

Toward a Comprehensive Talent Management Program: Level-I Hospital Commander Preparation

by

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USAWC STRATEGY RESEARCH PROJECT

**Toward a Comprehensive Talent Management Program:
Level-I Hospital Commander Preparation**

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Abstract

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The purpose of this study was to identify competencies that first-time Level-I Medical Treatment Facility commanders state need further development before assuming command. This study also identified potential opportunities and experiences that the AMEDD could formalize and tailor to the individual officer before taking command. Finally, this study aimed to identify variables among current commanders that may project an educational trajectory for medical officers who have certain backgrounds, education, experiences, and specialties to develop a future quasi-predictive model. The results of this study showed statistical and practical significant differences in preparation of officers based on their branch, civilian education, and previous positions. It is recommended that educational and training opportunities align with these findings in an effort to provide the right education to the right person at the right time before an officer taking hospital command. One size does not fit all and custom-developed educational experiences based on precise and evidence-based continuing needs assessments of this sub-population is warranted and aligned with Section 760 of the Floyd D. Spence National Defense Authorization Act, 2001.

Toward a Comprehensive Talent Management Program: Level-I Hospital Commander Preparation

Military medicine has an exigent future in which the engagement of strategic military medical leaders will be essential. The Department of Defense projects that the military's health care program will cost \$51–53 billion (approximately 10% of the Department of Defense's base budget) for fiscal year 2013.¹ From 2000 to 2010, military health care costs increased from \$17.8 to \$43.5 billion, which reflected an increase in costs from 4.5 cents for every Department of Defense dollar spent to 6.1 cents per dollar within ten years.² President Obama's strategic defense guidance stressed the need to transition the military while focusing on national efforts to build a strong and viable economy.³ The President's intent is for the Department of Defense to develop an enterprise that will meet the threats of the 21st century within the fiscal constraints of a strained economy. Of course, the Army Medical Department (AMEDD) will follow, however, with less flexibility than the organization would like because Congress seems not to have an appetite to consider the Military Health System's recommendations to assist with curbing healthcare costs such as modifying Tricare co-pays for working military retirees who have access to care through current employers.⁴ The future of the AMEDD currently revolves around a 2020 strategy to transform from a system of health care to a system of health that focuses on maintaining and improving leadership capacity within a resource-reduced environment. The U.S. Army's Surgeon General (TSG) desires to create an environment in which officers, non-commissioned officers, enlisted, and civilian employees can thrive by leveraging their strengths by retooling how personnel talent is managed. The TSG shared her vision on the attributes she expects the new talent management endeavor to embody. The process is required to be

1) non-negotiable, 2) enduring, 3) supported through vision, 4) designed through the operating company model (standards, consistent, desired outcomes, accountable, innovative), and 5) enterprise wide. The talent management model should go beyond the traditional human capital distribution mindset and focus on building the bench across each of the medical branches.⁵

The purpose of this study is to identify competencies that first-time Level-I Medical Treatment Facility commanders stated require further development before assuming command. This study also identifies potential opportunities and experiences the AMEDD could formalize and tailor to the individual officer before taking command. Last, this study aims to identify variables among current commanders that may project an educational trajectory for officers who have certain backgrounds, education, experiences, and specialties to develop a future quasi-predictive model.

Talent Management Background

The strategic literature offers different definitions of talent management.⁶ Organizations include many processes, ideologies, and functions under talent management, including early identification of high performers, leader development, career planning, performance management, position growth, succession planning, position assignment, competency management, retention, and professional development. Talent management within many non-military organizations as well as in the business literature is the encompassing practice of integrating recruiting, hiring, development, and succession planning.⁷ A talent management process uses an overarching conceptual analysis of the method that focuses on retaining high performing employees who exhibit high potential. Many organizations use matrix-driven technology-based tools to control the complicated initiative because turnover is so

expensive.⁸ Considering the reduced resource environment in which the military may soon be operating, initiatives should focus on reducing the cost of turnover through better succession planning and leadership development. Strategies should also aim to reduce the level of talent that exits the organization.⁹

The purpose of talent management is to transition the individual development and planning of “building the bench” and personnel management up to the highest levels of the organization. This transition is away from traditional personnel systems that fill positions to one that revolves around meeting the strategic needs of the entire organization.¹⁰ The emphasis on developing individual capacity and potential provides for the enterprise a shift from traditional training and personnel development, and replaces most organizations’ conventional strategies to include the AMEDD.¹¹ When applied to the AMEDD, this transition has the potential to change its culture to view officers as value-added through their capacity and ability. This culture could lead to long-term outcomes and changing the mind-set from seeing officers as expenditures to one of investing in human capital that conveys a belief in the future strength of the organization.¹² This shift changes the emphasis of talent management from a cost to the organization to an investment for the organization. When an organization synchronizes strategic priorities with the purposeful development of existing and future talent, employees become more engaged.¹³ Conceptually, talent management should aim to synergize the different human capital management principles. The interconnected attributes of talent management—planning, coordination, and implementation—should incorporate much more than the traditional human resource department.¹⁴ In addition, for talent management to succeed at the enterprise level, senior leadership must be

intricately involved. Senior leadership needs to prioritize and align resources to support human capital as a strategic objective of the organization.¹⁵ Talent management should not be treated as a separate objective; rather, it should be viewed as an undercurrent within the organization that encompasses early talent identification that begins at or shortly after recruitment and continues through professional development and succession planning. Talent management becomes embedded within the strategic objectives of the organization.¹⁶ The civilian sector has realized the need to exploit talent management to survive in the highly competitive personnel market of the future.¹⁷ Many organizations are finding success with strategically aligning and engaging leaders at numerous points along the talent management continuum within the organization.¹⁸ Talent management is a crucial ingredient.

Talent management is uniquely positioned to help mitigate the volatile, uncertain, complex, and ambiguous environments that face not only the AMEDD but also the U.S. Army.¹⁹ Successful talent management can provide a systematic process that merges once standalone human resource functions such as performance evaluations, identification of potential, competency assessments, career planning, succession planning, professional development and training, and promotion with the strategic organizational vision.²⁰

AMEDD Talent Management

The AMEDD's current talent management development program (spearheaded by the TSG in December 2012) is multi-faceted and includes each of the personnel product lines (officers, NCOs, enlisted, and civilian). The officer talent management initiative focuses on early identification of high performance/high potential personnel, follow-on assignments for key positions (command, senior service college, fellowships,

training with industry, and advanced education), career mapping based on strengths, and coordination of education opportunities, among others. Before assuming key positions, careful and purposeful education, experience, and knowledge accumulation are essential in preparing the “right person” for the “right job” at the “right time.” The AMEDD narrowed the working definitions of talent management to four.²¹ In February 2013, the following definition was adopted: Talent management is a deliberate process to identify, develop, retain, and position people across Army Medicine.

The Army Medicine Talent Management Concept (AMTMC) identifies overarching core attributes that underpin the ideology. The AMTMC contends that talent should be mentored, developed, trained, assessed, and recruited; and incorporate three lines of focus.²² The Office of the Surgeon General (OTSG) should coordinate key and developmental positions instead of at the branch level (MC, AN, MS, SP, VC, and DC). The AMTMC states that an operating company model should produce qualified strategic leaders for the future to ensure that the right person is in the right job at the right time for the right reason. Such maximizing of talent will allow strategic leaders to manage outcomes that ensure a highly professional performing organization. Because of the highly diverse environment of the AMEDD, ensuring that leadership coordination is multi-dimensional is important. Strategic leader input required for a successful talent management process originates from the OTSG, AMEDD Center and School, Human Resource Command, Consultants to The Surgeon General, Civilian Corps executive leadership, senior Command Sergeants Major, and the Chief Talent Officer (CTO).

Level-I Hospital Command Focus

Leadership positions within the AMEDD are varied and complex. In an attempt to obtain evidenced-based recommendations that have measured applicability, this study

will narrow its focus to one specific position. This paper will focus on the preparation of first-time Level-I Table of Distribution and Allowances (TDA) inpatient hospitals as one sub-category of the overall AMEDD talent management program. Typically, these hospitals are the first hospital command for the officer selected by a United States Army central board. Currently, 19 Level-I medical activities exist within the United States Army. These facilities are the smallest inpatient hospitals in the AMEDD. The command position is branch immaterial in that nurses, physicians, Medical Service Corps officers, and Medical Specialist Corps officers compete for command. The career path of each of these officers is very different. Each type of officer comes into his or her first hospital command with a variety of preparation, knowledge, expertise, and experience. Although this Level-I medical treatment facility (MTF) is only one senior leadership position within the AMEDD, it usually represents the first opportunity for an AMEDD officer to lead an inpatient hospital. Leading an inpatient hospital is much different from commanding a traditional military unit. A hospital is responsible for the care of patients, including service members, family members, and retired personnel, and has a large civilian employee population, many of whom are unionized. These are just a few examples of the uniqueness of leading a hospital within the military. Given the varied backgrounds of each of the branches, identifying knowledge gaps before officers take command is essential. The command slate is published approximately one year before the officer takes command, and early identification of needs can enable steps to be taken to better prepare officers before they take command, specifically during the year before filling the position. Furthermore, specific program development through the identification of needs distinguished among the different branches is possible. For example, Army Nurse Corps

officers who are not as prepared in areas such as facility management and budgeting, physicians who are not as acquainted with labor law and hiring protocols, and Medical Service Corps officers who need additional training on clinical research practices and provider credentialing can enroll in specific educational programs during the year before assuming command.

Arguably, the Level-I hospital represents the highest risk of failure for a first-time hospital commander. In addition, this risk is transferred to the constituents, namely the patients. Unlike traditional commands that are nested at the company, battalion, and brigade levels, in which each commander gains experience through commanding successive levels that prepare the officer for the next level, the Level-I hospital command is the first MTF command within the continuum of hospital commands.

Joint Medical Executive Skills Institute (JMESI)

The Department of Defense Appropriations Act of 1992 contained a provision requiring officers selected to command Medical Treatment Facilities to possess professional administrative competencies. The Assistant Secretary of Defense for Health Affairs drafted legislation through a task force that initially compiled 34 competencies mandating MTF commanders to possess before taking command as per Section 760 of the Floyd D. Spence National Defense Authorization Act, 2001.²³

DoD Instruction 6000.15 dictates the policy and designates responsibility for how the Military Health System (MHS) will satisfy the legislative requirement. This directive

Table 1. JMESI Competencies

JOINT MEDICAL EXECUTIVE SKILLS PROGRAM COMPETENCIES		
MTF Commanders	Lead Agents	Staff Members
Military Medical Competencies		Leadership and Organizational Management Competencies
o Medical Doctrine o Military Mission o Total Force Management o Medical Readiness Training o Emergency Management and Contingency Planning		o Strategic Planning o Organizational Design o Decision Making o Change Management o Leadership
Health Law and Policy Competencies		Health Resources Allocation Competencies
o Public Law o Medical Liability o Medical Staff By-Laws o Regulations o Accreditation and Inspections		o Financial Management o Human Resource Management o Labor-Management Relations o Materiel Management o Facilities Management o Information Management and Technology
Ethics in the Health Care Environment Competencies		Individual and Organizational Behavior Competencies
o Personal and Professional Ethics o Bioethics o Organizational Ethics		o Personal and Professional Individual Behavior o Group Dynamics o Conflict Management o Interpersonal Communication o Public Speaking o Strategic Communication
Performance Measurement and Improvement Competencies		
o Population Health Improvement o Clinical Investigation o Integrated Health Care Delivery Systems o Quality Management and Performance Improvement o Patient Safety		

formalizes the Joint Medical Executive Skills Development Program.²⁴ The commander of the AMEDD Center and School is the proponent for managing the Executive Skills

program for the U.S. Army Medical Command.²⁵ The competencies are divided into seven domains: 1) military medical readiness, 2) individual and organizational behavior, 3) leadership and organizational management, 4) health resource allocation, 5) health law and policy, 6) performance measurement and improvement, and 7) ethics in healthcare.²⁶ In January 2012, the voting review board added joint and interagency language, renamed five competencies, and combined others. This study used the previous competency names. One concern was that current commanders and those who had commanded when the previous competency names were being used would not be familiar with the new names.

