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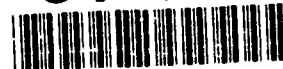
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PROVIDING EFFECTIVE ADMINISTRATIVE SUPPORT
TO THE PHYSICIAN DEPARTMENT & SERVICE CHIEFS
AT WALSON ARMY COMMUNITY HOSPITAL, FORT DIX, NEW JERSEY

"REPRODUCED AT GOVERNMENT EXPENSE"

A Graduate Management Project
Submitted to the Faculty of
Baylor University
In Partial Fulfillment of the
Requirements for the Degree
of
Master of Health Administration
by
Captain Richard G. Reale, MS
July 1990

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19. ABSTRACT (Continue on reverse if necessary and identify by block number) THIS STUDY PRESCRIBES A MORE EFFECTIVE SYSTEM FOR THE PROVISION OF ADMINISTRATIVE SUPPORT TO PHYSICIAN DEPARTMENT & SERVICE CHIEFS AT AN ARMY COMMUNITY HOSPITAL. THE PROJECT WAS UNDER- TAKEN IN RESPONSE TO CONCERNS VOICED BY PHYSICIAN DEPARTMENT & SERVICE CHIEFS THAT THEIR TIME WAS BEING INCREASINGLY DIVERTED FROM THE PROVISION OF DIRECT PATIENT CARE BY THE PERFORMANCE OF ADMINISTRATIVE TASKS. THE PRIMARY METHOD OF GATHERING DATA TO ADDRESS THIS MANAGEMENT PROBLEM WAS THE STRUCTURED INTERVIEW. AFTER CONDUCTING A COMPREHENSIVE REVIEW OF THE LITERA- TURE & OBSERVING THE EXISTING STRUCTURE & FUNCTIONING OF THE CLINICAL SUPPORT DIVISION, STRUCTURED INTERVIEWS WERE CONDUCTED WITH A VARIETY OF HEALTH CARE PROFESSIONALS FROM BOTH THE CIVILIAN & FEDERAL SECTORS. THEY INCLUDED ADMINISTRATORS & ASSISTANT ADMINISTRATORS FROM AREA CIVILIAN SECTOR HEALTH CARE FACILITIES; ADMINISTRATORS & ASSISTANT ADMINISTRATORS FROM VARIOUS UNIFORMED SERVICES & FEDERAL MEDICAL TREATMENT FACILITIES; WACH PHYSICIAN DEPARTMENT & SERVICE CHIEFS; & WACH SENIOR PHYSICIAN, NURSING & ADMINISTRATIVE STAFFMEMBERS. THE STUDY'S MAJOR RECOMMENDATION CALLS FOR RECONFIGURING WACH'S CLINICAL SUPPORT DIVISION (OVER)					
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TO ACCOMMODATE FIVE NEW CIVILIAN, NON-SUPERVISORY, ADMINISTRATIVE ASSISTANT POSITIONS. A SCHEMATIC DIAGRAM DETAILS THEIR ASSIGNMENT TO EITHER THE PRIMARY CARE SUPPORT BRANCH OR THE SPECIALTY CARE SUPPORT BRANCH OF THE CLINICAL SUPPORT DIVISION. THREE ADMINISTRATIVE ASSISTANTS EACH SUPPORT A SINGLE CLINICAL DEPARTMENT. THE OTHER TWO INDIVIDUALS ARE EACH RESPONSIBLE FOR SUPPORTING CLUSTERS OF CLINICAL DEPARTMENTS & SERVICES. THE RECOMMENDED ROLE OF THE ADMINISTRATIVE ASSISTANT IS OUTLINED IN A POSITION JOB DESCRIPTION. RECOMMENDATIONS ARE ALSO MADE REGARDING THE QUALIFICATIONS, GRADE LEVEL, RATING CHAIN, PERFORMANCE EVALUATION, OFFICE LOCATION, AND SOURCES OF TYPING SUPPORT FOR ADMINISTRATIVE ASSISTANTS.

DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
FORT DIX, NEW JERSEY 08640-6000

HSXG-AR

25 JULY 1990

MEMORANDUM FOR Residency Committee, U.S. Army-Baylor University Graduate
Program in Health Care Administration, Academy of Health
Sciences, U.S. Army, Fort Sam Houston, TX 78234-6100

SUBJECT: Resubmitted Graduate Management Project (GMP)

1. Reference memorandum from LTC Brown to COL Waters, dated 18 July 1990,
subject: Residency Report Requirement.
2. IAW the above-cited reference my GMP is resubmitted in an original and
two copies. All modifications necessary for the paper to meet the standards
established by the ACEHSA and the Army-Baylor Program have been made as
requested.
3. Any additional correspondence regarding this requirement, prior to
1 September 1990, should be sent to me at my leave address:

Captain Richard G. Reale
5 Tunney Terrace
Ortley Beach, New Jersey 08751

4. Correspondence dealing with this requirement after 1 September 1990
should be sent to this address:

Commander
USA MEDDAC
ATTN: Chief, CSD (CPT Reale)
Fort Devens, MA 01433-6401

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Richard G. Reale
RICHARD G. REALE
CPT, MS
Administrative Resident

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At Walson Army Community Hospital I am indebted to a sizeable segment of the staff who taught me a lot about the organization's operation and tolerated my questions. This group included physician department and service chiefs; clinic head nurses and noncommissioned-officers-in-charge; and senior physician, nurse and administrative staffmembers.

Specific thanks are extended to Lieutenant Colonel Mary P. King, Chief, Ambulatory Nursing Service, for her advice on revising this project's proposal and narrowing its scope; and to Mr. Michael Krawchuk, National Disaster Medical System Coordinator, for compiling and providing me with a list of area civilian hospitals and names of their administrators. Also, to Major Michael D. Wheeler, Chief, Clinical Support Division and Captain William D.

Evans, Chief, Primary Care Support Branch who provided invaluable assistance in defining the present structure and functioning of the Clinical Support Division, and served as constant sources of encouragement for the completion of this project.

To Colonel George A. Waters, Jr., Walson's Deputy Commander for Administration and my preceptor, I feel a special gratitude. Throughout my residency year he constantly stressed the importance of not only completing this project, but completing it on time. He was always available for help when I needed it, and afforded me more freedom and latitude in visiting civilian medical facilities, and during the residency in general, than I had ever thought possible.

Finally, to my wife Claudia who has had to defer the pursuit of her own career aspirations in pharmacy, so that I could further mine in health care administration. She has had to make many sacrifices because of the demands on my time.

ABSTRACT

This study prescribes a more effective system for the provision of administrative support to the physician department and service chiefs at Walson Army Community Hospital (WACH), Fort Dix, New Jersey. It was conducted during the period July 24, 1989 to July 20, 1990. The project was undertaken in response to concerns voiced by WACH physician department and service chiefs that their time was being increasingly diverted from the provision of direct patient care by the performance of administrative tasks.

The primary method of gathering data to address this management problem was the structured interview. After conducting a comprehensive review of the literature and observing the existing structure and functioning of WACH's Clinical Support Division, the author conducted structured interviews with a variety of health care professionals from both the civilian and federal sectors. These interviews included administrators and assistant administrators from area civilian sector health care facilities, administrators and assistant administrators from various uniformed services and federal medical treatment facilities, WACH physician department and service chiefs, and WACH senior physician, nursing and administrative staffmembers. *ss, *Physicians, *Health Care*

The study's major recommendation calls for reconfiguring WACH's Clinical Support Division to accommodate five new civilian, non-supervisory, Administrative Assistant positions. A schematic diagram details their assignment to either the Primary Care Support

*(attached), *Clinical medicine, admin. support*

Branch or the Specialty Care Support Branch of the Clinical Support Division. Three Administrative Assistants each support a single clinical department. The other two individuals are each responsible for supporting clusters of clinical departments and services. The recommended role of the Administrative Assistant is outlined in a position job description. Recommendations are also made regarding the qualifications, grade level, rating chain, performance evaluation, office location, and sources of typing support for Administrative Assistants.

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I. INTRODUCTION

Conditions Which Prompted The Study

Workload at Walson Army Community Hospital (WACH), Fort Dix, New Jersey, has declined markedly since the mid-1980s. During Fiscal Year (FY) 1984, 8,282 patients were admitted; however, this number dropped by 35% to 5,377 in FY 1988. The same timeframe saw outpatient visits fall by 10.3% from 457,481 to 410,430 (PAS&BA, 1989).

Speculation, as to the reasons for such declines in workload, has revealed a number of potentially contributing causes. Among them are the loss of physician staff, reduction of troop strength at Fort Dix, introduction of an adenovirus vaccine which reduced active duty admissions for acute respiratory disease, decreased availability of services for retirees and their family members, and diminished productivity by physicians due to increases in activities which detract from direct patient care. The last factor serves as the basis for the focus of this study.

WACH physicians, physician assistants and nurse practitioners are performing many tasks which should rightfully be handled by nursing and administrative support personnel. Time spent by these providers performing administrative functions detracts from their provision of direct patient care. Nursing and administrative support duties performed by physicians range from pushing patients around in wheelchairs to the typing of committee meeting minutes.

Actions which can be taken that allow more time for direct patient care are of primary importance.

The matrix organization present in the clinical departments and services has inherent problems. Clinic receptionists and appointment clerks work for the Clinical Support Division. Clinic head nurses, noncommissioned-officers-in-charge (NCOICs), and corpsmen fall under the control of the Ambulatory Nursing Service. Physicians work for their service or department chiefs. Each has his vertical chain of command, but simultaneously must work together horizontally, in a clinic, as part of a multidisciplinary team. The delineation of duties and responsibilities among clinic personnel is rarely straightforward. Areas which overlap often cause the "it's not my job" mentality. Placing NCOICs, who are often untrained and inexperienced, in charge of clinics compounds the problem. As a result, physicians frequently are required to perform non-patient care related activities.

Physician department, and service chiefs particularly, are burdened with administrative chores which draw them away from direct patient care. Many of these tasks are performed by department Administrative Officers at Army medical centers. Unfortunately, at WACH, as well as other Army community hospitals, administrative support is limited to that which is provided by the Clinical Support Division and the departmental secretaries. Clinical departments and services are devoid of assigned Administrative Assistants who could handle routine problems and administrative tasks on a daily basis.

If WACH physicians are to increase clinical productivity, the provision of effective administrative support to them in their departments and services must be given top priority.

Statement Of The Management Problem

The problem of this study was to devise the most effective system for the provision of administrative support to the clinical departments and services at Walson Army Community Hospital, Fort Dix, New Jersey. Administrative support was defined as that which is being provided or can be provided, to WACH's clinical departments and services with physician chiefs, by its Clinical Support Division.

Review Of The Literature

"The hospital is the most complex human organization we have ever attempted to manage, and, occasionally looking at it, I'm not sure it can be managed" (Drucker, 1979). As a result, the use of the matrix structure in health care organizations is becoming more common. In matrix organizations both vertical and horizontal coordination exist. Departmentalization creates a vertical or hierarchical structure: a formal chain of command. Simultaneously, an overlapping horizontal or lateral structure allows for coordination across departments through patient care teams (Neuhauser, 1972). Workers are required to report both to linking managers and to superiors in formal chains of command. They are supervised by two managers who jointly evaluate them. Because of this, "they will in theory respond to the different concerns of

each, internally providing the general management perspective required for integration" (Kimberly, Leatt & Shortell, 1983).

Hospital administrators must be skilled in both participatory and hierarchical styles of management; capable of maintaining differentiation through departmental lines and integrating specialized activities at the same time (Neuhauser, 1972).

Decentralization is a management technique which distributes 'authority to semi-independent decision units, while exercising carefully devised controls to make sure that all separate decision units are working towards common goals.' Health care institutions lend themselves well to decentralization since they have many areas where efficiency can be improved and cost savings realized. Decentralized management encourages department heads to individually manage their work areas. In facilities where decentralization is not practiced managers 'become overly dependent on their superiors for every decision and direction.' A decentralized organizational structure serves as a training ground for supervisors, middle managers and department managers. It affords these individuals the opportunity to make independent management decisions early-on during their careers at lower management levels. 'Today, effective and efficient health care delivery is more dependent than ever on the quality of department heads and supervisors at all levels' (Laliberty, 1988).

In larger health facilities the CEO often supervises and coordinates the activities of as many as forty administrative staff

members who provide administrative, medical or support services.

This staff may include assistants, to whom an administrator delegates parts of his responsibilities and authority.

Vice-president, associate administrator, assistant administrator and administrative assistant, are titles frequently assigned to staff members in accordance with the levels of their responsibilities (Goldberg & DeNoble, 1986). There is a difference in the duties and responsibilities of line and staff administrators. Terms such as assistant administrator, administrative assistant and assistant-to, should be succinctly defined (Moore, 1969).

Unit Managers

Hospitals have suffered under nursing personnel shortages for many years. The volume of administrative-clerical tasks required on nursing units has grown as well. One observation of nursing unit activities found that 25% of nursing supervisors' and head nurses' time was being spent on non-nursing management activities (Zimmerman, 1968). Another functional time study, conducted to determine how the nurse allocates time among direct and indirect nursing care, clerical work, personal time and other activities, classified 26.7% of nursing activities as non-nursing (Houtz, 1966).

The unit management program concept has addressed the nursing shortage, as well as the problem with nurses performing administrative-clerical duties. A unit manager is 'a professional manager with a college degree or equivalent experience whose role is to supervise the administrative functions of the patient care area.'

Typically, the unit manager is assigned to one unit, and has the responsibility for a broad range of administrative activities, and may have ward secretaries/clerks that report to him (Goldberg & DeNoble, 1986).

Whether the unit management function should be carried out by a nurse or a non-nurse has been the subject of debate. A non-nurse manager in an understaffed and overworked department cannot pitch in and help with the nursing, as a nurse manager might do. Therefore, he spends his time solving the essential administrative problems which may go unresolved with a nurse manager. "The non-technical manager is a servant to his departments, but nonetheless the manager of them in the fullest sense of the word. He is responsible for the total functioning of the departments, not just the administrative and housekeeping aspects" (Clifton, 1974).

A unit manager is a person inserted into the organizational structure of a facility's nursing service to help relieve nursing administrators of those responsibilities which fall outside the scope of direct patient care. "The unit manager is intended to provide administrative direction in the patient unit while the nursing staff retain full control over patient care" (Rowland & Rowland, 1985).

The specific responsibilities of a unit manager often include

- (1) handling supplies, equipment, and contacts with the maintenance services;
- (2) traditional ward clerk activities;
- (3) transcribing physicians' orders;
- (4) patient transportation

and messenger services; (5) on-unit housekeeping and dietary functions; (6) nonprofessional direct patient care; and (7) on-unit admitting, accounting, and central supply activities. ...In addition, orientation, training and supervision of clerical and messenger personnel, budgetary monitoring and patient advocacy may be shifted to the unit manager (p. 78).

Suggested qualifications include one year of college or its equivalent, at least one year's supervisory experience, and on-the-job training in the coordination of unit non-nursing services (Rowland & Rowland, 1985)

One orientation of unit management is to bring hospital administration to the patient unit. It focuses on managing the unit for physicians and nurses, not determining activities that the nurse does not need to do. A survey found that 62% of hospitals placed unit management under administration, and 38% placed it under nursing (Munson, 1983).

The unit manager, sometimes referred to as the unit coordinator, can have a subordinate, peer or superior relationship with a unit's head nurse. In the subordinate role, the unit manager is responsible to the head nurse who provides the necessary leadership. His duties are essentially clerical in nature. This role works best in a transitional arrangement when a hospital decides to reorganize the structure of its patient care divisions by inserting unit managers. The structure where unit managers and head nurses function as peers, is one growing in popularity: "the unit

manager is the administrator of the division; the head nurse is the administrator of patient care.' Here a unit manager can be either part of the nursing department and answer to one of its assistant directors, or work on a unit and report directly to someone in hospital administration. Relationships where unit managers are part of and responsible to, hospital administration, are considered progressive, since they free the nursing staff of administrative burdens. In the superior role, a 'highly prepared' unit director is assigned responsibility for all administrative activities on one or more patient care divisions or floors. He answers to an assistant hospital administrator who heads a 'department of unit management.' Physicians and residents, the head nurse, the unit housekeeper and unit dietician, answer to him as far as hospital policy is concerned, but are 'clinically responsible to their own professions.' Non-professional staff such as the unit secretary and clerks are under the absolute control of the unit director (Barrett, Gessner & Phelps, 1975).

One of the major functions of the unit manager is the coordination of patient care services--seeing that the work of doctors and nurses is facilitated by keeping the house in order and the machinery functioning smoothly (p. 229).

Massachusetts General Hospital views its unit manager positions as training areas for hospital administrators. There is a tremendous advantage gained from starting out as a manager in a patient unit--the very heart of a health care organization. Unit

managers are called floor-managers at some institutions (Munson, 1983).

