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ABSTRACT

The mission of this study was to describe the current and future roles of professional administrators, medical directors, and governing bodies of fee for service and prepay medical group practices of various sizes in such a way as to be potentially useful to health care delivery educators in curriculum evaluation and design. The position was taken that administrative roles derive from, and exist within, the total, generic complex of administration in any organization. This conceptualization led to the seven objectives of the study. Although data concerning all of the objectives are included in this report, the bulk of this document is concerned with objectives 1, 2, and 5, which are: (1) to describe and analyze administration in certain group practice forms of health care delivery, (2) to identify basic differences that occur in administration under different payment plans and under different sizes of group practices, as well as other identified factors, and (5) to describe and analyze the potential future roles of administrators in the management of group practice forms of health care delivery. Chapter headings are Methodological Approach, The Study Participants (And Nonparticipants), Generic Administration in Medical Groups, The Roles (Professional Administrator, Medical Director, and Governing Body), Effects of Size and Payment Mechanism, The Future of Health Care, Future Roles, Summary of Results, Educational Implications, and Conclusions and Recommendations. The annotated data tables consisting of all the data compiled for the final report are organized in a supplementary document. (HD)

GROUP PRACTICE ADMINISTRATION: CURRENT AND FUTURE ROLES

The Final Report
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PREFACE

The research herein reported was conducted under Contract Number NO1-MB-44176 from the Bureau of Health Manpower, Health Resources Administration, Public Health Service, United States Department of Health, Education, and Welfare to the Center for Research in Ambulatory Health Care Administration (CRAHCA). CRAHCA is a Section 501(c)3 tax exempt charitable organization as defined by the Internal Revenue Code. Founded in 1974, the purpose of CRAHCA is to improve ambulatory health care in general and group practice in particular through better administration by developing new and innovative educational, research, and demonstration programs. CRAHCA is an affiliate organization of the Medical Group Management Association (MGMA), which is a Section 501(c)6 tax exempt trade association. Founded in 1926, today MGMA is the oldest and largest membership organization representing group practice administration. The American College of Medical Group Administrators (ACMGA) is another affiliate organization, which is also a Section 501(c)6 corporation. ACMGA was founded in 1956 to provide recognition for and to promote professional advancement among group practice administrators. Through various combinations of governing boards and staff, various activities and programs are developed and implemented by MGMA/CRAHCA/ACMGA. The chief administrative staff for these organizations includes Richard V. Grant, PhD, Fred E. Graham, II, PhD, and J. Douglas Patterson, MHA.

This document is the final research report for the contract and includes the major results of the study. Appendix D contains a listing of all tabulated raw data that were delivered under this contract.

Contributions to the project by all study participants are hereby acknowledged with appreciation. Also acknowledged with appreciation are various contributions made by Leland R. Kaiser, PhD, James E. Shoemaker, and Barton H. Ghormley.

CONTENTS

CHAPTER 1

INTRODUCTION

This study was undertaken to provide some insight into the general questions, "What do administrators of group practice forms of ambulatory health care delivery currently do; that is, what are their jobs currently?" and "What might administrators of group practice forms of ambulatory health care delivery be doing in the future; that is, what might their jobs be in the future?"

The understanding and describing of the answers to these questions would seem to be a very formidable task. Many researchers have, for many years, been attempting to describe managerial jobs, to define the nature of managerial work, and to describe managerial behavior (Blake & Mouton, 1964; Campbell, Dunnette, Lawler, & Weick, 1970; Mintzberg, 1973; Simon, 1957). The results of this extensive body of research have not yielded a totally adequate method of determining or defining exactly what managers and administrators do. There is probably no one best method; the approach one takes depends greatly on the anticipated use of the results.

The goal of this report is not to develop a widely applicable model for describing managerial jobs, work, or behavior in general. While this area will not be consciously and actively avoided, it simply is not a prime objective of the study as it has been in some previous efforts. The importance of this study is to be found in the description of what administrators of medical group practices actually do. Even by limiting the efforts of the study to this one task, the problem remains sizable and complex.

The principle factor complicating the study and understanding of administration in medical group practice is the unusual organizational structure that is unique to medical group practice. On the one hand, physicians are typically the owners or principal shareholders of the medical group; while on the other hand, the same physicians are the primary operating and producing units in the group. The physician, then, wears two different hats: one hat is that of an owner when he sits on the governing body making policy decisions, and the other hat is that of a staff physician when he is involved in functioning under the daily routine of the group's operations (Towne, 1973). The professional administrator is thrust into the middle of this paradoxical situation. He must function by implementing and administrating policy concerned with management of the operational affairs of the same people who set policy in the first place (Therrell, 1972). The medical director, if the group has one, is perhaps in only a slightly better position than the professional administrator in this case. While he is a physician, and, therefore, a peer to the group's physicians, he also is concerned with implementing and administering policy to a group of people noted for their strong professional independence (Allison, 1975). It is not surprising, therefore, that administration in medical group practice oftentimes appears nonuniform, complicated, and generally confusing (at least to an outsider), and the goal of describing group practice administration would appear a formidable task.

Another factor that needs to be taken under consideration when attempting to describe and understand administration in group practice is that group practice as an industry is just now beginning to emerge. The history of group practice indicates that there have been many events and occurrences that have greatly influenced the development of groups and their administration. McFarland (1958) has written that "Most of the early groups were not consciously organized, but evolved in response to forces over which the physicians had little control (p. 16)." Two of these forces were identified by Stasel (1953) as being World Wars I and II. Stasel also identified two developments that accelerated the blooming of group practices. These developments were the medical laboratory and X-ray and the financing of health care by insurance companies. The influence of politics and governmental legislation on group practice and its administration was recognized by Clark (1973) who observed that governmental action has affected group practice by bits and pieces, causing gradual modification by group practices. Cutting (1965) has analyzed some of the important shifts in methods and philosophy that have occurred in the history of the delivery of medical care and has charted the history of the prepayment movement. Another brief historical outline of the development of health maintenance organizations has been prepared by Hamann (1973).

There have been few attempts to describe the roles of administrators in group practice probably because the origins of group practices have usually not been well documented or published. Those that have been written are usually based on personal experience (Davidson, 1954; Dean, 1964).

Two final sources of information on the history of group practice are *Group Medical Practice in the U.S., 1975* (in press) by Goodman, Bennett, and Oden and *The Organization and Development of a Medical Group Practice* (in press, by the Center for Research in Ambulatory Health Care Administration (CRAHCA). The former is an historical and statistical review of the growth of group practice, and the latter presents a comprehensive picture of the many factors that have impacted group practice since its earliest beginnings.

The historical perspective reveals that the group practice industry is emerging under the influence of

many factors that have resulted in a wide diversity within the industry. The diversity in such factors as legal structure, organizational structure, complexity of structure, kind of payment mechanism, and size of the organization complicates the study of administration considerably. In addition, because the industry is essentially in a developmental stage, group practices are changing and evolving, thus requiring administrative roles to change and evolve accordingly.

Operational Definitions

Before the mission and objectives of this study are described, it is appropriate to operationally define some terms critical to this study.

Medical Group Practice. The Medical Group Management Association's (MGMA) definition of a medical group practice was used as the working definition for this study (this definition generally corresponds with the American Medical Association's (AMA) definition of a clinic or group practice): "Medical group practice is the provision of health care services by a group of at least three licensed physicians engaged full-time in a formally organized and legally recognized entity; sharing the group's income and expenses in a systematic manner; and sharing equipment, facilities, common records, and personnel involved in both patient care and business management (Constitution of the Medical Group Management Association)."

Administration. Administration was operationally defined as the conglomeration of all tasks performed in the execution of an organization's business and public affairs—generic administration. This study was concerned only with the top levels of administration in medical group practices. In this context, the roles of professional administrators (medical group managers), physician administrators (medical directors), and governing bodies were of primary interest.

Administrative roles and tasks. A role was defined as an organized set of behaviors belonging to an identifiable office or position (Sarbin & Allen, 1968). The "organized set of behaviors" was determined empirically at the task level of detail. Tasks were the working level of activities of administrators—what administrators do.

Payment mechanism (plan). Administration in groups involved with both the fee for service and prepay payment mechanisms were studied. In addition, the study sample included some groups that had added or were in the process of adding a component of prepay payment to their existing fee for service payment, along with some groups that had settled on a mix of the two payment plans.

Sizes of group practices. The sizes of group practices were determined by the approximate number of full time equivalent (FTE) physicians in the group. For the purposes of this study, three categories of size were established and utilized: small — 3 to 15 FTE physicians; medium — 16 to 40 FTE physicians; large — 41+ FTE physicians.

Sampling units. The sampling units for the study were professional administrators, medical directors, and governing body chairpersons speaking for governing bodies as units.

Sampling variables. The sampling, or subgrouping, variables were payment mechanism (fee for service versus prepaid) and size (small versus medium versus large).

Future. The future was operationally defined as being approximately 1985.

Pattern of role interaction. Within any given group practice, some of the tasks that constitute administration typically were performed by the professional administrator, some of the tasks typically were performed by the medical director, and some of the tasks typically were performed by the governing body. This configural pattern of tasks by roles were defined as role interaction or the pattern of role interaction.

Mission of this Study

The mission of this study was to describe the current and future roles of professional administrators, medical directors, and governing bodies of fee for service and prepay medical group practices of various sizes in such a way as to be potentially useful to health care delivery educators in curriculum evaluation and design.

Scope of this Study

An overview of the scope of the endeavor can be obtained by analyzing the study's mission statement. For instance, "to describe" states that this research was considered to be investigative and descriptive in the sense that no a prion hypotheses were stated and tested. Administration in medical group practices was the subject of the study, and the focus was upon administrative tasks performed by professional administrators, medical directors, and governing bodies.

It was considered important to examine and describe current roles of administrators in order to develop a foundation based on an understanding of what currently is being done. An understanding of current roles would help in developing projections of what administrators might be doing in the future.

It was considered important to examine and predict possible future roles of administrators because of the lag times inherent in the educational process. In order for information such as developed in this study to be useful to educators, it must be somewhat predictive so that the system can evaluate the projections, analyze their implications, develop and test curricula and courses to meet the needs, and train students. Because of the time involved in this process, the qualifications of students trained, based upon today's requirements, might very well be obsolete by the time the students graduate and seek their first jobs. Of course, this argument is valid only by assuming that educators wish to be responsive to the "training" needs of practicing professionals and not simply with "educating" students.

Two variables, or sets of contrasts, were considered, a priori, important to the descriptions of administration and administrative roles. It was felt that both payment mechanism employed by group practices (fee for service versus prepayment) and sizes of the organizations would affect administration and the roles of administrators. Therefore, these two factors, size and payment mechanism, were considered independent or subgrouping variables.

Finally, although determining educational needs in terms of knowledge, skills, and abilities required to be a medical group practice administrator was not within the scope of this study, the last phrase was included in the mission statement to serve as a reminder that it should be possible to use the study's results as a basis for performing analyses that would yield educationally useful information. The study results have met this condition; they do contain information useful for educators. However, the transfer to educational needs is not direct in that knowledge, skills, and abilities are not overtly specified. The recommendation will be made that the necessary analyses to be performed on the results of this investigation in order to provide information more directly usable by the educational community.

Objectives of this Study

The administration of the group, of course, was the focus of this study. The position was taken that administrative roles derive from, and exist within, the total, generic complex of administration in any organization. This particular conceptualization led to the statement of the following objectives:

1. To describe and analyze administration in certain group practice forms of health care delivery.
2. To identify basic differences that occur in administration under different payment plans and under different sizes of group practices, as well as other identified factors.
3. To describe and analyze administrative interactions among professional administrators, medical directors, and governing bodies (boards of trustees, partnerships, committees, and so forth).
4. To identify basic differences in administrative interactions (if any are discernible) that occur under different payment plans and under different sizes of group practice.
5. To describe and analyze the potential future roles of administrators in the management of group practice forms of health care delivery.
6. To identify shifts or changes in administrative roles and in interactions among administrators as, and when, groups change from fee for service payment plans to prepay payment plans.
7. To describe and analyze basic demographic data and work histories of typical administrators of group practice.

While all of the objectives were within the scope of this effort, it was decided that trying to address each of the objectives equally might excessively dilute the final product of the study. Therefore, objectives 1, 2, and 5 were considered of primary importance and were the object of the majority of the analysis and interpretation efforts reported herein. Although data concerning all of the objectives are included in this report, the bulk of this document is concerned with objectives 1, 2, and 5. Furthermore, although roles of medical directors and governing bodies of group practices are described to some extent, the emphasis has been placed upon the examination and description of the medical group's professional administrator.

Summary of Findings

Taking into consideration both the mission and objectives of this study, the following summary of findings represents a synthesis of the study's major results. A detailed description of each conclusion is presented in Chapter 9.

1. The professional administrator is *responsible* for a majority of a group's administrative activities; but, these tasks are not usually of a high decision-making level. The professional administrator, however, significantly influences the functioning of his group by being generally *involved* in major decision- and policy-making through activities that could be labeled "persuasion" or "negotiation."

2. Professional administrators are generally highly educated and they actively pursue opportunities to increase the level of their knowledge. Professional administrators, however, have educational backgrounds that vary considerably in terms of college majors.

3. Professional administrators begin their careers in group practice administration with a wide variety of experience from many other career areas. Once in this profession, they tend to stay for long periods, usually with the same group.

4. The medical director is an unusual type of administrator. He is responsible for the least number of administrative tasks, yet he is highly involved with most of the group's administrative tasks. His principle role appears to be with the business-related medical aspects of the group and in administering to the personal and interpersonal needs of the group's physicians and other medical staff.

5. Medical directors are distributed fairly proportionately among groups of various size and payment mechanisms. Yet, only 20% of all respondent groups have a medical director. There are indications, however, that the number of medical directors will increase significantly in the future.

6. In the groups that have a medical director, the role of the governing body is most significantly affected. The medical director assumes some of the task responsibility of the governing body. The medical director also, to a lesser extent, assumes some of the professional administrator's tasks.

7. The governing body does not have the largest role in a group practice in terms of tasks for which it is responsible, but it does have the most powerful role. The

governing body approves the group's major policies and makes most of the important decisions for the group.

8. While the governing body is the highest decision-making body in a group, it is not very involved in the overall administration of a group.

9. The larger a group practice, the greater the number of administrative tasks that are performed and the fewer the number of tasks for which the professional administrator is responsible. In addition, the professional administrator is less personally involved in his group's administrative tasks the larger the group.

10. Many medium-sized group practices appear to be affected by an organizational transition period that involves a group switching from a loosely structured, very personal organization to a more structured, less personal type of business. This effect shows most clearly in the role of the medium-sized group's professional administrator who is more involved with the administrative tasks of his governing body than professional administrators of small or large groups.

11. Professional administrators in prepayment groups are responsible for more administrative tasks but less personally involved in the group's activities than are their counterparts in fee for service groups.

12. More administrative tasks are performed by prepayment groups than by fee for service groups.

13. Prepayment groups on the average have longer clinic hours, more physicians, and more satellites than fee for service groups. In addition, the professional administrator of a prepayment group has held more positions in the health care delivery field and works fewer hours than does the professional administrator of a fee for service group.

14. Administration within the prepayment groups of today resembles what administration in fee for service groups might look like in the future.

15. There is very poor agreement between administrative roles within a group as to who has chief responsibility for the group's administrative tasks. For each administrative role, however, there is a small core of tasks upon which there is high agreement.

16. The administrative tasks that the professional administrator feels are critical to his role seldom overlap the critical tasks mentioned by either the medical director or governing body. However, the critical tasks of the medical director and governing body frequently do overlap.

17. The medical director and governing body perform critical tasks that are on a higher functional level than those performed by the professional administrator.

18. The size of a group influences both the type and functional level of the professional administrator's critical tasks. The larger the group, the more that people-oriented tasks assume importance and data-oriented tasks decrease in importance. In addition, the professional administrator of a large group performs critical tasks that are on a higher functional level than those performed by small or medium-sized groups' professional administrators.

19. The majority of the professional administrator's duties are data-oriented, while the majority of the medical director's tasks are people-oriented. The medical director also performs fewer administrative tasks and spends less time on each than does the professional administrator.

20. The larger the group, the number of people-oriented tasks performed by the medical director decreases, and the number of data-oriented tasks increases. This is the opposite of the trend displayed by professional administrators.

21. Prepayment professional administrators perform more people-oriented tasks than data tasks compared to fee for service professional administrators. Prepayment medical directors perform more data-oriented tasks than people-oriented tasks compared to fee for service medical directors.

22. Based on all data, it appears that the professional administrator and the medical director have complementary roles. The professional administrator deals with the business aspects of the group while the medical director deals with the medical aspects of the group. The governing body sets policy and makes important decisions for the group.

23. In the future, group practice administrators will become more involved in tasks related to the boundary functions of the adaptive, supportive, disposal and procurement subsystems. These increased boundary functions will be necessary in order to cope with governmental regulatory bodies, consumer groups, labor unions, and prepaid purchasers of services.

24. Professional administrators will be particularly active in collecting and processing information about and from each of the following groups: regulatory information from the government, advice and opinions from consumers, grievances and demands from unions, and expectations from prepaid consumers.

25. To interact effectively with each of the groups mentioned above, professional administrators will need to increase their efforts in the areas of lobbying, public relations, and image building. These activities will assure groups and their administrators of success in their formal business relationships with their external environment.

26. Advertising, marketing, and competitive rate setting of and for services are additional activities that will become the administrator's responsibility with the increase in prepayment. These activities will have to be carefully balanced and adjusted to the constraints and expectations of union member employees, the government, and the public at large. This balancing and adjusting will require the professional administrator to become an even more skilled mediator with the courage to lead and set directions for these multiple groups.

27. Prepayment will involve administrators in service contract negotiation, in concerns for enrollment activities, and continued concern with patient satisfaction. The professional administrator will be involved in resolving patient-physician conflicts in the interests of high prepaid group membership. These negotiating and conflict-resolving activities will, at all times, need to be carefully done in the light of government regulations and expectations from union employees.

28. Above all, the increasing importance of the

interaction at the boundary between groups and their environments, will require professional administrators to make adjustments in the internally focussed subsystems, the maintenance and the managerial subsystems.

29. Internal information gathering, maintaining, and processing systems will need to be developed to cope with the capitation rate setting required for prepayment, the record keeping and reporting expected by the government, and the compliance required by labor union contracts.

30. These information-gathering and -processing functions will also be required to monitor the concerns of the group's employees and physicians, as well as its constituent consumer groups. The professional administrator will be required to know how to collect, analyze, and use the information effectively.

31. Professional administrators will have to recognize and address the increasing specification of job and role responsibilities required in order to meet government regulatory and labor union contractual requirements.

32. The increasing importance of the external environment, the needs for information, and the increasing requirement for clarification of responsibilities will require professional administrators and their groups to become more significantly involved in planning—both in the short run and in the long term.

33. This same convergence of significant boundary relationships and consequent internal changes will require the administrator to delegate more responsibilities to specially trained assistants and subordinates.

34. Finally, the shifting of responsibilities will bring the medical director in the group practice setting into a more significant role with more tasks and greater involvement.

CHAPTER 2

METHODOLOGICAL APPROACH

The study of current roles was initially conducted separately from the study of future roles; the methods employed were entirely different. Therefore, data collected during the initial phases of each study were totally independent of each other. The two "tracks" were merged at a critical point toward the end of the investigation to yield a synthesis of the data and projections of the future of group practice administration. It was hoped that this approach might lend validity and strength to the projections. In other words, by maintaining independence in the beginning and synthesizing only toward the end, neither method was confounded by the other nor prejudiced toward any particular outcome—the methodologies did not bias the projections.

Current Roles Methodology

Empirical methods were used to develop the basic description of generic administration in medical group practices. Administrative task statements were systematically solicited from, and evaluated by, practicing medical group administrators. By methods described in more detail in Chapter 4, the statements of administrative tasks were refined and synthesized into a relatively complete but parsimonious "Standard List of Administrative Tasks." The list was "standard" because it contained tasks performed by all of the sampling units of interest in the study; it was, therefore, a common (or standard) list of administrative tasks.

The standard list served two purposes. First, it represented the most basic, generalized statement of administration in medical group practices—it was the description of generic administration. Second, by incorporating it into a questionnaire that was mailed to professional administrators, medical directors, and governing body chairpersons, it served as the basis for a measuring instrument or index. The administration of the instrument yielded empirical data that: (a) enhanced the generic description; (b) differentiated among the roles of the administrators of interest (the sampling units); and, (c) measured the relationships among the sampling variables (size and payment mechanism), administration, and administrative roles.

A select number of time/activity logs and site visit interviews were employed as additional methodologies. The data from these techniques were used to support and enrich the descriptions based upon the task list and questionnaires.

The Future of Health Care Methodology

Before future roles, per se, of group practice administrators were investigated, an intervening step was necessary. Administrative roles exist in and are impacted by a host of situational and environmental variables. It was necessary, therefore, to control for, or at least specify the situational and environmental conditions upon which the roles are dependent, and from which the role descriptions were made. This intervening step, then, involved the investigation and specification of aspects of the future of health care that might impact the roles of group practice administrators.

The investigation into the future of health care was accomplished in several ways. Three Nominal Groups (Delbecq & Van de Ven, 1971; Delbecq, Van de Ven, & Gustafson, 1975; Van de Ven & Delbecq, 1972) were conducted using the future of health care relevant to group practice administration as the target topic. Nine interviews were conducted with experts, leaders and policy-makers, and seers and futurists in the health care and related fields. In addition, the data from two Delphi (Dalkey, 1972) studies of the future of health care, conducted under different studies, were incorporated into this investigation. Finally, through a procedure explained in detail in Chapter 7, data from the Nominal Groups, from the Delphis, and from the interviews were synthesized into several scenarios that specified possible alternative health care futures.

The Future Roles Methodologies

The scenarios developed as an output of the health care future investigation were very important to the future roles study since the scenarios served as a foundation or framework within which the description of future roles were structured. Two methodologies were used to project future administrative roles from the future of health care. It was within these two methodologies that the merging of the two "tracks," the study of current roles and the study of future roles, occurred. In one method, three difference summaries of the future scenarios were developed and served as the intervening condition in a pre-post design. Fifteen professional administrators who had already completed the study's survey questionnaire were asked to "retake" the questionnaire after reading one of the scenarios. The second method used to project future administrative roles was a staff analysis. The project staff participated in reviews of the current roles data and of the health care future data. By group analysis and discussion, the impact of the health care future data upon the current roles descriptions was assessed to produce projected future administrative roles.

CHAPTER 3

THE STUDY PARTICIPANTS (AND NONPARTICIPANTS)

Meaningful generalizations of this study's findings and of its recommendations for the administration of group practices should be based on the fact that the study participants are truly representative of the entire MGMA membership. To illustrate this, eight demographic variables which were available for the entire MGMA membership, study respondents as well as nonrespondents, were selected for descriptive and comparative purposes. These variables encompass two major attribute domains—the personal attributes of the administrator and his group's characteristics. Included among the administrator's personal attributes are sex, average age, and average educational level. The characteristics of the administrators' groups are geographic distribution of the groups by section; size of the groups, as defined by the number of physicians and nonphysician employees in the groups; legal organization of the groups; number of satellite clinics attached to the groups; and whether or not the groups have medical directors. These variables and the appropriate statistics for each are presented in Table 3-1 for the entire MGMA membership, the study respondents, and the nonrespondents.

TABLE 3-1

MEANS AND PERCENTAGES OF PROFESSIONAL ADMINISTRATORS' CHARACTERISTICS WITH SIGNIFICANCE TESTS BETWEEN NONRESPONDENTS, STUDY RESPONDENTS AND THE MGMA MEMBERSHIP

Variable	Nonrespondent	Study Participants	MGMA Membership	Significance Tests	
				Respondent vs. Respondent	Respondent vs. MGMA Membership
Sex				N.S.	N.S.
Male	86%	89%	88%		
Female	14%	11%	12%		
Mean Age	47.0	44.0	44.0	$p<.003$	N.S.
Mean Educational Level	—	15.8	15.6	—	N.S.
Mean Size				N.S.	N.S.
Physicians	20.3	17.8	18.4		
Employees	56.0	57.4	57.2		
Mean Number of Satellites	.39	.43	.33	N.S.	N.S.
Medical Director				N.S.	N.S.
Yes	23%	20%	24%		
No	77%	80%	76%		
Type of Organization				N.S.	N.S.
Association	7%	7%	9%		
Business Trust	1%	0%	1%		
Corporation	48%	55%	46%		
Foundation	0%	1%	1%		
Partnership	34%	35%	37%		
Sole Proprietorship	3%	0%	2%		
Other	5%	2%	4%		
Section				N.S.	N.S.
Western	28%	26%	28%		
Midwestern	25%	32%	28%		
Eastern	15%	14%	16%		
Southern	31%	27%	28%		

Demographic Description of the MGMA Membership

Descriptive information on the MGMA membership's personal and group characteristics was obtained from information in the *International Directory of the MGMA, 1974-1975* and from the MGMA data base. Emerging from these sources is a profile of the typical MGMA member—a professional, male administrator (88% of all professional administrators are male) approximately 44 years of age who has attended an average of 15.6 years of school.

The attribute profile of the groups represented by MGMA members indicates that the groups are located proportionately throughout the continental United States, with the Western, Midwestern, and Southern sections of MGMA each containing 28% of the total number of groups. Only the Eastern section, with 16% of the membership, is disproportionate with the other sections. The average size of MGMA groups, based on the number of physicians in each, is 18.4 physicians per group. The average number of non-physician employees in each group is 57.2. MGMA groups, therefore, have a proportion of 3.2 employees for each physician.

Six organizational types were employed to differentiate the various legal structures groups use for providing professional services. Forty-six percent (46%) of MGMA groups have a corporate form of organization. The other organizational types in descending order of their occurrence are: partnerships, 37%; associations, 9%; sole proprietorships, 2%; and business trusts and foundations, each with 1%. Miscellaneous forms of organization account for the remaining 4%. On the average, there are .33 satellite clinics for each group having a member in MGMA. Finally, 76% of the membership reported that they do not have formally designated medical directors within their groups.

The biographic and demographic variables outlined above form a partial attribute description of the MGMA membership and their groups. Using these same variables, it is possible to compare the study respondents to the entire MGMA membership of professional administrators. Failure to demonstrate that the study respondents are representative of the entire MGMA membership would cast serious doubt on the implications of the study's findings and its conclusions for the MGMA membership.

Comparison of Study Respondents to the MGMA Membership

The total population selected for study was the MGMA American membership as of November, 1975. At that time, there were 1,216 active members within the continental United States. The survey questionnaire was mailed to each of these members, along with survey questionnaires for medical directors and for governing body chairpersons. The latter questionnaires were mailed with the professional administrator's surveys because of a lack of reliable information concerning the existence of medical director and chairperson positions in all of the groups. In the survey cover letter (Appendix A), each professional administrator was requested to deliver the enclosed questionnaires to the appropriate respondents if possible.

The final response rate of usable questionnaires from professional administrators was 583 or 47.9% of the total MGMA membership. A total of 106 questionnaires were completed by medical directors. Although information on the absolute number of medical directors in MGMA represented groups is somewhat incomplete, an estimate based on the number of medical directors listed in the *International Directory* indicates that 36% of all medical directors responded to the survey. A total of 237 questionnaires were returned by governing body chairpersons. Again, due to the variety of organizational structures found in group practices, the actual number of chairpersons is not precisely known. Based on the total number of groups to which the survey was sent, the return rate of 237 governing body chairperson questionnaires would constitute 19.5% of the total population; however, this figure is probably based on an overestimate of the true number of governing body chairpersons. For a further numerical breakdown of type of respondents by group, the reader is referred to Appendix B, Table B-1.

A comparison of the figures presented in Table 3-1 for the study participants and the MGMA membership indicates that the two groups are highly similar in all eight comparison variables. Tests of significance for each variable did not produce any statistical differences between the two groups. Based on this information, it can be concluded that, in terms of the eight descriptive variables, the study participants are a representative sample of MGMA's membership.

Additional Description of Study Participants

A descriptive profile of the study participants would not be complete without additional information relevant to their educations, career development patterns, and other selected biographical and organizational characteristics.

Within the respondent sample, 78% of the professional administrators have a bachelor degree or higher. Twenty-seven (27%) of the professional administrators with bachelor degrees also have earned graduate degrees. Of the 22% who have less than a bachelor degree, a total of 73% have attended one to four years of college.

The undergraduate major most frequently mentioned by professional administrators with bachelor degrees is in the field of business or public administration. This major accounts for 34% of all undergraduate degrees. Accounting and economics are the second most mentioned majors for professional administrators, with 18% and 7% respectively. The remaining 41% is distributed among a wide variety of possible college

majors including health care administration, education, liberal arts, the physical sciences, political sciences, psychology, and many others.

The most represented major for professional administrators holding graduate degrees is health services administration. This degree accounts for 39% of all degrees higher than a bachelor-degree. Business administration is the next most frequently obtained graduate degree, accounting for 30% of all graduate majors listed. A third significant category of graduate majors is accounting and economics. Nine percent (9%) of the professional administrators received their graduate degrees in one of these two majors.

Eight percent (8%) of the total number of study participants indicated that they are presently working toward an advanced degree. Bachelor degrees account for 35% of this total and the remaining 65% are graduate degrees. A general conclusion regarding the education of professional administrators is that while they have obtained a high level of education, their educational backgrounds are not focused in any one area. Rather, professional administrators pursue educational training throughout a wide variety of college majors.

As the professional administrator has a varied educational background, so, too, does he have a varied background in work experience. The field of health care administration has not always been a first choice in the professional administrator's career. Of all job titles ever held by the study participants, only 57% were in the health care field. Twenty-three percent (23%) of the participants' former jobs were in a service type field; 13% were in manufacturing or retail areas; and 7% were in governmental positions.

The approximate number of positions held in the field of health care administration during the career of the typical study participant is two. Many of these positions have been within the same group. In addition, less than 53% of the professional administrators have had more than one title or position in health care administration. This tends to support the popular hypothesis that there is little transfer of administrative staff between group practices.

Study participants have held positions in the health care administration field for an average of 11 years. The typical professional administrator did not enter this field until an average of seven years after receiving his highest degree; however, 31% of the study participants went directly into health care administration at the conclusion of their formal schooling. It would appear that many professional administrators bring to the field of health care administration a wide variety of professional experience in addition to varied educational backgrounds. The professional administrator's education and experience must certainly influence the administrative functions of health care delivery, and conversely, the particular demands of health care administration must require adaptation on the part of the professional administrator.

The professional administrator's position in a group practice is analogous in some respects to positions held by managers at the top of the management hierarchy in general industry. The professional administrator spends an average of six and one half hours per week at his job beyond the traditional 40 hours week. Sixty-one percent (61%) of the study participants indicated that they are responsible only to the group's board of directors or chairperson. Among 60% of the study participants, fiscal responsibility for the group's major capital expenditures is either the main concern of the professional administrator alone or is shared with others. In 85% of the groups, the professional administrator has primary fiscal responsibility for all supplies and other maintenance needs related to his group.

One point of departure between the professional administrator's position and the administrator in industry is the degree to which the professional administrator is involved in the personal business affairs of the group's physicians. Almost 50% of the study participants indicated that they are involved "often" or to a "great deal" in the private business affairs of the group's physicians. Furthermore, only 25% of the study participants have their official duties or authority defined for them in a written job description.

The expanding growth rate among group practices is demonstrated by the 66% of the study participants who responded that their groups are growing in size; 31% indicated that their groups are remaining stable in size; and only 2% replied that their groups are decreasing in size. A total of 83% of the study participants indicated that their groups have no operational prepayment plans in existence. Of the remaining 17%, the average proportion of revenue generated by prepayment as opposed to fee for service revenues is 30%.

On the average, the participant groups offer full service 48 hours per week. The normal working hours for most groups are eight hours daily, Monday through Friday, half day on Saturday, closed on Sunday. Approximately 65% of the groups provide limited service hours in addition to their regular hours.

The average group in the study sees approximately 240 patients a day. This patient load is expressed in terms of outpatient load only. Considering that the average number physicians per group is slightly over 17, the average physician is able to see and treat approximately 14 patients a day. A final organizational characteristic of the groups of study participants is the number of branch clinics or satellites associated with each group. Twenty-five percent (25%) of the groups reported that they have satellites; the modal number was one per group. The most satellites reported by any one group was 10.

Nonrespondents

The nonrespondent population were those administrators who failed to complete and return the survey questionnaire. To describe this population, a random sample of 100 respondents was selected from the study's mailing list and descriptive characteristics for each were obtained from the *International Directory, 1974-1975*. It was not possible to obtain the necessary information on

each of the first 100 nonrespondents. Among the reasons for this was that many administrators have joined MGMA since the last update of the *Directory*; consequently, not all the nonrespondent professional administrators were listed. Secondly, while some nonrespondent professional administrators were listed in the *Directory*, there was no accompanying descriptive information for them or their groups. This situation occurs because the *Directory* is dependent upon each administrator to provide the necessary biographic and demographic data.

The process of randomly selecting nonrespondents was continued until a total of 100 were found for whom available information was usable. Table 3-1 contains the nonrespondent data according to the eight descriptive variables which describe the total MGMA membership and the study participants. Because neither the *International Directory* nor the MGMA data base contain information on average educational level of the nonrespondents), this data was not included in Table 3-1.

Comparisons between the nonrespondents and the study participants indicate that the two groups do not differ significantly in the sex of the member. The majority of the nonrespondents are male. The only significant difference between the two groups is the average age of the professional administrator. The nonrespondents represent an average age of 47, which is three years older than the study respondents. While this difference is not great, it was statistically significant and thus deserves close attention. One possible explanation for the difference in age might be that older professional administrators are more indifferent or skeptical of the possible benefits to be derived from survey results and, therefore, failed to participate in the study.

The characteristics of the nonrespondent groups vary only slightly from those of the study participants. Nonrespondent groups typically contain an average of .20 physicians and 56 nonphysician employees, a ratio of 2.8 employees for each physician. The nonrespondent groups have an average of .39 satellite clinics and only 23% have a medical director in the group.

The types of legal organization for nonrespondent groups reflect basically the same proportions as do those of study participants. There appears, however, to be slightly fewer corporations and more sole proprietorships. The greatest difference between nonrespondents and participants in terms of their section location is within the Midwestern section, where there are proportionately fewer nonrespondents than in any of the other sections.

CHAPTER 4

GENERIC ADMINISTRATION IN MEDICAL GROUP PRACTICES

Generic administration has been operationally defined as the conglomeration of all tasks performed in the execution of an organization's business and public affairs. Generic administration was operationalized for the purpose of this study as being made up of a set of tasks. This research was directed toward administration in medical group practices, and, furthermore, focused upon the administrative roles of professional administrators, medical directors, and governing bodies in fee for service and prepaid group practices of various sizes. Obviously, in many groups, administration involves many more people than simply the professional administrator, medical director, and governing body; however, this research was scoped to include only what was considered to be the three top levels or echelons of administration.

In order to describe generic administration, then, this study had to define and specify administrative tasks performed by professional administrators, medical directors, and governing bodies of fee for service and prepaid medical groups of various sizes. Because of the importance of this objective to the study, the manner in which the generic administrative tasks were developed was also important. Mintzberg (1973), in commenting on the inadequacies of prior research into the nature of managerial work, emphasized the importance of the development of the list of task statements.

> In assessing the reasons for this one can conclude that the important inductive research was done, not in the filling out of questionnaires or in the factor analysis, but in the development of the list of statements in the first place. For it was here that the researchers constrained their findings. Any important elements of managerial work inadvertently excluded at this point could not reappear later. From this point on, the studies simply *weighted* given job elements. It is surprising, therefore, that these researchers gave so little attention in their reports to the choice of statements, and so much to the routine mathematical manipulations of data (pp. 214-215).

In his study, Mintzberg solved the above problem by using direct observational data collection techniques instead of relying on a list of pre-established statements. Resource limitation of this project precluded the use of direct observation. However, Mintzberg's comments were heeded, and although the present study's approach was not as definitive as was Mintzberg's, the problem was addressed. The present study gave a good deal of attention to the development of task statements.

The Empirical Development of Administrative Task Statements

An empirical approach was taken to the specification of the generic administrative tasks. Rather than develop the administrative task statements a priori, practicing medical group administrators were asked to provide statements of what they do. Two sets of nine group practice administrators, each set including professional administrators, medical directors, and governing body chairpersons (speaking for the governing body as an entity), were recruited and asked to list tasks that they (or the governing body) perform in their jobs as administrators.

This activity was structured differently for the participants of each of the two groups. One group was asked simply to write as many task statements as they could think of on 3 x 5 index cards. The other group was asked to maintain, for a two-week period, a time/activity log of administrative tasks performed during the day.

The participating administrators wrote approximately 425 task statements. Some of the statements were duplications and some were variations of others. After some minor initial processing by the project staff, primarily to eliminate obvious duplication, a third, independent group of administrators evaluated the list for the understandability of each statement and for the comprehensiveness of the list.

The evaluation and resulting revisions yielded a list that contained approximately 350 discrete task statements, with each task being performed by at least one medical group administrator. Some duplication and overlap still existed among the statements, but it was difficult to revise the list because the statements were discrete and disorganized. There was not a systematic method of evaluating the overlap among the items of the comprehensiveness of the list. Therefore, several attempts were made to judgmentally construct a typology of the task statements to guide the further refinement of the list. The typology found to be the cleanest and most useful was one developed in an open systems context by Katz and Kahn (1966).

Construction of the Standard List of Administrative Tasks Using the Katz and Kahn Model

The Katz and Katz typology derives from a system theory of organizations. According to this system approach, the functioning of organizations can be described with respect to five basic subsystems:

> (1) production subsystems concerned with the work that gets done; (2) supportive subsystems of procurement, disposal, and institutional relations; (3), maintenance subsystems for tying people into their functional roles; (4) adaptive subsystems, concerned with organizational change; (5) managerial systems for the direction, adjudication, and control of the many subsystems and activities of the structure (p. 39).

Robert F. Allison (1975) and Allison, Dowling, and Munson (1975) previously have used the Katz and Kahn model in the only other empirical role studies directly related to health care administration published to date. Allison and his colleagues conceptualized the subsystems as identifying broad categories of organizational activities required by open systems. Using the categories as guides, individual organizational activities were specified by drawing upon prior research for most of the items. The resultant "Standard List of 46 Organizational Activities" was used to specify administrative roles by allowing respondents "to indicate which of the 46 organizational activities were relevant to their roles (Allison et al., 1975, p. 161)."

The use of the Katz and Kahn model was slightly different in this study. Rather than begin with the theoretical framework and then develop a list of organizational activities as did Allison and his colleagues, this study first empirically developed statements of administrative tasks independently of a theoretical framework and then used a framework to refine the statements into a standard list. For purposes of clarification for this project, the five Katz and Kahn subsystems were expanded into the following seven subsystems with interpretations of the functions of each:

1. *Production* subsystem, whose function is to produce some product or to perform some service.
2. *Maintenance* subsystem maintains stability within the organization and mediates between task demands and human needs.
3. *Boundary/Production Supportive—Procurement* subsystem obtains (and retains) raw materials; obtains supplies, equipment, plant, investment capital and services; and obtains personnel.
4. *Boundary/Production Supportive—Disposal* subsystem markets products and/or services and assures the supply of working capital so that production can continue.
5. *Boundary/Institutional Supportive* subsystem gains support and legitimation for the organization and what it is doing.
6. *Adaptive* subsystem maintains predictability and stability for the organization by:
   a. Attaining control over external forces (supply and market research).
   b. Sensing the need for modification of internal structures to meet the needs of a changing world (product and service research).
   c. Planning for future developments.
7. *Managerial* subsystem coordinates the functional substructures of the organization, resolves conflicts among hierarchical levels of the organization, and coordinates external requirements with organizational requirements and needs. (Katz and Kahn, 1966, pp. 34-99.)

The administrative task statements were judgmentally sorted by the project's staff into the seven subsystem categories. Within each category, the task statements were analyzed in detail, combined, and reworded to some extent using the theoretical specifications and dimensions of the appropriate subsystem as guidelines in the synthesis of the task statements into the Standard List of Administrative Tasks. The statements and the list were again subjected to evaluations by practicing administrators and revised as necessary.

The product of this effort was a Standard List of Administrative Tasks in which the task statements were derived empirically and synthesized into a relatively parsimonious list using a well documented, extant theoretical framework. It was felt that this approach minimized the constraining effects of simple a prion specification of the list of statements that Mintzberg warned against, and allowed a generous, if not totally complete, sampling and synthesis of task statements, a listing of which would tend to be as all-encompassing as any produced to date in the field of group practice administration.

The Standard List of Administrative Tasks served two purposes: (a) as the basic description of generic administration; and (b) as a basis for a measuring instrument. The following two sections discuss each use of the list.

The Standard List as the Basic Description of Generic Group Practice Administration

The description of administration derived from the standard list was "generic" for two reasons. First, it was generic because it contained administrative tasks performed by each of the administrators of interest to the study: the professional administrator, the medical director, and the governing body. Second, the description was generic because it contained tasks performed by administrators from both fee for service and prepaid groups of various sizes.

However, because the description (and the standard list) was generic, the tasks were not performed with equal frequency by all groups; some tasks were performed by only a small number of groups, while other tasks were more common in their performance across different groups. It was unlikely that any group performed all of the tasks in the standard list. Chapters to follow will describe the partitioning of the generic administrative tasks by roles and also by groups according to size and payment mechanism.

What follows immediately, however, is generic administration examined in relation to the expanded Katz and Kahn organizational subsystems. Table 4-1

TABLE 4-1

STANDARD LIST OF ADMINISTRATIVE TASKS BY KATZ & KAHN SUBSYSTEMS

PRODUCTION SUBSYSTEM

(No tasks in the standard list.)

MAINTENANCE SUBSYSTEM

15. *Develop, review, and/or revise* standard operating procedures for:
    a. Delivering patient care.
    b. Physician personnel administration.
    c. Non-physician personnel administration.
    d. Utilization control (non-physician).
    e. Cost controls.
    f. Billing and collecting.
    g. Interacting and dealing with outside agencies.
    h. Gathering, processing, and evaluating information important to your group.
17. Enforce adherence to standard operating procedures by:
    a. Physician members (participating).
    b. Physician employees (salaried).
    c. Nurses and medical technicians.
    d. Receptionists, clerks, and maintenance personnel.
    e. Administrative staff.
21. *Develop, review and/or revise* job specifications, job descriptions, and/or job standards of:
    a. Physician members (participating).
    b. Physician employees (salaried).
    c. Nurses and medical technicians.
    d. Receptionists, clerks, and maintenance personnel.
23. *Develop, review, and/or revise* payment plans/salary schedules and benefits for:
    a. Physician members (participating).
    b. Physician employees (salaried).
    c. Nurses and medical technicians.
    d. Receptionists, clerks, and maintenance personnel.
31. Orient and train new personnel:
    a. Physician members (participating).
    b. Physician employees (salaried).
    c. Nurses and medical technicians.
    d. Receptionists, clerks, and maintenance personnel.
32. Survey the job satisfaction of:
    a. Physician members (participating).
    b. Physician employees (salaried).
    c. Nurses and medical technicians.
    d. Receptionists, clerks, and maintenance personnel.
    e. Administrative staff.
33. Conduct job performance evaluations for:
    a. Physician members (participating).
    b. Physician employees (salaried).
    c. Nurses and medical technicians.
    d. Receptionists, clerks, and maintenance personnel.
    e. Administrative staff.
37. Interpret group policy and clarify procedures for staff and employees.
40. Discipline:
    a. Physician members (participating).
    b. Physician employees (salaried).
    c. Nurses and medical technicians.
    d. Receptionists, clerks, and maintenance personnel.
    e. Administrative staff.

BOUNDARY/PRODUCTION SUPPORTIVE—PROCUREMENT SUBSYSTEM

8. Negotiate purchase price/contracts for supplies, equipment, and/or non-medical services.
13. Search and negotiate for investment capital.
25. *Recruit* the following to fill openings in your organization:
    a. Physician members (participating).
    b. Physician employees (salaried).
    c. Nurses and medical technicians.
    d. Receptionists, clerks, and maintenance personnel.
26. *Negotiate* salary and benefit contracts with organized groups of personnel.
30. Negotiate contracts with physicians who wish to join the group.
41. Secure liability insurance coverage for your group and/or your physicians.
42. Survey patients to ascertain level of patient satisfaction and/or areas of dissatisfaction.
43. Resolve non-medical patient complaints (e.g., charges, fees, personality clashes, etc.).
44. Mediate/arbitrate between the group's physicians and patients in conflicts over medical services.
47. Visit the group's patients in the hospital for public relations purposes (non-medical purposes).
54. Negotiate *medical services* covered under health care contracts with organized consumer groups.
55. Negotiate *fees* or *prices* for health care contracts with organized consumer groups.
57. Settle grievances with industrial or group accounts.

TABLE 4-1 (Cont.)

BOUNDARY/PRODUCTION SUPPORTIVE—DISPOSAL SUBSYSTEM

45. Represent the group or individual physicians in court appearance on collection cases.
48. Transmit information about your group's facilities and services to interested persons and/or organized consumer groups.
49. Represent your group at health care workshops and meetings.
50. Represent your group in civic matters and projects.
51. Participate in public health education efforts.
58. Work with third party payors to assure efficient collections for the group.

BOUNDARY/INSTITUTIONAL SUPPORTIVE SUBSYSTEM

5. Attempt to influence the outcome of pending legislation or regulations that would affect your group practice.
52. Try to gain the community's (or public's) acceptance and support for your group and its various programs.
53. Work with the news media in releasing public and civic interest stories.

ADAPTIVE SUBSYSTEM

1. Collect information, process and evaluate information, and/or make recommendations relative to factors that might affect *patient demand* for your group's services, e.g.:
   a. General trends in the environment (e.g., population census and demographic data, social factors, economic data, etc.).
   b. Legislation and regulations (e.g., NHI & HMO legislation, MEDICARE-MEDICAID, etc.).
   c. Your group's "competition" (e.g., other medical groups, hospitals, etc.).
2. Collect information, process and evaluate information, and/or make recommendations relative to factors that might affect the *manner in which services are rendered* in your group, e.g.:
   a. New *medical* equipment and procedures.
   b. New *non-medical* equipment and procedures (e.g., POMR, Superbill, etc.).
   c. Legislation and regulations (e.g., PSRO, third party payor accountability regulations, etc.).
   d. Internal processes (e.g., patient flow, overtime, cash flow, etc.).
11. *Develop* long-range master plans (e.g., facility, financial, etc.).
18. *Develop* physician staffing plans.
19. *Develop* non-physician staffing plans.

MANAGERIAL SUBSYSTEM

3. *Establish/approve* your group's position on issues related to the practice of medicine in your group (e.g., PSRO, accountability, licensure/certification, etc.).
4. *Establish/approve* your group's position on issues related to the business operations of your group (e.g., taxes, Superbill, etc.).
6. *Establish/approve* the need to replace existing or purchase additional medical equipment.
7. *Establish/approve* the need to replace existing or purchase additional *non-medical* equipment and/or services.
9. *Approve* purchases of equipment or services costing in excess of $1,000.
10. *Establish/approve:*
   a. Criteria for quality care.
   b. Policies governing your group's organizational structure and type.
   c. Policies governing the number and kind of patients that your group will serve.
   d. Policies governing the growth or reduction in the number of physicians in your group.
   e. Policies governing the growth or reduction in the number of administrators in your group.
   f. Policies governing the specialty mix of your group's physicians.
   g. Financial policies.
   h. Accounting policies.
   i. Physician personnel policies.
   j. Non-physician personnel policies.
12. *Approve* long range master plans (e.g., facility, financial, etc.).
14. *Approve* your group's operating budget.
16. *Approve* standard operating procedures (new or revised) for:
   a. Delivering patient care.
   b. Physician personnel administration.
   c. Non-physician personnel administration.
   d. Utilization control (non-physician).
   e. Cost controls.
   f. Billing and collecting.
   g. Interacting and dealing with outside agencies.
   h. Gathering, processing, and evaluating information important to your group.
20. *Approve* staffing plans.
22. *Approve* job specifications, job descriptions, and/or job standards (new or revised) for:
   a. Physician members (participating).
   b. Physician employees (salaried).
   c. Nurses and medical technicians.
   d. Receptionists, clerks, and maintenance personnel.
   e. Administrative staff.
24. *Approve* payment plans/salary schedules and benefits (new or revised) for:
   a. Physician members (participating).
   b. Physician employees (salaried).
   c. Nurses and medical technicians.
   d. Receptionists, clerks, and maintenance personnel.
   e. Administrative staff.

TABLE 4-1 (Cont.)

MANAGERIAL SUBSYSTEM (cont.)

27. *Approve* contracts with organized groups of personnel.
28. *Approve* appointment/hiring of:
    a. Physician members (participating).
    b. Physician employees (salaried).
    c. Nurses and medical technicians.
    d. Receptionists, clerks, and maintenance personnel.
    e. Administrative staff.
29. *Approve* end of probationary appointments for physicians.
34. *Approve* promotions of:
    a. Physician members (participating).
    b. Physician employees (salaried).
    c. Nurses and medical technicians.
    d. Receptionists, clerks, and maintenance personnel.
    e. Administrative staff.
35. *Approve* dismissals and terminations of:
    a. Physician employees (salaried).
    b. Nurses and medical technicians.
    c. Receptionists, clerks, and maintenance personnel.
    d. Administrative staff.
36. Negotiate dissolutions from the membership of physician members (participating) who leave the group.
38. Counsel, to assist with *personal* problems:
    a. Physician members (participating).
    b. Physician employees (salaried).
    c. Nurses and medical technicians.
    d. Receptionists, clerks, and maintenance personnel.
39. Mediate/arbitrate *interpersonal* problems:
    a. Among physicians.
    b. Among nurses and medical technicians.
    c. Among receptionists, clerks, and maintenance personnel.
    d. Among administrative staff.
    e. Between physicians and nurses.
    f. Between physicians and administrators.
46. Represent the group or individual physicians in court appearances on malpractice litigation.
56. *Approve* contracts with organized consumer groups.

presents the Standard List of Administrative Tasks grouped according to the subsystem in which each task belongs. For example, tasks 15, 17, 21, 23, 31, 32, 33, 37, and 40 were considered to be maintenance subsystem tasks.

The standard list contained a total of 58 major items. Several major items had subparts yielding a total of 141 individual task statements. Of the 58 major items, none were production subsystem tasks, 9 were maintenance subsystem tasks, 13 were boundary/production supportive—procurement tasks, 6 were boundary/production supportive—disposal tasks, 3 were boundary/institutional supportive, 5 were adaptive subsystem tasks, and 22 were managerial subsystem tasks.

Production Subsystem

The function of the production subsystem is to accomplish tasks that produce some product or provide some service. In a medical group practice, production activities deal primarily with the diagnosis, treatment, and referral of patients. The production subsystem tasks in a medical group are performed principally by physicians, nurses, and technicians and are not directly administrative actions. Allison (1975) found that medical group managers "reported no production-type activities as being crucial to their role (p. 34)." Therefore, the standard list contained no production tasks.

Maintenance Subsystem

The function of the maintenance subsystem is to mediate between task demands and human needs in order to maintain stability within the organization. The mediation process is concerned with creating an environment in which production can be accomplished and sustained, and typically involves the following:

1. Development and reviewing/updating of job specifications, job descriptions, and job standards.
2. Development and reviewing/updating of standard operating procedures from policy approved by administration.
3. Enforcement of adherence to the procedures.
4. Administration of rewards, sanctions, and punishments.
5. Evaluation of performance.
6. Socialization of new personnel.
7. Training and development of new personnel.
8. Monitoring of personnel satisfaction.

The nine items indicated in Table 4-1 for the maintenance subsystem cover the areas listed above.

Boundary/Production Supportive—Procurement Subsystem

The function of this subsystem is to obtain (and retain) raw materials; to obtain supplies, equipment, plant, investment capital, and services; and, to obtain per-

sonnel. In the strictest interpretation, "raw materials" in medical group practices are patients. Therefore, Items 54 and 55 are related to "obtaining" or "procuring" patients. Items 42, 43, 44, and 57 are related to the "retention" of patients. These are activities or tasks carried out in medical groups to keep the patients happy and coming back.

Boundary/Production Supportive—Disposal Subsystem

The traditional function of this subsystem is to market the organization's product or service to provide working capital so that production can continue. This function is accomplished by advertising and selling, by establishing fees and charges, and by billing and collecting. Medical ethics prohibit blatant advertising and marketing of medical services, and even "soft" solicitation of potential patients. Administrators in medical groups must go about "disposing" of their services in other ways. Typically this can be done, for example, as indicated by Items 48, 49, 50, and 51. Items 45 and 58 relate to the assuring of working capital aspects of this subsystem.

Boundary/Institutional Supportive Subsystem

The institutional supportive subsystem gains support and legitimation for the organization and what it is doing by attempting to influence society or the public, by attempting to influence other institutions, and by attempting to influence regulatory agencies. Items 5, 52, and 53 express the functions of this subsystem in the standard list.

Adaptive Subsystem

The function of the adaptive subsystem is to maintain predictability and stability for the organization by attaining control over external forces, by sensing the need for modification of internal structures to meet the needs of a changing world, and by planning for future developments. This function is implemented by gathering information, by processing and evaluating information, and by formulating and making recommendations. Whereas the adaptive subsystem makes recommendations, the managerial subsystem makes decisions, and the appropriate subsystem then implements the decision.

There are five items in the standard list that are adaptive subsystem tasks. Items 11, 18, and 19 are relatively straightforward. In Item 1, parts a, b, and c, concerned with patient demand for services, are related to supply and market research or attaining control over external forces. Item 2, parts a, b, c, and d, concerned with the manner in which services are rendered, are related to product or service research or modifying internal structures.

Managerial Subsystem

The managerial subsystem coordinates the functional substructures of the organization, resolves conflicts among hierarchical levels of the organization, and coordinates external requirements with organizational requirements and needs. The subsystem accomplishes its function by establishing policy, by making decisions, and by mediating and arbitrating.

There are more task statements for this subsystem than any of the others. This, of course, is not inconsistent with the mission and objectives of the study. Many of the task statements in this subsystem category retain the language of the initial task statements obtained via the empirical method. Some of the items in this subsystem attempt to evaluate the management subsystem aspects of tasks in the other subsystems. Therefore, instead of "developing" and "recruiting," here the verbs are "approving" and "establishing."

Standard List in General

Two points will be made in this section related to the items in the standard list in general. The first point is that many of the items were subcategorized into "physician members (participating)," "physician employees (salaried)," "nurses and medical technicians," "receptionists, clerks, and maintenance personnel," and in some cases, "administrative staff." This subgrouping was done in order to facilitate the differentiation among, and the more detailed description of roles of professional administrators versus roles of medical directors versus roles of governing bodies. Involvement in some tasks was greatly dependent upon the object of the action of the task—toward whom the task was focused. For example, a medical director may be responsible for, and involved in, recruiting physicians, but not involved in recruiting clerks. Similarly, a professional administrator may discipline administrative staff but not physicians.

The second point to be made in this section is that several items might appear to be redundant in that they are paired, one stated "Developing . . .," for instance, and the second stated "Approve . . ." and/or "Establish . . .." These distinctions were made for two purposes. First it was done to, again, facilitate the differentiation among, and the more detailed description of roles of professional administrators versus roles of medical directors versus roles of governing bodies. Whereas a professional administrator or a medical director may "Develop, review, and/or revise" a payment plan, it may be required that the governing body "Approve" the plan.

Second, the distinctions were made in order to facilitate the differentiation among management subsystem and other subsystem tasks. It may be that for some tasks or in some group practices, one person may do both the "developing" and "approving." If that is the case, even though a single person performs both tasks, that person is operating in two subsystems. Given the nature of the group practice industry where the manager of a small or medium-sized group is often a "Jack of all trades," the various subsystems of the Katz and Kahn typology provided a convenient analysis model that organized and kept straight the various functions and activities of administrators.

The Standard List Incorporated Into the Survey Questionnaire

Once the generic administrative tasks were organized into the standard list, the next step was to develop a method to allow for the partitioning of the generic administrative tasks by roles and also by groups according to size and payment mechanism. The method used was to incorporate the task list into a questionnaire format. The task statements were used as stems, and three scales were employed to allow respondents to indicate which of the tasks were relevant to their roles. Respondents were asked the following three questions related to each task statement:

1. Is this task performed in your group? The response options were "Yes" or "No."
2. Who is *chiefly* responsible for satisfactory performance of this task in your group? The response options were:
   - NO = No One
   - LA = Lay Administrator
   - MD = Medical Director
   - GB = Governing Body
   - OT = Other
3. To what extent are *you personally* involved in performing this task? The response options were scaled "1" to "5" representing "no personal involvement" to "high personal involvement."

See Appendix A for copies of the questionnaires.

The questionnaires consisted of four sections in addition to the standard list:

1. Selected biographical questions were asked.
2. Selected organizational data were solicited.
3. A decision table was included that consisted of a list of ten hypothetical decisions that might be made in a group practice. Respondents were asked (a) to circle the position that would have the *final* authority in making the decision; and (b) to indicate all of those persons or groups who would participate in the decision.
4. In the "Critical Tasks" section, administrators were asked to list the five most important tasks that they perform as administrators.

The questionnaires were administered to professional administrators, medical directors, and governing body chairpersons speaking in behalf of the governing body as an entity. The responses from the professional administrators were the primary data for the study. However, the role descriptions were developed using the data provided by each kind of role incumbent. In other words, the professional administrator's role description was developed using the data provided by the professional administrators; the role description was based upon how the professional administrators view their roles. Similarly, the role descriptions of the medical directors and governing bodies were each developed based upon data provided by the respective respondents; the medical director's role description was based upon how medical directors view their roles, and the governing body's role description was based upon how the governing bodies (chairpersons) view their roles.

Internal Consistency of the Standard List

Cronbach's coefficient alpha (Cronbach, 1970) was computed for the items in each Katz and Kahn subsystem using the personal involvement scores (column 3). The coefficients for each of the subsystem involvement scores were as follows: .95 for the maintenance subsystem; .84 for the boundary/production supportive—procurement subsystem; .78 for the boundary/production supportive—disposal subsystem; .68 for the boundary/institutional supportive subsystem; .82 for the adaptive subsystem; and, .96 for the managerial subsystem. The magnitude of these coefficients indicates a high degree of internal consistency among the items of each subsystem. The relatively low coefficient alpha for the boundary/institutional supportive subsystem primarily reflects the small number (only three) of the items in the subsystem.

