A STUDY TO DETERMINE AN EFFECTIVE PROCEDURE WHICH WILL REDUCE THE PROCESSING TIMES OF MEDICAL EVALUATION BOARDS CONDUCTED AT LETTERMAN ARMY MEDICAL CENTER.

A Graduate Research Project
Submitted to the Faculty of
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Requirements for the Degree
of
Master of Health Administration

By

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The intent of this study was to evaluate and improve the processing time of Medical Evaluation Boards at Letterman Army Medical Center. Through comparison studies of Navy, Air Force and other Army Medical Center procedures the suggestions of improving Letterman's program was based.

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I. INTRODUCTION

Conditions Which Prompted the Study

When a soldier is identified as possibly being medically unfit for retention in the U. S. Army, his productivity and usefulness to the service is likely to diminish markedly. This may happen for several reasons. Primarily, his physical profile may prohibit his performing the duties required for his normal Military Occupational Specialty (MOS). Secondly, there is a general unwillingness on the part of local troop units to utilize soldiers with medical limitations. Many of the soldiers being processed by the disability system and who wear a brace, carry a cane, are on crutches, or who are being treated for a psychiatric condition cannot be attached or assigned to troop units simply because these units will not accept them. This has resulted from past experiences within these units where the "walking wounded" have caused either administrative or morale problems within the regular cadre. Thirdly, some of the soldiers being processed by the disability system are unable to participate in any work therapy programs due to the severity of their

conditions. Also, some of the more senior individuals being processed by the disability system are not able to find suitable work in the garrison because their presence would upset the intramural work relationships therein. In many instances, delays in the disability processing system cause soldiers and their families needless personal hardships. Finally, disabled soldiers occupying positions create situations where mission capability of the unit becomes compromised, tax dollars are wasted, readiness is degraded, and administrative burdens are increased. For these reasons, it is essential that soldiers being processed by the disability system are managed quickly and efficiently.

The portion of the disability system managed at Letterman Army Medical Center (LAMC) is the Medical Evaluation Board (MEBD). At LAMC, there are no specially designated Medical Holding Company (MED HOLD) barracks, and those soldier inpatients being processed by a MEBD and well enough to be taken off the wards, but unable to be attached or assigned elsewhere, or allowed to subsist elsewhere must be billeted within the two troop companies of the LAMC Troop Command. It is often difficult to control the soldiers so billeted, especially if these soldiers do not have skills which can be productively utilized within the hospital

military work environment. In many instances, delays in the processing of soldiers have caused the soldiers' families needless hardships, to say nothing of the increased costs to the government. Excessive delays in the processing of soldiers by MEBDs also reflects unfavorably upon LAMC and the U.S. Army Health Services Command (HSC). It is therefore important that when a soldier undergoes processing by a MEBD, his case is completed in an expeditious manner.

Letterman has been identified by HSC as having an excessive average processing time for its MEBDs. In the spring of 1986, the Commander, HSC informed the Commander, LAMC that he must take a "personal interest" in reducing the average processing time for MEBDs at LAMC. It was further detailed by the Commander, HSC that the goal for the processing of the MEBDs conducted at LAMC would be 30 days or less from the time of the report of the medical examination - as reflected on the Standard Form 88 (SF 88) - to the date that the MEBD case is received by the Physical Evaluation Board (PEB). With this guidance in mind, it was necessary at LAMC to develop procedures to meet the established processing time standard and ensure that unnecessary delays be eliminated in the processing of the MEBDs.

Problem Statement

To determine an effective procedure which will reduce the processing times of Medical Evaluation Boards conducted at Letterman Army Medical Center.

Objectives

1. Conduct a literature review of documents concerning the processing of Medical Evaluation Boards.
2. Evaluate the current administration of Medical Evaluation Boards at Letterman to identify reasons why delays occur in the case files being forwarded to the Physical Evaluation Board.
3. Determine if the Medical Evaluation Board processing time problem at Letterman is chronic or acute.
4. Compare the Medical Evaluation Board administration systems utilized by the Navy at the Oakland Naval Regional Medical Center (ONRMC) and the Air Force at the David Grant Air Force Medical Center (DGAFMC) with the system used at Letterman.
5. Compare the Medical Evaluation Board processing times at Letterman with those of other large Army Army Medical Treatment Facilities (MTFs).

6. Request from other Medical Treatment Facilities information which may identify methods of implementing effective Medical Evaluation Board processing procedures at Letterman.

7. Compare the manning utilized in administering Medical Evaluation Boards at Letterman with that utilized at other Army Medical Treatment Facilities.

8. Develop an alternative to the current Medical Evaluation Board administration system at Letterman which will reduce the average processing time and satisfy Health Services Command requirements.

Criteria

1. The Medical Evaluation Board administration at Letterman must allow the complete, individual monitoring of each case in order to prevent unnecessary delays in processing.

2. There must be a mechanism which identifies delays in processing and promotes corrective actions to be taken expeditiously.

3. Processing times for Medical Evaluation Boards will be within the Health Service Command standard of 30 days.

4. Soldiers being processed by a Medical Evaluation Board will be administered systematically.

5. Procedures for processing soldiers will ensure that consultative appointments and treatment are provided on a priority basis.

Assumptions

1. Medical Evaluation Boards can be more efficiently processed at Letterman Army Medical Center.
2. There will be no change in the Health Services Command processing time standard for Medical Evaluation Boards.
3. The importance of expediting the processing of Medical Evaluation Boards will not diminish.
4. The Commander and staff of Letterman are interested in satisfying the Health Services Command requirements regarding the processing of Medical Evaluation Boards.

Limitations

1. Only cases of soldiers undergoing Medical Evaluation Board Processing at Letterman will be studied in detail. Cases of individuals undergoing disability processing through the Air Force and Navy medical disability systems will also be studied as a basis for general comparisons of the processing systems.

2. The most effective procedure identified to reduce Medical Evaluation Board processing times must not indicate that an increase in manpower is necessary.

3. In-depth interviews with those involved with the processing of Medical Evaluation Boards at other Medical Treatment Facilities will, for the most part, be conducted telephonically due to financial constraints which preclude travel to these facilities.

4. No cases of deceased personnel will be considered in this study.

5. Only cases where records are available for inspection at Letterman of the Presidio of San Francisco Physical Evaluation Board will be individually examined.

6. Surveys will not be conducted with service members assigned to Medical Holding Companies due to specific prohibition against same in the Department of the Army's Sample Survey Procedural Guide.

Research Methodology

The following research methodology will be used:

1. Literature review.

a. Review of Army and Air Force regulations and Navy instructions regarding the processing of individuals through the respective disability systems.

b. Review of Standard Operating Procedures from other Medical Treatment Facilities regarding their particular methodologies for processing service members by Medical Evaluation Boards.

c. Review of articles covering the military disability systems in general, and the processing of Army disability cases in particular.

2. Non-structured interviews will be conducted with representatives of the following organizations in order to gain an understanding of the administrative and clinical responsibilities each has in processing individuals by the disability system.

a. Directorate of Patient Administration, Health Services Command.

b. Office of the Inspector General, Health Services Command.

c. Office of the Deputy Commander for Clinical Services, Letterman Army Medical Center.

d. Directorate of Patient Administration, Letterman Army Medical Center.

e. Directorate of Patient Administration, Brooke Army Medical Center.

f. Department of Medicine, Letterman Army Medical Center.

g. Department of Surgery, Letterman Army Medical Center.

h. Department of Psychiatry, Letterman Army Medical Center.

i. Ft. Sam Houston Physical Evaluation Board.

j. Presidio of San Francisco Physical Evaluation Board.

k. Patient Administration Department, Oakland Naval Regional Medical Center.

l. Patient Affairs Directorate, David Grant Air Force Medical Center.

3. Evaluation of the current system of processing MEBDs at Letterman.

a. Documents utilized by the Directorate of Patient Administration (LAMC PAD) and the clinical departments and services will be gathered and examined in order to evaluate the current MEBD processing system. This examination will identify and critique any procedures which are in place and determine areas of potential system improvement.

b. Follow each ongoing MEBD case to determine how they are being processed in order to meet the HSC processing standard.

c. Determine the responsiveness of the supervising clinical personnel to reports concerning

individual MEBD cases whose processing time may exceed, or has exceeded, the 30 day processing time standard.

d. Determine how items of MEBD processing interest are communicated to the professional and administrative staffs.

4. Information from other Army MTFs will be examined to identify procedures which enable them to better meet HSC processing time guidelines. The determination of whether or not the facility meets these guidelines will be based upon monthly reports of MEBD processing times generated by the U. S. Army Physical Disability Agency (USAPDA).

5. The medical disability processing systems of the Navy and the Air Force will be examined by interviewing patient administrators from the two other military medical centers in the area - David Grant Air Force Medical Center and the Oakland Naval Regional Medical Center. These interviews will not only provide a local comparison of the three different MEBD processing systems, but will also provide insight as to transferable procedural differences which make one system more effective than the others.

6. Recommendation of an alternative, more effective system whereby processing times may be reduced in order to meet the HSC processing time standard. This

recommendation will be based upon the information obtained through the literature review, the various interviews, discussions, observations of the current systems in place at other MTFs, and the operational constraints in place at Letterman Army Medical Center.

II. DIDACTIC PHASE

Literature Review

During the didactic portion of the graduate course - soon after determining what the topic and focus of the graduate research project would be - information was gathered concerning the disability processing system. It was decided that the first place to start looking for this type of information would be in Army regulations and pamphlets. For the purposes of this study, relevant documents include those addressing the concerns of medical records and quality assurance administration,[1] line of duty investigations,[2] personnel retention and separation,[3,4] standards of medical fitness,[5] and of course, medical, dental and veterinary care.[6] Next, information from the Navy, Air Force, and Department of Defense was sought to create a collection of comparative, if not complimentary, literature. Information was obtained concerning the Department of Defense's guidance toward physical disability separation[7] and the Air Force's[8] and Navy's[9,10] applicable regulations concerning the individual

conducting and administration of their Medical Evaluation Boards. To find information about how specific Army MTFs have documented their standard operating procedures for the conducting of MEBDs, information was requested from sixteen MTFs from which appropriate replies in the form of SOPs and local regulations were received from eleven.[11,12,13,14,15,16,17,18,19,20,21] It was also thought important to ascertain if any previous research or managerial analysis had been conducted concerning the various Department of Defense disability systems in general or, more specifically, the Army medical evaluation and physical disability systems. Although several articles were found concerning the subjects at hand,[22,23,24,25] only one example of a management analysis study was discovered concerning any specific Army disability situation or system.[26] Finally, it was determined that published information and guidance from the USAPDA would be helpful in garnering a broader perspective of relevant problems within the entire Army disability system to include their possible solutions. At the time of the initial contacts with representatives of the agency at Ft. Sam Houston, no such published information existed. In fact, the only documents which were able to be obtained from the agency were their

monthly processing time sheets - documents which were little more than lists of statistics that detailed the inability of most of the MTFs to ever achieve the HSC-directed processing time standard. Fortunately, during the administrative residency portion of the graduate research project, the Presidio of San Francisco Physical Evaluation Board began publishing documents[27,28,29] discussing the broader problems and the possible solutions to same which would be helpful in properly conducting the study.

With what was considered to be an adequate base of literature for accomplishing the graduate research project, the administrative residency was entered into confidently with the knowledge that adequate preparation to succeed had been accomplished.

Health Services Command

Since the didactic portion of the course was taken at Ft. Sam Houston Texas, it was decided to exploit the expertise at three organizations which are located there - Headquarters, Health Services Command, Brooke Army Medical Center, and the Ft. Sam Houston Physical

Evaluation Board. Perhaps the most important of these three organizations, at least as far as the topic of MEBD processing times is concerned, is HSC. It is from this headquarters that the MEBD processing time standard originates, therefore it was important to talk to the functional experts there in order to lay a solid base for the administrative residency work.

Two interviews were held with staff members of the HSC Office of the Inspector General.[30,31] Both of the interviewees were experienced patient administration officers who were serving as inspectors for HSC. Both of these officers were familiar with the HSC processing time standard for MEBDs and one of the officers had participated in the previous inspection of the Patient Administration Directorate at Letterman. During these interviews, four specific topical areas of the MEBD process were discussed in order to create a foundation where relevant questions could be asked during the administrative residency. These topical areas were the mechanics, the monitoring, the control, and the responsibilities of MEBD processing.

Concerning the mechanics of the MEBD processing system, it was conveyed that in order to evaluate an entire system with the intent to improve upon it, one must discover the small elements within the system

which, when combined, make up the entire system. For example, some of these small elements within the entire MEBD system relate to the identification of patients to be processed for MEBDs. Who does this identification? How is the identification made? When? Is the PEBLO surprised by the eventual identification of MEBD patients, or does the identification system in use increase the likelihood that the PEBLO will be able to anticipate - perhaps soon after these patients are admitted, or their outpatient cases presented in the clinic - that certain individuals will eventually be processed by MEBDs? Of particular concern should be those elements which determine the methodologies used to monitor patients being processed by MEBDs, or who have a likelihood of being processed. Is anything used - perhaps a long-term patient roster - to monitor inpatient stays? How does this monitoring relate to identification for MEBD processing or progress? How do other elements of the process relate to the prioritization of MEBD activities under the present system? For example, what priority of consultative appointments are given to those patients being processed by MEBDs? Are physical exams accomplished by the attending physician, or by the staff of the physical exam clinic? What kinds of suspense systems are being

utilized, and by whom? Are these suspense systems merely retrospective listings of patient names and dates, or is a more prospective, computerized management tool being used? How are the MEBD dictations and transcriptions accomplished? Who does them? Are they decentralized at the service, clinic, or department level, or are they centralized at the hospital level? How are MEBD dictations and transcriptions segregated from other dictations and transcriptions in the hospital to ensure expeditious processing? Are the MEBD dictations recorded differently than others? Are the MEBD transcriptions processed differently than the others?