Administrative Assistants

The use of unit managers in departments other than patient care units has occurred on a very limited basis. Instead, the idea of administrative assistant at the department level has met with success since its introduction in the late 1950s. "The administrative assistant is his boss' administrative brain--thinking, reacting, and performing--applying his own administrative experience to the situations facing his department head" (Conner, 1966).

This concept, where the medical director is responsible for clinical activities and a clinic manager (or administrative director) is in charge of administrative and personnel functions, excluding physicians, is becoming more and more popular. It allows the medical director to focus on the provision of health care, taking advantage of his clinic manager's business or health administration expertise. The concept is also supported by the fact that the delivery of health care in the ambulatory setting is on the increase--something which has caused hospitals to expand their outpatient clinics (Goldberg & DeNoble, 1986). These same authors further note that:

The use of the clinic manager is particularly common where there are several different clinics operating in one hospital. Depending on the size of the clinics, the manager may be able

to direct several at once, using head nurses to provide supervision in each individual clinic. (p. 136)

Administrative assistants have two bosses, reporting to an administrative head and the department chief. They are viewed, by all but their administrative boss, as belonging to their assigned department (Munson, 1983). In hospitals with large outpatient clinic operations, clinic managers may function at the administrative level; however, they will report to an assistant administrator, as will their clinic medical directors (Goldberg & DeNoble, 1986).

Administrative Tasks Versus The Provision Of Direct Patient Care

Physicians in military hospitals have long complained that their time is improperly utilized. Recent testimony before the United States House of Representatives' Committee on Armed Services' Subcommittee on Military Personnel & Compensation focused on a survey of 1,500 of the approximately 9,600 military physicians on active duty which sought "information on their attitudes and opinions of military medicine." Forty-one percent of the physicians cited "inadequate numbers of health care support personnel" as being among the top three factors which would influence a decision on their part to leave the service. With regard to support personnel, "86 percent said there were too few clerks, receptionists, and secretaries", "76 percent said that there were not enough corpsmen and orderlies", and "74 percent of all physicians said that there are fewer general duty and other nurses than needed" (Baine, 1989).

Another survey of military physicians, conducted by a health professionals study group, asked "whether they were satisfied with various kinds of professional support." Clinical and clerical support were shown to be great dissatisfiers. Eighty-four percent of the 4,220 physicians surveyed gave negative marks to clerical support services. Seventy-nine percent felt the same way about clinical support (Department of Defense, 1989). The contradictory results of a similar, although dated study "showed that 98.75% of the total time of physicians observed was spent accomplishing essential tasks that could only be performed by a physician" (Wallace, 1956).

A United States General Accounting Office report examined the extent to which military physicians perform administrative and clerical tasks. Such tasks include "typing, filing, answering the telephone, retrieving medical records, completing lab slips, and performing reception duties--instead of caring for patients." The report concluded that the administrative personnel shortage problem has been a cause for concern among military physicians for years. Physician performance of administrative and clerical tasks detracts from clinical practice time and adversely affects productivity. The problem's magnitude has not yet been quantified, but Department of Defense health care officials agree that it is a serious matter requiring priority attention. "Physicians maintain that they are much less productive than they could be because of the lack of staffing support, which decreases the level of services that can be

provided in military treatment facilities." The effects of any actions taken to address this problem, such as the reallocation of civilian administrative and clerical positions from nonmedical to medical areas, are only likely to be realized over the long term (United States, 1989a).

In apparent response to this General Accounting Office study, Headquarters, United States Army Health Services Command sent a memorandum to all of its hospitals and medical centers asking which types of additional support staff would be desired in the event that additional dollars became available to hire them. The types of personnel suggested for consideration were "medical clerks, medical records clerks, patient appointment clerks, medical record transcriptionists, receptionists, and ward clerks"; however, this list was not intended to be all inclusive (Taylor, 1989).

Another General Accounting Office study examined the factors which influence physicians to leave the military and reviewed the extent to which this has occurred since 1985. One influencing factor was inadequacy of support. "Nearly all military physicians were dissatisfied with the number of health or administrative personnel available to support them." Concerns expressed about insufficient administrative and clerical support focused on three types of personnel. Thirty percent of physicians indicated that they were extremely or moderately dissatisfied with the number of administrative officers. Sixty-five percent felt the same way about medical records clerks, and 86% were dissatisfied with the

availability of secretaries, clerks and receptionists. The study utilized anecdotes to help illustrate the lack of administrative support personnel. One physician respondent wrote: "Give me a receptionist/secretary to help out in the office. (I have to do all my typing. I have no typing support)." Another stated, "I type all my own correspondence, call all my own patients, and do much more secretarial work than is necessary." Yet another wrote: "Finally a comment on the lack of secretaries, etc. No problem, thanks to the Army I've learned to type close to 80 words/min. and I'm expert at using the Mackintosh System. I've purchased my own system (\$3,000) and my troubles are solved." This study also pointed out that physician views regarding support personnel shortages varied across specialities (United States, 1990).

An article written by an anonymous Army Medical Corps Colonel, who signed his/her name "A. Masochist", delineates many of the reasons for which military physicians are taken away from their direct patient care duties, and contends that such detractors are partially responsible for the "medical meltdown" in the military. Many non-patient care tasks are military-related, e.g. weigh-ins, urine and HIV testing, physical fitness training and testing, birth month annual readiness training, mandatory immunizations and classes, professional filler processing and training, officer's calls, alerts, etc. Other tasks are professional in nature, e.g. mass casualty drills, credentials file reviews, basic cardiac life support (BCLS) recertification requirements, on-call schedules,

numerous meetings, medical record reviews and audits, studying for specialty board certification, etc. All of the above, coupled with other detractors like Inspector General complaints, Congressional inquiries, patient representative interruptions and miscellaneous paperwork, serve to divert military physicians from direct patient care. Add unrealistic medical staffing levels, the decimating effects of summer physician rotations on a department or service, shortages of nurses, ancillary personnel, receptionists and secretaries, and an environment is created which breeds dissatisfaction and discontent (Masochist, 1989).

Few Department of the Army publications appear to address the management of physicians' time and their performance of administrative tasks. Health Services Command Regulation 40-5, entitled Ambulatory Primary Care, requires each medical treatment facility to establish an administrative management system for primary care which relieves "health care providers of those administrative functions that interfere with patient care." The system's structure must allow for interface between the "physician, nurse, and the administrative officer who provides the management services." The same regulation calls for the Clinical Support Division to perform a variety of administrative functions which would detract from available patient care time if accomplished by primary care providers. WACH's MEDDAC Memorandum 40-35, which is titled Standard Clinic Scheduling Protocols, states that no more than one hour administrative time may be scheduled for a physician

per day, excluding required meetings. It allows clinic (service) chiefs to schedule an additional two hours per week administrative time. Department chief administrative time is "scheduled based upon demand" and is subject to review by the Deputy Commander for Clinical Services. All administrative time must be used to perform functions which are job-related.

Workload Reductions At Military Medical Treatment Facilities

Decreases in productivity at U.S. Army medical treatment facilities (MTFs) have been a continuing cause for concern. A memorandum from Headquarters, U.S. Army Health Services Command (HSC) to its MTFs, noted, that as of July 1989, half of them were below their programmed workload levels for fiscal year (FY) 1989. It made mention that the FY 1989 program level equated to only 91 percent of HSC's total workload during FY 1981. The memorandum quoted a U.S. House of Representatives Appropriations Committee report found in the 1990 Department Of Defense (DOD) Appropriations Bill:

Since Fiscal Year (FY) 1981, the operation and maintenance funding for the DOD medical programs has grown by \$3,742,700,000, a 148 percent increase. Included in this amount is a growth of \$1,709,400,000, a 200 percent increase, for CHAMPUS. During this time, the eligible population has increased by only 1,619,091 or 18 percent. While a good portion of this growth is for inflation, a significant portion is due to the inability of the Department to offset program

growth with increases in productivity.

HSC MTFs have 'been doing less with more'--a situation which, should it continue, will invite greater scrutiny by Congress on future appropriations requests. To raise productivity, HSC MTFs must ensure the efficient and effective use of their personnel and resources (Major, 1989).

A United States General Accounting Office report examining how workload reductions at military hospitals between fiscal years 1985-87 have increased CHAMPUS costs listed several reasons why fewer patients were being treated. Among them were 'increased readiness training and deployments of medical personnel to temporary duty stations' and increased amounts of time being spent by physicians on quality assurance activities--both at the expense of time available for direct patient care. Data compiled by the Army showed that 'staff-days spent on deployments of medical staff increased from 26,594 in fiscal year 1985 to 32,776 in fiscal year 1986 to 42,917 in fiscal year 1987.' Readiness training data was not compiled by the Army. Quality assurance programs in place at military medical treatment facilities require extensive involvement by physicians. Physician activities include documentation in medical records, the completion of various worksheets and forms, and participation in quality assurance committee meetings (United States, 1989b).

By early 1987, Army MTFs had the means to more accurately define how employees were spending their time. Under the Uniform

Chart of Accounts Personnel Utilization System (UCAPERS) physicians were required to record the number of hours spent each day in the performance of regular patient care. They also had to account for their remaining time in one or more of a variety of other categories. These categories included temporary duty, on call, day off, training holiday, holiday time, leave, military organization related activities, military training, sick, maternity leave, pass, education & training, in/out processing, physical training, field training exercise, mobilization exercise, planning national support, and planning for overseas deployment, among others. A computer generated report, entitled 'Clinician Utilization Worksheet', can show how an individual physician's time was allocated among these categories during the course of any given month. Implementing this system seems to have helped the Army in calculating how much physician time was devoted to various aspects of the readiness mission. However, its present configuration is not specific enough to allow for the capture of time spent in meetings or time spent in the performance of a variety of administrative tasks. Time spent in these areas is not broken out, but counted as part of the regular patient care category.

The Automated Quality of Care Evaluation Support System (AQCESS) is an on-line computer system presently in use at most military hospitals and medical centers. Through its Appointment Scheduling Module (ASM), the amount of time blocked out for patient care by a specific physician, during any given day or month, can be

determined. Conversely, time not spent treating patients, which is being devoted to other functions, can be accounted for as well. Physicians can schedule non-patient care time for completing-the-clinic, continuing education, admin time, meetings, physical training, returning phone calls, quality assurance, morning report, lunch, and a variety of other tasks.

Administrative Support In Military Medical Treatment Facilities

In 1977, following the end of the Vietnam Conflict, the U.S. Army was experiencing physician shortages. Concerns of administrators focused on relieving physicians of 'unwanted or assumed administrative tasks' so that they could devote more time to the provision of direct patient care. In response, the U.S. Army Health Services Command issued a revision of its Ambulatory Patient Care (APC) Model #18. It was entitled 'Clinical Support Division'. Its purpose was 'to assist the medical treatment facility (MTF) Commander in establishing an improved administrative management system with the goal of increasing physicians' time available for direct patient care' (United States, 1977).

APC Model #18 was intended to maximize the effectiveness of all administrative personnel supporting hospital elements which provided direct patient care by placing them under the centralized managerial supervision and guidance of a Clinical Support Division (CSD). It set forth recommendations for the basic organizational structure of the CSD. The model called for a Chief, CSD (Associate Administrator) who reported to either the hospital's Executive

Officer (XO) or its Chief of Professional Services (CPS). The Chief, CSD would have two Assistant Administrators: one in charge of Inpatient Care & Ancillary Services and the other in charge of Ambulatory Services. Each Assistant Administrator would have one or more Administrative Officers working for him. All were recommended to be Medical Service Corps officers (United States, 1977). APC Model #18 was 'designed to be more responsive managerially to the department/service chief in particular, and the physician in general' (Egmon, 1986).

Eventually APC Model #18 was replaced by guidance in Health Services Command Regulation 40-5, dated 2 September 1985. It merely enumerated the responsibilities of the CSD, noting that 'it is considered part of an overall administrative management system whose purpose is to relieve health care providers of those administrative tasks that detract from time with the patient' (Egmon, 1986).

Walter Reed Army Medical Center (WRAMC) in Washington, DC, placed a modified unit manager system in place in the late 1970s. It was faced with the problem of 'how to best provide management and administrative support to widely scattered, diverse health care units.' The facility's patient floors were so large that each had more beds than an average-sized community hospital. Under the system each floor or group of floors was managed by an Associate Administrator--a field grade Medical Service Corps officer. For a time these floor administrator positions were viewed as a training ground for future administrators of Army community hospitals.

Company grade Medical Service Corps officers or civilian employees served as unit managers under the supervision of the Associate Administrators. "The Unit Managers coordinated receptionist, housekeeping, logistic, and safety functions for the supported units." The unit manager system has not been implemented at other military medical centers. Debate continues over whether WRAMC's system should be retained, modified, or scrapped (Haynes, 1988).

WRAMC's medical staff was organized into departments and services. For the most part, departments and services were directed by senior physicians, who also served as residency program directors. All major departments had a company grade Medical Service Corps officer and a sergeant to take care of administrative details. The clinical skills of department and service chiefs were too valuable for them to be managing support services--"the hospital felt that their time and energy should be conserved for clinical practice, teaching, and research." The duties of the departmental administrative officers were extensive (Haynes, 1988).

A few studies have examined systems for the provision of administrative support in U.S. Army Medical Treatment Facilities (MTFs). One recommended the establishment of an administrative support system for the professional departments of a medical center based on the U.S. Army Health Services Command Ambulatory Patient Care (APC) Model #18. The study noted that administrative support within the facility's professional departments had been less than optimal because of problems in two areas. One problem involved the

lack of experience of Administrative Assistants and the fact that their roles were ill-defined. The lack of job descriptions caused the roles of Administrative Assistants to be defined by trial and error and hampered the transition of new individuals into such positions. The second problem was rooted in the lack of 'central direction and guidance for the Administrative Assistants in their areas of responsibility.' Administrative Assistants needed an individual, besides their department chief or the facility's Executive Officer, to consult with on problems of an administrative nature. If an Administrative Assistant has to bring administrative problems to his department chief for resolution, the reason for his position--'relieving professionals of admin details so that they may perform in their primary duty of patient care'--is negated. The study also remarked that Administrative Assistants should not routinely be assigned menial tasks, e.g. Combined Federal Campaign, Army Emergency Relief, or Savings Bond representative. Individuals interviewed commented that Administrative Assistants should be aggressive, actively seek out ways to assist physicians, and be willing to take on responsibility. They also commented, that the grade level of such individuals (Lieutenant) was too low and should be upgraded (to Captain). Finally, since it took up to six months to train an Administrative Assistant, that individual should be one who can be stabilized in the position (Rians, 1975).

A similar study analyzed and compared three organizational structures for providing administrative support at a medical center.

It recommended APC Model #18 as the best managerial structure for providing such support. Comments regarding the administrative support system in place at the time of the study noted the youth and inexperience of the facility's (military) Administrative Assistants. Many performed "minor or meaningless" tasks since they had little knowledge of administrative functions like "budgeting, statistical data collecting, personnel management, planning, and evaluating information." When interviewed, these individuals were found to exhibit minimal motivation, and had "few responsibilities and almost no control over departmental resources" (Goodspeed, 1977).

Another study identified operational problems and recommended improvements for the provision of administrative support for clinical services at a community hospital. Recommendations included upgrading the number of support staff assigned to the facility's Clinical Support Division (CSD), placing the CSD under the supervisory control of the Deputy Commander for Clinical Services (DCCS), and bringing its organizational structure more in line with the one delineated in Health Services Command Regulation 10-1, entitled Organization & Functions (Egmon, 1986).

Purpose Of The Study

The purpose of this study was to analyze the current structure and functioning of the administrative system (the Clinical Support Division) in place to support the physician department and service chiefs at WACH and to recommend the most effective method for the provision of such support based on the following:

1. Information acquired from a comprehensive review of the literature.
2. Knowledge acquired about administrative support systems at area civilian medical facilities.
3. Knowledge acquired about administrative support systems at other uniformed services and Department of Veterans' Affairs medical facilities.
4. Feelings of WACH's physician department and service chiefs regarding the present and most effective systems for the provision of administrative support.
5. Feelings of senior members of WACH's physician, nursing and administrative staffs regarding the present and most effective systems for the provision of administrative support.

