



Center for Military Health Policy Research

A JOINT ENDEAVOR OF RAND HEALTH AND THE
RAND NATIONAL DEFENSE RESEARCH INSTITUTE

- CHILDREN AND FAMILIES
- EDUCATION AND THE ARTS
- ENERGY AND ENVIRONMENT
- HEALTH AND HEALTH CARE
- INFRASTRUCTURE AND
TRANSPORTATION
- INTERNATIONAL AFFAIRS
- LAW AND BUSINESS
- NATIONAL SECURITY
- POPULATION AND AGING
- PUBLIC SAFETY
- SCIENCE AND TECHNOLOGY
- TERRORISM AND
HOMELAND SECURITY

The RAND Corporation is a nonprofit institution that helps improve policy and decisionmaking through research and analysis.

This electronic document was made available from www.rand.org as a public service of the RAND Corporation.

Skip all front matter: [Jump to Page 1](#) ▼

Support RAND

[Purchase this document](#)

[Browse Reports & Bookstore](#)

[Make a charitable contribution](#)

For More Information

Visit RAND at www.rand.org

Explore the [RAND Center for Military Health Policy Research](#)

View [document details](#)

Limited Electronic Distribution Rights

This document and trademark(s) contained herein are protected by law as indicated in a notice appearing later in this work. This electronic representation of RAND intellectual property is provided for non-commercial use only. Unauthorized posting of RAND electronic documents to a non-RAND website is prohibited. RAND electronic documents are protected under copyright law. Permission is required from RAND to reproduce, or reuse in another form, any of our research documents for commercial use. For information on reprint and linking permissions, please see [RAND Permissions](#).

This product is part of the RAND Corporation monograph series. RAND monographs present major research findings that address the challenges facing the public and private sectors. All RAND monographs undergo rigorous peer review to ensure high standards for research quality and objectivity.

Developing Military Health Care Leaders

Insights from the Military, Civilian, and
Government Sectors

Sheila Nataraj Kirby, Julie A. Marsh, Jennifer Sloan McCombs,
Harry J. Thie, Nailing Xia, Jerry M. Sollinger

Prepared for the Office of the Secretary of Defense

Approved for public release; distribution unlimited



Center for Military Health Policy Research

A JOINT ENDEAVOR OF RAND HEALTH AND THE
RAND NATIONAL DEFENSE RESEARCH INSTITUTE

The research reported here was sponsored by the Office of the Secretary of Defense (OSD). The research was conducted jointly by the Center for Military Health Policy Research, a RAND Health program, and the Forces and Resources Policy Center, a RAND National Defense Research Institute (NDRI) program. NDRI is a federally funded research and development center sponsored by OSD, the Joint Staff, the Unified Combatant Commands, the Navy, the Marine Corps, the defense agencies, and the defense Intelligence Community under Contract W74V8H-06-C-0002.

Library of Congress Control Number: 2011920369

ISBN: 978-0-8330-5007-6

The RAND Corporation is a nonprofit institution that helps improve policy and decisionmaking through research and analysis. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors.

RAND® is a registered trademark.

© Copyright 2011 RAND Corporation

Permission is given to duplicate this document for personal use only, as long as it is unaltered and complete. Copies may not be duplicated for commercial purposes. Unauthorized posting of RAND documents to a non-RAND website is prohibited. RAND documents are protected under copyright law. For information on reprint and linking permissions, please visit the RAND permissions page (<http://www.rand.org/publications/permissions.html>).

Published 2011 by the RAND Corporation
1776 Main Street, P.O. Box 2138, Santa Monica, CA 90407-2138
1200 South Hayes Street, Arlington, VA 22202-5050
4570 Fifth Avenue, Suite 600, Pittsburgh, PA 15213-2665
RAND URL: <http://www.rand.org>

To order RAND documents or to obtain additional information, contact
Distribution Services: Telephone: (310) 451-7002;
Fax: (310) 451-6915; Email: order@rand.org

Summary

Background and Purpose

Over the past few years, military leaders have realized that the Military Health System (MHS) has to transform itself and the way it does business. This need has been driven by the rapid escalation in the costs of health care, a changing environment with an increased emphasis on performance management, the unprecedented challenges facing the U.S. military at home and abroad that require it to assume new roles and responsibilities, and the need to transform the medical force so that future medical support is fully aligned with joint force concepts. As part of a larger project providing assistance to the MHS in establishing a joint medical education and training campus at Fort Sam Houston, Texas, RAND was asked to examine the ways in which leaders in the health care field are prepared and supported in the civilian and military sectors, to review the competencies necessary to be a leader in the current environment, and to recommend improvements to the ways in which potential leaders are identified and developed for leadership positions in the MHS.¹

