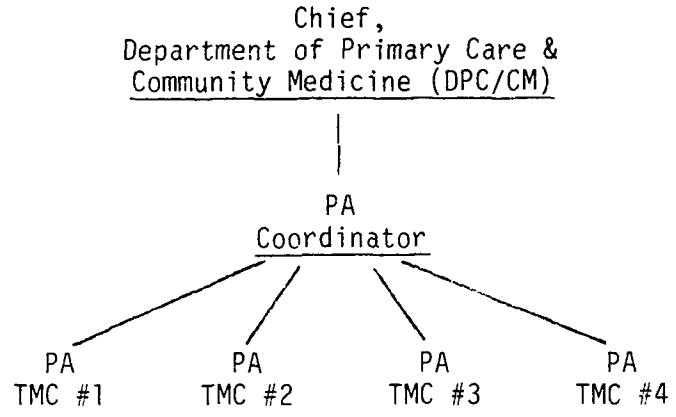
ADDITIONAL SURVEY INFORMATION

MEDDAC	No. P/PA Surveys		No. C/D Surveys		Type Post	Number	
	Mailed	Returned	Mailed	Returned		TMC	AVN
Ft. Sill	9	9	5	5	TRADOC	4	1
Ft. Belvoir	5	5	5	4	TRADOC	2	1
Ft. Benning	10	5	4	4	TRADOC with 3 FORSCOM Units	9	1
Ft. Bragg	9	6	4	2	FORSCOM	10	1
Ft. Campbell	24	12	3	3	FORSCOM	6	1
Ft. Hood	12	7	3	2	FORSCOM	10	2
Ft. Knox	15	4	5	4	TRADOC	5	1
Ft. L. Wood	10	7	5	5	TRADOC	6	0
Ft. Ord	6	4	Unknown	None	FORSCOM	4	1
Ft. Polk	16	7	8	8	FORSCOM	4	1
Ft. Riley	10	8	5	5	FORSCOM	8	1