Regarding the control of MEBD processing, it was learned through discussions with the HSC staff that it must be determined exactly who is in control of the processing system. Regardless of the presence or absence of any pre-established legal power to do so, it must be ascertained if the PEBLO is able to control the physician MEBD processing activities. How supportive are the Director of Patient Administration, the clinical chiefs, the Deputy Commander for Clinical Services and the Commander in helping the PEBLO get the control that is needed for processing to be accomplished expeditiously? Are the attending physicians allowed to

have so much control of the MEBD processing system whereby they are able, in essence, to process their patients at will with little or no fear of sanctions being placed upon them or their patients? Does the physician hierarchy of the medical center exercise its power to promote efficient MEBD processing, or is the power exercised in a way whereby the attending physicians are isolated from non-physician pressure? Is the utilization review process used to expedite processing of MEBD cases?

Concerning responsibility for MEBD processing activities, it was learned that an effective system will allow determination of fault or blame for cases which are not processed expeditiously. In an effective system, it should be easy for the observer to determine for each particular case where MEBD processing is not being accomplished effectively, who exactly is at fault. Mistakes should not be allowed to homogenize giving the appearance that all parties are equally at fault. It should be discovered if the clinical chiefs are held accountable, or even responsible, for uncomplementary processing time histories within their departments and services, or if their powers are so great that they and their staffs are able to shirk their responsibilities and pass off the blame to the administrative elements

within the hospital. It must be determined which responsibilities the Deputy Commander for Clinical Services have accepted towards effective MEBD processing. Does he know how well MEBDs are being processed? Does he acknowledge any problems within the system? Do the processing time figures concern him, or does the importance of keeping "teaching cases" within the medical center override the need to expeditiously process MEBD cases? The staff at HSC also indicated that it would be essential to determine early during the administrative residency the attitudes of the physician hierarchy at LAMC towards the expeditious processing of MEBDs.

Brooke Army Medical Center

Due to the fact that the second largest of all Army medical centers is located at Ft. Sam Houston, Texas, it was deemed necessary to talk to those responsible for the processing of MEBDs at Brooke Army Medical Center (BAMC) in order to get their opinions regarding the expeditious processing of MEBDs. On May 25, 1987, an interview was held with the PEBLO at BAMC.[32] She suggested areas where delays in the

processing of MEBDs would probably be found. The most important consideration, in her opinion, was to determine the attitude of the DCCS and the clinical service and department chiefs towards the processing of MEBDs. She stated that if these individuals did not actively promote the expeditious processing of MEBDs, that the MEBDs simply would not be efficiently accomplished. She looked over the reports of average processing times and indicated that LAMC indeed has a serious, chronic, problem as evidenced by it being among the slower, if not the slowest of all Army medical centers in processing MEBD cases. She suggested that early during the administrative residency the attitudes of the clinical hierarchy at LAMC concerning the processing of MEBDs be assessed. Once this was done, the specifics of the processing system in place at LAMC could be examined.

She said that it would be essential for a series of suspense systems, both within the clinical departments and within the MEBD processing section, to exist if efficient processing were to take place. After examining the processing time figures for LAMC which she had in her possession, she stated that perhaps no suspense systems were being used at LAMC. She personally used a series of cards where patient

information was recorded, although she anticipated that sometime in the future a computerized system for following the progress of MEBD cases would be made available to her. She indicated that she used her cards to remind the clinical departments and services when a patient was seemingly being delayed, and found that her initial reminder was usually sufficient to create movement in the processing of a particular MEBD case. She suggested that the use of the long-term patient roster would be a place to start if developing a suspense system for inpatients. This roster would be available at almost any time to any of the clinical or administrative staffs concerned, and the generation of figures would be standardized throughout the clinical and administrative areas. Prioritization of MEBD processing activities is another area that she suggested be looked into. She indicated that to have timely processing of MEBDs, priority consideration for all aspects must be instilled. Consultative appointments must be done on a priority basis. Members being processed by MEBDs must not be made to wait to have physical examinations accomplished, or to have their records transcribed in the same manner as those not being processed by MEBDs. The requests for personnel information must indicate that the patient is being

processed by a MEBD and that timely submission of documentation is required. Physicians, especially the interns and residents, must be educated to realize that their patients who are undergoing MEBD processing must be treated differently than their other patients. It must be made clear to these physicians that patients being processed by a MEBD must be expedited. It must also be made clear to the physician hierarchy that only those patients who can be reasonably expected to return to full duty within approximately one year should receive the maximum benefit of hospitalization. It was pointed out that many physicians feel that all of their active duty patients may be kept in the hospital for as long as the physician deems it necessary to accomplish he and his patient's individual or collective needs and desires. This wrong assumption on the part of these physicians must be corrected by their department and service chiefs. The policy of the Department of the Army concerning the medical treatment to active duty service members also must be understood and complied with.

Identification of service members who would likely be processed by MEBDs was the final area discussed. The BAMC PEBLO indicated that the physicians must be taught to report to the PEBLO those inpatients and outpatients

which are likely to require processing by MEBDs. The Army has guidelines which indicate those patients which should - or in some cases, must - be processed by MEBDs and it is necessary for the physician hierarchy to instill among their staffs the attitude that these guidelines will be followed. If this were done, the PEBLO and her staff would be able to anticipate processing of many of the MEBD cases that they are are eventually confronted with. This anticipation would enable them to more readily obtain the necessary personnel and Line of Duty information which so often delays disability processing. According to the BAMC PEBLO, effective identification of potential candidates for MEBD processing by the physician staff would enable almost every case to be accomplished within the HSC processing time standard. Education of the physician staff regarding the necessity of identifying these potential candidates for disability processing to the PEBLO promotes optimal disposition of all disability cases.

Physical Evaluation Board, Ft. Sam Houston

The other organization located at Ft. Sam Houston which would provide useful information concerning the

expeditious processing of MEBD cases was the Physical Evaluation Board. On May 7, 1986, an interview was conducted with Dr. Stanley Harris, the Medical Officer on the Ft. Sam Houston Physical Evaluation Board, regarding the efficient processing of MEBD cases.[33] Dr. Harris is a retired Army Medical Corps Colonel with over thirty years of experience in military medicine. He is a graduate of the U. S. Army-Baylor University Graduate Program in Health Care Administration, and is intimately familiar with the MEBD and PEB processing systems. It was obvious that the counsel, advice, and recommendations of one so eminently qualified to discuss both the administrative and clinical aspects of MEBD processing would be singularly valuable in developing an effective MEBD processing system at LAMC.

The interview with Dr. Harris was more like a teaching session than an interview. He started by giving a complete description of what an MEBD is and why it is accomplished. He discussed how it differs from a PEB, and how it is often easy to confuse the two. He related that many physicians doing MEBDs are often ignorant of the purpose of the MEBD and therefore make incomplete or inappropriate remarks in the narrative summary. He related that senior military physicians are often unsure about processing patients

for MEBDs and therefore either misinform, or keep their junior staffs uninformed about the processing system. He related that during the time when he was a resident that he and his colleagues were personally held accountable by the senior resident for their MEBD processing activities and learned "the hard way" how to properly accomplish MEBD processing. He indicated in his position as the Medical Officer of the Ft. Sam Houston Physical Evaluation Board, he felt that the type of mentoring that he received was, in many cases, not being given today. He believed that if it were, much of what was being forwarded to the PEB at Ft. Sam Houston would not be allowed to leave the clinical service, much less the MTF. He felt that it was obvious that many Army physicians were simply not being properly educated concerning the processing of MEBDs. He suggested that many of the senior physicians in the Army entered the service during the time when there was a shortage of physicians, and were never pressured into doing the administrative tasks of MEBD processing the "right way." They are therefore not able to relate to their staffs what is required in a properly constructed MEBD since they, in all likelihood, honestly don't know. Although he had no examples of any MEBDs from LAMC which had been forwarded to his office for PEB action, he did

specifically relate numerous cases of improperly constructed, poorly administered, and unprofessionally managed MEBDs which had been forwarded to the Ft. Sam Houston PEB. Looking at the processing time sheets for LAMC, he agreed with the BAMC PEBLO that LAMC is obviously experiencing a problem in the processing of its MEBDs. He suggested in a most sincere, yet urgent way, that his counterpart at the Presidio of San Francisco PEB be contacted soon after the start of the administrative residency to obtain specific information as to the particular problems being experienced by his PEB with LAMC cases. Since the Ft. Sam Houston PEB only occasionally considered a LAMC MEBD case, he was unable to offer suggestions regarding specific problems being experienced at LAMC. He did suggest, however, that perhaps an MEBD education program - not specifically for physicians only, but one that could be made available to the entire staff - would be useful at LAMC. It was his opinion that this education program, if promoted by the Commander and the clinical departmental and service chiefs, would help expedite MEBD processing activities throughout the medical center. He suggested that any educational system or program developed make it clear that a Medical Evaluation Board is really nothing more than a good narrative summary that is agreed to by three physicians and approved by the DCCS. It should contain:

a. identification background on the patient.

b. statement of any prior service.

c. statement as to why the patient is being seen by the physician at this particular time.

d. the story relating the history of the medical problem that the patient is being processed by the MEBD for.

e. any statements of pertinent family medical history.

f. a review of the patient's medical systems, to include consultations relating to the specific medical problems which have caused the MEBD to be initiated.

g. a good physical examination.

With this guidance in mind, and the Medical Evaluation Board being the final product, the physician who initiates the process should, upon initial examination of each of his active duty patients, determine a list of likely possibilities which are causing him to have his particular medical problem. After the physician has ordered and evaluated a series of medical tests, he should have identified the most likely condition causing the patient's problem. In many instances - especially those involving orthopedic, neurosurgical and trauma cases - the identification may

be relatively easy. In others, numerous tests and consultations will be required to narrow the possibilities. Once this determination is made of the most likely possibility, the physician should ask himself, with a familiarization of the Standards of Medical Fitness in mind, if the individual can reasonably be expected to return to duty - and if so, when. If it is likely that it will be at least five or six months before the patient will be able to return to duty, then the decision should be made to process the patient by an MEBD. An evaluation regarding the patient's fitness for worldwide deployability should also be made. The Medical Evaluation Board should consider the medical requirements for fitness. Questions as to what particular job the patient has, or what jobs he may be able to successfully hold in the Army with his particular physical condition should not enter into the physician's consideration. This will be taken into account by the PEB. The MEBD education program should also teach that once the decision is made that a MEBD will be accomplished, it is incumbent upon all personnel involved in the process to quickly and efficiently accomplish their necessary processing tasks. The concerns of the Department of the Army regarding the waste of resources caused by prolonged

MEBD processing should be discussed, and the responsibilities of each employee - civilian and military alike - to help expeditiously process MEBD cases should be emphasized. Dr. Harris felt that from his standpoint and experience, education of those involved in MEBD processing is the most effective way to reduce the processing times. He stated that he did not know if a system of sanctions would be necessary at LAMC to ensure that the educational message would be taken to heart. Perhaps the educational program itself would be so enlightening as to preclude the initiation of a sanction system. He did relate, however, that during his military medical training the fear of the senior resident's wrath was instrumental in he and his colleagues being able to efficiently and properly conduct an MEBD.

With the literature gathered, the review initiated, and the Ft. Sam Houston interviews completed, the administrative residency was entered into with sound advice on how to look for the problems plaguing the MEBD process at LAMC, and eventually find their solutions.

Endnotes

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III. RESIDENCY PHASE

Physical Evaluation Board, Presidio of San Francisco

Taking the advice of Dr. Harris of the Ft. Sam Houston PEB, a visit was made early during the administrative residency to the Presidio of San Francisco PEB. One purpose of this visit was to ascertain how the MEBD processing time situation at LAMC was being viewed by the PEB responsible for processing most of the LAMC MEBDs. It would be useful to discover where those at the Presidio of San Francisco PEB felt that the processing of LAMC MEBDs were being delayed. It would also be good to discuss any suggestions that the staff of the Presidio of San Francisco PEB had concerning possible solutions to the problems that they felt were causing the processing problems at LAMC. A series of two interviews were held with the Presidio of San Francisco PEB Medical Officer[1] and the alternate President.[2] Although these interviews were held on the same day, they were conducted separately and focused on differing areas of expertise that were available at the PEB.

The first interview was held with Dr. Joseph McGerity, the Medical Officer of the PEB. As with the interview conducted at Ft. Sam Houston with his counterpart there, the discussion centered around physician input and influences towards the MEBD. Dr. McGerity indicated that the Presidio of San Francisco PEB did not view the LAMC PEBLO or her staff as being at fault when considering the processing time difficulties being experienced. He indicated that the serious MEBD processing problem being experienced at LAMC was caused by almost the complete absence of command pressure put on the attending physicians. He emphasized that if constant command pressure were put on the processing physicians at LAMC, the processing times could easily be made to meet the HSC standard. He, like Dr. Harris, showed specific examples - but his were from LAMC physicians - of how ignorance of the processing system, ignorance of Army regulations, ignorance of Army MEBD processing guidelines and apparent managerial abdication of responsibility had created a serious, chronic, and costly MEBD situation. He showed example after example of cases from LAMC which had to be returned for re-processing due to inconsistent profiles being given in relation to the demonstrated physical condition of the patient. He displayed examples of long, protracted

narrative summaries rife with unnecessary, confusing, and incorrect information which were supposedly reviewed by senior, experienced, LAMC physicians - physicians who were placed in their positions for teaching purposes. This lack of quality assurance, in his opinion, indicated that the physician leadership at LAMC was not really concerned with properly processing MEBDs. He suggested that the only way for the situation to be corrected would be for the Commander of LAMC to be forced into acknowledging that the processing of MEBDs is an important part of military medicine. He suggested that it must be taught to junior physicians, must be monitored by senior staff, and must be done so in a timely manner. He suggested that a general inspection of the MEBD processing system at LAMC would yield damning information, and perhaps only then would the Commander have the incentive to improve physician input into the MEBD processing system. He indicated that the first step that an inspired LAMC Commander would take would be to establish an educational system where each physician coming into the hospital would be taught how to do MEBDs correctly. In this training, the necessity of expeditious processing would be emphasized, as would the reasons why delayed processing are considered unacceptable. The training program would help eliminate

misconceptions concerning MEBDs and PEBs, and promote a greater physician understanding of why it is necessary for them, as members of the Army, to accept the corporate philosophy concerning MEBDs. He felt very strongly that with proper presentation and command emphasis, the LAMC physicians would be able to correct their processing deficiencies and make expeditious disposition of their MEBD cases. This first step - the establishment of an educational system - could possibly be the only step needed to be taken to turn the MEBD processing time situation into something which the commander of LAMC could be proud.