II. METHOD & PROCEDURES

Due to the qualitative nature of this project, the primary method of gathering data to address the management problem was the structured interview. After conducting a comprehensive review of the literature and observing the existing structure of the Clinical Support Division, structured interviews were conducted with a variety of health care professionals from both the civilian and federal sectors. A series of structured interview questions was developed for each group of individuals; they are found at

Appendices A through D. The following outline represents the specific steps taken in conducting this study:

1. A comprehensive review of the literature was completed.
2. The existing structure and functioning of the administrative support system for clinical departments and services at WACH was observed. Specific attention was paid to the structure of the hospital's Clinical Support Division (CSD). The CSD was diagrammed and enough time was taken to thoroughly comprehend its current operation.
3. Sixteen civilian sector acute care medical facilities in New Jersey, ranging in size from small hospitals to large medical centers, were visited. Their organizational structures and administrative support systems were examined. Time spent at any one facility did not exceed three days. The structured interview questions found at Appendix A were used as a guide when speaking with medical facility administrators and assistant administrators.
4. Structured telephone interviews were conducted with administrators or assistant administrators of nine uniformed services and five Department of Veterans' Affairs medical treatment facilities regarding physician support systems. The questions found at Appendix B were used as a guide when speaking with these individuals.
5. Nine WACH physician department and service chiefs were questioned to determine which daily tasks detract from the provision of direct patient care. An effort was made to determine their

feelings about the present system of administrative support and to ascertain what types of non-patient care related functions they were performing. Each department and service chief was asked to estimate how much of his/her time is spent performing non-patient care related activities. The series of questions found at Appendix C was used.

6. Eight senior members of WACH's physician, nursing and administrative staffs were interviewed, using questions at Appendix D, regarding the present and most effective systems for the provision of administrative support to clinical departments and services.

7. Using the information and insight acquired in steps 1. through 6. above, a plan of what is believed to be the most effective method for the provision of administrative support to the clinical departments and services at WACH, was devised and recommended for implementation.

III. RESULTS

Literature Review Summary

The review of the literature generated some overview information regarding the hospital as a complex matrix organization. It also centered on the utilization of lay individuals (non-nurse unit managers & administrative assistants) in the provision of administrative support to physicians and nurses. Subsequently, a variety of sources helped narrow the focus of the review towards administrative support in military medical treatment facilities. Military physicians were found to be generally dissatisfied with clerical support. They believe that too few personnel are employed in this role. An interesting government study focused on the extent to which military physicians perform administrative tasks. An article by an anonymous Army Medical Corps Colonel elaborated on the extent to which military physicians are detracted from the provision of direct patient care. Workload reductions at military hospitals resulting in corresponding CHAMPUS cost increases were shown to be a growing cause for concern in Congress and the Department of Defense. Past studies of the provision of administrative support to physicians in U.S. Army medical facilities resulted in some interesting findings. Overall, the literature review uncovered a good deal of background material which was pertinent to this project. It yielded many ideas which were helpful in the formulation of the final recommendations.

Structure Of The Clinical Support Division

WACH's Clinical Support Division (CSD) was found to be responsible for the provision of centralized managerial and administrative support to the facility's clinical departments and services, as well as to the U.S. Army Health Clinic at the Defense Personnel Support Center (DPSC) in Philadelphia, and the Troop Medical Clinics (TMCs) located on Fort Dix. Its organization and functions were examined in detail. The CSD falls under the auspices of WACH's Deputy Commander for Clinical Services (DCCS). See Figure 1.

The CSD's present structure is depicted in Figure 2. The Office of the Chief, CSD, includes a Medical Service Corps Major and his secretary. There are two subordinate branches in the division: 1) the Primary Care Support Branch (PCSB) and 2) the Specialty Care Support Branch (SCSB). The Chief, PCSB is a Medical Service Corps Captain and the Chief, SCSB is a GS7 Department of the Army Civilian (DAC). The PCSB supports the Department of Primary Care & Community Medicine (DPCCM), which includes the U.S. Army Health Clinic at DPSC and the TMCs on Fort Dix. It also supports the Pediatrics, Gynecology, and Family Practice Clinics. The SCSB supports the Departments of Surgery (less Gynecology), Medicine (less Pediatrics), Psychiatry, Radiology and Pathology, in addition to the Community Mental Health Service. The Medical Library and Patient Representative Office are under administrative and managerial control of the CSD.

The supervisor of the hospital's Patient Appointment System (PAS) answers directly to the Chief, PCSB. She directly supervises a Master Appointment Scheduler and 26 medical clerks who are assigned to clinics throughout the hospital as receptionists and appointment clerks. There are also two positions for Administrative Noncommissioned Officers (NCOs) under the Chief, PCSB. Presently, one position is filled; the sergeant working for the Chief, CSD, as the division's NCOIC. The second position is vacant. The Chief, SCSB, also has two positions for Administrative NCOs, one of which is vacant.

Personnel in the CSD appear to spend an inordinate amount of time writing new contracts and managing contracts already in existence. As expected, they also handle a variety of routine administrative tasks for the supported physician department and service chiefs. The eventual addition of the Military-Civilian Health Systems Branch to WACH's Patient Administration Division should remove the burden of most contract responsibilities from the CSD, and allow its staff to refocus on their primary mission of providing administrative support to physicians.

Civilian Sector Medical Facility Visits

Site visits made to sixteen civilian sector acute care medical facilities located in central and southern New Jersey provided an understanding of the relationships between physicians and the hospitals at which they work, as well as the degree to which physicians are supported administratively. A list of the hospitals

visited, their locations, and numbers of licensed beds, is found at Appendix E. The sizes of facilities ranged from a small 158-bed community hospital to a huge 550-bed tertiary care, academic medical center with university affiliation. Structured interviews regarding organizational and administrative support systems were conducted with administrators and assistant administrators. Their responses emphasized some key differences in the structuring and staffing of civilian and military medical facilities.

In contrast to military hospitals, where almost all military and civilian physicians on staff are salaried employees, very few physicians are actually employed by civilian sector acute care hospitals. Many of the larger civilian hospitals were found to employ a physician Vice President for Medical Affairs, or a Coordinator for Medical Affairs, who functions as a liaison or buffer between administration and the medical staff. Other salaried physicians, referred to as house staff, were found at a few hospitals. Many facilities contract with independent physicians or physician groups to provide their Emergency Room, Pathology and Radiology services. Generally, physicians in the civilian sector are part of a group or practice independently. They are members of the medical staffs at one or more hospitals where they admit patients, perform surgical procedures, and make daily rounds.

All hospitals visited had presidents of their medical staffs and directors of their clinical departments. For the most part, physicians in these positions are elected by their peers, subject to

the subsequent approval of the hospital governing board. The Vice President for Medical Affairs at one hospital, a member of the American College of Physician Executives, estimated that the president of a hospital's medical staff loses 15% of his gross income by performing the duties of this position. Directors of clinical departments forgo 8-10% of gross income.

All hospitals visited currently provide the presidents of their medical staffs with an office, while some provide offices to the directors of their clinical departments as well. In some instances clinical directors operate out of practice association offices located in leased buildings on hospital grounds or out of other buildings in close proximity to the hospital.

Hospital-provided administrative support to the president of the medical staff, directors of the clinical departments and other staff physicians was found to be very limited. One or more secretaries to the medical staff were available at all hospitals. They are used primarily for typing various correspondence, committee meeting minutes, etc. Typically, physician practice associations employ office managers to assist them with billing and collection, advertising, the purchase of supplies and equipment, patient scheduling, personnel matters, and other administrative tasks. Independent physicians working out of their own offices or residences commonly employ a nurse or secretary to handle their billing and administrative tasks. Patient billing, insurance form

processing and compliance with various requirements for documentation have become a growing burden. Mandatory meetings and hospital departmental quality assurance requirements were the areas most often cited as detractors from direct patient care.

All hospitals visited employed non-physician Department Managers or Administrative Directors in their pathology and radiology departments. Some hospitals also employed them in their respiratory and rehabilitation departments. Only the largest facility visited (with the teaching function & university affiliation) employed non-physician Administrative Directors in other clinical departments, e.g. surgery, pediatrics and psychiatry. It also had salaried clinical department directors and numerous physicians who were employed directly by the facility.

Non-physician Department Managers and Administrative Directors were found to be primarily responsible for admin and personnel functions, while department physician chiefs or directors handled the clinical matters. Administrative duties performed include running the day-to-day operations of the department, billing, budgeting, capital equipment purchasing, maintenance, ordering of supplies, negotiating contracts, quality assurance, etc. Department Managers and Administrative Directors all performed in a supervisory capacity--having sizeable support staffs under their control.

All Department Managers and Administrative Directors worked for someone in administration, usually an assistant administrator for professional services. They attempted to cultivate and maintain

good working relationships with their department's physician director. This involved keeping the director informed and asking for his input in certain matters. Frequently, assistant administrators sought the input of physician directors when writing the evaluations of Department Managers or Administrative Directors.

In areas of facilities where non-physician Department Managers or Administrative Directors were not employed, e.g. emergency rooms, outpatient services, etc., head nurses or nurse coordinators were found to fill the administrative support role. They had supervisory responsibilities and managed sizeable staffs.

Administrators' and assistant administrators' responses varied widely when they were asked whether a non-physician, non-nurse, Department Manager or Administrative Director job should be viewed as an entry-level training type position, or one which requires an individual with previous experience (or a degree) in health care administration, business administration or some other discipline. Some viewed the master's degree--in health, business or public administration--as the standard credential for holding such a position. Others believed that a person with clinical or hospital experience and some academic preparation, at the associate's degree level in business or health services administration, would be able to successfully fill such a position. Only a few felt that this type position should be filled at the entry-level by someone right out of school with a bachelor's degree in business or health administration and no experience.

A number of individuals interviewed pointed out that, until recently, most graduates with master's degrees in health or hospital administration were hired by hospitals to fill positions at the assistant administrator level. However, more and more new graduates (because of a tightening market) are entering the field one level down--as department heads or managers. Typically, these individuals have no desire to be confined to one department for very long; they want to broaden their experience base and move up to positions of greater authority.

Despite their general disagreement regarding the ideal educational level and experience base for Department Managers or Administrative Directors, administrators and assistant administrators agreed that good oral and written communication skills and good business sense were a must. They also believed that certain intellectual, interpersonal and motivational qualities would be essential for success on the job. Intellectual skills and abilities mentioned included broadmindedness, proactivity, vision, analytical ability, decisiveness, creativity, capacity, and good listening skills. They also found good planning, organizing and problem-solving skills necessary. Interpersonal traits referred to were cooperation, participation, assertiveness, diplomacy, credibility, self-confidence, peacemaker, and respect for the dignity of others. Words depicting the desired motivational qualities included ambitious, energetic, enthusiastic,

action-oriented, self-starter, sense of urgency, goal-oriented, and challenge-seeker.

Collectively, the visits to civilian sector medical facilities provided for an excellent understanding of the relationships between physicians and the hospitals at which they work. They also yielded meaningful information about Department Managers and Administrative Directors, their qualifications, and desired personal qualities. However, the visits failed to produce assorted models of functional physician support system structures which were believed to have been in place. As a result, hoped for comparisons between WACH's CSD and civilian sector physician support systems were not possible.

Uniformed Services & Federal Medical Facility Interviews

Telephone interviews with administrators and assistant administrators at Army, Navy, Air Force and Department of Veterans' Affairs hospitals and medical centers resulted in explanations of a number of different physician support system structures. A list of the hospitals contacted is found at Appendix F. In all instances, as at WACH, the majority of physicians were employed on a full-time, salaried basis and maintained offices in the facility.

Army

The Clinical Support Divisions of large Army community hospitals contacted were structured very much like WACH's: the CSD falling under the DCCS; being comprised of the Primary (Ambulatory) Care and Specialty (Inpatient & Ancillary) Care Support Branches; and exercising administrative control over the Medical Librarian and

the Patient Representative. One difference was that the Patient Appointment System (PAS) section fell under the control of the Chief, Specialty Care Support Branch at some hospitals. Centralized PAS sections, with all appointment clerks working in a common area, were found at some hospitals, while others operated decentralized systems with clerks physically situated in their respective clinics. Some CSDs had NCOIC positions. Enlisted personnel working within CSDs held MOS71L (Administrative Specialist), MOS71G (Patient Administration Specialist) and MOS91C (Patient Care Specialist).

The largest Army community hospital contacted had Medical Service Corps and civilian Administrative Officers assigned to support one or more clinical departments each. Two Administrative Officers were assigned to the CSD's Primary Care Support Branch: one supporting the Department of Primary Care & Community Medicine (DPCCM) and the other functioning as the Officer-In-Charge (OIC) of an entity called the Consolidated Troop Medical Clinic. Three Administrative Officers were also assigned to the CSD's Inpatient & Ancillary Care Support Branch: one supporting the Departments of Surgery and Pediatrics; one supporting the Departments of Medicine and Psychiatry; and one supporting the Departments of Obstetrics and Preventive Medicine. Four of the five Administrative Officers were Medical Service Corps lieutenants or junior captains. The remaining Administrative Officer was a GS7 civilian. They all performed strictly administrative functions and had no supervisory authority over department personnel. Some Administrative Officers were

physically located in the area they supported; others were not. They were evaluated by the CSD chain of command. One major problem identified with this structure was that most military Administrative Officers were right out of field medical units or school and did not know what they were supposed to be doing. Another problem was that the presence of military Administrative Officers did not allow for continuity in the positions. The amount and type of work given to any one Administrative Officer was directly related to the degree of confidence which the physician department chiefs being supported had in that individual.

Another large Army community hospital contacted was in the middle of implementing a new support system structure. Called the 'Triad Model', the concept was devised by the facility's Commander, Chief Nurse and Chief, CSD. Focusing on service line management, this model calls for physically co-locating a physician - nurse - administrator triad in the area where care is being provided. Each service line (e.g. Surgery, Medicine, Maternal Child Care, Pediatrics, etc.) will have a triad managing it. The triad will be directly involved in the day-to-day decisions of their service line's operations. This should improve effectiveness and allow for better decisions to be made. Even though triad members will work together in a service line setting, they will continue to be evaluated by their respective chains of command. This system could result in the elimination of the Primary Care & Specialty Care Support Branch layer from the facility's CSD structure.

Administrative members of the service line triads could each report directly to the Chief, CSD.

In smaller Army community hospitals contacted, the structure of the CSD was found to be much less elaborate. It typically included a CSD Chief, who worked for the DCCS; an NCOIC; secretary; and a number of individuals functioning as either receptionists, appointment clerks, or both. Administrative control was exercised over the Patient Representative and Medical Librarian.

Navy

The first Naval Hospital contacted was a small 69-bed facility commanded by a Medical Service Corps (MSC) officer. Its top physician, the Director of Clinical Services (DCS), exercises line authority over its Directorates of Medicine and Surgery, each of which is comprised of a variety of subordinate services/clinics. All of these areas are staffed with medical enlisted personnel, nurses and some with civilian secretaries. The DCS has an MSC Admin Officer working directly for him, along with a secretary and an enlisted man. The secretaries within the Directorates fall under the DCS's secretary. The assigned medical enlisted personnel and nurses work for the Directorate of Nursing.

The other Naval Hospital contacted was a large 469-bed facility. Its Commanding Officer has subordinate Directors for Medical Services, Surgical Services, Ancillary Services, Nursing Services, Administration and Ministry & Pastoral Care. The Director for Medical Services and the Director for Surgical Services are both

physicians. Each has an Administrative Assistant (MSC officer) and a Chief Petty Officer (CPO) assigned. The Director for Ancillary Services, himself an MSC officer, also has an Administrative Assistant, but not a CPO. Administrative Assistants are rated by their respective service Directors, not the Director for Administration. They handle their Directorate's correspondence, budgeting, purchasing of equipment, and any problems which arise. They are also ultimately responsible for the large numbers of enlisted corpsmen and civilians assigned to their Directorates, but not for the nurses or physicians.

All Administrative Assistants assigned to this facility have at least a bachelor's degree, but their levels of experience vary. Some have previous experience in similar positions while others are straight out of college and Officer Indoctrination School. All are MSC officers, ranging in rank from Ensign (O-1) to Lieutenant (O-3). The larger Directorates usually have the more experienced Administrative Assistants assigned. Those Administrative Assistants fresh out of school are often trained on-the-job by their Directorate's CPO.

To be successful, Administrative Assistants have to be capable of handling people, finances and correspondence, and of developing a good rapport or working relationship with their Director. The extent to which a (physician) Director is taken away from direct patient care often depends on the skills and knowledge level of his Administrative Assistant.

Air Force

The Ambulatory Services Concept is a clinical support structure initiative which was mandated by the Air Force for use in all of its hospitals (but not medical centers) a few years back. In the typical Air Force hospital three individuals work directly for its physician Commander: the Administrator, Chief Nurse and Chief, Hospital Services (CHS). The CHS is the chief of the medical staff to whom the other hospital physicians and the Director of Ambulatory Services (usually an MSC officer) report. The Director of Ambulatory Services has supervisory (line) authority over records clerks, appointment clerks, the Health Benefits (CHAMPUS) Advisor, nursing technicians and outpatient nurses. He ensures the most efficient use of resources in the hospital's outpatient services arena. Inpatient nurses work for the Chief Nurse. Other MSC officers work for the Administrator.