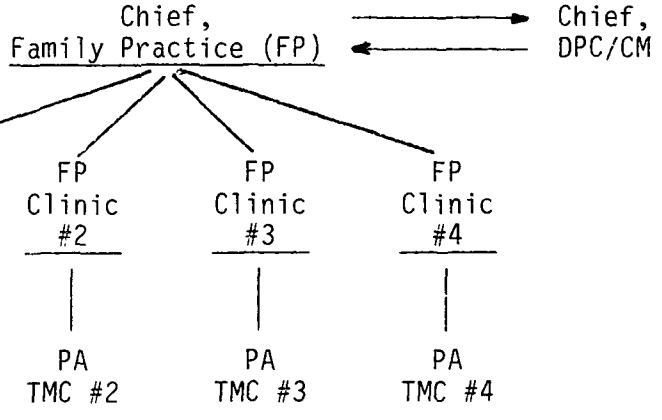
APPENDIX G

SKETCHES OF RESPONSIBILITY CHAINS FOR MEDICAL DEPARTMENT ACTIVITIES

FORT SILL MEDDAC

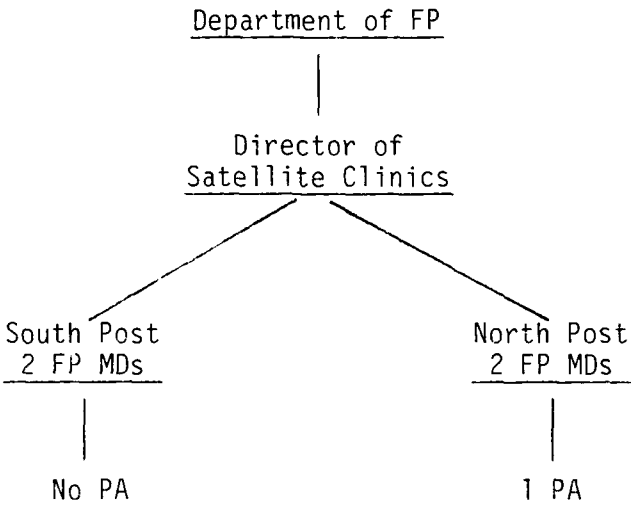


Administrative Responsibility Chain



Professional Responsibility Chain

FORT BELVOIR MEDDAC



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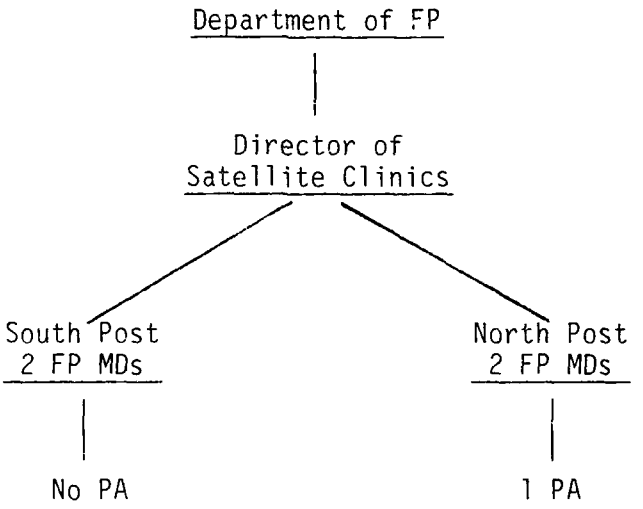
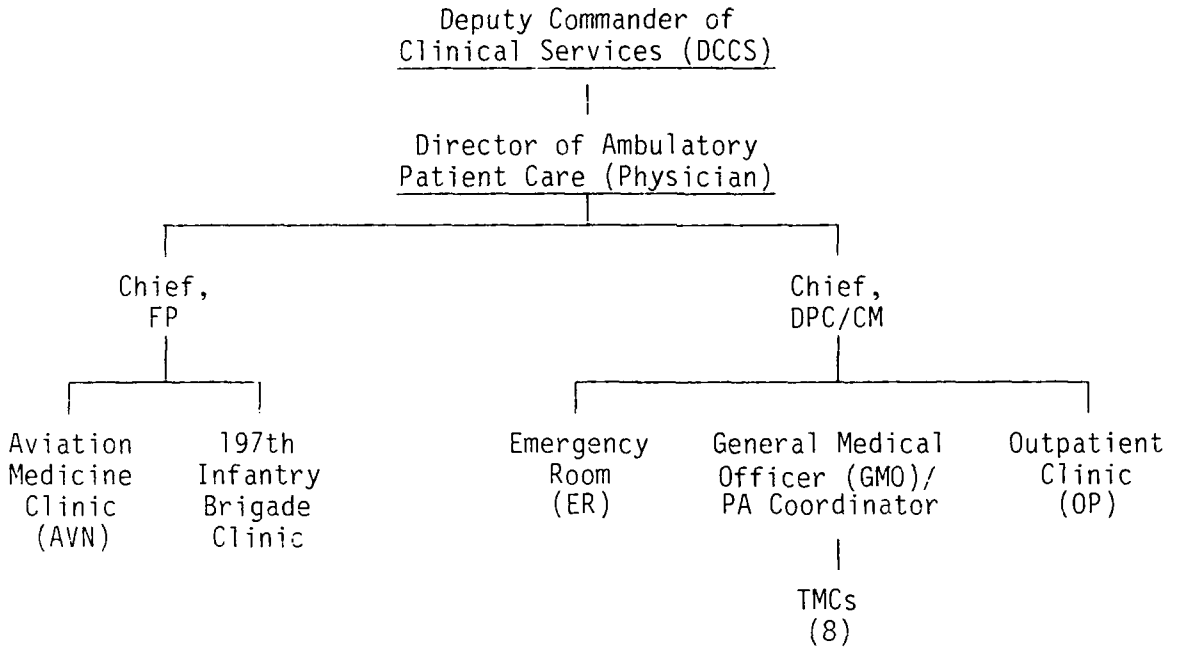