The interview with Colonel Serge Demyanenko, the alternate president of the Presidio of San Francisco PEB echoed some of the concerns of Dr. McGerity. Colonel Demyanenko said that he felt that at LAMC, as with any MTF, the processing of MEBDs is physician directed and controlled, therefore the key player in the process is the attending physician. He stated that it was rare for him to discover that the routine, local, administrative aspects were the cause of processing delays. He had documented information of numerous LAMC MEBD cases that indicated unwarranted delays caused by physicians not expediting processing. He did say that it was common in

the Army for administrative matters to delay the eventual disability disposition of patients, but as far as the LAMC processing of MEBD cases were concerned, the problem did not lie with the administrative staff. Colonel Demyanenko indicated that he thought that the PEBLO at LAMC was doing a remarkable job in preventing the chronic problem state of MEBD processing from getting any worse than it was. He said that he was aware that the LAMC PEBLO had many responsibilities in her position of Chief, Patient Affairs, and perhaps was "spread too thin." He also realized that as a civilian employee, she was constantly at a disadvantage when trying to persuade military physicians to expedite their cases. He agreed with Dr. McGerity that it would take a major shock to the LAMC Commander's reputation or pride - in the form of an general inspection report - to turn around the dismal MEBD processing history of LAMC. He also agreed with him as to the necessity of the physicians processing the MEBDs to be better educated in the processing system philosophy. He said that members of the Presidio of San Francisco PEB routinely participate in the LAMC Transition to Practice training, but that something else - something conducted close to the physician's arrival rather than near his departure - is needed to get the physicians "on the right track" as

far as the MEBD situation is concerned. He suggested that during the administrative residency, the attitudes of the senior physicians be assessed towards their staff's processing of MEBDs. He said that the command emphasis within the hospital should be weighed against what is being officially published by HSC concerning MEBD processing. He suggested that junior physicians be talked to in order to ascertain what they were being taught by their teaching chiefs regarding MEBDs. Once this were done, he said it would be obvious what corrective actions would need to be taken if LAMC were to effectively improve its MEBD processing record. With this, the interview was terminated, the information from the day's activities collected, and the remainder of the project initiated.

Letterman Medical Evaluation Board Processing System

After initial tours of the medical center and introductions to key members of the staff were accomplished, the majority of the administrative residency - the part concerning the completion of the graduate research project - was spent discovering the ways that MEBDs were being conducted at LAMC. Only

after discovering why the MEBDs were being processed so poorly could reasonable, locally acceptable suggestions for improvement be made. Once these suggestions were developed, only then could an effective MEBD processing system be presented to the hospital Commander and his staff which would have a reasonable chance of being implemented.

After discussing the graduate research project with the individuals at HSC, BAMC, and the Ft. Sam Houston and Presidio of San Francisco PEBs, it became evident that a significant portion of the graduate research project would be spent assessing the attitudes of those responsible for MEBD processing at LAMC.

As the initial weeks of the residency passed, opportunities were given to speak at both clinical and administrative meetings within the medical center concerning the graduate research project. These meetings were used as a forum not only to inform the staff members of the graduate research project, but also to inform the supervisory personnel of the intention of going throughout the medical center to gather information and conduct interviews with their employees. These meetings were also used as a tool to gauge the level of knowledge and interest among the clinical and administrative staffs concerning MEBD

processing at LAMC. The most significant clinical meeting which was regularly attended during the administrative residency was the Tuesday morning staff meeting conducted by the DCCS. At this meeting, the DCCS, who at LAMC is also the Approving Authority for MEBDs, informs his department and service chiefs of medical center policies, problems being experienced within the hospital, and administrative matters concerning them which they need to be made aware of. Throughout the first half of the administrative residency, little interest was detected either from the DCCS or any of the senior physicians attending these meetings concerning the processing of MEBDs at LAMC. Although polite nods of approval were generated by these physicians when informed of a specific intention to visit their individual areas to gather information, it appeared as if the situation with MEBD processing at LAMC was of such little concern to them that it really didn't matter what the administrative resident did in their departments concerning this matter. When the administrative residency was started, the Director of Patient Administration was clearing the Presidio to become the Chief of the Patient Administration Division at HSC. Consequently, the opportunity to discuss with him the MEBD processing situation at LAMC did not

present itself until somewhat later during the administrative residency when he visited the West Coast on a staff assistance visit. Apparently, the demonstrated difficulties in the processing of MEBDs at LAMC were not seen by senior Medical Service Corps managers as anything for which he should be held accountable, since he was being transferred to one of the most senior positions which a patient administrator can occupy. The new Director, an experienced officer through whom much was accomplished from the time he arrived until he left for an extended temporary duty tour during the Spring, was an experienced officer who had previously been assigned as the Chief, Patient Administration Division, both at the large Medical Department Activity and medical center level. From the time he assumed his duties, until the time when the new LAMC Commander had instilled a more enlightened management philosophy, the Director was forced to report the weekly number of delinquent medical records at the Joint Staff Conference. Since this number was never at a level acceptable to the LAMC Commander, although as a percentage it was well within accreditation standard guidelines, the Director's reporting the figures week after week amounted to little more than his placing himself in a pillory in front of the administrative and

professional staffs. Although outranked by all clinical department and most service chiefs, and not having the authority to order any physician to do what was necessary to remedy the delinquent record situation, he was still judged as a "bearer of bad news" by a Commander who was known as one who did not want to hear bad news. Perhaps the stigma from his weekly experiences at the Joint Staff Conference were the reason for his not taking an active, public stand in the hospital concerning the MEBD processing situation until the new Commander assumed his duties. Perhaps he felt more could be accomplished by letting the administrative resident be the spearhead in this matter and assist by providing behind-the-scenes guidance and counsel. Perhaps he was directed to let the resident take almost complete charge of developing the problem and finding the solution by the preceptor in order to provide a more realistic learning experience. For whatever reason, or combination of reasons, his public position concerning MEBD processing at LAMC was one of concern, but not of burning interest. From the discussions with the Director and his staff, it was learned that the lack of effective DCCS support to the directorate in helping remedy both the delinquent medical record and MEBD processing time situations was extremely frustrating.

Due to the attitudes displayed by the senior physicians in the hospital, the Director's efforts in personally calling service and department chiefs in order to expedite certain critical MEBD cases were little more than palliative intervention for acute episodes of a chronic problem. The Director stated that he hoped one day - perhaps through the efforts of the administrative resident - the problems would be corrected and MEBD processing would be handled efficiently at LAMC. It was stressed, however, that although the MEBD processing time situation represented the most pressing problem for the administrative resident, it was, in fact, just one of the many problems within the medical center which needed correcting.

During the first six months of the administrative residency - a time frame in which a general officer was assigned to command LAMC - the Commander made absolutely no comments concerning the graduate research project or the LAMC MEBD processing situation to either the administrative resident or the Deputy Commander for Administration. Having been the newly selected Commander during the 1985 Army General Inspection of LAMC, an inspection during which the medical center was officially cited for its failure to process MEBDs in a timely manner,[3] it was surprising that he had

seemingly so little interest in a research project which could possibly improve a verified deficiency in his organization. What was even more surprising was the fact that during the time period preceding the 1985 inspection, he was assigned as the LAMC DCCS. Much of the damaging MEBD processing information noted during the inspection was generated during the time when he was responsible not only for the approval of MEBDs conducted at LAMC, but also for their clinical management. Not until later in the residency, after a new Commander had been named and a more honest evaluation of personalities made, was it discovered that the initial Commander was an individual who did not want to hear any bad news about his organization or anything which he could be remotely held responsible for. His self-imposed isolation from hearing many of the serious problems present at the medical center, and his inability to grasp many of the concerns of his administrative staff caused his effectiveness and his respectability to be diminished. Only late in his command was it realized that one should not have been surprised that he had no interest in hearing about the MEBD problems which could reflect poorly on his managerial abilities.

In February, a new Commander was appointed at LAMC. From the time of his assumption of command, a

refreshing change occurred at the hospital. The new Commander was a clinical expert whose reputation and expertise had caused his being named to command the medical center temporarily until the commander-designee could finish his Army War College course. He viewed his temporarily commanding LAMC as a chance for him to improve the practice of military medicine in an organization where he had spent eighteen years of his distinguished career. Not long after taking command, he spoke with the administrative resident concerning the graduate research project and what had been discovered during the residency concerning the processing of MEBDs. He took a genuine interest in the MEBD processing time figures generated by the USAPDA and indicated that he was concerned with the poor showing which LAMC had chronically displayed. He directed that a formal study be conducted detailing the processing history of every on-going MEBD case in order that he, his DCCS, and the DCA could be jointly informed of the problems with MEBD processing currently being experienced at LAMC. After the 1987 Army General Inspection's repeat Category I finding concerning the processing of MEBDs at LAMC,[4] he directed that a study group be established to develop a new series of guidelines for MEBD processing. These guidelines would

be developed into command directives, policies, procedures and regulations and a new philosophy towards MEBD processing would be instilled within the staff. It was his intent that the new system of processing MEBDs would enable processing days to meet the HSC standard, improve the reputation of LAMC to HSC and the USAPDA, and decrease the number of "readiness days lost" caused by inefficient processing procedures. His philosophy was that the goal of providing appropriate medical care to patients being processed by MEBDs, and the goal of expeditiously processing these individuals were not mutually exclusive. He indicated that he would make it a priority to see that corrective actions be taken. The change of attitude at this high level in LAMC resulted in the morning reports and the clinical staff meetings being places where the situation with MEBD processing was discovered openly and unabashedly. The most dramatic change occurred in the the conduct of the Tuesday morning DCCS meeting, a meeting from which the previous Commander was always absent but that the new Commander never missed. Whereas previously the subject of MEBD processing was only brought up by the administrative resident, with little feedback being generated by the clinicians present, the current situation is one where the subject is repeatedly

discussed, with sometimes the majority of the session being used to discuss clinical and administrative responsibilities towards MEBD processing. There have also been several formal meetings conducted with the Commander, the DCCS, the DCA, and the Director, Patient Administration concerning the processing of MEBDs at LAMC. The attitudinal position of the senior clinicians has improved dramatically during the tenure of the new Commander. It appears as if more progress has been made in establishing the correct philosophy towards MEBD processing during the new Commander's short tenure than had been accomplished previously. There is the likelihood that soon, the system of processing MEBDs at LAMC will be more than a collection of nice-looking documents which contain directives which are neither understood or enforced. The attitude of the present Commander is that the new system of processing MEBDs at LAMC will be one that satisfies the needs of the patient and of the Army. Confidence exists that his enthusiasm will result in the development of an effective procedure which will solve the problem of MEBD processing.

Most of the administrative management of MEBD processing at LAMC is accomplished by two civilian employees. One, the Physical Evaluation Board Liaison Officer (PEBLO) is a General Schedule (GS) 9 employee

who also serves as the Chief of Patient Affairs. The other, a GS 7, serves as the alternate PEBLO but is also called upon to perform other patient affairs functions if the Chief is out of the office for any reason. Under the U.S. Government compensation systems in place at LAMC, both of them would be making more if they were unskilled food service workers at the hospital than they presently are in their administrative positions. In their MEBD processing activities, they are assisted in their work by only one enlisted clerk. They personally handle all necessary Line of Duty requests except those few for patients needing them who were assigned to a Presidio of San Francisco unit upon identification for MEBD processing. They both do what would be considered normal PEBLO and alternate PEBLO functions such as maintaining the long term patient roster, coordinating the physician input into all MEBD transcription, and counseling patients as to their rights and responsibilities concerning the military disability processing systems. They do, however, operate under some conditions which make their administrative managing of MEBDs difficult.

First of all, their office is located outside the main hospital building. In fact, there are no clinical facilities whatsoever located in the building where

Patient Affairs is. This makes it inconvenient for the physicians or the patients to visit the PEBLO or the alternate PEBLO. It is never possible for a physician or patient to "just drop in" and complete an administrative requirement because neither has any other reason to be near the area where the office is located. This situation has resulted in either the PEBLO or the alternate PEBLO having to be continually out of the office in order to reach their customers. Although the telephone is used extensively in assisting with MEBD processing, it is not usually possible to contact the patient of the physician until several attempts have been made. Many times, messages from the PEBLO are ignored by physicians since they are often uninformed as to the importance of maintaining contact with her, and are not penalized for their failures to complete administrative requirements. Due to the number of other customers constantly visiting Patient Affairs for information on such matters as insurance, third-party liability, autopsy reports, and death certificates, it is often difficult for the PEBLO and her alternate - each of whom are required to be patient affairs generalists - to leave their desks to personally visit patients and physicians. The system becomes bogged down

due to the communication difficulties and timely processing therefore becomes degraded.

Another reason why the situation is not satisfactory is the lack of sanctions utilized against individuals who do not provide adequate support for, or display inappropriate attitudes towards, MEBD processing. The physician staff, as mentioned earlier, showed little interest in the processing of MEBDs. The LAMC military personnel office, although staffed by people interested in making the MEBD processing system more efficient, was often handicapped in its efforts to retrieve necessary personnel documentation and records. This was due primarily to the lack of authority which the LAMC personnel office had in seeing that timely retrieval of necessary records and other information was accomplished.

The Directorate of Personnel does a fine job in requesting that the necessary information be forwarded for disability processing purposes. Its complete lack of authority to insure that this information is dispatched to the medical center in a timely manner is, however, defeating to those who work so hard in making the necessary requests to organizations which are often slow to respond. It is, therefore, often difficult for the LAMC Personnel Assistance Center (PAC) to obtain

military records for those undergoing MEBD processing. Although the PAC has the responsibility and authority to request records and maintain them for MEBD processing, it does not have a way to guarantee that the requests will be honored.

The PAC's requests for records always include a statement indicating that a timely response is necessary, however it is ultimately the requested unit's PAC which will decide exactly when the records will be dispatched. It is also the responsibility of the PAC to request the sending of the personnel microfiche from Ft. Benjamin Harrison. There is an internal suspense system at the LAMC PAC for the retrieval of personnel records for those undergoing an MEBD, and follow up communications are made to units who seem slow in responding. The experiences at LAMC indicate that the obtaining of personnel records can cause MEBD processing to be delayed, but usually all personnel records are available well before the clinical staffs have completed their processing activities. The PAC is usually able to sufficiently reconstruct a personnel file in a matter of hours if all other attempts in obtaining the original records in a timely manner fail.

