Chapter 19

ROLE OF THE CLINIC OFFICER-IN-CHARGE

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Introduction

This chapter discusses the job duties and responsibilities of a clinic officer-in-charge (OIC). Although each clinic OIC's exact duties and responsibilities will vary depending on the specific type and location of the clinic, there are certain standard functions of all OIC positions. Since most OIC positions are in primary care clinics, a section in this chapter is dedicated to the Army Medical Home (AMH) model, which encompasses some specifics of the Patient-Centered Medical Home (PCMH) and Soldier-Centered Medical Home (SCMH) models. These three models make up the Army's primary care system.[1] Taking a position as a clinic OIC is a challenging yet rewarding experience. For physician assistants (PAs), it provides an opportunity to expand their knowledge of the business of medicine, which is vital in both military and civilian health care systems. At the end of the chapter is a list of helpful resources.

Duties and Responsibilities

Army PAs selected as clinic OICs are responsible for the overall oversight and management of their assigned clinic. This oversight includes budgetary and personnel management, as well as ensuring clinic compliance with all clinic accreditation requirements. Fiscal duties involve overseeing the non-salary budget and ensuring that the clinic achieves productivity and receives maximum financial reimbursement. Personnel management duties include, but are not limited to, hiring actions, awards, counseling, evaluations, professional development, and disciplinary actions for both civilian and military personnel. The local troop command retains

the Uniform Code of Military Justice and administrative authority over active duty staff. The management of civilian staff may be new to many PAs and involves working closely with the Labor/Management Employee Relations (L/MER) office and employee unions.

The OIC also oversees customer and patient services, strategic planning, business practices, and process improvement. The OIC is responsible for safety and compliance with requirements of the Joint Commission (a national organization that accredits more than 20,000 health care organizations and is considered a condition of licensure by the majority of state governments) and the Health Insurance Portability and Accountability Act (HIPAA). OICs must also update clinic standard operating procedures annually and develop appropriate memoranda of understanding between the local military medical treatment facility (MTF) and other units that work with the clinic. Also, the OICs are responsible for providing medical care to their assigned panel of patients.

Requirements

To serve in this position, a PA must:

- have experience as a PA and Army Medical Department officer,
- hold the rank of captain, major, or lieutenant colonel, and
- be a graduate of Intermediate Level Education or Captain's Career Course (recommended),
- be credentialed and privileged in the clinic they work in, and
- have access to and proficiency in the systems used in the clinic, such as Medical Protection System (MEDPROS), Automated Time and Assistance Production System (ATAAPS), Defense Medical Human Resource internet (DMHRSi), and the Armed Forces Health Longitudinal Technology Application (AHLTA)/Genesis, as well as additional systems required for a joint service clinic.

Desired Skills and Attributes

The following attributes are helpful:

- diverse operational experience including deployment experience, preferably in multiple roles of care;
- strong work ethic;

- ability to work well with both military and civilian organizations;
- interest in medical administration processes;
- excellent customer service skills;
- solid written and verbal communication skills;
- excellent rapport with the leadership of both the MTF and the supported unit; and
- the ability to balance the demands of multiple mission requirements while ensuring the staff are taken care of.

Training

Because PAs typically spend most of their company-grade (ranks of the second lieutenant to captain) time with Army units outside of MTFs, previous MTF experience, along with a period working with the outgoing OIC, is essential during the initial transition phase. Additional recommended training is listed below.

- **Basic Healthcare Administration Course**. This was a 1-week course that provided an introduction to the administrative side of health care, offering basic knowledge about data quality and productivity metrics for a better understanding of the medical business model and improved communication with administrators. As of publication, the Defense Health Agency (DHA), now owner of the Military Health System and the AMH model, will identify a course for defining levels of performance. For additional information, individuals should contact their respective regional health centers on the status of this course or its equivalent (Regional Health Command/Atlantic, Regional Health Command/Europe, Regional Health Command/Pacific, or Regional Health Command/Central).
- **Supervisor Development Course**. This course is essential in learning the requirements for managing civilian employees. It must be completed by all newly appointed supervisors within 1 year of appointment to the supervisory position. It is available through the Army Training Requirements and Resources System (ATRRS) online.[2]
- **Patient-Centered Medical Home Training**. This training provides students a good understanding of the PCMH/SCMH model, which is necessary to ensure the clinic meets all National Committee for Quality Assurance (NCQA) requirements.