A primary goal of officer management is to produce qualified senior leaders who can function in both joint and service-specific environments and who have the competencies that are important for successful leadership. Our framework assumes that military medical officers are functionally qualified and continue to develop their domain knowledge and skills. Thus, our focus is on who is developed and where and how these officers receive the knowledge, experience, and acculturation necessary to qualify them for leadership in both service and joint environments. An organization's approach to leader development plays out against the larger backdrop of the local, regional, national, and global context, which shapes what an organization expects from leaders and how it designs and implements development strategies. These contextual factors also enable or constrain the ability of an organization to develop the needed leaders. There are three important dimensions of an organization's approach to leader development: how it

¹ We use the term *leader* to identify an individual who is likely to be in a command or executive position in an organization.

selects individuals who have the potential to be leaders, how it develops them, and how it incentivizes them to apply for and remain in leadership positions.

Data and Methods

The study encompassed several tasks, including a review of the literature on leader development and the creation of a conceptual framework to guide data collection and analysis. The conceptual framework focused on how organizations select “high-potentials” for leader development, the strategies that organizations use to incentivize and develop these leaders, and the extent to which the overall approach is systematic and purposeful. Obviously, an organization’s approach to leader development is affected by the context and the organizational environment and guided by explicit and implicit expectations for leaders. Using this framework as the basis for our interview protocol, we conducted structured interviews with 57 military health professions officers² and community managers and with 30 civilian health care leaders in 25 organizations. We also conducted a case study of how one government agency—the Veterans Health Administration (VHA)—approaches executive leader development. The case study included interviews with 16 top-level leaders and network and facility directors. The interviews were conducted over a period of two years—2007 through 2009. The MHS, the VHA, and the civilian health care organizations examined in this study are all facing the same kinds of pressures with respect to delivering high-quality health care while struggling with escalating costs and rising demand. As a result, lessons learned by the VHA and civilian health care organizations about designing and implementing leader development policies may have considerable relevance for the military.

Findings

Data from these interviews, along with our extensive review of service documents and the literature on the subject, provide a rich portrait of how health care leaders are currently developed in the three sectors, the competencies necessary to be a successful leader in today’s environment, perceived gaps in leader development, and some perceived best practices.

² Following U.S. Department of Defense (DoD) Directive 6000.12 (1996), we use the term *health professions officers* when referring to officers who are “serving in the Medical Corps, the Dental Corps, the Veterinary Corps, the Nurse Corps, the Medical Service Corps, the Army Medical Specialist Corps, the Biomedical Sciences Corps, officers whom the Secretaries of the Military Departments have designated as ‘qualified in specified healthcare functions,’ and those members in DoD programs leading to commissioning in, assignment to, or designation for service in any of those Corps” (Enclosure 2). When referring more generally to leaders in the civilian and military sectors, and in the Veterans Health Administration (VHA) more generally, we use the term *health care leaders*.

Our findings are organized around four research topics:

- desired attributes of leaders in the health care field
- military officers' perceptions about how well the current system works in preparing health professions officers to lead and succeed in performance-based and joint environments
- lessons learned from civilian health care organizations and the VHA regarding leader development
- recommendations to improve leader development of health professions officers in the services.

Desired Attributes of Health Care Leaders

To determine the kinds of knowledge, skills, and experience that organizations believe that leaders need, we reviewed a number of civilian health care leadership competency frameworks, the High Performance Development Model adopted by the VHA, and the military health care leadership competencies identified by the Joint Medical Executive Skills Program (JMESP) as necessary for successful command of a medical treatment facility or for other executive MHS positions. In addition, we asked respondents about the attributes that organizations looked for in their senior leaders—the skills, knowledge, attitudes, and experiences that organizations expected of their executives. Perhaps not surprisingly, there was remarkable consistency in the set of competencies identified both by the frameworks and individuals, which we categorized into three types of competencies and experiences.

First, *management knowledge and experience* includes the skills and abilities to effectively manage financial, human, and information resources to ensure successful fulfillment of organizational goals. Respondents often described the need for both “hard” and “soft” skills. Identified common hard-skill competencies that fall into this category include human resource (HR) management (such as recruitment, staffing, training, and evaluation and assessment), financial resource management (such as budgeting, asset management, and monitoring of financial resources), and information and technology management. The soft skills, or interpersonal and communication skills (with internal and external customers), were considered equally important.

Second, *leadership knowledge and experience* provides strategic and visionary guidance to help the organization meet future challenges. Competencies that fall into this category include visionary leadership (i.e., envisioning a future state and influencing movement toward it), change leadership (i.e., continuously seeking innovative approaches and welcoming changes as opportunities for improvement), flexibility and adaptability, and creative and strategic thinking and planning.

