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STRATEGY RESEARCH PROJECT

ROLE PERCEPTIONS OF ARMY HEALTHCARE ADMINISTRATORS: STRATEGIC IMPLICATIONS FOR LEADER DEVELOPMENT

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ABSTRACT

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TITLE: Role Perceptions of Army Healthcare Administrators: Strategic Implications for Leader Development

FORMAT: Strategy Research Project

DATE: 1 March 1997 Pages: 41 CLASSIFICATION: Unclassified

By title, the U.S. Army healthcare administrator is caught in an apparent multiplicity of diverse role requirements. These wide-ranging duties are the product of his or her being, at the same time, a member of the military and a healthcare administrator. As an Army officer the administrator is held responsible for the combat readiness of self, subordinates, and organization. As an administrator this individual is held responsible for the facility's adherence to the many military regulations and civilian laws and accreditation rules governing the peacetime administration of military health care. Surprisingly, despite this diversity, this study of "Role Perceptions of Army Healthcare Administrators" demonstrates a consistent and clear-cut description of duties, strengths, and areas needing improvement. The study also makes recommendations for leader development of Army healthcare executives.

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By title, the U.S. Army healthcare administrator is caught in an apparent contradiction of diverse role requirements. These wide-ranging duties are the product of his or her being, at the same time, a member of the military and a healthcare administrator. As an Army officer the administrator is held responsible for the combat readiness of self, subordinates, and organization. As an administrator this individual is held responsible for the facility's adherence to the many military regulations and civilian laws and accreditation rules governing the peacetime administration of military health care. Despite this diversity, however, the "Role Perceptions of Army Healthcare Administrators" demonstrates a clear-cut description of duties, strengths, and areas needing improvement. This study also illustrates that the Army healthcare administrator's role is changing over time.

The reader of this Strategy Research Project should be aware that the survey results which follow apply research that has been ongoing for nine years. The empirical results from that research are presented here with a strategic look at the perceptions of

Army healthcare administrators. Recommendations are then made to improve senior leader development of healthcare administrators.

BACKGROUND

ARMY HEALTHCARE ADMINISTRATORS

The basis of this study was a review of the relevant literature. Additionally, interviews were conducted with senior Army Medical Department (AMEDD) officers who are practicing healthcare executives, or are otherwise involved in the development, placement, or review of healthcare administrators. These reviews found that there is no empirical research into the roles of the Army healthcare administrator or executive. What writings can be found are sparse, anecdotal, and without continuity.

The first discussion of the Army administrator's role is found in Woodward's text of 1862. As the Assistant Surgeon General of the U.S. Army, he wrote on the many roles of the hospital steward. Among the duties he outlined were the administration of patient medical records, control of medical supplies, maintenance of the hospital's physical plant, and establishment of cost-containment programs.[1] An examination of the recent literature demonstrates that many of the roles

outlined by Woodward are found, though more fully developed and complex, in today's military healthcare administration environment.

Foxx, for example, was a psychologist appointed as temporary stand-in for the vacated position of Director, Administrative Services of a Navy hospital. He describes that his initial understanding of the military healthcare administator's main duty was to receive, read, and route correspondence. He discovered, though, that his actual healthcare duties included such roles as decision maker, resource allocator, communicator, monitor, planner, and liaison officer.[2]

Similar findings are described by Ginn and Thompson. They describe the training of physicians in certain healthcare administration skill areas.[3] The basis for their training program was to expose physicians to the duties of the administrator in order to enhance interpersonal functioning within a specific type of setting, the Army health care facility.

An examination of the areas they recommend for training young Army physicians reveals certain roles they describe as belonging under the control of the administrator. These include fiscal management, personnel management, disturbance handling,

monitoring, leading, and acting as a liaison officer. The liaison role is also addressed by Baldwin, among others.