Professional Responsibility Chain

FORT BENNING MEDDAC



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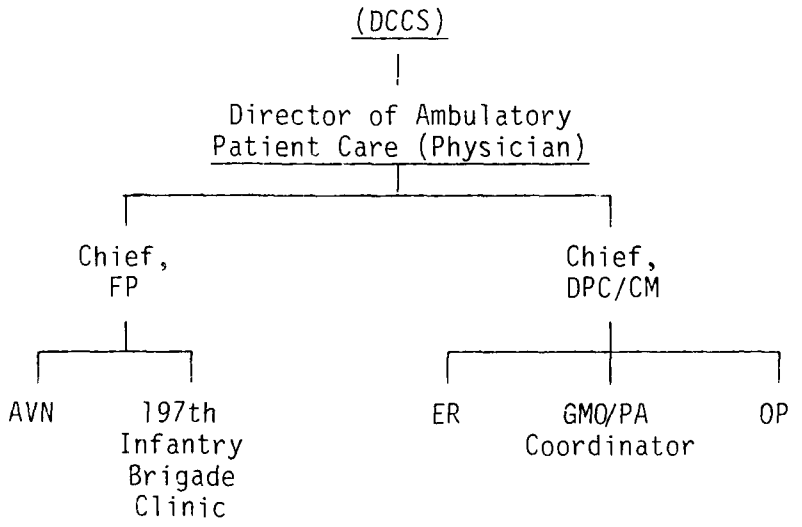
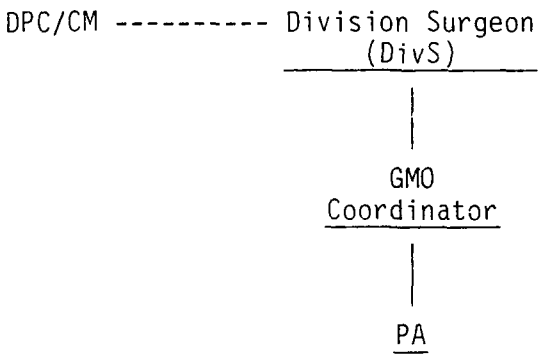


Professional Responsibility Chain

FORT BRAGG MEDDAC



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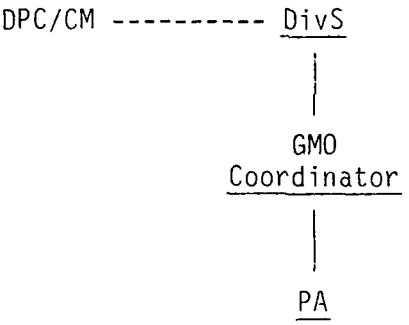
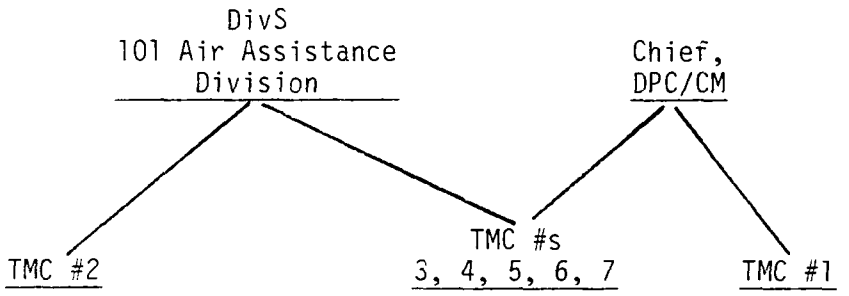
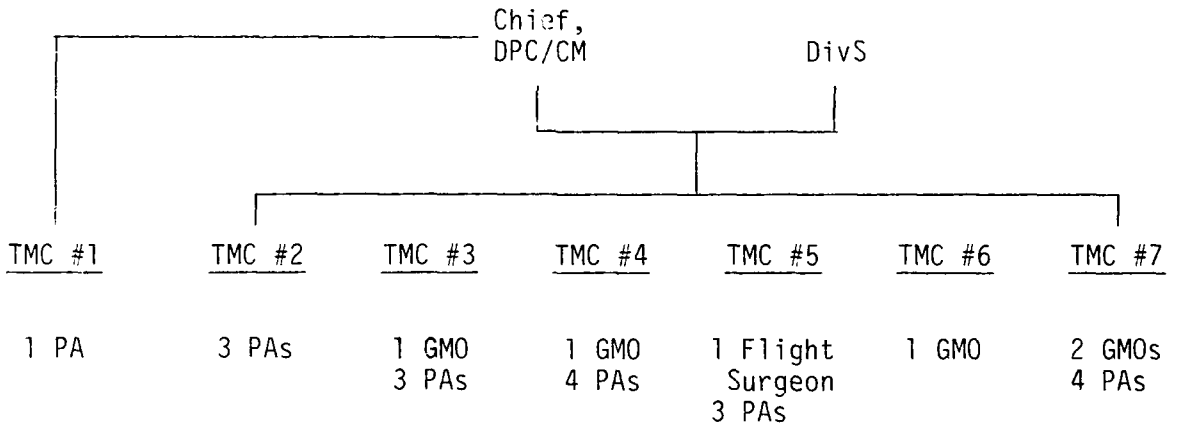


