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The TO&E Hospital as a Baylor Residency Site

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Abstract

The 1999-2000 Baylor Health Care Administrative Residency at the 21st Combat Support Hospital (CSH) marked the first time a resident served at a deployable Army hospital versus a fixed, non deployable hospital. This historic residency provided an opportunity for the resident to explore, and evaluate the learning opportunities available at a Table of Equipment (TO&E) hospital. The purpose of this graduate management project was to determine if the TO&E hospital is an appropriate residency site for Baylor Health Care Administrative residents. Using the six residency objectives and the eight Joint Medical Executive Competency groupings as a template for an appropriate residency site, the author used examples from the residency year to demonstrate that the TO&E hospital is an appropriate residency site, as the 21st CSH enabled the resident to meet all six residency objectives and develop joint medical executive skills from each of the eight competency groupings. The Bosnia deployment served as an added benefit to the residency year. Like other residency sites, the TO&E hospital has its strengths and weaknesses. Who and what type of student is best suited for the TO&E hospital residency is dependent upon the individual interests and learning needs of the student, and is not limited to students of certain rank or background. A challenge for the TO&E residency site is the consistent availability of qualified preceptors. The author concludes that the TO&E hospital is a valuable asset to the Baylor Health Care Administration program and should remain as a residency site because it broadens the available learning opportunities for students and produces an officer with a better understanding of the full spectrum of military medicine, from combat health support to fixed facility health care and hospitalization.

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Introduction

Conditions that Prompted the Study

The 1999-2000 Baylor Health Care Administrative Residency at the 21st Combat Support Hospital marked the first time a resident served at a deployable Army “field” hospital (referred to as a Table of Organization and Equipment (TO&E) hospital) versus a fixed facility, “brick and mortar” hospital (referred to as a Table of Distribution and Allowances (TDA) hospital). This historic residency provided an opportunity for the resident to explore, participate in, and evaluate the learning opportunities available at a TO&E hospital.

Statement of the Question

Is the Army TO&E hospital an appropriate residency site for Baylor health care administrative residents – why or why not, and who is best suited/least suited for this type of residency?

Literature Review

“Improving health management for the future will require a thoughtful analysis of the field and a thorough reassessment and redesign of health management education” (Richardson & Schneller, 1998, p. 88).

With the tremendous advances and changes in the health care industry over the last twenty years (medical and information technology, health care financing, population health needs) health care policy makers, administrators, and educators have recognized the need to take action to ensure the nation’s health care executives are adequately trained to function in the present and future health care arena (Richardson & Schneller, 1998). The first step towards ensuring appropriate training for health care executives has been “a thoughtful analysis of the field”

(Richardson & Schneller, 1998, p. 88) via the initiation of needs assessments of the health care administration profession.

A needs assessment, the first step in the systems approach to designing instruction (Dick & Carey, 1990) identifies the skills, knowledge, and abilities (SKAs) that an organization or profession requires its members to perform/possess. The needs assessment answers the questions, who is the target audience, what should the instruction accomplish, and what does competent performance look like. Conducted prior to committing resources to the design and development of educational curricula and programs, the needs assessment can take several forms, for example, surveys, focus group interviews, and direct observation (Mager, 1988).

A review of the literature reveals a variety of attempts to identify the specific SKAs required of health care administrators, both in the private sector, as well as in the military health system. The most frequently reported technique for assessing the professional needs of health care administrators is the Delphi study. The Delphi study “used to determine, predict and explore group attitudes, needs, and priorities....is seen as a way to obtain the most reliable consensus of opinion of a group of experts, by a series of intensive questionnaires interspersed with controlled feedback” (Rogers, Finstuen, Mangelsdorff, & Snyder 1999, p. 2). Other techniques described in the literature include survey research (Roberts, Crawford, & Orloff, 1993; Rubenstein, 2000), subject matter expert (SME) interviews and writings (Dolan, 1998; Richardson & Schneller, 1998), and SME working groups (Claypool, Baker, Jacoby, Kiley, McCarthy, Tibbits, & Watkins, 1998). This literature review will provide an overview of the findings from these four types of needs assessments.

Delphi Studies.

Hudak, Brooke, Finstuen, and Riley (1993) conducted a study of Fellows of the American College of Healthcare Executives (ACHE), from across the 50 United States, in order to obtain a consensus of opinion from senior health care executives regarding critical issues for health care organizations through the year 2000. The research team also sought consensus regarding the SKAs for successful health care executive performance. Using a Delphi design, the study identified nine health care administration domains in which health care executives would have to function through the end of the century. These domains from most important to least important are: (1) cost/finance, (2) leadership characteristics, (3) professional staff interaction, (4) health care delivery concepts, (5) accessibility to care, (6) ethics, (7) quality and risk management, (8) technology, and (9) marketing. The ACHE Fellows then identified the most important SKAs for each domain, as well as the most important SKAs across the nine domains. While the “within” domain SKAs generally reflected major issues specific to that domain, the “across” domain SKAs centered on interpersonal skills that enable the health care executive to relate to all areas of the hospital, to include the medical and hospital staffs and the board. From the results of their study Hudak et al. (1993) suggested that health care executives should strive to improve their leadership abilities and interaction skills in dealing with the professional staff, and focus their personal training within a number of complementary areas, such as communication and listening skills, conflict management, team building, leadership, and futurist training.

Hudak, Brooke, and Finstuen conducted a similar Delphi study in 1994, this time asking the commanders and deputy commanders for administration (DCAs) from 37 Army medical treatment facilities for the most important issues challenging their institutions, and the SKAs required to master these challenges. As with their earlier study, Hudak et al. identified nine

health care administration domains, but the domains identified in this study of Army hospital commanders and DCAs differed slightly from the domains identified in the study of Fellows of the ACHE. In order of importance, the domains creating challenges for Army hospital commanders and DCAs are: (1) cost/finance, (2) health care delivery, (3) access to care, (4) quality and risk management, (5) technology, (6) professional staff relations, (7) leadership, (8) marketing, and (9) ethics. Although cost/finance was ranked highest, and marketing among the least important domains in both studies, Army health care executives considered health care delivery, access to care, and quality-risk management as more important, and professional staff relations and leadership as less important issues for the future than their civilian counterparts. Hudak et al. suggested these differences are secondary to “real differences in environmental structure and organizational dynamics” (Hudak et al., 1994, p.499) between private sector health care and the military health care system. With respect to SKAs required to meet future challenges, Army medical leaders identified the need for improved understanding of managed care, contracting quantitative decision-making, information systems, and like their civilian counterparts, interpersonal skills.

In 1998, Sentell and Finstuen conducted a Delphi study with top Naval hospital executives (current commanding officers, executive officers, and directors for administration) to determine the most critical domains in Navy health care administration, and the SKAs required of health care executives to ensure success of Navy medicine as it enters the 21st century. As in the previous two studies, the researchers identified nine health care domains. In rank order of importance these domains are: (a) leadership, (b) health care delivery systems, (c) cost/finance, (d) technology, (e) accessibility, (f) professional staff relations, (g) marketing, (h) quality/risk management, and (i) ethics. Navy health care administrators rated interpersonal skills (people

skills, team building, personal responsibility, and communication skills) as the most important SKAs for the future. Least important SKAs for the future included quality/risk management skills (process action team management, epidemiology), cost/finance skills (prime vendor knowledge, procurement regulations, general accounting, grant writing), health care service skills (integration of GME, home health care delivery) and leadership skills (MHA/MBA degree, interpreting laws and regulations).

From their work with Navy medical executives, Sentell and Finstuen concluded that the continued reductions in available resources coupled with a constant demand for services necessitates that future Navy medical executives possess financial, quantitative and general managerial skills, as well as technical skills related to managed care organization administration and information systems. Additionally, they emphasized “that interpersonal and leadership skill development will be crucial in the complex medical delivery systems of the future. A blend of specialized and generalized skills will ensure successful leadership in the future” (Sentell & Finstuen, 1998, p. 7).

In 1999, Rogers, Finstuen, Mangelsdorff, and Snyder conducted a Delphi study of Coast Guard health care administrators and the commanding officers of units with large medical facilities, to identify the most important domains in Coast Guard health care administration and to delineate the SKAs required for future success in the Coast Guard health care system. Rogers et al. identified fifteen important health care administration domains: (a) managed care, (b) cost/finance, (c) personnel, (d) technology, (e) leadership, (f) education, (g) business, (h) strategic management, (i) quality, (j) healthcare delivery, (k) readiness, (l) access, (m) professional staff relations, (n) marketing, and (o) ethics. In addition to these domains, they also identified the most important and least important SKAs. Of the top ten SKAs, 36%

represented leadership skills (written/verbal communication, listening skills, conflict management), 27% represented managed care skills (medical care requirements, knowledge of TRICARE, customer relations skills) and 18% represented readiness skills (active duty medical standards, operational mission support). Cost/finance and professional staff relation skills accounted for the remainder of the top ten SKAs. Of the ten least important SKAs, 27% represented marketing skills (identifying competition), 27% represented managed care skills (contracting, knowledge of federal and state requirements, processing health claims), and the remaining 46% represented skills from the personnel, quality, education and business domains.

Like their Army and Navy counterparts, Coast Guard health care administrators and commanders rated interpersonal skills as being important for success in the future health care environment. Unlike the Army and Navy, Coast Guard administrators and commanders identified six additional health care domains of concern for the future. These include managed care, personnel, education, business, strategic management, and readiness. Rogers et al. (1999) believe these differences are related to the fact that the Coast Guard functions on a smaller scale than the Army and Navy, does not operate inpatient treatment facilities, and is structured and staffed differently than Department of Defense medical systems. Rogers et al. (1999) concluded that Coast Guard health care administrators and commanders have a different perspective on future health care issues and skills required of its executives because the Coast Guard is fundamentally different from its sister uniformed services.

Having first investigated health care administrator needs in traditional health care settings, Hudak, Brooke, Finstuen, and Trounson (1997) later turned their attention to the ambulatory health care setting. Hudak et al. conducted a Delphi study of 320 Fellows of the American College of Medical Practice Executives in order to “obtain a consensus of opinion from a large

and diverse population of experienced ambulatory health care administrators regarding the essential ambulatory health care management competencies, and their related skill, knowledge and abilities (SKA) requirements, that will be required for successful management performance in ambulatory health care delivery settings in the next five years” (Hudak, Brooke, Finstuen, & Trounson, 1997, p.219). The researchers organized the competencies and their related SKAs into six ambulatory health care management domains: (a) leadership/strategic management, (b) relationship management, (c) resource management, (d) functional management, (e) stakeholder management, (f) and patient care management. The Fellows “rated leadership and strategic management as the most important Management Domain. The highest ranked SKA emphasized interpersonal skills with next highest SKA relating to ethical and moral dimensions. Patient care management, as well as two SKAs relating to computer skills, were rated lowest” (Hudak et al., 1997, p.219). To prepare ambulatory health care administrators for future challenges, Hudak et al. suggested that graduate schools provide a “solid foundation in integrative and communicative skills, as well as functional and qualitative competencies.” (Hudak et al., 1997, p. 236). In addition to these suggestions for training, Hudak et al. recommended future research to identify competencies required at different stages throughout the career life cycle of ambulatory health care administrators.

Survey Research.

Since 1988, Rubenstein has conducted a biennial survey of Army Hospital Deputy Commanders for Administration (DCAs) to determine “how the wide-ranging duties of the Army hospital administrator impacted on his or her perceived roles” (Rubenstein, 2000, p. 25). Over the last twelve years, DCAs have consistently seen themselves “as leaders and entrepreneurs of their hospitals, though they would like to be better entrepreneurs. They spend most of their time

as disturbance handler and resource allocator. Their greatest satisfaction comes from being leaders and entrepreneurs while their least satisfaction comes from having to be a disturbance handler” (Rubenstein, 2000, p. 27).

