Strategy Research Project

A System Program Review of Army Medical Department Leader Development

by

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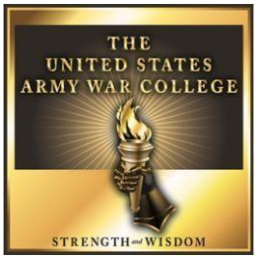
United States Army



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Abstract

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A System Program Review of Army Medical Department Leader Development

> The mission of leader development is to train, educate and provide experiences to progressively develop leaders to prevail in unified land operations and to lead the Army using mission command in a 21st century environment.
>
> —STAND-TO Edition[1]
> Wednesday June 19, 2013

In a recent military health system (MHS) review released by the Secretary of Defense (SECDEF), it found that the MHS is providing health care comparable in access, quality, and safety to average organizations in the private health care sector.[2] According to Secretary Hagel, the findings from this 90-day review of the MHS found that it provides access, quality, and safety on par to average private sector healthcare and ". . . we cannot accept average."[3] The review also found that leaders at military treatment facilities (MTF), but not all clinical personnel, have a working knowledge of what is required to make improvements for access, quality and patient safety.[4]

The United States (U.S.) Army Medical Department (AMEDD), as a part of the MHS, is responsible for providing health care to 3.95 million beneficiaries, which includes active duty service members, retirees, and Family members.[5] The AMEDD has experienced its own challenges in providing health care to its supported population including problems with some of its leaders. Over the past two years, eight AMEDD MTF commanders were relieved or suspended for a variety of reasons including command climate, medical error rates, and scrutiny of clinical practices.[6] These reliefs and suspensions caused questions regarding the leader development system of the AMEDD and whether the personnel that are selected to command are developed appropriately for what the Army is asking and requiring them to accomplish. Because of these questions, senior Army leadership directed the examination of AMEDD leader

development and commissioned a group, the AMEDD Officer Leader Development Study (OLDS) team, to develop recommendations to better prepare AMEDD officers to serve in command and leadership assignments.[7] The OLDS team found that the emphasis on the delivery of quality health care and the management of the business of health care often overshadow leader development.[8] This perceived difference in prioritization leads to a tension in providing quality medicine and good leadership in AMEDD organizations.

AMEDD leader development has been a topic of study by the Army for some time, largely discovering the same findings and each time resulting in the implementation of some incremental change. A study conducted in 1989 found there was difficulty in training Medical Corps officers, physicians, due to the clinical training being ranked in priority over military operational training.[9] The U.S. Army Training and Doctrine Command (TRADOC) conducted a study in 2008 and found that the unique nature of the AMEDD's focus on the provision of health care and maintaining the individual skills of health care providers resulted in less time for leader development experiences, operationally and institutionally, and facilitated tension in the AMEDD's leader development programs.[10] In 2011, the Army Medical Department Center and School (AMEDDC&S) Leader Training Center reviewed officer training and found that with some branches of AMEDD officers, the timing of professional military education is difficult but essential in the maintenance of high ethics and standards as in many cases these officers will lead, command, and affect Soldiers.[11] The problem remains to implement an AMEDD leader development system that has as its foundation the Army's leader development requirements and competencies and also meets the standards of

maintaining clinical competencies. The Army and the AMEDD, historically, have not shied away from reviewing their problems.

The OLDS observed the tension between quality medicine and good leadership, discovered the divergence from the Army's first strategic priority and a leader development foundation built on leadership competencies, and in doing so, set the conditions for a more in depth, holistic review of AMEDD leader development. The AMEDD currently has an opportunity to support the Army's path forward, nesting within the *Army Leader Development Strategy*, the *Army Campaign Plan*, and the Army Operating Concept's *Win in a Complex World*, by conducting a system program review of AMEDD leader development to identify an integrated model for developing leaders.