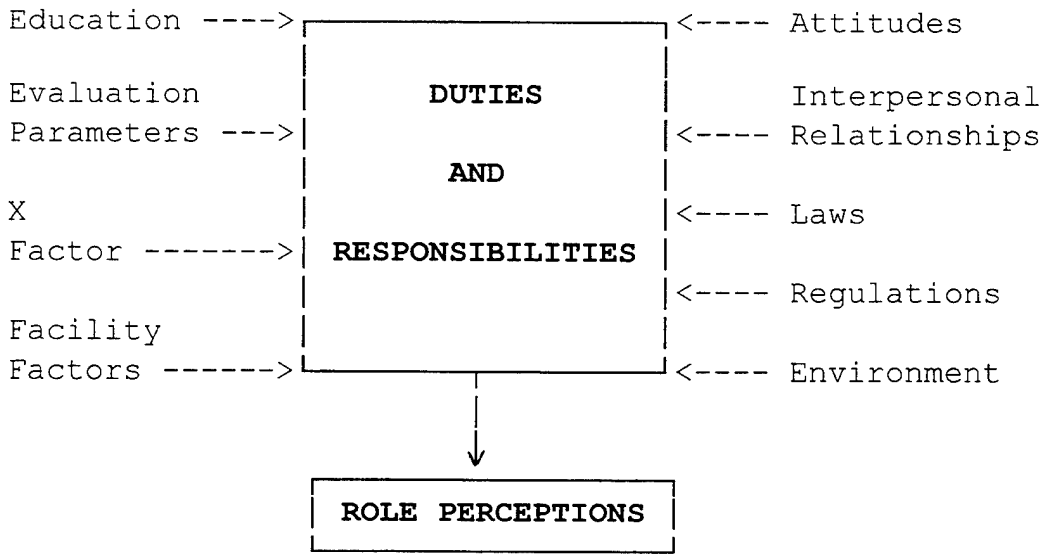
Baldwin's research determined that the administrator's role as a liaison was central to the present success and future viability of military healthcare administration. He also wrote that the military healthcare administrator of the future would need the ability to respond to duties requiring skill as a resource allocator, planner, and negotiator.[4]

In addition to the administrative duties discussed above, the literature recognizes the Army administrator's unique role in the military readiness of the medical treatment facility. Baldwin points out that the primary mission of the Army healthcare system is readiness.[5] So does the current Surgeon General of the Army.[6] McMarlin, similarly, describes the peacetime need for proper mobilization training in order to prepare for the provision of combat health care.[7] Skill sets to ensure that this training is prepared and conducted, according to McMarlin's experience and interviews, include those of coordination and planning. She then places responsibility for needed coordination and planning on the administrative element of the health care facility.

This review of the literature, scarce and dated as it is, would indicate that a specific, identifiable set of roles for the Army healthcare administrator, based on duties and responsibilities, does exist. The first step in modeling these roles is to link inputs which impact on those duties and responsibilities (Figure 1 on the next page). The second step, describing an Army role-set, requires an understanding of the various models available. This is best accomplished by reviewing the general and healthcare-specific research originating in the civilian environment.

This use of civilian models is further justified by the growing awareness in the similarities of the roles required of the Army administrator and those of his or her civilian counterpart. In 1992 Thomas Dolan, President of the American College of Healthcare Executives (ACHE), outlined various military roles and noted that Army "experiences reflect what the civilian sector is now doing."[8] Four years later he wrote that "there is a myth in healthcare management that the military and the civilian healthcare sectors are markedly different, and that those who honed their skills in the armed forces are not prepared to manage healthcare in the civilian sector. My experience has taught me that this belief is untrue."[9]

Tyler also inferred a link when he found, in studies of administrators leaving military service, that military retirees landed civilian-sector jobs within seven months and that 67 percent found jobs in traditional healthcare fields.[10] The ACHE selection of Air Force Colonel William Head as the 1994-1995 Chairman of the College reinforces the link between military and civilian healthcare administrators.



The X-Factor is a cult term used by various elements of military, governmental, and special interest groups understood to mean the special nature, obligations, and dangers of military service

Figure 1. Inputs to Army Healthcare Administrator Duties and Responsibilities

CIVILIAN MANAGEMENT MODELS

Healthcare administration is a special application of the general field of management. In this regard it is appropriate to discuss one of the earliest treatments of the administrator's roles. This distinction goes to Henry Fayol and his general theory of management. Fayol defined five basic roles for the administrator.

These roles encompassed planning, organizing, commanding, coordinating, and controlling. It was the contention of Fayol, and his adherents, that these roles could be applied to situations of management as diverse as business, military, and religious organizations.[11] Fayol's description of roles remained basically unchanged until the introduction of Henry Mintzberg's managerial roles approach.

Mintzberg's work is founded on the observation that Fayol's does not accurately describe what a manager actually does.[12] Mintzberg's original research led him to define ten roles performed by the manager. Each of the ten roles, as shown in Figure 2, next page, were placed into a broader classification defined as interpersonal, informational, and decision roles.[13]

Mintzberg described three interpersonal roles. The figurehead role encompasses duties of a ceremonial nature. As

the responsible agent for a team, group, or organization, the administrator demonstrates the leader role. In order to communicate outside the group or organization, for which the leader role is performed, requires duties within the liaison role. Mintzberg's theory then states that accomplishing these interpersonal roles leads the administrator to fill three informational roles.

The informational roles consist first of the monitor role whereby the manager continually scans the environment to receive information.