The Ambulatory Services Concept was implemented because no one person had been ultimately responsible for outpatient services. The command structure was matrixed. Although physicians worked for physicians, other individuals--records clerks, appointment clerks, nurses and technicians--had dual reporting requirements. They had to respond to the physicians in their work unit and to their superiors in the nursing or administrative chains of command. It was believed that better management could be achieved under a single person--a Director of Ambulatory Services.

After being implemented, the Ambulatory Services Concept worked well in some hospitals, but not in others. The concept's failure at certain hospitals stemmed from turf battles among the nursing, physician and administrative staffs--the result of changes which involved the traditional lines of authority. This controversy caused the Air Force to relent and make the Ambulatory Services concept optional at its hospitals.

Interestingly enough, the concept has been adopted with success at some Air Force medical centers, after they were initially excluded from the mandate because it was felt that their sheer size would be prohibitive. It is important that a facility's Commander be sold on the idea. Also, that the staff be willing to put patient care ahead of turf battles to make the system work.

The first Air Force hospital contacted was a 20-bed facility. It has the Ambulatory Care Concept, exactly as described above, in operation. It is said to be working well. However, this concept was not in place at the other Air Force facility contacted. The physician department chiefs (Medicine, Surgery, Radiology, Obstetrics, Mental Health & Flight Medicine) at this 301-bed medical center each have Medical Service Corps officers supporting them on a part-time basis. MSC officers fill regular positions at the facility (e.g. Logistics, Patient Administration, etc.) and are rated by members of its administrative hierarchy. At the same time, they are each part of the matrix structure of a multidisciplinary work unit--just like nurses, technicians and clerical personnel.

This facility's Departments of Medicine and Surgery each have an Administrative Assistant (GS9) assigned on a full-time basis as well. MSC officers have authority in their assigned departments, but lack supervisory control over personnel.

Department Of Veterans' Affairs (DVA)

The first DVA medical center contacted was a 571-bed acute care facility with a teaching function. Like most DVA facilities its entire medical staff is salaried. The major services at this facility are Medicine, Surgery, Psychiatry, Rehabilitation and Ambulatory Care. The medical center's Chief of Staff hires the physician chiefs for each of these services. They are selected from pools of applicants based on various qualifications: education, experience, board certification, academic ability, articles published, etc.

Each of the five major service chiefs has an Administrative Officer who reports directly to him. For the most part, Administrative Officers handle administrative (fiscal, supply, coordinating functions with other services, teaching program, etc.) and personnel matters, and involve their service chiefs in decisions when appropriate. Administrative Officers have line authority over their service's clerical staff; however, nurses and nurse's aides working within their service are accountable only to the Nursing Services hierarchy. Neither the physician service chief nor the Administrative Officer has line authority over nurses or aides

Most Administrative Officers at this facility had worked in the DVA system for some time. Some were nurses or technicians initially who decided to go into administration. All had at least a bachelor's degree and extensive experience in health care.

The second and third acute care DVA medical centers contacted had similar physician support system structures in place. A 671-bed facility's physician service (Medicine, Surgery, Radiology and Psychiatry) chiefs each had an Administrative Assistant assigned. The positions were graded as GS11. Administrative Assistants were evaluated by their physician service chiefs, often with input from the subordinate physician section chiefs. They supervised only the service's clerical personnel.

A 420-bed facility contacted had Administrative Officer positions in its Medicine, Surgery and Psychiatry Services. Originally, these positions were graded at the GS11 or GS12 level. Administrative Officers were involved in virtually every facet of their service's day-to-day operations, except writing orders for and treating patients. They were involved with funding, supply, space utilization, workload validation, supervision of clerical personnel, solving patient problems, providing admin support to residency programs, serving in a liaison capacity between the facility and affiliated medical schools, representing service chiefs at meetings, coordinating quality assurance, supporting the clinical privileging process, and more. Essentially, the role of each Administrative Officer was to support his service's medical staff so that they

could do their job treating patients. Recently, the job descriptions for Administrative Officers at this particular facility were revised and the positions downgraded to the GS9 level. Duties were limited to personnel, supply, space utilization, funding and other functions internal to the service. Dropping the grade level of Administrative Officer positions to the GS9 level was cause for concern at this facility; it allowed secretaries to apply for Administrative Officer positions.

The fourth DVA medical center contacted had 403 beds. GS7 Management Assistants were in place in its Medicine, Surgery and Psychiatry Services. They are evaluated by their physician chief and supervise only clerical personnel within the service. The title 'Management Assistant' was used because the position qualifications are lower than required for Administrative Assistant or Administrative Officer positions within the DVA system. A college degree was not a requirement for a Management Assistant position at this facility. People occupying the positions were promoted into them from clerical or secretarial jobs. While Management Assistants perform many of the duties mentioned above, their positions were described as less complex than Administrative Assistant or Administrative Officer positions at other DVA facilities.

The final DVA medical center contacted was more the size of a community hospital--265 beds. It had no Administrative Assistants, Administrative Officers or Management Assistants in direct support of the physician service chiefs. The only internal admin support

that each service chief had was a GS5 secretary. These secretaries were very familiar with, and involved in, the day-to-day operations of their services. The Administrative Assistant to the facility's Chief of Staff had the responsibility for solving administrative problems that could not be resolved at the service level.

Physician Department & Service Chief Interviews

A list of WACH physician department and service chiefs questioned is found at Appendix G. Most were at least somewhat familiar with the present structure of WACH's Clinical Support Division and how it provides support to their area. One chief was unsure of how CSD was supposed to support his area and felt that he would have benefited from a briefing in this regard during inprocessing. Another chief was not aware that he was supposed to be receiving support from CSD when necessary.

When asked about the adequacy of the present CSD system, department and service chief responses varied. Some chiefs believed the system was adequate, but most feel it is inadequate at least part of the time or could use improvement in at least some areas. Of those who viewed the system as inadequate, one chief felt that his area was large enough to have a Medical Service Corps officer assigned to oversee needs such as staffing, equipment, logistics, etc. Another commented that the existing system gives managers of clinics/services/departments no control over personnel (e.g. receptionists & appointment clerks) who work for them on a daily basis. He also questioned the efficiency of the CSD itself, noting

long lag times between problem identification and resolution. A third chief believes that clerks should be working for the clinics, not the CSD. He feels that the Patient Appointment System's Master Scheduler has too much power and is able to manipulate the time of physicians and clerks. The staffing of clinics with more support personnel and the provision of better library services were mentioned as areas which could use improvement. It was also noted that the present CSD structure allows physicians to be tasked with too many administrative functions. While some may enjoy this type of work, it results in an underutilization of physicians.

When asked for suggestions on how to improve the present CSD structure or suggestions for a new system, responses again varied widely. One chief felt that he had a good rapport with the CSD, got all the help he asked for, and had no suggestions for improvements. Other responses called for: assigning MSC officers or CSD 'liaisons' at the major department level; placing all employees (clerical, nursing & physician) under the direct control of their respective department or service; assigning clerks to the individual clinics instead of to the CSD; expanding and improving the available resources in the medical library; and decreasing the power of the Master Scheduler. Another chief suggested that all matters in need of resolution/action be presented to the DCCS first, and then to the CSD. This may help to assure that concerns/problems taken to CSD are acted upon and get the prompt attention that they deserve. While it did not address the adequacy of the present CSD structure,

a comment was made that the Commander and DCCS should both spend part of their time seeing patients and have offices in clinical areas of the hospital.

When asked to estimate the percentage of their time being devoted to non-patient care related activities physician department and service chief responses ranged from 15% to 60%, with the average being roughly 30%. Most chiefs felt that they were detracted from the provision of direct patient care to a greater extent than other providers working within their department or service.

When asked what specific tasks detracted them from the provision of direct patient care physician department and service chiefs referred to a variety of administrative duties. They included administrative paperwork, writing and typing letters, serving as the department/service quality assurance coordinator, attending meetings, especially non-critical ones, scheduling their time, performing quality assurance and peer review activities, handling patient administration type problems, accounting for time spent in various activities, and having to spend time negotiating for personnel, equipment and facilities, because of no direct command & control over these resources. Also mentioned were interviewing and attempting to hire people, sitting on various boards, coordinating meetings to resolve problems, following up on problems/issues, placing telephone calls, preparing audits,

completing surveys, mediating disputes between others, and doing secretarial work. One chief noted that his secretary was located seven floors away.

Senior Physician, Nurse & Administrator Interviews

A list of WACH senior physicians, nurses and administrators questioned is found at Appendix H. Most were at least somewhat familiar with the present structure of WACH's Clinical Support Division and how it provides support to the physician department and service chiefs.

When asked about the adequacy of the present CSD system, senior staffmember responses varied. A few believed the system was, for the most part, adequate. They felt that the CSD addresses the primary issues, is very involved in hospital operations, and is viewed as a critical component by the command. Also, that CSD is providing great support given its resource constraints, and that physicians are utilizing its personnel to the point of overtaxing them. Problems with library services and an inordinate amount of time spent on contracts by CSD personnel were viewed as inadequacies. One senior staffmember remarked that the present CSD structure is adequate, but only for a very small (10-15 bed) hospital with a few clinics. Those seeing the CSD structure as inadequate cited a variety of problems. They included overall understaffing, too few MSC officers, the requirement to write/monitor contracts (which detracts from the provision of other necessary support), and uncertainty as to whether or not the entire

hospital has a good understanding of the CSD's critical role in providing physician support. The CSD's focus was also described as "too broad". Other inadequacies noted were the lack of good substrata admin support of clinical services [e.g. clerical and logistical (to initiate & coordinate routine consumable and CEEP/MEDCASE supply requests)]; and library services. A comment was made that the way medicine is practiced in the military is changing. The current CSD structure may have been adequate in the past; however, it must now adapt to the new way of doing business. In the past, the need to extensively contract for civilian medical resources did not exist--today it does.

When asked for suggestions on how to improve the present CSD structure or suggestions for a new system, responses keyed on several different areas. One senior staffmember felt that the unit administrator concept should be considered. It would involve hiring additional military or civilian personnel to provide hands-on admin support for several clinical areas (both wards & clinics). Another staffmember believed that the CSD should have an admin section and a management section. The former could provide overall admin support to the clinical elements, while the latter could work directly with the clinics and be responsible for orchestrating their daily admin activities. Administrative Assistants, based out of the management section, could support one or more clinics each. Clinics could be clustered under Administrative Assistants, based on workload, or the number of physicians assigned. A few senior staffmembers remarked

that it would be nice to have Administrative Officers for all major department chiefs. MSC officers, NCOs and civilians were mentioned for these positions. Their work could be coordinated by the CSD. They could provide the focused (as opposed to broad) administrative support that the physician staff needs. One staffmember stated that the number of admin support personnel in the CSD needs to be doubled to adequately support the physician staff. The greater role that the CSD could play in marketing the organization, as well as marketing the positive things that it (the CSD) is doing, were also discussed. The Patient Representative's role, especially, could be broadened beyond patient complaints and Congressional inquiries to encompass community relations and customer relations. Greater involvement of the CSD in facility operations, e.g. utilization management, and the review and analysis process, was mentioned as well. Responses of other staffmembers were directed at improving library services (e.g. hours of operation, evening access, staff assistance, Medline search capability, etc.); marketing by CSD of its role to support the physicians; transferring the CSD's present contracting responsibilities to the DCA side of the house; and removing physicians from committees which could function effectively without them.

All senior staffmembers interviewed, except two, felt that physician department and service chiefs at WACH are being taken away from direct patient care duties by tasks of an administrative nature to a great extent. It was generally felt that administrative duties

are a great detractor and burden for the physicians. A good portion (although certainly not all) of their administrative tasks could be performed by others. One senior staffmember equated physician time spent in the performance of admin tasks and attending meetings with lost clinical time, and hence, lost dollars for the hospital because of decreased workload.

When senior staffmembers were asked what percentage of a physician department or service chief's time should be spent in the performance of direct patient care their responses ranged from 50% to 90%. It was noted that many variables ultimately come into play in determining how much time a chief can spend seeing patients, e.g. the size of the department or service, the span of control, how detailed the department or service quality assurance program is, how prepared chiefs want to be for committee meetings, the level of support being received from the CSD, etc. Most felt that the more time a chief could spend on direct patient care, the better. Senior staffmembers were well aware that administrative tasks are a big dissatisfier among physicians and that they reduce clinical time.

IV. DISCUSSION

General

Military and Department of Veterans' Affairs hospitals treat substantial numbers of outpatients as compared to civilian facilities, which tend to treat large numbers of inpatients. Military and DVA hospitals are therefore structured to operate much larger outpatient service departments. The typical military physician treats a few inpatients and operates a primary or specialty care clinic within the confines of a single facility. Military physicians, especially department and service chiefs, are more involved in day-to-day hospital operations than their civilian sector counterparts. This probably stems from the fact that military physicians are almost exclusively hospital-based, while civilian sector physicians are likely to maintain offices elsewhere and limit their interaction with hospitals to making rounds, performing procedures and attending required meetings. As a result, civilian sector physicians appear to have fewer administrative tasks imposed upon them. Civilian sector hospitals do not seem to have as great a need for administrative personnel to support physicians on their medical staff, although that need appears to be growing. Most physician group practices employ office managers, and many independent practitioners have secretaries, who provide any necessary administrative support outside of the hospital. Aside from being hospital-based and more involved in the day-to-day

operations of their facilities, the typical active duty physician also has impositions placed on his time by a variety of military mission-related requirements.

Originally, this study focused on the provision of administrative support to all clinical departments and services of WACH. Subsequently, the problem statement was refined and the scope of the project narrowed to cover the Clinical Support Division's administrative support to those departments and services staffed by physicians. Clinical areas excluded were the Department of Dentistry, the Department of Nursing, and the Social Work and Pharmacy Services. Each of these areas has individuals, or access to individuals, capable of providing administrative support. The Department of Dentistry has the Dental Activity's Executive Officer; a Medical Service Corps officer. Department of Nursing managers in the Ambulatory Nursing Service and the Clinical Nursing Service handle administrative matters. The Social Work Service and Pharmacy Service both have Medical Service Corps officers assigned.

Those clinical areas staffed by physicians became the focus of this project. They are the Departments of Medicine, Surgery, Primary Care & Community Medicine, Psychiatry, Radiology and Pathology (to include subordinate services). The Family Practice Service, a separate entity on WACH's organizational chart (Figure 1) is also part of the study group.

Alternatives

In arriving at a recommendation for a structure which will allow for the provision of more effective administrative support to the physician department and service chiefs at WACH, three distinct alternatives were considered. Alternative #1 involved assigning Department Managers or Administrative Directors to those departments with physician chiefs (see Figure 3). They would be responsible for the day-to-day operations of the department and serve in a supervisory role over all personnel except physicians, physician assistants and nurse practitioners. For all practical purposes, they would be managing the department for the physician chief in a fashion similar to a Radiology or Laboratory Manager in a civilian community hospital, or an Administrative Director of a clinical department in a large, civilian, university-affiliated, academic medical center. The manager or director would work directly for the physician department chief. This type of decentralized management structure is considered efficient and has its advocates.

Alternative #2 modified the current structure of the Clinical Support Division by removing its Primary Care & Specialty Care Support Branch chiefs and its four Administrative NCO positions (see Figure 4). Five civilian Administrative Assistant positions are created and substituted in their place. The role of the Administrative Assistant centers around relieving physicians of a variety of administrative tasks which detract from the provision of direct patient care, e.g. the preparation of correspondence,

communicating within and outside the department, quality assurance coordination, disaster planning, budgeting, internal control, etc., and is non-supervisory in nature. Administrative Assistants were each assigned a specific department or cluster of departments and/or services to support (see the bottom of Figure 4 and Figure 5). The Patient Appointment System section is also restructured. This alternative eliminated an entire layer of the CSD and created a leaner organizational structure capable of providing effective administrative support to the physician department and service chiefs. However, it left a structure which is perhaps too lean to respond to the needs of the DCCS and to handle complex administrative problems as they arise. The Chief, CSD, instead of dealing with two branch chiefs, must directly supervise five Administrative Assistants and the PAS Supervisor. While the addition of an NCOIC, CSD, may help in this regard, the CSD is forgoing the experience and buffer capability of the branch chiefs. The lack of branch chiefs leaves no one to replace the Chief, CSD, in his absence.

Alternative #3 removed four Primary Care & Specialty Care Support Branch-based Administrative NCO positions and replaced them with five civilian Administrative Assistant positions. It assigned each Administrative Assistant to support one or more physician department and/or service chiefs. Their role, like the role of the Administrative Assistants in Alternative #2, was intended to center around relieving the physicians of a variety of administrative tasks

which detract from the provision of direct patient care (see Figures 6 & 7).