The AMEDD has three primary educational opportunities that address the Joint Medical Executive competencies: AMEDD Executive Skills Course, the AMEDD Pre-command Course, and the JMESI Distant Learning Modules.

AMEDD Executive Skills Course

This course provides relevant education and training for key and essential personnel, including individuals selected as Deputy Commanders. Although this program is set up to provide “just-in-time” education in an effort to bolster the officer’s skills and abilities within the executive realm, the depth to which each of the JMESI competencies can be addressed is limited in a five-day course offered once a year in April, which may not be adequate for addressing complex topics such as, for example, health care finance, labor law, and facilities management. Current topics covered include:

- Healthcare Leadership
- Business Case Analysis

- Financial Management in the MTF
- Improving Hospital Performance
- Quality Management/Joint Commission
- Legal Issues
- Commander Perspective
- Corps Specific Breakout Session
- Hardwiring Excellence

The course director sends out an informal survey six months after the end of the course. Because officers assume their new deputy positions in June/July, they are only in the position for approximately three to four months at the time of the survey.

Moreover, the AMEDD Executive Skills Course conducts breakout sessions for each branch (MC, MS, and AN) to cover more specific information pertaining to their upcoming positions. Although doing so may enhance the officers within a specific corps, this practice further limits the learning opportunity by not exposing students to a broader range of critical topics of importance within other corps. Of note, from the time an officer attends the AMEDD Executive Skills Course to taking command is an average of two to five years. In addition, not all Level-I MTF commanders previously served as a deputy commander or attend this course.

AMEDD Battalion/Brigade Pre-command Course

In addition to the AMEDD Executive Skills Course, the AMEDD offers a two-week Battalion/Brigade Pre-command Course that covers some of the JMESI competencies. However, the curriculum is much broader because the officers attending the Pre-command Course enter a wider range of command positions, including research,

recruiting, training, table of organization and equipment (TO&E), logistics, and fixed-facilities such as hospitals. Only the following areas addressed in the AMEDD Pre-command course are covered that overlap with JMESI competencies:

- Media Relations
- Composite Risk Management
- Legal Issues for Commanders
- Congressional Delegations
- Risk Communications
- Human Capital Management & Distribution
- Homeland Security
- Contracting for MTF Commanders
- Fiscal Law
- Joint Commission/Quality Management
- MEDCOM Ombudsman Program
- Data Quality Control Management
- Human Dimension Training
- MEDCOM Operations Update

Although the AMEDD provides educational opportunities that address Joint Medical Executive competencies, some areas are more complex and generally less understood and require more time to cover with more intensity and in greater depth.

JMESI Training Modules

Thirty-five administrative competency training modules are available through the JMESI website at <https://jmesi.army.mil/login.aspx>. Although the modules are not

intended to provide the competencies, they are designed to provide an opportunity for successful performance and assist with obtaining the base knowledge required to start building one's executive skills education portfolio. The modules assist in “developing leader expertise in eight substantive areas including readiness, general management, health law and policy, health resources allocation and management, individual and organizational behavior, legal and ethical behaviors, clinical understanding, and performance measurement.”²⁷

Research Significance to the AMEDD

Currently, no formal tools, surveys, or data collection methods exist that AMEDD obtains from current or exiting Level-I commanders regarding preparedness or competencies. The AMEDD makes education determinations through the AMEDD Center and School without the benefit of validated and tested command exit surveys. Making educational policy changes in this manner is reactive and not evidence-based or reliable. Obtaining data that could lead to evidence-based policy and education changes would prove beneficial, introspective, and proactive. Because first-time Level-I MTF commanders are unique in that the position is often their first colonel level command, many have no command experience before taking a Level-I MTF, and a Level-I MTF command has unique challenges²⁸, a survey at the midway point of their command could reveal more insight into critical information that could lead to more accurate and valuable policy and education considerations regarding future commanders. This research will seek to understand more completely the different competencies of different types of medical officers entering command. By identifying areas of concentration, the AMEDD could initiate more specific and targeted education initiatives.

Theoretical Framework and Conceptual Model

Bachrach's²⁹ definition of theory contends that, systematically and synergistically, variables are associated by hypotheses and constructs are interconnected and interrelated by propositions. Theorists' assumptions underpin this entire arrangement. This study uses critical reflection theory to frame major constructs, variables, and propositions.

Critical Reflection Theory

Organizational effectiveness hinges on its ability to become a reflective learning organization.³⁰ Reflective learning concentrates on the type of learning accomplished through experience but is not an in-depth transformational process.³¹ Stephan Brookfield defined critical reflection as "reflecting on the assumptions underlying ours and other's ideas and actions, and contemplating alternative ways of thinking..."³² For an organization's leaders and policy makers to critically reflect, they must be self-aware.³³ In addition to the organization's leadership to be self-aware, they must also be able to accurately interpret experiences³⁴ and critically analyze assumptions and accepted truths.³⁵ Critical reflection theory underpins this study because it requires the collective to critically dismantle ideologies that may be commonly held, even for quite some time. Assumptions could be false. Organizations that vest into critical reflection will positively view imagining and exploring of assumptions. The intent of this study is to use Brookfield's phases for successful critical thinking on how the AMEDD prepares officers to assume Level-I MTF command. Brookfield's phases include:

1. Identifying a trigger event;
2. Appraisal of assumptions;
3. Exploration of alternatives to current assumptions;
4. Developing alternative perspectives; and,

5. Integration of new perspectives.³⁶

Critical reflection theory (CRT) has a direct application for exploring how the AMEDD prepares its officers for Level-I MTF command because it provides rationale and direction, which challenges currently held assumptions. CRT supports context-based, flexible organizational change methodology, as well as new and innovative thought processes that are essential to organizational change. Innovative thinking spurred by CRT leads to a critical assessment of traditions and historical processes and seeks methods that may lead to transformation. Although CRT is commonly used as an adult learning theory, adult learning theories have applicability to organizational theory to include organizational change application.³⁷

Design

This study used a descriptive non-experimental prospective design to ask current and post-command Level-I Medical Treatment Facility commanders to examine their perceptions, feelings, and experiences of their preparation on assuming a Level-I command and to assess the role played by their experiences and education. The purpose of a non-experimental descriptive study is to observe, describe, and document attributes of a situation as it normally and naturally transpired.³⁸ Descriptive correlational research describes the relationship among variables rather than cause-and-effect relationships.³⁹ A correlational research design is appropriate because it attempts to identify and examine the relationship between specific backgrounds and level of preparedness among different attributes. The conduct of this study adhered to appropriate ethical standards and principles.⁴⁰ This study also obtained U.S. Army War College IRB approval.⁴¹

Population and Sample

The population of interest for this study was all current Level-I Medical Treatment Facility commanders and previous commanders that have left command within the past two years. Currently, there are 19 Level-I Commanders, nine officers who left command in the summer of 2012, and 10 officers who left command in the summer of 2011, for a total of 38 officers. Only 36 are currently available and two have since retired. A convenience sample of officers identified volunteered to participate in the survey. All 36 officers were accessible.

Plan of Analysis

Statistical Methods

Descriptive statistics were used to present frequency distributions of the study participants, along with their responses to the survey questions. This information is used to examine the central tendency and variability of the data. Cross-tabulations illustrating descriptive statistics are included. Correlation analysis was performed to evaluate co-linearity between the chosen variables. In addition, analysis of variance was used as well as non-parametric significance tests. Last, a series of post hoc analyses were conducted using pairwise comparisons.

Survey and Data Collection Procedures

An OTSG-supported survey was administered in late January 2013.⁴² The questionnaire was developed using the existing JMESI competencies. Related to the goal of producing information from this study applicable to future Level-I MTF commanders, the aim was to use pre-existing and validated measures relevant to the study's goals of developing a tool to identify areas of need.

The link to the web-based questionnaire (see Appendix A) was e-mailed to each of the 36 officers mail from the researcher. This study used an Internet-based survey to obtain data for qualitative and quantitative analysis.⁴³

The design of this study, the construction of the questionnaire, and the procedures followed a modified Dillman's Method.⁴⁴ The intent was to align with Dillman's assertions that survey procedures need to create trust, rewards, and reduced cost to respondents. Specific to this study, the implicit reward for responding was that the officers might perceive that they contributed to the AMEDD and their profession by providing information about the status of command preparation. The use of an Internet-based survey eliminated costs and reduced the time to complete the survey to less than 20 minutes. Finally, in an attempt to establish trust, respondents were informed that their responses were confidential; steps were taken to ensure anonymity and participants were assured that the data would be reported only in the aggregate. The participants were offered the opportunity to receive the outcome of the survey after completion. The use of a commercial survey site assisted in alleviating respondents' concerns of anonymity, traceability, and retribution.

The survey was e-mailed to 36 officers identified as either currently in or within two years of being in a Level-I MTF command. The online survey site was disabled on February 15, 2013 with 31 surveys captured for an 86% response rate.

Data Quality

As previously stated, to maximize the response rate, a modified Dillman's Method was employed.⁴⁵ The results were downloaded from the Survey Monkey© site into a Microsoft Office® Excel® spreadsheet. After downloading, data were verified

twice through visual inspection and then data labels were reviewed before transferring them into SPSS Statistics 21.0® for further analysis.⁴⁶

Limitations

This study has three main limitations. First, this study included only 31 participants. Although these participants represented 82% of the defined population (N=39) and 86% of the available population (36), extrapolation to a wider defined population (all officers who were Level-I commanders in the past and all officers who will be Level-I commanders in the future) should be done with caution. Second, a cross-sectional study measures variables within a defined population at a single point in time (snapshot). The point in time nature has weaknesses in determining causality.⁴⁷ Distinct variables are measured simultaneously and may be related but usually cannot positively determine cause and effect. In addition, cross-sectional studies also present difficulty with the inclusion of confounding and extraneous variables. These variables may affect identified relationships between variables but many not affect the variables themselves. Last, a Neyman bias may be present. This prevalence-incidence bias occurs when subjects who answer surveys are unable to do so with 100% accuracy. This concern will magnify or minimize certain variable effects.⁴⁸

Results

Initially, a series of descriptive statistics were conducted on the items included in this study to present an initial description of these data and the respondents included. Descriptive statistics were conducted on all measures, including demographic items, as well as the measures focusing on respondents' level of preparedness in 41 different competencies. The purpose of the descriptive statistics conducted on the various

competencies was to determine the overall level of preparedness for the entire sample, including an exploration of the areas in which respondents feel they are least prepared.

First, the following table summarizes respondents with regard to a current stage of command. Slightly more than 25% of respondents were in their first year of Level-I MTF command and approximately 23% of individuals were currently in their second year of Level-I MTF command. Slightly more than 35% of respondents were in their first year of post-Level-I MTF command, and slightly more than 16% of respondents were in their second year of post-Level-I MTF command.

Table 2. Current Stage

<i>Category</i>	<i>N</i>	<i>%</i>
First year of Level-I MTF command	8	25.81
Second year of Level-I MTF command	7	22.58
First year post-Level-I MTF command	11	35.48
Second year post-Level-I MTF command	5	16.13
<u>Total</u>	<u>31</u>	<u>100.00</u>

Next, the following table summarizes responses with regard to previous command of a non-centralized selection list (non-CSL) clinic. Slightly more than 25% of respondents had previous command of a non-CSL clinic, and close to 75% of respondents had no such experience.