MINTZBERG'S TEN MANAGERIAL ROLES

INTERPERSONAL	INFORMATIONAL	DECISION
FIGUREHEAD	MONITOR	ENTREPRENEUR
LIAISON	DISSEMINATOR	DISTURBANCE HANDLER
LEADER	SPOKESPERSON	RESOURCE ALLOCATOR
		NEGOTIATOR

Figure 2. Mintzberg's Ten Managerial Roles

The disseminator role is the mechanism for the manager to pass along information needed by subordinates. Serving as a spokesman, at the other extreme, is the mechanism for the administrator to pass along specifically targeted information to

persons external to the organization. Rounding out roles incumbent to the interpersonal and informational categories of management are those found in decision making.

Mintzberg's four decision roles describe the manger's responsibility to arrive at proper and realistic decisions. The entrepreneur role details the manager's need to look for new ways to adapt to the environment. As a disturbance handler the manager is responsible to react to unsettling pressure on his or her organization. The resource allocator role explains the duties of disbursing the organization's available personnel, time, money, and equipment in an effective manner. Finally, the negotiator role tends to consolidate the skills needed to arrive at a consensus decision with those persons having an impact on the organization's success.

Mintzberg, however, is not without his detractors. Koontz, O'Donnell, and Weihrich, for example, point out that the ten managerial roles described by Mintzberg are actually descriptive examples of the five elements of Fayol's general theory of management. Additionally, these three authors feel that Mintzberg based his work on too small of a sample (five chief executive officers) to allow a generalization of the global population of managers.[14] This may be true considering their

allegation that the ten roles fail to address issues such as strategic planning, organizational design, and personnel selection and appraisal.

The consistency with which this management model has been used over the past 23 years, however, allows us to use it as a point of departure.[15] In fact, Koontz, et al, do concede that an understanding of the work done by managers is a valuable and needed element of managerial study.[16] Whether as independent roles or as descriptors for roles, Mintzberg's list of ten serves as a useful departure and model for the study of civilian and, subsequently, Army healthcare administrators.

CIVILIAN HEALTHCARE ADMINISTRATORS

The Koontz, et al, concession serves as a starting point for a study of recent writings describing the role of the civilian healthcare administrator. The review which follows below will then be the basis for studying roles self-identified by Army administrators. This crossover from civilian to Army roles is possible if one agrees with the thesis of Dolan and Tyler in their respective articles cited on pages five and six. Additionally, Schultz and Johnson write that "there is no one best role for all hospitals; [management models for healthcare

administrators] will vary according to a number of internal and environmental characteristics such as size and control of hospital, or whether it is teaching or non-teaching, [or whether it is military or civilian]."[17]

One classification of roles is presented by Kleiner in his anecdotal report of a study of 42 hospital directors. Among the duties he describes for the hospital director are planner, resource manager, liaison, and coordinator. The specific roles used by any one director, he says, is mainly a factor of corporate structure.[18]

Two other offerings from the early 1980s come from Schultz and Johnson's book Management of Hospitals and an article by Weil and Wesbury. Schultz and Johnson suggested that administrators serve in one of four roles: business manager, coordinator, corporate chief, or management team leader.[19] Although presented as separate roles, their examination of each contains many of the descriptors previously mentioned from the general and healthcare specific literature. Weil and Wesbury detail an American College of Healthcare Administrators (now ACHE) study. In this report the authors describe roles such as decision maker, resource manager, spokesman, entrepreneur, liaison, and monitor.[20]

More recently, Wallace describes nine administrator duties which can be matched to the roles previously outlined in Mintzberg and others.[21] And John Griffith's award winning The Well-Managed Community Hospital allows for this relationship in the book's "Functions of the Executive Office" section.[22] Finally, in an expansive look at Catholic healthcare executives, the Catholic Health Association studied key competencies of its healthcare executives. The study found that healthcare competencies fell within four groupings or clusters. Two of these, the Professional Expertise and the Integration and Action clusters, can be aligned with, and amplify, many of the roles described in the earlier literature.[23]

It is apparent from the preceding review that a researcher may adequately classify the many roles of the healthcare administrator as long as a supportable set of role descriptors is used. This has been well demonstrated over the past three decades using Mintzberg's ten roles, as done by Johnson, et al, in 1977,[24] Dwore and Murray in 1987,[25] and Roemer in 1996.[26]

Dwore and Murray studied hospital leaders in Utah applying Mintzberg's roles in an environment of change, cost consciousness, and competition. This world of change is not unlike that currently found in the Military Health Services

System, as described by Lanier and Boone.[27] And, as confirmed by Rohrbough and Torsch, "Health care reform legislation may have died in the 103rd Congress, but the Department of Defense (DoD) is continuing to reform the way health care is delivered...."[28]