Professional Responsibility Chain

FORT CAMPBELL MEDDAC

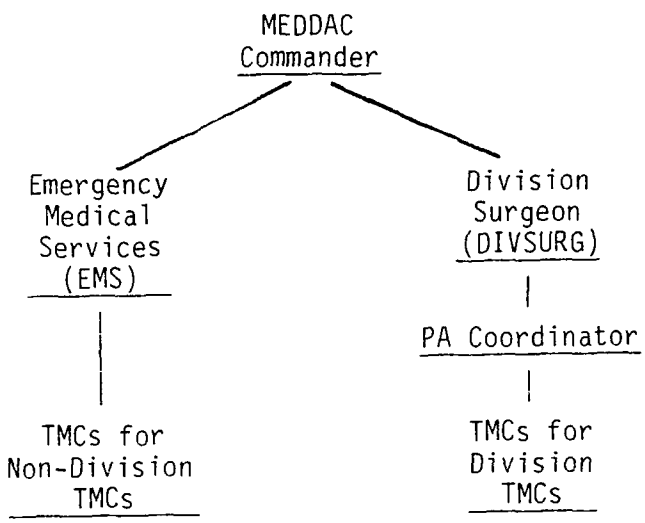


Administrative Responsibility Chain

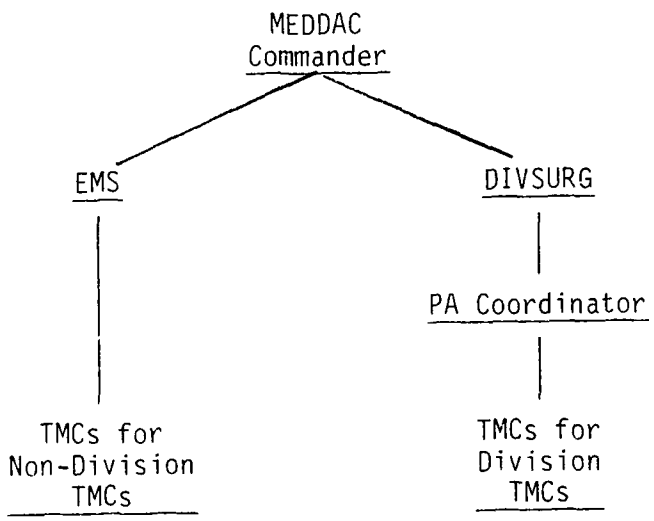


Professional Responsibility Chain

FORT HOOD MEDDAC

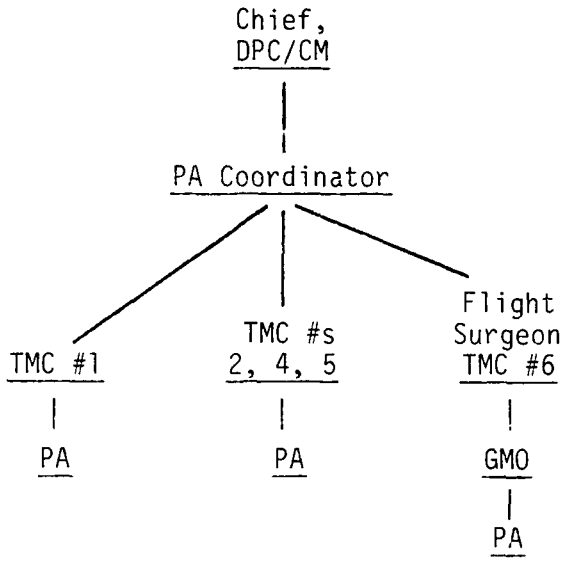


Administrative Responsibility Chain



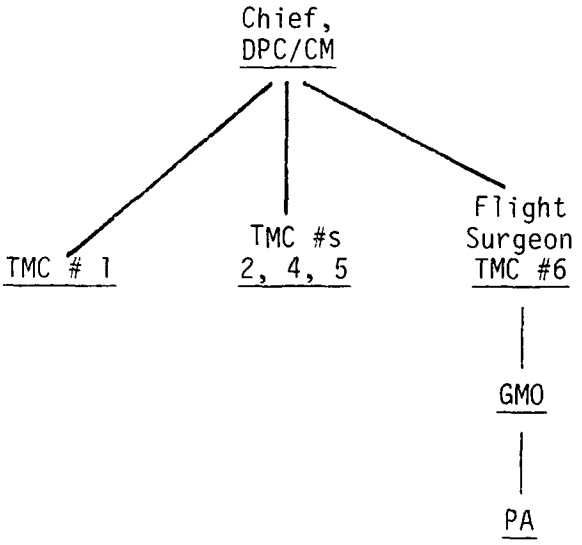
Professional Responsibility Chain

FORT KNOX MEDDAC



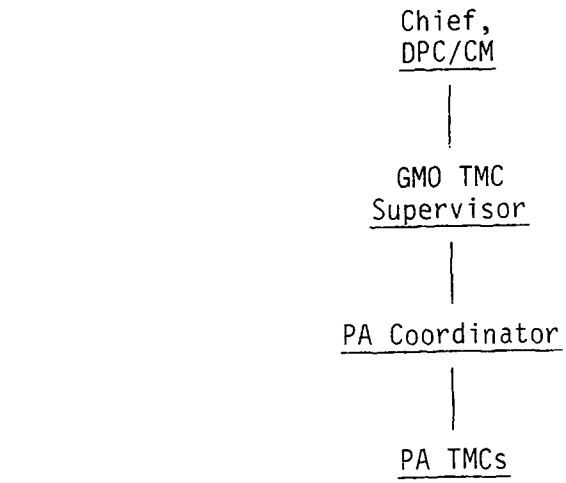
TMC #3 has Brigade Surgeon.