The high degree of internal consistency indicates that the items within each subsystem are highly related and tend to measure the same thing. These results tend to support the initial sorting of the empirically derived task statements into the Katz and Kahn subsystems. Further analyses, however, are necessary for the complete evaluation of the methodology.

CHAPTER 5

THE ROLES: PROFESSIONAL ADMINISTRATOR, MEDICAL DIRECTOR, GOVERNING BODY

Administration in medical groups has been generically described using a set of task statements that were derived empirically and synthesized into a Standard List of Administrative Tasks using a theory of organizations as a guiding framework. Utilizing the generic description as a foundation, and employing the Standard List of Administrative Tasks as a means, the administrative roles of professional administrators, medical directors, and governing bodies are described in this chapter.

Two concepts, measured by two of the three respondent scales of the questionnaire's standard list, were important in the delineation of roles. The first concept was "chief responsibility" as measured in column 2 of the standard list for each administrative task. One description of a role could be accomplished by listing the tasks for which each administrator was chiefly responsible. It is fairly obvious, however, that such a listing would not be truly representative of any administrator's role; administrators generally do much more than that for which they are responsible.

The method employed by this study for obtaining a measure of what administrators do in addition to that for which they are responsible was to include the third standard list respondent scale, "personal involvement." The personal involvement of the respondents in each of the tasks of the standard list, then, was the second concept important to the delineation of roles. Whether or not administrators are chiefly responsible for any given task, their role is determined in part by the extent of their involvement in the performance of that task. Using both responsibility and involvement in combination, therefore, allows more concise delineation and description of administrative roles.

The Role of the Professional Administrator

The role description of professional administrators will receive the greatest emphasis since they are the focal point of this report. The professional administrators' role will be described primarily from their responses to the Standard List of Administrative Tasks, with information from their responses to the decision table, from their listings of five most important tasks, and from the site visit interviews serving to supplement and verify the description wherever appropriate.

General Description of the Professional Administrator's Role

As mentioned above, in the second column of the standard list, the professional administrator was asked to indicate how the administrative tasks of his group are shared according to who has chief responsibility for each. Figure 5-1 represents the overall distribution of task responsibility in a group practice.

Of the three administrative roles, the professional administrator was chiefly responsible for the largest percentage of administrative tasks on the standard list; more than 52% of all tasks performed in a group practice were the chief responsibility of the professional administrator. This large proportion of administrative rsponsibility demonstrates the central role of the professional administrator in the functioning of a group practice.

For each task performed by his group, the professional administrator indicated in the third column of the survey questionnaire his degree of personal involvement in that task. Five responses were available to him, ranging from no involvement to high involvement on a scale of 1 to 5 respectively. The total average involvement of the professional administrator in the tasks performed by his group is 3.81. This average includes his involvement in all tasks, even those for which he is not chiefly responsible. Thus, it can be assumed that nearly all tasks performed in a group practice have some effect on his role.

Knowing that the professional administrator's average involvement in all tasks is 3.81 is helpful, but this does not indicate his degree of involvement with those tasks for which he is chiefly responsible, or how involved he is with the tasks for which other administrators are responsible.

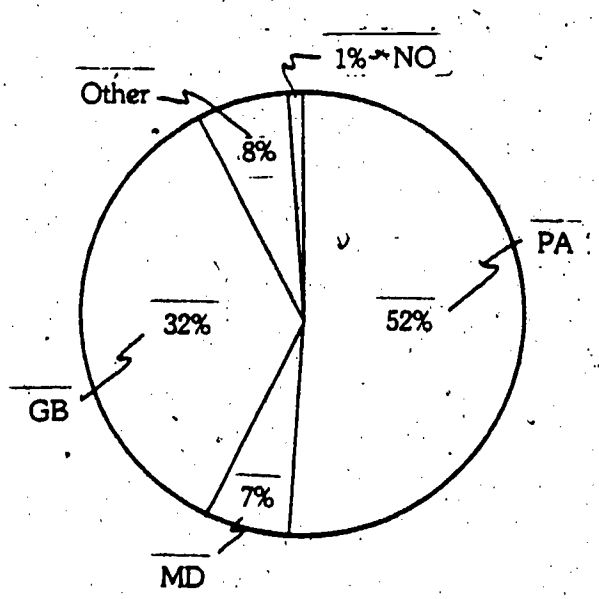

Figure 5-1. Percentage of professional administrators' responses as to who is chiefly responsible for administrative tasks (Column 2 of Standard List).

To determine these figures, the professional administrator's average involvement in the tasks for which he, the medical director, and the governing body are responsible was calculated. These average involvement scores, presented in Table 5-1, represent professional administrators' personal involvement in tasks that are the chief responsibility, respectively, of no one, of the professional administrator himself, of medical directors, of governing bodies, and of others. For example, the average personal involvement of professional administrators in tasks that they have indicated to be the chief responsibility of medical directors is 1.39 indicating a low level of personal involvement; professional administrators are not highly involved in medical director tasks.

As one would expect, the professional administrators have the most personal involvement in those tasks for which they are chiefly responsible; however, they also are involved to varying degrees in tasks that are not their own responsibility. This finding further supports the fact that the professional administrator's role in a group practice extends well beyond those tasks for which he is chiefly responsible. In fact it implies that every task within his group's generic administration in part defines his role.

Systems Description of the Professional Administrator's Role

In addition to being useful in the development of both the generic description of administration in medical groups and the standard list, the Katz and Kahn systems theory of organizations provides a useful framework within which to develop the role descriptions. The subsystems provide a convenient way to categorize the standard list tasks so that they can be systematically related to role descriptions. This approach allows the role descriptions, as well as the discussion to follow, to be developed in an organized, more logical manner.

As discussed in the previous chapter, the standard list tasks have been grouped according to the subsystem in which each task belongs (See Table 4-1). Presented in Table 5-2 are the percentages of the tasks in each subsystem for which "no one," "professional administrator," "medical director," "governing body," and "other" were chiefly responsible.

From Table 5-2, it is apparent that the professional administrator functions to a large extent in each of the subsystems. He is, in fact, responsible for a larger percentage of tasks in each of the subsystems than either of the two other administrative roles. It is also apparent that his responsibility varies among the subsystems, indicating that each subsystem affects his role to various degrees. He has the least responsibility for tasks in the boundary/institutional supportive subsystem and the most responsibility in the boundary/production supportive—disposal subsystem.

The higher an administrator's personal involvement in a subsystem, the greater the influence of that subsystem's tasks on his administrative role. The professional administrator's personal involvement in each of the six subsystems is displayed in Table 5-3.

The professional administrator's highest involvement is with those tasks that comprise the boundary/production supportive—procurement subsystem. To a lesser extent, the professional administrator is also highly involved in the adaptive, maintenance, managerial and boundary/production supportive—disposal subsystems. In general, there is only a small degree of difference among these five subsystems as far as the professional administrator's personal involvement is concerned. The subsystem that the professional

TABLE 5-1

PROFESSIONAL ADMINISTRATORS' AVERAGE PERSONAL INVOLVEMENT BY WHO IS CHIEFLY RESPONSIBLE (COLUMN 2-3 INTERACTION)

No One	Professional Administrator	Medical Director	Governing Body	Other
.36	4.28	1.39	3.02	2.06

TABLE 5-2

PROFESSIONAL ADMINISTRATORS' RESPONSES AS TO WHO IS CHIEFLY RESPONSIBLE EXPRESSED AS A PERCENTAGE OF TASKS IN EACH KATZ AND KAHN SUBSYSTEM (COLUMN 2 OF STANDARD LIST)

Subsystem	No One	Professional Administrator	Medical Director	Governing Body	Other
Maintenance	0.3	57.6	7.9	26.0	8.2
Procurement	0.6	63.9	6.8	18.7	9.9
Disposal	1.4	68.8	6.2	7.2	15.7
Supportive	2.7	41.1	9.1	25.4	11.8
Adaptive	1.7	62.5	6.9	21.8	7.0
Managerial	1.7	43.5	7.3	42.8	5.9

administrator has the least personal involvement in is the boundary/institutional supportive. This subsystem is the only subsystem where the average personal involvement was below the expected mid-point of the involvement scale.

The boundary/production supportive—disposal subsystem. The boundary/production supportive—disposal subsystem will be examined first because the professional administrator is responsible for the largest percentage of tasks in this subsystem. In Table 5-4 each item that was included in this subsystem is presented with the frequency distributions for the survey's professional administrator respondents' involvement with each disposal task.

Due to the financial status of medical groups and the ethics that govern medical practice, the professional administrator functions in this subsystem more by subtle facilitation than by actual marketing of his group's services. This is demonstrated by the three tasks for which the professional administrator is chiefly responsible, and in which he is most highly involved. One of the tasks is to ensure efficient collections for the group by working with third party payers. Since it is generally known that most of the group's working capital is obtained from third party payers, the professional administrator's responsibility and involvement with this task reflects the importance of working with third party payers to assure reimbursement for his group's services (Hageboeck, 1968). Another disposal task for which the professional administrator is chiefly responsible is representing his group at health care workshops and meetings. In addition, he is also responsible for, and highly involved in, the task of transmitting information about his group's facilities and services to interested persons and/or organized consumer groups. These last two activities demonstrate some of the subtle methods that a professional administrator can employ to market his group's services while remaining within the constraints of medical ethics.

The critical tasks mentioned by professional administrators reflect the relative unimportance of disposal tasks to his role. In general, his critical tasks related to the disposal subsystem dealt with representing his group both professionally (insurance industry, hospitals, and so forth) and for public relations purposes. Not many of these tasks were listed as critical and those that were mentioned usually ranked low in importance. In site visit conversations with professional administrators, two reasons were given for the performance of disposal tasks. The professional administrator was concerned about making a contribution to the community beyond the services his group offered and in letting the public know that his group existed. The one task for which the professional administrator had little responsibility, and in which his involvement was low, dealt with public health education efforts. While this task is a subtle form of "disposing" of a group's services, its medical aspects probably precluded it from the professional administrator's role.

One procedure that a professional administrator can employ to ensure that his group has sufficient working capital is to take individual collection cases to court. While the professional administrator is usually not chiefly responsible for this task, he does have high personal involvement in it. Site visit information indicated that his involvement normally takes the form of gathering and preparing the supporting data required by the lawyers who have the chief responsibility for this task.

TABLE 5-3

PROFESSIONAL ADMINISTRATORS' AVERAGE PERSONAL INVOLVEMENT IN EACH KATZ AND KAHN SUBSYSTEM (COLUMN 3 OF STANDARD LIST)

Subsystems					
Maintenance	Procurement	Disposal	Supportive	Adaptive	Managerial
3.80	3.98	3.67	3.38	3.89	3.80

TABLE 5-4

FREQUENCY DISTRIBUTION OF PROFESSIONAL ADMINISTRATORS' PERSONAL INVOLVEMENT RESPONSES TO BOUNDARY/PRODUCTION SUPPORTIVE—DISPOSAL SUBSYSTEM (COLUMN 3 OF STANDARD LIST)

	Personal Involvement				
	1	2	3	4	5
BOUNDARY/PRODUCTION SUPPORTIVE—DISPOSAL SUBSYSTEM					
45. Represent the group or individual physicians in court appearances on collection cases	64	67	48	40	139
48. Transmit information about your group's facilities and services to interested persons and/or organized consumer groups	9	54	83	88	197
49. Represent your group at health care workshops and meetings	23	63	110	100	225
50. Represent your group in civic matters and projects	22	65	102	102	171
51. Participate in public health education efforts	86	110	93	40	71
58. Work with third party payors to assure efficient collections for the group	16	32	94	107	282

The boundary/production supportive—procurement subsystem. The professional administrator indicated that he is chiefly responsible for 64% of the boundary/production supportive-procurement tasks, and his average personal involvement is higher in this subsystem than in any other. Frequency distributions of professional administrators' personal involvement for the items of this subsystem are presented in Table 5-5.

The professional administrator's chief responsibility in the procurement subsystem is to obtain the supplies, equipment, and manpower needed by the group to function. The basic kinds of business services and materials that the professional administrator obtains for the group are liability insurance, investment capital, nonmedical supplies, and nonmedical equipment. The procurement activities that reflect these areas, tend to be the tasks in which the professional administrators indicated they had the highest personal involvement. The professional administrator also included these types of procurement tasks as some of his most important critical tasks. Towne (1973), in a speech at a MGMA conference on the principles of clinic management, discussed the importance of these types of "purchasing" activities for the role of the professional administrator. He pointed out that performance of these tasks is not as simple as it might sound, but that such performance requires a good deal of knowledge and ability on the part of the administrator. The one task in this area for which the professional administrators had the highest frequency of involvement was securing liability insurance coverage for the group and/or its physicians. Towne also discussed the broad base of skills and understanding necessary on the part of the administrator to carry out this type of activity. The high level of the professional administrator's personal involvement in this activity indicates the significance the administrator places on this task.

The professional administrator's role in the recruitment of the group's manpower is sharply divided. On the one hand, he is chiefly responsible for recruiting and hiring nonmedical personnel for the group. In the recruitment of the group's physicians, however, he has very little responsibility. The professional administrator's personal involvement in procuring manpower is divided along similar lines. His involvement in obtaining nonphysician personnel is quite high as this is an area of his responsibility. In physician recruitment, his involvement is lower but still at a significant level. While the professional administrator does not have chief responsibility for recruiting physicians, site visit information indicated that he often suggests possible recruitment sources and methods and often handles the actual mechanics involved in physician recruitment. Recruitment of staff personnel was listed as a critical task more often than was the procurement of supplies and equipment. It also was ranked on the average, at a higher importance level.

The basic "raw material" that a group practice must obtain is the patients on which the entire system depends. While blatantly attempting to procure patients is ethically forbidden by the medical profession, groups

TABLE 5-5

FREQUENCY DISTRIBUTION OF PROFESSIONAL ADMINISTRATORS' PERSONAL INVOLVEMENT RESPONSES TO BOUNDARY/PRODUCTION SUPPORTIVE—PROCUREMENT SUBSYSTEM TASKS (COLUMN 3 OF STANDARD LIST)

		Personal Involvement				
		1	2	3	4	5
8.	Negotiate purchase price/contracts for supplies, equipment, and/or nonmedical services	14	17	50	108	375
13.	Search and negotiate for investment capital	27	28	39	80	204
25.	*Recruit* the following to fill openings in your organization:					
	a. Physician members (participating)	73	71	88	85	157
	b. Physician employees (salaried)	64	64	89	105	180
	c. Nurses and medical technicians	16	44	61	99	332
	d. Receptionists, clerks, and maintenance personnel	19	38	43	81	378
26.	*Negotiate* salary and benefit contracts with organized groups of personnel	9	5	10	13	88
30.	Negotiate contracts with physicians who wish to join the group	85	61	80	114	194
41.	Secure liability insurance coverage for your group and/or your physicians	18	16	37	80	406
42.	Survey patients to ascertain level of patient satisfaction and/or areas of dissatisfaction	6	19	84	67	153
43.	Resolve non-medical patient complaints (e.g., charges, fees, personality clashes, etc.)	12	38	102	—	302
44.	Mediate/arbitrate between the group's physicians and patients in conflicts over medical services	32	49	98	100	226
47.	Visit the group's patients in the hospital for public relations purposes (nonmedical purposes)	42	21	18	10	19
54.	Negotiate *medical services* covered under health care contracts with organized consumer groups	9	22	33	41	90
55.	Negotiate *fees* or *prices* for health care contracts with organized consumer groups	10	16	34	41	107
57.	Settle grievances with industrial or group accounts	11	24	53	56	151

can employ some methods to help them retain the patients that do employ the group's services and can secure groups of organized consumers who are interested in contracting for the group's services. The professional administrator generally has chief responsibility for these tasks. He monitors patient satisfaction with his group's services through patient satisfaction surveys. He also resolves the nonmedical complaints of patients and mediates disputes between physicians and patients in conflicts over medical services. The professional administrator's personal involvement in these task activities tends to be high, but not as high as in activities relating to obtaining materials, services, and manpower for his group. The site visit information revealed that these activities on the part of the professional administrator are not solely for the purpose of retaining the group's patients but also for the purpose of helping the group avoid possible court actions that may be taken by dissatisfied patients (Nasbaum, 1960).

Another method a group can employ to procure patients is to negotiate medical services and fees with organized groups of consumers. A group practice does not necessarily market its services to obtain these patients but is usually approached by representatives of the consumer group who wish to negotiate a service contract. Again this area of patient procurement is the chief responsibility of the professional administrator (Lauer, 1962), and he has above average personal involvement in these activities.

The adaptive subsystem. The professional administrator's role in the adaptive subsystem is reflected by the large portion of adaptive tasks for which he is responsible, and the high level of involvement he has in adaptive tasks. His chief responsibility in this subsystem is to keep up with population trends, legislation, regulations, and developments in other forms of health care delivery which could affect patient demands for his group's services. Site visit discussions indicated that these adaptive tasks are performed primarily for the purpose of aiding the professional administrator to prepare for changes that could affect his group in the future, or for the immediate purpose of planning to build a satellite clinic or adding a new type of medical service.

Table 5-6 lists the items in this subsystem and the frequency distributions of the responses by the professional administrators as to their personal involvement with each adaptive task. On the average, professional administrators have greater involvement and responsibility when the adaptive tasks are related to external events that could affect the group's services. The professional administrator monitors both the external environment for new nonmedical equipment and procedures that would benefit his group and the group's internal environment for processes such as patient flow, cash flow, and overtime that also might affect delivery of the group's services. When the adaptive tasks were related to medical issues in these two areas, the professional administrator's responsibility and involvement were sharply lowered. For example, the professional administrators, on the average, had little responsibility for, and low involvement with, keeping up with and making recommendations about new medical equipment that could affect his group's services.

The development of long range master plans was an adaptive task in which professional administrators were highly involved, but, less often, for which they were chiefly responsible. Due to the professional administrator's role in the adaptive subsystem, he is usually well

TABLE 5-6

FREQUENCY DISTRIBUTION OF PROFESSIONAL ADMINISTRATORS' PERSONAL INVOLVEMENT RESPONSES TO ADAPTIVE SUBSYSTEM TASKS (COLUMN 3 OF STANDARD LIST)

	Personal Involvement				
	1	2	3	4	5
ADAPTIVE SUBSYSTEM					
1. Collect information, process and evaluate information, and/or make recommendations relative to factors that might affect *patient demand* for your group's services, e.g.:					
a. General trends in the environment (e.g., population census and demographic data, social factors, economic data, etc.)	13	66	85	67	112
b. Legislation and regulations (e.g., NHI & HMO legislation, Medicare-Medicaid, etc.)	11	64	134	135	151
c. Your group's "competition" (e.g., other medical groups, hospitals, etc.)	16	79	121	80	100
2. Collect information, process and evaluate information, and/or make recommendations relative to factors that might affect the *manner in which services are rendered* in your group, e.g.:					
a. New *medical* equipment and procedures	34	111	171	127	110
b. New *non-medical* equipment and procedures (e.g., POMR, Superbill, etc.)	7	29	50	100	377
c. Legislation and regulations (e.g., PSRO, third party payor accountability regulations, etc.)	18	68	110	145	179
d. Internal processes (e.g., patient flow, overtime, cash flow, etc.)	7	13	31	87	427
11. *Develop* long-range master plans (e.g., facility, financial, etc.)	13	25	80	116	253
18. *Develop* physician staffing plans	59	81	138	93	105
19. *Develop* non-physician staffing plans	6	18	56	112	323

informed as to what the present and future demands on his group will be and, therefore, is highly involved in trying to motivate his group to look ahead. The professional administrator's critical tasks indicated that the only long range planning for which he may be responsible is planning the physical expansion of his group. Higher level critical tasks involving long range planning were seldom mentioned in the list of five most important tasks.

Another element of the adaptive subsystem is the development of staffing plans based on demands for the group's services. The professional administrator is chiefly responsible for and highly involved in developing these plans for nonphysician personnel, but he has only moderate involvement in physician staffing plans. The importance of developing staffing plans for the professional administrator is indicated by the number and high importance ranking he gave this task among his five critical tasks. Overall, the professional administrator's activities in this subsystem relate to preparing his group at a very practical business level for change caused by external pressures; however, he has little involvement in or responsibility for adaptive tasks when they are related to medical issues. This is true even when these issues are intricately tied up with the business affairs of the group.

The maintenance subsystem. The professional administrator plays a central role in the maintenance subsystem; but, again, his role is sharply divided. He is chiefly responsible for those maintenance tasks that deal with the nonmedical personnel and ordinary business procedures of the group. Maintenance activities that are in any way related to the group's physicians or medical aspects of the group are not the chief responsibility of the professional administrator. This relationship is also demonstrated by the level of personal involvement that the professional administrator has in maintenance activities. Table 5-7 indicates the frequency of involvement responses for each of the items in the maintenance subsystem. An overview of these items shows that the professional administrator's level of involvement divides along lines similar to those for tasks for which he is chiefly responsible.

The professional administrator is often highly involved in developing, reviewing, and revising standard operating procedures for nonphysician personnel administration, utilization control, cost controls, collections, dealing with outside agencies, and processing information important to his group. He also is involved in enforcing these procedures among the nonphysician personnel. The professional administrator is highly involved in developing job standards and descriptions for nonphysician employees, as well as in surveying their job satisfaction, evaluating their job performance, and meting out appropriate discipline when necessary. One task area in which the professional administrator has high involvement for all groups of employees, physician as well as nonphysician, is the development, review, and revision of payment plans, salaries, and benefits. On the other hand, the professional administrator has generally less involvement, in comparison to other maintenance tasks, for the orientation and training of the various groups of personnel in a group.

When maintenance activities are related to, or concerned with, physician personnel or any medically related aspect of the group, the professional administrator in general is much less involved. It would seem that the professional administrator's responsibility and involvement for maintenance tasks that involve the group's staff increases as the status of the personnel decreases (Lauer, 1962). One exception to this was the development of salary schedules and benefits for the physicians. Another exception is the task of interpreting group policy and clarifying procedures. In this task, the professional administrator functions as the figurehead for the group and, therefore, supercedes all status levels in the group. The maintenance task that he has the least responsibility for and the lowest personal involvement with is the disciplining of physicians.

The boundary/institutional supportive subsystem. The subsystem in which the professional administrator plays the least part in terms of overall chief responsibility is the boundary/institutional supportive. In general, the pattern that emerges is that the closer this subsystem's tasks come to actual contact with the public, the more likely the professional administrator is to be chiefly responsible. His personal involvement in these tasks as presented in Table 5-8 is also low because medical groups have not been required to actively seek out or gain the support of society (Allison, 1975).

The two items in this subsystem for which the professional administrator has above average involvement are (a) trying to gain the community's acceptance and support for his group and its various programs and (b) working with the news media in releasing public and civic interest stories. For both of these tasks the professional administrator usually has the chief responsibility. The one boundary/institutional supportive task in which the professional administrator has below average personal involvement and is not normally chiefly responsible for is attempting to influence the outcome of pending legislation or regulations that might affect the group practice.

The managerial subsystem. The professional administrator is chiefly responsible for performing less than 44% of the managerial subsystem tasks. However, his overall personal involvement in the tasks of this subsystem is well above average. The frequency of personal involvement responses to each of the items in the managerial subsystem are presented in Table 5-9. One of the chief responsibilities of the professional administrator is the determination of policy related to day-to-day business procedures for the group; however, he is not chiefly responsible for business policy decisions when they are related to broader or longer term issues. Furthermore, when business procedures become involved in some manner with medical issues, the professional administrator is not likely to be chiefly responsible.

Even though professional administrators are not generally chiefly responsible for the higher level policy decisions in their groups, they are highly involved in

TABLE 5-7

FREQUENCY DISTRIBUTION OF PROFESSIONAL ADMINISTRATORS' PERSONAL INVOLVEMENT RESPONSES TO MAINTENANCE SUBSYSTEM TASKS (COLUMN 3 OF STANDARD LIST)

	Personal Involvement				
	1	2	3	4	5
MAINTENANCE SUBSYSTEM					
15. *Develop, review, and/or revise* standard operating procedures for:					
a. Delivering patient care	50	105	147	82	87
b. Physician personnel administration	66	104	121	93	99
c. Non-physician personnel administration	5	7	40	98	411
d. Utilization control (non-physician)	9	16	56	100	253
e. Cost controls	5	6	36	100	395
f. Billing and collecting	9	29	49	86	401
g. Interacting and dealing with outside agencies	9	22	92	119	307
h. Gathering, processing, and evaluating information important to your group	5	24	88	109	326
17. Enforce adherence to standard operating procedures by:					
a. Physician members (participating)	72	116	136	75	69
b. Physician employees (salaried)	66	95	131	78	105
c. Nurses and medical technicians	18	31	95	132	267
d. Receptionists, clerks, and maintenance personnel	8	20	49	110	376
e. Administrative staff	12	14	49	85	378
21. *Develop, review and/or revise* job specifications, job descriptions, and/or job standards of:					
a. Physician members (participating)	59	91	87	59	51
b. Physician employees (salaried)	56	88	90	62	72
c. Nurses and medical technicians	12	38	100	120	235
d. Receptionists, clerks, and maintenance personnel	8	20	47	104	352
23. *Develop, review, and/or revise* payment plans/salary schedules and benefits for:					
a. Physician members (participating)	51	47	116	119	170
b. Physician employees (salaried)	44	50	105	122	174
c. Nurses and medical technicians	6	20	51	104	372
d. Receptionists, clerks, and maintenance personnel	7	9	42	86	418
31. Orient and train new personnel:					
a. Physician members (participating)	94	85	112	62	65
b. Physician employees (salaried)	83	94	120	79	81
c. Nurses and medical technicians	61	110	124	86	162
d. Receptionists, clerks, and maintenance personnel	35	86	87	94	251
32. Survey the job satisfaction of:					
a. Physician members (participating)	80	72	96	64	63
b. Physician employees (salaried)	71	76	94	70	86
c. Nurses and medical technicians	20	51	108	96	223
d. Receptionists, clerks, and maintenance personnel	15	37	71	98	291
e. Administrative staff	22	29	54	97	283
33. Conduct job performance evaluations for:					
a. Physician members (participating)	71	69	51	29	27
b. Physician employees (salaried)	81	77	59	40	36
c. Nurses and medical technicians	29	60	90	93	192
d. Receptionists, clerks, and maintenance personnel	20	50	60	91	273
e. Administrative staff	26	26	46	79	287
37. Interpret group policy and clarify procedures for staff and employees	8	12	43	122	370
40. Discipline:					
a. Physician members (participating)	169	91	81	35	30
b. Physician employees (salaried)	158	77	93	42	46
c. Nurses and medical technicians	19	44	93	112	269
d. Receptionists, clerks, and maintenance personnel	11	38	66	100	337
e. Administrative staff	28	19	54	81	344

TABLE 5-8

FREQUENCY DISTRIBUTION OF PROFESSIONAL ADMINISTRATORS' PERSONAL INVOLVEMENT RESPONSES TO BOUNDARY/INSTITUTIONAL SUPPORTIVE SUBSYSTEM TASKS (COLUMN 3 OF STANDARD LIST)

	Personal Involvement				
	1	2	3	4	5
BOUNDARY/INSTITUTIONAL SUPPORTIVE SUBSYSTEM					
5. Attempt to influence the outcome of pending legislation or regulations that would affect your group practice	48	102	136	92	84
52. Try to gain the community's (or public's) acceptance and support for your group and its various programs	12	52	76	76	125
53. Work with the news media in releasing public and civic interest stories	20	71	67	71	123

TABLE 5-9

FREQUENCY DISTRIBUTION OF PROFESSIONAL ADMINISTRATORS' PERSONAL INVOLVEMENT RESPONSES TO MANAGERIAL SUBSYSTEM TASKS (COLUMN 3 OF STANDARD LIST)

	Personal Involvement				
	1	2	3	4	5
MANAGERIAL SUBSYSTEM					
3. Establish/approve your group's position on issues related to the practice of medicine in your group (e.g., PSRO, accountability, licensure/certification, etc.)	76	150	151	64	53
4. *Establish/approve* your group's position on issues related to the business operations of your group (e.g., taxes, Superbill, etc.)	12	17	59	122	346
6. *Establish/approve* the need to replace existing or purchase additional medical equipment	21	55	154	171	159
7. *Establish/approve* the need to replace existing or purchase additional non-medical equipment and/or services	7	14	47	126	374
9. *Approve* purchases of equipment or services costing in excess of $1,000	13	20	87	153	292
10. *Establish/approve:*					
a. Criteria for quality care	83	140	151	57	60
b. Policies governing your group's organizational structure and type	22	45	159	143	175
c. Policies governing the number and kind of patients that your group will serve	42	80	136	97	84
d. Policies governing the growth or reduction in the number of physicians in your group	60	83	132	142	116
e. Policies governing the growth or reduction in the number of administrators in your group	42	26	46	79	215
f. Policies governing the specialty mix of your group's physicians	80	103	143	62	65
g. Financial policies	5	8	61	108	384
h. Accounting policies	6	6	39	89	430
i. Physician personnel policies	70	110	133	109	111
j. Non-physician personnel policies	7	7	24	83	448
12. *Approve* long range master plans (e.g., facility, financial, etc.)	42	50	105	102	177
14. *Approve* your group's operating budget	15	12	36	102	253
16. Approve standard operating procedures (new or revised) for:					
a. Delivering patient care	51	108	152	83	76
b. Physician personnel administration	68	113	137	92	73
c. Non-physician personnel administration	7	18	53	114	366
d. Utilization control (non-physician)	11	17	58	91	273
e. Cost controls	10	8	51	101	361
f. Billing and collecting	9	24	40	101	388
g. Interacting and dealing with outside agencies	13	36	88	131	261
h. Gathering, processing, and evaluating information important to your group	7	40	88	121	281
20. *Approve* staffing plans	23	34	94	131	223
22. *Approve* job specifications, job descriptions, and/or job standards (new or revised) for:					
a. Physician members (participating)	76	97	75	47	41
b. Physician employees (salaried)	78	99	83	56	48
c. Nurses and medical technicians	20	37	107	122	212
d. Receptionists, clerks, and maintenance personnel	8	16	53	89	353
e. Administrative staff	12	13	59	83	334
24. *Approve* payment plans/salary schedules and benefits (new or revised) for:					
a. Physician members (participating)	90	64	135	91	119
b. Physician employees (salaried)	80	71	125	92	127

TABLE 5-9 (Cont.)

	c. Nurses and medical technicians	22	29	68	111	313
	d. Receptionists, clerks, and maintenance personnel	17	22	53	100	365
	e. Administrative staff	37	22	61	97	334
27.	*Approve* contracts with organized groups of personnel	14	7	9	22	69
28.	*Approve* appointment/hiring of:					
	a. Physician members (participating)	137	89	116	80	70
	b. Physician employees (salaried)	120	88	114	90	87
	c. Nurses and medical technicians	21	37	62	109	323
	d. Receptionists, clerks, and maintenance personnel	16	27	41	84	394
	e. Administrative staff	35	14	43	83	366
29.	*Approve* end of probationary appointments for physicians	146	81	90	48	52
34.	Approve promotions of:					
	a. Physician members (participating)	102	68	45	34	22
	b. Physician employees (salaried)	116	81	67	51	41
	c. Nurses and medical technicians	23	31	88	114	263
	d. Receptionists, clerks, and maintenance personnel	13	27	53	96	363
	e. Administrative staff	26	16	48	89	339
35.	*Approve* dismissals and terminations of:					
	a. Physician employees (salaried)	168	193	92	43	63
	b. Nurses and medical technicians	29	53	78	103	281
	c. Receptionists, clerks, and maintenance personnel	12	28	52	78	392
	d. Administrative staff	39	28	36	76	364
36.	Negotiate dissolutions from the membership of physician members (participating) who leave the group	70	41	77	93	180
38.	Counsel, to assist with *personal* problems:					
	a. Physician members (participating)	54	69	98	61	96
	b. Physician employees (salaried)	49	66	102	68	102
	c. Nurses and medical technicians	21	72	116	78	204
	d. Receptionists, clerks, and maintenance personnel	22	64	108	77	236
39.	Mediate/arbitrate *interpersonal* problems:					
	a. Among physicians	98	84	130	77	95
	b. Among nurses and medical technicians	16	53	88	109	257
	c. Among receptionists, clerks, and maintenance personnel	9	52	66	102	315
	d. Among administrative staff	13	25	52	88	324
	e. Between physicians and nurses	22	36	105	107	240
	f. Between physicians and administrators	27	21	58	73	287
46.	Represent the group or individual in court appearances on malpractice litigation	121	76	59	37	51
56.	*Approve* contracts with organized consumer groups	16	17	38	38	87

many of them. For instance, professional administrators are highly involved in policies relating to their group's organizational structure, to the growth or reduction in the number of the group's physicians, to the growth or reduction of administrative staff, to accounting, and to physician personnel policies. One policy activity in which professional administrators have low personal involvement is establishing or approving policies that govern the specialty mix of the group's physicians. This policy decision is almost exclusively the responsibility of the group's physicians functioning as owners of the group.

Most of the 10 hypothetical decision tasks in the survey questionnaire's decision table were managerial tasks that required high level policy decisions. Although the professional administrator did not make the final decision for the majority of these tasks, he did participate in the decision-making processes for all of them. In addition, several of the professional administrator's five most important critical tasks indicated that he develops basic group policy and makes recommendations concerning the form group policy should take to be of maximum value for the group. Allison (1975) and others (Ellis, 1974; Green, 1974; Hardy, 1976; Therrell, 1972; Towne, 1973) have pointed out that the role of the professional administrator in the managerial subsystem is one of trying to influence the decision processes of the highest decision-making body in his group. In this manner, he inputs his expertise into the managerial activities critical to the overall operation of the group.

A second function of the managerial subsystem is to structure the basic elements of the group by approving standard operating procedures and by defining the work roles of employees. The professional administrator is not chiefly responsible for these managerial tasks when they relate to medical care in any way. As a nonphysician, these aspects of the managerial subsystem are not part of his expertise; yet he is involved in these tasks in much the same way as he is personally involved in high level policy decisions. The professional administrator's chief responsibility in this area lies in approving the standard business procedures of the group and in defining work roles for the group's nonmedical personnel. His personal involvement in these task areas is also quite high, reflecting the importance these activities have for his administrative role.

The professional administrator's role in the managerial subsystem is very similar to the statements made by several authors (Lauer, 1970; Therrell, 1972; Towne,

1973) that his job is to implement the policy decisions made by his superiors, the physicians. The managerial tasks for which the professional administrator is responsible indicate the operational level he employs to carry out these policy decisions. Furthermore, the high level of personal involvement he has in all managerial tasks indicates the relative importance of this subsystem's tasks to his role. His involvement in these activities can be best described as being a "salesman" (Towne, 1973) or a "diplomat" (Hardy, 1976; Starr, 1969). Employing these various modes, the professional administrator extends managerial control throughout his group without over-stepping the limits of his authority or responsibility.

One managerial task related to nonmedical personnel for which the professional administrator's chief responsibility is not high is the approval of salary schedules and benefits. Approximately 50% of the professional administrators were not responsible for this task. However their personal involvement in this task was high because it is the professional administrator who typically develops the salary schedules and submits them for approval. In other managerial tasks involving nonmedical personnel, the professional administrator is chiefly responsible for hiring, promoting, and terminating.

One other managerial function of the professional administrator is the arbitration of conflicts between and among the various hierarchical levels within the organization. He is chiefly responsible for dealing with conflicts among nonphysician personnel and, to a lesser degree, physician personnel. The smooth functioning of a group practice often depends on maintaining harmonious relations among both the medical and nonmedical staff (Allison, 1975). The importance of this is reflected in the high personal involvement the professional administrator has with these types of activities.

Responsibility—involvement interactions. The role of the professional administrator in each subsystem is apparent from both the percentage of tasks he is chiefly responsible for and the high level of personal involvement he has in all subsystem tasks. He is not responsible, however, for all administrative tasks, and his personal involvement varies according to who is chiefly responsible. In Table 5-10, the level of the professional administrator's average personal involvement in those subsystem tasks is presented for which each of the three administrative roles are chiefly responsible.

In each subsystem the professional administrator's personal involvement in his own tasks is higher than is his average involvement in all tasks. The next highest level of personal involvement for the professional administrator is with governing body's tasks and, in particular, governing body tasks in the maintenance and managerial subsystems. The governing body, as the highest decision-making level in group practice, is responsible for approving the group's major policies. These policy decisions can, in turn, affect the activities for which the professional administrator is responsible, as he must implement the policy set by the governing body. He, therefore, has high personal involvement with most governing body tasks.

Decision Table of the Professional Administrator

Data from the professional administrator's decision table (Appendix B, Table B-2) confirm some of the information obtained from the systems study of his role. The decision tasks for which the professional administrator had final authority were similar to the tasks for which he had chief responsibility in the managerial subsystem. There were two decision tasks clearly defined as the professional administrator's: one was establishing a new cost-finding system for the group and the other was routine work assignment scheduling for clerical personnel in the business office.

Even though the professional administrator did not have the final decision-making authority for most of the decision tasks, he did have a significant amount of input through participation in each of the tasks. For example, although it is a task in which one might not expect professional administrators to be involved, 51% of the professional administrators indicated that they would participate in a decision to initiate a new patient education program for diabetics.

In order to simplify the interpretation of the decision table, a decision index was developed. This index was formed by determining the average number of individuals who had a role in the decision making for all of the decision tasks. The average decision index was 2.38. The size of this index indicates the average number of people who would be involved in any typical decision made by a group.

TABLE 5-10

PROFESSIONAL ADMINISTRATORS' AVERAGE PERSONAL INVOLVEMENT BY WHO IS CHIEFLY RESPONSIBLE IN EACH KATZ AND KAHN SUBSYSTEM (COLUMN 2-3 INTERACTION)

Subsystem	No One	Professional Administrator	Medical Director	Governing Body	Other
Maintenance	.09	4.28	1.03	2.62	1.42
Procurement	.09	4.28	.79	2.31	1.30
Disposal	.09	3.80	.46	.55	1.03
Supportive	.12	3.53	.42	1.22	.57
Adaptive	.17	4.15	.81	2.43	.84
Managerial	.18	4.30	1.26	3.07	1.65

Content Analysis of the Professional Administrator's Critical Tasks

On the last page of the survey questionnaire, the professional administrator was asked to write the five most critical tasks he performed as an administrator. A total of 2,503 tasks were described. A content analysis was performed on these tasks so that administrative content areas could be identified and the descriptive analysis simplified. The tasks are best described by six content areas. The subject headings for these are: clinic administration, staff management, liaison, quality control, education and research, and miscellaneous. To provide more structure to these broad content areas, several subtopics were defined for each (Appendix B, Table B-3).

Most of the professional administrator's critical tasks were concentrated in two content areas, clinic administration and staff management. Clinic administration refers to the business and financial management of a group. Critical tasks in this content area deal with policy issues, growth of the group, accounting functions, and the day-to-day operations of a group. Staff management, on the other hand, is related to tasks concerning personnel functions such as staffing needs, employee performance evaluation, and recruitment. Tasks fitting this content area are typically directed at all staff, although they sometimes refer to only medical or nonmedical staff. A third content area is labeled liaison. This title was deemed appropriate since the critical tasks within this category concern the administrator performing in some intervening capacity. Typical critical tasks in this content area deal with liaison between medical staff and nonmedical departments, representing the group in professional relations, and representing the group in public relations. The critical tasks in the quality control content area were related to delivery of medical services. The professional administrator had few critical tasks in this area, the only major one being to ensure the patients' satisfaction with the clinic and staff. The education and research content area had the fewest critical tasks for professional administrators. Critical tasks such as conduct research, grants administration, and training/teaching are included in this content domain. The final content area was labeled miscellaneous since there are a number of individual critical tasks which do not fit any of the above areas. Miscellaneous critical tasks include such items as acting as secretary for the governing body meetings, informing the group about important issues, and other singular tasks.

In Table 5-11, a few of the most frequently mentioned critical tasks for the professional administrator are listed with their frequency distributions across the five importance levels. Table 5-5 indicates that the professional administrators are heavily involved in tasks dealing with the accounting and financial aspects of their groups as well as in supervising the group's personnel. These critical tasks demonstrate the importance of both maintenance and managerial subsystems tasks for the role of the professional administrator.

Functional Job Analysis of Professional Administrator's Critical Tasks

In order to determine the functional level or complexity of the professional administrator's five most important tasks, the content of the task statements was analyzed according to a methodology developed by Sidney A. Fine (1955, 1971) for use primarily by the U. S. Department of Labor's *Dictionary of Occupational Titles* (1965). This method categorizes the tasks performed in any job as dealing with either "data," "people," or "things." Within each of these categories, the level or complexity of the task can be assigned to a hierarchical functional level. Each category has nine functional levels and levels are assumed to be comparable across categories. Table 5-12 presents the frequency distribution for the content analysis of the five

TABLE 5-11
PROFESSIONAL ADMINISTRATORS' FREQUENTLY LISTED CRITICAL TASKS BY THE FIVE LEVELS OF IMPORTANCE

Content Area	Task	Level of Importance				
		1st	2nd	3rd	4th	5th
Clinic Administration	Manage/report financial status of group.	66	52	29	23	15
Clinic Administration	Develop/supervise procedures for billings.	32	53	32	37	27
Clinic Administration	Direct day-to-day business affairs of group.	76	22	15	17	22
Clinic Administration	Develop long range plans and goals (e.g., plans for community needs).	15	20	15	21	54
Clinic Administration	Control expenses to maintain [illegible]	32	24	19	19	12
Clinic Administration	Interpret/execute directives [illegible] g body.	18	15	14	6	3
Staff Management	Personnel administration—all [illegible]	41	64	49	12	12
Staff Management	Recruit/hire—all staff.	19	21	24	14	7
Staff Management	Facilitate employee satisfaction—all staff.	12	11	11	6	15
Staff Management	Direct/monitor work loads (e.g., work scheduling, routine and on-call hours).	20	3	12	11	3
Liaison	Liaison among medical staff departments or between medical staff and nonmedical departments.	23	21	14	14	10
Miscellaneous	Guide group in decision-making.	11	9	4	4	3

TABLE 5-12

FREQUENCY DISTRIBUTION OF PROFESSIONAL ADMINISTRATORS' RESPONSES TO THE FIVE MOST IMPORTANT CRITICAL TASKS BY FINE'S METHODOLOGY (CRITICAL TASKS)

Category	Functional Level	Level of Importance 1st	2nd	3rd	4th	5th
Data:						
	(1) No significant relationship (2) No significant relationship	4	0	0	0	0
	(3) Comparing	0	2	8	18	28
	(4) Copying	0	0	0	1	3
	(5) Computing	14	25	21	25	14
	(6) Compiling	124	120	135	150	95
	(7) Analyzing	101	89	84	83	77
	(8) Coordinating	51	26	22	17	10
	(9) Synthesizing	1	0	1	0	3
People:	(1) No significant relationship	0	0	0	0	0
	(2) Serving	9	7	4	4	11
	(3) Speaking—Signaling	3	6	9	19	19
	(4) Persuading	15	27	44	52	60
	(5) Diverting	2	6	4	10	7
	(6) Supervising	120	160	125	65	47
	(7) Instructing	5	5	11	8	6
	(8) Negotiating	58	39	30	29	33
	(9) Mentoring	3	1	0	1	4

critical tasks performed by the professional administrators using Fine's methodology.

The standardized descriptions of Fine's three categories of data, people, and things and the functional levels of each are:

DATA

The principal activity for these tasks requires *mental ability* and the tasks involve functions that are incapable of being touched. These tasks are performed by observation, investigation, interpretation, or mental creation. Data tasks can take the form of numbers, words, ideas, concepts, and oral verbalizations in relation to data, people or things.

1. (No Classification)
   No significant relationship
2. (No Classification)
   No significant relationship
3. Comparing:
   Examining readily observable functional, structural, or compositional characteristics of data, people, or things in order to discover resemblances or differences from obvious standards
4. Copying:
   Transcribing, entering, posting data; includes counting
5. Computing:
   Performing arithmetic operations and reporting on them; includes performing *prescribed* courses of action in relation to the computations if necessary
6. Compiling:
   Gathering, collating, or classifying information about data, people, or things; reporting and/or carrying out a prescribed action in relation to the information frequently involved
7. Analyzing:
   Examining and evaluating the meaning of data; presenting alternative actions in relation to the evaluation frequently involved
8. Coordinating:
   Determining what courses of action should be taken on the basis of analysis of data; involves the setting of times, places, and sequences of operation for the action; also involves the execution and/or reporting on the event
9. Synthesizing:
   Pulling together and integrating the analyses of data to discover facts and/or develop knowledge concepts or interpretations from the data integration.

PEOPLE

People tasks are those which involve dealing with people on an *interpersonal basis*. They include relations with people on both individual and group levels.

1. (No Classification)
   No significant relationship
2. Serving:
   Attending to the needs or requests of people or the expressed or implicit wishes of people; immediate response involved
3. Speaking-Signaling:
   Talking with and/or signaling people to convey or exchange information; includes giving assignments and/or directions to immediate helpers or assistants
4. Persuading:
   Influencing others in favor of a product, service, idea, method, procedure, or point of view; others

usually neutral

5. Diverting:
   Influencing or coaxing others to change their positions in relation to some product, service, idea, method, procedure, or point of view
6. Supervising:
   Determining or interpreting work procedures for a group of workers, assigning specific duties to them, maintaining harmonious relations among them, and promoting efficiency
7. Instructing:
   Teaching subject matter to others or training others through explanation, demonstration, and supervised practice; or making recommendations to others on the basis of expert opinion or technical training
8. Negotiating:
   Exchanging ideas, information, and opinions with others to formulate policies and programs and/or arrive jointly at decisions, conclusions, or solutions
9. Mentoring:
   Dealing with individuals in terms of their total personality in order to advise, counsel, and/or guide them with regard to problems that may be resolved by legal, scientific, clinical, spiritual, managerial and/or other professional principles

THINGS

These tasks involve dealing with inanimate objects as distinguished from human beings or nonphysical concepts such as substances or materials, machines, tools, equipment, products. A thing is tangible and has shape, form, and other physical characteristics.

1. (No Classification)
   No significant relationship
2. Handling:
   Using body members, handtools, and/or special devices to work, move, or carry objects or materials; involves little or no latitude for judgment with regard to attainment of standards or in selecting appropriate tool, object, or material; superficial or nontechnical examination or inspection of machines or physical objects; for example, opening mail
3. Feeding:
   Inserting, throwing, or placing materials in or removing them from machines or equipment which are automatic or tended or operated by other workers
4. Tending:
   Starting, stopping, and observing the functioning of machines and equipment; involves adjusting materials or controls of the machine; little judgment involved in making these judgments
5. Manipulating:
   Using body members, tools, or special devices to work, move, guide, or place objects of materials; involves some latitude for judgment with regard to precision attained and selecting appropriate tool, object, or material, (although readily manifest)
6. Driving-Operating:
   Starting, stopping, and controlling the actions of machines or equipment for which a course must be steered or which must be guided in order to fabricate, process, and/or move things or people; involves some estimating, turning, pushing or pulling; includes such machines as conveyor systems, tractors, and hoisting machines
7. Operating-Controlling:
   Starting, stopping, controlling, and adjusting the process of machines or equipment designed to fabricate and/or process objects or materials; involves setting up the machine and adjusting the machine or material as the work progresses
8. Precision Working:
   Using body members and/or tools or work aids to work, move, guide, or place objects or materials in situations in which the person has ultimate responsibility for the attainment of standards; requires exercise of considerable judgment
9. Setting up:
   Adjusting machines or equipment to prepare them to perform their functions, change their performance, or restore their proper functioning if they break down; setting up machines for other workers or setting up and personally operating a variety of machines *(Dictionary of Occupational Titles*, 1965 pp. 649-650)

None of the critical task statements written by the professional administrators dealt with functions in the things category; the professional administrator's critical tasks dealt with data and people exclusively. The selected group of professional administrators who completed time logs for the study, however, indicated that they were sometimes called upon to perform low level, things tasks. Generally, these tasks involved the professional administrator's aiding in major mechanical problems with the group's data processing equipment. The time log tasks were coded using Fine's methodology; therefore, this information on an administrator's day-to-day activities can be compared with his critical tasks.

Critical tasks dealing with data were listed by the professional administrator with greater frequency than were people tasks for each of the five importance levels. The difference in the frequency of both data and people tasks, however, was not great. Both categories play an important part in the critical tasks of the professional administrator. The time log information supports this on a day-to-day basis. Fifty-three percent (53%) of the day-to-day tasks of the professional administrator are data tasks and 47% are people tasks. An average of 0.2% are things activities.

When the professional administrator performs critical tasks dealing with data, his most frequent functional level is compiling. Using the above definition of compiling, this means that the professional administrator is often engaged in gathering, collating, or classifying information and then in reporting this information to a higher level. The professional administrator's time log data indicated

that 34% of his day-to-day activities are compiling tasks. The professional administrator listed fewer critical tasks that involved analyzing functions and even less that involved coordinating activities.

The professional administrators' critical tasks dealing with people are most frequently related to the three functions of supervision, negotiation, and persuasion. The most frequently listed critical tasks involved supervision, and the second most frequent functional level was negotiation. Mintzberg (1975) describing the roles involved in management work included a role labeled the "negotiator." He states that managers at all levels spend considerable time in negotiations. As the importance level of the professional administrator's critical tasks decreases, the frequency of persuading increases. Persuading tasks involve the influencing of others in favor of some issue. Most of the professional administrator's persuading involved his attempts to influence his governing body in favor of some policy or decision that he felt was important. On a day-to-day basis, the time log information indicated that the most common people function of the professional administrator is at the level of speaking-signaling. In Mintzberg's (1975) study of chief administrators, he found that 78% of their time was spent in oral communication. Most of these tasks involved the professional administrator's "keeping in touch" with his group's physicians and personnel and with other individuals not directly associated with his group. These activities appear to be a source for "intelligence gathering" on the part of the professional administrator (Mintzberg, 1975).

The Role of the Medical Director

Although there are few officially designated medical directors in group practice, the role of the medical directors has been discussed frequently (Davis, 1973; Gray, 1975; Ottensmeyer, 1974; Pollard, 1976; Saux, 1973). The discussion has revolved primarily around two issues: whether or not a medical director is needed in a group; and what the role of the medical director in a group is. The medical director's role will be examined from the medical director's responses to the second and third columns of the Standard List of Administrative Tasks and according to the pertinent Katz and Kahn subsystems.

Systems Description of the Medical Director's Role

Figure 5-2 presents the percentage of tasks for which three administrative roles are chiefly responsible in a group having a medical director.

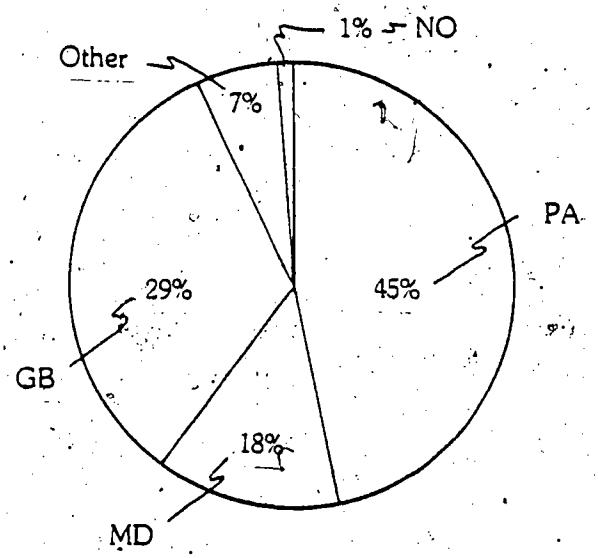

Figure 5-2. Percentage of medical directors' responses as to who is chiefly responsible for administrative tasks (Column 2 of Standard List).

The medical directors indicated that they are responsible for 18% of the administrative tasks as contrasted with 45% for the professional administrator and 29% for the governing body. These percentages demonstrate that the medical director does play a significant role in the functioning of his group. What his role is will be described according to the types of tasks in each of the subsystems for which he is chiefly responsible and in which he is personally involved.

The medical director's responsibility in terms of the percentage of tasks performed in each subsystem is: maintenance, 20%; boundary/production supportive—procurement, 16%; boundary/production supportive—disposal, 21%; boundary/institutional supportive, 21%; adaptive, 18%; managerial, 16%. The medical director is responsible for almost an equal proportion of tasks in each of the subsystems. Presented in Table 5-13 is the average personal involvement of the medical director for each of the Katz and Kahn subsystems.

The maintenance subsystem. The medical director is responsible for 20% of the tasks in the maintenance subsystem, and his principal involvement in this subsystem concerns tasks that maintain and stabilize the working environment for the group's physicians. In particular, he is most often responsible for orienting and training new physicians who join the group. He also is responsible for maintenance tasks involving the development of standard operating procedures for the medical aspects of the group and for enforcing adherence to those procedures by medical personnel.

TABLE 5-13
MEDICAL DIRECTORS' AVERAGE PERSONAL INVOLVEMENT IN EACH KATZ AND KAHN SUBSYSTEM
(COLUMN 3 OF STANDARD LIST)

Subsystems					
Maintenance	Procurement	Disposal	Supportive	Adaptive	Managerial
3.13	3.03	2.72	3.29	3.23	3.34

His maintenance role is less pronounced for developing salary schedules for physicians or for disciplining physicians, but he does have high personal involvement in these areas. One final maintenance task for which he is frequently responsible is to remain aware of the job satisfaction of the group's physicians.

The boundary/production supportive—procurement subsystem. In the boundary/production supportive — procurement subsystem, the medical director is responsible for 16% of the tasks. He recruits the physicians for the group and handles the medical issues related to the procurement of patients. He is most often involved in mediating between physicians and patients over conflicts in medical services and in visiting the group's patients in hospitals for public relations purposes. He has little involvement in the business aspects of obtaining personnel, materials, or patients.

The boundary/production supportive—disposal system. The medical director has his greatest level of responsibility (21%) in the boundary/production supportive—disposal subsystem. The medical director is responsible for disposal tasks that deal with the general public. The medical director, as a physician, is the logical choice for representing the medical aspects of his group to the public. He can have a greater impact than can the professional administrator in making the public aware of his group's medical services.

The boundary/institutional supportive subsystem. The medical director's high level of responsibility (21%) for tasks in the boundary/institutional supportive subsystem most likely results from the same reason as does his high level in the boundary/production supportive—disposal subsystem. He can gain institutional support for his group because he is a better representative for the production function (medical care) than is the professional administrator.

The adaptive subsystem. In the adaptive subsystem, the medical director is responsible for 18% of the tasks. He monitors the external environment for developments that could affect the medical services of the group and makes recommendations concerning these developments. In addition, he is often responsible for developing the physician's staffing plans for the group.

The managerial subsystem. The medical director's lowest level role is in the managerial subsystem where he is responsible for 16% of the tasks. His managerial duties most often involve tasks related to the medical performance of the group's physicians. He plays a major role in establishing criteria for quality care and in approving the group's stand on medical issues. In addition, he is highly involved in all physician personnel policies. Two tasks which best describe the medical director's role in the managerial subsystem are his counseling of physicians with personal problems and his arbitration of interpersonal problems among physician personnel. The medical director almost exclusively resolves conflicts among the top hierarchical levels of his group.

Content Analysis of the Medical Director's Critical Tasks

A review of the content analysis of the medical director's five critical tasks presented in Table B-3 of Appendix B, indicates that the medical director performs critical tasks that are often at a high functional level. He is seldom engaged in the minor day-to-day activities of the group. The content analysis of the medical director's critical tasks and time log data by Fine's methodology indicates that the medical director is much more people oriented than he is data oriented. In addition, Fine's methodology indicates that he is at a higher functional level for people tasks than he is for data tasks.

The Role of the Governing Body

The governing body is the highest administrative level within a group practice. Its form is determined by the group's legal organizational structure (partnership, professional corporation, foundation, etc.), and it is generally composed of some combination of owners, stockholders, and/or consumers. As governing bodies are often composed of more than a single individual, their administrative roles were examined through the responses of their chairpersons. The chairperson was chosen to be a spokesperson because he is generally called upon by his governing body to act as its representative to outside concerns. For this reason, he is often well informed concerning the functions of the governing body and can respond in relation to how the governing body functions as an entity.

Systems Description of the Governing Body's Role

The percentage of tasks that the governing body responded to as being the chief responsibility of the three administrative roles is presented in Figure 5-3.

The governing body is responsible for only 33% of the administrative tasks. The percentage of the governing body's responsibility in each subsystem is: maintenance, 27%; boundary/production supportive—procurement, 17%; boundary/production supportive—disposal, 6%; boundary/institutional supportive, 19%; adaptive, 22%; and managerial, 44%. The governing body's major role is in the managerial subsystem, and its smallest role is in the boundary subsystems. The governing body's average personal involvement in each of the six subsystems is presented in Table 5-14.

The governing body's personal involvement (Table 5-14) in the Katz and Kahn subsystem tasks was always lower than that for the professional administrator (Table 5-3) or the medical director (Table 5-13). The governing body, considering its authority, is not very involved in administration. Most governing bodies meet only on a weekly, monthly, or sometimes quarterly basis. In the meantime, the professional administrator carries out the administrative functions of the group and consults with individual governing body members whenever there is a need for it (Lauer, 1970). The small amount of time that

TABLE 5-14
GOVERNING BODYS' AVERAGE PERSONAL INVOLVEMENT IN EACH KATZ AND KAHN SUBSYSTEM
(COLUMN 3 OF STANDARD LIST)

Subsystems					
Maintenance	Procurement	Disposal	Supportive	Adaptive	Managerial
2.30	2.80	2.27	2.92	2.91	3.19

the governing body usually spends in administration accounts for its low personal involvement in the administrative tasks overall. As done previously for the medical director, the role of the governing body has been examined according to the types of tasks for which it is chiefly responsible and personally involved in for each of the Katz and Kahn subsystems.

The maintenance subsystem. In the maintenance subsystem, the governing body's role is to perform tasks that maintain and stabilize the medical environment of the group, with particular emphasis on the physician personnel. The governing body is chiefly responsible for developing standard operating procedures for both physicians and the delivery of patient care. The governing body also develops the job specifications and salary schedules for the group's physicians and is chiefly responsible for the disciplining of physicians when needed. One maintenance task regarding physicians that the governing body has less responsibility for is orienting and training new physicians.

The boundary subsystems. The boundary subsystems tasks will be examined as a group since the governing body has little responsibility for these subsystems. The governing body is mainly concerned with the internal functions of its group and so it has little to do with the exchanges made at the boundary of the group. The governing body has chief responsibility for only three tasks in these three subsystems. Two of these deal with the recruitment of physicians and negotiating contracts with them, and the third task deals with attempting to influence the outcome of legislation or regulations that would affect group practice. The governing body's personal involvement in these tasks is low even though its members are chiefly responsible for the tasks.