Third, *enterprise knowledge and experience* includes competencies that demonstrate a sound understanding of the profession and the organization, such as organizational awareness or stewardship; an understanding of the larger context in which the

organization operates (or systems-level thinking); and an understanding of the global environment.

All our respondents stressed the importance of educational achievement and competency in functional areas. In addition, several respondents also emphasized the importance of leaders who possess strong values and moral character (“a strong moral compass”) in addition to knowledge, skills, and abilities. According to several civilian and VHA respondents, a strong values orientation (e.g., organizational stewardship, integrity, financial responsibility) is included in competency profiles for top executives. Diversity of experience, practice in both managing and leading, and, in some cases, an understanding of and experience with the higher levels of the organization were mentioned as critical for leaders.

Respondents were divided in terms of the extent to which health care leaders should possess and maintain clinical skills. Some physician respondents—both military and civilian—stated that the greatest credibility of a health care leader comes from being a physician. In keeping with this belief, the Air Force has a policy of reserving command of medical centers and hospitals for physicians (Medical Corps, or MC). In contrast, the Army and the Navy have opened up these positions to all corps. Military respondents referred to these diametrically opposed policies as “best in breed” versus “best in show.” Most respondents (including some Air Force leaders) felt that the Air Force policy was shortsighted and out of step with practice in the civilian sector and organizations like the VHA, in which hospital leaders are often not physicians. Several leaders noted that clinical skills do not automatically translate into leadership skills.

Military Respondents’ Perceptions of the Current System of Leader Development

Context, Organizational Environment, and Organizational Leader Expectations. Several respondents recognized the complexity of the military environment and its effects on leader expectations. Particularly among Army and Navy respondents, leaders noted that the military and their respective services had become quite complex on a number of levels: for example, challenges of managing a workforce that now includes military, civilian, and contract workers; dealing with the stresses and demands of war and the disruptions caused by deployments; and new productivity demands and attention to the “bottom line.” All shape what is expected of leaders and how they are selected and evaluated.

Respondents in all three services identified differences in opportunities for leadership and growth across the corps. Several leaders in the Army and Navy believed that, when compared to Medical Service Corps (MSC) officers (who are trained in medical administration and other nonclinical skills), MC officers (who are doctors) are at a disadvantage in acquiring leadership skills. Some respondents believed that, given the length of time required for clinical training and the demand to keep officers in clinical positions, it often takes longer and is more difficult for MC providers to gain the requisite skills, although they have greater opportunities to move into leadership positions.

Some Navy respondents criticized the Navy's "lock-step" requirement that an individual must be a director, then an executive officer, then a commanding officer, pointing out that this system overlooks other opportunities for individuals to develop or demonstrate leadership skills. Some respondents noted that rank does not equate to leadership and that physicians, in particular, were often placed in leadership positions because of rank without the requisite experience and training.

Although some respondents in all three services were aware of a set of formal leadership competencies endorsed by the military, most did not remember the name (JMESP), and few found them to be particularly meaningful or consequential.

Overall Approach to Leader Development. There was variation across and within the services in terms of respondents' perceptions of how purposeful and systematic the services are in developing leaders. Most Air Force respondents considered the Air Force to have a reasonable and well-defined system in place for leader development and mentioned both the flight paths and the development teams as the formal process for managing careers. Perceptions were more mixed in the other two services, with some respondents characterizing the approach as lacking purposeful planning and design; they used descriptions such as "happenstance," "serendipity," and "being in the right place at the right time."

How to Select. All services use formal and informal methods to select high-potentials, but perceptions about the efficacy of these approaches varied. Most respondents in all three services viewed formal evaluation reports as one of the primary methods for identifying individuals with leadership potential, with below-the-zone promotions and "getting ranked" as important indicators of high leadership potential. Nevertheless, there was widespread concern about the limitations of these reports, including inflated ratings, subjectivity, the use of "code words" as discriminators, a lack of writing skills on the part of the raters, and raters being too far removed in rank from those being evaluated. Many respondents also mentioned the role that boards play in identifying and selecting individuals for leadership positions and leader development, but some expressed concern about the "soundness" and objectivity of this process. A few respondents mentioned interviews as another formal and effective way to select leaders, but this approach did not seem to be widely used. Many respondents across the services noted that an "informal system" with information gleaned from colleagues and word of mouth greatly affected the identification of leaders and potential leaders, and that these were often more important than formal methods in selecting leaders at the highest levels.