Concerning the procurement of Line of Duty information, the suggestion that a determination may

prevent timely MEBD processing is generally incorrect. When a Line of Duty Determination is deemed appropriate, and it is not available, the PEBLO simply sends a message requesting that an investigation be accomplished. A copy of the message requesting the Line of Duty determination - called a LOD TWIXT - is all the Line of Duty documentation required for the MEBD to be forwarded to the PEB. Although the processing of the PEB, something which the PEBLO becomes intimately involved with, is not completed and the work of the PEBLO is not finished until any necessary Line of Duty determination is made, MEBD processing is not delayed by the absence of the final Line of Duty determination.

Another reason why MEBD processing is not accomplished expeditiously at LAMC is the lack of adequate, modern management information assets made available to prospectively manage the appropriate cases. The only data processing equipment to which the PEBLO and her staff have convenient access are two obsolete word processing terminals. These non-interactive word processors allow only one person to access the MEBD data base at any one time. It is therefore impossible for the PEBLO and the alternate PEBLO, or anyone else, to use the system to document any administrative functions involved with, or to discover any information about more than one MEBD case at one

time. There is also no Automated Quality of Care Evaluation Support System (AQCESS) terminal located in the building where Patient Affairs is, and no information from the AQCESS data base can be entered into the MEBD data base in the word processing system without major investments in manpower and time. Even if the decision to make the necessary investments were made, the information would have to be continually transferred from one data base to the other in order to keep the information current. Although the AQCESS contains a standardized report which supposedly helps manage the processing of MEBDs, it was not utilized at LAMC until its print format was changed by the administrative resident. The standardized format, developed for use at all military hospitals, was found to be confusing, misleading, and unable to provide information which could be readily used to prospectively manage the processing of MEBD cases. This report, as with all AQCESS information, could not be used at all to manage outpatients, since the system manager had determined that AQCESS would only be used to process inpatient data. The only information used in MEBD processing generated by AQCESS was the long-term patient roster. This roster was discussed by the DCCS, the Director of Patient Administration, the PEBLO and a representative from Social Work Service approximately

every two weeks ostensibly as a procedure to better manage the disposition of patients and promote effective clinical utilization. Unfortunately, the long-term patient roster used was one that contained all long term patients without effective identification of which were active duty patients, which were retired, and which were dependents. Thus, the roster was quite long, and only a very few of the MEBD cases could be discussed during the allotted times of the meetings. Prospective management of MEBD patients was impossible through the use of this meeting due to the fact that the tool used - the long term patient roster - did not decode patient categories, did not contain accurate information as to patient location or status, and did not take into account any of the outpatients being processed since all information was based on hospital admission information. Therefore, the only regular, specifically designated discussions concerning the processing of MEBDs between representatives of the clinical and administrative managerial staffs during the great majority of the administrative residency were little more than cursory examinations of listings of long-term patients. Only limited amounts of information were exchanged regarding the dismal state of affairs in processing MEBD cases at LAMC.

In discussions with the PEBLO, the Information Management Officer, the Directors of Patient Administration, Logistics, Resource Management, and the DCA, it was realized that there were no plans to acquire an "intelligent" data processing system at LAMC in the near future to help with the processing of MEBDs. Resource constraints were so great at LAMC that the procurement of many clinical items were being delayed, therefore it was uncertain when funds would be made available to purchase hardware to help process MEBDs. Readily available software programs such as MEDBOARD - available from PAS&BA - or any similar one created by the LAMC computer programmer would essentially be useless because the equipment to use the software would not be available in the foreseeable future.

Adding to the problems associated with MEBD processing was the lack of a suspense cover sheet used on the case files, although the word processing system used to record the significant dates involved with each case did, in fact, create a suspense tool for MEBD processing activities. Records were kept whereby the number of processing days could be readily calculated for each inpatient and outpatient being processed for an MEBD, but nothing that any physician or personnel technician would normally use indicated to him how much

time had elapsed since processing was initiated and how much yet had to be done before processing would fail to meet the HSC standard. Even more difficulties were added to the already dismal MEBD processing situation by having a civilian contractor provide the majority of MEBD transcription service to LAMC.

Prior to 1982, LAMC physician dictation was accomplished, in all but a very few instances, by the "in-house" transcription service. There was one contract established to accomplish transcription services for the hospital on an "as needed" basis, but the vast majority of the transcription was handled by the pool of 17 transcribers. In 1983, the government decided to contract the majority of LAMC medical transcription. The one contractor who was already providing some transcription service to the hospital, along with three additional contractors, were employed and the LAMC transcription pool was disbanded - except for three individuals who would be used as "stat" transcribers in emergency situations and also serve as the hospital liaisons with the transcription contractors. For two years, the four contractors provided almost all transcription services to the hospital, and did so in a satisfactory manner, but in 1985, LAMC was ordered to encourage a small business to

take over sole responsibility for providing contracted transcription services to the hospital. Unfortunately, the small business which was awarded the contract had neither the managerial acumen or the qualified personnel to comply with the terms of the agreement, and after less than a year defaulted on the contract. From the time the contract was defaulted, until the time a new contractor was found to provide transcription services, a serious backlog occurred in medical transcription resulting in ward, clinic, service, and departmental clerical personnel having to be utilized in order to meet minimum requirements of record-keeping. When the new contract was let - which is still in effect today - a decision was made within several of the clinical departments and services to continue to keep doing some of their own transcription independently of the contracted transcription service in order to prevent a situation from re-occurring which had happened when the other contractor defaulted. This has resulted in the transcription liaisons within the Directorate of Patient Administration effectively losing control of transcription being accomplished by and for LAMC. The supervisory liaison and her two-person staff have little idea of which transcriptions are being sent to the contractor and which are being done within the clinical

areas. The present contractor is often not able to meet contract standards since he faces the same problem which caused LAMC to eliminate the transcription pool in the first place - high employee turn-over and higher paying transcription jobs elsewhere in the community. The current contractor is also experiencing some of the difficulties experienced by the contractor who defaulted, particularly in the area of having to serve too large of an organization with too few assets. When LAMC employed four transcription contractors, it was possible to spread out the work and experience a shorter turn-around time, but this is not possible now since there is only only one contractor providing the service. The situation with medical transcription has caused some difficulties in the processing of MEBDs at LAMC. As with the transcription supervisor, the PEBLO and the alternate PEBLO have no idea where to expect a MEBD transcription to come from. The same service may transcribe a portion of its MEBDs "in house" and send the remainder to be transcribed by the contractor, therefore the attending physician is often unsure of where a certain patient's transcription is being done. This has resulted in the PEBLO not immediately knowing where to look in order to find a late transcription. Only after she has called the ward, clinic, service, or

department is she able to ascertain if the transcription for a particular MEBD was done inside or outside of the hospital. If it were sent for outside transcription, she then has to go to the transcription supervisor in order to obtain a status update. The transcription situation at LAMC is one that causes delays in the processing of MEBDs, and confusion to those individuals responsible for their clinical and administrative management.

With an understanding of the attitudes of the clinical managers towards MEBDs developed, and with an identification of the personnel, data processing, and patient administrative problems made, it became possible to examine each on going MEBD with a better understanding of how these areas were affecting the overall process. If, in spite of all the problems and concerns discovered, the current case management had reversed the MEBD processing trends, then little would have to be done in order to develop an effective procedure to expedite the processing system. Under a mandate from the new Commander, and with the support of the DCA, a study was conducted examining the processing of the MEBDs currently being processed at LAMC. It was decided to pick a calendar date at random, and examine the processing of the current LAMC MEBDs as of this

date. In order to ascertain how current cases were being processed, ostensibly to meet the HSC standard, it had to be determined how those outpatients and inpatients already identified for MEBD processing were being expedited, and how those patients who had medical conditions which would necessitate their being considered for MEBD processing were being identified. Since Army military patients being processed for MEBDs come under the closest scrutiny by HSC and the USAPDA, it was decided to focus the efforts on these patients. There was also no question as to the authority of the MEBD processing system to help determine the ultimate disposition of these patients. The date of March 5, 1987 was the date picked to look at those Army patients who were either identified for MEBD processing, or who had a likelihood of being processed in view of their having been listed in the long term patient roster as of this date.

Since AQCESS could not be used in the processing of information concerning outpatients, all information regarding MEBD processing of these cases was obtained through use of the word processing data base located at Patient Affairs and through examination of available health records.

Seven outpatients were identified as being processed by ongoing MEBDs as of March 5, 1987. These seven MEBDs showed an average of over 101 days since the date recorded at Patient Affairs indicating the MEBD initiation date. The range of processing ran from 13 to 396 days, with each of the two patients who had been in the processing system less than 30 days having consultative appointments scheduled for time periods beyond their thirtieth day of MEBD processing. This appeared to indicate that priority appointments were not being given to the outpatients undergoing MEBD processing. A further examination of two of the outpatient MEBD cases was most enlightening. The individual who had been undergoing MEBD processing for 396 days had not received his first consultative appointment until 231 days had elapsed from the time he had been identified for MEBD processing. It was not known by the patient's physician or the PEBLO until 136 days after this first consultative appointment was scheduled that the clinic had lost the patient's health records. Therefore, it was not until the 367th day after identification that records of the first consultative appointment were available.

Another outpatient who was undergoing MEBD processing was an active duty general officer. This

individual, who occupied a very significant military position at the Presidio of San Francisco, simply did not want to have his MEBD completed, therefore he used his considerable influence to delay the MEBD processing of his case.

Regarding inpatients, 66 soldiers were on the long term patient roster as having been in the hospital for a period of over 30 days on March 5, 1987. Of these Army inpatients, information from the Directorate of Patient Administration showed that MEBD processing had been initiated on 49 of them with the remaining 17 expected to return to duty within a reasonable period of time. Those expected to return to duty were therefore not - as of March 5, 1987 - considered appropriate candidates for MEBD processing. By the time the examination of those inpatients undergoing MEBD processing was completed - March 24, 1987 - only 14 them had completed the processing. The other 35 who were still undergoing processing were in one of five different categories. These were:

a. Bed Occupied.

b. Convalescent Leave.

c. Ordinary Leave.

d. Temporary Duty.

e. Subsisting Elsewhere.

Even though these 35 patients were still undergoing MEBD processing, over half of them - 18 - were still allowed to live outside the confines of the medical center. On the next page is Table One. It lists by clinical service the number of patients in each category - as of March 5, 1987 - followed by the number of days from the last physician order.

DOCUMENTED PHYSICIAN ORDERS
FOR
MEDICAL EVALUATION BOARD
INPATIENTS

	STATUS				
	BED OCC	CON LV	ORD LV	TEMP DUTY	SUBS ELSE
ADMITTING SERVICE					
GENERAL SURGERY	1/39				1#/28
NEUROLOGY					1@
OTOLARGYNOLOGY	1/18				
CARDIOLOGY	1/34			1*	
ONCOLOGY	2/34.5				
CARDIOTHORACIC SURGERY					1*
ORTHOPEDIC SURGERY	4/60.5	1/14	1/9	1/187	3/86;1*
PSYCHIATRY	4/3	1/14			
NEUROSURGERY	1/42	1/4			1/14
UROLOGY	1/6			1*	1/20
INFECTIOUS DISEASE	2/6	2/5.5			

FIRST NUMBER - THE NUMBER OF PATIENTS PER SERVICE & STATUS
SECOND NUMBER - THE NUMBER OF DAYS SINCE DOCUMENTED ORDER
* INDICATES THE NUMBER OF LOST CHARTS - IF ANY
@ REPEAT BOARD
# CASE NOW BEING FOLLOWED BY DEPARTMENT OF MEDICINE

TABLE ONE

For those three cases where the inpatient records could not be located, the information utilized was found in the Patient Affairs word processing data base. Although it would seem unreasonable that the four orthopedic patients listed in the Bed Occupied status are, on the average, only having orders written for them once every 60 days, an examination of the four applicable charts indicates that this was indeed the case. Perhaps this can be explained by the fact that physician ordering practices on the minimal care ward - the place where these four orthopedic patients were located - are different than those in other inpatient areas of the hospital. Unfortunately, HSC MEBD processing-time guidelines do no give special consideration to minimal care wards. It is also understood that sometimes physicians see patients and do not document the care in the patient record. This may occasionally happen in individual instances, but is certainly not encouraged to happen. Since it appeared that those patients identified for MEBD processing were not receiving frequent, documented physician care or consultation, a determination on exactly how fast these patients were being processed was deemed appropriate. Table Two indicates the

number of each patient in a particular status followed by the average number of days having passed since the decision was made to have the patient processed.

NUMBER OF PROCESSING DAYS
FOR
MEDICAL EVALUATION BOARD
INPATIENTS

ADMITTING SERVICE	STATUS				
	BED OCC	CON LV	ORD LV	TEMP DUTY	SUBS ELSE
GENERAL SURGERY	1/14				1#/172
NEUROLOGY					1@/95
OTOLARGYNOLOGY	1/44				
CARDIOLOGY	1/199			1*/12	
ONCOLOGY	2/32.5				
CARDIOTHORACIC SURGERY					1*/202
ORTHOPEDIC SURGERY	4/84	1/221	1/75	1/164	4/310
PSYCHIATRY	4/54	1/84			
NEUROSURGERY	1/40	1/4			1/95
UROLOGY	1/325			1*/95	1/36
INFECTIOUS DISEASE	2/44	2/23			

FIRST NUMBER - THE NUMBER OF PATIENTS PER SERVICE & STATUS
SECOND NUMBER - THE NUMBER OF DAYS SINCE PROCESSING BEGAN
* INDICATES THE NUMBER OF CHARTS WHICH ARE LOST - IF ANY
@ REPEAT BOARD
# CASE NOW BEING FOLLOWED BY INTERNAL MEDICINE

TABLE TWO

With HSC guidance expressing a goal of 30 calendar days as the maximum for MEBD processing, and with the USAPDA policy being that physical evaluations must be current, it seemed as if LAMC's efforts to adequately support the disability system in these matters were abysmal.