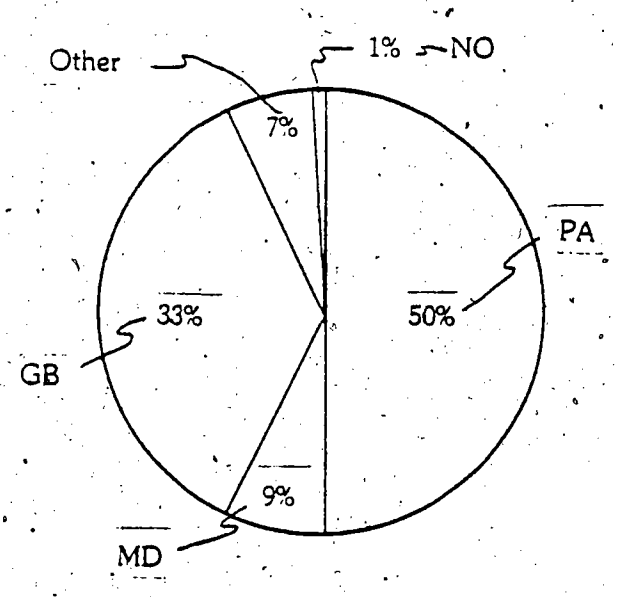

Figure 5-3. Percentage of governing bodys' responses as to who is chiefly responsible for administrative tasks (Column 2 of Standard List).

The adaptive subsystem. The governing body's tasks in the adaptive subsystem are to develop plans anticipation of external pressure for change. The governing body develops the staffing plans for both physicians and nonphysicians but is slightly less responsible for developing long range plans. The governing body does not perform adaptive tasks that involve the collection of information on external forces, but relies on others to perform these tasks and report to them so that plans for future developments can be made. The governing bodies indicated that the professional administrator is chiefly responsible for the collection of the adaptive information.

The managerial subsystem. As the governing body's title implies, its chief function is to "govern." The governing body is chiefly responsible for a large percentage of the managerial subsystems tasks. It is responsible for approving all major policy and issues related to the group and is responsible for all managerial tasks involving the medical aspects of the group, including the physician personnel. Some of the approval tasks governing bodies perform are: approving the group's position on medical issues, capital expenditures in excess of $1,000, criteria for quality care, financial policies, physician personnel policies, long-range master plans, the operating budget, and salary schedules. In addition, while the governing body is responsible for mediating interpersonal problems among physicians, it is not responsible for counseling physicians with personal problems. Overall, the governing body is chiefly responsible for approving all high level policy for its group.

Content Analysis of the Governing Body's Critical Tasks

The influence of the governing body in managerial tasks is apparent from its five most important critical tasks (Appendix B, Table B-3). The governing body's critical tasks often involve giving approval on issues related to medical or physician tasks. One frequently mentioned critical task of the governing body was consultation with the professional administrator on the group's business matters.

Agreement Among the Administrative Roles

Communication among the administrators of a group is extremely important, especially as it relates to defining who has chief responsibility for the tasks within a group. Lack of this type of communication can result in duplication of effort on some tasks while other tasks are not performed at all. Personal stress is another result of poor communication within a group. If an individual does not know what is expected of him, he is likely to experience stress due to ambiguity (Kahn, Wolfe, Quinn, Snoek, & Rosenthal, 1964). Communication among the administrators of a group practice was measured as the level of either agreement or disagreement among the administrative roles concerning who is chiefly responsible for each of the tasks in the Standard List of Administrative Tasks. Agreement scores were computed as the average number of tasks agreed upon to be the chief responsibility of an administrative role for the six Katz and Kahn subsystems.

Agreement Between the Professional Administrator and the Medical Director

The average agreement between professional administrators and medical directors in the same group are presented in Table 5-15. Due to missing data, the figures in the rows do not equal the number of tasks in each subsystem.

The maintenance subsystem. The professional administrator and the medical director agreed on an average of 15 tasks in the maintenance subsystem as being the chief responsibility of the professional administrator and on 3.7 tasks as being the responsibility of the medical director. The professional administrator's tasks on which there was the highest agreement deal with nonphysician personnel; medical director tasks deal with physician maintenance. The maintenance task in which there was found to be the most disagreement was the responsibility for interpreting group policy and clarifying procedures for staff and employees. Both medical directors and professional administrators claim this as their own task with little agreement between them.

The boundary/production supportive—procurement subsystem. In the boundary/production supportive—procurement subsystem, the highest agreement was on the professional administrator's tasks. There was agreement that the professional administrator is responsible for an average of 5.8 procurement tasks. These tasks usually deal with obtaining the nonmedical supplies and personnel for the group and resolving nonmedical patient complaints. There was very little agreement between the professional administrator and the medical director as to what the medical director's tasks were in this subsystem. The highest percentage of agreement on a medical director's task was 20%. This task involves the medical director's responsibility for recruiting physicians. Some of the highest agreements in this subsystem were that certain tasks were not performed by the group.

The boundary/production supportive—disposal subsystem. There was a great deal of disagreement concerning who had responsibility for the tasks in the boundary/production supportive—disposal subsystem. The professional administrator and medical director seldom agreed on the same administrative role being chiefly responsible for the tasks in this subsystem. The highest percentage of agreement on a disposal task was 54% for the professional administrator's being chiefly responsible for working with third party payers to ensure efficient collections. The disposal task with the greatest disagreement was concerned with who should be responsible for participating in public health education efforts.

The boundary/institutional supportive subsystem. The lowest overall agreement between the professional administrator and the medical director was for the boundary/institutional supportive subsystem tasks. The area of highest agreement between these two administrators for tasks in this subsystem was that several supportive tasks were not performed in the group. The supportive subsystem task generating the most disagreement was who has responsibility for gaining the community's acceptance and support for the group.

The adaptive subsystem. The professional administrator and the medical director agreed that 3.7 tasks in the adaptive subsystem are the responsibility of the

TABLE 5-15

AVERAGE NUMBER OF TASKS IN EACH KATZ AND KAHN SUBSYSTEM FOR WHICH THERE IS AGREEMENT BETWEEN PROFESSIONAL ADMINISTRATORS AND MEDICAL DIRECTORS AS TO WHO IS CHIEFLY RESPONSIBLE (COLUMN 2 OF STANDARD LIST)

Subsystems	No One	Professional Administrator	Medical Director	Governing Body	Other	Task Not Performed	Total Disagreement
Maintenance	0	14.91	3.74	5.08	1.05	2.34	11.46
Procurement	.01	5.80	.70	.83	.35	2.65	5.01
Disposal	0	2.13	.30	.18	.30	.50	2.05
Supportive	.03	.53	.17	.22	.24	.59	1.22
Adaptive	.01	3.75	.77	.86	.29	.63	3.19
Managerial	0	17.04	4.54	16.66	.87	3.59	18.54

professional administrator. The professional administrator is responsible for collecting information on new nonmedical equipment and procedures and for developing nonphysician staffing plans. He also is seen as being responsible for keeping track of internal processes that could affect the group's delivery of services. There was poor agreement as to which tasks were the medical director's. There often was conflict about whether the medical director is responsible for an adaptive task or whether the governing body is responsible. These conflicts almost always related to medical issues.

The managerial subsystem. The least disagreement between the professional administrator and medical director was in the managerial subsystem. They agreed on an average of 42.7 tasks in this subsystem. There was agreement that the professional administrator is responsible for [illegible] tasks, the medical director for 4.5, and the governing body for 16.7. Both the professional administrator and the medical director were high in their agreement that this is an important subsystem for the governing body.

The highest agreed upon tasks for the professional administrator were managerial tasks dealing with business procedures and nonphysician personnel. The medical director tasks that were frequently agreed upon by the professional administrator and the medical director were in counseling physicians with personal problems and in arbitrating between physicians with interpersonal problems. The latter task was the most agreed upon in any subsystem as being the chief responsibility of the medical director in a group practice; forty percent (40%) of the professional administrators and medical directors agreed that this is the chief responsibility of the medical director. The managerial task that had the lowest level of agreement concerned who has responsibility for representing the group or individual physicians in court appearances on malpractice litigation.

Agreement Between the Professional Administrator and the Governing Body

The average agreement between the professional administrator and the governing body in a group is presented in Table 5-16.

The tasks on which the professional administrator and the governing body agreed are the responsibility of the professional administrator are basically the same tasks covered in the previous section; therefore, these tasks will not be cited again. Only the tasks that the professional administrator and the governing body frequently agreed upon to be the governing body's tasks will be examined.

The maintenance subsystem. In the maintenance subsystem, there was agreement that the governing body is responsible for an average of 6.2 tasks. These tasks deal with maintenance procedures for medical care and for the group's physicians. The highest percentage of agreement related to the governing body's responsibility for developing salary schedules and benefits for the group's physicians.

The boundary/production supportive—procurement subsystem. The agreement on governing body tasks in the boundary/production supportive—procurement subsystem was low. The only governing body tasks, for which there was high agreement between the professional administrator and the governing body, deal with physician recruitment and the negotiation of contracts with physicians who wish to join the group.

The boundary/production supportive—disposal and the boundary/institutional supportive subsystems. The governing body did not have a significant role in either the boundary/production supportive—disposal or the boundary/institutional supportive subsystems; few tasks in these subsystems had high agreement as being those of the governing body. In fact, both subsystems can be characterized by a high level of disagreement between the professional administrator and the governing body concerning who is chiefly responsible for the subsystem tasks.

The adaptive subsystem. In the adaptive subsystem there was moderate agreement between the professional administrator and the governing body that the governing body is responsible for collecting information on new medical equipment, developing long-range plans, and developing physician staffing plans.

The managerial subsystem. It was agreed that the governing body is chiefly responsible for an average of 18 tasks in the managerial subsystem. This is approximately two tasks more than what was agreed the professional administrator was responsible for. The managerial tasks that the professional administrator and the governing body agreed upon most often deal with the governing

TABLE 5-16

AVERAGE NUMBER OF TASKS IN EACH KATZ AND KAHN SUBSYSTEM FOR WHICH THERE IS AGREEMENT BETWEEN PROFESSIONAL ADMINISTRATORS AND GOVERNING BODIES AS TO WHO IS CHIEFLY RESPONSIBLE (COLUMN 2 OF STANDARD LIST)

Subsystems	No One	Professional Administrator	Medical Director	Governing Body	Other	Task Not Performed	Total Disagreement
Maintenance	.01	15.24	1.20	6.22	1.04	2.76	11.76
Procurement	.01	5.83	.27	.81	.35	3.11	5.27
Disposal	.02	2.22	.11	.12	.35	.76	2.16
Supportive	.01	.58	.06	.22	.12	.89	1.54
Adaptive	.03	4.11	.22	.99	.18	.84	3.25
Managerial	.08	15.89	1.40	17.98	1.07	4.37	19.71

body's responsibility for approving high-level group policy. The two governing body tasks on which there was the highest agreement deal with the approval of equipment or service costing in excess of $1,000 and with approval of the hiring or termination of physician employees. The task that had the lowest percentage of agreement between professional administrators and governing bodies concerned who has the responsibility for mediating interpersonal problems between physicians and nurses; fifty-six percent (56%) of the professional administrators and governing bodies could not agree on who is responsible for this task.

Agreement Between the Professional Administrator, the Medical Director, and the Governing Body

The average number of tasks for which there was agreement among the professional administrator, the medical director, and the governing body is presented in Table 5-17.

A comparison of Table 5-16 with Tables 5-14 and 5-15 shows less agreement among the professional administrator, medical director, and governing body than between either the professional administrator and the medical director or between the professional administrator and the governing body. This result may not be unusual since Table 5-16 includes three individuals while both Tables 5-14 and 5-15 include only two. It is, in fact, surprising that there is not more disagreement among the three kinds of administrators.

A review of the tasks for which there was high agreement indicated that the tasks on which the three kinds of administrators agreed were the same as those upon which two administrators previously agreed. A conclusion to be drawn from this consistency is that each role has several well-defined tasks for which it is responsible; yet there remains a large number of tasks in group practice that are not well defined for any administrative role.

TABLE 5-17

AVERAGE NUMBER OF TASKS IN EACH KATZ AND KAHN SUBSYSTEM FOR WHICH THERE IS AGREEMENT AMONG PROFESSIONAL ADMINISTRATORS, MEDICAL DIRECTORS, AND GOVERNING BODIES AS TO WHO IS CHIEFLY RESPONSIBLE (COLUMN 2 OF STANDARD LIST)

Subsystems	No One	Professional Administrator	Medical Director	Governing Body	Other	Task Not Performed	Total Disagreement
Maintenance	0	12.81	4.00	4.41	1.59	3.00	12.96
Procurement	0	5.96	.89	.82	.68	2.61	4.39
Disposal	0	1.52	.49	.22	.47	.39	2.30
Supportive	0	.58	.23	.23	.23	.69	1.46
Adaptive	0	3.86	.69	.69	.22	.75	3.36
Managerial	0	16.45	3.18	15.79	1.15	3.60	18.60

CHAPTER 6

EFFECTS OF SIZE AND PAYMENT MECHANISM

Two organizational variables associated with medical group practices were selected as independent or subgrouping variables. It was felt that both the size of the groups and the kinds of payment mechanisms employed by the groups would affect the role of the professional administrators. While there may be many more organizational variables that are correlated with differences in group practice administration, these two subgrouping variables were selected for the following reasons:

1. They were considered to be among the most influential as far as their effect on administrative roles.
2. They, especially the size variable, were considered to encompass the effects of many other organizational variables related to differences in roles.
3. They were relatively easily measured.
4. They contained intuitive appeal as being of major importance to the professional administrator's role.

The Subgrouping Variables

The size variable was developed for each group practice from the number of full-time equivalent (FTE) physicians associated with each organization. Groups that had 15 or fewer physicians were considered to be "small," groups with 16 to 40 FTE physicians were labeled "medium," and groups with more than 40 FTE physicians, "large."

The second subgrouping variable was the kind of payment mechanism used by a group practice. This variable was measured by whether the group operated under a fee for service payment mechanism or a prepayment plan. If any amount of a group's revenue was generated by a prepayment plan, the group was considered to be a member of the prepayment subgroup; only groups for which no revenue was generated by prepayment were included in the fee for service subgroup. The number of professional administrators in each of these subgroups is presented in Table 6-1.

The totals in this table do not equal the total number of study participants because of missing data. Table 6-1 shows that the majority of group practices are both small in size and employ a fee for service payment mechanism. The effect of these two variables independently and in combination on the role of the professional administrator is examined below.

Organizational and Biographical Information by Size and Payment Mechanism

Professional administrators' responses to the organizational and biographical questions for both group size and payment mechanism are presented in Appendix B, Table B-4. There are several significant response differences between professional administrators in groups of varying sizes. Due to lack of space, however, only some of the more interesting differences associated with group size can be presented here. Generally, the larger the group:

- —the older the professional administrator,
- —the higher the administrator's educational level,
- —the more positions the administrator has held in the health care field,
- —the more hours the administrator is involved in work,
- —the more likely the group is growing,
- —the larger the amount of revenue generated by prepayment,
- —the more satellite clinics the group has.

The effects of type of payment mechanism on the professional administrator's organizational and biographical information are just as pronounced as are the effects of group size. Some of the basic differences for groups having a prepayment plan are:

- —the professional administrator has held more positions in the health care field,
- —the professional administrator works shorter hours,
- —the prepayment groups are open longer hours,

TABLE 6-1
NUMBER OF PROFESSIONAL ADMINISTRATORS BY SIZE AND PAYMENT MECHANISM

Payment Mechanism	Size			Totals
	Small	Medium	Large	
Prepayment	53	26	20	99
Fee for Service	298	119	25	442
Totals	351	145	45	541

—the prepayment groups have more physicians,
—the prepayment groups have more vacant physician positions,
—the prepayment groups have more satellite clinics.

Unlike the variable of size, payment mechanism had no significant effect on the age of the professional administrator or on his educational level.

Subsystem Tasks Performed in a Group by Size and Payment Mechanism

The average number of subsystem tasks that were performed are presented in Table 6-2 and are broken down according to size and payment mechanism. Judging from the total number of tasks performed in each group size, it becomes apparent that the larger the group, the more administrative tasks performed. One possible explanation for this is that larger groups may have more administrative staff who can perform more tasks than can just one administrator in a small group. The number of tasks performed in each subsystem follows the same basic pattern; the number of performed tasks increases as the size of the group increases. Both the maintenance and managerial subsystem are prime examples of this trend.

The Effect of Size on Tasks Performed in Subsystems

The maintenance subsystem. In the maintenance subsystem, as groups become larger, there is greater need to perform tasks that maintain the stability of the group and mediate between task demands and human needs to keep the group functioning smoothly (Allen, 1964). Larger groups tend to be more vulnerable to disruptive influences because of their size. These groups, therefore, must perform more formal tasks that standardize both the group's procedural tasks and its manpower so that there is less chance of ambiguity upsetting the operation of the group. Smaller groups can perform fewer maintenance tasks because their size allows the groups' administrators to become aware of trouble spots early and to correct them personally without the need for any formal structures.

The managerial subsystem. There are more managerial subsystem tasks performed in large groups because there are usually more issues requiring decisions, and there are more group functions needing coordination. There is greater potential in larger groups for inefficiency and waste due to poor coordinating. To avoid this, large groups must rely on performing more formalized managerial tasks that will increase the chance for long-term survival, optimize resources, and develop the group's capabilities. Small groups can place less emphasis on the managerial subsystem because there is less need to coordinate and structure the group on a formal level. Informal and more personalized control on the part of the administrator and governing body is generally sufficient.

The adaptive subsystem. The number of adaptive subsystem tasks also increases linearly as the size of the group increases. Larger groups tend to be more susceptible to pressure for change from the external world; therefore, more tasks devoted to monitoring changes in the environment and making recommendations for change to the managerial subsystem become necessary. Because rapid change becomes more difficult as size increases, large groups must always keep their intelligence tasks operative to be forewarned of possible changes. Small groups, on the other hand, are not as structurally sophisticated as large groups and, therefore, can afford to perform fewer adaptive tasks.

The boundary/production supportive—procurement and —disposal subsystems. Both the boundary/production supportive—procurement and —disposal subsystems follow the same trend of more performed tasks for larger groups. The larger a group becomes, the greater its need for securing production inputs of materials and manpower and for disposing of its outputs to obtain working capital. Thus, greater emphasis in the form of more tasks is placed on these subsystems to ensure the large groups of continued inputs and outputs.

The boundary/institutional supportive subsystem. More boundary/institutional supportive tasks are performed by larger groups because their size makes them more visible to other institutions. Large groups also have greater resources to draw upon from within their ranks to perform tasks in this subsystem.

The Effects of Payment Mechanism on Tasks Performed in Subsystems

The number of subsystem tasks performed by groups

TABLE 6-2

PROFESSIONAL ADMINISTRATORS' RESPONSES AS TO THE AVERAGE NUMBER OF TASKS PERFORMED IN EACH KATZ AND KAHN SUBSYSTEM BY SIZE AND PAYMENT MECHANISM (COLUMN 1 OF STANDARD LIST)

Subsystems	Fee for Service			Prepayment		
	Small	Medium	Large	Small	Medium	Large
Totals	114.58	119.66	123.13	117.42	123.14	129.53
Maintenance	34.30	35.52	36.54	34.43	36.00	38.56
Procurement	11.01	11.41	11.53	11.53	12.56	13.60
Disposal	4.57	4.98	4.94	4.94	5.24	5.25
Supportive	1.86	2.05	2.19	2.19	2.42	2.60
Adaptive	8.35	8.70	8.83	8.83	9.31	9.63
Managerial	55.48	57.95	56.00	56.00	59.05	61.40

with prepayment plans was always slightly higher than the number performed by similar-sized groups with fee for service as their payment mechanism. Significance testing between the two types of payment indicates, however, that there is no significant difference between the number of managerial or maintenance tasks performed. The type of payment mechanism affects only the number of boundary and adaptive subsystem tasks. Groups that employ prepayment plans must give greater attention to the external environment than do fee for service groups because they have greater dependence on external conditions for their economic survival (Allison, 1975).

Systems Description of the Administrative Roles by Size and Payment Mechanism

The professional administrators' responses by size and payment mechanism for who has chief responsibility for the groups' administrative tasks are presented in Table 6-3.

The percentage of tasks for which the professional administrator is responsible decreases as the size of the group increases. The same relationship holds true for the governing body's responsibility. It must be remembered, however, that the number of tasks performed in groups increases with size. The administrator and the governing body, therefore, may not be losing task responsibility but only delegating more of the tasks to other roles. The percentage of tasks that both the medical director and others are responsible for increases with size; it would appear that these two roles assume greater importance as group practices grow in size.

The percentage of tasks that the professional administrator in a prepayment group is responsible for is consistently greater than that of his counterpart in a fee for service group. Since prepayment groups also perform more tasks than do fee for service, the professional administrator in a prepayment group appears to be retaining these additional tasks as his own. The medical director in a prepayment group also assumes a greater proportion of the task responsibility than he does in fee for service groups. Site visit discussions at prepayment groups indicated that these groups are more consumer oriented than are fee for service groups; therefore, the medical director in a prepayment group is more likely to be responsible for tasks that concern patients and medical issues. The chief responsibility pattern is reversed for governing bodies in fee for service and prepayment groups. Governing bodies in prepayment groups have less responsibility for administrative tasks than do governing bodies in fee for service groups. This indicates a decreased role for for governing bodies in prepayment groups.

Description By Subsystem Tasks

Chief responsibility. Table 6-4 displays the percentage of task responsibility that the professional administrator has in each subsystem. The percentage of task responsibility for all administrative roles is presented in Appendix B, Table B-5.

Overall, professional administrators in large groups have less responsibility for subsystem tasks than do professional administrators in small groups. The administrator of a large group is more likely to have administrative staff, and if he does, he is certain to delegate some of his responsibility to his staff. Site visit discussions indicated this to be the case. In addition, large groups perform more tasks; therefore, the absolute number of tasks for which a professional administrator is responsible may not actually be different in different sized groups. There is a difference, however, in the level of the activities between administrators of small and large groups. This is indicated by the analysis of the professional administrator's critical tasks by Fine's methodology for size and payment mechanism (Appendix B, Table B-6). The administrator of a large group has a greater percentage of his critical tasks at a functional level higher than those of the administrator of a small group. This relationship remains stable for each of the five importance levels.

The role of the professional administrator in medium-sized groups presents a puzzling picture because it does not fit a standard pattern for all of the subsystems in either the level of responsibility or, as will be discussed, the degree of the professional administrator's personal involvement. The percentage of subsystem tasks for which the professional administrator in medium-sized groups is responsible or in which he is involved is sometimes higher, sometimes lower, but almost never forms a linear relationship from small to large groups. A

TABLE 6-3

PERCENTAGE OF PROFESSIONAL ADMINISTRATORS' RESPONSES AS TO WHO IS CHIEFLY RESPONSIBLE FOR ADMINISTRATIVE TASKS BY SIZE AND PAYMENT MECHANISM (COLUMN 2 OF STANDARD LIST)

	Fee For Service			Prepayment		
	Small	Medium	Large	Small	Medium	Large
No One	.01	.01	0	.01	.01	0
Professional Administrator	.53	.50	.48	.57	.53	.49
Medical Director	.06	.07	.07	.10	.15	.15
Governing Body	.35	.32	.26	.26	.24	.21
Other	.05	.10	.18	.06	.07	.15

TABLE 6-4

PERCENTAGE OF TASKS IN EACH KATZ AND KAHN SUBSYSTEM FOR WHICH PROFESSIONAL ADMINISTRATORS ARE CHIEFLY RESPONSIBLE BY SIZE AND PAYMENT MECHANISM (COLUMN 2 OF STANDARD LIST)

Subsystems	Fee for Service			Prepayment		
	Small	Medium	Large	Small	Medium	Large
Maintenance	59	55	52	60	55	53
Procurement	66	62	54	65	66	56
Disposal	70	66	60	72	82	53
Supportive	39	44	39	48	54	31
Adaptive	64	59	62	62	65	59
Managerial	44	41	42	48	45	45

possible reason for this unusual pattern is that medium-sized groups are going through an organizational transition period which, from organizational theory, is known to be very chaotic and disruptive for any organization (Porter, Lawler, & Hackman, 1975). Once the size of a group grows beyond the point that its functions and personnel cannot be controlled by personal interaction, the group must make the transition to a more explicitly structured organization (Pugh, Hickson, Hinings, & Turner, 1969). This would appear to be the case in medium-sized groups, and the role of the professional administrator in these groups reflects his efforts to help the group make the transition. A more detailed account of what occurs in a medium-sized group in a transition period has been given by Allen (1964).

The differences between the professional administrators in the two payment plans are slight. Significance tests between the subsystems on type of payment plan were not significant, indicating that the type of payment plan does not influence the amount of task responsibility for the professional administrator.

Personal involvement. The professional administrator's average personal involvement by Katz and Kahn subsystems for size and payment mechanism is presented in Table 6-5.

In general, the pattern that emerges for the professional administrator's personal involvement in each subsystem is that his involvement lessens as the group's size increases. Significance tests for each subsystem indicates that this is statistically valid for all but the boundary/institutional supportive, the adaptive, and the managerial subsystems. The professional administrator's involvement in these subsystems does not vary due to size of the group. In some subsystems, notably the adaptive and the boundary/institutional supportive, the effect of the medium-sized groups on the professional administrator's involvement is apparent. The medium-sized phenomenon is also apparent in prepayment groups for the boundary/production supportive—procurement and —disposal subsystems, the adaptive subsystem, and the managerial subsystem. There are no significant differences in personal involvement between professional administrators in prepayment and fee for service groups. Professional administrators are personally involved in each subsystem to the same degree no matter what payment mechanism is employed by their group.

To determine the specific effects of both size and payment mechanism on the role of the professional administrator, the level of the professional administrator's personal involvement for each item in a subsystem was examined for differences due to size or payment mechanism. A visual inspection of these scores, however, leads to the conclusion that there is little difference between subgroups for level of personal involvement. This occurs because of the limited range of the personal involvement scale and the large number of professional administrators in each subgroup. Therefore, significance tests were utilized to identify those items in each subsystem that were significantly different due to size or payment mechanism. The following examination of the professional administrator's role for each subgrouping category will focus exclusively on significant differences found.

The maintenance subsystem. In Table 6-6 the professional administrator's average personal involvement for each item in the maintenance subsystem is presented by both size and payment mechanism.

TABLE 6-5

PROFESSIONAL ADMINISTRATORS' AVERAGE PERSONAL INVOLVEMENT IN EACH KATZ AND KAHN SUBSYSTEM

Subsystems	Fee for Service			Prepayment		
	Small	Medium	Large	Small	Medium	Large
Maintenance	3.89	3.70	3.54	3.84	3.69	3.49
Procurement	4.06	4.00	3.60	3.89	3.93	3.65
Disposal	3.74	3.54	3.44	3.67	3.79	3.41
Supportive	3.31	3.45	3.45	3.43	3.65	3.44
Adaptive	3.90	3.90	3.92	3.83	3.94	3.66
Managerial	3.82	3.79	3.58	3.83	3.83	3.69

TABLE 6-6

PROFESSIONAL ADMINISTRATORS' AVERAGE PERSONAL INVOLVEMENT BY SIZE AND PAYMENT MECHANISM—MAINTENANCE SUBSYSTEM TASKS (COLUMN 3 OF STANDARD LIST)

	Small		Medium		Large	
	M	SD	M	SD	M	SD
MAINTENANCE SUBSYSTEM						
15. *Develop, review, and/or revise* standard operating procedures for:						
a. Delivering patient care.	3.28	1.29	3.38	1.17	3.20	1.28
	3.14	1.23	2.91	1.24	2.75	1.42
b. Physician personnel administration.	3.30	1.37	3.48	1.31	3.00	1.03
	3.09	1.34	2.95	1.34	3.17	1.40
c. Non-physician personnel administration.	4.46	0.94	4.20	1.04	4.40	0.68
	4.68	0.67	4.59	0.71	4.64	0.86
d. Utilization control (non-physician).	4.21	1.06	4.05	1.05	3.88	1.22 *
	4.46	0.90	4.26	0.89	4.16	1.21
e. Cost controls.	4.57	0.85	4.38	0.71	4.35	0.88
	4.69	0.68	4.62	0.66	4.52	0.82
f. Billing and collecting.	4.29	1.04	3.92	1.14	3.55	1.32 *
	4.64	0.79	4.44	0.92	4.12	1.27
g. Interacting and dealing with outside agencies.	4.08	1.15	4.17	0.87	4.25	0.85
	4.33	0.97	4.32	0.91	4.00	1.04
h. Gathering, processing, and evaluating information important to your group.	4.27	1.07	4.33	0.92	3.80	1.06 *
	4.40	0.88	4.31	0.94	4.08	1.19
17. Enforce adherence to standard operating procedures by:						
a. Physician members (participating).	3.21	1.32	3.00	1.06	2.78	1.06
	2.93	1.28	2.74	1.29	2.71	1.35
b. Physician employees (salaried).	3.30	1.23	3.19	1.13	2.95	1.23
	3.16	1.34	3.03	1.36	2.79	1.32
c. Nurses and medical technicians.	3.83	1.28	3.88	1.03	3.74	0.87
	4.23	1.00	4.02	1.14	3.92	1.18
d. Receptionists, clerks, and maintenance personnel.	4.44	0.8[illegible]	4.13	1.03	3.90	1.17 *
	4.61	0.78	4.34	0.94	4.24	1.13
e. Administrative staff.	4.35	1.05	4.44	0.92	4.55	0.69
	4.52	0.[illegible]	4.44	0.88	4.88	0.33
21. *Develop, review and/or revise* job specifications, job descriptions, and/or job standards of:						
a. Physician members (participating).	3.36	1.34	3.13	1.15	2.79	1.12
	2.90	1.30	2.61	1.23	2.50	1.50
b. Physician employees (salaried).	3.48	1.34	3.25	1.16	2.60	1.18 *
	3.10	1.34	2.70	1.27	2.53	1.50
c. Nurses and medical technicians.	3.98	1.09	3.55	1.06	3.71	1.16
	4.16	1.03	4.02	1.06	3.52	1.33 *
d. Receptionists, clerks, and maintenance personnel.	4.37	0.91	4.13	0.97	3.78	1.26 *
	4.61	0.79	4.33	0.97	4.26	1.10
23. *Develop, review, and/or revise* payment plans/salary schedules and benefits for:						
a. Physician memebers (participating).	3.89	1.10	3.87	1.10	3.42	1.39
	3.47	1.42	3.79	1.05	4.06	1.00
b. Physician employees (salaried).	3.81	1.15	3.84	1.11	3.65	1.39
	3.59	1.36	3.69	1.17	3.91	1.12

TABLE 6-6 (Cont.)

	Small		Medium		Large		
	M	SD	M	SD	M	SD	
c. Nurses and medical technicians.	4.43	0.82	4.14	1.11	4.32	0.95	
	4.54	0.85	4.49	0.82	4.54	0.88	
d. Receptionists, clerks, and maintenance personnel.	4.62	0.70	4.36	1.09	4.20	1.11	
	4.66	0.75	4.64	0.68	4.67	0.56	
31. Orient and train new personnel:							
a. Physician members (participating).	2.94	1.43	3.41	1.33	2.56	1.04	
	2.75	1.37	2.83	1.21	3.11	1.53	
b. Physician employees (salaried).	3.03	1.48	3.36	1.33	2.95	1.05	
	2.93	1.37	2.93	1.25	3.04	1.61	
c. Nurses and medical technicians.	3.46	1.40	3.19	1.29	2.68	1.11	*
	3.49	1.34	2.99	1.39	2.42	1.50	
d. Receptionists, clerks, and maintenance personnel.	4.06	1.16	3.39	1.34	2.58	1.17	*
	4.12	1.14	3.29	1.41	2.80	1.58	
32. Survey the job satisfaction of:							
a. Physician members (participating).	2.92	1.53	3.71	1.14	2.87	1.19	
	2.93	1.42	2.85	1.17	2.71	1.40	
b. Physician employees (salaried).	3.09	1.54	3.67	0.97	2.73	1.16	
	3.11	1.44	2.95	1.23	3.05	1.16	
c. Nurses and medical technicians.	3.85	1.30	3.33	1.24	3.28	1.02	*
	4.13	1.09	3.56	1.26	3.41	1.40	
d. Receptionists, clerks, and maintenance personnel.	4.27	1.04	3.57	1.33	3.47	1.12	*
	4.43	0.94	3.91	1.19	3.22	1.48	
e. Administrative staff.	4.19	1.14	4.24	1.00	4.47	0.77	
	4.25	1.15	4.06	1.12	4.36	1.18	
33. Conduct job performance evaluations for:							
a. Physician members (participating).	2.88	1.45	2.77	1.09	2.20	1.01	
	2.48	1.39	2.23	1.01	3.00	1.83	
b. Physician employees (salaried).	3.07	1.52	2.69	1.14	2.18	0.95	
	2.64	1.41	2.29	1.10	2.36	1.60	
c. Nurses and medical technicians.	3.64	1.29	3.28	1.18	3.16	1.12	*
	4.09	1.16	3.40	1.27	2.71	1.62	
d. Receptionists, clerks, and maintenance personnel.	4.21	1.15	3.48	1.29	3.15	1.14	
	4.43	0.94	3.74	1.33	2.82	1.59	
e. Administrative staff.	4.09	1.21	4.14	1.11	4.68	0.58	
	4.27	1.19	4.05	1.26	4.68	0.72	
37. Interpret group policy and clarify procedures for staff and employees.	4.33	1.07	4.25	1.07	4.42	0.77	
	4.53	0.84	4.57	0.66	4.48	0.82	
40. Discipline:							
a. Physician members (participating).	2.71	1.40	2.64	1.26	2.59	1.23	
	2.09	1.30	2.17	1.17	1.89	1.33	
b. Physician employees (salaried).	2.84	1.42	2.74	1.29	2.72	1.45	
	2.36	1.39	2.26	1.26	1.96	1.43	
c. Nurses and medical technicians.	3.90	1.23	3.70	1.18	3.74	1.19	*
	4.21	1.09	4.00	1.11	3.54	1.10	
d. Receptionists, clerks, and maintenance personnel.	4.18	1.06	3.96	1.20	3.60	1.19	*
	4.51	0.90	4.22	1.02	3.52	1.19	
e. Administrative staff.	4.18	1.20	4.64	0.81	4.70	0.66	
	4.23	1.24	4.51	0.81	4.38	0.92	

Note—For each task, the top row of numbers represents responses by prepayment groups, and the bottom row of numbers represents responses by fee for service groups.

Note—Asterisks on the left side of the table signify significant differences due to payment mechanism and asterisks on the right side of the table signify significant differences due to size.

* $< .01$

The professional administrator's personal involvement in those maintenance tasks that were significantly different due to size generally decreased as the size of the group increased. For many of these tasks, there was as much as or more than a full point (1.0) difference in personal involvement between the professional administrator in a small group and the professional administrator in a large group. Considering the large number of professional administrators in each size group and the limited 5-point involvement scale, these differences are quite meaningful. The number and magnitude of differences due to payment mechanism are less pronounced than the effects due to group size. In most instances, the professional administrator in a prepayment group is less personally involved than his counterpart in a fee for service group for the significant maintenance tasks.

The size of a group has various effects upon the role of the professional administrator in the maintenance subsystem. One of these effects concerns the professional administrator's involvement with the tasks of developing and endorsing standard operating procedures for his group. The larger the group the less involvement the professional administrator has with developing standard operating procedures for utilization control, obtaining information important to his group, and billing and collecting. The last item is interesting in that most small medical groups originally hire a professional administrator primarily to handle this function (Allen, 1964). The importance of this activity to the professional administrator of a small group is shown by the high level of personal involvement he has in this activity. As the group grows larger, however, the professional administrator's involvement in this task decreases. It would appear that the professional administrator of a large group can not be as involved in this activity as the professional administrator of a small group. Size differences also exist in terms of the professional administrator's involvement with enforcement of these standard operating procedures; the professional administrator of a small group is much more involved in enforcement of procedures than is the professional administrator of a larger group.

The pattern of less personal involvement the larger the group also pertains to the maintenance activities of developing job descriptions and standards, training and orienting, conducting performance evaluation, assessing job satisfaction, and disciplining the group's staff. In particular, differences between the three size groups for these activities concerned the professional administrator's involvement with the nonphysician staff of the group. With regard to physician personnel, there were hardly any differences due to group size for these maintenance tasks. For the maintenance tasks dealing with the group's physicians, the professional administrator's personal involvement was uniformly low regardless of the group's size.

There were two maintenance activities for which no differences existed between the professional administrators' involvement due to size. The first task concerned the development, review, and/or revision of payment plans, salary schedules, and benefits for all staff personnel, both physician and nonphysician. The second maintenance activity for which no difference existed was to interpret group policy and clarify procedures for staff and employees. Both of these tasks, therefore, can be considered of equal concern to all professional administrators regardless of the size of their groups.

The influence of a group's payment mechanism on the professional administrator's role in the maintenance subsystem overall is much less than the influence of group size. For most maintenance tasks, payment mechanism has no effect on the professional administrator's personal involvement. However, some significant differences do exist. The professional administrator of a prepayment group is less personally involved in developing standard operating procedures for nonphysician personnel administration, cost controls, and billing and collecting than is the professional administrator of a fee for service group. Billing and collecting would be less of a concern for the professional administrator of a prepayment group as part of the group's revenue is generated by one time payments for medical care. On the other hand, the professional administrator of a fee for service group must be concerned with collecting payments from patients each time they utilize his group's services.

The difference between payment mechanism groups on cost control is not as easily explained as the possible reason for the difference in collecting and billing. It would appear logical that the professional administrator of a prepay group would be more involved rather than less involved in developing standard operating procedures for cost controls than a professional administrator of a fee for service group. In a prepayment group, the professional administrator must be concerned with keeping his operating budget within the limits of the revenue generated by prepayment. If he fails to do so he does not have the option to increase fees or cut services as easily as the professional administrator of a fee for service group does. It would appear, therefore, that he would keep a tight reign through the development of standard procedures for cost controls in order to keep his group within its budget. In site visit discussions with professional administrators of prepayment groups, one possible explanation for the lower involvement with cost controls was uncovered. These professional administrators mentioned that in a prepayment group, the physicians took a more active role in keeping costs down and often imposed their own cost controls.

Differences in the professional administrator's personal involvement due to payment mechanism also exist regarding the enforcement of adherence to standard operating procedures by nonphysician personnel. The prepayment professional administrator is less involved in this activity than is the fee for service professional administrator. In a similar fashion, the professional administrator of a prepayment group is less involved in developing job descriptions or specifications for nonmedical staff. Also, he is much less involved in disciplining nonmedical personnel than is his counterpart in a fee for service group. This relationship, however, is reversed when the disciplining pertains to the group's physicians, either participating or salaried. For this task, the professional administrator of a prepayment group is more involved than is the

professional administrator of a fee for service group.

The boundary/production supportive—procurement subsystem. The breakdown of the professional administrator's personal involvement for boundary/production supportive—procurement tasks by size and payment mechanism is presented in Table 6-7.

The effect of group size on the professional administrator's involvement in the procurement tasks cuts across several activities within this subsystem. One of these activities is to negotiate purchase price/contracts for supplies, equipment, and/or nonmedical services. The larger the group, the less personally involved is the professional administrator in this task. Another task where this type of linear relationship is present is in the recruitment of nurses and medical technicians as well as all nonmedical personnel. The professional administrator of a small group is highly involved in recruiting these kinds of personnel, less so for the professional administrator of a medium-sized group and only moderately so for the professional administrator of a large group.

Two tasks that concern the professional administrator's involvement in the procurement of the group's patients also vary significantly due to size. The first of these two is to resolve nonmedical patient complaints and the second is to mediate/arbitrate between the group's physicians and patients in conflicts over medical services. The professional administrator's involvement in these two tasks is a decreasing function due to size: the professional administrator of a small group is much more involved in these activities than is the professional administrator of a medium or a large group.

The professional administrator's personal involvement in two other procurement tasks that are significantly different due to size demonstrates the influence of the organizational transition period discussed earlier. These tasks are: recruit physician members and secure liability insurance coverage for the group and/or it's physicians. The professional administrator of a medium-sized group is much more involved in these two tasks than the professional administrator of either a small or a large group. If the medium-sized group is in a transistion period, it is likely to be experiencing a fair amount of strain due to the need to restructure the organization. This could potentially lead to many of the group's physicians leaving the organization. If this is in fact what occurs, the professional administrator would be involved more than normally in recruiting physicians to replace those that leave the group. The higher involvement of the medium-sized group professional administrator in securing insurance for the group and its physicians would follow from the task of recruiting more physicians. If there are more new physicians in the group, the professional administrator would need to be more involved in securing insurance coverage for these physicians.

There are only three items in this subsystem for which there are differences in the professional administrator's personal involvement due to payment mechanism. The professional administrator for a prepayment group is less involved in negotiating purchase prices and contracts for supplies, equipment, and nonmedical services than is the fee for service professional administrator. In addition, there is less involvement on the part of the prepayment group professional administrator in recruiting nonphysician and nonmedical staff personnel. The professional administrator of a fee for service group is significantly more involved in these recruiting tasks.

The boundary/production supportive—disposal subsystem. There are two tasks in this subsystem for which significant differences exist between the professional administrator's personal involvement due to either group size or payment mechanism. The disposal subsystem tasks and the professional administrator's average personal involvement with them is presented in Table 6-8 by size and payment mechanism.

Representing the group or individual physicians in court appearances on collection cases is the one task in this subsystem that differentiates professional administrators in different size groups. The professional administrator of a large group has very little personal involvement with this activity compared to the professional administrator of a medium or a small group. The effect of payment mechanism is demonstrated only for the activity of working with third party payers to assure efficient collections for the group. The prepayment group professional administrator is significantly less involved in the task than is the fee for service professional administrator. Except for these two tasks, neither size nor payment mechanism seems to have much of an influence on the professional administrator's role in this subsystem.

The boundary/institutional supportive subsystem. There are three tasks in this subsystem, and none of these tasks varied significantly on the level of the professional administrator's personal involvement due to size or payment mechanism. The conclusion that can be drawn is that the professional administrator is involved with boundary/institutional supportive tasks to the same degree regardless of either the size of his group or its payment mechanism. The breakdown by size and payment mechanism for the professional administrator's personal involvement in these tasks is presented in Table 6-9.

The adaptive subsystem. The role of the professional administrator in the adaptive subsystem appears to be very uniform over size and payment types. There are only two tasks in this subsystem for which the personal involvement of the professional administrator varies significantly for either different-sized groups or groups with different payment mechanisms. The adaptive tasks and the professional administrators average involvement for each are presented in Table 6-10 by size and payment mechanism.

Differences in the professional administrator's personal involvement for either size or payment mechanism occurred for one major task in this subsystem. This activity is the collection, processing, and evaluation of information, and/or making recommendations relative to factors that might affect the manner in which services are rendered in the group. Of the four items relating to this task, there were significant differences in the professional administrator's involvement due to size for one,

TABLE 6-7

PROFESSIONAL ADMINISTRATORS' AVERAGE PERSONAL INVOLVEMENT BY SIZE AND PAYMENT MECHANISM—BOUNDARY/PRODUCTION SUPPORTIVE—PROCUREMENT SUBSYSTEM TASKS (COLUMN 3 OF STANDARD LIST)

	Small		Medium		Large		
	M	SD	M	SD	M	SD	
BOUNDARY/PRODUCTION SUPPORTIVE—PROCUREMENT SUBSYSTEM							
8. Negotiate purchase price/contracts for supplies, equipment, and/or non-medical services.	4.35	1.06	3.88	1.39	3.50	1.19	*
	4.61	0.79	4.47	0.87	4.08	1.22	
13. Search and negotiate for investment capital.	4.03	1.15	4.47	0.94	4.00	1.50	
	4.04	1.26	4.23	1.17	4.18	1.42	
25. *Recruit* the following to fill openings in your organization:							
a. Physician members (participating).	3.30	1.59	4.11	1.02	3.37	1.26	*
	3.34	1.51	3.64	1.21	2.89	1.64	
b. Physician employees (salaried).	3.58	1.47	4.00	1.12	3.45	1.15	
	3.53	1.47	3.65	1.21	3.25	1.70	
c. Nurses and medical technicians.	4.22	1.11	3.43	1.31	3.63	1.26	*
	4.50	0.89	4.03	1.21	3.42	1.61	
d. Receptionists, clerks, and maintenance personnel.	4.30	1.12	3.59	1.33	3.50	1.36	*
	4.63	0.82	4.16	1.22	3.46	1.64	
26. *Negotiate* salary and benefit contracts with organized groups of personnel.	3.70	1.76	4.63	0.74	4.44	1.13	
	4.35	1.20	4.68	0.58	4.67	0.82	
30. Negotiate contracts with physicians who wish to join the group.	3.33	1.54	4.29	0.91	3.72	1.27	
	3.52	1.48	3.58	1.41	3.04	1.54	
41. Secure liability insurance coverage for your group and/or your physicians.	4.45	0.96	4.56	1.04	4.00	1.26	*
	4.53	0.91	4.69	0.74	4.40	1.19	
42. Survey patients to ascertain level of patient satisfaction and/or areas of dissatisfaction.	4.03	1.08	3.74	1.19	3.83	0.92	
	4.16	1.00	3.80	1.13	4.22	1.06	
43. Resolve non-medical patient complaints (e.g., charges, fees, personality clashes, etc.).	4.23	1.04	3.80	1.15	3.65	1.04	*
	4.29	1.00	4.03	1.04	4.00	1.22	
44. Mediate/arbitrate between the group's physicians and patients in conflicts over medical services.	3.98	1.32	3.56	1.29	3.35	0.93	*
	3.96	1.25	3.78	1.18	3.61	1.62	
47. Visit the group's patients in the hospital for public relations purposes (non-medical purposes).	3.13	1.67	2.80	1.48	2.88	0.99	
	2.43	1.62	1.57	0.85	2.50	1.38	
54. Negotiate *medical services* covered under health care contracts with organized consumer groups.	3.84	1.43	4.47	0.84	3.40	1.45	
	3.98	1.22	4.09	0.86	3.43	0.98	
55. Negotiate *fees or prices* for health care contracts with organized consumer groups.	3.92	1.47	4.41	0.87	3.71	1.54	
	4.23	1.07	3.92	1.08	3.63	0.92	
57. Settle grievances with industrial or group accounts.	3.74	1.35	4.28	1.13	3.23	1.42	
	4.18	1.13	4.14	0.95	3.92	1.38	

Note—For each task, the top row of numbers represents responses by prepayment groups, and the bottom row of numbers represents responses by fee for service groups.

Note—Asterisks on the left side of the table signify significant differences due to payment mechanism and asterisks on the right side of the table signify significant differences due to size.

*$p < .01$

TABLE 6-8

PROFESSIONAL ADMINISTRATORS' AVERAGE PERSONAL INVOLVEMENT BY SIZE AND PAYMENT MECHANISM—BOUNDARY/PRODUCTION SUPPORTIVE—DISPOSAL SUBSYSTEM TASKS (COLUMN 3 OF STANDARD LIST)

	Small		Medium		Large	
	M	SD	M	SD	M	SD
BOUNDARY/PRODUCTION SUPPORTIVE—DISPOSAL SUBSYSTEM						
45. Represent the group or individual physicians in court appearances on collection cases.	3.42	1.58	3.12	1.69	2.53	1.25
	3.73	1.47	2.93	1.52	2.56	1.69
48* Transmit information about your group's facilities and services to interested persons and/or organized consumer groups.	3.76	1.36	4.13	1.06	3.93	0.80
	4.10	1.10	3.65	1.18	4.05	1.05
49. Represent your group at health care workshops and meetings.	3.71	1.20	4.00	1.06	3.95	0.97
	3.89	1.27	3.77	1.17	3.92	1.41
50. Represent your group in civic matters and projects.	3.63	1.25	3.92	1.06	3.94	0.87
	3.71	1.29	3.82	1.08	3.65	1.30
51. Participate in public health education efforts.	2.76	1.44	3.53	1.37	2.82	1.19
	2.81	1.42	2.43	1.14	2.24	1.22
58. Work with third party payors to assure efficient collections for the group.	4.09	1.17	3.83	1.27	3.33	1.33
	4.22	1.06	4.16	0.96	4.08	1.15

Note—For each task, the top row of numbers represents responses by prepayment groups, and the bottom row of numbers represents responses by fee for service groups.

Note—Asterisks on the left side of the table signify significant differences due to payment mechanism and asterisks on the right side of the table signify significant differences due to size.

* $p < .01$

TABLE 6-9

PROFESSIONAL ADMINISTRATORS' AVERAGE PERSONAL INVOLVEMENT BY SIZE AND PAYMENT MECHANISM—BOUNDARY/INSTITUTIONAL SUPPORTIVE SUBSYSTEM TASKS (COLUMN 3 OF STANDARD LIST)

	Small		Medium		Large	
	M	SD	M	SD	M	SD
BOUNDARY/INSTITUTIONAL SUPPORTIVE SUBSYSTEM						
5. Attempt to influence the outcome of pending legislation or regulations that would affect your group practice.	3.19	1.28	3.67	0.92	3.21	1.13
	3.07	1.25	3.15	1.26	3.47	1.22
52. Try to gain the community's (or public's) acceptance and support for your group and its various programs.	3.94	1.23	4.06	1.09	3.81	1.09
	3.77	1.22	3.68	1.16	3.22	1.26
53. Work with the news media in releasing public and civic interest stories.	3.61	1.27	3.65	1.06	3.75	1.18
	3.63	1.29	3.72	1.18	3.65	1.06

Note—For each task, the top row of numbers represents responses by prepayment groups, and the bottom row of numbers represents responses by fee for service groups.

Note—Asterisks on the left side of the table signify significant differences due to payment mechanism and asterisks on the right side of the table signify significant differences due to size.

* $p < .01$

TABLE 6-10

PROFESSIONAL ADMINISTRATORS' AVERAGE PERSONAL INVOLVEMENT BY SIZE AND PAYMENT MECHANISM—ADAPTIVE SUBSYSTEM TASKS (COLUMN 3 OF STANDARD LIST)

	Small		Medium		Large	
	M	SD	M	SD	M	SD
ADAPTIVE SUBSYSTEM						
1. Collect information, process and evaluate information, and/or make recommendations relative to factors that might affect *patient demand* for your group's services, e.g.:						
a. General trends in the environment (e.g., population census and demographic data, social factors, economic data, etc.):	3.47	1.38	3.71	1.10	3.35	1.27
	3.64	1.21	3.63	1.27	3.23	1.07
b. Legislation and regulations (e.g., NHI & HMO legislation, Medicare-Medicaid, etc.).	3.51	1.16	3.96	0.95	3.50	1.10
	3.73	1.12	3.78	0.95	3.79	1.18
c. Your group's "competition" (e.g., other medical groups, hospitals, etc.).	3.25	1.28	3.86	0.89	3.47	1.12
	3.39	1.19	3.52	1.22	3.53	1.07
2. Collect information, process and evaluate information, and/or make recommendations relative to factors that might affect the *manner in which services are rendered* in your group, e.g.:						
a. New *medical* equipment and procedures.	3.43	1.30	3.46	1.30	3.35	1.09
	3.26	1.16	3.36	1.11	3.29	1.30
b. New *non-medical* equipment and procedures (e.g., POMR, Superbill, etc.).	4.31	1.03	4.23	1.03	3.95	1.19
	4.53	0.91	4.49	0.84	4.38	0.97
c. Legislation and regulations (e.g., PSRO, third party payor accountability regulations, etc.).	3.46	1.25	4.17	0.83	3.55	1.15
	3.82	1.13	3.75	1.17	4.17	0.92
d. Internal processes (e.g., patient flow, overtime, cash flow, etc.).	4.67	0.52	4.30	1.02	3.95	1.15
	4.73	0.67	4.58	0.84	4.68	0.69
11. *Develop* long-range master plans (e.g., facility, financial, etc.).	4.12	1.10	4.67	0.56	4.40	0.88
	4.10	1.13	4.26	0.90	4.42	0.97
18. *Develop* physician staffing plans.	3.40	1.28	3.40	1.26	3.06	1.03
	3.30	1.35	3.03	1.25	3.09	1.38
19. *Develop* non-physician staffing plans.	4.45	0.77	4.04	1.06	4.15	0.88
	4.48	0.88	4.39	0.93	4.48	0.92

Note—For each task, the top row of numbers represents responses by prepayment groups, and the bottom row of numbers represents responses by fee for service groups.

Note—Asterisks on the left side of the table signify significant differences due to payment mechanism and asterisks on the right side of the table signify significant differences due to size.

* $p < .01$

and two items were affected by the type of payment mechanism. The professional administrator of a small group is more involved in the collection of information regarding the internal processes (for example, patient flow, overtime, cash flow, and so forth) of his group than is the professional administrator of a medium-sized group and even more so than the professional administrator of a large group. There was also a significant difference for this item between professional administrators of groups with different payment mechanisms; the professional administrator of a fee for service group is more involved in this activity than his counterpart in a prepayment group. A second part of the above task that also accounts for variance between the professional administrators of different payment mechanism groups deals with new nonmedical equipment and procedures. Again, the fee for service professional administrator is more involved in collecting, processing, and evaluating information concerning new nonmedical equipment and procedures than is the professional administrator of a prepayment group.

The managerial subsystem. The managerial subsystem is the largest subsystem in terms of the number of tasks included in it. It is also a subsystem that

has a large number of tasks for which there are significant differences in the professional administrator's personal involvement due to either size or payment mechanism. The professional administrator's average personal involvement for the managerial tasks by size and payment mechanism is presented in Table 6-11.

There are two managerial tasks for which professional administrator's personal involvement increases in a linear manner the larger the group size. That is, the larger the group, the higher the level of professional administrator's personal involvement in the two tasks. Both of these tasks deal directly with the number of administrators or administrative staff in the group. The first task is establish/approve policies governing the growth or reduction in the number of administrators in the group, the second deals with approval of dismissals and terminations of administrative staff. One possible explanation for this trend would be that a large group has a larger administrative staff than a medium-sized group and a small group. With a larger administrative staff, the professional administrator would most likely delegate some of his responsibility to his staff. This could be one explanation of why the professional administrator of a large group tends to be less involved in administrative tasks than the professional administrators of smaller groups. If the large group has a sizable administrative staff, this staff would have closer personal contact with the professional administrator and he with them. The result would be that the professional administrator would be more involved in tasks which relate to those individuals with whom he deals most often.

Another managerial task area for which size of group has a significant effect on the professional administrator's personal involvement is approving standard operating procedures. The differences exist for the tasks of approving operating procedures relating to utilization control, cost controls, billing and collecting, interacting and dealing with outside agencies, and, finally, gathering, processing, and evaluating information important to the group. The trend that exists for all of these tasks is that the professional administrator's personal involvement in these activities decreases as the size of the group increases.

There are several size differences in the professional administrator's personal involvement with managerial tasks related to the group's personnel. For all of these tasks, the professional administrator's involvement decreases as the size of the group increases. The approval of job specifications, job descriptions, and/or job standards for physician employees, nurses, medical technicians, and nonmedical personnel is one set of these activities. Another is the approving of the appointment or hiring of nurses, medical technicians and nonmedical employees. Size differences also exist for the professional administrator's involvement in approving the promotions of nonmedical personnel, as well as in approving terminations or dismissal for these employees.

Another area of managerial tasks where size differences exist is in the professional administrator's involvement with the personal or interpersonal problems of his employees. The professional administrator of a small group is more involved in counseling his group's nurses, medical technicians, and nonmedical staff with their personal problems than is the professional administrator of a medium-sized group; both of these professional administrators are, in turn, more involved in this task than the professional administrator of a large group. Furthermore, the professional administrator of a small group, in contrast to the professional administrator of a medium or large group, is also more involved in mediating/arbitrating interpersonal problems among these same groups of personnel. It would appear reasonable to conclude that the larger the group, the less involved the professional administrator will be with tasks concerning the personal or interpersonal problems of his group's nonphysicians and nonmedical staff.

The influence of the type of payment mechanism on the professional administrator's personal involvement with managerial tasks is less pronounced than is the effect of group size. There are, however, several managerial tasks that are significantly different due to payment mechanism. Two of these tasks concern the professional administrator's involvement with managerial activities dealing with the group's physician members. The professional administrator of a prepayment group is more involved with the task of approving job specification, descriptions, and/or standards for his group's physician members than is the professional administrator of a fee for service group. In addition, the prepayment group professional administrator is also more involved in the approval of payment plans/salary schedules and benefits for these physicians than is the fee for service professional administrator.

Most of the remaining managerial tasks for which there are significant differences between the level of the professional administrator's personal involvement in a prepayment or fee for service group concern the group's nonphysician personnel. The fee for service professional administrator is more involved with the approval of both the hiring and dismissal of his group's nonmedical personnel than is the prepayment professional administrator. He also has a higher involvement with approving promotions for nurses and medical technicians as well as nonmedical personnel than does the professional administrator of a prepayment group. This same relationship also prevails when the task is counseling to assist with the personal problems of nurses, medical technicians, and nonmedical personnel. However, when the managerial task is to mediate/arbitrate interpersonal problems, nonmedical personnel is the only group of employees for which there is a difference between the prepayment and fee for service professional administrators; the prepayment professional administrator is less involved in arbitrating among this group of personnel. One final task in the managerial subsystem for which there is a difference between the professional administrators of prepayment and fee for service groups is the approval of standard operating procedures for billing and collecting. The professional administrator of the fee for service group is more involved with this task than is the prepayment professional administrator.