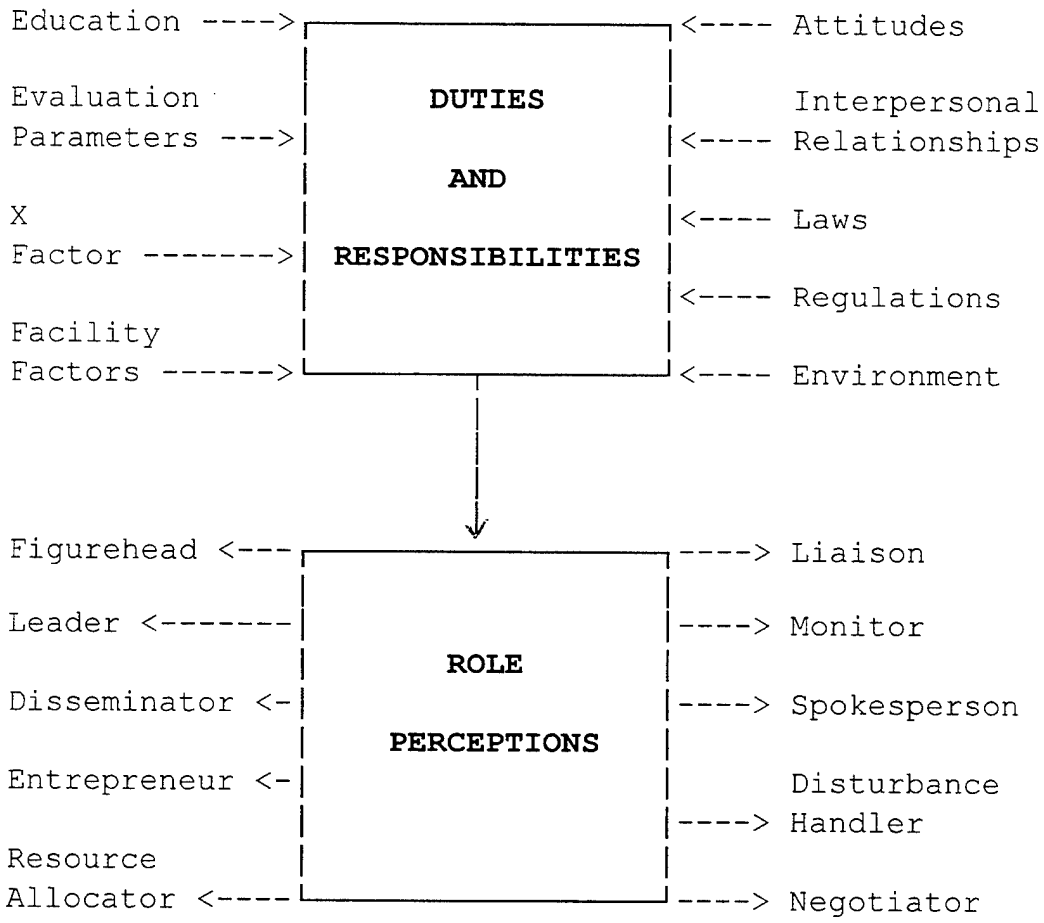
The Dwore / Murray instrument asked ten questions relating to the perceived role of the hospital administrator completing the survey. Their purpose was to "describe selected characteristics of hospital leaders in Utah" in order to "formulate a descriptive profile of Utah hospital leaders."[29]

In similar fashion, the survey discussed below, and remainder of this study, is designed to gain a better understanding of the perceived roles of Army hospital administrators. These perceptions will be determined in line with the Mintzberg model as it is applied to Army healthcare administrators and their roles. An Army specific model is suggested as shown in Figure 3, on page 14.

SURVEY METHODS

The survey questions used to determine role perceptions of Army administrators were the ones developed and used by Dwore and Murray.[30] This was done for two reasons. First, the use of an accepted instrument minimizes questions or errors raised by

validity and reliability issues. Second, the use of Dwore's questions allows for the comparison of two distinct groups of hospital administrators. This, in turn, expands the useable body of knowledge on this subject by including an additional, yet different, group to those studied by Mintzbeg and others.



The X-Factor is a cult term used by various elements of military, governmental, and special interest groups understood to mean the special nature, obligations, and dangers of military service

Figure 3. Army Healthcare Administrator Role Perceptions

To further evaluate the instrument's validity it was shared with ten senior AMEDD administrators. These seasoned officers were chosen based on their background, experience, and ability to offer a reasoned analysis of the tool.[31] Of the comments offered, three may be of some concern to the reader. One respondent stated that the choices required "tough decisions" on her part. Another remarked that he was "fascinated with the fine line between role descriptors." Yet another was not sure he agreed with the set of role descriptors (Mintzberg's) chosen by the author. These are useful comments but are not such as to invalidate the instrument for this study.