The identification of both outpatients and inpatients who could potentially require MEBD processing was found to be an area where LAMC was exceptionally weak. When the PEBLO was asked if there were any more than the 7 outpatients and 35 inpatients already identified for MEBD processing who had a likelihood of being processed, she indicated that she was sure that there were, but she had no way of proving her belief. She said that officially there were only 42 patients who were being processed by MEBDs with no other patients listed as potential cases. When asked if any of the 42 being processed were ever listed as a potential candidate for MEBD processing, she indicated that at LAMC, a listing of potential candidates for MEBD processing was not maintained. She further stated that the only times she is able to find out before hand if an MEBD is going to be accomplished is when one of her counterparts at another MTF calls to alert her of a patient being transferred to LAMC for disability processing purposes. In essence, there isn't any

prior identification of either LAMC inpatients or outpatients for potential MEBD processing unless the patient has originated from another MTF. Although there is a report in the AQCESS which has the capability of identifying potential inpatient candidates, the PEBLO said that this report is not used at LAMC. For outpatients, no such report exists, and some physicians are very reluctant to discuss certain outpatient cases with non-physicians due to the sensitivity of the illnesses involved. For example, the Chief, Infectious Disease Service at LAMC refuses to discuss his AIDS outpatient cases with non-physicians. Throughout most of the residency, Army policy did not require all AIDS patients to be identified for MEBD processing, but the prognosis of the disease would indicate that at least some of these patients - of which there are a substantial number - would have developed a manifestation suggesting the possibility of MEBD processing. Since even the presentation of these conditions were not discussed with, or identified to the PEBLO due to the sensitivity of the AIDS issue in the San Francisco community, the PEBLO was therefore forbidden by the physician of doing her job more efficiently and prospectively managing the MEBD processing of these outpatient cases. The PEBLO does

not have the authority or the power to tell the Army physician that he must report any of his cases to her, and the physician was allowed to manage his patients as he saw fit - including his decision to keep AIDS outpatient information from reaching administrative channels. Although no similarly blatant examples of keeping the PEBLO uninformed about potential MEBD candidates existed in any other outpatient areas, perhaps it would be more reasonable to find more than seven Army outpatients having medical conditions necessitating their being processed by an MEBD at this major Army MTF.

When asked how she and her staff are notified that a patient will be processed by an MEBD, she said that this could happen one of several ways. Most frequently, the patient would be told by his physician that he would be undergoing an MEBD and that contact should be made with the PEBLO to receive counseling. The patient would therefore seek out the PEBLO, and in doing so alert her and her staff that he was being processed by an MEBD. The next most frequent way of notification would be for someone from the ward, clinic, department or service to call the PEBLO and inform her that one of the physicians had made the decision have one of his patients processed by an MEBD. The least frequent way was for the

physician to personally contact the PEBLO - either by telephone call or by written note - that one of his patients would be undergoing MEBD processing. She stated that this personal notification by the physician was usually done by the most inexperienced of LAMC physicians who were going to be needing the PEBLO's help in processing their initial MEBD case.

The inability of the PEBLO to prospectively manage the processing of MEBD cases was felt to be an issue worth exploring. Why wasn't the PEBLO telling the physicians that early identification of both the verified cases for processing or the potential candidates for MEBD processing was essential? Why weren't many of the physicians letting the PEBLO know sooner who they thought might be requiring an MEBD? According to the PEBLO, she did let the physicians and the clinical supervisory staff know of her concerns. She reported that many times the DCCS was notified that the physicians should notify her when they felt that one of their patients may require an MEBD. She also reported that occasionally she would be able to formally brief small groups of physicians explaining to them the necessity of early identification in the MEBD process as well as other matters of interest regarding the disability processing system. She expressed

disappointment that so many of the inpatients on the list of those identified for MEBD processing at LAMC had indicated to her that they were certain that their processing could have been completed much earlier had adequate identification and PEBLO notification been practiced by their attending physicians.

After examining the information and talking to the PEBLO, it became necessary to talk to those physicians who were doing the majority of the clinical portion of the MEBD processing work at LAMC - the junior staff and the residents - in order to ascertain their understanding of the system before any complete problem identification be made concerning the processing of MEBDs at LAMC. It was learned during the time spent at the Ft. Sam Houston PEB that perhaps the modern Army physician of today is not being held to as high a standard concerning his responsibilities in processing MEBDs as had been the case of Army physicians in the past. It was also learned that perhaps the teaching chiefs in the medical centers were neglecting some of their responsibilities by not adequately instructing their residents and junior staff in the proper physician processing responsibilities concerning MEBDs. In order to get an idea of how much correct information regarding MEBDs and their processing was known by the LAMC

physicians, a total of 17 junior Medical Corps officers were interviewed on a very informal basis. What was discovered by the conversations with these highly intelligent individuals was disheartening. Only one of these physicians had remembered ever "hearing something about" how he should let "somebody" know that a patient would be processed by an MEBD. He did not remember who this "somebody" was, so he indicated that he personally lets the ward clerks or the service secretary know and they "always seem to take care of it." Two of the physicians interviewed did not know what an SF 88 is, much less the significance of the dates placed on the form. None of the physicians indicated that he had never done an MEBD, and several of them indicated that they had done "quite a few." Only one of them had indicated that she had heard that there was a concern as to their timely processing, but none knew of any processing time standard associated with the physical examination date. Questions were asked concerning the prioritizing of appointments for the patients being processed. Although all of the physicians interviewed indicated that, as inpatients, those soldiers being processed by MEBDs should be given priority consultations, none realized that the outpatient MEBD cases should also receive priority treatment. One of

the residents said that he didn't realize that outpatients could undergo MEBD processing as he had only done them on inpatients. He then volunteered that it was customary in one or two of the services to simply pass around an MEBD case file and sign it without more than a cursory glance. It was considered an administrative burden that would be accomplished only as time permitted - and certainly without any significant priority. When asked questions about any of the teaching that they had received from their clinical chiefs regarding MEBDs, only four of the physicians said that they had ever been to any briefings or formal instruction related to MEBD processing. One of these four said that he definitely remembered hearing the LAMC PEBLO talk about MEBDs but he could not remember anything significant from the briefing. The others were not sure where they had heard briefings on the subject. Only one of the interviewed physicians had ever received instruction from a physician supervisor on the processing of MEBDs. The others stated that when they had a question about processing MEBDs, they would usually ask one of their more experienced physician friends what needed to be done or give it "their best shot" and pass it on.

Since all of the physicians interviewed had been helping with the processing of MEBDs at LAMC, it became painfully obvious that the requirement for physicians who compose an MEBD to, as a minimum, be "familiar with the standards of medical fitness, disposition of patients, and disability processing,"[5] was not being met. If these physicians did not know enough to be familiar with the MEBD processing requirements, perhaps it was because their military medical education was deficient. In order to see if this were the case, several of the teaching chiefs were interviewed. Since many of the LAMC MEBDs are done in surgery and psychiatry, talking with the clinical chiefs from these areas was felt to be beneficial. The new Commander of the hospital had been the previous Chief of Surgery, so talking to him would be relevant concerning the Department of Surgery's philosophy toward MEBD processing. As a senior member of the hospital teaching staff with over 20 years of medical experience in the military, he has helped process hundreds of MEBDs and regarded them as necessary, but really did not appreciate the significance of their being processed in a timely manner until he took command of the medical center. Talks were also held with the Chief of General Surgery, also a senior military physician who had done

numerous MEBDs. He, like his previous department chief - now his Commander - confirmed that the priorities for processing MEBDs at LAMC were not high, because there were more critical skills which the younger, less experienced physicians had to learn during their residencies. He understood clearly the reasons for processing MEBDs expeditiously, and how their being done properly would benefit the patient, his family, and the Army. He was also quick to point out that when he was in the earlier part of his Army career, any MEBD processing guidance was of such low importance that it was practically non-existent. He did say, however, that as a matter of principle, all Army physicians should have the discipline to accomplish their MEBDs in a timely manner if this were really a significant Army priority. He was sure that for the majority of surgical cases, the attending physician and his colleagues could accomplish MEBD processing within the HSC standard, without an inordinate amount of sacrifice if the right attitude - coupled with the promise of appropriate sanctions - were displayed. Soon after talking with him, he directed that a session of General Surgery grand rounds be dedicated to MEBD processing. At this meeting, the Director of Patient Administration, the PEBLO, and the Medical Officer from the Presidio of

San Francisco PEB each talked to his staff. This session proved most beneficial, with many questions being asked by the physicians and much information being disseminated.

The talks with the Chief of Psychiatry revealed that he had previously been the Commander of a small MEDDAC where the processing of MEBDs was accomplished so well that his hospital was regularly recognized as being among the best of all facilities processing patients. He said that during his tenure as Commander, his hospital did not have very many MEBD cases per month, nor was his hospital's participation in medical education programs very involved. Therefore, he had the opportunity to turn MEBD processing into an "area of excellence" without sacrificing other priorities. He realized that the overall situation at LAMC was much different than it was as the hospital he commanded, but the same standard that he managed to attain so comfortably was the same one that LAMC was being held to presently. Now, instead of commanding a small hospital, he was responsible for the management of one of the major military psychiatric teaching programs. Since the inpatient psychiatric service was often closed to all but active duty patients, expeditious MEBD processing often seemed contrary to the educational necessity of extending

inpatient stays to allow psychiatric residents to provide continuity of care to their patients. Due to the change in his current military medical responsibilities, his priorities concerning MEBD processing changed too. He did believe that LAMC could do much better - in general - with processing if the physicians were educated as to the necessity of expeditious processing, and if there were sanctions in place which would help them remember this necessity.

With an examination of the processing of MEBDs at LAMC completed, it was felt useful to first examine MEBD processing at other Army MTFs and then to look at Navy and Air Force systems to provide a comparison.

Other Medical Treatment Facility Processing Systems

Soon after determining the nature of this research project, information was requested from other Army MTFs concerning the SOPs which were used to help them process their MEBDs. In all, requests were made from five HSC medical centers and eleven other MTFs. Hospitals were selected due to their being identified on the USAPDA listing of average processing times for MEBDs as having both high and low - bad and good - processing time

figures. Of the 16 requests, answers were received from 11 of the hospitals. On a whole, the documents received contained much specific information concerning the duties and responsibilities of physicians and administrators, and most seemed to indicate ways whereby each of the MTFs could reasonably be expected to meet the HSC MEBD processing time standard. Unfortunately, this was not the case. During the 28 month time period between January 1985 and April 1987, these MTFs showed that in only 62 instances, or 20 per cent of the time, were they individually able to achieve an average MEBD processing time of 30 days or less.[6] In fact, when one closely examines the data contained in the listings of average processing times, it becomes very clear that the processing of MEBDs within HSC standards is the exception rather than the rule.

Listed on Table Three, which is located on page 81, are compilations of information taken from the USAPDA "Average Processing Time, Medical Treatment Facilities" lists for the 28 months from January 1985 through April 1987. Although these figures indicate that not during even one of these months was LAMC able to keep its average MEBD processing time figure within ten days over the HSC standard, only during ten of these months were any of the other HSC medical centers - having processed

as many cases - able to meet the standard. In these ten months, at most two of the other medical centers attained the standard. The figures also indicate that during the 28 month time period, nc more than eight of the other MTFs which had processed as many cases as LAMC - cases certainly less complicated than those seen by the specialists at LAMC - were able to meet the HSC standard. Although LAMC was regularly among the very worst of the HSC medical centers so far as average processing times were concerned, never during the time span was the average of the seven other medical center's processing days able to attain the HSC standard.

LETTERMAN MEDICAL EVALUATION BOARD
PROCESSING TIME CHART

DATE	LAMC MEBD CASES PROCESSED	AVG # OF DAYS/CASE	A	B	C	D
JAN 85	10	59.8	8	6	2	38.3
FEB 85	16	40.3	2	4	1	48.2
MAR 85	14	77.7	8	6	0	46.4
APR 85	12	80.5	8	9	2	44.5
MAY 85	16	53.1	7	5	1	41.5
JUN 85	17	52.0	7	7	1	44.5
JUL 85	13	43.5	5	5	2	32.2
AUG 85	25	70.0	8	3	0	44.9
SEP 85	22	65.9	8	3	0	47.3
OCT 85	27	73.5	7	4	1	46.2
NOV 85	12	108.1	8	5	0	55.3
DEC 85	29	61.2	6	2	0	48.6
JAN 86	21	68.5	7	1	0	52.8
FEB 86	19	80.5	8	4	0	51.1
MAR 86	25	70.0	8	4	0	56.3
APR 86	20	68.9	6	5	0	59.1
MAY 86	22	77.6	7	4	0	59.6
JUN 86	23	59.8	6	2	0	61.6
JUL 86	28	56.8	5	1	0	52.6
AUG 86	19	102.3	8	0	0	61.6
SEP 86	20	64.6	7	3	0	52.5
OCT 86	19	44.1	6	3	0	47.7
NOV 86	10	65.7	7	5	1	55.2
DEC 86	20	48.0	3	4	1	63.2
JAN 87	10	48.3	3	4	0	62.8
FEB 87	20	48.0	5	1	0	52.5
MAR 87	21	51.8	7	0	0	47.1
APR 87	21	45.5	5	5	1	47.7

COLUMN A INDICATES THE LAMC RANKING AMONG THE 8 MEDCENS
COLUMN B INDICATES THE # OF HOSPITALS WITH A GREATER THAN OR EQUAL MEBD PROCESSING CASELOAD WHICH MEET THE HSC STANDARD
COLUMN C INDICATES THE # OF MEDCENS WITH A GREATER THAN OR EQUAL MEBD PROCESSING CASELOAD WHICH MEET THE HSC STANDARD
COLUMN D INDICATES THE OTHER 7 MEDCENS' AVERAGE NUMBER OF PROCESSING DAYS PER MEBD CASE