In today's environment, the AMEDD and its *System for Health* require more than technical expertise, administrative aptitude, and conventional management from AMEDD leaders.[12] The AMEDD needs leaders with far-reaching vision and the ability to communicate that vision in a self-confident manner. The U.S. Army's guidance and doctrine is clear when it comes to leader development. Developing "adaptive Army leaders for a complex world" is the Chief's of Staff of the Army (CSA) first strategic priority and this priority is included in the *Army Leader Development Strategy* and the new Army Operating Concept, *Win in a Complex World*.[13] Without adaptive, visionary leaders who are able to direct, align, and inspire actions, the AMEDD will remain challenged in producing the required change in support of the Army's vision and in mitigating the risks presented by the health care environment.[14]

Framing the Health Care Environment

The United States health care system is a volatile, complex system that is adding to the complexity of developing AMEDD leaders and its demands continue to increase

the tension between quality medicine and good leadership facing AMEDD leaders now and in the future. Today and for the unforeseeable future, the U.S. health care system faces challenges in cost, access, quality, and safety. Health care is an essential public policy issue and is at the pinnacle of readiness for our military. The AMEDD leaders are charged to effectively lead AMEDD organizations in this environment and make decisions affecting military readiness and the cost, quality, access, and safety of the health care that the AMEDD provides.

Cost

As a nation, the U.S. spends approximately 17 percent of its gross domestic product on health care, which makes health care the largest single sector of the United States economy.[15] Even with these expenditure levels, United States citizens largely experience no better life expectancy than citizens of many other nations.[16] The U.S. government health care spending continues to increase its share of the gross domestic product as a result of increased expenditures in Medicare, Medicaid, and insurance subsidies under the *Affordable Care Act*.[17] These increased expenditures are attributed to three factors. First, the aging of the population increases the demand on health care and the benefits received from government programs.[18] Second, excess cost growth regarding health care costs per beneficiary are exceeding growth rates more than potential gross domestic product per capita.[19] Lastly, the growing expansion of health care subsidies under the *Affordable Care Act* are predicted to cause increased federal spending on health care in the future.[20] The MHS faces similar challenges.

The annual expenditure for health care by the Department of Defense (DoD) is approximately $50 billion, which represents an increase of cost by 118 percent in the last 12 years.[21] The annual cost of the AMEDD providing health care to its 3.95 million

beneficiaries is $13 billion.[22] These costs include conducting research; operating eight medical centers, 27 medical activities, numerous health clinics, and five regional medical commands; operating numerous dental activities through five regional dental commands; conducting training and education at the AMEDDC&S; serving as the resource for wounded warrior care support through the U.S. Army Warrior Transition Command; serving as the expert in preventive medicine, veterinary services for the entire DoD, and health promotion under the auspices of the U.S. Army Public Health Command; and through the leadership and management of the Office of The Surgeon General (OTSG), overseeing numerous joint field operating activities for the SECDEF.[23] An AMEDD leader may find him or herself assigned to any of these activities and this adds to the challenge and complexity of developing AMEDD leaders.

The increase in costs for the MHS and the AMEDD are due to a variety of reasons. The AMEDD leader faces a health system where since 1995 costs borne by beneficiaries have decreased while the U.S. general populations' health care costs have increased significantly; the number of TRICARE beneficiaries have increased largely due to retirees who choose TRICARE's generous, lower cost plan over higher cost private plans; and the utilization of health care services per beneficiary has increased at a rate that is 82 percent higher than civilian counterparts.[24] Possessing business competencies are essential for an AMEDD leader to operate successfully in this environment. The AMEDD leader needs to develop the foundation of leadership competencies required to confront rising health care costs, support increased health care demand, and ensure better than average quality health care is provided.

Quality

The U.S. health care system also faces challenges in the quality of the health care services it provides. Health care quality is a multidimensional concept and includes receiving health care that is safe, timely, patient centered, appropriate, and efficient in the use of resources.[25] A RAND study found that American adults received about half of the recommended medical services and that *underutilization* is a greater problem than *overutilization*.[26] Health care quality issues were found in all types of care--chronic, preventive, and acute. Necessary care for chronic conditions, preventive care, and acute health problems was met 56, 55, and 54 percent of the time, respectively.[27] Similar to the overall U.S. health care system, the MHS has issues in the quality of care it is providing.

Providing top tier quality health care remains a challenge for MHS leadership. The SECDEF directed MHS review found that although there are areas that the MHS excels regarding quality, considerable quality variations exist both in specific quality measures and for individual MTFs.[28] This review looked at 18 Healthcare Effectiveness Data and Information Set (HEDIS) measures. The HEDIS is a nationally recognized instrument to measure performance, assess outpatient preventive services and health outcomes, and compare performance of health plans and health care organizations.[29] The MHS review found that of the 18 HEDIS measures that the MHS monitors, three were below the 25th percentile and seven were between the 25th and 50th percentile.[30] The MHS only monitors 12 HEDIS measures for the purchased care component, TRICARE, and that review found that 11 of these are less than the 75th percentile standard recommended by the National Committee for Quality Assurance.[31] AMEDD leaders must possess competencies including quality management and performance

improvement built on a foundation of leadership competencies to effectively lead AMEDD organizations and ensure quality health care is provided.