The survey was sent to each Army Medical Service Corps hospital administrator (titled Deputy Commander for Administration or Chief of Staff) in Army hospitals located in the continental United States, Alaska, and Hawaii. A longitudinal evaluation is possible as the survey has been administered bi-annually for the past nine years ('88-'96). In each instance the return has been greater than 90% based on no more than two mailings.

The survey was only ten questions in length. Each of the questions was worded so that Mintzberg's ten role descriptors were applicable based on the respondent's view of his or her

roles at the time. Only one best answer was to be given for each question. Additionally, the respondant was provided and abbreviated explanation for each role, as shown in Figure 4.

Figurehead	Representative ceremonial duties
Liaison	Developer of outside contacts/networks for information & favors
Leader	Aligns the needs of subordinates with those of the hospital
Disseminator	Shares outside information with subordinates
Spokesperson	Informs outsiders concerning hospital matters
Monitor	Sift information to maintain hospital awareness
Entrepreneur	Initiates changes to solve problems and create opportunities
Disturbance Handler	Deals with problems and crises
Resource Allocator	Establishes priorities & determines who gets what
Negotiator	Brings information & authority to negotiate with other parties

Figure 4. Explanation of Mintzberg's Ten Roles

SUMMARY OF RESULTS

The rate of return for all five surveys, over a nine year period, has been excellent, ranging from 100% with one mailing to 90% with two mailings. Personal discussions with the respondents over the years echo a common theme, as best described on the back of a '96 survey. This comment, by a new Deputy Commander for Administration, allowed that it was "very difficult to make a decision on which letter to put in each box...[but] thanks for the opportunity to participate."[32]

The results, as described in detail following, show the Army healthcare executives as seeing themselves as leaders who understand that the role most critical to their survival was that of resource allocator, though recently it has evolved to entrepreneur. The entrepreneur role is also identified as the one most needing improvements.

The survey findings also show that the formal, career-long education and training of Army healthcare administrators has best provided resource allocation and leadership skills. Resource allocation skills are the result of graduate progams which offer a strong foundation in financial management. Most Army hospital-based healthcare administrators received a masters degree from the U.S. Army / Baylor University Graduate Program in Healthcare

Administration, which has such a focus.[33] Leadership skills are the result of a career of formalized military leadership training. Most survey respondants have received regular military-specified leadership training.

Finally, trends over a nine-year period are clearly discernible, with a trend toward being an entrepreneur while deriving less enjoyment from that specific role.

ARMY RESULTS, '88 COMPARED TO '96

The Army's healthcare administrators of 1996 are survivors. Between 1988 and 1996 these executives' entire professional world has changed. America has gone to war, dramatically reduced the size of its military, and embraced (with a wide variety of ways, means, and ends) the need for health care reform. All this has taken a toll on the Army administrator. Those that remain have avoided annual boards designed to downsize senior leaders through early retirement and have chosen not to accept numerous and lucrative offers to join civilian contractors working health care reform with the military.

At the same time, the military began a number of health reform initiatives which have culminated in TRICARE. This particular health reform initiative is Department of Defense wide

and will cause the military health service system to "change from the traditional [military] health care delivery system model with the acute care, inpatient facility being at the epicenter of the system."[34] Central to the TRICARE concept are civilian-military contracts, hard and fast budgets, and accountability for developing broader access to quality health care while controlling costs.

Survey results for 1996, compared to 1988, show the deep impact that nine years of turmoil has had on the healthcare administrator (survey results follow as figure 5, page 21). Most telling are the changes to both questions relating to role satisfaction. Entrepreneurship has dropped from the most satisfying role (44% of respondents) to second most satisfying (30%). The least satisfying role has become disturbance handler (37%), which was second in '88 at 14%. This 32% drop in entrepreneurship as the most satisfying role and concurrent 164% rise in disturbance handler as the least satisfying role is important. It clearly shows the impact of nine years of stress, turmoil, and chaos on Army healthcare administrators, and their organizations.

The impact of moving into the business of healthcare is also seen in responses to improvement and criticality questions. Many

more administrators report a need to improve skills related to being an entrepreneur and a negotiator (60% in '96) than did in '88 (42%). Also, 19% of '88 administrators saw entrepreneur as their most critical role whereas twice as many '96 respondents (37%) saw it as most critical. Finally, leadership skills have grown in importance with one in four now seeing it as their most important role. This is appropriate given the administrator's duty to lead his or her organization into a new military frontier of healthcare as a business.