TABLE 6-11

PROFESSIONAL ADMINISTRATORS' AVERAGE PERSONAL INVOLVEMENT BY SIZE AND PAYMENT MECHANISM—MANAGERIAL SUBSYSTEM TASKS (COLUMN 3 OF STANDARD LIST)

	Small		Medium		Large	
	M	SD	M	SD	M	SD
MANAGERIAL SUBSYSTEM						
3. Establish/approve your group's position on issues related to the practice of medicine in your group (e.g., PSRO, accountability, licensure/certification, etc.).	2.67	1.38	3.15	1.32	1.79	0.92
	2.74	1.16	2.59	1.15	2.96	1.40
4. *Establish/approve* your group's position on issues related business operations of your group (e.g., taxes, Superbill	4.20	1.08	4.38	0.90	4.20	1.01
	4.40	0.94	4.55	0.81	4.63	0.58
6. Establish/approve the need to replace existing or purc medical equipment.	3.87	1.05	3.65	1.13	3.75	1.12
	3.61	1.12	3.88	1.00	3.67	1.40
7. *Establish/approve* the need to replace existing or purchase additional non-medical equipment and/or services.	4.41	0.88	4.27	1.00	4.20	1.06
	4.52	0.81	4.58	0.71	4.48	1.05
9. *Approve* purchases of equipment or services costing in excess of $1,000.	4.17	0.98	4.33	0.87	4.40	0.82
	4.21	0.99	4.37	0.85	4.12	1.20
10. *Establish/approve:*						
a. Criteria for quality care.	3.06	1.42	2.71	1.08	2.80	0.89
	2.77	1.20	2.41	1.16	2.41	1.26
b. Policies governing your group's organizational structure and type.	3.78	1.21	3.96	1.21	3.95	1.08
	3.73	1.09	3.81	1.01	3.92	1.26
c. Policies governing the number and kind of patients that your group will serve.	3.66	1.12	3.65	1.27	3.13	1.20
	3.23	1.22	3.00	1.23	3.19	1.29
d. Policies governing the growth or reduction in the number of physicians in your group.	3.46	1.24	3.64	1.32	3.37	1.06
	3.29	1.31	3.40	1.23	3.24	1.45
e. Policies governing the growth or reduction in the number of administrators in your group.	3.76	1.54	4.62	0.97	4.45	1.15
	3.72	1.47	4.22	1.00	4.58	0.97
f. Policies governing the specialty mix of your group's physicians.	3.12	1.31	3.26	1.32	3.00	1.05
	2.76	1.30	2.84	1.18	2.92	1.32
g. Financial policies.	4.48	0.70	4.72	0.68	4.60	0.60
	4.52	0.80	4.54	0.75	4.84	0.47
h. Accounting policies.	4.57	0.67	4.52	0.82	4.40	0.82
	4.66	0.73	4.68	0.68	4.76	0.83
i. Physician personnel policies.	3.41	1.31	3.29	1.43	3.20	1.06
	3.12	1.34	3.15	1.25	2.96	1.30
j. Non-physician personnel policies.	4.61	0.75	4.52	0.71	4.60	0.68
	4.72	0.71	4.71	0.64	4.64	1.00
12. *Approve* long range master plans (e.g., facility, financial, etc.).	3.73	1.34	4.23	1.02	4.20	0.89
	3.58	1.33	3.67	1.32	4.87	1.39
14. *Approve* your group's operating budget.	4.28	1.06	4.53	0.96	4.28	1.18
	4.33	1.05	4.37	0.90	4.57	1.03
16. Approve standard operating procedures (new or revised) for:						
a. Delivering patient care.	3.47	1.32	3.29	1.10	3.15	1.04
	3.12	1.18	2.72	1.17	2.46	1.32

TABLE 6-11 (Cont.)

	Small		Medium		Large	
	M	SD	M	SD	M	SD
b. Physician personnel administration.	3.24	1.34	3.19	1.08	3.11	1.15
	2.96	1.28	2.91	1.22	2.46	1.38
c. Non-physician personnel administration.	4.49	0.84	4.38	0.85	4.15	0.81
	4.53	0.84	4.43	0.88	4.12	1.23
d. Utilization control (non-physician).	4.39	0.88	4.20	1.01	4.00	1.00
	4.46	0.96	4.18	0.98	3.81	1.44
e. Cost controls.	4.54	0.82	4.25	0.79	4.25	0.85
	4.58	0.80	4.57	0.74	3.75	1.51
f. Billing and collecting.	4.53	0.86	4.13	1.03	3.40	1.27
	4.61	0.79	4.52	0.90	4.13	1.39
g. Interacting and dealing with outside agencies.	4.16	1.11	4.12	1.01	3.68	0.82
	4.22	1.03	4.06	1.09	3.67	1.27
h. Gathering, processing, and evaluating information important to your group.	4.27	1.01	4.12	1.09	3.80	1.01
	4.24	1.01	4.18	1.01	3.63	1.31
20. *Approve* staffing plans.	4.02	1.13	4.04	1.24	4.21	0.86
	4.03	1.15	3.84	1.11	3.79	1.44
22. *Approve* job specifications, job descriptions, and/or job standards (new or revised) for:						
a. Physician members (participating).	3.33	1.34	3.00	1.41	2.85	1.28
	2.65	1.29	2.45	1.15	1.82	1.29
b. Physician employees (salaried).	3.06	1.41	2.88	1.41	2.64	1.28
	2.80	1.28	2.61	1.22	1.79	1.23
c. Nurses and medical technicians.	4.14	1.09	3.38	1.07	3.67	1.28
	4.01	1.11	3.95	1.06	3.27	1.58
d. Receptionists, clerks, and maintenance personnel.	4.60	0.77	4.18	1.05	4.11	1.18
	4.55	0.86	4.36	0.92	4.30	1.11
e. Administrative staff.	4.43	1.03	4.57	0.68	4.67	0.59
	4.40	1.02	4.37	0.86	4.68	0.78
24. *Approve* payment plans/salary schedules and benefits (new or revised) for:						
a. Physician members (participating).	3.61	1.28	3.61	1.23	3.42	1.22
	3.04	1.44	3.30	1.25	3.06	1.80
b. Physician employees (salaried).	3.56	1.25	3.68	1.44	3.40	1.23
	3.19	1.43	3.24	1.32	2.86	1.75
c. Nurses and medical technicians.	4.27	1.02	4.27	0.83	4.24	0.90
	4.25	1.11	4.28	0.97	3.82	1.62
d. Receptionists, clerks, and maintenance personnel.	4.40	0.99	4.35	0.88	4.26	0.87
	4.44	1.00	4.39	0.94	3.96	1.43
e. Administrative staff.	4.02	1.33	4.50	0.72	4.53	0.70
	4.19	1.26	4.31	1.00	4.00	1.53
27. *Approve* contracts with organized groups of personnel.	3.44	1.88	4.29	1.50	4.33	0.87
	3.98	1.38	4.63	0.68	4.00	1.41
28. *Approve* appointment/hiring of:						
a. Physician members (participating).	3.00	1.48	3.26	1.36	2.89	1.24
	2.68	1.43	2.71	1.24	2.16	1.46
b. Physician employees (salaried).	3.15	1.49	3.46	1.27	2.95	1.15
	2.87	1.43	2.77	1.31	2.50	1.67

TABLE 6-11 (Cont.)

	Small		Medium		Large	
	M	SD	M	SD	M	SD
c. Nurses and medical technicians.	4.24	1.11	3.70	1.26	3.74	1.37
	4.35	1.07	4.15	1.10	4.08	1.38
d. Receptionists, clerks, and maintenance personnel.	4.45	0.99	3.88	1.26	3.53	1.43
	4.63	0.85	4.32	1.08	4.08	1.26
e. Administrative staff.	4.20	1.29	4.46	0.88	4.74	0.56
	4.30	1.24	4.49	0.92	4.48	1.01
29. Approve end of probationary appointments for physicians.	2.65	1.50	2.86	1.31	2.71	1.27
	2.47	1.44	2.45	1.19	2.17	1.65
34. Approve promotions of:						
a. Physician members (participating).	2.56	1.50	2.46	1.19	2.42	0.90
	2.39	1.35	2.00	1.07	1.93	1.49
b. Physician employees (salaried).	2.82	1.52	2.42	1.26	2.29	0.73
	2.61	1.41	2.29	1.24	2.10	1.55
c. Nurses and medical technicians.	3.97	1.22	3.60	1.15	3.47	1.39
	4.16	1.14		1.02	3.91	1.20
d. Receptionists, clerks, and maintenance personnel.	4.31	1.04		1.30	3.45	1.40
	4.57	0.88	.36	0.89	4.00	1.29
e. Administrative staff.	4.04	1.28	4.58	0.65	4.68	0.75
	4.33	1.16	4.41	0.95	4.56	0.92
35. Approve dismissals and terminations of:						
a. Physician employees (salaried).	2.59	1.52	2.90	1.45	2.53	1.18
	2.41	1.41	2.38	1.32	2.17	1.61
b. Nurses and medical technicians.	3.93	1.27	3.70	1.15	3.48	1.22
	4.09	1.24	4.06	1.18	3.84	1.37
c. Receptionists, clerks, and maintenance personnel.	4.38	1.09	3.84	1.21	3.55	1.19
	4.61	0.85	4.44	0.94	4.00	1.26
d. Administrative staff.	3.98	1.42	4.60	0.71	4.74	0.56
	4.18	1.33	4.53	0.93	4.60	1.00
36. Negotiate dissolutions from the membership of physician members (participating) who leave the group.	3.76	1.30	4.00	1.34	3.37	1.34
	3.57	1.50	3.72	1.40	3.05	1.64
38. Counsel, to assist with *personal* problems:						
a. Physician members (participating).	3.25	1.48	3.29	1.26	3.25	1.18
	3.25	1.35	3.21	1.39	3.07	1.39
b. Physician employees (salaried).	3.26	1.46	3.50	1.25	3.29	1.16
	3.30	1.34	3.30	1.38	3.31	1.30
c. Nurses and medical technicians.	3.50	1.21	3.09	1.41	3.38	1.36
	3.96	1.16	3.52	1.31	3.42	1.43
d. Receptionists, clerks, and maintenance personnel.	3.59	1.18	3.13	1.49	3.47	1.37
	4.08	1.14	3.69	1.32	3.40	1.35
39. Mediate/arbitrate *interpersonal* problems:						
a. Among physicians.	3.05	1.38	3.09	1.41	3.00	1.11
	3.05	1.41	2.87	1.34	2.46	1.50
b. Among nurses and medical technicians.	4.07	1.10	3.87	1.25	3.21	1.08
	4.19	1.08	3.90	1.20	3.52	1.34
c. Among receptionists, clerks, and maintenance personnel.	4.19	1.00	3.92	1.35	3.15	1.31
	4.44	0.93	4.00	1.16	3.58	1.21
d. Among administrative staff.	4.32	1.01	4.58	0.78	4.65	0.81
	4.32	1.08	4.36	0.97	4.75	0.44
e. Between physicians and nurses.	3.96	1.19	4.05	1.13	3.95	0.91
	4.02	1.19	4.02	1.11	3.83	1.11

TABLE 6-11 (Cont.)

	Small		Medium		Large	
	M	SD	M	SD	M	SD
f. Between physicians and administrators.	4.18	1.13	4.00	1.41	4.60	0.82
	4.20	1.20	4.35	1.10	4.17	1.24
46. Represent the group or individual in court appearances on malpractice litigation.	2.61	1.59	3.30	1.34	3.00	1.41
	2.53	1.43	2.23	1.26	2.27	1.61
56. Approve contracts with organized consumer groups.	3.74	1.45	4.39	0.92	3.47	1.51
	4.00	1.26	3.55	1.23	3.11	1.36

Note—For each task, the top row of numbers represents responses by prepayment groups, and the bottom row of numbers represents responses by fee for service groups.

Note—Asterisks on the left side of the table signify significant differences due to payment mechanism and asterisks on the right side of the table signify significant differences due to size.

*$p < .01$

Responsibility—involvement interaction. The professional administrator's personal involvement in tasks for which each administrative role is chiefly responsible is presented in Table 6-12 for both size and payment mechanism. This data for each of the subsystems are included in Appendix B, Table B-7.

The professional administrator's involvement in his own tasks shows a curvilinear relationship for size; that is, professional administrators in medium-sized groups have less involvement in their own tasks than do professional administrators in either small or large groups. Professional administrators in medium-sized groups, however, have more involvement in governing body tasks than do the administrators in either small or large groups. If the medium-sized groups are in a transition stage, the professional administrator typically directs more of his attention toward getting his governing body, as the highest decision-making level of a group, to implement the necessary policy and structure required to aid the group through the transition period (Allen, 1964). Thus, the professional administrator is less involved in his own tasks and more involved in the tasks of his governing body.

Decision Index. The decision index for size and payment mechanism is displayed below in Table 6-13. The decision index represents the average number of College of Medical Group Administrators (ACMGA) 10 hypothetical decision tasks in the survey questionnaire's decision table. The larger the index, the greater the number of individuals who participate in the decision making. While type of payment mechanism did not affect this index greatly, size of the group did. The larger the group, the more individuals who participate in the decision-making process. A bad decision made in a large group is not easy to change; therefore, more input from a larger number of individuals will reduce the chances that a pending decision will be made on faulty or incomplete data.

TABLE 6-12

PROFESSIONAL ADMINISTRATORS' AVERAGE PERSONAL INVOLVEMENT BY WHO IS CHIEFLY RESPONSIBLE BY SIZE AND PAYMENT MECHANISM (COLUMN 2—3 INTERACTION)

	Fee for Service			Prepayment		
	Small	Medium	Large	Small	Medium	Large
No One	.32	.43	.28	.48	.57	.24
Professional Administrator	4.38	4.22	4.31	4.05	3.96	4.11
Medical Director	1.18	1.46	1.79	1.63	1.16	2.34
Governing Body	3.04	3.10	2.85	2.65	3.30	3.21
Other	2.02	2.27	2.21	1.60	2.00	2.50

TABLE 6-13

PROFESSIONAL ADMINISTRATORS' DECISION INDEX BY SIZE AND PAYMENT MECHANISM (DECISION TABLE)

	Size		
Payment Mechanism	Small	Medium	Large
Fee for Service	2.31	2.52	2.56
Prepayment	2.25	2.47	2.94

CHAPTER 7

THE FUTURE OF HEALTH CARE

While there are a variety of methods for predicting the future in a qualitative sense, the data for this study drew on three types of predictive methodologies. Included in this study were three modified Nominal Groups (the Del Becq Technique), two Delphi panel studies, and nine interviews. The modified Nominal Groups all were conducted during the 1975 calendar year with the American College of Medical Group Administrators (nee American College of Clinic Managers), a group of California group practice administrators, and a set of group practice medical directors. The two Delphi panels, made up of a wide variety of health care experts, were conducted as parts of two other studies. These two Delphi studies were undertaken in 1973 and 1974 respectively. The interviews, with one exception, were all conducted in the latter half of 1975 with a wide variety of experts, leaders, and seers.

The Nominal Groups conducted as a part of this study involved three sets of group practice administrative personnel and were designed with the hope of achieving a convergence of ideas from a divergent group of participants. The first group, which was convened in February, 1975, included nine persons, seven of them being members of the executive board of the American College of Medical Group Administrators (ACMGA) and two being members of that College. The second group, which met in August, 1975, included ten preselected California group practice administrators. These administrators were selected on the basis of their written responses to a questionnaire about predicting the future mailed to all California administrators. The third Nominal Group included nine medical directors from group practice settings all across the country. Some of them were preselected on the basis of their written responses to a questionnaire while others were recruited on the basis of recommendations from leaders in group practice.

These Nominal Groups were convened for one day only and the participants were asked to spend one-half day each addressing the following two questions:

1. What do you *predict* will happen in the health care field that will affect the future role of group practice administrators?
2. If you were able to *control* or *invent* the future of health care delivery, what utopian projections would you make to establish the ideal in group practice administration?

Furthermore, with the first Nominal Group, a third question was addressed, namely:

3. How do you see your role as group practice administrator changing to cope with your future predictions?

Each of these groups proceeded through the six steps of the Nominal Group process and generated a list of responses to the questions with both their first-round ranking and their second-round ratings.

The two Delphi studies used in this project, were both conducted by faculty members on university programs in health care administrtion. The first one consulted for this study was published by David Starkweather from the University of California at Berkeley (Starkweather, Gelwick, & Newcomer, 1975). His study was conducted in 1973 and comprised a panel of 24 health care experts (administrators, planners, physicians, consumer advocates, and financing officials). The second one, as yet unpublished, was conducted by Mr. David Bergwall of George Washington University in 1974 (Bergwall & Ferry, 1975). His study was conducted as part of a Health Resources Administration contract. His Delphi panel consisted of twelve health care experts (seven university faculty, with the remainder being representatives of commercial, foundation, and public regulatory agencies in health care). In his study, Starkweather asked his panelists to focus their attention on the future of health care organizations, while Bergwall asked his to direct their attention broadly at the future of the health care delivery system.

The third methodology for viewing the qualitative aspects of the future was developed specifically for use in this study. A series of interviews was conducted by Ms. Carol Brierly, Editor of *Prism Magazine*, and President of Medit, Incorporated. She conducted the interviews with nine selected experts and leaders in the health care field and in broader fields. These interviewees included:

- Lawrence Altman, MD, Medical Writer, *New York Times*
- Isaac Asimov, PhD, Writer of Science Fiction & Non-fiction
- Amitai Etzioni, PhD, Professor of Sociology, Columbia University and Center for Policy Research
- Martin Feldstein, PhD, Professor of Economics, Harvard University
- Eliot Freidson, PhD, Chairman, Department of Sociology, New York University
- Mel Glasser, Director, Social Security Department, United Auto Workers
- Michael Halberstram, MD, Physician, Consultant, Writer
- John Knowles, MD, President, Rockefeller Foundation
- Walter McNerney, President, Blue Cross Association

The interviews were conducted at the workplace of the interviewee and lasted an average of two hours. Tape recordings of the interviews were transcribed for review

by the interviewer, the interviewees, and the project staff.

The final step in assessing the future group practice forms of health care delivery consisted of the combining of the results, the "coning down," from these separate approaches. The framework for organizing this material was derived by combining the Nominal Group results, focusing solely on the predictions (the responses to the first question) and weighting the responses in each of the groups by an index number (see Appendix C). This combining and indexing process resulted in a list of 18 ranked search topics considered probable by group practice administrators and medical directors. These search topics were then used to review the results of the two Delphi studies for further elaboration on detailed aspects related to each of the topics. Again, an index number was derived for each detail elaborated in a Delphi study. Finally, these same search topics were used to guide content analyses of the interviews for the detailed in-depth expert view on each of the topics.

These index scores and the analysis of the Delphi studies and interviews using the 18 search topics produced a spectrum of opinion. These opinions were used to provide a basis for developing scenarios of the alternative futures of health care delivery. These scenarios summarized the collective thinking of Nominal Group participants, Delphi panelists, and interviewees. Also, since it is not reasonable to try to predict the single future but rather the various alternatives that it can take, several scenarios were constructed from the data.

Nominal Group Results

The ACMGA set of group practice managers produced 46 predictions in response to the first question (see Appendix C, Table C-1). The analyzed responses, with their index scores, are displayed in Table 7-1. The item with the greatest agreement on the highest probability of occurrence was the group's prediction that there will be government-controlled health maintenance for every citizen (index score of 0.96). There was less agreement on the next most probable item, but the group predicted a much greater emphasis on ambulatory care (0.64). The remainder of the ACMGA group's predictions had an index score below 0.50, with the next three predictions being related to both organizational and financial aspects of health care delivery. They predicted an emphasis on large health care centers that will support satellite offices (0.48) and a diminution of solo practitioners who will team up with groups which will, in turn, enlarge and merge (0.31). On the financial side, they predicted diminishing fee for service with increased prepay/government/insurance health care (0.40).

The ACMGA group generated 44 responses to the question concerning controlling or inventing the future (see Appendix C, Table C-2). The responses to this question suggest less unanimity with their first two responses receiving almost equal ratings at 600. Thus, they ranked almost equally their desire for solutions to the many social problems which affect health care as well as a free competitive system with well organized, competently staffed health teams enjoying mutual respect, and genuine peer review of physicians, administrators, and fees without substantial government intervention. After this, their unanimity dropped off rather rapidly with their desire for a better awareness on the part of physicians rating only 470 and their desire that government involvement in medical care should occur only by default, rating a 340.

The ACMGA group was the only one that was also asked to address a third question: How do you see your role as a group practice administrator changing to cope with your future predictions? Because they found it difficult to address this question in the one-day session that was available, the ACMGA participants asked that this last question be handled by mail, somewhat as a Delphi process might be conducted. This was done, but in the interest of time the third question was abandoned in this study's other two Nominal Group meetings.

The participants in the California administrators' Nominal Group produced 68 responses as their predictions related to the first question (see Appendix C, Table C-3). Their analyzed responses and index scores are tabulated in Table 7-2. Their response with the greatest probability and the most agreement was not nearly as strong as the first item from the ACMGA

TABLE 7-1
INDEX NUMBERS FOR NOMINAL GROUP #1—ACMGA—FEBRUARY, 1975

Question 1: What do you *predict* will happen in the health care field that will affect the future role of group practice administrators?

Rank Number	Description	Index
1	Government controlled health maintenance for every citizen.	0.96
2	A much greater emphasis on ambulatory care (vertical surgery as a part).	0.64
3	Emphasis on large health care centers which will support satellite offices (urban, suburban, rural).	0.48
4	Diminishing fee for service, increased prepay/government/insurance health care.	0.40
5	Solo practitioner will become extinct, will team up with groups which will enlarge and emerge, etc.	0.31
6	Large health care centers broken down into units for: acute, chronic, preventive care.	0.17
7	All groups will have to be accredited to participate in NHI, with both physicians and administrators meeting certain requirements.	0.13
8	Consumer will have an increased role in the decisions.	0.12
9	Elaborate cost accounting will be necessary.	0.11

TABLE 7-2

INDEX NUMBERS FOR NOMINAL GROUP #2—CALIFORNIA ADMINISTRATORS—AUGUST, 1975

Question 1: What do you *predict* will happen in the health care field that will affect the future role of group practice administrators?

Rank Number	Description	Index
1	Universal health insurance.	0.60
2	Much, much, much greater involvement (control) of unions with physicians and employees.	0.58
3	Tremendous growth in the numbers of groups and the numbers of doctors in groups (i.e., average size of group larger).	0.54
4	Increased technical and educational skills required of administrators to cope with the above.	0.53
5	Organization will change to have consumer participation in clinic policy.	0.53
6	Government accountability with standard chart of accounting and government reporting.	0.49
7	Group practice quality standard review and accreditation.	0.48
8	Increased use of management engineering and techniques in the clinic environment.	0.41
9	Greater use of computer storage of health information, probably centrally controlled.	0.40
10	All clinics will be government owned, operated or controlled.	0.39

group. While they were in agreement that the most probable occurrence was some form of national health insurance by 1985, the response rated an index score of only 0.60. Beyond this point, their responses and predictions showed generally greater agreement, with half of the responses having an index score greater than 0.50 and the lowest being only 0.39. Thus, the California administrators foresaw significantly increased involvement with unions (0.58) and growth, in both the number and size, of group practices (0.54). They were in agreement that, for various reasons, administrators would be required to increase their technical skills (0.53) and that groups would be involved with substantial consumer input (0.53).

In response to the question concerning the invention of the future, the California administrators generated 51 responses (see Appendix C, Table C-4). These responses represented a similar range in unanimity, with ratings ranging from as high as 629 down to 355. The California administrators indicated that they wish to maintain freedom of choice in the health care delivery system and eliminate government involvement. In both of these feelings, they were in substantial agreement with the results from the ACMGA group. In a similar vein, they wished for less government regulation. Finally, they wished for the organizational framework to relate to total health care centers, again one of the significant predictions of the ACMGA group. Thus, overall, the California administrators agreed to a considerable extent with the ACMGA participants.

The combined results from these two group practice administrator Nominal Groups produced the prediction results seen in Table 7-3.

The list of 14 items resulted from the combining of similar items from the top ten rated responses from each of the groups. Six items of the 15 appear in the responses from both administrator Nominal Groups. Between the two groups there is agreement that there will be some form of national health insurance by 1985 (index score of 1.56), and there will be government control of health care (1.35). In addition, both sets of administrators agreed that there would be an increase in the number of group practices (0.85) and a significant increase in consumer participation in decision-making and health care (0.65).

TABLE 7-3

COMBINED NOMINAL GROUP INDEX SCORES—TWO ADMINISTRATOR GROUPS ONLY

Question 1: What do you *predict* will happen in the health care field that will affect the future role of group practice administrators?

Rank Number	Description	Index #1	Index #2	Sum
1	Some form of national health insurance. (1+1)	0.96	0.60	1.56
2	Government control of health care. (1+10)	0.96	0.39	1.35
3	Increase in number of groups. (5+3)	0.31	0.54	0.85
4	Increase consumer participation. (8+5)	0.12	0.53	0.65
5	Increased emphasis on ambulatory care. (2+0)	0.64	—	0.64
6	Accreditation of groups. (7+7)	0.13	0.48	0.61
7	Elaborate cost accounting with standard chart of accounts in groups. (9+6)	0.11	0.49	0.60
8	Greater involvement (control) by unions of physicians and employees. (0+2)	—	0.58	0.58
9	Increased technical and educational skills required of administrators. (0+4)	—	0.53	0.53
10	Emphasis on large health care centers with satellites. (3+0)	0.48	—	0.48
11	Increased use of management engineering and techniques in the clinic environment. (0+8)	—	0.41	0.41
12	Diminishing fee for service, increased prepay/government/insurance health care. (4+0)	0.40	—	0.40
13	Greater use of computer storage of health information, probably centrally controlled. (0+9)	—	0.40	0.40
14	Large health care centers broken down into units for: acute, chronic, and preventive care. (6+0)	0.17	—	0.17

The medical directors' Nominal Group generated 66 responses as their predictions in relation to the first question (see Appendix C, Table C-5). Their analyzed responses and index scores are shown in Table 7-4. There was high agreement among the medical directors that the most probable event will be federal supervision of the evaluation of medical care (index score of 0.91). Beyond that item, the medical directors agreed only to the extent that two of their items were above 0.50. Thus, they predicted that national health insurance will become a reality (0.73) and that most physician practitioners will join group practices (0.55). While all of the other items fell below 0.50, they ranged down to only 0.41, indicating some degree of consensus among the panelists.

When asked to invent their ideal future, the medical directors generated 51 responses to the question (see Appendix C, Table C-6). Their responses showed a range of unanimity similar to that for both of the administrators' groups in dealing with this question, that is, with ratings from a high of 613 to a low of 297. Their responses for inventing the ideal future were specifically focused on groups. They expressed the desire that physicians would not only be in groups but that these groups would be multi-specialty groups (ratings of 613) and groups would include a balanced, affordable team of health care providers (560). They further expressed a desire for the establishment of regional health care systems with appropriate personnel distribution and comprehensive, viable medical communications systems providing the modalities of literature review and continuing education for the practicing health professional. Finally, their fifth-ranked item expressed hope for total availability of health care to the total population.

Using the index numbers, the results and the predictions from all three Nominal Groups were then combined. When the top ten items from each of the three groups were combined, they revealed a convergence and a consensus to the extent that the overall list consisted of only 18 items as displayed in Table 7-5. However, only three items out of this 18 represented a total consensus across all three Nominal Groups. Thus, both groups of administrators and the group of medical directors concurred that there would be some form of national health insurance (combined index score of 2.29), that there would be increased numbers of physicians in groups (1.40), and that there would be increased consumer participation in decision making (1.11). Five items out of these 18 were common to at least two groups. Both administrator groups agreed that there would be government control of health care (1.35), that there would be required accreditation of groups (0.61), and that there would be elaborate cost accounting with standard charts of accounts (0.60). Only the ACMGA group and the medical directors agreed that fee for service would decrease and that prepayment would increase (0.84). Finally, only the California administrators and the medical directors agreed that there would be significantly increased use of computers (0.82). The remaining 11 items were ranked in the top ten by only one group, and these ranged from a high of 0.91 to a low of 0.41.

The Delphi Panels and Interviews

The eighteen topics identified through the Nominal Group processes were used as key phrases for the remainder of the study. Initially these key phrases were used to conduct a content analysis of the two relevant Delphi studies; any item in either of the Delphi studies having an index number greater than 0.50 was used. Subsequently the same eighteen topics were used for a content analysis of the eight interviews. For this section, the results of these two content analyses are combined into a narrative including the eighteen topics as grouped into five broad areas: the financing of health care, the regulation of health care, the organization of health care,

TABLE 7-4

INDEX NUMBERS FOR NOMINAL GROUP #3—MEDICAL DIRECTORS—DECEMBER, 1975

Questions 1: What do you *predict* will happen in the health care field that will affect the future role of group practice administrators?

Rank Number	Description	Index
1	Federally supervised evaluation of medical care as to: quality, cost effectiveness, efficiency, availability.	0.91
2	National Health Insurance will become a reality in five years, probably through the insurance industry, subsidized where necessary by feds; prepayment and HMO's will disappear.	0.73
3	Most practitioners will attempt to join groups already established, primarily for economic rather than philosophic reasons.	0.55
4	Administrators will be required to take a more active political role in their communities.	0.47
5	Increasing number of consumer boards (balance, lay/professionals) with input to administration to influence quality vs. cost.	0.46
6	Rapid growth of clinics (increased numbers of MD's) is going to set up great internal pressures: hence, great difficulty in managing.	0.46
7	Increase in prepayment over fee for service type remuneration.	0.44
8	Groups will be forced to make major decisions regarding regionalization.	0.42
9	Computers will have an increased role in: 1) appointments, 2) billing, 3) reporting, 4) record keeping, 5) statistical analysis, 6) clinical care.	0.42
10	Increased government intervention with ultimte public utility approach to health.	0.41

TABLE 7.5

COMBINED NOMINAL GROUP INDEX SCORES

Question 1: What do you *predict* will happen in the health care field that will affect the future role of group practice administrators?

Rank Number	Description	Index 1	2	3	Sum
1	Some form of National Health Insurance (1+1+2)	0.96	0.60	0.73	2.29
2	Increase in numbers of physicians in groups (5+3+3)	0.31	0.54	0.55	1.40
3	Government control of health care (1+10+0)	0.96	0.39	—	1.35
4	Increased consumer participation (8+5+5)	0.12	0.53	0.46	1.11
5	Federally supervised evaluation of quality of care (0+0+1)	—	—	0.91	0.91
6	Diminishing fee for service, increased prepayment (4+0+7)	0.40	—	0.44	0.84
7	Greater use of computers for appointments, billing, reporting, record keeping, statistical analysis, and clinical care (0+9+9)	—	0.40	0.42	0.82
8	Increased emphasis on ambulatory care (2+0+0)	0.64	—	—	0.64
9	Accreditation of groups (7+7+0)	0.13	0.48	—	0.61
10	Elaborate cost accounting with standard chart of accounts in groups (9+6+0)	0.11	0.49	—	0.60
11	Greater involvement (control) by unions of physicians and unions of employees (0+2+0)	—	0.58	—	0.58
12	Increased technical and educational skills required of managers (0+4+0)	—	0.53	—	0.53
13	Emphasis on large health care centers with satellites (3+0+0)	0.48	—	—	0.48
14	Administrators will be required to take a more active political role in their community (0+0+4)	—	—	0.47	0.47
15	Rapid growth in size of clinics is going to set up great internal pressures (0+0+6)	—	—	0.46	0.46
16	Groups will be forced to make major decisions regarding regionalization (0+0+8)	—	—	0.42	0.42
17	Increased government intervention with ultimate public utility approach to health care (0+0+10)	—	—	0.41	0.41
18	Increased use of management engineering techniques in clinic environment (0+8+0)	—	0.41	—	0.41

consumer involvement, and changes in internal management areas.

As a specific example of this process, national health insurance, as the first ranked topic from the Nominal Groups, was used to abstract the results of both of the Delphis and to abstract pertinent comments from all eight of the interviews. From the Nominal Group, the only conclusion that could be made was that there would be some form of national health insurance in the future. From the content analysis of the Delphis, the form of national health insurance was identified as being first, catastrophic within the next five years and second, comprehensive within ten years. The further analysis of the comments from the interviews provided an even greater depth of analysis as to the possible forms and the role of deductibles in national health insurance.

The results of this process are presented here by topics as grouped into the five broad areas outlined above. The rationale for this approach is that while eighteen individual topics appear in the combined Nominal Groups, these topics are not mutually exclusive and several of them are linked. For example, the extent of government control (topic 3) and the public utility approach (topic 17) are directly linked and to some degree could be mutually exclusive. Another example of this linking is the fact that the increase in ambulatory care (topic 8) and the increase in the grouping of medical practice (topic 2) are clearly interrelated. The grouping of the topics for this section, then, is as follows:

1. The financing of health insurance
   Topics: 1—National health insurance
   6—Decreasing fee for service and increasing prepayment
2. The regulation of health care
   Topics: 3—Government control
   5—Federal supervision of the evaluation of care
   9—The accreditation of groups
   17—Public utility approach
3. The organization of health care
   Topics: 2—Increased grouping of medical practice
   8—Increased emphasis on ambulatory care
   13—Increase in large centers with satellites
   16—Regionalization
4. Consumer involvement
   Topics: 4—Consumer participation
   14—Involvement in the community
5. Changes in internal management
   Topics: 7—Increased use of computers
   10—Elaborate cost accounting
   11—Increase in union involvement
   12—Increase in administrative skills required
   15—Increasing internal pressures
   18—Management engineering techniques needed.

The Financing of Health Care

Starkweather's Delphi panelists suggested that national health insurance would be on the scene within ten years, but that it would evolve in two stages (Starkweather et al., 1973). His panelists further opined that national health insurance would first be applied to catastrophic illnesses, but that it would ultimately be applied in a comprehensive fashion to health care coverage. Bergwall's panelists felt that first Medicaid would be federalized but concurred that catastrophic coverage would precede the later movement to comprehensive coverage (Bergwall & Ferry, 1975). More specifically, his panelists suggested that there would be three tiers of coverage, the first based on employment, a second related to the aged and disabled as under Medicare, and the third related to the poor, the near poor, and all others. Starkweather's panelists suggested that national health insurance would be financed by a combination of general tax revenues, employer contributions, and individual payments. Bergwall's panelists were strong in their opinion that national health insurance would result in universal coverage of the population.

Abstracting the comments from the various interviews as they related to national health insurance produced a similar pattern and general agreement with the above predictions. In other words, the interviewees predicted that national health insurance would be a part of the health care scene within ten years and that the insurance would be comprehensive. There was also a general consensus that first Medicaid would be federalized, and that there would be catastrophic insurance before comprehensive. In other words, both the Delphi panelists and the interviewees concurred that there would be an evolutionary development of national health insurance, and that it would not take an extremely radical form.

On the other hand, there was also considerable variation in the opinions of the interviewees. First, with regard to the timing, some expressed the opinion that national health insurance would be enacted within one year while others were arguing that it would take ten years. Glasser argued that there would be comprehensive national health insurance within four years, while Altman and Halberstram both felt that there would be no national health insurance for at least ten years. Freidson argued that this delay in national health insurance would occur because of our current scarcity mentality, but the general opinion of all of the interviewees was that some form of comprehensive national health insurance would be operating in about five years time. There was also variance among the interviewees concerning the financing. Their opinions differed regarding the balance of the public and private approaches and regarding the role of deductibles and coinsurance.

More specifically on the financing, the extremes of opinions ranged from that of Glasser who foresees a totally federal national health insurance system financed in its entirety through taxation. He argued that people are willing to be taxed for health services. Representing the opposite extreme are the opinions of Knowles and McNerney, who see linking the public plans, such as Medicare and Medicaid, to the private plans, with employers being allowed to keep or purchase plans which meet governmental standards. Feldstein, however, argued that how health care is financed is not the question. It is his opinion that, regardless of who finances it, the question of importance is the extent of the deductibles and coinsurance; that is, how much will there be in the way of out-of-pocket expenses by the families. Of the two possibilities, (a) a comprehensive insurance with all bills paid and only trivial deductibles and coinsurance or (b) a smaller plan with larger deductibles and coinsurance, Feldstein favors the latter. He argued that this market approach for what he calls major risk insurance would lead to each family paying a substantial share of its health bills, except for those in the catastrophic or excessive category.

There was general agreement that a national health insurance plan would be administered utilizing existing structures, both public (the Social Security Administration) and private. Glasser emphatically made the point that it would definitely (because of the unfortunate experiences with the Medicaid program) not be administered by state or local governments but, instead, by the federal government.

The demand problem was not directly touched upon in most of the interviews, but Freidson expressed the opinion that removing the payment barriers should not result in the assumed tremendous increase in utilization. On the other hand, he contended the removal of the payment barriers would only result in another kind of change, namely that of the time to get into the system.

The Starkweather panelists addressed the issue of fee for service and prepayment. Their opinions were of equal strength and on opposite sides of the issue. The panelists concluded that there would be both continuation of fee for service and increased capitation payments both by the government and by private insurers. While there were no specific statements with regard to the specific mechanisms from the Bergwall panelists, they did talk about the growth of health maintenance organizations from an organizational standpoint and as an approach to increasing preventive care. They did not, however, provide any overall statements on the balance of fee for service versus prepayment.

There was a general agreement among the interviewees that fee for service will continue to be a substantial part of the financing of medical care in the United States. There was also agreement that the growth of prepayment will be slow because of the complexity of the health maintenance legislation. In the words of John Knowles, "They kind of blew it" with the health maintenance organization (HMO) legislation.

There was a variance of opinions among the interviewees concerning the likelihood and desirability of the survival of the fee for service payment mechanism. Knowles, Feldstein, Glasser, and Altman all argued that we will always have some fee for service, but with an increasing amount of prepayment. Etzioni argued that from studies he has done, people do seem to favor the fee for service mode. He stated, "Citizens were more

adamant about fee for service than either community leaders or hospital administrators." Freidson commented that fee for service provides "immediate responiveness to individuals" and that physicians are "accustomed to a fee barrier as a way of coping with patient demands." It was McNerney's opinion that fee for service and prepayment will co-exist because multiple (pluralistic) payment mechanisms are part of the American pattern and perhaps the best way to go.

Several argued to the contrary that fee for service would not survive. Freidson agreed and stated that it is "terribly expensive to administer and control." Halberstram felt that fee for service payment would be minimal, if it exists at all in the future, and Glasser felt that it would disappear altogether over the long term.

Overall, the interviewees felt that fee for service versus prepayment was more than a financial issue. Fee for service, as they see it, is embedded in the relationships and expectations between physicians and patients; it is "the American idiom" addording to Glasser and Freidson. Hence, in the opinion of several of the interviewees, altering our predominant forms of payment in health care has significant sociological implications ultimately relating to demand. In other words, if the payment mechanism is to be switched from fee for service, new barriers need to be constructed to control demand, and these new barriers could be both bureaucratic and mechanical according to Freidson.

Prepayment was viewed by the interviewees as related predominantly to the health maintenance organization concept and there was near unanimity that the enabling legislation for HMO's had crippled the movement, both as a financial approach as well as a comprehensive care/preventive approach. Feldstein contended that the HMO movement has lost its momentum, and that there are really no financial incentives for an individual to join an HMO versus a good group insurance plan. Glasser's opinion was that the HMO legislation represents "a jerry-built law" riddled with inefficiencies and provided with miniscule amounts of money for development. Altman's contention was that we cannot change the American system overnight, particularly to another approach based upon a model derived from a few small successful health maintenance organization operations.

More generally, the opinion of the interviewees was that prepayment alone is not the answer to America's health care financing problems. Halberstram and Freidson both felt that prepayment has little effect on the quality and cost of health care. McNerney contended that, "What is so valuable about the health maintenance organization is it stands there as a constant and eloquent reminder of some of the limitations of the fee-for-service-type route." In a sense, the interviewees were arguing that regardless of what form national health insurance takes (that is, government control versus shared and total government financing versus shared financing) and regardless of whether fee for service survives and prepayment increases, the key issue is what happens to *demand*. There was no clear consensus among the interviewees that only one approach holds the promise of controlling demand or of even making it more rational.

The Regulation of Health Care

The Starkweather panelists did not directly address the issue of government control of group practices because they were asked to speak to the issue of the future of hospitals. However, in so far as these panelists predicted increasing linkages of groups to hospitals, their predictions about regulation of hospitals could, by implication, apply to groups. On the one hand, they predicted that there would be an official agency involved in performance review of both the financial and quality areas. They predicted increased commission-type regulation of services, facilities, and rate changes. On the other hand, the same panelists predicted, with similar strength of opinions, that there would simply be public disclosure of hospital income, expenses, and plans, with voluntary responsiveness in terms of control of services, facilities, and finance changes. By contrast to the opinion that an official agency would be involved, they felt that the hospital would be the agency of quality review.

The Bergwall panelists were more generic in their opinions and had a clear sense of a trend in their predictions. They expected increasing federal assumption of regulatory activity over the entire health care delivery system, leading to the development of a more "activist and interventionist stance." In particular, these panelists saw that the regulation of the health care delivery system, as a consequence of national health insurance implementation, will focus on inadequacies, accessibility, and quality. Particularly in the quality area, they saw regulation being extended through the Professional Standards Review Organization (PSRO)-type arrangement and ultimately into the ambulatory care arena. These same panelists simultaneously expressed a more pessimistic view, although it was certainly of less strength. They predicted that by 1985 the failure of regulation to achieve the desired quality results may lead to "consideration of government operated, as well as funded," health care delivery systems.

Perhaps rather than a national health service in the sense of a totally government-controlled system, a public utility approach might be taken, and this approach was predicted in both the Starkweather and Bergwall panels; this opinion was of moderate strength in both. Both the Bergwall and Starkweather panelists saw increasing resource allocation in the health field through a "quasi-public utility model." The Bergwall panelists further predicted "reliance on state-based but federally-mandated public utility type regulation."

The results from the interviews with regard to government control were similar to those from the Delphis, namely that there would be increasing regulatory activities especially in the cost and quality areas, but no national health service approach. The interviewees saw increasing regulation as closely tied to the form national health insurance takes. More specifically, the majority of the interviewees saw an inexorable steady progression and expansion of regulation. Knowles contended that there would be steady expansion of central authority with resting periods in between. Glasser saw a steady increase in this century in "governmental responsibility in the affairs of citizens and organizations." He argued

strongly that "You've got to go to the level that operates at the broadest for solving health problems." The implication for him was that control must be vested in the federal government, and he supported this argument by citing the failures and the mistrust of state and local governments. Freidson saw the increase in regulation as inexorable. Specifically, he argued that increased government involvement in financing, leads naturally to increased fiscal accountability and deepening federal involvement in health care. Altman saw many of the same things—more money and more regulation being a part of the future—but limited by American cultural values. Feldstein, on the other hand, argued that the degree of regulation and government control relates specifically to the form of national health insurance. If America adopts a form of comprehensive national health insurance with trivial deductibles and coinsurance, then the "involvement of government will have to be enormous."

By contrast Feldstein argued for decentralizing the decisions about medical care, operations, and hospitalization by high deductibles. In other words, he feels that putting the decision making on the individual and his or her physician, instead of on the government, would lead to us not needing "as much government control because it would be more self-regulating." McNerney espoused a similar view, namely, that we are learning the limitations of regulation—that regulation is captured by the regulated, and that it develops cumbersome administrative processes. Hence, in McNerney's view, the genius is "allowing regulation to establish the broad perimeters within which the system can play." In other words, he sees regulation as the ability to "annunciate your goals, establish your standards, and leave flexibility in the system."

Halberstram contended that medical groups "may be one of the best defenders of good medical practice." In a sense he sees them, if of a sufficient size, as having the ability to mediate and maintain the tension between insurers and regulators on the one hand and medical practitioners on the other.

The Organization of Health Care

Both the Delphi panels predicted an increased emphasis on ambulatory care. The Starkweather Delphi focused on hospitals, so there were no direct comments related to the details of ambulatory care or groups. The Bergwall panelists, however, saw an increased reliance on outpatient treatment and the delivery of an increasing variety of services: in doctors' offices rather than in hospitals, in clinics rather than in doctors' offices, and home therapy rather than in clinics. They saw this shift in medical practice being accompanied by an increased emphasis on ambulatory care in medical education taking place in ambulatory settings.

The interviewees were in general agreement that there will be an increased emphasis on ambulatory care principally because of economic restraints and government controls. There were, however, significantly differing views on how this care would be achieved. On the one hand, it was argued by three of the interviewees that the increasing emphasis on ambulatory care would be a prime way of cutting down health care costs, but that it would be accomplished through controls. Etizioni, Freidson, and Halberstram all argued that the increasing costs of hospital beds and the "extravagance of hospital costs" would necessitate the controls and the drive toward ambulatory care. On the other hand, Feldstein argued for cutting the costs through major risk insurance; that is, increasing the proportion to be paid for out of the pocket. This increase in out-of-pocket expenses could "restructure the demands towards more primary care." In his opinion the greater risk sharing by the public would give a real thrust to the development of ambulatory care and would not require control to implement such a movement.

Both of the Delphi groups also addressed the increased grouping of medical practice. The Starkweather panelists predicted increases in the number of groups up to the point of including, by 1985, 50% of all practicing physicians. The Bergwall panelists saw an increase in groups for reasons of increased efficiency and economies of scale. However, they were more extreme in their prediction and saw groups as predominant by 1985, with 25,000 groups involving more than 160,000 doctors. This prediction translates into an increase in the number of small groups with three to six physicians per group.

The interviewees were in general agreement with each other and with the Delphi panelists that there may be some increase in the grouping of medical practice, but there was great diversity of opinions among the interviewees as to the extent and purpose of the increase in the number of groups. Glasser argued that "Unequivocally, yes, there will be an increase in the number of groups for economic and tax reasons." In his opinion, ultimately group practice will be the predominant form of medical practice for two reasons. In the first place, the problem, unresolved by solo practice of dealing with large underserved populations, will demand groups. In the second place, the movement toward prepayment will also foster the growth of groups. A somewhat different opinion was expressed by Altman who felt that "most physicians, many more younger than older, like the concept of working in groups." He saw the reasons as relating to the physicians' desire to have more control over their time, to achieve a better way of life, and perhaps to achieve a healthier way of life. He predicted more physicians in groups, but as to whether the groups would be of the size of three or four physicians or thirty or forty physicians he could not say.

Halberstram saw fewer solo practitioners and more groups of three or four with many single specialty groups in the future. As he saw it, "groups without walls" is a valid concept fostered by the foundations for medical care and the health maintenance organization movements. "A[illegible]" he said, "depends on geographic and sociologic settings." McNerney predicted, "I don't think group practice is a take over idea . . . it suits some patients, it suits some doctors. More, yes. Take over, no." As he saw it, the various units in the health field will be more related and linked with physicians in groups numbering two to three.

Some very strong contrary forces that might not encourage the growth of groups were cited by Knowles and

by Freidson. Knowles argued that the increasing emphasis on primary, ambulatory care delivered by the general physician may imply the "reconstitution of the individual doctor's office." Freidson went a little deeper and argued that, "given the individualist tendencies of physicians," he would feel a lack of certainty about predicting the growth of groups. He sees physicians as individualists in "ways that make it difficult for them to work in groups." In his opinion a large minority of physicians may be attracted to groups because of the benefits of more controlled hours, ease of practice start-up, and ease of later tapering off. In his estimation and from his studies, he contended that "both mortality rate and the costs" have been high and that "group practice is unstable." He perhaps expressed the strongest view by saying that the majority of groups will be between three to five physicians, which to his mind, did not constitute a medical group. Hence, in his opinion, there is no trend towards groups and specifically no trend toward groups "that are large enough to carve out their own way of doing things in the bureaucracy."

The Delphi panelists also saw the increasing movement toward ambulatory care as a part of the shift toward an increasing degree of organization in the health care field. The Bergwall panelists specifically predicted a more organized system of medical care evolving with movements toward regionalization. The thrust for this realignment would be due to the desires for increased efficiency and the achievement of economies of scale in the health field. As to the forms of organization, the Bergwall panelists saw facilities as being increasingly concentrated around hospitals. The Starkweather panelists predicted "more specific organizational ties between groups, hospitals, ambulatory care, and specialized facilities, as a result more probably of the hospital consolidations, or perhaps of health care corporations." Specifically, the Starkweather panelists predicted "affiliation of more larger-size group practices with specific hospitals." As to the general form of organization of the health care field, the Bergwall panelists predicted a very large ambulatory care sector with "a smaller secondary care sector organized around voluntary hospitals, and regionally organized tertiary care facilities."

The interviewees were generally more cautious in their opinions concerning the extent to which the health care field will become more organized. In general, they felt that there would be a little more relation among units of the health care delivery system with some increase in the hospital basing of groups and other units. However, they were not nearly as enthusiastic and bold in their predictions as were the Delphi panelists. Knowles predicted "the grouping of physicians and surgeons adjacent to their technologies will accelerate" but not to the extent of organized salary groups of physicians within hospitals. Others contended that there may be less linkage in organizations, for the forces don't favor physician and hospital linkages. Altman argued that hospital based groups imply a larger size for groups, but that physicians prefer the smaller groups. Freidson said that the tendency towards decreasing the use of hospitalization in the health care field with an increased emphasis on ambulatory care would go against the need for linkage. "I don't know what advantage there would be for them to develop hospital-based groups," he stated.

Consumer Involvement

The Starkwether Delphi panelists made no specific comment on consumer participation, but the Bergwall panelists did address this issue. All of their opinions on the strong side were predictive of increased numbers of patients on boards and advisory committees and increased numbers of consumers on public and quasi-public bodies. They were emphatic, however, that while these bodies would be dealing with health care they would continue "to be effectively controlled by providers." There was a weaker opinion (at the level of 0.50) which reflected the ambivalence of the panel. Specifically, the panelists at the same time argued that consumers will have a dominant role in "primary care operations and a major role in policy setting" for health. The panelists also saw patients and consumers becoming "extensive participants in wellness promotion."

The interviewees displayed no real consensus on the extent of consumer participation. There was a wide range of opinions similar to those expressed by the Delphi panelists. One group of interviewees saw the consumer/patient role limited by the nature of health as a political issue. Both Freidson and McNerney made the point that there will be increased consumer participation, but the driving force and motivation for such roles will not be as strong as some may assume. Health as they see it is not a politically important issue. As Freidson sees it, sick people don't become a political force because "they are isolated from all other people, and illness is a personal experience."

By contrast it was argued by other panelists that the role of consumers will increase greatly. In Altman's opinion, individual consumerism as an awareness and a shopping around for health care will result in reduced costs and better medical decisions. He also sees the collective action of consumers as providing a significant impetus to change. Both of these actions, in his opinion, will lead to an "equal force system in the long run." McNerney thinks "the consumer should have a more forceful role in the running of the health establishment," with providers in the minority on decision-making boards. Glasser, too, argued for greatly increased consumer involvement.

Other interviewees, however, saw the health care institutions not just as passive in their role in relation to consumer involvement but as working proactively to establish meaningful linkages with consumers and communities. In other words, they saw the administrators as not just reacting but as reaching out to establish these relationships. In McNerney's view, the administrators in group practice have "constant attachment to the community" and should be preoccupied with the group's public to avoid developing antagonistic relationships. Glasser predicted a need for and the development of "a specialist in working with community groups." He sees health administration training as equipping administrators to deal with consumer individuals—lay people in management; and he sees these administrative specia-

lists as having a key role in "developing relations in the community and helping representatives in the community to participate."

Knowles expressed a quite different perspective which may also be part of the same movement. He sees the consumer/patient role as increasing in the sense of including increased responsibility for one's own health. In his view, "I think one of the big problems is going to be whether individuals can continue to feel that they have a personal role and are personally worthy of guiding their own future and thinking for themselves without looking to state and federal legislation." He believes the next major changes in health will involve more individual responsibility for health with more "rational behavior by individuals as it relates to their own health." He suggested that Breslow's six rules for healthy living would be the most significant change in consumer participation and responsibility: regular exercise, nutritious eating, maintaining proper body weight, alcohol not at all or in moderation, no smoking, and regular and adequate sleep.

Changes in Internal Management with Specific Reference to Groups

The Delphi panelists had few opinions relating to the specific changes in internal management of health care institutions. The Starkweather panelists had no comment on the increased use of computers, but the Bergwall panelists saw an increase in management information systems for day-to-day operations in health care institutions, both for decision making and for inventory control. The Starkweather panelists had no comments with regard to union activities, but again the Bergwall panelists did address these activities. They saw increased worker unrest with union activity and strikes in the health care field including both professionals and technical personnel. While this opinion was strongly expressed, they had a much weaker opinion representing their mixed thoughts about whether physicians would unionize and would engage in collective bargaining.

Several of the interviewees had no specific comments with regard to a number of internal management areas and, specifically, several of them had nothing to say about union activity. Where union activity was addressed, the feeling was that there would be a definite increase in union activity, but the disagreement related to how extensive it would be in terms of the personnel involved. Some interviewees felt that it would involve just nonprofessionals, others professionals, including some physicians. Glasser expressed this view: "As the groups get larger, there will be rapidly increasing unionization of the nonprofessional." Altman felt there is already unionization among physicians; unionization will continue, and it will include other professionals and technical personnel. However, he was cautious in pointing out that "they're not all going to end up being unionized; there will still be individualism."

The many changes in financing, regulation, organization, and consumer as well as employee involvement will require new and improved skills of administrators. These skills were not addressed by either of the Delphi groups cited here, although the Bergwall study used the results of this first panel on changes in the health care delivery system as a basis for a second panel's activities in addressing the required skills and competencies. The results from the second panel are not reported here.

The interviewees expressed the general consensus of a need, because of the increasing complexity, for an altered range of skills for health care administrators, with a couple of interviewees mentioning a trend toward increased numbers of physician administrators in health care delivery.

Etzioni makes a key disclaimer, for it is his opinion that "the future is not predictable." Given this premise he then argues that the important thing in the training for health care administrators is that they be trained for an unknowable future. This has a number of implications in his opinion. First, "the less specialized the preparation, the better off you are." Second, "the more wide the preparation, the better off you are." Others did not express this concern but rather seemed to reflect the general sense that basic managerial skills, particularly the interpersonal ones and a good sense of the external world, will be required. In terms of the Katz and Kahn framework, around which the current roles part of this study was based, interviewees addressed the need for knowledge and skills related to the production, the maintenance, the boundary/procurement, the adaptive, and the managerial subsystems.

With regard to the maintenance subsystem Halberstram sees administrators as requiring a knowledge of personnel work. Knowles sees administrators as needing a greater knowledge of the history of unionization, the activities of the National Labor Relations Board and specific skills in negotiation. Freidson sees the administrators, particularly in a group practice, as needing to be effective mediators between physicians. He sees this mediation as requiring excellent interpersonal skills and emphasizes this need most strongly. He is worth quoting extensively at this point, for his thoughts represent a dramatic change in his own view: "I think, and I've sort of recently been converted to it—I used to think that really the structure was the basic thing; I felt that was adequate. But, the more I thought about it, and the more I worked over my material, the more I felt that people develop their own ways of getting around these things, and they may not be the ways that are best either for them or for patients or for public policy."

In the boundary/procurement subsystem, Glasser expressed a great need for skills on the part of the administrator in dealing with the interface between the group on the one hand and the patients, the community, and the government on the other. He felt that the administrator should have a great sensitivity to consumers and the ability to educate the physicians to this view. In this same area, Altman sees the need for a greater understanding on the part of administrators of the socioeconomics of medicine. In addition, Knowles cited the need for a knowledge of the legal system, economics, and federal and local laws.

With regard to several of these subsystems, Glasser has perhaps reflected best a common theme touched on

by several of the interviewees: "the need for great skill in dealing with people." These people include physicians, employees (as individuals and in unions), patients, consumers, communities, and the government.

With regard to the adaptive system, Glasser cited the need to recognize new and innovative developments and the need to be able to sell them to the physicians. He also emphasized the need for the administrator to have skill in recognizing the true fit between the group and its society. In the managerial subsystem, Altman sees the need for administrators to be able to run a good office; Knowles sees the need for greater computer usage, and Halberstram sees the need for more knowledge of accounting and tax laws.

CHAPTER 8

FUTURE ROLES

Descriptions of current administration in medical groups from the generic to specific roles were developed in Chapters 4 through 6. Chapter 7 covered some of the aspects of the future of health care that have implications for group practice administration. This chapter will focus upon possible future roles of group practice administrators. The future roles data were developed by using the descriptions of current administration and roles as a baseline and by assessing the impact of the stated future of health care upon the current roles description. The results of this process, contained in this chapter, are descriptions of changes to current administration and to roles deduced from the descriptions of alternative health care futures.

Three different methodological approaches were taken in the examination of future roles: (a) a pre-post design using the survey questionnaire as the measuring instrument and descriptions of the future of health care as the intervening condition; (b) a logical analysis conducted by the project staff; and (c) site visit interviews with selected administrators. Each of the three approaches are explained in more detail in the following sections.

Pre-Post Design

The combining and "coning down" of the data derived from the Nominal Groups, the Delphi studies, and the interviews resulted in a concensus view of the possible futures of the health care delivery system. This information was employed to construct three summary scenarios of alternative health care delivery system futures that were employed as one means to assess the future's potential impact upon the role of the professional administrator (see Appendix C-2). The short, summary scenarios were used as intervening conditions in a pre-post design to empirically determine the shifts or changes that could occur in the professional administrator's role as a result of the future predicted conditions.

A select sample of 15 professional administrators chosen on the basis of modal characteristics from the respondents of the study's survey questionnaire were asked to "retake" the questionnaire after reading one of the scenarios. The professional administators were requested to fill out the questionnaire as if they were functioning under the conditions specified by the scenario in the year 1985. Any differences between the prescenario responses and the postscenario responses would suggest possible changes in the roles that might be associated with the conditions of the future scenario.

Staff Analysis

The project staff from MGMA/CRAHCA and the University of Colorado Medical Center participated in a review and discussion to develop a staff analysis of the implications for administrative roles. Initially these project staff members reviewed the current role data in terms of the Katz and Kahn (1966) and the Fine (1955, 1971) frameworks. Then the future predictions, which were derived from the Nominal Groups, the Delphi panels, and the interviews, were reviewed. Specifically, the staff studied the predictions as grouped into the five areas of financing, regulations, organization, consumer participation, and internal management. The staff looked at both the consensus areas from the major predictions and at the alternatives as expressed in the scenarios. After the review of the current role and the future predictions data the staff engaged in an analysis of this material for its future role implications.

Site Visit Interviews

One area of consensus about the future involves the increase in the amount of health care delivered under prepayment plans (not necessarily equivalent to health maintenance organizations). A relatively small number of medical groups are currently involved in prepayment programs, some more than others. If the future predictions concerning the increase in the amount of prepayment hold true, then it is possible that more administrators of purely fee for service groups would become involved in prepayment. To assess the potential impact of these circumstances upon administrative roles, administrators of groups currently involved in prepayment plans were interviewed. The assumption underlying these interviews was that the jobs of the few administrators currently involved in prepayment might be predictive of the jobs of many more administrators within ten years.

The site visit interviews were loosely constructed, but with a planned structure. The project staff conducting the interviews were involved in a one-day intensive training of "interview techniques." Also, the staff developed a structural framework for defining interview topics and for developing interview questions for each group practice involved. Prior to each interview, the staff spent a minimum of three hours in preparation for the site visit. This process ensured that similar information was being sought from each group practice being interviewed.