Access

Another competency area more related to the provision of quality medicine is understanding access to health care and it is one dimension of the quality of care that patients receive. In the U.S. health care system, disparities in the U.S. for access to health care exist between the sexes, different ethnic groups, and between socioeconomic groups.[32] Fortunately, the MHS does not suffer from these barriers to access, but has its own challenges.

Like the overall quality dimensions, access to health care in the MHS was found to vary and TRICARE access performance was immeasurable due to incomplete data. The MHS review looked at access based on type of care. Regarding acute or episodic care, the number of days for a patient to obtain an acute direct care appointment has gradually increased over time largely resulting from increased demand via the services' patient centered medical home initiatives.[33] In FY 2014, the AMEDD experienced an average 1.07 day wait for an acute care appointment, not meeting the MHS standard of one day.[34] For routine direct care appointments in FY 2014, the AMEDD performed better than the standard and the MHS average with only a 5.8 day average wait improving upon the seven day standard.[35] Regarding specialty direct care, the Army performed better than the benchmark of 28 days with an average wait of 12.2 days.[36] However, patient satisfaction with getting care quickly and getting the care needed did not meet the respective MHS benchmarks of 86 and 85 percent with the MHS hovering between 71 and 76 percent and all the services performing consistently since fiscal year (FY) 2010.[37] The AMEDD leaders must address patients' perceptions regarding access

and possess the requisite leader competencies to communicate successes to their beneficiaries while providing quality care in a safe environment. A foundation built on leadership competencies can enable these technical competencies.

Safety

Safety is the single most important dimension of quality health care as lives depend on safe health care environments. The reputations, financial solvency, and the continued existence of health care organizations are threatened by it if health care leaders do not work toward a culture of safety. Longstanding estimates state that as many as 44,000 to 98,000 Americans die in U.S. hospitals annually as a result of medical errors.[38] A study conducted in 2010 showed that the rate of safety incidents involving hospital inpatients between 2000 and 2007 was 25.1 per 100 admissions.[39] Research further indicated that the estimated annual number of preventable adverse events in adult patients, not including obstetrics, was over three million.[40] Besides life, the risk is also financially costly and costs U.S. hospitals an estimated $16.6 billion annually.[41] The MHS is not immune to safety issues and it remains a challenge for MHS leaders.

Health care safety is an issue that leaders in the MHS must address, possess knowledge of, and apply strategies to reduce organizational and patient risk. Unfortunately, due to the lack of national health care safety benchmarks, the MHS review was unable to assess whether a culture of safety exists within the MHS.[42] Currently, DoD policy does not address or define a culture of safety and limits the sharing of lessons learned and best practices for process improvement across the MHS.[43] Additionally, no MHS resource exists for leaders to advance the discipline and exercise of safety.[44] The MHS review found that fewer than 30 percent of staff actively

reports safety incidents.[45] In a September 2014 TEDMED talk, Lieutenant General Patricia Horoho, the Army Surgeon General, issued a call to action regarding health care safety.

> The problem is not the errors. The problem is that we ignore the errors. But in our U.S. hospitals, we talk about harm in hushed tones. We use metaphors. We talk about near misses, unintended complications, and close calls. To err is human. As individuals, we need the confidence, the integrity, and the courage to speak up. As leaders, we need to listen to our patients, to our Families, and to our staff. If we decide our system isn't working, we can change it.[46]

The AMEDD leadership recognizes that health care safety is an issue and it must implement a culture of safety. Safety incidents can result in a loss of trust in the health care system and decrease patient confidence and satisfaction. To change the culture in an organization, AMEDD leaders must know how to lead change. To lead change, AMEDD leaders require the competencies of an effective leader. For AMEDD leaders to rise to the call to action and to integrate and exercise health care safety requires the development and leveraging of a "system of effective leadership competencies."[47]