Given these three alternatives, a determination had to be made as to which support structure would best serve WACH's physician department and service chiefs. Would drastically revamping the hospital's organizational structure and establishing Department Manager positions (Alternative #1) be best? Would modifying the Clinical Support Division, by removing its branch chief and Administrative NCO positions and substituting departmental Administrative Assistants (Alternative #2), be better? Or would leaving the branch chief layer in place and converting the Administrative NCO positions to departmental Administrative Assistant positions (Alternative #3) be the answer?

Department Managers

Introducing lay managers (Medical Service Corps officers or Department of the Army civilians) to run one or more departments each and to supervise all assigned personnel, except physicians, physician assistants and nurse practitioners, would undoubtedly disturb the status quo and meet with resistance. A turf battle between nursing and administration would likely ensue. The existing system at WACH, wherein the Ambulatory Nursing Service provides head nurses, NCOICs and corpsmen to the various services, and the CSD provides receptionists and appointment clerks, appears to be running smoothly. Creating Department Manager positions would only upset

the traditional division of labor and not directly address the real issue--making more time for physicians to concentrate on the provision of direct patient care. Managers could conceivably become so bogged down with personnel-related issues and in running the day-to-day operations of their department(s) that any real assistance to physicians would be minimal. Alternative #1 would probably work better at a larger hospital. At WACH, the departments are small and would probably not justify a GS9 or GS11 Department Manager.

However, implementing a Department Manager system would have its benefits. It would reduce the problems inherent in the matrix organization currently in place. Department personnel would still be members of the same multidisciplinary teams, only they would fall under the supervision of a single individual--the Department Manager. They would no longer have to satisfy more than one master. The existing matrix structure, where each individual has a dual (vertical & horizontal) chain of command, would be eliminated. The duties, responsibilities and reporting requirements for non-clinician personnel would become more straightforward.

Administrative Assistants

Conversely, if Administrative Assistants were employed, free of the burdens of people management and operational concerns, they could concentrate their efforts solely on handling routine administrative tasks for physicians. Administrative Assistants would not take on tasks presently being performed by clinic head

nurses, NCOICs, receptionists and appointment clerks. The presence of Administrative Assistants would allow physicians, physician assistants and nurse practitioners to devote more time to direct patient care and afford them the opportunity to maximize their productivity, analogous to a non-nurse unit manager relieving a unit's head nurse of many administrative details and allowing her to spend a greater portion of time performing nursing care. Although the proper utilization of physicians' time is the primary concern, having Administrative Assistants in place will also allow the Chief, Clinical Support Division (and his Primary and Specialty Care Support Branch chiefs, if retained) to refocus his (their) efforts and concentrate on the more complex (broader) administrative issues confronting WACH and its physicians.

Requirements

Several considerations were examined in arriving at the number of Administrative Assistants required in the modified Clinical Support Division structures depicted in Alternatives #2 & #3. The department or cluster of departments and/or services supported by each Administrative Assistant also had to be determined. First, it had to be determined if there were any departments or services which would not really benefit from the services (either full or part-time) of an Administrative Assistant? The Department of Pathology has a Laboratory Manager (Medical Service Corps officer) and an NCOIC. The Department of Radiology has an NCOIC functioning as the first line supervisor for enlisted and civilian personnel.

A second consideration involved the existing setup of the Clinical Support Division--structured to provide support along outpatient and inpatient lines. Its Primary Care Support Branch assists all areas which a patient can access without a consultation or referral: the Department of Primary Care & Community Medicine, which includes the Emergency Room and Outpatient Clinic; and the Pediatrics, Gynecology and Family Practice Clinics. Its Specialty Care Support Branch assists the Departments of Surgery (less Gynecology), Medicine (less Pediatrics), Psychiatry, Radiology and Pathology, in addition to the Community Mental Health Service. Should the assignment of Administrative Assistants follow these same lines if Alternative #2 or Alternative #3 is chosen, or strictly follow department lines, e.g. the Department of Surgery to include Gynecology, the Department of Medicine to include Pediatrics, etc.?

A third consideration involved the assignment of Administrative Assistants based strictly on the numbers of physicians, physician assistants and nurse practitioners assigned to a given department or service (see Appendix I). Should one Administrative Assistant be assigned to a department with sixteen authorized providers, while another is assigned to a department or cluster of departments and services authorized only five or six?

A fourth consideration involved the workload of the various departments and services. Should Administrative Assistants be assigned based upon overall numbers of admissions or clinic visits over a specific timeframe? If so, is there any way to account for

fluctuations in the number of providers over time in any given department or service which would account for volume increases or decreases in workload?

Qualifications

Once the desired number of Administrative Assistants has been decided, their expected qualifications must be discussed and a job description developed. Like any other administrative support structure the effectiveness and efficiency of a newly-structured Clinical Support Division at WACH will depend on the talents and abilities of the personnel assigned. Ideally, an Administrative Assistant position should not be one where the incumbent is trained on the job. As noted earlier, many Medical Service Corps lieutenants, were considered ill-equipped to serve as departmental Administrative Officers. The training of these individuals on the job, often by the physician department chief being supported, served to negate the primary reason for the Administrative Officer's presence--to allow physicians to see more patients. That, coupled with the tendency for Medical Service Corps officers to frequently change jobs, raises the question of whether they should be employed in such positions at all. It is conceivable that civilians would be better suited to Administrative Assistant positions since clinical departments would probably be better served by tenured incumbents with extensive institutional memory as well as knowledge of current operations.

Civilian sector hospital administrators and assistant administrators interviewed were in general agreement that previous experience in a hospital and good communications skills were important things to look for in a candidate for a Department Manager or Administrative Director position. However, there was no agreement as to what educational level was best. The master's degree was mentioned as the formal education standard for individuals employed as Department Managers and Administrative Directors; however, these positions entail the supervision of sizeable staffs. The Administrative Assistant positions in Alternative #2 and Alternative #3 are non-supervisory in nature. Hence, a degree at either the bachelor's or associate's level would seem adequate. Basic requirements for an Administrative Assistant position might be either a bachelor's degree with a minimum of three years hospital experience or an associate's degree with at least five years hospital experience. Preferred degree disciplines might be business administration, health administration, health services management and public administration, but other related major programs of study may be acceptable.

Job Description

The primary reason for creating Administrative Assistant positions is to relieve physician department and service chiefs of those administrative tasks which serve as detractors from the provision of direct patient care. Ideally, the Administrative Assistant job description should reflect those administrative tasks.

Structured interviews conducted with physician department and service chiefs resulted in a delineation of specific tasks which are considered detractors. These specific administrative tasks and others were grouped into several categories: general administration; communications; preparation of correspondence; quality assurance; disaster planning; budgeting; internal control; and miscellaneous. Conversations with Head Nurses and NCOICs during clinic rotations helped determine the administrative tasks which they currently perform, as well as those which their clinic physicians perform. Their responses assisted in the preparation of the Administrative Assistant job description which is found at Appendix J.

Position Classification & Grade Level

Once the Administrative Assistant job description has been written the position must be classified into a Factor Evaluation System (FES) position classification series and subsequently graded out at a specific general schedule (GS) level. Pertinent United States Office of Personnel Management FES position classification standards for review include the Health System Administrator (GS-670), Health System Specialist (GS-671), and Miscellaneous Clerk & Assistant (GS-303) series. The GS-670 series is typically reserved for individuals with the ultimate responsibility for the management of a healthcare delivery system, an individual healthcare facility, or a major sub-division of such a facility (United

States, 1979b). If Alternative #1 were to be selected and Department Manager positions created, they would probably be classified in the GS-670 series.

Since the delivery of healthcare is a complex business it requires individuals in support positions "to advise on and/or coordinate administrative policies, programs and operations". The scope of the duties and responsibilities in support positions can vary widely, ranging from the analytical to the operationally oriented (United States, 1979b). Support positions in the GS-671 Health System Specialist series require incumbents to possess:

. . . specialized knowledge of the basic principles and practices related to the management of a health care delivery system and the ability to apply this knowledge to solve the unique problems arising in the particular health care delivery system in which they serve (p. 1).

The Administrative Assistant positions require this type of "specialized knowledge"; therefore, they should be classified in the GS-671 series. The GS-303 series would not apply since it pertains only to positions that "involve specialized work for which no appropriate occupational series has been established" (United States, 1979a).

To obtain Administrative Assistants or "Health System Specialists" the GS grade level for their positions will have to be commensurate with the desired education and experience requirements mentioned earlier. The annual salary rate for GS7 ranges from

#20,195 (Step 1) to #26,252 (Step 10) and may or may not be adequate compensation for the central region of New Jersey where WACH is located. Quality Administrative Assistants could probably be better lured by GS9 positions. This level's annual salary rate ranges from #24,705 (Step 1) to #32,121 (Step 10).

Interviewing

The ultimate success of an Administrative Assistant is likely to be measured by the working relationship and rapport developed with each physician department and service chief being supported. For this reason it would be prudent for the Clinical Support Division hierarchy to involve the appropriate chief(s) in the interview and selection process for new Administrative Assistants. While a candidate's resume or application for employment can say a lot about his education and experience, only the interview can determine whether he possesses the desirable personal characteristics for the position, e.g. communication skills, business sense, and certain intellectual, interpersonal and motivational qualities. Most importantly, the chief(s) can gauge whether or not he (they) will be able to work with that individual.

Locations, Rating Scheme, Guidance & Support

Department Managers (and Administrative Directors) in civilian sector hospitals are evaluated by, and receive guidance from, superiors in their administrative chains of command. Frequently, physician directors provide input for their performance evaluations. Department Managers maintain offices in their assigned areas.

Should Alternative #2 or Alternative #3 be chosen, a decision must be made as to where in the hospital the Administrative Assistants will be located. Presently, the entire Clinical Support Division, except the PAS section and assigned personnel, is situated in WACH's headquarters wing. However, it would seem illogical to base the Administrative Assistants in this same area, when the physician department and service chiefs being supported are scattered throughout the facility. Physically basing Administrative Assistants in close proximity to one or more of the department and service chiefs being supported seems to be the ideal scenario. Even though they have no supervisory authority in the areas which they support, it is important that Administrative Assistants experience the day-to-day activities firsthand and be readily accessible to their assigned physician chiefs.

If Administrative Assistants are centrally based out of the CSD it seems logical that their performance be evaluated by its chain of command, with input from the supported physician department and service chiefs. The Primary & Specialty Care Support Branch chiefs, if retained, could be the first line raters for their respective Administrative Assistants, and the Chief, CSD, could endorse their evaluations. Or the Chief, CSD could rate all Administrative Assistants himself, and the DCCS endorse their evaluations. In either case, both levels of evaluators should request and consider input provided by supported department and service chiefs.

Whenever possible, Administrative Assistants should turn to their superior(s) in the CSD for any necessary guidance regarding administrative matters, not the physician chiefs of their assigned departments and services. When in need of typing support, Administrative Assistants should utilize the department secretary as their primary source. In the event that a department secretary position is vacant or an Administrative Assistant is assigned to a cluster of services where no secretarial positions are authorized, typing support should be obtained from either the appropriate Primary or Specialty Care Support Branch secretary, or from the CSD secretary.

Phasing In Positions

Hiring five Administrative Assistants outright and assigning them to support specific physician department and service chiefs is probably not the best way to proceed with the Clinical Support Division's restructuring. Initially, hiring just one, or perhaps two, Administrative Assistants, will allow management to observe what they are accomplishing and how they are being received by physicians. After a predetermined trial period, perhaps six months, management may want to pass judgment on the new positions. If the positions have been well-received and their incumbents are making meaningful contributions, it may prove beneficial to hire the remaining Administrative Assistants immediately. Conversely, if Administrative Assistants have failed to fulfill their intended roles, it may be desirable to abandon the concept entirely. Or

perhaps the role of the Administrative Assistant just needs greater clarification: the job description may require revision; the position grade level may have to be changed; or an assortment of other details may have to be corrected.

Other Clinical Support Division Structure Changes

With the addition of five civilian Administrative Assistants to the Clinical Support Division, suggested in Alternatives #2 & #3, the four Administrative NCO positions can be eliminated. When not vacant, they have been staffed by Personnel Specialists (MOS71L30) with neither experience in, nor knowledge of, medical facility operations. The need for a sergeant in the CSD is viewed as essential; however, that individual needs to have a medical, as opposed to a personnel, background. A Medical NCO (MOS91B30) would be ideally suited and well-equipped to handle an NCOIC, CSD position. He would serve more in an advisory/troubleshooting capacity for the Chief, CSD, than as a supervisor. Supervisory authority would likely be limited to the division secretary.

Presently, the Chief, Specialty Care Support Branch position calls for a GS7 grade level. If the Administrative Assistant positions are graded out at the GS7 level as well, and fall under the Specialty Care Support Branch, its Chief position will need to be upgraded to GS9. (However, if it is decided instead to recruit Administrative Assistants at the GS9 level, the Chief, Specialty Care Support Branch position will need to be raised to GS11). The Chief, Primary Care Support Branch is a Captain's position, on equal

footing with the Chief, Specialty Care Support Branch. A GS9 grade level, as opposed to GS7, would make them a lot more comparable as far as annual compensation is concerned.

Any restructuring of the CSD would not be complete without an examination of the PAS section and addressing the problems in the Medical Library. As presently configured the PAS Supervisor's span of control is excessive (see Figure 2). She currently supervises twenty-six medical clerks (receptionists & appointment clerks) in support of seventeen clinics, and the Master Scheduler. HSC Pamphlet 40-7-1, titled Patient Appointment System, notes that lead clerks can be appointed to assist the PAS Supervisor if the span of control is large. In WACH's situation, taking two of the GS4 Medical Clerk positions and converting them to GS5 Lead Medical Clerk (Typing) positions should prove beneficial. Each of the Lead Medical Clerks would take on first line supervisory responsibility for twelve Medical Clerks, in addition to working as a clinic receptionist or appointment clerk. The grade level of the PAS Supervisor (GS6) should be upgraded to GS7, especially if GS7 grade level Administrative Assistant positions are created. This would give the PAS Supervisor parity, as well as provide greater recognition of the vital role that she plays.

The WACH Medical Library has been operated almost single-handedly by its GS9 Librarian for the past year. The GS5 Library Technician position has been vacant the entire time. Efforts to recruit for the position have proven unsuccessful. The Medical

Library also underwent a renovation during this time, and had new shelving and carpeting installed. These factors combined to drastically reduce the number of hours that the library was open to the hospital staff and resulted in the curtailment of normally available services. It is believed that library services will improve only if the library technician position can be filled with a qualified individual on a permanent basis. Filling this position with a Medical Holding Company soldier or a summer hire may help solve the problem temporarily, but will not provide the continuity required to improve library services over the long term.

V. CONCLUSIONS & RECOMMENDATIONS

Conclusions

The problem of this study was to devise a more effective system for the provision of administrative support to the clinical departments and services at WACH. Administrative support was defined as assistance provided to WACH's physician department and service chiefs by its Clinical Support Division.

As presently structured, the Clinical Support Division is a centralized managerial and administrative support system for WACH's clinical departments and services. Adopting Alternative #1 would put Department Managers in place and create a decentralized structure. It would likely result in the abolition of the Clinical Support Division. Its Primary Care & Specialty Care Support Branch chief positions would be converted to Department Manager jobs. Receptionists and appointment clerks (medical clerks), presently under the auspices of the Patient Appointment System supervisor, would be directly managed by the departments which they support. The Ambulatory Nursing Service would also have to be abolished; with personnel in its nurse, NCOIC, corpsman and technician positions reverting to the control of various Department Managers. Whatever positive benefits had been derived from the centralized control of personnel would be lost upon the dismantling of the existing structures.

Alternatives #2 & #3 both represent middle-of-the-road approaches; centralized/decentralized arrangements. Administrative Assistants would be centrally controlled by the Clinical Support Division. Yet each day they would be physically situated in the one of the clinical departments or services being supported--working under the direction of one or more physicians.

Based upon the results of this study and their subsequent discussion, it is believed that Alternative #3 would be the most effective system for the provision of administrative support (both broad and focused) to WACH's physician department and service chiefs.

Recommendations

The following recommendations are submitted to the Commander, Walson Army Community Hospital, supporting the implementation of Alternative #3:

Recommendation #1. The Clinical Support Division (as shown in Figure 2) should be reconfigured to conform to the organizational structure depicted in Figure 6. Specific actions/requirements include:

- a. Remove the four existing Administrative NCO positions.
- b. Add five civilian Administrative Assistant positions in the Health System Specialist Series (GS-671) in the grade of GS7, with two positions based in the Primary Care Support Branch and three in the Specialty Care Support Branch.
- c. Add an NCOIC, CSD position in MOS 91B30 (Medical NCO).

d. Raise the grade level of the Chief, Specialty Care Support Branch from GS7 to GS9.

e. Raise the grade level of the Patient Appointment System (PAS) supervisor from GS6 to GS7.

f. Reduce the PAS supervisor's large span of control by converting two of the twenty-six GS4 Medical Clerk positions to GS5 Lead Medical Clerk (Typing) positions.