Future Roles Based Upon Reactions to Scenarios

Preparation of the Scenarios

From the information on the future, derived from the Nominal Groups, the Delphi studies, and the interviews, four areas were identified on which there was a con-

vergence or a near unanimity of opinion. These four areas of convergence were:

1. There will be some form of federally sponsored national health insurance program within ten years' time.
2. A significant portion of the health care sector will continue to operate on a fee for service basis, although the amount of prepayment will increase.
3. Along with the movement toward national health insurance, collective action by health consumers will increase with consumers involved in some decision-making with regard to health care.
4. More physicians will become associated with medical group practices.

While there was concensus on these four general areas, there was a considerable divergence of opinion concerning the actual form and structure of various future interactions in the health care delivery systems. The divergent opinions appeared primarily in the interviews and suggested several alternative forms for the future related to the extent of government control, consumer participation, and unionization in the health field, as well as to the actual form of grouping for medical practice. The opinions expressed with regard to government control ranged from the feeling that there would be a total national health service along the lines of the British model to there being nothing more than federal supervision of the evaluation of quality of care. In between these two extremes was the notion that there would be more extensive government control through planning as related to manpower, quality, and facilities. There were also three alternatives that seemed to characterize the possibilities for consumer participation. At the least involved level, consumers would be expected to become more participative as members of advisory boards. Others thought that consumer involvement would take the form of control through planning board decision making, and some argued that consumers would be part of mandated boards for local decision making in health. Expectations regarding the extent of union involvement ranged from a feeling that there would be no unions (they would be excluded under a federalized health system) to the notion that unions would involve only non-professional employees. At the extreme was the concept that unions would involve not only nonprofessional employees but all professionals, including physicians. The increase in grouping could conceivably reflect any of several positions. There could be simply more independent group practice clinics located at or near hospitals. Or, through incentives and regulations, there could be a greatly increased number of group practices that became hospital based and directly affiliated. Again, at a more extreme position, group practices not only could increase but could become part of regionally organized health care delivery systems.

The four concensus areas were inserted into each of the three scenarios. The three alternatives listed for the four future interactions just discussed were used to flesh out each of the scenarios. A review of the information presented in the Nominal Groups, the Delphi panels, and particularly the interviews suggested that the alternatives under each of the four areas tended to group themselves. In other words, there was a pattern of thinking such that if some argued for a total national health service system, they also argued for extensive consumer participation and regionally organized group practices. These patterns were then used to group the alternative predictions with the concensus predictions to produce the three different scenarios. The composition of each scenario is reflected in Table 8-1.

Reactions to the Scenarios

In terms of the future, part of the Standard List of Administrative Tasks may be outmoded. That is, while most, if not all, of the standard tasks may yet be of critical importance in 1985, other tasks or new tasks could assume importance because of the demands made by the future system. This condition imposes a limitation on

TABLE 8-1
COMPOSITION OF SUMMARY SCENARIOS

	Scenario A	Scenario B	Scenario C
Concensus Predictions	1, 2, 3, 4	1, 2, 3, 4	1, 2, 3, 4
Alternative Predictions:			
1. Government Control	National Health Insurance—Government only	National Health Insurance—Government and Private	National Health System
2. Consumer Participation	Planning Boards	Advisory Boards	Mandated Local Boards
3. Unions	Physicians and Nonprofessional	Nonprofessional only	None
4. Grouping	Majority of Physicians in Groups	More grouping	All physicians, regionally organized

the use of the standard list as a structure for describing the professional administrator's future role, especially because this role is defined as a series of discrete tasks. To avoid this limitation, the future role will be described in terms of the scenarios' effects on overall Katz and Kahn subsystem scores. The subsystem scores reflect the relative importance of types of activities that will play a part in the professional administrator's future role. Differences between the selected professional administrators' Katz and Kahn subsystem scores for the current role and their reactions to the scenarios provide the basis for inferring shifts in the relative emphasis of types of activities due to possible alternative health care futures.

The impact of the future scenarios on group practice administration is initially demonstrated by the number of tasks that will be performed in 1985. The number of tasks performed by each of the three scenario groups in the prescenario and postscenario conditions are presented in Table 8-2.

The total number of tasks performed by the Scenario A group decreased an average of seven tasks by 1985. Most of this decrease is due to the reduction in performance of managerial-type tasks. As the managerial subsystem functions primarily to control, coordinate, and optimize the internal structure of the group, the decrease in the number of tasks performed could indicate that the future, as described by Scenario A, is less complex than the present situation. Thus, some of the burden of operating a group will be eased if these future conditions do occur.

The total number of tasks performed by Scenarios B and C reflect an opposite trend in comparison to Scenario A. Both groups had sharp increases in the total number of tasks that would be performed if the predicted conditions come about. Scenario B had a 10% increase in the number of tasks performed, and Scenario C increased by a total of 13%. For both of these groups, the greatest increases were in the maintenance, boundary/production supportive—procurement, and managerial subsystems.

The substantive changes predicted in these two scenarios could pose a threat to the internal stability of groups. Therefore, greater attention would of necessity be given to structuring the human and material "equipment" of groups so that the changes in the health care field would impact groups less severely. This concern is reflected in the increased number of maintenance tasks performed by these two scenario groups. The more dramatic the predicted change, the greater the number of maintenance-type of tasks performed. In order to meet the demands placed upon the group by changes in the health care field and yet maintain an efficient and orderly environment in which to work, more formalized tasks would be performed relating to mediating between the group's task demands and its human members' needs.

The predicted changes in both Scenarios A and B also concern the recruitment of physicians and patients. Obtaining the production workers for groups should not be a difficult task, as both scenarios predict that more physicians will look towards groups for employment either for economic reasons or because of government mandate. On the other hand, securing patients should pose a more difficult task. With predicted increases in the amount of prepayment in groups and with the greater vocalization of organized health consumer groups, there should be more emphasis placed upon "consumer-oriented" tasks. The patient as an organized consumer will be more selective or demanding in his choice of a health care facility. Therefore, groups will need to rely more on meeting the consumers needs if they hope to procure this basic "raw material." This situation suggests that

TABLE 8-2
COMPARISON OF PRESCENARIO WITH POSTSCENARIO AVERAGE NUMBER OF TASKS FOR EACH OF THE THREE SCENARIOS BY KATZ AND KAHN SUBSYSTEM
(COLUMN 1 OF STANDARD LIST)

Subsystem	Prescenario			Postscenario			Difference		
	A	B	C	A	B	C	A	B	C
1. Maintenance	37.6	34.8	34.0	36.0	39.0	40.0	-1.6	4.2	6.0
2. Boundary/Production Supportive—Procurement	11.8	11.2	11.8	12.8	14.2	15.8	1.0	3.0	4.0
3. Boundary/Production Supportive—Disposal	5.8	5.8	5.8	4.8	6.0	5.3	-1.0	0.2	-0.5
4. Boundary/Institutional Supportive	2.4	2.4	2.0	2.4	3.0	2.8	0	0.6	0.8
5. Adaptive	9.2	8.0	8.5	8.4	9.6	9.0	-.8	1.6	0.5
6. Managerial	57.2	58.0	58.8	52.6	60.8	64.3	-4.6	2.8	5.5
Total	124.0	119.8	120.8	117.2	132.6	137.0	-6.8	12.8	16.2

groups will spend more time and perform more tasks related to obtaining their patient populations. It is, in fact, confirmed for all three scenario groups by the increase in the number of tasks performed in the boundary/production supportive—procurement subsystem. The greatest increases are for Scenario B and Scenario C. These differences indicate that this subsystem will have greater emphasis placed upon it in the future if the conditions within the scenarios do occur.

How future changes in the health care system may affect the reallocation of responsibilities for the tasks performed in group practice are presented in Table 8-3 for each of the three scenarios.

The first most apparent change in the distribution of chief responsibilities is the dramatic decrease in each subsystem of the responsibility of "others" and the increased responsibility of the medical director. In the responses to each scenario, the percentage of tasks for which others are responsible drops sharply. Also, in Scenarios B and C the percentage of tasks for which the medical director is responsible increases for each subsystem. For these two scenarios, this situation indicates a significant change in the groups' operations, since none of the groups in the prescenario condition had medical directors. This general increase in the responses relating to medical directors indicates that more groups in the future may find it necessary to add this type of administrator to their staff if the health care system changes in the manner predicted.

In general, the chief responsibilities of the professional administrator increase only slightly for each of the three scenarios. The greatest changes occur for the profes-

TABLE 8-3

COMPARISON OF PRESCENARIO WITH POSTSCENARIO CHIEF RESPONSIBILITY FOR EACH OF THE THREE SCENARIOS EXPRESSED AS A PERCENTAGE OF SUBSYSTEM TASKS IN EACH KATZ AND KAHN SUBSYSTEM (COLUMN 2 OF STANDARD LIST)

Subsystem	Chief Responsibility	Prescenario			Postscenario			Difference		
		A	B	C	A	B	C	A	B	C
1.	Maintenance									
	No One	0	0	0	0	0	0	0	0	0
	Professional Administrator	56	55	43	59	59	37	3	4	-6
	Medical Director	0	0	0	8	7	15	8	7	15
	Governing Body	25	25	28	24	30	28	-1	5	0
	Other	18	20	29	9	4	21	-9	-16	-8
2.	Boundary/Production Supportive—Procurement									
	No One	0	0	0	0	0	0	0	0	0
	Professional Administrator	58	63	55	51	75	47	-7	12	-8
	Medical Director	3	0	0	5	5	13	2	5	13
	Governing Body	29	20	23	32	11	21	3	-9	-2
	Other	11	17	23	12	9	21	1	-8	-2
3.	Boundary/Production Supportive—Disposal									
	No One	0	3	10	0	0	0	0	-3	-10
	Professional Administrator	73	73	51	67	77	71	-6	4	20
	Medical Director	10	0	0	0	7	5	-10	7	5
	Governing Body	0	0	0	20	10	5	20	10	5
	Other	17	24	39	13	7	19	-4	-17	-20
4.	Boundary/Institutional Supportive									
	No One	0	0	13	0	0	0	0	0	-13
	Professional Administrator	57	60	29	50	73	33	-7	13	4
	Medical Director	6	0	0	0	6	8	-6	6	8
	Governing Body	16	13	50	37	20	50	21	7	0
	Other	20	27	8	13	0	8	-7	-27	0
5.	Adaptive									
	No One	0	0	0	0	0	0	0	0	0
	Professional Administrator	51	63	56	61	61	56	10	-2	0
	Medical Director	12	0	0	0	4	8	-12	4	8
	Governing Body	24	28	29	37	32	20	13	4	-9
	Other	13	9	10	2	2	16	-11	-7	6
6.	Managerial									
	No One	0	0	1	0	0	1	0	0	0
	Professional Administrator	39	49	30	49	47	34	10	2	4
	Medical Director	3	0	0	2	3	6	-1	3	6
	Governing Body	42	43	51	46	48	51	4	5	0
	Other	16	8	19	4	2	9	-12	-6	-10
Total										
	No One	0	0	1	0	0	1	0	0	0
	Professional Administrator	48	54	38	54	57	39	6	3	1
	Medical Director	4	0	0	4	5	10	0	5	10
	Governing Body	32	32	38	36	35	37	4	3	-1
	Other	16	13	23	7	3	15	-9	-10	-8

sional administrator's role in the boundary subsystem, particularly for the B and C Scenarios. With the various degrees of change predicted for the health care system by each of the scenarios, there will be substantially more forces impinging on the boundaries of groups than there is currently. These forces will come in the form of more governmental regulations, consumer groups, national health insurance, and unions of either employees or physicians or both. With these forces pressing at the boundaries of groups, the professional administrator will take on more task responsibilities in relation to the exchanges that must occur between the group and its external environment.

The prescenario-postscenario differences in chief responsibility imply that task responsibility will be much better defined in the future. This redefinition of tasks is indicated by the decline in the number of tasks for which others are chiefly responsible and by the increase in the number of tasks for which the medical director is responsible. This situation suggests that administrative tasks will become more the function of individuals who are strictly administrators and fewer administrative tasks will be performed by that loosely defined group of others. It is also important to note that the overall level of responsibility for both the professional administrator and the governing body change only slightly for the future scenarios. If these administrators are currently functioning at their optimal levels, it would be difficult to expect them to take on even more responsibilities in the future. Furthermore, the B and C Scenario groups indicated that a greater number of tasks would be performed in the future. For this reason and the concurrent decrease in tasks for which others are responsible, it is apparent why professional administrators indicated that the role of the medical director in group practice administration would increase.

The professional administrator's overall personal involvement in the subsystem tasks changed only slightly in reaction to the three scenarios. This result occurred even though each of the scenarios forcasted significant changes in the health care system that could affect group practices and thus, to some extent, could affect the professional administrator's role. There appears to be a ceiling effect on the absolute level of the professional administrator's personal involvement in his group's tasks. No matter what changes occur in the health care system, the professional administrator can only be involved to a certain degree in each of the subsystems, and his involvement in each subsystem for the future appears to be almost the same as it is currently. The involvement scores for each of the three scenario groups are presented in Appendix C, Table C-7.

In addition to the professional administrators' responses to the standard list, the impact of the future scenarios was also reflected in their responses to the organizational and biographical questions. Table 8-4 presents selected organizational variables compared by prescenario responses for the three groups.

Each of the three groups of professional administrators indicated that they would be spending less time as administrators in the future regardless of the predicted changes. In fact, the Scenario C group indicated that they would be involved in less work than the traditional 40 hours per week. A second interesting change for the three groups related to the size of their groups. Each scenario group reported that the size of their groups would significantly increase in terms of the total number of physician members. This increases in size for each scenario group indicates how much growth the professional administrators foresee occurring in their groups based on the predicted changes for 1985.

TABLE 8-4

SELECTED ORGANIZATIONAL VARIABLES COMPARED PRESCENARIO WITH POSTSCENARIO

Selected Variables	Scenario	Prescenario	Postscenario
1. Average number of hours in a typical week spent as group practice administrator:			
	Scenario A	44.7	40.7
	Scenario B	46.7	43.5
	Scenario C	50.5	37.5
2. Normal staffing level in terms of full time equivalents			
a. Total physician members:			
	Scenario A	10.7	29.5
	Scenario B	17.7	24.2
	Scenario C	15.5	22.2
b. Total physician employees:			
	Scenario A	5.6	1.7
	Scenario B	2.7	2.2
	Scenario C	8.2	1.2
3. Growth of group:			
	Scenario A	2.7	3.0
	Scenario B	8.2	3.0
	Scenario C	7.5	2.0
4. Percentage of gross operating revenue from prepayment:			
	Scenario A	0	3.7
	Scenario B	0	20.2
	Scenario C	0	23.7

Another organizational variable presented in Table 8-4 concerns the amount of the groups' revenue that will be generated by some type of prepayment. Each scenario predicted that the extent of prepayment in group practice would increase but not to the extent of exceeding the predominant payment mode of fee for service. The impact of this prediction on the professional administrators, none of whose groups currently have prepayment, is indicated in the fairly sizable increases of prepayment in their groups. The B and C Scenario groups reported that 20% and 24%, respectively, of their groups' revenues would be generated by this payment mechanism. The Scenario A group indicated only an increase of 4%. Again, these percentages indicate only what a sample of professional administrators feel will be the average amount of prepayment in their groups based on conditions predicted for the future.

Future Roles by Staff Analysis

The project staff's logical analysis consisted of comparing the current role data to the future of health care predictions and merging the results into an assessment of future administrative roles. This assessment was focused on the future roles of group practice administrators. A problem encountered in this analysis was that, because of the complexity of the task, the predictions concerning the future of health care were considered one at a time. In other words, the predictive methodologies look at one prediction, with its assumptions, in isolation from all others. The reality of the future, however, is that several things will occur simultaneously and not as single units. The staff analysis, therefore, is reported, first, as related to the individual predictions and, second, as related to an aggregation of the multiple and conflicting implications.

Another problem encountered in this analysis was that predicting can not and should not focus upon a *single* prediction of the future. Instead, descriptions and analyses of alternative futures allow for planning and adjustment to take place as the actual future evolves. As an example of this problem, the summary scenarios reflect three different options concerning the way a national health insurance program may evolve in the United States. In this analysis no attempt was made to predict which one of the three models might evolve; and, therefore, the staff analysis consisted of relating role implications individually to the three different scenarios.

Given this overview and the two problems, the staff then proceeded to assess the impact of the future of health care predictions upon the current role description. The Katz and Kahn model was again used to systematize the analysis. Therefore, rather than focus upon individual tasks in the standard list that might or might not be appropriate within 10 years, the analysis utilized the functional subsystem descriptions as bases for predicting future roles. Within the context of the Katz and Kahn framework, then, the staff predicted increases or decreases in the performance of kinds of tasks and increases or decreases in the involvement of administrators in those task areas.

This future roles analysis also involved the use of Fine's functional job description model as a basis upon which to structure the analysis and predictions. Using the Fine framework allowed the staff to describe qualitative role changes suggested by the future of health care predictions.

One final method of organization was employed. The analysis was accomplished within each of the five broad areas developed in the future of health care study: (a) financing of health care; (b) regulation of health care; (c) organization of health care; (d) consumer involvement; and (e) internal management.

Financing of Health Care

In this study's analysis of the future of health care, it was predicted that there would be some form of national health insurance, and that the extent of prepayment would increase. Although there was agreement among the predictions that there would be some form of national health insurance, there was no consensus on the mechanisms by which it would be implemented. These different possible mechanisms were, therefore, reflected in the three different scenarios. There was also agreement that, in the United States, fee for service would continue to be a major payment mechanism in health care, but that the prepayment mode of financing would increase. The degree of prepayment increase was not specified in any of the predictions, although there was a consensus that prepayment would not become dominant.

If (or when) national health insurance is implemented, the staff analysis concluded that there will be no change in the numbers of tasks performed or in the involvement of administrators in the tasks related to adaptive and supportive subsystems. This conclusion is based on the assumption that universal national health insurance would assure financing for health care, and this assurance of financing would lead to some complacency on the part of health care providers. It is also assumed that, with national health insurance involving the government and a few large third party payers, the supportive subsystem functions should take place largely between national associations and these larger units. The situation would leave the individual group practice with little direct activity in the supportive subsystem area.

The availability of universal national health insurance should increase the demand for health care services delivered by group practices and, thus, relieve their procurement problems with regard to patients. However, for physician recruitment into groups, the picture is not clear. On the one hand, national health insurance, with its demands for increased paper work related to billings and cost control, should encourage physicians to join groups where these functions can be taken care of for them. On the other hand, this drive for physicians to join groups conflicts with the basic physician individualism mentioned by Freidson in his interview. It is thus unclear whether national health insurance would cause physicians to wish to join groups or not. The disposal subsystem tasks should decrease in numbers under a national health insurance program, because such a program assures the financing. This financing assurance

should ease the problems related to billing and income generation from the patient population.

A universal national health insurance program probably should increase the number of tasks and involvement of administrators in those tasks for the maintenance subsystem. This increased number of tasks should result from both the increased demand in terms of patient numbers and the increase in terms of government expectations, particularly related to costs and productivity. The number of, and the administrator's involvement in, managerial tasks could be expected to decrease under national health insurance. In other words, national health insurance with its financing should lead to some routinization and some complacency in internal management.

In terms of Fine's functional approach, national health insurance should lead administrators to be more involved in analyzing and coordinating data because the insurance programs will result in close regulation of all costs and reimbursements. These conditions imply that group practice administrators will need to learn the skills that hospital administrators are now using, because their analysis and coordination of the internal data will be required in order to justify their desired rates of reimbursement. National health insurance will also influence how administrators deal with people specifically the physicians, in their groups. The closer regulation associated with national health insurance will require group practice administrators, as is now true with hospital administrators, to do a great deal more cajoling and coercing of the physicians. These activities will be a necessity in order to encourage physicians to comply with the regulatory requirements that will enable a clinic to be reimbursed without delay.

The movement toward more prepayment should have little effect on the adaptive subsystem in group practices because prepayment does not change the free enterprise mode of operation. On the other hand, prepayment should increase the number of, and the administrator's involvement in, the tasks related to the supportive subsystem. The increasing prepayment should require that the group practice and its administrative personnel be involved in image building as well as contract negotiation for the medical services. These activities, and particularly the negotiations, would bring the administrators into contact with large institutions such as unions or other groups of patients and consumers seeking their services.

Procurement and disposal functions, with the movement toward prepayment, should decrease in numbers of tasks performed and in administrative involvement; under prepayment, the business of obtaining patients and generating income becomes more of an annual instead of a daily function. Both of these activities are linked to the annual negotiation of contracts with prepayment of agreed upon rates for services to individuals and families. The maintenance and managerial subsystem should experience no change in the number of tasks or involvement because prepayment does not alter the basic form of free enterprise which characterizes group practices.

The increase in the degree of prepayment will have significant influences upon data-type tasks. While group practice administrators are currently largely involved in compiling and analyzing tasks, the movement toward prepayment will force them to do more coordinating and synthesizing of data, particularly as related to cost. The prospective setting associated with prepayment, the contracts for services, and managing to operate within those limits for a year put the group practice at a risk. This risk implies a need for coordination of data to understand and be able to communicate consequences of various rates to the physicians. The synthesizing of the data will be required for the establishment of capitation rates; the manager should be able to understand these processes in order to properly supervise and relate to the financial personnel in his group.

Under prepayment, people-oriented tasks will also become more complicated for the administrator. While current administrators are largely involved in supervising and negotiating tasks, they will be more involved in instructing their employees and physicians and in negotiating with consumer groups and unions. The risk taking associated with prepayment contrasts sharply to the current retrospective cost reimbursement system, and this sharp difference implies the need for substantially improved supervision of employees in the sense of running a "tighter ship." Physicians will have to be instructed by the administrators in capitation, risk taking, and rate setting in order to properly control costs under such a close-ended system. Most importantly, the administrator will become involved in substantial negotiation with the various groups in the health plan to determine benefits, services, and capitation rates.

Regulation of Health Care

There was also general agreement in the health care future analysis that there would be increasing regulation in the health care field, and that regardless of the source of the regulation, it would make life more complicated. In terms of role implications, the increasing regulation translates into the conclusion that there will be an increasing number of tasks and administrative involvement in both the adaptive and supportive subsystems. For the procurement subsystem, the number of tasks and involvement should increase in relation to patient procurement. The experience of hospitals should serve notice on groups that regulations will generate standards for patient mix, and particularly for the percentage of indigent patients that a group must serve. For the physicians, the regulatory mechanisms present a somewhat unclear picture. While the regulations will undoubtedly affect the geographic and specialty distributions of physicians, the influence of this kind of regulation on group practices will be specifically related to their own specialty mix and geographic location. If they happen to be in an area that has a surfeit of physicians and the wrong mix of specialties, groups may encounter difficulties in recruiting physicians to fit their desires.

The tasks related to the disposal subsystem should increase because of the constraining effect of regulation. Again, the mere fact of regulation means, with regard to

income generation, that more restrictions must be met than are now met by groups. The regulatory demands can be expected to increase the tasks and involvement related to the maintenance subsystem. On the other hand, the nature of the regulation itself will determine the specific influence on the managerial subsystem. If the increasing regulation comes in the form of more regulations but coordinated by one or two central sources, there should not be an increase of tasks in the managerial subsystem. On the other hand, if the regulations come from many different sources and are not coordinated, they should substantially increase the managerial subsystem tasks, an experience hospitals are now currently having.

Increasing regulation in the health care field also has major implications for the performance of data tasks. With increasing regulations the future administrator can be expected to be involved in more data compiling, as well as analysis and coordination, than his current role reflects. Undoubtedly the increasing regulations will specify certain forms of data that must be maintained, such as is true with the Medicare step-down accounting method. Under increased regulation administrators will also spend more time instructing and negotiating with physicians and persuading and supervising of employees.

Organization of Health Care

The increasing emphasis on ambulatory care predicted by the Nominal Groups, the Delphi panels, and the interviewees should express its initial effects on the boundary-spanning subsystems. The number of tasks related to the adaptive subsystem is likely to increase because the ambulatory care emphasis should increase demand, which will require awareness and responsiveness on the part of group practice administrators. The supportive subsystem tasks should also increase in number because there will be more interaction and cooperation among hospitals, groups, and their satellites. The procurement tasks should increase in number, but the direct involvement of the administrator in them should decrease. Here, the shifting emphasis toward ambulatory care should produce a greater availability of patients and, thus, simplification of the problems with regard to the principal purpose of this subsystem of tasks. The same should hold true for the disposal subsystem; namely, an increase in number of tasks with a decrease in involvement, since more patients implies a greater availability of resources. Again, this availability should provide for further simplification of the work; since a group will be beyond the point of worrying solely about survival.

Once this shift in emphasis toward ambulatory care has affected the boundary subsystems, it will also reflect itself in the internally focussed subsystems. In other words, the above mentioned changes will, in turn, affect the maintenance and managerial subsystems. For both of these subsystems there should be an increase in number of tasks and a decrease in administrative involvement resulting from the increased volume of activity for ambulatory care generally, and for group practice specifically.

The increasing emphasis on ambulatory care predicted by several of the sources has implications for both data- and people-oriented tasks. This increased emphasis on health care delivered via group practice should lead not to performance of different tasks, but to an increased frequency of performance of some tasks. Thus, in relation to this prediction, the administrator of the future could be expected to be involved more frequently in compiling and analyzing data as well as in supervising and negotiating with people.

Consumer Participation

The increase in any kind of consumer participation can be expected to have an impact on the total administrative system in group practices. In particular, increasing consumer participation should affect the professional administrator, the medical director, and the governing body by changing the distribution of tasks performed among the three administrative units. For this future prediction, a phenomenon similar to that expressed in the previous section results from the analysis. That is, first, there will be changes in the boundary subsystems that go one direction, and these will be followed by changes in the internally-focused subsystems that go a different direction. In the boundary-spanning subsystem, the number of tasks and the administrator's involvement in them will increase. By contrast, for the maintenance and managerial subsystems, the tasks will increase but there will be no change in involvement. This pattern reflects the fact that the increased tasks will relate to the introduction of a new party, the consumers, into the activities of the group with the involvement obviously being greatest at the boundary.

The increasing movement toward any kind of consumer participation will result in more compilation of data by administrators, but will probably cause little change in the amount of data analysis required. This shift in task activity relates to the need for presenting more data about operations at a fairly simple level for the consumers participating in decision making. Viewing the consumers as the referent group for the people-oriented tasks, there will be a shift in the administrator's role from persuading to diverting. Currently the consumer has little role in the delivery of health care, and administrators have been able to easily persuade a fairly neutral group on their ideas about group practice. For the future, increasing consumer involvement should lead to the development of stances and advocacy on their part. This will result in the administrator's need to perform diverting tasks and, in some cases, his need to convince consumers to change their positions.

Internal Management

An increasing use of computers was predicted in the health care future analysis, which should have implications principally for data-oriented tasks and some things-oriented tasks. In the data area, the increased use of the computer should lead to more automated compiling of data, leaving the administrator with more time to analyze data and to coordinate the data for computerization. Currently, one of the areas significantly missing in terms

of administrator tasks is the set of tasks related to things. Obviously with the increased use of computers, the administrator should have some involvement with things-oriented tasks. While the administrator may not need to know how to program a computer, he should need to be familiar with its basic operation—that is, how to start it, how to stop it, and how to retrieve certain data.

Another prediction resulting from the health care future analysis was that group practices in the future would be involved in elaborate cost accounting. Because this requirement for elaborate cost accounting comes from the external environment and is in the form of rules and regulations, the predominant influence in group practice should be in the maintenance subsystem. For this subsystem, group practice administrators will be involved with more tasks related to keeping the internal systems responsive to the external regulations.

An increase in union involvement was also predicted for group practices and could be expected to have a major impact on all of the subsystems. The adaptive and supportive subsystems will be heavily engaged, in that there are likely to be additional influences (for instance, unions, the NLRB, laws, and so forth) involved in group practice activities. These additional influences will increase the number of tasks and the administrator's involvement in them related to these two subsystems. While the number of tasks performed related to the procurement and disposal subsystems should not change in number, the administrator should be expected to be much more intensely involved in these task areas. The greater sensitivity of the issues and the contracts around jobs will influence who can be hired. On the other hand, the same contracts should produce considerable difficulty in the termination of employees, increasing the pressure to develop less fallible hiring processes. Furthermore, assuming that unionization implies higher wages, there will be more stress on the disposal, or income-generating, subsystem for group practices. The maintenance and managerial subsystems also will experience an increase in the number of tasks and administrative involvement. For the maintenance subsystem, continuous renegotiation and elaboration of policies and procedures related to contracts with unions will be required. For the managerial subsystem, the unionization implies the need for extensive investigation and negotiation of employee's grievances.

The increasing involvement of unions with the various entities in the health field also has implications for the type of future administrative tasks to be performed. Currently, with regard to unions and employees, data-oriented activities are fairly minimal if extant at all. In the future, with union involvement, administrators can be expected to do much more compiling, analyzing, and coordinating of employee-related information. The necessity of negotiating wages and benefits in union contracts requires much more data about costs, productivity, and so forth. The compiling and analysis, in the sense of interpreting the data to develop alternatives, will be absolutely essential to successful negotiations. With regard to people-oriented tasks, administrators, viewing unions as the referent groups, are currently involved simply in persuading. In the future, however, relationships between administrators and employees will become much more formalized through contracts; hence, negotiation, in the strict sense of the word, will become necessary.

Finally, increased internal pressures largely related to and resulting from physician behavior were predicted. The major implication of this prediction is that there will be a greater need for medical directors, but the other parts of the administrative system also will be needed in dealing with stresses. Specifically, the professional administrator will be engaged in monitoring and spotting the problems that the medical director will then mediate, and on which the governing board will make the final decisions. These mounting internal pressures imply an increase in the number of tasks performed and in the involvement of administrators in those tasks related to the internal adaptive subsystem; that is, the internal monitoring function. These same pressures should increase the number of tasks performed and the involvement of the administrators in those areas related to the maintenance and managerial subsystems.

These internal pressures also can be expected to generate a high degree of physician turnover; therefore, the administrator should be involved in compiling and in analyzing a good deal of data related to the needs for new and additional physicians. The people-oriented tasks will relate largely to the physicians as the referent group. With more and more diverse physicians entering groups, the role of the administrator will be to instruct the new physicians in the ways of group practice. He also will be involved substantially in more negotiating to relieve pressures and stresses. These same stresses should increase the demand for the administrator's role in mentoring, although this function will probably be mostly assumed by the medical director.

Summary of Staff Analysis

In the context of the Katz and Kahn framework, the staff analysis reveals a clear trend for an increase in the number of tasks and an increase in the involvement of the administrator in those tasks for the adaptive, the supportive, the maintenance, and the managerial subsystems. For the procurement and disposal subsystems, the implications for the future role of administrators are unclear across the several different predictions. In some cases the administrators will perform more tasks and be more involved; with regard to other predictions, the number of tasks performed and administrative involvement will decrease. The predictions clearly indicate that the most influential changes may be the intervention of new forces into the group practice arena in the forms of regulation, consumer participation, and union involvement. No other predictions seem to influence as profoundly the number of tasks performed and the involvement on the part of the administrators. With regard to grouping, if the movement is toward more but smaller groups, then the above pattern will not pertain. In fact, if the increase is in the number of small groups, then the opposite will take place in that administrators will be

performing a smaller number of tasks but with considerably more involvement in those tasks.

In the context of the Fine framework, the staff analysis shows some clear patterns as the results across the several predictions are mentally summarized. The data-oriented tasks will increase in complexity for the administrators with them doing more compiling than they do at present, as well as substantially more analyzing and coordinating of data. The most influential predictions related to these changes in tasks are the increased use of the computer and the shift toward prepayment. The people-oriented tasks for administrators of the future also will become more complex, with administrators continuing to be involved in supervising and negotiating, but with new roles in instructing and mentoring for medical directors. These changed tasks will result mostly from the increasing regulation, the shifting toward prepayment, and the increasing internal pressures in groups. If the increase in grouping of medical practice takes the form of increasing the average size of groups, then the changes in the tasks for data and people will follow the same patterns. If, however, the increase in grouping takes the form of an increase in the number of small groups, then the task changes will differ somewhat, with administrators involved in a good deal more compiling and less analyzing of data, but still involved principally in the supervision of and negotiating with people.

The summary combination of these two analyses suggests that on the consensus predictions, it can be expected that group practice administration will be generally more involved in more tasks that relate to the adaptive, the supportive, the maintenance, and the managerial subsystems. In addition, the nature of the tasks will change with administration being more involved in the analysis and coordinating of data and in the instructing of and negotiating with people. Overall, administrators will be involved in more tasks of greater complexity in the future, if these consensus predictions are accurate. The most influential predictions and factors relating to these changes are the intervening regulations, consumer participation, and union involvement. All three of these areas should lead to increased numbers of tasks performed with increased administrative involvement. The increasing use of the computer, the shift to prepayment, and the increasing internal pressures appear to contribute the most to the increasing complexity of the tasks for future group practice administrators.

The Impact of Prepayment on Future Roles

Interviews with the administrative staffs of 18 selected group practices were conducted in 1975. Sixteen of the group practices were chosen because of their participation in a prepaid health care plan and the other two group practices were in close proximity to a group involved with prepayment. The groups were located in 13 different states in all regions of the U.S. and varied in size from three physicians to 115 physicians, with 36 physicians as an average. Each group involved in prepayment had an average of 19.5% of its patient population participating in a prepaid health care plan. The range varied from a low of 1% to a high of 74%. Using the size definition of this study, seven of the clinics were considered large, five medium, and six small. The groups were located in rural areas, suburbs, and in various metropolitan environments.

Many of the administrators interviewed indicated that the addition of a prepaid health care plan to their existing fee for service mode of operations increased the importance of long range planning. The increased importance of long range planning, in turn, resulted in an increased emphasis upon the collection and processing of various data and information. For instance, in prepaid plans, information concerning patient demand for medical services becomes critical to the proper establishment of the size and scope of the prepaid programs. Most administrators indicated that it would be helpful to be aware of available resources for information related to patient demand for their specific geographical region or locality; for example, the chamber of commerce, state or regional planning office, and so forth. Another reason cited for increased interest in collecting data on patient demand was for long range planning related to the establishment of satellite facilities.

The addition of prepayment increased the emphasis on the collecting and processing of other kinds of data, also. These data involved statistics on patient utilization, costs of services, age, family size, employers, and so forth. These types of statistics are necessary for supporting the establishment and negotiation of capitation rates. One benefit resulting from prepayment plans is that the professional administrator usually is not so involved in collections because of the cash advances for services covered under the plan. It is the general concensus of the interviewees, however, that this benefit is more than offset by the increased man-hours required to maintain the accurate records necessary to support the establishment and negotiation of capitation rates.

The administrators indicated that the marketing associated with prepayment programs was a new skill for them. Marketing plans varied by clinics. In some states, the Blue Shield Plan marketed the prepayment program; other groups left the marketing to the local medical society or to commercial insurance firms. In all cases, however, the professional administrators were aware of the marketing protocol and of the implications for their group practices.

Patient satisfaction was cited as an area of concern related to the marketing aspects of prepaid plans. Potential new patients of a prepaid program quickly learn of satisfaction or dissatisfaction of plan members. Keeping a plan viable often depends upon this word-of-mouth kind of "advertising." Surveying the satisfaction of patients, therefore, is considered an important task in the prepaid aspects of the group.

Related to patient satisfaction, prepayment also causes another problem, that of the disgruntled patient who must stay with a plan until the contract expires. This situation can cause difficulty for both the patient and the group. Several administrators indicated that they often

become involved in mediating or arbitrating between the group's physicians and patients over medical services involved (or not involved) in a prepayment plan. A patient is often hesitant to discuss an issue with a physician but not hesitant to discuss the same problem with the professional administrator. The problem may be quite minor and be resolved to the satisfaction of the patient through simple adjustments to either the fee or to the services provided.

The interviewed administrators generally feel that "negotiation" skills are quite important to an administrator involved with a prepayment plan. "Negotiation" skills, which implies the ability to deal with third party payers, industrialists, patients, consultants, physicians, bureaucrats, and consumer groups, are probably more important for administrators in prepayment programs simply because prepayment administrators are required to negotiate with more people and groups than are fee for service administrators. Generally, most of the administrators felt that more continuing education in the area of negotiation skills would be helpful.

The administrators were then asked why they chose to initiate, or be involved in a prepaid health care plan; the answers were mixed; some of them related to:

—experimentation and evaluation of the concept of prepayment;
—defending themselves against government intrusion in the practice of medicine;
—fear of loss of patients if the organization did not participate in a community prepaid program;
—pressure by local businesses.

Even though all the administrators indicated that they were benefiting financially from their participation in a prepayment program, only one gave as his reason for participation "financial remuneration." One administrator indicated that his group was participating because of feelings of "social responsibility." Most administrators indicated that their main activities in implementing a prepayment program involved working with actuarial rates, studying local demographic characteristics, and reviewing the implications of numerous contracts. They indicated that there was no change in their automomy when either starting or participating in their prepayment program.

When asked, "What is a major irritant for you as an administrator?" the answers related to prepayment were as follows:

1. It is a problem when physicians agree to participate in a prepayment program but they do not understand how the program will work in the group practice.
2. Some prepayment subscribers assume that the group can and should provide any type of care even when the group does not have the proper facilities.
3. Often the administrator must act as an arbitrator between the patients and their physicians and must deal with the defensiveness of both the patient and the physician.

Finally, the administrators were asked: "If you had it to do over again, what could have been done differently in switching to a prepayment plan or adding a prepayment component to the group practice?" Several administrators stated that they would make no changes; but, predictably, others made recommendations related to the above irritants. Several administrators indicated that they would have spent more time educating the physicians and consumers to the meaning and operations of a prepaid plan. One administrator said that the participating patients must be educated to realize that, if they use the system correctly, the cost can be kept in line; however, if the patient misuses the system, costs will skyrocket accordingly.

Other administrators suggested that they would have delayed implementation until the federal legislation and regulations had been finalized. One person stated that he would have conducted a more thorough feasibility study and established separate corporations for the prepayment program, rather than having it included in the regular operations of the group. One administrator said that he would have asked for a higher capitation rate and established a deductible to help control costs of patients with minor complaints; another administrator indicated that he would have contracted with an insurance carrier to operate the program rather than having the group assume the initial cost of operations.

CHAPTER 9

SUMMARY OF RESULTS

Current Roles

The Role of the Professional Administrator

The professional administrator is responsible for a majority of a group's administrative activities, but these tasks are not usually of a high decision-making level. Administrative tasks that involve high-level policy making or that are related to the medical aspects of the group are not included among the chief responsibilities of the professional administrator. This situation does not mean, however, that the professional administrator plays a negligible role in the important, high-level activities of his group. The study's data support some aspects of the general literature concerning the role of the professional administrator; namely, that he significantly influences the functioning of his group by being generally involved in major decision making and policy making through activities that could be labeled "persuasion" or "negotiation."

Information from the Standard List of Administrative Tasks also indicates that the professional administrator is often highly involved in the governing body's tasks, especially in the managerial and maintenance subsystems. In addition, while the professional administrator seldom has final authority for the high-level policy decisions in the decision table, he does participate to a large degree in each.

An indication of the form that the professional administrator's involvement takes in these activities is given by information collected from the critical tasks, the site visits, and the time logs. The content analysis of the five most important critical tasks indicates that many of the professional administrator's important tasks are related to collecting data for the governing body so that they can make group policy decisions.

The functional task analysis of the critical tasks reveals that the professional administrator's most frequently performed people-oriented tasks involve the functions of persuading and negotiating. In addition, the time log data of the professional administrator's daily activities show that his second most frequent people-oriented activity was negotiation, and that he spent the majority of his time performing this function. Information obtained from the site visits provides a final indication of the form of the professional administrator's involvement in the governing body's tasks. The professional administrator sees himself as guiding and influencing the governing body in the decisions that they make concerning group policy.

Lauer (1962) has stated that the professional administrator should place a substantial wall between himself and the medical aspects of his group. It appears that this is the case as far as the professional administrator's chief responsibility is concerned. However, the medical elements of a group practice affect the financial and management aspects of the group and, for this reason, the professional administrator cannot ignore the medical elements totally. He uses his influence, therefore, in whatever style fits him best in order to provide subtle guidance for the persons who are responsible, so that they might be persuaded to adopt policy or make decisions that are in the best interests of the group. There is no implication that the professional administrator attempts to manipulate the medical decisions of the group; rather, there is an indication that the group's production function, the practice of medicine, is intricately related to the group's business affairs. The professional administrator directs his attention to the business side of medical decisions and lets the physicians, who are trained in medicine, handle the medical aspects. This situation suggests that the professional administrator must be knowledgeable of certain medical aspects of his group as well as of the business aspects. He must understand how business affairs affect the practice of medicine, and vise versa. In addition, he must be capable of separating the two aspects without interfering with the physician's responsibilities. The professional administrator is as ethically responsible as is the physician for seeing that the group's medical quality is as high as is possible. The professional administrator, however, can not be responsible for his group's medical aspects per se, even though they are necessarily and directly tied to the group's business. The medical aspects of the group are the domain of the physicians, and the professional administrator must keep up this standard for the good of the medical profession.

Professional administrators are, in general, highly educated. Less than 6% of all professional administrators have never gone to college and more than 21% have obtained graduate degrees. Professional administrators, however, have educational backgrounds that vary considerably in terms of the college major. The complete list of professional administrators' college majors reads like the possible degree programs from a college catalog.

In addition to being highly educated, professional administrators actively pursue opportunities to increase the level of their knowledge in regard to their profession. Less than 14% of the respondent professional administrators have not attended at least one educational seminar in the past three years. The average number of seminars attended by all professional administrators in the last three years is 4.66, or more than one seminar per year for each administrator. It is apparent that professional administrators are very educationally oriented.

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A majority of professional administrators begin their careers in group practice administration with a wide variety of work experience in many diverse career areas. Only 32% of the professional administrators reported that they began their careers in group practice administration immediately upon receiving their final educational degree. In addition, once in the profession, professional administrators tend to remain for a long period of time; the average tenure of all respondents in this field is about 11 years, most of which is spent with the same group.

The Role of the Medical Director

The position of medical director in group practice administration is somewhat unusual. Medical directors are found in proportionate numbers among groups of various size and payment mechanisms; yet, only 20% of all respondent groups had a medical director. There are indications, however, that the number of medical directors in group practice will increase significantly in the future.

Medical directors are typically responsible for the fewest number of administrative tasks (18%), compared to other types of administrators; yet they are highly involved with most of the group's administrative tasks. In fact, they are often more involved with tasks that are the responsibility of others than they are for the tasks that are their own chief responsibility. The percentage of tasks for which medical directors are responsible and in which they are personally involved do not vary to a large degree across the six subsystems. Furthermore, the types of tasks in each of the subsystems have some commonality. The medical director's principal duties appear to be concerned with the business-related medical aspects of the groups and with administering to the personal and interpersonal needs of the group's physicians and other medical staff. In addition to the medical director's tasks on the standard list, the content analysis of the five most important critical tasks indicated that the medical director performs many tasks that require him to deal with people, usually in a non-practicing medical context. The functional task analysis verified this occurrence and also pointed out that his tasks often involved fairly high functional levels of behavior. The relatively high functional performance level was further supported by time log data of the medical directors. The agreement data between professional administrators and medical directors in the same group further defined the nature of the medical director's functioning with respect to people. The one task on which there was the most agreement was arbitrating between physicians who have interpersonal problems. This task, and several others like it, appear to be the single most important function of the medical director.

Another effect the medical director has on the administration of a group practice involves the influence his role has on other administrative roles. In the groups that have a medical director, the administrative role most significantly affected seems to be that of the governing body. In these groups, the medical director assumes responsibility for some tasks that are typically the responsibility of the governing body. The medical director, to a lesser extent, also assumes responsibility for some of the professional administrator's tasks. However, within groups that had both a professional administrator and a medical director, there frequently was disagreement between the two roles as to who had responsibility for some of the group's administrative tasks. This disagreement occurred most frequently when the tasks concerned the implementation of group policy; both the professional administrator and the medical director claimed these tasks as being their chief responsibility.

The Role of the Governing Body

The governing body does not have the largest role in a group practice in terms of the number of tasks for which it is responsible, but it does have the most powerful role. The governing body is responsible for 33% of all administrative tasks in a group, and many of these tasks are associated with the managerial subsystem. The governing body makes most of the important decisions for the group and approves the group's major policies. It also is responsible for most of the medical aspects associated with the business functioning of the group. From the analysis of the task list data, it is obvious that the governing body is the highest decision-making body in a group. This conclusion is further supported by the decision table data and the content analysis of the critical tasks. The functional task analysis of the critical tasks also demonstrates that the governing body performs tasks that are on a higher functional level than those performed by the professional administrator for both people-oriented and data-oriented task categories.

While the governing body is the highest decision-making body in a group, it is not very involved in the overall administration of the group. The involvement scores of the governing body for each of the subsystems is lower than those for the professional administrator or the medical director. The governing body is not even very highly involved in those tasks that are its own responsibility. The most likely reason for this lack of personal involvement appears to be the result of the fact that governing bodies are composed of only part-time administrators. The majority of governing bodies meet on a regular basis only monthly or even less often.

The Effects of Group Size

On an a priori basis, three categories of size were defined as subgrouping variables, with the "small" category consisting of those groups with 3 to 15 FTE physicians. The overall average size of the groups responding to the study's survey questionnaire was 17.8 FTE physicians. The latest AMA survey of group practices (Goodman et al., in press), however, indicates that the average size of the groups responding to their survey was 7.9 physicians. Since this study's average-sized respondent group is so much larger than the AMA's, the small-sized category was further subdivided into groups of 3 to 7 FTE physicians and 8 to 15 FTE physicians in order to determine if the present study's results might be biased in favor of larger group practices. Testing for significance resulted in only a few significant differences between the

two new categories, and the differences were consistent with those found when comparisons were made among the original size categories. It does not appear, therefore, that basic administration in very small groups (3 to 7 FTE physicians) is substantively different from administration in small groups (8 to 15 FTE physicians). This conclusion must be tempered, however, by a word of caution: it is possible that there are actually significant differences in the administration of very small groups as compared with small groups, but the measuring instruments or the analytical methods used in the study were not sufficiently sensitive to demonstrate those differences. However, within the context of the current study and based upon the measuring instruments and analytical methods employed, important differences between very small groups and small groups were not discernible. Therefore, the size categories originally employed were considered as appropriate as any others that might have been selected for examining differences in administration associated with size.

The larger a group practice, the greater the number of administrative tasks that are performed and the fewer the number of tasks for which the professional administrator is responsible. In addition, as groups increase in size, it is more likely that the professional administrator is less personally involved in his group's administrative tasks. This effect was reflected in most of the administrative tasks regardless of subsystems.

Taking into consideration the professional administrator's responsibility for, and personal involvement in, subsystem tasks, reveals a second relationship associated with the effects of group size, between the size of the group and the transition of the organization. Many medium-sized group practices appear to be affected by an organizational transition period that involves a group switching from a loosely structured, very personal organization to a more structured, less personal type of business. This effect is demonstrated most clearly in the role of the medium-sized group's professional administrator who is more involved with the administrative tasks of his governing body than are professional administrators of either small or large groups. In general, the scores of the medium-sized group's professional administrator are not consistent with the score patterns of the professional administrators in either the small-sized or large-sized groups. The most apparent manifestation of this effect occurs in the column 2—3 interaction scores of the professional administrators. The professional administrator of the medium-sized group is less involved in his own tasks than would be expected and is more involved in the tasks of others, in particular the tasks of the governing body. Since many of the subsystems' tasks that are affected in this manner deal with the organizational structure of the group, it appears that the professional administrator's involvement is that of trying to influence his governing body to make the changes necessary to move the group through the difficult transition period.

The size of a group also influences both the content and functional level of the professional administrator's critical tasks. The larger the group, the more that people-oriented tasks increase in importance and data-oriented tasks decrease in importance. In addition, the professional administrator of a large group performs critical tasks that are on a higher functional level than those performed by small or medium-sized groups' professional administrators. This relationship is reversed for medical directors. From the data it appears that the larger the group, the more likely it is that the number of people-oriented tasks performed by the medical director decreases, and the number of data-oriented tasks increases. This finding is the opposite of the trend displayed by professional administrators.

The Effects of Payment Mechanism

Group practices were divided by the subgrouping variable of payment mechanism in order to form two groups, fee for service and prepayment. The purpose of this division was to determine if there were any significant relationships between payment mechanism and group practice administration. The groups included in the prepayment category, however, did not operate under total prepayment. In fact, all groups in this category had part of their revenue generated by some amount of fee for service. The average amount of revenue generated by prepayment in these groups was 30%. The effect of payment mechanism must, therefore, be considered as either the influence of groups being entirely fee for service versus groups operating under some combination of prepayment and fee for service.

The first notable differences between fee for service and prepayment groups were in the organizational data and in the demographic data of professional administrators. Prepayment groups typically have longer clinic hours, more physicians, and more satellites than do fee for service groups. In addition, the professional administrator of a prepayment group has generally held more positions in the health care delivery field and works fewer hours than does the professional administrator of a fee for service group. On the average, more administrative tasks are performed by prepayment groups than by fee for service groups.

The professional administrator of a prepayment group is responsible for more administrative tasks than is the professional administrator of a fee for service group. The professional administrator of a prepayment group, however, is less personally involved in the group's activities than is his counterpart in a fee for service group. Examination of the critical tasks and time log data of prepayment and fee for service professional administrators indicates that the professional administrator in a prepayment group performs more people-oriented tasks than data tasks as compared to the professional administrator in a fee for service group. On the other hand, prepayment medical directors perform more data-oriented tasks than people-oriented tasks compared to their counterparts in fee for service groups.

Site visit discussions with professional administrators of both fee for service and prepayment groups lead to the conclusion that administration within existing prepayment groups resembles what administration in fee for service groups might look like in the future. In the site

visits, one question asked of prepayment group professional administrators was: "What changes occurred in your role as a function of adding a prepayment component to your group?" Their answers were frequently the same: "None at all." However, as more detailed questions were asked, it became apparent that some subtle, but significant changes had occurred to their roles. In the staff analysis, when these data were examined, the conclusion was reached that the operation of fee for service groups in the future would closely resemble the dynamics that are occurring in the prepayment groups of today. There will be few dramatic changes in the administrative roles of fee for service groups, but like prepayment groups, subtle changes will occur that will significantly change the administrative roles. Data from the standard list and other sources support this conclusion. The prepayment group performs more administrative tasks than does the fee for service group, and the professional administrator of the prepayment group has more administrative tasks for which he is responsible than does the professional administrator of a fee for service group.

Pattern of Role Interaction

The agreement data between the three respondent roles within a group indicate that there is very poor overall agreement between administrative roles as to who has chief responsibility for the group's administrative tasks. The agreement that does exist is with the tasks that are considered to be the responsibility of the professional administrator. The agreement as to the tasks for which the medical director and the governing body are responsible is typically very low, with the role of the medical director being the least defined.

For each of the administrative roles, however, there are a small number of tasks upon which there is high agreement. These tasks could be considered to be the core elements of each administrative role. The professional administrator's core tasks are those dealing with the everyday business activities of the group. The medical director's tasks are those concerning the interpersonal relations and medical aspects of the group. Tasks dealing with the policy making or decision making of the group are the responsibilities of the governing body.

The content analysis of the five most important tasks suggests that the administrative tasks that the professional administrator feels are critical to his role seldom overlap the critical tasks mentioned by either the medical director or governing body. However, the critical tasks of the medical director and governing body frequently do overlap. Examination of these critical tasks of the three administrative roles reveals that they are not substantively different from the tasks in the standard list used to define the roles.

The functional task analysis of the five most important tasks showed that the professional administrator's most frequently performed tasks involve "compiling" in the data category and "supervising" in the people category. The medical director and governing body, on the other hand, performed tasks that are, on the average, at a higher functional level than the professional administrator's. Their most frequently performed critical tasks involve "analyzing" in the data category and "negotiating" in the people category. In addition, the medical director performs people-oriented tasks more frequently than does either the professional administrator or the governing body.

The time log data relating to the every day activities of the professional administrator and the medical director, indicate that the majority of the professional administrator's duties are data-oriented while the medical director's are people-oriented. The medical director performs fewer administrative tasks overall than does the professional administrator, and the medical director also spends less time on each task than does the professional administrator. On a day-to-day basis, the professional administrator operates at a slightly higher functional level than does the medical director. The only set of tasks in which the professional administrator's functional level is surpassed by the medical director's, is in "mentoring." There are fewer tasks performed by medical directors than professional administrators because most medical directors in the study were part-time medical directors, while all professional administrators were full-time administrators.

Based on all data, it appears that the professional administrator and the medical director have complementary roles. The professional administrator deals with the business aspects of the group while the medical director deals with the medical aspects of the group. The governing body sets policy and makes important decisions for the group.

Future Roles

Health Care Predictions

The predictions about the future of health care that were derived from the analysis of the Nominal Groups, the Delphi studies, and the interviews conducted as part of this study suggested changes in five major areas: (a) the financing of health care, (b) the regulation of health care, (c) the organization of health care, (d) consumer participation, and (e) internal management. In the financing of health care, it was predicted that by 1985 there would indeed be a national health insurance system operating in this country, and that prepayment would increase substantially, although it would never become predominant over fee for service. The predictors were confident that there would be more government regulation, especially related to cost and quality. The predictions were less consistent, however, in terms of the coordination of the regulations. The best of all possible worlds would be one in which more regulations would be accompanied by more central coordination of the regulations that, in turn, would lead to the elimination of duplication and conflict. However, the predictors were not confident that more coordination would occur; that is, there was always the possibility that more regulations would come from more sources and would be less coordinated.

Several predictions were made with regard to the organization of health care, but they could be summarized

simply in the notion that there will be more linkage among all components in the health care system. This linkage means specifically that neighborhood health centers, group practices, hospitals, and health maintenance organizations will find ways of working more effectively together. As a part of this increasing organization of health care, the predictors were unanimous in suggesting that more physicians will associate themselves in groups. However, there was no concensus as to whether the growth of groups would be simply an increase in the number of groups, meaning more smaller-sized groups, or an increase in the size of existing groups, that is, more physicians joining the already extant groups.

The predictors also felt confident that the consumer movement in our society, and in health care in particular, would have a significant impact on group practice. Consumers in the future, they felt, will participate more in groups, either in advisory roles or in decision-making roles. One form of consumer participation that is certain to take place is the increasing consumer role through prepayment. Once consumers become negotiating parties in matters such as the termination of services and the setting of rates, their influence in health care, especially in groups, will become significant.

Several changes were also predicted that would influence, specifically, the internal management of group practices. On the one hand, predictors were confident that collective bargaining with unions, which are now spreading throughout the health field, would involve groups. More importantly, internal pressures in groups would increase as physicians join groups. Some of the interviewees specifically predicted that internal pressures would increase as more physicians who might be less compatible with the group mentality joined groups.

It should be emphasized that the future predictions, and specifically their implications for future roles, were inductively derived using the Nominal Group process. A major consequence of using this approach is that, admittedly, the results are not comprehensive, and certain major and obvious areas may be missing from the predictions. One particularly noteworthy example of this occurrence is that nothing was specifically predicted through the Nominal Group process about major changes in medical technology in the next decade. It is with this limitation that the future predictions must be considered.

Influences on the Future Roles

The pre-post design, the staff analyses and the site visit interviews discussed in Chapter 8 suggested major changes in the roles of group practice administrators as they related to the boundaries between their organizations and the outside world. In the past, group practices have been able to pursue a more independent course than some of the other parts of the health care delivery system, particularly hospitals. The results of the future predictions and the various analytic techniques used to establish their implications for future roles suggest that this freedom will not persist. In fact, the boundary functions related to the external environment and particularly to the government, consumers, and unions will significantly affect the group practice administrator's role. In the future, group practice administrators will become more involved in the tasks related to the boundary functions, described as adaptive, supportive, disposal, and procurement. These increased boundary functions will be required in order to cope with governmental regulatory bodies, consumer groups, labor unions, and prepaid purchasers of services.

The new boundary function activities in which professional administrators will become involved will relate, in part, to collecting and processing more information about and from each of the groups mentioned. The professional administrator will need more accurate and up to date information about government regulations. He will need to find successful ways of obtaining advice and opinions from consumers in the public at large and specifically from the prepaid recipients of his group's services. The grievances and demands of unions will also have to become a part of his store of information. To interact effectively with each of the groups mentioned above, professional administrators will need to increase their efforts in the areas of lobbying, public relations, and image building. These activities will assure groups and their administrators of success in their formal business relationships with their external environment.

The predictions from the Nominal Groups, the staff analyses, and the site interviews suggested that prepayment would be a part of the lives of many groups in the future; hence, prepayment would command the attention of the professional administrator. The increasing importance of prepayment, which is suggested by some of the scenario-related data to be on the order of 17% of the business of many groups, would lead the administrators into new activities. Specifically, advertising, marketing, and competitive rate setting of and for services would be additional activities requiring the administrator's attention. Group practices would be required to seek the attentions of various consumers and organizations who might buy their prepaid package plans. The effect of government legislation directed toward the development of prepayment is to encourage competition among various prepayment groups. Hence, in order to develop marketable prepaid plans, groups would be required to determine needs and demands of various segments of the population. Based upon this kind of market research, groups would then be required to establish rates that would provide the required return, while at the same time allowing the groups to compete in the marketplace. Finally, groups would be required to engage in the straight forward business activity of advertising their plan, its services, and its rates.

The increase in prepayment would also involve administrators in the direct negotiation of contracts for services with various organizations. Once contracts were negotiated, administrators would be concerned with enrolling the organization's patients and consumers. Most important of all, this direct contact and linkage between consumers and group practices through contracts for services would require the administrators to be more concerned with patient satisfaction. The professional

administrator would be involved in resolving patient-physician conflict in the interests of retaining high prepaid group membership.

The movement into prepayment, even with the emphasis on competition, would not necessarily lead the group and the professional administrator into a free enterprise world of operation. In fact, the movement and associated activities will take place under increasing scrutiny from the government, from the public at large, from organized consumer groups, and from unions. Hence, all of these activities, which will be new to professional administrators and groups, will have to be carefully balanced and adjusted to the constraints and expectations of the group's union member employees, the government, and the public at large. This balancing and adjusting will require the professional administrator to become an even more skilled mediator with the courage to lead and set direction for these multiple groups.