Despite these consistencies, DCAs have noted a change in the most critical roles required of hospital administrators. In 1988, Army DCAs believed that resource allocation and disturbance handler skills were most critical to their survival. By 1999, DCAs described leadership and negotiator skills as most critical, yet reported that their education least prepared them to perform as negotiators (a critical skill) and entrepreneurs (a skill DCAs most wanted to improve). Rubenstein’s findings suggest the need for continuing education of present Army health care executives, especially in the areas of negotiation and entrepreneurial skills, and raise questions as to how the U.S. Army-Baylor University Graduate Program in Health Care Administration might use the results of the biennial survey to “refine or refocus the curriculum of the program” (Rubenstein, 2000, p. 31).

Turning from the Army to the Navy, in the early 1990’s, leaders within Navy medicine recognized a need to “expand and fine tune” (Roberts, Crawford, & Orloff, 1993, p. 19) the leadership skills, managerial skills, and expertise of Navy health care executives. This led to a partnership between the Navy Bureau of Medicine and Surgery and the Naval Post Graduate School for the purpose of developing an Executive Management Education Program. The first order of business for this partnership was to identify the SKAs unique to Navy medicine and to translate these SKAs into “education/skill requirements for current and prospective executives” (Roberts et al., 1993, p. 19). Using a survey questionnaire designed from interviews with Navy medical executives from across the United States, researchers surveyed 720 Navy Medical Department executives across all Corps, to include all commanding officers, executive officers,

directors, and all officers screened for commanding officer and executive officer positions. The objectives of the survey questionnaire, which addressed twenty-one different skill areas (Appendix A), were to: (a) assess perceived educational needs and managerial capabilities; (b) inventory previous management development and education; and (c) provide a database to guide the Executive Management Education program development.

Roberts et al. (1993) found that over half of the respondents reported all twenty-one skill areas as being highly important for the executive management of medical treatment facilities. Management of change/technology, conflict management, communications, and individual behavior were most frequently rated as highly important (90% or greater of survey respondents). The researchers found no significant effect of rank, corps, and job position on skill area ratings. Roberts et al. (1993) did note, however, that skills rated as most important for executive management of medical treatment facilities tended to be skills for which the commander “typically has no ‘in house’ expert or principal advisor” (p. 20), for example, management of change. Conversely, skills less frequently reported as highly important (financial management, information management, facilities management) tend to be areas for which the commander does have specific “in house” expertise, for example, chief financial officer or resource manager, information management officer, and facilities manager.

Over all, survey respondents reported knowledge gaps in all twenty-one skill areas, with information management, strategic planning, labor/management relations, and quality management representing those skills areas with the greatest gaps. Junior ranking officers reported greater knowledge gaps than more senior officers. Executive officers with less than twelve months on the job reported greater knowledge gaps than commanders, directors, or department heads. Medical Corps, Dental Corps, and Medical Service Corps officers reported

similar percentages of skill gaps, with the health care administrators of the Medical Service Corps reporting the smallest skill gaps. Nurse Corps officers reported more skill gaps than any other corps. Roberts et al. (1993) suggested that the larger skill gaps reported by Nurse Corps officers “is largely a function of the high skill requirements that nurses assign to each skill area since current skill levels are no lower among nurses than other groups” (p. 23).

Subject Matter Expert Interviews and Writings.

Richardson and Schneller (1998) conducted a series of interviews and focus group sessions with leading educators in health management, medicine, nursing, and with senior health managers from the public and private sectors in order to gain a “perspective of the current experience for health managers” (p. 90) and to identify needs for the future. The interviews and focus group sessions revealed that in addition to maintaining the basic skills of critical thinking and qualitative/quantitative problem solving, health managers need new managerial skill sets to keep pace with the changing health care environment. The subject matter experts (SMEs) included the following items in their recommendations for this new skill set: (a) collaborative and consensus-driven decision making, (b) strategic thinking vice strategic planning (c) knowledge of clinical care, especially primary care, (d) knowledge of the public health system and practices and (e) understanding of the relationship between health policy formulation and organizational success. Additionally, the SMEs recommended that educational programs include “pragmatic, on-site experiences” (p. 94), such as internships and fellowships, in order “to take the classroom into the real world and give students opportunities to apply their learning to real situations” (p. 94).

In his pursuit to identify what constitutes a good administrator, Katz (1974) proposes that effective administration rests on developing three basic, interrelated skills: technical, human, and conceptual, where technical skill is the ability to perform technical activities, human skill is the ability to understand and motivate individuals and groups, and conceptual skill is the ability to coordinate and integrate “all the activities and interests of the organization toward a common objective” (Katz, 1974, p. 5). These three skills vary in relative importance based on situational conditions and levels of responsibility of the administrator. Technical and human skills are most important at lower levels of administrative responsibility, and conceptual skills are most important at higher levels of administrative responsibility. Katz believes that administrators can develop required technical, human, and conceptual skills “through practice and through relating learning to one’s own personal experience and background” (Katz, 1974, p. 8). Finally, Katz recommends a variety of methods for developing requisite administrative skills, to include the use of: (a) case problems, (b) impromptu role playing, (c) coaching of subordinates by superiors, (d) special assignments involving interdepartmental problems, and (e) management boards, where junior executives serve as advisors to senior leadership on policy matters.

Similar in thought to Katz is Thomas Dolan, president and chief executive officer of the American College of Health Executives, who believes that the skills required for success in health care administration differ at each stage in a health care executive’s career. According to Dolan, early careerists require strong technical skills, but should also focus on developing interpersonal skills, such as working collaboratively with the clinical, as well as the administrative staffs. By mid career, interpersonal skills become increasingly more important in addition to broadening the professional knowledge base. For senior health care executives, leadership skills are crucial. Dolan also believes that senior health care executives must possess

a “comprehensive understanding of the organization’s internal operations as well as of the community the organization serves” (Dolan, 1998, p. 5). Unlike Katz, Dolan does not suggest any specific methods for developing the requisite skills for each career stage, but does recommend that health care executive seek continuing education and skill development, offering the ACHE as a resource to do so.

Subject Matter Expert Working Groups.

In 1996, the Army, Navy, and Air Force medical departments jointly collaborated on a project to identify the executive skills required of medical treatment facility commanders throughout the Department of Defense (DoD). To conduct the needs assessment, the service medical departments formed the Joint Medical Executive Skills Development Group (JMESDG) comprised of subject matter experts (SME) from all three services, current and former MTF commanders, curriculum developers, and service medical department points of contact. The JMESDG succeeded in identifying forty executive skills competencies, and listing specific behavioral objectives for each skill competency (Claypool et al., 1998). The JMESDG published their findings as the Joint Medical Executive Skills Development Program Core Curriculum, to be used by the service medical departments as a guide in the design and development of educational programs for health care executives.

Realizing that the core curriculum needed periodic updating, especially as the services became more involved with TRICARE, the JMESDG directed a working group of tri-service subject matter experts, commanders and former commanders, and a TRICARE lead agent representative to review and update the competencies. The Joint Medical Executive Skills Working Group revised the curriculum, to include current views on lead agency, TRICARE operations, and the current military health system, and then organized the forty executive skills

competencies into eight distinct competency groups (Appendix C). As in the first edition of the core curriculum, the working group identified the specific behaviors required of lead agents and military treatment facility commanders to demonstrate competency, but they went one step further. Recognizing that medical executives can't be, nor need to be, experts in all skills, the working group also assigned a specific level of knowledge required for each competency. The three levels of knowledge defined by the working group are familiarization, basic understanding, and full knowledge (Appendix D). The JMESDG published the revised curriculum in 1998 as the Joint Medical Executive Skills Development Program Core Curriculum, Second Edition (Claypool et al., 1998). Of note, the work of the JMESDG is distinguished from previous work cited in the literature because the Core Curriculum not only identifies required skills, but also the specific behaviors and level of knowledge required to demonstrate competency in that skill.

A common theme arises from this literature review: the need to adapt present health care administrator skills sets to meet the changing demands and complexities of the health care arena. Although many of the studies identified strong interpersonal skills as the most important skill set for health care administrators, the major issues (domains) facing health care administrators and the skills, knowledge, and abilities required to navigate these issues, are dependent upon the environment in which the health administrator works, for example, traditional hospital setting, versus ambulatory health clinic, versus military health system. Appendices E and F demonstrate this relationship. Appendix E provides a matrix illustrating the variety of issues facing health care administrators as identified by researcher and group studied, and Appendix F provides a listing of top rated SKAs required of health care administrators as identified by researcher and group studied.

The preponderance of the literature has focused on identifying the important domains that health care executives face in today's health care arena, and the specific skills, knowledge, and abilities required to navigate these domains. Unfortunately, very little information exists as to effective methods for training and developing these SKAs. Several experts have suggested hands on, practical experiences, such as internships, fellowships (Richardson & Schneller, 1998), case problems, role playing, and coaching (Katz, 1974), but there is no evidence in the literature that these methods are effective. Nor is there guidance as to who should the profession target for these skills development. For example, do health care administrators need all these skills prior to practicing, or is there a natural progression of skill development where administrators build on a basic set of skills as they advance? If there is a natural progression of skills development, what is the core set of skills needed by entry-level administrators, versus skills required of more senior administrators? The needs assessments of the health care administration profession have yet to answer these crucial questions.

Once the health care administration profession completes the needs assessment process, and identifies a core set of skills, as well as advanced skill sets, the profession must take the next step towards ensuring appropriate training for health care executives, "a thorough reassessment and redesign of health management education" (Richardson & Schneller, 1998, p. 88).

Purpose and Working Hypothesis

The purpose of this thesis is to explore and evaluate the learning opportunities of the TO&E residency to determine if a TO&E hospital is an appropriate residency site for Baylor Health Care Administrative Residents. An appropriate residency site is operationally defined as a location that provides an environment in which the resident has an opportunity to meet all

residency objectives (Appendix B), as well as develop medical executive skills from each of the eight Joint Medical Executive Competency groupings (Appendix C) in a supervised setting.

The working hypothesis is that the TO&E hospital is an appropriate residency site for Baylor Health Care Administrative Residents.

Thesis Statement

The TO&E hospital is an appropriate residency site for Baylor health care administrative residents because the TO&E hospital provides an environment in which the resident has an opportunity to meet all residency objectives, as well as develop medical executive skills from each of the eight Joint Medical Executive Competency groupings in a supervised setting.

Method and Procedures

Using the residency objectives and the eight Joint Medical Executive Competency groupings as a template, provide examples from the residency year to illustrate if and how the TO&E hospital residency enabled, or did not enable the resident to: (a) meet the stated residency objectives and (b) develop joint medical executive competencies from each of the eight Joint Medical Executive Competency groupings.

Results

The 21st Combat Support Hospital (CSH) provided an excellent mixture of learning experiences and opportunities for a resident to meet all six residency objectives and develop joint medical executive skills from each of the eight competency groupings. Starting with the six residency objectives (Appendix B), then the eight competency groupings (Appendix C), the results section contains examples from my residency experience illustrating how the TO&E hospital enabled/did not enable me to meet the residency objectives and develop joint medical executive competencies.

Residency Objectives

Objective 1

Apply the theories, concepts, and practices presented during the didactic phase in an operational setting.

The 21st CSH residency provided many opportunities to apply a variety of theories, concepts, and practices, presented during the didactic phase of the Baylor program, to real world situations. The most frequently applied theories, concepts, and practices came from the organizational behavior/theory (OB/OT) and human resource management portions of the Baylor curriculum, and included the use of communication skills, team building and group process skills, leadership and motivation skills, and conflict management skills. Examples of residency activities that enabled me to achieve this residency objective include: (a) receiving and integrating the professional filler system (PROFIS) health care providers into the 21st CSH prior to the Bosnia deployment; (b) building an effective medical task force from eight separate medical units, including units from the active Army component, Army National Guard, and allied nations; (c) building an effective task force staff; (d) facilitating the resolution of housing and space

utilization constraints; (e) supervising and facilitating the process of resizing the medical task force; (f) supervising and facilitating the planning, coordination, and execution of soldiers' redeployment to home station; and (g) facilitating the coordination and execution of the 21st CSH post deployment reintegration field training exercise.