Framing the Problem: The Need for Leader Development

The U.S. Army values leadership and recognizes the critical importance of leader development. General Raymond T. Odierno, CSA, places such a high value on leadership that his number one strategic priority is ensuring we have "adaptive Army leaders for a complex world."[48] General Odierno further explains the importance of leadership and leader development in the *Army Leader Development Strategy*: "Leadership underpins everything the Army does, which is why we will continue to invest in our people, even during times of austerity. Such an investment in our profession is the most certain way to ensure we are ready when the Nation calls."[49] Though the Army leadership places a high value on leader development, the Army has

issues that it needs to address to maintain the trust of the American people, Army leaders, and Soldiers to fulfill the CSA's vision of the "most highly trained and professional land force in the world."[50]

An Army Problem

In recent years, the U.S. Army experienced challenges with many senior leaders in its ranks. Many of these instances proved newsworthy and challenged Army values and, at least on a local level, may have eroded trust and confidence in our leadership or the ability of the Army to fairly execute justice. Since 2003, 98 battalion commanders, 31 brigade commanders, four lieutenant colonel staff officers, and four colonel staff officers have been relieved of duty.[51] Since 2008, the Army administered non-judicial punishment to 1,472 officers and court martialed 41 lieutenant colonels and higher, which included two general officers.[52] Likewise since 2008, seven general officers were removed from their duty positions.[53] In addition to these actions, since 2001, the Vice Chief of Staff of the Army issued 247 reprimands or letters of concern and conducted 45 verbal counseling sessions with general officers.[54] The U.S. Army recognizes that these adverse actions by leaders are inconsistent with Army Values and has developed initiatives, like the 2013 *Army Leader Development Strategy*, a new officer evaluation reporting system, and 360-degree leadership feedback and assessment tools to ensure the Army is developing leaders of character and competence. The Army Medical Department is not immune to these issues.

The AMEDD Part of the Army Problem

The AMEDD is experiencing similar issues as the rest of the Army regarding its senior leaders. Since 2012, eight Army MTF commanders were suspended or relieved for various reasons, which include command climate, sexually suggestive inappropriate

comments, medical errors resulting in patients' deaths, and questionable diagnoses protocols.[55] These incidents bring increased scrutiny from senior Army leadership and Congressional members. Regarding one case, Senator Patty Murray of Washington stated, "When the leadership of someone entrusted with overseeing the medical care of our nation's heroes is called into question, it must be taken very seriously" and she further stated that she would closely monitor the Inspector General's investigation.[56] These incidents erode trust with senior military and national leaders.

Since the late 2000s, the AMEDD has endured increased scrutiny regarding its provision of care and its leader development process. The Walter Reed Army Medical Center (WRAMC) scandal as reported by the *Washington Post* is not that far removed. These events reported in February 2007 described incidents of neglect and substandard living conditions at WRAMC's Building 18 by active duty patients and their Family members.[57] Many viewed this as a failure in leadership as there was a perception that Army and AMEDD leadership had no sense of accountability since they had known of these problems from earlier reports from 2005.[58] The current string of leadership breaches in trust resulted in additional examination of AMEDD leader development by Army senior leaders.

The AMEDD Officer Leader Development Study

The U.S. Army leadership believed it was time to look at the leader development process of AMEDD officers considering the events that transpired. On January 3, 2013, the Director of the Army Staff, at the direction of the CSA, signed the Terms of Reference memorandum directing the formation of an intra-Army committee to investigate, advise, and report on AMEDD leader development in accordance with Army Regulation (AR) 15-1, *Committee Management.*[59] Soon thereafter, the Secretary of the

Army approved the charter of the AMEDD OLDS group with a mission to “conduct an officer leader development study of the Army Medical Department in order to develop recommendations to better prepare AMEDD officers to serve in command and key leadership positions.”[60]

The study’s objectives included comparing and contrasting each of the six AMEDD Corps and the leader development processes between the AMEDD and Army Competitive Category; assessing applicable regulations, statues, and policies; assessing centralized selection (CSL) and non-centralized selection processes, policies, and criteria; assessing professional military education for AMEDD officers; assessing AMEDD officer assignment processes; collecting AMEDD leader development observations from internal and external populations to the AMEDD; comparing leader development initiatives between the AMEDD and TRADOC; submitting a written report; and ensuring any recommendations would not jeopardize the quality of health care provided to Soldiers and their Families.[61] The OLDS group conducted the study in nearly 120 days and visited 22 installations interviewing 38 senior leaders including various medical commands, division, corps, centers of excellence, Army command, Army Service Component Command, and Army Direct Reporting Unit commanding generals and command sergeant majors, Army principal staff members, and TRICARE Management Activity leadership.[62] Although this study included a wide breadth of Army activities and units, the study did not attempt to identify or address specific leadership competencies required for AMEDD leader development, AMEDD officer leader development in its entirety, AMEDD noncommissioned officer (NCO) leader development, or AMEDD civilian leader development.