Recommendation #2. The Administrative Assistants should support the physician department and service chiefs as depicted in Figure 7.

One Administrative Assistant supports each of the following departments or clusters of departments and services:

a. Department of Surgery (Orthopedics, Ophthalmology, Urology, General Surgery, and Anesthesia & Operative Services) less the Gynecology Service.

b. Department of Medicine (Dermatology, General Medicine, Neurology & Cardiology Services) less the Pediatrics Service.

c. Departments of Psychiatry and Radiology.

d. Department of Primary Care & Community Medicine [Emergency Room, Outpatient Clinic, Medical Exam Section, Aviation Medicine Service, Troop Medical Clinics & the U.S. Army Health Clinic located at the Defense Personnel Support Center (DPSC) in Philadelphia, Pennsylvania].

e. Family Practice Service, Gynecology Service & Pediatrics Service.

Recommendation #3. The position job description found at Appendix J should be used to define the role of the Administrative Assistants, as well as the qualifications (knowledge, skills & experience) required.

Recommendation #4. Physician department and service chiefs being supported should be afforded the opportunity to participate in interviews with prospective candidates for their Administrative Assistant position.

Recommendation #5. Administrative Assistants should be provided offices located in close proximity to the physician department and/or service chiefs being supported, not offices located in the Clinical Support Division.

Recommendation #6. Administrative Assistants should be rated within the Clinical Support Division chain of command, with input from the supported physician department and service chiefs.

Recommendation #7. Administrative Assistants should turn to their first line supervisor (Chief, Primary Care Support Branch or Chief, Specialty Care Support Branch) or second line supervisor (Chief, Clinical Support Division), for help with administrative matters.

Recommendation #8. Administrative Assistants should utilize department secretaries as their primary source of typing support and Clinical Support Division secretaries to provide backup support.

Recommendation #9. Initially, only one or two Administrative Assistants should be hired and the viability of the new system put to the test. After a predetermined trial period a decision should be made to either proceed and hire the remaining Administrative Assistants (with or without adjustments to the aforementioned recommendations), or to abandon this concept entirely.

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FIGURE 1

ORGANIZATIONAL STRUCTURE
WALSON ARMY COMMUNITY HOSPITAL (WACH), FORT DIX, NEW JERSEY

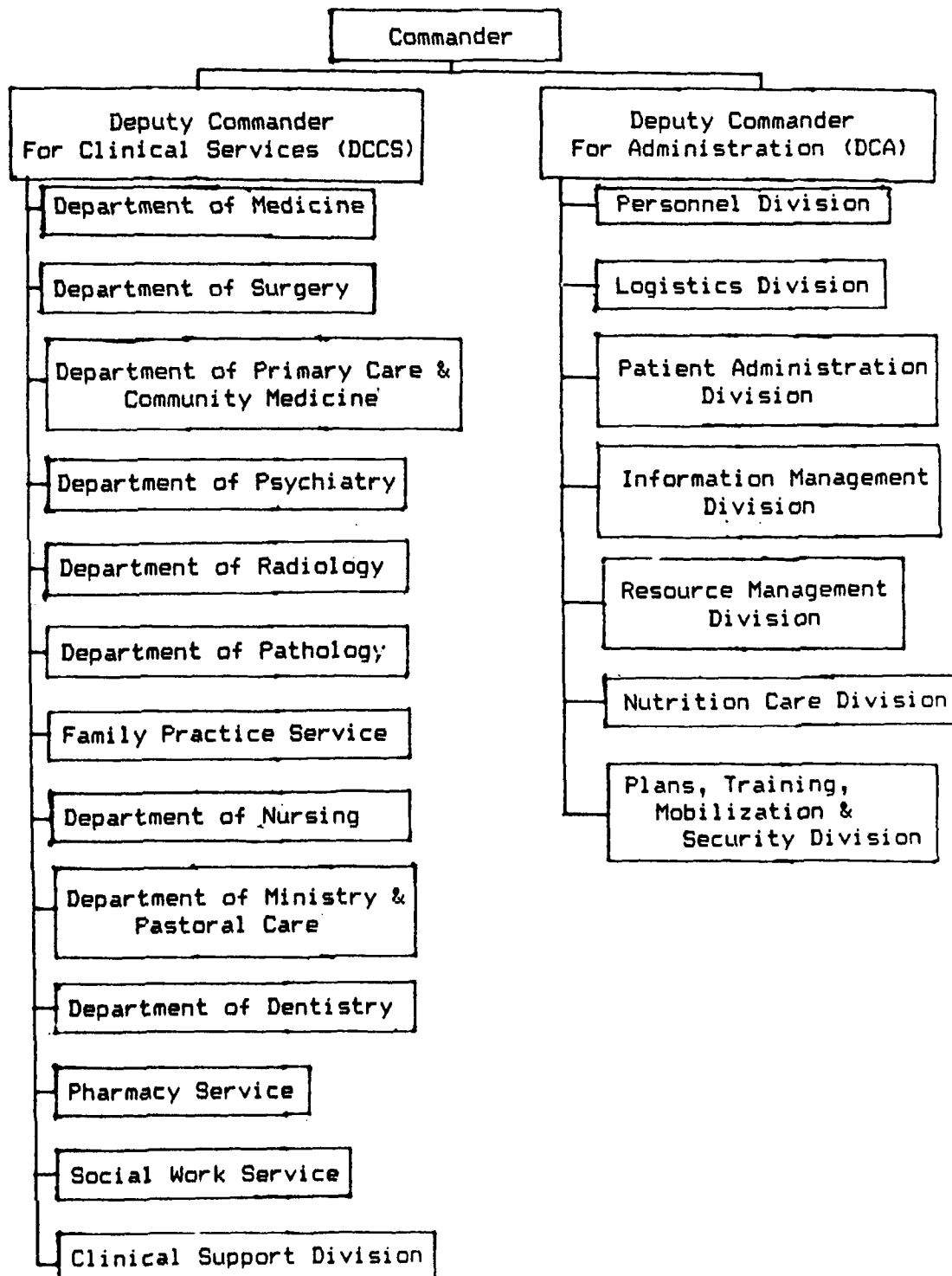
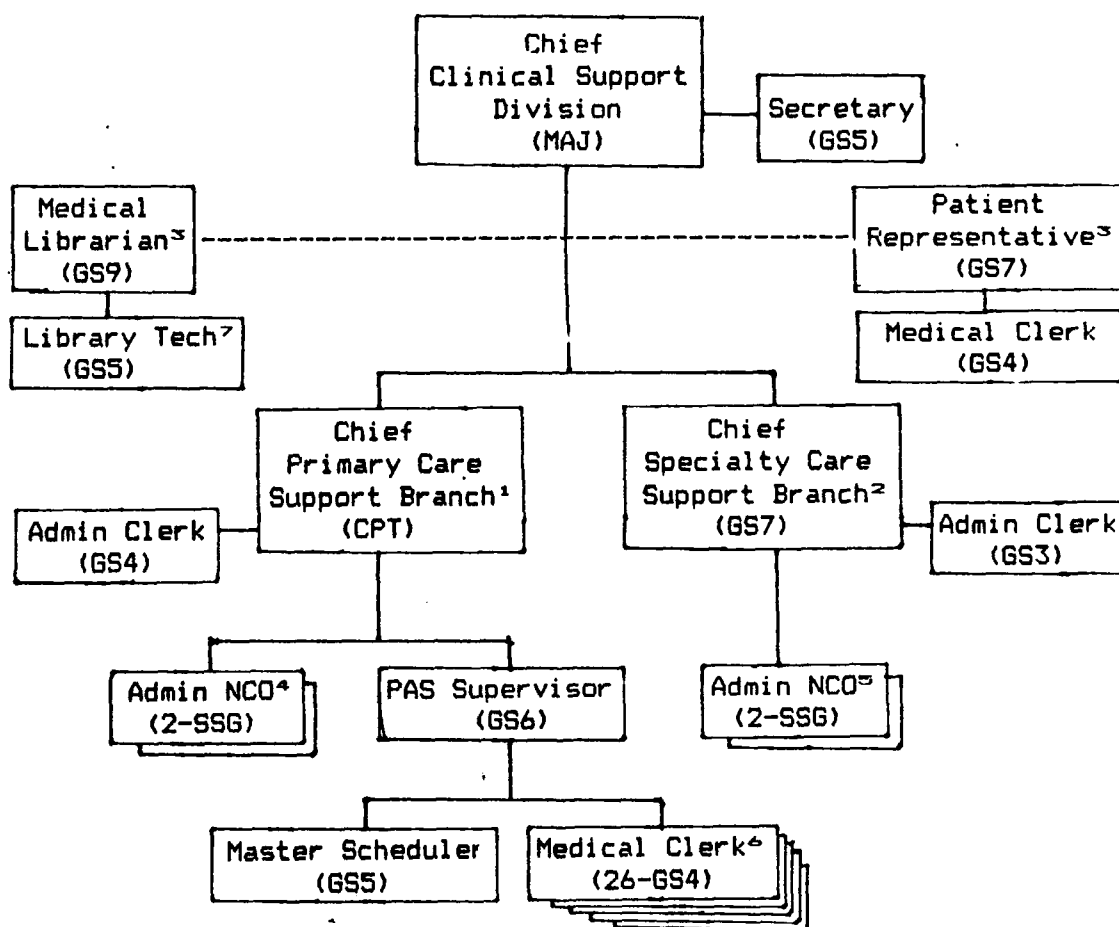


FIGURE 2

**PRESENT STRUCTURE OF THE CLINICAL SUPPORT DIVISION (CSD)
WALSON ARMY COMMUNITY HOSPITAL, FORT DIX, NEW JERSEY**

**NOTES:**

¹Supports Department of Primary Care & Community Medicine (DPCCM), Pediatrics Service, Gynecology Service & Family Practice Service.

²Supports Departments of Surgery (less GYN Service), Medicine (less Pediatrics Service), Psychiatry, Radiology & Pathology, and the Community Mental Health Service.

³Medical Library & Patient Representative Office are under the administrative and managerial control of the CSD.

⁴One position is filled with an Administrative Specialist (MOS71L) who functions as NCOIC, CSD. The second position is vacant.

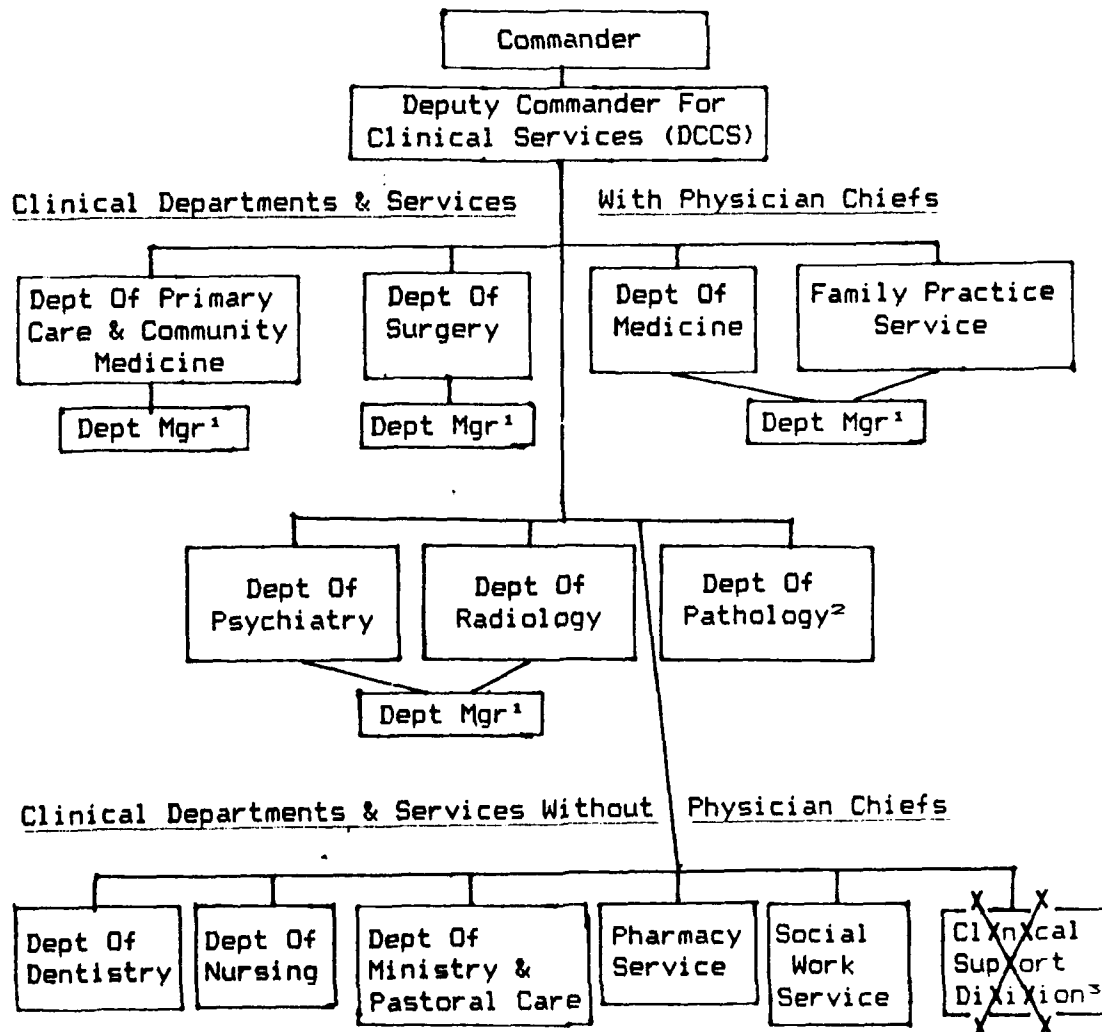
⁵One position is filled with an Administrative Specialist (MOS71L). The second position is vacant.

⁶Assigned to clinics throughout the hospital as receptionists & appointment clerks.

⁷Position is vacant.

FIGURE 3

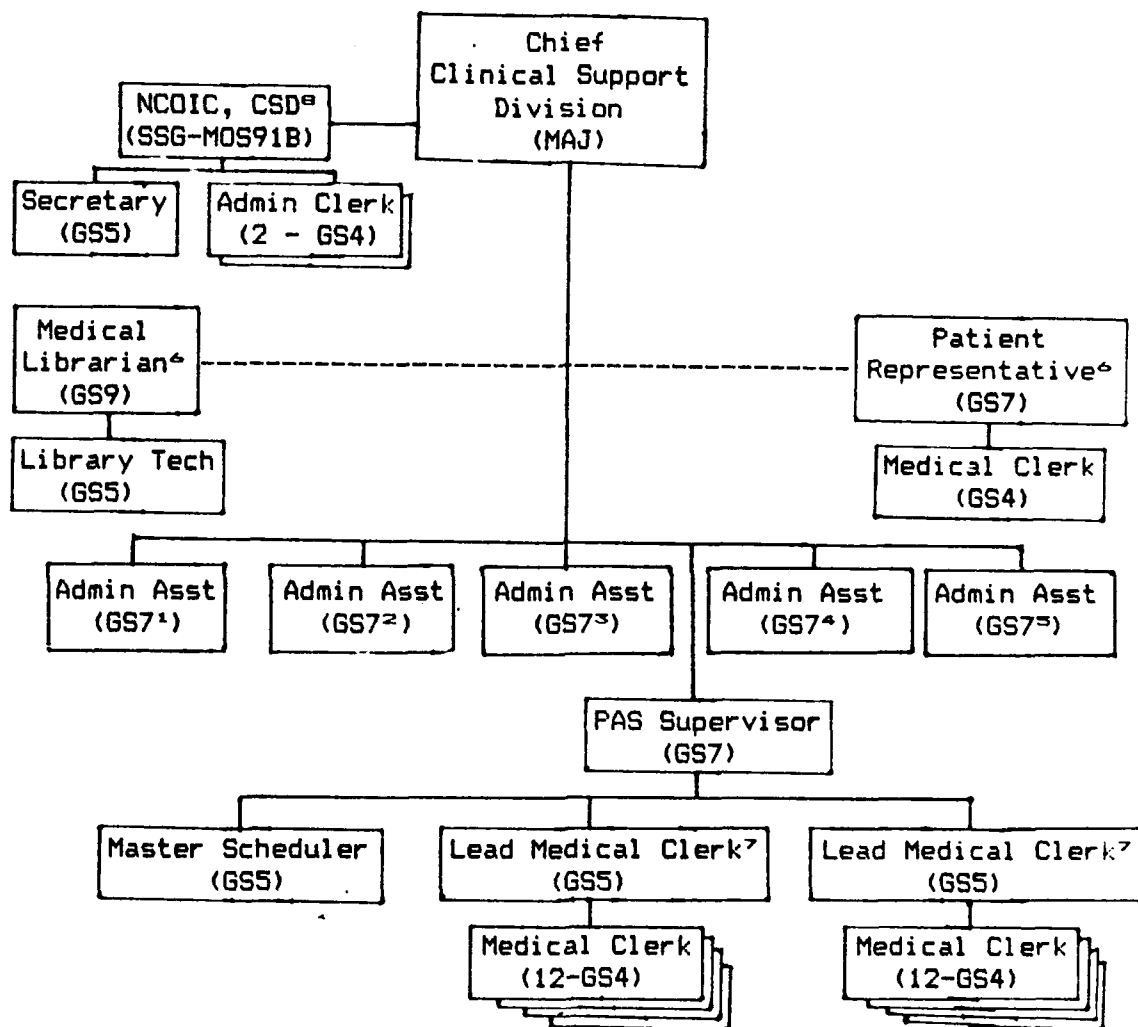
ALTERNATIVE #1
DECENTRALIZED ADMINISTRATIVE SUPPORT TO THE
CLINICAL DEPARTMENTS & SERVICES WITH PHYSICIAN CHIEFS
WALSON ARMY COMMUNITY HOSPITAL, FORT DIX, NEW JERSEY

**NOTES:**

- ¹Department Managers have supervisory authority over all secretaries, appointment clerks, receptionists, outpatient nurses, technicians & corpsmen assigned to the department/service.
- ²Laboratory Officer currently performs Department Manager role.
- ³Clinical Support Division is abolished. Patient Appointment System becomes completely decentralized to the department/service level.