Objective 2

Develop knowledge of the clinical and administrative elements of military and civilian health care institutions.

The 21st CSH residency provided superb opportunities to explore and participate in the entire spectrum of the tactical health care system, both in deployed and garrison environments. This resulted in a solid working knowledge of tactical medical units and medical command and control, and how they work together in an operational theater to create a coordinated, comprehensive health care system. Individual medical units explored include: the combat support hospital, combat stress control detachment, forward surgical team, preventive medicine detachment, medical logistics detachment, medical logistics battalion, ground and air evacuation companies, veterinarian detachment, dental detachment, and the battalion aid station. Medical command, control, and staff elements explored include the hospital/task force command team (commander and command sergeant major), the hospital/task force executive officer and primary staff (personnel, intelligence, operations, logistics, and communications), the hospital/task force ministry team, the medical group/brigade, the division surgeon, and the division medical operations center.

Because I entered the Baylor program with a strong background in the clinical and administrative elements of TDA military and civilian hospitals, I chose not to pursue rotations through Darnall Army Community Hospital, Fort Hood, Texas, or local civilian health facilities.

My personal learning needs and priorities were focused at the field health system level.

Therefore, I did not significantly further my understanding of civilian health care institutions during my residency year.

Residents requiring experience with TDA and civilian hospitals have a variety of external rotations from which to choose during the TO&E residency year. These external rotations include the TDA hospital at Fort Hood and its satellite clinics; and the civilian hospitals and health systems in the surrounding central Texas communities to include: (a) Metro Plex Health Systems in Killeen; (b) Scott and White Memorial Hospital, Temple, (c) Central Texas VA Medical Center, Temple, (d) King's Daughters Hospital, also in Temple, and (e) Cedar Crest Behavioral Health, in Belton.

Objective 3

Refine functional skills appropriate to middle level management positions in military health care settings.

The challenges and experiences of the 21st CSH residency provided opportunities to exercise and refine a wide variety of functional skills. Such functional skills include: (a) leadership, (b) written and verbal communication, (c) project management, (d) strategic planning, (e) budgeting, (f) team building, (g) conflict management, (h) the military decision making process, (i) the military staff process, (j) medical mission analysis, (k) coordinating and conducting command and staff meetings, (l) coordinating and conducting executive briefings, (m) cost benefit analysis studies, (n) health facilities planning and maintenance, (o) unit deployment and redeployment, (p) deployable medical equipment (DEPMEDS) utilization and maintenance, and (q) materiel management.

In my experience, of these functional skills, the 21st CSH residency provided the greatest opportunity to refine leadership skills. I entered the residency feeling comfortable with my leadership skills, having served in a number of clinical leadership positions and having attended various leadership development courses. The TO&E residency challenged me to stretch my leadership skills and to apply them to unfamiliar scenarios and circumstances. Serving as the TFME 6 executive officer presented the biggest leadership challenge requiring that I build an effective task force staff from the ground up, and facilitate the quick development of a cohesive task force from eight separate medical detachments. Working to reintegrate the 21st CSH following redeployment from Bosnia provided additional leadership opportunities and challenges that further helped me to polish my leadership style and skills. For example, during the planning phase of the reintegration exercise the CSH executive officer suddenly was unavailable secondary to a family illness. Taking the skills I learned and practiced in Bosnia I stepped into the acting executive officer role and facilitated the planning and execution of the reintegration exercise. This included working with the staff to resolve a last minute transportation problem for deploying vehicles and equipment, and providing a decision brief to the commander.

Objective 4

Gain needed additional experience in those areas identified by preceptors and faculty readers as requiring additional challenge and support.

Neither my preceptor nor my faculty reader identified specific health care administration areas in which I needed additional experience or exposure, rather, my preceptor ensured I had the opportunity to take advantage of unique learning opportunities. These learning opportunities included: (a) serving as executive officer, Task Force Med Eagle 6, (b) facilitating the mission analysis and the restructuring of the U.S. medical task force in support of Operation Joint Forge,

Bosnia and Herzegovina, (c) participating in U.S. negotiations with the Danish Army (Nordic Polish Battle Group) for level three medical support in Multinational Division (North), Bosnia and Herzegovina, and (d) participating in health facilities planning for U.S. Army medical treatment facilities in Multinational Division (North) (MND (N)).

Objective 5

Strengthen and crystallize a code of personal ethics, a philosophy of management, and a dedication to the high ideals and standards of excellence for health care administration.

I entered the Baylor residency with a strong sense of my personal code of ethics and philosophy of leadership and management, which I developed over sixteen years as a health care provider and clinic manager. The Baylor residency provided me the opportunity to apply my code of ethics and leadership/management philosophy and style across a broader area of responsibility and to unfamiliar scenarios. Because the residency required that I think, act, and lead on a larger scale than ever before, my residency experience helped me to strengthen my existing code of ethics and leadership/management philosophy. For example, as executive officer of TFME 6, I was no longer responsible for the operation of one clinic, but responsible for facilitating the smooth operation of a multifunctional medical task force to include a tactical hospital. This broader responsibility required that I focus on the well being of the entire combat health support organization, balancing needs across the entire organization, and not just a small functional component of the organization.

Objective 6

Develop, submit, and revise a Graduate Management Project Proposal (GMPP), and execute and complete an approved Graduate Management Project (GMP).

The 21st CSH residency presented a variety of intriguing issues and management challenges appropriate for the development of a GMPP/GMP beneficial to TO&E hospitals and the AMEDD. Examples of potential GMPP/GMP topics include: (a) the PROFIS system, its strengths and weaknesses and methods for improvement; (b) Class VIII medical supply challenges, and working with TDA hospitals to improve efficiencies while decreasing waste; (c) medical proficiency training for TO&E medics; (d) strengths and weaknesses of the organizational design of the TO&E hospital in garrison and during deployment; (e) challenges of providing realistic medical training for TO&E hospital staff and PROFIS providers in a field environment, to include designing a training template or road map to facilitate the coordination of real surgical patients during field training exercises.

Despite the variety of appropriate management project topics and issues, the 21st CSH did present some challenges in terms of developing and completing the GMPP/GMP. Because TO&E hospitals do not have the luxury of a library, I had to seek out library resources at the local TDA hospital and the library at Fort Sam Houston in order to conduct a review of the literature. Although I had access to the Internet, I was not able to obtain adequate or sufficient information for a literature review via this resource. For example, while in Bosnia, I found access to certain academic web sites, such as my academic advisor's web page containing many valuable links to health care administration resources, blocked for security reasons. I could have pursued access to these blocked sites, but did not secondary to the effort involved and time constraints.

Joint Medical Executive Skills Competencies

Competency Group 1 - Military Medical Readiness

The preparation for deployment, the Bosnia deployment, and the post deployment activities enabled me to exercise and develop six of the seven military medical readiness skills during my residency year. I did not pursue learning opportunities in the arena of national disaster medical systems management/Department of Veterans Affairs role.

Medical Doctrine. My experiences as executive officer of Task Force Med Eagle 6 (TFME 6) provided daily training in medical doctrine. In addition to working with the members of the eight medical units that comprised task force Med Eagle (combat support hospital, air ambulance, ground ambulance, medical logistics, combat stress control, preventive medicine, veterinary, and Swedish/Danish medical detachments), I worked with U.S. Air Force medical evacuation teams, the division surgeon's office, battalion aid station staff, and echelons above corps medical assets (European Regional Medical Command and Staff and Landstuhl Army Medical Center). These experiences provided me an opportunity to learn about and participate in the full spectrum of medical doctrine. At the conclusion of the deployment I supervised the completion of TFME 6's after action report, and represented TFME 6 during the 10th Mountain Division's post deployment conference at Fort Drum, New York. During the conference, I discussed medical doctrinal issues and lessons learned with members of the medical teams slated for future Bosnia deployments.

Military Mission. My experiences as executive officer of TFME 6 also provided daily training in conducting mission analysis in medical support of the line commander. The best learning opportunity came when TFME 6 received instruction from MND (N) headquarters to restructure (downsize) the medical task for the second half of the deployment. This new medical

task force structure would also serve as the structure for the follow-on medical task force, TFME 7. Restructuring required extensive mission analysis and coordination with the 10th Mountain Division Surgeon, to determine the medical package required to support the 10th Mountain Division Commander and the soldiers of MND (N).

Joint Operations/Exercises. The Bosnia deployment was not a joint operation, rather, it was a combined operation in the sense that MND (N) consisted of American (Army and Air Force) and allied military elements (Denmark, Norway, Sweden, Finland, Estonia, Latvia, Lithuania, Poland, Turkey, and Russia). As the TFME 6 executive officer I supervised the planning, execution, and after action review of several “combined” air evacuation, ground evacuation, and mass casualty exercises. Throughout these exercises, as well as throughout the deployment, I worked to facilitate effective use of command, control, communications, computers, and intelligence (C4I).

Total Force Management. TFME 6 consisted of eight medical units: five from the active Army, two from the Army National Guard, and one unit from Sweden/Denmark. Each unit brought specific resources, expertise, and functional capabilities to the team. For example, the National Guard units provided the air and ground evacuation capabilities, and the Swedish and Danish detachments provided armored ground evacuation capabilities. As executive officer, I worked to ensure the full reception and integration of all medical units in order to forge a cohesive health care team, and supervised daily operations that included the coordinated use of all TFME 6 assets.

National Disaster Medical Systems Management/Department of Veterans Affairs Role. Although I did not work towards the development of this skill during my residency year, through it's relationship with the 1st Medical Brigade, III Corp, and Darnall Army Community Hospital,

the 21st CSH residency does provide opportunities to develop skills in national disaster medical systems management and the role of Department of Veterans Affairs in national disaster management.

Medical Readiness Training. I began medical readiness training the moment I arrived at the 21st CSH, first by participating in Bosnia deployment training, then by working to validate the deployment readiness of the seven American units of TFME 6. I had additional opportunities to work medical readiness training issues later in the residency year, while working with the 21st CSH staff. These included the planning and execution of a reintegration field training exercise which included PROFIS training for approximately 80 providers and an ARTEP (Army Training and Evaluation Program) of the 85th Combat Stress Control Detachment.

Contingency planning. In Bosnia, TFME 6 was responsible to MND (N) for the planning and execution of several medical contingency plans. As executive officer I worked with the task force operations officer to supervise the contingency planning and execution process.

Competency Group 2 - General Management

The 21st CSH residency enabled me to exercise and develop all five of the general management skills.

Strategic Planning. As executive officer I facilitated a strategic planning process that brought together the operational needs and projections of the line community with the medical recommendations of the TFME 6 staff to build a medical package that would continue to support the evolving medical needs of the line community. TFME 6's strategic planning efforts resulted in a number of successes such as: (a) working with the Health Facilities Planners from the European Regional Medical Command (ERMC) to identify medical facilities construction and

maintenance requirements; (b) requisitioning a treadmill for cardiac testing in the Bosnia theater, decreasing the need to evacuate patients to Germany for cardiac stress testing; (c) obtaining a demineralized water source for the hospital sterilizers and dental equipment, extending the operational life of this equipment; (d) obtaining approval for the construction of a line conditioner platform, extending the operational life of the CT scan; and (e) working with a telemedicine team from ERMC to assist with identifying present telemedicine capabilities and training needs, obsolete versus required equipment, and future capabilities, equipment, and training needs.

Organizational Design. I had several opportunities to work organizational design issues during the residency year, the most significant being the restructuring of the medical task force during the opening weeks of the deployment. As executive officer, I organized and facilitated a multidisciplinary team to determine the best mix of clinical and administrative personnel to operate the hospital, meet the medical mission, while meeting reduced end strength requirements.

Decision Making. My residency year provided virtually daily opportunities to practice and fine tune the military decision making process. This included: (a) working with the staff to identify issues/problems, (b) determining facts and assumptions bearing on issues/problems, (c) designing and evaluating alternative courses of action, (d) recommending specific courses of action to the commander, and (e) monitoring decision implementation. Examples of my involvement in the decision making process include the TFME restructure, the mid tour and end of tour redeployment, the TFME motor pool consolidation and move, TFME construction and facilities upgrade projects, and the 21st CSH reintegration field training exercise at Fort Hood.