While a few were satisfied with the timing of selection for leadership opportunities and training, several leaders in the Army and Navy argued that identification needed to occur earlier than it currently does. For example, many Navy leaders believed that formal development opportunities often came too late in one's career to be useful and that the Navy needs to be more proactive in providing opportunities to individuals before they are in leadership positions, rather than offering them "after

the fact, when you take over one of these organizations.” As discussed earlier, in all three services, respondents mentioned that physicians do not receive leader development opportunities early enough in their careers and often lack leadership and management skills and experience. Some respondents, particularly those in the Navy, mentioned the need to accord diversity more consideration in the selection process.

How to Develop. In our interviews, approaches to developing high-potential candidates as described by respondents fell into three broad categories: job assignments, education and training, and mentoring.

Job Assignments. Many of our respondents viewed on-the-job experience as the most valuable and effective means of developing leaders, but not all were satisfied with this emphasis. Others felt that this approach was particularly challenging for physicians. Most agreed that diversity of job experience and wide exposure to different types of jobs and responsibilities are important for leader development.

Enterprise knowledge and experience are increasingly seen as important for military leaders as operations become more joint and integrated (i.e., interservice, interagency, intergovernmental, and multinational). Across the services, many respondents considered joint experiences to be beneficial to leader development; however, they did not tend to endorse mandatory requirements for joint experience and assignments, noting that the lack of joint billets available to health care officers made mandating them difficult.

Education and Training. Almost all our respondents described receiving formal education and training for certain positions and commands. However, views were mixed about the value of the current education and training. Some believed that certain courses were valuable; others noted that coursework must be teamed with experiential learning. Leaders across the services cited a need for better writing skills and more instruction on the business aspects of medicine, particularly for clinicians.

All respondents discussed senior-level professional military education opportunities, including their service’s war college and the National War College. Almost all agreed that in-residence attendance at war college was far more valuable than completing the coursework through correspondence, which was viewed as a way of merely “checking a box.” However, several leaders noted downsides to resident participation, including the high opportunity costs for both the individual and the service. Navy respondents were more critical of that service’s war college in terms of the time needed to complete the coursework, the limited slots available, the potential for doctors to lose their bonuses, and the lack of planning in subsequent career assignments that prevented some physicians from applying what they learned.

Respondents were hesitant to endorse mandatory joint education, given the limited number of seats at schools offering joint professional military education.

Respondents across the services identified the value of educational and training opportunities provided by individuals and organizations outside of the military, many of which are sponsored by the services. These included graduate school, strategic lead-

ership courses, and the Interagency Institute for Federal Health Care Executives. In other cases, leaders across the services described seeking out their own education outside of the military (such as courses offered by the American College of Healthcare Executives).

Mentoring. There was widespread agreement across the services that mentoring was important for leader development, and almost all respondents described personal experiences with mentoring or being mentored. Mentor relationships were initiated from either the top or the bottom. While some leaders noted that their service had a formal mentoring system, almost all described informal mentoring and tended to believe that it was more effective than formal mentoring programs.

How to Incentivize. Several respondents described how leaders were motivated to participate in certain “development opportunities” because they greatly affect promotion and command opportunities (for example, the advanced professional military education courses). Others related their own decision to seek education and assignments to promotion incentives. Several respondents mentioned that retention was an important constraining factor in the ability to identify, grow, and mentor high-potentials and that the military needed to look at ways to retain good people. In particular, some respondents mentioned that two-year assignments were short and disruptive to families and acted as a disincentive to retention.

Lessons Learned from Civilian Health Care Organizations and the VHA Regarding Leader Development

Our interviews with leaders in civilian health care organizations and the VHA mirrored research findings about best practices in leader development and also provided some additional insights. Next, we highlight some practices that leaders in these organizations believed were important or effective.

Context, Organizational Environment, and Organizational Leader Expectations.

Two major themes emerged in this area. One was the importance of supporting leadership development at the highest level and the belief that “investing in leadership is as or more important than other investments and priorities.” This includes investing in infrastructure resources and making a commitment to managing the process of identifying potential leaders. A second was the need to develop a “living” competency model that is linked to organizational goals and strategic improvement plans—a model that drives the organization’s approach to leader development. In these organizations, the leader’s competencies were infused throughout the leader development process, guiding recruitment and selection, assessment of needs for professional and management development, development of programs, and evaluation.

Approach to Leader Development. Most organizations adopted purposeful approaches that were clearly aligned with the strategic and business goals of the organization.