Administrative Responsibility Chain

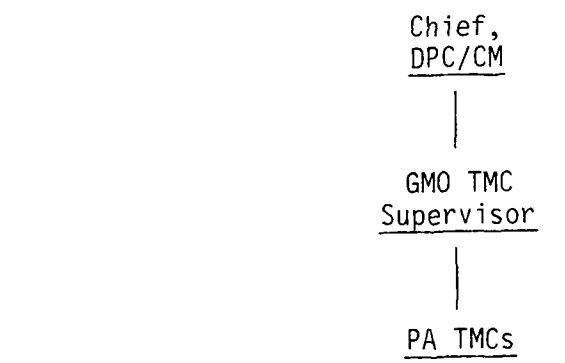


Professional Responsibility Chain

FORT LEONARD WOOD MEDDAC

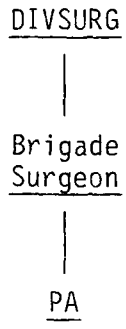


Administrative Responsibility Chain



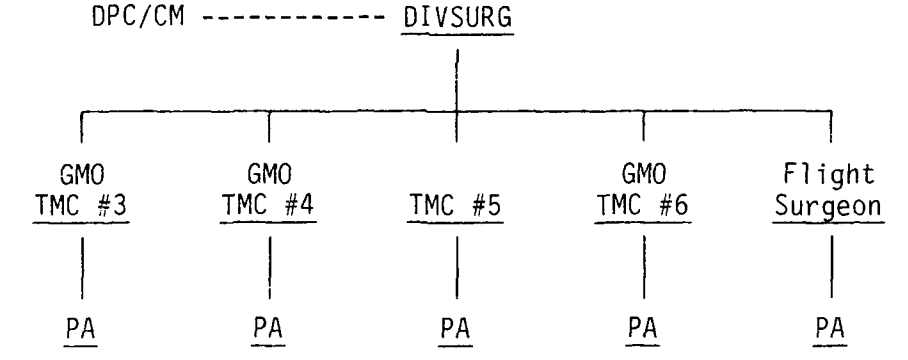
Professional Responsibility Chain

FORT ORD MEDDAC



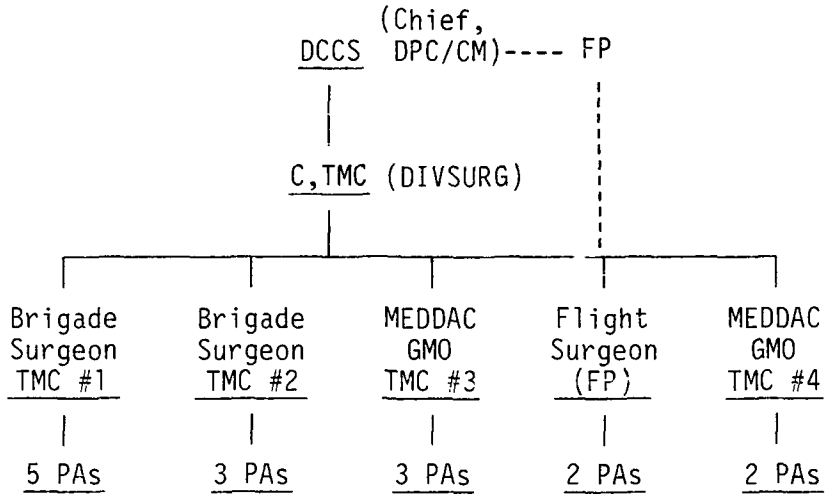
NOTE: MEDDAC has no control.