Change and Innovation. During my tenure as executive officer, TFME 6, I had a variety of opportunities to work with change and innovation. The restructuring of the task force presented the greatest challenge, as it not only required my communicating to the organization the requirement for change, but also required my working with the organization to design and execute a plan for the change. This was further complicated by the fact that the change required breaking up a team that had formed under difficult and emotional conditions, prior to the December-January holiday season. A second challenge that required change and innovation was an unexpected eviction from the TFME motor pool to make room for a civilian company that had been awarded a support contract that included occupying the TFME motor pool structure and grounds. My staff and I faced the challenge of finding a new location to reestablish the motor pool, while reassuring the company commanders and the follow on task force leadership that TFME would continue to meet its maintenance mission. Despite the inconvenience of the sudden order to vacate the existing motor pool, we used the opportunity to scrutinize the necessity of each piece of equipment maintained by the motor pool. The result was a TFME 6 wide cooperative project to identify and turn in excess equipment or to upgrade equipment as indicated. The end product was a new, more efficient motor pool with fewer pieces of equipment to maintain.

Leadership. The 21st CSH residency served as a leadership lab, enabling me to learn through observation and discussion, the styles and techniques of a variety of leaders and the effects and outcomes of their styles and techniques, for example the leadership style of the 10th Mountain Division Commander as he interacted with the international community. The residency also provided me opportunities to serve as both a formal and informal leader, challenging me to apply and stretch my leadership skills to scenarios and issues I had never

before encountered. Examples of such scenarios include deploying and redeploying a task force, building a cohesive and effective task force staff from the ground up, and supervising facilities construction projects.

Competency Group 3 - Health Law/Policy

The 21st CSH residency experience provided limited direct exposure to health/law policy issues. Because I chose not pursue health law/policy learning opportunities outside of the TO&E hospital environment, I was able to develop fully only two of the five skills, and partially develop the remaining three.

Public Law. I had limited exposure to public law as it applies to health care during my residency year. As executive officer, TFME 6, I did work with theater specific medical rules of engagement and Title 10 restrictions regarding eligibility of medical care (who the U.S Army could or could not medically treat) at Task Force Med Eagle. As an Article 32 Investigating Officer for the 13th Corps Support Command, Fort Hood, Texas, I had the opportunity to delve into the Uniformed Code of Military Justice and gain further experience with the military justice system.

Medical Liability. Other than TFME's investigation of the feasibility of providing medical care for Americans in host nation medical facilities, I had minimal exposure to medical liability issues during my residency year.

Medical Staff By –Laws. I also had minimal involvement with medical staff by-laws during my residency year as the credentialing and privileging process for deployment was coordinated by the Chief Nurse prior to my arrival at the 21st CSH. During the Bosnia deployment, I did have an opportunity to follow TFME's unsuccessful efforts to obtain

credentialing and privileging for foreign medical personnel (under operational control of TFME) to provide surgical and nursing care in the U.S. Army Hospital at Eagle Base.

Regulations. As executive officer, TFME 6, I had daily opportunities to identify, interpret and apply medical regulations, Title 10 restrictions, and theater specific medical rules of engagement regarding eligibility of medical care at TFME. Examples of scenarios that required me to exercise this skill included: (a) Brown and Root Services personnel requesting flu vaccination, (b) a local civilian hospital requesting Japanese encephalitis vaccine, and (c) the Russian Brigade surgeon requesting interferon.

External Accreditation. During the Bosnia deployment, TFME did not have access to formal, external accreditation bodies such as the Joint Commission on Accreditation of Health Care Organizations. Instead, we utilized available experts to assist us in evaluating the medical task force. For example, the Base Camp Assessment Team conducted a monthly environmental safety and hazards inspection of the entire medical task force. TFME also invited a health facilities planning team from ERMC to assist in identifying and prioritizing facilities repair and upgrade issues, and areas for improvement in hospital safety and environment of care. Additionally, TFME requested a subject matter expert from Landstuhl Army Medical Center to conduct an external validation of the care rendered by our Combat Stress Control Detachment and a medical logistics team from San Antonio to review medical logistics procedures and to provide training in the Theater Army Medical Management System.

Competency Group 4 - Health Resources Allocation and Management

The 21st CSH residency provided opportunities to exercise and develop in depth, five of the six health resources management skills. The residency experience provided limited opportunity to develop labor-management relations skills.

Financial Management. I had many opportunities during the residency year to develop financial management skills. For example, in Bosnia, Task Force Med Eagle vied with all other units within Task Force Eagle for construction and facilities upgrade funds. Through the joint acquisition and review board (JARB) process, TFME had to justify each expense request to MND (N). The project justifications required cost benefit analyses and an explanation of how the project supported the greater strategic picture for medical support. An example of a project approved by the JARB was the demineralized water source for the hospital sterilizers and dental equipment. As the executive officer, I worked with construction and supply experts to clearly demonstrate a cost savings to the U.S. government by outfitting the hospital complex with a demineralized water source, thus extending the operational life of the sterilizers and dental hand instruments, and minimizing disruption to patient care.

Human Resource Management. As the executive officer of TFME 6 I had numerous opportunities to work human resource management issues, for example, working with the 21st CSH staff prior to deployment to ensure TFME 6 had its required mix of trained personnel, and once in Bosnia, establishing a process for the evaluation and recognition of TFME soldiers. Two of the largest human resource management projects I worked during the residency year were the restructuring of the medical task force and the planning and execution of a training program to transition the medical mission from TFME 6 to TFME 7. The restructuring project required me to work manpower issues, such as determining the total number of soldiers required to perform the mission and in what mixture of clinical and support specialties. The transition training program, know as Right Seat/Left Seat Ride, required intensive coordination and supervision to plan and execute a program in which the members of TFME 6 provided individual and collective training and testing for members of the incoming task force. During the first week of the

transition program, Right Seat Ride, soldiers of TFME 7 learned the tasks and skills that they would need to assume the medical mission. During the second week of the program, Left Seat Ride, soldiers of TFME 7 performed the daily skills and tasks required to operate the medical task force, while soldiers from TFME 6 provided guidance and validation testing to ensure that TFME 7 was prepared to assume the medical mission in Bosnia.

Labor-Management Relations. I had minimal exposure to labor-management relations, and no exposure to union negotiations during my residency year as neither the 21st CSH nor TFME 6 had civilian employees working directly for the health care organization. The 21st CSH and TFME 6 did utilize contracted civilian employees hired by American contractors responsible for supporting the medical mission. For example, in Bosnia, TFME 6 had a local civilian physician on staff to serve as an interpreter. To address labor-management issues such as work schedules, vacation time, expanding duties, I worked through the contractor, thus providing me some opportunity to practice labor-management relations skills.

Materiel Management. During the residency year, I had a variety of opportunities to gain experience with and to develop skills in materiel management. For example, in Bosnia I worked closely with the medical logistics detachment in the procurement, distribution, and maintenance of medical equipment for MND (N) and in the identification, inventory, and turn-in of excess medical equipment to the U.S. Army Medical Materiel Center-Europe. I also worked closely with TFME's logistics officer and safety officers to ensure TFME acted in compliance with hazardous waste and medically regulated waste requirements. At Fort Hood, I shadowed the Combat Support Hospital's Chief Nurse and Chief Ward Master in their efforts to reduce expendable Class VIII medical supply costs and waste in the TO&E hospital setting. Their work provided me insight into TO&E specific medical logistics issues and possible money saving

initiatives, such as collaborating with TDA hospitals for the procurement and storage of Class VIII supplies for peace time training.

Facilities Management. My experience as executive officer of TFME 6 provided me an opportunity to develop the full gamut of this skill. Examples of opportunities and projects that enabled me to develop facilities management skills include: (a) working with the Base Camp Coordinating Agency in finalizing design and construction plans for the TFME tactical operations center (TOC) and administrative/logistics operations center (ALOC); (b) providing TFME oversight of the TOC/ALOC construction; (c) working with facilities planners from ERMIC to identify physical plant and infrastructure needs of TFME and the troop medical clinics/aid stations throughout MND (N); (d) incorporating the findings and recommendations of the ERMIC facilities planners into TFME strategic plans; and (e) working with the Base Camp Coordinating Agency to ensure maintenance and upgrade of TFME facilities.

Information Management. Despite information technology constraints in Bosnia and at Fort Hood, I had sufficient opportunity to exercise information management skills throughout my residency year. As with other units in Bosnia, TFME 6 was limited to a set number of computers, email accounts, and telephone lines. I worked with the communications officer and leaders within TFME 6 to determine the optimal distribution of computer and communications equipment. I also worked with TFME 6's intelligence and communications officers to implement and ensure safeguards for information and information systems throughout TFME. Additionally, I maximized the use of e-mail, conference calls, and video teleconferencing to coordinate activities between Bosnia and Fort Hood, especially the December 1999 and March 2000 redeployments.

Competency Group 5 - Ethics in the Health Care Environment

The 21st CSH residency provided several opportunities from which to examine ethical dilemmas and to observe leadership working to resolve these dilemmas and establish a climate of ethical behavior. Through observation and participation, my experiences as a resident enabled me to exercise and develop all four of the ethics in the health care environment competencies.

Three scenarios come to mind from which I learned methods of establishing an ethical environment. The first scenario occurred the day after TMFE 6 assumed the medical mission in Bosnia. Two Russian soldiers, critically wounded in a vehicle accident, were evacuated to the hospital at TFME. Surgeons of the 21st CSH stabilized the soldiers, but informed the TFME Commander that the soldiers would not survive the night if not further treated at a higher level medical facility, such as Landstuhl Army Medical Center in Germany. The Russian Army Brigade in Bosnia was not able to arrange for immediate evacuation, and asked that TFME hold the soldiers until the Russian Army could coordinate evacuation at a later time (several days to two weeks). TFME was able to coordinate evacuation to Landstuhl within hours. The leadership of the Russian Army Brigade understood the gravity of the medical situation, but clearly stated that they did not want the soldiers evacuated to Germany (the soldiers were incapacitated and unable to speak for themselves). The TFME Commander faced the dilemma of evacuating the soldiers to save their lives, while ignoring the request of the Russian Army leaders, or honoring the request of the Russian Army leaders, knowing that it meant the death of the two soldiers. A second scenario developed during the deployment concerning TFME soldiers and a newly established Task Force Eagle policy allowing soldiers to take leave while deployed, mission permitting. The TFME Commander was faced with balancing the needs of the medical mission with the needs, demands, and expectations of his soldiers. The third

scenario involved a married TFME soldier (husband was in the U.S.) who became pregnant while in Bosnia and immediately experienced medical complications associated with the pregnancy that required her evacuation to Landstuhl for more definitive care. Policy within the 10th Mountain Division was to send all pregnant soldiers back to the U.S. within 72 hours; the TFME soldier wanted to complete her tour in Bosnia, and not leave her section short staffed. The ethical concern was that once at Landstuhl, the soldier's desire to return to Bosnia might unduly influence her decision to keep/abort the baby, thinking that if she was no longer pregnant, she could return to TFME.

Ethical Decision Making. The three ethical dilemmas described above provided wonderful case studies with which to consider different ethical arguments and decision making approaches. Working with my preceptor, I examined the underlying issues of each dilemma: (a) in the first case the duty to preserve life, limb, and eyesight versus honoring the request of a foreign ally; (b) in the second case, duty to the mission versus the wishes of a subordinate; and (c) in the third case, avoiding undue command influence in a soldier's right to choose (abortion versus maintaining the pregnancy). As the ethical dilemmas unfolded I discussed each case with my preceptor, learning his thought processes for making ethical decisions, and observing his leadership and commandship techniques for communicating his decisions.