TABLE THREE

Where two extremely well-written SOPs[7,8] evidenced 32 instances where monthly processing times were able to meet the HSC standard, two other well-written and reasonable SOPs[9, 10] yielded only two months where the standard was achieved. In order to determine how seemingly similar SOPs were yielding such dramatically different results, the PEBLOs or alternate PEBLOs of each of the CONUS MTFs from which MEBD processing documents had been received were called. Also, in order to gain even more information, each of the PEBLOs or alternate PEBLOs in the Presidio of San Francisco PEB region and of all the CONUS medical centers were called to discuss the duties and responsibilities of those who manage the administrative processing of MEBDs at their facilities. During the discussions with these employees, I noticed that their responsibilities were similar but that the delegation of duties showed some marked differences. In some of the smaller MTFs, the PEBLO function was simply another job that someone had to do. At Walter Reed Army Medical Center, the specialization of functions had been taken to such an extreme that three highly graded civilians - each of whom was paid at a GS rating equal to or higher than all but one of their counterparts throughout the country - seemingly had no responsibilities other than

to manage the processing of the disability cases. At William Beaumont Army Medical Center, the PEBLO was also the Assistant Chief of Patient Administration. Due to his other responsibilities within the hospital, almost all of his PEBLO duties were handled by the alternate PEBLO. At Madigan Army Medical Center, the PEBLO had no alternate and was assisted only by one active-duty Temporary Duty Retirement List (TDRL) clerk. Not only did this PEBLO have to do all of the counseling of patients and all the coordination of MEBD processing activities, she had no one to back her up during an absence. She felt that an MEBD cover sheet [11] being utilized at her MTF helped immensely in the processing activities. Late in the administrative residency, when she was visiting the Presidio of San Francisco PEB, the opportunity was taken to interview her in person. She indicated that she had very good relationships with the departmental Medical Service Corps administrative officers and said that their help was essential in her keeping up with the MEBD processing case load. She also reaffirmed the importance of the MEBD cover sheet saying that without it, the MEBD processing times at her MTF would be increased considerably. Not having an alternate PEBLO made it mandatory that tools such as the cover sheet be used to help process her MEBDs.[12]

Navy Medical Board Processing System

During the week of January 11, 1987, the opportunity to visit the personnel who process Medical Boards at the Oakland Naval Regional Medical Center (ONRMC) was taken. It was felt that a visit with these people would enable a comparison to be made between the Army MEBD the Navy Medical Board processing systems. In the past, the hospital had a demonstrated administrative problem with the processing of their Medical Boards as they were constantly taking more that what the Navy considered a reasonable amount of time to process personnel through their system. Pressure from "the fleet" caused the new Commanding Officer to take what were considered strict measures in order to lessen the Medical Board processing times. Although the Medical Board processing system at ONRMC cannot be said to exactly duplicate the way Medical Boards are processed at other Navy MTFs - much the same as it can not be said that the processing of an MEBD at one Army hospital mirrors the processing system at all other Army MTFs - in can be stated that the instructions under which the ONRMC operates are the same as those under which other Navy MTFs process their Medical Boards.

When discussing Medical Board processing at any Navy MTF, it is important to be reminded of the fact that unlike the Army and the Air Force, the Navy does not use a physical profile system to determine medical or physical qualification for full or limited duty. If a seagoing Marine or sailor has a medical condition where he is temporarily not able to return to sea duty, but is able to work productively, he is placed on a limited duty status at a shore station for a period of time ranging form six months to two years. Since there are no profiles, most Medical Boards in the Navy are used to determine if a service member should be placed on full or limited duty. Every Navy hospital and medical center Commanding Officer has the independent authority to grant a sailor or Marine up to one year of limited duty. The second year is obtained, if necessary, by forwarding the medical record and physician recommendation to the Office of Naval Disability. If a service member occupies a shore billet and has a medical condition where he may be productively utilized although temporarily unable to perform his normal duties after medical treatment, he too may be put on limited duty status. It is assumed that those in a limited duty status will be given responsible positions, but it is a fact that many of these personnel are doing

little more than "showing up for work" and being utilized for various details requiring little effort, little supervision, little administration, and little management. In fact, senior enlisted personnel or junior officers placed on limited duty status often supervise those junior personnel similarly categorized. The system is well established in the Navy, and the practice of keeping those individuals "on board" in a limited duty status until they are completely recovered is an accepted practice. Those individuals who have a medical conditions suggesting that they may never return to full duty are processed by a Medical Board for disability. Since all of the services disability systems are based on statutory laws, Navy Medical Boards serve essentially the functions as do Army MEBDs. The Navy system of processing their Medical Boards is similar to the Army's processing of MEBDs, although once a Medical Board is completed, it is sent either to a centralized Navy PEB or to the Naval personnel office in Washington D.C. Navy instructions state that ten working days is considered the maximum period of time to process a Medical Board. The processing time commences at the time the Medical Board report is dictated and ends when it is signed by the convening authority.[13] The Navy, therefore, does not have the problem where

processing days are counted from the time it was decided to do the Medical Board. The Navy's processing time standard, therefore, serves as more of an evaluation of the patient administrative functions getting the Medical Board case files through the hospital than as an inspiration to have the physician complete his administrative and clinical responsibilities once it has been decided that the service member will be processed. During the visit, it was told that upon assumption of command, the current Commanding Officer at ONRMC found herself confronted with a situation where the Medical Board processing was being delayed by personnel, namely physicians, not knowing how to properly format the medical board dictation. This caused multiple dictations and corrections to be done, and therefore increased the processing times to exceed Navy standards. The Commanding Officer corrected this problem by directing that a guide for preparing Medical Boards be created and distributed to all physicians assigned to the hospital. In order to guarantee that this guide would be used by physicians, and not merely filed, she ordered her Executive Officer to implement a serious of sanctions which would be levied upon those physicians demonstrating willful non-compliance with the preparation guide procedures. She also directed that

patients being processed for Medical Boards would not be allowed to leave the area of the hospital until the Medical Board had been signed. This eliminated the problem of patients not being available for consultative appointments due to their not being in the area when needed. Finally, she made a local policy whereby any Medical Board taking more than 20 days to complete, or dictated more than twice would be cancelled. Cancellation of a Medical Board at ONRMC, other than causing the entire consultative and administrative process to start over, is a very dramatic event for the attending physician and his supervisor. Unless there are extremely unusual circumstances which necessitated the board taking over 20 days, a cancelled Medical Board results in derogatory comments made on the efficiency reports of both the attending physician and his clinical chief.

The actual processing of a Navy Medical Board at ONRMC is much more efficient than the processing of an MEBD at LAMC, although a number of similarities do exist. As is the case at LAMC, the Medical Board passes from the attending physician, usually a resident or a junior staff physician, to the senior member of the board - typically the clinical chief of the service where the junior member works. Through informal

discussions, the junior member coordinates the content of his narrative summary and Medical Board report with the senior member thereby making concurrence of recommendations automatic. Unless the case involves a psychiatric conditions, a third physician concurrence is not required for forwarding to the convening authority for approval.

The administrative requirements for personnel information and Line of Duty determinations differ markedly between the Navy and Army in the processing of Medical Boards. Navy requirements are much less involved in that the MTF is only responsible for requesting, through message communication, that the centralized Navy personnel records facility provide a "statement of service" to the PEB. This eliminates the Medical Board processing personnel at the MTF from having to wait for personnel or Line of Duty information as it is passed directly to the central PEB as part of the "statement of service."

Concerning those who are manage the administrative processing of Medical Boards at ONRMC, another interesting observation was made. As with most Navy hospitals, the person at ONRMC who counsels the service member as to their disability benefits is a senior enlisted service member. This person, called the

Disability Evaluation System Counselor (DESC), only concerns himself with actions after the PEB has made its initial, "informal" decision. The DESC almost never gets personally involved with a Medical Board other than as a source of information for the administrative staff helping to process the case. At ONRMC, those who do process the cases are three lower graded, GS 5 to GS 6, employees and an E-6 military personnel clerk. The ONRMC Medical Board processing staff, and the DESC all indicated that they personally felt that the LAMC PEBLO was "stretched too thin" in being responsible for not only keeping track of the MEBD processing, but also the counseling of individuals - to say nothing of her other responsibilities as Chief of Patient Affairs. The DESC, in particular, was not impressed with the Army's having a civilian employee - one who has never been in the military - serve as the PEBLO. He felt that it is much better for a service member to talk to "one of his own" when discussing service connected disability options. Although he stated that he had a very good professional relationship with the PEBLO at LAMC, he did feel that the Army's practice of utilizing civilians with no prior military experience as PEBLOs was improper.

Another item of interest was a standardized cover sheet used as a suspense form for every Medical Board

being processed at ONRMC. This sheet gave a very clear indication of how long the case had been in the processing system, and alerted all personnel who worked with the case how close to the 20 day limit the case was coming. A log book of each case was also kept by the Medical Boards supervisor in order to eliminate the loss of case files. She had her own suspense of five working days for the coordinated rough copy of the initial dictation to be returned to her section. If the case file was not back at her office in that time frame, she indicated that she would try to trace the record, but still had five days for the record to get to her before having to re-create the entire case file. She indicated that it was rarely necessary to contact a physician about a misplaced case file since all were more than aware of the Commanding Officer's penalties. Other than the suspense cover sheet and the log book, no other management aids were utilized in the processing of Medical Boards. Also, no word processing or computerization existed whatsoever in the section. Transcription of the physician dictation was done on a priority basis within ONRMC, and the communications between the transcription pool, the clinic and service clerical personnel, and the Medical Boards supervisor were excellent. The system had been running so

efficiently that since the initiation of the new Commanding Officer's directives concerning Medical Boards, sanctions had not been applied to any administrative personnel. The Medical Board supervisor personally felt that the driving force behind ONRMC ability now to process Medical Boards efficiently - where they were unable to do this before - was the new Commanding Officer's willingness to penalize those who did not follow her wishes. She felt it would be possible to improve the system of MEBD processing at LAMC if a similar system of sanctions were initiated.

Air Force Medical Evaluation Board Processing System

During the week of January 19, 1987, the Medical Boards Section of the David Grant Air Force Medical Center (DGAFMC) was visited. In the Air Force MTF classification system, DGAFMC has been designated as the PEB referral hospital for the Western United States and Pacific Ocean regions. As with the Navy, the Air Force only has one centralized PEB, and all case files being forwarded to the PEB must be so done through a PEB referral hospital.

The discussions with the supervisor of the Medical Boards Section revealed a different system of processing MEBDs being employed in the Air Force than those used by the Army or the Navy.[14] Even though the Air Force disability system, like those of the Army and the Navy, establishes a system of medical evaluation for disability processing which conforms to the requirements of public law, the Air Force MEBD processing system is different in one very unique way - it is not time restrictive. That is, there are no firm guidelines established by Air Force regulations indicating that the MEBD must be processed within a certain period of time. Whereas the issues of processing days and readiness days lost play an extremely important part in the processing of Army MEBDs and Navy Medical Boards, the concept of a higher headquarters holding those processing MEBDs to a similar standard is completely foreign in the Air Force. Perhaps the holding out of some pre-established MEBD processing time standard in the Air Force is a moot point, since Air Force processing methodologies appear to provide a system which ensures - in almost all cases - that the MEBDs are accomplished expeditiously. The Air Force utilizes an official form, AF Form 570, "Notification of Patient Medical Status," to

indicate an anticipated MEBD or PEB action. This same form is used to report their Seriously Ill and Very Seriously Ill patients as well as to report incidents of hospital injuries, prolonged hospitalizations, and communicable diseases. Although the form is primarily used for inpatients, it is also used for reporting information on outpatients. The use of this form serves to alert Air Force Patient Affairs, of which the Medical Boards Section is a part, that a MEBD is anticipated for certain patients. Those in the Medical Boards Section are then able to monitor the care given to the identified patients and coordinate their activities should a MEBD actually be required. The information on the form is reported throughout the clinical and administrative staffs, and becomes a part of the official outpatient or inpatient record. As reported before, the Air Force MEBD processing system is not time restrictive, but once a patient has been identified as an actual or potential MEBD case on the AF Form 570, his care is expedited. All consultative appointments are done on a priority basis since all care givers are made aware that the patient has been identified for potential or actual MEBD processing. No suspense sheets are used, because there really is no time limit to provide the necessary care. Although much of the regular physician

dictation is transcribed outside of DGAFMC, those cases identified as having the potential for MEBD processing are done within the hospital transcription pool - on a priority basis. There are no sanctions applied for not doing this, it just appeared that the staff had the understanding that these cases would be treated as special - receiving priority clinical and administrative consideration. Because of the way the staff views the MEBD cases, it rarely takes over three weeks for one to be processed and forwarded to the PEB. Patients having conditions which involve a teaching program at DGAFMC may remain in the hospital to receive maximum benefit of hospitalization, if it is honestly felt that the patient has a reasonable chance to return to work in the Air Force. In general, once the attending physician has made the decision to have a patient processed by a MEBD, he tries to move this case as quickly as possible towards final disposition.

Once patients have signed acknowledgment of their MEBD, they are routinely allowed to go on convalescent leave or subsist elsewhere while awaiting final PEB determination of their cases. There is no medical holding unit at DGAFMC, so those patients who must remain near the hospital, and cannot be housed elsewhere, are given rooms at the transient enlisted

quarters. The patients do routinely participate in work therapy programs throughout Travis AFB, and very few disciplinary problems are experienced. Most of these patients have decided that they either want to stay at Travis or they realize the need to stay close to a medical center. Those who want to go home often do so inexpensively since Travis AFB has a very active Military Airlift Command mission. For a processing system without an official time standard, MEBD processing at DGAFMC seems very reasonable. The patients do receive the necessary care, the physicians are able to have a constant source of cases, beds are not occupied unnecessarily, and disciplinary problems are minimized.

Late in the administrative residency, the opportunity to personally observe Air Force MEBDs being conducted was taken. Unlike those held by the Army and Navy, Air Force MEBDs are more formal with the physician participants meeting face to face with each other and representatives of the Medical Boards Section. As with the Navy, the PEBLO was a military member who really did not get involved in the any of the processing until the MEBD made its recommendation to the PEB. Also, in the Air Force physician participation in MEBDs is directed by official military orders. Only staff physicians are

allowed to participate as members of an MEBD, although no member of the board can be an attending physician on the case being discussed. It is possible, however, to have interns, residents, and attending physicians come before the board to provide clarification to what is contained in the MEBD report, but this is usually not required. This provides a system whereby each approved Air Force MEBD case is agreed to by five or more physicians - the attending physician who dictates the narrative summary and MEBD report, the three physician members of the board, and the approving authority.