Administrative Responsibility Chain

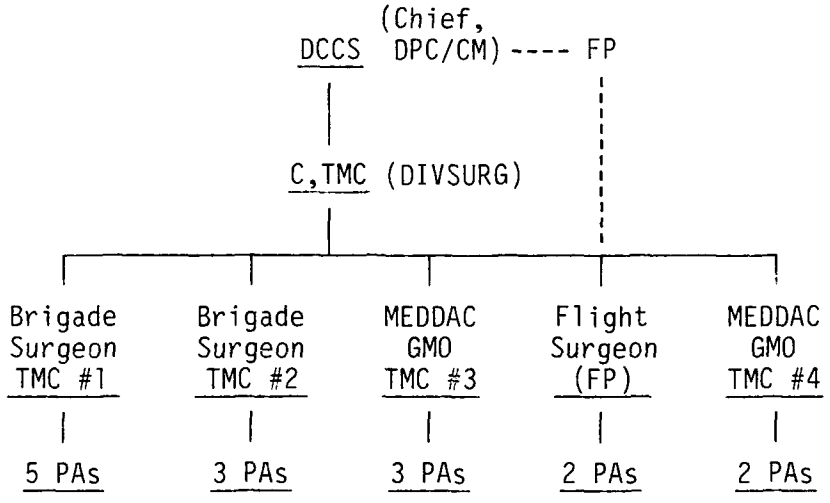


Professional Responsibility Chain

FORT POLK MEDDAC

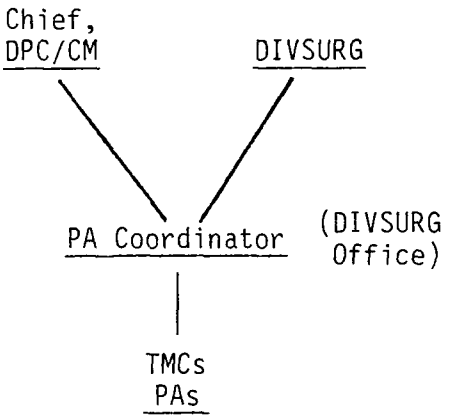


Administrative Responsibility Chain

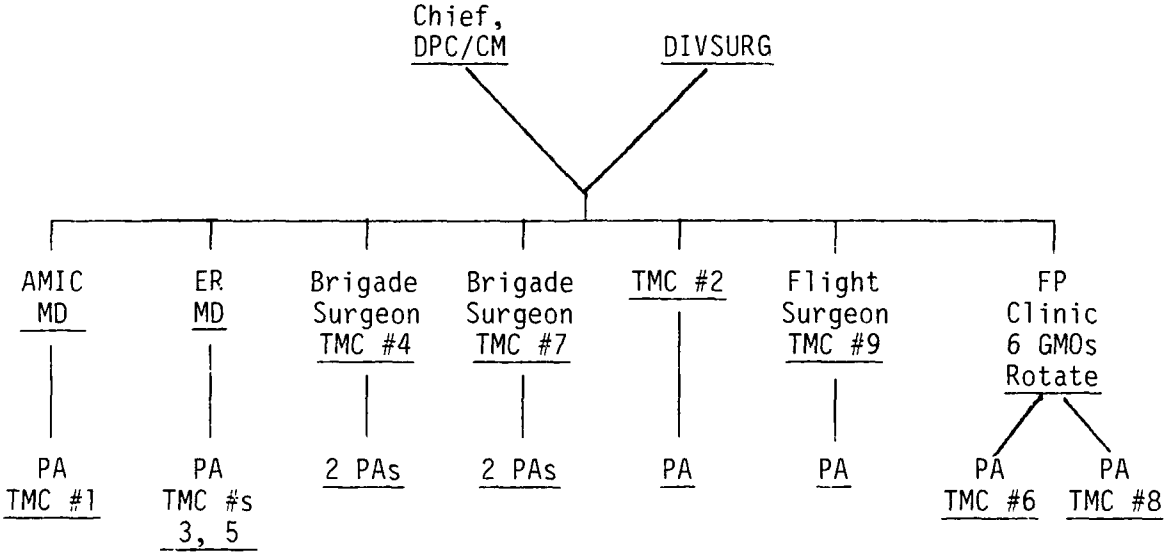


Professional Responsibility Chain

FORT RILEY MEDDAC



Administrative Responsibility Chain



Professional Responsibility Chain

APPENDIX H

RECAPITULATION OF SURVEY OUTCOMES

BY CRITERION

CRITERIA

1. Congruence of chains
2. Manageable span of control
3. Delineated responsibility
4. Availability of professional and administrative consultation
5. Continuity of professional and administrative consultation
6. Facilitation of PA growth
7. Agreement with system by those within it
8. Mechanism to conduct medical audit
9. Maximum effective utilization of and between physician and PA
10. Adequate staffing

RECAPITULATION OF SURVEY OUTCOMES BY CRITERION