Personal and Professional Ethics. Each of the three scenarios described above developed within uniquely military settings, and required the Commander to balance the needs of the mission with the needs of the soldier, despite his personal feelings. In the case of the Russian soldiers, the Commander did not let the protests of angry Russian Officers or nervous American liaison officers influence his decision to act to save the lives of the Russian soldiers. In the cases of TFME soldiers requesting leave to return stateside to deal with personal problems, the

Commander acted consistently within his stated policy, despite the lack of popularity for the policy. In the case of the pregnant soldier, regardless of the Commander's personal beliefs about the right to life versus abortion, the Commander acted in a way that would eliminate possible command and situational influence so that the soldier could make a clear decision about her pregnancy. As with ethical decision making, I learned the unique military aspects of this skill from observing and dialoging with my preceptor, the TFME Commander.

Bioethics. In addition to working to support the Commander in providing the pregnant soldier an environment in which she could make an informed decision concerning her pregnancy, without undue influence, I also had an opportunity to work patient privacy issues. Because of the high visibility of the hospital at TFME, many dignitaries and commanders requested tours of the hospital or information concerning patients treated. I worked with the hospital and TFME staff to balance patient privacy issues with the need to share information in a highly political environment.

Organizational Ethics. As the commander of the 21st CSH and TFME 6, my preceptor successfully established an ethical command climate. By observing his actions and leadership techniques, and discussing with him his command philosophy, I learned methods of establishing and communicating an ethical command climate. Examples of techniques I learned from my preceptor include: (a) publishing a command philosophy and providing it to soldiers on laminated pocket cards, (b) leveraging the ministry team to communicate and foster an ethical command climate and to obtain grass roots feedback from within the organization, (c) providing an open door policy and establishing a reputation for a willingness to listen, (d) working closely with the Command Sergeant Major to obtain an accurate assessment of the organization to

include the thoughts and concerns of the soldiers, and (e) spending one-on-one time with the duty driver to obtain first hand feedback from the soldiers' perspective.

Competency Group 6 - Individual and Organizational Behavior

The 21st CSH residency provided me the opportunity to exercise and develop all five of the individual and organizational behavior skills. As with the general management and ethics skills, I learned much through observation and dialog with the Commander, taking ideas and techniques, and adding them to my own skill sets.

Individual Behavior. As executive officer and resident I served daily as a representative of the commander, working to demonstrate and communicate his command philosophy, mission, and vision, as well as to solicit feedback on issues and concerns throughout the command. During the residency year I also had the opportunity to serve as mentor, coach, motivator, rater, and senior rater to a number of officers and noncommissioned officers.

Group Dynamic. As a resident I had the opportunity to hone my skills in group dynamics by leading and directing groups, as well as by serving as a member of external groups. For example as executive officer I lead the group work of the TFME 6 staff on a daily basis, and designed and facilitated the group responsible to the commander for the task force restructuring. Additionally, I had the opportunity to design and task groups to tackle specific issues such as space utilization. I also served as a member of external groups, such as when representing TFME 6 during U.S. efforts to negotiate an equivalent values health care agreement with the Nordic Polish Battle Group, and when working with the 10th Mountain Division staff on restructuring and redeployment issues.

Conflict Management. As executive officer of TFME 6, I exercised conflict management skills on a daily basis. Examples of situations that enabled me to exercise these skills include: (a) working to dispel concerns that the 21st CSH chain of command would favor their soldiers over the soldiers of the smaller units within the task force, (b) working to resolve conflicts over working and living space, and (c) working to resolve conflicts between physician and nursing leadership concerning personnel support for the hospital's continuing medical education program.

Communication. The Bosnia experience provided daily challenges and opportunities to practice the full spectrum of communication skills: listening, verbal, non verbal, and written. Upon arriving in Bosnia, I faced the immediate challenge of communicating accurate and timely information from the command and staff to the soldiers of TFME 6. Through trial, assessment, and reassessment of communication methods, TFME 6 command and staff utilized a variety of forums to share information, such as daily battle update briefings, weekly command and staff meetings, and e-mail. As executive officer I also used informal sensing and feedback sessions with task force staff and subordinate leadership in order to improve communication between the command, staff, and units of TFME 6. In addition to exercising communication skills within TFME 6 (to include daily communication with my preceptor), I regularly communicated, coordinated, and corresponded with higher headquarters in Bosnia, Germany, and Fort Hood, as well as with lateral U.S. and allied units in Bosnia.

Public Speaking. I entered the residency with experience and competence in public speaking. The 21st CSH residency provided additional opportunities to practice my public speaking skills, especially to audiences I previously had minimal exposure to, such as general officers, dignitaries, and international allies.

Public and Media Relations. During the residency year I had several opportunities to work with public and media relations. For example, during predeployment training at Fort Carson, Colorado I gave an interview to a mock television news team. Following the interview, I reviewed my performance on tape and received feedback from my peers, as well as from media relations experts. While in Bosnia I worked with TFME's adjutant to coordinate for public affairs coverage of TFME 6 events, such as multinational mass casualty exercises, and to ensure that TFME communicated an accurate and consistent message.

Competency Group 7 - Clinical Understanding

The 21st CSH residency provided opportunities to develop all three of the clinical understanding skills. As I had a basic level of competency in clinical investigation, I chose not to pursue additional learning experiences in this skill during my residency, but did pursue learning experiences to further develop skills in epidemiological methods and alternative health care delivery systems.

Epidemiological Methods. The Bosnia deployment provided me an opportunity to observe and learn first hand the application of epidemiological methods and tools to ensure force medical protection. Throughout the deployment the preventive medicine (PM) and veterinarian (VET) detachments of TFME 6 worked with base camps across MND (N) to ensure safe air, food, water, and living environments. As executive officer, I followed the activities, findings, recommendations, and corrective actions of the PM and VET detachments, and learned how difficult, but important it was to educate the lay public in a clear and timely manner on issues involving public health and safety. For example, during the deployment a soldier found a piece of a hypodermic needle embedded in his bratwurst. Quick reaction by the VET detachment commander enabled TFME to work with the 10th Mountain Division to identify and pull the food

product from the supply system. Timely and accurate communication of the removal of the threat averted possible panic. In another case, soldiers and their leaders at a particular base camp in Bosnia believed they were getting sick from air polluted by a nearby factory. Soldiers saw dark smoke billowing from the factory's smokestack, observed black residue on the snow, and concluded that the factory was responsible for any illness in the soldiers at the base camp. Despite assessing the air quality at the base camp and determining no short term health risk to the soldiers, the PM detachment commander had a difficult time dispelling the already entrenched association of factory smoke to soldier illness.

Clinical Investigation. As I had previous experience with initiating and conducting clinical investigation, I did not pursue further development of this skill during my residency year. For interested residents or residents in need of this skill, the 21st CSH does provide opportunities to develop clinical investigation skills via the support relationship with the troop medical clinic, the soldier readiness center, and Darnall Army Community Hospital.

Alternative Health Care Delivery Systems. Although limited, I did have an opportunity to explore a variety of issues related to alternative health care delivery systems. For example, I worked with the 10th Mountain Division Surgeon, a U.S. contract negotiations team from ERMIC, and a delegation from the Danish Army to determine a the health care agreement between the U.S. and the Nordic Polish Battle Group. I followed the TFME Commander and the Deputy Commander for Clinical Services in their efforts to explore possible cooperative agreements between TFME 6 and the German Army hospital in Sarajevo and TFME 6 and the Tuzla Clinical Center, Tuzla Bosnia. I also followed the TFME Commander's efforts to market health promotion and injury prevention throughout MND (N) via the Fit Eagle Program, a traveling health promotion program that included TFME's dietician, physical therapist, and

members of the combat stress control detachment. Finally, at Fort Hood, I worked with the Chief, Physical Therapy Clinic, Darnall Army Community Hospital to discuss the clinic's resource sharing initiative and methods of contracting for civilian clinicians to backfill deployed PROFIS physical therapy providers.

Competency Group 8 - Performance Measurement

I entered the residency with competency in performance measurement, having developed these skills via professional military and civilian short courses, previous graduate work, self-study, and work experience. During the residency I repeatedly used two of the four performance measurement skills: quality management and quantitative analysis. Although I did not actively pursue opportunities to further develop my performance measurement skills, the 21st CSH residency does provide opportunities to develop all four of the skills.

Quality Management. As executive officer of TFME 6, I facilitated a continuous improvement process by coaching and training members of the task force to use fact based decision making and improvement processes, rather than emotional or snap decisions. For example, when the OR staff requested that TFME pursue a construction project to improve gurney access to the secondary OR suite, I worked with the hospital staff to objectively evaluate the issue. The hospital staff found that reorganizing the OR supply area resolved the access issue faster and better than their originally requested construction project, with the added benefits of no interruption to patient services or cost to the government.

Quantitative Analysis. My work as executive officer required daily use of quantitative analysis tools, especially when researching and communicating the cost benefits and cost effectiveness of the many improvement projects at TFME. Examples of improvement projects in which I used quantitative analysis skills include: (a) obtaining a distilled water source for the

sterilizer and dental hand tools to prolong the life of the equipment and decrease interruption to patient care; (b) purchasing a cardiac stress testing treadmill to decrease the need for evacuating soldiers to Landstuhl to rule out myocardial infarction; (c) competing with the line commanders for heaters for the air ambulance hanger to improve maintenance capabilities and safety of soldiers and equipment, (d) redesigning the OR suite to improve gurney access; (e) obtaining approval for construction of a line conditioner platform to extend the life of the CT scan and decrease interruption to patient care, and (f) obtaining approval for reinforcement of the satellite dish support platform to preserve the equipment and ensure continued telemedicine capability.

Outcome Measurements. Although I did not pursue outcome measurement opportunities, such as determining best practice guidelines during my residency, such opportunities existed via a residency rotation through Darnall Army Community Hospital, or the 21st CSH supported troop medical clinic (TMC 6).

Clinical Performance Improvement. I did not pursue opportunities to further develop my clinical performance improvement skills. For residents wishing to develop this skill, the 21st CHS's support relationship with TMC 6 provides untapped opportunities to pursue clinical performance improvement initiatives.

Discussion

Effectiveness of the TO&E Residency

The 21st Combat Support Hospital provided an environment that enabled me to meet all six of the Baylor residency objectives (Appendix B). Whether deployed to Bosnia or stationed stateside, the TO&E hospital provided a sufficiently diverse mixture of learning experiences and challenges that required me as the resident to apply health care administrative skills, knowledge, and attributes to combat health support scenarios. The Bosnia deployment, although valuable, was not essential to meeting all residency objectives. As the deployment occupied approximately half of the residency year, many of my learning experiences, and therefore opportunities to accomplish the residency objectives, just happened to unfold during my time in Bosnia. Similar to a TDA hospital residency in which the hospital is undergoing a Joint Commission accreditation survey, deployment, like a Joint Commission survey, is not essential to the success of the residency, but is a wonderful and fortunate learning opportunity.

In addition to providing an environment that enabled the completion of the six residency objectives, the TO&E residency provided an environment conducive to the development of the Department of Defense's Joint Medical Executive Skills. My residency experiences with the 21st CSH enabled me to exercise and develop 32 of the 40 Joint Medical Executive Skills, to include competencies from each of the eight competency groupings (Appendix C). The most completely exercised competency groupings were General Management (5 of 5 competencies), Ethics in the Health Care Environment (4 of 4 competencies), and Individual and Organizational Behavior (6 of 6 competencies). Military Medical Readiness and Health Resources Allocation and Management competencies were also well exercised (6 of 7 and 5 of 6 competencies respectively). The least exercised competency groupings were Clinical Understanding (2 of 3

competencies), Performance Measurement (2 of 4 competencies), and Health Law/Policy (2 of 5 competencies).

The eight competencies I did not exercise during the residency were readily attainable, either at the CSH or via external rotations at Fort Hood. Because of previous experience, training, or expertise, I personally chose learning experiences that resulted in limited or no opportunity to exercise all 40 of the Joint Medical Executive Skills. The eight competencies not exercised during the residency year include: (a) National Disaster Medical Systems Management/ Department of Veterans Affairs Role (Military Medical Readiness), (b) Public Law (Health Law/Policy), (c) Medical Liability (Health Law/Policy), (d) Medical Staff By-Laws (Health Law/Policy), (e) Labor Management Relations (Health Resources Allocation and Management), Clinical Investigation (Clinical Understanding), Outcome Measurements (Performance Measurement), and Clinical Performance Improvement (Performance Measurement).