The AMEDD is responsible for the provision of health care for the Army and its share of the MHS beneficiaries, but it does so under some unique circumstances when compared to the larger Army. There are six AMEDD officer corps, comprising 21 percent of the Army's officers, consisting of 91 different areas of concentration (AOC) of which 79 percent of AOCs enter at a rank above first lieutenant with 80 percent of AOCs requiring licensure or certification.[63] In addition, Medical and Dental Corps officers are exempt from Defense Officer Personnel Management Act (DOPMA) field grade constraints.[64] The AMEDD personnel are assigned both to the Army's operating and generating forces and the AMEDD must develop leaders to lead in both of these forces. For the operating force, the AMEDD contributes personnel and leaders to 340 different modification table of organization and equipment (MTOE) units across all Army components.[65] The AMEDD generating force contributions include the U.S. Army Medical Command (MEDCOM), the management and operation of 616 facilities, and the training, morale, discipline, and leadership of over 86,000 AMEDD military, civilian, and contract personnel.[66] This context further adds to the complexity of developing leaders for these two environments and adds to the tension between quality medicine and good leadership.

The OLDS confirmed concerns about a perceived tension existing between providing good quality medicine and good quality leadership. This has resulted in exemptions for AMEDD officers to some standards applicable to the Army Competitive Category officers as codified in current regulations, policies, or statutes.[67] The OLDS report described a unique context in which the AMEDD operates, addressed five strategic findings, and provided recommendations to U.S. Army leadership.

The tension between quality medicine and quality leadership is exemplified by two of the study's strategic findings. First, 63 percent of AMEDD officers receive direct commissions as health care professionals and are not commissioned from traditional sources.[68] This leads to AMEDD officers not being properly inculcated or indoctrinated into the Army profession or culture, especially when an AMEDD officer experiences poor pre-commissioning training or non-attendance at a basic officer leaders course.[69] Second, the prioritization of managing the business aspects of the AMEDD often is placed over leader development. For example, the OLDS found that leader development metrics were not monitored at the MEDCOM level; MEDCOM provided no incentives for subordinate commands sending officers to military education, training, or broadening assignments; and the Army Medicine 2020 Campaign Plan did not nest within the *Army Campaign Plan's* imperative of "Develop leaders to meet the challenges of the 21st Century."[70] The findings reveal an emphasis on medicine or the business of medicine overshadows leader development. This tension, over time, may have contributed to policy, regulation, and statute divergence from the greater Army.

Because of the relative weighting and importance of the provision of quality health care over leader development, the policies, statutes, and ARs were modified to accommodate, exempt, or waive leader development requirements for AMEDD officers. Three of the strategic findings demonstrate the inconsistency of standards between the AMEDD and the Army Competitive Category. First, consistent with the emphasis on the "business of medicine," the OLDS found that many AMEDD officers were not developed appropriately through military education, training, and assignments.[71] This was demonstrated by many AMEDD officers not having leader development opportunities in

initial assignments; inconsistent timing of, and relevancy of, material included in the AMEDD Captains' Career Course; a lack of a requirement to complete Intermediate Level Education or Senior Service College and consequentially, few authorized seats; and senior mission commanders who had not sought opportunities to develop their assigned or supporting AMEDD officers.[72] Second, some AMEDD officers who are less experienced and trained in the Army profession than their Army Competitive Category (ACC) counterparts are selected for command due to existing policies, not necessarily past successful experience as a commander.[73] This results in an inverted command pyramid, with more Colonel than Lieutenant Colonel commands available.[74] It also results in a number of other difficulties: multiple processes for selecting AMEDD commanders, CSL, non-CSL, and simple assignment processes; board membership requirements in terms of rank and assignment experience inconsistent with the ACC; the possibility of multiple Colonel-level commands; and no identification of key and developmental positions by rank or branch.[75] This process has led to an inconsistent application of discipline with officers who failed to adhere to the highest standards of moral and ethical behavior required of the officer corps.[76] Third, the regulations, policies, and U.S. statutes concerning AMEDD leader development need refined to ensure they do not create and/or contribute to double standards between the AMEDD and the ACC in three areas. The first area is promotions. Currently, there are specific general officer rank requirements for specific AMEDD corps that are stipulated in law.[77] Likewise, an exemption to DOPMA field grade goals may lead to an environment that results in a lack of promotion competitiveness.[78] Second, double standards exist regarding retention of certain AMEDD officers versus the ACC. The OLDS found that AMEDD officers who