Table 3. Previous Non-CSL Clinic Command

<i>Category</i>	<i>N</i>	<i>%</i>
Yes	8	25.81
No	23	74.19
<u>Total</u>	<u>31</u>	<u>100.00</u>

With regard to the position that the respondent felt best prepared them for Level-I MTF command, close to 55% of respondents indicated that serving as a deputy commander best prepared them for command, and slightly more than 16% indicated serving as chief of staff best prepared them. Close to 13% of respondents indicated that non-CSL command best prepared them, with less than 8% of respondents each

indicating that battalion (BN) command, other previous command, or division surgeon prepared them best.

Table 4. Best Preparing Previous Position

<i>Category</i>	<i>N</i>	<i>%</i>
Non-CS Command	4	12.90
BN Command	1	3.23
Chief of Staff	5	16.13
Deputy Commander	17	54.84
Previous Command (other)	2	6.45
Division Surgeon	2	6.45
<u>Total</u>	<u>31</u>	<u>100.00</u>

Within this sample, more than 77% of respondents were found to have served previously as a deputy commander, and slightly more than 22% had not served.

Table 5. Previous Deputy Command Position

<i>Category</i>	<i>N</i>	<i>%</i>
Yes	24	77.42
No	7	22.58
<u>Total</u>	<u>31</u>	<u>100.00</u>

Next, the following table summarizes respondents with regard to highest level of education. Slightly more than 58% of respondents had a non-clinical masters other than a Masters of Health Administration (MHA), and close to one third of the sample had an MHA masters. Close to 50% of respondents had a clinical doctorate (MC-physicians) and slightly more than 16% of individuals had a clinical masters degree.

Table 6. Highest Civilian Education Level

<i>Category</i>	<i>N</i>	<i>%</i>
Masters (Clinical)	5	16.13
Masters (non-clinical other than MHA)	18	58.06
Masters (MHA)	10	32.36
<u>Doctorate (Clinical)</u>	<u>15</u>	<u>48.39</u>

With regard to the highest military level of education, close to 52% of respondents indicated that Senior Service College (SSC) (Correspondence) was their highest level of education, and close to 30% of respondents indicating that SSC (Resident) was their highest level of military education. Nearly 10% indicated that

CGSC/ILE (Resident) was their highest level of military education, with the same percentage indicating that CGSC/ILE (Correspondence) was their highest military level of education.

Table 7. Highest Military Education Level

<i>Category</i>	<i>N</i>	<i>%</i>
CGSC/ILE – Resident	3	9.68
CGSC/ILE – Correspondence	3	9.68
SSC – Resident	9	29.03
SSC – Correspondence	16	51.61
<u>Total</u>	<u>31</u>	<u>100.00</u>

The following table summarizes respondents with regard to corps. Slightly more than 45% of respondents served in the Medical Corps, and close to 40% served in the Medical Service Corps. Close to 13% of individuals were serving in the Army Nurse Corps, and slightly more than 3% served in the Medical Specialist Corps.

Table 8. Corps/Branch

<i>Category</i>	<i>N</i>	<i>%</i>
MS	12	38.71
AN	4	12.90
MC	14	45.16
SP	1	3.23
<u>Total</u>	<u>31</u>	<u>100.00</u>

Next, the following table summarizes responses with regard to level of knowledge, understanding, and ability when Level-I MTF command was first taken. Respondents most commonly indicated that they were "completely comfortable" with the following areas: medical doctrine, military mission, national disaster medical systems management, the Department of Veterans Affairs role, medical readiness training, contingency planning, strategic planning, organizational design, decision-making, change/innovation, leadership, medical liability, medical staff bylaws, regulations, external accreditation, human resources management, materiel management, facilities management, ethical decision making, personal/professional

ethics, bioethics, organizational ethics, individual behavior, group dynamics, conflict resolution, communication, public speaking, public/media relations, clinical investigation, alternative health care delivery systems, quality management, quantitative analysis, outcome measurements, and clinical performance improvement.

Respondents most commonly indicated they were "somewhat comfortable" with the following areas: joint operations, total force management, public law, information management, and epidemiological methods. With regard to financial management, an equal number of respondents indicated that they were "completely comfortable" and "somewhat comfortable." In no case did respondents most commonly indicate that they were neither comfortable nor uncomfortable, were somewhat uncomfortable, or were completely uncomfortable with their level of knowledge, understanding, and ability when they first took Level-I MTF command.

Table 9. Competency Comfort

<i>Category</i>	<i>Completely Comfortable</i>	<i>Somewhat Comfortable</i>	<i>Neither</i>	<i>Somewhat Uncomfortable</i>	<i>Completely Uncomfortable</i>
Medical Doctrine	23 (74.19%)	8 (25.81%)			
Military Mission	30 (96.77%)	1 (3.23%)			
Joint Operations	11 (35.48%)	16 (51.61%)	3 (9.68%)	1 (3.23%)	
Total Force Mgmt.	11 (35.48%)	16 (51.61%)	4 (12.90%)		
National Dis. MSM	13 (41.94%)	12 (38.71%)	5 (16.13%)	1 (3.23%)	
Dept. of VA	15 (48.39%)	10 (32.26%)	5 (16.13%)	1 (3.23%)	
Med. Read. Tng	23 (74.19%)	8 (25.81%)			
Cont. Planning	19 (61.29%)	10 (32.26%)	2 (6.45%)		
Strategic Planning	20 (64.52%)	10 (32.26%)	1 (3.23%)		
Org Design	20 (64.52%)	9 (29.03%)	2 (6.45%)		
Decision-Making	29 (93.55%)	2 (6.45%)			
Change/Innovation	26 (83.87%)	5 (16.13%)			
Leadership	27 (87.10%)	4 (12.90%)			
Public Law	5 (16.13%)	19 (61.29%)	7 (22.58%)		
Medical Liability	17 (54.84%)	13 (41.94%)	1 (3.23%)		
Med Staff Bylaws	17 (54.84%)	12 (38.71%)	1 (3.23%)	1 (3.23%)	
Regulations	17 (54.84%)	14 (45.16%)			
Ext Accreditation	25 (80.65%)	6 (19.35%)			
Financial Mgt	12 (38.71%)	12 (38.71%)	2 (6.45%)	5 (16.13%)	
HR Management	16 (51.61%)	12 (38.71%)	3 (9.68%)		
Labor Mgmt. Rela.	15 (48.39%)	11 (35.48%)	3 (9.68%)	2 (6.45%)	
Materiel Mgmt.	14 (45.16%)	13 (41.94%)	4 (12.90%)		
Facilities Mgmt.	13 (41.94%)	12 (38.71%)	4 (12.90%)	2 (6.45%)	
Information Mgmt.	11 (35.48%)	17 (54.84%)	2 (6.45%)	1 (3.23%)	
Ethl Dec.-Making	30 (96.77%)	1 (3.23%)			
Pers./Prof. Ethics	31 (100.00%)				
Bioethics	16 (51.61%)	10 (32.26%)	4 (12.90%)	1 (3.23%)	
Org. Ethics	31 (100.0%)				
Individual Behavior	29 (93.55%)	2 (6.45%)			
Group Dynamics	27 (87.10%)	4 (12.90%)			
Conflict Resolution	21 (67.74%)	10 (32.26%)			
Communication	26 (83.87%)	4 (12.90%)	1 (3.23%)		
Public Speaking	23 (74.19%)	7 (22.58%)	1 (3.23%)		
Public/Media Rela.	18 (58.06%)	10 (32.26%)	3 (9.68%)		
Epi. Methods	9 (29.03%)	16 (51.61%)	4 (12.90%)	2 (6.45%)	
Clinical Invest	12 (38.71%)	10 (32.26%)	8 (25.81%)	1 (3.23%)	
Alt. Health Care	12 (38.71%)	11 (35.48%)	6 (19.35%)	2 (6.45%)	
Quality Mgmt.	18 (58.06%)	13 (41.94%)			
Quant Analysis	15 (48.39%)	11 (35.48%)	4 (12.90%)	1 (3.23%)	
Outcome Meas.	19 (61.29%)	9 (29.03%)	3 (9.68%)		
Clin. Perf. Improv.	21 (67.74%)	9 (29.03%)	1 (3.23%)		

The following table summarizes responses with regard to the top three areas in which respondents believed they would have most benefited from additional education and experience. In all cases, only a minority of respondents indicated these items as being their first, second, or third choice. Overall, the areas most indicated by

respondents as being one of their first three choices consisted of financial management, public media relations, Veterans Affairs, labor laws, clinical performance, facility management, and human resources management. In all of these cases, five or more respondents indicated that these were one of their top three choices of areas in which they felt additional education and experience would have most benefited them.

Table 10. Top Least Prepared Competencies

<i>Category</i>	<i>First Choice</i>	<i>Second Choice</i>	<i>Third Choice</i>
Add. Financ. Mgmt.	7 (53.85%)	4 (30.77%)	2 (15.38%)
Additional Leadership	1 (50.00%)	1 (50.00%)	
Add. Team Building			2 (100.00%)
Add. Pub. Media Rela.	3 (60.00%)	1 (20.00%)	1 (20.00%)
Add. Public Law		1 (25.00%)	3 (75.00%)
Add. Veterans Affairs	1 (20.00%)	2 (40.00%)	2 (40.00%)
Add. Alt. Health	1 (33.33%)	1 (33.33%)	1 (33.33%)
Add. Clin. Investig.	1 (100.00%)		
Add. Epi. Methods		1 (25.00%)	3 (75.00%)
Add. Labor Law	3 (42.86%)	4 (57.14%)	
Add. Health Law			1 (100.00%)
Add. National Dis.	1 (50.00%)	1 (50.00%)	
Add. Bioethics		2 (100.00%)	
Add. Clinical Perf.	1 (20.00%)	2 (40.00%)	2 (40.00%)
Add. Info. Tech.		2 (50.00%)	2 (50.00%)
Add. Fac. Mgmt.	1 (20.00%)	1 (20.00%)	3 (60.00%)
Add. Medical Staff	2 (66.67%)	1 (33.33%)	
Add. Conting. Plan		1 (100.00%)	
Add. External Acc.			1 (100.00%)
Add. Total Force Mgmt.	1 (50.00%)	1 (50.00%)	
Add. Joint Operations	1 (100.00%)		
Add. Med. Readiness			1 (100.00%)
Add. HR Mgmt.	3 (50.00%)	2 (33.33%)	1 (16.67%)
Add. Org. Design	1 (100.00%)		
Add. Conflict Resol.			1 (100.00%)
Add. Materiel Mgmt.	2 (100.00%)		
Add. Med. Doctrine		1 (100.00%)	
Add. Regulations		1 (100.00%)	

Following this, statistical analyses were conducted to determine whether statistically significant differences in the level of preparedness were present between members of the following groups:

- Those who previously commanded a non-CSL clinic;
- Those who were previously a deputy commander;

- Level of education; and,
- Corps/branch.

Because the first two items consist of dichotomous measures (i.e., respondents either commanded/served in this position or they did not), a series of Mann-Whitney U tests were conducted on all items relating to level of preparedness on the basis of these groups. The Mann-Whitney U test was conducted because the dependent variables in all cases were ordinal, and was measured using a five-point Likert scale. This scale would make the independent-samples t-test, which assumes normal distribution, continuous dependent variables, which are inappropriate in this case. Instead, the Mann-Whitney U test, a non-parametric statistical test that does not incorporate this assumption, was utilized.