Unlike the residency objectives, I believe the Bosnia deployment did facilitate my ability to exercise in depth so many of the Joint Executive Skills. Because the environment at Task Force Med Eagle and MND (N) was fast paced, issues from all facets of combat health support evolved quickly and frequently. My role as executive officer often placed me in the center of the action, providing many opportunities to utilize health care administrative skills in combat health support scenarios. Additionally, the Bosnia deployment provided some unique opportunities that may not have been available stateside in the CSH, such as working to integrate Army National Guard soldiers into the organization and working with health facility planners to assess medical facility needs in a theater of operation.

Strengths and Weaknesses

Despite providing the mixture of learning experiences and challenges necessary for meeting residency objectives, and developing Joint Executive skills, the 21st CSH residency did have its specific strengths and weaknesses with respect to the availability and depth of learning experiences. In terms of strengths, the 21st CSH residency was best at providing the following learning opportunities: (a) medical readiness training, particularly PROFIS coordination and training, (b) medical operations planning and execution, (c) health facilities planning, (d) human resource management, (e) organizational behavior challenges, (f) leadership training, and (g) the full spectrum of doctrinal combat health support. In terms of weaknesses, the CSH residency was least able to provide the following learning opportunities: (a) TRICARE operations and issues, (b) managed care, (c) Joint Commission on Accreditation of Health Care Organization requirements and survey process, (d) hospital budget and finance, (e) civilian labor relations, (f) day-to-day relationships and interaction between the various components of an operating hospital, for example how nurses, doctors, ancillary clinical staff, and support staff interact; and (g) day-to-day demands and challenges of caring for patients.

A deployment or an extended field exercise involving patient care activities, mitigates the weaknesses of the TO&E hospital residency. The presence of real patients during a deployment or an extended field exercise, especially surgical patients or patients requiring hospitalization, requires the TO&E hospital to function more like a traditional, 24 hour-a-day hospital. This more traditional hospital environment provides the resident the opportunity to interact in day-to-day hospital relationships among and between clinical and administrative staff and to become involved in the daily demands and challenges of caring for patients.

Matching the TO&E Residency with the Right Resident

Like other non-traditional residencies such as training with industry (TWI) and the Health Facilities Planning Agency, the TO&E residency provides Baylor residents an additional option above the standard “brick and mortar” hospital residency sites. Who and what type of student is best suited for the TO&E residency is dependent upon the individual interests and learning needs of the student.

The TO&E residency is not inherently limited to students of certain rank or occupational specialty, having the ability to meet the learning needs of students from a variety of backgrounds and experience levels. At a baseline level, the TO&E residency provides residents with a foundation (basic or advanced as determined by need of resident) in operational field medicine, to include: (a) the organization and mission of the tactical hospital, (b) the key command and staff elements of the tactical hospital, (c) levels of and responsibility for medical care, (d) DEPMEDS, and (e) higher command support to the tactical hospital. As in TDA hospital residencies, TO&E residents develop this fundamental understanding via rotations through the major components of the hospital to include the command team (commander and command sergeant major), the executive officer and each of the primary staff sections (personnel, intelligence and security, plans and operations, logistics and maintenance), the chief nurse and chief ward master, and the ministry team. From the baseline rotations, residents may tailor the residency to meet more specific learning needs and interests. For example, nurse corps officers of all experience levels may choose to explore the role of the hospital Chief Nurse in medical proficiency training, medical equipment and supply readiness, PROFIS preparation, as well as, the role of the Chief Nurse at the Medical Group and Medical Brigade levels. Junior medical service corps, specialist corps, and nurse corps officers with limited staff experience can more

deeply explore specific staff roles such as personnel, logistics, maintenance, and operations, and learn to function as staff officers. Junior officers with interest in becoming company commanders can spend time with and shadow the medical company commanders and first sergeants. More senior residents with interest in assuming future leadership roles within TO&E hospitals (Chief Nurse, Deputy Commander for Clinical Services, Commander) or the Army Medical Department (AMEDD) in general, can design learning experiences that will help prepare them for these positions. For example, more senior residents might explore opportunities to work with the Medical Group/Brigade and/or the Division Surgeon's Office, improve their understanding of staff roles and functions, or seek projects to better understand and improve the PROFIS system. Finally, residents of all ranks and experience levels, have the opportunity to coordinate external rotations with TDA or civilian health care facilities to round out the residency experience and meet specific learning needs.

Although residents at TDA facilities have the opportunity to coordinate external rotations through TO&E hospitals and participate in similar learning experiences as described above, this part time learning experience is not equal to a full time residency at a TO&E hospital. As a full time resident, the officer becomes a part of the hospital team, engrossed in the day-to-day operations and challenges of the organization over an extended period of time. The TO&E resident fully experiences life within the TO&E environment, and is free to explore and experiment without fear of hindering the hospital's mission due to inexperience in field medicine. On the other hand, the TDA resident participating in an external rotation is not an integrated member of the TO&E hospital, but rather an outsider looking in at a brief snap shot of the TO&E hospital and its workings. As an outsider, the TDA resident doesn't get the full

picture or understanding of the organization, and doesn't have the same opportunity to live and experiment within a TO&E environment.

Whether interested in a full time residency within the TO&E hospital or a short external rotation as part of a TDA residency, the TO&E hospital requires a resident capable of self directed learning. The TO&E residency is new, and unlike traditional TDA residencies, does not have an established layout for the residency year. The resident must be willing and able to help blaze the trail. The TO&E environment is also very fluid. The resident must be able to adapt his residency plan to maximize learning opportunities as they present, and to coordinate external rotations in order to pursue desired learning opportunities not available at the TO&E hospital. As the TO&E hospital has no library or research librarian, the resident also must be willing and able to seek out external library resources and maximize the Internet in order to stay current in health care administration literature and conduct a literature review in preparation for developing a GMPP. Additionally, the TO&E resident must be capable of seeking out his own mentors and teachers. As the TO&E hospital has limited mid and senior level managers/leaders within the organization, the TO&E resident does not have the same resources to exploit, nor the availability of multiple peers and superiors with whom to share and debate ideas, as the resident in TDA hospitals. For example, in a TDA hospital, not only is the preceptor well versed in hospital administration issues, but also the chiefs of clinical support, resource management, managed care, and budget/finance. These section and department chiefs are often Baylor graduates or graduates of advanced training, and are available to help guide and teach the resident.

Because the TO&E hospital does not have redundant health care administration expertise within the organization, availability of qualified officers to serve as preceptor is limited. Realistically, the commander, the executive officer, and the chief nurse are the only officers

senior enough to possess the requisite characteristics and qualifications to serve as a preceptor, but there is no guarantee that the officers filling these three positions comes to the TO&E hospital preceptor qualified. Unlike the TDA hospital, the TO&E does not have an assigned deputy commander for administration (DCA), who by job qualification is almost always preceptor qualified. This creates a problem when planning future residency sites for students, as Baylor faculty can't easily project when an officer capable of serving as preceptor will be assigned to a given TO&E hospital. This in effect limits the availability of TO&E hospitals as residency sites.

Regardless of who serves as the preceptor in a TO&E residency, the commander, executive officer, or chief nurse, their responsibility to the resident is the same: teach and facilitate the learning process (The Administrative Residency, 1999, p. 3). And regardless of who serves as the preceptor, he or she must be flexible and creative enough to assist the resident in maximizing the traditional and non traditional learning opportunities as they present during the residency year.

The fact that the preceptor doesn't function in the traditional role of DCA, and could possibly be a Nurse Corps, Medical Service Corps, Medical Corps, or Specialist Corps officer, just adds flavor, professional perspective, and variability to the TO&E residency not present in TDA hospital residencies. This added flavor, perspective, and variability is not necessarily good or bad, but it is a factor for Baylor faculty and students to consider when assigning students to specific residency sites. For example, a TO&E residency site at which an Army Nurse Corps officer is serving as the hospital chief nurse and as the Baylor preceptor, may attract a nurse corps resident more than residents from other branches. The nurse corps officer might see the residency as an excellent opportunity for mentorship and a follow on job. On the other hand, a

TO&E residency site at which an Army Nurse Corps officer is serving as the hospital commander and Baylor preceptor, may or may not have any bearing on what resident is attracted to that residency site. The job position and professional background of the preceptor, may or may not matter to the resident as he makes his choice of residency site, but this information should be available in order for the resident to make an informed choice.

Another factor for Baylor faculty and students to consider when assigning students to TO&E residency sites is the limited availability of follow on jobs. As discussed above, the organizational structure of the TO&E hospital is limited with respect to positions requiring health care administration skills. Additionally, many of the officer positions require specific selection or training not associated with the Baylor program, and therefore, are not automatically open to graduating residents. For example, the hospital commander is selected at the Department of the Army Level. The executive officer position requires completion of the Command and General Staff College, and is a highly competitive assignment. The operations and logistics officer billets each have their specialty training requirements. The most feasible follow on job, and one where health care administrative skills would prove beneficial, is for a nurse resident to move into the chief nurse position. In reality, upon completion of the TO&E residency, the resident most likely will have to move on to another organization.

Defining an Appropriate Baylor Residency Site

The fundamental question behind this graduate management project asks, is the TO&E hospital an appropriate residency site for Baylor Health Care Administrative residents? To tackle this question I needed a definition for an appropriate residency site, a set of criteria with which to compare the TO&E residency. Interestingly, I found no definition or set of criteria for an appropriate residency site in the Baylor Residency Manual or in a review of the literature.

Therefore, I operationally defined an appropriate residency site as a location that provides an environment in which the resident has an opportunity to meet all residency objectives (Appendix B), as well as develop medical executive skills from each of the eight Joint Medical Executive Competency groupings (Appendix C), in a supervised setting. I chose this operational definition because it was simple and logical. A residency site should foster the completion of the Baylor program's stated objectives. And as the Assistant Secretary of Defense for Health Affairs and the service medical departments have identified executive skills required of health care management organization leaders and their staffs (Claypool et al., 1998), it seems reasonable that the Baylor program, to include the residency, ought to support the development of these skills.

Based on my operational definition of an appropriate residency site, I demonstrated that the TO&E hospital is an appropriate residency site for Baylor Health Care Administrative residents. But my operational definition outlines just one possible set of criteria for an appropriate residency site. The absence of a solid, well accepted, and well communicated definition of an appropriate residency site raises the question as to what criteria are needed for a residency site to be deemed appropriate by the Baylor program? For example, should there be a requisite number of Baylor alumni or ACHE certified administrators at each residency, willing and able to assist in teaching and mentoring the resident? Should there be a minimum number of resident contact hours in a patient care facility or mandatory rotations through hospital areas such as managed care, budget and finance, resource management, and the department of nursing? Additionally, should the residency site enable residents to develop some or all of the 40 Joint Executive skills and if so, at what level of knowledge? The exploration of these questions is beyond the scope of this graduate management project. Rather, the question of what constitutes an appropriate residency site is an issue for the Baylor faculty to address to ensure a basic level of consistency

across residency experiences. Before the Baylor faculty can determine whether a residency site is appropriate or not, they must define what an appropriate residency looks like to include the skills, knowledge, and attributes the resident should possess upon completion of the residency.

The Bosnia Deployment as a Unique Learning Opportunity

The TO&E hospital residency provided two unique and unanticipated professional challenges: deployment to an operational theater and service as an executive officer. Prior to the start of the residency, I met with my preceptor who informed me that a portion of the 21st CSH was slated to deploy to Bosnia as the tactical hospital and the command and control element of Task Force Med Eagle 6. As Commander of the 21st CSH, my preceptor would also serve as the TFME 6 Commander. He discussed his plan to leave the 21st CSH executive officer back at Fort Hood as the rear detachment commander to continue the unit's stateside mission and to ensure that the non deploying soldiers and equipment of the 21st CSH were well cared for. This created an opening for the executive officer position within Task Force Med Eagle 6. My preceptor offered me the job, and I accepted.