FIGURE 4

ALTERNATIVE #2
MODIFIED STRUCTURE OF THE CLINICAL SUPPORT DIVISION (CSD)
WALSON ARMY COMMUNITY HOSPITAL, FORT DIX, NEW JERSEY

**NOTES:**

¹Supports Chief, Dept of Primary Care & Community Medicine.

²Supports Chief, Family Practice Svc; Chief, Pediatrics Svc (from Dept of Medicine); and Chief, GYN Svc (from Dept of Surgery).

³Supports Chief, Dept of Surgery, less GYN Svc.

⁴Supports Chief, Dept of Medicine, less Pediatric Svc.

⁵Supports Chief, Dept of Psychiatry & Chief, Dept of Radiology.

⁶Medical Library & Patient Representative Office remain under the administrative and managerial control of the CSD.

⁷Lead Medical Clerks supervise medical clerks assigned to clinics throughout the hospital as receptionists & appointment clerks.

^aNCOIC, CSD position is established. He supervises the CSD Secretary and two Admin Clerks formerly assigned to branch chiefs.

FIGURE 5

ALTERNATIVE #2
ADMINISTRATIVE ASSISTANT SUPPORT TO THE
PHYSICIAN DEPARTMENT & SERVICE CHIEFS AT
WALSON ARMY COMMUNITY HOSPITAL, FORT DIX, NEW JERSEY

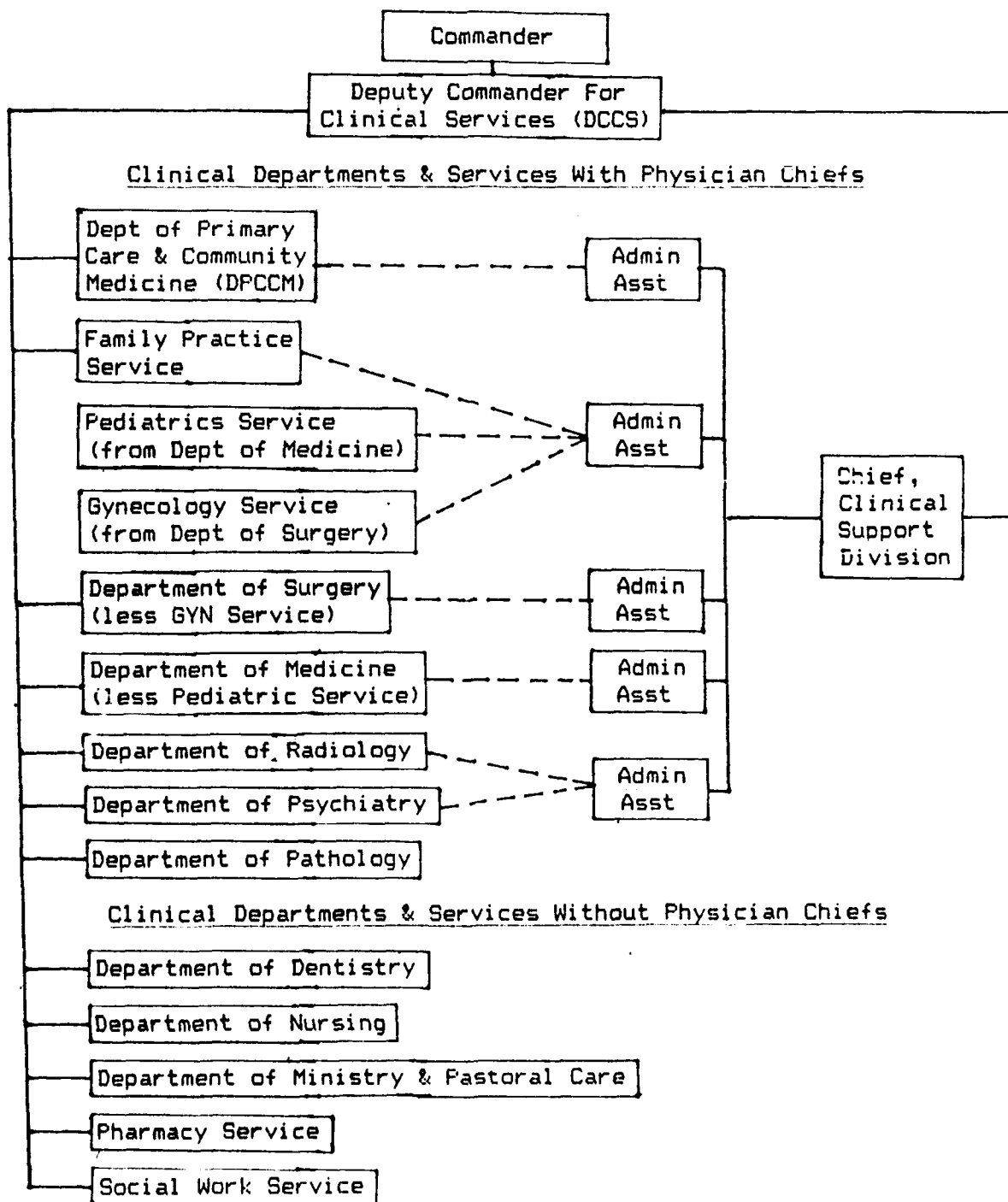
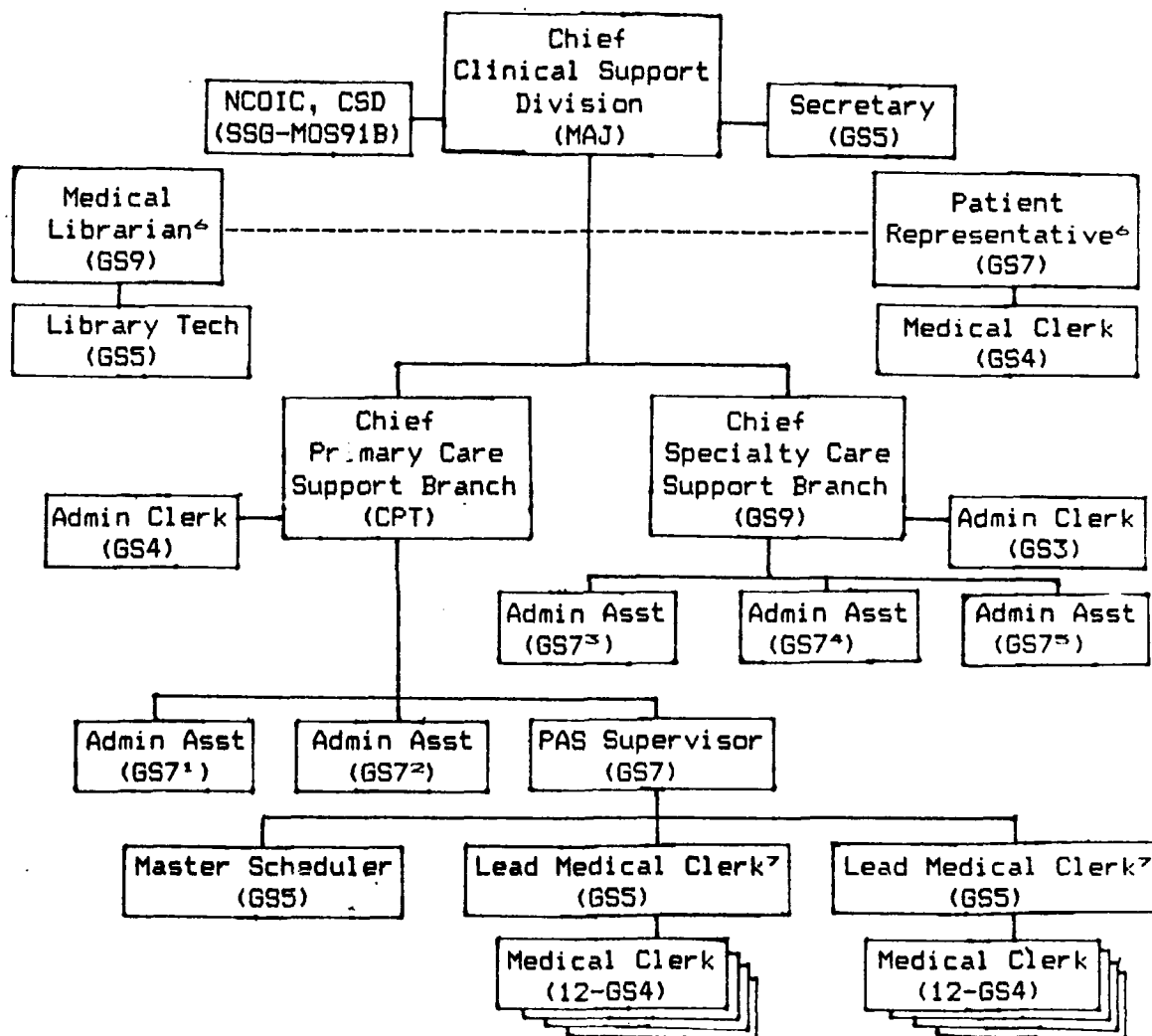


FIGURE 6

ALTERNATIVE #3
MODIFIED STRUCTURE OF THE CLINICAL SUPPORT DIVISION (CSD)
WALSON ARMY COMMUNITY HOSPITAL, FORT DIX, NEW JERSEY

**NOTES:**

¹Supports Chief, Dept of Primary Care & Community Medicine.

²Supports Chief, Family Practice Svc; Chief, Pediatrics Svc (from Dept of Medicine); and Chief, GYN Svc (from Dept of Surgery).

³Supports Chief, Dept of Surgery, less GYN Svc.

⁴Supports Chief, Dept of Medicine, less Pediatric Svc.

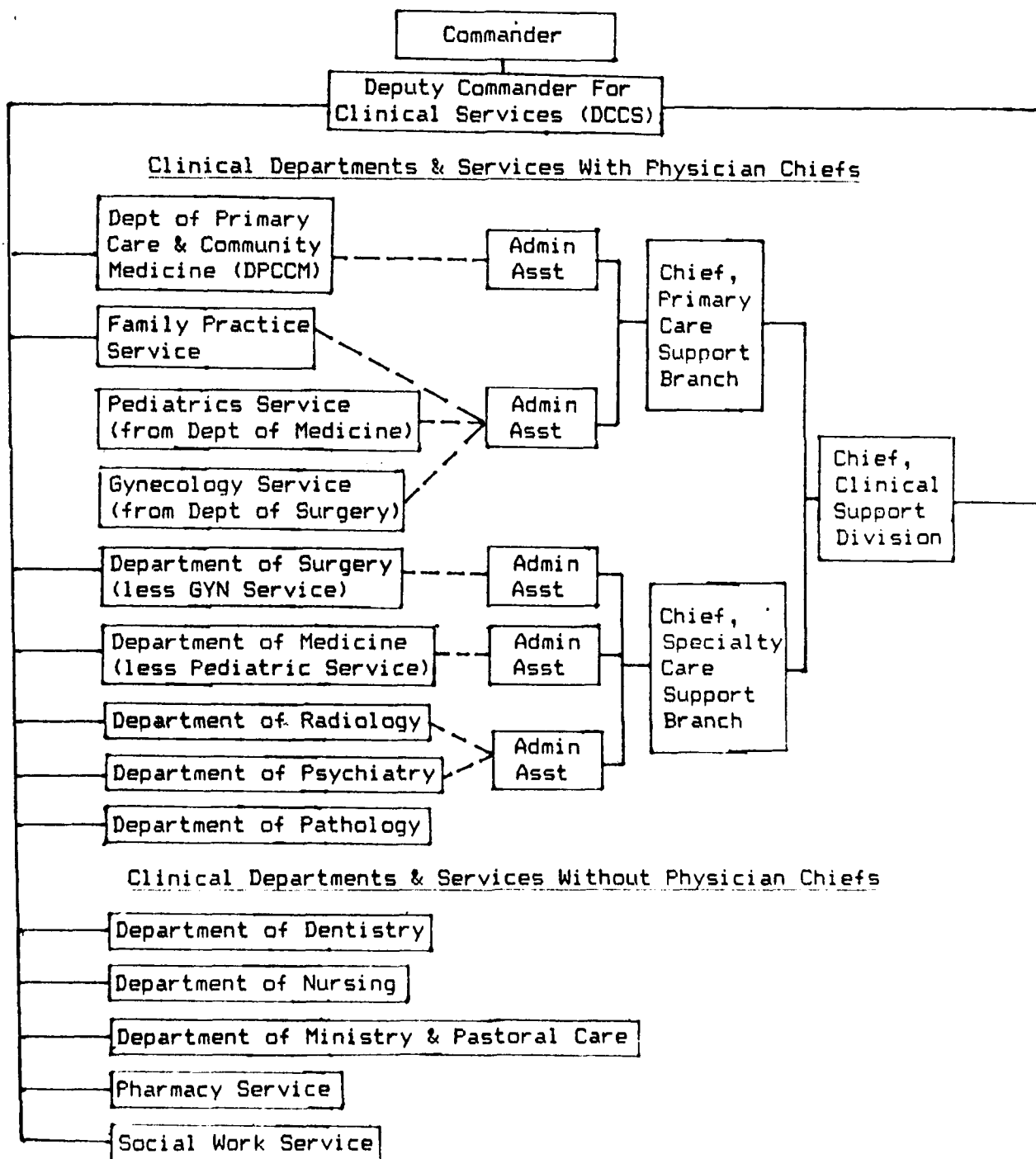
⁵Supports Chief, Dept of Psychiatry & Chief, Dept of Radiology.

⁶Medical Library & Patient Representative Office remain under the administrative and managerial control of the CSD.

⁷Lead Medical Clerks supervise medical clerks assigned to clinics throughout the hospital as receptionists & appointment clerks.

FIGURE 7

ALTERNATIVE #3
ADMINISTRATIVE ASSISTANT SUPPORT TO THE
PHYSICIAN DEPARTMENT & SERVICE CHIEFS AT
WALSON ARMY COMMUNITY HOSPITAL, FORT DIX, NEW JERSEY



APPENDIX A

STRUCTURED INTERVIEW QUESTIONSRegarding Organizational & Administrative Support Structures
At Civilian-Sector Acute Care Medical Facilities

1. Size of facility (# of beds): _____
2. Is a diagram of the facility's organizational structure available and can a copy be examined? _____
3. Does facility provide outpatient care? _____
If yes, in what areas?

4. Does facility employ physicians on a full-time, salaried basis?
_____ If yes, in what areas? _____

5. To what extent are independent physicians or physician groups contracted by the facility? _____

6. Does the facility employ a physician who serves as V.P. for Medical Affairs or Coordinator for Medical Affairs? _____
If yes, does he have a support staff? _____

7. Does the facility have a President of its Medical Staff and chiefs (directors) of its clinical departments/services? _____
If yes, how are they selected? _____

8. Do the President of the Medical Staff and the individual physician department/service chiefs (directors) have offices provided to them by the facility? _____

INTERVIEW QUESTIONS - Civilian Medical Facilities (continued)

9. Is there any type of administrative support provided to the President of the Medical Staff or the physician department/service chiefs (directors)?