do not meet basic standards, such as height and weight, Army school failure, or physical fitness test were not separated due to their training or education service obligation or their value to the AMEDD.[79] Finally, talent management is conducted differently than the ACC. In contrast to the ACC's single management office to manage colonels, The Surgeon General has 137 consultants who provide advice on the management of senior officers within the AMEDD.[80] In addition, current regulations, policies, and statutes further increase the tension between the provision of medicine versus the provision of good leadership and lead to double standards between AMEDD and ACC officers.

The OLDS offered good insight into identifying and framing an Army leader development problem that existed within the AMEDD. This study also offered incremental recommendations to address this complex problem of how does the Army develop its AMEDD leaders while providing quality health care to its beneficiaries and quality leadership to its Soldiers. The CSA approved 28 of the 29 recommendations with many already enacted.[81] Among those approved and being adapted to current requirements include: the reversal of the inverted command pyramid, the formation of a talent management office, the revision of pre-commissioning requirements for health care professionals, and the inclusion of a leader development line of effort (LOE) in the *Army Medicine 2020 Campaign Plan*.[82] The OLDS was a good start and the Army and the AMEDD have made some short-term gains that have helped reduce the tension between the business of health care delivery and leadership. However, it is time for greater change, change that will enable the Army and the AMEDD to reduce the tension between medicine and leadership.

A Historical Approach for Review

In the past, the U.S. Army approached reviews of systems and subjects in a deliberate manner. System program reviews were used to consider the status of an Army system or subject of Army level interest, discuss it, and receive guidance from Army senior leadership.[83] According to the former AR 11-4, *System Program Reviews* provide "intensified management measures to bring senior Army management consideration to subjects that require special attention because of priorities, unusual problems, or other circumstances."[84] The AMEDD last conducted a System Program Review in 1984 when Army medicine faced new Army operating concept priorities and out of date AMEDD doctrine, training regimens, and force structure.

In 1984, the Commandant of the Academy of Health Sciences (AHS), Major General William P. Winkler, Jr., committed the AHS and the AMEDD to conducting a medical system program review (MSPR) with TRADOC; U.S. Army Forces Command (FORSCOM); Headquarters, Department of the Army (HQDA) Office of the Surgeon General; and U.S. Army Health Services Command.[85] The MSPR provided the AMEDD an opportunity to conduct a complete review of its doctrine, organization, training, materiel, leadership and education, personnel, facilities, and policy to bring them into alignment with Army doctrine.[86] The MSPR generated 79 findings impacting the Army and requiring solutions and recommendations were presented to senior Army leadership for decision.[87] The sense of urgency was generated by the need to integrate the AMEDD system within the larger Army operating concept and the experience of bringing people together across Army commands proved both productive and educational.[88]

New Army Operating Concept: New AMEDD Opportunity

This same system program review model provides an opportunity to create a similar synchronized, coordinated, and integrated approach to AMEDD leader development identified within the OLDS. A similar sense of urgency exists today. It is now time to create the framework for a system of substantive change with the opportunity that is present today that would allow the conduct of a more holistic review of the AMEDD leader development system to address the tension it creates within the health care system.

Framing the Approach for an AMEDD Leader Development System Program Review

There is no better opportunity than now for the Army and the AMEDD to conduct a partnered, holistic review of AMEDD leader development to include the following agencies, but not limited to HQDA OTSG, MEDCOM, TRADOC, HQDA G1, FORSCOM, and other Army commands as appropriate to serve as the guiding coalition. The review should also determine and prioritize necessary AMEDD leader competencies and determine competency assessment tools. This system program review, nested with the *Army Leader Development Strategy*, the *Army Campaign Plan*, and the Army operating concept goal to "develop innovative leaders and optimize human performance" should assess and determine objectives and supporting efforts across three lines of effort: training, education, and self-study in the three domains of operational, institutional, and self-development.[89] In order to do this, a vision for AMEDD leader development is necessary and should nest with the Army's vision for leader development: "An Army of competent and committed leaders of character with the skills and attributes necessary to meet the challenges of the 21st century."[90] This review should result in a comprehensive, competency based AMEDD leader development

strategy with defined objectives, concepts, and resources to fulfill the AMEDD strategy's vision.