Army healthcare administrators today are much more aware of the importance of being a capable entrepreneur with associated business skills. While resource allocation is still important, the ability to stay ahead of business opportunities, negotiate successfully when they are presented, and lead the organization through times of uncertainty and change (chaos) are also critical.

1. Which role do you perform best?

Army '88	%	Army '96	%
Leader	28	Leader	33
Entrepreneur	22	Entrepreneur	20
Resource Allocator	22	Negotiator	13
Other	25	Other	34

2. Which role would you most like to improve?

Army '88	%	Army '96	%
Entrepreneur	36	Entrepreneur	40
Liaison	22	Negotiator	20
Spokesperson	17	Leader	13
Other	25	Other	27

3. Which role is most critical to your survival as an administrator?

Army '88	%	Army '96	%
Resource Allocator	39	Entrepreneur	37
Disturbance Handler	25	Resource Allocator	30
Entrepreneur	19	Leader	23
Other	17	Other	10

4. Which role is least critical to your survival as an administrator?

Army '88	%	Army '96	%
Figurehead	75	Figurehead	83
Spokesperson	14	Liaison	6
Liaison	6	Monitor	6
Other	5	Other	5

5. Which role did your education best prepare you for?

Army '88	%	Army '96	%
Resource Allocator	36	Resource Allocator	30
Leader	28	Leader	23
Entrepreneur	19	Negotiator	17
Other	17	Other	30

Figure 5. Role Perceptions Comparing Army '88 and Army '96 Healthcare Administrators, Items 1-5 (continued next page)

6. Which role did your education least prepare you for?

Army '88	%	Army '96	%
Liaison	22	Liaison	20
Negotiator	19	Negotiator	20
Figurehead	14	Figurehead	20
Spokesperson	14	Other	40
Other	31		

7. In which role do you spend the most time?

Army '88	%	Army '96	%
Disturbance Handler	36	Disturbance Handler	33
Resource Allocator	31	Resource Allocator	23
Entrepreneur	8	Entrepreneur	13
Leader	8		
Negotiator	8		
Other	3	Other	31

8. In which role do you spend the least time?

Army '88	%	Army '96	%
Figurehead	58	Figurehead	50
Liaison	14	Spokesperson	20
Negotiator	11	Liaison	17
Other	14	Other	13

9. Which role brings you the most satisfaction?

Army '88	%	Army '96	%
Entrepreneur	44	Leader	63
Leader	42	Entrepreneur	30
Disturbance Handler	6		
Other	8	Other	7

10. Which role brings you the least satisfaction?

Army '88	%	Army '96	%
Figurehead	39	Disturbance Handler	37
Disturbance Handler	14	Figurehead	33
Negotiator	11	Monitor	17
Other	30	Other	13

Figure 5. Role Perceptions Comparing Army '88 and Army '96 Healthcare Administrators, Items 6-10

ARMY RESULTS, '88 THROUGH '96

The survey's longitudinal results are biannual over a nine-year period (survey results follow as figure 6, page 26). Several findings are possible when the surveys are examined in this manner. Specific determinations are made if the results are reviewed with an understanding of the Department of Defense and Army move to a healthcare system which is more accountable for dollars and delivery.

Question 3 (critical role) shows the continuous rise to prominence of the entrepreneur, from 19% of all respondents in '88 to 37% in '96. This can be correlated to the evolution in the military to treat healthcare from a business perspective, not as a renewable budget with an indemnity cost-share plan as an escape valve. The fact that the resource allocator role remains high in both position and response rate indicates that AMEDD administrators see themselves as a source of new business plans and, at the same time, the decision maker or arbitrator in resourcing decisions. This is an important issue as the Army develops curriculum decisions for its health administration graduate students.

Such a conclusion is further supported when the "most critical role" question is compared to the "education

preparedness" questions. The majority of Army healthcare administrators received their formal education ten or more years ago. Resource allocation was the critical skill, and received the focus in graduate programs, specifically the Army's primary source program: the U.S. Army / Baylor University Graduate Program in Healthcare Administration. Today's students, however, are getting a much greater exposure to the business aspects of healthcare. It is clear from the results that the entrepreneur role deserves an expanded focus in graduate and continuing education forums. Fortunately, the roles least supported by education are also the roles reported to be least critical to success and least time consuming.

Also of interest is the 32% drop of entrepreneur as the most satisfying role. It seems that this role was more personally rewarding when each executive was left to his or her own devices. Satisfaction is lower now that military healthcare is a system that holds leaders accountable for business decisions, entrepreneurship, and negotiation successes. Apparantly, current realities of being an entrepreneur are not as enjoyable as the heady days of doing one's own thing. The simultaneous 50% rise in the leader role may speak to the AMEDD administrator feeling more comfortable with a skill that has been formally developed

and routinely used since his or her earliest days as an Army officer. Today's administrator seems to be saying that there is more satisfaction in using a known and comfortable skill (leading the organization) than using new and unfamiliar skills such as negotiation and entrepreneurship. If so, a developed, system-wide program for continuing education, which will be addressed in this study's conclusions, becomes important.