Although unprecedented, deploying and working as executive officer, while assigned as the Baylor resident, was in keeping with the Baylor Program's philosophy of tailoring the residency "to meet the specific needs of the Resident" (The Administrative Residency, 1999, p. 1). At the start of my residency, I already possessed a solid knowledge of and a comfort level with TDA based hospital systems. Where I needed and wanted experience was in TO&E health care systems. Serving as the executive officer of a deployed medical task force put me at the center of action, and provided me the personal and professional challenge I was looking for in the residency experience. For the first half of my residency, my role as resident was to be the

executive officer of a multifunctional medical task force. Unorthodox, yes, but this met my learning needs.

In addition to providing a tremendous professional challenge, the Bosnia deployment provided another benefit to the residency. The Bosnia deployment enabled me to live, work, and view the combat health support mission from a 360 degree perspective to include the predeployment, deployment, and redeployment of a medical task force and all the associated personnel, training, equipment, planning, and leadership challenges. Instead of training to deliver combat health support, the task force actually delivered combat health support, seven days a week, 24 hours a day. As the executive officer of TFME 6 and Baylor resident, the deployment provided the opportunity to take an active role in addressing and resolving the real world issues, concerns, and challenges associated with providing health care in a theater of operation. Without the deployment, I would have had only an abbreviated opportunity to experience combat health support in action during field training exercises.

Serving in a functional capacity, with specific operational responsibilities to the organization was what I chose for much of my residency experience, but it may not work for future residents at TO&E hospitals. Future TO&E residents may not want the added responsibility of functioning in a primary staff role. Additionally, the opportunity to serve in a primary staff role and/or deploy in that staff role may not be available to the resident. Not all TO&E hospitals will deploy while a resident is assigned. Even if a resident is assigned to a deploying hospital, the resident may not be able to deploy with the hospital for two reasons. First, if the preceptor does not deploy, the resident can't deploy, as the resident follows the preceptor. Second, there is little to no opportunity to bring extra personnel along on a deployment. If the resident is not qualified

to fill an authorized position on the deployment personnel roster (sourcing document), the resident most likely will not deploy.

Conclusion

The TO&E hospital is an appropriate residency site for Baylor health care administrative residents because the TO&E hospital provides a fertile environment in which the resident has the opportunity to meet all residency objectives and develop medical executive skills from each of the eight Joint Medical Executive Competency groupings, under the supervision and mentorship of a preceptor. As with other residency sites, the 21st CSH residency had both its strengths and weaknesses with respect to the availability and depth of learning experiences. Strengths included: (a) the full spectrum of doctrinal combat health support, (b) leadership training, (c) medical readiness training, particularly PROFIS coordination and training, (d) medical operations planning and execution, (e) health facilities planning, (f) human resource management challenges, and (g) organizational behavior challenges. Weaknesses included: (a) TRICARE operations and issues, (b) managed care, (c) Joint Commission on Accreditation of Health Care Organization requirements and survey process, (d) hospital budget and finance, (e) civilian labor relations, (f) day-to-day relationships and interaction between the various components of an operating hospital, for example how nurses, doctors, ancillary clinical staff, and support staff interact; and (g) day-to-day demands and challenges of caring for patients. The deployment served to mitigate these last two weakness as the CSH functioned as a fully operational hospital, with nurses, physicians, allied health care providers, and administrators all working together to provide inpatient, outpatient, and surgical care.

Despite the appropriateness and effectiveness of the TO&E hospital as a residency site, the TO&E residency is not for everyone, just as training with industry, Health Facilities Planning, or

the TRICARE Management Agency is not right or desirable for all residents. Who and what type of student is best suited for the TO&E residency depends upon the individual interests and learning needs of the resident. The residency is not inherently limited to students of certain rank or occupational specialty, but the fluid environment of the TO&E hospital requires a resident capable of self directed learning.

As a residency site, the TO&E hospital is challenged by the lack of redundant health care administration expertise with the organization. Unlike its TDA hospital counterparts, the TO&E hospital does not have an assigned DCA, Clinical Support Division Chief, or Chief of Managed Care. This lack of redundant health care administration expertise limits the availability of qualified officers to serve as preceptor for the resident. Realistically, the commander, the executive officer, and the chief nurse are the only officers senior enough to possess the requisite characteristics and qualifications to serve as a preceptor, but there is no guarantee that the officers filling these three positions comes to the TO&E hospital preceptor qualified. This creates a problem when planning future residency sites for students, as Baylor faculty can't easily project when an officer capable of serving as preceptor will be assigned to a given TO&E hospital. This in effect limits the availability of TO&E hospitals as residency sites.

The TO&E hospital is a valuable asset to the Baylor Health Care Administration program because it broadens the available learning opportunities for students. The TO&E residency provides students the option of pursuing an understanding of combat health support by working in a safe and supervised environment, one in which the resident can explore, learn, stretch, and challenge themselves without fear of hurting the mission due to inexperience. In turn, the TO&E residency benefits the AMEDD as the residency produces an officer with a better understanding

of the full spectrum of military medicine, from combat health support to fixed facility health care and hospitalization.

Recommendations

Based on my residency experiences at the 21st Combat Support Hospital, I recommend the Baylor faculty pursue the following recommendations:

1. Maintain the TO&E hospital as a Baylor residency site.
2. Task the resident at each residency site to provide a 1-2 page abstract describing the pros and cons of that residency site, information that will help the student understand what to expect from that residency site. The abstract should address available learning opportunities to include external rotations, library and research resources available, challenges the resident may face, potential follow on jobs, and any other issues that could help students in making their choice of residency site. Update the abstract at the end of each residency year.
3. Post the residency site abstract to the Baylor web page, and encourage students to review the abstracts as they make their selection of preferred residency sites.
4. Clearly define what constitutes an appropriate residency site.
5. Identify the skills, knowledge, and attributes a resident should possess upon completion of the residency.
6. Design an assessment tool to evaluate if and how well the resident achieved these skills, knowledge, and attributes.
7. Instruct the preceptor and the resident in the use of the assessment tool.
8. Project and coordinate the availability of TO&E hospital residency sites by tracking qualified preceptors as they enter TO&E hospital billets.

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Appendix A

Medical Executive Skill Areas as Reported by Roberts, Crawford, and Orloff (1993)

1. Management of Change/Technology
2. Conflict Management
3. Communications
4. Individual Behavior
5. Group Dynamics
6. Ethics
7. Systems Perspective
8. Organizational Design
9. Quality Management
10. Personnel Management
11. Decision Making
12. Legal Issues
13. Productivity Management
14. Strategic Planning
15. Alternative Health Care Systems
16. Financial Management
17. Labor/Management Relations
18. Information Management
19. Facilities Management
20. Quantitative Management
21. Materials Management

Appendix B

Baylor Health Care Administrative Residency Objectives

As listed on page 2 of the 1999-2000 Residency Manual

The objectives of the administrative residency are fully in concert with those set forth by The Surgeons General of the Army, Navy, and Air Force; the Department of Veteran Affairs and Baylor University, and meet the standards and guidelines of the Accrediting Commission on Education for Health Services Administration (ACEHSA). The residency is designed to provide the Resident with an opportunity to:

1. Apply the theories, concepts, and practices presented during the didactic phase in an operational setting.
2. Develop knowledge of the clinical and administrative elements of military and civilian health care institutions.
3. Refine functional skills appropriate to middle level management positions in military health care settings.
4. Gain needed additional experience in those areas identified by preceptors and faculty readers as requiring additional challenge and support.
5. Strengthen and crystallize a code of personal ethics, a philosophy of management, and a dedication to the high ideals and standards of excellence for health career administration.
6. Develop, submit, and revise a Graduate Management Project Proposal (GMPP), and execute and complete an approved Graduate Management Project (GMP).

Appendix C

The Forty Joint Medical Executive Skills Competencies Organized into Competency Groupings
As Listed on Pages 7- 37 of the Joint Medical Executive Skills Development Program Core
Curriculum (Second Edition, June 9, 1998)

1. Military Medical Readiness

Medical Doctrine: Medical doctrine describes the fundamental principles by which medical forces guide their actions in support of military objectives. Medical doctrine provides a common perspective that requires judgment in application (p. 7).

Military Mission: The military mission establishes the relationship between the health care management organization and the line (p. 8).

Joint Operations/Exercises: Joint operations/exercises require participation in realistic individual, collective, unit, medical readiness training o include joint combined exercises or deployment (p. 8).

Total Force Management: Total Force management includes doctrine and procedures regarding management of military medical components (p. 9).

National Disaster Medical Systems Management/Department of Veterans Affairs Role: The National Disaster Medical System (NDMS) is a joint Federal, state, and local organization that provides a coordinated medical response in time of war, U.S. national emergency, or major U.S. domestic disaster. Other federal agencies that share responsibilities include the department of Health and Human Services (DHHS), Department of Transportation (DOT), the Federal Emergency Management Agency (FEMA), and the Department of Veterans Affairs (DVA) (p. 9).

Medical Readiness Training: Medical readiness training incorporates those courses, hands-on training programs and exercises designed to develop, enhance, and maintain military medical skills. Medical readiness training includes individual, collective, and unit training experiences to ensure health care personnel and units are capable of performing operational missions (p. 10).

Contingency Planning: Contingency planning requires the preparation for the delivery of medical services/care in emergencies involving military forces. Natural disasters, terrorists, subversives, or military operations may lead to these service requirements. Contingency planning, readiness planning, organization, management, logistics, personnel, and patient care are to meet operational and peacetime requirements (p. 10).

2. General Management

Strategic Planning: Strategic planning is the iterative organizational process for assessing the situation, establishing direction, developing, and executing HCMO strategic goals in support of mission requirements (p. 11).

Organizational Design: Organizational design is the configuration of the HCMO's design elements for efficiency and effectiveness (p. 12).

Decision Making: Decision making is the process of selecting courses of action from alternatives (p. 12).

Change and Innovation: Change and Innovation present opportunities to shape the future of the HCMO (p. 13).

Leadership: Leadership is the art and science of influencing others to accomplish the mission. It requires a complex set of skills and values to work with and through others (p. 15).

3. Health Law/Policy

Public Law: For the HCMO, public law includes all laws that specify requirements in areas such as public health, patient consent/rights, and environmental standards (p. 16).

Medical Liability: Medical liability includes tort and criminal offenses that may incur risk to the care facility or individual provides (p. 18).

Medical Staff By-Laws: Medical staff by-laws outline the conduct and privileges of the medical staff. The by-laws are typically developed and amended by the medical staff using Joint Commission on the Accreditation of Health Care Organization requirements regarding medical staff governance (p. 19).

Regulations: Regulations include Federal (including DoD), state, and local guidance that affect the HCMO (p. 20).

External Accreditation: External accreditation is an evaluative process performed by an accrediting organization that is an objective review of health care delivery practices within a health care facility. These accreditations are sought by medical facilities for various reasons, most important being the assurance to the facility seeking accreditation that it meets quality standards of patient care. Some of the more prominent accrediting organizations include the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), Inspector General, College of American Pathologists (CAP), and the National Committee on Assurance (NCQA) (p.20).

4. Health Resources Allocation and Management

Financial Management: Financial management includes the use of analytical techniques to assure that adequate resources are available to meet the HCMO's mission. Financial management includes operating the HCMO in a managed care environment, maintaining

financial records, controlling financial activities, identifying deviations (especially shortfalls) from planned performance, and strategic resourcing of the HCMO (p. 21).

Human Resource Management: Human resource management includes the staffing, management, and retention of personnel (p. 21).

Labor-Management Relations: Labor-management relations are the interactions between HCMO management and civilian staff. They include collective bargaining, the ability to recognize and implement fair labor practices, deal effectively with union negotiators, and handle grievances productively (p. 22).