Air Force MEBDs are only conducted after all consultations, examinations, and tests are complete and finalized, and a coordinated and corrected narrative summary has been dictated and typed. Patient input to the physician regarding his medical condition and possible disposition is discussed prior to the finalization of the narrative summary, and any patient disagreement with what the physician has written is never considered by the MEBD, only forwarded to the PEB as additional information.

All Air Force MEBDs, even those recommending the return of a patient to his normal duties, are forwarded to the central PEB for final action. The MEBD is forwarded with any necessary Line of Duty investigation

report, the medical history, the physical examination - which may be up to one year old - the MEBD report, and if possible, the outpatient health record. The MEBD report is acknowledged by the patient, and as discussed earlier, any comments by him or any disagreements that he wishes to be made known are forwarded as additional information. The patient never appears before the MEBD although may, if desired, appear before the PEB once it has made its initial decision. Personnel records are not forwarded to the PEB and if reasonable attempts to locate the health records prove fruitless, then the case files are forwarded without them. No MEBD case involving an injury will be forwarded to the PEB until a completed Line of Duty investigation report is received by the Medical Boards Section, but its absence does not, in itself, prevent the MEBD from making its recommendations. It is the responsibility of the central PEB to obtain any personnel records which it may need - not the responsibility of the MTF - although it is the responsibility of the MTF to obtain any necessary Line of Duty investigation reports.

Due to the way the Air Force MEBDs are formally conducted - with the physician members being on orders to meet with the administrative staff face to face at a designated place and time - the processing system can

move very smoothly. It is typical for five or six MEBDs to be completed within one hour. During the time the administrative resident was present at the MEBD, four cases were held in less than one hour.

It was surprising to find that the Air Force is not under the same pressures to speed their processing the way the Army and the Navy is. Surely, there are patients, especially those subsisting elsewhere or home on convalescent leave, whose continuance on full pay status are creating unfavorable manpower situations within the Air Force much the same as they would in the Army. Why the Air Force seems to be immune from these concerns was not ascertained. What was discovered was the attitudes of the administrative and clinical staffs concerning the way Army MEBDs are conducted. When informed of the Army MEBD processing situation at LAMC, they could not comprehend why the Army had not adapted a similar system of processing MEBDs to that of the Air Force. They quickly pointed out the pitfalls of having a segmented, informal system of passing records around without the administrators being present, and were not surprised that the LAMC situation was showing an extended processing day history. They suggested that LAMC formalize its MEBD processing system, at least as far as physician participation is concerned. The Air

Force physicians on the MEBDs observed indicated that without their being formally placed on orders to participate in MEBD processing, their other priorities would delay their "getting around" to doing the MEBD on their own. They reported that having the system formalized made it a more palatable, duty-related procedure. It also gave them the opportunity to discuss other's cases, and learn more about other medical specialties and conditions.

Endnotes

[1] McGerity, Joseph L., Presidio of San Francisco Physical Evaluation Board 1986, (Interview Conducted August 29, 1986).

[2] Demyanenko, Serge P. C., Presidio of San Francisco Physical Evaluation Board 1986, (Interview Conducted August 29, 1986).

[3] Headquarters, United States Army Health Services Command. Report of the General Inspection, FY 1985, Letterman Army Medical Center, California (July 1985): Finding 104 pp. 66-67.

[4] Headquarters, United States Armyy Health Services Command. Report of the General Inspection, FY 1987, Letterman Army Medical Center, California (May 1987): Finding 27 p. 1.

[5] Department of the Army, Army Regulation 40-3: p. 37.

[6] U. S. Army Physical Disability Agency "Average Processing Time (January 1985 - April 1987) Medical Treatment Facilities."

[7] Blanchfield Army Community Hospital.

[8] William Beaumont Army Medical Center, Regulation 635-40.

[9] Dwight David Eisenhower Army Medical Center.

[10] Madigan Army Medical Center, Regulation 40-1.

[11] Ibid., p. A-5.

[12] Jones, Carolyn, Madigan Army Medical Center Directorate of Patient Administration 1987, (Interview Conducted May 27, 1987).

[13] Huff, Mabrie, Oakland Naval Regional Medical Center Patient Administration Department 1987, (Interview Conducted January 14, 1987)

[14] Cobb, Margaret, David Grant Air Force Medical Center 1987, (Interview Conducted January 22, 1987).

IV. CONCLUSIONS & RECOMMENDATION

Conclusions

Medical Evaluation Board processing at Letterman Army Medical Center can be improved! It can be improved in such a way as to enable it to meet both the HSC standard and the Army's goal of reducing the number of "readiness days lost." In the recent past, there seems to have been little real importance attached to the expeditious processing of MEBDs throughout Army MTFs in general, and at LAMC in particular. This has caused a situation to exist at LAMC where many of the senior physicians do not effectively understand, nor have they instilled among their staffs, the attitude and goals of the Army regarding MEBD processing today. This failure to comprehend the realities associated with protracted MEBD processing times has caused LAMC much embarrassment throughout HSC and the Army, and reflected negatively both on the clinical and administrative staffs.

Although the lack of modern data processing resources and the use of a medical transcription process

which can at best be called unfortunate both hinder the expeditious processing of MEBDs, the correcting of these deficiencies in the near future is very doubtful. Financial, procurement, and political constraints, of which some are not under the least bit of control by the medical center or the Army, almost guarantee that as far as these two areas are concerned, nothing will change in the near future. Regardless of this dismal reality, MEBD processing at LAMC can be improved, and improved immediately. If the Commander is willing do initiate some of the practices used at other MTFs throughout the Army, Navy, and Air Force, MEBD processing at LAMC - even with the present medical transcription and data processing systems in place - can be turned into something in which he can be proud, not embarrassed. It will only take the willingness to do what is necessary to make the staff realize how important MEBD processing now is, and to work within the constraints placed upon the medical center. Others have developed concepts and tools to help them process MEBDs and medical boards efficiently, and their methods are transferable to LAMC. Although implementation of the concepts and tools available may not be palatable to some of the clinical staff, it will provide a procedure where MEBD processing at LAMC is done expeditiously. In time, new procedures

will be accepted, bruised egos healed, and problems corrected. Eventually, LAMC will remain with a MEBD processing system which will enable it to provide appropriate, expeditious military medical disposition to its patients along with the excellent care already given.

Recommendation

In order for an effective procedure being established at LAMC which will reduce the processing times of MEBDs, changes will have to be made in the areas of staff education, staff responsibilities, staff discipline, and staff assistance. Without these areas being affected, the new Commander will be forced to live with a processing system which has brought serious discredit upon the hospital during the past several years. Since he will be starting his first tour of duty at LAMC, he is free from the prejudices against changing a system with which he is familiar. He will realize, by examining the documented history of LAMC MEBD processing times, that changes are needed now - before any rationale permitting the present system to continue enters into his thinking.

With increased command emphasis demonstrated by the mandating of this study, the first area where changes will have to be made is in the area of staff education. Of particular need of educating is the clinical staff. It has been shown that many of the physicians involved in the processing of MEBDs at LAMC do not understand them, do not realize what they are for, do not know how to properly accomplish them, do not know where to go for correct information, and do not realize the importance of their being accomplished expeditiously. Education of LAMC physicians is the key to solving these demonstrated problems as studies have shown that education can be a key to changing physician behavior,[1] especially when coupled with sanctions or incentives.[2] First of all, every physician assigned to LAMC should attend one of the on-going training sessions conducted by the Presidio of San Francisco PEB. These are geared to the audience involved, and are able to be scheduled at the convenience of the attendees. The staff of the PEB is willing to conduct this training whenever and wherever needed, and to conduct it as many times as necessary whereby every physician will receive the training. The training not only involves, from a physician and administrator's viewpoint, what is required in an acceptable MEBD, but also why the information is required. Misconceptions are clarified,

and common problems identified and discussed, as well as the rationale for the processing requirements explained. The sessions conducted by the PEB staff are both informative and entertaining, with attendance certain to be of benefit for all who participate. Other MTFs have done well in utilizing this training to improve their processing systems, and LAMC's not using such a convenient resource is unwise. Not only should the inexperienced physicians attend this training, but the senior ones as well. Many of the chiefs and department heads feel that they know all that is needed to know about MEBD processing, but the hospital processing record indicates that this is not the case. It is never convenient for many of the LAMC physicians to attend this type of training, and excuses why certain individuals should not be made to attend will certainly be forthcoming. The potential of the PEB-conducted training to improve the MEBD processing system at LAMC is so great that any reasons why certain physicians should not be required to attend the training should be completely discounted. As the complement of physicians receiving this training increases, staff education should continue through the mentoring process. The MEBD processing activities of the less experienced physicians should be monitored by those over them, and guidance

given towards the processing activities much the same as it is towards patient care. With time, the realization that MEBD processing is an important part of military medicine will be accomplished, and future generations of Army physicians trained at LAMC will be more effective physician soldiers.

As far as staff responsibilities are concerned, changes will have to be made in the understanding of many of the LAMC staff members concerning their input to the MEBD process. A formalized, documented, series of responsibilities, like those listed as the appendix to this project, needs to be established for the physician responsible for the patient, his clinical departmental and service chiefs, the Chief Nurse, the Troop Commander, the Chief, Clinical Support Division, the Director of Patient Administration, and the PEBLO. Each of these individuals has unique responsibilities which must be known to the others in order for each to accomplish his portion of the MEBD processing activities more effectively. Without the responsibilities formalized, and known to the other participants, processing difficulties can cause a series of easily solved problems to degenerate into a situation where pride is damaged, personalities become inflamed, cooperation destroyed, and communication terminated.

The area of staff discipline is one which many professionals, especially physicians, often do not wish to discuss, especially with with those outside of their profession. Unfortunately, it is often necessary to discipline professionals, including military physicians, in order to bring about desired results. As briefly mentioned before, studies have shown that sanctions and incentives[3] are sometimes useful in altering physician behavior. In the military, it is not acceptable to offer additional compensation for following military orders, but it is a well-established practice to levy sanctions and disciplinary actions on those who fail to obey orders. Although not recently exercised throughout the Army Medical Department, the use of formal sanctions against officers who fail to comply with instructions remains an effective tool. Within the past year at LAMC, a command policy suspending favorable personnel action has been initiated due to a large number of officers - mainly physicians - ignoring orders to participate in military training. Their ignoring the orders resulted in the officer corps being embarrassed among the enlisted compliment, and caused a morale problem among those officers who did attend the training. This command policy closely followed one suspending favorable personnel actions for individuals

who failed to meet the Army's height and weight requirements. Several senior officers have had their promotions delayed by their failure to maintain proper physical fitness, and these delays have resulted in loss of pay and prestige for these individuals. Since these command policies have been established, marked improvement in physician participation in military training has been shown. Over 90% of the applicable staff have participated fully in deployment training, something which would have been unheard of several years ago. The experience at ONRMC indicates that the use of a system of sanctions to help promote expeditious and effective Medical Board processing does work. Not only are these sanctions available for military physicians, but for administrators as well. With a system in place already providing that sanctions be applied to officers who fail to meet height and weight requirements, or who fail to participate in military training, it would be easy to use the same sanctions against those officers who are responsible for a MEBD being unnecessarily delayed. With the responsibilities towards MEBD processing formalized, documented, available and understood, those responsible for unnecessarily delaying the processing of a MEBD case could easily be identified. It is anticipated that the initial exercise

of these sanctions, and the resulting concern among the professional staff, will provide the necessary incentive for many MEBDs to be accomplished very efficiently.

The final part of the recommendation has to do with staff assistance. What is meant by this is not a series of visits by outsiders into the organization to discuss the problems of MEBD processing, but rather the use of procedures and tools which will help expedite MEBD processing. The first of these is the establishment and use of a MEBD processing cover sheet. This sheet, which, like the one used at Madigan Army Medical Center, should be of a color that is not used on any other medical record document within the medical center. It should be able to be recognized, on sight, at distances greater than it is possible to read what is printed on the form itself. It should stand out so those physicians and clerical staff members who see it will realize that it is covering a MEBD and must be handled expeditiously. It should state the date when the MEBD process was initiated, and by which date it must be completed. Regardless of what starting date will soon be used by the Army in determining MEBD processing times, that date decided upon must clearly be stated, as should an indication of where the file has to go in order to be completely processed. The cover sheet must

suspend activities and actions on a time schedule which agrees with the times listed under the personnel responsibilities in the appendix. This will create a congruent system of processing time responsibilities which will be both understood, and able to meet the MEBD processing time standard of HSC.

The next tool which should be use in the processing of MEBDs is already being tested at LAMC. Using data contained in the AQCESS, and changing a report format which had previously proven useless to both the clinical and professional staffs, a "Listing of Inpatients Identified for Letterman Medical Evaluation Board Processing" has been developed for use. It gives, by clinical service, a listing of all military inpatients who have been in the hospital for 30 days or more who have been identified to the PEBLO for MEBD processing. The patients are segregated not only by clinical service, but also by branch of service and whether they are commissioned officers or enlisted. The listing also reports their registration number, and counts the number of days from when the patient was identified for MEBD processing. It reports the patient's diagnosis, and continues to report processing days until the time that the patient is removed from the hospital register. It also allows the PEBLO to make remarks which can be

seen by the clinical chiefs. It can be separated in such a way that only the applicable portion of the report is forwarded to each service chief, or it can also be distributed as a whole to those who desire a listing of all inpatients being processed by MEBDs. Unfortunately, due to the AQCESS's inability to process any information on outpatients, it is unable to be used in the management of these MEBD cases. The report uses a minimum of abbreviations, and is easily understood by anyone with even a limited amount of MEBD processing experience. The use of this listing has enabled many of the senior physicians at LAMC to realize how out of hand they had let the MEBD processing situation become. Although the report does require updating by the PEBLO, its being related to the AQCESS enables the processing days to be updated automatically. Any changes in the patient ward location or diagnosis are also reported in the listing as the information is entered into the data base. This report serves as a major improvement over the "Long-term Patient Roster" used previously to discuss the processing of MEBD cases.