Similar issues are raised when exploring the 164% increase, over the nine years, of disturbance handler as the least satisfying role. This demonstrates the administrator's rising frustration with having to deal with increasingly tough and complex problems and crises in an organization undergoing turmoil, downsizing, and dwindling resources. As suggested on these past two pages, the chaos of the past nine years has taken its toll on the Army healthcare administrator.

Over a nine-year period, the AMEDD administrators report their role descriptors fairly consistently. The steady rise or drop of particular roles, over time, shows that the population is feeling relatively the same pressures, successes, and frustrations. These findings allow for several conclusions and directed recommendations.

1. Which role do you perform best?

'88	Leader	28%	Entrepreneur, Resource Allocator 22%
'90	Leader	46	Entrepreneur 23
'92	Leader	43	Entrepreneur 26
'94	Leader	43	Entrepreneur 29
'96	Leader	33	Entrepreneur 20

2. Which role would you most like to improve?

'88	Entrepreneur	36%	Liaison 22%
'90	Entrepreneur	20	Liaison, Spokesperson 20
'92	Entrepreneur	26	Liaison 23
'94	Entrepreneur	29	Liaison, Leader 14
'96	Entrepreneur	40	Negotiator 20

3. Which role is most critical to your survival as an administrator?

'88	Resource Allocator	39%	Disturbance Handler 25%
'90	Resource Allocator	34	Entrepreneur, Leader, Disturbance 17
'92	Resource Allocator	29	Entrepreneur 29
'94	Entrepreneur	37	Resource Allocator 26
'96	Entrepreneur	37	Resource Allocator 30

4. Which role is least critical to your survival as an administrator?

'88	Figurehead	75%	Spokesperson 13%
'90	Figurehead	77	Spokesperson 9
'92	Figurehead	74	Monitor 14
'94	Figurehead	74	Disseminator, Spokesperson 6
'96	Figurehead	83	Liaison, Monitor 6

5. Which role did your education best prepare you for?

'88	Resource Allocator	36%	Leader 28%
'90	Resource A, Leader	37	Entrepreneur, Disturbance Handler 11
'92	Leader	35	Resource Allocator 32
'94	Resource Allocator	37	Leader 17
'96	Resource Allocator	30	Leader 23

Figure 6. Role Perceptions: Army Healthcare Administrators, 1988 - 1996, Items 1-5 (continued next page)

6. Which role did your education least prepare you for?

'88..	Liaison	22%	Negotiator 19%
'90..	Liaison	20	Negotiator, Entrepreneur 20
'92..	Negotiator	20	Liaison, Disturbance Handler 17
'94..	Figurehead	23	Liaison 20
'96..	Figurehead	20	Liaison, Negotiator 20

7. In which role do you spend the most time?

'88..	Disturbance Handler	36%	Resource Allocator 31%
'90..	Disturbance Handler	51	Resource Allocator 31
'92..	Disturbance Handler	32	Resource Allocator 21
'94..	Disturbance Handler	40	Entrepreneur 20
'96..	Disturbance Handler	33	Resource Allocator 23

8. In which role do you spend the least time?

'88..	Figurehead	58%	Liaison 14%
'90..	Figurehead	51	Liaison 20
'92..	Figurehead	47	Liaison, Spokesperson 18
'94..	Figurehead	57	Liaison 11
'96..	Figurehead	50	Spokesperson 20

9. Which role brings you the most satisfaction?

'88..	Entrepreneur	44%	Leader 42%
'90..	Entrepreneur	43	Leader 34
'92..	Entrepreneur	43	Leader 37
'94..	Leader	40	Entrepreneur 37
'96..	Leader	63	Entrepreneur 30

10. Which role brings you the least satisfaction?

'88..	Figurehead	39	Disturbance Handler 14%
'90..	Figurehead	34	Disturbance Handler 31
'92..	Figurehead	37	Disturbance Handler 29
'94..	Disturbance Handler	34	Figurehead 29
'96..	Disturbance Handler	37	Figurehead 33

Figure 6. Role Perceptions: Army Healthcare Administrators, 1988 - 1996, Items 6-10

CONCLUSIONS

This Strategic Research Project study takes advantage of an established theoretical model in order to describe "Role Perceptions of Army Healthcare Administrators." It describes the Army healthcare administrator as an individual who performs best as a leader while acknowledging that the most critical role has evolved from resource allocator to entrepreneur. Most of this executive's time is spent as a disturbance handler while, at the same time, the least satisfying role is as that same disturbance handler. Such results are critical in understanding the operational framework of Army healthcare administrators.