- **Team Strategies and Tools to Enhance Performance and Patient Safety** (TeamSTEPPS; Health Research & Educational Trust, American Hospital Association). This system is the foundation for communication within the medical home.[3]
- **Lean Six Sigma**. This optional training is a continuous process improvement certification program used throughout the Army. Knowledge in this area will help in developing clinic process improvement plans.[4]
- **Army Medical Department Executive Skills Course**. This optional course is designed to prepare new and projected deputy commanders, command sergeants major, and other Army Medical Department leaders for executive medical positions within MEDCOM.[5] The course is part of the Joint Medical Executive Skills Program and focuses on teaching management and executive leadership skills.[6]

Key Facts

This position is typically a 2- to 3-year tour and is considered a broadening assignment, usually coded as an 05A (Army Medical Department immaterial officer) or 61H (Medical Corps officer in Family Medicine) position with no other additional skill identifier requirements. The exact position of the 65D PA within the organization varies depending on rank, the PA's experience, and openings available; however, it usually falls under the chief of the Department of Family Medicine or whichever department the clinic falls under. This is a leadership position and is primarily nonclinical, but the clinic OIC must maintain National Commission on Certification of Physician Assistant certification and MTF credentials, and perform the required patient workload or FTE requirements (which may vary but usually range between 0.25 and 0.7 FTE).

The rater is frequently the primary care chief, and the senior rater is the deputy commander for clinical services (DCCS), but this can vary from facility to facility. Alternatively, the OIC may be rated by the DCCS and senior-rated by the hospital commander. While the position is frequently a Medical Department activity position, some models operate under a memorandum of understanding (MOU) with the Forces Command (FORSCOM) unit providing the OIC.

Under this model, the rater is typically the unit executive officer, the intermediate rater is the primary care chief, and the senior rater is the unit commander.

The Army Medical Home Model

The SCMH, PCMH, and Community-Based Medical Home (CBMH) have been combined to make up the AMH. The use of the term AMH is designed to spread parity across the health care system and limit any perceived difference between the SCMH, PCMH, and CBMH. The implementation of the AMH is a top priority for DHA; if a clinic is not already an AMH, it is in the transition process of becoming one.[1]

The overall goal of an AMH is to "deliver care using the whole-person concept, coordinating and integrating evidence-based primary, specialty and wellness/preventive care in a comprehensive care plan process to customize care to the unique needs of each patient."[1] Health care is coordinated across the entire spectrum of care, including acute care, chronic care, preventive services, and care received outside of the facility. Doing this efficiently and effectively requires team organization and the understanding that it is a team effort. Each team member plays an integral and essential role in providing patient-centered health care.[3]

The AMH leadership team consists of the clinic OIC, medical director, practice manager/administrator, clinical nurse OIC, and clinic noncommissioned officer-in-charge (NCOIC). The leadership team deals with the day-to-day activities of running the AMH, ensuring that high-quality, evidence-based, friendly, and efficient patient care is provided at all times. The clinic OIC has overall responsibility for the supervision and management of the clinic. If the clinic OIC is a PA, there will also be a medical director, within either the clinic or the department, who is the senior clinical expert.[3]

The AMH is a business. It involves specific metrics that are reported to DHA through the accountable care organization (the MTF)[3] and the regional health command. The OIC serves as the commander's expert on the requirements for setting up an AMH and using the Healthcare Effectiveness Data and Information Set (HEDIS)—health care performance metrics used to determine and improve the overall health of the clinic's beneficiaries.[3,7] It is crucial that the OIC be well educated on the metrics and requirements of the NCQA.[8]

Tips for Success

These are the tips for success for the clinic OIC:

- Data quality and productivity measures are a crucial part of the job and are used to evaluate the success of the clinic. Coding is part of the data quality/productivity metrics used to assess the clinic's ability to be productive and adequately resourced.
- It is vital to have an excellent working knowledge of these data and ensure the clinic complies. The OIC must understand coding, apply it, and be able to articulate to subordinates and peers why it is vital to complete it correctly.
- The OIC should have monthly meetings with the division, corps, or senior command surgeon to optimize the use of division and corps assets (providers and medics) in the clinic. OICs should develop MOUs and installation support plans with the senior mission commander for the installation, which will help ensure that the AMH is primarily staffed with organic FORSCOM medical assets along with additional MEDCOM support. Having these documents in place and a good working relationship between MEDCOM and FORSCOM units is necessary for clinic success.
- Several operational order requirements involve having a specific number of specialties in the clinic. Specialties such as PharmD (Doctor of Pharmacy), registered dietician, physical therapist, behavioral health care provider, nurse case managers, public health nurse, and medical support assistant/administrative support will enhance the efficiency of the clinic.[3]
- The AMH model dictates a 3:1 ratio of support staff per provider, which is extremely important to ensure the proper flow of patients. This team includes licensed practical nurses, screening medics, team registered nurses, and medical support assistants.
- The MTF has a signed collective bargaining agreement with the employee union. It is essential to have a good working relationship with the L/MER specialist (an advisor to management in dealing with bargaining union employees concerning conditions of employment and personnel actions).[8] A good relationship will allow the organization to run smoothly, and buy-in from the union will make temporary changes easier.

- Stakeholder meetings with the active duty units supported by the clinic, including representatives from the unit family readiness group, will improve the working relationship between the clinic and patients and provide valuable feedback for clinic improvement. It is better to be proactive and meet beneficiaries outside of the clinic, where information on policies and procedures can be provided, than to meet them in the clinic after they have had a problem navigating the system or have filed a complaint.
- The OIC should handle patient concerns and complaints directly and quickly. They should develop an understanding of which concerns or complaints need their attention and which can be delegated to the medical director, administrator, or patient representative. Remember, there are three sides to every story (patient, staff, and correct). The effect of an OIC or key clinic leader speaking directly to a concerned patient, in person or via telephone, should not be underestimated.
- The OIC must have an understanding of the jobs and requirements of the administrator, clinic NCOIC, and medical director. OICs should not micromanage the staff, but should do spot checks and hold leadership accountable.
- The clinic will not run successfully if the OIC is behind the computer all day. It is imperative to walk through the clinic and engage staff and patients regularly. The OIC should also attend morning staff or team huddles and conduct routine checks to ensure standards are being met. Random visits should be made to the clinic during all hours of operation (morning sick call, regular duty hours, and evening clinics) to ensure standards are being met throughout the day.

Lessons Learned

These are lessons learned for the clinic OIC:

- Understanding the needs of the hospital and the supported units is critical for the OIC. If there is a robust training schedule for the supported units, the providers may not be available to meet all DHA metrics, and demand may vary based on training cycles.
- If several units fall under the clinic for support, the OIC should discuss and review the training calendars with unit providers. Anticipating absences well in advance will help reduce facility cancellations and allow time to adjust staffing.

- The OIC should attend required training as early into the tour as possible. The needs and rules of clinics are frequently interpreted because "it's the way we do it here." Learning the right way early will reduce these instances and improve the outcome when the Joint Commission visits.
- Leadership should be engaged early when problems arise. Some changes take several months to implement within the facilities, so the sooner leadership buys in, the more successful the OIC will be.
- The OIC should read and understand the installation health services plan and MOUs with any unit that falls within the clinic's footprint.
- The OIC, or a designated representative, should ensure that everyone working in the clinic knows how to input their DMHRSi timecards upon arrival to the clinic. Improper timecard entry may result in the loss of staff and support in the future.
- If the local hospital or clinic has established referral guidelines, the OIC should make sure new providers know how to find them. This will decrease unnecessary referrals and help maintain access for specialty providers.
- Documentation is still one of the most important things an OIC can do, even for civilian employees. Documenting good and poor performance will help everyone.

Conclusion

The clinic OIC position is an excellent opportunity for PAs to gain clinic leadership experience and implement changes that can transform the Military Health System, while learning the business of medicine. It is a challenging and rewarding position that is not afforded to all PAs. The OIC PA will learn the importance of supervising and rating civilian employees, coordinating with other departments in the facility, and balancing the demands of multiple entities within the footprint. Once the tour is complete, the PA will have a much greater knowledge of the role of the Military Health System and its impact on the medical readiness of Army soldiers and the PA profession.

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Helpful Resources

- Standards and guidelines for the National Commission on Quality Assurance's Patient-Centered Medical Home (2014). Accessed June 15, 2020. http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx

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