The final element of assistance which can be given to the staff involves LAMC's adapting one of the procedures utilized by the Air Force in processing its MEBDs. Although it is probably not necessary to issue

additional duty orders to Army MEBD members, nor is it necessary for only staff physicians to be officially designated as such, the procedure where those board members formally discuss the cases with each other and with those responsible for their administrative management in a conference setting is one that should be utilized at LAMC. Not only would this insure that boards be scheduled for completion at designated times, it would also give the incentive for those attending physicians responsible for their processing to have the work completed on time. If the physician knows that he will have to formally present his recommendations not only his colleagues, but also to those responsible for the administrative management of the MEBD, he may be willing to put forth an effort in which he and his chief can be proud. Of course, the risk of his embarrassing himself in front of his colleagues, his chief, and the PEBLO may also serve as an incentive for his processing the MEBD appropriately.

It is felt that the previously detailed recommendation will enable LAMC to initiate a procedure where its MEBDs are processed expeditiously. Within the operating constraints of the medical center, it offers an effective procedure which will reduce the processing times of MEBDs conducted there.

Endnotes

[1] Martin, Albert R.; Wolf, Marshall A.; Thibodeau, Lawrence A.; et al. "A Trial of Two Strategies to Modify the Test-Ordering Behavior of Medical Residents." New England Journal of Medicine. 303 (December 4, 1980): 1330-1336.

[2] Schroeder, Steven A.; Myers, Lois P.; McPhee, Stephen J.; et al. "The Failure of Physician Education as a Cost Containment Strategy." Journal of the American Medical Association. 252 (July 13,1984): 225-230.

[3] Ibid.

APPENDIX

Personnel Responsibilities

The responsible physician will:

1. Be aware of HSC and Letterman goals concerning processing of individuals by a Medical Evaluation Board.

2. Be responsible for the expeditious medical management of any active duty service member being processed for, or identified as being potentially a candidate for, a Medical Evaluation Board.

3. Be aware of the administrative limitations that are placed on patients who will be potentially, or definitely be processed by a Medical Evaluation Board.

4. Determine if the patient meets the physical standards in AR 40-501 and if he will be processed by a Medical Evaluation Board, after having completed the physical examination and consultative appointments.

5. In accordance with Chapter 6 of AR 40-3, ensure that the patient receives maximum benefit of hospitalization if it is determined that he will eventually, after appropriate convalescence and temporary duty limitations, be able to return to full, worldwide duty.

6. Ensure that prolonged definitive care, as indicated in Chapter 2 of AR 40-3, is not provided for military patients who are unlikely to return to duty.

7. Notify the ward clerk, the clinical service/departmental administrative personnel, the Personnel Directorate and the PEBLO immediately after deciding that the patient will be processed by a Medical Evaluation Board at Letterman.

8. Arrange for the immediate and appropriate disposition of the patient once he has either received the maximum benefit of hospitalization or the optimal hospital improvement for disposition purposes.

9. When presented with a patient who will potentially be processed by a Medical Evaluation Board - who is not a member of the Army - contact the PEBLO and receive counseling as to the administrative options in dealing with this patient.

10. Using Chapter 3 of AR 40-501 as a guide, direct that priority consultative appointments be scheduled to evaluate conditions presented which may necessitate MEBD action.

11. Initiate LAMC Form 782, "Patient Administrative Actions," for all active duty Army inpatients - except general officers - who will be processed by a Medical Evaluation Board.

12. Instruct patients to immediately contact PEBLO upon determination of the necessity to conduct a Medical Evaluation Board.

13. Ensure that distribution of Medical Evaluation Board documentation is handled expeditiously through other than the message center distribution system.

14. Notify department/service chiefs and/or representatives of the Troop Commander - as appropriate - for the reasons why consultative appointments were missed.

15. Set an estimated date, with the assistance of his department and/or service chief, by which the patient will have received the optimal hospital improvement for disposition purposes, after determining that the patient will not be medically fit, will not be worldwide deployable, or has a condition listed in Chapter 3, AR 40-501.

16. Ensure that the patient participates in work therapy to the maximum extent possible within his medical limitations.

17. Ensure that the PEBLO, the ward, departmental and clinical services administrative personnel are notified at least once per week of progress being made in the clinical processing of patients undergoing a Medical Evaluation Board.

18. Be aware of the sanctions which may be placed on him, as well as the patient, if the expeditious processing of a Medical Evaluation Board case does not meet LAMC standards.

19. Ensure that inpatients being processed by MEBDs remain in an inpatient accountability status except for short time periods - normally weekends - when passes may be granted.

20. Only under the emergency circumstances, and with the full knowledge of his service/department chief, recommend to the Troop Commander that any identified patient be granted an emergency leave during Medical Evaluation Board processing.

21. Accomplish the initial dictation of the Medical Evaluation Board documentation within three regular duty days of the completion of the physical examination and all consultative appointments.

22. Return any subsequent dictations, corrections, and or addenda - to include appropriate signatures - to transcription within four regular duty days of receipt.

23. Notify the Director of Patient Administration if transcribed dictation and/or corrected dictation is not received from transcription within three regular duty days of dispatch to transcription.

24. Ensure that Medical Evaluation Board Reports (DA Form 3947) and Reports of Physical Examination (SF Form 88) are forwarded to the PEBLO no later than 14 calendar days after their being signed - indicating completion of the MEBD or examination - by the physician.

25. Notify ward clerk when patient is transferred to the control of another department/service or ward within the hospital.

26. Afford the patient the opportunity to receive ordinary leave or reside outside of the San Francisco Bay area after the MEBD paperwork has been completed and the findings of the PEB have been signed by the patient. If the patient will be living within 55 miles of LAMC and can report within two hours of recall notification, permit the patient to live outside of the confines of the hospital before the findings of the PEB have been signed.

The clinical departmental and services chiefs will:

1. Develop a mechanism whereby the PEBLO, Chief, Clinical Support Division, Personnel Director, and Chief, Department of Nursing are notified of patients being processed by a Medical Evaluation Board immediately upon that determination by the responsible physician.

2. Establish an internal suspense system for Medical Evaluation Board processing.

3. Ensure that prolonged definitive care, as indicated in Chapter 2 of AR 40-3, is not provided for military inpatients who are unlikely to return to duty.

4. Ensure that procedures are established where physicians and administrative staff members notify the PEBLO of patient progress through the Medical Evaluation Board system.

5. Ensure that patients identified for Medical Evaluation Boards be given priority appointments, treatment and administrative support to guarantee expeditious processing.

6. Ensure that the Personnel Director, PEBLO, Chief, Clinical Support Division, and Chief, Department of Nursing are notified of the name of the responsible physician for each patient being processed by a Medical Evaluation Board.

7. Establish appropriate sanctions to ensure that clinical responsibilities, particularly on the part of the responsible physician, are managed effectively.

8. Be aware of the sanctions applied to patients being processed by Medical Evaluation Boards.

9. Be aware of sanctions which may be applied to officers determined to have caused unnecessary delays in processing of a Medical Evaluation Board.

10. Strictly control and monitor the responsible physician's recommendations for approval of emergency leave for those patients who are identified for Medical Evaluation Board processing.

11. Ensure that documentation of Medical Evaluation Board processing be handled expeditiously and not through the message center distribution system.

12. Ensure that administrative personnel assist responsible physicians and other staff in the expeditious distribution of Medical Evaluation Board documentation throughout the hospital to the appropriate service(s)/department(s) and Directorate of Patient Administration.

13. Notify the Director of Patient Administration if transcribed dictation and/or corrected dictation is not received from transcription within three regular duty days of dispatch to transcription.

14. Arrange transfer for any non-Army military member to the appropriate medical treatment facility if requested by the Commander, Letterman Army Medical Center, and the Commanding Officer of another service's medical treatment facility.

The Chief, Department of Nursing will:

1. Ensure that ward nursing reports containing information on soldiers undergoing MEBD processing are processed efficiently and expeditiously with continuous updates provided to the Director of Patient Administration, as necessary.

2. Ensure the ward administrative personnel and nursing staff understand the restrictions that are placed on patients who have been identified for Medical Evaluation Board processing.

3. Ensure that distribution of Medical Evaluation Board documentation is not handled through the message center distribution system.

4. Ensure that the patients being processed by Medical Evaluation Boards be available for consultative appointments.

5. Ensure that nursing personnel report dates of all consultative appointments, dates of missed appointments - to include reasons why the appointment was missed - and reappointment dates to the responsible physicians.

The Troop Commander/Director of Personnel will:

1. Ensure that administrative and clinical personnel understand the restrictions that are placed on patients who have been identified for Medical Evaluation Board processing.

2. Ensure that patients see the PEBLO for an interview as soon as possible upon being assigned or attached to the Medical Holding Company.

3. Ensure that PEBLO receives one copy of each assignment order to the Medical Holding Company.

4. Ensure that appropriate medical, dental, and personnel records are requested from the custodian of such records within three regular duty days of the date the responsible physician notifies Personnel that the patient will be processed by a Medical Evaluation Board.

5. Establish a suspense system for receipt of all personnel, medical and dental records; and Line of Duty requests (as necessary).

6. Enforce appropriate sanctions - flagging actions, restrictions, or non-judicial punishments - to ensure that patients are processed expeditiously by MEBDs.

7. Allow subsisting out status for patients living within a 55 mile radius of LAMC being processed by Medical Evaluation Boards only with the express permission of the responsible physician and coordination with the PEBLO.

8. Strictly control the granting of emergency leave for any patient who is being processed by a MEBD by coordinating this leave through the American Red Cross, the responsible physician, and the PEBLO.

9. Ensure that patients able to work participate in the work therapy program to the maximum extent possible, considering their medical limitations and physicians' orders.

The Chief, Clinical Support Division will:

1. Assist the DCCS to ensure that prolonged definitive care is not provided for military patients who are unlikely to return to duty.

2. Ensure that patients being processed for MEBDs be given priority consultative appointments and treatment.

3. Ensure that administrative personnel understand the restrictions that are placed on patients who have been identified for Medical Evaluation Board processing.

4. Ensure that administrative personnel assist attending physicians and other personnel in the distribution of Medical Evaluation Board documentation throughout the hospital to the appropriate department(s)/ service(s) and to the Director of Patient Administration. This will not include the use of the message center distribution system.

5. Ensure that administrative personnel report dates of consultative appointments, dates of missed appointments - to include why the appointment was missed - and reappointment dates to the responsible physicians.

6. Coordinate identification of those responsible military clinicians and administrators for each patient being unnecessarily delayed in MEBD processing and provide a listing of these individuals to the Director of Personnel for sanctioning actions.

Director, Patient Administration will:

1. Ensure that changes to the ward nursing report are entered into the AQCESS data base continuously.
2. Will monitor the progress of patients being processed by Medical Evaluation Boards and report any serious delays to the DCA/DCCS and Commander as necessary.
3. Will ensure that data is entered into the "Listing of Inpatients Identified for Letterman Medical Evaluation Board Processing."
4. Ensure that a complete copy of the "Listing of Inpatients Identified for Letterman Medical Evaluation Board Processing" be provided to the following on a weekly basis:

Commander, LAMC
Chief, Clinical Support Division, LAMC
DCCS, LAMC
Director of Patient Administration, LAMC
Troop Commander, LAMC
Chief, Department of Medicine, LAMC
Chief, Department of Surgery, LAMC
Commander, Medical Holding Company, LAMC
Chief, Medical Hold Separations, Personnel Directorate, LAMC
Administrator, Department of Surgery, LAMC
Administrator, Department of Medicine, LAMC
PEBLO, LAMC

5. Ensure that the appropriate clinical service chiefs will be provided, on a weekly basis, a copy of the appropriate clinical service section from the "Listing of Inpatients Identified for Letterman Medical Evaluation Board Processing."

6. Ensure that Medical Evaluation Board dictations and transcriptions are given priority processing support.

7. Ensure that distribution of Medical Evaluation Board documentation is handled expeditiously through other than the message center distribution system.

8. Coordinate transfer for any non-Army military member to the appropriate medical treatment facility if requested by the Commander, Letterman Army Medical Center, and the Commanding Officer of another service's medical treatment facility.

9. Educate the appropriate, responsible LAMC staff members, and the patients involved, as to the need for efficient MEBD processing.

10. Ensure that administrative and clinical personnel understand the restrictions that are placed on patients who have been identified for Medical Evaluation Board processing.

The Physical Evaluation Board Liaison Officer (PEBLO) will:

1. Establish a suspense system for every patient who has been identified for potential processing by a Medical Evaluation Board. This system will be used to monitor each stage of the necessary administrative and clinical processing, and will be used to identify and limit delays associated with the processing of the board.

2. Establish a cover sheet which will be used to expedite Medical Evaluation Board processing.

3. Report "Date of Admission to Letterman," "Date Identified for LAMC Medical Evaluation Board," "Date Records Forwarded to Physical Evaluation Board," and "PEBLO Remarks" for data entry into the "Listing of Inpatients Identified for Letterman Medical Evaluation Board Processing."

4. Notify representatives of the Troop Command/Director of Personnel when a patient has been identified for potential processing by a Medical Evaluation Board.

5. Interview each patient assigned or attached to the Medical Holding Company for reasons of MEBD processing.

6. Ensure that a request for a LOD be accomplished, if necessary, within three regular duty days from the date of patient interview.

7. Counsel soldiers undergoing MEBD processing.

8. Monitor progress of each Medical Evaluation Board case.

9. Report delays, or potential delays, in the processing of MEBDs to the appropriate administrative and/or clinical chief(s).

10. Inform the Director of Patient Administration, and the appropriate department/service chief(s), or DCCS, as necessary, when priority consultative appointments cannot be made.

11. Notify appropriate department/service chiefs, Director of Patient Administration, and/or DCCS, as necessary, when dictation, corrections to transcriptions, or signatures are not received within appropriate time frames.

12. Return all dictation, and corrections of previous dictations, to the appropriate attending physician, or department/service chief, as necessary, within three regular duty days of receipt from transcription.

13. When notified that a memberof another service will potentially be processed by a MEBD at LAMC, contact representatives of the Air Force or Navy medical departments to determine if the Commanding Officer of the appropriate medical facility and the Commander, LAMC

desire to have the patient transferred from LAMC before the decision to process the service member by a Medical Evaluation Board is officially made.

14. Keep the appropriate medical treatment facility notified as to the progress of any non-Army service member being processed by a Medical Evaluation Board at Letterman.

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