From this understanding suggestions can be offered that focus on the development and utilization of Army healthcare administrators. Such suggestions, as derived from this study, will be useful to the Office of The Army Surgeon General, the Director of the U.S. Army / Baylor University Graduate Program in Healthcare Administration, and the incumbent healthcare administrators themselves.

The Army Surgeon General is responsible for the leader development plan of the Army Medical Department. This plan describes how leaders, to include healthcare administrators, are best prepared for their duties. An element of this requirement

is oversight into continuing education and training of healthcare administrators. The results of this study will be presented to the Office of The Surgeon General for use in ensuring education and training is appropriate and properly programmed at the corporate level of the Army Medical Department.

Specific recommendations to The Surgeon General include:

* Develop continuing education that focuses on chaos and change, and their impact on the organization's senior leader(s). Such training will provide a basis from which these leaders can forecast, plan for, and respond to rapid change and chaos in the healthcare and military environments.

* Provide continuing education related to healthcare business skills. This will benefit today's leaders who's formal education was in an era, not long ago, of allocating relatively unlimited resources. This recommendation specifically addresses the longitudinal survey results which show that executive skills needed in today's healthcare environment are changing.

The primary source of masters degreed healthcare executives in the military is the U.S. Army / Baylor University Graduate Program in Healthcare Administration. The Director of the Program is responsible for its curriculum development and execution. The results of this study will be presented to the

Director for use in evaluating and maintaining the currency of the curriculum, and preparation of the students.

The author acknowledges that educators must look to the future to ensure appropriate curriculum adequacy. Suggestions can be offered, however, to the extent that these retrospective survey results have some bearing on future education needs. In other words: the recent past is a window (albeit murky at times) to the needs of the future.

In particular, the surveys' results lead to recommendations for a review of the Program's curriculum to ensure:

* An appropriate focus is placed on the entrepreneur role which is claimed to be the most critical and the role the administrators would most like to improve.

* That the competencies for which there was least academic preparation are appropriate. The review should determine if additional emphasis is required. These skills would specifically include the negotiator and liaison roles.

The military suffers from continuous turnover of senior healthcare executives (Army Deputy Commander for Administration tenure is about two years).[35] The results of this study will continue to be shared with all sitting Army hospital chief executive officers to provide immediate feedback.

Hospital administrators are urged to:

to validate their individual responses and better appreciate what their cohorts are experiencing and feeling. If nothing else, there seems to be an opportunity for comfort in numbers, when the numbers match.

* Present the results to their replacements as a method to facilitate the transition process. A discussion of population and hospital-specific results will serve to facilitate a rapid learning curve for the new administrator. It would seem that this is particularly true for the first-time administrator.

CONTINUING STUDY

This study will continue biannually within the Army, continental United States, hospital community.

Another continuing study on this topic should include a current survey of civilian healthcare executives to detect the status of their role perceptions. This is particularly important given an environment evolving to various models of managed care, wellness, and partnerships. The results could then be viewed against the current views of Army executives for a contemporary comparison.

The basis for this relationship is a comparison of the 1988 Dwore and Murray study with the 1988 Army-only study. A clear-cut resemblance between Army healthcare executives and their Utah-based civilian counterpart is shown. This is effective in establishing a baseline for comparison, though the 1996 relationship between Army and civilian administrators is not specifically addressed in this Strategic Research Project.

Questions from such an extended study would include: Is the move to a global military health service system important to the ongoing healthcare reform debate in America? Does the Army have lessons that are of substance to the civilian sector? Are the stresses and dissatisfactions seen in the '88 through '96 surveys to be expected if civilian healthcare moves to a global healthcare system? And, are there broad, profession-wide continuing education issues from the Army lessons and the Army-Utah survey comparisons?

If nothing else, knowledge that military executives share many of the same concerns as their civilian contemporaries should spur the military officer to more aggressively seek and develop relationships in the local civilian healthcare community. These relationships will include both business-related and professional interactions. The payback is both immediate and long-term.

Immediate, as today's problems are discussed and brainstormed. Long-term, as tomorrow's networking relationships are built.

A final, although certainly not least, benefit of this study is built upon civilian acceptance of Army-civilian similarities in healthcare roles. This acceptance underscores the usefulness of an exchange of workplace concepts and innovations in order to succeed in an ever changing healthcare environment. In the long run, a strong military-civilian health service relationship is beneficial to the provision of healthcare to the entire community.

ENDNOTES

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