The increasing importance of the interactions at the boundary between groups and their environments will require professional administrators to make adjustments in their internally-focussed subsystems—the maintenance and managerial subsystems. Internal information-gathering, -maintaining, and -processing subsystems will be required in order to cope with the capitation rate setting required for prepayment, the record keeping and reporting expected by the government, and the compliance required by labor union contracts. Accurate business and service information is the only means by which groups will be able to successfully set competitive capitation rates and survive in a world and an environment that will not allow them to recoup their losses retrospectively at the end of the year. The government's increasing regulation in the areas of cost and quality of care will require accurate documentation of compliance. This documentation implies extensive record keeping and, as hospitals have experienced, the hiring of additional people to handle the data and to complete the necessary reports. Union labor contracts will specify procedures and activities that must be followed with regard to union member employees and their grievances. Compliance with these union contracts and, ultimately, the development of defensible positions rest upon accurate record keeping and reporting.

Similar kinds of information-gathering and -processing functions will also be required to monitor the concerns of the group's employees and physicians, as well as its constituent consumer organizations. The professional administrator will be required to know how to collect the personal and interpersonal information necessary to monitor the "pulse" of his employees, his physicians, and his group. Just as importantly, the professional administrator will have to possess a sensitivity to the needs and interests of consumer groups and the public; knowledge of such needs and interests may affect the image and the ultimate success of a group in a community.

Professional administrators in the future will also be involved in much more systematic personnel management in groups. As groups increase in size, as they shift toward prepayment with its demands for successful management, and as they come under the public scrutiny of the government and unions, groups will have to be run in a much more systematic fashion. This emphasis on systematizing will require increasing specification of job and role responsibilities, not only for successful management but also to meet government regulatory and labor union contractual requirements. The increasing need for successful management in the face of the convergence of significant boundary relationships will require the administrator to delegate more responsibilities to specially trained assistants and subordinates.

Above all, the increasing importance of the external environment, the needs for information, and the increasing requirement for clarification of responsibilities will require professional administrators and their groups to become more significantly involved in planning, both in the short run and in the long term.

Finally, the shifting of administrative responsibilities will bring the medical director in the group practice setting into a more significant role with more tasks to perform and greater involvement in administration. While the medical director is currently involved largely in personal and interpersonal interactions in a group, his activities in the future will shift as groups become more highly managed toward data tasks in addition to just the people tasks. Specifically these shifts will require that medical directors become involved in the traditional management functions of planning, organizing, directing, controlling, and budgeting. While the medical director currently seems to be searching for a role or is in a transition role, it is clear that in the future, in group practices with the many boundary interactions and their implicit internal influences, the medical director will become a manager in the true sense of the word. To prepare medical directors for these expanded roles, the development of specific training programs appropriate will be needed.

In summary, while the current role data suggest that group practice administrators are not chiefly responsible for high level decisions and that medical directors involve themselves principally with personal and interpersonal tasks, both of these trends will change in the future. The boundary-spanning functions, relating specifically to the government, consumers, and unions, will change both of these roles. Professional administrators in the future will need to be successful negotiators, mediators, and leaders for their groups. The increasing complexity of the interactions at the boundary will demand that professional administrators assume many of the new functions, since the tasks will consume more time than can be devoted to them by governing boards made up of practicing physicians. At the same time, many of these same changes will result in the shifting of responsibilities and decision making from governing boards to medical directors. In other words, while the current role data suggest that governing boards retain substantial control in the traditional management functions, the influence of the external environment on group practices in the future will shift much of the responsibility and the authority to professional administrators and medical directors.

CHAPTER 10

EDUCATIONAL IMPLICATIONS

Determining educational needs in terms of the knowledge and skills required to be a medical group practice administrator was not within the scope of this study. From the outset, however, there existed an implicit goal of developing results that would yield educationally useful information. The results are potentially useful to educators, but further analysis is required in order to achieve the full potential contained in the study's data. Systematic, in-depth analyses of the current role data, especially the Standard List of Administrative Tasks, would yield a basis from which educational objectives could be developed. These educational objectives would define, in general, a curriculum that would train professional administrators of medical group practices as the field currently exists. Once the general "current curriculum" were defined, then the impact of the future on the curriculum could be evaluated, and a curriculum that might meet the needs of future group practice administrators could be delineated.

Although the analysis that could lead to the current curriculum definition has not been accomplished, a cursory logical analysis of the future data and of the future professional administrator's role description was conducted in order to gain some insight into possible implications for future curriculum requirements.

Implications for Future Curricula

The analysis of future educational implications focussed primarily upon knowledge/content areas, as opposed to applications/skills areas, that the study's future and future role data suggested might be important to future group practice administrators. Some of the knowledge/content areas defined generally correspond with those from the Accrediting Commission on Education for Health Services Administration (Criteria for an Accredited Program in Health Administration, effective July 1, 1976). Initially, therefore, the Commission's curriculum criteria will be used as an outline in describing the educational implications of this study.

Social-Behavioral and Management Sciences

Analysis of this study's future and future role data indicates that the group practice administrator of the future will be required to possess a knowledge of the content area of economics. Given the projected influence of factors such as government regulation, consumer involvement, and prepayment with its necessary capitation rate setting, the topic within economics of pricing theory would seem to be important.

In order to deal with the active forces of the future, it will be necessary for professional administrators to be knowledgeable in many of the areas of organizational theory. The traditional topics of organizational structure and organizational behavior will, of course, be important. A general systems theory approach to organizational theory would provide the knowledge for allowing group practice administrators to gain the skills in "conceptualizing" that would seem to be so important in the future.

The future and future role data also indicate the importance of the knowledge of political science. Awareness of the procedures involved in the legislative process and of the government's budgeting process will be useful in dealing with the government. In addition, knowledge of policy development and policy analysis in general, as well as in relation to the functioning of government, will be important.

Knowledge of three areas of law were identified as being important to future group practice administrators: (a) administrative law, (b) contract law, and (c) labor law. In the area of quantitative methods, future administrators should be knowledgeable in statistics, operations research, and systems analysis. With the importance of data and the complexity of the organization, automated data processing and management information systems are going to be required.

It almost goes without saying that the data indicate the importance to the future administrator of knowledge of the management functions. Financial management, including financial planning, will be required to help administrators maintain the viability of their groups in the face of the many external forces and requirements to which groups will be subjected. The impending union movement stresses the need for knowledge in labor relations, and several aspects of the future data emphasize the need for extensive knowledge in personnel management.

Health and Disease

In the broad concern of the individual, social, and environmental determinants of health and disease, the future and future roles data indicate that knowledge of the areas of medical practice, medical and professional ethics, and medical equipment will be of prime concern to the group practice administrator. The topics of medical and professional ethics and medical equipment require no explanation. Knowledge of the area of "medical practice" is herein defined as an awareness of the intervention process in terms of the roles of physicians in health and disease and a general understanding of what it is that physicians do and how they accomplish their goals. The administrator will be required to understand relationships between medical practice and the running of a medical group as a business. He will be required to,

sort out the business from the medical aspects of the group practice and to deal with interrelationships among the medical and business aspects smoothly and without violating medical ethics.

The Elements of Medical Care

The future administrator will be required to know about health care delivery in general, and about group practice in particular and how it interrelates with other delivery systems. The staff analysis suggests that the administrator's direct role in quality assessment and social accountability may be minimal, even though these issues almost certainly will become important for the organization.

Further Educational Implications

Identification of knowledge/content areas that are not specifically detailed in the Accrediting Commission's criteria resulted from the staff's logical analysis of the future and future roles data for educational implications. Even though some of these areas may be subsumed under many of the more general topics of the Commission's criteria list the additional areas are described separately. It was felt that it would be useful to describe these additional areas separately since, in many cases, the topics delineate in more detail the Commission's criteria. Furthermore, it may be that many of the additional areas are those that distinguish the needs of group practice administrators from the needs of health administrators in general.

Future group practice administrators will be required to be knowledgeable in the content area of marketing. Marketing knowledge will be required principally by administrators whose groups are involved in prepayment, but it is very likely that some knowledge of marketing, for instance market research, would benefit fee for service administrators as well.

Knowledge of the topic of "attitude change" in social psychology would help the future group practice administrator deal with both external forces, such as consumers and consumer groups, and forces internal to his group, such as employees and unions. Administrators need not become social psychologists specializing in changing attitudes, but they should be aware of some of the techniques employed for changing people's attitudes and the effectiveness of these methods.

In the area of quantitiative methods, the staff analysis identified some areas in addition to the more traditional topics of statistics, operations research, and systems analysis. The topic of research methods is often considered a part of statistics, but too often does not receive the emphasis it deserves. Furthermore, a particular research method, survey research, is typically the most appropriate and useful to practitioners such as administrators, but is also the most ignored in methodology courses. Knowledge of topics such as demographics, census, and population dynamics in terms of what they are and what are typical sources of information (for instance government regulations, consumers, unions, and purchasers) and how to utilize these sources will be important.

In the broad category of organization theory, topics were identified that are both more detailed and also not necessarily always considered in organization theory. Knowledge of the content area of "complex organizations" was identified as being important to future group practice administrators. Part of the content of the topic of complex organizations is probably addressed in the Commission's criteria related to the study of the elements of medical care involving "the various ways of delivering personal health services with special regard for their major components, their stable and changing characteristics and interrelationships (Accrediting Commission on Education for Health Services Administration, July 1, 1976)."

The content of complex organizations as herein defined involves intraorganizational structuring and functioning, interorganizational structuring and functioning, organizational bureaucracy, and organizational communications. Intraorganizational structuring and functioning deals with an organization as a complex system and relates, for instance, departments to departments, central facilities to satellites, and so forth. Interorganizational structuring and functioning deals with several organizations as a complex system and relates, for instance, organizations to conglomerates, professional corporations to foundations, and so forth. The term organizational bureaucracy is meant to involve bureaucratic functioning of government, consumer groups, unions, and so forth. Organizational communications involve the study of the ways in which communications are carried on, both within organizations and between organizations. Some knowledge of this area of complex organizations, then, should prove to be useful to future administrators.

Another content area identified by the staff analysis consists of several subareas or topics that generally fit under the broad category of personnel management. Future administrators would benefit from some knowledge of group dynamics and role theory. A knowledge of the manner in which professionals are socialized into their roles will be useful. Even more useful to the future administrator will be knowledge of how to manage professionals, in particular physicians, and an understanding of the typical "physician mentality."

More directly related to traditional personnel management, future administrators will be required to possess knowledge in the area of personnel psychology. Most of the traditional areas of personnel psychology will be important: job analysis, selection, placement, performance appraisal, and so forth. Three areas will be especially important: (a) recruitment of physicians; (b) management of supervisory personnel; and (c) human relations, including job satisfaction and enrichment, training, and development.

The Need for Additional Study

The results of this analysis should not be given more weight than they deserve—they are preliminary implica-

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tions only. Since the current curriculum has not been developed to serve as a baseline, it is not known whether the future proposed requisites are included in current requirements. In addition, it is not known whether any aspects of current requirements will cease to be important in the training of future group practice administrators. It is hoped that future research will bridge these gaps.

In addition, the educational implications in this chapter have been directed at an ideal situation. Part of this ideal involves a training program for a group practice administrator who might enter the field by becoming the chief administrator of a small to medium-sized group, or an assistant in a larger group. This administrator would probably be interested in progressive career advancement. Some of the educational implications may not be appropriate for the manager of a small group with three to six FTE physicians. In other words, it is possible that size differences exist that have differential implications for educating administrators. It has not been possible to perform sufficiently detailed analyses in order to define the effects of size of group on educational implications; this area of study yet remains to be done.

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CHAPTER 11

CONCLUSIONS AND RECOMMENDATIONS

Some general conclusions and specific recommendations can be drawn from the results of this study. These conclusions and recommendations relate to administration of and administrative roles in medical group practice, to the education of group practice administrators, and to the development of curricula for preservice and inservice programs for the education of group practice administrators. Each of these three topics will be discussed in this chapter.

Administration and Administrative Roles

It is felt that the Standard List of Administrative Tasks is generically representative of tasks performed in the administration of medical group practices. There are probably not many medical groups in existence that perform all of the tasks on the list; nor are there many that perform only tasks that appear in the list. The list is admittedly less appropriate for the administrators of some single specialty groups, for example some pathology and radiology groups; some of the task statements are not worded optimally for administrators of university-based groups. However, the task list yielded useful and valid data that were representative of what many administrators of medical groups actually do.

The role of professional administrators in medical groups is broad; the role is affected or influenced in some way and to some degree by virtually every task in the standard list. In fact, if it is assumed that the administrators who participted in the study are accurate in their responses, and there is no obvious reason to think otherwise, then one conclusion that can be drawn from the data is that many professional administrators are very near their limits of involvement and performance in the administration of their groups. Humans are very adaptable animals, and administrators could probably function adequately beyond what, at this time, might appear to be their limits. However, this is not the point. The point may be exemplified by the fact that many group practice administrators have expressed the opinion that it is no longer as much "fun" to be an administrator as it once was.

If administrators are currently performing near their limits, then the future can not be encouraging to them. In the future, administrators very likely will be responsible for more administrative tasks and, in many cases, tasks different from those in which they are currently involved. The pressures resulting from the situation in which future administrators may find themselves most certainly will not contribute to the enjoyment of their jobs. No proposal is being made that efforts should be directed toward making administrators' jobs "fun" again. It is being suggested that efforts be directed toward helping administrators cope with their current situations and toward preparing them to cope with their future environment.

The medical director in group practice can help both current and future professional administrators cope with their environments and function in their roles. The results of this study indicate that medical directors have a definite role in the administration of groups and can perform functions important and useful to their groups. Currently, the principal role of medical directors in group practices involves the business-related medical aspects of the group and the administration of personal and interpersonal needs of the group's physicians and other medical staff. The future may see medical directors more and more becoming administrators, and becoming involved in the traditional management functions such as planning, organizing, directing, controlling, and budgeting.

The results of this study, however, also suggest that in groups that currently have medical directors, the cooperation among them, the professional administrator, and the governing body is not always at optimum levels. There seems to be little overall agreement among the professional administrator, medical director, and governing body as to who has chief responsibility for satisfactory performance of the tasks within the group. The small amount of agreement that does exist relates to the tasks that everyone agrees are the responsibility of the professional administrator. Agreement on tasks the medical director and governing body are responsible for is typically low, with the role of the medical director being the least defined. If group practice is to effectively respond to such forces as increasing government regulations, increasing organizational complexity, increasing consumer and union involvement, and increasing internal pressures, then it seems obvious that roles, responsibilities, and interrelationships be given critical attention.

A greater degree of cooperation among professional administrators, medical directors, and governing bodies could be achieved if the roles of each were more specifically defined. It is recommended that a concerted effort be made to clearly define and develop the jobs of medical directors in groups and to further clarify their interrelationships with the jobs of professional administrators and governing bodies. This task should be accomplished to make the three roles synergistic, and not inefficiently competitive and redundant. Data have been collected in this study that, if used, would lead to the desired results. By using this data it would be possible to produce a much

more detailed description of the roles of medical directors and their interrelationships to and effects upon the total administration of medical groups.

The Education of Group Practice Administrators

Another way to help professional administrators cope and function is have them better prepared educationally, both in terms of preservice training and inservice, continuing education. It has been the ultimate goal of this project to provide information that would help in better preparing group practice administrators. However, further analysis of this study's data is required in order to provide information that would be most directly useful in the education of administrators. It is, therefore, recommended that additional study, based upon the results of this project, be conducted to define and develop educational material that could be useful in the further development of both preservice and inservice curricula and of course materials for use by current and future administrators.

The next section on curriculum development contains some recommendations concerning how the results of this project might be further analyzed to produce curriculum and course materials. Further study would also allow for the follow-up of certain preliminary hypotheses suggested by the data. For instance, this study contains no directly relevant analyses, but cursory examination of the data compared with the Accrediting Commission's curriculum criteria (Accrediting Commission on Education for Health Services Administration, 1976) suggests that much of the knowledge required by group practice administrators is very similar to the knowledge required by health care administrators in general. On the other hand, the data also suggest that group practice administrators require knowledge in some areas that other health care administrators do not require. Some of the obvious differences are, for example: (a) detailed knowledge of the organizational structure and function of medical groups, (b) knowledge of marketing, and (c) knowledge of the area of physician compensation plans.

Furthermore, some of the knowledge areas that appear to be the same may have slightly different, but important, emphases. For example, it is important for health care administrators to know and understand the "physician personality and mentality," but for group practice administrators this understanding must go one step further. The group practice administrator not only must understand the physician mentality and be able to work with physicians, but he must also be knowledgeable of and be able to work within the peculiar owner-production worker status of physicians in groups.

Initial analyses indicate that differences in administration and in roles associated with size are primarily in the magnitude of administrative involvement and not in actual content of the tasks. That is, groups of various sizes perform approximately the same administrative tasks; the differences associated with size are primarily in the degree of involvement of administrators. Consistent differences associated with payment mechanism do exist for the content of tasks performed, as well as for the involvement of administrators.

Regardless of any differences in tasks performed, there seems to be a common core of knowledge areas required of the administrators. However, even if additional analysis positively identifies a core of knowledge areas common to the requirements of administrators, regardless of size of groups or payment mechanism employed by groups, two questions will remain to be answered: (a) Do all administrators, regardless of size or payment mechanism, require the same level of knowledge and understanding of the core areas? and (b) Do all administrators, regardless of size and payment mechanism, require the same skills or skill levels with relation to the core knowledge areas?

With respect to both hypotheses (the one concerning group practice administrators versus other health care administrators and the one concerning differences among different group practice administrators), initial impressions of the results of this study suggest that:

1. A core of knowledge/content area topics could be identified that might be common to the training needs of health care administrators, including group practice administrators. This common core of knowledge might represent a fairly substantial portion of a group practice administrator's training requisites. The core topics might possibly be appropriate for most group practice administrators, regardless of the size of their groups or of the payment mechanism employed by their groups.

2. In addition to the common core of knowledge/content areas, administrators in each delivery system, in each size category, and/or in each payment mechanism have the need for unique knowledge important to their particular situations.

3. Even though a common core of knowledge/content areas could be defined, the level of detail and sophistication within each content area required by administrators might be different according to delivery system (group practice versus hospital versus long term care unit, and so forth), size of group, and payment mechanism employed. Furthermore, the skills and/or skill levels within each core content area might also be different according to delivery system, size, and/or payment mechanism. For example, an administrator of a small group may be required to construct a job description. An administrator of a large group may be required to know what a job description is, to know when one is needed, and to know how to delegate the task of constructing one; he need not perform the actual construction himself.

The desire for further research is a standard recommendation resulting from studies such as this one, and additional research would be profitable. However, some recommendations can be made now. These recommendations are important regardless of the outcome of additional study. Four such recommendations are as follows:

1. Students in health administration programs should be made aware of the existence of medical group practices and the potential opportunities in the field. One mechanism by which this objective can be accomplished

is via practicing medical group administrators speaking to students in health administration survey or prosem-inar courses. This mechanism has been employed in the past but is currently not being used enough. More cooperation is needed among university programs in health administration (both undergraduate and graduate) and professional organizations representing various interests in group practice.

2. When basic, common core, knowledge/content are applied in the classroom setting, group practices occasionally should be used in examples. Illustrative examples and some case study materials demonstrating the use of management principles in group practice settings should be developed and used.

3. Extant and future faculty in health administration programs should be made aware of the existence and importance of medical group practices. They should also become sufficiently familiar with the operation and administration of group practices so that examples and case study materials relative to groups can be effectively utilized. Toward this end, health administration faculty should be encouraged to become substantively involved in consulting and research in medical groups.

4. Organizations such as those already mentioned should work toward defining roles of group practice administrators, developing both preservice and inservice curricula based upon the roles, and fostering synergistic relationships among professional administrators and medical directors in group practice.

Curriculum Development

It has been repeatedly recommended that further study of this project's results be conducted. This recommendation has been heavily stressed because utilization of the results for curriculum development is important and because there exists the opportunity for developing a curriculum based upon empirical data. Educators, training specialists, curriculum planners, and others generally agree that, when possible, the first step in designing an educational or training program is to define the role or job of the target position. Even when a role or job is defined, however, the role descriptions or job analyses are seldom fully utilized in the designing of courses or curricula. Reasons for the underutilization of the empirical data are many; among them are the following:

1. The process of relating curricula and courses directly to job behavior and performance is difficult and time consuming.
2. Oftentimes the specifications of roles and jobs do not lend themselves to the required analyses.
3. Role descriptions and job analyses do not exist for all jobs.
4. Some educators and planners simply are not interested in relating courses and curricula directly to job behavior.

For whatever reason, *not* relating course content and curricula to job behavior and performance may be what has put educators too often in the position of defending their curricula against the criticism that courses are not applicable in the real world.

As has been repeatedly emphasized, the role descriptions contained herein do lend themselves to the required analyses; in fact the job descriptions have been developed specifically for such a purpose. Furthermore, the specification of knowledge and skills necessary to function as administrators of medical groups should be of interest and use to at least the following:

1. The DHEW in evaluating university health care administration training programs and as a source of data and information for use in its decision making processes.
2. Educators, of both graduate and undergraduate programs, for use with a minimum of translation in evaluating, modifying, enriching, and planning their university curricula in health administration.
3. Professional organizations in evaluating, modifying, enriching, and planning their continuing education efforts.
4. Course and curriculum designers and planners in general as a procedural model of an empirical approach to course design and curriculum planning.
5. Other researchers, in order to determine commonalities, applicability, and generalizability of these data to other jobs and industries.

An appropriate methodological approach to the utilization of this study's results for curriculum development might include the following steps:

1. Analyze the medical group practice professional administrators' role description and translate the tasks performed into a comprehensive but parsimonious set of terminal behavioral objectives.
2. Perform iterative task analyses on the terminal objectives, in order to reduce each objective to pedagogically pure statements of requisite knowledge and skills, and document the results of each successive iteration required. (See Davis, 1974 and Gagne, 1970 for examples of the strategy to be used in this step.)
3. Determine if the inventory of knowledge and skills, stated as instructional objectives, can be ordered into an hierarchy according to the most pedagogically sound point of emphasis, as indicated by the following categories:
   a. Preservice education
      1) Undergraduate level
      2) Graduate level
   b. Inservice training (continuing education)

   If an hierarchy can be defined, do so. Use as back-up data and support for the taxonomy, results from the current study related to differences in roles associated with sizes of groups, payment mechanism, and administrators' educational level.
4. Establish and use panels of consultants, consisting of professional administrators and education experts, to assist in 1, 2, and 3 above and to evaluate the results of the analyses.

The results of such an effort will produce a systematized and cataloged inventory, which could possibly be taxonomic in structure, of knowledge and skills necessary to function as a professional administrator of a medical group practice. The full potential of this project and its results will then be more nearly realized.

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APPENDIX A

APPENDIX A-1

Medical Group Management Association

FOUNDED 1926

CENTER FOR RESEARCH IN AMBULATORY HEALTH CARE ADMINISTRATION
4101 E. LOUISIANA AVE.
DENVER, COLORADO 80222
303 / 753-1111

September 1975

We would like to request your participation in a significant research project involving MGMA members, medical directors, and chairpersons of governing bodies.

The Center for Research in Ambulatory Health Care Administration, the research affiliate of MGMA, has been awarded a research contract to study the roles of administrators in medical group practices. Your participation in this project will lead to improvements in educational curricula and continuing education programs for group practice administrators.

The project has been approved by the Joint Research Committee of the American College of Clinic Managers and the Medical Group Management Association. It has also been endorsed and has the full support of MGMA President, Raymond A. Howe, and the Executive Council.

If you take the time to complete the enclosed questionnaire, we think you will find it interesting and informative. Numerous administrators have tested the questionnaire so you should find it practical and relevant to your position and organization. In addition, when you complete and return the questionnaire, you will have an impact on the final results. On the other hand, if you choose not to participate in this study, a description of group practice administration will be developed without the benefit of important and unique information about you, your position, and your group. We will provide all participants with a summary of the preliminary results obtained from the administration of this questionnaire.

You will find enclosed three questionnaires. If you agree to complete your questionnaire, we would like to ask your assistance in securing the cooperation of your Medical Director (if your group has a person so designated officially) and the Chairperson of your Governing Body by passing on the questionnaires to the appropriate physician(s). We would greatly appreciate your

helping us in this matter, since one of the more interesting aspects of the study will be the investigation of administrative interactions among lay administrators, medical directors, and governing bodies. In this respect, participation by medical directors and governing body chairpersons will contribute greatly to the scope and quality of the study.

We apologize for the length of the questionnaires; but, administration is a difficult topic to study, and administration in medical groups is no exception. However, we feel that our approach is especially sound and will yield useful and practical information. We are certainly convinced of the value of our study, and hope that you are also convinced enough to complete the questionnaire.

If you have any questions, please feel free to contact Ed Morita, Assistant Project Director, at the MGMA/CRAHCA offices in Denver.

As is usual with everyone these days, we are working under a severe time constraint. We would greatly appreciate your completing the questionnaire and returning it to us in the enclosed prepaid envelope by September 23, 1975.

Thank You.

Best Wishes,

William D. Barry
Executive Director, Joslin Diabetes Foundation
Chairman, National Advisory Committee

Enc.

P.S. Our Advisory Committee members have very generously given their time and interest to the project. Now we need your help to make the study a success worthy of being associated with MGMA.

O.M.B. #68-S75069
Approval Expires 12/31/75

Reference Number _____

MEDICAL GROUP
MANAGEMENT ASSOCIATION

Survey on the Role of the Medical Group Practice ADMINISTRATOR

CENTER FOR RESEARCH
In Ambulatory Health Care Administration
4101 East Louisiana Avenue
Denver, Colorado 80222
(303) 753-1111

STATEMENT OF CONFIDENTIALITY

Confidential — All information which would permit identification of an individual or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to other persons or used for any other purposes.

FOR OFFICE USE ONLY

I. BIOGRAPHICAL

1. Year Born _____

Education

2. Please provide a brief summary of your educational experiences:

Degree	Major	Year Received

3. Are you presently working on any additional degrees?

No ☐
Yes ☐

If yes, what degree? _____

what major area? _____

4. How many professional continuing education seminars have you attended in the last four years?

_____ Number

Experience

5. Please indicate below your past professional work experience (not necessarily health related). Please be as specific as possible. Start with present position, and list most recent first.

Industry	Job Title	Dates From	Dates To
			Present

II. ORGANIZATIONAL INFORMATION

6. What do you consider to be the governing body of your organization? (Please specify *exact* name.) _____

Answer all of the questions in this survey pertaining to the governing body based on your response above.

7. Are the authority and duties of the administrator (business manager) defined in a written statement, such as a job description?

No ☐
Yes ☐

If yes, please attach a copy.

8. How many hours in a typical week do you spend as a group practice administrator? _____ Hours

9. To whom do you report? _____ Position

10. Who has fiscal responsibility in your group? (If fiscal responsibility is shared, check as many as are appropriate.)

	Capital Expenditures	Supplies Recurring Items
A. Lay Administrator:	☐	☐
B. Medical Director:	☐	☐
C. Governing Body:	☐	☐
D. Other, please specify:	_____	_____

11. To what extent are you consulted in the personal business affairs of the physicians (e.g., income tax, insurance, investments, etc.)? Exclude fringe benefit programs of the clinic.

A. Never ☐
B. Seldom ☐
C. Often ☐
D. A great deal ☐

12. During what hours are the following services provided in your group? (Do not include on-call hours.)

	Full Service From	Full Service To	Limited Service From	Limited Service To
A. Monday - Friday	____	____	____	____
B. Saturday	____	____	____	____
C. Sunday	____	____	____	____

13. What is your group's present normal staffing level in terms of full-time equivalents? (FTE, see example below.)

	Physician Members (Participating)	Physician Employees (Salaried)
A. Physicians:		
Total	____ FTE	____ FTE
Filled	____ FTE	____ FTE
Vacant	____ FTE	____ FTE
B. Non-physician employees:		
Total		____ FTE
Filled		____ FTE
Vacant		____ FTE

Convert all physicians to full-time equivalent. If one or more physicians were with the organization less than the full year, enter the total number of the fractional amount. If one or more doctors are working less than full-time, enter the equivalent fractional amounts. See example:

Example:		
	1 person working full-time, full year	*1.00*
	1 person working half-time, full year	*.50*
	1 person working full-time, six months	*.50*
	1 person working full-time, three months	*.25*

14. Is your group presently:

A. Decreasing in size ☐
B. Remaining stable in size ☐
C. Growing in size ☐

15. What is the amount of gross operating revenue generated by your clinic medical staff per year?

$ _____
Gross Operating Revenue

16. What percent of your gross operating revenue is attributable to pre-payment or a capitation basis of care? (Do not count advances on maternity costs, Blue Cross/ Blue Shield, or other third party payers as pre-payment.)

_____ %

17. On the average, what is the combined total number of patients seen per day by all physicians in your group? (Professional service visits only. Do not include X-ray, lab, or testing services.)

_____
Patients per Day

18. Are there any clinic offices or satellites in other than the main clinic location?

No ☐
Yes ☐

If yes, what is the distance from main location?

First satellite: _____ Miles

Second satellite: _____ Miles

If there are more satellites, please indicate below:

19. Please list below your standing clinical and management committees:

Clinical Committees	Management Committees

III. STANDARD LIST OF ADMINISTRATIVE TASKS

This section contains a Standard List of Administrative Tasks that are commonly performed in health care delivery organizations. Please indicate for each of the tasks the following information in the appropriate columns:

1. Indicate if the task is performed in your medical group. *If the task is not performed in your group, circle "1" for that task and go directly to the next task statement.*

2. If the task is performed by someone in your group, indicate who is *chiefly* responsible for satisfactory performance of the task in your group according to the following key:

   NO = No one in your organization
   LA = Lay Administrator
   MD = Medical Director (*not* simply any physician)
   GB = Governing Body
   Other = Someone other than the Governing Body, Medical Director, or Lay Administrator

3. *Regardless of who is chiefly responsible for satisfactory performance of the task,* please indicate the extent of *your personal* involvement in the performance of the task on the scale ranging from "no personal involvement" (1) to "high personal involvement" (5).

Remember, if you circle a "1" in Column 1 (indicating that the task is not performed by anyone in your group), you need not complete Columns 2 and 3 for that item.

STANDARD LIST OF ADMINISTRATIVE TASKS

*Key: NO = No One
LA = Lay Administrator
MD = Medical Director
GB = Governing Body
Other = Other

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one) No Personal Involvement — High Personal Involvement				
	No	Yes	NO	LA	MD	GB	Other					
1. Collect information, process and evaluate information, and/or make recommendations relative to factors that might affect patient demand for your group's services, e.g.:												
a. General trends in the environment (e.g., population census and demographic data, social factors, economic data, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
b. Legislation and regulations (e.g., NHI & HMO legislation, MEDICARE-MEDICAID, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
c. Your group's "competition" (e.g., other medical groups, hospitals, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
2. Collect information, process and evaluate information, and/or make recommendations relative to factors that might affect the manner in which services are rendered in your group, e.g.:												
a. New medical equipment and procedures.	1	2	1	2	3	4	5	1	2	3	4	5
b. New non-medical equipment and procedures (e.g., POMR, Superbill, etc.)	1	2	1	2	3	4	5	1	2	3	4	5
c. Legislation and regulations (e.g., PSRO, third party payor accountability regulations, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
d. Internal processes (e.g., patient flow, overtime, cash flow, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
3. Establish/approve your group's position on issues related to the practice of medicine in your group (e.g., PSRO, accountability, licensure/certification, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
4. Establish/approve your group's position on issues related to the business operations of your group (e.g., taxes, Superbill, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
5. Attempt to influence the outcome of pending legislation or regulations that would affect your group practice.	1	2	1	2	3	4	5	1	2	3	4	5
6. Establish/aoprove the need to replace existing or purchase additional medical equipment.	1	2	1	2	3	4	5	1	2	3	4	5
7. Establish/approve the need to replace existing or purchase additional non-medical equipment and/or services.	1	2	1	2	3	4	5	1	2	3	4	5

*Key: NO = No One
LA = Lay Administrator
MD = Medical Director
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Other = Other

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
								No Personal Involvement				High Personal Involvement
	No	Yes	NO	LA	MD	GB	Other					
8. Negotiate purchase price/contracts for supplies, equipment, and/or non-medical services.	1	2	1	2	3	4	5	1	2	3	4	5
9. Approve purchases of equipment or services costing in excess of $1,000.	1	2	1	2	3	4	5	1	2	3	4	5
10. Establish/approve:												
a. Criteria for quality care.	1	2	1	2	3	4	5	1	2	3	4	5
b. Policies governing your group's organizational structure and type.	1	2	1	2	3	4	5	1	2	3	4	5
c. Policies governing the number and kind of patients that your group will serve.	1	2	1	2	3	4	5	1	2	3	4	5
d. Policies governing the growth or reduction in the number of physicians in your group.	1	2	1	2	3	4	5	1	2	3	4	5
e. Policies governing the growth or reduction in the number of administrators in your group.	1	2	1	2	3	4	5	1	2	3	4	5
f. Policies governing the specialty mix of your group's physicians.	1	2	1	2	3	4	5	1	2	3	4	5
g. Financial policies.	1	2	1	2	3	4	5	1	2	3	4	5
h. Accounting policies.	1	2	1	2	3	4	5	1	2	3	4	5
i. Physician personnel policies.	1	2	1	2	3	4	5	1	2	3	4	5
j. Non-physician personnel policies.	1	2	1	2	3	4	5	1	2	3	4	5
11. Develop long-range master plans (e.g., facility, financial, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
12. Approve long range master plans (e.g., facility, financial, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
13. Search and negotiate for investment capital.	1	2	1	2	3	4	5	1	2	3	4	5
14. Approve your group's operating budget.	1	2	1	2	3	4	5	1	2	3	4	5
15. Develop, review, and/or revise standard operating procedures for:												
a. Delivering patient care.	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician personnel administration.	1	2	1	2	3	4	5	1	2	3	4	5
c. Non-physician personnel administration.	1	2	1	2	3	4	5	1	2	3	4	5
d. Utilization control (non-physician).	1	2	1	2	3	4	5	1	2	3	4	5
e. Cost controls.	1	2	1	2	3	4	5	1	2	3	4	5

*Key: NO = No One
LA = Lay Administrator
MD = Medical Director
GB = Governing Body
Other = Other

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
	No	Yes	NO	LA	MD	GB	Other	No Personal Involvement				High Personal Involvement
15. Continued.												
f. Billing and collecting.	1	2	1	2	3	4	5	1	2	3	4	5
g. Interacting and dealing with outside agencies.	1	2	1	2	3	4	5	1	2	3	4	5
h. Gathering, processing, and evaluating information important to your group.	1	2	1	2	3	4	5	1	2	3	4	5
16. Approve standard operating procedures (new or revised) for:												
a. Delivering patient care.	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician personnel administration.	1	2	1	2	3	4	5	1	2	3	4	5
c. Non-physician personnel administration.	1	2	1	2	3	4	5	1	2	3	4	5
d. Utilization control (non-physician).	1	2	1	2	3	4	5	1	2	3	4	5
e. Cost controls.	1	2	1	2	3	4	5	1	2	3	4	5
f. Billing and collecting.	1	2	1	2	3	4	5	1	2	3	4	5
g. Interacting and dealing with outside agencies.	1	2	1	2	3	4	5	1	2	3	4	5
h. Gathering, processing, and evaluating information important to your group.	1	2	1	2	3	4	5	1	2	3	4	5
17. Enforce adherence to standard operating procedures by:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
18. Develop physician staffing plans.	1	2	1	2	3	4	5	1	2	3	4	5
19. Develop non-physician staffing plans.	1	2	1	2	3	4	5	1	2	3	4	5
20. Approve staffing plans.	1	2	1	2	3	4	5	1	2	3	4	5
21. Develop, review and/or revise job specifications, job descriptions, and/or job standards of:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5

*Key: NO = No One
LA = Lay Administrator
MD = Medical Director
GB = Governing Body
Other = Other

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
	No	Yes	NO	LA	MD	GB	Other	No Personal Involvement				High Personal Involvement
22. Approve job specifications, job descriptions, and/or job standards (new or revised) for:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
23. Develop, review, and/or revise payment plans/salary schedules and benefits for:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
24. Approve payment plans/salary schedules and benefits (new or revised) for:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
25. Recruit the following to fill openings in your organization:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
26. Negotiate salary and benefit contracts with organized groups of personnel.	1	2	1	2	3	4	5	1	2	3	4	5
Approve contracts with organized groups of personnel.	1	2	1	2	3	4	5	1	2	3	4	5

*Key: NO = No One
LA = Lay Administrator
MD = Medical Director
GB = Governing Body
Other = Others

	1. Is this task performed in your group? (Please circle one)		2. Who is ... responsi... satisfac... mance of... in your ... (Please c...	
	No	Yes	NO	LA
22. Approve job specifications, job descriptions, and/or job standards (new or revised) for:				
a. Physician members (participating).	1	2	1	2
b. Physician employees (salaried).	1	2	1	2
c. Nurses and medical technicians.	1	2	1	2
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2
e. Administrative staff.	1	2	1	2
23. Develop, review, and/or revise payment plans/salary schedules and benefits for:				
a. Physician members (participating).	1	2	1	2
b. Physician employees (salaried).	1	2	1	2
c. Nurses and medical technicians.	1	2	1	2
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2
24. Approve payment plans/salary schedules and benefits (new or revised) for:				
a. Physician members (participating).	1	2	1	2
b. Physician employees (salaried).	1	2	1	2
c. Nurses and medical technicians.	1	2	1	2
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2
e. Administrative staff.	1	2	1	2
25. Recruit the following to fill openings in your organization:				
a. Physician members (participating).	1	2	1	2
b. Physician employees (salaried).	1	2	1	2
c. Nurses and medical technicians.	1	2	1	2
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2
26. Negotiate salary and benefit contracts with organized groups of personnel.	1	2	1	2
Approve contracts with organized groups of personnel.	1	2	1	2

*Key: NO = No One
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	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
								No Personal Involvement				High Personal Involvement
	No	Yes	NO	LA	MD	GB	Other					
28. Approve appointment/hiring of:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
29. Approve end of probationary appointments for physicians.	1	2	1	2	3	4	5	1	2	3	4	5
30. Negotiate contracts with physicians who wish to join the group.	1	2	1	2	3	4	5	1	2	3	4	5
31. Orient and train new personnel:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
32. Survey the job satisfaction of:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
33. Conduct job performance evaluations for:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5

*Key: NO = No One
LA = Lay Administrator
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Other = Other

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
								No Personal Involvement				High Personal Involvement
	No	Yes	NO	LA	MD	GB	Other					
34. Approve promotions of:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
35. Approve dismissals and terminations of:												
a. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
b. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
c. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
d. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
36. Negotiate dissolutions from the membership of physician members (participating) who leave the group.	1	2	1	2	3	4	5	1	2	3	4	5
37. Interpret group policy and clarify procedures for staff and employees.	1	2	1	2	3	4	5	1	2	3	4	5
38. Counsel, to assist with personal problems:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
39. Mediate/arbitrate interpersonal problems:												
a. Among physicians.	1	2	1	2	3	4	5	1	2	3	4	5
b. Among nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
c. Among receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
d. Among administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
e. Between physicians and nurses.	1	2	1	2	3	4	5	1	2	3	4	5
f. Between physicians and administrators.	1	2	1	2	3	4	5	1	2	3	4	5

*Key: NO = No One
LA = Lay Administrator
MD = Medical Director
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Other = Other _____

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
	No	Yes	NO	LA	MD	GB	Other	No Personal Involvement				High Personal Involvement
40. Discipline:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintanance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
41. Secure liability insurance coverage for your group and/or your physicians.	1	2	1	2	3	4	5	1	2	3	4	5
42. Survey patients to ascertain level of patient satisfaction and/or areas of dissatisfaction.	1	2	1	2	3	4	5	1	2	3	4	5
43. Resolve non-medical patient complaints (e.g., charges, fees, personality clashes, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
44. Mediate/arbitrate between the group's physicians and patients in conflicts over medical services.	1	2	1	2	3	4	5	1	2	3	4	5
45. Represent the group or individual physicians in court appearance on collection cases.	1	2	1	2	3	4	5	1	2	3	4	5
46. Represent the group or individual physicians in court appearances on malpractice litigation.	1	2	1	2	3	4	5	1	2	3	4	5
47. Visit the group's patients in the hospital for public relations purposes (non-medical purposes).	1	2	1	2	3	4	5	1	2	3	4	5
48. Transmit information about your group's facilities and services to interested persons and/or organized consumer groups.	1	2	1	2	3	4	5	1	2	3	4	5
49. Represent your group at health care workshops and meetings.	1	2	1	2	3	4	5	1	2	3	4	5
50. Represent your group in civic matters and projects.	1	2	1	2	3	4	5	1	2	3	4	5
51. Participate in public health education efforts.	1	2	1	2	3	4	5	1	2	3	4	5
52. Try to gain the community's (or public's) acceptance and support for your group and its various programs.	1	2	1	2	3	4	5	1	2	3	4	5

*Key: NO = No One
LA = Lay Administrator
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Other = Other

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
								No Personal Involvement				High Personal Involvement
	No	Yes	NO	LA	MD	GB	Other					
53. Work with the news media in releasing public and civic interest stories.	1	2	1	2	3	4	5	1	2	3	4	5
54. Negotiate medical services covered under health care contracts with organized consumer groups.	1	2	1	2	3	4	5	1	2	3	4	5
55. Negotiate fees or prices for health care contracts with organized consumer groups.	1	2	1	2	3	4	5	1	2	3	4	5
56. Approve contracts with organized consumer groups.	1	2	1	2	3	4	5	1	2	3	4	5
57. Settle grievances with industrial or group accounts.	1	2	1	2	3	4	5	1	2	3	4	5
58. Work with third party payers to assure efficient collections for the group.	1	2	1	2	3	4	5	1	2	3	4	5
59. Please write in any tasks that you feel should be added to this list and complete the appropriate columns for each additional task.												

Below are a number of hypothetical changes that might be made in a medical group practice. Please review the list, then do two things:

1. First, indicate by *circling* the number in the appropriate box, the person or group who would have the *final* authority in making the decision before the change would be made.
2. Then, indicate by *placing an "X"* in the appropriate box(es), all those persons or groups who would participate in the decision.

Decision	Governing Body	Medical Director	Clinic Administrator or Assistant Administrator	Medical Department Head	Non-Medical Department Supervisor	Individual Physician	Other (Please Specify)
Initiate a new patient education program for diabetics	1	2	3	4	5	6	7
Setting the fee schedules for the clinic	1	2	3	4	5	6	7
Change in the level of remuneration for an individual physician member (participating)	1	2	3	4	5	6	7
Change in the hours of clinic service	1	2	3	4	5	6	7
Establish a new cost finding system for the clinic	1	2	3	4	5	6	7
Redecorate and refurnish the clinic waiting area	1	2	3	4	5	6	7
Business insurance decisions for the group (e.g., liability insurance, not fringe benefits)	1	2	3	4	5	6	7
Termination of a non-physician professional person	1	2	3	4	5	6	7
Approval of a feasibility study on a partial pre-paid medical program in the group	1	2	3	4	5	6	7
Routine work assignment scheduling for clinical personnel in business office	1	2	3	4	5	6	7

IV. CRITICAL TASKS

Please list the five most important tasks* that you perform as an administrator.

1. Most important task: _____

2. Second most important: _____

3. _____

4. _____

5. _____

*A task is herein defined as a working-level activity in which *you personally* participate. A task statement (five of which you are asked to provide) must describe *what you do* and *for what purpose*. Try to make your task statements *midrange*, i.e., neither too specific nor too general.

APPENDIX A-2

FOUNDED 1926

Medical Group Management Association

CENTER FOR RESEARCH IN AMBULATORY HEALTH CARE ADMINISTRATION
4101 E. LOUISIANA AVE.
DENVER, COLORADO 80222
303 / 753-1111

September 1975

Medical Director

Dear Doctor:

We would like to request your participation in a significant research project concerned, in part, with developing a clearer understanding of administration in medical group practices. One aspect of administration in which we are interested is the role played by medical directors such as yourself. Your participation in this project will contribute greatly to the scope and quality of the study. Gaining a clearer understanding of the roles of medical directors can lead to improvements in working relationships with lay administrators and also lead to improvements in educational curricula for physicians in administration.

If you take the time to complete the enclosed questionnaire, we think you will find it interesting and informative. Numerous physician administrators have tested the questionnaire so you should find it practical and relevant to your position and organization. In addition, when you complete and return the questionnaire, you will have an impact on the final results. On the other hand, if you choose not to participate in this study, a description of group practice administration will be developed without the benefit of important and unique information about you, your position, and your group. We will provide all participants with a summary of the preliminary results obtained from the administration of this questionnaire.

One of the more interesting aspects of the study will be the investigation of administrative interactions among lay administrators, medical directors, and governing bodies. In this respect, participation by physician administrators will contribute greatly to the scope and quality of the study.

We apologize for the length of the questionnaire; but, administration is a difficult topic to study, and administration in medical groups is no exception. However, we feel that our approach is especially sound and will yield useful and practical information. We are certainly convinced of the value of our study, and hope that you are also convinced enough to complete the questionnaire.

If you have any questions, either you or your lay administrator in your behalf, should feel free to contact Ed Morita, Assistant Project Director, at the MGMA/CRAHCA offices in Denver.

As is usual with everyone these days, we are working under a severe time constraint. We would greatly appreciate your completing the questionnaire and returning it to us in the enclosed prepaid envelope by September 23, 1975.

Thank You.

Best Wishes,

Bill Barry

William D. Barry
Executive Director, Joslin Diabetes Foundation
Chairman, National Advisory Committee

Enc.

P.S. The team concept of management is prevalent in group practices. Your efforts on our behalf are quite important to this project.

Bill

O.M.B. #68-S75069
Approval Expires 12/31/75

Reference Number _____

FOUNDED 1926

MEDICAL GROUP
MANAGEMENT ASSOCIATION

Survey on the Role of the Medical Group Practice

MEDICAL DIRECTOR

CENTER FOR RESEARCH
In Ambulatory Health Care Administration
4101 East Louisiana Avenue
Denver, Colorado 80222
(303) 753-1111

STATEMENT OF CONFIDENTIALITY

Confidential — All information which would permit identification of an individual or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to other persons or used for any other purposes.

FOR OFFICE USE ONLY

I. BIOGRAPHICAL

1. Year born: _____

Please provide copy of your Curriculum Vitae or Resume. If a copy is not available, please complete the following:

Undergraduate Degree _____

Where did you receive your M.D. Degree? _____

Where did you do your:

Internship? _____

Residency? _____

What is your medical specialty? _____

How long have you practiced medicine? _____ Years

How long did you practice medicine before becoming a medical director? _____ Years

How long have you been medical director of the clinic? _____ Years

II. ORGANIZATIONAL INFORMATION

2. What do you consider to be the governing body of your organization? (Please specify *exact* name.) _____

Answer all of the questions in this survey pertaining to the governing body based on your response above.

3. How is the medical director selected? (Please check the most appropriate one.)

A. Elected	By the governing body	☐
	By all the partners, associates, etc.	☐
B. By rotation	Among the governing body	☐
	Among all the partners, associates, etc.	☐
	Among the physician department heads	☐
C. By virtue of seniority		☐
D. By virtue of being founder		☐
E. Other, please specify: _____		☐

4. Are the authority and duties of the medical director defined in a written statement, such as a job description?

No ☐
Yes ☐

If yes, please attach to questionnaire if available.

5. Is the position of medical director considered to be:
(Check one.)

Full-time ☐
Part-time ☐

6. What percent of your working hours are devoted to:

Seeing Patients	____ %
Medical Director Responsibilities	____ %
Other	____ %
Total	100 %

7. What is the group administrator's or business manager's organizational relationship to the medical director?

A. Administrator works with medical director as equal. ☐
B. Administrator reports to medical director. ☐
C. Medical director reports to administrator. ☐
D. Other, please specify: _____

8. Does your group have a quality review mechanism?

No ☐
Yes ☐

If yes, please attach a written description if available; if not available, please describe:

9. What types of continuing education and formal education do you think would be most helpful to you in performing your role as medical director?

5. Is the position of medical director considered to be:
(Check one.)

6. What percent of your working hours are devoted to:

Seeing Patients

Medical Director Responsibili

Other

Total

7. What is the group administrator's or business manager's organizatio
to the medical director?

A. Administrator works with medical director as equal.

B. Administrator reports to medical director.

C. Medical director reports to administrator.

D. Other, please specify: _____

8. Does your group have a quality review mechanism?

If yes, please attach a written description if available; if not av
describe:

9. What types of continuing education and formal education do you thin
helpful to you in performing your role as medical director?

III. STANDARD LIST OF ADMINISTRATIVE TASKS

This section contains a Standard List of Administrative Tasks that are commonly performed in health care delivery organizations. Please indicate for each of the tasks the following information in the appropriate columns:

1. Indicate if the task is performed in your medical group. *If the task is not performed in your group, circle "1" for that task and go directly to the next task statement.*

2. If the task is performed by someone in your group, indicate who is *chiefly* responsible for satisfactory performance of the task in your group according to the following key:

   NO = No one in your organization
   LA = Lay Administrator
   MD = Medical Director (*not* simply any physician)
   GB = Governing Body
   Other = Someone other than the Governing Body, Medical Director, or Lay Administrator

3. *Regardless of who is chiefly responsible for satisfactory performance of the task,* please indicate the extent of *your personal* involvement in the performance of the task on the scale ranging from "no personal involvement" (1) to "high personal involvement" (5).

Remember, if you circle a "1" in Column 1 (indicating that the task is not performed by anyone in your group), you need not complete columns 2 and 3 for that item.

*Key: NO = No One
LA = Lay Administrator
MD = Medical Director
GB = Governing Body
Other = Other

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
								No Personal Involvement				High Personal Involvement
	No	Yes	NO	LA	MD	GB	Other					
1. Collect information, process and evaluate information, and/or make recommendations relative to factors that might affect patient demand for your group's services, e.g.:												
a. General trends in the environment (e.g., population census and demographic data, social factors, economic data, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
b. Legislation and regulations (e.g., NHI & HMO legislation, MEDICARE-MEDICAID, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
c. Your group's "competition" (e.g., other medical groups, hospitals, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
2. Collect information, process and evaluate information, and/or make recommendations relative to factors that might affect the manner in which services are rendered in your group, e.g.:												
a. New medical equipment and procedures.	1	2	1	2	3	4	5	1	2	3	4	5
b. New non-medical equipment and procedures (e.g., POMR, Superbill, etc.)	1	2	1	2	3	4	5	1	2	3	4	5
c. Legislation and regulations (e.g., PSRO, third party payor accountability regulations, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
d. Internal processes (e.g., patient flow, overtime, cash flow, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
3. Establish/approve your group's position on issues related to the practice of medicine in your group (e.g., PSRO, accountability, licensure/certification, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
4. Establish/approve your group's position on issues related to the business operations of your group (e.g., taxes, Superbill, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
5. Attempt to influence the outcome of pending legislation or regulations that would affect your group practice.	1	2	1	2	3	4	5	1	2	3	4	5
6. Establish/approve the need to replace existing or purchase additional medical equipment.	1	2	1	2	3	4	5	1	2	3	4	5
7. Establish/approve the need to replace existing or purchase additional non-medical equipment and/or services.	1	2	1	2	3	4	5	1	2	3	4	5

*Key: NO = No One
LA = Lay Administrator
MD = Medical Director
GB = Governing Body
Other = Other

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
	No	Yes	NO	LA	MD	GB	Other	No Personal Involvement				High Personal Involvement
8. Negotiate purchase price/contracts for supplies, equipment, and/or non-medical services.	1	2	1	2	3	4	5	1	2	3	4	5
9. Approve purchases of equipment or services costing in excess of $1,000.	1	2	1	2	3	4	5	1	2	3	4	5
10. Establish/approve:												
a. Criteria for quality care.	1	2	1	2	3	4	5	1	2	3	4	5
b. Policies governing your group's organizational structure and type.	1	2	1	2	3	4	5	1	2	3	4	5
c. Policies governing the number and kind of patients that your group will serve.	1	2	1	2	3	4	5	1	2	3	4	5
d. Policies governing the growth or reduction in the number of physicians in your group.	1	2	1	2	3	4	5	1	2	3	4	5
e. Policies governing the growth or reduction in the number of administrators in your group.	1	2	1	2	3	4	5	1	2	3	4	5
f. Policies governing the specialty mix of your group's physicians.	1	2	1	2	3	4	5	1	2	3	4	5
g. Financial policies.	1	2	1	2	3	4	5	1	2	3	4	5
h. Accounting policies.	1	2	1	2	3	4	5	1	2	3	4	5
i. Physician personnel policies.	1	2	1	2	3	4	5	1	2	3	4	5
j. Non-physician personnel policies.	1	2	1	2	3	4	5	1	2	3	4	5
11. Develop long-range master plans (e.g., facility, financial, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
12. Approve long range master plans (e.g., facility, financial, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
13. Search and negotiate for investment capital.	1	2	1	2	3	4	5	1	2	3	4	5
14. Approve your group's operating budget.	1	2	1	2	3	4	5	1	2	3	4	5
15. Develop, review, and/or revise standard operating procedures for:												
a. Delivering patient care.	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician personnel administration.	1	2	1	2	3	4	5	1	2	3	4	5
c. Non-physician personnel administration.	1	2	1	2	3	4	5	1	2	3	4	5
d. Utilization control (non-physician).	1	2	1	2	3	4	5	1	2	3	4	5
e. Cost controls.	1	2	1	2	3	4	5	1	2	3	4	5

*Key: NO = No One
LA = Lay Administrator
MD = Medical Director
GB = Governing Body
Other = Other

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
	No	Yes	NO	LA	MD	GB	Other	No Personal Involvement				High Personal Involvement
15. Continued.												
f. Billing and collecting.	1	2	1	2	3	4	5	1	2	3	4	5
g. Interacting and dealing with outside agencies.	1	2	1	2	3	4	5	1	2	3	4	5
h. Gathering, processing, and evaluating information important to your group.	1	2	1	2	3	4	5	1	2	3	4	5
16. Approve standard operating procedures (new or revised) for:												
a. Delivering patient care.	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician personnel administration.	1	2	1	2	3	4	5	1	2	3	4	5
c. Non-physician personnel administration.	1	2	1	2	3	4	5	1	2	3	4	5
d. Utilization control (non-physician).	1	2	1	2	3	4	5	1	2	3	4	5
e. Cost controls.	1	2	1	2	3	4	5	1	2	3	4	5
f. Billing and collecting.	1	2	1	2	3	4	5	1	2	3	4	5
g. Interacting and dealing with outside agencies.	1	2	1	2	3	4	5	1	2	3	4	5
h. Gathering, processing, and evaluating information important to your group.	1	2	1	2	3	4	5	1	2	3	4	5
17. Enforce adherence to standard operating procedures by:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
18. Develop physician staffing plans.	1	2	1	2	3	4	5	1	2	3	4	5
19. Develop non-physician staffing plans.	1	2	1	2	3	4	5	1	2	3	4	5
20. Approve staffing plans.	1	2	1	2	3	4	5	1	2	3	4	5
21. Develop, review and/or revise job specifications, job descriptions, and/or job standards of:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5

*Key: NO = No One
LA = Lay Administrator
MD = Medical Director
GB = Governing Body
Other = Other

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
	No	Yes	NO	LA	MD	GB	Other	No Personal Involvement				High Personal Involvement
22. Aporove job specifications, job descriptions, and/or job standards (new or revised) for:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
23. Develop, review, and/or revise payment plans/salary schedules and benefits for:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
24. Approve payment plans/salary schedules and benefits (new or revised) for:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
25. Recruit the following to fill openings in your organization:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
26. Negotiate salary and benefit contracts with organized groups of personnel.	1	2	1	2	3	4	5	1	2	3	4	5
Approve contracts with organized groups of personnel.	1	2	1	2	3	4	5	1	2	3	4	5

*Key: NO = No One
LA = Lay Administrator
MD = Medical Director
GB = Governing Body
Other = Other _____

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
								No Personal Involvement				High Personal Involvement
	No	Yes	NO	LA	MD	GB	Other					
28. Approve appointment/hiring of:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
29. Aporove end of probationary appointments for physicians.	1	2	1	2	3	4	5	1	2	3	4	5
30. Negotiate contracts with physicians who wish to join the group.	1	2	1	2	3	4	5	1	2	3	4	5
31. Orient and train new personnel:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
32. Survey the job satisfaction of:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
33. Conduct job performance evaluations for:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5

*Key: NO = No One
LA = Lay Administrator
MD = Medical Director
GB = Governing Body
Other = Other

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
	No	Yes	NO	LA	MD	GB	Other	No Personal Involvement				High Personal Involvement
34. Approve promotions of:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
35. Approve dismissals and terminations of:												
a. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
b. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
c. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
d. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
36. Negotiate dissolutions from the membership of physician members (participating) who leave the group.	1	2	1	2	3	4	5	1	2	3	4	5
37. Interpret group policy and clarify procedures for staff and employees.	1	2	1	2	3	4	5	1	2	3	4	5
38. Counsel, to assist with personal problems:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
39. Mediate/arbitrate interpersonal problems:												
a. Among physicians.	1	2	1	2	3	4	5	1	2	3	4	5
b. Among nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
c. Among receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
d. Among administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
e. Between physicians and nurses.	1	2	1	2	3	4	5	1	2	3	4	5
f. Between physicians and administrators.	1	2	1	2	3	4	5	1	2	3	4	5

*Key: NO = No One
LA = Lay Administrator
MD = Medical Director
GB = Governing Body
Other = Other

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
								No Personal Involvement				High Personal Involvement
	No	Yes	NO	LA	MD	GB	Other					
40. Discipline:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
41. Secure liability insurance coverage for your group and/or your physicians.	1	2	1	2	3	4	5	1	2	3	4	5
42. Survey patients to ascertain level of patient satisfaction and/or areas of dissatisfaction.	1	2	1	2	3	4	5	1	2	3	4	5
43. Resolve non-medical patient complaints (e.g., charges, fees, personality clashes, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
44. Mediate/arbitrate between the group's physicians and patients in conflicts over medical services.	1	2	1	2	3	4	5	1	2	3	4	5
45. Represent the group or individual physicians in court appearance on collection cases.	1	2	1	2	3	4	5	1	2	3	4	5
46. Represent the group or individual physicians in court appearances on malpractice litigation.	1	2	1	2	3	4	5	1	2	3	4	5
47. Visit the group's patients in the hospital for public relations purposes (non-medical purposes).	1	2	1	2	3	4	5	1	2	3	4	5
48. Transmit information about your group's facilities and services to interested persons and/or organized consumer groups.	1	2	1	2	3	4	5	1	2	3	4	5
49. Represent your group at health care workshops and meetings.	1	2	1	2	3	4	5	1	2	3	4	5
50. Represent your group in civic matters and projects.	1	2	1	2	3	4	5	1	2	3	4	5
51. Participate in public health education efforts.	1	2	1	2	3	4	5	1	2	3	4	5
52. Try to gain the community's (or public's) acceptance and support for your group and its various programs.	1	2	1	2	3	4	5	1	2	3	4	5

*Key: NO = No One
LA = Lay Administrator
MD = Medical Director
GB = Governing Body
Other = Other

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
								No Personal Involvement				High Personal Involvement
	No	Yes	NO	LA	MD	GB	Other					
53. Work with the news media in releasing public and civic interest stories.	1	2	1	2	3	4	5	1	2	3	4	5
54. Negotiate medical services covered under health care contracts with organized consumer groups.	1	2	1	2	3	4	5	1	2	3	4	5
55. Negotiate fees or prices for health care contracts with organized consumer groups.	1	2	1	2	3	4	5	1	2	3	4	5
56. Approve contracts with organized consumer groups.	1	2	1	2	3	4	5	1	2	3	4	5
57. Settle grievances with industrial or group accounts.	1	2	1	2	3	4	5	1	2	3	4	5
58. Work with third party payors to assure efficient collections for the group.	1	2	1	2	3	4	5	1	2	3	4	5
59. Please write in any tasks that you feel should be added to this list and complete the appropriate columns for each additional task.												