Criterion	Fort Sill	Fort Belvoir	Fort Benning	Fort Bragg	Fort Campbell	Fort Hood	Fort Knox	Fort L. Wood	Fort Ord	Fort Polk	Fort Riley
1	NM	M	NM	M	NM	M	FM	M	NM	FM	NM
2	NM	FM	FM	NM	ADM--NM PROF--M	NM	M	FM	ADM--NM PROF--M	FM	ADM--M PROF--NM
3	FM	NM	FM	NM	NM	NM	NM	ADM--M PROF--NM	NM	NM	NM
4	FM	FM	FM	M	NM	M	FM	FM	FM	FM	ADM--M PROF--NM
5	ADM--M PROF--NM	FM	ADM--FM PROF--NM	NM	ADM--M PROF--NM	M	M	FM	ADM--M PROF--NM	NM	NM
6	NM	FM	NM	NM	NM	NM	NM	NM	M	M	NM
7	M	M	M	M	M	NM	NM	M	M	M	M
8	NM	FM	FM	FM	FM	FM	FM	FM	NM	FM	FM
9	NM	M	NM	M	NM	NM	NM	M	NM	M	M
10	NM	ADM--M PROF--NM	NM	NM	NM	ADM--M PROF--NM	ADM--M PROF--NM	ADM--NM PROF--M	ADM--NM PROF--M	ADM--NM PROF--M	ADM--M PROF--NM

FM = Fully Met
M = Met
NM = Not Met
ADM = Administrative chain
PROF = Professional Chain

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BIBLIOGRAPHY

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