Materiel Management: Materiel management is the phase of medical logistics that includes managing, cataloging, requirements determinations, procurement, distribution, maintenance, and disposal of supplies and equipment (p. 23).

Facilities Management: Facilities management is the maintenance and upkeep of real property, such as a building, structure, or utility system. It includes ensuring compliance with regulations (Occupational Safety and Health Administration (OSHA), fire codes, and requirements for handicap access) and oversight of facility design and construction (p. 24).

Information Management: Information management includes the principles, methods, and techniques for collecting, analyzing, processing, and delivering information to support readiness and the business processes of the HCMO (p. 25).

5. Ethics in the Health Care Environment

Ethical Decision-Making: Ethics consists of the processes, structures, and social constructs by which the rightness or wrongness of actions is assessed. Ethical issues emerge from a complex environment of reciprocal, intersecting, and, occasionally conflicting rights, duties, expectations, values, and morals. Ethical dilemmas arise when there is a conflict between

two legitimate, but mutually exclusive, demands. Ethical decision-making is the process of resolving such conflicts (p. 25).

Personal and Professional Ethics: Personal ethics are bases on which individuals determine the rightness or wrongness of conduct; professional codes of ethics represent articulated group or association statements of the morality of the members of the profession with regard to their professional roles (p. 26).

Bioethics: The discipline of bioethics represents the application of normative ethics to the life sciences, including medicine and associated research. It includes clinical ethics, which is typically restricted to the recognition and resolution of ethical problems involved in the care of a single patient but is more broad in scope, addressing the more general application of ethics through policy (p. 27).

Organizational Ethics: Organizational ethics describes the structures and processes by which an organization ensures conduct appropriate to its mission and vision. It is typically formalized in a code which addresses such matters as marketing, admission, transfer, discharge, pricing and billing, and describes the ethical dimensions of the internal and external relationships the organization has with its staff, contractors, educational institutions, and payers (p. 28).

6. Individual and Organizational Behavior

Individual Behavior: Individual behavior is the effect of the commander's behavior and personality on the HCMO (p. 29).

Group Dynamics: Group dynamics is the interaction among members of a group. To facilitate effective group behavior, the commander may employ team building, empowerment, responsibility, and motivation (p. 30).

Conflict Management: Conflict management involves the identification and use of techniques to effectively manage interpersonal, intra- and inter-group, and organizational conflicts. It requires impartiality, and use of negotiating and listening skills (p. 31).

Communication: Communication occurs when the receiver understands the sender's intended message. Effective communication relies on formal and informal channels established between sender and receiver both internal and external to the HCMO (p. 31)

Public Speaking: Public speaking is the set of verbal and organizing skills that permits one to effectively communicate ideas and concepts to others. It involves the ability to speak to audiences of many types, such as military and dependent beneficiaries, hospital staff, professional groups, community organizations, and others (p. 32).

Public and Media Relations: Public and media relations are the activities of shaping public opinion as the outcome of effectively delivering one's message in ways that cause it to be understood as intended (p. 33).

7. Clinical Understanding

Epidemiological Methods: Epidemiology is the science that deals with the current prevalence and incidence of disease within a population. Epidemiological methods include medical surveillance, interventions, and risk communications as key aspects of force medical protection (p. 32).

Clinical Investigation: Clinical investigation encompasses the acts surrounding the initiation, performance, completion, publication, and use of research. It requires compliance with multiple regulatory agency requirements, and federal, state, and local laws concerning the use of human and animal subjects (p. 34).

Alternative Health Care Delivery Systems: Alternative health care systems provide health care options in diverse, integrated delivery and finance systems (i.e., HMOs, PPOs, hospices, home health care organizations, and other community based health care delivery organizations) (p. 35).

8. Performance Measurement

Quality Management: Quality Management (QM) encompasses the procedures that emphasize involvement, empowerment, and continuous performance improvement. It focuses on customer satisfaction, critical processes, statistical measurement, and analysis as the primary tools for organizing and interpreting data. Effective QM addresses systemic problems and deficiencies (p. 35).

Quantitative Analysis: MHS quantitative analysis ensures that information is available for decision-making through the use of analytical tools and methodologies to collect, organize, arrange, analyze, interpret, and evaluate data (p. 36).

Outcome Measurements: Outcome measurements permit the HCMO commander to make fact-based decisions (p. 36).

Clinical Performance Improvement: Managing clinical performance is an ongoing, iterative process used to ensure the HCMO exploits opportunities for constant improvement. The effective program includes ongoing assessment of patient care, customer feedback, risk management, provider qualifications, utilization review, and the implementation of corrective and follow-up actions, where indicated (p. 37).

Appendix D

Knowledge Levels

As Listed on Page 7 of the Joint Medical Executive Skills Development Program Core

Curriculum (Second Edition, June 9, 1998)

Familiarization

- Correctly uses basic terminology
- Explains the major domain of interest
- “Understands” the need for the field
- Relies on others for all actions

Basic Understanding

- Uses full vocabulary
- Explains dominant issues
- Has a “working knowledge”
- Relies on others for technical support

Full Knowledge

- Evaluates studies and findings
- Capable of contributory writing
- Capable of full technical actions
- Consults with experts on an equal basis

Appendix E

Matrix of Important Health Care Domains/Skill Areas by Researcher

Interpreting the Matrix:

- Numbers indicate how the Domain/Skill area was prioritized in that particular study (the lower the number the higher the priority).
- YES indicates that a particular Domain/Skill area was identified, but not ranked in the study.
- NA indicates that a particular Domain/Skill was not identified in the study.

Researcher & Group Studied Domain/ Skill Area	Hudak et al. (1993) ACHE	Roberts et al. (1993) Navy	Hudak et al. (1994) Army	Hudak et al. (1997) ACMPE	Claypool et al. (1998) DoD	Sentell, Finstuen (1998) Navy	Rogers et al. (1999) Coast Guard
Cost/Finance	1	16	1	NA	NA	3	2
Leadership	2	NA	7	1	NA	1	5
Professional Staff Interaction	3	NA	6	NA	NA	6	13
Health Care Delivery Concepts	4	NA	2	6	NA	2	10
Access to Care	5	NA	3	NA	NA	5	12
Ethics	6	6	9	NA	YES	9	15
Quality & Risk Management	7	9	4	NA	YES	8	9
Technology	8	1	5	NA	NA	4	4
Marketing	9	NA	8	NA	NA	7	14
Managed Care	NA	NA	NA	NA	NA	NA	1
Personnel	NA	10	NA	NA	NA	NA	3
Education	NA	NA	NA	NA	NA	NA	6
Strategic Management	NA	14	NA	1	NA	NA	8
Readiness	NA	NA	NA	NA	YES	NA	11
Business	NA	NA	NA	NA	NA	NA	7
Relationship Management	NA	NA	NA	2	NA	NA	NA
Resource Management	NA	21	NA	3	YES	NA	NA
Functional Management	NA	NA	NA	4	NA	NA	NA
Stakeholder Management	NA	NA	NA	5	NA	NA	NA
General Management	NA	NA	NA	NA	YES	NA	NA
Health Resources Management	NA	NA	NA	NA	YES	NA	NA

Matrix continued from previous page

Researcher & Group Studied Domain/ Skill Area	Hudak et al. (1993) ACHE	Roberts et al. (1993) Navy	Hudak et al. (1994) Army	Hudak et al. (1997) ACMPE	Claypool et al. (1998) DoD	Sentell, Finstuen (1998) Navy	Rogers et al. (1999) Coast Guard
Individual & Organizational Behavior	NA	4	NA	NA	YES	NA	NA
Clinical Understanding	NA	NA	NA	NA	YES	NA	NA
Health/Law Policy	NA	12	NA	NA	YES	NA	NA
Management of Change	NA	1	NA	NA	NA	NA	NA
Conflict Management	NA	2	NA	NA	NA	NA	NA
Communications	NA	3	NA	NA	NA	NA	NA
Group Dynamics	NA	5	NA	NA	NA	NA	NA
Systems Perspective	NA	7	NA	NA	NA	NA	NA
Organizational Design	NA	8	NA	NA	NA	NA	NA
Decision Making	NA	11	NA	NA	NA	NA	NA
Productivity Management	NA	13	NA	NA	NA	NA	NA
Alternative Health Care Systems	NA	15	NA	NA	NA	NA	NA
Labor/Management Relations	NA	17	NA	NA	NA	NA	NA
Information Management	NA	18	NA	NA	NA	NA	NA
Facilities Management	NA	19	NA	NA	NA	NA	NA
Quantitative Management	NA	20	NA	NA	NA	NA	NA

Appendix F

A Listing of Top Rated SKAs by Researcher and Group Studied

Hudak et al. (1993) Fellows of the American College of Healthcare Executives

1. Patience, listening skills, and communications
2. Leadership, management, and human relations
3. Strategic thinking and sense of vision
4. Understand physician motives, needs, and politics
5. Skills in conflict management, team building, and motivational leadership
6. Sensitivity to staff problems and human relations
7. Ability to lead a board and medical staff
8. Knowledge of hospital finance/cost accounting
9. Creative problem solving, interpersonal, and practice management skills
10. Solve long-range problems and strategic planning
11. Ability to speak, write, and think fast on feet

Hudak et al. (1994) Commanders and Deputy Commanders for Administration from Army
Medical Treatment Facilities

1. Patience, listening skills, communication
2. Understanding managed care contracts and initiatives; Leadership, management, and human relations
3. Strategic thinking and sense of vision; Studies in conflict management, tea building, and motivational leadership

- 4 Leadership in mentoring, attracting quality people, and give clear guidance;
 - Creative thinking and the analytic ability to measure productivity with human resources
5. Creative problem solving, interpersonal and practice management skills;
 - Ability to lead a board and medical staff;
 - Knowledge of populations served and the ability to develop mission statements;
 - Health planning skills with an emphasis on managed ambulatory care;
 - Know hospital requirements;
 - Diplomatic, political, and negotiation skills
6. Effective quality assurance training, utilization management;
 - Know JCAHO trends and future requirements
7. Understanding and recognition of cost benefits of use in hospitals;
 - Polished information management skills, the ability to quantify and identify

Hudak et al. (1997) Fellows of the American College of Medical Practice Executives

1. Ability to listen, hear, and respond
2. Ability to build trust, respect and integrity
3. Ability and adaptability to change
4. Skill to speak effectively, write with a purpose, and listen attentively
5. Ability to work with many types of individuals
6. Exercise ethical and moral courage
7. Ability and adaptability to change
8. The ability to conduct win-win negotiations with physicians, hospitals, and colleagues
9. Ability to build shared vision for organization
10. Ability to communicate why change is needed to physicians

Sentell and Finstuen (1998) Naval Hospital Commanding Officers, Executive Officers, and Directors for Administration

1. People skills
2. Team building
3. Personal responsibility
4. Innovation
5. Communication skills
6. Moral integrity
7. Organizational ethics
8. Managing multidisciplinary teams
9. Wellness program development
10. Developing a “we” focus

Richardson and Schneller (1998) Senior Health Managers and Leading Educators in Health Management, Medicine, Nursing (SKAs not ranked)

- Critical thinking
- Qualitative/quantitative problem solving
- Collaborative and consensus-driven decision making
- Strategic thinking vice strategic planning
- Knowledge of clinical care, especially primary care
- Knowledge of the public health system and practices
- Understanding of the relationship between health policy formulation and organizational success

Claypool et al. (1998) SMEs from the Three Service Medical Departments, Current and Former MTF Commanders, Curriculum Developers, and a TRICARE Lead Agent Representative

- Identified forty executive skills competencies, unranked
- See Appendix C for a listing of the forty executive skills competencies

Rogers et al. (1999) Coast Guard Health Care Administrators and Commanding Officers of Units with Large Medical Facilities

1. Written communication skills
2. Listening skills
3. Ability to communicate orally
4. Active duty medical care requirements
5. Ability to create and manage a budget
6. Active duty medical standards
7. In-Depth knowledge of TRICARE Program; Ability to handle conflict
8. Ability to interact with providers
9. Health care customer relations skills
10. Requirements to support operational mission up