First, the following table summarizes the results of the Mann-Whitney U tests conducted on whether or not the respondent had previous command of a non-CSL clinic. With regard to each group and for the entire sample, sample sizes are presented, along with the rank sum and expected rank sum. The calculated z-score and the associated probability level, which determines statistical significance, are also presented in the following table for each analysis. As shown, statistical significance was found for the following items: strategic planning, public law, medical liability, financial management, and outcome measures. In all of these cases, individuals who had previous command of a non-CSL clinic had a significantly higher score than what was expected on these measures, indicating that these individuals were significantly less

Table 11. Mann-Whitney U Tests: Previous Command of a Non-CSL Clinic

<i>Measure</i>	<i>Yes</i>			<i>No</i>			<i>Total</i>			<i>z</i>	<i>p</i>
	<i>N</i>	<i>RS</i>	<i>Exp.</i>	<i>N</i>	<i>RS</i>	<i>Exp.</i>	<i>N</i>	<i>RS</i>	<i>Exp.</i>		
Medical Doctrine	8	142.5	128	23	353.5	368	31	496	496	.863	.388
Military Mission	8	124	128	23	372	368	31	496	496	.590	.555
Joint Operations	8	111.5	128	23	384.5	368	31	496	496	.824	.410
Total Force Mgmt.	8	149	128	23	347	368	31	496	496	1.049	.294
National Dis. MSM	8	138.5	128	23	357.5	368	31	496	496	.510	.610
Dept. of Veteran Affs.	8	159.5	128	23	336.5	368	31	496	496	1.543	.123
Med. Read. Training	8	142.5	128	23	353.5	368	31	496	496	.863	.388
Contingency Planning	8	144	128	23	352	368	31	496	496	.842	.400
Strategic Planning	8	164.5	128	23	331.5	368	31	496	496	1.971	.049
Organizational Design	8	147.5	128	23	348.5	368	31	496	496	1.047	.295
Decision-Making	8	135.5	128	23	360.5	368	31	496	496	.795	.426
Change/Innovation	8	123.5	128	23	372.5	368	31	496	496	.319	.750
Leadership	8	112	128	23	384	368	31	496	496	1.243	.214
Public Law	8	172	128	23	324	368	31	496	496	2.286	.022
Medical Liability	8	169	128	23	327	368	31	496	496	2.120	.034
Medical Staff Bylaws	8	115	128	23	381	368	31	496	496	.665	.506
Regulations	8	118.5	128	23	377.5	368	31	496	496	.497	.619
External Accreditation	8	135	128	23	361	368	31	496	496	.462	.644
Financial Management	8	188.5	128	23	307.5	368	31	496	496	2.911	.004
HR Management	8	139	128	23	357	368	31	496	496	.554	.580
Labor Mgmt. Rela.	8	165.5	128	23	330.5	368	31	496	496	1.845	.065
Materiel Mgmt.	8	149.5	128	23	346.5	368	31	496	496	1.064	.288
Facilities Mgmt.	8	129.5	128	23	366.5	368	31	496	496	.073	.942
Information Mgmt.	8	138.5	128	23	357.5	368	31	496	496	.533	.594
Ethical Dec.-Making	8	124	128	23	372	368	31	496	496	.590	.555
Pers./Prof. Ethics	8	128	128	23	368	368	31	496	496	-	-
Bioethics	8	130.5	128	23	365.5	368	31	496	496	.124	.901
Org. Ethics	8	128	128	23	368	368	31	496	496	-	-
Individual Behavior	8	135.5	128	23	360.5	368	31	496	496	.795	.426
Group Dynamics	8	127.5	128	23	368.5	368	31	496	496	.039	.969
Conflict Resolution	8	134.5	128	23	361.5	368	31	496	496	.362	.717
Communication	8	125.5	128	23	370.5	368	31	496	496	.177	.860
Public Speaking	8	130	128	23	366	368	31	496	496	.118	.906
Public/Media Rela.	8	131	128	23	365	368	31	496	496	.154	.877
Epi. Methods	8	148	128	23	348	368	31	496	496	.987	.324
Clinical Investigation	8	149.5	128	23	346.5	368	31	496	496	1.028	.304
Alt. Health Care	8	143	128	23	353	368	31	496	496	.718	.473
Quality Mgmt.	8	122.5	128	23	373.5	368	31	496	496	.290	.772
Quantitative Analysis	8	154	128	23	342	368	31	496	496	1.280	.201
Outcome Meas.	8	168	128	23	328	368	31	496	496	2.092	.036
Clin. Perf. Improv.	8	148	128	23	348	368	31	496	496	1.107	.268

comfortable with these items compared with those who did not have previous command of a non-CSL clinic.

Next, the following table summarizes the Mann-Whitney U tests conducted on whether the respondent previously served as a deputy commander.

Table 12. Mann-Whitney U Tests: Previously Served as a Deputy Commander

<i>Measure</i>	<i>Yes</i>			<i>No</i>			<i>Total</i>			<i>z</i>	<i>p</i>
	<i>N</i>	<i>RS</i>	<i>Exp.</i>	<i>N</i>	<i>RS</i>	<i>Exp.</i>	<i>N</i>	<i>RS</i>	<i>Exp.</i>		
Medical Doctrine	14	230	224	17	266	272	31	496	496	.314	.754
Military Mission	14	217	224	17	279	272	31	496	496	.907	.364
Joint Operations	14	224.5	224	17	271.5	272	31	496	496	.022	.983
Total Force Mgmt.	14	225.5	224	17	270.5	272	31	496	496	.066	.948
National Dis. MSM	14	226.5	224	17	269.5	272	31	496	496	.107	.915
Dept. of Veteran Affs.	14	212.5	224	17	283.5	272	31	496	496	.495	.621
Med. Read. Training	14	199	224	17	297	272	31	496	496	1.309	.191
Contingency Planning	14	189.5	224	17	306.5	272	31	496	496	1.596	.111
Strategic Planning	14	197.5	224	17	298.5	272	31	496	496	1.259	.208
Organizational Design	14	190.5	224	17	305.5	272	31	496	496	1.581	.114
Decision-Making	14	225.5	224	17	270.5	272	31	496	496	.140	.889
Change/Innovation	14	189	224	17	307	272	31	496	496	2.180	.029
Leadership	14	211.5	224	17	284.5	272	31	496	496	.854	.393
Public Law	14	213	224	17	283	272	31	496	496	.503	.615
Medical Liability	14	238	224	17	258	272	31	496	496	.637	.524
Medical Staff Bylaws	14	241.5	224	17	254.5	272	31	496	496	.788	.431
Regulations	14	203.5	224	17	292.5	272	31	496	496	.944	.345
External Accreditation	14	228.5	224	17	267.5	272	31	496	496	.261	.794
Financial Management	14	217	224	17	279	272	31	496	496	.296	.767
HR Management	14	196.5	224	17	299.5	272	31	496	496	1.217	.224
Labor Mgmt. Rela.	14	213.5	224	17	282.5	272	31	496	496	.454	.650
Materiel Mgmt.	14	216.5	224	17	279.5	272	31	496	496	.326	.744
Facilities Mgmt.	14	192	224	17	304	272	31	496	496	1.364	.172
Information Mgmt.	14	188.5	224	17	307.5	272	31	496	496	1.584	.113
Ethical Dec.-Making	14	217	224	17	279	272	31	496	496	.907	.364
Pers./Prof. Ethics	14	224	224	17	272	272	31	496	496	-	-
Bioethics	14	260.5	224	17	235.5	272	31	496	496	1.593	.111
Org. Ethics	14	224	224	17	272	272	31	496	496	-	-
Individual Behavior	14	225.5	224	17	270.5	272	31	496	496	.140	.889
Group Dynamics	14	211.5	224	17	284.5	272	31	496	496	.854	.393
Conflict Resolution	14	185	224	17	311	272	31	496	496	1.911	.056
Communication	14	204	224	17	292	272	31	496	496	1.242	.214
Public Speaking	14	198	224	17	298	272	31	496	496	1.354	.176
Public/Media Rela.	14	181.5	224	17	314.5	272	31	496	496	1.922	.055
Epi. Methods	14	263	224	17	233	272	31	496	496	1.693	.091
Clinical Investigation	14	268.5	224	17	227.5	272	31	496	496	1.870	.062
Alt. Health Care	14	253.5	224	17	242.5	272	31	496	496	1.241	.215
Quality Mgmt.	14	226	224	17	270	272	31	496	496	.093	.926
Quantitative Analysis	14	220.5	224	17	275.5	272	31	496	496	.152	.880
Outcome Meas.	14	222	224	17	274	272	31	496	496	.092	.927
Clin. Perf. Improv.	14	264	224	17	232	272	31	496	496	1.947	.052

Statistical significance was found only with regard to change/innovation. In this case, individuals who had not served as a deputy commander had significantly higher scores than what was expected, indicating that these respondents were significantly less

comfortable with change/innovation compared with those who had served previously as a deputy commander.

Kruskal-Wallis ANOVAs were conducted for the final two sets of analyses because the independent variable in these analyses contained more than two response categories. Kruskal-Wallis ANOVAs were selected over one-way ANOVAs because, again, the dependent variables in these analyses were ordinal and measured on a five-point Likert scale. Therefore, the Kruskal-Wallis ANOVA, a non-parametric test that does not assume normality, was selected instead of the parametric one-way ANOVA. Essentially, the Kruskal-Wallis ANOVA is an extension of the Mann-Whitney U test for cases in which the independent variable has three or more categories.

First, the following table summarizes the results of the analyses conducted that focused on respondent education. As shown (*), statistical significance was found with regard to joint operations, contingency planning, financial management, Human Resource (HR) management, labor management relations, materiel management, personal/professional ethics, bioethics, and organizational ethics.

In order to determine between which levels of education there existed significant differences in these variables, a series of post hoc analyses were conducted on all significant measures. First, with regard to joint operations/exercises and contingency planning, no significant pairwise comparisons were found. Additionally, no significant pairwise comparisons were found with regard to financial management. However, with regard to human resource management, a significant difference was found when comparing individuals with MHA masters and doctorate degrees. Specifically,

individuals with doctorates felt significantly less comfortable with human resource management as compared with individuals with an MHA masters.

Table 13. Kruskal-Wallis ANOVAs: Education

<i>Measure</i>	<i>MA Clinical</i> <i>N = 1</i>	<i>MA Non-Clinical</i> <i>N = 6</i>	<i>MHA</i> <i>N = 9</i>	<i>Doctorate</i> <i>N = 15</i>	χ^2 (df)	<i>p</i>
	<i>Rank Sum</i>	<i>Rank Sum</i>	<i>Rank Sum</i>	<i>Rank Sum</i>		
Medical Doctrine	27.50	87.50	139.00	242.00	3.100 (3)	.377
Military Mission	15.50	93.00	139.50	248.00	1.067 (3)	.785
Joint Operations*	19.50	147.50	108.00	221.00	9.206 (3)	.027
Total Force Mgmt.	6.00	76.50	121.50	292.00	5.924 (3)	.115
National Dis. MSM	7.00	92.00	113.00	284.00	4.469 (3)	.215
Dept. of Veteran Affs.	20.50	93.00	104.50	278.00	4.148 (3)	.246
Med. Read. Training	12.00	72.00	139.00	273.00	3.942 (3)	.268
Contingency Planning*	24.50	74.50	104.50	292.50	8.315 (3)	.040
Strategic Planning	10.50	78.00	109.50	298.00	7.632 (3)	.054
Organizational Design	10.50	83.00	123.50	279.00	3.531 (3)	.317
Decision-Making	15.00	90.00	135.00	256.00	2.207 (3)	.531
Change/Innovation	13.50	96.50	121.50	264.50	3.054 (3)	.383
Leadership	14.00	99.50	126.00	256.50	2.157 (3)	.540
Public Law	15.00	91.00	124.00	266.00	1.517 (3)	.678
Medical Liability	9.00	99.00	126.00	262.00	1.885 (3)	.597
Medical Staff Bylaws	9.00	97.50	190.00	199.50	6.125 (3)	.106
Regulations	9.00	85.00	143.00	259.00	1.518 (3)	.678
External Accreditation	13.00	93.50	148.00	241.50	.309 (3)	.958
Financial Management*	18.50	82.00	93.00	302.50	8.083 (3)	.044
HR Management*	8.50	93.00	76.50	318.00	14.580 (3)	.002
Labor Mgmt. Rela.*	8.00	87.00	85.00	316.00	12.206 (3)	.007
Materiel Mgmt.*	21.00	80.50	94.50	300.00	8.385 (3)	.039
Facilities Mgmt.	19.50	95.50	88.00	293.00	7.648 (3)	.054
Information Mgmt.	20.00	87.50	133.50	255.00	.846 (3)	.839
Ethical Dec.-Making	15.50	108.50	139.50	232.50	4.167 (3)	.244
Pers./Prof. Ethics*	16.00	96.00	144.00	240.00	– (3)	<.001
Bioethics*	21.50	143.00	155.50	176.00	10.029 (3)	.018
Org. Ethics*	16.00	96.00	144.00	240.00	– (3)	<.001
Individual Behavior	15.00	90.00	150.50	240.50	.782 (3)	.854
Group Dynamics	14.00	99.50	126.00	256.50	2.157 (3)	.540
Conflict Resolution	11.00	81.50	114.50	289.00	5.840 (3)	.120
Communication	13.50	96.00	121.50	265.00	3.086 (3)	.379
Public Speaking	12.00	87.00	138.00	259.00	1.199 (3)	.753
Public/Media Rela.	23.50	105.50	113.50	253.50	2.933 (3)	.402
Epi. Methods	17.50	103.00	165.00	210.50	1.698 (3)	.637
Clinical Investigation	6.50	121.00	171.50	197.00	5.447 (3)	.142
Alt. Health Care	18.00	102.00	133.00	243.00	.327 (3)	.955
Quality Mgmt.	9.50	88.00	163.00	235.50	1.561 (3)	.668
Quantitative Analysis	8.00	107.50	121.00	259.50	2.448 (3)	.485
Outcome Meas.	10.00	108.00	124.00	254.00	1.908 (3)	.592
Clin. Perf. Improv.	11.00	81.00	164.00	240.00	1.944 (3)	.584