Review Statues, Army Regulations, Policies, and Doctrine

The review team must understand statutory requirements that the Army and AMEDD currently must meet regarding appointments or promotions. Therefore, the system program review must consider all pertinent statutes, regulations, policies, doctrine, and guidance that pertain to leader development, personnel, education, training, and command, to include officer, NCO, and civilian leader development within the AMEDD.[91] The goal of this review is to inform the system program review of the current laws, regulations, policies, and doctrine that lead to the current leader development systems and tensions experienced today.

Review and Establish Clear and Defined Competencies

Before the system program review looks at potential objectives or supporting efforts across the lines of effort and within the training and leader development domains, the Army must place the leadership competencies at the foundation of this review to ensure AMEDD leaders are developed as Army leaders with the desired technical and conceptual expertise required of both the military *and* the health care system. To obtain the desired refinement of AMEDD leader development, the Army and the AMEDD must assess, develop, refine and prioritize the criteria they are using to develop, identify, and assess leaders.[92] It is important for this review to consider the Army competencies as listed in ADP 6-22, *Army Leadership*, as these establish the foundation for leader development. However, there is a need to consider how to nest the AMEDD technical competencies within the Army leader development competencies. Likewise, it is essential that the review consider the 35 medical executive skills (e.g.,

demonstrated professional administrative skills by prospective MTF commanders, TRICARE lead agents, and senior staff members) required by the Department of Defense Appropriations Act of 1992.[93] Additionally, this review needs to consider the knowledge, skills, and attributes currently used, but not reconciled with the 35 medical executive skills, that are used to assign AMEDD officers to identified MEDCOM and OTSG strategic billets.[94] This system program review should prioritize these competencies based on level of proficiency required for AMEDD leadership and command positions.

With no prioritization of the 35 medical executive skills and without the leadership competencies serving as a foundation, it is difficult to focus training and education as a means for developing and assessing performance and growth in AMEDD leaders.[95] Prioritization can also assist targeted assessments at various points in an AMEDD leader's development and career. Prioritizing the leadership competencies and determining which competencies are important to the AMEDD will inform the approach to the AMEDD's leader development strategy.

Three Lines of Effort Operating in Three Domains

The system program review provides the key to the success of AMEDD leader development by ensuring that the education, training and assessment of the appropriate competencies occurs within all three domains and across all three LOEs. There are numerous stakeholders in the three LOEs of training, education, and experience across the three domains of institutional, operational, and self-study. Multiple AMEDD entities contribute differently in each domain, which adds to the complexity of developing AMEDD leaders. In the institutional domain, OTSG and MEDCOM serve as the proponent for policy guidance. The AMEDDC&S, regional medical commands (RMC)

and MTFs execute numerous training, education, and self-study programs. Additionally in the institutional domain, Health Services Division, Human Resources Command manages assignments and serves as the proponent of Army Pamphlet (PAM) 600-4, *Army Medical Department Officer Development and Career Management*. In the operational domain, RMCs, MTFs, Major Command/Army Service Component Command Surgeons' staffs, and MTOE unit commanders provide oversight to training, education, and assignment management. The self-study domain requires a personal commitment and bridges the gaps of both institutional and operational learning.[96] Training, education, and experience enables the AMEDD to develop leaders with the leader attributes and proficiency in the core leadership competencies.

Line of Effort 1: Training

The review will need to analyze and provide recommendations in all three domains and assess current objectives, concepts, and resources as they apply to this LOE. In the institutional domain, the review must ensure that all programs are implemented in accordance with the Army Learning Model.[97] Programs such as *Training With Industry*, broadening opportunities, military occupational specialty and area of concentration training, and other training opportunities need assessed to ensure they support those leader competencies determined as essential for leadership development. An assessment of MTOE and MTF training in the operational domain is needed to ensure it is realistic, allows leaders to lead in all roles of health care, and supports the identified leader competencies. In the self-study domain, the review should assess if structured self-development, guided self-development, and personal self-development programs are bridging the gaps for training in the other two domains to meet the determined competency requirements. In addition to training leadership

competencies, education needs to support competency development in AMEDD leaders.