10. Does the facility employ non-physician Department Administrators, Administrative Directors, Department Managers or Administrative Assistants in any of its departments or services with physician chiefs? _____

If no, go to question 11. If yes, answer the following:

In which clinical departments/services are they employed? _____

Are these individuals responsible for the administrative & personnel functions, while physician chiefs/directors are responsible for clinical activities?

Do these individuals report directly to the physician chiefs/directors or do they work for the administrator or an assistant administrator?

What are the primary duties of such individuals, as specified in their job descriptions? _____

Do these individuals have a support staff? _____ If yes, what is the size & composition of the support staff? _____

INTERVIEW QUESTIONS - Civilian Medical Facilities (continued)

11. If the facility does not use non-physician Department Administrators, Administrative Directors, Clinic Managers or Administrative Assistants in departments/services with physician chiefs, how is administrative support provided to those areas?

12. Should a non-physician, non-nurse, Department Manager position be viewed as an entry-level training type position, or one which requires an individual with previous experience (or a degree) in health care administration, business administration, or some other discipline?

13. If physician chiefs/directors are presently performing administrative tasks, what types of tasks are they and what percentage of their time is devoted to them?

14. Are the facility's physicians (as well as physician assistants and nurse practitioners, if utilized) taken from their direct patient care responsibilities to any great extent? _____

If yes, for what reasons? _____

APPENDIX B

TELEPHONE INTERVIEW QUESTIONS
For Administrators & Assistant Administrators
Of Uniformed Services & Federal Medical Treatment Facilities

Greeting: My name is CPT Richard Reale. I am the Administrative Resident at Walson Army Community Hospital, Fort Dix, New Jersey. I am working on a project to determine the most effective method for the provision of administrative support to Walson's physician department and service chiefs. Part of my project's methodology involves obtaining information regarding the administrative support systems in place at other uniformed services and federal hospitals. I would like to ask you a few questions regarding your facility and the provision of administrative support to your physician department and service chiefs/directors.

1. What is the size of your facility (* of beds)? _____
2. Is your medical staff salaried? _____
3. Are your facility's physicians (as well as physician assistants and nurse practitioners, if utilized) detracted from their direct patient care duties to any great extent? _____
 If yes, for what reasons?

4. Is there any type of administrative support provided to the physician department & service chiefs/directors? _____
 If yes, explain the support structure in place, e.g. Clinical Support Division in Army community hospitals.

5. Does your facility have non-physician Department Administrators, Administrative Directors, Department Managers or Administrative Assistants in any of its clinical departments/services? _____

If no, go to question 6. If yes, ask the following:

INTERVIEW QUESTIONS - Uniformed Services & Federal Facilities (con)

In which clinical departments/services are these positions found?

Are these individuals responsible for the administrative & personnel functions, while physician chiefs/directors are responsible for clinical activities?

Do these individuals report directly to the physician chiefs/directors or do they work for the administrator or an assistant administrator?

What are the primary duties & responsibilities of such individuals, as specified in their job descriptions?

What are the backgrounds, and education and experience levels of these individuals?

Do these individuals have a support staff? _____
If yes, what is the size & composition of such a staff?

6. If your facility does not use non-physician Department Administrators, Administrative Directors, Department Managers or Administrative Assistants in its clinical departments/services, how is administrative support provided to these areas?
-
-
-

APPENDIX C

STRUCTURED INTERVIEW QUESTIONS
For Physician Department & Service Chiefs
At Walson Army Community Hospital (WACH)

Introduction: As part of the requirements for the U.S. Army-Baylor University Graduate Program in Health Care Administration I am working on a Graduate Management Project which will recommend the most effective method for the provision of administrative support to WACH's clinical departments and services. Part of the project's methodology involves obtaining the views of clinical department and service chiefs regarding the existing administrative support system. I'd like to ask you several questions in this regard.

1. Are you familiar with the present structure of the Clinical Support Division (CSD) and how it provides support to your department/service? (Explain the provision of support by the CSD if necessary.) _____
2. Do you believe that this system is adequate? _____ If no, why not? _____

Do you have any suggestions on how to improve it? Or any suggestions for a new system? _____

3. As a Department (or Service) Chief, can you estimate the percentage of your time which is devoted to non-patient care related activities? _____
4. What specific tasks detract from your provision of direct patient care? _____
5. Do you believe, that as a Department (or Service) Chief, you are detracted from the provision of direct patient care to a greater extent than physicians (as well as physician assistants & nurse practitioners, if applicable) working in your department or service? _____

APPENDIX D

STRUCTURED INTERVIEW QUESTIONSFor Senior Physician, Nursing & Administrative Staffmembers
At Walson Army Community Hospital (WACH)

Introduction: As part of the requirements for the U.S. Army-Baylor University Graduate Program in Health Care Administration I am working on a Graduate Management Project which will recommend the most effective method for the provision of administrative support to WACH's clinical departments and services. Part of the project's methodology involves obtaining the views of senior members of WACH's physician, nursing and administrative staffs. I'd like to ask you several questions in this regard.

1. Are you familiar with the present structure of the Clinical Support Division (CSD) and how it provides administrative support to the departments and services with physician chiefs? (Explain the provision of support by the CSD if necessary).

2. Do you believe that this system is adequate? _____ If no, why not?

3. Do you have any suggestions on how to improve it? Or any suggestions for a new system?

4. To what extent do you believe that physician department & service chiefs at WACH are being detracted from their direct patient care duties by tasks of an administrative nature?

5. What percentage of their time should physician department & service chiefs be spending in the performance of direct patient care?

APPENDIX E

Civilian Sector Acute Care Medical Facilities Visited In New Jersey

<u>Facility Name</u>	<u>Location</u>	<u>* Of Beds</u>
Cooper Hospital/University Medical Center	Camden	550
Kimball Medical Center	Lakewood	354
Ocean County Medical Center Point Pleasant Division	Point Pleasant	330
South Amboy Memorial Hospital	South Amboy	161
Riverview Medical Center	Red Bank	506
Rancocas Hospital	Rancocas	318
Our Lady Of Lourdes Medical Center	Camden	375
Freehold Area Hospital	Freehold	250
Helene Fuld Medical Center	Trenton	355
West Jersey Hospital Camden Division	Camden	224
Mercer Medical Center	Trenton	344
West Jersey Hospital Voorhees Division	Voorhees	249
Community Medical Center	Toms River	460
The Medical Center At Princeton	Princeton	250
Bayshore Community Hospital	Holmdel	218
Zurbrugg Hospital	Riverside	158

APPENDIX F

Uniformed Services & Federal Medical Facilities
Contacted Regarding Physician Support System Structures

<u>Facility Name</u>	<u>Location</u>	<u># Of Beds</u>
Wood Army Community Hospital	Ft. Leonard Wood, MO	170
Martin Army Community Hospital	Ft. Benning, GA	240
Darnall Army Community Hospital	Ft. Hood, TX	263
Cutler Army Community Hospital	Ft. Devens, MA	68
Patterson Army Community Hospital	Ft. Monmouth, NJ	49
Naval Hospital Philadelphia	Philadelphia, PA	69
Naval Hospital Portsmouth	Portsmouth, VA	469
USAF Hospital	Dover, DE	20
Wright-Patterson AF Medical Ctr	Wright-Patterson AFB, OH	301
DVA Medical Center	Brooklyn, NY	571
DVA Medical Center	Philadelphia, PA	420
DVA Medical Center	East Orange, NJ	671
DVA Medical Center	Wilkes-Barre, PA	403
DVA Medical Center	Wilmington, DE	265

APPENDIX G

WACH Physician Department & Service Chiefs Interviewed

Chief, Department of Surgery

Chief, Department of Medicine

Chief, Department of Psychiatry

Chief, Department of Radiology

Chief, Family Practice Service

Chief, Orthopedic Service

Chief, General Medicine Service

Chief, Pediatric Service

Chief, Dermatology Service

APPENDIX H

WACH Senior Physician, Nursing & Administrative
Staffmembers Interviewed

Hospital Commander

Deputy Commander for Clinical Services

Deputy Commander for Administration

Chief, Department of Nursing

Assistant Chief, Department of Nursing

Chief, Ambulatory Nursing Service

Chief, Inpatient Nursing Service

Chief, Patient Administration Division

APPENDIX I

Physician, Physician Assistant & Nurse Practitioner Authorizations
Walson Army Community Hospital, Fort Dix, New Jersey

Department	--Physicians--		Physician	Nurse	Total
	Military	Civilian	Assistants	Practitioners	
SURGERY	1	-	-	-	1
Gen Surg Svc	2	-	-	-	2
GYN Svc	2	2	-	-	4
Ortho Svc	3	-	1	-	4
Opthal Svc	1	-	-	-	1
Urology Svc	1	-	-	-	1
Anes/Oper Svc	-	1	-	-	1
Total	10	3	1	-	14
MEDICINE	1	-	-	-	1
Peds Svc	3	3	-	2	8
Gen Med Svc	5	2	-	2	9
Neuro Svc	1	1	-	-	2
Cardio Svc	-	1	-	-	1
Derm Svc	1	-	-	-	1
Total	11	7	-	4	22
PC&CM	1	-	-	-	1
Outpt Clinic	4	-	-	-	4
Avia Med Svc	1	-	-	-	1
Trp Med Clin	1	-	3	-	4
Emergency Rm	3	-	-	-	3
Med Exam	-	1	-	-	1
Occup Health	-	2	-	-	2
Total	10	3	3	-	16
RADIOLOGY					
Total	3	-	-	-	3
PSYCHIATRY					
Total	2	1	-	-	3
PATHOLOGY					
Total	2	-	-	-	2
FAMILY PRACTICE SERVICE					
Total	4	-	-	-	4

NOTE: The above figures do not include contract or partnership physician positions.

APPENDIX J**Job Description**

JOB TITLE: Administrative Assistant

JOB SUMMARY: This is a multifaceted position in which the Clinical Support Division-based incumbent serves the administrative needs of one or more physician department chiefs and all subordinate service chiefs. It gives the clinical departments daily access to an individual with specialized knowledge of the basic principles and practices related to the management of health care delivery systems. The primary focus of the incumbent is to handle a variety of administrative tasks which tend to detract physicians from the provision of direct patient care and to reduce their productivity. The position is strictly administrative in nature, as opposed to managerial, since the incumbent has no supervisory authority over any members of the department(s) served.

PRINCIPAL DUTIES & RESPONSIBILITIES:

1. Administration

- a. Maintains a reference chart that reflects all position assignments of personnel working within the department (to include subordinate services).
- b. Maintains an updated file of MEDDAC regulations, policy letters, memorandums, and departmental standard operating procedures (SOPs).
- c. Regularly meets with the department chief & frequently consults with the service chiefs regarding their administrative needs.
- d. Writes and updates departmental SOPs as necessary.
- e. Ensures that the department secretary orders any necessary office supplies, publications, blank forms, and other materials.
- f. Arranges interviews for department and service chiefs with personnel applying for positions within the department.
- g. Prepares physician duty rosters.
- h. Assists with department/service preparation for Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Surveys, utilizing Accreditation Manual For Hospitals (AMH) standards and any any available scoring guidelines.

JOB DESCRIPTION - Administrative Assistant (continued)**2. Communications**

- a. Facilitates communications within the department.
- b. Assists in publicizing educational, recreational & social events within the department.
- c. Serves as a liaison between the department and other areas of the hospital, e.g. Personnel Division, Logistics Division, Information Management Division, Patient Administration Division, etc.
- d. Helps orient newly-assigned physicians to the department and explains to them the structure and role of the Clinical Support Division.
- e. Interacts with department personnel (physicians, nurses, nurse practitioners, physician assistants, enlisted, receptionists & appointment clerks) as necessary to expeditiously resolve problems.
- f. Provides advice and assistance within the department regarding administrative matters where necessary.
- g. Attempts to resolve (trouble-shoot) any problems arising that would adversely affect the operation of the department.
- h. Serves as a liaison within the department, with head nurses & service chiefs, to monitor activities and to identify and discuss plans and problems.

3. Preparation Of Correspondence

- a. Investigates and prepares draft responses to Congressional inquiries and patient complaints directed at the department.
- b. Assists physicians in the preparation of efficiency ratings or performance appraisals.
- c. Writes award recommendations for military and civilian personnel within the department when asked to do so by the department chief.
- d. Prepares draft written plans of correction for deficiencies noted during JCAHO Surveys and Inspector General (IG) inspections.
- e. Assists in the preparation and administration of new contracts or Internal Partnership Programs (IPPs) which result in non-government physicians working within the department.

JOB DESCRIPTION - Administrative Assistant (continued)

f. Assists in paperwork preparation for the renewal of existing contracts.

g. Assists department physicians in the preparation of Temporary Duty (TDY) orders and in processing their claims for reimbursement.

h. Writes letters for department physicians that deal with patients or medical activities, as requested.

i. Examines all recurring and one-time reports originating within the department before they are sent to the department chief for review/signature.

4. Quality Assurance

a. Prepares agendas for department and service Quality Assurance (QA) meetings.

b. Serves as the recorder during department and service QA meetings.

c. Monitors QA as it is accomplished within the department, ensuring that the 10-step model is being utilized.

d. Monitors department for JCAHO compliance using the latest edition of the AMH as a guide.

e. Monitors department physician compliance with hospital requirements for the timely completion of medical records (e.g. dictation of narrative summaries & operation reports), medical boards, etc.

5. Disaster Planning

a. Publishes the department recall roster for assigned physicians.

b. Ensures that the departmental disaster plan conforms with the MEDDAC's Emergency Preparedness Plan (EPP).

c. Ensures that all department members know their emergency duty station and role in the event of a mass casualty situation at the hospital.

JOB DESCRIPTION - Administrative Assistant (continued)**6. Budgeting**

- a. Maintains the department's operating budget.
- b. Monitors department variable expenses, i.e. TDY, travel, civilian overtime, expendable supplies, etc.
- c. Recommends various alternatives to increase the efficiency of department operations, indicating cost of alternatives and any savings which may result.
- d. In conjunction with department and service chiefs, investigates the need for new equipment. Prepares Capital Expense Equipment Program (CEEP) and Medical Care Support Equipment (MEDCASE) Program acquisition requests as appropriate.

7. Internal Control

- a. Ensures that effective control procedures are in place within the department for the handling of drugs, narcotics and other sensitive items.
- b. Periodically inspects department for general cleanliness, personal appearance of department personnel, physical plant deficiencies, fire & safety hazards, etc.
- c. Monitors storage, stockage levels, proper usage, and security of expendable supplies within the department.
- d. Investigates and recommends improvements in the method of delivery of health care services within the department.
- e. Ensures that department physicians are maximizing the number of appointments being scheduled. Assists in reworking schedules upon request.
- f. Compiles physician-specific productivity figures for the department chief upon request.
- g. Systematically reviews & analyzes for accuracy, the administrative work methods and operational procedures within the department for counting workload and reporting statistical data to the Patient Administration Division.
- h. Monitors department for adherence to hospital & departmental policies and procedures.

JOB DESCRIPTION - Administrative Assistant (continued)**8. Miscellaneous**

- a. Serves as the coordinator/recorder for department and service staff meetings. Consolidates and distributes all materials necessary for conducting meetings.
- b. Represents the department and/or service chiefs at meetings when requested.
- c. Assists in the planning of department continuing education seminars and inservice training programs.
- d. Assists medical students rotating through the department.
- e. Ensures that department and service bulletin boards are kept current.
- f. Coordinates the use of Red Cross volunteers within the department.
- g. Coordinates beautification of the department/service areas.
- h. Performs any additional administrative tasks deemed necessary by the department chief.

WORKING CONDITIONS:

- a. Individual works out of an office located in close proximity to one of the physician department or service chiefs being supported.
- b. Position requires communication with the medical staff, nursing personnel, other department supervisors, and members of the beneficiary population.
- c. Individual must be able to move intermittently throughout the hospital during the work day, and possess sight, hearing and speech senses that will allow him to fulfill the requirements of the position.
- d. Individual should be willing to work beyond normal duty hours, and on weekends and holidays, when necessary.

JOB DESCRIPTION - Administrative Assistant (continued)**KNOWLEDGE, SKILLS & EXPERIENCE REQUIRED:**

a. Individual must possess either a bachelor's degree and a minimum of three years hospital experience, or an associate's degree with at least five years hospital experience. Preferred degree disciplines are business administration, health administration, public administration, and health services management; however, other related major programs of study may be acceptable.

b. The ability to function independently, good planning, organizing & problem-solving skills, and the ability to communicate effectively in English, are a must.

c. The individual must also be proactive, a good listener, creative, diplomatic, assertive, action-oriented and a self-starter. In addition, the individual must possess a working knowledge of computer systems and be able to operate a word processor.