With respect to labor management relations, a significant pairwise comparison was also found when comparing individuals with MHA masters and doctorate degrees. Again,

individuals with doctorate degrees felt significantly less comfortable with labor management relations as compared with those who had MHA masters. No significant pairwise comparisons were found with regard to materiel management or personal and professional ethics. With regard to bioethics, a significant pairwise comparison was found between individuals with non-clinical non-MHA masters and doctorate degrees. Specifically, individuals with non-clinical non-MHA masters degrees were significantly less comfortable with bioethics as compared with those holding doctorate degrees. Finally, no significant pairwise comparisons were found with regard to organizational ethics.

The next set of analyses also utilized Kruskal-Wallis ANOVAs and focused on the respondent's corps/branch. The following table summarizes the results of these analyses, which found significant differences (*) with regard to medical staff bylaws, HR management, labor management relations, facilities management, personal/professional ethics, bioethics, organizational ethics, public/media relations, and clinical investigation.

As before, a series of post hoc analyses were conducted in order to compare each category of the independent variable, corps/branch, with respect to all significant analyses. First, with regard to medical staff bylaws, no significant pairwise comparisons were found in these analyses. With regard to human resource management, a significant difference was found when comparing individuals in the Medical Service (MS) and the Medical Corps (MC). Specifically, individuals in the MC were significantly less comfortable with human resource management as compared with those in the MS.

Next, with regard to labor management, no significant pairwise comparisons were found.

Table 14. Kruskal-Wallis ANOVAs: Corps

<i>Measure</i>	<i>MS</i> <i>N = 12</i> <i>Rank Sum</i>	<i>AN</i> <i>N = 4</i> <i>Rank Sum</i>	<i>MC</i> <i>N = 14</i> <i>Rank Sum</i>	<i>SP</i> <i>N = 1</i> <i>Rank Sum</i>	<i>χ² (df)</i>	<i>p</i>
Medical Doctrine	175.00	94.50	214.50	12.00	5.871 (3)	.118
Military Mission	186.00	62.00	232.50	15.50	1.214 (3)	.750
Joint Operations	185.50	89.50	201.50	19.50	3.173 (3)	.366
Total Force Mgmt.	163.00	51.00	262.50	19.50	3.414 (3)	.332
National Dis. MSM	183.00	53.00	253.00	7.00	2.491 (3)	.477
Dept. of Veteran Affs.	151.50	89.50	247.00	8.00	5.709 (3)	.127
Med. Read. Training	175.00	48.00	245.50	27.50	5.330 (3)	.149
Contingency Planning	155.00	69.00	262.00	10.00	4.261 (3)	.235
Strategic Planning	161.50	57.00	267.00	10.50	4.365 (3)	.225
Organizational Design	155.00	62.00	268.50	10.50	4.904 (3)	.179
Decision-Making	180.00	60.00	241.00	15.00	2.512 (3)	.473
Change/Innovation	162.00	69.50	251.00	13.50	4.195 (3)	.241
Leadership	168.00	71.50	242.50	14.00	3.244 (3)	.356
Public Law	170.00	73.00	238.00	15.00	1.211 (3)	.750
Medical Liability	190.00	51.00	231.00	24.00	1.747 (3)	.627
Medical Staff Bylaws*	252.50	50.50	169.50	23.50	9.627 (3)	.022
Regulations	154.50	67.00	250.00	24.50	3.903 (3)	.272
External Accreditation	202.50	52.00	228.50	13.00	1.436 (3)	.697
Financial Management	147.00	69.00	273.50	6.50	6.049 (3)	.109
HR Management*	130.00	62.00	295.50	8.50	11.169 (3)	.011
Labor Mgmt. Rela.*	148.00	45.00	295.00	8.00	9.710 (3)	.021
Materiel Mgmt.	144.00	65.50	279.00	7.50	6.985 (3)	.072
Facilities Mgmt.*	121.50	81.50	286.00	7.00	11.812 (3)	.008
Information Mgmt.	137.50	89.50	249.00	20.00	7.199 (3)	.066
Ethical Dec.-Making	186.00	77.50	217.00	15.50	6.750 (3)	.080
Pers./Prof. Ethics*	192.00	64.00	224.00	16.00	– (3)	<.001
Bioethics*	256.50	73.00	145.00	21.50	12.321 (3)	.006
Org. Ethics*	192.00	64.00	224.00	16.00	– (3)	<.001
Individual Behavior	195.50	60.00	225.50	15.00	.413 (3)	.938
Group Dynamics	168.00	71.50	242.50	14.00	3.244 (3)	.356
Conflict Resolution	147.50	59.50	278.00	11.00	7.435 (3)	.059
Communication	162.00	69.00	251.50	13.50	4.193 (3)	.241
Public Speaking	174.00	63.00	247.00	12.00	1.688 (3)	.640
Public/Media Rela.*	142.00	100.50	244.00	9.50	9.611 (3)	.022
Epi. Methods	240.50	70.50	180.00	5.00	6.737 (3)	.081
Clinical Investigation*	255.50	57.00	166.00	17.50	8.011 (3)	.046
Alt. Health Care	216.50	49.00	212.50	18.00	1.626 (3)	.654
Quality Mgmt.	222.50	53.50	210.50	9.50	2.653 (3)	.448
Quantitative Analysis	171.00	65.50	238.50	21.00	1.113 (3)	.774
Outcome Meas.	202.00	54.00	230.00	10.00	1.167 (3)	.761
Clin. Perf. Improv.	227.00	44.00	214.00	11.00	4.259 (3)	.235

In terms of facilities management, a significant comparison was again found when comparing individuals in the MS and the MC. Again, individuals in the MC were

significantly less comfortable with facilities management as compared with individuals in the MS. No significant pairwise comparisons were found with regard to personal and professional ethics, while with regard to bioethics, a significant comparison was again found between individuals in the MS and the MC. In this case, individuals in the MS were significantly less comfortable with bioethics as compared with those in the MC. No significant results were found with regard to organizational ethics, public and media relations, or clinical investigation. The final set of analyses focused on the associations between the measures relating to respondents' level of knowledge, understanding, and ability at the time they first took Level-I MTF command, and the top three areas/competencies in which they felt they needed better preparation. With regard to the top three areas/competencies, only 28 of the original 41 competencies were included within these questions, and some of these 28 were removed because they did not precisely match with the original 41 or because insufficient observations existed for the analysis to be conducted. These top three areas/competencies variables were reverse coded before these analyses were conducted to correspond with the original 41 questions.

The following table summarizes the results of these analyses. Spearman's rho, a non-parametric correlation coefficient, was used in these analyses. As shown, a significant correlation was found only with regard to epidemiological methods, in which case a perfect positive correlation was found. Overall, these results do not indicate significant associations between these sets of measures, whereas the very small sample sizes present within these analyses severely limited statistical power, providing much greater difficulty in finding any significant associations.

Table 15. Spearman's Correlations between Areas/Competencies

<i>Measure</i>	<i>N</i>	<i>Rho</i>	<i>p</i>
Financial Mgmt.	13	.208	.495
Public Law	4	-.577	.423
Dept. Vet. Affairs	5	-.216	.727
Epi. Methods	4	1.000	<.001
Clin. Perf. Improvement	5	-.471	.423
Facilities Mgmt.	5	.177	.776
Med. Staff Bylaws	3	.500	.667
HR Management	6	.424	.402

Discussion

JMESI Competencies

The results convey that common areas existed in which commanders believed they needed better preparation before taking command, as well as areas in which, as a whole, they felt sufficiently prepared. These findings purport that the AMEDD should refocus on common areas in which commanders felt less prepared. Focusing on these areas and possibly less on the better prepared areas would allow the AMEDD to concentrate limited resources on areas that would obtain the highest outcomes.

Although there were no competencies for which a majority of respondents indicated that they were neither comfortable nor uncomfortable, were somewhat uncomfortable, or were completely uncomfortable with their level of knowledge, the responses should be treated as a sliding scale of “comfort” instead of strictly by the label descriptor given the potential reluctance of the majority of the commanders to report that they were “uncomfortable” with a competency that would translate to “incompetent.” Therefore, analyzing the data in a manner that accounts for the spread of answers given for a competency instead of solely the descriptor has value. For example, all respondents reported that they were completely comfortable with organizational ethics (representing a uni-polar distribution). The majority (84%) of the respondents stated they were comfortable (completely and somewhat) with labor

management relations; however, the spread between completely comfortable and somewhat uncomfortable is greater. This result reveals an overall group concern with their comfort with labor management relations as compared to organizational ethics than if only the descriptor labels were considered. In essence, distributions are more important than labels.

Interestingly, the results show very little difference in competency levels of comfort (other than change/innovation) on taking command between those who were previously a deputy commander and those who were not. A widely held belief is that serving as a deputy commander is one of the best positions for preparation as a future commander. Moreover, although those who had been a deputy reported that they felt that position best prepared them, no large difference in competency was found between those who did and did not serve as a deputy. This finding questions the assumption that having previously been a deputy is as salient as generally thought.

An initial assumption would be that officers who had served as a non-CSL commander would feel more comfortable in most competency areas; however this was not the case for strategic planning, public law, medical liability, financial management, and outcome measures. To determine if there were possible confounding variables attributing to these results, a regression analysis could be performed. Since the comfort level variables are ordinal, a linear regression analysis would be appropriate if the variables were found to be close to ordinal. However, ordinal logistic regression analysis would be appropriate if they're not. This level of statistical analysis is beyond the scope of this study and is recommended in future analyses.

As a group, regardless of corps, previous assignment history, or civilian education, there were competencies most frequently mentioned as areas felt needing better preparation prior to taking command (financial management, public media relations, Veterans Affairs, labor laws, clinical performance, facility management, and human resources management). These areas should be focused on for future commanders and would be the best starting point and quickest implementation opportunity to improve preparedness for upcoming commanders. However, there is the opportunity to develop a more advanced custom education program based on the findings. The results showed differences between levels of preparedness among differing civilian educational backgrounds as well as corps. These findings can lead to the ability to customize education opportunities based on an officer's corps and civilian education further tailoring an appropriate educational package in an effort to maximize efficiency as well as effectiveness.