Below are a number of hypothetical changes that might be made in a medical group practice. Please review the list, then do two things:

1. First, indicate by *circling* the number in the appropriate box, the person or group who would have the *final* authority in making the decision before the change would be made.

2. Then, indicate by *placing an "X"* in the appropriate box(es), all those persons or groups who would participate in the decision.

Decision	Governing Body	Medical Director	Clinic Administrator or Assistant Administrator	Medical Department Head	Non-Medical Department Supervisor	Individual Physician	Other (Please Specify)
Initiate a new patient education program for diabetics	1	2	3	4	5	6	7
Setting the fee schedules for the clinic	1	2	3	4	5	6	7
Change in the level of remuneration for an individual physician member (participating)	1	2	3	4	5	6	7
Change in the hours of clinic service	1	2	3	4	5	6	7
Establish a new cost finding system for the clinic	1	2	3	4	5	6	7
Redecorate and refurnish the clinic waiting area	1	2	3	4	5	6	7
Business insurance decisions for the group (e.g., liability insurance, not fringe benefits)	1	2	3	4	5	6	7
Termination of a non-physician professional person	1	2	3	4	5	6	7
Approval of a feasibility study on a partial pre-paid medical program in the group	1	2	3	4	5	6	7
Routine work assignment scheduling of [illegible]ical personnel in business [illegible]ffi[illegible]	1	2	[illegible]	4	5	6	[illegible]

IV. CRITICAL TASKS

Please list the five most important tasks* that you perform as a medical director.

1. Most important task:

2. Second most important:

3.

4.

5.

*A task is herein defined as a working-level activity in which *you personally* participate. A task statement (five of which you are asked to provide) must describe *what you do* and *for what purpose*. Try to make your task statements *midrange*, i.e., neither too specific nor too general.

APPENDIX A-3

Medical Group Management Association

FOUNDED 1926

CENTER FOR RESEARCH IN AMBULATORY HEALTH CARE ADMINISTRATION
4101 E. LOUISIANA AVE.
DENVER, COLORADO 80222
303 / 753-1111

September 1975

Governing Body Chairperson

Dear Doctor:

We would like to request your participation in a significant research project concerned, in part, with developing a clearer understanding of administration in medical group practices. One aspect of administration in which we are interested is the role played by governing bodies. Your participation in this project will contribute greatly to the scope and quality of the study. Gaining a clearer understanding of the roles of governing bodies can lead to improvements in working relationships with lay administrators and also lead to improvements in educational curricula for physicians in administration.

If you take the time to complete the enclosed questionnaire, we think you will find it interesting and informative. Numerous physician administrators have tested the questionnaire so you should find it practical and relevant to your position and organization. In addition, when you complete and return the questionnaire, you will have an impact on the final results. On the other hand, if you choose not to participate in this study, a description of group practice administration will be developed without the benefit of important and unique information about you, your position, and your group. We will provide all participants with a summary of the preliminary results obtained from the administration of this questionnaire.

One of the more interesting aspects of the study will be the investigation of administrative interactions among lay administrators, medical directors, and governing bodies. In this respect, participation by physician administrators will contribute greatly to the scope and quality of the study.

We apologize for the length of the questionnaire; but, administration is a difficult topic to study, and administration in medical groups is no exception. However, we feel that our approach is especially sound and will yield useful and practical information. We are certainly convinced of the value of our study, and hope that you are also convinced enough to complete the questionnaire.

If you have any questions, either you or your lay administrator in your behalf, should feel free to contact Ed Morita, Assistant Project Director, at the MGMA/CRAHCA offices in Denver.

As is usual with everyone these days, we are working under a severe time constraint. We would greatly appreciate your completing the questionnaire and returning it to us in the enclosed prepaid envelope by September 23, 1975.

Thank You.

Best Wishes,

Bill Barry

William D. Barry
Executive Director, Joslin Diabetes Foundation
Chairman, National Advisory Committee

Enc.

P.S. The team concept of management is prevalent in group practices. Your efforts on our behalf are quite important to this project.

Bill

O.M.B. #68-S75069
Approval Expires 12/31/75

Reference Number _____

FOUNDED 1926

MEDICAL GROUP
MANAGEMENT ASSOCIATION

Survey on the Role of the Medical Group Practice

GOVERNING BODY

CENTER FOR RESEARCH

In Ambulatory Health Care Administration
4101 East Louisiana Avenue
Denver, Colorado 80222
(303) 753-1111

STATEMENT OF CONFIDENTIALITY

Confidential — All information which would permit identification of an individual or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to other persons or used for any other purposes.

FOR OFFICE USE ONLY

I. BIOGRAPHICAL

1. Year Born: _____

Please provide copy of your Curriculum Vitae or Resume. If a copy is not available, please complete the following:

Undergraduate Degree _____

Where did you receive your M.D. degree? _____

Where did you do your:

Internship? _____

Residency? _____

What is your medical specialty? _____

How long have you practiced medicine? _____ Years

How long have you been chairman of this group's governing body? _____ Years

II. ORGANIZATIONAL INFORMATION

2. What is the legal type organization providing medical services?

A. Partnership ☐
B. Professional Corporation ☐
C. Foundation ☐
D. Sole Proprietorship ☐
E. Association ☐
F. Other, please specify: _____

3. What do you consider to be the governing body of your organization? (Please specify *exact* name.)

_____

Answer all of the questions in this survey pertaining to the governing body based on your response above.

4. How many members of your governing body are:

A. Physician(s) _____
B. Clinic Administrator(s) _____
C. Community Business Leader(s) _____
D. Consumer(s) _____
E. Other, please specify: _____

5. What is the tenure of office for members of the governing body?

_____ Years

6. Is there any financial remuneration for serving on the governing body?

No ☐
Yes ☐

7. How often does the governing body meet?

A. Annually ☐
B. Quarterly ☐
C. Monthly ☐
D. Other, please specify: _____

_____

8. How does an individual become a member of the governing body? (Please check the most appropriate one.)

A. All physicians, both participating and salaried, are included. ☐
B. Only member physicians (participating) are included. ☐
C. Members are elected by both participating and salaried physicians in the group. ☐
D. Members are elected by member physicians (participating) only. ☐
E. Other, please specify: _____

_____

9. How does one become chairman of the governing body? (Please check the most appropriate one.)

A. Elected: By the governing body ☐
By all the partners, associates, etc. ☐
B. By rotation: Among the governing body ☐
Among all the partners, associates, etc. ☐
Among the physician department heads ☐
C. By virtue of seniority ☐
D. By virtue of being founder ☐
E. Other, please specify: _____

10. What is the customary length of tenure for the chairman of the governing body?

_____ Years

11. How many hours each month do you, as chairman, spend on governing activities?

_____ Hours

12. Between meetings of the governing body, what individual (title) makes the day-to-day decisions about:

A. Financial business of the clinic? _____ Title
B. Medical activities of the clinic? _____ Title

13. Does the governing body have a written statement on authorities and responsibilities to guide its total activity?

No ☐
Yes ☐

If yes, please attach to this survey if available.

14. Are you presently conducting research activities which are funded by sources outside the group practice? (Research being conducted in any non-profit foundation connected with your group should be included.)

No ☐
Yes ☐ 40

15. Are there formal continuing education programs within the group, such as a regular series of medical conferences, conducted for the entire physician staff?

No ☐
Yes ☐ 41

If yes, how often do they meet? _____ 42 43

16. Do you have a centralized medical library in your clinic?

No ☐
Yes ☐ 44

17. Does a clinic committee audit medical records formally and systematically?

No ☐
Yes ☐ 45

18. How are new physicians selected? (Please check the most appropriate one.)

A. Department Decision ☐
B. Medical Director ☐
C. Procurement Committee/Director ☐ 46
D. Governing Body ☐
E. Other, please specify: _____

19. Please attach a copy of your organization chart - a rough sketch will be satisfactory if printed copy is not available.

III. STANDARD LIST OF ADMINISTRATIVE TASKS

This section contains a Standard List of Administrative Tasks that are commonly performed in health care delivery organizations. Please indicate for each of the tasks the following information in the appropriate columns:

1. Indicate if the task is performed in your medical group. *If the task is not performed in your group, circle "1" for that task and go directly to the next task statement.*

2. If the task is performed by someone in your group, indicate who is *chiefly* responsible for satisfactory performance of the task in your group according to the following key:

   NO = No one in your organization
   LA = Lay Administrator
   MD = Medical Director (*not* simply any physician)
   GB = Governing Body
   Other = Someone other than the Governing Body, Medical Director, or Lay Administrator

3. *Regardless of who is chiefly responsible for satisfactory performance of the task,* please indicate the extent *that your governing body* is involved in the performance of the task on the scale ranging from "no personal involvement" (1) to "high personal involvement" (5). *Please speak for the involvement of your governing body as a whole.*

Remember, if you circle a "1" in Column 1 (indicating that the task is not performed by anyone in your group), you need not complete columns 2 and 3 for that item.

STANDARD LIST OF ADMINISTRATIVE TASKS

*Key: NO = No One
LA = Lay Administrator
MD = Medical Director
GB = Governing Body
Other = Other

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
	No	Yes	NO	LA	MD	GB	Other	No Personal Involvement				High Personal Involvement
1. Collect information, process and evaluate information, and/or make recommendations relative to factors that might affect patient demand for your group's services, e.g.:												
a. General trends in the environment (e.g., population census and demographic data, social factors, economic data, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
b. Legislation and regulations (e.g., NHI & HMO legislation, MEDICARE-MEDICAID, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
c. Your group's "competition" (e.g., other medical groups, hospitals, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
2. Collect information, process and evaluate information, and/or make recommendations relative to factors that might affect the manner in which services are rendered in your group, e.g.:												
a. New medical equipment and procedures.	1	2	1	2	3	4	5	1	2	3	4	5
b. New non-medical equipment and procedures (e.g., POMR, Superbill, etc.)	1	2	1	2	3	4	5	1	2	3	4	5
c. Legislation and regulations (e.g., PSRO, third party payor accountability regulations, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
d. Internal processes (e.g., patient flow, overtime, cash flow, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
3. Establish/aporove your group's position on issues related to the practice of medicine in your group (e.g., PSRO, accountability, licensure/certification, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
4. Establish/aoorove your group's position on issues related to the business operations of your group (e.g., taxes, Superbill, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
5. Attempt to influence the outcome of pending legislation or regulations that would affect your group practice.	1	2	1	2	3	4	5	1	2	3	4	5
6. Establish/aoprove the need to replace existing or purchase additional medical equipment.	1	2	1	2	3	4	5	1	2	3	4	5
7. Establish/aporove the need to replace existing or purchase additional non-medical equipment and/or services.	1	2	1	2	3	4	5	1	2	3	4	5

*Key: NO = No One
LA = Lay Administrator
MD = Medical Director
GB = Governing Body
Other = Other

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one) No Personal Involvement ... High Personal Involvement
	No	Yes	NO	LA	MD	GB	Other	
8. Negotiate purchase price/contracts for supplies, equipment, and/or non-medical services.	1	2	1	2	3	4	5	1 2 3 4 5
9. Approve purchases of equipment or services costing in excess of $1,000.	1	2	1	2	3	4	5	1 2 3 4 5
10. Establish/approve:								
a. Criteria for quality care.	1	2	1	2	3	4	5	1 2 3 4 5
b. Policies governing your group's organizational structure and type.	1	2	1	2	3	4	5	1 2 3 4 5
c. Policies governing the number and kind of patients that your group will serve.	1	2	1	2	3	4	5	1 2 3 4 5
d. Policies governing the growth or reduction in the number of physicians in your group.	1	2	1	2	3	4	5	1 2 3 4 5
e. Policies governing the growth or reduction in the number of administrators in your group.	1	2	1	2	3	4	5	1 2 3 4 5
f. Policies governing the specialty mix of your group's physicians.	1	2	1	2	3	4	5	1 2 3 4 5
g. Financial policies.	1	2	1	2	3	4	5	1 2 3 4 5
h. Accounting policies.	1	2	1	2	3	4	5	1 2 3 4 5
i. Physician personnel policies.	1	2	1	2	3	4	5	1 2 3 4 5
j. Non-physician personnel policies.	1	2	1	2	3	4	5	1 2 3 4 5
11. Develop long-range master plans (e.g. facility, financial, etc.).	1	2	1	2	3	4	5	1 2 3 4 5
12. Approve long range master plans (e.g. facility, financial, etc.).	1	2	1	2	3	4	5	1 2 3 4 5
13. Search and negotiate for investment capital.	1	2	1	2	3	4	5	1 2 3 4 5
14. Approve your group's operating budget.	1	2	1	2	3	4	5	1 2 3 4 5
15. Develop, review, and/or revise standard operating procedures for:								
a. Delivering patient care.	1	2	1	2	3	4	5	1 2 3 4 5
b. Physician personnel administration.	1	2	1	2	3	4	5	1 2 3 4 5
c. Non-physician personnel administration.	1	2	1	2	3	4	5	1 2 3 4 5
d. Utilization control (non-physician).	1	2	1	2	3	4	5	1 2 3 4 5
e. Cost control.	1	2	1	2	3	4	5	1 2 3 4 5

*Key: NO = No One
LA = Lay Administrator
MD = Medical Director
GB = Governing Body
Other = Other

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
	No	Yes	NO	LA	MD	GB	Other	No Personal Involvement				High Personal Involvement
15. Continued.												
f. Billing and collecting.	1	2	1	2	3	4	5	1	2	3	4	5
g. Interacting and dealing with outside agencies.	1	2	1	2	3	4	5	1	2	3	4	5
h. Gathering, processing, and evaluating information important to your group.	1	2	1	2	3	4	5	1	2	3	4	5
16. Approve standard operating procedures (new or revised) for:												
a. Delivering patient care.	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician personnel administration.	1	2	1	2	3	4	5	1	2	3	4	5
c. Non-physician personnel administration.	1	2	1	2	3	4	5	1	2	3	4	5
d. Utilization control (non-physician).	1	2	1	2	3	4	5	1	2	3	4	5
e. Cost controls.	1	2	1	2	3	4	5	1	2	3	4	5
f. Billing and collecting.	1	2	1	2	3	4	5	1	2	3	4	5
g. Interacting and dealing with outside agencies.	1	2	1	2	3	4	5	1	2	3	4	5
h. Gathering, processing, and evaluating information important to your group.	1	2	1	2	3	4	5	1	2	3	4	5
17. Enforce adherence to standard operating procedures by:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
18. Develop physician staffing plans.	1	2	1	2	3	4	5	1	2	3	4	5
19. Develop non-physician staffing plans.	1	2	1	2	3	4	5	1	2	3	4	5
20. Approve staffing plans.	1	2	1	2	3	4	5	1	2	3	4	5
21. Develop, review and/or revise job specifications, job descriptions, and/or job standards of:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5

*Key: NO = No One
LA = Lay Administrator
MD = Medical Director
GB = Governing Body
Other = Other

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
	No	Yes	NO	LA	MD	GB	Other	No Personal Involvement				High Personal Involvement
22. Approve job specifications, job descriptions, and/or job standards (new or revised) for:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
23. Develop, review, and/or revise payment plans/salary schedules and benefits for:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
24. Approve payment plans/salary schedules and benefits (new or revised) for:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
25. Recruit the following to fill openings in your organization:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
26. Negotiate salary and benefit contracts with organized groups of personnel.	1	2	1	2	3	4	5	1	2	3	4	5
27. Approve contracts with organized groups of personnel.	1	2	1	2	3	4	5	1	2	3	4	5

*Key: NO = No One
LA = Lay Administrator
MD = Medical Director
GB = Governing Body
Other = Other _____

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
	No	Yes	NO	LA	MD	GB	Other	No Personal Involvement				High Personal Involvement
28. Approve appointment/hiring of:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
29. Approve end of probationary appointments for physicians.	1	2	1	2	3	4	5	1	2	3	4	5
30. Negotiate contracts with physicians who wish to join the group.	1	2	1	2	3	4	5	1	2	3	4	5
31. Orient and train new personnel:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
32. Survey the job satisfaction of:												
a. Physician members (participating):	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
33. Conduct job performance evaluations for:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5

*Key: NO = No One
LA = Lay Administrator
MD = Medical Director
GB = Governing Body
Other = Other

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
								No Personal Involvement				High Personal Involvement
	No	Yes	NO	LA	MD	GB	Other					
34. Approve promotions of:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
35. Approve dismissals and terminations of:												
a. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
b. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
c. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
d. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
36. Negotiate dissolutions from the membership of physician members (participating) who leave the group.	1	2	1	2	3	4	5	1	2	3	4	5
37. Interpret group policy and clarify procedures for staff and employees.	1	2	1	2	3	4	5	1	2	3	4	5
38. Counsel, to assist with personal problems:												
a. Physician members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
39. Mediate/arbitrate interpersonal problems:												
a. Among physicians.	1	2	1	2	3	4	5	1	2	3	4	5
b. Among nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
c. Among receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
d. Among administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
e. Between physicians and nurses.	1	2	1	2	3	4	5	1	2	3	4	5
f. Between physicians and administrators.	1	2	1	2	3	4	5	1	2	3	4	5

Key: NO = No One
LA = Lay Administrator
MD = Medical Director
GB = Governing Body
Other = Other

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
	No	Yes	NO	LA	MD	GB	Other	No Personal Involvement				High Personal Involvement
40. Discipline:												
a. Physician-members (participating).	1	2	1	2	3	4	5	1	2	3	4	5
b. Physician employees (salaried).	1	2	1	2	3	4	5	1	2	3	4	5
c. Nurses and medical technicians.	1	2	1	2	3	4	5	1	2	3	4	5
d. Receptionists, clerks, and maintenance personnel.	1	2	1	2	3	4	5	1	2	3	4	5
e. Administrative staff.	1	2	1	2	3	4	5	1	2	3	4	5
41. Secure liability insurance coverage for your group and/or your physicians.	1	2	1	2	3	4	5	1	2	3	4	5
42. Survey patients to ascertain level of patient satisfaction and/or areas of dissatisfaction.	1	2	1	2	3	4	5	1	2	3	4	5
43. Resolve non-medical patient complaints (e.g., charges, fees, personality clashes, etc.).	1	2	1	2	3	4	5	1	2	3	4	5
44. Mediate/arbitrate between the group's physicians and patients in conflicts over medical services.	1	2	1	2	3	4	5	1	2	3	4	5
45. Represent the group or individual physicians in court appearance on collection cases.	1	2	1	2	3	4	5	1	2	3	4	5
46. Represent the group or individual physicians in court appearances on malpractice litigation.	1	2	1	2	3	4	5	1	2	3	4	5
47. Visit the group's patients in the hospital for public relations purposes (non-medical purposes).	1	2	1	2	3	4	5	1	2	3	4	5
48. Transmit information about your group's facilities and services to interested persons and/or organized consumer groups.	1	2	1	2	3	4	5	1	2	3	4	5
49. Represent your group at health care workshops and meetings.	1	2	1	2	3	4	5	1	2	3	4	5
50. Represent your group in civic matters and projects.	1	2	1	2	3	4	5	1	2	3	4	5
51. Participate in public health education efforts.	1	2	1	2	3	4	5	1	2	3	4	5
52. Try to gain the community's (or public's) acceptance and support for your group and its various programs.	1	2	1	2	3	4	5	1	2	3	4	5

*Key: NO = No One
LA = Lay Administrator
MD = Medical Director
GB = Governing Body
Other = Other

	1. Is this task performed in your group? (Please circle one)		2. Who is *chiefly* responsible for satisfactory performance of this task in your group? (Please circle one *only*)*					3. To what extent are *you personally* involved in performing this task? (Please circle one)				
	No	Yes	NO	LA	MD	GB	Other	No Personal Involvement				High Personal Involvement
53. Work with the news media in releasing public and civic interest stories.	1	2	1	2	3	4	5	1	2	3	4	5
54. Negotiate medical services covered under health care contracts with organized consumer groups.	1	2	1	2	3	4	5	1	2	3	4	5
55. Negotiate fees or prices for health care contracts with organized consumer groups.	1	2	1	2	3	4	5	1	2	3	4	5
56. Approve contracts with organized consumer groups.	1	2	1	2	3	4	5	1	2	3	4	5
57. Settle grievances with industrial or group accounts.	1	2	1	2	3	4	5	1	2	3	4	5
58. Work with third party payors to assure efficient collections for the group.	1	2	1	2	3	4	5	1	2	3	4	5
59. Please write in any tasks that you feel should be added to this list and complete the appropriate columns for each additional task.												

Below are a number of hypothetical changes that might be made in a medical group practice. Please review the list, then do two things:

1. First, indicate by *circling* the number in the appropriate box, the person or group who would have the *final* authority in making the decision before the change would be made.

2. Then, indicate by *placing an "x"* in the appropriate box(es), all those persons or groups who would participate in the decision.

Decision	Governing Body	Medical Director	Clinic Administrator or Assistant Administrator	Medical Department Head	Non-Medical Department Supervisor	Individual Physician	Other (Please Specify)
Initiate a new patient education program for diabetics	1	2	3	4	5	6	7
Setting the fee schedules for the clinic	1	2	3	4	5	6	7
Change in the level of remuneration for an individual physician member (participating)	1	2	3	4	5	6	7
Change in the hours of clinic service	1	2	3	4	5	6	7
Establish a new cost finding system for the clinic	1	2	3	4	5	6	7
Redecorate and refurnish the clinic waiting area	1	2	3	4	5	6	7
Business insurance decisions for the group (e.g., liability insurance, not fringe benefits)	1	2	3	4	5	6	7
Termination of a non-physician professional person	1	2	3	4	5	6	7
Approval of a feasibility study on a partial pre-paid medical program in the group	1	2	3	4	5	6	7
Routine work assignment scheduling for clerical personnel in business office	1	2	[redacted]	4	5	6	[redacted]

IV. CRITICAL TASKS

Please list the five most important tasks* that your governing body performs.

1. Most important task: _____

2. Second most important: _____

3. _____

4. _____

5. _____

*A task is herein defined as a working-level activity in which *your governing body* participates. A task statement (five of which you are asked to provide) must describe *what your governing body does* and *for what purpose*. Try to make your task statements *midrange*, i.e., neither too specific nor too general.

APPENDIX B

TABLE B-1

Number of Respondents Per Group Practice

Number of Respondents	f
Lay administrator only	315
Medical director only	7
Governing body chairperson only	3
Lay administrator and medical director	36
Lay administrator and governing body chairperson	171
Medical director and governing body chairperson	2
Lay administrator, medical director, and governing body chairperson	61

TABLE B-2

FREQUENCY DISTRIBUTION OF PROFESSIONAL ADMINISTRATORS' RESPONSES TO DECISION TABLE SECTION

1. Final authority for decision	
a. Initiate a new patient education program for diabetics:	
Governing body	257
Medical director	63
Administrator	9
Medical department head	72
Non-medical department supervisor	0
Individual physician	101
Other	11
b. Setting the fee schedules for the clinic:	
Governing body	419
Medical director	17
Administrator	47
Medical department head	14
Non-medical department supervisor	0
Individual physician	28
Other	16
c. Change in the level of remuneration for an individual physician member (participating):	
Governing body	470
Medical director	23
Administrator	13
Medical department head	5

TABLE B-2 (CONTINUED--2 OF 14)

1. c. (Continued)	
Non-medical department supervisor	0
Individual physician.	7
Other	20
d. Change in the hours of clinic service:	
Governing body.	453
Medical director.	25
Administrator	30
Medical department head	4
Non-medical department supervisor	0
Individual physician.	11
Other	18
e. Establish a new cost finding system for the clinic:	
Governing body.	197
Medical director.	20
Administrator	313
Medical department head	0
Non-medical department supervisor	0
Individual physician.	0
Other	11
f. Redecorate and refurnish the clinic waiting room:	
Governing body.	335
Medical director.	20

1. f. (Continued)

Administrator	180
Medical department head	2
Non-medical department supervisor	1
Individual physician	4
Other	10

g. Business insurance decisions for the group (e.g., liability insurance not fringe benefits):

Governing body	338
Medical director	20
Administrator	174
Medical department head	1
Non-medical department supervisor	0
Individual physician	3
Other	11

h. Termination of a non-physician professional person:

Governing body	172
Medical director	28
Administrator	321
Medical department head	14
Non-medical department supervisor	2
Individual physician	4
Other	8

1. (Continued)
   i. Approval of a feasibility study on a partial pre-paid medical program in the group:

Governing body	428
Medical director	19
Administrator	59
Medical department head	0
Non-medical department supervisor	0
Individual physician	2
Other	16

   j. Routine work assignment scheduling for clerical personnel in business office:

Governing body	13
Medical director	4
Administrator	442
Medical department head	1
Non-medical department supervisor	84
Individual physician	0
Other	11

2. Persons who participate in decision
   a. Initiate a new patient education program for diabetics:
      (1) Governing body:

No.	498
Yes	88

TABLE B-2 (CONTINUED--5 OF 14)

2. a. (Continued)		
(2) Medical director:		
	No.	445
	Yes	138
(3) Administrator:		
	No.	286
	Yes	297
(4) Medical department head:		
	No.	413
	Yes	170
(5) Non-medical department supervisor:		
	No.	528
	Yes	55
(6) Individual physician:		
	No.	317
	Yes	266
(7) Other:		
	No.	565
	Yes	18
b. Setting the fee schedules for the clinic:		
(1) Governing body:		
	No.	517
	Yes	65

2. b. (Continued)
(2) Medical director:

No.	438
Yes	145

(3) Administrator:

No.	136
Yes	447

(4) Medical department head:

No.	466
Yes	117

(5) Non-medical department supervisor:

No.	547
Yes	36

(6) Individual physician:

No.	351
Yes	232

(7) Other:

No.	558
Yes	25

c. Change in the level of remuneration for an individual physician member (participating):
(1) Governing body:

No.	551
Yes	32

2. c. (Continued)
(2) Medical director:

No.	343
Yes	140

(3) Administrator:

No.	235
Yes	348

(4) Medical department head:

No.	518
Yes	65

(5) Non-medical department supervisor:

No.	582
Yes	1

(6) Individual physician:

No.	408
Yes	175

(7) Other:

No.	559
Yes	24

d. Change in the hours of clinic service:
(1) Governing body:

No.	533
Yes	49

2. d. (Continued)
(2) Medical director:

No.	430
Yes	152

(3) Administrator:

No.	136
Yes	447

(4) Medical department head:

No.	475
Yes	107

(5) Non-medical department supervisor:

No.	510
Yes	72

(6) Individual physician:

No.	375
Yes	207

(7) Other:

No.	568
Yes	15

e. Establish a new cost finding system for the clinic:
(1) Governing body:

No.	445
Yes	138

2. e. (Continued)
(2) Medical director:

No.	502
Yes	81

(3) Administrator:

No.	366
Yes	217

(4) Medical department head:

No.	538
Yes	45

(5) Non-medical department supervisor:

No.	509
Yes	74

(6) Individual physician:

No.	518
Yes	65

(7) Other:

No.	554
Yes	29

f. Redecorate and refurnish the clinic waiting area:
(1) Governing body:

No.	486
Yes	97

2. f. (Continued)
(2) Medical director:

No.	507
Yes	76

(3) Administrator:

No.	234
Yes	349

(4) Medical department head:

No.	528
Yes	55

(5) Non-medical department supervisor:

No.	513
Yes	70

(6) Individual physician:

No.	476
Yes	107

(7) Other:

No.	557
Yes	26

g. Business insurance decisions for the group (e.g., liability insurance, not fringe benefits):
(1) Governing body:

No.	471
Yes	112

2. g. (Continued)
(2) Medical director:

No.	486
Yes	97

(3) Administrator:

No.	252
Yes	331

(4) Medical department head:

No.	563
Yes	20

(5) Non-medical department supervisor:

No.	574
Yes	9

(6) Individual physician:

No.	498
Yes	85

(7) Other:

No.	558
Yes	25

h. Termination of a non-physician professional person:
(1) Governing body:

No.	474
Yes	109

2. h. (Continued)
(2) Medical director:

No.	488
Yes	95

(3) Administrator:

No.	406
Yes	187

(4) Medical department head:

No.	503
Yes	80

(5) Non-medical department supervisor:

No.	491
Yes	92

(6) Individual physician:

No.	436
Yes	147

(7) Other:

No.	566
Yes	17

i. Approval of a feasibility study on a partial pre-paid medical program in the group:
(1) Governing body:

No.	526
Yes	57

2. 1. (Continued)
(2) Medical director:

No.	447
Yes	136

(3) Administrator:

No.	172
Yes	411

(4) Medical department head:

No.	522
Yes	61

(5) Non-medical department supervisor:

No.	558
Yes	25

(6) Individual physician:

No.	472
Yes	111

(7) Other:

No.	558
Yes	25

2. (Continued)
   j. Routine work assignment scheduling for clerical personnel in business office:
      (1) Governing body:

No.	562
Yes	21

      (2) Medical director:

No.	561
Yes	22

      (3) Administrator:

No.	503
Yes	80

      (4) Medical department head:

No.	570
Yes	13

      (5) Non-medical department head:

No.	435
Yes	[illegible]

      (6) Individual physician:

No.	559
Yes	24

      (7) Other:

No.	566
Yes	17

TABLE B-3

FREQUENCY OF RESPONSES BY PROFESSIONAL ADMINISTRATORS, MEDICAL DIRECTORS, AND GOVERNING BODIES--
CONTENT ANALYSIS OF THE FIVE MOST IMPORTANT TASKS

	LA					MD					GB				
	1st	2nd	3rd	4th	5th	1st	2nd	3rd	4th	5th	1st	2nd	3rd	4th	5th
TOTAL (n)	530	522	486	489	476	84	83	83	70	60	178	160	156	144	124
A. Clinic Administration:															
1. Business Management:															
a. Approve contracts.....	0	0	0	0	0	0	0	3	0	0	0	0	1	1	1
b. Approve administrative decisions.....	0	0	0	0	0	0	4	0	0	2	8	24	6	5	1
c. Consult with professional administrator on group business matters (e.g., salaries, finance, personnel).....	0	0	0	0	0	5	7	4	5	3	3	10	6	3	5
d. Coordinate computer management system.....	1	6	1	3	1	0	0	0	0	0	0	0	0	0	0
e. Coordinate planning of prepaid program.....	0	0	0	0	0	2	1	0	0	1	0	1	0	0	0
f. Direct/evaluate professional administrator in business matters.....	0	0	0	0	0	2	0	0	1	0	1	0	2	4	6
g. Interpret governmental regulations regarding group's policy and procedures.....	0	0	0	0	0	0	0	0	0	0	0	1	1	2	0
h. Develop job descriptions.....	0	2	0	1	0	0	0	0	0	0	0	0	0	0	0
i. Develop/update organizational structure.....	0	0	2	5	1	0	0	0	0	0	1	1	0	0	0
j. Develop standard operating procedures in all aspects of clinic operation.....	17	12	26	21	16	0	0	0	0	0	0	0	0	0	0
k. Direct day-to-day business affairs of group.....	76	22	15	17	22	0	0	0	0	0	0	0	0	0	0
l. Evaluate performance of outside consultants (e.g., lawyers, accountants).....	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
m. Follow volume figures of group practice.....	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0
n. Handle malpractice lawsuits.....	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1
o. Interpret/execute directives/policies of governing body.....	18	15	14	6	3	5	2	1	0	1	6	0	1	0	0

TABLE B-3 (CONTINUED--2 OF 6)

	LA					MD					GB				
	1st	2nd	3rd	4th	5th	1st	2nd	3rd	4th	5th	1st	2nd	3rd	4th	5th
A. 1. (Continued)															
p. Make major decisions	0	0	0	0	0	1	0	0	0	0	12	0	2	1	3
q. Prevent union intervention in operation	0	1	0	2	0	0	0	0	0	0	0	0	0	0	0
r. Supervise maintenance of facilities	0	2	11	18	20	0	0	0	0	0	0	0	0	0	2
2. Finance:															
a. Accounting functions	17	22	26	19	8	0	0	0	0	0	0	0	0	0	0
b. Approve major expenditures	0	0	0	0	0	0	0	1	2	2	3	5	13	12	13
c. Approve management of finances	0	0	0	0	0	1	0	1	0	0	12	15	13	3	5
d. Budget preparation	5	8	8	8	5	0	0	1	0	0	0	0	0	0	0
e. Conduct fund raising activities	0	0	0	0	0	1	0	0	0	1	0	0	0	0	1
f. Control expenses to maintain cash flow	32	24	19	19	12	0	0	0	0	0	0	0	0	0	0
g. Develop/supervise procedures for billings	32	53	32	37	27	0	0	0	0	0	0	1	1	1	0
h. Establish and adjust fees	0	0	0	0	0	0	0	0	0	0	1	3	4	1	0
i. Manage/report financial status of group	66	52	29	23	15	0	0	0	0	0	0	0	3	2	0
j. Manage pensions/profit-sharing plans/investments	2	1	5	12	10	0	0	1	0	0	0	1	2	5	2
k. Purchase equipment and supplies	0	6	18	32	21	0	0	0	0	0	0	0	0	0	0
l. Supervise payroll	2	0	1	0	3	0	0	0	0	0	0	0	0	0	0
3. Growth:															
a. Approve plans for physical expansion (e.g., remodeling, property acquisition)	0	0	0	0	0	4	4	11	9	5	0	1	1	2	0
b. Develop long range plans and goals (e.g., plans for community needs)	15	20	15	21	54	0	0	0	0	0	0	0	0	0	0
c. Develop or approve long range plans and goals	0	0	0	0	0	8	19	7	8	12	4	3	6	5	0
d. Develop plans for physical expansion (e.g., remodeling, property acquisition)	3	1	5	6	7	0	0	0	0	0	0	0	0	0	0

TABLE B-3 (CONTINUED--3 OF 6)

	LA					MD					GB				
	1st	2nd	3rd	4th	5th	1st	2nd	3rd	4th	5th	1st	2nd	3rd	4th	5th
A. 3. (Continued)															
e. Secure new accounts (e.g., individual and group).	0	1	1	0	0	1	1	2	0	0	0	3	1	1	1
4. Policy:															
a. Determine personnel policy.....	3	2	7	2	3	0	0	0	0	0	0	0	0	0	0
b. Develop/approve changes in group practice policies.	0	0	0	0	0	0	0	0	0	0	0	2	3	2	1
c. Develop/approve fiscal policies.....	0	0	0	0	0	0	0	0	0	0	0	0	3	2	1
d. Develop/approve internal policies and by-laws....	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
e. Develop/approve group practice policies.....	0	0	0	0	0	3	0	2	0	0	28	10	0	0	0
f. Develop/approve personnel policies.....	0	0	0	0	0	0	0	2	1	0	0	0	2	3	1
g. Develop group practice policies.....	5	6	6	5	2	0	0	0	0	0	0	0	0	0	0
h. Develop/approve operations policies.....	0	0	0	0	0	0	0	0	0	0	7	0	2	2	4
i. Recommend changes in policy.....	3	5	2	3	2	0	0	0	0	0	0	0	0	0	0
B. Staff Management															
1. Determine compensation (e.g., salaries, fringe benefits, profit sharing).	5	14	9	4	8	0	2	0	0	0	2	5	8	6	2
2. Determine nonmedical personnel staffing needs.....	2	7	7	3	1	0	0	0	0	0	0	0	0	0	0
3. Direct/monitor work loads (e.g., work scheduling, routine and on-call hours).	20	3	12	11	3	7	2	3	5	2	1	0	1	2	1
4. Establish/monitor educational standards for employees.	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
5. Evaluate proficiency of staff:															
i. All staff.....	1	3	4	7	2	0	0	0	0	0	0	0	0	0	0
ii. Medical staff.....	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
iii. Nonmedical staff.....	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0

TABLE B-3 (CONTINUED--4 OF 6)

	LA					MD					GB				
	1st	2nd	3rd	4th	5th	1st	2nd	3rd	4th	5th	1st	2nd	3rd	4th	5th
B. (Continued)															
6. Facilitate employee satisfaction:															
a. All staff	12	11	11	6	15	1	1	5	2	0	2	10	8	3	4
b. Medical staff	12	8	6	6	7	0	0	0	0	0	0	0	0	0	0
c. Nonmedical staff	6	8	3	5	5	0	0	0	0	0	0	0	0	0	0
7. Maintain communications/information flow	10	6	7	10	9	0	0	0	0	1	0	0	0	0	0
8. Mediate personal/professional conflicts:															
a. All staff	8	10	6	3	8	0	0	0	0	0	0	0	0	0	0
b. Medical staff	7	6	2	4	5	9	5	4	3	5	7	4	14	11	6
c. Nonmedical staff	1	1	0	1	1	0	0	0	0	0	0	0	0	0	0
9. Personnel Administration:															
a. All staff	41	64	49	12	12	0	0	0	0	0	0	0	0	0	0
b. Medical staff	1	4	3	2	0	0	0	0	0	0	0	0	0	0	0
c. Nonmedical staff	12	13	3	3	2	0	0	0	0	0	0	0	0	0	0
10. Recruit/hire staff:															
a. All staff	19	21	24	14	7	0	0	0	0	0	0	0	0	0	0
b. Professional administrator	0	0	0	0	0	0	1	2	0	0	1	0	1	0	0
c. Medical staff	3	8	14	8	5	7	10	2	4	3	10	13	7	3	8
d. Nonmedical staff	5	4	2	6	2	0	0	0	0	0	0	0	0	0	0
C. Liaison															
1. Liaison among medical staff departments or between medical staff and nonmedical departments	23	21	14	14	10	0	3	2	3	2	2	2	0	1	0
2. Liaison between governing body and group physicians	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3. Liaison between governing body and hospital medical staff	0	0	0	0	0	1	3	0	0	0	0	0	0	0	0
4. Liaison between governing body and professional administrator	0	0	0	0	0	0	0	1	1	1	0	0	0	0	0

TABLE B-3 (CONTINUED--5 OF 6)

	LA					MD					GB				
	1st	2nd	3rd	4th	5th	1st	2nd	3rd	4th	5th	1st	2nd	3rd	4th	5th
C. (Continued)															
5. Liaison between professional administrator and medical staff.	0	0	0	0	0	4	6	6	2	1	0	5	1	0	2
6. Represent group in professional and public relations.	9	8	5	8	3	1	4	8	11	7	0	0	5	10	11
7. Represent group in professional relations (e.g., accountants, insurance industry, hospital, medical society).	6	4	6	16	20	1	0	0	0	0	0	0	1	0	0
8. Represent group in public relations.....	3	5	16	19	52	0	0	0	0	1	0	0	0	0	0
D. Quality Control															
1. Assure patients' satisfaction with clinic and staff..	7	13	4	18	21	0	4	1	2	7	4	2	1	1	0
2. Coordinate the continuity of medical care for patients.	0	0	0	0	0	4	0	0	0	1	8	4	0	0	1
3. Develop programs for improving health care (e.g., expanded services).	3	2	6	2	6	4	1	1	4	4	3	0	5	2	1
4. Maintain standards of quality of medical care.....	0	0	0	0	0	7	7	9	2	5	19	14	6	14	8
5. Provide adequate supplies and adequate nonmedical equipment for group	0	1	0	1	1	0	1	0	1	1	1	3	2	0	0
6. Set good example of professionalism through own specialty.	0	0	0	0	0	1	2	1	1	1	1	0	0	0	1
E. Education and Research															
1. Advise physicians of research alternatives/possibilities.	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
2. Adviser for medical library.....	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
3. Conduct research.....	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0
4. Encourage/plan continuing education programs for staff.	0	0	2	1	2	1	1	2	3	2	0	0	1	1	1
5. Grants administration.....	1	2	0	1	0	0	0	0	0	0	0	0	0	0	0

TABLE B-3 (CONTINUED--6 OF 6)

	LA					MD					GB				
	1st	2nd	3rd	4th	5th	1st	2nd	3rd	4th	5th	1st	2nd	3rd	4th	5th
E. (Continued)															
6. Self-improvement through continuing education.....	0	0	1	4	6	0	0	0	0	0	0	0	0	0	0
7. Training/teaching.....	0	1	1	1	1	1	0	0	0	1	0	0	0	0	1
F. Miscellaneous															
1. Act as secretary for governing body meetings.....	2	3	0	1	3	0	0	0	0	0	0	0	0	0	0
2. Appoint/coordinate committee members.....	1	1	1	0	2	0	0	2	0	0	0	1	4	2	1
3. Elect officers of corporation.....	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
4. Evaluate recommendations of committees.....	0	0	0	0	0	1	1	0	0	0	0	0	1	3	1
5. Guide group in decision-making.....	11	9	4	4	3	0	1	1	0	3	2	1	1	0	0
6. Manage physician's personal financial affairs.....	0	3	0	3	8	0	0	0	0	0	0	0	0	0	0
7. Inform group about important issues (e.g., government regulations).....	7	6	15	14	14	0	1	2	3	0	0	4	1	1	8
8. Innovate/exchange new ideas for group.....	1	1	2	2	6	0	1	1	0	2	2	1	2	0	1
9. Participate in committee meetings.....	0	0	0	0	0	1	2	3	0	2	1	1	0	0	0
10. Place signature on documents/complete forms and surveys.....	0	0	0	0	1	1	0	1	2	1	0	0	0	0	1
11. Preside at stockholders and governing body meetings (e.g., plan agenda).....	1	1	4	3	1	5	4	3	1	0	2	2	1	4	1

TABLE B-4

PERCENTAGE OF PROFESSIONAL ADMINISTRATORS' RESPONSES
BY SIZE AND PAYMENT MECHANISM--ORGANIZATIONAL AND BIOGRAPHICAL DATA

	Small	Medium	Large
Percentage of respondents			
Lay administrator only	57	39	53
	62	38	28
Medical director only	2	0	0
	1	0	0
Governing body chairperson only	2	0	0
	0	0	0
Lay administrator and medical director	6	15	11
	5	6	4
Lay administrator and governing body chairperson	26	19	16
	26	45	48
Medical director and governing body chairperson	0	0	0
	0	0	0
Lay administrator, medical director, and governing body chairperson	8	27	21
	6	12	20
I. Biographical			
a. Birth and sex			
a. Year born:			
1906--1910	2	0	0
	1	1	0
1911--1915	4	0	0
	5	10	4
1916--1920	20	20	21
	8	16	17
1921--1925	9	36	11
	14	12	8
1926--1930	7	8	16
	14	18	13
1931--1935	17	16	16
	15	18	8
1936--1940	13	12	21
	18	7	17
1941--1945	17	8	11
		18	21
1946--1950	11	0	5
	11	1	13
1951--1955	0	0	0
	1	0	0

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		Small	Medium	Large
1. (Continued) b. Sex:				
	Male	92 86	100 94	95 100
	Female	8 14	0 6	5 0
**********				
2. Educational experience a. Degree				
	8th grade or less	0 0	4 0	0 0
	9--11 years	0 0	0 0	0 0
	High school graduate	6 9	4 2	0 0
	1--4 years college	18 19	13 13	5 8
	BA degree	56 57	33 59	53 54
	Graduate degree	20 15	46 26	42 38
b. Major for BA degree:				
	Accounting	13 18	22 25	21 18
	Administration of health services	0 2	4 0	0 0
	Business/Public Administration	33 37	35 30	16 36
	Creative arts	0 1	0 36	0 0
	Economics	8 6	4 10	26 9
	Education	5 1	0 2	0 0
	Liberal arts	10 3	4 3	0 5
	Management/Marketing	0 6	4 6	5 5
	Mathematics	3 1	0 1	0 0
	Medical technology	0 1	0 0	0 0
	Physical sciences	3 4	13 8	11 9

	Small	Medium	Large
2. b. (Continued)			
Political science	3	9	11
	2	1	5
Psychology	8	4	5
	2	5	9
Social sciences	6	0	0
	3	1	0
Other	10	0	5
	16	8	5
c. Major for graduate degree:			
Accounting/Economics	9	15	13
	7	12	0
Business administration	18	23	0
	46	23	20
Health services administration	36	46	63
	22	50	60
Law	9	0	0
	5	4	0
Physical sciences	0	0	0
	0	0	0
Social sciences	18	0	13
	2	4	0
Other	9	15	13
	17	8	20
d. Year last degree received:			
1913	0	0	0
	1	0	0
1926--1930	0	0	0
	1	0	0
1931--1935	3	0	0
	1	2	0
1936--1940	3	5	5
	4	11	5
1941--1945	3	5	0
	6	5	0
1946--1950	11	14	32
	13	17	0
1951--1955	8	29	16
	9	17	19
1956--1960	17	10	16
	16	11	5

TABLE B-4 (CONTINUED--4 OF 28)

		Small	Medium	Large
2. d. (Continued)				
	1961--1965	17	10	11
		17	16	38
	1966--1970	25	14	5
		18	10	4
	1971--1975	14	14	16
		16	12	19
3. Presently working on additional degree:				
	No.	94	96	84
		90	95	96
	Yes	6	4	16
		10	5	4
a. Degree for which presently working:				
	BA degree . . .	0	0	0
		46	0	0
	Graduate degree	100	100	100
		54	100	100
b. Major area of current work:				
	Accounting.	0	0	0
		12	20	0
	Administration of health services	0	0	0
		8	20	100
	Business/public administration. .	0	100	33
		62	40	0
	Education	0	0	0
		4	20	0
	Management/Marketing.	0	0	67
		0	0	0
	Social sciences	100	0	0
		0	0	0
4. Continuing professional educational seminars attended last four years:				
	0 .	19	12	5
		16	10	12
	1--2.	21	12	5
		23	17	8
	3--4.	25	23	47
		30	33	32
	5--6.	21	27	21
		10	17	12

4. (Continued)

	Small	Medium	Large
7--8	4	4	11
	11	13	16
9--10	2	4	5
	5	2	4
11--12	4	12	5
	1	4	12
13--14	2	8	0
	1	1	0
15--16	2	0	0
	2	1	0
17--18	0	0	0
	0	1	0
19--20	0	0	0
	1	1	4
25	0	0	0
	0	1	0

****

5. Past professional work experience
   a. Number of jobs/titles in health care field:

0	0	0	0
	1	0	0
1	40	35	26
	48	45	44
2	25	31	32
	30	29	8
3	23	23	21
	15	14	32
4	10	8	16
	5	12	12
5	0	4	5
	1	0	4
6	2	0	0
	0	0	0

---

   b. Total years in health care field:

0	2	0	0
	1	0	0
1--5	44	19	21
	37	23	24
6--10	15	15	21
	25	24	36

5. b. (Continued)

	Small	Medium	Large
11--15	10	12	21
	13	19	24
16--20	12	12	16
	11	14	4
21--25	8	19	16
	8	11	8
26--30	8	23	5
	5	9	4
31--35	2	0	0
	2	2	0
36--40	0	0	0
	0	0	0
41--45	0	0	0
	0	0	0

---

c. Number of jobs/titles in service field:

0	44	60	74
	49	42	71
1	37	28	16
	34	34	25
2	14	4	5
	13	18	0
3	4	8	5
	4	5	4
4	2	0	0
	0	1	0

---

d. Total years in service field:

0	44	60	74
	49	41	71
1--5	35	24	21
	26	26	25
6--10	10	8	0
	14	19	4
11--15	4	8	0
	5	9	0
16--20	4	0	5
	5	3	0
21--25	2	0	0
	1	2	0

		Small	Medium	Large
5. d. (Continued)				
	26--30	0	0	0
		0	1	0
	39	2	0	0
		0	0	0
e. Number of jobs/titles in manufacturing/retail field:				
	0	72	72	58
		69	69	63
	1	24	20	21
		21	19	33
	2	4	8	11
		8	7	4
	3	0	0	11
		2	4	0
	4	0	0	0
		0	1	0
f. Total years in manufacturing/retail field:				
	0	72	72	58
		69	69	63
	1--5	16	16	16
		15	17	21
	6--10	10	8	16
		6	6	8
	11--15	0	4	5
		6	3	8
	16--20	2	0	0
		1	2	0
	21--25	0	0	5
		2	3	0
	26--30	0	0	0
		1	0	0
	31--35	0	0	0
		0	0	0
	36--40	0	0	0
		0	1	0

TABLE B-4 (CONTINUED--8 OF 28)

		Small	Medium	Large
5. (Continued)				
g. Number of jobs/titles in government:				
	0	84	76	84
		79	77	75
	1	14	24	11
		19	20	25
	2	2	0	5
		2	2	0
	3	0	0	0
		0	1	0
h. Total years in government:				
	0	82	76	84
		78	78	75
	1--3	10	4	5
		8	9	0
	4--6	2	16	11
		7	11	21
	7--9	2	4	0
		1	1	0
	10--12	0	0	0
		1	1	0
	13--15	0	0	0
		1	0	0
	16--18	2	0	0
		0	0	0
	19--21	0	0	0
		1	0	0
	22--24	0	0	0
		1	0	4
	25--27	2	0	0
		0	1	0
	28--30	0	0	0
		1	0	0
i. Number of years out of school until first full-time clinic administration job:				
	0	35	26	33
		34	27	30
	1--5	30	22	17
		22	23	39
	6--10	16	35	28
		18	23	22
	11--15	12	9	6
		12	10	0

TABLE B-4 (CONTINUED--9 OF 28)

		Small	Medium	Large
5. I. (Continued)				
	16--20	0	0	11
		8	7	4
	21--25	5	9	6
		4	4	0
	26--30	0	0	0
		0	3	4
	31--35	0	0	0
		1	2	0
	36--40	2	0	0
		0	1	0
	**********			
II. Organizational information				
6. Governing body of organization:				
	Association	2	0	0
		0	0	0
	Board of directors/trustees/regents	66	58	53
		59	52	64
	Executive/management committee	8	27	37
		10	33	24
	Foundation	0	0	0
		0	0	0
	Founder/sole proprietorship	0	0	0
		1	0	0
	Partnership	8	12	5
		19	9	0
	Stockholders	6	0	0
		2	0	0
	Other	10	4	5
		9	7	12
	**********			
7. Authority and duties of lay administrator defined in written statement:				
	No.	73	69	58
		78	70	64
	Yes	28	31	42
		23	30	36
	**********			
8. Hours in a typical week spent as group practice administrator:				
	0	0	0	0
		0	0	0
	1--10	4	12	0
		0	0	0
	11--20	2	0	10
		1	0	4

TABLE B-4 (CONTINUED--10 TO 28)

		Small	Medium	Large
8. (Continued)				
	21--30	4	0	0
		2	2	4
	31--40	21	8	0
		27	9	0
	41--50	54	62	60
		58	66	58
	51--60	15	19	25
		11	21	33
	61--70	0	0	5
		1	2	0
	71--80	0	0	0
		0	0	0
9. Lay administrator reports to:				
Administrative director		2	0	0
		1	0	12
All physicians		2	4	0
		6	0	8
Board of directors/regents		26	24	25
		27	21	16
Chairman/president		43	32	40
		30	53	40
Founder/sole proprietorship		0	0	0
		0	0	0
Medical director		14	20	15
		7	7	4
Partners		4	0	0
		11	2	4
Other		10	20	20
		18	17	16
10. Fiscal responsibility for group a. Capital expenditures:				
Administrator		19	12	20
		11	5	20
Administrator and governing body		33	39	20
		34	38	40
Administrator and governing body and other		2	8	0
		1	4	8
Administrator and medical director		4	4	0
		4	3	0
Administrator and medical director and governing body		12	4	15
		4	6	4

TABLE B-4 (CONTINUED--11 OF 28)

	Small	Medium	Large
10. a. (Continued)			
Administrator and medical director and governing body and other	0	0	0
	0	1	0
Administrator and medical director and other	0	0	15
	0	0	0
Administrator and other	2	0	0
	4	3	0
Governing body	23	27	15
	36	33	16
Governing body and other	0	0	10
	1	4	4
Medical director	2	2	5
	1	2	0
Medical director and governing body	4	4	0
	1	0	0
Medical director and governing body and other	0	0	0
	0	0	0
Medical director and other	0	0	0
	0	0	0
Other	0	0	0
	2	2	8
b. Supplies or recurring items:			
Administrator	78	85	79
	89	85	88
Administrator and governing body	10	4	0
	2	5	4
Administrator and governing body and other	0	4	0
	1	0	0
Administrator and medical director	0	4	5
	3	4	0
Administrator and medical director and governing body	4	0	0
	0	0	0
Administrator and medical director and governing body and other	0	0	0
	0	0	0
Administrator and medical director and other	0	0	5
	0	0	0
Administrator and other	2	4	5
	3	2	0
Governing body	4	0	0
	0	0	0
Governing body and other	0	0	5
	0	0	4

TABLE B-4 (CONTINUED--12 OF 28)

	Small	Medium	Large
10. b. (Continued)			
Medical director	2	0	0
	0	0	0
Medical director and governing body	0	0	0
	0	0	0
Medical director and governing body and other	0	0	0
	0	0	0
Medical director and other	0	0	0
	0	0	0
Other	0	0	0
	2	4	4

****

11. Lay administrator's involvement in personal business affairs of physicians:

Never	9	4	5
	8	7	4
Seldom	47	54	35
	41	55	48
Often	23	29	35
	30	25	36
A great deal	21	13	25
	22	13	12

****

12. Scheduled hours of service provided by the group practice
a. Full service hours on Monday--Friday:

0	0	4	0
	1	1	0
1--3.	0	0	0
	0	1	0
4--6.	0	0	0
	1	1	0
7--9.	74	69	70
	77	65	72
10--12	17	27	20
	19	29	28
13--15	6	0	5
	2	3	0
16--18	0	0	0
	0	0	0
19--21	0	0	0
	0	0	0
22--24	4	0	5
	0	0	0

12. (Continued)

b. Full service hours on Saturday:

	Small	Medium	Large
0	45	35	35
	53	35	56
1--3.	17	12	20
	14	9	12
4--6.	23	46	40
	27	45	28
7--9.	9	8	0
	5	8	4
10--12	0	0	0
	0	4	0
13--15	2	0	0
	0	0	0
16--18	0	0	0
	0	0	0
19--21	0	0	0
	0	0	0
22--24	4	0	5
	0	0	0

c. Full service hours on Sunday:

0	94	100	90
	97	100	100
1--3.	2	0	0
	1	0	0
4--6.	0	0	5
	1	0	0
7--9.	0	0	0
	0	0	0
10--12	0	0	0
	0	0	0
13--15	0	0	0
	0	0	0
16--18	0	0	0
	0	0	0
19--21	0	0	0
	0	0	0
22--24	4	0	5
	0	0	0

TABLE B-4 (CONTINUED--14 OF 28)

12. (Continued)

d. Limited service hours on Monday--Friday:

	Small	Medium	Large
0	91	54	50
	78	70	64
1--3	4	15	5
	7	11	8
4--6	2	4	10
	2	6	8
7--9	0	0	0
	1	0	0
10--12	0	8	15
	2	3	0
13--15	2	12	15
	8	9	16
16--18	2	4	5
	3	1	4
19--21	0	0	0
	0	0	0
22--24	0	4	0
	0	0	0

e. Limited service hours on Saturday:

0	79	54	25
	73	71	60
1--3	9	0	5
	9	5	0
4--6	6	23	15
		9	20
7--9		0	5
		2	4
10--12	0	0	20
	1	3	0
13--15	0	0	0
	0	2	4
16--18	2	4	5
	1	2	0
19--21	0	12	20
	3	5	4
22--24	2	8	5
	3	2	8

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		Small	Medium	Large
12. (Continued) f. Limited service hours on Sunday:				
	0	93	73	55
		86	80	76
	1--3	2	0	0
		2	3	4
	4--6	0	4	5
		1	5	0
	7--9	2	0	0
		1	1	4
	10--12	0	0	5
		0	1	4
	13--15	0	0	5
		0	1	0
	16--18	0	0	5
		0	0	0
	19--21	0	0	0
		0	0	0
	22--24	2	23	25
		9	10	12

****

13. Normal staffing level in terms of full-time equivalents - a. Physicians (1) Physician members (i) Total positions:				
	0	19	12	15
		9	6	16
	1--10	60	8	0
		77	7	0
	11--20	21	31	0
		14	48	12
	21--30	0	42	5
		0	29	12
	31--40	0	8	20
		0	11	20
	41--50	0	0	15
		0	0	16
	51--60	0	0	15
		0	0	8
	61--70	0	0	5
		0	0	4
	71--80	0	0	5
		0	0	8
	81--90	0	0	0
		0	0	4

TABLE B-4 (CONTINUED--16 OF 28)

13. a. (1) (i) (Continued)

	Small	Medium	Large
91--100	0	0	0
	0	0	0
101--110	0	0	0
	0	0	0
111--120	0	0	5
	0	0	0
250	0	0	0
	0	0	0

(ii) Filled positions:

0	19	12	20
	10	7	16
1--10.	66	8	0
	77	10	4
11--20.	15	31	0
	13	49	8
21--30.	0	42	5
	0	25	12
31--40.	0	8	20
	0	9	28
41--50.	0	0	20
	0	0	12
51--60.	0	0	15
	0	0	8
61--70.	0	0	5
	0	0	4
71--80.	0	0	5
	0	0	4
81--90.	0	0	5
	0	0	4
91--100	0	0	0
	0	0	0
101--110	0	0	5
	0	0	0
250	0	0	0
	0	0	0

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TABLE B-4 (CONTINUED--17 OF 28)