Line of Effort 2: Education

The system program review also provides an opportunity to assess and provide recommendations for education programs across the three domains and assess the objectives, concepts, and resources committed to this LOE. In the institutional domain, the review should assess policy guidance regarding education opportunities and attendance statistics across the six AMEDD Corps. It is essential to consider the assessment of *Long Term Health Education and Training Programs*, education broadening opportunities, professional military education, and fellowships assessed against the determined competencies across all six AMEDD Corps. Likewise, curricula for AMEDD education programs at the AMEDDC&S and at MEDCOM MTFs needs assessed to ensure it supports the required competencies to increase the effectiveness of AMEDD leaders leading military health care teams. It is important to review programs at unit and staff levels for MEDCOM and MTOE units used to assess and prepare leaders for educational opportunities. An assessment of the self-study domain will help ensure structured self-development, guided self-development, and personal self-development programs are bridging the gaps for training in the other two domains. Education can aid in preparing AMEDD leaders' for their assignment experiences and support required competency development in leading the business of health as well.

Line of Effort 3: Experience

The system program review should assess and provide recommendations for experience management programs across the three domains and this LOE's objectives, concepts, and resources. In the institutional domain, it is important to conduct the

assessment and provide oversight of the practice and execution of mission command, the execution of talent management across the six AMEDD Corps, the review of PAM 600-4, and the oversight of the provision of education and broadening opportunities in support of determined competencies. Likewise, MTFs need to incorporate leader development competencies in their medical training and education programs and assess Soldiers serving in leadership roles as a part of these programs. In the operational domain, the utilization of mission command is imperative and needs assessed to ensure subordinate leaders are allowed to accomplish missions in accordance with the commander's intent. The assessment of MEDCOM and MTOE units' talent management and assignment of leaders should occur as well as the balance between MEDCOM and MTOE assignments for AMEDD leaders in support of determined competencies. Like in the other lines of effort, it is essential to assess the self-study domain to ensure it is bridging gaps in the other domains. Assessment of the required leader competencies of the AMEDD leader is essential in this and all lines of effort and across all domains.

Assessment and Analysis

A disciplined methodology is critical in the conduct of this review. Key leader interviews should ensure the review is informed by the vision, purpose, and guidance for AMEDD leader development from OTSG/MEDCOM and Army leadership. The utilization of surveys and interviews is essential in determining requirements and prioritizations of competencies. An assessment of the efficacy of current education and training programs, and effectiveness of statues, regulations, and policies is also critical for success. Focus groups are often helpful in refining assessments and analyses of competencies, education and training, and regulatory requirements. The analysis of the

system program review findings should result in recommendations that result in an AMEDD leader development strategy with objectives, concepts, and resources required and defined that better mitigate the tensions of medicine versus leadership. Just as important, it will also allow senior Army leadership to assume risk where they deem appropriate regarding the provision of health care and AMEDD leader development.

Conclusion

The Army and its Army Medical Department have an important opportunity to conduct a system program review of AMEDD leader development concepts and practices to ensure AMEDD leaders are developed as both Army leaders and leaders within the health care system. This program review will help rationalize the OLDS study and help the AMEDD achieve better objectives to benefit Soldiers, their Families, and all AMEDD beneficiaries. The AMEDD OLDS provided another beginning to a former dialogue and it is time to continue the conversation and act. A renewed call for a leader development focused system program review provides a historic opportunity to help reduce the tension between the provision of quality medicine and the exercise of quality leadership by better balancing the two requirements through the identification and prioritization of AMEDD leader competencies. These competencies will enable the objectives, concepts, and resources of an AMEDD leader development strategy through three LOEs, training, education, and experience and provide competency assessment tools in all three domains. The review also allows the Army leadership to make informed decisions and assume any appropriate risk regarding its medical department. The health care environment is a volatile, complex system, which requires strong leaders to lead its AMEDD organizations. Soldiers deserve great leadership. Beneficiaries of the AMEDD and MHS deserve strong leadership and better than average quality health

care. The Army and the AMEDD can provide both through a strong AMEDD leader development system, as leadership remains the most dynamic and important element of the Army.

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