Non-JMESI Competencies

The respondents had the opportunity to convey additional areas other than the JMESI competency attributes in which they felt they needed more preparation before taking command. The areas mentioned most often were the Uniform Code of Military Justice (UCMJ), contracting, and advanced healthcare business operations. Five officers also stated that they felt more information regarding the U.S. Army Medical Command's (MEDCOM's) performance metrics than was warranted. One commander was as specific as to recommend "An entire block (8–16 hours) of the AMEDD pre-command course should be dedicated to teaching commanders how their commands will be evaluated and the tools (CMS, APLLS, ATC, PASBA, etc.) needed to guide decisions and priorities." Numerous areas were mentioned at lower frequency:

- Credentialing/privileging;
- Command-specific legal issues;
- Clinical performance drivers;
- Family Readiness Group integration;
- ARFORGEN;
- Spiritual fitness integration;
- Congressional responses;
- Strategic planning;
- Aerospace/Flight Medicine/AERO;
- Electronic health records; and,
- Organizational structure.

Individual responses provided by the officers gave additional insight.⁴⁹ Some officers strongly supported placing officers in developmental positions.⁵⁰ One officer who was in his or her second year post-command provided detailed feedback by stating that hospital commanders should have already worked at the executive level and recommended creating a larger executive support staff.⁵¹ Four officers conveyed that they did not believe that one position best prepared them for Level-I MTF command, “...no one position prepared me but a compilation of previous positions and experiential learning.”⁵²

One officer made the recommendation that future commanders should attend the Uniformed Services University (USU) Joint Military Medical Executive Skills and complete the joint Medical Executive Skills courses before assuming a Level-I command in addition to obtaining either a MBA with a focus on healthcare or a MHA.

Another officer stated that, although the competencies were valuable, it was more important to “posses strong qualities of inspirational leadership, like intellect, energy, honor/integrity, selflessness, humility, and a passion for team building, developing subordinates, and continuous quality improvement.” Two officers made specific comments regarding the commander-deputy commanders’ synergistic relationships.⁵³

Recommendations

The AMEDD leadership should continue to survey Level-I MTF commanders annually and separately from other commanders in an effort to build trends and to measure successfulness of current competency training and education programs, as well as to identify gaps for this unique and challenging command. Ideally, these commanders should be surveyed one year after taking command and again at the end of their command. These surveys should include multiple data points to triangulate patterns that lead to success and an effort should be made to identify areas that may need improvement that correlate with previous experiences and background, to include corps and education, to build an efficient and effective preparation model.

The AMEDD Pre-command course should be modified to address specific areas identified through the annual survey. Although the AMEDD Pre-command course modifies course curriculum based on numerous points of input, specific effort should be made to address the needs of Level-I commanders through formal assessments. The Pre-command course should provide corps-specific breakout sessions based on weaknesses rather than strengths. Currently, the Pre-command course conducts breakout sessions correspond to type of command (Table of Distribution and Allowances (TDA) vs. Table of Organization and Equipment (TOE), for example); however, the course should go one additional step and conduct breakout sessions

specifically for Level-I commanders based on the previous year's needs assessment as it relates to corps, experience, and educational background.

In a similar manner, the AMEDD Executive Skills Course should be expanded to include corps' specific breakout sessions that cover needs identified in the annual survey, not only items that are corps-specific but also areas that certain corps report in which they need to be better prepared. Nurses may need more information on financial management, healthcare administrators may need more information on bio-ethics, and physicians may need more information on human resource and facilities management. If officers continue to break out of the group and focus on corps-specific items only, they will isolate themselves from other areas of need. The AMEDD Executive Skills Course should be modified to accommodate branch-specific breakout sessions to attempt to provide more detailed and specific training in areas of need based on corps, civilian education, and previous experience. The breakout sessions need to be of two types: corps-specific (currently being done) and corps-specific based on the needs assessment survey (not currently being done).

A final recommendation is to mandate the completion of JMESI distributed learning modules that correlates to previous command surveys based on both collectively identified areas (areas that are common needs to all commanders) and those identified specifically for each branch, type of education, or previous position. Intense distributed learning model training (such as those already developed by JMESI) should be required for the top ten areas of weakness identified by current and previous Level-I commanders. These packages could be sent out to officers identified on the Level-I TDA MTF command list based on a review of their previous experiences, civilian

education, and corps. Completion of these training modules should be mandatory during the year before taking command.

Conclusion

Leader development is an extremely complex construct, and leader development assessment is even more complex. The development of valid and reliable assessment tools is important to the leader development process. Significant time is spent identifying needed attributes and competencies, developing curricula, and executing training/education programs, but more time should be provided in conducting rigorously valid and reliable assessments that have statistical and practical underpinnings. Appropriate assessments should focus evidence-based educational and preparation efforts on the right person at the right time and contribute to increased effectiveness and efficiency of the education. Ensuring leaders are adequately prepared and minimizing the resources required to prepare them will become more paramount in a resource-constrained environment when the importance of leaders being best prepared will be more important than it has in the past. Continually assessing the preparation of first-time hospital commanders is essential to AMEDD success and the is the foundation for long-term planning and resource allocation in an environment of competing interest, other priorities, and scarce resources.

Endnotes

¹ U.S. Congressional Budget Office, *Long-term Implications of the 2013 Future Years Defense Program* (Washington, DC: U.S. Congressional Budget Office, July 2012), 20. http://www.cbo.gov/sites/default/files/cbofiles/attachments/07-11-12-FYDP_forPosting_0.pdf (accessed August 15, 2012).

² U.S. Department of Defense, *The Budget for Fiscal Year 2012* (Washington, DC: U.S. Department of Defense, 2010), 61.

<http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/defense.pdf> (accessed August 15, 2012).

³ U.S. Department of Defense, *Sustaining U.S. Global Leadership: Priorities for 21st Century Defense* (Washington, D.C.: U.S. Department of Defense, January 2012), 1.

⁴ Leigh Munsil, "Hikes in cost of veterans' health care draw fire," April 4, 2012, <http://www.politico.com/news/stories/0412/74846.html> (accessed December 1, 2012).

⁵ LTG Patricia Horoho, "The Surgeon General's Talent Management Guidance," teleconference with unscripted commentary, Office of the Surgeon General, Falls Church, VA, December 5, 2012.

⁶ Price Waterhouse Coopers and ORACLE, "Creating an Agile Workforce: Leading Practices in Transforming Talent Management," Oracle, July 2008, http://download.oracle.com/education/leading_practices/071708_54041/index.htm (accessed November 1, 2012). Price Waterhouse Coopers and ORACLE define the construct as, "The strategic set of integrated business processes which manage the planning, acquisition, development, retention and advancement of talent to achieve business goals and optimize performance."

⁷ Darin E. Hartley, "Tools for Talent," *T + D* 58, no. 4 (2004): 20, in ProQuest (accessed December 3, 2012).

⁸ Heather Boushey and Sara J. Glynn. "There Are Significant Business Cost to Replacing Employees," *Center for American Progress* (November 16, 2012). <http://www.americanprogress.org/wp-content/uploads/2012/11/CostofTurnover.pdf> (accessed December 3, 2012). Replacement of talent is a costly consequence of turnover that organizations continually struggle to overcome. For many years, organizations have measured the cost of turnover within their organization and more recently started to measure the cost of talent management and retention. The cost to replace a middle manager or senior leader ranges from 30% to 213% of his or her annual income.

⁹ U.S. Office of Personnel Management, *The Reinvention of Government Talent Management in Crisis* (Washington, DC: U.S. Office of Personnel Management, June 30, 2011), 1. http://www.opm.gov/HiringReform/News/06_30_2011_HCI_Govt_Talent_Summit.pdf (accessed December 4, 2012).

¹⁰ Gregory Kesler and Paul Kirincic, "Roadmaps for Developing General Managers: The Experience of a Healthcare Giant." *HR. Human Resource Planning* 28, no. 3 (2005): 24–37, in ProQuest (accessed December 5, 2012).

¹¹ Ram Charan, "Ending the CEO Succession Crisis." *Harvard Business Review* 83, no. 2 (2005): 72–81, 147, in ProQuest (accessed December 5, 2012).

¹² Lance A. Berger and Dorothy R. Berger. *The Talent Management Handbook: Creating a Sustainable Competitive Advantage by Selecting, Developing, and Promoting the Best People*. (New York: McGraw-Hill, 2010).

¹³ Lockwood, Nancy R. "Talent Management: Driver for Organizational Success." *HRMagazine* 51, no. 6 (2006): S1–S11.

¹⁴ U. S. Government Accountability Office, *Human Capital: Selected Agencies have Opportunities to Enhance Existing Succession Planning and Management Efforts*. USGAO Publication No. GAO-05-585, (Washington, DC: U.S. Government Accountability Office, 2005), 24–26. <http://www.gao.gov/new.items/d05585.pdf> (accessed December 3, 2012).

¹⁵ U. S. Government Accountability Office, *The Human Capital Strategic Plan: Fiscal Years 2004–2006*, USGAO Publication No. GAO-04-1063SP, (Washington, DC: U.S. Government Accountability Office, 2004), 22. <http://www.gao.gov/assets/210/202430.pdf> (accessed December 3, 2012).

¹⁶ Nancy R. Lockwood, "Talent Management: Driver for Organizational Success," *SHRM Research Quarterly* (June 2006): 2–11. <http://www.shrm.org/research/articles/articles/documents/0606rqartpdf.pdf> (accessed December 15, 2012).

¹⁷ Joan E. Pynes, "The Implementation of Workforce and Succession Planning in the Public Sector." *Public Personnel Management* 33, no. 4 (2004): 389–404, in Proquest (accessed December 2, 2012).

¹⁸ Steward L. Tubbs and Eric Schulz, "Exploring a Taxonomy of Global Leadership Competencies and Meta-Competencies." *Journal of American Academy of Business, Cambridge* 8, no. 2 (2006): 29–34, in Proquest (accessed December 2, 2012).

¹⁹ Mark Busine and Bruce Watt, "Succession Management: Trends and Current Practice." *Asia Pacific Journal of Human Resources* 43, no. 2 (2005): 225–237, in Proquest (accessed December 15, 2012).

²⁰ Berger, *The Talent Management Handbook*, 43.

²¹ 1). An integrated enterprise process to identify, develop, and retain strategic leaders to meet the organizational vision, mission, and future requirements. 2). Deliberate approaches to assess, develop, and retain a workforce with the aptitude and abilities to meet current and future missions. 3). A continuous integrated approach to assess, develop, retain, and deploy talent across the organization to meet current and future missions. 4). A deliberate process to recruit, develop, and retain the workforce (Officers, Enlisted, Civilian) to accomplish current and future missions.

²² The AMTMC incorporates three lines of focus: 1) High Performers/Strategic Leaders, 2) Enhancement Programs, and 3) Shape the Strategic Environment. The High Performers/Strategic Leaders line of focus establishes criteria for skills, knowledge, and attributes required of future strategic leaders. It develops a process of identifying and cultivating talent early within an employee's career. The inclusion of input from the consultants to The Surgeon General, senior Command Sergeants Major, executive civilian corps personnel, and CTO are critical. The desired outcome is to track high performers through a developmental evidence-based process that encourages the development of strategic leaders. The second line of focus is the Enhancement Programs. These opportunities are a combination of Army-wide, AMEDD, and local opportunities that contribute to the development of leaders.²² A key attribute

of these opportunities is not to stovepipe assignments within any branch, but to give high performers a broad range of experiences to enhance their skills, knowledge, and attributes.