		Small	Medium	Large
13. a. (1) (Continued) (iii) Vacant positions:				
	0	87	96	80
		85	75	76
	1--10	13	4	15
		15	24	16
	11--20	0	0	5
		0	2	4
	21--30	0	0	0
		0	0	4
(2) Physician employees (i) Total positions:				
	0	40	12	25
		42	16	16
	1--10.	57	65	30
		57	65	28
	11--20.	4	15	5
		1	16	12
	21--30.	0	0	5
		0	3	12
	31--40.	0	8	10
		0	1	4
	41--50.	0	0	15
		0	0	12
	51--60.	0	0	5
		0	0	4
	61--70.	0	0	0
		0	0	4
	71--80.	0	0	0
		0	0	0
	81--90.	0	0	0
		0	0	0
	91--100	0	0	5
		0	0	0
	130	0	0	0
		0	0	4
	167	0	0	0
		0	0	4

TABLE B-4 (CONTINUED--18 OF 28)

13. a. (2) (Continued)

(ii) Filled positions:

	Small	Medium	Large
0	42	12	30
	130	17	16
1--10.	55	68	25
	55	66	32
11--20.	4	12	10
	1	15	8
21--30.	0	0	0
	0	2	16
31--40.	0	8	10
	0	1	0
41--50.	0	0	15
	0	0	12
51--60.	0	0	5
	0	0	4
61--70.	0	0	0
	0	0	4
71--80.	0	0	0
	0	0	0
81--90.	0	0	0
	0	0	0
91--100	0	0	5
	0	0	0
123	0	0	0
	0	0	4
167	0	0	0
	0	0	4

(iii) Vacant positions:

0	94	84	85
	81	81	76
1	4	12	0
	6	6	4
2	0	0	0
	6	6	4
3	0	0	0
	6	6	0
4	0	4	0
	1	1	4
5	0	0	0
	1	1	0
7	0	0	5
	0	0	4

13.. a. (2) (iii) (Continued)

	Small	Medium	Large
10	0	0	5
	0	0	4
14	0	0	0
	0	0	4
15	0	0	5
	0	0	0
16	2	0	0
	0	0	0

b. Non-physician employees
(i) Total positions:

0	0	0	0
	1	2	0
1--50..	90	23	20
	94	26	14
51--100	6	46	0
	5	51	14
101--150	2	19	20
	0	17	27
151--200	0	12	15
	0	5	23
201--250	0	0	5
	0	0	5
251--300	0	0	15
	0	0	0
301--350	0	0	0
	0	0	0
351--400	0	0	10
	0	0	0
401--450	2	0	5
	0	0	5
451--500	0	0	5
	0	0	0
501--550	0	0	0
	0	0	0
551--600	0	0	0
	0	0	9
825	0	0	2
	0	0	2
1150	0	0	2
	0	0	2
1498	0	0	2
	0	0	2

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13. b. (2) (Continued)

(ii) Filled positions:

	Small	Medium	Large
0	0	0	5
	1	2	0
1--50	90	23	20
	95	29	18
51--100	6	46	0
	5	48	9
101--150	2	19	15
	0	17	27
151--200	0	12	15
	0	5	23
201--250	0	0	5
	0	0	5
251--300	0	0	15
	0	0	0
301--350	0	0	0
	0	0	0
351--400	0	0	10
	0	0	5
401--450	2	0	5
	0	0	0
451--500	0	0	5
	0	0	0
501--550	0	0	0
	0	0	0
551--600	0	0	0
	0	0	9
820	0	0	2
	0	0	2
1148	0	0	2
	0	0	2
1420	0	0	2
	0	0	2

(iii) Vacant positions:

0	89	92	80
	93	86	68
1	4	0	0
	5	6	0
2	6	4	5
	2	3	5
3	0	4	0
	0	1	0

13. b. (2) (iii) (Continued)

	Small	Medium	Large
4	0	0	0
	0	3	0
5	0	0	0
	0	0	9
6	0	0	0
	0	0	5
8	0	0	5
	0	0	0
10	0	0	0
	0	0	5
14	0	0	5
	0	0	0
15	0	0	0
	0	1	0
17	0	0	0
	0	1	0
18	0	0	0
	0	0	0
22	0	0	0
	0	0	5
28	2	0	0
	0	0	0
45	0	0	0
	0	0	5
78	0	0	5
	0	0	0

****

14. Growth of group:

Decreasing	6	0	0
	2	2	0
Stable	38	27	10
	39	19	8
Growing	57	73	90
	59	80	92

****

15. Annual gross operating revenue (in thousands of dollars) generated by clinic medical staff:

0--1,000	50	8	0
	54	4	4
1,001--2,000	40	16	11
	42	26	8
2,001--3,000	10	12	5
	4	34	8

15. (Continued)

	Small	Medium	Large
3,001--4,000.	0	40	5
	0	22	8
4,001--5,000.	0	8	11
	0	6	12
5,001--6,000.	0	16	26
	0	6	20
6,001--7,000.	0	0	11
	0	0	16
7,001--8,000.	0	0	5
	0	1	0
8,001--9,000.	0	0	5
	0	1	4
9,001--10,000	0	0	11
	0	0	8
10,000+	0	0	11
	0	0	72

****

16. Percentage of gross operating revenue from prepayment:

0	0	0	0
	100	100	100
1--10.	43	54	55
	0	0	0
11--20.	6	8	10
	0	0	0
21--30.	15	4	0
	0	0	0
31--40.	4	0	5
	0	0	0
41--50.	8	0	10
	0	0	0
51--60.	4	4	5
	0	0	0
61--70.	4	0	0
	0	0	0
71--80.	9	8	0
	0	0	0
81--90.	8	4	0
	0	0	0
91--100	0	19	15
	0	0	0

****

		Small	Medium	Large
17. Average number of patients seen per day by all physicians in your group:				
	0	0	0	0
		0	0	0
	14-100	38	8	6
		36	8	4
	101--200	35	17	6
		41	8	16
	201--300	21	13	0
		18	25	4
	301--400	4	17	6
		4	32	24
	401--500	2	21	12
		1	17	12
	501--600	0	13	18
		1	7	16
	601--700	0	4	12
		0	2	8
	701--800	0	4	12
		0	1	8
	801--900	0	4	6
		0	1	4
	901--1000	0	0	12
		0	1	4
	1001+	0	0	12
		0	0	0

****

18. Presence of clinic offices or satellites in other than the main clinic location a. Number of clinic satellites:				
	0	74	69	37
		77	74	80
	1	19	8	16
		16	18	8
	2	6	8	32
		5	3	8
	3	2	8	16
		1	3	4
	4	0	0	0
		1	2	0
	5	0	8	0
		0	1	0
	10	0	0	0
		0	1	0

		Small	Medium	Large
18. (Continued) b. Average distance of satellites from clinic (miles):				
	1--5.	23	25	9
		25	31	0
	6--10	8	13	46
		13	28	50
	11--15	46	0	18
		35	9	25
	16--20	8	25	9
		10	3	0
	21--25	0	25	0
		7	6	0
	26--30	8	0	0
		3	9	0
	31--35	0	0	9
		0	3	0
	36--40	0	0	0
		5	3	0
	41--45	0	13	0
		2	0	0
	46--50	0	0	9
		0	0	0
	50+	8	0	0
		0	6	25

****

19. Standing clinical and management committees a. Standing clinical committees (1) Clinical Utilization:				
	No.	100	96	84
		99	97	84
	Yes	0	4	16
		1	3	16
(2) Educational:				
	No.	93	89	53
		93	85	68
	Yes	8	12	47
		7	15	32
(3) Fee:				
	No.	98	92	95
		98	97	88
	Yes	2	8	5
		2	3	12

TABLE B-4 (CONTINUED--25 OF 28)

		Small	Medium	Large
19. a. (Continued)				
(4) Medical information:				
	No.	94	100	65
		97	93	92
	Yes	6	0	35
		3	7	8
(5) Medical policy:				
	No.	96	65	74
		97	91	92
	Yes	4	35	26
		3	9	8
(6) Medical records:				
	No.	89	81	63
		96	81	56
	Yes	11	19	37
		4	19	44
(7) Review of professional performance:				
	No.	83	58	25
		93	74	64
	Yes	17	42	75
		7	26	36
(8) Review of special performance:				
	No.	96	77	68
		97	95	84
	Yes	4	23	32
		3	5	16
(9) Scientific:				
	No.	98	92	79
		99	98	92
	Yes	2	8	21
		1	2	8
(10) Specialty:				
	No.	98	88	95
		97	95	92
	Yes	2	12	5
		3	5	8

TABLE B-4 (CONTINUED--26 OF 28)

		Small	Medium	Large
19. a. (Continued) (11) Supporting services facilities:	No.	94	73	70
		90	71	76
	Yes	6	27	30
		10	29	24
(12) Other:	0	85	85	35
		88	86	80
	1	9	12	30
		9	12	8
	2	4	0	15
		2	2	0
	3	2	0	10
		1	0	0
	5	0	4	0
		0	0	0
	7	0	0	5
		0	0	0
	8	0	0	5
		0	0	0
b. Standing management committees (1) Community relations:	No.	98	96	95
		98	99	96
	Yes	2	4	5
		2	1	4
(2) Compensation, benefits, and insurance:	No.	91	65	55
		88	65	72
	Yes	9	35	45
		12	35	28
(3) Coordination and liaison:	No.	96	100	95
		100	98	92
	Yes	4	0	5
		0	2	8

TABLE B-4 (CONTINUED--27 OF 28)

		Small	Medium	Large
19. b. (Continued)				
(4) Current facilities and maintenance:				
	No.	94	88	89
		94	81	80
	Yes	6	12	11
		6	19	20
(5) Equipment:				
	No.	98	96	100
		98	99	96
	Yes	2	4	0
		2	1	4
(6) Executive/governing:				
	No.	60	42	53
		67	45	60
	Yes	40	58	47
		33	55	40
(7) Fiscal:				
	No.	96	77	60
		91	67	64
	Yes	4	23	40
		9	33	36
(8) Personnel management:				
	No.	87	88	79
		94	81	80
	Yes	13	12	21
		6	19	20
(9) Planning:				
	No.	92	81	63
		95	72	72
	Yes	8	19	37
		5	28	28
(10) Satellite:				
	No.	98	100	84
		99	98	96
	Yes	2	0	16
		1	2	4

TABLE B-4 (CONTINUED--28 OF 28)

19. b. (Continued)
(11) Selection/recruitment:

	Small	Medium	Large
No.	96	81	79
	94	74	80
Yes	4	19	21
	6	26	20

(12) Other:

0	92	81	40
	92	82	50
1	4	15	15
	7	12	25
2	4	4	15
	1	5	21
3	0	0	20
	0	1	4
4	0	0	10
	0	0	0

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TABLE B-5

PROFESSIONAL ADMINISTRATORS' RESPONSES BY SIZE AND PAYMENT MECHANISM--CHIEF RESPONSIBILITY EXPRESSED AS A PERCENTAGE OF SUBSYSTEM TASKS IN EACH KATZ AND KAHN SUBSYSTEM (COLUMN 2 OF STANDARD LIST)

Subsystem / Chief Responsibility	Fee For Service			Prepayment		
	Small	Medium	Large	Small	Medium	Large
1. Maintenance						
No One	0	0	0	0	0	0
Professional Administrator	59	55	52	60	55	53
Medical Director	6	8	7	10	20	17
Governing Body	29	24	20	22	19	16
Other	5	12	21	7	7	14
2. Boundary/Production Supportive-Procurement						
No One	1	0	0	1	1	0
Professional Administrator	66	62	54	65	66	56
Medical Director	6	6	9	9	11	15
Governing Body	22	17	13	17	10	7
Other	7	14	24	8	12	22
3. Boundary/Production Supportive-Disposal						
No One	1	3	2	0	1	0
Professional Administrator	70	66	60	72	82	53
Medical Director	6	7	9	6	3	14
Governing Body	9	5	5	4	2	4
Other	13	17	24	18	12	29
4. Boundary/Institutional Supportive						
No One	2	5	4	0	3	2
Professional Administrator	39	44	39	48	54	31
Medical Director	8	9	9	8	11	27
Governing Body	31	18	17	20	16	18
Other	9	15	22	10	17	16
5. Adaptive						
No One	1	2	0	3	1	1
Professional Administrator	64	59	62	62	65	59
Medical Director	6	6	6	11	12	13
Governing Body	24	23	13	15	16	13
Other	5	9	18	7	6	15
6. Managerial						
No One	0	1	0	0	0	0
Professional Administrator	44	41	42	48	45	45
Medical Director	5	7	6	13	14	15
Governing Body	46	43	37	34	35	29
Other	4	8	15	3	6	12

TABLE B-6

PERCENTAGE OF PROFESSIONAL ADMINISTRATORS' RESPONSES BY SIZE AND PAYMENT MECHANISM--CRITICAL TASKS BY FINE'S METHODOLOGY

	Small	Medium	Large
1. First most important task			
a. Data:			
(1) No significant relationship	2	0	0
	1	0	0
(2) No significant relationship	0	0	0
	0	0	0
(3) Comparing	0	0	0
	0	0	0
(4) Copying	0	0	0
	0	0	0
(5) Computing	2	0	5
	3	1	5
(6) Compiling	29	5	11
	28	19	25
(7) Analyzing	31	32	16
	15	25	20
(8) Coordinating	2	18	21
	9	11	15
(9) Synthesizing	0	0	0
	0	0	0
b. People:			
(1) No significant relationship	0	0	0
	0	0	0
(2) Serving	0	5	0
	2	0	0
(3) Speaking--Signaling	0	0	0
	0	2	0
(4) Persuading	2	14	0
	2	5	5
(5) Diverting	2	0	0
	0	0	0
(6) Supervising	20	0	21
	26	20	20
(7) Instructing	0	0	5
	1	1	0
(8) Negotiating	8	27	21
	12	17	10
(9) Mentoring	2	0	0
	0	0	0

TABLE B-6 (CONTINUED--2 OF 5)

	Small	Medium	Large
2. Second most important task			
a. Data:			
(1) No significant relationship	0 0	0 0	0 0
(2) No significant relationship	0 0	0 0	0 0
(3) Comparing	0 0	5 0	0 0
(4) Copying	0 0	0 0	0 0
(5) Computing	6 6	0 3	0 0
(6) Compiling	25 26	9 20	16 20
(7) Analyzing	19 16	18 20	16 20
(8) Coordinating.	6 3	9 7	21 5
(9) Synthesizing.	0 0	0 0	0 0
b. People:			
(1) No significant relationship	0 0	0 0	0 0
(2) Serving	2 2	0 0	0 5
(3) Speaking--Signaling	0 1	0 2	5 0
(4) Persuading.	10 2	18 6	0 10
(5) Diverting	0 1	5 2	0 0
(6) Supervising	31 35	14 32	21 25
(7) Instructing	0 1	0 25	5 5
(8) Negotiating	0 7	0 8	16 10
(9) Mentoring	0 0	0 0	0 0

TABLE B-6 (CONTINUED--3 OF 5)

	Small	Medium	Large
3. Third most important task			
a. Data:			
(1) No significant relationship	0	0	0
	0	0	0
(2) No significant relationship	0	0	0
	0	0	0
(3) Comparing	0	0	0
	2	2	0
(4) Copying	0	0	0
	0	0	0
(5) Computing	4	5	0
	7	0	0
(6) Compiling	31	27	16
	27	25	21
(7) Analyzing	8	18	26
	16	20	32
(8) Coordinating	4	14	16
	3	5	0
(9) Synthesizing	0	0	0
	0	0	0
b. People			
(1) No significant relationship	0	0	0
	0	0	0
(2) Serving	2	0	0
	1	0	0
(3) Speaking--Signaling	0	0	5
	2	4	0
(4) Persuading	8	5	5
	9	12	16
(5) Diverting	2	5	0
	1	0	0
(6) Supervising	40	23	21
	27	16	26
(7) Instructing	0	5	5
	2	4	0
(8) Negotiating	0	0	5
	5	13	5
(9) Mentoring	0	0	0
	0	0	0

TABLE B-6 (CONTINUED--4 OF 5)

	Small	Medium	Large
4. Fourth most important task			
a. Data:			
(1) No significant relationship	0	0	0
	0	0	0
(2) No significant relationship	0	0	0
	0	0	0
(3) Comparing	6	5	0
	4	3	6
(4) Copying	0	0	0
	0	0	0
(5) Computing	8	35	5
	7	2	0
(6) Compiling	33	15	21
	35	29	35
(7) Analyzing	23	5	11
	14	26	24
(8) Coordinating.	2	5	11
	3	3	6
(9) Synthesizing.	0	0	0
	0	0	0
b. People:			
(1) No significant relationship	0	0	0
	0	0	0
(2) Serving	0	0	11
	0	0	0
(3) Speaking--Signaling	4	0	5
	4	3	12
(4) Persuading.	8	15	16
	11	9	6
(5) Diverting	4	10	5
	2	0	0
(6) Supervising	4	5	21
	14	18	6
(7) Instructing	2	5	5
	1	1	0
(8) Negotiating	4	5	0
	5	7	6
(9) Mentoring	0	0	0
	0	0	0

TABLE B-6 (CONTINUED--5 OF 5)

5. Fifth most important task	Small	Medium	Large
a. Data:			
(1) No significant relationship	0	0	0
	0	0	0
(2) No significant relationship	0	0	0
	0	0	0
(3) Comparing	5	0	6
	8	8	7
(4) Copying	0	0	0
	1	0	0
(5) Computing	2	6	0
	5	2	0
(6) Compiling	29	13	0
	26	21	20
(7) Analyzing	17	19	17
	18	19	20
(8) Coordinating	2	13	6
	1	1	7
(9) Synthesizing	0	0	0
	1	0	0
b. People:			
(1) No significant relationship	0	0	0
	0	0	0
(2) Serving	0	0	6
	4	2	0
(3) Speaking--Signaling	5	0	6
	3	8	7
(4) Persuading	19	31	17
	13	17	0
(5) Diverting	2	0	0
	1	2	0
(6) Supervising	7	19	22
	10	9	13
(7) Instructing	5	0	6
	1	0	0
(8) Negotiating	7	0	17
	7	10	13
(9) Mentoring	0	0	0
	1	0	13

TABLE B-7

PROFESSIONAL ADMINISTRATORS' RESPONSES BY SIZE AND PAYMENT MECHANISM--
PROFESSIONAL ADMINISTRATORS' AVERAGE PERSONAL INVOLVEMENT BY WHO IS
CHIEFLY RESPONSIBLE IN EACH KATZ AND KAHN SUBSYSTEM (COLUMN 2--3 INTERACTION)

Subsystem / Chief Responsibility	Fee For Service			Prepayment		
	Small	Medium	Large	Small	Medium	Large
1. Maintenance						
No One	.09	.10	.08	.02	0	.21
Professional Administrator	4.39	4.16	4.33	4.13	3.90	4.07
Medical Director	.86	1.16	.98	1.11	2.05	1.41
Governing Body	2.71	2.63	2.47	2.04	2.74	2.67
Other	1.41	1.41	2.06	1.10	1.30	1.78
2. Boundary/Production Supportive-Procurement						
No One	.06	.15	.0	.04	.32	.10
Professional Administrator	4.39	4.26	4.24	4.00	3.95	3.95
Medical Director	.62	.70	.64	1.19	1.55	1.98
Governing Body	2.40	2.43	2.05	2.05	1.89	1.64
Other	1.05	1.68	2.37	.98	1.47	2.09
3. Boundary/Production Supportive-Disposal						
No One	.11	.08	.18	0	.05	0
Professional Administrator	3.91	3.64	3.95	3.58	4.01	3.29
Medical Director	.40	.54	.54	.29	.32	1.44
Governing Body	.63	.45	.46	.45	.36	.40
Other	.93	1.10	1.21	1.11	1.16	1.44
4. Boundary/Institutional Supportive						
No One	.08	.45	.20	0	.18	.06
Professional Administrator	2.07	2.38	2.27	2.55	3.45	2.01
Medical Director	.33	.45	.67	.38	.68	1.16
Governing Body	1.31	1.00	1.57	1.01	1.53	1.03
Other	.42	.66	.98	.70	1.06	1.00
5. Adaptive						
No One	.13	.28	0	.29	.10	.05
Professional Administrator	4.21	4.16	4.29	3.74	4.05	4.11
Medical Director	.59	.83	.90	1.20	1.87	1.68
Governing Body	2.56	2.57	2.00	1.78	2.43	3.04
Other	.66	1.08	1.62	.65	.95	1.69
6. Managerial						
No One	.15	.19	.13	.28	.40	0
Professional Administrator	4.39	4.28	4.39	4.02	4.04	4.12
Medical Director	1.02	1.38	1.59	1.55	1.97	2.20
Governing Body	3.10	3.18	2.84	2.67	3.29	3.02
Other	1.50	2.02	2.15	1.15	1.60	2.42

APPENDIX C

APPENDIX C-1

Computation of Index Numbers for Future Studies
(Normalized Scores)

Nominal Group #1 -- ACCM

N = 9 Scores Reported as Rating

Rating $\div$ (N x 100) = Normalized Score = Index

Example:

Rating = 865

$$\text{Index} = \frac{865}{9 \times 100} = \frac{865}{900} = 0.96$$

Nominal Group #2 -- California Administrators

N = 10

Example:

Rating = 600

$$\text{Index} = \frac{600}{10 \times 100} = \frac{600}{1000} = 0.60$$

Delphi #1 -- Starkweather

N = 24 Scores as Percentile Ratings

Rating Given As:

Probability of Occurrence (O)		90%	50%	10%
Percentage of Panelists Indicating	(P)	.75	.10	.05

$$\text{Rating} = N\left[(P_1 \times O_1) + (P_2 \times O_2) + (P_3 \times O_3)\right]$$

$$\text{Index} = \frac{\text{Rating}}{N \times 90} \quad \frac{N\left[(P_1 \times O_1) + (P_2 \times O_2) + (P_3 \times O_3)\right]}{N \times 90}$$

$$\text{Index} = \frac{(P_1 \times O_1) + (P_2 \times O_2) + (P_3 \times O_3)}{90}$$

Example: $I = (.75 \times 90) + (.10 \times 50) + (.05 \times 10) =$

$$\frac{67.50 + 5.00 + .50}{90} = \frac{73}{90} = 0.81$$

Delphi #2 -- Bergwell

N = 15 Scores Reported as "Mean Probabilities"

$\frac{\text{Mean Probability}}{100}$ = Index as Calculated in the Other

Example: Mean Probability = 86.5

$$\text{Index} = \frac{86.5}{100} = 0.87$$

TABLE C-1

ACCM NOMINAL GROUP
THE DENVER HILTON
Jan. 31 - Feb. 1, 1975

Question: 1. What do you predict will happen in the health care field that will affect the future role of group practice administration (objective)?

	First Round -Ranking- Total	Rank	Second Round -Rating- Total	Rank
1. Government controlled health maintenance for every citizen (Fee-for-service extinct, NHI will be a reality).	24	1	865	1
2. Increased volumes of care for each patient (more use of more procedures by each patient).				
3. In NHI for 22 years, poor medical care, hence return to conventional delivery system.				
4. Emphasis on large health center which will support satellite offices (urban, suburban, rural).	9	4	435	3
5. Expanded use of ancillary, more specialized personnel.	3	8	-	-
6. Large health care centers broken down in the center into: acute, chronic, and preventive care.	5	6	149	6
7. Health care centers will provide a broader spectrum of services.	3	8	-	-
8. Solo practitioner will become extinct, will team up with groups which will enlarge and merge, etc.	8	5	275	5
9. "Doctor" will change with the government paying for their education; hence, many of the lower classes will enter medicine because it's available, resulting in a different set of rules.	2	9	-	-
10. Information exchange will be on more of an international basis because of technological advances.				
11. Centralization of care with networks, efficient (non-overlapping), with outside decisions.				
12. All groups will have to be accredited to participate in NHI, with both physicians and Administrators meeting certain requirements.	5	6	115	7
13. Diminishing fee-for-service, increased prepay/government/insurance health care.	8	5	350	4
14. Delivery of health care will be more specialized, with more physicians/population, less hours/physicians and reduced income.				
15. Centralized data banks will be regionalized with access by Social Security number.	3	8	-	-
16. Employee groups (including physicians) will have a greater influence on the operation of health centers.				
17. Consumers will have an increased role in the decisions.	5	6	110	8
18. Vertical surgery will come into its own.				
19. With advances, physician status will be downgraded, and health care administrators will be responsible to the federally controlled organization of health care.	4	7	-	-
20. Physicians and administrators will be assigned specific areas to work and live in by the federal government.				
21. Return to physicians for primary care with specialists to be located in the health centers.				
22. All employee groups will become unionized.	1	10	-	-

TABLE C-1 (CONTINUED--2 OF 2)

ACCM Nominal Group
The Denver Hilton
Jan. 31 - Feb. 1, 1975
Question 1 Continued

	First Round -Ranking-		Second Round -Rating-	
	Total	Rank	Total	Rank
23. Equipment used by health care centers will be more complex and expensive.				
24. Health Care Delivery System will become more complex.	1	10	-	-
25. Medical buildings, as we know them, will become obsolete, buildings will be lighter, more flexible.	5	6	-	-
26. Health care as a right will be mandated (equal health care opportunity).	18	2	combined with 1	
27. Strictly controlled malpractice insurance run by federal government, run along lines of no-fault workman's compensation.				
28. Physicians will be less dedicated.				
29. Security will play a prominent role in the construction of buildings.				
30. In large controlled centers, there will be screening with: -Primary Care Physician determine problems -Psychological Social Workers -Surgery on premise with after care on premises -A teaching preventive medical unit.	4	7	-	-
31. A much greater emphasis on ambulatory care (vertical surgery as a part).	13	3	580	2
32. Buildings will be designed by the government with pre-fab, etc.				
33. Hippocratic Oath will be out of vogue.				
34. Change in land usage with fewer autos, more public transportation, hence less parking problems.				
35. Licensing criteria for physicians will change, hence be related to training.				
36. Billing will be changed to an automatic, computerized system.				
37. Increased automation.				
38. Women will play a more prominent role, there will be centralized nurseries.				
39. The South will rise again.				
40. Administrative services for group practice will be handled through a service corporation.	3	8	-	-
41. Doctors choices of medications will be limited (government formulary).	1	10	-	-
42. Elaborate cost accounting will be necessary.	5	6	100	9
43. Time study, motion analyses will become more necessary.				
44. Statistical support will be necessary for all changes, because they will be subject to approval.	3	8	-	-
45. Continuing education will play a greater role for all personnel (physicians, Administrators, RN's, etc.).	2	9	-	-
46. All emergency care will be administered in institutions.				

TABLE C-2

ACCM NOMINAL GROUP
THE DENVER HILTON
Jan. 31 - Feb. 1, 1975

Question: 2. If you were able to control or invent the future of health care delivery, what utopian projections would you make to establish the ideal in group practice administration?

	First Round -Ranking- Total	First Round -Ranking- Rank	Second Round -Rating- Total	Second Round -Rating- Rank
1. Government should be involved in medical care only by default.	10	4	340	4
2. Better awareness on the part of physicians of patients, their needs, what they are saying and thinking.	11	3	470	3
3. Organizational structure gives the administrator full authority to manage clinic in area of qualifications.	5	7	130	8
4. Quality (not luxury) health care available to all.				
5. Require relicensing or recertification of physicians.				
6. A problem-solving computer for administrators.				
7. Equalization of fees between specialities and proper cost-pricing of all tests.	6	6	225	6
8. Private foundation type funding for clinics, so as to quarantee equal helath care for each patient based on need, i.e., removing financial barriers to care).				
9. Get physicians out of the real estate business; get rid of obsolete buildings.				
10. Patients who have means should pay for own care, patients who don't should be helped by the government.	10	4	220	7
11. Complete computerization of medical records, automatic billing procedures.	4	8	-	-
12. Solutions to the many social problems which affect health care (aged, sanitation, etc.).	17	1	600	1
13. Establish accountability for physicians and standards of patient care.	4	8	-	-
14. Public relations rather than economics may be the prime responsibility of the administrator.				
15. Some method of educating physicians, which is not in a completely protected environment, that gives exposure to the rest of the world.	7	5	285	5
16. Mandatory continuing education for all clinic personnel, including support personnel; in-service training (to be included in their salary).	3	9	-	-
17. Every clinic should be an educational center, for employees, patients, and trainees (students), paramedicals, etc.	3	9	-	-
18. The practice of medicine should be allowed to become more competitive (pricing, advertising, etc.).	1	11	-	-
19. Adequate and available supplies of physicians and ancillary personnel.	4	8	-	-
20. A free competitive system well organized, competently staffed health teams enjoying mutual respect, with genuine peer review of physicians, administrators, and fees without substantial government intervention.	14	2	597	2
21. Establish standards of performance to measure effectiveness of administrators.				
22. Recognition by the physician of the profession of administration.	2	10	-	-
23. Adequate policing of quality of physicians by physicians (weed out bad apples).				
24. Preventive medicine should be taught to patients in every clinic.				
25. More trained staff (social workers and paramedicals) in the triage process.				

TABLE C-2 (CONTINUED--2 OF 2)

ACCM Nominal Group
The Denver Hilton
Jan. 31 - Feb. 1, 1975
Question 2 Continued

	First Round -Ranking-		Second Round -Rating-	
	Total	Rank	Total	Rank
26. Remove preoccupation with malpractice.	4	8	-	-
27. Good relations with other organizations in the health care delivery system (hospitals, nursing homes, etc.).	5	7	-	-
28. Availability of full technological and professional information through visual media equipment placed in every office.	2	10	-	-
29. Eliminate duplication of expensive equipment and facilities.	1	11	-	-
30. Establishment of medical services corporations for the purpose of: -purchasing -maintenance -personnel -billing and collections } leased to physicians.	3	9	-	-
31. Legal controls on malpractice plus some realistic method of censuring attorneys who act without proper cause.	1	11	-	-
32. Screening of new patients by psychiatric social workers to determine whether problem is physical or emotional.				
33. Retain the incentives to physicians to continue practicing.				
34. Provide motivation for tax support of hospitals to cut costs and improve efficiency.				
35. More health educators and better education of patients as to functions and realistic expectation of physician and the HCD system.				
36. Some method of handling indigents without taking a financial beating.				
37. Greater recognition by physicians of psychosomatic diseases, taught in medical school and/or continuing education.				
38. Maintain fee for service medical care system.	2	10	-	-
39. Establishment of free clinics for indigents.				
40. Changing labor laws to give the employer an even break.				
41. Physicians should be salaried so there would be a realistic base of worth.	1	11	-	-
42. Control and restriction of physician performance to areas of qualification.				
43. Catastrophic coverage over some percent of annual salary.				
44. No matter what the future, keep all clinic personnel out of the bureaucracy of the civil service system.				

TABLE C-3

CALIFORNIA GROUP PRACTICE ADMINISTRATORS
NOMINAL GROUP PROCESS MEETING
SAN FRANCISCO HILTON INN
August 8, 1975

Question: 1. What do you predict will happen in the health care field that will affect the future role of group practice administration (objective)?

	First Round -Ranking-		Second Round -Rating-	
	Total	Rank	Total	Rank
1. Formalized planning processas.				
2. Price competition.	10			
3. Groups will contract with employers to provide total care to include industrial as well as group (employees and families).	2			
4. Structured fees-for-services will force changes in methods of income distribution, fringe benefits, and mobility.	9			
5. Mandatory multi-phasic clinics in every community with a population of 100,000 and citizens shall be required to take exam every other year.				
6. All clinics will be government owned, operated, or controlled.	39	1	386	10
7. Make greater use of physicians' assistants and/or reduced training for physicians who would play role of triage doctors (primary care).	6			
8. Organization will change to have consumer participation in clinic policy.	21	6	526	5
9. Health care will be provided for the jobless.	10			
10. Government accountability with standard chart of accounting and reporting.	25	3	490	6
11. Closer alignment of groups with hospital - hospital based or shared services.	12			
12. Better informed patient population.				
13. Schools to be used for all well-baby care and immunizations.	7			
14. Future legislation will place tight controls over costs allowable.	22	5	-	-
15. Women shall outnumber men in MGMA by 8% in the year 2000.				
16. Half the physicians will be women.				
17. Greater use of computer storage of health information, probably centrally controlled.	16	8	398	9
18. Clinic patients will have some kind of membership to be seen.	1			
19. All payment for medical services will be by third party.	7			
20. Group practice quality standards review and accreditation.	15	9	480	7
21. Increased use of management engineering techniques in the clinic environment.	20	7	410	8
22. Erosion of the old medical school tie.	4			
23. Doctor groups to be used for sick care only.	8			
24. Constraints will be placed on the freedom to expand, add new specialties, add new equipment.	10			
25. Advertising [redacted]ctions will be removed from most medical				
26. [redacted]es in clinic administration.	5			
27. Much, much greater involvement (control) of unions with physicians and employees.	21	6	576	2
28. Most large clinics will have a teaching program for employees and professionals.	6			
29. Increased utilization of medical care will cause deterioration of quality.	6			
30. Administrators will be licensed.	6			
31. Mandatory patient education programs.	7			

TABLE C-3 (CONTINUED--2 OF 3)

	First Round -Ranking- Total	Rank	Second Round -Rating- Total	Rank
32. Decreasing physician income.	13			
33. Employers to contract with hospitals for care on a per diem basis for employees and their families, whether industrial or group.	1			
34. Tremendous growth in numbers of groups and numbers of doctors in the group (i.e., average size of group larger).	23	4	544	
35. Six semester units of medical patient education will be required of every high school graduate.				
36. Chain, pyramid, or concentric circles clinics system.	8			
37. Ancillary services (optical, pharmaceutical, PT, midwifery) to be provided by non/M.D.'s or at no profit to the M.D. (out of clinic and control financially of doctors)	7			
38. Financial data will be disclosed for public scrutiny.	2			
39. Tremendous increase in numbers of administrative personnel to handle increased load of paper work.	10			
40. Increased out-patient care, e.g., surgical care, etc.	6			
41. Development of clinic associations (cooperative) to share in services and to reduce costs.	9			
42. Educational requirements for clinic administrators will be on a par with hospital administrators.				
43. Easier access to medical care by setting up adolescent clinics and geratology clinics in high schools.	6			
44. Most administrator's and physician income levels to be guaranteed on a scale related to civil service levels.				
45. Government trained paramedics with indentured servitude for training.				
46. Hospitals will lose the battle to become the total providers of health care (clinics will survive!)	1			
47. Ideal clinic will be master clinic with as many satellite clinics as community can justify.	6			
48. Present regulations will bankrupt the provision of health care and we will have a totally new system in 15 years.				
49. Universal health insurance.	21	6	600	1
50. New scientific instrumentation, use of computers and television in the treatment of patients.	3			
51. Diversification of interests by administrators and physicians of companies within and without the health industry.	5			
52. Government administered mal-practice insurance.	26	2	-	-
53. Use of mobile vans for multi-phasic screening to be used by employees in lieu of physicals in the office.	4			
54. With the advent of national health care insurance, a 70% increase in demand for services will destroy the present health care system.	26	2		
55. All administrators will be required to have a data processing degree.				
56. Large chief clinic administrators will be political appointees.				
57. Duties, responsibilities, etc., of clinic administrators to be standardized (less M.D. interference).				
58. Rights of patients will exist to refuse care.				
59. M.D.s will work in shifts around the clock and to use space and facilities more efficiently.	6			
60. Hospitals and medical groups will become public utilities or "The decline and fall of the medical diety."	20	7	-	-
61. Increased technical and educational skills required of administrators to cope with the above.	14	10	530	4
62. Hospital emergency rooms to assume role of doctors office for all after-hours care.	10			
63. Administrators will be the chief decision makers.	10			

TABLE C-3 (CONTINUED--3 OF 3)

	First Round -Ranking- Total	First Round -Ranking- Rank	Second Round -Rating- Total	Second Round -Rating- Rank
64. There will be increased use of prepayment and capitation to anticipate medical costs, i.e. to budget effectively.	16	8	-	-
65. Overnight facilities for relatives will become part of larger clinic facilities.				
66. A lower proportion of R.N.s in the clinic.				
67. Elimination of the doctor's mystique with newly graduated doctors being considered as other employees.				
68. More M.D. administrators.	13			

TABLE C-4

CALIFORNIA GROUP PRACTICE ADMINISTRATORS
NOMINAL GROUP PROCESS MEETING
SAN FRANCISCO HILTON INN
August 8, 1975

Question : 2. If you were able to control or invent the future of health care delivery, what utopian projections would you make to establish the ideal in group practice administration?

	First Round -Ranking- Total	Rank	Second Round -Rating- Total	Rank
1. Maintained freedom of choice. - doctors and patients - prepaid and fee-for-service	40	1	629	1
2. Less government regulation of private health care.	27	5	575	3
3. Capitation and/or prepayment eliminating billings.	19	8	-	-
4. Eliminate all bureaucratic required reporting that cannot be cost justified, and does not provide useful data not produced by other reports.	11			
5. Employ a method of payment to M.D.s oriented to actual production, and weighted by specialty.	14			
6. Federal-state funded, county-operated, group practice buildings for all medicaid eligible patients, (equipment and service provided by county).	12			
7. Total health care center as the core for all acute illness and accidents, staffed by specialties required, and supported by strategic satellites, all under one administration.	31	3	554	4
8. Schedule work time for physicians.	8			
9. Restrict M.D.s to practice of medicine.	2			
10. Increase supply of well trained M.D.s - decrease supply of lawyers.				
11. Revised mal-practice system. - less costly - justified awards.	36	2	469	6
12. Higher compensation for administrators.	3			
13. Public health facilities for immunizations, well-baby care, patient education, family planning, adolescent counseling, nutrition, and preventive health maintenance.	12			
14. Eliminate government's involvement in all elements in health care delivery.	30	4	603	2
15. Basic economic and personnel subjects required in pre-med.				
16. All medical care should be funded by pre-pay, provided by employers or government.	9			
17. Adopt separation between acute and nonacute care.				
18. Larger and better staffed and equipped multi-specialty clinics operating in voluntary cooperation with other health providers.	13			
19. No unions.	18	9	361	9
20. M.D.s paid in correlation with quantity and quality of work provided.				
21. M.D.s not suitable to groups or with personality problems, be assigned to projects not requiring a group adjustment.				
22. Administrators authorized to eliminate waste where quality of care not effected.	15	10	395	8
23. Prohibit M.D.s from becoming their own landlords.				
24. Low interest, long-term loans for buildings and equipment.	14			
25. Exotic procedures requiring special equipment and staff, be strategically located to avoid duplication.	15	10	460	7
26. Pre-select patients.	11			
27. Require regular peer-review of patient care.	11			

TABLE C-4 (CONTINUED--2 OF 2)

	First Round -Ranking- Total	First Round -Ranking- Rank	Second Round -Rating- Total	Second Round -Rating- Rank
28. Develop a patient education process to cope with the "worried-well" and "worried-sick".	21	7	355	10
29. Peer-review committees should have power to discipline poor medical practice.	17			
30. VNA for control of chronic illnesses in the home to avoid unnecessary clinic visits.	5			
31. Legal restrictions on mal-practice: - awards - M.D. liability - statute of limitations - attorney contingency fees	25	6	548	5
32. Reasonable transportation system.				
33. Put more money into research to improve health care delivery.	1			
34. Better education for administrative assistants, e.g., insurance clerks, receptionists, etc.	4			
35. Adequate, but reasonable salaries for M.D.s.	8			
36. Shortening of over-populated specialties and requiring those specialists to work in medically under-served areas for two years.				
37. 50% reduction in income taxes.	4			
38. Computerize the medical record and appointments.	4			
39. Increased availability of paramedical personnel.				
40. Compulsory, problem-oriented medical records.	14			
41. M.D.s that are content to practice medicine only, and are content with their salaries.	11			
42. Sufficient M.D.s to care for sick persons unless result of distribution problem.				
43. All graduate medical students and administrators must pass handwriting legibility tests.				
44. Develop a system to adequately monitor quality of care.	4			
45. Assignment of M.D.s in the hospital for hospital practice, and allowing sufficient coverage in the office for appointments and walk-ins.	4			
46. Never having to explain what "overhead" is.	3			
47. Minimal 3-day notice for M.D. time-off.				
48. M.D.s would never exaggerate or lie.				
49. 100% government control and ownership of all health care.				
50. The South won't rise again.				
51. Allow lay ownership of medical practices.				

TABLE C-5

PHYSICIAN NOMINAL GROUP PROCESS
DENVER HILTON HOTEL
December 6, 1975

QUESTION #1: What do you predict will happen in the health care field that will effect the future role of group practice administration?

	First Round -Ranking- Total	Rank	Second Round -Rating- Total	Rank
1. Increase in group practice in large urban areas, professional resistance in suburban and rural areas.				
2. Fragmentation will occur in management as it has in medicine (specialization in administration will produce fragmentation) good and bad.	9			
3. Most practitioners will attempt to join groups already established, primarily for economic rather than philosophic reasons.	18	7	495	3
4. Increased government intervention with ultimate public utility approach to health.	23	4	370	10
5. Planning and financing of health care facilities will become major problems with obligatory cost accounting and consumer involvement.	9			
6. Increase in prepayment over fee-for-service type of remuneration.	18	7	392	7
7. Development of more complete systems for ambulatory medical care services, including that for first, second, and third echelons.	6			
8. Unionization of ambulatory personnel with the clinic or group.	16	8	252	
9. Increasing pressures to provide first dollar comprehensive prepaid health care.	9			
10. Groups will assume greater educational functions at all levels with academic accreditation.	4			
11. Hospitals will influence and form the hiatus of medical care.	9			
12. New groups of physicians will form, hospital based, or otherwise--for help in operating, they will turn to AMA, AHA--form service bureaus which will fail!				
13. Groups will be forced to make major decisions regarding regionalization.	16	8	380	8
14. Net take home pay for administrators and MDs will decrease in proportion to the inflationary spiral.	2			
15. Less money for the acquisition of facilities and equipment.	2			
16. Regionalization of health care delivery systems, in part in some areas, total in other areas.	9			
17. Increasing number of consumer boards (balance, lay professionals) with input to administration to influence quality vs. cost.	21	5	418	5
18. Increasing third-party pressure for monitoring quality and cost.	10			

TABLE C-5 (CONTINUED--2 OF 4)

QUESTION #1 (Continued)

	First Round -Ranking- Total	First Round -Ranking- Rank	Second Round -Rating- Total	Second Round -Rating- Rank
19. Development of rotational personnel programs and regionalized services (e.g., "branch banking").	6			
20. Increased competition (patients, equipment, MDs, all) from medical schools caused primarily by government (every level) intervention.	6			
21. MGMA and AGPA will be involved late (by default) in educating newcomers to group practice	6			
22. Major changes in the image of physicians; will influence the kind of people entering the profession.	7			
23. Administration will be required to take a more active political role in their communities.	23	4	424	4
24. Increased involvement of government in licensing and accrediting of MDs and non-MD professionals.				
25. Federally supervised evaluation of medical care as to: quality, cost effectiveness, efficiency, availability.	30	2	815	1
26. Continued government encouragement of group practice through financial incentives, tax breaks, etc.				
27. Increasing demands for preventive medicine and education--departments of education manned by health education specialists.	5			
28. Groups will use physician managers specifically trained in clinical and managerial skills.	12	10	259	10
29. Continue to put medical schools first and at center of all medical care.	6			
30. Pressure from public and union/management coalition will force the establishment to allow favorable economic treatment for groups.	4			
31. Society will turn their attentions more to accessibility and quantity and away from quality of care; hence, the tension will shift to smaller groups away from highly technical (quantity instead of quality).	11			
32. Patients will receive less personalized care--hence, more complaints at the front office.				
33. Increased teaching and educational roles for MDs in group practice.	8			
34. Major consumer involvement to influence numbers and types of MDs and other types of health care professionals; thus, medical health care delivery.	7			
35. Increased pressure and acceptance for regionalized group practice particularly in rural areas.	5			
36. Unions and others will push hard for capitation prepayment, preferably by agreement with existing groups, if need be by forming their own.				
37. Increased use of para-professionals will create status problem and medical staff organization, compensation.	12	10	196	

TABLE C-5 (CONTINUED—3 OF 4)

QUESTION #1 (Continued)	First Round -Ranking- Total	First Round -Ranking- Rank	Second Round -Rating- Total	Second Round -Rating- Rank
38. Increased decremental quality of medical care, caused by intervention of unions, consumers, government, will make entire field less attractive to bright minds.	8			
39. An out-patient oriented allied health culture will develop its own training programs and will seek their own recognition.	9			
40. Consumerism within ten years will fade away.	1			
41. Computers will have ancincreased role in: 1) appointments 2) billing 3) reporting 4) record keeping 5) statistical analysis 6) clinical care.	20	6	378	9
42. Economics as part of the behavioral science curriculum will be introduced into all undergarduate and graduate training programs.				
43. Mass screening will move out of clinic and emerge as an entirely new discipline with its own personnel and its own plant.	7			
44. Recognition of the difference between health and medical care with clinics medical care co-functioning with social and health agencies.				
45. Federal government will finally be forced to recogniza, certify, and license four or five levels of medical care.	4			
46. Formation of a federation of group practica providers (including MGMA, AGPA, group practice, hospitals, atc.)				
47. Increase in doctor's unions.				
48. Development of comprehensive patient education systems for all health care matters.	1			
49. Many bright minds enter health care field, but they will look at it differently.	4			
50. Terrible difficulties planning because of government inconsistencies.	4			
51. Required continuing education and reevaluation of physicians for relicensing.	8			
52. Rapid growth of clinics (increased number of MDs) is going to set up great internal pressures; hence, great difficulty in managing.	26	3	417	6
53. Formal forms of NHI which will require accommodation by clinics.				
54. In three to five years, malpractica will not be a problem.				
55. Physician's workweek will decrease in the number of hours.				
56. Pressures and incentives to put MDs in rural and ghetto areas.	1			
57. Federal research monies will be carefully allocated, rigidly controlled, and monitored for cost effectiveness.				
58. Development of almost totally prepaid health care systems.	9			

TABLE C-5 (CONTINUED--4 OF 4)

QUESTION #1 (Continued)

	First Round -Ranking- Total	First Round -Ranking- Rank	Second Round -Rating- Total	Second Round -Rating- Rank
59. National Health Insurance will become a reality in five years, probably through the insurance industry, subsidized where necessary by feds, prepayment, and HMOs will disappear.	35	1	661	2
60. Within ten years, health care will no longer occupy as great a public interest.	3			
61. Loan repayment schemes will fail in rural and inner city areas.				
62. Fee-for-service will always be a part of the medical scene.	1			
63. More women will be involved in medical care.				
64. By the year 2,000 a better (not utopian) process of medical care will evolve.				
65. Universal data bank via social security number will be available on all patients.	13	9	75	
66. Medical education will be rigidly controlled at both undergraduate and graduate levels.	7			

TABLE C-6

PHYSICIAN NOMINAL GROUP PROCESS
DENVER HILTON HOTEL
December 6, 1975

QUESTION #2: If you were able to control or invent the future of health care delivery, what utopian projections would you make to establish the ideal in group practice administration?

	First Round -Ranking- Total	Rank	Second Round -Rating- Total	Rank
1. All medical care will be delivered by multi-specialty groups, with or without satellites (composed either of MDs or paramedics).	45	1	613	1
2. Maintain fee-for-service system; okay to balance with prepaid.	14	8	297	10
3. Multi-specialty health centers located regionally according to population needs.	2			
4. Health planning bodies staffed mainly by providers, with informed layman consumers in an advisory capacity only.			79	
5. Total availability to the total population.	37	2	490	5
6. Establish regional health care systems with appropriate personnel distribution.	30	3	535	3
7. Delivery of health care should integrate in and out-patients; in-patient facilities should be controlled by the out-patient groups.	9			
8. Encourage a balanced team (i.e., MD, nurse, consumer, dentist, etc.) approach to the development of a health care system that the U.S. can afford and live with.	17	6	560	2
9. Eliminate solo practice.				
10. Health care monitoring (cost and quality) standards should be set by groups such as: MGMA, AGPA with input by third-parties (government, insurance, etc.) federal input limited to this only.	29	4	343	9
11. Development of harmonious balance between acute and preventive ambulatory care.				
12. Malpractice costs be a shared community and professional responsibility with use of appropriate peer review and ethics committees.	6		20	
13. Greater use of and subsidization for group practice facilities and personnel in the education of MDs, non-MD professionals, and paramedical personnel.	8			
14. High capability to triage the sick, the well, and the worried-well	4		--	
15. Top administrator of regional health center should be an MD with specialty training in administration.	14	8	380	7
16. Mandatory, binding arbitration for all liability, profassional and otherwise.	15	7	344	8
17. Set up more post-graduate schools and encourage use of same to train MD administrators.				
18. Develop a flexible capitation system capable of full prepayment but adaptable to divergent cost coverages.	9			

TABLE C-6 (CONTINUED--2 OF 3)

QUESTION #2 (Continued)	First Round -Ranking- Total	First Round -Ranking- Rank	Second Round -Rating- Total	Second Round -Rating- Rank
19. Pluralistic methods of prepayment be allowed to continue (capitation based on quasi-fee-for-service or fee-for-service).	6			
20. Continuance of development of third-party payment for appropriate out-patient procedures.	1			
21. Develop national mandatory National Health Insurance, premiums to be funded by private, industrial fringe benefits, and federal funds for aged and indigent.	23	5	405	6
22. Mimimun of government intervention at all levels (federal, state, local).	13	9	45	
23. Comfortable MD income and retirement benefits, based on periodic group peer review.	9			
24. Medical education and training organized so that generalists are "captains" of care and specialists are consultants.	10			
25. Guaranteed reimbursement for all legitimate services regardless of where or by whom rendered.	4			
26. Greater effort in education of lay public in the preservation of their health and the cost of medical care, with its limitations.	4			
27. Create independent government agency with all executive staffing by personnel with identified clinical, planning, and administrative capabilities.	3			
28. Hospital based group practice where feasible. (MDs not hospital employees)	5			
29. All clinics should provide on an extensive scale, patient education, provided by health education specialists funded by all third party carriers.	7			
30. Continued development of paramedical system, acceptable to the provider and the consumer, and controlled.	6			
31. Develop an independent, non-federal organization, consisting of research, academic, and practicing health professionals, to establish the proper balance in energy expenditure in research and clinical medical education.				
32. Preservation of traditional lines of referral, without interferrance by arbitrary or geographic boundaries.	9			
33. Primary role of medical schools is basic science education, with all clinical training in regional health systems.	4			
34. Clinical education provided by groups should be adequately reimbursed.				
35. Institute into the medical school curriculum instruction and experience in health care administration, so that all MDs have some knowledge and interest in this area.	6			
36. Develop a rural health strategy based on groups integrated from primary through tertiary care levels.	5			
37. Adequate education and training of both MDs and laymen in group practice administration.	2			

TABLE C-6 (CONTINUED--3 OF 3)

QUESTION #2 (Continued)

	First Round -Ranking- Total	First Round -Ranking- Rank	Second Round -Rating- Total	Second Round -Rating- Rank
38. Much more attention will be paid to transportation of patients to regional health facilities, rather than establishing numerous small clinics.	7			
39. Return to a system that accepts the most qualified individuals rather than "filling" medical schools.	3			
40. Developing a comprehensive, viable medical communications system, providing the modalities of literature review and continuing education for the practicing health professional.	13	9	524	4
41. Physical facilities planning to be strongly influenced by knowledgeable experienced MDs.				
42. Consolidate quality assurance along due care lines, cutting down on fragmented surveys.	6			
43. Encourage (mandate) greater (majority) MD participation of development of a practical health delivery system.	7			
44. Eliminate medical school tuition and base admissions only on capabilities for excellence.				
45. Sophistication in data processing in the business office and in appropriate clinic activities.	3			
46. MDs in top management will have 40 hour weeks, and at least six weeks of annual time off, with a minimum of two of these weeks spent on education.				
47. Self-care facilities established at all hospital based group practices, for continuing patient care, rehabilitation, and education.	3			
48. Create periodic sabbaticals without financial penalties, to prevent medical professional stagnation.				
49. Group managers will have nationally standardized prerequisite college training programs, degrees, and internship requirements and will be compensated on level with MDs.	10			
50. Greater integration and cooperation between MDs and lay administrators, both of whom are well-trained.	12	10	279	
51. National licensure of all MDs.	4			

TABLE C-7

COMPARISON OF PRESCENARIO WITH POSTSCENARIO AVERAGE PERSONAL INVOLVEMENT FOR EACH OF THE THREE SCENARIOS BY KATZ AND KAHN SUBSYSTEM (COLUMN 3 OF STANDARD LIST)

Subsystem	Prescenario			Postscenario			Difference		
	1	2	3	1	2	3	1	2	3
1. Maintenance	3.74	3.79	3.40	3.63	3.63	3.56	-.11	-.16	.16
2. Boundary/Production Supportive--Procurement	4.15	4.00	4.28	3.86	4.15	3.92	-.29	.15	-.36
3. Boundary/Production Supportive--Disposal	3.49	3.53	3.47	3.53	3.57	3.38	.04	.04	-.09
4. Boundary/Institutional Supportive	3.73	3.90	2.83	3.50	3.87	3.67	-.23	-.03	.84
5. Adaptive	3.86	4.23	3.74	4.15	3.90	3.63	.29	-.33	-.11
6. Managerial	3.70	3.83	3.53	3.61	3.72	3.61	-.11	-.11	.08
Total	3.75	3.84	3.56	3.68	3.75	3.62	-.07	-.09	.06

APPENDIX C-2

SCENARIO A

SCENARIO OF THE FUTURE OF HEALTH CARE

By 1985, the United States will have a federally sponsored national health insurance program. It will not be patterned after the British model; rather it will be solely a health insurance system, totally controlled and administered by the federal government. It will have evolved through two different stages, having begun with a catastrophic insurance program, but ultimately having reached the point of including comprehensive health insurance coverage for all Americans.

While the government will not control health care, as it might under a national health service, its control will be extensive. Instead of a totally controlled system, the approach taken in the U.S. will consist in centralization through planning boards. These planning boards/health service agencies will be responsible within each region for approving not only health care facility expansion and equipment addition, but also the specialty and geographic distribution of physicians. Quality of care will also be supervised through extensions of the Professional Standards Review Organizations. In other words, government intervention in terms of costs, quality, and services will be substantial but it will continue to be of the current multi-focal type. No single office or agency will be solely responsible for regulating health care delivery in the U.S.

The advent of this comprehensive national health insurance program will not, however, radically alter the predominant payment modes. A significant portion of the health care sector will continue to be reimbursed on a fee-for-service basis, even though the extent of prepayment will increase.

Along with the movement toward a national health insurance program, collective action by consumers will be increasing. This participation will initially take the form of political action, but by 1985 consumers will compose the majority of the regional planning boards/health service agencies. Their decisions will significantly influence not only facilities and services, but also physician distribution.

As part of this same movement toward collective action on the part of those feeling overwhelmed by the health care delivery system, unions of physicians and non-physicians employees, respectively, will form and become influential forces. While the unions in the health field will be few, large and powerful, physicians and non-physicians will be separate.

For economic reasons and through regulatory incentives, more physicians will become associated with medical group practices. These groups will increase both in numbers and in size with ultimately more than 50% of practicing physicians in groups. These groups will not only be hospital based but also affiliated, i.e., under the same management as the hospital. The rapid increase in size and numbers of groups, as well as the different organization bases, will contribute to great internal pressures and demands for highly skilled administrators. One unfortunate consequence of this rapid expansion will be the accompanying failure of overstressed or underexperienced groups.

SCENARIO B

SCENARIO OF THE FUTURE OF HEALTH CARE

By 1985, the United States will have a federally sponsored national health insurance program. It will not be patterned after the British model; rather it will be solely a health insurance system. This insurance program will be jointly administered through the federal government and private insurors as is currently the case with Medicare. This national health insurance program will evolve in two stages, beginning with catastrophic insurance, but culminating in comprehensive health insurance coverage for all Americans.

It is important to emphasize that this insurance program will not be accompanied by increases in control over the distribution of physician manpower, services and facilities in health care. The only significant intervention will be federal supervision of the evaluation of the quality of care.

Health planning boards will exist, but their control will be accomplished through cost and quality monitoring. The end result of this two-pronged federal supervision will be to establish health care as a public utility with the appropriate regulatory mechanisms.

The advent of a comprehensive national health insurance program and public utility approach to regulation will not, however, radically alter the predominant payment modes. A significant portion of the health care sector will continue to be financed through fee-for-service, even though the extent of prepayment will increase.

Along with the movement toward national health insurance, collective action by health consumers will increase. Their participation in clinic medicine will however, be limited to occupying positions on voluntary advisory boards to group practices.

As part of this same movement toward collective action, unions of non-physician employees in group practice settings will become [illegible] influential. With physicians able to maintain a sense of autonomy through group practice, there will be no great increase in the unionization of physicians.

Predominantly for economic reasons, more physicians will become associated with medical groups. Group practices will increase both in numbers and size, but they will not include all or even a significant majority of physicians. These groups may be located at or near hospitals but they will not be affiliated with or controlled by hospitals. This orderly growth in group practice will lead to more successful groups and stability in the clinic field with modestly increased demands on the skills of administrators.

SCENARIO C

SCENARIO OF THE FUTURE OF HEALTH CARE

By 1985, the United States will have a federally sponsored national health insurance program. It will be patterned after the British system, that is it will be a total system, a national health service, not just an insurance program. This system will evolve in stages beginning with a catastrophic national health insurance program, but ultimately embracing comprehensive health care under one system and for all Americans.

The advent of this comprehensive national health service will not, however, radically alter the predominant payment modes. A significant portion of the health care sector will continue to be reimbursed on a fee-for-service basis, even though the extent of prepayment will increase.

Along with the movement toward a national health service, collective action by consumers will be increasing. Their participation will initially take the form of political action, but by 1985 consumers will compose the majority of the local community health decision making boards mandated under the legislation establishing this country's national health service.

As part of this same movement toward increased collective action, there will be attempts to unionize both physicians and non-physician employees in group practices. However, these unionization attempts will be running counter to the federal thrust of essentially nationalizing health services. The struggle will be exceedingly intense, but unresolved by 1985.

Physicians, by federal mandate, will become associated with medical groups. Group practices, as part of the federally established national health service, will include all practicing physicians. These group practices will, in turn, be part of regionally organized health care delivery systems under federal control. This rapid and involuntary increase in size and numbers of groups will result in great internal pressures and demands for highly skilled administrators.

APPENDIX D

Annotated Data Tables

The annotated data tables consist of all the data compiled for this final report. These data are organized in a supplementary document, and the supplement's contents are presented in this appendix.

These tables of annotated data may be ordered from the Center for Research in Ambulatory Helath Care Administration, 4101 East Louisiana Avenue, Denver, Colorado, 80222. With your order, please specify the table number of the table which you desire. There will be a slight charge for reproduction and handling costs.

Annotated Data Tables