How to Select. In addition to succession planning, respondents reported that their organizations were thoughtful and deliberate in their recruiting, interviewing, and hiring processes for executives. Several respondents reported using behavioral interview questions to identify individuals who possessed the competencies and behaviors they sought, while others mentioned specific screening techniques to assess individuals' values. The U.S. Department of Veterans Affairs uses performance-based interviewing extensively as a selection and assessment tool. Some civilian and VHA respondents mentioned that it was important to develop not only people with high potential but also "solid performers" because they are the "bread and butter" of the organization and also need opportunities for growth.

Several respondents considered diversity issues when deciding whom to target. One organization felt strongly that it needed to be proactive to better ensure that the hospital staff reflected the community. Respondents from civilian organizations described diversity strategies aimed at ensuring that more women and minorities were promoted to senior roles, which involved working to develop these candidates at less senior levels.

How to Develop. Respondents mentioned that their leader development programs went beyond the traditional classroom format to include some or all of the following: stretch assignments or details to leader positions, short-term projects overseen by preceptors, 360-degree or other rigorous types of assessment and feedback, mentoring or coaching, personal development plans, and structured reflection. Promising specific strategies included the following:

- job assignments
- coaching or mentoring
- cross-functional and team development
- 360-degree feedback.

Respondents also stressed the need to evaluate these strategies on a regular basis and to revise or adapt them as needed to improve their effectiveness.

How to Incentivize. Respondents from both civilian organizations in our sample and the VHA reported involving top executives in some form of annual performance-based evaluation. These processes tend to emphasize evaluation based on measurable metrics that are tied to broader organizational goals as well as to individual ones, and they generally link to incentive or compensation plans based on weighted formulas. Some organizations seem to focus exclusively on outcomes and measurable objectives. While most systems evaluate what leaders accomplish over the year, some also assess how they have accomplished their goals. The "how" tends to be guided by leadership competencies and was described by some as the "non-measurables," such as how an individual develops others, handles HR issues, and demonstrates organizational stewardship, among other things. A handful of respondents noted the importance of non-

pecuniary rewards and recognition for leaders and emerging leaders. These approaches could include providing a special title or project to individuals with demonstrated talent or accomplishments.

Recommendations

Overall, the majority of our military respondents believed, with some caveats, that the services do a good job of preparing their military health care leaders for executive positions in the MHS by using a multipronged approach that includes job assignments, education and training, informal mentoring, and annual reviews. Their comments, along with those of our civilian and VHA respondents, suggest possible avenues for change and improvement. To distill lessons learned about effective ways to develop leaders for executive positions, we returned to the MHS's stated goal—to prepare health care leaders to succeed in joint, performance-based environments—and its desire to adopt a new paradigm for changing the way “we think and act,” in particular to move to jointly staffed facilities, performance-based management, and total force and team development. We then looked for recommendations that would help transform leader development to meet the MHS's strategic goals.

Organizational Leader Expectations

- Reexamine the JMESP competency model to ensure that it meets the MHS's strategic goals, and infuse the competencies throughout the leader development process.
- Emphasize the importance of soft skills along with the hard skills in selection and evaluation.

How to Select

- Consider using performance-based interviews to recruit and evaluate officers for executive-level positions.
- Improve diversity among those selected for leader development opportunities.
- Implement a policy of “best in show” rather than “best in breed.” In doing so, examine the health corps structure to ensure that all corps have equitable access to leadership opportunities.

How to Develop

- Reexamine the overall approach to leader development to determine whether it is feasible to provide shorter-term projects or stretch assignments to high-potentials.

- Provide physicians with leader development opportunities along with business and management skills earlier in their careers.
- Encourage the use of 360-degree feedback, and make it an integrated part of leader development.
- Examine ways of providing and validating shorter-term and more tailored joint training and education opportunities for health professions officers.
- Recognize the importance of mentoring in evaluations, and consider providing formal training in mentoring and coaching.
- Evaluate leader development programs for currency and relevancy.

How to Incentivize

- Consider a separate evaluation process or form for health professions officers that integrates the competencies that the military considers important. At the same time, consider ways to reduce subjectivity and inflation in evaluations.
- Examine ways of implementing three-year assignments for health professions officers.

We recognize that many of these approaches will require structural changes and may be difficult to implement. In addition, some may require difficult trade-offs. For example, selecting physicians for early leader development opportunities requires selecting fewer of them and necessarily narrowing the pipeline. This may result in overlooking some officers who have the potential to be effective leaders but who may not have the opportunity to distinguish themselves early in their careers. Going to three-year assignments has the same potential downside. Emphasizing joint education and training may mean reducing emphasis on other necessary management or leadership skills and training. Nonetheless, the recommendations here provide a useful starting point for discussion of how best to align leader development of health professions officers with the MHS's vision for transformation.