The third line of focus in the AMTMC is Shape the Strategic Environment, which recognizes the importance of influencing the external environment through personnel assignments outside Army Medicine. This line of focus ensures the identification of personnel best qualified for positions such as Joint billets, liaison officers, and Special Assignments. The positions leverage Army Medicine's talent to shape the environment to support the capabilities needed for the Army Medicine Campaign Plan 2020, ensuring that the future force supports the shift to health. The three lines of effort aim to ensure a leadership development process that focuses on metrics and quantitative values assigned to skills, knowledge, and attributes. The process will ensure that Army Medicine has the best qualified strategic leaders and allows shaping the force to maximize outcomes.

²³ Section 760 of the Floyd D. Spence National Defense Authorization Act (2001) states, "No person may be assigned as the commander, deputy commander, or managed care coordinator of a military medical treatment facility or as a TRICARE lead agent or senior member of the staff of a TRICARE lead agent office until the Secretary of the military department concerned submits a certification to the Secretary of Defense that such person has completed training described in subsection (a) Provision of Training."

²⁴ U.S. Department of Defense, DoD Instruction 6000.15. *Joint Medical Executive Skills Development Program*, April 19, 1999. <http://www.dtic.mil/whs/directives/corres/pdf/600015p.pdf> (accessed October 2, 2012). "The MHS will prepare officers to be MTF commanders and TRICARE lead agents through progressive series of career enhancing duty assignments and educational experiences to develop leadership skills and professional competencies. The Military Departments will implement this policy within the context of their individual medical department personnel management policies and systems; however, none of the funds appropriated in this Act may be used to fill the commander's position at any military medical facility with a health care professional unless the prospective candidate can demonstrate professional administrative skills."

²⁵ The Joint Medical Executive Skills Institute Home Page, <https://jmesi.army.mil/about.aspx> (accessed November 10, 2012).

²⁶ Center for Naval Analysis, *Military Medical Executive Education Review*, (Arlington, VA: Center for Naval Analysis, September 1, 2007).

²⁷ Joint Medical Executive Skills Institute, <https://jmesi.army.mil/background.aspx> (accessed January 12, 2013).

²⁸ Nancy Nicosia, Barbara O. Wynn, and John A. Romley, *Assessing the Performance of Military Treatment Facilities* (City: Rand Corporation, 2011). The U.S. Department of Defense's challenge of sustaining TRICARE health benefits when medical costs continue to increase is critical. The transformation of Military Health System business practices into performance-based planning and financing ties resource allocation to accountability within the system. Targets have been set for health care utilization within MTFs as a reward/penalty system focusing on performance. Pay-for-performance systems assume that MTF leaders are able to effectively manage care in the same manner as civilian hospitals. The Office of the Assistant Secretary of Defense for Health Affairs has been tracking cost and utilization performance for each MTF

using “per member per month” metrics; however, these measures may be more appropriate for larger MTFs instead of smaller MTFs in which outcomes are more variable because of a smaller amount of enrollees and the effect of catastrophic cases on the financial bottom line. One report ascertained that the use of similar performance assessments is less useful at smaller facilities, and a number of variables are outside the control of the hospital senior leadership. However, smaller MTFs (Level I) are still measured against these performance measures, which strengthens the stance that the preparation of Level I MTF commanders is crucial.

²⁹ S. B. Bacharach, “Organizational Theories: Some Criteria for Evaluation” *Academy of Management Review* 14, no. 4 (1989): 496–515.

³⁰ Arthur Wilson and Elisabeth Hayes, eds. *Handbook of Adult and Continuing Education* (San Francisco: Jossey Bass, 2000).

³¹ Patricia Cranton, *Understanding and Promoting Transformative Learning: A Guide for Educators of Adults* (San Francisco: Jossey-Bass, 1994).

³² Stephan Brookfield, *Developing Critical Thinkers: Challenging Adults to Explore Alternative Ways of Thinking and Acting* (San Francisco: Jossey-Bass, 1987), 87.

³³ Wilson and Hayes, *Handbook of Adult and Continuing Education*.

³⁴ D. Randy Garrison, “Critical Thinking and Self-directed Learning in Adult Education: An Analysis of Responsibility and Control Issues,” *Adult Education Quarterly* 42, no. 3 (1992): 136–148.

³⁵ Jack Mezirow, ed. *Learning as Transformation: Critical Perspectives on a Theory in Progress* (San Francisco: Jossey-Bass, 2000).

³⁶ Brookfield, *Developing Critical Thinkers*, 89.

³⁷ Adrian Geering, “*Organization Theory and its Application to Adult Education*” (Washington, DC, 1980): Distributed by ERIC Clearinghouse.

³⁸ Denise Polit and Cheryl Beck, *Nursing Research: Principles and Methods*, 7th ed. (Philadelphia: J.B. Lippincott Co., 2004).

³⁹ Ibid.

⁴⁰ H. J. Streubert and D. R. Carpenter. *Qualitative Research in Nursing: Advancing the Humanistic Imperative*, 2nd ed. (Philadelphia: Lippincott, 1999). A leadership support process was initiated at the OTSG to gain support for the survey distributed to identified officers. This study was conducted according to the guidelines published in Army Regulation 40-38 “Medical Services Clinical Investigation Program,” Code of Federal Regulation, 45 CFR 46, “Protection of Human Subjects,” and The Belmont Report, dated April 18, 1979. In accordance with the study timeline, the proposal was submitted to the U.S. Army War College Institutional Review Board (IRB) for approval before data collection in accordance with U.S. Army War College rules and regulations. Confidentiality of the data collected from the participants was maintained, thereby keeping with the principles of beneficence and justice. Additionally, person-identifiable data (name and survey code to facilitate follow-up reminders) were protected on a password-

protected computer. Only aggregate data were reported. Every attempt was made to ensure that no retribution occurred to the study participants, thus keeping with the principle of non-maleficence. Given an awareness of the military culture, this study ensured that study participants had the freedom to participate or not participate, which fully supported individual autonomy.

⁴¹ This study adheres to accepted standards with respect to the protection of human subjects. This proposal obtained IRB approval from the U.S. Army War College before data collection. Per guidelines, the study met exemption category 2 because it was a quantitative survey and the data obtained could not be individually identifiable. Appendix B includes a copy of the U.S. Army War College IRB approval letter. For the study, an electronic version of the data collection initiation also included information explaining that participation in the study was voluntary and that informed consent was assumed if the participant completed the online survey. No potential harm to the officers occurred from participating in this study other than potential threats to confidentiality. All information collected was confidential and no identifying data remained in the data sets during analysis.

⁴² A panel discussion with four high-ranking AMEDD Officers within different levels of the department, including the OTSG, Branch Corps Chiefs, and two experienced AMEDD researchers, reviewed and endorsed the survey's content and face validity. Although the measures in the survey have high face validity, incorporating a pilot study was important to obtaining feedback and normative comparisons to further hone the instrument, particularly for reliability. Difficulties with the format, wording, and structure of the survey identified through the panel discussion among the four senior officers further refined the survey. The first draft of the survey was administered to a convenience sample of 20 senior AMEDD officers in December 2012 and again in January 2013.

⁴³ J. Fawcett and E. L. Buhle, "Using the Internet for Data Collection: An Innovative Electronic Strategy," *Computers in Nursing* 13 (1995): 273–279. This method was selected to allow the survey of a geographically diverse population. In addition, an Internet-based survey was efficient and effective regarding time and cost. No data entry was required, as it was carried out by the participants and eliminated mailing and postal costs. Fawcett and Buhle ascertained that the use of Internet-based methods for data collection is "feasible and yields informative responses."

⁴⁴ D. A. Dillman, J. D. Smyth, and L. M. Christian. *Internet, Mail and Mixed-mode Surveys: The Tailored Design Method*, 3rd ed. (Hoboken: John Wiley & Sons, 2009).

⁴⁵ First, an initial e-mail was sent to each officer informing him or her of the survey and encouraging participation. Second, three days after the initial introduction e-mail was sent, the survey site link and cover letter was e-mailed to each officer. Third, five days after the survey link was sent, a third e-mail including the survey link was sent to all officers. Fourth, one week thereafter, another e-mail was sent to all nurses encouraging them to complete the survey. Fifth, the following week, all officers were sent another encouraging e-mail with the survey link included. Sixth, two days before closing the survey, all officers received a final encouraging e-mail with the survey link.

⁴⁶ This study used Survey Monkey®, an Internet-based host site, to create the survey and to collect data. The questions were inserted into a questionnaire template on Survey Monkey®. Survey Monkey®'s basic survey functionality allows questions with "radio buttons" that enable only one answer per question, a checkbox lists option to allow the respondent to select more

than one answer (including a write-in text box for answers that have not been anticipated), questions in matrix format to allow respondents to select a grade or scale as in a Likert scale, and the ability to create logical conditions with a drop-down selection box. For example, for the case in which the answers are either Yes or No, the respondents who answered Yes may be presented with further questions if needed, and those who answered No may be taken straight to another question or to the end of the survey (usually considered a “skip” attribute).

⁴⁷ Polit and Beck, *Nursing Research*.

⁴⁸ Ibid.

⁴⁹ “Senior AMEDD Leaders and those selected to command must support TSG (‘Get out of the Box’ and ‘You’re the Captain of your own ship in command and can do your own thing’ is not an appropriate response from any Senior Leader).”

⁵⁰ “In general, prior job experiences were the best training - Clinic Chief, Department Chief, Division Surgeon, Deputy Commander, clinic command - good progression from ‘simple to complex’. The Human Resource, Financial, and Contracting are not always as visible in even Deputy jobs (especially as a DCCS vs. DCA). I suspect MSC officers would say their quality management, and clinical training, was not sufficient while they are very comfortable with budgets, facilities, human resources, etc.”

⁵¹ “You cannot run a hospital well without having worked at the executive level in a hospital for many years prior to taking over. Further, you cannot run a large organization well if you are not familiar with what a well run large organization looks like. For example, to run a large organization of the same size and budget as an Army hospital, in the civilian setting or in the regular Army combat units, commanders would have a vastly larger, experienced administrative staff. AMEDD commanders do not have that advantage and try to make do with what the line officers would scream to improve. We need to be more vocal in making sure we share a vision for how all our hospitals should be staffed then commit to staffing them well. The DCCS of a MEDCEN for example should have both a senior civilian and senior military deputy and several iron majors to share the immense work load. The nurses have been more vocal and built supporting bureaucracies but they might benefit with more staff as well. All deputies should be equally as well supported.”

⁵² “Sadly, many O-6 MTF commanders have never commanded before--at any level! And some have never even been a Deputy Commander. The best way to develop leaders is to give them progressively greater leadership responsibilities. I feel that just as we have reorganized the One-staff to mimic the rest of the Army, we should consider re-organizing the structure of our MTFs to mimic the structure of the rest of the Army. Without adding additional personnel, we should create subordinate commands within the MTF, with the current Department Chiefs and NCOICs taking on Company Commander and 1SG levels of responsibility and authority for their people and resources and the Deputies and their NCOICs taking on O-5 level commander authorities and responsibilities. This one step which could be done without additional manpower would do more to develop leaders than any expensive TDY or school could ever do.”

⁵³ “I had an exceptional team of deputies that complemented my knowledge or lack thereof. Great teamwork at the executive level is essential. Need to consider if there is a process for selecting the executive team as a collaborative effort among branches based on knowledge and communication capabilities.” and “Because the MTF organizational structure provides for deputy

commanders with expertise in medicine, administration, and nursing, the MTF commander doesn't require extensive knowledge or experience in any of the fore mentioned areas to be successful."

Appendix A

Toward a Comprehensive Talent Management Program

Welcome

The Army Medical Department is committed to the success of its leaders. The development and preparation of AMEDD officers assuming their first MTF command is of critical importance in ensuring their success. Your feedback regarding your experience as a commander plays a crucial role in ensuring the successful training and development of future commanders. The purpose of this study is to solicit important feedback from current commanders asking them to identify areas in need of more exposure, preparation or educational opportunities, resulting in better preparation for officers entering their first Level I MTF command.

Through forthright and candid feedback from current commanders the AMEDD can better devise opportunities for future commanders. The study aims to identify the professional development process you went through as an AMEDD officer that prepared you for command.

This survey consists of 42 items and will require approximately 15 minutes of your time. Confidentiality is assured through the use of a third party web survey program. Please do not enter your name anywhere on the survey.

The information obtained from this survey will be treated as group data only, not individual data. The participants will in no way be identified and the results will be reported in the aggregate.

Although you are in no way obligated to participate in this project, its success depends on your involvement. Thank you in advance for your participation. If you have questions, suggestions or recommendations for improvement please contact LTC Timothy Hudson (Timothy.Hudson@us.army.mil)

*1. Are you currently in your (select one):

- ☐ First year of Level I MTF command
- ☐ Second year of Level I MTF command
- ☐ First year post-Level I MTF command
- ☐ Second year post-Level I MTF command

*2. Have you previously commanded a non-CSL clinic?

- ☐ Yes
- ☐ No

3. Position you have had in the past you feel best prepared you for Level I MTF command?

- ☐ non-CSL Command
- ☐ BN Command
- ☐ Chief of Staff
- ☐ Deputy Commander
- ☐ Previous Command (other)
- ☐ Division Surgeon

Toward a Comprehensive Talent Management Program

***4. Have you served as a deputy commander prior to assuming Level I MTF command?**

- ☐ Yes
- ☐ No

5. What is the highest level of education you have completed?

- ☐ Masters (Clinical)
- ☐ Masters (non-clinical other than MHA)
- ☐ Masters (MHA)
- ☐ Doctorate (Clinical)

***6. What is your highest military education level obtained?**

- ☐ COC/OAC - Resident
- ☐ COC/OAC - Correspondence
- ☐ COC/OAC - Constructive Credit
- ☐ CGSC/ILE - Resident
- ☐ CGSC/ILE - Correspondence
- ☐ CGSC/ILE - Constructive Credit
- ☐ SSC - Resident
- ☐ SSC - Correspondence
- ☐ SSC - Constructive Credit

***7. Time in grade upon taking command (months):**

***8. Please select:**

- ☐ MS
- ☐ AN
- ☐ MC
- ☐ SP
- ☐ DC

Toward a Comprehensive Talent Management Program

***9. Please select the statement that best matched your level of knowledge, understanding, and ability in each area at the time you first took Level I MTF command.**

	Completely comfortable	Somewhat comfortable	Neither	Somewhat uncomfortable	Completely uncomfortable	I have not had to deal with this area during my command
Medical Doctrine	☐	☐	☐	☐	☐	☐
Military Mission	☐	☐	☐	☐	☐	☐
Joint Operations/Exercises	☐	☐	☐	☐	☐	☐
Total Force Management	☐	☐	☐	☐	☐	☐
National Disaster Medical Systems Management	☐	☐	☐	☐	☐	☐
Department of Veterans Affairs Role	☐	☐	☐	☐	☐	☐
Medical Readiness Training	☐	☐	☐	☐	☐	☐
Contingency Planning	☐	☐	☐	☐	☐	☐
Strategic Planning	☐	☐	☐	☐	☐	☐

***10. Please select the statement that best matched your level of knowledge, understanding, and ability in each area at the time you first took Level I MTF command.**

	Completely comfortable	Somewhat comfortable	Neither	Somewhat uncomfortable	Completely uncomfortable	I have not had to deal with this area during my command
Organizational Design	☐	☐	☐	☐	☐	☐
Decision Making	☐	☐	☐	☐	☐	☐
Change and Innovation	☐	☐	☐	☐	☐	☐
Leadership	☐	☐	☐	☐	☐	☐
Public Law	☐	☐	☐	☐	☐	☐
Medical Liability	☐	☐	☐	☐	☐	☐
Medical Staff By-Laws	☐	☐	☐	☐	☐	☐
Regulations	☐	☐	☐	☐	☐	☐
External Accreditation	☐	☐	☐	☐	☐	☐
Financial Management	☐	☐	☐	☐	☐	☐
Human Resource Management	☐	☐	☐	☐	☐	☐
Labor-Management Relations	☐	☐	☐	☐	☐	☐

Toward a Comprehensive Talent Management Program

***11. Please select the statement that best matched your level of knowledge, understanding, and ability in each area at the time you first took Level I MTF command.**

	Completely comfortable	Somewhat comfortable	Neither	Somewhat uncomfortable	Completely uncomfortable	I have not had to deal with this area during my command
Materiel Management	☐	☐	☐	☐	☐	☐
Facilities Management	☐	☐	☐	☐	☐	☐
Information Management	☐	☐	☐	☐	☐	☐
Ethical Decision-Making	☐	☐	☐	☐	☐	☐
Personal and Professional Ethics	☐	☐	☐	☐	☐	☐
Bioethics	☐	☐	☐	☐	☐	☐
Organizational Ethics	☐	☐	☐	☐	☐	☐
Individual Behavior	☐	☐	☐	☐	☐	☐
Group Dynamics	☐	☐	☐	☐	☐	☐
Conflict Resolution	☐	☐	☐	☐	☐	☐

***12. Please select the statement that best matched your level of knowledge, understanding, and ability in each area at the time you first took Level I MTF command.**

	Completely comfortable	Somewhat comfortable	Neither	Somewhat uncomfortable	Completely uncomfortable	I have not had to deal with this area during my command
Communication	☐	☐	☐	☐	☐	☐
Public Speaking	☐	☐	☐	☐	☐	☐
Public and Media Relations	☐	☐	☐	☐	☐	☐
Epidemiological Methods	☐	☐	☐	☐	☐	☐
Clinical Investigation	☐	☐	☐	☐	☐	☐
Alternative Health Care Delivery Systems	☐	☐	☐	☐	☐	☐
Quality Management	☐	☐	☐	☐	☐	☐
Quantitative Analysis	☐	☐	☐	☐	☐	☐
Outcome Measurements	☐	☐	☐	☐	☐	☐
Clinical Performance Improvement	☐	☐	☐	☐	☐	☐

Toward a Comprehensive Talent Management Program

13. Please list in ranking order the top 3 areas previously listed in question 9-12 that you feel you would have most benefited from additional education and experience. You can use the Prev button at the bottom of the page to return to those questions if needed.

	Greatest Need	Second Greatest Need	Third Greatest Need
Financial Management	☐	☐	☐
Leadership	☐	☐	☐
Team Building	☐	☐	☐
Public Media Relations	☐	☐	☐
Public Law	☐	☐	☐
Veterans Affairs	☐	☐	☐
Alternate Healthcare	☐	☐	☐
Clinical Investigation	☐	☐	☐
Epidiological Methods	☐	☐	☐
Labor Law	☐	☐	☐
Health Law	☐	☐	☐
National Disaster Management	☐	☐	☐
Bio ethics	☐	☐	☐
Clinical Performance	☐	☐	☐
Informational Technology	☐	☐	☐
Facilities Management	☐	☐	☐
Medical Staff Bylaws	☐	☐	☐
Contingency Planning/Operations	☐	☐	☐
External Accreditation	☐	☐	☐
Total Force Management	☐	☐	☐
Joint Operations/Exercises	☐	☐	☐
Medical Readiness	☐	☐	☐
Human Resource Management	☐	☐	☐
Organizational Design	☐	☐	☐
Conflict Resolution	☐	☐	☐
Material Mangement	☐	☐	☐
Medical Doctrine	☐	☐	☐
Regulations	☐	☐	☐

Toward a Comprehensive Talent Management Program

14. Please list any additional areas, that are not listed in question 9-12 that you feel through education and experience would have better prepared you for Level I MTF command.

15. Please feel free to make additional comments.

Your time is greatly appreciated. If you are interested in receiving the aggregated results from this survey, send a request to timothy.hudson@us.army.mil.

Appendix B



DEPARTMENT OF THE ARMY
UNITED STATES ARMY WAR COLLEGE AND CARLISLE BARRACKS
CARLISLE, PENNSYLVANIA 17013

REPLY TO
ATTENTION OF

Office of the Dean of the School of Strategic Landpower

Lieutenant Colonel Timothy L. Hudson
Box Number 206
U.S. Army War College
122 Forbes Avenue
Carlisle, Pennsylvania 17013

Dear Lieutenant Colonel Hudson:

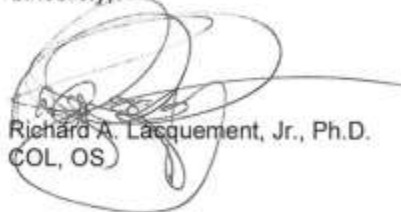
The U.S. Army War College received your request to engage current Level I medical treatment facility commanders and officers in a survey effort in support of your Strategy Research Project. The goal of this survey is to help identify possible changes in or alternatives to programs or procedures in preparation for command.

Approval to engage in the survey is provided for the time period of 26 December 2012 to 8 June 2013. Permission is terminated after that period. Your IRB Number is USAWC IRB: AY13-01.

As a reminder, in accordance with standard and customary research procedures, your subjects may withdraw at any time from this survey effort. This withdrawal does not require reason, cause, or explanation.

The point of contact for this action is Dr. Anna Waggener, Director, Institutional Assessment, commercial 717-245-3365. Her e-mail address is Anna.t.waggener.civ@mail.mil. Please contact her if you have further questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Richard A. Lacquement, Jr.", is written over a circular stamp.

Richard A. Lacquement, Jr., Ph.D.
COL, OS

CF:
COL Judith Robinson
Department of Command, Leadership, and Management



DEPARTMENT OF THE ARMY
UNITED STATES ARMY WAR COLLEGE AND CARLISLE BARRACKS
CARLISLE, PENNSYLVANIA 17013-5215

REPLY TO
ATTENTION OF

To: LTC Timothy L. Hudson, AY13 Resident Education Program Student
From: USAWC IRB Exempt Determination Officer

AW Waggener
Authorized signature on behalf of USAWC IRB Exempt Determination Officers

Approval Date: 12/26/2012
Expiration Date of Approval: 06/08/2013

RE: Notice of USAWC Approval as Exempt (under 32 CFR 219)
Exempt Category: #5: Possible changes in or alternatives to programs or procedures
IRB Number: USAWC IRB: AY13-01
DOD Assurance: DOD A20199

Study Title: "Toward a Comprehensive Talent Management Program: Preparing AMEDD Officers for Level I Medical Treatment Facility Command"

This submission has been approved by the USAWC IRB for the period indicated. It has been determined that the risk involved in this research is no more than minimal.

Study Description: Purpose: To identify areas in which AMEDD officers assuming their first MTF command would have liked to have had more exposure, preparation, and educational opportunities to be better prepared for their first Level I MTF command. Participants: current Level I MTF commanders and officers who departed command in the summer of 2012. Procedures: Survey.

Regulatory: This research requires informed consent.

Investigator's Responsibilities: Federal regulations require that all research be reviewed at least annually. It is the Principal Investigator's responsibility to submit for renewal and obtain approval before the expiration date. You may not continue any research activity beyond the expiration date without IRB approval. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.

You are required to obtain USAWC IRB approval for any changes to any aspect of this study before they can be implemented. Should any adverse event or unanticipated problem involving risks to subjects or others occur, it must be reported immediately to the USAWC IRB. This approval is for USAWC only and approval of the study does not extend to any other institution.

This study was reviewed in accordance with federal regulations governing human subjects research including 32 CFR 219 and DOD Directive 3216.2 where applicable.

Anna T. Waggener, Ph.D.
Director, Institutional Assessment
Exempt Determination Officer, USAWC Institutional Review Board
Building 122, B21
U.S. Army War College
Carlisle, PA 17013
Anna.t.waggener.civ@mail.mil
Phone 717 245 3365; fax 717 245 4973

